# KIRIBATI

## A SITUATION ANALYSIS OF CHILDREN, WOMEN & YOUTH

GOVERNMENT OF KIRIBATI
with the assistance of UNICEF

2005

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# TABLE OF CONTENTS

## PART 1

## DEVELOPMENT TRENDS IN KIRIBATI 1

The situation analysis 2

Kiribati: an atoll nation 3

The Islands and Ocean 3

The People 4

National Development Indicators 4

The Uneven Pattern of development 6

The Nature of poverty in Kiribati 6

The growing concentration of population and economic activity on South Tarawa 9

Problems of Outer Island Development 13

Ill-health, poor diet and loss of food security 15

HIV and AIDS 16

The changing social and cultural contexts of children's and women's lives 17

The structure of I-Kiribati society 17

Enviromental health 18

The place of children 19

The place of youth 19

The roles of women 20

The role of the media in social change 20

The churches 21

## PART 2

## THE SITUATION OF CHILDREN 25

Children in the population 26

Health and well-being 27

Diarrhoeal Diseases 29

Child immunisation 30
Nutrition Problems 32
Child development 33
Early childhood education 33
Access to basic education 34
High enrolments 34
Concerns about quality 37
Health and well being issues 39
School facilities for disabled children 41
Children in special need of protection 41
Child adoption 41
Children who are neglected or abused 41
Children who are exploited 42
Children who become pregnant 43
Children involved with the law 43
Public understanding about child rights 43

PART 3
THE SITUATION OF YOUTH 47
Introduction 48
Education and Livelihoods 48
Health and well-being 49
Sexual reproductive health 49
Substance abuse 50
Injuries 53
Mental illness and Suicide 53
Social Problems 54
Rapid Social Change 54
Crime 55
The Local Sex Industry 56
Policy Developments 57

## Part 4
## The situation of women

The situation of women 59

The general advancement of women 60

Women's health 61

Health differences between women and men 61

Non-communicable diseases 62

Reproductive health 63

Domestic and sexual violence 64

Education 65

Livelihoods and Employment 66

Institutional mechanisms to promote the interests of women 69

Government agencies 69

Non Government Organisations 70

## Part 5
## The agenda for change

The agenda for change 73

References 77

Annexes 78

## List of Figures

Figure 1 Expected population growth, Kiribati,2000-2025 5

Figure 2 Human Development Index, Pacific Islands, 1999 5

Figure 3 Growth of the Kiribati and South Tarawa populations, 1920-2000 10

Figure 4 The rate of population growth, Kiribati and South Tarawa, 1930-2000 10

Figure 5 Household size, South Tarawa, 2000 11

Figure 6 Island Projects approved for Funding-2001 14

Figure 7 Reported cases of HIV in Kiribati, 1991-2003 17

Figure 8 Age and sex of People known to have HIV in Kiribati,1991-2003 17

Figure 9 Age structure of the kiribati population 26

Figure 10 Expected population growth, Kiribati,2000-2025 31

Figure 10. Expected population growth, Kiribati,2000-2025 31
Figure 11. Growth in pre school enroments, 1990-2004 34
Figure 12. School Enrolment by Class and sex. 2004 35
Figure 13. The changing structure of Kiribati's education system,1995-2004 35
Figure 14. School Enrolments by Age, 2004 37
Figure 15. Percent of qualified Primary School teachers, 2003 37
Figure 16. State of Primary School Classsrooms,2002 40
Figure 17. Enrolments at Kiribati Teachers College and Tarawa technical college, 1995-2003 49
Figure 18. Total fertillity rates by Age - Group 50
Figure 19. Deaths from 'International injuries' 1991-2001 54
Figure 20. Total Reported Crime, Kiribati, 1995-2000 55
Figure 21. Percentage of no longer married adults, by Gender,2000 61
Figure 22. Rising life expectancy at birth, 1973-2000 62
Figure 23. Educational attainment of all people over 15 years, by gender, 2000 65
Figure 24. Distribution of Kiribati Development Bank loans by gender, 1999-2002 67

## List of Tables

Table 1 Progress in Kiribati towards the goal of the World Summit for Children 6
Table 2 Estimated incidence of material poverty in Kiribati, 2002 8
Table 3 Living conditions on south Tarawa 13
Table 4 Various definitions of a 'child' in Kiribati 27
Table 5 The state of infant and child health in Kiribati 28
Table 6 Ministry of Health, total reported cases affecting children, 2002 29
Table 7 ECD enrolments by district 34
Table 8 Pupil-teacher ratio in primary school and JSS, 2002 38
Table 9 Fertility indicators for Kiribati 60
Table 10 Causes of Death for adults aged over 30 years, Kiribati, 1991-2001 62
Table 11 Outcomes from reported assaults 65
Table 12 Economic activities of the adult population, 2000 68
Table 13 The gender balance in public sector employment, 1994-2003 69

# EXECUTIVE SUMMARY

This report is an update of the Government of Kiribati and UNICEF's 2001 'Situation Analysis of Children and Women in Kiribati.'

Kiribati is a country of 33 atolls and low lying reef islands scattered along the equator in the central Pacific. The country is faced with significant problems of transportation and communication. The current population is around 93,000 and with an annual growth rate of around 2.3% - the population could easily double by 2013, presenting major social and economic implications. The level of development in Kiribati is one of the lowest in the region. There is uneven development and the two general patterns are:

- the uneven distribution of income and resources and the hardship faced by households
- the general disadvantage of outer island communities relative to South Tarawa.

Although extreme poverty or destitution is not common in Kiribati, many households now have difficulty meeting their basic needs.

In 1995, the Government of Kiribati ratified the Convention on the Rights of the Child (CRC), thereby acknowledging obligations to ensure health, education, protection and the participation of children in society.

To address the relatively high infant and child mortality rates, Government in partnership with UNICEF have been working on:

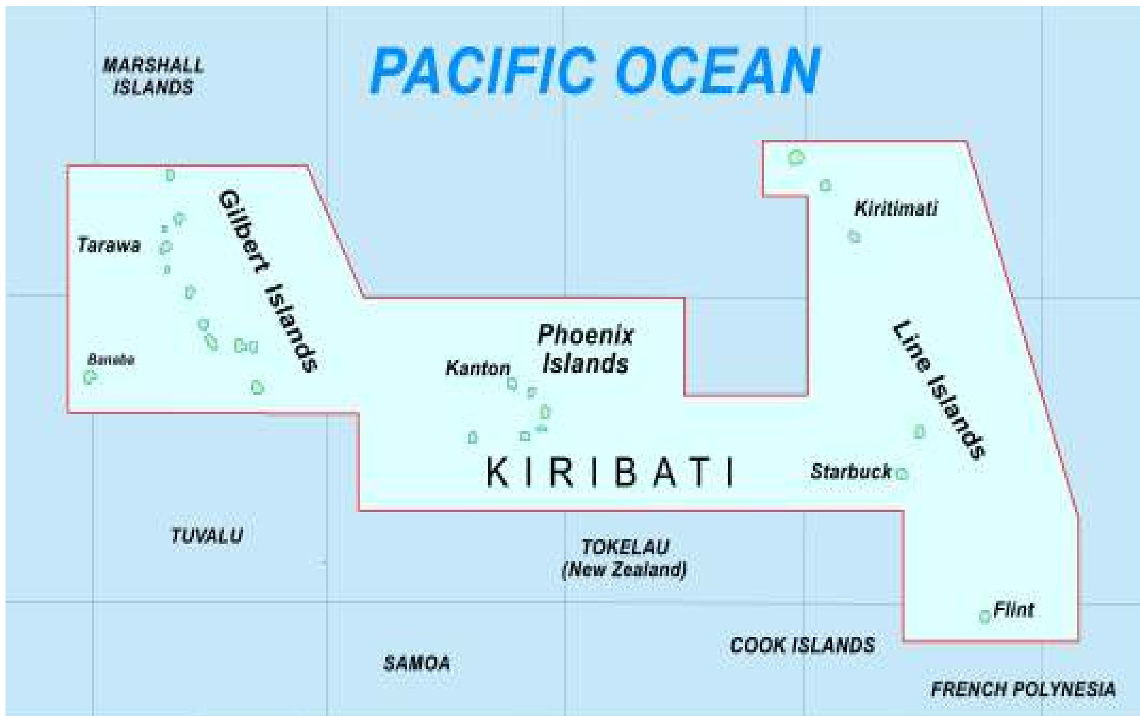
- capacity building for health workers and community volunteers including traditional birth attendants on issues related to childhood diseases and safe motherhood.
- combating immunisable diseases including Hepatitis B.
- improving nutrition by training health workers about the importance of micronutrients, distributing Vitamin A capsules and promoting exclusive breastfeeding for the first six moths of a child's life.

Two other issues are of particular concern. First, the breakdown of the family support structure is having an impact on I Kiribati society, particularly on young people in South Tarawa. Tensions between traditional values and modern or western ways are causing social problems such as increase in crime, drug abuse, violence, suicide and on incidence of diseases like HIV/AIDS and Sexually transmitted infections (STI). There is high unemployment rate due to high school dropout rate and the limited employment opportunities available. This further aggravates the situation of youths in Kiribati.

Second, while men dominate most of the cash work, the involvement of women in paid employment is growing. However, there is still need for more investment in facilities and infrastructure that will help women generate the cash they require to meet family and social needs. The health situation for women in Kiribati is better compared to men but with the increasing cases of non communicable diseases (NCD), there is anecdotal evidence of obesity, alcohol drinking and smoking among women. The rate of women smokers is one of the highest in the world. The most common reasons for hospitalisation for women relate to reproductive health. With proper training of health care workers, complications related to delivery or child birth has lead to fewer deaths and injuries to both mothers and infants. Cervical cancer is the most common type of cancer among women. Domestic violence is common and most are not reported to proper authority as the practice is still accepted by the community.

Most of the issues affecting children, youth and women can be effectively addressed through the Government's commitment to the obligations of international conventions such as the Convention on the Rights of the Child (CRC) and the Elimination of All forms of Discrimination against Women (CEDAW). Government should provide resources to the Kiribati National Advisory Committee on Children (KNACC) and also put in place effective advocacy structures to ensure children and women's issues are known and mainstreamed into the national development agenda.

# MAP OF KIRIBATI




In terms of land area and population, Kiribati is one of the smallest nations in the world, but in geographic spread it is one of the largest. The distance from the capital Tarawa in the west to Kiritimati in the east is about the same as from Los Angeles to Washington in the United States. With a total land area of 810 square kilometres, the islands of Kiribati make up only 0.02 per cent of the nation's sea area. Kiribati's many small islands make transport and communications expensive and difficult. Its location in the centre of the Pacific Ocean puts it far away from the world's main markets and transport routes.

# Part 1
## Development trends in Kiribati

### *1.1 The Situation Analysis*

As part of its country programmes, UNICEF assists governments to produce a report on development trends in their country that describes how these changes affect the well-being of children, youth and women. The national reports help to direct UNICEF's programmes and also provide a useful reference for national agencies, the public and other development partners.

This report is the second overview of the situation of children and women in Kiribati in the first decade of the 21st century, and updates the 2001 report. It was drafted with help from many people in Kiribati, and draws upon published and unpublished information and reports.

The Republic of Kiribati is recognised by the United Nations as a Least Developed Country. Although Kiribati is a recent member, the United Nations has had a long-standing relationship with the Government in supporting its efforts to improve living standards and economic development in the country. In 1995, the Government ratified the Convention on the Rights of the Child (CRC), thereby acknowledging the obligation to ensure the survival and health of children; to ensure that all children benefit from education; to protect children from exploitation and cruelty; and to ensure that children are allowed to participate in society in accordance with their maturing capacities.

The CRC is one of several commitments made by the Government of Kiribati to recognise and reach international development and human rights standards. Others relevant to this report are:

- Endorsement of the goals of the World Summit for Children, 1990;
- Endorsement of the goals of Health for All, 1990;
- Endorsement of the goals of Education for All, 1990;
- Endorsement of the International Conference on Population and Development Programme of Action, first decided at Cairo, 1994;
- Endorsement of the Beijing Plan of Action, 1995, and the Pacific Platform of Action, 1995, to ensure the rights of women;
- Endorsement of the goals of the World Social Summit, 1996;

- Endorsement in 2000 of the Millennium Declaration and the Millennium Development Goals to be reached by 2015; and

- Ratification in March 2004 of the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW).

UNICEF's programmes in Kiribati aim to improve the situation of children and women. UNICEF works mainly through the Ministry of Internal and Social Affairs but also with NGOs, such as the Kiribati Association of Non Government Organisations (KANGO) and the Kiribati Early Childhood Education Association. Since 2000, UNICEF-sponsored activities have focused on:

- Capacity building of health workers and community volunteers, by improving the skills and technical knowledge of medical professionals, including Traditional Birth Attendants on issues related to childhood diseases; safe motherhood; monitoring, planning and community mobilisation; and imparting skills and knowledge to Nursing Aids, Village Welfare Groups (community volunteers) and community members on primary health care services, practices and reporting systems.
- Combating immunizable diseases, including Hepatitis B;

- Improving nutrition by training health workers about the importance of micronutrients, distributing Vitamin A capsules, and promoting exclusive breast-feeding for the first six months of a child's life;

- Helping Kiribati meet its treaty obligations in regard to the Convention on the Rights of the Child, by assisting the Kiribati National Advisory Committee for Children to report on the implementation of the convention.

## 1.2 Kiribati: an atoll nation

### The islands and ocean

Kiribati is a country of 33 atolls and low lying reef islands widely scattered along the Equator in the central Pacific Ocean. The eastern Line and Phoenix Islands are sparsely populated. Most people live in the western Gilbert Group, and over 40 per cent of the national population is concentrated on the

southern end of one atoll, Tarawa. The economy of South Tarawa is much more monetised than those of the other islands. While the cash economy has to some extent now spread everywhere, on the outer islands the economy operates at mostly subsistence level, there is almost no cash employment other than with the government or councils, and access to services is quite restricted.

The national economy depends primarily on remittances from I-Kiribati people working abroad (mainly merchant seamen and fishermen on foreign-owned ships), fishing licence fees, exports of copra and sea products (including seaweed, beche-de-mer and aquarium fish), and foreign aid. An important resource is a national trust fund of A$636 million (2001), accumulated through many years of careful investment. Kiribati's vast Exclusive Economic Zone of ocean is another important resource, but income from it comes mainly from licences sold to foreign fishing vessels to work the world's last viable tuna fishing grounds.

Kiribati is one of very few countries in the world that are entirely comprised of atolls. Even among small island developing states, that puts Kiribati in a uniquely vulnerable position. These flat, narrow, sandy islands have few natural resources, particularly fresh water, and are prone to drought. Traditionally, people relied more on the sea and the culture of these islands emphasised self-reliance, resilience and thrift, qualities that are still highly valued. Newer environmental threats come from solid waste, water and air pollution, depletion of ground water, salt-water excursion into the subterranean fresh-water lens, deforestation, depletion of inshore fisheries and coastal erosion. Traditional I-Kiribati culture incorporated a deep understanding of the environment of these islands, and natural resources were sustained through social controls such as fishing regulations, clan taboos, and population controls that limited demand upon resources. But with social and economic change, many of these mechanisms have broken down.[1] As the world climate changes, Kiribati may also be badly affected by more frequent, powerful storms and the rising sea level.

### *1.3 The people*

The population of Kiribati is almost entirely indigenous Micronesians with a small expatriate community of mostly professional workers and their families. Although the birth rate is slowly dropping, it still is quite high, with a total fertility rate in 2000 of 4.3.[2] There is little migration from Kiribati, although many men periodically work overseas, mainly as fishermen or seamen. There is also a small but growing number of I-Kiribati professionals working abroad.

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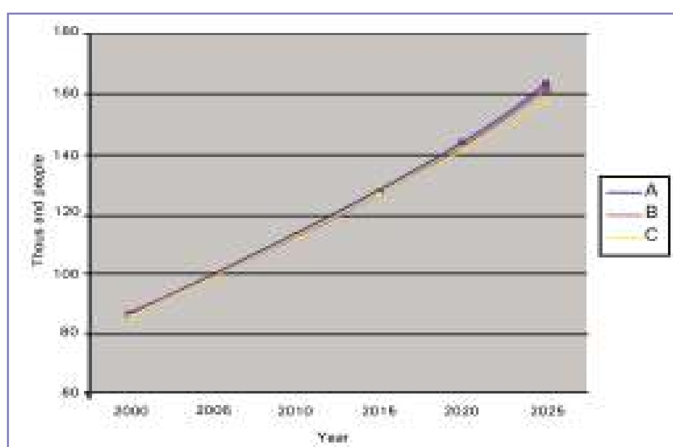
[1] Saito, 1995.
[2] SPC, 2004.
[3] SPC, 2004.

The national population of approximately 93.1 thousand is growing at around 2.3 per cent a year. At this rate - should it continue - the number of people could double by the year 2030.[3] Population growth is recognised as a serious national concern and a population policy was recently adopted by Government. Nevertheless, because children make up a large part of Kiribati's population, the number of people is likely to keep rising quickly for at least the next decade or two (Figure 1). Indeed, the only other possible prediction would be that migration out of Kiribati increases sharply - and one way this might come about is if sea levels should abruptly rise over the next few decades, as some forecasts suggest they will.

**Figure 1. Expected population growth, Kiribati, 2000 - 2025**



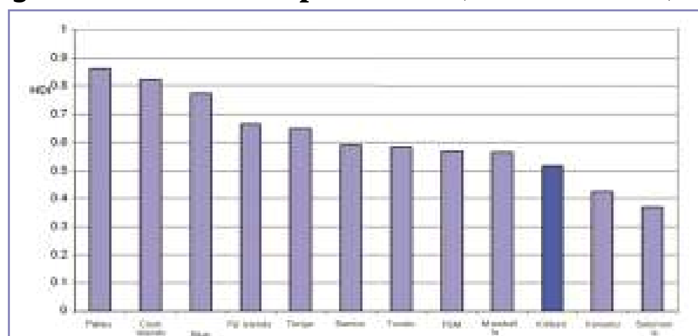

Source: Demgraphy Programme, SPC, 2001.

Note: A assumes that current population trends continue unchanged; B assumes that fertility declines slowly; C assumes that fertility declines more quickly.

## *1.4 National development indicators*

In terms of mortality and morbidity, living conditions and per capita GDP, Kiribati's level of development is almost the lowest in the pacific region. The relatively high infant and child death rates reflect the sad fact that children in kiribati still die from readily preventable causes. On the Human Development index, Kiribati ranks 129th on the global scale and 11th out of the 14 countries in the Pacific Island region.

**Figure 2. Human Development Index, Pacific Islands, 1999**




Source: UNPD, 1999

Note: HDI is a composite measurment of literacy, life expectancy, and GDP per capital

Even so, important progress has been made in many respects. Over the past three decades, since the mid-1970s, infant mortality has been halved. Life expectancy at birth has steadily risen - although less so for men than women - to 61.2 years and 66.9 years, respectively. School enrolments for adolescents have risen sharply since the late 1990s. The infrastructure of a modern society is expanding, with the spread of telephones and a major programme of solar power electrification of the outer islands. The Government spends almost a fifth of its recurrent budget on education, one of the highest proportions in the Pacific Island region. Expenditure on health also increased significantly in the 1990s, to around 16 per cent of the recurrent budget in 2000.

The 1990 World Summit for Children set several goals for children's welfare. They included reducing infant and child mortality rates by one third and maternal mortality rates by one half, reducing malnutrition among children under the age of five, and ensuring that all children have access to basic education, clean water and sanitation. Kiribati continues to make progress towards these goals, but there is still some way to go.

**Table 1. Progress in Kiribati towards the goal of the World Summit for Children**

| Goal | Measurement | 1990 | 2000+ | Progress |
|---|---|---|---|---|
| Reduce mortality for children under the age of five 1 | Infant mortality rate (deaths per 1,000 live births) | 65 | 43 | → |
| | Child mortality rate (deaths under 5 yrs per 1,000 live births) | 88 | 69 | → |
| | Immunization coverage for infants (%) | | 70 | ↔ |
| Reduce child malnutrition 2 | Newborns weighing at least 2500 gm at birth (%) | | 94 (1998) | |
| | Under-weight children under 5 yrs (%) | 5 | 13 | ← |
| Improve adult literacy 3 | Adult literacy rate (%) | 92 | 92 | ↔ |
| Ensure universal access to basic education 4 | Net primary enrolment (%) | 76 | 93 | → |
| | 10-14 yr olds in school (%) | 91 | | |
| Ensure universal access to safe drinking water and sanitation 5 | Safe drinking water (% of households) | 35 | 49 | → |
| | Basic sanitation (% of households) | 24 | 31 | → |
| Reduce maternal mortality 6 | Maternal mortality rate (pregnancy related deaths per 100,000 live births) | 225 | 56 | → |

Source: Regional MDG Report

## *1.5 The uneven pattern of development*

### *1.5.1 The nature of poverty in Kiribati*

Kiribati has always been a fairly egalitarian society but patterns of disadvantage are becoming more evident. Countering this uneven development is one of the Government's highest priorities. Beyond Kiribati's general position among the least developed countries of the world, there are

two general patterns of disadvantage: the uneven distribution of incomes and resources and the hardship some households face; and the general disadvantage of outer island communities relative to those on South Tarawa.

Although extreme poverty or destitution7 is not common in Kiribati, many households have difficulty meeting their basic needs. Most people have a materially poor lifestyle but still an adequate one by I-Kiribati standards. Cash incomes are generally low and many households also engage in gardening, fishing, carpentry and the manufacture of local goods such as mats and housing materials. Parallel to the cash economy is a tradition of distributing goods along lines of kinship. But despite the high value I-Kiribati people put on this tradition of sharing, neither the cash-based nor the kin-based economy ensures that resources are evenly distributed among all households.

In 2002, an Asian Development Bank (ADB) study estimated the Food Poverty Line (i.e. the cost of a basic nutritious diet) for South Tarawa to be A$600 per capita per annum (in 1996 prices), almost three times higher than that for the outer islands, of A$167, reflecting much greater consumption of home-produced food in the outer islands. When other non-food basic-needs expenditure needed for a minimum standard of living was taken into account, the overall Poverty Lines for South Tarawa and the outer islands were estimated to be A$750 and A$201 per capita per year respectively.

Despite the marked differences in household income and expenditure between the outer islands and South Tarawa, the ADB study concluded that the incidence of poverty was very similar in the two regions. In both cases, around 39 per cent of households were suffering from food poverty and around 50 per cent had per capita expenditures below the Poverty Line (Table 2). The results for South Tarawa were consistent with a community survey conducted in 2001 in which 52 per cent of the households interviewed reported that they regularly experienced a shortage of cash to meet daily needs.[4]

[4] Sanitation, Public Health and Environment Project, South Tarawa Community Survey, 2001.

**Table 2 Estimated incidence of materail poverty in Kiribati, 2002**

| | Food Poverty Line (FPL) (A$ per capita per yr) | Poverty Line (PL) (A$ per capita per yr) | Per cent of households in poverty | | | |
|---|---|---|---|---|---|---|
| | | | Based on recorded income | | Based on recorded expenditure | |
| | | | FPL | PL | FPL | PL |
| South Tarawa | 600 | 750 | 46 | 59 | 39 | 50 |
| Outer Islands | 167 | 201 | 65 | 69 | 39 | 51 |

Source: ADB, 2002. Note: Estimations based on 1996 prices.

Surveys conducted on Onotoa and South Tarawa in 1996 and on Butaritari in 2002 found that cash incomes were very unevenly distributed among households. On Onotoa, five households earned two-fifths of all the cash income, the other third went to another five households, and the other 41 households had no cash income during the two week survey. When households had no money, they usually borrowed or bought from local shops on credit.[5] On South Tarawa, the traditional system of wealth redistribution was weaker and demands for cash for everyday living were much higher. Most cash was spent on food, mainly rice, fish, frozen meat and sugar, for local produce was expensive and scarce.[6] The Butaritari survey similarly found large differences in household expenditure and that some households were struggling, mainly those with little land or no male of working age. Other than wages, important sources of cash were relatives, weaving, copra and local fishing.[7]

Poverty of opportunity is where people lack opportunities to participate as they would wish in the social, economic or political life of their society, and this type of poverty is even more widespread in Kiribati.

There is a great unmet demand for employment opportunities, especially from young people. With just under half (47 per cent) of the population under the age of 18, the labour force is likely to grow by some 40 per cent by 2010.[8] Most of these people will be looking for paid work. Meanwhile, the low retention rate through secondary school and the focus on academic training causes a shortage of technical and managerial skills in the workforce.

Most paid jobs are in the public sector and on South Tarawa. In 2000, around 10 per cent of the population worked in the cash economy, two thirds of all employed people worked in the public sector; and two-thirds of them were on South Tarawa. Outer island households mainly earn cash from copra and seaweed production and fishing. Unemployed migrants from the outer islands

[5] Department of Statistics, 1996.
[6] Department of Statistics, 1996.
[7] ADB, 2002b.
[8] ADB, 2002b.

have a particularly difficult time surviving on South Tarawa. The concentration of economic opportunities contributes to the development of both rural poverty - in regard to incomes and opportunities - on the outer islands and urban poverty - in regard to incomes and living conditions - on South Tarawa.[9]

The quality of basic services is lower on the outer islands. For example, outer island health facilities are generally poorly supplied and maintained, they often lack water and toilet facilities, and almost all of Kiribati's doctors are on South Tarawa.

On South Tarawa especially, an important aspect of poverty of opportunity is that many people have no choice but to live in sub-standard, unhealthy and crowded conditions in part because of the large amount of rubbish and pollutants there. For years, all the machinery, vehicles, household goods, office equipment, batteries, chemicals, bottles, cans, plastics and the like that have come onto the island have of necessity stayed there until, with time and luck, some have decayed. Many derelict vehicles lie among the houses and litter the island, cluttering people's yards, posing a hazard to children who play on them, and polluting the ground. Compounding this are the many chickens, dogs and pigs that forage amongst the rubbish and around the houses.

Vulnerability to poverty is where individuals or communities face circumstances that are likely to damage their livelihoods or ability to meet their basic needs. There is a strong spirit of family support; I-Kiribati abroad send back a good part of their salaries or stipends, and around one quarter of all households rely on remittances for some part of their income. The effectiveness of the traditional support system is nevertheless weakening as the country becomes more monetized, attitudes change, and families face increasing demands on their resources. There is no formal social security system to take its place. The most vulnerable households are those with no land, disabled or ill adult members, or no male workers.

### *1.5.2 The growing concentration on South Tarawa*

For many years the gap between the economies and lifestyles of South Tarawa and the outer islands has steadily grown, despite policies and programmes that have aimed to counter it. Over the past decade, the populations of most outer islands have dropped because of out-migration. South Tarawa's population, by contrast, grew three times faster than the national population, at an average rate of 5.2 per cent per year (1995-2000).

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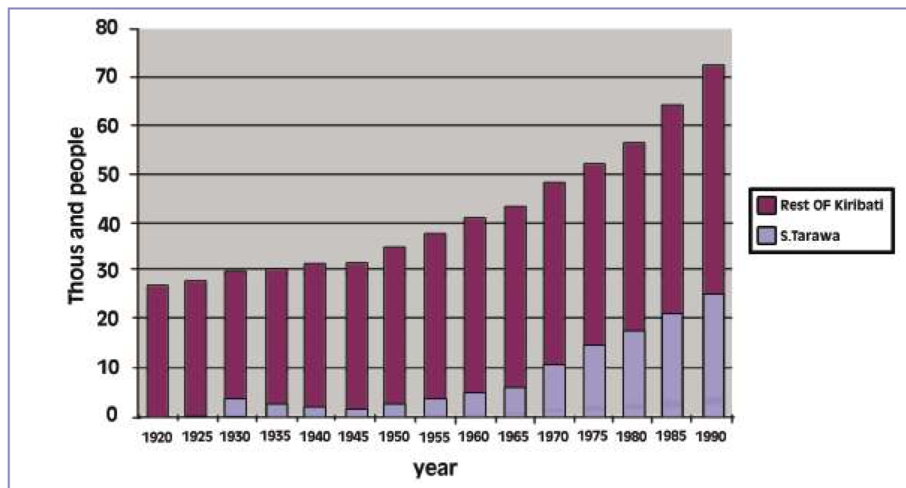
[9] ADB, 2002a.

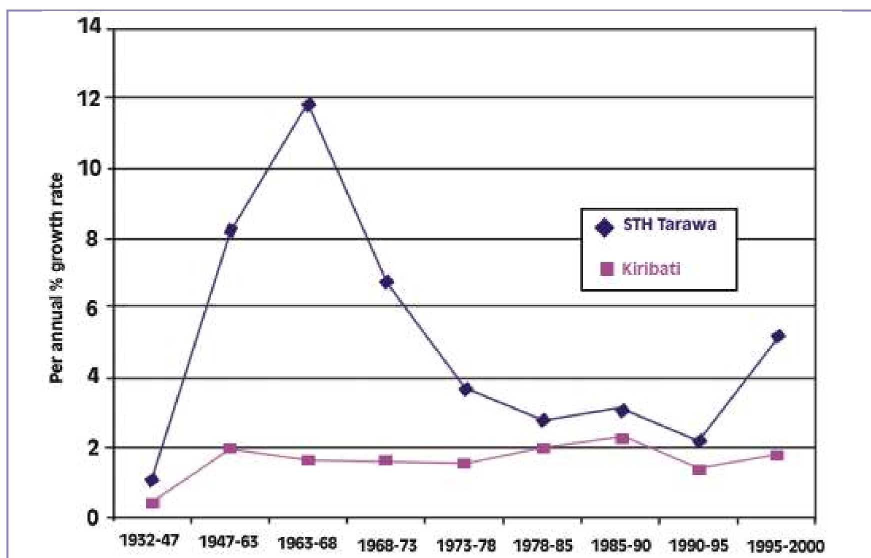
In 2000, 44 per cent of the national population was living on South Tarawa, up from 37 per cent in 1995. South Tarawa's population is growing both because of in-migration, which bounced up again in the mid-1990s, and also because of the number of births there and the momentum of growth that the concentration now generates. The national government, the main secondary schools, tertiary institutions, the main hospital, most businesses and jobs, the international airport, and ever increasing numbers of motor vehicles and volumes of solid waste are all located on this crowded strip of small islets.

**Figure 3 Growth of the Kiribati and South Tarawa populations, 1920 - 2000**




Source: Kiribati National Census, 2000

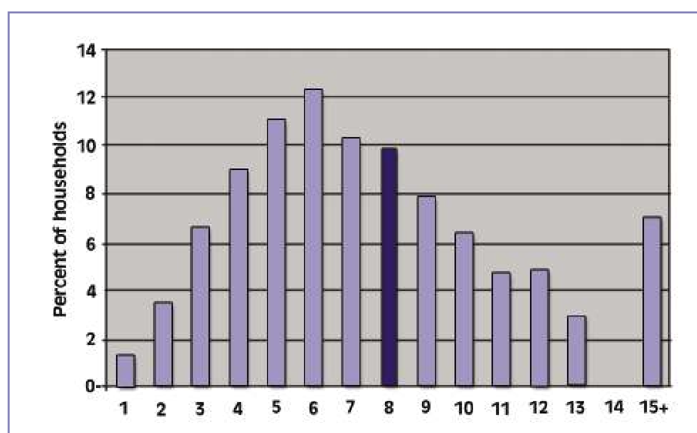
**Figure 4 The rate of population growth, Kiribati and South Tarawa, 1930 - 2000**




Source: Kiribati National Census, 2000

Because opportunities to earn cash are concentrated on South Tarawa, many outer island households make a conscious effort to have some of their members living there. Households are generally larger on South Tarawa than elsewhere because they must accommodate migrant relatives. The national average size is 8.3 residents, but over one quarter (28 per cent) of households on South Tarawa have ten or more members. Very crowded living conditions contribute to health, financial and social problems.

**Figure 5. Household size, South Tarawa, 2000**




Source: Kiribati National Census, 2000
Note: Average household size on South Tarawa is 8.3 residents.

The average population density on South Tarawa is now around 2,300 persons per sq. km. but on the islet of Betio it is over 6,600 per sq km., making this islet one of the most densely packed square miles of single-storied dwellings in the world. Congested as South Tarawa now is, if the present growth rate should continue, twice as many people could be living on the island by 2020 as there were in 2000. Environmental health is an urgent concern. A survey in 2001 found that most households considered poor sanitation, inadequate water supply, congestion, and the social problems they engender to be their main problems.[10] They may yet get worse.

- The main water supply is piped from a subterranean water lens in the northern part of the atoll. Although recently upgraded with the construction of a restricted flow system, the water supply is over-stretched by growing demand and threatened by settlements encroaching onto land above the water lens and pollution of ground water. Well water is often highly contaminated. Many households have invested in rainwater tanks, assisted in part by a government loan scheme run through the Kiribati Housing Corporation.

[10] SAPHE, 2001.

• I-Kiribati traditionally use the sea as their toilet, and on sparsely populated outer islands this poses little health risk. On crowded South Tarawa around one quarter of households regularly use the beaches leaving the lagoon badly contaminated. On the shallow atoll soils, pit and water-seal toilets pollute the water lens. The sewerage system in Bikenibeu and Bairiki was recently upgraded but not extended to other parts of the island. Efforts to promote composting toilets have not yet succeeded as they came up against cultural barriers.

• Various efforts have been made recently to reduce and better manage the high volume of household garbage and pollutants such as waste oils and chemicals, derelict vehicles and machinery on the island. They have included the construction of new land-fills, the introduction of garbage sorting by the Councils and use of biodegradable plastic bags for household garbage ('green bags'), the establishment of a recycling facility, the removal of persistent organic pollutants, community education activities, island-wide clean-up campaigns, and the promotion of household use of organic wastes.[11]

[11] These projects include the ADB-funded Sanitation and Public Health Education (SAPHE) and Community Development and Sustainable Participation (CDSP) Projects; Kaoki Mange!, which has been funded by various donors including UNDP, ADB, NZAID and AusAID; and the International Waters Pilot Project and Persistent Organic Pollutants Project, both funded through the South Pacific Regional Environment Programme.

**Table 3 Living conditions on South Tarawa**

| Type of toilet used | Per cent of households | Main source of drinking water | Per cent of households |
|---|---|---|---|
| Flush toilet | 48 | Rain water | 24 |
| Water-sealed toilet | 29 | Piped water | 70 |
| Lagoon beach | 26 | Open well | 33 |
| Ocean beach | 28 | Protected well | 18 |
| Other place | 4 | | |

Source: Kiribati National Census, 2000

Note: Average household size on South Tarawa is 8.3 residents, more than one type of toilet may be used in some households.

### *1.5.3 Problems of outer island development*

In recent years, several reviews have been conducted into the constraints on outer island development. Beyond the difficulties posed by the geography of Kiribati, such as few natural resources and long distances between small, remote settlements, there are a number of institutional barriers to island development.

A review of island governance in 2000 found there was an urgent need for reform of the island councils, particularly in regard to ways in which they frustrated people's aspirations for development.[12] Demands on island councils had grown but the institution had remained static, held in place by the 1966 Local Government Ordinance. Where once the Government had only required the councils to maintain peace and security, now they were expected to facilitate island development, implement development projects, and resolve social problems. On the other hand, island residents saw the council's main function to be levelling taxes.

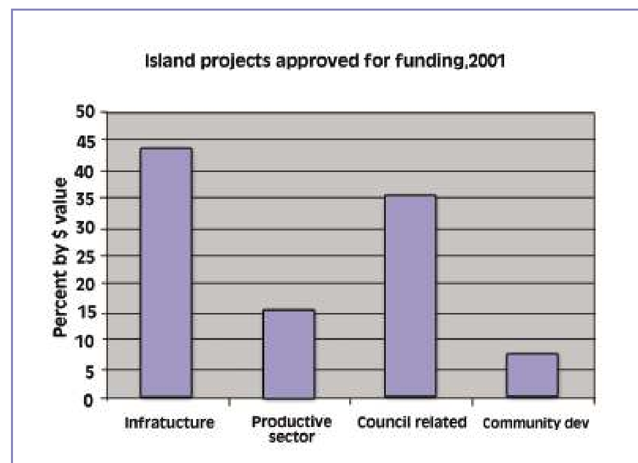
A study into the funding of island development in 2001 found that the projects that were put forward by the Councils and received government funding were mainly for infrastructure, council-owned facilities, or 'productive' activities, such as small industries. There was little evidence of community involvement in the selection of projects. Island Development Committees were established in the 1980s to facilitate this but few now operate properly. Women and youth groups felt particularly left out. Their proposals were usually for community development-type projects - community or women's centres, household or street lighting, playing fields and sports facilities, school transport, public telephones and the like – but were rarely funded.[13]

Various programs of infrastructure development or service delivery have commented on the

[12] Local Government Review, conducted by Local Government Section of the Ministry of Home Affairs and Rural Development, 2000.
[13] Outer Island Trust Fund Feasibility Mission, ADB, 2001.

confusion that often exists over responsibilities for operating or maintaining these facilities. Services such as education and health are often seen to be the responsibility of central government and there is little feeling of village or island ownership or responsibility. This contributes to maintenance and quality problems, vandalism, the further attrition of community involvement, and an attitude of dependence on the government.

**Figure 6 Island Projects Approved for Funding-2001**




Source: Ministry of Home Affairs and Rural Development, 2001, unpublished data

In its most recent development plan, the Government gives high priority to the establishment of growth centres on the outer islands. Proposed sites include Kiritimati and North Tabietuea. Studies are underway to identify possibilities for sustainable economic growth in these islands and determine the necessary infrastructure and services necessary to support private sector growth, generate employment and livelihoods, and ensure the sustainable use of natural resources.

### 1.6 *Ill-health, poor diet and loss of food security*

Kiribati faces a high incidence of infectious disease, a dramatic increase of non-communicable diseases due to changes in lifestyle and diet, high risk from sexually transmitted diseases and, mainly on South Tarawa, a large number of traffic accidents. The Government's 1999-2002 Public Health Plan aimed to reduce under-nutrition among children by 25 per cent, reduce iron deficiency anaemia among children and pregnant women, decrease the prevalence of obesity and non-communicable diseases in adults, increase self-sufficiency in food and improve household food security. There is no evidence that any of this has been achieved.

Non-communicable diseases, in particular heart disease, hypertension, diabetes and cancer, are becoming more prevalent and this is contributing to increased hardship in the community and higher health service costs. In 2003, it was estimated that these diseases accounted for 8 per cent of all hospital admissions. Tobacco and alcohol-related illnesses accounted for almost 10 per cent of these admissions, a figure that could soon double.[14] Government has taken some action in this regard by developing policies to aim to reduce the harm caused by alcohol and tobacco, including the endorsement of the National Strategy to Prevent and Control Non-Communicable Diseases 2004-2009. The most challenging task will be to convert these policies into changed behaviour, with people adopting more healthy lifestyles and diets, taking more exercise, and cutting down on their use of alcohol and tobacco.

Much of the increase in non-communicable diseases arises from poor nutrition. Outer island households produce much of their own food but, on South Tarawa especially, traditional foods have been mostly replaced by imported low-grade foods - white flour, white rice, sugar and fatty meat - which are cheaper and more readily available than traditional foods. People have also acquired tastes for these foods but do not understand the associated health risks. Although there have been no recent detailed surveys, the common deficiencies in Vitamin A and C, calcium and iron are evidently caused by diets high in sugar and fatty foods and low in of fruit and vegetables.[15] Among children, the main nutrition-related illnesses are malnutrition, vitamin A deficiency and anaemia. In adults they are anaemia, obesity, diabetes and heart disease.

Poor oral health is common. Many people have toothache caused either by tooth decay or gum disease. Public knowledge of oral care is poor and the demand for dental services is high.[16]

[14] Doran, 2003.
[15] ADB, 2002a.

### 1.7 HIV AND AIDS

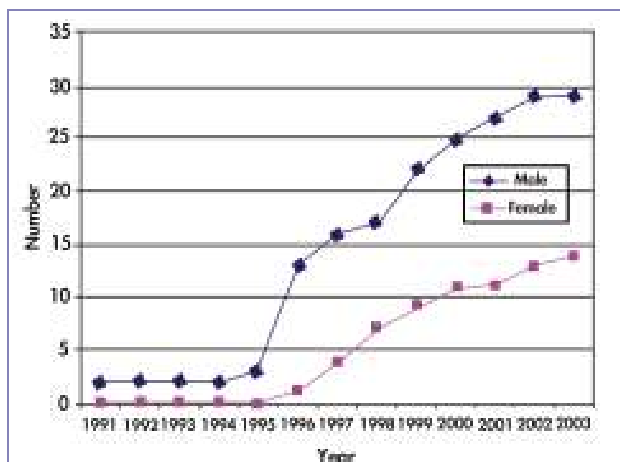
There is an incipient HIV epidemic in Kiribati. First detected in Kiribati in 1992, by 2003 there were 43 recorded cases of HIV, with 10 deaths from AIDS. Most of the people known to have HIV are adult men. Five are children under the age of five. The surveillance system is still weak but surveys are planned in order to strengthen it. Testing for HIV is only available at the national hospital on South Tarawa, with confirmation testing completed in Australia (soon to be in Fiji). A national strategy to counter the threat of HIV and AIDS was developed in 2000.[17] It proposed to increase information about the incidence of HIV in Kiribati, encourage young people to protect themselves against infection, increase the distribution of condoms, ensure that blood was screened for HIV, improve health facilities for HIV testing, treatment and care, and generally increase public understanding about how to prevent HIV from spreading. Unfortunately, implementation of the strategy has been hampered by the few resources available.

The main route for infection into Kiribati has evidently been the many men who work overseas who infect their wives and other people in Kiribati on their return through heterosexual contact. There is now mandatory testing of all seamen as they depart from Kiribati.

The prevalence of other sexually transmitted diseases and patterns of sexual behaviour increase the susceptibility of the population to HIV. The emphasis on female virginity in I-Kiribati society affects the dynamics of sexual behaviour that lie behind this vulnerability. A study conducted in 1995 of the potential health risk of AIDS in an outer island population found that women were expected to be virgins at marriage but men were encouraged to gain sexual experience and almost the only opportunity on the island to do so was through the traditionally recognised nikiranroro, or sexually available women.[18] These women are those who are known to be non-virgin but do not have a sexual partner now – a girl who has lost her virginity, even through rape, or a divorced or widowed woman.This type of sexual network would very effectively distribute a sexually transmitted infection around a small population.

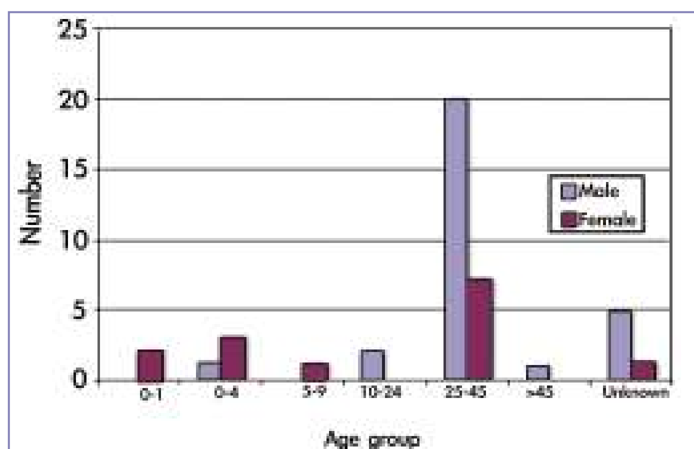
[16] ADB, 2002a.
[16] Ministry of Health, 1999.
[17] Marfarlane Burnett Centre, 2000.
[18] Brewis, 1995.

**Figure 7 Reported cases of HIV in Kiribati, 1991-2003**




Source: Ministry of Health, 2003

**Figure 8 Age and sex of people known to have HIV in Kiribati, 1991-2003**




Source: Ministry of Health, 2003

## *1.8 The changing social contexts of children's and women's lives*

### *1.8.1 The structure of I-Kiribati society*

The main decision-making levels in Kiribati are the villages, the islands and the national government. Traditional authority lies with the unimane (senior men) and the maneaba, while national authority rests with the Government and its agencies.

At the island level, decisions are variously made by the Island Council, the collective unimane, church groups, or other associations such as women or youth groups. On many islands, the community and the councils see themselves as quite separate. The unimane constitute an island-wide 'council' which often operates independently of the government-sponsored Island Council

in activities such as in organising projects or fund-raising. Women and youth groups are active on most islands but their interests get little attention from these main powerbrokers. Therefore, while the community supports the various activities of the councils, as they must, they do not necessarily consider them to be their own or expect to see any direct returns from them.

At the village level, decisions about community activities (mainly hosting visitors or events) are generally made by the unimane. Decisions about creating new facilities (eg a village well) may be suggested by the unimane but are more decided and acted upon by the bouanikaua or rorobuaka (mature men) or te ientaboniba (youth). Several years back, the Government instituted Village Welfare Groups to provide a functional decision-making body at the village level, focussed around health issues, but these committees are rarely strong. Makoro groups, usually church based, are another community institution. Generally, villages serve as a loose collective of individual households and there is a strong sense of independence between them.

### *1.9 Enviromental Health*

Kaoki Mange! – which means 'Return the Rubbish!' – is an innovative scheme to recycle aluminum cans, plastics, and other recoverable materials. Begun in 2003 as an initiative of the Kiribati branch of the Foundation of the Peoples of the South Pacific (FSP-K) and assisted by UNDP, ADB and other donors, Kaoki Mange has made good headway in reducing the amount of rubbish lying about on South Tarawa. Through its extensive public information programme, it has also encouraged people to think more about how they deal with their rubbish.

In order to support this programme, Parliament passed legislation in late 2004 to set up a Container Deposit Fund from a surcharge on imported cans. In the trial phase, Kaoki Mange paid out 2 cents per can, and in one weekend on Betio alone, 100,000 cans were collected. When the recycling programme is fully operating, the refund will rise to 4 cents per can. The whole scheme will be self-funding through the container deposits.

As well as helping to clean up the environment of South Tarawa, the Kaoki Mange programme has evolved into a viable private sector enterprise, tendered by Government to local business people. Exports of the 'rubbish' add to Kiribati's foreign earnings. From being a notoriously garbage-strewn island, South Tarawa is now leading the way in the Pacific Island region in sustainable recycling.

### 1.10 The place of children

The upbringing of children generally involves the extended family rather than simply the biological parents, although this is slowly changing, more so on South Tarawa. From an early age, children are expected to be respectful and obedient to their elders. As they mature, they are expected to take on household chores that are considered appropriate to boys or girls. The survival, development, protection and participation of children in their society will be discussed further in the chapter on children.

### 1.11 The place of youth

The Kiribati Government defines 'youth' as the age between 15 and 30 years.[19] In traditional I-Kiribati society, young unmarried people have little authority or independence from their family or community. Both young men and women are expected to contribute their labour and salaries to their families, although young men have more free time to themselves. There is a strong cultural value for premarital chastity and social expectations about the correct behaviour of young people generally remain strong. The attitudes and expectations of young people themselves are changing faster, more quickly perhaps in South Tarawa than on the more traditional outer islands. Social problems involving young people are growing, especially on South Tarawa.

Over the past decade, opportunities for secondary and tertiary education have soared. More young people are becoming qualified for jobs that are in short supply in Kiribati. Some are finding work abroad. Most, however, are out of school by the age of 15 or so, and must find their livelihoods in household work or semi-subsistence fishing or farming. Church youth organisations involve young

[19] Ministry of Environment and Social Development, 2001.

people in activities such as fund raising, cleaning or constructing church buildings, sports events, and cultural activities such as singing or dancing competitions. Young people in rural communities are quite busy but on South Tarawa there is more unemployment and less unpaid work to do.

### *1.12 The roles of women*

Although the status of women in Kiribati is changing, they are generally treated as subordinate to men. Women can inherit or own land in I-Kiribati tradition, but they usually still have less access to modern types of resources. There are nevertheless a growing number of women working in skilled and professional jobs, including at the highest levels of government.

The position of a woman in I-Kiribati society is largely defined by her age and marital status. A married woman with children has prestige but her husband holds considerable authority over her, and this has much bearing on the freedom she can exercise to take part in activities. There are many restrictions on women's movements to safeguard their reputation, in line with traditional values regarding chastity. Within the household, women are largely responsible for domestic work including cooking, cleaning, child care and overall family welfare. Within the village community, women are often responsible for meeting the bukinibwai (village shares, often for food, money or entertainment) as stipulated by the unimane. This can be quite a heavy obligation, for giving and meeting social obligations is a matter of community pride. Within the broader community, women have a large responsibility for producing the cash and traditional goods that are the currency of the traditional economy. This includes regular fund-raising for community functions and the church.

### *1.13 The role of the media in social change*

In 2005, South Tarawa acquired its first television station, beaming in programmes from the United States (CNN) and Australia (ABC Pacific). Local programmes are restricted to a few hours in the evening, mainly news or a video from a local production company. This has considerably increased access for people on South Tarawa and a few outer islands to international news. Until a few years ago, there was only one radio station and one newspaper, both run by the Government. There are now other services available but, even so, radio reception and newspaper circulation is quite restricted in the more distant outer islands. Telephone connections are expanding but are also still limited in the outer islands because of reception difficulties. Connection to the Internet is available on South Tarawa and Kiritimati but few locals yet use it, in part because it is expensive. I-Kiribati

people also travel quite often and this again serves to bring new experiences and ideas into the culture.

Videos and DVDs have been widely available throughout Kiribati for some years. There is often little consideration of the appropriateness of their content for young people. Many children watch violent and sex-related movies, becoming conversant with things that would have been unthinkable even a generation ago.

> The problem we face is that children are the ones who go to video shops to hire cassettes. If they choose cassettes that are not appropriate for them, the video shopkeeper does not prevent them from obtaining that film. Even at home children watch without strict guidance from parents. We find it a waste of time to do ratings without enforcement. Those who hire out films do not comply with our rating instructions. There is no clear law to guide enforcement.
>
> Chief Comptroller of Customs, Member of Film Censorship Board, September 2004, as quoted in RRRT and UNICEF, 2004.

### *1.14 The churches*

The churches are a strong institution in Kiribati and an important source of both social change and stability. Almost all of the population are Christian. The Catholic Church and the Kiribati Protestant Church (KPC) account for one half and one-third of the population respectively. Other denominations include the Seventh Day Adventists, the Church of the Latter Day Saints, the Assembly of God, and the Church of God. The other most sizeable faith is Bahai. The churches provide spiritual direction and are also involved in social and community development. They operate almost all of the secondary schools and engage community groups in various activities, such as sports programmes for youth and domestic training for women. Church affiliated community groups, or te makoro, are active in fund-raising and in the organization of community activities. Church fund-raising draws the community together for a common purpose but also puts some economic and social pressure on families. Families contribute to te karea (offerings) for the church, with some fees being almost $300 a year, with much shame put on the family if the fee is not met.

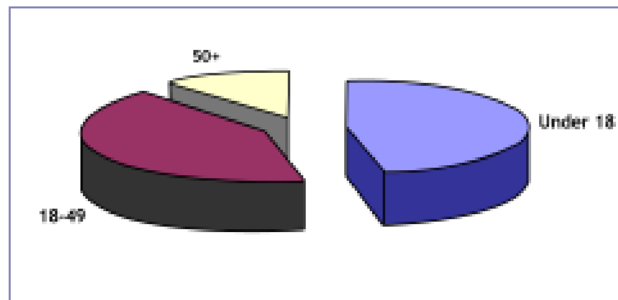
VOLUME 15
THE
SESAME STREET
LIBRARY
With Jim Henson's Muppets
FEATURING
THE NUMBER
15
15

# Part 2
## The Situation of Children

## *2.1 Children in the population*

People under the age of 18 years make up just less than half (47 per cent) of Kiribati's population. The median age of the Kiribati population is 19.7 years, making it one of the more youthful in the Pacific Island region. This means that national investment in services for children, particularly education and health, will need to remain high for at least another generation.

**Figure 9 Age structure of the Kiribati population**




Source: Kiribati National Census 2000

There is no definition of the word 'child' in Kiribati law, nor is there any specific legislation in regard to juvenile justice. As outlined in Chapter One, Kiribati is signatory to several international agreements to improve the status of children. In line with Article 1 of the Convention on the Rights of the Child, this report describes children as persons under the age of 18 years, but it is important to note that there is some ambiguity in Kiribati law as to who is a child (Table 5).[20]

National policies in Kiribati have long sought to improve the survival and development of children. The emphasis on meeting basic needs is reflected in the distribution of government spending. The broader commitment to children's rights that comes with ratification of the Convention on the Rights of the Child is not yet so well understood or acted upon.

[20] National Advisory Committee on Children, 2002

**Table 5 Various definitions of a 'child' in Kiribati**

| Definition | Age | Source |
|---|---|---|
| Minimum age for criminal responsibility<br>Minimum age for trial in court<br>Minimum age for criminal responsibility unless it can be proved that they had the capacity to know their act or omission was wrong | 10 yrs<br>10 yrs<br>14 yrs | Penal Code, Section 14, Cap 67 |
| Minimum age for imprisonment | 15 yrs | Penal Code |
| Juvenile offender: If jailed, must be separated from 'young persons' and adults | Under 16 yrs | Penal Code |
| Presumed incapable of having sexual intercourse. A child's alleged willingness to engage in sexual activity therefore cannot be used as a legal defense by the perpetrator | Under 12 yrs | Penal Code, Section 134 |
| Minimum age for sexual offences or sexual consent | 13 yrs | |
| Minimum age for marriage<br>Marriage requires consent of parent or guardian | 16 yrs<br>Over 16 and under 21 years | Marriage Ordinance, Section 5 |
| Minimum age to drink alcohol, enter drinking establishments, sell or serve liquor | 21 years | |
| Minimum age for any employment<br>Minimum age for employment in industrial work or on ships, or any other activity, unless otherwise approved by the Minister | 14 years<br>15 years | Employment Ordinance, Section 84 |
| Ages for compulsory attendance at school | 6-14 years | Education Ordinance. (However under Section 29, the Minister can specify the ages of children in specific places or islands to which parents must ensure their regular attendance at a registered school.) |

Source: National Advisory Committee on Children, 2002

## *2.2 Health and well-being*

Diarrhoea and respiratory infections are the main killers of children, and water and food-borne diseases are major causes of illness. Nevertheless, infant and child mortality rates have apparently dropped considerably over the past decade (Table 6), although these statistics are not particularly certain.

According to the last census in 2000, infant mortality was higher in urban South Tarawa than in other parts of the country. The rate for males was 50.3/1000 live births in the urban area, compared with 41.0 in rural areas. There was a smaller differential for female infants, of 40.0 in the urban area and 39.7 in rural areas. Overall, the census recorded 20 per cent higher infant mortality on South Tarawa than elsewhere in the country, despite better access there to medical services.[21] Hospital admission records appear to tell the opposite story but unfortunately the state of medical statistics is too weak to allow for a sound analysis.

**Table 6 The state of infant and child health in Kiribati**

| | Males | | | Females | | |
|---|---|---|---|---|---|---|
| | 1990 | 1995 | 2000 | 1990 | 1995 | 2000 |
| **Child survival indicators** | | | | | | |
| Infant mortality rate | 68.3 | 67.5 | 45.0 | 66.5 | 56.3 | 43.0 |
| Childhood mortality (1-4 yrs) | 28.3 | 27.8 | 14.0 | 26.8 | 20.8 | 13.0 |
| Total Under 5 mortality | 96.6 | 95.3 | 59.0 | 93.3 | 77.1 | 56.0 |

Source: Statistics Office, 2004

| **Related medical services** | 1985 | 1990 | 1995 | 2000 | latest |
|---|---|---|---|---|---|
| % of births delivered by trained personnel | 76 [1] | 54 [3] | - | 85 (1998) [3] | 81 (2003) [3] |
| Immunisation coverage for infants (av) | | | | 73.1 [4] | |
| % of population covered by Primary Health Care | | 80 [2] | 90 [2] | 95 (1998) [3] | |

Sources: [1] Statistics Office, 1989; [2] UNFPA, 1996; [3] WHO, various dates; [4] Ministry of Health

| **Child health indicators** | 1985 | 1990 | 1995 | latest |
|---|---|---|---|---|
| Percent of newborns weighing less than 2500 gm at birth | -- | -- | 3 (2) | 5.4 (1998) (3) |

Data on causes of ill-health are weak in that a high proportion of the reported cases are only classified as 'others' (Table 7). Acute respiratory disease and diarrhoea top the list for children under the age of 15 years and although it is not a common cause of hospitalisation, malnutrition is an underlying cause of much of their ill-health.

[21] Statistics Office, 2004.

**Table 7 Ministry of Health, total reported cases affecting children, 2002**

| Under 1 year | | | 1-4 years | | | 5 – 14 years | | |
|---|---|---|---|---|---|---|---|---|
| Disease | Number | Per cent | Disease | Number | Per cent | Disease | Number | Per cent |
| Others | 3656 | 27.4 | Others | 14620 | 37.3 | Others | 17550 | 47.8 |
| Other ARI | 3301 | 24.8 | Other ARI | 7439 | 19.0 | Acute fever | 6357 | 17.3 |
| Acute fever | 2921 | 21.9 | Acute fever | 7041 | 17.9 | Other ARI | 6036 | 16.4 |
| Diarrhoea | 1470 | 11.0 | Diarrhoea | 4308 | 11.0 | Diarrhoea | 2244 | 6.1 |
| Pneumonia | 724 | 5.4 | Dysentery | 2042 | 5.2 | Conjunctivitis | 1755 | 4.8 |
| Scabies | 420 | 3.2 | Conjunctivitis | 1406 | 3.6 | Dysentery | 1413 | 3.8 |
| Conjunctivitis | 362 | 2.7 | Pneumonia | 1169 | 3.0 | Pneumonia | 463 | 1.3 |
| Dysentery | 264 | 2.0 | Scabies | 659 | 1.7 | Scabies | 432 | 1.2 |
| Malnutrition | 112 | 0.8 | Malnutrition | 269 | 0.7 | Fish or food poisoning | 184 | 0.5 |
| Dengue | 84 | 0.6 | Dengue | 174 | 0.4 | Malnutrition | 125 | 0.3 |
| Meningitis | 7 | 0.1 | Fish or food poisoning | 74 | 0.2 | Dengue | 108 | 0.3 |

Source: Ministry of Health, 2005, unpublished data

### *2.2.1 Diarrhoeal diseases*

The incidence of diarrhoea is high because of poor environmental health and the prevalence of rotavirus. (Rotavirus is the most common cause of severe diarrhoea among children globally but is more often fatal in poor countries like Kiribati.) Better sanitation and possibly the development of rotavirus vaccine could markedly drop the incidence of diarrhoea, but even now there is no good reason for children to die from it. One reason these readily preventable deaths continue in Kiribati is that many people do not recognise that it is the delay in rehydration that is so often fatal.

A 1995 study identified the cultural underpinnings of community understanding about diarrhoeal diseases and people's behaviour towards hygiene.[22] Children's health was commonly understood in terms of 'te bae,' a generic term for children's illnesses in traditional medicine. Diarrhoea was so common a problem in children than mothers often considered it unavoidable and even 'normal' at some times such as teething, monthly high tides or festivities, or after a child had taken traditional cleansing medicine (te kabekanako). Resumption of sexual intercourse or a new pregnancy was also thought to cause diarrhoea by altering breast milk. Local medicine and massage were sought as first cures when mothers suspected te bae or that a child had a 'broken tail bone,' an expression for the period when a child was changing from crawling to walking and still often fell. Many mothers did not know that exclusive breast-feeding and immunisation helped to prevent diarrhoea in their infants.

[22] Saito, 1995.

The survey found that most people said they knew how to prevent diarrhoea (by boiling water, personal hygiene), but few said they actually followed these methods. Most babies were breast-fed but feeding bottles were widely used, often in unhygienic ways. Children were usually allowed to defecate anywhere and these faeces were mistakenly perceived to be 'harmless.' Although most mothers recognised that dehydration posed some danger, they usually waited to see if the diarrhoea would stop of its own accord or would give the child local medicine which would make the diarrhoea worse. Most did not seek treatment until the child had passed watery stools several times, was vomiting, or showed real signs of dehydration.

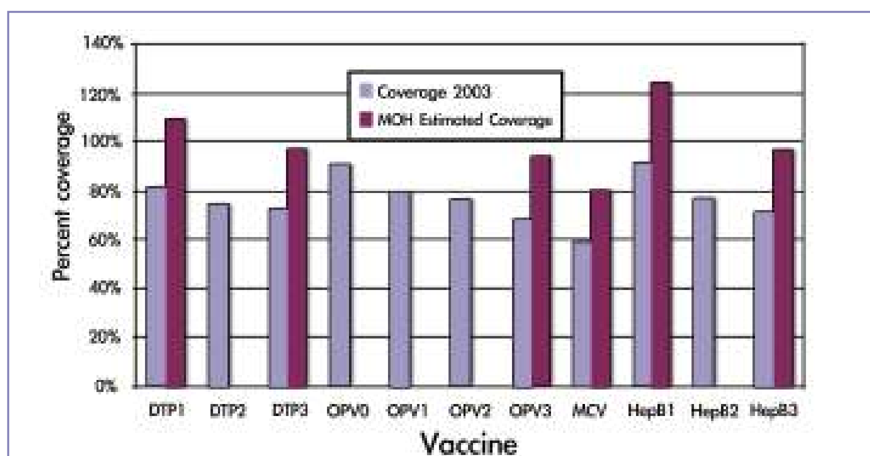
A decade later, health workers find that community attitudes remain the greatest obstacle to preventing children dying from diarrhoea. Oral rehydration salts are widely available in health centres but a common belief is that this 'medicine' is worthless because it does not cure diarrhoea. Of course, the role of the salts is not at all to stop the diarrhoea but to prevent the child from dehydrating while the disease runs its course. Somehow, despite many health education programs, this message has still not been sufficiently integrated into local perceptions of health and illness.

### *2.2.2 Child immunisation*

The Ministry of Health has been conducting immunisation programmes against main childhood diseases since 1983, including tuberculosis (BCG), diphtheria (DTP3), polio (Pol3), measles and hepatitis B (HepB3). Kiribati was declared polio free (together with neighbouring Pacific Island countries) in 2001.

Coverage of the immunisation programmes has been uneven, particularly in the outer islands. The Ministry of Health reports that they average out at around 90 per cent, but the denominator used to calculate these rates is the number of children under the age of one year from the 2000 census, a population that may have been under-counted. As no allowance was made for annual growth, this figure would under-estimates the true size of this population. When the denominator is adjusted to do so, the estimated immunization rate drops significantly, by up to 20 per cent. (Figure 10) .

**Figure 10 Reported and estimated immunization coverage rates, 2003**




Immunization coverage rates (children under 1 year) from 2000 to 2004 have been recalculated using as the denominator the 2000 census total population adjusted by the crude birth rate of 26.4 (births per 1000) and an annual growth rate of 1.69 per cent.

The National Health Plan, 1999-2002 aimed to strengthen the National Expanded Programme on Immunization (EPI) by maintaining routine coverage at least at an average 90 per cent; maintaining adequate supplies of vaccines, carriers, syringes, needles and safety boxes; adequately maintaining all cold chain equipment; increasing community understanding about the importance of immunization; immunizing children sick with a fever, cough, diarrhoea or other mild illness in order to reduce missed opportunities, immunizing every woman aged 15-44 years against tetanus; and giving hepatitis B vaccine to all infants as early as possible after birth.

Evidently these goals have not been reached. EPI coverage has not improved and may even have slipped. Difficulties in the implementation of the EPI programme include:

- Operating and maintaining equipment. Most cold chain equipment is old and currently only 45 per cent of health centres have this equipment in any working condition. Some operating procedures have not been followed closely enough. Many vials of vaccines have been spoiled. There is a high on-going cost of repairs to equipment particularly on the outer islands;
- Maintaining an adequate level of training of health staff, particularly where there has been a high turn-over of personnel;
- Maintaining a sufficient level of reporting from the health centres to ensure that the national EPI programme is thorough and efficient. There have been difficulties with monitoring vaccine usage and stock control;
- Poor disposal of hospital waste, including used syringe needles.

Measles coverage is particularly weak and young children are at risk of a severe measles outbreak. Most children over the age of seven years would have developed immunity from measles immunization programmes in 1997 and 2001 as well as past exposure, for measles outbreaks were common before 1997. The recently low rate of measles immunization (an average of 62 per cent over the past five years) and less than total efficacy of the vaccine means that there is a sizeable number of young children who have no immunity. Given the high rate of malnutrition and the high infectious disease load, a measles outbreak would be most dangerous. Mass measles vaccination campaigns have been conducted every five years since 1990, and Kiribati is due for another one.

### *2.2.3 Nutrition problems*

Nutrition problems in children result from repeated bouts of diarrhoea, heavy worm infestation, and the general change in diets. The problem is more that of children eating unhealthy or inappropriate foods than having inadequate food. While there still is limited access to 'junk' food in Kiribati, children eat a lot of food high in sugar, such as 'ice-blocks' – heavily concentrated cordial sold in plastic bags. There has been no survey of dental caries although almost certainly it is increasing.

The Government's 1999-2002 Public Health Plan aimed to reduce under-nutrition among children by 25 per cent by 2002, eliminate vitamin A deficiency, and reduce iron deficiency anaemia among

children and pregnant women. While poor child nutrition quite evidently contributes to the prevalence of child illness and deaths, there is very little data on nutrition standards in Kiribati. A national survey in the late 1980s was not well conducted. A STEP survey was underway in the outer islands in early 2005.

Breastfeeding, which is still common in Kiribati, reduces nutrition problems in infants. On South Tarawa, however, breastfeeding is declining. Possible reasons for this include insufficient follow-up by midwives to make sure that breastfeeding is established, more accessibility to bottles and breast-milk substitutes, and, along with higher cash incomes, some people believe that bottle-feeding is the western norm and therefore better.

Vitamin A deficiency still affects children in Kiribati. Vitamin A is a nutrient essential for the normal body function and a deficiency of this micro-nutrient increases the risk of night blindness (xerophthalmia), persistent diarrhoea, growth retardation, skin disorders and generally low resistance to infection. Green vegetables and fruit such as pawpaw and pandanus are high in Vitamin A. Traditionally, neither figured much in the local diet, although tastes are changing. Since 1992, UNICEF has funded the distribution of Vitamin A capsules and supported education programs to encourage parents and children to eat and produce more Vitamin A rich food.[23]

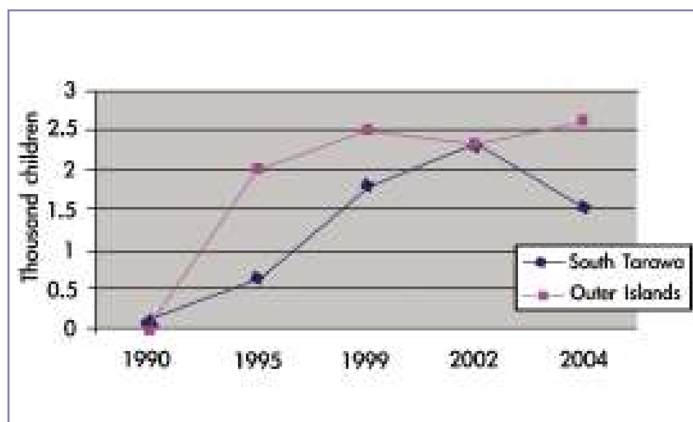
## *2.3 Child development*

### *2.3.1 Early Childhood Education*

Since the early 1990s, early childhood education has grown quickly in Kiribati, and with it the number of centres and pupils. From almost zero preschool enrolments in 1990, by 2004, 62 per cent of new entrants to Class 1 in Kiribati's outer islands had attended preschool programs (Table 8). This success in expanding access to early childhood development programmes has come about through the collaborative efforts of UNICEF and the University of the South Pacific, and support from the Ministry of Education. In particular, the energetic work of the Kiribati Early Childhood Education Association (KECEA) has made a great contribution to community understanding about the importance of early childhood development and strong parental and community support for it. The preschool programme is, nonetheless, not yet fully developed. For example, although KECEA has developed a curriculum, it is not enforced and many preschools do not follow it.

[23] Ministry of Health and Medical Services, 1999.

**Figure 11 Growth in pre school enroments, 1990-2004**




Sources: Ministry of Education and UNICEF, 2000 for data to 1999; Kiribati Education Management Information System for 2002 and 2004

The Ministry of Education allocates no funds to preschools but from 1996 provided a one-year certificate course at the Kiribati Teacher's College, a programme that was discontinued in 2001 but will soon resume. The Bahai Church also runs a preschool training programme. Training workshops for pre school teachers have been conducted on South Tarawa and most of the outer islands.

**Table 8 ECD Enrolment by District**

| | Gross enrolment in ECD programs (%) | New entrants to Class 1 who had attended ECD programs (%) |
|---|---|---|
| District North | 25 | 51 |
| District South | 57 | 86 |
| District Central | 39 | 66 |
| Linnix District | 14 | 25 |
| Outer Island total | 33 | 62 |
| South Tarawa | 45 | 49 |

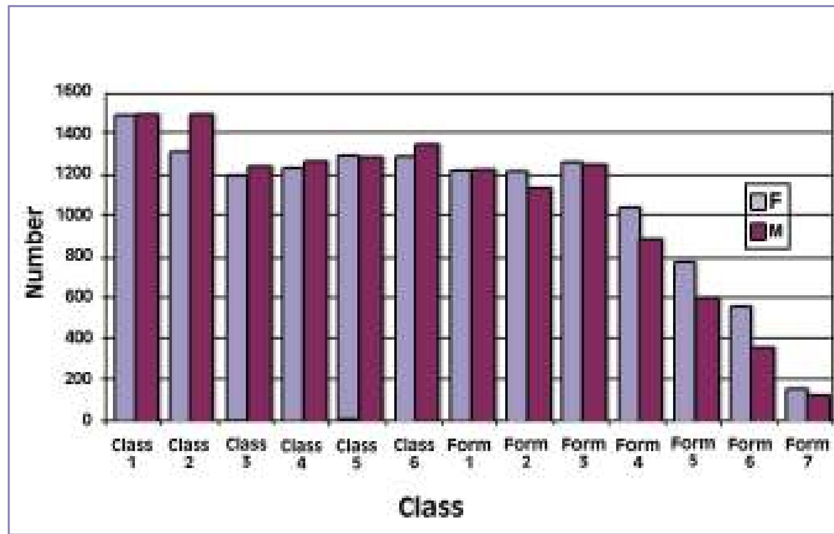
Source: Kiribati Education Management Information System. 2005

## *2.4 Access to basic education*

### *2.4.1 High enrolments*

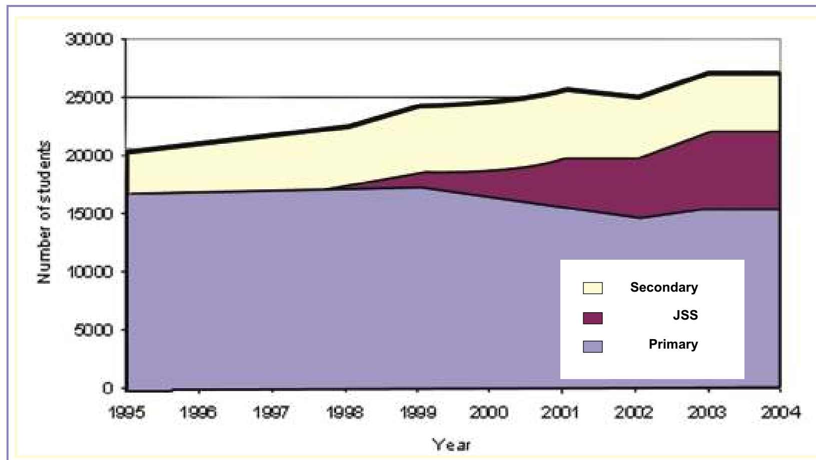
Over the past two decades, there has been a large expansion of the education system in Kiribati. Enrolments of girls and boys at primary school are roughly equal, but girls now outnumber boys at secondary school and tertiary level (Figure 12).

**Figure 12 School Enrolment by Class and Sex. 2004**




Source: Kiribati Education Management Information System, 2004

**Figure 13 The changing structure of Kiribati's education system, 1995-2004.**




Sources: Ministry of Education, 2001 (1995-2001) KEMIS, 2005 (2002-2004)

In 1998, attendance at primary school (6 to 11 years) and Junior Secondary School (JSS) (12 to 14 years) became free and compulsory for children throughout Kiribati. There is a high level of primary school enrolment, although despite the requirement that all children aged 6 to 14 years must attend, according to the Census in 2000 around 9 per cent of boys and 7 per cent of girls did not.

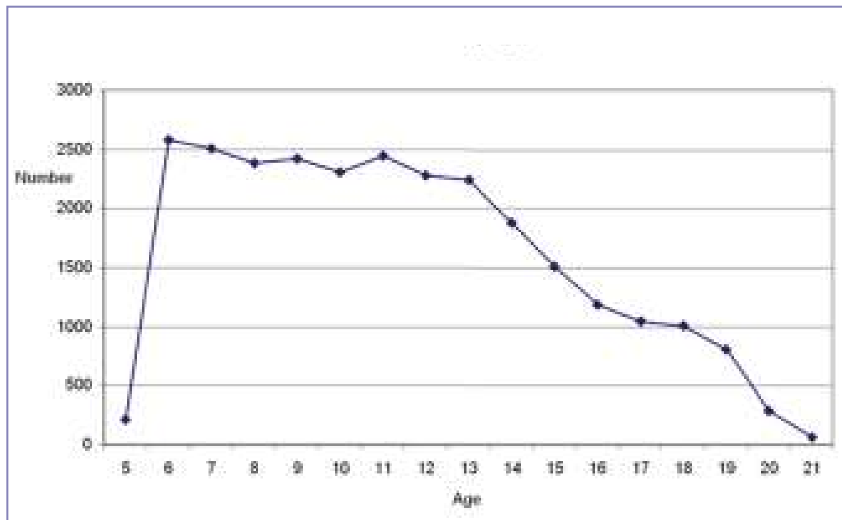
The first Junior Secondary Schools (JSS) were established in 1998 to expand opportunities for post-primary education especially on the outer islands and ensure that all children up to the age of 14 could attend school. Built with assistance from AusAID, 24 new, well-designed schools with good facilities were in operation by 2004, with a total enrolment of 5,860 students aged 12 to 16 years. Where the JSS have been less endowed, however, is with qualified and experienced teachers. This is perhaps inevitable in such a fast growing system. The Ministry of Education is working quickly to meet the demand for trained teachers but in 2002, over one third (37 per cent) of JSS teachers had three years or less of teaching experience. An associated problem is poor discipline in some JSS, with principals reporting rowdy behaviour, drunkenness and vandalism and local communities complaining that students do not abide by village rules.

In the final JSS year, students sit the Junior Secondary Certificate Examination, and this allows for competitive entry into church and government-run secondary schools. Secondary school enrolments have also expanded but increasingly concentrate on senior levels. Junior secondary level students are being phased out and the last year for enrolment of Form 3 students was 2003. There are still not enough secondary school places for all potential students however and they remain concentrated on South Tarawa, accounting for 52 per cent of enrolments in 2003. This situation controls to constrain academic opportunities and achievements.[24]

The schools are being complemented in rural areas with a programme of developing Island Learning Centres, with assistance from the European Union. These centres will provide trade training for young people who leave the JSS but do not continue on to secondary school, as well as a venue for other non-formal and community education programmes.

[24] Kiribati Education For All Report, 1999.

**Figure 14 School Enrolments by Age, 2004**

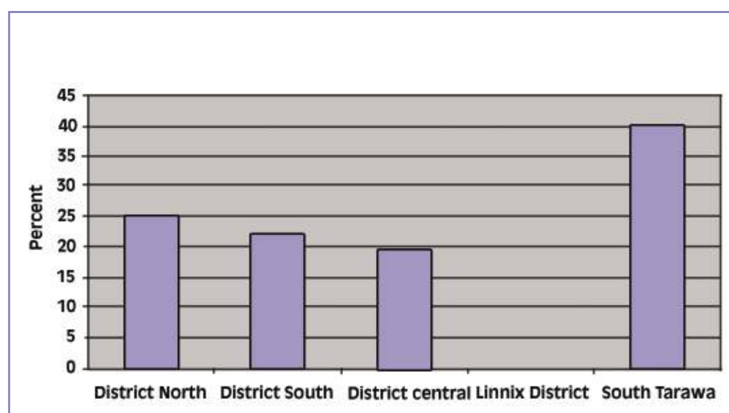



Sources: Kiribati Education Management Information System.2004

### *2.4.2 Concerns about quality*

While much progress has been made in increasing access to school, there are concerns with the quality of education that is provided. The Ministry of Education regularly reports on enrolment figures, teacher qualifications and physical infrastructure, but information on learning outcomes must be gleaned from national examination results (generally low) and deduced from data on teacher qualifications and experience (mostly limited).

**Figure 15 Percent of qualified Primary School Teachers, 2003**




Source: Kiribati Education Management Information System, 2004

While efforts are being made to close the gap, outer island schools are generally disadvantaged in that they often have poorer facilities and less qualified teachers, are more difficult for the Ministry to supervise, and suffer the inevitable handicaps of remoteness. Fewer of their students qualify to enter secondary school than from South Tarawa schools, in part because outer island children have less fluency in English, the main language of instruction at secondary school.

The expectation of better quality education in South Tarawa encourages families to send their children there, or to move there themselves. Schools on South Tarawa are often crowded - the average enrolment in 2004 was 475, but the largest school had over 1000 pupils - while many outer island schools are quite small.  The distribution of teachers, however, is now quite even throughout the country in relation to the number of pupils, and this represents important progress towards improving the quality of education throughout the country.

**Table 9  Pupil-Teacher Ratios in Primary Schools and JSS, 2002**

| School District | Primary Schools | Junior Secondary Schools |
|---|---|---|
| Central | 21.9 | 18.7 |
| North | 23 | 19.8 |
| South | 23 | 16.6 |
| Linnix | 29.7 | 18.3 |
| **Outer Island Average** | **23.2** | **18.4** |
| South Tarawa | 21.6 | 20 |

Source: METT Annual Statistical Report, 2002

Since its establishment in 2002, the Kiribati Education Management Information System (KEMIS) has brought about a great improvement in the quality, range, and timeliness of information about Kiribati's education system. This AusAID-funded project is also helping to integrate sound, well-chosen indicators into decision-making processes in the Ministry of Education. Using EXCEL-based software, KEMIS enables the production of comprehensive annual reports on all aspects of the education system, and provides a dynamic database that readily caters for a wide variety of queries.

Plans to further develop KEMIS include refining the software, increasing the skills of Ministry personnel and improving organisational processes within the Ministry of Education, Youth and Sports, in order to:

- Widen the scope of available data and improve its quality and reliability;
- Develop the ability of the MEYS Statistics Unit to produce published data and manage data resources;

• Develop the capacity of senior management to interpret and analyze available information as part of the Ministry's planning process; and

• Provide information that will support Ministry staff at an operational level.

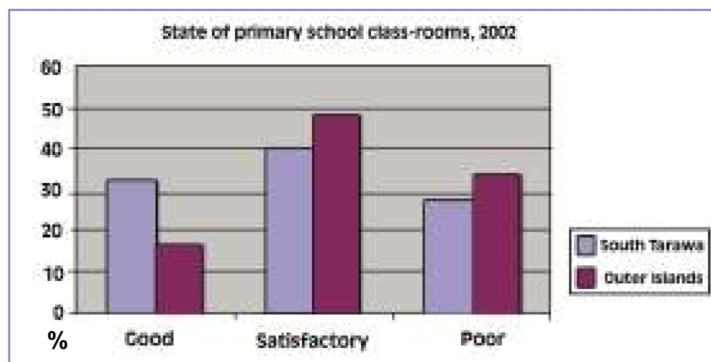
### *2.4.3 Health and well-being issues*

An issue of concern is the physical conditions in which children attend school and the consequences to their health. Children spent around five hours during the hottest part of most days on school compounds and even more walking to and from schools. Many buildings are in poor condition, many schools have an inadequate water supply, and on the crowded school compounds in South Tarawa especially, the lack of working toilets poses a health hazard to the children and neighbouring residents.

• In 2002, only 15 per cent of outer island classrooms were categorised by the Ministry of Education as "good", compared with one third of the classrooms in South Tarawa schools (Figure 16). Even on South Tarawa, therefore, many students attend school in dilapidated buildings with damaged equipment and few facilities. 'Permanent' school buildings are often in need of repair, especially in the outer islands, with leaking or collapsing roofs, broken walls, and broken or missing windows and doors.[25]

[25] ADB, 2002b.

**Figure 16 State of Primary School Classrooms, 2002**




Source: Ministry of Education, 2003

- In 2003, only 21 per cent of Kiribati's primary schools had a 'very good' water supply. In 40 per cent of schools it was 'satisfactory' (meaning perhaps one tank or well) and in the other 39 per cent of schools, it was 'poor' or 'very bad'.[26] In 2004, the SAPHE Project donated two rain-water tanks to each of the primary schools on South Tarawa to provide a safe source of drinking water for the children. Before this, several schools had no water supply for the children or, if anything, sometimes a small ferro-cement tank for the teachers' use. According to head-teachers, children either had to bring a bottle of drinking water to school (few did) or 'drink ice-block', small plastic bags of highly sugared cordial that are sold on the school compound, and whose water quality can be questionable.[27]

- In 2004, few toilets in South Tarawa primary schools were in working order. A survey of the 12 primary schools found only seven had any working toilets, and these were mostly reserved for teachers. Children used the beach and nearby vegetation. In all, there were 27 toilets in any working order for the 6,514 primary school students on the island, an average of one for every 241 students – in reality most children had no access to a toilet at all.[28]

A difficulty that head-teachers face is vandalism or theft of school property by neighbouring residents, including the trampling of fences and deliberate breaking of water tanks. Some schools in Bairiki and Betio are well resourced and maintained, particularly those that have strong parent-teacher associations. Schools in poorer areas generally lack both extra resources and community support. Head-teachers are almost powerless to prevent damage to school facilities.[29]

[26] METT, 2003.
[27] Community Development and Sustainable Participation Project, MESD, 2004.
[28] Community Development and Sustainable Participation Project, TA 3838_KIR, 2004.
[29] Community Development and Sustainable Participation Project, MESD, Workshop for South Tarawa Head Teachers, August 2004.

This problem connects back to the lack of a sense of ownership of, or responsibility for, school facilities by the community. A recent ADB report noted that even Island Councils seemed to feel that the repairs were the responsibility of Government, even if that meant that no repairs would be made. Building repairs and maintenance take up a large part of the Ministry of Education's budget for primary schools, and these funds might be used more effectively if they were managed by people with a direct interest in the school. 'The capacity of communities to care for schools should not be underestimated. If they have ownership of the outcomes, they can transform the school environment.' [30]

### 2.4.4 School facilities for disabled children

There are very few facilities for disabled children and many do not attend school. The only school in the country that caters to children with disabilities or special learning needs is on South Tarawa, and is supported by the Red Cross. The school has a small staff and is wholly supported by local and international donations. Through the efforts of its dedicated management committee and parent's committee, the school facilities have recently been upgraded.

## 2.5 Children in special need of protection

### 2.5.1 Child adoption

Many children are adopted informally in Kiribati in accordance with the tradition of sharing children between families. There is little information available about this and it can only be assumed that these traditions continue to provide protection for adopted children. It is more apparent that aspects of the law relating to formal adoption do not fully protect the child, and this law may need to be revised. For example, it allows that a legal adoption could be annulled by the Court if the adopted child or grandchild is not sufficiently dutiful or caring towards his or her adoptive parents or grandparents.[31] The Social Welfare Department is sometimes asked by the Court to prepare a welfare report on the child and the prospective parents, but this is at the discretion of the magistrate, not a firm requirement.

### 2.5.2 Children who are neglected or abused

Very few reports reach the Department of Social Welfare or the Courts regarding neglect or abuse

[30] ADB, 2002b.
[31] Pulea, 1986:141.

of children. This is not considered to be a prevalent problem in Kiribati and it is generally assumed that the extended family provides children with some buffer against an abusive home situation. Nevertheless, parent-child relationships in Kiribati are very formal with little scope for negotiation and punishment can be a very severe physical beating. Mothers seem to be a little more flexible than fathers, and grandparents tend to be more approachable than either mothers or fathers.[32]

A passive form of neglect is quite common. Many children are sent to stay with relatives while they attend school on South Tarawa and in the large households common there, they may get little supervision or attention given to their needs. Parents often busy with their jobs or community affairs spend less time with their children. There are many single parent families, especially with men working overseas. The break-down of family ties between parents and children and Western influence have been blamed for the increased incidence of youthful misdemeanours and crimes.[33]

### *2.5.3 Children who are exploited*

The Employment Ordinance sets the minimum age for employment at 14 years. Because of the high demand for paid employment there are very few children under this age employed in the formal sector. In Kiribati's semi-subsistence economy, however, the line between child labour and the household chores normally expected of children is more blurred. Children who are out of school are usually expected to help with household work, assuming heavier tasks as they get older. In South Tarawa, some young children are sent out to sell brooms, combs, garlands and other small goods on the street.

Child sexual abuse is common and a serious concern, not just because of the heinous nature of this crime but because of the particularly serious repercussions for the victim in this society. Even a very young child who loses his or her virginity through rape can be labelled as 'permanently spoiled' and face enduring stigma. Most reported cases of child rape involve close relatives, usually men or boys well known to the victim. A spate of attacks in 2000 on very young children sparked community concern. A national workshop that year, organised by the Ministry of Environment and Social Development, discussed the connection between alcohol, family violence and sexual abuse; the lack of legal protection or counselling for victims; and the need to provide other livelihoods to young girls to counter the enticement of prostitution. A central problem is that the true extent of sexual

[32] McMurray, 2001.
[33] Ministry of Environment and Social Development, 2001.

abuse of children is not known – indeed it is still denied by some people - and there is very little information to guide future policy and law reform.[34]

There is no evidence of organised child sex tourism or child trafficking for sexual purposes.[35] Kiribati has a very small tourism industry. Most visitors to the country are on short-term work assignments, rather than on holiday, although cruise ships make brief visits to Fanning Island. Both hard-core and soft pornography, however, are quite widely available on videos and via the Internet. In 2004, one case of pornography production was before the Court, possibly involving young I-Kiribati girls as subjects.[36]

### *2.5.4 Children who become pregnant*

Few young teenagers become pregnant in Kiribati but it does happen and, as is usually the case, is reportedly often a result of rape or incest. In the ten years from 1994 to 2003, there were 25 recorded births to girls aged 15 or less. This number is certainly an undercount as it comes from hospital admissions only. Many births are attended by Traditional Birth Attendants and the age of the mother is not recorded. Because of the shame associated with early teenage pregnancies, more likely than not, births to very young mothers occur outside of the official health system whenever possible.

When a girl loses her virginity, consensually or through rape, apology and reconciliation (te kabara bure') is sought between the two families and her marriage is often arranged to the boy or man involved. Most schools will not accept girls as students once they are engaged, married or pregnant, a policy which discriminates against girls and, in the case of rape or an unintended pregnancy, adds to their burden of guilt and shame.[37]

### *2.5.5 Children involved with the law*

Few children come before the Courts in Kiribati. The CRC advocates that all children up to the age of 18 be given special treatment by the judiciary and that judicial proceedings and institutional placements should be avoided wherever possible. In Kiribati, there are no special provisions yet in place for children, and children as young as ten years old can be held criminally responsible and tried in Court.

[34] RRRT and UNICEF, 2004.
[35] RRRT and UNICEF, 2004.
[36] RRRT and UNICEF, 2004.
[37] RRRT and UNICEF, 2004.

## 2.6 Public understanding about child rights

After Kiribati acceded to the CRC in 1995, all provisions of the Convention became binding, except Articles 24b, c, d, e, f; 26; 28b, c, and d, on which the Government declared its reservations. In 2004, the Government lifted reservations on all articular except 26. After its ratification, the Government established the Kiribati National Advisory Committee on Children (KNACC) to oversee advocacy for and implementation of the Convention. Responsibility for the KNACC first rested with the Ministry of Environment and Social Development, and after 2004, with the Ministry of Internal and Social Affairs.

During its first few years, the KNACC was handicapped by inadequate resources in terms of people and funds. No separate budget was allocated for implementation or monitoring of the CRC. For Committee members, the work involved was additional to their often already heavy work-loads. The Committee had little access to the types of information that were needed to gather information on issues pertinent to the CRC. Even more critically, the Committee lacked coordination or leadership. Its members themselves did not fully understand the responsibilities of the Committee nor how the CRC relates to the everyday work of the Government and NGOs, particularly as membership of the Committee constantly changed.[38]

Despite the early difficulties, an Initial Report on the CRC in Kiribati was produced in 2002 and presented to the UNHCRC in Geneva in 2005. The judiciary, police, Social Welfare Department and some NGOs have also taken some actions to address child rights and protection issues in Kiribati, with assistance from international donors.

[38] KNACC, 2002.

# Part 3
# The Situation of Youth

### 3.1 Introduction

In Kiribati, youth are defined as people aged 15 to 30 years, which partly overlaps with the age-group of children.[39] In 2000, this age-group made up 25 per cent of Kiribati's population, down from 28 per cent in 1995.

Young people in Kiribati are privileged by the wider opportunities they have today for education, compared with their parents' generation, but this education is less likely to translate into paid employment. They also especially face the effects of rapid social change. The Government of Kiribati has recognised that social problems among young people are growing more serious and that outer island youth face special difficulties. According to the National Youth Policy 2001-2005, critical issues for young people are high unemployment, limited opportunities for education and vocational training, social pressures, risk to their physical and mental health, and too few facilities for recreation and sports.

### 3.2 Education and livelihoods

The education system does not equip young people well for the livelihoods available to them. Low quality education makes it difficult to advance in the formal school system. Opportunities for vocational training are growing but this expansion is not being matched by growth in the public or private sector jobs, or opportunities for self-employment. The semi-subsistence sector absorbs some excess labour but both unemployment and labour migration are increasing. On South Tarawa, an estimated 70 per cent of young people are unemployed or underemployed.[40]

Of the young people who continue at school, a fortunate few young men gain entry to the Marine Training School or the Fisheries Training School and after graduation find work overseas. A few young women are now finding work on cruise ships overseas. The Tarawa Technical Institute, the USP Centre, the Kiribati Teacher Training College, and the Tungaru Nurse Training School also provide vocational-type education in Tarawa. The academically best students get scholarships for tertiary education overseas and the best chance of a prized civil service job when they return home.

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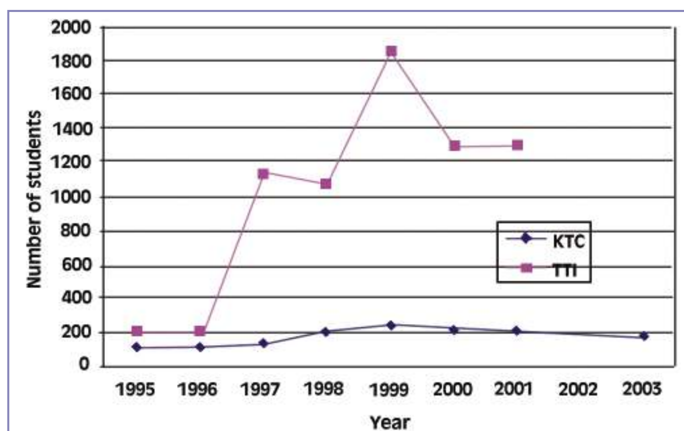
[39] Ministry of Environment and Social Development, 2001.
[40] United Nations, 2002.

**Figure 17 Enrolments at Kiribati Teachers College and Tarawa Technical College, 1995-2003**




Source: Ministry of Education, various dates

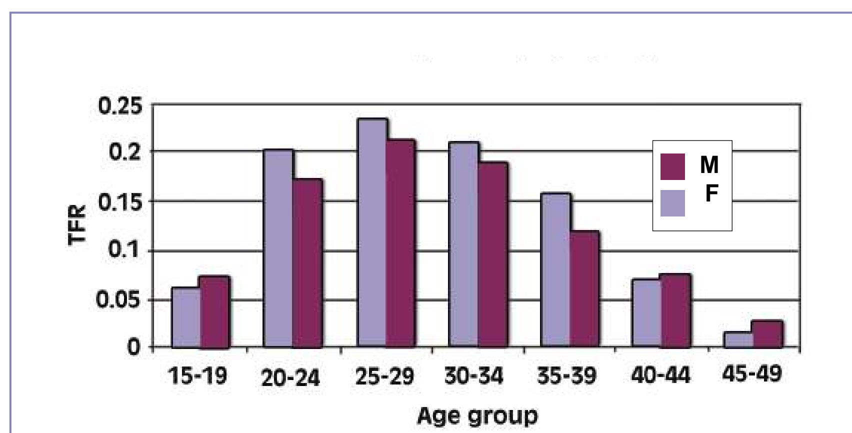
### *3.2.1 Health and well-being*

Other than respiratory and other infections that make up so much of the burden of ill-health in Kiribati, significant risks to young people's health are posed by: accidents; substance abuse mental health problems and the high suicide rate; unprotected sex and the attendant risks of unwanted pregnancies and sexually transmitted infections (STIs).

### *3.2.2 Sexual and reproductive health*

The teenage pregnancy rate is not high but the issue is of concern in this culture where the premarital chastity of girls is highly valued. Some births to young women are intended. While the average age of marriage for women has risen slightly, from 21.6 years in 1995 to 22.1 years in 2000, the birth rate for 15-19 year olds has also risen, suggesting that more births to this age-group are to single women. It is evident that despite cultural values, some young people engage in unprotected sex and risk having unwanted pregnancies or contracting sexually transmitted diseases.

**Figure 18  Total Fertility rates by Age - Group**




Source: Kiribati National Census, 2000

Beyond South Tarawa, sexual health services for young people are almost non-existent. There is little confidentiality in the health services where everyone knows everyone and young people can risk ridicule or beatings by asking for contraceptives or seeking for treatment even when they know they have a sexually transmitted infection.

### *3.2.3 Substance abuse*

Substance abuse by young people is generally unacceptable in Kiribati and most parents forbid adolescent family members to drink or smoke. The Liquor Ordinance 1973 and the Manufacture of Alcohol Act 1997 prohibit consumption of alcohol or its sale to people under 21 years. Yet drunkenness among youths is common, under-age drinkers are quite evident in the bars, and a growing number of teenagers are being brought before the courts and charged with being drunk and disorderly. Cigarettes and beer are particularly cheap. Legal restrictions on alcohol and tobacco sales are not being enforced by any of the agencies responsible for their administration: the police, Island Councils or the Ministry of Health.[41]

A study conducted on South Tarawa in 2001 found that young people use various substances.[42] Those that are smoked include commercial cigarettes, hand-rolled tobacco and, rarely, marijuana. Substances drunk include imported beer and spirits, kaokioki (fermented toddy), methylated

[41] Humphrey et al., 2003.

[42] McMurray, 2001

spirits, and an array of home brewed concoctions, including fermented sugar and fruits (usually pandanus but also pumpkin hollowed out, filled with sugar and fermented), 'steam' (a distilled toddy or fruit mix), 'yeast' (bakers yeast, sugar and water), 'Colgate' (toothpaste mixed with water), 'Bingo' (flavoured cooking essence with 50 per cent alcohol), 'Marmite' (fermented Marmite, sugar and water), 'Fijian' (fermented rice starch, sugar and water), and 'Hawaiian tea' (fermented tea, sugar and water). Some people drink or sniff deodorant or perfume spray, or sniff benzine.

In order to purchase cigarettes and alcohol, the study revealed that young people sometimes stole from their parents, used money given by them for other purposes such as groceries or school lunches, or traded things, including their clothes. Smoking was more limited by affordability than was drinking, evidently because homemade tobacco substitutes were less palatable or acceptable than homebrewed alcohol. It was also unfashionable for young people to smoke hand-rolled tobacco.

The people interviewed generally agreed that girls should not drink but if they did, they should drink less than boys. Binge drinking to excess nevertheless was the most common form of drinking among both sexes, with deliberate mixing of drinks to increase their effect. Heavy drinking was entrenched behaviour among students at the tertiary colleges. Both drinking and smoking were done in secret, on the beach, in hiding places or in places such as 'behind the maneaba' but also in formal settings such as hotels, nightclubs and the many bars retailing commercially or homebrewed alcohol.

Drinking and smoking were regarded as modern, 'adult' behaviours that helped to bond friends. Smoking mainly helped to pass time and releave boredom. Young people drank to 'break out' from usual social constraints, overcome shyness, and feel confident enough to make sexual advances. Drinking was clearly associated with sexual activity, and pregnancy and HIV infection was often mentioned as a 'consequence' of drinking. The almost certain disapproval and strict attitudes of parents and other adults acted as reverse psychology and evidently encouraged this prohibited behaviour. Many young people therefore drank and smoked heavily despite knowing that this was injurious to their health.

Abuse of alcohol is not confined to youth but is a problem in the adult community as well. A survey conducted in 2001 found a close relationship between alcohol abuse and family hardship,

including domestic violence.[43] The Social Welfare Department has noted an increase in alcohol-related family problems.[44] An estimated 90 per cent of injury cases admitted to hospitals are alcohol related.[45] In the past few years, some attention has been given to addressing this problem at both the national and community levels. Some NGOs and government agencies provide counselling and educational programmes for alcoholics and the public. They include: the Alcohol Anonymous and Family Recovery (AAFR) run by the Catholic Church; the Welfare Division of the Ministry of Internal and Social Affairs; the Health Education Division of the Ministry of Health; and the Kiribati Counselling Association.[46] The Blue Liquor Task Force, a body of senior civil servants, was set up to address the abuse of methylated spirits by a small group of adult males.

The problem, however, remains much larger than providing services to assist the most obvious victims. An Alcohol Policy has been drafted which proposes to address some of the weaknesses in the legislation and regulations and the way in which they are implemented.

- Alcohol is cheap and very accessible. An Alcohol Excise Tax has been proposed in order to raise the cost of alcohol and thereby reduce the purchasing ability of young people. (In 2005, a Container Deposit 'tax' was implemented to support a recycling scheme, raising the cost by 5c per can.)

- Uncertainty about who is responsible for administrating the Liquor Ordinance contributes to large illegal sales and production of alcohol on South Tarawa.[47] In 2001, in the Tarawa Teinanano Urban Council (TUC) area, there were 54 licenced outlets selling imported alcohol and 19 licenced outlets selling kaokioki. The Betio Town Council (BTC) had issued licences for 90 outlets selling imported alcohol and 15 selling kaokioki. Both Councils however acknowledged that unlicenced outlets also sold imported alcohol, kaokioki, and the prohibited locally distilled alcohol. Both the Councils and the Police were reluctant to trace the unlicenced outlets. The Councils refused to be involved in what they regarded as the statutory function of the Police Force to round up the unlicenced sellers of alcohol and the prohibited production of local alcohol. This matter needs to be resolved.

- Alcohol contributes to the high rate of traffic accidents on South Tarawa, yet the

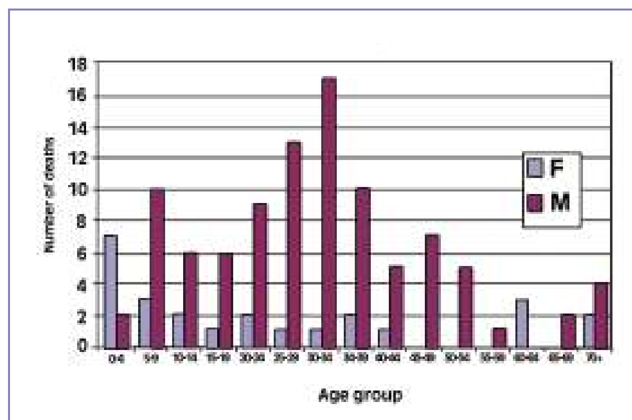
[43] Teiwaki, 2001.
[44] Humphrey et al., 2003.
[45] SPC, 2002.
[46] Teiwaki, 2001.
[47] Teiwaki, 2001.

Police have no capacity to test blood alcohol levels, nor is it regularly tested at the hospital's Emergency Department. It is unclear what the legal blood alcohol limit is for driving, and there are no specific penalties associated with drink driving. International evidence suggests that consistently enforced drink driving legislation is highly effective in reducing alcohol-related crash injuries. The draft Alcohol Policy recommended that a review of the Traffic Offences Act be undertaken in regard to drink driving.

### *3.2.4 Injuries*

Connected with alcohol use is a high rate of traffic accidents, especially on South Tarawa. Speed bumps have been placed along the road and the police use a speed-camera to apprehend speeding vehicles, but the buses particularly often speed, competing for passengers. There are also many other forms of injury, from all causes, and young males are by far the most likely to die from them (Figure 18).

**Figure 18 Deaths from Accidental Injuries 1991- 2001**




Source: Ministry of Health data.

### *3.2.5 Mental illness and suicide*

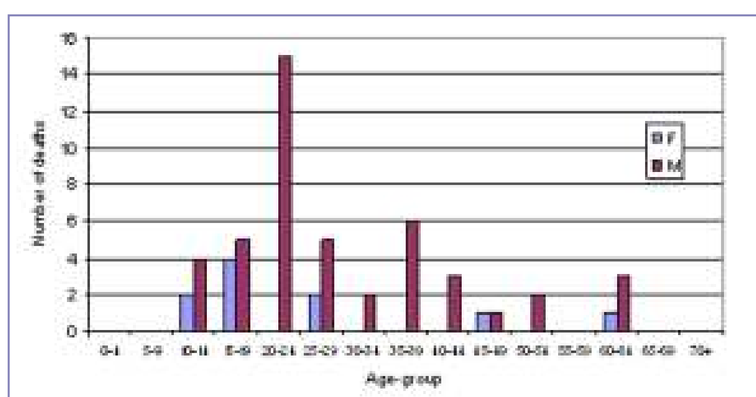
Mental disorders are a serious concern with a sharp rise in the number of cases, particularly involving males in the 15-44 age group, with the most common condition being various types of schizophrenia.[48] There is, however, very little diagnosis or treatment of mental illness. Contributory factors have been cultural shock in young men suddenly exposed to city life as they fly off to their ships in Europe; excessive alcohol drinking while they are away from Kiribati and continued after

48 Ministry of Health, 1998.

their return home; local witchcraft; and mental fatigue caused by longstanding conflicts between people or clans.[49] The prevalence of marriage break-ups and family feuds is probably another contributing factor. There is a high rate of relapses amongst patients discharged from the small mental hospital on South Tarawa. Many soon return to the hospital, saying that they were "not wanted" by their relatives or there was no one they could go to.[50]

Suicide is quite common among young people, especially young men. Figure 19 shows Ministry of Health data on deaths from 'intentional injuries' over a ten year period to 2001. As murder is rare in Kiribati, presumably many of these deaths were suicides. Although the Police Statistics Unit is also trying to more systematically collect information on suicides, these data are still poor. Suicide is often not recorded as the cause of death because of the shame it brings the family. It is believed that suicide is often linked to a broken relationship, excessive alcohol use, or depression.

**Figure 19 Deaths from 'intentional injuries' 1991-2001**




Source: Ministry of Health data.

## 3.3 Social problems

### 3.3.1 Rapid social change

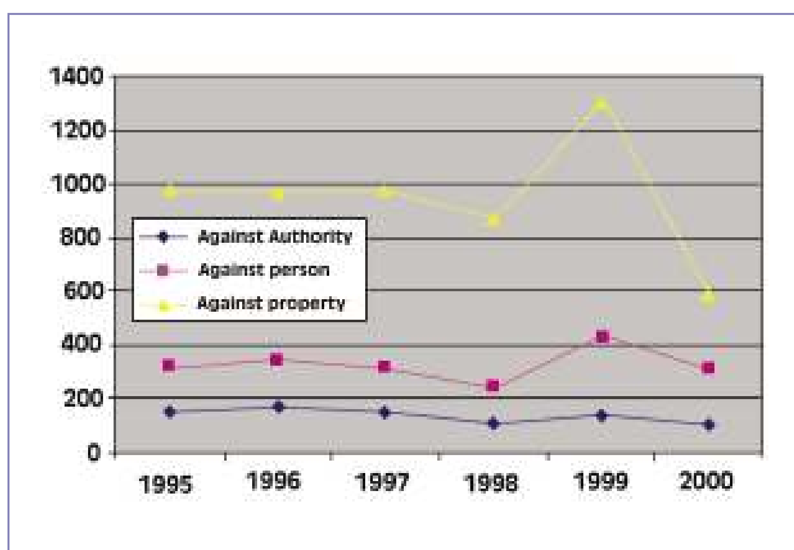
The breakdown of the family support structure is having an impact on I-Kiribati society, particularly on young people in south Tarawa. Tensions between traditional values and modern ways are being reflected in the emergence of youth 'gangs', increased violence, youth suicide and general social disorder and crime. Boredom affects many young people for not only is there little work to do, there are very few sports or recreational facilities. The churches make an important contribution here in organising and supporting activities for young people and in helping to maintain their involvement in the larger community.

[49] Ministry of Health, 1998.
[50] Ministry of Health, 1998.

### *3.3.2 Crime*

There is growing concern with youth crime, especially on South Tarawa. Most crimes are against property and the person, and often they are fuelled by alcohol abuse. Rape is a well known occurrence in Kiribati but is very under reported by both the Ministry of Health and the Police because of the shame felt by the family (particularly when the perpetrator is a relative) and the stigma attached to the victim.[51]

**Figure 20 Total Reported Crime, KIRIBATI, 1995 - 2000**




Source: Kiribati Police Force, unpublished data, 2003.

Alcohol abuse is often a factor in attacks by young men on their parents or female relatives. For example, police records from Bonriki (South Tarawa) in 1999-2000 noted that 58 per cent of the victims of domestic violence were women and all the offenders were drunk young men. Of the female victims, 18 were the mothers of the perpetrator, 13 were wives, six were sisters, one was the grandmother, two were nieces, one was a daughter-in-law, and one was a mother-in-law.[52]

[51] Humphreys et al., 2001.

[52] NZODA, 2000.

### *3.3.3 The local sex industry*

Concern over prostitution is focussed on South Tarawa but there may also be some development in Kiritimati. The growth of the local sex industry is closely connected to the shortage of other paid work for young women. A small group of regular sex workers, known as 'te korekorea,' mostly operate near the Betio Wharf. They have sex with seamen on foreign fishing boats and local men in return for goods and cash. They take risks with unprotected sex and experience violence and alcohol abuse. Police regularly check the fishing boats, particularly during transfer of tuna to the mother ships, and arrest people found on board without official permission. Most are young girls, some as young as 14 years of age. Some declare that they have the support of their families and care little about cultural and social attitudes to their trade.[53]

The police and community are more concerned with sanctioning the te korekorea than with their clients or business managers. Some bar owners, moteliers, taxi drivers, toddy sellers, parents and police reportedly gain from the sex industry.[54] In 2002, Police reported more than 40 cases of women boarding the boats, down from 70-80 women arrested in 2000,[55] but anecdotal evidence suggests the trade is growing. As there are difficulties regarding evidence of prostitution, and no clear legal definition of it, the women were charged with custom offences.

[53] Humphreys et al., 2001; Vunisea, 2003.
[54] RRRT and UNICEF, 2004.
[55] Report to NZAID GAD Mission, 2003; RRRT and UNICEF, 2004, for 2000 figure.

# Part 4
# The Situation of Women

## *4.1 The general advancement of women*

Respect for women is valued in I-Kiribati society but sexist behaviour is condoned in the name of custom. I-Kiribati women are still subordinate to men in many aspects of their lives: within both the household and national economies, within community and national politics, in their access to economic resources, and in their capacity to make decisions about their lives, health and lifestyles.

Significant changes are nevertheless underway. The gender gap in education has closed at all levels and females now predominate at the secondary and tertiary levels. Women are becoming more active in the economy. In the public sector, more women are being promoted to positions of responsibility. In 2004, the Kiribati Government ratified the Convention for the Elimination of All Forms of Discrimination Against Women, thereby promising to review and redress underlying structures of discrimination and disadvantage against women.

An important aspect of this changing status is the decline in fertility, although this is happening only slowly in Kiribati. Universally, this decline reflects more deliberate choice being exercised about child-bearing and a reduced burden of pregnancy-related ill-health and work-loads.

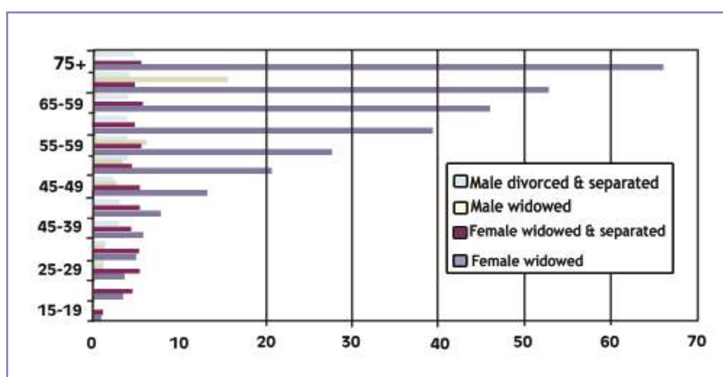
**Table 11 Fertility indicators for Kiribati**

| | 1980s | 1980s | 1980s |
|---|---|---|---|
| % births attended by health professionals | 59 | 72 | 85 |
| Contraceptive prevalence rate (%) | 23 | 28 | 21 |
| Crude birth rate (per 1000 population) | 29 | 32 | 26 |
| Total fertility rate | 4.7 | 4.5 | 4.3 |

Sources: Ministry of Health

Other social changes are more ambiguous as to the benefits they bring to women. The number of women-headed households is growing, through divorce, men working overseas, and the higher death rates for men. There is no information available about the economic or social status of women-headed households. But given the fact that women have considerably less access to economic resources, especially paid work, than men, it is likely that many of these households are relatively poor.

**Figure 21 Percentage of no Longer Married Adults, by Gender, 2000**



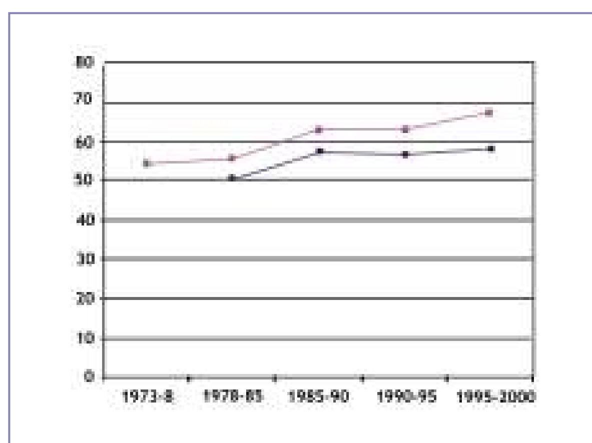

Source, Kiribati National Census 2000

## *4.2 Women's health*

### *4.2.1 Health differences between women and men*

Kiribati has one of the lowest average life expectancies at birth in the Pacific, but there is a widening gap between women and men. The difference in life expectancy at birth is usually around 3-4 years but here women outlive men by an average 5.9 years. This situation points to a generally improving health situation for women and a stagnating one for men. Since 1990, death rates have dropped faster for females than for males. Some of this difference can be seen in infant and child mortality rates, although higher mortality for infant boys is common to many countries. A higher death rate for men is becoming more evident in early to mid adulthood. The reason for the mortality difference has not been fully explored but it can be seen from **Table 12** that death rates from both non-communicable diseases and injuries are much higher in men than women. One likely factor is gender differences in lifestyle, such as alcohol use. Another factor may be the high hepatitis B carrier rate and the prevalence of hepatic cancer in young men.

**Figure 22 Rising life expectancy at birth, 1973 - 2000**




Source: Kiribati National Census, 2000

Note: While average life expectancy at birth has continued to rise, there is a widening gap between the longevity of women and men.

**Table 12 Causes of death for adults aged over 30 years, Kiribati, 1991-2001**

| | Females | | | | | Males | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Age | Comunica-ble, mater-nal & nutri-tional | NCD | Injuries | Ill-defined conditions | Total | Communi-cable, maternal & nutritional | NCD | Injuries | Ill-defined conditions | Total |
| 30-34 | | | | | | | | | | |
| 35-39 | 11 | 5 | 1 | 13 | 30 | 16 | 52 | 12 | 23 | 101 |
| 40-44 | 9 | 35 | 2 | 22 | 68 | 12 | 69 | 11 | 26 | 118 |
| 45-49 | 11 | 54 | 1 | 13 | 79 | 19 | 57 | 10 | 37 | 163 |
| 50-54 | 7 | 56 | 1 | 16 | 80 | 19 | 80 | 6 | 29 | 134 |
| 55-59 | 7 | 61 | 0 | 18 | 86 | 32 | 126 | 3 | 38 | 199 |
| 60+ | 5 | 35 | 0 | 15 | 55 | 14 | 71 | 0 | 25 | 110 |

Source: Ministry of Health data

### *4.2.2 Non-communicable diseases*

Of the non-communicable diseases, hypertension and diabetes are increasing particularly fast. Both are related to diet. There are no recent data on the prevalence of obesity, but this also affects many I-Kiribati women. While relatively few women drink alcohol heavily, many smoke tobacco. This is not a new problem. Recent estimates of tobacco use in Kiribati range from 65 to 74 per cent of women. At the higher figure, this gives Kiribati one of the highest rates of women smokers in the world.[56]

[56] Doran, 2003, citing Khaleghian (2001) and Stanton (2001). The 2000 Census asked whether any household members smoked or drank alcohol but did not report this by sex. Eighty-one per cent of households indicated that at least one member smoked, while 38 per cent had a member who drank alcohol.

### 4.2.3 Reproductive health

The decline in fertility generally reduces the burden of ill-health in women but there are still important reproductive health issues for women in Kiribati.

- The most common reasons for women to be hospitalised relate to reproductive health, namely vaginal bleeding, ante- and post partum bleeding, and offensive vaginal discharge.

- The maternal death rate is still moderately high, with an estimated average of 56 for 1995-2000,[57] but in such a small population even a single death makes an enormous difference to the annual rate, which therefore fluctuates a good deal.

- Health care for women has improved, particularly in the proportion of births that are attended by a trained health worker, and this has contributed to falling death and injury rates for both mothers and infants (Table 11). Wherever possible, women with difficult pregnancies or labour are air-lifted to the national hospital, but poor facilities and transport and communication difficulties on the outer islands remain a barrier to a good distribution of quality maternal care. Because around 20 per cent of births are supervised not by health professionals but traditional birth attendants (TBA), UNICEF supported a programme in the Ministry of Health to improve the skills and knowledge of TBAs, particularly on safe and hygienic delivery practices and care for mothers and new-born babies.

- The contraceptive prevalence rate remains low, at around 20 per cent, although it is slowly climbing. Particularly in the outer islands where health services are weaker, it is still difficult for women to exercise a full choice over their use of contraceptives.

- Cervical cancer is now the most common type of cancer in Kiribati, but there are limited facilities for diagnosis through pap smears, or for treatment. The main causal organisms for cervical and vaginal infections are Gardnerella sp and Trichomonas vaginalis, with smaller numbers of tests showing Candida sp, Chlamydia and Human Papilloma Virus.

[57] UN, 2001.

### 4.2.4 Domestic and Sexual Violence

Domestic violence is common in Kiribati, and there is still community acceptance that men can, or even should, physically punish their wives and children. The rape of women or children is a traditional (but generally unaccepted) form of punishment in I-Kiribati society.[58] The level of domestic violence is highest on South Tarawa, where it is exacerbated by alcohol consumption, pressures on households from economic hardship and unemployment, crowded living conditions, and weakened community and family controls over behaviour. Most attacks involve men beating their wives or children, but police records include many cases of young drunk men attacking other family members, usually women, and damaging the family house or other property.[59] One community in Betio has relocated several elderly women to live in a community maneaba where they would be safer from such attacks.

Most incidents of domestic violence are not reported to authorities. The Police and the Social Welfare Department keep some case records, but they are quite incomplete. Some victims are seen at the hospital, but the Ministry of Health keeps no record as to the cause of physical injuries.

In the late 1990s, a training program on domestic violence was conducted for police officers in South Tarawa.[60] Registers of cases were established, and to some extent maintained, in all four police stations on the island. A survey of these registers in 2003 found that most complaints – 80 to 90 per cent - were withdrawn by the victim or complainant (usually a woman) in the following day or so. The police confirmed that women were often further threatened or pressured by their families if they did not withdraw. Domestic violence cases often took three to six months to be heard in Court, and this delay caused even more cases to be withdrawn. Of the small proportion of offenders who went to Court, almost all were fined – a form of punishment that often rebounded on the whole household, including the original victims of the violence. There was little if any counselling available for either victims or offenders.[61]

In 2000, the Commissioner of Police tendered a submission to the Attorney General's Office proposing amendments to the Criminal Procedure Code relating to police powers of arrest, powers

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[58] Carroll, 1976.
[59] NZAID Gender Program Formulation Report, 2003.
[60] The Safer Homes Project, supported by NZAID.
[61] NZAID Gender Programme Formulation Report, 2003.

to enter private property, and consideration to extending police powers to impose conditions of bail. This matter has not yet been responded to and the Kiribati National Council of Women, Aia Maea Ainen Kiribati (AMAK) and the Regional Rights Resource Team (RRRT) have added their voices to support this proposal, as well as a thorough review of legislation that applies to domestic violence, such as definitions of rape.

**Table 13 Outcomes from reported assaults**

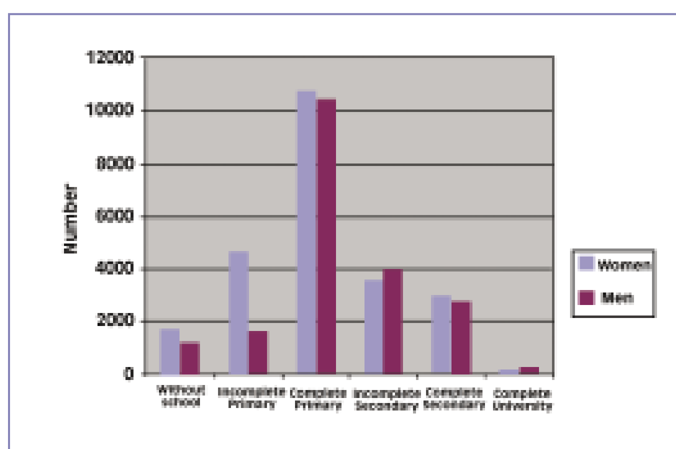
| Year | Reported assaults | Taken to Court (%) | Court action | |
|---|---|---|---|---|
| | | | Fined | Jailed |
| 1995 | 240 | 83 | n.a | n.a |
| 1996 | 214 | 66 | n.a. | n.a. |
| 1997 | 240 | 83 | n.a. | n.a. |
| 1998 | 173 | 47 | 77 | 5 |
| 1999 | 299 | 33 | 100 | 6 |
| 2000 | 233 | 40 | 86 | 7 |

Source: Kiribati Police Force records (unpublished)
Note: KPF records are not disaggregated to show domestic violence as separate from all assault cases.

## *4.3 Education*

Although the gender gap in education has closed for people who are now at school, older generations of women were quite disadvantaged and this shows up in the overall educational attainment of the adult population. Older women are more likely than men to have not completed primary school or to have not attended school at all. Today more attention is being given to gender equity at all levels, including tertiary scholarships and in–service training. Women are well represented at local tertiary institutions such as Tarawa Teachers College, Tarawa Technical Institute, the National Nursing School and the University of the South Pacific extension centre on South Tarawa.

**Figure 23 Educational attainment of all people over 15 years, by gender, 2000**




Source: Kiribati National Census, 2000

Other than the tertiary institutions, non-formal adult education is provided mainly through women's organizations run by the churches and the National Council of Women. A system of rural island education centres is also being established to help meet the demand for non-formal education. While most attention is given to the education of children, the issue of adult education is particularly important for Kiribati because of the need to expand livelihood opportunities in both the informal and formal sectors. The self-sufficiency of rural communities is eroding. Although most people will continue to live a semi-traditional, semi-subsistence lifestyle, they nevertheless want to be part of the wider world. Adult education can provide people with knowledge and skills to cope with changing circumstances and develop new forms of livelihood from them.

### *4.4 Livelihoods and employment*

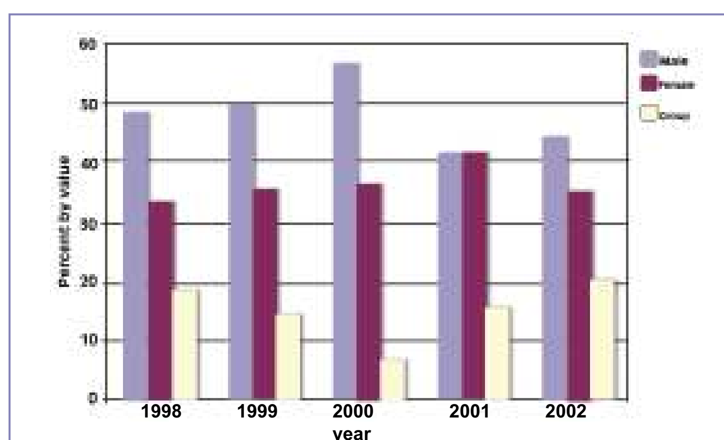
Women's work is at the heart of the traditional economy that plays an important redistributive and welfare role in Kiribati communities. The growing demand for cash to pay for modern goods, education, and church activities translates into increasing demands on women's time. Women raise money through a number of traditional mechanisms such as informal credit union schemes. such as te karekare (informal cooperatives), as well as te tarau (buying on credit) and te bubuti (requesting or borrowing goods or money, land, children and so on) in order to meet social obligations. Bingo games are another popular way to raise funds for church or community activities.

There are not many opportunities to raise money outside of cash employment, and this is a significant part of the poverty of opportunity that women particularly face. Opportunities to earn cash on the outer islands are mostly in copra cutting, fishing, vegetable farming, making sour toddy, handicraft and local produce making, bread making, nii moko (local cigarettes) and casual employment. Cash-earning opportunities are limited by lack of business management skills, 'copycat' business development, cash flow problems, inadequate marketing structures, and the general lack of infrastructure or community support. Development projects for women still must go through a male dominated community system. Women and children may be the ones who contribute their labour (as in seaweed production) but do not have their voices heard. On many islands, women have long requested to have their own centres where they can produce and store their goods. Some islands have a women's centre but often it is a small building with a few mats and broken down sewing machines, or some incomplete or derelict structure.[62]

[62] NZAID Gender Programme Formulation Report, 2003.

The Village Bank scheme assists with small-scale credit and loans are also available from the Development Bank of Kiribati (DBK), although this requires more formal applications. Given that household loans are often in the name of the male head, quite a high per cent of DBK loans are taken out by women (Figure 24).

**Figure 24 Distribution of Kiribati Development Bank loans by gender, 1999-2002**




Source: Development Bank of Kiribati

There is a need for more investment in facilities and infrastructure that will help women generate the cash they require to meet family and social commitments. Women also need opportunities to have a voice in island decisions about development priorities. Opportunities also need to be set up for women to explore and articulate their needs. When representatives of the National Council of Women or AMAK canvass women – particularly outer island women – about their needs, they generally refer to practical matters such as training in cooking and sewing. They usually have little interest in questioning more fundamental issues such as their rights and roles in the community because this is beyond the scope of their experience.[63]

While men dominate most of the cash work, the involvement of women in paid employment is growing. There is as yet no legal requirement for equal employment opportunities or conditions and in both the public and private sectors, Women predominate in lower paid and lower responsibility positions. As well as paid jobs, women are working for cash by running their own businesses, such as retail shops. A growing number work for cash in the informal sector, selling produce such as fish, fruit or cooked food.[64] As a national average, 13 per cent of women are in

[63] AMAK staff, personal communication.
[64] Tekanene, 2004.

paid employment, a figure that rises to 19 per cent on South Tarawa and drops to 8 per cent in the outer islands. Women comprise 37 per cent of all paid workers nationally and 38 per cent in South Tarawa – up from a national figure of 28 per cent in 1990.

**Table 14 Economic activities of the adult population, 2000**

| | National | | Tarawa | | Outer Islands | |
|---|---|---|---|---|---|---|
| | M | F | M | F | M | F |
| Economically active | | | | | | |
| Employment | 5810 | 3390 | 3650 | 2239 | 2160 | 1151 |
| Village work | 14502 | 16210 | 5069 | 7449 | 9433 | 8761 |
| Economically inactive | | | | | | |
| Home duties | 212 | 2437 | 58 | 337 | 154 | 2100 |
| Unemployment | 311 | 333 | 220 | 171 | 91 | 162 |
| Old | 511 | 926 | 211 | 392 | 300 | 534 |
| Disabled | 102 | 75 | 26 | 18 | 76 | 57 |
| Prisoner | 43 | 0 | 36 | 0 | 7 | 0 |
| Student | 2469 | 2825 | 1155 | 1281 | 1274 | 1544 |
| Not specified | 37 | 27 | 21 | 18 | 16 | 5 |
| Total | 23997 | 26223 | 10488 | 11905 | 13511 | 14318 |

Source: Kiribati National Census, 2000

Over the past decade, there has been a considerable increase in the number of women working in senior positions in the public sector. In 1994, only 16 per cent of senior (L1-L9) posts were held by women. By 2003, this had increased to 42 per cent (Table 15). The Vice-President of Kiribati is a woman, as is the Secretary to Cabinet and several Permanent Secretaries. According to the 2000 census 44 per cent of administrators and managers and 51 per cent of professionals were females, mainly teachers and nurses. Thus, gender equity appears to be improving and demonstrates the impact of education on raising the status of females in society.

**Table 15 Economic activities of the adult population, 2000**

| Positions in Civil Service | 1994 | | 1998 | | 2002/2003 | |
|---|---|---|---|---|---|---|
| | Women | Men | Women | Men | Women | Men |
| Parliament | 0 | 20 | 0 | 20 | 2 | 39 |
| % | 0% | 100% | 0% | 100% | 5% | 95% |
| Boards | 6 | 78 | 3 | 130 | 13 | 120 |
| % | 7% | 93% | 2% | 98% | 10% | 90% |
| Senior Positions (L1-L9) | 23 | 119 | 58 | 152 | 281 | 391 |
| % | 16% | 84% | 28% | 72% | 42% | 58% |
| Civil Service | 893 | 1418 | 1101 | 1386 | 1360 | 1455 |
| % | 39% | 61% | 44% | 56% | 48% | 52% |

Source: Kiribati National Census, 2000

## *4.5 Institutional mechanisms to promote the interests of women*

### *4.5.1 Government agencies*

Government efforts to improve the welfare of women are coordinated through the Ministry of Internal and Social Affairs (having been transferred from the Ministry of Environment and Social Development in 2004). The Women's Affairs Unit was established within MESD in 1995 as part of the Social Welfare Unit. Its budget, however, has remained small and most activities that have been carried out have been funded by foreign donor organisations.

In local government, most Island Councils reserve a seat for a women's representative, although women remain very much a minority on the Councils, at an average of around 7 per cent of all members (1999-2001).[65] Women Interest Worker (WIW) positions on the Island Councils were set up in the mid 1960s by the Women Interests Section of the Education Department to co-ordinate the women's activities in the rural sector, including training workshops for women.[66] The pioneering WIWs were trained by the South Pacific Commission and were hired by the national government. After 1985, responsibility for recruiting and employing the WIW was transferred to the Island Councils. The very poor conditions offered to WIW by most Island Councils encouraged many to quit their outer island jobs for better opportunities elsewhere.[67] Government is now resuming responsibility for hiring the WIW, but the issue remains of their often low status among Council staff, their often little training or experience, and an unclear work program. They are, nonetheless, an important resource in disseminating understanding about women's status and the issues involved in CEDAW.

[65] Tekanene, 2003a, quoting Island Council Minutes, Ministry of Internal Affairs and Social Development.
[66] Teiwake, 2001.
[67] Teiwake, 2001.

### 4.5.2 Non-government organisations

At an island level, women's organisations are mostly defined by church membership, and there is strong competition and little cooperation between them. Women's organisations do not, however, serve all women in Kiribati. (According to the 2000 census, around 40 per cent of households have no membership of these organisations.) While women's organisations provide a useful avenue for women's development programs, Here programs tend to focus on the organisations and are not generally available to all women.

Aia Mwaea Ainen Kiribati (AMAK) was established as a non-government organisation in 1982, to serve as a national umbrella organisation for the various church-affiliated women's organisations, the largest being Reitan Ainen Kiribati (RAK, the Protestant women's group), Te Itoiningaina (the Catholic women's group) and Te Irekenrao (a non-sectarian women's club). For the next decade or so, the management of AMAK struggled to overcome bickering between its constituent bodies. A review of AMAK conducted by ESCAP in 1991 identified its main problems to be a lack of money, lack of strong leadership, and communication difficulties leading to infighting and competition within various women's groups.[68]

Following the 1993 National Women's Conference, a comprehensive Five Year Development Plan for Women in Kiribati was drawn up, AMAK was dissolved as an umbrella organisation, and a complicated arrangement was set up to integrate the NGO and government functions. The Women's Affairs Unit was reintegrated to the newly formed Ministry of Environment and Social Development (MESD). An Advisory Board for Women's Affairs (ABWA) was created to serve as the coordinator for the women's organisations. There were also two new government positions established to support the work of the Advisory Board. This new structure retained the name of AMAK, and ABWA became known as the National Council of Women (NCW).

Not surprisingly, confusion was the main outcome of this arrangement. The problems that AMAK now faces centre on its ambiguous state as a quasi-Government organisation, being neither an NGO nor Government and running under two bosses, the NCW and Government, with differing priorities and unclear roles and responsibilities. The National Council of Women finds that it can make decisions but not implement them because resources or decisions are withheld or delayed by

[68] O'Neill et al., 2002.
[69] NZAID Gender Program Formulation Report, 2003.

government. They also have no authority over the work activities of the government counterparts.[69] This ambiguity furthermore discourages donor support. In its struggle for funds, AMAK tends to follow any donor requirement and its sense of mandate has become befuddled. A strategic planning exercise was begun in 2004 to resolve these problems.

The Government's ratification of CEDAW makes it all the more necessary that there are effective government and NGO agencies in Kiribati that can follow the CEDAW agenda through and conduct public education activities on the issues involved.

# PART 5
# THE AGENDA FOR CHANGE

As a particularly vulnerable island state, Kiribati faces enormous challenges to its development and prosperity. Steady improvements have been made in terms of standard development indicators, such as child survival and school enrolments. Other issues, however, are proving more difficult to resolve, such as the increased unevenness of development, especially in outer island. The overcrowding of South Tarawa, and the urgent shortage of employment or livelihood opportunities for young people.

Children account for almost half of Kiribati's population. The Government has for a long time invested heavily in their education and health and achieved some success in improving conditions for children in these respects.  Infant and child death rates have fallen, although many children still die from readily preventable causes. The number of children in school has risen quite quickly, although there are still issues of concern regarding the quality and conditions of this education. Other issues have been given less attention by policy-makers, including diet-related illnesses and child abuse. There has been some complacency about the supportive nature of I-Kiribati society for children, yet some children quite clearly lack the family, legal and other forms of protection they need. New technologies – including videos and the Internet – expose children to new risks such as pornography, and these risks also need to be countered.

There has been a plethora of new policies proposed to play either by the Kiribati Government or particular development programmes, but few have been incorporated into government budget processes and implemented. For example, the National Youth Policy 2001-2006 promised to strengthen the National Youth Unit to coordinate and facilitate government and NGO youth programmes and provide advisory, counselling and micro-credit services to young people. The Sports Section of the Social Welfare Division was to be strengthened to upgrade sports facilities and encourage participation in organised sports. All school students would be encouraged to stay at school until at least Form 3. Employment and income generating opportunities were to be identified for young people, with a youth entrepreneurship scheme to include business training and micro-credit for young people. Health services would be made more accessible to young people, with special programmes on HIV, STIs, sexual and reproductive health problems and other topics. Legislation affecting young and juvenile offenders was to be developed or improved, and public education programmes to inform young people about their rights. Cultural pride and civic consciousness was to be promoted among young people. But other than the growth in Junior

Secondary School enrolments, very little of this has happened. No special resources were set aside to implement the policy. The problems remain the same and have only become more pressing. In 2005, the policy will be revised, this time to more closely involve young people in its formulation. There is little point in devising a policy for youth – or for children or women for that matter – unless it is to be incorporated into the national budget process and acted upon.

The same conclusion can be reached about many parts of Ministry of Health's Fourth National Health Plan, and various similar plans. It appears that either these plans are devised independently of budget processes or they are overly optimistic about the resources that will be available to implement them.

Moving forward on the commitments made to various conventions, particularly the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), will require not only resources but effective advocacy structures. For children, there is already the Kiribati National Advisory Committee on Children (KNACC) which is doing good work, albeit often handicapped by inadequate resources and low attendance. Similar agencies need to be strengthened for youth and women, in order to follow through on the development agenda and ensure that the public is educated and involved in the process.

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# ANNEXES

## Annex 1 KIRIBATI MDG INDICATORS

| MDGs | Year | Value | Unit | Note | |
|---|---|---|---|---|---|
| 1. Proportion of households below $1 (PPP) per day | 1996 | 38 | proportion (%) | | ADB |
| 3. Share of poorest quintile (20%) in national consumption | 1996 | 6 | % total consumption | | ADB |
| 4. Prevalence of underweight children under-five years of age | 1990 | 5.0 | % under 5 years | Undernutition cases | SPC |
| 4. Prevalence of underweight children under-five years of age | 1999 | 13 | % under 5 years | Undernutition cases | ADB |
| 6. Net enrolment ratio in primary education | 1990 | 76.2 | % primary age group | | Kiribati Department of Statistics |
| 6. Net enrolment ratio in primary education | 2000 | 93.5 | % primary age group | | Kiribati Department of Statistics |
| 7. Proportion of pupils starting grade 1 who reach grade 5 | 1990 | 58 | % grade 1 completing grade 5 | | UN Human Development Report 2003 |
| 8. Literacy rate of 15-24 year-olds | 1990 | 52 | Rate per 100 | indirect, all adults | Pacific Human Development Report, 1999 |
| 10. Ratio of literate females to males of 15-24 year-olds | 1990 | 1.0 | ratio of women to men (1 is equal) | | Kiribati Department of Statistics |
| 10. Ratio of literate females to males of 15-24 year-olds | 2000 | 1.0 | ratio of women to men (1 is equal) | | Kiribati Department of Statistics |
| 11. Share of women in wage employment in the non-agricultural sector | 1990 | 33.5 | % employed women | indigenous pop, cash sector | Kiribati Department of Statistics |
| 11. Share of women in wage employment in the non-agricultural sector | 2000 | 37.6 | % employed women | indigenous pop, cash sector | Kiribati Department of Statistics |
| 12. Proportion of seats held by women in national parliament | 1998 | 4.8 | % seats | | UNIFEM |
| Ratio of girls to boys in primary school | 1990 | 157.8 | ratio of girls per 100 boys | 5 - 12 year age group | Kiribati Department of Statistics |
| Ratio of girls to boys in primary school | 2000 | 53 | ratio of girls per 100 boys | 5 - 12 year age group | Kiribati Department of Statistics |
| Ratio of girls to boys in secondary school | 1990 | 116.4 | ratio of girls per 100 boys | 13 - 18 year age group | Kiribati Department of Statistics |

| Ratio of girls to boys in secondary school | 2000 | 114.1 | ratio of girls per 100 boys | 13 - 18 year age group | Kiribati Department of Statistics |
|---|---|---|---|---|---|
| Ratio of girls to boys in tertiary education (USP enrolments) | 1995 | 1 | ratio of girls per 100 boys | | USP |
| Ratio of girls to boys in tertiary education (USP enrolments) | 1996 | 1 | ratio of girls per 100 boys | | USP |
| Ratio of girls to boys in tertiary education (USP enrolments) | 1997 | 0.9 | ratio of girls per 100 boys | | USP |
| Ratio of girls to boys in tertiary education (USP enrolments) | 1998 | 1 | ratio of girls per 100 boys | | USP |
| Ratio of girls to boys in tertiary education (USP enrolments) | 1999 | 1 | ratio of girls per 100 boys | | USP |
| Ratio of girls to boys in tertiary education (USP enrolments) | 2000 | 1 | ratio of girls per 100 boys | | USP |
| Ratio of girls to boys in tertiary education (USP enrolments) | 2001 | 1.2 | ratio of girls per 100 boys | | USP |
| Ratio of girls to boys in tertiary education (USP enrolments) | 2002 | 1.4 | ratio of girls per 100 boys | | USP |
| Ratio of girls to boys in tertiary education (USP enrolments) | 2003 | 1.5 | ratio of girls per 100 boys | | USP |
| 13. Under-five mortality rate (CMR) | 1990 | 88 | per 1,000 live births | | UN Human Development Report 2003 |
| 13. Under-five mortality rate (CMR) | 2001 | 69 | per 1,000 live births | | UN Human Development Report 2003 |
| 14. Infant mortality rate (IMR) | 1990 | 65 | per 1,000 live births | | ADB |
| 14. Infant mortality rate (IMR) | 2000 | 42.8 | per 1,000 live births | | ADB |
| 15. Proportion of 1 year-old children immunised against measles, per cent | 1990 | 67 | % children under 1 year | | Ministry of Health |
| 15. Proportion of 1 year-old children immunised against measles, per cent | 2001 | 76 | % children under 1 year | | UN Human Development Report 2003 |
| 16. Maternal mortality ratio per 100,000 live births | 1990 | 10 | per 100,000 live births | | Ministry of Health |
| 16. Maternal mortality ratio per 100,000 live births | 1995-2000 | 56 | per 100,000 live births | | Ministry of Health |

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|---|---|---|---|---|---|
| 17. Proportion of births attended by skilled health personnel | 1988 | 60 | % births | | Ministry of Health |
| 17. Proportion of births attended by skilled health personnel | 1999 | 85 | % births | | ADB |
| TB incidence rate per 100,000 population | 1989 | 177.9 | (incidence) per 100,000 persons | TB incidence not prevalence | WHO |
| TB incidence rate per 100,000 population | 1990 | 100 | (incidence) per 100,000 persons | TB incidence not prevalence | WHO |
| TB incidence rate per 100,000 population | 1992 | 140.9 | (incidence) per 100,000 persons | TB incidence not prevalence | WHO |
| TB incidence rate per 100,000 population | 1996 | 408.8 | (incidence) per 100,000 persons | TB incidence not prevalence | WHO |
| TB incidence rate per 100,000 population | 1998 | 275.7 | (incidence) per 100,000 persons | TB incidence not prevalence | SPC |
| TB incidence rate per 100,000 population | 1999 | 298 | (incidence) per 100,000 persons | TB incidence not prevalence | WHO |
| TB incidence rate per 100,000 population | 2000 | 250 | (incidence) per 100,000 persons | TB incidence not prevalence | WHO |
| TB incidence rate per 100,000 population | 2001 | 216.7 | (incidence) per 100,000 persons | TB incidence not prevalence | SPC |
| TB incidence rate per 100,000 population | 2002 | 212.6 | (incidence) per 100,000 persons | TB incidence not prevalence | SPC |
| TB incidence rate per 100,000 population | 2003 | 321.8 | (incidence) per 100,000 persons | TB incidence not prevalence | SPC |
| TB death rate per 100,000 population | 1994 | 13 | per 100,000 persons | | WHO |
| TB death rate per 100,000 population | 2001 | 9.8 | per 100,000 persons | | SPC |
| TB death rate per 100,000 population | 2002 | 5.7 | per 100,000 persons | | WHO |
| Tuberculosis, DOTS detection rate, per cent total population | 1997 | 35 | % population (new ss+) | | |
| Tuberculosis, DOTS detection rate, per cent total population | 1998 | 154 | % population (new ss+) | | SPC |
| Tuberculosis, DOTS detection rate, per cent total population | 1999 | 183 | % population (new ss+) | | SPC |
| Tuberculosis, DOTS detection rate, per cent total population | 2000 | 167 | % population (new ss+) | | SPC |

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|---|---|---|---|---|---|
| Tuberculosis, DOTS detection rate, per cent total population | 2001 | 267 | % population (new ss+) | | SPC |
| Tuberculosis, DOTS detection rate, per cent total population | 2002 | 241 | % population (new ss+) | | SPC |
| Tuberculosis, DOTS treatment success, per cent total population | 1998 | 83 | % new cases | | WHO |
| Tuberculosis, DOTS treatment success, per cent total population | 1999 | 88 | % new cases | | WHO |
| Tuberculosis, DOTS treatment success, per cent total population | 2000 | 90.7 | % new cases | | WHO |
| 30. Proportion of households with sustainable access to an improved water source, urban and rural | 1990 | 35.1 | % (households) population | | Kiribati Department of Statistics |
| 30. Proportion of households with sustainable access to an improved water source, urban and rural | 2000 | 49.1 | % (households) population | | Kiribati Department of Statistics |
| Proportion of households with sustainable access to an improved water source, urban | 1990 | 54.5 | % (households) population | | Kiribati Department of Statistics |
| Proportion of households with sustainable access to an improved water source, urban | 2000 | 60.4 | % (households) population | | Kiribati Department of Statistics |
| Proportion of households with sustainable access to an improved water source, rural | 1990 | 24.7 | % (households) population | | Kiribati Department of Statistics |
| Proportion of households with sustainable access to an improved water source, rural | 2000 | 42.3 | % (households) population | | Kiribati Department of Statistics |
| 31. Proportion of urban and rural households with access to improved sanitation | 1990 | 24.4 | % (households) population | | Kiribati Department of Statistics |
| 31. Proportion of urban and rural households with access to improved sanitation | 2000 | 31.1 | % (households) population | | Kiribati Department of Statistics |
| 31. Proportion of urban households with access to improved sanitation | 1990 | 32.9 | % (households) population | | Kiribati Department of Statistics |
| 31. Proportion of urban households with access to improved sanitation | 2000 | 54.4 | % (households) population | | Kiribati Department of Statistics |

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|---|---|---|---|---|---|
| 31. Proportion of rural households with access to improved sanitation | 1990 | 21.5 | % (households) population | | Kiribati Department of Statistics |
| 31. Proportion of rural households with access to improved sanitation | 2000 | 22.2 | % (households) population | | Kiribati Department of Statistics |
| 25. Proportion of land area covered by forest | 1996-2003 | 12.5 | % land area | % of land covered by forest (excluding forest plantation) | |
| 26. Ratio of area protected to maintain biological diversity to surface area | 2003 | 32.9 | % land (marine) area | Protected areas: terrestrial areas with active and inactive management. Marine and costal protected areas are not included in the data | Conservation international, July 2003 |
| Carbon dioxide emissions (CO2), metric tons, per capita | 1990 | 0.32 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions (CO2), metric tons, per capita | 1991 | 0.37 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions (CO2), metric tons, per capita | 1992 | 0.32 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions (CO2), metric tons, per capita | 1993 | 0.28 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions (CO2), metric tons, per capita | 1994 | 0.28 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |

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|---|---|---|---|---|---|
| Carbon dioxide emissions ($CO_2$), metric tons, per capita | 1995 | 0.28 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions ($CO_2$), metric tons, per capita | 1996 | 0.28 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions ($CO_2$), metric tons, per capita | 1997 | 0.28 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions ($CO_2$), metric tons, per capita | 1998 | 0.28 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions ($CO_2$), metric tons, per capita | 1999 | 0.24 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions ($CO_2$), metric tons, per capita | 2000 | 0.28 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions ($CO_2$), metric tons, per capita | 2001 | 0.27 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Carbon dioxide emissions ($CO_2$), metric tons, per capita | 2002 | 0.3 | metric tons per capita | Carbon Dioxide Emissions from the Consumption and Flaring of fossil fuels | Energy Information Administration, International Energy Annual 2002 |
| Consumption of ozone-depleting CFCs (ODP tons) | 1986 | 1 | tons | Consumption defined as production plus imports minus exports of ozone depleting CFCs | UNEP Ozone Secretariat |

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|---|---|---|---|---|---|
| Consumption of ozone-depleting CFCs (ODP tons) | 1993 | 1 | tons | Consumption defined as production plus imports minus exports of ozone depleting CFCs | UNEP Ozone Secretariat |
| Consumption of ozone-depleting CFCs (ODP tons) | 1994 | 1 | tons | Consumption defined as production plus imports minus exports of ozone depleting CFCs | UNEP Ozone Secretariat |
| Consumption of ozone-depleting CFCs (ODP tons) | 1995 | 1 | tons | Consumption defined as production plus imports minus exports of ozone depleting CFCs | UNEP Ozone Secretariat |
| Consumption of ozone-depleting CFCs (ODP tons) | 1996 | 1 | tons | Consumption defined as production plus imports minus exports of ozone depleting CFCs | UNEP Ozone Secretariat |
| Consumption of ozone-depleting CFCs (ODP tons) | 1997 | 1 | tons | Consumption defined as production plus imports minus exports of ozone depleting CFCs | UNEP Ozone Secretariat |
| 37. ODA received in small island developing States as proportion of their GNIs | 1990 | 35.9 | ODA as % of GNI | | OECD |
| 37. ODA received in small island developing States as proportion of their GNIs | 1991 | 30.1 | ODA as % of GNI | | OECD |

| | | | | | |
|---|---|---|---|---|---|
| 37. ODA received in small island developing States as proportion of their GNIs | 1992 | 43.1 | ODA as % of GNI | | OECD |
| 37. ODA received in small island developing States as proportion of their GNIs | 1993 | 25.9 | ODA as % of GNI | | OECD |
| 37. ODA received in small island developing States as proportion of their GNIs | 1994 | 22 | ODA as % of GNI | | OECD |
| 37. ODA received in small island developing States as proportion of their GNIs | 1995 | 21.2 | ODA as % of GNI | | OECD |
| 37. ODA received in small island developing States as proportion of their GNIs | 1996 | 17.6 | ODA as % of GNI | | OECD |
| 37. ODA received in small island developing States as proportion of their GNIs | 1997 | 17.7 | ODA as % of GNI | | OECD |
| 37. ODA received in small island developing States as proportion of their GNIs | 1998 | 19.3 | ODA as % of GNI | | OECD |
| 37. ODA received in small island developing States as proportion of their GNIs | 2000 | 21.8 | ODA as % of GNI | | OECD |
| 37. ODA received in small island developing States as proportion of their GNIs | 2001 | 17.5 | ODA as % of GNI | | OECD |
| 37. ODA received in small island developing States as proportion of their GNIs | 2002 | 26.3 | ODA as % of GNI | | OECD |
| 44. Debt service as a percentage of exports of goods and services | 1995 | 3 | % exports | | ADB |
| 44. Debt service as a percentage of exports of goods and services | 1999 | 1.7 | % exports | | ADB |
| Unemployment rate of 15-24 year-olds, female | 1990 | 2.54 | % labour force | Labor force includes: Cash workers, village work | National Population and Housing Census |

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|---|---|---|---|---|---|
| Unemployment rate of 15-24 year-olds, female | 2000 | 2.26 | % labour force | Labor force includes: Cash workers, village work | National Population and Housing Census |
| Unemployment rate of 15-24 year-olds, male | 1990 | 4.74 | % labour force | Labor force includes: Cash workers, village work | National Population and Housing Census |
| Unemployment rate of 15-24 year-olds, male | 2000 | 2.1 | % labour force | Labor force includes: Cash workers, village work | National Population and Housing Census |
| Unemployment rate of 15-24 year-olds, total | 1990 | 3.6 | % labour force | Labor force includes: Cash workers, village work | National Population and Housing Census |
| Unemployment rate of 15-24 year-olds, total | 2000 | 2.1 | % labour force | Labor force includes: Cash workers, village work | National Population and Housing Census |
| Unemployment rate of 15-24 year-olds, female | 2000 | 2.2 | % labour force | Labor force includes: Cash workers, village work | National Population and Housing Census |