# Establishing and Maintaining Reproductive Health Programs in Countries Coping with the Effects of War and Civil Strife: Experiences in Albania, Cambodia, and Eritrea

SEATS

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*Building a Family Planning Program in Albania in a Time of Social and Political Upheaval*

**Priya Mammen**
*Rebuilding Public and Private Health Care Systems in Cambodia in an Environment of Civil War and Unrest*

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*Reproductive Health Programs in Eritrea Following a 30-Year War for Independence*

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# Acronyms

AFPA ..... Albanian Family Planning Association
ARI ..... Acute Respiratory Infection
BASICS ..... Basic Support for Institutionalizing Child Survival
CDD ..... Control of Diarrheal Diseases
CMA ..... Cambodian Midwives Association
DHS ..... Demographic and Health Survey
EPLF ..... Eritrean People's Liberation Front
FGC ..... Female Genital Cutting
FP ..... Family Planning
IEC ..... Information, Education, and Communication
MCH ..... Maternal and Child Health
MOH ..... Ministry of Health
NGO ..... Non-Governmental Organization
NUEYS ..... National Union of Eritrean Youth and Students
PHC ..... Primary Health Care
PSI ..... Population Services International
RACHA ..... Reproductive and Child Health Alliance (Cambodia)
RH ..... Reproductive Health
RHAC ..... Reproductive Health Association of Cambodia
SEATS ..... Family Planning Service Expansion and Technical Support Project
TBA ..... Traditional Birth Attendant
TFR ..... Total Fertility Rate
UNFPA ..... United Nations Population Fund
UNICEF ..... United Nations International Children's Fund
USAID ..... United States Agency for International Development
WHO ..... World Health Organization

# 1 Introductory Remarks by David O'Brien

We are pleased to present this paper which was delivered by a panel at the 1998 American Public Health Association (APHA) Annual Meeting: *Establishing and Maintaining Reproductive Health Programs in Countries Coping with the Effects of War and Civil Strife: Experiences in Albania, Cambodia, and Eritrea*.

This panel included three separate presentations. Each presentation described the experiences of the Family Planning Service Expansion and Technical Support (SEATS) Project in providing technical assistance and implementing reproductive health (RH) services in countries devastated by war or undergoing civil unrest, including Albania, Cambodia, and Eritrea.

The SEATS Project is funded by the Office of Population of the United States Agency for International Development (USAID) under a performance-based contract with John Snow, Inc., a public health management consulting firm. This project is one of USAID's largest service delivery programs, working in Africa, Asia, and the Newly Independent States. SEATS works with both public- and private-sector agencies to develop and deliver high-quality, sustainable family planning and reproductive health (FP/RH) services.

SEATS works in a number of areas recovering from or currently afflicted by war or civil strife. These presentations highlight countries from different regions, each with its own particular difficult situation. SEATS staff entered these countries and, in collaboration with different host country institutions, assessed the FP/RH needs and designed and implemented activities and technical assistance. Each of these countries has had long experience with internal violence, civil strife, isolation from the outside world, and severe and ongoing internal economic and political changes. The panel's presentation describes how SEATS is working to establish basic reproductive health services in the areas of greatest need, while simultaneously contending with ongoing effects of civil instability. We present some of the history of these countries and a description of some of the factors facing project staff.

## *Albania*

The first section by William Gerard presents *Building a Family Planning Program in Albania in a Time of Social and Political Upheaval.* William, who previously served as a Peace Corps volunteer in Albania, is a Program Associate overseeing the Albania country activities. As someone who has been evacuated from Albania, he knows firsthand the effects of the country's continued unrest.

Albania has had over five centuries of occupation, and is only six years out of communism. The SEATS Project has faced a tremendous challenge providing technical assistance in FP/RH services in an environment that has had strong pro-natalist policies for over 50 years. Since 1997, Albania has been plagued with economic turmoil, and SEATS is experiencing its second evacuation from the country in less than three years. Strong country staff, master training teams in country, and close donor collaboration have allowed program implementation to continue without the intensive external technical assistance normally provided in times of peace.

## *Cambodia*

The second section by Priya Mammen presents *Rebuilding Public and Private Health Care Systems in Cambodia in an Environment of Civil War and Unrest.* Priya is also a Program Associate with the SEATS Project, focusing on Cambodia. She has held previous positions with a micronutrient project, a children's AIDS program, and a family advocacy program.

The severity of the problem facing Cambodia centers on its lack of trained health professionals and health care workers, and on the flow of health professionals from the public sector to the private sector, due to the poor quality of health care facilities and the systems to support these facilities. Cambodia has myriad donors and non-governmental organizations (NGOs) working in a largely unregulated environment. They can often create confusion in the health care system by working in parallel or replicative ways. In response, the SEATS Project has concentrated on institutionalizing focused capacity building within Cambodian organizations.

## *Eritrea*

The third and last speaker is Marni Lavarentz. Marni is the Program Associate responsible for backstopping and assisting with the SEATS country program in Eritrea. She was a Peace Corps volunteer in Burkina Faso, and she previously worked with Sudanese refugees in Iowa on a domestic nutrition project. Her presentation is entitled *Reproductive Health Programs in Eritrea Following the 30-Year War for Independence.*

The revolutionary government's spirit has remained in place, underlying a tremendous and fierce pride in setting policy and in providing the direction and leadership for this young country. Its leaders, all previous freedom fighters, have carried this national dignity into the planning of their health care system. Like Albania, SEATS/ Eritrea's program success is largely due to an effective local staff and strong collaboration with financial donors. Another essential ingredient is the tremendous program support from the Government of Eritrea. Unlike Cambodia, Eritrea has had a clear understanding of its desired outcome from the outset of its freedom and has exerted control over the sources of external assistance.

### *Crosscutting Themes*

All of these countries, in particular Eritrea and Cambodia, face tremendous shortages of well trained health care personnel and lack both infrastructure and basic equipment. Programs must address a wide variety of needs in the health care systems including policy development; national protocols; training curricula; logistics; management information systems; strategic planning; national information, education, and communication (IEC) materials; quality; sustainability; and more.

Within each of these settings, a strong, reliable working relationship with the government, in conjunction with flexible and creative programming, has proven integral to project success. Our partners have been very receptive to new ideas and approaches, demonstrating a desire to improve services and a knowledge of good management practices. Technical assistance must be provided in a delicate and facilitating fashion, allowing governments and host country institutions, who have fought long and hard for independence, to be in control.

As George Bernard Shaw once said, "Peace is not only better than war, but definitely more arduous."

# 2 Building a Family Planning Program in Albania in a Time of Social and Political Upheaval

## *Geography and Demographics*

Albania, a small nation in southern Europe, is bordered by the Adriatic Sea to the west, former Yugoslav nations to the north and east, and Greece to the south. Roughly the size of Maryland, Albania is 70 percent mountainous, and has a population of approximately 3.5 million. Significant populations of Albanians reside in neighboring Macedonia, to the east, and the Yugoslav province of Kosova on Albania's northeast border. The situation in Kosova, in particular, is widely publicized. However, other than refugee flows and some armed camps in the border areas, the war in Kosova has not yet had a major impact on Albania. See the map in Figure 2-1.

The largest population centers are the capital, Tirana, and the largest port, Durresi. The rate of urbanization is high, with immigration to cities—especially Tirana—and to western Europe increasing steadily. Nonetheless, the population is still approximately 60 percent rural, a direct result of the strict, communist-era restrictions on internal and external movement.


***Figure 2-1***

## *Albanian History*

For most of its modern history, repression and seclusion have been the norm in Albania. Figure 2-2 shows an overview of Albanian occupation including five centuries of occupation by the Turks followed by a brief period of independence, then occupation by various European states. By the end of World War II, communist partisans, under Enver Hoxha, seized control and ushered in 50 years of extreme isolation and repression. The communists produced continued impoverishment and underdevelopment, and very effectively insulated Albania from foreign ideas. Listening to foreign radio was not permitted, and dissenters, even those with family overseas, were persecuted and jailed. While this strict centralized system improved health care somewhat and produced a highly literate population, it only heightened the isolation that had existed for centuries.

### Modern Albanian History

- 1479-1912: Turkish occupation
- 1912-1914: Independence; Ismail Qemali
- 1914-1944: Occupation by European powers, and Italian-puppet monarchy
- 1944-1990: Communism (Enver Hoxha; Ramiz Alia)

***Figure 2-2***

Enver Hoxha's obsession with foreign invasion led to a strong pro-natalist policy during the five decades of communist rule. As outlined in Figure 2-3, abortion and family planning were outlawed, allowing women only traditional, and not very effective, methods of controlling their fertility. Illegal, unsafe abortion was widespread, contributing to a high maternal mortality ratio—nearly 60 deaths per 100,000 live births in 1990 (as well as many unreported deaths). Meanwhile, from 1960-1990, the total fertility rate (TFR) fell from six children per woman to less than three, indicating a strong desire among

### Reproductive Health in the Communist Era

- Pro-natalist:
  - Abortion illegal, although widespread
  - Family planning illegal
- Maternal mortality: 60 deaths/ 100,000 live births by 1990
- Total Fertility Rate: falling
  - 6 children/woman in 1960
  - 3 children/woman by 1990

***Figure 2-3***

Albanian women to reduce their fertility despite the hostile laws and policies of the communist era and the complete lack of family planning services.

## *Recent History*

The rough transition to democracy began with the collapse of the communist regime in 1992. For several years there was widespread rioting and destruction, looting of public buildings, and damage to infrastructure such as roads, telephone, and power networks. Massive emigration ensued. Significant strides were made toward democratization during four subsequent years of relative calm. This was disrupted, however, in early 1997, when several government-sanctioned financial pyramid schemes collapsed, depleting the savings of most Albanian families. Antigovernment anger was fueled by violence and anarchy, the effects of which are still felt today. Westerners were evacuated and returned six months later to find the situation little improved. Banditry remained widespread, and street conflict continued between socialists and the ousted democrats, inflicting further damage on the already poor infrastructure. Theft of equipment from projects, ministries, and other offices was ongoing, and emigration continued. Furthermore, internal security was ineffective, attracting drug smugglers, international fugitives, and terrorists. In August of 1998, American personnel, including SEATS Project members, were evacuated once again as a result of threats made by foreign terrorists who had taken refuge in Albania.

**Recent History: Chronic Instability**

- 1990-92: Collapse of Communist regime; anarchy
- 1997: Collapse of pyramid schemes; anarchy
- 1998: Continuing disorder
  - Evacuation of American personnel
  - Violent confrontation between ruling Socialists and opposition Democrats

***Figure 2-4***

**Ministry of Health (MOH) Hospital**

***Figure 2-5***

## *Present Day Conditions*

Today, six years post-communism, the health care and RH systems are heavily influenced by carry-over from the communist era. The Ministry of Health (MOH) system has hospitals, like that shown in Figure 2-5, in all 36 district capitals. Polyclinics and ambulatory care centers are located in the rural areas. Maternity hospitals and polyclinics have nominal reproductive health and family planning services offered by obstetrician/gynecologists and midwives. Women in many areas of the country, however, still do not have reliable access to modern birth control

methods because contraceptives are not always reaching health centers. In fact, poor infrastructure, unpaved roads, recent political instability, and banditry have made travel and communication with the 60 percent of Albanians who live in rural areas treacherous.

Albania has the worst public infrastructure in all of Europe, and the health care system is particularly unstable in this regard. As shown in Figure 2-6, hospitals and health care centers are severely underequipped, even in the highest-volume central sites such as those in Tirana. Frequent power disruptions, lack of functioning equipment, and infrequent access to running water are just a few of the problems. The structures are usually in severe disrepair, with no glass panes in the windows, no heat even in the cold and damp mountain winters, cracks in the decrepit cement and stone walls, broken furniture, etc. Poorly paid Albanian doctors and midwives do the best they can under the circumstances.

**Health Centers: Underequipped**

***Figure 2-6***

Unfortunately, these providers are often poorly trained, as medical schools and health centers rarely have access to modern equipment or teaching materials. In general, reference materials are hard to come by and modern ideas are slow to reach most areas of the country. This is reflected in many of the traditional approaches to treating patients and in the poor, often incorrect information shared on family planning. In Albania, where family planning was illegal and information from the rest of the world was inaccessible, this is hardly surprising. As a result, abortion remains the method of choice in limiting childbirth throughout much of the country.

Abortion was first legally practiced at maternity hospitals in 1991. As indicated in Figure 2-7, the maternal mortality ratio quickly dropped by half to the current rate of 30 deaths per 100,000 live births. The abortion rate is very high, and MOH data suggest that the nationwide average is about one abortion for every two live births. This rate has been increasing since 1992, particularly among

**Abortion**

- First legally practiced in 1991; maternal mortality reduced by 50%
- Current rate is 1 abortion for every 2 live births, and increasing, especially among youths
- Tirana: 30% of all abortions performed nationwide; outnumber deliveries.

***Figure 2-7***

younger women. In Tirana, where nearly 30 percent of the country's abortions are performed, abortions actually outnumber births.

The prevalence of abortion suggests a substantial unmet need for family planning, and is further evidence of the lack of information or access to services and commodities. The health risk posed by unsanitary conditions, inconsistent clinical practices, and old, poorly maintained abortion equipment is substantial.

**Focus Group Research: "We want to know everything about it: Albanian women speak about family planning"**

- Research with women of reproductive age, all ages; including postpartum, postabortion, and young women
- Women reported
  - Most unfamiliar with methods
  - Many unfamiliar with family planning concept
  - Women aware of providers' ignorance of methods
  - Most very interested in family planning; for health, economics, and free choice

***Figure 2-8***

The lack of accurate information about family planning reaching women was reflected in a focus group study conducted by SEATS in 1996. The vast majority of women interviewed were unfamiliar with family planning methods. For many, even the concept of family planning was unknown. Of those who were familiar with it, many thought that available birth control methods were toxic or harmful. This bias, particularly regarding oral contraceptives, mirrors the attitudes of service providers. While these women expressed frustration that even providers are uninformed, they still indicated a strong interest in learning about family planning. Figure 2-8, shows that concerns about health, economics, and reproductive freedom are prevalent.

It is clear that a substantial need for contraceptives and improved family planning and reproductive health services exists, but there are considerable obstacles.

## *Goals for the SEATS Project*

To meet the needs identified in a 1995 reproductive health assessment of Albania, the USAID Albania Mission has funded SEATS activities

**SEATS/Albania Goals**

- To enhance Albanians' ability to make informed choices that allow them to achieve their reproductive goals.
- To improve knowledge and skill levels of health professionals to provide quality FP/RH services.
- To increase the number and quality of service delivery points available in the public and private sectors.

***Figure 2-9***

through the end of 1999. As shown in Figure 2-9, the goals of the SEATS/Albania subproject are:

- To enhance Albanians' ability to make informed choices that allow them to achieve their reproductive goals;
- To improve the knowledge and skill levels of health professionals to provide quality FP/RH services;
- To increase the number and quality of service delivery points available in the public and private sectors.

## *Key Project Components*

During this two and a half year subproject, SEATS has worked primarily in Tirana and Durresi Districts to develop tools and approaches that are expanding to adjacent districts.

In order to meet these goals in the most efficient manner, the project has been divided into three key components. These components, as indicated in Figure 2-10, are:

- IEC: Addresses the needs of women and service providers for information;
- Provider Training: Addresses the need for skill and knowledge building among service providers, including pharmacists, to improve the services they provide to clients;
- Contraceptive Logistics: Improves the flow of contraceptive commodities and service information to increase much-needed access.

**SEATS/Albania Project Components**

- Information, Education, and Communication (IEC)
- Provider training
- Contraceptive logistics system

***Figure 2-10***

## *Obstacles to Success*

In addition to the structural and knowledge-based obstacles mentioned earlier, Albania's chronic political instability is an added constraint to both local activities and international assistance. Since 1990, recurring episodes of anarchy and civil disorder have made mere survival a challenge for many people, let alone running clinics, distributing contraceptives, or conducting provider trainings. When we designed the program, we were aware of the challenges of working in a country such as Albania. However, the scope of the anarchy and instability of the last year and a half was not anticipated. Obviously, the evacuations have resulted in a number of unanticipated delays. Also, the dangers of banditry and political

violence have prevented project personnel from traveling far outside the capital, making a national program nearly impossible at this point. In addition, the turnover in posts at MOH and other partners (due to restructuring and political dismissals related to the transfer of power from democrats to socialists in 1997) and subsequent emigration, has made our close work with and training of ministry officials essential to program success.

Activities continue despite the absence of expatriate staff and consultants. This continued activity is mostly due to the tenacious efforts of our competent and dedicated Albanian staff. They have maintained their momentum despite constant political turmoil and ongoing periods of great personal danger. Windows of our office building were shot out during the June 1997 elections, and our Program Coordinator was nearly a victim of a car bombing at a nearby building. In spite of frightening and dangerous daily conditions, our staff and partners continue working hard to keep activities on track.

**Clinical Training Programs**

- Courses in
  - Contraceptive technology update, client counseling, contraceptive logistics system
  - Training-of-Trainers
  - Postabortion/postpartum services
  - Pharmacist training (with AFPA)
- Total of 761 participants trained in 35 courses

***Figure 2-11***

## *Successes*

In addition to the leadership of our Program Coordinator and staff, the local organization which has been built in the form of master training teams has payed off enormously. The training teams work in very difficult conditions, and have braved dangerous travel to conduct trainings, as outlined in Figure 2-11, in three different districts. A total of 35 courses, for 761 providers and health care officials, have been completed thus far. Most of these courses were conducted with our master trainers, including five four- and five-day seminars held since the most recent evacuation. However, the ability and willingness of trainers to travel beyond short day-trips is questionable, indicating that further expansion of the program will require the creation of regional training teams.

One encouraging development is the slow and significant, albeit incomplete, democratization taking place in Albania. The culture of fear and repression of the communist era that was still visible when we first began working in Albania is beginning to subside. Providers who were once afraid to criticize now demonstrate an increased willingness to suggest alternative strategies, and to openly question various activities. Both providers and clients show a greater interest in and awareness of fertility and family planning choices, indicating a growing sensibility for reproductive rights. It

is noteworthy that the first Albanian Constitution, which has been drafted and was in a national referendum in November 1998, contains a statement in support of reproductive rights.

This growth in civil awareness is further indicated by the flourishing NGO community. This community, which developed suddenly and in large numbers in the early years after communism, has endured despite the difficult political and economic climate of recent years. The women's NGO groups have been particularly active, partly as a result of the increasing economic status of women since the fall of communism.

**Client Choice**

***Figure 2-12***

In nearly all cases, our partners in the MOH and providers have been openly receptive to our programs, ideas, and models. As Figure 2-13 illustrates, Albanian providers want knowledge about western FP/RH practices and approaches. As a result, it is difficult to keep up with the overwhelming demand for our training program. Similarly, the MOH has strongly praised our contraceptives logistics system, and has said that, if feasible, it will become the national system during the remainder of our project.

Collaboration with other financial donors and contractors has been immensely helpful in overcoming the obstacles posed by an unstable environment. For example, a quality reproductive health services logo for providers and pharmacists was designed with the input of a group of relevant foreign and Albanian organizations. SEATS and other contractors and donors also continue to help each other distribute materials to different sites around the country. For example, SEATS distributes Albanian Family Planning Association (AFPA), European Union Support, Population Services International (PSI), and United Nations Children's Fund (UNICEF) project posters to our sites; while PSI, the United Nations Population Fund (UNFPA), and the World Health Organization (WHO) distribute SEATS provider reference cards and reproductive health newsletters when they visit distant sites.

**Provider Training**

***Figure 2-13***

Yet another successful collaboration has been the contraceptive logistics system. UNFPA purchases the contraceptives and pays for the distribution, while SEATS logistics system ensures timely and appropriate resupply and captures relevant statistics.

### *Summary*

In summary, post-communist Albania poses many challenges to a FP/RH program, including tremendous need, poor conditions, and continued political instability. Despite dangers and frustrations, the program continues unabated with dedicated Albanian staff, master trainers, partners, and other collaborators, as we strive to improve reproductive health and family planning services and access for the people of Albania.

# 3 Rebuilding Public and Private Health Care Systems in Cambodia in an Environment of Civil War and Unrest


*Figure 3-1*

## *Geography*

Cambodia is a poor, rural agricultural country in Southeast Asia, surrounded by Vietnam to the east/southeast, Laos to the northeast, Thailand to the north and west, and the Gulf of Thailand to the southwest.

## *Population*

A census conducted in 1962 showed a population of 5.73 million. As indicated in Figure 3-2, the population was relatively balanced between the sexes, and the average life expectancy was 43 years. The majority of the population was concentrated in the lowland plains around the rivers and lakes.

**Population**

- 1962 population: 5.73 million
  - Balanced between the sexes
  - Average life expectancy - 43 years
- Population concentrated in lowland areas around rivers and lakes

*Figure 3-2*

## *Historical Background*

When Phnom Penh fell to the Khmer Rouge in April of 1975 and during the subsequent years under its rule until 1979, mortality reached high levels—estimated to be between one to two million—with an additional one million people emigrating to foreign countries. During this time, ten percent of the male population and three percent of the female population were killed. Many more died due to poor health care and other survival issues as a result of the war. Pol Pot's regime intentionally killed the university-educated population, including physicians and pharmacists, and virtually destroyed the existing public health, medical, and educational infrastructure. By 1979, only an estimated 45 doctors remained in Cambodia. A census completed in 1980 indicated a total population of 6.59 million, reflecting massive teen and adult loss during the period between 1975 and 1979, especially among the male population.

**Historical Background**

- 1965-1973: Vietnam Conflict
- 1975-1979: Khmer Rouge invasion
  - Estimated 10% male and 3% female population killed
  - Large-scale emigration
  - 1979: an estimated 45 doctors in Cambodia
- 1980: Population 6.59 million
- Vietnamese invasion early 1979
- Current population: 10.7 million
  - More females than males
- Estimated 50% of population less than 19 years old

***Figure 3-3***

The war left a largely decimated professional corps and an overall rudimentary human capital in its wake. A 1997 MOH census shows that 50 percent of the population of 10.7 million people is less than 19 years old. Females still outnumber males. Figure 3-3 shows both an historical account and current statistics.

## *History of NGOs*

During the reign of the Khmer Rouge, expatriate and NGO presence was nonexistent. As shown in Figure 3-4, a small number of these organizations had reemerged by 1982. They began to rebuild, beginning with the health and agricultural sectors (Mysliwiec, 1993). Between 1988 and 1992, the number of NGOs doubled, resulting in the expansion of the scopes of their work and in the number of areas where they were located. The rise of the indigenous NGO community in Cambodia complemented this effort.

The ten years following the fall of the Khmer Rouge is notable for the complete absence of indigenous

**History of NGOs**

- No international NGO presence during Khmer Rouge rule
- 1982: Small number of NGOs reestablished
  - Focus on health and agriculture sectors
- 1988 to Present—Number of NGOs and international donors steadily increasing
- No local, indigenous NGOs before 1989
- Sharp rise in numbers since 1993

***Figure 3-4***

organizations focused on development and community restructuring. Since 1989, however, many indigenous organizations have been reestablished, representing virtually all sectors.

## *Public Health Sector*

Public sector health resources have declined steadily. As Figure 3-5 indicates, the World Bank found that less than $1 per capita was spent on health in 1993. The situation is further exacerbated by the low rate of use. The physical infrastructure of the public health system never fully recovered from the destruction caused by the Khmer Rouge era. The system suffered deeply at the district level and below, leaving the primary health care delivery system virtually nonfunctional. The health care system is currently working to improve facilities and services and to increase the rate of utilization. Presently, many of the commune-level clinics have been demolished and others are staffed with poorly skilled workers. The services offered are minimal, consisting mostly of vaccinations and few, if any, curative activities. Moreover, the location of the facilities, many of which were chosen for political rather than health-related reasons, is often inappropriate. The MOH reported that the current system does not meet even the essential health needs of the population.

**Public Sector**

- 1993—Less than US $1 per capita spent on health (World Bank)
- Low use of public-sector health facilities

***Figure 3-5***

## *Goals of Reform*

As outlined in Figure 3-6, the overall goal of health care reform is to improve and extend primary care through the implementation of a district-based health system and to emphasize integration of services at the peripheral level. The second goal is to establish government leadership and control of a system that has been allowed "uncontrolled development" in the private sector and in the international donor community. Another goal of reform is to reverse the negative public perception, and consequent lack of use, of public-sector health facilities and services.

**Goals of Reform**

- Improve and extend primary care through the implementation of a district-based health system and emphasize integration of services at the peripheral level
- Regain control of a system that has been allowed "uncontrolled development" in private sector/international donor community (MOH)

***Figure 3-6***

District Health Clinic

Inherent in this restructuring is a revision of the expected roles and functions of each level of care—Central, Intermediate, and Peripheral. Figure 3-7 graphically depicts these proposed revisions. The Central Level is comprised of the MOH, National Institutes, National Programs,

and National Hospitals. The intermediate level consists of the provincial directorates, and the peripheral level includes the district and provincial hospitals. The peripheral level is divided into two parts. The first part, the operational district, is composed of all clinics and health centers, and the second part consists of all referral hospitals. The type of services offered at the district level will be expanded to encompass preventative, curative, and primary care activities. At this level, which boasts the closest contact with the immediate population, the Ministry hopes to ensure accessibility and the delivery of quality care, and to encourage a dialogue that promotes strong community involvement.

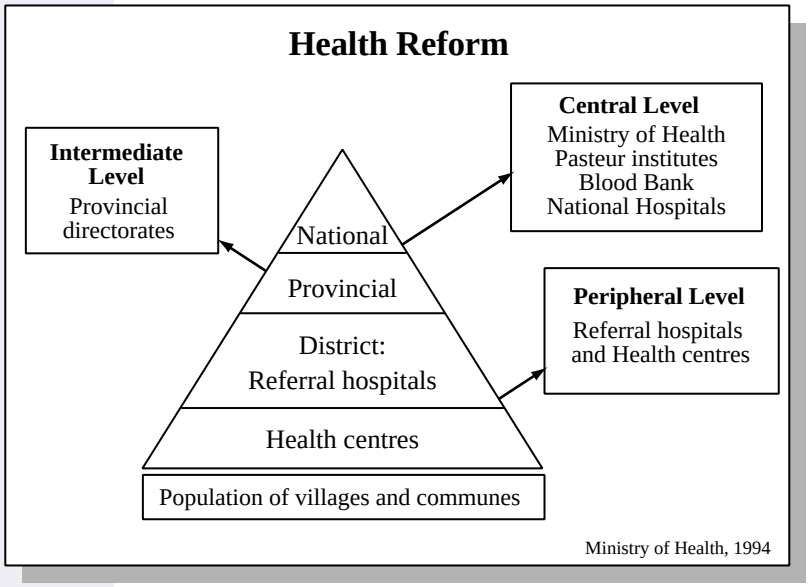


***Figure 3-7***

## *Program Objectives*

The SEATS Project supports three ongoing programs in Cambodia— the Reproductive and Child Health Alliance (RACHA), the Reproductive Health Association of Cambodia (RHAC), and the Cambodian Midwives Association (CMA). These programs focus on reproductive health and family planning, safe motherhood, midwifery skill upgrading and logistics management activities. This three-pronged approach allows SEATS' support to address many levels including the policy level, the community level and service delivery, and the private and public sectors.

SEATS' initial involvement in Cambodia began in 1996 as a consortium member of RACHA. This alliance was developed in response to the USAID Maternal and Child Health (MCH) Strategy as a collaborative effort among SEATS, the USAID-funded BASICS (Basic Support for Institutionalizing Child Survival), and AVSC International. Under this MCH Strategy, the technical focus areas of RACHA include safe motherhood, birth spacing, and control of diarrheal diseases/acute respiratory infection

**Program Objectives**

Reproductive and Child Health Alliance

- Consortium of SEATS, BASICS, AVSC
- Technical focus areas
  - Safe Motherhood
  - Birth Spacing
  - CDD/ARI
  - Logistics Management
- Focus provinces
  - Siem Reap
  - Pursat
  - Kampot
  - Strung Treng

***Figure 3-8***

(CDD/ARI). The SEATS Project is responsible for safe motherhood, birth spacing, and essential drugs logistics management. The project focuses on the policy level in four of the 22 provinces in Cambodia.

### *RACHA*

The main goal of RACHA, as outlined in Figure 3-9, was to promote safe motherhood. To accomplish this goal, it sought to develop approaches to improve maternal health in Cambodia by implementing such activities as drafting and finalizing a Safe Motherhood National Strategy with the Government of Cambodia; developing protocols for use by the MOH as standardized measures; and developing curricula and training programs for midwives.

**RACHA**

- Safe Motherhood
  - Develop approaches to improve maternal health
    - *Safe Motherhood Strategy*
    - *Protocols*
    - *Midwifery skill-upgrading*
- Essential Drugs Logistics Management
  - Develop appropriate guidelines, policies, and management tools
    - *Procurement, supply and request of contraceptives*
    - *Stock level survey of government health facilities*
    - *Database to monitor stock supply*
  - Train and develop skills of local staff

***Figure 3-9***

With regards to logistics management, the main focus remains on developing appropriate guidelines, policies, and management tools and on training and skills development of local staff. RACHA was also asked to revise procedures and to develop guidelines for procurement, supply, and request of contraceptives for the district and peripheral levels. A stock level survey of the government health facilities established baseline data on existing supply and store conditions; and a database was designed and developed in coordination with the MOH and the Essential Drugs Bureau to monitor stock supply.

**RHAC**

- Reproductive Health Association of Cambodia (RHAC)
  - Family Planning and Spacing Project implemented by Family Planning International Assistance (1994-1997)
  - 1996- RHAC becomes local NGO
  - 1997- SEATS/RHAC partnership begins
- RHAC provides FP/RH services
  - Phnom Penh, Sihanoukville, Battambang
  - 1st to offer Norplant
  - began 1st comprehensive RH program for youth
- Community Based Distribution
  - Takeo, Kampong Speu, Svey Reing
- Training Center

***Figure 3-10***

### *RHAC*

A partnership between the RHAC, an indigenous NGO with funding from USAID, and SEATS was forged in 1997. As seen in Figure 3-10, RHAC began as the Family Health and Spacing Project, set up by Family Planning International Assistance in 1994, and by May of 1996 RHAC was officially founded. The cofounders, Dr. Ouk Vong Vathiny and Dr. Var Chivorn, currently serve as the Executive Director and Deputy Director, respectively.

**Primary Objectives of RHAC**

- Increase use of and access to high quality RH services through strategic expansion and service delivery
- Increase RHAC's capacity to strategically plan, implement, and monitor high quality RH service delivery in private sector nationwide
- Strengthen RHAC's financial planning and budgeting capabilities, increase level of cost recovery & income generation in RHAC programs, and diversify donor support

***Figure 3-11***

RHAC provides family planning and reproductive health services in four clinics in Battambang, Phnom Penh, and Sihanoukville, and also supports a community-based distribution of contraceptives program in Kampong Speu, Svey Rieng, and Takeo provinces.

The primary objectives of RHAC are outlined in Figure 3-11. The areas of focus lie in organizational development, including strategic planning and financial planning systems, contraceptive supply (logistics), clinical service delivery, community-based distribution of contraceptives, and training in clinical skills. The SEATS Project supports these identified priorities. Specific support is designed toward institutional development.

RHAC offers a variety of family planning and sexually transmitted disease prevention methods to its clients and was the first NGO in Cambodia to provide Norplant®. In addition, RHAC began the first comprehensive reproductive health program for youth in Cambodia (Huff-Rousselle, 1998). The community-based distribution program achieved great success, with more than 350 volunteers in the three provinces offering family planning products such as contraceptives and information to the more rural, hard-to-reach populations.

### *CMA*

Finally, a partnership between the CMA and SEATS began in July 1997. CMA focuses on training and education. The main components of this project, as shown in Figure 3-12, are assessment of member training needs, development of continuing education curriculum

**Cambodian Midwives Association (CMA)**

Key Components:

- Assessment of CMA member training and education needs
- Continuing education curriculum and training
- Institutional development

***Figure 3-12***

and training, development of training-of-trainers curriculum, and institutional development. By working with the largest unifying body of midwives, SEATS hopes to add breadth and depth to the cadre of health care providers in Cambodia.

### *Lessons Learned*

The greatest limiting factor to all Cambodian health programs is the scarcity of well trained health professionals and health care workers. While definite progress has been made, where 45 remaining doctors in 1979 grew to 705 doctors and 15,180 medical support personnel by 1990 (Barister, et al, 1993), the limited absorptive capacity of this small cadre has continued to affect both the public and private health system in Cambodia. In addition to the minimal physical health infrastructure, any forward momentum in health activities is invariably hindered by a lack of trained Cambodian workers to follow through. Furthermore, the language barrier makes the provision of technical assistance and training from an American project somewhat arduous and complex as English is not the first, and in some cases not even the second, language of Cambodians.

As a result of the low number of trained health care professionals, the "brain drain" phenomenon has had a profound impact on both the public and private sectors. Local, indigenous organizations cannot provide the same salary or work environment as an international or bilateral organization. Consequently, recruitment is difficult. With such a small group with which to work, trained health care workers are eagerly sought out by those who require their services. RHAC has dealt with many instances where a staff member went through its rigorous orientation and training process only to be tempted away by another organization that offers salaries that RHAC can not match. Such occurrences result in high turnover rates that undermine the overall strength and continuity of the team. This fundamentally hinders progress and takes energy away from the organization, though perhaps improves the human resource pool nationally.

This is particularly true for the public sector. The lines between public and private sector are more ambiguous in Cambodia than in many other countries. As a consequence of the exceedingly low salaries offered by the government for civil service workers, most trained health care professionals are employed in the private sector. In most cases, health care providers work for a few hours in the district clinics and then go to their private practice for the rest of the day (World Bank, 1994). The poor quality of health care facilities, the lack of dependable services, and the unavailability of health care staff undermine the population's trust in the public health care system.

More and more, the donor and NGO communities must adhere to the reform goals of the MOH. Since 1988, donor organizations have been granted virtual “free reign” by the Cambodian government, in that their activities were neither well monitored nor restricted. Now, the Ministry is asserting its leadership to ensure that private-sector activities support the reform goals and aid in increasing public-sector utilization. While there is generally very strong coordination among the donors, inclusion of the government has not been significant. Donor funds mostly bypass the central government for direct access to the local levels, creating an “uncoordinated patchwork of activities.” In previous years, when

limited restriction was imposed by the Ministry, the distribution of health organizations and programs did not always correspond to demographic need. Donor assistance favors certain regions of Cambodia. The World Bank found that in 1994, Phnom Penh, with seven percent of the population, received 43 percent of the donor funding while the central lowlands provinces, with 66 percent of the population, received only 21 percent of the funding. Although this is partly, if not mostly, due to instability in the country, an opportunity to better rationalize the allocation of health resources exists.

**Lessons Learned**

- Greatest limiting factor to health programs is the scarcity of skilled health professionals and health care workers
  - 1990 705 doctors and 15,180 medical support personnel
- Human Resource Constraints
  - Internal "brain drain" phenomena
  - High staff turnover rate
  - Shifting between public & private sectors
- NGOs must adhere to Ministry reform goals
  - "Uncoordinated patchwork of activities"
  - Opportunity to better rationalize the allocation of health resources
- Increased involvement of government is positive step
- International NGO and donor implementation constrained by adherence to reform that is not yet fully functional

***Figure 3-3***

The government is attempting to curb the private sector's "uncontrolled development" via increased leadership and regulation. They are organizing the efforts of the private sector and international community by establishing a coordinating body for health programs. New programs, such as one soon to be implemented by the Asian Development Bank, are choosing provinces that have been previously underserved by the Ministry and international donors in which to focus their efforts. Moreover, the Ministry is working with WHO to strengthen national programs aimed at eradicating principal communicable and preventable diseases.

The increased involvement of the government is a positive sign. Although, it is necessary to have the government involved in an overall health care policy, many NGOs and international donors have been constrained by reform that is not yet functional (Kinzie, 1998). The system is weak, and change is slow. By forcing NGO activities to fall in step with government reform, the progress and successes of the donor community may begin to deteriorate. However, a stronger relationship and collaboration between the NGOs and the government should be fostered to establish a level of sustainability and to ensure future progress. Figure 3-13 chronicles the numerous lessons learned from this experience.

## *Conclusion*

Given immediate needs and priorities, Cambodians in many ways appear unable to invest in long-term development of their country, resulting in dependency on foreign aid. However, they have survived an atrocious and brutal recent history with their sense of determination and hope unscathed. Slowly they are emerging from the seemingly unending effects of their war-torn past, moving toward a future in which they are no longer victims.

# 4 Reproductive Health Programs In Eritrea Following 30-Year War for Independence

## *Introduction*

Eritrea, Africa's newest nation, was liberated in May 1991, after a 30-Year War with Ethiopia. Independence was formally declared on May 24, 1993, following a referendum in which 99 percent of the people voted for autonomy.

Eritrea's terrain ranges from the rugged mountainous central region to the arid desert along the Red Sea coast and the dry lowlands savanna in the west. The extreme temperatures, deforested rugged terrain, and lack of paved roads in most of the country, make transport and communication to rural areas difficult. Figure 4-1 shows a map of Eritrea.


***Figure 4-1***

Following decades of colonial rule and ongoing struggle for independence from Ethiopia, the self-reliance forced upon Eritreans

became a strength that helped them survive through a generation of war, years of drought, and the horrors of famine. The Eritrean people are committed to creating a better society by relying principally on themselves. Their tenacity is resolute and inspiring.

## *Post-War*

Eritrea was left completely impoverished by the war, with a gross domestic product of less than US$150 per capita. However, the corruption often found in governments of poverty-stricken countries was, and still is, almost nonexistent in Eritrea. The leadership of the Eritrean People's Liberation Front (EPLF) during the war, as shown in Figure 4-2, established an exceptionally high degree of trust in the government and its social services, including health. Eritreans emerged eager to independently rebuild their nation and shape a new society.

**Health Status and Development**

Role of the EPLF

- Established health services, formal schools, and professional colleges
- Fostered a strong will and determination in Eritrea

***Figure 4-2***

## *Health Status and Development*

During Italian rule, Eritreans did not receive even basic health services. The health status of Eritreans showed little improvement when the British gained control of Eritrea at the end of World War II. At the time of annexation by Ethiopia, the Ethiopian government did not set health improvement as a high priority; and the ensuing war of liberation saw the destruction of the little infrastructure that had been in place. During their fight for freedom, the EPLF established both preventive and curative health services for areas under their control. Working under cover and in very difficult circumstances, they established hospitals, rehabilitative and drug manufacturing units, and even formal education and professional (e.g., for health professionals) training camps in their bunkers.

Under the acacia trees and in the bunkers away from the Ethiopian Migs, the social departments of the EPLF established formal schools for elementary and secondary education. These schools were attended by both the young and by women. It was the first time that women found a system that recognized and helped them in their development. In response, they quickly became contributing members of the community as both freedom fighters and as active members of the society.

These camps soon became colleges, providing training for various professions including all facets of the health care profession. Many highly-educated Eritreans, who had been displaced to European cities by the struggle, were now able to sneak back into the camps to provide much needed technical support. Others who remained displaced provided financial and material assistance to support the educational and medical services/programs. Even from behind enemy lines, the fighters were able to effectively tackle the health care problems resulting from war and drought.

**Eritrea Post-Independence**

S. Ross

- Lack of infrastructure
- Exodus of trained Eritrean health professionals
- Limited MOH capacity
- High level of trust in government

***Figure 4-3***

Regardless of such substantial strides, Eritrea found itself with a devastating lack of infrastructure upon gaining independence. As indicated in Figure 4-3, the few remaining facilities were hardly capable of providing curative health care, let alone preventive health services. Long years of war led to the exodus of trained Eritrean health professionals, including physicians, nurses, midwives, dentists, pharmacists, and more. The lack of human capital left the MOH with limited capacity to absorb technical assistance and implement rapid improvements. Additionally, the population losses suffered over decades of war had created a general desire on the part of the Eritrean people to increase rather than decrease or maintain their population size.

On a more positive note, the war years fostered a strong will and determination on the part of the Eritrean people to succeed in every national and individual endeavor. This unparalleled level of enthusiasm and motivation to make things work in Eritrea, and to do so on their own terms, coupled with a high level of trust in the government and a willingness to take complete responsibility for program planning and implementation, set the stage for tremendous development.

**Health Indicators 1995 DHS Figures**

- Population: 3.8 million
- Birth per 1,000: 43
- Population under 15 years of age: 44%
- Natural Increase: 3%
- TFR: 6.1
- CPR: 8.0
- CPR (modern methods) 4.0
- Unmet Need: 27.5%

***Figure 4-4***

## *Health Indicators—1995 DHS Figures*

At independence, the available data and statistics on health were limited. In 1995, the Eritrean Demographic and Health Survey (DHS) indicated that the overall population was, as shown in Figure 4-4, approximately 3.8 million with 44 percent of the population under 15 years of age. The birth rate per thousand was approximately 43, and the population had a natural increase of 3 percent.

By 1995, the average TFR was 6.1. This rate was high compared to other countries in the region. At that time only four percent of married women in child bearing ages who wished to delay pregnancy were using modern birth control methods. An additional four percent used traditional methods for an overall contraceptive prevalence rate (CPR) of eight percent. Only 66 percent of women were aware of contraceptive methods, indicating a need to focus the attention of health care service providers on issues of fertility, reproductive health, safe motherhood, and demographic trends. The unmet need is estimated at 27.5 percent.

**Health Indicators 1995 DHS Figures**

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- Infant Mortality Rate: 72/1,000 live births per year
- Under 5 Mortality Rate: 136/1,000 live births per year
  - Common Causes of Death
    - *Communicable Disease*
    - *Malaria*
    - *Acute Respiratory Tract Infections*
    - *Malnutrition*

***Figure 4-5***

As shown in Figure 4-5, the infant mortality ratio was 72/1,000 live births and the mortality ratio of children under five years of age was 136/1,000 live births per year in 1995. Only 41 percent of children 12-23 months old had completed immunization, while only 29.8 percent had completed their immunizations by the age of 12 months. With this low coverage, vaccine-preventable communicable illnesses are still a common cause of childhood morbidity and mortality. In addition, acute respiratory infections, malaria, and malnutrition are common causes of death among young children.

As shown in Figure 4-6, the maternal mortality ratio in 1995 was estimated at 998/100,000 live births per year, one of the highest in the world. This rate, amazingly,

**Health Indicators 1995 DHS Figures**

S. Ross

- Maternal Mortality Rate: 998/100,000 live birth per year
- 18% of women deliver in health institutions
- < 21% deliver under supervision of trained health personnel
- FGM is almost universal at 95%

***Figure 4-6***

was even higher during the war, especially for the nomadic communities. Only 18 percent of women deliver their children in health institutions, and fewer than 21 percent of women deliver their children under the supervision of trained health care personnel. Women of reproductive age represent approximately 20 percent of the total population. As the status of women is low, they are an especially vulnerable group. They are exposed to traditional practices such as female genital cutting (FGC) which places them at high risk during pregnancy and childbirth. Although the practice was discouraged during the fight for independence, FGC is nearly universal (95 percent) among women of childbearing age, often leading to childbirth complications, hemorrhage, and infection. Moreover, the early marriage of girls, combined with multiple poorly spaced pregnancies and malnutrition negatively affects the health of Eritrean mothers and children.

### *Immediate Priorities in the Eritrean Health Sector*

The most immediate priority of the Government of Eritrea with regard to the health sector is the establishment of targets for health infrastructure development, covering 10,000 persons per health station and 50,000 per health center.

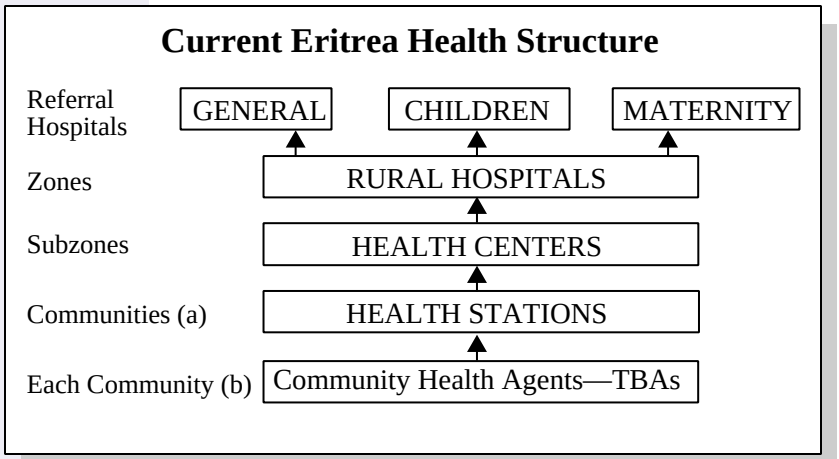


***Figure 4-7***

As you can see from the diagram in Figure 4-7, the health care system is divided into different levels. At the community level, workers focus on such areas as health promotion and malaria prevention. Traditional birth attendants (TBAs) also provide delivery services. Training programs for community- level workers and for TBAs have been intensified.

The next level consists of health stations, which are usually two-room structures staffed by two or three health assistants. Some health stations may even have nurses. The services provided here are generally curative. They also have couches for emergency deliveries and some provide Expanded Programme on Immunization (EPI) and MCH care. Family planning activities are generally limited to condom distribution. The target for the MOH is for each of these health stations to serve approximately 10,000 people.

The next level is the health centers. These centers, which supervise about five health stations in the area, are targeted to serve 50,000 people. They generally have one to four nurses, three to six health assistants, and a midwife on staff. They provide maternity services, a curative outpatient department, inpatient care for emergencies, laboratory service, MCH care, and FP.

In the future, the MOH plans to have six zonal referral hospitals and 12 rural hospitals within each of the zones. The referral hospitals will have specialists and about 200 beds in each facility. Each rural hospital will have 80-100 beds and will be staffed by a director, one or two doctors, eight to 12 nurses, and about 20 health assistants.

**Immediate Priorities in the Eritrean Health Sector**

- Full integration and improvement of PHC services
- National PHC guidelines
- Quality RH services - service guidelines, clinical protocols, training curricula
- Institutional capacity and training to address FP/RH service needs
- Coordination of all externally funded programs

***Figure 3-11***

The final goal is to have three major referral hospitals, each with its own speciality areas. One facility is currently under renovation to become a large National Central Referral Hospital with 500 beds that will house all specialties of medical care in one building.

## *Priorities in the Health Sector*

Other MOH priorities with regard to the health sector, as shown in Figure 4-8, include the full integration and improvement of integrated primary health care (PHC) services, the development of national PHC guidelines, the provision of quality RH services, improved institutional capacity to address FP/RH needs, and coordination of all externally funded programs.

The Ministry's efforts to improve RH services include development of service provision guidelines, clinical protocols for safe motherhood, and training programs (e.g., for TBAs and on family planning). In addition, training institutes for mid-level health providers will be strengthened.

SEATS was funded by the USAID Mission in Eritrea to provide technical assistance to the MOH to address these health program priorities.

**Current MOH/USAID/SEATS Programs**

MOH Every Opportunity: Eritrea Family Planning Service Delivery

- Increase knowledge of and demand for FP/RH services in three zones
- Provide training in FP/RH to all health workers in subzones
- Improve the quality and management of services
- Expand service delivery

***Figure 4-9***

## *Current MOH/USAID/SEATS Programs*

Since 1995, SEATS has assisted the MOH in implementing the FP/RH component of the bilateral USAID Eritrean Health and Population Project. This component's aim is to increase knowledge of and demand for FP/RH services, and integrate and expand quality FP/RH services through the MOH PHC system. To assist the MOH, the following programs were developed.

**1) MOH-Every Opportunity: Eritrea Family Planning Service Delivery Subproject**

As stated in Figure 4-9, this program aims to:

- Increase knowledge of and demand for FP/RH services in three zones (Southern, Central, and Gash-Barka);
- Provide training in FP/RH to all (approximately 100) health care workers in subzones;
- Improve the quality and management of services;
- Expand service delivery.

**2) National Union of Eritrean Youth and Students (NUEYS)**

In another subproject, SEATS worked with the National Union of Eritrean Youth and Students (NUEYS). NUEYS was created in 1968 and has over 100,000 members. During the 30-Year War, NUEYS was a leadership organization for young fighters. Today, it remains one of the most important groups in Eritrea, and it is committed to improving the health status of Eritreans. NUEYS administers youth centers in zones and subzones throughout the country.

**Current MOH/USAID/SEATS Programs**

National Union of Eritrean Youth and Students(NUEYS)

- Increase access to and use of FP/RH services among sexually active youth
- Provide youth with information and education to increase knowledge
- Strengthen capacity of NUEYS staff and volunteers

***Figure 4-10***

As depicted in Figure 4-10, SEATS works with NUEYS to:

- Increase access to and use of FP/RH services among sexually active youth;
- Provide youth with information and education to increase knowledge of services, sexuality, and contraceptive method options;
- Strengthen the capacity of NUEYS staff and volunteers to promote, develop, and implement youth programs.

**3) Safe Motherhood Initiative**

As a result of a National Safe Motherhood Conference in 1996, a Safe Motherhood Action Plan, as outlined in Figure 4-11, was developed in 1997. The MOH asked SEATS to provide technical assistance for the implementation of the Safe Motherhood Initiative. MOH priorities for Safe Motherhood are to:

**Safe Motherhood Initiative**

- Enhance advocacy
- Develop appropriate IEC and community mobilization interventions
- Provide quality facility-based service delivery
- Strengthen human resource development
- Promote research on Safe Motherhood

***Figure 4-11***

- Enhance advocacy;
- Develop appropriate IEC and community mobilization interventions;
- Provide quality, facility-based service delivery;
- Strengthen human resource development;
- Promote research on safe motherhood. An example of this is ongoing life-saving skills training classes for midwives and TBAs.

## *Resumed Border Conflict/1998 Border War*

Over the last six months, conflict with Ethiopia has arisen again over border disputes. Violence has erupted and the all-too-familiar symptoms and patterns of a country at war have resurfaced in Eritrea.

## *Effects of Eritrean/ Ethiopian Conflict on the Health System*

Some of the effects SEATS has seen since the conflict resumed, as outlined in Figure 4-12, include:

- A significant reduction in utilization of family planning services at rural sites;

**Effects of Eritrean/Ethiopian Conflict on the Health System**

- Significant reduction in utilization of FP services
- Slow down of training and human resources development activities
- Rapidly-evolving policies which affect program implementation
- Slow-down of donor assistance and even cessation as many agencies are under an evacuation order
- Renewed interest in larger families and overall population size

***Figure 4-12***

- A slowdown of training and human resources development activities as many health care professionals and providers have been mobilized to prepare for and attend to emergency needs at the front;
- Rapidly evolving policies, which sometimes make it difficult for organizations to operate effectively and efficiently, and other times result in redeployment of personnel, affecting program implementation;
- A slowdown of donor assistance and even cessation as many agencies are under an evacuation order;
- Renewed interest in larger families and overall population size, both to compensate for potential personal losses related to war casualties and to amass a larger force of person-power to engage in war or otherwise thwart external political threats.

### *Effects on the SEATS Project Assistance to the Eritrean Health Sector*

**Effects of Conflict on the SEATS Project Assistance to the Eritrean Health Sectors**

- Two of SEATS' three target zones are in disputed areas
- MOH energy shifted toward emergency situations
- Renewed interest and belief in larger family sizes

***Figure 4-13***

The renewal of hostilities with Ethiopia has made Eritrea a more difficult setting for development activities. Some of the effects SEATS has already experienced, depicted in Figure 4-13, include:

- Two of SEATS' three target zones are in disputed areas, making it unsafe to conduct activities. Some local institutions are temporarily closed. With USAID issuing an evacuation order to technical agencies such as SEATS, we have minimal in-country technical presence, which prohibits necessary assistance.
- Due to the tension with Ethiopia, the MOH has had to shift its energy toward emergency situations. For example, efforts to prevent and treat malaria are now a high priority (in order to be well prepared for what might become a longer-term war), while family planning has become less important;
- And, finally, there is renewed interest and belief that larger family sizes are important to maintain adequate personal/family numbers and political strength**.** Such positions and attitudes can thwart progress already made and clearly present challenges for working successfully in such an environment in the foreseeable future.

Tensions between Eritrea and Ethiopia continue, and war could break out between the two countries at any time. However, Eritreans have proven themselves to be a resilient people who can overcome obstacles. As longtime fighters they are dedicated to making their country, and the health sector in particular, a showplace in Africa. They will do everything possible to continue to improve the lives of mothers, children, and families. The Eritreans already came out of the 30-Year War for Independence charged, committed, and motivated. Their skills and talent will allow them to continue to achieve improvements regardless of the circumstances.