Healthcare of the Eritrean People's Liberation Front and its Politicization, 1970–1991: Treating the Body Politic

Clarissa Charlotte Hjalmarsson

Abstract: This article explores the health service provided by the Eritrean People's Liberation Front (EPLF) during the Eritrean Liberation War, and its political dimensions and implications. The EPLF used healthcare to define itself politically against its rivals and to penetrate communities. It aimed to incorporate population groups into the struggle, to inculcate EPLF ideology, and to transform the national community. EPLF practitioners were most successful when they cooperated with existing structures of power. The progressive, dynamic, and transformative nature of the healthcare system is inextricable from the coercion sometimes used to achieve the ideals of the EPLF, and the way in which healthcare became an instrument of biopolitical control.

Résumé: Cet article explore les services de santé fournis par le Front populaire de libération de l'Érythrée (FPLE) pendant la guerre de libération érythréen, ainsi que ses dimensions et ses implications politiques. Le FPLE a utilisé les soins de santé pour se définir politiquement par rapport à ses rivaux et pour pénétrer les communautés. Il visait à intégrer des groupes de population à la lutte, à inculquer l'idéologie FPLE et à transformer la communauté nationale. Les intervenants FLPE ont eu plus de succès lorsqu'ils ont coopéré avec les structures de pouvoir existantes. La nature progressive, dynamique et transformatrice du système de santé se révèle indissociable à la coercition parfois utilisée pour atteindre les idéaux énoncés par le FLPE et à la manière dont la santé est devenue un instrument de contrôle biopolitique.

Resumo: Este artigo analisa os serviços de saúde providenciados pela Frente de Libertação do Povo Eritreu (sigla inglesa, EPLF) durante a Guerra de Independência

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da Eritreia, bem como as suas dimensões e consequências políticas. A EPLF utilizou os cuidados de saúde para definir a sua identidade, distinguindo-a dos seus rivais, e para se infiltrar nas comunidades. O seu objetivo era arregimentar alguns setores da população para a luta, disseminar a ideologia da EPLF e transformar a comunidade nacional. Sempre que cooperaram com as estruturas de poder existentes, os médicos da EPLF foram muito bem-sucedidos. A natureza progressista, dinâmica e transformadora do sistema de cuidados de saúde é inextrincável dos métodos coercivos a que por vezes se recorreu para implementar o programa ideológico da EPLF, bem como do modo como os cuidados de saúde se tornaram um instrumento de controlo biopolítico.

Keywords: Eritrea; Eritrean People's Liberation Front (EPLF); Eritrean Liberation War; healthcare; medicine; biopolitics

Introduction

The Eritrean Liberation War, from 1961 to 1991, was waged against Ethiopian annexation of Eritrea and lasted until the liberation of Eritrea in 1991. Several different revolutionary groups were initially involved; after an initial period of civil war, the Eritrean People's Liberation Front (EPLF) emerged as dominant in 1974. The EPLF was centrally directed by the Eritrean People's Revolutionary Party (EPRP), a secret Marxist party which fostered a "deeply-rooted militaristic political culture" in Eritrea during the Liberation War (Reid 2014:85). It carried out all state functions in the liberated areas, including defense and the provision of social services, and simultaneously acted as a political party and a trade union (Amanuel Mehreteab 2004:82). Guided by Maoist doctrine, the EPLF espoused a social revolutionary nationalism that sought not only to liberate but also to transform Eritrean society (Connell 2001:345–46). These military and ideological objectives were inextricably intertwined and mutually reinforcing, and continue to define Eritrea's political culture today.

The proto-government's structurally decentralized, centrally-controlled healthcare service epitomized these goals. EPLF healthcare was free at the point of care, tailored to rural and marginalized populations, and focused on prevention rather than cure. It aimed to eradicate contagious diseases, promote public health, and take a scientific approach to traditional medicine.

The achievements of the EPLF Healthcare system between 1970 and 1991 are notable. In 1970, the liberation front had only a single mobile clinic (Assefaw 2009:20), and though hospitals existed in Ethiopian-held urban areas such as Asmara and Dekamhare, vast expanses of the country had no access to modern healthcare and relied solely on traditional healers (Wilson 1991:140). By 1978, the Front had developed a comprehensive service that treated 1.6 million patients per year (Kloos 1998:517), and epitomized the WHO guidelines for primary healthcare (Baylies 1986:68–69).

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The vaccination rate climbed to 90 percent, life expectancy increased by over ten years despite the conflict from 1961 to 1991, and infant mortality dropped continuously by an average of 2.1 percent per year (ODI 2011: 11–12). However, despite these myriad achievements, there were no opportunities for autonomous associations or alternative healthcare strategies during the Liberation War, as the EPLF monopolized the provision of medical services in the post-civil war period. The EPLF centralized organizational and administrative structures, enforced secularization, and suppressed dissent and independent organizations. In the absence of independent and external associations, or alternative opportunities for healthcare professionals (Kibreab 2008:282, 371), it is less surprising the service flourished.

This nexus of progressive developmentalism and coercion has been extensively explored by Tricia Redeker Hepner and David O'Kane, whose seminal work on Eritrea examines how the EPLF used biopolitical strategies to mobilize its citizens in pursuit of liberation, modernization, and development (2009:xxvii–iii). In typically high-modernist fashion, the EPLF sought to radically remake society using state power in the context of "a prostrate civil society with limited capacity for active resistance" (Scott 1998:97, 352–53). A central tenet of this strategy was the provision of social services, which functioned both to alter society in favor of its oppressed, and to recruit support for the guerrilla proto-state. Direct and frequent encounters with the proto-state routinized Eritrean national identity and the role of the EPLF as primary provider and protector (Hepner & O'Kane 2009:167). The healthcare service created close links between Eritreans and the proto-state, which ultimately provided the current People's Front for Democracy and Justice (PFDJ) with the tools of control and surveillance it continues to use for coercive rule. While these tendencies have become more marked in the post-2002 period, Tekle M. Woldemikael argues that the PFDJ's use of coercion in pursuit of political power and progressive ideals represents continuity rather than a break with past practice (2013:v–xix).

This transformation attracted substantial international attention, and the EPLF's demonstration of unity and self-sufficiency during the liberation war earned Eritrea the ill-fated accolade of "Renaissance African State," along with Uganda, Rwanda, South Africa, and Ethiopia. These countries were expected by analysts to reject "corruption, poverty, inequality, and violence" in order to modernize the continent (Woldemikael 2013:vi–vii).

Foreign journalists played a significant role in documenting the revolution during the 1970s and 1980s, and they continue to offer a valuable insight into the Liberation Front. However, accounts by these "guerrilla groupies" were influenced by the climate of optimism surrounding socialist guerrilla movements of the era. This article relies heavily on the detailed accounts of Tekeste Fekadu (2002, 2008, 2015) whose memoirs of life as an EPLF surgeon are invaluable for their in-depth and highly technical account of the Struggle. Nevertheless, Tekeste's work is supportive of the current regime, and continues to be published by the state-controlled Sabur.

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Excellent critical analyses by Gaim Kibreab (2008, 2009) and David Pool (2001) engage primarily with the politics of the EPLF and EPRP rather than the health service. Recent work on Eritrea has focused predominantly on the subsequent period of human rights abuses and open-ended military service under the PFDJ, rather than on the preceding period. Academic work on the Liberation War is currently hampered by the destruction of any meaningful research culture in Eritrea itself, as Richard Reid has demonstrated, as well as the government's anti-intellectualism and proclivity to impede "anything resembling free and independent historical research or public debate." This has precluded an objective analysis of Eritrea's history, dampened scholarly interest, and fostered a "presentist" approach in most current research (Reid 2014:85–90). Research is further hindered by fears in the diaspora community of international PFDJ surveillance. Reid's survey of existing literature (2014) and Bettina Conrad's work on diaspora narratives (2006) offer detailed analyses of the achievements and current challenges of conducting historical research on Eritrea.

For this article, the author read primary accounts of the EPLF medical service along with a diverse range of secondary literature. She conducted a series of interviews with Assefaw Ghebrekidan via Skype in December 2016, January 2017, and July 2018. Assefaw was director of the Central Hospital from 1982 to 1987 and of the Civilian Health Service from 1987 to 1991; he is a public critic of the current regime. She also talked informally to several friends and associates of Dr. Nerayo Teklemichael, former director of the Eritrean Relief Association (ERA).

Sara Rich Dorman emphasizes the importance of "mov[ing] beyond myths of Eritrean exceptionalism…critically examining policy creation and implementation, and assessing the impact of the struggle and the state-building project" (2005:217–18). This study attempts to synthesize published research and contemporary reportage with interview material to provide an overview of the health service offered by the EPLF and to examine the role of healthcare in promoting EPLF legitimacy, as a vehicle for EPLF political ideology, and as a means of creating social change, before briefly discussing its links with the international community. Ultimately, this study aims to examine the extent to which the "authoritarian and repressive patterns deeply lodged within the EPLF since the days of struggle" identified by Hepner and O'Kane (2009:xxiii) existed in, and were propagated by, the health service during the liberation war.

A Modern Healthcare System (1970–1991)

The Liberation War defined the health service in myriad ways, and healthcare provision and administration demonstrated considerable improvement as the war progressed. In 1970, the EPLF established its first mobile clinic to provide first aid, and an underground hospital was set up in Sahel (ODI 2011:8). In 1972, several Stationary Health Clinics were established, and the first barefoot doctors were trained, although there remained no

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systematized services. The temporary ceasefire with parent and rival guerrilla organization Eritrean Liberation Front (ELF) in 1973–74 allowed the various factions of the EPLF to coalesce; this facilitated the creation of a joint administrative department (Pool 2001:81), followed by military and civilian pathways in 1975–76. The EPLF instigated lasting social, economic, and political programs from 1975, as young people fled the repressive policies of the Ethiopian regime (Connell 1993:41), and political developments including the congress of revolutionary groups led to an influx of skilled professionals into the EPLF (Pool 2001:81–82). The organization established a second hospital at Keren, introduced frontline medical care, and held an organizational congress in 1977 (Tekeste 2002:137).

The EPLF's military and political situation was radically altered in the face of the Ethiopian offensive from 1978, which resulted in a major military retreat to Eritrea's rural highlands referred to as the 1979–1982 "Strategic Withdrawals." The Central Hospital was transferred to Orota, and the health service underwent a major expansion and restructuring in order to meet the requirements of mixed mobile and guerrilla warfare (Tekeste 2002:10–11). Medical personnel from the central, regional, and frontline hospitals converged in August 1980 to restructure the service in order to improve patient management, specialization, and quality of care (Tekeste 2008:102). The Eritrean Public Health Programme (EPHP) was established in 1981 to provide a comprehensive primary healthcare service for civilians in the liberated zones, with an emphasis on women and children, while the Eritrean Medical Association (EMA) brought together Eritrean healthcare professionals in the diaspora (Tekeste 2008:280). Healthcare provision was highly influenced by the WHO manual "Global Strategy for Health for All by the Year 2000" (1981), which Assefaw confirmed was obtained, translated, and used as a manual by the Front (interview, January 2017).

Healthcare infrastructure was a microcosm of the EPLF, with a pyramidal system in which resources were concentrated on the front lines, with central coordination and supervision. From 1976, the health service was separated into military and civilian pathways, although patients were referred to the same regional and central hospitals for specialized care.

Civilian Healthcare Service

Though the healthcare system developed in size and complexity over the course of the war, civilian health policy remained focused on primary healthcare. Village Health Workers (VHWs) and Traditional Birth Attendants (TBAs), who were retrained in modern midwifery, composed each village's Community Health Service. VHWs carried out health education, administered first aid, and maintained health records on every Eritrean family (interview with Assefaw, July 2018). TBAs returned to home deliveries, but also ran ante- and post-natal clinics (Firebrace & Holland 1984:105–7).

Outside villages, barefoot doctors (*agar hakim*) formed the backbone of the health service. Inspired by the "Barefoot Doctor" strategy adopted by

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the People's Republic of China, where several members of the EPRP received military training in the 1960s, barefoot doctors treated common diseases, provided health education, and taught self-defense. Some barefoot doctors also carried out suturing and amputation (Firebrace & Holland 1984:105–6). By 1985, 1,600 barefoot doctors had been trained; however, a large proportion were subsumed into military roles. Roy Pateman estimates that around 800 were operating in 1987 (1998:221–22).

In contested and rural areas, Mobile Health Units (MHUs) provided basic medical care. Sources disagree on the exact make-up of these units; they appear to have included two barefoot doctors, a TBA, and two medical assistants (Firebrace & Holland 1984:105). By 1982 there were over 20 units operating (Assefaw 2009:24–25). At the sub-district level, Stationary Health Clinics (SHCs) were manned by an EPLF barefoot doctor, five VHWs and a TBA (Wilson 1991:145). From SHCs, patients could be referred on to larger regional health centres.

Military Healthcare Service

The military arm of the Health Service provided systematized frontline services beginning in 1976 (Pool 2001:101). The first point of contact for casualties was with Combat Zone Medics allocated to each platoon before evacuation to Battalion Clinics, then Brigade Clinics, Mobile and Frontline Surgical Units (MSUs and FSUs, respectively), and finally Division Hospitals. Introduced in 1976, FSUs were staffed by a doctor, senior surgical nurse, and several barefoot doctors. They provided injured combatants with emergency surgery, including amputation, debridement, and colectomies, and immediate aftercare before they were evacuated to Frontline Hospitals (Tekeste 2008:173–79). After FSUs became targets for aerial bombings, wards, operating rooms, and supply stores were built underground (Tekeste 2008:28). By 1982, there were ten FSUs and MSUs operating "fully and with great flexibility" across two frontlines. At the tertiary level were Frontline Hospitals, established at Hawel'e, Gil'e, Anberbeb, Nakfa, Halibet, and Zara (Tekeste 2008:173, 253). These contained 150 to 200 hospital beds, x-ray machines, laboratories, and a team of specialist staff capable of further surgery and rehabilitation (Pateman 1998:221–22; Tekeste 2008:252–23).

Hospital Care

Complex civilian and military cases were referred to regional hospitals, or directly to the Central Hospital at Orota. Regional hospitals were located in Sahel, Danakil, Filfil, the southern highlands, and on the Mereb border (Pateman 1998:221). Similar to frontline hospitals, these regional hospitals contained x-ray equipment, laboratories, and medical stores, and were built partially underground; James Firebrace and Stuart Holland report that Serae hospital could be sealed and camouflaged within twelve hours (1984:109).

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The first Central Hospital was founded at Seberqete in 1975 in a concealed mountain-ridge valley (Tekeste 2002:20–21), before the establishment of Orota Central Hospital in 1978. Orota was six kilometres long (Wilson 1991:142–43), camouflaged under trees and carved into the rock of a mountain valley (Firebrace & Holland 1984:110). Orota housed three underground operating theatres able to provide complex reconstructive surgery (Burgess 1989:131), a radiology unit, and specialized medical and surgical wards organized by discipline. It also contained a pharmaceutical plant capable of producing over 240 litres of infusions, 80 million of 32 essential tablets, and 40 million of four different capsules by 1989 (Kibreab 2009:108). A major restructuring in 1980 organized the Central Hospital into eight departments, with each specialty assigned a team of staff (Tekeste 2008:102–3). By 1984, Orota's director claimed the hospital was able to treat 99 percent of war injuries, with a 97.6 percent survival rate (Firebrace & Holland 1984:110).

Training, Education & Improving Outcomes

The EPLF mandated education as a means of eliminating class structures, population divisions, and male dominance (Dines 1980:139), and all Eritreans were encouraged to "take control" of their health as a means of maintaining and improving overall population health. All patients treated by the service received ten to fifteen minutes of health education before outpatient appointments (interview with Assefaw, July 2018). In MHUs, the staff gave lectures from a specific curriculum produced by the Health Department. Public health was also promoted in EPLF-held areas using a bi-monthly health manual in Arabic and Tigrinya (Wilson 1991:134), and the widely-read educational quarterly magazine, "Ray of Health," circulated from 1977 (Firebrace & Holland 1984:104). Basic health education messages were even incorporated into literacy classes and popular plays (Firebrace & Holland 1984:105–7; Matzke 2006:460).

An example of more intensive health education was the "hybrid" institution Zero School, a school, clinic, and hospital for up to 2,500 orphans, child refugees, and the children of fighters. Healthcare was interwoven with pupils' lives, including daily medical checks, health education lessons (Dines 1980:137), and holidays spent training in EPLF Departments including Health (Berhe 2000:22).

Within the Health Service, rigorous training, continuous professional development, and frequent evaluation were the bedrock of EPLF achievements. The service boasted around 2,000 health professionals by 1988, most of whom were trained by the EPLF. Barefoot doctors were trained over three years of hospital courses, fieldwork placements, and advanced specialist training, VHWs for three months in their community, and TBAs for six months at the Central Hospital's maternity ward. Existing practitioners were also encouraged to undertake further training and specialization; nurses and former medical students were "upgraded" to doctors, and clinical and battalion staff received advanced training (Firebrace & Holland 1984:105–6; Pool 2001:102).

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The service translated Werner's "Where There is No Doctor" into Tigrinya and Tigray and distributed a copy to every barefoot doctor and TBA. Harrison's "Principles of Internal Medicine" and a variety of American medical textbooks were also translated into Tigrinya, providing the first opportunity for Eritreans to study in Tigrinya rather than Amharic. These formed part of a 3,000-book educational library maintained in Orota Hospital (interview with Assefaw, July 2018).

The high staff turnover, which reached 50 percent between 1985 and 1987 due to war casualties (Kloos 1998:517), necessitated constant education and standardization of protocol. Tekeste references "continuous training and drilling" on specific practical procedures, and staff held daily meetings on casualty management and discussed every patient death. Inter-departmental training also took place, as FSUs consulted combat and battalion medics on chemical warfare and managing casualties (Tekeste 2002:77). Kibreab has argued that monthly reports, written by staff at all levels and forwarded to the Health Department and ERA, were critical to the service's success (2009:109).

Constraints on the development of Healthcare

The main cause of injury, illness, and pain was the decades-long war, exacerbated by famine and drought. By 1983, 40 percent of children under five were malnourished (Pateman 1988:167), and anemia exacerbated by malaria was a leading cause of complications in pregnancy and reduced female life expectancy (Wilson 1991:145–46). Severe malnutrition and undernourishment increased the risk of bleeding in surgery and time taken for wound healing. Dysentery, measles, and parasitic infections were common, and malaria, typhoid, and tuberculosis were endemic (Dines 1980:135). Poor sanitation, hard physical labor, and low-quality housing in rural areas facilitated the spread of infection (Firebrace & Holland 1984:102–3). This extended to medical staff, whose high workload and insufficient nutrition made them similarly vulnerable (Tekeste 2008:312).

Despite the recycling of consumables (Tekeste 2002:102–3), covert extraction and capture of Ethiopian supplies (Pateman 1998:217), and donations via the ERA, a shortage of basic supplies limited the service. Shortage of anesthesia was a recurrent problem during the Liberation War. Though Tekeste insists that no patients died from maladministration of anesthetics, frontline services suffered from the absence of trained anesthetists and appropriate drugs. Choice of anesthetics was often determined by cost and availability rather than surgical indication, and on some occasions serious mistakes were made (2002:39–41, 104, 163).

Furthermore, the service operated under extreme territorial constraints, particularly during the extended period in which the EPLF was based in the mountainous and largely barren Sahel region. Though beyond the scope of this article, this is thoroughly addressed elsewhere (see Pool 2001:5–7).

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Healthcare as a demonstration of EPLF legitimacy

The social revolution, spearheaded by the healthcare program, was a crucial feature of the liberation struggle and laid the foundations for a new conception of national identity. The EPLF's territorial nationalism necessitated the development of national unity that transcended ethnic and social divisions. Public participation, aimed at a "profound structural transformation of society," legitimized the EPLF's assertion of a national and democratic struggle (Houtart 1988:83). Yohannes Tseggay Berhe has argued that the provision of vital services in the post-colonial liberation war period was a demonstration of economic renewal and social justice that empowered communities to take an active role in healthcare (2000:8).

The EPLF strove for "moral as well as military firepower" (Reid 2009: 210–11), not least against the ELF. During the civil war of the 1970s, as the EPLF splintered from and ultimately usurped the ELF, ideological differences emerged and crystallized between the two groups (Pool 1980:34).

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Though social transformation took place on both revolutionary fronts (With 1987:66), the EPLF used its social movements, and healthcare in particular, to define itself as the superior resistance movement. The EPLF sent out propaganda squads and barefoot doctors to liberated areas, and engaged directly with peasants at the village level. This provided a deliberate contrast to the ELF, whose propaganda was tailored to pastoral groups (Pool 1980:46–47). The ELF's zonal strategy also contributed to the hoarding of essential supplies (Kibreab 2008:154), a problem overcome by the EPLF's central administration. Furthermore, the ELF was criticized for confining women to traditionally female roles, while the EPLF defined itself as inclusive and supportive of women (Cowan 1983:143–51). Over the longer term, the EPLF asserted its identity as a nationalist force "impervious to social, ethnic, regional, tribal, religious and ideological divisions" (Pool 2001:55), as opposed to the ELF, which was ultimately unable to transcend its ethnic and religious origins. Medical care and health education promoted social cohesion and national unity, as this article will go on to discuss, and formed a central tenet of the EPLF's claim to moral superiority.

Furthermore, healthcare was a crucial way in which the EPLF emphasized its state-building against Ethiopian destruction. The identical medical treatment and rations given to Ethiopian POWs provided an opportunity not only for military intelligence but also for a moral victory over Ethiopia (Tekeste 2002:59–60). Furthermore, the EPLF extended the provision of healthcare into rural areas that had remained untouched by Ethiopian services during federation, developing the reach of the state-in-waiting further than its predecessor and adversary. However, this relationship was not as clear-cut as EPLF propaganda suggests, as early gains in EPLF healthcare came at the cost of Ethiopian services: Eritrean doctors smuggled out medicine, microscopes, and essential provisions from Ethiopian hospitals during the early stages of the war (Assefaw 2009:20).

In addition to the legacy of Ethiopia in Eritrea, healthcare provision also defined the EPLF's social revolutionary ideology against "garrison socialism" and centralized medicine in Ethiopia during the war (Markakis 1981:7, 20). Ethiopia supplied its own rural population with health services beginning in 1946, with a focus on preventative healthcare and epidemic control. However, it was heavily reliant on external assistance, and funds allocated to primary health services in rural areas were frequently diverted to hospitals. Ethiopian health outcomes in 1974 were the lowest worldwide, with poor coverage and a focus on curative rather than preventative health. While the 1974 Ethiopian revolution brought rapid expansion in healthcare (Kloos 1998:506), and a pyramidal structure of services strikingly similar to the EPHP (Kloos et al. 1987:1003–19), Helmut Kloos has shown that modern health services remained underutilized, and villagers relied predominantly on traditional medicine. Though healthcare improved with external support in the 1980s (1990:101–14), Ethiopian services continued to provide a striking counterpoint to the efficiency, coverage, and self-sufficiency of the EPHP.[1]

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Healthcare was closely linked to modernity, and the denial of appropriate healthcare during Eritrea's colonial period was portrayed as having intentionally hindered Eritrean development and self-sufficiency. During the Italian occupation, healthcare remained the preserve of colonists, despite devastating outbreaks of cholera, plague, and typhus in the 1920s and 1930s. EPLF publications explicitly invoked the neglect of Eritrean health during the colonial period, asserting that services excluded the rural population and were unsuited to its needs (Pateman 1998:220); one publication argued that Italian colonialists aimed "to push the Eritreans to extinction to give space to Italian settlers." Though the situation improved marginally during the British occupation, services remained modest and some facilities were dismantled when the British left (Sabo & Kibirge 1989:678–79). Services further declined during federation to Ethiopia from 1952; though Haile Selassie built a large modern hospital in Massawa (Tekeste 2008:221), budgets were cut from 1956 to 1965, and many health clinics were closed or destroyed by fighting in the 1960s (Firebrace & Holland 1984:103–4). Provision of a comprehensive, far-reaching healthcare service thus provided a favorable point of comparison between the EPLF and its predecessors.

Internationally, a successful healthcare system demonstrated the EPLF's successful provision of state services and legitimized the state-in-waiting. As the war intensified, so too did the battle for international recognition for healthcare. The EPLF set up Departments for Research in 1977 to promote medical theory (Tekeste 2002:137), published the inaugural issue of the *Eritrean Medical Journal* during the Sixth Offensive in September 1982, and held the First Congress of the Eritrean Medical Association at Orota Central Hospital (Tekeste 2008:261, 334).

Healthcare was thus crucial to legitimizing the EPLF domestically and internationally, as the EPLF demonstrated its state capabilities against its civil war rival, the ELF, and against the previous Ethiopian occupation, as well as against contemporaneous services in Ethiopia. In addition, the EPLF also drew favorable comparisons between its service provision and that of its former colonizers, Italy and Britain.

Healthcare as a tool for politicization

The provision of healthcare was a political decision taken by the EPRP, as the former head of the civilian health service confirmed (interview with Assefaw, July 2018). Healthcare services were an important means of establishing links with local Eritrean populations, and they had the potential to function as a conduit for the social revolutionary ideology espoused by the EPLF. Several authors concur on its success: Lionel Cliffe suggested that free healthcare was a crucial way of "showing the people that the EPLF care[d] about them" (1988:99), and Alemseged Abbay has argued that social services convinced peasants "that the EPLF were friends in need" (1998:118). The EPLF focus on Mother and Child health and Immunization brought

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the state-in-waiting into contact with Eritreans at the earliest possible opportunity (Berhe 2000:20). After areas were liberated, healthcare was often the first means of contact between the EPLF and the population, as barefoot doctors entered newly liberated villages with armed propaganda squads (Pool 2001:100). Civilians in Azien and Barka received free medical care immediately after the cities were liberated (Houtart 1980:101; Wilson 1991:143), and EPLF practitioners provided healthcare in post-liberation Keren, including elective and minor surgeries, for free or at a nominal fee. Tekeste Fekadu argues that people "understood the true nature of the EPLF" after receiving healthcare (2002:173).

The EPLF pursued a similar policy with Eritrea's pastoralist populations. In Sahel, MHUs delivered free healthcare to pastoralists starting in 1972, and hospitals and SHCs set up during conflict in the Barka province were used to provide care to pastoralists after liberation (Assefaw 2009:27–28). Similarly, agropastoralists in Wadi Lakba, who had remained almost untouched by the Ethiopian state, were incorporated into the EPLF sphere of influence by the medical and veterinary services provided by barefoot doctors (Pool 2001:114–15). Assefaw Ghebrekidan has described how EPLF teams were initially restricted to treating serious medical conditions; repeated successes slowly won pastoralists' trust and support, and EPLF teams progressed to providing primary, secondary, and tertiary care.

The delivery of healthcare created a relationship of trust and dependence with which the EPLF aimed to promulgate its political message and mobilize the population. As the EPLF became established in villages and among pastoralists, it used healthcare to deliver education aimed at developing Eritreans' political consciousness (With 1987:103; Connell 2001:346). In the obligatory health education that preceded outpatient appointments, medical practitioners emphasized citizens' "right to be healthy," likening it to economic and women's rights. They used politically charged language, emphasizing that basic healthcare education made Eritreans "masters of their health," and that "free people don't need to depend on others." They also highlighted that "the colonizers never gave this to you; we are the first to do this as you are Eritreans and we are Eritreans" (interview with Assefaw, July 2018). Dan Connell agreed that health education encouraged people to associate positive change with the EPLF and impressed upon villagers their own ability to create lasting change (1993:64).

However, it is difficult to assess the extent to which those who used EPLF services and received the education and implicit political messages within them supported the EPLF's (socio)political ambitions. As Assefaw noted, "people learned to listen, even if they didn't like the content" (interview, July 2018). Much of the literature on the subject credits the health service with success; Connell suggests that medicine paved the way for the successful development of a political consciousness favorable to the EPLF among highland farmers (1993:62–63). Similarly, Pool suggests that healthcare generated significant support among the rural population "in a way that politicization through political education with its unfamiliar Marxist/Maoist

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class analysis did not" (2001:81). Assefaw related that civilians were grateful for the services they were offered, and did not routinely scrutinize the EPLF's provision of medical care for political motivations. It is difficult to isolate the effect of health education before outpatient care in mobilizing hearts and minds for the EPLF, given that it formed part of a much broader program of increasing political awareness through local assemblies, education, free veterinary care, and other state services. Nevertheless, populations who encountered the EPLF through its social services did mobilize on behalf of the regime; for example, Tekeste argues that inhabitants of Keren "started to participate actively in different mass organisations" after receiving healthcare (2002:173). Assefaw confirmed that through healthcare, the EPLF "consolidated power and became accepted by the people," but equally stressed that citizens felt a sense of ownership over the service. He cited the repeated delegations, sent after independence by groups from Sahel to Isaias in Asmara to report that they were short of resources and to request his intervention, as evidence of their faith both in the EPLF and in their political right to national resources (interview, July 2018).

In addition to raising political consciousness among the civilian population, healthcare practitioners also received political instruction themselves. The majority of foreign visitors reported a striking uniformity of political views among health workers, despite assurances to the contrary; Connell argues that "ambiguity was not part of the political culture" (1993:42). Tekeste describes an FSU giving "intensive medical and political lessons to its entire staff," and recounts that "heated discussions" were a feature of hospital life. Tekeste reports that "criticism and self-criticism," as well as "counselling and advising" were used to unify political views, and credits this and "political lessons" with improving service quality (2002:131, 2008:28–29, 191–95). In the EPLF, "criticism and self-criticism" denoted a Maoist-style session in which individuals were encouraged to detail their own and others' failures to comply with party doctrine. Sessions were organized in various departments of the EPLF to allow members of the secret EPRP to attack political opponents. However, in the healthcare service, this was complicated by factionalism between two of its senior figures, Dr. Assefaw Ghebrekidan and Dr. Haile Metsun, who were members of the secret EPRP and differed "on matters of dogma." These differences precluded any targeted action against medical staff, as each defended their supporters from political attacks. Medical staff were unaware of the deeper EPRP divisions at play, and Assefaw argued that this factionalism, combined with the medical department's relative independence, protected staff from all but superficial political criticism.[2] Instead, meetings focused on providing constructive feedback about service provision (interview with Assefaw, July 2018).

Nevertheless, it is essential to emphasize the genuine nationalist and humanitarian motivations of what seems to be the vast majority of those involved in the provision of health services. Doctors gave up hard-won, lucrative careers in which they were treated "like Gods" in order to join the EPLF health service, where they made do without wages and on scant

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supplies (interview with Assefaw, July 2018). As Kibreab emphasizes, volunteers "wanted to sacrifice their lives in pursuit of the lofty ideals of democracy, justice, fairness, freedom, rule of law and independence. They wanted change for all the people, not only for those with whom they had affective social relations… These examples of commitment, dedication, devotion and reciprocal cooperation to public causes were nothing but incontrovertible expressions of a highly developed sense of public spirit and [civic] engagement" (2009:346). This is echoed by many textual sources, which emphasize the genuine enthusiasm and dedication of medical staff (Connell 1993:37, 42; Tekeste 2008:176).

Furthermore, the medical service itself enjoyed comparative political independence. Isaias respected the achievements of the healthcare service, and frequently referred any questions from outsiders or the committee to Assefaw. The medical department was given full independence and authority, and senior members such as Dr. Nerayo, as head of the Eritrean Public Health Association, undertook annual trips to the U.S. and Europe to coordinate with specialists and buy medicine and equipment (interview with Assefaw, August 2018). In addition, village health workers and traditional birth attendants were not only elected by each village to form the Community Health Service but were also tasked with advocating for the village in matters of health (Leonard 1988:130–31; interview with Assefaw, August 2018).

The EPLF employed healthcare as a means of accessing urban, rural, and pastoral populations and mobilizing them on behalf of the EPLF. Through the provision of vital services in newly liberated or previously isolated areas, the EPLF successfully won the trust of local populations and used this relationship as a vehicle for delivering political education directly to civilians. This pattern was replicated within the healthcare system, as its hierarchy functioned to homogenize political views. In some respects the Healthcare Department enjoyed relative political independence, and staff motivations certainly seem to have been humanitarian and nationalist rather than political in nature. Nevertheless, the EPLF used healthcare to promulgate its political views, recognizing the provision of medical services as an instrument not only of social cohesion, but also of mobilization.

Healthcare as a Vehicle for Social Change

The climate of the struggle was conducive to profound social change. As previously discussed, ethnic groups excluded from civil society during the Italian and Ethiopian occupations were assiduously reincorporated by EPLF policy, while the comparative lack of ethnic and class dimensions in the organization itself may have contributed to reducing existing social barriers. Though Eritrean nationalism emerged in the colonial period, a "common" national identity that transcended existing social divisions was engendered during the liberation war (Bundegaard 2004:32–33).

The healthcare service was crucial in facilitating this, not least by training a national network of around 5,000 villagers as healthcare professionals

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(Berhe 2000:21), who demonstrated exceptionally high cooperativity and resilience. Healthcare workers sacrificed wealth and status for a life in the field with no pay and limited resources, and a medical system which rejected the traditional hierarchy of doctors and nurses (Wilson 1991:144). Nevertheless, doctors reported that working in EPLF medical teams fostered a unique degree of dedication and cooperation. Members of the healthcare service recollected that they would sit together in the evenings and study to improve the medical services provided, and at times medics relied on blood donations by medical staff and stretcher-bearers for transfusions (Tekeste 2008:336). Teamwork was credited with achieving remarkable feats of medicine, including a successful craniotomy in an FSU tent (2002:62–64). For fighters, the effect of emergency surgery on reducing morbidity and mortality had a "tremendous psychological impact" (Kibreab 2009:109); Tekeste suggests that the popular perception of head, chest, and abdomen injuries was transformed from a death sentence, to "if you arrive at the FSU (alive) you will survive" by 1977 (2002:102). Nevertheless, while Kibreab recognizes the highly-developed sense of public spirit and civic morality among EPLF volunteers, he argues that it is imperative not to over-state this harmony. He suggests that this "economy of affection" in which people set aside their differences was driven by necessity, and that some inevitable conflict and disharmony took place (2008:335–46).

In civil society, anecdotal evidence suggests that healthcare helped to foster cooperation between class and social groups and reduce historic divisions. Civilians in Debub and Ela'gemed donated animal products to medical staff, while female volunteers in the FSUs of Debub, Keren, and Karneshim assisted medical staff by preparing and delivering food, washing textiles, assisting in medical wards, and collecting firewood (Tekeste 2002:184–213). At the central hospital, volunteers built underground wards, transported laundry, tailored clothes, grew vegetables, and harvested grain to support the medical team and the liberation war more generally (Connell 1993:36–37). Pastoralist support became essential to warfare in hostile terrain, particularly by providing camels to transport supplies and casualties. Furthermore, in 1977, a group of thirty volunteers from Sahel requested training in the diagnosis and treatment of common illnesses to reduce the strain on doctors, which was duly arranged (interview with Assefaw, January 2017). As Firebrace and Holland and Tekeste identify, the support and active participation of local populations shaped the experience of war for all those that took part, while mass inclusion provided the basis of the social revolution.

Ultimately, issues linked to the changing role of women engendered the most discussion and division. War often overturns traditional gender roles, and the EPLF took advantage of the dramatic societal flux generated by the struggle to drive through measures aimed at women's liberation. The EPLF stressed a holistic approach that saw health services as interlinked with other goals including the emancipation of women (Wilson 1991:140) and legitimized the promotion of gender equality in line with policies of

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"maximum participation" and in light of military successes (Amanuel Mehreteab 2004:151–54). Changes in the role of women occurred rapidly, as the demand for personnel superseded any objections, and Mary Dines emphasizes that all kinds of traditionally male skills were attained by women (1980:134, 139). Amrit Wilson's account emphasizes the prevalence of women in medical service, from "young Eritrean women doctors in mobile units at the battlefront" to "traditional midwives with modern kits" (1991:139). Healthcare certainly employed a large number of women; 80 percent of health workers, all TBAs, and 55 percent of medical staff were female (interview with Assefaw, July 2017). By the late 1980s, this was reflected in Department of Health, which had 49 percent female personnel (Tekeste 2008:164). Nicole Ann Cowan praises a nursery for fighters' children in which male and female barefoot doctors cared for children from six to nine months of age. Though Cowan acknowledges that cooking and childcare were rarely undertaken by men in the civilian population, Cowan hailed the nursery as "one of the most convincing examples of the Front's commitment to women's emancipation" (1983:149–51). Furthermore, testimonials from women have shown that perceived gender equality between EPLF members was one of the struggle's greatest attractions (Burgess 1989:128).

Dan Connell argues that the EPRP used advances in health and other social and economic services to override objections to policies such as quotas on the number of female participants, suggesting that contesting women's prominence was unpatriotic (2001:354). This allowed the EPLF to push through a central tenet of its "social revolution," the liberation and equality of women, and thus employ the health service as a tool for women's emancipation. However, some women were forcibly co-opted into services towards the end of the 1980s (Kibreab 2008:316), and women remained underrepresented at the highest levels of the healthcare service. Amanuel Mehreteab is not alone in suggesting that women were constrained by a lack of education and experience (2004:153–54); however, the numerous accounts of highly-skilled female practitioners, thirty-year span of the Liberation War, and significant amount of education and training that took place limit this argument.

The EPLF also employed healthcare in its effort to eliminate female circumcision. Initially, the EPLF banned clitoridectomy, which was practiced in the Christian highlands, and infibulation, which was prevalent among lowland Muslim communities (Firebrace & Holland 1984:107–8), with considerable international support. However, enforcement proved difficult: Assefaw recounted that infibulation preceded a feast, and was considered "a village event" and a "stepping stone in the child's life." At the inception of the Civilian Health service, pastoralist women were reportedly circumcised without exception (interview, July 2018). After significant backlash, the EPLF lifted the ban in favor of an educational program. Healthcare practitioners explained the medical objections to the practices, and stressed the risks of the surgery and subsequent complications (Wilson 1991:146). However, real progress was only made when the local sheikhs agreed to

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denounce the surgery (interview with Assefaw, July 2018). Ultimately these policies were highly successful, as female circumcision was reportedly eliminated among EPLF fighters and significantly reduced in EPLF-administered areas (Firebrace & Holland 1984:107–8).

It remains difficult to quantify the extent to which the EPLF successfully integrated with rural communities and transformed society. Generally, Assefaw suggests that citizens trusted the EPLF to serve their interests, particularly in regions where there had previously been no provision for health or education (interview, August 2018). The healthcare system facilitated and accelerated social change and facilitated positive interactions between EPLF members and the communities in which they worked. Within the Health Service, there was an ostensible absence of class and social barriers, which contributed to an exceptionally high degree of teamwork and cooperation. Healthcare improved the position of women, who made up the majority of healthcare practitioners, though there were limits to women's advancement. However, the EPLF also used healthcare to override social norms in its drive for national transformation.

Coercion & Compromise in Healthcare

Across the EPLF, Kibreab argues that the "democratic centralism" that made services effective prevented autonomy and ideological pluralism. As the civilian population in semi-liberated and liberated areas became dependent on the Front for healthcare, they became less autonomous and lost political leverage; this allowed the ELF and EPLF to ignore civilian demands without fear of political repercussions (2008:355, 374). Connell suggests that the EPLF's descent into control was inevitable, given the persistent internal and external ideological, military, and physical threats to its existence (2001:362). Nevertheless, the intimate nature of healthcare necessitated close cooperation between the EPLF and local communities and required that the EPLF navigate existing structures of power.

As Carol Barker and Meredeth Turshen have shown, the successful implementation of primary healthcare both requires and facilitates a high degree of government control. As a result, citizens "trade some measure of individual freedom for improved individual health" (1986:79–81). Complaints against doctors were extremely rare; medicine was a prestigious profession, and deaths were generally felt to be "god's will" (interview with Assefaw, August 2018). Indeed, Tekeste notes that not having to obtain consent, combined with patient obedience to EPLF doctors, facilitated efficient treatment (2002:39). However, this violates widely held principles of bodily autonomy (Etchells et al. 1996:177–80). A similar compromise was adopted with women of the Rashaida ethnic group, who expressly prohibited male healthcare professionals from checking their throat or tonsils. As relations between the EPLF healthcare professionals and the Rashaida improved, qualified medical male doctors were allowed access into the women's tent. Nevertheless, one barefoot doctor was

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believed to be the head of the hospital and thus allowed to treat Rashaida women (interview with Assefaw, July 2018). While this facilitated treatment, it could be seen to breach the standards of transparency and honesty expected of medical professionals.

However, cooperation with established healthcare traditions was crucial to the EPLF's successful integration of existing social groups into the liberation war, despite early attempts to outlaw traditional medicine and practices. Officially, the EPLF preserved the "good" aspects of traditional medicine and rejected the "bad" wholeheartedly (Wilson 1991:140), although in practice this distinction seems to have been less clear-cut, and a complex system of mutual dependence developed. This was particularly true of Traditional Birth Attendants and traditional healers. Birth attendants were a pillar of village communities, with high community status and extensive client networks. The EPLF recognized that most births were reasonably priced and problem-free, and that attendants were highly experienced (Assefaw 2009:19–33). By training existing birth attendants in modern technique and presenting them with a modern delivery kit, the EPLF aimed to eliminate existing harmful practices, and incorporate traditional practitioners into the healthcare system.

A less formalized cooperative approach was adopted with traditional healers, after unsuccessful attempts to eliminate traditional medicine. The EPLF initially banned healers and sheikhs from practicing, decrying their prices as excessive and their treatments harmful. Several practitioners were arrested and jailed, and many went into hiding or sought refuge in their communities. However, traditional healers and sheikhs were deeply embedded in local societies, and traditional medicine remained popular throughout the liberation war to treat *himam nebsi* (spiritual causes), even among EPLF fighters (Tekeste 2002:135–36). Assefaw suggests that the ban was unsuccessful and undermined trust in the EPLF, prompting a shift from prosecution to cooperation (2009:27–28). As healers could see more than 150 patients a day, compared to around thirty attending a local clinic, some EPLF services worked with local healers to manage patients more effectively. As an EPLF surgeon, Assefaw formed an agreement under which he would refer patients with viral diseases, epilepsy, convulsions, and psychiatric problems to a local sheikh, and the sheikh would refer diseases such as tuberculosis to Assefaw's surgical team. In practice, many patients saw both practitioners. There is a striking parallel between the EPLF's experience and the ZANLA's compromise between socialist idealism and traditional medicine in Zimbabwe, where the state cooperated with traditional medicine in order to maintain moral and political authority in the eyes of the rural population (Lan 1985:146–49, 164–66). Nevertheless, Assefaw argued that the EPLF were never able to fully repair the damage caused by the initial persecutions and "arrogance of Western medicine" (interview with Assefaw, July 2018).

The phenomenon of "malingering" gives us an insight into those who found the harsh conditions and enormous social and political pressure of the Front harder to tolerate. It is difficult to ascertain how widespread this

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practice was, as it is absent from almost all literature on the period. Tekeste describes fighters who inflicted severe self-injury or feigned illness "for a few days rest in the hospital" after experiencing traumatic events, or out of dislike of the Front. Until 1979, doctors diagnosed patients with non-physical symptoms as "malingering" and sent them back to their divisions, where they were branded "cowards" or "opportunists" (Tekeste 2002:178). However, this resulted in more complex and well-researched presentations of illness, and there were worries that "malingering" patients might either disengage with medical services, or refrain from seeking treatment due to the risk of social stigma. From 1979, Tekeste's team began to investigate the patient fully and diagnose the condition as inconclusive, while providing informal counselling and advice. This was an ad hoc initiative; there remained no official provision for any forms of post-traumatic stress disorder, and any fighter exempted from duty could be subsequently investigated (2008:180–90). These unofficial provisions echo arrangements in the civilian healthcare service described above; in the absence of resources for psychiatric treatment, patients with suspected mental illnesses were referred to local sheiks for traditional treatments (interview with Assefaw, July 2018). While Tekeste's general statements about malingering emphasize the coercive nature of the EPLF, both senior figures describe the informal emergence of something akin to psychiatric care, complicating the picture of homogeneity among not only fighters, but also doctors. In a similar manner to the "self-criticism" described above, the biopolitical protocol for "malingering" patients seems to have been diluted by the realities of providing medical care.

Some groups appear to have been more critical of the service than others; Sahel pastoralists continued to question and criticize the EPLF. A crucial example of this is their exercise of the "right to candor," a tenet of medical ethics mandating that patients receive candid information about medical errors. After a woman treated by the EPLF died during childbirth, a group of pastoralists raised a public complaint with senior figures in the service. They cited the service's pronouncement that "if you do exactly as we tell you, no mother will die during labor," and questioned the methods and authority of the EPLF's modern medicine. The complaint resulted in a "full investigation." Though the healthcare service was eventually exonerated, Assefaw revealed that the incident served as a "warning to be careful, even in the middle of war." While far from standard practice in the EPLF system, this request highlights the ongoing negotiations between civilians and healthcare services during the war. The former director described the incident as evidence of the EPLF's success in political education: citizens were "aware of their power" to the extent that they called the methods and authority of doctors into question (interview, July 2018).

Ultimately, the biopolitical manner in which the EPLF pursued healthcare delivery compromised individual rights, and facilitated the increasing incursion of (proto-)state power into Eritreans' lives. However, the Front

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also met with significant opposition and traditional forms of healthcare that it was unable to eradicate. While successful healthcare was able to extend centralized control, the EPLF healthcare system succeeded only when it entered into dialogue with the communities it sought to change.

International Dimensions of Healthcare

Eritrea received "no more than a trickle" of international relief during the struggle (Dines 1980:132), and at various points both the United States and the Soviet Union supported Ethiopia against Eritrea. As Assefaw remarked to the *New York Times*: "Our struggle has been a very isolated one. No superpower supports us. To the Soviets we are agents of imperialism. To the West we are Marxists. But there is some good about isolation. It steels us. We are self-sufficient" (Kifner 1988).

The EPLF also maximized the involvement of its diaspora. Salary remittances provided the economic support necessary for a viable healthcare system (Bundegaard 2004:33), and the diaspora also drove the formation of the EMA, the Research and Information Center on Eritrea, and the ERA (Leonard 1988:111). The latter, a humanitarian organization established by Eritrean refugees, provided emergency relief and long-term development programs in EPLF-controlled areas, including medicines, raw materials, and medical equipment, from 1984 to 1992 (Berhe 2000:2–3, 12).

A predilection for underplaying the role of international partners by effusive journalists and the current PDFJ regime makes the exact contributions of foreign collaborators difficult to ascertain; this uncertainty has legitimized Eritrean claims of self-sufficiency at the expense of acknowledging its substantial and long-term international collaborations. Support for the EPLF was characterized by small-scale projects between individuals or small organizations rather than foreign governments. One such project was a microscope designed by Scottish doctor John McArthur in 1983 specifically for the EPHP, which revolutionized the diagnosis and treatment of malaria, tuberculosis, and intestinal parasites by barefoot doctors. The production of intravenous fluid was made possible by funds and technical assistance from the Belgian Support Committee, while the raw materials for tablet and capsule production were donated by British NGOs (Firebrace & Holland 1984:114–15), and the hospital complex in Afabet was Swedish-built (Dines 1980:134). In total, over thirty NGOs worked with the EPLF to fund the purchase of surgical equipment and anesthesia machines from overseas. International supporters from Denmark, Sweden, Italy, France, and Norway provided specialized teaching and training (With 1987:155–59; Firebrace & Holland 1984:104–5), and Eritrean barefoot doctors shared their expertise in hostile environments with foreign paramedics. Detailed reports on the health service were compiled and forwarded to the ERA's NGO partners each month (Kibreab 2009:109).

Praise by Western observers also shaped the service and the struggle, as glowing reports of the healthcare service legitimized the EPLF proto-state

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and drew attention away from deeper currents of coercion and increasingly centralized control. The EPLF's achievements with regard to health "rarely failed to impress visitors, including doctors and other trained medical personnel" (Firebrace & Holland 1984:102); John Kifner's (1988) effusive reports in the *New York Times* demonstrate how closely healthcare was linked to EPLF legitimacy. Kibreab argues that such "eulogistic observations" contributed to the EPLF leadership's sense of infallibility and facilitated the creation of the present military state (2009:14).

The EPLF received remarkably little formal international support, and was reliant on remittances from diaspora Eritreans. In addition, the ERA and its NGO partners were instrumental in organizing supplies and international training for the healthcare program. Several informal international partnerships were conducted, which developed the healthcare service and improved its self-sufficiency. However, international media attention to the health service may have deflected critical assessments of the EPLF and contributed to the organization's sense of infallibility.

Conclusions

While it is difficult to quantify the direct contribution of the EPLF Health Service to the success of the Liberation War, the pyramidal, multi-tiered pathways of civilian and military healthcare delivered a high-quality, efficient medical service, which focused on the delivery of primary healthcare while also offering sophisticated referral services. This defined the EPLF against its rivals, and provided it with moral legitimacy. Healthcare successfully penetrated urban, rural, and pastoralist communities, and relationships developed through the provision of healthcare were used to incorporate population groups into the EPLF project, inculcate its political ideology, and alter society. Nevertheless, the system was most successful when it cooperated with traditional forms of medicine and existing community authorities, and compromised its more vociferous biopolitical policies. Health education was of intrinsic importance, not only to improve services, encourage social mobility, and empower the population, but as a means of disseminating EPLF ideology. The service demonstrated high levels of transethnic, transreligious, and transregional cooperation and trust (Kibreab 2008:346–54). However, the politicization of healthcare, and the lack of any alternative system, allowed it to become an instrument of control. While this may have aided female emancipation, the healthcare service was largely intolerant of dissent and worked to homogenize political views.

The central achievement of the medical service was the development of a relationship between the EPLF and its fighter and civilian populations. Many of those working for the health service were genuinely motivated by altruism to support both the Liberation War and their fellow Eritreans. The achievements of this remarkable system relied upon the compromises made by those providing healthcare, who worked tirelessly through the brutality and deprivation of war. This is not only reflected in current regime

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propaganda, but also by the powerful memories of positive change among those who took part in the Struggle and now actively criticize the regime. Nevertheless, the healthcare service seems to have compromised individual rights and pressured individuals to conform in the service of its lofty aims. The delivery of healthcare, a process popularly seen as distinct from politics, was intentionally used to disseminate political education and gain support for the EPLF. The increasingly close relationship between the party and the population brought the former into every stage of civilians' lives, which facilitated the biopolitical control and coercive state power that have become the defining features of post-independence Eritrea.

Many governments use healthcare as a means of gaining political support, creating dependency on a state system, and extending centralized control. Furthermore, many contemporary commentators saw the infringement of human rights during the Liberation War as a necessary feature of the permanent state of emergency from which the EPLF emerged, as with other guerrilla struggles of the late twentieth century. However, the most progressive elements of the EPLF's unique healthcare service were inextricably intertwined with those that threatened individual liberties and created a system and society vulnerable to authoritarian control. Thus the healthcare system formed a potent tool that was used by the increasingly totalitarian EPRP, and later PFDJ, in the service of biopolitics and coercion.

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Notes

1. It is worthy of note that the Tigrayan People's Liberation Front (TPLF) developed a similar healthcare system to the EPLF, rooted in community-based mobilization and intersectoral collaboration. However, relations between the erstwhile collaborators and current political opponents are complex, and the interplay between these two health systems remains to be examined.
2. Haile Metsun, who was supported by Tekeste Fekadu (a military surgeon whose memoirs are quoted extensively in this paper), succeeded Assefaw as director of the civilian healthcare service in the post-war period due to his party loyalty. Assefaw was demoted and eventually dismissed by Isaias Afeworki after repeated disagreements between the two EPRP members over issues including the medical treatment of ex-ELF fighters. Assefaw reported that Tekeste was a member of the Haile faction, but unaware of the existence of the EPRP and thus the factionalism at play. Criticism and self-criticism is dealt with in passing in Tekeste's account of the healthcare service, as referenced above.