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Eritrean remarkableachievement of MDGs in reducing child mortalityGeneral overview At the start of the new millennium, world leaders assembledat the United Nations to outline a broad vision to fight poverty in its manydimensions. That vision, which was converted into eight Millennium DevelopmentGoals (MDGs), has remained the principal development agenda for the world forthe previous 15 years. As we are reaching the termination of the MDG period, theworld community have many reasons to celebrate. Thanks to determined global, regional, national and local efforts, as a result the MDGs have saved millionsof lives and improved living environments for many more. The data and analysispresented in this report prove that, with targeted interventions, soundstrategies, adequate resources and political will, even the poorest countriescan make dramatic and unprecedented progress. The report also acknowledgesuneven achievements and shortfalls in many areas. The work is not complete, andit must continue in the new development era which is Sustainable DevelopmentGoals (SDGs)Disastrous events withhigh death tolls always make the headlines, and rightfully so. Yet there aremany daily, recurring tragedies in the world which create as much or moresuffering and often go unnoticed.

In early-modern times, child mortality was very high; in18th century Sweden every third child died, and in 19th century Germany everysecond child died. With declining poverty and increasing knowledge and servicein the health sector, child mortality around the world is declining veryrapidly: Global child mortality fell from 18. 2% in 1960 to 4. 3% in 2015; while4. 3% is still too high, this is a substantial achievement. One reason why we do not hear about how global living conditionsare improving in the media is that these

are the slow processes that never makethe headlines: In 1990 7. 6 million children died before they were five yearsold, in 2013 the number of children dying in childhood was downto 3. 7 million.

1 Thishappened at a time when the number of children being born increasedglobally. Unfortunately, the media is overly obsessed with reportingsingle events and with things that go wrong and does not nearly pay enoughattention to the slow developments like these that reshape our world. A media that would report global development could have had theheadline " The number of children dying globally fell by 455 sinceyesterday" and they wouldn't have this headline once, but every single day overthese more than 2 decades. 2Big countries like Brazil and China reduced their child mortalityrates 10-fold over the last 4 decades. Other countries – especially in Africa –still have high child mortality rates, but it's not true that thesecountries are not making progress. In Sub-Saharan Africa, child mortality hasbeen continuously falling for the last 50 years (1 in 4 children died inthe early 60s – today it is less than 1 in 10). Over the last decade thisimprovement has been happening faster than ever before. Rising prosperity, rising education and the spread of health care around the globe are the majordrivers of this progress.

Goal 4: Reducechild mortality targetThe Target Ø Reduce by two thirds, between 1990 and 2015, the under-five mortality rate. The dramatic decline in preventable child deaths over thepast quarter of a century is one of the most significant achievements in humanhistory. Substantial progress in reducing child mortality has been made, butmore children can be saved from death due to preventable causes • The global under-five mortality rate has

declined bymore than half, dropping from 90 to 43 deaths per 1, 000 live births between1990 and 2015. • Despitepopulation growth in the developing regions, the number of deaths of childrenunder five has declined from 12.

7 million in 1990 to almost 6 million in 2015globally. • Since the early1990s, the rate of reduction of under-five mortality has more than tripledglobally. • In sub-Saharan Africa, the annual rate of reduction ofunder-five mortality was over five times faster during 2005–2013 than it wasduring 1990–1995. • Measlesvaccination helped prevent nearly 15.

6 million deaths between 2000 and 2013. The number of globally reported measles cases declined by 67 per cent for thesame period. • About 84 percent of children worldwide received at least one dose of measles containingvaccine in 2013, up from 73 per cent in 2000. Sub Saharan Africachild mortality rateDespite the impressive improvements in most regions, current trends are not sufficient to meet the MDG target. At today’s rate ofprogress, it will take about 10 more years to reach the global target. Theglobal advance in child survival continues to elude many of the world’syoungest children and children in the most vulnerable situations. About 16, 000children under five continue to die every day in 2015.

Most of them will perishfrom preventable causes, such as pneumonia, diarrhea and malaria. Though sub-SaharanAfrica has the world’s highest child mortality rate, the absolute decline inchild mortality has been the largest over the past two decades. The under-fivemortality rate has fallen from 179 deaths per 1, 000 live births in 1990 to 86in 2015. Yet the region still faces an urgent need to accelerate progress. Notonly does sub-Saharan

Africa carry about half of the burden of the world'sunder-five deaths—3 million in 2015—but it is also the only region where boththe number of live births and the under-five population are expected to risesubstantially over the next decades.

This means that the number of under-fivedeaths will increase unless progress in reducing the under-five mortality rateis enough to outpace population growth. Eritreanshowcase towards achieving MDGsEritrea has a positive a unique story to tell about health relatedmillennium development goals (MDGs). Eritrea was among the few an expectedcountry to achieve the MDGs in health due its poor economic condition. Nevertheless, Eritrea has now achieved all the three health related MDGs namely MDG-4, reducechild mortality, MDG-5, improve maternal health and MDG-6, combat HIV/AIDS, malaria and other diseases. Based on the latest data available and through an analysis of thetrends of the 8 MDGs, as well as current supportive policy and politicalenvironment in Eritrea, this report is going to tell about the experience inachieving MDG-4 which is reducing child mortality. Specifically, this report will highlight innovations, bestpractices as well as challenges and bottlenecks that need to overcome in orderto sustain the gains achieved so far. STATUS OF HEALTH-RELATED MILLENNIUM DEVELOPMENT GOALTheset target for this MDG is " reduce by two-thirds, between 1990 and 2015, theunder-five mortality rate.

" Indicators designed to assess its progress are: Under five mortality rate; Infant mortality rate (per 1, 000); and Proportion of one-year old children immunized against measles. Theunder-five mortality rate was 49. 5% in 2013, which already surpasses 50% targetset for 2015; infant mortality was

42% in 2010 and is projected to meet thetarget of 20% by 2015; and the proportion of one-year children immunizedagainst measles was 99% in 2013, which surpasses the target of 98% set for2015. From available statistics as reported, it is evident that Eritrea hasalready achieved MDG 4.

However, this achievement needs to be maintained andeven improved, and the Eritrea authorities are prepared not look back butcontinue the path of improving the status of this MDG in the coming yearsahead. 3. 1.

Goal 4: Reduce Child Mortality MDG 4 calls for thereduction of the under-five mortality rate by two-thirds between 1990 and 2015. The global annual rate of reduction has steadily accelerated since the 1990–1995period, more than tripling from 1. 2 per cent to 4. 0 per cent in the 2005–2013period. Despite these gains, child survival remains an urgent global concern.

Eritrea has witnessed an unprecedented reduction in infant mortality rates per1, 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 mortalityrate per 1, 000 live births was reduced from 150 in 1990, to 89 in 2000, to 50in 2013 (UNICEF, 2014). Eritrea has therefore achieved MDG 4 as of 2013. The Integrated Management of Childhood Illness (IMCI)program was formally launched in 2000, and by 2010, all facilities had at leastone health worker trained to manage childhood illnesses in line with IMCIguidelines. Although there are no current statistics, a recent evaluation ofIMCI implementation confirmed improvements in the use of antibiotics, thequality of care and the level of knowledge and skills of health staff, as wellas a reduced case fatality rate.

To complement the IMCI program, Eritreaintroduced Community IMCI (C-IMCI) in 2005. As revealed in figure 2, immunization coverage for the third dose of the diphtheria, tetanus toxoids andpertussis (DPT) vaccine (and since 1998 with the third dose of the hepatitis Bvaccine) increased from 10 per cent in 1991 to 98 per cent in 2013. As a result of its strong routine immunization program, Eritrea was certified as a polio-free country by the World Health Organization(WHO) in 2008.

Eritrea has maintained its polio-free status, despite itsproximity 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 childrentaking their doses according to schedule. In recognition of Eritrea’s strongimmunization program, the Global Alliance for Vaccine Initiative awarded thecountry for high and sustained immunization coverage on October 17, 2009 inHanoi, Vietnam. DRIVING PROGRESS TOWARDS THE HEALTH MDGS4. 2.

Efforts towards universal health coverage in theEritrean health care planning and delivery process, the drive for equity callsfor universal coverage, with care provided according to need. In principle, no oneshould be left out, no matter how poor or how remote they are. If all cannot beserved, those most in need should have priority.

Here lies the “ all” in thehealth for all mantra. Here also is the basis for planning services for definedpopulations, and for determining differential needs in all administrativelocations. 4. 3. Integrated health service provision in Eritrea The 2010Overseas Development Institute study of Eritrea’s

progress towards thehealth-related MDGs concluded that the success of the Eritrean experience wasparticularly due to the cost-effective inter-sectoral interventions and theGovernment's long-term approach to tackling the country's health issues. 2 TheGovernment runs a coordinated and stratified three-tier health care delivery systemthat has also proven capable of meeting the needs of communities at all levels.

The diagram below attempts to depict how this health care delivery systemworks. (i) Primary level of service consists of community-based health serviceswith coverage of an estimated 2, 000 to 3, 000 people. This level provides thebasic health care package (BHCP) services by empowering communities andmobilizing and maximizing resources. The key delivery agent is the communityhealth worker led by the Village Health Committee; (ii) Health Stations offerfacility-based primary health care services to a catchment population ofapproximately 5, 000-10, 000; (iii)The Community Hospital is the referralfacility for the primary health care level of service delivery, serving a communityof approximately 50, 000-100, 000 people. Community hospitals provide allservices available at lower level facilities, and also deliver obstetric andgeneral surgical services with the aim of providing vital life-saving surgical, medical and other interventions.

4. 4. Strategy of comprehensive service delivery4.

4. 1. Community involvement Eritrean communities have along-standing culture of being actively involved in all issues. Theirinvestment in the country's political, social and economic issues is one of keydrivers of the made towards the health-related MDGs. Studies have shown thatone of the

key success stories of Eritrea's development process is its abilityto mobilize and motivate communities to participate in the design, developmentand utilization of program, including those related to health.

4. 4. 3. Political commitment and leadership The Governmentemphasizes the importance of communities developing self-reliance andinter-sectoral approaches to health, as well as the affordability and sustainabilityof all interventions and program. The National Health Policy and the HealthSector Strategic Development Plan (2011-2015) were formulated with a clearunderstanding of the principles and imperatives of the above-discussedstrategies. Organizational structures and capacities are also set to extendservices and support this well acculturated development process and agenda inEritrea.

5. CHALLENGES TO SUSTAIN AND IMPROVE THE HEALTH-RELATED MDGSIN ERITREA5. 1. Need for more money for health No country, no matterhow rich, has been able to ensure that everyone has immediate access to everytechnology and intervention that may improve their health or prolong theirlives.

Universal coverage should articulate who is covered for what, whatservices are covered, and how much of the cost is covered. Health financing ismuch more than a matter of raising money. It is also a matter of who is askedto pay, when they pay, and how the money raised is spent.

This is one area inwhich Eritrea would benefit from learning about the experiences of others. 5. 3. Maternal and child health as previously mentioned, while more than 90 per cent of pregnant women attend

antenatal care (ANC), onlyabout half are delivered by skilled professional attendants. In addition, whilethere has been drastic reduction in the maternal mortality ratio since 1990 (77per cent), it is still high at 380 per 100, 000 live births. There remains theeven more pressing need to reduce neonatal mortality, which currently accountsfor close to half of infant mortality. Tuberculosis control is also a remainingchallenge that requires the expansion of existing interventions with specialemphasis on the DOTS Strategy in order to improve overall coverage. Despitecommendable achievements in the control and prevention of malaria, the threatof resurgence due to climatic changes, cross border transmission and thenational strategy on irrigation expansion for food security, remains a realthreat in the foreseeable future.

The remarkable progress in this area shouldnot lead to complacency. 5. 5. Human resources for health The rapid expansion of thehealth infrastructure since independence to cater to national health needs ledto a high demand for health personnel. The adoption of primary health care as apolicy priority was effectively implemented with the necessary re-orientationof health workers, including re-training of staff to standardize the skills ofthe different categories of health cadres that existed. Newer reforminitiatives such as decentralization to the zobas have also introduced newhealth resource requirements and further challenges for the sector. With theincrease of non-communicable diseases combined with the burden of communicablediseases, the sector is faced with the challenge of providing specializedservices that require a higher level of skilled staff. In essence, the currentissue is not only numbers but also competency and the right mix of

the healthprofessionals that are able to respond to current, emerging or re-emerginghealth conditions in Eritrea.

5. 6. Health care financing Considering the desireto improve the quality of care in health facilities for a growing populationwith an increasing burden of non-communicable diseases, there is need totransform the financing framework that has been in existence sinceindependence.

The aim should be to reduce, the economic risks to individualsand householdsEnsure healthy lives andpromote well-being for allSincethe creation of the Millennium Development Goals there have been historicachievements in reducing child mortality, improving maternal health andfighting HIV/AIDS, Malaria and other diseases. Since 1990, there has been anover 50 percent decline in preventable child deaths globally. Maternalmortality also fell by 45 percent worldwide. New HIV/AIDS infections fell by 30percent between 2000 and 2013, and over 6.

2 million lives were saved fromMalaria. Despitethis incredible progress, more than 6 million children still die before theirfifth birthday every year. 16, 000 children die each day from preventablediseases such as measles and tuberculosis. Every day hundreds of women dieduring pregnancy or from child-birth related complications, and, in developingregions, only 56% of births in rural areas are attended by skilled professionals. AIDS is now the leading cause of death among adolescents in sub-Saharan Africa, a region still severely devastated by the HIV epidemic. Thesedeaths can be avoided through prevention and treatment, education, immunizationcampaigns, and sexual and reproductive healthcare.

The Sustainable DevelopmentGoals make a bold commitment to end the epidemics of AIDS, tuberculosis, malaria and other communicable diseases by 2030. The aim is to achieveuniversal health coverage, and provide access to safe and effective medicinesand vaccines for all. Supporting research and development for vaccines is anessential part of this process as well as providing access to affordablemedicines. Promotinghealth and well-being is one of 17 Global Goals that make up the 2030 Agenda for Sustainable Development.

An integrated approach is crucial forprogress across the multiple goals. Conclusion References1