



STATE OF ERITREA



UNITED NATIONS

# State of Eritrea

Health Millennium Development Goals Report

## Innovations Driving Health MDGs in Eritrea

September, 2014

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## Acronyms

AfDB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral Drug
BCG	Bacillus-Calmette-Guerin
BMI	Body Mass Index
CBO	Community-Based Organisation
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CFCs	Chlorofluorocarbons
CLTS	Community Led Total Sanitation
CPT	Cotrimoxazole Preventive Therapy
CRC	Convention on the Rights of the Child
DOT	Directly Observed Treatment
DIN	Department of Immigration and Nationality
DST	Drug Susceptibility Testing
EPHS	Eritrea Population and Health Survey
EDA	Eritrean De-Mining Authority
CARMME	Campaign on Accelerated Reduction of Maternal Mortality in Eritrea
ECD	Early Childhood Development
EFA	Education for All
EPHS	Eritrean Population and Health Survey
EU	European Union
FAO	Food and Agriculture Organisation
FDI	Foreign Direct Investment
FDI	Foreign Direct Investment
FPL	Food Poverty Line
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GoSE	Government of the State of Eritrea
GNP	Gross National Product
HCFC	Hydro chlorofluorocarbons
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HPI	Human Poverty Index
IAEA	International Atomic Energy Agency
ICT	Information and Communications Technology
IES	Incomes and Expenditure Survey
IFI	International Financial Institutions
ILO	International Labour Organization
INGO	International Non-Governmental Organisation
IMF	International Monetary Fund
ITN	Insecticide-Treated Net
IWRM	Integrated Water Resources Management
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDGR	Millennium Development Goal Report
MIMS	Multiple Indicator Monitoring Survey

MoND	Ministry of National Development
MDG	Millennium Development Goals
MPR	Malaria program-performance review
MoA	Ministry of Agriculture
MoE	Ministry of Education
MoEM	Ministry of Energy and Mining
MoFA	Ministry of Foreign Affairs
MoH	Ministry of Health
MoLHW	Ministry of Labour and Human Welfare
MoMR	Ministry of Marine Resources
MoTC	Ministry of Transport and Communication
MoTI	Ministry of Trade and Industry
MoWLE	Ministry of Land Water and Environment
MIS	Malaria Indicator Survey
NATCoD	National HIV/AIDS & Tuberculosis Control Division
NSO	National Statistics Office
NTCP	National TB Control Programme
NMCP	National Malaria Control Plan
ODA	Official Development Assistance
ODS	Ozone Depleting Substance
OVC	Orphans and Vulnerable Children
PASS	Poverty Assessment Study Survey
PICES	Poverty, Income Consumption and Expenditure Survey
PMTCT	Prevention of Mother-To-Child Transmission
SPCF	Strategic Partnership Cooperation Framework
STI	Sexually Transmitted Infection
SZTBC	Sub-Zoba TB Coordinator
TB	Tuberculosis
TCPL	Total Consumption Poverty Line
WFFC	World Fit For Children
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UN AIDS	Joint United Nations Programme on HIV/AIDS UNCTAD United Nations Conference on Trade and Development
UNDP	United Nations Development Programme
UND PI	United Nations Department of Public Information
UNEP	United Nations Environment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UN FPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organization
UNODC	United Nations Office on Drugs and Crime
UNO PS	United Nations Office for Project Services
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UN WTO	United Nations World Tourism Organization
WFP	World Food Programme
WHO	World Health Organization
ZTBC	Zoba TB Coordinator

## Message from H.E. Amina Nurhussien, Minister for Health



The overall goal for the health system in Eritrea as articulated in the Health Sector Strategic Plan Development Plan (2013-2016) is the improvement of health status, general wellbeing, longevity and economic productivity for all Eritreans. Accordingly, over the last few years, the country has achieved remarkable progress on basic health indices. Key among them include significant reductions in maternal and child mortality ratios, and HIV prevalence. In the period since independence in 1991, access to healthcare within a radius of 10 kilometers increased from 46 percent to 78 percent, while over 60 percent of the population enjoys access to health care facilities within a radius of 5 kilometers; leading substantial improvements in the access to and utilization of quality and timely healthcare. Evidence already points towards the fact that Eritrea will meet all the health MDG targets by the 2015 deadline.

These significant improvements and achievements recorded in the Millennium Development Goals (MDGs) are a result of a concerted effort by government, citizens, civic and community leadership, and development partners. These gains can be attributed to several complementary factors; key among these are the high prioritization of health and education and a strong commitment to development among Eritreans, as well as to innovative multi-sectoral approaches to health.

However, it is important to note that all the eight MDGs are inter-linked. Hence, to sustain the gains made in the health MDGs would also need complementary support from, and attention to the other sectors covered by the other five MDGs.

Despite, these achievements, much more remains to be done especially with regards to non-communicable diseases. In addition, there are also threats by new and emerging communicable diseases, already among the ten leading causes of morbidity and mortality in adults. Furthermore, more resources would be needed to realize our aspirations the general well-being of our people.

As we approach the 2015 deadline, and going forward, it is our sincere hope that useful lessons can be drawn from Eritrea's successes so far in the health sector which could help formulate, shape and implement the post 2015 global development Agenda.

Thank you.

## **Acknowledgements**

The Eritrea Health MDGs Report was made possible through a participatory and consultative process involving Government ministries, United Nations agencies, international organisations, Global Fund for HIV, TB and malaria, private sector partners, academia and research institutions, and civil society organisations. The Government of Eritrea wishes to acknowledge the invaluable contributions made by officials from both the Government and the UN agencies and other development partners that provided technical guidance, relevant data and statistics for evidence-based analysis, including the input on innovations, best practices, and challenges that appear in this report.

The following ministries especially facilitated the consultative process through co-ordination and crafting of the final report:

- Ministry of Health
- Ministry of National Development
- Ministry of Foreign Affairs

The Government of Eritrea wishes to extend appreciation to the UN Resident and Humanitarian Coordinator and the UN Country Team for the partnership and technical support and overall backstopping and co-ordination of the report-writing. Special mention goes to the consultant<sup>1</sup> who assisted with the preparation of the report.

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<sup>1</sup> Dr. Godwin Hlatshwayo of the Redroof Brands: redroof2009@gmail.com

## **Executive Summary**

Eritrea has a positive and unique story to tell about health related Millennium Development Goals (MDGs). Eritrea is one of the few countries expected to achieve the MDGs in health. Infant and child mortality rates have reduced dramatically; immunisation coverage has increased sharply; malaria mortality and morbidity have plummeted; and HIV prevalence has almost halved in a very short period of time.

Based on the latest data available and through an analysis of the trends of the three MDGs, as well as the current supportive policy and political environment in Eritrea, this report tells the Eritrean experience in achieving MDGs 4, 5, and 6. Specifically, this report highlights innovations, best practices, as well as challenges and bottlenecks that need to be improved on in order to sustain the gains achieved thus far for the health MDGs in Eritrea.

Eritrea's march towards promoting equitable, accessible and affordable health services to the majority of its citizens has been commendable. Concerted government programmatic and resource investment in the health sector made it possible to reduce under-five mortality from 150 per 1,000 live births in 1990 to 50 by 2013. During the same period, the maternal mortality ratio decreased from 1,700 per 100,000 live births to 380.

Significant reduction of maternal mortality has been achieved as well; from 998/100,000 live births in 1995 to 486/100,000 live births in 2010. The major interventions leading to these achievements have been the provision of effective health-facility delivery services, comprehensive immunization, family planning, nutrition interventions, control of communicable diseases including HIV and AIDS, tuberculosis (TB), malaria and, expansion of community based interventions.

To further improve maternal health, a Roadmap for Maternal and New-born Health is in place, supported by the Campaign on Accelerated Reduction of Maternal Mortality in Eritrea (CARMME). The triple threat of HIV, TB and malaria is being effectively tackled through a partnership involving the GoSE; Global Fund on AIDS, TB and Malaria; and the UN system. Supportive health sector policy and strategic plans have also been developed and implemented rigorously over the same period<sup>2</sup>. The results, if sustained, are very promising to sustain the gains and further improve healthcare programming in Eritrea.

The Malaria Performance Review (MPR) (2013) also highlighted the following achievements recorded by the government to create an enabling operating and programming environment in the health sector: a series of costed strategic plans, with involvement of major stakeholders (with clear vision, goal, targets); fairly adequate funding mobilized; introduced relevant curricula in the University and satellite

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<sup>2</sup> See a comprehensive listing of the MOH health policy frameworks and strategic plans developed and implemented in the health sector over the past decade. They are documented and presented at the end of the report as secondary bibliography



associate nursing schools with degree programs in medicine, dentistry, nursing, pharmacy, public health and clinical laboratory sciences; training of Public Health Technicians (PHTs) and deployment of Community Health Agents (CHAs);

The MPR (2013) concluded that Eritrea is winning the war against malaria. Morbidity and mortality due to malaria have decreased by 85 percent and 90 percent, respectively, since 1998. Incidence of malaria is now at a low level of 1,282 per 100,000. Likewise, the incidence of tuberculosis has decreased from 243 per 100,000 (1990) to 97 (2011). If life expectancy at birth is taken as a composite indicator of health status, its trends are equally encouraging. Life expectancy at birth increased from 48 years in 1990 to 63 years in 2013.

The HIV prevalence result from the 2010 Eritrean Population & Health Survey (EPHS) is 0.93%. HIV incidence has decreased from 45 per 100,000 in 2001 to less than 8 in 2012. Furthermore, data derived from VCT and PMTCT clients and blood donors continually show a reduction in HIV and syphilis positivity rates.

Knowledge about HIV/AIDS is still maintained at a high level and condom distribution is also increasing. PLWHAs put on ART every year are averaging 1,000. Although all these development are encouraging, there is more work to be done to control the epidemic further.

Despite the commendable achievements in the control and prevention of malaria, the threat of resurgence due to climatic changes, cross border transmission and partly due to the national strategy on irrigation expansion for food security, remains a real threat in the foreseeable future. Hence, the remarkable success achieved in preventing and controlling malaria with a reduction of around 90 percent in malaria morbidity and mortality, since 1999 should not lead to complacency in Eritrea.

Historically in Eritrea life expectancy at birth went from 39.1 in 1960 to 59.5 years in 2008. Infant (0-1 year old) and under-five mortality (0-5) have both shown extraordinary improvements: the former went from 122.2 to 40.8 deaths per 1,000 live births and the latter from 205 to 58.2 between 1975 and 2008<sup>3</sup>. Progress in other sectors, e.g. water and sanitation and education, has also contributed to improved health outcomes. It is important to note that, owing to the relative isolation of Eritrea, information and resources are extremely limited. It is impressive that Eritrea is one of the few countries to achieve the MDGs in health, particularly targets in child health<sup>4</sup>.

The GoSE runs an effective three tier health delivery system which has also proved to be formidable in meeting the felt needs of communities at all levels. This is another key and notable strategic approach and structural planning process that has contributed to the efforts leading to the achievement of the health MDGs in Eritrea.

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<sup>3</sup> World DataBank.

<sup>4</sup> Progress in health in Eritrea: Overseas Development Institute p3.

Understanding how the health delivery system works across the country improves appreciation of how Eritrea has marched towards to achievement of health MDGs. This health delivery structure can be called a best practice and an innovation in a country with limited resources and with some of its populations located in hard-to-reach areas.

Apart from the structure of the health delivery system that GoSE delivers comprehensive packages of low-cost, high-impact interventions to improve child survival, including:

- a) Breastfeeding protection and promotion
- b) Complementary feeding
- c) Micronutrient supplements to combat iron and iodine deficiencies
- d) Vitamin A supplementation and supplementary and therapeutic feeding
- e) Immunization, including Hib vaccine and Hemophilic influenza type B and recently (August 2014) Rota Virus
- f) Insecticide-treated bed nets
- g) Prompt treatment for malaria
- h) Oral re-hydration therapy and zinc supplementation for diarrhea treatment
- i) Prevention and care of pediatric HIV/AIDS
- j) Antibiotic treatment for pneumonia, sepsis and dysentery
- k) Antenatal care and TT vaccination in pregnancy
- l) Safe delivery and emergency obstetric care
- m) Essential newborn care including postpartum visits
- n) Promotion of sanitation, hygiene and hand washing
- o) Building and use of maternity waiting homes

One other critical area the GoSE has paid close attention is the development of adequate health facilities and infrastructure. Since independence in 1991, the number of hospitals increased from 16 to 28, health centers increased from 5 to 56 and health stations (including clinics and MCH facilities) from 72 to 256. However, as shown elsewhere in this report, this quantitative increment, significant as it is, does not fully reflect the qualitative improvements that resulted from the replacement of old and run-down facilities by the construction of new and improved facilities. Infrastructure improvement alone does not also automatically equate to quality health care delivery. The GoSE recognizes that health care facilities should be adequately resourced and well managed in order to cause a difference in the lives of communities they are meant to serve.

One of the biggest challenges facing the GoSE is to provide quality health care services in all facilities, old and new. To prepare for that, three of the five strategic integrated priorities that the GoSE plans to focus on in the current government programming period include: 1) Basic Social Services; 2) National Capacity Development; 3) Food Security and Sustainable Livelihoods; 4) Environmental Sustainability. Improving programming in these strategic areas will help the GoSE to among other things improve quality of health care delivery to its population over time. Basic Social

services include primary health, WASH and education that are highly needed for the health care system to be vibrant. National capacity development will be required in national infrastructure, human resource development, research, and multisectoral programming that will sustain the health MDGs by creating sustainable linkages with the other five MDGs. The area of food security and sustainable livelihoods will boost the health care and nutrition needs of the nation to support a health nation. The environmental sustainability agenda is vital to buttress the agro based economy of Eritrea.

However, the country still faces serious challenges from communicable and non-communicable diseases (NCDs); malnutrition; occasional disease outbreaks; compounded by culturally and socially created health challenges such as female genital cutting (FGM/C) and violence against women including abortion complications. The efforts made in the control of communicable diseases and the changes in the living standards and lifestyles of Eritrean people as well as environmental factors are leading to an epidemiologic shift from communicable to non-communicable diseases. There is growing frequency of non-communicable diseases such as hypertension, diabetes, cancers, chronic lung diseases (asthma) and mental health problems, and re-emergence of chronic Neglected Tropical Diseases (NTDs).

Despite the challenges targets and indicators show that as of 2013 Eritrea has achieved all three health MDGs: MDG-4 on child health, MDG-5 on maternal health, and MDG-6 on combating HIV/AIDs, Malaria and other diseases.

The remaining MDGs that are still a challenge to Eritrea are MDG1: Eradicating extreme poverty and hunger; MDG2: Achieve Universal Primary Education; MDG 3: Promote Gender Equality and Empower Women; MDG7: Ensure Environmental Sustainability; and MDG8: Develop a Global Partnership for Development. Though evidence based studies are yet to be carried out, targets under these goals are unlikely to be met by the 2015 deadline.

## **1. Introduction**

### **1.1. Background to the MDGs**

All member states of the United Nations including Eritrea adopted the MDGs in 2000. Since then MDGs have become a global framework for development and are now broadly understood as a lynchpin to global security and an indicator of the international systems ability to set and follow-through on practical targets for global partnership.

The significance of the MDGs lies in the linkages between them: they are a mutually reinforcing framework to improve overall human development. In the comprehensive nature of the MDGs is the recognition that development is an inter-sectoral and interdependent process. For example, improved nutrition affects school completion rates. Improved education levels contribute to better health. Better health contributes to poverty reduction. Poverty reeducation contributes to employment creation and wealth creation.

The Secretary General reports annually on progress towards achieving the MDGs and identifies areas where greater follow through is required to accelerate progress. While there has been significant progress in a number of countries, other countries have huge hurdles to meet all targets by 2015. The most recent global reports<sup>5</sup> show that the position is most severe in Sub Sahara Africa where many countries are off track. Overall, the poverty target (MDG1) may not be met till 2147; achieve universal access to primary education (MDG2) until 2129; and reduce under five mortality by two-thirds (MDG4) until 2165. It is in this complex context that Eritrea feels privileged to tell her story of achievements, prospects, innovations and progress made thus far in MDGs 4,5, and 6.

Although Eritrea has produced only one national MDG report (in 2006) since independence in 1991, the GoSE has initiated and implemented several enabling policies and programmes that have facilitated integrated development planning and multisectoral programming in the country. These include equal opportunity development objective, free education and health programmes, proactive approach to immunization, collaboration between traditional and orthodox health practices and accelerated health infrastructure enhancement, among others. These sustained policy actions have impacted on many of the MDG goals and targets. However, these have not been articulated in the form of a report at the national and sub-national levels since 2006.

Just about fifteen months to the terminal date of the MDGs, as a preliminary and partial effort to have a national report on the MDGs, the Eritrean Government has prepared a background document on its performance on the health MDGs in close

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<sup>5</sup> Background document to the Millennium Development Goals UNDG p1. The Development Section of the 2006 Report of the Secretary General on the Work of the Organisation (GA A/61/1) provides a more comprehensive background on the Millennium Development Goals (MDGs)

collaboration with the United Nations Country Team in Eritrea. This report documents progress on MDGs 4, 5 and 6. It showcases policy and institutional innovations driving progress on these targets, identifying challenges for consolidating progress and emerging lessons that the Government of Eritrea and other African countries could use to drive the MDGs to buttress the sustainable development agenda post 2015. Based on a trend analysis of each MDG, evaluated against the target of each goal, this report assesses progress the country has made and innovative strategies employed along the way to achieving the health MDGs.

The report, prepared under the oversight of Ministry of Health (MoH) and coordinated by MND examines what is going well, key drivers responsible for this performance and also investigating what is not progressing well and why, highlighting good practices for MDG achievement which can be further built upon or replicated. A particular emphasis is being placed on innovative strategies that may have simultaneously accelerated progress on the MDGs 4, 5 and 6 with positive spill over effects to other MDGs. Photographs and brochures clearly depicting the progress made are an important part of the report and presentation. This approach is intended to deepen the national, regional and international understanding of why progress was achieved on these MDGs. Areas of improvement are suggested, together with key messages and lessons learnt. This forward looking report will identify areas for relevant partnerships in scaling up the achievements at regional and global levels, while ensuring strong national support and ownership at home.

The outcome of this exercise is meant to be presented during the side event being organized by the Government of Eritrean in collaboration with the United Nations Development Programme. The side event is tentatively planned for 26 September 2014 in New York, USA.

Although this report focuses on the three MDGs which are directly related to the activities of the Ministry of Health (MDGs 4, 5, 6), health is also an important contributor to several other MDGs and sectors: Goal 1: eradicate extreme poverty and hunger; Goal 2: achieve universal primary education; Goal 3: promote gender equality and empower women; Goal 7: Ensure environmental sustainability. Much of MOH's work, directly or indirectly supports these other MDGs, particularly the eradication of extreme poverty and hunger (Goal 1) and ensuring environmental sustainability (Goal 7), particularly water and sanitation aspects. Therefore clear lessons and synergies have to be drawn to make a case for the interrelatedness and cross-fertilization of all the MDGs.

The health MDGs and the rest of the other MDGs are interlinked. The success of innovative strategies on MDGs depends on translating existing policy promises on sustainable development into concrete actions. The Report evaluates progress on linking health MDGs targets to sustainable development in practice, examining the tensions and bottlenecks inherent in the Eritrean economy, and opportunities and innovative success stories, by drawing from observations and documentary analysis of the actions and outcomes since the 2006 MDGs Report.

## **1.2. Methodology**

Eritrea has prepared this evidence-based 2014 Eritrea Health MDGs progress report through a comprehensive analysis of the achievements, their drivers, as well as challenges and lessons learned. The methodology involved collecting data from various sources at national and regional levels. The approach was to mine data at global, national and sub national levels. The main method of data collection was desk review of data and information sources. Data analysis used both quantitative and qualitative methods as appropriate. Data/information used for the preparation of the report was drawn from Government sources (administrative and surveys only in the absence of census data). Critical data/information gaps of Government sources were bridged by UN credible sources. Additional inputs from the UN Country Team in Eritrea were also accommodated in the report.

Thus the assignment was undertaken through primary and secondary information sources. All relevant secondary documents and publications from Ministry of Health, relevant agencies of Governments and international organizations were reviewed to provide evidence for articulating the report. Therefore literature survey was done through primary and secondary data sources<sup>6</sup>. The Ministry of Health developed the working draft with input from Ministry of National Development and the United Nations Country Team in Eritrea. The consultant, in collaboration with the Ministry of Health, then developed the final report, incorporating comments from the UN System. This was done to complement information from secondary sources. The limitations and constraints to developing this report were the short space of time available to develop a fully consultative report [3 weeks]. However the shortcomings in the report can be attributed to the consultant who had the final accountability to develop the final document.

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<sup>6</sup> Two sets of bibliography has been developed and attached to this report for further reference.

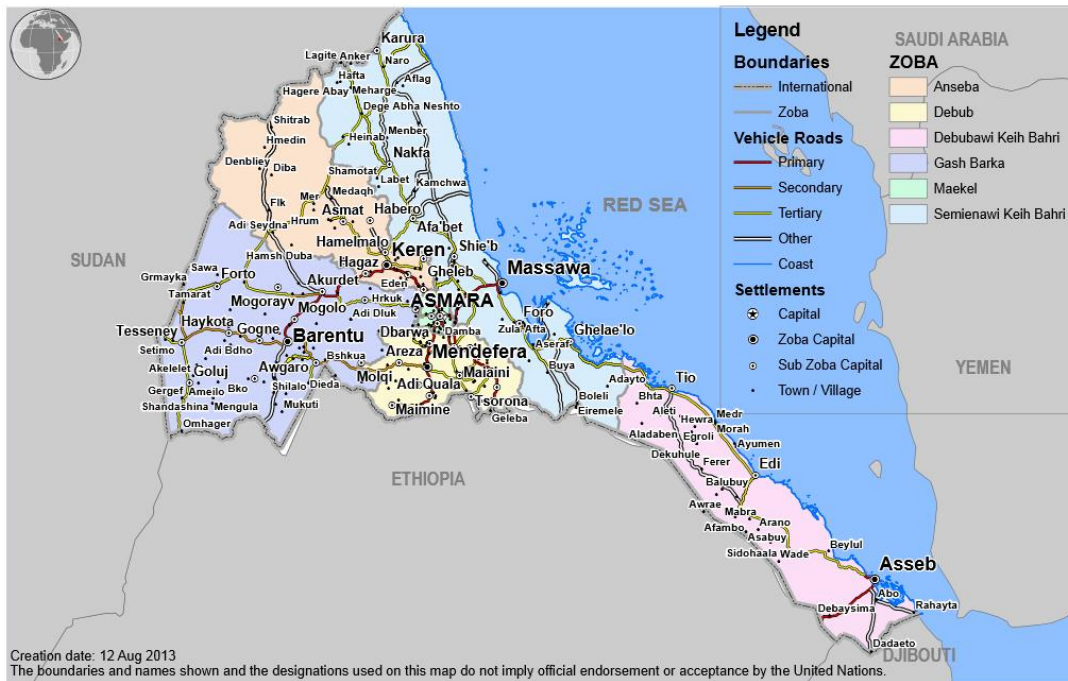
## **2. Country Background and Development Context**

### **2.1. Country Background**

Eritrea is situated in the Horn of Africa and lies north of the equator between latitudes 12°22' N and 18°02' N, and longitudes 36°26'21" E and 43°13' E, where arid and semi-arid climatic conditions prevail. It has an area of 124,000 square kilometers and is bordered by the Red Sea to the east, Djibouti to the southeast, Ethiopia to the south, and the Sudan to the north and west. Administratively, Eritrea is divided into six *zobas* (regions): Anseba, Debub, Debubawi KeihBahri, Gash-Barka, Maekel, and Semenawi KeihBahri, and 58 *sub-zobas* (sub-regions) (NSEO 2013; MOH, 2012)

Eritrea has varied topography with land rising from below sea level to 3,000 meters. There are three major physiographic zones: the Western Lowlands, the Central and Northern Highlands, and the Eastern Lowlands. Rainfall in Eritrea ranges from less than 200 mm per annum in the Eastern Lowlands to about 1,000 mm per annum in a small pocket of the escarpment. There are two major periods of precipitation. One, from June to September, covers both the Western Lowlands and the Highlands, and the second between October and March covering the Eastern Lowlands. This topography and rainfall pattern has impact on the disease pattern requiring decentralized policy approaches and interventions for health care delivery.

A complete population census is pending. However, based on the Eritrean Population and Health Survey (EPHS) conducted in 2010, the National Statistics Office (NSO) estimates Eritrea's resident population in 2014 as 3.5 million. It is estimated that the population under 15 constitutes 47 percent while the population 65 years and above accounts for only 7 percent of the total population. The population is essentially rural with about 65 percent living in the countryside. Eritrea is a multi-ethnic society with nine different ethnic groups speaking nine different languages and professing two major religions, namely, Christianity and Islam (NSO, 2013). Below is the latest map of Eritrea.



## 2.2. Country Development Context

Soon after independence in 1991, Eritrea formulated and implemented socio-economic development policies and strategies resulting in marked improvements in key sectors for the period up to 1997. However, a border dispute with neighbouring Ethiopia (1998-2000), which escalated into a full-scale war, reversed the gains. The unresolved no-peace-no-war border stalemate remains a major impediment to the Government's developments efforts as a number of possible national socio-economic initiatives and resources remain tied to the border stalemate. However, more recently, there have been signs of good economic prospects as investments in the mining sector continue to grow. This resource constraint informs the need for choosing high impact and targeted interventions that would bring major results.

Eritrea's development aspiration is to achieve rapid, balanced, home-grown and sustainable economic growth with social equity and justice, anchored on the self-reliance principle. Moreover, the Government places emphasis on community and individual rights as well as issues of social justice, such as access to education, health, food and equitable access to services regardless of locality. At the time of preparing this report, Government was still finalising the overarching national development plan. In the absence of the plan, development processes are guided by the sector strategies and policies in cooperation to the Strategic Partnership Cooperation Framework signed with the UN system. Based on the sector-specific policy documents, national priorities focus especially towards; food security; education;



health; access to portable water at reasonable distance: roads and infrastructure development; environment and natural resources management; human and institutional capacity development and; information and communication technology. These all support concrete and measurable improvements in the MDGs, especially the health MDGs. The health sector activities, including the health MDGs are guided by the Nutritional Health Policy and the Health Sector Strategic Plan. These documents emphasize equity and health for all with minimal cost, using the Primary Health Care approach.

Due to its geographical location, the country is vulnerable to adverse effects of climate variability, recurring droughts and environmental degradation, hampering agricultural development efforts. The economy is thus largely based on subsistence agriculture. Persistent drought has had adverse effects particularly on the vulnerable communities, groups and households (especially the female-headed). The country's socio-economic conditions (livelihoods, food security, and national budget), environment (land degradation, desertification) also suffer drought effects. Furthermore, the border conflict has left large areas of land unused due to unexploded landmines especially the prime fertile agricultural regions of Gash-Barka and Debub which are considered to be the "bread baskets" of Eritrea. This has impact on the lifestyle of a significant proportion of the populations that adopt migratory lifestyles in search of water and pasture for their animals. This calls for innovative approaches to health service delivery to reach those groups of people.

Despite these challenges and setbacks, Eritrea has made tremendous progress towards its own development goals and aspirations. The Government has endeavoured to protect the most vulnerable segments of the population and to implement its long-term development policies. It maintains an extensive social safety net, investing in three priority areas: (i) food security and agricultural production; (ii) infrastructure development; (iii) human resources development.

The current economic outlook for Eritrea is improving<sup>7</sup>. Improvements are under way in the education and health sectors thanks to increased investments in those sectors, but significant challenges remain, especially with respect to creating an enabling business environment. Eritrea is currently not well-integrated into global value chains, but there is potential for an increased internationalisation of production and trade for mineral and agro food exports. Reflecting these factors, estimated real GDP growth for 2013 was 7% largely driven by copper production at the Bisha mine. Gold production is expected to start at the Zara mining project in 2015; and continued exploration activity and investment in the mining sector. In the medium term, Eritrea sees further prospects in oil production, fisheries and tourism. Exports are projected to grow in 2014, driven by the onset of copper and gold mines.

In this scenario and improving economic outlook, the progress registered and any areas of improvement on health related MDGs should be appreciated in the context

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<sup>7</sup> AfDB, OECD, UNDP: African Economic Outlook: Eritrea Report, 2014, p2.

of Eritrea's past development and political evolution and be measured for possible future sustainable improvements in cooperation with the Strategic Partnership Cooperation Framework<sup>8</sup> (SPCF). Lessons drawn from the last United Nations Development Assistance Framework (UNDAF) evaluation reveal that the UN and development partners have a vital role to play in accelerating the progress towards the MDGs while supporting the integration of critical enablers to effective programming: such as capacity development; data management; human rights and effective monitoring and evaluation of development initiatives.

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<sup>8</sup> Strategic Partnership Cooperation Framework is a development and partnership development agreement between the GoSE and the United Nations Country Team in Eritrea for the period 2013-16.

### 3. Status of Health Related Millennium Development Goals

The first and only MDG Report<sup>9</sup> produced for Eritrea 2006, among other things, assessed MDG4, 5, and 6 as on track. The same report also mentioned challenges faced by Eritrea that included: 1) attracting private investment and mobilizing required resources; 2) ensuring food security; and 3) achieving sustained, rapid economic growth. This report focuses on the same health MDGs and explores enablers, innovations and challenges encountered along the way to success. The storyline attempts to demonstrate what was done, how, and what lessons and challenges were encountered along the way.

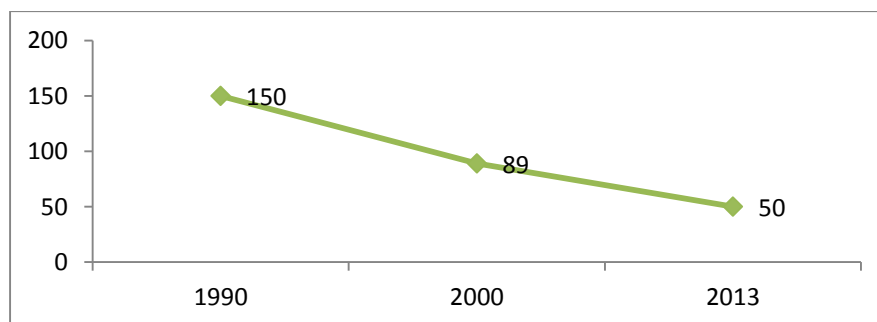
#### 3.1. Goal 4: Reduce Child Mortality

Millennium Development Goal 4 (MDG 4) calls for reducing the under-five mortality rate by two-thirds between 1990 and 2015. The under-five mortality rate is a key indicator of child well-being, including health and nutrition status. It is also a key indicator of the coverage of child survival interventions and, more broadly, of social and economic development.

The global annual rate of reduction has steadily accelerated since 1990–1995—more than tripling from 1.2 percent to 4.0 percent in 2005–2013. Despite these gains, child survival remains an urgent concern. At a global level progress has been insufficient, and the MDG 4 target risks being missed at the global level<sup>10</sup>. At the country level, historical trends show that progress for most countries has been too slow and that only 12 of the 60 countries with high under-five mortality rates (at least 40 deaths per 1,000 live births) are on track to achieve MDG 4 if current trends continue<sup>11</sup>.

In that context Eritrea has witnessed an unprecedented reduction in infant mortality rates per 1,000 live births from 92 in 1990 to 58 in 2000, and to 37 in 2012 (WHO, 2014). During the same period, under-five mortality rate per 1,000 live births was reduced from 150 in 1990 to 89 in 2000, and to 50 in 2013 (figure 1) (UNICEF, 2014). MDG 4 calls for reducing under-five mortality by two-thirds between 1990 and 2015. Hence Eritrea has achieved MDG-4 as of 2013.

**Figure1:** Progress in Reducing Under-5 Mortality Rate by Year 2015



<sup>9</sup> Government of Eritrea: Millennium Development Goals Report, 2006. *Asmara, Eritrea*

<sup>10</sup> UN Inter-agency Group for Child Mortality Estimation: Levels & Trends in Child Mortality Report (2014). P4.

<sup>11</sup> Ibid. p4

**Source:** UN IGME 2014 Report

The MDG-4 target for 2015 is 50.

**Eritrea has achieved MDG-4**

The statistics and review below demonstrates that Eritrea has achieved MDG4.

**GOAL 4: Reduce Child Mortality**

**Table 1: Status at a Glance**

<b>Goal 4: Reduce Child Mortality</b>	1993-95	2001-03	2010	2013	Target 2015
<b>Target 4A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate</b>					
<b>Indicator 1: Under five mortality rate</b>	136	93	63	49.5	50
Male			75		
Female			61		
<b>Indicator 2: Infant mortality rate (per 1,000)</b>	72	48	42	-	20
Male			50		
Female			37		
<b>Indicator 3: Proportion of one-year old children immunized against measles</b>	51	64.2	91.4	99	98
Male			91.6		
Female			91.3		

Source: Eritrea Population and Health Survey (EPHS) (2010); Eritrea EDHS (1995; 2002); Progress made in Health MDGs by Dr. Mismay Ghebrehwet, 2013

There are a number of strategies and lessons Eritrea has learned and applied over time to achieve this milestone. The GoSE recognises the involvement of communities in rural areas as an effective and affordable way of preventing disease and promoting primary health care. Communities have been trained and awareness has been raised, resulting in improved health-seeking behaviours and in health services being brought closer to the community. For example, community involvement in successful immunisation campaigns, which are entry points for maternal and child health interventions, has been critical in improving uptake of services and reducing dropout rates<sup>12</sup>. Other interventions include Community Integrated Management of Childhood Illness and Community-Based Therapeutic Feeding, as well as the National Malaria Control Programme and the HIV and AIDS Programme.

Most studies and reports confirm this best practice<sup>13</sup> in Eritrea. The GoSE puts much premium to the active involvement of the community in running their own affairs. Most developmental programmes at the Zoba level have direct inputs and control from the locality concerned. The governance structure itself emphasizes local empowerment through greater devolution to Zoba Administrations that have increasing latitude in mapping out and implementing development programmes at

<sup>12</sup> Ministry of Health (2004) ‘The State of Eritrea Ministry of Health Financial Sustainability. Plan for the EPI.’ Report to GAVI.

<sup>13</sup> Eritrea Second Cycle UPR Report p18.

the local level. The introduction of Community Courts is closely associated with the concept of delegating adjudication of certain civil disputes at the local level. The Zobas have also legislative bodies with jurisdiction on local issues.

To achieve and sustain this progress, the Ministry of Health (MOH) adopted a holistic approach to improving child health that depends less on the use of sophisticated and expensive technologies than on the implementation of strategies that have proven effective worldwide. The Ministry's overall policy with regard to child and adolescent health is that all Eritrean children—newborns, infants, young children, school children, children out of school and adolescents—have access to adequate health care at all levels, including health facilities, schools, and communities.

Soon after independence, the Ministry of Health began to introduce comprehensive packages of low-cost, high-impact interventions to improve child survival, including:

- a) Breastfeeding protection and promotion
- b) Complementary feeding
- c) Micronutrient supplements to combat iron and iodine deficiencies
- d) Vitamin A supplementation and supplementary and therapeutic feeding
- e) Immunization, including Hib vaccine and Hemophilic influenza type B and recently (August 2014) Rota Virus
- f) Insecticide-treated bed nets
- g) Prompt treatment for malaria
- h) Oral re-hydration therapy and zinc supplementation for diarrhea treatment
- i) Prevention and care of pediatric HIV/AIDS
- j) Antibiotic treatment for pneumonia, sepsis and dysentery
- k) Antenatal care and TT vaccination in pregnancy
- l) Safe delivery and emergency obstetric care
- m) Essential newborn care including postpartum visits
- n) Promotion of sanitation, hygiene and hand washing
- o) Building and use of maternity waiting homes

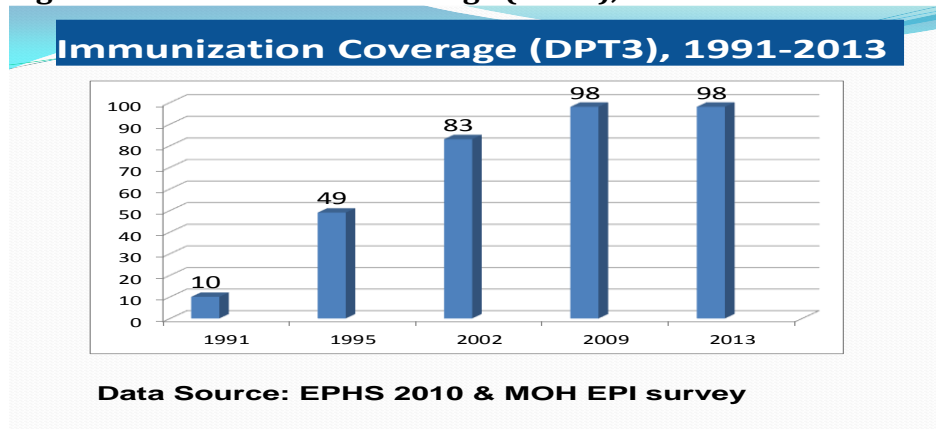
Scientific research and global child survival studies have shown that 63 per cent of child mortality could be avoided if such packages of proven preventive and curative interventions are fully implemented. Eritrea has made strides toward reducing child mortality through a mixture of strategic interventions, including routine immunization and care through the formal health care system, community-based care (C-IMCI), and nationwide immunization and supplementation campaigns that reach over 95 percent of children.

Chief among the successful interventions were the introduction of large-scale immunization of children, through Eritrea's Expanded Program of Immunization (EPI), and the introduction of Integrated Management of Childhood Illness (IMCI) programs. Together, the two initiatives combine to protect infants (through vaccinations) and children under five (through improved diagnosis, care and treatment) from the main sources of child morbidity and mortality.

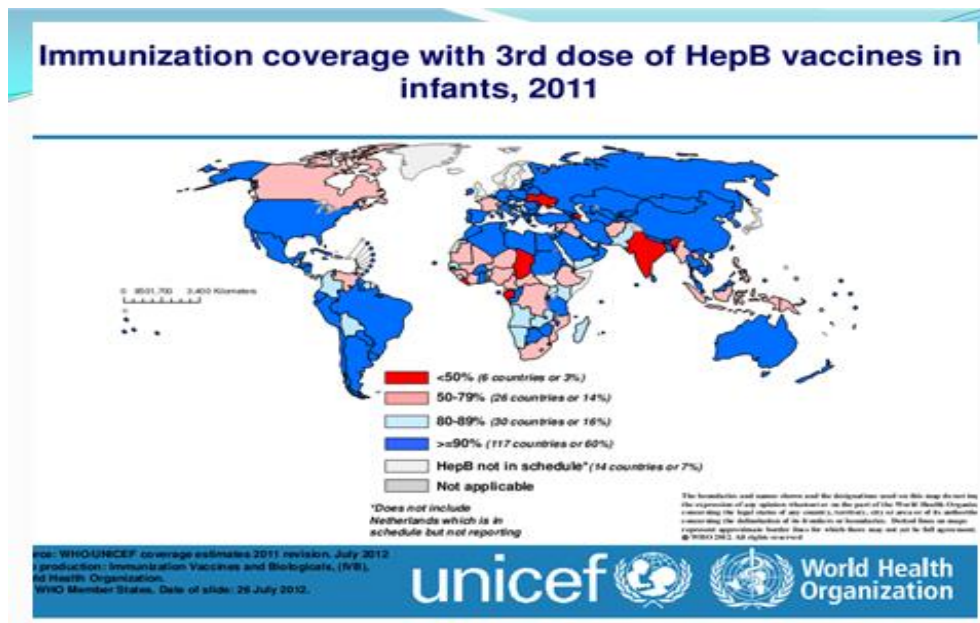
Eritrea's IMCI program was formally launched in 2000, and by 2010, all facilities had at least one health worker trained to manage childhood illnesses in accordance with IMCI guidelines. Although there are no current statistics, a recent evaluation of IMCI implementation confirmed improvements in the use of antibiotics, quality of care, and level of knowledge and skills of health staff, as well as a reduced case fatality rate. To complement the IMCI program, in 2005 Eritrea introduced Community-IMCI (C-IMCI).

As revealed in figures 2 and 3, coverage in immunization for the third dose of DPT (and since 1998 with the third dose of HepB) increased from 10 percent in 1991 to 98 percent in 2013.

**Figure 2: Immunization Coverage (DPT3), 1991-2013**



**Figure3: Immunization Coverage with 3<sup>rd</sup> Dose of HepB Vaccines in Infants, 2011**



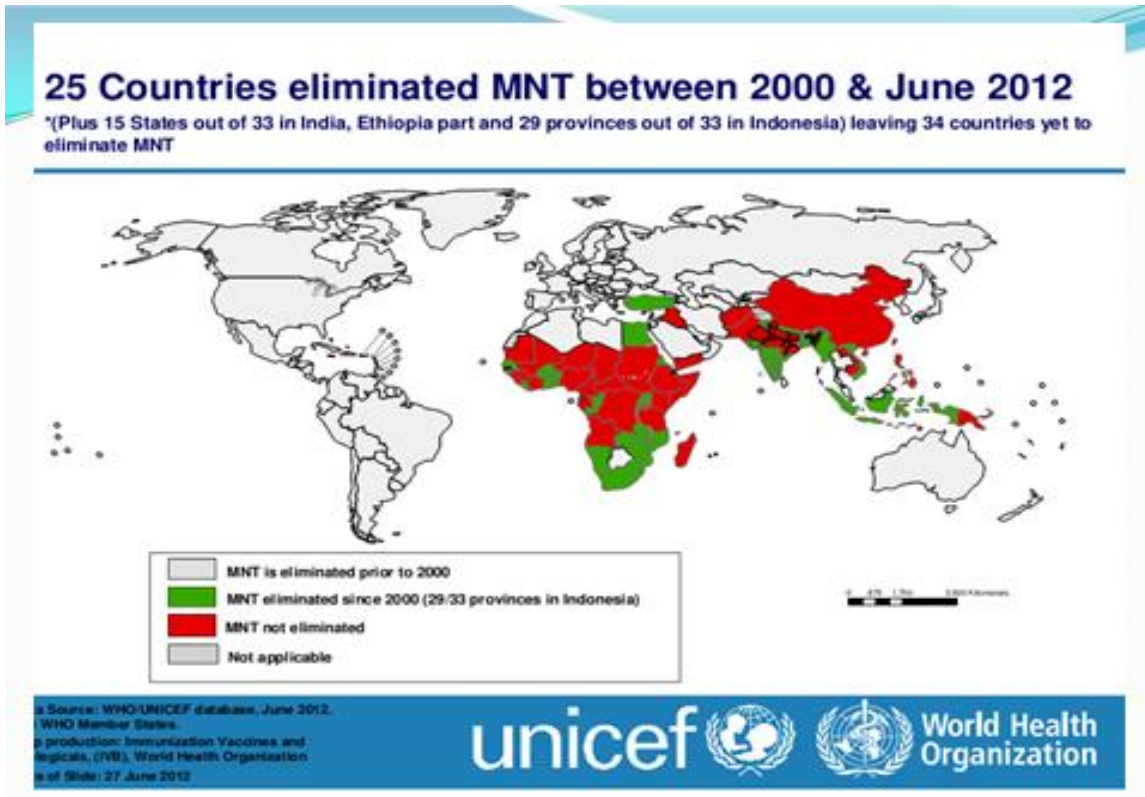
In addition to routine immunization, National Immunization Days (NIDs) were also undertaken for 10 years from 1996 to 2005, with high coverage. As the result of the NIDS complemented with strong routine immunization program, Eritrea was certified by WHO as 'polio free country' in 2008 and has maintained its polio free status, despite its proximity to countries where polio has not yet been contained.

Eritrea has virtually eliminated neonatal tetanus since 2004 and was certified by WHO in 2007. The successful outcome is the result of the incorporation of TT vaccine into routine and antenatal care, and an initiative providing tetanus inoculations to school age girls (Figure 4).

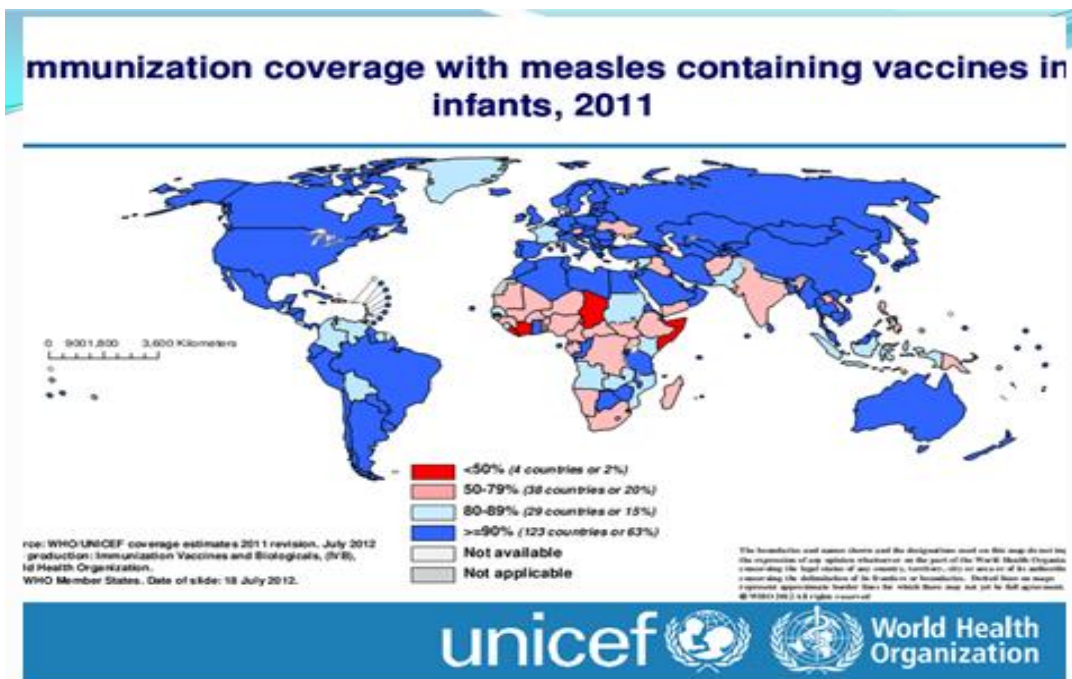
At the moment, measles no longer pose a major threat to children in Eritrea. Virtually all children receive a dose at 9 months, and most receive a booster dose at 18 months through routine health care. Others are reached during Supplementary Immunization Activity (SIA) (Figure 4).

Due to the above mentioned strengths in the immunization program, Eritrea was awarded by GAVI (Global Alliance for Vaccine Initiative) on October 17, 2009 in Hanoi, Vietnam for high and sustained immunization coverage.

**Figure 4: Twenty Five Countries Eliminated MNT between 2000 & June 2012**



**Figure 5: Immunization coverage with measles containing vaccine in infants, 2011**





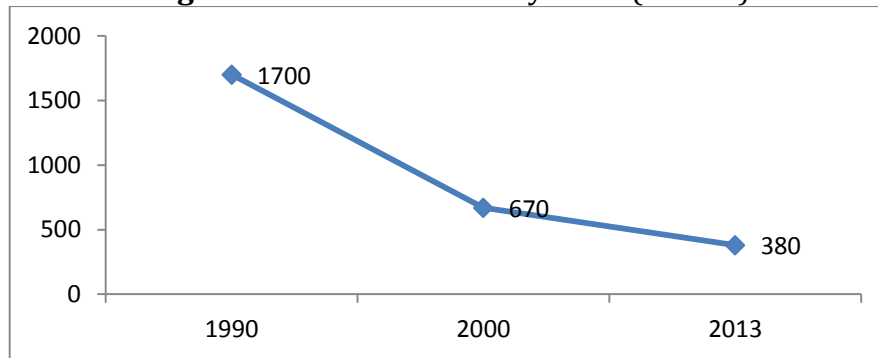
### 3.2. Goal 5: Improve Maternal Health

The target of MDG 5 (MDG 5A) is to reduce maternal mortality by three quarters (75 percent) between 1990 and 2015. As indicated in figure 6 below, the WHO Statistics Report 2014, reveals that the maternal mortality ratio declined from 1,700 per 100,000 live births in 1990 to 670 per 100,000 live births in 2000 and to 380 in 2013 (WHO, 2014).

The maternal mortality ratio, which is defined as the ratio of the number of maternal deaths to the number of pregnancies, is an indicator of the risk of dying that a woman faces for each pregnancy she undergoes. Although conceptually the denominator should include all pregnancies, operationally, because of the difficulty of counting miscarriages and induced abortions, the denominator used instead is live births. The innovations such as the maternity waiting homes, contributed to the achieving Goal 5. As indicated elsewhere in this report the challenges of skilled health personnel; specialists, transport, FGM/C, obstetric fistula still negatively the sustainable attainment of this goal.

The target of MDG 5 (MDG 5A) is to reduce maternal mortality by three quarters (75 percent) between 1990 and 2015. Accordingly, the 2015 target for Eritrea is 425 per 100,000 live births. This is a demonstration that Eritrea has already achieved the MDG-5, earlier than the due date of 2015 (see Figure 6). At their meeting in Luanda, Angola, 14-17 April 2014 (organized by African Union Commission and the World Health Organization of the African Region) African Ministers of Health acknowledged that Eritrea was one of the three African countries that have achieved the MDG-5.

**Figure 6: Maternal Mortality Ratio (MDG-5)**



Source: World Health Statistics, 2014

The MDG-5 target for 2015 is 425

**This demonstrated that Eritrea has achieved MDG-5**

Below is a table which demonstrates that Eritrea has achieved MDG5, showing status at a glance.

## GOAL 5: Improve Maternal Health

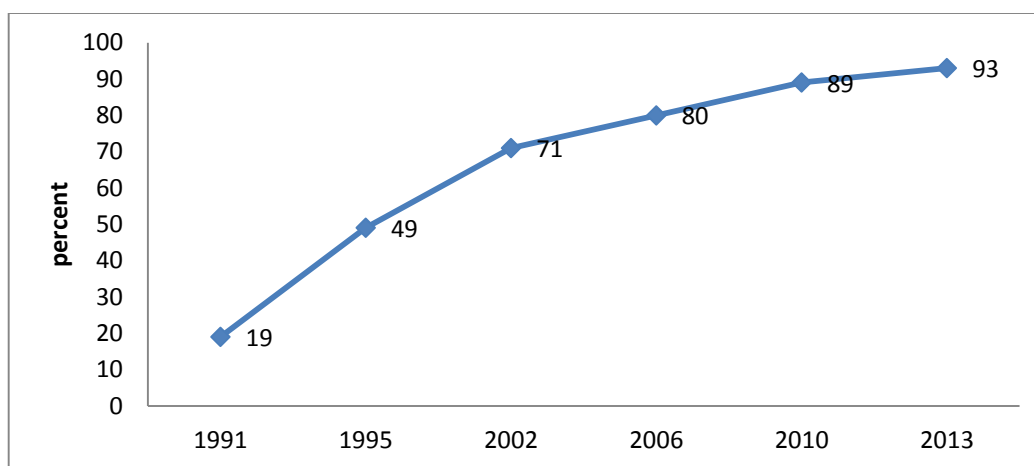
Table 2: Status at a Glance

Goal 5: Improve Maternal Health	1993-95	2001-03	2010	2013	Target 2015
<b>Target 5 A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio</b>					
<b>Indicator 1:</b> Maternal mortality ratio (per 100,000 live births)	985	581	486	209	220
<b>Indicator 2:</b> Proportion of births attended by skilled health personnel	20.6	28.3	34.1	55	69.6
Male			34.4		
Female			33.8		
<b>Target 5 B: Achieve, by 2015, universal access to reproductive health</b>					
<b>Indicator 1:</b> Contraceptive prevalence rate (currently married or all women)	8	8/5.8	10.6	-	100
Male			16.3		
Female			8.4		
<b>Indicator 2:</b> Adolescent birth rate	23	14	-	-	0
<b>Indicator 3:</b> Antenatal care coverage (at least 1 and 4 visits)	48	70.4	89	93	100
<b>Indicator 4:</b> Unmet need for family planning	27	27	17	-	0

Source: Eritrea Population and Health Survey (EPHS) (2010); Eritrea DHS (1995; 2002); Progress made in Health MDGs by Dr. Mismay Ghebrehwet, 2013

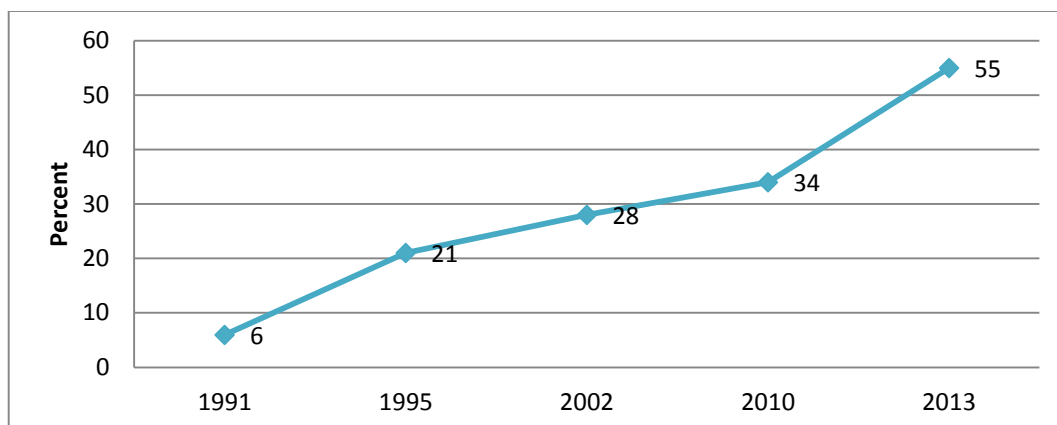
Figure 7 indicates that the antenatal coverage for at least one visit during pregnancy increased from 19 percent in 1991 to 93 percent in 2013. Also as illustrated in figure 8, for the same period, delivery by skilled birth attendant increased from 6 percent in 1991 to 55 percent in 2013.

**Figure 7: Antenatal Care Attendance, 1991 - 2013**



Source: EPHS 2010, and LQAS Study (MOH (a), 2013

**Figure 8: Percent of deliveries attended by health workers, 1991 - 2013**



**Source: EPHS 2010, and LQAS Study (MOH (a), 2013**

To improve coverage of post-natal care the Ministry of Health undertakes a “6-6-6” program, meaning 6 hours, 6 days and 6 weeks. All mothers who deliver in a health facility get examined 6 hours after delivery, while still in the health facility. Those delivered at home and those who delivered in a health facility get visited by a health worker in their home, six days after delivery. All of them also get invited to come to a health facility six weeks after delivery. Accordingly, the percentage of mothers who get at least on post natal care is 96 (MOH (a), 2013).

Access to emergency obstetric care services increased from 21 percent in 1995 to 88 percent by 2013 (increase of 319%). Additionally, one of the strategies that have contributed to the decline in the MMR in Eritrea is the use of Maternal Waiting Homes in nearby delivery facilities where pregnant mothers from remote areas receive services before their expected date of delivery.

### 3.3. Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

#### GOAL 6: Combat HIV/AIDS, Malaria and Other Diseases

Table 3: Status at a Glance

<b>Goal 6: Combat HIV/AIDS, malaria and other diseases</b>					
<b>Target 6 A: Have halted by 2015 and begun to reverse the spread of the HIV/AIDS</b>					
	1993-95	2001-03	2010	2013	Target 2015
<b>Indicator 1:</b> HIV prevalence among population aged 15-24 years	-	2.4	0.93	-	0
<b>Indicator 2:</b> Condom use at last high-risk sex (%) (Male)	-	2	91.9	-	100
<b>Indicator 3:</b> Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (%)	-	96	27.9	-	100
Male			33.8		
Female			24.7		
<b>Indicator 4:</b> Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years	-	-	95.3	-	100
Male			104.1		
Female			89.5		
<b>Target 6B: Achieve by 2010 universal access to treatment for HIV/AIDS for all those who need it</b>					
<b>Indicator 1:</b> Proportion of population with advanced HIV/AIDS infection with access to antiretroviral drugs	-	-	-	-	100
<b>Target 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major disease</b>					
<b>Indicator 1:</b> Incidence and death rates associated with malaria (per 1,000)	-	36	12	-	0
<b>Indicator 2:</b> Proportion of children under 5 sleeping under insecticide-treated bed-nets	-	4	27.9	-	100
Male			28.4		
Female			27.4		
<b>Indicator 3:</b> Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs		4	1.5	-	100
Male			1.8		
Female			1.2		
<b>Indicator 4:</b> Incidence, prevalence and death rates associated with tuberculosis		70	97	<u>2011</u> 97	0
Male		-	-	151	0
Female		-	-	4.7	0
<b>Indicator 5:</b> Proportion of tuberculosis cases detected and cured under directly observed treatment short course		85	-	-	100

Source: Eritrea Population and Health Survey (EPHS) (2010); Eritrea DHS (1995; 2002); HDR, 2011

The cumulative outlook on the HIV and AIDS situation in Eritrea is that steady progress has been made in expanding both the preventive and treatment services in the national response. The NATCoD report of 2010 shows that as a result of the concerted efforts made in the national program, the prevalence of HIV and syphilis in the 2009 round of ANC sentinel surveillance was found to be 1.31% and 0.58%, respectively, which is remarkably lower than the previous rounds of ANC surveys. The HIV prevalence result from the 2010 Eritrean Population & Health Survey (EPHS) is 0.93%. Furthermore, data derived from VCT and PMTCT clients, and blood donors continually show a reduction in HIV and syphilis positivity rates.

Knowledge about HIV/AIDS is still maintained at a high level and condom distribution is also increasing. PLWHAs put on ART every year are averages 1,000. Although all these are encouraging, there is more work to be done to control the epidemic further. For example, in the past two years, the number of VCT clients volunteering to test for HIV has been steadily declining, despite the expansion of services for the same. The good news is that PLWHAs put on ART every year is averaging 1,000 and condom distribution is steady both in the public sector (MOH) and through condom social marketing (ESMG).

The NATCoD/UNAIDS report on universal access shows that close to 80% of the estimated HIV infected men, women and children who are eligible for treatment are receiving free treatment currently available in well-established hospitals and military medical units. Less than 30% of HIV positive pregnant women get access to PMTCT and the establishment of TB programmes and activities within the HIV program and the co-management of TB and HIV infection has great potential to improve the response to HIV and AIDS.

Data currently available indicates that performance was above established Universal Access targets in the following seven service areas:

1. Percentage of women, men, and children with advanced HIV infection who receive anti-retroviral treatment is 79.8% above the target percent of 76% despite the percentage of health facilities delivering anti-retroviral treatment being below the target percent.
2. The percentage of HIV positive people and dependents receiving care and support is 21% above the target percent of 20%.
3. The percentage of HIV negative children born to HIV positive women is 95% above the target percent of 87%.
4. The percentage of health facilities providing HIV counseling and testing is 58.4% above the target percent of 45%.
5. The number of female condoms distributed annually by public and private sectors is 35,230 above the target of 4,800.
6. The percentage of government and non-government institutions implementing the 3 Ones Principle is 100%.
7. The percentage of schools with teachers who took part in Life Skills based HIV education including Life Skills Education integrated in school curriculum for grades 4 – 12 is 100%.

However of concern is that data currently available indicates that performance is below established targets in the following five service areas:

1. The percentage of health facilities delivering basic anti-retroviral treatment services,
2. The percentage of antenatal clinic sites delivering anti-retroviral prophylaxis to HIV positive pregnant women to prevent the transmission of HIV to their children,
3. The percentage of HIV positive pregnant women receiving a complete course of anti-retroviral prophylaxis,

4. The number of male condoms distributed annually by the public and private sectors,
5. The percentage of TB clinics and hospitals that institutionalized provider initiated HIV testing is below the target percent,

The same report also noted paucity of data in seven (7) key response areas including: (1) percentage of orphans and vulnerable children receiving basic external support; (2) percentage of the population receiving an HIV test in the past 12 months and receiving their results; (3) percentage of the population aged 15 to 24 years who have had sex before age 15; (4) percentage of youth who correctly identify ways of preventing the sexual transmission of HIV; (5) percentage of people with advanced HIV infection still alive 12 months after being on anti-retroviral treatment; (6) number of communities that established behaviour change and communication peer discussions; (7) the number of national and community campaigns to reduce stigma and discrimination; and (8) the percentage of women care givers and victims of sexual violence who were provided with income generating activities. Strengthening data management should be part and parcel of sustaining and improving how the MDGs will be implemented moving forward. Resources are needed in this area to ensure that Eritrea does not lose the gains already achieved.

Controlling the three diseases HIV/AIDS, TB and malaria is crucial to achieving many of the MDGs, not just those pertaining to the three diseases. A successful fight against HIV/AIDS, TB and malaria will also have far-reaching impact on reducing poverty and child mortality and improving maternal health. Therefore more resources are still needed to sustain gains achieved on these three diseases.

In Eritrea the prevention response to HIV-AIDS has focused on the following very critical and required preventive and treatment approaches:

- Various behavior change communication activities (BCC) that address HIV/AIDS and STIs within the broad context of human sexuality and with special focus on high risk groups.
- Counseling and testing (C&T)
- Prevention of mother-to-child transmission (PMTCT)
- Male condom social marketing and free distribution of male and female condoms in the public sector.
- Early diagnosis and treatment of STI
- Safe blood transfusion and infection prevention

The 2010 EPHS estimated that the HIV prevalence for the general population in Eritrea is below 1.0 percent (0.93 percent). Women are more than two times as likely to be infected with HIV as men (1.13 percent and 0.5 percent, respectively). The female-to-male infection ratio of 2.26 is consistent with female-to-male ratio observed in other countries in sub Saharan Africa, for example Senegal (2.3), Guinea (2.1), and Kenya (1.9). As revealed in figure 9, HIV prevalence levels for both men and women rise with age, peaking among both women and men in their late 30s. The

age patterns suggest that young women are particularly vulnerable to HIV infection compared with young men. Among women age 15-19, for example, 0.15 percent are HIV infected, compared with nil for men age 15-19.

**Table 4: HIV Prevalence by Age & Sex, EPHS+ 2010**

<b>Age</b>	<b>Women</b>	<b>Men</b>	<b>Total</b>
15-19	0.15	0.00	0.09
20-24	0.23	0.00	0.16
25-29	1.49	0.26	1.21
30-34	1.72	0.82	1.5
35-39	2.89	1.61	2.55
40-44	1.32	1.52	1.38
45-49	0.91	0.89	0.9
<b>Total</b>	<b>1.15</b>	<b>0.5</b>	<b>0.93</b>

Source: EPHS 2010

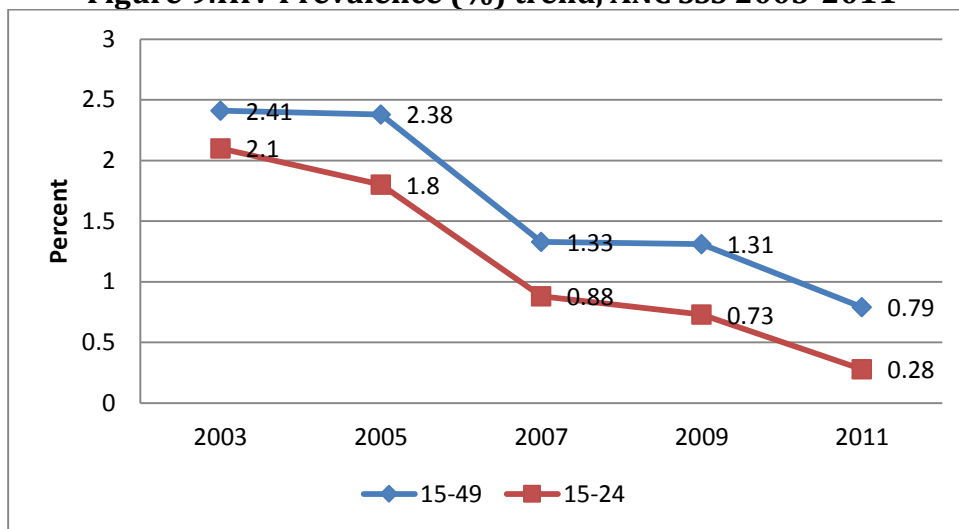
Urban residents have a substantially higher risk of HIV infection (1.44) than rural residents (0.5). There is also regional variation in HIV-infection, with highest in Zoba (Region) Maekel (1.64), followed by Zobas Debubawi KeihBahri (0.98), Gash Barka (0.84), Debub (0.67), Semenawi KeihBahri (0.66), and Anseba (0.59).

The World Health Statistics (WHO, 2014), indicates that the incidence of HIV AIDS in Eritrea has decreased from 45 per 100,000 population in 2001 to less than 8 in 2012. During the same period, the prevalence of HIV/AIDS decreased from 738 per 100,000 populations in 2001 to 290 in 2012.

International experience has shown that the prevalence of HIV among Antenatal Care (ANC) attendees closely reflects the HIV prevalence in the general adult population. As a result, ANC HIV Sentinel Surveillance forms the basis for mapping and tracking the HIV epidemic worldwide. Because blood is usually drawn as part of ANC service delivery (e.g., for Hemoglobin testing), it is fairly easy to arrange the logistics of collecting blood samples for HIV/STI testing in Eritrean health facilities.

Based on the Sentinel Sites Surveillance reports, Figure 9 reveals a steady decline in the prevalence of HIV infection among young pregnant women in the age group 15-24. Prevalence in this age group could be roughly considered as a proxy to prevalence. This is one of the indications of decreasing incidence of HIV in Eritrea.

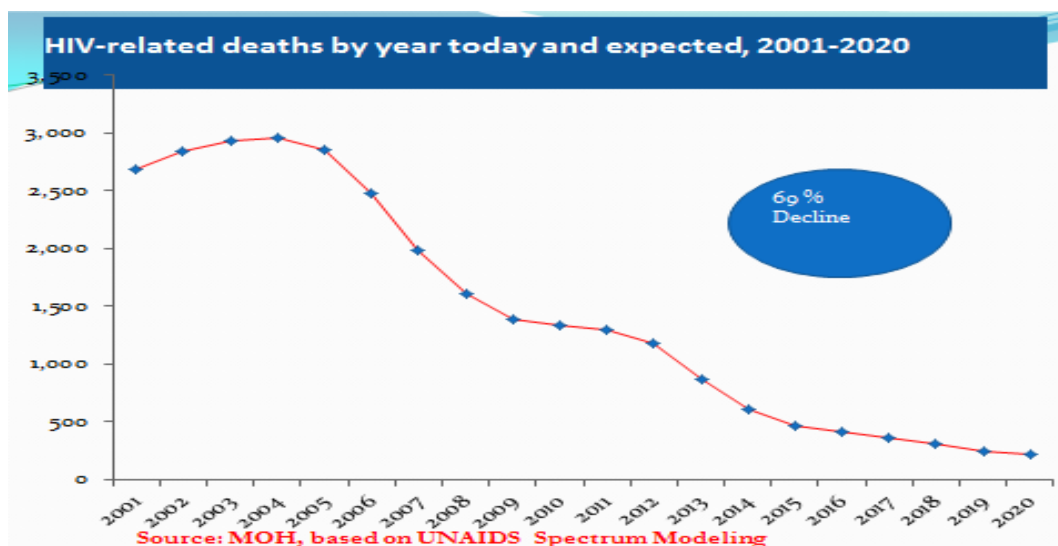
**Figure 9: HIV Prevalence (%) trend, ANC SSS 2003-2011**



Source: ANC SS Survey, Eritrea

With decreasing trends in the incidence and with the increased use of antiretroviral therapy, HIV related deaths have been decreasing and are expected to continue declining (Figure 10).

**Figure 10: HIV-Related Deaths by Year Today & Expected, 2001 - 2020**



Examination of data on trends in the annual number of AIDS cases and AIDS deaths, as well as trends in available data on HIV prevalence among pregnant women, blood donors, and VCT clients suggest a reversal and stabilization of HIV infection rates in the general population.



### 3.3.1. Malaria Control

Malaria is endemic in Eritrea. The country faced serious malaria epidemics following an unusually heavy rainfall in 1998 and the El Nino of 1997. It has been estimated that approximately 7 to 12 days are lost on average per episode of malaria, thus having an enormous impact on the productive labor force. In addition, available data indicate that the average cost for treating an episode of uncomplicated malaria is about 30 Nakfa (2.00 USD equivalent) and about 70 Nakfa (5.00 USD equivalent) for severe cases at health facilities (RBM Core Indicators Survey, 2001).

The Malaria program-performance Review (MPR) (2013)<sup>14</sup> concluded that Eritrea is winning the war against malaria. The following are the evidence in support of this conclusion: low 2012 malaria incidence of 4.78 per1000 people at risk (ranging from 0.5 in Northern red Sea Zone to 12.6 in Gash Barka Zone) associated with 91% reduction in malaria incidence from 53.5 cases/1000 population at risk in 1998 to 4.78 cases/1000 population in 2012, and 96% reduction in malaria specific deaths from 0.198 deaths/1000 population in 1998 to 0.0076 deaths/1000 population in 2012; ongoing elimination of plasmodium falciparum - % Pf declining in all Zones between 2004 and 2012: e.g., from 96% to 47% in NRS Zone; low parasite prevalence nationwide; possible stratification of the country into two malaria-risk areas - low risk and moderate risk areas; and “break in malaria transmission” – a situation in which some parts of a sub-zone (district) is malaria-free while other parts have ongoing localized transmission at low or moderate levels, is occurring in many parts of Eritrea; in some other cases, sub-zobas that previously reported thousands of cases are reporting very few or nil cases (for instance Ghindae sub-zone of Northern Red Sea Zone reported 19,853 cases in 1998 but 228 cases in 2012, a 99% reduction in malaria burden; while Dahlak subzone reported 104 cases in 1998, it has not seen a single case of malaria since 2008, a 100% elimination of malaria.

The MPR also noted that there were key worrying issues the GoSE should take note of: rising incidence of malaria in the last 3 years; increase of malaria deaths from 2011 to 2012 and sporadic outbreaks in many sub zones of the country. The Test Positivity Rate (TPR) is higher than the cut-off point (5%) required for transition from control to pre-elimination. In spite of the challenges, the MPR concluded that with the Eritrean spirit of resilience and commitment, it was possible for Eritrea to move towards a malaria-free future. The lessons and key messages to take from this situation are:

- Building capacity for analysis and interpretation of malaria data at health facility,

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<sup>14</sup> The current Eritrea malaria control strategic plan was for the period, 2010-2014. It was conceived as a malaria-pre-elimination plan. Since it is nearing the end of its lifespan, the MPR was handy as an end of term evaluation. The other reasons Eritrea launched the MPR were the fact that between 2008 and 2012, the malaria disease burden and death rate had remained stagnant and the bottlenecks were not well understood; and the Ministry of Health and its partners believed that Eritrea was ripe to proceed from control to pre-elimination in the malaria control-elimination continuum, hence the need for an MPR.

- sub-zonal, zonal and at national levels to guarantee evidence based actions.
- Stratification and re-stratification of the country into moderate-risk and low-risk areas.
  - Adapting and strengthening the surveillance system to appropriate epidemiological context.

Considering the health, social and economic importance of malaria as a public health problem, the MOH launched a Roll Back Malaria Strategy that took place in the city of Mendefera in July 1999. During that period of time, malaria ranked first as a cause of morbidity and mortality in the country. Since 1999, the Government launched implementation of its strategic plan with the objective of reducing malaria morbidity and mortality by 80 percent within five years. The MOH, in collaboration with other Government agencies, communities and other national and international partners worked intensively to reduce the incidence, prevalence and death due to malaria. The program included community involvement in environmental management and other activities, bed net distribution, training health professionals in malaria prevention, control and malaria case management, and ensuring availability of drugs and supplies for treatment. Prevention, early diagnosis and prompt treatment of malaria are the chief goals of Eritrea's National Malaria Control Program (NMCP). These are strategies that have produced positive results.

By 2006, malaria morbidity had decreased by 74%, mortality by 85% and case fatality by 78%. The number of cases per 100,000 plunged by 92% between 1998 and 2006<sup>15</sup>. Meanwhile, HIV prevalence remained low, and even reduced among pregnant women attending ANC, from 2.42% in 2003 to 1.33% in 2007<sup>16</sup>.

By 2008 malaria accounted for just 1 percent of all deaths of children under five, representing a major success story within Sub-Saharan Africa, if not globally.

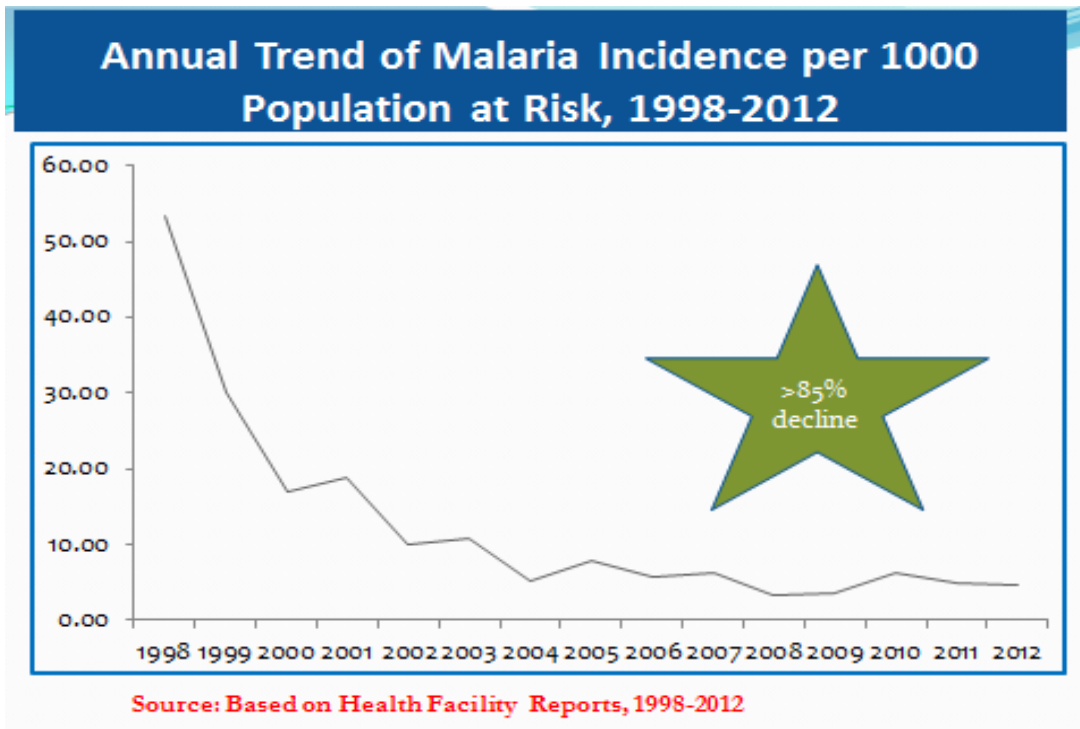
As revealed in figures 11 and 12, Eritrea achieved the objectives it set in 1999, by reducing malaria morbidity by more than 85 percent and mortality due to malaria by 90 percent.

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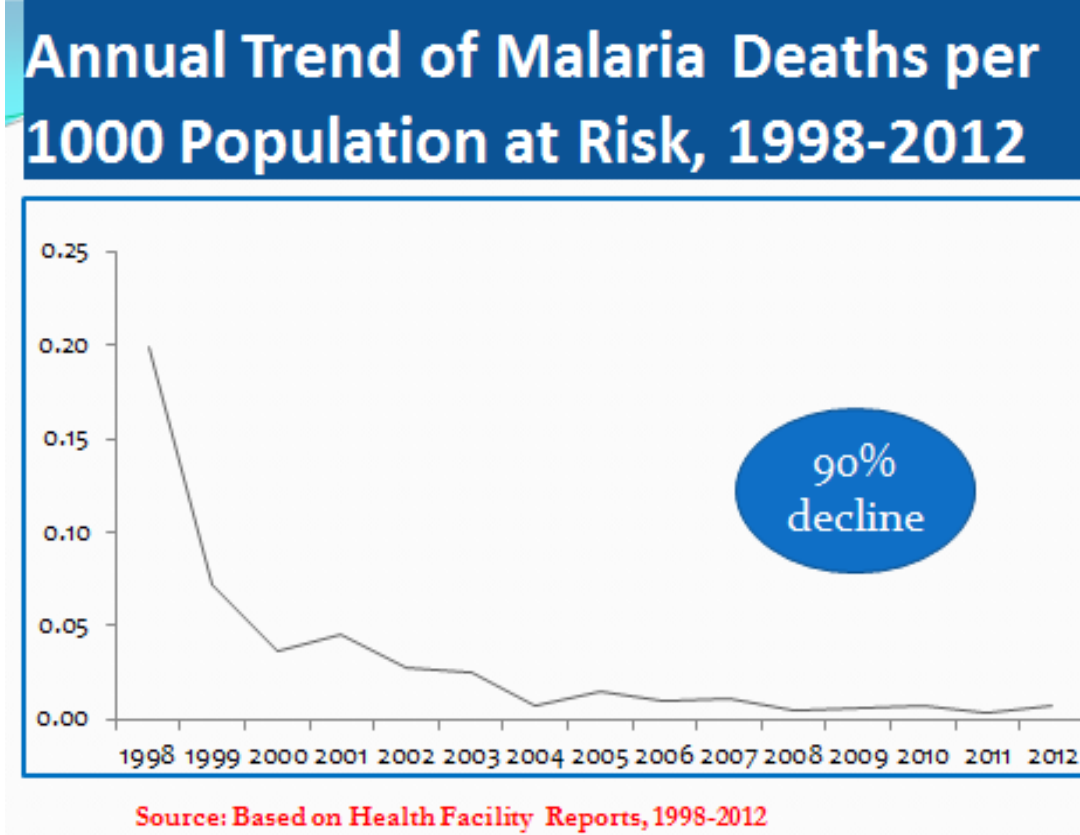
<sup>15</sup> <http://go.worldbank.org/0F0ZMFB6U0>.

<sup>16</sup> WHO (2009) 'Country Cooperation Strategy 2009-2013.' Brazzaville: WHO Regional Office

**Figure 11:** Annual Trend of Malaria Incidence per 1000 Population at Risk, 1998 – 2012

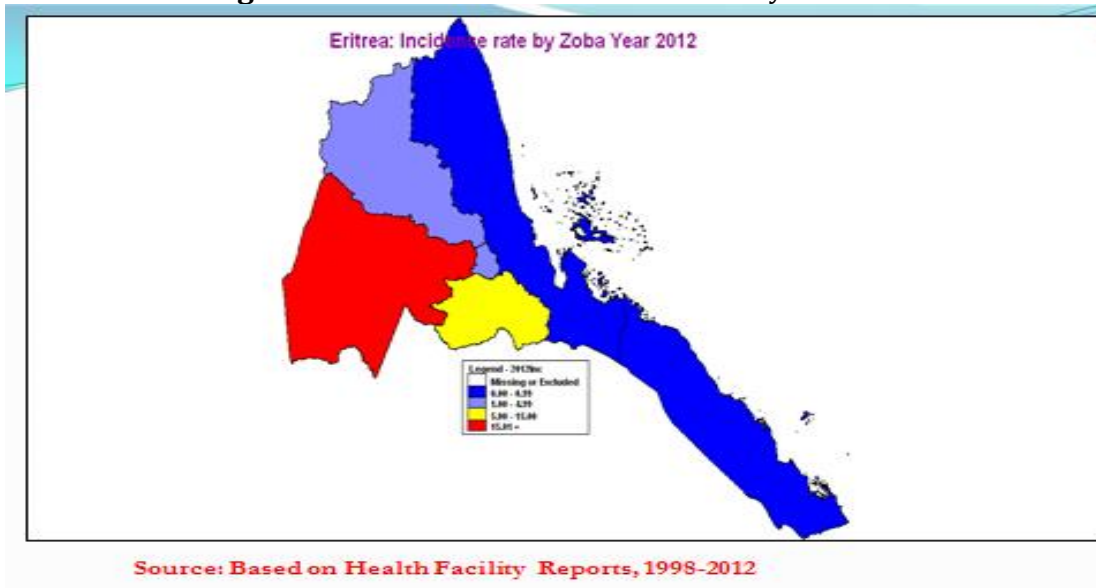


**Figure 12:** Annual Trend of Malaria Deaths per 1000 Population at Risk, 1998 - 2012



The World Health Statistics (WHO, 2014), indicates that the incidence of malaria in 2012 was 1,282 per 100,000 population. As shown in Figure 13, two of Eritrea’s six regions (Gash Barka and Debub) are malaria-endemic with incidence of more than 5 and 15, respectively per 1,000, while two other regions (Southern and Northern Red Sea) have very low incidence, below 1. The remaining two Regions (Maekel and Anseba) have below 5 incidence rates. Consequently, the four Regions with low incidence are now moving from a malaria control mode to elimination of malaria.

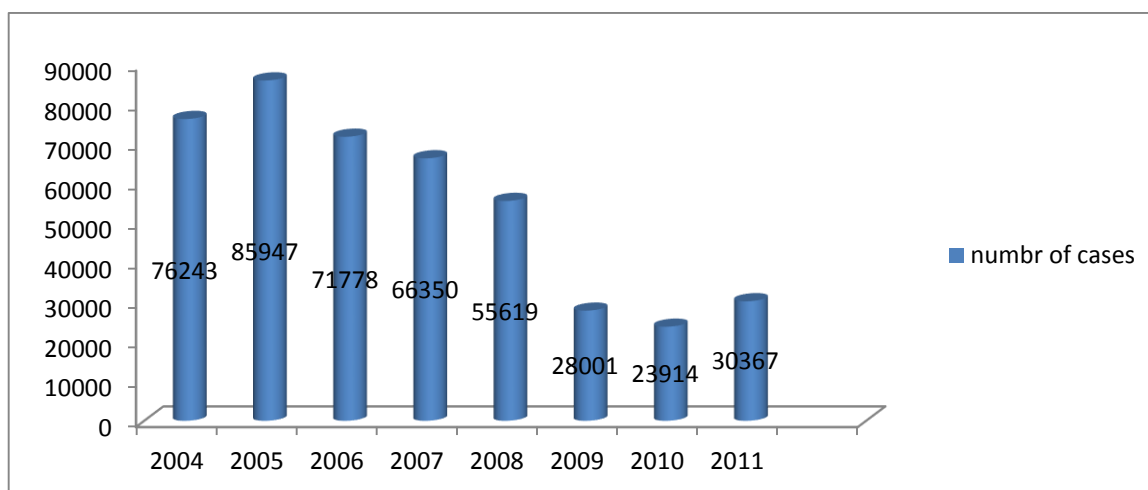
**Figure 13: Eritrea Malaria Incidence Rate by Zoba in 2012**



### 3.3.2. Community-Based Management of Malaria

Since inception in 1999, a total of 4,067 Community Health Agents (CHAs) have been trained; the CHAs are trained to focus on the following: diagnosis and appropriate treatment of fever cases within the community; coordination of environmental activities; and provision of health education on bed net use, environmental management, and early treatment to the community. In 1998, it was estimated that the CHAs treated 51.7% of all cases of malaria in Eritrea (See figure 14 for the annual trends). The 2012 MIS showed that 24.2% of respondents had seen/heard messages related to malaria from CHAs. The training and deployment of Community Health Agents has proven to be an innovative and effective strategy to control malaria both in the short and long term.

**Figure 14: Numbers of CHA-treated malaria cases, 2004-2011**



Source: Eritrea MPR Final Report: May, 2013

There is an ongoing retraining of CHAs on home management of malaria, environmental control, use of insecticide treated bed nets, and early health seeking. About 1,800-2000 of the CHAs have been covered so far.

### 3.3.3. Tuberculosis Control

As revealed in Table 5, the incidence of tuberculosis has decreased from 243 per 100,000 in 1990 to 97 in 2011, a 60 percent reduction. During the same period, prevalence of tuberculosis has decreased from 478 to 151 per 100,000, a 68 percent reduction. Mortality due to tuberculosis has decreased from 12 per 100,000 in 1990 to 4.7 in 2011, a 61 percent reduction.

The World Health Statistics (WHO, 2014), indicates that the prevalence of tuberculosis in Eritrea has decreased from 192 per 100,000 in 2000 to 152 in 2012.

**Table 5. Progress in Combating Tuberculosis, 1990 – 2011**

Indicators	Estimates per 100,000 population		Percent reduction 1990-2011
	1990	2011	
Incidence	243	97	60
Prevalence	478	151	68
Mortality due to TB	12	4.7	61
<b>Incidence of TB is less than the global average of 125/100,000 population &amp; Africa average of 243/100,000.</b>			

Source: Health Bulletin, MOH (b)

### 3.3.4. Trends in Life expectancy

Trends in life expectancy are usually taken as a summary indicator of many other health indicators. As revealed in Table6, life expectancy at birth increased significantly from 48 years in 1990 to 63 years at the present moment. While many other developing countries were showing a decline in life expectancy due to the rising toll in deaths related to HIV/AIDS, life expectancy at birth in Eritrea was continually showing a positive growth. This is partly due to the reduction in infant and child mortality as well as the reduction in adult mortality due to malaria and other communicable diseases.

<b>Table 6: Eritrea, Life Expectancy</b>						
<b>Life expectancy (years)</b>	<b>Both sexes</b>		<b>Male</b>		<b>Female</b>	
	<b>1990</b>	<b>2012</b>	<b>1990</b>	<b>2012</b>	<b>1990</b>	<b>2012</b>
Life expectancy at birth	48	63	46	61	50	66
Life expectancy at age 60	12	15	11	13	13	17

*Source: World Health statistics Report, 2014*

#### **4. Innovations Driving the Health MDGs in Eritrea**

In telling the Eritrean story about the health MDGs, this report attempts to achieve two objectives. The first is to celebrate *what* the Eritrean people have done to achieve MDG 4, 5, and 6. Chapters two and three of this report have done that. In this section of the report the objective is to narrate and share *how* Eritrean achieved the health MDGs. While some of the innovations and best practices have received cursory mention elsewhere in this report, they deserve an extended and special mention here to provide the reader with a deeper appreciation and a storyline of how achievements were made.

##### **4.1. Cross-Cutting Innovative Strategies Employed to Drive Health MDGs**

The GoSE accords health a prominent place in its priorities and it is committed to achieving and sustaining the gains of health goals. In particular, the Government fully appreciates and continuously emphasizes the decisive role of all Eritreans in the development and self-reliance programmes from sub-zoba to central governmental levels. The Government is, therefore, determined to create the requisite social, economic and political conditions conducive to their realization.

Good health is essential to human welfare and to sustained development. Health services being promoted by the GoSE includes a mix of health promotion, prevention, treatment, and rehabilitation. However it is very evident that some ways of promoting, protecting and sustaining health targets lie outside the confines of the health sector. Education, housing, food and employment all impact on health. All the other 5 MDGs impact the health MDGs. A fuller and more comprehensive MDG status Report can reveal those relationships that help to foster integrated planning of the national development agenda.

The early innovative best practices used to achieve health MDGs for all Eritreans, started with the Eritrean People's Liberation Front (EPLF) prior to independence. These were consolidated by the Government of Eritrea since independence. Chief among them was the adoption of the Primary Health Care (PHC) approach as the principal strategy towards the attainment of the health MDGs.

An early innovation which became enculturated in the Eritrean development process has been intersectoral collaboration and close coordination between the health and education sectors during the war, which was formalised after independence in the inter-sectoral School, Health and Nutrition Project which, from kindergarten to secondary school, addresses the specific needs of children and youth<sup>17</sup>. The government realised that the only institutions throughout the country that could reach even the most hard-to-reach areas were schools and teachers. Using these as a mechanism to implement health interventions, the government trained teachers as allies to health workers. Tasks include regular monitoring and screening of students

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<sup>17</sup> World Bank (2008) 'One Childhood.' Documentary Film on School Health and Early Child Development in Eritrea. Asmara: World Bank.

for basic health problems, as well as lecturing on health education (nutrition, hygiene, HIV and AIDS prevention and life skills).

This inter-sectoral collaborative approach was then extended to all other sectors using line ministries through local level planning and local decentralized administrative jurisdictions. This approach has proved very effective in all development programming and is a guiding management philosophy in Eritrea.

#### **4.2. Efforts Towards Universal Health Coverage**

In the Eritrean health care planning and delivery process, equity is the call for universal coverage of the population, with care provided according to need. In principle no one should be left out, no matter how poor or how remote. If all cannot be served, those most in need should have priority. Here lies the “all” in the *health for all* mantra. Here also is the basis for planning service for defined populations, and for determining differential needs in all administrative locations of the country.

The GoSE recognizes that this principle of universal coverage may come into conflict with efforts to promote cost effectiveness, because those most in need may be more costly to reach. Although, promoting efficiency is an important strategy, under such circumstances for Eritrea, equity overrides concerns over cost effectiveness because it is the basis of social justice and is the cornerstone of the Eritrean Constitution, National Charter and Macro Policy of Eritrea. Although it is usually more efficient to locate services in populated areas, reaching the unreached in remote or sparsely populated areas require locating services closer to them. Here the burden of cost is to some extent ameliorated by a multisectoral approach described above.

Simply choosing from a menu of options, or importing what has worked in other settings was not sufficient for Eritrea. Health equity strategy in Eritrea is home-grown, pushing towards universal coverage out of experiences of the armed struggle before independence and over the past two decades after independence. For example, the development of health care infrastructure like health stations, health centers and hospitals in Eritrea was largely based on need as determined by population density and availability of health facilities and other factors including feasibility. Basically it has been a strategy that puts people first. Need and equity override all other considerations in this strategy. In the final analysis this strategy has proved to be cost effective, long-term and yielding compounded and measurable results to deliver the health MDG targets for Eritrea.

#### **4.3. Integrated Health Services Provision in Eritrea**

The core question is: *what makes the Eritrean experience innovative, creative and unique* to deliver health MDGs and achieve the health targets across the country?

The Overseas Development Institute study (2010) of Eritrea’s health MDGs concluded that the success of the Eritrean experience was especially based in the cost-effective inter-sectoral interventions and a long-term perspective the government has taken



to tackle health issues in the country<sup>18</sup>. The report cites three key messages from the Eritrean experience which are noteworthy:

- (i) Despite profound poverty, Eritrea is expected to achieve the Millennium Development Goals (MDGs) in health in general and in child health in particular. Areas of achievement include: child mortality rates; immunisation coverage; malaria mortality morbidity; and HIV prevalence.
- (ii) Eritreans' commitment, both at home and abroad, to the development of health and education is led by the government, which at the same time retains tight control of programmes and policies.
- (iii) Out of necessity, Eritreans' experience in adapting to adverse circumstances has given them the capacity to develop innovative multi-sectoral approaches to health.

The Ministry of Health contends that in addition to these key messages, community involvement has enabled improved health-seeking behaviours as well as widespread buy-in across the country.

At independence in 1991, the health status of the Eritrean people was very low as reflected in the findings of the Eritrean Demographic and Health Survey (EDHS) of 1995 when Eritrea was characterized with low life expectancy, high maternal mortality ratio, and high under-five mortality rate (NSO, 1996). To address the challenges of poor health status among the population, the GoSE initiated the process of building a national healthcare system by adopting a policy based on the principles of primary health care, self-reliance and home-grown multisectoral collaboration and planning. Furthermore, it quickly developed appropriate strategies<sup>19</sup> of which rehabilitation of the devastated health infrastructure, and development of human resources were the main ones. The effort was quite successful in building a National Health Service system with fairly equitable access. This effort to rehabilitate the National Health Service system is far from over and should be supported by substantial technical and financial resources from development partners as articulated in the current SPSF.

The GoSE is committed to continue improving the country's situation on health, nutrition, and HIV and AIDS with the main objectives to promote high quality curative and preventive health and nutrition services among Eritrean people. However these improvements can only be realised and sustained with additional international support and cooperation to build the national capacity to deliver MDGs, especially the health MDGs.

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<sup>18</sup> Progress in health in Eritrea: Cost-effective intersectoral interventions and a long-term perspective p6.

<sup>19</sup> At present, the Government, through the Ministry of Health, is the main healthcare provider in the country. As described in the 2012-2016 Health Sector Strategic Development Plan (HSSDP 2012-2016), provision of health services in Eritrea is through a three-tier system (see: figure 1) which includes primary, secondary and tertiary levels of service (MOH, 2012).

Eritrea's march towards promoting equitable, accessible and affordable health services to the majority of its citizens has been commendable. The major interventions leading to the achievements have been the provision of integrated and effective health-facility delivery services, immunization<sup>20</sup>, family planning, nutrition interventions, control of communicable diseases including HIV and AIDS, tuberculosis (TB), malaria and, expansion of community based interventions. To further improve maternal health, a Roadmap for Maternal and New-born Health is in place, supported by the Campaign on Accelerated Reduction of Maternal Mortality in Eritrea (CARMME). The triple threat of HIV, TB and malaria is being tackled through a partnership involving the GoSE; Global Fund on AIDS, TB and Malaria; and the UN system. The results, if sustained are very promising.

The GoSE runs a coordinated and stratified three tier health care delivery system which has also proved to be formidable in meeting the felt needs of communities at all levels. It is a system that takes care of the population from the very local levels to national levels. This is another key and notable strategic approach and structural planning process that has contributed to the efforts to achieve the health MDGs in Eritrea. Understanding how the health delivery system works across the country improves appreciation of how Eritrea achieved health MDGs. This health delivery structure can be called a best practice and innovation in a country with limited resources and with some of its populations in hard-to-reach areas.

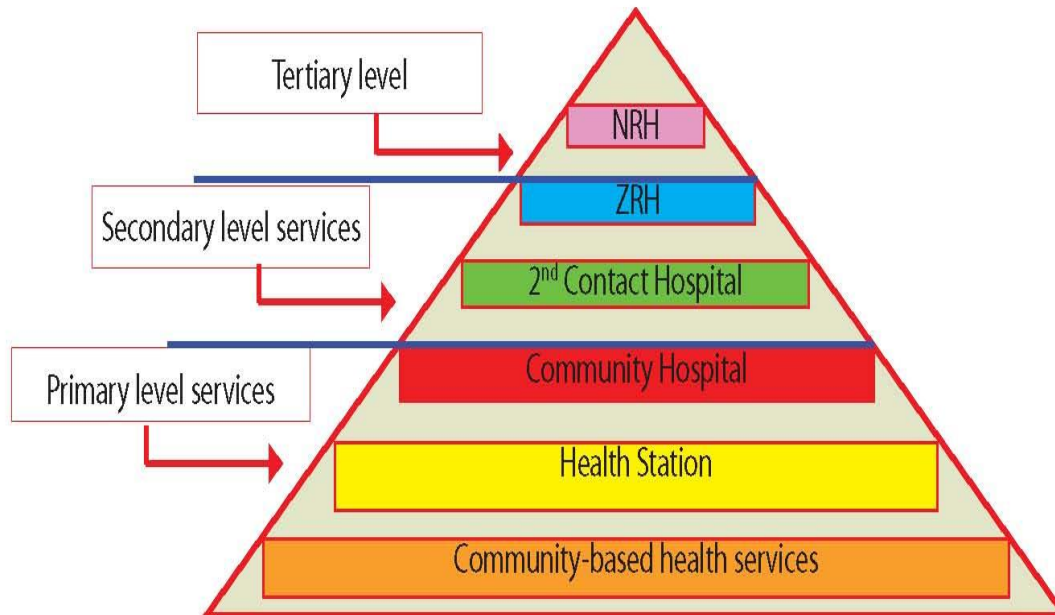
The diagram below attempts to depict how this health care delivery system works.

- (i) Primary level of service consists of community-based health services with coverage of an estimated 2,000 to 3,000 people. This level provides basic health care package (BHCP) services by empowering communities, and mobilizing and maximizing resources. The key delivery agent is the community health worker under the leadership of the Village Health Committee;
- (ii) (ii) Health Stations offer facility-based primary health care services to a catchment population of approximately 5,000-10,000;
- (iii) (iii) Community Hospital is the referral facility for the primary health care level of service delivery serving a community of approximately 50,000-100,000 people. Community hospitals provide all services available at lower level facilities, and additionally deliver obstetric and general surgical services with the aim of providing vital lifesaving surgical, medical and other interventions closest to the people.

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<sup>20</sup> The five major vaccine preventable diseases (poliomyelitis, measles, Diphtheria, Tetanus and Whooping Cough) no longer pose major public health problem in Eritrea. The country has eliminated maternal and neonatal tetanus and reduced to less than 90% of the 1991 levels the menace of measles. The country has been certified as "Dracunculiasis free" (Guinea worm) and is heading towards achieving polio-free status.

Figure 1: Eritrea three tier health delivery structure



*Source: MOH, HSSDP 2012-2016 (MOH, 2012)*

*NRH – National Referral Hospital  
ZRH – Zoba (Regional) Referral Hospital*

According to the National Health Policy (NHP 2010) and Health Sector Strategic Development Plan (2012-2016), Health Centers shall be phased out by gradually being upgraded to community hospitals. If and when upgrading them is not necessary due to the availability of another nearby hospital, then they may be downgraded to health stations.

Based on the Health Sector Strategic Development Plan (2012-2016), secondary level services are to be provided by the regional (zonal) referral hospitals and 2nd contact hospitals. Secondary level health facilities serve as referral centers for the lower level facilities and as teaching/training institutions for middle and operational level professionals. They also facilitate limited operational/applied research at their level (MOH, 2012).

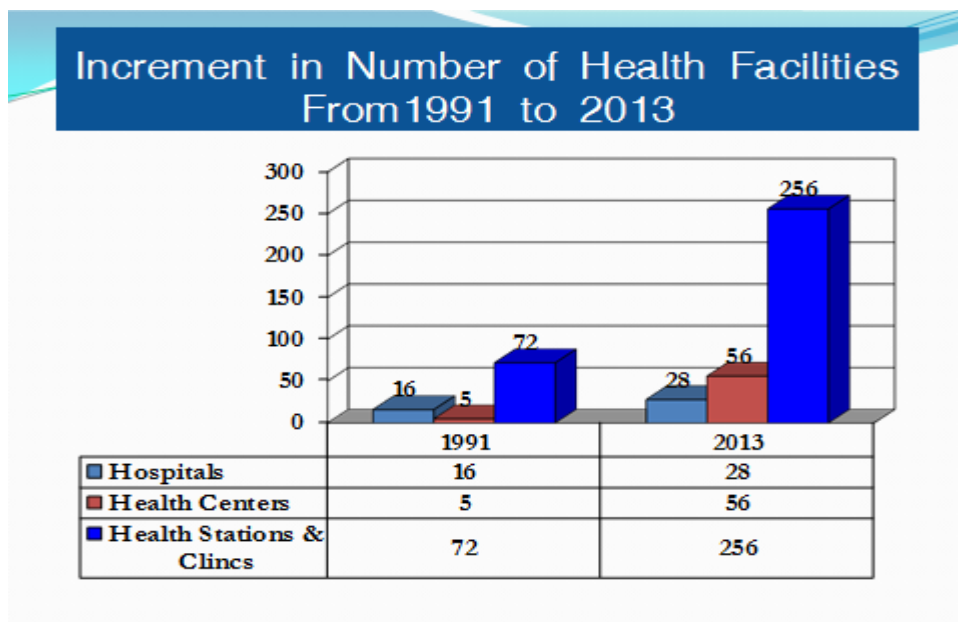
Tertiary level of service is provided by the national referral hospitals that are situated in the capital city- Asmara. Tertiary level health facilities not only serve as national referral facilities but also as centers of excellence for specialized training/ education, research and continuing education.

As illustrated in figure 15, since independence in 1991, the number of hospitals increased from 16 to 28, health centers increased from 5 to 56 and health stations (including clinics and MCH facilities) from 72 to 256. However, as shown in figures 16 and 17, this quantitative increment, significant as it is, does not fully reflect the qualitative improvements that resulted from the replacement of old and run-down facilities by the construction of new and improved facilities.

Basic Social services include primary health, WASH and education that are highly needed for the health care system to be vibrant. National capacity development will be required in national infrastructure, human resource development, research, and multisectoral programming that will sustain the health MDGs by creating sustainable linkages with the other 5 MDGs. The area of food security and sustainable livelihoods will boost the health care and nutrition needs of the nation to support a health nation. The environmental sustainability agenda is vital to buttress the agriculture based economy of Eritrea.

While the numbers of health facilities in themselves are not a guarantee of quality health care delivery, the GoSE should be commended for putting substantial resources in this sector since independence. This strategy has improved access in a dramatic way, especially for the hard-to-reach populations

**Figure 15: Increment in number of health facilities, 1991 to 2013**



Source: Health Bulletin (MOH (b), 2013)

**Figure 16: Some Hospitals Constructed after Independence<sup>21</sup>**



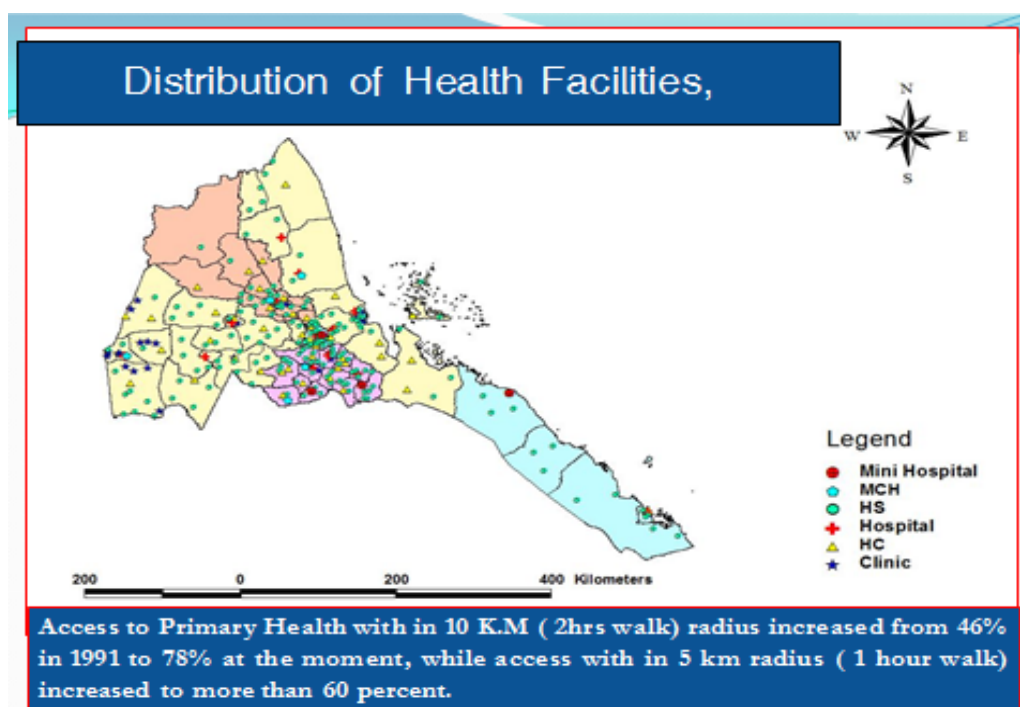
As the result of the concerted efforts made to expand health services by building health facilities and equipping them with the necessary equipment and skilled health personnel, access to health care within 10 Km radius, increased from 46 percent at the time of liberation to 78 percent at the present moment. Currently, over 60 percent of the population lives within 5 kms from a health facility (figure 5).

While 5 kms seems close there are still other layers of complexity to be resolved in facilitating effective health services delivery mechanisms in Eritrea. 5kms can still be prohibitive. Some populations are mobile. Others live in very prohibitive mountainous terrain to navigate 5kms to the nearest health facility. Yet others experience other socially constructed prohibitions in health seeking behaviours. One very innovative best practice the GoSE has perfected is the development and continuous improvement of the mobile health care services especially to such hard-to-reach communities. These are strategies where health care services “come” to the populations rather than vice versa. Allied to that some health workers work and live with these communities.

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<sup>21</sup> Major Hospitals constructed after independence include:

**Figure 17:** Distribution of health facilities in Eritrea, 2014



Source: Health Bulletin (MOH (b), 2013)

#### 4.4. Strategy of Comprehensive Services Delivery

Comprehensiveness of services means services should be promotive, preventive, curative and rehabilitative, i.e. services should not only be curative, but also should promote the population's understanding of health and healthy styles of life, and reach towards the root causes of disease with preventive emphasis. Treatment of illness and rehabilitation are as important as well.

The MOH is increasingly emphasizing promotive and preventive services besides the curative services. The improvement of percentage of immunized children from about 10 percent in 1991, to more than 95 percent at the moment; the reversal and stabilization of HIV infection in the general population at a low level below one percent; the elimination of polio and neonatal tetanus; the control of measles and malaria, are concrete examples of the emphasis made on promotive and preventive services in the health care sector in Eritrea.

Improvements in clinical services with improving quality and standards of curative and pharmaceutical services and ensuring availability, affordability and quality of essential and other medicines for both preventive and curative services are other examples of efforts in promoting comprehensive services. This strategy still needs to be studied for to evaluate the quantitative, qualitative and beneficial outcomes of this approach.

#### **4.4.1. Community Involvement**

Eritrean communities have a long-standing culture of being actively involved in all issues; political, social and economic matters that concern them before and after independence and this is one of key drivers of the progress made in the Health MDGs. One of the unique features of the struggle for the liberation of Eritrea is self-reliance and the remarkable degree of community involvement at every stage in the history of the struggle. After independence the GoSE continued building up on this success. It has been observed through various studies that one of the key success stories of Eritrea's development process is its ability to mobilize and motivate communities to be involved in the design, development and utilization of development programmes, including the health MDG activities.

In low-income countries, mismatch between services and needs is so common such that it gives rise to the often seen paradox that communities are under-served and well-constructed facilities are underutilized. Hence, much depends not only on the infrastructure of health care- but also on the personnel and how they are trained, oriented, supervised and supported- and their interaction with the Community.

#### **4.4.2. Intersectorial Approaches**

Approaches to health should relate to other sectors of development. The cause of ill health is not limited to factors that relate directly to health, and the paths to be taken to deal with ill health must not be solely health interventions. The Eritrean intersectoral collaboration success story was bolstered by initiatives such as education for literacy, income supplementation, clean water and sanitation, improved housing, ecological sustainability, more effective marketing of products, building of roads or waterways, enhanced roles for women as part of the development agenda across sectors. All those approaches have had a positive and substantial impact on the health MDGs. Experience showed that communities have often responded more readily to broader, localised and bread and butter approaches to development as opposed to fragmented sector by sector approach.

The strength of these interactions needs to be appreciated in the context of long term perspective. There are situations in which health is too inextricably tied to other aspects of development that there will be limited opportunity for advancing either health or development unless progress is made along both lines. Intersectoral approach in Eritrea is again a culture well developed in the struggle for the liberation. At the zonal level all social services and development programs are directly accountable to the Local Government, which ensures multisectorial approach to social services and development programs. What remains for the Eritrean agenda is to use these lessons learnt to apply to the rest of the MDGs and across all development planning at sub zoba, Zoba and national levels.

The concept we have known as "health in all polices", is based on recognition that population health can be improved through polices that are mainly controlled by sectors other than health. The health content of school curricula, industry's policy

towards employees' safety, or the safety of food and consumer goods are all issues that can profoundly influence or even determine the health of entire communities, and that can cut across national administrative boundaries. It is not possible to address such issues without intensive intersectoral collaboration that gives due weight to health in all policies. This is a lesson Eritrea has learned over the years that needs to be applied to other MDGs which are either off track or those that require acceleration through the "MDG Acceleration Framework" (MAF) methodology<sup>22</sup>.

#### **4.4.3. Political Commitment and Leadership**

The political commitment of the GoSE to the health of the population is straight forward in that all of the above discussed guiding principles and strategies of health policy in Eritrea are also the guiding principles of Macro Policy and the Charter of Eritrea since before independence. The government particularly emphasizes the importance of communities developing self-reliance and intersectoral approaches to health and affordability and sustainability of all interventions and programs. The National Health Policy and the Health Sector Strategic Development Plan (2011-2015) are formulated with clear understanding of the principles and imperatives of the above discussed strategies. There will be strengthening of some field based research and information gathering and analysis capabilities of implementers, as well as effective feedback that informs policy makers and health managers about the challenges that inevitably arise as planning proceeds through implementation to evaluation. Organizational structures and capacities are also set to extend services and support this well enculturated development process and agenda in Eritrea.

#### **4.5. Summary of Innovations Driving Health MDGs**

The positive achievements in maternal and child health, including HIV, Malaria and other diseases are not being realized in isolation. They are getting a boost from other activities, which can be described as 'collateral gain' and "incremental cultural knowledge". These can be summarized as follows:

- a) Selfless Government committed to national development by the people and for the people
- b) The Government of Eritrea has formulated a Poverty Reduction Strategy, where it once again indicated its commitment to improve access to health services, by making mother and child health a top priority within the framework of its Poverty Reduction Strategy.
- c) Dedicated service providers and community participation/ ownership

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<sup>22</sup> The year 2010 provided the setting for a comprehensive review of progress on the MDGs including the impact of new challenges and realities, such as the global economic and financial crises and climate change, as well as new evidence and innovations to accelerate and sustain progress towards the MDGs. At the country level, such a review works towards identifying bottlenecks and the solutions needed to accelerate progress on lagging MDGs, consistent with existing planning processes. To facilitate this outcome, the UN has developed and tested an "MDG Acceleration Framework" (MAF). The Framework helps countries to analyse why they are lagging behind on specific MDGs, prioritize the bottlenecks to progress, and identify collaborative solutions involving governments and all relevant development stakeholders.



- d) Collateral gains and incremental cultural knowledge base with improved road network; access to potable water; reliable power supply; and infrastructure for health.
- e) Effective local and intersectoral partnerships
- f) Equitable distribution of health services
- g) Complementarity with other related programs, such as Malaria, HIV/ AIDS, expansion of road and telephone networks, water and sanitation etc.)
- h) Pre-service and on-going in-service training activities
- i) Encouragement of research and innovation

## **5. Challenges to Sustain and Improve Health MDGs in Eritrea**

The story of Eritrean achievements in Health MDGs faces some challenges, including: the challenges to sustain and improve on the gains already achieved-beyond 2015 (e.g. in providing quality health care services in all facilities, old and new); ability of the GoSE to develop spill-over strategies that carry the lessons so far learned to other MDGs and other development initiatives; attracting global partnerships with sufficient technical, research, financial and good will capacities to support the GoSE in its development journey. Eritrea remains a poor country, with low capacity, attracting little international development financing, and requiring much basic infrastructure and human resource development support. Some of these challenges are discussed below.

### **5.1. Need of More Money for Health:**

The first challenge is the availability of resources. No country, no matter how rich, has been able to ensure that everyone has immediate access to every technology and intervention that may improve their health or prolong their lives. Universal coverage is not one-size- fits-all concept; nor does coverage for all people necessarily mean coverage for everything. Universal coverage needs working out who is covered from what, what services are covered, and how much of the cost is covered. Health financing is much more than a matter of raising money for health. It is also a matter of who is asked to pay, when they pay, and how the money raised is spent. This is one area Eritrea still has a lot to learn from others.

In Eritrea health care in general and maternal and child health care in particular are almost free. Although cost recovery through the levying of very nominal registration fees has been introduced, mostly for non-maternal and child health services, in Eritrea, the majority of health care users get all of the services they need for free as they can easily get poverty certificate from their village administration. In Eritrea, the conclusion on user charges is not considered as isolated policy measure, but as a package of measures designed to improve service quality while maintaining accessibility and affordability by ensuring that those who can't pay are exempt; and ensuring that those who can pay do. This is attempted through provision of private wing in public health facilities, where those who can pay get easier access to a physician of their choice. To this effect, almost all hospitals and some selected other

facilities have private or for profit wing or section, that works in the evening hours, after closure of the regular outpatient (non-emergency) outpatient section in public health facilities. It is not pragmatic for health workers to have to determine a patient's eligibility to pay. Hence, local government is given the mandate to do so.

The resources generated are expected to contribute positively to the sustainability and quality of health care. A share of the resources collected will be retained for utilization at the local level. The efficacy of this experiment is has to be evaluated through proper studies over a prolonged period of time and trials.

It is important to find ways to minimize negative effects of direct payments at the time people need care. However, at the moment this is not a problem in Eritrea because the use health care and services in Eritrea are provided totally free or at a very nominal fee, with negligible cost recovery. Although this is seen as a form of government funded social insurance, the Ministry of Health is fully aware that even the free services targeted to the poor are captured by the rich, who use them more than the poor. It is also questionable as to how cost effective this approach is.

For those reasons specific studies of overall health care financing has been and shall continue to be conducted in Eritrea, including an assessment of health care expenditure patterns, and an assessment of a range of financing options such as social or private health insurance, including an assessment of the impact and ways of improving the effectiveness and efficiency of the just begun private or for profit section in public hospitals.

## **5.2. Need of More Health for the Money:**

The second challenge is the inefficient and inequitable use of the already available resources. Raising sufficient money for health is imperative, but just having the money will not ensure universal coverage. Nor will removing financial barriers to access through prepayments and pooling. The critical question and abiding challenge now is how can Eritrea make the “best bang for the dollar”?

The final requirement is to ensure resources are used efficiently. Globally, at conservative estimate, 20 to 40 percent of health resources are being wasted. Need of getting “More Health for the Money”. Quality assurance in health care warrants considerable attention. Community demand for quality care is bound to increase with ever increasing public awareness. Presently in Eritrea, efforts are being made to continuously improve quality of health care services and to institutionalize systematic approaches to measure and assure optimal levels of quality in the provision of health services.

Besides developing policies and explicit policy guidelines, clinical protocols, treatment guidelines and manuals national standards have been developed. The challenge created by the academic environment in the teaching and learning process

in the teaching hospitals and other health facilities is an added asset and an opportunity for improving quality of health care.

Medicines are the most common causes of inefficiency. For example, in many health facilities of Eritrea, antibiotics and injections are overused<sup>23</sup>. Medicines are the most common causes of inefficiency. To get the most out of technologies and health services they should be appropriate and regulated approaches, methodologies and measurable targets to evaluate return on investment. Currently that lacks in Eritrea.

Appropriateness of technology/services means that services should be effective, culturally acceptable, affordable and manageable. Service that are not effective can't ensure universal coverage. Ensuring effectiveness also requires careful planning and management of programs that are directly relevant to local problems. However, effectiveness cannot be at the cost of cultural acceptability; indeed the two are mutually dependent.

A key success factor is a functioning and reliable health information system. Health managers and decision makers at various levels shall have information that tells them the extent to which their programs have the coverage and whether they are accomplishing what is intended. The information shall also be in a form appropriate for use.

From the outset, the GoSE has been very keen in making sure that all programs whether they are fully government funded or funded in collaboration with partners are appropriate in terms of, effectiveness, cultural acceptability, affordability and sustainability. For example the Government doesn't allow initiation of programs, which are not appropriate or sustainable. The Government doesn't accept assistance or 'donations' that doesn't adhere with its development policies and priorities in the respective field.

### **5.3. Maternal and Child Health:**

As previously mentioned, while more than 90% of pregnant women attend antenatal care (ANC), only about half are delivered by skilled professional attendants. In addition, while there was drastic reduction (77%) in maternal mortality ratio (MMR) since 1990, it is still high at 380 per 100,000 live births. There remains the greater need to reduce neonatal mortality which currently accounts for close to half of infant mortality and, TB control is still a challenge that requires expansion of existing interventions with a special emphasis on DOTs Strategy in order to improve the overall coverage.

Despite the commendable achievement in the control and prevention of malaria, the threat of resurgence due to climatic changes, cross border transmission and partly due to the national strategy on irrigation expansion for food security, remains a real

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<sup>23</sup> Ministry of Health, September, 2014

threat in the foreseeable future. Hence, the remarkable success achieved in preventing and controlling malaria with a reduction of around 90 percent in malaria morbidity and mortality, since 1999 should not lead to complacency in Eritrea.

Furthermore, while there has been good progress in the reduction of the incidence, prevalence and case fatality rate of acute respiratory tract infections and diarrhoeal diseases, they remain to be diseases of public health concern.

#### **5.4. Non-communicable Diseases (NCDs):**

As discussed elsewhere in this report, NCDs are becoming a menace in Eritrea. Although non-communicable diseases were historically viewed as a burden of the industrialised nations, evidence shows that this trend is expected to dramatically change globally over the next decade. Epidemiologists estimate that by the year 2020, chronic diseases will account for “seven out of ten deaths in low-income regions of the world compared with less than half today”. This trend is already evident in Eritrea as the prevalence of non-communicable diseases and injuries is increasing. The increasing trend of non-communicable diseases added to the prevailing disease burden of communicable diseases, poses a double disease burden challenge.

In this regard Eritrea still faces serious challenges from communicable and non-communicable diseases (NCDs); malnutrition; occasional disease outbreaks; compounded by socially created health challenges such as female genital cutting (FGM/C) and violence against women including abortion complications. The efforts made in the control of communicable diseases and the changes in the living standards and lifestyles of Eritrean people as well as environmental factors are leading to an epidemiologic shift from communicable to non-communicable diseases.<sup>24</sup> There is growing frequency of non-communicable diseases such as hypertension, diabetes, cancers, chronic lung diseases (asthma) and mental health problems, and re-emergence of chronic Neglected Tropical Diseases (NTDs).

Mortality data from hospitals and health centres in Eritrea<sup>25</sup> show that, in the population older than five years, hypertension, heart failure, diabetes mellitus, and liver diseases were among the 10 leading causes of deaths in 2003. These diseases combined were responsible for 35.5% of all hospital deaths. Just five years earlier in 1999, they were responsible for only 17% of all hospital deaths. In addition, hypertension, heart failure, and diabetes mellitus each ranked above malaria as a cause of death in 2003.

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<sup>24</sup> Prevalence of Non-Communicable Disease Risk Factors in Eritrea study (2006) by Abdulmumini Usman at el found among others that the prevalence rate of daily smoking is 7.2% with variations among age, sex, religion and regions. A high prevalence of low fruit and low vegetable intake was observed at 84.7% and 50.6% respectively. Alcohol drinking was 39.6%. Level of physical activity was high (90%). The prevalence of obesity was low at 3.3%. The prevalence of hypertension in the general population was 16%, while 2.2% were known diabetic patients. More than 80% of the hypertensive persons were not aware of their condition. No significant rural/urban or sex difference was seen in hypertension prevalence.

<sup>25</sup> Ministry of Health, Eritrea. National Health Management Information System. Asmara, Eritrea

These risks and health concerns are straining the health system and will need to be addressed more comprehensively with more policy and strategic interventions. Notably, Eritrea has improved the tracking and reporting on outbreaks of major communicable diseases including meningococcal meningitis and avian influenza. These are relatively new health risks Eritrea cannot contain and turn around alone with specialized technical and financial support and cooperation from the international development community.

#### **5.5. Human Resources for Health:**

The rapid expansion of the health infrastructure since independence to cater for national health needs led to a high demand for health personnel. The adoption of primary health care as a policy priority was effectively implemented with the necessary re-orientation of health workers including re-training of staff to standardize the skills of different categories of health cadres that existed. Newer reform initiatives such as decentralization to the zobas have also introduced new health resource requirements and further challenges for the sector. With the increase of non-communicable diseases together with the burden of communicable diseases, the sector is faced with the challenge of providing specialised services that require a higher level of skilled staff. In essence, the current issue is not only numbers but also competency and the right mix of the health professionals that are able to respond to current, emerging or re-emerging health conditions in Eritrea.

Human resource planning therefore, shall be more responsive to the prevailing health needs and burden, quantity/quality of available resources, technological developments, and other national, regional and international developments. Human resource planning also shall consider the staffing patterns at all levels, expansion and restructuring of health care delivery system, attrition and other (such as decentralisation) policies of the government.

#### **5.6. Health Care Financing:**

Considering the desire to improve the quality of care in health facilities for a growing population with an increasing burden of non-communicable diseases, there is need to transform the financing framework that has been in existence since independence, with the aim of reducing the economic risks borne by individuals and households and concurrently generating other resources for the attainment of the sectors' strategic objectives.

## **6. Lessons Learnt and implications for the Post-2015 Global Development Agenda**

### **6.1. Summary of Prospects of Sustaining MDGs**

A focus on self-reliance, particularly during years of war, has helped Eritreans be flexible when facing adverse circumstances and has led to the development of innovative solutions in the health sector. Examples are mobile clinics to reach remote populations in contested areas and the tackling of personnel shortages by training community members and teachers as health workers. Human resource capacity remains key to sustaining gains and sustaining the MDGs moving forward.

During the war, the Eritrean People's Liberation Front (EPLF) deemed health and education essential investments in the country's future after independence, with children a top priority. Programmes survived in spite of protracted war, drought, famine and a general lack of resources. For example, in line with the stance of self-reliance, and despite its relative isolation, Eritrea has increased its number of skilled health professionals by setting up training colleges and schools.

Following the establishment of the Asmara Medical School, the country is producing an average of 30 general practitioners annually since 2009 thereby increasing the capacity for skilled care. This has enabled even community hospitals to have doctors. The Medical School is also training Obstetricians (4 have already graduated), Paediatricians (15 have graduated) and Anaesthetists hence increasing the national pool of specialists for CEmONC<sup>26</sup>.

The Asmara College of Health Sciences trains Comprehensive Nurse /midwives in a three year course. The students average 140 per class trained in two streams. The training mainly focuses on the theoretical aspects of EmONC due to several constraints as alluded to above; hence they are all subjected to LSS training before deployment to address this gap. Evidence suggests that the more advanced the training, the greater the reduction in maternal and neonatal mortality. The country should therefore consider investing in midwifery training.

Infrastructure, particularly in rural areas, has expanded. However, the sector still suffers from a serious shortage of skilled personnel, with the number of physicians increasing from only 0.2 in 1993 to 0.5 in 2004 per 1000 population. More and sustained funding is required to improve infrastructure, train more health workers, and attend to targets in other five MDGs which are either off track or in need of acceleration.

The Eritrean diaspora has played a significant role, throughout the war and during reconstruction, financially<sup>27</sup> and politically but also through skills transfers (e.g.

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<sup>26</sup> Mid Term Review of the Sexual and Reproductive Health Strategic Plan 2011-2015, (June 2013) p16

<sup>27</sup> The government collects a 'voluntary' 2% tax of earnings abroad and private remittances significantly exceed official development assistance.

provision of medical care, training of colleagues and barefoot doctors during the war). Many returned to Eritrea to join the war; others returned after independence to contribute to reconstruction. Despite mixed global perceptions of Eritrea's political situation, diaspora groups play a role in promoting and facilitating collaboration and partnerships between the Ministry of Health and medical organisations, universities, non-governmental organisations and doctors from other countries.

## 6.2. Summary of Lessons Learnt

With less than 500 days to the end of the Millennium Development Goals adopted in 2000, many countries have started to draw lessons on how the experience from the implementation of the MDGs could assist in the formulation and management of its successor. Accordingly, the lessons drawn from the above indicated interventions and successes should help Eritrea itself in the articulation and operationalization of further health goals in the post 2015 development agenda. These lessons learned include:

- 1) A strong government, with the ability to motivate and mobilise people behind a clear goal, emerges as key to progress in Eritrea, despite accusations of authoritarianism and political repression. The EPLF has managed to generate a unique sense of community among a diverse group of ethnicities and religions. Involvement of the diaspora is closely linked with the idea of unity for the greater good.
- 2) Community participation and involvement in health service delivery, besides helping alleviate shortages of skilled staff, has brought services closer to the community. This has also had an important impact on awareness at community level and, as such, has removed barriers to the dissemination of health information. Additionally, it has reinforced a sense of belonging and of contributing towards the common good.
- 3) Investment in human capital as a key driver of development has been of vital importance. The government foresaw future needs and made long-term investments in health and education, although this has as yet not stemmed widespread poverty.
- 4) Government ownership of development projects and programmes is important to ensure sustainability and commitment to goals, as well as to avoid unpredictable shifts in donor priorities and/or financial commitments. However, less political isolation might also promote progress in areas such as economic growth, where the country has not been so successful.
- 5) Effective coordination among sectors avoids duplication of efforts and allows for cost-effective projects. In the Eritrean health sector, what might have constituted rivalry between ministries has been transformed into opportunities to scale up services more efficiently.

- 6) A strong understanding and down-to-earth assessment of the resources available to foster development encourages both realistic actions and common-sense policies. Meanwhile, if fewer resources had been devoted to defence and war, progress in other sectors might also have been visible.

### **6.3. Post 2015 Development Agenda**

The MDGs, adopted in 2000, set out a shared global framework of development priorities for the following 15 years. At the time, they were unique amongst other development commitments, in that they had a unanimous global adoption and an integrated, ambitious, time-bound and quantifiable nature. While the MDGs will expire on 31 December 2015, even with the majority of the global targets unmet, there is global consensus that substantial progress has been made in many areas. Thus, there is a global understanding that the momentum towards sustainable development created by the MDGs needs to be preserved.

The establishment of a post-2015 development agenda will need to capitalise on the strengths of the MDGs, while at the same time ensuring that the gaps are addressed and that the new development context is considered. The world has changed considerably since the year 2000, as have individual countries and populations. The fourteen years since the start of the millennium have seen new crises affecting development, such as the global financial and economic crisis and an acute food crisis, especially in Sub Sahara Africa. The impact of climate change is also affecting our planet to a much higher degree.

Current global development planning has also reached consensus that a new set of goals or development framework will need to reflect these realities. The Rio+ outcome document, *The future we want* gave the mandate that the Sustainable Development Goals (SDGs) should be coherent with and integrated into the UN development agenda beyond 2015<sup>28</sup>. SDGs are accompanied by targets and will be further elaborated through indicators focused on measurable outcomes. They are action oriented, global in nature and universally applicable. They take into account different national realities, capacities and levels of development and respect national policies and priorities. They build on the foundation laid by the MDGs, seek to complete the unfinished business of the MDGs, and respond to new challenges. These goals constitute an integrated, indivisible set of global priorities for sustainable development. Targets are defined as aspirational global targets, with each government setting its own national targets guided by the global level of ambition but taking into account national circumstances. The goals and targets integrate economic, social and environmental aspects and recognize their inter-linkages in achieving sustainable development in all its dimensions.

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<sup>28</sup> Introduction to the Proposal of The Open Working Group for Sustainable Development Goals, July 17, 2014, p2



The global discussion on these issues has already begun and Eritrea should not miss out on the opportunity to contribute to that global discussion and help to shape the post-2015 development agenda and carry over the unfinished agenda for the unmet MDGs.

#### 6.4. **Shaping the National Discussion on the Post-2015 Agenda**

*“Though these goals [MDGs] addressed important development areas such as poverty reduction, education and health, the required inter-linkages between the goals are however missing – this has led to an absence of synergy and constitutes the main shortcoming across all of the MDGs.”*

Respondent, post 2015 National Country Consultation, Iran

There are increasing calls to go beyond the MDGs and include challenges that are now becoming critical for our common global well-being<sup>29</sup>. Many of these elements and principles were addressed in the Millennium Declaration but did not figure in the MDGs. Four issues stand out here: inclusive growth and decent jobs; governance and accountability; peace and security; and environmental sustainability. Participants in the majority of post 2015 consultations also showed clearly how important values such as equality are needed in the Sustainable Development Goals. People are demanding not only education, food and health, but also justice, participation and dignity for everyone. There is no lasting progress if people are left behind.

Overall, the My World results<sup>30</sup> suggest a clear and resounding call for education, health, secure jobs and income, and honest and responsive government to be part of the post-2015 agenda. These priorities have been expressed by MY World voters from all types of countries and all categories of population (old, young, male, female); they confirm that the core focus of MDGs continues to be relevant and that MDGs should undoubtedly be the building blocks for our future development agenda. Eritrea should not miss the opportunity to be an active participant in the agenda setting dialogue, and also benefit from global resources required to implement the emerging programmes therefrom.

Central questions that will form the discussions on a post-2015 agenda are:

- i. Whether the MDGs should be retained in their current configuration with an extended deadline;
- ii. Whether they should be reformulated; or
- iii. Whether they should be replaced by a new framework or a new set of goals.
- iv. Another question is whether a greater emphasis on intermediate rather than final outcomes and a focus on ‘enablers’ of development would generate more development impact? Or is an MDG+ option the best way forward?

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<sup>29</sup> The MDGs were drawn from the Millennium Declaration as well as the UN conferences of the preceding decade, but with limited popular engagement. Some groups have criticized the MDGs for capturing a reduced and simplistic vision of development: one that ignores the linkages between issues as well as the root causes of poverty, inequality and discrimination.

<sup>30</sup> A Million Voices: The World We Want, p46 United Nations Development Group 2013.

There are also suggestions that the post-2015 development agenda could be built around sustainable development goals emanating from the Rio+20 process. The issue thus far has been that global development has included only limited attention to the natural environment. The new approach therefore will seek to include critical problems that affect all communities, such as the plight of the poor, political, social and economic stability, as well as peace and security. As such, the post-2015 development agenda will combine sustainable development and poverty reduction themes.

A bottom-up approach will add enormous value to, and influence, the global post-2015 discussions. In the case of Eritrea, at national level, discussions could ask the following set of questions:

- Do the remaining five unmet MDGs adequately address the key development challenges in Eritrea? If not, what has been left out and how can it be formulated into concrete and measurable goals for the next 15 to 20 years? How can a new set of goals best address the changing context and development challenges in Eritrea.

Despite the optimism, the post 2015 global consultations<sup>31</sup> highlight the considerable challenges that still lie ahead. Countries continue to face relatively high poverty rates, have low levels of education to contribute meaningfully to development, and can barely cope with the burden of diseases. Reducing poverty, enhancing food security and nutrition, improving access to quality education and health care, as well as access to clean water and sanitation, are repeatedly mentioned as priorities in all the consultation reports.

The MY World survey results<sup>32</sup> for the Africa region confirm this finding: good education, better health care, better job opportunities, and access to clean water and sanitation appear as the top four issues of concern. The results also show the significance that participants attach to having an honest and responsive government, both for the management of national resources and for creating the fiscal space to provide quality services to citizens. They findings will be crucial to sustain the gains already achieved in the health MDGs, while accelerating solutions for the remaining five MGDs.

The consultations have revealed a huge appetite and demand for involvement not only in the design of the development agenda, but also in its future implementation. One million voices are a clear call that people, businesses and civil society organizations want to be engaged in creating development solutions while holding governments and the international community accountable for implementation. People from various walks of life are asking for transformation — not just of the ‘what’, but also ‘how’ we do development. They are asking not just for a one-off consultation, but an ongoing conversation and concrete opportunities for

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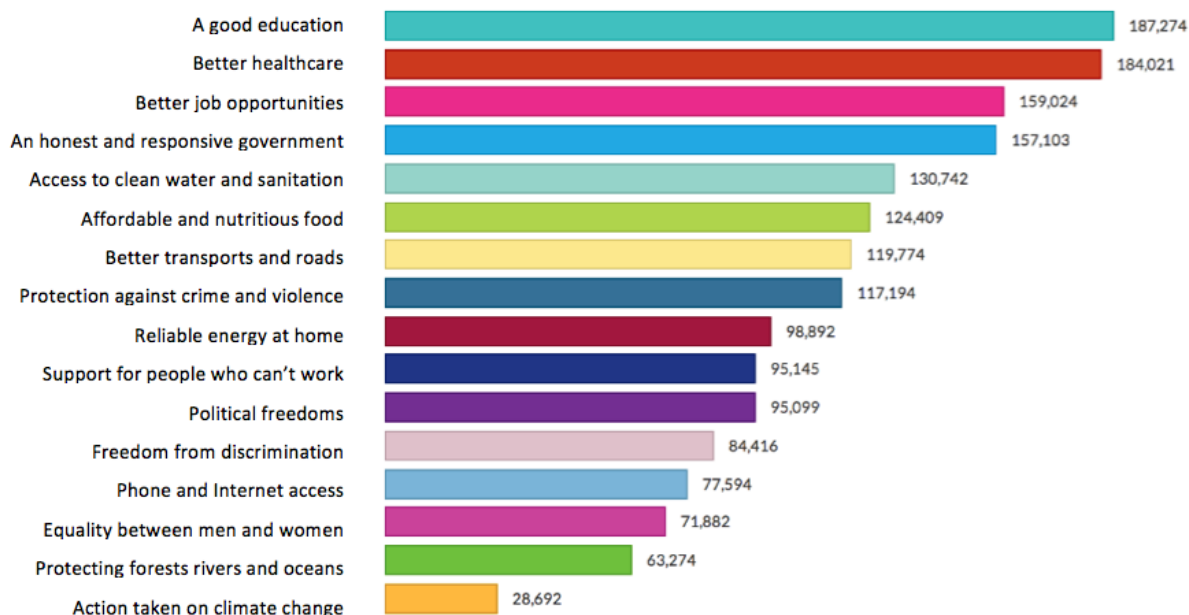
<sup>31</sup> Ibid, p49

<sup>32</sup> Ibid, p50

engagement. They want not only to articulate the problems, but to help find solutions and be involved in implementing them.

The Africa Survey results shown below already show a formidable agenda on which Sustainable Development Goals can be implemented. The Eritrean population, like the citizens of the 50+ other African countries share the same priorities for the post 2015 agenda.

### My World Survey Results: From Africa August 2013<sup>33</sup>



*“Since the Millennium Declaration was adopted, many types of inequalities have worsened, in a period when the Millennium Development Goals did not focus systematically on trends ‘beneath the averages. Even where human development progress has been rapid in aggregate terms, particular inequalities have often persisted or become more severe. Increased global access to technology and social media has highlighted the extent of inequalities, driving awareness and increasing demand for change.”*

#### Addressing Inequalities consultation, final Report-post 2015 Agenda

Overall, the consultations in Africa reveal the unfinished business on the MDG agenda<sup>34</sup>, and more: they expose new realities and challenges that need to be addressed, such as quality of education and health care, growing inequalities and unemployment even in countries experiencing economic growth, the strong

<sup>33</sup> In addition to the approximately 800,000 people who have taken part in the MY World survey, approximately 362,600 people shared their views during the national consultations. Broken down by region this is: 110,000 people in 31 sub-Saharan African countries; 20,600 in Latin America and the Caribbean; 92,000 in Asia Pacific; 6,000 in the Middle East and Northern Africa region; and 124,000 people in Eastern Europe and Central Asia.

<sup>34</sup> A Million Voices: The World We Want, p68 United Nations Development Group 2013.

connection between the environment and people's livelihoods, and the importance of taking an integrated approach to development. These issues have resonated with all stakeholder groups: women, men, young people, policymakers, minority groups and the private sector alike.

In addition, people have said emphatically that the challenges – and indeed opportunities – they face are complex and interlinked. Access to affordable and nutritious food is linked to land degradation and the availability of water. Fetching water or fuel can expose people to crime and violence, and unsafe energy sources can cause deaths from toxic smoke.

#### **6.5. Where do we go from here and how?**

People find it more difficult to access services, have equal opportunities or benefit from the wealth of their country's natural resources when institutions are weak or corrupt. These issues point to the need to go beyond a silo approach and arrive at a future sustainable development agenda that is more integrated and holistic. People demand that this new agenda be built on human rights, and universal values of equality, justice and security. Better governance, of markets and of the environment, underpins many of their calls. Because our world is now linked inextricably through the global economy, our common environment and our ability to instantly share ideas, they emphasize the need for a universal agenda that applies to all countries and all people. There is also a strong call to retain the focus on concrete, measurable goals, yet improve dramatically the way we measure progress against them. This requires a significant upgrading of the information we have available to us, through public statistics systems as well as new forms of data. Enhanced and disaggregated data will allow us to track gains for all groups of people, to help ensure that no one is left behind. Populations everywhere demand continued participation – not just in this process to determine the world's priorities, but also to hold governments, business, international organizations and civil society to account for achieving them. Greater commitment, stronger action, enhanced resources and better partnerships will be required to deliver the “world we want”.

The post 2015 Agenda requires the mobilization and equitable sharing of resources, especially to countries that require them the most in order to complete the unmet MDGs, while focusing on the next agenda as articulated by the Sustainable Development Goals. Eritrea is ready to be part of that global dialogue and planning.

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