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SOLOMON ISLANDS ISSUES REPORT

A. INTRODUCTION

1. The land and the people of Solomon Islands

1.1 Solomon Islands form an archipelago in the South West Pacific approximately 1,900 kilometres north east of Australia lying between longitudes 155 and 170 degrees east and latitudes 5 to 12 degrees south. The country's terrain ranges from rugged, mountainous islands to low lying coral atolls and forms a 1,400 kilometre chain from Papua New Guinea to Vanuatu. The capital, Honiara, is located on the island of Guadalcanal.

1.2 There are six large islands, Choiseul, New Georgia, Santa Isabel, Guadalcanal, Malaita and Makira; roughly two dozen small islands and many small islets, atolls and reef comprising 922 islands or atolls scattered over 800,000 square kilometres of sea. The landmass is 28,369 square kilometres, 30% is considered potentially arable. The islands are part of the Pacific volcanic rim with several active and dormant volcanoes. The islands also lie on a major earthquake belt and all islands are subjected to earthquakes.

1.3 In 2001 Solomon Islands had an estimated population of 432,000 with and annual average population growth of 2.8 percent. Solomon Islands has a young population with 0-14 year olds making up 41.5 percent of the population. There are more males than females in Solomon Islands. The sex ratio (number of males for every 100 females) is 107. In the young age group 0-14 years, males comprise 52 percent and 15-49 age group males comprise 49.5 percent.

2. The political system and the economy

2.1 The traditional political system in Solomon Islands is organised around tribes, clans, lineage and the family. Traditional political practices include both the *Big Man* and the *Chiefly* systems of leadership. Under the *Big Man* system (not an inherited leadership), any man in the community can aspire to be the *Big Man,* which can be achieved by gaining the support of the kinsmen and women and the extended *wantok* system. The general qualifications for gaining this status are; respect and seniority, humility and the possession of leadership qualities. In chiefly communities, power and authority are inherited through the most senior males. The traditional political units include the tribe, the clan, lineage and the family.

2.2 Solomon Islands gained its independence from Great Britain on 7th July 1978. It has a unicameral legislature; the National Parliament has forty seven elected members. It is administratively divided into nine provinces and a municipal

authority, each with their own political and administrative structure, which resembles a federal system of government.

2.3 Solomon Islands is a member of the Commonwealth. The British Monarch, as Head of State, is represented locally by a Governor-General, who is recommended to the Queen by the National Parliament. The governmental and political institutions of Solomon Islands are firmly established in theory and practice on principles and systems of democratic governance.

2.4 During 199-2001 Solomon Islands experienced civil unrest, which destabilised the country (collapsed economy, inability to derive an income and escalating national debt) and traumatised much of the population (the presence of guns had become a normal part of life). It caused the deterioration of the health and education sectors and has left the public service in tatters due to the inability of the government to pay, on a regular basis, fortnightly salaries.

2.5 In 2001 the Townsville Peace Agreement (TPA) was signed and since that time significant work has been done on bringing about reconciliation and healing at individual, community and national levels. However, there is still a need for more work to be done to ensure that sustainable peace in achieved.

2.6 *The Peace Process:* The root cause of the conflict revolved around land issues, the exploitation and distribution of natural resources, population movement, political autonomy and identity. Finding solutions which will lead to enduring peace has not been easy. The Peace Monitoring Council (PMC) was established to oversee the implementation of the TPA. This body has since been replaced by the National Peace Council (NPC).

2.7 *Law and Order:* Incremental improvements have been made in regaining law and order. Australia and New Zealand are playing significant roles in assisting in the revitalisation of the police force and engendering confidence in it as the legal law enforcement entity within the country. While there are some encouraging signs of improvement there is still considerable work to be done particularly with the strengthening of the judiciary and re-integration of ex-militants back into society.

2.8 *Economy and Governance:* The economy is in serious crisis with many industries being scaled down or closing down completely. The closure of businesses has limited employment opportunities and has reduced the amount of revenue collected by the government. This reduction has had an impact on the government's ability to provide basic services and has lead to massive overspending of the budget (the 2002 budget was overspent by SD28.3 million, which is equivalent to USD4 million, within the first eight month of the financial year). The government has been called upon to develop a 'realistic and responsible' budget, which gives priority to basic services.

3. Situation analysis of children

3.1 Solomon Islands has a young population with almost 50% under the age of 18 years. In each of the nine provinces the trend is similar with very little variance (Table shows the population distribution for the age group 0-19), except for Renbel where there is a much smaller population. According to a recent government report, the young population structure has an in-built momentum for continued population growth as a higher number of girls reach childbearing age. Government budget allocations (on paper this appears to be a large amount) and actual expenditure for child-related services are proving to be insufficient due to the erratic and unsustainable fiscal situation. The salaries of teachers and health professionals plus the expenses associated with the running of the education and health services are being paid in an ad hoc manner, and poorly managed.

Table 1: Population Distribution 0-19 yrs

Province		Age Group	M	F	% Distribution by age group
	Total	0-19 yrs			
Solomon Islands	409,042	215,622	112,114	103,508	52.7
Choiseul	20,008	10,858	5,701	5,157	54.2
Western	62,739	32,478	16,958	18,349	51.8
Isabel	20,421	10,695	5,554	5,141	52.4
Central	21,577	11,295	5,874	5,421	52.3
Renbel	2,377	840	634	564	35.3
Guadalcanal	60,275	31,890	16,588	15,302	52.9
Malaita	122,620	68,755	35,547	33,208	56.1
Makira	31,006	16,881	8,826	8,055	54.4
Temotu	18,912	9,963	5,092	4,871	52.7
Honiara	49,107	21,609	11,340	10,269	44.0

Source: SIG National Census, 1999

3.2 In the initial *National Report on Two Years Implementation of the United Nations Convention on the Rights of the Child, March 1998*, it was reported that education in Solomon Islands was neither compulsory nor free; this remains the situation in 2003. Many parents do not earn a regular income and are unable to pay school fees, resulting in children being denied access to basic education. The 1998 Report also found that around 25% of children leave school after completing grade six and only a mere 5.6% of children enrolled at the primary level will complete secondary education. One of the reasons given was there was a lack of "adequate schools". During the consultation process it was found that unqualified teachers are working within the education system and there is an acute shortage of qualified teachers. It was further stated that many of the existing classrooms are not a conducive learning environment; they are unhygienic, lacking appropriate ventilation and are in a state of disrepair. There is a chronic shortage of basic learning and teaching materials, i.e. chalk and books. Throughout Solomon Islands literacy rates are low in the adult population and therefore parents often do not recognise the value in educating their children. Educational opportunities still

favour boys over girls. Children are being confronted with disruption to their education due to teachers striking, which is creating learning problems difficulties.

3.3 In the initial report several social issues affecting young people were beginning to emerge. In 2003 those issues are now presenting as a major challenge to the government and society as a whole. Teenage pregnancy is common throughout Solomon Islands; large reported numbers of sexually transmitted infections (STIs) amongst youth; increase in alcohol and drug abuse; high rate of youth delinquency and sexual and physical abuse. Since the tension there has been further erosion of traditions and culture. The family, once the backbone of Solomon Islands' society, no longer offers security to children as more and more marriages are ending in divorce. Another phenomenon to impact on young children in Solomon Islands is sexual exploitation. During the consultation process people in Honiara reported that there is a steady increase in "sex tourism" which specifically targets young children and youth, most notably in Honiara.

3.4 It was previously reported that there had been considerable improvement in the health status of children. Mortality and morbidity from infectious diseases were decreasing. However, acute respiratory infections, diarrhoea, malaria and other infectious diseases continued to be of concern for the children in Solomon Islands. Today these illness persist, there is an acute shortage of medicines and vaccines throughout the entire country. In the rural areas knowledge and understanding of health issues is low and often results in reluctance on the part of parents in seeking assistance for a sick child, and taking environmental measures to prevent illness.

B. DATA and STATISTICS

1. Health Status and Indicators of Solomon Islands

Under Solomon Islands constitution, everyone person has the right to a healthy life. Successive Governments have stated this as a political priority. The National Health policies and Development Plans 1999-2003 aim to provide a high quality health system that is accessible; appropriate; responsive; and equitable and is aimed at "promoting, protecting and maintaining the good health and well being, and hence improve the quality of life of all people in Solomon Islands"

Table 2: Health Status Indicators of Solomon Islands 1986, 1995 &1999 (%)

Indicator	1986	1995	1999
Population	**285,176**	**393,759**	**409,042**
Women (15-49)	59,887	83,752	97,459
Total live births	NA	17,350	16,325
Crude Birth rate (per 1000 population)	42	38	34
Crude Death rate (per 1000 population)	10	8	8
Population Growth rate	3.4	2.8	2.8
Infant mortality rate (per 1000 live births)*	40	38	66
1-4yr child mortality rate (per 1000 population)	NA	7.1	NA
Maternal mortality rate (per 100,000 population)	NA	549	209
Total fertility rate	6.1	5.8	4.5
Low birth weight babies (less than 2500g)	NA	11	12
Underweight children (under 5yr)	NA	23	20
Births attended by a health worker	NA	86	90
Life Expectancy at birth (years) -male	59.9	63	63
Life expectancy at birth (years) - female	62	65	65.3
Family Planning Coverage		10.6	9.2

Source: [a] 1986 National Census [b] MHMS 1997 [c] 1999 National census.
**(Infant Mortality Rate was calculated based on different formula for 1999 compared to 1986 and 1995 calculations)*

However, infant mortality remains high. In 1999 the national census figures indicated that the infant mortality rate was 66/1,000 live births (see Table 2). The standard guide for "Health for All 2002" set by the World Health Organisation (WHO) is 50/1,000. Within the Pacific islands context this rate is also high. Since 1995 there has been a considerable decline in the maternal mortality rate, from a high 549/100,000 to 209/100,000 (Table 2). Since 1986 there has been a steady decline in the population and fertility rates, however the population growth rate is still considered high at 2.8% in 1999.

1.1 Health Status of Children in Solomon Islands

Children in Solomon Islands are vulnerable to illness and poor health from birth. The Reproductive Healthcare Division's recent report found that low birth weight in babies has worsened by 1% since 1995. The reported rate of low birth weight babies was 12% in 1999. Children's survival, well-being and development depend on the care provided by their parents or major care-givers.

The most up-to-date study on major health issues confronting Solomon Islands was conducted in 1989. It was found that severe malnutrition was rare but mild to moderate malnutrition among children under five years was almost one in four. Along with malnutrition the key health problems affecting children in Solomon Islands are malaria, Acute Respiratory Infections (ARI), tuberculosis (TB), diarrhoea, sexually transmitted infections (STIs), and non-communicable diseases such as diabetes, and skin diseases such as yaws.

1.2 Major Health Status Indicators

The infant mortality rate is used as one of the key indicators of social development. It is generally the case that there is a correlation between the rate of infant and adult mortality. As mentioned earlier the infant mortality (see Table 2) rate is declining, which would indicate an overall improvement in the health status of the population, however, this rate is high in comparison to world standards.

Complications during child birth and delivery have been a major cause of infant mortality. In 1999, 42.9% of infant deaths were attributed to complications at the time of birth. This was a dramatic increase on the previous 1997 figure of 13.6% (see Table 3); the Reproductive and Healthcare Division explained that this rise may have be a result of an increase in the number of home births or deliveries made in rural health clinics.

Main causes of morbidity and mortality in the neonatal period [from birth to 28days] from figures from the neonatal ward of the National Referral Hospital for 1998-2000, revealed the following:

- Neonates with reactive VDRL is the main cause of morbidity, followed by low birth weight, jaundice, pre-term, neonatal sepsis and aspiration.

- Pre-term is shown to be the main cause of mortality, followed by aspiration and neonatal sepsis, reactive VDRL, low birth weight and jaundice. These problems are associated with complications of births and delivery.

Cause for concern is the increased appearance in the percentage of pregnant women who are VDRL positive. Figures from the National Referral Hospital recorded VDRL reactive as the main cause of morbidity of 22.3% in 1998, 24.5% in 1999 and 19.9 % in 2000. Over the past four years it has become more common to find babies that have been born with congenital syphilis.

Table 3: Major causes of Death in Infants [%] in Solomon Islands 1994, 1997 &1999

Cause	1994	1997	1999
Complications of birth	32.6	13.6	42.9
Pneumonia	8.7	34.6	9.5
Malaria	13.0	3.6	14.3
Diarrhoea	13	7.4	9.5
Meningitis	4.3	12.3	7.1
Others	28.4	28.4	16.7

Source: Reproductive and Child Health Division, Ministry of Health 2001

Malaria remains a critical health problem in Solomon Islands, despite more than 30 years of intensive efforts to bring it under control. There had been significant inroads to reducing the incidences of Malaria during the period 1992-1999. It is assumed that since the tension and the cessation of the eradication campaign there will be an increase in the incidence of malaria. In 1999, 14.3% of deaths in infants 0-1 year were caused by Malaria (see Table 3). Other illnesses to cause deaths within this age group are Acute Respiratory Infection (ARI) – pneumonia, diarrhoea and meningitis. Accidents account for 16.7% of deaths in infants under the age of one year.

Malaria continues to be the major cause of death in children 1-5 years but the rate has been steadily decreasing since 1994 (see Table 4). ARI remains a major cause of health problems and is not showing signs of decreasing. To bring about a reduction it is necessary that proper diagnosis is made and appropriate treatment is given. Other diseases that are increasing and effect children are asthma and diabetes.

Table 4: Major causes of Death in Children 1-5 years [%]

Cause	1994	1997	1999
Malaria	41.7	33.3	25.0
Pneumonia	16.7	12.8	16.7
Diarrhoea/Dysentery	16.7	10.3	16.7
Meningitis/septicaemia	8.3	5.1	16.7
Accidents	8.3	7.7	7.9
Others	8.3	30.8	17.0

Source: Reproductive and Child Health Division/Ministry of Health 2001.

1.3 **Maternal Health**

Antenatal and postnatal figures for the period 1999-2000 reflect the effects of the ethnic conflict on these services and women's attendance rates across all provinces, which also affected the quality of reporting [during the period. For example, in Guadalcanal only 34% of women reported receiving antenatal care in 2000, whilst Malaita recorded abnormally high antenatal care coverage of 104.2%. This reflected the movement of Malaitans during the period from Guadalcanal and an underreporting for Guadalcanal. Overall between 66%-74% attended at least one antenatal care before delivery.

- *Births and Deliveries:* Overall 80-85% of women give birth at a health facility attended to by a healthcare professional. The remaining 15-20% were home births. This may explain why there were more deaths due to complications at childbirth. The Ministry of Health estimates that there are more than 12,000 reported births in a year. The total fertility rate has declined from 7.4% in 1976 to 6.1% in 1986 and to 4.5% in 1999 (see Table 2). This decline could be due to socio-economic pressures rather than real human development.

- *Maternal Deaths:* Maternal mortality rate [per 100,000 population] based on sisterhood method was around 549/100,000 live births in 1992, 394/100,000 in 1997 and 209/100,000 in 1999. There is some improvement in the maternal mortality rate since 1992. The National Health Programme, instigated by the government, aims to reduce maternal mortality rate by 50% at the end of 2003, which is considered a feasible target as most of the causes are preventable. The main causes of maternal deaths relate to complications at delivery, which recorded 70/1,000 live births in 1976 and has reduced to 28/1,000 live births in 1999. Out of this 50% would have been from those who give birth at home and encountered complications.

1.4 **Major Childhood Illnesses**

The patterns of illness in Solomon Islands is in and epidemiological transition phase. According to the *Sustaining Human Development in Solomon Islands Report* 2002, it is now transiting from communicable and predominantly infectious and parasitic diseases to non-communicable diseases (such as cardiovascular diseases, diabetes, cancer and accidents). The changes have been attributed to dietary habit where people have shifted from traditional high nutritional foods to imported foods with high sugar and salt content. Nevertheless, the major or common childhood illnesses in Solomon Islands remain as ARI, diarrhoeal diseases, non-communicable diseases diabetes, other non-communicable diseases (i.e. asthma) and other illnesses such as yaws and skin and ear infections.

1.4.1 Acute Respiratory Infections are common in children less than 5 years of age, especially coughs and cold, which are mostly due to viral infection. Many children have low immune systems due to malnutrition of under nourishment, which makes them vulnerable to infections. During the period 1997-2000 the provinces of Malaita, Rennell and Bellona all demonstrated higher incidence rates for ARIs than the other provinces. Honiara had the lowest rate during the same period, which appears to be due to the improvement in diagnosis and treatment of these illnesses by healthcare workers.

1.4.2 Other common illnesses, including yaws and infections such as skin and ear are quite prevalent. The high prevalence rate is due primarily to poor personal hygiene and low living standards, i.e. overcrowding and poor nutrition.

There have been significant improvements in the provision of clean and safe water supplies in both rural and urban areas. The 1999 population and housing

census reported that 69% of households have access to safe water. However, there is a cost for the water and with the economical downturn that cost is not able to be met by everyone who has access to safe, clean water. While safe water is widely provided throughout the country sanitation is another issue altogether. The 1999 census report found that one in every five household (approximately 23%) had modern toilet facilities. Both these issues have an impact on the overall well-being of the children in Solomon Islands.

2. Nutritional Status of Children

Malnutrition or under-nutrition in children under 5 years of age is a health concern as the nutritional status of the child is closely linked to the risk in a child developing pneumonia, diarrhoea, malaria and other infectious disease. Malnutrition affects the child's immune system to withstand infectious diseases.

Only one National Nutrition Survey has been conducted since 1989 and there is an urgent need to update data on indicators specific to monitor nutritional status of children. At time of the survey, indications were that there was a high prevalence of moderate under nutrition amongst children 0-4 years. It was found that approximately 23% were underweight. The highest rate was those between 9 -24 months. Between 4-5 months growth faltering starts mostly due to poor weaning practices. This is the stage where infants are highly vulnerable to infections.

In response to the finding, the following policies were adopted:

- National Food & Nutrition Policy [1995]
- Breast Feeding Policy
- National Nutrition Plan of Action

The Reproductive and Child Health Division continues to implement its *Provincial Growth Monitoring Programme Training* for various stakeholders particularly nurses and community at large. It aims it to improve monitoring the growth of infants and children and to encourage better feeding practices. In 2002 this training was concluded for Isabel Province. Along the same line, a growth-monitoring programme illustrated that when children's growth was monitored regularly and active follow-up plan is implemented there was a reduction in the percentage of malnourished children. This effective educational approach provides the primary caregiver with a better understand on how to feed children using local food base. It is envisaged that the training programme will be adapted and implemented in other provinces in the future.

The Ministry of Health has a Health Information System that measures the level of malnutrition based on the "standard weight for ages". Figures for 2001 showed that for the total of children less than two years 13% were considered malnourished. While 16% of the children between the ages of 2 years to 4 years were considered malnourished.

Many planned programme activities for 1998-2002 were not implemented due to the delay of proposed funding from UNICEF. This included the production and printing of growth monitoring IEC materials, protocols and guidelines plus the development of a programme database for nutrition.

The 1990 Nutritional survey indicated that the breast feeding pattern was reasonable with 70% of mothers giving colostrums, 100% breastfeed for 0-3 months and 50% maintained breast-feeding until 18-21months. Figures from the 1999 census on exclusive breast-feeding reported 89% breast-fed their babies from birth 35% completed exclusive breast-feeding after 4months, which implies that most mothers started supplementary feeding after 3-4months and 41% continued after 6 months the Ministry of Health is striving to ensure that breast-feeding practices continue and is maintaining its Baby Friendly Hospital Initiative, which promotes and encourages mothers to breast-feed new born babies. Promoting breast-feeding is an important priority as breast milk provides protection from infectious disease, which is the major cause of morbidity and mortality among infants and children.

As reported earlier the incidence of low birth weight babies was 11% in 1995 and 12% in 1999. The main contributing factor appears to be anaemia and malaria during pregnancy in addition to poor eating habits. Pregnant women in the rural communities often work extremely hard, do not eat well nor take time to rest. These factors often have a negative impact on the birth weight of their babies.

A survey was conducted in 1999 [Julie Brimblecombe] to assess the risk of Vitamin A deficiency throughout selected provinces. Some findings were as follows:

- Paw paw and slippery cabbage were the two most common Vitamin A foods consumed in all provinces.
- Intake of Vitamin A foods were low in Isabel, Choiseul and Western Provinces and very low in Malaita province.
- Children with cough, diarrhoea and Malaria had significantly lower mean intake of Vitamin A foods.
- A fifth of the population studied had received Vitamin A capsules in the last months.

The Ministry of Health is considering reviewing the Vitamin A protocol, which was introduced and implemented in 1996. Currently the protocol prescribes a 6 monthly Vitamin A supplementation for children 6 months to 5 years who are " at risk" i.e.; underweight < than 80% standard weight for age, children with diseases such as pneumonia, diarrhoea, malaria or serious infectious diseases. The protocol now needs to be revised in view of high rate of morbidity and mortality in children from infectious diseases and under-nutrition, which still prevails in the country.

3. Expanded Programme for Immunisation (EPI)

The Expanded Programme for Immunisation is extremely effective however the country is facing problems of vaccine shortages. This Programme is important as it protects children from life threatening illness such as polio, measles, diphtheria, tetanus, whooping cough, tuberculosis and hepatitis B.

While the EPI coverage is high actual data through the Health Information System is not completely reflective of the situation. Nevertheless, there have not been any reported cases of measles since 1995 nor have there been any reported cases of diphtheria or polio for several decades.

Table 5: National EPI Coverage Rates (%) for 1995-2000.
[Infants and pregnant women]

Year	BCG	Hepatitis B3	DPT 3	OPV 3	Measles	Tetanus
1998	72	72	69	69	64	55
1999	64	62	62	60	59	50
2000	84	73	81	83	77	60

The overall immunisation coverage in the country is 80%, although previous figures have shown much lower coverage in comparison to year 2000. The difference was that 1995-1999 coverage rates were calculated using the extrapolated population data from the 1986 census. The 2000 coverage rate was based on the 1999 population census data, which is more reliable.

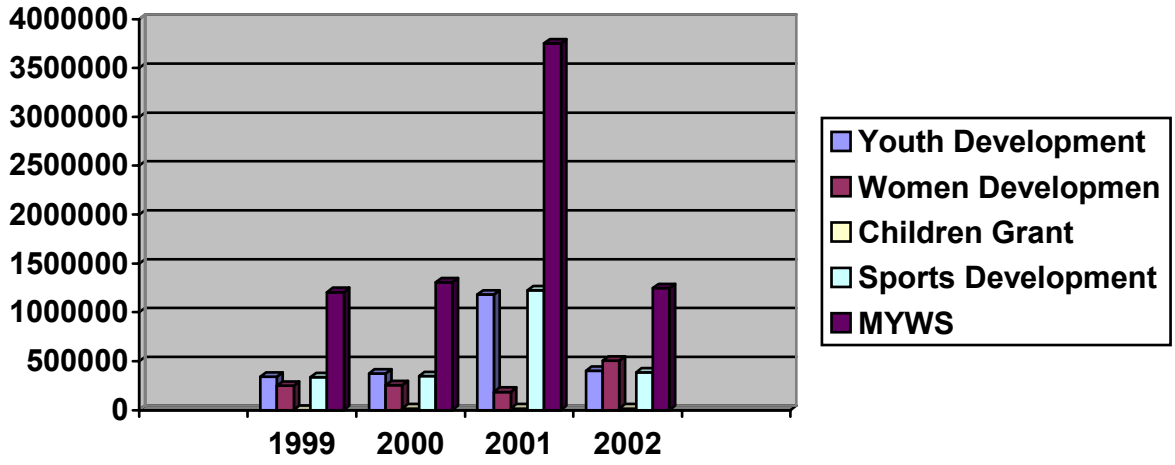
The biggest challenge of the programme is maintaining the cold chain from the national level down to the rural clinics in order to ensure potency of vaccines. An urgent issue at present is the inability of the government to purchase vaccines under the Vaccine Independent Initiative. The country has not been able to meet its financial contribution for the last three years.

4. Budget Allocation for Children's Services

Prior to the abolishing of the lead Ministry responsible for Children Affairs in August 2002, the Ministry of Youth Women and Sports (MYWS) was one of the smallest Ministries, which provides a possible explanation as to why it was the first to be picked to merge with three other Ministries. Due to its small size, its annual recurrent budgetary allocations have also been small relative to other bigger Ministries. Regrettably, there has never been any significant or specific budget allocation for children services or programmes since the Convention on the Rights of the Child was ratified apart from nominal allocations in 2001 and 2002 budgets of SBD16,000 (USD 2,500) as Youth and Children grants. The issues of youth and women are crosscutting with those of children, Figure 1 below indicates the budget trend for youth, women and sports projects. No doubt children benefit as there is a flow-on effect and while this is an unlooked for bonus it does not, however, address child-specific issues.

2002 budgets for the various departments of the MYWS, in terms of the overall total allocations, were greatly reduced due to the effects of the economic crisis in the country although demands for its services were not reduced. However, it was greater than 1999 and 2000 budgets in terms of percentage of the total government expenditure, (see Table 6). Children grants, however, remained the same, although negligible for any real services to be offered. Moreover, most of these budget allocations appear only in written figures without any actual disbursement of funds. There is a great need to continue advocating on children issues at the highest level to redirect political focus to the importance of the allocating more resources to children programmes.

Figure 1 Youth, Women, Children, Sports, MWYS Expenditure Budget Trend



Source: Solomon Island Government, 2001 Budget Estimate

Table 6: Budget Allocations for Women, Youth & Sports as Percentage of Government Expenditure 1999 - 2002

MYWS	As % Total Government Expenditure	Children Grants as % of Total MYWS Expenditure
1999	0.3	0
2000	0.3	1.2
2001	0.8	0.4
2002	0.5	1.2

Source: SIG National Budget Estimates

National budget allocations in other areas directly impacting on children such as health and education show incremental increases over the years, but the actual funds

expended is reducing. The overall share of the education budget out of the total expenditure is high, at least by Pacific standards. Despite the government's financial difficulties, the share of the education budget remained over 15%. However, the issue of cost-effectiveness of financial allocations is still in question. The operational cost allocation is disproportionately expended on higher levels of education rather than concentrating expenditure at the level where the majority of children are situated.

Similarly, health-financing trends by the government show priority being placed on health services. 11 to 15% of the recurrent budget allocations over the years have been allocated to health. While there is commitment at policy level to move the emphasis towards a preventive rather than a curative health system, a significant proportion of the budget is still absorbed by the hospital-based curative health services. For example, more than 30% of the recurrent budget allocation was given for the National Referral Hospital in the capital town. Table 7 indicates trends of budget allocations for health and education. The trend of incremental increases in terms of percentages of the total government expenditure for both sectors was maintained in 2002, although there was a big reduction in terms of the total national recurrent budget. The reduction was due to the economic crisis in the country worsened by the effects of the conflict.

Table7: Public Expenditure on Health and Education

Year		Health			Education	
	Recurrent Budget	As % of total Govt. expense	As % of GDP	Recurrent budget	As % of total Govt expenditure	As 5 Of GDP
1991	20.5	12.6	3.7	34.2	15.1	6.2
1994	34.4	13.5	3.8	46.9	18.3	5.2
1998	48.7	13.4	2.8	64.3	17.2	3.6
2000	61.2	16.2	4.4	88.5	23.3	6.3
2001	66.9	14.9	5.9	90.1	20.1	8.0
20002	40.7	16.3	5.9	56.0	22.4	8.1

Source: UNDP Human Development Report 2002

Despite the increasing trend in the percentages of total public expenditure for health and education, the reduction in terms of the total budget in 2002 is alarming. The Ministry of Education noted with concern the non-availability and non-release of any portion of the budgeted allocations for the education service for the last three years (see Box 1). With the current adverse economic situation of the country there does not appear to be much likelihood that funds from the allocated budget for 2003 will be forthcoming to restore education services. This is a constraining factor for the three year target of achieving 100% primary enrolment and 25% enrolment into Form 1 in the secondary education as well as to the objective of attaining a 100% enrolment in basic education up to Form 3 by 2015.

With the target of 100% primary enrolment in the medium term, budget allocation trend has shifted from secondary and tertiary education getting larger portions to primary education now being allocated a bigger share of the overall education budget. The allocation for 2003 has been increased by 7% to SBD 3.8 million (USD540,000). The funds will be used to procure and distribute essential educational materials for Primary schools. This government allocation is still insufficient to run the primary schools efficiently and effectively. For them to function it is necessary to impose school fees of SBD100 (USD13).

Apart from internal sources of funds for schools, development partners have been assisting in the education sector and will continue to provide aid in the foreseeable future. For example, the European Union's Stabex 99 Funds will be used to upgrade and reform basic education for Form 1 to Form 3. The World Bank, ADB and other bilateral aid donors have also indicated interest in resuming educational funding for school operations in the future.

Box 1

The past three years of under-funding had seen a serious deterioration in school infrastructure, teacher morale and the quality of education taught in Solomon Islands schools. The Ministry appeals to the Ministry of Finance that approved allocations in 2003 Recurrent Budget be released in their entirety as another year of practically zero financing for non-salary operational costs from government will cause further deterioration and neglect.

Ministry of Education submission and presentation in the Parliamentary Budget Session December 2002.

4.1 Health Financing & Resource Allocation

Recurrent funding for health services both at the provincial and central levels is provided primarily by the national government. The analysis provided is based on the Government Recurrent Budget for the period 1998-2002. This does not reflect Total Health Financing as private sector figures are not included, which excludes services provided by the church groups and industrial companies. The figures do reflect the overall trends in resource allocations. The government's development budget usually takes into account the areas that are donor funded.

Table 8: Total Government Budget and Allocations 1998-2002-12-26

Years	Total Govt Recurrent Budget	Health Recurrent Budget	Share [%] to health
1998	532.5	54.3	14.4%
1999	441.0	56.7	16.3%
2000	*396.7*	64.6	*16.0%*
2001	*448.9*	63.5	*
2002	*	40.7	*16.3%*

Source: Account section Ministry of Health / National Annual Health reports 2000.

For the years 1999-2002, the recurrent health budget continues to be 16% of the total government budget. In 2002 however there was a decline in budget estimates from 63.m in 2001 to 40.7 m. Although health services remain the second highest allocation to education, overall it reflects that resources allocated for health are decreasing in the face of increasing health needs of an increasing population.

Table 9: Distribution of the Recurrent Health Budget 1999-20002. (SBD)

Sections	**1999**	**2000**	**2001**
Headquarter & Administration	5.7m	3.4m	4.8m
National Referral Hospital	13.7m	14.2m	16.0m
Dental	686,523	1.3m	1.3m
X-Ray	740,277	690,042	882,494
Laboratory	1.1m	1.4m	1.4m
Pharmacy & Stores	7.0-m	7.2m	7.7m
Health Education	669,285	1.8m	1.2m
Environmental Health	560,778	1.3m	1.0m
Medical research and training institute	1.2m	1.3m	1.5m
Social Welfare Division	40,564	334,075	237,708
Malaria	2.3m	2.9m	832,032
Provincial Health service and Wages Grants	18.0m	19.9m	24.6m
Physiotherapy Service	212,853	765,162	854,182
Nursing	1.2m	4.0m	3.6m
National Psychiatric Unit	75,545	795,668	954,598

Source: Account Section, Ministry of Health.

The trend, since 1991, has been that out of the total Recurrent Budget Allocation for health over 60% is spent at the central level, which includes the National Referral Hospital and the Ministry headquarters. Whilst health services for all the other provincial

health services constitutes the other 30%. The current thrust is to reverse the centrally biased funding allocation to favour provincial financial support.

National health policies and Development Plan 1999-2000, reports that the National Referral Hospital [curative services] consumes the highest portion of 45%, pharmacy division [drugs & supplies] 22.9%, Ministry of Health national offices 13.5%, nursing division national office 12.8% and Public Health Divisions [reproductive health, environment health, Malaria etc] 10.8%. The total Provincial Health Services is 18.8%.

Further breakdown of the recurrent budget allocation for the period 1999-2000 reveals the following:

- Ministry of Health personal remunerations constitute 56% and 67% of the total budget.
- Allowances constituted 13% and 28% of personnel remunerations.
- The National Referral Hospital services cost 38% and 45% of the total budget.
- NRH personnel remunerations constitute between 18% and 27%.
- Provincial health services make up 39% and 45%.
- Public health services constitute 4% to 7%.
- Revenue collected is 0.27% to 1%, which is far less than projected in the budget.

In terms of resource allocations for public health programmes including child health programme activities based on the recurrent budget [mostly government funded] this is a low priority as salaries and wages remunerations consumes a large portion of the budget.

There is a huge difference between the cost of hospital services [curative care] that serves the lesser portion of the population and primary health care. The provincial health service, which serves over 80% of the rural population, receives less than the National Referral Hospital.

To address this disparity in resource allocation the Ministry of Health is currently undertaking to increase the recurrent health budget to community and public health programmes, provincial health services and health education and promotion. [National Health Report Ministry of Health, 2000). The Ministry has identified the lack of appropriate mechanisms or technology to monitor and evaluate the performance management of the health budget. At present it is almost impossible to measure both the operational and the impact of health care services at the central level versus provincial level. Ministry of Finance who is ultimately responsible for the formulation of the budget practice item rather than output budgeting.

The decline in real terms of the health budget particularly since 1999 has created a serious urgency for the Ministry to practice more efficiency in resource use and allocation with a push for cost-containment and cost recovery measures to be undertaken. The Australian aid agency, AusAID funded Solomon Islands Health Institutional Strengthening Project is assisting the Ministry in the area of health sector financial management.

4.2 Donor Financing for Health

The Director for the Reproductive and Child Health Division of the Ministry of Health, in its Draft Report *on the Current Status of Reproductive and Child Health in Solomon Islands [2001]* stated that 'all the Reproductive and Child Health programmes implemented through the Ministry of Health and Medical Services are funded from outside sources. The current sources of funding include the following:

- United Nations Population Fund, UNICEF, WHO, World Bank, AusAID and Secretariat of Pacific Community [SPC] In the past, Save the Children Fund Australia, South Pacific Alliance for family Health [SPAFH] and Family Planning Australia have contributed significantly for the development of many on-going activities.

Developing partnerships is considered paramount for the health sector if it is going to meet the cost of delivering health services. This includes more effective donor assistance and co-ordination to avoid duplication of activities and programmes, which impacts on scarce and vital resources.

5. CHILDREN with DISABILITY

5.1 General situation

A feasibility study conducted in 1991/1992 estimated an overall disability rate of 3.2% in the areas surveyed. This was an estimated 10,000 people with disabilities throughout the country. It was estimated then that 4,000 would have been children. [UNICEF Situation Analysis 1998]

The national census recorded a total of 11,107, or 2.7% of the total population as having some form of disability either physical or mental. Of this number, 1925 or 17.4% are children from 0-19 years.

The figures on disability as provided by the national census, is subjected to interpretation of the term disability by the respondent. The figures for 0-9 depended on the response by the caregiver on behalf of the child. It is possible that in some instances that diagnosis has not been made (the child is very young and has not displayed any symptoms) and therefore the figures presents could be under reported.

***Table 10: No* of People with Disabilities by Province and by Gender**

Province	**Total**	Percentage	**Male**	Female
Malaita	3,571	32.2	1,859	1.712
Choiseul	559	5.1	288	271
Western	1,775	16	975	800
Isabel	479	4.3	265	214
Central	549	4.5	300	249
Renbel	131	1.1	68	63
Guadalcanal	1.,624	15	969	655
Makira	807	7.2	450	357
Honiara Town council	950	8.6	610	340
Temotu	662	6	374	288
National	**11,107**	**100**	**6,158**	**4,949**

Source: National Census 1999.

The most common form of disability overall is impairment of sight [32.1%] followed by hearing impairment [18.5%] and crippling [17.1%]. Overall more males [55.4%] reported having some form of disability than females [44.6%]. Provincial distribution indicates that Malaita has the highest number of disability of 3,571 (32.2%], followed by Western 1,775 [16%] and Guadalcanal 1,624 [15%] Renbel has the lowest of 131 [1.1%]. Approximately 90% of those with disabilities live in the rural areas and only 8.6% are reported to be located within the bounds Honiara Town Council.

5.2 Children with Disability

A provincial breakdown in figures of the age group 0-19 (covered by the Convention on the Rights of the Child) indicates that Malaita has the highest number of children with disabilities [525] followed by Western Province [335] and Guadalcanal [305] (see Table 11), which highlights the fact that the majority of children are rural based as opposed being located within Honiara [184].

Table 11: Children [0-19yrs] with Disability by Province

Province	Age [0-19]	Male	Female
Malaita	525	278	247
Choiseul	100	56	44
Western	335	186	149
Isabel	116	63	53
Central	79	49	30
Renbel	26	13	13
Guadalcanal	305	194	111
Makira	135	67	68
Temotu	120	74	46
Honiara Town Council	184	**92**	92
National	**1,925**	**1,072**	**853**

Source: Compiled from Census figures

Table 12: Children [0-19] by age group by disability type

Age - years	Total Disabled	Sight	Hearing	Speaking	Moving	Gripping	Mental	Multiple
0-9	839	90	143	224	119	43	46	174
10-19	1,086	167	210	214	141	44	103	207
Total	**1,925**	**257**	**352**	**438**	**260**	**87**	**149**	**381**

Source: Compiled from census figures.

In Solomon Islands there are a total of 118,108 children in the age group 0-9 years throughout the country 839 or 0.7% (less than 1%) in this age group were reported to have some form of disability. Within this age group the major reported disability relates to speech (26.7%) followed by multiple disabilities (20.8%) and hearing impairment (17%) (see Table 12).

There are 97,514 children aged between 10-19 years in Solomon Islands within this age group at total of 1,086 children are reported to have some form of disability. Within this group the major disability also relates to speech (20.2%) (19.4%) is relates to sight and (15.4%) relates to hearing impairment. Mental disability does not appear too prevalent amongst the age group 0-9 however within 10-19 year old children it relates 9.5% of that group. It should be noted that mental disabilities, was

highest for those between the age groups 20-29 years. It would appear that as a child ages the likelihood of suffering some form of mental illness increases. It was suggested that this could be a reflection of the increased incidences of drug and substance abuse amongst young people over recent times.

5.3 Causes of Disability

The Ministry of Health reports some of the disabilities that children have can be attributed to birth injuries or complications of their delivery, which may be high in home births. Neonatal infection and other infectious disease are also high and contribute to the morbidity and mortality rates within the country. Children who survive many of these infections develop some form of disability for life. Congenital, malnutrition and infectious. Whilst in Solomon Islands disabilities have many causes, most are preventable; which points to develop sound educational programmes aimed at prevention. The success of such programmes can be seen through the impressive gains made in combating polio and leprosy through immunisation and improved case management.

While many disabilities are preventable; i.e. drug abuse, others are caused by road accidents, industrial accidents and domestic accidents. In more recent times environmental pollution has been added to this list.

5.4 Children with Disabilities in Education

The Education Act does not have any special provision for children with disability. As such there are no special institutions for children with disabilities. The formal education system faces major challenges with the provision universal education without contemplating meeting the requirements of children with special needs. Children with disabilities therefore are disadvantaged.

Census figures on population 5-19 years of age collated by type of disability and school attendance indicates a very low portion of children with disabilities attend regular schooling. Those attending were mainly clustered in the primary age group and cut off in the secondary or tertiary levels. Out of the total of 2,511 children with disabilities within the age group 5-19 years overall only 471 or 19% reported attending regular schooling. Out of this total, 107 are aged 5-9 years; 197 are from 10-14 and 122 from 15-19 years.

Furthermore, of the 471 who attended regular school, the majority were hearing impaired while others were sight impaired or suffered from some form of movement disability. Children suffering some form of mental illness were the least likely to attend

school. These figures do not show the drop out rate or the children who would continue after primary level. Nor do the figures presented above reflect the severity of the type of disabilities. As reported elsewhere, many children with disabilities such as blindness, major limb disability or cerebral palsy will never go to school" (UNICEF Situational analysis).

Since the education system does not catered for children with special needs problems arise when a child with a disability attends regular school. Teachers are neither trained nor have the time to give the level of attention that the children require or in fact deserve. It is quite common for children with disabilities usually drop out of school (UNICEF Situation analysis page).

5.5 Health Care Services for Children with Disabilities

The Ministry of Health's Rehabilitation Division is involved in service provision for persons with disabilities, which includes physiotherapy services, manufacture of adaptive equipment such as prosthetics and crutches. It also provides consultative touring, training of community based rehabilitation (CBR) aides, education awareness and supportive roles to CBR aides.

It should be noted that while a national policy for people with disabilities is yet to be developed; some aspects are catered for under the Policy Goal of the Rehabilitation Services as part of the Ministry of Health's NHP & DP 1999-2003. It includes:[I] *"To assist individuals who have been disabled by disease, traumatic injury or other causes to achieve their maximum potential in terms of physical activity, Functional ability, independence in daily living and the potential for useful and important member of the society. [ii] To ensure that people with disabilities are rehabilitated to be adaptive to the national, provincial and community environmental changes through the National Community Based Rehabilitation Programme" [*Ministry of Health]

The staff of the Rehabilitation Division enjoys a close working relationship with the medical staff in the central hospital, which provides diagnostic, treatment and surgical services as well as limited medical and surgical touring. The dental and eye clinics also provides diagnostic, medical treatment, corrective surgery and limited assistant devises.

The Tuberculosis and Leprosy Unit provides diagnosis, treatment compliance and follow-up services to clients. Improved case management has led to decrease in physical disabilities caused through these illnesses.

The Reproductive and Child Health Division participates in providing preventative and educational measures through the immunisation campaigns, training of nurses in antenatal and child health such as the proper recording of child health book.

Nursing officers play key roles as community based rehabilitation supervisors and provincial co-ordinators at the provincial level. Nursing officers play key roles in diagnosing childhood disabilities through the health system

Apart from the Community Based Rehabilitation Programme, as reflected above health care services for disabled persons and including children with disability are provided mainly through the general health services. Church groups also support people with disabilities in their respective communities.

5.6 Community Based Rehabilitation Programme

Prior to the establishment of the Community Based Rehabilitation Programme (CBRP) and services in 1994, most services for disabled persons were located in Honiara or otherwise part of the integrated health services. The vast majority of disabled persons therefore had no access to rehabilitation services. The services and care they receive is limited to family members' contributions and the community at large.

The main aim of the CBRP is to equip local people with the basic skills in rehabilitation and works with disabled individuals and their families developing therapeutic programmes to improve their daily lives. It also provides referral system to the hospital, to the Red Cross as well as to other government services where appropriate. One of its major strengths that it works with communities and clinic services providing education about disability, care and management. It also provides education and awareness-raising on preventable disabilities.

A review of the CBRP was conducted in 2000. [Pollard, A. CBR Programme/SI Programme Evaluation Report 2001], which reported that from the period 1995 to 2000 a total of 1,976 people with disabilities were registered as clients of the CBRP. This represents 18% of the total number of people registered in the national census. Out of this total, the highest of 343 clients were based in Malaita, followed by 290 in the Western province and 277 in Guadalcanal. Honiara was second lowest with 80 clients.

Major achievements in assisting people with disabilities:

- It an innovative approach and low cost services delivery through networking with local communities and other NGOs.
- Established a computer registration data base of clients.
- 200 projects have been funded by various donors for people with disabilities

The review highlighted that the CBR programme was successful in establishing provincial structures by recruiting CBR aides who were based in their provinces. In 2001, there were 27 aides located throughout all the provinces. Communities and disabled persons have expressed appreciation for the work of the CBRP. The government has taken over the responsibility for most of the CBRP aides salaries.

Constraints:

- Reliance on aid donor funding major donors e.g. UNICEF withdrawal of assistance in 1999.

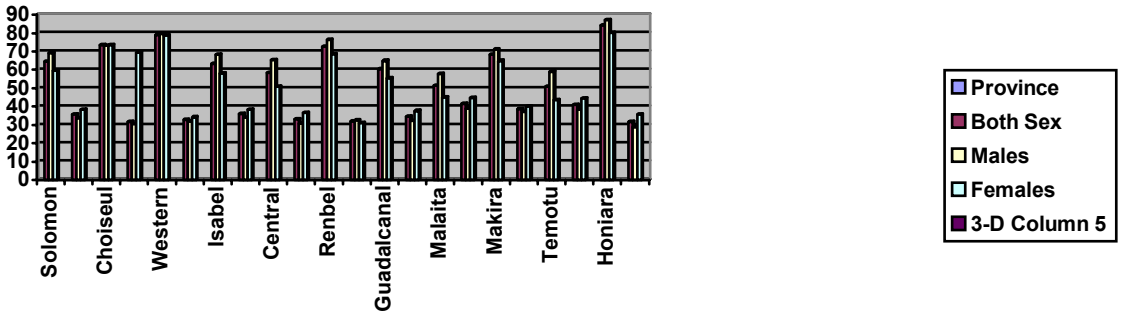
5.7 NGOs and other organisation providing assistance to people with disabilities:

- Solomon Islands Red Cross Handicapped Centre
- Disabled Persons Rehabilitation Association
- Society for Crippled People in Solomon Islands
- SIDT
- Family support centre
- Church groups
- Donor partners

6. Literacy

The literacy rate for the population 5 years and over is recorded in the 1999 census as 64.4%. The adult literacy level is 76%. The methodology used in the census was based on self-responses to the simple question '… can you read and write a letter to a friend'? The 1991 literacy survey was based on a test in reading and writing English and Pidgin. This is considered a more accurate assessment on a person's ability to read and write and therefore most agree that there is a need to carry out another survey to properly determine the level of literacy in the country.

Figure 2 – **1999 Literacy Rates by Provinces, 5 Year Age Group and Gender**



Note: The 1999 National Census only records the above age group.

While there does not appear to a great variance in the literacy a rate between provinces, (Figure 2) nevertheless, there is an indication of difference between more urban and semi-urban areas in the country. For example, Honiara, being the capital of the country, records the highest percentage in literacy rates and Temotu province as the most remote from the capital has the lowest. A similar situation is revealed in terms of the differences in the rates between males and females. However, a high or low literacy rate for some provinces does not necessarily reflect more urban or less urban situation or the proximity to capital. As is the case with Guadalcanal province where the capital is located where a low literacy rate is recorded, while the Rennell-Bellona province which is considered less urban has a higher rate of literacy. One possible explanation would be that Rennell-Bellona province is less populated but more exposed to urban areas.

In terms of gender equality in literacy, Choiseul, Western and Honiara have greater equality in literacy between males and females. Temotu demonstrates the greatest gender inequality and is followed by Malaita and Central provinces.

7. Education

Education in Solomon Islands is not compulsory. Formal education refers to the highly institutionalised, chronologically graded and hierarchically structured education system ranging from lower primary school to the upper reaches of university.

7.1 Early Childhood Education

Early childhood education (ECE) is not strictly part of the formal education system in the country as yet although it is now receiving focused attention from the national and provincial governments. There are three levels of early childhood education – early childhood (ages 3-4), pre-school years (ages 4-5), and preparatory (ages 5-6). Pre-

service ECE teacher training is currently offered by the Solomon Islands College of Higher Education (SICHE) with an annual intake of about 15 trainees. There 272 ECE centres participating in field-base training programmes in the country. There is a total of 329 early childhood education teachers trained under the Field Based Training Programme (FBTP) and another 179 who are currently undergoing training and 40 FBTP trained and are currently on probation.

Preparatory classes form the first year of the formal education system and are mostly offered in primary schools for children aged 5–6years although some schools offer a pre-school year for children aged 4–5 years. In 2000, there were approximately 13,000 children aged 5–6 years enrolled in preparatory classes. This represents approximately 50% of 5-6 year olds eligible for enrolment.

Table 12: ECE Centres, ECE Teacher Training, 2002

Province	ECE Centres	FBTP Trained	Under Training
Choiseul	33	35	15
Western	34	36	12
Isabel	42	33	12
Central	21	27	26
Renbel	10	22	12
Guadalcanal	5	0	0
Malaita	42	59	41
Makira	41	16	20
Temotu	31	42	17
Honiara	13	59	24
Total	272	329	179

Source: Ministry of Education Strategic Plan, 2002-2004

7.2 Primary and Secondary Enrolment

Primary education begins in Standard 1 and ends in Standard 6. The legal entry age for primary education ranges from 6 to 9 years. Primary education is free to all but as stated earlier, is not compulsory

Table 13: School Age Population 5 – 14 years by sex

Age in 1999	Number of People	**%**	Males	**%**	Females	**%**
All Ages	409,042	100.0	211,381	51.7	197,661	48.3
0	13,513	3.3	7,061	52.3	6,452	47.7
1 – 4	50,119	12.9	26,089	52.1	24,030	47.9
5 – 9	54,476	13.3	28,407	52.1	26,074	47.9
10 – 14	51,693	12.6	26,970	52.2	24,723	47.8
	169,801	41.5				

In 1999 there were 106,169 young people in the 5 to 14 years age group, 58% of these children attended school in 1999 and 58% were girls. This is the primary and junior secondary age group. 63, 632 children were between 0 to 4 years and who will become

eligible for enrolment in the next two to three years. In total this represents 41.5 % of the total population (see Table 13).

Table 14: Primary Enrolment in % of total age group 5 – 14 yrs by sex

Country	Primary Enrolment, 5 – 14 yrs											
	1999	**M**	**F**	**2000**	**M**	**F**	**2001**	**M**	**F**	**2002**	**M**	**F**
Solomon Islands	58.0	58.6	62.9	65.9	66.4	62.9	70.9	75.8	72.1	70.3	71.8	75.5

There has been a steady increase in primary school enrolments, within the 5 to 14 years age bracket, which is attributed to the establishment of Community High Schools however, 2001 and 2002 experienced a slight decrease. This was said to be due to the adverse economic effects caused by the ethnic tension, whereby families experienced difficulties in paying up school fees.

Table 15: School Enrolments by Provinces, by age group 5 – 14 years, both sexes

Province	% Enrolment		Province	% Enrolment	
	1999	**2000**		1999	**2000**
Malaita	48.9	62.0	Temotu	63.7	75.4
Honiara	73.0	62.1	Isabel	67.3	77.5
Guadalcanal	39.7	68.3	Choiseul	65.4	77.6
Western	68.9	69.8	Makira	67.2	84.0
Central	57.7	73.7	Renbel	74.9	119.8
Solomon Islands	67.7	73.0			

Ministry of Education Strategic Plan 2002 - 2004

Enrolment in the capital of Honiara dropped in 2000-2001, which was said to be the result of families moving out of Honiara to the provinces for security reasons. Despite the overall growth in enrolment, many children between the ages of 5 and 15 are not attending school. There were approximately 33,650 in 1999; 39,530 in 2000 (due to the outbreak of the ethnic conflict resulting in family displacement some schools closed); 33,950 in 2001 and; 34,640 in 2002.

Table 16:1999 Attendance at school x province x age group 5 – 14 yrs x by sex

Province	% Enrolment			Province	% Enrolment		
	Total	M	**F**		**Total**	**M**	**F**
Malaita	48.9	50.1	47.5	Temotu	63.7	65.2	62.2
Honiara	73.0	73.1	72.9	Isabel	67.3	67.2	67.4
Guadalcanal	39.7	40.1	39.2	Choiseul	65.4	64.6	66.3
Western	68.9	67.7	70.2	Makira	67.2	67.0	67.3
Central	57.7	58.9	56.5	Renbel	74.9	74.9	74.8

Source: Ministry of Education 2000

In 1999, there were more males than females attending school in all provinces (see Table 16). However, when the data is analysed in percentage of gender attending school (number of girls attending school/total number of girls in this age group x 100), the following emerges:

- In Western and Choiseul provinces a larger percentage of girls than boys were attending school;

- In Isabel, Rennell-Bellona (Renbel), Guadalcanal and Makira-Ulawa (Makira) provinces and Honiara, approximately equal percentages of boys and girls attended school.
- In Central, Malaita and Temotu provinces a smaller percentage of girls than boys attended school.

There was also variance between provinces in single age group. For example, the percentage of 10-year girls attending school was higher than 80% in Isabel, Choiseul, Western and Renbel provinces, while about 75% was found in Makira and Temotu provinces. Less than 70% of 10-year old girls attended school in Central province and less than 60% in Malaita and less than 50% in Guadalcanal (see Table 16). While this is encouraging, more attention is needed to further improve female school relative to the total population.

Table 17: Secondary Enrolment by three year period, by sex and Provinces

Province	Secondary Enrolment						
	1999	M	F	2000/2001 (sex grouping not available)	2002	M	F
Choiseul	626.	353	273	1001	941	471	470
Western	2219	1208	1011	3880	3760	2032	1728
Isabel	991	561	430	1370	1341	732	609
Central	606	396	210	925	546	312	234
Renbel	75	54	21	55	115	75	40
Guadalcanal	1794	1060	734	2837	2831	1704	1127
Malaita	3720	2264	1456	4910	4540	2609	1931
Makira-Ulawa	1017	600	417	2427	2426	1419	1007
Temotu	559	314	245	800	769	454	315
Honiara	4703	2809	1894	4812	4346	2549	1797
Total	16310	9619	6691	23117	21615	12357	9258

It is a matter of high priority for the Ministry of Education to incorporate activities within other programmes and special programmes to achieve gender equity in access to basic education by 2005.

Table 18: Primary Enrolment in Grade 6 (End of Primary Education

Province	**Primary Enrolment in Grade 6 (end of primary schooling)**						
	1999	**M**	**F**	2000	M	**F**	2002
Choiseul	384	212	172	595	292	303	524
Western	1210	654	556	1191	628	563	1395
Isabel	351	177	174	511	255	256	539
Central	405	238	167	350	211	139	413
Renbel	48	31	17	62	31	31	61
Guadalcanal	784	438	346	1023	558	465	1130
Malaita	1896	1032	866	2194	1267	927	1942
Makira/Ulawa	670	383	287	868	456	412	902
Temotu	396	230	166	554	320	234	502
Honiara	802	429	373	864	452	412	851
Total	6946	3824	3122	8212	4470	3742	8259

Source: Ministry of Education, 2000

Data for school enrolments in 2001 is not available. The school enrolments for 2000 and 2002 for Preparatory – Standard 6 indicate a negligible difference (see Table 19). This is illustrated by the Standard 6 enrolment in 2000, which was 10.6% of the total primary enrolment in 2002 it was 10.1% (see Table 19). Statistics show higher enrolments in the early primary levels, which decrease in the higher grades. There is a further decrease with the progression into secondary enrolments, (see Table 20).

Table 19: Primary Enrolment in Grades Prep. To 6

Year	Prep	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5	Grade 6	Total
2000	13,112	11,394	10382	9,782	9,060	8,524	8,212	70,476
2002	15,825	13,756	12,225	11,810	10,659	9,550	8,259	82,084

Source: Ministry of Education, 2002

Table 20: Secondary Enrolment in Forms 1 - 7

Year	Form 1	Form 2	Form 3	Form 4	Form 5	Form 6	Form 7	Total
2000	5,699	5,458	4,539	2,910	2,367	554	88	21,615
2002	3,766	3,473	3,058	1,781	1.201	231	53	13,527

Source: Ministry of Education, 2002

There has not been any specific statistical data collection done for dropouts, repetition and retention for any level of education. However, the declining enrolment in the higher grades could reflect some dropouts, repetition or retention. There is need for a thorough study to be undertaken in these areas.

The drop-out rate in the progression from Standard 6 to Form 1 remains a concern despite the establishment and expansion of Community High Schools. The absence of data on the 2001 Form 1 enrolment eliminates the ability to determine the exact number of pupils that dropped out of the school system at Standard 6 at the end of 2000. However, those selected to go to secondary schools in 2000 would have been in Form 2 in 2002 and the total enrolment for 2002 had dropped from the Standard 6 enrolment in 2000 by 42.9% (see Table 19). While it could be assumed that some children did not return to school at the end of Form 1 in 2001 it would also seem likely that the bulk comprised of the dropouts in Standard 6 at 2000.

The Ministry of Education's Strategic Plan includes identifying the needs of 10–19 years of age who had been pushed out of the formal education to re-enter the system or to progress along alternate education and training programmes such as the non-formal education.

7.3 Teachers

The ratio teacher per children is not accurately known. Recent studies provide a range of teacher numbers from 3100 to 3700. The 2001 primary teacher payroll lists 2920 teachers; of that number 2665 are being paid. The secondary school payroll for teachers has 1104 listed and currently 986 are being paid (see Table 22).

Table 21: Teachers in Primary and Secondary Education

	Trained teachers	Untrained teachers	Total
Primary	2150-2200	480-500	2630-2700
Secondary	650-700	150-170	800-870
Total	2800-2900	630-670	3430-3570

Source: Ministry of Education Strategic Plan 2002 - 2004

Table 22: School Staff of Primary and Secondary Education

Category of Paid teachers	Primary	Secondary
Classroom teachers	935	604*
Probationers	119	90
Untrained teachers	164	16
Head teachers/principals	63	24
Unspecified	1384	252
Total	2665	986

* includes executive positions

The total of 2665 primary teachers if divided amongst the estimated primary school enrolment of 77,188 in 2001 this would give the ratio of approximately one teacher to 29 pupils. The ratio of a trained teacher (average total of 2155) per child would be 1:36. Trained teachers are not equitably distributed between provinces, but this has not been quantified. Variations in median class sizes and the practice of 'attaching' teachers to schools in excess of establishment numbers provide evidence of surplus capacity in particular areas. The Ministry of Education aims to achieve an average of one trained teacher for every class of 30 to 35 pupils. However, mean class size reported by surveyed schools in 2000 indicates that it is significantly less than this, and declines between Preparatory and Standard 6.

Table 23: Primary Class Size, 2000 Survey by Provinces

Province	Schools Survey	Mean Class Size						
		Prep	1	2	3	4	5	6
Choiseul	40	13	13	12	12	11	9	11
Western	71	20	20	18	17	17	15	17
Isabel	16	30	25	23	23	28	23	18
Central	21	29	22	17	18	14	14	12
Renbel	9	19	14	11	9	9	10	9
Guadalcanal	16	36	27	23	20	21	17	15
Malaita	62	37	29	26	24	19	20	16
Makira	48	14	15	17	14	15	14	12
Temotu	30	20	18	15	17	19	14	18
Honiara	5	34	27	30	31	36	29	27
Total	318	24	21	19	18	17	16	15

The national average enrolment per school is 126 pupils. It is useful to understand that there is a wide range in mean school enrolments, with a number of very small and very large schools in each province. There are also variances between provinces as to the mean size of each school, with the mean school enrolment in Honiara, Malaita, Guadalcanal and Isabel being higher than the national average. Data from a survey of

318 primary schools conducted in late 2000 serves to illustrate this trend and is presented in Table 24.

Table 24: Mean Primary School Enrolment, 2000

Province	Schools Surveyed	Enrolments	
		Total	Mean/School
Choiseul	40	3224	81
Western	71	8576	121
Isabel	16	2411	151
Central	21	2643	126
Renbel	9	566	63
Guadalcanal	16	2421	151
Malaita	62	10615	171
Makira	48	4803	100
Temotu	30	3603	120
Honiara	5	949	190
Total	318	39811	125

The data reflects various factors for non-attendance at school for many children including; remote and scattered community settlements; schools established by different churches for own their church affiliated communities regardless of the size of the communities relative to the population of the province. The data suggests a means to reduce costs might be achieved through the merger of some smaller schools to enable larger classes, with one trained teacher and a full class of 30–35 pupils. That is six primary grades, each with 30 pupils per grade, providing a school population of 180. It has also been recommended that there is a need for local level planning to ensure equitable access within provinces and at the national level. In addition, good coordination is needed to ensure that children in one province gains advantages over other provinces or visa-versa. The adoption of multi-grade teaching would allow classes to be amalgamated and thereby reduce the number or trained or untrained teaches in smaller schools.

7.4 Boarding Schools

The limited number of boarding schools contributes to the inequitable access to education within provinces. All 9 National Secondary Schools and 15 Provincial Secondary Schools and 19 Community High Schools are boarding schools while some Community High Schools provide only limited boarding for primary school children. Actual number of such Community High Schools providing boarding for primary aged students is not quantified. The total number of boarding secondary students in 2002 was 12,384 with a mean boarding school size of 288 and represented 59.4 % of the total secondary enrolment in 2002.

Table 25: Boarding Secondary Schools in 2002

Province	No. of Boarding Schools				Total Boarding
	NSS	PSS	CHS	Total	
Guadalcanal	4	3	1	8	3,142
Makira	2	1	5	8	1,946
Renbel	0	1	0	1	90
Temotu	0	1	0	1	403
Malaita	1	3	0	4	1,790
Central	0	1	0	1	108
Western	2	2	9	13	3,094
Choiseul	0	1	1	2	471
Isabel	0	2	3	5	1,340
Total	9	15	19	43	12, 384

Source: Ministry of Education 2002

There is a significant under-representation of women in both primary and secondary teaching. In addition, the findings of a survey in late 2000 revealed that there were fewer untrained female teachers than male teachers especially in Community High Schools with 32% untrained female teachers and 68% males. While male untrained teachers are far greater than female, overall the latter are under-represented in the education service but over-represented in the untrained category.

8. Adolescent Health Situation

8.1 Family Planning

Overall family planning within population of women of child-bearing age is very low. People still do not understand the benefits of family planning. Misconceptions about family planning with religious and cultural norms preventing people from making informed choices. This is despite the fact that various methods of contraceptive may be available at a health facility.

Ministry of Health reports indicate a downward trend in family planning coverage rate between the years 1997-2000. In 1998 the national coverage rate was 10.5%, 9.2% in 1999 and 6.7% in 2000. The likely reason for the decline is the reduction in family services.

8.2 Teenage Deliveries and Single Mother Deliveries*

Health information on teenage pregnancies [*less than 18 years] and single mother [unmarried teens and young women] are under reported and incomplete, this is an area where the Reproductive and Child Health Division is endeavouring to improve its collection of relevant data through the health system, which will assist in being responsive to needs as they arise. From preliminary data received from the provincial health services, Choiseul province as an example, in 1998 had 7% of its total deliveries as teenage pregnancies and 17.5% as single mothers. In 1999 4.5% of the babies born were teenage deliveries and 13.5% single mothers. This is the similar trend with other

provinces. Some provinces may have a higher rate. Adding both figures for teenage and single deliveries implies that many babies are unplanned or unwanted, which places high risks on both mother and child. According to the national census about 5.4% of women at child bearing age gave birth to their first baby at or less than 19 years.

Recent studies on Sexual Transmitted Infections [STIs] indicate that young people are participating in unsafe sexual practices at an early age. The most recent study on "Situational Analysis of STI & HIV in the Solomon Islands" was conducted in 1999. Some of the relevant findings highlighting the issues needing to be addressed are as follows:

- Extramarital and premarital sex occurring at a high level.
- Increase use of alcohol and marijuana among young people. A lack of condom use is linked with the alcohol consumption.
- Lack of economic opportunities.
- Awareness on the use of condom could be high but young people still do not protect themselves.
- Young people are aware that treatment is available for STIs therefore are not concerned about contracting an infection.
- Only a few young people know that HIV/AIDS can be prevented by the use of condom. This indicates the lack of knowledge of HIV/AIDS and the risk of unprotected sex among young people.
- Girls are unable to negotiate safe sex with male partners.

A report from a Honiara Town Council clinic produced in 1996 highlighted the seriousness of the problem of unprotected sex and STI's amongst young people. In that year 75% of all STI patients were young people. In 1998, 87% of all recorded STI cases that were treated were between the ages of 15-30 years. High levels of STIs among youths and increasing teenage pregnancies are indicators of unprotected sex as well as indicators of levels of sexual activity. Bursle et. al [1998] surveyed teenagers who were sexually active found that 42% of girls had more than one partner and 81% of boys had more than one partner and 51% of the males had more than 5 partners.

Sexually Transmitted Infections such as syphilis and gonorrhoea are increasing each year. The increase in the number of reported cases of STIs is worrying as it is an indicator for the presence of HIV. More worrying is a report from recent Adolescent Reproductive Health Media workshop that younger children are now experimenting with sex and their level of knowledge on STIs/HIV/AIDS is minimal.

Reproductive and Child Health Division reports that it is only in recent years that the Ministry of Health in partnership with partner NGOs such as the Save the Children Australia, Solomon Islands Planned Parenthood Association, and Family Support Centre has taken greater interest in advocating preventive measures and initiatives in the areas of adolescent reproductive and sexual health. NGOs on the other hand have

been attempting to address these issues long before the government considered this a major health issue.

A regional Adolescent Reproductive Health Project [2000-2003] is currently being implemented in Solomon Islands. It is funded by the United Nations Population Fund and executed by the Secretariat of the Pacific Community [SPC], Solomon Islands is one of the 9 project countries. Project activities are being co-ordinated from a project office in the country. The major aims of the project is to raise awareness on issues relating to adolescent reproductive health, sexuality and life skills and to empower young people to make informed choices about their sexual lives. Its project strategies are categorised in 4 components i.e. school-based programme, out of school programme, mobilising religious support and participation and development of a multi-media approach to facilitate the delivery of information, education and communication {IEC} activities. The project has concluded a number of training workshops for various stakeholders including youth leaders, peer group training.

9 Abuse and Neglect of Children

Section E.6 of the Convention on the Rights of the Child Initial Report on Solomon Islands presents an overview of the legal context and the general situation regarding forms of abuse and neglect of children in the country. Child and women abuse has been an increasing phenomenon throughout the country and it is as recent as the late 1990s that it became a growing concern that measures have been taken since then to address it. The Family Support Centre has carried out awareness training workshops for targeted clients on the rights of women and children and the negative consequences of violence and abuses. Family Support Centre offers counselling and legal assistance to victims of violence and abuse, in most instances this is women and children. Domestic violence and child abuse are the major issues that people have sought either legal assistance or counselling (see Table 27).

According to the Family Support Centre, the situation has worsened since the crisis in 2000. Many family units have broken down leaving children as the victims of neglect and abuse, much of which has gone unreported nor could it be backed by hard evidence. The social unrest weakened the institutional links between relevant authorities dealing with violence, abuse and neglect cases. The lack of resources of the Family Support Centre hindered more effective approaches to addressing these issues.

While a number of people in the country are now aware of the negative impact of violence and abuse of children (13,200 people directly benefited from awareness training workshops with further training planned in rural areas) the lack of effective mechanisms to deal with situations involving domestic violence and child abuse leaves women and children vulnerable to ongoing abuse.

Table 27: Counselling and Legal services offered at the FSC from 1997 – February 2000

Year	No. of clients for counselling	Types of problems addressed	No. of clients for legal assistance	Types of legal assistance sought	Total number of clients for both counselling and legal services
1997	29 (2 males)	Domestic Violence (DV) and relationship problems	42	Child sexual abuse, child physical abuse	71
1998	117 (9males)	DV (28), sexual abuse (9), family relationships (36) (8 couples), child abuse (28)	116	DV (59), Ca (38), sex discrimination at work and sexual harassment (4), legal separation on cases of DV	233
1999 Feb.2000	29 (3 males)	DV, Child Abuse (CA), marriage break-ups	97	Legal service (31), legal representations in courts (66)	116
Total	175		255		430

Source: Family Support Centre Evaluation Report, 2000

10. Children In Conflict with the Law

Statistical data available on juvenile offences is very scant and does not provide locations of crimes committed, period of sentences/detention, suspended sentences and other vital information that would comprehensively reflect situation of children committing crimes. Table 28 presents some information, which is quite useful, albeit limited, in gaining and insight into the extent of involvement of children engaging in criminal activities.

In 2002 there was a significant increase in crimes committed by juveniles although detention cases were fewer than those reported. This increase reflects the pressure on people including children have been put under as a result of the adverse effects of the social and economic unrest. Although the total juvenile offences is showing as only 5% of the total crimes committed in the country in 2000, it nevertheless poses a serious situation that needs urgent attention to curtail a further escalation of crimes committed by juveniles. Due to the deteriorating law and order situation in the country, many crimes are not being reported and therefore a threat to future sustainable peace in Solomon Islands.

Table 28: A Four-Year Frequency Distribution of Juvenile Offenders by Age Group

1999	Reported	Convicted	M	F	Age	Detained
Crime against person	28	15	15		13 to 15	7
Crime against property	17	5	5		12 to 14	3
Murder						
Crime against public order	22	12	12	2	12 to 16	

Total	**67**	**32**	**30**	**2**		**10**
2000						
Crime against person	16	8	8		12 to 16	
Crime against property	32	17	17		13 to 15	
Murder	Nil					
Crime against public order	43	18	18	16	16 yrs	17
Total	**91**	**43**	**43**	**16**		**17**
2001						
Crime against person	17	9	9		15 yrs	
Crime against property	25	5	5		15 to 17	
Murder	Nil					
Crime against public order	35	15	15		15 to 16	
Total	**77**	**29**	**29**			
2002						
Person	45	35	19	7	14-18 yrs	19
Property	55	30	20	17	14-16 yrs	8
Murder	13	4	2		17-18 yrs	2
Public Order	121	76	56	3	13-18	79
Total	**236**	**145**	**97**	**27**		**106**

Source: Solomon Islands Police Headquarter, Honiara, 2002

11. Child Labour

According to the 1999 national census , out of the total population in paid work in Solomon Islands approximately 7% of this figure were aged between 14-19 years, the majority of whom were engaged under category – skilled agriculture and fisheries. However, there were more children in this age group that were engaged in unpaid work or were in the informal sector, such as unskilled agriculture, fishing and hunting, craft and community work. This group would account for about 14% out of the total unpaid workers of 14 years and over with 51% being females. The same age groups constituted 15% of the total of both paid and unpaid work, 58% were females. Out of the total unemployed of 27,652 just over 20% were aged between 14 and 19 years (see Table 29). There were more males than females in this category.

Table 29: Population 14-19 years, by activity status in paid and unpaid work

Age Group	Employed in paid work	Unemployed (seeking paid work	Not active in paid work	Paid work status not stated
Solomon Islands	57,472	27,652	161,223	2,821
14	261	568	1,732	195
15-19	3,855	5,080	36,169	717
Total	4,116	5,648	37,901	912

Source, SIG National Census, 1999

Table 29 highlights the activity status for people 14 years and over in the labour force in 1999 compared to the age group 14–19 years to reflect the situation of children in the formal employment sector.

Table 30: Population 14 – 29 years, by employment status

Employment Status for persons working for pay								
Age Group	Total	Self-employe	Waged Labour	Family help	Contract labour	Other	Not stated	Not employed but looking for work
Solomon Is.	85,124	19,625	30,366	2,403	3,507	738	833	27,652
14	261	130	67	28	23	6	7	568
14 –19	3,855	1,471	1,573	342	332	71	66	5,080
20 – 24	9,605	2,645	5,672	413	624	103	148	6,395
25 - 29	11,212	3,096	6,795	386	646	123	166	4,717

Source: SIG National Census, 1999

Section H.4, 4.1 of the Initial Report on Convention on the Rights of the Child covers the legislation regarding child labour, which prohibits children less than 12 years to be employed. There is still no statistical data available on children under 12 years being employed. The law also prohibits children of a certain age to be engaged to work in certain work environments. It is a common practice in Solomon Islands society for children to help out with family or domestic work. However, there is anecdotal evidence that children have been over worked within the domestic sphere. This needs to be addressed to ensure that child exploitation in the domestic work is curtailed. The labour inspection division of the government has not been effective in monitoring general working conditions, which includes the use of child labour. This inability to carry out this duty has been due to lack of appropriate infrastructure to carry inspections. It has been worsened by the current low morale of public officers and the non-payment of their salaries.

The size of the labour force by 1999 indicated in Tables 29 and 30 has greatly reduced in recent times as a result of the closure of large companies. This in turn led to closure of a substantial number of small businesses. Young people, who are permitted by law to work, are out of jobs as they were the first to be made redundant as a result of cost-cutting measures taken by employers in the face of the economic crisis.

In relation to child prostitution, there have not been any organised studies on the topic in Solomon Islands. However, a case cited in a number reports involved two Australians having a sexual relationship with a boy child from the Western Province. They took the boy back to Australia with the consent of the parents. The parents believe that they were deceived by the generous treatment from the expatriates and did not fully appreciate the situation. Street talk also indicates that girls as young as nine were used to provide service to militants at the height of the ethnic tension. Further information would be forthcoming from an in-depth study.

C. General Measures of Implementation

1. Measures Taken to Harmonise National Law with the Convention

Since the ethnic crisis children's issues have been put onto the "backburner" and not given priority at policy and decision-making levels. Currently the government is doing little or nothing to promote the Convention on the Rights of the Child. This issue is considered by the government as subordinate to issue of law and order. Consequently, efforts to harmonise domestic laws with the Convention have ground to a halt. This situation has been further exacerbated by the chair of the Law Reform Commission taking up an appointment with the judiciary. To date the office exists in name only. Laws requiring reform have been left alone and with them is the work that had been done on the Convention.

In 2001 key government ministries including, the Ministries of Health and Medical Services (MHMS), Education and Human Resource Development (MEHRD), Youth, Women and Sports (MYWS) and the Attorney General's Chamber (AGC) became involved in working on moving the government forward on its implementation of the CRC. The AGC allocated an attorney to take on the role of chair of the Child Protection sub-committee, which is currently revising the Child Rights Bill. It is anticipated that further work on the Bill will take place during 2003. Until this Bill is enacted, the Convention on the Rights of the Child may not be directly invoked before the courts.

2. Mechanisms for Coordination of Policies and Programmes Related to the CRC Implementation

Government mechanisms and non government organisations (NGOs) are linked to the Convention's implementation through the National Advisory Committee on Children (NACC). The draft of the 'Solomon Islands Policy, Strategy and Plan of Action for Children' has yet to be endorsed by Cabinet and is in urgent need of updating. This process of approval was disrupted by changes in portfolio arrangements by successive governments and the uncertainties created in relation to the lead Ministry responsible for children affairs. Positive steps have been taken place since 2001and the executive head of the MYWS assumed the chair of the NACC. In addition an officer has been successfully recruited for to the position of Child Desk to exclusively deal with children affairs. The Child Desk took up this position at the beginning in January 2003. This step was made possible with the assistance of the New Zealand Aid (NZAID), Save the Children Australia (SCA) and UNICEF.

While positive developments are encouraging there remains an absence of political will on the part of the government, which is reflected in the abolishing of the Ministry responsible for children. This occurred in August 2002 just three months after the ratification of CEDAW in April 2002. The portfolio of women, youth, children and sports became a function within a Division of the Ministry of Home Affairs (MHA). Assurances from the Structural Adjustment Ministry and the Policy and Evaluation Unit of the Prime Minister's Office (PMO) that the move is only a temporary policy re-direction in the light of the overall efforts in economic recovery and to maintain law and order, is not

sufficient to guarantee the re-prioritisation of women, children and youth matters. These groups have been the most vulnerable and most affected by the crisis and the disbanding of the Ministry responsible is only a regressing step.

At this point, the government relies heavily on donor agencies (mainly AusAID, JICA, European Union and NZAID) to provide social services particularly in health and education. It also relies on the NGOs community to provide additional social services. Such NGOs include the Family Support Centre for matters in family violence and neglect (an increasing trend as a result of the crisis), basic counselling services, community awareness raising and advocacy, training, Solomon Islands Red Cross (services for the disabled, humanitarian assistance in times of emergencies and emergency planning), Solomon Islands Development Trust (broad community development assistance programmes), Solomon Islands Christian Association (education for health issues, youth activities, advocacy), Save the Children Australia (youth programming, reproductive health services, peer counselling, child rights advocacy), Oxfam (community development in education and health), World Vision (community development that also focuses on children), individual churches (youth rehabilitation especially child soldiers and drug abusers). Several international organisations are also carrying out programmes that impact on women and children in the country without interference from the government.

Government non-interference in NGOs programmes is seen as an advantage through their ability to reach a wide audience and out into rural areas. NGOs such as Save the Children Australia are providing technical and moral support to the Child Desk Officer and to the NACC. To this end a week long workshop for NGOs and government officials on the CRC was hosted by Save the Children Australia in March 2003. It is generally agreed that there is insufficient resources for the work that needs to be done. Further weaknesses that exist are limited opportunities for local capacity building, law and order issues and effective coordinating mechanisms. Even the various NGOs programmes lack proper coordination resulting in duplication of activities that could have saved much needed resources for equitable distribution of services throughout the country.

3 National Advisory Committee on Children

NACC is the only official body that monitors and advocates for children's rights. NACC's terms of reference and representation/members is as at Annex 1 of the Update on the Initial Report on Solomon Islands. Apart from Ministry of Health and Medical Services' representatives, other members particularly those representing relevant government ministries have been quite inactive not only in meeting attendance but also in contributing to implementing and monitoring relevant provisions of the CRC. The revision of the NACC terms of reference does allow for the involvement in monitoring and evaluation of children issues including advocating on local and national government levels. Unlike other countries, the Ombudsman office in Solomon Islands is constitutionally limited to investigate into children issues.

Since the establishment of the NACC, Save the Children Australia has been providing the secretariat role. Although the government is required to provide the chair of the committee to reflect its position as a key stakeholder and the government commitment to the CRC, Save the Children Australia has been one of the main campaigners for the implementation of the CRC by the Government of Solomon Islands. It has worked closely with the NACC and other stakeholders to ensure all tasks and responsibilities are carried out in a timely manner.

Presently, there is no accessible means for children to lodge complaints outside of the culturally established extended family system and traditional church counselling. Continuing efforts by the Family Support Centre to train community members to assist children in difficult circumstances have been hampered by limited financial resource and short term funding of Family Support Centre specialist staff such as the expatriate Counsellor/trainer and legal Adviser/trainer. The lack of local specialists in handling child abuse claims and cases is a problem. Counsellor training carried out by Family Support Centre for a few individuals was inadequate to develop confidence and commitment in the recipients to begin counselling work. Training sessions were usually too short to enable participants to grasp the complexities of the issues of domestic violence, sexual and child abuse. Furthermore, the implication of introducing new Western methods of healing to a society such as Solomon Islands is at odds with the traditional practices such as family, village elders and church counselling.

The abovementioned issues place constraints on the services provided by Family Support Centre and also serve to highlight the difficulties of the implementing of the CRC. These issues were brought to the attention of the 1999 Child Protection Conference (co-sponsored by UNICEF). Suggestions made to help address these issues included strengthening of the Division of Social welfare, review of the existing law structures, and research into the definition of child abuse in the Solomon Islands context. Some of these issues have been included in the draft Protection of the Rights of the Child Bill. Part III of the Bill provides for the protection of the child by stipulating a procedure for lodging and investigating of child abuse and child neglect cases. In addition, it outlines a procedure for instituting court proceedings on such cases. It is important therefore, that effective networking by relevant authorities in dealing with children cases is established.

The NACC has developed a programme of activities it plans to carry out in 2003. The programme focuses mainly on finalising the National Children Policy and a National Plan of Action as well as advocacy and raising awareness on the CRC. Such advocacy programmes include nominating a Children's National Day, exploring possibilities of a children's park and production of Children's Peace Album. The document can be obtained at the Save the Children Australia and the Children's Division of the Ministry of Home Affairs.

4 Cooperation between Government and Non-Government Institutions on Design and Implementation of Policies and Programmes Related to Children

The multi-sectoral membership of NACC comprising government ministries and NGOs including church organisations represented by the Solomon Islands Church Association is the first positive sign of local cooperation on matters related to children. The practice of having the executive officer of the ministry responsible for women and implicitly for children as well as the appointment for the first time of a desk officer for children affairs within the Ministry reflect the importance accorded to children by the government. Nevertheless, the recent abolishing of the Ministry in late 2002 begs the question of just how important the government does view children's affairs. Furthermore, most representatives of government ministries in the NACC, particularly representatives of ministries responsible for developmental areas, are inactive members. This is a hindering factor to mainstreaming CRC provisions into national policies and national plan of actions and calls to question the level of cooperation that will be forthcoming.

Good cooperation between government ministries is absent especially at these times of social and economic crisis in the country with a demoralised public service. Unless economic recovery is achieved and financial resources available as well as full restoration of law and order there is little hope that the establishment of the children's desk officer will improve the current situation. There is opportunity, however, for the desk to assist in increasing the present level of cooperation between active representatives of government ministries and NGOs and in ensuring the civil society is actively involved in children related programmes. The present institutional arrangement of the Government Desk Officer for Children being physically located to the Save the Children Australia office is a reflection of the significant position and role the latter has been holding and performing in ensuring Solomon Islands meets its obligations as a party to the CRC.

4.1 Institutional Cooperation in Health Service

Government is the main provider of health services, which is provided free. The health system is a referral system with five different levels of health facilities. It is through this system that programmes relating to reproductive and child health are provided.

At the top is the central hospital, which is the National Referral Hospital based in Honiara, followed by seven provincial hospitals, two mini-hospitals, 23 Area health centres, 95 Rural Health Clinics, 129 Nurse Aide Posts and 154 Village Health worker posts [Report*: Current Health care system In SI/ Ministry of Health 2002].*

Besides the government, non-government organisations, mostly churches, also run some of the health facilities. Figures for 1999 indicate that out of total seven hospitals two are run by the church, one mini-hospital is church/community based, 15 Rural Health Clinics are run by churches, six Rural Health Clinics [others] five Nurse Aide

Posts [church] five Nurse Aide Posts [others] 13 Village Health Workers [church] 14 Village Health Workers [others].

Village Health and Nurse Aide Posts provide the very basic health service. Rural health clinics are the next line above the baseline services. These three levels of the system are where majority of the rural population access health care. Basic maternal services such as antenatal care, delivery, postnatal, family planning and basic health education are provided in varying degrees in Nurse Aide Posts, Rural Health Clinics and Area Health Centres. The area health centres are the first line of referral for more complicated and curative health care. Provincial hospitals provide paediatric, surgical and maternity services plus a level of para-medical services. Specialist service for the entire country is provided only at the National Referral Hospital, which currently has a bed capacity of 285 beds [*[UNDP Human Development Report 2002].*

Access to health services was reported to have improved based on 1996 figures when it was reported that over 70% were within walking distance to the nearest health facility. How ever access is also determined by other factor such as the availability of drugs and medical equipment and even the educational level of communities.

The Ministry of Health has reported that in the period 1999–2002, due to the delay of provincial grants some Nurse Aide workers were laid off resulting in closure of Nurse Aide Posts. Parts of Guadalcanal and Malaita were severely disrupted and some Rural Health Clinics were almost non-functioning due to lack of medical supplies. A number of Nurse Aide Posts were downgraded to Village Health Worker level. Quality of health services was affected with the suspensions of many health care services. This has reflected in the decline in immunisation coverage, family planning and antenatal care etc.

In the years 2000-2002, under a Community Peace and Restoration Funds Project, funded by the Australian Government Humanitarian Relief funds were provided to assist in the basic renovation of clinics throughout the country. In 2000 approximately SBD800,000.00 was spent on basic maintenance, renovations and rehabilitation of clinics and nurse aids posts.

The backbone of the health-service rests on the nurses. In 1999 there were a total of 495 nurses; over 300 Nurse Aides [this could have been lower due to redundancies. There were a total of 69 doctors registered under the Medical Board, 127 Village Health workers, 162 Malaria technicians and 30 health educators. Nurse-per population ratio varies between provinces. In some provinces it is one per 300 population and others one per 500 populations. The national level doctor-per population in 1999 was reported to be as high as one per 9,500 besides there was large variance between provinces.

4.2 Non Government Organisations Promoting Health.

A number of NGOs in Solomon Islands are active in promoting, enhancing, or providing health services. The main organisations are Solomon Islands Red Cross Society, Solomon Islands Development Trust, Disabled People Rehabilitation Association, Solomon Islands Planned Parenthood Association and Save the Children Australia.

The scope and range of services and activities provided by these organisations vary widely and include the following:

- family health and family planning programmes,
- education programmes through formal health education and drama groups
- assistance in personnel health
- health surveys
- financing and production of health materials

The organisations contribute greatly to the achievement of improved health for people of Solomon Islands. Their role is vital in capacity building, training villagers and channelling health education and development programmes to the grassroots.

Part II

Translation of the Convention on the Rights of Child

The official language of Solomon Islands is English as derived from the colonial days of the British Empire. To date there is no translation of the CRC into the national or local languages. Some translations were done on various advocacy materials and publications. NACC is looking into translating the CRC into Pidgin (Solomon Islands) using the Papua New Guinea model.

Part III

1 New Bills or Enacted legislations

Listed below are new legislation enactment and new bills related to children:

- Amendment to the Birth and Death Registration Act in 1998 providing for the Minister to make regulations
- Amendment to the Citizenship Act providing for equal duration of 10 years of residence for males and females before eligible for acquiring citizenship.
- Amendment to the Islanders Divorce (Cap 48)
- Child Rights Bill 2003

2 New Institutions and Institutional Arrangements

- Newly appointed Desk Officer for Children Affairs. However, government recent institutional re-arrangement had resulted in the abolishing of the lead Ministry responsible for children, MWYS, in August 2002. It is now a functional division of the Ministry of Home Affairs.
- Assigning of an Attorney in the Attorney General's Office to children related matters.
- Non-Functioning of the Law Reform Commission
- Ministry of Structural Adjustment that recommended the abolishing of MWYS.
- Ministry of Peace and Reconciliation.
- Policy and Evaluation Unit of PMO.
- Voice of Mere disseminating information on women, National Committee for Women.
- Don Bosco Non-Formal Education
- National Training Board
- Reestablishment of School Boards and Management
- Education Executive Leadership Group to improve communication between Ministry of Education authorities

3. New Policies

- National Women Policy
- National Youth Policy
- Non-Formal Education Policy
- National Training Policy

3.1 Major Health Policies to Address Children's Health and Welfare

Major health policy directions of the Ministry of Health as stipulated in its 1999-2003 National Policy and Development plans are:

- Disease prevention, health promotion and primary health care focus
- Improving health sector management and supervision
- Making more efficient use of existing health care resources and services
- Developing the skills and capacity of health sector staff
- Reducing morbidity and mortality in key health problem areas
- Improving reproductive, maternal and child health
- Upgrading rural water supply, sanitation and health facilities
- Forming Health Development Partnership

[*Pikacha J. Reproductive Child Health Divisional Report 2002. Page 7]*

4. Newly Implemented Programmes and Projects

- National Women Plan of Action

- National Training Programme
- Technical and Vocational Education Programme
- Curriculum Review and Reform Programme
- Reestablishment of National Examination Board
- National Teacher Development Plan and Committee
- World Bank Fourth Education Project
- Secondary Teaching Upgrading programme
- STABEX '99 for restructuring and capacity building of the Ministry of Education.
- Provincial Education Plans
- Teaching Service handbook
- Training Seminars on school inspection for all teachers
- Teaching Service Register Review
- School Inspection Programme
- SICHE School of Education Building refurbishment and re-equipment Plan
- Recruitment of six more Curriculum Development Officers
- In-service programme to prepare teachers to deliver new materials
- Tightened security of examination system
- Primary School-based Assessment
- Tracer Study of Rural Training Centre and SICHE
- First National Skills Survey
- National Training Plan
- Structural reorganisation of SICHE
- SICHE Programme Plan
- Community awareness of the Education reform
- Financial Planning and Budgeting Procedures
- Database for Education programme monitoring
- Capacity building in Education Authorities
- National Education Strategic Plan
- Funding Formula to provide materials and replacement for basic and secondary education

4.1 Major Health Programmes to Address Children's Health

Six main programmes are coordinated and implemented by the Reproductive and Child Health Division of the Ministry of Health. These include Nutrition and Growth Monitoring [including breast feeding] and Baby Friendly Hospital Initiative, Expanded Programme on Immunisation, Control of Diarrhoeal Diseases, Acute Respiratory Infections, Family Planning, safe motherhood Initiatives and Adolescent Reproductive Health [ARH]. These programmes are currently run as vertical programmes, centrally coordinated at the headquarter level by the Division and with provincial coordinators at the provincial levels.

In 2001 the Ministry of Health introduced a strategy known as an “integrated management of child hood illnesses” [promoted by WHO] to address major health issues affecting children under 5 years of age. Using this approach it is envisaged that a number of programmes / services will be integrated into the overall health service delivery. Nurses or health-workers will be trained to screen, diagnose and treat or advise on all forms of childhood illnesses as presented at the health facility. It is envisaged that this will improve the quality of care given to children through better clinic assessment and also be an efficient use of health scarce resources. Initial series of facilitators training courses have been concluded regionally and locally. It will be a major redirection in service delivery once it becomes fully operational.

Another major development is the establishment of a national midwifery programme to meet the country’s need for qualified and competent midwives to provide high quality, safe motherhood services for women and children. The Advance Diploma in Nursing-Midwifery is run in collaboration with the Nursing school of Solomon Islands College of Higher Education. The programme has commenced in July 2001.

Since October 2002, a United Nations Volunteer/Medical Statistician has been assisting the division in developing its Reproductive and Child health information and data collection system. The system will be part of the National Health Information system, but will be addressing more specific data & indicators relating to the major reproductive & child health programmes. This will assist in the effective monitoring and evaluation of its programmes.

ANNEX 1.

Revised Organizational Structure

NATIONAL ADVISORY COMMITTEE ON CHILDREN (NACC)