



## Situation Analysis of Children in the Marshall Islands



TRANSFORMER

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# Executive Summary

## Introduction

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

RMI is located in the Micronesian region of the Pacific, and is made up of around 1,200 islands, islets and atolls, with a total land mass of 180 km<sup>2</sup>. The islands are grouped into two chains: the eastern group, Ratak, and the western group, Ralik. RMI had a population of 53,158, as of 2011, with around 40 per cent of the population below the age of 15 years. More than half of RMI's total population live in the capital of Majuro. Only 26 per cent of the population live in rural areas. RMI is highly vulnerable to coastal flooding and is prone to seasonal cyclones and droughts.

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

## Key barriers and bottlenecks

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

**Climate change and disaster risks:** RMI is affected by a range of climate and disaster risks, including rising sea levels, desertification, pollution from ships, coral reef erosion and typhoons. A key finding of this report is that climate change and disaster risks have a considerable impact on all sectors in relation to the realisation of children and women's rights.

**Financial and human resources:** RMI relies heavily on external development aid and the support of the US Government provided through the Compact of Free Association. Though the economy has shown annual growth rates between 0.6 per cent to 1.5 per cent in recent years, RMI still suffers from a lack of resources across government departments for the delivery of services for children. The lack of financial resources translates into a lack of appropriate equipment and adequately trained professionals, particularly in the health and WASH sectors, but also in justice and child protection.

The **geography** of RMI creates significant barriers to the realisation of children's and women's rights due to remoteness and transportation constraints. Children and women living in rural areas generally experience worse outcomes and access to basic services than those in urban areas.





**The impacts of poverty** are significant in RMI, and children and families are highly exposed to risk and economic shocks. The 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. The lack of opportunities, particularly for young people, perpetuate cycles of poverty.

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

**Data availability:** There are useful data sources in some sectors for RMI. However, this report has identified several data gaps, and the absence of this data is, in itself, a key finding. There are no up-to-date estimates of child stunting and wasting rates. 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 there is limited data on the disparities between different population groups, such as gender disparities, and disparities between urban and rural areas.

## Snapshot of outcome areas

<p><b>Health</b></p>	<p>Child mortality rates in RMI have been declining over the last few decades. However, RMI has not yet met international child mortality reduction targets, and it has amongst the highest child mortality rates of the PICTs. Immunization coverage for vaccine-preventable diseases remains low, with only 4 out of 12 recommended vaccines reaching coverage rates above 90 per cent. Immunization coverage is particularly low in rural areas. Male babies are more likely to have higher vaccination coverage than female babies. RMI has the second-highest TB prevalence in the whole Pacific region. The unadjusted maternal mortality ratio stands at 110 deaths per 100,000 live births, which is still significantly above the SDG target. Coverage rates for ante- and post-natal health care in RMI are adequate, with some room for improvement: 80 per cent of pregnant women have at least one ante-natal visit, and 90 per cent give birth in the presence of a skilled health attendant. Contraceptive prevalence is at 45 per cent – the third-highest rate in the PICTs region. Even though RMI has reported a relatively low number of HIV infections, it records the fourth highest prevalence rate of sexually transmitted infections (amongst pregnant women) in the PICTs region, indicating that the underlying behavioural risks for HIV transmission are high.</p>
<p><b>Nutrition</b></p>	<p>Information on childhood wasting and stunting is not available, which represents a significant data gap. Anaemia rates are high amongst pregnant women (38 per cent) and pre-school children (33 per cent). Low birth weight prevalence stands at 18 per cent: the second-highest prevalence rate in the PICTs group. Obesity and associated non-communicable diseases are a significant public health concern for the adult population, especially women. Up-to-date data on obesity amongst children are not available. At 31 per cent, exclusive breastfeeding prevalence in RMI is the lowest of the whole PICTs group.</p>
<p><b>WASH</b></p>	<p>RMI has achieved a steady increase in improved water coverage since the early 1990s, and coverage currently stands at a near-universal 95 per cent. However, only a very small proportion of households have water piped directly into their premises (3 per cent). Major gaps remain in relation to improved sanitation coverage (currently at 77 per cent), particularly in rural areas. Seven per cent of the population still practice open defecation (one of the highest rates in the region), and 38 per cent of households dispose of children’s faeces in an unhygienic manner.</p>



<p><b>Education</b></p>	<p>Heavy reliance on donor funding and difficulties associated with providing educational services on remote islands represent key challenges for the education sector. A decline in female enrolment rates at both primary and secondary school levels, and a growing drop-out rate for both sexes are also areas of concern. The net enrolment ratio (NER) in early childhood education is 59 per cent (2012-2013 figures). The NER was 79 per cent for primary education and 45 per cent in secondary education, as of 2016.</p>
<p><b>Child protection</b></p>	<p>Corporal punishment is widespread in RMI, with 12 per cent of children being physically punished once per week. Commercial sexual exploitation of girls in RMI is linked to foreign shipping vessels that dock in Majuro, with reports of some Marshallese children being transported to the US and subjected to sexual abuse. The legal framework for child protection in RMI was recently updated and has very few gaps.</p>
<p><b>Social protection</b></p>	<p>Up-to-date data on poverty rates are lacking for RMI. However, estimates suggest that up to 20 per cent of the population are unable to afford basic needs, with trends pointing to an increase in poverty. Data suggest that poverty particularly affects households in rural areas. A recent assessment of the social protection system ranks it as the second-highest within the PICTs group in terms of comprehensiveness and impact. However, social protection is limited to (mostly male) formal sector workers, and excludes the majority of workers in the informal economy (many of whom are female), and is therefore not targeted at the poorest members of society.</p>

# Acronyms

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ART</b>	Antiretroviral Therapy
<b>CDD</b>	Community Development Division
<b>CEDAW</b>	Convention on the Elimination of Discrimination Against Women
<b>CEFM</b>	Child and Early Forced Marriage
<b>CESCR</b>	Committee on Economic, Social and Cultural Rights
<b>CMI</b>	College of the Marshall Islands
<b>CPiE</b>	Child Protection in Emergencies
<b>CRC</b>	Convention on the Rights of the Child
<b>CRPD</b>	Convention on the Rights of Persons with Disabilities
<b>DHS</b>	Demographic and Health Survey
<b>EAPRO</b>	East Asia and Pacific Regional Office
<b>ECE</b>	Early Childhood Education
<b>EFA</b>	Education for All
<b>FAO</b>	Food and Agriculture Organization of the United Nations
<b>FHS</b>	Family Health and Safety
<b>GADRRRES</b>	Global Alliance for Disaster Risk Reduction and Resilience in the Education Sector
<b>GDP</b>	Gross Domestic Product
<b>GER</b>	Gross Enrolment Rate
<b>GSHS</b>	Global School-based Health Survey
<b>HIV</b>	Human Immunodeficiency Virus
<b>ICESCR</b>	International Covenant on Economic, Social and Cultural Rights
<b>ICT</b>	Information and Communications Technology
<b>JMP</b>	WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene
<b>MDG</b>	Millennium Development Goal
<b>MHM</b>	Menstrual Hygiene Management
<b>MIDPO</b>	Marshall Islands Disabled Persons Organization
<b>MISAT</b>	Marshall Islands Standards Achievement Test
<b>MMR</b>	Maternal Mortality Ratio
<b>MoE</b>	Ministry of Education
<b>MOH</b>	Ministry of Health
<b>MWSC</b>	Majuro Water and Sewage Company
<b>NCD</b>	Non-Communicable Disease
<b>NER</b>	Net Enrolment Rate
<b>NGO</b>	Non-governmental Organization
<b>NMDI</b>	National Millennium Development Indicator
<b>ODA</b>	Official Development Assistance
<b>PICTs</b>	The 14 Pacific Island Countries and Territories that are the subject of the Situational Analyses

**PNG** Papua New Guinea  
**RMI** Republic of the Marshall Islands  
**SDG** Sustainable Development Goal  
**SitAn** Situational Analysis  
**SOWC** State of the World's Children  
**SOPAC** South Pacific Applied Geoscience Commission  
**SP** Strategic Programme  
**SPC** Pacific Community  
**SPI** Social Protection Indicator  
**STI** Sexually Transmitted Infection  
**TB** Tuberculosis  
**TVET** Technical Vocational Education and skills Training  
**U5MR** Under-five child Mortality Rate  
**UN** United Nations  
**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  
**UNOCHA** UN Office for the Coordination of Humanitarian Affairs  
**UPR** Universal Periodic Review  
**US** United States  
**USA** United States of America  
**US\$** United States Dollar  
**VAWG** Violence Against Women and Girls  
**WASH** Water, Sanitation and Hygiene  
**WHO** World Health Organization  
**WUTMI** Women United Together Marshall Islands



# 1.

## Introduction

### 1.1. Purpose and scope

This report aims to present a comprehensive assessment and analysis of the situation of children in the Republic of the Marshall Islands (RMI). It intends to present an evidence base to inform decision-making across sectors that are relevant to children and instrumental in ensuring the protection and realisation of children's rights. It particularly intends 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 the UNICEF Procedural Manual on 'Conducting a Situational Analysis of Children's and Women's Rights' ('UNICEF SitAn Procedural Manual'), the specific aims of this Situation Analysis (SitAn) are:

- 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 in 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.

- 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.<sup>1</sup>

This SitAn report focuses on the situation of children (persons aged under 18 years old), adolescents (aged 10 to 19) and youth (aged 15 to 24).<sup>2</sup> An assessment and analysis of the situation relating to women is included, to the extent that it relates to outcomes for children (for example, 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 the UNICEF SitAn Procedural Manual. A rights-based approach was adopted for conceptualising **child outcomes**, which are presented in this SitAn according to rights categories contained in the UN Convention on the Rights of the Child (CRC). These categories also correspond to UNICEF Strategic Programme (SP) Outcome Areas. Child outcomes are therefore grouped into: Health/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 is to identify trends and patterns in the realisation of children's rights and key international development targets, and any gaps, shortfalls or inequities in the realisation of these rights and targets. The assessment employed an equity approach, and highlighted trends and patterns in outcomes for groups of children, identifying and assessing disparities in outcomes according to key identity characteristics and background circumstances (e.g. gender, geographic location, socio-economic status, age, and disability).

A number of analytical techniques were employed to **analyse** immediate, underlying and structural causes of child outcomes, including:

- **Bottlenecks and barriers analysis:** a structured analysis of the bottlenecks and barriers that children and groups of children face in the realisation of their rights, with reference to the critical conditions and determinants<sup>3</sup> (quality; demand; supply and enabling environment) needed to realise equitable outcomes for children).

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1 UNICEF, March 2011. *Guidance on Conducting a Situation Analysis of Children's and Women's Rights*. pp. 5-6 retrieved from: <http://www.unicef-emergencies.com/downloads/eresource/docs/Rights%20based%20equity%20focused%20Situation%20Analysis%20guidance.pdf> [30.01.17].

2 These are the age brackets used by UN bodies and agencies 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 UNICEF SitAn Procedural Manual Table 3, page 20.

The analysis is also informed by:

- **Role-pattern analysis:** the identification of stakeholders responsible for and best placed to address any shortfalls and inequities in child rights outcomes.
- **Capacity analysis** to understand the capacity constraints (e.g. knowledge; information; skills; will and motivation; authority; financial or material resources) on stakeholders who are responsible for and best placed to address the shortfalls and inequities.

The analysis did not engage in a comprehensive causality analysis, but immediate and underlying causes of trends, shortfalls and 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 that suffer the worst deprivations in society, have access to the resources and services necessary for their survival, growth and development.<sup>4</sup> 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 faced by children according to their gender.

A **risk-informed analysis** requires an analysis of disaster and climate risks (hazards; areas of exposure to the hazard; and vulnerabilities and capacities of stakeholders to reduce, mitigate and manage the impact of the hazard on the attainment of children’s rights). This is particularly relevant to the PICTs, which face climate change and other disaster risks. 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 (particularly the Sustainable Development Goals [SDGs]) in each of the child outcome areas (see Table 1.1).

**Table 1.1: Assessment and analysis framework by outcome area**

Outcome area	Assessment and analysis framework
<b>Health and nutrition</b>	<ul style="list-style-type: none"> <li>- CRC (particularly the rights to life, survival and development and to health)</li> <li>- SDGs (particularly SDG 3 on ensuring healthy lives and promoting well-being)</li> <li>- Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030)</li> <li>- WHO Global Nutrition Targets (child stunting; anaemia; low birthweight; obesity/overweight; and breastfeeding)</li> </ul>



<b>WASH</b>	<ul style="list-style-type: none"> <li>- CRC (Article 24)</li> <li>- SDGs (particularly SDG 6 on ensuring availability and sustainable management of water and sanitation for all)</li> </ul>
<b>Education</b>	<ul style="list-style-type: none"> <li>- CRC (Articles 28 and 29)</li> <li>- Article 13 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)</li> <li>- SDGs (particularly SDG 4 on ensuring inclusive and quality education for all and promoting lifelong learning)</li> <li>- Comprehensive School Safety Framework<sup>1</sup></li> </ul>
<b>Child protection</b>	<ul style="list-style-type: none"> <li>- CRC (Articles 8, 9, 19, 20, 28(2), 37, 39 and 40)</li> <li>- SDGs (particularly SDGs 5, 8, 11 and 16)</li> </ul>
<b>Social protection</b>	<ul style="list-style-type: none"> <li>- CRC (Articles 26 and 27)</li> <li>- ICESCR rights to social security (Article 9) and adequate standard of living (Article 11)</li> <li>- SDG target 1 (end poverty in all its forms everywhere)</li> </ul>

### 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.<sup>5</sup> Key datasets were compiled from the UNICEF Statistics database (available at: <https://data.unicef.org/>) and the Pacific Community (SPC) Minimum Development Indicators (NMDI) database (available at: <https://www.spc.int/nmdi/>).<sup>6</sup> The 2016 State of the World's Children (SOWC) report was utilised as the latest available UN-validated data (available at: <https://www.unicef.org/sowc2016/>). The SPC NMDI database also compiles data produced through national sources.<sup>7</sup> Other institutional databases such as from the World Bank, UNICEF/WHO Joint Monitoring Programme, WHO and the United Nations Educational, Scientific and Cultural Organization (UNESCO) Institute of Statistics were used where relevant.

The analytical techniques used for 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 covered by the analysis. Gaps in the availability of up-to-date, quality data are noted

5 These datasets were reviewed and verified by UNICEF.

6 Data from national sources and other reputable sources is compiled and checked for consistency before being registered in UNICEF Statistics database and used for the annual SOWC report.

7 The database is updated as new data becomes available.

throughout the report. The analysis of causes and determinants of rights shortfalls relied heavily on existing published reports, and therefore some areas in the analysis have not been the subject of robust and recent research. The gaps are highlighted as necessary.

A further limitation was the tight timeframe and limited duration according to which this SitAn has been produced. This required the authors to prioritise areas of focus and to exclude some matters from the analysis. This also led to limitations in the extent of, for example, the causality analysis (which is considered but does not include problem trees), and the role pattern and capacity gap analyses, which inspire the presentation of the information but have not necessarily been formally performed for all duty-bearers.

## **1.4. Governance and validation**

The development and drafting of this SitAn has been 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 was particularly important given the limitations in data gathering and sourcing.

# 2.

## Context

Map 2.1: Map of the Marshall Islands



Source: World Atlas



## 2.1. Geography and demographics

RMI is situated in the Micronesian region of the Pacific Ocean. It is made up of around 1,200 islands, islets and atolls, with a total land mass of 180 km<sup>2</sup>.<sup>8</sup> The islands are grouped into two chains: the eastern group (Ratak or 'Sunrise'), and the western group (Ralik or 'Sunset').<sup>9</sup> The islands are scattered over some 750,000 miles<sup>2</sup> of the Pacific Ocean, and share maritime borders with Kiribati, the Federated States of Micronesia (FSM) and Wake Island.<sup>10</sup>

The 2011 Marshall Islands Census recorded a total population of 53,158 (48.8 per cent female and 51.2 per cent male [sex ratio: 105.1]), with a median age of 20.6 years (20.9 for females, 20.3 for males).<sup>11</sup> Forty per cent of the population were under 15, and 14.5 per cent of the population under 5.<sup>12</sup> Some 56.1 per cent were aged between 15 and 59, and 4 per cent were 60 and over.<sup>13</sup> A further breakdown of the population can be seen in Figure 2.1. The graphs highlight the decrease in population of the 15 to 19 age group, who would have been a part of the five to 9-year age group in the 1999 census.<sup>14</sup> While the statistical significance of this observation is not mentioned in the census, the report suggests that the decrease results from out-migration of families with young children.<sup>15</sup>

Kwajalein, which is home to 21.5 per cent of the population and has a density of 1,802 persons per square mile, is RMI's largest island. The combined populations of Majuro and Kwajalein (73.8 per cent) represent the urban inhabitants of RMI, while the remaining 26.2 per cent reside in rural areas.<sup>16</sup>

The 2011 census shows a decline in the average annual growth rate of the population. From 1988 to 1999 the rate was 1.5 per cent, which decreased to a 0.4 per cent average between 1999 and 2011. The main reason for the slow growth rate since 1988 is emigration, with 9,800 Marshall Islanders reported to be migrants in 2013.<sup>17</sup> The primary destinations were reported to be the United States, the Philippines, Guam and FSM.<sup>18</sup> Quantitative data on the drivers of emigration from RMI is unavailable. However, it is understood that economic opportunity and

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8 UN OCHA. Country Profiles, Marshall Islands. <https://www.unocha.org/pacific/country-profiles/marshall-islands>.

9 Ibid.

10 Nations Online, Marshall Islands. [http://www.nationsonline.org/oneworld/marshall\\_islands.htm](http://www.nationsonline.org/oneworld/marshall_islands.htm).

11 Economic Policy, Planning and Statistics Office, Republic of the Marshall Islands, and the SPC Statistics for Development Programme, Noumea, Republic of the Marshall Islands 2011 Census report. Retrieved from [http://prism.spc.int/images/census\\_reports/Marshall\\_Islands\\_Census\\_2011-Full.pdf](http://prism.spc.int/images/census_reports/Marshall_Islands_Census_2011-Full.pdf).

12 Ibid.

13 Ibid.

14 Ibid.

15 Ibid.

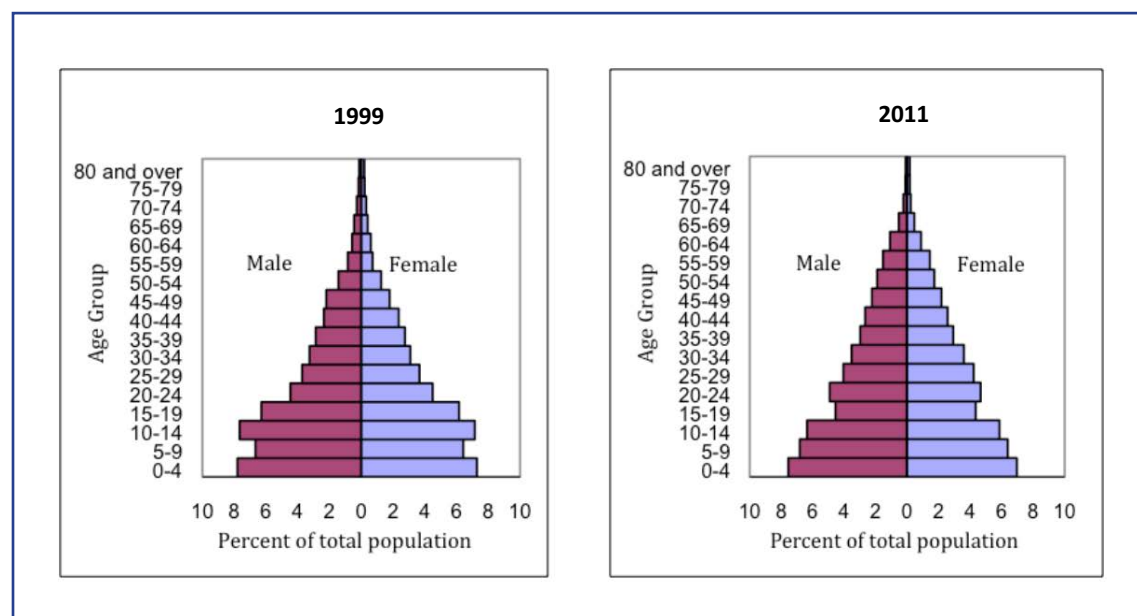
16 Ibid.

17 Ibid.

18 World Bank Group. Migration and Remittances Factbook 2016, Third Edition, Marshall Islands. p. 179. <https://openknowledge.worldbank.org/bitstream/handle/10986/23743/9781464803192.pdf>.

the pursuit of education are significant push factors.<sup>19</sup> Gender- and geographically disaggregated data on emigration is unavailable.

**Figure 2.1: 2011 Marshall Islands Census: age-sex pyramids 1999 and 2011**



Source: Census, 2011<sup>20</sup>

A drop in fertility in RMI, which decreased from 5.7 per woman in 1999 to 4.1 in 2011, is also thought to have contributed to the decline in population growth rate. The census shows higher fertility rates in rural than urban areas of 4.5 and 3.9, respectively. This is reflected in Figure 2.2, which shows that 46.1 per cent of the population in rural areas was under the age of 15 compared to 37.7 per cent in urban areas.<sup>21</sup> Whether this difference is statistically significant was not reported.<sup>22</sup>

The 2011 Marshall Islands Census does not provide information on ethnic or religious groups. However, the CIA World Factbook states that 92.1 per cent of the population belongs to the Marshallese ethnic group, 5.9 per cent are mixed Marshallese and 2 per cent are 'other', while the official languages are Marshallese and English.<sup>23</sup> The Factbook also provides information on the religious groups on RMI, with 54.8 per cent of the population recorded as Protestant, followed by Assembly of God (25.8 per cent), Roman Catholic (8.4 per cent), Bukot nan Jesus (2.8 per

19 Migration Policy Institute. 2014. Marshall Islanders: Migration Patterns and Health-Care Challenges. 2014. <http://www.migrationpolicy.org/article/marshall-islanders-migration-patterns-and-health-care-challenges> [14.06.17].

20 Ibid.

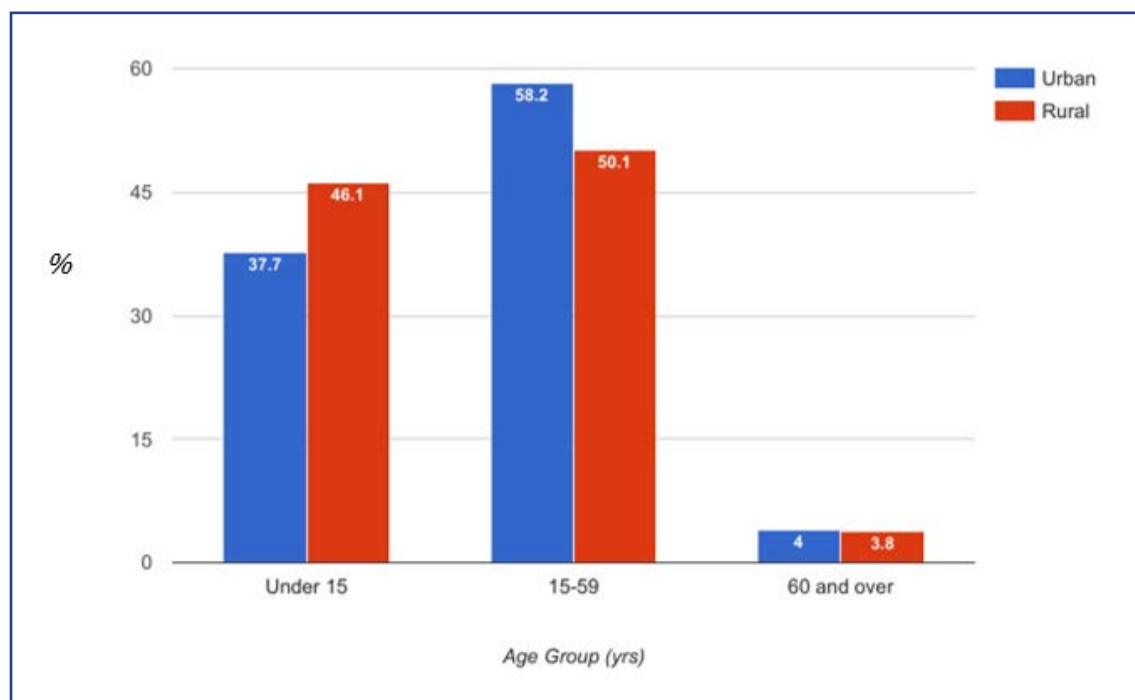
21 Prism. Reports, Census, Marshall Islands, 2011. <http://prism.spc.int/reports/census>.

22 Economic Policy, Planning and Statistics Office. Op. cit.

23 Central Intelligence Agency, The World Factbook, Marshall Islands, People and Society. <https://www.cia.gov/library/publications/the-world-factbook/geos/rm.html>.

cent), Mormon (2.1 per cent), Other Christian (3.6 per cent), Other (1 per cent) and None (1.5 per cent).<sup>24</sup> The 2011 census does however provide information on immigration, recording 3,250 (6.11 per cent) foreign-born individuals living in RMI.<sup>25</sup> The origins of this population include, most significantly, USA (22.1 per cent), Hawaii – USA (21.5 per cent) and Philippines (16.5 per cent).<sup>26</sup>

**Figure 2.2: Marshall Islands Census: percentage distribution of population by urban-rural residence**



Source: Census, 2011<sup>27</sup>

## 2.2. Main disaster and climate risks

According to the UN Office for the Coordination of Humanitarian Affairs (UNOCHA), RMI has a low vulnerability to tsunamis, earthquakes and landslides, medium vulnerability to cyclones and droughts, and a high vulnerability to coastal flooding.<sup>28</sup>

24 Ibid.

25 Economic Policy, Planning and Statistics Office, Republic of the Marshall Islands, and the SPC Statistics for Development Programme, Noumea, Republic of the Marshall Islands 2011 Census report. Op. cit.

26 Ibid.

27 Ibid.

28 UN OCHA, Country Profiles, Marshall Islands. <https://www.unocha.org/pacific/country-profiles/marshall-islands>.



In February 2016, the President of RMI declared a State of Emergency, followed by a State of Natural Disaster in March and an extension of State of Natural Disaster in April.<sup>29</sup> This was due to a drought brought on by El Niño (a warming of surface ocean waters in the eastern tropical Pacific),<sup>30</sup> which was claimed by the National Oceanic and Atmospheric Administration to be one of the strongest in recorded history.<sup>31</sup> Some 21,000 individuals were reported to be affected by severe drought conditions, with over 1,000 households affected on the outer islands and over 5,000 in urban areas.<sup>32</sup> The International Organization for Migration partnered with the Government, USAID, Australian Aid and Women United Together Marshall Islands to respond to the drought.<sup>33</sup> The country has also been affected by severe flooding over the past decade, with 600 people directly affected by floods in 2008, and a further 360 affected by flooding in 2014.<sup>34</sup> Information on the economic costs of natural disasters in RMI is unavailable.

RMI, like Kiribati, is affected by climate change, with rises in sea-level contributing to coastal erosion and flooding caused by waves and high tides. Higher carbon dioxide levels cause a rise in ocean acidification, which is harmful to the marine ecosystem and fishing.<sup>35</sup>

### 2.3. Government and political context

Following World War II, the United States gained military control of RMI from Japan, and administered the nation and other Micronesian countries under a Trusteeship Agreement made in 1947.<sup>36</sup> RMI broke away and ratified its own Constitution in 1979, gaining independence and signing a Compact of Free Association with the United States in 1986.<sup>37</sup> Although the 1979 Constitution provides for a unicameral parliamentary system, the President is elected by members of parliament (*Nitijela*), serving as the head of both government and state. The Council of Iroij acts as an upper house for traditional leaders, and advises on customary issues.<sup>38</sup>

The Nitijela has 33 Senators and 19 single-member constituencies.<sup>39</sup> Elections are held every four years, and there have been four presidents since its independence. The two main political parties

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29 Reliefweb. 14 April 2016. Report, Marshall Islands, 'El Nino Drought Response IOM Marshall Islands Situation Report.' <http://reliefweb.int/report/marshall-islands/el-nino-drought-response-iom-marshall-islands-situation-report-april-14-2016>.

30 UNOCHA. El Niño in the Pacific. <http://www.unocha.org/el-nino>.

31 Reliefweb, Report, Marshall Islands. Op. cit.

32 Ibid.

33 Ibid.

34 CRED Database.

35 Pacific Islands Climate Education Partnership, Climate Change in the Republic of the Marshall Islands. 2014. [ftp://ftp.soest.hawaii.edu/coastal/USAPI\\_CLimateChangeBooklets/Marshall%20Islands%20Climate%202016.pdf](ftp://ftp.soest.hawaii.edu/coastal/USAPI_CLimateChangeBooklets/Marshall%20Islands%20Climate%202016.pdf).

36 Nitijela, the Parliament of the Republic of the Marshall Islands, History of the Nitijela. <https://www.rmparliament.org/cms/about.html>.

37 Ibid.

38 Ibid.

39 Global Partnership for Effective Development Co-operation. October 2016. Monitoring Profiles, Marshall Islands, [http://effectivecooperation.org/wp-content/uploads/2016/10/Marshall-Islands\\_4.10\\_arrows-edited.pdf](http://effectivecooperation.org/wp-content/uploads/2016/10/Marshall-Islands_4.10_arrows-edited.pdf).

are the Ailin Kein Ad Party and the United Democratic Party.<sup>40</sup> The 2016 elections saw the voting in of Casten Nemra, the RMI's youngest president.<sup>41</sup> However, he was ousted a few weeks later after facing a no-confidence motion.<sup>42</sup> History was then made in RMI, as the Nitijela voted in Dr. Hilda Heine, the first female president of the nation or any independent PIC.<sup>43</sup> Including the President, there are three women with seats in the Nitijela (Hon. Amenta Mathew and Hon. Daisy Alik-Momotaro).<sup>44</sup>

The Marshall Islands National Youth Congress falls under the umbrella of the Pacific Youth Council, along with the National Youth Councils of nine other PICTs. The Pacific Youth Council is an NGO established in 1996 and holds a General Assembly every three years.<sup>45</sup>

## 2.4. Socioeconomic context

*The most recent national development plan in use is the Republic of the Marshall Islands National Strategic Plan 2015-2017, focuses on five strategic areas: social development; environment, climate change and resiliency; infrastructure development; sustainable economic development; and good governance.*<sup>46</sup>

RMI is an upper middle-income country that uses the US\$ as its currency and has a Gross Domestic Product (GDP) per capita of US\$3,385.97 (2015).<sup>47</sup> According to Asian Development Outlook 2017, GDP growth in RMI increased from 0.6 per cent in Fiscal Year 2015 to 1.5 per cent in 2016. This was due to the strengthening of fisheries and the continuation of infrastructure projects with the nation's association with the United States.<sup>48</sup> GDP is projected to grow by 4 per cent in Fiscal Year 2017, as a result of public investments, and to slow to 2.5 per cent in 2018 as a result of limited capacity to implement projects.<sup>49</sup> The economy relies largely on the support provided by the United States, as part of the Compact of Free Association, as well as fisheries and agriculture. The World Bank has classified RMI as suffering from a fragile situation, due to its limited public sector.<sup>50</sup>

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40 Ibid.

41 Ibid.

42 Ibid.

43 Ibid.

44 Pacific Women in Politics, Marshall Islands. <http://www.pacwip.org/future-elections/marshall-is/>.

45 Youth Policy, Pacific Youth Council. <http://www.youthpolicy.org/blog/structures/pacific-youth-council/>.

46 Republic of the Marshall Islands National Strategic Plan 2015-2017. <https://www.adb.org/sites/default/files/linked-documents/cobp-rmi-2016-2018-ld-04.pdf> [1.8.17].

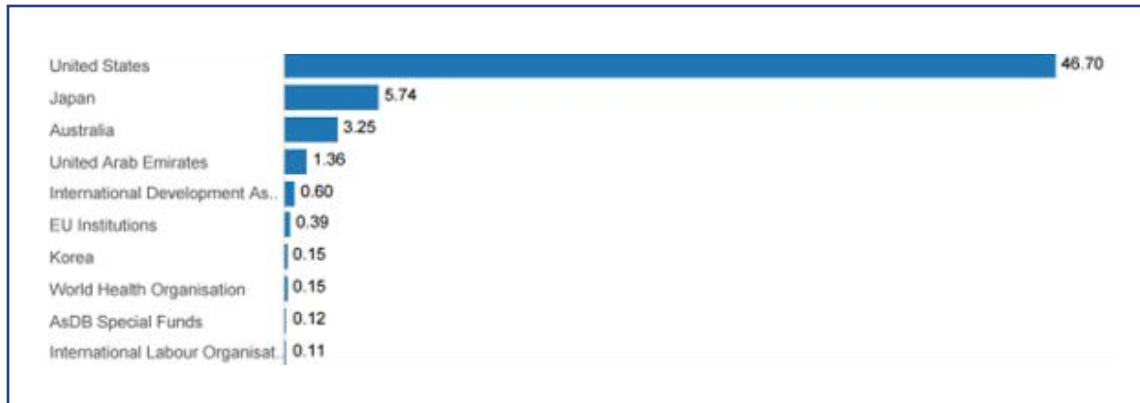
47 World Bank Data, GDP per capita (current US\$), Marshall Islands. <http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=MH>

48 Asian Development Bank, Asian Development Outlook 2017: Transcending the Middle-Income Challenge, North Pacific economies. <https://www.adb.org/publications/asian-development-outlook-2017-middle-income-challenge>.

49 Ibid.

50 Global Partnership for Effective Development Co-operation. Op. cit.

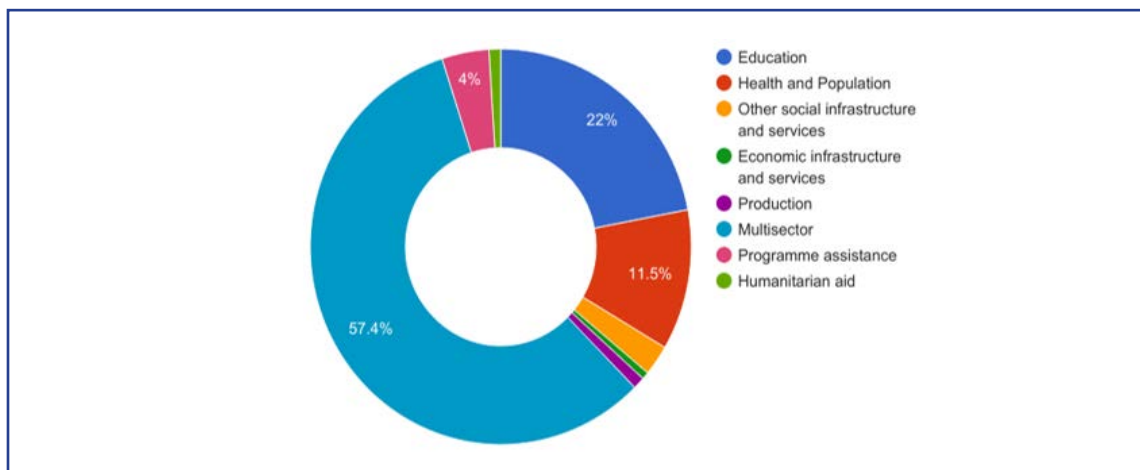
**Figure 2.3: Top ten donors of gross Official Development Assistance for the Marshall Islands (2014-2015 average) (US\$ million)**



Source: OECD, Aid charts at a glance, 2014-2015<sup>51</sup>

The Official Development Assistance (ODA) received by RMI accounts for around 40 per cent of its gross national income.<sup>52</sup> Figure 2.3 shows that the United States was the largest donor of ODA, with a 2014-15 average of US\$46.7 million.<sup>53</sup> Around 36 per cent of ODA was received by the education, health and population and other social infrastructure services, as seen in Figure 2.4.<sup>54</sup>

**Figure 2.4: Bilateral ODA received by sector for Marshall Islands (2014-2015)**



Source: OECD, Aid charts at a glance, 2014-2015<sup>55</sup>

51 OECD. Top Ten Donors of Gross ODA for Marshall Islands. <http://www.oecd.org/countries/marshallislands/aid-at-a-glance.htm#recipients>.

52 Pacific Islands Forum Secretariat, Pacific Regional MDGs Tracking Report 2015. <http://www.forumsec.org/resources/uploads/embeds/file/2015%20Pacific%20Regional%20MDGs%20Tracking%20Report.pdf>

53 OECD. Op. cit.

54 Ibid.

55 Ibid.

There are 12,647 employed individuals in RMI (23.8 per cent of the total population):<sup>56</sup> 65.3 per cent male and 34.7 per cent female.<sup>57</sup> The 2011 census recorded a total unemployment rate of 3.2 per cent (4.6 per cent for females and 2.4 per cent for males).<sup>58</sup> Whether the disparities in employment and gender were statistically significant is not known, and gender-disaggregated data by employment sector is unavailable. The median annual household income in 2011 was US\$6,476; a decrease from the 1999 figure of US\$6,840.<sup>59</sup> The figures vary according to the atoll, with Kwajalein and Majuro reporting the highest median annual household incomes of US\$11,640 and US\$9,400, respectively. This differs greatly from the Lae atoll, where the figure is almost nil for a population of 347 individuals.<sup>60</sup>

Although national income is largely dependent upon funding from the Compact of Free Association, the public sector plays a key role in contributing to GDP and employment. The government sector, including state-owned enterprises, accounts for around 40 per cent of GDP and 41 per cent of formal employment.<sup>61</sup> The primary commercial industries include: wholesale and retail trade; general business services; commercial fisheries; construction; tourism; and light manufacturing. Increases in annual export values are mainly due to continued exports of tuna from locally based fishing operations.<sup>62</sup> Other primary export products include tropical fish, ornamental clams and corals, coconut and copra cake and crafts. However, RMI relies heavily on imports and continues to run trade deficits.<sup>63</sup>

While there are no recent statistics on poverty in RMI, it has yet to achieve the first Millennium Development Goal (MDG) of eradicating extreme poverty and hunger. The 2010 Majuro and Kwajalein Household Water Survey revealed a serious problem in these urban areas, where some households had no water or electricity.<sup>64</sup>

## 2.5. Legislative and policy framework

The RMI Judiciary consists of five levels of courts: the Supreme Court; the High Court; the Traditional Rights Court; the District Court; and the Community Courts.<sup>65</sup> These exist alongside a Judicial Service Commission and court staff.<sup>66</sup>

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56 Economic Policy, Planning and Statistics Office, Office of the President, Government of the Republic of Marshall Islands, National Strategic Plan 2015-2017. July 2014. <http://www.eppso.org/view-national-strategic-plan>.

57 Ibid.

58 Economic Policy, Planning and Statistics Office, Republic of the Marshall Islands, and the SPC Statistics for Development Programme, Noumea, Republic of the Marshall Islands 2011 Census report. Op. cit.

59 Ibid.

60 Ibid.

61 UNDP Pacific Office in Fiji. About the Marshall Islands. [http://www.pacific.undp.org/content/pacific/en/home/countryinfo/marshall\\_islands.html](http://www.pacific.undp.org/content/pacific/en/home/countryinfo/marshall_islands.html).

62 Ibid.

63 Economic Policy, Planning and Statistics Office, Strategic Plan 2015-2017. Op. cit; UNDP Pacific Office in Fiji, About the Marshall Islands. Op. cit.

64 Sustainable Development, Republic of the Marshall Islands: National Report. May 2013. [https://sustainabledevelopment.un.org/content/documents/1104216Marshall%20Is%20SIDSReport\\_endorsed-Final%20May%2012%202013.pdf](https://sustainabledevelopment.un.org/content/documents/1104216Marshall%20Is%20SIDSReport_endorsed-Final%20May%2012%202013.pdf).

65 Republic of the Marshall Islands Judiciary, Annual Reports, 2015 Annual Report. <http://rmicourts.org/annual-reports/>.

66 Ibid.



The Supreme Court is the court of last resort, and has the final authority to adjudicate all cases brought before it. The High Court is the highest court at the trial level and is a superior court of record, with general jurisdiction over controversies of law and fact in RMI. The Traditional Rights Court supports the High Court at the trial level, and is a special jurisdiction court of record consisting of three or more judges.<sup>67</sup> The judges are selected to include fair representation of all classes of land rights. The Traditional Rights Court has jurisdiction over land rights and other legal interests in relation to customary law and traditional practices.<sup>68</sup> While the Constitution of Marshall Islands states that the decisions given by the Traditional Rights Court are to be given substantial weight, they are not binding unless the High Court agrees.<sup>69</sup> There are 24 Community Courts on the Outer Islands, which are limited-jurisdiction courts of record for the local government area.<sup>70</sup> The judges are lay judges with limited training; however they can receive training in Majuro with District Court judges.<sup>71</sup> The Marshall Islands judiciary aims to provide training for Community Court judges every two years.<sup>72</sup>

The Marshall Islands Constitution includes a Bill of Rights, consisting of 18 articles, providing a comprehensive range of human rights protections.<sup>73</sup>

In March 2015, Marshall Islands ratified the Convention on the Rights of Persons with Disabilities (CRPD).<sup>74</sup> The Disability Rights Fund is an organization that aims to change attitudes, environments and rights frameworks for individuals with disabilities.<sup>75</sup> The Fund is a 'grantmaking collaborative' between donors and the global disability rights community, and resourcing organizations led by those with disabilities in Africa, Asia, the Pacific Islands and the Caribbean.<sup>76</sup> This includes the Marshall Islands Disabled Persons Organisation: the first national disabled persons' organization. The grant received by the Organisation will be used to advance knowledge and support of the CRPD across RMI, to increase awareness of those with disabilities living in the Outer Islands of the CRPD, and to ensure that National Disability Policy accords with the CRPD. The Organisation received grants from the Disability Rights Fund in 2013, 2015 and 2016.<sup>77</sup>

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) was ratified in March 2006.<sup>78</sup> The Women United Together Marshall Islands NGO was established in

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67 Ibid.

68 Ibid.

69 Ibid.

70 Ibid.

71 Ibid.

72 Ibid.

73 Constitution of the Marshall Islands, 2005. <http://www.parliament.am/library/sahmanadrutyunner/marshalyankxziner.pdf>.

74 United Nations Human Rights, Ratification Status, Marshall Islands. [http://tbinternet.ohchr.org/\\_layouts/TreatyBodyExternal/Treaty.aspx?CountryID=40&Lang=en](http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?CountryID=40&Lang=en).

75 Disability Rights Fund, About. <http://disabilityrightsfund.org/about/>.

76 Ibid.

77 Disability Rights Fund, Our Work, Our Grantees, Marshall Islands. <http://disabilityrightsfund.org/our-work/our-grantees/#/country=marshall-islands/>.

78 United Nations Human Rights, Ratification Status, Marshall Islands. Op. cit.

1987, and aims to empower women and raise awareness of violence against women in RMI.<sup>79</sup> The intense advocacy led by the NGO and its supporters resulted in the passing of the Domestic Violence Prevention and Protection Act 2011.<sup>80</sup> One in three women in RMI experience domestic violence according to Women United Together Marshall Islands, and the Act makes it an offence, and outlines the protection orders in place to increase women's safety.<sup>81</sup> The NGO has also been supported by 'Pacific Women', a 10-year US\$320 million programme that supports 14 Pacific countries to work on gender equality.<sup>82</sup> It has enlisted a Domestic Violence Counselling Service Advisor to develop a support service for women and children who have experienced domestic violence.<sup>83</sup>

The CRC was ratified by RMI in October 1993, but it has yet to ratify the optional protocols to the CRC.<sup>84</sup>

The National Youth Policy (2009-2014) set out priorities for youth, covering seven policy areas.<sup>85</sup> These include: addressing issues between youth, their families and communities; improving education, health and social services; and promoting the personal development of youth. However, a lack of resources and political will must be addressed, to ensure that the Policy will be implemented and live up to the expectations of the stakeholders consulted in its creation.<sup>86</sup>

## 2.6. Child rights monitoring

RMI is overdue on its reporting obligations under CRC and CEDAW, as illustrated below.

	Status	Past reports	Next report due
<b>CRC</b>	4 October 1993 (R)	Last report submitted 7 December 2004	3 <sup>rd</sup> and 4 <sup>th</sup> periodic reports overdue since November 2010.
<b>CEDAW</b>	7 March 2006 (A)	-	Initial report overdue since 1 April 2007
<b>CRPD</b>	17 March 2015 (A)	-	Initial report due in 2017

79 AVI (Australian Volunteers International), Inspiring Partners, Women United Together Marshall Islands. <https://www.avi.org.au/inspiring-partners/women-united-together-marshall-islands/>.

80 Ibid.

81 Pacific Women, Women United Together Marshall Islands (WUTMI). <http://www.pacificwomen.org/pacific-links/women-united-together-marshall-islands-wutmi/>.

82 Pacific Women, About Pacific Women. <http://www.pacificwomen.org/about/about-pwspd/>.

83 Pacific Women, Women United Together Marshall Islands. Op. cit.

84 United Nations Human Rights, Ratification Status, Marshall Islands. Op. cit.

85 World Assembly of Youth, Marshall Islands, Youth Policy, Urban Youth in the Pacific. <http://www.way.org.my/directory/item/marshall-islands>.

86 Ibid.

# 3.

## Health and Nutrition

The situation analysis of child and maternal health in RMI is framed around the CRC (particularly the rights to life, survival and development, and to health) and the SDGs, particularly 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; and maternal health and adolescent health. Furthermore, the analysis of child and maternal nutrition considers the six thematic areas described in the WHO Global Nutrition Targets: childhood stunting; anaemia; low birth weight; obesity/over-weight; breastfeeding; and wasting/acute malnutrition. The specific international development targets pertaining to each thematic area are set out in detail in the respective sub-sections.

### 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

<b>3.2</b>	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
<b>3.3</b>	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
<b>3.7</b>	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 programmes	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 of causes of shortcomings and bottlenecks in relation to child and maternal health 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.”<sup>87</sup> 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.<sup>88</sup> The analysis of underlying causes of shortcomings and bottlenecks in relation to child (and maternal) health and nutrition takes these building blocks of the health system into account. Furthermore, cross-references to other relevant parts of the SitAn (e.g. WASH) are made because 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 to 28 days), infant mortality (under 1 year), and under-5 mortality in RMI have been declining continuously over recent decades. However, despite this progress, RMI has not been able to meet international development goals related to child mortality, and has amongst the highest child mortality rates in the PICTs group.<sup>89</sup>

87 [https://www.unicef.org/supply/files/GLC2\\_160615\\_WHO\\_building\\_blocks\\_and\\_HSS.pdf](https://www.unicef.org/supply/files/GLC2_160615_WHO_building_blocks_and_HSS.pdf) [02.03.17].

88 Ibid.

89 NMDI data. [https://www.spc.int/nmdi/vital\\_statistics](https://www.spc.int/nmdi/vital_statistics) [25.04.17].



According to the latest national estimates summarised in the 2016 State of the World's Children (SOWC) dataset, the under-5 child mortality rate (U5MR) in RMI was 36 deaths per 1,000 live births as of 2015: a 28 per cent reduction since 1990.<sup>90</sup> Note that, as of 2015, the U5MR has remained somewhat higher for boys (40/1,000) than for girls (32/1000). The 36/1,000 average U5MR means that RMI has not reached SDG 3.2 on under-5 child mortality (at least as low as 25/1,000 by 2030). However, recent progress indicates that RMI is on course to meet the target.

The infant mortality rate was estimated at 30/1,000 as of 2015: a 25 per cent reduction from 40/1,000 in 1990.<sup>91</sup> The SDGs do not include an explicit target linked to infant mortality, but instead focus on under-5 and neonatal mortality. Neonatal mortality in RMI is estimated at 17 deaths per 1,000 live births,<sup>92</sup> which is short of the SDG 3.2 target for neonatal mortality (at least as low as 12/1,000 by 2030).

Available information on the immediate and underlying causes of child mortality in RMI is very limited. A 2008 WHO regional report on Health in Asia and the Pacific suggests that one of the main underlying causes of neonatal mortality in RMI is low birth weight.<sup>93</sup> The SOWC data suggest that around 18 per cent of children born in 2015 had low birth weight.<sup>94</sup> The importance of low birth weight as an underlying cause of child mortality in RMI is confirmed by causes-of-death estimates from the Institute of Health Metrics, which establish underweight as the leading risk factor for children aged under 5.<sup>95</sup>

The latest UNICEF estimates suggest that preterm (19 per cent of all deaths) and intrapartum (11 per cent) complications, congenital diseases (12 per cent), pneumonia (17 per cent), and diarrhoea (7 per cent) were the main causes of death in under-5 children in RMI in 2015.<sup>96</sup> The WHO 2014 Country Cooperation Strategy brief for Marshall Islands states that sepsis, malnutrition, pneumonia, drowning and prematurity were the major causes of infant mortality, while severe malnutrition, bacterial meningitis, gastroenteritis, and pneumonia accounted for most childhood mortality.<sup>97</sup>

### 3.2. Child health, immunization and communicable diseases

There is a lack of quantitative data on some of the key child health indicators for RMI. For example, there are no up-to-date national estimates of the proportion of under-5-year-old children with

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90 SOWC 2016.

91 Ibid.

92 Ibid.

93 WHO. 2008. Health in Asia and the Pacific. [http://www.wpro.who.int/health\\_information\\_evidence/documents/Health\\_in\\_Asia\\_Pacific.pdf](http://www.wpro.who.int/health_information_evidence/documents/Health_in_Asia_Pacific.pdf) [25.04.17].

94 SOWC 2016. Op. cit.

95 Institute for Health Metrics. 2010. Global Burden of Disease Study: Marshall Islands Country Profile. [http://www.healthdata.org/sites/default/files/files/country\\_profiles/GBD/ihme\\_gbd\\_country\\_report\\_marshall\\_islands.pdf](http://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_marshall_islands.pdf) [25.04.17].

96 UNICEF statistics. <https://data.unicef.org/topic/child-survival/under-five-mortality/> [25.04.17].

97 Exact age bracket not specified. WHO. 2014. Country Cooperation Strategy for Marshall Islands. At a Glance. [http://apps.who.int/iris/bitstream/10665/136940/1/ccsbrief\\_mhl\\_en.pdf](http://apps.who.int/iris/bitstream/10665/136940/1/ccsbrief_mhl_en.pdf) [25.04.17].

suspected pneumonia taken to a health provider or receiving antibiotics.<sup>98</sup> Furthermore, there appear to be no up-to-date quantitative data on the availability of insecticide-treated nets, or the proportion of children sleeping under nets.<sup>99</sup> However, the gaps in the data in relation to malaria may not be too problematic because there is currently no risk of malaria transmission in RMI.<sup>100</sup>

The latest UN estimates suggest that around 38 per cent of children aged under 5 with diarrhoea receive oral rehydration salts, which is significantly below the regional average of 47 per cent for East Asia and Pacific (excluding China).<sup>101</sup> Following a severe and prolonged drought affecting the northern atolls in 2013, UNICEF recorded a sharp increase in gastritis and diarrhoea, particularly in children however, the situation report did not provide prevalence estimates of diarrhoea in children.<sup>102</sup>

Limited immunization coverage for vaccine-preventable diseases remains a significant public health concern in RMI. UN estimates that only 36 per cent of under-1-year-olds are fully immunized against diphtheria and that only 70 per cent are immunized against measles, which suggests that major coverage gaps remain.<sup>103</sup>

WHO Global Health Observatory estimates also indicate significant gaps in immunization coverage for 8 out of 12 universally recommended vaccines, for which RMI has so far reached less than 80 per cent coverage (see Figure 3.1).

Results from the 2007 Demographic and Health Survey (DHS) indicate that children in urban areas are more likely to be fully immunized than children in rural areas. The DHS data also suggest that male babies are more likely to have higher vaccination coverage (37 per cent) than female babies (32 per cent).<sup>104</sup>

SDG target 3.3 encourages all countries to eradicate tuberculosis (TB) by 2030.<sup>105</sup> TB is endemic in RMI, but transmission risk is thought relatively low.<sup>106</sup> According to NMDI data, RMI has the second-highest TB prevalence in the whole Pacific region, with an estimated 490 TB cases per 100,000 population (see Figure 3.2).<sup>107</sup>

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98 SOWC 2016 and UNICEF Statistics: <https://data.unicef.org/country/mhl/> [25.04.17].

99 SOWC 2016. Op. cit.

100 US Centres for Disease Control <https://wwwnc.cdc.gov/travel/yellowbook/2016/infectious-diseases-related-to-travel/yellow-fever-malaria-information-by-country/marshall-islands> [25.04.17].

101 SOWC 2016. Op. cit.

102 UNICEF. 2013. UNICEF Situation Report No. 1 Drought Situation Republic of the Marshall Islands Date: 10 May 2013. [https://www.unicef.org/appeals/files/UNICEF\\_Pacific\\_Drought\\_Situation\\_of\\_Marshall\\_Islands\\_SitRep\\_No1\\_10May2013.pdf](https://www.unicef.org/appeals/files/UNICEF_Pacific_Drought_Situation_of_Marshall_Islands_SitRep_No1_10May2013.pdf) [25.04.17].

103 UNICEF Statistics. Op. cit.

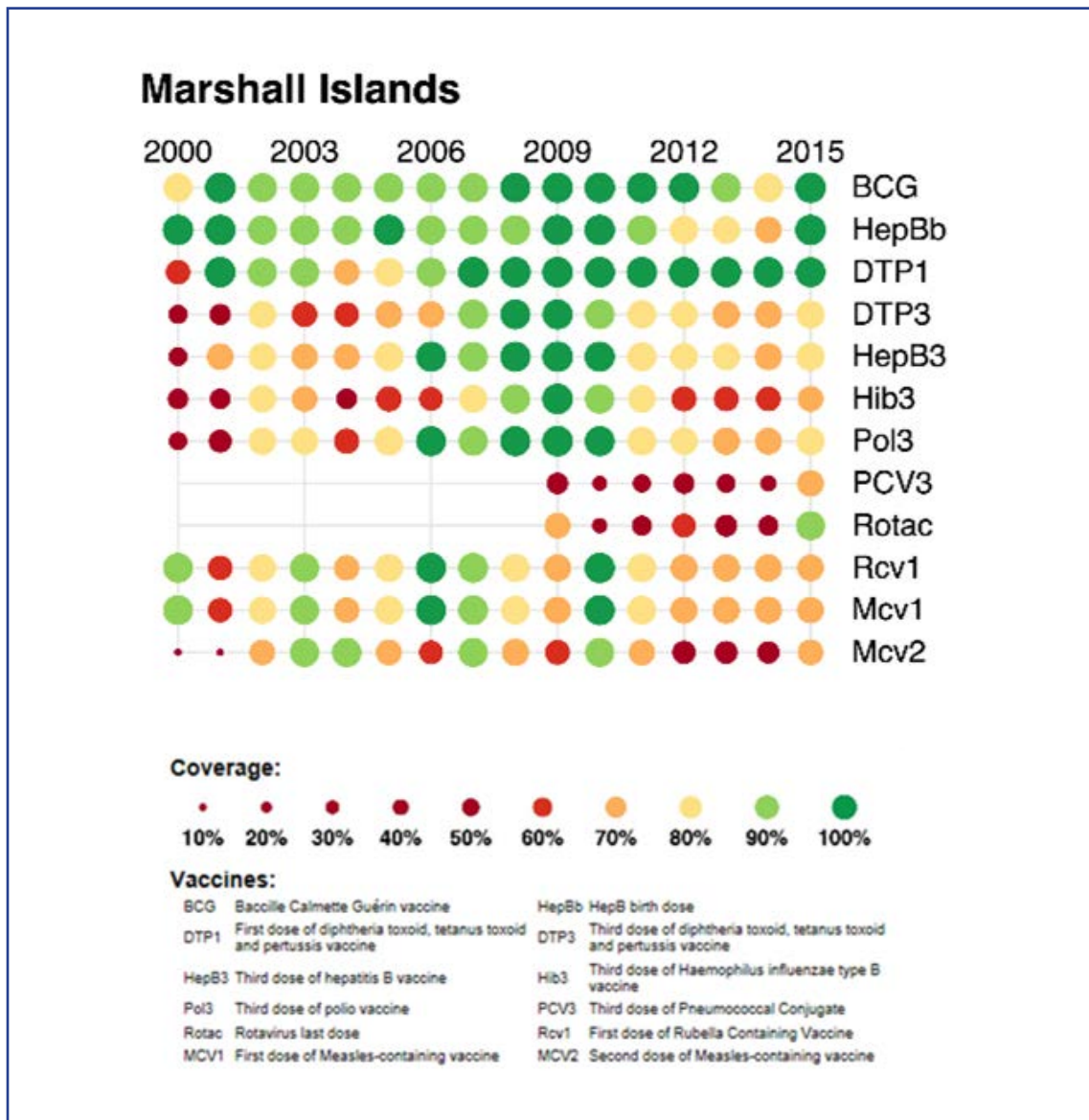
104 Economic Policy, Planning and Statistics Office (EPPSO), SPC and Macro International Inc. 2007. Republic of the Marshall Islands Demographic and Health Survey 2007. <http://catalog.ihnsn.org/index.php/catalog/2962/study-description> [25.04.17].

105 See <https://sustainabledevelopment.un.org/sdg3> [25.04.17].

106 International Association for Medical Assistance to Travellers: <https://www.iamat.org/country/marshall-islands/risk/tuberculosis> [25.04.17].

107 NMDI data. [https://www.spc.int/nmdi/communicable\\_diseases](https://www.spc.int/nmdi/communicable_diseases) [25.04.17].

**Figure 3.1: Immunization coverage in the Marshall Islands**

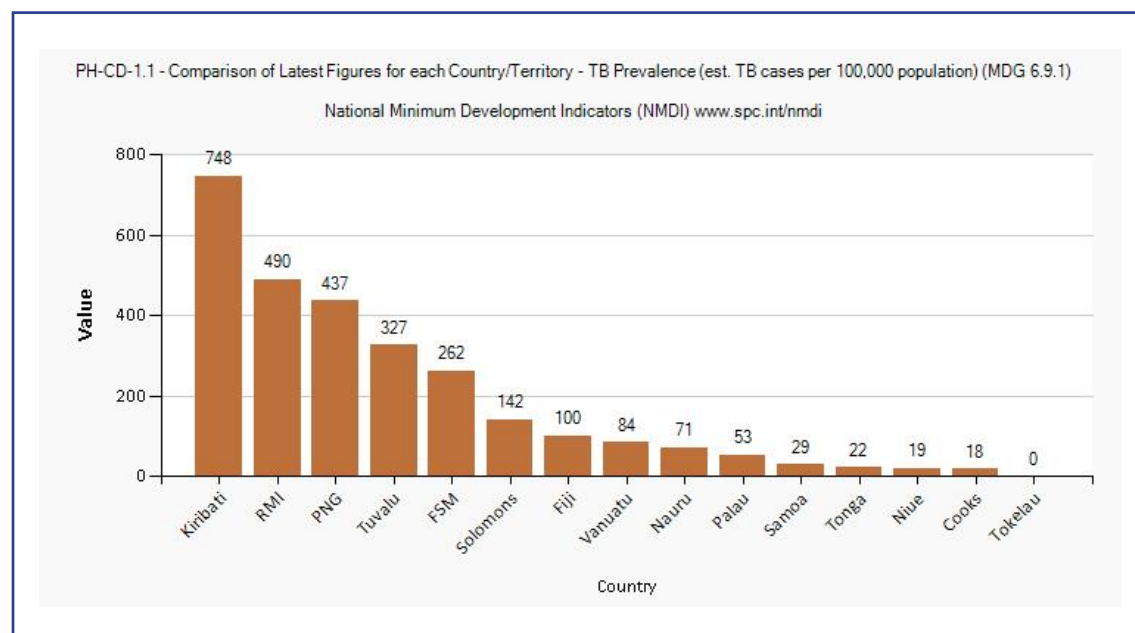


Source: WHO, Global Health Observatory, 2016<sup>108</sup>

On a positive note, the TB detection rate was estimated at 80 per cent as of 2013, which places RMI in the middle range of the PICTs group. WHO estimates also suggest TB treatment coverage of around 76 per cent as of 2015, which suggests that most TB-positive individuals in RMI have access to health care.<sup>109</sup>

108 WHO immunization coverage data are reviewed and the estimates updated annually. 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. <http://apps.who.int/gho/data/node.wrapper.immunization-cov?x-country=KIR> [25.04.17].

109 WHO Tuberculosis country profiles. <http://www.who.int/tb/country/data/profiles/en/> [25.04.17].

**Figure 3.2: TB prevalence per country**

Source: NMDI, 2016<sup>110</sup>

### 3.3. Maternal health

SDG 3.1 calls on all countries to reduce the maternal mortality ratio (MMR) to less than 70 per 100,000 live births by 2030. According to latest SOWC estimates (2015), the RMI MMR stands at 110 per 100,000 live births: significantly above the SDG target.<sup>111</sup> However, it is important to note that MMR estimates are quite unstable, because they are based on a very small number of deaths per year. The 2013 UNICEF report on child and maternal survival suggests that all of the most recent maternal deaths reported in RMI resulted from haemorrhage.<sup>112</sup> However, it is difficult to establish a meaningful cause of death ‘hierarchy’, based on such a small number of cases.

Highlighting a very distinct maternal health concern affecting women in RMI, UN Women have pointed to the long-lasting, generational health impacts of the atmospheric atomic and thermonuclear weapons tests carried out on RMI territory between 1946 and 1958. According to UN Women, these include high instances of birth defects (‘jellyfish babies’), miscarriages, and weakened immune systems, as well as high rates of thyroid, cervical, breast and other cancers.<sup>113</sup>

110 NMDI data. Op. cit.

111 SOWC 2016 data. Note that the World Bank and the United Nations Population Division produce internationally comparable sets of maternal mortality data that account for the well-documented problems of under-reporting and misclassification of maternal deaths, which are unfortunately not available for Marshall Islands. <https://data.unicef.org/topic/maternal-health/maternal-mortality/> [25.04.17].

112 UNICEF. 2013. Marshall Islands: Tracking Progress in Maternal and Child Survival. A Case Study Report. p. 14..

113 UN Women. <http://asiapacific.unwomen.org/en/countries/fiji/co/republic-of-the-marshall-islands> [25.04.17].



Birth defects cause particular distress to Marshallese women, as local culture views reproductive abnormalities as a sign that women have been unfaithful to their husbands.<sup>114</sup>

Under Article 24(2)(d) of the CRC, RMI has an obligation to ensure appropriate ante- and post-natal health care for mothers. Data suggests that overall coverage rates for ante- and post-natal health care in Marshall Islands are adequate, with room for improvement.

Estimated antenatal coverage for at least one visit stands at 81 per cent, which indicates that initial antenatal health care is accessible to a majority of pregnant women.<sup>115</sup> However, antenatal coverage for at least four visits is estimated at 77 per cent. UN data also suggest that an overwhelming majority of pregnant women in RMI give birth in the presence of a skilled health professional (90 per cent) and that 85 per cent of all deliveries take place in a health facility ('institutional delivery').<sup>116</sup> According to UN data, Caesarean sections are carried out in 9 per cent of births.

There appear to be no data on rural-urban disparities in relation to births attended by a skilled health professional, and there are also apparent data gaps about disparities in birth attendance rates between rich and poor women.<sup>117</sup>

However, some evidence suggests that rural-urban disparities exist in RMI regarding access to antenatal care. For example, DHS data from 2007 suggest that mothers in urban areas are more likely than mothers in rural areas to receive antenatal care from a doctor (80 per cent and 50 per cent, respectively), rather than from a health assistant, nurse/midwife, or traditional birth attendant.<sup>118</sup> The role of traditional birth attendants appears to be negligible in RMI, with less than 1 per cent of women in both urban and rural areas indicating that they had received antenatal care from a traditional birth attendant as their most qualified provider.<sup>119</sup>

### 3.4. Violence against women

Violence against women and girls (VAWG) is a key public health concern, and the data suggest that it is a significant problem in RMI. According to the 2014 Republic of Marshall Islands National Study on Family Health and Safety ('FHS study'), around 48 per cent of ever-partnered women reported having experienced physical violence at the hands of their intimate partners.<sup>120</sup> For a more detailed discussion of VAWG, see Chapter 6.

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114 Ibid.

115 SOWC 2016. Op. cit.

116 Ibid.

117 Ibid.

118 Economic Policy, Planning and Statistics Office (EPPSO), SPC and Macro International Inc. 2007. Republic of the Marshall Islands Demographic and Health Survey 2007. <http://catalog.ihnsn.org/index.php/catalog/2962/study-description> [25.04.17].

119 Ibid.

120 MRI. 2014. Republic of the Marshall Islands National Study on Family Health and Safety. <http://countryoffice.unfpa.org/pacific/drive/RMIFHSSReportweb.pdf> [25.04.17].

### 3.5. Adolescent health

The population of RMI is relatively young, with 40 per cent of the population under the age of 15, and only 4 per cent 60 years or above.<sup>121</sup> Unfortunately, a population proportion breakdown for adolescents aged 10 to 19 is not provided in the 2011 census report (the bracket includes 15 to 59), or the SOWC 2016 database.<sup>122</sup> As of 2011, the median ages of urban and rural populations were 21.3 years and 17.9 years, respectively, suggesting that the proportion of adolescents is larger amongst the rural population.<sup>123</sup>

#### 3.5.1. Fertility and contraceptive use

According to the 2011 census report, RMI witnessed a substantial decline in fertility over the previous two decades. The report also notes higher fertility among women rural than urban areas.<sup>124</sup> According to a 2010 United Nations Population Fund (UNFPA) report, around 90 per cent of the natural increase in the population is offset by migration abroad.<sup>125</sup>

It appears to be common for women in RMI to have children at a relatively young age. According to 2007 DHS data, 20 per cent of surveyed women aged 20 to 49 had already given birth to at least one child by the age of 18, with the proportion increasing to 47 per cent by the age of 20.<sup>126</sup> Teenage pregnancies impact on 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.

There are no World Bank estimates of adolescent fertility rate trends in RMI.<sup>127</sup> SOWC 2016 data suggest that, as of 2015, there were 85 births per 1,000 women aged 15 to 19, which is a significantly higher than the East Asia and Pacific average of 22/1,000.<sup>128</sup> A 2010 UNFPA report suggests that the teenage fertility rate is the highest in the whole Pacific region.<sup>129</sup>

Data on adolescent marriage rates (aged 15 to 19)<sup>130</sup> highlight significant inequity between genders. While an estimated 5 per cent of men in this age group were married or in union,

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121 RMI. 2012. Republic of the Marshall Islands 2011 census report. Economic Policy, Planning and Statistics Office, Republic of the Marshall Islands, and the SPC Statistics for Development Programme. [http://prism.spc.int/images/census\\_reports/Marshall\\_Islands\\_Census\\_2011-Full.pdf](http://prism.spc.int/images/census_reports/Marshall_Islands_Census_2011-Full.pdf) [25.04.17].

122 SOWC 2016. Op. cit.

123 RMI. 2012. Republic of the Marshall Islands 2011 census report. Op. cit. p. 20.

124 Ibid. p. 46.

125 UNFPA. 2010. Family Planning in the Pacific Islands: Current Status and Prospects for Re-Positioning Family Planning on the Development Agenda. <http://www.icomp.org.my/new/uploads/fpconsultation/Pacific.pdf> [25.04.17], p. 8.

126 Economic Policy, Planning and Statistics Office (EPPSO), SPC and Macro International Inc. 2007. Republic of the Marshall Islands Demographic and Health Survey 2007. Op. cit.

127 World Bank data <http://data.worldbank.org/indicator/SP.ADO.TFRT?locations=MH> [07.03.17].

128 SOWC 2016. Op. cit.

129 UNFPA. 2010. Op. cit., p. 13.

130 SOWC 2016. Op. cit.

the percentage more than quadruples to 21 per cent for women.<sup>131</sup> The marriage rate for adolescent girls is also significantly higher than the East Asia and Pacific average of 6 per cent.<sup>132</sup> 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.<sup>133</sup>

Contraceptive prevalence is an estimated<sup>134</sup> 45 per cent of the population, which is significantly lower than the East Asia and the Pacific average of 63 per cent,<sup>135</sup> but at the higher end of the range for the PICT group.<sup>136</sup> Interestingly, women in urban areas are less likely to use contraception (43 per cent) than those in rural areas (48 per cent).<sup>137</sup> This difference was found to be statistically significant even when controlling for other covariates (such as women's educational level or income).<sup>138</sup> RMI is one of only three PICs where contraceptive prevalence is higher in rural than urban areas, but it is not clear why.<sup>139</sup>

Contraceptives are sourced primarily through the public sector, from which 94 per cent of contraceptive users report to have obtained their supply.<sup>140</sup> The most important supplier of contraceptives is the Majuro hospital, which accounts for over 50 per cent of all public contraceptive supplies. Ebeye Hospital covers 21 per cent of supplies, and 16 per cent of users obtain their supplies from an Outer Islands Health Centre.<sup>141</sup>

The 2007 DHS data suggest that 8 per cent of currently married women in Marshall Islands have an unmet need for family planning, with unmet need for limiting higher (5 per cent) than unmet need for spacing (3 per cent).<sup>142</sup> Unmet need for family planning appears to be particularly high amongst teenage women, affecting, according to DHS data, 33 per cent of women aged 15 to 19. It has been noted that, because Marshallese parents typically do not discuss sex with their children, and sex education is not taught in schools, most Marshallese children and teens do not have adequate information to make informed decisions about birth control.<sup>143</sup>

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131 Ibid.

132 Ibid.

133 See 'Getting the Evidence: Asia Child Marriage Initiative'. <https://plan-international.org/publications/getting-evidence-asia-child-marriage-initiative> [29.03.17].

134 The 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 time. Women 'of reproductive age' is usually defined as women aged 15 to 49. See e.g. <http://indicators.report/indicators/i-29/> [21.03.17].

135 SOWC 2016; the regional average excludes China.

136 UNFPA. 2010. Op. cit. p. 26.

137 Economic Policy, Planning and Statistics Office (EPPSO), SPC and Macro International Inc. 2007. Republic of the Marshall Islands Demographic and Health Survey 2007. Op. cit. Available at: <http://catalog.ihsn.org/index.php/catalog/2962/study-description> [25.04.17], p. 71.

138 UNFPA. 2010. Op. cit. p. 28.

139 Ibid.

140 Ibid. p. 74.

141 Ibid.

142 Women who do not want any more children or who want to wait two or more years before having another child but are *not* using contraception, are considered to have an unmet need for family planning.

143 See Questions Submitted by Hana Like Staff of Parents and Children Together (PACT). Responses by Julie Walsh Kroeker, Small Island Networks (Draft). [http://www.hawaii.edu/cpis/mi\\_workshop/files/hana\\_questions.htm](http://www.hawaii.edu/cpis/mi_workshop/files/hana_questions.htm) [14.07.17].

Unmet need for family planning drops dramatically in older age brackets, affecting only 7.6 per cent of women aged 30 to 34.<sup>144</sup> Unmet need appears to be higher amongst women in rural areas and women from poorer households.<sup>145</sup>

Data also highlight demand-side constraints that impact on family planning, with relatively low demand for contraceptive methods. The DHS data suggest that about 53 per cent of all married women have a demand for family planning (whether met or unmet). Demand appears lowest amongst the youngest age group, at 17 per cent for women aged 15 to 19.<sup>146</sup>

DHS data indicate that total demand for family planning is higher in rural than urban areas (58 per cent and 50 per cent, respectively). Interestingly, demand appears highest for women in the lowest wealth quintile, which suggests that economic considerations play an important role in determining demand.<sup>147</sup>

The 2007 DHS found that, amongst married women aged 15 to 49, the most commonly cited reason for not intending to use contraception was fear of side effects (30 per cent), followed by the desire to have as many children as possible (21 per cent) and health concerns (11 per cent).<sup>148</sup> On a positive note, only 7 per cent of women aged 15 to 49 were opposed to using contraception, which suggests a very high level of acceptance within the population. Contraceptive costs and husbands' opposition to its use appear to play an insignificant role in suppressing demand.<sup>149</sup> Gender-discriminatory beliefs around contraception, such as that a woman who uses birth control is cheating on her partner, also appear to suppress demand for contraceptives amongst Marshallese women.<sup>150</sup>

### 3.5.2. HIV/AIDS and sexually transmitted infections

RMI is considered a low HIV-prevalence country.<sup>151</sup> The 2015 Global AIDS Progress Report from noted 28 cumulative cases of HIV between 1984 and 2015. Perhaps because 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, antiretroviral therapy (ART) treatment coverage or HIV-related deaths in RMI.<sup>152</sup> The 2015 progress report also suggests that virtually no HIV testing has been done on the Outer Islands, which makes it difficult to establish accurate prevalence data for the country.<sup>153</sup>

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144 Economic Policy, Planning and Statistics Office (EPPSO), SPC and Macro International Inc. 2007. Republic of the Marshall Islands Demographic and Health Survey 2007. Op. cit. Available at: <http://catalog.ihns.org/index.php/catalog/2962/study-description> [25.04.17], p. 104.

145 Ibid. p. 105.

146 Ibid.

147 Ibid.

148 Ibid.

149 Ibid. p. 79.

150 See Questions Submitted by Hana Like Staff of Parents and Children Together (PACT). Op. cit.

151 RMI Ministry of Health. 2016. Global AIDS Progress Report 2015. Available at: [http://www.unaids.org/sites/default/files/country/documents/MHL\\_narrative\\_report\\_2016.pdf](http://www.unaids.org/sites/default/files/country/documents/MHL_narrative_report_2016.pdf) [26.04.17].

152 SOWC 2016 and <https://data.unicef.org/country/mhl/> [11.04.17].

153 RMI Ministry of Health. 2016. Global AIDS Progress Report 2015. Op. cit.

The 2015 AIDS progress report compiled by the Ministry of Health (MOH) recorded 11 confirmed AIDS-related deaths, but it is unclear whether any of them were children. Only eight of all Marshall Islanders living with HIV were residing there as of 2015 (the others having migrated), with seven receiving ART treatment.<sup>154</sup>

The 2015 progress report suggests that low levels of knowledge about HIV/AIDS and unprotected sexual activity, particularly among young people, are the most significant risk factors associated with HIV. However, it also points out that there has been very little new data since the 2007 DHS, making it difficult to establish whether there have been any changes in adolescents' knowledge and sexual behaviour over the last 10 years.<sup>155</sup>

In the 2015 fiscal year, the RMI national AIDS response funding allocations amounted to US\$432,816, with only US\$382,747 being spent. Underutilisation of existing funds appears to be particularly pronounced in the areas of HIV prevention, sexually transmitted infections (STIs) and surveillance.<sup>156</sup> The national AIDS response depends heavily on external donor funding, in particular US Federal Funds and the Global Fund, which raises concerns about the sustainability of existing prevention and treatment programmes.<sup>157</sup>

The little data that is available suggests that STIs are a significant problem. For example, NMDI estimates a chlamydia prevalence amongst young people aged 15 to 24 of 8 per cent, as of 2011, which places RMI in the middle range of the PICTs group (see Figure 3.3).<sup>158</sup> The chlamydia rate rises to 25 per cent among women receiving ante-natal care, which represents the fourth-highest prevalence rate among PICTs.<sup>159</sup> The relatively high STI rates raise concerns about potential future increases in HIV cases, as they indicate significant underlying behavioural risks for HIV transmission.

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154 Ibid.

155 Ibid. p. 7.

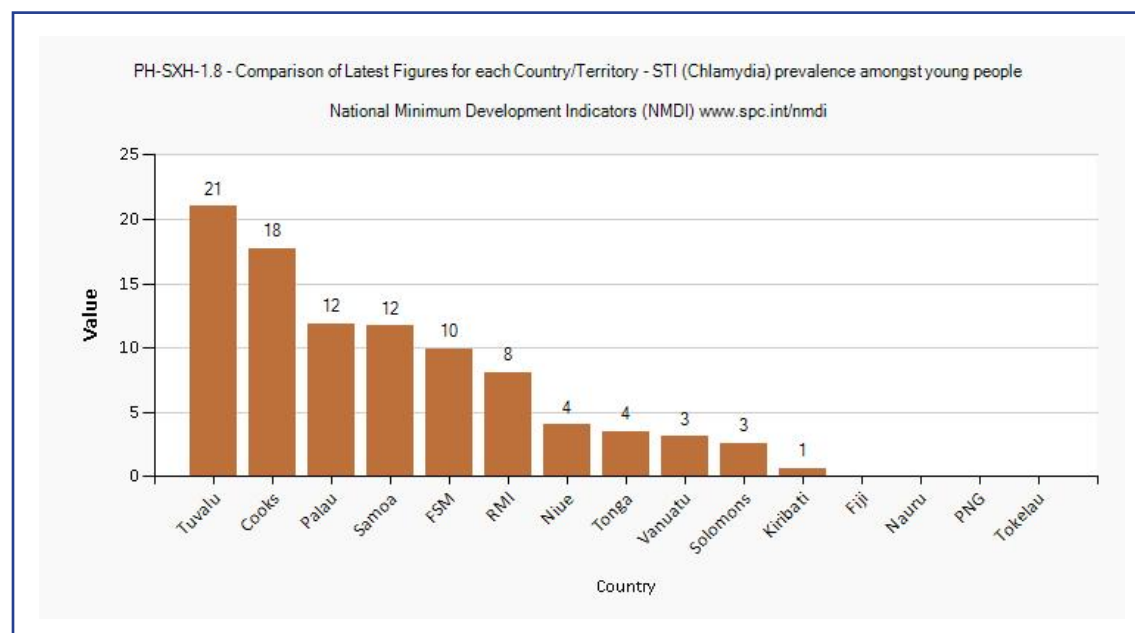
156 Ibid. p. 24.

157 RMI Ministry of Health. 2016. Op. cit.

158 NMDI data [https://www.spc.int/nmdi/sexual\\_health](https://www.spc.int/nmdi/sexual_health) [26.04.17].

159 Ibid.



**Figure 3.3: Chlamydia prevalence amongst 15-24 year olds per country**

Source: NMDI, 2016<sup>160</sup>

### 3.5.3. Substance abuse

According to SDG target 3.5, RMI should strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. Available information on alcohol use amongst the *adult* population suggests that it is a major problem, which primarily affects men. For example, a 2016 regional review of evidence on alcohol use in the Pacific indicates that 28.4 per cent of men, and 3.1 per cent of females aged 25 to 64 years currently drink alcohol in RMI (i.e. consumed alcohol in the previous 12 months). Worryingly, amongst all male ‘current drinkers’, 65 per cent were classified as ‘heavy drinkers’ (individuals consuming on average six or more standard drinks per day).<sup>161</sup>

There appears to be very little quantitative data on substance abuse amongst adolescents in RMI. In contrast to many of its neighbouring countries, it has not implemented a Global School-based Health Survey (GSHS), which typically covers topics including alcohol use, smoking and other drug use.<sup>162</sup> The relatively outdated WHO Status Report on Alcohol from 2004 suggests that 11.4 per cent of adolescents aged 14 to 19 consumed alcohol in the previous year, with boys (18.7 per cent) being significantly more likely to consume alcohol than girls (2.9 per

<sup>160</sup> Ibid.

<sup>161</sup> Kessaram et al. 2016., Alcohol use in the Pacific region: Results from the STEPwise approach to surveillance, Global School-Based Student Health Survey and Youth Risk Behaviour Surveillance System, *Drug and Alcohol Review* (July 2016), 35, pp. 412-423.

<sup>162</sup> See <http://www.who.int/chp/gshs/datasets/en/> [12.04.17].

cent).<sup>163</sup> It is unclear whether alcohol use amongst adolescents has increased or decreased since then.

#### 3.5.4. Mental health

In 2011, Marshall Islands adopted a Mental Health Policy, which sets out the Government's main mental health objectives. A new mental health law is being drafted, which is intended to comply with the CRPD.<sup>164</sup>

There is very little quantitative data on mental health in RMI, which makes it difficult to establish the prevalence, incidence and profile of mental health problems.<sup>165</sup> However, anecdotal evidence suggests that depression (and related alcohol abuse) is a common mental health problem.<sup>166</sup>

Some evidence suggests that suicides and alcohol use are closely related in RMI. The WHO Status Report on Alcohol from 2004 notes that, for the period 1991 to 1995, 38 of the total of 56 recorded suicides (about 70 per cent) occurred when the victim was intoxicated (which does not explain the underlying causes of suicide).<sup>167</sup> The close connection between suicides and alcohol is also highlighted by a 2015 WHO Profile on Mental Health in Marshall Islands.<sup>168</sup>

The age profile of suicide cases is not known. RMI not implemented a GSHS survey, which would typically contain information on suicide attempts amongst school children. However, some evidence suggests that suicides are primarily male. For example, WHO indicates that 96.5 per cent of recorded suicides between 2000 and 2006 were committed by men (84 out of 87). Unfortunately, it appears that reporting methods were changed after 2007, no longer distinguishing between genders.<sup>169</sup>

RMI spends approximately 0.4 per cent of the total health budget (US\$22.6 million in 2012) on mental health. According to WHO, mental health spending is primarily geared towards medication and staff costs, rather than other mental health treatment such as psychosocial intervention.<sup>170</sup> The report also suggests a lack of appropriately trained mental health professionals in RMI, especially on the Outer Islands.<sup>171</sup>

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163 Unfortunately, it is unclear whether these figures are nationally representative. See WHO. 2004. Status Report on Alcohol. Marshall Islands Country Profile: [http://www.who.int/substance\\_abuse/publications/en/marshall\\_islands.pdf?ua=1](http://www.who.int/substance_abuse/publications/en/marshall_islands.pdf?ua=1) [12.04.17].

164 Alfred J., Edwin M., Funk M., Handtke O., and McGovern P. 2015. WHO Profile on mental health in development (WHO proMIND): Republic of the Marshall Islands, Geneva, World Health Organization. [http://apps.who.int/iris/bitstream/10665/185038/1/9789241509435\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/185038/1/9789241509435_eng.pdf) [10.04.17].

165 Ibid.

166 Ibid. p. 3.

167 WHO. 2004. Status Report on Alcohol. Op. cit.

168 Alfred J., Edwin M., Funk M., Handtke O. and McGovern P. Op. cit.

169 Ibid. p. 18.

170 Ibid.

171 Ibid. p. 26.

### 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 5 years of age (the ‘WHO Global Nutrition Targets’), and addressing the nutritional needs of adolescent girls, pregnant and lactating women, and older women.<sup>172</sup>

According to the WHO Global Nutrition Targets, Marshall Islands should, by 2025, aim to: achieve a 40 per cent reduction in stunting among children under 5; achieve a 50 per cent reduction of anaemia in women of reproductive age; achieve a 30 per cent reduction in low birth weight; ensure that there is no increase in childhood overweight; increase the rate of exclusive breastfeeding in the first 6 months up to at least 50 per cent; and reduce and maintain childhood wasting to less than 5 per cent.<sup>173</sup>

#### WHO Global Nutrition Targets

	Targets	Indicators
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 birth weight	Percentage of infants born with low birth weight (< 2,500 grams)
4	By 2025, ensure that 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 breast fed
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

172 <https://sustainabledevelopment.un.org/sdg2> [10.04.17].

173 <http://www.who.int/nutrition/global-target-2025/en/> [02.03.17].

### 3.6.1. Child stunting and wasting

There are no up-to-date UN estimates of child stunting (short height for age or 'chronic malnutrition') or child wasting (low weight for height or 'acute malnutrition') in RMI, which represents a significant data gap.<sup>174</sup>

### 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:<sup>175</sup> increasing the risk of blood loss at delivery and postpartum haemorrhage.<sup>176</sup> The nutritional status of the mother during pregnancy and lactation can also impact on the health and nutritional status of the child. For example, anaemic mothers are at greater risk of delivering premature and low-birth-weight babies, who also have an increased risk of dying.<sup>177</sup> De-worming and iron supplementation can be effective in reducing anaemia in pregnant women and children.<sup>178</sup>

According to WHO/Food and Agriculture Organization of the United Nations 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 for RMI.<sup>179</sup> Anaemia prevalence amongst non-pregnant women of reproductive age is estimated at 20 per cent (as of 2011) and anaemia in pre-school children is estimated at 33 per cent (as of 2011).<sup>180</sup>

### 3.6.3. Low birth weight and underweight

The 2007 DHS in RMI found that 18 per cent of children weighed less than 2.5 kg at birth (i.e. underweight), which is the second-highest prevalence rate in the PICTs group (after Nauru) (see Figure 3.4).<sup>181</sup> Low birth weight is a leading risk factors for under-5 mortality.<sup>182</sup>

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174 SOWC 2016 and UNICEF Statistics: <https://data.unicef.org/country/mhl/> [10.04.17].

175 Black et al. 2008. Maternal and child undernutrition: global and regional exposures and health consequences.

176 See e.g. K4Health. Anaemia Prevalence, Causes, and Consequences. <https://www.k4health.org/toolkits/anemia-prevention/anemia-causes-prevalence-impact>.

177 Ibid.

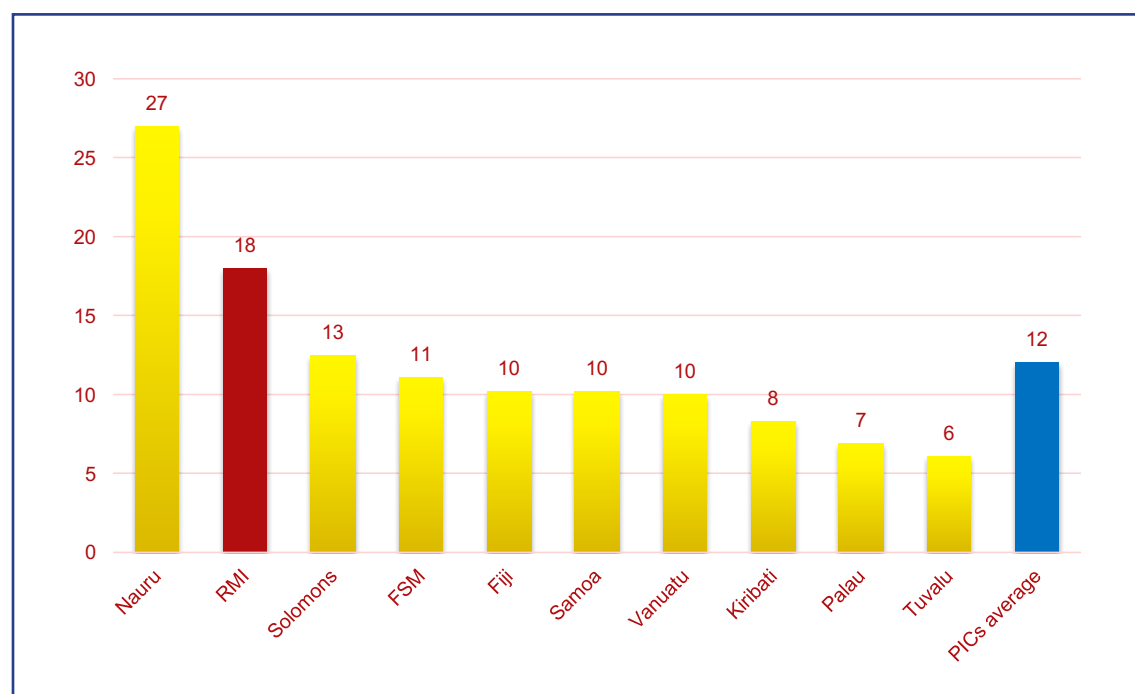
178 WHO/FAO. 2015. Marshall Islands – Food and Nutrition Security Profiles. [http://www.fao.org/fileadmin/templates/rap/files/nutrition\\_profiles/DI\\_Profile\\_-\\_Marshall\\_Islands\\_280714.pdf](http://www.fao.org/fileadmin/templates/rap/files/nutrition_profiles/DI_Profile_-_Marshall_Islands_280714.pdf) [26.04.10].

179 Ibid.

180 Food Fortification Initiative. Marshall Islands Country Profile. [http://www.ffinetwork.org/country\\_profiles/country.php?record=127](http://www.ffinetwork.org/country_profiles/country.php?record=127) [26.04.10].

181 2007 DHS report. P.139. Note that low birth weight data are not available for Cook Islands, Niue, Tonga, and Tokelau.

182 Institute for Health Metrics. Op. cit.

**Figure 3.4: Low birth weight prevalence (%)**

Source: SOWC, 2016.

There appears to be no up-to-date data on underweight prevalence in under-5 children in RMI.<sup>183</sup> However, the outdated and non-representative Pacific Helminths Initiative Study, implemented in two schools in 2001, suggested that around 15 per cent of surveyed children aged 5 to 14 years were underweight.<sup>184</sup>

### 3.6.4. Obesity

According to the Institute of Health Metrics, the leading causes of ill-health and death in RMI in 2010 were: non-communicable diseases (NCDs) (diabetes: 10 per cent of years of life lost, ischemic heart disease: 6 per cent, stroke: 5 per cent, chronic kidney disease: 3 per cent); some communicable diseases (lower respiratory infections: 5 per cent, diarrheal diseases: 2 per cent, meningitis: 2 per cent); preterm birth complications (4 per cent); and injuries (road injuries: 2 per cent, interpersonal violence: 2.2 per cent).<sup>185</sup> While the disease burden of injuries, communicable diseases and diarrheal diseases has been on the decline since the 1990s, the disease burden of NCDs has increased rapidly, with RMI witnessing almost epidemic rises in diabetes and chronic

183 See SOWC 2016 and World Bank data: <http://data.worldbank.org/indicator/SH.STA.MALN.ZS?locations=MH> [25.04.17].

184 WHO. Undated. Marshall Islands Nutrition Overview. <http://www.wpro.who.int/nutrition/documents/docs/msi.pdf?ua=1> [25.04.17].

185 Institute of Health Metrics.Op. cit.



kidney disease.<sup>186</sup> The WHO Country Cooperation Profile 2013-17 observes that diabetes-related diseases and cancer are now leading causes of death in RMI.<sup>187</sup>

Many of these NCDs are related to overweight and obesity, which have been estimated to affect up to 80 per cent and 47 per cent of the adult population in RMI, respectively, as of 2008.<sup>188</sup> Obesity and overweight appear to be a particular problem amongst the female population, with 82 per cent considered overweight, compared to 78 per cent of males; and 54 per cent of females considered obese, compared to 39 per cent of males.<sup>189</sup>

Up-to-date national estimates of obesity and overweight prevalence in children and adolescents appear to be lacking.<sup>190</sup>

### 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.<sup>191</sup> Exclusive breastfeeding rates appear quite low in RMI. According to the most recent UN estimates, only 31 per cent of children in RMI receive exclusive breastfeeding for the first six months after their birth, which is 29 percentage points below the 50 per cent target set out in the WHO global nutrition targets for 2025, and the lowest rate in the PICTs group (see Figure 3.5). On a positive note, it has been suggested that public breastfeeding is not generally a concern among Marshallese, since breasts are not sexualized in Marshallese society.<sup>192</sup>

DHS data from 2007 indicate that in most cases breastfeeding is initiated shortly after birth, with 73 per cent of babies being breastfed within one hour of birth, and 96 per cent breastfed within one day of birth.<sup>193</sup> DHS data also suggest that around half of Marshallese children continue to breastfeed until the age of 24 months. However, exclusive breastfeeding quickly declines from birth to the age of six to eight months, when a substantial proportion of children (around 80 per cent) are already fed water, other milk, and other complementary foods.<sup>194</sup> The early introduction of food and liquids other than breast milk can contribute to the high prevalence of underweight children in RMI.<sup>195</sup>

2007 DHS also data reveal significant disparities between urban and rural areas in relation to breastfeeding practices. For example, children in rural areas are more likely to be breastfed in

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186 Ibid.

187 WHO Country Cooperation Strategy for Marshall Islands 2013-2017, p. 38.

188 Global Nutrition Report. 2014. Marshall Islands. [http://www.globalnutritionreport.org/files/2014/12/gnr14\\_cp\\_marshall\\_islands.pdf](http://www.globalnutritionreport.org/files/2014/12/gnr14_cp_marshall_islands.pdf) [25.04.17].

189 Ibid.

190 SOWC 2016. Op. cit.

191 WHO [http://www.who.int/elena/titles/exclusive\\_breastfeeding/en/](http://www.who.int/elena/titles/exclusive_breastfeeding/en/) [13.04.17].

192 See Questions Submitted by Hana Like Staff of Parents and Children Together (PACT). Op. cit.

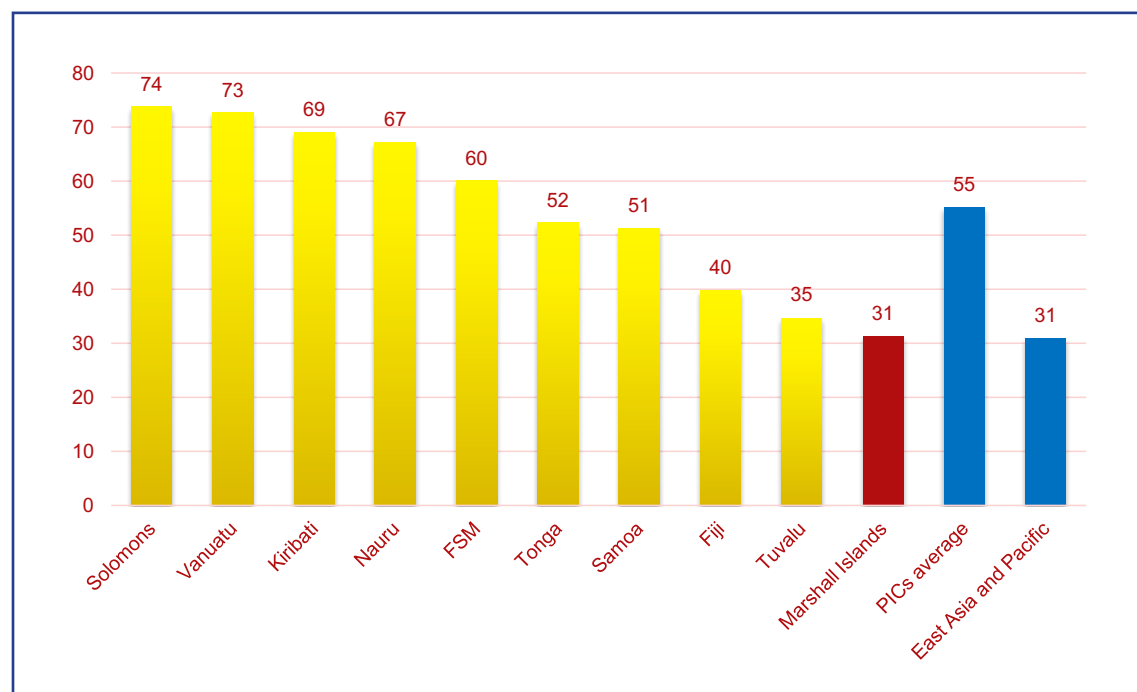
193 2007 DHS report. p. 155.

194 Ibid. p. 157.

195 Ibid. p. 139.

the first place, are more likely to be initiated to breastfeeding within one hour of birth, and (on average) breastfeed for longer than urban children.<sup>196</sup>

**Figure 3.5: Exclusive breastfeeding prevalence (%)**



Source: SOWC, 2016

### 3.7. Key barriers and bottlenecks

As one of the most generously donor-funded countries in the PICT group, RMI has an exceptionally well-funded public health system.<sup>197</sup> However, there are a number of important barriers and bottlenecks to further progress in the area of health.

#### 3.7.1. Transportation

A major challenge facing the health system is the remoteness of the 29 coral atolls (comprising of 1,156 individual islands and islets), and the difficulties associated with transferring patients in need of specialised health care, especially from the remote Outer Islands. For example, the WHO 2011 country health information profile notes that one of the key barriers to delivering health

196 Ibid. p. 154-159.

197 Alfred J., Edwin M., Funk M., Handtke O. and McGovern P. Op. cit.

services in the remote Outer Islands is the unpredictable flight schedule of Air Marshall Islands.<sup>198</sup> The infrequent, unpredictable and costly transportation links present a significant risk for patients in need of urgent access to medical care, especially in the event of medical emergencies.<sup>199</sup> Furthermore, many of the Outer Islands rely on outreach teams for all primary healthcare services, including immunization, diabetes clinics, TB and leprosy clinics, prenatal services, and health promotion services.<sup>200</sup>

### 3.7.2. 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 those needing health care.<sup>201</sup> A 2011 WHO health information profile for RMI highlights a range of climate and disaster risks, including rising sea levels, desertification, pollution from ships, coral reef erosion and typhoons.<sup>202</sup>

According to a recent WHO assessment report, the key climate-sensitive health risks in RMI are diarrhoeal diseases, malnutrition, vector-borne diseases (especially dengue fever) and ciguatera (fish poisoning).<sup>203</sup> Climate and health data also suggest that higher temperatures in Majuro (the main urban area of Marshall Islands) are associated with more frequent cases of gastroenteritis, respiratory complaints and health problems related to diabetes.<sup>204</sup>

The WHO Country Cooperation Strategy for Marshall Islands 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, people with disabilities, people with pre-existing illnesses (e.g. NCDs) and individuals in certain occupations (farmers, fishermen and outdoor workers).<sup>205</sup>

On a positive note, it appears that the Government is aware of the importance of tackling climate-related health risks, with WHO noting that “a significant amount of activity and planning has been taking place over several years within the climate change arena in the Marshall Islands.”<sup>206</sup> For example, RMI has developed a Joint National Action Plan for Climate Change Adaptation and Disaster Risk Management, which considers the health impacts of climate change under Goal 5.<sup>207</sup>

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198 WHO. 2011. Country health information profile. [http://www.wpro.who.int/countries/mhl/16MSIpro2011\\_finaldraft.pdf](http://www.wpro.who.int/countries/mhl/16MSIpro2011_finaldraft.pdf) [25.04.17].

199 Ibid.

200 Ibid. p. 210.

201 WHO Country Cooperation Strategy for Marshall Islands 2013-2017.

202 WHO. 2011. Country health information profile. Op. cit.

203 WHO. 2015. Human health and climate change in Pacific island countries. p. 66. [http://iris.wpro.who.int/bitstream/handle/10665.1/12399/9789290617303\\_eng.pdf](http://iris.wpro.who.int/bitstream/handle/10665.1/12399/9789290617303_eng.pdf) [13.03.17].

204 Ibid.

205 WHO Country Cooperation Strategy for Marshall Islands 2013-2017. Op. cit. p. 12.

206 WHO (2015) Human health and climate change in Pacific island countries. Op. cit. p. 69.

207 Ibid.

While it appears that Marshallese communities are still (understandably) concerned about radiation-induced illnesses, following a series of devastating US nuclear tests in the 1940s and 1950s, the WHO assessment report concludes that climate change and disasters (short of further nuclear events) will not significantly impact health risks associated with radiation, which now primarily affect the elderly.<sup>208</sup>

### 3.7.3. Myths and misperceptions

Myths and misperceptions about particular diseases and health interventions may also pose risks to the effective functioning of the RMI health system.

The historical absence of severe epidemics of vector-borne diseases appears to have given rise to a widespread belief (apparently also held amongst some MOH officials) that the Marshallese are immune to diseases such as dengue fever.<sup>209</sup> Such misperceptions have the potential to undermine the country's prevention and response efforts to vector-borne epidemics, as was evidenced in December 2011, when Marshall Islands experienced a severe dengue epidemic.<sup>210</sup>

It also appears that misperceptions about contraceptive use are suppressing demand for family planning in RMI. For example, the 2007 DHS data suggest that, amongst married women aged 15 to 49, the most commonly cited reason for not intending to use contraception was fear of side effects, with around 30 per cent of women citing this as their main reason.<sup>211</sup>

### 3.7.4. Health financing

While health financing in RMI is adequate, and per capita spending is above the PICT average, according to NMDI data from 2011,<sup>212</sup> high travel costs and heavy reliance on external donor assistance (in particular US grants) represent potential health financing bottlenecks.

According to regional NMDI data, the health budget was approximately 16.5 per cent of GDP, as of 2009, which is the highest in the whole PICT group.<sup>213</sup> Expenditure as a percentage of GDP is also significantly above the recommended 5 per cent.<sup>214</sup> Government expenditure on health made up around 20 per cent of total government expenditure, which, according to NMDI data, is the second-highest figure in the PICT group, only topped by FSM (see Figure 3.6).<sup>215</sup>

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208 Ibid. p. 69. p. 70.

209 WHO. 2015. Human health and climate change in Pacific island countries. Op. cit. P66 p.70

210 Ibid.

211 Ibid.

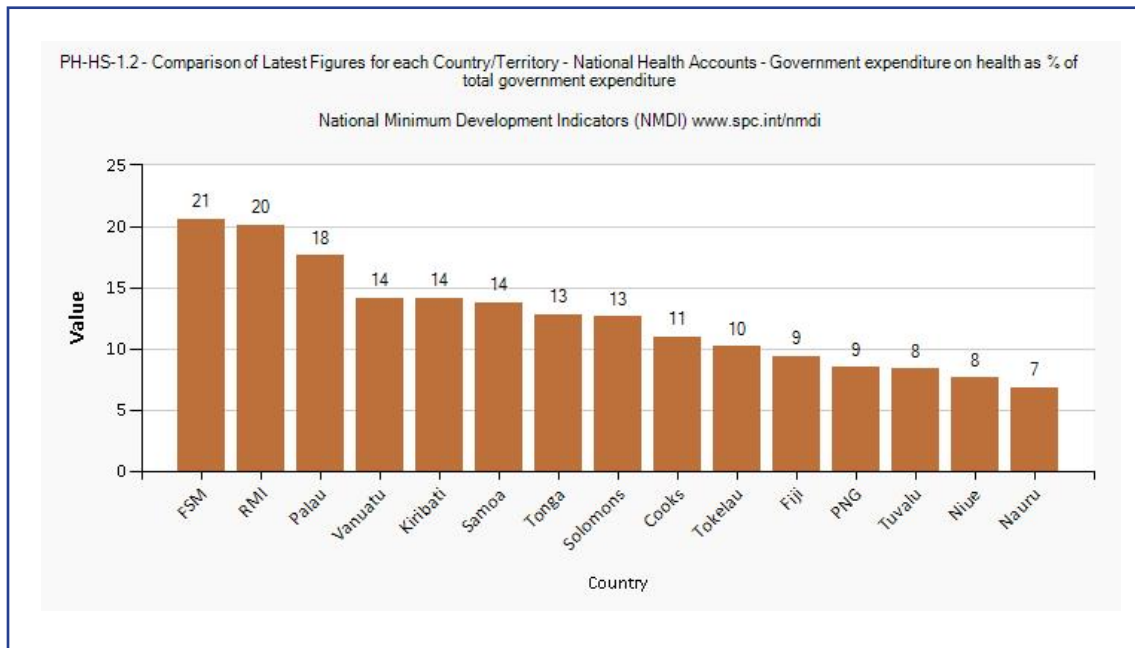
212 NMDI data. [https://www.spc.int/nmdi/health\\_systems](https://www.spc.int/nmdi/health_systems) [12.04.17]

213 Ibid.

214 Note that this often-cited "WHO recommended 5 per cent threshold" was never officially approved by the World Health Assembly. See e.g. [http://www.who.int/health\\_financing/en/how\\_much\\_should\\_dp\\_03\\_2.pdf](http://www.who.int/health_financing/en/how_much_should_dp_03_2.pdf), especially Annex A. [25.04.17].

215 NMDI data. Op. cit.

**Figure 3.6: Government expenditure on health as percentage of total government expenditure**



Source: NMDI, 2016

Total government expenditure on health in RMI was estimated at US\$22.6 million in 2012, with US grants accounting for more than half (59 per cent) of the health budget.<sup>216</sup> An additional source of revenue for the health budget comes from insurance premiums collected from salaries, which have ranged from US\$2.9 to US\$4.3 million per annum in recent years.<sup>217</sup> Out-of-pocket spending is minimal and, in 2007, only 2.6 per cent of healthcare expenditure came from the private sector.<sup>218</sup>

Funding for health care is not disbursed equitably. Almost 97 per cent is directed towards the urban centres, even though the population living in these areas make up only 75 per cent of the total population.<sup>219</sup> A significant proportion of funding is allocated to tertiary services, such as hospitalisation and specialised overseas treatment (primarily in Hawaii or the Philippines).<sup>220</sup>

A key risk to the health budget is the potentially high cost of travel for patients referred abroad and from the Outer Islands. A recent WHO report on the health workforce suggests that while the MOH invites international clinical teams to visit once a year to reduce these costs, the financial burden associated with overseas referrals remains high. According to WHO, there were 109

216 Alfred J., Edwin M., Funk M., Handtke O. and McGovern P. Op. cit.

217 Ibid. p. 26.

218 WHO. 2011. Country health information profile. Op. cit.

219 WHO. 2014. Human resources for health country profiles: Marshall Islands. Available at: [http://www.wpro.who.int/hrh/documents/publications/wpr\\_hrh\\_country\\_profiles\\_marshall\\_islands\\_upload2.pdf?ua=1](http://www.wpro.who.int/hrh/documents/publications/wpr_hrh_country_profiles_marshall_islands_upload2.pdf?ua=1) [25.04.17].

220 Alfred J., Edwin M., Funk M., Handtke O. and McGovern P. Op. cit., p. 26.



referrals in 2010, totalling US\$1.35 million.<sup>221</sup> Costs for health programmes related to the growing disease burden from NCDs, climate change-related health burdens, and workforce development can also be expected to put additional strain on Marshall Islands' health budget.

Heavy reliance on external funding sources also raises questions of financial sustainability. Health funding is heavily reliant on external development assistance (especially US grants), with US funding currently amounting to about 80 per cent of the Government's annual budget, and around 60 per cent of the health budget.<sup>222</sup>

### 3.7.5. Health workforce

As of 2012, RMI had a total of 515 health workers, 512 of whom were employed in the public health sector.<sup>223</sup> As in many other PICTs, nurses make up the largest group within the RMI health workforce, (around 30 per cent, either advanced practice nurses, graduate nurses or vocational nurses).<sup>224</sup>

There are about 3.6 nurses per 1,000 individuals in RMI, which is the same as the PICTS regional average (including Papua New Guinea [PNG]).<sup>225</sup> According to estimates from 2010, RMI has 0.6 physicians per 1,000 individuals, which is below the PICT average (including PNG) of 0.9.<sup>226</sup> The ratio of 0.08 dentists to 1,000 individuals (there were four in 2012) is also below the regional average.<sup>227</sup> WHO has highlighted the lack of appropriately trained mental health professionals in RMI.<sup>228</sup>

While the health worker to population rates are generally quite low (except for nurses), it is also important to highlight that the health workforce is not equitably distributed across RMI, and that significant rural-urban disparities exist. Majuro hospital employs 65 per cent of all health workers, even though its estimated immediate catchment is only 48 per cent of the population.<sup>229</sup> For individuals in rural areas, treatment beyond basic primary health care requires travel to the main urban centres (Majuro and Ebeye), which, according to the WHO, is one important driver of internal migration and rapid urbanisation.<sup>230</sup>

The key underlying causes of the health workforce shortage appear to be high staff turnover, the out-migration of qualified professionals and the inability of the public health system to retain

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221 WHO. 2014. Human resources for health country profiles: Marshall Islands. Op. cit.

222 WHO. 2011. Country health information profile. Op. cit.

223 WHO. 2014. Human resources for health country profiles: Marshall Islands. Op. cit.

224 Ibid. [25.04.17], p. 6.

225 NMDI data. Op. cit.

226 Ibid.

227 See WHO. 2014. Human resources for health country profiles: Marshall Islands. Op. cit. p. 6; and NMDI data. Op. cit.

228 Alfred J., Edwin M., Funk M., Handtke O. and McGovern P. Op. cit.

229 WHO. 2014. Human resources for health country profiles: Marshall Islands. Op. cit.

230 Ibid. p. 8.

professionals.<sup>231</sup> WHO suggests that most of the attrition in the health workforce has been due to resignations, with many doctors resigning before their contracts have ended, citing poor working conditions, lack of essential equipment and inadequate salaries.<sup>232</sup> Retention of nurses also appears to be a significant challenge.<sup>233</sup> Many highly-qualified health professionals move abroad to pursue better working opportunities (especially to the US, where there are no travel restrictions for RMI citizens).<sup>234</sup>

On a positive note, it appears that the health system can, at least to some extent, compensate for the out-migration of Marshallese health professionals, by attracting new recruits from neighbouring countries. The salaries of nurses in RMI are comparatively higher than those in other PICTs, and there are a number of expatriate nurses (mostly from Fiji and the Philippines).<sup>235</sup>

### 3.7.6. Service delivery

There are two hospitals in RMI, one in Majuro (101 beds) and one in Ebeye (45 beds). There are also 58 primary health centres, mostly in the Outer Islands.<sup>236</sup> A major challenge facing the RMI health service delivery system is the high cost and administrative difficulty of delivering services to a population that is dispersed across many islands, and that have minimal infrastructure and transport links. According to a 2014 WHO report on the health workforce, problematic inequities exist between the Outer Islands and the main urban areas, with a disproportionate share of healthcare funding and human resources allocated to the main urban areas (especially Majuro hospital).<sup>237</sup> Infrastructure in the primary healthcare centres on the Outer Islands is reported to be poor, and basic health interventions such as vaccinations need to be administered by visiting outreach teams, as there are usually no refrigeration or storage facilities.<sup>238</sup>

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231 WHO Country Cooperation Strategy for Marshall Islands 2013-2017. p. 38.

232 WHO. 2014. Human resources for health country profiles: Marshall Islands. Op. cit. p. 16.

233 Ibid.

234 Ibid.

235 Ibid. p. 4.

236 Ibid.

237 Ibid.

238 Ibid.

# 4.

## Water, Sanitation and Hygiene

Ensuring that all children have access to safe and affordable drinking water, as well as adequate sanitation and hygiene, is crucial for achieving a range of development goals related to health, nutrition and 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-5 child mortality in the Pacific region.<sup>239</sup> Evidence also suggests that poor WASH access is linked to stunting.<sup>240</sup> 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.<sup>241</sup> This chapter assesses and analyses the situation in RMI 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.

The WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) has produced estimates of global progress in WASH since 1990.<sup>242</sup> The JMP was previously responsible for tracking progress towards MDG 7c on WASH and, following the introduction of the 2030 SDGs, now tracks progress towards the SDG WASH targets.<sup>243</sup> The JMP uses a 'service ladder' system to benchmark and compare progress across countries, with each 'rung' on the ladder representing progress towards the SDG targets.<sup>244</sup> The sections within this chapter utilise the relevant service ladders to assess RMI's progress towards meeting the SDG targets.

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239 WHO. 2016. Sanitation, drinking-water and health in Pacific island countries. 2015 Update and Future Outlook.

240 UNICEF. 2016. Looking back, moving forward. A snapshot of UNICEF's work for Pacific Island children 2015-16.

241 Ibid.

242 WHO and UNICEF. 2017. Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva. p. 6.

243 Ibid.

244 Ibid. p. 2, 7.

## Key WASH-related SDGs

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

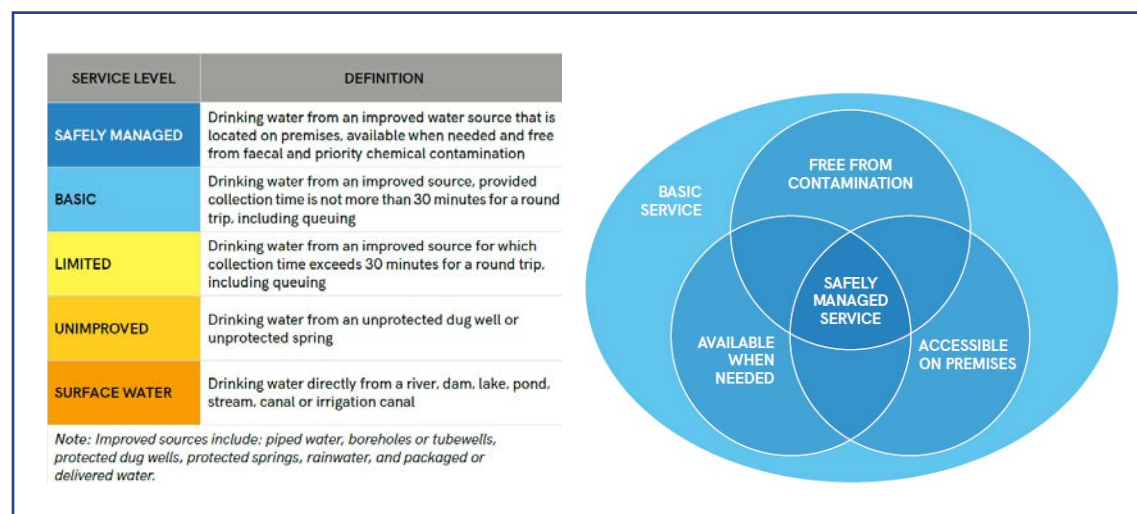
### 4.1. Access to improved water sources

For a country to meet the criteria for a **safely managed drinking water service (SDG 6.1)**, the population should have access to an improved water source fulfilling three criteria: it should be accessible on the premises; water should be available when needed; and the water supplied should be free from contamination.<sup>245</sup> 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)**, and if water collection from an improved source exceeds 30 minutes, it will be categorized as a **limited service**.<sup>246</sup> The immediate priority in many countries will be to ensure universal access to at least a basic level of service.<sup>247</sup>

245 WHO and UNICEF. Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Op. cit. p. 8.

246 Ibid.

247 Ibid. p. 10.

**Figure 4.1: JMP service ladder for improved water sources**

Source: JMP<sup>248</sup>

As an atoll country, RMI's potable water is drawn primarily from rainwater and freshwater lenses.<sup>249</sup> No estimate of the proportion of population using safely managed drinking water services<sup>250</sup> is available for RMI, as data are not available for the proportion of the population using an improved source that is accessible when needed, or using an improved source that is free from contamination.<sup>251</sup> According to JMP 2017 estimates, as of 2015, 98.7 per cent of the population used an improved drinking water source.<sup>252</sup> However, of these, only 78.3 per cent had access to a 'basic service', while 20.6 per cent had access to a 'limited service'.<sup>253</sup> This means that RMI is some way from providing basic services for all of its population and meeting SDG 1.4. It also places RMI among the poorest performing PICTs in relation to provision of basic water services (see Figure 4.2). According to the 2017 JMP Report, 1.3 per cent of the RMI population was estimated to be using unimproved water sources in 2015.<sup>254</sup>

JMP estimates indicate significant disparities in relation to access to basic services between urban and rural areas in RMI.<sup>255</sup> In urban areas an estimated that 99 per cent of population has access to basic drinking water services, compared to only 70.3 per cent in rural areas.<sup>256</sup> This indicates that, in order to meet SDG 4.1, RMI should prioritise efforts in rural areas. Differences can also be seen between urban and rural areas in relation to how improved water is accessed,

248 Ibid.

249 SPC Pacific Water. Republic of the Marshall Islands. <http://www.pacificwater.org/pages.cfm/country-information/republic-of-marshall-islands.html> [05.05.17].

250 The indicator for SDG 6.1, safely managed drinking water services are defined as use of an improved drinking water source which is accessible on premises, available when needed and free from contamination.

251 JMP data for Marshall Islands available from <https://washdata.org/data#!/mhl> [02.08.17].

252 Ibid.

253 Ibid.

254 Ibid.

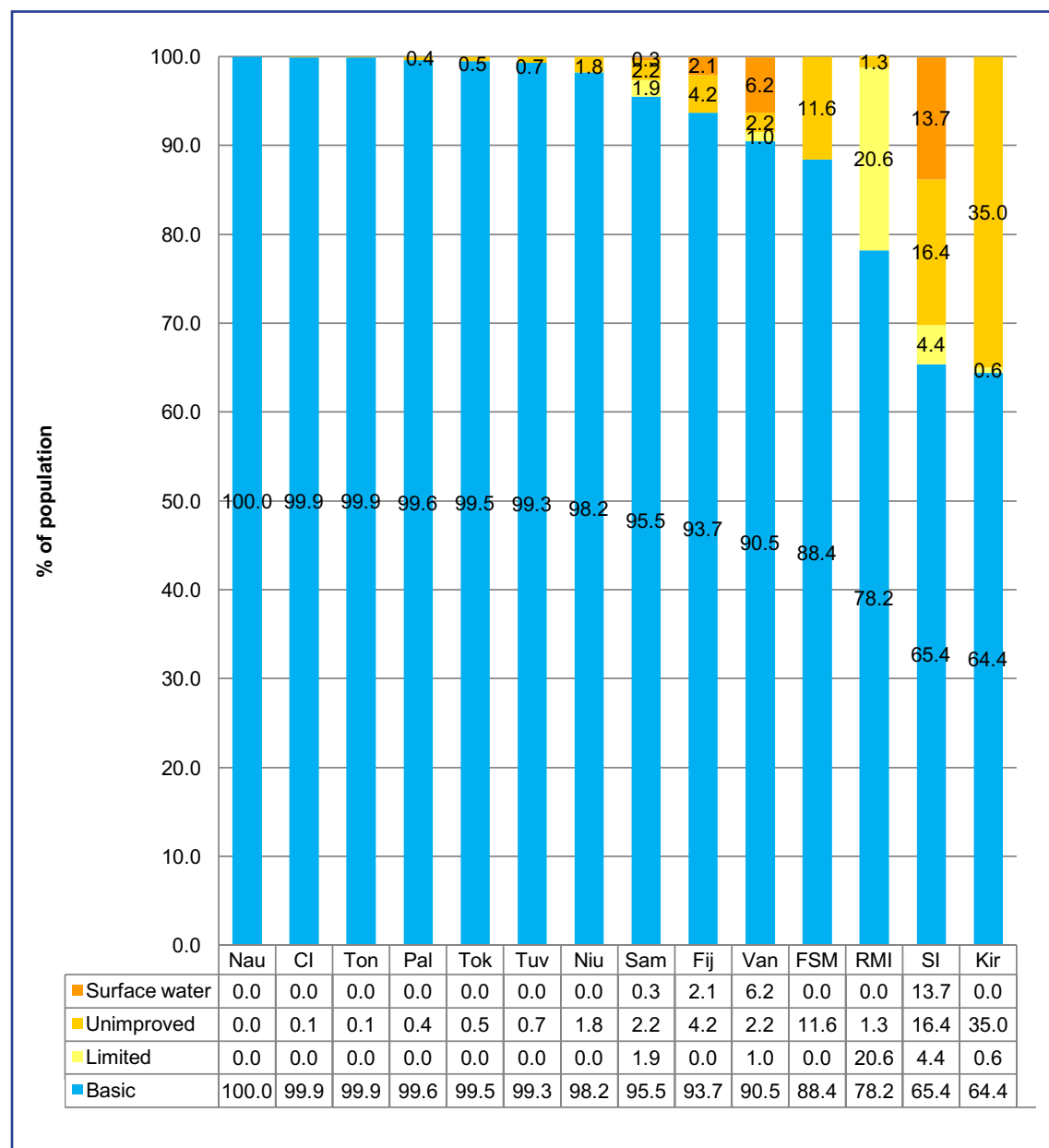
255 Ibid.

256 Ibid.



with 15.1 per cent of the population using an improved source in urban areas with access to piped water, compared to as low as 0.1 per cent in rural areas, according to estimates for 2015.<sup>257</sup>

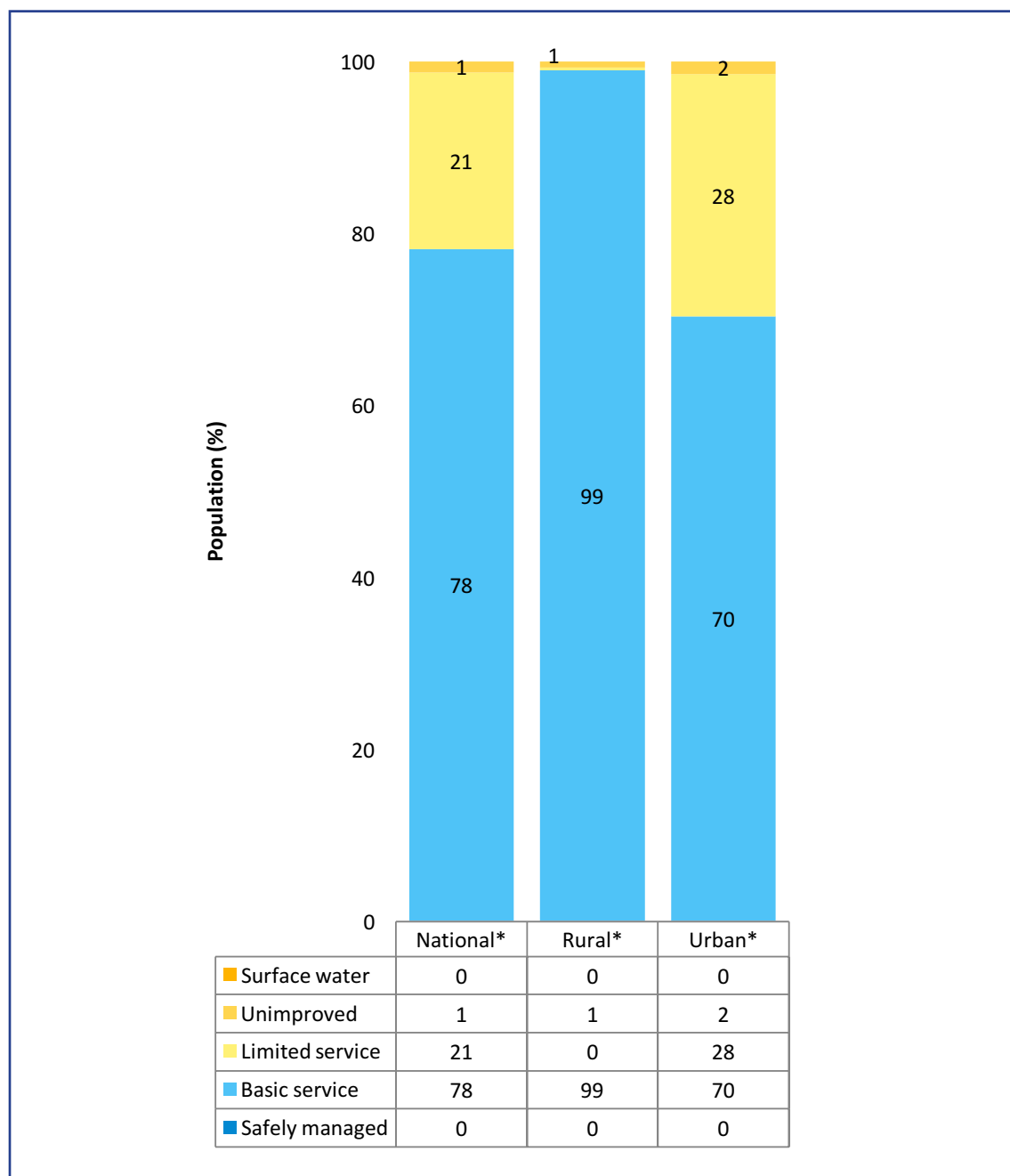
**Figure 4.2: Provision of drinking water services as per JMP service ladder, 2015 estimates**



Source: JMP<sup>258</sup>

257 Ibid.

258 Ibid.

**Figure 4.3: Provision of drinking water services in RMI, 2017 estimates**

Source: JMP<sup>259</sup>

Table 4.1 indicates trends over time in terms of access to improved water supply in RMI. The data indicate stable rates over the past 14 years, and, although improved water rates are high, further efforts are required to accelerate progress and meet targets by 2030 (as no data were available for year 2000, data from 2001 has been included).

**Table 4.1: Provision 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 which are:				
						Piped	Non-piped	Accessible on premises	Available when needed	Free from contamination
2001	98.8	79.3	19.4	1.2	0.0	10.4	88.4	75.3	-	-
2005	98.7	79.0	19.8	1.3	0.0	10.6	88.2	74.9	-	-
2010	98.7	78.5	20.2	1.3	0.0	10.8	88.0	74.4	-	-
2015	98.7	78.2	20.6	1.3	0.0	11.0	87.8	74.0	-	-

Source: JMP<sup>260</sup>

While it is estimated that 71 per cent of households (at least in Majuro) have their own rainwater catchment systems,<sup>261</sup> the low piped water coverage suggests that many households in Marshall Islands face significant burdens associated with fetching and gathering water: a task which, in much of the world, has traditionally been the responsibility of women and girls.<sup>262</sup>

Although RMI has come close to meeting international development targets, some issues remain. Majuro's current 36 million-gallon reservoir capacity has been described as insufficient, and would need to be doubled to meet growing demand.<sup>263</sup> Furthermore, it is estimated that 50 per cent of Majuro's water supply system is 'lost' due to leakage.<sup>264</sup> In Ebeye, RMI's second urban centre, it appears that frequent power cuts exacerbate water supply problems.<sup>265</sup>

## 4.2. Access to improved sanitation facilities

To meet SDG 6.2 in relation to safely managed sanitation service, the population of RMI should have access to improved sanitation facilities that are not shared with other households, and the

260 Ibid.

261 SOPAC et al. 2007. National Integrated Water Resource Management Diagnostic Report. SOPAC Miscellaneous Report 639. [http://www.pacificwater.org/userfiles/file/GEF\\_per\\_cent20IWRM\\_per\\_cent20Final\\_per\\_cent20Docs/MR0639RMI.pdf](http://www.pacificwater.org/userfiles/file/GEF_per_cent20IWRM_per_cent20Final_per_cent20Docs/MR0639RMI.pdf) [05.05.17], p. 11.

262 See UNICEF. 2003. WASH and Women. [https://www.unicef.org/wash/index\\_womenandgirls.html](https://www.unicef.org/wash/index_womenandgirls.html) [05.05.17].

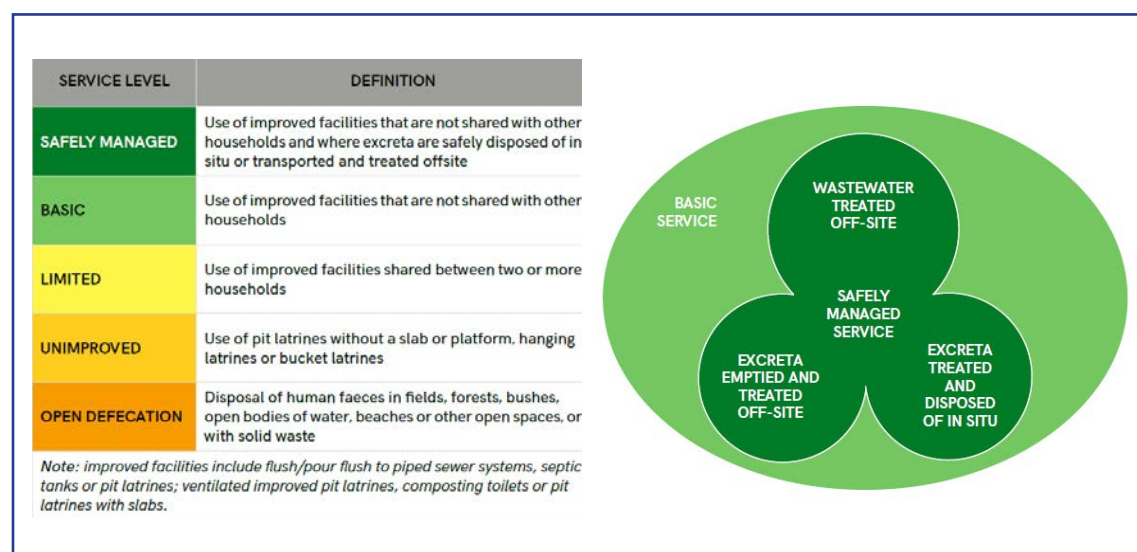
263 SPC Pacific Water. Republic of the Marshall Islands. Op. cit.

264 This is estimated comparing the amount of water supplied against invoices for water received and paid for. See SPC Pacific Water Majuro Water Resources Situation Assessment. Republic of the Marshall Islands. <http://www.pacificwater.org/pages.cfm/water-services/water-demand-management/project-goal-objective-outputs/project-profile/project-profile-majuro-water-resources-situation-assessment-republic-of-marshall-islands.html> [05.05.17].

265 Ibid.

excreta produced should either be 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.<sup>266</sup> 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), and those using improved facilities that are shared with other households will be classified as having a limited service.<sup>267</sup> Under SDG target 6.2, specific focus is also put on ending the practice of open defecation.<sup>268</sup> While SDG target 6.2 aims to progressively raise the standard sanitation services for all, the immediate priority for many countries will be to first ensure universal access to at least a basic level of service.<sup>269</sup>

**Figure 4.4: JMP service ladder for improved sanitation facilities**



Source: JMP<sup>270</sup>

No estimate of the proportion of population having access to safely managed sanitation services is available for RMI, as data on excreta management is lacking.<sup>271</sup> According to 2017 estimates, however, as of 2015, 86.9 per cent of the population had access to basic sanitation facilities (improved facilities that are not shared between households).<sup>272</sup> Some 2.4 per cent of the population was still using unimproved services as of 2015.<sup>273</sup> This is below the PIC average for access to basic sanitation facilities and means that RMI has some way to go to provide basic sanitation services to all of its population and meet SDG 1.4.

266 WHO and UNICEF. Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Op. cit. p. 8.

267 Ibid. pp. 8-9.

268 Ibid.

269 Ibid. p. 10.

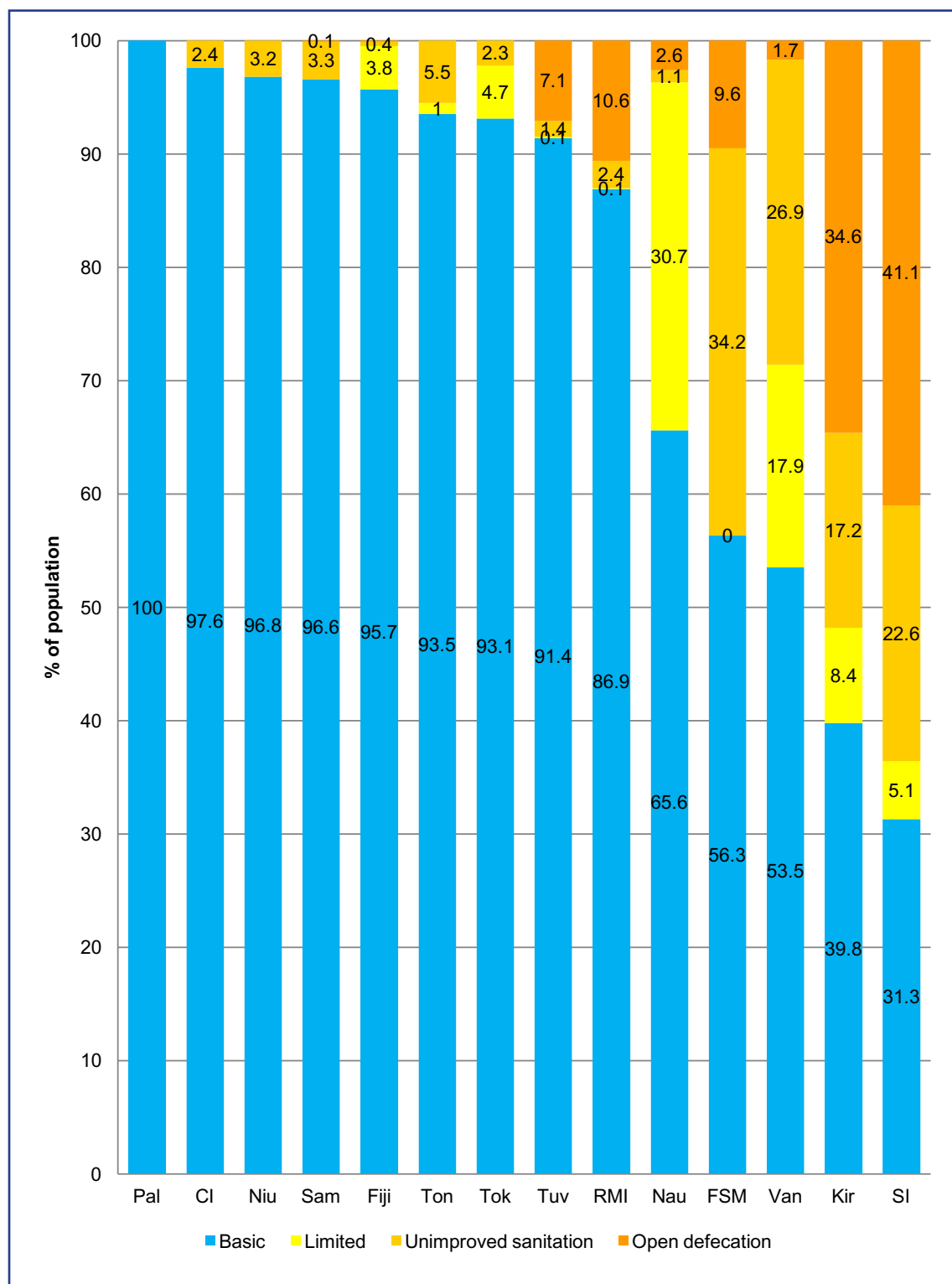
270 Ibid.

271 JMP data for Marshall Islands. Op. cit.

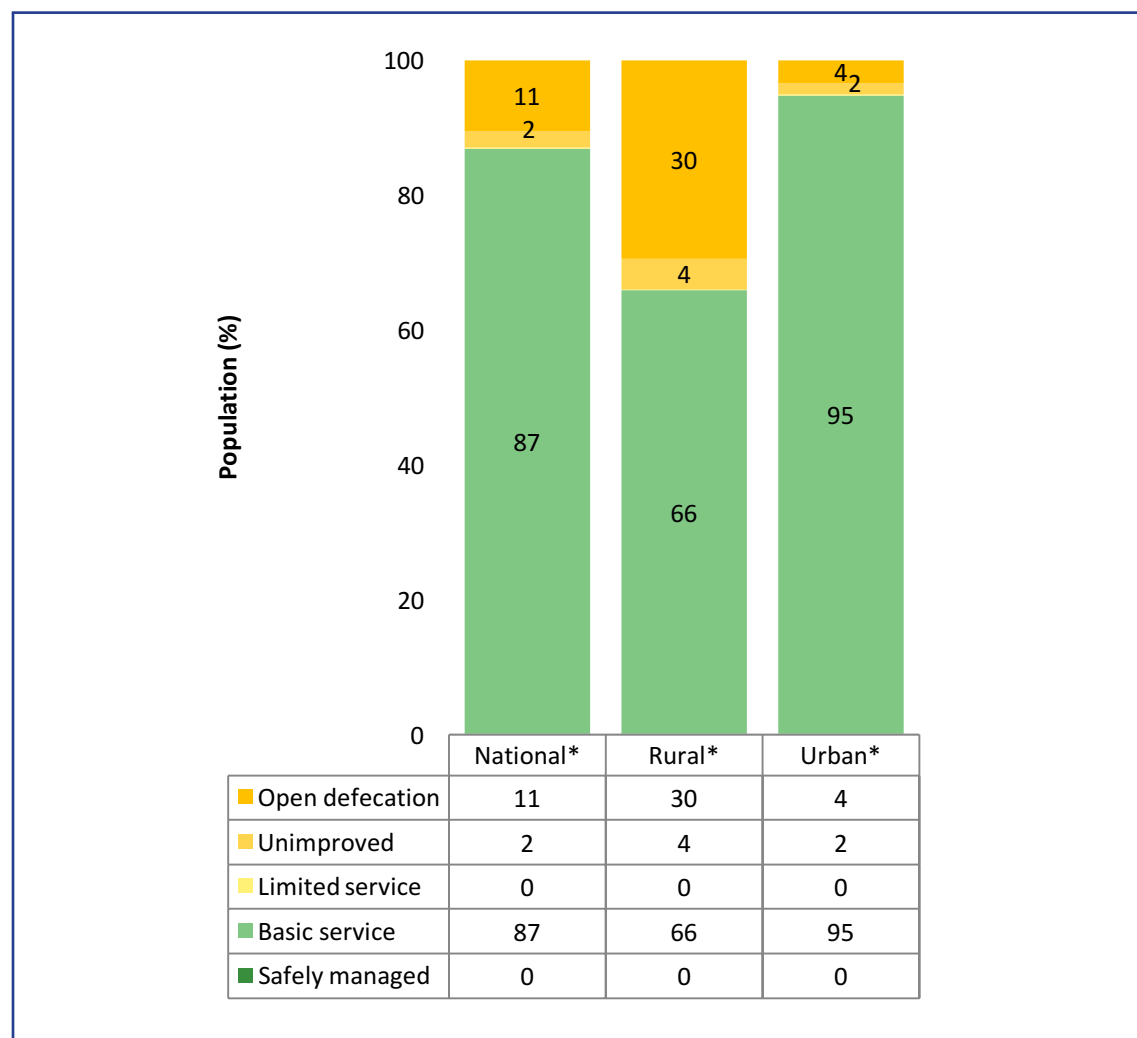
272 Ibid.

273 Ibid.

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



Source: JMP<sup>274</sup>

**Figure 4.6: Provision of sanitation facilities in RMI, 2017 estimates**

Source: JMP<sup>275</sup>

Figure 4.6 suggests there are stark differences in access to sanitation facilities between urban and rural areas. While in urban areas basic sanitation coverage is at 94.9 per cent, in rural areas, only 66 per cent of the population had access to basic services. This indicates that in order to meet SDG 1.4, RMI should prioritise improvements in rural areas, while seeking to increase access in urban areas.

Table 4.2 provides an indication of trends in access to basic sanitation facilities in RMI, showing a steady increase between 2001 and 2015.



**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 improved and not shared sanitation facility:					
						Latrines and other	Septic tank	Sewer connection	Disposed in situ	Emptied and treated	Wastewater treated
2000	-	-	-	-	-	-	-	-	-	-	-
2005	86.2	86.1	0.1	2.5	11.3	15.4	28.4	42.3	-	-	-
2010	86.6	86.5	0.1	2.4	11.0	15.1	28.3	43.1	-	-	-
2015	87.0	86.9	0.1	2.4	10.6	14.8	28.1	43.9	-	-	-

According to SDG target 6.2, RMI should end any practice of open defecation by 2030. Most recent estimates (see Table 4.2) suggest that open defecation was still practiced by 10.6 per cent of the population in 2015 – the third highest PICT rate – meaning that RMI has some way to go to meet this important WASH development target.<sup>276</sup> Disaggregated data show disparities between urban and rural areas in this area (see Figure 4.6), with estimated open defecation rates of 3.5 per cent in urban areas and as high as 29.5 per cent in rural areas.<sup>277</sup> Progress has also been slow in this area, with rates remaining constant in rural areas, and urban areas experiencing a small decrease over the past 15 years.<sup>278</sup> In order to meet SDG 6.2 in 2013 Marshall Islands will need to accelerate progress and in particular prioritise efforts in rural areas.

### 4.3. Hygiene practices

According to SDG target 6.2, RMI should, by 2030, 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 and school attendance.<sup>279</sup>

The presence of a handwashing facility with soap and water on the premises has been identified as the priority indicator for global monitoring of hygiene under the SDGs.<sup>280</sup> Households with a handwashing facility with soap and water available on the premises will meet the criteria for a

276 Ibid.

277 Ibid.

278 Ibid.

279 See e.g. UN-Water Decade Programme on Advocacy and Communication Information Brief. [http://www.un.org/waterforlifedecade/waterandsustainabledevelopment2015/images/wash\\_eng.pdf](http://www.un.org/waterforlifedecade/waterandsustainabledevelopment2015/images/wash_eng.pdf) [27.03.17].

280 WHO and UNICEF. Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Op. cit. pp. 8-9.

**basic** hygiene facility (SDGs 1.4 and 6.2).<sup>281</sup> 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.<sup>282</sup>

**Figure 4.7: JMP service ladder for improved hygiene services**

SERVICE LEVEL	DEFINITION
<b>BASIC</b>	Availability of a handwashing facility on premises with soap and water
<b>LIMITED</b>	Availability of a handwashing facility on premises without soap and water
<b>NO FACILITY</b>	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<sup>283</sup>

There is a lack of data on hygiene practices in RMI, and no data on hygiene practices is provided by the 2017 JMP study. In contrast to many neighbouring countries, RMI has not implemented a GSHS, which would include information about hygiene practices (hand-washing and dental hygiene) amongst school children.<sup>284</sup>

If human faeces are not disposed of safely, diseases may spread by direct contact or animal contact.<sup>285</sup> 2007 DHS survey data suggest that only 34 per cent of households in RMI dispose of children's faeces in a safe and hygienic manner (by flushing them down the toilet or burying them), and that 38 per cent of households dispose of children's faeces by simply throwing them into the garbage.<sup>286</sup> According to the 2007 DHS, children's faeces are more likely to be hygienically and safely disposed in urban areas (41 per cent), than rural areas (21 per cent), which may be because toilet facilities are generally more available in urban areas.<sup>287</sup> It is unclear whether these DHS figures from 2007 still reflect hygiene practice in Marshall Islands in 2017.

281 Ibid.

282 Ibid.

283 Ibid.

284 See <http://www.who.int/chp/gshs/datasets/en/> [12.04.17].

285 2007 Marshall Islands DHS report. p.152.

286 Ibid. p.153.

287 Ibid.

## 4.4. WASH in schools, menstrual hygiene management and disabilities

No information was obtainable on WASH in Schools in RMI. Data also appears to be lacking on access to WASH for persons living with disabilities and other disadvantaged groups.

There appears to be very little information on menstrual hygiene management (MHM) programmes in RMI. Anecdotal evidence suggests that access to adequate and modern menstrual hygiene products is limited, especially on the Outer Islands. According to one observer, women in RMI sometimes have access to sanitary napkins, but “often they need to make do with cut-up disposable diapers, or scraps of material.”<sup>288</sup> In Marshallese society, menstruation is seen as a ‘women’s issue’ and considered taboo – not to be discussed in the presence of men.<sup>289</sup>

## 4.5. Barriers and bottlenecks

Even though data on the WASH sector in RMI is quite limited, evidence suggests that there are several key structural barriers and bottlenecks that could prevent it from making further progress in WASH.

### 4.5.1. Geography

As with health service provision, a major challenge facing RMI’s WASH sector is the high cost and administrative difficulty of delivering services and implementing WASH programmes to a population that is dispersed across the 29 coral atolls, many of which have very minimal infrastructure and transport links.<sup>290</sup>

### 4.5.2. Climate and disaster risks

Rising sea levels and flooding, desertification, drought, pollution from ships, coral reef erosion and typhoons are key risks facing RMI. A recent WHO assessment report identified the key climate-sensitive health risks as diarrhoeal diseases, vector-borne diseases (especially dengue fever) and ciguatera (fish poisoning), which are affected by water safety.<sup>291</sup> Water safety therefore needs to be treated as a top priority in preventing and mitigating climate-sensitive health risks in RMI.

288 See Saunders, A. 2016. Cookhouse Confidential: Menstruation in a Tropical Paradise. Reuters Trust, Wednesday, 18 May 2016. <http://news.trust.org/item/20160518051429-kf7py> [05.05.17].

289 Ibid.

290 See e.g. SOPAC et al. 2007. National Integrated Water Resource Management Diagnostic Report. Op. cit.

291 WHO (2015) Human health and climate change in Pacific island countries. Op. cit. p. 66.

Marshall Islands is also extremely reliant on consistent rainfall for its water supply. The northern atolls are particularly vulnerable to droughts and rainfall shortages during climatic extremes such as El Niño periods, which exacerbate the already very limited freshwater supply.<sup>292</sup> In early 2016, for example, the President declared a national emergency, after the country received just a quarter of its usual rainfall during the November to February period, which forced some to drink from coconuts and eat unripe breadfruit.<sup>293</sup>

### 4.5.3. Financial and human resources

Inadequate financial and human resources are also likely to be key barriers to more rapid progress in improving access to WASH. Unfortunately, it was not possible to obtain detailed information on WASH financing in RMI, which is not included in the Global Annual Assessment of Sanitation and Drinking-Water, which usually includes indicators for measuring adequacy of funding.<sup>294</sup> However, according to a report by the Pacific Community (SPC), the main water utility in RMI, the Majuro Water and Sewerage Company (MWSC), is under-resourced, both in terms of staff and finance.<sup>295</sup> According to a somewhat outdated South Pacific Applied Geoscience Commission (SOPAC)-UN report from 2007, MWSC's expenses exceeded revenue in the 2005 financial year, with losses of US\$211,702 US\$.<sup>296</sup> The SPC report also suggests that training and capacity building needs at MWSC are high.<sup>297</sup>

There appears to be a fragmentation of authority and responsibility over water and sanitation issues in RMI. The 2007 SOPAC-UN report suggests that there is some informal collaboration between the Environmental Protection Authority, the Weather Station, MWSC and other entities, which it suggests could be strengthened and formalised.<sup>298</sup>

In March 2014, the RMI Cabinet endorsed a National Water and Sanitation Policy and a corresponding 5-year Action Plan,<sup>299</sup> which, according to the RMI National Strategic Plan 2015-2017, sets out the responsibilities for water and sanitation investment and activities for all relevant sector stakeholders.<sup>300</sup> It appears that the Environmental Protection Authority has since been given the responsibility for monitoring and implementing the Policy and Action Plan.<sup>301</sup> However, it is unclear to what extent the policy has been implemented as of 2017.

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292 SPC Pacific Water. Republic of the Marshall Islands. Op. cit.

293 See The Guardian <https://www.theguardian.com/world/2016/apr/28/obama-marshall-islands-drought> [05.05.17].

294 WHO. 2014. UN-Water Global Analysis and Assessment of Sanitation and Drinking-water (GLAAS). [http://www.who.int/water\\_sanitation\\_health/monitoring/investments/glaas/en/](http://www.who.int/water_sanitation_health/monitoring/investments/glaas/en/) [05.05.17].

295 SPC Pacific Water. Majuro Water Resources Situation Assessment. Op. cit.

296 SOPAC et al. 2007. National Integrated Water Resource Management Diagnostic Report. Op. cit.

297 SPC Pacific Water. Op. cit.

298 Ibid.

299 See Pacific IWRM <http://www.pacific-iwrm.org/community/showthread.php?177-RMI-Water-and-Sanitation-Policy> [05.05.17].

300 RMI. 2014. Republic of the Marshall Islands National Strategic Plan 2015–2017. Available at: <https://www.adb.org/sites/default/files/linked-documents/cobp-rmi-2016-2018-ld-04.pdf> [05.05.17]

301 See RMI. 2016. National Environmental Protection (Amendment) Act 2016. <https://www.rmiparliament.org/cms/images/LEGISLATION/BILLS/2016/2016-0033/NationalEnvironmentalProtectionAmendmentAct2016.pdf> [05.05.17].

#### 4.5.4. Community awareness and gender norms

The 2007 SOPAC-UN report suggests that public awareness of water-related issues is low in RMI communities, and that outreach and awareness-raising activities are limited. According to the report, this holds true for the general public as well as officials from relevant ministries.<sup>302</sup>

Gender norms also appear to restrict women's and girls' access to menstrual hygiene products. In Marshallese society, menstruation is seen as a 'women's issue' and considered taboo, which may in turn mean that access to menstrual hygiene products is not prioritised in the community.

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302 SOPAC et al. 2007. Op. cit.

# 5.

## Education

### Key Education-related SDGs

SDGs	Targets	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 information and communications technology (ICT) skills, by type of skill



<b>4.5</b>	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
<b>4.6</b>	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
<b>4.7</b>	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 (i) global citizenship education and (ii) education for sustainable development, including gender equality and human rights, are mainstreamed at all levels in: (a) national education policies, (b) curricula, (c) teacher education and (d) student assessment
<b>4.A</b>	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 handwashing facilities (as per the WASH indicator definitions)
<b>4.B</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 information and communications technology, technical, engineering and scientific programmes, in developed countries and other developing countries	Volume of official development assistance flows for scholarships by sector and type of study

<b>4.C</b>	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
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The right to education is a fundamental human right, enshrined in Articles 28 and 29 of the CRC and Article 13 of ICESCR. According to the UN Committee on Economic, Social and Cultural Rights (CESCR), the right to education encompasses the following “interrelated and essential features”: availability; accessibility; acceptability; and adaptability.<sup>303</sup> 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.” Goal 4 requires States to “ensure inclusive and quality education for all and promote lifelong learning.” The SDGs build upon the MDGs, including MDG 2 on universal primary education, and UNESCO’s Education for All (EFA) goals, which are referenced throughout this section.

In addition to these rights and targets, the United Nations International Strategy for Disaster Reduction (UNISDR) and Global Alliance for Disaster Risk Reduction and Resilience in the Education Sector (GADRRRES) Comprehensive School Safety Framework set 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 RMI, which is vulnerable to disaster and risk. Information on the efforts made to prepare schools for natural disasters is extremely limited. The 1997 Hazard Mitigation Plan notes that it is the responsibility of the Ministry of Education (MoE) to close public schools in outer areas in the event of danger, and to open other schools that are capable of sheltering people during the event.<sup>304</sup> Unfortunately, up-to-date data on the impact of natural disasters on school infrastructure and children attending schools during natural disasters is unavailable.

## 5.1. Context

The education sector in RMI is governed by the MoE, which administers both public primary and secondary programmes and is responsible for issuing charters to authorise private schools.<sup>305</sup> Current education sector policy is outlined in the most recent MoE Strategic Plan for 2013-

303 UN Committee on Economic, Social and Cultural Rights. 1999. General Comment No. 13. The Right to Education, 8 December 1999, E/C.12/1999/10 (CESCR GC No. 13 (1999)), para. 6.

304 Marshall Islands, Hazard Mitigation Plan, 1997, <http://www.pacificdisaster.net/pdnadmin/data/documents/159.html>.

305 See: The Public School Systems Act, 2013, (P.L. 2013-23); Education for All Report, Republic of the Marshall Islands, 2015. <http://unesdoc.unesco.org/images/0022/002297/229722E.pdf>.

2016 – ‘Invest in Children: An Agenda for Change’. The document outlines 43 priority objectives, identified in consultation with the Ministry’s major external partners, and 249 implementing strategies.<sup>306</sup>

Up-to-date statistics regarding government investment in the education sector are unavailable. Education funding, similar to other areas of the Marshallese economy, is characterised by significant reliance on external assistance from the US through the Compact of Free Association between the USA and the Marshallese Government.<sup>307</sup> This funding is divided into a Basic Compact Grant, a grant for the Ebeye Special Needs sub-sector (for the Marshallese community living on Ebeye and elsewhere in the Kwajalein Atoll who are affected by the US military presence on the islands), the Supplementary Education Grant, and US Federal Grants.<sup>308</sup> In 2013, the MoE budget was US\$25,843,044, with the majority of funding derived from the Basic Compact Grant (44.9 per cent), followed by the Supplementary Educational Grant (22.7 per cent).<sup>309</sup>

The structure of the education system in RMI consists of early childhood education (ECE), primary school (grades 1 to 8) and secondary school (grades 9 to 12), except at one middle school on Majuro serving students in grades 7 and 8 only.<sup>310</sup>

ECE is provided through the Supplementary Education Grant, designed to serve children aged 5.<sup>311</sup> The Government also provides free and compulsory primary and secondary schooling across the islands for all children aged 6 to 18. The language of instruction from grades 1 to 3 is Marshallese. From grade 4 onwards, the official language becomes English, with Marshallese only used as the official language of instruction in Marshallese Language classes.<sup>312</sup> The standardised national curriculum focuses on the English Language, Marshallese Language, Arts, Maths, Science and Social Studies/Marshallese Studies.<sup>313</sup> Alongside these core subjects, schools are expected to allocate time each week for career education, health, population and physical education, and art/music classes.<sup>314</sup> Furthermore, the Government provides secondary-level Technical Vocational Education and skills Training (TVET) programmes as electives in the five public high schools, and various options for tertiary education. There are two institutions providing post-secondary education: the College of the Marshall Islands (CMI) and the University of the South Pacific-Marshall Islands Campus.

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306 Education for All, Marshall Islands, 2015.

307 Compact of Free Association: Agreement between the United States of America and the Marshall Islands. April 30, 2003. <https://www.state.gov/documents/organization/173999.pdf> [22.06.17].

308 Education for All, Marshall Islands, 2015. Op. cit.

309 MoE, Annual Report: SY 2012-2013, p. 14.

310 Education for All, Marshall Islands, 2015. Op. cit.

311 Section 314(e) of the Public School Systems Act (PL. 2013-23) mandates the Government to offer “free public kindergarten to all five year olds in the Republic as resources permit.” Education for All, Marshall Islands, 2015.

312 Education for All, Marshall Islands, 2015. Op. cit.

313 Ibid.

314 Ibid.

## 5.2. 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, especially for the most vulnerable and disadvantaged children. Up until the 2003-2004 school year, ECE was provided by the US federally-funded Head Start programme.<sup>315</sup> However, from 2004 to 2005, grants assigned to the Head Start and other educational programmes were reportedly rolled into the new Supplemental Education Grant.<sup>316</sup> This has reportedly led to an increase in funding in recent years for ECE at local level.<sup>317</sup> As a result of this funding expansion, Head Start was replaced by a national kindergarten programme that was fully integrated with the country’s public primary schools, and provided free of charge to children aged 5.<sup>318</sup>

The transformation in funding has seen a significant increase in the capacity of the sub-sector, with enrolments increasing from 423 in the 2004-2005 school year, to 1,419 in 2005-20.<sup>319</sup> Enrolments peaked in 2007-2008 at 1,551, but have slowly decreased to 1,295 children enrolled in 2012-2013.<sup>320</sup> As such, the gross enrolment rate (GER) increased from 41 per cent in 2004-05 to a high of 113 per cent in 2007-2008, before decreasing to 84 per cent by 2012-2013.<sup>321</sup> However, it has been reported that in 2012-2013, over 400 children enrolled in ECE were either younger or older than 5, resulting in the net enrolment rate (NER) for that year (58.8 per cent), being far lower than the GER.<sup>322</sup> Further, the NER indicates that just over half of the population of 5-year-olds were enrolled in ECE in 2012-2013, reflecting a need for up-to-date data on ECE enrolment and on the barriers and bottlenecks hindering progress towards SDG 4.2.

## 5.3. Primary and secondary education

The EFA goals and SDGs include targets for 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 goals (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.

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315 Ibid. p. 11.

316 For further information, see: United States Government Accountability Office, *Compacts of Free Association: Micronesia and the Marshall Islands Continue to Face Challenges Measuring Progress and Ensuring Accountability*. <http://www.gao.gov/assets/660/658031.pdf> [22.06.17]; Education for All, Marshall Islands, 2015, p. 11.

317 Education for All, Marshall Islands, 2015. Op. cit.

318 Ibid.

319 Ibid.

320 Ibid.

321 Ibid.

322 Ibid.

### 5.3.1. Access

Compulsory primary education in RMI applies to children aged 6 to 13 (grades 1 to 8) and is provided freely by the Government. A notable proportion of children enrolled in primary school attend private primary schools, which are partially subsidised by the Government, based on student enrolment numbers.<sup>323</sup> In 2012-2013, public school enrolment accounted for the significant majority of enrolments at approximately 83 per cent, with the remaining 17 per cent enrolled in private schools.<sup>324</sup>

The latest available figures show that RMI has not achieved universal enrolment in primary education. In 2016, the NER was 79 per cent.<sup>325</sup> However, compared to the GER for the same year (86.4 per cent),<sup>326</sup> there appears to be a small proportion of children enrolled in primary school who fall outside the official age group for primary schooling. From 2004 to 2015, GERs remained above 90 per cent.<sup>327</sup>

Secondary school is also compulsory and provided freely by the Government. According to the National Education for All Report 2015, the official secondary school age is 14 to 18 and consists of grades 9 to 12.<sup>328</sup> However, secondary school enrolment rates are low. The NER for secondary education in 2016 was 44.8 per cent,<sup>329</sup> indicating that over half of the population in the official secondary school age group are not enrolled in secondary school. The GER for secondary schools in the 2013-2014 school year was 64 per cent (for Years 9 to 12),<sup>330</sup> although without updated GER figures, it is not possible to assess the extent to which children enrolled in secondary school in 2016 fell outside the official age group.<sup>331</sup>

The CRC Committee reported in 2007 that there were serious concerns over the under-representation of girls in primary and secondary education.<sup>332</sup> Since its Concluding Observations, the record on gender-balanced enrolment appears to have reversed, with a higher proportion of females than males enrolled in primary and secondary school. In 2016, at primary level, the male NER was 77.8 per cent, compared to a NER of 80.32 per cent for females.<sup>333</sup> In the same year, the secondary NER was 40.39 per cent for males and 49.6 per cent for females.<sup>334</sup> This trend is

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323 Ibid.

324 Ibid.

325 Source: MIEMIS 2016 data cited on the website of the Pacific Regional Information System, retrieved from <https://www.spc.int/nmdi/education> on 12 June 2017 although it has not been possible to verify this figure against its original source.

326 Ibid.

327 Education for All, Marshall Islands, 2015, Op. cit.; and Source: MIEMIS 2016 data cited on the website of the Pacific Regional Information System. Op. cit.

328 Education for All, Marshall Islands, 2015. Op. cit. p. 25.

329 Source: MIEMIS 2016 data. Op. cit.

330 Source: MoE Digest 2013-2014 cited on the website of the Pacific Regional Information System, retrieved from <https://www.spc.int/nmdi/education> on 12 June 2017, although the authors have not verified this figure against its original source.

331 Education for All, Marshall Islands, 2015. Op. cit.

332 CRC Committee Concluding Observations. 2007. [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/MHL/CO/2&Lang=En](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/MHL/CO/2&Lang=En) [22.06.17].

333 Source: MIEMIS 2016 data. Op. cit.

334 Source: MoE Digest 2013-2014. Op. cit.

reflected in the GER. At primary level in 2016, the GER was 85.49 per cent for males and 87.28 for females.<sup>335</sup> Further, the secondary school GER Gender Parity Index in 2016 was 123.2, indicating a significantly higher proportion of females than males enrolled in secondary school.<sup>336</sup>

Primary and secondary drop-out and survival and completion rates are key indicators for measuring progress towards SDG 4.1. The drop-out rate was highlighted as a concern in the CRC Committee Concluding Observations in 2007,<sup>337</sup> and the issue persists according to recent reports. According to the National Education for All Report 2015, while drop-out rates vary from year to year, in any given year, significantly less than half the students enrolling in grade 1 will ever graduate from high school.<sup>338</sup> The Report also indicates that students tend to drop out in higher numbers in the first year of primary education (from grade 1 to 2), or towards the end of primary school: not making the transition from grade 6 to grades 7 and 8.<sup>339</sup> It has been reported that the MoE Education Management Information System data collection system does not permit the calculation of the primary school survival rate, as defined by UNESCO.<sup>340</sup> Instead, the MoE collects data it refers to as the “persistence rate,” comparing enrolment numbers by grade and gender without regard to whether a student is a new entrant or repeater.<sup>341</sup> The persistence rate in 2005-2006 (the most recent year for which this data was available) was 68.2 per cent, with enrolment dropping from 1,596 in grade 1 to 1,088 in grade 8.<sup>342</sup> Furthermore, calculations from cohorts from 2002 to 2006 show an overall persistence rate of 63.9 per cent, with drop-outs between grades 1 and 8 numbering 2,355.<sup>343</sup>

In 2007, the CRC Committee highlighted concerns over accessibility of primary and secondary education for children with disabilities,<sup>344</sup> calling for greater access to specialised educational programmes when required, particularly in the Outer Islands, including programmes outside the school environment.<sup>345</sup> Subsequently, MoE instituted several measures to address this deficit. In its State report to the CRC Committee in 2015, the Government states that its Special Education Program conforms to the US Individuals with Disabilities Act and requires monitoring and reporting for all students who have an Individualised Education Plan.<sup>346</sup> Further, it reports that 95.4 per cent of students with Individual Education Plans were provided with free public education in regular classes for the most part.<sup>347</sup> Furthermore, 98 per cent of these students were equipped with a Transition Plan to prepare them for leaving secondary education and for employment.<sup>348</sup>

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335 Source: MIEMIS 2016 data. Op. cit.

336 Ibid.

337 CRC Committee Concluding Observations. 2007. Op. cit.

338 Education for All, Marshall Islands, 2015. Op. cit.

339 Ibid.

340 Ibid. p. 22.

341 Ibid.

342 Ibid.

343 Ibid.

344 Committee on the Rights of the Child, Concluding Observations. 2007. Op. cit.

345 Ibid.

346 Marshall Islands CRC Submission, 2015, p.25. [http://tbinternet.ohchr.org/\\_layouts/TreatyBodyExternal/countries.aspx?CountryCode=MHL&Lang=EN](http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/countries.aspx?CountryCode=MHL&Lang=EN) [22.06.17].

347 Ibid. p. 36.

348 Ibid.



Unfortunately, data concerning the numbers of students with disabilities enrolled in primary and secondary education, as well as completion rates and disaggregated data, are unavailable.

### 5.3.2. Quality

Two of the key indicators of educational quality are the literacy and numeracy rates. Up-to-date data on literacy and numeracy rates are not available and, based on the most recent figures, significant improvements are required in the quality of primary and secondary education for RMI to achieve SDG 4.1 by 2030. The MoE Education Digest (2013-14) places the literacy rate at primary school level at 18.8 per cent of the total number of students in grade 6 who were tested on English reading skills and graded as 'proficient or above'.<sup>349</sup> The literacy rate in Marshallese in the same year is higher, at 33.1 per cent.<sup>350</sup> Furthermore, the numeracy rate was recorded as 19.2 per cent in 2013.<sup>351</sup>

Children are required to sit English, Maths, Science and Marshallese examinations in Years 3, 6 and 8. According to the National Education for All Report 2015, in the 2012-2013 school year, girls outperformed boys in all tests except grade 3 science and the Grade 8 Marshall Islands Standards Achievement Test (MISAT).<sup>352</sup>

In the 2004-2005 school year, there were significantly fewer female teachers (299) than male teachers (416).<sup>353</sup> Following comments from the CRC Committee in 2007 regarding the need to improve the standards of qualification and certification of teaching staff, MoE has made significant efforts to improve the quality of teaching in primary and secondary education. In 2007, MoE passed the Teacher Certification Act,<sup>354</sup> the Teacher Standards and Licensing Board was established (responsible for certifying and licensing teachers in RMI),<sup>355</sup> and new minimum qualification requirements were established.<sup>356</sup> Following these reforms, progress appears to have been made in increasing levels of teacher certification and qualifications, although this issue remains a challenge. In the 2012-2013 school year, 24.3 per cent of teachers possessed only a high school diploma.<sup>357</sup> This marks an improvement from the 52.3 per cent rate recorded in 2004-2005.<sup>358</sup> Furthermore, in 2012, 23 teachers earned their Associate or Bachelor degrees in education.<sup>359</sup>

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349 Percentage of students in grade 6 who sat the MISAT examination in English Language reading and achieved 'proficient' level. MoE, Education Digest, 2013-14. [http://prism.spc.int/images/EducationDigests/MARSHALL%20ISLANDS/2013-2014\\_Digest.pdf](http://prism.spc.int/images/EducationDigests/MARSHALL%20ISLANDS/2013-2014_Digest.pdf) [22.06.17].

350 MISAT Results, Grade 6 English reading, students achieving Proficient level in %, MoE, Education Digest, 2013-14. Ibid.

351 Ibid.

352 Education for All Report, 2015. Op. cit.

353 Data disaggregated between primary and secondary schools is unavailable. Education for All, 2015. p. 35.

354 Teacher Certification Act, P.L. 2007-92.

355 Education for All, Marshall Islands, 2015. Op. cit.

356 Ibid.

357 Ibid.

358 Portfolio Budget: FY 2008, p.12, Education for All, Marshall Islands, 2015.

359 Education for All, Marshall Islands, 2015. Op. cit.

### 5.3.3. Barriers and bottlenecks

Geographical disparities are a significant barrier to achieving universal access to quality primary and secondary education.<sup>360</sup> Specifically, the distribution of primary schools across the two main islands, Majuro Atoll and Kwajalein Atoll, where the majority of the population live in urban areas, and the Outer Islands/Atolls, presents significant challenges. In a drive to achieve universal access to primary education, MoE has established schools on 20 atolls, including many sparsely populated Outer Island Atolls and Islands.<sup>361</sup> In 2012-2013, enrolments spanned 93 separate schools (80 public and 13 private).<sup>362</sup> There were nine public schools on the Majuro Atoll, six on the Kwajalein Atoll, both enrolling large numbers of students, and 65 public schools spread across the Outer Islands and Atolls, enrolling comparatively small numbers of children.<sup>363</sup> Of the 65 public schools on the Outer Islands and Atolls, 23 are considered 'micro-schools', enrolling between 1 and 49 pupils.<sup>364</sup> The Education for All (2015) report highlights that as a result of the small size of many of the schools on the Outer Islands and Atolls, teachers must often teach subjects with which they are unfamiliar, in multi-grade classrooms, and to students with diverse capabilities:<sup>365</sup> inhibiting opportunities for specialised learning.

Students attending schools in more remote locations on the Outer Islands are disadvantaged in terms of high transportation costs and delays in receiving on-site technical assistance.<sup>366</sup> Furthermore, training programmes for teachers tend to be located in urban centres: limiting access for teachers in the Outer Island/Atoll schools.<sup>367</sup>

The limited availability of teaching materials is a barrier to ensuring quality education. Teachers reportedly lack the resources to deliver the National Curriculum in a way that is accessible to students, including 'curriculum frameworks' that set out individual standards in building knowledge and skills, and advice on effective teaching and classroom assessment strategies.<sup>368</sup> To address these concerns, MoE launched a project with the assistance of the Fiji Volunteer Scheme, to develop a range of lesson plans to be used by teachers in grades 1 to 8.<sup>369</sup> While the scheme was to be implemented in the 2013-2014 school year, data on its outcomes and impact are not available.

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360 The Committee cites concerns with the lack of hygiene, access to drinking water and sanitation, and transportation challenges. Committee on the Rights of the Child, Concluding Observations, CRC/C/MHL/CO/2, November 2007.

361 Education for All, Marshall Islands, 2015. Op. cit.

362 Ibid.

363 Ibid.

364 Ibid.

365 Ibid.

366 Ibid.

367 Ibid.

368 Ibid.

369 Ibid.

## 5.4. Tertiary education

According to SDG 4.3, by 2030, all women and men should have access to affordable and quality technical, vocational and tertiary education, including university.

In 2007, the CRC Committee highlighted concerns over the quality and availability of vocational training in schools.<sup>370</sup> MoE has taken important steps to address this concern by providing secondary-level, formal TVET programmes as elective classes in five public secondary schools, rather than through specialised TVET centres as in many other PICTs.<sup>371</sup> These elective TVET courses range from cooking to teacher training, to auto mechanics and agriculture.<sup>372</sup>

The introduction of TVET programmes into secondary schools has been a source of debate and dispute in RMI. The establishment of vocational training in schools stemmed from calls from employers, claiming that many businesses were forced to look for employees internationally, due to a lack of qualified candidates in RMI.<sup>373</sup> Shortages in qualified applicants for positions were recorded in almost all major traditional trades, including plumbing, carpentry, electrical work, mechanics and construction.<sup>374</sup> The same shortfall applied to jobs in the tourism industry (food preparation workers, hospitality managers and general tourism staff).<sup>375</sup> Opinion in RMI is reportedly divided over TVET. Many saw the introduction of TVET programmes as a welcome opportunity for young people to gain valuable skills and experience, preparing them for employment.<sup>376</sup> Furthermore, it was regarded as an opportunity for young people who were considered more adept to practical and ‘hands-on’ learning to thrive.<sup>377</sup> The policy has, however, encountered resistance. There have reportedly been arguments that TVET programmes in secondary schools divert attention away from the need to develop basic literacy and numeracy skills.<sup>378</sup> Furthermore, there have been concerns that TVET programmes will be used to effectively exclude less academically successful children from mainstream teaching at a relatively early age.<sup>379</sup> MoE recognises these views, and believes that, “the issue should not be framed in terms of a choice between academic and vocational skills, but as a challenge to design a curriculum in which the two components complement and reinforce each other.”<sup>380</sup>

Tertiary education in RMI is provided by two institutions: the CMI, established in 1992 under the College of the Marshall Islands Act (14 Marshall Islands Revised Code Ch. 2); and the University

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370 Committee on the Rights of the Child, Concluding Observations. November 2007. Op. cit.

371 Education for All, Marshall Islands, 2015. Op. cit.

372 Ibid.

373 Ibid.

374 ADB, Technical-Vocational Skills Development in the Republic of the Marshall Islands, Project No. TRA 38634, June 2007; Education for All, Marshall Islands, 2015. Op. cit.

375 Ibid.

376 Education for All, Marshall Islands, 2015. Op. cit.

377 Ibid.

378 Ibid.

379 Ibid.

380 Ibid.

of the South Pacific-Marshall Islands Campus, established in 1993.<sup>381</sup> In the Spring Semester, 2016, CMI enrolled 995 students.<sup>382</sup> Enrolment rates have varied over the past 13 years, growing steadily from 621 in 2004 to 1,087 in 2014, and dropping to 995 in 2015 and 2016.<sup>383</sup> The gender balance of enrolled students across this period has reportedly been generally even.<sup>384</sup> The most recent academic year, 2016, recorded a gender makeup of 50/50.<sup>385</sup> Having redirected its focus in the early 2000s from providing vocational courses to strengthening its Associate of Arts and Associate of Science programmes in liberal arts, business studies, education and nursing, CMI has recently re-introduced TVET programmes in carpentry, construction and maritime training.<sup>386</sup> Unfortunately, gender-disaggregated data regarding the makeup of college courses is unavailable.

In addition to degree level and vocational education, CMI offers the Adult Basic Education Program, for students aged 17 and above who did not complete high school, which leads to a high school equivalency diploma, or General Educational Development credential. Comprising five core subjects (reading, writing, math, science and social studies), this option has reportedly proven highly popular with young people who would otherwise be unable to gain high school level qualifications.<sup>387</sup> In spring 2014, 271 students (97 female and 174 male) were enrolled on the Program, having dropped from 318 in the autumn of 2013.<sup>388</sup>

Financial assistance is available to Marshallese students through the Marshall Islands Scholarship, Grant and Loan Board, established in 1979 under the Scholarship Assistance Act.<sup>389</sup> Scholarships are awarded regardless of school location, to students in financial need, and whose course of study will assist RMI to achieve its national development goals.<sup>390</sup> The majority of students receiving scholarships attend university outside RMI, including institutions in Hawaii, Guam, Fiji and the US mainland.<sup>391</sup> Gender-disaggregated data on scholarship and financial assistance recipients are unavailable.

Further to traditional tertiary education, the National Training Council in RMI provides grants to various local and regional organizations to support training in basic education and life skills, entrepreneurship and micro-enterprise development, and technical-vocational skills.<sup>392</sup> The Council aims to support young people (particularly those out of school and employment) aged 16 to 24 by upgrading their employment-oriented skills. In 2013, there was a total of 456 young people being served by the National Training Council (252 male and 204 female).<sup>393</sup> The majority were

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381 Ibid.

382 CMI, Office of Institutional Research, Fact Book, 2016. <https://www.cmi.edu/index.php/en/factbook>.

383 Ibid.

384 Ibid.

385 Ibid.

386 CMI, Vocational Education. <https://www.cmi.edu/index.php/en/academics/departments/vocational-education>.

387 Education for All, Marshall Islands, 2015. Op. cit.

388 MoE, Annual Report on Student Performance, School Year 2012-2013, Education for All, Marshall Islands, 2015. Op. cit.

389 Education for All, Marshall Islands, 2015. Op. cit.

390 Ibid.

391 MISGLB, Annual Report: Fiscal Year 2012; Education for All, Marshall Islands, 2015. Op. cit.

392 Education for All, Marshall Islands, 2015. Op. cit.

393 Ibid.

engaged in technical-vocational courses (326), followed by entrepreneurship courses (105), and the remaining 25 (all males) were enrolled in basic education courses.<sup>394</sup>

Concerns over the quality and accessibility of tertiary education remain, based on educational and employment status rates for 14 to 25 year olds from 2011. While the 2011 census placed the number of young people in this age range at 13,204, only 5,643 (43 per cent) were enrolled in formal education or employed. Some 57 per cent of the total number of young people (7,561) were recorded as 'unaccounted for'.<sup>395</sup> Training programmes provided through the National Training Council did not account for many of those in employment or formal education, reportedly reaching only 6 per cent of the total young people not employed or in college.<sup>396</sup> The high numbers of young people unemployed and out of education presents a serious issue to the MoE, highlighting the need for additional programmes to support young people who do not progress to either secondary school or further education.

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394 Ibid.

395 2011 Marshall Islands Census; Education for All, Marshall Islands, 2015. Op. cit.

396 Ibid.

# 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 recognises that parents have primary responsibility for the care and protection of their children, it also emphasises 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 experienced 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 abduction, sale and trafficking*

*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	Eliminate all forms of violence against women and girls in the 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	(from <a href="https://sustainabledevelopment.un.org/topics/sustainabledevelopmentgoals">https://sustainabledevelopment.un.org/topics/sustainabledevelopmentgoals</a> ):  Take immediate and effective measures to eradicate forced labour, end modern slavery and human trafficking and secure the prohibition and elimination of the worst forms of child labour, including recruitment and use of child soldiers, and by 2025 end child labour in all its forms	Proportion and number of children aged 5–17 years engaged in child labour, by sex and age

SDG	Target	Indicators
11.7	By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular 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
16.1	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 against torture of 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.”<sup>397</sup> The UNICEF East Asia and Pacific Region Child Protection Programme Strategy 2007 similarly emphasises 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.

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.”<sup>398</sup> The main elements of a child protection system are:

### Main Elements of a child protection system

<b>Legal and policy framework</b>	This includes laws, regulations, policies, national plans, SOPs and other standards compliant with the CRC and international standards and good practices.
<b>Preventive and responsive services</b>	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.
<b>Human and financial resources</b>	Effective resource management must be in place, including an adequate number of skilled workers in the right places and adequate budget allocations for service delivery.
<b>Effective collaboration and coordination</b>	Mechanisms must be in place to ensure effective multi-agency coordination at the national and local levels.
<b>Information Management and Accountability</b>	The child protection system must have robust mechanisms 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 the RMI; 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

RMI 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. Nevertheless, available information indicates that Marshallese children experience violence in several contexts, including at home, in schools and in the community.

#### 6.1.1.1. Violence in the home

RMI children appear to experience significant levels of violence in the home. Adult responses to a recent 2017 Integrated Child Health and Nutrition Survey about use of discipline found that 64 per cent of children aged 1 to 4 years were subject to at least one form of psychological aggression or physical punishment by a household member during the previous month. This includes 30.6 per cent of children experiencing psychological aggression, 61.1 per cent experiencing physical punishment, and 7.6 per cent subjected to severe physical punishment (hit or slapped on the face, head or ears or hit repeatedly as hard as the adult could). Boys were subjected to physical discipline at almost exactly the same prevalence as girls and there was also no significant difference in the use of violent discipline methods between urban and rural areas.<sup>399</sup>

The 2012 Child Protection Baseline Study also found that corporal punishment of children was common. Of the children interviewed, 37 per cent reported that they were physically abused by someone in their home at least once in the past month, with 8 per cent reporting that this occurred every day in the previous month, 12 per cent reported being physically punished once per week, 5 per cent once every two weeks and 6 per cent once a month. The most common forms of violence at home were light spanking (38 per cent) and smacking on the head with an open hand (35 per cent). Among children reporting violence at home, 29 per cent said their father was the perpetrator and 27 per cent said their mother. In addition, 17 per cent of children reported that their siblings abused them physically. The reasons given for the violence were that the perpetrator was stressed or lost his temper, the child made a mistake, or that the violence was used as a form of education or discipline.<sup>400</sup> The Child Protection Baselines Study also found relatively high levels of emotional abuse. Of the children surveyed, 31 per cent reported that they were emotionally abused at least once in the past month, including being called stupid (33 per cent) or worthless (30 per cent).<sup>401</sup>

Marshallese children are also exposed to fairly high rates of family violence in their homes. A 2014 National Study on Family Health and Safety found that over half (51 per cent) of ever-partnered women had experienced physical and/or sexual violence by a partner during their lifetimes.<sup>402</sup> This is slightly higher than the average of 48 per cent for the PICTs for which data are available.<sup>403</sup>

399 RMI Ministry of Health and Human Services and UNICEF. 2017. Integrated Child Health and Nutrition Survey (publication pending), p. 109.

400 UNICEF. 2012. *Ajiri in Ibulunini: Value and Protect Our Precious Children*; Child Protection Baseline Study, p. 119. The remaining 4% refused to answer.

401 Ibid.

402 Republic of the Marshall Islands. 2014. 'National Study on Family Health and Safety'. p. 55.

403 Palau, Cook Islands, FSM, Tonga, Samoa, RMI, Nauru, Vanuatu, Fiji, Solomon Islands, Kiribati.

In addition, the study found that, of ever-pregnant women, roughly 10 per cent had experienced violence during a pregnancy.<sup>404</sup> Of the women who had ever experienced physical partner violence, 16 per cent said that their children had witnessed the abuse several times, 7 per cent said the children had witnessed the abuse many times, while 7 per cent said they didn't know.<sup>405</sup>

#### **6.1.1.2. Violence in schools**

Marshallese children also continue to experience corporal punishment in schools. Of the key informants interviewed as part of the Child Protection Baseline Study, the vast majority (87 per cent of children, 91 per cent of parents) believed that, in general, teachers are kind to children. However, 46 per cent of respondents agreed that 'teachers in the school in the community hit, smack, pinch, kick, pull or twist children's ears' (24 per cent of adults and 25 per cent of children).<sup>406</sup> No information was available about peer violence or bullying in RMI schools.

#### **6.1.1.3. Sexual abuse**

Sexual abuse is also a concern for RMI children. A 2014 Family Health and Safety Study found that the prevalence rate for women reporting that they had been sexually abused under the age of 15 years was 11 per cent. Of the women who disclosed child sexual abuse, most reported that it occurred once or twice between the ages of 10 and 14. The perpetrator was mostly a male family member, with one woman reporting that she was sexually assaulted by a male teacher. In addition, 15 per cent of women reported that they were forced into their first sexual experience, the highest number being those who were younger than 15 (26 per cent) followed by those aged 15–17 (13 per cent).<sup>407</sup>

Of the children who participated in the Child Protection Baseline Study, 14 per cent reported that they had experienced inappropriate touching, and 9 per cent refused to answer or did not know. Among those who reported inappropriate touching, 27 per cent had been touched on the buttocks, 22 per cent on the genitals, 18 per cent on the chest, 11 per cent on the lips with a light kiss, and 8 per cent on the thighs. Most (58 per cent) were touched by an adult, and 34 per cent touched by another child.<sup>408</sup>

#### **6.1.1.4. Trafficking, commercial sexual exploitation of children and child labour**

The US State Department Trafficking in Persons Report 2017 describes RMI as "a source and destination country for trafficking in Marshallese women and children and a destination for women from East Asia subjected to sex trafficking." RMI girls are reportedly recruited by foreign business owners and are subjected to sex trafficking with crew members of foreign shipping vessels that

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404 Republic of the Marshall Islands 'National Study on Family Health and Safety'. Op. cit. p. 59.

405 Ibid. p. 81.

406 UNICEF. Ajiri in Ibutuni: Value and Protect Our Precious Children. Op. cit. p. 108.

407 National Study on Family Health and Safety. Op. cit. p. 69-70.

408 Child Protection Baseline Study. Op. cit. p. 131-132.

dock in Majuro. The report further notes that “some Marshallese children are transported to the United States where they are subjected to situations of sexual abuse with indicators of sex trafficking.”<sup>409</sup> Despite these concerning reports from the international community, RMI advised in its State Party Report to the UN Committee on the Rights of the Child, that “Currently, there are no documented cases of children involved in prostitution, pornography or sex trafficking.”<sup>410</sup>

In its 2016 State Party Report to the UN Committee on the Rights of the Child, RMI noted that there is limited data on child labour and economic exploitation, and that there are no known instances of children below the minimum legal age of employment involved in child labour. However, the report notes increased anecdotal evidence of children out of school selling food products and handmade jewellery in front of supermarkets.<sup>411</sup>

#### **6.1.1.5. Child marriage**

According to the SOWC 2016 dataset, marriage prevalence rates in Marshall Islands are 26.6 per cent for children under 18 and 5 per cent for children under 15.<sup>412</sup> The Government reported in its 2016 State Party Report to the UN Committee on the Rights of the Child that the 2011 census did not disaggregate the marriage data by age for ages 15-59, but according to the census, no children aged 14 and under are married. It noted that “a challenge for the Government is that although child marriages officiated by the courts do not exist, this does not take into account the much more common practice of customary marriages or cohabitation. There have been no studies conducted on customary marriages and cohabitation in children, though there is considerable anecdotal evidence of children below the legal marriageable age cohabitating.”<sup>413</sup>

In its submission to the 2015 Universal Periodic Review (UPR) process for RMI, the UN Country Team noted that child marriage tends to be accepted at the community level, and that there is also a high teen pregnancy rate.<sup>414</sup> Community acceptance of early marriage was also noted in a 2016 report on child, early and forced marriage (CEFM) in Asia-Pacific, which found that, because customary marriages are not covered or governed by the law, “women and children may be left unprotected in situations involving CEFM.”<sup>415</sup>

#### **6.1.1.6. Children in conflict with the law**

RMI’s 2016 State Party Report to the CRC Committee provided details on the number of juvenile cases in 2014, revealing a relatively high rate of children referred to the District Court. The number

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409 US Department of State. ‘Trafficking in Persons Report 2017’. p. 274.

410 State Party Report to the Committee on the Rights of the Child. 2016. Marshall Islands. para 198.

411 Ibid. para 198.

412 SOWC 2016; Measured as percentage of women 20 to 24 years old first married or in union before 15, and percentage of women 20 to 24 first married or in union before 18.

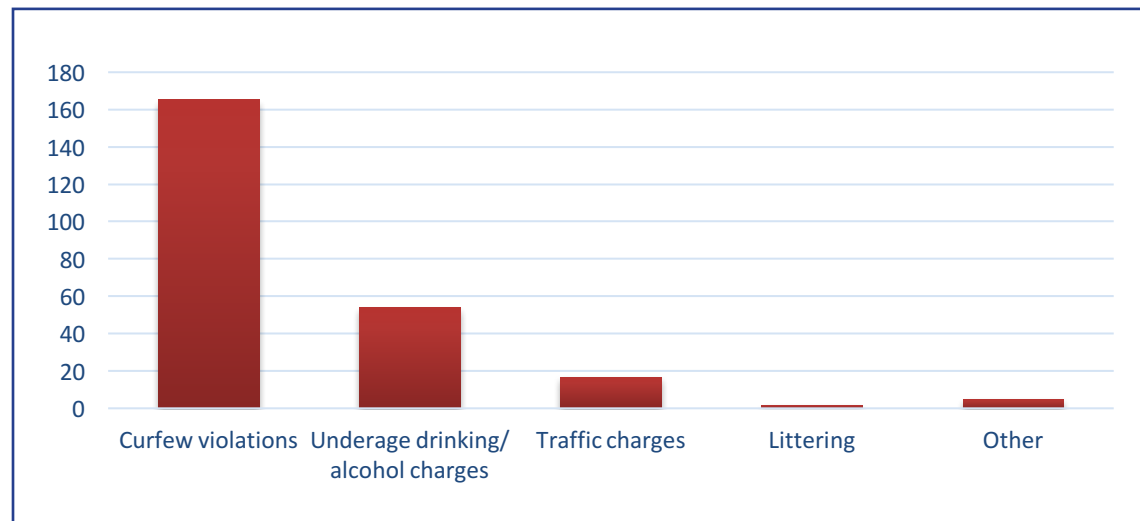
413 State Party Report. Op. cit., para 67-68.

414 UN Stakeholders Submission to UPR process Marshall Islands. 2015. para 27.

415 Inter-Parliamentary Union and WHO. 2016. ‘Child, early and forced marriage legislation in 37 Asia-Pacific countries. p. 69, <http://www.ipu.org/pdf/publications/child-marriage-en.pdf>.

of juvenile cases filed with the court has increased steeply from a low of 22 cases in 2011, to 154 in 2012, 175 in 2013 and 343 in 2014.<sup>416</sup> The vast majority of cases involved the status offence of curfew violation, as well as other minor offences such as alcohol-related and traffic violations.

**Figure 6.1: Cases involving children in conflict with the law 2014**



Source: State Party Report to the Committee on the Rights of the Child, 2016.<sup>417</sup>

The RMI has very few children coming before the courts for serious offences. The Annex to the State Party Report to the CRC Committee 2016 reports that, between 2010 and 2104, there were only 9 child offender cases before the High Court, one case in each of the years 2010 to 2012, four cases in 2013 and three new cases in 2014. The three 2014 juvenile cases filed in Ebeye were for burglary.<sup>418</sup>

### 6.1.2. Community Knowledge, Attitudes and Practices

Family is paramount to the Marshallese people, and traditional extended family practices of looking out for each other and caring for children helps to keep children safe from harm and reduce the situation of neglect and poverty. Respondents who participated in the Child Protection Baseline study highlighted a number of community practices that keep children safe, including 'big families/shared responsibilities', traditional methods of the extended family looking out for out-of-character behaviour, and customary adoption.<sup>419</sup> The traditional method of the extended family looking out for unusual behaviour, and then reporting it, helped keep children safe from harm, as did multi-generational support and guidance amongst family members. However, these

416 Annex to State Party Report to the Committee on the Rights of the Child. 2016. Marshall Islands, p.11.

417 State Party Report. Op. cit., para 210.

418 Ibid. para 209.

419 Child Protection Baseline Study. Op. cit. p. 119.



traditional practices are reportedly under threat and no longer practiced by everyone, particularly in urban centres.<sup>420</sup>

As in many areas of the Pacific, many Marshallese children live away from their parents or main caregivers, mainly for the purpose of education. The four public high schools are located in the urban centres, where students from all outer islands are sent for school. *Kakajiriri*, or traditional adoptions, are also common. The vast majority (98 per cent) of participants in the Child Protection Baseline Study did not believe that sending children to live away from main caregivers was a major factor in compromising the child's safety. However, 7 per cent of children who were interviewed as part of the study felt that 'overburdening hosted children with chores', 'sending children away' and 'abandonment' were factors that make children NOT feel safe in the community, and 13 per cent of key informants identified 'children living away from home' as a factor contributing to dangers to children in the community.<sup>421</sup>

The Child Protection Baseline Study found that both children and parents were broadly supportive of positive parenting as the most effective way to discipline children. When asked to identify the three best ways to discipline children, respondents showed strongest support for showing a good example (30 per cent), rapport and communication (28 per cent) and rewarding good behaviour (24 per cent). The Study noted that, although there was no 'significant change' in parenting practices within the lifetime of adult participants, there was a noticeable trend toward positive discipline, with the decrease in physical punishment and increase in communication.<sup>422</sup> However, many in the community continue to view corporal punishment as a necessary tactic to discipline children under their care.<sup>423</sup> The 2017 Integrated Child Health and Nutrition Survey found that the majority of caregivers (69.1 per cent) believe that physical punishment is a necessary part of child-rearing.<sup>424</sup>

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

The Child Protection Baseline Study highlighted a number of social norms and community practices that impact on child protection, including that: children are considered to 'belong' to their parents and therefore subject to treatments considered 'right' by their parents; women and children have little or no say in traditional culture and community governance; children are 'not to be heard or seen' when adults meet and their perspectives are not considered important in family matters; children living away from home; informal/customary adoption of children is common within the extended family system; cultural taboos that prevent discussion of sexual abuse; lack of understanding of abuse; and high tolerance for violence and general acceptance of corporal punishment as a form of discipline.<sup>425</sup>

Erosion of the traditional family support system was also highlighted as a factor contributing to children's vulnerability. Due to the substantially monetized economy, communities are departing

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420 State Party Report. Op. cit., paras 13, 104.

421 Child Protection Baseline Study. Op. cit., p. 102.

422 Ibid. pp. 100, 104.

423 Addendum to the State Party Report. Op. cit., para 18.

424 Op. cit., p. 111.

425 Child Protection Baseline Study. Op. cit., pp. 18, 41, 102.

from self-sufficiency and relying on salaried jobs. The shift from communal self-sufficiency to a monetized economy has resulted in many families struggling to meet their needs, and contributed to the erosion of the traditional extended family support that was once available for parents having difficulty caring for their children.<sup>426</sup> In addition, while domestic violence was traditionally dealt with by the family or clan, this protection system has gradually broken down and traditional forms of conflict resolution no longer serve to protect women. In particular, the gradual erosion of matrilineal succession of land rights in RMI has resulted in a lack of 'protection' previously provided by brothers and uncles.<sup>427</sup> Cultural taboos that were in place to discourage sexual abuse are no longer practiced.<sup>428</sup>

The pressures of migration and urbanization, especially into Majuro and Ebeye, has also undermined the care and protection of children. Overcrowding and growth of squatter settlements has undermined quality of care for children. Emigration also affects children when they are sent to Hawaii or the mainland for 'better opportunities', or when the parents migrate overseas, primarily to the U.S., and leave the children with grandparents or relatives who are not always equipped to care for them.<sup>429</sup> The 2017 Integrated Child Health and Nutrition Survey found that more than 1 in 10 (10.5 per cent) RMI children aged 0 to 4 has one or both parents living abroad; 7.4 per cent with only the father living abroad, 0.9 with only the mother living abroad, and 2.2 per cent with both parents living abroad.<sup>430</sup>

Social and culture norms also discourage children from reporting abuse, thus perpetuating violence. Domestic violence is considered a 'private' family matter, and there is strong cultural reluctance in RMI to discuss domestic violence in the public arena or to report abuse.<sup>431</sup> Cultural taboos are often seen as prohibiting discussion of matters such as sexual abuse or inappropriate touching.<sup>432</sup> The Child Protection Baseline Study found, for example, that of the children that had been physically abused in the previous month, 46 per cent did not report the abuse.<sup>433</sup> Similarly, over 90 per cent of respondents in the National Family Health and Safety Study reported that they did not tell anyone about the violence they had experienced.<sup>434</sup>

Children's lack of empowerment and limited knowledge and skills to protect themselves also contributes to abuse and exploitation. The Child Protection Baseline Study found that 20 per cent of child respondents did not understand the difference between touching that was 'OK' and touching that was 'not OK', with 13 per cent responding that adults and other children have the right to touch a child's body in an unacceptable manner, or responding that they did not know the answer to this question.<sup>435</sup> This suggests that children lack bodily autonomy and an awareness of their right not to be touched in a way that makes them feel uncomfortable.

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426 State Party Report. Op. cit., paras 13, 104, 110.

427 UNIFEM. 2010. Ending Violence against Women and Girls: Literature Review and Annotated Bibliography. <https://www.unicef.org/pacificislands/evaw.pdf> [25.04.17].

428 State Party Report. Op. cit., paras 13, 104, 110.

429 Ibid. para 111.

430 Op. cit., p. 114.

431 National Study on Family Health and Safety. Op. cit., p. 24.

432 Child Protection Baseline Study. Op. cit., p. 131.

433 Ibid. p. 40.

434 National Study on Family Health and Safety. Op. cit., p. 18.

435 Child Protection Baseline Study. Op. cit., p. 129.

Key structural causes 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).

## 6.2. The child protection system

The RMI government has made some 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

RMI lacks an over-arching child protection policy or plan of action, but a comprehensive child protection law has recently been introduced, and some child protection risks are addressed under the National Action Plan to Combat Trafficking. Children’s right to care and protection has been addressed under a variety of national laws:

#### Key Child Protection Laws

Child care and protection	Child Rights Protection Act 2015; Domestic Violence Prevention and Protection Act 2011
Child custody and maintenance	Domestic Relations Act
Child marriage	Birth, Death and Marriage Registration Act
Adoption	Adoptions Act 2002
Birth registration	Births, Deaths and Marriages Registration Act
Child labour	None <sup>iii</sup>
Penalisation of physical abuse, sexual abuse, and sexual exploitation	Criminal Code 2011; Child Rights Protection Act 2015; Domestic Violence Prevention and Protection Act 2011; Prohibition of Trafficking in Persons Act 2017; National Action Plan to Combat Trafficking
Child victims and witnesses in criminal proceedings	Child Rights Protection Act 2015
Violence in schools	Public School System Act 2013; Public School System Child Protection Policy
Children in conflict with the law	Child Rights Protection Act 2015; Juvenile Procedures Act 1966; Rules of Procedures for Juvenile Delinquency Proceedings

Children with disabilities	Rights of Persons with Disability Act, 2015; National Policy on Disability Inclusive Development (2014-2018)
Child protection in emergencies	Joint National Action Plan for Climate Change Adaptation & Disaster Risk Management (2014-2018)

RMI has established 18 as the age of majority<sup>436</sup> and sets some minimum ages designed to protect children from abuse and exploitation:

### Legal Definition of the Child under RMI Law

Definition of a child under child welfare law	18
Minimum age for marriage	18 <sup>IV</sup>
Minimum age for employment	None
Minimum age for engaging in hazardous work	None
Age for consent to sexual activity under criminal laws	14
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

The primary legal framework for governing child and family welfare services in RMI is the Child Rights Protection Act 2015. The Act designates the Ministry of Internal Affairs as focal point for the CRC and child welfare and gives it responsibility for: the establishment of a national child hotline; receiving reports and undertaking assessments of suspected child abuse and neglect; licensing and coordinating child protection service providers (government and non-government); and maintaining a registry of child abuse and neglect.<sup>437</sup> It outlines general procedures for reporting, assessment and intervention in cases of children who have been or are at risk of abuse or neglect, including, where necessary, obtaining a Care Order or Supervision Order from the High Court.<sup>438</sup> Temporary Protection Orders (for up to 28 days) and Protection Orders are also available under the Domestic Violence Prevention and Protection Act 2011 where a person, including a child, has experienced or is at risk of domestic violence.<sup>439</sup>

With respect to services for children and their families, the Child Rights Protection Act states that child victims are entitled to free medical assistance, as well as continued psychological,

436 Domestic Relations Act (26 MIRC 107).

437 Section 19.

438 Part IV.

439 Sections 906 – 909.

educational and vocational consultation to facilitate their recovery and reintegration.<sup>440</sup> The Minister is responsible for ensuring that a sufficient amount of its budget is available to fund activities under the Act, and the Act calls for the establishment of a Child Protection Assistance Fund.<sup>441</sup> In general, the Act is grounded in the principle of the best interest of the child,<sup>442</sup> but lacks an explicit focus on family strengthening and family preservation, is primarily response-oriented, and does not make specific provision for the active involvement of children, parents or extended family in care and protection planning.

Alternative care for children is governed by the Child Rights Protection Act 2015 and the Adoption Act 2002. Under the Child Rights Protection Act, the Government is responsible for ensuring safe alternative care for children who are victims or at risk of neglect, abuse, maltreatment, and exploitation, but not children who are orphaned, abandoned or otherwise without appropriate parental care. The Act makes provision for kinship care, foster care and residential care, and gives the Ministry of Internal Affairs responsibility for authorising and monitoring alternative care providers.<sup>443</sup> The Adoption Act 2002 requires the establishment of a Central Adoption Authority under the Ministry of Internal Affairs to serve as the central receiving point for all children to be adopted, with responsibility for assessing the background and circumstances of children and prospective adoptive parents, providing pre-and post-adoption counselling services, and making recommendations to the Court on adoption applications.<sup>444</sup> The Act requires adoptions to be approved by the High Court, and states that the controlling consideration is the best interest of the child. It further states that the court may appoint an attorney or guardian *ad litem* to act on behalf of the interests of the child, that the views of the child must be sought and given due consideration by the court, and that consent of the child is required from the age of 12.<sup>445</sup> However, no distinction is made between domestic and inter-country adoption, and RMI is not a member of The Hague Convention on the Protection of Children and Co-operation in Respect of Intercountry Adoption.

### **6.2.1.2. Legal framework for justice for children**

RMI's Criminal Code 2011 penalises various forms of violence, abuse and exploitation of children, including assault, kidnapping, interference with child custody, sexual assault, incest, child abuse and neglect, endangering the welfare of a child, harassment, stalking, and trafficking in children.<sup>446</sup> Sexual offences provide equal protection to both boys and girls, and generally have penalties that reflect the gravity of the crime. Although any corporal punishment of a child would constitute the offence of assault, Criminal Code 2011 allows the use of "reasonable force" against a child by a parent, guardian, teacher, or other person responsible for the care and supervision of a child.<sup>447</sup>

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440 Section 32.

441 Sections 24 and 41.

442 Sections 5 and 6 and Part II.

443 Sections 16, 31.

444 Section 806 (1).

445 Sections 809 and 819.

446 Articles 211, 212, 213, 230, 250, 251.8.

447 Section 3.08.

The Child Rights Protection Act 2015 states that abduction, sale and trafficking in children are “punishable offences” but does not stipulate a penalty.<sup>448</sup> There is no prohibition of child labour, child prostitution or child sex tourism, other than in the context of trafficking in children, and no provisions with respect to child pornography or online solicitation / grooming of children. Criminal Code 2011 creates general offences in relation to prostitution, but there is no separate and more serious offence for commercial sexual exploitation of children.

The Domestic Violence Prevention and Protection Act 2011 introduced a ‘no-drop policy’,<sup>449</sup> ensuring that police and prosecutors may not withdraw or dismiss cases of domestic violence, and the police have reportedly developed a First Response Protocol to victims of violence and abuse (including children).<sup>450</sup> In addition, the Child Rights Protection Act 2015 includes a number of provisions designed to facilitate children’s participation in the criminal justice process and to reduce hardship and trauma, including: guarantees of the child’s privacy; free legal representation; designation of specially trained police, judges, prosecutors and lawyers; provision of information about the proceedings and the services available; presumption that a child is a capable witness; and use of child-sensitive court procedures (in-camera proceedings, participation of a parent and support person, use of screens or closed-circuit television, strictly limiting intimidating cross-examination, and admitting the child’s statement given prior to trial).<sup>451</sup>

RMI lacks comprehensive juvenile justice legislation addressing special handling of children at all stages of the criminal justice process. The minimum age of criminal responsibility is set at 10, with a presumption that children aged 10 to 14 are not criminally responsible except in relation to homicide and sexual assault, in which case the presumption is rebuttable.<sup>452</sup> This is below the ‘absolute minimum age’ of 12 recommended by the CRC Committee.<sup>453</sup> In addition, children of any age may be brought before the courts as “delinquent” for not being “subject to the reasonable control” of his/her parents, teachers or guardian; being “wayward or habitually disobedient”; being habitually truant from home or school; for “deporting himself so as to injure or endanger the morals or health of himself or others”;<sup>454</sup> or violating a 10 pm curfew.<sup>455</sup> Although a determination of delinquency is not a criminal conviction, it can lead to deprivation of liberty in the form of ‘confinement’.<sup>456</sup> These provisions constitute punishment for ‘status offences’ contrary to the recommendations of the UN Committee on the Rights of the Child.<sup>457</sup>

The Juvenile Procedures Act 1966 states that “flexible procedures” should be adopted by the courts in handling cases involving juveniles, including: a report by a welfare or probation officer in advance of trial; detention, “where necessary”, apart from adult offenders; hearing informally in closed session; and interrogation of parents or guardians and release in their custody if appropriate.

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448 Sections 18,

449 Section 924.

450 State Party Report. Op. cit. para 197.

451 Sections 36 and 37.

452 Criminal Code 2011 Section 1.11.

453 Committee on the Rights of the Child. General Comment 10. para. 31.

454 Juvenile Criminal Procedures Act 1966, Section 303.

455 Ibid., section 312.

456 Ibid., section 307.

457 UN Committee on the Rights of the Child, General Comment No. 10. Op. cit., para 8.

These provisions apply to all children under the age of 18, but the court has broad discretion to treat any juvenile age 16 years or older as an adult if “in the opinion of the court his physical and mental maturity so justifies.”<sup>458</sup> This is inconsistent with international standards, which require all children in conflict with the law (aged up to 18) to be afforded special protections.

The Child Rights Protection Act 2015 provides further safeguards for children in conflict with the law.

Any child accused of having violated the law must be informed promptly and directly of the charges against her/him, have prompt access to free legal assistance, have the matter determined without undue delay, be presumed innocent, and be neither compelled to give testimony nor to confess guilt.<sup>459</sup> No detailed guidance is provided on pre-trial diversion of children, but the Act states that “alternatives to the formal and traditional judicial forum, such as mediation and other forms of alternative dispute resolution, shall be encouraged whenever these serve the child’s best interests and whenever these guarantee the same level of legal safeguards.”<sup>460</sup> The Child Rights Protection Act also outlines guidelines for sentencing children, stating that: prioritisation must be given to rehabilitation and reintegration rather than punishment or retaliation; imprisonment shall be used only as a measure of last resort and shall be avoided whenever possible; as an alternative, the court may order counseling, probation, reconciliation, mentoring, or educational programmes; and prison sentences must be subject to periodic review (but frequency is not indicated).<sup>461</sup> The Act further states that children who are restricted in or deprived of their liberty must be kept separate from adults, held in a manner that “avoids harm to their dignity and is appropriate to their age”, must have educational and vocational programmes “subject to good behaviour”, and must not be subject to torture, cruel, and degrading treatment.<sup>462</sup>

## **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 minimise 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 RMI Ministry of Internal Affairs, Community Development Division (CDD) has primary responsibility for child, youth and women services, including coordinating services and activities for children and monitoring compliance with the CRC. At the national level, the Ministry has a Child

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458 Section 303.

459 Section 38.

460 Section 36(3).

461 Section 39.

462 Section 40.



Rights Office with a Child Rights Coordinator.<sup>463</sup> The Children Rights Coordinator is responsible for liaising and working closely with stakeholders in coordinating child rights initiatives, and works in close cooperation with the other offices within the CDD, including the Youth Services Bureau, the Gender and Development Office (GAD), and the Disability Coordination Office.<sup>464</sup> The CDD recently created two positions in order to assist in supporting the needs of women and children, however they are not qualified social workers.<sup>465</sup> CDD staff are all centralised at the national level and there are no district-level child protection structures or child protection staff.

Although the Ministry has been given broad responsibilities for coordinating prevention and response services under the Child Rights Protection Act 2015, the Child Protection Baseline Study found that the CDD focuses more on child rights promotion and prevention rather than treatment and care.<sup>466</sup> The CDD has reportedly coordinated a number public awareness campaigns on child rights, child protection, domestic violence and trafficking in children in collaboration with other government agencies and NGOs. This has included national radio, newspaper, social media campaigns, as well as activities in communities, schools and churches. The *Wa Kuk Wa Jimor* have been actively going to the Outer Islands on public awareness campaigns.<sup>467</sup> However, there are no structured programmes to strengthen and support parents, or to identify and provide early intervention services to children and families at risk.

RMI has yet to establish a working mechanism for reporting, referral and case management of children who are at risk of or have experienced harm, and the hotline mandated by the Child Rights Protection Act has not yet been set up. There are no standard operating procedures or inter-agency protocols for handling cases of children suspected of being abused or neglected,<sup>468</sup> and the Ministry does not yet have a structured process for intervention planning and monitoring of children in need of protection.<sup>469</sup> For cases that come to the attention of law enforcement, the police will often consult with the Child Rights Officer who may complete home visits and report the findings to the police or the courts, but there is no clear procedure for this.<sup>470</sup>

Social welfare services to support children and their families and to promote children's recovery and reintegration are also quite limited. There are counselors and mental health support available through the Ministry of Health, as well as a range of CSOs involved in child protection, including Mission Pacific, Women United Together in the Marshall Islands (WUTMI), Waan Aelon in Majel (WAM), Youth-to-Youth-in-Health, and the Salvation Army. For example, WUTMI has developed a national support service for women and girls experiencing domestic violence and provides an early child education programme for young parents. CMI provides second-chance high school education for youth, Youth-to-Youth-in-Health provides youth leadership and family planning clinics for young people, and Mission Pacific provides counselling to youth.<sup>471</sup> However, the Child

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463 Child Protection Baseline Study. Op. cit., p.11.

464 State Party Report. Op. cit., para 41.

465 Addendum to State Party Report. Op. cit., para 22.

466 Child Protection Baseline Study. Op. cit., p. 93.

467 State Party Report. Op. cit., para 201; US Department of State. 'Trafficking in Persons Report 2017', p. 274.

468 Child Protection Baseline Study. Op. cit., p. 67.

469 State Party State Party Report. Op. cit., para 212.

470 Ibid.

471 State Party Report State Party Report. Op. cit., para 213; Child Protection Baseline Study. Op. cit., p. 80.

Protection Baseline Study notes that the limited government and non-governmental programs in place to address children's needs are not well coordinated and lack a systemic approach to issues, and therefore the vulnerabilities children are facing 'seem to go unattended for the most part'.<sup>472</sup> Additional bottlenecks identified were limited access to services on outer islands, as well as low awareness of available services in the community.<sup>473</sup>

With respect to alternative care, The RMI State Party Report to the UN Committee on the Rights of the Child advised that, due to human and financial constraints, there is no formal assistance available for children separated from their family. The Government acknowledged that, although the Child Rights Protection Act provides for a range of alternative care options for children, "these services are yet to be established", and lack of human capacity and financial resources are major constraints preventing full implementation of these services. The Report notes that many children live apart from their biological parents for a number of reasons, but there are no systems in place to monitor their care. RMI has no formal foster care system.<sup>474</sup>

Customary adoption is reportedly common in RMI. Traditionally, family members adopt children as a response to the adoptive parents, need for labour or care, to solidify family relationships, or to ensure rights of inheritance. Customary adoption is viewed as an 'open arrangement' which serves to expand family and clan boundaries. Whilst informal adoption can help ensure the care and protection of children, the Government has acknowledged that monitoring these arrangements has been difficult, and there are "areas of concern, in particular, child protection issues" that it is working to address.<sup>475</sup>

Formal adoptions approved by the court are managed by the Central Adoption Authority under the Ministry of the Interior. Available data indicates that the vast majority of formal adoptions are inter-country adoptions. The Child protection Baseline Study notes that, of the 21 adoptions approved by the court in 2010, only two involved adoption of a child by RMI residents.<sup>476</sup> Data provided by RMI in the Addendum to its State Party Report similarly suggest that inter-country adoptions are the norm, rather than the exception, representing 30 out of 34 adoptions in 2014, 13 out of 20 adoptions in 2015, and 13 out of 18 adoptions in 2016.<sup>477</sup>

Although the Child Rights Protection Act represents a significant step in the development of a comprehensive child protection system for RMI, the lack of human and financial resources acts as a significant barrier to effective delivery of child and family welfare services. The CDD lacks qualified social workers capable of providing case management services to children and their families, and it would require investment in capacity building to be able to play a lead role in child protection policy development and service delivery as envisioned by the Act. The Government has also acknowledged that financial constraints undermine its ability to deliver support services for children in need of protection. The Ministry reportedly appropriates separate funding for the

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472 Child Protection Baseline Study. Op. cit., pp. 8, 11.

473 Ibid. p.12.

474 State Party Report State Party Report. Op. cit., paras 104, 115, 122.

475 Ibid. para 119.

476 Child Protection Baseline Study. Op. cit., p. 36.

477 Addendum to State Party Report State Party Report. Op. cit., p. 28.

Child Rights Office in its Fiscal Year Budget, and the Government has committed to work towards strengthening the child impact assessment process to better understand the impact of budgetary, policy and legal decisions on children.<sup>478</sup> The Child Protection Assistance Fund mandated under the Child Rights Protection Act has not yet been established.

### **6.2.2.2. Access to child-friendly justice**

RMI has limited specialisation within the justice sector for ensuring access to child-friendly justice for children in conflict with the law or child victims/witnesses. There is no specialised police unit or designated specialists handling cases involving children. The Child Protection Baseline Study noted that police have not received any specialised training on children's cases, and that "capacity constraints are the norm rather than the exception."<sup>479</sup> Training has been provided to police, prosecutors and judges on domestic violence and trafficking in persons, and the police have developed a First Response Protocol in cooperation with WUTMI to ensure an appropriate response to domestic violence cases.<sup>480</sup> However, it is not clear whether this includes a specific focus on special procedures, skills and techniques for dealing with children's cases.

The Child Protection Baseline Study found that special measures are taken in some child victim cases, including: using closed court proceedings for the child's evidence; using prohibitions on publication of any identifying details of the child; using closed-circuit television for witness evidence; allowing a support adult to sit with the child while giving evidence; and using child-friendly language. However, these measures were not consistently and universally applied by all respondents.<sup>481</sup> There is no support programme to familiarize children with the court process and provide support at all stages of the process.<sup>482</sup>

RMI does not have specialist judges to handle cases involving children in conflict with the law. However, in practice, children's cases are heard separately from adult proceedings, and some child-friendly court procedures are used, including closing the court to the public, ensuring the child has legal representation, and attendance of the child's parent or guardian.<sup>483</sup> No information was available on sentencing practices, or on the percentage of children in conflict with the law who are deprived of liberty. As noted, above, the high number of children being referred to the court for status offences such as breach of curfew is cause for concern.

Although RMI does not have formal diversion programmes, available information suggests that many cases are diverted by the police without referring the case to court by issuing a warning or referring the child to a chief or pastor. Table 6.1 shows the answers given by 14 police officers who participated in the Child Protection Baseline Survey when asked how many cases involving children they had handled in the previous month.

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478 State Party Report State Party Report. Op. cit., para 46-47.

479 Child Protection Baseline Study. Op. cit., pp. 65, 70.

480 State Party Report State Party Report., Op. cit., paras 199, 216-217; US State Department, 'Trafficking in Persons Report 2017'. p. 274.

481 Child Protection Baseline Study. Op. cit., p. 33.

482 Ibid. p. 69.

483 Ibid. p. 65-66, 73.

**Table 6.1: Police responses to number of cases involving children processed within previous month**

No of respondents	Answer
2	N/A or didn't respond
4	71 cases of giving the child a warning and letting them go
1	No number specified but 'many cases of warning and letting go'
1	No number specified but 'few cases of warning and letting go'
1	10 cases of formal caution
1	No number specific but many cases of diversion-like activities
3	215 cases (in total) of charging with crimes
2	1 case each of physical punishment
1	5 cases referred to chiefs
1	No number specified but many cases to chiefs
1	5 cases referred to pastor
5	19 cases (in total) returned to family
1	No number specified but many cases returned to family

Source: UNICEF, 2012<sup>484</sup>

Children who are in police custody are kept separate from adult detainees; although there are no separate pre-trial detention facilities for children, they are reportedly kept separated from adults by detaining them in the Marshall Islands Police Department administration building in individual offices. There is no specialized prison facility for juvenile prisoners, and conditions in the Majuro prison reportedly do not meet international standards. Due to the lack of facilities for them, females are generally held under house arrest. The Government is in the process of securing property in Laura village, Majuro, for a new facility for women, and for juveniles convicted of serious crimes.<sup>485</sup> Child offenders are allowed to continue their education while serving their sentence, and the Waan Aelon in Majol NGO provides them with counselling<sup>486</sup>.

There is no authority responsible for rehabilitation and reintegration services for children in conflict with the law. The Child Protection Baseline Study found that child offenders are not provided with well-coordinated support programmes, and while there are some ad hoc programmes for children released from detention, most, if not all, are provided by NGOs.<sup>487</sup>

484 Ibid.

485 State Party Report State Party Report. Op. cit., para 204.

486 Child Protection Baseline Study. Op. cit., p. 74

487 Ibid. p. 56.

Many cases involving both children in conflict with the law and child victims are resolved informally at the community-level, without resort to the formal criminal justice system. According to a recent report for UNICEF Pacific, informal justice is used often in RMI: “The Marshall Islands, Nauru and Tuvalu are the three PI-countries where customary/traditional justice is used most often.”<sup>488</sup> When asked how communities handled cases involving children in conflict with the law, the most common answers from participants in the Child Protection Baseline Study were referral to the police (17 per cent), diversion through community work (15 per cent), and referral to a community leader (10 per cent).<sup>489</sup> In terms of how communities deal with child offenders, the most common responses were community work (23 per cent), counselling (22 per cent), fine, 83 (11 per cent), traditional practices including extended family system of care and supervision (10 per cent), and education or vocational training (9 per cent).<sup>490</sup> This suggests that informal community mechanisms provide a positive and restorative alternative for handling offences committed by children. However, of concern is the lack of safeguards or monitoring and oversight of this process. With respect to child victims, informal resolutions may encourage child victims and their families to accept an apology or compensation to settle a case at community level, rather than seek access to justice through the formal process, and do not adequately ensure the care and protection of the child.

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

RMI’s Ministry of Education has taken steps to create a safe and violence-free environment for children. Both the Public School System Act 2013<sup>491</sup> and the Child Rights Protection Act 2015<sup>492</sup> prohibit corporal punishment in school. In 2014, a Public School System Child Protection Policy was introduced to enforce the school system’s commitment to “safeguarding and protecting children, maintaining vigilance and acting in their best interests”. The policy includes a framework to assess and manage risk to children and the measures and systems put in place to respond to concerns about their wellbeing, including procedures for reporting violations. It also includes guidelines for recruitment and induction of teachers and volunteer teachers, and introduces a Code of Conduct for Working with Children that all regular and volunteer teachers are required to sign.<sup>493</sup> However, no training has been provided to teachers on the Policy and Code of Conduct.

The Ministry of Health has yet to develop a policy addressing the role of the health sector in child protection. Hospitals reportedly provide care and treatment for child victims of abuse when those services are sought, and public health workers could play a role in prevention and early identification through their community outreach work with mothers and infants. However, there are no structured programmes, protocols or training on the role of health professionals in child protection, and health workers who participated in the child Protection Baseline Study indicated

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488 Van Welzenis, Ingrid. 2016. Internal UNICEF EAPRO Report: Country-Level Summaries of Diversion and Other Alternative Measures for Children in Conflict with the Law in East Asian and Pacific Island Countries. p. 150.

489 Child Protection Baseline Study. Op. cit., p. 32.

490 Ibid. p. 34.

491 Section 324.

492 Section 9(2).

493 State Party Report v paras 71, 181.

their lack of awareness about child abuse and neglect.<sup>494</sup> A Domestic Violence Protocol for Health Care Providers Standard of Care was drafted in 2014 (approval pending), and describes in detail how to respond, support, and document when caring for individuals who are experiencing domestic violence.<sup>495</sup> However, these are primarily responsive, and it is unclear whether they include a specific focus on children.

Limited progress has been made in the labour sector to ensure that children are protected from harmful, hazardous or exploitive work. RMI has yet to establish a minimum age for employment of children, or to designate a list of harmful or hazardous work prohibited for children under the age of 18. The Child Rights Protection Act includes a general definition of 'economic exploitation of children',<sup>496</sup> and defines it as a form of abuse, but it does not set a minimum age for employment or place any concrete restrictions on children's work, and does not make it an offence to engage children in child labour (other than in the context of the offence of trafficking in children). The Seamen's Protection Act provides limited protection for children by prohibiting children under 16 from being employed on Marshall Islands vessels engaged in foreign trade, except on vessels on which only members of the same family are employed, school-ships or training ships.

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

RMI does not have a national coordinating council or committee responsible for child protection strategic planning and inter-agency coordination. A Trafficking in Persons Taskforce has been established with representation from the Attorney General's Office, Marshall Islands Police Department, Ministry of Foreign Affairs, WUTMI, MLSC and International Organization for Migration,<sup>497</sup> but its remit is limited to human trafficking.

Effective planning, policy development and monitoring of the RMI child protection system is also hampered by the lack of a centralised child protection information management system, and limited data on the number of children reported as victims of abuse and/or neglect.<sup>498</sup> Some statistics on reported children's cases are kept by different government departments, including the police, courts and health sector, but there are no regular, systematic mechanisms for ongoing data collection and analysis. This acts as a significant barrier to evidence-based planning and policy development for child protection.

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494 Child Protection Baseline Study. Op. cit., p. 93.

495 Addendum to State Party Report State Party Report. Op. cit., para 20.

496 Section 1(j)(ii).

497 State Party Report State Party Report. Op. cit., para 62.

498 Ibid. para 129.

## 6.3. Other Child Protection Issues

### 6.3.1. Birth Registration

RMI's Births, Deaths and Marriages Registration Act of 1988 requires that all births be registered. Parents or another qualified informant are required to report the birth within 10 days, and there are no costs associated with birth registration. Responsibility for birth registration rests with the Ministry of Internal Affairs, which houses a centralized Birth and Death Registration Office. On Majuro, all births are logged by nurses in logbook and then reported to the Vital Statistics Office where they are entered into the VRIS computer system. A physical copy of the birth certificate is then printed and delivered to the Registrar's Office at the Ministry. For Ebeye, births are also logged into the VRIS, and then the Vital Statistics staff in Majuro access the information and prints and delivers the birth certificate to the Registrar. On the Outer Islands, local health assistants keep track of births and report them during a weekly radio call to the Vital Statistics staff to log and create a birth certificate.<sup>499</sup>

The 2016 SOWC reports a birth registration rate for RMI of 96 per cent.<sup>500</sup> There is no discrepancy between birth registration in urban and rural areas but there is a reported difference between rates among the poorest and richest 20 per cent, of 98 per cent and 92 per cent, respectively.<sup>501</sup> Despite the overall high levels as compared to the PICT regional average of 74 per cent, the State Party Report to the CRC Committee in 2016 noted that, while the system for registering attended births on Majuro and Ebeye is efficient, ensuring accurate and timely reporting of births on the Outer Islands is still a challenge due to issues with transportation and communication. Some of the more remote islands do not have Health Assistants, and if the Health Assistant is not present at his/her duty station, it is possible that births may not get reported for some time or at all. There are still some children whose births are only registered once they are attempting to enrol in school or acquire a passport, which is evidence that there remains room for improvement. A 2017 Integrated Child Health and Nutrition Survey found that 62.5 per cent of mothers of unregistered children reported that they know how to register a birth, which suggests barriers, other than lack of awareness, are impeding birth registration.<sup>502</sup> The Government notes that cooperative efforts between the Vital Statistics Office, the Outer Island Health Services Office at MOH, and the Registrar's Office have gone a long way to ensure timely and accurate recording of births.<sup>503</sup>

### 6.3.2. Children with disabilities

RMI established a Disability Coordination Office in 2013. The Office provides support for the Marshall Islands Disabled Persons Organization (MIDPO), coordinates Government activities,

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499 Ibid. para 87.

500 Percentage of children less than 5 years old who were registered at the moment of the survey. The numerator of this indicator includes children reported to have a birth certificate, regardless of whether it was seen by the interviewer, and those without a birth certificate whose mother or caregiver said the birth had been registered.

501 SOWC 2016. Op. cit.

502 Integrated Child Health and Nutrition Survey. Op. cit., p. 106.

503 State Party Report State Party Report. Op. cit., para 87-88.



and was tasked with drafting the Disability Policy and Action Plan 2014-2018. The stated purpose of the policy is to “provide a comprehensive framework for improving the quality of life of person with disabilities and to increase their meaningful participation in society” in line with the goal that “the RMI becomes a barrier-free society that respects the rights of all persons with disabilities by empowering, including and providing them with the means of achieving their rights.” The Disability Policy is organized around 10 priority areas: coordination; legislation; signature and accession of the CRPD; awareness and advocacy; education and training; employment and livelihoods; access to health services; mainstreaming of disability across Government and civil society; strengthening of MIDPO; and women with disabilities and youth with disabilities.<sup>504</sup> RMI ratified the CRPD in March 2015 and enacted the Rights of Persons with Disabilities Act later that year.

The MOH is responsible for treating mental and physical disabilities, and the MoE is responsible for supporting special education for children with disabilities. MOH, in collaboration with the Public School System, carries out ‘child find’ surveys to identify children with special needs and refer those who need to attend special education programmes. The Special Education Programme, financed by the US Government, is the only specially funded programme that provides additional services to children with disabilities.<sup>505</sup> In addition, the Disability Coordination Office provides administrative and logistical support for MIDPO, including assistance in accessing funding to provide the first ever-public handicapped accessible vehicle in the country.<sup>506</sup>

In a 2012 satisfaction survey, families expressed difficulty in meeting the needs of their children with special health care needs, in particular with costs related to medical equipment such as hearing aids, wheelchairs and glasses. Parents also expressed the need for more home visits and an increase in the provision of direct services. Parents felt ill-prepared to provide the care and services required for the children suffering with disabilities, particularly for children with limited mobility and requiring a sustained level of care and support.<sup>507</sup>

### 6.3.3. Climate change and natural disasters

Like most PICTs, RMI is vulnerable to the impacts of climate change and natural disasters. In the event of a natural disaster, children are the most vulnerable population. The effects of climate change, including drought and high tides, also harm vulnerable children.

RMI have taken steps to strengthen their capacity to prepare for disasters. A Joint National Action Plan for Climate Change Adaptation & Disaster Risk Management (2014-2018) has been developed and provides a detailed strategy for ‘holistically and co-operatively’ addressing risks in the RMI. Its goals include: establishing and supporting an enabling environment for improved coordination of disaster risk management/climate change adaptation in the RMI; providing public education and awareness of effective Climate Change Adaptation and Disaster Risk Management from local to

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504 *ibid.* paras 40, 159-160.

505 *Ibid.* para 161.

506 *Ibid.* para 43.

507 UNICEF. 2013. ‘Children in the Republic of the Marshall Islands: An Atlas of Social Indicators’. p. 60.

national level; enhancing emergency preparedness and response at all levels; and making sure the needs of vulnerable groups are given priority, including children.<sup>508</sup>

In addition, a Country Preparedness Package (CPP) has been prepared as part of a joint initiative of the Government and the Pacific Humanitarian Team to help strengthen emergency preparedness and collaboration and promote awareness of and access to national and international tools and services. The CPP has a section on Gender and Protection Mainstreaming, with a particular focus on children, and includes a number of international Child Protection in Emergencies (CPiE) preparedness and response tools. RMI does not have a Protection Cluster, but the NDMO and each of the five clusters are responsible for mainstreaming gender and protection in their preparedness and response activities. As yet there are no gender or protection focal points in any of the government-lead ministries, and the MoCIA does not necessarily conduct protection mainstreaming activities to support the NDMO and the five clusters.<sup>509</sup>

CPiE training has been provided for key stakeholders and CPiE awareness activities conducted with various groups, including the Majuro Local Government, Police Officers, Youth-to-Youth-in-Health, and National Youth Rally Participants. Five CPiE training sessions have also been conducted in select villages and outer islands. In each location, a survey was conducted with local elementary school students to find out what kind of storms they were most affected by.<sup>510</sup>

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508 State Party Report. Op. cit., para 40.

509 RMI NDMO and Pacific Humanitarian. 2017. RMI Country Preparedness Package, p. 18.

510 Addendum to the State Party Report State Party Report. Op. cit., para 61-62.

# 7

## Social Protection

A comprehensive social protection system is essential for reducing 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 can thereby help close inequality gaps. Social protection measures can also help to cushion families from livelihood shocks, including unemployment, loss of a family member or 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<sup>511</sup> to poverty and deprivation, and mitigating their effects.”<sup>512</sup> Social protection systems are essential to ensuring that the rights of children to social security<sup>513</sup> and a standard of living adequate for their physical, mental, spiritual, moral and social development<sup>514</sup> are realised. According to the CRC, States 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.”<sup>515</sup> Effective social protection measures are also essential to achieving SDG 1: to eradicate extreme poverty (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.

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511 UNICEF distinguishes between the two as follows: “[p]overty 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.”

512 UNICEF. 2012. *Social Protection Strategic Framework*. p. 24.

513 CRC. Article 26.

514 Ibid. Article 27.

515 Ibid. Article 27(2).

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 floor consists of two main elements: essential services (ensuring access to WASH, health, education and social welfare services); and social transfers (a basic set of essential social transfers in cash or in-kind, paid to the poor and vulnerable).<sup>516</sup>

### Key social protection-related SDGs

SDGs	Targets	Indicators
1.1	By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than \$1.25 a day	By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than \$1.25 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 the UNICEF 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, water and sanitation, and child protection.<sup>517</sup>

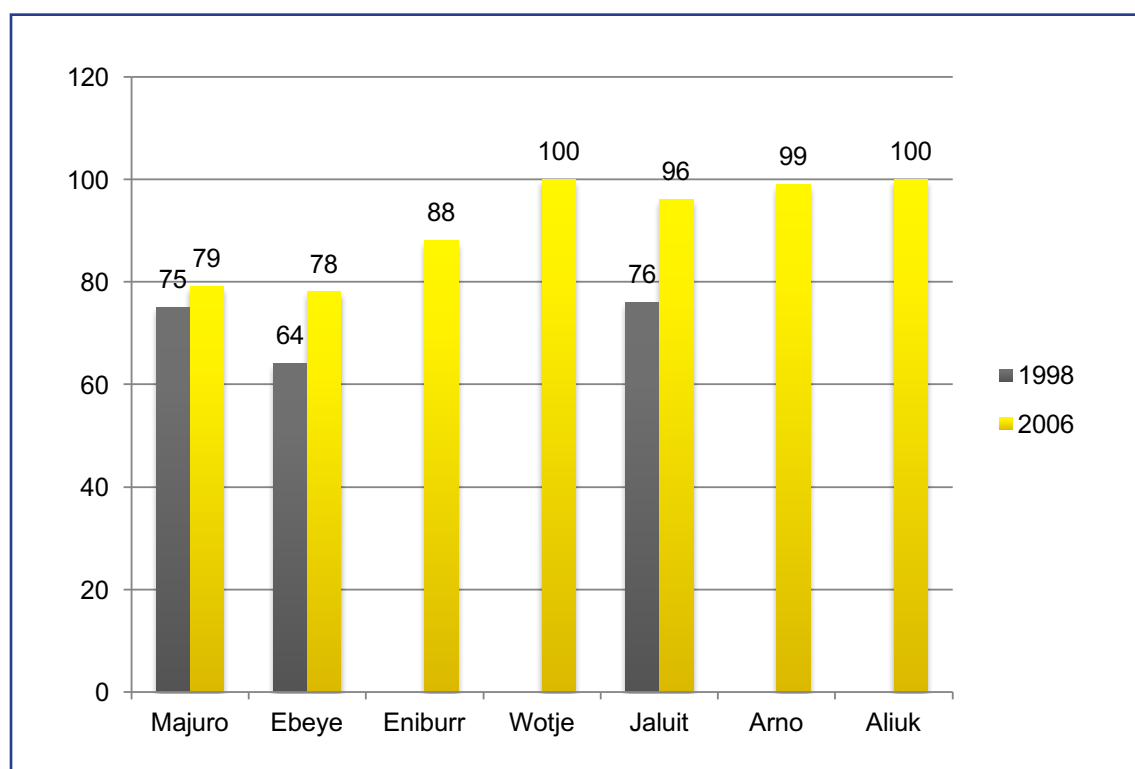
516 ILO and WHO. October 2009. 'The Social Protection Floor: A joint crisis initiative of the UN Chief Executive Board for Coordination on the Social Protection Floor'. <http://www.un.org/ga/second/64/socialprotection.pdf>.

517 UNICEF. Social Protection Strategic Framework. Op. cit. p. 31.

## 7.1. Profile of child and family poverty and vulnerability

Unfortunately, there is no recent data on poverty rates in RMI; the last Household Income and Expenditure Survey was carried out in 2002. There is also no current official national poverty line, and no recent data on the extent and nature of child poverty. This lack of data creates difficulties in understanding the extent and nature of poverty, along with groups of the population that are vulnerable to poverty, and in turn, in devising effective, targeted measures to reduce poverty. However, data suggests that rates of basic needs poverty are relatively high and that poverty rates are increasing. The Asian Development Bank estimated in 2011 that 20 per cent of the population were unable to afford basic needs.<sup>518</sup> The World Bank also indicated in a recent publication that RMI had an extreme poverty rate (less than US\$1.90 a day) of higher than 10 per cent.<sup>519</sup> Data also indicates that poverty rates may have increased in recent years, as set out in Figure 7.1 (which uses a US poverty line).

**Figure 7.1: Percentage of families below the US poverty line in selected atolls: 1998; 2006**



Source: RMI Community Survey, not nationally representative, 2006<sup>520</sup>

518 Asian Development Bank. 2013. in UNESCO. No date. *Income support schemes in Pacific Island Countries: A brief overview*.

519 World Bank. 2016. *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. 12.

520 RMI Community Survey. 2006. extracted from UNICEF Atlas of social indicators: Republic of Marshall Islands, 2011, p. 24. Note that data was not available from 1998 in some atolls.

This suggests that RMI may face challenges meeting SGD Goals 1.1 (eradicate extreme poverty for all) and 1.2 (halve the population living below national poverty line). This assessment is supported by the recent SPC report on the performance of PICTs in relation to the MDGs. According to this report, while no recent nationally representative data on poverty exists, poverty and hardship are likely to be widespread, and macroeconomic conditions, rising unemployment and limited social safety nets indicate that levels of poverty are not on track to decrease.<sup>521</sup>

Unfortunately, there does not appear to be any recent data available to establish the proportion of children who are living in poverty.

As elsewhere, the national poverty averages for RMI may mask inequality within the country. Poverty appears to be found mostly in rural areas. According to calculations based on DHS data (2007), 9 out of 10 rural inhabitants were in the bottom two wealth quintiles (see Figure 7.2).

According to a recent World Bank report, poverty is particularly pronounced on Outer Islands, where a lack of economic opportunities and access to services and infrastructure means that poverty is structural and persistent.<sup>522</sup> This is a general characteristic of PICTs, where rural areas, particularly in more geographically isolated outer islands, tend to be poorer than more centrally located islands:<sup>523</sup> a trend compounded by lack of access to basic services, including health and education.<sup>524</sup> According to a recent United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) report, “the greater concentration of economic activity in urban areas, as well as the greater provision of public services, contributes to this trend.”<sup>525</sup>

However, it should be noted that pockets of poverty also exist in the two urban locations of Majuro and Ebeye, particularly among those living in informal ‘squatter’ settlements (dwellings on land to which the residents have no legal title). RMI has one of the most urbanised populations among the PICTs; rapid urbanisation caused by migration from more remote areas and outer islands and lack of jobs in urban centres, along with an inability to rely on subsistence food production, contributes to poverty in urban locations.<sup>526</sup> Conditions in squatter settlements across the Pacific are generally very poor. They are characterised by poor quality, overcrowded housing without access to improved water sources, sanitation or other basic services.<sup>527</sup> Poor housing conditions have negative impacts on children, including poor health and, relatedly, poor educational attainment.<sup>528</sup> This is likely to perpetuate a cycle of poverty, exclusion and deprivation for children living in these settlements.

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521 Pacific Island Forum Secretariat. 2015. *Pacific regional MDGs tracking report*.

522 World Bank. *Systematic country diagnosis*. Op. cit. p. 12.

523 UNESCAP. *State of Human Development in the Pacific: A report on vulnerability and exclusion at a time of rapid change*. p. 20.

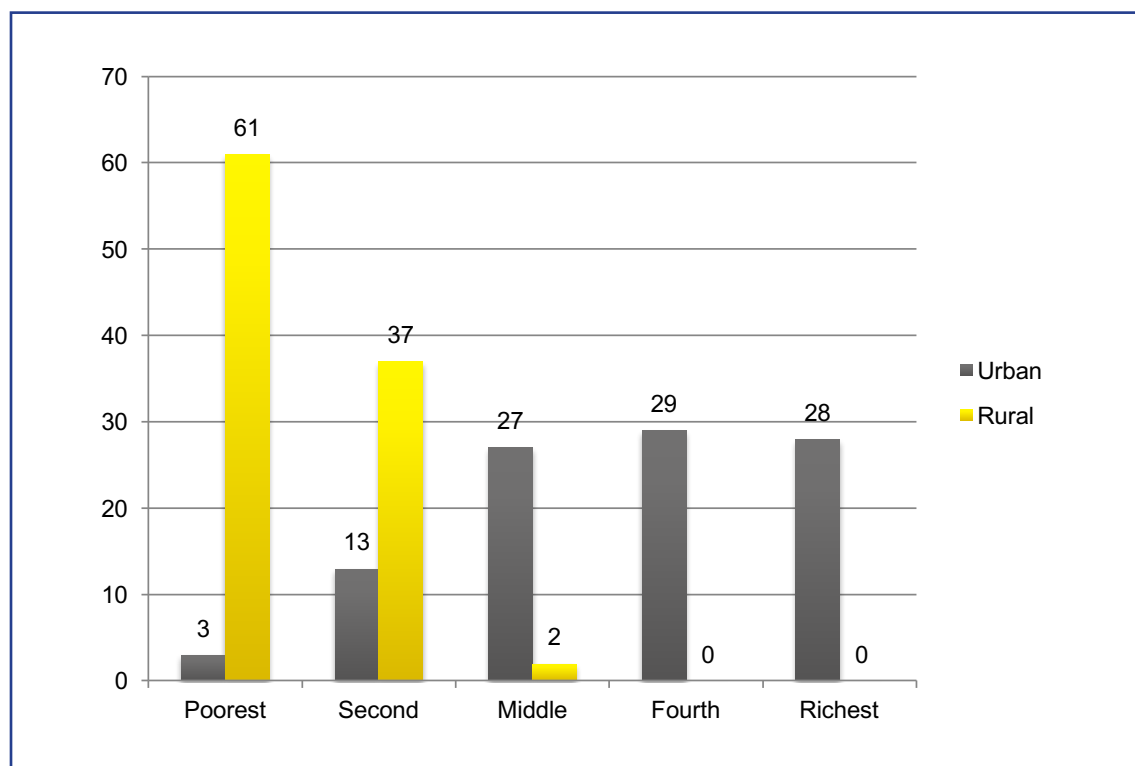
524 AusAID. 2012. *Poverty, vulnerability and social protection in the Pacific: The role of social transfers*.

525 UNESCAP. *State of Human Development in the Pacific*. Op. cit.

526 Asian Development Bank. 2005. *Juumemmej: Republic of the Marshall Islands social and economic report*.

527 World Bank. 2014. *Hardship and Vulnerability in the Pacific Island Countries*.

528 Ibid.

**Figure 7.2: Distribution of wealth along quintiles, rural vs urban dwellings**

Source: UNICEF, Atlas of social indicators: Republic of Marshall Islands, 2011<sup>529</sup>

Unfortunately, there does not appear to be any data available that examines associations between poverty and factors including education level, employment, gender and disability. However, it should be noted that women's economic participation in RMI is generally quite low.<sup>530</sup> Women do not appear to have equitable access to the formal job market. This is likely to have an impact on levels of poverty among women.

The causes of child and family poverty in RMI are complex, interconnected and operate on multiple levels. As a small island economy, RMI faces many of the general challenges confronting PICTs, and the more particular challenges common to other island atoll states. Economic challenges including "a stagnant economy, failing per capita income, rising population densities worsening economic inequality" have created a situation of emerging pockets of deep poverty.<sup>531</sup> RMI has a small economic base with diminishing livelihood sources for its population. Traditional sources of livelihood and food security, such as fishing and subsistence agriculture, are no longer viable options for much of the population, given the factors of rapid population growth and small surface area.<sup>532</sup> In addition,

529 Calculated based on household assets, dwelling and other characteristics from 2007 DHS data, extracted from UNICEF Atlas of social indicators: Republic of Marshall Islands, 2011. Op. cit. p. 24.

530 Pacific Islands Secretariat. 2006. *Gender profile: Republic of Marshall Islands . 2006.* [http://www.forumsec.org/resources/uploads/attachments/documents/RMI\\_Gender\\_Profile.pdf](http://www.forumsec.org/resources/uploads/attachments/documents/RMI_Gender_Profile.pdf)

531 Asian Development Bank. *Juumemmej.* Op. cit. p. 2.

532 Ibid. Asian Development Bank, Asian Development Bank, *Juumemmej.* Op. cit. p. 2.

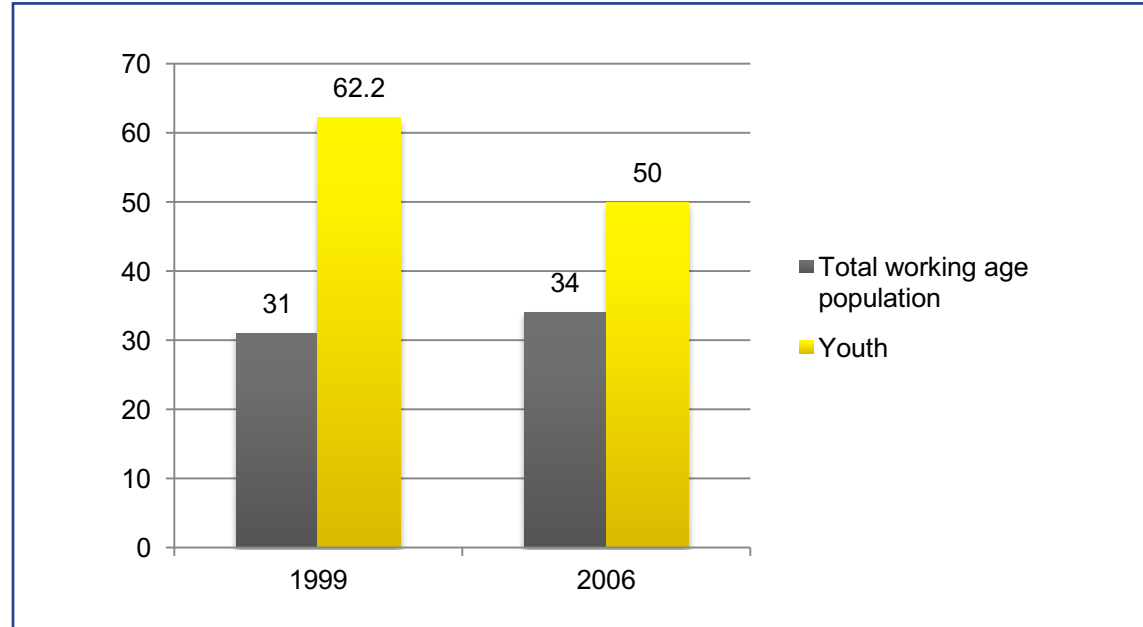


“the potential of the natural environment to sustain the population has meanwhile diminished by contamination with solid and radioactive wastes and overexploitation of marine resources.”<sup>533</sup>

The openness of the economy, while necessary to mitigate the effects of small economies and geography, contributes to economic vulnerability by exposing the population to global price fluctuations. This particularly affects RMI, given its small landmass, which limits agricultural productivity, and makes it heavily reliant on food imports.<sup>534</sup> In RMI, as in Kiribati and Tuvalu, the ratio of food imports is three to five times higher than the developing country average.<sup>535</sup> RMI faces an uncertain future. It is heavily reliant from assistance provided under the US Compact of Free Association, which is due to expire in 2023.

A limited economic base and exposure of the economy to shocks have led to a poverty of opportunity in PICTs, including RMI, which has a significant number of unemployed, particularly young people. Across the Pacific, economies are unable to generate sufficient jobs for the number of job-seekers. The large number of young people with inadequate skills contributes to the youth unemployment.<sup>536</sup> While youth unemployment appears to have dropped in recent years, it is still very high and a significantly higher proportion of young people are unemployed compared to adults (see Figure 7.3).

**Figure 7.3: Percentage of unemployment for youth and total working age population, 1999; 2006**



Source: NDMI, 2016<sup>537</sup>

533 Ibid.

534 World Bank. *Hardship and Vulnerability in the Pacific Island Countries*. Op. cit. p. 17

535 World Bank. *Systematic country diagnosis*. Op. cit. p. 90

536 AusAID. *Poverty, vulnerability and social protection in the Pacific*. Op. cit. p. 4

537 NDMI. 2016. from census data (note that 2011 Census data is not included as home production was considered employment according to this survey, in contrast to previous ones.)

Salaries also appear to be quite low, and it has been reported that real incomes in the Marshall Islands fell by 40 per cent between 1997 and 2009.<sup>538</sup>

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

## 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 programmes (e.g. contributory schemes to provide security against risk, such as unemployment, illness and disability); social assistance programmes (non-contributory measures such as regular cash transfers targeting vulnerable groups, including persons living in poverty, persons with disabilities, the elderly and children); and social care services (child protection prevention and response services, detailed in section 6). There has been a growing recent acceptance that social security (particularly the provision of regular cash transfers to families living in and vulnerable to poverty) should be a key component of a social protection system.<sup>539</sup> Cash transfers provide households with additional income that enables them to invest in children's wellbeing and human development.<sup>540</sup>

The comprehensiveness and impact of the 'formal' social protection system in RMI appears to be quite strong, at least in comparison with other PICTs. The Asian Development Bank's Social Protection Indicator (SPI [formerly Index]) assesses social protection systems against a number of indicators to generate a ratio, which is expressed as a percentage of GDP per capita. In 2016, the SPI for Marshall Islands was 3.7. This is well above the Pacific regional average (including PNG) of 1.9 (see Figure 7.4).<sup>541</sup>

However, the data indicates that the vast majority of social protection expenditure is for social insurance measures (see Table 7.1).

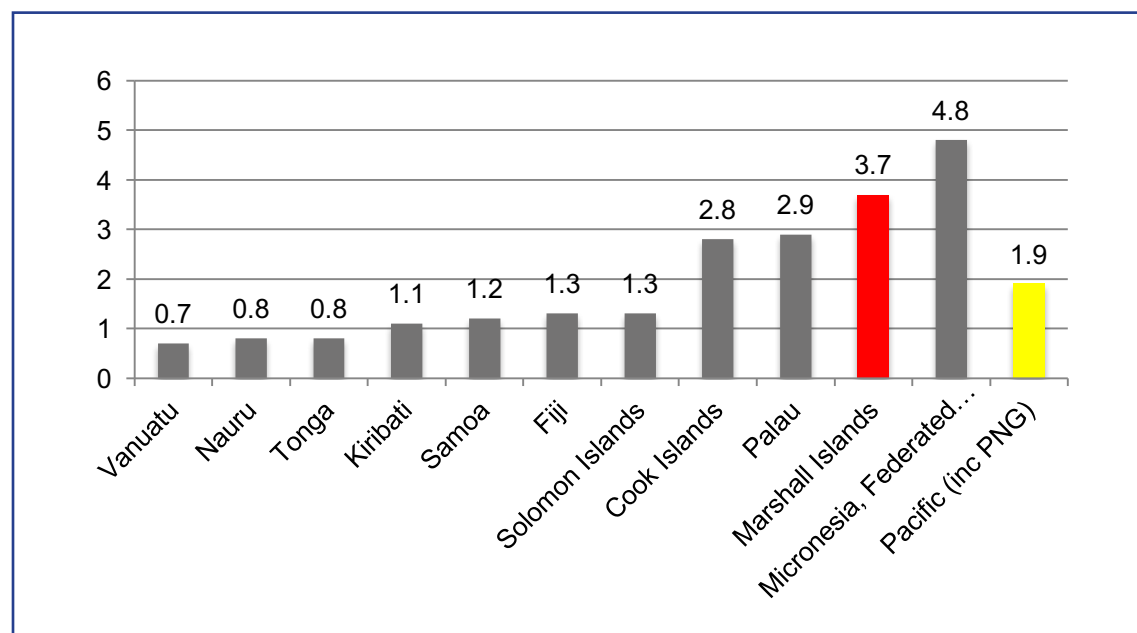
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538 AusAID. *Poverty, vulnerability and social protection in the Pacific*. Op. cit.

539 UNICEF and Fiji Ministry of Women, Children and Poverty Alleviation. 2015. *Child Sensitive Social Protection in Fiji*, p. 6.

540 UNICEF. 2012. *Social Protection Strategic Framework*.

541 Asian Development Bank. 2016. *The social protection indicator: assessing results for the Pacific*. p. 16.

**Figure 7.4: Social Protection Indicator by country<sup>542</sup>**

Source: Asian Development Bank, 2016<sup>543</sup>

**Table 7.1: Social protection indicator by type of programme**

Programme	Social Protection Indicator (%)
Overall	3.7
Social Assistance	0.4
Labour Market Programmes	-
Social Insurance	3.3

Source: Asian Development Bank, 2016<sup>544</sup>

Social insurance is provided through a contributory pension fund, which applies to persons over a set retirement age. The proportion of the population above the legal retirement age is high (63 per cent).<sup>545</sup> However, this form of social protection is limited to formal sector workers, and excludes the majority of workers who operate in the informal economy – it is therefore not targeted at the poorest members of society. Contributory schemes involving formal sector workers also tend to

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

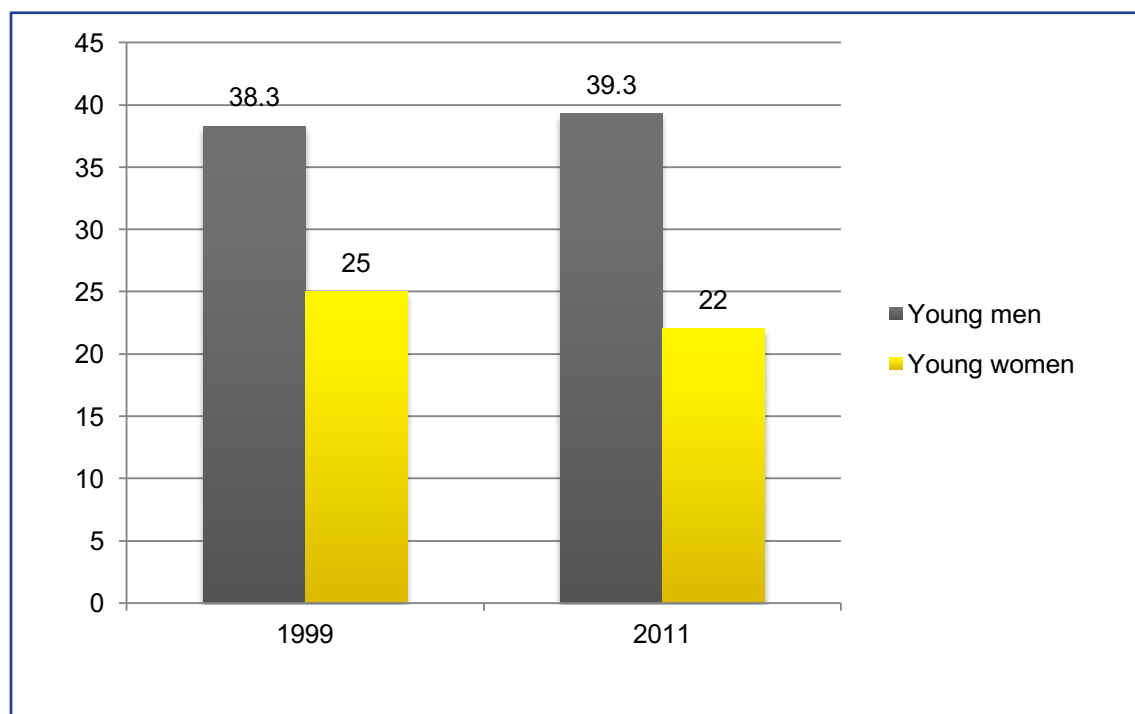
543 Data extracted from Asian Development Bank. The social protection indicator: assessing results for the Pacific. Op. cit. p. 16.

544 Ibid.

545 UNESCAP No date. *Income support schemes in Pacific Island Countries: A brief overview*. p. 20.

have a gender bias, as the majority of formal sector workers are men.<sup>546</sup> Women appear to lack access to the formal job market. According to census data, the labour force participation rate of women in 2011 was 22 per cent, compared to 39.3 per cent for men. Unlike men, women's participation rate dropped from 1999 to 2011 (see Figure 7.5).

**Figure 7.5: Labour force participation rate, men and women, 1999**



Source: Census, 2011<sup>547</sup>

Therefore, although the scheme covers 35 per cent of older persons,<sup>548</sup> it does not target the most vulnerable members of the population.

It should be noted that economic participation of women in RMI in general is low, compounding the negative impact of their lack of access to the formal job market and lack of (direct) access to contributory pension schemes. Women face a number of constraints. For instance, despite the customary matrilineal succession of land rights, in which every resident inherits land through their mother, women today are less aware of these rights and clanship relationships, and “an increasing population and migration make tracing lineage and land ownership even more complex,”<sup>549</sup> resulting in women rarely owning land independently.<sup>550</sup> Women also appear

546 UNDP. State of Human Development in the Pacific. Op. cit.

547 Republic of Marshall Islands. Census, 2011 data.

548 ILO. 2010. in UNESCAP. No date. *Income support schemes in Pacific Island Countries: A brief overview*. p. 20.

549 Pacific Islands Secretariat. Op. cit.

550 World Bank. *Systematic country diagnosis*. Op. cit. p. 22.

to have limited access to decision-making positions at all levels, owing to “customary norms, stereotypes of women’s roles, and the lack of public awareness about election processes.”<sup>551</sup>

The benefit structure of the social insurance programmes in RMI, along with FSM and Palau, differs from the provident funds in other PICTs. In contrast to the provident funds, social insurance schemes are based on a ‘defined benefit’ model and are not paid solely on the basis of member and employer contributions and the interest they generate. Benefits are provided to retired persons, surviving spouses and surviving children.<sup>552</sup> A disability benefit is available to members who are unable to engage in the continued performance of their duties due to medical, physical or mental impairment.<sup>553</sup> It has been noted that the slow growth in the number of contributing members means that the number of beneficiaries is increasing faster than the number of new members, causing deficits.<sup>554</sup>

RMI has very limited social assistance programmes. There is no children’s benefit, and no comprehensive system of cash payments based on vulnerability. However, a number of programmes provide subsidies and in-kind benefits to vulnerable children, including school meals, and (for children with disabilities) a special education programme that assists children by meeting the costs of transport, wheelchairs and other needs to ensure that they are able to access free and appropriate education.<sup>555</sup>

Another component of social protection systems is activities to generate and improve access to employment opportunities among (young) people (labour market programmes). However, there was insufficient data to determine the SPI for this component.

The data indicates that the depth of social protection systems in RMI (the average benefits received by actual beneficiaries) is quite high, particularly in comparison to other PICTs (see Figure 7.6).

The high rating for depth of benefits is attributed mainly to benefits administered through the contributory insurance scheme set out in Table 7.2, which shows that the relatively high depth indicator is attributed largely to social insurance programmes. The depth indicator was lower for social assistance programmes, though still slightly above the PIC average. This is attributed to the social education programme that covers a small number of beneficiaries.<sup>556</sup>

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551 Pacific Islands Secretariat. *Gender profile*. Op. cit.

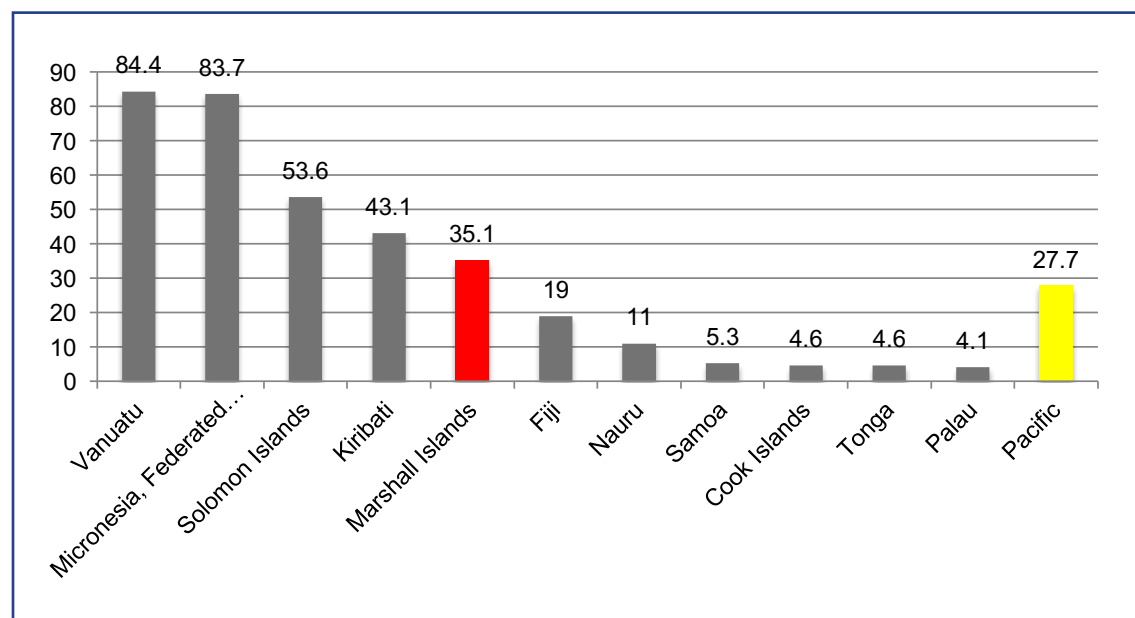
552 Asian Development Bank. *The social protection indicator*. Op. cit. p. 25.

553 Ibid.

554 Ibid.

555 Ibid. p. 29.

556 Ibid.

**Figure 7.6: Depth of social protection indicator, by country<sup>557</sup>**

Source: Asian Development Bank, 2016<sup>558</sup>

**Table 7.2: SPI depth indicator, by type of programme**

Programme	Social Protection Indicator (%)
Overall	35.1
Social Assistance	11.5
Labour Market Programmes	-
Social Insurance	47.1

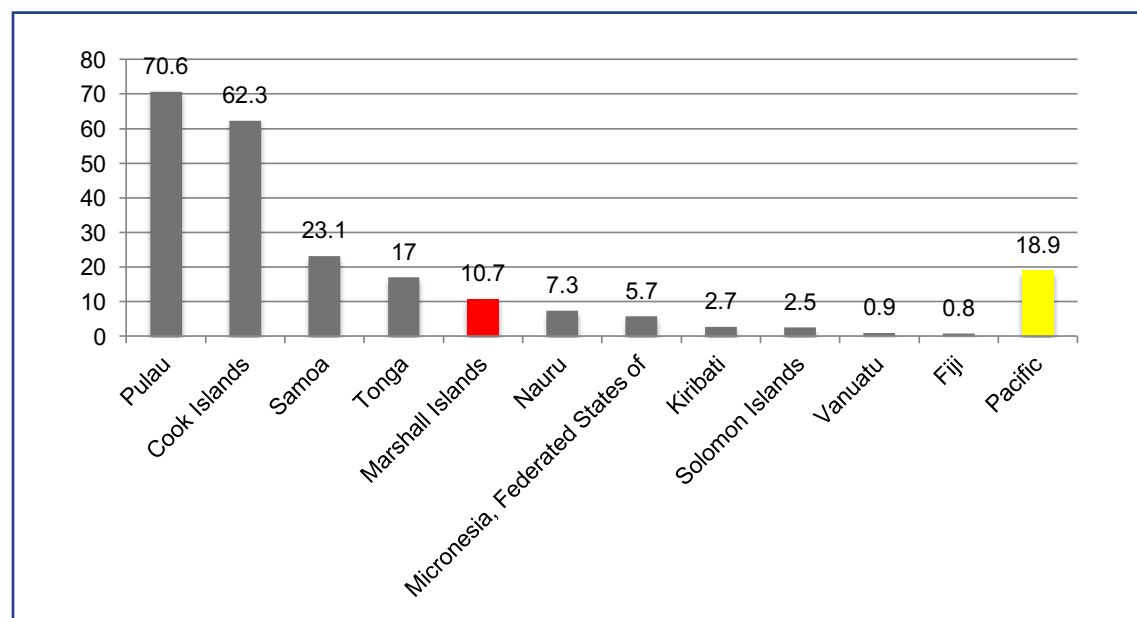
Source: Asian Development Bank, 2016<sup>559</sup>

Breadth indicators represent the proportion of potential beneficiaries (those who could qualify for benefits) who actually receive social protection benefits. According to the Asian Development Bank assessment, RMI received a moderate breadth indicator, though it was below the regional average. This indicates that, while the amount of assistance provided to beneficiaries is relatively high, the number of beneficiaries receiving benefits is relatively low.

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

558 Data extracted from Asian Development Bank, The social protection indicator. Op. cit.

559 Ibid.

**Figure 7.7: Breadth of social protection indicator, by country<sup>560</sup>**

Source: Asian Development Bank, 2016<sup>561</sup>

The breadth indicator was highest for social insurance programmes (7.1), compared to social assistance (3.6) (see Table 7.3). This indicates that only a very small proportion of the population benefit from the relatively generous level of payments under social insurance and provision under the social assistance schemes.

**Table 7.3: SPI breadth indicator, by type of programme**

Programme	Social Protection Indicator (%)
Overall	10.7
Social Assistance	3.6
Labour Market Programmes	0
Social Insurance	7.1

Source: Asian Development Bank, 2016

The data for the Pacific also indicates that social protection schemes are not well targeted. When the SPI is disaggregated between the poor and non-poor, the non-poor are found to be the main beneficiaries of social protection programmes (the aggregate SPI for the poor in Pacific island

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

561 Asian Development Bank. *The social protection indicator*. Op. cit.



countries 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 is due to the dominance of social insurance programmes.<sup>562</sup>

The targeting of social protection programmes also appears to have a gender dimension. The social protection indicator for women in the Pacific was 0.8 per cent of GDP per capita compared to 1.1 per cent for men.<sup>563</sup> This is attributed to the differential access of women and men to social insurance measures.<sup>564</sup> Social insurance measures have a gender bias, as access is generally restricted formal sector workers, who are predominantly male.

Other, non-State forms of social protection in RMI should be considered in development policies and systems on social protection. Informal extended family and community systems provide important safety net support. Traditional safety nets based on extended family networks provide some protection; however, these systems are coming under pressure with declining per capita income.<sup>565</sup>

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. The 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.

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562 Ibid.

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

564 Asian Development Bank. The social protection indicator. Op. cit.

565 Asian Development Bank. *Weaving social safety nets*.

# 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 RMI. Please note that these are not listed in any order of priority.

### 8.1. Climate change and disaster risks

A key finding of this report is that climate change and disaster risks have a considerable impact on all sectors in relation to the realisation 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 due to damaged schools, challenges to access and diverted resources.
- Climate change and extreme weather and other disasters also impact upon **child protection** concerns, by exacerbating the risk of violence against children, uprooting families and leaving children living in difficult and unsafe conditions.

## 8.2. Financial and human resources

RMI continues to rely heavily on external development aid, particularly from the US, and limited opportunities for economic development have led to a poverty of opportunity and high unemployment rates, particularly among young people. This leads to a lack of available resources across nearly all government departments and a resultant lack of financial resources for delivery of services and systems for children. It also seems to be linked to a lack in human resources (training and expertise) in several sectors.

- The lack of financial resources translates to a lack of appropriate equipment and professionals, particularly in the **health** and **WASH** sectors, but also in **justice** and **child protection**.
- This 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 RMI plays a living role in the realisation of the rights of women and children.

- Those living in rural and remote areas generally experience worse outcomes and access to basic services than those in urban areas.
- Geography poses primary access challenges, to, for example, hospitals and healthcare centres, courts, police stations, schools and other facilities providing services to children and women.

## 8.4. Norms and attitudes

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

- The erosion of traditional community care, and the limitations of community care in urban areas, means that children are increasingly exposed to child protection concerns.
- Traditional attitudes that are permissive of violence, and the lack of community planning around child protection also expose children to risk.
- Traditional gender roles support and facilitate **violence** against women and girls, and marginalised groups, including **children with disabilities**.

- Traditional norms were also found to underlie key risk factors associated with negative health outcomes, such as the high smoking prevalence amongst RMI's youth population.

## 8.5. Gender

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

- Socio-cultural norms around gender and gender roles appear to condone and facilitate violence against women, and leave women in controlling relationships, experiencing violence, while facing barriers that prevent them from reporting the violence against them.

## 8.6. Poverty and vulnerability

The impacts of poverty are significant in RMI, 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.
- The lack of opportunities, for adolescents and young people particularly, perpetuates cycles of poverty.

## 8.7. Data availability

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

- There are no up-to-date estimates of child stunting and wasting rates, which represents a significant data gap.
- There is a lack of data around factors including 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 is limited data on the disparities between different population groups, such as gender disparities, and disparities between urban and rural areas.

### Footnotes in tables

- I UNISDR and GADRRRES. January 2017. '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'. on [http://gadrrres.net/uploads/images/pages/CSS\\_Booklet\\_2017-updated.pdf](http://gadrrres.net/uploads/images/pages/CSS_Booklet_2017-updated.pdf) [24.01.17].
- II Table reproduced from Ibid. p. 2.
- III The Child Rights Protection Act includes a general definition of 'economic exploitation of children' (s.1(j)(ii)), but does not set a minimum age for employment, does not place any concrete restrictions on children's work, and does not make it an offence to engage children in child labour (other than in the context of the offence of trafficking in children' (s.18(4)). The Seamen's Protection Act prohibits children under 16 from being employed on Marshall Islands vessels engaged in foreign trade, except on vessels on which only members of the same family are employed, school-ships or training ships.
- IV For girls between 16 and 18 years old, consent of the parents or legal guardian is required.



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