Country Cooperation Strategy for WHO and Djibouti
2006–2011

Djibouti

World Health Organization
Regional Office for the Eastern Mediterranean
Cairo, 2006
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviations</td>
<td>5</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>7</td>
</tr>
<tr>
<td><strong>Section 1. Introduction</strong></td>
<td>9</td>
</tr>
<tr>
<td><strong>Section 2. Country Health and Development Challenges</strong></td>
<td>13</td>
</tr>
<tr>
<td>2.1 Political and economic context</td>
<td>15</td>
</tr>
<tr>
<td>2.2 Health profile and progress towards the Millennium Development Goals</td>
<td>17</td>
</tr>
<tr>
<td>2.3 The national health system</td>
<td>18</td>
</tr>
<tr>
<td>2.4 Health expenditure/financing/coverage</td>
<td>23</td>
</tr>
<tr>
<td>2.5 Key health policy issues and current perspectives</td>
<td>25</td>
</tr>
<tr>
<td><strong>Section 3. Development Assistance and Partnerships: Aid Flows, Instruments and Coordination</strong></td>
<td>31</td>
</tr>
<tr>
<td>3.1 Multilateral partnerships</td>
<td>33</td>
</tr>
<tr>
<td>3.2 Bilateral partnerships</td>
<td>33</td>
</tr>
<tr>
<td><strong>Section 4. Current WHO Cooperation</strong></td>
<td>39</td>
</tr>
<tr>
<td>4.1 The programmes</td>
<td>41</td>
</tr>
<tr>
<td>4.2 WHO action for community development</td>
<td>43</td>
</tr>
<tr>
<td>4.3 Role of WHO in health coordination</td>
<td>44</td>
</tr>
<tr>
<td>4.4 Technical staff and working conditions</td>
<td>45</td>
</tr>
<tr>
<td><strong>Section 5. WHO Policy Framework: Global and Regional Directions</strong></td>
<td>47</td>
</tr>
<tr>
<td>5.1 Operating framework</td>
<td>49</td>
</tr>
<tr>
<td>5.2 Country level functions</td>
<td>49</td>
</tr>
<tr>
<td>5.3 WHO-wide strategic directions</td>
<td>50</td>
</tr>
<tr>
<td>5.4 WHO global priorities</td>
<td>50</td>
</tr>
<tr>
<td>5.5 WHO regional priorities</td>
<td>51</td>
</tr>
<tr>
<td><strong>Section 6. Strategic Agenda: Priorities Jointly Agreed for WHO Cooperation in and with Djibouti</strong></td>
<td>55</td>
</tr>
<tr>
<td>6.1 Expectations of national partners</td>
<td>57</td>
</tr>
<tr>
<td>6.2 Medium-term cooperation strategy</td>
<td>58</td>
</tr>
<tr>
<td>6.3 Priority areas of cooperation</td>
<td>59</td>
</tr>
</tbody>
</table>
Country Cooperation Strategy for WHO and Djibouti

Section 7. Implementing the Strategic Agenda: Implications for WHO Secretariat, Follow-up and Next Steps at Each Level

7.1 Implications for the country office 67
7.2 Involvement of the Regional Office and Headquarters 68

Annexes 69

1. Other documents consulted 69
2. Methodology used to select priority lines of country cooperation or CCS between WHO and the government of Djibouti 71
3. Participant in the CCS mission to Djibouti 72
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADEPF</td>
<td>Djibouti Association for the Equilibrium and Promotion of the Family</td>
</tr>
<tr>
<td>AfBD</td>
<td>African Development Bank</td>
</tr>
<tr>
<td>AFD</td>
<td>French Agency for Development</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute respiratory infections</td>
</tr>
<tr>
<td>BDN</td>
<td>Basic development needs</td>
</tr>
<tr>
<td>CCS</td>
<td>Country Cooperation Strategy</td>
</tr>
<tr>
<td>CFPS</td>
<td>Health Personnel Training Centre</td>
</tr>
<tr>
<td>DPHP</td>
<td>Directorate of Prevention and Public Hygiene</td>
</tr>
<tr>
<td>DPT3</td>
<td>Diphtheria, pertussis, tetanus (vaccine, 3rd injection)</td>
</tr>
<tr>
<td>EDAM</td>
<td>Djibouti household survey</td>
</tr>
<tr>
<td>EDSF</td>
<td>Djibouti survey on family health</td>
</tr>
<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>IDB</td>
<td>Islamic Development Bank</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
</tr>
<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>LDC</td>
<td>Least Developed Countries</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>NGO</td>
<td>Nongovernmental Organization</td>
</tr>
<tr>
<td>OPS</td>
<td>Office of Social Protection</td>
</tr>
<tr>
<td>ORT</td>
<td>Oral rehydration therapy</td>
</tr>
<tr>
<td>PAP-FAM</td>
<td>(Survey) Pan Arab Project/Family</td>
</tr>
<tr>
<td>PNDS</td>
<td>National health development plan</td>
</tr>
<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>UNPFA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
The goal of the World Health Organization (WHO) Country Cooperation Strategy for Djibouti is to set out the policy and programme bases for cooperation between the Republic of Djibouti and WHO for the period 2006-2011, and to define the implementation process to achieve the expected results, given the priority health needs of the population of Djibouti.

The aim is not just to build a platform on which to base cooperation between the World Health Organization (WHO) and the Republic of Djibouti insofar as it defines the framework for all WHO initiatives in the country, but also to serve as an instrument to help face the challenges that are still obstacles to the promotion of health.

Consequently, the WHO Cooperation Strategy has been developed in accordance with WHO guidelines and recommendations, in parallel to the review of a large number of documents, including the national plan for health development (2002-2011) and the associated medium-term programming (2002-2006) as well as the Poverty Reduction Strategy Paper, developed by the Republic of Djibouti and defining the directions, priorities and goals of the country in the field of health.

Moreover, the national and international partners have expressed their expectations from WHO. Whatever the value and usefulness of priority-setting for medium-term collaboration between WHO and the Government of Djibouti, the WHO Representative, as a technical adviser to the Minister of Health, should be prepared to provide the necessary support to the country, first to face emergency situations and, second, to achieve health for all, as defined in the Organization's charter, encompassing all aspects of wellbeing. WHO can play a useful role in facilitating intersectoral action, particularly in AIDS prevention and control; protecting the health of children and adolescents; combating substance abuse, including tobacco; promoting community-based initiatives, environmental health and sanitation, and school health. WHO can also play a major role in advocacy to increase the contribution of international partners in the health sector and facilitate its coordination. A specific action by WHO is expected in the implementation of the Bamako Declaration; the fight against female genital mutilation; the management of health care waste; and the strengthening of health security and vigilance, including the exchange of health information with the countries that share borders with Djibouti, and are members of the WHO African Region.

This cooperation strategy covers the period 2006-2011 and falls within the scope and timeframe of the National Strategic Plan 2002-2011. It reflects WHO's vision of the priority actions likely to have an impact on the reform of the health sector and health development in the Republic of Djibouti.

The key principles underlying the choice of priority areas for cooperation were, inter alia:

- the positioning of involvement in the health sector in the context of poverty reduction;
the quest for tangible results in WHO's action and their role as part of a consistent medium-term vision;

the consideration of the involvement of other partners in the health development led by the government.

Maintaining a degree of flexibility to respond to new challenges and to address the country's new needs should be taken into consideration.

The priority areas for cooperation have been identified based on the analysis of the situation, and the application of a set of criteria. Five areas have been selected:

Reform of the health sector and establishment of a primary health care system.

Financing of the system, including international aid.

Development of human resources, and capacity-building of personnel of health facilities.

Implementation of a national policy for quality essential medicines and strengthening of the rational use of medicines.

Support for the development and implementation of priority national programmes and basic health services, including quality of care.

For each priority area of cooperation, the national objectives of the health sector reform to which WHO is expected to contribute have been identified, as well as the strategic approach to WHO involvement. The strategic approaches to cooperation define the parameters that will guide specific action, mobilization and use of WHO resources.

The role and responsibilities of WHO are defined according to the following classification:

Direct support for the implementation of national programmes

Support for the adoption of technical innovations, the adaptation of strategies, the development of guidelines, including with a view to initiating and speeding up large-scale implementation

Support for research and development, policy experimentation, evaluation of health system performance, anticipation of trends in health sector development

Information sharing on health policy options, guidelines and standards, and best practices advocacy

Provision of specific policy advice and high-level technical advice likely to influence the action of the Government and development partners, including in a role of broker and arbitrator where necessary.
Section 1. Introduction

The goal of the World Health Organization (WHO) Country Cooperation Strategy for Djibouti is to set out the policy and programme bases for cooperation between Djibouti and WHO for the period 2006-2011, and to define the implementation process to achieve the expected results, given the priority health needs of the population of Djibouti.

The aim is not just to build a platform on which to base cooperation between the World Health Organization (WHO) and Djibouti insofar as it defines the framework for all WHO initiatives in the country, but also to serve as an instrument to help face the challenges that are still obstacles to the promotion of health.

Consequently, the goals of the WHO Cooperation Strategy are a) to define the areas of WHO involvement in the country, b) to establish a balance between the needs of Djibouti and WHO priorities, c) to define the platform for cooperation between WHO and Djibouti, stating what WHO is to accomplish and how, d) to create a guiding framework for WHO’s work in Djibouti and to use this framework to develop programme budgets and action plans, e) to clarify WHO’s role in Djibouti as part of an enlarged supporting role based on approaches to development, poverty reduction, improvement of the quality of life of the Djibouti population and sector-wide programmes, and finally f) to contribute to the other changes in the development and health promotion process in relation to the Millennium Development Goals (MDG).

The WHO Country Cooperation Strategy for Djibouti is thus an integral part of WHO corporate strategy and its effectiveness will be judged on the following results:

- a better focused and more selective work programme, with a reduced number of priorities;
- a more consistent work programme addressing the needs with the highest priorities in Djibouti;
- a more strategic role for WHO, emphasizing its role in health promotion policy;
- an enlargement and strengthening of cooperation with the other partners to increase influence on their policy and the allocation of resources to sectors that have priority in the country.

To ensure its applicability and efficiency, this WHO Cooperation Strategy has been developed taking into account a number of parameters, paramount among which are:

- health status of the population and its social, economic and environmental determinants;
- state of the health services;
- political and socio-economic conditions surrounding health development;
- capability of local infrastructures to implement changes on the professional level;
- government policies, strategies and action plans;
- ongoing cooperation programme between WHO and Djibouti;
other needs expressed by Djibouti authorities in specific areas.

The WHO Country Cooperation Strategy has consequently been drafted in accordance with WHO guidelines and recommendations.
Section 2

Country Health and Development Challenges
2.1 Political and economic context

Djibouti is characterized by the aridity of its climate, limited natural resources and great vulnerability to natural disasters, notably drought and flooding. The population of the Republic of Djibouti is currently estimated at around 500 000, for a total area of 23 000 square kilometres.\(^1\) Annual natural population growth is estimated at around 3%. Three quarters of the population are concentrated in the capital, Djibouti City, where almost all the country's economic activities are also located, these being based on the manufacturing and service sectors. Migratory flow from neighbouring countries exerts significant pressure on the country's economy and health structures; in fact, more than one third of health care users are from neighbouring countries.

The country is poor and is listed among the Least Developed Countries (LDC) with an average annual income of US$ 805 per capita. In 2002, the country ranked 154th among the world's 177 countries for its human development index.

The country's economic situation has significantly deteriorated since the start of the 1990s, i.e. less than 20 years since the country became independent in June 1977. This is essentially due to the following factors:

- The drying up of donations from friendly countries.
- The outbreak of an internal conflict between the FRUD (Front for the Restoration of Unity and Democracy) and the governmental forces in 1991;
- The general laxity of the administration.

This has dragged down the income per capita by more than 25% from its level in 1984, while the government budget deficit attained 10.1% of the Gross Domestic Product (GDP) in 1995. At the same time, the main indicators of sustainable human development, the gross school enrolment ratio, the infant, child and maternal mortality rates and access to drinking water continued to deteriorate constantly (Poverty Reduction Strategy Paper).

The most recent surveys have shown that 60% of the population live below the poverty line (EDAM), the overall rate of illiteracy among children aged over 6 years stands at 42.9% (32.0 for boys and 52.8 for girls)\(^2\) and life expectancy at birth is 45.5 years.\(^3\) These three indicators illustrate the difficult living conditions of the majority of the population of Djibouti. The other health indicators are shown in Table 1.

In this context, the authorities have adopted a political and economic framework that creates hope for a better future. Also, agreements with Bretton Woods financial institutions (IMF, WB), the adoption of legislation to favour internal and foreign investment (new investment code) and the launch of privatization processes for

---

1. Djibouti Household Survey (Enquête Djiboutienne Auprès des Ménages) EDAM-2, 2002
2. PAP-FAM, 2003
<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization coverage rates (%)</td>
<td></td>
</tr>
<tr>
<td>BCG</td>
<td>74.94</td>
</tr>
<tr>
<td>DPT-Polio 3</td>
<td>49.64</td>
</tr>
<tr>
<td>Measles</td>
<td>47.83</td>
</tr>
<tr>
<td>Tetanus (pregnant women)</td>
<td>45</td>
</tr>
<tr>
<td>Coverage of pregnant women with one antenatal visit (%)</td>
<td>77</td>
</tr>
<tr>
<td>Deliveries in health facilities (%)</td>
<td>77</td>
</tr>
<tr>
<td>Prevalence of contraception (%)</td>
<td>6.4</td>
</tr>
<tr>
<td>(2003)</td>
<td></td>
</tr>
<tr>
<td>Fertility rate (per woman)</td>
<td>5.8</td>
</tr>
<tr>
<td>Net primary school enrolment ratio (%)</td>
<td>65</td>
</tr>
<tr>
<td>Access to an improved drinking water source (%)</td>
<td>84</td>
</tr>
<tr>
<td>(2002)</td>
<td></td>
</tr>
<tr>
<td>Access to improved sanitation (%)</td>
<td>69</td>
</tr>
<tr>
<td>(2002)</td>
<td></td>
</tr>
<tr>
<td>Birth rate (per 1000 population)</td>
<td>47.5</td>
</tr>
<tr>
<td>Crude death rate (per 1000 population)</td>
<td>17.7</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births)</td>
<td>107</td>
</tr>
<tr>
<td>(2002)</td>
<td></td>
</tr>
<tr>
<td>Under 5 mortality rate (per 1000 live births)</td>
<td>124.4</td>
</tr>
<tr>
<td>(2002)</td>
<td></td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100 000 live births)</td>
<td>546</td>
</tr>
<tr>
<td>(2002)</td>
<td></td>
</tr>
<tr>
<td>Female genital mutilation (%)</td>
<td>98</td>
</tr>
<tr>
<td>Overall life expectancy at birth (years)</td>
<td>45.8</td>
</tr>
<tr>
<td>(2002)</td>
<td></td>
</tr>
<tr>
<td>Prevalence of disability (%)</td>
<td>2.9</td>
</tr>
<tr>
<td>(2002)</td>
<td></td>
</tr>
<tr>
<td>Prevalence of chronic diseases (% of population suffering from at least one chronic disease)</td>
<td>3.8</td>
</tr>
<tr>
<td>(2002)</td>
<td></td>
</tr>
<tr>
<td>Annual incidence of tuberculosis (per 100 000 population)</td>
<td>3572</td>
</tr>
<tr>
<td>Annual risk of infection by tuberculosis (%)</td>
<td>3.1</td>
</tr>
<tr>
<td>Annual incidence of malaria (per 100 000 population)</td>
<td>4000</td>
</tr>
<tr>
<td>Prevalence of HIV/AIDS (%)</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>2.9</td>
</tr>
<tr>
<td>(2002)</td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>3.3</td>
</tr>
<tr>
<td>(2002)</td>
<td></td>
</tr>
<tr>
<td>Acute malnutrition among children under 5 (%)</td>
<td>17.9</td>
</tr>
<tr>
<td>Chronic malnutrition among children under 5</td>
<td>26.8</td>
</tr>
</tbody>
</table>
a number of public institutions, (Djibouti International Airport [AID], Djibouti International Autonomous Port [PAID], telecommunications, etc.) might reinvigorate the country and spark economic growth.

Moreover, major development projects have been completed or are in progress: the Dry Port (DDP), the development of new duty-free zones (DFZ), the construction of new port facilities at Doraleh, etc. However, economic growth remains insufficient to absorb unemployment which affects some 60% of the working-age population.

On the political level, in September 1992, under the combined effect of civil war, the new international situation with the disappearance of power blocks and the pressure of domestic opinion, the Government secured the adoption by referendum of a constitution legalizing a multi-party system. Subsequently, political stability was restored in the country with the consecutive signatures of peace agreements with the two fractions of the FRUD (the political wing in November 1994, and the military wing in 2000). This new stability has been demonstrated by three multi-party elections that have been held without incident: the presidential elections in 1999 and 2004 and the legislative elections in 2002. At the behest of the President of the Republic, elected in April 1999, a one-week seminar on governmental action was held in February 2002. This new policy has also been reflected in a will to improve the life of the people: administrative decentralization; reform of the two key social sectors of education and health, which receive 70% of public investment, with a view to improving their performance; and the adoption of a national poverty reduction strategy paper (PRSP) prepared under the leadership of the Prime Minister and largely devoted to the most vulnerable segments of the population. This document addresses many of the conclusions and recommendations that were formulated at the end of the above seminar.

Compared with previous years, 2002 was somewhat disappointing in terms of public investment in the socioeconomic sectors. With a portfolio of 2772 million Djibouti francs (DJF) compared with DJF 5145 million allocated in 2001, investment plummeted by 46.1%.

2.2 Health profile and progress towards the Millennium Development Goals

Despite the lack of health data, it is clear that the country has a health profile comparable to that of developing countries, as demonstrated by the life expectancy at birth which does not exceed 45.8 years. The major causes of morbidity and mortality are infectious diseases (diarrhoea, malaria, lung diseases including tuberculosis, which is showing signs of recrudescence, HIV/AIDS, etc.). The situation is aggravated by the weakness of the health structures that suffer from a lack of equipment, inadequate maintenance of facilities and a shortage of trained and motivated personnel. However, the general trend is towards a relative improvement of infant health, the rates of infant and child mortality per 1000 live births having fallen, respectively, from 114 and 154 in 1989 to 103 and 124.4 in 2002 (Figure 1). Malnutrition is very prevalent among children aged under 5 (17.9% suffering from acute malnutrition and 26.8% from chronic
According to the EDSF/PAP-FAM survey, maternal mortality fell sharply to 546 per 100 000 live births.

The current health situation bears witness to improvements that have been made in the last few years, particularly in the areas of immunization, malaria and reproductive health. However, Djibouti still has major challenges to overcome if it is to meet the goals it set itself for 2015 as part of the PRSP, and also its commitments to the Millennium Development Goals, which are an integral part of its national development strategy.

2.3 The national health system

2.3.1 Khat, a public health problem

The consumption of khat is a habit deeply rooted in Djibouti society. Khat weighs heavily on the economy as it drains more than half of many families’ income and distracts workers from their jobs for hours. Consumers are mainly male, and from all classes, but consumption is starting at an increasingly early age and growing among women.

It is hard to quantify the physiological effects of khat as its active principle content varies according to the age, origin and freshness of the plant. Khat consumption is accompanied by an increased use of tobacco and sugar, and this has a negative impact on the health of women and children. Also, daily consumption of khat, aggravated by changes in social structures and precarious economic conditions, is a triggering/aggravating factor in mental illness in Djibouti.

Most consumers recognize the perceptible or apparent effects of khat and

![Figure 1. Infant mortality (1990–2015)](image)

4 PAP-FAM survey, 2002
are even fully aware of them. Addiction is nonetheless hard to fight because of the high level of tolerance within Djibouti society and the absence of appropriate legislation.

2.3.2 Environmental health aspects

Environmental factors have a direct or indirect influence on the health of the population, and demand special attention. Law no 48/AN/99/4ème L (3 July 1999), on the orientation of health policy, in fact sets out the following government priorities for public health: (i) prevention of major diseases; (ii) protection of maternal and child health; (iii) nutritional and health information and education; (iv) public health and sanitation.

Pollution by chromium and copper arsenate in the port of Djibouti in January 2002 highlighted the country's vulnerability to chemical pollution, particularly in relation with the port activities and the transit of goods to Ethiopia. A WHO consultant undertook three missions to assess the public health impact of this incident. One of his recommendations was the establishment of a poison control centre.

The hygiene department of the Directorate of Prevention and Public Hygiene (DPHP) responsible for the quality of water, food, urban sanitation and pest control is not very efficient due, inter alia, to a lack of qualified inspectors and laboratory staff.

There is a need to focus on a number of issues: revision of the institutional and regulatory framework for hygiene, capacity-building, particularly in water quality monitoring and control, wastewater reuse, food quality control, and health-care waste management, and the promotion of health and environmental activities in schools and as part of community-based initiatives.

2.3.3 National health development strategy and policy

The Djibouti health care system is still based on a paternalistic welfare state model. The Government provides medical care to the population, often free of charge or for a minimum fee. The Government budget finances health care with foreign assistance.

Since the difficult economic situation of the 1990s, the limits of this model have become apparent and the Government has launched a vast programme to reform the health system in order to improve the health care delivery system, to increase people’s access to health care, to fight poverty, to improve efficiency and to ensure the sustainability of the health care system.

It was in this perspective that studies of the health system, funded by the World Bank, were undertaken at the start of the 1990s involving all health stakeholders: state institutions, the civil society, the private sector and multilateral and bilateral partners.

This determination to improve the health sector led to:

- The adoption of strategies to reform the sector “Proposals for the reform of the health sector” by the Government’s Council of Ministers (June 1996);
- The promulgation of Law no 48/AN/99/4ème L (3 July 1999) on the orientation of health policy identifying governmental priorities for public health: (i) prevention of major diseases;
(ii) protection of maternal and child health; (iii) nutritional and health information and education; (iv) public health and sanitation.

Interrupted for a few years by macroeconomic reforms, the process restarted in summer 1999 with World Bank funds from the Japanese donation. After a much needed updating of the sector analysis documents, a 10-year strategic plan and a medium-term national health development plan (PNDS) 2002–2006 were developed with support from CREDES. These documents detail the proposals for reform with five strategic thrusts:

- Improve the organization, management and operation of the health system, which involves redefining the legislative and regulatory framework of the health sector, implementing, monitoring and evaluating the health development plan, and decentralizing gradually the managerial and decision-making processes for the health system.

- Adapt the funding and the use of public financial resources in line with the health policy objectives, which implies a better management of the population's financial resources devoted to health expenditure.

- Adapt the operation and quality of health services to address the needs of the population, involving availability of health care for the population, responsive to the needs and conforming to standardized quality criteria for patients in peripheral health facilities, better care during pregnancy and childbirth, improved hygiene and sanitation.

- Enhance and develop human resources to meet the needs of the health system, which involves strengthening human resources, implementing an initial training programme for medical and paramedical personnel, as well as a continuing education programme.

- Improve the availability, accessibility and rational use of quality medicines, involving the implementation of a policy of quality essential medicines, supply of each public health facility as set out in the national medicines list, and the rational promotion of generic medicines.

To execute these reform plans successfully, a round table of donors was organized in Djibouti with WHO support in February 2002. The participants pledged financial support, led by the World Bank, which will provide the major part of the funds required for the implementation of the National Health Development Plan (PNDS) 2002–2006.

Furthermore, many of the activities planned in the reform process are in progress with funds provided by bilateral and multilateral partners. The Ministry of Health has set up a steering committee to monitor the field implementation of the reform plan.

Finally, the reform includes special provisions for HIV/AIDS, malaria and tuberculosis. Since November 2001, the Ministry of Health, with the support of the World Bank and CREDES, has been working on the first-ever national intersectoral strategic plan in Djibouti to fight HIV/AIDS, tuberculosis and malaria. This comes in the wake of intensive studies on HIV/AIDS, among the findings of which are the
identification of the HIV seroprevalence level of 2.9% in the general population. This plan is followed by intersectoral action plans that are being currently implemented with financial support from the World Bank as part of MAP II (Multi-Country HIV/AIDS Programme).

2.3.4 Health care provision structures

In Djibouti, there are three categories of health care providers, referred to as "sectors" (Table 2). The public sector includes structures under the Ministry of Health, the Ministry of the Interior, the Ministry of Defence and the hospital run by the French military cooperation. The parapublic sector is made up of facilities attached to the Office of Social Protection (OPS). The private sector includes private-practice health professionals. The French military hospital also provides private health care services to any members of the population on request.

Support facilities:
- the pharmaceutical sector
- blood transfusion
- the Health Personnel Training Centre
- the national health laboratory

Human resources for health

Indicators on human resources for health show a shortage in all categories, whether physicians, dentists, pharmacists, nurses, administrators, statisticians or managers (Table 3). The success of the health sector reform will depend to a large extent on the availability of adequate human resources, both quantitatively and qualitatively.

Resource indicators
- inhabitants/bed: 550
- inhabitants/physician: 3880
- inhabitants/paramedical worker: 1100

<table>
<thead>
<tr>
<th>Table 2. Health infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Public sector</td>
</tr>
<tr>
<td>Parapublic sector</td>
</tr>
<tr>
<td>Private sector</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3. Medical and paramedical personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Public sector</td>
</tr>
<tr>
<td>Parapublic sector</td>
</tr>
<tr>
<td>Private sector</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
The Ministry of Health defines, according to the Orientation Law, the public health policy which is adopted by the Government. For disease management, the Ministry of Health has structures divided into four levels of care that cover the whole country. The Ministry, through the Inspectorate, controls the importation and transit of pharmaceutical products. The Ministry is responsible for the health profession practice. Vertical health programmes (Expanded Programme on Immunization, reproductive health, tobacco control, etc.) contribute to preventing vaccine-preventable diseases and promoting behaviour changes.

The Ministry of Defence provides general care to military personnel (the Djibouti National Army AND), the gendarmes (Gendarmerie Nationale, GN) and the Garde Républicaine. The two latter corps each have only one clinic, located in the capital. The Army has a Family Health Centre in Djibouti city and at least one infirmary in each of the inland districts. It is worth noting that the Army has the country’s only dialysis centre and ambulances with resuscitation equipment. The Army participates in emergency referrals of patients from inland districts to Peltier Hospital and has aircraft for this purpose.

A convention signed by the Republic of Djibouti and the French Forces stationed in Djibouti (FFDJ) for hospitalization and specialized medical care provides for any necessary care to be given to needy servicemen at the French Military Hospital. This hospital also provides private care.

The Ministry of the Interior is involved in health care in two ways: firstly through its medical centre which provides outpatient
care and consultations to police personnel (and their families). Secondly, this department is responsible for collecting and transporting injured and sick persons on public roadways (Fire Brigade).

The Ministry of Employment: within this ministry, the Office of Social Protection (OPS) has two health centres through which it provides only ambulatory care and medicines to affiliated personnel and their families. The OPS is responsible for occupational medicine.

University institutions are still embryonic and do not have health departments. However, the Ministry of Health does provide training for basic paramedical workers through its Health Personnel Training Centre (CFPS).

The civil society: in response to the economic crisis which had become entrenched during the 1990s, a large number of associations were created with the encouragement of international agencies and became pivotal partners. They were over one hundred in 2000. In spite of their number, the activities conducted by the associations, such as prevention and information messages on hygiene issues, child health or during cholera epidemics, and cleanliness, immunization and malaria control campaigns, have limited scope and impact. More recently, prevention activities against HIV infection and female genital mutilation (National Djibouti Women's Union) have been initiated in conjunction with donors and the government. A number of associations, such as ADEPF, Al Bir, Bender Djedid, Solidarité Féminine, etc., have substantial logistic and administrative resources.

The civil society is involved in public health initiatives (nongovernmental organizations, traditional or religious authorities, individuals acting in a private capacity), taking part in epidemic prevention and control campaigns and improvement of hygiene in city districts or camps in rural areas.

The private sector is involved in the provision of routine health care and a small number of hospital beds for general medicine through three clinics and four private surgeries (including dental surgeries) officially located in Djibouti, which also play a part in the epidemiological surveillance of some diseases with epidemic potential such as malaria, measles, poliomyelities, diarrhoeal diseases, meningitis, etc.

2.4 Health expenditure/financing/coverage

2.4.1 Overview of health expenditure funding in Djibouti

According to the national health accounts, total health expenditure (public and private) accounted for around 7% of GDP in 1996. Unfortunately, the proportion of domestic resources allocated to health (appropriations/amounts voted) has diminished constantly as a percentage of GDP. Amounting to around 2.2% at the beginning of the 1990s, it has stood at around 1.6% since 1999 (Figure 2).

This reduction in resources was amplified by the reduction in foreign assistance contributions which fell from US$ 11 million in 1998 to 7 million in 1999, i.e. around 36%.

Furthermore, budget allocation between the different levels of health
care is disproportionate between central administration and the reference hospital, and the primary, preventive care facilities and those in the districts. A major part of the health budget still goes for salaries (66% of the budget in 2002).

It should be noted that funds mobilized as part of international cooperation remain uncertain and vary from one year to another.

2.4.2 Households
According to the national health accounts for 1996, the direct contribution of households to the financing of health services amounted to 24% in the form of payments in both the public and private sectors but also to traditional healers. The Government has introduced a policy of cost recovery in public health facilities. However, the cost recovery rate remains very low.

2.4.3 The State
The government finances health through the national budget that has been following a clear downward trend over the past few years. Affected by both the international economic situation at the start of the 1990s (reduction in foreign assistance), increase in the defence budget because of the civil war and implementation of the structural adjustment programme in 1996, the budget allocation to health fell from 7.7% of the national budget in 1986 to 4.38% in 2003 (Table 4).

Economic stakeholders
There is practically no institutionalized solidarity, and health insurance coverage is still very low even though national legislation requires that all stakeholders in the economy and independent institutions become affiliated to the Office of Social Protection, which covers the affiliates and their families for outpatient care. The Office of Social Protection provides care to these affiliates. It collects health contributions (6.2%) but only 17% of the collected funds are channelled back into the health sector.
2.5 Key health policy issues and current perspectives

2.5.1 Sustainability of financing

There is a downward trend in public investment in the social sectors, particularly the health sector, which only received an allocation of DJF 356 million in 2002, despite the fact that in the previous year the sector used up resources worth DJF 465 million.

As mentioned earlier, health is financed by different and varied resources, namely the government budget, the OPS, households and donors. Moreover, Djibouti servicemen and their families receive care at Bouffard Hospital (the French Army Hospital) in the form of hospitalization and private consultations. However, they can also receive care in public sector facilities under the same conditions as the rest of the population. Medical coverage for low-income people is entirely provided by the

<table>
<thead>
<tr>
<th>Year</th>
<th>Government budget (DJF)</th>
<th>Health ministry budget (DJF)</th>
<th>Health budget as % of national budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>22 851 267 000</td>
<td>1 751 778 000</td>
<td>7.7</td>
</tr>
<tr>
<td>1987</td>
<td>22 113 950 000</td>
<td>1 657 999 000</td>
<td>7.5</td>
</tr>
<tr>
<td>1988</td>
<td>23 116 900 000</td>
<td>1 784 954 000</td>
<td>7.7</td>
</tr>
<tr>
<td>1989</td>
<td>23 709 200 000</td>
<td>1 719 115 000</td>
<td>7.3</td>
</tr>
<tr>
<td>1990</td>
<td>23 968 100 000</td>
<td>1 807 013 000</td>
<td>7.5</td>
</tr>
<tr>
<td>1991</td>
<td>25 872 597 000</td>
<td>1 841 939 000</td>
<td>7.1</td>
</tr>
<tr>
<td>1992</td>
<td>27 008 900 000</td>
<td>1 984 076 000</td>
<td>7.3</td>
</tr>
<tr>
<td>1993</td>
<td>28 320 669 000</td>
<td>1 979 292 000</td>
<td>7</td>
</tr>
<tr>
<td>1994</td>
<td>32 485 898 000</td>
<td>1 933 542 000</td>
<td>6</td>
</tr>
<tr>
<td>1995</td>
<td>31 636 158 000</td>
<td>1 632 814 000</td>
<td>4.3</td>
</tr>
<tr>
<td>1996</td>
<td>34 907 350 000</td>
<td>1 577 540 000</td>
<td>3.5</td>
</tr>
<tr>
<td>1997</td>
<td>36 808 634 000</td>
<td>1 650 631 000</td>
<td>4</td>
</tr>
<tr>
<td>1998</td>
<td>31 561 442 000</td>
<td>1 784 272 000</td>
<td>5.6</td>
</tr>
<tr>
<td>1999</td>
<td>35 174 000 000</td>
<td>1 500 053 000</td>
<td>4.3</td>
</tr>
<tr>
<td>2000</td>
<td>35 862 000 000</td>
<td>1 568 856 000</td>
<td>4.4</td>
</tr>
<tr>
<td>2001</td>
<td>38 232 122 000</td>
<td>1 769 460 000</td>
<td>4.6</td>
</tr>
<tr>
<td>2002</td>
<td>39 559 000 000</td>
<td>1 831 199 000</td>
<td>4.6</td>
</tr>
<tr>
<td>2003</td>
<td>41 187 000 000</td>
<td>1 804 657 000</td>
<td>4.4</td>
</tr>
</tbody>
</table>
Government. In this context, mechanisms to target the actual poverty-stricken population are not well defined, which adds to the burden borne by the Government.

This disparity in financing and the reduction of government budgetary resources allocated to health points to the need for a reform of financing in this sector. Moreover, the Government plans to extend the role of the OPS to include coverage of government employees. Finally, the problem of providing support and care for the poor (those who cannot afford to subscribe to the OPS nor pay directly for health care) remains unsolved: the criteria to qualify for care on grounds of poverty and the creation of a solidarity fund to cover health expenditure are apparently being discussed by the authorities concerned.

2.5.2 Human resources

There is currently a shortage of qualified health professionals at all levels of the health system.

First, it is important to develop and formulate a human resource development policy that would receive the undivided support of all the partners concerned. It is essential to conduct an in-depth survey of human resources, taking into account the health profile and current health policy needs. For example, the refocusing of health policy on prevention, community participation and health promotion implies the need to reappraise the categories of health personnel and their training requirements: community health workers, specialized nurses (mental health, school health, ophthalmology and otorhinolaryngology, and public health), environmental hygienists, radiographers, etc. There is also a need to establish a system for regulating and authorizing (licensing) public health practice. There is an overriding need to train public health physicians and reinforce the management skills of health teams as part of a decentralization policy.

The award of fellowship for studies abroad is expected to continue to contribute to the preparation of doctors, dentists and pharmacists. The creation of universities in the country could prove costly and a prior feasibility study is recommended. However, the preparation of nurses, midwives and paramedical professionals should continue in the country. Support to the Health Professional Training Centre (CFPS) and the “University Pole” should be stepped up to enable them to assume their responsibilities and meet demands for the subsequent development of human resources.

One option to improve access to, and use of PHC services within the community is the recruitment and training of community health workers who could notably take responsibility for the tasks of promotion, prevention, education and collection of information. This would mean modifying the Ministry’s staffing table to include these new categories of health workers.

2.5.3 Medicines availability and accessibility

Since the health reform in 2002, a new medicines policy that is still in an embryonic state has been designed notably to ensure the supply of public health facilities with generic medicines. A new organization, the “Medicines and Pharmacy Directorate”, has been set up as a steering body to implement the medicines policy.
As regards medicines financing, users' contribution to costs is expected to remedy the shortage of medicines in public facilities. In this respect, the experience of the phasing-in of community pharmacies, a policy that began over a year ago (in seven centres in Djibouti city and in four inland districts), is encouraging. Though medicines are available today through community pharmacies, there is still a need to improve management committees, the organization and in some cases the financial sustainability of some community pharmacies. The coverage of emergencies remains another sensitive area that has not been discussed, and there is a consequent risk of emergency cases being turned away for financial reasons.

The legal status of the Central Purchasing Agency for Essential Medicines and Materials (CAMME), set up as part of the health reform, has been defined (Decree n°59/PR/MS/2004) and CAMME has just received its first endowment from the World Bank. However the first allocation of the budgetary provision from the government for its facilities is still due and the methods for supplying the health centres have not yet been determined.

Moreover, the lack of an information and education programme to accompany the introduction of generic medicines poses the problem of misuse, with its attendant risks. Training for prescribers and the monitoring of the prescription through a set of indicators are in their infancy, with the potential of excessive prescription of some medicines such as antibiotics, and the corollary emergence and increase of resistance.

The Medicines and Pharmacy Directorate needs to build the capacity of its staff through training, the development of monitoring and evaluation tools and the initiation of medicines control by establishing a level 1 quality control laboratory.

Medicines inspection is the weak link in the current system.

Despite the government’s efforts in medicines legislation, a number of weaknesses remain, particularly in terms of regulations relating to pharmaceutical products in transit to neighbouring countries, coordination of donations from different partners and the development of a medicines management system, appropriate to the level of peripheral services.

2.5.4 Emergencies

The country regularly suffers from the unstable situation in the Horn of Africa, the presence of tens of thousands of refugees and displaced persons, extreme climatic variations (cyclic drought, torrential rain and flooding, the latest having occurred in April 2004) and the particularly limited financial resources available in the country to implement the reconstruction and development programmes.

Moreover, chemical disasters threaten the country, especially in maritime port areas and along the road corridor to Ethiopia. An accidental spillage of highly toxic products in 2002 revealed Djibouti's fragility and lack of preparation for this type of event.

Currently, emergencies and disasters are managed as and when they occur. There is no prevention system. When the PRSP document was prepared, the question of developing a national strategy for disaster
Country Cooperation Strategy for WHO and Djibouti

Prevention was raised but this has not yet materialized. However, a national profile for the integrated management of chemicals was drafted last year.

Finally there is a mechanism for coordinating action during disasters, called "ORSEC plan", under the authority of the Ministry of the Interior.

2.5.5 The country’s vulnerability to communicable diseases and epidemics

Communicable diseases are still major causes of mortality and morbidity in Djibouti. Considering the socioeconomic and sanitary conditions, the lack of water and insufficiently trained personnel to face up to the challenge, Djibouti runs a high risk of epidemics.

The plan to reinforce the early warning system for communicable diseases, introduced by the Ministry of Health in collaboration with WHO since 2003 in all health centres and hospitals in Djibouti city, is operational in most health services. The role of each of the peripheral, intermediary and central levels is defined and data collection tools (registers) and the surveillance guide have been developed.

With WHO support, a real effort has been made in terms of training and supervision to revitalize the network of focal points in health centres and medical-hospital centres in all the country’s districts.

However, the epidemiological surveillance system is not efficient enough and is still fragile, especially at the most peripheral level. The following constraints deserve special attention.

- The health laboratories at district and national level are not efficient.
- Inaccessibility and the lack of involvement of (untrained) mobile teams are obstacles to the collection, analysis and timely feedback of data from the country's rural areas, where the risk of transmission of diseases is increased by the unfavourable social conditions.
- Because of a shortage of skilled and mobile human resources, insufficient use is made of collection tools (registers).
- The lack of supervision of peripheral health centres by the chief medical officers and of districts by the unit responsible for epidemiological surveillance at central level affects the quality and reliability of the data collected.
- Data analysis is not performed at the level of the basic health care centres and medical-hospital centres.
- The "early warning" system is only operational in the basic care services, and because access to care remains limited there is underreporting of cases.

2.5.6 Infant and maternal mortality

Infant and maternal mortality rates are still among the highest in the world.

The leading causes of death and hospitalization among children are diarrhoea, acute respiratory infections (ARI), malaria and nutritional problems.

The government has developed a national immunization strategy aimed at achieving immunization coverage of 85% for DPT3, eradicating poliomyelitis, eliminating
neonatal tetanus and measles, reducing by up to 65% the rate of vitamin A deficiency, and ensuring 100% safety of injections, while strengthening social mobilization and human resources capacity. In this area, Djibouti receives support from WHO, GAVI, UNICEF and USAID. The Inter-Agency Coordination Committee (ICC) regularly monitors the implementation of the EPI programme. However, routine immunization rates are still unsatisfactory due to the lack of micro-planning (the target population is largely unknown to most of the health services), of a cold chain, of adequate vaccine management, continuing education and supervision.

The Ministry of Health has also adopted the IMCI strategy and this was initiated with WHO support in Djibouti-city district in July 2004. Within one year, IMCI was introduced in 31% of health centres covering 61% of the child population (12 out of 35 centres); 27% of health workers (i.e. 47 out of 174 workers in total) have been trained. Some problems however subsist, including the quality of IMCI workers (insufficient motivation), the lack of re-nutrition and oral rehydration therapy (ORT) units in most health centres, the insufficient care for a number of serious cases (severe malnutrition) and the improper management of patient records (filing and archiving). When the strategy was first implemented, the health system was weakened by years of malfunctioning linked to socio-economic problems; this made the improvement of quality of care a real challenge. The IMCI community component has not yet been introduced but the related action plan exists and should be implemented in the near future. There is a need to speed up the extension of IMCI to the country’s other districts and above all to introduce/initiate the community component to enlist the participation and support of the population for the health initiatives from which it should benefit.

The national study on family health (PAP-FAM, May 2003) shows that 27% of children under 5 are underweight and 18% are severely undernourished, while 60% of children admitted into paediatric care suffer from severe malnutrition. It would appear that over 40% of women discontinue breastfeeding when their infant children are ill, 40% of women are found anaemic at their first antenatal visit, and around 6% of schoolchildren have goitres and palpable nodules.

Many local factors linked to poverty, chronic food insecurity, popular beliefs and practices, khat consumption, and the high rate of maternal morbidity and mortality explain this major health problem in Djibouti. The Government has emphasized the urgent need to develop an appropriate strategy and a national intersectoral plan of action, with a concerted approach by the partners. The Ministry of Health is currently deploying efforts to upgrade nutritional rehabilitation points in health centres, which are supported by the WFP. Also WHO launched a local low-cost complementary food production project 5 years ago, but this was stopped for lack of funding and follow-up. WHO has trained one doctor in therapeutic care for malnutrition. Recently, a team from the FSAU (Food Security Assessment Unit) in Somalia visited Djibouti to establish a sentinel surveillance system for malnutrition and related illnesses.
Current food programmes do not meet needs because of the lack of a clear strategy, procedures and standards in the centres for screening and care of the malnourished. Major constraints to the setting up of a national programme to combat malnutrition in the health sector are: the absence of an institutional framework and specialized human resources, and the lack of therapeutic foods and of training for health workers in how to use them; the major need of consultation and coordination for a holistic and multisectoral approach, as the different sectors involved do not have the same level of commitment; the shortage of financial resources; and the need to ensure the continuous commitment of partners during the phase-in period.

Djibouti has a high maternal mortality ratio: 546 per 100 000 live births. The reproductive health programme for Djibouti includes in its strategy the various components of maternal health, family planning, antenatal and post-natal visits, the improvement of quality of care in deliveries and management of obstetric emergencies, the fight against female genital mutilation (FGM), community awareness-raising on the use of reproductive health services, and the reproductive and sexual health of adolescents. The integration of the prevention of parent-child transmission of HIV/AIDS and the prevention and management of other STI in reproductive health services are an integral part of the minimum package of activities of the reproduction health programme. There was a decline in hospital maternal deaths at national level from 709 per 100 000 in 1999 to 290 per 100 000 in 2004. However, great efforts still need to be made to reduce maternal mortality.
Development Assistance and Partnerships: Aid Flows, Instruments and Coordination
Section 3. Development Assistance and Partnerships: Aid Flows, Instruments and Coordination

3.1 Multilateral partnerships

Development partners, the most important of which are WHO, UNICEF and UNFPA, contribute funds for health through cooperation programmes with the Ministry of Health according to a specific cycle for each partner. These United Nations agencies deliver "regular" health activities through vertical programmes and provide technical assistance. At the government's request, they also cover the country's exceptional needs, especially in emergencies.

3.2 Bilateral partnerships

France has a preponderant position for historical reasons but also because of the presence of technical assistants and project financing.

Italian Cooperation supports the operation of Balbala Hospital (located on the edge of the capital, and offering care essentially for the poorest segments of the population) which was built ten years ago and the extension of which is planned in the very near future.

Over the last few years, other partnerships have been undertaken in the field of health in Djibouti, namely Egyptian and Chinese cooperation. Their contribution cannot be quantified in figures as they are provided essentially in the form of technical assistance.

Finally, an agreement has been signed recently between the Ministry of Health and USAID to finance activities that will contribute to improving coverage of essential health services. The agreement instrument is entitled: "Project for Expanded Coverage of Essential Health Services (PECSE)". This consists in assisting the Ministry of Health in Djibouti to:

1. Increase the supply of essential health services through the rehabilitation of health facilities, the provision of materials and equipment and the rehabilitation of drinking-water supply sources.

2. Improve the quality of services through strengthening management systems and training for improving the skills, knowledge and performance of providers.

3. Enhance local capacity to sustain health services by increasing community participation in health programmes, strengthening the role of local associations, nongovernmental organizations and other community groups in community mobilization and in communication activities to address health issues of importance to the community, as well as through expanding the model of community-based services.

International cooperation fulfils an important role in public health both through the number of partners and the scope of the assistance provided. The main interventions, the amounts contributed and the periods of financial coverage are detailed in Table 5. To better coordinate foreign assistance and ensure that it is used rationally, the Ministry of Health has established a project management unit (UGP).
Moreover, with the contribution of WHO (DJF 108 million for the period 2002-2003) and UNFPA (DJF 106 million for the period 2003-2007), this sector has been able to implement various health projects. Another DJF 106 million donation from France in 1999 helped continue the rehabilitation of Peltier Hospital.

It is important to point out that in February 2002, with WHO support, the Government of Djibouti, in collaboration with the World Bank, organized a round table of donors in an attempt to mobilize the resources required to finance its ambitious health development programme. The results of this important meeting were conclusive. Many donors expressed their interest to participate in financing the National Health Development Plan (PNDS) (Table 5).

### Table 5. Health partners involvement

<table>
<thead>
<tr>
<th>Partner</th>
<th>Field of action</th>
<th>Type of funding</th>
<th>Amount in millions</th>
<th>Period of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO</td>
<td>Title: Cooperation programme between the Government of Djibouti and WHO</td>
<td>Donation</td>
<td>US$ 2.7*</td>
<td>2004–2005</td>
</tr>
<tr>
<td></td>
<td>Health policy support</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support for the implementation of basic health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support to national vertical programmes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support for the development of human resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support for the essential medicines policy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNICEF</td>
<td>Title: Cooperation programme between the Government of Djibouti and UNICEF</td>
<td>Donation</td>
<td>US$ 3.4</td>
<td>2003–2007</td>
</tr>
<tr>
<td></td>
<td>Health component: Integral development of young children</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV/AIDS prevention and control Objectives: Contribution to the reduction of infant and child mortality rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contribution to the reduction of maternal mortality rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contribution to the reduction of genital mutilation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention of HIV/AIDS among the young</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention of mother-to-child transmission</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Including extrabudgetary resources but excluding the cost of WHO staff visiting the country on consultancies and the cost of the participation of Djibouti nationals in intercountry meetings organized by WHO.
<table>
<thead>
<tr>
<th>Partner</th>
<th>Field of action</th>
<th>Type of funding</th>
<th>Amount in millions</th>
<th>Period of implementation</th>
</tr>
</thead>
</table>
| UNFPA   | Title: DJI/03/P01 “Reproductive health: availability, quality and information”  
Objectives:  
Improve reproductive and sexual health of all couples and individuals, including adolescents  
Create a supportive environment for the promotion of women and gender equity  
Strengthen the implementation of the health sector reform | √ | US$ 1.5 | 2003–2007 |
| WFP     | Title: Assistance to Vulnerable Groups and Refugees: PRO10283  
Health component: “Health and Nutrition”  
Of particular interest among the project’s designated objectives is health, namely to maintain and improve the nutritional status of vulnerable groups  
The programme is focused on health and nutrition through targeted distribution in social institutions | √ | US$ 6.9 | 2003–2005 |
| UNDP    | Programme to support the fight against poverty:  
Support for national strategies and policies to fight poverty  
Support for sustainable local development in provincial districts  
Health component: HIV/AIDS control strategy  
The main objective is to strengthen coordination of all stakeholders in order to improve prevention and management of communicable diseases, including HIV/AIDS. | √ | US$ 1.19 | US$ 0.88 |
<table>
<thead>
<tr>
<th>Partner</th>
<th>Field of action</th>
<th>Type of funding</th>
<th>Amount in millions</th>
<th>Period of implementation</th>
</tr>
</thead>
</table>
| **France**       | **Title:** Blood transfusion safety-AIDS prevention and control  
Objectives  
Support to the reform of the health system  
Organization and sustainability of a countrywide therapeutic regimen in conjunction with the therapeutic models in neighbouring countries  
**Title:** exceptional assistance  
Objectives  
Rehabilitation of Peltier Hospital and construction of a new surgery building  
Rehabilitation of Peltier hospital sanitation systems | Donation          | 0.7 EU            | 2003–2005               |
|                  |                                                                                                                                                    |                  | 1.2 EU            | 1999–2003               |
| **Bilateral**    |                                                                                                                                                    | Donation          | 2.7 EU            | 1999–2005               |
| United States    | **Title:** USAID programme in the Republic of Djibouti  
Health component: Project for Expanded Coverage of Essential Health Services  
Objectives:  
Increase access to health services particularly for poor populations  
Improve the quality and efficiency of health care to reduce infant and maternal mortality  
Develop the coverage of key health services. | Donation          | US$ 12            | 2004–2007               |
<p>| Italy            | Civil engineering work and equipment of Balbala Hospital                                                                                          | Donation          | 9.2 EU            | ?                       |
| China            | Establishment of a dialysis unit in Djibouti                                                                                                       | Donation          | DJF 40            | ?                       |
| Morocco          | Rehabilitation of the Martial Building, Peltier General Hospital                                                                               | Donation          | US$ 0.3           | ?                       |
| Saudi Arabia     | Emir Sultan Abdul-Aziz dialysis centre                                                                                                           | Donation          | 2.2               | 2004–2005               |</p>
<table>
<thead>
<tr>
<th>Partner</th>
<th>Field of action</th>
<th>Type of funding</th>
<th>Amount in millions</th>
<th>Period of implementation</th>
</tr>
</thead>
</table>
| WORLD BANK       | Title: Project for development of the health sector: PDSS  
                  Project to fight HIV/AIDS/MAL/TB  
                  Components of PDSS:  
                  Improvement of the quality of health services  
                  Improvement of the availability of human resources  
                  Improvement of access to medicines  
                  Improvement of health sector management  
                  Components of the HIV/AIDS/MAL/TB project:  
                  Capacity-building and implementation of the communicable disease control policy  
                  Involvement in the health sector for the prevention and control of HIV/AIDS/MAL/TB  
                  Multisectoral support for HIV prevention  
                  Support for community-based initiatives  
| AfDB             | Title: Basic health care  
                  Civil engineering work  
                  Equipment and medicines  
                  Training  
                  Title: Construction of three health centres and rehabilitation of Obock and Tadjourah medical-hospital centres (CMH)  
                  (Social Development Fund) | Donation ✓      | US$ 8.3            | 2004–2009            |
| IDB              | Title: Basic health care  
                  Improvement of the Pelletier General Hospital technical platform  
                  Title: Construction of a regional hospital with 100 beds in Ali Sabieh | Donation ✓      | US$ 5.5            | 2004–2008            |
| AFD              | Title: Construction of the PK12 Health Centre | Donation ✓      | ?                  | DJF 46.2             | ?                   |
| GLOBAL FACILITY  | Title: Support for AIDS prevention and control | Donation ✓      | US$ 12             | 2005–2008            |
Partner coordination

The "Poverty Reduction Strategy Paper" is now the reference document in the field of cooperation and provides the framework for the efforts undertaken to achieve the Millennium Development Goals (MDG) in Djibouti.

Apart from the project management unit established within the Ministry of Health, there is no true coordination structure worthy of the name, nor is there is a predefined programming instrument that can be used to channel donor investments.

Throughout the cooperation project development process, the Ministry of Foreign Affairs and International Cooperation as well as the Ministry of Economy, Finance and Planning, responsible for privatization (particularly its foreign funding department responsible for forecasting recurrent costs in public investment projects) are intimately linked. However, there is a concerted approach as well as a vision shared by some development partners, namely the United Nations Systems agencies that have drafted a United Nations Development Assistance Framework (UNDAF) 2003-2007, that acts as a reference, in addition to the Millennium Development Goals.

As regards the coordination of health interventions, the Ministry of Health set up the Group of Health Partners (GPS) in February 2005 to act as a framework for consultation between partners. Its main missions are to:

- Support the Ministry of Health in the development and implementation of national policies and strategies for health reform to optimally address the PRSP, and the Millennium Development Goals for health.
- Facilitate the regular exchange of information and coordination between partners on the level of financing and the attainment of goals set by the PNDS and others.
- Assist the Government of Djibouti in mobilizing additional internal and external resources for health and optimizing the use of allocated resources.
- Provide the technical support needed to ensure the monitoring and evaluation of planned projects and measurable outcomes towards the Millennium Development Goals.
- Support the Ministry of Health to ensure linkage and consistency between the different health investors in the private and public sectors, as well as other development programmes in support of national priorities.
Section 4

Current WHO Cooperation
Section 4. Current WHO Cooperation

The Basic Agreement between WHO and the Government of Djibouti concerning the provision of technical assistance of a consultative nature enabled the opening of the Office of the WHO Representative in Djibouti in 1984.

4.1 The programmes

The funds allocated under the regular budget for each biennium since the opening of the WHO Office are shown in Figure 3.

In total, more than US$ 16 million have been mobilized by WHO for Djibouti since 1984, excluding intercountry activities and extrabudgetary resources that accounted for more than US$ 2.2 million during the last four biennia and were essentially allocated to poliomyelitis eradication, malaria control, child and maternal health, and prevention and control of sexually transmitted diseases, including HIV/AIDS.

In line with the priorities and objectives selected in the national health development plan, the programme of cooperation of the World Health Organization with the Government of Djibouti for the period 2002-2003 spanned 19 action programmes, compared with 21 in the 2004-2005 programme.

The funds allocated directly to activities in the country during the biennium 2002-2003, including extrabudgetary resources, amounted to US$ 1345 550. The eight action programmes listed in table 6 mobilized more than 81% of this amount.

Action relating to a number of collaborative programmes is detailed briefly below:

1. In health policy and strategic planning, special attention has been given to the strengthening of the national health accounts, monitoring and evaluation.

Figure 3. Regular budget and extrabudgetary allocations
2. The preparation of a plan of action for the development of human resources was supported to ensure that the Health Personnel Training Centre was in line with the plan to reform the health sector through the analysis and revision of health personnel functions and tasks, trainers' education training, the update of nursing and midwifery curricula to integrate public health aspects, continuing education and retraining of paramedical staff.

3. Priority has been given to improving the efficiency and quality of the basic health care system through the development of the health map, capacity-building of the primary health care directorate, improved accessibility of health care for populations that are not served by the health system, the strengthening of health services management and technical support for planning, management, and monitoring and evaluation of the health system.

4. To promote national medicines policies based on essential medicines, WHO has contributed to the development of technical guidelines on good procurement practices, and of regulations for the control of medicines transiting through the Republic of Djibouti, and to the training of personnel in medicines management.

5. Priority has also been given to the development of activities, the improvement of the organization, management and operation of the national laboratory network, and the restructuring of the public health laboratory activities.

6. Emphasis has been placed not only on health education but also on school health, as well as on the need to sensitize the population on the consequences of tobacco use. In this context, the importance of intersectoral
collaboration is underlined, given the influence of other sectors on health and quality of life determinants.

7. In the area of noncommunicable diseases, special attention is given to the prevention of blindness and the prevention of cardiovascular diseases. Mental health now occupies a special place in the WHO collaborative programme.

8. The maternal mortality ratio in Djibouti being one of the highest in the world, reproductive health is a WHO priority programme. The actions supported by WHO are the improvement of the quality of care during pregnancy, training of health personnel in obstetric emergency units and social mobilization on reproductive health issues, including female genital mutilation.

9. WHO participates actively with the Ministry of Health and the other partners in the promotion and adoption of the integrated management of child health approach with the involvement of the community.

10. In the area of health and the environment, WHO intends to focus on the revision of the institutional and regulatory framework for hygiene, capacity-building in this area and the promotion of health and environmental activities in schools as part of community-based initiatives.

11. In the area of communicable disease prevention and control, priority is given to diseases that are considered important in terms of morbidity and mortality, namely tuberculosis, malaria and HIV/AIDS, the designation of Djibouti in 2003 as a priority country in the 3x5 strategy being an illustration, and also childhood communicable diseases addressed by the immunization programme. WHO is also active in the eradication of poliomyelitis, especially in the training and supervision of personnel as well as in the organization of national immunization campaigns.

12. WHO has contributed to addressing emergencies in the country, particularly by participating in the coordination of relief work and active surveillance of epidemic diseases and by providing medicines.

4.2 WHO action for community development

Focus was placed on the improvement of quality of life by reducing poverty through the activities of the Basic Development Needs programme (BDN). The BDN programme is based on the dynamics of an integrated, socioeconomic community development and on coordinated intersectoral action. The programme is currently operational in five districts, with one site per district. The districts of Tadjourah and Dikhil have two BDN sites. The programme covers a population of 17 248 people.

By being based at the Ministry of Health, the BDN programme can more easily integrate health programmes in order to strengthen primary health care. The BDN programme provides a platform and an entry point for health interventions and could consequently contribute to improving health indicators and people's access to health services. The Ministry of Health has plans
to institutionalize the BDN programme by integrating it into the health policy in order to strengthen primary health care. Hence the Ministry of Health's request that the programme be evaluated by the Regional Office in February 2005.

The results of the evaluation have demonstrated a clear improvement in health indicators in BDN sites compared with national levels. For example, while the national rate of immunization coverage for children under 1 year is 64.1%, it lies in the range of 96%-100% in BDN sites. Access to water at the different sites of the project is 100%, whereas it is only 52% at national level. Moreover, 480 adults attended literacy courses; 295 women and girls received training and 36 people were able to have income-generating activities for which a 100% refund rate was achieved. Also 300 young people received training in information technology, and 80 of them were able to find work.

Evaluation pinpointed several strengths such as the mobilization and organization of communities, the strong involvement of women and partner mobilization. The projects implemented as part of the BDN programme have also enabled environmental improvement in villages, facilitated access to employment for young people, and promoted development for women. The beneficiaries of the BDN programme have raised the issue of the importance of maternal and child health projects, agricultural projects and health education projects.

The Ministry of Health's commitment to institutionalizing the BDN by integrating it into the national health policy in order to strengthen primary health care, and the significant interest shown by development partners for coordinating their action with the BDN programme are an encouragement to exploring ways of extending the BDN approach to the whole country.

The evaluation mission made the following recommendations with a view to nationwide programme extension: improve intersectoral collaboration by involving the district regional councils; strengthen capabilities and build on the achievements made by the programme; increase the number of sites, and develop a national plan of action.

4.3 Role of WHO in health coordination

In the last few years, the number of United Nations agencies and organizations represented in Djibouti has increased: the WHO Office participates in different work and actions of the United Nations system, such as the development of the United Nations Development Assistance Framework (UNDAF). In this connection, the WHO Representative has been chairing the sustainable health and HIV theme group since January 2004 and since 2005, the UNAIDS/Djibouti theme group. WHO has contributed to the process of drafting the national strategic plan for AIDS prevention and control and to the country coordination mechanism (CCM) that resulted in securing support from GFATM (Global Fund to Fight AIDS, Tuberculosis and Malaria).

The WHO Representative coordinated external assistance provided to the health sector following the flooding that occurred in April 2004 and in 2005 was appointed Chairperson of the Group of Health Partners; since 2005 she has chaired
this Group. The WHO Country Office has
initiated and supported the preparation
of the country’s proposal for GAVI funds,
and was responsible for supervising the
monitoring and evaluation of the World
Bank AIDS projects.

It is also important to note that the WHO
Representative is chairing the interagency
committee for coordination and monitoring
of the immunization programme.

It is however regrettable that WHO
involvement in the reform of the national
health system has been limited and belated.

4.4 Technical staff and
working conditions

In addition to the Representative, the
technical staff of the WHO Office in Djibouti
consists of a medical officer providing
direct support to the Minister of Health, a
programme officer for immunization (STP),
a technical assistant for BDN (SSA). The
latter two are temporary positions. The lack
of qualified personnel at ministry level is
reflected by a significant demand for direct
support and follow-up by the WHO country
office. The areas in which the shortage of
qualified personnel is most acutely felt in
addressing this demand in the country office
are the development of human resources
for health, the development of the health
system based on PHC, the development
of the reproductive health programme and
the health information system. The use of
French as the working language adds to
the workload for the country office in terms
of interfacing with the Regional Office.
Moreover, it is to be noted that there is a
critical weakness in logistic support (lack of
means of transport) as well as administrative
and secretarial support.

Due to lack of staff, documentation
on work accomplished, dissemination
of success stories and exchange of
information remain insufficient, despite
the fact that an efficient communication
strategy is essential for WHO’s image and
mobilization of extrabudgetary resources,
without which it is impossible to address
the need for supervision and development
of collaborative activities.

Since the recent move of the WHO country
office, working conditions have improved.
WHO Policy Framework: Global and Regional Directions
Section 5. WHO Policy Framework: Global and Regional Directions

5.1 Operating framework

Health systems in developing countries are becoming more complex. The role of the state in provision of health care is diminishing rapidly, with the private sector and civil society becoming active and important players. Also, globally, a number of development organizations and financial institutions have become heavily involved with health development activities in developing countries. It was, therefore, timely for WHO to respond to this changing environment by calling for new ways of working with its Member States.

WHO has adopted a broad approach to health within the context of human development with a particular focus on the links between health and poverty reduction. It is assuming a greater role in establishing wider national and international consensus on health policies, strategies and standards, through managing the generation and application of research, knowledge and expertise. At the country level, through the CCS process, it is envisaged that:

- WHO collaboration will be more strategic and focused on fewer priority areas, which will be an amalgam of global, regional and national priorities;
- increased emphasis will be given to WHO’s role as a policy adviser and broker;
- opportunities will be sought for increasing and strengthening partnerships with other international and national agencies, including nongovernmental organizations working in the field of health;
- innovative approaches will be sought to increase the effectiveness of WHO support;
- attempts will be made to ensure the utilization of the knowledge and skills present in the country for WHO’s normative work.

5.2 Country level functions

To carry out WHO operations at the country level four WHO functions have been identified:

- catalysing the adoption and adaptation of technical strategies; seeding large-scale implementation;
- supporting research and development; monitoring health sector performance;
- information and knowledge sharing; providing generic policy options; standards; advocacy;
- providing specific policy advice; serving as broker; influencing policy, action and spending.

It should be noted that the sequence in which the above functions are listed is not an indication of their priority. In fact, the relative importance of these functions would vary from country to country depending on its state of development and strategic priorities identified for collaboration with WHO during the process of formulation of CCS.
5.3 WHO-wide strategic directions

WHO’s current (2002–2005) General Programme of Work lists the following four inter-related strategic directions to provide a broad framework for focusing WHO’s technical work.

- Strategic direction 1: reducing excess mortality, morbidity and disability, especially in the poor and marginalized populations.

- Strategic direction 2: promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.

- Strategic direction 3: developing health systems that equitably improve health outcomes, respond to people’s legitimate demands and are financially fair.

- Strategic direction 4: framing an enabling policy and creating an institutional environment for the health sector and promoting an effective health dimension to social, economic, environmental and developmental policy.

5.4 WHO global priorities

Based on the analysis of major challenges in international health, WHO has established a set of global priorities. The selected global priorities as stated in the General Programme of Work for 2002–2005 are as follows:

1. Malaria, tuberculosis and HIV/AIDS: these three major communicable diseases pose a serious threat to health and economic development and have a disproportionate impact on the lives of the poor.

2. Cancer, cardiovascular diseases and diabetes: there is a growing epidemic of these diseases in the poor and in transitional economies.

3. Tobacco: is a major killer in all societies and rapidly growing problem in developing countries.

4. Maternal health: the most marked difference in health outcomes between developed and developing countries show up in maternal mortality data and it is difficult to reduce maternal mortality without a well-functioning health system.

5. Food safety: poses a growing public health concern with potentially serious economic consequences.

6. Mental health: five of the ten leading causes of disability are mental health problems; major depression is the fifth contributor to the global burden of disease and may be second by 2020.

7. Safe blood: is both a potential source of infection and a major component of treatment, and crucial in the fight against hepatitis and HIV/AIDS.

8. Health systems: development of effective and sustainable health systems underpins all the other priorities; demand is substantial from Member States for support and advice on health sector reform.

9. Investing in change in WHO: is a prerequisite for WHO to become a more efficient and productive organization.
and one capable of response within an increasingly complex environment. The development of new skills, systems and process is central to the effective management of WHO’s core functions.

5.5 WHO regional priorities

The Eastern Mediterranean Region has the demographic profile of a developing region. It is a low-middle income region. Poverty and unemployment affect a large number of people. Communicable diseases are still prevalent in the least developed countries and tuberculosis, malaria and HIV/AIDS are major killers. A number of countries in the Region are in a state of conflict and emergency. Malnutrition is still a significant problem in some countries. Water scarcity is a region-wide challenge. Also, the lack of adequate safe water supply and proper sanitation are major health hindrances in the least developed countries, which constitute a large percentage of the population in the Region. Similarly, rapid urbanization and increase in car ownership have resulted in severe air pollution in major cities of the Region. Solid waste management, particularly of hazardous and medical wastes, is particularly weak in a significant number of countries of the Region.

An epidemiological shift is being witnessed in the Region. Currently, due to changes in lifestyles, noncommunicable diseases constitute 40% of the disease burden. It is projected that by 2020 the share of the burden for noncommunicable diseases will increase to 60%. This is creating a double burden of both communicable and noncommunicable diseases. Maternal mortality is still unacceptably high in some countries. The average maternal mortality ratio for the Region in 2001 was as high as 330 per 100 000 live births, while over 60% of infant deaths occur in the neonatal period in most countries. Foodborne diseases are also on the rise and represent a major public health challenge. The rapid change in lifestyles in many countries is having a clear impact in terms of stress and mental health-related conditions.

The health system, including governance, quality assurance, service delivery, health regulation, and medical technologies and medicine, needs major strengthening in almost all countries. Health financing is a major emerging issue in the Region. In lower income countries most health expenses are borne by people. The middle-income countries have a mix of private and public sector. In these countries, in some instances, there is a surplus of trained human resources, such as physicians. In high-income countries the major share of health expenditure is borne by governments. The health information system in almost all countries needs to be strengthened. The nursing picture is rather gloomy, both in terms of adequate numbers in poor countries and career structure.

In light of the above situation, the Regional Office has identified certain priority areas for its collaboration with Member States. These were spelled out in the programme budget for the period 2004–2005 which was endorsed by the Regional Committee for the Eastern Mediterranean at its Forty-ninth session held in October 2002 (EM/RC/49/R.2). The priorities include the following.
Health protection and promotion

- Promotion and development of healthy lifestyles through programmes such as the Tobacco Free Initiative, healthy communities, villages and cities, action-oriented school health activities, health of special groups and health education.

- Strengthening of national and regional initiatives to improve nutritional status through raising awareness of individuals and the community and control of micronutrient deficiencies.

- Integration of health promotion aspects with clinical approaches at all levels of the health care system, such as in the example of the regional initiatives to integrate at the primary health care level maternal, child and adolescent health, prevention and control of noncommunicable diseases and mental health activities.

- Promotion and strengthening of environmental health initiatives, particularly those relating to water safety and security, environmental health impact assessment, food safety and healthy environments for children and development of intersectoral activities in this respect.

Community development

- Addressing the underlying determinants of health and poverty as essential to ensuring sustainable development and sustained health improvements in the long term. Community-based initiatives such as basic development needs (BDN), healthy cities, healthy villages and women in health and development are among the priorities adopted by countries. In all these initiatives special emphasis is given to strengthening and enhancing the role of women as major stakeholders in achieving and sustaining the desired health and development goals.

- Efforts to facilitate achievement of the Millennium Development Goals, aiming to halve the number of people living in absolute poverty by the year 2015. This will include the development of various policies and plans such as Poverty Reduction Strategy Papers, to create supportive political, physical and economic conditions for all segments of the population to produce a positive impact on the overall quality of life. Concerted efforts are being made to make health systems better oriented to the needs of the poor by giving greater attention to promoting health throughout the life span, and reducing inequities in health status.

Disease control

- Improvement of epidemiological profiles using quantitative methods, such as burden of disease assessment and forecasting techniques. Efforts should be made to strengthen national and regional capabilities in epidemiology and national information systems through developing national and subnational registries for priority health problems. Efforts should also be made to benefit from epidemiological research studies in designing health policies and strategies. Priority diseases that are the main contributors to the disease burden and at the same
time are amenable to intervention strategies will be identified.

- An integrated approach in communicable disease control programmes through ensuring political commitment, integrating cross-cutting control activities, scaling-up disease-specific control activities, and developing synergy of managerial processes.

- Essential packages of services for prevention and control of priority diseases and indicators to monitor and evaluate these programmes will be developed.

- Integration of cross-cutting control activities will cover at least communicable disease surveillance, epidemic preparedness and response including developing early warning and surveillance systems, infection control and containment of antimicrobial resistance, integrated human resource development, health education and advocacy, and operational research.

- Scaling-up of disease-specific activities includes immunization programmes, tuberculosis control, malaria control, HIV/AIDS/STD prevention and control, elimination and eradication of specific diseases.

- Immunization programmes maintained and strengthened, with particular focus on countries that have lower immunization coverage and problems in certification of poliomyelitis eradication. The Regional Office will pursue its policy aimed at achieving self-sufficiency in vaccine production.

- Integrated management in control of noncommunicable diseases. Particularly attention will be paid to quality assurance programmes and to emerging needs, such as palliative care for cancer patients and health of the elderly.

Health systems and services development

- Promotion of a culture of strategic thinking in decision-making, using evidence-based policies and strategies, and development of important components of the stewardship function, such as regulation, public-private mix management, coordination, etc.

- Strengthening decentralization of health systems through capacity-building and technical expertise, and supporting district health systems through institutionalization of the district team problem-solving approach and development of sustainable management through national management effectiveness programmes.

- Improving quality in health service delivery through implementation of a programme of continuous quality improvement based on quality standards for individuals, departments and organizations against which performance will be measured.

- Support to accreditation initiatives, such as multidisciplinary assessments of health care functions, organizations and networks, as an important approach for improving the quality of health care structures.
Enhancing national information systems in order to provide necessary data on spending on health, particularly on private services, making use of household expenditure and utilization surveys and national health accounts analysis.

Testing of the WHO framework and tools for health system performance assessment and development of an observatory in the Regional Office to assess, manage and monitor health sector reforms.

Development and decentralization of laboratory activities, health imaging technology, blood safety and blood transfusion.

Strengthening of the essential drugs programme and ensuring use of essential drugs lists by most countries while promoting rational drug use and traditional medicine.

Improvement of coordination for human resources development and promotion of continuing education for health personnel at the various levels of the system. Efforts will focus on developing innovative approaches for human resources development, including community-oriented health personnel education.
Section 6

Strategic Agenda: Priorities Jointly Agreed for WHO Cooperation in and with Djibouti
6.1 Expectations of national partners

Parallel to the review of a large number of documents (Annex 1), including the national plan for health development (2002-2011) and the associated medium-term programming (2002-2006) as well as the Poverty Reduction Strategy Paper, developed by the Republic of Djibouti and defining the directions, priorities and goals of the country in the field of health, the members of the mission met the main partners in the country's health development: the Minister of Health and his close collaborators; the Minister of Agriculture, Animal Industry and Fisheries in charge of water resources; the Minister for Youth, Sport, Leisure and Tourism; the Minister for Housing, Town Planning and the Environment and Land Use Planning, in charge of sanitation; the Minister of Education; the Minister of the Economy, Finance and Planning, responsible for privatization; the Director of the Prime Minister's Cabinet, and the Director of the Cabinet of the Delegate Minister responsible for the promotion of women, family well-being and social affairs.

The following aspects emerged from these consultations between WHO and the national partners:

- The comprehensive approach of the Government of Djibouti to health development in the country is expressed most completely in the Poverty Reduction Strategy Paper.

- The existence, at all levels of the health system, of a well motivated staff who is adequate, both qualitatively and quantitatively, is considered by all as a prerequisite for the country's health development.

- WHO should take into account in its collaboration activities the main options taken by the Government such as the promotion of the role of women in development and decision-making.

- Whatever the value and usefulness of priority-setting for medium-term collaboration between WHO and the Government of Djibouti, the WHO Representative, as a technical adviser to the Minister of Health, should be prepared to provide the necessary support to the country, first to face emergency situations and, second, to achieve health for all, as defined in the Organization's charter, encompassing all aspects of well-being.

- WHO can play a useful role in facilitating intersectoral action, particularly in HIV/AIDS prevention and control; protecting the health of children and adolescents; combating substance dependence, including tobacco; promoting community-based initiatives, environmental health and sanitation, and school health.

- WHO can also play a major role in advocacy to increase the contribution of international partners in the health sector and facilitate its coordination;
A specific action by WHO is expected in the implementation of the Bamako Declaration; the fight against female genital mutilation; the management of health care waste; and the strengthening of health security and vigilance, including the exchange of health information with the countries that share borders with Djibouti, and are members of the WHO African Region.

6.2 Medium-term cooperation strategy

This cooperation strategy covers the period 2006-2011 and falls within the scope and timeframe of the National Strategic Plan 2002-2011. It reflects WHO’s vision of the priority actions likely to have an impact on the reform of the health sector and health development in Djibouti.

The key principles underlying the choice of priority areas for cooperation were, inter alia:

- the positioning of involvement in the health sector in the context of poverty reduction;
- the quest for tangible results in WHO’s action and their role as part of a consistent medium-term vision;
- the consideration of the involvement of other partners in the health development led by the government.

Maintaining a degree of flexibility to respond to new challenges and to address the country’s new needs should be taken into consideration.

The priority areas for cooperation have been identified based on the analysis of the situation summarized in the previous sections, and the application of a set of criteria. Five areas have been selected:

- Reform of the health sector and establishment of a primary health care system.
- Financing of the system, including international aid.
- Development of human resources, and capacity-building of personnel of health facilities.
- Implementation of a national policy for quality essential medicines and strengthening the rational use of medicines.
- Support for the development and implementation of priority national programmes and basic health services, including quality of care.

For each priority area of cooperation, the national objectives of the health sector reform to which WHO is expected to contribute have been identified, as well as the strategic approach to WHO involvement. The strategic approaches to cooperation define the parameters that will guide specific action, mobilization and use of WHO resources.

The role and responsibilities of WHO are defined according to the following classification:

- Direct support for the implementation of national programmes
- Support for the adoption of technical innovations, the adaptation of strategies, the development of guidelines, including with a view to initiating and speeding up large-scale implementation
Support for research and development, policy experimentation, evaluation of health system performance, anticipation of trends in health sector development

Information sharing on health policy options, guidelines and standards, and best practices advocacy

Provision of specific policy advice and high-level technical advice likely to influence the action of the government and development partners, including in a role of broker and arbitrator where necessary.

6.3 **Priority areas of cooperation**

6.3.1 Reform of the health sector and establishment of the primary health care system

**Government objectives**

- Provide the Ministry of Health with the structural and functional means to implement the orientations of the government health policy

- Restructure the health pyramid in order to set up integrated, coordinated and complementary health services addressing all the health needs of the population at each of the three levels of the health system

- Improve the quality of health care services

- Facilitate and strengthen the involvement of the community in the management of health facilities

**Strategic approach to cooperation**

- Contribute to the updating of the health map as a tool for setting up primary health care, monitoring and evaluating the application of the measures provided for in the health map

- Provide technical support for updating and implementing effectively the minimum package of activities and complementary package of activities

- Promote the evaluation of the performance of the national health system, advise the ministry on enhancing the performance of the national health information system and adjusting it to the needs of management and decision-making

- Provide technical support for the quality assurance of health services, the rational use of essential medicines based on recommended treatment protocols, the evaluation of the performance of health care providers, the promotion of quality assurance systems for health services and care

- Assist the government in defining approaches to promote the role of nongovernmental organizations and associations (especially of women) in the implementation of primary health care, and establishing mechanisms to involve the community in the management of health services as part of the basic development needs initiative
6.3.2 Financing the system, including international aid

Government objectives

- Improve the amount, allocation and management of public financial resources in line with the health policy objectives
- Redirect international aid towards priority health policy objectives

Strategic approach to cooperation

- Assist the government in defining an equitable system for financing services and care
- Advise the authorities on options and approaches for establishing mutual fund and health insurance mechanisms, and the financial participation of health care beneficiaries in care services
- Assist in developing tools for national health accounts and their analysis to support decentralized management of allocations and expenditure
- Assist the authorities in the quest to match health development assistance with national objectives, and in the analysis of strategic approaches and technical options being considered by the partners
- Create conditions for a coordinated action and stronger synergy among health development partners

6.3.3 Development of human resources, and capacity-building of personnel in health facilities

Government objectives

- Create the prerequisites for the implementation of a human resource development policy
- Improve the skills of qualified and unqualified nursing staff in all health facilities

Strategic approach to cooperation

- Assist the government in drafting a national policy for the development of human resources for health while considering new options such as institution of community health workers
- Assist the government in updating the national plan for the development of human resources for health
- Contribute to the revision of training curricula on the basis of a prior definition of the skills required for the implementation of primary health care
- Provide technical support for further developing the Health Personnel Training Centre and building up its capacity
- Provide technical support for studies and planning
- Contribute to continuing education of nursing and non-nursing staff and retaining of unqualified medical staff with a view to implementing effectively the minimum package of activities and managing health services
6.3.4 Implementation of a national policy for quality essential medicines and strengthening the rational use of medicines

Government objectives

- Implement a national policy for quality essential medicines
- Strengthen the rational use of generic essential medicines

Strategic approach to cooperation

- Support the updating of the national medicines policy document and facilitate consensus around this policy
- Assist in defining quality control procedures for medicines and establishing a medicines quality assurance system
- Advise the government on the updating of the list of essential medicines and materials, as required by the provisions of the health map, monitoring and evaluation of its application
- Advise the government with a view to generating awareness and promoting the rational use of essential medicines, and promoting generic medicines among consumers, prescribers and pharmacists

6.3.5 Support for the development and implementation of priority national programmes and basic health services

Government objectives

- Strengthen the integration and implementation of priority national health programmes in basic health services

Strategic approach to cooperation

Basic development needs (BDN)

- Extend the BDN programme to new sites while maintaining:
  - support to the community in all programme stages and community capacity-building especially in project management;
  - balance between economic and social projects.
- Strengthen programme organization and improve its performance
- Develop promotional and management tools
- Improve the contribution of national health programmes and intersectoral collaboration; establish a national intersectoral committee
- Develop joint programmes with the different United Nations agencies and other partners to reinforce the partnership in the existing BDN sites and extend it to other sites

Surveillance and control of epidemics

- Assist the Ministry of Health in making the epidemiological surveillance and epidemic early warning unit operational
and strengthen the central and district capacity to contribute to the surveillance system

- Strengthen the early warning system through an effective and active involvement of the community, the establishment of sentinel sites and capacity-building of the laboratories in the diagnosis of diseases

- Provide early and complete information on communicable diseases with high epidemic potential

- Prevent epidemics by strengthening national control programmes and ensuring adequate and timely response to epidemic outbreaks

- Support the introduction of a programme for the prevention and control of zoonoses

- Collaborate at the sub-regional level to prevent epidemics.

Mother and child health

- Promote and technically support the analysis of risk factors for maternal mortality, and the update of strategies, approaches and technical guidelines

- Provide support for the evaluation of care during pregnancy and childbirth provided by basic health services

- Promote an intersectoral approach to combat genital mutilations, and contribute to raise awareness of decision-makers and the population on the risks

- Advise on the strategy to extend IMCI to the whole country, the adaptation of protocols, training of personnel and community mobilization

Expanded Programme on Immunization

- Participate in the implementation, micro-planning and evaluation of the national EPI programme

- Support the strengthening of routine immunization coverage

- Support the efforts for poliomyelitis eradication and measles and tetanus elimination

- Promote the introduction of new vaccines

- Promote the involvement of the community, and information and communication that are essential for achieving the programme objectives

- Assist in maintaining ongoing partner commitment (technical and financial support) through coordination and advocacy.

Information, education and communication (IEC)

- Provide support for the analysis of studies conducted within the framework of different programmes to identify IEC priorities

- Assist the ministry in the publicization of instruments targeting behavioural change in high-risk groups

- Support the introduction of interfaces responsible for social mobilization for health

- Support the establishment of intersectoral committees

- Strengthen IEC capabilities
School health

- Assist in defining the essential school health services and how they can be articulated with the basic health system
- Facilitate the implementation of the joint action plan with coordination between the ministries of health and education
- Promote South-South cooperation
- Train managers and trainers

Tobacco and substance dependence

- Advise the government with a view to ratifying the international convention on tobacco control, and provide support for the application of its articles

Mental health

- Continue advocacy with the authorities to address mental health in the national policy and include it in basic health care, and with partners for concerted support
- Assist the authorities in the field of surveillance, health care provision, and capacity building of professionals and communities in mental health
- Provide technical advice with a view to developing health care standards and guidelines for the management of major mental illnesses
- Support the participation of the civil society in the development (promotion?) of mental health

Noncommunicable diseases

- Support the development of a national noncommunicable disease control programme

Sight and blindness

- Prioritize advocacy for the integration of prevention and care in primary health care and in school health care
- Facilitate international cooperation with Djibouti in this area

AIDS and sexually transmitted infections

- Participate in strengthening treatment and care of persons living with HIV/AIDS as part of the 3 by 5 initiative
- Contribute to updating strategies and protocols for the reduction of HIV mother-child transmission
- Strengthen the management of curable sexually transmitted infections, including in peripheral health facilities
- Strengthen epidemiological surveillance and set up sentinel sites.

Tuberculosis

- Continue to support planning, programme management, monitoring and evaluation of the national tuberculosis control programme (DOTS) as part of basic care
- Assist the authorities in improving coverage and quality of tuberculosis control services and strengthen the capacities of personnel as well as community involvement
- Advise the authorities on the integration of HIV/AIDS and tuberculosis control
- Assist in the mobilization of financial resources
Malaria

- Continue advocacy and support for the process to develop the multisectoral strategy on integrated vector control.
- Create opportunities and support the proposals submitted by Djibouti to the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Environment Facility.
- Provide support for strategic planning, training, supervision, monitoring and evaluation.
- Provide support for the studies needed to update case management and vector control guides.
- Provide support for strengthening Djibouti's role and participation in the HANMAT network (Horn of Africa Network for Monitoring Antimalarial Treatment).

Environment and health

- Contribute to updating policies, standards and guides as well as train personnel and mobilize resources to promote hygiene and the environment (particularly with regard to the evaluation of health hazards, water surveillance and quality control, safe reuse of wastewater, food quality control and management of health care waste).
- Facilitate the intersectoral coordination that is essential for ensuring the synergy of action between different partners.
- Promote healthy cities/healthy villages.
- Support training of health inspectors.

Nutrition

- Facilitate assessments of the situation and establishment of national nutritional surveillance with a view to improving the health system response in terms of prevention and management of malnutrition.
- Contribute to the development of a national strategy with emphasis on vulnerable groups, and its implementation integrated into primary health care and health education.
- Provide technical support to the development of practical guides for training health personnel.
- Support partnership and a national multisectoral approach for nutrition and food security.

Emergencies

- Assistance in the development and implementation of a plan of action for health emergency preparedness.
Implementing the Strategic Agenda: Implications for WHO Secretariat, Follow-up and Next Steps at Each Level
Despite the recent improvements made to the health system in Djibouti through the health reform project and the redynamized bilateral financial aid, major weaknesses subsist, notably in planning, monitoring and evaluation, while there is a shortage of qualified human resources at all levels of the system, particularly in health management and public health. This has implications for the way in which WHO operates and its role in Djibouti, in view of the demand that is greater than elsewhere for technical support and closer monitoring of national activities.

### 7.1 Implications for the country office

Special importance should be attached as soon as possible to the restructuring of the Representative’s office in terms of reinforcing the permanent technical framework. This is because it is difficult to respond efficiently at the same time to the needs of the Ministry of Health, to the health challenge in an already difficult general context, and to the need to assist and strengthen international partnership and mobilize funds, without recruiting a public health physician, an international WHO staff member, to permanently support the representative.

Likewise, a successful CCS implementation process is still dependent on the capacity of the WHO Representative’s Office to strengthen its cooperation with international partners in order to mobilize extrabudgetary funds. There is a need for a sustained information and communication effort on the role of WHO and its achievements, and the comparative advantages of WHO in terms of expertise and its contribution to achieving the Millennium Development Goals. Information, communication and health education also have essential contributions to make to the successful implementation of the programmes proposed within the framework of this strategy. It is therefore necessary to reinforce the WHO office by appointing a professional in health education and communication, at least as a first step.

Moreover, the implementation of the CCS requires the development of a critical mass of technical personnel to be assigned to the office to support specifically national programmes. Sustained reinforcement is required in the first phase in the following areas:

- Development of the health system to support the implementation of health system reform strategies concerning financing, the health information system and basic health care.
- Mother and child health.
- Epidemiology, and prevention and control of communicable diseases.

Provision should be made to reinforce the administration and general staff to ensure more efficient operations at the WHO office and proper work organization. In the very specific operational context in Djibouti, the staff is called upon for frequent field supervision work and is directly involved in the implementation of national activities.
Requirements for logistics and transport should be met.

7.2 Involvement of the Regional Office and headquarters

The fact that the Regional Office and headquarters mainly use the English language causes a serious problem for communication and dissemination of WHO messages and strategic and technical documents. During this strategy implementation period, there is therefore a need to find an effective means of communication in a language that is appropriate for Djibouti, notably French. This means that the Regional Office and headquarters should make every effort to communicate official correspondence and technical documents and reports to the Office of the WHO Representative in French.
Annex 1

Other documents consulted

Stratégie de mobilisation sociale intégrée en matière de santé, Ministry of Health, October 2004

“Priorité Santé” No 2, Newsletter - Ministry of Health, September 2004

Mission d’appui a la mise en œuvre du DCRP Djibouti, Rapport d’un consultant, projet, DJI/003/001-UNDP/DAES-NU, June 2004

Protracted Relief and Recovery Operation (PRRO), World Food Program, Djibouti, June 2004


Santé et environnement – Coordination des interventions en milieu rural à Djibouti, Ministry for Habitat, Town Planning, the Environment and Territorial Development and the Ministry of Health, April 2004


Plan d’action 2004 sur la Stratégie PCIME (Prise en charge intégrée des maladies de l’enfance), Ministry of Health, Djibouti

“Résumé des interventions des partenaires dans le secteur santé en République de Djibouti”, January 2004

World Report on Human Development, UNDP 2004


UNICEF Action Plan 2004, un-dated

Cadre stratégique de lutte contre la pauvreté (synthèse), Republic of Djibouti, December 2003

“Enquête Djiboutienne sur la Health de la Famille PAPFAM”, May 2003

“Enquête Djiboutienne auprès des Ménages- Indicateurs Sociaux 2002-EDAM-IS2- Draft December 2002


Stratégie Nationale d'Intégration de la Femme dans le Développement- SNIFD-UNDP- Ministre délégué auprès du Premier Ministre, charge de la promotion de la Femme, du Bien Être Familial et des Affaires Sociales, November 2002


Code de la Famille, Loi No 152/AN/02/4eme L – Promulgated on 31 January 2002

Plan national de développement sanitaire, 2002-2011, Ministry of Health, December 2001
Plan national de développement sanitaire - Programmation à moyen terme, 2002-2006, Ministry of Health, December 2001
Politique et organisation du système de santé, Ministry of Health, December 2001
Propositions pour la reforme du système de santé, Ministry of Health, December 2001
Rapport sur les objectifs de développement pour le millénaire à Djibouti, Ministry of Foreign Affairs, December 2001
Plan d'action national pour l'Environnement 2001-2010 – Territorial Development and Environment Department, Ministry for Habitat, Town Planning, the Environment and Territorial Development, December 2001
CREDES- Analyse du secteur de la santé - August 2001
Schéma directeur et Plan d'action 2001-2005 - Table Ronde Sectorielle sur l'Education des partenaires techniques et financiers, Djibouti, October 2000
Centre de Recherche d'Information et de Production de l'Education Nationale (CRIPEN) – Department for Teaching Methods – Ministry for National and Higher Education, un-dated
Statement of Work USAID/Djibouti- Special objective: Expanded Coverage of Essential Health Services (un-dated)
Annex 2
Methodology used to select priority lines of country cooperation or CCS between WHO and the government of Djibouti

To define the priority lines of the Country Cooperation Strategy between WHO and the Government of Djibouti, as described in Section 6 of this document, the mission took as its starting point the objectives and strategic directions set in the National Health Development Plan, 2002-2011, finalized by the Ministry of Health in December 2001.

The members of the mission thus considered each of the goals selected in the plan and used the following approach to determine the possible contribution of WHO to its implementation taking into account the criteria proposed for the selection of strategic directions for WHO involvement, namely:

1. The relevance of the choice of area with regard to the country's needs/challenges.
2. Relevance to WHO priorities.
3. Feasibility of the intervention.
4. Effect of the intervention on the improvement of the health status of the populations, especially the poorest.
5. Actual and potential advantage/capacity of WHO to support the area of intervention (organizational capacity, availability and capacity of human resources, availability of financial resources)
6. Existence of opportunities for new or strengthened partnership within the framework of resource mobilization.

At the first stage, each team member noted each of the objectives listed in the national health development plan (PNDS) and graded them from 1 to 5 by ascending level of priority. The grades given by the team members were then consolidated as a final grade, also in the range 1 to 5, allocated on a consensual basis taking into account:

- The experience of WHO office in Djibouti and the Ministry of Health.
- The expectations of national partners.
- The documents consulted by the mission, with particular attention being paid to the Poverty Reduction Strategy Paper.

The goals to which the members of the mission assigned a grade of 3 or more were selected for the definition of cooperation activities between WHO and the Government of Djibouti.

Subsequently, the strategic directions/areas listed under each selected goal were examined in the same perspective. When deemed necessary, strategic directions were grouped together in such a way as to ensure the consistency of a possible activity.

Finally, the actions proposed for cooperation between WHO and the government of Djibouti were formulated with a view to indicating the type of action required and the functions involved, using the coding defined in the CCS (cf. end of section 6.2).
Annex 3

Participants of CCS mission to Djibouti

Jihane Tawila, WHO Representative, Djibouti

Dr Khanh Nguyen
Planning Officer, Planning, Resource Coordination and Performance monitoring, WHO, headquarters

Dr Hussein Abouzaid, Coordinator Healthy Environment Programme, Regional Office for the Eastern Mediterranean

Dr Nabil Kronfol, Short Term Consultant, Djibouti

Dr Saleh Banoita Tourab, National Consultant

Mr. Abdourahman Aboubaker, National Consultant