# 1 EXECUTIVE SUMMARY

Located in the corner of Africa at the entrance of the Red Sea, the Republic of Djibouti is a small country of 23,200 square kilometers (8,958 square miles) and a population of 793,000 in mid 2005. The population is mostly urban (82%), with the balance being nomads (18%). The population per square mile is 89. Djibouti occupies a very strategic geographic location at the mouth of the Red Sea and serves as an important trans-shipment location for goods entering and leaving the east African highlands. France, and more recently the United States, maintains a significant military presence in the country.

Djibouti is desert; torrid, dry land with a coastal plain and plateau separated by central mountains. Djibouti has few natural resources and little industry. Its natural resources are geothermal areas, gold, clay, granite, limestone, marble, salt, diatomite, gypsum, pumice, petroleum. Lake Assal is the lowest point in Djibouti as well as in Africa (155 meters). The highest point is Mount Moussa Ali (2,028 meters). Scanty rainfall limits crop production to fruits and vegetables, and most food must be imported.

The Republic of Djibouti is divided administratively into five districts or circles namely Ali Sabieh, Dikhil, Djibouti, Obock and Tadjoura. The population of the Republic of Djibouti was estimated at 793,000 in mid 2005. (The last census dates from 1987). It is constituted by the ethnic groups: Somali 60%, Afars 35%, French, Arab, Ethiopian, and Italian 5%. Djibouti, as one of the Horn of Africa countries, is confronted with the general difficulties of the region, namely Instability, Nomads, Refugees, Hardship and difficult living conditions1. The number of refugees appears to have been reduced in the past year after a process of repatriation undertaken with assistance from friendly countries and assistance agencies. Nevertheless the frontiers remain porous between Djibouti and its neighbors.

Education has been a sector that has received and continues to receive a great deal of attention and budgetary support from the Government. The development of human resources, in all sectors, has been highlighted as a priority of the Government. Particular attention is also paid to technical education.

The economy is based on service activities connected with the country's strategic location and status as a free trade zone in northeast Africa. Scanty rainfall limits crop production, and most food must be imported. Djibouti provides services as both a transit port for the region and an international trans-shipment and refueling center. It has few natural resources and little industry.

Djibouti is heavily dependent on foreign assistance to help support its balance of payments and to finance development projects. An unemployment rate of 50% continues to be a major problem. Inflation is not a concern, however, because of the fixed tie of the Djiboutian franc (DF) to the US dollar. Per capita consumption dropped an estimated 35% over the last seven years because of recession, civil war, and a high population growth rate (including immigrants and refugees). Faced with a multitude of economic difficulties, the government has fallen in arrears on long-term external debt and has been struggling to meet the stipulations of foreign aid donors.

The health sector reform is based on a « pro-poor » policy that promotes national strategies through Decentralization, Community Development and the establishment of regional districts and Councils. The reform is also based on the effective and efficient expenditures of available resources, on facilitating access to services and on better coordination between projects. "Attempts at cost recovery will be strengthened.

The constraints were defined by the Minister of Health, as follows:

- The budget of the Ministry of Health is highly dependent on external assistance
- There is a need to coordinate this external assistance and orient it to the needs of the country
- Align the budgetary process with the long term plans of the Ministry
- The multiplicity of public providers of health services (Defense, Police, OPS)
- Lack of trustable data
- Lack of analysis of existing data
- Incomplete evaluation of the project causing them to fail or to be stopped
- Lack of trained and qualified staff, adding to the costs provided by external assistance

The Republic of Djibouti has adopted the Basic Development Needs (BDN) program that is based on the mobilization of the community and its direct participation and empowerment. The BDN approach integrates the programs of reproductive health, nutrition, access to safe water, presence of sewers and hygiene together. BDN facilitates the process of economic self-sufficiency of communities and human settlements.

Djibouti's health service, which is largely provided by the public sector, is in principal free of charge to its population regardless of social status and is relatively accessible. However there are disparities that remain between urban and rural areas and is due mainly to lack of access to health care due to poor infrastructure outside the capital and main district towns.

Following a civil war and an influx of refugees in the early 90s, the Republic of Djibouti has experienced a significant decrease in the level of health expenditure, a deterioration of the health system and a worsening of the health status of the population. Budgetary spending on health has fallen close to 1.5 percent by 2002 from over 2.2 percent in the early 90s, and has not kept pace with the growing population. Djibouti's population is growing rapidly at 3 percent annual due to a high fertility rate (4.2 children per woman) and a significant migratory influx. Inadequate health personnel and a limited material budget has led the supply o f health services to decline both in terms of quality and quantity.

Life expectancy at birth is among the world's lowest at 49 years. Infant mortality and child mortality rates have improved relative to their 1989 levels, though it remains one of the highest relative to Middle-Eastern and Sub-Saharan countries. Between 1989 and 2002, infant mortality rates dropped from 114 to 103.1 per 1,000 live births and for child mortality, it fell from 154 to 128.9 per thousand. Maternal mortality rate was estimated in 1989 at 740 per 100,000 live births and has declined to 546 per 100,000 live births based on the 1996 EDSF-PAPFAM health and family survey. According to the same survey, 58 percent of deaths in childbirth occur outside the hospital setting, and qualified medical personnel are involved in 72 percent of births nationwide. Malnutrition, diarrhea disease due to low water quality, and acute respiratory infections associated with chronic malnutrition are the most common causes of morbidity and infant mortality.

Female genital mutilation (FGM) is also a public health problem and a risk factor in maternal mortality, due to the problems it causes in childbirth. According to the PAPFAM survey, 98 percent of non-single women aged 15 to 49 are subjected to this harmful practice. Malnutrition remains a worrisome public health problem given its negative

impact on the health of mothers, and the prevalence of anemia among pregnant women is a factor in their mortality rates.

The population continues to be plagued by a high and rising incidence of tuberculosis, malaria, cholera and AIDS. Malaria has only been a problem in Djibouti since the late 1980s. In 1997, according to a report by the Ministry of Health (MOH), diarrheal illnesses (e.g., cholera, typhoid fever, amebic dysentery, viral hepatitis, etc.) accounted overall for 11 percent of medical consultations, and this figure was 16.5 percent for children under the age of five years. Since 1989, Djibouti has experienced four cholera epidemics, the last three of which affected nearly the entire country. The HIV/AIDS situation has worsened steadily since 1986, when the first case was diagnosed in Djibouti. A national survey conducted in 2002 revealed an HIV prevalence rate o f 3.0 percent for the whole population which is lower than expected.

A new organization for the Ministry of Health is being proposed, in an effort to promote decentralization. Several facilities are being considered for an autonomous status similar to the status currently enjoyed by the principal hospital, Hopital General Peltier. Decentralization is also granted to each of the five medical districts, at the governmental level. This could also promote the principles of community empowerment, multi-sectorial cooperation and grass root involvement in social and health affairs.

Djibouti's public health service is provided through seven hospitals, eighteen rural and eight urban dispensaries. Based on year 2000 data from CEDES, the main general hospital (Hospital Peltier) in Djibouti City has a capacity of 395 beds. The Paul Faure Center (204 beds), the second largest hospital, specializes in tuberculosis and other respiratory diseases. There is also a 60-bed maternity, pediatric and obstetric hospital (Balbala). The four district hospitals-with a total capacity of 300 beds and act as reference hospitals for the rural dispensaries. The private health care sector is relatively under-developed.

Based on data from a 1996 household survey, about 78 percent of Djiboutians have access to a health center in less than 30 minutes (in the rural areas), and most sedentary households have a dispensary within walking distance. Nomads do not use the health centers, because these are too far away and the trip is too expensive (to the transportation cost one needs to add subsistence for the sick, plus the opportunity costs of accompanying the sick person). Instead, nomads hire traditional healers, and go to a dispensary or hospital only incases of severe illness.

Officially, drugs are provided free of charge by "Pharmacie Nationale d'Approvisionnernent. In reality, drugs are rarely available, and the fact that the expenditure for drugs is the largest private expenditure component associated with health care as was found in the 1996 household survey, indicates that they are not free. Patients often have to go to private pharmacies to have their prescriptions filled.

Health and hospital services in Djibouti are available to everybody and are virtually free. As a result, sick people cross the border from Somalia and Ethiopia to obtain these services. Many of these patients are suffering from such protracted illnesses as tuberculosis (TB), and AIDS. Over 60 percent of persons hospitalized for TB in Djibouti are non-Djiboutians, as reported in several Government documents. Because the government's budget problems do not allow allocation of extra money to the health sector, it is impossible to rehabilitate the structures destroyed by the war.

The assessment of the governance system in Djibouti draws on the six governance indicators developed by Kaufmann et a1 (2003). The data show that in a sample of about 200 counties worldwide, Djibouti scores in the lower end for most governance

indicators, such as political stability, the rule of law, government effectiveness, the regulatory framework, control of corruption as well as voice and accountability. On average, only 20 percent of counties have worse governance indicators than Djibouti.

As regards the strengthening of good governance, the government plans to enhance and streamline public expenditure management. Overall, the aim will be to consolidate the current gains, along the following lines:

- Effective application of the new procedures for budget preparation and expenditure tracking and control;
- Strengthening of fiscal control through the publication of the 2003 report of the Audit and Fiscal Discipline Office;
- Publication of the audited financial statements of public enterprises; and
- Implementation of the recommendations on the real sector by end-September 2005, with a view to participating as soon as possible in the IMF's GDDS.

The share of the Ministry of Health as a percent from the national budget has been decreasing over the past several years. It represents about 4-5% of the national budget as shown herewith below. Nevertheless, even with this relatively small percentage, only 46% of the budget was effectively expanded in 2001 and 60% in 2002.

The budget of the Ministry of Health derives from the taxes and revenues collected by the Government (Ministry of Finances) in addition to grants from external donors. The government recovers (or attempts to recover) a portion of the costs of hospitalization and of outpatient consultations.

The government assures free public health care services and health care services for primary, secondary and tertiary levels of care. Since 1986, the state does not anymore take care of treatment abroad. These Government services benefit in particular all citizens who are recognized as poverty-stricken (Obtain a "certificate d'indigence" from the Minister of the Interior). The poor who are ill are hospitalized in the third category of health care service of the state.

4.7 percent of Djiboutians reported themselves ill or injured in the 4 weeks before the interview. 82 percent sought health care of some type. Fewer of the poorest (82.1 percent) than the richest (86.7 percent) sought health care. Dispensaries are the most common source, used by 34.3 percent of all Djiboutians. The Hospital Peltier is the next most common source of care, used by 15.6 percent of Djiboutians. There are, however, large differences among welfare groups as to where people seek care. Those in the poorest quintile rely on dispensaries more than twice as often as those in the richest quintile. Likewise, those in the poorest quintile are only half as likely as those in the richest quintile to seek curative care at the Hospital Peltier- 11.2 percent versus 28.9 percent of cases.

The Office of Social Protection (OPS) provides health services to its beneficiaries through its own local medical dispensaries (SMI) which provide only outpatient consultations (at the tune of 150,000 visits per year). The insured include the employees in the government sector and private sector (and their families). The enrolled pay a contribution of about 7.2% of their salary paid through their employers. The employees of the Civil Service are not covered. The funds of OPS are derived from the employee contributions. It is believed that the government has not paid its dues to OPS for many years. OPS does not reimburse the costs of hospitalization unless it is work-related. Certain businesses do cover these medical services whether either with public or private providers.

Private health insurance is practically non-existent. It would be helpful if efforts were to be expanded to enlarge the pool of coverage of the social health insurance (OPS) and to develop the mechanisms for controlling health costs. The initial NHA analysis doesn't allow for using the data obtained to project trends and models for developing social health insurance. Services are provided by the private facilities for ambulatory consultations, hospitalization and medicines purchased from private pharmacies. There is no private insurance. Citizens not covered by the government or OPS, in particular the privileged classes and foreigners do use the private sector for their medical needs. Payment is made directly out of pocket. Reimbursement is on the basis of fee-for-service.

According to the information available, health expenditures represent 7% of the Gross Domestic Product. The respective share of the financing of medical care is as follows:

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| External assistance | 29% |
| Public Funds | 27% |
| Households | 24% |
| Employers | 20% |

Households assume an important part of total health expenditures. This has been acknowledged both in the NHA and in the more recent population-based surveys. Households purchase medications and health services either directly from the private providers or through the disbursement of a co-payment at General Peltier Hospital. The purchase of medications represents 58% of the household expenses.

The development of human resources has been repeatedly underscored by government officials and officers of the external assistance agencies. All sectors of the Government (including health care) will require better educated and prepared professionals to assist in the development of the country. The development of human resources in Health is undertaken through in-country training as well as through educational fellowships for education abroad. There are two educational centers in the country, namely the Center for the formation of Health Professionals (a MOH unit) and the "Pole Universitaire", the "embryonic" vision of the University of Djibouti.

The Center trains two categories of health professionals.

1. The "Techniciens de Sante" (Health Technicians): Nurses, Midwives, Laboratory Technicians
2. "Techniciens adjoint de sante" (Assistant Technicians): Assistant nurses, ass't midwives, ass't laboratory technicians.

Students receive a stipend during their study years. A total of 151 health professionals were graduated over the 12-year period since the establishment of the Center. There is currently a determination of the Government to establish a Faculty of Medicine in Djibouti.

The following are the major constraints that contribute to the weakness in the delivery of health care services in the country in terms of availability, accessibility, and quality:

1. Shortage of qualified nurses, midwives and allied health professionals.
2. Many of the nurses, midwives, laboratory, and pharmacy auxiliaries at the health facilities have been trained on the job.
3. Lack of accurate information with regard to the numbers and nature of the work of the health workforce especially nursing, midwifery, and allied health.

4. Lack of clarity and role definition of the different health categories.
5. Absence of national standards for curriculum development for all health professions.
6. Proliferation of disease- specific vertical training programs.
7. Lack of health professional regulation.
8. Lack of continuing education programs for all health professionals.
9. Deficient clinical training sites both at the hospital and community level.

In addition, to the above constraints, lack of resources, the poor physical status of the health facilities, shortage of prepared faculty, lack of teaching-learning resources including books and references, equipment and materials, and lack of community-based learning facilities further impede the human resources development process in Djibouti.

The legislation of July 1999 has highlighted the importance of health programs to achieve the Government strategy of Health for All. Priority has been given to several health programs, considered as principal causes of ill health. Respiratory infections, acute diarrheas, Malaria and Tuberculosis constitute the principal causes of morbidity, Mortality and Hospitalization. Malnutrition is also prevalent, especially amongst children.

The Ministry of Health has embarked on several national programs, namely:

1. Reproductive Health and Safe Motherhood: This program focuses on the reduction of maternal mortality, the promotion of family planning, the combat of the mutilation of female genitalia (prohibited by Law since 1995) and the protection of child care. This program also targets malnutrition and anemia in mothers after a survey revealed that up to 70% of pregnant women suffer from iron deficiency anemia.
2. Expanded Program of Immunization
3. Nutrition: It is estimated that 35% of deaths in children under five years of age are related to the poor nutritional status of children. There are currently eight centers to combat malnutrition in Djibouti-City and a unit in each of the five districts. Malnutrition may have worsened due to the early weaning of infants
4. Communicable Diseases: Communicable diseases remain the most important causes of morbidity and mortality. The principle diseases are Tuberculosis, Diarrheas, malaria and Measles.
5. Campaign against HIV/AIDS[2],[3]
6. Non Communicable Diseases: Cardiovascular diseases constitute the first cause of deaths in adults older than 35 years. Intra-hospital mortality is high at 21%. Malignancies represent 8.8% of hospital mortality. Mental diseases are also on the increase particularly amongst men

The Government sector includes the facilities of the Ministries of Health, Interior, Defense and Hospital Bouffard that is linked to the French Cooperation. The Parastatal sector represented by the facilities of the Office of Social Protection (OPS).The Private sector that includes essentially office based practice. The State is responsible for the provision of health care to the people of Djibouti. Otherstakeholders include:

1. The Ministry of Defense provides medical care to the military and their dependents, including the Internal Security forces and the Presidential Guard.

2. The Ministry of Interior operates a medical center and provides ambulatory care to the members of the police force and their dependents. It also is responsible for the transportation of the wounded and road victims through the fire brigade force.
3. The Ministry of Labor through the Office of Social Protection provides medical care and pharmaceuticals through its two dispensaries to all registered employees and their dependents, in addition to its responsibility for occupational medicine.
4. Educational institutions are still at the embryonic stage. Nevertheless, the Ministry of Health through the Center for the formation of health professionals (CFPS) trains health professionals for the country (Nursing and paramedical workers)
5. Civil Society is involved in public health: NGOs, traditional and religious organizations are involved in the prevention of diseases, epidemics and sanitation in towns and villages. Women organizations, Bender Djedid, ADEPF, Al Bir provide assistance in health promotion and prevention, maternal and child health, and disease control.
6. The private sector provides medical care, essentially on outpatient basis except for few inpatient beds through 3 clinics and 4 office-based practices (inclusive of dental care) essentially in the capital. Physicians do report to the Ministry cases of communicable diseases, and thus assist in prevention and control.

Access to safe water is assured by the "Office National de l'Eau" that pumps water from 28 wells in Ambouli and distributes it through a 90 km long conduit. In residential quarters, water is available at 100% while it reaches barely 5% of dwellings in some other quarters. In these centers, water is distributed in cisterns. Water control is the responsibility of the Directorate of Hygiene in the MOH. Water sewerage system is limited to 5 kms of conduits serving 25,000 persons, or less than 10% of the population of the city. The water and sewerage systems deserve to be improved in order to improve sanitation and reduce the morbidity associated with oro-fecal contamination. The current ratio doctor-population is one for every 6800 persons.

The financing of pharmaceutical products continues to remain a critical problem. Both low equipment budget allocation and execution rates have contributed to drug shortages. A 1996 household survey confirms that drugs form nearly half of total private health expenditure. The decision to establish the "Pharmacies Communautaires" (the CAMME) is considered a welcome improvement.

The Ministry of Health prepared a strategic plan in February 2002 for the development of the health sector. A mission from the International Development Association (IDA) visited Djibouti in February 2002 and recommended financial support, along three phases, over the period 2002-2014. The Government of the Republic of Djibouti has already taken exceptional measures to address the difficulties that have been faced by the country over the past two decades. Natural emergencies such as floods, draught and famine, civil unrest, regional tensions have had bearing on the development of the country. Difficulties in generating resources have led to the need to borrow money, delay payments, further choking the possibilities of the Government to meet the challenges.

The situation has changed remarkably over the past few years. The regional tensions and the situation in neighboring countries have in fact provided an opportunity for Djibouti to carve for itself an important role in the development of the Horn of Africa. There have been discussions with officials about the potential of Djibouti to adopt the model of Singapore or Dubai in its developments over the next two decades. A careful reading of the projects being considered reveal that this vision could well be realized4,5.

The present situation offers several advantages to Djibouti, namely:

- Djibouti is a small country with a population of about 750,000 people, the majority living in Djibouti-City and in few other large towns
- Djibouti is a safe haven, secure with no un-surmountable political problems
- It has drawn the attention of friendly countries that have indicated their willingness to support its further development
- External assistance for the support of its development plans is real and considerable
- The country has few of the burdens that other countries have to face in their development such as outmoded infrastructure, organized pressure groups or other serious constraints

All these factors provide Djibouti with an opportunity that ought not to be missed. The country has currently very favorable conditions that should be taken advantage of, in a timely manner. The opportunities for action are ripe and timely.

There is evidence that there exists a strong political will on the part of the Government to improve the health care system, to combat poverty and promote development. This commitment has also been supported by the donors' community and considerable resources have been identified. In fact, questions have been raised about the existing capacity of the Government to coordinate these inputs despite the commitment and dedication exhibited by the staff and officials alike.

There is no doubt that Djibouti faces immense challenges in its quest for development. As noted by a senior official "everything is a priority in Djibouti". The country is witnessing an influx of suggestions and proposals to change and develop, and to achieve these objectives and goals within a defined span of time.