HEALTH MILLENNIUM DEVELOPMENT GOALS REPORT ABRIDGED VERSION

INNOVATIONS DRIVING HEALTH MDGs IN ERITREA

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SEPTEMBER, 2014

United Nations

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MESSAGE

FROM H.E. AMINA NURHUSSIEN, MINISTER FOR HEALTH

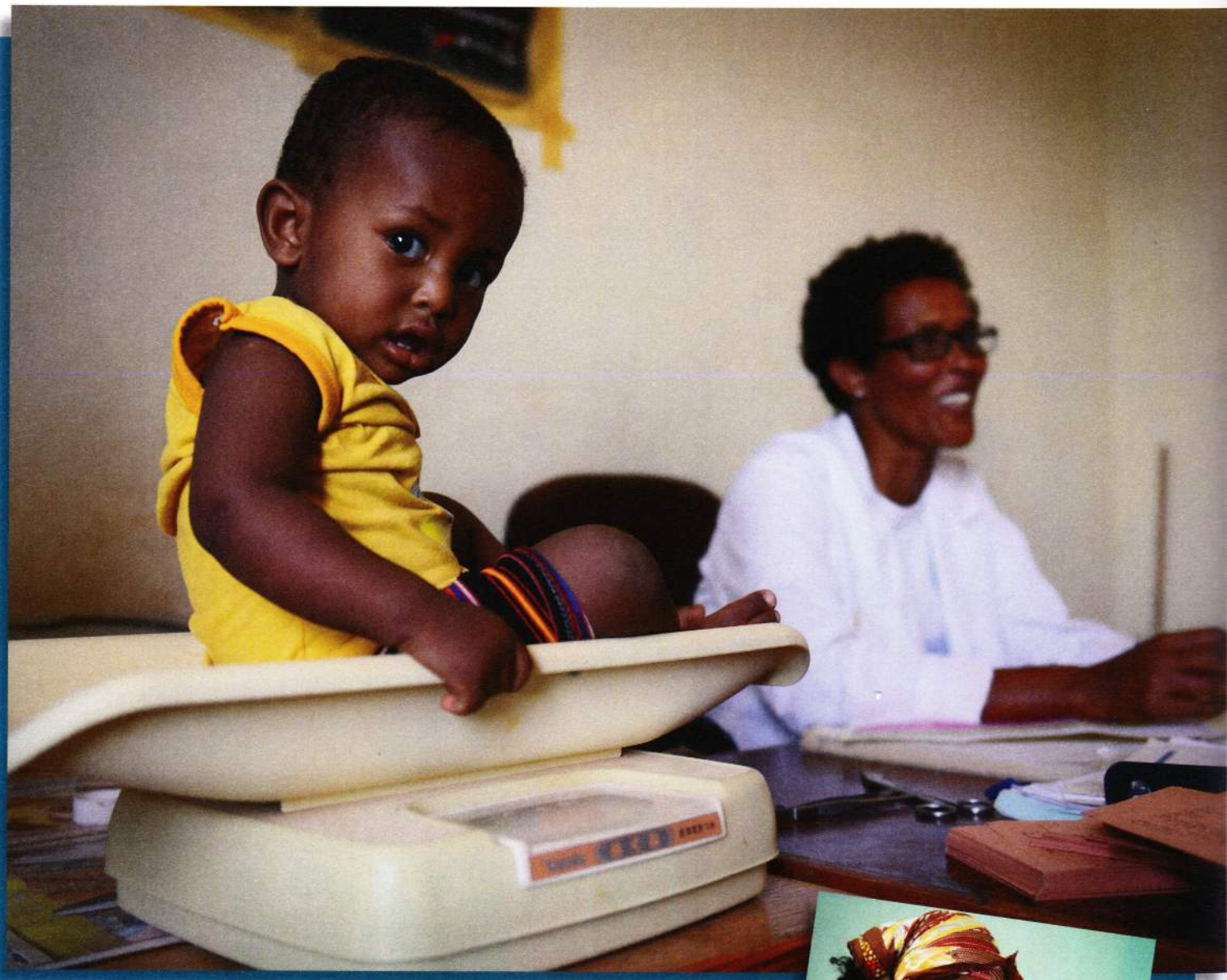
As articulated in the Health Sector Strategic Plan Development Plan (2013-2016), the overall goal of the health system in Eritrea is the improvement of health status, general wellbeing, longevity and economic productivity for all Eritreans. Over the last few years, the country has achieved remarkable progress on basic health indicators, including significant reductions in maternal and child mortality ratios and HIV prevalence. Access to healthcare within a 10-kilometre radius has increased significantly since Eritrea gained independence in 1991, from 46 per cent to 78 per cent. More than 60 per cent of the population enjoys access to health care facilities within a 5-kilometre radius, which has generated substantial improvements in access to and utilization of quality and timely healthcare. Eritrea is now poised to meet the three health-related Millennium Development Goals (MDGs) by the 2015 deadline.

These achievements are the result of a concerted effort undertaken by the Government, the citizens of Eritrea, civic and community leaders and development partners. The country's progress is also tied to the high priority placed on health and education, the population's commitment to development and our innovative multi-sector approaches to health.

Much work remains to be done, however, especially with regards to non-communicable diseases and new and emerging communicable diseases, which are already among the 10 leading causes of morbidity and mortality in adults. It is also important to note that the eight MDGs are inter-linked, and sustaining the gains made in health will require support from and attention to the sectors covered by the other five MDGs. Furthermore, more resources are needed to improve the general wellbeing of all Eritreans.

As we approach the 2015 deadline and the years ahead, it is our sincere hope that useful lessons can be drawn from Eritrea's successes in the health sector that can help formulate, shape and implement the post-2015 global development agenda.

Thank you.



1. INTRODUCTION

1.1. Background on the MDGs

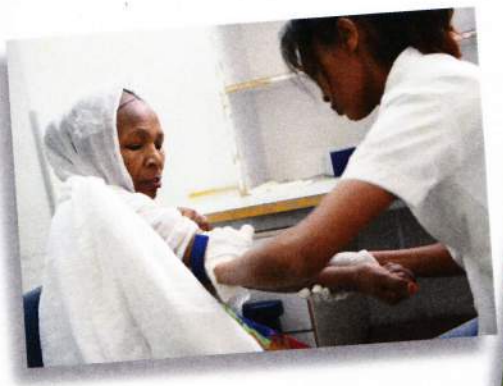
All United Nations member states, including Eritrea, adopted the eight mutually reinforcing Millennium Development Goals (MDGs) in 2000 as a global framework for development monitoring aimed at ensuring a commitment to overall human security and development.

Although Eritrea has produced only one national MDG report (in 2006) since independence in 1991, the Government of the State of Eritrea (GoSE) has initiated and implemented several enabling policies and programmes that have facilitated integrated development planning and multi-sector programming. These sustained policy actions have had an impact on a number of the MDGs and their associated targets.

This report on Eritrea's progress on the health-related MDGs, which was prepared under the oversight of the Ministry of Health (MoH), is a preliminary and partial effort towards a national MDG progress report, fifteen months before the 2015 deadline. It documents the achievements made towards MDGs 4, 5 and 6 to showcase the policy and institutional innovations driving that progress, and identify challenges and emerging lessons that Eritrea and other countries may use to bolster post-2015 development agendas. The report also highlights good practices for achieving the MDGs that can be further developed or replicated. Particular emphasis is placed on the innovative strategies that may have both accelerated progress towards MDGs 4, 5 and 6 and generated positive momentum towards the other five MDGs.

1.2. Methodology

This evidence-based progress report was prepared through a comprehensive analysis of the achievements, their drivers, challenges and lessons learned. A desk review was conducted, with information drawn from a variety of sources at national, sub-national and regional levels, including Government surveys. Data was analysed using both quantitative and qualitative methods, as appropriate. Critical data/information gaps were supplemented using credible UN sources. Additional inputs from the UN Country Team in Eritrea were also included in the report.



2. COUNTRY BACKGROUND AND DEVELOPMENT CONTEXT

2.1. Country background

Eritrea is located in the Horn of Africa region, where arid and semi-arid climatic conditions prevail. Rainfall in Eritrea ranges from less than 200 millimetres per annum in the eastern lowlands to about 1,000 millimetres per annum in a small pocket of the escarpment. The country is therefore vulnerable to the adverse effects of climate variability, recurring droughts and environmental degradation, all of which hamper development efforts.

2.2. Country development context

In the six years following independence in 1991, Eritrea formulated and implemented socioeconomic development policies and strategies that resulted in marked improvements. However, a border dispute with neighbouring Ethiopia (1998-2000), which escalated into a full-scale war, reversed these gains. The unresolved no-peace-no-war border stalemate remains a major impediment to the Government's developments efforts, as a number of initiatives and resources are tied to the border stalemate.

In addition, Eritrea's economy, which is largely based on subsistence agriculture, the country's socio-economic conditions, and the environment, have all struggled in the face of persistent drought. Vulnerable communities, groups and households (especially the female-headed), are particularly impacted by the effects of drought.

More recently, however, economic prospects have shown signs of improvement, especially as investments in the mining sector continue to grow. Although Eritrea is currently not well integrated into global value chains, there is the potential for increased global production and trade for mineral and agricultural exports. Reflecting these factors, estimated real gross domestic product growth was 7 per cent in 2013, largely driven by growing investment in the mining sector. In the medium term, Eritrea anticipates additional prospects in oil production, fisheries and tourism. Improvements are also underway in the education and health sectors, thanks to increased investment. Significant challenges remain, however, especially in regards to creating an enabling business environment.

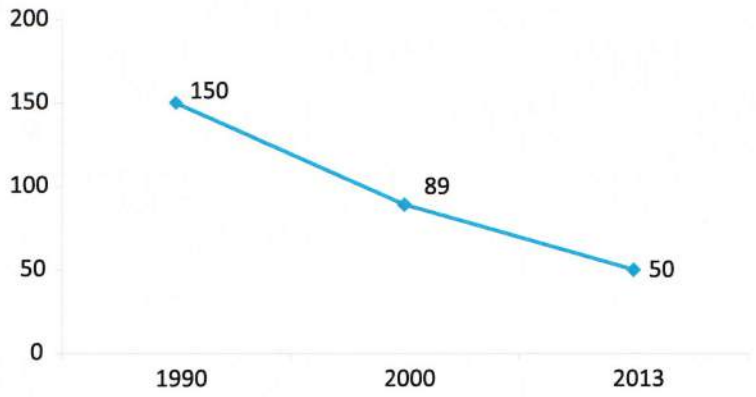
3. STATUS OF HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALS

3.1. Goal 4: Reduce Child Mortality

MDG 4 calls for the reduction of the under-five mortality rate by two-thirds between 1990 and 2015. The global annual rate of reduction has steadily accelerated since the 1990–1995 period, more than tripling from 1.2 per cent to 4.0 per cent in the 2005–2013 period. Despite these gains, child survival remains an urgent global concern.

Eritrea has witnessed an unprecedented reduction in infant mortality rates per 1,000 live births, from 92 in 1990, to 58 in 2000, to 37 in 2012 (WHO, 2014). As illustrated in figure 1, during the same period, the under-five mortality rate per 1,000 live births was reduced from 150 in 1990, to 89 in 2000, to 50 in 2013 (UNICEF, 2014). Eritrea has therefore achieved MDG 4 as of 2013.

Figure 1: Progress in Reducing Under-5 Mortality Rate by Year 2015

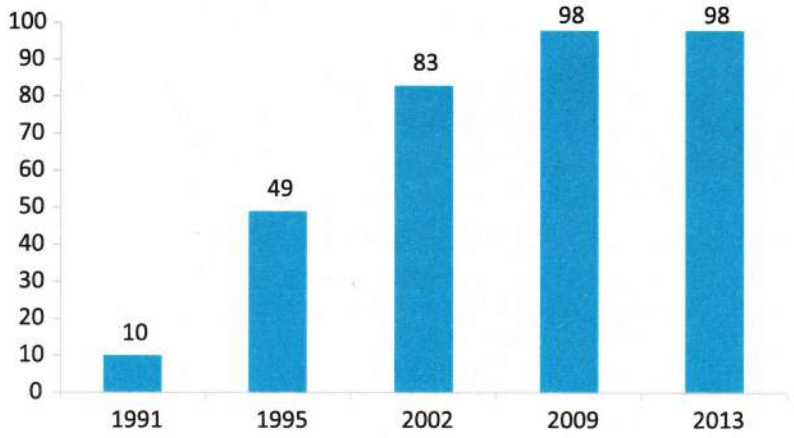


Source: UN IGME 2014 Report

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

As revealed in figure 2, immunization coverage for the third dose of the diphtheria, tetanus toxoids and pertussis (DPT) vaccine (and since 1998 with the third dose of the hepatitis B vaccine) increased from 10 per cent in 1991 to 98 per cent in 2013.

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



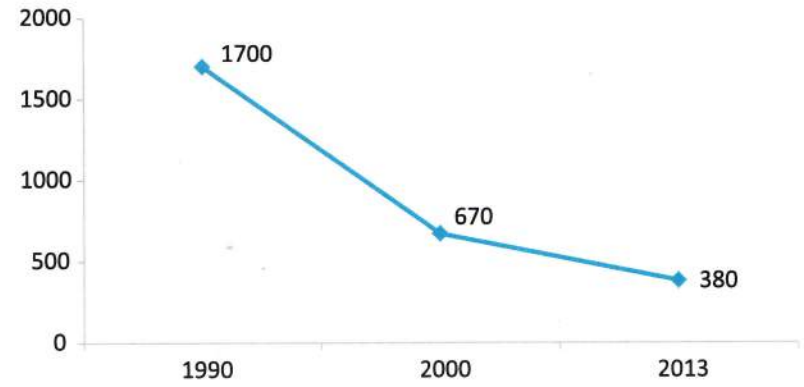
Source: EPHS 2010 & MOH EPI survey

As a result of its strong routine immunization programme, Eritrea was certified as a polio-free country by the World Health Organization (WHO) in 2008. Eritrea has maintained its polio-free status, despite its proximity to countries where polio has not yet been contained. Since 2004, neonatal tetanus has been virtually eliminated, as certified by WHO in 2007. Measles also no longer pose a major threat to children with virtually all children taking their doses according to schedule. In recognition of Eritrea's strong immunization programme, the Global Alliance for Vaccine Initiative awarded the country for high and sustained immunization coverage on October 17, 2009 in Hanoi, Vietnam.

3.2. Goal 5: Improve Maternal Health

The MDG-5 target is to reduce maternal mortality by three quarters between 1990 and 2015. As illustrated in figure 3, the maternal mortality ratio for Eritrea per 100,000 live births declined from 1,700 in 1990, to 670 in 2000, to 380 in 2013 (WHO, 2014). Eritrea has already exceeded its MDG-5 target of 425 per 100,000 live births.

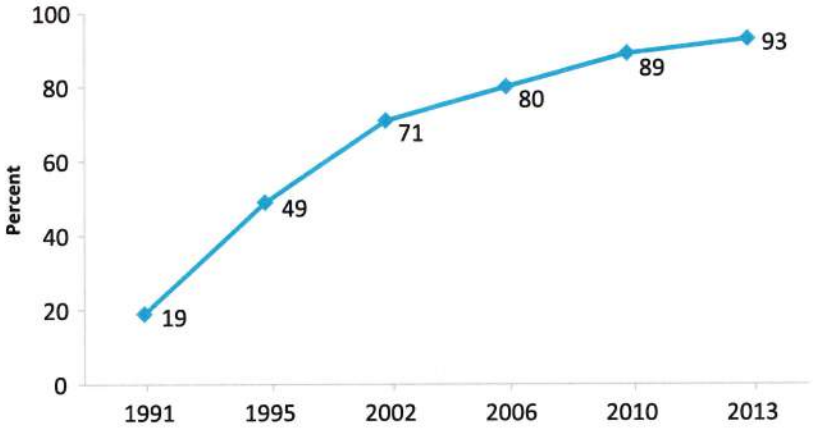
Figure 3: Maternal Mortality Ratio (MDG-5)



Source: World Health Statistics, 2014

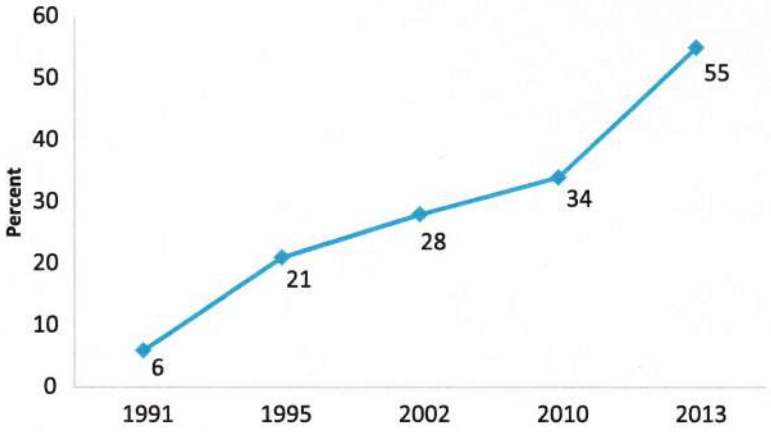
As shown in figure 4,antenatal coverage (measured as at least one visit during pregnancy) increased from 19 per cent in 1991 to 93 per cent in 2013. As illustrated in figure 5, delivery by a skilled birth attendant increased during the same period, from 6 per cent to 55 per cent.

Figure 4: Antenatal Care Attendance, 1991 – 2013



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

Figure 5: Per cent of deliveries attended by health workers, 1991 – 2013



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

Ninety-six per cent of mothers get at least one post-natal care visit (MOH, 2013 (a)). Access to emergency obstetric care services increased by more than 300 per cent between 1995 and 2013, from 21 per cent to 88 per cent. The Ministry of Health uses a '6-6-6' programme to improve post-natal care coverage, which means a six hour, six day and six week follow-up monitoring process.

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

Steady progress has been made towards expanding both prevention and treatment services in Eritrea's national response to HIV and Tuberculosis. The 2010 National AIDS and Tuberculosis Control Division report shows that HIV and syphilis prevalence were 1.31 per cent and 0.58 per cent, respectively, which is remarkably lower than the prevalence rates noted in previous surveys. There is also evidence of declining HIV prevalence among pregnant women (attending antenatal care services), with extrapolated national adult prevalence rate falling from 2.41 per cent in 2003 to 2.38 per cent in 2005 and further to 1.33 per cent in 2007. As shown in table 1, the 2010 Eritrean Population & Health Survey (EPHS) documented HIV prevalence at 0.93 per cent, with women more than two times as likely to be infected with HIV as men. Furthermore, data derived from blood donors and clients

of voluntary counselling and testing and prevention of mother-to-child transmission services continually shows a reduction in HIV and syphilis positivity rates. In addition to generating progress towards MDG 6, controlling HIV/AIDS, tuberculosis and malaria will have far-reaching impacts on reducing poverty and child mortality and improving maternal health, and s therefore key to achieving the other health-related MDGs.

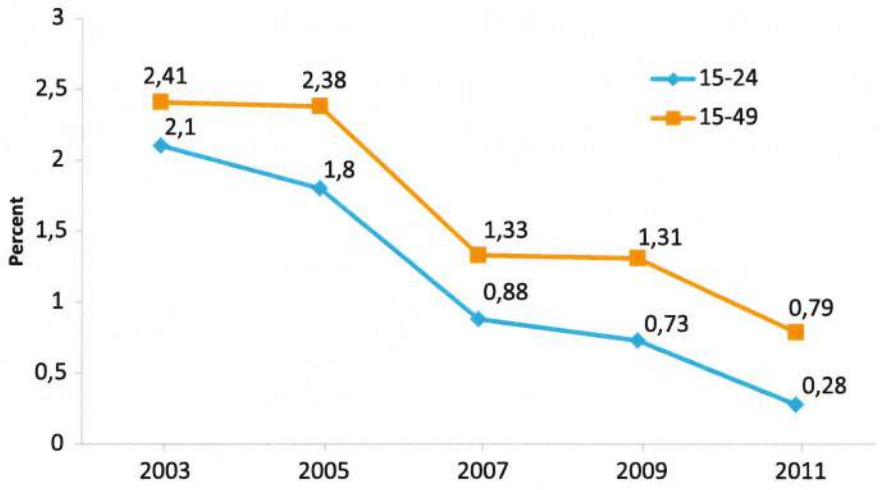
Table 1: HIV prevalence by age and sex, EPHS 2010

Age	Women	Men	Total
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
Total	1.15	0.5	0.93

Source: EPHS 2010

As illustrated in figure 6, Sentinel Sites Surveillance reports reveal a steady decline in the HIV prevalence among young pregnant women aged 15-24. Declining prevalence in this age group can be considered a rough proxy for declining prevalence overall.

Figure 6: HIV Prevalence (%) trend, ANC SSS 2003-2011



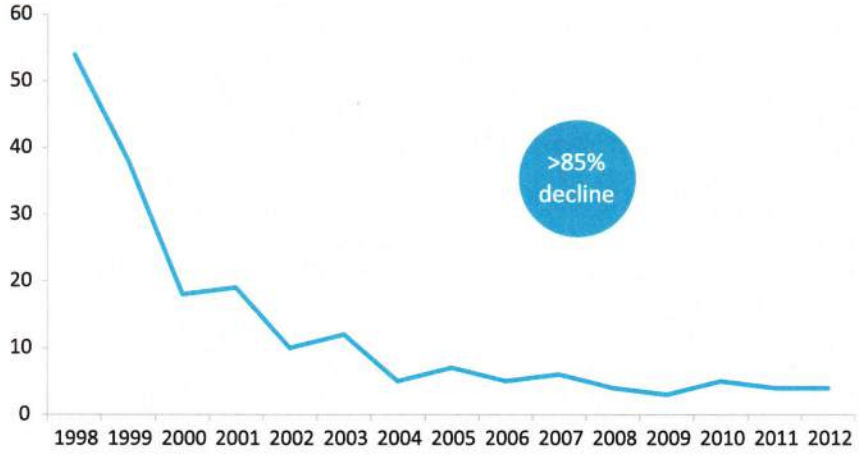
Source: ANC SS Survey, Eritrea

With decreasing trends in HIV incidence and increasing use of antiretroviral therapy, HIV-related deaths are decreasing and are expected to continue decreasing. Data on the annual number of AIDS cases and AIDS deaths and HIV prevalence among pregnant women, blood donors and voluntary counselling and testing clients suggest a reversal and stabilization of HIV infection rates within the general population,

3.3.1. Malaria control

Eritrea faced serious malaria epidemics following an unusually heavy rainfall in 1998 and the 1997 El Nino. It has been estimated that approximately 7 to 12 working days are lost on average per episode of malaria, which has an enormous impact on the productive labour force. By 2006, malaria morbidity had decreased by 74 per cent, mortality by 85 per cent and case fatality by 78 per cent. The number of cases per 100,000 plunged by 92 per cent between 1998 and 2006 (World Bank). By 2008 malaria accounted for just 1 per cent of all deaths among children under five, representing a major success story within sub-Saharan Africa. Malaria morbidity has declined by more than 85 per cent and mortality due to malaria by 90 per cent. According the World Health Statistics the incidence of malaria in 2012 was 1,282 per 100,000 (WHO, 2014), moving the country towards malaria pre-elimination status. The Government does note, however, that the incidence of malaria cases has risen over the last three years.

Figure 7: Annual Trend of Malaria Incidence per 1000 Population at Risk, 1998 – 2012



Source: Based on Health Facilitiy Reports, 1998-2012

3.3.2. Community-based management of malaria

A total of 4,067 Community Health Agents (CHAs) have been trained since 1999 to focus on 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. In 1998, the CHAs treated an estimated 51.7 per cent of all cases of malaria in Eritrea. The 2012 Malaria Indicator Survey showed that 24.2 per cent of respondents had seen or heard messages related to malaria from CHAs. The training and deployment of CHAs has been an innovative and effective strategy to control malaria both in the short and long terms.

There is an ongoing retraining of CHAs on home management of malaria, environmental control, use of insecticide treated bed nets, and early health seeking. Between 1,800 and 2,000 CHAs have been covered so far.

3.3.3. Tuberculosis control

As shown in table 2, the incidence of tuberculosis per 100,000 has decreased by 60 per cent, from 243 in 1990 to 97 in 2011. During the same period, tuberculosis prevalence per 100,000 decreased by 68 per cent, from 478 to 151. Mortality due to tuberculosis decreased by 61 per cent, from 12 per 100,000 in 1990 to 4.7 per 100,000 in 2011. According to the World Health Statistics, tuberculosis prevalence per 100,000 decreased from 192 in 2000 to 152 in 2012 (WHO, 2014).

Table 2. Progress in combating tuberculosis, 1990 – 2011

Indicators	**Estimates per 100,000 population**		**Per cent reduction 1990-2011**
	1990	2011	
Incidence	243	97	60
Prevalence	478	151	68
Mortality due to TB	12	4.7	61

Incidence of TB is less than the global average of 125/100,000 population & Africa average of 243/100,000.

Source: Health Bulletin, MOH (b)

3.3.4. Life expectancy trends

Life expectancy trends are usually taken as a summary indicator of many other health indicators. As shown in table 3, life expectancy at birth increased significantly from 48 years in 1990 to 63 years in 2012. This is partly due to reductions in infant and child mortality, as well as the reduction in adult mortality due to malaria and other communicable diseases.

Table 3: Eritrea, life expectancy

Life expectancy (years)	**Both sexes**		**Male**		**Female**	
	1990	**2012**	**1990**	**2012**	**1990**	**2012**
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 PROGRESS TOWARDS THE HEALTH MDGS

4.1. Cross-cutting innovative strategies driving progress towards health MDGs

The Government places a high priority on health and is committed to achieving and sustaining the progress made towards achieving its health-related goals. The Government particularly appreciates and continuously emphasizes the decisive role of all Eritreans in development and self-reliance programmes at all levels. The innovative best practices used early on to achieve strong progress in health were initiated by the Eritrean People's Liberation Front (EPLF) prior to independence and have been consolidated since independence. Chief among these is the adoption of the Primary Health Care (PHC) approach as a principal strategy.

The Eritrean development process has been an inter-sectoral collaboration. Under the School, Health and Nutrition Project, the health and education sectors coordinate closely to address the specific needs of children and youth from kindergarten to secondary school.[1] The Government realised that schools were the only institutions that could reach even the most remote areas and so began using schools to implement health interventions by training teachers to be allies for health workers. Tasks include regularly monitoring and screening students for basic health problems, and providing lectures on topics in health education such as nutrition, hygiene, HIV and AIDS prevention and life skills.

4.2. Efforts towards universal health coverage

In the Eritrean health care planning and delivery process, the drive for equity calls for universal coverage, with care provided according to need. In principle, no one should be left out, no matter how poor or how remote they are. 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 services for defined populations, and for determining differential needs in all administrative locations.

[1] World Bank (2008) 'One Childhood.' Documentary Film on School Health and Early Child Development in Eritrea. Asmara: World Bank.

4.3. Integrated health service provision in Eritrea

The 2010 Overseas Development Institute study of Eritrea's progress towards the health-related MDGs concluded that the success of the Eritrean experience was particularly due to the cost-effective inter-sectoral interventions and the Government's long-term approach to tackling the country's health issues.[2]

The Government runs a coordinated and stratified three-tier health care delivery system that has also proven capable of meeting the needs of communities at all levels. 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 the basic health care package (BHCP) services by empowering communities and mobilizing and maximizing resources. The key delivery agent is the community health worker led by the Village Health Committee;

(ii) Health Stations offer facility-based primary health care services to a catchment population of approximately 5,000-10,000;

(iii) The 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 also deliver obstetric and general surgical services with the aim of providing vital life-saving surgical, medical and other interventions.

4.4. Strategy of comprehensive service delivery

The MoH increasingly emphasizes promoting and preventive services in addition to curative services. Examples include the improvement in the percentage of immunized children, from about 10 per cent in 1991, to more than 95 per cent today; the reversal and stabilization of HIV infection in the general population at less than one per cent prevalence; the elimination of polio and neonatal tetanus; and the control of measles and malaria.

[2] Progress in health in Eritrea: Cost-effective intersectoral interventions and a long-term perspective, p. 6.

4.4.1. Community involvement

Eritrean communities have a long-standing culture of being actively involved in all issues. Their investment in the country's political, social and economic issues is one of key drivers of the made towards the health-related MDGs. Studies have shown that one of the key success stories of Eritrea's development process is its ability to mobilize and motivate communities to participate in the design, development and utilization of programmes, including those related to health..

4.4.2. Intersectorial approaches

The success of inter-sectoral collaboration in Eritrea is demonstrated by approaches 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 of these approaches have had positive and substantial impacts on the health-related MDGs. Experience has shown that communities often responded more eagerly to broader, localised and bread and butter approaches to development, as opposed to fragmented sector-specific approaches.

4.4.3. Political commitment and leadership

The Government emphasizes the importance of communities developing self-reliance and inter-sectoral approaches to health, as well as the affordability and sustainability of all interventions and programmes. The National Health Policy and the Health Sector Strategic Development Plan (2011-2015) were formulated with a clear understanding of the principles and imperatives of the above-discussed strategies. Organizational structures and capacities are also set to extend services and support this well acculturated development process and agenda in Eritrea.

5. CHALLENGES TO SUSTAIN AND IMPROVE THE HEALTH-RELATED MDGS IN ERITREA

5.1. Need for more money for health

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 should articulate who is covered for what, what services are covered, and how much of the cost is covered. Health financing is much more than a matter of raising money. 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 in which Eritrea would benefit from learning about the experiences of others.

5.2. Need for more health for the money

Raising sufficient money for health is crucial, 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 is how can Eritrea get the 'best bang for the limited dollar'? Efforts are currently being made to continuously improve the quality of health care services and to institutionalize systematic approaches to measuring and ensuring optimal levels of quality in health service provision.

5.3. Maternal and child health

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

Despite commendable achievements in the control and prevention of malaria, the threat of resurgence due to climatic changes, cross border transmission and the national strategy on irrigation expansion for food security, remains a real threat in the foreseeable future. The remarkable progress in this area should not lead to complacency.

5.4. Non-communicable diseases (NCDs)

NCDs are becoming a menace in Eritrea. 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 combined with the prevailing disease burden of communicable diseases pose a double disease burden challenge.

5.5. Human resources for health

The rapid expansion of the health infrastructure since independence to cater to 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 the 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 combined 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.

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. The aim should be to reduce, the economic risks to individuals and households and concurrently generating additional resources to support the achievement of the sectors' strategic objectives.

6. LESSONS LEARNED AND IMPLICATIONS FOR THE POST-2015 DEVELOPMENT AGENDA

6.1. Summary of lessons learned

With less than 500 days to MDG deadline, many countries have started to note lessons that can assist in the formulation and management of its successor framework. The lessons drawn from the Eritrea's successes in the health sector which could help formulate, shape and implement the post-2015 global development agenda include:.

1) A strong Government, with the ability to motivate and mobilise people behind a clear goal is key to progress. The EPLF has managed to generate a unique sense of community among a diverse group of ethnicities and religions.

2) Community participation and involvement in health service delivery both helps, alleviate shortages of skilled staff and brings, services closer to the community. This has also had an important impact on awareness at the community level and, as such, has removed barriers to the dissemination of health information.

3) Investment in human capital as a key driver of development. 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.

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.

6.2. Post-2015 development agenda

The establishment of a post-2015 development agenda will need to capitalise on the strengths of the MDGs, while also 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-Saharan Africa. The impact of climate change is also affecting our planet to a much greater extent. The global discussion on these issues has already begun and Eritrea should not miss the opportunity to contribute to those global discussions and help to shape the post-2015 development agenda.

6.3 Shaping the national discussion on the post-2015 agenda

There are increasing calls to go beyond the MDGs and address challenges that are now becoming critical for our common global wellbeing.[3] Many of these elements and principles were addressed in the Millennium Declaration but did not into the MDGs. Four issues stand out: inclusive growth and decent jobs; governance and accountability; peace and security; and environmental sustainability. Participants in the majority of post 2015 consultations also clearly shown how important certain values are, such as equality. 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.

6.4 Where do we go from here and how?

Greater commitment, stronger action, enhanced resources and better partnerships are required to deliver the 'world we want'. The post-2015 agenda requires the mobilization and equitable sharing of resources, especially for countries that require them the most, in order to complete the unmet MDGs, while focusing on the next agenda. Eritrea is ready to be part of that global dialogue and planning.

[3] 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.

THE STATUS AT A GLANCE

GOAL 4: REDUCE CHILD MORTALITY

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

GOAL 5: IMPROVE MATERNAL HEALTH

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

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Target 6A: Have halted by 2015 and begun to reverse the spread of the HIV/AIDS	1993-95	2001-03	2010	2013	Target 2015
Indicator 1: HIV prevalence among population aged 15-24 years	-	2.4	0.93	-	0
Indicator 2: Condom use at last high-risk sex (%) (Male)	-	2	91.9	-	100
Indicator 3: Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (%)	-	96	27.9	-	100
Male			33.8		
Female			24.7		
Indicator 4: 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		
Target 6B: Achieve by 2010 universal access to treatment for HIV/AIDS for all those who need it					
Indicator 1: Proportion of population with advanced HIV/AIDS infection with access to antiretroviral drugs	-	-	-	-	100
Target 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major disease					
Indicator 1: Incidence and death rates associated with malaria (per 1,000)	-	36	12	-	0
Indicator 2: Proportion of children under 5 sleeping under insecticide-treated bed-nets	-	4	27.9	-	100
Male			28.4		
Female			27.4		
Indicator 3: 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		
Indicator 4: Indicator 4: Incidence, prevalence and death rates associated with tuberculosis (estimates per 100,000)	**1990**			**2011**	
Incidence of TB	243	-	-	97	0
Prevalence of TB	478	-	-	151	
Mortality due to TB	12	-	-	4.7	
Indicator 5: 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)

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For more information or queries please contact:
Dr Mismay Ghebrehiwet,
Office of the Minister, Ministry of Health,
Asmara, Eritrea,
Tel: +291 -1-121562
Email: gmismay@yahoo.com