# ANNUAL REPORT OF THE HUMANITARIAN / RESIDENT COORDINATOR ON THE USE OF CERF GRANTS

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| **Country** | **ERITREA** |
| **Humanitarian / Resident Coordinator** | **MACLEOD NYIRONGO** |
| **Reporting Period** | **JANUARY-DECEMBER 2007** |

## I. Executive Summary

Eritrea's humanitarian situation stems from the lack of progress in the demarcation of the border and chronic food insecurity due to recurrent droughts. The stalemate over the disputed border with Ethiopia means that thousands of able-bodied men and women and other national resources are committed to national service, restricting the scope of domestic production and efforts to mitigate the adverse impact of drought.

Chronic drought conditions negatively impact food security, health, nutrition, and water availability. Inadequate supply of agricultural inputs and erratic rainfall contribute to disruption in agricultural production, undermining the capacity of the population to provide for itself. Furthermore, in 10 percent of the country's communities--655,000 people --are plagued by land mine and unexploded ordnance, limiting agricultural production in the country's breadbasket regions of Gash Barka and Debub. Periodic food shortages have resulted in very high malnutrition rates in children and woman. Infant and under-five mortality rates stand at 47 and 89 per 1,000 live births, respectively. Overall, only 32 percent of rural population have access to protected water sources. Finally, Eritrea also hosts 4,642 refugees and asylum seekers, mainly from Somalia and Sudan, and there remained 12,000 Internally Displaced Persons (IDPs) in camps-mainly in Debub, all of whom require assistance.

The rapid assessment of Rural Water Supply and Sanitation conducted by the Water Resources Department (WRD) in 2006 indicates that 254 out of 2,750 villages have a toilet of any kind. No latrines were found in 2,496 villages. Nationally, about 55 percent – 80 percent of households have no latrine. Less than 20 percent of the households dispose of stool of babies properly, leading to high risk of diarrhoeal diseases. The average monthly Incidence of diarrhoea is above 10,000-100,000 or 10 percent and several outbreaks of diarrhoeal diseases were reported in 2006.

Eritreans in coastal and western lowland areas bear the most brunt of the harsh conditions. An estimated 2.3 million people, mainly nomadic pastoralists and agriculturalists in Anseba, Gash Barka and Southern Red Sea zones, are the country's most vulnerable, with high levels of maternal and infant mortality rates nationwide. Seasonal migration by 80 percent of this population deprives it of access to basic health services, adequate nutrition and adequate shelter.

Many remote areas are not covered by routine or outreach services at all. Only 26 percent of women deliver in health facilities. Fully vaccinated children range from 36.8 percent in Southern Red Sea to 49 percent in Northern Red Sea. Immunization drop out rate due to population displacement has reached up to 50 percent in many communities. In addition to the outbreaks of diarrhoeal diseases, other outbreaks include that of meningitis and suspected Dengue fever.

A combination of the above affect the entire spectrum of basic social service provision, including education. Low attendance and high drop-out rates in primary schools present challenges in remote areas.

The overall operational environment, characterized by the government's reluctance to acknowledge the full extent of these challenges, and in which traditional resource mobilization by humanitarian partners is discouraged imply critical funding gaps remain in efforts to meet the emergency needs of the population.

The $ 3 million allocated by the Emergency Relief Coordinator from CERF's underfunded window was essential in enabling humanitarian partners to assist in filling these gaps to provide needed assistance to vulnerable populations. Overall, CERF funds have been vital in strengthening the resilience of vulnerable groups against a decline in livelihoods, climatic hazards and conflicts.

For example, CERF funding for Eritrea:

- Enabled the World Health Organization (WHO) to facilitate the expansion of sustained outreach health services thus ensuring that a greater proportion of the traditionally unreached population was reached with a package of basic health services
- Covered the food needs until the end of 2007 for 3,900 Somali and Sudanese refugees.
- Ensured the continuation and monitoring of the national Vitamin A campaign and vaccination outreach interventions in hard to reach communities.
- Made it possible to provide timely basic health and nutrition services especially for under five children in the IDP sites.

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| **Total amount of humanitarian funding required and received (per reporting year)** | **Required:** $ **49,771,737**<br>**Received:** $ **21,478,156** | | | |
| **Total amount of CERF funding received by funding window** | **Rapid Response: $ NA**<br>**Under funded:** $ **3,000,909**<br>**Grand Total:** $ **3,000,909** | | | |
| **Total amount of CERF funding for direct UN agency/IOM implementation and total amount forwarded to implementing partners** | **Total UN agencies/IOM:** $ **210, 064**<br>**Total implementing partners:** $ **2,790,845** | | | |
| **Approximate total number of beneficiaries reached with CERF funding (disaggregated by sex/age if possible)** | **Total** | **under 5 years of age** | **Female (If available)** | **Male (If available)** |
| | **1,602,032** | **685,352** | ---------- | ---------- |
| **Geographic areas of implementation** | **Gash Barka, Debub, Northern and Southern Red Sea** | | | |

## II. Coordination and Partnership-building

### (a) Decision-making process:

Following communication by the Emergency Relief Coordinator (ERC) to the Humanitarian Coordinator (HC) and the Office for the Coordination of Humanitarian Affairs (OCHA) of CERF allocation to Eritrea, UN agencies were informed of the 2007 CERF under-funded emergencies window and the possibility of funding. Some agencies received this information through their headquarters. The agencies reviewed relevant information from various sources, including surveys, and conducted rapid assessments to further establish priority needs. The results of these needs analysis exercises were then discussed within the respective sectors-clusters with NGOs and national counterparts and proposals based on consensus presented for final decision. These proposals were based on humanitarian priorities agreed to by partners in the 2007 Common Humanitarian Action Plan (CHAP). Project proposals were sent to OCHA and discussed at the heads of agencies meetings. The selection of the twelve projects in six sectors (health and nutrition; mine action; assistance to refugees; water and sanitation; agriculture and emergency education) was made in close consultation with all UN agencies and in keeping with the criteria set forth by the CERF Secretariat for funding of under-funded emergencies. The division of the allocated CERF

funding over the sectors was discussed in the UN Country Team and only life saving, short-term disaster mitigation and under-funded emergencies were taken into account for selection. The involvement of NGO partners in the planning and implementation of the projects has not been possible because of provisions in the NGO proclamation, issued in 2005, that bar UN agencies from channelling funding through NGOs in Eritrea. As such, NGOs are not implementing partners for CERF-funded projects in Eritrea.

### (b) Coordination amongst the humanitarian country team

The Inter-Agency Standing Committee (IASC) in Eritrea is the main humanitarian decision making body in the country. It is chaired by the Humanitarian Coordinator and includes the entire spectrum of partners- the Red Cross Movement, donors, NGOs and UN agencies present in the country. The IASC decided to develop a CHAP in 2007 to prioritize humanitarian interventions and to serve as a coordination tool. It is on the basis of the identified and agreed to priorities in the 2007 CHAP that decisions on which sectors and projects to request CERF funding for was based. The IASC in Eritrea meets once every month under the chairmanship of the Humanitarian Coordinator. The final endorsement of the CERF projects was done by the HC on the basis of:

- Sector meetings comprising participating agencies;
- Meetings of the Joint Programme on IDPs led by the United Nations Development Programme (UNDP) and comprising UNDP, the United Nations Children's Fund (UNICEF) and the United Nations High Commissioner for Refugees (UNHCR);
- OCHA consultations with the agencies;
- The decisions of three IASC meetings in early 2007 and two other meetings in the second half of 2007.

Restrictions on the activities of NGOs and part of the Red Cross Movement (the Eritrean Red Cross) have and continue to prevent a more inclusive implementation strategy. Project implementation is limited to relevant government ministries/departments and regional administrations which act as implementing partners. CERF projects were implemented through the Ministries of Health, Education, Local Government, the Office of Refugee Affairs, and the Eritrea Demining Authority; the Regional Administrations of Debub, Gash Barka, Northern Red Sea and Southern Red Sea.

### (c) Partnerships

Partnership has been enhanced between sectors and government ministries-departments in the health, water and sanitation sectors. Similarly the working engagement for continued assistance to refugees and asylum seekers has continued the working relationship between UNHCR and the Office of Refugee Affairs (ORA). Inter-agency collaboration has been more advanced in the health sector and in the Joint Programme on IDPs. However, as mentioned above, the full engagement of all partners in the IASC in CERF activities remain impeded by government policy, which through a 2005 proclamation bar UN agencies from channelling funds to NGOs. Because CERF funds are transmitted to UN agencies, implementation has been done primarily through and with government departments and local authorities. Similarly, as a result of government policy, partnership with the government on strategic levels continues to be a significant challenge. Conversely, the decentralized nature of the government and thus local implementation through regional and sub-regional authorities has enhanced local-level working relationships between affected populations and local officials.

### (d) Prioritization process

The prioritization process was undertaken at two levels:

1. *Strategic level*: The IASC in Eritrea endorsed a CHAP at the beginning of 2007 outlining five Strategic areas of focus for the year. These were:
   - Support activities related to the return of the IDPs and assistance to refugees;
   - Provide access to water and sanitation to the population of the coastal areas of Eritrea;
   - Reduce malnutrition of under-five-year-old children, but not limited to the displaced, refugees or other emergency situations;
   - Disaster mitigation and preparedness;

- Mainstreaming cross-cutting issues such HIV-AIDS, gender-based violence, reproductive health and environment in programming.

The first three priorities were given emphasis in the CERF application process.

2. *Sector level:* Respective sectors employed a variety of methods to prioritize or were faced with glaring funding gaps for unmet needs. Food for refugees exemplifies the latter case. The health projects were based on the findings of rapid assessments, various surveys and analysis of various data.

The prioritization was a combination of the strategic priorities of the CHAP 2007, projects exhibiting chronic funding shortages as well as areas with displaced populations and the respective sector needs as presented to the IASC. Prioritization was based on a continuum of needs from emergency provisions (e.g. food for refugees) to critical basic social services (health, water and sanitation, agriculture, education and mine action).

## III. Implementation and Results

### Under-funded emergency projects

The discontinuation of the Consolidated Appeals Process (CAP) for 2006 was part of a broader government policy re-orientation towards *self-reliance*. This development, apart from drastically re-organizing key government humanitarian organs, also created new challenges for mobilizing resources for humanitarian needs. The overall policy shift was and continues to be marked by the government's insistence that mobilization of resources by UN agencies should derive from core funding. As a result of these developments and/or at the request of the government some traditional donors to Eritrea have left the country entirely (e.g. USA) and in the absence of ability to monitor projects, many have significantly scaled down support.

These developments are despite the fact that the country is facing huge challenges posed by years of chronic drought, desertification, poor infrastructure and continued insecurity along the border with Ethiopia. As a result, malnutrition rates are high, water-borne diseases are widespread and cause many deaths. While tens of thousands of IDPs have been resettled/returned to areas of origin, 11,010 more still remain internally displaced in camps in Zoba Debub. Similarly, UNHCR is providing food assistance to approximately 3,700 refugees in Emkulu and Elit refugee camps.

The key areas of vulnerability have been and remain food insecurity, water, health and nutrition. The IASC in Eritrea has and continues to prioritize activities that provide access to water and sanitation to the population of the coastal areas of Eritrea and directs support towards projects aimed at reducing malnutrition in children under the age of five, including among the displaced and refugees Additionally, humanitarian response prioritize those projects that provide assistance to returning IDPs displaced since the 1998-2000 border war and to refugees, mainly from Sudan and Somalia.

In 2007, the CERF under-funded window advanced $3,000,909 in support of projects in all these areas against total requirements of $49,771,737. At year's end, a total of $21,478,156 was received from other sources. Together, the CERF and resources from other sources totalled $24.5 million just under 50 percent of the total requirements for the year.

In terms of sectors, the availability of CERF funding enabled the World Health Organization (WHO) to facilitate the expansion of sustained outreach health services thus ensuring that a greater proportion of the traditionally unreached population was reached with a package of basic health services, including immunization, mineral supplemtation to pregnant women and ante-natal and post-natal services

UNHCR faced serious funding constraints in 2006 and 2007 endangering the continuation of provision of food and basic services to refugees in Eritrea. The CERF covered the food needs until the end of 2007 for 3,900 Somali and Sudanese refugees in Emkulu and Elit refugee camps.

In health, CERF funding enabled continuation and monitoring of the national Vitamin A campaign and vaccination outreach interventions in hard to reach communities. Without this contribution it would not

have been possible to support the government in implementing the national vitamin A supplementation campaign, a life-saving intervention contributing to the reduction of child morbidity and mortality. CERF funds were also instrumental in the screening of children aged 6-59 months for malnutrition in five out of the six regions and referral to therapeutic and supplementary feeding was carried out where needed.

In education, CERF grants enabled the provision of both technical and financial assistance to the Ministry of Education and Local Government in Gash Barka Region to ensure education services for IDP children in returnee/resettlement communities. CERF funds were used for the construction of makeshift classrooms and the provision of educational materials as well as teachers' training. CERF funding made it possible to provide timely basic health and nutrition services especially for under five children iin the IDP sites. CERF funding also allowed for timely support to dought-affected communities and newly resettled IDPs in gaining access to safe and clean water.

Resettling IDPs in 2007 were assisted with CERF funding under the Joint IDP Programme with the government in efforts to improve their food security situation.

Food insecurity, although in large part due to the cummulative effect of successive years of unfavourable rainfall, is also partly due to mine infestation in the war affected areas. As part of assistance package for restoration of production and resettlement of displaced persons, the CERF complemented the Recovery and infrastructure component of the response with funding for mine action. Mine clearance continue in these areas.

Overall, CERF funds have been vital in strengthening the resilience of vulnerable groups against a decline in livelihoods, climatic hazards and conflicts.

### *(a)* Monitoring and evaluation

Various monitoring and evaluation tools and methodologies were used by respective agencies for their projects. These operate under the monitoring and evaluation Task Force of the United Nations Country Team (UNCT). This group is nascent and is being strengthened. Monitoring and evaluation took the form of field visits, supportive supervisory visits and assessments from which reviews corrective measure, as required were instituted to ensure project activities' goals were realized.

**WHO:** Information from the Health Management Information System (HMIS), the Integrated Disease Surveillance and Response (IDSR) databases and project reports were analyzed regularly to determine the trend and institute appropriate corrective actions. Rapid assessment missions and supportive supervisory visits were regularly conducted by the World Health Organization (WHO), UNICEF and the Central Ministry. Reports from these assessment missions and supervisory visits were analyzed and appropriate actions instituted to ensure the achievement of desired results.

**UNICEF**

***Health and Nutrition:***
Central and regional level supervisors were supported to conduct regular field visits to monitor the implementation of the planned activities and provide on-the-job training to the health facility staff. Project monitoring was carried out jointly by the Ministry of Health and UNICEF.

***Water Sanitation and Hygiene (WASH):***
Sites for repairing/rehabilitating hand pumps and for dug-well rehabilitation were selected by the Water Resource Department (WRD) and the regional administrations using baseline data from the rapid assessment rural water and sanitation.

***Education:***
Regular field monitoring visits were made by UNICEF and Ministry of Education counterparts at sub-regional and district levels to track progress and constraints if any. The Project Management Unit (PMU) of the Education Sector Development Programme (ESDP) made joint visits to adjust/refocus programme interventions and project management as well as taking accelerative remedial measures as required.

**UNHCR:** Through the Programme Unit and Management of UNHCR, regular field visits were conducted as part of monitoring implementation of projects by implementing partners, in this case the Office of

Refugee Affairs. (ORA). The ORA also periodically submits project financial documents for UNHCR's verification of implementation of the project.

**UNDP**

***Mine Action:*** The UNDP Recovery Team conducted regular monitoring visits to project sites to evaluate project progress and monitor implementation, ensuring these were within the budget and timely.

***Agriculture:*** The Joint Programme on IDPs (UNICEF, UNDP, UNHCR) conducts regular constellations with regional authorities in Debub and Gash Barka regions on the implementation of the Programme.

### *(b)* Other initiatives which complemented CERF–funded projects

One impact of the CERF funding, in addition to the positive impact it continues to have on the well-being of the affected population, is the interest its impact in some areas has generated among partners. Through partial funding from previous CERF allocations and previous projects funded by the European Commission Humanitarian Aid Office (ECHO), a migratory routes map of the nomadic population from the Northern Red Sea and Southern Red Sea Zobas was produced. The migratory routes map has facilitated improved planning of basic health interventions for the nomadic population and have accordingly increased their access to these interventions. As a result funding levels for health outreach services has improved with the generation of more funds from ECHO as a result of the use of information derived from the tool. Health workers and health authorities at both central and regional levels are paying more attention to the under-served as a result.

Similarly, other funding sources enabled nutrition-related interventions funding therapeutic and supplementary food supplies. In health, the second round of Vitamin A supplementation was funded by other sources. In Water, Sanitation and Hygiene, (WASH) promotion activities and training of sanitarians complemented the water supply intervention, through promoting hand washing and ensuring quality control of water supply. Also, construction of water supply systems in drought-affected villages have been covered by other funding sources, complementing activities to provide clean water to the affected population.

The activities of the Eritrea Demining Authority and the UN Mine Action Coordination Committee (UNMACC) have complemented the CERF Mine Action project in the clearance and expansion of agricultural land in Debub and Gash Barka regions, resulting in improved productivity.

## IV. Lessons learned

CERF funding has made possible the continuation of various projects in Eritrea, enabling provision of assistance to more than 1.5 million people. Whereas overall policy constrains resource mobilization to address these critical needs, the CERF provides an acceptable avenue without which these critical needs would largely remain unaddressed.

The restrictions imposed on partners, principally NGOs and private contractors, impose constraints on timeliness of project implementation and assistance to affected populations. This is true for projects involving construction of one or another kind. The Country Team is exploring joint procurement for partners to leverage these challenges. However it remains a challenging undertaking because of the limited number of partners which limit economies of scale in procurement.

The CERF allocation process by the country team has improved transparency and coordination between UN agencies. However as indicated elsewhere in the report, the overall policy environment limits this to within the UN agencies as other partners' activities are highly regulated by the authorities and the UN is not allowed to implement UN-funded projects. One encouraging development of this environment is the increased level of community participation in and therefore enhanced ownership of CERF-funded projects. This has the promise of sustainability of interventions. However, it does not solve continuing problems with aspects of projects that require high levels of technical expertise.

CERF funding allows for filling of critical gaps in humanitarian activities and complements other funding sources. In an environment such as Eritrea, the CERF has allowed for an increase in the scope of activities, ensuring that complimentarily of activities for optimal outcomes can be balanced, e.g. in health, sustainable health outreach services in harsh and hard to reach areas in themselves cannot produce the right outcomes unless water quality, sanitation practices and hygiene conditions are also addressed. The CERF has enabled the balancing of these interventions for optimal outcomes.

## IV. Results

| Sector/ Cluster | CERF projects per sector | Amount disbursed ($) | Number of Beneficiaries (by sex/age) | Implementing Partners | Expected Results/Outcomes | Actual results and improvements for the target beneficiaries |
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| **Water and Sanitation** | ***07-CEF-069-A*** *Water, Sanitation and Hygiene* | *210,000* | ***9,600 people*** | Water Resource Department, Ministry of Health and Regional Administrations | ▪ 9,600 people from 10-20 drought affected communities have access to safe water through repair and rehabilitation of 20 non-functioning hand pumps, and rehabilitating eight unprotected dug-wells identified as part of the rapid assessment carried out in 2006. | ▪ Ten hand dug wells fitted with hand pumps were rehabilitated in Anseba, and a further five in Southern Red Sea (SRS).<br>▪ 22 hand pumps were rehabilitated, providing 6,600 drought-affected people with access to improved water supply.<br>▪ Three sets of solar pumping systems have been installed in three drought-affected villages of SRS. With this intervention 2,750 people gained access to safe water.<br>▪ Eight boreholes were drilled in villages in SRS and NRS, providing nearly 10,000 people affected by drought with clean water. |
| | ***07-CEF-021*** *Water, Sanitation and Hygiene for IDPs* | *506,500* | ***9,000 people*** | Water Resource Department, Ministry of Health and Regional Administrations | ▪ Provide access to water supply for 9,000 people from IDP resettlement and surrounding areas by installing 28 hand pumps in 20 rehabilitated traditional water sources such as dug-wells and eight newly drilled boreholes.<br>▪ 600 household latrines will be constructed and used, covering 3,000 people. | ▪ 20 non functioning hand pumps have been installed, providing 6,000 people with access to safe and adequate water.<br>▪ Water supply system for Tologoma IDP resettlement village in Gash Barka has commenced and is near-completion, covering 2,300 people with safe and adequate water.<br>▪ 3,500 jerry cans were distributed to 1,750 households in IDP resettlement villages in Gash Barka and Debub.<br>▪ A total of 600 household latrines, covering 3,000 people have been constructed in Folina and Elala in Gash Barka.<br>▪ Three water bladders of 10,000 litres have been to IDP resettlement villages and health facilities in Debub for storage of water delivered through water trucking.<br>▪ Four boreholes were drilled in IDP resettlement villages in Debub, providing 1,200 people with access to clean water. |

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| | ***07-CEF-021*** *Water, Sanitation and Hygiene for IDPs* | *53,500* | | | ▪ Water safety ensured in eight newly drilled boreholes and 20 rehabilitated traditional water sources for 9,000 people in IDP resettlement and surrounding areas | ▪ Water safety ensured for 7,200 people in IDP resettlement and surrounding areas. |
| **Health** | ***07-CEF-069-B*** *Facility-based therapeutic and supplementary feeding* | *175,938* | ***850 severely under-nourished and 5,000 moderately under-nourished under 5 children, 50% boys and 50% girls*** | Nutrition Unit, Ministry of Health | ▪ At least 85 percent of the estimated 850 severely malnourished children in 53 health facilities including IDP children in current and new resettlement sites recovered over a period of three months<br>▪ At least 70 percent of estimated 5,000 moderately malnourished children in six regions including IDP children in current and new resettlement sites recovered over a period of the three months | ▪ A total of 3,352 severely malnourished children admitted in 53 therapeutic feeding centres had a recovery rate of about 90 percent, death rate of five percent and defaulter rate of four percent<br>▪ Under the supplementary feeding programme 32,592 moderately malnourished children were reached between January and September 2007 |
| | ***07-CEF-029*** *National Vitamin A Plus Campaign* | *350,000* | ***460,000 children (245,000 girls and 215,000 boys), 6-59 months of age*** | Ministry of Health | ▪ **Overall objective**:<br>▪ To supplement vitamin A to 460,000 children 6-59 months in order to reduce childhood morbidity and mortality by using an integrated approach to deliver a package of interventions that includes vitamin A supplementation and other health and nutrition interventions.<br>▪ Specific objectives: first round of NVAD+ implemented to:<br>▪ To sustain the high coverage of vitamin A supplementation among children aged 6– 59 months at least above 90 percent at the regional level<br>▪ To increase routine vaccination | ▪ The first round of Vitamin A Supplementation campaign had coverage of 95 percent. 397,900 children aged 6-59 months were reached in each round.<br>▪ Nationwide DPT3/HepB 3 coverage reached 76 percent in December 2007, while the coverage in low coverage districts ranged from 16 percent to 71percent. |

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| | | | | | coverage to at least 80 percent from the present coverage of 15 percent in the 16 low vaccination coverage and hard to reach districts | |
| | ***07-WHO-015*** *Reducing Mortality from Health and Nutritional Hazards among Eritrea's Low Land Migrant Population* | *350,000* | **Total: 768,258**<br><br>**219,502 children under 5; 548,756 women of child-bearing age** | *Zoba (Regional) Health Office, Sub zoba (District) health management team, and UNICEF* | ▪ 70 percent timeliness of weekly reports of diseases and nutritional surveillance achieved<br>▪ Outbreaks rapidly and adequately detected, confirmed and controlled<br>▪ Integrated outreach services including vaccination provided to the vulnerable groups | ▪ Timeliness of weekly reports of diseases and nutritional surveillance maintained above 80 percent<br>▪ Trends of communicable diseases monitored on a weekly basis and results regularly shared in the fortnightly bulletin<br>▪ Responsible zoba (region) was informed to immediately conduct investigation and institute appropriate actions to avert possible outbreak when thresholds were reached<br>▪ Capacity to treat at least 10,000 children with diarrhoea provided through the procurement of ORS, Vitamin A and antibiotics<br>▪ Expansion of outreach services to reach a greater proportion of the traditionally un-reached population<br>▪ Drastic reduction in reported cases of diarrhoeal disease |
| | ***07- WHO - 054*** *Reducing Mortality from Health and Nutritional Hazards among Eritrea's Low Land Migrant Population* | *175,000* | **Total: 252,522**<br><br>**96,679 children under 5; 128,906 women of child-bearing age** | *Zoba (Regional) Health Office, Sub zoba (District) health management team, and UNICEF* | ▪ 80 percent of children in the targeted villages fully vaccinated by the end of the project period<br>▪ 60 percent of health facilities have capacity to provide integrated outreach services and undertake life saving procedures and treatment for referred cases<br>▪ 50 percent of mothers in the targeted villages have capacity to correctly manage diarrhoea at home<br>▪ Weekly report timeliness maintained at minimum of 80% and 100 percent of emergencies reported within 24 hours of occurrence | *This Project is ongoing. Training on diarrhoea prevention and treatment, support to mothers to prevent and manage diarrhoea at home, community level reporting for nutritional and communicable diseases early warning systems through community sensitization and data collection and analysis have been instituted in project regions.* |

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| **Food** | ***07-HCR-024 & 07-HCR-011*** *'Care and Assistance to Somali and Sudanese Refugees* | *399,986* | ***3,900 Somali and Sudanese refugees*** | Office of refugee Affairs (ORA) Eritrea | ▪ 3,900 refugees receive at least 2,100 Kcal per person per day | ▪ 3,900 refugees received between 2,100-2,965 Kcal/person/day |
| **Mine Action** | ***07-UDP-009*** | *240,000* | ***72,000 (IDPs) in return and resettlement areas in Debub and Gash Barka (38,520 women and 33,480 men)*** | *Eritrea Demining Authority* | ▪ Villages/areas identified in LIS survey verified with the list of the return/resettlement villages;<br>▪ Infested areas marked;<br>▪ Reduced fatalities through increased mine awareness;<br>▪ Increased agricultural production | ▪ 430,000 square meters of land verified with 13 return/resettlement villages in Gash Barka and Debub allowing for safe return'<br>▪ 500,000 square metres of grazing land marked in Debub, preventing accidents and fatalities;<br>▪ 38,275 people (19,373 men and 18,902 women) in 27 villages in Gash Barka and Debub sensitized on Mine and related risks;<br>▪ 470,000 square metres of land cleared of landmines and UXOs in nine villages in Debub and Gash Barka allowing for improved food security. |
| **Agriculture** | ***07-UDP-028*** *Joint Programme on IDPs in return/resettlement areas* | *239,985* | ***4,967 HHs (20,902 IDPs), 65 percent of which are female headed households*** | *Regional Administration of Gash Barka, Ministry of Agriculture and local Administrations* | ▪ Food security assured at the household level. | ▪ *Project Ongoing* |

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| **Education** | ***07-CEF-028*** *Basic Education for IDP Children* | *300,000* | *3,000 7-14 year old school-age children* | *Ministry of Education and Regional Education Offices* | ▪ Create and expand 10 additional safe and protective temporary learning spaces for schooling<br>▪ Procure 1,000 pupils' desks and benches<br>▪ Train 60 teachers and community facilitators to not only facilitate gender fair learning environments but also provide basic psycho-social care and support<br>▪ Provide essential educational and recreational materials | ▪ 12 semi-permanent and make-shift classrooms were constructed, providing safe learning spaces to 738 children.<br>▪ Over 1,800 children and their teachers in IDP schools benefited from the provision of 600 units of students' desks, 34 units of teachers' tables and chairs and other basic classroom furniture.<br>▪ 55 teachers in IDP areas and members of Parent-Teacher Association received training on basic psychosocial care<br>▪ 75 recreational kits have been distributed, and around 6,000 children benefited from teaching/learning materials and other students supplies, including supplementary reading materials. |

## V. CERF IN ACTION: Success stories

### Health (WHO)

Poor rain fall and subsequent drought necessitates the migration of people living in lowland areas to the high lands in search of pasture and water for their animals as well as food for their families. As a direct result of this migratory lifestyle, this population lacked access to vital life saving health interventions including immunization, antenatal care and skilled delivery attendance, and has been subjected to increased risk of outbreaks from communicable diseases including diarrhoea due to poor water supply and poor sanitation in addition to the movement from non-endemic to endemic areas.

Through part funding from this CERF window and previous ECHO projects, a migratory routes map of the nomadic population from the Northern Red Sea and Southern Red Sea Zobas was produced. The presence of this migratory routes map has facilitated improved planning of basic health interventions for the nomadic population and has accordingly increased their access to these interventions.


Hard to reach area (Kebabi Ruba-Hadas) *WHO Eritrea*

The availability of CERF funding facilitated the expansion of the Sustainable Outreach Services (SOS) thus ensuring that a greater proportion of the traditionally non reachable population was reached with a package of basic health interventions. As a direct result of the expansion of the SOS in 2007, a total of 4,043 children less than two years of age received OPV/DPTHepB immunization while a total of 64,314 women of child bearing age received TT immunization. Additionally, antenatal services with Iron Folate supplementation were provided to 2,096 pregnant women while 108 women received post natal services. Health promotion activities were conducted in hard to reach areas involving a total of 8,886 community members (*End*)


*Mountainous area (Kebabi Ruba Hadas) WHO Eritrea*

**Food (UNHCR)**

UNHCR Eritrea Age, Diversity, Gender Mainstreaming (ADGM) Multi-Functional Team (MFT) members composed of UNHCR staff from the Protection, Programme, and Finance and Administration Units along with MFT members from the Office of Refugee Affairs (ORA),-UNHCR's implementing partner for the Care and Maintenance for Somali & Sudanese refugees in Eritrea-visited the Emkulu Refugee Camp 01-03 March, 2007 in order to conduct an AGDM exercise for assessing refugee needs.

Food distribution to Somali Refugees in Emkulu Refugee Camp *(UNHCR*)

The MFT members organized themselves into groups and discussed with various groups of the refugee community. Different age groups of girls, boys, women, and men and other diverse groups of the refugees discussed their situation and needs with the MFT groups.

Among other things, the food situation in the camp was discussed with the refugees and findings of the MFT were that food distribution was regular and that there were no major complaints in that sector.

In 2006 and 2007, UNHCR experienced a serious shortage of funding to cover the basic needs of refugees in Eritrea. In order to raise the required funds for its under-funded project activity, UNHCR applied for resources from the UN Central Emergency Response Fund (CERF). Taking into consideration the life-saving and core humanitarian activity of feeding the refugees, CERF allocated USD 299,993 in 2006 and USD 399,986 to cover the food needs until the end of 2007 for 3,900 Somali and Sudanese refugees in Emkulu and Elite refugee camps.

With the funding provided by CERF wheat flour, beans, vegetable oil, salt, and sugar to cover the basic food rations for the refugees were purchased and distributed in Emkulu and Elite refugee camps. UNHCR monitored activities performed by Implementing Partner using its standard reporting formats and through visits to the refugee camps. (*End*)

**Water, Sanitation and Hygiene (WASH) UNICEF**

***Ergoli – Southern Red Sea, Eritrea***

12 year old Fatima sets off from her home every morning to fetch water from the nearest water source, a one-hour walk along a rugged, dusty terrain. With a full 20-litre jerry can – which weighs roughly half of her frail body - strapped onto her back, she staggers back home to her village under the unforgiving, scorching Southern Red Sea sun, occasionally stopping to adjust the straps or wipe beads of sweat forming on her forehead. This is not the only journey Fatima makes in a day to fetch water: she makes on average two to three trips to satisfy the needs of her family for drinking, cooking and washing. Even this, she says, does not always allow her to get enough water for her six-member family.

Water is a scarce resource for people living in the rural area of Eritrea, where only 57 percent of the population has access to clean water. Many parts of the country, including Fatima's community, continue to suffer from the effects of drought in recent years. The cycles of drought have caused the water table throughout the country to drop significantly, impacting 80 percent of the population, which depends on agriculture and pastoralism as main sources of livelihood. Children are especially vulnerable to lack of clean water and adequate sanitation, as they increase the risk of diarrhoea and other waterborne diseases, which also exacerbates child malnutrition.

Lack of water also impacts girls' education, as girls are often given the task of fetching water from distant water sources. "I spend about four to five hours - sometimes more - each day to get water for my family," says Fatima. Although Fatima attends school, she is sometimes late for her classes when she has a lot work to do at home, or she is often tired after her journeys carrying water for many hours.

As part of its emergency support to drought-affected communities, UNICEF assisted the Government of State of Eritrea and regional administrations in 2007 with CERF funds to provide safe water through rehabilitation and installation of 22 hand pumps, ten hand-dug wells, eight boreholes and three sets of solar pumping systems, benefiting more than 14,000 people. The newly rehabilitated hand-dug well and hand pump in Ergoli has brought clean water closer to the community, allowing girls like Fatima to spend less time on collecting water, and for families to gain access to enough water. The hand-pumped well, which stands in the middle of the village, operates six hours a day and the families each get turns filling their jerry cans for their daily use.

"What I used to spend many hours doing every day, now only takes not more than half an hour, and most of all, the water is clean, unlike the one in the water source we used to collect from," says Fatima happily.

Provision of safe water contributes to the protection and promotion of children's survival, health and development, and to the realization of their basic rights. (End)

*Girls carrying water in Southern Red Sea region. In Eritrea, girls are often tasked to fetch water for the entire family.* © UNICEF Eritrea

**Health and Nutrition (UNICEF)**

***Adi Keyh - Debub, Eritrea***

Three-year old Senay runs around playfully in the courtyard of a health centre in Adi Keyh, Debub region, as his mother tries to catch him to bring him to his weekly check-up. Senay was brought to the centre five weeks ago, suffering from severe acute malnutrition. “I cannot believe he is so well now, the boy was like a shadow of himself now just a month ago, and I was very worried that he may not survive.”

Senay’s weak and emaciated limbs are now plumper, and his life-less eyes are shiny again after receiving therapeutic feeding at the centre. Senay was among an estimated 6,700 under-five children suffering from severe malnutrition in the catchments areas n the country. The global acute malnutrition rate among under-five children in Eritrea ranged between 9 percent and 21 percent – above the WHO threshold of 10 percent in many parts of the country - according to a 2006 nutritional survey.

The causes of child malnutrition in Eritrea are complex and multidimensional: recent year’s Horn of Africa drought, poverty, food insecurity and low access to water and sanitation, and traditional feeding practices all contribute to under-nutrition among children. While Eritrea enjoyed good rains in 2007 and the highest crop yield in recent years, only around 40 percent of the country’s total cereal consumption requirement was met. Children are also vulnerable to the low access to clean water and sanitation particularly in rural areas, with access rates which stand at 57 percent and two percent, respectively.

Many malnourished children have previously gone untreated due to low access to health facilities and barriers in health-seeking behaviour, including the inability to afford transportation costs to reach the health services. Most mothers and caretakers of children are also unable to spend time in therapeutic feeding centres while the children receive treatment. CBTF was introduced to overcome these barriers, by bringing the service closer to the communities. Severely malnourished children without complications are brought to health centres offering CBTF to receive detailed check ups and provision of therapeutic food

(plumpy'nut) and nutrition education is provided by health workers and community volunteers to the caretakers, to allow children to be treated at home.

Senay was initially admitted at the referral hospital to receive facility-based therapeutic feeding (FBTF) as he was also suffering from pneumonia. Once his respiratory infection was treated, he was transferred to the CBTF programme. "With my farming work and four other children at home, I could not have stay with my son in a hospital for any longer." says Senay's mother. Children are brought to the CBTF sites for weekly check ups to monitor their recovery.

CERF Funding enabled UNICEF to support the Ministry of Health in providing nutritional supply as well as essential medicines to treat complication, and to train health workers and community volunteers to screen, manage, monitor and refer malnourished children. In 2007, 90 percent of 3,352 severely malnourished children admitted in 53 facility-based therapeutic feeding sites recovered, and death rate was kept at 5 percent. In the meantime, 67 percent of 1,018 severely malnourished children admitted in 39 Community-based Therapeutic Feeding (CBTF) sites around the country recovered, and the death rate was less than one per cent. 32,592 moderately malnourished children under five years of age were also provided with supplementary food or UNIMIX, nutritious fortified flour.

Senay, who weighted only 68 percent of the average weight of a three year old, has now recovered to more than 80 percent of the weight of children his age, and is not far from recovery. "I was at a complete loss when I first brought my son to the hospital, but I now have all the support he needs and feel confident about how to look after him," says his mother. (*End*)

*A severely malnourished child in a facility-based therapeutic centre in Adi Keyh health centre, Debub region. Global Acute Malnutrition in Eritrea ranges from 9 to 21 percent, above the WHO threshold of 10 percent in many regions.* © UNICEF Eritrea

**List of Acronyms:**

**ADGM**- Age, Diversity, Gender Mainstreaming
**CAP**- Consolidated Appeals Process
**CBTF**- Community-based Therapeutic Feeding
**CERF**- Central Emergency Response Fund
**CHAP**-Common Humanitarian Action Plan
**ERC**- Emergency Relief Coordinator
**ECHO**- European Commission Humanitarian Aid Office
**ESDP**- Education Sector Development Programme
**FBTF**- Facility-based therapeutic feeding
**GAM**- Global Acute Malnutrition
**HC** -Humanitarian Coordinator
**HMIS** -Health Management Information System
**IASC**- Inter- Agency Standing Committee
**IDSR** -Integrated Disease Surveillance and Response
**IDPs** -Internally Displaced Persons
**MFT** -Multi-Functional Team
**OCHA** - Office for the Coordination of Humanitarian Affairs
**ORA** -Office of Refugee Affairs
**PMU** -Project Management Unit
**SOS** -Sustainable Outreach Services
**UNDP** -United Nations Development Programme
**UNICEF** -United Nations Children's Fund
**UNCT** -United Nations Country Team
**UNHCR** - United Nations High Commissioner for Refugees
**UNMACC** -United Nations Mine Action Coordination Committee
**USAID** – United States Agency for International Development
**WHO** -World Health Organization
**WRD** -Water Resources Department