

3 HEALTH STATUS AND DEMOGRAPHICS

Djibouti's health services, largely provided by the public sector, are in principal free of charge to its population regardless of social status and are relatively accessible. However there are disparities that remain between urban and rural areas and are 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 have led the supply of health services to decline both in terms of quality and quantity.

3.1 Health Status Indicators

Table 3-1 Indicators of Health status

Indicators	1990	1995	2002	2004
Life Expectancy at Birth:	-	-	50	52
HALE:	-	-	-	-
Infant Mortality Rate:	-	-	107	99.8
Probability of dying before 5 th birthday/1000:	-	-	124.4	-
Maternal Mortality Ratio:	-	-	730	546
Percent Normal birth weight babies:	-	-	80	-
Prevalence of stunting/wasting:	-	-	-	-

Table 3-2 Indicators of Health status by Gender and by urban rural

Indicators	Urban	Rural	Male	Female
Life Expectancy at Birth:	-	-	51	54
HALE:	-	-	-	-
Infant Mortality Rate:	-	-	114.8	98.9
Probability of dying before 5 th birthday/1000:	-	-	98	108
Maternal Mortality Ratio:	-	-	-	-
Percent Normal birth weight babies:	-	-	-	-
Prevalence of stunting/wasting:	-	-	-	-

Table 3-3 Top 10 causes of Mortality/Morbidity

Rank	Mortality	Morbidity/Disability
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Source:

Reliable health statistics are lacking for Djibouti, but the limited data indicates an alarming health situation. In spite of its relatively high nominal per-capita income (Djibouti's estimated GDP per capita in 2003 was USD 742 compared to an average of USD 510 for Sub-Saharan Africa), Djibouti has one of the poorest sets of social indicators in the world.

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.

According to the 2004 Djibouti's Poverty Reduction Strategy Paper (PRSP), foreign nationals represent 15 percent of the total population). The population continues to be plagued by a high and rising incidence of tuberculosis, malaria, cholera and AIDS. Tuberculosis (TB), the ailment most typically associated with poverty, overcrowding and poor hygiene, is the disease with the longest history in Djibouti. With 588 cases of TB per 100,000 inhabitants, Djibouti has the second highest rate of TB incidence in the world after Swaziland. However about 40 percent of the cases comes from neighboring countries, in particular from Ethiopia, which inflates the rate. Foreigners come to Djibouti

because it offers more and better-quality service free of charge. Over the last ten years, Djibouti has recorded an average of about 3, 572 new cases of tuberculosis per year, peaking in 2000 with 4,121 diagnosed cases. As with other countries, the link between HIV and TB is apparent. Although the sero-prevalence rate in the general population is less than 3 percent, it was 26.1 percent among TB patients in 2001, up from 13.1 percent in 1999. Even though the national program remains one of the best in the region with 72 percent therapeutic success (treatment completed and patients cured) in 2000, a dire lack of personnel and the loss of financial assistance from France Cooperation in June 2002 will make it difficult to maintain past performance levels.

Malaria has only been a problem in Djibouti since the late 1980s. Before 1973, where there was no urbanization, no irrigation and an active attempt to control the vector during the rainy season, more than 80 percent of the notified cases were from people entering Djibouti from neighboring countries. From 1973 to 1987, more Djibouti nationals cases appeared along the main transport lines linking Djibouti to neighboring countries and after 1987, cases manifested in the urban areas as thousands of refugees resettled in Djibouti. Since 1988, the spread of malaria has increased steadily. Uncontrolled urbanization with inappropriate water supply, non-existent wastewater evacuation system, settlement of nomad population in rural areas, increased irrigated areas and frequent floods contributed to the endemic. Djibouti currently records over 4,000 confirmed cases of malaria each year.

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. In addition, the MOH's 1996 report indicates that diarrheal illnesses are the second most frequent cause of in-hospital mortality, accounting for 12 percent of such deaths. The same report identifies diarrheal illnesses as the second most frequent cause of death for children between the ages of one and four years. Poor water quality affecting mainly the rural and poorer segments of the population is a contributing factor in these cases.

Since 1989, Djibouti has experienced four cholera epidemics, the last three of which affected nearly the entire country, although the majority of cases were in the city of Djibouti. Care of those stricken with cholera has gradually improved: while the epidemic of 1989 lured 8 percent of its victims, the mortality rate was 2 percent for the epidemics of 1993 and 1997, and even higher for the most recent epidemic in 2000. During the 1997 cholera epidemic, increased epidemiological surveillance of diarrheal illnesses revealed that dysentery accounted for about 10 percent of the cases of diarrhea recorded during the outbreak.

The HIV/AIDS situation has worsened steadily since 1986, when the first case was diagnosed in Djibouti. As of December 2000, 10,274 persons had tested positive for HIV and 2,197 had been identified by the National AIDS/STD Prevention Program as having AIDS. A national survey conducted in 2002 revealed an HIV prevalence rate of 3.0 percent for the whole population which is lower than expected. However, analysis of the data by age groups, shows a prevalence higher than 5 percent among persons aged 20-35, indicating that early on HIV infects the economically productive and sexually active persons.

3.2 Demography

Table 3-4 Demographic indicators

Indicators	1990	1995	2002	2005
Birth Rate per 1,000 Population:	-	-	47.5	32
Death Rate per 1,000 Population:	-	-	17.7	13
Population Growth Rate:	-	-	2.13	1.9
Dependency Ratio %:	-	-	-	-
% Population <15 years	-	-	-	41
Total Fertility Rate:	-	-	4.2	4.2

Source:

Table 3-5 Demographic indicators by Gender and Urban rural

Indicators	Urban	Rural	Male	Female
Crude Birth Rate:	-	-	-	-
Crude Death Rate:	-	-	-	-
Population Growth Rate:	-	-	-	-
Dependency Ratio:	-	-	-	-
% Population <15 years	-	-	-	-
Total Fertility Rate:	-	-	-	-

Source:

Demographic patterns and trends

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 conditions¹². 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.

The demographic indicators have been estimated officially as follows:

Proportion in the population of women in the age group 15-49 years	27
Age bracket 0-14years %	43.1
Age bracket 0-14 years	197000
Age bracket 15-64 years %	53.9
Age bracket 15-64 years	250000
Age bracket 65+ years %	3
Age bracket 65+ years	14000
Median age (years) Both sexes	18.3
Median age (years) Men	18.9
Median age (years) Women	17.7

The Djiboutian Survey of Family Health PAFAM, May 2003

The survey has been undertaken under the auspices of the Ministry of Health, and was implemented by the Directorate of Statistics and Demography. The survey is part of the project PAFAM (The Pan Arab Project for Family Health), undertaken by the League of Arab States. This survey has been supported by the AGFUND, UNFPA, UNICEF, WHO, OPEP, ESCWA and the UN Statistical Division.

The principal goal of the EDSF/PAPFAM survey was to collect information that would assist in the follow up and evaluation of policies and programs targeting Family and Reproductive Health. This goal serves also to support the national capabilities of the Ministry of Health and other national organizations to conceptualize, plan, implement and evaluate programs in Family and Reproductive Health.

The survey covered the entire national territory and consisted of three distinct components: Component I targets households and women in the reproductive age in urban and rural areas; Component II targets the youth in the same areas as I above and Component III- Targets households and women in the reproductive age group in Nomadic areas.

The survey was carried out on 5,000 housing units yielding 5,600 households obtained through a two-phase random sampling method. In the final analysis information was obtained from 4,400 households and 2,741 women. The response rate was of 81% for households and 83% for the women in the targeted age group.

Family Health Survey EDSF 2002 Indicators

	Urban	Rural	Totals
Households interviewed	3293	1107	4400
Sample represents	80.4	90	82.6
Proportion of non-single women age 15-49 yrs	1977	764	2741
Sample represents	84.1	80.1	82.9
Individuals surveyed	20247	4766	25013
Percent individuals surveyed	84.1	80.1	82.9
Proportion of nuclear households	63.7	83.4	68.7
Average number of individuals per household	6.1	4.3	5.7
Percent population below age 15 years	37.3	38.2	37.5
Proportion of households living alone in a villa or apt	28.3	2.7	21.8
Proportion of households with running water	43	0.2	32.2
Proportion of households with electricity	54	0.2	40.4
Percent of individuals age 15+yrs married- Men	44.8	61.4	47.9
Percent of individuals age 15+yrs married- Women	39.7	57.2	43
Percent of individuals age 15+yrs married-Both sexes	42.1	59.2	45.3
Percent of population illiterate age 6+yrs Men	23.6	68.6	32
Percent of population illiterate age 6+yrs Women	45.8	83.4	52.8
Percent of population illiterate age 6+yrs Both sexes	35.2	76.3	42.9
Percent of population age 12+yrs in labor force Men	28.6	24.5	27.9
Percent of population age 12+yrs in labor force Men	12.7	12.7	12.7
Percent of population age 12+yrs in labor force Men	20.2	18.3	19.8
Percent of non-single women who have never watched TV	57.4	98.3	68.8
Percent of non-single women who have never listened to radio	46.3	64.3	51.3
Average age at first marriage Men	31.2	28.7	30.7
Average age at first marriage Women	28.8	24.3	28

The information derived from this survey highlights the paucity of services in the rural areas: only 0.2% of households have running water and electricity. The nuclear families

constitute the overwhelming majority of households in both urban and rural areas. The degree of illiteracy is far more prevalent in the rural areas. Of interest is the information that 98.3% of women have never watched television in the rural areas and 64.3% have never listened to the radio: this would limit the role of mass media in health promotion and education, particularly since power networks are limited.

Reproductive Health	Urban	Rural	Totals
Pregnant women at the time of the interview %	10.8	13.6	11.6
Fertility rate over past 5 years	4.1	4.9	4.2
Proportion of women aged 15-49 yrs having used contraception	21	0.5	15.3
Proportion of women aged 15-49 yrs using contraception	12.5	0.4	9
In the preceding year, did not seek advice during pregnancy	7.7	65.2	22.7
In the preceding year, did seek medical advice during pregnancy	38.3	3.4	29.2
In the preceding year, did not seek advice due to lack of service	20.5	52.8	44.6
Proportion of deliveries in a health facility	92.4	22.1	74.1
Proportion of deliveries receiving postnatal care	17.7	5.1	14.5
Maternal Mortality per 100,000 live births			546
Median number of months of lactation	13.1	20.3	17.9
Infant Mortality Rate per 1,000 live births	107.2	91.2	103.1
Under five years Child Mortality per 1,000 live births	122	131.5	124.4
Proportion of children suffering from stunting	22	27.1	23