

**UNFPA**  
**COUNTRY PROGRAMME**  
**2003-2007**  
**REPUBLIC OF DJIBOUTI**

**Second CYCLE of UNFPA Assistance**

**Country Category: A**

**Date of start and Duration: January 2003 till December 2007 (5 years)**

**Total amount of programme: US\$ 3.25 Million**

**Proposed amount of UNFPA Assistance: US\$ 2.25 Million**

**Amount to be sought from other sources: US\$ 1.0 Million**

## CP 2002-2006 DJIBOUTI

(revised, Sept 2002)

### Part I. Situation analysis

According to current estimates and in the absence of any valid census, the population of Djibouti is around 600,000. It was 520,000 in 1991 (demographic survey) and the growth rate is 3% per year, due to a combination of natural growth and immigration. This high growth affects very seriously the environment, the scarce natural resources and the distribution of social services, incl. health and education.

Overall, the population is **young**, with over 50% aged less than 18 years, and **urban** (83% in 2001), with a rapidly growing rate of urbanisation due to internal and external migration. Djibouti-ville alone gathers 65% of the total country population, and the local conditions favour growing precarity, unemployment, environmental degradation, social unrest, violence, and trafficking of all sorts.

The country is still at an early stage of demographic transition, with a CBR of 47 and a CDR of 17 per thousand. TFR is estimated at 5.8 children per women. Infant, under-5, and maternal mortality rates were estimated in the early 90's at 114, 165 and 7.4 per 1000 LB respectively, while life expectancy at birth was 49 for men and 51 for women. The current rates will be known when the the 2002 PAFAM survey will be published in 2003

Officially there are 10,000 refugees living in 2 UNHCR-operated camps (with NGO providing RH services), but the number of temporarily displaced people may be 4 times higher, according to fluctuations linked to drought and political events in neighbouring countries.

UNAIDS has estimated a sero-prevalence rate for HIV of 11% among the 15-49yr population, placing Djibouti among the 12 most affected countries in Africa, a situation that was only recently recognised and talked about by the highest authorities. The UN Population Division has further

calculated a reduction of life expectancy at birth down to 38 years in 2010 in the absence of serious measures to curb the extension of the epidemy.

Due to the extreme political sensitivity created by the cohabitation of distinct ethnic communities in the Republic, there was no explicit population policy addressing the negative effect of population growth on resources, on environment and on poverty. However, the government has published a series of national strategies and action plans regarding family planning, safe motherhood, reduction of female genital mutilations (FGM), STIs and AIDS, integration of women in development, family code, environmental protection, poverty reduction, education for all, and health reform. Good governance is affected by structural and institutional factors such as inadequate staffing, poor capacity and competence, donor driven planning, general weakness in data collection and data analysis, and short-term planning.

In terms of contraception, the number of users raised from 1000 in 1997-1999 to 4500 in 2001 with a contraceptive prevalence rate of 4%, steadily growing by about 1% per year (with a method mix in favour of injections 47%, oral pill 43% and IUD 11%). Very few unmarried women use contraceptives procured from the public sector, and private outlets are rare.

Only 56% of all births (26,000 per year) take place in medically assisted facilities, while 95% of all cesarean sections (2.5% of all births) are performed in one single reference hospital.

A survey made in 1990 revealed that 97% of all women had been subjected to FGM while the Penal Code has explicitly forbidden the practice in Article 333. It is only in 2001 that the first public trial condemning the author of FGM has been publicised. The prevalence of FGM needs to be measured for there are indications

that it is less practised, particularly among educated families.

Sex differentials are still wide in education, literacy and school attendance. There are very few women in positions of power (only 1 minister, of women's affairs) or influence (no MP, no directors in Ministries, only the Chair of the Supreme Court and a few lawyers). Djibouti has ratified the CEDAW without reservation but the recently approved revision of Family Code has maintained the great majority of the traditional elements of the shari'a, with the exception of the age at first marriage for girls, set up at 18 years. It seems that religious prescriptions tend to take over traditional cultural practices regarding the place and the role of women. Men in their great majority continue to consider that the role of women is to contribute to economic income and not necessarily to remain at home, and that educating girls is not a priority when compared to the needs of homework. However, they continue to promote conservative attitudes vis-a-vis marriage, divorce, FGM, etc. A recent survey shows that fathers favour more than their wives the practice of FGM for their daughters.

The civil society has only recently started to develop but still needs to improve the NGO capacity for formulating, funding, and executing projects. There are about 20 registered effective development NGOs, but virtually no co-ordination mechanism.

Drought, poverty and the frequent conflicts in the region encourage urban migration, with growing violence and the emergence of street children, of both sexes, particularly vulnerable.

Also due to poverty and to the presence of many soldiers, dockers, and truck drivers (on the highway Djibouti-Addis Abeba), the number of sexual workers is increasing, while their awareness of risks related to unprotected sex does not improve.

Abortion is prohibited by law, however lots of women, and particularly adolescents, abort in unsafe conditions. RH

of adolescents has been long neglected, with no specific services directed at them.

## **Part II. Past cooperation and lessons learned**

The first full fledged country programme (CP) of UNFPA assistance to Djibouti, initially designed to cover 1997 to 2000, has been extended by 2 years till the end of 2002, with supplementary funding, in order to synchronise with the CPs of UNDP and UNICEF. The total budget for 6 years amounted to US\$ 3.2 million, all from UNFPA resources.

The overall goal of the first CP was to **build national capacity** in terms of RH programme management and service delivery (integration of all its components according to the ICPD Plan of Action) and PDS. A population census was initially planned to serve as a base for policy setting. Two years after the start of the census preparation, it became evident that the Government had mobilised neither the national resources nor the international commitment to be able to conduct a population census, and the project was interrupted and postponed to a later date. The funds were redirected to safe motherhood and to a more modest support to national statistical institutions in order to rebuild their capacity, secure a sampling frame and set the ground for a PAPFAM survey. The survey is scheduled end 2002.

The overall implementation rate after 6 years will be over 80%, due to the good performance of the three RH projects technically assisted by the co-executing agency Free University of Brussels (ULB).

The main measurable results of the first CP have been: 1/ establishment of national capacity to set up and manage the 4 national programmes concerned with RH ("Equilibre Familial", Safe Motherhood, STI/Aids, and FGM); 2/ initiation of a sustainable growth of FP users, with a CPR growing from less than 1% to 5% of married women of reproductive age; 3/ successful testing of national execution,

first by M. of Education (Poped), then by M. of Health.

### **Part III. Proposed programme**

The proposed five-year (2003-2007) programme is a response to two of unanimously recognised priorities of the Republic of Djibouti: 1/ increasing utilisation of quality RH services, including FP and sexual health, particularly among adolescents and youth; and 2/ upgrading the national capacity to integrate gender approaches in policies, based on improved analysis of quality population data. Therefore it is proposed to have two inter-linked outcomes, with Gender completely integrated in both. The **goal** will be to contribute to the improvement of reproductive and sexual health among all couples and individuals, including adolescents, and to the creation of a favourable environment for the promotion of women status and gender equality.

The two above-stated priorities, clearly present in both the Country Population Assessment and in the UN-Common Country Assessment finalised in February 2002 and reiterated by the Government of Djibouti in their National Development Plan, will be the contribution of UNFPA to the national objectives stated in the UNDAF document, i.e. **poverty alleviation** (which includes equitable access to basic health services) and promotion of **good governance** in the respect of rights (which includes reproductive rights and gender equity). UNDAF, which has been endorsed by the government, is expected to be published by September 2002.

The overall strategies, in view of the specific constraints affecting development in Djibouti, will be 1/ capacity building, 2/ outreach, and 3/ support to partnership

UNFPA is well suited in Djibouti to tackle these areas of assistance, because of its past experience with the Ministry of Health and Ministry of Education in the one hand,

and the national statistical institution and the Ministry of Women's Affairs on the other hand (see part II above), as well as with several institutions of the civil society

UNFPA plays a leading role among UN and non UN donors in the co-ordination of efforts concerning RH (all aspects), integration of women in development, gender and development, and population analysis. The other main donors in RH are UNICEF, UNDP, the World Bank, WHO, the African Development Bank, France, Japan, and the Islamic Development Bank.

**For Reproductive Health**, the outcome is "increased utilisation of integrated RH services, including family planning and sexual health", with a focus on four priority areas: FP, Emergency Obstetrical Care (EmOC), FGM, and STI/AIDS. Three outputs are envisaged: 1/ improved availability of integrated RH services; 2/ improved quality of services, including those for adolescents; and 3/ IEC to ensure that all women, men, adolescents and youth are properly informed about the risks of unplanned pregnancies and unprotected sex, as well as the availability of RH services.

Technically and programmatically, the proposed strategy of outreach will be to distribute IEC services and FP outlets as close as possible to the population in villages, city quarters, schools, associations and youth clubs, while quality services (for obstetric care in particular) will be focused upon in reference hospitals with complete EmOC package. Special attention will be given to the referral of obstetrical complications, specially for cesarean section and blood transfusion. The national capacity for setting up, operating and utilising a health information system will be given special attention.

This programme will be assisting, through capacity building, the Directorate of Primary Health Care of the MoH, which will be responsible for policy setting, regulation and standardisation, posting of appropriate physical and human resources,

and collection of data for the health information system.

The third output, IEC and awareness creation, with particular attention to youth and adolescents, will need a co-ordinated partnership between MoH and other institutions involved (Ministry of Youth, Ministry of Education, Ministry of Women's Affairs, NGOs, communities).

**For Population and Development**, it is proposed to focus on two directions: gender mainstreaming and capacity building for population data analysis.

The outcome is to contribute to the sound utilisation of population data (quantitative and qualitative) by decision makers, leaders, and the civil society, in order to influence development policies in the direction of individual rights, reproductive rights, basic social needs, gender equality and equity.

Among other outputs, there will be: 1/ the mainstreaming of the fight to eliminate violence against women, 2/ the eradication of FGM, and 3/ technical assistance for national surveys and for the forthcoming population census (possibly to take place in 2005, when government is ready).

This part of the programme will be implemented in partnership with the Ministry of Women's Affairs, the Ministry of Finance and Planning, the Ministry of Interior and institutions of the civil society.

**Technical assistance, with a focus on capacity building**, will be provided by the regional CST, particularly for Gender mainstreaming and P&D strategies, while ad-hoc contracts will be established, with specified terms of reference, with external institutions offering reproductive health expertise, such as universities or regional centres of excellence.

#### **Part IV. Programme management, monitoring and evaluation**

The proposed programme will be managed by the Djibouti Country Office which is currently composed of a NPO, a Fin/

Admin Assistant and a secretary, supervised by a non resident Country Director. In view of the overall volume and scope this 5-year programme, serious strengthening of this team will be required. Based on the positive experience and lessons learnt in the first CP, where national execution has been introduced on a trial basis and successfully evaluated, the proportion of national execution will be increased, with all attached controls and procedures (Letters of Understanding, annual audits, etc.).

The last year of the first CP was sanctioned by an external audit which helped the CO to review and improve internal controls, now in place.

The overall budget proposed is US\$ 3.25 million over 5 years (see table). External additional resources will be actively searched and mobilised from donors interested in RH, multilateral donors (WB and African Development Bank, League of Arab States) as well as from bilateral donors (France, Japan, Italy), and also private foundations (AGFUND and others).

<b>Resources</b>	<b>Regular</b>	<b>Other</b>	<b>Total</b>
RH	1.5	1.0	2.5
P&D	0.5	-	0.5
Support	0.25	-	0.25
<b>Total</b>	<b>2.25</b>	<b>1.0</b>	<b>3.25</b>

The main executing partners will be MoH, National Statistical Institute and M. of Women's Affairs. The support project (« umbrella ») will be used for monitoring the country programme, provide technical assistance, fund advocacy activities, and support some NGO-initiated activities.

In order to ensure the proper management of the programme in a RBM perspective, national project personnel will be recruited, particularly for technical coordination and information systems.

Each project will be subjected to an annual planning meeting, an annual review, while a mid-term review will be organised in 2005 to evaluate the suitability and adequation of results with objectives.

## DJIBOUTI COUNTRY PROGRAMME 2003-2007 - ANNEX : RESULTS AND RESSOURCE FRAMEWORK

<b>UNDAF Objective C : Promotion of sustainable health and reduction of HIV/AIDS and other transmissible diseases</b>				
<p><b>UNFPA Goal 1 :</b> To contribute to overall <b>improvement</b> of Reproductive Health including Family Planning and Sexual Health</p>	<p><b>UNFPA outcome (Purpose) :</b> increased <b>utilisation</b> of quality RH services including FP and SH by the underserved</p>	<p><b>Indicators of outcome (purpose) :</b></p> <ul style="list-style-type: none"> <li>- Increase of 3 points per year of prenatal coverage (rate as of December 2001 =44%)</li> <li>- Increase of 3 points per year of obstetrical coverage (rate as of December 2001 =43%)</li> <li>- Increase of 3 points per year of postnatal coverage (rate as of December 2001 =4%)</li> <li>- Increase of 1 point per year of contraceptive prevalence rate (rate as of December 2001 =5%)</li> </ul>	<p><b>Outputs and indicators :</b></p> <p><b>1. Availability</b></p> <ul style="list-style-type: none"> <li>- Increased number of SDP offering ANC , Obstetrical care, PNC, FP, STI treatment, counselling,</li> <li>- Increased percentage of SDP offering at least 3 of above</li> <li>- Created integrated service-counselling centres for adolescents</li> <li>- Created 2 centres offering complete EmOC outside Djibouti-ville</li> <li>- Increased number of technical supports standards, decision trees, partograms, HIS documents</li> </ul> <p><b>2. Quality</b></p> <ul style="list-style-type: none"> <li>- Improved technical service quality by application of standards, algorithms, partograms,</li> <li>- Improved managerial quality by proper use of HIS documents and contraceptive logistics</li> </ul> <p><b>3. IEC</b></p> <p>Implemented community mobilisation, media information, decision makers advocacy, in-school and out-of-school IEC for youth, particularly for Sexual and reproductive health &amp; HIV/Aids</p>	<p><b>Resources for Output:</b> UNFPA : 1.5 millions</p> <p>Govt ~ 1 million</p> <p>Other donors :</p> <ul style="list-style-type: none"> <li>- UNICEF</li> <li>- WHO</li> <li>- France (HIS, HIV/AIDS)</li> <li>- World Bank</li> </ul>

<p><b>UNFPA Goal 2 :</b></p> <p>Contribute to the goals of national Aids programme and regional activities to curb the expansion of Aids epidemic</p>	<p><b>UNFPA outcome (Purpose) :</b></p> <p>Improved and expanded preventive and advocacy activities for social and political mobilisation</p>	<p><b>Indicators of outcome (purpose) :</b></p> <ul style="list-style-type: none"> <li>- HIV incidence in adults (and/or among pregnant women) decreased</li> <li>- number of institutions (gov and civil society) participating in HIV/aids programme increased.</li> </ul>	<p><b>Outputs and indicators :</b></p> <ul style="list-style-type: none"> <li>- number of IEC materials and prevention activities developed, particularly for youth.</li> <li>-number of condoms distributed</li> <li>-number of providers trained in STI T.</li> <li>- number of seropositive mothers detected and counselled for preventing mother-to-child transmission</li> </ul>	<p><b>Resources :</b></p> <p>UNFPA : 0.2 M Government : 1M</p> <p>Others : WB, UNDP, UNICEF, Global Fund,</p>
<p><b>UNDAF Objective B : GOOD GOVERNANCE AND PROMOTION OF HUMAN RIGHTS (including reproductive rights and gender equity)</b></p>				
<p><b>UNFPA Goal 3:</b></p> <p>To contribute to create an environment favourable to achieve gender equality and women empowerment</p>	<p><b>UNFPA outcome (Purpose) :</b></p> <p>Integrated gender approach in the analysis and monitoring of population issues</p>	<p><b>Indicators of outcome (purpose) :</b></p> <ul style="list-style-type: none"> <li>- life expectancy at birth by sex (increased in both)</li> <li>- number of women in decision making positions (increased by 20 %)</li> <li>- number of women victims of violence (decreased to none)</li> <li>- schooling rates for girls (increased to 90%)</li> <li>- literacy rates for women (increased but currently unknown with precision)</li> </ul>	<p><b>Outputs and indicators :</b></p> <p><b>1. Population analysis and monitoring</b></p> <ul style="list-style-type: none"> <li>- Developed advocacy for the formulation of population policies</li> <li>- Contributed to resource mobilisation for for pop. Census</li> <li>- Strengthened capacity of national statistical institutions for data analysis and follow-up of international conferences</li> </ul> <p><b>2. Gender sensitive data bases</b></p> <ul style="list-style-type: none"> <li>- Ensured availability of sex-disaggregated population data</li> <li>- Integrated gender approach as planning tool and strengthened national capacity for integrating gender in population programmes</li> </ul>	<p><b>Resources :</b></p> <p>UNFPA : 0.5 million</p> <p>Govt ~ 1,5 millions (for a census)</p> <p>Other donors :</p> <ul style="list-style-type: none"> <li>- UNDP</li> <li>- Bilaterals</li> <li>- Multilaterals/WB</li> </ul>