REPRODUCTIVE HEALTH at a GLANCE

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DJIBOUTI

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Country Context

A real GDP increase from 4.8 percent in 2006 to 5.9 percent in 2008 has contributed to Djibouti's progress towards its MDG health and education goals including nearly universal coverage for one-year-old immunizations against major diseases.[1] Despite these improvements, nearly a fifth of the population still subsists on less than US $1.25 per day.[2]

Djibouti's large share of youth population (37 percent of the country population is younger than 15 years old[2]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. This is especially important in a context of decelerated growth rate arising from the global recession.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[3] In Djibouti, the literacy rate among females ages 15 and above is 64 percent.[2] Fewer girls are enrolled in secondary schools compared to boys with a 70 percent ratio of female to male secondary enrollment.[2] 63 percent of adult women participate in the labor force[2] that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Djibouti ranks 129 of 157 countries in the Gender-related Development Index.[4]

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[3]

Djibouti: MDG 5 Status

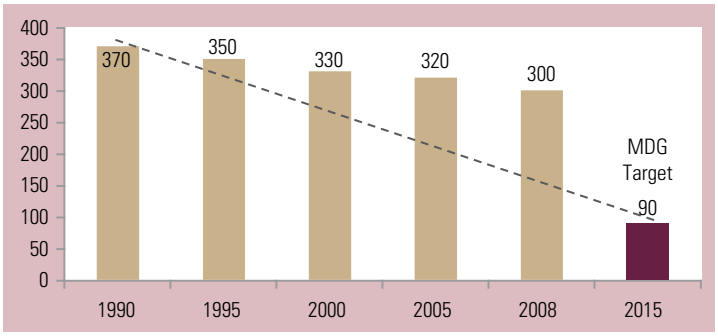
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	300
Births attended by skilled health personnel (percent)	93
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	17.8
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	22.5
Antenatal care with health personnel (percent)	92.3v
Unmet need for family planning (percent)	22

Source: Compiled from multiple sources.
[a] No DHS estimate available.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Djibouti has made insufficient progress over the past two decades on maternal health and is not yet on track to achieve its 2015 targets.[5]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Djibouti

The Bank's current ***Country Assistance Strategy*** is for fiscal years 2009 to 2012.

Current Project:
P107395 DJ-Improving Health Sector Performance ($7m)

Pipeline Project: None

Previous Health Projects:
P071062 DJ-Health Sector Development Project
P073603 DJ-HIV/AIDS, Malaria and TB Control

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Key Challenges

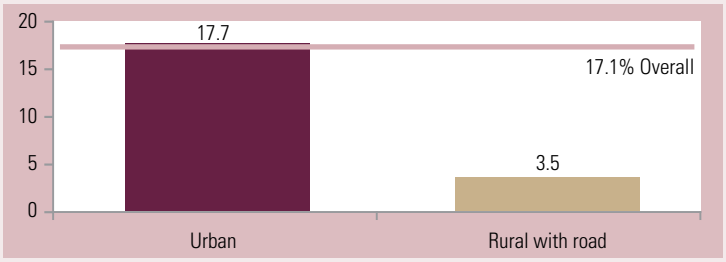
Moderate fertility

Total fertility rate (TFR) fell from an estimated 6.1 births per woman in 1990 to 2.9 births per woman in 2008.[2] Data on TFR among women in the different socio-economic groups are not available.

Adolescent fertility rate is moderate (23 reported births per 1,000 women aged 15-19 years) affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[3, 6] About 10% of young women are married before they reach 18 years old.

Use of modern contraception is increasing. Current use of contraception among married women rose from 12 percent in 2002 to 18 percent in 2006.[7] More married women use modern contraceptive methods than traditional methods (17.1 percent and 0.7 percent). The pill is the most commonly used method (14 percent), followed by injectables (3 percent). Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: modern contraceptive use is 18 percent among urban women and 4 percent among rural women (Figure 2).[7] Similarly, 12 percent of women with no education use modern contraception as compared to 33 percent of women with secondary education or higher.

Figure 2 ▪ Use of contraceptives among married women by residence



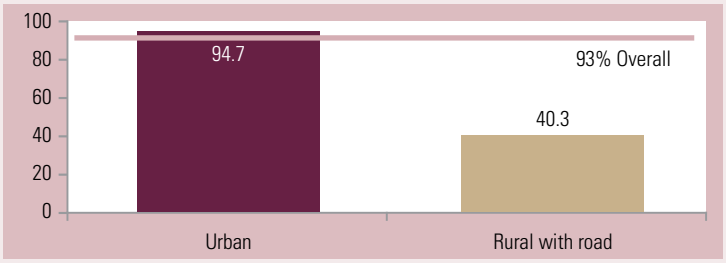
Source: MICS3 Final Report, Djibouti 2006.

Unmet need for contraception is high at 22 percent[7] indicating that women may not be achieving their desired family size.[8]

Poor Pregnancy Outcomes

Majority of pregnant women use skilled birth attendants but access in rural areas is low. Over nine-tenths of pregnant women receive antenatal care from health personnel (doctor, nurse, midwife, or auxiliary midwife).[7] A similar proportion of pregnant women deliver with the assistance of health personnel but only 40 percent of pregnant women in rural areas seek such assistance (Figure 3). The latter is even less at 31 percent for deliveries with skilled birth attendants (doctor, nurse, or midwife). Further, 56 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[9]

Figure 3 ▪ Birth assisted by health personnel (percentage) by residence



Source: MICS3 Final Report, Djibouti 2006.

Human resources for maternal health are limited with only 0.18 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.568 per 1,000 population.[2]

The moderately high maternal mortality ratio at 300 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[5]

STIs/HIV/AIDS is a growing public health concern

HIV prevalence is high at 3.1 percent. Several factors contribute to the likelihood of increased HIV prevalence in Djibouti, including its location as a trade corridor with Ethiopia, the presence of military bases, and high prevalence of sex trafficking as well as drug use.[10] Further only 26 percent of females aged 15–24 years reported use of condoms at the prior high-risk sexual intercourse.[11]

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While about 50% young women are aware that using a condom in every intercourse prevents HIV, only 6 percent of married women in this age group report using condom.

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Increase access to modern contraceptives for rural women and emphasize community-based distribution. Employ alternative methods to deliver fertility reduction messages including through peer education and women's groups.
- Assist in improving the quality of family planning services especially those tendered to the poor and women in rural areas.
- Promote the use of ALL modern contraceptive methods, including longterm methods, through proper counseling which may entail training/re-training health care personnel.

Reducing maternal mortality and morbidity

- Target women in rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).
- Address the inadequate human resources for health by training more midwives and deploying them to the rural areas.
- Improve the content of antenatal care (with particular attention to the high prevalence of anemia).

Reducing STIs/HIV/AIDS

- Avail HIV testing and counseling as part of the antenatal package. Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Focus HIV/AIDS providing information, education and communication efforts on adolescents, youth, married women, and other high risk groups including IDUs, sex workers and their clients, and migrant workers.

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12. World Bank Reproductive Health Action Plan 2010–2015 (RHAP). www.worldbank.org/population.

Development Partners Support for Reproductive Health in Djibouti

WHO: Rapid reduction of infant and maternal mortality

UNFPA: Reproductive health and rights

UNICEF: HIV/AIDS; FGM

USAID: HIV; child vaccination

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DJIBOUTI REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2008	3.9	Population, total (million)	2008	0.8
Adolescent fertility rate (births per 1,000 women ages 15–19)	2008	22.5	Population growth (annual %)	2008	1.8
Contraceptive prevalence (% of married women ages 15–49)	2006	17.8	Population ages 0–14 (% of total)	2008	36.6
Unmet need for contraceptives (%)	2006	22	Population ages 15–64 (% of total)	2008	60.2
Median age at first birth (years) from DHS	—	—	Population ages 65 and above (% of total)	2008	3.2
Median age at marriage (years)	—	—	Age dependency ratio (% of working-age population)	2008	66.1
Mean ideal number of children for all women	2007		Urban population (% of total)	2008	87.3
Antenatal care with health personnel (%)	2006	92.3	Mean size of households	—	—
Births attended by skilled health personnel (%)	2006	93	GNI per capita, Atlas method (current US$)	2008	1130
Proportion of pregnant women with hemoglobin <110 g/L	2008	56.2	GDP per capita (current US$)	2008	1030
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	370	GDP growth (annual %)	2008	3.9
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	350	Population living below US$1.25 per day	2003	18.8
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	330	Labor force participation rate, female (% of female population ages 15–64)	2008	63.2
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	320	Literacy rate, adult female (% of females ages 15 and above)	2008	64
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	300	Total enrollment, primary (% net)	2008	47.6
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	90	Ratio of female to male primary enrollment (%)	2008	88.3
Infant mortality rate (per 1,000 live births)	2008	76	Ratio of female to male secondary enrollment (%)	2008	69.6
Newborns protected against tetanus (%)	2008	79	Gender Development Index (GDI)	2008	129
DPT3 immunization coverage (% by age 1)	2006	56.8	Health expenditure, total (% of GDP)	2007	7.2
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	1.3	Health expenditure, public (% of GDP)	2007	5.5
Prevalence of HIV, total (% of population ages 15–49)	2007	3.1	Health expenditure per capita (current US$)	2007	70.8
Female adults with HIV (% of population ages 15+ with HIV)	2007	58	Physicians (per 1,000 population)	2005	0.18
Prevalence of HIV, female (% ages 15–24)	2007	2.1	Nurses and midwives (per 1,000 population)	2005	0.568

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	—	—	—	—	—	—	—	—	—	—
Current use of contraception (Modern method)	—	—	—	—	—	—	—	—	—	—
Current use of contraception (Any method)	MICS	2007	—	—	—	—	—	17.8	—	—
Unmet need for family planning (Total)	MICS	2007	—	—	—	—	—	22.0	—	—
Births attended by skilled health personnel (percent)	MICS	2007	—	—	—	—	—	92.9	—	—

National Policies and Strategies that have Influenced Reproductive Health

Ministry for the Promotion of Women, Family Well-Being, and Social Affairs: *created in 1999 for advancing the rights, participation, and well-being of women and families*

National Strategy for Women's Integration in Development (SNIFD): *addresses women's health, education, and decision-making*

Declaration asserting the precedence of religion and traditional values over mandates of the **Convention on the Rights of the Child** (ratified 1990). Relevance to FGM/C (98 percent prevalence).