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Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women

Replies of Djibouti to the list of issues and questions in relation to its combined fourth and fifth periodic reports*

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* The present document is being issued without formal editing.

I. National machinery for the advancement of women

A. Monitoring role of the Gender Observatory

1. The Gender Observatory is a monitoring body that ensures respect for the principles of gender equity and equality to support the implementation of the national gender policy. It also oversees the implementation of laws and regulations related to international conventions on the subject.

2. It is based on a shared strategic vision of generating momentum for the development of innovative approaches to gender mainstreaming.

3. The overall mission of the Observatory is to regularly document challenges related to the national gender policy and to provide advice and recommendations to the Government. It will produce an annual progress report that will be submitted to the President of the Republic, the Prime Minister and the President of the National Assembly.

4. It liaises with all relevant national, regional and international development actors.

5. The Observatory has been entrusted with the following tasks:

- Contribute to influencing, directly or indirectly, the drafting, implementation and interpretation of laws, standards, regulations and, more generally, any measures or decisions taken by the public authorities, with a view to making them gender-sensitive;
- Facilitate and support gender mainstreaming by integrating it into the practices, conduct and culture of institutions responsible for planning, monitoring and evaluating national public policies, strategies, programmes and action plans;
- Track the gender mainstreaming commitments of various sectors and actors in a reliable and objective manner, with clear, precise, quantifiable and measurable indicators, to better assess gender inequalities and the progress made towards gender equality;
- Encourage reflection, the strengthening of evidence-based knowledge, and the exchange of experiences and best practices with respect to gender mainstreaming;
- Develop and consolidate partnerships with various stakeholders at the national, local (institutions, civil society organizations, universities, etc.) and international levels.

B. Access to justice

6. Access to justice is a fundamental right guaranteed by the Constitution.

7. With a view to guaranteeing the right of access to justice, the State party has taken a wide range of legislative and administrative measures. All these measures are based on the principle of equality and non-discrimination, which is also enshrined in the Constitution. Under article 1 of the Constitution, “all persons are equal before the law, regardless of their language, origin, race or religion”. Measures to facilitate access to justice, including for women living in rural areas, include:

- Adoption of laws providing for legal aid to enable people with insufficient means to pursue legal claims;
- Since 2020, establishment of courts in the interior regions. These courts are supported by hearings held in the most remote areas, including refugee villages;

- Establishment, also in 2020, of a school of judicial studies to improve the quality of justice.

8. The aim of all these measures is to improve citizens' access to justice.

9. Women can freely initiate legal proceedings and have their cases heard by a judge, regardless of subject matter or location, on an equal basis with men.

10. The Republic of Djibouti has three courts of first instance, one administrative court, two courts of appeal and one supreme court.

11. According to the Constitution, justice is based on the principles of legality and equality. These principles are given effect through the Family Code, the Code of Criminal Procedure and the Code of Civil Procedure.

12. The Republic of Djibouti does not have any laws that prevent women whose rights have been violated, including women who have suffered discrimination, from exercising their right to legal recourse.

13. The most important achievement in terms of access to justice has been the creation of the support, information and counselling centre. Established on the initiative of the National Union of Djiboutian Women, this centre provides a platform for combating violence against women and girls. It also provides a safe space for victims to report complaints and grievances. They are then offered social, medical and psychological assistance. In addition, the centre is tasked with providing requisite support to women victims of violence by informing them of their fundamental rights, directing them towards appropriate institutions and services, and facilitating their access to judicial bodies. Women and girls who are victims of violence also receive help and assistance with administrative and legal procedures.

14. In addition, the State party ensures that vulnerable people have access to justice and constitutional remedies through the provision of legal aid.

15. Pursuant to Act No. 136/AN/11/6 L of 20 July 2011 on legal aid, vulnerable groups such as women, children, older persons, the sick and people living with HIV/AIDS are given priority access to legal aid. Such financial or legal aid is granted by the State to claimants lacking sufficient income to obtain access to justice.

16. This applies to anyone with a monthly income of less than 100,000 Djibouti francs. This ceiling is raised to 150,000 francs when the person concerned proves that he or she has three dependent children.

17. The Legal Aid Office offers the following services:

(a) *Legal aid in criminal matters*. Legal aid in criminal matters is provided to persons accused of, or under investigation for, various criminal offences under the law. Services include legal advice, bail applications and legal representation in court;

(b) *Legal aid in civil matters*. Legal aid in civil matters is granted to persons involved in civil proceedings, as a litigant or a concerned party;

(c) *Legal advice and assistance*. The Legal Aid Office also provides general legal advice and assistance in all legal matters. This can include advice on the application of the law in particular circumstances, legal assistance to prevent and resolve disputes, and legal representation in court;

(d) *Public legal education*. The Legal Aid Office offers public legal education on various legal issues and procedures to the general public. Particular emphasis is also placed on educating the public about the existence and functions of the Office.

18. The responsibilities of the Gender Observatory are listed below.

Data collection, analysis and dissemination

19. The Gender Observatory works to bring about sociopolitical and cultural change to support gender equity and equality and political decision-making. It does so by objectively interpreting, leveraging and reproducing data (indicators, graphs, maps, etc.) and producing forecasts through a participatory and inclusive approach involving institutions and stakeholders, the Departments of Research and Statistics, Planning, and Monitoring and Evaluation of the Ministry for Women and the Family, and the National Institute of Statistics of Djibouti, and by producing studies, surveys and targeted action research led by the Observatory and/or in collaboration with sectors, local authorities or research institutions.

Monitoring and evaluation

20. The Gender Observatory is tasked with ensuring respect for the principles of gender equity and equality in the planning of public policies, strategies, programmes and projects, and with monitoring the implementation of laws and regulations related to international conventions on the subject.

21. The monitoring and evaluation system or mechanism will enable the Observatory to fulfil the following three functions:

- *Ensuring compliance*. Reporting on the execution, results and impact of the activities under its action plan, and the degree of achievement of objectives and expected results (with particular reference to the three-year (2019–2021) action matrix of the national gender policy), including the Observatory's contribution to the monitoring and evaluation activities of the Ministry for Women and the Family;
- *Providing insights*. Carrying out activities and sharing information;
- *Facilitating decision-making*. Building on and disseminating results and their impact.

Information-sharing, communication and advocacy

22. By providing space for consultation and reflection, the Gender Observatory serves as a platform for dialogue, expertise and communication for the actors involved in the various activities, as well as for evaluating those activities.

23. To this end, a communications strategy and an action plan will be developed to provide a common framework for communications with stakeholders (government officials, decision-makers, parliamentarians, technical and financial partners, etc.).

24. This strategy is part of a systemic vision that takes into account the connections between different contexts, and the formal and informal communication channels that change as attitudes and behaviours evolve.

II. Discriminatory stereotypes and harmful practices

25. The national strategy to combat female genital mutilation came to an end in 2021 and the Ministry for Women and the Family began to evaluate it in November 2023. When that process is completed, a new national strategy to combat female genital mutilation for the period from 2024 to 2029 will be produced in 2024. A committee was established in 2008 but it was replaced by the platform for the protection of children in 2018.

26. In addition, the 2019 national survey on violence against women was conducted. This was the first survey specifically designed to cover all aspects of violence against

women, unlike previous surveys of the Pan Arab Project for Family Health, which only included genital mutilation and women's views on abuse.

27. The national survey on violence against women was carried out by the national statistical office at the request of the Ministry for Women and the Family, with funding from the United Nations Population Fund (UNFPA), the United Nations Children's Fund and the European Union. Its main aim is to assess developments related to violence against women in Djiboutian society.

28. The survey was conducted in two stages, one quantitative and one qualitative. The quantitative survey took place in November 2019 with a sample of 5,000 households. The qualitative survey was carried out in December 2019 through focus groups and individual interviews.

29. The most important statistics derived from the survey data are summarized below.

A. Female genital mutilation

30. Nationally, taking all ages into consideration, the prevalence of female genital mutilation is 70.7 per cent. That prevalence is lower than in 2012, when the figure was 78.4 per cent.

31. It should be noted, however, that the prevalence only declined in urban areas, where it fell from 78.5 per cent to 69.1 per cent between 2012 and 2019. In the same time period, it rose slightly in rural areas from 77.8 per cent in 2012 to 78.6 per cent.

32. There is also a regional disparity in the prevalence of female genital mutilation: in the Ali Sabieh Region (61.2 per cent) and the city of Djibouti (68.5 per cent) the prevalence is much lower than in the other regions, including Obock (73.6 per cent), Arta (76.4 per cent), Dikhil (82.0 per cent) and Tadjourah (88.2 per cent).

33. The results also show that the most severe types of female genital mutilation (infibulation and excision) are gradually being abandoned in favour of the simplest form, known as sunna, which is more common among women under 25 years of age.

34. Among people aged 15 and over, 79.1 per cent said they had heard of female genital mutilation. That proportion is 95.3 per cent for women and 60.3 per cent for men. Of those respondents, 71.3 per cent said that the practice of female genital mutilation has decreased in their community; 70.2 per cent know that there is a law prohibiting the practice of female genital mutilation; and 69.5 per cent believe that the practice of female genital mutilation should be abandoned.

B. Early marriage

35. The rate of women married under the age of 18, or early marriage rate, is 13.3 per cent overall, with a significant difference between urban and rural areas, where it is 10.3 per cent and 26.9 per cent, respectively.

C. Domestic abuse

36. *Physical abuse*. Among ever married women, 7.2 per cent suffered at least one act of physical violence at the hands of their last husband/partner during the course of their relationship, and 4.6 per cent did so in the previous 12 months. For single women, the prevalence of such violence is 6.1 per cent.

37. Deep wounds, broken bones, broken teeth or other serious injuries were reported by 22.5 per cent of women victims of spousal abuse at the hands of their last husband/partner.

38. *Sexual abuse*. Among ever married women, 5.3 per cent suffered at least one act of sexual violence at the hands of their last husband/partner during the course of their relationship. That prevalence was 3.5 per cent over the previous 12 months. The prevalence of sexual violence among single women was 0.6 per cent.

39. *Emotional abuse*. Among ever married women, 9.4 per cent suffered emotional abuse at least once during their relationship with their last husband/partner.

40. *Control exerted by husband/partner*. Among ever married women, 31.0 per cent suffered at least one act of control exerted by their husband/partner during the relationship.

41. *Seeking help for abuse*. Among all women aged 15–64 who suffered physical and/or sexual abuse, only 21.1 per cent sought help at some point. Help was mainly sought from the victims' own families (71.3 per cent); the families of husbands/partners (54.8 per cent); men and women law enforcement officers (35.8 per cent); neighbours (23.9 per cent); and non-governmental organizations or the National Union of Djiboutian Women (23.7 per cent).

Summary of results

Indicators	*National*	*Urban*	*Rural*
Female genital mutilation			
Prevalence – all ages (percentage)	70.7	69.1	78.6
Prevalence – girls 0–10 years (percentage)	21.2	15.9	41.5
Prevalence – girls 11–14 years (percentage)	62.9	59.2	86.2
Prevalence – women 15–24 years (percentage)	82.5	80.9	94.1
Prevalence – women aged 25 and over (percentage)	94.3	93.6	98.2
Proportion type I: sunna (percentage)	41.0	40.8	41.7
Proportion type II: excision (percentage)	18.5	18.5	18.4
Proportion type III: infibulation (percentage)	40.1	40.4	38.8
Proportion of female genital mutilations performed by traditional practitioners or household members (percentage)	93.2	92.5	96.6
Proportion of female genital mutilations performed at home (percentage)	96.0	95.5	98.3
Average age when female genital mutilation was performed (years)	5.8	6.2	3.9

42. To support the victims of female genital mutilation, a protocol on their care has been drafted and training has been provided for midwives throughout the country.

D. Medical care for victims of female genital mutilation

43. Treatment of physical complications ranges from advice and support to medical or surgical services. When the patient's condition is assessed, the provider must identify the appropriate type of care.

Receiving the patient

- Greet the patient warmly;
- Welcome her;

- Offer her a seat;
- Introduce self to the patient;
- Ask her name;
- Provide assurances as to confidentiality.

Patient interview and registration

- Collect general information (surname, first name, age, marital status, occupation, etc.);
- Ask the reason for the consultation;
- Note medical, surgical and family history and vaccination status;

If the patient is a woman, note:

- Her gynaecological and obstetric history;
- History of female genital mutilation;
- Functional signs: dyspareunia, frigidity, vaginismus, dysuria, etc.

Examination of the patient

Perform a physical examination of the patient:

- Prepare the equipment necessary for the examination;
- Explain the examination procedure to the patient;
- Wash hands and dry them with a clean, dry individual cloth;
- Help the patient to settle in;
- Perform a general examination;
- Take vital signs: blood pressure, pulse, weight, temperature;
- Examine the conjunctivae;
- Examine the breasts for lumps, changes in consistency, breast discharge, etc.;
- Palpate the abdomen (liver, spleen) to detect lumps or tenderness;
- Perform a cardiac auscultation to detect sounds, abnormal murmurs;
- Examine the lower limbs for pain, oedema, heat, varicose veins.

Perform a gynaecological examination of the patient:

- Explain the purpose of the examination to the woman;
- Ensure that the bladder and rectum are empty;
- Help the woman to place herself in the gynaecological position;
- Wash hands with soap and dry them with a clean, individual towel or air-dry;
- Wear gloves that are sterile or have undergone high-level disinfection;
- Inspect the external genitalia for lesions (scratches, scars from female genital mutilation, etc.) or discharge;
- If possible, perform a speculum examination to detect cervico-vaginal redness, discharge or ulceration;
- Place the speculum in decontaminating solution;

- Perform a bimanual examination to assess the condition of the cervix, appendages and uterus;
- Perform a digital rectal examination if necessary (to assess the condition of the uterus, appendages and parameters)
- Soak gloved hands in decontaminating solution;
- Remove gloves and place them in decontaminating solution;
- Wash hands with soap;
- Help the patient to get up and get dressed;
- Inform the patient of the results of the examination;
- Record examination results in registers, operational files and medical records;
- Request additional tests if necessary;
- Prescribe tetanus vaccine as a preventive measure;
- Prescribe curative treatment or make a referral if necessary;
- Book the next appointment, stressing the importance of keeping the appointment;
- Inform the patient that she should return to the centre whenever necessary;
- Thank the patient, see her out and say goodbye;
- Make a referral in complicated cases.

Treatment of complications by different entities

44. Treatment will depend on the entity involved, staff qualifications and the equipment available. The complications concerned are set out below.

Haemorrhage

45. This is a relatively substantial loss of blood following female genital mutilation.

46. The signs/symptoms are:

- Bleeding;
- Signs of severity: cold sweat, thirst, loss of consciousness, shock.

Treatment of haemorrhage by different entities

Entity	*Action to be taken*	*Persons responsible*
Village/community	Reassure the patient Provide counselling Make an emergency referral	Traditional birth attendants, practitioners of female genital mutilation, liaison officers
Health posts	Non-severe cases: Ensure haemostasis by compression or by application of a haemostatic, or suture if necessary Give analgesic (paracetamol) and antibiotics (amoxicillin) according to weight and age Place an intravenous catheter and secure it	Midwives, State-qualified nurses, matrons

Entity	*Action to be taken*	*Persons responsible*
	Check vaccination status; administer anti-tetanus serum and/or tetanus vaccine if necessary	
	Check blood pressure and pulse	
	If there is an improvement:	
	Continue treatment and counselling	
	If there is no improvement (signs of severity develop):	
	Same treatment as for non-severe haemorrhage and:	
	Inform relatives of the need for referral	
	Notify the referral facility	
	Fill in a referral form	
	Make an emergency referral (arrange medical escort)	
Hospital medical centres	Same as for health posts and:	Doctors, midwives, State-qualified nurses
	Administer lactated Ringer's solution	
	Determine blood group/rhesus factor, perform complete blood count	
	Give analgesic (paracetamol morning, noon and night) and antibiotics (amoxicillin)	
	Provide specific counselling for the discontinuation of female genital mutilation	
Hospitals	Same as for hospital medical centres	Doctors, midwives, State-qualified nurses

Shock

47. Shock is a condition in which systolic blood pressure falls below 80 mm Hg, with or without impaired consciousness of varying degrees.

48. The signs/symptoms are:

- Rapid, weak pulse (heart rate 110 beats per minute or higher);
- Low blood pressure (systolic less than 80 mm Hg);
- Pallor (especially inside the eyelids, on palms of hands or around the mouth);
- Sweating, rapid breathing (30 or more breaths per minute), anxiety, confusion or loss of consciousness.

49. The emergency steps are:

- Quickly place an intravenous line and secure it;
- Request blood – same blood group, same rhesus factor;
- Begin aetiological treatment at the same time as cardiovascular resuscitation.

Treatment of shock by entity

Entity	*Action to be taken*	*Persons responsible*
Village/community	Reassure the patient Make an emergency referral	Traditional birth attendants, practitioners of female genital mutilation, community liaison officers
Health posts	Have the patient lie supine in the Trendelenburg position Place an intravenous catheter with isotonic saline or lactated Ringer's solution and secure it Ensure haemostasis: apply haemostatic ointment and suture if necessary Administer anti-tetanus serum and tetanus vaccine if the patient is not vaccinated Monitor pulse and blood pressure If there is no improvement: Inform relatives of the need for referral Advise relatives to arrange for money and blood donors Inform the referral facility Fill in a referral form Make an emergency referral (arrange medical escort)	Midwives, State-qualified nurses, matrons
Hospital medical centres	Same as for health posts and: Give oxygen Determine blood group/rhesus, perform complete blood count Give a transfusion if necessary – same blood group, same rhesus factor Re-examine the wound and ensure haemostasis if necessary Give analgesic (paracetamol) and antibiotics (amoxicillin) Provide counselling	Doctors, midwives, State-qualified nurses
Hospitals	Same as for hospital medical centres	Doctors, midwives, State-qualified nurses

Infections

50. These are invasions of the mutilation site by microorganisms of various kinds.

51. The signs/symptoms are:

- Fever, shivers
- Local redness and pain
- Pus discharge, etc.

Treatment of infections by entity

Entity	*Action to be taken*	*Persons responsible*
Village/community	Reassure the patient Provide counselling Provide guidance	Traditional birth attendants, practitioners of female genital mutilation, community liaison officers
Health posts	Reassure the patient Perform an examination Apply a local treatment with a mild antiseptic (gynaecological Betadine) Give oral antibiotics (amoxicillin) in appropriate dosage for seven days Give tetanus serovaccination depending on vaccination status Provide counselling If there is no improvement: Inform relatives of the need for referral Advise relatives to arrange for money Inform the referral entity Make a referral	Midwives, State-qualified nurses, matrons
Hospital medical centres	Same as for health posts and: Request additional tests Provide aetiological treatment If there is no improvement: Make an emergency referral	Doctors, midwives, State-qualified nurses
Hospitals	Same as for hospital medical centres and: Take a pus sample + perform an antibiotic susceptibility test Provide treatment	Doctors, midwives, State-qualified nurses

Acute urinary retention

52. Total urinary retention or acute urinary retention is the complete inability to urinate despite the bladder being full.

53. The signs/symptoms are:

- Distended bladder, easy to detect on clinical observation

Treatment of acute urinary retention by entity

Entity	*Action to be taken*	*Persons responsible*
Village/community	Reassure the patient Provide counselling Provide guidance	Traditional birth attendants, practitioners of female genital mutilation, community liaison officers
Health posts	Use aseptic techniques Insert an indwelling catheter Give oral antibiotics (amoxicillin) in appropriate dosage for seven days Provide counselling If it is impossible to insert a catheter or if there is no improvement: Make a referral	Midwives, State-qualified nurses, matrons
Hospital medical centres	Same as for health posts and: Insert a suprapubic catheter Perform cytobacteriological examination of urine plus antibiotic susceptibility test Make a referral	Doctors, midwives, State-qualified nurses
Hospitals	Same as for hospital medical centres and: Request a specialized urology consultation	Doctors, midwives, State-qualified nurses

E. Care for pregnant women

During prenatal consultations

54. It is important to examine pregnant women who have undergone excision in order to determine the type of female genital mutilation and the size of the vulvar orifice. This examination helps to identify possible complications during childbirth and thus to determine the appropriate course of action.

55. Such an examination is only possible after a positive initial encounter and by establishing an environment of trust. Observations must be carefully recorded in the patient's file to avoid repeat examinations. (Note: Counselling may be necessary to discuss with the woman the type of excision and the effects on her health and that of the baby. At this point a conversation may also be held with the husband).

56. For women who have been infibulated with an opening that does not allow for a vaginal examination, disinfibulation before delivery may be advisable. The best time for disinfibulation appears to be between weeks 20 and 28 of gestation. This procedure is not recommended during the first trimester in order to avoid exposure to anaesthetic agents. This also prevents the procedure from being viewed as the cause should a miscarriage take place. Disinfibulation during pregnancy must be performed under the best possible conditions by professionals who are experts in the field. Some women may prefer to wait until childbirth, so that "everything can be done at once".

57. It is recommended to speak to the woman, and possibly her partner, about the issue of disinfibulation during these consultations (see section titled “During the post-partum period” below).

During childbirth

58. Upon admission, the type of genital mutilation and the vaginal opening should be assessed and the conditions of delivery discussed as appropriate if this has not previously been done during the course of the pregnancy.

Women at first childbirth

59. For women who have undergone infibulation or who have a vaginal opening that prevents examination of any kind, it may be advisable to make an anterior incision under local anaesthesia at the scar site at the start of labour in order to enable a manual exam and assess the progress of labour.

60. In cases where a manual vaginal exam is possible, the anterior incision should be made during expulsion. Once the head is visible at the perineum, an anterior incision is made, protecting the urethra. If this is not sufficient, and a tear seems imminent, a posterolateral episiotomy is also performed, but only after the anterior incision.

Multiparous women

61. Once the head is visible at the perineum, an assessment is made as to whether an anterior incision is necessary.

62. Note that the degree of elasticity of the scar tissue varies greatly in each woman and requires individual assessment. Every woman and every fetus must be monitored very closely in order to ensure early detection of fetal or maternal distress.

63. While the first delivery in a primiparous woman who has been infibulated (type III) always requires an anterior incision and a posterolateral episiotomy as needed, some multiparous women, on the other hand, may not require an incision. In addition, a controlled expulsion of the head must be performed, and the perineum must be protected during expulsion. A posterolateral episiotomy alone, as usually performed, is not appropriate, as the anterior scar tissue may tear. If necessary, a posterolateral episiotomy should only be performed after the anterior incision.

During the post-partum period

After the Caesarean section

64. If the patient asks to be disinfibulated: both exposed edges should be sutured with an absorbable suture to reconstitute the labia majora (see technique below). Some patients, including those who are completely infibulated, may no longer have their labia minora but may still have an intact clitoris. The couple and/or the patient should be informed of the physiological changes that will occur after disinfibulation, affecting urination, menstruation and sexual activity.

65. When women attend prenatal consultations, it is recommended that the matter be discussed right away, to the extent possible, rather than waiting until the last moment. Indeed, it is difficult to address these issues calmly immediately after the birth. The doctor or midwife will simply proceed with repairing the scar tissue that has split. The benefits of disinfibulation for sexual activity, urine flow and menstruation should be explained to the couple and/or the woman.

Disinfibulation technique

(a) Preparation

Unless childbirth is imminent, time must be devoted to explaining what disinfibulation involves. Anatomical illustrations of a normal vulva and an infibulated vulva may be shown (e.g. *The Universal Childbirth Picture Book* and other materials). The benefits of disinfibulation should be explained, as well as the changes it will bring about in urination, menstruation and sexual activity.

(b) Type of anaesthesia (depends on when it is administered):

- During pregnancy (in the second trimester): A short general anaesthetic or spinal anaesthesia is preferred to avoid the risk of causing psychological trauma resulting from flashbacks of infibulation performed during childhood;
- During labour: Epidural analgesia;
- At the time of expulsion: Epidural analgesia or local anaesthesia.

Table showing recent data on early marriage and other forms of violence against women and girls

Indicators	*National*	*Urban*	*Rural*
Early marriage			
Age at first marriage for women			
10–14 years (percentage)	3.3	2.1	8.8
15–17 years (percentage)	10.0	8.2	18.1
Aged 18 or older (percentage)	86.7	89.7	73.2
Average age at first marriage (years)	23.2	23.5	21.3
Violence against women (aged 15–64 years)			
Spousal physical abuse at any time (percentage)	7.9	7.6	9.2
Spousal physical abuse in past 12 months (percentage)	4.6	3.9	7.6
Physical violence at any time, single, never married (percentage)	6.1	6.4	2.3
Spousal sexual abuse at any time (percentage)	5.3	4.8	7.4
Spousal sexual abuse in previous 12 months (percentage)	3.5	2.9	6.1
Sexual abuse at any time, single, never married (percentage)	0.6		
Spousal emotional abuse at any time (percentage)	9.4	9.4	9.4
Spousal emotional abuse in previous 12 months (percentage)	4.7	4.6	5.1
Controlling behaviour by husband/partner at any time (percentage)	31.0	33.8	18.6

III. Participation in political and public life

66. The increase in the legislated gender quota between 2002 and 2018 (from 10 per cent to 25 per cent) had an effect on the proportion of women in elected and appointed bodies at various levels.

67. Between 2011 and 2017, the number of elected positions held by women in parliament increased from 9 to 17 (13 per cent to 26 per cent) and included a vice-chair and chairs of standing committees such as the Commission on Laws and Human Rights. The same applies to regions and municipalities (from 10 per cent to 29 per cent). There has been a slight increase in appointed positions (from 21 per cent to 22 per cent), which is more nuanced when broken down by position level.

68. The presence of women in senior political positions (ministers, ambassadors or members of the Constitutional Council) has fallen (from 14 per cent to 9 per cent), but has risen in senior administrative positions (from 23 per cent to 25 per cent).

69. Six of the 24 members of the current Government are women (25.07 per cent), which is a record for the country. The increase in the number of women managers speaks for itself (from 20 per cent to 32 per cent).

70. Out of 24 ministers 6 are women (25 per cent); out of 65 members of Parliament 17 are women (26 per cent); 4 secretaries-general of ministries are women; out of 6 members of the Constitutional Council 2 are women; out of 9 members of the National Commission on Communication 5 are women; out of 10 members of the Supreme Court 7 are women; and there are 14 women on the Court of Appeals.

71. With regard to decentralization, the proportion of women elected in the last two regional and communal elections (held in 2012 and 2017) has also increased, from 10 per cent in 2006 (11 of 103) to 29 per cent in 2012 (48 of 168); the proportion remained stable in 2017 (56 of 194, or 28.8 per cent).

72. In terms of women's representation at the international level, as in the civil service, women account for only a quarter of the senior managerial staff of the Ministry of Foreign Affairs. Only 24.59 per cent of the senior staff of the Ministry of Foreign Affairs are women. The distribution of senior managerial staff of the central administration of the Ministry of Foreign Affairs is approaching parity, while the distribution of staff in the field is not.

73. In diplomatic missions abroad, the situation has improved when compared with 2013. In 2016, the first woman ambassador to Kenya was appointed, serving until 2018.

74. In addition, another woman has held the position of Ambassador Extraordinary and Plenipotentiary of the Republic of Djibouti to the Swiss Confederation since 2016. She is also Permanent Representative to the United Nations Office, the World Trade Organization and other specialized agencies based in Geneva.

IV. Education

A. Causes of school dropout among girls

75. Girls face many barriers to education, including the following:

- Sociocultural factors;
- Family poverty;
- Remoteness of facilities;
- Violence in schools;
- Child marriage and early pregnancy;
- Emergencies.

76. The Ministry of Education has been working hard for over a decade to remove these obstacles, including through the following:

- Construction of new schools and school extensions to combat girls' isolation and school dropout;
- Addition of school canteens providing two hot meals in all regions and localities;

- Distribution of free school textbooks in the regions and localities;
- Free uniforms;
- Establishment of a gender office at the Ministry;
- Combating gender-based violence in schools (through a survey and awareness-raising);
- Combating school dropout (through a survey and awareness-raising).

B. Literacy programme

National literacy programme – participation, obstacles and success

77. The goal of the programme is to propose ways and means to identify possible improvements to ensure quality literacy education that will ensure the achievement of its objectives, namely the Millennium Development Goals.

78. The national literacy programme is in its fifth year of operation, and the component funded by the Ministry for Women and the Family is in its fourth year. The national literacy programme is currently considered to be a priority for the country that should be supported by both public authorities and international partners. Literacy is considered to be a fundamental human right.

79. In fact, it has been proven that illiteracy is not only a feature of developing countries and that even in developed countries that have achieved universal school enrolment, it is not uncommon to find a certain level of illiteracy among young people and adults, which is a contributing factor to their marginalization and social exclusion.

80. The national literacy programme seems positive overall but it still faces difficulties commonly associated with attendance at and completion of the three-year literacy course. While annual enrolment is highly satisfactory, the fact remains that the number of students fluctuates just as much enrolment does. Students miss class and then return, resulting in a somewhat fragmented literacy that is detrimental to both the learner and the teacher. However, most permanent withdrawals occur after a year's attendance which can be considered somewhat reassuring because, after a year of classes, an individual will presumably have acquired a basic knowledge of reading, writing and arithmetic.

81. Approximate class sizes are established at the start of each new school year at between 20 and 25 enrolled students. However, the latest figures show that the annual dropout rate remains high at around 55 per cent.

82. That statistic raises the question of what is hindering attendance at and completion of the three-year literacy course, despite the efforts made.

83. An analysis of the answers collected from women during visits to the literacy centres in the city of Djibouti and in the regions showed that most were related to social insecurity. Many women and men indicate that they cannot always attend class, including because of their living conditions. They are mostly women who work in the informal sector and in the main run small businesses selling such things as flatbread, bread or khat.

84. Another reason given by a large majority of the students interviewed is connected with the lack of motivation at the end of the programme. In other words, students wonder what they can expect at the end of the course. Such expectations might include financing for an income-generating activity or an employment opportunity. In other words, the hope of some form of social integration.

85. Despite all these factors underlying the persistent high dropout rate, the national literacy programme remains a reliable social measure whose continuation is a moral obligation for both public authorities and all development partners. The latest statistics show that, despite recurrent dropout and a high completion rate, the national literacy programme is meeting its commitments, as may be seen from the table below.

86. Although achieving the Millennium Development Goals requires sacrifice, their realization requires a commitment on the part of everyone. It is both necessary and essentially imperative to ensure the continuation of the national literacy programme by incorporating the expectations of its women students to provide them with reliable upward social mobility and to avoid any marginalization that could widen the social gap even further.

Literacy students who have contacted the programme since 2019

	Level 1	*Level 2*	*Level 3*	*Total*
City of Djibouti	1 371	545	358	2 274
Balbala	1 637	664	434	2 735
Arta	452	471	181	1 104
Dikhil	1 287	511	336	2 134
Ali-Sabieh	635	377	322	1 334
Tadjourah	727	361	307	1 395
Obock	399	312	230	941
Total	**6 508**	**3 241**	**2 168**	**11 917**

V. Employment

A. Occupational segregation in the labour market

87. Occupational segregation in the labour market is prohibited in Djibouti. Article 3 of Act No. 133/AN/05/5 L concerning the Labour Code stipulates that employers may not take gender into account in hiring decisions.

88. The article reads as follows: “Subject to explicit provisions of this Code or of any other law or regulation protecting women, children and young people, as well as provisions relating to the status of aliens, an employee’s sex, age, race, colour, social origin, nationality or national extraction, membership or non-membership of a trade union, or opinions, particularly religious and political opinions, shall not be taken into account by any employer in making decisions relating in particular to recruitment, conduct, distribution of work, vocational training, advancement, promotion, remuneration and other conditions of employment, the granting of social benefits, disciplinary matters or the termination of employment contracts.”

89. Also, article 15 of Act No. 48/AN/83/1 L of 26 June 1983 concerning the general status of civil servants, under title 2 on recruitment, states:

“No one may be appointed to or employed in a public position:

- Unless of Djiboutian nationality;
- If deprived of his or her civil rights and not of good character;
- If not in compliance with the laws on army recruitment;

- If not physically fit to perform the function and not found to be free of tuberculosis, cancer, any nervous condition, leprosy or poliomyelitis, or definitively cured of such condition. The conditions for application of this provision are established pursuant to a decree issued by the Council of Ministers;
- If he or she does not hold the qualifications or degrees required by the special status."

B. Principle of equal pay for work of equal value

90. The principle of equal pay for work of equal value is recognized in the labour regulations of Djibouti. Article 137 of the Labour Code stipulates that "for work of equal value, all workers shall receive equal pay".

91. Article 137 stipulates: "For work of equal value, all workers shall receive equal pay, regardless of origin, sex, age, status or religion, under the conditions set forth in this Code."

92. It also provides that collective bargaining agreements may not amend the methods by which the principle of "equal pay for work of equal value" shall be applied.

93. Article 259, paragraph 4, of Act No. 221/AN/17/8 L amending and supplementing Act No. 133/AN/05/5 L of 28 January 2006 concerning the Labour Code provides that "collective bargaining agreements may not amend the provisions of this Code concerning the methods by which the principle of 'equal pay for work of equal value' shall be applied, regardless of the origin, sex or age of the worker".

94. The salaries of Government civil servants are index-linked and those of Government contractual employees are set by category, taking into account the employee's degrees and qualifications, not the employee's origin, sex or age.

C. Sexual and moral harassment in the workplace

95. With regard to sexual and moral harassment in the workplace, article 4 of Act No. 221/AN/17/8 L amending and supplementing Act No. 133/AN/05/5 L of 28 January 2006 concerning the Labour Code prohibits sexual harassment in the workplace and encourages victims to file complaints against offenders. Article 4 ter states that "sexual harassment in the workplace is the act of subjecting an individual, repeatedly, to comments or behaviour with sexual connotations that either undermine that individual's dignity owing to their degrading or humiliating nature, or create a situation that is intimidating, hostile or offensive to the individual". Sexual harassment includes any form of serious pressure, even if not repeated, with the real or apparent aim of obtaining an act of a sexual nature, whether the act is sought for the benefit of the perpetrator or a third party. The perpetrator may be a colleague, superior or subordinate of the victimized employee. Employers shall adopt all necessary measures to prevent, put an end to and punish acts of sexual harassment in their workplace. Any employee who engages in acts of sexual harassment is liable to disciplinary action. Article 4 provides that "when a dispute arises concerning the application of articles 4 bis and 4 ter, the employee shall present evidence of the existence of harassment". In the light of that evidence, the onus is on the defendant to prove that the acts do not constitute harassment and that they are explained by objective factors unrelated to harassment. The judge renders his opinion after ordering, if necessary, any investigative measures he deems useful.

96. The perpetrators of moral or sexual harassment in the workplace shall be punished with a fine of from one million francs (FD 1,000,000) to two million francs (FD 2,000,000) and one month's imprisonment and, in the event of a repeat offence, two months' imprisonment and double the fine, or only one of these two penalties, in accordance with the provisions of article 290 k of Act No. 221/AN/17/8 L amending and supplementing Act No. 133/AN/05/5 L of 28 January 2006 concerning the Labour Code.

D. Child labour

97. Child labour is prohibited in Djibouti and the minimum age for employment is 16.

98. Article 5 of the Labour Code stipulates: "The minimum age for employment is set at 16."

99. Article 108 of the Labour Code states: "In accordance with article 5 of the Code, child labour is prohibited in the Republic of Djibouti. For the purposes of this Code, 'young people' means workers aged between 16 and 18."

VI. Health

100. Maternal and neonatal health is considered a national priority because it affects a vulnerable population, contributes to sustainable human development and is a prerequisite for achieving the Sustainable Development Goals, to which the Republic of Djibouti is committed. In support of that priority, the health sector strategy of the Ministry of Health was redefined through the development of the national health development plan for 2020–2024. This plan was designed to address all the maternal and neonatal health challenges with a view to accelerating progress towards universal health coverage and the Goals related to maternal and neonatal health. To consolidate achievements in maternal and neonatal health, and to build on the recommendations and strategic priorities of the plan, the Ministry of Health developed a national strategy for accelerating the reduction of maternal and neonatal mortality for the period 2022–2026. This strategy was developed through a participatory and inclusive planning approach involving health sector stakeholders and partners at every level.

101. The key achievements of the Ministry of Health in 2022 and 2023 were:

- Launch of the national strategy for accelerating the reduction of maternal and neonatal mortality for the period 2022–2026;
- Development of the hospital management project;
- Survey on reproductive health commodity security (UNFPA);
- Project to upgrade polyclinics and deliver health care (UNFPA);
- Establishment of the first University Hospital of Djibouti;
- Training of health-care providers (doctors, midwives, matrons, etc.) (World Health Organization (WHO)/UNFPA);
- Production of updated practice guidelines based on WHO guidelines and tailored to Djibouti (2022);
- Provision of technical support and coaching to four referral hospitals in implementing the new guidelines on maternal and neonatal health;

- Production of informational materials on the prenatal care programme for eight contacts;
- Adaptation and adoption of the new WHO programme;
- Implementation of the recommendation on good practices in obstetric and neonatal care and the introduction of clinical audits to improve obstetric practice in hospitals (UNFPA);
- Adoption of the list of essential medicines for maternal and neonatal health (UNFPA).

102. *Adolescent health*. Adolescents have access to health-care services, but there are no specific adolescent health programmes, for example, to prevent pregnancy and abortion.

103. *Abortion*. Djibouti is one of the countries where abortion remains illegal unless the woman's life or health is at risk or there are serious malformations of the fetus that make it not viable.

104. If the life or health of the pregnant woman is at risk, an abortion is authorized to save her.

105. If there are severe malformations of the fetus that make it not viable (anencephaly, hydrocephalus), an abortion is performed.

106. In cases of rape, the victim is given the morning-after pill within 72 hours, and abortion remains illegal.

107. In cases of incest, court authorization is required for an abortion, but no cases of incest have been reported in our hospitals thus far.

108. *Family planning*. In Djibouti, family planning services are available to all women, whether married or not. Modern short- and long-term contraception methods are available. Irreversible methods such as forced sterilization are not provided in Djibouti.

109. The Ministry of Health has organized campaigns to raise awareness of prenatal examinations, vaccinations and malnutrition. With regard to family planning, community liaison officers and women from associations sometimes hold awareness-raising sessions with the support of the department for the promotion of health or the National Union of Djiboutian Women.

HIV

110. The HIV epidemic in Djibouti seems to have a mixed profile, with a high prevalence of HIV among the general population, resulting in the epidemic being classified as generalized in the country. In 2022, the prevalence rate stood at 0.44 per cent [0.28–1.2 per cent], having steadily decreased since 2002, when the prevalence rate was twice as high (2.9 per cent) among people aged 15 to 49 years (Spectrum version 6.27, February 2023).

111. According to 2023 Spectrum modelling estimates, the number of people living with HIV was estimated at 4,438 [3,177–9,212] adults and children in 2022, with about 151 children aged 0 to 14 years (or 197 [109–287]).

112. Of the 4,438 people living with HIV in 2022, 2,310, or more than 50 per cent, were women. The prevalence rate was estimated at 0.5 per cent for women aged 15–49 years and 0.4 per cent for men in the same age bracket.

113. Antiretroviral treatments are available in health facilities for people living with HIV, whatever their age or sex.

114. Although there are no objective figures, people living with HIV and key populations face a significant amount of stigmatization and discrimination. Police violence and raids are also reported on the ground, sometimes even involving peer educators. The goal under the national strategic plan of reducing the number of people living with HIV who avoid services for fear of stigmatization and discrimination to less than 5 per cent by 2022 is far from being achieved.

115. The Stigma Index 2.0 study to measure indicators relating to stigmatization and discrimination, which was planned as part of the new national strategic plan, has not been carried out yet. Pursuant to the framework of non-negotiable conditions for the conduct of the study, and in order to uphold the principle of greater involvement of people living with or affected by HIV/AIDS and strengthen the community monitoring system, the Global Network of People Living with HIV/AIDS is the appropriate institution to carry out the study.

116. Several of the activities to combat stigmatization that were planned under the national strategic plan have not yet been carried out, including the drafting of a decree implementing the Act against Stigmatization and Discrimination, the development of a national strategy on human rights and HIV, the establishment of redress mechanisms, awareness-raising among key populations and people living with HIV of their rights, awareness-raising and training for partners, and the mobilization and engagement of the National Human Rights Commission.

117. In addition, the HIV response has not been evaluated from a gender perspective, and recommendations for the implementation of a transformative gender and HIV strategy tailored to the Djibouti context have not been produced. The commitment at the highest level and the national priority given to women's rights provide an opportunity to ensure a gender-sensitive HIV response.

VII. Economic empowerment of women

118. Since 2016, the Ministry for Women and the Family has been implementing the Economic Empowerment and Strengthening of Women's Communities initiative. Its main objective is to develop the skills of vulnerable women in the regions and suburban areas in order to facilitate their economic empowerment, by supporting them in establishing income-generating activities.

119. In 2018, a value chain strategy targeting four products was developed using a diagnostic study conducted by an international consultant from 7 January to 10 February. The aims of this strategy are to develop market access mechanisms and to increase commercial supply by stepping up production and building the capacity of women's associations.

120. The overall objective is to promote the value chains of the four targeted local products: honey/jam, milk, aloe vera and moringa.

121. Other products with a high development potential will be taken into account during the identification process. Technical assistance will be provided in the following areas:

- Analysing the profile of women's associations in production centres;
- Highlighting the strengths, weaknesses, opportunities and threats associated with each sector, as well as the main problems (specific and cross-cutting), and providing recommendations;
- Developing a value chain strategy for the four products;

- Defining operational strategies and subsequently holding a workshop involving the private sector and other stakeholders to discuss and approve the strategy;
- Developing technical assistance to provide support and assistance in the implementation of the chosen strategy.

122. To date, 29 associations benefiting from the programme have received technical training in crafts, agriculture and poultry farming from an international expert and national consultants.

123. A total of 14 associations have been provided with equipment relating to their field of activity (such as baskets and beads for craftswomen, and carts, buckets and hoses for women farmers).

124. In addition to these community-strengthening activities, the Ministry has supported 140 vulnerable families in establishing income-generating activities of their choice to enable them to become financially independent (e.g. running local shops, using sewing machines, or selling kitchen utensils, fruit and vegetables or clothing).

125. Furthermore, 25 widowed women from five inland regions received livestock on International Widow's Day in August 2018.

126. This project has strengthened the capacity of vulnerable women in the regions and suburban areas and has facilitated their economic and social integration.

127. The target beneficiaries are vulnerable women and girls from suburban and rural areas who belong to associations working in various fields, in particular crafts, agriculture and livestock breeding. This project will enable the associations to restructure as cooperatives.

128. The implementation of the value chain development strategy for the four products and their supply chains has supported the production of milk and cheese, market garden produce, moringa, hibiscus, fruit jam, improved traditional chickens and table eggs.

129. In 2020, a total of 13 cooperatives were established, including 5 cooperatives of rural craftswomen.

130. As part of national Djiboutian women's week, the Ministry, in collaboration with the National Union of Djiboutian Women, organized a wellness event at Douda beach for women with special needs.

131. This event presented an opportunity to provide kits for income-generating activities to 21 women with special needs, with a view to supporting the needs and improving the living conditions of these vulnerable women. The expected result is to enable these women to achieve greater economic autonomy through income-generating activities.

132. The Ministry for Women and the Family was approached by the Ministry of Commerce with a view to joining efforts towards better coordination and greater synergy in the promotion of crafts. The Ministry for Women and the Family was invited to participate in the establishment of an award for crafts and in the elaboration of the national strategy for crafts and the free trade area. The crafts sector, which mostly comprises women and girls in vulnerable situations, is a vehicle for promoting economic development and national heritage at the international level. Thus, in the context of the implementation of the free trade area, the Ministry for Women and the Family and the Ministry of Commerce decided to cooperate in:

- Developing products that could bring value for our country;
- Empowering women;

- Strengthening rural cooperatives;
- Helping women with marketing procedures;
- Addressing any obstacles to the inclusion of women in the free trade area.

VIII. Climate change and natural disasters

133. In 1992, many countries recognized the need for global climate governance with the adoption of the United Nations Framework Convention on Climate Change. This Convention lays the foundation for collaboration among all nations of the world to address concerns about the continuing degradation of the environment.

134. The report entitled “Our Common Future”, the founding document of the Rio summit, establishes the responsibility of the leadership of all signatory countries.

135. Other measures include the following:

- Constructing wells in rural areas affected by recurrent drought and desertification;
- Encouraging nomadic populations to convert to other activities;
- Building dykes to retain rainwater, as climate change is causing unpredictable rainfall in Djibouti, as the occurrence of both droughts and devastating floods is on the rise;
- Restoring mangrove forests in Tadjourah and in Djibouti Regions to protect the ecosystem;
- Training local communities to protect themselves against the harmful effects of climate change;
- Reforesting regions affected by drought and coastal areas;
- Improving the social integration of drought-affected women in villages in inland regions;
- Encouraging women to engage in income-generating activities;
- Developing ecotourism by helping nomadic women to showcase their skills in making cultural objects that can be sold to tourists.

136. The National Gender Policy 2023–2030 of the Ministry for Women and the Family addresses both gender and climate change. For example, strategic direction No. 3 is aimed at combating vulnerability and building resilience by developing the capacity and skills of communities in relation to sustainable environmental management, climate change and humanitarian disasters and emergencies. Its priorities are:

- Building resilience and adaptability to climate hazards and natural disasters by strengthening both human capacities and the ecosystem;
- Integrating climate change measures into national and regional development policies, strategies and programmes;
- Increasing the involvement of civil society in efforts to combat climate change.