3.3. Core Commitments for Education

Relevant Core Commitments for Children in Emergencies in Initial Response (usually 6- 8 weeks):

- *Set up temporary learning spaces with minimal infrastructure.*
- *Resume schooling by reopening schools and starting the reintegration of teachers and children by providing teaching and learning materials and organizing semi-structured recreational activities.*

Relevant Core Commitments for Children in Emergencies after the Initial Response (up to and beyond six months):

- *Re-establish and/or sustain Primary Education. Provide education and recreation kits and basic learning materials and teacher training.*
- *Promote the resumption of quality education activities in literacy, numeracy, and life skills issues such as HIV/AIDS, prevention of sexual exploitation and abuse, conflict resolution and hygiene.*
- *Establish community services around schools (such as water supply and sanitation), where appropriate.*

3.3.1 Education context

The Solomon Islands education system is administered under the Education Act of 1978. The Act provides for the country's education system, decentralised to the nine provincial education authorities, the Honiara City Council and five private and church education administration authorities. The education arrangement in the Solomon Islands allows children to attend a school system which starts with an Early Childhood Education (ECE) programme that includes kindergarten schools/kindies. From kindies, the children attend prep-school before joining the more formal primary education programme. The age of children attending primary school ranges from 7-12 years. The secondary education programme consists of form 1-6 with children/youth in the age range of 13-18 years.

Prior to the disaster, the total number of students enrolled in Western and Choiseul Provinces, according to the 2006 data is 26,937. In the Western Province, there are 50 ECE Centres with a total enrolment of 1,977 students, 103 primary schools with a total enrolment of 19,453, and 26 secondary schools with a total enrolment of 6,550 students. There are also 6 Rural Training Centre scattered throughout the provinces' islands. The total number of teaching and management staff for the Western Province is 776.

In Choiseul Province, enrolment figures at the following institutions are: 50 ECE Centres with 709 students; 43 primary schools with 3,818 students; and 9 secondary schools with 2,381 students. There is only one Rural Training Centre in Choiseul Province. The total teaching staff and principals is 239.

The earthquake and tsunami and other associated disturbances like landslides and flooding, had an enormous impact on the communities directly hit by the disaster. The education system in the affected areas also suffered tremendously. The Ministry of Education and Human Resources Development (MEHRD) Emergency Assessment showed that at least 89% of the enrolled students within their assessment area were affected directly by the disaster.

According to an assessment by the Ministry of Education and Human Resources Development of the 179 schools assessed in Western and Choiseul Provinces, 11% were destroyed, 36% endured major damage, 32% suffered minor damage and 21% were relatively unaffected (Table 2).

Table 2 – Summary of damage categories for schools assessed

Damage Category	Number of schools	% of schools assessed	Student enrolment
1 – destroyed	20	11%	2,406
2 – major damage	64	36%	9,172
3 – minor damage	58	32%	6,680
4 – no damage	37	21%	2,312
Total schools	**179**	**100%**	**20,570**

Source: MEHRD Disaster Assessment 2007

School management, teaching staff and provincial authorities were also directly impacted. Having lost most, if not all of their possessions and belongings, most staff lived in Internally Displaced Persons (IDP) camps for several months, and some continue to do so.

3.3.2. UNICEF'S Education Response

UNICEF assistance was largely based on MEHRD assessments and guided by the Task Force on Education in Emergency Situations. UNICEF has supported collaboration between MEHRD, the Ministry of Women, Youth and Children's Affairs (MWYCA) and the Social Welfare Division (SWD) (in the Ministry of Health and Medical Services), Save the Children Australia (SCA) and New Zealand Agency for International Development (NZAID) to establish safe play and learning areas.[14] The partnership between UNICEF and the MEHRD has been long established but the strength of that partnership was tested and cemented by the disaster.

The MEHRD and UNICEF began its first phase of emergency response in the education sector within the first month of the disaster. As part of its response UNICEF engaged an education consultant and employed two education officers to provide technical assistance and support to the MEHRD. UNICEF also provided supplies including tarpaulins, and tents, school-in-a-box kits, recreation kits, other recreation supplies and school bags. UNICEF also funded the purchase of a boat and motor for Provincial Education Authorities (PEA) to use in Western and Choiseul Provinces. UNICEF was able to provide excellent support in the provision of funds (DSA, fuel, driver allowances etc.) to allow PEA to visit schools to make early assessments of needs and damages. This particular UNICEF support for primary school activities meant that funds provided by other donor partners could be effectively used for non-UNICEF related activities/travel.

UNICEF provided important contributions to facilitate the establishment of an Education Sector Working Group (ESWG) and enabling the ESWG to:

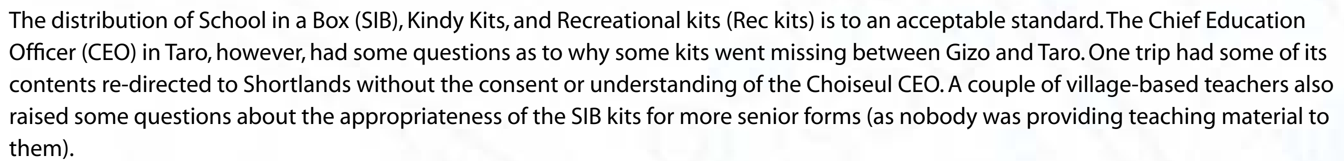
- Conduct an assessment on learning spaces and resources, involving staff from MWYCA and SWD;
- Create temporary spaces for play, recreation and learning; and
- Develop a child-centred recovery plan and back-to-school campaign.

Distribution of Education Supplies
The distribution of initial education supplies happened relatively quickly but was hampered by lack of precise knowledge of the "true" scale of disaster. Instead of bulk supplies being sent on a plane from Copenhagen, trickles of it were purchased or acquired in piecemeal batches.

School-in-a-box and Kindy Kits
School-in-a-box (SIB) kits, which contains a variety of teaching material as well as school books were also delivered within the emergency phase and continued to be distributed throughout recovery phase. The SIB kits contents were appropriate and very much appreciated by the teachers. It was reported in one community that a teacher is so appreciative of the SIB that he takes it home every night for safe keeping.

Kindy Kits capture children's attention during a difficult period. Kindy school teachers were extremely grateful to have colourful building blocks and other items.

[14] UNICEF Solomon Islands Emergency Management Plan, Version 5. June 2007



The distribution of School in a Box (SIB), Kindy Kits, and Recreational kits (Rec kits) is to an acceptable standard. The Chief Education Officer (CEO) in Taro, however, had some questions as to why some kits went missing between Gizo and Taro. One trip had some of its contents re-directed to Shortlands without the consent or understanding of the Choiseul CEO. A couple of village-based teachers also raised some questions about the appropriateness of the SIB kits for more senior forms (as nobody was providing teaching material to them).

School Bags

Distribution of school bags (21,000) in October, although very late, was an incentive to get children back to classes. It was successful in most villages. Due to the limited number of school bags allocated to each province, kindy kids were not allocated bags which caused a few tears.

Tents

School Tents (75 in total) were also supposed to be part of the initial emergency response. However, due to the bulk of tents arrived almost 5 months after the disaster, it became a part of the recovery phase.

Coordination

The delivery of the huge and heavy school tents could have become a nightmare but both the Western and Choiseul PEAs were involved in planning of the distribution logistics. Within two weeks of their arrival into Honiara, the 50 tents reached their final destinations without major problems. The distribution of tents to schools in Choiseul Province now stands as a major accomplishment of which UNICEF can be justly proud. There was effective utilisation of community good will to construct the tents must also be highlighted. Volunteer youths participated in the construction of tents in both Western and Choiseul Provinces. A small team of tent construction workers was initially taught by UNICEF Gizo Logistics officer in Gizo. This trained team was then sent out with delivery boats to Western Province schools and with the landing barge to Choiseul Province.

Both the Western and Choiseul Province Education Authorities (PEA) now enjoy a close partnership with UNICEF as well as with other partners. In the Western Province, the Education Partnership web can be described as a series of links between the Provincial Education Authority with UNICEF, Save The Children (Play Safe Areas), Oxfam (Health Promotion), World Vision (Water and Sanitation), the EU-Stabex/Task Force for Education in Emergency Situations – TEES (infrastructure rebuilding) as well as the Japan International Cooperation Agency – JICA (Informal youth programme). In Choiseul Province, the education web is a set of partnerships between the Choiseul Province Education Authority, UNICEF (emergency response), Save The Children, and the EU-Stabex/Task Force for Education in Emergency Situations – TEES (infrastructure rebuilding).

3.3.3. Summary of Education Key Achievements

Although precise quantitative data on the numbers of children back in school were not available at the time of writing the evaluation report, UNICEF's support for the resumption of learning as soon as possible for school aged children undoubtedly enabled many schools to re-open classes as soon as tents or temporary classrooms are erected. By the six month mark, 75 school tents had been distributed to provide classrooms or dormitories in affected villages in both Choiseul and Western Provinces and 21,000 school bags had been handed out to students in schools in the affected areas, providing a strong incentive for students to return to school. All the education kits (180 school-in-the-box, Kindy Kits made from 1440 wooden toy sets, 182 Rec Kits) were also very useful to ensure that education was maintained.

> *"Kindy students really enjoyed using the kindy kits. They loved the colourful building block and other toys which took their minds off the frightening experience"*
>
> - quote from Chief Education Officer, Dalcy Sito

The most notable achievement for Choiseul Province has been with the distribution of educational supplies and tents. To date, this single sector achievement has played an important role in strengthening the partnership between the Provincial Authorities and UNICEF.

3.3.4. Constraints and Gaps in the Education Response

The bulk of the education kits for Choiseul Province could have been distributed much earlier than in late (August) and could have been done more effectively. In one instance, UNICEF's Gizo-based logistics officer refused the advice of the Choiseul PEA on the logistical arrangements for SIB distribution to Choiseul Province. The Officer insisted on contracting one boat to transport all the SIB to Choiseul, requiring 4 separate return trips (between Gizo and Choiseul). The PEA had suggested a quicker and easier alternative which included securing 4 NDC boats (at a much cheaper cost) to take the SIB in one 5 hour journey. Such local advice is not only vital for efficiency of delivery, but also to maintain a good partnership arrangement. As a result of this incident, the relationship between Choiseul PEA and UNICEF Gizo was temporarily soured.

Although all PEA and teachers were highly appreciative of the school tents, some students and teachers questioned why the tents did not come with desk, since it is common knowledge that if the classroom is washed away, then all its contents would also be lost!

By far, the biggest problem for this sector was the length of time it took to get the school tents to Gizo. The total number of tents actually required was also problematic. For example, Western PEA said they have 18 primary and 6 secondary schools and only 25 tents. Most schools need more than one tent, thus the actual need is 35 tents.

Water and Sanitation is a key component in UNICEF's emergency assistance. Currently, most temporary schools or tents are built on areas which do not have any access to either running water or ablution block. Where possible, partner organisations have put up rain catchment tanks and dug pit latrines.

> *"For Sanitation purposes however, the children prefer to use the mangrove as their toilet area. They have built a platform within the mangroves and are using that instead of a proper slab toilet here"*
>
> \- Puzivae CHS Principal

3.3.5. Lessons and Recommendations for the Education Response

Effective partnership is built on good relationship, listening to local knowledge, understanding cultural sensitivity, and proven by having the right personality to deal with local politics and culture. The key lesson for UNICEF in education – and the only reason why it was such a success in Choiseul Province – is that the education consultant went and did a thorough assessment and then decided that an UNICEF Education officer should be based there. However, the Taro Education Officer has since been recalled to the Gizo office, leaving a vacuum once again. In order to maintain such partnership in the education sector, UNICEF must be prepared to be in Western and Choiseul Provinces for the long-term. The importance of building partnerships with all levels (from senior management as well as with junior staff) cannot be undermined by having a haphazard presence. A final point to having a successful relationship and programme is providing practical materials assistance to solve (office/people's) problems eg. providing computers and a generator set for an office.

3.4. Core Commitments for Health and Nutrition

3.4.1. Health and Nutrition context

Relevant Core Commitments for Children in Emergencies in Initial Response (usually 6-8 weeks):

- *Provide measles vaccination, vitamin A, essential drugs and nutritional supplements: vaccinate children between 6 months and 14 years of age against measles, providing vitamin A supplementation as required. Provide essential drugs, basic and emergency health kits, oral rehydration, fortified nutritional products and micronutrient supplements. Provide post-rape-care kits, including post-exposure prophylaxis for HIV, where appropriate. Provide other emergency supplies such as blankets, tarpaulins, etc.*
- *Provide child and maternal feeding and nutritional monitoring: with the World Food Programme (WFP) and NGO partners, support infant and young child feeding, therapeutic and supplementary feeding. Introduce nutritional monitoring and surveillance.*

Relevant Core Commitments for Children in Emergencies after the Initial Response (up to and beyond six months):

- *Expand support to vaccination and preventive health services;*
- *Support infant and young child feeding, including breastfeeding and complementary feeding and, when necessary, support therapeutic and supplementary feeding programmes;*
- *Establish, improve and expand safe water and sanitation facilities and promote safe hygiene behaviour.*

The Ministry of Health and Medical Services (MHMS) is responsible for the administration and coordination of the provision of health services throughout Solomon Islands. Service provision is decentralised with Provincial Health services responsible for the day-to-day management of staff, resources and services. While the situation in the health sector has improved since the ethnic tensions (1999-2003), the national health system remains severely under resourced. This is reflected in the quality of services and health information available, poor infrastructure, inadequate supplies and equipment, and limited transport and communications capacity. It has also been difficult to recruit, train, accommodate and retain motivated staff due to limited resources.

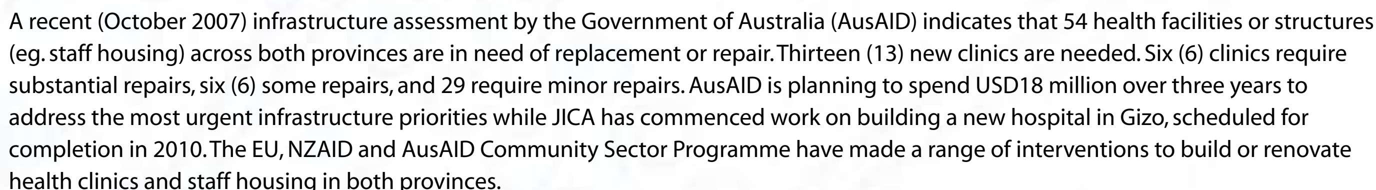
Prior to the disaster, the Western Provincial health service consisted of 2 hospitals (Gizo and Helena Goldie), 29 Area Health Centers and Health Clinics, and 25 Aid Posts. Even prior to the April 2nd emergency, the service was severely stretched and under-funded with 2007's budget for delivery of health services through 56 health facilities throughout the Western Province just SI$4.3 million (USD0.6 million).

The Choiseul Provincial health care system consists of 2 hospitals, at Sasamunga and Taro, 1 Area Health Centre, 9 Health Clinics, and 14 Aid Posts. Choiseul Province's 2007 budget of SI$1.2 million (USD0.17 million) funds medical services throughout the province.

Major health problems include malaria, acute respiratory infections, diarrhoeal diseases, skin disorders, and non-communicable diseases. Under-nutrition represents a chronic problem in most Solomon Islands communities and diets frequently lack essential micronutrients and vitamins and rely heavily on starch such as rice and root vegetables.

The April 2 disaster had major impacts on the ability of basic health services to function in both provinces. Gizo (Western) and Sasamunga (Choiseul) main referral hospitals sustained major structural damage while Helena Goldie (Western) and Taro (Choiseul) hospitals had increased demand for services and supplies. Hospital staffs were among the most affected population. For example, 20 staff houses were destroyed at Gizo exacerbating a housing shortage that was already critical.

There was a substantial international response to health priorities in the immediate aftermath of the disaster. The Solomon Islands Red Cross, with support from the International Federation of Red Cross and Red Crescent Societies (IFRC) was active in both provinces and the French Red Cross has been active in Choiseul, and in particular at Sasamunga where they financed the rebuilding of the laboratory, installed water tanks and built latrines. Six Australian medical teams attended to disaster victims in the affected areas, including some of the most remote villages and islands.



A recent (October 2007) infrastructure assessment by the Government of Australia (AusAID) indicates that 54 health facilities or structures (eg. staff housing) across both provinces are in need of replacement or repair. Thirteen (13) new clinics are needed. Six (6) clinics require substantial repairs, six (6) some repairs, and 29 require minor repairs. AusAID is planning to spend USD18 million over three years to address the most urgent infrastructure priorities while JICA has commenced work on building a new hospital in Gizo, scheduled for completion in 2010. The EU, NZAID and AusAID Community Sector Programme have made a range of interventions to build or renovate health clinics and staff housing in both provinces.

3.4.2. UNICEF'S Health and Nutrition Response

UNICEF Pacific mobilised emergency medical supplies and health expertise shortly after hearing news of the disaster. UNICEF Pacific's Chief of Integrated Childhood Health and Development (ICHD) and Emergency Focal Point, was deployed from Suva on the day of the disaster arriving in Honiara on 3 April (Day 2). UNICEF's initial response was aimed at ensuring that the health and nutrition needs and special vulnerabilities of children and pregnant and lactating mothers in emergencies were recognised and prioritised according to the CCCs.

UNICEF Pacific had pre-positioned emergency medical kits with the capacity to supply hospitals serving a community of 10,000 people for 3 months with MHMS in Honiara prior to the disaster occurring. This preparedness initiative allowed 3 of these kits to be deployed within 14 days of the disaster to hospitals in the affected areas. One kit was sent to Gizo hospital, 1 to Sasamunga, and 1 kit was deployed to the Shortland Islands.

In partnership with MHMS, and in line with UNICEF CCCs, UNICEF provided technical assistance, funding and medical supplies to support measles immunisation and vitamin A supplementation targeting 95% of children aged 6 months to five years in affected areas. A proposal was prepared and decision to commence the campaign was taken within 1 week of the disaster, training of staff for the campaign commenced within 2 weeks of the disaster, and the team began the campaign within 3 weeks of the disaster.

A nutritionist was deployed to Gizo on 9 April (Day 7) to assess and coordinate a response to nutrition needs. The need for micronutrients was identified and a supply of multiple-micronutrient powder or 'Vitalita' was identified and flown from Indonesia. This was distributed during the first phase of a health promotion campaign. A very limited supply of multi-vitamins was mobilized from Vanuatu and distributed to 40 pregnant and lactating mothers in Ugele and Madali on Rendova Island before supplies were exhausted.

Oral Rehydration Salts (ORS) were sourced in the first 72 hours and provided to boost the MHMS stores for distribution to facilitate home-treatment of diarrhea. UNICEF also identified a further need for a comprehensive deworming, Vitalita, and Vitamin A campaign in affected areas of both provinces. Despite advocacy by UNICEF, this campaign has not yet materialised, in part because of delay in printing Family Health Cards (FHC) which MHMS had planned to disseminate during the campaign and, apparently, due the preference of provincial health counterparts to delay the campaign until early 2008.

Limited food distribution, mainly rice, was carried out by other stakeholders. It soon became apparent that there was not an acute need for widespread, long term supplementary feeding. Most communities were still able to source food from their gardens and the forest. It was, however, noted by UNICEF's Health and Nutrition consultants that there were chronic and unacceptably high levels of under-nutrition in some communities. A lack of available data initially made it difficult to establish how serious and widespread this concern was. Many health records were lost in the disaster and monitoring and surveillance prior to the disaster were limited.

UNICEF recruited a Health and Nutrition Monitoring Officer to support MHMS and provincial health services in the systematic collection, analysis and reporting of EPI and nutrition data. Records have been collected from clinics and verified against existing reports held at hospitals. These data were analysed in October by UNICEF's Health and Nutrition Consultant. According to preliminary analysis between 14-17% of the under 5 population are underweight for their age.

3.4.3. Summary of Health and Nutrition Key Achievements

UNICEF Pacific's achievements in health and nutrition have been substantial and significant results have been achieved in line with the CCCs and the EMP results matrix.

First 6-8 weeks
CCC: Vaccinate against measles

- UNICEF support for measles immunization and Vitamin A in the initial response was timely and effective. Given the logistical challenges the campaign achieved excellent coverage (over 95%) in both provinces and provided a valuable opportunity to identify other acute illnesses. It helped ensure there was not a measles outbreak while the provision of Vitamin A is likely to address Vitamin A deficiencies and support children's immunity to other diseases.
- UNICEF's Vaccine Independence Initiative has ensured that the Government has rapid access to uninterrupted supply of low-cost inoculations should these be required.

CCC: Provision of essential drugs, health kits oral rehydration mix, fortified nutritional products and micronutrient supplements.

- Pre-positioning of medical supplies in MHMS stores in Honiara was a commendable initiative which answered a specific need, saved time, money and potentially lives.
- Identification of ORS supplies in case of outbreak of diarrhea was a useful precautionary measure.
- The quick identification and purchase of supplies of multiple-micronutrient powder or 'Vitalita' was a useful initiative and may have been partially successful in addressing anemia and other nutrient deficiencies in communities where both adequate distribution and consumption occurred (note discussion below).

Beyond Initial Response

CCC: Provide essential drugs

- UNICEF has progressed planning for a comprehensive campaign to do further distribution of Vitalita and Vitamin A to address anaemia and other micronutrient deficiencies among children in affected area (note discussion on Vitalita below).

CCC: Nutrition monitoring and surveillance reactivated

- UNICEF's achievements with regard to reactivation of HIS nutrition monitoring through providing practical assistance (e.g. computer and software for provincial Primary health care units) have been excellent.
- Substantial efforts have been made to improve assessment and monitoring capacity of health staff in both provinces with demonstrated results.
- A further achievement has been UNICEF's identification and training of a health nutrition monitor. In the view of the evaluation team, the approach taken to developing this officer's existing capacities (e.g. providing training in computer use and data analysis) whilst 'on-the-job' represents 'best practice' in terms of staff development in emergency settings and has positive implications for the sustainability and coherence of UNICEF's interventions.

3.4.4. Constraints and Gaps in the Health and Nutrition Response

Many of the so-called 'gaps' in UNICEF's emergency health and nutrition response represent issues that are a product of long term development challenges. It is not realistic that these could all be adequately addressed in either the initial response or early recovery efforts without substantially greater investments of staff and resources. These developmental challenges are not unique to the affected provinces nor due to the disaster's impacts.

Measles Vaccination

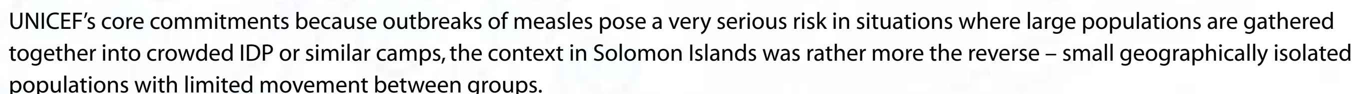
UNICEF's support for a comprehensive measles campaign was based on standard epidemiological practice and supported by WHO. The campaign's success is a significant achievement but was questioned by MHMS health staff interviewed by the team who noted:

'In reproductive and child health why should we cover immunisation? We had a campaign for measles, polio, hep B through January, February and March. Was it really necessary to give a second dose of measles. Things were not clear. We understood the focus on nutrition but why measles?'

Or more simply:

> *"I was thinking to myself 'Why a measles campaign after tsunami?'"*

The rationale and substantial investment of time, staff and resources in the campaign was also questioned by an expatriate Tropical Health specialist, particularly given the very recent campaign by the Provincial authorities. While, vaccination against measles is one of



UNICEF's core commitments because outbreaks of measles pose a very serious risk in situations where large populations are gathered together into crowded IDP or similar camps, the context in Solomon Islands was rather more the reverse – small geographically isolated populations with limited movement between groups.

The campaign may have been justified as a precaution but its rationale appears not to have been well explained to local partners. Given the experience of these partners with regard to specific health risks in the Solomon Islands context, the high EPI coverage from the previous campaign and the suggestion that perhaps the vectors for transmission of measles were fairly limited, it seems worth re-examining this decision for future emergency response efforts.

At the provincial level in Western Province there was reportedly some resentment by local health staff that it was mainly staff from Honiara who were deployed on the immunization teams. While coverage during the campaign was reported at 109% (due to some of non-target population were immunized) and that 100% of the target population was reached, actual coverage appears to have been lower due to the dispersal of populations inland and possibly due to insufficient local knowledge of where communities were.

Medical supplies

Based on the team's observations and interviews with health staff at Sasamunga Hospital, and supported by separate observations by UNICEF Health and Nutrition consultants in June and October UNICEF medical supplies in Sasamunga hospital have not been fully utilized. This may be due to limited capacity to manage medical supplies (a common problem in Solomon Islands) or simply an excess in supplies. Coordination of medical supplies is a common problem in many emergency responses and the provision of technical expertise to support MHMS or their equivalent is something UNICEF could consider for future emergencies.

Respiratory Infections and a case for distribution of blankets in emergencies in the Pacific

Health surveillance data collected and analyzed by UNICEF and cross-checked with senior provincial health staff indicate that there has been little or no excess mortality associated with the disaster.[15] There have been only incidental cases of diarrhea and normal trends in malaria observed. The team notes that they received anecdotal evidence from several sources (MHMS in Honiara, Sasamunga Hospital staff, and UNICEF staff) that there has been an increase in deaths among the elderly due to pneumonia and other acute respiratory infections (ARI). Numerous communities reported 'flu' as a health problem they have experienced since the disaster. Possible causes of a slight increase in ARI include the relocation of communities to temporary shelters located further up hill away from the coast where it is cooler and windier at night.

If there is evidence of increased prevalence of ARIs then it may be appropriate to undertake a distribution of blankets to the affected population now, and to include blanket distribution as a standard protocol in future emergency responses where populations are displaced and where shock and stress are likely consequences of the disaster (ie. most of them).

Vitalita

This evaluation supports the findings of the Omnibus survey and monthly reporting by UNICEF Health and Nutrition consultants suggesting that coverage of Vitalita distribution has been extremely variable and that consumption of Vitalita when available has been limited. Communities reported that the amount received ranged from 3-months supply in Mandali on Rendova Island in Western Province to 3 days supply in Salakana, and none at all at Solowai villages in Choiseul Provinces. At least 7, and possibly 8 out of 8 communities visited by the team in Western Province received Vitalita at least once since the disaster (at Legana village on Simbo the men reported that limited distribution had occurred but women reported that no distribution had occurred). In 3 villages in Western Province and 1 village in Choiseul Province, there were reports that children refused to eat food they knew had Vitalita in or on it as they 'thought it was medicine' or 'were scared of it'.

While in a few villages parents actively encouraged their children to eat Vitalita, there was only one village (Salakana in Choiseul) where women and men interviewed separately confirmed that their 'children like Vitalita'. Where Vitalita was distributed it was frequently reported that insufficient explanation was given regarding its use and benefits. It is apparent based on the above, that substantial constraints stand in the way of UNICEF meeting its target of ensuring 100% of children aged 6 months to 5 years in affected areas are receiving recommended daily nutrition intakes.

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[15] Health and Nutrition Report.

3.5.5. Lessons and Recommendations for the Health and Nutrition Response

Immediate

- Continue to provide support to improved surveillance (EPI and EWARN) and use analysis from this to inform identification of both emergency and development priorities.
- Continue to support current health promotion activities and particularly the radio campaign implemented by the national health officer.
- Undertake baseline nutrition survey (this is already planned for 2008).
- Increase presence and improve effectiveness in Choiseul by positioning a National health officer at Taro.
- Investigate anecdotal reports of increase ARIs in Choiseul since the disaster.
- Consider distribution of blankets to the affected population in both Western and Choiseul Provinces (if MHMS, Provincial health authorities and health surveillance evidence suggest it necessary and appropriate).

Future emergencies

- Consider distribution of blankets in the first 72 hours as a standard protocol in most emergencies in the Pacific and pre-position supplies accordingly.
- Re-examine CCCs to ensure they encourage interventions according to the greatest health risks in the Pacific.
- Carry out epidemiological research to assess the greatest risks in the individual context of the 14 UNICEF Pacific countries and inform disaster preparedness planning.
- Assess whether technical assistance is required to support MHMS in coordination, effective distribution and development of local capacity to cope with inundation of medical supplies that occurs in most emergencies.
- Learn from the effective example of on-the-job training approach demonstrated by Gizo office.

Food, supplementary feeding and nutrition

Very early on in the emergency is was recognized that food or a lack of it was not a survival issue in this emergency and that food distribution or 'supplementary feeding' needs were minimal. The World Food Programme's team member in the UNDAC mission assessed the Solomon Islands Government had capacity to meet any necessary food shortages.

The NDMO Director offered additional insights into the Melanesian ways of coping with disasters:

- With the exception of a few disadvantaged communities, food relief should not be done.
- Most communities have their main food gardens up in the hills behind their villages. These gardens are not affected by the tsunami. Even during cyclones remote communities will prepare by lopping off the tops of root vegetables and store food, water and coconuts so they have food for several weeks in advance.
- Food relief may actually discourage communities from gardening and slow down the recovery process and return to normalcy.
- During emergencies UNICEF should work with partners to ensure that emergency interventions support good nutrition practices.
- UNICEF emergency interventions such as distribution of nutritional supplements 'Vitalita' should include educational material on good natural sources of essential nutrients.
- Incentives or assistance should be aimed at encouraging communities to meet their own nutrition needs as soon as possible, eg. distribution of tools and seeds and working with or seeking advice from partners such as Kastom Garden and the Ministry of Agriculture.

Moana's Story

Prior to the tsunami Moana had been retired after many years as a Registered Nurse and midwife. She joined UNICEF in August 2007 as a Health Promotion and Monitoring Officer.

"I started with UNICEF on 13 August after 3 months with World Vision. I was in the market selling my wholemeal bun when the earthquake and tsunami struck. One doctor was buying buns from me when everything began to shake. We both held on to the poles just to stay upright. We agreed I would watch the sea while [the doctor] watched the electricity pole in case it fell on us. I saw the wave… and just yelled to everyone in the market just run to the hills! After the tsunami I saw World Vision first. I just came down to ask if there was any job to help for the emergency. I had experience in emergencies from PNG. I worked as a nurse in Bougainville during the conflict and in the Highlands, when there was trouble in Mt Hagen. After the tsunami I told my husband I'm going to help there will be a stack of people hurt. Some of the staff from the hospital were traumatised."

Moana was very positive about UNICEF's achievements in health, education and WATSAN but quite frank about the constraints facing UNICEF staff in the field.

"The biggest constraint we have is the supplies are late, slow. We promise to assist in an area and the communities are discouraged when we don't deliver. Communities hesitate to come and listen because others ahead of them have promised them and not delivered. Nothing has been done! They were not given those things they were promised! In health we do the distribution ourselves and the communities like that, to do a fair distribution. The others [some NGOs] don't do that. They just give to the chief or head man or pastor but it is not fairly distributed. People fight over things."

"It is also difficult to get monitoring reports from implementing partners."

"We do our own monitoring too. Assess drugs, clinics, effects of tsunami, EPI, Nutrition,Our findings from monitoring health clinic records show that from January to July especially children under 2 years are malnourished. They indicate that 14-16% of children are malnourished but this is only based on attendance figures! So we don't know for sure what is going on. We need a health and nutrition baseline survey."

Moana was excited about the new skills and opportunities that working for UNICEF had provided. She had learnt to use a computer and was now a radio broadcaster.

"Now I am doing a health promotion RADIO Program on SIBC. I'm excited because it is a new field for me. It's a new experience for me and I learn a lot of things. Everything I learn I share with the staff at the hospital – I share everything new concerning the health point of view. People sometimes don't like to share information but it is important to let people know."

(The evaluation team expresses their gratitude to Moana for giving us permission to share her story and photo).