EMRO

HEALTH SYSTEM PROFILE

DJIBOUTI

Regional Health Systems Observatory
World Health Organization

2006

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FOREWORD

Health systems are undergoing rapid change and the requirements for conforming to the new challenges of changing demographics, disease patterns, emerging and re emerging diseases coupled with rising costs of health care delivery have forced a comprehensive review of health systems and their functioning. As the countries examine their health systems in greater depth to adjust to new demands, the number and complexities of problems identified increases. Some health systems fail to provide the essential services and some are creaking under the strain of inefficient provision of services. A number of issues including governance in health, financing of health care, human resource imbalances, access and quality of health services, along with the impacts of reforms in other areas of the economies significantly affect the ability of health systems to deliver.

Decision-makers at all levels need to appraise the variation in health system performance, identify factors that influence it and articulate policies that will achieve better results in a variety of settings. Meaningful, comparable information on health system performance, and on key factors that explain performance variation, can strengthen the scientific foundations of health policy at international and national levels. Comparison of performance across countries and over time can provide important insights into policies that improve performance and those that do not.

The WHO regional office for Eastern Mediterranean has taken an initiative to develop a Regional Health Systems Observatory, whose main purpose is to contribute to the improvement of health system performance and outcomes in the countries of the EM region, in terms of better health, fair financing and responsiveness of health systems. This will be achieved through the following closely inter-related functions: (i) *Descriptive function* that provides for an easily accessible database, that is constantly updated; (ii) *Analytical function* that draws lessons from success and failures and that can assist policy makers in the formulation of strategies; (iii) *Prescriptive function* that brings forward recommendations to policy makers; (iv) *Monitoring function* that focuses on aspects that can be improved; and (v) *Capacity building function* that aims to develop partnerships and share knowledge across the region.

One of the principal instruments for achieving the above objective is the development of health system profile of each of the member states. The EMRO Health Systems Profiles are country-based reports that provide a description and analysis of the health system and of reform initiatives in the respective countries. The profiles seek to provide comparative information to support policy-makers and analysts in the development of health systems in EMR. The profiles can be used to learn about various approaches to the organization, financing and delivery of health services; describe the process, content, and implementation of health care reform programs; highlight challenges and areas that require more in-depth analysis; and provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries. These profiles have been produced by country public health experts in collaboration with the Division of Health Systems & Services Development, WHO, EMRO based on standardized templates, comprehensive guidelines and a glossary of terms developed to help compile the profiles.

A real challenge in the development of these health system profiles has been the wide variation in the availability of data on all aspects of health systems. The profiles are based on the most authentic sources of information available, which have been cited for ease of reference. For maintaining consistency and comparability in the sources of

information, efforts have been made to use as a first source, the information published and available from a national source such as Ministries of Health, Finance, Labor, Welfare; National Statistics Organizations or reports of national surveys. In case information is not available from these sources then unpublished information from official sources or information published in unofficial sources are used. As a last resort, country-specific information published by international agencies and research papers published in international and local journals are used. Since health systems are dynamic and ever changing, any additional information is welcome, which after proper verification, can be put up on the website of the Regional Observatory as this is an ongoing initiative and these profiles will be updated on regular intervals. The profiles along with summaries, template, guidelines and glossary of terms are available on the EMRO HSO website at www.who.int.healthobservatory

It is hoped the member states, international agencies, academia and other stakeholders would use the information available in these profiles and actively participate to make this initiative a success. I would like to acknowledge the efforts undertaken by the Division of Health Systems and Services Development in this regard that shall has the potential to improve the performance of health systems in the Eastern Mediterranean Region.

Regional Director

Eastern Mediterranean Region

World Health Organization

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:

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.

2 SOCIO ECONOMIC GEOPOLITICAL MAPPING

2.1 Socio-cultural Factors

Table 2-1 Socio-cultural indicators

Indicators	1990	1995	2002	2005
Human Development Index:	-	-	-	157
Male Literacy (Ages 15-24 years):	-	-	37.8	-
Female Literacy (Ages 15-24 years):	-	-	18.3	-
Women % of Workforce	-	-	-	-
Primary School enrollment – Boys	-	-	-	46
Primary School enrollment – Girls	-	-	-	35
Primary School enrollment - Total	-	-	-	40
Primary education, pupils (% female)	-	-	-	-
Secondary School enrollment - Total	-	-	-	-
Urban Population (%)	-	-	-	84

Source:

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. In 2004, the Government mandated a period of "military and civic" service to encourage the youth to be technically trained in order to cut the rate of unemployment6.

Significant support has also been extended to the "Pole Universitaire", the embryonic university of Djibouti that enrolls secondary school leavers (holders of the Baccalaureat) and educates in the fields of Business, Technology, Accountability (see below).

Educational Indicators	
Crude rate of schooling- Primary %	71.1
Crude rate of schooling- Primary Girls %	65.9
Crude rate of schooling Obligatory %	47.1
Crude rate of schooling- Secondary %	22.4
Ratio Girls/Boys Secondary schooling	65.8
Literacy Rate 15+ years % Men	37.8
Literacy Rate 15+ years % Women	18.3
Literacy Rate 15+ years % Both Sexes	27.3
Crude schooling rate %	42.7
Crude schooling rate % Urban	52.9
Crude schooling rate % Rural	12.4
Net schooling rate %	34.7

At his address to the Commission of Macroeconomics and Health (CMH) meeting in Geneva in October 2003, HE the Minister of Health provided the following situation analysis of the country:

Djibouti is a city-state of 500,000 inhabitants, 80% of whom live in urban settings, 74.4% live below monetary poverty, especially in the rural areas. Life expectancy at birth is below 50 years, infant mortality stands at 103 per 1,000 live births, maternal mortality at 546 per 100,000 live births. The principal causes of Maternal Mortality are an elevated fertility rate, Malnutrition, Anemia, poor coverage of maternity services and a high prevalence of the practice of mutilation (female genitalia). The crude schooling rate is only 34.7%. About a quarter of children suffer from stunted growth.

Over the period of 1996 and 2002, there has been a marked increase in relative poverty from 45 to 74% and in absolute poverty from 9 to 42% of the population. 96.7% of the population living in rural areas is considered poor[7]. The Minister of Health outlined the following basic obstacles to the economic growth of Djibouti:

1. Poor natural resources
2. Elevated costs of labor and production (Energy, Telecommunications, Water)
3. A weak labor force due to inadequate schooling and poor health, with an unemployment rate of 59%
4. A heavy external public debt

The principal challenges to Development in Djibouti revolve on the need for a national consensus to integrate the economic, health and environmental policies that reinforce each together, and develop a coordinating mechanism to implement the strategies of Development. There is also a wide gap between the resources needed for a long term vision for Development and the effective national budgets available that remain insufficient.

To address these constraints and difficulties, the Government of Djibouti has announced multi-sectoral strategies derived through national consensus. These strategies are anchored on the Poverty Reduction Strategy paper (PSRP) document, on an inter-ministerial effort to combat HIV/AIDS, Tuberculosis and Malaria, on a national effort to support the role of Women and on the reform the health sector.

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 Center for the education and training of health professionals will be supported in its plans to increase its capacity and diversify its programs. The Central Office for the purchase of medicines and medical supplies (CAMME) will be institutionalized, the public health laboratory will be strengthened and health planning (“Carte sanitaire”) will be highlighted to assure the provision of basic health needs to all communities” (Minister of Health).

To combat HIV/AIDS, Tuberculosis and Malaria, an inter-ministerial council has been established, chaired by the Prime Minister, with the Minister of Health as Deputy. A technical committee headed by the Secretary General of the Ministry of Health has been constituted. Implementation is assured through an executive secretariat that proposes plans and programs, assures the follow up and the evaluation of all activities.

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

2.2 Economy

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.

The nation is, therefore, 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.

Economic Indicators

Gross Domestic Product purchasing power parity $ millions	619
GDP Growth rate (2002 est) %	3.5
% of GDP Agriculture	3.5
% of GDP from Industry	15.8
% of GDP from Services	80.7
Percent of Health expenditures provided through Donors	28
Proportion of population living in relative poverty 2002	74
Proportion of population living in absolute poverty 2002	42.1
Rural areas Relative poverty % 2002	96.7
Relative Poverty % 1996	45.1
Extreme Poverty % 1996	9.6
Gini Index %	40.9
Index of poverty- National	56.7
Index of poverty- Rural	78.2
Unemployment %	59
Unemployment <30 years % of global unemployment	58
Unemployment amongst the poor population %	66
Unemployment amongst the extremely poor population %	72

** Relative poverty has been stated to be 216450 DJF ($ 1223) per capita per year; Absolute poverty has been fixed at 100,299 DJF ($ 566). These rates were derived from the cost of a food basket that provides for a dietary intake of 2,100 calories per day per capita.*

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.

In addition, Djibouti has embarked on an ambitious program for the reduction of poverty and is mobilizing resources to achieve the Millennium Development Goals (MDGs) in close collaboration with UN agencies and bilateral donors.

Table 2-2 Economic Indicators

Indicators	1990	1995	2000	2002
GNI per Capita (Atlas method) current US$	-	-	890	-
GNI per capita (PPP) Current International	-	-	1300	2270
Real GDP Growth (%)	-	-	619	-
Real GDP per Capita ($)	-	-	3.5	-
Unemployment % (estimates)	-	-	59	-

Source:

Table 2-3 Major Imports and Exports

Major Exports:	Hides, Skins, Coffee
Major Imports	Food, Beverage, Chemicals, Petroleum, Transport equipment

Exports are valued at $250 million (2004 est.) and consist essentially of re-exports of hides and skins, coffee (in transit) to Somalia 64.2%, Yemen 22.7%, Ethiopia 5% (2005). Imports are valued at $987 million (2004 est.) and consist of foods, beverages, transport equipment, chemicals, petroleum products from Saudi Arabia 20.9%, India 12.5%, Ethiopia 11.9%, China 10.5%, France 4.7%, US 4.5%, Japan 4.4% (2005)

Key economic trends, policies and reforms

The economy and social situation in Djibouti remain fragile despite seven years of adjustment efforts under IMF-supported programs (1996–99 Stand-By Arrangement and 1999–02 Poverty Reduction and Growth Facility—PRGF). The fiscal position has gradually been restored, and progress has been made toward the government finance reform8.

These programs have made it possible to stabilize fiscal revenue, streamline fiscal expenditure, increase social spending, and reduce the sizeable domestic fiscal arrears since 2001. However, the structural reform program, intended to remove obstacles to growth, has not been completed, and as a result, economic growth has not been strong enough to foster job creation and poverty reduction.

The major steps taken by the Djibouti authorities to restore fiscal balance in the short and medium terms through various structural adjustment programs led to an improvement in the economic aggregates such as GDP growth and inflation, but

unfortunately did not reduce poverty, as shown by the results of the latest household survey conducted in July 2002 (EDAM-2).

Bearing in mind the poverty prevalent in the country and nevertheless concerned with maintaining the fiscal stability so painstakingly achieved, the Djibouti authorities have embarked on a poverty reduction process. Accordingly, the government has entered into a commitment with the international community to halve poverty by 2015, by taking steps toward achieving the Millennium Development Goals (MDG).

Moreover, the objective of reducing poverty in Djibouti, which is the cornerstone of any development-oriented action in the country, falls within the framework of the Poverty Reduction Strategy Paper (PRSP) drawn up by the government. The basic objective of this PRSP is to create a momentum toward growth and accumulation of human capital that can reduce poverty and unemployment, and improve the living conditions of all citizens. It is based on a long-term vision aimed at taking advantage of the country's strategic assets, its geographic location and its port, and developing its human resources to achieve a radical improvement in the competitiveness of the economy and give it an advantageous position in the global economy.

The Djibouti authorities thus embarked, in 2004, on the country's first staff-monitored program (SMP) with the Fund. The results of this SMP have proved modest, essentially owing to an increase in expenditure much greater than forecast in the SMP and to nonobservance of the set timetable in the implementation of a number of structural reforms aimed at improving the competitiveness of the economy. The objective announced by the Djibouti authorities is to establish two consecutive quarters of satisfactory performance, so as to initiate a PRGF as of 2006, with a view to financing the Poverty Reduction Strategy Paper (PRSP).

Sectoral developments in the national economy in 2004, compared with the previous year, were as follows:

- Overall, the volume of port traffic declined by 19 percent as a result of the reduction in trans-shipment trade (-15 percent), which alone represented more than 85 percent of all port activities.
- Air transport, by contrast, recorded a satisfactory performance, notably in aircraft movements (+10 percent) and passenger traffic (+17 percent). However, freight fell by 20 percent during the period.
- Traffic on the railway linking Djibouti and Ethiopia continued to decline, with the volume of merchandise transported falling by 25 percent (notably, a decrease of 43.7 percent for Ethiopian imports).
- With a total of 120,657 truck movements, road transport between Djibouti and Ethiopia decreased by 6 percent.

The production of running water by the national water authority (ONED) remained virtually the same (-0.1 percent), while the production of electric power by the national electricity company (EDD) rose by 4.3 percent. In addition, the invoiced consumption of these two public enterprises increased during the year by 3 percent and 4 percent, respectively. As regards economic activity, the first five months of 2005, compared with the same period in 2004, show the following:

(a) An improvement in port traffic, up 5 percent owing to stronger exports; and

(b) An annual inflation rate of about 3 percent.

The cost of Government employees constitutes more than one third of all government expenditures. There has been discussion lately to decrease this financial burden: however, the 2004 budget has made provision for additional recruitment of staff, albeit in the social sectors (Health, Education and Social Affairs). Budgets are adjusted or corrected at the end of the respective fiscal year. Attention is drawn to the discrepancies between the budgeted assets and expected liabilities and the actual disbursement or receipts.

The economy grew at 2.6% of the GDP, with inflation at 1.5%. The law on “Code de famille” was promulgated, as a support to Women. The adjusted budget is balanced between assets and expenditures. The amount received from the rent of Camp Lemonier to the US forces encouraged Government to cancel the tax on cooking oil that impacts adversely the poor. Overall, there has been an increase of the State assets by 2.18%. However the budget of the Programme d’Investissements publiques (PIP)” has decreased by close to 54% to the previously anticipated budget (from 8.5 billions to 3.9 billions DJF) due to an over-optimistic expectation of external assistance.

Taxation has been decreased to encourage the growth of the transportation sector to encourage industrial production. Tax on tobacco, petrol has been increased by about 16% to offset the decrease in direct taxes. Government expenditures reveal an increase in the Personnel of the Ministries of Education, Health, Justice, Social Affairs and to the “Pole Universitaire” (60 millions DJF). A draft for the Youth is programmed for a period of one year that includes 3 months of military service and 9 months of technical training to facilitate job searching (225 millions DJF). The budget of the Ministry of Health witnesses an increase in the number of employees leading to an increase of 10.62% in the budget. Also there is an increase in the amount slotted for equipment, medical supplies and Hopital Peltier.

Foreign Investment by Dubai and the United Arab Emirates

Dubai Ports International (DPI), part of the Ports, Customs and Free Zone Corp. (PCFC), is working closely with the Government of Djibouti and developing a master plan for Djibouti and Doraleh with a total investment of $30 million. "This huge plan will encompass a vision for the development of a container terminal, free zone and logistics centre and an oil terminal in Doraleh[9].

"In the initial stage, DPI will create a deep water oil jetty capable of handling vessels up to 80,000 dwt. On the landside, DPI will provide a causeway linking the tank farms to the Djibouti-Ethiopia highway. This will provide the necessary link to the highway providing access to a major market in Ethiopia from Djibouti." The new project is part of a strategic development plan designed by DPI to develop the Djibouti port as a hub port for shipping on the Red Sea and the Indian Ocean. "The project has already received commitments from customers who will build and operate tank farms in Doraleh utilising the oil jetty being constructed by DPI. Work on the oil terminal project along with the road linkages has already commenced.

Djibouti Port handled 242,705 TEUs in 2003 compared with 177,954 TEUs in 2002. It also handled 4,566,538 metric tons of bulk cargo in 2003, compared with 3,523,019 in 2002. Investment by various Dubai-based entities in Djibouti has exceeded Dh2.2 billion ($600 million) following a management takeover of the country's major harbor by DP World, Dubai's government-owned port operator, officials said[10].

Following investments made by key Dubai government entities in Djibouti, some UAE-based private investors are also gearing up to launch projects in the strategically located East African nation. These plans include setting up of two hotels and a waterfront tourist

complex. DP World manages the country's seaport and airport and has committed $300 million to build a new container terminal in the Doraleh area, where a $150-million oil terminal has been built. Djibouti is also developing a free trade zone that is managed by Jebel Ali Free Zone Authority. The country also has an agreement with Dubai Customs International to manage its customs administration.

2.3 Geography and Climate

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.

Map of Djibouti

2.4 Political / Administrative Structure

Basic political / administrative structure and any recent reforms

The French Territory of the Afars and the Issas became Djibouti in 1977. Hassan Gouled Aptidon installed an authoritarian one-party state and proceeded to serve as president until 1999. Unrest among the Afars minority during the 1990s led to a civil war that ended in 2001 following the conclusion of a peace accord between Afar rebels and the Issa-dominated government. In 1999, Djibouti's first multi-party presidential elections

resulted in the election of Ismail Omar Guelleh.; he was re-elected to a second and final term in 2005.

Djibouti occupies a strategic geographic location at the mouth of the Red Sea, close to the oil fields and near the busiest shipping lanes. Djibouti thus serves as an important trans-shipment location for goods entering and leaving the east African highlands. The present leadership favors close ties to France, which maintains a significant military presence in the country, but is also developing stronger ties with the US. Djibouti hosts the only US military base in sub-Saharan Africa and is a front-line state in the global war on terrorism.

Djibouti has a unicameral Chamber of Deputies of 65 seats; members are elected by popular vote for five-year terms). Last elections were held 10 January 2003 (next to be held January 2008). Djibouti has five administrative districts namely 'Ali Sabih, Dikhil, Djibouti, Obock, Tadjoura. Djibouti's political system remains relatively open but national checks and balances need to be strengthened. In Djibouti, presidents do not serve for life -they are elected by direct suffrage for six-year terms. The national assembly is also elected and constitutionally bears primary responsibility for the legislative process.

While the constitution mandates the classical separation of powers, the country is de-facto governed by a strong executive. In practice the presidential prerogatives- especially those related to the role of the president, the cabinet, the legislature and the judiciary- position the head of the state as a referee among various authorities in the political system. The legislative branch (Chamber of Deputies) is institutionally weak, lacks opposition representation and remains dependent on the executive. The judiciary branch is administratively subservient to the executive branch. The Supreme Audit Institutions (Court of Accounts and the General Inspection Office) were only set up recently. The Court of Accounts has been operational since 2001 and its audit reports on the government budget are published since 2004. The General Inspection Office lacks financial and human resources, impinging on its ability to adequately perform its supervisory role[11].

The judiciary is composed of a lower court, appeals courts, and a Supreme Court. Codes based on French civil law are administered in a lower court and a court of appeals in the capital. Urban crime is dealt with in the regular courts in accordance with French-inspired law and judicial practice. Civil actions may be brought in regular or traditional courts. Shari'a (Islamic code) is restricted to civil and family matters. Traditional law (xeer) is often used in conflict resolution and victim compensation. The Supreme Court rules on constitutional questions.

External accountabilities also remain weak Djibouti holds regular and peaceful elections monitored by foreign observers, and a vocal independent press that openly demands greater accountability in the governance process is allowed to circulate freely. However, the opposition remains weak and without representation in parliament as a result of the “winner-takes-all” electoral system. The Djibouti electoral system awards the party that wins the majority in one district all the parliamentary seats of that constituency. This means that the opposition, which scored under 50% in each of the five constituencies in the last parliamentary elections - failed to win a single seat. Djibouti's civil society remains weak and fragmented, playing a limited oversight role.

Women's political representation has slowly increased over the years. Currently a woman serves as Minister of State for the Promotion of Women's, Family, and Social Affairs. Another woman was appointed as President of the Supreme Court, becoming the highest-ranking female official and, according to the Constitution, could become interim President should that position become vacant. Legislation was introduced to slowly

change this imbalance. Political parties are now obliged to include a given minimum of female candidates on their lists. The last parliamentary elections, held in January 2003 marked the first time women will sit in the Djibouti assembly: seven female candidates were elected as members of parliament.

Key political events/reforms

Internal Accountability: National Checks and Balances

Djibouti's political system remains relatively open but national checks and balances need to be strengthened. (See section above) The elected national assembly constitutionally bears primary responsibility for the legislative process. And there is a relatively strong constitutional basis for parliamentary and judiciary authority over the executive. However, in practice the presidential prerogatives are over-bearing. Consequently, the legislative, the judiciary and the supreme audit institutions remain a limited source o f internal checks and balances.

The legislative branch (Chamber of Deputies) is institutionally weak, lacks opposition representation and remains dependent on the executive. Djibouti's national assembly is made of a fragmentary body of politicians, mostly grouped into the presidential party bloc, with some seats informally assigned along ethnic and tribal lines. The constitution grants the legislative branch the authority to approve the state budget which is sent to parliament for approval in November. But parliamentary discussions on the budget are not detailed and hence do not serve as an effective legislature oversight o f the executive.

Overall, the parliament's input in policy implementation remains minimal, partly because the parliament does not have the staff and resources necessary to effectively monitor and control Djibouti's government, but also because the executive often communicates all important proposals too late, preventing the legislature from exerting any meaningful influence. And even assuming adequate and timely information, Djibouti's parliament lacks the institutional tools necessary to influence the course of rule-making. Nor does Djibouti's legislature have direct links with public opinion. The public has notice only once a final rule or piece of legislation is passed.

The judiciary branch is also administratively subservient to the executive branch. The Ministry of Justice and the Ministry of Finance control the appointment, promotion, assignment, income and benefits of judges. The government promulgated a new law on judicial organization in 2000 providing for the separation of the court system from the Ministry of Justice. However, the law has not been enforced to date. Constitutional provisions for a fair trial are not respected universally because of interference from the executive branch. And the Constitutional Council, which was set up with the main objective of granting the judiciary branch oversight capacity over the executive and the legislature, has not been an effective source of checks-and-balances.

The Supreme Audit Institutions (Court of Accounts and the General Inspection Office) were only set up recently and do not perform yet effective oversight functions. These central oversight bodies are all attached to the office of the Prime Minister and essentially report, through him, to the Council of Ministers. This affects the independence and the effective functioning of these internal audit institutions. In addition, the intervention of these central oversight bodies is often resisted by the incumbent Ministers -who as members of the Council of Ministers are constitutionally higher in authority than the civil servants at the head of the oversight agencies. Since 2001, Ministries are required by law to provide accounting documentation to the Court of Accounts for review. In 2003, the Court of Accounts released its first audit report on the

government budget. Since 2004 its audit reports are published. While the General Inspection Office (set up in 2001) is also invested by law with power to audit public accounts, it has not been operational yet owing to lack o f human resources.

External Accountability: Elections, the Media and Civil Society

Djibouti holds regular and peaceful elections monitored by foreign observers -but the opposition remains weak and without representation in parliament as a result of the winner-takes-all electoral system. Political pluralism was slowly introduced in Djibouti. A 1992 law restricting political parties to four expired in 2002. Before 1992, Djibouti had been a one-party state since gaining independence from France in 1977. The country first full multi-party elections was held in January 2003. The pro-presidential coalition took all 65 seats in the national assembly leaving the country with no parliamentary opposition. Parties supporting the President - grouped under the “Union pour la majorite presidentielle” (UMP) - won 63 percent o f the votes. Even if the opposition alliance gained over 37 percent of all votes given in Djibouti, it will have no parliamentary representation during the next six years. The Djibouti electoral system awards the party that wins the majority in one district all the parliamentary seats of that constituency. This means that the opposition - which scored under 50 percent in each of the five constituencies in the last parliamentary elections – failed to win a single seat.

Women's political representation has slowly increased over the years. Women generally have been excluded from senior positions in government and in the political parties even though they legally were entitled to participate in the political process. No women served in the legislature. In 1999 the President announced the appointment of the first female minister to his cabinet. Hawa Ahmed Youssouf served as Minister of State for the Promotion of Women's, Family, and Social Affairs, and reports to the Prime Minister. Khadija Abeba, was appointed as President of the Supreme Court, becoming the highest-ranking female official and, according to the Constitution, could become interim President should that position become vacant. Legislation was introduced to slowly change this imbalance. Political parties are now obliged to include a given minimum of female candidates on their lists. The last parliamentary elections, held in January 2003 marked the first time women will sit in the Djibouti assembly: seven female candidates were elected as members of parliament.

A vocal independent press that openly demands greater accountability in the governance process is allowed to circulate freely. The government owns the principal newspaper, “La Nation”, which is published biweekly. There are several opposition-run weekly and monthly publications that circulate freely and openly criticize the Government. The government also owns the radio and television stations (RTD). The official media is generally uncritical of government leaders and government policy. Foreign media (The British Broadcasting Corporation, Radio France Internationale and Voice of America) broadcast in the country. Djibouti has only one government-owned Internet service provider. Academic freedom is broadly respected. Teachers can speak and conduct research without restriction.

The Constitution, while declaring Islam to be the state religion, provides for freedom of religion, and the Government generally respected this right in practice. Djibouti's civil society remains weak and fragmented, playing a limited oversight role. The Constitution provides for freedom of peaceful assembly and association provided certain legal requirements are met. Non-political associations must register and be approved by the Ministry of Interior (MOI). The Ministry of Interior also requires permits for peaceful assembly and monitors opposition activities. While permits have been generally

approved, the Ministry of Interior has instructed security forces to disperse popular demonstrations and strikes.

The NGO community in Djibouti is fragmented into a small myriad of associations, whose most active members are women and young people who play an advocacy role on health, education and environmental issues (HIV/AIDS, youth unemployment, female genital mutilation, child mortality, gender gaps in education, and so on). Even though the government launched a consultative process with civil society in the context of the PRSP formulation, the involvement of civil society organizations in the country's governance process remains fairly limited.

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 o f 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 5th 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 5th 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 o f 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 lulled 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 o f 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 o f 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 PAPFAM, 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 PAPFAM (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

4 HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

The first health facility in Djibouti was established in 1897 by the Ethiopian Railways Company. This facility was purchased by the State in 1901 to which was added a small facility for the tuberculosis patients and a pavilion of 12 beds for the medically indigent. In 1949, another pavilion for patients suffering from pulmonary diseases and a laboratory were added. The total capacity had become 330 beds then. In 1953, a surgical block was added named after Guibert Germain, as well as clinics for the civil servants, a blood transfusion unit and a new kitchen.

In 1955, the hospital is renamed after General Peltier, to commemorate his contribution as Chief Physician over 25 years; A new wing of operating theaters were also added then. In 1968, a 35-bed maternal ward (Maternite Martial), as well as a 30-bed pavilion for Eye and ENT were added. In 1989, the Dar Al Hanan Maternity ward was inaugurated.

4.2 Public Health Care System

Organizational structure of public system

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. Autonomy is proposed for the secondary care hospital in Balbala, for the Dar Al Hanan maternity, for the Centre Paul Faure for Tuberculosis and Pulmonary diseases and for the Centre Yonis Toussaint dedicated for the screening, diagnosis, treatment and follow up of patients suffering from HIV/AIDS and other STDs. In addition to health care facilities, autonomous status is being considered for the Ministry's educational centre and for the Epidemiologic surveillance unit. Autonomy has also been granted to CAMME, the procurement and distribution agency established to insure the availability of medicines and medical supplies.

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. The proposed decentralization scheme would produce the following organization chart for the Ministry of Health[13]:

1. Minister of Health
    1.1. Autonomous Facilities
        - Hopital General Peltier
        - Centre Paul Faure
        - Hopital de Balbala
        - Maternite de Dar Al Hanan
        - Centre de Transfusion Sanguine
        - CFPS
        - CAMME
    1.2. Advisory Boards

- Professional Orders
- Conseil National de Sante Publique

1.3. Advisors

1.4. Inspection Generale de la Sante

- Inspection Technique
- Inspection Administrative et Financiaire
- Inspection des Pharmacies

1.5. Secretaire General

1.5.1. Unite de Gestion des Projets

1.5.2. Direction des Etudes de la Planification Sanitaire et de la Cooperation Internationale (SIS, EP)

1.5.3. Direction d'Epidemiologie et d'Hygiène Publique

- Service de Contrôle des maladies Transmissibles
- Service d'Hygiène Publique
- Laboratoire de Santé Publique
- Centre Yonis Toussaint

1.5.4. Direction des Soins de Santé de Base

- Service d'Organisation Sanitaire et de la Décentralisation
- SME
- SEPS/MEPS
- Médecine Scolaire
- Service National des Laboratoires
- Organes Consultatifs et Comites techniques

1.5.5. Direction du Médicament et de la Pharmacie

- Service Réglementation
- Service Pharmacopée
- Service Contrôle de Qualité des laboratoires
- Organes Consultatifs : Comite national des médicaments et Commission Contrôle Publicité Pharmaceutique

1.5.6. Direction Administrative et Financière

- Service Ressources Humaines
- Service Financier
- Service Juridique
- Service Bâtiments, Equipements et Maintenance

1.5.7. CFPS

The referral system is based on the following structures:

- Health posts
- Community health centers
- District medical centers
- Units for Hygiene and Epidemiology
- Maternity at Hayableh
- Centre Yonis Toussaint
- Centre Paul Faure (Tuberculosis and Pulmonary)
- Maternity Dar Al Hanan

- Hospital Balbala
- Hospital General Peltier

The referral scheme, produced herewith below, depicts the regionalization of care and the four levels of the referral system[14]. Health posts would number 22 in the country; there will be 7 community health centers in Djibouti-town; each of the five regional districts would have community health centers with additional facilities for in-patient care for maternity and simple conditions (Level III). The central units, all in the capital, would provide the support in Level IV.

Every level of care has been detailed as far as the responsibilities attached to every unit. In addition, job descriptions of the human resources needed to staff these facilities have been drawn and approved, within the "carte sanitaire" health planning project[15], initiated by WHO and finalized by the Planning Unit in the Ministry of Health.

Level I	Health Posts	Djibouti	Gabode (Prison) Dorale PK 12
		Ali Sabieh	Mouloud Assamo Dasbio Holl-Holl Ali-Adde Goubetto
		Dikhil	Yoboki As-Yela Gourabous
		Arta	Wea Damerjog
		Tadjourah	Sagalou Randa Adaylou Dorra Day
		Obock	Allaili-Dada Wadi Medeo (not functional)

Health posts undertake basic health needs and CPN/PF

Level II	Community Health Centers	Djibouti	Farahad Ibrahim Balala Ambouli Arhiba Einguella Balbala II Hayableh

Community health centers offer in addition clinical services in General Medicine, Minor surgery, Nutrition. It also provides laboratory services and pharmaceuticals.

Level III	"Centre Medico-Hospitalier"	Ali Sabieh
		Dikhil
		Tadjourah
		Obock
		Arta

The "Centres Medico-Hospitaliers" offer in addition Minor surgery, Maternity, radiological services, and pharmaceuticals including treatment against Tuberculosis.

Level IV	Hospitals	Hopital General Peltier (Referral Hospital)
		Hopital de Balbala (General hospital)
		Maternite Dar Al Hanan (including Echography)
		Centre Paul Faure (Tuberculosis and Pulmonary)
		Centre Yonis Toussaint
		Service d'Hygiene

Key organizational changes over last 5 years in the public system, and consequences

Planned organizational reforms

4.3 Private Health Care System

The government puts great store by the promotion of private investment, which is the engine of economic growth. To achieve this objective, the government will finalize the revision of the laws on the various tax exemptions, with a view to harmonizing and

integrating them into the Budget Law and the General Tax Code. These arrangements will facilitate the simplification and streamlining of the exemptions system. The authorities undertake to adopt the Investment Charter in 2006.

The acceleration of growth that is at the heart of the economic reform cannot occur unless the private sector reacts favorably to the reforms. These essential structural reforms will be implemented on the basis of the following key positions:

- In the area of tax reform, the objectives are to improve revenue collection with a view to reducing the tax burden without disturbing the overall fiscal balance;
- For public expenditure, the objective is to improve management through more efficient functioning of the productive utilities and social services: education (including training) and health (including prevention and hygiene);
- For the structural reforms, the objective is to improve the external competitiveness of the economy, with the adoption of reforms of the Labor, Commercial, and Investment Codes, and to set up an operational one-stop shop;
- Improvement of the banking system through the enhancement of supervision; and
- Out of awareness that the establishment of a climate conducive to the development of private investment is dependent on reducing the costs of production factors, the government will, in particular, pursue in 2005 the reforms of public enterprises (Electricité de Djibouti, Office National des Eaux de Djibouti, and Djibouti- Télécom), as well as the improvement of their financial profitability. The finalization of these reforms will require the financial support of donors and lenders, and notably of the World Bank.

To achieve these objectives, the government will set up, within the Ministry Finance responsible for Privatization, a unit responsible for ensuring observance of the pertinent terms and conditions. The country's medium-term development strategy is announced in the PRSP finalized at the beginning of 2004. The program of reforms is hinged on the establishment of a favorable macroeconomic and structural environment with the following objectives:

- Adoption of a medium-term fiscal policy likely to reduce the financial vulnerabilities while improving the composition of public expenditure in support of growth and poverty reduction; and
- Growth driven by the private sector, with the promotion of an attractive climate for private investment.

The strategy pursued is based on four key actions: (i) the establishment of a legal framework conducive to private investment; (ii) the improvement of labor conditions; (iii) the pursuit of the reforms aimed at reducing the costs of production factors and improving the management of public enterprises; and (iv) the strengthening of good governance.

The authorities will promote the development of private initiative, with the implementation of a strategy and mechanisms in support of small and medium-sized enterprises and industries (SMEs and SMIs). The purpose of the approved management center set up within the Djibouti Chamber of Commerce is to assist private operators in their management and eventually to enhance their competitiveness on both the national and regional markets. The authorities will also strengthen the expansion of microfinance, in particular by formulating a national microfinance strategy, already being drafted in collaboration with the Central Bank of Djibouti.

4.4 Overall Health Care System

Organization of health care structures

Brief description of current overall structure

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.

5 GOVERNANCE/OVERSIGHT

5.1 Process of Policy, Planning and management

National health policy, and trends in stated priorities

Health policy is based on the following objectives and is being implemented within the Health Sector Reform in partnership with the donor's community:[16]

- To insure access to health services to the entire population and restore the confidence in these services through the amelioration of the quality of services provided
- Enforce a coherent and properly coordinated policy based on Prevention
- Strengthen Human resources through Education and Training
- Define a policy on Pharmaceuticals that insures the availability of medicines at affordable prices
- Encourage the Community to progressively participate in the financing of medical services
- Strengthen the national health programs (Malaria, HIV/AIDS, Tuberculosis, Reproductive Health)

There has been a consistent expression for the need to establish effective mechanisms to recover part of the costs incurred in the delivery of health care, most notably as concerns the purchase of medicines.

The rationale behind this cost recovery stems from several factors, namely:

- The population is effectively paying to receive care, because of the fact that medicines may be lacking, or because they often seek care in private facilities
- There is a large proportion of the population that is not Djiboutian, since expatriates from neighboring countries and refugees seek care in the country because of the availability of services
- The principle of cost recovery may in fact lead to a rationalization of the demand for services
- There is a need to obtain funds to insure the availability of services and pay for minor repair and maintenance

The Government has established the CAMME or "Pharmacies Communautaires" as one measure to increase the recovery of the costs of medicines and medical supplies, albeit the cost will be less since generics will be used and the purchase in volume of medications will bring down the costs.

One should note that the health policy omits the need to encourage the provision of care through the private providers, and is notably vague on the possibility of financing care through social health insurance. We will discuss these matters in details further down in this report.

Formal policy and planning structures, and scope of responsibilities

Governance environment

Improved governance, and in particular stronger accountability, both internal and external, would contribute to improve public expenditure performance. Internal and external accountability are not substitutes. They reinforce each other. Stronger external accountability systems can reveal weaknesses in internal accountability, thus requiring action by the government to be able to respond more effectively to external demands. Stronger internal accountability is needed to generate information about what the government is doing, information on which external accountability depends. Allowing more public debate on the state budget and greater citizen's voice in the quality of service delivery (external accountability) will lead the government to pay more attention to monitoring and evaluating expenditure performance.

Publication of reports by effective government audit agencies (internal accountability) will improve budget control. Progressive focus on performance-oriented budgeting will help reform the civil service corps to achieve greater bureaucratic efficiency. Tackling accountability weaknesses can help improve budget management. When institutional capacities are low at the start, the road to improved budget management may need to be covered in small steps.. Reforming basic incentives that strengthen accountability is the place to start. As incentives become better aligned and internalized and as administrative capacity grows, more advanced reforms can be deployed to support deeper institutional change. Strong accountability in public administration can help the government spend wisely and predictably in line with priorities. By ensuring more active participation of citizens in decision-making, stronger accountability can respond to the needs o f the different ethnic groups present in the country. It can also help develop and deploy administrative capacity to take sound decisions at the top and to implement them well. Stronger accountability can also help better manage aid flows. For one, donor coordination is easier where the recipient has a legitimate and credible national development strategy and budget process that can serve as the common framework.

Transparent and accountable budget and public procurement systems can also encourage donors to shift responsibility toward the recipient, reducing duplication, waste and transaction costs. And it can allow donors to provide budgetary aid flexibly, keeping them from crowding into a few fashionable sectors - and thus lessen concerns about absorptive capacity.

A number of practical measures can help strengthen accountability in budget management. These measures include: (i)improving budget classification to link expenditures with expected outcomes; (ii) consolidating public finances by bringing contingent liabilities under the state budget's oversight; (iii) improving budget credibility by casting fiscal choices in the medium-term, taking into account revenue and financing constraints; and (iv) moving the budget process towards a greater performance orientation.

In the current context of Djibouti, it is not realistic to expect improved budget formulation in the form of full-fledged medium-term expenditure frameworks. Rather, the government could benefit from the consultative process that was initiated during the PRSP preparation to translate policy priorities into budget allocations. This would entail including in the budget key sectoral programs to be financed and the main services that are expected to be rendered. Even if just for one year, that would be already a good start. In the short-run, it will be necessary to take a pragmatic approach by building incrementally on existing systems to achieve more effective monitoring capacity and

strengthen accountability. In the absence of a baseline medium-term expenditure framework, multi-year fiscal scenarios can help in assessing likely patterns of spending.

Analysis of plans

Cost recovery is considered a “regressive” measure as far as the poor and indigent population is concerned. In most cases, it may lead to inequity in the access of care and in its financing, to the detriment of the poor. This policy goes against the “pro-poor” policies that are advocated by the Government and by international donors. In the case of anti-retrovirals, a decision to charge non-Djiboutians for these medicines, may also challenge the responsibility of the Government to protect Society, since well treated HIV patients do decrease the risk of transmission of this disease. (See below)

Key legal and other regulatory instruments and bodies: operation and any recent changes

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.

Djibouti's position in global governance data

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.

Djibouti's lowest scores pertain to perceptions of its overall government effectiveness. Djibouti's scores only 16.5, compared with 49.9 for the MENA region and 41.5 for lower middle income countries. This index uses a scale ranging from 0-100, and higher is better.) The quality of public service provision and of the bureaucracy, the competence o f civil servants, the independence of the civil service from political pressures, and the credibility of the government's commitment to policies are among the aspects measured by this indicator of government effectiveness.

However, the six aggregate governance indicators should be interpreted with caution in view of the paucity of governance data available for Djibouti. Out of the 200 cross-country indicators used by Kaufmann et a1 (2003) to construct their six aggregate governance indicators, only 10 are available for Djibouti. These ten indicators are derived from the only 2 data sources that cover Djibouti (Freedom House and Heritage Foundation and Wall Street Journal), out of the 25 data sources employed by Kaufmann et a1 (2003).

5.2 Decentralization: Key characteristics of principal types

5.3 Health Information Systems

Organization, reporting relationships, timeliness

Data availability and access

Sources of information

The follow up and monitoring of the Health Sector Project will be the responsibility of the Directorate of Studies and Planning. This will be accomplished through the conduct of surveys on the utilization of medical services, the epidemiologic indicators, the availability of pharmaceuticals, the PAPFAM study planned for 2002 to establish the baseline indicators for child and maternal mortality rates and the review of quality provided. In addition, data will be collected on the human and physical resources available for the health system.

5.4 Health Systems Research

5.5 Accountability Mechanisms

Governance and service delivery

In Djibouti service delivery outcomes remain among the lowest in the world, in spite of its relatively high GDP and the large amount of foreign grants per capita (about $900 and $ 77 respectively). Djibouti's social indicators rank 157th among 174 countries on the UNDP's Human Development Index. Djibouti displays extremely high rates of adult illiteracy, morbidity and maternal and infant mortality. About 50 percent o f Djibouti's children do not attend school, compared to over 70 percent in neighboring Yemen, and more than 20 percent of those enrolled do not complete the six years of primary education. Female illiteracy reaches 70 percent (compared to 49 percent for men). Despite progress in expanding access, Djibouti's education system is still not on track to meet the Millennium Development Goals (MDGs). Illiteracy is also very high, especially for women (85 percent). There are also large inequalities in access to education services: enrollment varies widely across income levels, gender, and regions. Basic health indicators are also very low. Life expectancy, the overall health index, is estimated at 49 years, one of the shortest in the world. Infant mortality is at 103 per 1000, high by international standards. The immunization rate is only 45 percent, and malnutrition is a serious problem, with indications that 14 percent of children under the age of five suffer from acute malnutrition, and 31 percent from chronic malnutrition. Diarrheic illnesses and acute respiratory infections are the most extant causes of infant

mortality. Maternal mortality rate is high at about 700 per 100,000 live births and for extremely poor women this rate is as high as 9 percent.

The quality of governance in Djibouti has affected the link between public expenditures and their expected outcomes. Recent World Bank research powerfully argues that governance affects service delivery (World Bank Development Report "Making Services work for the poor",2004; World Bank Middle East and North Africa Report "Better Governance for Better Economic and Social Development, 2003). Recent cross-country empirical studies corroborate these findings. Rakjumar and Swaroop (2002) found that governance affects the relationship between public expenditures and their expected outcomes. In particular, the authors found that public health spending lowers child and infant mortality as countries improve governance. Their findings also revealed that as countries improve governance, public spending on primary education becomes more effective in increasing primary education attainment. Weaknesses in governance (in particular insufficient inclusiveness and accountability in public affairs and the budget process) have negatively affected the link between public expenditures in education and health and their outcomes.

Insufficiencies in accountability (reflected in the excessive political interference and discretion in the administration of public affairs) have rendered the Djibouti public sector vulnerable to weak expenditure management and bureaucratic inefficiency. Given the important role of government in delivering public services in Djibouti, the institutional arrangements that govern public sector management (budgetary rules, procedures, restraints and alike) impinge on actual service delivery. Because budgets translate policymakers' priorities into policies, programs and projects, a review o f the budget process (formulation, execution and control) shows the degree of accountability between policymakers, service agencies and the service users. In spite of considerable progress achieved in expenditure management reform over the past few years, weak transparency and accountability remain a concern throughout the budget process.

A transparent and accountable public expenditure system may be a central mechanism for ensuring good service delivery, but it is only as effective as the civil service that administers it. In Djibouti, institutional weaknesses and inefficiencies in civil service administration have also hampered effective service delivery. With virtually no room for spending on other non-wage aggregates, policy actions on the wage bill are crucial steps in allowing greater budget flexibility, improved efficiency o f social spending and control of public finances. Wages and salaries take up most of the public expenditure devoted to the social sectors. And access to water and energy is also limited owing to the high utility prices and insufficient capital and maintenance spending.

Governance and the business climate

The quality of governance, through its impact on economic, fiscal and regulatory policy decisions, have also affected Djibouti's business climate. The private sector contributes only about 20 percent to GDP and investment has been staggering. Governance increases the cost of doing business in Djibouti owing to: (i) high production costs (capital, labor and utilities) triggered by weak accountability and weaknesses in public sector administration, and (ii) high transaction costs triggered by bureaucratic red tape. This confirms recent empirical findings on the link between governance, investment and growth (Kauffman et al, 2003)

A key aspect of the quality of the business climate is the rule of law - the security of property rights, Main concerns expressed by investors include the unpredictability of the judiciary (due to the lack of autonomy of judges) and the slowness of the court system in resolving disputes. A good illustration of the impact of these governance weaknesses

on the business climate and the cost of doing business in Djibouti is the lengthy liquidation of two commercial banks (A1 Baraka Bank and the Banque de Djibouti et Moyen Orient), which has yet to be finalized. The two banks were placed in liquidation in 1998 and 1999 respectively. But the recovery of these bank's debts and the gradual reimbursement of depositors have been slow, owing to judicial delays and difficulties in liquidating real state collateral.

Investors in Djibouti are also concerned about the high transaction costs triggered by administrative delays and cumbersome procedures for starting and exiting a business. This has hampered the development of small and medium enterprises, leading a growing number of small entrepreneurs to operate in the informal sector. Another obstacle for businesses operating in Djibouti is the lack of predictable application of rules and regulations which impedes the analysis of investment returns. Entrepreneurs in Djibouti have expressed concerns about the bureaucratic arbitrariness in the determination of taxable profits, the inconsistent application of tax exemptions, and the lack of a commercial court for the resolution of commercial disputes.

Djibouti's governance quality has also affected the cost of doing business through its impact on production costs (mainly, its impact on administrative overheads, labor costs and utility prices). Weaknesses in the judiciary framework have contributed to the high cost of capital and limited credit availability to the private sector. Faced with growing non-performing loans (due to unresolved disputes over real state collaterals and difficulties in enforcing loan agreements) commercial banks have been forced to restraint credit to the private sector and increase the cost of capital, in spite of their comfortable liquidity position. Lending rates average 13 percent on secure loans, and between 18 percent and 25 percent on cash facilities. The apparent insensitivity of wage rates in Djibouti to the high level of unemployment reflects weaknesses in governance, and in particular, a rigid legal framework governing the labor market, and a high level of public wages (which serve as a benchmark for private sector wages). Estimated average salaries for Djibouti public sector employees are more than five times the level in Ethiopia and about four times the level in Yemen. The Labor Code (practically unmodified since 1952) includes a number of regulations that inhibit the efficient functioning of the labor market. Besides labor costs, firms operating in Djibouti face high production costs affected by utilities prices (water, telecommunications, power). As the previous section noted, utilities are expensive because of high public wages, a large and increasing tax burden, and poor management practices. Poor collection rate and payment arrears by the central government have also affected utilities' prices.

Moving the governance agenda forward to improve the link between public spending and outcomes

The Djibouti government has embarked on a reform agenda to improve service delivery and the business climate. One of the key pillars of the PRSP is the improvement of governance and public expenditure management to strengthen the effectiveness of public service delivery. The authorities are also committed to a reform agenda aiming at improving the business environment through: i) the simplification and rationalization of the tax system; ii) the reform of the investment, commerce and labor codes in view of reducing the costs of doing business in Djibouti; and iii) the reform of public utilities' management to improve their efficiency and reduce tariffs. A strong political commitment and sustained efforts in these areas will contribute to shift the perceptions of foreign investors about the business climate in Djibouti.

But these reforms will no go far in the absence of stronger accountability, both internal and external, that would be need to improve the link between public expenditure and

outcomes. Internal and external accountability are not substitutes. They reinforce each other. Stronger external accountability systems can reveal weaknesses in internal accountability, thus requiring action by the government to be able to respond more effectively to external demands. Stronger internal accountability is needed to generate information about what the government is doing, information on which external accountability depends.

Allowing more public debate on the state budget and greater citizen's voice in the quality of service delivery (external accountability) will lead the government to pay more attention to monitoring and evaluating expenditure performance. Publication of reports by effective government audit agencies (internal accountability) will improve budget control. Progressive focus on performance-oriented budgeting will help reform the civil service corps to achieve greater bureaucratic efficiency.

6 HEALTH CARE FINANCE AND EXPENDITURE

6.1 Health Expenditure Data and Trends

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.

Budget Ministry of Health
(% of National Budget)

1997	4.5
1998	5.7
1999	4.7
2000	4.4
2001	4.2

Nevertheless, even with this relatively small percentage, only 46% of the budget was effectively expanded in 2001 and 60% in 2002! This under-spending cuts across all budget lines, suggesting that this may be related either to the non-availability of funds, or to a delay in approval of the budget or to over-planning or to a host of bureaucratic delays or to a combination of these and other factors. One will note that despite the fact that there is an outcry on the availability of medicines, heard across all reports and interviews, 30 and 23% of the pharmaceutical outlays were used in 2001 and 2002 respectively.

Budget Ministry of Health (in Thousands DJF)	**Budget 2001**	**Effective 2001**	**Budget 2002**	**Effective 2002**
Office of the Minister of Health	3350	2868	188650	234626
Office of Studies and Planning				
Directorate of Prevention	6657	1300	6657	1350
General Peltier Hospital	83356	69469	83356	67454
Balbala Hospital	1369		1369	204
Centre Paul Faure	5700	1373	25700	945
District of Djibouti	4668	1088	4668	631
District of Ali Sabieh	5722	3507	5722	5356
District of Dikhil	5662	4935	5622	4449
District of Tadjourah	5720	2777	5720	3810
District of Obock	5447	4175	5447	4289
Directorate of Pharmaceuticals	220360	68782	320360	75614
Directorate Administration & Finances	490	41	490	400
Centre Yonis Toussaint			2500	775
Totals	**348501**	**160315**	**656261**	**399903**

Most of the Manpower attached to the Ministry of Health serves in the Hopital General Peltier and the other Level IV facilities, as would be expected (see below). There has

been discussion with donors on the need to decrease the level of staffing in order to alleviate the budget allocated to employment in the Ministries across all sectors. However, as detailed under Government budget above, more employees will be employed in 2004.

Manpower Ministry of Health 2002

Ministry of Health	89
Hopital General Peltier	320
Dar Al Hanan Maternity	29
Balbala Hospital	63
Centre Paul Faure	38
Centre de Sante Communautaire	90
Health Post	12
DHEP	53
CMH Ali Sabieh	33
CMH Dikhil	26
CMH Obock	15
CMH Tadjourah	35
Others	45
Totals	**848**

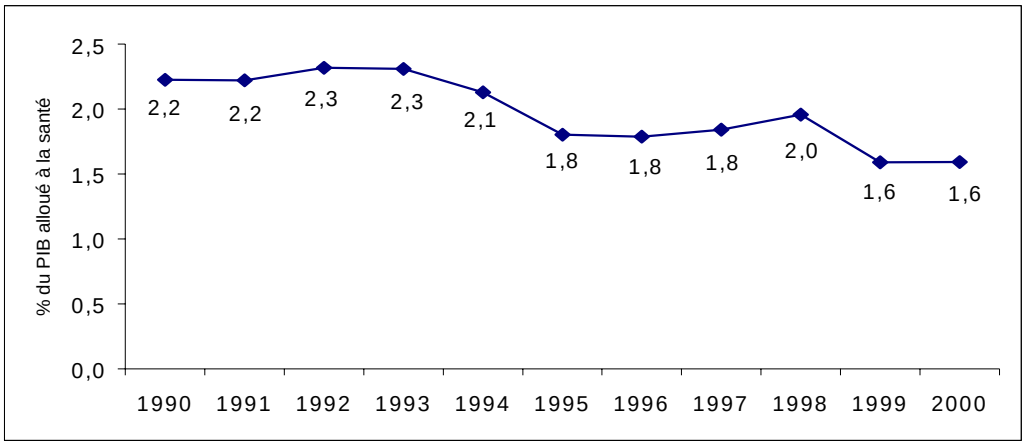
Health care Financing

As noted above, the financing of health care is provided through many sources, including the Treasury, OPS, households, donors. To a large extent, these sources are variable and may not be sustainable.

Percent of the GDP allocated to health care 1990 - 2000

Households

As documented in the National Health Accounts, Households contribute up to 24% of the total health expenditures



The Treasury contribution to health expenditures 1986 – 2003

Years	Overall state budget in Djibouti Francs	Ministry of Health budget in Djibouti Francs	Percent of health budget to total budget
1986	22 851 267 000	1 751 778 000	7.7
1987	22 113 950 000	1 657 999 000	7.5
1988	23 116 900 000	1 784 954 000	7.7
1989	23 709 200 000	1 719 115 000	7.3
1990	23 968 100 000	1 807 013 000	7.5
1991	25 872 597 000	1 841 939 000	7.1
1992	27 008 900 000	1 984 076 000	7.3
1993	28 320 669 000	1 979 292 000	7
1994	32 485 898 000	1 933 542 000	6
1995	31 636 158 000	1 632 814 000	4.3
1996	34 907 350 000	1 577 540 000	3.5
1997	36 808 634 000	1 650 631 000	4
1998	31 561 442 000	1 784 272 000	5.6
1999	35 174 000 000	1 500 053 000	4.3
2000	35 862 000 000	1 568 856 000	4.4
2001	38 232 122 000	1 769 460 000	4.6
2002	39 559 000 000	1 831 199 000	4.6
2003	41 187 000 000	1 804 657 000	4.4

Table 6-1 Health Expenditure

Indicators	1990	1995	2000	2002
Total health expenditure/capita,	-	-	-	-
Total health expenditure as % of GDP	-	-	-	7
Investment Expenditure on Health	-	-	-	-
Public sector % of total health expenditure	-	-	-	4.6

Source:

Table 6-2 Sources of finance, by percent

Source	1990	1995	2000	2002
General Government	-	-	-	27
Central Ministry of Finance	-	-	-	-
State/Provincial Public Firms Funds	-	-	-	-
Local	-	-	-	-
Social Security	-	-	-	-
Private	-	-	-	-
Private Social Insurance	-	-	-	-

Other Private Insurance	-	-	-	-
Out of Pocket	-	-	-	24
Non profit Institutions	-	-	-	-
Private firms and corporations	-	-	-	20
External sources (donors)	-	-	-	29

Source:

Trends in financing sources

Information on the various sources of health care financing is available in the National Health Accounts of Djibouti (NHA) 200017, undertaken in the year 1999-2000. The NHA used the 1996 household survey (EDAM) as well as information received from the providers of health care financing, most notably the Ministries of Health, Interior, Defense and the Office of Social Protection (OPS). Estimates of household expenditures were made using a population base 450,000 inhabitants estimated by the EDAM in 1996.

A follow up of the NHA accounts was undertaken in March 200318. The report of this mission states that the NHA exercise of the year 2000 had the merit of introducing the NHA methodology to the stakeholders and to get an initial approximation of the health expenditures. It was noted nevertheless that the exercise did suffer from several lacunae. These were detailed in the consultant report of March 2003. Moreover, the institutionalization of the NHA team has not been formally established despite the passage of three years already. Certain stakeholders had been sensitized though in an informal manner. The needs for information have not been entered into the information system. No discussion or dissemination of the results had taken place and finally no follow up has been executed.

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.

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. This aide may be paid in kind; for example the purchase direct of medicines and medical equipment. The budget of the Ministry of Health serves also to pay the share of the government in international health initiatives (conventions)

The Office of Social Protection (OPS)

OPS provide 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 do 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.

Some important efforts were undertaken to improve the management of resources at OPS and to increase the control over the expenses of drugs/medicines. The efforts used by the pharmacies of OPS to reinforce the consumption of generic products and to improve the management of medical stocks, supported by an international NGO, will provide for a more rational use of available drugs. Important education efforts regarding prescriptions should be made in order to better meet the objectives of the OPS in control of medications.

Private Health insurance

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.

Private health sector

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.

The sources of financing care

According to the information available, health expenditures amounted to 6,051,589,000 FDJ in 2000. This would represent 7% of the Gross Domestic Product, if we retain the calculations of DINAS. These numbers ought to be treated with caution given the uncertainty of the data related to the size of the population. Nevertheless, one should note that the cost of services in the private sector is elevated due to the regulations relative to the importation of medications and the poor regulation of the private market.

The respective share of the financing of medical care is as follows:

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

Financing Medical Care
(Thousands of FDJ)

	External Cooperation	Employers	State	Households	Totals	Percent
Other Ministries			139000		139000	2.2
Households				1440450	1440450	23.7
Ministry of Health	1777000		1496919		3273919	54.0
OPS		1205220			1205220	19.85
Totals	1777000	1205220	1635919	1440450	6058589	**100**
Percent of Totals	**29.33026**	**19.89275**	**27.00165**	**23.77534**	**100**	

According to studies in 2000, foreign aid constitutes the main source of financing of the health sector. Of each 100 Djibouti francs, 27 come from foreign bilateral or multilateral aid and from NGOs which operate in the country. The difficulties faced by the Ministry of Health, combined with the lack of coordination of donor agencies, leave the task of coordinating this particularly difficult.

According to information in the UNDP 1999 report, the shares of principal donors of foreign funds are:

France	35 %
Spain	32 %
Italy	7.8%
WHO	7.8%

The NGO contribution, which has become very important in the last few years, is difficult to measure in the absence of a national coordinating body for foreign aid. The important role of foreign aid in health care financing highlights the problem of sustainability. The new organizational structure of the Ministry of Health includes a planning department, which will be, among other things, responsible for the coordination of international donors and aid.

Other sources of financing

The contribution of the semi-private-public institutions has been estimated at 128,000,000 FDJ in the 1999 NHA accounts. This last estimate was made after a declaration on the state of affairs by ten important businesses. The Ministry of Interior covers the police force and their dependents estimated at 15,000 persons. This population engenders 2,214 inpatient admissions, 670 deliveries and 45,000 ambulatory visits) The Ministry of Defense covers the Military and their dependents as well (8.5 million DJF). School health expenditures are about 2.5 million DJF.

Finally, the health expenditures incurred at the French military hospital, CHA Bouffard (56 beds- 22,000 ambulatory visits) ought to be taken into consideration. This facility is an important source of secondary and tertiary level services. This facility is contracted to provide medical care to the Djiboutian army personnel and their dependents, in addition of course to the French Army positioned in Djibouti and their families. Many families from the middle and upper classes do use the facilities of CHA Bouffard in return for payment. A figure of 6 millions euros has been advanced as the amount of free care provided by the hospital in 2003!![19]

Household Expenditures on Health Care

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. It is estimated that the total amount spent on medications is 850 million FDJ. The purchase of medications represents 58% of the household expenses. It is important to note that the individual importation of medicines by the pharmacies in small quantities doesn't allow for the competitive pricing.

The total annual expenses for outpatient consultations is estimated at 400 million FDJ, including consultations at the practices of traditional healers who represent 12% of the providers. According to the data from the household survey, hospitalization expenses are 164 million FDJ. The cost of transportation for sick people is estimated at 65 million FDJ or 4% of the total expenses.

Health expenditures by Households

Ambulatory care	24
Hospitalization	11
Medicines	58
Transportation	4
Others	3
Totals	**100**

The recently completed EDAM 2002 survey has only released part of its findings. In response to the question *"Combien le ménage a-t-il depense ay cours des 12 derniers mois pour les soins de sante, pour l'ensemble des membres? »i.e. "How much did the household spend on the health care of its members over the past 12 months*", an average amount of 10,500 DJF was obtained with a median household expenditure of 5,000 francs only. The standard deviation was however (as expected) quite large (26,000+ DJF), which indicates wide variation in the cost of care financed by households.

More information is to be made available as well from the PAPFAM survey.

Household expenditures on Health (EDAM 2002)	**Cumulative**
Expenditures up to 800 DJF per year per household %	40
Expenditures up to 5000 DJF per year per household %	50
Expenditures up to 7000 DJF per year per household %	60
Expenditures up to 10000 DJF per year per household %	70
Expenditures up to 12000 DJF per year per household %	75
Expenditures up to 15000 DJF per year per household %	80
Expenditures up to 25000 DJF per year per household %	90
Average Expenditures per year per household	10569
Median Expenditures per year per household	5000
Standard Deviation	26104

It is important to emphasize that the household surveys are the principal source of information concerning the consumption of health services y households. These will need to be updated to provide information on private medical care. An effort to train personnel must be made particularly in the areas of general accounting and cost analyses for health care services (See below please).

Health expenditures by category

Djibouti's government budget allocation to the health sector is relatively low compared to other countries, at less than 2 percent of GDP. The public health share as a percentage of GDP is showing a disturbing downward trend, falling from 1.70 percent in 1996 to 1.5 percent in

2002. Since the early 1990% resources allocated to health through a voting system have decreased nominally. This decrease was further compounded by lower external aid receipts which fell from USD 11million in 1998 to USD 7 million in 1999, which is a significant 36 percent decline.

Public health expenditure has fluctuated over the past decade and continues to do so. In 1996, the government spent USD 8.42 million which rose to USD 9.12 million in 2000. It then declined to U S D 8.74 million in the following year and increased to USD 9 million in 2002. The share of current expenditure allocated towards health has averaged around 5 percent for the last 5 years decreasing from over 7 percent during the second half of the 1980s, whereas the international standard is around 10 percent. Djibouti's share of total health expenditure to GDP is relatively larger when compared to African countries its size and Sub-Saharan Africa, it falls behind in the proportion of total public expenditure spent on health.

Within the health budget, expenditure on personnel has on average formed 78% of the total public heath bill between I996 and 2001. However, a near doubling of expenditure on equipment from U S D 1.96 million in 2001, to U S D 3.68 million in 2002, lowered the personnel share to 64 percent, which remains high. The delivery of health services depends critically on an adequate level of material or equipment and the low levels o f spending on health equipment in Djibouti continues to remain a concern.

On a per-capita basis, public health expenditure declined from USD 14.52 in 1996 to USD 11.4 in 2002, which is not keeping pace with the growing population. A declining share o f the health budget in GDP, a rapidly expanding population, together with the continued provision of free health care is leading to a deterioration in health infrastructure and fall in the quality o f care.

Djibouti is among the relatively higher GDP per capita African countries that also has high health care costs. Djibouti's external aid for health is one of the highest in Africa. Despite these high expenditures, however, Djibouti's health indicators are among the worst in Africa.

Table 6-3 Health Expenditures by Category

Health Expenditure	1992	1995	2000	2002
Total expenditure: (only public)	-	-	-	-
Per capital expenditure	-	-	-	-
% By type of service:	-	-	-	-
Curative Care	-	-	-	-
Rehabilitative Care	-	-	-	-
Preventive Care	-	-	-	-
Primary/MCH	-	-	-	-
Family Planning	-	-	-	-
Administration	-	-	-	-
% By item	-	-	-	-
Staff costs	-	-	-	-
Drugs and supplies	-	-	-	-
Investments	-	-	-	-
Grants Transfer	-	-	-	-
Other	-	-	-	-

Source

6.2 Tax-based Financing

Levels of contribution, trends, population coverage, entitlement

Key issues and concerns

6.3 Insurance

Table 6-4 Population coverage by source

Source of Coverage	1990	1995	2000	2002
Social Insurance	-	-	-	-
Other Private Insurance	-	-	-	-
Out of Pocket	-	-	-	-
Private firms and corporations	-	-	-	-
Government	-	-	--	-
Uninsured/Uncovered	-	-	-	-

Health insurance, provided through the OPS, is only open to workers in the private sector and contractual workers in the public sector. Civil servants do not have health insurance (they use the public hospital services). The President o f the Republic of Djibouti has recently requested that the OPS assess the viability of extending health insurance coverage to them.

Primary care is provided through two OPS health centers, one for families and another for employees. Hospitalizations are referred to the public hospital Peltier, where employers are supposed to finance costs.

While the health branch at present is generating an operational surplus, current financing arrangements are not based on technical valuation of unit costs and utilization patterns across the insured population. Health expenditures (including those related to work-related accidents) currently represent 5 percent o f the total non-administrative expenditures of the OPS (less than 0.1 percent o f GDP). Since the health branch is financed by a 6.2 percent contribution rate, in theory it has revenues of DF 1.17 billion-10 times current expenditures. In reality, part of the surplus of the health branch is financing the deficit of the pensions branch, where revenues (resulting from 8 percent contribution) represent only 80 percent of expenditures.

Current statistics of primary health services suggest reasonable utilization rates. No data is available regarding the utilization of tertiary services. There are, on average, 6 visits per plan member (contributors, beneficiaries, and families). Of these, roughly 50 percent require medical attention, costing on average DF 1,548 (USD 9). With this level of utilization and average cost, expanding coverage to the 6,900 civil servants and retirees (assuming similar family sizes and utilization patterns) would cost additional DF 31 million (28 percent of current expenditures). These costs, however, do not include hospitalization, which is likely to be an important, and currently unaccounted item.

An actuarial valuation of the health insurance branch of the OPS is required urgently. The OPS is preparing terms of reference to launch an initial phase of this study, which would consist of collecting detailed data on utilization and costs. Technical assistance for this study could be financed through the Health Sector reform project currently under implementation. Indeed, the second phase of this project has a component on health financing, with a budget set aside for studies.

In the context of the health sector reform project, a study should be conducted to assess the potential of the OPS to become the core of the health insurance system in Djibouti. This study will first explore the financial implications of extending current services to the population of civil servants. A second component of the study will assess the appropriateness of the benefit package, contractual arrangements with providers, payment systems, financing mechanisms, and management and information systems. The study will propose a multi-year program to strengthen and expand the health insurance system in Djibouti as well as the needs in terms of technical assistance

Trends in insurance coverage

Social insurance programs: trends, eligibility, benefits, contributions

Social insurance programs are designed to mitigate risks such as disease, disability, death, longevity, and unemployment. In Djibouti, social insurance comprises old-age, disability, and survivorship pensions (available to all workers in the formal sector) and health insurance (only available to workers in the formal private sector and contractual workers in the government). No unemployment insurance program is available.

The newly created Conseil National de Securite Social (CNSS) is the governing body of the social insurance system. The CNSS houses the Organisme de Protection Social (OPS) and the Caisse National de Retraite (CNR). The OPS provides health insurance, insurance against work- related accidents, family allowances, and old-age, disability, and survivorship pensions to private sector employees and contractual workers in the public sector. The CNR only provides pension benefits to civil servants, parliamentarians, and the police. The military are covered by a separate regime, the Caisse Militaire de Retraite (CMR), which is part of the Ministry of Defense.

Altogether the social insurance system costs 5.1 percent of GDP and covers 23 percent of the workforce. Pension expenditures amount to 3.8 percent o f GDP. The OPS is the largest scheme, with close 20,400 plan members, revenues of DF 4.1 billion (4 percent of GDP), and reserves of DF 4.6 billion (4.5 percent of GDP). Pension expenditures in the OPS account for 45 percent of the total.

Private insurance programs: trends, eligibility, benefits, contributions

New initiatives: Micro-insurance and private health insurance (Mutuelles)

The Ministry of Social Affaires and National Solidarity (MSANS) is considering the

Development of a micro-insurance system to provide health insurance coverage to those outside the formal economy. The rationale put forward is that, given financial constraints, the public health system can no longer provide free health care to the whole population. While formal cost- recovery fees are not yet in place, those demanding health services - particularly low-income groups - face hidden costs. It is estimated that only 30 percent of the population has access to the public health system. MSANS is

currently seeking technical assistance to assess the feasibility of this initiative, including an assessment of the potential population of beneficiaries, institutional arrangements, and financing mechanisms. If this initiative moves forward, the idea is to start with one or two pilot projects, before a more aggressive expansion o f the system.

There is also an initiative championed by the Ministry of Health (with support from the African Development Bank) to develop private health insurance schemes. These institutions would be designed following the model of the French mutuelles, which complement the social security system.

The main concern of the World Bank is that this type of initiatives should be part of a coherent, integrated strategy for health financing in Djibouti. Before considering the introduction of new institutions, it is recommended to carefully look at the potential offered by the public system (OPS). As previously discussed, resources and technical assistance currently are available through the health reform project.

6.4 Out-of-Pocket Payments

(Direct Payments) Public sector formal user fees: scope, scale, issues and concerns

Much of what is known about distributional impact of public health spending for Djibouti is based on a household survey conducted in 1996 known as EDAM or (Enquete Djiboutienne aupres des Menages) . Households shoulder a large share o f total health expenditure. The very poor are households that could not afford to purchase the food basket needed to maintain a minimum amount of calorie consumption of 2015 per adult equivalent. The poor are classified as individuals who not able to meet basic needs compromising of food and non-food items. Those in the highest 20 percent income quintile are classified as better-off.

On average, each household spends an equivalent of USD 87.35 per year for drugs. When considering only those with positive expenditure, the average expenditure on drugs jumps to USD 178, which a significant 50 percent of a household's health budget. The average expenditure of the richest quintile was USD 282.5, and the average expenditure of the poorest 20 percent of households was USD 102.2. Almost everybody who had a positive expenditure for health care paid for drugs. This strongly supports the conclusion that drugs are not free.

The average per-capita private health expenditure of USD 17.83 in 1996 is close to the 1993 level of USD 19. Private per-capita health expenditure for the poorest household was USD 3.48 compared to USD 52.31for the richest households.

Health expenditures last 12 months sedentary households	**All Quintiles**	**First Quintile**	**Second Quintile**	**Third Quintile**	**Fourth Quintile**	**Fifth Quintile**
Purchase Medications						
Average per household	**15625**	**3074**	**8343**	**11261**	**16460**	**35231**
Average per individual	**2335**	**454**	**1167**	**1585**	**2362**	**6211**

Ambulatory services						
Average per household	2886	385	1009	1294	3451	7405
Average per individual	431	57	141	182	495	1305
Average per consultation	781	156	252	332	841	1859
Hospitalizations						
Average per household	1229	12	690	1536	1621	2135
Average per individual	184	2	97	216	233	376
Average per patient-day	364	3	292	567	793	380
Traditional practitioners						
Average per household	715	356	239	625	1112	1157
Average per individual	107	53	33	88	160	204
Average per consultation	4008	3251	2491	2189	7654	4744
Cost of transport for health care						
Average per household	965	241	523	1263	1373	1363
Average per individual	144	36	73	178	197	240
All costs						
Average per household	21420	4068	10804	15979	24018	47291
Average per individual	3201	600	1512	2249	3447	8337

Information only from households that provided information; if one or more info is lacking, households have been excluded

(Direct Payments) Private sector user fees: scope, scale, type of provider involved, issues and concerns

Given the importance of drugs in the household's health budget, further efforts should be made to determine programs that can reduce cost through group purchases and better information for both private and public drug providers. The public sector provides most of the curative medical services in Djibouti. The non-poor are more likely to turn to the private sector for professional health services. On average, less than 6 percent of the households have used a traditional healer in the last 12 months. Nearly 58 percent o f households have used a public health facility in the last 12 months, and 17 percent o f households have used a private health facility in the same period. The results show that the demand for different kinds of health care providers is correlated with household income. The use of health facilities increases with economic well-being. The poor did not use private facilities, but one third of the richest 20 percent of households used private health facilities.

The 1996 data also informs us that the type of health treatment varies with the material standing of a family. If medical treatment is sought, many poor families choose to go to a dispensary. Nationally, almost two-thirds of the very-poor sought professional treatment from a dispensary. Among the non-poor only half of sick used a dispensary. It is clear that richer people tend to use hospitals, while the poor and the very-poor make larger use of dispensaries and traditional healers. In the past, the free provision o f health services induced many people to switch from traditional healers to Government facilities. However, the 1996 Participatory Poverty Assessment (PPA) stated that the unavailability of drugs, meager economic resources, and a recent introduction of a cost sharing mechanism induced many households to revert to herbs and other traditional medicines which are less expensive than at a health facility.

Many households are not satisfied with the quality of the dispensaries which are mainly utilized by the poor: 33 percent o f the inhabitants of Djibouti consider the system poor, and 33.4 percent consider the system only average. There seems to be no difference in the perceived quality of services for rural and urban locations. According to the 1996 PPA, people are very dissatisfied with the services offered by Government dispensaries because the basic infrastructures needed to ensure quality is missing. The other two main concerns are the low quality o f personnel and the sporadic availability of drugs. In contrast, the refugee population living in camps can use the services of a well-organized dispensary run by an NGO.

Public sector informal payments: scope, scale, issues and concerns

Cost Sharing

6.5 External Sources of Finance

Since the public sector is the largest provider of health care in Djibouti, the quality of care is determined to some degree by the national budget allocation towards health. It was already noted the amount spent by the government on health per person is declining. Thus, the population is forced to contribute to the cost of care in order to stay in reasonable health. According to the 2004 PRSP, the total health care bill for the country is financed by the state (27 percent), external aid (29 percent), households (24 percent) and by assessment on employers and wages (20 percent). Foreign aid constitutes the primary source of financing health care. Based on a 1999 United Nations Development Report (UNDP), the major donors are France (35%), Spain (32%), Italy (7.8%) and the World Health Organization, WHO (7.8%).

Levels, forms, channels, use and trends

The World Health Organization has been an active partner of the Ministry of Health in the conduct of its development and reform plans. At the present, the projects supported by WHO within the biennium plan consist of the following[20]:

- Support to the health policy and strategic plan
- Support to the development of nursing and paramedical personnel
- Support to the PHC services

- Support to sustainable development through the empowerment of women and community initiatives
- Support to the pharmaceutical policies based on the essential list of medications
- Support to the Public Health laboratories and health technologies
- Promotion of healthy lifestyles and health education
- Support to Mental health
- Support to the anti-tobacco campaign
- Support to the anti-Blindness campaign
- Support to the Non-Communicable Diseases program
- Support to the Reproductive Health and safe Motherhood Program
- Support to Child Health
- Support to water quality and sanitation
- Support to the Expanded Program of Immunization
- Support to the anti-Tuberculosis, Malaria, HIV/AIDS and STD programs
- Support to the Epidemiologic Surveillance function

It is evident from the WHO program that it encompasses most of the sectors and activities that will require support within the health sector reform activities and the pro-poor policies of the Ministry. In fact, the recommendations suggested in this report are remarkably similar to the support already provided by WHO.

Given the amount of funding provided by the donors, WHO's contribution is focused principally as a technical partner to the MOH in the planning, implementation and evaluation of the programs of external assistance. WHO is a respected technical agency of the United Nations and has the experience needed to support the Ministry in these programs. It is trusted by the donors, many of whom will need partners to implement their plans. WHO may wish to consult with the Ministry to provide additional support and guidance to the health sector reform principally to the recommendations related to the forward vision of the role of the Ministry of Health, the development of the community health workers program, to health manpower development and to the options for financing health care. WHO has already provided useful input into these four programs and may consider continuing this support, as a partner to the Ministry of Health.

Development Partners

External assistance is critical to the reform and the further development of the health sector, as well as to the Government strategies to combat Poverty. Donors provide more than 30% of the budgetary requirements for the health sector. While it remains difficult to note the support given by all donors, a compilation has been approximated and appears in the table herewith.

Republic of Djibouti- Selected donors to the health sector[21]

As of January 2004

	Millions $			
UNDP	23.9	20	Combat HIV/AIDS	Support the establishment of regional committees to combat HIV/AIDS Establish a national multi-sectorial team Support the implementation plans, the training of NGO, follow up of efforts
European Union	16	48	Sanitation	Urban environment; water systems;
UNFPA	2.448	60	Reproductive Health	Gender issues; genital mutilation;
World food program	5.1	18	Nutrition	Beneficiaries 43,000 persons poorly nourished children, lactating and pregnant mothers, AIDS patients, orphelins, refugees
Save the Children		36	HIV/AIDS	Reduce the rates of transmission of HIV AIDS in the high risk corridor Truckers, dockers, prostitutes
USAID	12	36	MCH	
UNICEF		48	Children and HIV	
World Bank	12	60	CCD	Support systems of prevention of communicable diseases
World Bank	5.4		HSR	
WHO	3.2	24	HSR	
French Cooperation	6	30	HIV AIDS	
French Cooperation	16		HSR	Cooperation with the World Bank
French Cooperation	0.35	48	Anesthesia	Emergency Medicine
Totals	**102.398**			

The World Bank Institutions

Djibouti joined the World Bank in 1980. Since then, the focus of the World Bank assistance has been to foster sustainable economic growth and reduce poverty in the country. In March 2005, the World Bank adopted its second Country Assistance Strategy for Djibouti covering the period 2005 -2008. The CAS, developed in close partnership with the Government of Djibouti, serves as a roadmap for World Bank assistance to the country. The CAS program for Djibouti in support of the Poverty Reduction Strategy Paper (PRSP) involves several interconnected actions, building on the investment and structural adjustment programs started under the previous CAS. Specifically, it involves:

1. Moving a step further in addressing fiscal consolidation, improving competitiveness, and income distribution--this would be carried out through a combination of further wage bill adjustments to create more fiscal room to expand priority public services and transfers to the poor, and through the restructuring of utility sectors (power and water) to reduce the costs of doing business and improve access of the poor to these essential public services;
2. Sustaining development and improved management of the Ethiopia Djibouti transport infrastructure in support of port activities, the economic backbone for growth and employment; and
3. Vocational training to enable local work force take advantage of spillover activities related to the expansion of the port.

As of July 2005, the World Bank has financed 17 operations in the country for a total original commitment of US$ 155.5 million. The World Bank's current portfolio, as of July 2005, in Djibouti comprises five active investment projects, namely.

1. Flood Emergency Rehabilitation
2. Public Works and Social Development rahabilitation
3. HIV/AIDS, Malaria and Tuberculosis Control Project
4. Health Sector Development Project
5. Djibouti Social Development and Public Works Project

Health Sector Development Project

The purpose of the Health Sector Development Project is to support the Government of Djibouti's long-term health sector development program in order to meet the Millennium Development Goals for the reduction of under-five child mortality and maternal mortality rates. There are four main components.

1. The first component improves health services by improving the physical and human capacity of health facilities; establishing Integrated Management of Childhood Illness (IMCI) programs in all facilities; reinforcing the malaria control program; and supporting immunization.
2. The second component improves the availability of trained personnel by increasing capacity and improving the curriculum of Centre de Formation des Personnel de la Sante Publique (CFPS); and by improving service conditions for qualified paramedics.
3. The third component improves the availability of drugs and medical consumables by supporting the stocking of drugs in emergency health facilities; establishing a self-sustaining independent drug fund (CAMME); and supporting the development of community pharmacies that buy generic drugs from CAMME and sell them at a low cost to patients.

4. The fourth component improves sector management through capacity building in the health ministry and supports administrative autonomy of Hopital Peltier.

The support from US AID[22]

The underlying force behind the contribution from USAID is to assist in the development of a healthy, literate and skilled workforce that could sustain the transformation of Djibouti into a modern commercial state. The USAID support is focused on the social sectors with programs in Education, Health, Food security and Regional livestock marketing.

1. Education

The goal is to assist the MOE in the reform of its programs throughout the country. The program focuses on basic education (Grades I-12) and has four elements:

1. Increased access to basic education
2. Improved quality of teaching and learning
3. Increased opportunities for girls
4. Provide sustainable employment for graduates, particularly girls

The strategies rely on the provision of new information and communication technology in addition to basic educational principles. This will entail the preparation of teachers (Teacher Training), the improvement of the curriculum, the preparation and dissemination of textbooks, the physical rehabilitation of schools and radio-assisted education.

The International Foundation for Education and Self-Help (IFESH) will begin its Teachers for Africa Program in Djibouti. Seven experts in the training in English Language will be placed in MOE and the private sector to promote the mastery of the English language. IFESH has been registered as an NGO and will place volunteers to teach English.

It is expected that the project will benefit up to 135,000 children between the ages of 6 to 15 years. This component has a budget of $ 14 millions over the period 2003-2006 (3 years). EQUIP has been awarded the contract to improve basic education. EQUIP is a worldwide project that focuses on the improvement of basic education. An office has been set up for EQUIP in Djibouti. Two schools which serve over 3,000 children have already been rehabilitated namely

2. Health

The goal is to support the development of the health sector, increase access particularly for the poor population, increase the quality and efficiency of care in order to reduce infant, child and maternal mortality. The program calls for the provision of an essential package of services that will include child health programs to address acute respiratory illnesses, control diarrheic diseases, improve nutrition and immunization and promote reproductive health. In addition, focused activities will be undertaken at the district level to prevent infectious diseases including tuberculosis, malaria, HIV/AIDS. This program will consist in the physical upgrading of health facilities to provide the essential basic packages, support quality care and train community health workers. The local communities will be engaged in the process as well.

It is anticipated that the project will benefit approximately 120,000 people, mainly women and children. The sum of $ 12 millions have been earmarked over the period of 3 years. The implementation is likely to be entrusted to local partners and UNICEF. The French Cooperation and the World Bank have agreed to participate in the technical evaluation committee that will select the contractor(s).

3. Food security

The Famine Early Warning System will consist of a network of country offices throughout East Africa and the Horn of Africa to monitor food security. The system monitors a basket of indicators and reports on the status of food availability and nutrition deficiencies in countries and regions. The program will be monitored from the regional office in Nairobi. One million $ have been earmarked for this component.

In addition, Djibouti is considered a country with a chronic food deficit requiring about 13,000 metric tons of food annually. In cooperation with the World Food Program, USAID will develop an operation to provide rural Food for Work activities and urban institutional feeding, in addition to providing relief to Somali refugees in Djibouti. The target group is expected to amount to 43,000 persons (including about one third of refugees). In 2003, 4,000 metric tons were distributed.

4. Livestock project

The project consists of a regional activity to develop a Livestock marketing (export) health certification facility in Djibouti. A facility will be built for the large scale holding and health certification of all types of livestock for shipment to the Middle East. The facility will include holding pens, quarantine facilities and modern veterinary services. This project will be a private sector operation. It is expected that over one million head of livestock will be exported to the Gulf States per year. Four million $ have been obligated for 2004.

US AID Health sector
As of January 2004

	Millions $	**Three year Program 2003-2006**
Facilities	2.5	Renovation, rehabilitation of water supply
Equipment	1.5	
Systems and Training	2.5	Strengthening of systems and training at facility level
Training	1.5	Center for training health professionals Certificate and non certificate training programs
Community mobilization	2.5	
Program Management	1.5	
Totals	**12**	

6.6 Provider Payment Mechanisms

The issues that relate to the financing of health care ought to be reviewed and dealt with once the MOH and Government have adopted a vision for the nature of the health care system of Djibouti in the medium and long terms. The vision will clearly delineate the principal functions of the MOH and that of the other partners, such as the civil society, the private sector, the employers, the donors and other stakeholders.

In the domain of health financing, Djibouti has made an ideological beginning by espousing and legislating the establishment of the Office of Social Protection (OPS). In other terms, Djibouti has opted for a social security system, based on solidarity amongst the population. The current OPS has had difficulties in its finances and accounts that seem to be over at the present time given the effective administrative and financial measures that have been implemented in the last few years. It may be opportune at this time to consider the further development of the OPS.

The Social Security system is typically a "public" organization that has the managerial flexibility of the private sector. It has usually several funds that must be totally and absolutely separate from each other and from the Government budget. The funds are typically those of retirement and end of service, sickness, workman's compensation and occupational injuries, and family allocations.

The Sickness Fund is a social health insurance scheme. It derives its funding from employers, employees and Government, a tripartite funding. It is pegged to a proportion of the salary (or estimated income); hence the wealthier individuals would contribute proportionately more than the poorer segments of the population.

The issue that will be faced by the Government is the payment of the contribution (or premium) by the poor, the unemployed and the people with special needs (the handicapped). The Government could provide for this contribution in association with Charity, religious institutions (such as the Zakat fund). Additional funds for the poor could be levied through "sin" taxes such as earmarked taxes on cigarettes, liquor, "khat", airline travel, compulsory car insurance and other venues deemed acceptable by the Government. The percent of contribution on salaries and income could also be increased to provide for the poor. This would be in line with the concepts espoused by the Macroeconomics and Health Commission as well as the Millennium Development Goals. The issue of equity in Finance must be addressed by the proposed study.

The merger of all sectors into one social security system would increase the pool of the population that is covered, spread the risks, provide for better provider payment mechanisms (public and private in the future). Thus civil servants, the uniformed forces and other groups ought to be consider for enrollment within the proposed social security scheme, as it develops.

The enrollment within the social security scheme will finalize the status of health care as a human right, as a citizen right, rather than a "gift" or "give-away" from the paternalistic government. This will lead to an improvement in the quality of care and service provided in the facilities since the service is already pre-paid for through the contributions. This will support the autonomy status that has been bestowed on the Level IV facilities and will support their respective finances. A detailed study and analysis is recommended to be undertaken by the Government to consider options for the development of the social security system, based on the existing OPS.

7 HUMAN RESOURCES

7.1 Human resources availability and creation

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.

I- The Center for the Formation of Health Professionals[23] (CFPS)

The Center trains two categories of health professionals. Admission follows testing.

1. The "Techniciens de Sante" (Health Technicians): Nurses, Midwives, Laboratory Technicians- Ought to possess a secondary school leaving certificate or having attended the final year in the secondary cycle of education. Duration of the course is three years. All are state-licensed.
2. "Techniciens adjoint de sante" (Assistant Technicians): Assistant nurses, ass't midwives, ass't laboratory technicians. Ought to possess the intermediate school leaving certificate (BEPC). Duration of the program is two years. 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. This was due to the adoption of the system of repetitive intakes rather than continuous cycles of education. In other words, it was only when an intake has been trained over a period of three years and graduated that the second intake is advertised and recruited. This policy has been changed. The center is now accepting yearly intakes of students to be trained in the same disciplines and health professions.

Total Number of Graduates since 1992

Midwives	30	Two intakes
Nurses	52	Three intakes
Assistant Midwives	12	One intake
Assistant Nurses	24	One intake
Laboratory Technician	19	Two intakes
Assistant Laboratory Technician (Continuing Education)	14	One intake
Totals Number of Graduates	**151**	

Centre de Formation des Personnels de Sante

Students currently at the Center	Number	Date of Graduation
Midwives	17	2003
Midwives	25	2007
Nurses	23	2003
Nurses	35	2007
Assistant Midwives	28	2004
Assistant Nurses	36	2003
Laboratory Technician	20	2004
Totals Number of current students	**184**	

As indicated, only laboratory technicians are trained. There are no other paramedical training programs, such as programs for training sanitary technicians or radiographers.

II- Pole Universitaire ("University" of Djibouti)[24]

1. "Institut de Formation Universitaire"

With the new intake in October 2004, the IFUD offered 697 students the option of **nine** DEUG "Diplomes Etudes Universitaires Generales" and **five** "Licenses", as follows:
University of Burgundy (Dijon): Contemporary Literature
University of Franche Comte (Besancon): History, Geography, Administration, Economy
University Pierre Mendes France (Grenoble): Law, Management
University of Nancy 2: English
University of Bordeaux: Foreign Languages

The successful candidates receive degrees from these French universities.

2. "Institut Superieur des Affaires"

The 368 candidates were offered the following options:

Assistant in Management, Year II
Assistant in Administration, Year I
Managerial Accounting, Years I and II
Commerce Years I and II
Management Information systems Years I and II
Transportation Years I and II
Management (in Arabic) Years I and II

3. "Institut Superieur de Technologie"

BTS in industrial maintenance
BTS in Building

"Pole Universitaire" de Djibouti

Institutes	Year I	Year II	Year III	
IFUD	470	155	72	Institut de formation universitaire
ISAD	198	170		Institut Superieur des Affaires
ISTD	57	22		Institut Superieur de Technologie
Totals	**725**	**347**	**72**	

Personnel

Administrative	52
Teaching	**91**
Djibouti nationals	68
French nationals	16
Other nationals	7
Totals	**91**

III- Education Abroad through Fellowships[25]

Current Student Fellowships In Medicine	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Totals
Benin		2		5	3	3	1	**14**
Mali		1	1	4	4		1	**11**
Morocco	1		6		1			**8**
Tunisia				1				**1**
Madagascar			1					**1**
Cuba	19							**19**
Italy		16						**16**
Totals	**20**	**19**	**8**	**10**	**8**	**3**	**2**	**70**

Current Student Fellowships in Pharmacy	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Totals
Benin		2						**2**
Algeria	1							**1**
Sudan		1		1				**2**
Tunisia					1			**1**
Totals	**1**	**3**	**0**	**1**	**1**	**0**	**0**	**6**

Table 7-1 Health care personnel

Personnel (per 100,000 pop)	1994	1995	2000	2002
Physicians	-	-	-	15
Dentists	-	-	-	0.7
Pharmacists	-	-	-	1.3
Nurses	-	-	-	70
Paramedical staff (LHVs)	-	-	-	7.5
Midwives	-	-	-	6.7
Community Health Workers (LHWs)	-	-	-	-
Others	-	-	-	-

Source:

Table 7-2 Human Resource Training Institutions for Health

	Current		Planned		
Type of Institution*	Number of Institutions	*Capacity	Number of Institutions	Capacity	Target Year
Medical Schools	-	-	1		
Schools of Dentistry					
Schools of Pharmacy	-	-			
Nursing Schools	1	-	1		
Midwifery Schools	1	-	1		
Paramedical Training Institutes	1	-	1		
Schools of Public Health	-	-			

*Capacity is the annual number of graduates from these institutions.
Source:

7.2 Human resources policy and reforms

The education and training of health professionals is a priority to the Government of Djibouti. The indicators for human resources in health reveal a shortage in all categories whether physicians, dentists, pharmacists, nurses, administrators, statisticians or managers. The success of the reform of the health sector will depend to a large extent on the capabilities of the human resources. We fully recommend that the preparation of human resources be considered a priority and that several measures be taken to support the development of these professionals.

The preparation of nurses, midwives and paramedical professionals ought to remain in country, as is the current practice. Support must be provided to the “Centre de formation”(CFPS) to increase enrollment, diversify its programs, revise its curriculum and improve its educational resources. In the same vein, the “pole universitaire” (PU) must be supported to introduce educational programs for health professionals, in close articulation with the CFPS.

There is currently a determination of the Government to establish a Faculty of Medicine in Djibouti. Perhaps the optimal solution would consist in the development of a health manpower master plan that defines the needs of the country in terms of all kinds of health professionals and all specialties. This master plan ought also to take into consideration the needs for the continuing education of the present pool of health professionals, as well as the need to develop the teaching staff and instructors in the educational institutions.

The PU has embarked on the establishment of a center for technology. This center could be used to facilitate the use of the technologies in the education and training of health professionals. This will need to wait for the development of capacity in the communications sector of Djibouti and on the lowering of the cost of utilization. This improvement is likely to be completed in the next few months.

The preparation of health professionals will be facilitated if the quality of education in the intermediate and secondary educational cycles is satisfactory. This will permit the articulation of programs between the CPFS and the University, especially as concerns the entry levels and the language of instruction. Attention ought to focus on the introduction of "bridging" programs between these two institutions to allow for career progression especially of nurses. As indicated earlier, the CFPS may also support the preparation of the community health workers.

The reform of the health sector will require professionals educated in the field of health care management, finance, administration and accounting, to name few of the managerial sciences. It is recommended that educational programs in these fields be introduced. The eight modules prepared by the World Bank Institute do serve well and are recommended. Each of the modules spans over one week and is offered by senior professionals from leading universities in the USA, Canada, Europe and the Middle East. The World Bank Project does usually support the offering of these courses in-country, under reimbursement from the WB loan. In view of the small number of candidates and participants expected to enroll from Djibouti, consideration could be given to offer these modules and courses at a sub-regional level, to involve other countries from the Horn of Africa. This would support cooperation amongst these neighboring countries in the field of Health. Health Service Delivery

In a duty travel report (2004), WHO made the following assessment of the human resources situation in Djibouti:

"Presently there is a shortage of qualified health professionals in the country both quantitatively and qualitatively at all levels of the health services from the Center to the periphery, especially nurses and midwives. The number of nurses and midwives graduating from the CFPS is not sufficient to meet the demands of the present and future health services.[26]

There is a need to review the actual role of Human Resources specially nurses and examine the utilization and the distribution of human resources. There is misutilization of nurses. This year MOF has agreed to-fund 90 posts for training of nurses, midwives and laboratory technicians that should help in graduating more health professionals to meet the health services needs. With the health policy shift towards prevention of disease and promotion of health, it is necessary to reform health professions education to contribute to the achievement of this policy shift.

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.

Human Resources policy and Planning

1. There is an urgent need for a national policy on human resources development (HRD). It is important to develop and formulate a written human resources development policy which is agreed upon with all the partners and stakeholders with a consensus building national workshop. WHO could provide the necessary technical assistance in this area.

   - The produced HRD policy should have the following elements:
   - Principles of HRD policy
   - Governance
   - Pre-service education (basic education) of health personnel
   - Admission policy to health professions education institutions
   - Education of nurses, midwives, and allied health personnel
   - Continuous professional development
   - Management of health personnel
   - Certification and licensing

2. Prior to the development of the HRD policy, it is essential to conduct an in-depth review of the current human resources for health profile.
3. There is also a need for development of a database on human resources for health integrated within the overall health information system to ensure appropriate planning for the production of the required human resources. Certification and licensure of all health personnel is another challenge that has to be addressed to ensure regulation of health human resources to protect the health of the public in Djibouti. There is a medical commission that has as it's function assurance of physician's qualifications and their competency, but this committee has not been very effective.
4. There is a committee at the MOH, which deals mostly with the operational aspect of the Human Resources. It deals with recruitment and training of nursing and allied health professionals.
5. Job descriptions of health professionals have been developed within the health map, however these job descriptions need to be adopted and staff oriented to them.
6. As recommended by the WHO STC Dr Achour, there is a need to appoint an HRD focal point in the Ministry of Health to move forward the HRD agenda, however it is necessary to develop the capacity of the national focal point to enable him/her to

assume the proposed role appropriately. It is advisable to assign the HRD function under the planning unit at the Ministry.

Categories of health personnel

- The HRD policy has to define the different categories of health personnel required to meet the health services needs in line with the health services delivery framework and national health policy.
- The concept of community health workers (CHW) needs to be defined and agreed upon.
- Nursing specialization especially midwifery needs to be at the post basic level which could prove to be more efficient and lead to effective use of the limited resources
- There is a need to develop post-basic community health nursing (to include school health nursing and mental health nursing programs.
- There is a need to develop environmental hygienists, radiography technician, anesthesia technicians, ophthalmology technicians and pharmacy technicians.
- There is a need for specialist medical doctors in the area of psychiatry, gynecology, ophthalmology, otolaryngology and public health.
- There is an urgent need to develop the management capacity of the health team with the move towards decentralization. District Team problem solving (DTPS) approach could be a useful tool to build the management capacity of the nationals. In addition there is a need to train physicians at the district level in public health.
- There is an urgent need for physicians in specific specialties in the country.
- There are volunteers performing different roles in the health Centers. They need to be regulated.

Center for Training of Health Personnel (CFPS)

1. Existing Programs

- Three years diploma nursing post 12 years of schooling
- Two years auxiliary nursing post 10 years of schooling
- Three years diploma midwifery post 12 years of schooling
- Two years auxiliary midwifery post 10 years of schooling
- Three years laboratory post 12 years of schooling

2. Enrollment

60 students are accepted every year, 20 in each of the programs with one intake every three years or every two years for the auxiliary preparation programs. From next year, a new group will be admitted every year. This is a positive change

3. Curricula

Nursing and Midwifery curricula are based on the medical model, curative oriented, with no correlation between theory and practice, teachers in the Center are not involved in the clinical teaching of students

4. Teachers

There is a shortage of tutors and the teachers are over burdened with training in the different vertical health programs. Teachers are not involved in the decision-making concerning the Center. The organizational structure of the Center needs to be reviewed and restructured to be able to meet with the present and future expectations and challenges.

5. Educational program

A phased plan needs to be developed aiming at introducing new programs that the country needs and reforming the existing ones at the Center to make these programs community oriented, student centered, and competency based.

6. Facilities

- The Library needs to be strengthened to include all the up to date textbooks, journals, and other reference materials.
- The nursing skills laboratory has to be updated and better organized to meet the students learning needs.
- It is suggested to establish an Educational Development Center at the CFPS and equip it with the necessary material and human resources to provide the services aimed at improving the teaching - learning process, faculty development, curriculum review, evaluation, and management training.
- A computer lab funded by the World Bank is being established at the Center To reform nursing and midwifery education, it is vital to develop the clinical learning environment (preparation of head nurses in the hospitals and health Centers to mentor students, development of nursing procedure and policy manuals, preparation of clinical preceptors), lack of equipment, supplies and materials for provision of care at he clinical sites further impedes the students learning attainment, this is compounded with the inability of the system to maintain equipment.
- Development of community based learning facilities is crucial for the enhancement of the educational process of health professionals' education, use of BDN sites for students to develop their health education programming and teaching skills and also management skills should be explored and developed.

Educational Institutions capacity building

- There is a need to establish twining with institutions outside the country (Tunisia, Senegal, Lebanon, Morocco, Kenya- Aga Khan) to strengthen the institutional capacity of the existing health professions education institute
- Fellowships to be continued to further develop the national capacity building process
- To enhance the existing physicians competencies, a course such as the Liverpool course in tropical medicine could be implemented in Djibouti

Resources

Lack of financial resources poses a major challenge for the development of health professions education in the country.

Recommendations

1. Provide technical support to develop a human resources development policy and a national strategic plan for human resources development in the country.
2. Provide technical and logistical support to the CFPS in Djibouti to facilitate the reform of the existing educational programs and establishment of new ones. The Center should assist in the development of the pre-service allied health specialties required by the country based on a phased plan.
3. Re-orient the present general nursing curriculum towards primary health care and community needs and change it to a competency - based curriculum.
4. Establish a board of education for the Center under the chairmanship of the Minister of Health, which should be responsible for setting the overall policy and strategic plan of the Center; this board should have a broad membership with regional and

central representatives from MOH, Universities (once established), the business community, the private health sector, relevant NGO's, WHO, and others.

5. Develop a regulatory system to certify, register and license health personnel and regulate the volunteers working in the health facilities in the country.
6. Hold a national workshop on health professions education to define categories of health professionals and support personnel needed, identify the core competencies required of each category, and reach consensus on these issues.
7. Provide fellowships to familiarize key personnel and teachers from different disciplines to the regional and international experiences in health professions education with special emphasis on community based, problem based education.
8. Establish an educational development Center at the CFPS
9. Establish a national system for registration of health personnel and develop a national HRD database linked to the HIS and the overall planning of health services.
10. Strengthen the capacity of senior staff at MOH through provision of management training both at the central and regional level; the district team problem solving (DTPS) training approach should be started to build the management capabilities of the nationals.
11. Develop a strategic alliance with other UN agencies and other partners to enhance the process of human resources development process in the Djibouti.
12. Change the title of the Center (CFPS) to “National Institute of Health Sciences or a similar title which would denote the functions of the Center in terms of not only training but education."
13. A built - in evaluation system should be developed to for both student academic performance (theoretical and clinical exams) and the teaching/learning process.
14. Provide support to strengthen the teachers' capabilities, and the Center's library.
15. Develop a formal link between the Center and one or more of the parallel Institutes or Colleges in the Eastern Mediterranean and African region and begin a twinning process between these Institutes.

7.3 Planned reforms

8 HEALTH SERVICE DELIVERY

8.1 Service Delivery Data for Health services

Table 8-1 Service Delivery Data and Trends

TOTAL (percentages)	1990	1995	2000	2002
Population with access to health services	-	-	-	-
Married women (15-49) using contraceptives	-	-	-	9
Pregnant women attended by trained personnel	-	-	-	52
Deliveries attended by trained personnel	-	-	-	74.1
Infants attended by trained personnel (doctor/nurse/midwife)	-	-	-	60
Infants immunized with BCG	-	-	-	62
Infants immunized with DPT3	-	-	-	61.1
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	62
Population with access to safe drinking water	-	-	-	80
Population with adequate excreta disposal facilities	-	-	-	50

Source:

URBAN (percentages)	1990	1995	2000	2002
Population with access to health services	-	-	-	-
Married women (15-49) using contraceptives	-	-	-	-
Pregnant women attended by trained personnel	-	-	-	-
Deliveries attended by trained personnel	-	-	-	-
Infants attended by trained personnel	-	-	-	-
Infants immunized with BCG	-	-	-	-
Infants immunized with DPT3	-	-	-	-
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	-
Population with access to safe drinking water	-	-	-	82
Population with adequate excreta disposal facilities	-	-	-	-

Source:

RURAL (percentages)	1990	1995	2000	2002
Population with access to health services	-	-	-	-
Married women (15-49) using contraceptives	-	-	-	-
Pregnant women attended by trained personnel	-	-	-	-
Deliveries attended by trained personnel	-	-	-	-
Infants attended by trained personnel	-	-	-	-
Infants immunized with BCG	-	-	-	-
Infants immunized with DPT3	-	-	-	-
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	-
Population with access to safe drinking water	-	-	-	67
Population with adequate excreta disposal facilities	-	-	-	-

Source:

Access and coverage

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. These three factors- who is ill, who seeks care, and where they seek care-influence the final distribution of the use of each service. This in turn affects the efficiency of government expenditures in reaching the poor. According to the 1997 Djibouti Poverty Assessment (DPA), government expenditures on SMI and dispensaries are fairly well targeted to the poor, with 41 percent of the total dispensary spending allocated to the poorest 40 percent o f the population. By contrast, the poorest 40 percent receive only 22 percent o f hospital subsidies, compared with the 20 percent of individuals in the top quintile who gain 29 percent o f total hospital subsidies.

8.2 Package of Services for Health Care

The National Health Programs

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.

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

2. Expanded Program of Immunization

Immunization coverage % for:	
BCG	62
DPT III	61.1
Polio III	61.1
Measles	62
TT II	29

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. A survey in 1990 revealed that acute malnutrition is prevalent in 10% and chronic malnutrition in 22.2% of the population. Rural areas suffer proportionately more than urban regions. Another survey in 1995 revealed that 24.4% of the under five years have a stunted growth and that 14% suffer from acute malnutrition.

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. It appears that 12.1% are weaned at the age of 3 months, 14.5% at 6 months, 14.5% at 9 months and 24.4% at one year of age. Average breastfeeding was calculated at 3.8 months only. More than 50% of babies receive artificial milk at the age of 4 months.

4. Communicable Diseases

Communicable diseases remain the most important causes of morbidity and mortality. The principle diseases are Tuberculosis, Diarrheas, malaria and Measles. Tuberculosis remains a principal threat and remains rampant due to the influx of patients from neighboring countries, estimated at 36% of patients at the Centre Paul Faure and at 66% at Ali Sabieh. Over the past ten years, close to 3,600 new cases are registered every year with a peak of 4121 cases diagnosed in the year 2000. Anti-Tuberculosis centers exist in the five districts as well as in Djibouti-City. DOTs has been used as the principal treatment strategy since 1992.

Diarrheal diseases include Cholera, Typhoid, amebic dysentary, viral hepatitis in addition to Salmonellosis, Shigellosis and viral causes. In 1997, diarrheas were responsible for 11% of all consultations and 16.5% of children's. Diarrheas constitute the second cause of mortality in both adults and children, according to the 1996 MOH annual report.

The disease surveillance system at the Ministry of Health has been able to combat cholera effectively during the epidemics of 1993, 1997 and 2000. It has also revealed that 10% of diarrheic diseases were caused by the amebic dysentery. Malaria registers an excess of 4,000 new cases every year. Malaria cases peak over the period October through March. Measles and poliomyelitis have been effectively controlled through the expanded program of immunization and through close surveillance. Only one case of polio has been registered over the period 1996 through 1999.

5. Campaign against HIV/AIDS[27,28]

A World Bank mission evaluated the preparations for the project aiming at the control of HIV/AIDS in October 2002. A sero-prevalence study on the general population as well as additional surveys had been undertaken by the project team. These studies have confirmed that the prevalence is far lower than previously estimated using the standard models. The overall prevalence of HIV/AIDS was found to be 2.9% (3.1% for women, 2.8% for men) in the general population. However it is 5% in the age bracket of 20-35 years, i.e. in the economically active population.

The World Bank Project supports the National Campaign for the control of HIV/AIDS, Tuberculosis and Malaria, in cooperation and coordination with the other donors through:

1. Implement the policy of the Government against the diseases and provide support to the authorities in the various phases of the campaign

The Bank will reinforce the capacity of the Inter-Ministerial Committee and the National Committee that targets communicable diseases (CNLMT), as well as the executive Secretariat (SEP). It will assist in the preparation of strategic and operational plans, as well as in the conduct of evaluation and follow up of the activities. It will assist in the preparation of the strategy to coordinate activities.

The Project will provide funds for the construction of a diagnostic biologic and chemical laboratory at Peltier Hospital and for the physical rehabilitation of the offices and facilities of the Project team, including the Younis Toussaint Center. The Executive Secretariat SEP will be charged with the financial and administrative tasks of the project including the implementation, evaluation, follow up and coordination.

2. Support the "Health" component of the campaign

The Bank will support the efforts of the Ministry of Health to prevent, diagnose, provide treatment at the ambulatory and hospital levels. It will support the involvement of the Military Medical Services, the Police Medical forces and the OPS in these activities. A protocol defining this partnership will be prepared.

3. Support multi-sectorial activities that target vulnerable groups

4. Support community efforts to reduce vulnerability, transmission and the socio-economic impact of the disease

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

Percent of regular smokers Men	23
Percent of regular smokers Women	2.4
Percent of regular smokers Both sexes	12.1

8.3 Primary Health Care

Infrastructure for Primary Health Care

As noted earlier, the primary health care system is based on the following structures:

- Health posts
- Community health centers
- District medical centers
- Units for Hygiene and Epidemiology
- Maternity at Hayableh

Health posts would number 22 in the country; there will be 7 community health centers in Djibouti-town; each of the five regional districts would have community health centers with additional facilities for in-patient care for maternity and simple conditions (Level III). The central units, all in the capital, would provide the support in Level IV.

Every level of care has been detailed as far as the responsibilities attached to every unit. In addition, job descriptions of the human resources needed to staff these facilities have been drawn and approved, within the "carte sanitaire" health planning project, initiated by WHO and finalized by the Planning Unit in the Ministry of Health.

Public/private, modern/traditional balance of provision

Health care delivery: Public and Private

- 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

	Level I	Level II	Level III
Public sector	32	4	6
Parastatal sector		2	
Private sector	17		
Totals	49	6	6

Supporting facilities include:

- The pharmaceutical sector
- The Blood Bank
- The Center for manpower development (CFPS)
- The Public Health Laboratory

Human Resources: Public and Private

	Physicians	Pharmacists	Dentists	Paramédicals
Public sector	106	11	7	431
Parastatal sector	8	2		15
Private sector	14	6	3	
Totals	**128**	**19**	**10**	**446**

Responsibilities for Health Care

The State is responsible for the provision of health care to the people of Djibouti.

1. The Ministry of Health defines the health policy, provides care through the four levels of the referral system that cover the entire territory. The Ministry oversees the pharmaceutical sector, the licensing of physicians and health facilities, the prevention of diseases and medical care including the vertical programs.
2. The Ministry of Defense provides medical care to the military and their dependents, including the Internal Security forces and the Presidential Guard. The ISF and the PG operate one dispensary each in the capital city. The Army operates a clinic in each district. The Army medical services operates the only renal dialysis center in the country. It also provides ambulance services and evacuation to Hopital Peltier in the capital. The agreement with the French Military also provides for the medical care of the uniformed in the French Military Hospital Bouffard.
3. 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.
4. The Ministry of Labor: 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.
5. 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)
6. 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.

7. 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.

Primary care delivery settings and principal providers of services; new models of provision over last 10 years

The primary health care (PHC) in Djibouti ought to be reviewed with the intent of facilitating access to services. PHC services must also highlight the promotion of health, the prevention, in addition to the important need to assure care services. As described earlier, the Ministry has embarked on a program of decentralization into five regional districts. It has also established health posts, community health centers, community medical centers and the referral system. It has also promoted the basic development needs. These activities are noteworthy, are very much needed and the Ministry has done well in this respect.

The current system is however based on a "passive" approach to PHC. It invites the population to access the services whenever the individual perceives the need to seek medical advice and care.

A consultant[29]has recommended that community health workers be recruited and trained to support the PHC services and facilitate the access of the population to the promotion, prevention and care programs advocated by the MOH. Although the details are best provided by the MOH, some of the following suggestions may be adopted:

The community health workers (CHW) would number two (one man, one woman acting as a team) for every 750-1000 persons, in all rural, nomadic and urban areas. These CHW would be chosen from the community they live in; they could be even nominated by the community leaders and ranks. The CHW should at least be able to read and write, although preference would be given to intermediate school leavers, if available. An important feature in their recruitment would be their interest in civic work, their enthusiasm, their willingness to learn and to serve.

The CHW will be trained by the MOH. Algorithms will be made available. The role of the MOH (district as well as central) would be to support the education and work of the CHW. The CHW will receive a stipend for their work that would be equivalent to the minimum wage (about $ 100 per month).

The functions of the CHW would be to visit every dwelling and household. The CHW would be the vehicle for health promotion, education and prevention. They will support the people in their quest for maternal and child care, immunization, nutrition, infectious disease control, screening, birth control, malaria testing and other tasks as needed and as directed by the MOH. The male CHW will attend to environmental issues, water treatment, hygiene issues and will provide support for the other tasks. The CHW will be trained to fill in demographic, epidemiologic, utilization indicators that would be forwarded to the district or to the central department of statistics. The CHW will be trained and supported to carry on household surveys on a continuous basis. The CHW would play an important role as the "ombudsman" of the village, tribe or town quarter they are working within.

This scheme would support the organization of the community and its empowerment in health issues. It will call on the community leaders to support a change in culture from dependence to active participation in the development of the community. The support of religious leaders will also be sought to promote health and hygiene.

The development of the CHW program will require financial resources, at the tune of about $ 1.5 million per year (about 1,000 CHW). This will create employment and cut down on the level of poverty. The program will require a center for training the CHW, preferably in each medical district and in Djibouti-Ville. The CHW will be based in the health post (Level I) and will be supported by the community health center (Level II and III). The input of non-governmental organizations, women associations and other civil society groups could also be channeled through the CHW.

This scheme has been implemented with success in the Islamic Republic of Iran (the "behvarz" program). The reproductive health and safe motherhood program in Djibouti has also had a successful experience, albeit a limited one in the use of CHW. WHO has extensive experience in this respect. The CHW program could also be coupled with the BDN program, the healthy villages and the lifestyles advocacy, as deemed appropriate by the MOH.

Public sector: Package of Services at PHC facilities

Private sector: range of services, trends

Referral systems and their performance

Utilization: patterns and trends

Utilization of services by households

Utilization of nearest health center	Country	Djibouti Town	Urban	Rural
Did utilize services	73.6	69.4	96.7	83.5
Did not, service insufficient	6	7.2	0.5	1.9
Did not, other reasons	20.4	23.4	2.8	14.6
Totals	**100**	**100**	**100**	**100**
Evaluation of services				
Good	24.5	23	34.8	23.7
Average	33.4	32.3	38.5	37.7
Poor	33.4	35.1	24.6	28.5
Undetermined	8.7	9.6	2.1	10.1
Totals	**100**	**100**	**100**	**100**
Access to Health Center				
Walking	64	58	96.7	77.3
Bus	29.5	35.3	1.3	10
Car	3.5	3.8	0.5	4.8

Others	3	2.9	1.5	7.9
Totals	**100**	**100**	**100**	**100**
Time to access the health center				
< 15 minutes	37.3	35	46.3	49.8
15-29 minutes	41.2	43	40.4	19.6
30-59 minutes	16.2	17.6	9.5	11.9
1-2 hours	2	1.8	1	6.6
> 2 hours	0.2		0.5	2.6
Others	3.1	2.6	2.3	9.5
Totals	**100**	**100**	**100**	**100**

Utilization of services by Sedentary households

Utilization of nearest health center	**All Quintiles**	**First Quintile**	**Second Quintile**	**Third Quintile**	**Fourth Quintile**	**Fifth Quintile**
Did utilize services	73.6	85.8	81.8	77.6	68.1	58.4
Did not, service insufficient	6	2.5	4.4	3.9	6.9	11.1
Did not, other reasons	20.4	11.6	13.8	18.5	25	30.5
Totals	**100**	**99.9**	**100**	**100**	**100**	**100**
Evaluation of services						
Good	24.5	29.6	24.2	24.5	20.8	23.5
Average	33.4	34.3	33.5	33.5	33.3	32.4
Poor	33.4	28.9	36.3	36	34.8	31.6
Undetermined	8.7	7.2	6	6	11.1	12.5
Totals	**100**	**100**	**100**	**100**	**100**	**100**
Access to Health Center						
Walking	64	79.9	75.7	71.9	55.3	42
Bus	29.5	13.4	22.2	26.3	39.4	43.3
Car	3.5	1.2	0.2	0.1	1.8	12.2
Others	3	5.5	1.9	1.7	3.5	2.5
Totals	**100**	**100**	**100**	**100**	**100**	**100**
Time to access the health center						
< 15 minutes	37.3	36.1	37	40	32.8	40.1
15-29 minutes	41.2	38.5	42.3	38.5	44.7	41.8
30-59 minutes	16.2	16.4	16.5	17.7	17.4	13.8
1-2 hours	2	2.9	1.5	1.8	2.2	1.7
> 2 hours	0.2	0.7	0.1	0.3		0.1

Others	3.1	5.4	2.6	1.7	2.9	2.5
Totals	**100**	**100**	**100**	**100**	**100**	**100**

Current issues/concerns with primary care services

Planned reforms to delivery of primary care services

The national vertical programs include the national program to combat HIV/AIDS, Malaria, Tuberculosis, as well as the other national PHC programs such as the Expanded Program of Immunization, Nutrition, Reproductive Health and Safe Motherhood. These programs have been well supported and appear to be effective.

It is not early to start planning for other national programs, in particular the programs to combat non-communicable diseases. Although these illnesses may still rank low on the priority list of the country, programs of health education, particularly amongst the youth to curtail the tobacco epidemic and encourage the adoption of healthier lifestyles. Another program that could be of priority to Djibouti is the control of zoonotic diseases and their transmission.

The school health program merits additional support. In most countries of the region, this program has not had the scope it merits. School health has the advantage of targeting a captive population, over a period of twelve years, the duration of the entire educational cycle. Pupils come to school, hence minimal efforts are exerted to target and reach the future generations. During their school years, pupils can be taught the good health promoting practices, could receive the recommended immunizations, can be screened for various diseases, can be encouraged to adopt healthy oral health practices, amongst other things. Programs to check the vision, the hearing, their growth can be implemented with little efforts. Measures could also be taken to control drug dependence and substance abuse. Pupils could also serve as the vehicle of transmission of healthy messages to their parents, their families and communities. Pupils may dissuade their community members to smoke or even to spend time “chewing” khat, in case this practice is to be curtailed by the Government.

In the Eastern Mediterranean region, WHO has promoted the programs of “schools promoting healthy lifestyles”, in cooperation with national and regional NGOs, prominent of these being the “Arab Association of schools promoting healthy practices”. School health could also be the mechanism to start changing the culture of dependence and welfare by encouraging civil responsibility amongst the youth and school children, promote healthy lifestyles amongst the school pupils, the adolescents and their families and community. In addition to the health promotion and prevention aspects, school health programs could serve to provide medical care to this important group over a period spanning their entire general educational cycle.

8.4 Non personal Services: Preventive/Promotive Care

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 treatment of water, hospital waste and the control of vectors are matters that require attention and solutions. These issues will need to be addressed at a later stage yet short term interim solutions will be enacted to control these issues.

- **Availability and accessibility:**

- **Affordability:**

- **Acceptability:**

Organization of preventive care services for individuals

Djibouti has embarked on the development of a strategy to implement the recommendations of the commission on Macroeconomics and Health (CMH). In his address to the October 2003 meeting in Geneva, HE the Minister of Health of Djibouti summarized the accomplishments of this strategy, as follows:

1. The implementation of a pro-poor national strategy to combat the three diseases considered as priorities in the health sector, namely HIV/AIDS, Tuberculosis and Malaria
2. The establishment of an inter-sectorial council and an executive secretariat to coordination these policies at the level of the office of HE the Prime Minister
3. The strengthening of the cooperation with the civil society, the policy makers and the private sector in the implementation of these strategies
4. The introduction of cost recovery mechanisms through the CAMME and the "Pharmacies Communautaires" to insure the sustainability of financing
5. The increased interest within the donors' community to support the allocation of human and financial resources to implement these strategies.
6. The implementation of decentralization in the Ministry and the increased cooperation with the community
7. The collaboration with the non-governmental organizations in the conduct of these activities

The Minister defined the steps that will be taken by the Government in the immediate future as follows[30] :

1. The provision of services to the poorer segments of the population
2. The adoption of the Poverty Reduction Strategy Paper (PRSP)[31] to improve the health and welfare of the population

3. To support the Basic Development Needs programs and the inter-sectoral council of the HIV/AIDS programs
4. To move towards the achievement of the Millennium Development Goals (MDGs)

The description of the progress in the Macroeconomics and Health Strategy32 outlined the significant political, economic and social factors that impact on this adoption of this strategy. The various indicators related to the macroeconomic context were also presented.

As outlined earlier, the Minister described the efforts made to inject more financial resources in the health services, with special attention to the priority programs for the poorest segments of the population. The poverty indicators that are based on the MDG benchmarks were also submitted as below:

Poverty indicators based on the MDG benchmarks

National Poverty rate	56.7
Population living on under $1/Day	42.1
Malnutrition Prevalence % of the <5 years	18.2%
Low birth weight babies as % of births	20%
Infant Mortality rate/1000 births	94.6
Under 5 years mortality rate/1000 births	106
Immunized against Measles	73.4%
Maternal Deaths per 100,000 births	540
Percent of births attended	74.1
Tbc incidence (SS+)	353/100,000
Tbc cases detected	64.9%
Tbc cases treated successfully %	62%
% HIV+ women 15-24 years	5%
Children orphaned by HIV	
% population with access to improved water	80
% population with access to improved sanitation	50
Female literacy	44.5%

The reforms of the health sector have been carefully prioritized and specific benchmarks have been indicated to define the progress in the achievement of the objectives of the reform. The capacity of the Planning department in the Ministry of Health has been expanded. The coordination with the donors has also been improved.

Indicators for non-financial constraints

Number of physicians per 1,000 population	1.5
Number of nurses per 1,000 population	7
Hospital beds per 1,000 population	2.5
% population with access to health care	37

However, despite the progress that has been noted in the implementation of the health sector reform, and the preparation of the Poverty Reduction Strategy Paper (PSRP), the Committee on Macroeconomics and Health has not been established as yet. Efforts will be made however to integrate the policies and activities described in the PSRP towards the implementation of poverty reduction and the achievement of the MDG goals33. A

national investment plan has been drafted by the Government and is currently being discussed.

It should be noted that the feasibility of meeting the MDGs in the low-income countries is widely misjudged. On the one side of the debate are those who believe that the health goals will take care of themselves, as a fairly automatic by-product of economic growth. They take the view that it's just a matter of time before the mortality rates in the low-income world will converge with those of the rich countries. This is likely not to be true for two reasons.

First, the disease burden itself will slow the economic growth that is presumed to solve the health problems; second, economic growth is indeed important, but is very far from enough. Health indicators vary widely for the same income level. The disease burden can be brought down in line with the MDGs only if there is a concerted, global strategy of increasing the access of the world's poor to essential health services[34].

The World Bank emphasizes that PRSPs should be written and produced by countries themselves, and go beyond macroeconomic stabilization and liberalization to address issues of poverty and equitable growth. Studies suggest that an important discussion of the health component of the PRSP is required- between "a health strategy for poverty reduction", and *a "health strategy to meet the needs of the poor(est)"* – these two objectives are overlapping, but different.

The former implies broad recognition of the need to make health investments as part of overall development strategy, based on new evidence of the role of health in reducing poverty. It is manifest in greater health spending, and strategies to extend health services and make them more efficient and responsive. This will, undoubtedly, improve the health of many poor people, but it is based on assumptions about what works to reach the poor rather that a systematic evaluation of needs in the local situation.

The latter implies an approach tailored to the country context. What are the main health problems suffered by the poorest? What are the barriers that prevent them from accessing care? How can we monitor progress to make sure that the poor are benefiting? Most PRSPs recognize that health is key to economic growth and include strategies which can be categorized as pro-poor, such as expanding primary health care and increasing health spending at district level.

However PRSPs tend to focus on goals and targets (e.g. to reduce maternal mortality), and lack detail on how. This in part reflects the lack of detail in the analysis section on why (for example, reproductive and child health indicators are worst among the poorest groups?). Most PRSPs do not provide the evidence to justify, from a poverty perspective, many of the health strategies they outline.

PRSPs do present important opportunities for the health sector which, to date, few countries have grasped. PRSPs could catalyze the process of taking a fresh look at existing health plans, in order to ask: what needs to be different in order to make a real impact on poverty? To ensure that health outcomes improve for the poor? Rather than simply summarizing or drawing out the perceived pro-poor components of existing national health strategies, health stakeholders could use the PRSP process to reassess existing health strategies from a poverty perspective.

Following on from this, the PRSP should prompt some locally-specific analysis and poverty targeting within health. There are some examples, of strategies which can be seen as best practice in this regard. These include regionally disaggregated health statistics (correlated with poverty data), monitoring of national strategies – such as vaccination – at regional level, ad hoc surveys of vulnerable groups, out-reach strategies

for those with the worst health outcomes, and action to address the impoverishing costs of seeking health care.

If the PRSP is to add value from a health perspective it should lead to a more detailed analysis of the how health can better contribute to poverty reduction and begin the process of making the health strategy more focused on the needs of the poorest.

PRSPs recognize poverty as multi-dimensional, and in most cases state that ill health is one characteristic of poverty. However, the analysis of the links between poverty and ill-health remains sketchy. It would be best if there is:

- a clear indication of the complex nature of poverty;
- an examination of how poverty affects ill health and how ill health affects poverty;
- an exploration of how improved health contributes to poverty reduction;
- a breakdown of varied health needs of poor people.

It is recommended that the Government of Djibouti continues its efforts to implement the recommendations of the Commission on Macroeconomics and Health (with particular focus on targeting the poor) and to integrate these activities within the Government's strategies to combat Poverty (PSRP) and achieve the Millennium Development Goals. These strategies must be undertaken in cooperation with the community and the civil society organizations. These efforts ought to be supported by the World Health Organization and by other donors and agencies

Environmental health

Health education/promotion, and key current themes

Changes in delivery approaches over last 10 years

Current key issues and concerns

Estimating the costs of attaining Health MDGs

In 2000, the government of Djibouti with the assistance of its technical partners and financing from the World Bank, undertook an overall assessment o f the health sector that led to recommendations for reform and the development of a ten-year health sector reform plan in line with the Millennium Development Goals. The 2002-2011 Strategic Plan sets out five objectives:

- Improve the organization, management and operation of the health system,
- Tailor the operations and health services to the population's needs,
- Improve and adapting financial resources to the needs of the health system,
- Promote and develop human resources according to the requirements of the health system and
- Improve the availability, accessibility and utilization of high-quality drugs.

In the short run, the main objectives by2006 in the area of health are to reduce infant mortality from 103.1 per 1,000 births to 75 per 1,000 in 2006 and to reduce maternal mortality from 690.2 per 100,000 live births in2002 to 570 in 2006. To achieve these

objectives, a study carried out in 2001 by CREDES estimated the current expenditure implications. These estimations offer an indication of the potential fiscal pressures on future state budget, averaging an additional amount of 2 million USD per year. This represents an annual increase in the total national health budget of about 9 percent.

Planned changes

The non-personal health services ("Public Health") will always remain the responsibility of the public sector under any vision of the MOH. There has been a great deal of support to the services of this Directorate, in particular in the areas of epidemiologic surveillance, information systems, planning and studies and public health laboratories. The control of infectious diseases, especially the "vertical" programs against HIV/AIDS, Malaria, Tuberculosis is also the responsibility of this division. These functions must be supported and strengthened. The role of the Government is derived from its responsibility towards the protection of Society from danger, ills and calamities.

Supported by external assistance, notably by the European Union, the safe water system and the used water disposal systems are being revamped and improved. It is important for the Directorate of Hygiene to be involved in this project, to insure the safety of water and the proper disposal of waste. The chlorination (and perhaps fluoridation) of drinking water ought to be controlled on a continuous basis by the public health laboratory of the MOH. The disposal of domestic and medical waste is also an issue that requires the attention and control of the MOH.

The control of food safety and the inspection of food handlers rest with the MOH as well as with the Central PH Laboratory. This will necessitate the recruitment and preparation of technicians, as well as the availability of modern equipment for inspection and control.

The Division of Epidemiology in the MOH has advocated an early warning system for epidemics and diseases. This measure ought to be supported through the process of "active" surveillance, in addition to the more traditional and tested passive surveillance and disease reporting.

8.5 Secondary/Tertiary Care

General Peltier Hospital (GPH)[35]

In 1955, the main government hospital was renamed after General Peltier, to commemorate his contribution as Chief Physician over 25 years; A new wing of operating theaters were also added then. In 1968, a 35-bed maternal ward (Maternite Martial), as well as a 30-bed pavilion for Eye and ENT were added. In 1989, the Dar Al Hanan Maternity ward was inaugurated.

The hospital has a capacity of 603 beds, although in reality only 401 beds are really functional. It is spread over an area of 5 hectares. It is capable and equipped to handle 80% of the inpatient care in the country.

Bed Distribution General Peltier Hospital

	Nominal	Real	% real/nominal
Medicine	160	106	66.3
Surgery	171	93	54.4
Maternity	122	87	71.3
Pediatrics	36	33	91.7
Psychiatry	50	50	100

Specialty beds	43	12	27.9
Recovery Wing	12	11	91.7
Emergency ward	9	9	100
Totals	**603**	**401**	**66.5**

GPH receives three kinds of patients: the paying patients (6.7%), the insured (35.1%) and the medically indigent that represent the majority of the patients (58.5%). GPH employs a total of 337 persons, as follows: 248 health professionals, 49 administrative staff and 40 support staff. The hospital employs 31 physicians and pharmacists (only 14 of which are nationals). The Nursing and Midwifery staff constitutes 27% of the professionals. The Hospital aims at a ratio of 0.7 nursing staff per bed.

The physical rehabilitation of the GPH has been undertaken primarily through external assistance namely from Spain, France, the World Bank, Morocco, China, and the Islamic Bank in addition of course to the State of Djibouti. The GPH became an autonomous entity as per the legislation dated March 18 2002. The GPH has a Board of Administration and its own accountability. Unfortunately its finances are over-burdened by accounts receivables mainly from other autonomous public offices such as the OPS. This has been justified by the fact that the Government in turn does not settle its obligations to the OPS and to the other agencies.

General Peltier Hospital Indicators of service

Inpatients	10262
Patient Days	62723
Surgeries	2560
Births	1764
Deliveries	1943
C-Sections	608
Deaths	627
Outpatients	30654

The issue related to the access of the poor to health care is real and must be addressed. The certificate of financial need provides access to Hopital General Peltier but it does take time to be issued and is good for only one usage. This curtails access and delays the provision of care to the poor, who are already in an advanced stage of the disease.

In spite of the extent of poverty in Djibouti-city, the rural areas are even more in need of support. Non Governmental organizations and voluntary associations have started to be active in the provision of care. The Balbala hospital is a secondary care general hospital, Level IV in the referral system of the country. It provides inpatient and outpatient services in the major specialties. Its bed complement is 70 beds (2003). The hospital has a strong pediatric service. It is managed by the Italian Cooperation.

Balbala Hospital Beds 2002

Pediatrics	35
Obstetrics	25
Surgery	10
Total Beds	**70**

Source: "Annuaire Statistique de la Sante for the year 2002"- MOH 2003

Table 8-2 Inpatient use and performance

	1990	1995	2000	2002
Hospital Beds/1,000	-	-	-	-
Admissions/1000	-	-	-	-
Average LOS (days)	-	-	-	-
Occupancy Rate (%)	-	-	-	-

Public/private distribution of hospital beds

Key issues and concerns in Secondary/Tertiary care

Apart from concerns about low level of health equipment expenditure, the MOH suffers both qualitatively and quantitatively in terms of human resources. Most health personnel are employed under the MOH and their numbers have not kept pace with population growth. In 1973 there were 621 personnel with the MOH. Taking the average population growth rate o f 3%, there should have been at least 1300 personnel in 2003. Instead there were only 841 health workers. More disturbing, there were fewer workers in 2003 compared to 1997 at 1168, though it rose by 128 employees by 2004. Between 1994 and 2001, there was a 15 percent decrease in overall staff, affecting mainly maintenance and sanitary staff. Until 2004, the Appropriation Law eliminated vacated positions due to retirement. However as of January 2004, departures are to be match by numerically equivalent replacements which explains the increase in staff between 2003 and 2004.

The relative small size of health care workers is aggravated by the lack of authority that the MOH has over personnel management. A complex process is involved in the hiring new personnel which starts with the MOH, then moves through the Ministry o f Solidarity and ultimately to the Ministry of Finance, the latter then makes the proposal to the Primer Minister and then to the President. The MOH is only able to make recruitment proposals. Promotions have been frozen since 1993 and the absence of professional advancement has left personnel demoralized. Absenteeism is widespread and disciplinary actions can only be taken after a 15-day absence for state health staff and six week absence for government staff.

Most doctors and State accredited or senior health technicians reside in the capital - Djibouti-Ville, which exacerbates the disparities in health services between the city and inland districts. Looking at the geographical distribution of MOH staff in 2001, the majority resides in the capital (84%) followed by the districts o f Tadjourah (4.7%), Ali Sabieh (3.9%), Dikhil(3.4) and Obock (2.3%).

The current ratio doctor-population is one for every 6800 persons, which is short of the WHO recommendation of one doctor for every 10,000 persons. To attain this level, 91 doctors would be needed by 2011 if the population growth at the rate of 3 percent, implying 3 additional doctors per year. There is also a need for specialists in areas of basic and secondary care such as public health, pediatrics, gynecology/obstetrics, surgery and anesthesiology. Given the country's epidemiology, venereal disease specialists need to be given priority.

Reforms introduced over last 10 years, and effects

Planned reforms

The General Peltier Hospital (GPH) is the principal referral hospital in the health care system in Djibouti. Legislation granting autonomy to the hospital has been promulgated in the past few years. Autonomy is proposed for the other Level IV health facilities of the country.

Several suggestions have been advanced by the consultant in February 2004, namely:

1. The possibility of introducing "limited private practice" for physicians has been discussed. This policy consists in allowing MOH physicians to care for paying patients within the confines of the GPH, during "limited" sessions, typically two sessions per week. The income generated from this limited practice is shared between the hospital and the physician, since the hospital would be reimbursed for the provision of the clinic and the staff. The merits of the limited private practice lie in the fact that it encourages physicians to practice within the public system, rather than be forced to leave the service of the government if that were the regulations. If the regulations allow for practice in both sectors, there is the risk of physicians "siphoning" away paying patients to their clinics and to private facilities, if and when they exist. Limited private practice provides also for all social classes to be treated within the same premises, thus avoiding the labels of having hospitals for the poor and other clinics for the rich. This will impact on the level of care, the service component of the service and the accountability of the hospital since decision makers would seek care in the same facility as the less privileged population. Using the same facility is likely to induce change and improvement in the facility.

2. The opening of a "private" wing or "private sections" in the hospital was also recommended. The model proposed was the UK NHS experience in the private wings in the NHS hospitals. The administration noted that there are new facilities being established in the GPH that could serve this purpose.

3. The UK experience in the "Private Finance Initiative" (PFI) was also reviewed. This initiative could provide capital funds for the construction of units or wings in the hospital by the private sector, according to a process regulated by the MOH (bids, specifications, cost recovery, etc.). This initiative would enable the private sector to invest in the construction and equipping of public sector facilities through the provision of the capital required, then recover the cost (and profit) from the management of the unit or from the revenues of its operations.

4. The fiscal situation of the hospital needs to be reviewed. It was suggested that a sub-national health accounts (specific to the GPH) be undertaken within the overall NHA at the next round of the accounts.

8.6 Long-Term Care

	Men	Women	Totals
Population with at least one chronic illness %	2.9	4.6	3.8
Population with at least one handicap %	2.6	3.2	2.9
Population of smokers aged 10 years+ %	23	2.4	12.1

Structure of provision, trends and reforms over last 10 years

Current issues and concerns in provision of long-term care

Planned reforms in provision of long-term care

8.7 Pharmaceuticals

Essential drugs list: by level of care

Manufacture of Medicines and Vaccines

Regulatory Authority: Systems for Registration, Licensing, Surveillance, quality control, pricing

Systems for procurement, supply, distribution

Reforms over the last 10 years

Current issues and concerns

In an environment where the major share of the public health bills is spent on wages, the financing of pharmaceutical products continues to remain a critical problem. Both low equipment budget allocation and execution rates have contributed to drug shortages. The MOH company Pharmapro provides drugs to all health facilities in the private sector and has been suffering from a chronic lack o f financing which amounts to less than one USD per capita after medical deductions, resulting in limited availability of drugs. Drugs in principal are supplied by Pharmapro free of charge. However low availability and inadequate restocking has forced patience to either purchase drugs from the private sector or forfeit treatment. A 1996 household survey confirms that drugs form nearly half of total private health expenditure. Poor quality staffing has affected the monitoring and management of inventory. Due to the company's liabilities with foreign suppliers, purchases are made from more expensive private pharmacies and further eats into its limited budget.

Planned reforms

The decision to establish the "Pharmacies Communautaires" (the CAMME) is considered a welcome improvement. The autonomous agency will be responsible for the importation of medications and their distribution in-country. The list of medicines will consist primarily of the essential drugs and the generics. The purchase in bulk of medicines by the CAMME will decrease the cost of medications and insure their availability to patients. The establishment of CAMME has been supported by the World Bank who will also support the development of the inventory and distribution systems.

The CAMME is planning to recoup at least some of the cost of the medications through a cost recovery scheme from all patients. There has been concern expressed as to the possible financial burden this cost recovery may cause to the poor; the concern has focused even more so on the decision to charge HIV/AIDS patients for the cost of the medications, if the patient is not a Djibouti national.

The team who advocates the recovering of the cost of the anti-retroviral therapy from the non-Djibouti patients support their view point on the basis that Djibouti cannot afford to pay the medicines on behalf of all patients, and that these expatriates and refugees ought to receive treatment in their countries or have the relief agencies pay for these medications. This may be in fact a strategy by the MOH to have the medications reimbursed by these agencies thus alleviating the budget of the CAMME of this financial burden.

Research36 supports the findings that patients on anti-retroviral therapy have demonstrated a far smaller load of the virus in their blood and their body fluids. This finding indicates that HIV patients on treatment are far less prone to spread the infection and thus pose less of a public health risk to the community and to Djibouti. Supporting the treatment of all patients could thus be considered as yet another measure to contain the spread of the epidemic and protect Society, which is a basic responsibility of the State. Within this optic, the Government ought to provide the treatment to all patients, regardless of their nationality, as one of the externalities of public health, much as it does so currently with Tuberculosis and the immunization program.

In addition, the cost recovery of medications could be construed as an anti-poor measure, since some of the poor patients may not even wish to come forward to be diagnosed and treated if in fact they have no money to pay for the medications. Yet another point of view supports the treatment of all patients free because of the high cost of the anti-retrovirals, thus considered as a "catastrophic illness" because it will make households even poorer.

The arguments for cost recovery point to the reality of the current situation in that patients do pay for the medicines at the present time because the "free" drugs are seldom available in the pharmacies of the State and have to be purchased from the private pharmacies at a higher cost.

The financing of the medications is an important component of the financial burden that illness imposes on households in most developing countries (58% in Djibouti), especially on the poor in these societies. Until the financing of health services is covered through a social health insurance scheme, the situation is likely to remain unchanged causing an inequity in the financing of health care by the poorer segments of Society.

The CAMME is also invited to look into ways and means to reduce the cost of the medications it purchases on behalf of the State. The experience of South Africa is worthy to note for it seems that the cost of a one year treatment for anti-retrovirals does not exceed 125 $ per patient.

8.8 Technology

Trends in supply, and distribution of essential equipment

Effectiveness of controls on new technology

Reforms in the last 10 years, and results

Current issues and concerns

Planned reforms

9 HEALTH SYSTEM REFORMS

9.1 Summary of Recent and planned reforms

Determinants and Objectives

The financial determinants in Djibouti's health care system can be summarized as follows:

1. Weak link between available resources and outcomes- despite relatively higher per-capita income and per capita aid, Djibouti suffers from one of the poorest health status indicators in the world.
2. Public expenditure in health in Djibouti is falling as a percentage o f GDP as well as on a per-capita basis and not keeping pace with its rapidly expanding population. The assessment identified many serious dysfunctions concerning the delivery, quality and equity of the health services. The major constraints involve deficiencies in planning and management of the system, shortage of qualified personnel and inadequate management of human resources, weak infrastructure, poor availability of drugs and inadequate funding of the health sector.
3. A large portion of the public health bill is spent on wages, at the expense of medial equipment and material.
4. Budget executions rates for material and equipment are low- at disturbing 50 percent.
5. The supply of public health services is declining both in terms of quality and quantity due to shortage of qualified health personnel and limited material budget.

The policy implications of these findings are as follows:

1. Budget spending should increase in the next few years, if the PRSP goals are to be met by 2006. There is urgent need to mitigate the deterioration in the performance of the health system with the emphasis on rehabilitating the health infrastructure, hiring more qualified personnel and increasing the availability of affordable drugs.
2. Streamlining drug expenditure within both public and private health care facilities, in particular considering the usage of generic as opposed to branded drugs could bring substantial savings. These might be allocated to budget items with better cost benefit ratios such as preventive medicine programs that are currently under funded and often covered by foreign aid.
3. In the interest of cost recovery, The MOH may consider making some of its currently free health service fee-based. Its resources are overstretched as it provides free medical coverage not only to Djibouti nationals but to a large foreign population. A reasonable fee system could contribute to finance the MOH budget and if accompanied by stronger accountability mechanisms it could help improve the delivery o f health services. A proposal by the Center for Health Research and Study (CREDES) in 2000 has put forward a number of tariff scheme options and their potential implications in terms of cost recovery taking into account the household budget constraints of low-income groups. An alternative policy option is to allow greater private sector participation in the provision of some health services. In this case, the role of the public sector would need to be revisited and its regulatory capability would need to be strengthened;

4. Strengthen the national health information system. The current status of the national health information system, in terms of both personnel and equipment makes it difficult to link expenditure to outcomes and to measure their impact on the quality of life and morbidity. Additional technical training and funding to recruit qualified staff can help improve the assessment of the health care system.
5. In general, the downward trend in health care personnel must cease and departing agents must be replace in a systematic manner based on health policy objectives and taking into account growth in the population. The shortage of qualified staff within the MOH and its inability to recruit for lack of funds compromises it ability to achieve objectives under the Heath Strategy plan and to absorb donor financing. The fiscal implications of increased health personnel on the overall wage bill would need to be carefully assessed;
6. Increased budget expenditures need to be accompanied by greater accountability in health service delivery. The long route to accountability needs to involve policy-makers, budget administrators, service-providers and final users. This will help improve the link between health expenditures and outcomes. For instance, greater accountability o f service providers to policy-makers will contribute to reduce personnel management inefficiencies, such as double-dipping (public doctors that use the official working hours to offer private consultation) and absenteeism. The use of expenditure-tracking user surveys can also help identify and tackle key sources of inefficiency and inequity in the utilization of health resources;
7. Greater role of the health sector ministry in formulation, management and monitoring of the sector budget would help mitigate the low budget execution problems in key items (such as materials and supplies). These problems may be associated to the cash-based management plan that, albeit important to keep arrears under control, it does not grants payment authority to the sectors. A greater performance-orientation of the budget, assigning clear responsibilities to sector agencies for results and setting up efficient oversight mechanisms could be an option to consider in view of improving the efficiency and equity impact o f the budgetary resources allocated to health.

Chronology and main features of key reforms

Process of implementation: approaches, issues, concerns

Progress with implementation

Process of monitoring and evaluation of reforms

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 phases of the Project

Phase I (2002-2007) is planned to support the urgent measures required to improve the quality of care provided in the most important health facilities, and to finance the preparatory studies needed to the formulation of the plan of action related to health reforms, most notably the financing of the health system. Specifically Phase I will consist in the:

1. **Improvement of maternal care through the delivery of surgical and non-surgical services related to Pregnancy and Delivery**. This will include the physical rehabilitation of facilities, the training of human resources, the provision of pharmaceuticals and medical supplies. This phase will also support cooperation with UNFPA to promote the health of mothers and women within their communities through health education, the mobilization of community resources and the monitoring of deliveries outside the health facilities (Reproductive Health and Safe Motherhood National Programs).
2. **Improvement of child care** through the support of WHO and UNICEF efforts to establish a structure, at the central level, that would implement the strategies of the PCIME and the improvement of care provided to children in health centers in the urban and rural regions.
3. **Strengthen the efforts against Malaria through the support of the Epidemiology surveillance unit at the Ministry of Health, as well as the parasitology, entomology and laboratory functions**. The surveillance will also be extended to the four districts. In addition, support will be provided to the chemical and biologic campaign against vectors. At the rural level, support will be provided to promote individual protection through the widespread provision of anti-mosquito impregnated nets and the mobilization and sensitization of the community to the hazards of Malaria.
4. **Support to the expanded program of Immunization** undertaken by the MOH, WHO to reinforce the GAVI procurement program.
5. Address the shortage of medicines through the immediate provision of medications to the health facilities and the **establishment of the Central Unit for the Purchasing of medicines and medical supplies (CAMME)** to assure the sustainable and long term provision of medications and supplies.
6. Reduce the shortage in human resources through the **support of the Center for the preparation of health professionals CFPS**; in particular the provision of pre-service and in-service training programs.
7. **Support the program for the autonomy of General Peltier Hospital** (the country's reference hospital) through technical assistance and training programs
8. **Strengthen the managerial capabilities of the Ministry of Health** through the provision of technical assistance and training to the Directorate of Planning, Studies and International Cooperation (DEPCI) in particular its information systems; support to studies and research undertaken by the Directorate to monitor the health situation and measure the impact of health reforms; and finally to provide technical assistance and training to the other departments in the Ministry of Health.

Phase II (2006-2010) will be initiated in an evolutionary manner when the following indicators will be met:

1. Increase in the percentage of deliveries taking place in health facilities from 49 to 55%

2. Reduction of 35% in maternal deaths within health facilities due to obstetrical complications related to pregnancy and delivery
3. A coverage of 65% of children under the age of 1 year for immunization with DPT III
4. Increase to 75% of children sick with malaria receiving anti-malarial therapy as per the directives of the PCIME
5. 35% of children receive anti-mosquito nets impregnated with insecticides in malaria high prevalence zones
6. Improvement of work conditions (remuneration, social benefits, career progression) for state licensed nurses, midwives and laboratory technicians) to be at par with teachers in the civil service of the Ministry of Education
7. Nurses, midwives and laboratory technicians, licensed by the State, will have the same work conditions in the rural areas as the teachers working in the MOE
8. CAMME is well established along with its systems for the cost recovery of medications
9. A budget line has been earmarked in the budget of the Government for the purchase of medicines and medical supplies
10. Enforcement of the administrative autonomy of General Peltier Hospital including the control of personnel and budget systems.

Phase III (2009-2014) will enter into operation once the following indicators are met:

1. Increase in the percentage of deliveries within health facilities to 70%
2. The four maternal and health centers of Ali Sabieh, Dikhil, Obock and Tadjourah will be equipped and properly staffed to undertake Cesarian sections when indicated
3. The expanded program of immunization will cover 80% of the targeted population
4. CAMME has attained financial viability
5. The budget line for medications and medical supplies has become adequate to cover the shortfall between the cost of medicines and the amount recovered from patients; in addition, this budget line should be made available at the beginning of the fiscal year to assure a steady and continuous supply of medicines.

The provision of medicines and medical supplies (CAMME)

Djibouti has finalized a national policy for the provision of pharmaceuticals within a strategic plan to provide essential services to the population. The establishment of CAMME will be supported by the International Development Agency (IDA) as detailed herewith below:

1. The project will support the feasibility study to establish CAMME as an autonomous, not-for-profit association, of public utility. Its mission will be to purchase, administer and make available to health providers in the public sector the essential medicines and medical supplies at the least cost and with maximal efficiency.
2. Prior to the establishment of CAMME, the MOH will need to finalize the statutes of CAMME; recognize its statutes; finalize the convention between the State (represented by the MOH) and CAMME; Establish the Board of Directors of CAMME; finalize and publish the list of medicines and medical supplies to be made available in facilities.
3. The Project will then provide technical assistance to CAMME to prepare its systems of Management, stock taking, Purchasing, Distribution of medicines, Human resources and manning tables. This technical assistance will build on the expertise currently available in Pharmapro that will be merged within CAMME.

4. The MOH will also provide space and personnel, on an interim basis, to start the operations of CAMME in an efficient manner. It will also assure a budgetary line to provide for the essential supplies of Peltier Hospital, Centre Paul Faure, Center of Prophylaxis, CTS. An amount of 220 million FDJ has been allocated for 2002; 350 millions will be necessary for 2003.

The French Cooperation will assist in the physical rehabilitation of the facilities housing CAMME. UNICEF and IDA will assure the rapid procurement of medicines and supplies.

The project will also support the Government to put in place a system for the cost recovery of medicines and supplies in the public sector. At the end of Phase II, the average share of pharmaceuticals in the health expenditures per household ought to be less than 60% and the share of generics ought to be superior to one third of the total expenditures on pharmaceuticals.

The future: Towards a new outlook

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 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 reveals that this vision could well be realized[3738]

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

In addition, Djibouti has a group of dedicated leaders and officials who are committed to the development of their country. They are well educated, work hard and view the development of their country as a challenge to their career and a legacy for their children. 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.

A new vision for the health sector

The health care system of Djibouti remains patterned on the “paternalistic” model of the welfare state. The Government offers medical care to the people, often at no cost or at a minimal pay. The budget of the State finances the health care provisions, with the support of external assistance. Most countries, even those far wealthier than Djibouti, have realized that this model is unlikely to be sustainable over the long term. It

encourages dependence on the part of the population. It is likely to become very costly as the population becomes more demanding and more sophisticated.

The Ministry of Health ought perhaps to define its new vision for the health system over the medium and long term. As the country develops, as the people become wealthier, as investments increase as anticipated in the country development plans, what roles will the Ministry of Health undertake? This vision is essential to define the strategies of the Ministry of Health to shoulder its responsibilities.

Government has the responsibility to lead the development of the health sector. In all countries, the Government must shoulder the responsibility of developing the non-personal health services and protect Society from the threats of epidemics. Only Governments can undertake these duties since the State is the only party that can legislate and promulgate Laws.

The Ministry of Health is invited to re-examine the current situation and project the development of the health sector over the next ten years or so, given the vision of what Djibouti would likely be, in the light of the development projects currently being implemented or programmed. The MOH may still decide to continue in its current responsibilities as a welfare state and as the provider of all services. However, this will be a decision that remains to be taken after due diligence and evaluation.

It is recommended that a study be commissioned to define the vision of the health care system in the medium and long term. It is proposed that this exercise define the role, functions and responsibilities of the Ministry of Health in the future as well as its potential partners in the development of the health sector, such as the private sector, the financing agencies and the mutual funds.

As stated above, the future vision of the health sector is a necessity for the medium and long term. Until this is detailed, reviewed and endorsed, the Ministry of Health will still have to shoulder its current responsibilities and provide for the development of the health sector.

Future reforms

Results / effects

Concluding remarks

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.

Concern has been expressed on the need to induce a change in the "culture" of the population, in order to make it less dependent on support from the Government, by empowering the civil society and inviting the community to initiate efforts on its own rather than await the efforts of the Government.

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. External assistance demands specific milestones and preparatory works that tax the relatively few officials in charge of the execution of the various projects. Meanwhile the general population is passively awaiting the results of these efforts. It needs to be organized and empowered. It needs guidance to share in these activities. The civil societies, the women's organizations are active but are few and are located in the capital.

The challenges faced by Djibouti are real. However the possibilities of success are also considerable given the size of the land and the population, and the favorable regional conditions. The situation is likely to change fast, perhaps within a decade of time. Djibouti would then be quite different and so will the indicators that have been listed.

10 ANNEXES

The list of indicators (2000 - 2004)

	2000	2003	2004
People			
Population, total	7146000	7648000	7791000
Population growth (annual %)	3.0	2.0	1.8
Life expectancy at birth, total (years)	52.5	52.9	53.1
Fertility rate, total (births per woman)	5.3	5.0	4.9
Mortality rate, infant (per 1,000 live births)	107.0	..	101.4
Mortality rate, under-5 (per 1,000)	136.0	..	125.6
Births attended by skilled health staff (% of total)	..	61.0	..
Malnutrition prevalence, weight for age (% of children under 5)	..	..	..
Immunization, measles (% of children ages 12-23 months)	50.0	66.0	60.0
Prevalence of HIV, total (% of population ages 15-49)	..	2.9	..
Primary completion rate, total (% of relevant age group)	29.3	31.1	29.1
School enrollment, primary (% gross)	33.4	38.0	39.1
School enrollment, secondary (% gross)	14.4	19.5	21.5
School enrollment, tertiary (% gross)	..	1.3	1.6
Ratio of girls to boys in primary and secondary education (%)	71.0	73.5	75.2
Literacy rate, adult total (% of people ages 15 and above)	..	..	..
Environment			
Surface area (sq. km)	23,200.0	23,200.0	23,200.0
Forest area (sq. km)	60.0	..	..
Agricultural land (% of land area)	69.1	73.4	..
CO2 emissions (metric tons per capita)	0.5	..	..
Improved water source (% of population with access)	..	..	..
Improved sanitation facilities, urban (% of urban population with access)	..	..	..
Economy			
GNI, Atlas method (current US$)	554.2 million	667.8 million	739.1 million
GNI per capita, Atlas method (current US$)	780.0	870.0	950.0
GDP (current US$)	552.9 million	625.0 million	663.1 million
GDP growth (annual %)	0.7	3.5	3.0
Inflation, GDP deflator (annual %)	2.4	2.0	3.0
Agriculture, value added (% of GDP)	3.7	..	..

Industry, value added (% of GDP)	14.2	..	..
Services, etc., value added (% of GDP)	82.1	..	..
Exports of goods and services (% of GDP)	44.6	..	..
Imports of goods and services (% of GDP)	62.8	..	..
Gross capital formation (% of GDP)	12.9	..	..
States and markets			
Military expenditure (% of GDP)	4.0	..	..
Fixed line and mobile phone subscribers (per 1,000 people)	13.9	43.4	..
Internet users (per 1,000 people)	2.0	8.5	11.6
Roads, paved (% of total roads)	..	..	..
Global links			
Merchandise trade (% of GDP)	43.1	44.0	47.7
Foreign direct investment, net inflows (BoP, current US$)	3.3 million	11.4 million	33.0 million
Long-term debt (DOD, current US$)	237.9 million	366.5 million	393.9 million
Present value of debt (% of GNI)	..	..	44.9
Total debt service (% of exports of goods, services and income)	..	..	..
Official development assistance and official aid (current US$)	71.4 million	78.9 million	64.1 million
Workers' remittances and compensation of employees, received (US$)	..	..	..
Source: *World Development Indicators database*, April 2006			

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[31] Poverty Reduction Strategy Papers, or PRSPs, are national planning frameworks for low-income countries. All countries wishing to access concessional loans from the World Bank (WB) or IMF, or wishing to benefit from debt relief under the Highly-Indebted Poor Countries (HIPC) initiative are required to produce a PRSP. As of September 2002, 18

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[33] The Millennium Development Goals (MDG), derived from the World Summits and Conferences of the 1990s, were adopted by 189 nations in the Millennium Declaration in September 2000 and strongly reaffirmed by all UN member states in the Monterrey Consensus and in the Johannesburg Plan of Implementation in 2002. Global targets were set to mobilize political commitment and to provide benchmarks for measuring progress in promoting human development and poverty reduction. The MDGs represent an unprecedented commitment by the member states of the UN and the UN system and the World Bank.

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The Regional Health Systems Observatory is an undertaking of the WHO Regional Office for the Eastern Mediterranean. The Observatory supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health systems in the EMR. Its primary goal is to contribute to the improvement of health system performance and outcomes, in terms of better health, fair financing and responsiveness of health systems. The aim of this initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health systems and to serve as repository of information on health systems.

This document is part of a series of in-depth health systems profiles, produced and updated by the Observatory using standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

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