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The Health Care System in Eritrea

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Content

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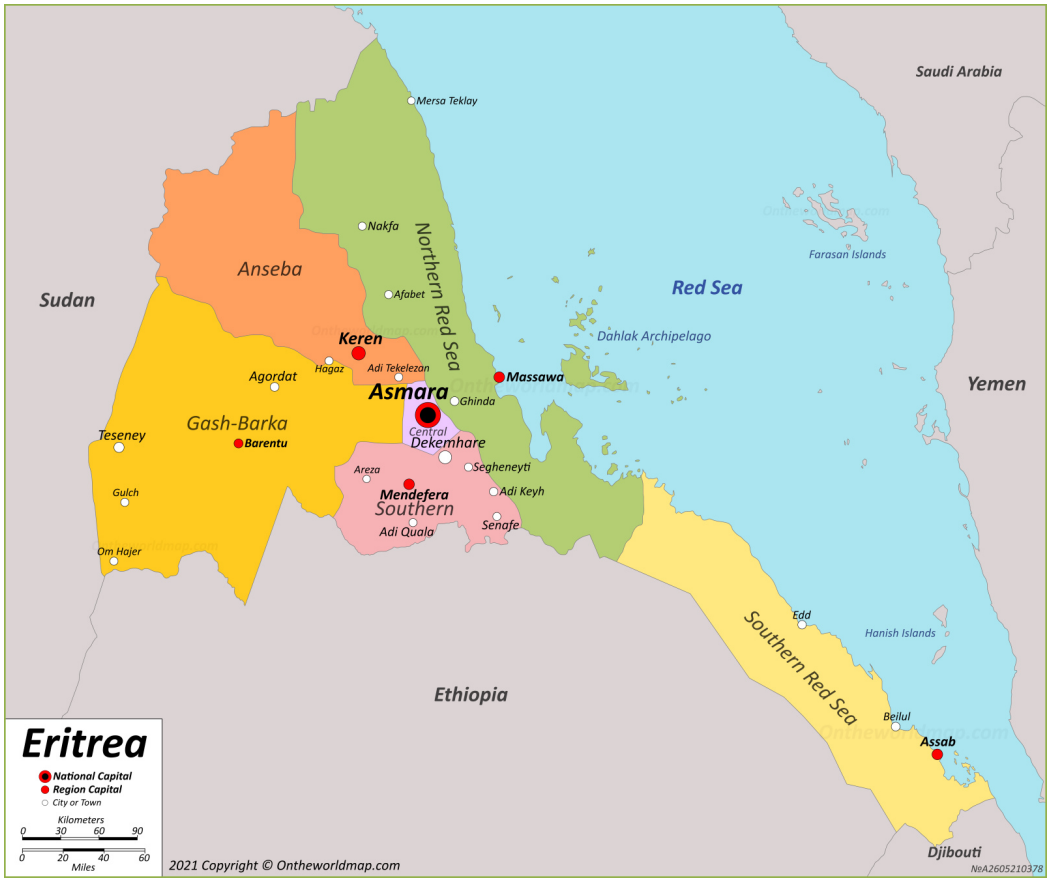
1. Country overview



Source: https://ontheworldmap.com/eritrea/ (Accessed Jan. 13, 2026)

- Sub-Region: Eastern Africa
- Capital: Asmara
- Official Language: Tigrinya, Arabic, English
- Population size: 3,748,901 (World Bank, 2023)
- Share of rural population: 57 % (World Bank, 2023)
- GDP: 2.07 billion US $ (World Bank, 2023)
- Income group: Low Income
- Gini Index: No data available
- Colonial period and independence: Eritrea was colonised by Italy from 1885 until 1941, when the country was placed under British administration during World War II (World Factbook, 2024). In 1952, the UN General Assembly decided to establish Eritrea as an autonomous region within the Ethiopian Federation, granting full autonomy in all domestic affairs (Haile, 1987). After repeated violations of the corresponding United Nations Resolution, Ethiopia finally annexed Eritrea in 1962, leading to the outbreak of a 30-year war of independence (Haile, 1987; World Factbook, 2024). Eritrea achieved de facto independence in 1991, which was confirmed in a referendum in 1993.

2. Selected health indicators

Indicator	Country	Global Average
Male life expectancy in years*	64	70
Female life expectancy in years*	69	75
Under-5 mortality rate per 1,000 live births*	37	37
Maternal mortality rate per 100,000 live births**	758	254
HIV prevalence of the total population ages 15-49*	0.4 %	0.7 %
Tuberculosis prevalence per 100,000 people*	69	133

Source: *World Bank (2022); **World Bank (2010)

Eritrea is a country located in East Africa, bordering the Red Sea in the northeast, Sudan in the west, Ethiopia in the south, and Djibouti in the southeast. The country also shares maritime borders with Saudi Arabia and Yemen. With a population of about six million people (World Factbook, 2024), Eritrea has an area of 124,320 km². The country's economy is largely dominated by subsistence agriculture. Of a total population of 4.1 million (2002), 62 percent are estimated to live in rural areas, a decrease from 82 percent in 1995, and 38 percent in urban areas, an increase from 27 percent for the same period (EDHS, 2002). Approximately 30 percent of the total population is comprised of semi-nomadic agro-pastoralists (World Bank, 2004).

3. Healthcare before independence

The introduction of modern health services into Eritrea is relatively recent. The first hospital was established in Asmara by the Italians at the end of the nineteenth century. Services later expanded into some parts of Eritrea. The British also opened a network of dispensaries and a hospital in Zula during their 10 years of occupation. In the period prior to federation with Ethiopia, Eritrea had a relatively advanced health services, at least by the standards of the time. In the late 1950s, however, Haile Selassie's regime began to cut Eritrea's budget, which by 1965 had fallen to a third of its 1955 level (Firebrace and Holland, 1987). As the Eritrean liberation movement became more active, the Ethiopians began to close and destroy clinics. During the three decades of war for independence, almost all existing health facilities were destroyed, medical supplies were disrupted, and health professionals abandoned their posts (EDHS, 2002).

In all the war zones, the Eritrean People's Liberation Front (EPLF) was the sole health services provider. EPLF set up several clinics in the settled areas, and served the nomadic zones and the contested areas with mobile teams. The EPLF health service started in 1970 with a single mobile clinic, only competent to treat malaria and give basic first aid. Training of the first group of 25 'barefoot doctors' began in 1972, but it was not until the period 1975-78 that the health service really became effective. During these years, hundreds of skilled Eritreans, including doctors, nurses and paramedical staff, fled the towns and joined the EPLF. Health services were rendered to both combatants and civilians (Firebrace and Holland, 1984). The EPLF also established a drug production plant in the liberated zone and was able to manufacture some 44 items, including I.V. fluids, tablets, capsules and ointments (MOHE, 1999). In 1981, the EPLF introduced the Eritrean Public Health Programme (EPHP) under the stewardship of a Health Department (Findlay, 1989). The EPHP comprised comprehensive primary healthcare services, focused on healthcare services for women and children. It promoted breastfeeding, family planning, immunization, nutrition programs, health education, and a wide range of therapeutic services (Findlay, 1989; Jones, 1991; Sabo & Kibirige, 1989). By the end of the 1980s, the EPLF had developed a comprehensive health service that treated 1.6 million patients per year. By 1987, the EPLF operated 40 mobile health units, 42 health posts, 22 health centers, and six hospitals in the liberated and contested areas (Kloos, 1998). At the time of independence, there was only one referral hospital in the capital city of Asmara.

4. Subsequent historical development of health care policy

Eritrea's current healthcare services were adopted from EPLF, which were developed during the 30 years of the armed struggle, i.e. from 1961 to 1991. Following independence, Eritrean health services were reformed to align with those of Ethiopia, and to modernize the services as a whole. A national healthcare system has not been established yet. However, we can say that Eritrea is currently in the process of establishing a healthcare system that incorporates universal healthcare coverage and social insurance systems. To this end, the Eritrean Government has issued several proclamations on control of drugs, cosmetics and sanitary items, tobacco control, control of private practice, and control of female genital mutilation (FGM), etc. During the period of the implementation of the Health Services Sector Development Program-I (HSSDP I), the health issues were covered by the civil and penal codes. The Legal Office, however, has limited expertise in medico-legal issues. It has not developed a strategic plan, nor does it have annual operational plans. In 1996, a first health financing policy was developed and revised in 1998, in order to cover various aspects of interest, including the cost sharing through levying of user fees (World Bank, 2004). This version of the health financing policy was again revised in 2007, in order to have a more comprehensive policy, incorporating a deeper consideration of the key health financing functions: revenue collection mechanisms, revenue pooling and risk management, and resource allocation and purchasing. Currently, health services in the country are highly subsidized by the government, but other mechanisms have to be established to ensure universal health coverage and national health security (MOHE, 2010).

Cross-subsidization of basic health packages for the poor is an important health policy in Eritrea. In a situation of limited financial resources, it is important to base the allocation of public health funds on cost-effective programs. Basic health packages for mothers and children (e.g. immunization, delivery, antenatal and postnatal care, etc.), and for the poor and elderly are highly subsidized (World Bank, 2004). This is in line with the World Bank argument that poor countries must target their resources to the poor so that they can obtain some meaningful health care.

Table 1. Pro-poor health care policies in Eritrea.

Disease targeting	Geographical targeting	Cross-subsidies	Exemption for the poor
Focus on the burden of diseases of the poor: malaria, tuberculosis, HIV/AIDS, diarrhea, respiratory infections, malnutrition, diabetics, hypertension, leprosy, mental illness and reproductive health.	Focus on rural areas; Larger subsidies to primary level health care facilities (health centers and health stations).	Higher mark-up and co-payments on diseases with lower levels of priority; High subsidies for maternity and child health services; Free immunization and oral dehydration therapy as well as promotion activities.	Exemptions left to the discretion of local governments; Exempted categories include widows, orphans, elderly, disabled, and the destitute.

Source: Habtom, G.K. (2017)

Other priorities include control of communicable and non-communicable diseases, as well as strengthening the health system, designed around the strategic priorities, to contribute to healthy lives and well-being for all at all ages.

5. Description of current health care services

a. Organisational structure

The Government of Eritrea adopted administrative decentralization as a national policy in May 1996. The MOH is in the process of establishing a decentralized health service system, in which the major portions of the duties traditionally performed at the central level are executed at the regions.

According to the Proclamation for the Establishment of Regional administrations (GoSE, 1996), the MOH role is to:

- formulate policies, prepare regulations, directives, standards, integrated plans and development of budgets, as well as supervise their implementation throughout the country;
- undertake research and studies, compile and collect statistical data;
- provide technical assistance and advice to regional programs and administration;

» comply with national policy, standards and regulations and, upon agreement of the Ministry of Local Government, assign regional executives, recruit, transfer, promote and dismiss employees; and
» seek external funding for regional development programs.

At the regional level, the main functions of the Zonal Medical Officers are:

» Planning, including the preparation of annual plans and budgets, project monitoring and, to a limited extent, evaluation.
» Coordination of all development activities including those of the private sector and external agencies.
» Implementation is a core function at the zonal and sub-zonal levels. This involves managing relations with sub-regional and community administration officials, mobilization of community resources, handling contacts and financing mechanisms and providing support for operation and maintenance.

b. Coverage

The general public attends government health facilities, paying only nominal user fees, because the health system is subsidized by the government. The poor, who have an indigent certificate, get free medical care. Members of the military and police, and college and university students, are entitled to free medical care. Private healthcare insurance is mostly provided to company workers by their employers, which make up 0.06% of the population.

c. Provision

Looking at infrastructure, current data show that there are 27 hospitals, 55 health centers and 187 health stations. 34 clinics are owned by different industries and/or organizations, which serve their workers. Of the 27 hospitals in the country, 5 are the National Public Referral Hospitals, 6 are Regional Referral Hospitals, and 13 are community hospitals, while 1 is a for profit public-private mix hospital (Habtom, 2017). There are several referral hospitals, with at least one in each region, and clinics in most villages. In addition, the government has taken on significant initiatives to solve and expand the health of its people by starting medical schools and expanding the existing medical education institutions.

The country has a mental hospital, which is called St. Mary's Neuro-Psychiatric Hospital, that provides inpatient care and long-stay residential services (Amahazion, 2021). As well, there is a community residential care facility, which serves those with relatively stable and chronic mental disorders not requiring intensive medical interventions.

The structure of Eritrea's national health system and health services is organized in a three-tier system, with the primary level constituting community health services, the health stations, health centers, and community hospitals, while the secondary level constitutes the regional hospitals, first contact hospitals, and zonal referral hospitals, and the tertiary level with national referral hospitals. As a matter of government policy, there are no private health facilities operating in the country. However, there is a system of private practice within government health facilities, by way of partnership between the Government and health workers.

Table 2. Levels of health care facilities and threshold population in Eritrea

Level of Healthcare	FacilityThreshold Population
National Referral Hospitals	The whole population
Regional Referral Hospitals	200,000 or more
First Contact Hospitals	50,000–200,000
Health Centers	10,000-50,000
Health Stations	1000-10,000
Community Health Services	1,000

Source: Ministry of Health Eritrea (2001).

Eritrea has 216 medical doctors, 1012 nurses and nurse midwives, 42 pharmacists, 23 sanitarians, 81 public health technicians, 275 laboratory technicians, 62 X-ray technicians, and 2,172 associate nurses (MOHE, 2016). The Health Personnel Population Ratio for Medical Doctors is 1:16,000, for Nurses 1:3386, for Laboratory Staff 1:8976. and that of Health Assistants is 1:1,600 (MOHE, 2010).

d. Financing

In Eritrea, health care financing is channeled through government taxes, private funding, and donor funding. Out-of pocket payments make up the largest portion of private health spending, which stood at 48.6% in 2018 (AHB, 2021). 15.5% is funded by the government, and the remainder from a mixture of private and donor funds (World Bank, 2024). In 1996, the Ministry of Health planned to introduce a National Health Financing Policy (World Bank, 2004), which would be a mixture of both private and public insurance. So far, no actions have been made to implement these plans (Habtom, 2017).

The problem is that many people in Eritrea simply do not understand the concept of health insurance. It takes time to explain the concepts of risk sharing and insurance. The idea of handing over money that will be used to pay for other people's health care is hard to explain and to absorb. Their main fears are about paying money for nothing, i.e., if they are not ill, and paying for others, especially the very poor, who are sick more frequently than the better off (Habtom, 2018). Particularly for traditional rural communities, paying money in advance for health care means inviting diseases or bad luck for the family. In rural areas, there is a pervading culture of fatalism that resists cover; as a result, most rural communities are not used to taking personal responsibility for their health.

To ensure a sustainable healthcare financing system in Eritrea, there is a need for the introduction of combined cost recovery systems (general taxation, social insurance, private health insurance, and limited out of pocket user charges) (Habtom, 2018). To this end, the MOHE should revise its strategies and intervention mechanisms to maximize the use of available healthcare resources.

In 2020, Eritrea spent 4.1% of its GDP on health care, according to World Factbook (2024). The development of a health care financing policy and a clear strategy for health system financing remains a gap to be addressed. The Eritrean government subsidized more than 85% of total health related expenditures for its citizens, as compared to the 9.8% average allocated to the health sector in Africa (WHO, 2020). The existing economic situation of Eritrea did not allow the government to collect substantial amounts of revenue from user fees (MOHE, 2010).

Table 3. Eritrea Healthcare Spending - Historical Data

Year	Per Capita (US $)	% of GDP
2020	$24	4.09%
2019	$25	4.46%
2018	$24	4.13%

Source: Macro Trends (2010-2024)

e. Regulation of dominant system

In Eritrea, regulatory power rests with the Ministry of Health (MOHE) through the medical and other professional councils. As Eritrea's Ministry of Health evolved from providing direct service delivery to financing, purchasing and oversight of the health care sector, regulation of the health sector should, as a consequence, become a major public sector responsibility. Three areas are key to the regulatory function in Eritrea: licensing, accreditation (or certification), enforcement of national treatment standards for health care providers, and quality assurance to provide adequate levels of care. In addition to legal requirements, the government also uses financial and other incentives (taxes, subsidies, and training opportunities) to influence the behavior of private providers. The Eritrean MOHE enforces its regulatory power through the Department of Pharmaceutical Services (DPS) and Division of Clinical Services.

There exists the National Medicines and Food Administration (NMFA), a body of the Ministry of Health that regulates the quality of pharmaceuticals and medical supplies in the country, to ensure that the public has access to quality, safe, efficacious and affordable pharmaceuticals and medical supplies.

Health service delivery has been guided by the National Health Policy, the first Health Sector Strategic Development Plan (HSSDP I, 2012-2016) and program specific policies and strategies. The HSSDP I, being in-line with the Health Policy, outlined the health sector strategies aimed at achieving the national health development priorities and the Millennium Development Goals (MDGs).

In Eritrea, there has been no National Health Act or Regulation, but there are several Proclamations on control of drugs, cosmetics and sanitary items, tobacco control, control of private practice and control of female genital mutilation (FGM) (MOHE. 2016).

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