# WHO contribution in Djibouti

## Executive summary


World Health Organization

*Photo caption: Two health workers make public announcements on a megaphone in Djibouti City for the national polio vaccination campaign conducted by the Ministry of Health, UNICEF and WHO in October 2022.*

*WHO/DGO/EVL/2025.37*

*Photo credit: WHO*

# Executive summary

## Context

The Evaluation of the WHO contribution at the country level in Djibouti was requested by WHO Djibouti Country Office (WCO) and jointly commissioned by the WHO Evaluation Office and the WHO Regional Office for the Eastern Mediterranean (EMRO). This evaluation took place at a time when Djibouti was undergoing rapid transition, embarking on new processes of support to the Djibouti Ministry of Health (MoH) in the current context. Thanks to its economic development progress[1], Djibouti is soon expected to join the upper middle-income countries (UMIC) group. Despite a positive economic and security situation, a challenge for Djibouti outlined in the country's Vision 2035 is to ensure that economic growth translates into tangible benefits for all sections of the population. Despite the progress, Djibouti is not on track to meet health-related sustainable development goals. As compared to other countries in the region, it performs worse on good health and well-being indicators such as maternal mortality ratio (244 deaths per 100 000 live births in Djibouti in 2019 versus 179 in EMRO) or infant mortality rate (at 46 deaths per 1 000 live births in 2021 compared to 36 in EMRO).[2]

## Purpose and scope

The main purpose of this formative and summative evaluation of the WHO contribution in Djibouti is to account for results and draw lessons learned, with a view to inform future strategic direction of WHO in the country and the region. The evaluation covers all development and humanitarian interventions undertaken by three levels of WHO (Country Office, Regional Office and headquarters) in the last three biennia (2019 – 2023).

## Object

The object of the evaluation is WHO contributions at the country level in Djibouti. While WHO has been present in Djibouti over the past 50 years, the country does not currently have a country cooperation strategy (CCS), the last one covering the 2013–2016 period. WHO is part of the UN Country Team (UNCT) and works under the UN Sustainable Development Cooperation Framework (UNSDCF) 2022–2024.

The total budget of Djibouti in the period 2019–2023 was US$20 471 610 for activities and US$6 743 395 for staff, equivalent to eight full-time positions. Key priorities for the country between 2019 and 2023 have been on enabling it to develop and implement universal health coverage (UHC) and primary health care (PHC) strategies, and supporting the emergency response context. Another component of WHO work in the past four years has been responding to the COVID-19 crisis and supporting surveillance and infection prevention, response, and preparedness systems.

## Methods

[1] See Complete Report, Official PDF (https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099610404122328480/idu006ae3bbb01fb604e370935903b59bdbeab28, accessed 27 January 2024).
[2] WHO, Global Health Observatory (https://www.who.int/data/gho, accessed 24 November 2023).

The evaluation team used a theory-based approach, by reconstructing a theory of change to test assumptions and pathways to expected results. The theory of change was discussed with the WHO country team at the end of the country mission and a revised version was produced on this basis. The evaluation adopts a gender equality and health equity lens in its process and content and has considered aspects of human rights and disability inclusion to the extent possible. The evaluation team used mixed methods in responding to evaluation questions. Data sources include a review of over 60 documents and quantitative databases, individual key informant interviews with 67 respondents and three group discussions with seven UNCT representatives, 12 female community mobilizers and five members of an association protecting minorities' rights. The evaluation team conducted a one-week field visit in Djibouti. The evaluation sought to consult with all relevant categories of WHO stakeholders at the three levels: the Government of Djibouti; UN and other multilateral and funding agencies; and civil society, health services providers and users. A majority of respondents were men (63%). Most of the persons consulted were based in Djibouti, but interviews were also conducted remotely with stakeholders outside the country.

## Key findings

*Photo credit: WHO*

**Relevance: WHO interventions objectives and design have responded to Djibouti's health priorities and the population's health needs based on health system outcome indicators.** WHO has focussed on addressing health equity issues by addressing geographical barriers to health care and ensuring the inclusion of migrant and refugee populations in health interventions. However, gender, disability inclusion and human rights have not been systematically integrated in WHO's interventions' design.

WHO's interventions have focused on providing technical assistance and capacity development to specific programme areas, including the essential programme on immunization, maternal and neo-natal health, HIV, tuberculosis (TB) and malaria, noncommunicable diseases and mental health, whereas health system-level issues would benefit from increased support. These include strengthening the leadership and regulatory authority of the Ministry of Health (MoH) over all actors in the health system, ensuring availability of a package of essential services at primary care level, supporting the institutionalization of a community health worker system, and addressing health issues in the subregion of the Horn of Africa, for example, in relation to health care for migrant populations.

**Coherence: The internal and external coherence of WHO's interventions in Djibouti has been mixed.** The biannual Joint Government/WHO Programme Review Mission (JPRM), Djibouti's main planning document, was based on a strong consultative process with the MoH. The JPRM has also been structured alongside WHO Thirteenth General Programme of Work (GPW 13) results framework and is aligned to

the UNSDCF health priority areas. However, the absence of a valid country cooperation strategy (CCS and of biannual country support plans (CSP) outlining the contribution of the three levels of the Organization hampers internal coherence and effective prioritization of WHO support in the medium and long term. A factor hindering coordination and external coherence between WHO and health partners interventions is the absence of operational plans and budgets to implement the *Plan National de Développement de la Santé* (PNDS), which would guide the positioning of partners on priorities defined by the MoH. As a result, coordination with health sector partners beyond the United Nations (UN) sector is weak. In addition, the lack of a functional government-led coordination platform for health agencies has hindered the ability of WHO and other agencies to support the MoH in a complementary way. Despite efforts by WHO, civil society participation in health governance has been weak, and WHO has not engaged significantly with networks of service users. WHO engagement in multisectoral health responses, for example on noncommunicable diseases (NCDs) and antimicrobial resistance, has been limited.

**Effectiveness: The extent to which WHO interventions achieved expected results has varied overtime, with a renewed dynamic in the current biennium (2022 – 2023).** Factors such as the COVID-19 pandemic, the instability in the relationship with the MoH and the position of the WHO representative being vacant for some time, have hindered the capacity of the Organization to deliver planned interventions. WHO interventions have mostly focused on outputs relating to improved access to quality essential health services under the UHC pillar, and on responding to emergencies such as that with COVID-19 under the health emergencies pillar. Outputs under the healthier populations pillar have generally not been achieved, in part due to the lack of capacity at the MoH level to coordinate multisectoral work on health determinants and NCD risk factors. Given implementation difficulties, in particular during the biennia 2018–2019 and 2020–2021, WHO progress on achieving outputs has been mixed. As most activities have been implemented since 2022, the lack of recent data on health-system outcomes hinders the identification of the WHO contribution to outcome-level changes. There is robust evidence, however, of WHO contributions to positive outcomes on reproductive, maternal, newborn and child health (RMNCH) services, COVID-19 vaccination coverage and surveillance data completeness. WHO contribution to health equity has focused on improving access to care for migrant populations and reducing geographical barriers to accessing care through promoting community health service mechanisms in the regions. In particular, WHO contributed to a successful integrated outreach project with the United Nations Children's Fund (UNICEF) and MoH on vaccination, antenatal care and nutrition. However, the scale of these interventions has been limited, and other WHO interventions have generally not focused on promoting gender equality, health equity and the right to health for different marginalized groups.

**Efficiency: WHO capacity to deliver results in an economic and timely way has varied.** WHO was able to reallocate its resources rapidly to respond to health emergencies, such as the COVID-19 pandemic. There were instances, however, where WHO interventions have not been efficient. WHO has often engaged in funding direct implementation in Djibouti, a departure from its usual mandate in non-emergency contexts. The current efforts to recruit national staff have proven useful in facilitating relationships with counterparts and thus progressing on the implementation of planned WHO interventions. However, over-reliance of consultants has impacted WHO efficiency, hindering the continuity of technical support to the MoH and the follow-up of planned activities. The new WHO organogram has yet to be implemented, with delays in recruiting positions due to slow internal human resources processes at EMRO level. In terms of results-based management systems, monitoring of WHO outputs and outcome results in Djibouti has been weak. In particular, the corporate output scorecard (OSC) system, which

relies on self-assessment by the WHO country office (WCO), is not well reported against. While the EMRO key performance indicators provide more detail on the programme, they focus on technical areas and less on cross-cutting health system strengthening areas. The use of monitoring data to guide programmatic decisions has been limited. Whereas programs are well integrated at the WCO level, programmatic silos at the regional office (RO) level and requests from the RO sometimes hamper the ability of the WCO to focus on agreed priorities. Support from WHO headquarters has been limited to filling gaps in technical capacity in response to WCO requests and has not caused similar issues.

**Sustainability: WHO contribution to the resilience of the health system and responsiveness to external shocks has been limited, hindering the sustainability of WHO efforts on health system strengthening.** The health system remains fragile and fragmented, as large para-public service providers do not fall under the MoH. The public health sector is highly dependent on donor funding; however, the support from major donors is expected to decrease over the coming years. There are expectations from funding partners and the MoH that WHO will increase its work on sustainable health sector financing.


*Photo credit: WHO*

# Conclusions

### Conclusion 1

**Relevance: WHO interventions have generally been highly relevant to the country's health needs.** However, priorities have not always been based on evidence of health system and health outcome results. WHO interventions have not been guided by an analysis of the situation of vulnerable groups in the country. The focus on providing technical assistance to disease-based programmes at the expense of a health system approach for PHC has hindered the full realization of the contribution of the Organization to the UHC agenda. WHO in Djibouti is at a time of strong opportunities to redefine its role and refocus its efforts strategically, in the context of developing ambitions of the country to join the World Bank's upper middle-income countries (UMIC) group and play an increased role regionally as well as in several strategic planning processes taking place in the country. The evaluation identifies several areas for WHO to add value and capitalize on its role to strengthen the health system.

### Conclusion 2

**Coherence: WHO has been well aligned and complementary to other health partners in Djibouti; however, internal and external coherence of WHO work has been hampered by the lack of a valid CCS, the lack of operational plans and budgets to implement the Plan National de Développement de la Santé (PNDS), and the lack of a coordination platform for health actors in Djibouti.** The absence of a valid CCS and of a related biannual CSP outlining the contribution of the three levels of WHO hampers effective prioritization of interventions. Crucially, a future WHO strategy needs to address the bottlenecks to the effective implementation of the PNDS. There are examples of successful collaborations for WHO within the UNCT; however, coordination with major health partners outside the UNCT has been limited by the lack of a functional, formal platform under the leadership of the MoH. A new positioning of WHO on those issues would require a shift in the type of work that WHO has been delivering, as the Organization has not displayed the leadership and convening roles that form part of its mandate to a great extent. It would also require addressing the perception of those partners who consider WHO as a small donor agency. Despite efforts, WHO has had limited success in promoting a whole-of-society, whole-of-government approach to health sector governance and securing the participation of all relevant multisectoral stakeholders.

### Conclusion 3

**Effectiveness: While WHO clearly contributed to improve health system outcomes in maternal and neonatal services, TB treatment and health information availability, overall, the implementation of planned interventions by WHO has been limited.** Between 2018–2021 WHO's planned interventions experienced delays as human and financial resources were primarily redirected to respond to emergencies and outbreaks. Furthermore, the effectiveness of WHO's contributions in Djibouti were limited by the WHO representative's turnover and the relationship with the MoH. Nevertheless, WHO support of the national government emergency response to COVID-19 was effective. There were few interventions on emergency preparedness and on the healthier population pillar as compared to what was planned in the JPRM. Beyond interventions addressing the lack of community health services to reduce barriers to accessing health care, WHO work in Djibouti has not systematically integrated gender equality, health equity analysis and the rights of different marginalized groups.

### Conclusion 4

**Efficiency: Overall, a large share of resources was dedicated to direct implementation, which may not have been the most efficient use of resources in the context of Djibouti. Resources are also insufficient to deliver on WHO's objectives.** While WHO's responsiveness to MoH needs and emerging requests has been positive, especially in health emergencies, there is a need to strike a balance between flexibility and maintaining strategic positioning on agreed priorities. Human resources in the WCO are not adequate to deliver on the ambitions of the Organization due to slow recruitment processes. Enhanced staffing levels would allow the WCO to take on additional responsibilities, including on its convening and health leadership roles, on health system strengthening and on engagement with regional initiatives. Monitoring data currently does not reflect the work conducted by the WCO, nor is it used sufficiently to guide programming. While crucial in many technical areas, support from the RO is not always timely and aligned to country priorities.

### Conclusion 5

**Sustainability: WHO contribution to a more resilient health system has been limited and emergency preparedness remains weak.** Overall, government investment in the public health system has been fragmented between different service provision schemes. Investment in the programmes managed by the MoH has been low, leaving them vulnerable in case of a reduction in external support. There is a




*Photo credit: WHO / Zeinab Ismail*

need for reforms and regulations to reduce fragmentation, as well as supporting sustainable financing of the health sector alongside planning a transition to increased domestic funding and national ownership of the health agenda.

## Recommendations

### Recommendation 1

In the next five years WHO, WCO and EMRO should prioritize health system strengthening interventions and develop a PHC approach as the overarching framework under which to implement programme-specific work. This involves strengthening the health system, focusing on areas where health indicators are lagging behind, advocating for a health sector reform based on the harmonization of the health system to deliver a package of essential services, supporting the institutionalization of community health services and ensuring that barriers to accessing health care for different sections of the population are analysed and addressed.

### Recommendation 2

**WHO future interventions should systematically address barriers to accessing health care and determinants of health,** in particular through supporting the development of community-based health services, as well as an emergency preparedness plan detailing the roles and responsibilities of different public and para-public health actors, documenting and analysing different factors affecting health inequalities and strengthening the capacity of the health system to respond to them, and investing more resources to deliver interventions under the healthier populations pillar.

### Recommendation 3

**By March 2024 refine the reconstructed theory of change (Toc), as a basis to develop an evidence-based, theory of change-based CCS and related CSP.** The ToC should reflect the strategic priorities on health system strengthening, primary health care approach and addressing health-care barriers (see recommendation 2). The CCS should be based on a situational analysis of health barriers and outcomes and translate the GPW 13 results framework in specific targets for Djibouti. These should be aligned to the PNDS and outline the WHO contribution to the national targets as well as to the UN common objectives. This CCS should be accompanied by a biannual CSP, replacing the JPRM, outlining the expected contribution of the three levels of the Organization in Djibouti.

### Recommendation 4

**WHO at country and regional levels should support the MoH in strengthening its leadership and coordination role**, by providing ongoing technical assistance to the operationalization of the PNDS, supporting its review and the development process of the new PNDS, improving coordination of health sector actors by revitalizing the *Groupe des Partenaires Santé* (GPS), as well as activating existing global donor coordination mechanisms at the country level.

### Recommendation 5

**WHO should improve its effectiveness by supporting a whole-of-society, whole of government approach**, through seeking avenues to broaden participation of civil society and community actors in the health sector and enabling the MoH to coordinate multisectoral work on areas requiring collaboration between different ministries.

### Recommendation 6

**Strengthen efficiency of WHO through improved allocation of financial resources, human resources and management systems**, by urgently implementing a new WCO organogram filling the administrative and technical capacity gaps to support the new ambitions of WHO in Djibouti, ensuring that the new CCS is accompanied by a monitoring framework that outlines indicator baseline and target values for Djibouti, and improving quality of data reporting and use of monitoring data. At EMRO level, WHO should support the WCO through a country-focused, streamlined approach.

### Recommendation 7

**Ensure that the CCS is accompanied by a monitoring framework that outlines indicator baseline and target values for Djibouti, in line with the global results framework and the regional key performance indicator (KPI) framework.** This would also require improving the quality of data reporting and use of monitoring data to focus interventions.

### Recommendation 8

**Together with other development partners, WHO should actively support the government on health sector reform,** through strengthening the leadership, coordination role and regulatory power of the MoH over all actors engaged in the provision of health services and supporting the development and implementation of a health sector financing strategy.

Any enquiries about this evaluation should be addressed to:
Evaluation Office, World Health Organization
Email: evaluation@who.int
Website: Evaluation (who.int)