World Health Organization

Country Cooperation Strategy *at a glance*

Djibouti

http:// www.who.int/countries/en/

WHO region	Eastern Mediterranean
World Bank income group	Lower-middle-income
CURRENT HEALTH INDICATORS	
Total population in thousands (2012)	860
% Population under 15 (2012)	33.72
% Population over 60 (2012)	5.96
Life expectancy at birth (2012) Total, Male, Female	60 (Male) 63 (Female) 61 (Both sexes)
Neonatal mortality rate per 1000 live births (2012)	31 [19-51] (Both sexes)
Under-5 mortality rate per 1000 live births (2012)	81 [49-128] (Both sexes)
Maternal mortality ratio per 100 000 live births (2010)	200 [100-410]
% DTP3 Immunization coverage among 1-year-olds (2012)	81
% Births attended by skilled health workers (2006)	78.4
Density of physicians per 1000 population (2006)	0.229
Density of nurses and midwives per 1000 population (2008)	0.8
Total expenditure on health as % of GDP (2011)	7.9
General government expenditure on health as % of total government expenditure (2011)	14.1
Private expenditure on health as % of total expenditure on health (2011)	31.9
Adult (15+) literacy rate total	
Population using improved drinking-water sources (%) (2011)	100 (Urban) 67 (Rural) 92 (Total)
Population using improved sanitation facilities (%) (2011)	61 (Total) 73 (Urban) 22 (Rural)
Poverty headcount ratio at $1.25 a day (PPP) (% of population)	
Gender-related Development Index rank out of 148 countries	
Human Development Index rank out of 186 countries (2012)	164

Sources of data:
Global Health Observatory April 2014
http://apps.who.int/gho/data/node.cco

HEALTH SITUATION

Despite progress on many levels, indicators for maternal and child mortality in Djibouti are still high. There is a heavy burden of morbidity from communicable diseases for both (diarrheal diseases including cholera, pneumonia being the most common), from complications during and after delivery, and from malnutrition .Malnutrition rates recently documented through the SMAR survey (2013) showed 18% country-wide malnutrition and more than 5.6% severe acute malnutrition, with important regional disparities.

Djibouti faces a generalized HIV epidemic, and prevention activities have been very limited. The country has experienced problems of funding, including bottlenecks with the Global Fund. Partially as a consequence, the number of women who tested positive and who were put on ARVs, as well as whose newborns received ARVs, is very low.

MDGs achievements in health are limited to education enrollment at primary level;, the rest of the MDGs have shown progress but are not realized. Implementation of the FCTC has shown important results on the legislation and on restriction of smoking in public places, though there is need to increase the tax and the awareness activities.

Geographically, the country has a number of remote and dispersed communities with difficult transportation due to poor-quality roads. 40% of the population lives below the poverty lie. Patterns of migration, especially due to porous borders and an important transport corridor between Ethiopia and Djibouti, further complicate the provision of services to the population.

High prevalence and incidence of tuberculosis constitutes one of the major disease burdens, and an increasing number of multi-drug resistance cases indicate a worry trend.

Djibouti faces an unstable cyclical malaria situation, with malaria epidemics resurfacing in 2013 and 2014 after several years of drought.

Limited information exists on the burden of NCD; however there has been a notable increase in diabetes, cardiovascular diseases and cancers cases. Quat, a narcotic herb, is regularly chewed by the adult population.

Djibouti has requested an extension of 2 years for IHR implementation until 2016.

HEALTH POLICIES AND SYSTEMS

Despite significant progress in the implementation of the national health development plan 2008-2012, Djibouti's health system still faces several challenges - especially in the area of human resources for health and sustainable health financing schemes. These are addressed in the new Health Development Plan 2013-2017. It has among its objectives to: ensure a more participative and transparent governance for a more equitable and better performing health sector; move towards universal access to quality health services; improve availability, accessibility and rational use of medicines and diagnostics; adapt financing per the requirements of health system; and stress human resources for health as a main priority.

The Monitoring and evaluation framework was recently developed, and the costing of the plan is underway using the One Health tool. The Government has also developed a plan to collect and report on the Commission of Information and Accountability.

Djibouti is implementing an accelerated maternal, neonatal and child health plan following the development of a common national MNCH plan as per the Dubai declaration. Fighting female genital mutilation is high on the agenda, with the First Lady as a chief advocate.

The public health sector remains the most important provider; however, the private sector has started growing recently, highlighting the needs for better regulations. Health insurance legislation has been recently approved in 2014. A plan for social protection has been finalized recently. Health services are in principle free of charge to the population and services do not discriminate between nationals and non-nationals. There are many associations and NGOs working in the country focusing on food distribution – though very few work on malnutrition - and awareness of hygiene.

COOPERATION FOR HEALTH

Djibouti is a signatory to IHP+ but has not developed a compact yet. Under the Every woman Every Child, the common national MNCH acceleration plan is being implemented.

Djibouti's health partners and donors include a variety of partners from UN agencies, bilateral and multilateral cooperation and development banks, including IOM, World Bank, Global Fund, GAVI, JICA, USAID, FHI (implementing ROADS project under PEPFAR), French Development Agency, Italian National Institute for Health, IGAD (cross border HIV). The health development partners are regularly invited to coordination meetings but attendance is not always optimal. Participation in the Country Coordination mechanism established by the Global Fund is not open to all development partners. In addition, civil engineering teams from the US military, AFRICOM, the Islamic Development Bank, Italy, China and Sudan are involved in infrastructure and construction of health facilities.

Under the UNDAF, a health and nutrition group has been established and coordinates UN activities. A Joint UN program on AIDS is also very active. UNDP is the current principal recipient for the Global Fund. Djibouti is preparing a concept note for the GF for the three diseases for the next three years, pending the payment of the requested reimbursement. WHO, UNICEF, UNFPA, WFP and UNAIDS work closely on all aspects related to health, HIV/AIDS and nutrition, especially maternal, neonatal and child programs.

A new GAVI Health System Strengthening proposal has just been approved. Japan is implementing a project on strengthening midwifery services. A new World Bank project was launched in September 2013 under the credit facility and to focus on performance-based results management and institutional capacity development. Additional projects for food security have built in nutrition. UN agencies have been mobilizing humanitarian support through appeals in 2012 and 2013, and have been implementing humanitarian funds for nutrition, health and water sanitation clusters. A strategic response plan to cover the needs of 250 000 was launched on May 6, 2014.

WHO COUNTRY COOPERATION STRATEGIC AGENDA (2012-2016)

Strategic Priorities	Main Focus Areas for WHO Cooperation
STRATEGIC PRIORITY 1: Support the governance and leadership of the health sector by MOH	• Support the implementation of the new National Health development plan • Enhance the dialogue and partnerships, through the health development partners, coordination and involvement of the civil society • Develop institutional capacity for efficient aid management moving from projects to programme management • Develop the PHC strategy and implement as a base for sectoral and district based management as well as intersectoral coordination
STRATEGIC PRIORITY 2: Support the development, implementation, monitoring and evaluation of the national strategies for health financing, human resources for health, health information and disease surveillance, and for medicines and health technologies	• Support the collection, analysis, monitoring of financial health data and the National health accounts cycles as well as financing for UHC • Contribute to the development and implementation of the human resources for health strategy and the improved performance aspects • Strengthen health information and disease surveillance system and IHR capacities • Support to policies, capacities and mechanisms for pharmaceutical, and medical technological products
STRATEGIC PRIORITY 3: Strengthen the priority maternal child health, communicable and noncommunicable diseases programs ensuring an integrated, equitable health services	• Support the implementation and monitoring of the national MNCH acceleration plan • Provide technical support and capacity to TB, malaria HIV and communicable diseases programs • Support the development of the National NCD plan and its integration within PHC and linkages with other key sectors • Contribute to the development of a national action plan for the disabilities

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