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FOR ACTION

RECOMMENDATION FOR FUNDING FROM GENERAL RESOURCES AND SUPPLEMENTARY FUNDS FOR A PROGRAMME IN THE MIDDLE EAST AND NORTH AFRICA REGION WITH AN ANNUAL PLANNING LEVEL NOT EXCEEDING $1,000,000*

SUMMARY

The present document contains a recommendation for funding from general resources and supplementary funds for a programme with an annual planning level not exceeding $1,000,000. The Executive Director recommends that the Executive Board approve the following amount from general resources, subject to the availability of funds, and the following amount in supplementary funds, subject to the availability of specific-purpose contributions, for the country programme listed below.

Country/programme	Amount (United States dollars)		Duration
	General resources	Supplementary funds	
Djibouti	3 500 000	3 750 000	1994-1998

A summary of the individual recommendation follows.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1993, will be contained in the "Summary of 1994 recommendations for general resources and supplementary funding programmes" (E/ICEF/1994/P/L.3 and Add.1).

DJIBOUTI

Basic data (1992 unless otherwise stated)

Child population (millions, 0-15 years)	0.2
Under-five mortality rate (U5MR) (per 1,000 live births)	158
Infant mortality rate (IMR) (per 1,000 live births)	113
Underweight (per cent moderate and severe) (1990)	23
Maternal mortality rate (MMR) (per 100,000 live births) (1989)	740
Literacy (per cent, male/female) (1985)	15/9
Primary school enrolment (per cent net, male/female)	45/33
Percentage of grade 1 reaching grade 4 (1988)	89
Access to safe water (per cent) (1991)	84
Access to health services (per cent) (1990)	86
Gross national product (GNP) per capita (1991)	.. a/
One-year-olds fully immunized against (percentage):	
tuberculosis	84
diphtheria/pertussis/tetanus	84
measles	83
poliomyelitis	81
Pregnant women immunized against (percentage):	
tetanus	89

a/ GNP per capita is estimated to be in the $500-$1,499 range.

The situation of children and women

1. Progress in child survival, development and protection in Djibouti has been limited by a lack of national capacity, weak economic growth and the unstable political situations inside the country and in the Horn of Africa. As a result, most of the children and women of Djibouti live in poverty. Djibouti is an almost entirely arid land with no mineral or other natural resources, water is scarce and there is limited agricultural potential. The frail economy is able to absorb less than 60 per cent of the labour force, and most of those employed earn only subsistence wages. Ninety-five per cent of Djibouti's food supply consists of imports, which are among the most expensive in Africa. As a result of these and other socio-economic indices, Djibouti ranks 163 out of the world's 173 countries, according to the United Nations Development Programme (UNDP) Human Development Index. Moreover, poverty may be increasing due to declining trade with Ethiopia and Somalia.

2. Internal conflict has led to the destruction of health centres and schools in the northern districts, where the fighting has been concentrated. It is

draining a large portion of the government budget, which would otherwise be allocated to development activities. The internal conflict is creating a climate of uncertainty and instability, which is detrimental to efforts to provide basic services. In addition, some 40,000 people have been displaced from their homes.

3. Another serious problem is the unstable and impoverished conditions that characterize the Horn of Africa region as a whole. Djibouti's economy, highly dependent on neighbouring Somalia and Ethiopia, has been severely affected by the unrest in those countries. The presence of approximately 120,000 displaced persons, refugees and nomadic Somalis and Ethiopians in Djibouti's population of 520,000 is placing a major strain on the country's meagre resources. It is estimated that these groups from neighbouring countries utilize a major portion of resources for health services. The continuous inflow of refugees also makes it difficult to control communicable diseases effectively and complicates the implementation of other basic services, such as primary education.

4. With an annual population growth rate of over 3 per cent, the country's population is projected to double in just 22 years. Fifty-two per cent of the population are under 20 years of age. The country is highly urbanized - nearly 75 per cent of the population is concentrated in Djibouti City. Most of the refugees live in shanty towns, in the streets of Djibouti City or in four refugee camps.

5. In 1992, the infant mortality rate (IMR) was estimated at 113 per 1,000 live births and the under-five mortality rate (U5MR) at 158 per 1,000 live births. Both IMR and U5MR were found to be 20 points lower for boys than for girls. Lack of proper prenatal and delivery care services, maternal malnutrition and anaemia and obstetrical complications arising from female genital mutilation contribute to high neonatal mortality. The most important determinants of infant mortality are acute respiratory infections (ARI) and diarrhoeal diseases, both acting in concert with malnutrition. Deaths from vaccine-preventable diseases, largely reduced in recent years, also remain a potential threat among the one fourth of the population who are rural nomads and among newly arrived, unimmunized refugee children. Acquired immune deficiency syndrome (AIDS) is spreading and is increasingly a threat to children.

6. Malnutrition is a major contributing factor to virtually all deaths of children under five years of age. A nationwide survey in 1990 revealed that 11 per cent of infants were acutely malnourished and 22 per cent were chronically malnourished. Women, on average, breast-feed for just five months; only 42 per cent of mothers still breast-feed at six months and just 10 per cent at 12 months. At age two months, one fifth of infants are fed solid food. However, hospitals and health centres, where 60 to 70 per cent of deliveries take place, are being exposed to the Baby-Friendly Hospital Initiative (BFHI). Three hospitals met the BFHI criteria in 1992 and another four did so in 1993. All health facilities no longer give out free infant formula and they are promoting exclusive breast-feeding during the first four to six months.

7. A 1989 national survey by the Ministry of Health, in cooperation with the World Health Organization (WHO) and UNICEF, estimated the maternal mortality rate (MMR) to be 740 per 100,000 live births, the highest in the region. Based

on a fertility rate of seven, 1 out of every 20 pregnant women will die from pregnancy-related causes. Major immediate causes of maternal mortality include haemorrhage, infection, obstructed labour, pre-eclampsia and eclampsia. Complications from female genital mutilation, maternal malnutrition and anaemia, high fertility and short birth intervals and lack of adequate antenatal, perinatal and post-natal care are all important indirect causes. The practice of female genital mutilation remains almost universal.

8. A lack of high-quality primary education prevents the majority of children from achieving basic literacy, numeracy and other important life skills. The net enrolment for primary school in 1991 was only 39 per cent. The situation is particularly bad for girls, whose enrolment is only 33 per cent as compared to 45 per cent for boys. The rate of repetition averages about 12 per cent annually and also reflects the shortcomings of the education system in meeting basic learning needs. Literacy among adults (over 15 years of age) is among the lowest in the world, 9 per cent for women and 15 per cent for men.

9. All of the above-mentioned circumstances illustrate the tremendous challenges facing the country in achieving the decade goals for children. However, there are opportunities as well. There is a high level of government attention to children's issues. The Government has ratified the Convention on the Rights of the Child; endorsed the goals of the World Conference on Education for All; signed the Declaration of the World Summit for Children; and, most importantly, integrated a national programme of action for the survival and protection of children during the 1990s into its 1991-1995 national plan.

10. The process of democratic reform in the country has created a climate more conducive to attention to the needs of children and women. There is a large network of community leaders and groups committed to the promotion of children's issues. The country's small size serves to foster close working relations among organizations concerned with the situation of children and women. With a population of about 500,000 concentrated in a small area, communication and awareness-raising campaigns are able to reach communities rapidly and effectively.

Previous programme cooperation

11. UNICEF cooperation during the 1980s focused on the promotion and implementation of primary health care (PHC), especially for universal child immunization (UCI). Cooperation also included the promotion of oral rehydration therapy (ORT), breast-feeding and supplementary feeding to reduce child malnutrition.

12. When the national immunization programme was launched in 1984, vaccination services were limited to a small number of urban children and the national coverage level was 7.5 per cent. There was a highly centralized, hospital-based health system, as well as little public awareness of the importance of immunization. UNICEF, in close collaboration with the Ministry of Health, WHO, the French Cooperation Mission and the National Union of Djiboutian Women, played a leading role in the formulation and launching of the national expanded programme on immunization (EPI) campaign. UNICEF provided vaccines, disposable needles and syringes and cold-chain equipment and expertise and sponsored social

mobilization campaigns and training of health workers and vaccinators. WHO and UNICEF also worked closely with the Ministry of Health to integrate immunization services with other PHC services. As a result, UCI was achieved in 1989, a target which had widely been perceived as impossible. In 1992, vaccination coverage for all six antigens and tetanus toxoid for pregnant women was sustained at more than 80 per cent. Pockets of low coverage in localities affected by civil strife continue to exist. In addition, with a large influx of unvaccinated refugee children, there is a potential for the resurgence of vaccine-preventable diseases. UNICEF also supported the provision of oral rehydration salts (ORS) and essential drugs for an outbreak of cholera in 1993.

13. UNICEF cooperation has also focused on the situation of women in terms of health, education and the overall social status of women. UNICEF provided supplies and equipment for all of the country's maternal and child health (MCH) centres and supported the training of nurses, midwives and traditional birth attendants (TBAs). More than three quarters of women now have access to prenatal care and supervised deliveries. Still, 1 out of every 20 pregnant women dies of pregnancy-related causes because the quality of services is low, and the status of women remains low.

14. Extensive efforts were made to empower women and girls through the national literacy/life skills programme, which was launched in 1991. The programme makes use of facilities and teachers from the formal school system and provides two-hour classes four evenings a week during the school year. The first hour of each class is devoted to developing core functional literacy and numeracy skills, using real life examples, while the second hour is devoted to developing general life skills and knowledge. The programme provides a choice of either French or Arabic for the reading and writing component, and of either Somali, Afar or Arabic for the life skills component, for 4,000 women.

Lessons learned

15. Although the survival and development of women and children has been high on the government agenda, progress was impeded by, inter alia, a lack of adequately trained managers and a continuing influx of refugees and displaced persons. Achieving the mid- and end-decade goals will require reaching more displaced and squatter populations with basic services. Particular emphasis should be placed on improving the capacities of the health system for controlling communicable diseases, AIDS, malaria and tuberculosis.

16. Raising awareness of mothers, and in fact of entire families, has not been sufficiently a part of all major programmes. Therefore, priority should be given to more effective and sustainable communication and social mobilization activities. The high drop-out rate among women in the literacy programme, in spite of their strong demand for learning opportunities, strongly suggests that the conceptual, organizational and funding elements of the programme need to be revised. More involvement of women community leaders in programme planning and management could reinvigorate the programme.

17. More efforts should focus on strengthening government capacities in programme management, which would include preparedness for and response to emergency situations and their linkages with regular national programmes.

Training in setting up improved mechanisms for monitoring and evaluation at the different administrative levels of service delivery also needs to be one of the top priorities during the next cooperation period.

Recommended programme cooperation, 1994-1998

Estimated annual expenditure

(In thousands of United States dollars)

	1994	1995	1996	1997	1998	Total
General resources						
Health	180	345	340	330	325	1 520
Education	150	165	165	165	160	805
Advocacy and planning	30	30	25	25	25	135
Programme support	140	210	220	230	240	1 040
Subtotal	500	750	750	750	750	3 500
Supplementary funding						
Health	590	575	495	480	495	2 635
Education	100	160	235	250	230	975
Advocacy and planning	60	15	20	20	25	140
Subtotal	750	750	750	750	750	3 750
Total	1 250 a/	1 500	1 500	1 500	1 500	7 250

a/ Additional funds in the amount of $250,000 for the January-April 1994 period were approved by the 1993 UNICEF Executive Board in a separate proposal (E/ICEF/1993/P/L.25).

18. Government/UNICEF cooperation during the period 1994-1998 will include three interrelated and mutually supportive programmes: health; education; and advocacy and social planning. The country programme will address four major goals, the first three being (a) to reduce IMR from 113 per 1,000 live births to 60 and U5MR from 158 per 1,000 live births to 80; (b) to reduce MMR from 740 per 100,000 live births to 370; and (c) to reduce severe and moderate malnutrition among children under five years of age by at least 50 per cent. These goals are based on the national programme of action and on the National Five-Year Plan, 1991-1995. The fourth goal, to empower all women and girls with the basic knowledge and skills needed for healthy living, was adopted in view of the inextricable link between basic education as an empowerment strategy and the overall well-being of children and mothers. All programme activities will be linked with these four national goals for children for the 1990s.

19. The programme formulation process led to the identification of a number of cross-cutting strategies, the most important of which are (a) developing national capacity; (b) a more focused strategy on the needs of urban slum dwellers; (c) community empowerment through increasing the basic skills and knowledge of families; (d) reducing gender gaps by improving the situation of girls; (e) promoting stronger linkages and coordination between development agents; and (f) mobilizing community and religious leaders as leaders in child survival, development and protection. These cross-cutting strategies will permeate the country programme.

Health

20. This programme will be comprised of four projects: MCH and nutrition; control of childhood diseases; urban community health; and control of AIDS.

21. The objective of the MCH and nutrition project is to help to reduce by 50 per cent malnutrition among children under five years of age and maternal mortality, and to improve the prenatal and post-natal health status of mothers. This will involve increasing the awareness and actions of health workers and families regarding the importance of proper maternal and child nutrition; early, exclusive and prolonged breast-feeding; maternal care; family planning; and the harmful nature of traditional practices such as female genital mutilation. Relevant information will be widely disseminated through television and radio spots, information materials based on Facts for Life and community outreach by child health workers, Imams (Islamic religious leaders) and schoolteachers. UNICEF will support capacity-building through in-service training for health staff on breast-feeding, growth monitoring and promotion, safe motherhood and family planning. Special information tutorials for TBAs will give priority to issues such as the harmful consequences of female genital mutilation. UNICEF will also support the establishment of nutrition information and rehabilitation centres at selected health dispensaries, provide child scales and growth monitoring and promotion charts for use in health dispensaries, and advocate for the establishment of institutions and legal provisions in support of breast-feeding.

22. The control of childhood diseases project will help to reduce mortality and morbidity caused by ARI and diarrhoeal and vaccine-preventable diseases in children under five years of age and will aim to eliminate neonatal tetanus and substantially reduce the incidence of measles and poliomyelitis. These objectives can be achieved if all displaced and squatter child populations are immunized to control disease transmission. Therefore, it is planned to support annual multi-antigen national campaigns to boost the high coverage already achieved through regular service delivery. UNICEF will provide vaccines, needles, syringes and cold-chain equipment for EPI. To combat diarrhoeal diseases, a capacity-building strategy will include the promotion of correct case management through the supply of ORS and the promotion of ORT, the training of health staff and the provision of diagnostic charts and treatment manuals. Support will also include the development of visual aids, printed materials and mass media spots directed at all family members and child care workers. Other activities will include public information seminars on community hygiene and sanitation, and religious leaders, TBAs, child health workers and teachers will be mobilized as communication agents. Major strategies to control

ARI will include establishing standardized case management at all health centres and raising public awareness that ARI is a major killer of children.

23. A major effort to address specifically the problems of refugees and displaced families will be made through the urban community health project in Balbala, which is a peri-urban slum area housing over 110,000 of the country's most disadvantaged women and children. The main objective of the project is to accelerate delivery of services for the control of diarrhoeal diseases and ARI, essential drugs, family planning, prenatal and post-natal care, growth monitoring and promotion, breast-feeding and maternal nutrition. The activities will be managed from the four Balbala health dispensaries and a hospital, and will be implemented under the direct supervision of newly established local technical committees. These local committees are linked closely with their corresponding national committees in each of the major programme areas. Particular emphasis will be placed on capacity-building through the training of health staff and the provision of health education equipment and supplies, improved reporting systems and monitoring and evaluation. Support will also be provided for expanding and improving two ongoing community empowerment initiatives: (a) systematic outreach by trained community health workers (CHWs); and (b) upgrading the quality of traditional community health care through the training of TBAs. The lessons learned and experience gained in Balbala will be used for developing similar programmes in other under-served peri-urban areas and for improving the national MCH programme.

24. In close cooperation with WHO, a project will be implemented to prevent the human immunodeficiency virus/AIDS by raising public awareness through the work of CHWs with high-risk groups such as sex workers and youth. A wide dissemination of information materials and mass media spots, along with the mobilization of religious leaders, TBAs, CHWs and women's literacy teachers will be essential in promoting AIDS awareness. A regional AIDS information and resource centre will be established, with WHO and UNICEF assistance, to serve as a focal point for region-wide AIDS prevention and regular experience exchange for health professionals and other concerned groups. A non-governmental organization (NGO) will serve as an AIDS contact group and will register high-risk populations and provide them with AIDS prevention information and regular medical examinations.

Education

25. While overall promotion of universal primary education will be important, the education programme will focus on increasing the access of girls and women to basic numeracy and reading/writing and life skills through both the formal school system and non-formal education. A basic capacity-building strategy is to upgrade the quality of formal primary education, while building a responsive non-formal system for wider coverage. The formal component will centre on improving the relevance of learning by incorporating the themes of Facts for Life into teacher-training programmes and primary school curricula. It will also selectively upgrade poor environmental conditions of schools in outlying rural areas so as to create a more acceptable environment for girls to attend school. Nationwide non-formal education will focus on reaching girls and women who cannot be reached by the formal system at this time. A community-based learning programme for out-of-school girls and women will be established. The

curriculum will combine basic numeracy and reading/writing skills with life skills, for example, health, hygiene, environmental care, nutrition and family income skills related to fishing, farming and handicrafts. This programme will also include Facts for Life learning for women. It will teach life skills subjects in the local languages of Afar and Somali, and basic literacy and numeracy skills in either of the official languages of French and Arabic. Special radio programmes on Facts for Life will be broadcast twice each evening for half an hour in Arabic and French to promote appropriate family health practices and to reinforce newly acquired skills and knowledge. In developing a network of non-formal education centres for women and girls, efforts will centre initially on reorienting the existing network of nine youth houses. The libraries at the centres will be supplemented with a variety of materials.

Advocacy and planning

26. The advocacy and planning programme will be composed of two components, advocacy and capacity development. The advocacy component will help to raise the profile of women's and children's issues generally, and in particular will increase public awareness of and concern for child rights. UNICEF, through its membership in the Higher Council for the Protection of Children and Mothers and the national programme of action subcommittee for child rights, will assist the Government with the incorporation of provisions of the Convention on the Rights of the Child into the country's laws and judicial practices. The increased involvement of religious leaders as advocates for women and children will help to promote stronger ethics for children. UNICEF will support the production of multi-media communication materials that address important issues, for example, the promotion of UCI, the use of ORT and harmful traditional practices. The establishment of a non-governmental child rights advocacy group will also be supported. It will disseminate public information on the Convention on the Rights of the Child, sponsor educational programmes and documentaries for television and radio and organize seminars and workshops for the mass media.

27. The capacity development component will aim at improving planning, monitoring and evaluation for the implementation of the national programme of action. Sectoral subcommittees, under the National Intersectoral Committee for Follow-up on the World Summit Goals, will be established. They will refine sectoral strategies for national programme of action goals, upgrade databases and reporting systems for the national programme of action and monitor the progress of implementation. UNICEF will provide technical assistance for setting up an information management system for analysing and evaluating indicators related to the World Summit and national programme of action goals in relevant government ministries and statistical centres. UNICEF will also support training of health staff at the peripheral, district and central levels in data collection and analysis, record-keeping and reporting systems and the design and conduct of surveys.

Monitoring and evaluation

28. Along with specific emphasis on monitoring and evaluation of the national programme of action, monitoring progress and evaluating achievements in relation to objectives of the proposed cooperation will be important for all programmes. Monitoring and evaluation capacities will be strengthened through more efficient

use of routine reporting systems, feedback from field workers, cost-effectiveness appraisals and national household health and health facility surveys planned for 1994 and 1997. Monitoring and evaluation systems will be based on major indicators for each programme, for example, access, coverage and impact indicators. Annual programme reviews will be conducted during the last quarter of each calendar year under the coordination of the Ministry of Cooperation and with the participation, as and where appropriate, of United Nations agencies and other interested parties. These reviews will identify programming adjustments and resource allocations for annual project plans of action. A mid-term programme review, supported by relevant evaluation studies, will be undertaken in mid-1996; it will analyse overall trends and progress towards objectives and assess the effectiveness of strategies. The situation analysis of children and women will be updated annually and will figure prominently in the mid-term and annual reviews.

Inter-agency cooperation

29. The programme of cooperation will complement the activities of other United Nations agencies. Health activities will involve continued close collaboration with WHO and increased cooperation with UNDP and the United Nations Population Fund, particularly in the fields of family planning, safe motherhood and prevention of AIDS. Activities in the nutrition sector will involve collaboration with the World Food Programme and the Food and Agriculture Organization of the United Nations. The United Nations Educational, Cultural and Scientific Organization will be an important partner in efforts to incorporate basic life skills and knowledge into primary school curricula and in developing non-formal education for girls and women. Other international partners include the Italian Cooperation Mission, the primary implementing partner in the urban community health project; the French Cooperation Mission, active in both the health and nutrition sectors; the European Union, involved in the development of PHC, AIDS prevention and a variety of other areas; and the Inter-Africa Group, active in the fight against female genital mutilation.

30. Increased emphasis will be placed on cooperation with national NGOs and local groups in all programmes as part of the empowerment strategy to develop community capacity. Major national NGO partners will include the National Union of Djiboutian Women, which is active in safe motherhood promotion, girls' non-formal education and women's learning of life skills, and the Centre for Research, Information and Production of Education, which is involved in the development of learning materials, textbooks and radio programmes with Facts for Life themes. Local groups and leaders, including Imams and other religious leaders, local community health committees, municipal leaders, social service providers, TBAs, CHWs and non-formal education teachers will have important roles in all elements of the country programme.
