Table 1. Demographic and reproductive health indicators, Djibouti, 2002–2008

Indicator	Parameter	Year	Source
Total population	632 000	2007	PAPFAM
Population growth rate (%)	3		
Crude birth rate	N/A		
Crude death rate	N/A		
Urban to rural population, ratio	80:20	2002	
Number of women of reproductive age (15–49 years)	N/A		
Total fertility rate	4.2	2002	PAPFAM
Percentage of pregnant women attended by skilled personnel (of all pregnant women) (%)	96.3	2006	EDIM
Number of facilities with functioning essential obstetric care per 500 000 persons	5	2008	DSME
Percentage of deliveries attended by skilled personnel (of all deliveries) (%)	92.9	2006	EDIM
Percentage of deliveries undertaken in health facilities (of all deliveries) (%)	92.6	2006	EDIM
Percentage of caesarean sections (of all deliveries) (%)	10	2007	DSME
Pregnant women with anaemia (of all pregnant women)	N/A		
Percentage of newborn infants with low birth weight (of all newborn infants) (%)	17.8	2006	EDIM
Maternal mortality per 100 000 live births	546	2002	PAPFAM
Perinatal mortality per 1000 live births	N/A		
Neonatal mortality per 1000 live births	45	2002	PAPFAM
Life expectancy at birth female (years)	N/A		
Life expectancy at birth male (years)	N/A		
Contraceptive prevalence rate among married women of reproductive age (15–49), all methods (%)	22.5	2008	DSME
Traditional methods (all)	N/A		
IUD	0.5%		
Condom	N/A		
Pill	10.0%		
Injectables	12.0%		
Implants	N/A		
Female sterilization	N/A		
Factors for not using modern methods among married women	N/A		
Fear of side-effects	N/A		
Lack of knowledge	N/A		
Cost	N/A		
Lack of access	N/A		
Traditional *misconceptions*	N/A		
Partner opposes	N/A		
Unmet need for modern contraception	N/A		
Receipt of postpartum care and family planning counselling	N/A		
Incidence of sexually transmitted infection (per 100 000)	N/A		
Syphilis	N/A		
Gonorrhoea	N/A		
Chlamydia	N/A		
Trichomoniasis	N/A		
HIV prevalence (%)	N/A		
Number of verified HIV cases	N/A		

Source:

PAPFAM: Pan Arab Project for Family Health
DSME: Directorate of Maternal and Child Health, MOH
EDIM: The Djibouti multiple indicator survey, 2006

© World Health Organization 2010
www.emro.who.int
WHO–EM/WRH/067/E

Djibouti

Reproductive health profile 2008

World Health Organization
Regional Office for the Eastern Mediterranean

Health care system

The health sector reform is based on a 'pro-poor' policy that promotes national strategies through decentralization, community development and establishment of regional and district councils for health. A new organizational structure for the Ministry of Health (MoH) is being proposed in an effort to promote decentralization. The reform is also based on the effective and efficient expenditure of available resources, facilitating access to services and ensuring improved coordination between projects. Djibouti has adopted the basic development needs (BDN) programme that focuses on the mobilization of the community and its direct participation and empowerment. The BDN approach integrates reproductive health, nutrition, access to safe water and sanitation programmes.

The population of Djibouti continues to be plagued by a high and increasing incidence of tuberculosis, malaria, cholera and AIDS. Malaria has been a problem in the country since the late 1980s. In 1997, according to a MoH report, diarrhoeal illnesses (e.g. cholera, typhoid fever, amoebic dysentery, viral hepatitis, etc.) accounted for 11% overall of medical consultations, while the same figure was 16.5% for children under-five years of age.

Djibouti's health service, largely provided by the public sector, is free of charge to its population regardless of social status and is relatively accessible. However, there are disparities in accessibility between urban and rural areas. Djibouti's public health service is provided through 7 hospitals, 18 rural and 8 urban dispensaries. Officially medicines are provided free of charge by "Pharmacie Nationale d'Approvisionnernent". In reality, medicines are rarely available. In the 1996 household survey the expenditure for medicines was the largest private expenditure component associated with health care indicating that medicines are costly.

Budgetary spending on health has fallen to nearly 1.5% (2002) from over 2.2% in the early 1990s, and has not kept pace with the rapidly growing population. Djibouti's population is growing at 3% annually due to a high fertility rate (4.2 children per woman) and a significant migratory influx. A shortage of adequately trained health personnel, together with a limited material budget, has caused the supply of health services to decline, both in terms of quality and quantity.

Reproductive health

The national health development plan for 2008–2012 has recently been defined and focuses specifically on reproductive health. The national strategy for integration of women in development has been implemented and a national strategy opposed to female genital mutilation has been developed.

No accurate data on the maternal mortality ratio are currently available, but the estimated figure in 2002 was 546 per 100 000 live births. In order to address the shortage of reliable population data, especially on health issues, the Djibouti multiple indicators cluster survey was conducted and sponsored by United Nations agencies and bilateral organizations. The final report of the multiple indicator cluster survey was released in February 2008 and has shown that approximately 90% of deliveries are conducted in health facilities. The rate of deliveries attended by trained personnel is increasing consistently. Prenatal consultation has increased from 67.9% to 72.1% between 2006 and 2007. In the same period postnatal consultation has increased from 28.1% to 30.5%.

The caesarean section rate rose to 10% in 2007, indicating an improvement in the quality of emergency obstetric care. Nevertheless, there has reportedly been an increase in the number of maternal deaths in hospitals from 18 to 44 between 2006 and 2007. The main causes of death are haemorrhage, eclampsia and delayed referral of complicated cases (rapid means of transport is limited).

In 2008, the contraceptive prevalence rate was estimated at 22.5%. However, this figure conceals a significant discrepancy between urban and rural areas. In rural areas contraceptive prevalence is approximately 5%. The discontinuation rate of contraception is very high. In 2007, the continuation rate of modern contraception was 62.5%, though nearly half of the users were new acceptors. A safety stock of reproductive health commodities and supplies has been created and the logistics management system for commodity tracking at the centres has been strengthened. However, there is a need for further effort in the planning of sustainable procurement.

Strong initiatives by the HIV/AIDS prevention programme and its partners have had a positive impact on stabilising disease prevalence. However, the use of condoms, notably by young people, is still insufficient. Only 44% of young people acknowledge using condoms during first intercourse (Youth KAP survey in 2006). UNFPA has sponsored purchase of about 720 000 condoms for 2008.

A system of peer educators has been set up in schools and community development centres to provide sexual and reproductive health information to young people. However, these activities have yielded no tangible results because the services do not meet the needs of young people, and national and international partner initiatives have been fragmented and inconsistent. In an attempt to solve this problem, a national strategy for young people has been put together by the Ministry of Health in collaboration with a number of other ministries and nongovernmental organizations, including the Ministries for Youth, Education and Higher Education, Communication and Promotion of Women. This strategy is planned to be adopted in 2008.

In 2007, the first counselling centre was established providing information and guidance to women who have been victims of violence. Since its opening, over 300 women have sought assistance in the centre. In spite of strong political commitment, and efforts to help women in distress by a number of nongovernmental organizations and individuals, there has been a manifest lack of human resources. Djibouti does not have enough social workers or psychologists to provide counselling. To address this shortfall, some 50 people from different ministerial departments, including the Armed Forces, the Gendarmerie and nongovernmental organizations have received training from the UNFPA country technical services team for Arab States in Amman, and UNFPA offices in Morocco and Algeria.