

Eritrea finds ways to reach the goal

ERITREA is one of the few countries in sub-Saharan Africa currently on track to meet Millennium Development Goal 4. Its under-five mortality rate fell by roughly 50 per cent, from 147 per 1,000 live births in 1990 to 74 per 1,000 in 2006. The decline can be attributed to a number of factors. Chief among them is increased immunization coverage, leading to a decreased prevalence of vaccine-preventable diseases. Eritrea is polio free, maternal and neonatal tetanus have been eliminated, and there have been no measles deaths during the past two years. There has also been a sharp reduction in malaria morbidity, from 125,750 cases in 2001 to 34,100 cases in 2005, and in malaria mortality, from 129 deaths in 2001 to 38 deaths in 2005.

Since independence in 1993, and after a 30-year-long conflict with neighbouring Ethiopia, Eritrea has made great efforts to ensure access to health-care services by investing in reconstruction of destroyed facilities, training for health workers, and increased provision of drugs and equipment. As part of its strengthening of the health system, the Ministry of Health has used campaigns to protect children from such illnesses as polio and measles and to provide vitamin A supplements to boost the immune system and avoid *nyctalopia*, or night blindness. However, many children living along the Red Sea coast miss out on health care, and, not surprisingly, child mortality is higher in the two coastal regions than in the other four regions.

Community Integrated Management of Childhood Illness (C-IMCI):

This approach was introduced in 2005 in 17 villages or clusters of villages. Equipped with information, education and communication materials, timers, thermometers, scales, medicines, registers and medical cards, 37 community health workers assisted more than 2,000 children and gave advice to caregivers. In 2006, the first C-IMCI evaluation revealed that community

action through volunteers had the potential to reduce child mortality and that bringing care to the community might remove some barriers to seeking care in health facilities, thereby increasing health-care coverage. It was observed that enthusiasm on the part of community health workers was high, and that workers who provided curative care had a higher level of motivation than those who were limited to health promotion. Monthly refresher training in health facilities – and with it the opportunity to follow up on the work of community health workers – also proved successful.

Based on ‘lessons learned’, it was decided to launch C-IMCI in another 63 villages in 2007. Adi-Rosso is one of those villages, and the community health workers – one for every 75 children – selected by each village committee were being sent on training courses according to the village plan. By the end of the process they will be able to identify and, if necessary, prescribe drugs for the most common childhood illnesses, and to refer severe cases to appropriate health facilities. Because half of all under-five deaths occur when children are less than one month old – and a majority of those deaths occur during the first week after birth – the Government has decided to add a neonatal component to the Integrated Management of Childhood Illness at both facility and community levels.

Community-based therapeutic feeding:

Based on successful community participation in addressing threats against children’s health and survival, community-based therapeutic feeding was introduced in Eritrea in 2006. Still early in the implementation phase, it is evident that this intervention may be able to reach those children who cannot access facility-based therapeutic feeding. Community-based feeding is allowing children and their caregivers to stay in their community and family while being treated – thus addressing women’s workloads, one of the main obstacles to facility-based treatment.

Outreach: Families in Adi-Rosso take their children to a health centre in Nefasit for immunization. The

journey takes at least a day and costs families 120 nakfa (US\$8) for the rent of a camel. Eight dollars is a lot of money in a country where more than 60 per cent of the population lives on US\$16 a month. Another way of reaching the most vulnerable children in very remote villages has been to send out teams from health centres with enough equipment to treat common illnesses, refer severe cases, and provide essential immunization and vitamin A supplementation. Health staff from Foro in the Northern Red Sea region, where an estimated 40 per cent of the population does not have access to health services, explain how they use camels to reach the most remote and mountainous villages – rides that sometimes take up to five days. Although implementation is very recent, it looks as if the outreach initiative, coupled with campaigns, has boosted immunization coverage.

Vitamin A campaigns: Since 2006, the Eritrean Government has been committed to reaching all children aged 6 to 59 months with vitamin A supplementation. This is especially important because undernutrition rates are high in most regions and there is a strong chance that children already weakened by undernutrition will have severe complications due to other illnesses; thus a boost to the immune system can become a life-saving measure. Vitamin A-plus campaigns in 2006 were complemented by measles vaccination and a hand-washing campaign in elementary schools and kindergartens. In May 2007, the activity was combined with a catch-up campaign in 16 subregions to increase routine child vaccination to at least 80 per cent and increase coverage of two doses of tetanus toxoid vaccine among pregnant women to at least 50 per cent. Screening of undernutrition among children under age five was included in the Anseba region campaign. Coverage of vitamin A supplementation is more than 95 per cent in the campaigns – reaching children in even the most remote areas through the use of donkeys, camels and boats.

See References, page 50.