Eritrea has recorded significant achievements in disease control and made substantial progress towards the attainment of health MDGs through the implementation of proven interventions. Overall, the health status of the population has improved significantly.

The country has succeeded in reducing its child mortality significantly and is currently on record as being on track with regard to attainment of MDGs 4, 5 and 6. Its infant mortality rate decreased from 72 deaths per 1000 live births in 1995 to 48 deaths in 2002 and 42 deaths in 2010. Under-five mortality rate dropped from 136 deaths per 1000 live births in 1995 to 93 deaths in 2002 and 63 deaths in 2010. Maternal mortality ratio has declined from 998 per 100 000 live births in 1995 to 486 per 100 000 live births in 2010. Challenges however exist in the reduction of neonatal mortality. The outcomes of EDHS 1995 and 2002, and EPHS+ 2010 show that neonatal mortality virtually stabilized at 25, 24 and 23 per 1000 live births respectively.

The eight major vaccine-preventable diseases no longer pose any major public health challenge. The country has eliminated maternal and neonatal tetanus and reduced measles incidence to less than 90% of the 1991 levels. It has been certified as “Dracunculiasis-free” (guinea-worm disease) and has achieved polio-free status with the last polio case reported in 2006. The prevalence of HIV/AIDS is showing a declining trend from year to year. The prevalence of HIV infection in the general population is sustained at less than 1%. The country is moving towards pre-elimination of malaria.

Non-communicable diseases, especially incidence of hypertension and diabetes, cardiovascular diseases, chronic obstructive pulmonary diseases and cancer, are on the rise. Malnutrition remains also as one of the major public health problems in the country.

Although Eritrea has yet to ratify the Framework Convention on Tobacco Control, it is a state party to the International Health Regulation (IHR 2005).

Key gaps and challenges to justify the CCS strategic agenda include: low percentage of pregnant women who have access to skilled birth attendance; high neonatal mortality; the need to prevent, control/manage the double burden of communicable and non-communicable diseases; access to progressive technological advancement in health; high demand for appropriately skilled health personnel; improving the quality of health care, establishing a well-functioning referral system, strengthening the health information system, identification and documentation of traditional medicines, and vulnerability to natural disasters including earthquakes and volcanic eruptions.

### HEALTH SITUATION

Eritrea is not a UN Delivering as One (DaO) country, but within the SPCF there are on-going discussions with other UN agencies including UNDP and FAO to develop joint programmes including on the control of NCDs.

### HEALTH POLICIES AND SYSTEMS

The existing national health policy aims to ensure equity and access by majority population to essential health services at affordable cost, consistent with the Universal Health Coverage principles. The policy prioritizes addressing maternal and child health issues to meet MDG targets and beyond. Other priorities include control of Communicable and Non Communicable Diseases, as well as strengthening Health System components in line with WHO leadership priorities as outlined in 12th GPW and therefore informed strategic agenda of cooperation.

The National health policy is translated into health sector strategic plan as well as other roadmaps and strategies to address identified health priorities. These includes roadmaps and strategies for maternal morbidity reductions; adolescent and child health; HIV, TB and malaria strategies; national joint plan of action on Health and Environment; non-communicable diseases strategic plans including for violence and injuries; medicines quality assurance and registration systems; and HR strategic plan.

The health delivery system in Eritrea is organized in three-tier system namely primary, secondary and tertiary levels. As a matter of government policy, there are no private health facilities operating in the country. However, there is a system of private practice within government health facilities by way of partnership between the Government and health workers. Health insurance scheme is yet to be developed in the country. The development of a health care financing policy and a clear strategy for health system financing remains a gap to be addressed.

### COOPERATION FOR HEALTH

Few development partners, mainly agencies of the UN system, European Union, GFATM, GAVI and JICA provide direct or indirect development assistance to support health development. These agencies contribute to health care financing in the country mostly through specific programmes for disease control and maternal/child health, among others.

In 2012, a Strategic Partnership Cooperation Framework (SPCF) was prepared. In the SPCF the main development partners are the multilateral agencies of the UN system that are to provide continuous support to the Government. Health and nutrition is one of the key outcome areas of the SPCF. Eritrea is not a UN Delivering-as-One (DaO) country, but within the SPCF there are on-going discussions with other UN agencies including UNDP and FAO to develop joint programmes including on the control of NCDs.

### HEALTH INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Adult (15+) literacy rate</td>
<td>85.2%</td>
</tr>
<tr>
<td>Population using improved drinking-water sources (%)</td>
<td>49.9% (Rural), 72.9% (Urban), 57.9% (Total)</td>
</tr>
<tr>
<td>Population using improved sanitation facilities (%)</td>
<td>4% (Rural)</td>
</tr>
<tr>
<td>Poverty headcount ratio at $1.25 a day</td>
<td>42% (PPP % of population)</td>
</tr>
<tr>
<td>Gender-related Development Index rank out of --- countries</td>
<td>NA</td>
</tr>
<tr>
<td>Human Development Index rank out of --- countries</td>
<td>NA</td>
</tr>
</tbody>
</table>

Sources of data: 1 HMIS 2012, 2 EPHS 2010
### WHO CCS STRATEGIC AGENDA (Time frame)

#### Strategic Priorities

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Main Focus Areas for WHO Cooperation</th>
</tr>
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</table>
| **STRATEGIC PRIORITY 1:** Contribute to the achievement of the health-related MDGs through the implementation of high impact interventions; and support the preparation of the health sector to address future challenges through the post-2015 development agenda | MDG 4: Support the attainment of MDG 4 (Reduce child mortality)  
MDG 5: Support the attainment of MDG 5 (Improve maternal mortality).  
MDG 6: Support the attainment of MDG 6 (Combat HIV/AIDS, malaria and other diseases) |

| **STRATEGIC PRIORITY 2:** Support the surveillance, control, elimination and eradication of priority communicable diseases including the neglected and emerging communicable diseases. | NTD: Support the implementation of the national neglected tropical diseases (NTDs) prevention and control master plan – 2013/2017  
IHR: Support the implementation of International Health Regulations (2005) action plan.  
Provide technical support for the elimination and eradication of targeted diseases. |

| **STRATEGIC PRIORITY 3:** Support the surveillance and control of emerging threats of non-communicable diseases | NCD: Support the updating and implementation of the chronic NCDs strategic plan in line with the global strategy for NCDs.  
Mental Health: Support the implementation of the mental health strategic plan.  
Violence and injuries: Support the implementation of the violence and injuries prevention strategic plan. |

| **STRATEGIC PRIORITY 4:** Support the strengthening of the health system components including addressing the social, economic and environmental determinants of health with a view to achieving universal coverage. | Policy Coherence: Provide advocacy and evidence for policy coherence within the health sector and across other sectors.  
UHC: Support the attainment of universal health coverage (UHC).  
SEDH: Provide advocacy and technical support for the development and implementation of strategies for social and environmental determinants of health (SEDH) including risk management and health response to emergencies. |

Number of words of the text of the Strategic Agenda - 600-700 words maximum