Eritrea: The First Achiever of All Three Health Millennium Development Goals in WHO Africa Region

Abridged Report

September 2014

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Message from H.E. Amina Nurhussein, Minister of Health

The significant improvements in the health status of the Eritrean populationand the achievements recorded in the Millennium Development Goals are a result of a concerted effort by government, citizens, civic and community leadership, and development partners. Among the crucial factors that can be mentioned are good policy and programs, accelerated human resource development, construction of an expanded network of healthcare facilities, availability of appropriate drugs, supplies, and equipment, and sustained political commitment. All of these contributed substantially to health awareness and improved citizens' access to quality and timely healthcare. In the period since national liberation 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 care facilitieswithin a radius of 5 kilometers.

In brief, the progress made in the health sector over the past two decades resulted in a reduction in under five mortalityfrom 150 per 1,000 live births in 1990 to 50in 2013. During the same period, the maternal mortality ratio decreased from 1,700 per 100,000 live births to 380.

HIV prevalence was halted at a low level, below 1 percent, while its incidence has decreased from 45 per 100,000 in 2001 to less than 8 in 2012. Morbidity and mortality due to malaria havedecreased 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.

These 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.Accordingly, Eritrea is the first, and so far the only country in WHO-Africa Region to achieve all three health MDGs.

Although much has been achieved so far, much more remains to be done especially in the case of non-communicable diseases such as cardio vascular diseases, diabetes, hypertension, cancers, liver diseases, etc. These emerging diseases are already among the ten leading causes of morbidity and mortality in adults. This has created a situation where the country has to tackle a double disease burden. Taking into account thisincreasing trend of non-communicable diseases, the Government of Eritrea is taking actions to prevent, control and manage non-communicable diseases. The effort is being launched without losing focus to the need of sustaining our achievements in the prevention and control of communicable diseases.

As the conclusion of the Millennium Development Goals adopted in 2,000 approaches, many countries have started to draw lessons from the implementation of the MDGs in formulation and management of its successor. Accordingly, it is our sincere hope that useful lessons can be drawn from Eritrea's successes so far in the area of health MDGs. The Ministry of Health of the State of Eritrea is prepared to share our experience as well as to learn from the experiences of other nations.

1. Health Millennium Development Goals (MDGs)

1.0 Introduction

1.1 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. 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, DebubawiKeihBahri, Gash-Barka, Maekel, and SemenawiKeihBahri, 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.

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).

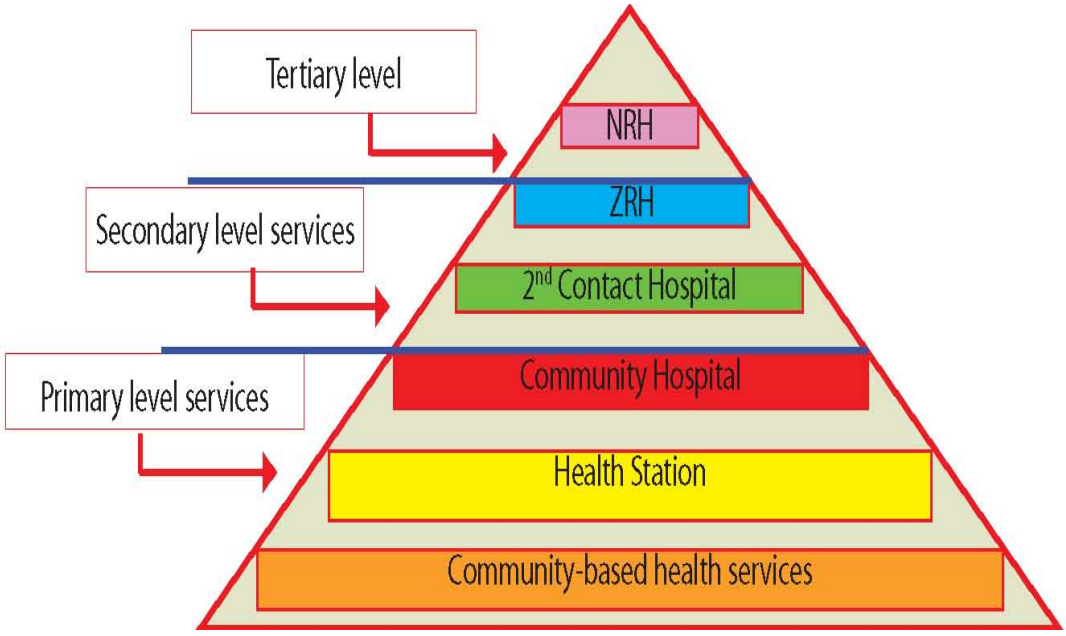
1.2 Health Services Background

Although modern health and medical care was introduced in Eritrea at the end of the 19th century by the Italian colonialists, the people of Eritrea did not have access to the services> In successive colonial occupations, the healthcare system was designed to serve the purpose of the colonialists. Hence, at the time of national liberation in 1991, the health status of the Eritrean people was very poor. This was reflected in the findings of the Eritrean Demographic and Health Survey (EDHS) undertaken in 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 Government of the State of Eritrea initiated the process of building a national healthcare system by adopting a policy based on the principles of primary health care. Furthermore, it quickly developed appropriate strategies 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 servicesystem with fairly equitable access.

At present, the Government, through the Ministry of Health, is the main healthcare provider in the country. As described in the 2012-2016 Heath 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).

Figure 1: Eritrea three tier health delivery structure



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

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

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

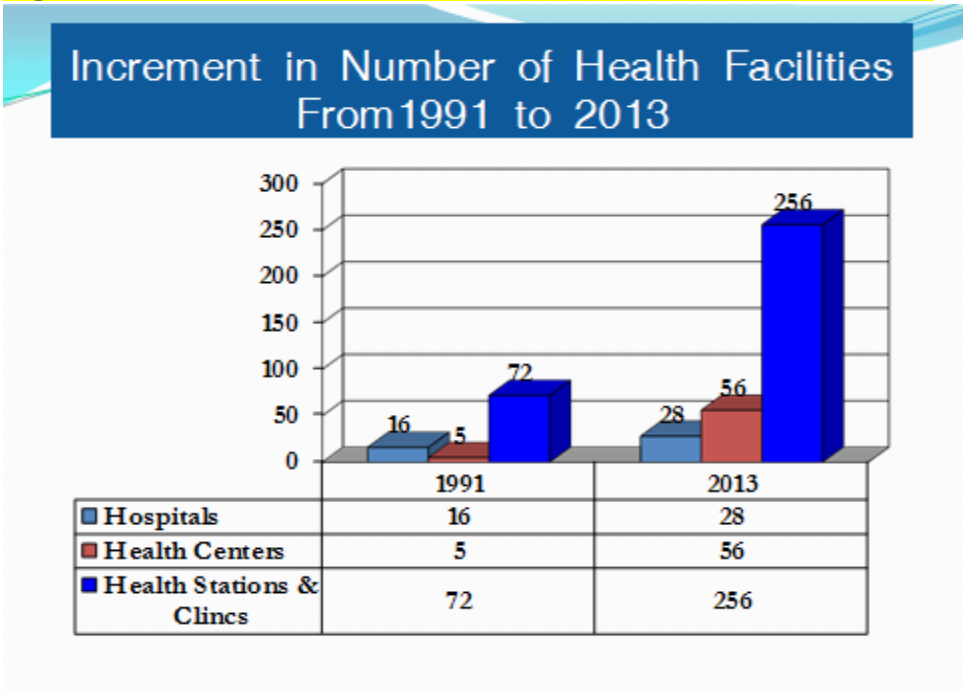
According to the National Health Policy (NHP 2010) and Health Sector Strategic Development Plan 2012-2016, Health Centers shall be phased out by gradually being upgraded to community hospitals. Ifand when upgrading them is not necessary due to the availability of another nearby hospital, theymay be downgraded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

Based on the Health Sector Strategic Development Plan 2012-2016, secondary level services are to beprovided 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 2, since liberation 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 3 and 4, 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.

Figure 2: Increment in number of health facilities, 1991 to 2013



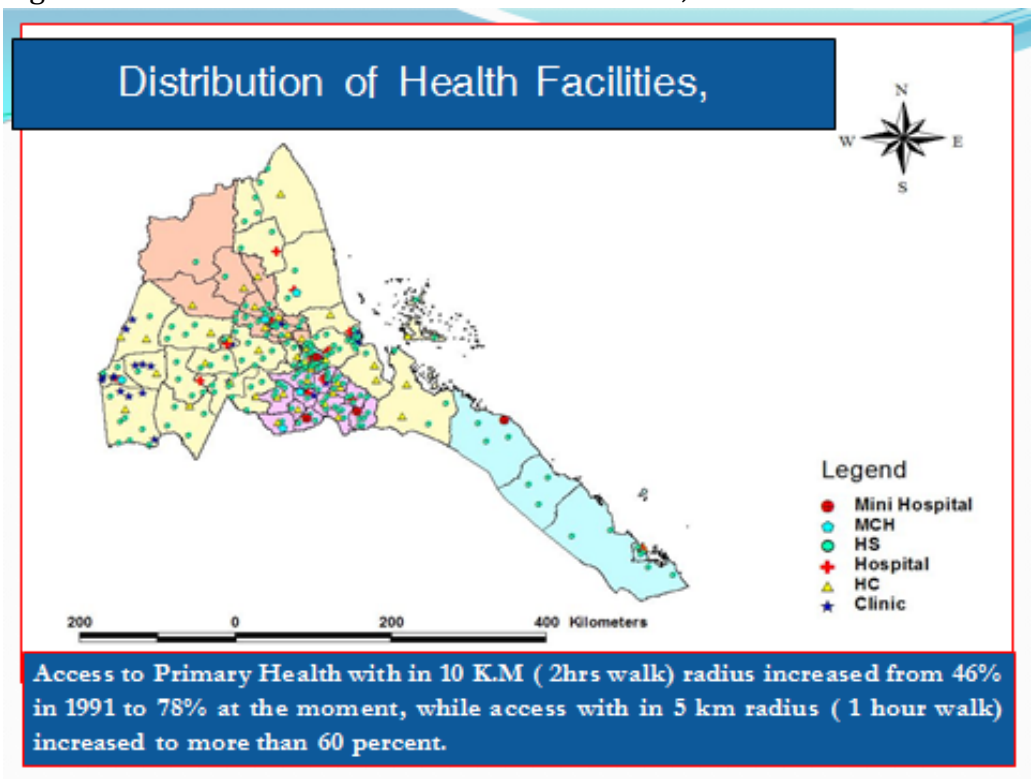
Source: Health Bulletin (MOH (b), 2013)

Figure 3: Some Hospitals Constructed after Liberation

Figure 4: Qualitative Change: Upgrading Health Facilities

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, over60 percent of the population live within 5 kms. from a health facility (figure 5).

Figure 5: Distribution of health facilities in Eritrea, 2014



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

1.3 Background to the MDGs

The eight MDGs based on agreements made at United Nations conferences in the 1990s, represent commitments to reduce poverty and hunger, and to tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation.

Three out of the eight goals (Goal 4 - reduce child mortality, Goal 5- improve maternal health, and Goal 6- combat HIV/AIDS, malaria and other diseases), eight of the 16 targets, and 18 of the 48 indicators relate directly to health. This report presents a summary of the progress made inEritrea by end of 2010.

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 Millennium Development Goals is the recognition that development is an intersectoral and interdependent process: improved nutrition affects school completion rates, improved education levels contribute to better health, and better health contributes to poverty reduction, and so on.

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. Much of MOH's work, directly or indirectly supports many of the other MDGs, particularly the eradication of extreme poverty and hunger (goal 1) and ensuring environmental sustainability (goal 7) and particularly its water and sanitation aspects.

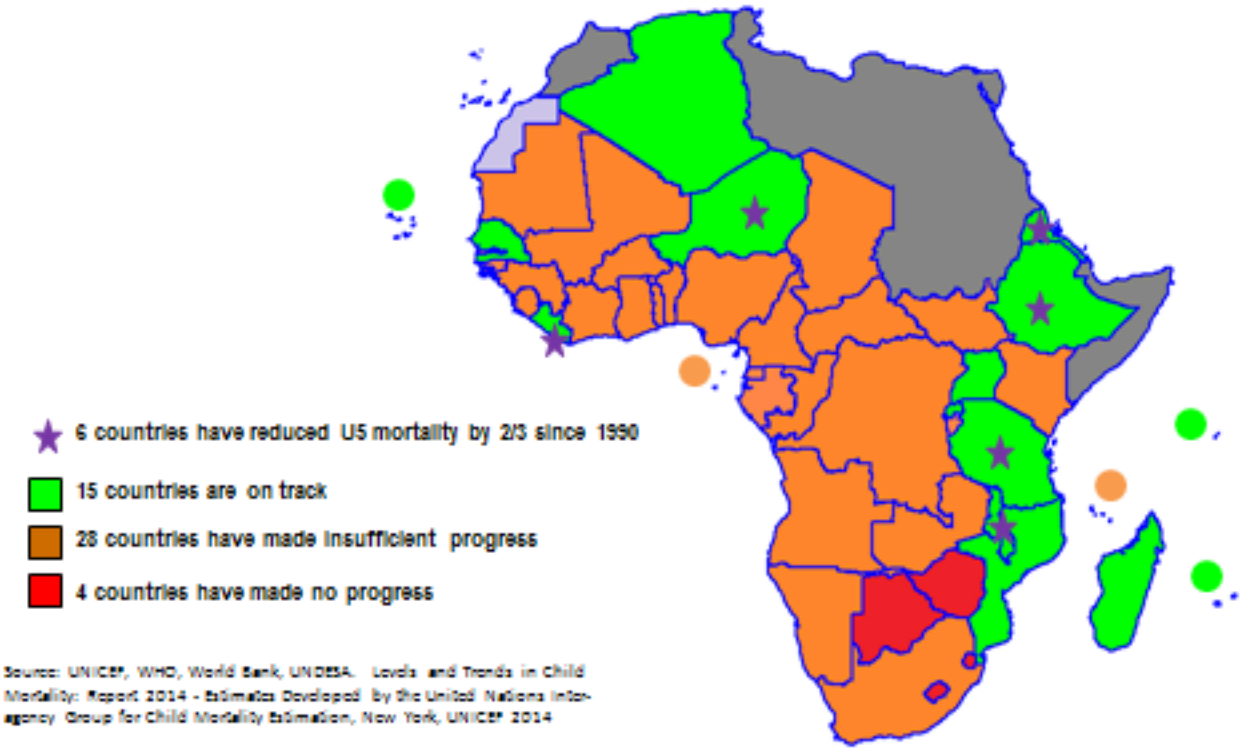
2. Status of Health Related Millennium Development Goals

2.1 Goal 4: Reduce Child Mortality

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 36 in 2013 (WHO, 2014, UNICEF 2014). During the same period, under-five mortality rate per 1,000 live births was reduced from 151 in 1990 to 89 in 2000, and to 50 in 2013 (figure 6) (UNICEF, 2014).MDG 4 calls for reducing under-five mortality by two-thirds between 1990 and 2015. Hence Eritrea hasachieved MDG-4 as of 2013.

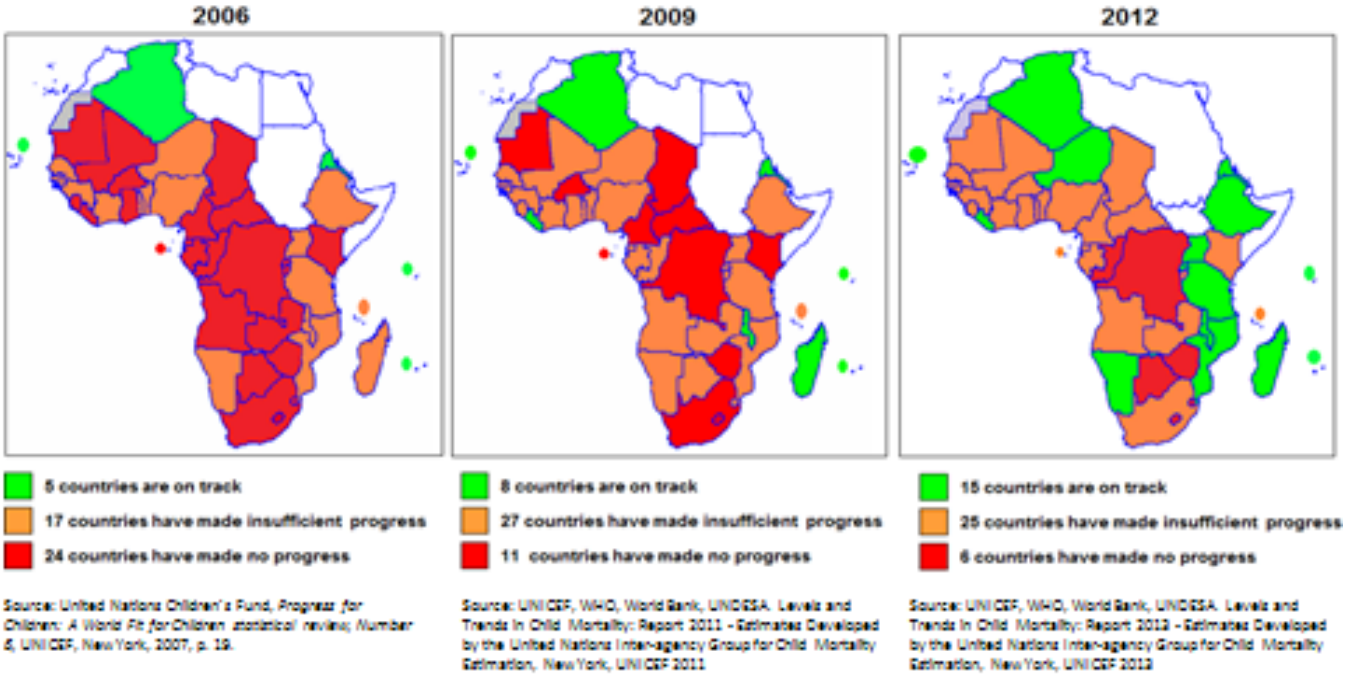
Figure 6: Progress in Reducing Under-5 Mortality Rate by Year

Progress towards achievement of the fourth Millennium Development Goal in the African Region, 2013



Source: UNICEF, WHO, World Bank, UNDESA. Levels and Trends in Child Mortality: Report 2014 - Estimates Developed by the United Nations Inter-agency Group for Child Mortality Estimation, New York, UNICEF 2014

Progress towards achievement of the fourth Millennium Development Goal in the African Region, 2006 to 2012



Source: United Nations Children's Fund, *Progress for Children: A World Fit for Children statistical review, Number 6*, UNICEF, New York, 2007, p. 19.

Source: UNICEF, WHO, World Bank, UNDESA. Levels and Trends in Child Mortality: Report 2011 - Estimates Developed by the United Nations Inter-agency Group for Child Mortality Estimation, New York, UNICEF 2011

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To achieve and sustain this progress, the Ministry of Health (MOH) adopted an 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 began to introduce comprehensive packages of low-cost, high-impact interventions to improve child survival, including:

- Breastfeeding protection and promotion

- Complementary feeding
- Micronutrient supplements to combat iron and iodine deficiencies
- Vitamin A supplementation and supplementary and therapeutic feeding
- Immunization, including Hib vaccine and Haemophilus influenza type B and recently (August 2014) Rota Virus
- Insecticide-treated bed nets
- Prompt treatment for malaria
- Oral re-hydration therapy and zinc supplementation for diarrhea treatment
- Prevention and care of pediatric HIV/AIDS
- Antibiotic treatment for pneumonia, sepsis and dysentery
- Antenatal care and TT vaccination in pregnancy
- Safe delivery and emergency obstetric care
- Essential newborn care including postpartum visits
- Promotion of sanitation, hygiene and hand washing
- 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.

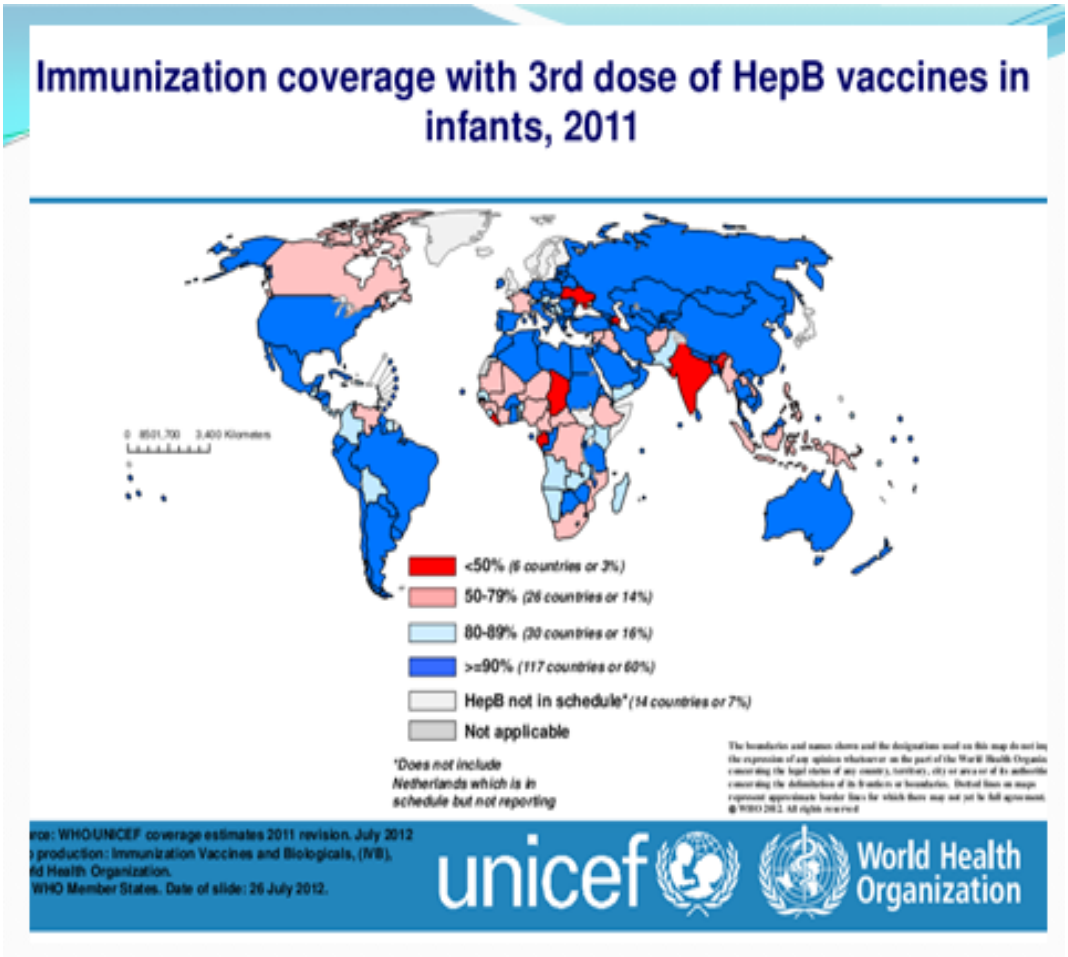
Eritrea's IMCI program was formally launched in 2000, and by 2010, all facilities had at least one health worker trained to manage childhood illnesses in accordance with IMCI guidelines.

An 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 7 and 8, 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.

Figure7: **Immunization Coverage (DPT3), 1991-2013**

Figure8: Immunization Coverage with 3rd 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 9).

At the moment, measles no longer poses 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 10).

Figure9: Twenty Five Countries Eliminated MNT Between 2000 & June 2012

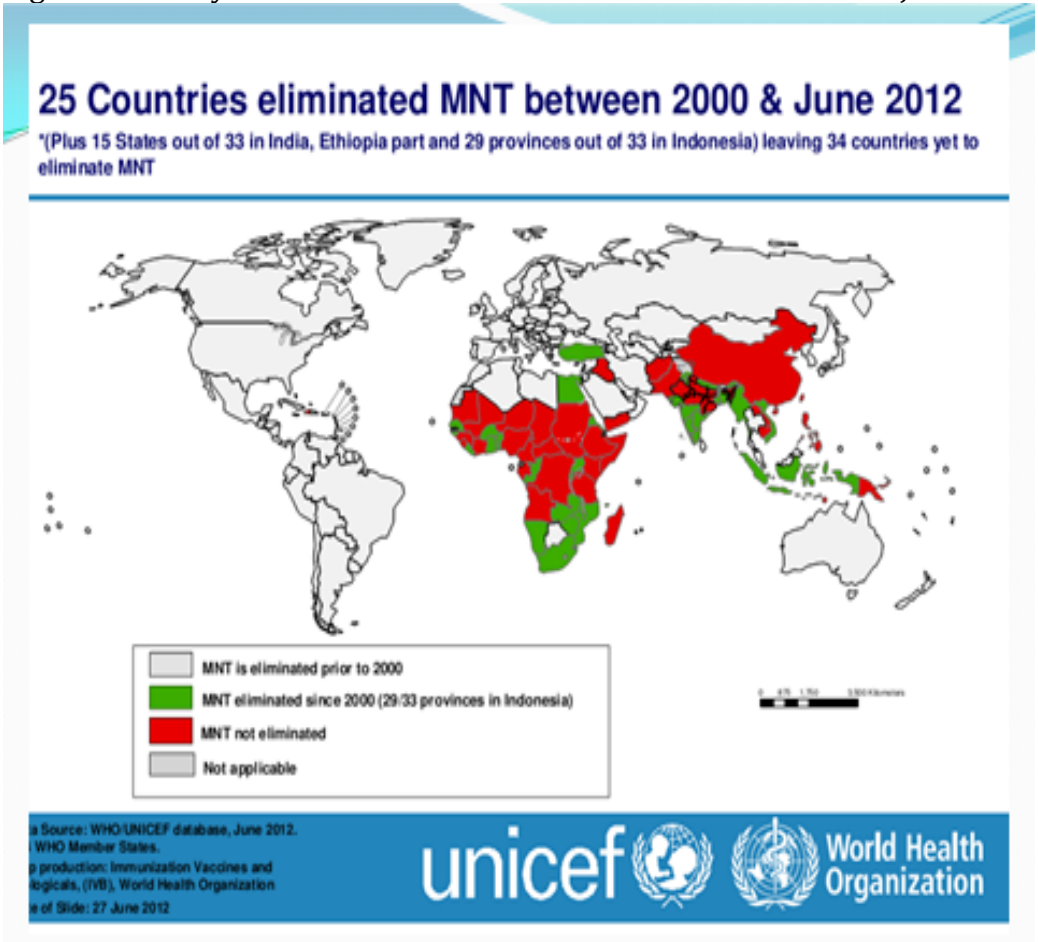
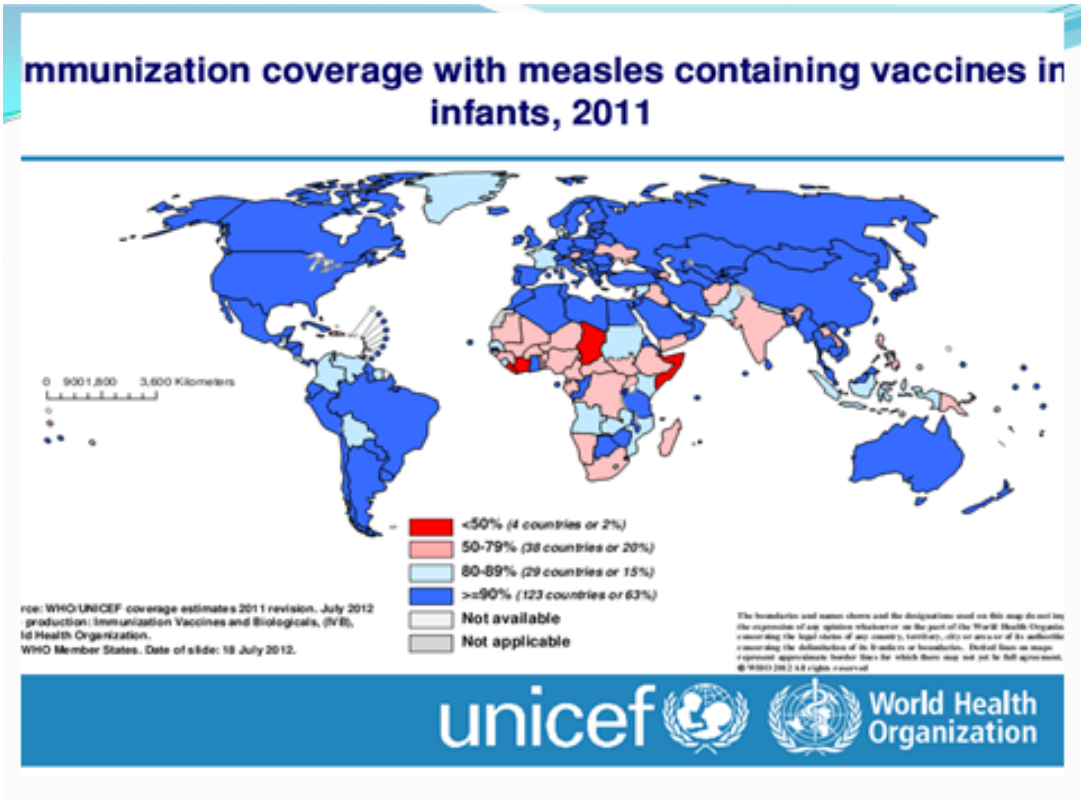


Figure 10: Immunization coverage with measles containing vaccine in infants, 2011



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.

2.2 Goal 5: Improve Maternal Health

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 is live births.

As indicated in figure 11, the world Health Statistics Report 2014, reveals that the Maternal Mortality Ratio has declined from 1,700 per 100,000 live births in 1990 to 670per 100,000 live births in 2,000 and to 380 in 2013 (WHO, 2014). Moreover, it was highlighted in the African Ministers in charge of health meeting in Luanda, Angola, 14 – 17 April 2014 (organized by African Union Commission and the World Health Organization of the African Region) that Eritrea was one of the three African countries that have achieved the MDG-5. One of the strategies that could be taken as best practice in the reduction of MMR could be the building and use of Maternal Waiting Homes in the nearby delivery facilities where pregnant mothers come from remote areas before their expected date of delivery.

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. Eritrea has already achieved the MDG-5, earlier than the due date of 2015 (Fig. 11).

Figure 11: Maternal Mortality Ration (MDG-5)

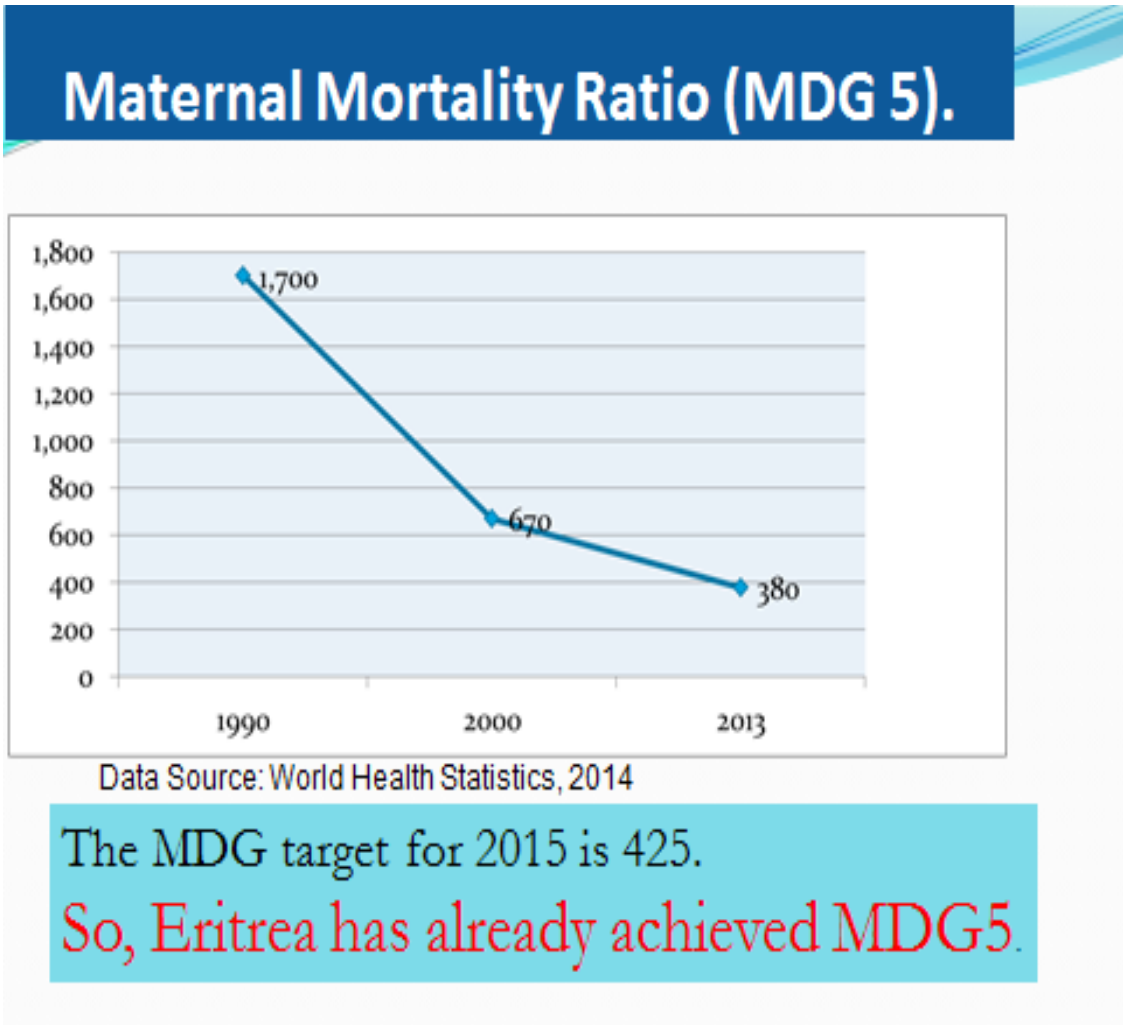


Figure 12 indicates that the antenatal coverage for at least one vest during pregnancy increased from 19 percent in 1991 to 93 percent in 2013. Also as illustrated in figure 13, for the same period, delivery by skilled birth attendant increased from 6 percent in 1991 to 55 percent in 2013.

Figure 12: Antenatal Care Attendance, 1991 - 2013

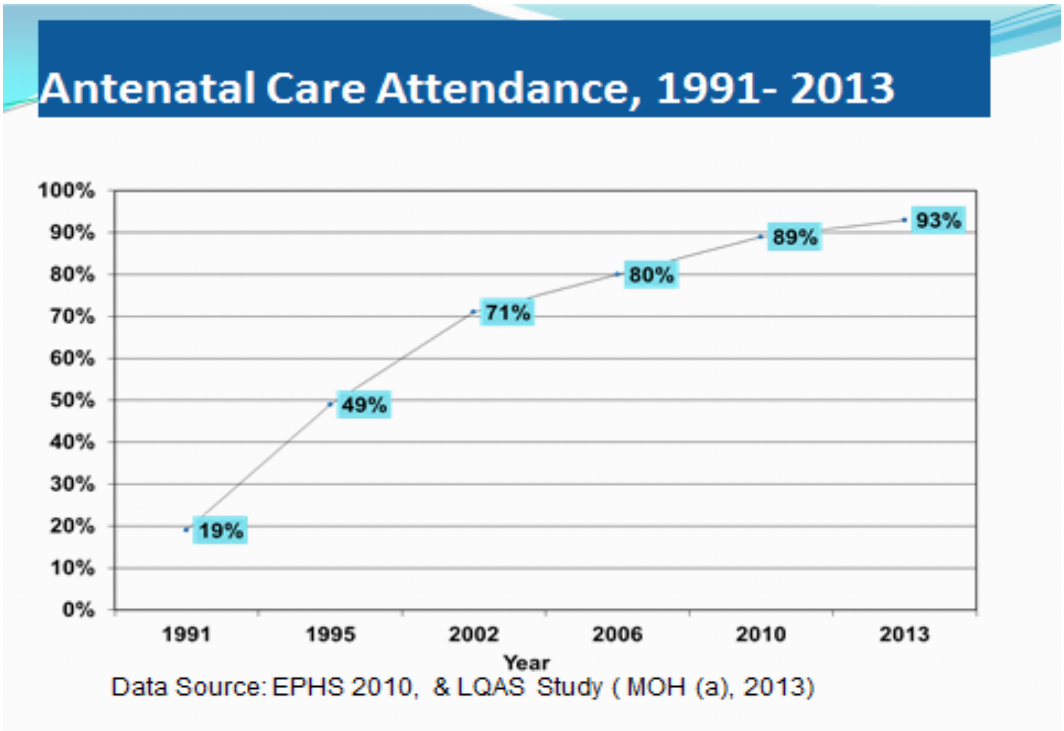
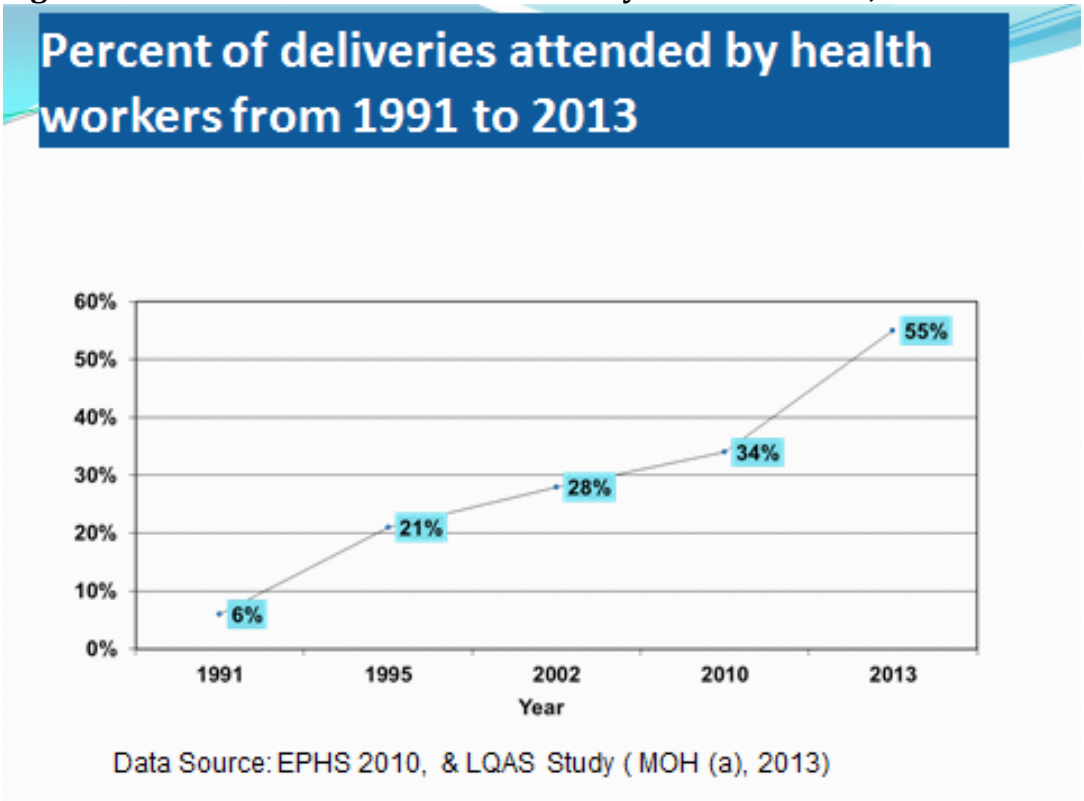


Figure 13: Percent of deliveries attended by health workers, 1991 - 2013



To improve coverage of post natal care the Ministry of Health undertakes a "6-6-6" program, meaning 6hours, 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,thepercentage of mothers who get at least on post natal care is 96 (MOH (a), 2013).

Access to emergency obstetric care services has increased from 21 percent in 1995 to 88 percent in 2013 (increaseof 319%).

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

Controlling the three diseases HIV/AIDS, TB and malaria is crucial to achieving many of the Millennium Development Goals, 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.

2.3.1 HIV-AIDS

Eritrea is committed to halting the spread of HIV and other infectious diseases. The first AIDS case was identified in the port city of Assab in 1988. After thatthe national HIV incidence increased slowly but steadily until the government of independent Eritrea made determined interventions.

The prevention response to HIV-AIDS has focused on the following:

- 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 estimatedthat 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 14, 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.

Figure 14: HIV Prevalence by Age & Sex, EPHS+ 2010

HIV prevalence by age/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	1.50
35-39	2.89	1.61	2.55
40-44	1.32	1.52	1.38
45-49	0.91	0.89	0.90
Total	1.15	0.5	0.93

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 ZobasDebubawiKeihBahri (0.98), Gash Barka (0.84), Debub (0.67), SemanawiKeihBahri (0.66), and Anseba (0.59).

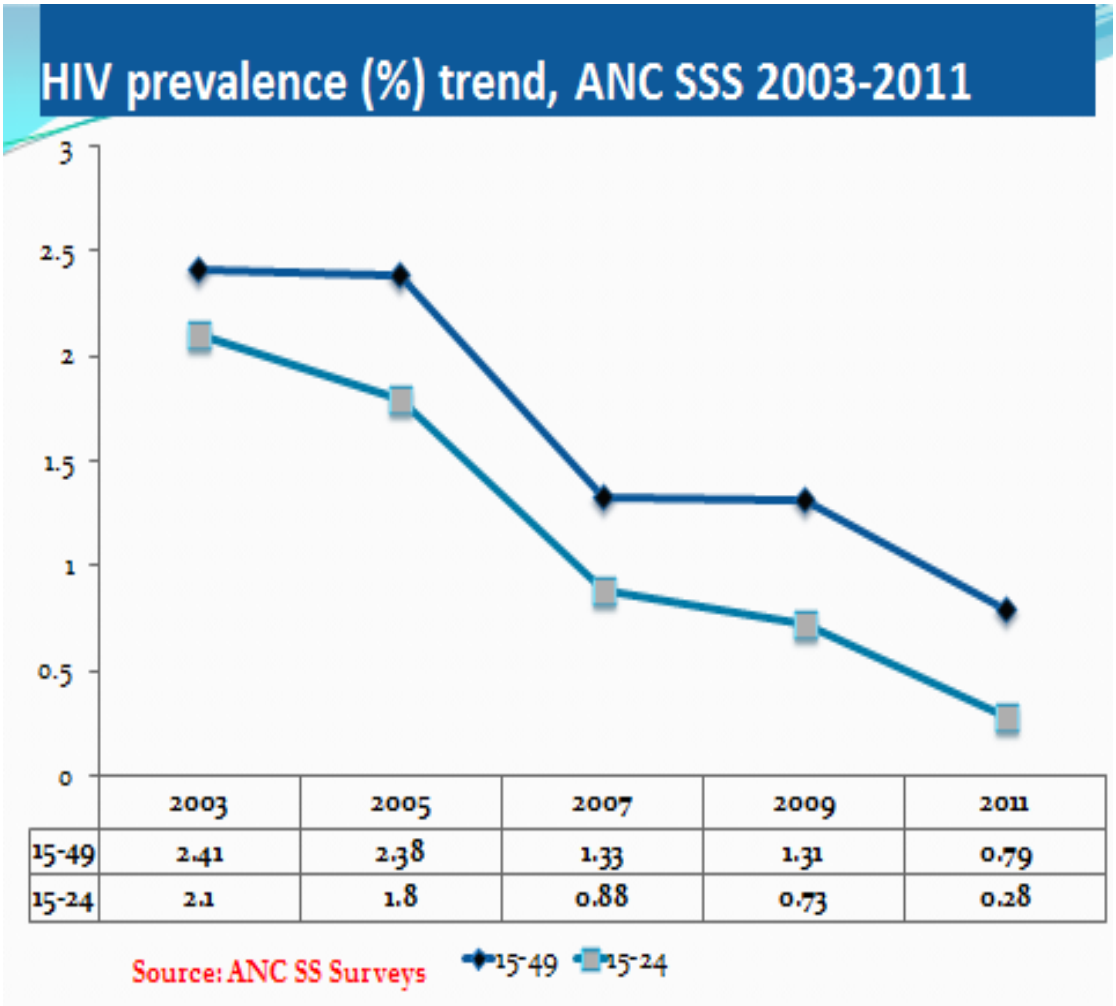
The World Health Statistics (WHO, 2014), indicates that the incidence of HIV AIDS in Eritrea has decreased from 45 per 100,000 population in 2001 to less than 8 in 2012. During the same period, the prevalence of HIV/AIDS decreased from 738 per 100,000 populations in 2001 to 290 in 2012.

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. Women who are pregnant have obviously had unprotected sex for that pregnancy. They are fairly easy to access (even in

resource-constrained settings, most pregnant women come in contact with the formal health system at least once during the pregnancy). Because blood is usually drawn as part of ANC service delivery (e.g., for Haemoglobin testing), it is fairly easy to arrange the logistics of collecting blood samples for HIV/STI testing.

Based on the Sentinel Sites Surveillance reports, Figure 15 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 deceasing incidence of HIV in Eritrea.

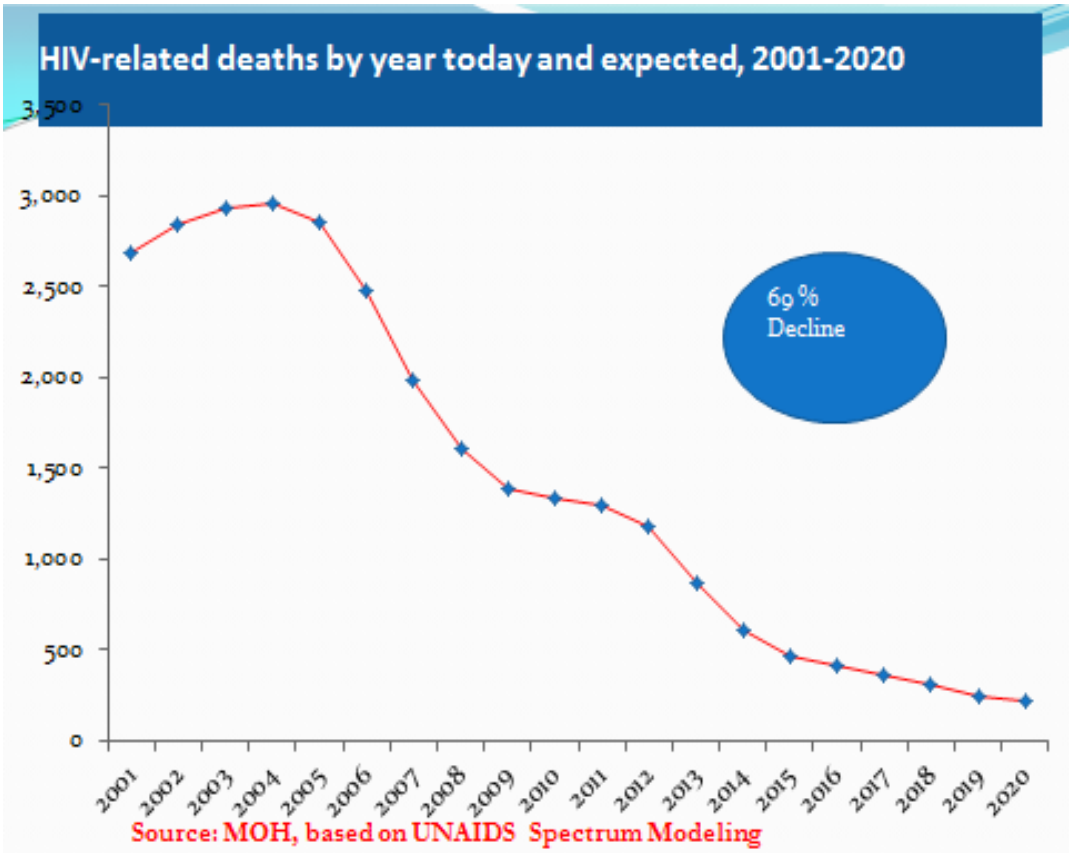
Figure 15:



	2003	2005	2007	2009	2011
15-49	2.41	2.38	1.33	1.31	0.79
15-24	2.1	1.8	0.88	0.73	0.28

With decreasing trend in the incidence and with the increased use of antiretroviral therapy, HIV related deaths have been decreasing and are expected to continue declining (Figure 16).

Figure 16: 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.

2.3.2 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 the 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).

Considering the health, social and economic importance of malaria as a public health problem, the Ministry of Health 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 Ministry of Health in collaboration with other Government agencies, the 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).

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 17 and 18, 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.

Figure 17: Annual Trend of Malaria Incidence Per 1000 Population at Risk, 1998 - 2012

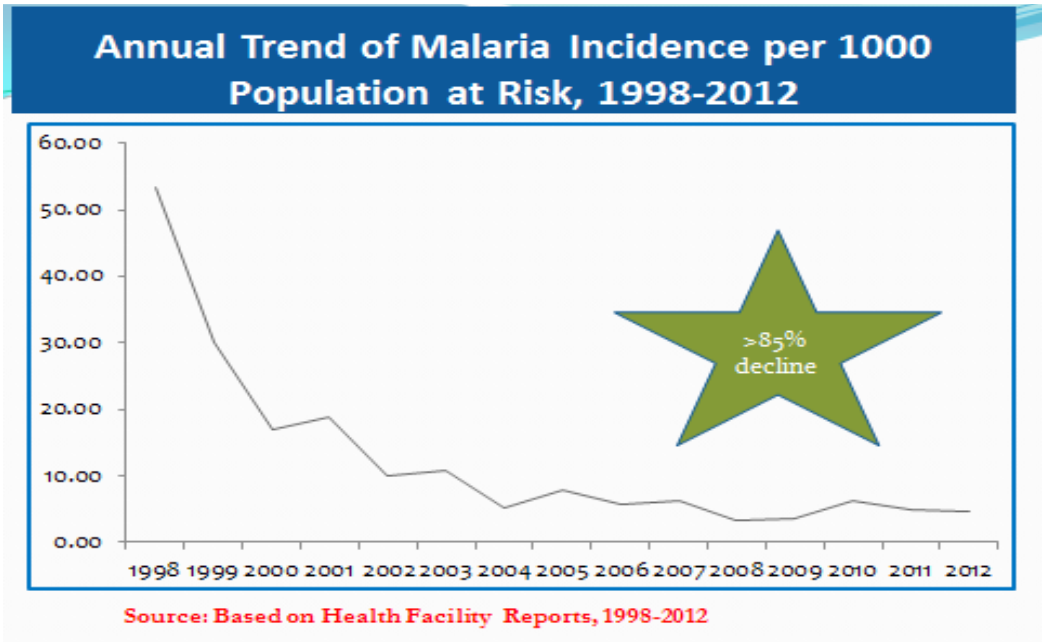
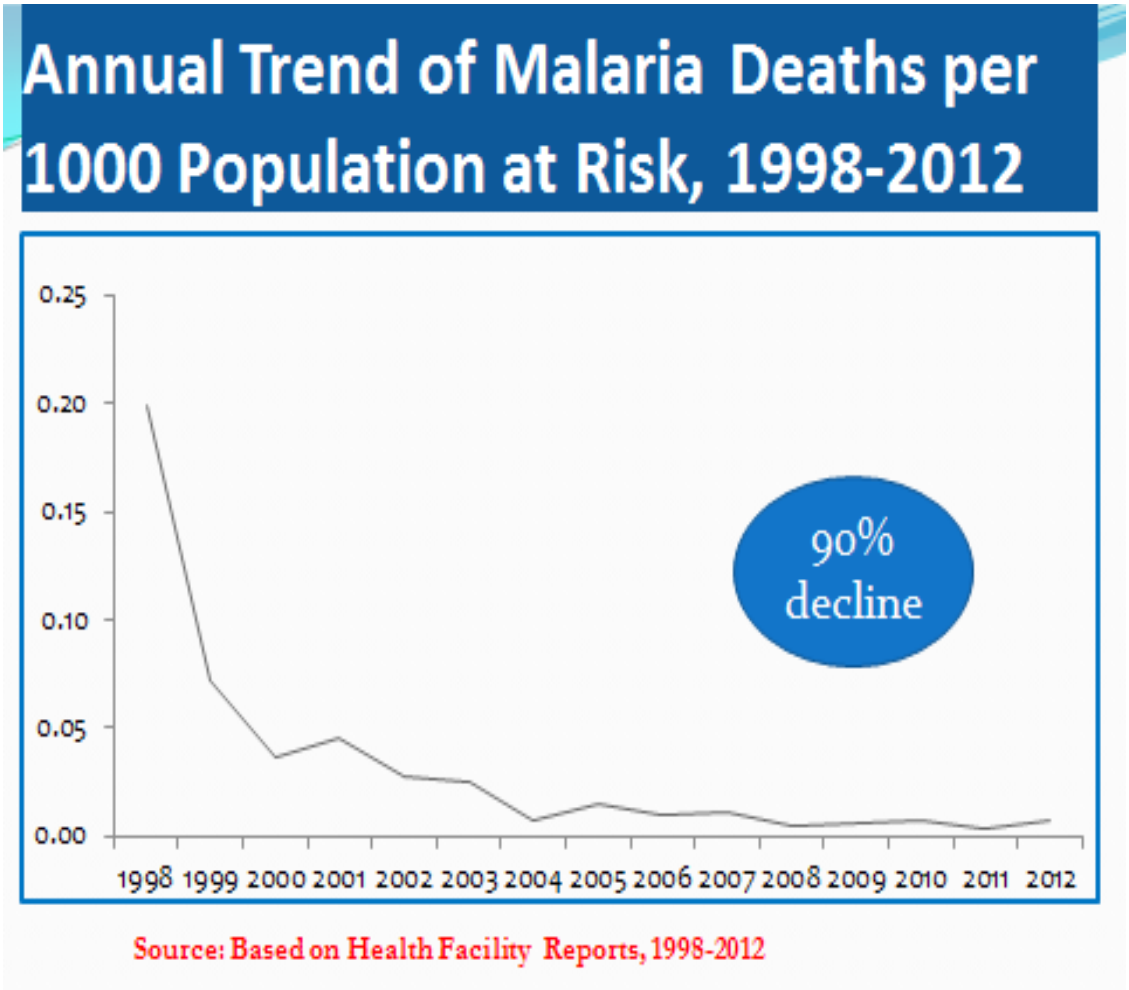
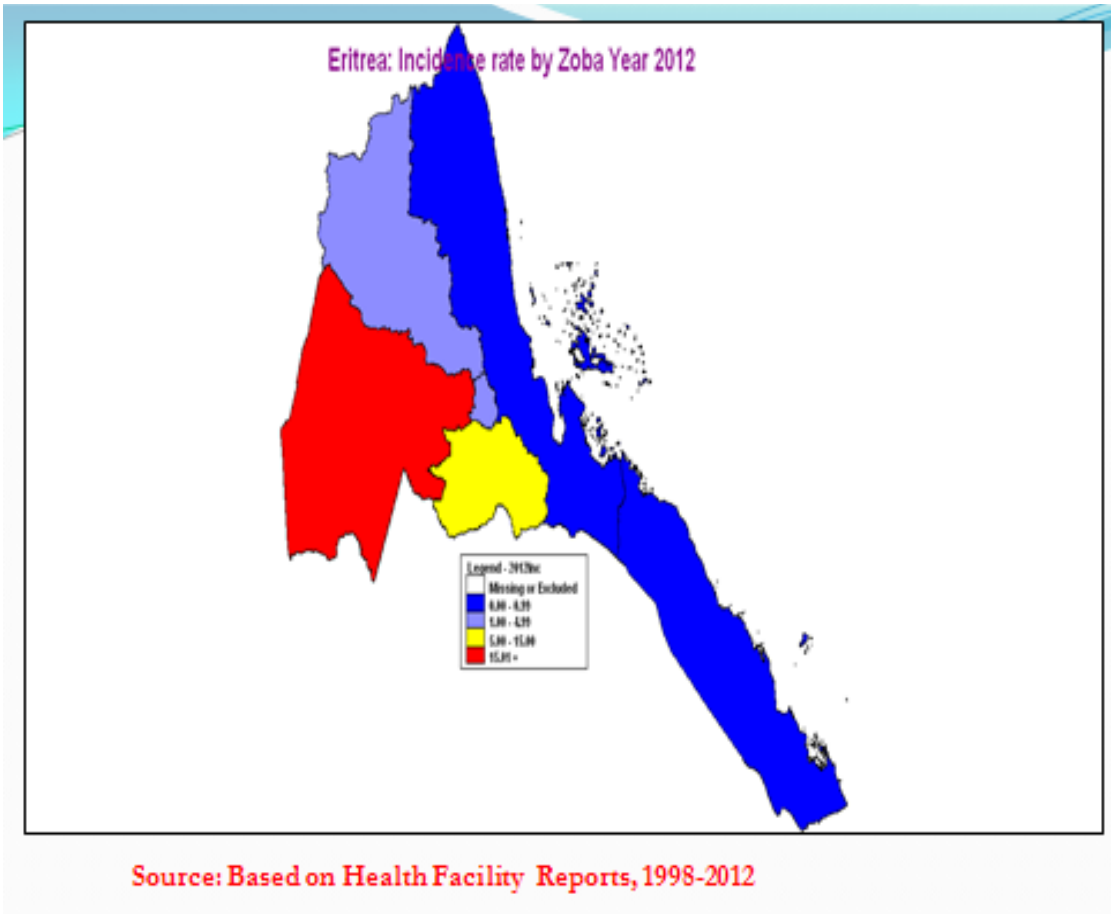


Figure 18: Annual Trend of Malaria Deaths Per 1000 Population at Risk, 1998 - 2012



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 19, 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 froma malaria control mode to elimination of malaria.

Figure 19: Eritrea Malaria Incidence Rate by Zoba in 2012

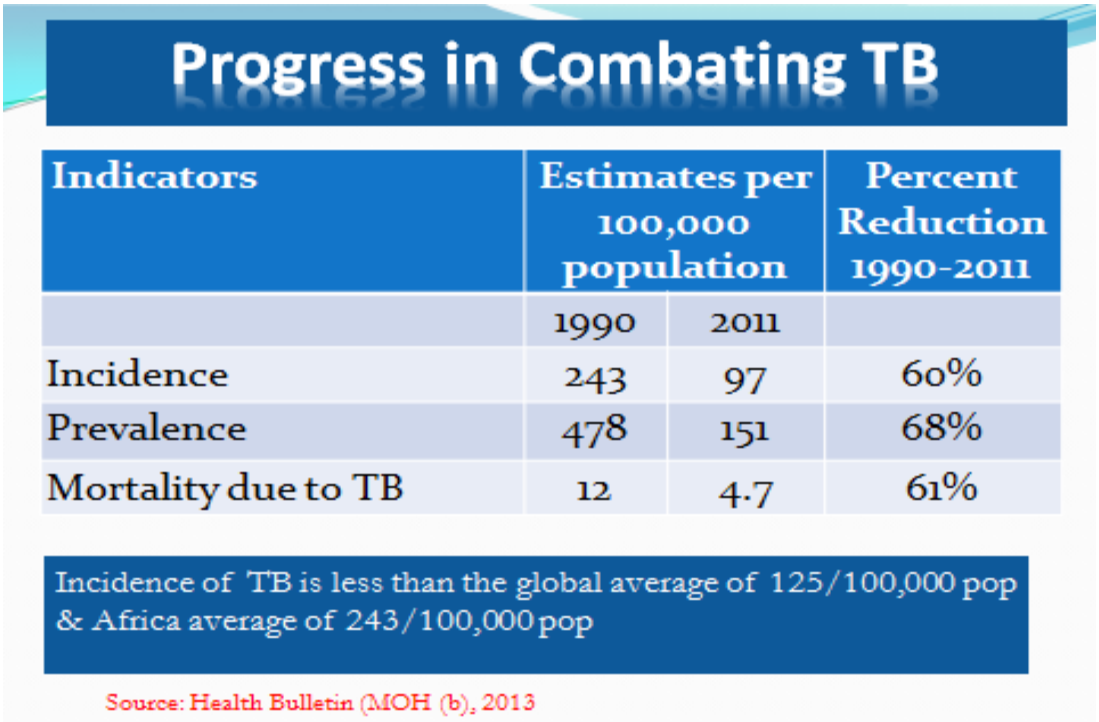


2.3.3 Tuberculosis Control

As revealed in figure 20, 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 form 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.

Figure 20: Progress in Combating Tuberculosis, 1990 - 2011



3. Trends in Life expectancy

Trends in life expectancy are usually taken as a summary indicator of many other health indicators. As revealed in Table 1, 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.

Table 1: 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

Data Source: World Health statistics Report, 2014

4. Opportunities

The political commitment of the State of Eritrea to the betterment of health of the population is one of the biggest opportunities that make the policy environment favourable for progress in health. There are also many other opportunities that are unique to Eritrea, including its history of long struggle for independence and social cohesion. One of the most important contributors to the success in health in Eritrea is its highly responsive population. The following are some of the other factors that contributed to the above noted successes in the area of health:

- Highly socially accountable Government committed to human development and health of the population.
- Highly patriotic, committed and responsive population.
- Policy and strategic orientation based on principles of Primary Health Care
- Community Participation
- Availability of dedicated health workforce
- Highly organized local government and village structure
- The development of good health infrastructure,
- Collateral gain from other development programs, including the availability of good roads
- The experience and existence of a heritage of participatory development and active involvement of communities in prompting health and preventing diseases.
- The technical experience accumulated in running successful Primary Health Care programs and controlling communicable diseases.
- Application and use of advancedbut appropriate health technology
- International partnership

5. Constraints and Challenges

As anywhere else in developing countries there are also constraints and challenges. Among the main challenges/constraints are: -

- Financial constraints;
- Imbalances between various types of health workers (Need of appropriate mix), with absolute and/or relative shortage for some types of health professionals and specialists; and
- Double burden of diseases, with increasing trend of non communicable diseases before communicable diseases are fully controlled.

6. Conclusion

So far, Eritrea is the first,and only country in the WHO-Africa Region that has achieved all the three health MDGs, namely MDGs 4, 5 and 6.

With less than 500 days to the end of the Millennium Development Goals adopted in 2,000, 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.

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