

Republic of the Marshall Islands

Millennium Development Goals National Progress Report



A joint RMI-UNDP Publication
with the
Economic Policy, Planning and
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and
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Development Program Office



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Forward

This report is an accurate assessment of where we, the Marshall Islands, are at in addressing the goals and intentions of the Millennium Development Goals. The report indicates that there is much that needs to be done particularly with education, skills development and the health of the people. It is hoped that this document will continue to contribute to the local policy development process by providing more information and more recommendations for future government policy making, but clearly the policy discussion concerning the emerging situations in the urban areas and the outer islands needs to become more focused and more serious. The consequences of not doing so will be extremely expensive for future generations.

There are some positive items to report, such as the improvement in several of the public health indicators and the development and use of performance budgeting in the government. More and more decision-making is being affected by the use of facts and statistics and continued use of this approach can only help and benefit the development situation in these islands. The increased demand for results, performance and accountability is a positive development, but much more is required if we are to reach the targets of the Millennium Development Goals.

I would like to take this opportunity to say kōmmol tata to all those who have provided comments to the report, particularly the NGO's of the RMI. I would also like to say that Ms. Emi Chutaro has worked extremely hard in putting this report together, collecting all the relevant statistics for this report took a lot of effort and imagination. This report would not have been possible without Emi's dedication.

Sincerely,

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TABLE OF CONTENTS

<u>Section Title</u>	<u>Page</u>
Acknowledgements	3
Table of Contents	4
List of Abbreviations	5
List of Terms and Definitions	6
I. Executive Summary	8
II. Introduction	
A. Country Profile.....	12
III. Millennium Development Goals	13
A. Goal 1: Eradicate Extreme Poverty and Hunger.....	16
B. Goal 2: Achieve Universal Primary Education.....	23
C. Goal 3: Promote Gender Equality and Empower Women.....	25
D. Goal 4: Reduce Child Mortality.....	30
E. Goal 5: Improve Maternal Health.....	31
F. Goal 6: Combat HIV/AIDS, Malaria and Other Diseases.....	32
G. Goal 7: Ensure Environmental Sustainability.....	36
H. Goal 8: Develop a Global Partnership for Development.....	41
IV. Conclusion	42
V. Appendix	
A. Map of the RMI.....	45
B. SPC Database (Regional MDG Report).....	46
VI. References	55

LIST OF ABBREVIATIONS

ADB – Asian Development Bank
ARH – Adolescent Reproductive Health
CMI – College of the Marshall Islands
CPI – Consumer Price Index
EPPSO – Economic Policy, Planning and Statistics Office
GEF – Global Environment Fund
HIV/AIDS – Human Immunodeficiency Virus / Advanced Immune Deficiency Syndrome
IWP – International Waters Programme of the Pacific Islands
MDGs – Millennium Development Goals
MIJ – Marshall Islands Journal
MIMRA = Marshall Islands Marine Resources Authority
MMR = Measles, Mumps, Rubella (triple cocktail vaccination)
MOE – Ministry of Education
MOH – Ministry of Health
NGOs – Non-Government Organizations
ODA – Overseas Development Assistance
OEPPC – Office of Environmental Planning, Policy and Coordination
PDMC – Pacific Developing Member Country (ADB)
PPP – Purchasing Power Parity (1993)
RH – Reproductive Health
RMI – Republic of the Marshall Islands
RMIEPA – Republic of the Marshall Islands Environmental Protection Agency
ROC – Republic of China
SPC – Secretariat for the Pacific Community
STDs – Sexually Transmitted Diseases
TB – Tuberculosis
UNFCCC – United Nations Framework Convention on Climate Change
UNCBD – United Nations Convention on Biological Diversity
UNDCCD – United Nations Convention to Combat Desertification
UNDP – United Nations Development Program
USP – University of the South Pacific
WHO – World Health Organization

LIST OF TERMS AND DEFINITIONS

1. Crude Birth Rate (CBR) = frequently used measure of fertility which relates the number of births in a given year to the mid-year population of that same year. The mathematical calculation is as follows: $CBR = (\# \text{ of births in year } n / \text{ mid-year population in year } n) \times 1,000$

2. Crude Death Rate (CDR) = frequently used measure of mortality which relates the number of deaths in a given year to the mid-year population of that same year. The mathematical calculation is as follows: $CDR = (\# \text{ of deaths in year } n / \text{ mid-year population in year } n) \times 1,000$

3. Dependency Ratio (DPR) = it is defined as the ratio of the economically dependent part of a population to the economically productive part of the population. Those considered dependent are those aged 65 and over and those under the age of 15. The economically active part of the population is defined as those between 15 and 64 years of age. Often, the ratio can be disaggregated by relating only the under 15 population to the economically active population (Youth Dependency Ratio), or by relating only the 65 and older population to the economically active population (Old Age Dependency Ratio). The general mathematical calculation is as follows: $DPR = (\text{total population under 15} + \text{total population 65 years and older in year } n) / \text{total population ages 15 to 64 in year } n$

4. Fertility Rate (GFR) = otherwise known as the General Fertility Rate / frequently used measure which relates the number of births in a given year to the mid-year population of women of childbearing age in that same year. The defined childbearing age is defined as women between the ages of 15-49 years. The mathematical calculation is as follows: $GFR = (\# \text{ of births in year } n / \text{ mid-year population of childbearing age in year } n) \times 1,000$

5. Infant Mortality Rate (IMR) = frequently used measure that refers to the number of deaths of infants under one year of age for each 1,000 live births for one calendar year. The mathematical calculation is as follows: $IMR = (\# \text{ of deaths to infants } < 1 \text{ year of age} / \text{ number of live births}) \times 1,000$

6. Maternal Mortality Rate (MMR) = different than the triple combination vaccination also indicated by the abbreviation MMR which stands for Measles, Mumps and Rubella / frequently used measure which relates the number of women who die as a result of childbirth in a given year per 100,000 live births in that same year. The mathematical calculation is as follows: $MMR = (\# \text{ of female deaths due to childbirth in year } n / \text{ number of live births in year } n) \times 100,000$

7. Population Growth Rate (r) = otherwise known as the Annual Rate of Population Growth. The mathematical calculation is calculated using an exponential growth model as follows: $P_{(2)} = P_{(1)}e^{rt}$ where $P_{(1)}$ = the size of the population at point 1 (or initial population base), $P_{(2)}$ = the size of the same population at point 2 at a later date, r = the

average rate of growth during the time interval between points 1 and 2, t = the interval in years between points 1 and 2, and e = the base of the natural log system

Source: Secretariat for the Pacific Community (2005). **Course Module 2: Population and Social Statistics**. Noumea, New Caledonia: Joint SPC-UNESCAP Publication (March).

I. Executive Summary

In 2003, the ADB conducted a summary review of the MDGs in the RMI. The ADB described the progress of the RMI in meeting the specific targets of the MDGs as “slow” (ADB, 2003:13). In some areas, particularly in reducing infant and maternal mortality and increasing gender equality in education, the RMI was praised for making marked improvements. However, in other areas, the RMI was seen as making little or only moderate progress, particularly in terms of access to clean water and sanitation, combating communicable diseases such as HIV/AIDS, TB, other sexually transmitted diseases, diabetes, influenza, etc., and addressing specific poverty reduction strategies such as access to employment opportunities and reducing development gaps between the urban centers and rural outer-islands.

Examining the findings of this report, the targeting and achievement of the MDGs by the RMI can still be characterized as slow, with improvements in some areas, but with little or moderate progress in others. Following the ADB’s general conclusions, the RMI continues to make marked improvements in reducing infant and maternal mortality rates, with only one maternal death reported in the last several years. However, with regards to the quality of education outputs, reduction of communicable diseases such as syphilis, influenza and TB, equitable access to sanitation and clean water services and facilities, availability of employment opportunities and quality healthcare, and the reduction of the development gaps between the urban centers and the rural outer-islands, the RMI still falls significantly short of both its own national goals and targets, and those of the MDGs. With regards to poverty, the evidence strongly suggests that poverty and hardship in the RMI are on the rise, and are being compounded by the lack of appropriate development and implementation of effective and relevant health, education and economic policies and initiatives. The following table is a summary of the main statistics/findings identified in this report:

MDG GOAL	SUMMARY FINDINGS
Eradicate Extreme Poverty and Hunger	<ul style="list-style-type: none"> ▪ No national definition of poverty and hardship resulting in the lack of a national Poverty Line and related indicators with which to measure the extent of poverty and hardship in the RMI ▪ A 2002 Participatory Poverty Assessment indicated a rise in poverty and hardship amongst urban and rural populations due to lack of employment opportunities, access to quality education and training, and low development of the outer-islands ▪ A 1999 nutrition survey conducted at 7 public primary schools on Majuro Atoll indicated that 51% of the student population were classified as undernourished, with a majority of these students being categorized as having acute to chronic malnutrition ▪ A 2004 Socio-Economic Survey of Majuro Atoll’s Jenrok village revealed rise in poverty and hardship with a 47% unemployment rate and an average debt to income ratio of 38%. Food consumption is dependent upon processed, imported foods of low nutritional value.
Achieve Universal Primary	<ul style="list-style-type: none"> ▪ National laws support universal primary education, however, only 53% of primary school-age children attend school ▪ Majority of primary school-age children are ‘push-out’ of the

Education	<p>school system due to lack of space, particularly in the urban areas</p> <ul style="list-style-type: none"> ▪ Significant decrease in gross enrollment in primary schools since 1995 ▪ Steady decrease in overall drop-out rates in both public and private schools ▪ Little or no data available on gender-specific drop-out/retention rates ▪ No data available on youth literacy rates ▪ Adult literacy rate calculated at 97% is suspect due to other evidence indicating that the general and student population lack basic literacy and numeracy skills
Promote Gender Equality and Empower Women	<ul style="list-style-type: none"> ▪ Gross enrollment ratios at primary and secondary school levels of females and males are roughly equivalent ▪ Female drop-out rates higher than males at secondary and tertiary levels ▪ Out of 33 elected seats in the national parliament, only one is being held by a female ▪ Low female participation in the national and local governments ▪ Though female participation in the labor force has been increasing over time, there are still significant gender disparities with females earning significantly less than their male counterparts despite equivalent qualifications ▪ Gender issues are a low priority
Reduce Child Mortality	<ul style="list-style-type: none"> ▪ In 1999, the IMR was 37 infant deaths per 1,000 live births and decreased down to 23 infant deaths per 1,000 live births in 2004 ▪ Majority of infant deaths caused by highly preventable conditions such as sepsis and pneumonia ▪ Only 1% of infants born on Majuro in 2003 were fully immunized with the MMR triple vaccine
Improve Maternal Health	<ul style="list-style-type: none"> ▪ Since 2001, only one maternal death has been recorded ▪ 18% of the hospital staff are expatriate ▪ Pre-natal care and services have improved dramatically over the past four years, resulting in early and improved detection of potentially fatal conditions in pregnant women
Combat HIV/AIDS, Malaria and Other Diseases	<ul style="list-style-type: none"> ▪ There are a total of 13 confirmed cases of HIV/AIDS in the RMI ▪ Young population under 34 are increasingly vulnerable to new HIV/AIDS infections due to high prevalence of other sexually transmitted diseases such as syphilis, gonorrhea and chlamydia ▪ Data on condom use rate not available but evidence suggests that it is very low due to high teenage pregnancy rate at 17% and rise in sexually transmitted diseases ▪ RH Clinic data shows that population more concerned about

	<p>prevention of pregnancy than sexually transmitted diseases</p> <ul style="list-style-type: none"> ▪ No malaria cases to date in the RMI ▪ Data indicates continued high numbers of new TB cases despite moderate success in the use of the DOT method to cure new cases ▪ Over the past several years, there has been a steep rise in the number of cases of influenza and infantile diarrhea suggesting a need to examine environmental and sanitation factors in the RMI leading to rise in communicable diseases ▪ Type II diabetes one of the major causes of adult morbidity with 4,786 cases in 2004 and is a major burden on the financial resources of the healthcare system
Ensure Environmental Sustainability	<ul style="list-style-type: none"> ▪ National government established RMIEPA and OEPPC to monitor, enforce, coordinate and develop policies and environmental regulations in accordance with national and international laws and conventions ▪ Solid waste disposal, coastal contamination, and access to clean and safe drinking water are major problems and are particularly acute in the urban areas ▪ RMIEPA testing of potable water sources in the rural and urban areas revealed that an overwhelming majority were contaminated and unsafe for human consumption ▪ In Jenrok survey, 10% of households use ground water wells as only source of water / all ground water wells were tested and found to be contaminated ▪ In Jenrok survey, only 2% of households are connected to the main sewer line, while only 75% had own toilet facilities and 59% had water catchments as their sole source of water
Develop a Global Partnership for Development	<ul style="list-style-type: none"> ▪ 48% of the RMI national budget is composed of ODA ▪ RMI highly dependent on external aid to supplement its budget, to drive economic activity and to fund infrastructure development projects

The data collected indicate that there needs to be a concerted effort made to improve the targeting, development and implementation of poverty reduction strategies, and to better coordinate and support multi-level and cross-sectoral stakeholders in the development and implementation of MDG-related policies. Without such concerted efforts, the long-term statistics suggest that poverty and hardship will increase exponentially within the near future.

Some of the primary concerns identified as a cause of the slow progress of the RMI in targeting the MDGs, is the lack of appropriate and effective targeting of available financial and human resources towards the development, implementation and monitoring of MDG-oriented initiatives and programs. Human resource constraints continue to be a hindrance in the sustainability of numerous initiatives and programs despite the availability of funding. Further, there must be improvement in policy development and

coordination, with more attention given to issues that will address poverty alleviation. Lastly, in order for the MDGs to be adequately addressed, there must be continued support by the RMI government, its agencies and elected officials at all levels. It is hoped that the transition to a performance-based budgeting system will enable the RMI government and its agencies to improve the management of available financial resources. Such a system would also clarify the type and level of human resource development needed to support the development and implementation of national poverty reduction and development policies and programs.

Finally, within the past decade Marshallese civil society and the NGO sector have expanded significantly, with many becoming increasingly proactive in developing and implementing various poverty reduction programs and initiatives. Many have actively sought to collaborate with various government ministries and agencies to expand and improve these programs and initiatives. The inclusion of civil society organizations and local NGOs in developing and implementing poverty reduction programs and initiatives will greatly determine to what extent and scope of these activities will reach the grassroots level, and ultimately the success and/or failure of targeting the MDGs.

II. INTRODUCTION

A. Country Profile

The RMI is composed of 29 coral atolls and low-laying islands located in the central North Pacific Ocean. The land area is 181 square kilometers spread over 1.94 million square kilometers. The two urban centers are located on Majuro, Majuro Atoll and Ebeye, Kwajelein Atoll. All other atolls and low-laying islands are classified as rural, outer-islands.

The population of the RMI is composed primarily of indigenous Marshallese, but with a steadily increasing population of expatriates largely composed of Americans, Filipinos, Chinese/Taiwanese and persons from neighboring Pacific Island countries. The official languages are English and Marshallese, with Marshallese the primary language of exchange. Culturally, the population is predominately homogenous, with the traditional matrilineal and chief/clan system still largely followed.

According to the 1999 Population and Household Census, the population of the RMI is estimated at 50,840 persons. In 1999, the annual population growth rate was 1.5%, with a fertility rate of 5.7. In comparison to the 1988 census, both rates declined significantly from 4.3% and 7.2, respectively. The crude birth rate also declined from 1988 to 1999 from 49.2 to 41.8, respectively. There was also a marked decline in the crude death rate between the two census years, declining from 8.9 in 1988 to 4.9 in 1999.

In addition, the population of the RMI is young with 42.9% of the population under the age of 15. Approximately 27.2% of the population is between the ages of 10 and 19. In 1999, 18% of all live births were to teenage mothers, compounding the young profile of the population. The overall dependency ratio was 82.2. In comparing urban versus rural areas, the child dependency ratio for the urban centers was 70.6, and the rural areas was higher at 94.8. The old age dependency ratio for the urban centers was 3.5, with the rural areas again higher at 4.9.

In terms of population density, the RMI illustrates some of the highest population densities in the Pacific region. In 1999, the urban center of Majuro had a population density of 6,314 persons per square mile. The urban center of Ebeye has the highest population density in the entire Pacific with a density of 66,750 persons per square mile. The average household size in 1999 was 7.8 persons. The urban centers of the RMI are therefore characterized by heavy occupation of small areas of land. Though the population growth rates are declining over time, the population explosion of the 1980s is having a negative impact on individual access to land and other resources and services. This situation is particularly acute in the over-crowded conditions of the urban centers. Current demographic trends still indicate a high internal migration from the rural, outer-islands to the urban centers, primarily for employment and access to better health and education services. This migration pattern has and still continues to aggravate the already crowded conditions of the urban centers.

The government of the RMI is modeled after the British Westminster parliamentary system with a bi-cameral legislature composed of two houses; the Council of Iroij (Chiefs) and the Nitijela (Parliament). The Council of Iroij does not have legislative or executive power, but can make comments on bills in reference to customary law and other traditional practices. Executive power is exercised by the President, the appointed Cabinet, the Attorney General, and the Chief Secretary. The President is elected from within the Nitijela, which is composed of 33 elected senators popularly elected from their respective electoral districts. At the municipal level, each atoll has a local government composed of an elected Mayor and Council, officials and a police force.

The economic profile of the RMI is largely dictated by the US economy with the official currency being the US dollar. Since the end of World War II, the RMI has retained close social, economic and political ties with the US. Since 1986, this relationship has been formalized in the form of the two subsequent Compacts of Free Association, outlining US assistance and diplomatic ties to the RMI. As a result of the compacts, the US retains the right to maintain a military missile testing base on Kwajalein, while RMI citizens have free access to the US and certain education, health and welfare services and federal funding.

As a result of the compacts of free association, the RMI's national budget and economy are largely dictated by the scope and content of economic assistance outlined within the compacts. The large amount of financial assistance provided under the compacts has enabled the national government to provide numerous public and other services resulting in public sector and public enterprise expenditures dominating and driving economic growth in direct competition with the private sector. Consequentially, there has been little real growth in the private sector.

Further, the RMI government is highly dependent on other external sources of assistance, particularly from the ADB, ROC and to a lesser extent, Japan. Most of the assistance from these sources take the form of technical assistance loans and grants (ADB), funding of infrastructure development projects (Japan), and supplementation of the national budget (ROC). The dependence of the RMI government on external funding assistance poses significant issues regarding the sustainability of national development efforts, and whether the RMI can adroitly coordinate external donor priorities and agendas along with its own national priorities and initiatives.

III. Millennium Development Goals

In 2000, the RMI became party to the United Nations Millennium Declaration. In that declaration, developed and developing countries agreed to focus on major global development issues with significant emphasis on poverty reduction and improved targeting of donor aid to developing countries. In the declaration, eight major goals entitled the Millennium Development Goals, or MDGs, were identified as global targets that member countries agreed to meet by 2015. The eight goals identified were the following:

- ❑ Goal 1: Eradicate Extreme Poverty and Hunger
- ❑ Goal 2: Achieve Universal Primary Education
- ❑ Goal 3: Promote Gender Equality and Empower Women
- ❑ Goal 4: Reduce Child Mortality
- ❑ Goal 5: Improve Maternal Health
- ❑ Goal 6: Combat HIV/AIDS, Malaria and Other Diseases
- ❑ Goal 7: Ensure Environmental Sustainability
- ❑ Goal 8: Develop a Global Partnership for Development

In the RMI, key institutional and legislative changes have been implemented within the past couple of years which stand to ensure improved targeting of the MDGs, particularly in the education and health sectors. One of the two key factors that will influence the ability of the RMI to improve targeting of the MDGs for the next ten years will be the recently agreed upon Compact of Free Association II, As Amended (2003-23) between the RMI and the US, that stipulates heavy emphasis on education and health. Under the Compact, technical assistance and other resources will be provided by the US to assist the RMI better meet its stated development needs. There has been some criticism that internal reforms are being driven by the outside, but overall, most Marshallese agree that such reforms need to take place if the RMI is to lessen its dependency on foreign aid, and to improve targeting of national development goals.

The second factor is the implementation of a performance-based budgeting system within the government ministries and agencies to improve the effectiveness and efficiency of national processes. Specifically, the aim of the new budgeting system is to increase effectiveness and efficiency in the targeting and implementation of national development goals, strategies and policies, by specifying inputs and outputs that have to be implemented by each of the government sectors within a stated period of time. Stated outputs and inputs are directly drawn from national and ministerial master plans, largely drawn from the RMI government's *Vision 2018 Strategic Development Plan Framework*.

In addition, within the last decade the NGO sector has expanded significantly. Social services focusing on youth, women and outer-island, rural community development are now largely addressed by the NGO sector. Though still small, the NGO sector has been effective in building a national and international support network for joint NGO and government initiatives and programs. It is clear that one of the key means to achieving the MDGs and sustaining current efforts, will be the strengthening of collaborative efforts between government and civil society. As stated in the UNDP Human Development Report (HDR) 2003, “[t]he Millennium Development Compact is based on shared responsibilities among major stakeholders. It requires many combined and complementary efforts from rich and poor countries, international agencies, local authorities, private actors and civil society organizations” (UNDP, HDR 2003: 20). The expansion of the NGO sector, and the increasing ties between the government and NGOs will determine, to a large extent, the appropriateness, direction and effectiveness of national strategies in reaching all levels of Marshallese society.

In reading this report, it is important to keep in mind that the RMI has made some recent and significant structural and institutional changes that, if managed effectively and given appropriate national support, will stand to make marked improvements in the future development of the RMI. These transformations have yet to affect change amongst the data that has been collected to date. So while the report may indicate major socio-economic problems and issues, it stands to reason that if the RMI can sustain and improve the quality of these efforts over a long period of time, it is possible that the RMI can make significant inroads into improving the targeting and achievement of the MDGs to the benefit of the Marshallese people.

However, to ensure the sustainability of such efforts and changes, the RMI should closely examine its governance structures to ensure transparency and accountability in all national processes. Government officials need to carefully evaluate development efforts to ensure relevancy to the national context, available resources and current capacities, while also ensuring minimal negative impact on Marshallese society and the environment. Public engagement in debating and directing national development efforts will be crucial in determining the effectiveness and relevancy of the overall social, economic, political and environmental development of the RMI.

To gauge how well the RMI has tackled the issue of development, this report will attempt to provide a formal assessment of the status of the MDGs in the RMI. Utilizing information gathered from the public and private sectors and civil society, an assessment of the past and current status of each of the MDG goals will be provided, along with recommendations for action. Specific data, statistics and other information utilized in this report were primarily gathered from sources such as the Performance and Budget Annual Reports of the relevant government ministries and agencies, statistical abstracts from the national statistic office, interviews with heads of government ministries and agencies and civil society, surveys and censuses conducted by the national government and affiliated agencies and NGOs, and national and international development strategies, assessments and related documents.

The process of MDG monitoring and reporting is in the developmental stages in the RMI. A data collection framework specific to MDG monitoring and evaluation is still being developed and implemented. Consequently, there continues to be significant amounts of information that remain unavailable to support the MDG monitoring and reporting process. In compiling this report, 'proxy' data had to be used, primarily using sources from civil society and affiliated governmental and international agencies (e.g. ADB). The use of proxy data is significant, particularly in addressing MDG Goals 1 and 7.

Until recently, there had not been a formally appointed government body tasked to monitor and report on the status of the MDGs. A National MDG Task Force has yet to be formally established. To begin developing a framework for MDG monitoring and reporting, EPPSO formed a partnership with UNDP to establish a program office within EPPSO. In addition to other UNDP duties, the UNDP Program Manager is tasked to provide assistance to EPPSO to monitor and report on the MDGs, and to provide technical support to the National MDG Task Force upon its establishment.

This report is a product of the UNDP-EPPSO Program Office, whose ultimate purpose is to provide an overall status report on the achievement of the MDGs in the RMI. Conclusions and recommendations are drawn from the findings of the data and information collected. Draft versions of the report have been distributed to the relevant national, regional and international agencies for comment and data verification, prior to general distribution and publication.

A. Goal 1: Eradicate Extreme Poverty and Hunger

Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

The RMI is fortunate not to have extreme poverty and hunger in comparison to other countries in the Asia-Pacific region. However, current surveys and socio-economic indicators suggest that poverty and hunger are on the rise, both in the rural and urban areas. This raises concern as to whether the RMI has been appropriately developing and implementing community and private sector development strategies and programs to address poverty and its alleviation.

One of the main difficulties in accessing the level of hardship and poverty in the RMI is the lack of poverty-related statistics and data. To date, the RMI has not developed a formal definition of poverty. Consequently, no Poverty Line has been developed with which to measure the level of poverty or hardship against both national and international standards. Although some calculations have been made by organizations such as the ADB (based on the 2002 Household Income and Expenditure Survey), little data is available which allows for the comprehensive and long-term calculations of the percentage of the population living under the internationally agreed level of USD 1 per day (1993 PPP), the percentage of those living under the national Poverty Line, and other poverty-related indicators. The use of 'proxy' data and information is, therefore, needed to provide some insight into the level of poverty and hardship in the RMI.

In 2002, the ADB conducted a Participatory Poverty Assessment, targeting multiple stakeholders in both rural and urban communities. The overall findings of the report indicated that a majority of Marshallese people believed that hardship and poverty were on the rise, with poverty largely being defined in terms of poverty of opportunity. Key issues raised by participants surveyed were: 1) lack of employment and other income-generating opportunities, particularly in the outer-islands, 2) poor quality of schools and education outcomes resulting in low confidence in the effectiveness of the education system, 3) lack of outer-island transport and reduction of global copra prices, making copra production a less viable means of income-generation, 4) rise in social problems such as domestic and alcohol abuse, teenage pregnancy, suicide and gang violence, impacting the quality of life of communities.

Nearly all participants in the rural and urban areas identified themselves as experiencing hardship in some manner. In particular, women stakeholders indicated that women were experiencing increased hardship. With many of their husbands unemployed, many women were becoming the primary breadwinners of their families, turning to handicraft production as their main source of income. Many women indicated that as handicraft production was very time consuming, they increasingly had little time to spend with their children. Many noted that income generated from handicrafts was only sufficient to purchase basic goods needed for survival, but insufficient to afford education and healthcare services.

In conjunction with the Participatory Poverty Assessment, the ADB produced a discussion paper on poverty and hardship in the RMI, including a series of policy recommendations and strategies for equitable growth and poverty alleviation. The paper stated that the RMI ranked 8th in terms of poverty among the 12 PDMCs of the ADB. This score was determined by the percentage of people not expected to survive to age 40 (13%), percentage of illiterate adults (26%), percentage of underweight children under the age of 5 (17%), and the percentage of people without access to safe water (18%) or health services (5%) (ADB, 2002:5). The low scoring of the RMI, relative to other countries in the Pacific, was largely dependent on the high proportion of illiteracy in the population, high percentage of under 5 year-olds who are malnourished, and high proportion of the population without access to safe water.

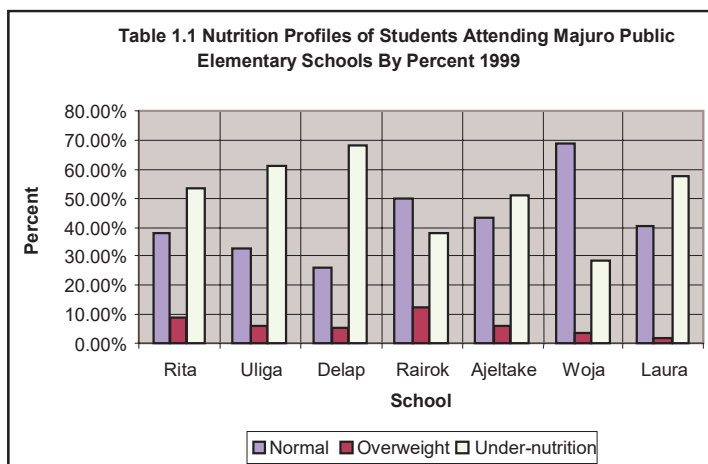
The report highlighted high levels of inequality between rural and urban incomes, including between individual rural, outer-islands. It stated that “[t]he average annual per capita income for the outer islands was \$418 or \$1.15 per day in 1999. This compared with the national average per capita income of \$3.87. The median per capita annual income showed that half of the outer island population was actually earning only \$0.62/day. Both measures of per capita income indicate that almost two-thirds of the outer island population had per capita incomes below the UNDP standard poverty threshold of \$1.00/day (1993 PPP)...(ADB, 2002:6)”. In addition, the report stated that “the national level data indicate that the first three quartiles (75%) of households receive only about 35% of the total income. Taking the urban and compensation islands alone indicates the first 75% of households receive about 43% of the income...indicating the dominance of urban and compensation incomes in the overall national household income distribution. [Further]...there is also a very high level of inequality in the outer islands where the data indicates that the first 75% of households receive only about 30% of the income. Indeed, the data suggests that the lowest 40% of outer island households receive only 7% of the income. This effectively confirms the likely high level of income poverty experienced in the outer islands (ADB, 2002:6)”.

The primary issue for the income security of many rural, outer-island communities is the high dependence on copra production as the main source of income. With the simultaneous conditions of declining global prices and lack of consistent and timely outer-island boat services, copra production has become a less than reliable source of income for outer-island communities. Since 1999, the global price of copra has fallen from an average of \$200 short ton to \$180 short ton in 2001 (ADB, 2002: 14). In

response to the decline in global copra prices, the RMI continues to follow a policy of subsidizing the copra industry to stabilize internal copra prices, but there is concern that if global prices continue to decline, this policy will increasingly become unsustainable. Reports from the MIJ have indicated increased desperation on part of some of the outer-island communities where individuals have been caught filling copra bags with extra pieces of stone and other non-copra items to increase the volume and weight of their production outputs (MIJ, 2004:1 and 2).

In terms of hunger, the discussion paper did not provide much evidence, except to state that in 1999 approximately 17% of children under 5 were classified as underweight. In a national nutrition survey conducted in 1991, 40% of school-age children were identified as malnourished (ADB, 2002: 27). Malnourishment was stated as being a combination of under-nutrition and over-nutrition (i.e. heavy reliance of processed and junk foods as the primary source of sustenance). Heavy reliance on imported, processed food products is a consequence of peoples' reduced capacity to produce their own food due to lack of skills and space, and the cheap price of canned goods as opposed to fresh produce. The increasing population of the RMI, even in some of the rural, outer-islands, is putting considerable strain on peoples' abilities to produce/procure their own foodstuffs from available land and marine resources. As arable land is scarce, and what land is available is unable to sustain crop production due to the high salt content of the soil and exposure to high ocean winds, people are increasingly having to depend on imported foodstuffs to either supplement what they are able to gather from the land and sea, or to completely replace what previously had been primarily a subsistence-based diet.

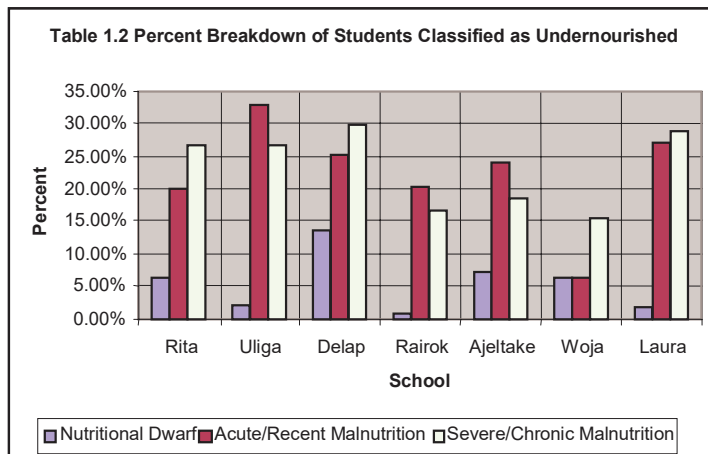
The issue of hunger is, therefore, becoming an issue of concern, particularly in the urban centers where a majority of people simply do not have the space to cultivate enough produce to sustain the number of people within their households. Until recently, the clan system had been strong with needy members of a clan able to seek assistance from other clan members. However, as Marshallese society becomes increasingly urbanized, with multiple layers of extended families migrating to different locations, there has been a noted breakdown in this system. What had previously been a social safety net for people, is now no longer as readily available. In such instances, evidence indicates that hunger is becoming an increasing characteristic of hardship and poverty in the RMI, and is particularly acute in the urban centers.



In 1999, the CMI Land Cooperative Research and Extension Land Grant Program conducted a nutritional survey at seven public elementary schools on Majuro Atoll. The findings indicated that a significant majority of public elementary students in Majuro were undernourished as indicated by Table 1.1.

Delap Elementary School had the highest percentage of undernourished students, with 68.47% of the students classified as undernourished. The second highest was Uliga Elementary School with 61.39% of the students classified as undernourished. The third highest was Laura Elementary School with 57.69% of the student population classified as undernourished. The percentage of students classified as undernourished at Rita, Ajeltake, Rairok and Woja Elementary Schools were 52.97%, 50.94%, 38.05%, and 28.13%, respectively. The survey clearly illustrated that an overwhelming majority of Majuro elementary school students were not receiving sufficient and nutritious sustenance on a daily basis.

Based on local and international standards of child development indicators, the survey further categorized the students identified as undernourished into three sub-categories: nutritional dwarf, acute/recent malnutrition, and severe/chronic malnutrition. As illustrated in Table 1.2, an overwhelming majority of these students fell in the acute/recent to severe/chronic malnutrition categories, and that many of these children were well below WHO's child development standards.



Both tables indicate a persistent state of undernourishment and malnourishment experienced by a significant majority of Majuro public elementary school students. Such persistent undernourishment and malnourishment will have future negative health implications for the students as they grow into adolescence and adulthood, making them increasingly vulnerable to

communicable diseases and other chronic, lifestyle-related conditions. In turn, a rise in disease rates (e.g. diabetes and TB) within the future adult population will mean increasing costs to healthcare provision and associated services. There is concern amongst current healthcare workers that the RMI healthcare system would be unable to meet the rising costs of healthcare if disease rates continue to increase from current levels, and that a health crisis might be inevitable.

Overall, the nutrition survey gave undisputed evidence that hunger (as defined in terms of undernourishment and malnutrition) is clearly evident in the RMI, and is particularly acute in the school-age population in the urban areas. Similar studies have not been conducted for school-age children in the rural areas and the general adult population, but other studies and surveys suggest that a similar profile will likely be seen in the adult population in the urban centers, where peoples' access to sufficient and nutritious sustenance is greatly limited by demographic, geographic and other socio-economic constraints (i.e. lack of employment and other income-generation opportunities and limited access to quality education).

As a result of the survey, there was a call by both the MOE and the public to establish a school-based feeding program. To date, only one public high school has been able to maintain a school feeding program, using a combination of funds from both the government and parents. However, nearly all public elementary schools still do not have a school-based feeding program, although negotiations have been under way for the last year and a half to use specific US Compact funding to fund a school-based feeding program. In addition to a school-based feeding program, the MOE and MOH will need to make a concerted and collaborated effort to educate parents and communities on the importance of proper nutrition for infants and children.

In July 2004, another major study was conducted that highlighted increasing poverty, hardship and hunger in the urban centers. With funding from the International Waters Programme of the Pacific Islands, a socio-economic survey was conducted in the urban community of Jenrok (Majuro) to provide baseline information for the development of an urban recycling and sanitation program. The findings of the survey provided concrete evidence of rising poverty and hardship in a specific urban, Marshallese community.

Of a total of 215 households, 194 (91%) households participated in the Jenrok survey. The average household size was calculated at 9.5 persons, with houses averaging 2.2 rooms. The estimated unemployment rate was calculated at 47%, nearly 17% higher than the national average. Male unemployment was estimated at 75%. The average hourly wage for those employed was \$2.57 per hour, with a majority working in the private and service sectors (IWP, 2004: 21-2).

Of the 194 households surveyed, 53% had loans, the vast majority of which were for the following purposes in decreasing order of priority: basic needs, funerals, house improvements, education, birthday parties. 23% of the households had store credit at various local stores. 65% of household had allotment schemes arranged with their employers to pay debts direct to creditors. From the survey, the average household debt was calculated at approximately \$325.47 per month, resulting in an average debt to income ratio for the Jenrok community of 38% (IWP, 2004: 23). Information gathered from the Majuro Water and Sewer Company revealed that of 211 water-metered customers in the Jenrok area, 102 (48%) were recently disconnected due to non-payment, and of the remaining 109 remaining customers, two-thirds were more than 60 days overdue on their bill payments. Information gathered from the Marshalls Energy Company revealed that of 178 metered customers in the Jenrok area resulting in a coverage of 56%, 58 (33%) were disconnected due to non-payment, with an additional two-thirds more than 60 days overdue on bill payments (IWP, 2004: 21-2).

It is evident from the data that the Jenrok community is facing high levels of economic hardship. Due to lack of employment opportunities (the survey revealed that only 14 or 25% of local companies were planning to hire more workers), the main breadwinners of families are unable to obtain employment. Due to a lack of skills (the surveyed revealed that only 52% of school-age boys and 47% of school-age girls attended school), many who are employed are employed in low-skilled and therefore low-paying jobs (IWP,

2004: 23-4). Consequently, many households have depended on loans and credits to obtain basic needs. Over time, debt to income ratios appear to be increasing per household, as allotment thresholds are increasingly unable to meet minimum payment requirements to creditors. Further, as average paychecks are not high to begin with, allotments often take up a major proportion of the checks, resulting in little or no cash-in-hand at the end of each pay period.

As a result of limited income levels, the dependency on cheap, processed foodstuffs as the primary source of nourishment is evident. The survey found that 100% of households purchased white rice as their primary food purchase. The next four top items purchased were white flour, chicken legs, packaged noodles (ramen), and canned meats. The high dependency on such items has resulted in a dramatic increase in major lifestyle and other nutrition-related diseases and conditions (e.g. diabetes, vitamin A deficiency in children, anemia, hypertension, etc.). Sometimes local produce is acquired or purchased to supplement this diet, but is highly dependant on the season, and is comparatively more expensive than processed foods.

What is highlighted in both the ADB and IWP documents is the fact that poverty and hardship in the RMI is increasing. Greater numbers of people feel unable to participate in society due to lack of employment, alternate income-generation activities, and poor access to quality education and other training opportunities. As will be explained in greater detail in the following sections, the lack of access to safe water and sanitation, lack of adequate transport services between rural and urban communities to support development efforts, and the rise in social problems also support peoples' perceptions of the rise of poverty and hardship in the RMI.

Compounding the poverty and hardship experienced by many Marshallese is the stagnant growth of the private sector in the RMI economy. With approximately 48% of the national budget composed of ODA, the public sector dominates economic growth and development. Major industrial activities and companies are public rather than private enterprises. Consequentially, private sector growth has been very minimal, with some of the major private companies receiving subsidies from the government in order to continue operating. Most social and other services are either under government control, or are heavily subsidized by the government. There is very little incentive for private sector growth as the government assumes the responsibility of a majority of services, and many private sector companies are simply unable to compete. This has led to minimal and slow growth in private sector employment opportunities as illustrated in Table 1.3.

Table 1.3 Total Employment By Institutional Sector FY 1997-2004

Sector	1997	1998	1999	2000	2001	2002	2003	2004
Private Sector	2,622	2,808	2,758	3,085	3,435	3,653	3,707	3,708
Public Enterprise	693	680	599	623	661	793	706	693
Banks	96	109	114	114	132	133	129	146

RMI Government	1,802	1,693	1,523	1,487	1,481	1,644	1,773	1,776
Government Agencies	394	357	488	533	580	592	588	573
Local Government	520	503	557	616	652	686	713	753
NGOs and Non-Profits	362	364	373	384	395	394	370	384
Foreign Embassies	11	11	13	13	15	13	14	14
Kwajelein US Base	1,007	1,027	1,113	1,150	1,204	1,180	1,289	1,114
TOTAL	7,506	7,551	7,538	8,004	8,554	9,087	9,289	9,161

Source: EPPSO, ADB TA RMI-4199

The dominance of the public sector and affiliated enterprises in comparison to the private sector is also illustrated in the difference in average annual earnings as illustrated by Table 1.4. Due to the heavy influx of ODA, the national government and its affiliated agencies and enterprises are able to provide much higher earnings than the private sector. In essence, this has led to a ‘brain drain’ of human resources away from the private sector and into the public sector, compounding the private sector’s inability to compete with the public sector.

Table 1.4 Average Annual Earnings Per Employee FY 1997-2004 (USD)

Sector	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004
Private Sector	5,957	5,641	5,817	5,431	5,305	5,059	4,907	4,865
Public Enterprise	10,109	10,262	10,557	10,920	10,395	9,464	10,454	11,187
Banks	13,007	13,678	12,309	11,950	11,534	13,290	14,933	14,666
RMI Government	9,091	9,366	10,337	10,353	11,426	12,014	11,324	13,275
Government Agencies	10,185	11,855	11,731	11,969	11,144	11,966	12,968	13,025
Local Government	7,595	6,784	6,342	6,405	6,444	7,583	7,625	7,391
NGOs and Non-Profits	4,657	4,678	4,500	4,508	4,700	4,807	4,990	4,768
Foreign Embassies	10,072	9,960	10,716	10,820	11,469	10,965	10,713	12,415
Kwajelein US Base	12,046	12,259	12,837	13,924	13,971	13,553	12,472	14,296
TOTAL	8,278	8,238	8,607	8,561	8,539	8,563	8,474	9,003

Source: EPPSO, ADB TA RMI-4199

Overall, GDP growth has been minimal as illustrated in Table 1.5. Any significant increases in GDP has been primarily due to influx of Compact funds. As an example, in FY 2000 and FY 2002, the RMI national government received major drawdowns of Compact funds from the US, driving gross GDP growth to increase from 1.1% in FY 1999 to 4.9% in 2000, and from 4.9% in 2001 to 6.6% in 2002. Real GDP per capita growth, as a result, has largely been impacted by US Compact funds being siphoned through the RMI national government.

Table 1.5 RMI GDP Aggregates (USD) FY 1997-2004

Sector	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004
1. Nominal GDP (Gross)	101,687	102,790	103,949	108,998	114,316	121,907	126,595	134,518
<i>Annual Change</i>		1.1%	1.1%	4.9%	4.9%	6.6%	3.8%	6.3%
2. GDP per capita	2,061	2,052	2,045	2,107	2,172	2,276	2,323	2,426
<i>Population</i>	49,348	50,089	50,840	51,730	52,635	53,556	54,493	55,447
<i>Annual Change</i>		-0.4%	-0.4%	3.1%	3.1%	4.8%	2.1%	4.4%
3. Real GDP (1997 USD)	101,687	99,883	99,154	103,025	106,103	111,306	117,810	124,028
<i>CPI (Marh 2003=100)</i>	94.5%	97.3%	99.1%	100.0%	101.9%	103.5%	101.6%	102.5%
<i>Annual Change</i>		-1.8%	-0.7%	3.9%	3.0%	4.9%	5.8%	5.3%
4. Real GDP per capita	2,061	1,994	1,950	1,992	2,016	2,078	2,162	2,237
<i>Annual Change</i>		-3.2%	-2.2%	2.1%	1.2%	3.1%	4.0%	3.5%

Source: EPPSO, ADB TA RMI-4199

As illustrated by the evidence above, it is clear that the national government must begin to re-evaluate its role in the development processes of the country. This is particularly critical with regards to poverty alleviation. Current fiscal policies such as the provision of services other than education and health, heavy subsidization of major industrial and private sector companies, and numerous administrative and legislative barriers, have created a highly inefficient economic system that inhibits real economic growth and is unsustainable in the long-run if foreign assistance is no longer received. The heavy role of the public sector in the economy has provided a disincentive for many would-be small business owners as they are unable to compete. As a result, people of the RMI are not only increasingly perceiving themselves as experiencing hardship and poverty, but are actually experiencing key aspects of poverty; deprivation, marginalization, and unequal/lack of access to quality education and health services.

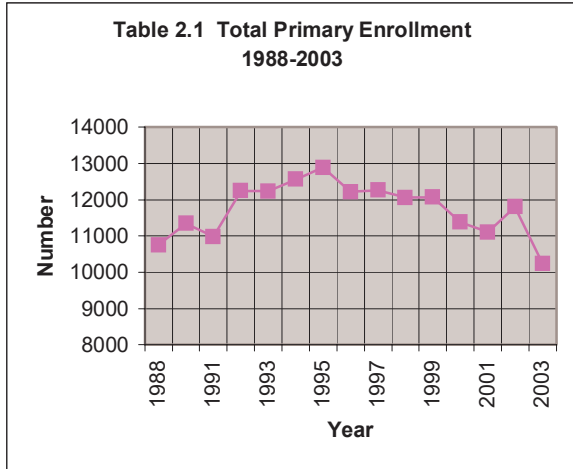
B. Goal 2: Achieve Universal Primary Education

***Target 3:** Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling*

In January 2004, the RMI government passed a new law revising the mandatory school age, reducing the age from 6 to 4 years, and expanding the language of the act to include compulsory secondary education. Further, this legislation mandated the MOE to address the following areas:

- Provision of comprehensive and quality early childhood and kindergarten education at all public elementary schools
- Expand current elementary and secondary school facilities and classrooms, including establishment of new secondary schools, and expansion of vocational training programs for those unable to successfully attend secondary school

Currently, early childhood education and kindergarten classes are primarily provided by private elementary schools. As a result of the new legislation and increased funding to education from the Compact of Free Association, the MOE has developed a phased implementation plan to establish early childhood and kindergarten classes at all public primary schools, starting with Majuro and Ebeye, and incrementally to the rest of the

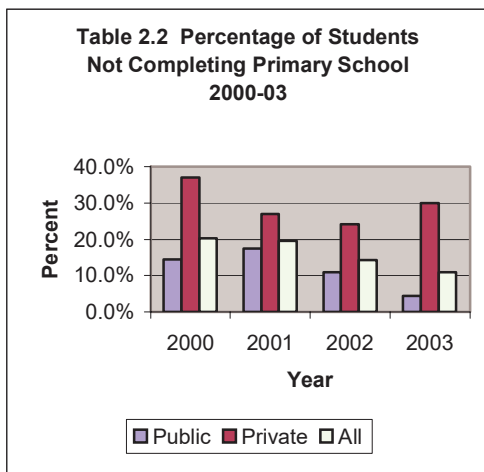


outer-islands. Once completed, there will be a marked improvement in overall gross enrollment rates.

However, as illustrated in Table 2.1, there has been a marked decrease in gross enrollments since 1995. It is not clear why this is the case, but may be attributed to several factors; 1) decrease in overall fertility rates, 2) increase in out-migration to other Pacific Island countries, and 3) closing of some schools and/or classrooms due to damage and neglect. It appears, however, that these

three factors may not fully explain the sharp increase between 2001 and 2002, and the then steep decline in enrollment between 2002 and 2003. One plausible conclusion is that there may have been major errors in the collection and/or analysis of total enrollment figures, accounting for these discrepancies. There is concern as to whether previous enrollment data are accurate, and whether the picture of overall enrollment decline is valid.

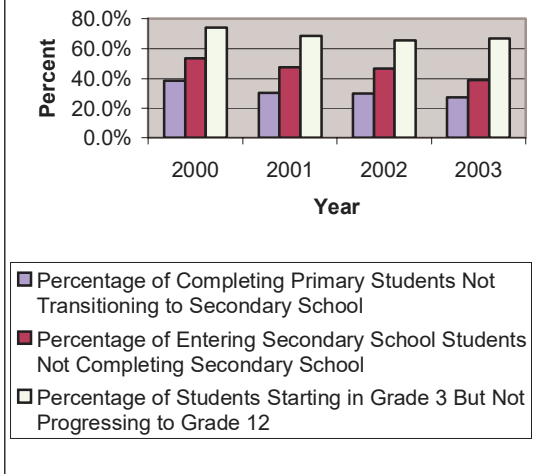
Further, drop-out and retention rates have not been consistently collected by the MOE and individual schools, making it difficult to determine strong trends in overall enrollment patterns. Also, there is little or no data available on drop-out/retention rates aggregated by gender and by grade levels after 1996 (primary) and 2000 (secondary). However, the data that does exist suggests certain key conclusions as illustrated in the following tables.



In Table 2.2, overall drop-out rates have been steadily decreasing for both public and private primary schools. The decrease is most notable for public schools since 2001. Private school drop-out rates are significantly higher than public school rates, despite improvement since 2000. The higher drop-out rates for private schools may primarily be attributed to parents and guardians unable to maintain tuition payments. In addition, private schools in the RMI tend to have stricter academic and other performance criteria, and some students may drop-out due to expulsion or failure to meet minimum academic requirements. Lastly,

students who attend private schools tend to come from more advantaged families, and over the years, anecdotal evidence suggests that increasing numbers of Marshallese families are sending their children to schools abroad due to the poor quality of education in the RMI.

Table 2.3 Overall Drop-Out Trends for Private and Public Schools 2000-03



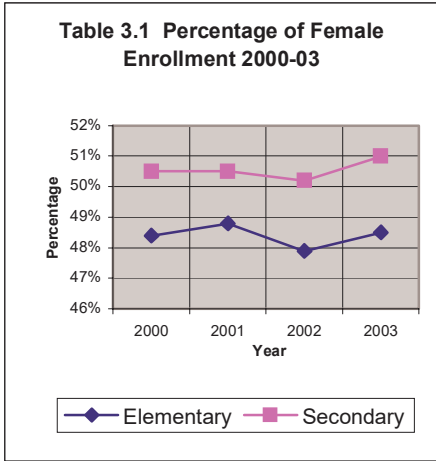
The expansion of schools and related facilities is critical due to the strong relationship between low primary school enrollment and the lack of classroom space. In the urban centers, where a majority of the Marshallese population reside, there are not enough classroom space to accommodate all primary school-age children. Statistics indicate that of all primary school-age children, approximately 53% actually attend school (based on 1999 Census under 15 population figures). A significant majority are ‘pushed-out’ due to lack of space. It appears that in order to effectively address the issue of universal primary education in the RMI, it is important to consider the issue of school

‘push-out’, in addition to examining drop-out and retention rates. Examining only drop-out and retention rates would reveal a limited picture of the current situation of primary school enrollment, and would not provide useful information about children outside of the school system. The Compact is now providing approximately \$37.6 million (FY04-06) for infrastructure development of new school facilities and expansion of existing classroom space. For School Year 2004-05, these activities have as yet to result in any significant increases in primary education enrollment, but it is likely that once the new classroom facilities are completed, there will be a significant rise in total enrollment for primary education.

To date, the RMI does not collect information on youth literacy levels. According to the 1999 Population and Household Census, the adult literacy rate for persons above 10 years is 97%, with 96.8% for males and 97.2% for females. Adult literacy in the RMI is defined as the ability to read and write a simple message in any language. However, there is concern that this figure is not accurate due the overall poor academic performance of primary, secondary and tertiary students on national achievement tests, and other evidence from the private sector that indicate that a significant number of Marshallese employees have low literacy (Marshallese and English) and numeracy skills. A more accurate test for literacy would be to not only test for reading and writing skills, but also comprehension based on having read a complex passage and answering questions based on the passage (most likely from a newspaper article).

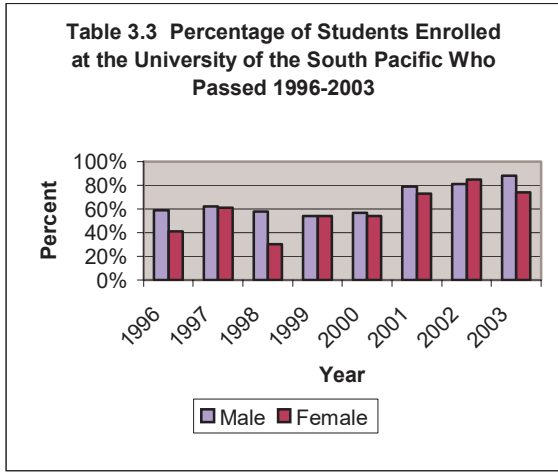
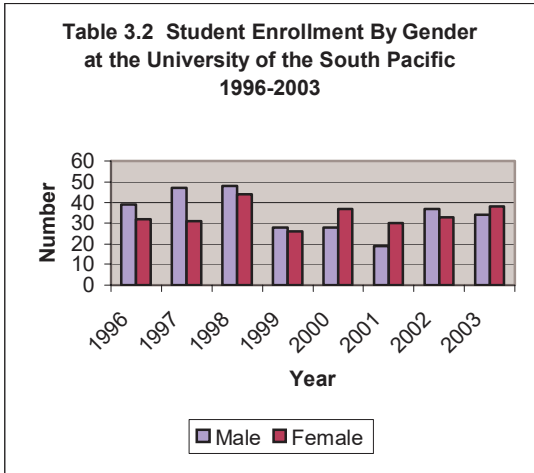
C. Goal 3: Promote Gender Equality and Empower Women

Target 4: *Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015*



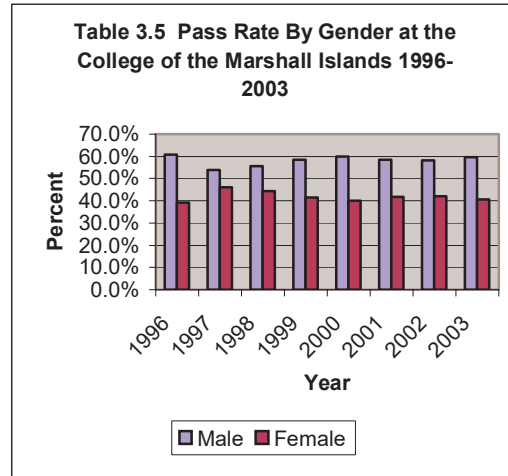
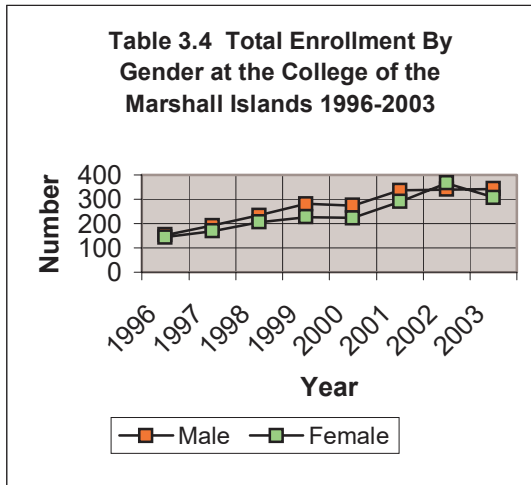
In the area of gender equality in primary and secondary education, the RMI is essentially on target. Gross primary and secondary enrollment rates, both public and private, indicate that female to male enrollment ratios are roughly equivalent, with slight variations from year to year. Overall, female enrollment, as a percentage of total enrollment, has slightly increased for both primary and secondary levels, but more so for secondary school as illustrated in Table 3.1. Over the past several years, girls have been out-numbering boys as percentage of total secondary school enrollment, particularly in the private schools.

However, issues of gender disparity arise when examining school drop-out/retention rates. At primary and secondary levels, evidence suggests that female drop-out rates appear to be increasing over time compared to male drop-out rates (i.e. female completion rates lower than for males). The general consensus from public discussions suggest that the increasing drop-out rates of females versus males are due to the rise in teenage pregnancy rates, as well as socio-cultural expectations of females needing to be at home to help the parents take care of younger children, and to assist in events such as funerals. Having missed school for lengthy periods of time during the school year, many are unable to catch up and drop out of school.

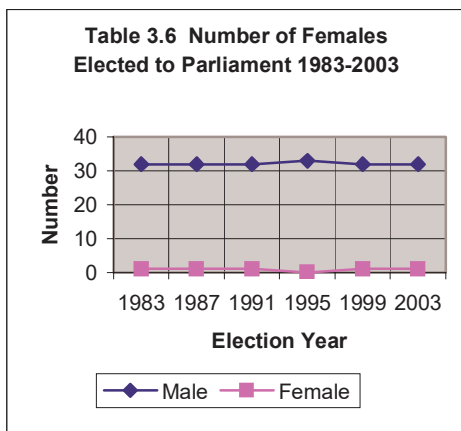


Examining student enrollment at the tertiary level illustrates the above point more clearly. For the USP Majuro Extension, Table 3.2 indicates that total female enrollment has increased over time, with some years having more females enrolled than males. However, in examining Table 3.3, a different picture begins to emerge. Here, even though the pass rate for both males and females increased over time, there is concern that female pass rates were not always on par with males. Of the eight years studied, only three of the years indicated that female pass rates equaled or exceeded male pass rates.

At CMI, the second tertiary institution in the RMI, the same essential patterns can be seen in Table 3.4 with roughly equivalent and increasing female enrollment. In examining Table 3.5, the pattern of lower pass rates for females than males is reinforced. Unlike USP, CMI's data indicates greater disparity between male and female passing rates, with females passing at far lower rates than their male counterparts. This poses great concern as to the ability of females to obtain more advanced education and/or to sustain such efforts over a period of time.

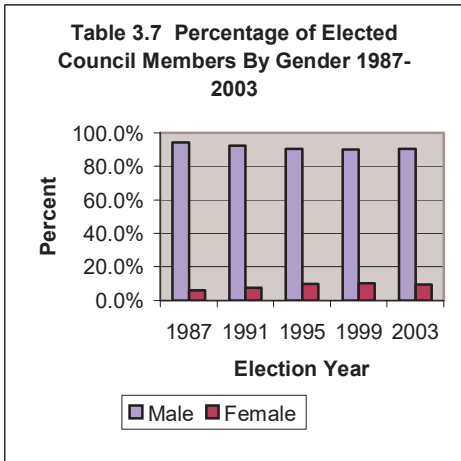


Although, the above data do not necessarily suggest a strong trend or pattern throughout the education system of the RMI, other anecdotal evidence from the primary and secondary levels appear to indicate that the potential for gender discrepancies can become an issue if not addressed. More research and data collection are needed conducted to examine whether this trend is increasing or decreasing, and to identify what are the constraints and conditions that prevent females from succeeding or completing school.



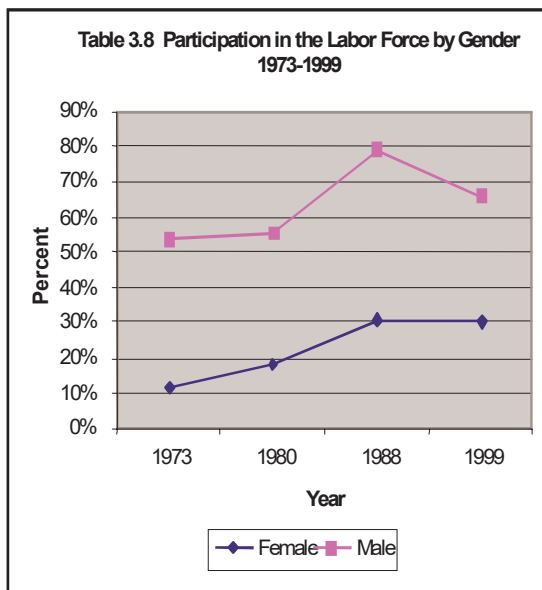
With regards to women's participation in the national parliament and wage employment in the non-agricultural sector, there are significant gender. In Table 3.6, the number of women elected into parliament has remained basically static for the past 6 elections (with the exception of election year 1995 where no women were elected). In the election years where women were elected, only one seat out of thirty-three was held by a female. There is a slight improvement in the number of women elected into local councils (Table 3.7), but the total numbers still remain very low. Traditionally,

women of chiefly rank have always had significant influence in decision-making processes. The Council of Iroij (Chiefs) has primarily been composed of roughly equal numbers of males and females who, although do not wield much legislative power, do have considerable influence on matters relating to traditional land tenure and customary rights. However, it appears that women, overall, find it difficult to push women's issues



either in parliament or in national discussions. This suggests that the current political environment is not ‘gender sensitive’ and/or does not readily view women’s issues as national priority. In order to effectively address gender issues in the RMI, political leaders and parliamentarian need to include and consider gender issues in national and local policies and legislation to ensure equal representation.

In terms of the employment sector, in 2004, Ben Graham, a MBA candidate at Georgetown University in the US, did extensive research on the situation of women in the RMI. One of the main findings of his study indicated that despite legislation ensuring equal treatment of women in the workplace, significant gender discrepancies still existed with regards to female labor force participation and earning power.



Graham’s study indicated that female participation in the employment sector increased significantly between 1973 and 1988, but then decreased slightly between 1988 and 1999 by 0.2% points (Graham, 2004:6). However, as illustrated in Table 3.8, overall female participation in the labor force was consistently and significantly lower than comparative figures for males in all four time periods.

Regarding earning power, the study gave evidence to additional gender discrepancies. Analyzing data from the 1980 Population Census and the 2002 Household Income and Expenditure Survey, it was calculated that the female to male wage ratio in 1980 was .58. By 1999, this had increased to .71. Though the increase indicates positive improvement, the gap is still considerable. Further evidence indicates that for some occupations, despite females and males having equal educational qualifications and backgrounds, there were significant differences in pay scales. It was seen that males, on average, received higher pay than females. In terms of mean annual wage of employed in 2002, the female mean annual wage was USD 7,595, as opposed to the male mean annual wage of USD 10,772 (Graham, 2004:6).

When examining the relationship between education levels and increase in pay by gender, it was seen that there was strong correlation for males than for females. In other words, there was a strong positive correlation for males that with every increase in

educational level/qualification, there was a corresponding step increase in pay. For females, the correlation was not as strong. In terms of real wages, the on-average increase for males with one level of increase in education level was USD 1,423. For females, this was approximately USD 880 (Graham, 2004:6). Overall, the study gave strong indication that gender discrimination is occurring in the RMI labor force.

The causes of gender inequality in the RMI cannot be easily identified without further examination of the traditional cultural and modern socio-economic contexts. Given current social conditions, it does not appear that women are deliberately marginalized from participating in parliament or other national discussions and decision-making processes. As Marshallese society is traditionally matrilineal, women in the RMI continue to wield considerable influence in family and cultural affairs, with women chiefs and traditional landowners holding considerable sway on how clan lands are utilized, and how family affairs are conducted. However, it is also accepted traditional practice that the eldest males are recognized as the 'public spokesman' who speak on behalf of the family matriarch. This has led to some confusion in modern times as to who is the true 'head' of the clan/family, with some community leaders indicating that only males can hold titled positions within the clan structure, and are the only recognized decision-maker for the clan.

It is unclear how this shift in thinking has come about, but some believe it is largely the influence of Western/Asian cultural and social biases regarding the roles and capacities of women to undertake tasks outside of the home, that are essentially patriarchal in nature. In contrast to these external beliefs and norms, it is recognized within Marshallese society that the primary domain of women is in the management of the household and in child-rearing. However, this is not due to any perception that women are incapable, but rather an emphasis on the powerful role women play in ensuring the continuity of Marshallese society, and in the preservation of cultural values and norms. The most powerful example is under customary law where children who are born to non-Marshallese mothers are not eligible to inherit or lay claim to clan lands inherited by their Marshallese fathers (whose mother, grandmother, etc. were Marshallese).

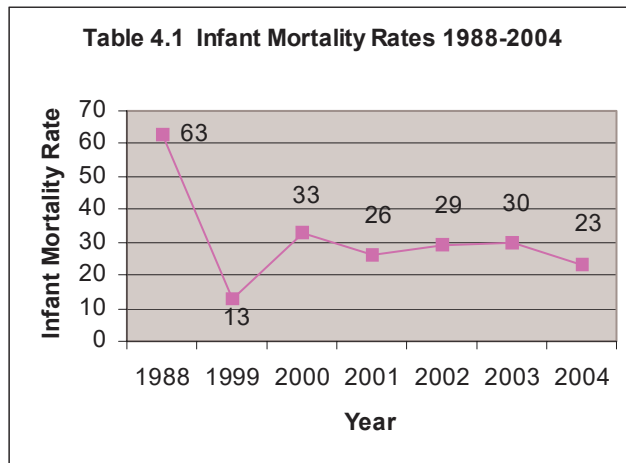
As in Graham's study, it has been suggested that gender discrepancies may have arisen from other additional factors such as the high teenage pregnancy rates resulting in many females dropping out of school, which in turn has resulted in higher percentages of females without adequate skills to enter the labor force. Increasing poverty and hardship was another factor stated which has resulted in increasing numbers of females remaining in the home to care for younger children while parents seek work, prohibiting them from either entering and/or completing school. In both scenarios, females are increasingly finding themselves unable to fully engage in society at any level.

Yet, neither of these scenarios fully explains why there are discrepancies, for example, in pay scales between males and females of equivalent educational skills and qualifications, or low election/appointment rates into the local councils and other government offices for women who are qualified. Is it an issue of appropriate and targeted legislation to reduce gender discrepancies? Or, is it the lack of enforcement of existing legislation that

safeguards the constitutional right of women to equal treatment? Given the lack of information and research regarding women’s issues in the RMI, neither question can be fully addressed within this report. As such, it is evident that more research needs to be collected to identify the underlying causes and issues surrounding gender inequality in the RMI.

D. Goal 4: Reduce Child Morality

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate



In 1999, the Census of Population and Housing stated that the IMR was 37 per 1,000 live births overall (41.4 for males and 32.4 for females) a significant reduction from 63 per 1,000 live births in 1988. As indicated in Table 4.1, the IMR has essentially stabilized with a significant decline in 2004. This indicates significant improvement in reducing infant mortality over time.

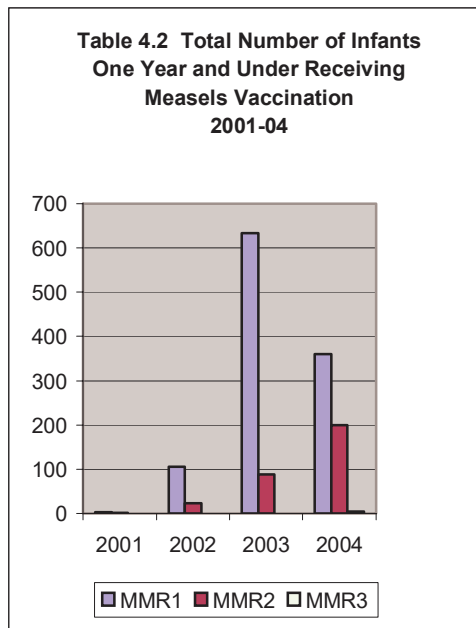
The current 2004 IMR is 23 per 1,000 live births. In 2004, there

were 38 registered infant deaths. The MOH 2004 Annual Report indicated that the major causes of infant deaths, in order of most to least important causes, were 1) sepsis (i.e. infection), 2) pneumonia, 3) birth complications, 4) aspiration and 5) congenital anomalies. The first two major causes, sepsis and pneumonia, are highly preventable and treatable conditions given early and appropriate medical care and treatment. Since 1999, death due to sepsis has been one of the top two major causes of morbidity. The high incidence of infant death due to sepsis, especially, may indicate a serious problem in the delivery and quality of health services and treatment.

In 2004, on Majuro Atoll, 360 children one year and under received MMR1 (first dose), 199 receive MMR2 (second dose) and 4 received MMR3 (third dose). In order to be fully immune to measles, infants must obtain all three doses within a certain period of time. In examining the total number of infants who received the first dose of MMR, only 1% were completely immunized against measles (completed the second and third doses). In comparing these numbers with the total number of registered live births in 2003 (1,565) and 2004 (1,431), the coverage for all three doses of MMR is extremely low.

Despite improvements in MMR vaccinations to infants one year and under for all three doses (see table above), the pattern of low numbers of infants receiving MMR in comparison to the total number of infants born, and steeply declining proportions of first dose recipients receiving the second and final doses, has been the same since 2001. This shows serious issues with regards to follow-up immunization programs, and how

effective they are in informing parents of the importance of receiving all three doses. The measles outbreak in 2003 suggests that the potential for future and more serious outbreaks is high if these patterns are not addressed.



In terms of under-five mortality rates, the last calculated rates were in the 1988 and 1999 Population and Household Censuses. In 1988, the rate was 93 per 1,000 live births, and in 1999 the rate decreased to 48 per 1,000 live births. As such, there has been a notable improvement in under-five mortality rates, largely due to the improvement and expansion of health services both in the urban centers and rural outer-islands. The 2004 under-five mortality rate has as yet to be calculated by the MOH.

There is concern that the general lack of data on immunizations and major health indicators such as under-five mortality rates may present an inaccurate picture of the general progress perceived of the RMI health sector in addressing key health issues. It is clear from the data that

infant and child immunization outputs are significantly low, potentially resulting in increased health risks to the general and future populations. In addition, though the IMR has greatly decreased over time, infants are still dying from highly preventable/treatable conditions such as sepsis and pneumonia when detected early. This may call into question whether true progress has been achieved in the provision of quality healthcare in the RMI. More data will need to be gathered to make a more accurate assessment of the RMI healthcare system.

E. Goal 5: Improve Maternal Health

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Current MOH statistics indicate that maternal mortality rates have declined drastically since 1988. In the Statistical Yearbook 2003 and the MOH Annual Report FY 2004, it is stated that in the years 1991, 1996 and 2001-04, only one maternal death was registered.

The reasons for the decrease in maternal mortality rates can be attributed to three main factors. The first factor is the notable increase in trained midwives and maternal health staff at the local hospitals on Majuro and Ebeye. In addition, all outer-islands have trained Health Assistants who are trained to identify potentially risky pregnancies, which are then referred to the hospital on Majuro or Ebeye. In this case, women who normally would not have had access to pre-natal and antenatal care, are now able to access it more readily.

The second factor is that within the last several years, the hospitals have greatly strengthened their pre- and antenatal programs through comprehensive training of local staff, and streamlining of the process of pre- and antenatal visits, ensuring efficiency in detecting potentially dangerous pregnancies and/or births. This process has also included the hiring of qualified expatriate medical staff, and purchasing of modern monitoring equipment. In 2004, expatriate staff constituted 18% of the total medical personnel. They were primarily composed of nurses and medical professionals (doctors, lab technicians, dentists, etc.).

The third factor is the current referral system to modern hospitals in Hawaii and the Philippines. Pregnancies or births that would have normally resulted in death are now primarily referred to hospitals in Hawaii and the Philippines, greatly reducing the incidence death for both mother and newborn.

F. Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

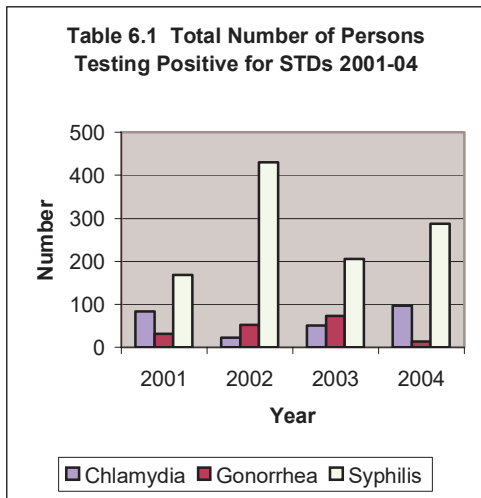
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

The incidence of HIV/AIDS is fortunately low in the RMI. As of 2005, an officially confirmed total of 13 persons have tested positive for HIV/AIDS in the RMI, two of which are confirmed to have AIDS. Current statistics from the MOH and the 2003 Statistical Yearbook indicate that there is potentially three more confirmed cases, bringing the total to possibly 16, but there needs to be further clarification of the data.

What is of major concern is the ages of the persons testing positive for HIV/AIDS. Since 1996, the age groups of those testing positive at the time of their tests were 15-19 years, 20-24 years, 25-29 years and 30-34 years. In other words, almost all of those testing positive were under the age of 34, with most of the cases falling below 29 years. Further, the Statistical Yearbook 2003 indicates that a majority of the new cases of HIV/AIDS were female. Many of the new cases were primarily from the urban center of Ebeye, but with the last two cases detected in Majuro in 2005.

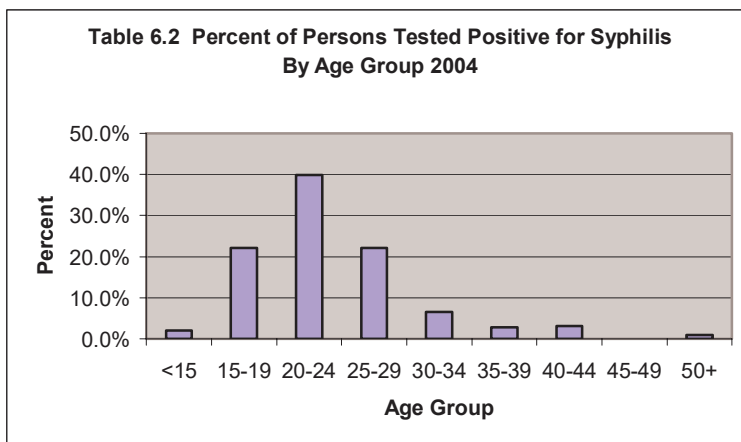
The data suggests that the infection rate of HIV/AIDS in the RMI may increase over time. In addition to new cases of HIV/AIDS, there has been and continues to be steep increases in new infections for the other sexually transmitted diseases such as syphilis, gonorrhea and chlamydia (Table 6.1), indicating increased vulnerability of the population to new HIV/AIDS infection. The steep rise in new sexually transmitted cases indicates a high level of engagement in high risk behaviors such as no condom use during sexual encounters and engagement in sex at earlier ages. Lastly, there has been a significant rise in international seamen entering the RMI. As a result, the prostitution trade has increased. Much of this population does not access the medical system for testing and/or treatment of STDs.

The high incidence of STDs, particularly in the under 34 population, means that this age group will become increasingly vulnerable to new HIV/AIDS infections in the future. Global studies show that there is a strong correlation between high incidences of sexually transmitted diseases and TB with proportionally higher incidences of new HIV/AIDS infections. What is of further concern is that a vast majority of the new infections indicated in Table 6.1 were from those persons between 15 and 29 years of age. Looking at new syphilis infections in 2004 in Table 6.2, the most affected age groups were those in the 20-24 years age range.



The high prevalence of sexually transmitted diseases amongst those getting tested suggests a

low incidence of condom use rate amongst those of child-bearing age. In the 2003 Statistical Yearbook, of the family planning services provided, condom distribution



accounted only for 8.9% of services (to females only). In addition, in 2001, only 11 males received family planning services (vasectomy only). In 2002, only 2 males received family planning services (vasectomy only). In 2003, no males received or requested any types of services. This data suggests that the main

burden of family planning and reproductive health is on the female, with few or no males taking responsibility for the prevention of pregnancy.

This observation is supported when examining the RH Clinic data. According to the MOH Annual Report FY 2004, the most popular form of contraceptive was DepoProvera at 39.62% of female clients using this method. The next popular method for female clients were contraceptive pills at 23.19%. Condoms and bilateral tubal ligations were 15.15% and 13.39%, respectively, for female clients. In other words, of the total female clients visiting the RH Clinic, 84.85% of them were using methods that did not prevent the transmission of STDs (spermicidal foam accounted for 0% of usage by females). The primary concern of the female clients appears to be prevention of pregnancy. The data does not suggest a strong inclination on part of the female clients to prevent STDs. The low incidence of condom usage rate is further supported by the very high rate of teenage pregnancy. In 2004, 17% of all registered live births were by females between 15 and 19

years of age. Though this figure is lower than in previous years, the rate is still quite high.

In terms of male usage of the RH Clinic in 2004, only a total of 50 males visited the clinic. Of the 50 males, 49 requested condoms and 1 requested a vasectomy. 12 males were from the 15-19 age group, 7 from the 20-24 age group, 8 from the 25-29 age group, and only 3 from the 30-34 age group. Of this group nearly all preferred condoms as the primary form of contraceptive. However, what the data indicates is that male utilization of the clinic is extremely low, particularly amongst the most vulnerable age group of 15-29 year olds.

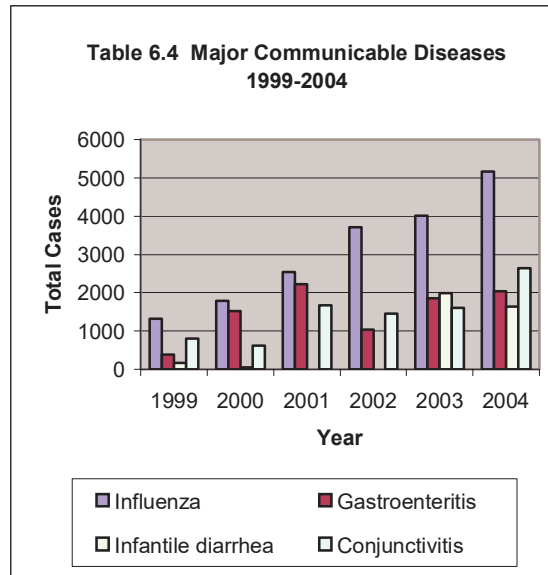
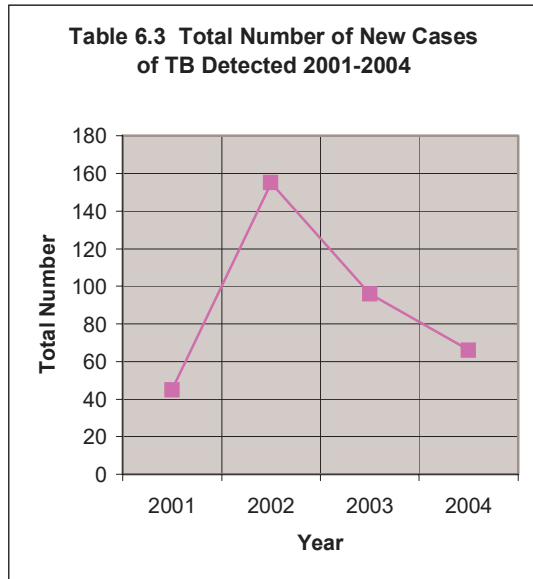
The high incidence of teenage pregnancy, combined with increases in sexually transmitted diseases, and the low incidence of condom usage at the RH and Family Planning Clinics reveal a potentially dangerous situation when it comes to the overall health and well-being of the future population of the RMI. This raises potentially negative economic and social implications on the ability and capacity of the health and social services to meet the soon-to-be very high demands of the population to provide expensive treatment and referral services. The fact that well over half of the current population is under the age of 24 suggests that the demands on future health services will be very high. The concern is whether the future health services of the RMI will be able to meet these demands in terms of provision of adequate financial and human resources.

What is of greater concern is that a majority of the cases of sexually transmitted diseases are caught during pre- and anti-natal visits. This means that a greater proportion of the general population is not being tested. Discussions with health providers indicate that many people do not get tested until the later stages of the diseases when symptoms are more noticeable (and in some instances, at a point where it is no longer treatable); or in the case of chlamydia, women find that they are infertile and/or have severe abdominal pain and infections (often leading to a hysterectomy). It also means that there is a greater proportion of males who are not being tested and treated, possibly leading to additional cases of new infections that are not currently being detected.

With regards to malaria and TB, the RMI does not have any documented cases of malaria to date. However, the issue of TB is of major concern. According to SPC, EPPSO statistics state that in 1992 the TB incidence rate was 121 per 100,000 persons. In 2001, this increased to 134 per 100,000 persons. During the past three years, the number of new TB cases still remains high, with a TB warning issued in late 2004 due to a steep rise in newly detected cases. Table 6.3 illustrates the rise in TB cases over the past four years showing that on average, the number of new TB cases has increased since 2001 despite significant progress after 2002. Though not available, anecdotal evidence suggests that the true number of TB cases is higher than indicated in Table 6.3, with many TB carriers and patients unwilling to get tested and/or treated due to the negative social stigma associated with the disease.

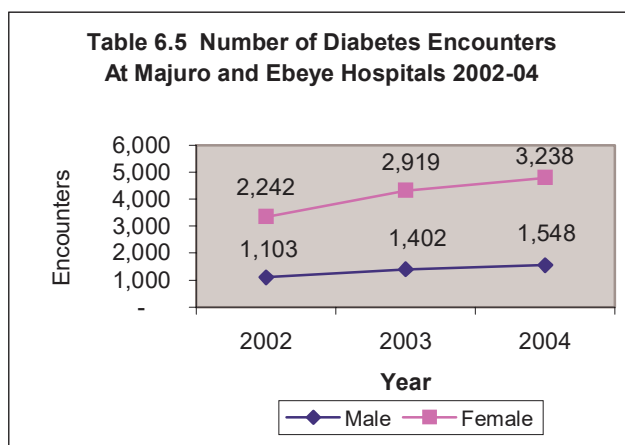
Despite such evidence, there has been marked improvement in the detection and treatment of existing and newly detected cases, largely due to the use of the Direct

Observation Therapy (DOT) treatment method. In 2004, 38.3% of all the cases receiving treatment under the DOT method were cured.



However, other communicable disease such as influenza and conjunctivitis are also raising concern. In addition, the steeply rising numbers of infantile diarrhea and gastroenteritis cases need to be examined further, and may indicate a potential public health crisis with regards to the prevention and treatment of communicable diseases. The high incidence of the diseases indicated in Table 6.4 suggest that there are other factors besides quality healthcare that need to be considered to understand why these diseases are on the rise.

One major factor is reliant on the environmental conditions within which communities reside. In Ebeye, where a majority of the new cases of TB are being detected, concern has been raised about the overly crowded and poor sanitation conditions as a factor in the rise in TB cases. The same concern has been raised for the Darrit-Uliga-Delap area of Majuro Atoll which is similarly densely populated. In both areas, a significant number of households do not have access to clean water and sanitation, potentially encouraging the rapid spread of air/water-borne and other communicable diseases. Treating these types of infectious diseases would be difficult to address until the conditions/environment within which people are living are addressed as well.



What is of particular concern is the rise in non-communicable, lifestyle-related diseases such as Type II diabetes. In 2004 on Majuro and Ebeye, 4,786 diabetes cases were seen at the hospitals. Type II diabetes is currently one of the major contributing factors of adult morbidity in the RMI, and is a major

financial burden on the healthcare system. At the later stages of the disease, many patients have to be referred for medical treatment in Hawaii or the Philippines at major expense to both patient and the MOH Medical Referral Service. The number of new cases of Type II diabetes is still rising and poses major concerns as to the ability of the healthcare system to adequately address the treatment needs of patients given available and limited resources.

In addressing these major healthcare issues, local NGOs and churches have taken an active stance on educating the population about disease prevention. In the case of HIV/AIDS, both the MOH and the NGO sector have been active. In 2004 and 2005, the MOH hired two consultants, through financial support from AusAid, to develop the RMI National HIV/AIDS Strategic Plan 2005-2008. A planning workshop was conducted this past April to develop a draft of the strategic plan. Stakeholders from the various government ministries, churches and civil society organizations were invited to assist in the development of the draft. The draft is still a work in progress at the time of this report.

Immediately after the MOH planning workshop, Youth to Youth in Health, a local ARH NGO, conducted a HIV/AIDS Forum and Lecture Series, funded by the United States Embassy in the RMI. Three HIV positive persons from the Fiji Network of Positive Persons and the Samoa AIDS Foundation were invited to speak of their HIV status in the forum and selected schools on Majuro Atoll. An additional four persons from the Kiribati HIV/AIDS Task Force, the Fiji World Council of Churches HIV/AIDS Program, SPC and AusAid were invited to speak of their respective organizations' programs and activities in addressing HIV/AIDS. Involved in the forum and lecture series were participants from the government, secondary and tertiary institutions, churches and other civil society organizations.

In addressing key health issues such as HIV/AIDS, teen pregnancy, diabetes and TB, there have been several key initiatives and programs that have been implemented by both the MOH and civil society. This indicates increasing concern and involvement on part of the government and civil society to educate the public on health issues and prevention strategies. It is not clear yet whether these activities are having any significant impact, and only time will tell how effective these programs and activities are in stemming the rise in certain diseases in the RMI.

G. Goal 7: Ensure Environmental Sustainability

Target 9: Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources

Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

In 1984, the RMI government established the RMIEPA to protect the land and marine resources of the RMI. The RMIEPA is divided into four divisions: 1) Water Quality Monitoring Laboratory Services, 2) Education, Information and Training, 3) Coastal Management and Geographical Information System, and 4) Environmental Health and Sanitation. Since 1984, the RMI has signed on to seven international protocols and conventions, notably the UNFCCC and Kyoto Protocol, Biodiversity Convention, Stockholm Convention, UNCBD and Cartagena Protocol, UNDCCD (Sustainable Development and Barbados Programme of Action), Fisheries Conservation, and the GEF amongst others.

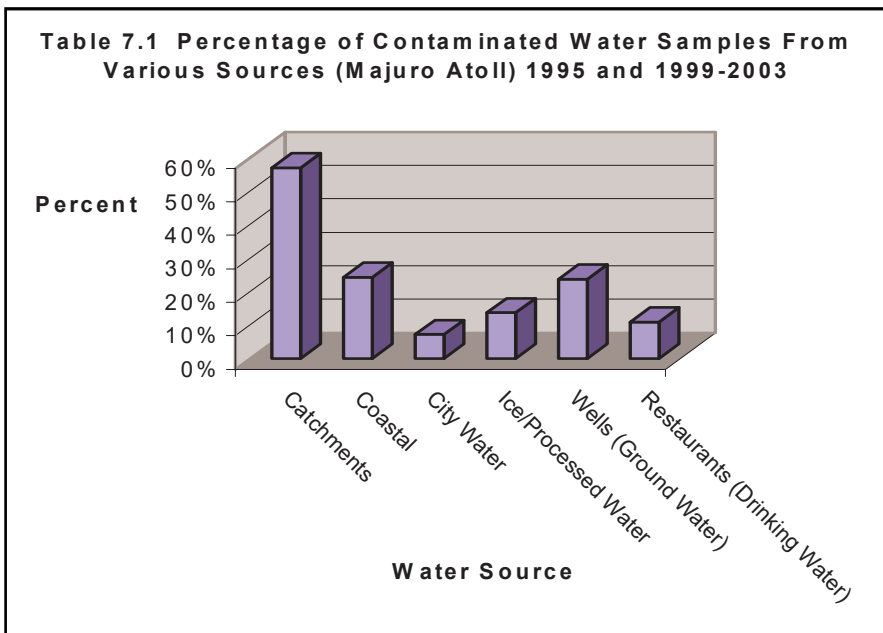
In 2003, to improve its adherence to international Multilateral Environmental Agreements, the RMI government approved the establishment of the OEPPC under the Office of the President. OEPPC is now the RMI focal office that coordinates, implements and monitors the RMI's Multilateral Environmental Agreements. The primary activities of OEPPC are to: 1) provide environmental policy advice to the RMI government and its offices regarding climate change, environmental vulnerability issues, and adaptation strategies, 2) coordinate the development of environment-related activities with key government agencies such as the RMIEPA, EPPSO and MIMRA, and 3) coordinate the establishment and activities of the RMI Waste Management Task Force composed of multiple government and non-government stakeholders.

With the establishment of the RMIEPA and OEPPC, it is clear that the RMI government does consider the issue of environmental sustainability as key to the overall sustainable development of the RMI. During the National Economic and Social Summit of 2001, public stakeholders clearly stated to the government that the issue of environmental sustainability was critical to the continued welfare of the Marshallese people. Public stakeholder comments were then integrated into the government's *Vision 2018 Strategic Development Plan Framework*. In addition, other key advisory and implementing agencies such as EPPSO and MIMRA are required to collaborate with RMIEPA and OEPPC to coordinate policies and activities to support and encourage sustainable environmental development.

However, despite the establishment of the RMIEPA and affiliated offices, environmental statistics relating to water quality, sanitation, waste disposal, marine resource preservation, and prevention of land degradation continue to raise concerns as to the effectiveness of environmental policies, strategies and enforcement capacities of relevant government agencies. In recent times, there have been numerous outcries raised by both the public and private sectors concerning solid waste disposal, contamination of coastal waters and access to clean and safe drinking water, particularly in the crowded urban areas.

In terms of access to clean water and sanitation, the RMI has fallen short of meeting the MDG targets. In the 2003 Statistical Yearbook, statistics indicate that there is a high level of contaminated sources of potable water, both in the urban and rural areas. In 1995 and between 1999-2003, the RMIEPA tested a sampling of various water sources on

Majuro Atoll. As indicated in Table 7.1, over half of all water catchments tested were found to be contaminated.



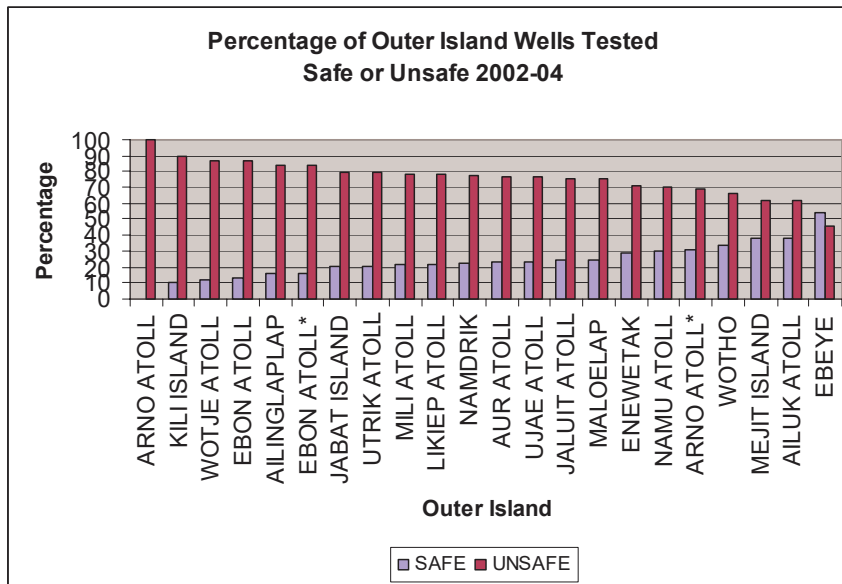
During the same period, similar tests were conducted on a small sampling of water sources on 8 identified rural, outer-island atolls (Arno, Jaluit, Kili, Likiep, Mili, Wotje, Lae and Namdrik). A similar pattern was observed, where a significant proportion of samples tested

were found to be contaminated. Of the 698 water catchments tested, 41% were contaminated. Of the 8 atolls, the ones with the highest percentages of contaminated water catchments were Namdrik (100%), Lae (93%), Wotje (50%), and Mili (79%). Of the 425 ground water wells tested in 1995 and 2001-2 on Arno, Jaluit, Kili, Likiep, Mili and Wotje Atolls, 26% were found to be contaminated. Of these, the atolls with the highest percentages of contaminated ground water wells were Arno (100%), Wotje (43%), and Kili (22%) (EPPSO, 2003: 239-40).¹

More recently, between 2002 and 2004, the EPA conducted a more comprehensive series of water quality tests on a majority of the urban and rural, outer islands. The findings of the tests also indicated that a significant majority of water sources throughout the RMI were deemed unsafe for human consumption. The overall findings are illustrated in Table 7.2 below.

In addition, in the same IWP Socio-Economic Survey mentioned under Goal 1, access to clean and safe water was identified as a significant problem in the Jenrok community. Only 5 (2%) households are connected to the main sewer line, with 67% of households connected to their own septic tanks. Only 75% of households have their own toilet facilities, with the rest of the households using the lagoon or ocean for their personal needs. In terms of access to water, 51% of households were connected to government

¹ It is important to note that the number of samples was significantly low, and the percentages of contaminated water catchments may be artificially high. However, as similar findings have been found in more recent surveys and tests with higher sampling numbers, it is safe to conclude that a significantly high proportion of water sources are contaminated and are unsafe for human consumption (refer to Table 7.2).



water, with 59% catching rainwater in makeshift (55-gallon fuel drums) or purchased storage tanks to meet their water needs. Many households dug communal wells, with 10% of households using well water as their primary source of drinking and bathing water. In

2004, the RMIEPA conducted a test on 11 wells in Jenrok and found that all were highly contaminated and unfit for human consumption and did not meet WHO standards for safe potable water.

The survey also revealed a major problem of solid waste disposal in the Jenrok community. The survey revealed that 98% of households used the trash bins serviced by the local government, but only 79% felt the bins were adequate to meet the needs of the community. Considerable evidence has been gathered of overflowing bins. During high winds, the trash from overflowing bins are strewn to nearby areas. In addition, community members will leave trash next to the bins if they perceive the bins to be over full. Children have been seen opening the trash bags and searching for items of use to them, posing particular health concerns for both children and community members. The Jenrok survey identified statistics from the MOH that indicated that the Jenrok community had one of the highest incidences of water-borne and other communicable diseases in the Capital. From the survey itself, 59 households reported cases of diarrhea, 20 households experienced outbreaks of typhoid, and 17 households experienced cases of amoebic dysentery.

In communities where access to a trash bin is difficult, particularly in the rural, outer-islands where solid waste and other sanitation facilities are scarce or non-existent, people often dig holes near their homes, within which they burn all their solid waste. When full, the hole is covered over by sand, and another hole is dug in another location. Composting is sometimes practiced in some of the outer-island communities, but it is becoming increasingly common for household members to burn their waste, both organic and non-organic in the same trash heaps. With increasing access to industrial plastics and other man-made materials in outer-island communities, there is concern that toxic fumes are being generated by the trash heaps. No formal analysis has been conducted to verify/dispute this claim.

The capacity of the RMIEPA to adequately meet its mandates with regards to fresh and coastal water testing, education, and enforcement of safety standards for safe potable water and solid waste management is a crucial issue to be addressed if the RMI is to meet MDG Goal 7. At this time, it is clear that the RMIEPA cannot fully meet its mandates as clearly indicated in the lack of consistent data over time due to a lack of both resources and capacity.

Many urban and outer-island communities are not being observed by the RMIEPA, and it is unclear what the true scale of contamination of various water sources are throughout the RMI, and whether the levels of contamination are increasing/decreasing over time. Similarly, it is unclear what are the major sources of contamination, and what policies are being developed or enforced to safeguard the communities from potentially harmful diseases and conditions due to water-borne and other environmental contaminants. For example, the Jenrok survey stated that chlorine tablets were not being distributed by the RMIEPA to sanitize household water catchments, despite reports confirming that a majority of household water catchments were contaminated well above the WHO's standards for safe potable water. The RMIEPA, itself, indicated that it has not been able to conduct water quality tests in recent times due to the lack of testing membranes.

For its part, the RMI government has to recognize the important role of the RMIEPA in addressing key environmental issues that have a tremendous impact on the welfare and health of the Marshallese population. With regards to infant deaths, much concern has been raised to the incidences of child mortality due to water-borne and sanitation-related diseases and conditions. The incidence of these diseases is also high amongst the adult population, placing increasing financial pressures on the healthcare system to provide treatment and other services. Further, coastal degradation is having a direct negative impact on communities who are experiencing land loss due to erosion and lack of adherence to proper land protection techniques. In some cases, as illustrated in the Jenrok survey, peoples' homes are being lost due to erosion.

In other instances, peoples' livelihoods are being negatively impacted upon. Land that had been previously available for cultivation is now over-exposed to high winds due to the cutting down of trees to make way for more homes, airport runways and other facilities. Specifically, in terms of the development of a black pearl farm industry, some studies conducted by the College of the Marshall Islands Land Grant and Extension Program have indicated that black pearl mortality rates increased when exposed to high levels of contamination in lagoon waters. Finally, several articles in the MIJ have revealed tourist and visitor concerns over the evident pollution of the urban centers of Majuro and Ebeye, discouraging many other tourists from visiting the RMI.

Overall, sustainable environmental development has not been adequately addressed in the RMI. As stated earlier, human and financial resource constraints continue to inhibit the ability of the relevant agencies to meet their mandates. In addition, in examining national budgetary allocations to environment-related activities, programs and agencies, the RMI allocations are significantly small as compared to other sectors of the RMI.

H. Goal 8: Develop a Global Partnership for Development

ODA comprises a major portion of the RMI economy and national budget. Current EPPSO estimates state that ODA comprises approximately 48% of the national budget. The national budget is highly dependent on foreign assistance to sustain even basic administrative and operational costs. This poses significant issues on whether the national government can sustain current fiscal and other development policies if and when foreign assistance is no longer available.

External donor coordination of aid and technical assistance has not been as straightforward or as forthcoming as promised by international donor discussions and conferences. There is still strong resistance by certain external donor agencies regarding the issue of the utilization of funds for development-oriented projects, with these same donor agencies putting forward their own agendas; sometimes in contrast to stated national goals and fiscal procedures. EPPSO, which participates in many negotiations with external donor agencies to ensure coordination and appropriateness of aid packages, has found it difficult to sway certain donor agencies to revise their aid and fiscal policies to ensure appropriateness to the RMI national context.

Aid packages continue to enter the RMI with significant restrictions attached in terms of scope, content, and/or method of implementation. Although the main rationale for having these restrictions is related to maintaining transparency and accountability, much of the restrictions are unnecessarily inflexible and often do not allow for context-specific conditions. Such conditions include the capacity and availability of human resources, level of community engagement in the development process, scope of private sector development, and available legislation (and enforcement of legislation) to provide a supportive framework for the implementation of whatever aid package is being proposed by the donor agency. The lack of acknowledgement of these conditions has resulted in the failure of many past donor-driven projects and grants.

As a result of the difficulties in coordinating international donor aid and the lack of incentive of donor agencies to revise their aid and fiscal policies to fit the country context, development in the RMI has and continues to be distorted². For the amount of aid that has entered the RMI, it is clear from social and economic statistics highlighted in the sections above that the RMI is far from meeting all the targets of the MDGs. A

² Distorted development is defined as existing “in societies where economic development has not been accompanied by a concomitant level of social development. In these countries, the problem is not an absence of economic development but rather a failure to harmonize economic and social development objectives, and to ensure that the benefits of economic progress reach the population as a whole....Typically, the distribution of income and wealth...is highly skewed, ostentatious wealth and abject poverty coexist, investments in education and social services are low, and the rate of unemployment and underemployment is often high...[It] is manifested not only in poverty, deprivation, low health status and inadequate housing but in the exclusion of sections of the population from full participation in development...[Finally, it is] also manifested in the environmental degradation which particularizes many societies where exploitation of natural resources characterizes development efforts. The wealth that is derived from these resources is very considerable but too often it brings few benefits to local people....Worse, the ravaging of these resources results in permanent environmental damage which jeopardizes the well-being of future generations” (Midgley, 1995:4-6).

considerable proportion of the Marshallese population is not leading the quality of life inherent within the MDGs, and in fact, is experiencing increasing poverty and hardship.

IV. Conclusion

As indicated in this report, the status of the RMI in meeting the MDGs is slow but steady. Overall, there has been improvement in some areas focused upon by the MDGs, but in other areas, notably MDG Goals 2, 6 and 7, the RMI still has a long way in addressing core issues relating to education, health (communicable diseases), access to safe water and sanitation, and equitable access of goods and services to the rural, outer islands. More specifically, the major areas of concern for the RMI highlighted in the report are the following:

- High female drop-out rates at the secondary and tertiary school levels
- Low female participation in elected government positions
- High level of gender inequality in the labor force
- Dramatic rise in STDs such as syphilis, chlamydia, gonorrhoea in the under 34 population and increase in the total number of new HIV/AIDS cases
- High incidence of communicable diseases such as TB, influenza and conjunctivitis
- High incidence of water-borne and lifestyle-related diseases such as infantile diarrhoea and Type II diabetes
- Low level of development and services to the rural, outer-islands
- Low access to safe and potable water in both rural and urban communities
- Low access to sanitation and solid waste disposal services, particularly in the crowded urban centers
- High proportion of the national budget composed of ODA

Compounding these concerns is the lack of a national poverty reduction alleviation strategy that is built into the policy and decision-making framework of the government and affiliated agencies. Consequentially, there are no specific national and local plans to focus government efforts on poverty assessment and reduction. This, in large part, may explain why meeting/targeting the MDGs has and continues to be slow in the RMI, with some areas reflecting marked improvements, while little or no improvements are reflected in other areas.

In addition, the linkage between social, economic and political development is weak, with economic development efforts often deliberated in isolation of social and environmental considerations. Some external development and aide workers have raised the concern that the RMI is taking a 'band aide' approach to development and poverty alleviation, targeting symptoms rather than addressing key issues at their root causes, and that to effectively address these root causes will require concerted efforts on part of the government and civil society to reform their attitudes towards and understanding of development and poverty.

It is clear that the RMI has significant hurdles to overcome in its goal to achieve the aims of the Millennium Declaration and the MDGs. As mentioned in this report, some of the major hurdles include:

- Low level of human resource capacities
- Domination of the public sector and resulting low level of private sector development
- Low development levels of rural, outer-island communities and supporting infrastructure (i.e. transportation and communication services)
- Lack of relevant policies, legislation and enforcement of policies to support poverty reduction and socio-economic development
- Poor access to quality of education services
- Insufficient resource allocations to sectors such as the environmental sector by the national government to support implementation and enforcement of environmental policies and standards
- Lack of a comprehensive national framework for poverty alleviation

There are numerous other constraints and barriers, but the ones above appear to be the most pervasive and have a knock-on effect, compounding existing hurdles and creating new ones over time.

To ensure that poverty does not increase in the RMI, there are several key considerations for action. First, it is important that the RMI establish a poverty alleviation and action framework. Within this framework, the RMI will need to define poverty in the Marshallese context, and develop indicators with which to accurately measure poverty in the RMI, and to gauge whether certain policies and actions are making a positive or negative impact. It is crucial that such a framework be integrated into the development and master plans of all the government's ministries, agencies and enterprises to ensure comprehensive and efficient targeting of poverty alleviation goals and objectives. Such a framework would then form a basis from which specific policies, legislation and actions can be discussed, developed, implemented and enforced. The role of EPPSO, the Cabinet and the National MDG Task Force in developing such a framework is critical to ensure political and civil society involvement and support for this framework.

Second, the RMI national government has to seriously consider the issue of human resource management and training to increase the efficiency, effectiveness and quality of public services, particularly in the health, education and environment sectors. The appropriate targeting and achieving of the MDGs is heavily reliant on a public sector that is not only dedicated to addressing development and poverty issues in the RMI, but also on a public sector that is highly qualified and well-supported with the appropriate infrastructure support and resources needed to accomplish their tasks in an efficient and cost-effective manner.

Third, the development of the rural, outer-islands must be considered and advanced. This is crucial not only for the benefit of the rural communities to prevent poverty and to improve quality of life, but also to relieve social and economic pressures in the urban

centers due to the heavy migration of Marshallese to the urban centers to seek employment, education and health services. Basic services and support infrastructure such as transportation and communication services, improved health and education services, and the development of alternate income generating opportunities within the outer-islands will need to be addressed.

Fourth, the domination of the public sector and its resulting negative effect on the growth of the private sector needs to be stemmed. In the long run, the poor level of private sector growth will greatly inhibit the ability of Marshallese to seek, obtain and retain employment, and as such will impact their ability to lead a good quality of life. It is unrealistic to assume that the national government will continue to receive significant amount of ODA to sustain current government operations, programs and enterprises. It is possible that a future point in time, such aid may no longer be forthcoming, and current public services and enterprises will no longer be sustainable. As the public sector is the largest employer within the RMI, the effect of government downsizing will have a great impact on peoples' livelihoods. Already, there has been a significant out-migration of professional and young Marshallese who feel that such a future is inevitable, and that leaving the country is a better alternative.

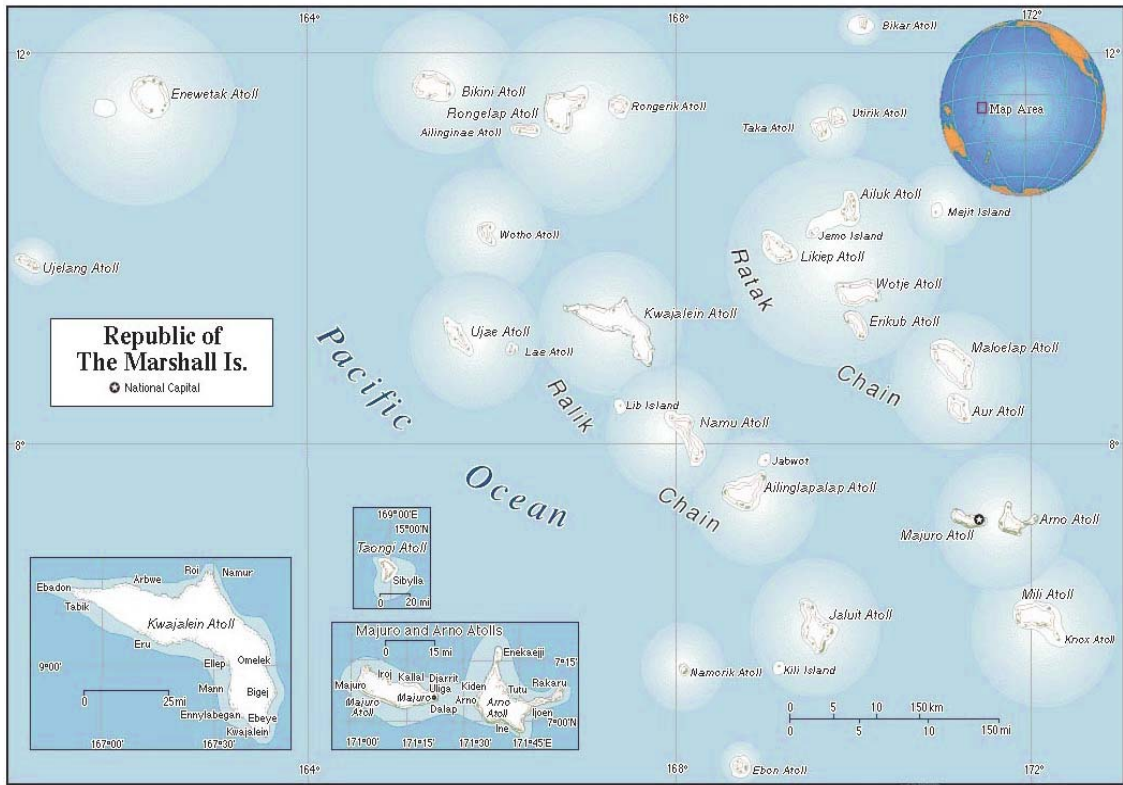
Fifth, to effectively and efficiently target the MDGs to affect the most number of Marshallese, the RMI national government will have to make a more concerted effort to include civil society and local NGOs in the development and implementation of national policies and programs. Such collaboration will be not only cost-effective for the government and NGOs, but will also ensure that national policies and legislation will reach the grassroots level.

These recommendations are by no means the only ones, but are some of the most critical and pressing to be addressed. In this report, specific actions are not given, but rather key issues are highlighted that need to be dealt with if the RMI is to prevent the growth of poverty and hardship, and to improve its targeting of the MDGs.

Overall, the RMI is hypothetically standing on a thin line. On the one hand, the RMI has shown that it can meet some of the aims of the Millennium Declaration and the objectives of the MDGs (e.g. lower infant and maternal mortality rates); but on the hand, it has also shown that it has been unable to repeat such achievements to the rest of the MDG goals and objectives - hence, the unevenness of RMI efforts in achieving the MDGs, and of development efforts on the whole. Saying this, it is clear that a positive outcome can be achieved if the RMI government and civil society are willing to follow through and support policies and actions that will help alleviate poverty and hardship, and to improve the quality of life of the Marshallese people.

V. Appendix

A. Map of the RMI



B. SPC Database (Regional MDG Report) 30/08/2004

G1_T1_1	1. Proportion of households below \$1 (PPP) per day	1999	20	Proportion (%)		ADB	
G1_T1_3	3. Share of poorest quintile (20%) in national consumption	1999	1.59	% total consumption		EPPSO	www.spc.int/prism/countr y/mh/stats/
G1_T1_3	3. Share of poorest quintile (20%) in national consumption	2002	3.32	% total consumption	2002 estimate only, provisional	EPPSO	www.spc.int/prism/countr y/mh/stats/
G1_T2_4	4. Prevalence of underweight children under-five years of age	1991	19	% under five years		ADB	
G1_T2_4	4. Prevalence of underweight children under-five years of age	1999	27	% under five years		ADB	
G2_T3_6	6. Net enrolment ratio in primary education	1988	89.68	% primary age group		EPPSO	www.spc.int/prism/countr y/mh/stats/
G2_T3_6	6. Net enrolment ratio in primary education	1999	84.13	% primary age group		EPPSO	www.spc.int/prism/countr y/mh/stats/
G2_T3_7	7. Proportion of pupils starting grade 1 who reach grade 5	1988	88.04	% grade 1 completing grade 5	estimate & higher than actual	EPPSO	www.spc.int/prism/countr y/mh/stats/
G2_T3_7	7. Proportion of pupils starting grade 1 who reach grade 5	1999	86.05	% grade 1 completing grade 5	estimate & higher than actual	EPPSO	www.spc.int/prism/countr y/mh/stats/
G2_T3_8	8. Literacy rate of 15-24 year olds	1989	74	Rate per 100	Indirect, all adults	Pacific HDR* 1999	
G3_T4_10	10. Ratio of literate females to males of 15-24 year-olds	1988	1.04	Ratio of women to men (1 is equal)		EPPSO	www.spc.int/prism/countr y/mh/stats/
G3_T4_10	10. Ratio of literate females to males of 15-24 year-olds	1999	1.00	Ratio of women to men (1 is equal)		EPPSO	www.spc.int/prism/countr y/mh/stats/
G3_T4_11	11. Share of women in wage employment in the non-agriculture sector	1988	33.53	% employed women	Employed includes self-employed and unpaid workers	EPPSO	www.spc.int/prism/countr y/mh/stats/
G3_T4_11	11. Share of women in wage employment in	1999	35.95	% employed women	Employed includes self-	EPPSO	www.spc.int/prism/countr y/mh/stats/

	the non-agriculture sector				employed and unpaid workers		
G3_T4_12	12. Proportion of seats held by women in national parliament	1983	3.03	% seats		EPPSO	www.spc.int/prism/country/mh/stats/
G3_T4_9a	Ratio of girls to boys in primary school	1988	85.11	Ratio of girls per 100 boys		EPPSO	www.spc.int/prism/country/mh/stats/
G3_T4_9a	Ratio of girls to boys in primary school	2002-03	83.08	Ratio of girls per 100 boys		EPPSO	www.spc.int/prism/country/mh/stats/
G3_T4_9b	Ratio of girls to boys in secondary school	1988	91.16	Ratio of girls per 100 boys		EPPSO	www.spc.int/prism/country/mh/stats/
G3_T4_9b	Ratio of girls to boys in secondary school	2002-03	104.08	Ratio of girls per 100 boys		EPPSO	www.spc.int/prism/country/mh/stats/
G3_T4_9c	Ratio of girls to boys in tertiary education	2002-03	90.97	Ratio of girls per 100 boys		EPPSO	www.spc.int/prism/country/mh/stats/
G3_T4_9cu	Ratio of girls to boys in tertiary education (USP enrolments)	1995	0.5	Ratio of girls per 100 boys		USP	
G3_T4_9cu	Ratio of girls to boys in tertiary education (USP enrolments)	1996	0.3	Ratio of girls per 100 boys		USP	
G3_T4_9cu	Ratio of girls to boys in tertiary education (USP enrolments)	1997	0.5	Ratio of girls per 100 boys		USP	
G3_T4_9cu	Ratio of girls to boys in tertiary education (USP enrolments)	1998	0.5	Ratio of girls per 100 boys		USP	
G3_T4_9cu	Ratio of girls to boys in tertiary education (USP enrolments)	1999	0.5	Ratio of girls per 100 boys		USP	
G3_T4_9cu	Ratio of girls to boys in tertiary education (USP enrolments)	2000	1.7	Ratio of girls per 100 boys		USP	
G3_T4_9cu	Ratio of girls to boys in tertiary education (USP enrolments)	2001	1.5	Ratio of girls per 100 boys		USP	
G3_T4_9cu	Ratio of girls to boys in tertiary education (USP enrolments)	2002	2	Ratio of girls per 100 boys		USP	

G3_T4_9cu	Ratio of girls to boys in tertiary education (USP enrolments)	2003	1.3	Ratio of girls per 100 boys		USP	
G4_T5_13	13. Under-five mortality rate (CMR)	1988	93	Per 1,000 live births		EPPSO	www.spc.int/prism/country/mh/stats/
G4_T5_13	13. Under-five mortality rate (CMR)	1999	48	Per 1,000 live births		EPPSO	www.spc.int/prism/country/mh/stats/
G4_T5_14	14. Infant mortality rate (IMR)	1988	63	Per 1,000 live births		EPPSO	www.spc.int/prism/country/mh/stats/
G4_T5_14	14. Infant mortality rate (IMR)	2002	29	Per 1,000 live births		EPPSO	www.spc.int/prism/country/mh/stats/
G4_T5_15	15. Proportion of 1 year old children immunized against measles percent	1998	70	% children under 1 year		EPPSO	www.spc.int/prism/country/mh/stats/
G4_T5_15	15. Proportion of 1 year old children immunized against measles percent	2001	80	% children under 1 year		EPPSO	www.spc.int/prism/country/mh/stats/
G4_T6_16	16. Maternal mortality ratio per 100,000 live births	1991	0	Per 100,000 live births		EPPSO	www.spc.int/prism/country/mh/stats/
G4_T6_16	16. Maternal mortality ratio per 100,000 live births	2002	73.80	Per 100,000 live births		EPPSO	www.spc.int/prism/country/mh/stats/
G6_T7_19c	19c. Contraceptive prevalence rate	1995	30.6	%		MOH	www.spc.int/prism/country/mh/stats/
G6_T7_19c	19c. Contraceptive prevalence rate	2001	34	(incidence) per 1000,000 persons		MOH	
G6_T8_23a	TB incidence rate per 100,000 population	1989	17.5	(incidence) per 1000,000 persons	TB incidence not prevalence	WHO	
G6_T8_23a	TB incidence rate per 100,000 population	1992	120.9	(incidence) per 1000,000 persons	TB incidence not prevalence	EPPSO	www.spc.int/prism/country/mh/stats/
G6_T8_23a	TB incidence rate per 100,000 population	1996	101.8	(incidence) per 1000,000 persons	TB incidence not prevalence	WHO	
G6_T8_23a	TB incidence rate per 100,000 population	1998	81.3	(incidence) per 1000,000 persons	TB incidence not prevalence	WHO	
G6_T8_23a	TB incidence rate per 100,000 population	1999	67	(incidence) per 1000,000 persons	TB incidence not prevalence	WHO	
G6_T8_23a	TB incidence rate per 100,000 population	2000	56	(incidence) per 1000,000 persons	TB incidence not prevalence	WHO	
G6_T8_23a	TB incidence rate	2001	133.7	(incidence)	TB	EPPSO	www.spc.int/

	per 100,000 population			per 1000,000 persons	incidence not prevalence		prism/country/mh/stats/
G6_T8_23a	TB incidence rate per 100,000 population	2002	98	(incidence) per 1000,000 persons	TB incidence not prevalence	WHO	
G6_T8_23b	TB death rate per 100,000 population	2002	10	Per 100,000 persons		WHO	
G6_T8_24a	TB, DOTS detection rate, percent total population	1998	56	% population (new ss+)		WHO	
G6_T8_24a	TB, DOTS detection rate, percent total population	1999	86	% population (new ss+)		WHO	
G6_T8_24a	TB, DOTS detection rate, percent total population	2000	55	% population (new ss+)		WHO	
G6_T8_24a	TB, DOTS detection rate, percent total population	2001	128	% population (new ss+)		WHO	
G6_T8_24a	TB, DOTS detection rate, percent total population	2002	108	% population (new ss+)		WHO	
G6_T8_24b	TB, DOTS detection rate, percent total population	1998	51	% new cases		WHO	
G6_T8_24b	TB, DOTS detection rate, percent total population	1999	71	% new cases		WHO	
G6_T8_24b	TB, DOTS detection rate, percent total population	2000	90.9	% new cases		WHO	
G6_T8_24b	TB, DOTS detection rate, percent total population	2002	86	% new cases		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_30	30. Proportion of households with sustainable access to an improved water source, urban and rural	1988	92.50	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_30	30. Proportion of households with sustainable access to an improved water source, urban and rural	1999	84.66	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_30 a	Proportion households with sustainable access to an improved	1988	96.73	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/

	water source, urban						
G7_T10_30 a	Proportion households with sustainable access to an improved water source, urban	1999	83.29	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_30 b	Proportion households with sustainable access to an improved water source, rural	1988	84.81	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_30 b	Proportion households with sustainable access to an improved water source, rural	1999	87.32	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_31	31. Proportion of urban and rural households with access to improved sanitation	1988	73.80	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_31	31. Proportion of urban and rural households with access to improved sanitation	1999	80.15	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_31 a	31. Proportion of urban households with access to improved sanitation	1988	87.16	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_31 a	31. Proportion of urban households with access to improved sanitation	1999	92.08	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_31 b	31. Proportion of rural households with access to improved sanitation	1988	49.46	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T10_31 b	31. Proportion of rural households with access to improved sanitation	1999	56.70	% (households) population		EPPSO	www.spc.int/prism/country/mh/stats/
G7_T11_32	32. Proportion of households with access to secure tenure (owned or rented)	1999	0.96	% households	Includes rented for free with owner's consent	EPPSO	www.spc.int/prism/country/mh/stats/
G7_T9_26	26. Ratio of area protected to maintain biological diversity to surface area	2003	0	% land (marine) area	Protected areas: terrestrial areas with active and inactive management. Marine and coastal protected areas not included in the data.	CI**, July 2003	
G7_T9_28b	Consumption of ozone-depleting CFCs (ODP tons)	1986	1	tons	Consumption defined as production	UNEP*** Ozone Secretariat	

					plus imports minus exports of ozone depleting CFCs		
G7_T9_28b	Consumption of ozone-depleting CFCs (ODP tons)	1989	1	tons	Consumption defined as production plus imports minus exports of ozone depleting CFCs	UNEP Ozone Secretariat	
G7_T9_28b	Consumption of ozone-depleting CFCs (ODP tons)	1990	1	tons	Consumption defined as production plus imports minus exports of ozone depleting CFCs	UNEP Ozone Secretariat	
G7_T9_28b	Consumption of ozone-depleting CFCs (ODP tons)	1991	1	tons	Consumption defined as production plus imports minus exports of ozone depleting CFCs	UNEP Ozone Secretariat	
G7_T9_28b	Consumption of ozone-depleting CFCs (ODP tons)	1992	1	tons	Consumption defined as production plus imports minus exports of ozone depleting CFCs	UNEP Ozone Secretariat	
G7_T9_28b	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	
G7_T9_28b	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	
G7_T9_28b	Consumption of ozone-depleting CFCs (ODP tons)	1998	1	tons	Consumption defined as production plus imports minus exports of ozone depleting CFCs	UNEP Ozone Secretariat	

G7_T9_28b	Consumption of ozone-depleting CFCs (ODP tons)	1999	1	tons	Consumption defined as production plus imports minus exports of ozone depleting CFCs	UNEP Ozone Secretariat	
G7_T9_29	29. Proportion of households using solid fuels	1988	13.81	% (households) population	firewood	EPPSO	www.spc.int/prism/country/mh/stats/
G7_T9_29	29. Proportion of households using solid fuels	1999	29.87	% (households) population	firewood	EPPSO	www.spc.int/prism/country/mh/stats/
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	1991	0.35	ODA as % of GNI		OECD	
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	1992	9.09	ODA as % of GNI		OECD	
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	1993	36.16	ODA as % of GNI		OECD	
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	1994	51.47	ODA as % of GNI		OECD	
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	1995	33.24	ODA as % of GNI		OECD	
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	1996	66.92	ODA as % of GNI		OECD	
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	1997	59.93	ODA as % of GNI		OECD	
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	1998	45.75	ODA as % of GNI		OECD	
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	1999	55.96	ODA as % of GNI		OECD	
G8_T14_37	37. ODA received in small island	2000	48.5	ODA as % of GNI		OECD	

	developing states as proportion of their GNIs						
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	2001	60.86	ODA as % of GNI		OECD	
G8_T14_37	37. ODA received in small island developing states as proportion of their GNIs	2002	48.43	ODA as % of GNI		OECD	
G8_T15_44	44. Debt service as a percentage of exports of goods and services	1990	39.8	% exports		ADB	
G8_T15_44	44. Debt service as a percentage of exports of goods and services	2000	57.9	% exports		ADB	
G8_T16_45 a	Unemployment rate of 15-24 year-olds, female	1988	31.62	% labor force	Labor force includes: working for cash (does not include subsistence workers)	National Population and Housing Census	
G8_T16_45 a	Unemployment rate of 15-24 year-olds, female	1999	67.01	% labor force	Labor force includes: working for cash (does not include subsistence workers)	National Population and Housing Census	
G8_T16_45 b	Unemployment rate of 15-24 year-olds, female	1988	27.53	% labor force	Labor force includes: working for cash (does not include subsistence workers)	National Population and Housing Census	
G8_T16_45 b	Unemployment rate of 15-24 year-olds, female	1999	59.81	% labor force	Labor force includes: working for cash (does not include subsistence workers)	National Population and Housing Census	
G8_T16_45 c	Unemployment rate of 15-24 year-olds, total	1988	28.72	% labor force	Labor force includes: working for cash (does not include subsistence workers)	National Population and Housing Census	
G8_T16_45 c	Unemployment rate of 15-24 year-olds, total	1999	62.64	% labor force	Labor force includes: working for cash (does not include subsistence	National Population and Housing Census	

					workers)		
G8_T18_47 a	Telephone lines per 100 population	1995	6.08			EPPSO	www.spc.int/ prism/countr y/mh/stats/
G8_T18_47 a	Telephone lines per 100 population	2001	6.8			EPPSO	www.spc.int/ prism/countr y/mh/stats/
G8_T18_47 b	Cellular telephone subscribers per 100 population	1998	0.70	Rate per 100 population	1998 first year for cellphone statistics	EPPSO	www.spc.int/ prism/countr y/mh/stats/
G8_T18_47 b	Cellular telephone subscribers per 100 population	2001	1.00	Rate per 100 population	1998 first year for cellphone statistics	EPPSO	www.spc.int/ prism/countr y/mh/stats/
G8_T18_48 a	Personal computers in use per 100 population	2002	2.05	Rate per 100 population		RMI Government	
G8_T18_48 b	Internet users per 100 population	1998	0.53	Rate per 100 population		EPPSO	www.spc.int/ prism/countr y/mh/stats/
G8_T18_48 b	Internet users per 100 population	2001	0.86	Rate per 100 population		EPPSO	www.spc.int/ prism/countr y/mh/stats/

*HDR = Human Development Report

**CI = Conservation International

***UNEP = United Nations Environment Programme

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