D’HNET
H’TSANAT:
FOR THE WELFARE OF CHILDREN
UNICEF In Eritrea: Two Decades of Collaboration
FOREWORD

Eritrea is the second youngest country in the world, and its independence in 1991 was a well-deserved reward for the people who had fought a 30-year war to achieve their freedom. Eritrea is not well known, despite its location on the Red Sea, with a 1,200-km coastline facing Yemen and Saudi Arabia. Historically, the country has served as a meeting point, where Europeans, Africans and peoples of the Middle East and Asia all left their footprints. Eritrea was colonized by the Italians at the turn of the 20th century, and its graceful capital, Asmara, exhibits some of the world’s best examples of Art Deco architecture.

In addition to its cultural and ethnic heterogeneity, Eritrea also exemplifies religious heterogeneity and tolerance. One of the earliest countries to adopt Christianity, Eritrea was also home to the world’s first mosque, in the seaport town of Massawa.

Eritrea is a small and rural country, and more than three quarters of the population is engaged in agriculture or pastoralism. Located in the most arid part of Africa, the country is challenged by continuous cycles of drought. As a result, environmental sustainability and food security are national concerns.

Half of the country’s estimated 3.5 million people are children, and this is where UNICEF comes in. The Eritrean war of independence left behind a devastated infrastructure and thousands of orphaned children. The new Government of Eritrea invited UNICEF to become a partner as the country developed the systems and services that a modern state offers its citizens.

This publication aims to document this successful partnership. It provides a snapshot of UNICEF in Eritrea over the years and summarizes the work of all involved under the leadership of the Government of the State of Eritrea as it has pursued better lives for children and women. In that respect it is also a success story about Eritrea’s endeavour to realize the development and well-being of all its people.

Eritrea is doing its level best to achieve the Millennium Development Goals, which are also guiding the country’s national development efforts. The country has made spectacular progress on half the Goals - Goal 4 (child mortality), Goal 5 (maternal mortality), Goal 6 (HIV/AIDS, malaria and other diseases), and is on track to meet the target for access to safe drinking water (Goal 7). These successes have spurred the Government on as it addresses the challenges ahead.

No one underestimates those challenges. Yet Eritrea has a clear national vision of a country in which all children are happy, healthy and able to live their dreams. The history of Eritrea demonstrates that what may seem impossible IS possible – with dedication, passion and hard work. Given such a history, the future of Eritrea looks very promising.

Dr. Hamid El Bashir
UNICEF Eritrea Country Representative
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Since Eritrea’s independence and establishment of the UNICEF country office, the following donors have supported programmes on behalf of the children of Eritrea. We offer our deepest gratitude to all our donors over the past 20 years for their generosity.

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I
THE LONG
ROAD BACK:
1992 TO 1995

For the Welfare of Children
were getting the Eritrean officials to appreciate what we were doing. It was very important initially to identify strategic allies in the critical ministries. Once we had these allies and won their confidence, the rest was not so hard."

Six months after he arrived, UNICEF and Eritrea signed a Basic Cooperation Agreement. Slowly the office grew; by 1994, UNICEF had 24 staff members, including 4 internationals. Due to the shortage of people with skills and expertise, “I hired some people from the Government, with the government’s concurrence,” said Mr. Maeda. “You need people with technical competence but also credibility. It was a matter of getting the same people to deliver who knew it was their programme, involving their own people in developing the programme.”

DAUNTING CHALLENGES: THE SITUATION AT INDEPENDENCE

“During the years of the liberation war, the liberation movement demonstrated exemplary commitment to the protection of children and women,” noted Frontlines of a different struggle, a UNICEF publication from 1996. “It guaranteed expanded participation by women in politics, the economy and education as well as assertion of women’s equality in the family and in land/property ownership. It initiated a programme of care for orphaned and disadvantaged children, produced a school curriculum that inculcated assertiveness and self-expression, and specified threshold ages for marriage.”

In other words, even before Eritrea became an independent nation, it was working to ensure equitable treatment of its children and women. Over the next 20 years, this commitment to its most vulnerable citizens would produce impressive results as the country outpaced many of its richer and more developed neighbours in fulfilling the rights of children and women.

Having formally ratified the Convention, Eritrea now needed to ‘nationalize’ it – to develop a distinctive interpretation reflecting the national context – and determine how to make it a living tool for realizing child rights. For that purpose, a national workshop was held in December 1994. Among the 230 participants were delegates from various communities across the country, as well as government ministers and officials, the National Union of Eritrean Women and the Save the Children organizations from Norway, Sweden and the United Kingdom. Religious leaders also participated, coming together to make a joint declaration in support of the Convention.

The most significant participants were 30 children, before it was common for children to be involved in such conferences. They came from all corners of the country, and their participation was genuine. They influenced the country’s interpretation of the Convention and made recommendations on issues such as age of marriage, access to elementary school and the importance of fulfilling child rights in Eritrea’s villages and households.

With this workshop, Eritrea opened up a national dialogue on issues affecting children, including hunger, work, abuse, early marriage and FGM/C. It also reached agreement on the broad path forward. But with no infrastructure and no systems, it was impossible to know exactly what the situation was and what needed to be done. A good start is needed for a good finish, so UNICEF’s first priority was to develop a foundation of information.

“We invested a lot in baseline studies,” recalled Isiye Ndombi, Deputy Representative from 1993 to 1997. “People kept asking me why, and I said, ‘It’s very important to know where you’re starting so you can know where to go.’”
MAKING HOMES
FOR ERITREA’S CHILDREN

War doesn’t just kill fighters; it shatters families, traumatizes children and destroys communities. Around 8,600 children lost both parents in the independence fight, and more than 85,000 children lost one parent. The 30-year war provided Eritrean authorities with the tragic opportunity to become experts in caring for orphaned children.

“The fighters had to set up orphanages during the war, but they saw the bad effects on children so they started closing orphanages and created group homes,” said Baerbel Hoefers, a child protection specialist who would oversee UNICEF support for orphan reunification 10 years later. “The war created a unique unity among the people. They started working on traditional safety nets, which were fantastic in Eritrea.”

### Table 1

**Child Rights Challenges Around The Time Of Independence**

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHILDREN UNDER 5</strong></td>
<td>Infant mortality</td>
<td>72 per 1,000 live births</td>
</tr>
<tr>
<td></td>
<td>Under-five mortality</td>
<td>148 per 1,000 live births</td>
</tr>
<tr>
<td></td>
<td>Stunted (low height for age)</td>
<td>66 per cent</td>
</tr>
<tr>
<td></td>
<td>Underweight</td>
<td>44 per cent</td>
</tr>
<tr>
<td></td>
<td>Wasted (low weight for height)</td>
<td>10 per cent</td>
</tr>
<tr>
<td></td>
<td>Children fully immunized</td>
<td>14 per cent</td>
</tr>
<tr>
<td><strong>CHILDREN 9-11</strong></td>
<td>Iodine deficiency disorders</td>
<td>82 per cent</td>
</tr>
<tr>
<td><strong>WOMEN</strong></td>
<td>Maternal mortality</td>
<td>998 per 100,000 live births</td>
</tr>
<tr>
<td></td>
<td>Malnutrition (among those having given birth in the past 3 years)</td>
<td>41 per cent</td>
</tr>
<tr>
<td><strong>HIV AND AIDS</strong></td>
<td>Reported AIDS cases</td>
<td>4,177</td>
</tr>
<tr>
<td></td>
<td>Estimated HIV infections</td>
<td>40,000-60,000</td>
</tr>
<tr>
<td><strong>ACCESS TO SAFE WATER</strong></td>
<td>Rural areas</td>
<td>7 per cent</td>
</tr>
<tr>
<td></td>
<td>Urban areas</td>
<td>44 per cent</td>
</tr>
<tr>
<td></td>
<td>Per cent of households 1 km or more from any water source (safe or unsafe)</td>
<td>54 per cent</td>
</tr>
<tr>
<td><strong>ACCESS TO ADEQUATE SANITATION</strong></td>
<td>Rural households</td>
<td>Less than 1 per cent</td>
</tr>
<tr>
<td></td>
<td>Urban households</td>
<td>Less than 12 per cent</td>
</tr>
<tr>
<td><strong>ACCESS TO HEALTH SERVICES</strong></td>
<td>Access within 10 km of home</td>
<td>10 per cent</td>
</tr>
<tr>
<td><strong>ELEMENTARY SCHOOL ENROLMENT</strong></td>
<td>Children aged 7-11 (gross enrolment)</td>
<td>40 per cent</td>
</tr>
<tr>
<td></td>
<td>Estimated percentage of children starting school who complete five grades</td>
<td>25 per cent</td>
</tr>
<tr>
<td><strong>CHILDREN AT RISK</strong></td>
<td>Number of orphaned children</td>
<td>90,000</td>
</tr>
<tr>
<td></td>
<td>Prevalence of female genital mutilation/cutting</td>
<td>95 per cent</td>
</tr>
<tr>
<td></td>
<td>Children with disabilities</td>
<td>7,000</td>
</tr>
</tbody>
</table>
In safe water and sanitation: UNICEF supported the rebuilding of the water supply system in Keren, Eritrea’s second largest town, and of numerous boreholes and wells in rural areas. In addition 10 teams were trained to repair hand pumps and were equipped with tool kits and a three-year supply of spare parts. As preparation for activities planned during the upcoming five-year country programme, a knowledge, attitudes and practices survey was undertaken to provide a baseline for participatory hygiene education.

In education: Raising school enrolment and improving quality were the chief objectives of UNICEF assistance to the Ministry of Education during this period. UNICEF provided basic school supplies and logistical support, along with capacity development of Ministry of Education staff. In addition UNICEF supported the reconstruction of 19 primary schools in the deprived lowland regions of Southern and Northern Red Sea and Gash-Barka, a significant contribution to reducing geographic disparity in access to school. Curriculum reform and training of preschool teachers also received support. Girls had lower rates of enrolment than boys, so workshops were held to raise gender awareness among teachers. A coaching course was also established for potential female teacher trainees to raise the number of female teachers, so they could serve as role models and encourage girls’ education.

Box 1

Salt Iodization: From 0 To 98 Per Cent In Five Years

The iodine deficiency survey, completed in 1994, revealed that 82 per cent of children aged 9 to 11 were deficient in iodine – one of the highest levels in the world. Nationwide almost a quarter of the children had goitre, and girls, at 26 per cent, were worse off than boys, at 19 per cent. The reason for the deficiency became clear when the Eritrea Demographic and Health Survey was published: just 0.2 per cent of the population was consuming iodized salt.

In 1994 UNICEF began working with the Ministries of Health and Industry and Trade, and in 1995 the country officially pledged to achieve universal salt iodization. Nutrition Officer Yemane Kidane was one of the participants in the task force responsible for this initiative.

“In Eritrea, if one ministry believes in a certain aspect of innovation, they get support from other ministries,” he said. The Ministry of Health undertook surveys of iodine deficiency disorders (IDD), developed the IDD control strategy and coordinated the task force. It also advocated for consumption of iodized salt with everyone from salt producers to merchants to communities. The Ministry of Industry and Trade rehabilitated the iodization plants and trained the private producers to operate and maintain the equipment. The Eritrean Standards Institute monitored salt quality. UNICEF purchased the equipment and bought the chemicals, in addition to supporting capacity development of health workers and salt producers. By the end of 1995 two public salt works were inaugurated, in Massawa and Assab.

“One once they got the idea, these public salt production units became almost like extension agents, supporting the private units,” said Mr. Kidane. Change came harder for the private producers, who were reluctant to make the investment. “I remember two times we went to meet with private producers in Assab, along with high-level people – the Ministers of Health and Trade and Industry plus the administrator of Southern Red Sea region. It is almost 1,000 kilometres from Asmara, and this was at a time when there wasn’t even a gravel road. It took two or three days just to get there.”

The effort paid off. Just three years after the pledge to achieve universal salt iodization, by 1998 Eritrea was iodizing 98 per cent of the salt being sold in the country, while also exporting it to nearby countries. And the people were consuming the salt.

“The Ministry of Health included messages about using iodized salt with the vaccination campaigns twice a year, which had very high coverage throughout the country,” recalled Mr. Kidane. “That helped to sustain the high consumption, especially in the highlands, which had a high magnitude of iodine deficiency diseases.”
F ORGING AHEAD THROUGH PEACE AND WAR: 1996-2001
PUBLIC HEALTH
GOALS ARE UNIVERSAL

As the first five-year country programme of cooperation got under way, one of UNICEF’s main roles was to advocate with government officials for child-friendly policies and practices, particularly in health.

“In most cases there was no disagreement, because public health goals are universal,” said Dr. Ivan Camanor, Chief of Young Child Survival and Development from 1999 to 2003. “You cannot argue that measles is good for children. We all know that all children should be vaccinated.” The point, he added, is that UNICEF advocates for the issues and then, “You have to allow the Government to be in the driver’s seat, to make the decisions. The Government was very motivated, and there was a high level of integrity among health workers. There was a high level of transparency and trust; we did not have a problem working with the ministries.”

Given the poor state of the health infrastructure at independence, Eritrea adopted a strategy of providing broad access to primary health care and engaged in a colossal effort to build infrastructure. During this country programme, UNICEF assisted in building 10 new health facilities and upgrading the Asmara paediatric hospital to serve as the country’s training centre for Integrated Management of Childhood Illness (IMCI). Maternal and child health kits were provided for 80 health stations, 35 health centres and all 8 referral hospitals, and 3 ambulances were supplied for emergency maternal care. Supplies of essential drugs and immunizations expanded dramatically. As a result, access to health services increased from less than 10 per cent of the population in 1991 to 70 per cent in 1998. The number of doctors in the country more than doubled between 1991 and 1998, from 58 to 117, and the number of nurses more than tripled, from 228 to 720.

Training and other forms of capacity building have always been a hallmark of UNICEF programmes, but they were taken to new heights in Eritrea during this period. Three new maternal and child health training centres were built and manuals were developed. Around 30 managers were trained over two years, 10 of them as trainers of trainers. Regional health teams were trained, as were national and regional cold-chain maintenance staff members. At least 120 village malaria workers were trained in diagnosis, case management and malaria control and community mobilization techniques. In Debub region, 34 staff members were trained in logistics and financial management.

Immunization is the gold standard for measuring the success of health systems, and Eritrea made spectacular progress during the first country programme. In 1993 just 14 per cent of children were fully immunized, but by 2002 the percentage had grown more than fivefold, to 76 per cent of children – despite the emergency of the two-year border conflict. UNICEF was the Ministry of Health’s main partner in the expanded programme on immunization.

“It was easy to organize an immunization campaign in Eritrea in terms of mobilizing people, and they had systems,” said Dr. Camanor. “They said, ‘We have warehouses, give us the supplies, we’ll give you a report on how we use them.’ I wasn’t disappointed at all with that. The difficulty was in the lack of roads and the high level of poverty.”

Routine immunization grew exponentially in the early years. Roughly from 1993 to 1997, the proportion of fully immunized children grew from one seventh to more than half. Polio immunization, virtually non-existent at independence, was almost universal by 1999. Infant mortality fell almost by half. Coverage of vitamin A supplementation and salt iodization was over 90 per cent by 1999, reducing the incidence of IDD from 82 per cent in 1994 to 25 per cent in 1998. By 2000, routine immunization services were being provided in more than 400 sites, covering all six regions. As a result of high vaccination coverage, no
ELIMINATING A KILLER:
MALARIA

Malaria was an infamous killer in Eritrea. After a severe outbreak following the 1998 rains, in 1999 Eritrea held its first Roll Back Malaria Conference. This led Ministry of Health officials to develop a five-year plan and a detailed plan of action for 2000. It also resulted in regional conferences and workshops on malaria prevention, management and control, which helped reduce both deaths and cases of malaria. Many thousands of insecticide-treated mosquito nets were distributed in malaria-endemic regions; in 1999 UNICEF provided 60,000 nets and in 2000 raised the number to 86,000. Households were sprayed and breeding sites were eliminated.

One of the country’s innovations was local malaria control agents, another component of Eritrea’s indispensable corps of volunteers. In 1998 and 1999 combined, over 500 agents were trained and deployed.

“The agents were appointed by the community and trained by the Ministry of Health to distribute nets and drugs to treat anyone with symptoms that looked like malaria,” remembered Dr. Camanor. “If they were achy, feverish, you treated.” And communities appreciated the interventions, so compliance was not much of a problem (box 2).

The efforts worked: Malaria cases plummeted from 280,000 in 1998 to 63,000 in 2000, a reduction of 78 per cent. Mortality fell similarly, from 510 deaths in 1998 to 88 by October 2001, a decline of 88 per cent.

Dr. Camanor remembered a field visit he made with the Minister of Health as the rate of malaria plummeted. “The Minister said, ‘I used to go to my district hospitals during malaria season, and they were full. Now it’s difficult to monitor treatment effectiveness because there aren’t enough cases.’”

Community engagement: “We know the importance of what you do”

The political involvement of citizens in post-independence Eritrea was an enormous aid in achieving the country’s development objectives.

“The communities were very easy to mobilize because they were politically aware and used to meeting and discussing,” recalled Dr. Camanor. “They were highly motivated to improve their own welfare. I got interesting feedback from one villager in a community outside Massawa. I remember he said, ‘We know the importance of what you do. Because of the vaccination campaign, we no longer see children suffering from measles. We know that malaria cases are falling because of the bednets and teaching our people. We know what you people do.’

“That feedback was really important for me,” said Dr. Camanor. “You see the effort that people are making to improve their situation and you see that they understand what we’re trying to do to help.”
institutional inertia about addressing the problem. Substantial support was also provided to help finalize the communication strategy of the national HIV and AIDS control programme.

During this period, “Eritrea did well compared to other countries in the region,” said Rachel Odede, Communication for Development officer from 1999 to 2002. “Initially there was denial, but because of their pride in being unique, and the opportunity to learn from other African countries that denied HIV, they took it head on. They said, ‘OK, this is our problem, let’s deal with it.’”

Ms. Odede sat in on a class during pretesting of life skills education materials aimed at reducing the risk of infection among young people. Not surprisingly, there was embarrassment even among the teachers, and shyness and giggling among the students. The parents were reluctant too, she recalled.

“They felt the teaching was too explicit, that it would teach their children to have sex at an early age,” said Ms. Odede. “But the parent-teacher associations explained the importance of sex education and how it helps to postpone sex. The headmaster would say, ‘This is a new disease, it is preventable. If we can empower our students with the right information and the right skills and link them with services, Eritrea will have an HIV-free society.’”

Gradually people adjusted. Ms. Odede said, “When I went back in preparation for the midterm review, to see if we could scale up the programme, the teachers had gotten over their inhibitions and made a strong link with communities through the parent-teacher associations.”

EDUCATION:
MAKING UP FOR LOST TIME

It has never been a secret to the Eritrean Government that the many years of struggle left behind a society of undereducated citizens. “During the successive decades of occupation and war, Eritreans were generally denied access to education, and the few that had obtained skills were forced into exile,” noted the National Policy Framework 1998-2000.

“Consequently, the shortage of appropriate human capital is impacting all aspects of the development effort in both the private and public sectors… The success of its economic and social development strategy hinges on a successful development of appropriate and sufficient human capital.”

As a result, education was a major priority during this country programme. The country went on a massive school construction and rehabilitation campaign.

“We had helped them prepare a five-year plan after the war to accelerate enrolment in schools,” Dr. Morah recalled. “The biggest problem was lack of buildings; the children were studying outside. Whatever resources we wanted to give them, they wanted to use to build schools.” But it’s not part of UNICEF’s mandate to build infrastructure, and when Dr. Morah explained that, his Ministry of Education partner said, “You want us to spend money doing training, but we can do the training ourselves. Let us use your money to build schools in far-flung areas where children are denied school, and we will ensure those schools are filled with children.”

The government’s arguments were so persuasive that in the end UNICEF headquarters granted exceptional permission to support construction. By 1998, the Government had built 270 new schools and rehabilitated 315 damaged schools, and UNICEF had supported the construction of around 17 per cent of them. And indeed, more schools meant more students – the net enrolment rate increased from 28 per cent in 1993/1994 to 42 per cent by 2000/2001.
Gender awareness training for teachers as well as community members was another initiative. In 1999 alone, 1,500 community leaders participated in gender sensitization workshops in Debub and Gash-Barka regions. The purpose was to sustain community commitment to promote girls’ education.

Another major concern was the quality of that schooling. As of 2000, two thirds of the country’s 6,668 elementary school teachers were unqualified, and there was just one training institute to prepare them. Textbooks and teaching aids were inadequate. Teaching methods were passive and far from child centred. The government’s Education Sector Development Programme was frank about what was taking place in the classroom: “A typical pattern is as follows: The teacher writes the lesson on the board (in the absence of textbooks for students); the students passively copy the notes into their lesson books; the teacher recites and the students listen.”

“They wanted to deal with quality issues in a major way,” remembered Cecilia Baldeh, Chief of Education from 2000 to 2002. “The Government wanted to track performance more systematically and use it as a basis for teacher training, management training and parental support, and they wanted to know what children should know at any given point in the year.” The South African Human Sciences Research Council was brought in to help with training and strategy development. Instruments were developed, including teacher questionnaires and tests for pupils, to reveal what was working and what was not. Even parents were involved to help them understand the factors that go into learning. The result was development of a system to monitor learning achievements.

Part of the effort involved getting teachers to make the shift to an active teaching methodology, a difficult accomplishment when so few resource materials were available. Yet teachers did their best with what they had. “One thing that always stuck in my mind about Eritrean teachers is that they always said, ‘We will do whatever we can to make sure the children have learning opportunities,’” Ms. Baldeh said. “They weren’t obsessed with money or incentives like in some places. They were dedicated.”

The push to improve education quality led in many directions. During school vacations hundreds of teachers and school directors were trained on topics that included child-friendly teaching methods, school management, conduct of competency tests and promotion of school-based environmental clubs. UNICEF supported the development of education statistics and the Education for All 2000 Assessment, and, in 1999 alone, the printing of 663,000 textbooks. UNICEF also aided development of an education management information system and the training of staff in using it. Four Ministry of Education officials were sent with UNICEF support to the National Institute of Educational Planning and Administration in India for a six-month training course on education planning and administration. Parent committees were established in 500 schools. Everyone was doing their part.

**FIRST STEPS TOWARDS ENDING A HARMFUL TRADITIONAL PRACTICE**

When the country programme began in 1996, most UNICEF offices were using the term ‘children in especially difficult circumstances’ to describe what soon became known as ‘child protection’. This broader term more accurately conveys the idea that all children need to be protected, not just those living in ‘especially’ difficult circumstances. The new term applied particularly to one of Eritrea’s most widespread and deep-seated protection issues: female genital mutilation/cutting (FGM/C). The Eritrean Demographic and Health survey of 1995 revealed that 95 per cent of the country’s women had been cut.
"The whole history the people went through makes them very special. The fighters went straight from the trenches into the government. Everyone was working hard in a very special historical moment."

A “SPECIAL HISTORICAL MOMENT” COMES TO AN END

“The years from 1992 through 1998 were full of hope,” remembered Baerbel Hoeffers, who lived in Eritrea from 1992 through 2005 and was Chief of Child Protection for UNICEF from 2000 to 2005. “The whole history the people went through makes them very special. The fighters went straight from the trenches into the Government. Everyone was working hard in a very special historical moment, everybody wanted to do something for the country.”

But in May 1998, Eritrea’s special historical moment ended, and its breakneck pace towards development hit a colossal roadblock. The border war that erupted with Ethiopia resulted in a massive shift of resources towards defence and forced the country programme to shift towards emergency response. The conflict, called the largest and bloodiest conventional war since the Second World War, affected more than half the population, almost three quarters of them children. Eventually 1 million people were displaced. The conflict also affected another 250,000 in host communities and led to the deportation of more than 68,000 people from Ethiopia. Most of the people living near the border were moved to 31 camps for internally displaced people, while the remainder were absorbed by host communities.

At the same time the country was afflicted by drought, affecting another 400,000 people and severely diminishing food production.

UNICEF played a major role during this double emergency, especially in 1998, before other humanitarian organizations joined in the effort. UNICEF fielded 16 air charters of emergency supplies, and all sections of the office shifted their focus to emergency response. UNICEF provided pumps, generators and other equipment to supply water to roughly 150,000 internally displaced people, and in the areas affected by drought boreholes were drilled to serve 29,000 people. Emergency funding doubled the annual budget to the highest level since UNICEF was established in Eritrea in 1992. (Reflecting the UNICEF policy that long-term development cannot be sacrificed to emergencies, the budget was almost equally split between emergency relief and the regular programme.) The UNICEF Executive Director came from New York and visited some of the camps for displaced people, and the Representative spent a night in a border community and visited many IDP camps and arriving deportees.

“We worked in teams, along with all the other UN agencies,” recalled Dr. Camanor. “The coordination by the Government was very good. We assessed needs, and each agency identified what they would contribute.” The combined response involved support for child feeding, nutrition monitoring, vaccination programmes, health services and provision of water, essential drugs and mosquito nets. “That was the emergency response,” he noted. “The regular programme continued to focus on child health, malaria prevention, integrated management of childhood illness, nutrition support and so forth. The idea was to continue developing the systems while also responding to the emergency.”

Eritrea already had a disturbingly high rate of malnutrition – in 1995, just after Independence, 44 per cent of children were underweight and 16 per cent were wasted. Now, in addition to the border conflict, the country was also facing one of the most severe droughts in its history. As a result of these two crises, an estimated 2.3 million people – nearly two thirds of the population – were in need of immediate humanitarian assistance.

During 1998-1999, the Government and its partners responded swiftly to provide supplementary food and therapeutic feeding to an estimated 60,000 children under 5 years old and pregnant and breastfeeding women. Attempts were made to distribute these
children orphaned by HIV and AIDS, it was clear that the country had an enormous number of vulnerable children needing support. About one third of the orphaned children were in the Gash-Barka region.

In response, the Ministry of Labour and Human Welfare launched the War Orphan Reunification Programme in 1994, covering three regions, Gash-Barka, Anseba and Debub. Within five years it had reunified 13,768 children with blood relatives and provided socioeconomic support to 6,947 host families living in precarious circumstances. While these efforts were a relief for each of those children, they were far from sufficient to end child vulnerability.

Two important assessments were undertaken in 1999, one to understand the level of trauma experienced by children and the capacity of structures to help them (box 3), and a second on children in Eritrea and Ethiopia who were separated and unaccompanied due to the border conflict, performed jointly by UNICEF in both countries. The second assessment revealed the extent of unaccompanied children, and finding homes for them became a major part of UNICEF’s cooperation with the Government during this country programme. The Ministry’s reunification programme was extended and named Mahzel, the Tigrinyan word for baby carrier, to emphasize protection of children.

The project was designed by an Italian anthropologist who had studied the impacts of the orphanages on children. This had led to the closure of orphanages before UNICEF began its support for the reunification programme, and reunification led to the closure of more. The programme operated throughout the entire Gash-Barka region.

“The regional child protection official who ran the programme was an ex-fighter who had lost an arm,” Ms. Hoefers said. “I never met anyone like him again. He was absolutely committed to his work. He lived in poverty, separated from his family due to his work, traveling to and fro around a very extended area.”

The initiative involved a tremendous amount of detailed field work for government officials. “They would begin with the children and find out where they were from, and then they would go into those communities and try to identify anybody who might be a family

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**Box 3**

**The psychosocial impact of the border conflict on children**

Over 130,000 children were either displaced in Eritrea or expelled from Ethiopia during the border conflict. A psychosocial needs assessment was made in August 1999 to determine how they had been affected. It also aimed to establish what type of support they would need and the condition of community coping mechanisms that normally care for children in times of trouble. The assessment was a major breakthrough for both the Government and UNICEF in terms of creating an opportunity to plan interventions appropriate to the circumstances on the ground.

The assessment found that the children experienced their displacement and expulsion as a cruel betrayal. It was a bitter reminder of events during the independence struggle that most of them had only heard about. It led to severe economic hardship and interrupted their personal and social growth. For most of the children, it also led to a sudden and unpredictable exposure to violence.

The majority of the children met by the assessment team manifested considerable psychosocial distress. It was expressed by pervasive fear, night terrors, difficulty concentrating and inability to envision a peaceful future. Most of them were affected developmentally by idleness, resulting from lack of opportunity to attend school or to play or work. While parents identified their main concern as fulfilment of basic needs, the children mentioned school as their first priority, even before food.
NO PEACE, NO WAR, NO RAIN: 2002-2006
A major role for UNICEF during that time, Ms. Berry-Koch said, was helping the Government identify the hardest hit geographic areas and then the most vulnerable populations within them, allowing the Government to target its response. “In an area like Eritrea with such strong cohesion within the communities, they’re pretty well organized,” she noted. “With their long isolation and strong culture, their own safety nets are strong.” One such structure she recalled involved groups of families pooling a small amount of money each month, perhaps $5. Every two or three months the whole pot of funds would go to one family to fund a major purchase such as a goat.

The two crises had a catastrophic effect on the economy and the people. Eritrea’s per capita income of $200 in 1998, already among the lowest in the world, had fallen to $180 by 2002. Rising prices for fuel, energy and basic goods and commodities, coupled with very low food production, increased the economic burden of the country and led to inflation over the course of the programme. Access to international markets was limited, compounding dependence on food aid as high prices prevented people from buying basic commodities in both the towns and the countryside. In 2002, with four of the six regions suffering from critical levels of malnutrition, the Government declared a national emergency and set up a task force to combat malnutrition and the drought. By 2003, 18 per cent of babies were born underweight, compared to 8 per cent in 2001. By 2004, 20 to 30 per cent of rural households faced food security challenges.

As a first step in developing growth policies and poverty reduction targets, in 2003 the Government conducted a poverty assessment. It found that two thirds of the population was poor, living on per capita expenditure of about 60 US cents per day. More than a third of the population – 37 per cent – was found to be extremely poor.

Political changes presented another challenge, as Eritrea turned further inward following the war. The emphasis on self-reliance expanded. In 2005, with government concerns growing about possible links between aid and dependence, the World Food Programme was asked to shift from distribution of free food to a ‘food for work’ approach. Fuel shortages and field access restrictions limited UNICEF staff movement and project implementation and monitoring. A law was passed that prohibited channeling of donor funds through NGOs, and by the end of the country programme only 10 NGOs remained in Eritrea, affecting implementation of initiatives. Construction contracts were frozen in 2006.

On the positive side, a number of sectoral policies were developed during this period. Among the issues they covered were early childhood development, food security, water and sanitation, school health, gender education and HIV/AIDS in the education sector, laying the groundwork for advances to come. In 2005 the Government published its first report on the Millennium Development Goals (MDGs). It noted that Eritrea was on track for achievement of Goals 4, 5 and 6 (on child mortality, maternal health and HIV and AIDS) and for partial achievement of Goals 3 and 7 (on gender equality and environmental sustainability).

The country programme was also being influenced by emerging international trends. The human rights–based approach increasingly took hold as the foundation for developing initiatives and judging results.

**WATER: BEYOND HARDWARE**

The drought put pressure on the entire country programme, but not surprisingly, especially on the water component. UNICEF has long been a partner to Eritrea’s Water Resources Department in building sustainable water supply systems. Getting safe water to the people was always a challenging undertaking, as suggested by the 2004 UNICEF annual report. “Even in ‘normal’ times of adequate rain, only 50 per cent of the Eritrean population (22 per cent in rural areas and
You have a new water point that needs to be managed and sustained, you're talking capacity, training, the supply chain—all these things around development. You attend to immediate needs with water, but it lasts longer and is an entry point for issues on sanitation and hygiene."

“You don’t just give hardware and dig a well,” he explained. “Before you do that you must talk to people, agree on where to dig the well, give the land. In areas with no women involved in running the community, you use it to attract women to the management committee. You have a new water point that needs to be managed and sustained, you’re talking capacity, training, the supply chain—all these things around development. You attend to immediate needs with water, but it lasts longer and is an entry point for issues on sanitation and hygiene.”

One water system Mr. El-Fatih remembers with particular pride was developed in the village of Hamelmalo in Anseba region, not far from Keren. It was home to around 3,000 people who had never had secure access to water.

“Women were not a part of the society when we started,” he recalled. “But they became a strong component. We worked through the community to decide where to put the wells and other parts, where to put the water kiosks in the village, and to elect a management group—and we ended up having half of it women. They had been active among themselves before, with small trades and businesses, but now they were part of the community management structure.”

Hamelmalo’s water supply system was completely managed by the community. Funds raised from the sale of water allowed the residents to expand the system according to their own village plan and replace the broken water pump.

Building a water system is only one part of ensuring sustainable access to water. To avoid the all-too-common problem of non-functioning water pumps, training mechanics and system operators was a major part of system development. Consistent with UNICEF’s approach of combining emergency assistance with long-term development, in each community that received trucked water, an assessment was made for provision of sustainable water systems.

Providing water also serves a larger purpose. “It is the first service demanded by communities as a priority need,” noted the 2003 annual report, “and can be used as an entry point for other interventions.”

**CHANGING THE CULTURE OF SANITATION**

The most obvious intervention to be paired with water is sanitation. This is a priority in every country where UNICEF operates, given its importance for child health, and Eritrea had little culture of latrine use. Diarrhoea was the second leading cause of death among Eritrean infants and children during this period, responsible for 15 per cent of deaths among children in health facilities. This was not a surprise, given that by 2004 only 3.6 per cent of the rural population had access to improved sanitation facilities. Yet diarrhoea is particularly a problem when rain washes faeces into drinking water, and because Eritrea’s rains are short and seasonal, so is diarrhoea. Thus there wasn’t the same sense of urgency for sanitation as in countries with more regular rainfall and more sustained rates of diarrhoea.

Much has been learned about sanitation and hygiene over the years, much of it from failures in all parts of the world. Earlier approaches did not succeed, said Mr. El-Fatih, because “the focus was on technology instead of human beings. Now we talk about human behaviour. You talk about hygiene knowledge and why it’s important and that is what convinces you to build a latrine. Before they called the sector ‘water and sanitation’, but they forgot they were doing health. If you don’t bring in hygiene, it doesn’t go anywhere.” Reflecting this reality, around this time the acronym for the sector was changed to WASH—water, sanitation and hygiene.

Yet given the prolonged drought in Eritrea, conditions were not conducive to dramatic progress on sanitation. In 2005, for example, only 150 households built and used household latrines.
By 2003, 70 per cent of the population had access to health services, up from just 10 per cent at independence. Construction of three regional warehouses and a national cold chain and dry store, funded by UNICEF, provided safe storage for essential drugs, vaccines and other medical equipment. Immunization coverage continued to grow, reaching 76 per cent in 2003. Also that year, a massive measles immunization catch-up campaign reached more than 1 million children under age 15 – coverage in excess of 98 per cent. As a result, the number of cases plummeted from 600 in 2000 to 49 in 2004, and 1 death.

Throughout the programme antenatal care services spread to more and more health care facilities, and by 2006 virtually all health facilities (246 out of 251) were providing antenatal care. As a result, by 2005 two thirds of pregnant women had at least one antenatal visit. However, only 26 per cent of deliveries were attended by skilled personnel in 2005, one reason for a maternal mortality rate estimated at 630 deaths per 100,000 births – one of the highest in the region, yet an improvement from the 998 per 100,000 estimated at independence.

Child death rates were also coming down. The Eritrea Demographic and Health Survey released in 2002 reported that infant mortality had fallen to 48 deaths per 1,000 live births, compared to 72 per 1,000 in 1995, and under-5 death rates had fallen to 93 per 1,000, from 148 in 1995. Neonatal tetanus was eliminated in Eritrea in 2004. But neonatal mortality rates were largely unchanged, and in 2005, 80 per cent of deaths in health care facilities were among children under 1 year old.

Malnutrition continued to stymie efforts to improve child survival and health, worsened by the drought. After the Government declared a national nutrition emergency in 2002, the situation deteriorated further.

In 2004 the national nutrition surveillance survey found that 49 per cent of children under 5 and pregnant and breastfeeding women were receiving supplementary food. The proportion of infants born underweight grew from 11 per cent in 2003 to 14 per cent in 2006. Consumption of iodized salt, which had skyrocketed to 99 per cent in 1998, fell to 63 per cent in 2004, probably a result of the insecurity around the border. Ministry of Health nutrition surveys found that global acute malnutrition among children under 5 years ranged from 9 per cent to 25 per cent. In 2005 the Government developed a five-year national plan of action for nutrition, aiming to move the country towards a sustainable nutrition situation. The Ministry established therapeutic feeding centres in all regions. Over 70 doctors and other health workers were trained that year on managing severe malnutrition, and as a result the case fatality rate fell to 6 per cent, from 11 per cent in 2002.
All the UN agencies, all the NGOs, the Government – everyone came together and said, ‘How are we going to respond to HIV/AIDS in Eritrea?’ Everybody was at the table, and that was really important.”

established to combine expertise of diverse organizations on issues of mutual concern, in Eritrea everyone came together to form a technical working group on HIV and AIDS.

“All the UN agencies, all the NGOs, the Government – everyone came together and said, ‘How are we going to respond to HIV/AIDS in Eritrea?’” recalled Ms. Blacking. “The interesting thing for me was that I had just come from another country in Africa where the government response was poor. In Eritrea the infection rate was so much lower, but everybody was at the table, and that was really important. My impression is that the Government took it very seriously.”

In Eritrea the World Bank was the major actor in fighting AIDS through its HIV and AIDS, Malaria, STDs and TB project, known as HAMSET. UNICEF’s main focus was prevention of transmission among young people and from mothers to children, along with care and support for people living with AIDS and protection of orphaned children. In 2004 UNICEF also brought a small team of HIV and AIDS activists from South Africa to hold a workshop on positive living, involving everyone from nuns to the Ministry of Health to caregivers and NGOs.

“The workshop brought some new thinking,” said Ms. Blacking. “It helped people with coping skills, and it broke barriers and opened up a lot of debate on stigma and discrimination. It also reminded people about the need for respectful treatment of people with HIV/AIDS.”

A major strategy for prevention of mother-to-child transmission (PMTCT) was integrating voluntary counselling and testing services into maternal and child health centres. This enlightened strategy, introduced in 2004, avoids the stigma of separate AIDS clinics. In 2005 Eritrea introduced ‘opt out’, so that all pregnant women coming for prenatal care or for child vaccinations were counselled and tested unless they declined.

Box 5

100% acceptance of PMTCT services

The Felege Hiwet health station in Asmara serves a catchment population of around 30,000 with a staff of just 3 health assistants, headed by a nurse counsellor named Freweini Samuel. In 2005 the staff achieved a near-miraculous result: every single pregnant woman who received antenatal care agreed to accept PMTCT services.

The centre’s strategy is continuous care from the time each woman steps in the door. It begins with highly participatory pre-counselling group education, moving to pre-test counselling and then testing. Freweini attributes the success to the strategy of ‘opting out’. Each woman is informed, in plain and simple language, that PMTCT is part of the standard package of care for all pregnant women, but every woman is also informed that counselling and testing for HIV is voluntary.

To provide quality care for the 43 women who tested positive that year, Freweini created a ‘cell of support’ system in the neighbourhood, establishing a self-help unit with one knowledgeable care provider for every four women. The HIV-positive women who live near each other meet regularly. The counsellor makes it a point to meet with at least one team each week. Through the National Union of Eritrean Women, Freweini even managed to provide some financial incentive to the care providers. She also organized a post-test club at her facility; the only prerequisite for ‘membership’ is to be tested. A group of previously tested women attend group meetings to support others.

Part of the routine is registering infected pregnant women for services through the association of people living with HIV and AIDS, called Bidho, which means ‘challenge’ in Tigrinya. Bidho seeks financial and material support for its clients from ministries, churches and other organizations.

Freweini also managed to mobilize and train health workers providing antenatal care in four nearby health facilities. Her advice to the workers was simple: “Teach and explain mother-to-child transmission to all mothers attending your antenatal care services, and in case they have fear and uncertainties, refer them to me.”
programme, 5,891 orphans were unified with about 2,198 host families. A community-based follow-up survey was carried out for the 1,400 host families and 3,149 orphans assisted during 2001-2002. Preliminary findings showed an overall success rate of 93 per cent in families’ management of the livestock assets provided by the Government, despite the drought. In addition, an estimated 95 per cent of the 3,000-plus orphaned children aged 7 to 16 years were attending school. The support of community elders and local administrators was crucial to the success of the effort.

Box 6

Group homes weave children into Eritrean society

As much we care about where we are heading in life, we also wonder about where we came from. That quest is more difficult for orphaned children, who often lack family members to answer their questions about their heritage. But Hannah is doing all she can to create a real family for the 12 children whom she mothers in a group home in the village of Tsaeda Christian.

As one of them, Helen Mehari, 7, arrives home from school, it’s clear that she has no doubt about her mother’s identity. Without even looking at a group of visitors, she runs and buries her face in Hannah’s lap, hugging her with tiny hands stretched wide. Hannah fondly caresses her head.

Hannah has been raising her 12 children since 2003. “There are only five left now,” she says. “The rest are in college. Look at their prizes,” she adds, pointing proudly to the living room wall, which displays certificates and medallions won by her children for achievements in sport and academics. “They send letters and spend their vacation here with us. They belong to this place. If you ask them where their origin is, they will proudly say ‘Tsaeda Christian’.”

Around 8,600 Eritrean children lost both parents during the liberation struggle, so the Government has long experience in caring for orphaned children. After the independence war, officials quickly learned the important lesson that institutions are not a good home for these children.

“We don’t encourage orphaned children to grow up in institutions, as they don’t cultivate important family values, which form the basis of identity,” says Tekle Tesfai, Director of the Child Welfare Division at the Ministry of Labour and Human Welfare. Instead, close relatives or extended family members are asked to raise orphaned children with some support from the Government. But if relatives cannot be identified or are unwilling, the child is put in a group home. Each home cares for a maximum of 12 children, who grow up together under the watchful eye of a mother. With support from UNICEF, the Ministry of Labour and Human Welfare currently sustains 12 group homes in Eritrea, supporting a total of 144 children.

“Children are nurtured by a mother and with the support of the hosting community,” adds Mr. Tekle. “They learn important family values and grow with a sense of belongingness. The communities acknowledge the orphans growing in their villages, recognize their rights and treat them equally with the other children, including providing access to land and other support.”

Supported by the Ministry, Hannah endeavours to fulfil the needs of her children, caring for their health and well-being and following up on their education. Above all, she is expected to cherish them, instill belongingness and bring them up as a united family of brothers and sisters.

“At times it is very difficult to cope,” she confesses. “Just last month Helen was sick and hospitalized for a month. It was hard to look after her and attend to the needs of the rest of the children at home. But they are my children. I know I have to do it. And at last the fruit is very rewarding. Look at their achievements!” Hannah says, pointing again at the awards on the wall.

Identity and a sense of belonging are the fine threads that weave and bind the fabric of a society. The Government has designed its response to orphaned children in a way that keeps children rooted in their communities, benefiting both them and society at large.
INCREMENTAL STEPS FORWARD IN EDUCATION

Fulfilling the right to quality education for boys and especially girls has been a challenge throughout Eritrea’s history. The country got off to a late start because of the independence struggle – a generation of young adults who might have spent their lives teaching in a classroom instead found themselves fighting on the battlefield. Three quarters of the demobilized fighters had less than a sixth grade education, so they could not immediately become a corps of teachers. Many schools were damaged during the independence war and later during the border conflict.

“There was not the kind of progress in education that one would have expected,” said Mr. Balslev-Olesen. “We suggested that it could be rolled out faster and more effectively by building simple structures, even using tents. But the Government wanted the perfect infrastructure, which was complicated and expensive to roll out.”

As the 2004 annual report noted, net enrolment had risen from 31 per cent in 1995/1996 to 53 per cent in 2003/2004, an impressive achievement. Yet repetition and dropout rates of around 15 per cent indicated problems of quality, and average enrolment rates camouflaged marked disparities. In Northern Red Sea region, for example, only 2 in 10 children were enrolled. Opportunities for schooling were limited to the children of the 60,000 people still living in camps for displaced people. Similarly unable to fulfil their right to education were most of the children of semi-nomadic families. This group comprises around 30 per cent of Eritrea’s population and is therefore an important target of efforts to increase equity.

“I talked quite a bit with the communities and parents and teachers, and they wanted their children to be educated,” said Simon Mphisa, Chief of Education from 2003 through 2005. But for families in poverty, the opportunity cost of losing a pair of working hands can be high, along with ancillary costs such as uniforms. The obstacles increase for girls, whose education often loses out to domestic duties, early marriage, fears about security and lack of latrines at school. Nomadic families were less inclined to send their children to school, especially their daughters. And even if they were, they would find few schools in nomadic areas. Another obstacle was the annual school calendar and daily schedule, both incompatible with a nomadic lifestyle. These issues would be addressed in the next country programme.

Trained teachers have always been in short supply in Eritrea, but the Asmara Teacher Training Institute, the country’s only teacher preparation academy, can turn out only 600 teachers a year, well short of the need. Beginning in 2001, in-service training was conducted for uncertified teachers during the summer holidays, reaching 600 elementary-level teachers that year. This programme was designed to upgrade teacher trainees’ skills quickly to speed up their certification. During three consecutive summers, the programme trained more than 600 uncertified teachers and 500 new teachers. By 2004 the proportion of unqualified teachers had fallen to 28 per cent.

The country was so short of female teachers that for the 2003/2004 academic year the Ministry of Education decided to recruit only female trainees.

“The gaps between boys’ and girls’ enrolment were a real concern for UNICEF and for the Government,” said Mr. Balslev-Olesen. “Coming out of the liberation struggle, where women were so important, the Government wanted to make sure women were equally represented among the teachers, as a strategy for getting more girls in school.”

The previous country programme had demonstrated that feeder schools could raise girls’ attendance in isolated areas, and 10 new ones were added to the 25 already built. In the worst-affected regions, Northern and Southern Red Sea and Gash-Barka, an incentive scheme was begun to encourage parents to send their daughters to school.
CONQUERING CHRONIC CHALLENGES: 2007-2012
mortality rate by two thirds, from the baseline year of 1990 – when Eritrea was still fighting for its independence. Add to this the fact that Eritrea remains one of the poorest countries in the world, with per capita gross national income of only $340, and the magnitude of the achievement begins to come into focus.

It has come about by squeezing every Nakfa out of the budget and concentrating relentlessly on the basics. This has meant a focus on immunization, expansion of access to primary health care services and adoption of community-based integrated management of childhood and neonatal illness (c-IMNCI).

In 2000 the Ministry of Health had adopted IMCI as its main strategy for improving child health. It aims to develop the capacity of health workers to treat the principal causes of morbidity and mortality. In 2005 the community component of IMCI was piloted in 17 villages and now covers four regions. With addition of a neonatal component in 2007/2008, community IMNCI now reaches 80 per cent of communities in Anseba and Debub, 60 per cent in Northern Red Sea and 40 per cent in Gash-Barka. Given the difficulty of reducing neonatal mortality, in 2010 UNICEF began collaborating with the Ministry of Health to establish neonatal centres throughout the country. So far five units have been established and another seven are in the pipeline for 2012.

Box 7

Volunteer community health workers: The backbone of Eritrea’s health system

It is late afternoon, and the Gheleb Health Facility in Anseba region is in a state of controlled chaos. Mothers with babies cradled on their backs in tightly wrapped shawls obediently line up to have their children weighed and measured. Two women are carefully assisting mothers to place their children in the weighing harness while soothing crying babies, conducting mid-upper-arm screenings and offering advice to concerned mothers. These quietly efficient women are Sherifa Jabir and Amna Mussa, two of Gheleb’s community volunteers.

Sherifa and Amna are in the clinic today because it’s their turn to support the staff in weighing and measuring children and distributing therapeutic food for malnourished children. But normally the two women spend their days walking the length and breadth of their communities monitoring the health of pregnant women, mothers and children.

“There are 101 children in the Shuq community that I look after,” says Sherifa, herself a mother of two boys. “I go from home to home and speak to mothers, examine the children and perform mid-upper-arm-circumference screening. Based on the results I tell the mother to come to the health facility where they can receive treatment and food for their children.” Amna adds, “Sometimes I even accompany the mother to the clinic, if they have never been to a health facility, especially some of the mothers who migrate from other communities.” Amna covers 35 children in the community of Tablineji. In addition to her work she cares for her daughter and son.

The 2 volunteers are among 11 community health workers at the Gheleb health facility who have been trained through the Ministry of Health in partnership with UNICEF. “It is a tiring job, but I love that I am helping the children and mothers in this community and I am helping to save lives,” says Sherifa. “It would be nice if we received payment or an incentive but I would continue to do this work without any payment.” Amna adds, “We are mothers, and we want to save the lives of all children.”

The two women have been community health workers for six years. At the beginning, both faced criticism for their work.

“In Tigre culture it is not acceptable for women to work, and there were many in the community who told us we should not do this,” says Amna. Sherifa adds, “And also in our culture it is the tradition for the women to have their babies at home, so we really had to encourage and explain to pregnant mothers how important it was for them to visit the health facility and have their babies here.”

But six years later the community sees the benefits in saved lives and healthy children. “Now they even come to us if they have a cold and ask us what to do,” says Sherifa, smiling proudly.
Another approach that has made the most of the country's scarce resources is Health and Nutrition Weeks. Building on Eritrea's famed organization, they now take place twice a year, with the objective of preventing child illness and malnutrition. Massive organization involves virtually the whole country, with teams going out village by village. During the most recent campaign, conducted in April 2012, more than 90 per cent of children were immunized against measles and given vitamin A supplements while being screened for signs of malnutrition and ill health.

The near-defeat of malaria is also a result of this emphasis on the basics: prevention through wide use of insecticide-treated mosquito nets along with early diagnosis and treatment. Despite the fact that 67 per cent of the population lives in malaria-endemic areas, by 2006 malaria had fallen off the list of the top 10 causes of in-patient deaths. Ministry of Health statistics from 2010 show that malaria accounted for less than 1 per cent of outpatient deaths and 0.5 per cent of inpatient deaths among children under 5 years.

Like many poor countries, Eritrea continues to battle a high rate of death from pregnancy-related causes. Nonetheless, the mortality rate has fallen by more than half since the rate estimated at independence, to 486 deaths per 100,000 live births in 2010, and the country is working to reach the three-quarters reduction needed to achieve MDG 5. Access to antenatal care is almost universal, at 89 per cent. However, only 34 per cent of babies are delivered in a facility or by a skilled attendant. For the other two thirds of Eritrean women, who deliver at home, an emergency during childbirth can quickly become a life-threatening crisis, sometimes resulting in death. A promising solution is maternity waiting homes attached to health facilities, initiated in 2002.

“At month seven and a half up to month nine, pregnant women are identified by community health workers and encouraged to go to the health facility and stay at the maternity waiting home,” said Dr. Majeed. The mother usually moves into the home along with her other children and her mother-in-law, who cares for the family. By 2011 there were a total of 38 homes, serving all regions except Maekel, where the need is less because people have better access to Asmara’s health care facilities. In addition, 11 health facilities have been strengthened to provide basic emergency obstetric care through distribution of supplies, and more than 300 health workers have been trained.

Eritrea is also on track to achieve the HIV and AIDS reduction target of MDG 6. A decade ago the country had a prevalence rate of around 4 per cent, but by 2011 it had plummeted to 0.45 per cent.

“This impressive achievement is due to the country’s willingness to acknowledge and talk about the epidemic,” said Dr. Majeed, “along with diligent attention to every aspect of prevention and treatment.” This includes raising awareness about causes and prevention, providing broad access to voluntary counseling and testing, distributing free condoms, teaching life skills in school, integrating prevention services into health services and providing antiretroviral drugs to pregnant HIV-positive women and their children. “Community awareness in the last few years has been wonderful,” he added. “They have reached almost all the villages with information on how to prevent new cases.”
NATURE AND POVERTY HAMPER PROGRESS ON NUTRITION

Children cannot be healthy if they are poorly nourished, and nutrition has long been a challenge in Eritrea. The situation deteriorated seriously beginning in 2001, and five years later 40 per cent of the country’s children were underweight. At the same time malnutrition afflicted one third to two thirds of women of child-bearing age.

“When the malnutrition rate is above 10 per cent, UNICEF considers it an emergency, and when it’s above 15 per cent it’s a crisis,” said Dr. Majeed. “In 2006 two regions were in crisis and four were in emergency. By 2009 the four in emergency were approaching crisis, so it was a really serious situation.” In much of the country rates of acute malnutrition continued to increase through 2010, especially in the two Red Sea regions.

The reasons for the persistence of malnutrition are not a mystery. Food production is constrained by the country’s limited arable land and shortage of water, so even in years with good harvests Eritrea needs to import food. Poverty is the other major factor – many people cannot afford to buy sufficient food to supplement what they can grow. In recent years these longstanding issues have been compounded by the prolonged drought and inflation, making imported food even more costly. Another factor has been United Nations sanctions, imposed in 2009 and tightened in 2011. In addition to contributing to rising food prices, the sanctions are seen as partly responsible for recent shortages of fuel, power supplies and spare parts. The most vulnerable people – children, youth and women – have been hit the hardest.

At the government’s request, in 2009 UNICEF began blanket feeding in four regions, providing supplementary food to all children under age 5 and pregnant and breastfeeding women, without regard to nutritional status. People could pick up the food at health centres. In 2011 alone over 32,000 moderately and severely malnourished children were treated.

“About 70 per cent of people are within 10 km of a health facility, so we anticipated that 70 per cent would come,” noted Dr. Majeed. “But in fact 90 per cent came, even those further than 10 km from the health centre.” Gradually, the situation began to improve, and by 2012 only two coastal regions and a few subregions needed blanket feeding.

Community-based therapeutic feeding expanded rapidly during the country programme. It began as a pilot project in 2006, and by 2012 there were 212 sites, supplemented with 57 facility-based centres to serve children with additional complications, such as disease. Every subregion has a community-based therapeutic feeding site now, and about 85 per cent of the country is covered.

“Community-based therapeutic feeding expanded rapidly during the country programme. It began as a pilot project in 2006, and by 2012 there were 212 sites, supplemented with 57 facility-based centres to serve children with additional complications, such as disease. Every subregion has a community-based therapeutic feeding site now, and about 85 per cent of the country is covered.

“A NEW STRATEGY JUMPSTARTS SANITATION

No one can live without water, but in rural countries like Eritrea where there’s plenty of open space, there’s less sense of urgency in solving the sanitation problem. There lies the reason for the skewed rates of achievement on these two critical and connected development issues.
The old approach was more technological, focusing on constructing latrines, whether or not people were using them. With community-led total sanitation, the focus is on behaviour change.

“The old approach was more technological, focusing on constructing latrines, whether or not people were using them,” said Yirgalem Solomon, WASH Specialist since 2008. “With community-led total sanitation, the focus is on behaviour change.” This fundamental shift in focus seems to have broken the logjam. Implementation of the new approach got a major boost in 2009, when Mr. Kar was brought to Eritrea to train CLTS trainers. Just three years later, about 25 per cent of rural households have access to a latrine.

The approach works on various human emotions. “We involve lots of people, starting with the governor of the region and going down to the public health technicians and then the community,” said Ms. Solomon. “The key is to persuade everyone about the value of being free of open defecation, and the first step in the process is holding a ‘triggering’ session.” Everyone in the community must participate – men, women and children. This session demonstrates very graphically the connection between open defecation and contamination of food. It is not a pleasant experience.

“You have to use the crude terms so the people will be irritated,” she pointed out. “This was hard for the technicians. And it is very hard for the community.”

After the triggering session, everyone is asked to commit to building a latrine. Those who are reluctant face a bit of social pressure (Box 10). The ‘resisters’ are grouped separately from the people who agree to build a latrine, and photos are taken of each group. The photos will go in the report, the community is told. But people do not want to be identified as failing to support the activity, so they say, “We want to build a latrine, but we don’t have the means.”

“In Eritrea there’s a great tradition of supporting each other in the community,” Ms. Solomon noted, “so they come up with a solution.” The technicians suggest various options for materials and construction, and community members come forward and say, ‘We will help so all of us will have one.’ Once the community agrees to become free of open defecation, a water and sanitation committee is formed to keep the process on track. Groups are formed, particularly involving women and young people, to promote the initiative.

The approach is working better than any past strategy. Just three years after the workshop by Mr. Kar, “138 villages have been declared free of open defecation,” said Pranab Shah, Chief of WASH since 2012. “The concept of CLTS is quite accepted, and the process has started in all six regions. National rural coverage of sanitation was 3 per cent in 2004, and according to a Ministry of Health survey at the end of 2011 it’s now about 25 per cent. It is CLTS that has been the cause.”

Roy Bowen, Deputy Representative since 2011, recalled attending an inauguration of CLTS in a community in Southern Red Sea. “It’s a huge celebration, and everybody wants to show what they have built,” he said. “They’re all different types, from latrines made of concrete blocks to latrines...”

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Box 10

Community sanitation challenge:
“Why can’t we all do it?”

“I remember one village in the Maekel region when a senior official was holding a meeting on community-led total sanitation,” said Ms. Solomon. “There were resisters; they were making a lot of complaints and saying they did not have the resources to build latrines. But then a 71-year-old man stood up and talked about a proverb in Tigrinya: ‘The one who doesn’t want to work brings a lot of reasons.’ It was very striking. Then everybody started saying, ‘He’s right – we are making all these complaints, but they are not realistic.’

“Then the old man said, ‘Now, I am going to build my latrine. And it will help me not to have to walk a long distance, because I am very old and I cannot walk so far. Why can’t we all do it? We have done a lot of things before in our community.’” His wise words persuaded the resisters, and the community started on the path to becoming free of open defecation.

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to their livelihoods, school schedules are not organized around their lifestyles and school curricula are not suited to their beliefs and needs.

In 2007 the Ministry of Education prepared a nomadic education policy to address these challenges. The same year it opened eight pilot schools for nomadic children, two in each of the regions with high concentrations of nomadic families. By 2011 the initiative had been expanded to 65 schools, reaching over 7,500 children, 43 per cent of them girls.

“Nomadic schools are not different from regular schools in terms of the curriculum,” said Yodit Tesfaghebriel, UNICEF Eritrea Education Specialist since 2011, “but the daily schedule and the academic year are flexible. Regular schools start in September and close in June, but nomadic schools might open in November and close in May, depending on their movements. They try to cover the lost time by extending the number of hours in the school day.”

The teachers come from the community, so they can teach in the children’s mother tongue, but it is a challenge to find qualified candidates. Most of the teachers are not certified, though the Ministry provides them with training. “Unfortunately almost all are men,” she added, “because when the Ministry looks for candidates they look for people who have completed tenth grade, while the maximum schooling for most nomadic girls is just elementary school.”

A similar effort to educate unreached children, especially girls, is the complementary elementary education (CEE) approach, which seeks out children aged 10 to 14 who have never attended. Reflecting the older age of these students, the CEE learning centres condense five years of
in behavioural change. This comprehensive, community-supported approach, known as the Habarawi (collective) approach, is being documented as a best practice to be shared with other countries.

“In the past, the acceptable practice was for families to cut their daughters and infibulate their women after delivery, and the stigma was in not conforming to these social norms,” said Gbemisola Akinboyo, Chief of Child Protection since 2009. “However, these days, cutting of girls and women has become the new stigma in Eritrea. Government sectors, NGOs, development partners and communities are working together to prevent this harmful traditional practice and protect the rights of girls and women. Progress will continue if this solid collaboration is sustained.”

Another issue for many countries is finding alternative sources of income for the circumcisers, but that is less of a concern in Eritrea. The Government has provided some alternative income-generating support for circumcisers, such as sewing machines. However, most of them were doing it not for money but for social recognition.

Holdouts remain, particularly in extremely remote communities and among some nomadic groups. They will be targeted in the next country programme. It seems clear that it is just a matter of time before FGM/C is finished in Eritrea.

CLOSING INSTITUTIONS, BUILDING FAMILIES

Eritrea has reduced the number of children in orphanages nationwide to just 341 in 2010, and an additional 144 live in community-based group homes. This means that throughout the country fewer than 500 children remain in any form of institutional care. This achievement is even more extraordinary given that as of 2006, Eritrea had almost 105,000 orphaned children.

The system dating back to the independence struggle works on five levels. It starts with the ideal solution, reunification with extended family members, and works down through progressively less desirable options – adoption, fostering, group homes and finally, as a last resort, orphanages. Ever since UNICEF came to Eritrea it has supported the country’s efforts to reunify children with their extended families, and this support has paid off. Just between 2008 and 2010, 7,362 children were reunified with 2,905 families.

The system is holistic, providing services like community rehabilitation and economic support to families. Guidance and counselling services help the children to address any issues that arise as they become part of their new families. The economic assistance, in addition to improving the families’ food security and nutrition, boosts the children’s school attendance.

The country keeps a watchful eye on these children and recognizes that whatever hazards children face, they do best when living in familiar communities. In 2007 the Ministry of Labour and Human Welfare began implementing a comprehensive programme for social protection of orphaned and vulnerable children through community-based child well-being committees. These are comprised of representatives from government ministries, civil society and religious groups as well as community leaders and children. After identifying children’s specific problems and vulnerabilities, they develop locally appropriate solutions and promote community care for children lacking family support. They also work to strengthen the capacities of vulnerable and foster families and child-headed households by helping them improve their livelihoods and income-earning capacity, along with linking them to social services.

By 2011, 27 child well-being committees were operating, and in that year alone they provided assistance for over 9,000 children. UNICEF supported training for 70 social workers and members of these committees, which helped to improve the quality of referral services and
An important development in 2011 was preparation of the National Strategic Plan for Injury and Violence Prevention and Control.

“Now mine risk education is being addressed as a public health matter, and it’s being handled more holistically,” said Ms. Akinboyo. “The policy addresses disabilities and incorporates risk education in general, advocating for awareness to protect children from all types of injuries and accidents.”

Eritrea has over 23,000 children with disabilities, according to a 2004 survey, and in 90 per cent of the country they are served by community-based rehabilitation. The Ministry of Education has also introduced an inclusive education policy to integrate children with disabilities into mainstream schools at all three levels. To make sure they can get to school, UNICEF has provided donkeys to almost 900 children with disabilities (box 12). UNICEF has also supported training for more than 2,500 community volunteers and 500 social workers to respond to children with special needs.

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**Box 12**

**How donkeys improve performance at school**

Osman, age 14, lives in the village of Afta in Northern Red Sea region. The boy, who had polio as a young child, is a clever student who loves mathematics and science. He was able to get around with crutches until he outgrew them.

“I am illiterate,” said Ibrahim. “I came to understand that educated people are always at the helm of any society, and I saw clearly that education made a big difference in Osman’s life. If he is educated I know he will have a good life, and that is why I am always ready to do everything I can to help my child get an education.”

And ‘everything’ meant that each day he carried Osman on his back to school, more than an hour’s walk from their home. As Osman grew too big to carry, Ibrahim borrowed a neighbour’s camel to transport him. But this forced Ibrahim to take leave from his job.

Things changed for both Osman and Ibrahim when the Donkey for School project came to their village in 2009. Implemented by the Ministry of Labour and Human Welfare with support from UNICEF, it focuses on children with physical disabilities and hard-to-reach girls in 30 communities. Each family receives a donkey to enable the child to go to school. With Osman now riding his donkey to school, Ibrahim was able to return to work.

“As a result of the donkey, I am going to school without bothering my family, especially my father,” Osman said. “My performance has improved and I stood first in class during the first semester. This support has motivated me and I want to continue my education up to college. I love science more than any other subject and I want to be a scientist,” he said, smiling proudly.

A 2011 evaluation of the Donkey for School project found that it has increased enrolment and attendance and reduced dropout, which in turn contribute to improved academic performance. The children interviewed said that previously they were missing one or two days of school per week, but their attendance had increased markedly once they received the donkey. Of the children with disabilities, 84 per cent said they had not been absent from school in the two weeks before the survey. Their average travel time to reach school was reduced by almost one half, from 65 minutes to 35 minutes.

The survey further showed a modest increase in their performance, from 67 per cent to 70 per cent. Although this improvement cannot be entirely attributed to the donkeys, better morale and on-time arrival at school no doubt had a positive effect. Of the children supported by the project, 93 per cent were attending school at the time of the survey.

The donkeys help families in other ways. Some use them to fetch water and firewood, easing the workload of girls and women. Others rent them out or use them to sell firewood, generating income for the family.
There is no World Record for ‘hardest work to build a country from scratch’. But if there were, Eritrea would be a contender. Two decades ago it was broken and destitute. Today it is a nation on the path to development, surpassing many richer countries in its progress towards achievement of the Millennium Development Goals.

The self-reliance of the country and its people has to get credit for much of this success.

“Even if in the international arena the self-reliance policy is problematic, it has given people in Eritrea an incredible amount of resilience, an appreciation for what they have and a focus on innovation,” said Dr. El Bashir. “At the individual level it is working. People are very content, very focused on the future. Self-reliance is more a philosophy of life in Eritrea than just a political philosophy, and it has permeated the culture. That matters.”

Indicators of child well-being today reflect vast improvement compared to the situation 20 years ago. Yet much remains to be done to fulfill the rights of each of the country’s children:

- More than 98 per cent of children are immunized, compared to 14 per cent – but that still leaves around 2,300 children unprotected from infectious diseases.
- The under-five mortality rate is 63 per 1,000 live births, compared to 148 per 1,000 – but 6 children in 100 still die before their fifth birthday.
- More than three quarters of the population has access to health care within 10 kilometres of home, compared to 10 per cent – but that still leaves a quarter of the people facing difficult access to a health facility.
- More than 60 per cent of the population has access to safe water, compared to 7 per cent – but around 40 per cent of the people still drink unsafe water carried, usually by children, from an unprotected source.
- Around 25 per cent of rural residents have access to a latrine, compared to less than 1 per cent – but that still leaves 75 per cent of Eritrea’s people subjected to open defecation and the resulting health hazards.
- Iodine deficiency afflicts only 2 in 10 children today, compared to 8 in 10 children – but that still leaves 20 per cent at risk.
- Half of Eritrea’s children graduate from elementary school, compared to 25 per cent – but that leaves half the country’s children unable to fulfill their right to education and the opportunity to realize their full potential.
- The rate of maternal death has been cut by more than half, to 486 per 100,000 live births, compared to 998 per 100,000 – but that still leaves almost 1 of every 200 women dying in childbirth each year.
- The prevalence of FGM/C among girls under age 5 is 12 per cent as of 2010 – but 1 in 10 girls under 5 are still being cut.
- The prevalence of HIV has plummeted to 0.45 per cent of the population, compared to 4 per cent – but around 1,800 people still get infected every year.

As this document went to press, a new UNICEF-Government of Eritrea country programme was about to begin, covering 2013 to 2016. The challenges it will address are clear.

“The Government wants to achieve the Millennium Development Goals,” said Dr. El Bashir. “They have the desire and they have the strength and the capacity and of course our support. Eritrea is achieving very much with very little.”

He added, “The Eritrean Government always has a road map – they may not have the resources, but they know where they are going.” UNICEF will always be a partner on the journey.