Community Health

Policy and Implementation Landscape Mapping in the Middle East and North Africa Region 2024

Djibouti Country Brief

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Ministere de la Santé
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1. Community health in Djibouti

Community health policy in place	Community health workers recognized as part of the national health workforce	Total number of community health workers currently deployed	Formal linkages between community health and other sectors	Inclusion of community health workers in emergency preparedness plans	Domestic funding available	Community engagement mechanisms in place
Yes	Yes	70	Yes	No	No	Yes

1.1 Country context

The Republic of Djibouti, a country located in the Horn of East Africa, shares its borders with Eritrea to the north, Somalia to the south-east, and Ethiopia to the southwest.[1] The country covers an area of 23,200 km^2 with an estimated population of 1,024,206[2] and a population density of 40.5 inhabitants per km^2. The country is divided into six administrative regions, including Djibouti City, the capital, and the regions of Obock, Tadjourah, Dikhil, Ali Sabieh and Arta.[1, 3, 4]

Djibouti's health system is based on the Primary Health Care (PHC) strategy and organized according to the district health system approach.[1, 3, 4] The organization of Djibouti's health system consists of three levels (peripheral, intermediate and central), complemented by three sub-sectors (public, semi-public and private). It is governed by the health services map, which must be revised every five years.

The health situation throughout the country has improved in recent years thanks to the health policy reforms led by the Ministry of Health.[1, 3, 4] However, the national health system is still beset by structural and organizational difficulties.[1, 3, 4]

1 Ministère de la Santé. (2023). Politique national de la sante communautaire de la république de Djibouti. République de Djibouti.

2 Camara, F. B. N. & Souldan, F. H. (2018). Rapport des projections démographiques à l'horizon 2035. DISED. UNFPA.

3 Ministère de la Santé. (2024). Plan stratégique national de la santé communautaire 2024-2028 de la république de Djibouti. République de Djibouti.

4 Ministère de la Santé. (2024). Plan stratégique national de la santé communautaire 2024-2028 de la république de Djibouti : Analyse de la situation. République de Djibouti.

1.2 Overview of community health

In Djibouti, there is no holistic or overarching system for managing community health activities and associated stakeholders.[1, 3, 4] Since 2000, several community initiatives have been carried out in a scattered and ad hoc manner. Funded by technical partners and donors, a diverse network of community level actors (including *relais communautaires,* awareness raisers, health ambassadors/counsellors) undertook vaccination, nutrition, sanitation and women's empowerment projects in various localities.[1, 3, 4, 5] More specifically, in 2008, 100 community health workers (CHWs) were recruited and received nine months of training at the Higher Institute of Health Sciences, followed by 11 days of practical training on health promotion and curative services packages as well as well as tools (guides, modules, etc.) developed for this purpose. This initiative continued with an additional recruitment of up to 400 CHWs, i.e. 100 per year.

5 Ministère de la Santé. (2024). La Sante au Quotidien. Le magazine d'information du Ministère de la Santé. Djibouti.

2. Health systems pillars

2.1 Governance and accountability

- In 2023, the country developed a National Community Health Policy,[1] which was followed by a National Strategic Plan (NSP) budgeted for 2024-2028.[3] Various stakeholders in Djibouti city and as well as in the regions were involved and consulted in the design of the policy and the subsequent strategy.
- Moreover, the country has also established a new department dedicated to community health and is working on decentralizing decision-making by setting up communication, social mobilization and community involvement focal points in primary and secondary level structures to coordinate community activities at facility level.
- The current priority is to establish regulations and recruit community health personnel, with the intention of integrating community health into the national health system (and more specifically into the PHC system), and to foster engagement at community level.
- In Djibouti, the private sector makes little contribution to community health.[6]

2.1.1 Community engagement

- Currently, there are no clear mechanisms put in place with respect to the participation of CHWs in decision-making processes or social accountability related to services provided by CHWs. However, in the National Strategic Plan there are provisions to strengthen the capacities of community leaders for better engagement and decision-making in an attempt to promote accountability and ownership of problems by populations. It is anticipated that the community will participate in community diagnosis, intervention planning, implementation and evaluation.[3]
- Community engagement mechanisms currently in place include health committees, training on key health topics and health promotion/lifestyle activities.

2.2 Health management information systems

- The country uses the DHIS2 as its national health management information system (HMIS). Although this system has the capacity to include data at the community level, this has not yet been integrated.
- It is difficult to monitor community-level interventions and to assess performance given the lack of community indicators and tools for collecting data at community level.
- The establishment of medical secretaries to collect data electronically and communications focal points to ensure the transmission of community information in reports at the level of each structure, should pave the way for informing the DHIS2 and the National Health Information System.

6 World Health Organization. (2024). Understanding the private health sector in Djibouti. Cairo: WHO Regional Office for the Eastern Mediterranean. License: CC BYNC-SA 3.0 IGO.

2.3 Medicines and health commodities

- Community staff do not have kits (equipment, materials, products or inputs) and means of transport for implementing interventions in remote areas, which makes home visits irregular.
- The list of products authorized for community activities has not been standardized, and the data relating to them is not yet linked to the National Health Information System.

2.4 Health workforce

- To date, most of the health-related activities at the community level have been undertaken by different health/social professionals at the Primary Health Care Centre (PHCC) level or through volunteers that are trained, supervised, and evaluated by non-governmental organizations (NGOs). The number of volunteers is estimated by each NGO and the criteria for selection vary based on the project and NGO priorities.
- In 2008, 100 CHWs were trained and deployed as part of an effort to strengthen community-based approaches and community participation in the country's health care system. The Expanded Coverage of Essential Health Services in Djibouti Project (PECSE), set up in 2003, enabled the extension of health care services to sites in rural areas and furthered the development of community interventions. However, this programme was eventually terminated in 2008 due to lack of funding.
- The country currently has several community-level actors (including sub-commissions, mères conseillères, health committees, and relais communautaires) spread across the country, who are periodically engaged during the implementation of programmes and according to needs. That stated, their numbers are not well known.
- The country has set up communication, social mobilization and community engagement focal points in each health facility. The focal points are selected by the Regional Chief Medical Officers.
- As a starting point for mobilizing the community, the communication, social mobilization and community involvement focal points in each health facility support a mapping exercise of all the associations, religious leaders, community leaders, etc. working with their facility at sector level.
- According to the National Strategic Plan for Community Health (PSNSC), the plan is to hire and train 100 CHWs per year. The content and methods of training are still under discussion. As of 2024, 70 CHWs have been hired.
- Some selection criteria for CHWs have been established. CHWs must be literate, have a secondary education and must not have another current occupation. Focal points, on the other hand, must additionally have a bachelor's degree. That stated, more thought needs to be given to these criteria, as well as the training and development of a career plan for CHWS, which would be a source of motivation for them.
- Transportation remains a problem for community workers, mainly because of the associated cost and accessibility of remote areas. It has been suggested that community workers could be provided with motorbikes to facilitate their work. However, this would pose problems for women, who do not drive motorbikes because of cultural norms.

Insight: Community initiatives

- In 2008, UNICEF supported the Ministry of Health in developing a medium-term expenditure framework with an investment plan for child survival and development. This enabled the Ministry of Health to conduct a high-level recruitment campaign for 100 CHWs selected from host communities to act as a relay between the community and health facilities. Unfortunately, given the country's unmet needs in terms of primary health staff, the CHWs were redeployed to replace nurses and midwives in the health posts and carry out associated duties.[3]
- Since 2008, community dialogues have been carried out by community management committees. Committee members, elected by the community, are voluntary positions and are made up of representatives from across neighbourhoods. In 2021, the various committees received kits including computer and office equipment, equipment for income-generating activities as well as equipment to help protect against COVID-19.[7]
- In 2009, the WFP project enabled the recruitment and redeployment of around 400 *meres conseilleres* to improve food security. The counsellors were responsible for raising awareness on nutrition issues, as well as screening and reporting malnutrition and referring malnourished children, mothers and pregnant women to health centres.[3]

2.5 Service delivery

- A community Minimum Package of Services (MPS) was established in 2012, but it needs updating. There is a need to start a discussion on defining the MPS by cadre (health workers, *relais communautaires,* etc.) based on the MPS that were drawn up when CHWs were introduced in 2008.
- Trained *relais communautaires* carry out social mobilization activities, counting zero-dose children, acutely malnourished children and pregnant women through home visits.
- There are no constraints regarding access to services for migrants, refugees and displaced persons, who are considered part of the population and enjoy the same benefits.

2.6 Partnerships and financing

- At present, community interventions are mainly financed by technical financial partners and donors, and there is inefficient use of available financial resources due to the lack of a coordination framework.[1, 3, 4]
- There is also little community involvement in the mobilization of resources, and local authorities make virtually no contribution to the funding of community interventions, despite the existence of a budget line allocated to health in the Regional Plans.[1, 3, 4]
- A national strategic plan that includes a budget line for quality community health human resources (CHWs and other community health staff) in the form of a state-paid salary to coordinate community activities in health facilities has been developed, budgeted for and recently validated.[3]

7 Zouhour. (2021). Remise des kits de renforcement aux comités de gestion communautaire. La Nation. https://www.lanation.dj/remise-des-kits-de-renforcement-aux-comites-de-gestion-communautaire/

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2.7 Cross cutting issues

2.7.1 Gender considerations

- The gender is not specifically mentioned in the PSNSC when it comes to community health workers but there is a plan for an equitable distribution according to gender, with men and women involved on an equal footing.

2.7.2 Emergency preparedness

- It is anticipated that CHWs will play an important role in emergency situations moving forward, especially following the experience of COVID-19, which demonstrated the need to have actors on the ground to support the efforts of the Ministry of Health.

2.7.3 Refugees and Internally Displaced Persons (IDPs)

- Refugees, migrants and displaced persons are already theoretically integrated into the system. IOM and UNHCR were present when the National Community Health Policy was developed, and the idea is to utilize focal points who have already been trained and are already engaged in the various camps in the region.

3. Conclusions

3.1 Challenges

- Although there are several technical partners and international/national actors carrying out community activities in the different regions and localities, the coordination of these activities and their monitoring remains inadequate and can lead to duplication.
- It is difficult to ensure the sustainability of the community health, given that most interventions are funded externally.
- Human resources for community health are the weak link in Djibouti's community health strategy. Work needs to be done to attract, motivate and retain community health workers. There is a need to redefine the role of CHWs and revitalize them.
- Communication on behaviour change and social norms is weak.
- Community intervention management capacities at all levels of the pyramid are weak due to a lack of planning and monitoring mechanisms for community engagement programmes.
- The uptake and use of health services remains low across the country, which means there is a need to strengthen demand and encourage citizens to take advantage of the care offered.
- The inability to involve local communities and the lack of community participation in and commitment to defining and meeting their needs is a major obstacle to setting up a community health.
- To date, there are no community indicators and tools for collecting community data. Strengthening the community health management system and making data available through indicators and data collection and management tools would help to improve the availability and quality of services.

3.2 Enablers

- Djibouti has established a national community health and a national strategic plan budgeted for 2024-2028. These have facilitated the implementation of community health.
- There is a strong commitment on the part of the Ministry of Health, and a real willingness to promote and advocate for the establishment of community health.
- The creation of a department for health promotion within the Ministry and the appointment of focal points in health posts have been important first steps for community health.
- The existence of trained community players in all regions, including Djibouti city, has been an important asset.
- The presence of community development programmes and other groups and associations that implement community interventions, especially in remote areas, provides a favourable environment for putting in place community health.

3.3 Priority policy directions

- Update the regulatory texts concerning selection criteria and training of CHWs and those of the minimum package of services. This is essential for the implementation of community health programmes.
- Organize a thorough review of CHWs' career plans to improve motivation and retention.
- Carry out regular evaluations and ongoing monitoring of community activities to ensure the sustainability of the programme.
- Provide last-mile service delivery to ensure equitable, high-quality services.
- Develop training and regular refresher courses for CHWs to improve their performance.
- Propose indicators for integrating community data into the DHIS2. List and disaggregate CHWs and evaluate the provision and quality of services available.

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