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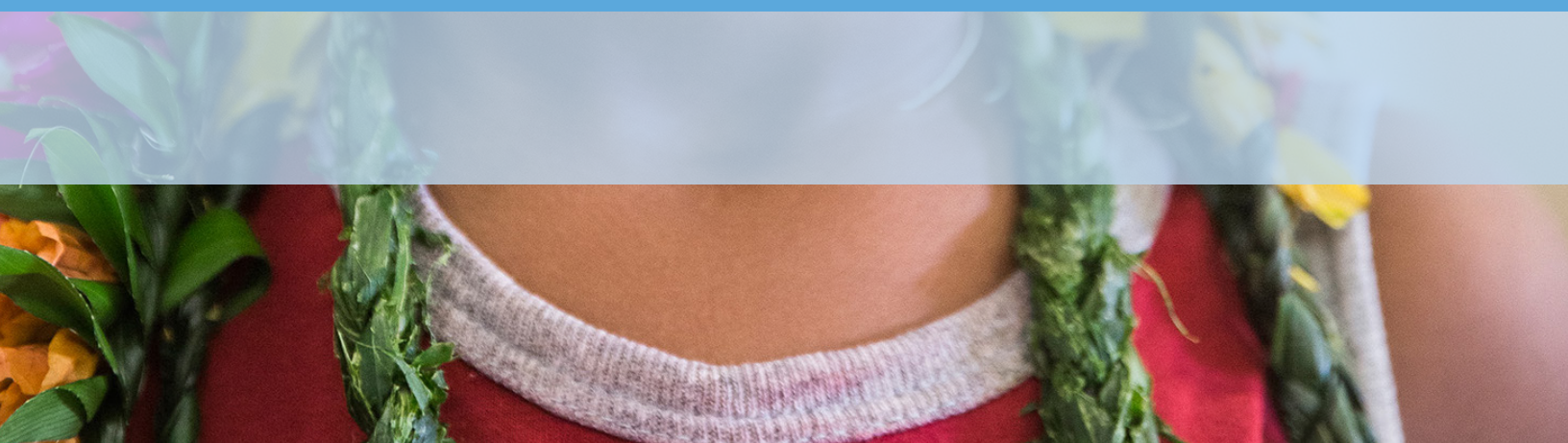
Situation Analysis of Children in the Federated States of Micronesia



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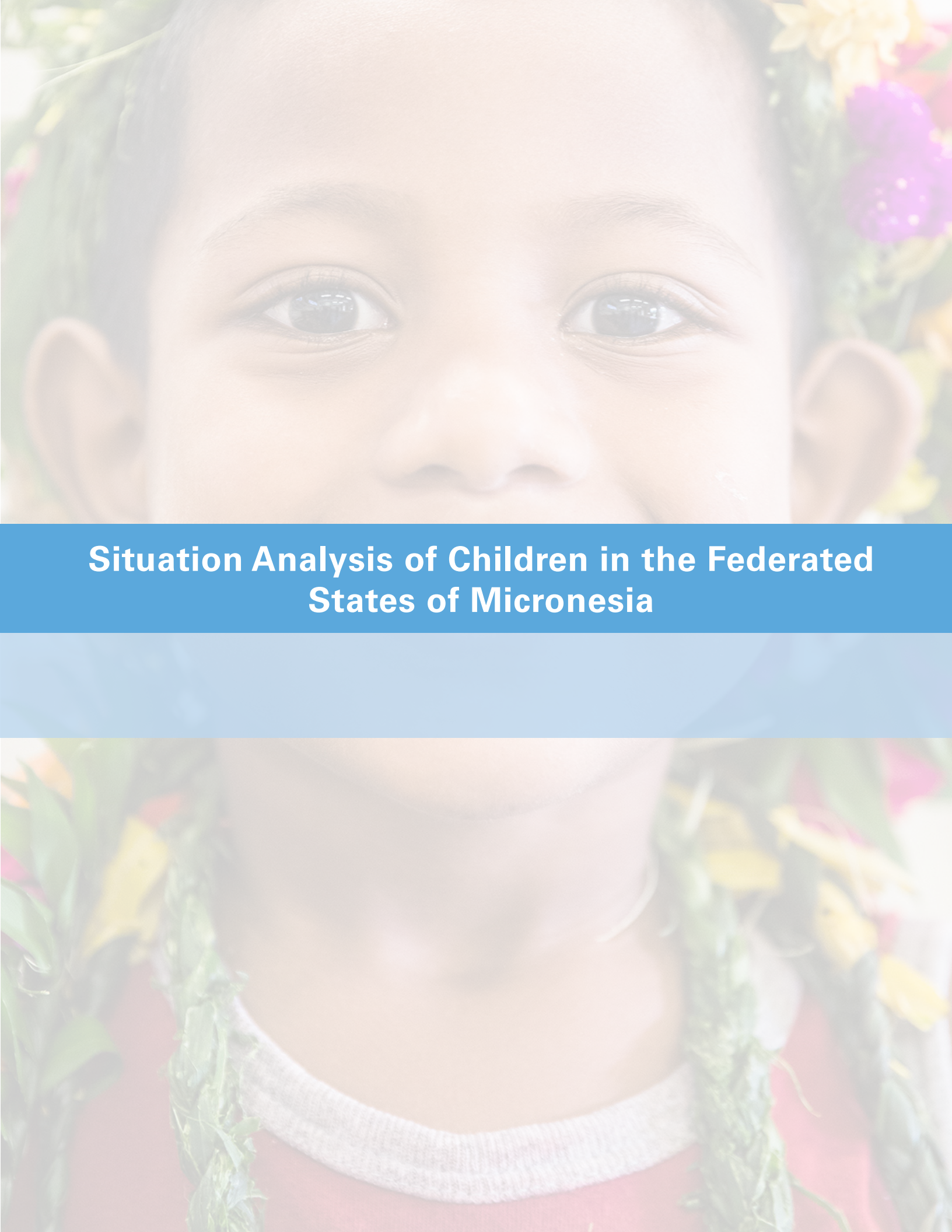

Situation Analysis of Children in the Federated States of Micronesia

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Executive Summary

Introduction

This report presents a comprehensive assessment and analysis of the situation of children and women in the Federated States of Micronesia (FSM). 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 FSM.

FSM is a group of 607 small islands, 65 of which are inhabited, located in the Micronesian region of the Pacific. FSM is divided into four states: Yap, Chuuk, Pohnpei and Kosrae, which are spread over approximately 3 million km^2. FSM had a population of 102,843 as of 2010. The population is relatively young (with 35 per cent below 15 years), but out-migration and a reduction in fertility rates have recently led to a decline in the proportion of individuals aged 0–19 years old. A large proportion of FSM's population lives in Chuuk State (47 per cent) and Pohnpei (35 per cent). A total of 77 per cent lives in rural areas. FSM is highly prone to disaster and climate risks, including tropical 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 for children and women in relation to these outcomes and in relation to the relevant Sustainable Development Goals (SDGs), it seeks to highlight trends, barriers and bottlenecks in the realization of children's and women's rights in FSM.

Key barriers and bottlenecks

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

Climate change and disaster risks: A whole range of climate and disaster risks affect FSM, including rising sea levels, water shortages owing to extreme climate variability, coastal 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 realization of children and women's rights.

Financial and human resources: FSM relies heavily on external development aid and the support of the US government provided through the Compact of Free Association, which is due to phase out in 2023. Though the economy has shown annual growth rates of around 2.5 per cent in recent years, thanks to the development of retail trade, fisheries and manufacturing, FSM still suffers from a lack of resources across government departments for the delivery of services for children. Lack of financial resources translates into lack of appropriate equipment and adequately trained professionals, including in the **health** and **WASH** sectors in particular, but also in **justice** and **child protection**.

The **geography** of FSM creates significant barriers to the realization of children's and women's rights, particularly remoteness and transportation constraints. Children and women living in rural areas enjoy, on the whole, lesser outcomes and access to basic services than those who live in urban areas. However, in the education sector, the increase in migration away from the Outer Islands

to state capitals means schools in urban areas are becoming overcrowded.

Legislation is missing or incomplete in relation to corporal punishment, child labour and domestic violence, in all but Kosrae State. In addition, there are several legislative gaps in relation to children in contact with the law.

Cultural norms and approaches: Traditional attitudes were found to act as a barrier to the realization of children's and women's rights in several sectors in FSM, for example through permitting violence against women and girls and discouraging the reporting of such violence. A shift in the ways families and communities are structured, from communal family living to more nuclear families, has also led to children facing greater child and social protection risks from within nuclear families that have less capacity to support their children compared with the wider community.

Data availability: There are useful data sources in some sectors in FSM. However, this report has identified several data gaps, and the absence of these data is, in itself, a key finding. Data on child and maternal health are particularly limited in relation to family planning, substance abuse, mental health, child stunting and wasting, under-five underweight, overweight and obesity among children and adolescents and breastfeeding practices. Challenges in accessing data in relation to educational indicators stem from inconsistent processes for collecting data between the four states. The implementation of nation-wide surveys, such as Demographic and Health Surveys or the Global School-Based Health Surveys, and the introduction of data collection mechanisms in other sectors would go a long way towards addressing these data gaps.

Snapshot of outcome areas

Health	Child mortality rates in FSM have been declining over the past few decades. However, FSM has not yet been able to meet international child mortality reduction targets, and it has among the highest child mortality rates in the Pacific Island Countries and Territories (PICTs) group. Immunization coverage for vaccine-preventable diseases remains low in FSM, with only three out of 12 recommended vaccines reaching coverage rates above 90 per cent. Immunization coverage is particularly low in Chuuk State, compared with the other three states. TB and leprosy continue to plague FSM's population. The maternal mortality ratio stands at 70 deaths per 100,000 live births, which is still above the SDG target. A total of 80 per cent of pregnant women make at least one antenatal visit; however, only 19 per cent do so during their first trimester. Traditional birth attendants play an important role in FSM's rural areas. On a positive note, contraceptive prevalence is at 55 per cent – the highest rate in the PICTs region. Even though FSM has reported a relatively low number of HIV infections, it records the third highest prevalence rate of sexually transmitted infections in the PICTs region, indicating that the underlying behavioural risks for HIV transmission are high.
Nutrition	Information on childhood wasting and stunting is not available, which representes a signifcant data gap. Aneamia rates are high among pregnant women (38 per cent) and pre-school children (19 per cent) – signifcantly higher than the regional averages. Low birthweight prevalence stands at a high 11 per cent, and is a leading risk factor for child mortality in FSM. Obesity and associated non-communicable diseases are a signifcant public health concern for FSM's adult population, especially women. Up-to-date data on obesity among children are not available. At 60 per cent, exclusive breastfeeding prevalence in FSM is in the middle range of the PICTs region.
WASH	FSM still has some way to go to meet the SDG targets in relation to WASH. Worryingly, FSM has experienced a decrease in improved water coverage since the early 1990s, and overall improved sanitation coverage remains low, at only 57 per cent. A total of 10 per cent of FSM's population still practises open defecation. FSM has one of the largest rural–urban WASH inequities in the region, with rural areas generally having more limited access to WASH. FSM's water and sanitation infrastructure also remains extremely vulnerable to natural disasters. For example, following Typhoon Maysak in 2015, schools on some islands had to close for more than one year as a result of damage to sanitation infrastructure.

Education	Heavy reliance on donor funding and difficulties associated with providing educational services on remote islands represent key challenges to FSM's education sector. The net enrolment ratio (NER) for children aged four to five years in early childhood education (ECE) currently stands at 46 per cent, suggesting that more than half of all children in this age bracket are not enrolled in formal ECE. The combined primary and secondary school NER currently stands at 74 per cent. Teacher qualifications and training, as well as high pupil–teacher ratios, remain areas of concern.
Child protection	Corporal punishment is widespread, with 32 per cent of children being subject to physical discipline in their household. FSM is considered a source, transit and, to a limited extent, destination country for men, women and children subjected to forced labour and sex trafficking. Customary marriages, which have no minimum age requirement, are permitted in FSM. So far, only Kosrae has passed a Family Protection Act, and there appears to be resistance to introducing similar legislation in Pohnpei, Chuuk and Yap as a result of traditional attitudes towards women.
Social protection	Around 30 per cent of households in FSM live below the basic needs poverty line, with trends pointing to an increase in poverty. Existing data suggest that poverty particularly affects children and female-headed households, and that poverty rates are significantly lower in Yap than in the other three states. A recent assessment of FSM's social protection system ranks it as the highest within the PICTs group in terms of its comprehensiveness and impact. However, social protection is limited to formal sector workers, and excludes the majority of workers who operate in the informal economy, therefore is not targeted to the poorest members of society.

Acronyms

AA Associate of Arts
ADB Asian Development Bank
AIDS Acquired Immune Deficiency Syndrome
AS Associate of Science
AusAID Australian Agency for International Development
CAT Convention Against Torture
CEDAW Convention on the Elimination of Violence Against Women
CERD Committee on the Elimination of Racial Discrimination
COM-FSM College of Micronesia-FSM
CRC Convention on the Rights of the Child
CRPD Convention on the Rights of Persons with Disabilities
CSC Chuuk State Code
CSHCN Special Health Care Needs
CSOs Civil Society Organizations
CTE Career and Technical Education
DHS Demographic and Health Survey
DoE Department of Education
DoHSA Department of Health and Social Affairs
DTaP Vaccine for Diphtheria, Tetanus, Pertussis
DPT Diphtheria, Tetanus, Pertussis
EAPRO East Asia and Pacific Regional Office
ECE Early Childhood Education
EFA Education For All
FAO Food and Agriculture Organization of the UN
FSM Federated States of Micronesia
FSMC Code of FSM
GADRRRES Global Alliance for Disaster Risk Reduction and Resilience in the Education Sector
GDP Gross Domestic Product
GER Gross Enrolment Ratio
GLAAS UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water
GPI Gender Parity Index
GSHS Global School-Based Health Survey
HepB Hepatitis B
Hib3 Haemophilus Influenzae type B
HIES Household and Income Expenditure Survey
HIV Human Immunodeficiency Virus
ICCPR International Covenant on Civil and Political Rights
ICESCR International Covenant on Economic, Social and Cultural Rights
ICT Information Communications Technology
IFPRI International Food Policy Research Institute

ILO International Labour Organization
IMF International Monetary Fund
IPU Inter-Parliamentary Union
ITC International Trade Centre
JEMCO Joint Economic Management Committee
JMP UNICEF/WHO Joint Monitoring Programme for Water Supply, Sanitation and Hygiene
KII Key Informant Interview
KSC Kosrae State Code
MCV1 Measles Containing Vaccine 1st dose
MDG Millennium Development Goal
MDR Multi-Drug Resistant
MHM Menstrual Hygiene Management
MMR Measles Mumps and Rubella
NCD Non-Communicable Disease
NER Net Enrolment Ratio
NGO Non-Governmental Organization
NMCT National Minimum Competency Tests
NMDI National Minimum Development Indicator
NMI Northern Mariana Islands
OCHA United Nations Office for the Coordination of Humanitarian Affairs
ODA Official Development Assistance
OECD Organisation for Economic Co-operation and Development
OHCHR Office of the United Nations High Commissioner for Human Rights
PCV3 Pneumococcal Conjugate Vaccine
PICTs The fourteen Pacific Island Countries and Territories that are the subject of the Situational Analyses
PNG Papua New Guinea
RCV1 Rubella Containing Vaccine
Rotac Rotavirus
SDG Sustainable Development Goal
SitAn Situational Analysis
SOP Standard Operating Procedure
SOWC State of the World's Children
SP Strategic Programme
SPC Pacific Community
SPI Social Protection Indicator
SRIM Sexual Rights Information of Micronesia
STI Sexually Transmitted Infection
TB Tuberculosis
UN United Nations

UNDP United Nations Development Programme
UNESCAP United Nations Economic and Social Commission for East Asia and the Pacific
UNESCO United Nations Educational, Scientific and Cultural Organization
UNFPA United Nations Population Fund
UNICEF United Nations Children's Fund
UNICEF SitAn Procedural Manual UNICEF's 'Guidance on Conducting a Situation Analysis of Children's and Women's Rights' (March 2012)
UNISDR United Nations International Strategy for Disaster Reduction
UPR Universal Periodic Review
US United States
USA United States of America
USAID US Agency for International Development
US$ United States Dollar
VHF Very High Frequency
WASH Water Sanitation and Hygiene
WHO World Health Organization
YSC Yap State Code

1. Introduction

1.1. Purpose and scope

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

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

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

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

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

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

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

1.2. Conceptual framework

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

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

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

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

The analysis is also informed by:

- **Role-pattern analysis:** The identification of stakeholders responsible for/best placed to

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

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

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

address any shortfalls/inequities in child rights outcomes; and

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

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

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

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

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

Table 1.1: Assessment and analysis framework by outcome area

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

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

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

1.3. Methods and limitations

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

The analysis phase required a synthesis and analysis of secondary data and literature, including small-scale studies and reports. It also included a mapping and analysis of relevant laws, policies, and government/SP Outcome Area strategies. In-country data collection was carried out in FSM. One of the limitations of the methodology is the lack of recent, quality data in relation to some of the areas the analysis covers. Gaps in the availability of up-to-date, strong data are noted throughout the report. The analysis of causes and determinants of rights shortfalls relied heavily on existing published reports and, therefore, some areas in the analysis were not subject to robust and recent research; again, gaps are highlighted as necessary.

A further limitation was the tight timeframe and limited duration of this SitAn process. This required the authors to make determinations as to priority areas of focus, which entailed the exclusion

5 These datasets were reviewed and verified by UNICEF.

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

7 The database is updated as new data become available.

of some issues from the analysis. This also led to limitations in the extent of, for example, the causality analysis (which was conducted but does not include problem trees), and the role-pattern and capacity gap analyses, for which information is presented but which were not necessarily performed for all duty-bearers in a formal manner.

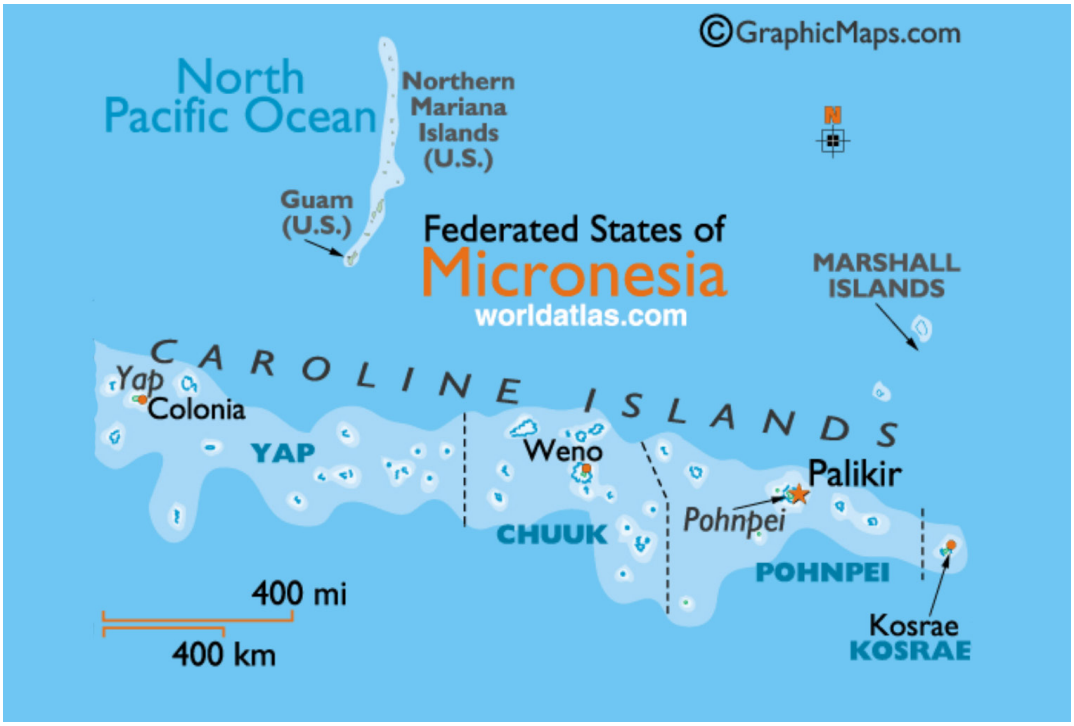
1.4. Governance and validation

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

2. Context

2.1. Geography and demographics

Figure 2.1: Map of FSM



Source: World Atlas.[8]

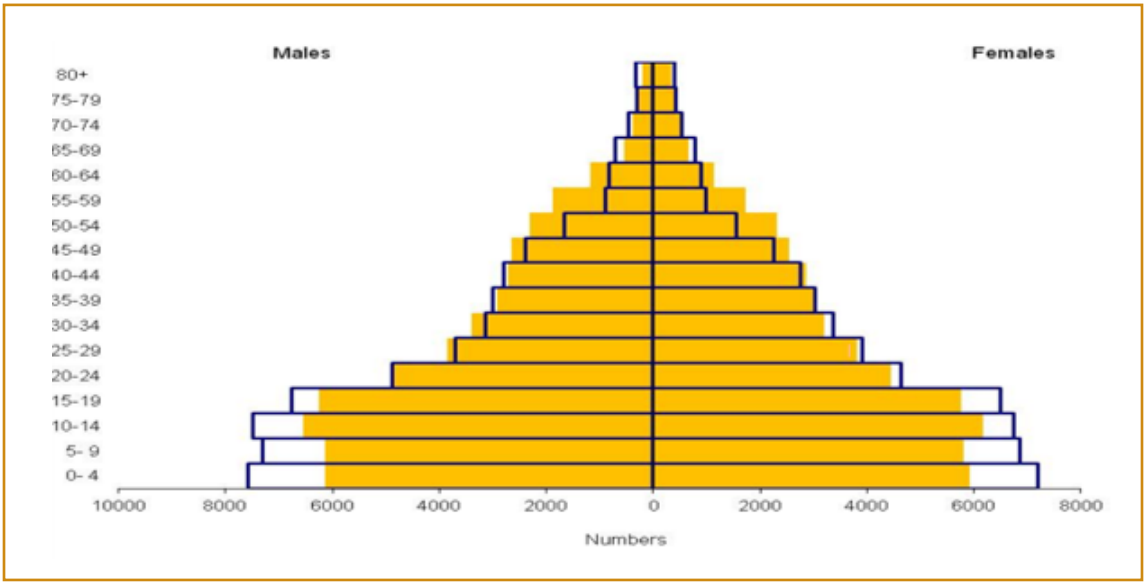
8 http://www.worldatlas.com/webimage/countrys/oceania/fm.htm [15.08.17].

FSM is a group of 607 small islands, 65 of which are inhabited, with a total land area of around 702 km^2. The islands are divided into four states – Yap, Chuuk, Pohnpei and Kosrae – and are spread over approximately 3 million km^2.[9]

The 2010 FSM census recorded a total population of 102,843 individuals.[10] This shows a decrease of over 4,000 from the 2000 figure of 107,021 and reflects a negative annual population growth rate of -0.4 per cent per year since the 2000 census. The population comprises 52,193 males (50.8 per cent) and 50,650 females (49.2 per cent), with a median age of 21.5 years, with 35 per cent of the population below the age of 15 years. Despite the increase in median age (from 18.9 years old in 2000), FSM has a relatively young population compared with its neighbours (e.g. around 29 years for Guam and around 35 years for Palau).

The population pyramid set out in the census (Figure 2.2) shows the high proportion of children and youth in 2000. The changes in the proportion of 10–14 year olds and 15–19 year olds between 2000 and 2010 is in line with reports of increasing levels of family migration out of FSM, including the migration of the younger people to seek education or work opportunities. Migration out of FSM has also been highlighted as a cause of reduction in fertility rates, which is reflected in the change in population among the 0–4 age group.

Figure 2.2: Age–sex pyramids (2010 shaded, 2000 outlined)



Source: 2010 Census of Population and Housing.

As of 2013, emigration from FSM was recorded at 29,300, accounting for 28.3 per cent of the country's total population. The primary destinations of emigrants were the USA, Guam, the Northern Mariana Islands (NMI), Palau, Marshall Islands, Canada and Australia. Immigration

9 BBC News, 'Micronesia Country Profile', on http://www.bbc.co.uk/news/world-asia-pacific-15494620 [15.08.17].

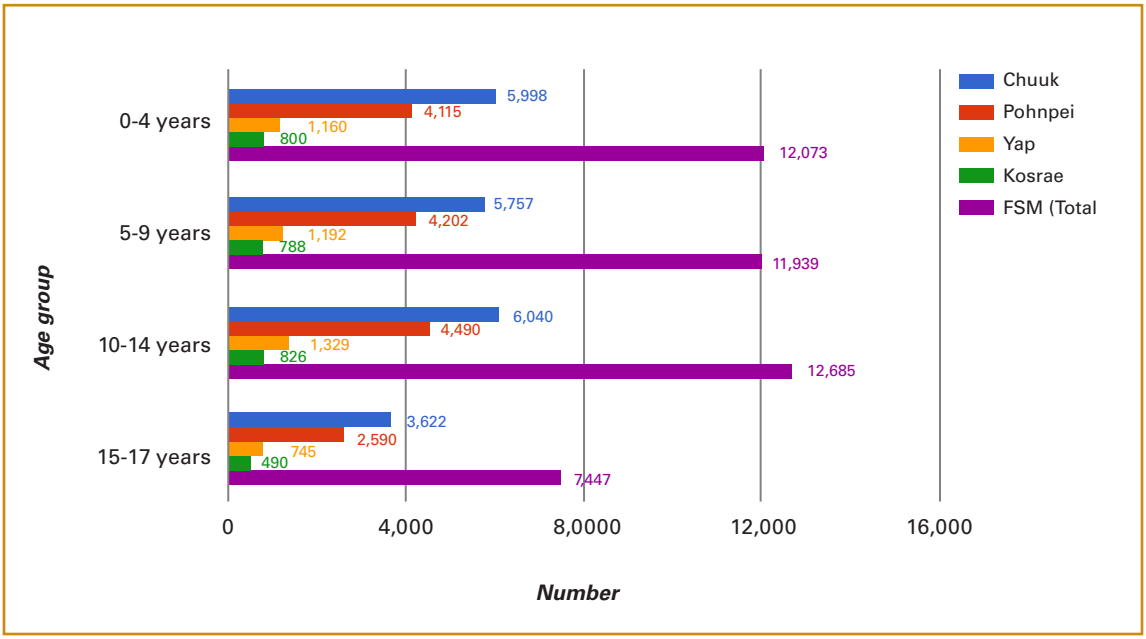
10 Division of Statistics, 'Summary Analysis of Key Indicators, from the Federated States of Micronesia 2010 Census of Population and Housing', on http://www.spc.int/nmdi/reports/FSM_2010_Census_Indicators_Final.pdf [15.08.17].

figures were significantly lower, at 2,600, with the top immigrant-sending countries being the Philippines, the USA, China, Guam, Marshall Islands, NMI, Palau and Japan.[11]

In terms of FSM's four states, Chuuk has a population of 48,654, or 47.3 per cent of the total population; Pohnpei has a population of 36,196, or 35.2 per cent of the total population; Yap has a population of 11,377, or 11.1 per cent of the total population; and Kosrae has a population of 6,616, or 6.4 per cent of the total population.[12] The capital of FSM, Palikir, is located on the island of Pohnpei.

According to the 2010 FSM census, 22.3 per cent of the total population lives in defined urban areas across the four states and 77.7 per cent in rural areas. Figure 2.3 shows a breakdown of the number of children in each state: 48.5 per cent of children live in Chuuk, 34.9 per cent in Pohnpei, 10.0 per cent in Yap and 6.6 per cent in Kosrae. A total of 44 per cent of the population of Chuuk was recorded to be 17 years or younger, with the child population standing at 42.5 per for Pohnpei, 43.9 per cent for Kosrae and 38.9 per cent for Yap.[13]

Figure 2.3: Number of children aged 0–17 by age group and state in FSM



Source: 2010 Census of Population and Housing

A total of 49.3 per cent of FSM's population belongs to the Chuukese/Mortlockese ethnic group, followed by Pohnpeian with 29.8 per cent, Kosrean with 6.3 per cent, Yapese with 5.7 per cent,

11 World Bank Group, 'Migration and Remittances Factbook', Third Edition, 2016, p. 183, on https://openknowledge.worldbank.org/bitstream/handle/10986/23743/9781464803192.pdf [15.08.17].

12 Division of Statistics, 'Summary Analysis: 2010 Census of Population and Housing'.

13 State Party Report to the Committee on the Rights of the Child 2017 [unpublished].

Yap outer islander with 5.1 per cent, Polynesian with 1.6 per cent and Asian with 1.4 per cent. A total of 0.8 per cent were recorded as belonging to other ethnic groups. Similar to Kiribati, over half (54.7 per cent) of the population in FSM was recorded to be Roman Catholic. This is followed by Protestant with 41.1 per cent, which includes Congregational (38.5 per cent), Baptist (1.1 per cent), Seventh-Day Adventist (0.8 per cent) and Assembly of God (0.7 per cent).[14]

2.2. Main disaster and climate risks

According to OCHA, FSM has high vulnerability to natural disasters and experiences a cyclone season each year.[15] The most recent cyclone with severe consequences occurred at the end of March/beginning of April 2015. Cyclone Maysak formed near Pohnpei and moved west with increasing strength. At its strongest, its centre was located near Yap, with wind speeds of around 160 km/h. Extensive damage was caused to homes and crops in the Ulithi and Fais islands in Yap State, as well in Kosrae.[16] Chuuk State was affected by strong winds and heavy rainfall, which damaged houses and power lines. It was reported that at least four individuals were killed in Chuuk State.[17] An estimated 60–80 per cent of houses in Chuuk's capital of Weno were damaged and over 800 houses were destroyed.[18] Around 6,000 people sought refuge either with family or in emergency shelters, and up to 90 per cent of crops were damaged.[19] The US Agency for International Development (USAID) is reported to have provided over US$ 2 million in assistance to FSM in relation to Cyclone Maysak, providing over US$ 600,000 to the Food and Agriculture Organization (FAO) to aid in the restoration of agricultural production.[20]

Like most PICTs, FSM is vulnerable to the impacts of climate change. Despite the centre islands (Chuuk, Kosrae, Pohnpei and Yap) of each states being volcanic and reaching up to 791 metres above sea level, most of the Outer Islands are low-lying atolls reaching only a few metres above sea level, making them vulnerable to rising sea levels.[21] Increases in ocean temperatures and acidification are contributing to coral reef damage and bleaching, subsequently increasing the exposure of islands and atolls to the Pacfic Ocean. This contributes to coastal erosion, leaving the

14 Regional Rights Resource Team, 'Human Rights in the Pacific', 2016, on http://www.spc.int/wp-content/uploads/2016/12/Human-right-Pacific.pdf [15.08.17].

15 OCHA, 'Country Profiles, Federated States of Micronesia', on http://www.unocha.org/pacific/country-profiles/federated-states-micronesia [15.08.17].

16 Reliefweb, 'Updates, Federated States of Micronesia – Tropical Cyclone Maysak', ECHO Daily Map, 30 March 2015, on http://reliefweb.int/map/micronesia-federated-states/federated-states-micronesia-tropical-cyclone-maysak-echo-daily-map [15.08.17].

17 Ibid.; Reliefweb, 'Updates, Tropical Cyclone Maysak – Federated States of Micronesia, Philippines', ECHO Daily Map, 2 April 2015, on http://reliefweb.int/map/micronesia-federated-states/tropical-cyclone-maysak-federated-states-micronesia-philippines-echo [15.08.17].

18 CRED, 'Federated States of Micronesia: Disaster Management Reference Handbook 2016', on http://reliefweb.int/report/micronesia-federated-states/federated-states-micronesia-disaster-management-reference [15.08.17].

19 Reliefweb, 'Typhoon Maysak – March 2015', on http://reliefweb.int/disaster/tc-2015-000028-fsm [15.08.17].

20 USAID, 'Assistance for Typhoon Maysak Victims in the Federated States of Micronesia', News and Information, Fact Sheets, on https://www.usaid.gov/pacific-islands/working-crises-and-conflict/typhoon-maysak-assistance-fsm [15.08.17].

21 FSM, 'Preliminary Report to the Conference of the Parties of the Convention on Biological Diversity', 2001, on https://www.cbd.int/doc/world/fm/fm-nr-01-en.pdf [15.08.17].

islands more vulnerable to storm surges and floods.[22] Severe dry weather events in recent years in FSM have led to droughts, fires and food and water shortages, leaving many families in more isolated regions of FSM unprepared and vulnerable to hazards.[23]

2.3. Government and political context

Following the Second World War, in 1947, FSM became a part of the Trust Territory of the Pacific Islands, which was under US administration, along with the Commonwealth of the NMI, Marshall Islands and Palau.[24] The 1970s saw NMI, Marshall Islands and Palau demand separate status from the islands of Kosrae, Pohnpei, Chuuk and Yap, proceeding to ratify a constitution establishing FSM. In 1986, FSM became an independent and sovereign state.[25] FSM entered into a Compact of Free Association with the USA in the same year, which means the USA carries the defence responsibility for FSM and has the right to set up military bases in FSM and to deny other nations access to FSM.[26] FSM citizens are allowed to live, work and study in the USA without visas, and US citizens are able to live and work in FSM with no visa requirements. In 2003, the Compact was renegotiated and signed for a further 20 years.[27]

The Executive Branch of the National Government of FSM comprises the president (H.E. Mr Peter M. Christian) and vice president (Hon. Mr Yosiwo P. George) and is located in Pohnpei.[28] The National Congress comprises 14 senators, with four elected from each of the four states to serve four-year terms, and 10 elected from single-member constituencies to serve two-year terms. The senators themselves select the president of FSM from among the four state senators, rather than a popular vote being held.[29]

Two women stood for the national congress at the 20th congressional election in 2017, but among the 14 senators elected there were no women. It has been reported that FSM is one of the only countries in the world to have never elected a woman into its national legislature.[30] Lack of female representation in decision-making has been tied to social perceptions of gender roles in FSM. Traditionally, Micronesian societies, with the exception of Yap and a few atolls in Pohnpei, have emphasized matrilineal descent, with the acquisition of property, rights and titles traced through female hereditary lines. However, following governance during the era of colonization, most decision-making powers were transferred to male members of the family, based on stereotyped

22 U.S. Fish and Wildlife Service, 'Climate Change in the Pacific Region', on https://www.fws.gov/pacific/Climatechange/changepi.html#OceanAcidification [15.08.17].

23 CRED, 'Federated States of Micronesia: Disaster Management Reference Handbook 2016'.

24 US Department of State, 'U.S. Relations with the Federated States of Micronesia', 25 February 2016, on https://www.state.gov/r/pa/ei/bgn/1839.htm [15.08.17].

25 State Party Report to the Committee on the Rights of the Child 2017.

26 BBC News, 'Micronesia Country Profile'.

27 US Department of State, 'U.S. Relations with the Federated States of Micronesia'.

28 Government of FSM, 'National Government, Executive Branch', on www.fsmgov.org/ngovt.html#LEGI [15.08.17].

29 Pacific Women in Politics, 'FSM', on http://www.pacwip.org/future-elections/fsm/ [15.08.17].

30 Ibid.

gender roles. This gendered approach has persisted into the contemporary era, with impacts on women's ability to participate in decision-making.[31]

Each of the four states also has its own legislature, varying in size depending on the state. The Kosrae Congress consists of 14 senators, Pohnpei has 23 and Yap has 10; and the Chuuk Congress has 28 delegates (House of Representatives) and 10 senators (Upper House). Out of all 85 members of the state congresses, there are two female senators.[32]

The FSM National Youth Council acts as an umbrella organization for youth clubs and state councils, and also works with the government to implement FSM youth policy, but it does not receive any financial assistance from the government.[33]

2.4. Socio-economic context

FSM's current National Development Plan is the Strategic Development Plan 2004–2023, which includes strategic aims and indicators around economic development, private sector development, agriculture, fisheries, tourism, environment, health, education and gender.[34]

FSM is a lower-middle-income country, with a 2015 gross domestic product (GDP) per capita of US$ 3,015.23. In the 2016 fiscal year, the economy is estimated to have grown by 3 per cent, through fisheries, retail trade and manufacturing, especially from the new water bottling plants. The economy is expected to grow 2.5 per cent in both 2017 and 2018, with the national government passing responsibility for project implementation to the USA in 2016 after amending legislation.[35] Infrastructure grants under FSM's Compact with the USA became available in fiscal year 2015; however project implementation has been restricted by limited capacity in the national and state governments.[36]

The main exports of FSM are fish and other related products, with the major export partners Thailand, Japan, China and Republic of Korea.[37] These exports amount to US$ 17,620 million of the country's total US$ 20.6 million export economy, with marine resources regarded as having

31 Pacific Women, 'Stocktake of the Gender Mainstreaming Capacity of Pacific Island Governments, FSM', 2012, pp. 6–7, on http://www.pacificwomen.org/wp-content/uploads/FSM-gender-stocktake.pdf [14.06.17].

32 Pacific Women in Politics, 'FSM'.

33 Youth Policy, 'Micronesia', Factsheet, on http://www.youthpolicy.org/factsheets/country/micronesia/ [15.08.17].

34 https://www.adb.org/sites/default/files/linked.../cobp-fsm-2015-2017-sd-02.pdf [01.08.17].

35 World Bank, 'GDP Per Capita, Micronesia, Fed. Sts', on http://data.worldbank.org/indicator/NY.GDP.PCAP.CD?locations=FM [15.08.17].

36 ADB, 'Asian Development Outlook 2017: Transcending the Middle-Income Challenge, North Pacific Economies', on https://www.adb.org/publications/asian-development-outlook-2017-middle-income-challenge [15.08.17].

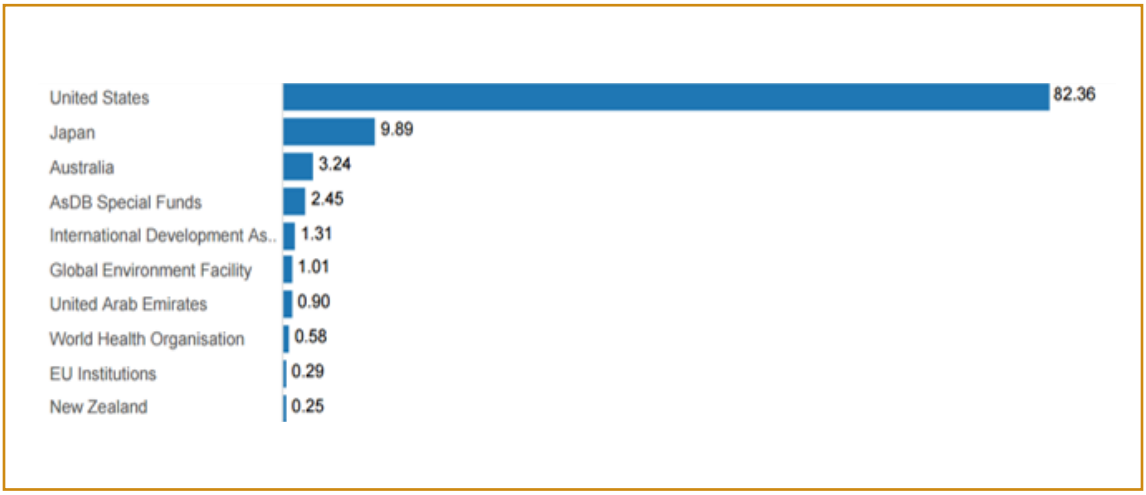
37 ITC, 'Countries/Territories, Micronesia (Federated States of)', on www.intracen.org/country/micronesia/ [15.08.17].

the most potential for development.[38] The fishing industry has been enhanced through the construction of cold storage facilities and processing plants, with the domestic fishing industry increasingly providing a revenue source – a part of the long-term strategy of FSM.[39] Main imports include foodstuffs, manufactured goods and machinery and equipment. The primary partners are the USA, Republic of Korea, Japan and Australia.[40] FSM has experienced increasing reliance on imported food recently, with many farms in Chuuk being destroyed as a result of high tides. For example, in March 2007 high waves wiped out taro fields, destroying much of the main food supply of Chuuk State.[41]

FSM is highly dependent on funds provided through the Compact with USA, which are critical for economic development. The aid the USA provides aims to facilitate the establishment of a stable democratic government and a move towards economic independence. A portion of the aid provided is directed to a jointly managed Trust Fund.[42]

Gross average official development assistance (ODA) for FSM in 2015 amounted to US$ 84.8 million, with the USA as the top donor, contributing approximately US$ 82 million (2014–2015 average contribution).[43] Figure 2.4 also shows the remaining donors.

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



Source: OECD Aid at a Glance 2014–2015[44]

38 The Observatory of Economic Complexity, 'Micronesia', on http://atlas.media.mit.edu/en/profile/country/fsm/ [15.08.17].

39 CFE-DM, 'Disaster Management Reference Handbook'.

40 ITC, 'Countries/Territories, Micronesia (Federated States of)'.

41 CFE-DM, 'Disaster Management Reference Handbook'.

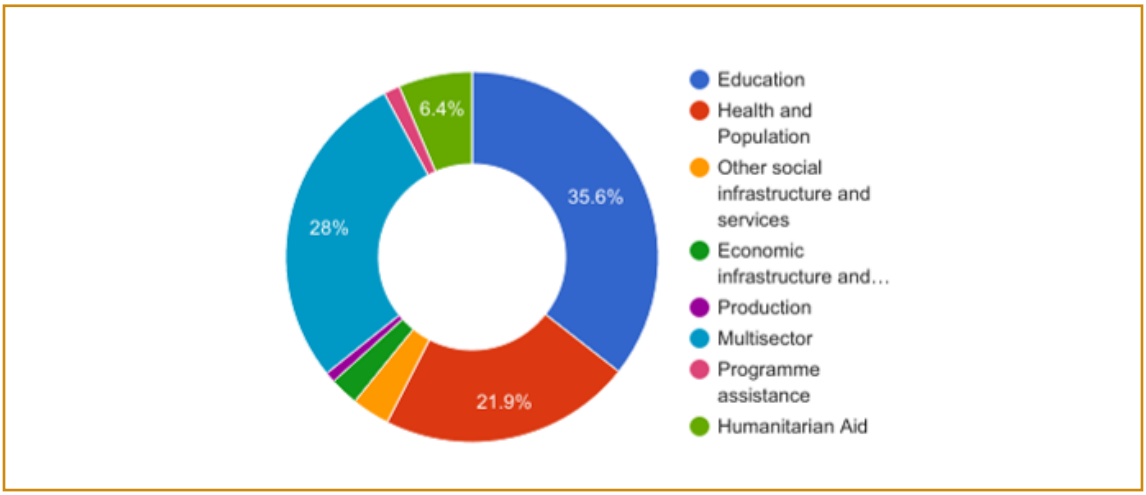
42 Ibid.

43 OECD, 'ODA Recipients, Federated States of Micronesia', on http://www.oecd.org/countries/micronesia/aid-at-a-glance.htm [15.08.17].

44 http://www.oecd.org/countries/micronesia/aid-at-a-glance.htm#recipients [15.08.17].

Figure 2.5 presents the distribution of ODA received, with most given to education, health and population and the multi-sector programming. Other social infrastructure and services receive 3.3 per cent, economic infrastructure and services 2.5 per cent, programme assistance 1.4 per cent and production the least, with 0.9 per cent.

Figure 2.5: Bilateral ODA received by sector for FSM (2014–2015 average) (%)



Source: OECD Aid at a Glance 2014–2015[45]

FSM's central government distributes the Compact funds among the states.[46]

The internal economy of FSM consists largely of subsistence farming and fishing, employing over half of the adult population,[47] with the agriculture sector in particular employing 27.5 per cent of workers.[48] Of adults working in the cash economy, more than half are employed in the public sector earning 58 per cent of the total national wages.[49]

The latest available data, from 2013, show that inequality in FSM is high, with the Gini Coefficient calculated at 42.5, combined with a distribution of income and consumption of 48.1 per cent among the richest quantile in FSM. However, improvements are to be noted on 2000, when the richest 20 per cent of the population controlled 65.9 per cent of income and consumption in FSM. [50]

The International Monetary Fund (IMF) assessed in 2015 that a relatively small proportion of FSM's population lived under the national food poverty line, or 11 per cent, and concluded that

45 http://www.oecd.org/countries/micronesia/aid-at-a-glance.htm#recipients [15.08.17].

46 US Department of State, 'U.S. Relations with the Federated States of Micronesia'.

47 See CFE-DM, 'Disaster Management Reference Handbook', and US Department of State, 'U.S. Relations with Federated States of Micronesia'.

48 http://data.un.org/CountryProfile.aspx?crName=Micronesia%20%28Federated%20States%20of%29 [15.08.17].

49 US Department of State, 'U.S. Relations with the Federated States of Micronesia'.

50 World Bank data, on http://povertydata.worldbank.org/poverty/country/FSM [18.05.17].

poverty and extreme poverty were not a widespread phenomenon.[51] However, other sources, referencing World Bank data from 2013, suggest that one in five people are living on less than US$ 2 per day. However, the government of FSM has criticized this assessment for not considering the practicalities of island life and the large number of children and young adults in the country.[52] Poverty concerns are particularly relevant because FSM's poorest population is most vulnerable to natural disasters, including frequent floods, droughts and earthquakes.[53]

In 2017, about 16 per cent of the total labour force was unemployed and there were noted gender inequalities in relation to employment.[54] The labour force, as recorded in the 2010 census, appears to be male-dominated, consisting of 66.1 per cent male and 48.4 per cent female. Generally, women are reported to lack access to economic and social resources.[55] The Australian government estimates that men outnumber women by about two to one in waged employment and that women are also underrepresented in the subsistence economy.[56]

2.5. Legislative and policy framework

FSM is a constitutional confederation with a central government. Each of the four states has its own constitution, elected legislature, governor and court system.[57] The Federal Constitution is superior to all state constitutions such that all state laws and regulations are required to comply with it. The national government also has exclusive competence in specific legal and regulatory matters, as set out in the FSM Code, and represents FSM internationally. [58]

In 2012, the Australian government set up an aid fund for Pacific women to improve their political, economic and social opportunities, with funding of approximately AU$ 1.4 million for a period of 10 years from 2015.[59] The government is working to establish an effective national gender policy.[60] The FSM Constitution as well as the four state constitutions guarantee fundamental rights and freedoms as conferred on all FSM citizens regardless of sex, race, ancestry, national origin, language, religion or social status.[61]

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51 IMF, 'Country Report No. 15/128', 2015, on https://www.imf.org/external/pubs/ft/scr/2015/cr15128.pdf [18.05.17].

52 The Borgen Project, 'Five Facts about Poverty in Micronesia', March 2017, on https://borgenproject.org/facts-about-poverty-micronesia/ [18/05/17].

53 CFE-DM, 'Disaster Management Reference Handbook'.

54 State Party Report to the Committee on the Rights of the Child 2017.

55 CFE-DM, 'Disaster Management Reference Handbook'.

56 Australian Government, 'Pacific Women Shaping Pacific Development: Country Plan Summary 2015–2019', on http://www.pacificwomen.org/wp-content/uploads/FSM-Country-Plan-Summary-2015.pdf [19.05.17].

57 State Party Report to the Committee on the Rights of the Child 2017.

58 UN General Assembly Human Rights Council, 'National Report Submitted in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21, Federated Sates of Micronesia', 2015, on https://www.upr-info.org/sites/default/files/document/micronesia_federated_states_of/session_23_-_november_2015/a_hrc_wg.6_23_fsm_1_e.pdf [19.05.17].

59 Australian Government, 'Pacific Women Shaping Pacific Development'.

60 State Party Report to the Committee on the Rights of the Child 2017.

61 Ibid.

In 2016, FSM ratified the Convention on the Rights of Persons with Disabilities (CRPD). Children with disabilities are supported by the state until they reach 21 years and a national special education programme is dedicated to support children with disabilities.[62]

2.6. Child policy monitoring

FSM acceded to the CRC in 1993 and became a party to the Optional Protocol on the sale of children child prostitution and child pornography in 2012 and to the Optional Protocol on the involvement of children in armed conflict in 2015. The country submitted its first report to the Committee on the Rights of the Child in 1996, with the Committee reviewing this in January 1998. The second report was due in June 2000, and has not yet been submitted.[63] FSM has undergone two Universal Periodic Review (UPR) processes, in 2010 and 2015,[64] as set out in Table 2.1.

Table 2.1: FSM's treaty reporting obligations

Treaty	Status[II]	Past reports	Next report due
CRC	5 May 1993 (A)	Cycle I due: 3 June 1995 Submitted: 16 April 1996	3 June 2000
CRC OP1 (AC)	26 October 2015	-	-
CRC OP2 (SC)	23 April 2012	-	May 2014
CEDAW	1 September 2004 (A)	Cycle I due: 1 October 2005 Submitted: 4 August 2015 (combined I–III)	March 2021
ICESCR	Not ratified/accepted	-	-
ICCPR	Not ratified/accepted	-	-
CRPD	7 December 2016	-	-
CERD	Not ratified/accepted	-	-
CAT	Not ratified/accepted	-	-
ILO No 138	Not a member of ILO[III]		
ILO No 182	Not a member of ILO		

Source: OHCHR[65]

62 Ibid.

63 UN Human Rights Office of the High Commissioner, 'Reporting Status for Micronesia (Federated States of)', on http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Countries.aspx?CountryCode=FSM&Lang=EN [19.05.17].

64 https://www.upr-info.org/en/review/Micronesia-%28Federated-States-of%29 [19.05.17].

65 http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Treaty.aspx?CountryID=113&Lang=EN [18.08.17].

A child protection baseline report completed in 2014 by UNICEF included an evaluation of national legislation and its adherence to the provisions in the CRC. This evaluated national legislation against indicators constructed according to the CRC's provisions.[66] It found that, out of 270 indicators investigated, the country was fully compliant with 76, partially compliant with 52 and non-compliant with 142 CRC provisions.[67]

Children are defined as all persons under the age of 18 under the state laws of Pohnpei, Chuuk, Kosrae and Yap. However, the definition of 'child' varies under some of the national and state laws, depending on relevant contexts.[68]

No main law or bill exists to cover children's rights. Fundamental rights and freedoms, including the right to life, protection, expression, assembly, etc., are covered under the FSM Constitution. During the UPR review in 2015, however, the Country Team brought attention to the fact that, although Section 5 of the Constitution includes provisions for non-discrimination, on the grounds of sex, race, ancestry, national origin, language and social norms, it does not mention gender, sexual orientation and disability as such grounds.[69]

No national strategy or plan of action for children exists. Instead, each department at national level has its own strategies and plans in relation to its support for children's programmes. A FSM National Youth Policy was in place between 2004 and 2010 and is currently up for review.[70] The Social Affairs Division of the Department of Health and Social Affairs (DoHSA) is the coordinating body for services and activities for children, and monitors compliance with the CRC.[71] However, no specific budget allocation exists in relation to implementation of the CRC.[72]

There is currently no labour law in place in FSM providing for a minimum age and conditions for employment, and FSM is not a member of the International Labour Organization (ILO) and thus has not ratified the conventions on Minimum Age (C138) or the Worst Forms of Child Labour (C182).[73]

66 Ibid.

67 UNICEF Pacific, 'Protect Me with Love and Care: Child Protection Baseline Report for the Federated States of Micronesia', 2014, p. 9, on https://www.unicef.org/pacificislands/FSM_2014_Baseline_Report_.pdf [19.05.17].

68 State Party Report to the Committee on the Rights of the Child 2017.

69 UN General Assembly, Human Rights Council, 'Compilation'.

70 UNICEF Pacific, 'Protect Me with Love and Care', p. 83.

71 Ibid., p. 10.

72 State Party Report to the Committee on the Rights of the Child 2017.

73 UPR of FSM, on www.upr-info.org/sites/default/files/document/micronesia_federated_states_of/session_23_-_november_2015/unct_pacific_region_upr23_fsm_e_main.pdf [19.05.17].

3. Health and Nutrition

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

Key Health and Nutrition-related SDGs

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

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

The analysis here takes a 'health systems approach'. A country's health system includes 'all organisations, people and actions whose primary intent is to promote, restore or maintain health'.[74] 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.[75] The analysis of the underlying causes of shortcomings and bottlenecks in relation to child (and maternal) health and nutrition in FSM takes these building blocks of the health system into account (where relevant). Furthermore, cross-references to other relevant parts of the SitAn (e.g. WASH) are made where necessary, given that the causes of shortcomings in health systems are often multi-faceted and interlinked with other areas covered in the SitAn.

3.1. Child mortality

Neonatal mortality (0–28 days), infant mortality (under one year) and under-five mortality in FSM have been declining continuously over the past decades. However, despite this progress, FSM has not been able to meet international development goals related to child mortality, and has among the highest child mortality rates in the PICTs group.[76]

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

75 Ibid.

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

According to the latest national estimates, summarized in the 2016 SOWC dataset, the under-five child mortality rate in FSM stands at 35 deaths per 1,000 live births as of 2015, which represents a 38 per cent reduction since 1990. Note that, as of 2015, the under-five mortality rate in FSM remains somewhat higher for boys (38/1,000) than for girls (31/1,000). The 36/1,000 average means FSM has not yet reached SDG 3.2 on under-five mortality – or, reduction of the rate to at least 25/1,000 by 2030. However, in light of FSM's progress over the past decades, it is likely the country will reach the SDG target of 25/1,000 by 2030.

The SOWC 2016 estimates the infant mortality rate (for under one year olds) to stand at 29/1,000 as of 2015, which represents a 33 per cent reduction from 43/1,000 in 1990. The SDGs do not include an explicit target linked to infant (under-one) mortality, but instead focus on under-five mortality and neonatal mortality. Neonatal mortality in FSM is estimated to stand at 19 deaths per 1000 live births, according to the SOWC data. This means FSM has also not yet met the SDG 3.2 target for neonatal mortality, which aims for a rate of 12/1,000 by 2030.

Regarding the child mortality indicators above, it is important to highlight that estimates are unstable and can fluctuate heavily from year to year, given the small overall number of vital events that occur in FSM. Furthermore, it has been noted that infant mortality rates from FSM are likely to suffer from underreporting, as infant deaths on the Outer Islands are typically not recorded.[77] As a result of the small number of overall deaths, it is difficult to establish an accurate 'hierarchy' of immediate and underlying causes of child mortality in FSM.

Causes-of-death estimates for 2010 from the Institute of Health Metrics suggest childhood underweight is the leading risk factor for children under the age of five.[78] The SOWC data suggest around 11 per cent of children born in the country have low birthweight. A 2013 UNICEF progress report on maternal and child survival suggests acute infections, complicated by malnutrition, are a major cause of infant mortality in FSM.[79] A 2007 review of paediatric hospital admission data found that, in all four states of FSM, respiratory diseases (e.g. pneumonia), gastrointestinal diseases (e.g. diarrhoea), skin infections, injuries and abscesses made up the top five reasons for admission.[80] Latest UNICEF estimates suggest that pre-term complication (19.5 per cent of all deaths), intra-partum complications (14 per cent), congenital diseases (12 per cent), pneumonia (15 per cent), injury (7 per cent) and diarrhoea (6 per cent) were the main causes of death in under-five children in FSM in the year 2015.[81] Note, again, however, that a small number of individual events can significantly alter this causes-of-death hierarchy and that estimates are inherently unstable in small populations such as FSM's.

77 UNICEF, 'Tracking Progress in Maternal and Child Survival, Case Study Report for the Federated States of FSM', July 2013, on https://www.unicef.org/pacificislands/14-02-2014_FSM_Case_Study_For_Delivery_to_UNICEF_8-29-2013_conversion.pdf [25.04.17]

78 Institute for Health Metrics, 'Global Burden of Disease Study: FSM Country Profile', 2010, on http://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_federated_states_of_FSM.pdf [25.04.17].

79 UNICEF, 'Tracking Progress in Maternal and Child Survival'.

80 As cited in UNICEF, 'Tracking Progress in Maternal and Child Survival', p. 10.

81 UNICEF statistics, on https://data.unicef.org/topic/child-survival/under-five-mortality/ [25.04.17].

The 2015 Annual Report of the DoHSA in turn states that the leading causes of death among infants and young children are respiratory infection, undernutrition, prematurity, sepsis and pneumonia; among older children, teenagers and young adults, it is suicide and cancer. Unfortunately, the Annual Report does not provide a detailed breakdown of proportions and age groups.[82]

3.2. Child health, immunization and communicable diseases

There is a lack of quantitative data on some of the key child health indicators for FSM. For example, there are no national estimates of the proportion of under-five children with suspected pneumonia taken to a health provider.[83] There are also no recent estimates of the proportion of children under five with diarrhoea receiving oral rehydration salts, which is a significant data gap, given the importance of diarrhoeal diseases as causes of child mortality in FSM.[84]

Furthermore, there appear to be no quantitative data on the availability of insecticide-treated nets or the proportion of children sleeping under nets in FSM.[85] The gaps in the data in relation to malaria may not be too problematic, though, given that there is currently no risk of malaria transmission in FSM.[86] However, there are sporadic outbreaks of mosquito-borne diseases such as dengue fever and Zika virus.[87]

Large gaps in immunization coverage for vaccine-preventable diseases remain a significant public health concern in FSM, and recent years have even seen a worrying decline in immunization coverage rates, at least for some universally recommended vaccines. Available estimates suggest only 81 per cent of under-one year olds in FSM are fully immunized against DPT and that 91 per cent are immunized against measles.[88]

Estimates provided by the WHO Global Health Observatory also indicate that FSM has significant gaps in immunization coverage for nine out of 12 universally recommended vaccines, with only three vaccinations (DTP1, RCV1, MCV1) reaching coverage rates above 90 per cent (see Figure 3.1). Particularly worrying in this respect are coverage rates for HepB, Hib3, PCV3 and Rotac vaccines, which have been on the decline in recent years, and in some cases have dropped to less than 60 per cent.[89]

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82 DoHSA, 'Annual Report 2015', p. 11.

83 SOWC 2016 and UNICEF statistics, on https://data.unicef.org/country/fsm/ [25.04.17].

84 SOWC 2016.

85 Ibid.

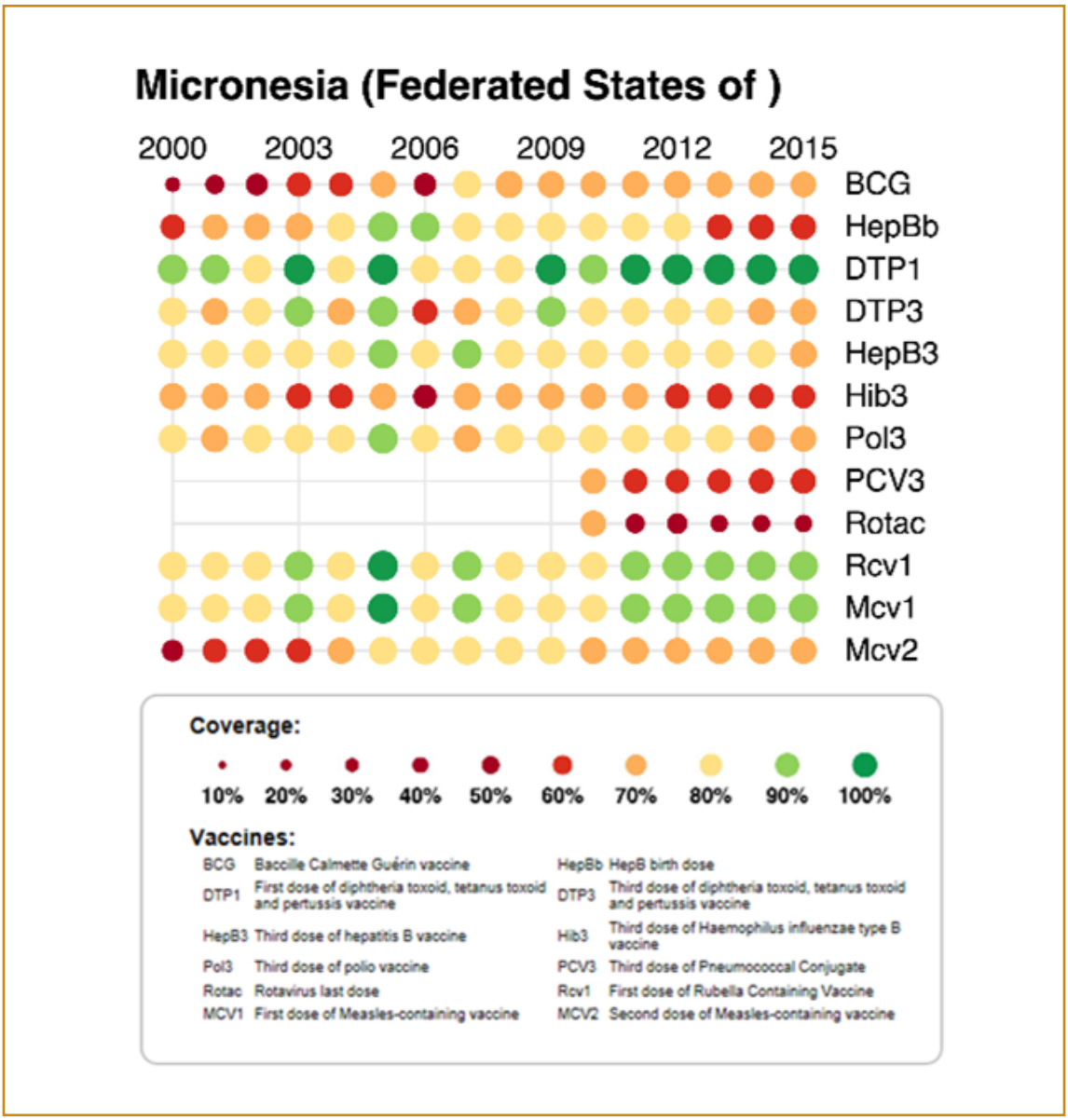
86 US Centers for Disease Control, on https://www.cdc.gov/malaria/travelers/country_table/m.html [25.04.17].

87 Country Cooperation Strategy for FSM 2013–2017 at a Glance, 2014, http://apps.who.int/iris/bitstream/10665/136945/1/ccsbrief_fsm_en.pdf [25.04.17].

88 UNICEF statistics, on https://data.unicef.org/country/fsm/ [25.04.17].

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

Figure 3.1: Immunization coverage in FSM

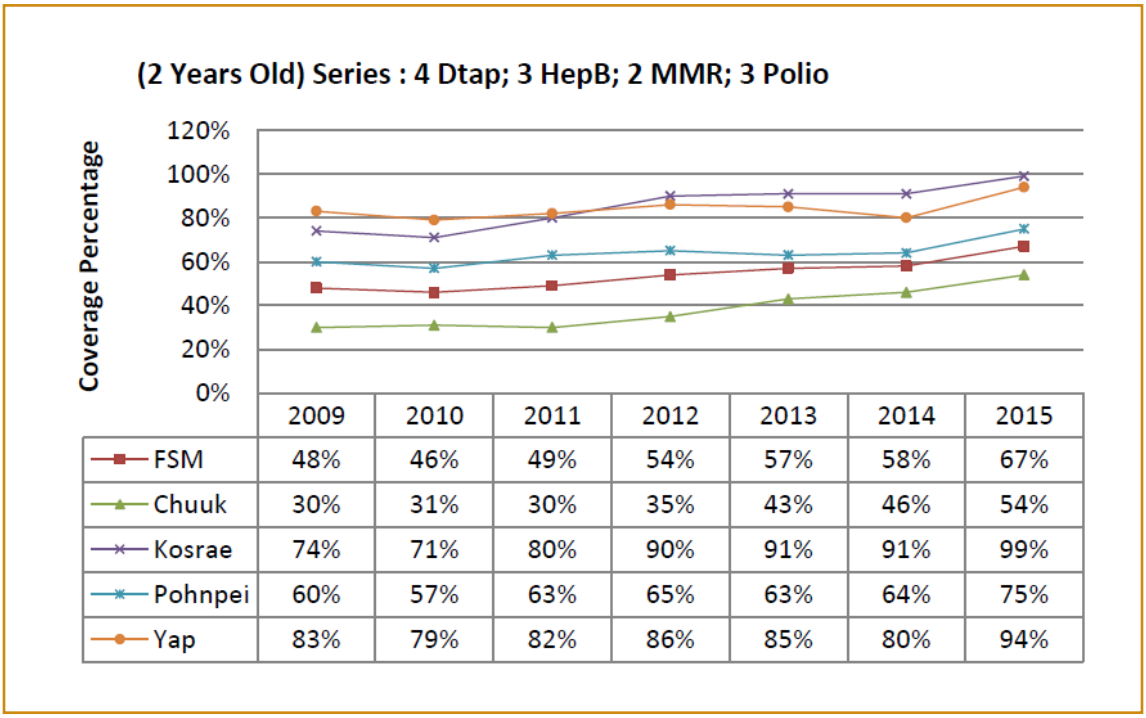


Source: WHO Global Health Observatory 2016[90]

Data from the DoHSA 2015 Annual Report also reveal that immunization coverage varies widely between states within FSM. For example, while estimated coverage rates in 2015 among two year olds (for DTaP, HepB, MMR and polio) stood at 99 per cent in Kosrae and 94 per cent in Yap, these drop to a much lower 75 per cent in Pohnpei and 54 per cent in Chuuk (see Figure 3.2).

90 WHO's immunization coverage data are reviewed and the estimates updated annually. See http://apps.who.int/gho/data/node.wrapper.immunization-cov?x-country=FSM [25.04.17].

Figure 3.2: Immunization coverage by state



	2009	2010	2011	2012	2013	2014	2015
FSM	48%	46%	49%	54%	57%	58%	67%
Chuuk	30%	31%	30%	35%	43%	46%	54%
Kosrae	74%	71%	80%	90%	91%	91%	99%
Pohnpei	60%	57%	63%	65%	63%	64%	75%
Yap	83%	79%	82%	86%	85%	80%	94%

Source: DoHSA Annual Report 2015, p. 33

UNICEF's 2013 report on maternal and child survival attributes low, and in some cases declining, immunization coverage rates to the increased number of vaccines added to the schedule, insufficient personnel, logistical challenges and difficulties with a new immunization data collection system, which was introduced in 2008.[91]

SDG target 3.3 encourages all countries to eradicate TB by 2030. TB is highly endemic in FSM.[92] According to NMDI data, FSM has the fifth highest TB prevalence in the whole Pacific region, with an estimated 292 cases per 100,000 population (see Figure 3.3 for regional comparison).[93] Worryingly, in May 2008 a cluster of patients with Multi-Drug Resistant (MDR) TB were identified in Chuuk State. However, a concerted effort on the part of international agencies and the FSM government appears to have since halted the spread of MDR TB, with the total number of cases among notified pulmonary TB cases estimated to stand at six as of 2015.[94]

As of 2012, the TB detection rate was estimated to stand at 72 per cent, which places FSM in the lower range of the PICTs group (including Papua New Guinea, PNG).[95] WHO estimates also

91 UNICEF, 'Tracking Progress in Maternal and Child Survival', p. 11.

92 International Association for Medical Assistance to Travellers, on https://www.iamat.org/country/micronesia-federated-states/risk/tuberculosis [25.04.17].

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

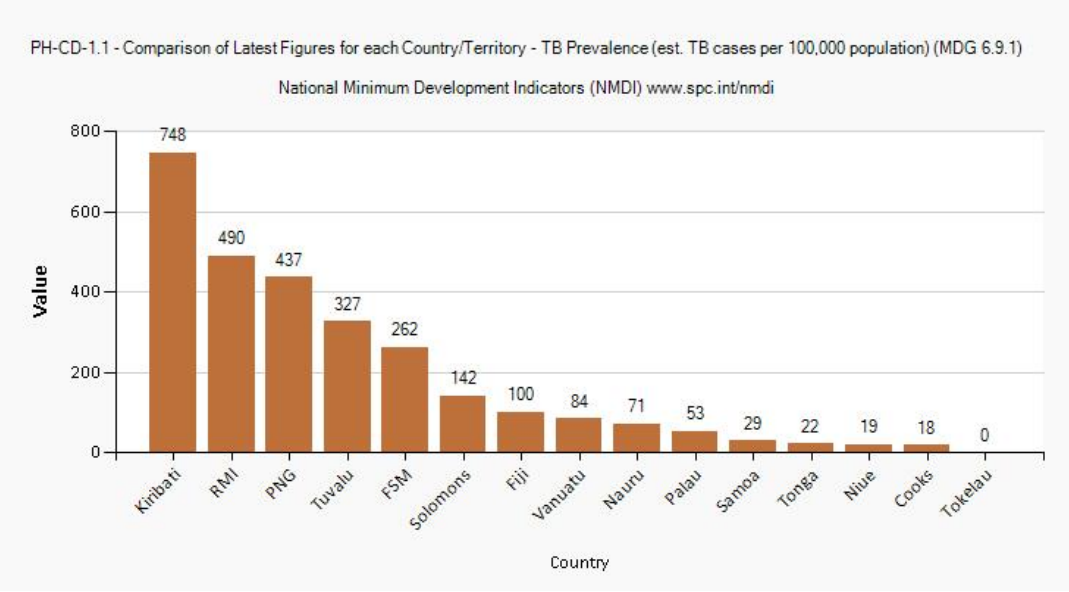
94 See Fred, D. et al., 'Multi-Drug Resistant Tuberculosis in Chuuk State, Federated States of Micronesia, 2008-2009', *Pac. Health Dialog,* April 2010, 16(1): 123–7.

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

suggest TB treatment coverage stood at around 80 per cent as of 2015, which suggests most TB-positive individuals in FSM have access to health care.[96]

Leprosy continues to plague the population of FSM. According to the DoHSA 2015 Annual Report, FSM has not yet reached the desired 'elimination level' of leprosy (1/10,000 population).[97] It is thus considered one of only three PICTs that, according to WHO, have not reached this critical threshold (the other countries being Kiribati and Marshall Islands).[98]

Figure 3.3: TB prevalence by country



Note: RMI = Marshall Islands.
Source: NMDI data 2016.[99]

3.3. Maternal health

According to SDG 3.1, all countries should aim to reduce the maternal mortality ratio to less than 70 per 100,000 live births by 2030. According to the latest SOWC estimates, FSM's ratio stands at 100 per 100,000 live births, which is still significantly above the SDG target.[100] However, it

96 WHO Tuberculosis Country Profiles, on http://www.who.int/tb/country/data/profiles/en/ [25.04.17].

97 P. 7.

98 WHO, 'Eliminating Leprosy in the Western Pacific', on http://www.wpro.who.int/leprosy/elimination/en/ [25.04.17].

99 https://www.spc.int/nmdi/communicable_diseases [25.04.17].

100 The World Bank and the UN 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. See https://data.unicef.org/topic/maternal-health/maternal-mortality/ [25.04.17] In contrast, the DoHSA 2015 Annual Report suggests maternal mortality stood at 54/1,000 in 2014, and the SOWC 2016 unadjusted rate is 160/1,000.

is important to note that estimates for FSM are quite unstable, given that they are based on a very small number of vital events per year. For example, the 2013 UNICEF report on maternal and child survival suggests only one additional maternal death per year could change FSM's maternal mortality ratio by 50 points. There appear to be no large discrepancies between FSM's four states in relation to maternal mortality. However, it has been noted that, in remote areas of the country (i.e. the Outer Islands), health staff are frequently unsure of what should be recorded as a maternal death, which would lead to underestimates of the maternal mortality ratio in these islands.[101]

In 2015, the DoHSA recorded a total of three maternal deaths.[102] Based on such a small number of cases, it is difficult to establish a meaningful causes-of-death 'hierarchy'. However, the 2017 draft Second Combined Periodic Report on the Implementation of the CRC reveals some of the underlying bottlenecks that lead to maternal deaths in FSM. For example, the report suggests that FSM's relatively high maternal mortality owes at least in part to limited access to quality pre-natal care as well as the remoteness of many communities from medical facilities, especially in emergency situations.[103]

Under the CRC, FSM has an obligation to ensure appropriate pre- and post-natal health care for mothers.[104] Existing data suggests that overall coverage rates for pre- and post-natal health care in FSM are adequate, with room for improvement, especially in relation to early antenatal care in the first trimester.

According to recent SOWC data, estimated antenatal coverage for at least one visit stands at 80 per cent, which indicates that initial antenatal health care is accessible to a majority of pregnant women in FSM. Antenatal coverage estimates for at least four visits are unavailable in the SOWC, which represents a significant data gap. Worryingly, it appears that only 19 per cent of pregnant women receive antenatal care during their *first* trimester, with the overwhelming majority instead only coming to their first antenatal consultation in their second or third trimesters.[105]

SOWC data also suggest that nearly all pregnant women in FSM give birth in the presence of a skilled health professional (100 per cent) and 87 per cent of all deliveries take place in a health facility (institutional delivery). Caesarean sections are carried out in 11 per cent of births in FSM, significantly lower than the regional average of 28 per cent for East Asia and the Pacific.

There appear to be no quantitative data in the SOWC on wealth disparities in relation to births attended by a skilled health professional, and data gaps also appear to exist in relation to urban–rural disparities in birth attendance rates. However, there is some anecdotal evidence suggesting rural–urban disparities exist in FSM regarding women's access to antenatal care. For example, UNICEF's 2013 report on maternal and child survival indicates that women living on the remote Outer Islands face significant barriers in accessing early antenatal care because of transportation

101 UNICEF, 'Tracking Progress in Maternal and Child Survival', p. 10.

102 DoHSA, 'Annual Report 2015', p. 38.

103 State Party Report to the Committee on the Rights of the Child 2017.

104 Article 24(2)(d) of the CRC and CRC General Comment No. 15, on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health, paras 51–7.

105 UNICEF, 'Tracking Progress in Maternal and Child Survival', p. 6.

difficulty and because of the widespread cultural belief that women should not travel on boats during their first trimester.[106]

The role of traditional birth attendants also appears to be larger in FSM's rural areas. For example, the DoHSA 2015 Annual Report states that, while most rural women deliver their first birth in a hospital setting, subsequent deliveries are frequently carried out by traditional birth attendants and midwives in remote hamlets.[107] Unfortunately, it is not clear which data source the Annual Report relies on. According to FSM's 2017 draft report to the Committee on the Rights of the Child, the traditional practice of using family- or community members as midwives may be harmful when, for example, appropriate sterilization methods are not applied.[108]

3.4. Violence against women and girls

Violence against women and girls (is a key public health concern, and the available data suggest it is a significant problem in FSM. According to the 2014 FSM Family Health and Safety Study, 33 per cent of ever-partnered women had experienced physical and/or sexual violence at the hands of their intimate partners at least once in their lifetime.[109] A more detailed discussion of the extent and underlying causes of violence against women and girls in FSM is provided in Chapter 6 on 'Child Protection'.

3.5. Adolescent health

As of 2015, according to the SOWC, FSM's adolescent population aged 10–19 makes up 24 per cent of the total population, which equates to around 25,000 individuals in total. This proportion is significantly above the regional average of East Asia and the Pacific, which stood at 13 per cent as of 2015.

3.5.1. Fertility and contraceptive use

According to the 2013 UNICEF progress report, FSM has witnessed a substantial decline in total fertility rates over the past few decades, from an estimated five children per women in 1990 to 3.1 children in 2010.[110] The current population growth rate is estimated to stand at a 0.4 per cent, which is one of the lowest rates in the whole Pacific.[111]

106 Ibid., p. 14.

107 P. 10.

108 State Party Report to the Committee on the Rights of the Child 2017.

109 DoHSA, 'Family Health and Safety Study', 2014, on http://countryoffice.unfpa.org/pacific/drive/FSMFHSSReportweb.pdf [25.04.17].

110 UNICEF, 'Tracking Progress in Maternal and Child Survival', p. 5.

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

In contrast with the above-mentioned overall population trends, there is some evidence to suggest that, at least in some parts of the country, teenage fertility rates have been on the rise in recent decades. For example, the 2013 UNICEF progress report states that the fertility rate among 15–19 year olds in Chuuk State has experienced a steady overall increase since 1994, and that increases have been seen between 2000 and 2010 in Kosrae and Yap States also. Pohnpei is the only state with a steady decrease in the teenage fertility rate since 1994, which the report attributes to the successful roll-out of an adolescent reproductive health programme in 2004.[112] Teenage pregnancies affect young women's educational and economic prospects and those of their children, as children of teenage mothers tend to have poorer health and education outcomes.

According to World Bank estimates from 2015, the adolescent fertility rate in FSM stands at 14 (births per 1,000 women aged 15–19), which is below the regional average of 22/1,000 for East Asia and the Pacific, as well as the average of 36/1,000 for the Pacific Island Small States.[113]

Data on marriage rates among the adolescent population group appear to be lacking. Furthermore, there are no quantitative data on marriage rates among FSM's adolescent population.

Contraceptive prevalence in FSM is relatively high compared with its neighbours in the region. It is estimated in the SOWC that contraceptive prevalence in FSM stands at around 55 per cent of the population, which is somewhat lower than the regional average of 63 per cent for all of East Asia and the Pacific, according to the SOWC, but the third highest rate in the PICTS group. The country is outperformed only by Cook Islands and Marshall Islands.[114]

Quantitative data on rural–urban disparities in relation to contraceptive prevalence appear to be lacking. In addition, data on 'unmet need' for contraception are unavailable for FSM. These gaps in the data exist because FSM has not yet implemented a Demographic and Health Survey (DHS), which would typically address these issues.

A range of contraceptives are provided free of charge through FSM's maternal and child health programme.[115] However, there is some evidence to suggest that a number of supply- and demand-side constraints create barriers to accessing modern family planning methods in the country.

Demand for contraceptives appears to be suppressed as the result of an interplay of dominant social norms that stigmatize sexual activity (especially among young women) and a lack of confidential access to reproductive health services. For example, one key informant from the Youth Council of Pohnpei suggested that '*Privacy is an issue – if neighbours see you getting condoms, they will look at you in a different way … for girls especially, there is stigma … It all comes back to culture – when you're dating, you can't show it.*'[116]

112 UNICEF, 'Tracking Progress in Maternal and Child Survival', p. 11.

113 http://data.worldbank.org/indicator/SP.ADO.TFRT?locations=FM [07.03.17].

114 NMDI data, on https://www.spc.int/nmdi/maternal_health [21.03.17].

115 UNICEF, 'Tracking Progress in Maternal and Child Survival', p. 5.

116 KII with representative from Youth Council of Pohnpei, May 2017.

On the supply side, it appears that dispensaries are frequently out of stock and that the supply of modern contraceptives is particularly limited in the Outer Islands: '*Why are [young people in FSM] not using contraception? It is not available. Who will run to capital every day to get condoms?*'[117] Furthermore, it appears that misconceptions about sex and contraception reduce demand for modern contraceptive methods. Consider, for example, the following quote from an interview with a representative from the DoHSA: '*In some parts of the country [people] still think that condoms promote sex.*'[118]

3.5.2. HIV/AIDS and sexually transmitted infections

FSM is considered a low HIV-prevalence country.[119] According to the 2015 Global AIDS Progress Report, there were 48 cumulative cases of HIV between 1989 and 2015 in the country. Perhaps as a result of the small overall number of cases, there are no available estimates of HIV incidence (in children and women), mother-to-child transmission rates, anti-retroviral therapy coverage or HIV-related deaths in FSM.[120]

According to the 2015 Global AIDS Progress Report, there are more than 10 HIV-positive individuals currently living in FSM (no exact figures provided). While the report suggests there were no AIDS-related deaths in 2015, no information is provided on the overall number of confirmed AIDS-related deaths in FSM, and whether any of them were children.[121] There are no data on HIV prevalence among young people.

Citing relatively out-dated data from the Second Generation Surveys conducted in Pohnpei, Yap and Chuuk in 2006–2008, the Global AIDS Progress Report suggests that low levels of knowledge about HIV/AIDS transmission and prevention, limited condom use (particularly among young women) and limited HIV testing are the key risk factors associated with HIV. However, there has been very little new data since the 2006–2008 Second Generation Surveys, making it difficult to establish whether there have been any changes in HIV-related knowledge and sexual behaviour over the past 10 years. Furthermore, there are no data on these issues for Kosrae State.

In the 2015 fiscal year, FSM's spending on national HIV/AIDS programmes amounted to US$ 344,269 $, with the vast majority spent on 'Governance and Sustainability' (79 per cent) and relatively small proportions going to prevention (6.4 per cent) and treatment (14.3 per cent). It appears that FSM's national AIDS response is heavily dependent on external donor funding, in particular US Federal Funds, which raises concerns about the sustainability of existing prevention and treatment programmes.[122]

117 KII with representative from National Youth and Disability, DoHSA, May 2017.

118 Ibid.

119 FSM, 'Global AIDS Response Progress Report 2015', on http://www.unaids.org/sites/default/files/country/documents/FSM_narrative_report_2016.pdf [26.04.17].

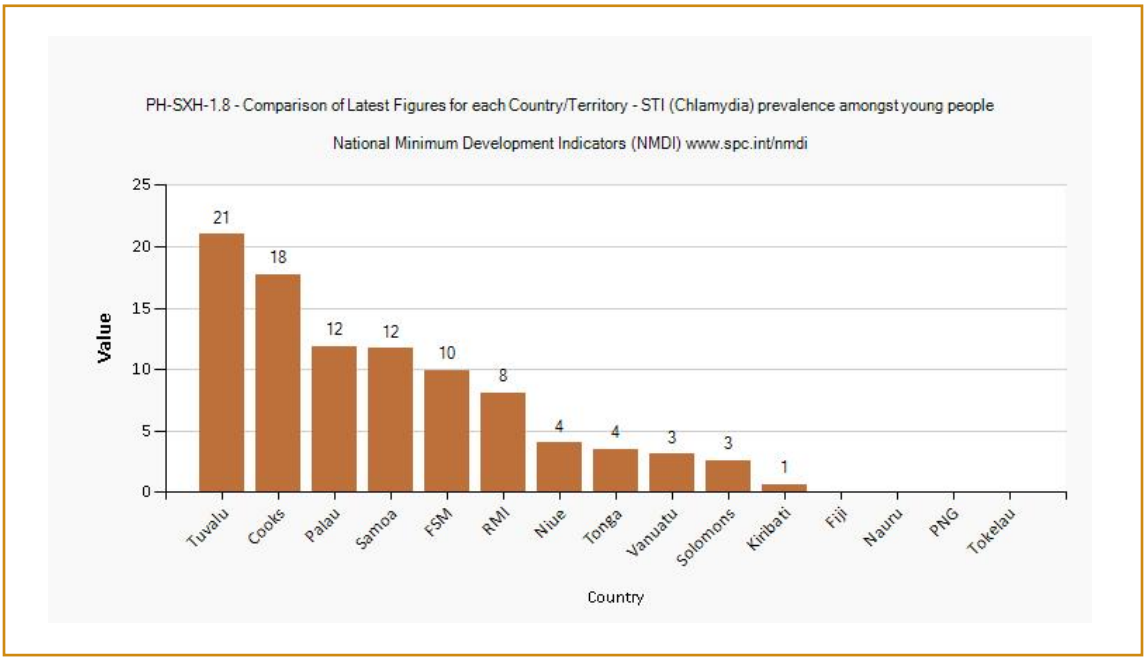
120 SOWC 2016 and UNICEF data, on https://data.unicef.org/country/fsm/ [11.04.17].

121 FSM, 'Global AIDS Response Progress Report 2015'.

122 Ibid.

The few data that are available suggest that sexually transmitted infections (STIs) represent a significant problem. For example, NMDI estimates suggest that prevalence of chlamydia among young people aged 15–24 stands at 10 per cent, as of 2011, which is the fifth highest rate in the whole PICTS group (see Figure 3.4). Among women receiving antenatal care, these rates rise to 25.8 per cent, which represents the third highest prevalence in the PICTS group (only surpassed by Fiji and Samoa).[123] These relatively high STI rates raise concerns about potential future increases in HIV cases, as they indicate that the underlying behavioural risks for HIV transmission are significant.

Figure 3.4: Chlamydia prevalence among 15-24 year olds per country



Source: NMDI data 2016[124]

3.5.3. Substance abuse

According to SDG target 3.5, FSM should strengthen its prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. Available information on alcohol use among the *adult* population suggests this is a major problem in FSM, primarily affecting men. For example, a 2016 regional review of evidence on alcohol use in the Pacific indicates that 33 per cent of men (but only 1 per cent of women) aged 25–64 years 'currently drink' alcohol in Chuuk State (i.e. consumed alcohol in the past 12 months), with even higher figures in Pohnpei State (44 per cent of men and 9 per cent of women). Worryingly, large proportions of male 'current drinkers' in Chuuk and Pohnpei, 82 per cent and 46 per cent respectively, were classified as

123 NMDI data, on https://www.spc.int/nmdi/sexual_health [26.04.17].

124 https://www.spc.int/nmdi/sexual_health [26.04.17].

'heavy drinkers' – defined as individuals consuming on average six or more standard drinks per day.[125] Alcohol-related violence accounts for the great majority of arrests in all four states of FSM, with reports estimating rates at 80–90 per cent.[126]

There appear to be very few up-to-date quantitative data on substance abuse among children and adolescents in FSM. Unlike many of its neighbouring countries, FSM has not yet implemented a Global School-Based Health Survey (GSHS), which typically covers topics such as alcohol use, smoking and other drug use.[127] However, the relatively out-dated 2001 Health Behaviour and Lifestyle of Pacific Youth Survey, which was implemented in Pohnpei only, found that alcohol use was quite common among school children aged 14–17, with almost half of surveyed students reporting that they had been drunk at least twice in the past, and one in five reporting that they had been drunk more than 10 times.[128]

Available data also suggest that many young people are initiated into using alcohol at very early age. For example, the Youth Risk Behaviour Survey, implemented in Pohnpei in 2003, found that 18 per cent of high school students had their first alcoholic drink before the age of 13 years.[129] In Pohnpei in particular, it appears that drinking of a narcotic root extract called *sakau* (or *kava*) together with alcohol, is popular among adolescents.[130] It is unclear whether alcohol use among children and adolescents has increased or decreased since the early 2000s, and the above-mentioned survey findings apply only toe Pohnpei, not the whole of FSM. Data gaps on alcohol use and substance abuse among adolescents are most acute for Yap and Kosrae States.

3.5.4. Mental health

As of 2014, FSM lacks a national mental health policy, but it appears that work is underway on a National Mental Health Policy, Strategy and Action Plan. An updated mental health law is urgently needed, as FSM currently relies on an out-dated legal code, whereby people with mental illness can be detained in jail or penal institutions temporarily once they have been committed for 'insanity'.[131]

There are very few quantitative data on mental health in FSM, which makes it difficult to establish the prevalence, incidence and profile of mental health problems in the country.[132] However, anecdotal evidence suggests suicides (and related alcohol abuse) are a serious

125 Kessaram, T. et al., '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: 412–23.

126 As cited in Walliby, K. et al., 'WHO Profile on Mental Health in Development (WHO proMIND): Federated States of Micronesia', 2014, p. 17, on https://www.mindbank.info/item/6276 [10.04.17].

127 See WHO, 'Chronic Diseases and Health Promotion', on http://www.who.int/chp/gshs/datasets/en/ [12.04.17].

128 Unfortunately, it is unclear whether these figures are representative of all school children aged 14–17 in Pohnpei. See WHO, 'Status Report on Alcohol. FSM Country Profile', 2004, on http://www.who.int/substance_abuse/publications/en/micronesia.pdf?ua=1 [12.04.17].

129 FSM, 'Substance Abuse Epidemiological Profile Community Profile: Pohnpei', March 2009 Update, on http://www.guamhealthpartners.com/photo_albums/pdfs/Community%20Profile_2009%20Update.pdf [12.04.17].

130 KII with representative from Public Defenders Office, May 2017.

131 Walliby, K. et al., 'WHO proMIND: FSM', 2014, p. 25.

132 Ibid.

problem, primarily affecting young men. The DoHSA Annual Report for 2015 states that, in 2014, there were a total of 12 completed suicides in FSM (with four in each state, except in Kosrae). This equates to a suicide rate of 11.6 per 100,000 population, which makes FSM one of the countries with the highest suicide rates in the world.[133] Alcohol was associated with 45 per cent of completed suicides in FSM from 1991 to 1996.[134] The age profile of suicide cases is not known. As mentioned above, FSM has also not yet implemented a GSHS, which would typically contain information on suicide attempts among school children. However, there is some evidence to suggest suicides are confined primarily to the male sex. For example, a 2011 WHO country health information profile suggests suicide rates for young adult males in FSM are among the highest in the world.[135]

Mental health care in FSM is largely community-based and integrated into the primary care system.[136] As of 2014, there were no in-patient facilities for mental health in FSM, only a holding unit in each of the four state hospitals. There is only one psychiatrist, based in Chuuk, who provides services to patients in all four states.[137]

According to a 2014 WHO report, there is no FSM government funding allocated specifically to mental health or substance abuse disorders. Furthermore, health insurance in FSM does not cover treatment of mental health and substance abuse disorders. Limited funding for mental health programmes comes primarily from US grants, and spending is geared towards primary prevention and public awareness.[138]

3.6. Nutrition

SDG 2.2 encourages states to end all forms of malnutrition by 2030, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under five years of age (the WHO Global Nutrition Targets), and to address the nutritional needs of adolescent girls, pregnant and lactating women and older women.[139]

According to WHO's Global Nutrition Targets, FSM should, by 2025, aim to, achieve results in relation to stunting, anaemia, low birthweight, childhood overweight, exclusive breastfeeding in the first six months and childhood wasting.[140]

133 P. 104.

134 Walliby, K. et al., 'WHO proMIND: FSM', 2014, p. 15.

135 http://www.wpro.who.int/countries/fsm/17MICpro2011_finaldraft.pdf [12.04.17].

136 Walliby, K. et al., 'WHO proMIND: FSM', 2014, p. 15.

137 Ibid., p. 3.

138 Ibid., p. 27.

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

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

WHO global nutrition targets

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

3.6.1. Child stunting and wasting

There are no up-to-date UN estimates of child stunting (short height-for-age or 'chronic malnutrition') and child wasting (low weight-for-height or 'acute malnutrition') in FSM, which represents a significant data gap.[141]

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,[142] increasing the risk of blood loss at delivery and post-partum haemorrhage.[143] The nutritional status of the mother during pregnancy and lactation can also have an impact on the health and nutritional status of the child. For example, anaemic mothers are at greater risk of delivering premature and low-birthweight babies, who also have an increased risk of dying.[144]

141 SOWC 2016 and UNICEF statistics, on https://data.unicef.org/country/fsm/ [10.04.17].

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

143 See e.g. K4Health, 'Anaemia Prevalence, Causes, and Consequences', on https://www.k4health.org/toolkits/anemia-prevention/anemia-causes-prevalence-impact [26.04.17].

144 Ibid.

According to WHO/FAO estimates, the prevalence rate of anaemia in pregnant women stands at a high 38 per cent, which makes maternal anaemia a serious public health concern for FSM.[145] Anaemia prevalence among non-pregnant women of reproductive age is estimated to stand at 24 per cent, and anaemia in pre-school children at 19 per cent.[146] De-worming and iron supplementation can be effective in reducing anaemia in pregnant women as well as children.[147]

3.6.3. Low birthweight and underweight

Low birthweight and childhood underweight are significant public health concerns in FSM. The 2016 SOWC database suggests that, as of 2009, 11 per cent of children were born with low birthweight. As mentioned on child mortality, low birthweight is a leading risk factor in under-five child mortality.[148] The 2013 UNICEF progress report suggests malnourished babies are frequently not taken to the clinic because of traditional beliefs about the reasons for the lack of weight gain.[149]

There appear to be no up-to-date data on underweight prevalence in under-five-year-old children in FSM.[150] However, out-dated survey data from 1997 suggests around 15 per cent percent of surveyed children under the age of five years are underweight.[151]

3.6.4. Obesity

According to estimates provided by the Institute of Health Metrics, the leading causes of premature death in FSM in 2010 were non-communicable diseases (NCDs) (diabetes: 8 per cent of years of life lost; stroke: 7.5 per cent; ischemic heart disease: 7.4 per cent; cirrhosis: 2.4 per cent; and chronic kidney disease: 2.4 per cent), followed by some communicable diseases (lower respiratory infections: 5 per cent), self-harm (2.6 per cent) and road injuries (2.5 per cent). While the overall disease burden of communicable diseases has been on the decline since the 1990s, the disease burden of NCDs has increased rapidly, with FSM witnessing almost epidemic rises in diabetes (81 per cent change since 1990) and chronic kidney disease (63 per cent change).[152]

Many of the above-mentioned NCDs are related to overweight and obesity. According to data from the 2006 STEPwise Approach to Chronic Disease Risk Factor Surveillance Survey among the adult population aged 25–64 years, prevalence of obesity is 47.3 per cent. The STEPwise survey also found that prevalence of hypertension among adults stood at 15.2 per cent, diabetes at 35.4 per

145 WHO/FAO, 'FSM – Food and Nutrition Security Profiles', 2015, on http://www.fao.org/fileadmin/templates/rap/files/nutrition_profiles/DI_Profile_-_Micronesia__Federated_States_of__280714.pdf [26.04.10].

146 Note that these estimates are from 2005 and are relatively out-dated.

147 WHO/FAO, 'FSM – Food and Nutrition Security Profiles', 2015.

148 Institute for Health Metrics, 'Global Burden of Disease Study: FSM Country Profile', 2010.

149 UNICEF, 'Tracking Progress in Maternal and Child Survival', 2013.

150 See SOWC 2016 and World Bank data, on http://data.worldbank.org/indicator/SH.STA.MALN.ZS?locations=FM [25.04.17].

151 WHO, 'FSM Nutrition Overview', on http://www.wpro.who.int/nutrition/documents/docs/msi.pdf?ua=1 [25.04.17].

152 Institute of Health Metrics, 'Global Burden of Disease Study: FSM Profile', 2010.

cent and elevated blood cholesterol at 19.2 per cent.[153] According to WHO estimates from 2014, around 70 per cent of adults are overweight (Body Mass Index > 25) and 37 per cent obese (> 30).[154]

Obesity and overweight appear to be a particular problem among the female population of FSM: 75 per cent of females are considered overweight compared with 64 per cent of males; and 44 per cent of females are considered obese compared with 31 per cent of males.[155]

Up-to-date national estimates of obesity and overweight prevalence in children and adolescents appear to be lacking, according to the SOWC. Implementation of a GSHS for FSM would help fill this data gap, as such surveys typically collect information about overweight and obesity among school children.

3.6.5. Breastfeeding

WHO recommends infants are exclusively breastfed for the first six months of life to achieve optimal growth, development and health.[156] Exclusive breast-feeding rates appear to be relatively adequate in FSM. With room for improvement. According to the most recent UN estimates in the SOWC, 60 per cent of children in FSM receive exclusive breastfeeding for the first six months after their birth – already 10 percentage points above the 50 per cent target set out in WHO's Global Nutrition Targets for 2025.[157]

There are data gaps in relation to the prevalence of early initiation of breastfeeding, continued breastfeeding rates and the introduction of solid, semi-solid, or soft foods after six months. Also missing are data on rural–urban disparities as well as wealth disparities in relation to breastfeeding practices.

3.7. Key barriers and bottlenecks

As one of the most generously donor-funded countries in the PICTS group, FSM has an exceptionally well-financed public health system. However, there are a number of important barriers and bottlenecks to further progress in the area of health, which are described below.

3.7.1. Transportation

A major challenge facing FSM's health system relates to the remoteness of many of the 607 islands that make up the country. For example, the DoHSA 2015 Annual Report states that, even

153 Cited in WHO Country Cooperation Strategy for FSM 2013–2017 at a Glance.

154 Cited in IFPRI, 'Global Nutrition Report – Country Profile Micronesia', 2015, on http://www.ifpri.org/publication/nutrition-country-profile-micronesia [20.03.17].

155 IFPRI, 'Global Nutrition Report – Country Profile Micronesia'.

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

157 Even though the exact data source is not displayed, it appears the 60 per cent exclusive breastfeeding rate is based on quite out-dated survey data, from 1999. See e.g. IFPRI, 'Global Nutrition Report – Country Profile Micronesia', p. 2.

though there is one hospital in each of the four states, these hospitals are *in practice* accessible only to residents of the urban centres around the hospitals, given very limited transportation links with the Outer Islands. Infrequent and often unpredictable transportation (primarily by boat) to the country's urban centres presents a significant risk for patients from the Outer Islands in need of urgent access to more specialized medical care, especially in the event of medical emergencies. On a positive note, it appears that the government of FSM is aware of the need to increase transportation links, especially for the remote Outer Islands. Consider, for example, the following quote from a key informant in the Department of Finance:

> *Right now – there are limited transport means around the islands. We have two big ships to transport supplies to outer islands, and one small aircraft servicing outer island ... In next year's budget submission [there will be] investment in outer island airports. So transport may be the key issue right now, but hopefully it will be better in the future.*[158]

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 individuals wanting to access health care.[159] According to a recent WHO report on climate change and health risks in the Pacific, FSM is affected by a whole range of climate and disaster risks, including rising sea levels, water shortages due to extreme climate variability, coastal erosion and typhoons.[160] Consider, also the following excerpt from a key informant interview conducted with the director of the National Office of Environment and Emergency Management:

What are the biggest environmental and emergency risks to children and families?

> *Climate change is the biggest risk at the moment, and it's a big focus. It impacts on crops, water, leads to coral bleaching, affecting marine resources. Cyclones are risks too: Pohnpei and Kosrae 'manufacture' cyclones – they develop here and move west and intensify to Chuuk, Yap, Guam, and the Philippines. Drought is also a risk – we had one last year than impacted everyone from Palau to RMI. Now and then we have [salt water] inundation. Last time we had a big one that affected the whole of FSM in 2008, and it coincided with a king tide. Waves went into the islands – cars had to stop, it flooded the islands, especially the coastal areas. That is where most people reside. The flat atolls were greatly impacted. That one destroyed most of their food crops – taro patches turned brown. And taro is our staple, so it is a big problem.*[161]

158 KII with representative of Budget and Economic Management Division, Department of Finance, Palikir, May 2017.

159 WHO Country Cooperation Strategy for FSM 2013–2017.

160 WHO, Country Health Information Profile, 2015: http://www.who.int/gho/countries/fsm.pdf?ua=1 [25.04.17].

161 KII with representative of the National Office of Environment and Emergency Management, Palikir, May 2017.

The key climate-sensitive health risks in FSM have been identified as vector-borne diseases (especially dengue fever and Zika virus), zoonotic infections (primarily leptospirosis), food- and water-borne diseases, malnutrition and ciguatera (fish poisoning). Fish poisoning has particularly severe impacts on the nutritional stats of FSM's inhabitants, as fish has traditionally been the predominant source of protein.[162] An analysis of the available climate and health data also suggests higher temperatures in Pohnpei are associated with more frequent cases of respiratory disease and diarrhoeal illness.[163]

WHO's Country Cooperation Strategy for FSM 2013–2017 anticipates that certain vulnerable sectors of the population will disproportionately bear climate-related health problems – the very poor, young children, the elderly, people with disabilities, people with pre-existing illnesses (e.g. NCDs) and individuals in certain occupations (e.g. farmers, fishers and outdoor workers).[164] Evidence from key informant interviews suggests climate and disaster risks in FSM primarily affect children's health through their negative consequences on nutritional security and safe water sources.[165]

On a positive note, it appears that the government of FSM is aware of the importance of tackling climate-related health risks. For example, it appears that FSM has started formulating a Climate Change and Health Action Plan, which aims at mainstreaming climate change considerations into activities for the health sector and health considerations into the activities of other sectors.[166]

3.7.3. Health financing

Overall, FSM spends a significant amount of financial resources on health care; however, per capita spending remains inadequate and in the middle range of the PICTS group, according to NMDI data from 2011.[167] High travel costs and heavy reliance on external donor assistance (in particular US grants) represent potential bottlenecks in relation to FSM's health financing.

According to regional NMDI data, the health budget was approximately 13.8 per cent of GDP as of 2009 – the second highest figure in the whole PICTS group (only Marshall Islands has a higher rate).[168] Expenditure as a percentage of GDP is also significantly above the recommended 5 per cent of GDP.[169] Government expenditure on health made up around 20.6 per cent of total government expenditure, which, according to NMDI data, is the highest figure in the PICTS group (see Figure 3.5).

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162 WHO, 'Human Health and Climate Change in Pacific Island Countries', 2015, pp. 52–3, on http://iris.wpro.who.int/bitstream/handle/10665.1/12399/9789290617303_eng.pdf [13.03.17].

163 Ibid., p. 66.

164 P. 12.

165 KII with representative of the National Office of Environment and Emergency Management, Palikir, May 2017.

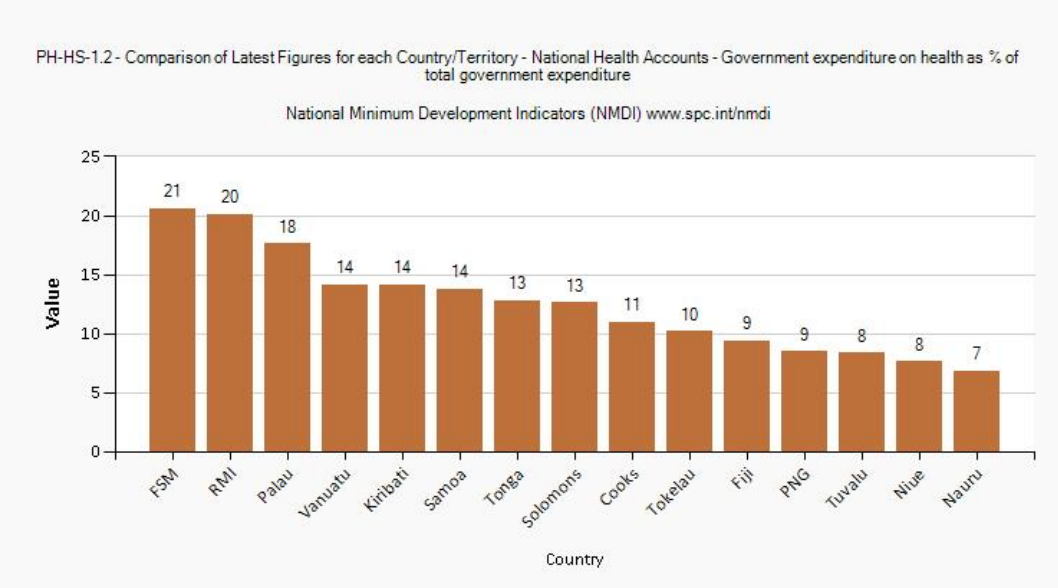
166 See FSM Climate Change and Health Action Plan 2011, on http://www.fsmgov.org/press/pr090611.htm [17.05.17].

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

168 Ibid.

169 Note that the World Health Assembly never officially approved this often-cited 'WHO recommended 5 per cent threshold'. See e.g. http://www.who.int/health_financing/en/how_much_should_dp_03_2.pdf, especially Annex A [25.04.17].

Figure 3.5: Government expenditure on health as percentage of total government expenditure



Source: NMDI data 2016[170]

Total expenditure on health goods and services in 2008 was estimated at US$ 32.7 million, two thirds of which (US$ 22.7 million) came from external donor funding. Private expenditure on health accounted for only 9.3 per cent of total health expenditure in 2008, of which almost all was out-of-pocket payments.[171] As of 2015, around 80 per cent of health funding went to programmes at the state level; only 20 per cent was spent at the national level.[172]

Around 65 per cent of state-level health funding is allocated to curative services, with 15 per cent going to overseas referral costs, 10 per cent to public health and prevention and 10 per cent to administration.[173]

A key risk to FSM's health budget is the potentially high cost of travel for patients referred abroad and/or from the Outer Islands. The DoHSA Annual Report for 2015 indicates that FSM regularly invites international clinical teams to visit in order to reduce these costs, but the financial burden associated with overseas referrals remains high. The Annual Report suggests the average state-level overseas referral costs amounted to 9.2 per cent of the total health budget, but Pohnpei State in particular appears to face significantly higher relative costs associated with overseas referrals. In 2014, referral costs amounted to 18 per cent of total health sector expenditure in Pohnpei, which is nearly double the national target of 10 per cent.[174]

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

171 Walliby, K. et al. 'WHO proMIND: FSM', 2014, p. 28.

172 DoHSA, 'Annual Report 2015', p. 8.

173 Walliby, K. et al. 'WHO proMIND: FSM', 2014, p. 28.

174 P. 106.

Heavy reliance on external funding sources also raises questions related to financial sustainability. As mentioned earlier, FSM's health funding is heavily reliant on external development assistance (especially US Federal Grants). For example, in 2008 local financing of health care expenditure amounted to around US$ 10 million, compared with US$ 22.7 million that came from external funds.[175]

3.7.4. Health workforce

As in many other countries in the PICTs group, nurses make up the largest group within the health workforce of FSM. According to the DoHSA Annual Report for 2015, there are 210 nurses in the public health workforce (with an additional 115 auxiliary nursing staff), compared with 79 doctors, 21 dentists and 27 pharmacists/technicians.[176] However, the ratio of nurses to population in FSM is significantly below the regional average. As of 2009, FSM had about 2.1 nurses per 1,000 individuals, which is below the PICTS regional average of 3.6/1,000 (including PNG).[177]

According to estimates from 2010, FSM has 0.6 physicians per 1,000 individuals, which is also below the PICTS average (including PNG) of 0.9 physicians per 1,000 individuals. The ratio of 0.1 dentists to 1,000 individuals is also below the regional average.[178] Furthermore, WHO has highlighted a lack of appropriately trained mental health professionals in FSM, with only one psychiatrist available for the whole country.[179] Lastly, it has been suggested that FSM's health services also lack specialized hospital administrators, epidemiologists, medical record administrators, pharmacists, laboratory technicians, radiologists and environmentalists.[180]

The key underlying causes of the health workforce shortage in FSM appear to be high retirement rates of an ageing workforce, the out-migration of qualified professionals and the inability of FSM's public health system to retain professionals.[181] Training and retention of a sufficiently large number of nurses appears to be a particular challenge facing the country's health system.[182] In 2011, a nursing programme was established at the College of Micronesia-FSM, aimed at addressing this bottleneck.[183]

Furthermore, according to the 2015 DoHSA Annual Report, many high-qualified health professionals migrate abroad to pursue better working opportunities (exact figures are not provided). In addition, FSM has an ageing health workforce, and a large number of professionals are expected to retire in the next few years.[184]

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175 WHO, 'Country Health Information Profile, 2011'.

176 P. 18.

177 NMDI data, on https://www.spc.int/nmdi/health_systems [20.03.17].

178 Ibid.

179 Walliby, K. et al. 'WHO proMIND: FSM', 2014.

180 WHO, 'Country Health Information Profile, 2011'.

181 DoHSA, 'Annual Report 2015', p. 18.

182 WHO, 'Country Health Information Profile, 2011'.

183 See e.g. http://www.comfsm.fm/myShark/news/item=44/mod=03:48:05 [12.04.17].

184 P. 18.

3.7.5. Service delivery

There are four hospitals in FSM – one in each of the country's four states, with occupancy rates ranging from 58 per cent in Chuuk Hospital (130 beds) to 83 per cent in Kosrae (45 beds). Furthermore, there are five community health centres – four in Yap and one in Pohnpei – as well as 96 dispensaries, which are primarily located in small municipalities and on the Outer Islands.[185] While the federally funded community health centres are relatively well equipped and staffed by doctors, the dispensaries are funded by local government and are staffed by minimally trained primary health care workers (health assistants).[186] In addition to the public health facilities, there is one private hospital in Pohnpei, as well as seven private clinics (most of which are also in Pohnpei).[187]

A major challenge facing FSM's health service delivery system is the high cost and administrative difficulty of delivering services to a population that is dispersed across many islands that have minimal infrastructure and transport links.[188] Infrastructure and quality of care in the dispensaries on the Outer Islands are reported to be poor.[189]

3.7.6. Limited data

Lack of data on key child and maternal health (and nutrition) indicators also represents a major bottleneck for FSM. This makes it difficult to measure progress and target interventions at groups and areas that are in particular need. Areas where up-to-date quantitative data are particularly limited include maternal health, family planning, substance abuse, mental health, child stunting/wasting, under-five underweight, overweight/obesity among children and adolescents and breastfeeding practices. Furthermore, existing quantitative data are rarely broken down by rural–urban differences, or gender and wealth disparities. The implementation of nation-wide health surveys, such as a DHS or GSHS, would go a long way towards addressing these data gaps.

185 DoHSA, 'Annual Report 2015', p. 16.

186 Walliby, K. et al. 'WHO proMIND: FSM', 2014.

187 DoHSA, 'Annual Report 2015', p. 16.

188 DoHSA, 'Annual Report 2015'.

189 Walliby, K. et al. 'WHO proMIND: FSM', 2014.

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 whole range development goals related to health and nutrition as well as education. For example, a lack of basic sanitation, hygiene and safe drinking water has been shown to contribute to the spread of water-related diseases (including diarrhoea), which are in turn a significant cause of under-five child mortality in the Pacific region.[190] Existing evidence also suggests poor WASH access is linked to growth stunting.[191] 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.[192] This chapter assesses and analyses the situation in FSM regarding children's access improved water sources and sanitation facilities, as well as children's hygiene practices, using SDGs 6.1, 6.2 and 1.4 as set out in the below table as benchmarks.

The WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) has produced estimates of global progress on WASH since 1990. The JMP was previously responsible for tracking progress towards MDG 7c on WASH; following the introduction of the 2030 Sustainable Development Agenda, it now tracks progress towards the SDG's WASH targets. The JMP uses a 'service ladders' system to benchmark and compare progress across countries, with each 'rung' on the ladders representing progress towards the SDG targets.[193] The sub-sections below utilize the relevant service ladders to assess FSM's progress towards meeting the SDG targets.

190 WHO, 'Sanitation, Drinking-Water and Health in Pacific Island Countries. 2015 Update and Future Outlook', 2016.

191 UNICEF, 'Looking Back, Moving Forward. A Snapshot of UNICEF's Work for Pacific Island Children 2015–16', 2016.

192 Ibid.

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

Key WASH-related SDGs

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

4.1. Access to improved water sources

In order for a country to meet the criteria for a **safely managed drinking water service, SDG 6.1**, the population should use an improved water source fulfilling three criteria: it should be accessible on premises; water should be available when needed; and the water supplied should be free from contamination. If the improved source does not meet any one of these criteria, but a round trip to collect water takes 30 minutes or less, it will be classified as a **basic drinking water service (SDG 1.4)**. If water collection from an improved source takes longer than 30 minutes, the source is categorized as giving a **limited service**.[194] The immediate priority in many countries is to ensure universal access to at least a basic level of service.[195]

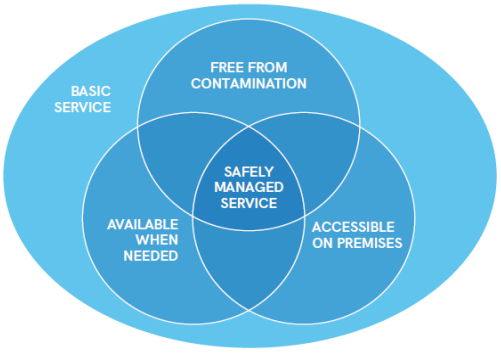
194 Ibid., p. 8.

195 Ibid., p. 10.

Figure 4.1: JMP service ladder for improved water sources

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

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



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

FSM's potable water is drawn primarily from water, groundwater and rainwater.[196] While the country's small islands rely primarily on rainwater and shallow wells, given their low elevation, the larger raised islands are much less dependent on rainfall, with relatively more abundant surface and groundwater sources.[197] Furthermore, since the early 1990s, bottled water has become increasingly popular and available in FSM.[198]

No estimate of the proportion of population using safely managed drinking water services is available for FSM, as data are not available in relation the proportion of the population using an improved source that is accessible when needed and that is free from contamination.

According to 2017 JMP estimates, as of 2015 88.4 per cent of the population in FSM had access to an improved drinking water source within a 30-minute round trip. However, with 11.6 per cent of the population having access only to an unimproved source of water, FSM is still some way from providing basic drinking water services for all of its population and meeting SDG 4.1. Data estimates in relation to access sources are available only from 2013; in these, out of the 88.3 per cent of the population with access to improved water, 37.2 per cent had access via a piped source and 51.1 per cent via a non-piped source. Estimates from 2015 further suggest that 63.3 per cent of the population had access to improved water at premises.[199] As Figure 4.1 shows, provision of drinking water services in FSM is among the most limited in the PICTs.

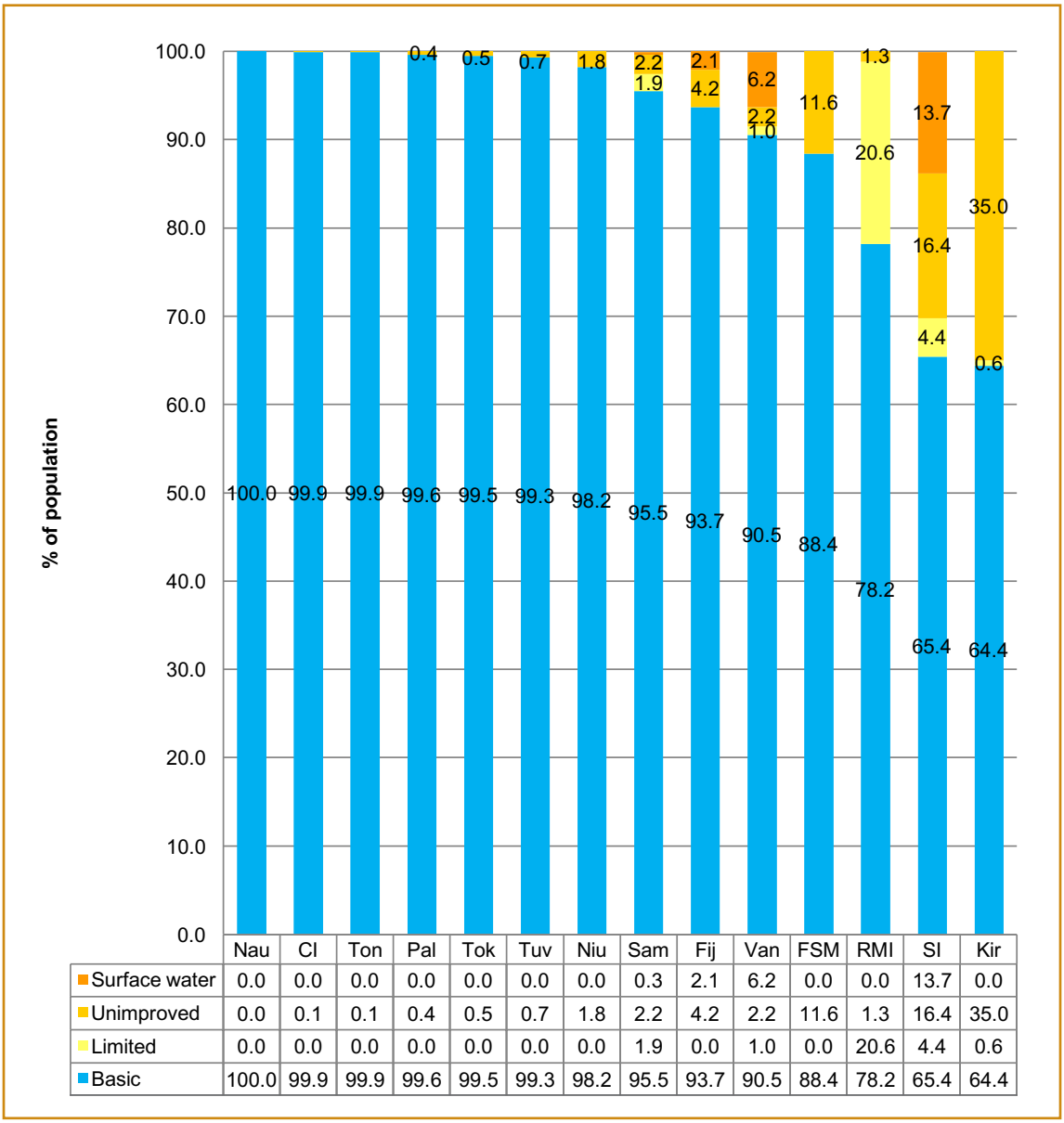
196 SPC Pacific Water, on http://www.pacificwater.org/pages.cfm/country-information/federated-states-of-micronesia.html [05.05.17].

197 SPC Pacific Water, 'IWRM National Diagnostic Report – FSM', 2007, on http://www.pacificwater.org/userfiles/file/GEF%20IWRM%20Final%20Docs/MR0636fsm.pdf [12.05.17]

198 Ibid.

199 https://washdata.org/data#!/fsm [01.08.17].

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



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

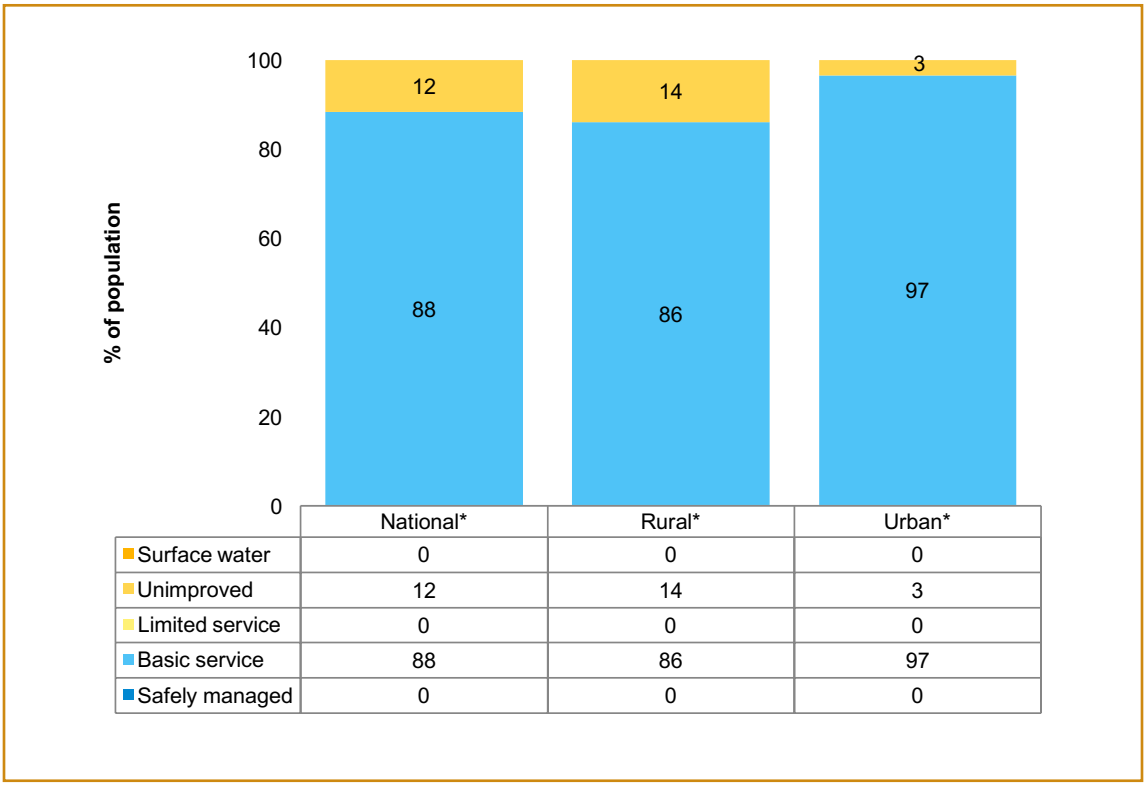
Source: JMP data[200]

Figure 4.3 suggests significant rural–urban disparities in relation to improved water access. While improved water coverage stood at 96.6 per cent in urban areas as of 2015, coverage estimates for rural areas were at only 86 per cent in the same year.

Table 4.4 below provides an indication of trends over time in terms of access to improved water supply in FSM.

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

Figure 4.3: Provision of drinking water services, 2017 estimates



	National*	Rural*	Urban*
Surface water	0	0	0
Unimproved	12	14	3
Limited service	0	0	0
Basic service	88	86	97
Safely managed	0	0	0

Source: JMP data[201]

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 that are:				
						Piped	Non-piped	Accessible on premises	Available when needed	Free from contamination
2000	92.6	92.6	-	7.4	0.0	-	-	66.4	-	-
2005	90.8	90.8	-	9.2	0.0	-	-	65.1	-	-
2010	89.1	89.1	-	4.0	7.0	37.2	51.9	63.8	-	-
2011	88.7	88.7	-	4.3	7.0	37.2	51.5	63.6	-	-
2015	88.4	88.4	-	11.6	0.0	-	-	63.3	-	-

Source: JMP data[202]

201 https://washdata.org/data#!/fsm [01.08.17].

202 Ibid.

Worryingly, as Table 4.1 sets out, JMP estimates from 2017 suggest FSM has experienced a *decrease* in the proportion of the population with access to basic drinking water services (access to improved water sources within a 30-minute round trip) since 2000 (the first year for which data are available in the 2017 JMP study). It was not possible to determine if this trend is statistically significant, and this should be investigated further.

An analysis of disaggregated data for urban and rural areas in FSM indicates that the overall decrease in access may be attributed to a decrease in access in rural areas. During the period 2000–2015, the proportion of the population with access to basic drinking water in rural areas decreased from 92 per cent to 86 per cent, while coverage in urban areas saw an increase over the same period. This indicates that efforts to provide basic drinking water coverage across FSM, in line with SDG 4.1, must prioritize rural areas.[203] However, longer-term data indicate that FSM has still come a long way over the past 25 years. While data estimates prior to 2015 cannot be used to rate FSM on the JMP service ladder because data are not available for all criteria, a broad look at access to improved water more generally[204] shows that rates in 1990 were as low as 19 per cent.[205]

Even though access to improved water sources is generally better on FSM's more urbanized islands, these areas also appear to face significant challenges in relation to providing safe drinking water. For example, in April 2000 an outbreak of cholera on Pohnpei, attributed to poor wastewater control, affected around 3,500 individuals and caused 20 deaths.[206]

4.2. Access to improved sanitation facilities

In order to meet SDG 6.2 on safely managed sanitation services, people need to be using improved sanitation facilities that are not shared with other households, and the excreta produced should be either treated and disposed of *in situ*, stored temporarily and then emptied, transported and treated off-site or transported through a sewer with wastewater and then treated off-site.[207] If excreta from improved sanitation facilities are not safely managed, people using these facilities will be classed as having access to basic sanitation service (SDG 1.4); if using improved facilities that are shared with other households, this will be classified as having a limited service. SDG target 6.2 also puts a specific focus on ending the practice of open defecation.[208] While the target aims to progressively raise the standard sanitation services level for all, the immediate priority for many countries will be to first ensure universal access to at least a basic level of service. [209]

203 WHO and UNICEF, 'Progress on Drinking Water, Sanitation and Hygiene: 2017 Update and SDG Baselines', p. 68.

204 i.e. as measured previously in relation to the MDGs.

205 UNICEF and WHO, 'Progress on Sanitation and Drinking Water – 2015 Update and MDG Assessment', 2015, p. 66, on http://www.who.int/water_sanitation_health/publications/jmp-2015-update/en/ [16.08.17].

206 SPC Water, on http://www.pacificwater.org/pages.cfm/country-information/federated-states-of-micronesia.html [22.05.17].

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

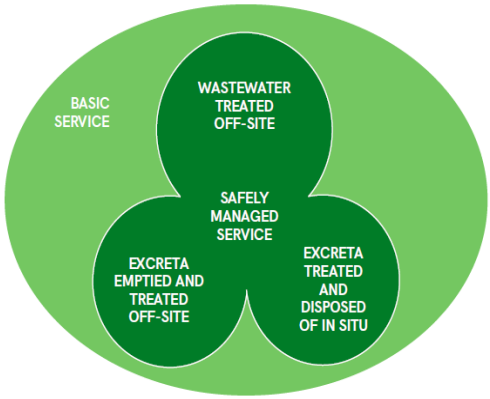
208 Ibid., pp. 8–9.

209 Ibid., p. 10.

Figure 4.4: JMP service ladder for improved sanitation facilities

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

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



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

As data on excreta disposal are unavailable for FSM, no estimate of the proportion of the population with access to safely managed sanitation services is available.[210] Further data from the recent JMP study in 2017 are more limited for FSM than for other countries in the region, with estimates available only for the years 2006–2014. As Figure 4.5 shows, for example, FSM has the fourth lowest outcomes in relation to access to sanitation in the PICTs.

According to 2017 JMP estimates, as of 2014 only 56.3 per cent of the population in FSM had access to basic sanitation services – that is, using improved sanitation facilities that were not shared, with 34.2 per cent of the population having access only to unimproved sanitation facilities.[211] Thus FSM still has some way to go in providing basic sanitation services for all of its population and meeting SDG target 4.1.

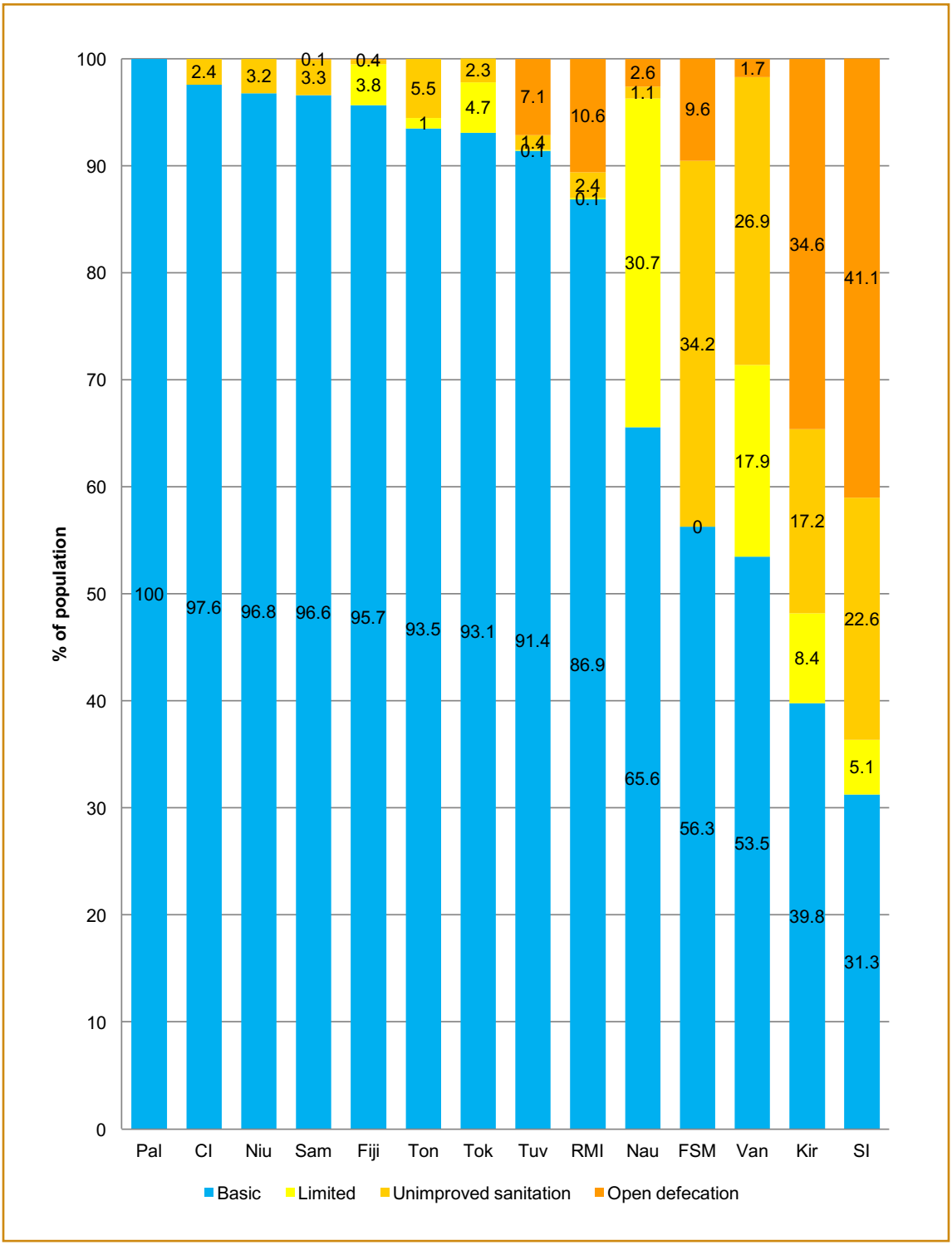
Disaggregated data highlight stark inequities between rural and urban communities in FSM when it comes to access to improved sanitation facilities. While estimates suggests that, as of 2015, 83.2 per cent of the urban population had access to basic sanitation facilities, the same rate for rural areas was only 48.5 per cent. Indeed, it appears that the urban–rural divide in access to improved sanitation facilities is among the largest in the region. JMP data provide estimates of improved sanitation only for the years 2006–2014 but indicate a very minor increase in the proportion of the population with access to basic services, from 56.2 per cent to 56.3 per cent, during that period.[212] This indicates that, unless the rate of progress sees a significant acceleration over the next years, FSM will struggle to meet SDG 1.4 in relation to sanitation by 2030.

210 JMP data for FSM, on https://washdata.org/data#!/fsm [01.08.17].

211 Ibid.

212 Ibid.

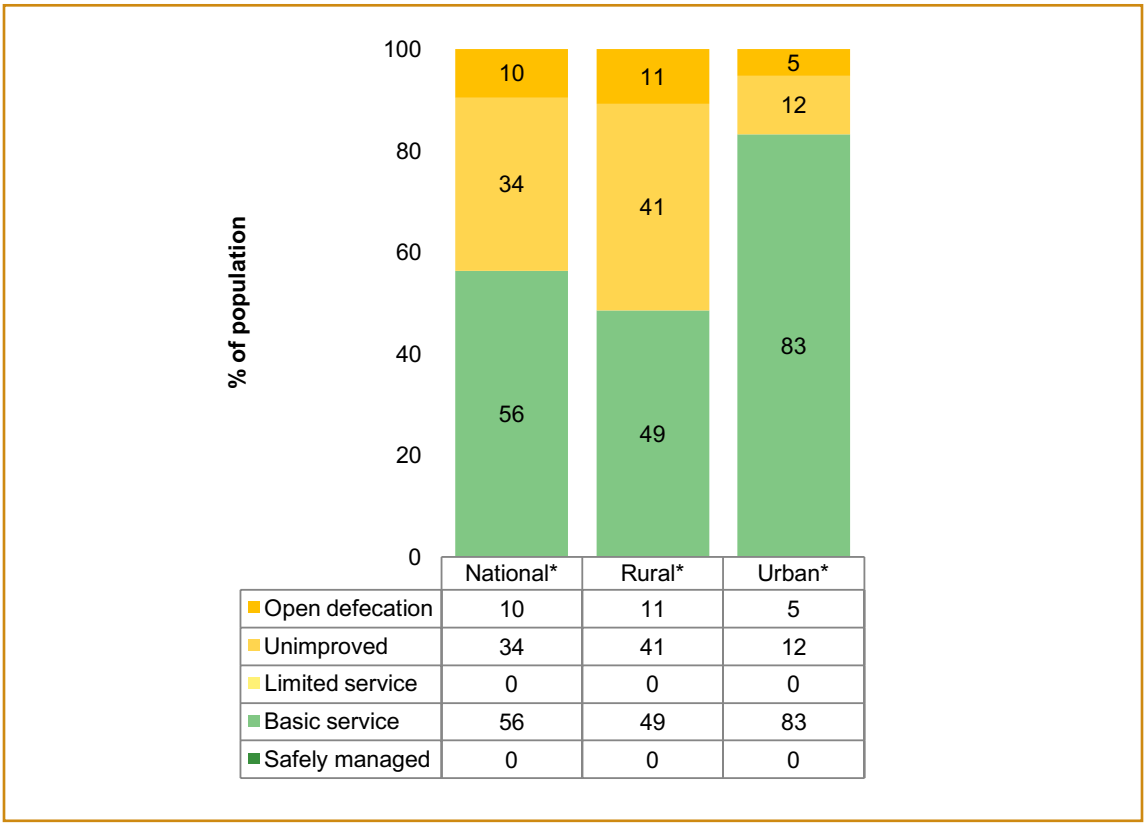
Figure 4.5: Provision of sanitation facilities as per JMP service ladder, 2015



Source: JMP data[213]

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

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



	National*	Rural*	Urban*
Open defecation	10	11	5
Unimproved	34	41	12
Limited service	0	0	0
Basic service	56	49	83
Safely managed	0	0	0

Source: JMP data[214]

Yet, as we have seen, longer-term data suggest FSM has come a long way over the past 25 years. While data estimates prior to 2015 cannot be used to rate FSM on the JMP service ladder, as data are not available for all criteria, and it must be recognized that data prior to 2015 and after 2015 are not directly comparable, as the number of data points used for estimates differ, consideration of the rates of access to improved water in 1990 shows that rates at that point were as low as 19 per cent.[215]

According to SDG target 6.2, FSM should aim to end any practice of open defecation by 2030. JMP data from 2017 suggest 9.6 per cent of the population in FSM still practiced open defecation in 2014 and also indicate a significant rural vs. urban disparity: rates in rural areas are at 10.8 per cent and rates in urban areas at 5.3 per cent. Prevalence of open defecation in FSM has been fairly stable, with the data suggesting a constant rate of 9.6 per cent between 2006 and 2014. This indicates that increased efforts may be needed to meet this important WASH-related international development target in FSM.[216]

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

215 UNICEF and WHO, 'Progress on Sanitation and Drinking Water – 2015 Update and MDG Assessment', p. 66.

216 UNICEF data, on https://data.unicef.org/country/fsm/ [22.05.17].

4.3. Hygiene practices

According to SDG target 6.2, FSM 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 affects important development outcomes such as those related to child mortality or school attendance.[217]

Presence of a hand-washing facility with soap and water on premises has been identified as the priority indicator for the global monitoring of hygiene under the SDGs. Households that have such a facility will meet the criteria for a **basic** hygiene facility (SDGs 1.4 and 6.2). Households that have a facility but lack water or soap will be classified as having a **limited** facility, and distinguished from households that have no facility at all.[218]

Figure 4.7: JMP service ladder for improved hygiene services

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

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

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

There is a lack of up-to-date data on hygiene practices in FSM, with the recent JMP study providing no data. Unlike many of its neighbouring countries, FSM has not yet implemented a GSHS, which would include information about hygiene practices (hand-washing and dental hygiene) among school children.[219] Furthermore, FSM has not yet implemented a DHS, which usually collects data on the safe disposal of children's stools and associated hygiene practices.

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

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

219 See http://www.who.int/chp/gshs/datasets/en/ [12.04.17].

A relatively out-dated study (from 2006) on hygiene behaviours among secondary school students (aged 12–17 years) in Pohnpei found moderate levels of optimal hygiene behaviour, suggesting there is ample room for improvement. For example, 78 per cent of surveyed pupils indicated that they brushed their teeth more than once per day. The study also found that 65 per cent of surveyed pupils in Pohnpei always washed their hands before eating and 81 per cent always washed their hands after using the toilet. The other two PICTs included in the study (Tonga and Vanuatu) were found to have lower levels of optimal hygiene behaviour.[220] Finally, the study found girls were more likely to report optimal hygiene behaviour, even when controlling for age, socio-economic background and other factors.[221]

Findings from the 2006 study may no longer be reflective of hygiene practices among Pohnpei's school children as of 2017. Furthermore, the focus of the study on Pohnpei means that findings cannot be applied to the other three states of FSM (i.e. Yap, Chuuk and Kosrae).

4.4. WASH in schools, MHM and disabilities

No up-to-date quantitative information was obtainable on the situation of WASH in schools in FSM. However, evidence collected through key informant interviews suggests inequities exist, and that WASH facilities in schools are vulnerable to extreme weather events such as typhoons. Consider, for example, the following excerpt from an interview with a key informant from the Pohnpei State Education Department, responsible for early childhood education (ECE).

> Do you have a WASH programme in ECE?
>
> *Yes, we provide hand-soap, and a place to wash hands.*
>
> What is the quality of toilet facilities in schools?
>
> *We have a maintenance guy – so if anything goes wrong, they report to the office and we send a guy out to fix [the problem]. So in ECE, there are no serious problems with the fa cilities. But this is different to elementary schools – generally they have less good quality toilets.*[222]

One key informant from the National Office of Environment and Emergency Management in Palikir highlighted the vulnerability of WASH facilities in schools to extreme weather events, and the long-lasting impacts disasters can have on children's education.

> *Schools had to close down [after Typhoon Maysak in 2015] because of sanitary conditions – the toilets were not working. Schools were closed for the whole school year on some islands – there was no school for these children for one year.*[223]

220 Tran et al., D., 'Hygiene Behaviour of Adolescents in the Pacific: Associations with Socio-Demographic, Health Behaviour and School Environment', *Asia Pacific Journal of Public Health*, 2006, p. 5.

221 Ibid., p. 8.

222 KII with representative from Pohnpei State Education Department, May 2017.

223 KII with representative from the National Office of Environment and Emergency Management, Palikir, May 2017.

Up-to-date data on access to WASH for persons living with disabilities and other disadvantaged groups in FSM appear to be lacking. However, it appears that FSM's current disaster management plans do not consider the situation of children with disabilities, which are particularly vulnerable to losing access to WASH facilities and services in the case of disasters.[224]

There appears to be no information on menstrual hygiene management (MHM) in FSM.

4.5. Barriers and bottlenecks

While FSM has achieved some improvements in the area of WASH over the past decades, for example in relation to improved sanitation coverage, the sector still faces significant challenges. Open defecation rates remain unacceptably high, and access to improved water sources has not increased since the early 1990s. Furthermore, FSM remains one of the PICTs with the largest rural–urban discrepancies in relation to access to improved water and sanitation. FSM also lacks a comprehensive national water and sanitation policy, and there appears to be little coordination between FSM's four states on water and sanitation policy and programming.[225] Existing evidence suggests there are a number of key structural barriers and bottlenecks that could prevent FSM from achieving further progress in the area of WASH.

4.5.1. Geography

As with health service provision, a major challenge facing FSM's WASH sector is the high cost and administrative difficulty of delivering services and implementing programmes to a population that is dispersed across 74 inhabited islands, many of which have very minimal infrastructure and transport links.[226]

4.5.2. Climate and disaster risks

A recent WHO assessment report concluded that some of the key climate-sensitive health risks in FSM were water-borne diseases (including cholera) and vector-borne diseases (especially dengue fever).[227] A recent UNICEF progress report on WASH and health in the Pacific region also suggests FSM has the highest rate of diarrhoea-related child mortality in the whole PICTs group (excluding PNG).[228] Water safety therefore needs to be treated as a top priority in preventing and/or mitigating climate-sensitive health risks in FSM.

224 KII with representative from the Department of Health and Social Affairs, Kolonia, May 2017.

225 FSM, 'Resolution No. 01-2011 from the National and State Water Summit 2011'.

226 See, e.g., Johnston, M. 'FSM IWRM Outlook Summary and NWTF Report', undated, on http://www.preventionweb.net/files/27083_fsmwatsanoutlook.pdf [22.05.17]

227 WHO, 'Human Health and Climate Change in Pacific Island Countries', 2015, p. 84.

228 WHO, 'Sanitation, Drinking-Water and Health in Pacific Island Countries 2015 Update and Future Outlook', p. 41.

Evidence from key informant interviews conducted in FSM points to the vulnerability of the country's safe water supply to extreme weather events such as typhoons. Consider, for example, the following excerpt from an interview with a representative from the National Office of Environment and Emergency Management in Palikir.

> *Water resources are hit during typhoons such as Typhoon Maysak in 2015 – when it hit Chuuk's outlying islands, the problem with water sources was the community was advised to boil water, even from the water catchments, because flying debris went into water sources.*[229]

As mentioned earlier, FSM's lower-lying islands are also heavily reliant on consistent rainfall for their water supply (as there are no piped water systems and households depend almost exclusively on rainfall catchment), making them vulnerable to droughts and rainfall shortages induced by El Niño weather systems. For example, in 2016, several islands in FSM (especially in Yap and Chuuk) faced severe water shortages, resulting from the worst El Niño-induced drought in recorded history.[230]

4.5.3. Limited resources

It was not possible to obtain detailed information on WASH financing in FSM. The country is not included in the Global Annual Assessment of Sanitation and Drinking-Water (GLAAS), which usually includes indicators for measuring the adequacy of funding.[231] However, according to a recent assessment report, FSM's financial resources in the area of WASH are limited, with heavy reliance on external donor support, especially from the USA.[232]

The report estimates that, under the Second US Compact fund, for the period 2004–2023, FSM will receive a total of US$ 142 million for investment in its water supply and wastewater sector. However, it also notes that FSM would struggle to implement the planned WASH projects without external donor support. With the Second US Compact fund due to be phased out in 2023, there is an urgent need for FSM's WASH sector to become financially self-sustaining.[233]

In relation to human resources, it appears that FSM's WASH sector is also heavily reliant on foreign support, with a recent report noting that 'quite often consultants are required to be employed from abroad at a great expense'.[234]

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229 KII with representative from the National Office of Environment and Emergency Management, Palikir, May 2017.

230 See e.g. Radio New Zealand, 'Little Water Left as Micronesia Struggles with Long Drought', 1 April 2016, on http://www.radionz.co.nz/international/programmes/datelinepacific/audio/201795416/little-water-left-as-micronesia-struggles-with-long-drought [05.05.17].

231 UN-Water 'GLAAS Report, on www.who.int/water_sanitation_health/monitoring/investments/glaas/en/ [05.05.17].

232 Johnston, M., 'FSM IWRM Outlook Summary and NWTF Report'.

233 Ibid.

234 Ibid.

4.5.4. Deforestation

A relatively out-dated (2007) diagnostic report identified deforestation of FSM's watersheds as one of the major challenges facing the country's safe water supply. For example, the report notes that, on Pohnpei island alone, encroachment by *kava* growers into the upper watershed has reduced the area of primary forest significantly (from 15,000 ha in 1975 to 4,200 ha in 2002), which has in turn resulted in sediment pollution of reefs and caused significant damage to traditional marine food supplies in Pohnpei.[235]

235 SPC Pacific Water, 'IWRM National Diagnostic Report – FSM', 2007.

5. Education

5.1. Context

Education is a fundamental human right, enshrined in Articles 28 and 29 of the CRC and Article 13 of the ICESCR. According to the UN Committee on Economic, Social and Cultural Rights, the right to education encompasses the following 'interrelated and essential features': availability; accessibility; acceptability; and adaptability.[236] The right to education is also contained in the SDGs, which recognize that 'Quality education is the foundation to improving people's lives and sustainable development.' SDG 4 requires states to 'ensure inclusive and quality education and promote lifelong learning for all.' The SDGs build on the MDGs, including MDG 2 on universal primary education, and UNESCO's Education for All (EFA) goals, which this chapter references throughout where relevant.

Key Education-related SDGs

SDG	Target	Indicators
4.1	By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes	Proportion of children and young people (a) in Grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex
4.2	By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education	Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex
		Participation rate in organized learning (one year before the official primary entry age), by sex

236 General Comment No. 13, on the Right to Education, 8 December 1999, para. 6

SDG	Target	Indicators
4.3	By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university	Participation rate of youth and adults in formal and non-formal education and training in the previous 12 months, by sex
4.4	By 2030, substantially increase the number of youth and adults who have relevant skills, including technical and vocational skills, for employment, decent jobs and entrepreneurship	Proportion of youth and adults with ICT skills, by type of skill
4.5	By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations	Parity indices (female/male, rural/urban, bottom/top wealth quintile and others such as disability status, indigenous peoples and conflict-affected, as data become available) for all education indicators on this list that can be disaggregated
4.6	By 2030, ensure that all youth and a substantial proportion of adults, both men and women, achieve literacy and numeracy	Percentage of population in a given age group achieving at least a fixed level of proficiency in functional (a) literacy and (b) numeracy skills, by sex
4.7	By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development	Extent to which (a) global citizenship education and (b) education for sustainable development, including gender equality and human rights, are mainstreamed at all levels in (i) national education policies, (ii) curricula, (iii) teacher education and (iv) student assessment
4.A	Build and upgrade education facilities that are child, disability and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all	Proportion of schools with access to (a) electricity; (b) the Internet for pedagogical purposes; (c) computers for pedagogical purposes; (d) adapted infrastructure and materials for students with disabilities; (e) basic drinking water; (f) single-sex basic sanitation facilities; and (g) basic hand-washing facilities (as per the WASH indicator definitions)

SDG	Target	Indicators
4.B	By 2020, substantially expand globally the number of scholarships available to developing countries, in particular least developed countries, small island developing States and African countries, for enrolment in higher education, including vocational training and information and communications technology, technical, engineering and scientific programmes, in developed countries and other developing countries	Volume of ODA flows for scholarships by sector and type of study
4.C	By 2030, substantially increase the supply of qualified teachers, including through international cooperation for teacher training in developing countries, especially least developed countries and small island developing states	Proportion of teachers in (a) pre-primary; (b) primary; (c) lower secondary; and (d) upper secondary education who have received at least the minimum organized teacher training (e.g. pedagogical training) pre-service or in-service required for teaching at the relevant level in a given country

The trajectory of FSM's education sector has been governed in recent years by the FSM Strategic Development Plan 2004–2023. The Plan contains five key goals to be realized in the education sector: improve the quality of learning; improve the quality of teaching; consolidate performance monitoring and data-based decision-making; strengthen participation and accountability of the education system to communities; and, finally, ensure education is relevant to the lives and aspirations of the FSM people.[237]

The education system in FSM is governed by the national Department of Education (DoE), which is responsible for setting national minimum standards such as teacher certification levels, school accreditation and school assessments; reporting on the status of education in the country; providing technical support and assistance to state DoEs; and coordinating external funding for the education system.[238] State DoEs assume responsibility for education instruction.[239] As such, services like curriculum development come under the state DoEs.[240] The EFA National Plan 2015 identifies the sense of autonomy and territoriality of individual states as a challenge to the development of the education system, with individual states often reluctant to accept the perceived interference of the national DoE in monitoring local school activities.[241]

237 Pp. 462–69, on http://www.mra.fm/pdfs/news_StrategicPlan.pdf [19.05.17].

238 UNICEF, 'Children in the Federated States of Micronesia – an Atlas of Social Indicators', 2013, p. 24; EFA National Plan 2015, p. 15.

239 Ibid. p. 24; EFA National Plan 2015, p. 15.

240 Ibid. P. 24.

241 Ibid. P. 15.

FSM's geography and the dispersal of its islands and atolls over a large area are recognized as a barrier to ensuring equitable access to quality education across all areas of the country at all levels.[242] The EFA National Plan states that, although air transportation between islands is generally reliable and available, when faced with airline and shipping constraints the Outer Islands could be cut off from educational resources and school supplies as well as transport links.[243] Furthermore, the increase in migration away from the Outer Islands to state capitals has reportedly meant that schools in urban areas have become overcrowded, with many facing textbook and resource shortages.[244] These issues merit particular attention, particularly as, according to statistics from the 2014–2015 school year, 35 per cent of FSM's schools are located on the outer islands of Chuuk, Pohnpei and Yap.[245]

A significant challenge to the development of the education system in FSM has been its reliance on external funding, raising questions regarding the sustainability of achievements in this sector. Funding for the education system in FSM has been derived primarily from US federal grants, most notably under the Compact of Free Association with the USA.[246] Further, it has been reported that funds actually allocated towards education programmes have been insufficient.[247] Per pupil expenditure was US$ 1,198 in the 2014–2015 school year, marking an increase from the previous year's US$ 1,166.17. This increase occurred alongside a decrease in student enrolment from 27,826 to 27,157.[248]

The ability to monitor progress in education is hampered by challenges in acquiring reliable data. These challenges stem from inconsistent processes and tools for collecting data between the four FSM states, as well as late submissions of data between schools and the DoE at national and state levels.[249] This challenge is a particular issue for the Outer Islands, where modes of data transmission can be unreliable (VHF radio, ship and small aircraft) and where monitoring often occurs only when a boat travels to these locations.[250]

Climate change-induced natural disasters, including cyclones and droughts, are significant barriers to ensuring equitable access to quality education for all children in the country. Those living on the low-lying Outer Islands are particularly vulnerable to climate change-induced displacement, as a result of eroding coastlines and high tides,[251] which can disrupt school attendance. School infrastructure is also vulnerable to damage by natural disasters. For example, Typhoon Mesa in 2014 hindered water supplies, including in schools, resulting in their closure for up to one year on some islands. Further, schools may be closed for use as shelters for people who have lost their

242 Ibid.; UNICEF, 'Children in FSM – an Atlas of Social Indicators', 2013, p. 24.

243 P. 15.

244 UNICEF, 'Children in FSM – an Atlas of Social Indicators', 2013, p. 24.

245 JEMCO, 'Federated States of Micronesia, Education Sector' ('JEMCO Report'), 2015, p. 2.

246 EFA National Plan 2015, p. 13; KII with representative of Economic Management Division, Department of Finance, May 2017.

247 EFA National Plan 2015, p. 13.

248 JEMCO Reports, 2014; 2015.

249 Ibid. 2015, p. 2.

250 Ibid.; KII with representative from national DoE, 8 May 2017.

251 WHO, Western Pacific Region, 'Climate Change Country Profile', on http://www.wpro.who.int/environmental_health/documents/docs/FSM_E2FE.pdf?ua=1 [16.08.17].

homes.[252] To address this situation, public and international development organizations construct tents or makeshift buildings to use as temporary classrooms,[253] raising concerns as to the safety of the learning environment as well as its conduciveness to learning. Disaggregated statistical data on the impact of natural disasters on school infrastructure and school attendance are unavailable. The UNISDR and GADRRRES Comprehensive School Safety Framework sets out three essential and interlinking pillars for effective disaster and risk management: safe learning facilities; school disaster management; and risk reduction and resilience education. These pillars should guide the development of the education system in FSM.

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 preprimary 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.

ECE in FSM targets children aged five but is non-compulsory – a gap in the legislative framework that may be regarded as a primary driver of low ECE enrolment and attendance[254] (see below for more details). ECE centres formerly ran independently, and functioned outside the 'formal education system', relying on US federal grants for funding, although some ECE was provided and funded by religious groups (notably the four main religious groups in the country: Protestants; Catholics; Seventh-Day Adventists; and Calvary Baptist).[255] However, ECE has now been merged within the national DoE, and is provided by DoEs at the state level.[256] This is reportedly resulting in moves towards the development of minimum standards for ECE instruction and integration of ECE within the primary school curriculum.[257] In Pohnpei, state-run ECE is provided through primary schools.[258] Furthermore, there are a number of private ECE providers operating across the country. However, challenges associated with limited investment in ECE persist,[259] including difficulties in acquiring instruction materials and providing transport to facilitate access.[260]

There are very few data on ECE in FSM such that a comprehensive assessment and analysis of ECE is not possible. According to national DoE data published in 2012, also displayed in Figure 5.1,[261] the ECE enrolment rate of children aged four–five years fluctuated between 2007 and 2012

252 KII with representative of the National Office of Environment and Emergency Management, May 2017.

253 Ibid.

254 KII with representative from national DoE, 8 May 2017.

255 EFA National Plan 2015, p. 26.

256 KII with representative from national DoE, 8 May 2017; KII with representative from Pohnpei DoE, May 2017.

257 Ibid.

258 KII with representative from Pohnpei DoE, May 2017.

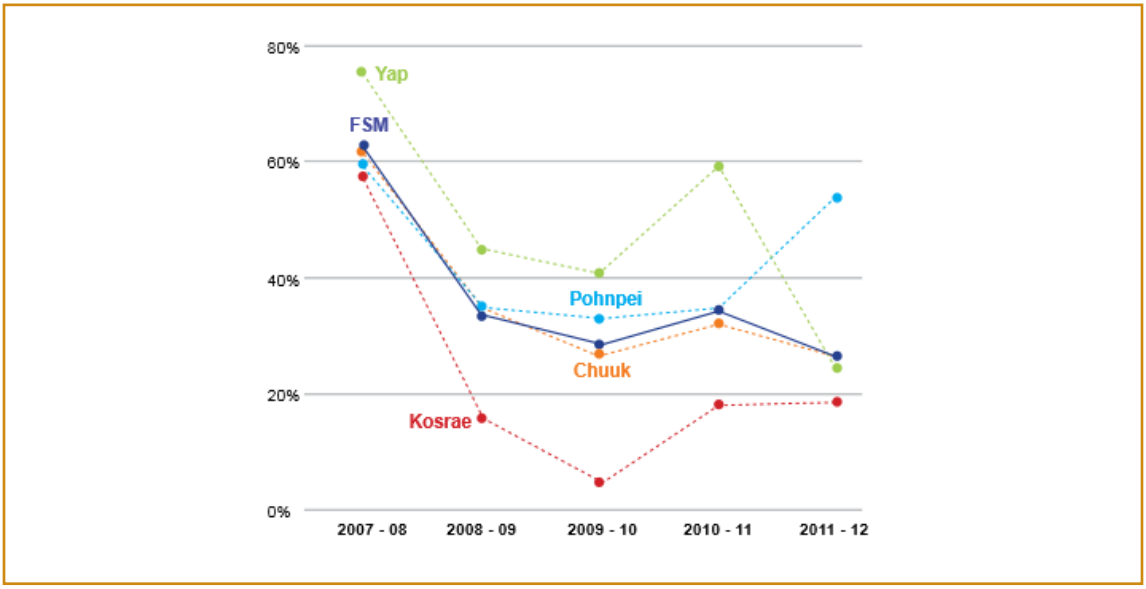
259 EFA National Plan 2015, p. 26; KII with representative from Pohnpei DoE, May 2017; KII with representative from national DoE, 8 May 2017.

260 KII with representative from Pohnpei DoE, May 2017.

261 UNICEF, 'Children in FSM – an Atlas of Social Indicators', 2013, p. 26.

but dropped overall from approximately 63 per cent to approximately 28 per cent.[262] However, the national DoE reported that in 2014–2015, 46 per cent of children aged four–five were enrolled in school (presumably in an ECE institution),[263] suggesting an increase in the ECE enrolment rate for this age group. Gender-disaggregated data on ECE enrolments are unavailable.

Figure 5.1: Base school-age population enrolled in ECE (4–5 years old), by state, 2007–2012



Source: DoE 2012, in UNICEF, 'Children in FSM – an Atlas of Social Indicators', 2013, p. 26.

Disaggregated data show that ECE enrolment has varied significantly between states. Between 2007 and 2012, Yap is shown to have seen the most pronounced decline in NER, dropping from almost 80 per cent to just below the national average (approximately 37 per cent). By contrast, Pohnpei, while demonstrating a decline between 2007 and 2009, saw an increase in enrolments of four–five year olds from approximately 35 per cent in 2009 to approximately 50 per cent in 2012.[264] The disaggregated figures by state from 2015 indicate that enrolment of children was significantly higher in Yap (72 per cent) compared with the other states (42 per cent in Chuuk; 43 per cent in Pohnpei; and 46 per cent in Kosrae).[265] Drop-out rates for ECE were most recently recorded in 2014–2015 at 2.3 per cent for males and 2.2 per cent for females.[266]

Varying ECE enrolment rates can be attributed to a number of factors. ECE is not compulsory by law, which is a key barrier to access.[267] Further, there is a shortage of ECE school places in certain

262 DoE, 2012, in ibid.

263 JEMCO Report, 2015, p. 5.

264 UNICEF, 'Children in FSM – an Atlas of Social Indicators', 2013, p. 26.

265 JEMCO Report, 2015, p. 5.

266 Ibid., p. 6.

267 EFA National Plan 2015, p. 26; KII with representative from Pohnpei DoE, May 2017.

areas; for example, in some areas of Pohnpei, ECE centres run waiting lists. Further, in remote areas, the long distances to the nearest centre present further barriers to access, with parents deciding to wait until children are of primary school age and can make their own way to school.[268] In Pohnpei, DoE cuts to the 2018 budget mean the state can no longer fund transport to address this barrier.[269] In Pohnpei, there are reportedly 19 ECE centres, all except one located on the mainland.[270]

Since the sub-sector merged with the national DoE, teachers have required certification, gained through passing a competency test set by the national government. Despite this requirement, teacher quality remains a concern. In addition to the challenges related to funding teaching materials and resources (see above), there are few data on teacher absenteeism. However, it is a concern that there are no substitute teachers in ECE centres: if teachers are absent, children will often not be taught. The ECE pupil–teacher ratio in Pohnpei is estimated at 1:15, with current DoE policy dictating that an ECE centre must have a minimum of 15 children in order to operate.[271]

ECE programmes are also available to children with special needs, aged three to five. While national data on the quality and accessibility of ECE for disabled children are unavailable, in Pohnpei state there are currently 20 children with special needs enrolled in ECE centres, including children with physical disabilities, health problems and hearing and vision impairments. The centres have medical services available for such children but often struggle to recruit specialized doctors.[272]

5.3. Primary and secondary education

The EFA goals and SDGs include targets on primary and secondary education. According to SDG 4.1, by 2030 all girls and boys shall complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes. The SGDs, 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, and complete, free and compulsory primary education of good quality.

> *In FSM, primary education is free and consists of nine years of compulsory schooling for children aged six to 14, or until completion of Grade 8. Secondary school is also free and consists of four years of non-compulsory schooling (Grades 9–12).*[273]

5.3.1. Access

A significant barrier to assessing and analysing the situation of children in primary and secondary schools is the lack of up-to-date data on key SDG (as well as MDG and EFA) indicators, and research

268 KII with representative from Pohnpei DoE, May 2017.
269 The 2018 budget amendments will remove the provision for transportation for children attending ECE; ibid.
270 KII with representative from Pohnpei State Education Department, May 2017.
271 Ibid.
272 Ibid.
273 UNICEF, 'Children in FSM – an Atlas of Social Indicators', 2013, p. 24.

into the drivers and causes of these trends. However, based on the data available, it appears that FSM has not achieved universal primary enrolment, and that low secondary enrolment rates are an area of significant concern.

The national DoE reported that, in 2015, 74 per cent of children aged between four and 18 were enrolled in primary and secondary school (35,475 children in total). Specifically regarding primary level, school enrolment of children aged six to 13 years was 88 per cent in the year 2014–2015. Although this does not correspond exactly to the reported compulsory primary school age (six to 14), and it is not clear in what school tier these children were enrolled, it nevertheless suggests a high primary net enrolment ratio (NER) that falls short of universal primary school enrolment. Further, the disaggregated figures between states from 2015 suggest varying NERs, with 72 per cent of children aged six to 13 in Yap enrolled in school, compared with 100 per cent in Kosrae, 91 per cent in Pohnpei and 88 per cent in Chuuk.[274] In 2015, the primary gross enrolment ratio (GER) was reportedly 108 per cent and said to relate to primary ages six to 13.[275]

According to the national DoE, school enrolment is lower for older children, which is unsurprising as secondary enrolment is not compulsory: only 63 per cent of children between the ages of 14 and 18 were enrolled in school in the 2014–2015 school year. It is not clear, however, whether these children were enrolled in primary or secondary education. Enrolment of children in this age group was significantly high in Kosrae, at 81 per cent, compared with 66 per cent in Yap, 65 per cent in Pohnpei and 59 per cent in Chuuk.[276] National DoE drop-out rates further suggest school participation decreases markedly at Grade 9, which is the first year of secondary school; the drop-out rates for primary level are below 1 per cent for both boys and girls, but jump to 2.7 per cent for boys and 1.3 per cent for girls at Grade 9, after which they both decrease to 0.7 per cent at Grade 12.[277] In 2015, the secondary GER was 57 per cent, although said to relate to children aged 14–18.[278]

SDG 4.5 focuses on the need to strive towards removing all gender disparities in education, ensuring equal access and participation for both girls and boys. From 2009 to 2011, FSM achieved gender parity for the primary GER. However, this rate fell to 93 per cent in 2015,[279] indicating that a lower percentage of girls than boys were enrolled in primary education that year. At secondary level, in 2010 the Gender Parity Index (GPI) for the secondary GER was 113 per cent, dropping to 109 per cent in 2011 and 96 per cent in 2015.[280] The underrepresentation of girls as school progresses may be partly attributable to the societal pressure placed on girls to assume household responsibilities as they approach adolescence.[281]

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274 JEMCO Report, 2015, p. 5.

275 National JEMCO 21 Indicators 2014–2015, on https://www.spc.int/nmdi/education [23.06.17].

276 JEMCO Report, 2015, p. 5.

277 Ibid., p. 6.

278 National JEMCO 21 Indicators 2014–2015, on https://www.spc.int/nmdi/education [23.06.17].

279 JEMCO Reports, 2009–2011, on https://www.spc.int/nmdi/education [23.06.17], although the authors have not verified these figures in the original source. Note these figures refer to six to 13 as the official primary school age group.

280 Ibid. Note these figures refer to 14–18 as the official secondary school age group.

281 Pacific Women, 'Stocktake of the Gender Mainstreaming Capacity of Pacific Island Governments, Federated States of Micronesia', p.6, on http://www.pacificwomen.org/wp-content/uploads/FSM-gender-stocktake.pdf [14.06.17].

School completion rates can provide an indication of the quality of and access to education. In Chuuk in 2015, completion of Grade 8 (the last year of primary school) was recorded at just 76 per cent in public schools, although the equivalent completion rate in private schools was a high 96 per cent. Rates of completion were much higher for Grade 8 pupils in Pohnpei and Yap's public schools, both at 98 per cent (the figures for private schools in these states were unavailable), as well as in Kosrae, which achieved a 100 per cent completion rate in 2015 for both public and private schools. At secondary level, in 2015 Chuuk had the lowest completion rate, of 78 per cent, for public secondary schools, compared with 99 per cent in Pohnpei, 94 per cent in Yap and 91 per cent in Kosrae.[282] Gender-disaggregated data are unavailable.

FSM ratified the CRPD on 7 December 2016, reflecting its commitment to protect the rights of persons with disabilities. The country is taking important steps to implement these commitments in the education sector. It adopted a National Policy on Disability 2009–2016 in order to identify priority areas for action in order to promote a more inclusive society, create greater awareness of the needs of persons with disabilities and improve the delivery of disability services.[283] FSM Public Law 14-8 generally provides that free, appropriate education should be available to disabled children and young people, up until the age of 21.[284]

Education services for disabled children and young people are delivered through the US federally funded Special Education Program (requiring compliance with the Individuals with Disabilities Education Act of 2004).[285] As of 2012, 1,891 children and youth aged three to 21 were enrolled in the programme. The majority (43.7 per cent) were registered as a having 'specific learning disabilities', 34.6 per cent were registered as having speech/language impairments and 5 per cent were registered as having multiple disabilities. The remaining 16.8 per cent were recorded as experiencing disabilities including 'other health impairments', orthopaedic impairments, visual and hearing impairments, intellectual disabilities, developmental delay, emotional disturbance, autism and deaf-blindness.[286] Further research is needed to determine whether and what steps are being taken to integrate children with disabilities into mainstream schools.

5.3.2. Quality

The FSM government has highlighted quality of education as a key area of concern, particularly with regard to teacher qualifications, training and pupil–teacher ratios. These ratios can be an effective indicator of educational quality, as they reflect the ability of teachers to dedicate attention and resources to students as well as teaching efficiency. Furthermore, they can show if teachers are overburdened and therefore delivering lower-quality teaching. The government's most recent statistical analysis, conducted in 2015, placed the ratio at 15 for public primary schools and 18 for

282 JEMCO Report, 2015, p. 8.

283 https://www.mindbank.info/item/1158 [23.06.17].

284 DoE, 'Special Education Programs and Services', on http://www.fsmsped.org/dashboard/sped_history.php, and Public Law 14-8, on www.fsmcongress.fm/pdf%20documents/14th%20Congress/Public%20Laws/Public%20Law%2014-08.pdf [23.06.17].

285 DoE, Special Education Programs and Services, and Public Law 108-446, on http://www.fsmsped.org/dashboard/documents/IDEA/PL108-446-IDEA.pdf [16.08.17].

286 Special Education Program, 2012, in UNICEF, 'Children in FSM – an Atlas of Social Indicators', 2013, p. 51.

public secondary schools.[287] It is lower in private schools, being recorded at 12 for private primary schools and 10 for private secondary schools.[288] In terms of geographical disparities in the for public schools, Pohnpei records significantly higher rates than other states, at 17 for primary schools and 22 for secondary schools. Yap, conversely, records eight for primary and 14 for secondary schools, and Kosrae nine for primary and 13 for secondary schools.[289]

The 2015 EFA National Plan raises concerns about the adequacy of the qualification levels of teachers in FSM's primary and secondary schools.[290] As of the 2014–2015 school year, there were 1,790 teachers across FSM and 363 staff, the majority of whom were employed in primary schools (1,375 teachers and 199 staff, compared with 415 and 164 in secondary schools).[291] The FSM Teacher Certification Policy states that 'No person shall serve as a teacher in any elementary or secondary school within the Federated States of Micronesia, without first having obtained a National Teacher Certificate from the FSM National Department of Education.' Furthermore, it dictates that, alongside the appropriate certification, teachers must have at least an AA/AS degree. The deficit in teachers possessing the minimum qualifications has been identified as a concern, with 20 per cent of teachers recorded as having no degree in 2012.[292] The numbers of teachers without a degree dropped over the following years, however, which is encouraging (see Figure 5.2). From 2012 to 2013, the number went down to approximately 17 per cent, and they went down further to 16 per cent in 2014 and finally to 14 per cent in 2015.[293]

Disaggregated data show that, in the 2014–2015 school year, there was significant variation between states. In Yap, approximately 30 per cent of teachers had no degree, compared with 17 per cent in Chuuk, 8 per cent in Kosrae and 3 per cent in Pohnpei.[294] These figures illustrate that geographical location may have an impact on the quality of teaching delivered. In the case of teacher qualifications, Yap and Chuuk are particularly disadvantaged.

The 2015 EFA National Plan also raised commitment of teachers to their jobs and their students as a concern. The DoE speculates that many teachers may be dis-incentivized as a result of a lack of guidelines on teacher attendance and behaviour.[295] As such, the education sector suffers from high turnover rates and a subsequent shortage in qualified teaching staff. In 2012, teacher attendance was recorded at 90 per cent in primary schools and a lower 85 per cent in secondary schools.[296] That 10 per cent of primary school teachers and 15 per cent of secondary school teachers are absent from classes represents a serious barrier to delivering quality education in FSM. The National EFA Plan aims to combat this by establishing professional development workshops for all principals and teachers and setting up an appraisal system with proper

287 JEMCO Report, 2015, p. 4.

288 Note that only Chuuk and Kosrae provided data for private school pupil–teacher ratios. Ibid., p. 5.

289 JEMCO Report, 2015, p. 4.

290 Ibid., p. 18.

291 Ibid., p. 4.

292 JEMCO Report, 2012, p. 5.

293 JEMCO Reports, 2012–2015.

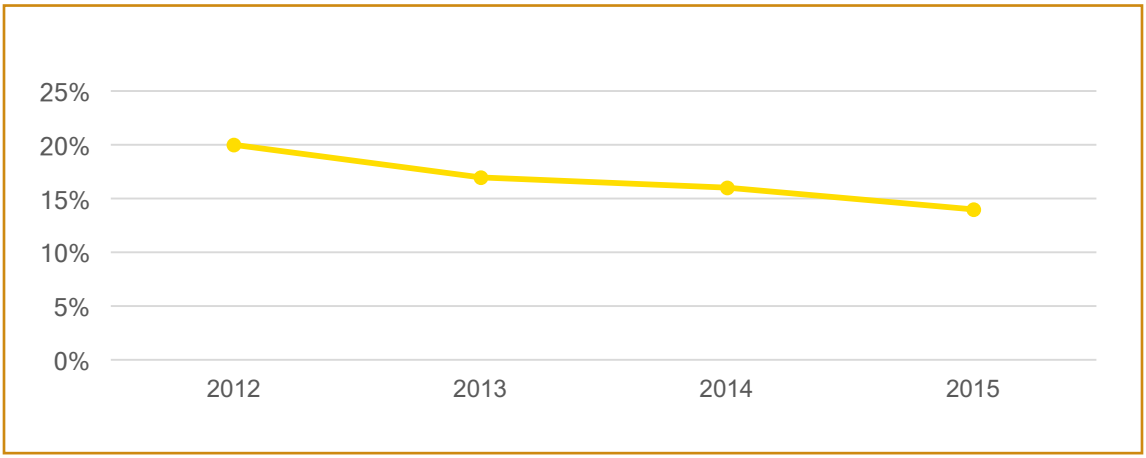
294 JEMCO Report, 2015, p. 4.

295 P. 24.

296 JEMCO Report, 2012, p. 5.

guidelines and support systems, as well as developing course workshops to up-skill teachers on content, knowledge and attitudes.[297] However, teacher absenteeism continues to be a concern for the national DoE, since, when a teacher is absent, there is often no one to replace them and students will not be taught for the day.[298]

Figure 5.2: Proportion of teachers with no degree, 2012–2015



Source: JEMCO Reports, 2012–2015

The DoE is responsible for the development of standardized literacy and numeracy assessments. The National Minimum Competency Tests (NMCTs) in Reading and Mathematics are FSM's primary educational assessment instruments. Children are tested in Mathematics in Grades 4, 6, 8 and 10, and English Language Arts in Grades 6, 8 and 10.[299] Scores over recent years have been a cause for serious concern: high numbers of children have not achieved minimum standards of literacy and numeracy, particularly in Grade 8, the final year of compulsory, primary education. In the 2014–2015 school year, only 22 per cent 'met or exceeded' the minimum competency expectations for Mathematics as defined by the NMCT standards.[300] This figure marks a slight decrease in the percentage achieving appropriate levels of numeracy from the 23 per cent recorded in 2011.[301] Reading scores shows higher levels of literacy than numeracy, but the figures remain a severe worry. In the 2014–2015 school year, 35 per cent of children 'met or exceeded' the minimum competency expectations,[302] only a slight increase from the 32 per cent recorded in 2011.[303]

297 EFA National Plan 2015, p. 24.
298 KII with representative from the national DoE, May 2017.
299 DoE, 'Curriculum and Assessment', on http://www.fsmed.fm/index.php/homepage-assessment [16.08.17].
300 JEMCO Report, 2015, p. 7.
301 JEMCO Report, 2011, p. 13.
302 JEMCO Report, 2015, p. 7.
303 JEMCO Report, 2011, p. 15.

5.4. Tertiary and vocational 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.

Post-secondary education in FSM is provided through the College of Micronesia-FSM (COM-FSM), spread over five campuses, across FSM's states. The College consists of the national campus, in Palikir, Pohnpei, regional campuses in Chuuk, Yap and Kosrae and a further campus in Pohnpei, plus an additional specialized Fisheries and Maritime Institute in Yap. COM-FSM provides courses for Associate degrees in a wide range of subjects, as well as Certificate programmes. In addition, COM-FSM provides 'career and technical education' (CTE) programmes.[304]

In the semester of spring 2015, there were 2,028 students enrolled across COM-FSM's five campuses, the majority of whom were female (1,089 compared with 939 male students). This marks a decrease in student enrolment numbers from the previous semester (autumn 2014), recorded at 2,344.[305] A total of 398 students graduated from higher education institutions in 2015, indicating a 5 per cent decrease on the previous year. The most popular degree in 2015 was an AA in Teacher Preparation (63 students), followed by an AA in Liberal Arts (42 students). Teacher Preparation enrolments are dominated by female students (17 compared with five male students), as are those in the second most popular course, the AA in Liberal Arts (18 compared with three male students). Conversely, popular courses such as Computer Information Systems are dominated by male student enrolments (13 compared with six female students). Similar to enrolment numbers, more female than male students graduate (90 compared with 57).[306]

Financial assistance for tertiary education in FSM is provided through various scholarship funds. The National Scholarship Fund is available to undergraduate students and the Sin Tax Scholarship, made up of taxes on national tobacco sales, can be awarded to students seeking to study at graduate level. There are also external sources of funding available for FSM students looking to study abroad. The USA provides assistance to students through the Federal Student Aid Program, Australia has the Australian Development Scholarship for those wishing to study at Australian universities and, finally, the New Zealand Scholarship – Micronesia is also available for FSM students.[307]

In the 2014–2015 academic year, 585 students were awarded scholarships, the majority of them freshman students (166 students). The majority of scholarship funding was awarded by the Chuuk DoE, with 239 scholarships, followed by Yap DoE, with 143; Kosrae DoE awarded 103 scholarships and Pohnpei 100.[308]

Scholarship assistance declined between 2012–2013 and 2014-2015 academic years. As Figure 5.3 shows, while the overall numbers of scholarship recipients fell at all academic levels, freshman and

304 COM-FSM, 'General Information', on www.comfsm.fm/catalog/2016-2017/general-information.pdf [16.08.17].

305 JEMCO Report, 2015, p. 9.

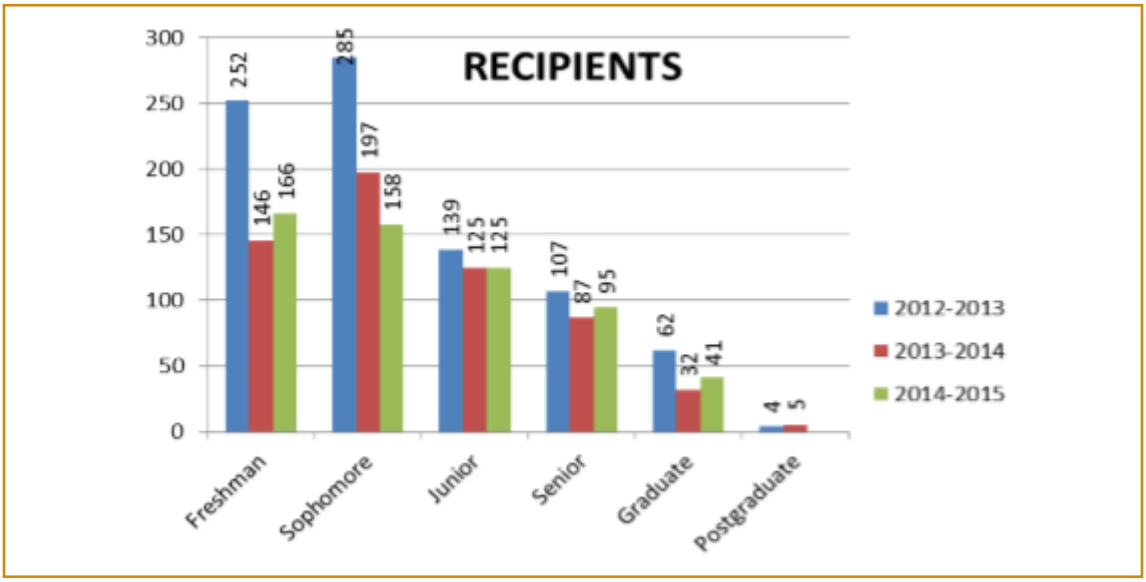
306 Ibid., p. 10.

307 DoE, 'Funding', on http://www.fsmed.fm/index.php/student-services/2014-03-14-01-31-22 [16.08.17].

308 JEMCO Report, 2015, p. 11.

sophomore years saw the most significant reductions in scholarship availability. Between 2012–2013 and 2014–2015, awards fell from 252 to 166 for freshman year students, and from 285 to 158 for sophomore students.[309] Scholarship recipient data disaggregated by gender are unavailable.

Figure 5.3: Scholarship recipients, 2012–2013 to 2014–2015



Source: JEMCO Report, 2015, p. 11

The CTE Strategic Plan of 2010 governs vocational training policy in FSM, seeking to improve access to vocational improvement programmes across the country.[310] There are limited data available on the quality of vocational training in FSM, either as an alternative to non-compulsory secondary education or as post-secondary training. The national DoE has, however, recognized, in the EFA National Plan, that the quality and accessibility of CTE during primary and secondary school, as well as at the post-secondary level, require significant improvement and investment.

The EFA National Plan identifies that the lack of attention given to vocational education and training in FSM's formal education system reflects broader societal perceptions of non-traditional education – namely, that it is not as valuable or desirable as an academic education. As such, the Plan highlights the need to educate parents of children in school on the value and relevance of life skills and vocational training for children's development. Furthermore, it recognizes the negative impact of a lack of vocational training options on students' transition into work after secondary school.

The Plan therefore sets out various measures intended to address the deficit of vocational education in FSM. These include revisions to primary and secondary school curricula, instituting life skills as a required subject in schools and training teachers in life skills subjects. Furthermore, it sets out the intention to develop vocational education pathways for adults.

309 Ibid.

310 DoE, 'Career Education', on http://www.fsmed.fm/index.php/about-us/division/career-education [16.08.17].

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. While the CRC recognizes that parents have primary responsibility for the care and protection of their children, it also emphasizes the role of governments in keeping children safe and assisting parents in their child-rearing responsibilities. This includes obligations to support families to enable them to care for their children, to ensure appropriate alternative care for children who are without parental care, to provide for the physical and psychological recovery and social reintegration of children who have experience violence, abuse or exploitation, and to ensure access to justice for children in contact with the law.

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

Article 7 – The right to identity and to be registered at birth
Article 19 – The right to protection from all forms of physical or mental violence, abuse or neglect, or exploitation
Article 23 – The rights and special needs of children with disabilities
Article 32 – The right to protection from economic exploitation
Article 33 – The right to protection from illicit use of narcotic drugs
Article 34 – The right to protection from all forms of sexual exploitation and sexual abuse
Article 35 – The right to protection from the abduction, sale and traffic in children
Article 36 – The right to protection from all other forms of exploitation
Article 37 – The right to protection from torture, cruel or inhuman treatment, capital punishment, and unlawful deprivation of liberty
Article 39 – The right to physical and psychological recovery and social integration
Article 40 – The rights of the child alleged as, accused of or recognized 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; the Convention on the Rights of People with Disabilities; ILO Convention 138 on Minimum Age; ILO Convention 182 on the Worst Forms of Child Labour; the UN Guidelines for the Alternative Care of Children (2010); UN Standard Minimum Rules for the Administration of Juvenile Justice (1985); the UN Guidelines for the Prevention of Juvenile Delinquency (1990); the UN Rules for the Protection of Juveniles Deprived of their Liberty (1990); and the UN Guidelines for Justice on Child Victims and Witnesses in Criminal Proceedings (2005).

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

Key child protection-related SDGs

SDG	Target	Indicators
5.2	End all forms of violence against women and girls in public and private spheres, including trafficking and sexual and other types of exploitation	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
		Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence
5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation	Proportion of women aged 20–24 years who were married or in a union before age 15 and before age 18
		Proportion of girls and women aged 15–49 years who have undergone female genital mutilation/cutting, by age
8.7	Take immediate and effective measures to 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, particularly for women and children, older persons and persons with disabilities	Proportion of persons victim of physical or sexual harassment, by sex, age, disability status and place of occurrence, in the previous 12 months
16.1	By 2030, significantly reduce all forms of violence and related deaths everywhere	Number of victims of intentional homicide per 100,000 population, by sex and age
		Conflict-related deaths per 100,000 population, by sex, age and cause
		Proportion of population subjected to physical, psychological or sexual violence in the previous 12 months
		Proportion of population that feels safe walking alone around the area they live in
16.2	End abuse, exploitation, trafficking and all forms of violence and torture against children	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by care-givers in the previous month
		Number of victims of human trafficking per 100,000 population, by sex, age and form of exploitation
		Proportion of young women and men aged 18–29 years who experienced sexual violence by age 18
16.3	Promote the rule of law at the national and international levels and ensure equal access to justice for all	Proportion of victims of violence in the previous 12 months who reported their victimization to competent authorities or other officially recognized conflict resolution mechanisms
		Unsentenced detainees as a proportion of overall prison population
16.9	By 2030, provide legal identity for all, including birth registration	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age

UNICEF's global Child Protection Strategy calls for creating a protective environment 'where girls and boys are free from violence, exploitation and unnecessary separation from family; and where laws, services, behaviours and practices minimize children's vulnerability, address known risk factors, and strengthen children's own resilience'.[311] The UNICEF East Asia and Pacific Region

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

Child Protection Programme Strategy 2007 similarly emphasizes that child protection requires a holistic approach, identifying and addressing community attitudes, practices, behaviours and other causes underpinning children's vulnerability, engaging those within children's immediate environment (children themselves, family and community), and ensuring an adequate system for delivery of holistic prevention, early intervention and response services.

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.'[312] The main elements of a child protection system are:

Main elements of a child protection system

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

Source: Adapted from UNICEF Child Protection Resource Pack 2015

6.1. Child protection risks and vulnerabilities

This section provides an overview of available information on the nature and extent of violence, abuse, neglect and exploitation of children in FSM; 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

There is limited quantitative data available on the nature and extent of violence, abuse, neglect and exploitation of children in FSM, and as a result it is not possible to present a clear picture

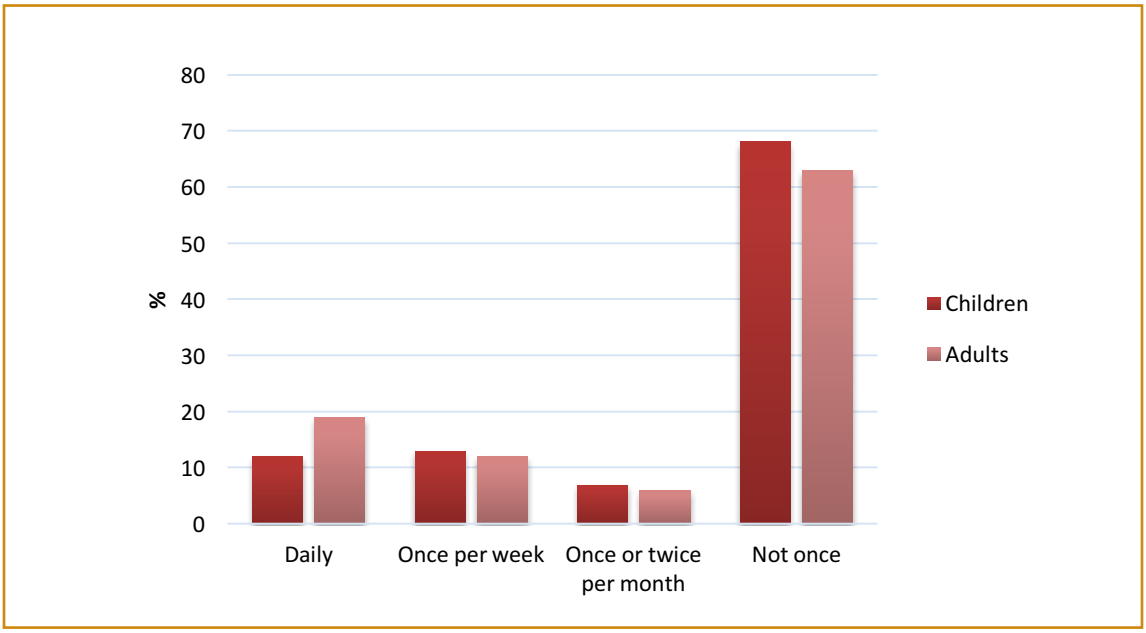
312 Ibid.

of the nature and extent of this. Nonetheless, available information indicates that FSM children experience various forms of violence, abuse, neglect and exploitation in several contexts, including within the home, in schools and in the community.

6.1.1.1. Violence in the home

The use of corporal punishment against children remains common in FSM. In a 2014 Child Protection Baseline Study conducted by UNICEF in association with the government of FSM, a total of 32 per cent of child respondents and 37 per cent of adult respondents reported household punishment in which adults had physically hurt their children within the month prior to the survey.[313] This is broken down as follows:

Figure 6.1: Responses from children and adults in relation to frequency of physical punishment in the home



Source: Child Protection Baseline Study 2014

Adult respondents stated that mothers and fathers were most likely to perpetrate physical violence, with a rate of attribution at 55 per cent for mothers and 18 per cent for fathers. Child respondents, however, reported that 'other relatives' (30 per cent), 'other adults' (24 per cent) and siblings (23 per cent) were the more frequent perpetrators, and did not mention mothers or fathers. The study proposed an explanation for this: 'Although parents punish their children physically with more frequency, they either do not physically hurt the child or, the child accepts parental physical punishment as normal but interprets physical hurt from others as physical abuse.'[314]

313 Government of FSM and UNICEF, 'Protect Me with Love and Care: Child Protection Baseline Study', 2014, p. 38.

314 Ibid.

Children in FSM also experience emotional violence, including humiliation, being called names or being made to feel unwanted. Of the children who participated in the Child Protection Baseline Study, 12 per cent reported this happening daily, 13 per cent once a week and 7 per cent once or twice a month.[315] When children were asked what types of abuse they had had to put up with in the past month, their responses ranged from being called 'stupid, loose screws in the brain, an idiot' (16 per cent), being called 'lazy, good-for-nothing' (15 per cent), other 'general swearing' (14 per cent) and making fun of the child's appearance (5 per cent) including opposite gender appearance (7 per cent). In addition, 9 per cent reported being hit with either closed fist, belt, ruler or other object or being kicked, 11 per cent reported being hit with an open hand on their head or had their hair pulled, and 11 per cent reported light spanking or a slap on the hand.

In addition, results from a 2014 Family Health and Safety Study suggest that a significant number of FSM children are also exposed to family violence in their homes. The study found that 32.8 per cent of ever-partnered women had experienced violence (physical and/or sexual) perpetrated by a partner at least once in their lifetime, and 6.3 per cent of ever-pregnant women reported experiencing physical partner violence in pregnancy.[316] When women who reported experiencing physical partner violence were asked whether their children ever witnessed such violence, nearly half (44.4 per cent) reported that their children had witnessed the violence, 24.6 per cent indicated that their children had witnessed the violence once or twice, 21.2 per cent indicated that their children had witnessed it several times, and 3.8 per cent reported their children witnessed violence many times. The study highlighted the impact of domestic violence on children, finding that children of women who had experienced violence were at increased risk of suffering nightmares, bedwetting, being withdrawn and being aggressive than the children of women who had not experienced partner violence. They were also almost three times more likely to have stopped or dropped out of school than children of women who had never experienced partner violence.[317]

6.1.1.2. Violence in schools

Physical punishment and bullying are reportedly common in FSM schools. As part of the Child Protection Baseline Study, children were asked if, in general, they felt safe and protected in the home, school, and community. Children reported that they felt most safe and protected at home (92 per cent), but their sense of feeling safe and protected decreased substantially while at school (69 per cent). The study revealed 'a high degree of bullying and fighting in public high schools.'[318] In addition, although most children reported positive disciplining and praising by teachers (87 per cent), 42 per cent reported that physical punishment took place in schools.[319] Parents who participated in the study were more inclined than children to report that physical punishment was used in school (55 per cent), while key informants underestimated it, with 77 per cent stating that teacher/school administrators did not use physical punishment.[320] The study concluded that

315 P. 13.
316 Ibid., p. 19.
317 P. 58.
318 P. 39.
319 P. 37.
320 Ibid.

corporal punishment was present in schools throughout the country, and that, although most children and parents do not agree with the practice, some either accept corporal punishment as part of the educational experience or do not feel empowered to report the abuse.[321]

6.1.1.3. Sexual abuse

The 2014 Family Health and Safety Study found that approximately 14 per cent of all women had experienced sexual abuse before the age of 15, with the most common perpetrators being male relatives and male friends.[322] The prevalence of child sexual abuse was highest in Kosrae (21.9 per cent) and lowest in Pohnpei (10.7 per cent), with prevalence in Chuuk and Yap at 16.9 per cent and 14.7 per cent, respectively.[323] The rate of prevalence for child sexual abuse, at 14 per cent, is lower than the average of 17 per cent for the PICTs for which data are available.[324]

Among women who reported sexual abuse in childhood, 74 per cent indicated being aged 10–14 when the abuse first occurred, and 12 per cent reported being aged five to nine. In addition, women who had their first sexual experience before the age of 15 and at ages 15–17 were also more likely to report such experiences as forced (18 per cent and 10.3 per cent, respectively). Although most respondents believed that young girls were most often the victims of child sexual abuse, they also provided examples of boys being abused. Several participants indicated knowing boys who had been sexually molested by male and female family members.[325]

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

FSM is considered a source, transit, and, to a limited extent, destination country for men, women, and children subjected to forced labour and sex trafficking.[326] Girls are reportedly vulnerable to commercial sexual exploitation through prostitution by crew members of docked Asian fishing vessels, and some women from FSM may be trafficked to the USA and US territories. There have also been reports of children trafficked by family members for commercial sex purposes, particularly to foreign fishermen and other seafarers.[327]

According to one key informant from the DoHSA, the Department is looking into the issue of commercial sexual exploitation of children within the fishing industry. The informant noted concerns that some families viewed child prostitution as an opportunity to make money, while in other cases, girls engage in commercial sexual exploitation 'autonomously', in order to make money for themselves. Though most of the girls involved are reported to be teenagers, some as young as 11 or 12 are reported to have been referred to the Department. Recruitment for

321 P. 97
322 P. 11.
323 P. 48.
324 Cook Islands, Fiji, Kiribati, Marshall Islands, Nauru, Palau, Samoa, Solomon Islands, Tonga and Vanuatu.
325 P. 49.
326 US State Department, 'Trafficking in Persons Report 2017'.
327 Ibid.

commercial sexual exploitation is said to take place, in Pohnpei, at a bar and through networks that include taxi drivers.[328]

No quantitative data were available on child labour in FSM. Employment of children for wages is reportedly not a concern, but children often assist their families in subsistence farming and family-owned shops.[329]

6.1.1.5. Child marriage

The Child Protection Baseline Study notes that Yap and Chuuk in particular have strong traditional customs in the area of marriage, which often take precedence over legislation. Some traditional marriages take place where the girl is as young as 13 years of age. Concern about this situation has been raised in the health sector in Chuuk because of problems related to teen pregnancy. One submission to the 2010 UPR Process noted that child marriage was common in FSM and large age gaps between older men and younger wives were accepted culturally. It was noted that customary marriages, which have no minimum age requirement, were permitted under Article 5 of the Constitution of FSM, which seeks to protect traditional practices. This provision has been used to facilitate child marriage and related harmful traditional practices, including 'bride price', even in communities that would not traditionally have sought this.[330]

6.1.1.6. Children in conflict with the law

No data were available on the number of children in conflict with the law in FSM. According to a representative from the Public Defender's Office, their office handles cases involving children in conflict with the law approximately once a week in Pohnpei, two to three times a week in Chuuk and rarely in Kosrae. No information was provided about Yap. Most cases reportedly relate to drinking under age, disturbing the peace or very minor offences, though it was noted that the office has also dealt with cases of attempted murder and rape in Chuuk.[331]

6.1.2. Community knowledge, attitudes and practices

In FSM, traditional and religious leaders have strong influence and standing in communities, and both child and adult respondents who participated in the 2014 Child Protection Baseline Study highlighted traditional community practices as a source of care and protection for children.[332] Traditionally, the upbringing of children was a community responsibility, rather than the sole responsibility of biological parents, and it was common for children to be raised by their extended

328 Interview with representatives of DoHSA, Pohnpei, May 2017.

329 US State Department, 'Micronesia 2015 Human Rights Report', p. 12.

330 SRIM, 'Report on the Federated States of Micronesia 9th Session of the Universal Periodic Review', November 2010, p. 3, on http://lib.ohchr.org/HRBodies/UPR/Documents/session9/FM/SexualRightsInformation.pdf [19.06.17].

331 Interview with representative from Public Defender's Office, May 2017.

332 P. 38.

family.[333] Violence, abuse and neglect of children were viewed as an offence against the entire extended family, not just the individual victims, and addressed by a complex system of familial sanctions. However, these traditional methods of coping with family discord are reportedly breaking down with increasing urbanization, monetization of the economy, and greater emphasis on the nuclear family in which victims have been isolated from traditional family support.[334]

A representative from the State Governor's Office reported that challenges to the delivery of child protection in FSM included the shift in family and community life, from communal living, in which extended families '*had a network to look after the wife and child, along with members in the community who take responsibility as they are part of the whole village*' to a situation in which this no longer exists, such that the government now needs to take the place of the extended family by providing social care and other services to nuclear families.[335] This concern was reflected in the Family Health and Safety Study 2014, which found that, 'Because of these family structure changes and less efficient social controls by the extended family, children and women are more easily targeted for abuse.'[336] Respondents who participated in the 2014 Child Protection Baseline Study identified erosion of the traditional family support system as one of the major factors contributing to danger to children in the community.[337]

At the same time, the Child Protection Baseline Study found some positive changes in parental discipline practices and general attitudes and behaviour in relation to the protection of children. Parents and care-givers over the age of 25 were more involved in group activity to measure changes in parenting practices as compared with their own parents. This showed some improvement in parent/child relationships and discipline techniques in the space of one generation, including a decrease in the use of physical punishment and scolding, and increased communication with children.[338] However, in a 2014 Family Health and Safety Study, 23 per cent of women who had children believed they needed to resort to physical punishment 'in order to raise the child properly',[339] suggesting that corporal punishment remains an accepted practice for a significant portion of the population.

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

The 2014 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; children are 'not to be heard or seen' when adults meet and their perspectives are not considered important in family matters; a high tolerance for violence encourages a culture that allows corporal punishment at home and in schools; and cultural taboos prevent discussion of and reporting of sexual abuses,

333 DoHSA. Family Health and Safety Study. p.18.

334 US Department of State. 2016 Human Rights Report: Federated States of Micronesia. Bureau of Democracy, Human Rights, and Labor.

335 Interview with representative from State Governor's Office, May 2017.

336 P. 19.

337 P. 40.

338 P. 37.

339 P. 47.

particularly if family members are involved.[340] Respondents further highlighted lack of parental guidance and loss of the traditional family support system as contributing to child protection risks in the community.[341] As households become more nuclear and family structures change, there is less social control by the extended family and as a result children and women are more vulnerable to abuse.[342]

The general acceptance of corporal punishment as a form of discipline, lack of awareness of the negative impact of verbal and emotional abuse and neglect on children and the perception of violence against children as a private 'family matter' also perpetuate violence against children and acts as a barrier to reporting and referral of cases. One key informant noted that, despite a legal provision requiring the reporting of instances of child abuse, '*People are reluctant to report it, saying "It's none of my business, why am I interfering with the family?" Or they will just inform the relatives and ask them to take a look*.'[343]

The high number of children living away from their parents has also been highlighted as a factor contributing to children's vulnerability. The Child Protection Baseline Study found that, as in many areas of the Pacific, many children in FSM live away from their parents or main care-givers – mostly for the purpose of education. Emigration also affects children when they are sent to Hawaii or the mainland for 'better opportunities' or when the parents go away and leave the children with extended family and other care-givers.[344]

Violence against girls is also driven by the low status of women in FSM. Violence against women and girls is seen as something that is 'normal' or to be handled within the family, which leads to under- or non-reporting.[345] This concern is reflected in the 2010 submission to the UPR Process by Sexual Rights Information of Micronesia (SRIM) organization, which stated that '"culture" is frequently invoked as justification for discrimination against, and even violent and abusive treatment of, women and girls. However, the "customs" and "traditions" that are invoked are often distorted versions of the original, which have been modified to suit the needs of the males in the family.'[346]

Children's limited bodily autonomy and lack of empowerment to protect themselves is also a contributing factor to violence and exploitation. The Family Health and Safety Study found that child sexual abuse was rarely disclosed or reported because victims felt ashamed and perpetrators were often family members.[347] The Child Protection Baseline Study similarly found that 78 per cent of child respondents knew the difference between touching that was acceptable and touching that was unacceptable; however, 35 per cent of children who had experienced inappropriate touching had not reported the incident to anyone. Of particular concern is that 14

340 P. 18.

341 P. 40.

342 DoHSA Family Health and Safety Study 2014, p. 18.

343 Interview with representative from Department of Justice, Pohnpei, May 2017.

344 P. 89.

345 DoHSA Family Health and Safety Study 2014, p. 5.

346 P. 3.

347 P. 49.

per cent of children did not agree that 'adults or older children do not have the right to touch their body in an unacceptable manner,' while 22 per cent of adults did not agree 'that adults or older children do not have the right to touch a child's body in an unacceptable manner'. This means that over one in seven children and one in five adults have a belief that it is acceptable for an adult or for an older child to touch a younger child's body without permission.[348]

Economic hardship is also a factor contributing to children's vulnerability, particularly in relation to commercial sexual exploitation. As a result of economic challenges, families that are struggling to make ends meet may view child prostitution as an opportunity to make money, particularly as girls may not otherwise have the ability to earn an income.[349]

The lack of political commitment and resulting insufficient resource allocation to the social sector has an impact on the prevalence of child protection issues and on the responses provided. For example, one key informant from the DoHSA noted that political resistance to introducing family protection legislation was the result of cultural and traditional attitudes towards women and girls. In Pohnpei, '*We have a recognized role for women. There is disparity between genders and the role of women is to look after the family … So men are questioning, why are we introducing this law? What are you trying to do?*' In general, family protection acts are seen as a subversion of male rights, and are reported to be met with suspicion.[350]

A key structural cause contributing to children's vulnerability to violence, abuse, neglect and exploitation is represented by 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

FSM has made some progress in strengthening the child protection system; however, significant gaps and challenges remain.

6.2.1. The legal and policy framework for child protection

FSM lacks comprehensive child protection legislation or a national child protection policy or plan of action. The National Youth Policy 2004–2010 (applicable to young people between the ages of 15 and 24) included a focus on youth and justice, but not child protection more broadly.

Children's right to care and protection has been addressed under a variety of federal and state laws, with some notable gaps:

348 P. 41.

349 Interview with representatives of DoHSA, Pohnpei, May 2017.

350 Interview with representatives from DoHSA, Pohnpei, May 2017; KII with members of Youth Council of Pohnpei, May 2017.

Key child protection laws

Child care and protection	Federal Code (41FSMC5), Kosrae Family Protection Act 2015; State Codes (16KSC12, 23 CSC 9, 52PSC2)
Child custody and maintenance	Federal Code (6FSMC16)
Adoption	Federal Code (6FSMC16), State Codes (6KSC31, 23CSC7, 51PSC5)
Birth registration	41 FSMC 105
Child labour	None
Penalization of physical abuse, sexual abuse and sexual exploitation	FSM Trafficking in Person Act 2012; State Codes (12CSC4, 13KSC3, 5, 11YSC2, 6, 61PSC5, 9)
Child victims and witnesses in criminal proceedings	None
Violence in schools	None
Children in conflict with the law	Federal Code (12FSMC11), State Codes (23CSC11, 6KSC48, 53PSC4, 11YSC12)
Children with disabilities	Federal Code (40FSMC11)
Child protection in emergencies	Disaster Relief Act 1989; Disaster Risk Management Plan; Climate Change Policy

Federal and state laws establish 18 years as the age of majority and set some minimum ages designed to protect children from abuse and exploitation:

Legal definition of the child under FSM law

Definition of a child	Under 18
Minimum age for marriage	Kosrae, Chuuk and Pohnpei: 18 for males and 16 for females; none stipulated for Yap[v]
Minimum age for employment	None
Minimum age for engaging in hazardous work	None
Age for consent to sexual activity under criminal laws	Kosrae, Yap:13; Pohnpei: 16; Chuuk: 18
Minimum age of criminal responsibility	10
Maximum age for juvenile justice protections	18, but children from 16 can be treated as adults in some cases.

6.2.1.1. Legal framework for child and family welfare services

The FSM Federal Code and State Codes all include a declaration of the government's policy to provide for the protection of children who have injuries inflicted upon them and who may be further threatened or injured by the conduct of those responsible for their care and protection.[351] However, legislation is limited to mandatory reporting provisions obligating certain professionals to report to the police in the event a child has suffered serious injuries. There is no comprehensive legal framework guiding the delivery of child protection prevention, early intervention and response services, no stated obligation on the government to support parents in their child-rearing responsibilities, no clear authority for a government agency to intervene and protect a child who is suffering or at risk of harm (including, where necessary, removing the child from his/her parents or guardian), and no regulation of the various forms of alternative care.

In terms of child protection response procedures, the Federal and State Codes require that any person examining, attending, teaching or treating a child and having reason to believe that the child has had serious injury (physical or mental) inflicted upon him or her as a result of abuse, must report promptly to the district chief of police. These reporting obligations apply to physicians, dentists, health assistants, nurses, schoolteachers or other school officials, day-care workers, peace officers, or law enforcement officials. Reports can be made by telephone, but must then be committed to writing. The written report must include the name and address of the child and his or her parents or other persons responsible for his or her care, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries, and any other information that the maker of the report believes might be helpful in establishing the cause of the injuries and the identity of the person or persons responsible. [352]

However, both the Federal and State Codes are silent on what steps should be taken in response to a child abuse report to ensure the care, protection and well-being of the child. This lack of detailed statutory guidance acts as a significant barrier to ensuring a standardized, coordinated and multi-disciplinary response to children in need of protection. According to the survey of professionals conducted as part of the 2014 Child Protection Baseline Study, there are standard operating procedures for dealing with child abuse cases in the education and health sectors, and in the Social Affairs Division of the DoHSA. However, it is not clear if these provide detailed guidance on inter-agency referral and response procedures to ensure a holistic, multi-agency response to children in need of protection.

Kosrae has introduced a Family Protection Act in 2015 that aims to 'provide for the protection and safety of those persons who, by reason of their sex, age, marital status, physical or mental disability, or other condition, are subject to physical, sexual or mental abuse occurring within, or as a consequence of, their domestic interpersonal relationship with the abuser or abusers.[353] The Act classifies most domestic violence offences, including physical and sexual assaults, as felonies. In the other three states, similar bills have been drafted and submitted for consultation, but have not yet passed.

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351 Federal Code (41FSMC5); State Codes: 16KSC12, 23 CSC 9, 52PSC2.

352 Ibid.

353 Kosrae Family Protection Law. Tenth Kosrae State Legislature, L.B. No. 10-20, L.D. 3.

6.2.1.2. Legal framework for justice for children

The FSM State Codes criminalize various forms of violence, abuse and exploitation of children, including sexual assault, sexual abuse, incest, physical assault, exposing children to pornographic or obscene material (Kosrae, Pohnpei and Chuuk only) and endangering the welfare of children (Chuuk and Yap only).[354] There is no explicit prohibition against corporal punishment in the home, schools, detention or alternative care facilities, though this could amount to the offence of assault. Only Pohnpei and Chuuk criminalize prostitution, but with no specific provision for child prostitution, and none of the states criminalize production, sale, or distribution of child pornography in accordance with the Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography. Trafficking in children has been comprehensively addressed under the FSM Trafficking in Person Act 2012, which includes a specific offence of trafficking in children defined in accordance with the Trafficking Protocol.[355] However, there is no minimum age for employment or regulation of the condition of employment for children under either federal or state laws, which leaves children exposed to exploitation.

FSM has yet to introduce special procedure to ensure that investigation and trials involving a child victim or witness are conducted in a child-sensitive manner and that measures are taken at all stages of the criminal process to facilitate the child's testimony and reduce hardship and trauma. No special provision has been made for child victims and witnesses under either the criminal procedure laws or the State Rules of Criminal Procedure. The lack of special measures to facilitate children's effective participation in the criminal justice process is a significant barrier to children accessing child-friendly justice, and to the effective prosecution of perpetrators.

Penalisation of violence, abuse and exploitation of children

FSM State Codes prohibit various forms of violence, abuse and exploitation of children under their general provisions relating to offences against the person and offences against public welfare, including the Yap State Code (11 YSC 2 and 6), the Kosrae State Code (13 KSC 3 and 5), the Chuuk State Code (12 CSC 4) and the Pohnpei State Code (61 PSC 5 and 9.) All States have set a minimum age for consent to sex which is generally in line with international standards. Chuuk recently raised the age of consent to 18, which was intended to provide added protection to children but may lead to an increase in teenagers being prosecuted for engaging in consensual sexual conduct. Current provisions on child prostitution and child pornography fail to meet FSM's obligations under the Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography. Access to justice for children and effective prosecution of perpetrators is hampered by the lack of special measures to facilitate children's testimony.

FSM does not have a comprehensive law governing the handling of children in conflict with the law; however, both the Federal and State Codes set out limited provisions in relation to 'juveniles'.

354 State Codes: 12CSC4, 13KSC3, 5, 11YSC2, 6, 61PSC5, 9.

355 Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Conventions against Transnational Organized Crime (Palermo Protocol).

The Federal Code does not set a minimum age of criminal responsibility, stating only that children under the age of 14 are not criminally responsible 'unless there is clear proof that at the time of engaging in the wrongful conduct, they knew it was wrong.'[356] The State Codes establish 10 as the minimum age of criminal responsibility, and reiterate the presumption under the Federal Code in relation to children between the ages of 10 and under 14. This is below the 'absolute minimum' age of 12 recommended by the UN Committee on the Rights of the Child.[357] In addition, both the Federal and State Codes allow children of any age to be disciplined for 'delinquency'. Both the Federal and State Codes define children as 'delinquent' and penalize them for the status offences of being habitually truant from home or school, not being under the reasonable control of their parents or guardian, being 'wayward or habitually disobedient' and, under the Yap State Code, violating curfew.

Courts are required under the Federal and State Codes to adopt 'flexible' procedures when dealing with cases of children, including: 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. The Yap State Code further requires: notice to parents or guardian that the minor has been taken into custody whether or not the minor has been charged; written notice of the specific charge or factual allegations given to the child and his parents or guardian sufficiently in advance of the hearing to permit preparation; notification to the child and his parents or guardian of the child's right to counsel; advising the child and his or her parents or guardian, by the court, of the child's right against self-incrimination; access to social records and probation or similar reports; and presence of the child's parents or guardian throughout the proceedings. Punishments upon conviction (for both children and adults) include imprisonment, fines, probation and community service.[358] The Yap State Code also makes provision for children to be placed in the custody of their parents, guardians or some other responsible adult with authority over the child under custom and tradition as an alternative to confinement.

FSM's law on children in conflict with the law

There is no separate system of law for children in conflict with the law in FSM, though titles within the Federal Code (12FSMC11), the Yap State Code (11YSC12), the Kosrae State Code (6KSC48) and the Chuuk State Code (23CSC11) set out limited provisions in relation to 'juveniles'.

These special procedures generally apply to all children in conflict with the law who are under the age of 18; however, under the Federal and State Codes, children from the age of 16 may be tried as adults 'if in the opinion of the court his physical and mental maturity so justifies.'[359] In general,

356 3FSMC301A.

357 UN Committee on the Rights of the Child, General Comment No. 10, para. 30.

358 11FSMC1202.

359 12FSMC1101.

the existing safeguards for children in conflict with the law fall short of FSM's obligations under the CRC and international standards. No provision has been made for limits on arrest, police custody and use of force, for the presence of a parent or legal representative at all stages of the proceedings (other than in Yap), or for pre-trial diversion of children. There is no explicit statement of the principle of deprivation of liberty as a last resort and for the shortest appropriate period, there is a limited range of non-custodial alternatives at the pre-trial stage and after conviction and children's right to be separated from adults in places of detention is not absolute. The Department of Public Safety, which also handles the prison, lacks Minimum Standard Rules for prisoners, including child offenders.

6.2.2. Child protection structures, services and resourcing

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

6.2.2.1. Child and family welfare services

The CRC Unit of the Division of Social Affairs is the lead agency for child protection in FSM and is responsible for the promotion of child protection policies and the prevention of violence, abuse, neglect and exploitation of children. At the national level, the Department of Social Affairs has staff responsible for the monitoring of compliance regarding the CRC, as well as a staff member responsible for youth activities. However, there is a very limited number of social workers in the state governments throughout FSM.[360]

A number of civil society organizations (CSOs) and youth groups also provide prevention programmes, such as Youth for Change, which conducts awareness-raising for youth in communities, the Women's Advisory Councils, which provide early child education programme to young parents, and the Salvation Army. There are also youth counselling programmes on HIV/AIDS, teen pregnancy, sexually transmitted infections and drug and alcohol awareness.[361]

The responsibility of the CRC Unit in responding to children in need of protection and providing comprehensive case management is not clear in law or in practice. Although the Division of Social Affairs holds responsibility for matters affecting children, one key informant suggested that this may not be the situation in practice, or that this responsibility has not been made clear to others working in child protection or related fields.[362] There is a lack of effective coordination, and reportedly a lack of clarity among agencies as to where to refer cases.[363] The 2014 Child Protection Baseline Study noted that the Social Affairs Division focused more on promotion and prevention,

360 KII with representatives from DoHSA, Pohnpei, May 2017.

361 Government of FSM and UNICEF, Child Protection Baseline Study, 2014, p. 73.

362 Interview with representatives from Pohnpei State Governor's Office, May 2017.

363 Interview with representatives from DoHSA, Pohnpei, May 2017.

rather than care and protection, and that the child protection case management system was currently not operational.[364]

Social welfare services for children who have experienced violence, abuse, neglect or exploitation are limited. The 2014 Child Protection Baseline Study notes that that some counselling is available through the Division of Social Affairs, churches and CSOs, and that there are substance abuse programmes and programmes to support pregnant teens. However, the study found that welfare services for children were poorly coordinated and there was no adequate support, coordination and supervision by government agencies of CSOs delivering the programmes. A key barrier to children's access to existing services is that they are not well known within the community, and as a result are underused. Official reporting and requests for help in child abuse cases are also quite low owing to community perceptions that violence is a 'family matter'.[365]

FSM has limited alternative care services for children who are without parental care or cannot, for their own safety, remain with their parents. In all four states, alternative care arrangements have traditionally been made informally within families and communities. Many children in FSM live with relatives other than their parents (39 per cent of children in Yap, 39 per cent in Chuuk, 40 per cent in Pohnpei and 44 per cent in Kosrae), a rate considered 'high' in the 2013 Atlas of Social Indicators.[366] While these arrangements are often within the best interests of the child, formalization of and oversight over kinship and foster care arrangements would better ensure the child is safeguarded.[367] FSM currently has no formalized foster care programme or residential care facilities for children.[368] A representative from the DoHSA explained that, in relation to the child protection system as it functions at present, '*In terms of housing these children, there is nothing – a few months back, we needed to house some kids as they were just moving about as they had no support system. We had nowhere to place them. We were looking at how best to respond to these children, but there are no facilities*.' [369]

In addition to child protection, the Division of Social Affairs is also responsible for several other issues and faces significant resource constraints. Financially, there are no special budget allocated funds attached to the assistance of children in need of protection.[370] Lack of adequate resources is a significant barrier to the development of a comprehensive child protection system. FSM also faces significant geographical challenges to service delivery, data collection and monitoring, with 600 islands dispersed over approximately 3 million km^2 of the Pacific Ocean.

364 P. 10.

365 P. 34–35.

366 UNICEF, 'Atlas of Social Indicators. FSM', 2013. p. 54.

367 Government of FSM and UNICEF, Child Protection Baseline Study, 2014, p. 10.

368 Interview with representative from Public Defender's Office, May 2017.

369 Ibid.

370 Government of FSM and UNICEF, Child Protection Baseline Study, 2014, p. 34.

Case study

A representative from the DoHSA recounted a specific case that highlighted the existing barriers in the child protection system in FSM.

Question: What happens when a child is sexually abused? How does the community and authorities respond?

If it is major … where there is a clear sign that the victim needs to go to hospital – they go to hospital and the procedure is they should report it to public safety (police), but in reality, there is no mechanism to provide services for victims. Doctors are hesitant to report cases to police as there is nothing to support the victims when they do make a report. Sometimes the cases are sent to public safety (police), but at some point they are dropped.

Question: Why?

It is unclear – I can't understand why these cases get dropped. It is a small place so the relatives might influence the police. Sometimes the doctors have to report, but there is no support system for victims, so the doctors are reluctant. It might expose the victim as a victim, without even giving them support, so it is risky. If it's severe, it gets reported, but I don't know what happens after that.

Question: In the case of 'severe abuse' by a father, where would the child be taken?

'We had a recent case [in which] kids were taken to a church, as the father was trying to force the kids into prostitution … [the] church was asking for help – they couldn't understand the behaviour of the children and they didn't know how to provide support. The children were transferred to the women's centre to be counselled and looked after. But the same problem happened – they had to call the police again and I think they ended up being transferred to the relatives. But in these situations, normally we utilize the extended families.

This case study reveals the interconnectedness of demand and supply barriers: without a suitable system in place to provide services and protection to children after referral, doctors are reluctant to report cases for fear of causing harm to the child. The case study also reveals concerns over police handling of cases involving sexual abuse, but also over the lack of services available to support and rehabilitate children where such abuse is identified and referred.

6.2.2.2. Access to child-friendly justice

FSM has made some progress in promoting specialization in the handling of cases involving child victims and witnesses. A Transnational Crime Unit has been established under the FSM Department of Justice, and nation-wide training has been provided to police and public safety officials on the Human Trafficking Act. In Pohnpei, a Domestic Violence Unit has been set up within the State Department of Public Safety and police have been provided specialist training. Pohnpei, Yap and Kosrae have 'no-drop' policies designed to increase charging of alleged perpetrators of domestic violence.[371]

371 US Department of State. 2016 Human Rights Report: Federated States of Micronesia. Bureau of Democracy, Human Rights, and Labor.

However, barriers remain to ensuring that child victims have access to justice and perpetrators are effectively prosecuted. Reportedly few, if any, justice representative have had specific training in handling cases of violence, abuse and exploitation of children, though some may have attended a workshop on the subject.[372] A US Department of State report noted that four cases of trafficking in children came before the courts in 2016, but all were dismissed for inadequate police handling of evidence.[373] The 2014 Child Protection Baseline Study highlighted concerns about overall lack of training and resources within the justice sector to ensure timely and effective handling of children's cases.[374] Effective prosecution of violence against children is also hampered by under-reporting and the police perception that domestic violence it is a private family problem. A key informant noted that, even when child victims did come forward, lack of services often hindered effective investigation:

> *'A girl who was being abused, but the mum kept denying it to the police saying she was making it up. Since we don't even have a service to bring in the girl to have her checked out for signs of abuse, the police will just take the dad and question him and the case will get thrown out and the mum will defend the dad most of the time. They will be saying that the child is just making it up. We cannot get physical evidence because there are no services to physically check the person.'*[375]

With respect to children in conflict with the law, the 2014 Child Protection Baseline Study noted that, although there are codes of conduct, police manuals and standard operating procedures (SOPs) for the police on handling cases involving children, there is a lack of knowledge of them by police officers, poor compliance, poor oversight and poor enforcement.[376] There are no specialized courts for children, but proceedings involving a juvenile accused are conducted separately from adult proceedings. The courts 'ensure that parents/guardians of individuals charged as young offenders are involved in the trial process when they choose to be involved, and that the young person is legally represented.'[377] However, concerns have been raised that difficulties with age determination and lack of skilled professionals means that these safeguards are not uniformly applied in all children's cases. One key informant reported, for example, that, in Chuuk, '*Even though a person is a juvenile, they file a case against them as an adult and stuck them in jail for a while … there are not many birth certificates and so they are treated as adults*.' Age determination can slow the justice process down if the child does not have a birth certificate or is not registered with a church. There are also concerns that the limited availability of trained professionals to assess children means determination about criminal capacity is made based on the use of a checklist by a lay person.[378]

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372 Government of FSM and UNICEF, Child Protection Baseline Study, 2014, p. 67.

373 US Department of State, 2016 Human Rights Report: Federated States of Micronesia, Bureau of Democracy, Human Rights, and Labor.

374 DoHSA Family Health and Safety Study 2014, pp. 8–9; Radio New Zealand, 'Micronesian Police Attend Sensitising Workshop', 2016, on www.radionz.co.nz/international/programmes/datelinepacific/audio/201800371/micronesian-police-attend-sensitising-workshop [19.06.17].

375 Ibid.

376 P. 62.

377 Pp. 8–9.

378 Ibid.

No data were available on sentencing practices of the court. Key informants advised that, in many cases, convicted children were sent home to their families rather than being subjected to imprisonment.[379] However, there are limited services available to aid children's rehabilitation and reintegration. Some support programmes are available through churches and CSOs, primarily counselling, vocational training and alternative basic or secondary education, but the 2014 Child Protection Baseline Study notes that these services are poorly coordinated and receive little support from the government. FSM does not have separate detention facilities for children, and as a result children who commit serious offences may be held in the same facilities as adults. The Baseline Study states that children are kept separate from adult prisoners;[380] however, key informants advised that they were sometimes held in custody alongside adults.[381] There is no authority designated responsible for the reintegration of children after their release.[382]

No data were available on the use of pre-trial diversion in children's cases. The Baseline Study notes that there is a diversion programme for children involved in substance abuse and for those with mental health problems.[383] In addition, informal justice mechanisms are reportedly commonly used as an alternative to the formal justice process in cases involving both children in conflict with the law and child victims.[384] As one key informant from the Department of Justice explained:

> *'Parents of the child can go and do an apology to the other family for the child's act and then they don't even have to go to the court or report the matter to the police. They will just apologize and be forgiven. Sometimes the chief will interfere and bring together the two families. If a child is committing crime – the chief will be the one responsible to ensure that there is no repeat offence committed by child.'*[385]

When asked what types of punishments were used in their community for children in conflict with the law, respondents who participated in the 2014 Child Protection Baseline Study stated that physical punishment, community work, restitution, traditional practices and counselling were the most common.[386]

The use of informal justice mechanisms can, with proper safeguards, benefit children in conflict with the law because it removes them from the formal justice process and has greater potential for promoting rehabilitation and reintegration. However, the use of physical punishment by communities as a means of resolving juvenile offending is cause for concern. Concern has also

379 Interview with representative from the Department of Justice, May 2017; interview with representative from Public Defender's Office, May 2017.

380 P. 67.

381 Interview with representative from Public Defender's Office, May 2017.

382 Government of FSM and UNICEF, Child Protection Baseline Study, 2014, p. 66.

383 Ibid.

384 Van Welzenis, I., 'Country-Level Summaries of Diversion and Other Alternative Measures for Children in Conflict with the Law in East Asian and Pacific Island Countries', Internal UNICEF EAPRO Report, 2016, p. 152.

385 Interview with representative from Department of Justice, May 2017.

386 P. 32.

been expressed that resolving incidents of violence against children through informal justice mechanisms prioritizes community reconciliation and peace over ensuring the best interest of the child and does not provide adequate support and protection for child victims.[387]

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

According to the survey of professionals conducted as part of the 2014 Child Protection Baseline Report, there are SOPs dealing with child abuse, violence and exploitation cases in the education and health sectors; however, these are not being consistently applied in practice.[388] While health professionals reportedly provide medical care and treatment to child victims of violence and exploitation, FSM has yet to develop detailed guidance and training for health workers on identification and response to child abuse, and on forensic medical examination of child victims.

FSM also lacks a detailed policy on child protection in schools. A key informant from the DoE advised that corporal punishment in schools was against the law and was 'not accepted among the communities' to the extent that, in the informant's opinion, communities would respond negatively to and challenge any corporal punishment of children that they observed.[389] The 2014 Child Protection Baseline Study notes that all schools are expected to have rules and policies that guide the behaviour of students, teachers and administrators. However, these tend to be 'general school and discipline rules' regulating children's behaviour, rather than separate or explicit 'child protection policies'. Teachers and counsellors have reportedly been trained on reporting of suspected cases and spotting potential abuse cases, and the DoE also has programmes to reach out to school drop-outs to re-enrol them, and to encourage pregnant teens to stay in school.[390]

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

FSM does not have a national coordinating council or committee responsible for child protection strategic planning and inter-agency coordination. The 2014 Child Protection Baseline Study notes that FSM has a Presidential National Advisory Council on Children, but it is not fully active.[391]

FSM also lacks a child protection information management system or other robust mechanism to ensure accountability and evidence-based planning in child protection. There are limited systems in place for systematic data collection, research, monitoring and evaluation. The Division of Social Affairs is responsible for collecting data on children's issues, and the 2014 Child Protection Baseline Study provided a useful snapshot of the child protection situation. However, 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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387 US Department of State. 2016 Human Rights Report: Federated States of Micronesia. Bureau of Democracy, Human Rights, and Labor.

388 P. 30.

389 Interview with representative from federal DoE, Pohnpei, May 2017.

390 P. 39.

391 P. 70.

6.3. Other Child Protection Issues

6.3.1. Birth registration

Pursuant to the FSM Federal Code, the Department of Health Services is responsible for prompt collection of vital statistical information concerning all births, preparing forms and issuing instructions necessary for the uniform registration of births, filing a copy of the certificate of birth or with the clerk of courts of the district in which the birth occurred, and compiling, analysing and publishing vital statistics concerning births. State courts are responsible for issuing birth certificates.[392]

The 2014 Child Protection Baseline Study in FSM suggested that 'Birth registration is not considered a major problem in FSM since most births occur at hospitals and children are registered at birth.' It also noted that, where children are not registered at birth, the process is completed when they register at schools, around the age of five, as having a birth certificate is a requirement of school enrolment,[393] and thus is considered an enabler for the registration of all children.[394] For births that occur outside of hospital, traditional birth attendants have been trained in the birth registration processes.[395] There are also some mobile registration facilities, which are connected to school registration and immunization centres. However, a US Department of State report notes that, on remote outer islands where there are no hospitals, authorities do not register children until and unless they come to a main island for education.[396]

6.3.2. Children with disabilities

Section 4 of the FMC Constitution guarantees equality and prohibits discrimination on the grounds of sex, race, ancestry, national origin and social status, but not disability. However, its commitment to protect the rights of persons with disabilities has been affirmed with the ratification of the Convention on the Rights of Persons with Disabilities in 2016 and adoption of the National Policy on Disability 2009–2016. The latter identifies priority areas for action in order to promote a more inclusive society, create greater awareness of the needs of persons with disabilities and improve the delivery of disability services. By law, children with disabilities have the right to special education and training up to the age of 21.[397]

Screening of infants and children to detect disability takes place at Well-Baby Clinics, during annual Child Find Surveys, at community mobile clinics and during school physical examinations. Between 2007 and 2011, approximately 17 per cent of children with identified development difficulties were comprehensively assessed and admitted to the Children with Special Health

392 41 FSMC 105.

393 P. 11.

394 P. 75.

395 Pp. 11, 75.

396 US Department of State. 2016 Human Rights Report: Federated States of Micronesia. Bureau of Democracy, Human Rights, and Labor.

397 Federal Code (FSMC107).

Care Needs (CSHCN) Programme (an average of 56 children annually). This programme is a collaborative interagency effort involving the Maternal and Child Health Programme, the Special Education Programme, the Early Childhood Education Programme, the state hospital, and community nutrition programmes. In 2011, a total of 1,160 children (0–21 years) were recorded in the CSHCN Registry as eligible for individualized clinic and follow-up services. Funding for services and programming for children with disabilities is provided through US federal grant programmes to the government of FSM, which focuses mainly on education but also includes special preschool; transition programmes between the home, school and work; training for parents and other care-givers; and related services such as speech or physical therapy and vocational guidance. However, it has been recognized that there remain many gaps in the service delivery system for children with special needs because of a critical shortage of appropriately trained professionals and transportation problems.[398] In 2011, less than half of families caring for children with disabilities indicated that community-based service systems were well-organized, only 54 per cent were satisfied with the services they received, and only 25 per cent of youth with special health care needs received the services necessary to make transitions to all aspects of adult life (including adult health care, work and independence).[399]

6.3.3. Climate change and natural disasters

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

Governance of disaster risk management and climate change is delivered through the FSM Climate Change Country Team and the FSM National Disaster Committee. The FSM Strategic Development Plan includes strategies for addresses climate change by raising awareness of climate change among the general population; developing coastal management plans in all four states; and developing ways to 'climate proof' facilities and structures that support social and other services. A Disaster Risk Management and Climate Change Policy have been developed for the FSM, building on the Disaster Relief Act 1989, to provide overarching policy guidance for joint Disaster Risk Management and Climate Change Action Plans at state level.[400] However, children are not identified as a particularly vulnerable group, and child protection has not been integrated into emergency preparedness or response plans.

398 UNICEF 'Children in the Federated States of Micronesia: An Atlas of Social indicators', 2013, p. 48.

399 CSHCN Survey, in: Title V Information System (FSM Application for Title V MCH Block Grant for FY2013, DHSA, 2012).

400 UNICEF 'Children in the Federated States of Micronesia: An Atlas of Social Indicators, 2013', p. 57.

7.

Social Protection

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

According to UNICEF, social protection is 'the set of public and private policies and programmes aimed at preventing, reducing and eliminating *economic* and *social* vulnerabilities[401] to poverty and deprivation, and mitigating their effects'.[402] Social protection systems are essential to ensuring realization of the rights of children to social security (CRC Article 26) and a standard of living adequate for their physical, mental, spiritual, moral and social development (CRC Article 27). According to Article 27(2) of the CRC, State Parties are required to 'take appropriate measures to assist parents and others responsible for the child to implement this right [to an adequate standard of living] and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing'.

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

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

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

In order to achieve this, SDG 1.3 requires the implementation of 'nationally appropriate social protection systems and measures for all, including [social protection] floors'. A social protection floors consist of two main elements: essential services (access to WASH, health, education and social welfare); and social transfers (a basic set of essential social transfers in cash or in kind, paid to the poor and vulnerable).[403]

Key Social Protection-related SDGs

SDG	Target	Indicators
1.1	By 2030, eradicate extreme poverty for all people everywhere, currently measured as people living on less than US$ 1.25 a day	Proportion of population below the international poverty line, by sex, age, employment status and geographical location (urban/rural)
1.2	By 2030, reduce at least by half the proportion of men, women and children living in poverty in all its dimensions according to national definitions	Proportion of population living below the national poverty line, by sex and age
		Proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions
1.3	Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable	Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable
1.4	By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance	Proportion of population living in households with access to basic services
		Proportion of total adult population with secure tenure rights to land, with legally recognized documentation and who perceive their rights to land as secure, by sex and by type of tenure

Under UNICEF's Social Protection Strategic Framework, to achieve social protection it is necessary to develop an integrated and functional social protection system. This means developing **structures and mechanisms** to coordinate interventions and policies to effectively address multiple economic and social vulnerabilities across a range of sectors, such as education, health, nutrition, WASH and child protection.[404]

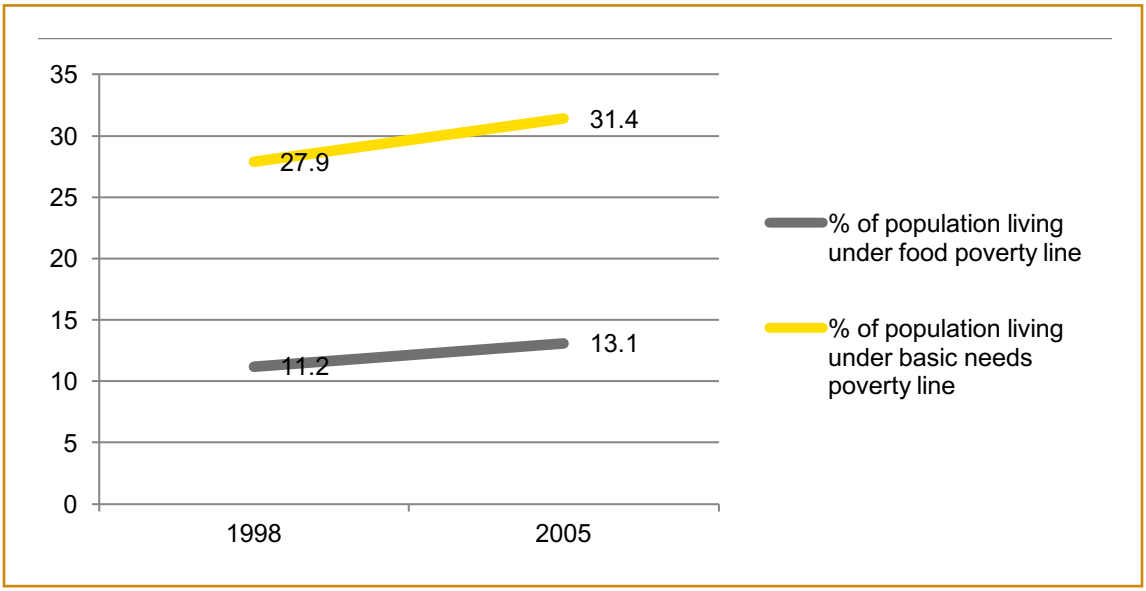
403 ILO and WHO, 'The Social Protection Floor: A Joint Crisis Initiative of the UN Chief Executive Board for Coordination on the Social Protection Floor', October 2009, on http://www.un.org/ga/second/64/socialprotection.pdf [14.08.17].

404 UNICEF Social Protection Strategic Framework, p. 31.

7.1. Profile of child and family poverty and vulnerability

As set out above, a significant proportion of FSM's population is living in poverty or facing hardship. Unfortunately, recent data are not available: a Household Income and Expenditure Survey (HIES) was carried out in 2013–2014 but has not yet been the subject of a poverty analysis (a poverty/hardship analysis is in draft format but is reportedly awaiting finalization).[405] According to the 2005 HIES, 13.1 per cent of households are living below the food poverty line, and 31.4 per cent are living below the basic needs poverty line; these poverty rates are quite high in comparison with other countries in Micronesia. Poverty also increased between 1998 and 2005, as Figure 7.1 shows.

Figure 7.1: Proportion of population living below basic needs and food poverty lines, 1998 and 2005



Source: Office of Statistics, Budget and Economic Management data[406]

This represents an increase in food poverty of 6.6 per cent and basic needs poverty of 14 per cent between 1998 and 2005. In addition, some households were found to be vulnerable to poverty: in 2005, 4.8 per cent had expenditures less than 10 per cent above the basic needs poverty line. After the 2005 HIES was carried out, the 2010 MDG Status Report found 'increased oil and food prices have created widespread hardship while the number of jobs has declined', making it likely that households vulnerable to poverty had slipped under the basic needs poverty line, increasing the poverty rate. This indicates that FSM may not be progressing well against SDG target 2.1 (reduction by at least half the proportion of the population living in poverty according to national definitions).

405 KII with representative from the Statistics Division, Department of Resources and Development, Palikir, May 2017.

406 'Millennium Development Goals and the Federated States of Micronesia: Status Report', 2010; HIES 2005.

It has been suggested that the rise in the incidence of basic needs poverty between 1998 and 2005 was a reaction to slow rates of economic growth (caused by an interplay of factors including out-migration, declining commercial agriculture, slow tourism growth and lack of new investment), and a decline in incomes as a result of a freeze in public sector wages.[407]

Children appear to be more at risk of poverty in FSM. The proportion of children (aged 0–14 years) living below the basic needs poverty line was higher than the proportion of the total population living below the basic needs poverty line in 2005: 33 per cent compared with 31.4 per cent.[408] Children were also more likely to be vulnerable to poverty: 9 per cent of children aged 0–14 years were living less than 10 per cent above the basic needs poverty line compared with 4.8 per cent of the total population.[409] The rates of food poverty were the same for children as for the total population.[410] The impacts of poverty are more significant for children, and there is growing evidence that children experience poverty more acutely than adults: the negative impacts of poverty on their development can have profound and irreversible effects into adulthood.

Unfortunately, a multi-dimensional child poverty assessment does not appear to have been carried out in FSM.

As in most countries, national poverty averages in FSM mask inequalities within the country. Rates of basic needs poverty are spread fairly evenly across the states; however, poverty rates are significantly lower in Yap, as Figure 7.2 shows. Interestingly, Yap State has the lowest reliance on cash incomes, and high rates of production for own consumption: according to the 2013–2014 HIES, a quarter of consumption is home-produced (compared with only 15 per cent at the national level and only 5 per cent in Kosrae).

However, the 2013–2014 HIES points to significant inequality between states. According to this survey, Pohnpei accounts for half of FSM's total expenditure but only a third of its population. Chuuk, in contrast, contains almost half of the population of FSM but contributes less than 30 per cent to total expenditure. More than 60 per cent of households in the lowest quintiles (quintiles 1 and 2) are from Chuuk and more than half of the high-income quintile (quintile 5) from Pohnpei.[411]

Rates of poverty were fairly consistent in most states between in 1998 and 2005. Only in Kosrae was there a significant increase in the rate of basic needs poverty. This has been attributed to 'public sector retrenchment there without comparable private sector growth'.[412]

407 Government of FSM and UNDP Pacific, 'Federated States of Micronesia: Analysis of the 2005 Household Income and Expenditure Survey', 2008, p. 26.

408 Government of FSM and UNDP Pacific, '2005 HIES Analysis', 2008.

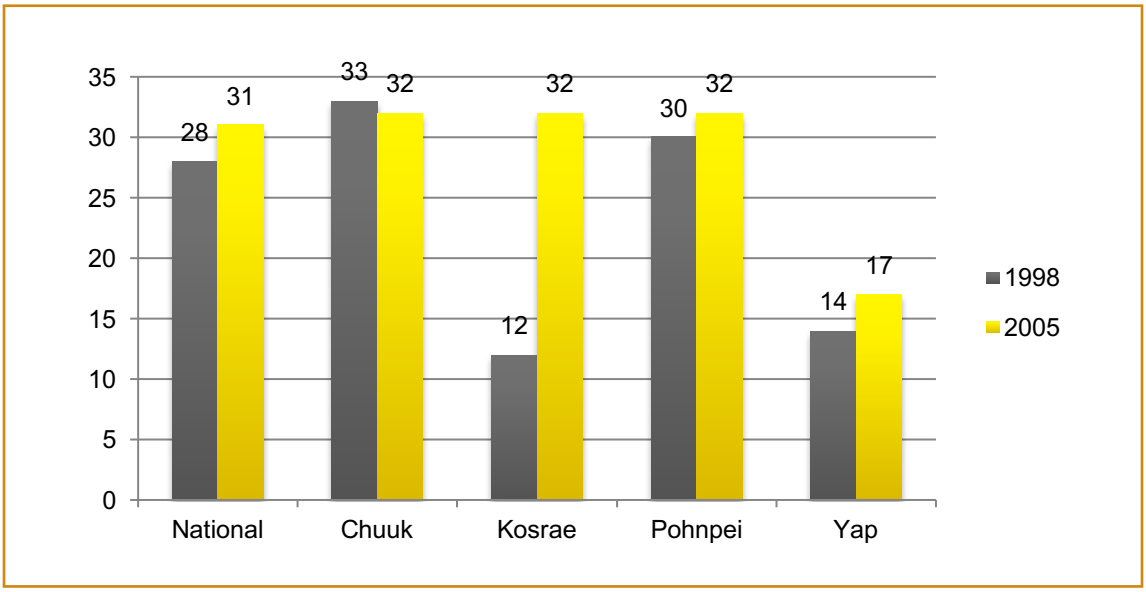
409 UNDP, 'State of Human Development in the Pacific: A Report on Vulnerability and Exclusion at a Time of Rapid Change', 2014.

410 Government of FSM and UNDP Pacific, '2005 HIES Analysis', 2008.

411 Office of Statistics, Budget and Economic Management, 'HIES 2013–2014 Main Analysis Report', 2014.

412 MDG Status Report, 2010.

Figure 7.2: Proportion of population living below basic needs poverty line by state, 1998 and 2005



Source: Office of Statistics, Budget and Economic Management data[413]

Unfortunately, there seems to be no recent analysis of poverty in urban vs. rural locations. However, a recent report by the World Bank found that rural poverty in FSM (and other PICTs) was likely to be structurally persistent. In particular, poverty on the Outer Islands was reported to be 'associated with multiple deprivation and a lack of cash livelihoods', with those living there finding it difficult to move out of poverty and vulnerable to falling back into poverty once they did.[414]

Income and expenditure levels are associated with gender in FSM: according to the 2013–2014 HIES, female-headed households contribute 18 per cent to the total national household income, while households headed by men earn on average 9 per cent more than female-headed households. The gender dimension of poverty is particularly pronounced in Chuuk: here, households headed by men earn 42 per cent more than households headed by women.

Poverty is also associated with educational level and employment/type of economic activity. According to the 2005 HIES, households without any member in employment were disproportionately represented in the lower income deciles: while nationally 18.4 per cent of all households were without any member in employment, these households accounted for 22.1 per cent in the bottom three deciles. However, employment was found not to be a guarantee against poverty. A significant proportion of households with one or more employed members still fell below the poverty line, particularly where the employment was in the informal sector: in Yap, 42.8 per cent of households in the lowest three deciles had at least one person in

413 MDG Status Report, 2010; HIES 2005.

414 World Bank, 'Systematic Country Diagnosis, Republic of Kiribati, Republic of Marshall Islands, Federated States of Micronesia, Republic of Palau, Independent State of Samoa, Kingdom of Tonga, Tuvalu, Republic of Vanuatu', 2016.

employment; in Chuuk and Pohnpei, this proportion was 42.0 per cent and 31.4 per cent, respectively.[415]

According to the 2005 HIES, households in the lowest quintiles are disproportionately headed by persons with no or low educational level. While at the national level 7.2 per cent of heads had no schooling, these households accounted for 11.6 per cent of households in the bottom three deciles, and only 4 per cent in the highest three deciles. Household heads with elementary-level education accounted for 35.8 per cent of all households but 46.6 per cent in the poorest three deciles.[416]

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

Persons living below the poverty line are also more vulnerable to natural disasters. In particular, such disasters particularly affect subsistence farmers who depend more on natural resources for their livelihoods.

The causes of child and family poverty in FSM are complex, interconnected and open to fluctuation. As a small island economy, FSM faces many challenges confronting PICTs more generally, including distance from global markets, limited and fragile resource bases, inability to achieve economies of scale, vulnerability to changes in the global economy and vulnerability to natural disasters, which cause economic shocks.[417] FSM, being heavily reliant on imports, is particularly vulnerable to shocks caused by global price fluctuations. In particular, 'in recent years, food and fuel prices have been high and volatile'; FSM, like most PICTs, 'lacks the resources and size to insulate their people from these shocks'.[418] It is also heavily reliant on foreign aid, particularly that received under the Compact agreement with the USA. It is also vulnerable to other external shocks, including climate change in particular (as discussed above). As a country that relies heavily on its marine resources to generate livelihoods, the impacts of climate change will be significant. A weak regulatory framework, causing costs and risks to doing business, impedes opportunities for economic growth.[419]

A limited economic base and exposure of the economy to shocks has led to a poverty of opportunity in PICTs, including FSM, which has a significant number of unemployed, particularly young people. Across the Pacific, economies are not able to generate sufficient jobs for the number of job-seekers. Also, the large number of young people with inadequate skills contributes to the youth unemployment.[420] According to the most recent census data (2010), the youth unemployment rate was 11.3 per cent.

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415 P. 32.

416 Ibid.

417 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific: The Role of Social Transfers', 2012, p. 4.

418 World Bank, 'Hardship and Vulnerability in the Pacific Island Countries', 2014, p. 58.

419 World Bank, 'Systematic Country Diagnosis', 2016, p. 75.

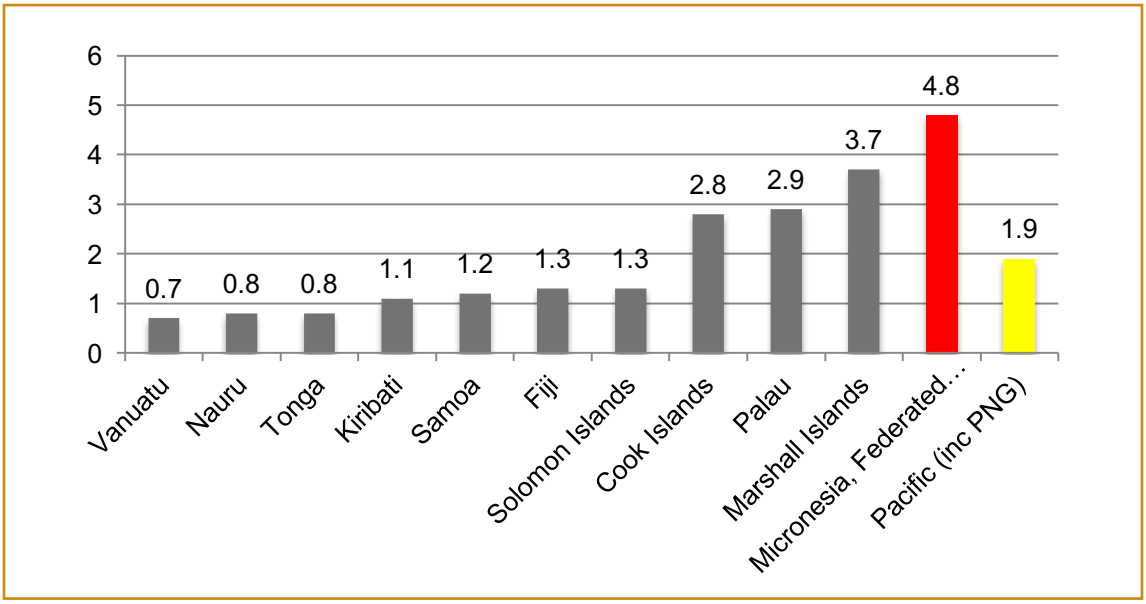
420 AusAID, 'Poverty, Vulnerability and Social Protection in the Pacific', p. 4.

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

Social protection encompasses many different types of systems and programmes, including social insurance (e.g. contributory schemes to provide security against risk, such as unemployment, illness, disability, etc.); social assistance (non-contributory measures such as regular cash transfers targeting vulnerable groups, such as persons living in poverty, persons with disabilities, the elderly, children); and social care (child protection prevention and response services, detailed in Chapter 6). There has been a growing acceptance in recent times that social security, in particular the provision of regular cash transfers to families living in and vulnerable to poverty, should be a key component of a social protection system.[421] Cash transfers provide households with additional income that enables them to invest in children's well-being and human development.[422]

The comprehensiveness and impact of FSM's 'formal' social protection system appears to rate favourably compared with those in other PICTs. The Asian Development Bank's (ADB's) Social Protection Indicator (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. The SPI for FSM was, in 2016, 4.8. This is significantly higher than the Pacific regional average (including PNG) of 1.9,[423] as set out in Figure 7.3.

Figure 7.3: Social Protection Indicator by country



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

421 UNICEF and Fiji Ministry of Women, Children and Poverty Alleviation', 'Child-Sensitive Social Protection in Fiji', 2015, p. 6.
422 UNICEF, Social Protection Strategic Framework, 2012.
423 ADB, 'The Social Protection Indicator: Assessing Results for the Pacific', 2016, p. 16.

However, according to the data, the vast majority of social protection expenditure is for social insurance measures, as Table 7.1 shows.

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

Programme	Social Protection Indicator (%)
Overall	4.8
Social assistance	0.3
Labour market programmes	-
Social insurance	4.5

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

Social insurance is provided through a contributory pension fund, which applies to persons over a set retirement age (65 years for the national government and Kosrae State and 60 for other states). The fund reportedly has 6,500 beneficiaries.[424] 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 to the poorest members of society. Contributory schemes involving formal sector workers also tend to have a gender bias, as the majority of such workers are men.[425] In FSM, women face particular challenges accessing formal employment. According to the latest census data (2010), the labour force participation rate is 66.1 per cent for males and 48.4 per cent for females. This inequitable access has been attributed to 'traditional ideas about the roles of women, historic limitations on women's participation in education, lack of control by women over land and other productive resources, and difficulties women face in accessing credit'.[426]

Therefore, although the scheme covers a significant number of beneficiaries, it does not target the most vulnerable members of the population.

The benefit structure of social insurance in FSM, along with that in Marshall Islands and Palau, differ from the provident funds in other PICTs. In contrast with 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 interest generated on these. They also include a contributory disability pension; however, this is available only to persons who work in the formal sector.[427]

The sustainability of the social insurance scheme is questionable. It was noted that slow growth in the number of contributing members means the number of beneficiaries is increasing faster

424 KII with representative from Social Security Administration, Kolonia, Pohnpei, May 2017.

425 UNDP, 'State of Human Development in the Pacific', 2014.

426 Pacific Forum Secretariat, 'Gender Profile: Federated States of Micronesia', on http://www.forumsec.org/resources/uploads/attachments/documents/FSM_Gender_Profile.pdf [17.08.17].

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

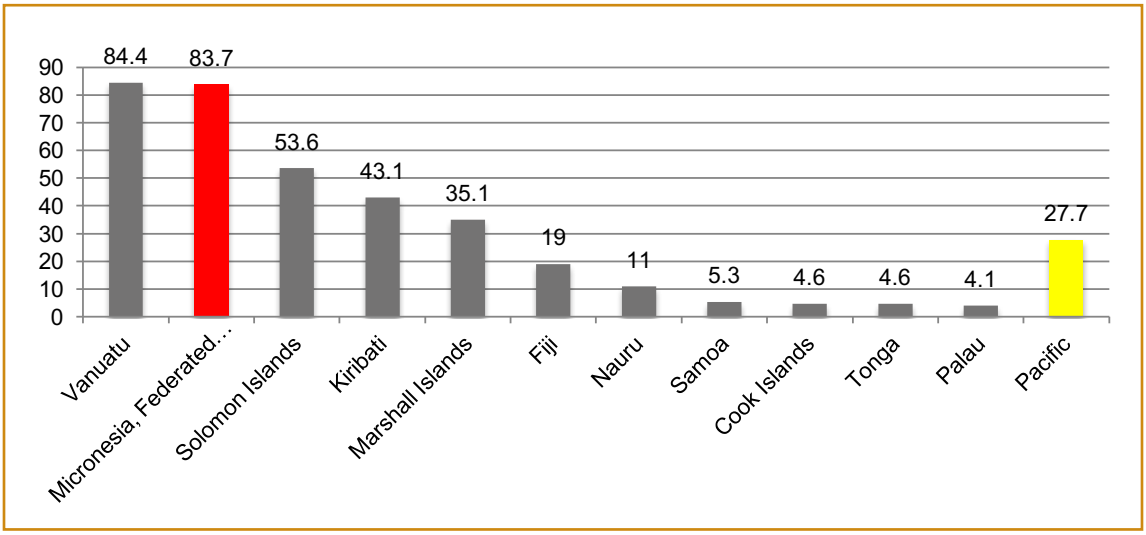
than the number of new members, leading to deficits.[428] According to one key informant, the plan is currently funded only through member contributions, at 16 per cent of its liabilities; it therefore relies on government funding to meet the shortfall (usually between US$ 1 and 2 million each fiscal year). Limited economic growth will likely cause further problems in the member–beneficiary ratio, exacerbating this shortfall. This need to close the gap between collections and payments has led to moves to make amendments to the Social Security Act to change the benefit formula in order to close the gap and incentivize continued employment beyond the retirement age.[429]

FSM 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 with disabilities. A special education programme supports eligible children with disabilities from birth to 21 years, to assist them in accessing suitable education. However, there are no direct cash benefits.[430]

Another component of social protection systems is activities to generate and improve access to employment opportunities among young people. However, there were no data available to assess FSM's coverage in this area.

The data indicate that the depth of social protection systems in FSM (the average benefits received by actual beneficiaries) is quite high, particularly in comparison with in other PICTs, as Figure 7.4 shows.

Figure 7.4: Depth of Social Protection Indicator, by country



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

428 ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 25.
429 KII with representative from Social Security Administration, Kolonia, Pohnpei, May 2017.
430 ADB, 'The Social Protection Indicator: The Pacific', 2016, p. 30.

The high rating for depth of benefits is attributed mainly to payments made under the social insurance (defined benefit) scheme, as shown Table 7.2 shows.

Table 7.2: SPI depth indicator, by type of programme

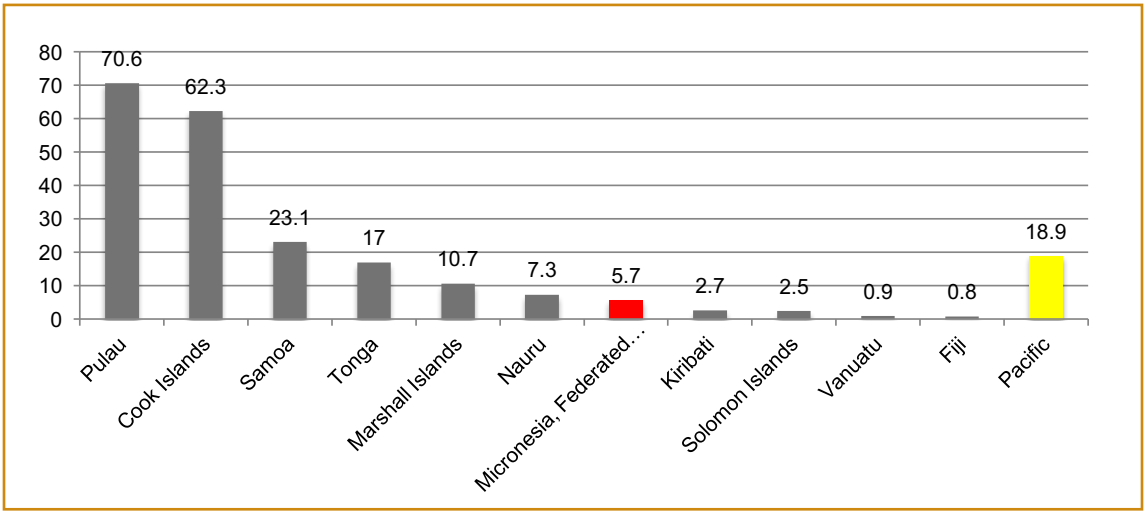
Programme	SPI Depth Indicator (% of per-capita GDP)
Overall	83.7
Social assistance	18.7
Labour market programmes	-
Social insurance	**109.5**

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

While this indicates a generous level of payment for beneficiaries (mostly those covered under the social insurance scheme), the administrator of this programme reported that benefits received (between US$ 100 and US$ 800 a month) are intended to be a supplemental form of income. This is based on the assumption that persons are partially able to fund their own retirement.[431]

Breadth indicators represent the proportion of potential beneficiaries (those who could qualify for benefits) who actually receive social protection benefits. According to the ADB assessment, FSM receives a relatively low breadth indicator (5.7, compared with a regional average of 18.9), as Figure 7.5 shows. This indicates that, while the amount of assistance provided to beneficiaries is relatively high, the number of beneficiaries receiving benefits is relatively low.

Figure 7.5: Breadth of Social Protection Indicator, by country



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

431 KII with representative from Social Security Administration, Kolonia, Pohnpei, May 2017.

The breadth indicator is highest for social insurance programmes (4.1), compared with social assistance (1.6) and labour market programmes (-). This indicates that only a very small proportion of the population benefits from the relatively generous level of payments under the social insurance scheme. Social assistance schemes, which target more vulnerable members of the population, appear to have very limited coverage.

Table 7.3: SPI breadth indicator, by type of programme

Programme	SPI breadth indicator (%)
Overall	83.7
Social assistance	18.7
Labour market programmes	-
Social insurance	**109.5**

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

The data for the Pacific also indicate 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 PICTs is only 0.2 per cent of GDP per capita, whereas the SPI for the non-poor is 1.7 per cent of GDP per capita). This owes to the dominance of social insurance programmes.[432]

The targeting of social protection programmes also appears to have a gender dimension. Overall, the SPI for women in the Pacific is 0.8 per cent of GDP per capita, compared with 1.1 per cent of GDP per capital for men.[433] This is attributed to the differential access of women and men to social insurance measures.[434] As noted above, social insurance measures have a gender bias, as access is generally restricted to formal sector workers, who are predominantly male.

Other non-state forms of social protection exist in FSM and should be taken into account in development policies and systems on social protection. Informal extended family and community systems represent important safety nets and support. In addition, remittances received from relatives living and working abroad (mostly in the USA) offer an additional safety net. According to the 2013–2014 HIES, 41.6 per cent of households receive remittances and 50 per cent give gifts in kind away to other families. However traditional safety net systems are being placed under stress, owing to migration, urbanization and cultural change.

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

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

433 Ibid.

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

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

8.1. Climate change and disaster risks

As a Pacific Island nation with multiple low-lying atolls, FSM has already faced a number of climate disasters, including Typhoon Maysak in 2015 and droughts affecting crops and livelihoods. According to a recent WHO report on climate change and health risks in the Pacific, FSM is affected by a whole range of climate and disaster risks, including rising sea levels, water shortages owing to extreme climate variability, coastal erosion and typhoons.[435] As one key informant stated:

> *'Climate change is the biggest risk at the moment, and it's a big focus. It impacts on crops, water, leads to coral bleaching, affecting marine resources. Cyclones are risks too: Pohnpei and Kosrae 'manufacture' cyclones – they develop here and move west and intensify to Chuuk, Yap, Guam and the Philippines. Drought is also a risk – we had one last year that impacted everyone from Palau to Marshall Islands. Now and then we have [salt water] inundation. Last time we had a big one that affected the whole of FSM in 2008, and it coincided with a king tide. Waves went into the islands – cars had to stop, it flooded the islands, especially the coastal areas. That is where most people reside. The flat atolls were greatly impacted. That one destroyed most of their food crops – taro patches turned brown. And taro is our staple, so it is a big problem.'*[436]

435 WHO, 'Human Health and Climate Change in Pacific Island Countries', 2015.

436 KII with representative of the National Office of Environment and Emergency Management, Palikir, May 2017.

This SitAn has identified the following specific concerns in relation to climate change and disaster in FSM across the **all sectors**. Specifically:

- The key climate-sensitive **health** risks in FSM are vector-borne diseases (especially dengue fever and Zika virus), zoonotic infections (primarily leptospirosis), food- and water-borne diseases, malnutrition and ciguatera (fish poisoning).[437] Higher temperatures are also associated with more frequent cases of respiratory disease and diarrhoeal illness.[438]

- 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 (e.g., farmers, fishers and outdoor workers).[439]

8.2. Geography, transportation and equity

The geography of FSM is a major challenge across all sectors. The remoteness of many of the 607 islands that make up FSM and the difficulties associated with transportation to, from and between these represent a considerable barrier.

- FSM is one of the PICTs with the **largest rural–urban discrepancies** in relation to access to improved **water and sanitation**, with remote Outer Islands particularly disadvantaged.

- In the **health sector**, transferring patients in need of specialized health care, especially from the remote Outer Islands, is a major challenge, though the DoHSA is aware and interested in improving in this area.[440]

- The high cost and administrative difficulty of accessing a population that is dispersed across many islands that have minimum infrastructure and transport links is a major challenge to FSM's **health service delivery**.[441] Infrastructure and quality of care in the dispensaries on the Outer Islands are reported to be poor.[442]

- In the **education sector**, when faced with airline and shipping constraints, the Outer Islands can be cut off from educational resources and school supplies as well as transport links.

437 WHO, 'Human Health and Climate Change in Pacific Island Countries', 2015, pp. 52–3.

438 Ibid., p. 66.

439 WHO Country Cooperation Strategy for FSM 2013–2017, p. 12

440 KII with representative from Budget and Economic Management Division, Department of Finance, Palikir, May 2017.

441 DoHSA, Annual Report 2015.

442 Walliby, K. et al., 'WHO proMIND: FSM', 2014.

- In relation to lack of services in other areas such as **education,WASH** and **child protection**, the vast spread of the 607 islands comprising FSM over more than 3 million km^2 acts as a considerable barrier to the establishment and delivery of services. From a practical perspective, it is extremely difficult to ensure the full population has access to services.

8.3. Financial and human resources

FSM relies heavily on external development aid and the support of the USA provided through the Compact of Free Association, which is due to phase out in 2023. Though the economy has shown growth of 2.5 per cent in recent years, thanks to the development of retail trade, fisheries and manufacturing, FSM still suffers from a lack of resources across government departments in several sectors.

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

- High travel costs and heavy reliance on external donor assistance (in particular US grants) represent potential bottlenecks in relation to FSM's **health financing and education sector**. A key risk to FSM's health budget is the potentially high cost of travel for patients referred abroad and/or from the Outer Islands.

- The **health service** faces a further challenge in the form of a workforce shortage, which is linked to an ageing workforce and out-migration of trained staff.

- In the **education** sector, there are concerns over the quality of the education workforce with regard to qualifications and training of teaching staff in all sectors of the system, in particular primary and secondary education.

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

8.4. Service delivery

Data assessed in this SitAn suggest there is lack of services across all sectors assessed. Specifically:

- In the **education** sector, the increase in migration away from the Outer Islands to state capitals means schools in urban areas are becoming overcrowded, with many facing textbook and resource shortages. There is also a notable deficit in the provision of vocational training services and opportunities.

- A comprehensive child protection system is lacking, including, for example, services for victims of violence, exploitation, abuse and neglect, both as part of the **child protection system** and as part of the **justice system** for victims of criminal offences.

- There is inadequate provision of **services for children in conflict with the law**, including, for example, juvenile courts and separate places for detention/custody or for rehabilitation and reintegration within the community.

- **Social protection** schemes are not well targeted, with most support benefiting the non-poor.

8.5. Legislative framework

Gaps in the legislative framework were identified within the **child protection** chapter to this report, which notes that provisions are missing in relation to corporal punishment, child labour and domestic violence in all but Kosrae State. In addition, this SitAn has found several gaps in relation to the legislative system for children in contact with the law. One particular concern is that, just as states are able to develop and enact their own legislation, they are able to omit to do so, which leaves children and women in some states less well protected.

8.6. Cultural norms

Cultural norms, attitudes and traditions could act as barriers (and, in some cases, as enablers) in relation to the realization of children's rights in FSM:

- Traditional attitudes may prevent children and others from reporting cases of violence against women and children (**child protection**), both because traditional norms are permissive of such violence but also because child abuse, domestic violence and indeed more serious offences against children are seen as family or private matters. Without a legislative or policy framework to regulate this, children and women are vulnerable to lack of justice, as cases are not reported or are dropped.

- A shift in the ways families and communities are structured, from communal family living to more nuclear families, has led to children facing greater **child and social protection** risks from within nuclear families that have less capacity to support their children compared with the wider community, and a reduction in the ability of the community to respond to these risks. As the government has limited resources itself, it appears not to have 'caught up' to the shift in community behaviours and provides insufficient support services.

- **Informal justice** processes, while a potential enabler for child rights realization, are used for children in conflict with the law and children who are in contact with the law as victims and witnesses. Little is known about the processes used and whether they safeguard children's rights and take the best interests of the child into account.

- In **social protection**, traditional safety nets are being placed under stress and are less able to provide support for the community than in the past, though remittances from family members abroad continue to provide some support.

8.7. Gender

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

- Traditional gender roles support and facilitate sexual violence against girls and discourage the reporting of cases, because such violence is accepted and considered a private matter and because formal responses to reports are inadequate.

- Cultural attitudes towards gender roles have prevented domestic violence legislation from being passed in Chuuk, Pohnpei and Yap, leaving women and girls in these states additionally vulnerable to violence without appropriate recourse to justice.

8.8. Data availability

This analysis has revealed several data gaps in FSM. The absence of these data is, in itself, a key finding, but it also makes a full analysis of the situation for children and women in FSM impossible.

- Data on key child and **maternal health (and nutrition)** are particularly limited in relation to maternal health, family planning, substance abuse, mental health, child stunting/wasting, under-five underweight, overweight/obesity among children and adolescents and breastfeeding practices.

- Where quantitative data do exist in all sectors, they are rarely broken down by rural–urban differences or gender and wealth disparities.

- Challenges in accessing data in relation to **education** stem from inconsistent processes and tools for collecting data between the four FSM states, as well as late submissions of data between schools and the DoE at national and state levels.[443] On the Outer Islands, modes of data transmission can be unreliable (VHF radio, ship and small aircraft) and data

443 JEMCO Report, 2015, p. 2.

monitoring may occur only when a boat travels there; data are therefore unpredictable and incomplete.[444]

- There are limited data on **child protection** and **children in conflict with the law**, and FSM has not participated in a GSHS, which would provide data in relation to the situation for school-age children.

- The implementation of nation-wide surveys, such as a DHS or GSHS, and the introduction of data collection mechanisms in other sectors, would go a long way towards addressing these data gaps.

444 Ibid.; KII with representative from national DoE, May 2017.

Footnotes in tables

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

II UN Human Rights Office of the High Commissioner, 'Reporting Status for Micronesia (Federated States of)'.

III UN General Assembly, Human Rights Council, 'Compilation Prepared by the Office of the United Nations High Commissioner for Human Rights in Accordance with Paragraph 15 (b) of the Annex to Human Rights Council Resolution 5/1 and Paragraph 5 of the Annex to Council Resolution 16/21 Federated States of Micronesia', on https://www.upr-info.org/sites/default/files/document/micronesia_federated_states_of/session_23_-_november_2015/a_hrc_wg.6_23_fsm_2_e.pdf [19.05.17].

IV Table reproduced from ibid., p. 2.

V The minimum age of marriage in Kosrae, Chuuk and Pohnpei is 18 for males and 16 for females, though permission is required in these states for a girl under the age of 18 to marry: IPU and WHO, 'Child, Early and Forced Marriage Legislation in 37 Asia-Pacific Countries', 2016, p. 72.

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