WHO contribution in Djibouti

Evaluation report

World Health Organization

WHO contribution in Djibouti: evaluation report
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Cover page photo caption: Two health workers visit local communities door-to-door in Djibouti City for the national polio vaccination campaign conducted by the Djibouti Ministry of Health, UNICEF and WHO in October 2022.
Credit: WHO / Zeinab Ismail

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Acronyms

AFD Agence Française de Développement
AIDS Acquired immunodeficiency syndrome
AMO *Assurance maladie obligatoire*
AMR Antimicrobial resistance
ANC Antenatal care
ART Antiretroviral treatment
ARV Antiretroviral
CAMME *Centrale d'Achats de Matériels et Médicaments Essentiels*
CCA Common country analysis
CCS Country cooperation strategy
CERF UN Central Emergency Response Funds
CHW Community health worker
CNSS Caisse Nationale de Sécurité Sociale
CO Country office
COVID-19 Coronavirus disease 2019
CSO Civil society organization
CSP Country support plan
CSU Country support unit
DAC OECD Development Assistance Committee
DDI Division of Data, Analytics and Delivery for Impact
DEPSI *Direction Étude et Planification, Coopération Internationale*
DHIS2 Health Data Information Management System
DG *Direction Générale*
DIS *Direction de l'Information Sanitaire*
DMPLIP *Direction des Médicaments, de la pharmacie, des laboratoires et de l'Industrie pharmaceutique*
DTP3 Diphtheria tetanus toxoid and pertussis
EQ Evaluation question
EML List of essential medicines
EPI Essential Programme on Immunization
ERG Evaluation reference group
FAO UN Food and Agriculture Organization
FGD Focus group discussion
FGM/C Female genital cutting/mutilation
GAVI GAVI Vaccine Alliance
GER Gender, equity and rights
GFTAM The Global Fund to Fight AIDS, Tuberculosis and Malaria
GHO Global Health Observatory
GPEI Global Polio Eradication Initiative
GPS *Groupe des Partenaires Santé*
GPW 13 Thirteenth General Programme of Work
GSM Global management system
HEARTS Technical package for cardiovascular disease management in primary health care
HIV Human immunodeficiency virus
HPOP Healthier populations
IAEA International Atomic Energy Agency
IBBS Integrated biological and behavioural assessment
IGAD Intergovernmental Authority on Development
IHP+ International Health Partnership and related initiatives
IHR International health regulations (2005)
ILO International Labour Organization
INSPD *Institut National de Santé Publique de Djibouti*
IOM International Organization for Migration
IPC Integrated food security phase classification
ITN Insecticide-treated bed net
JPRM Joint Government/WHO Programme Review Mission
KII Key informant interview
KPI Key performance indicator
LMICs Low- and middle-income countries
mhGAP Mental health global action programme
MNCH Maternal, neonatal and child health
MNH Maternal and neonatal health
M&E Monitoring and evaluation
NCD Noncommunicable diseases
NTD Neglected tropical diseases
ODA Official Development Assistance
OECD Organisation for Economic Cooperation and Development
OSC Output scorecard
PASS Programme d'assistance sociale santé
PEN WHO Package of Essential Noncommunicable Disease Interventions
PHC Primary health care
PNDS *Plan National de Développement de la Santé*
RMNCH Reproductive, maternal, newborn and child health
RO Regional office
SARA Service availability and readiness assessment
SCAPE Strategic Plan for Economic and Social Development
SDG Sustainable development goals
SSA Surveillance system for attacks on health care
TB Tuberculosis
ToR Terms of reference
UHC Universal health coverage
UMIC Upper middle-income country
UN United Nations
UNAIDS Joint United Nations Programme on HIV and AIDS
UNCT United Nations Country Team
UNDAF United Nations Development Assistance Framework
UNDP United Nations Development Programme
UNEG United Nations Evaluation Group
UNHCR United Nations High Commissioner for Refugees
UNICEF United Nations Children's Fund
UNSDCF United Nations Sustainable Development Cooperation Framework
US$ United States dollar
WCO WHO Country Office
WFP World Food Programme
WR WHO representative

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. 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 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 WHO Regional Office for the Eastern Mediterranean) or infant mortality rate (at 46 deaths per 1 000 live births in 2021 compared to 36 in WHO Regional Office for the Eastern Mediterranean).[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 WCO 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.

[1] Djibouti | Data (worldbank.org)
[2] WHO, Global Health Observatory (https://www.who.int/data/gho, accessed 24 November 2023).

Methods

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 (42 male and 25 female) 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. Most of the persons consulted were based in Djibouti, but interviews were also conducted remotely with stakeholders outside the country.

Key findings

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 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 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 Ministry of Health. 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 Ministry of Health. 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 Ministry of Health in a complementary way. Despite efforts by WHO, civil socie *Photo credit: WHO / Zeinab Ismail; Visit of High Chinese Delegation, WHO Djibouti Office - February 2023*
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 last biennium (2022 – 2023). Factors such as the COVID-19 pandemic, the instability in the relationship with the Ministry of Health 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 Ministry of Health 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 Ministry of Health 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 Ministry of Health 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 WHO Regional Office for the Eastern Mediterranean 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 WHO Regional Office for the Eastern Mediterranean 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 Ministry of Health. 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 Ministry of Health that WHO will increase its work on sustainable health sector financing.

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 Ministry of Health. 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 Ministry of Health. 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 Ministry of Health 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 Ministry of Health has been low, leaving them vulnerable in case of a reduction in external support. There is a 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 WHO Regional Office for the Eastern Mediterranean 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 Ministry of Health 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 Ministry of Health 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. At WHO Regional Office for the Eastern Mediterranean 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 Ministry of Health over all actors engaged in the provision of health services and supporting the development and implementation of a health sector financing strategy.

1. Introduction

1.1 Background and context

The evaluation of WHO contributions in Djibouti was requested by WHO Djibouti and jointly commissioned by the WHO Evaluation Office and the WHO Regional Office for the Eastern Mediterranean.

This evaluation took place at a time when the WCO was undergoing rapid transition, embarking on new processes of support to the Djibouti Ministry of Health in the current context. Planning processes are underway, such as the review and development of the National Development Plan (2020 – 2024); the revision of the current PNDS in preparation for the next plan for the period 2020–2024, and the revision and development of the UNSDCF (2022 – 2024). Hence, a key focus of the evaluation was to inform WHO's planning and strategic direction going forward.

As of 2023, the Republic of Djibouti had an estimated population of 1.1 million inhabitants[3] for an area of 23 200 km2, being the smallest country in the Middle East and North Africa region. Since independence, it has been a pole of stability in the Horn of Africa where neighbouring countries have faced insecurity and political instability. Djibouti has experienced a strong economic growth, with an estimated 7% annual GDP growth rate between 2015 and 2019. While the COVID-19 pandemic considerably affected this, it is expected that from 2022 Djibouti will have about regained pre-pandemic growth rates.[4] Economic activities are linked to port infrastructure developments and the logistics hub as part of the maritime trade routes passing by the Aden Gulf, the dividends from the five foreign military bases hosted by the country and the communications sector. Given the economic progress of the country, Djibouti is soon expected to join the UMIC group.

Despite the positive economic and security situation of the country, several challenges affect the health and well-being of the population. Climate change engenders high food insecurity and extreme poverty for rural and nomadic populations in the regions outside the capital city. There is a significant rural–urban migration to Djibouti Capital City and its suburbs, which gather 70% of the country's population.

Djibouti is not on track to meet the third Sustainable Development Goal (SDG3) on health and well-being, with most reported indicators showing insufficient progress to meet the 2030 targets, as shown in Table 1 below. Some indicators are faring worse than the regional average (on maternal mortality rate, infant mortality rate and aged under 5 years mortality rate), and are worsening on certain trends, such as on malaria and TB incidence.

Table 1. Progress on SDG3 targets

SDG target	Djibouti	WHO Regional Office for the Eastern Mediterranean
Reducing maternal mortality ratio to 70 per 100 000 by 2030	244 per 100 000 (2019)	179 per 100 000 (2019)
Reducing infant mortality rate to 12 per 1000 live births by 2030	45.85 per 1000 (2021)	36 per 1 000 (2021)
Reducing aged under 5 years mortality rate to 25 per 1000 live births by 2030	54 per 1000 (2021)	45 per 1 000 (2021)
Ending the epidemics of AIDS, TB and malaria by 2030	Malaria incidence raised from 19 per 1000 in 2017 to 70.5 in 2021.	11.6 per 1 000 (2021)
	Prevalence of HIV among adults has decreased from 1.2% in 2018 to 0.7% in 2021[5]	<0.1% (2021)

[3] State of World Population report 2023. https://www.unfpa.org/sites/default/files/swop23/SWOP2023-ENGLISH-230329-web.pdf
[4] Common Country Analysis (2021) Equipe Pays des Nations Unies à Djibouti https://minio.uninfo.org/uninfo-production-main/d00b7e7f-fe9d-43b6-a6cc-45b71c803b7d_Djibouti_CCA_official_janvier_2022_final.pdf
[5] DHIS 2 data, quoted in IBBS survey protocol 2023

	Prevalence of TB has increased from 195 per 100 000 population in 2020 to 240 in 2022.	112 per 100 000 (2021)
By 2030, reduce by one third premature mortality from NCDs and promote mental health and wellbeing	Probability of dying from the four main NCDs was estimated at 22% in 2019, mostly stable from 22.25% in 2016.	24.5% (2019)
Achieve UHC, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	UHC service coverage index declined from 45 to 44 between 2017 and 2021. However, the longer-term trend in Djibouti is positive, with UHC service coverage increasing from 33 to 44 between 2000 and 2021.	57 (2021)

Source: WHO Global Health Observatory

A challenge outlined in the country's Vision 2035[6] is to ensure that the country's economic growth translates into tangible benefits for all sections of the population, and that health inequities are reduced. In this respect, the situation of different marginalized and vulnerable groups in Djibouti must be considered. At the heart of a region marred with political instability, Djibouti is home to approximately 35 000 refugees and asylum seekers[7] as well as "*populations flottantes*" including displaced populations and migrants, estimated at 150,000,[8] transiting from Ethiopia to Saudi Arabia through the desert region of Obock. Djibouti has been welcoming to refugees and is a signatory to the United Nations High Commissioner for Refugees (UNHCR) Comprehensive Refugee Response Framework and the UN Global Compact for migration. It has also welcomed refugees from Yemen and Somalia in past years.

Other populations to consider in line with "leaving no-one behind" principles, according to the 2022 UN common country analysis (CCA) include:

a. Children in rural areas, who are particularly affected by high rates of malnutrition: 42.3% of children in rural areas aged under five years are stunted.[9]
b. Women and girls: Data on women's economic activity show that women's participation in the labour market is much lower than that of men (32% compared to 59% for men) and so is access to formal education for girls (38.2% compared to 64.5% for boys), constituting an obstacle to their economic integration.[10] Lower access to economic resources may affect access to health-care services, although data on health services access disaggregated by sex is not available. In addition, Djibouti counts high rates of maternal mortality (244 per 100 000 live births in 2019) and of female genital mutilation, at 93.1% in 2006.[11]
c. People living with a disability: Up-to-date data on people with a disability is not available. The CCA identifies issues of discrimination and barriers to inclusion for people with disabilities in the education system, access to employment and participation in decision-making processes that concern them.
d. People living with HIV: According to the Joint United Nations Programme on HIV and AIDS (UNAIDS),[12] there were about 6 700 people living with HIV in Djibouti in 2019, and under 30% of those were accessing antiretroviral (ARV) treatment.

The Government of Djibouti is promoting efforts to strengthen the health system, social security access and improve health services. However, the Djibouti Vision 2035 identifies the following challenges for the health sector: poor operational health infrastructures, lacking equipment and ambulances; weak water and electricity supply; and difficult access of rural populations to urban centres due to the poor transport infrastructure. According to the CCA, drugs supply is insufficient, community pharmacy stocks are not regularly renewed, and private pharmacies are not widely available in the regions. Lack of sanitation in major towns also affects health. Government financing of the health system is low, at 4.3% of general government expenditure in 2020.

Several policy and institutional bottlenecks affect the realization of UHC. Firstly, the health system is fragmented, as para-public health services and budgets do not fall under the authority of the Ministry of Health. The Ministry of Labour oversees the *Caisse Nationale de Sécurité Sociale* (CNSS), whereas the Ministry of Interior oversees the para-public service providers that cater for the

[6] Djibouti 2035 Vision
[7] UNHCR Country Office at https://www.unhcr.org/countries/djibouti
[8] IOM Migration Trends Dashboard. December 2022 https://dtm.iom.int/sites/g/files/tmzbdl1461/files/reports/12.%20DJI_FM_Dec22_Dashboard_EN.pdf
[9] Ibid
[10] World Bank, « Résultats de la quatrième enquête djiboutienne auprès des ménages pour les indicateurs sociaux (EDAM4-IS) » (2017).
[11] WHO. Global Health Observatory. https://www.who.int/data/gho
[12] AIDSInfo, https://aidsinfo.unaids.org/

army, gendarmerie, police and coast guard personnel and their families. Secondly, the Ministry of Health -regulated public health system is highly centralized and little decision power is devolved at regional level. Thirdly, there is no institutionalized community health system linked to primary care facilities.

1.2 Object of the evaluation

The object of the evaluation is the WHO contribution at the country level in Djibouti. The WCO does not currently have a CCS, as the last CCS covered the 2013–2016 period. WHO is part of the UNCT, and its set of interventions are included under the Health, Nutrition and WASH, and the protection of vulnerable groups domains within the UNSDCF).

WHO priorities in Djibouti between 2019 and 2023 have focused on health system strengthening, the emergency response context and health promotion, including responding to the COVID-19 crisis and supporting surveillance and infection prevention, response and preparedness systems. Key priorities guiding WHO interventions in the period 2018–2023 are presented in Table 2 below.

Table 2. WHO priorities in Djibouti under GPW 13 pillars 2018-2023

GPW 13 pillar	Key interventions in Djibouti
UHC	• Strengthen health system including disease control programmes, in particular Essential Programme on Immunization (EPI) and malaria. • Develop and implement strategies for Reproductive, Maternal, Neonatal and Child Health (RMNCH), as well as adolescent health, including introduction of new vaccines. • Develop NCDs and mental health psychosocial support strategies and action plans. • Evaluate the burden of neglected tropical diseases (NTD) and support leishmaniasis interventions. • Updating of the national essential medicines list (EML).
Health Emergencies	• Support the development of a one-health strategy, including antimicrobial resistance (AMR) through collaboration with the UN Food and Agriculture Organization (FAO). • Provide technical assistance and capacity support for the olio outbreak response, including campaign and surveillance strengthening. • Develop case management of medical complication of severe acute malnutrition and integrated surveillance systems within the food insecurity/nutrition crisis response. • COVID-19 pandemic: strengthen infection prevention and control; laboratories and diagnostics; case management and therapeutics; vaccination; risk communication, community engagement and health data management; surveillance, outbreak investigation contact tracing; and essential health services and systems.
Healthier Populations	• Support to the development of emergency care, including trauma care, as part of future development of a road safety policy. • Develop the first protocol for occupational health and security together with the International Labour Organization (ILO). • Health promotion interventions, including the campaign Healthy Djibouti City, and reinforcing the Health Promotion Department at the Ministry of Health.
WHO enabling functions	• Comprehensive review of the health information system needs.

Source: WHO Djibouti JPRM

1.3 Budget

The total budget of the WCO in the period 2018–2023 was US$20 471 610 for activities and US$6 743 395 for staff, representing eight equivalent full-time positions. Table 3 below shows the biannual budget breakdown by category of interventions. BASE categories include four WHO core areas of mandate: UHC, health emergencies, healthier populations and WHO enabling functions. Emergencies refer to both COVID-19 and non-COVID-19 emergencies. Polio category comprises funds supporting polio eradication strategies. Major donors during the 2020–2021 and 2022–2023 programme budget periods include GAVI Alliance, Germany, Italy, UN Central Emergency Response Funds (CERF), East Africa Community, Bill & Melinda Gates Foundation, United States of America, Azerbaijan, Rotary International, United Kingdom of Great Britain and Northern Ireland, and National Philanthropic Trust.

Table 3. WHO country office funding information.

Programme budget	2018-2019			2020-2012			2022-2023		
Category	**Planned costs**	**Funds received**	**Utilization**	**Planned costs**	**Funds received**	**Utilization**	**Planned costs**	**Funds received**	**Utilization**
BASE	5,022,865	3,982,300	3,948,296	4,622,924	4,049,275	3,656,626	7,253,675	6,907,984	4,939,240
Emergencies	850,533	850,533	821,457	5,297,075	5140755	4,344,473	3500933	3,413,543	3,223,244
Non PB	337,000	287,000	189,286	180,000	180,000	178,977	150,000	150,000	28,016
Total	**6,210,398**	**5,119,833**	**4,959,039**	**10,099,999**	**9,370,030**	**8,180,076**	**10,904,608**	**10,471,527**	**8,190,500**

Source: WHO Global Management System (GSM)a[13]

1.4 Monitoring and evaluation system

The WCO reports against GPW 13 outputs are linked to the global 12 outcomes through an Output Score Card.[14] The results-based monitoring system in Djibouti is thus linked to the WHO Thirteenth Global Programme of Work 2019-2023 (GPW 13) results framework[15] to reach the triple billion targets.[16] In addition, the WCO reports to WHO Regional Office for the Eastern Mediterranean on KPIs for each GPW 13 output that has been prioritized for the country. KPIs are scored according to a traffic light system, indicating the status of completion of output indicators from a 2019 baseline. Each indicator is accompanied by a narrative part describing the progress on implementing activities by WHO, results, challenges and next steps.

1.5 Evaluation users

[13] For the 2022–2023 biennium, utilization corresponds to the period up to third quarter of 2023. Numbers do not include the Global Polio Eradication Initiative budget.

[14] The Output Scorecard (OSC) is a methodology for measuring the WHO Secretariat's contributions to outcomes and impacts. Country Offices report on two scorecards, one on technical areas and another on enabling functions. The technical OSC covers six dimensions: global public health goods, leadership, achievement of results, technical support, gender, equity and human rights, and value for money. The enabling functions OSC covers other six areas: strategic direction and leadership, achievement of results, accountability, client service delivery, gender, equity and human rights and value for money. The OSCs are scored against each of these dimensions through self-assessment by the WCO. More details can be found on the OSC at: https://www.who.int/publications/m/item/output-scorecard-2020-2021-mid-term-review

[15] See WHO. The Triple Billion targets. A visual summary of methods to deliver impact. https://www.who.int/data/stories/the-triple-billion-targets-a-visual-summary-of-methods-to-deliver-impact

[16] This uses a sub-set of 46 outcome indicators: 39 SDG indicators and seven Member State-approved indicators covering a range of key health topics.

The primary expected users of this report are the WHO Country Office (WCO) in Djibouti and the Djibouti Ministry of Health. Other WHO users include the WHO Regional Office for the Eastern Mediterranean focal points and management, WHO headquarters management, and WHO Executive Board. Secondary users include implementing partners, donors, other government stakeholders, members of the United Nations Country Team (UNCT) in Djibouti and other actors working in the health and development sector in Djibouti.

Photo credit: WHO
WHO Regional Director Dr Ahmed Al Mandhari visits Djibouti, March 2019

1.6 Purpose, objectives and scope of the evaluation

The main purposes of the evaluation are to enhance accountability for results, including identify critical strategic shifts/direction for the country office going forward, as well as strengthen organizational learning for informed decision-making processes and for the development of strategic documents such as UN Development Cooperation Framework (UNSDCF) and the new WHO Country Cooperation Strategy (CCS). The evaluation is both summative and formative. Summative aspects sought to achieve a better understanding of the types of results and achievements, both intended and unintended, stemming from WHO interventions. For the formative part, the evaluation identified lessons learned and priorities to inform the design and implementation of WHO interventions and strengthen WHO collaboration across the three levels of the Organization.

The evaluation objectives are to:

a. Assess achievements against the objectives formulated in country-level strategic instruments and corresponding expected results developed in the WCO biennial workplans.
b. Assess past successes, challenges and lessons learnt from WHO work.
c. Define strategic shifts needed to improve the strategic positioning of WHO going forward.
d. Assess communication and coordination approaches among the three levels of the Organisation and with in-country stakeholders.

The evaluation's scope covers all development and humanitarian interventions undertaken by WHO (WCO, RO and headquarters) throughout the country, as framed in the relevant strategic instruments (such as UNSDCF, United Nations Development Assistance Framework (UNDAF), and any relevant national policies), covering interventions which took place over the last three biennia (2019 – 2023). The evaluation scope does not cover the impact level contribution of WHO to health outcome results but focused on identifying health-system level changes.

2. Methodology

2.1 Evaluation criteria and questions

In line with the revised OECD Development Assistance Committee (DAC) criteria,[17] the evaluation was guided by five main evaluation questions and related 11 sub-questions focussing on assessing relevance, coherence, effectiveness, efficiency and sustainability of WHO interventions in Djibouti (see Annex 5 for full details). The main evaluation questions and sub-questions are:

1. Relevance: To what extent are WHO interventions and positioning relevant to the Djibouti context and the evolving needs and health rights of the Djibouti population, as well as country and regional partners and institutions' needs, policies and priorities, and continue to do so if circumstances change?

1.1 To what extent have WHO objectives and interventions responded to Djibouti's beneficiaries' needs and rights, including those of the most marginalized populations?

1.2 With Djibouti having the ambition of becoming a middle-income county (MIC), what should WCO Djibouti focus on in the coming years?

2. Coherence: To what extent are WHO interventions and positioning coherent and demonstrate synergies and consistence with one another as well as with interventions carried out by other partners and institutions in Djibouti?

2.1 To what extent are interventions aligned to country and regional partners' and institutions' policies and priorities as well as to WHO GPW 13 and other sector-specific policies?

2.2 What has been the effect of the sociopolitical and economic landscape in Djibouti on the health sector and how has this complemented or affected WHO role, including engagement with stakeholders? What adaptations, refinements and strategic shifts are needed to improve the strategic positioning of WHO going forward?

3. Effectiveness: To what extent were WHO results (including contributions at outcome and system levels) achieved or are likely to be achieved and what factors influenced (or not) their achievement?

3.1 To what extent were programme outputs delivered and did they contribute to: (a) progress toward the stated programme outcomes; and (b) the adoption and implementation by the national health system of interventions, programmes and services aimed at reducing the inequalities and exclusion, related to socioeconomic and environmental determinants of health?

3.2 What factors influenced their achievement or non-achievement, and to what extent has WHO demonstrated a reasonable contribution at the outcome or health system level?

3.3 What has been the added value of WHO regional and headquarters contributions to the achievement of results in Djibouti?

4. Efficiency: To what extent did WHO interventions deliver, or are likely to deliver results in an efficient and timely way?

4.1 To what extent do WHO interventions reflect efficient economic and operational utilization of resources, including in response to new and emerging health needs that require adjustment or re-prioritization of interventions?

4.2 To what extent are results-based management systems adequate to ensure efficient operational and timely allocation of resources and adequate measurement of results, including in changing circumstances?

5. Sustainability: To what extent has WHO contributed towards building national capacity and ownership for addressing Djibouti's humanitarian and development health needs and priorities?

5.1 To what extent has WHO supported Djibouti's national longer-term goals and a resilient, shock-responsive health system, including building national capacity in view of ongoing and future health needs?

5.2 To what extent have WHO interventions supported national ownership for health system strengthening, as well as national capacity to deliver on and achieve the results as planned in the relevant national health policies and strategies? Is there evidence that the benefits will be sustained over time?

[17] See the OECD DAC criteria at https://www.oecd.org/dac/evaluation/revised-evaluation-criteria-dec-2019.pdf.

2.2 Methodological framework: approach and methods

2.2.1 Approach

The evaluation utilized a theory-based approach. The evaluation team reconstructed a theory of change (ToC) model during the inception phase, which served as a touchstone for the evaluation of the contribution of WHO to expected results presented in evaluation question 3 above relating to the effectiveness criteria. This model was revised based on the evaluation findings to produce a forward-looking ToC that can be further developed to inform the future strategy of WHO in Djibouti. The process and outcome of the revised ToC are presented in Annex 4.

External quality assurance was be provided by the Regional Evaluation Officer in WHO Regional Office for the Eastern Mediterranean and the WHO Evaluation Office. The Evaluation Reference Group (ERG) provided a second line of external quality assurance to ensure that the evaluation products (inception report, draft report and final report) were of sufficient quality to maximize their usefulness to the programme and the Organization.

The ToC, comprising a graphic and a narrative part, is presented below in Box 1.

Box 1: Theory of change narrative

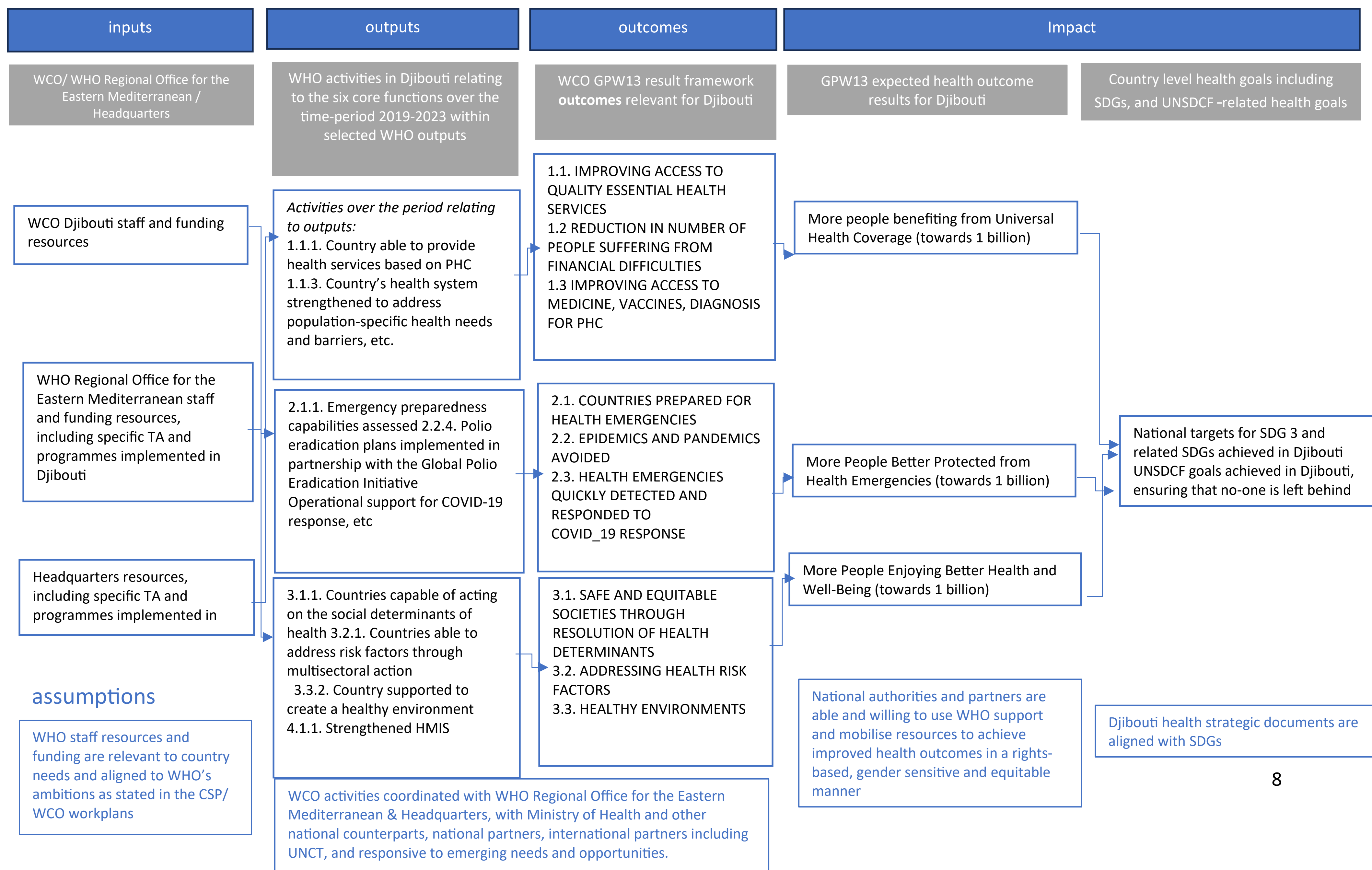
The ToC considers that *if* WHO at the three levels has had adequate human and financial resources, both technical and administrative/management capacity, and has been guided by adequate, well-aligned plans and strategy, *then* it has the capacity to implement its functions, such as playing a health leadership and advocacy role among development partners, providing technical assistance, mobilizing resources for health or monitoring and assessing health trends.

If WHO can perform those functions, *then* it would be able to deliver a series of outputs aligned to its expected immediate/output-level results. Those outputs are delivered in partnership with the Ministry of Health counterparts, UN agencies such as UNICEF and the Food and Agriculture Organization (FAO), as well as other implementing partners (UNCT, One Health and antimicrobial resistance (AMR). They include: strengthening the overall policy framework and Ministry of Health institutional capacity by supporting a health sector review and the development of the PNDS; the development of a national list of essential medicines (EML) and sector-specific strategies and programmes (in maternal and newborn health, nutrition, NTDs; mental health and psychosocial support); supporting emergencies response and preparedness and direct implementation to the COVID-19 response; and contributing to the polio response; as well as supporting health information capacity for disaster preparedness. Another leadership output for WHO is the coordination of the health and nutrition response in the UNCT.

If WHO will achieve those outputs, *then* it would be able to contribute to higher level changes, such as improved UHC through a focus on health systems strengthening, especially PHC and community health systems that reach the most vulnerable; improved health emergencies preparedness through rapid detection and response to epidemics and pandemics; improving health and well-being through addressing health determinants; reducing NCD risk factors through multisectoral responses, and implementing health promotion programmes. In addition, the health sector capacity will be strengthened through better surveillance and data management systems, improved governance and resources for health. Across those outcomes, it is expected that WHO will have contributed to improving gender equality, reducing health inequities and addressing human rights issues in health.

Those high-level changes are expected to translate into health impact level gains that would manifest through improved health outcomes/SDG indicators and health equity in line with GPW 13 goals and national health goals and SDGs (see Fig. 1 below). Those high-level changes are expected to translate into health impact level gains that would manifest through improved health outcomes/SDG indicators and health equity in line with GPW 13 goals and national health goals and SDGs.

Figure 1. Theory of change diagram developed at inception



2.2.2 Data collection

The evaluation relied on a cross-section of information sources from various stakeholder groups and used a mixed methodological approach to ensure triangulation of information in responding to the evaluation questions.

Documents review. Over 60 documents and published papers were reviewed for the evaluation, falling in the categories of WHO strategic and guidance documents, documentation from WHO at country level, national strategic and policy documents, reports and analysis produced by different partners in Djibouti, UNCT strategies and reports, and published papers. Documents were prepared by the WCO and WHO Regional Office for the Eastern Mediterranean for the purpose of the evaluation and additional documents were sourced or referred to by respondents during the evaluation. A complete list of the documents reviewed is included in Annex 3.

Quantitative indicator data. Data on health and health system-level indicators were extracted from several databases, including the WHO GHO, the UN SDG data portal and AIDSInfo.

Stakeholder interviews. The sampling of respondents was purposive, based on an analysis of stakeholders' specific interests in the evaluation and engagement with WHO interventions. A total of 67 individual respondents participated in individual interviews. Most of the interviews (86%) were conducted in Djibouti, while other interviews were conducted remotely with WHO headquarters, regional office respondents and partner agencies not based in Djibouti. The majority of respondents were men (42 men and 25 women). Individual interviews were conducted with the following respondents:

a. Twenty-one from WHO at the three levels, including staff responsible for the areas of programme management and monitoring and evaluation, country support, and specific technical areas such as polio, vaccination and PHC, as per WHO work in Djibouti.
b. Twenty-nine government officials, principally from the Ministry of Health but also from the Centrale d'Achats de Matériels et Médicaments Essentiels (CAMME), the CNSS and the Institut National de Santé Publique de Djibouti (INSPD). Officials included those from the Office of the Secretary General and staff from relevant health Directorates under the Secretary General's supervision.
c. Twelve multilateral and donors active in Djibouti from UN agencies, the Global Fund and GAVI.
d. In addition to those above, the director from a civil society organization providing services to diabetic children agreed to an individual interview.
e. Also, public health care providers, comprising Médecins chefs (4) in four regions, consented to individual interviews.

In addition to key informant interviews, the evaluation team conducted three group discussions with:

Seven representatives of UN agencies working in Djibouti to discuss WHO contribution to collective results of the UNCT.

a. Seven representatives of UN agencies working in Djibouti to discuss WHO contribution to collective results of the UNCT.
b. Twelve female community mobilizers from Djibouti metropolitan areas, who shared their experience of participating in outreach activities on maternal and child survival conducted by WHO and partners. The group discussion explored the lack of institutionalized community health services in Djibouti (see Introduction section).
c. Five men who have sex with men, members of the Association "*Autres Regards*" in Djibouti city, formerly supported by UNAIDS until the agency left Djibouti in 2022 and handed over its activities to WHO. Participants shared their experience in accessing health care services as a marginalized group.

Country mission During a one-week country visit, the evaluation team (Team Leader and National Consultant), in collaboration with WHO headquarters and WHO Regional Office for the Eastern Mediterranean Evaluation Managers, conducted in-person interviews and focus groups discussions as well as visiting a health facility. On the last day of the visit, a debrief session took place at the office of the Secretary General of the Ministry of Health to share emerging findings from the mission. A debriefing was also conducted with the WCO team, followed by a session on theory of change outlining how evaluators understood the WHO contribution to Djibouti, building on the ToC presented at inception and where initial adjustments were discussed for the WCO approach going forward. Following the country visit, the national consultant continued data collection in the country, with additional stakeholders referred to the evaluation team by respondents were discussed for WCO's approach going forward. Following the country visit, the national consultant continued data collection in the country, with additional stakeholders referred to the evaluation team by respondents.

2.2.3 Data analysis

Secondary data from the document review was compiled in an evaluation grid structured by evaluation questions. Interview material was analysed by stakeholders' categories, gender, and evaluation questions categories. Interviews and focus groups data were analysed and coded for themes and sub-themes, identifying any differences and convergences among different stakeholders' groups. Quantitative data was analysed for trends and comparison to regional averages. Where available, disaggregated data were presented.

Evaluation findings were drawn after triangulation of all information related to each evaluation question. Strength of evidence was assessed, based on availability of concurring quantitative and qualitative data from reliable sources and respondents' categories respectively. This information is presented in the report under Evaluation Question 3 on the effectiveness criteria, in relation to assessing the contribution of WHO to outcome results.

Based on the cross-checked evaluation findings, the team formulated answers to the evaluation questions. These answers informed the drafting of the conclusions and lessons learned identified during the evaluation.

Recommendations were made for future adjustments and actions. Each recommendation was based on the answers to evaluation questions and overall conclusions based on the evidence presented in the report.

2.2.4 Validation and finalization

Prior to the finalization of the evaluation report, several validation processes were considered.

a. A first validation process was conducted at the end of the field visit through the sharing and discussion of emerging findings with the WCO team and counterparts in the Ministry of Health.
b. Following the production of the draft evaluation report, a validation workshop was held with the Evaluation Reference Group (ERG)[18] on 23 November 2023. This virtual workshop involved participants from the three levels of WHO as well as external stakeholders, such as the Ministry of Health and the UN Resident Coordinator Office to assess the validity and accuracy of the evaluation findings and their relevance to the Djibouti context and programmes. Stakeholders were invited to help the evaluators identify, co-create and prioritize recommendations to maximize the relevance, usefulness and usability of the evaluation. The feedback on the draft report was then documented, including where any divergent views arose from the findings to inform the development of the final report.
c. After the production of the final report, the WHO representative will prepare the management response. Final recommendations and the way forward on those will be discussed at a high-level stakeholder meeting, attended by stakeholders from the government and other relevant actors to further ensure confirmation and uptake of findings.

2.3 Gender, equity and human rights issues

The evaluation adopted a gender equality and health equity lens in its process and content, and integrated cross-cutting issues of gender equality, health equity, human rights and disability inclusion to the extent possible. The evaluation adhered to the United Nations Evaluation Group (UNEG) and WHO guidance and policies relating to gender, disability inclusion, equity and human rights, such as UNEG Guidance on Integrating Human Rights and Gender Equality in evaluations,[19] UNEG Guidance on Integrating

[18] The ERG was established to ensure the evaluation's relevance, accuracy and utility through a consultation and validation process. The ERG included relevant staff from WHO Regional Office for the Eastern Mediterranean and Djibouti WHO Country Office; representatives from both the Government of Djibouti and Ministry of Health, implementing partners, and UN agencies in Djibouti. The ERG reviews the key deliverables (the TOR, inception report, the draft and final reports) of the evaluation including validation of the technical findings.

[19] WHO, Guidance on Integrating Human Rights and Gender Equality in evaluations, UNEG (2014) https://www.unevaluation.org/document/detail/1616

Disability Inclusion in Evaluations,[20] the WHO Policy and Strategy on Health Equity, Gender Equality and Human Rights, 2023–2030, the WHO Policy on Disability[21] and the Guidance note on integrating health equity, gender equality, disability inclusion and human rights in WHO evaluations.[22] This was done specifically through the following means:

a. The evaluation framework included specific questions relating to marginalized populations, health equity, determinants of health such as gender, disability and other factors of exclusion (migratory status, rural–urban, geographical location).
b. The inception interviews and initial document review assessed the evaluability of gender, health equity and human rights issues. This preliminary analysis showed that quantitative disaggregated data on health outcomes and health determinants was scant in Djibouti. Findings on gender, equity and human rights (GHER) relied primarily on qualitative data collected during the evaluation as well as secondary sources such as other organizations' evaluation reports.
c. The evaluation approach emphasized the participation of a wide range of stakeholders in data collection, attempting to provide diverse perspectives on the areas of focus for WHO in Djibouti to the extent possible. When selecting stakeholders for interviews, attention was paid to gender, geographical areas and factors of exclusion. Despite efforts made to ensure the participation of a maximum number of female participants, the gender distribution of respondents was largely skewed towards males: 63% of respondents were men and 37% were women. Although most of the respondents consulted were in Djibouti City, efforts were made to reach out to health providers in the regions, and four *Médecins chefs* were interviewed in four of the five regions of Djibouti. One interview was conducted with a representative from a civil society organization providing services to diabetic children with support of WHO. The evaluation team also met with a group of men who have sex with men, as described above.
d. The evaluation team was not able to meet with respondents from other health services user groups and marginalized groups, such as women and girls, migrants and people living with disabilities. Issues of barriers to access for different sections of the population, the "*populations flottantes*", were discussed, inter alia, with health providers in the regions.
e. Where available, quantitative and qualitative data on gender equality, health inequities and barriers to accessing health care for marginalized groups was analysed, paying specific attention to how these issues have been addressed at planning, implementation, monitoring and evaluation stages by WHO.

2.4 Limitations and mitigation strategies

The lack of a CCS outlining priorities and expected results for WHO in Djibouti has been a limitation for assessing the relevance and effectiveness of WHO work. This has been mitigated against by using other results' frameworks, such as the prioritization exercise of GPW 13 outcomes and outputs, and the WHO Regional Office for the Eastern Mediterranean KPI framework to develop a reconstructed ToC for the programme as a basis for the evaluation.

Another limitation is the absence of performance indicators, means of verification and targets (including baseline values) on WHO results at country level. While WHO programme budgets contain global output and outcome indicators, few targets are specified for Djibouti. The evaluation team relied largely on the WHO Regional Office for the Eastern Mediterranean KPI monitoring system, as well as financial data extracted from the Programme Budget web portal and the Global Management System (GSM) to obtain information on progress of implementation and results.

A risk identified at the inception stage was that the evaluators may not be able to consult with a sufficiently wide range of stakeholders to obtain a balanced perspective. It was noted that there may be limited opportunities to obtain first-hand information from the diversity of vulnerable and excluded groups given that civil society organizations and networks may not be

[20] WHO, Guidance on Integrating Disability Inclusion in Evaluations, UNEG (2022) https://www.un.org/sites/un2.un.org/files/2022/06/uneg_guidance_on_integrating_disability_inclusion_in_evaluation_0.pdf
[21] WHO, Policy on Disability, WHO (2021) https://iris.who.int/bitstream/handle/10665/341079/9789240020627-eng.pdf?sequence=1
[22] WHO, Guidance note on integrating health equity, gender equality, disability inclusion and human rights in WHO evaluations, WHO (2023) https://cdn.who.int/media/docs/default-source/evaluation-office/guidance-note-on-integrating-he-ge-di-and-hr-in-who-evalautions-final.pdf?sfvrsn=6d842306_3&download=true

present to provide a channel for these consultations. The evaluation attempted to mitigate this risk by pursuing every effort to secure a broad understanding and buy-in during the evaluation process by a range of governmental and non-governmental actors to open doors and gain access to existing organizations through a snowball approach. However, success on this has been mixed, as only one service user group was consulted as part of the evaluation.

2.5 Ethical considerations

Due diligence was given to effectively integrating good ethical practices and paying due attention to ethical considerations in accordance with the WHO Evaluation Practice Handbook[23] and the UNEG Ethical Guidelines for Evaluation.[24] The evaluation adhered to ethical considerations, including confidentiality and anonymity, do-no-harm approaches, use of the appropriate ethical protocols, gender and human rights consideration in the conduct of interviews and group discussions with respondents. When conducting key informant interviews, care was taken to ensure that the interviewees felt comfortable to express their opinions. Confidentiality and use of data were explained to the participants and interview notes were treated as confidential by the evaluation team. Verbal informed consent was collected at the outset of the interview. For the conduct of group discussions, participants were selected according to their affiliation: UNCT representatives; community mobilizers and service users' part of a marginalized group. At the beginning of the discussion, the context, purpose and process of the evaluation were clearly explained to the participants before seeking their verbal consent to participate in the discussion. Obtaining informed consent from participants involved explaining that their contributions would be on an anonymous basis and kept confidential, and that participants had the right to stop participating at any time during the discussion. Participants from community mobilizers and user groups categories were provided with transport reimbursement, as per WCO policy, and this was signed to confirm that they had received this.

[23] WHO, Evaluation Practice Handbook (2013) https://cdn.who.int/media/docs/default-source/evaluation-office/who-evaluation-practice-handbook-2013.pdf?sfvrsn=2513394e_3&download=true
[24] UNEG, Ethical guidelines for evaluation (2020) https://www.unevaluation.org/document/download/3625

3. Evaluation findings

RELEVANCE: To what extent are WHO interventions and positioning relevant to the Djibouti context and the evolving needs and health rights of the Djibouti population, and continue to do so if circumstances change?

The relevance section examines the extent to which WHO interventions and strategic positioning respond to Djibouti's health context, relevant national health population indicators and needs of the most marginalized populations. The section also explores the relevance of WHO interventions in relation to the political and economic situation, including Djibouti's plan to graduate to upper middle-income status. The section assesses the extent to which GEHR considerations are incorporated in WHO interventions.

Key findings

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.

Finding 1: WHO interventions have generally focused on areas of greater health needs, despite limited country-generated health data. WHO has actively supported routine vaccination, polio and measles outbreak surveillance and response, malaria prevention, RMNCH services capacity, response to acute severe child malnutrition, and the setting up of a mental health programme. However, certain priority areas have seen less interventions from WHO, such as emergency preparedness and NCD risk factors.

Finding 2: Analysing and addressing barriers to accessing health services have been insufficiently prioritized. Gender, disability inclusion, health equity and human rights have not been integrated in WHO interventions in a transversal manner.

Finding 3: The focus on disease-based programmes at the expense of a health system strengthening approach have hindered the full realization of the contribution of the Organization in the country.

Finding 4: Going forward, there are opportunities for redefining the strategic positioning of WHO in Djibouti, in the context of developing ambitions of Djibouti to join the World Bank's middle income countries group and play an increased role regionally.

Photo credit: WHO / Zeinab Ismail
Delivery of mobile clinics to the Ministry of Health Djibouti funded by Italy, March 2023

3.1 To what extent have WHO objectives and interventions responded to Djibouti's beneficiaries' needs and rights, including those of the most marginalized populations?

The main planning document for WHO in Djibouti is a biannual plan developed jointly by WHO and the Ministry of Health, namely the JPRM. Key intervention areas by WHO outlined in the JPRM are summarized in Table 2 in the Introduction section.

Assessing the relevance of WHO interventions to Djibouti's population health needs and rights, including those of the most marginalized populations, is challenging as WHO does not systematically produce situation analyses that include disaggregated data or studies that capture the situation of marginalized groups. This is compounded by the lack of nationally generated health data.[25] There is also a lack of disaggregated data and specific studies to capture the situation of marginalized groups.

The halting of population health surveys while the national census is underway has hampered recent progress on this. To overcome the lack of recent routine and administrative data, the evaluation team drew from an analysis of health outcome indicator trends and results for Djibouti based on GHO[26] data, which allows identifying relevant health areas requiring enhanced WHO focus. Table 4 below presents a descriptive analysis of trends in health outcome indicators in Djibouti in comparison to

[25] The last Demographic Health Survey took place in 2013 in Djibouti
[26] Global Health Observatory https://www.who.int/data/gho, accessed on 24/11/2023

other countries in the region (average values). According to this analysis, areas needing particular attention for being both lower performing than regional averages and worsening are health services coverage (UHC coverage index), malaria prevention (ITN use), immunization coverage (DTP3, measles, polio), health system and emergency preparedness capacity (captured in the IHR index composed of 13 indicators), and mental health (captured by the indicator on suicide attempts). Other areas perform lower than regional average although being on an improving trend. Those include maternal and newborn health (captured by indicators on family planning and antenatal care), ART coverage, certain NCD risk factors such as use of clean household fuels and alcohol use, and road traffic mortality and severe child malnutrition (indicators on wasting in children under 5 years old). Some areas perform better than regional average but are on a worsening trend. These include hospital bed density, NCDs and NCD risk factors indicators such as hypertension, diabetes, obesity (in adults and children) and ambient air quality. It is important to note, however, that the STEPwise survey has not yet been implemented in Djibouti, so data on NCD risk factors prevalence is limited to trend estimates. Lastly, some areas are performing better than regional average and are also improving, for example, care seeking for children with pneumonia, tuberculosis (TB) treatment and stunting in children aged under 5 years.

Table 4. Djibouti health outcome indicators trends and in relation to regional average values by the three billion pillars (2021)

	Latest value worse than regional average			**Latest value better than regional average**		
	Indicator	**Country value**	**Regional value**	**Indicator**	**Country value**	**Regional value**
Universal Health Coverage (UHC) pillar						
Negative or stagnating trend	UHC Coverage index	Declined from 45 to 44 between 2017 and 2021. However, the longer-term trend in Djibouti is positive, with a UHC service coverage having increased from 33 to 44 between 2000 and 2021.	57 (2021)	Hospital bed density	Hospital bed density decreased from 17.5 to 14 per 10 000 population between 2002 and 2017.	14 (2017)
	Insecticide-treated bed net (ITN) use	Population with access to an ITN for malaria protection (modelled) decreased from 30.8% to 10.4% between 2018 and 2021	30% (2021)	Hypertension	Age-standardized prevalence of hypertension among adults aged 30–79 years. Increased from 26.8% to 34.2% between 2015 and 2019	37.8% (2019)
	DTP3 immunization	Proportion of population covered by all vaccines included in national programmes (DTP3, MCV2, PCV3) declined from 85% to 59% between 2019 and 2021.	84% (2022)			
	IHR core capacity index	Decreased from 41 to 40 between 2021 and 2022	67 (2022)	Diabetes	Raised fasting blood glucose: 8.1% (2014), slightly increasing from 8% (2010)	13.7% (2014)
Positive trend	Family planning (modern methods)	Demand for family planning satisfied with modern methods increased from 47.40% to 48.90% between 2019 and 2020	62.25% (2022)	Care seeking for pneumonia	Care-seeking for children with symptoms of acute respiratory infection increased from 62% to 94.4% between 2002 and 2012	N/A
	4+ ANC visit	Proportion of women (aged 15-49 years) who received antenatal care 4+ times increased from 7.1% to 25.7% between 2002 and 2012	N/A	TB Treatment	80%, stable over 2019-2022. The Global Fund reports an increased number of people on treatment, from 1825 to 2151 between 2019 and 2022.	58% (2021)
	HIV ART	Adults and children currently receiving ARV therapy among all adults and children living with HIV estimates stable at 30%	55% (2020)			
Health emergencies protection pillar						
Negative or stagnating trend	Prepare (IHR)	Preparedness (IHR 2010-2017): decreased from 26 to 0 between 2014 and 2017	67 (2017)			

	Measles	Measles-containing-vaccine second dose (MCV2) immunization coverage by the nationally recommended age: decreased from 81% to 48% between 2019 and 2021	77% (2021)			
	Polio	Polio (Pol3) immunization coverage among 1-year-olds decreased from 85% to 59% between 2019 and 2021	83% (2021)			
Healthier populations pillar						
Negative or stagnating trend	Reduced suicide attempts	Suicide mortality rate per 100 000 population increased from 9.3 to 9.6 between 2016 and 2019	5.8 (2019)	Adults not obese	Age-standardized prevalence of obesity among adults increased from 12.9% to 13.5% between 2014 and 2016	20.8% (2016)
				Children not obese	Prevalence of obesity among children and adolescents: increased from 3.9% to 4.3% between 2014 and 2016	8.2% (2016)
				Ambient air quality	Annual mean concentrations of fine particulate matter (PM2.5) in urban areas (µg/m3): increased from 20 to 20.7 between 2014 and 2019	48 (2019)
Positive trend	Clean household fuels	Proportion of population with primary reliance on clean fuels and technology: increased from 9% to 10% between 2019 and 2021	74% (2021)	Children not stunted	Prevalence of stunting in children under 5, decreased from 21.5% to 18.7% between 2019 and 2022	25.1% (2022)
	Safe sanitation	Proportion of population using safely managed sanitation services: increased from 38.6% to 39.6% between 2018 and 2022	54.9% (2022)			
	Road safety	Road traffic mortality rate, (per 100 000): decreased from 27.3 to 23.5 between 2015 and 2019	17.8 (2019)			
	Reduced alcohol use	Total alcohol per capita (≥ 15 years of age) consumption of 1L (litres of pure alcohol) decreased from 0.65L to 0.4L between 2015 and 2019	0.3l (2019)			
	Children not wasted	Prevalence of wasting in children aged under 5 years decreased from 13.9% to 10.6% between 2013 and 2019	6.9% (2013-2022)			

a Unless stated otherwise, the source of data is the Global Health Observatory, available at https://www.who.int/data/gho

In general, available data from WHO interventions and respondents' perceptions indicate that WHO in Djibouti has been responsive to key and emerging health issues under the three billion pillars. Under the UHC pillar, WHO has supported campaigns for child vaccination, insecticide-treated bed net (ITN) distribution, the development of a national strategy outlining a RMNCH services package at primary care level, and the national NCD and mental health strategies development. Under the health emergencies protection pillar, WHO has rapidly mobilized and redirected resources to address measles outbreak or COVID-19. Under the healthier populations pillar, WHO has focused on developing severe acute malnutrition services in complement of activities by other agencies (UNICEF, FAO, WFP) on addressing the critical issue of child malnutrition. More details on WHO interventions and their contribution to health results are presented under evaluation question 3 on the effectiveness criteria. Respondents highlighted the contribution of WHO to the improvement of health services in Djibouti and in addressing emerging health needs. A UN respondent commented:

> *WHO is essential to try to maintain a minimum level of quality of services provided to the population because, currently, hospitals lack staff, skills and medicines. WHO is very responsive to emergencies, or when there are refugee movements. WHO has a good visibility with the Government, they are close to health centres in the regions, this helps to understand the needs.*

However, some areas that appear highly relevant based on available health indicators data have not been a major focus in WHO interventions. In particular, the interventions planned under the "prepare" outcome within the health emergency pillar, such as conducting a joint external evaluation to provide recommendations for improving the health preparedness status of the country, have not been implemented. Yet, Djibouti fares poorly on the International Health Regulations (IHR) core capacity index, with a score of 31 in 2019 compared to a 67 regional average in WHO Regional Office for the Eastern Mediterranean.[27] Similarly, most interventions planned on addressing NCD risk factors and environmental health under the healthier populations pillar have not been carried out.

Analysis of the biannual JPRM documents and GSM extracts for Djibouti reflecting expenditure by output show that a large share of WHO interventions has focused on providing technical assistance to disease-based programmes. These interventions include supporting the development and implementation of malaria treatment protocols, the national strategy to reduce maternal and neonatal health mortality, technical package for cardiovascular disease management in primary health care (HEARTS), the drafting of the antimicrobial resistance (AMR) strategy, the mental health and psychosocial support strategy, TB control including multi-drug resistant TB and the EPI strategy. Interviews with WHO staff and Ministry of Health officials also indicate that WHO efforts outside emergency responses have focussed on programme-specific technical assistance.[28] While WHO has supported important interventions improving health services coverage, these have been limited to the frame of specific programmes, such as EPI, rather than developed through a health system strengthening approach to support the UHC agenda. A Ministry of Health respondent explained that "health partners' programmes are verticalized", with many agencies having a specific disease focus. This is not the case for WHO, however, as specific efforts have already been undertaken on health system strengthening. For example, WHO supported the health sector review through organizing a National Health Symposium; it provided normative guidance on the revision of the list of essential medicines (EML), and it supported the strengthening of the data and surveillance system with the DHIS2. However, these cross-cutting interventions have been few over the period considered by the evaluation.

[27] Global Health Observatory, WHO https://www.who.int/data/gho accessed on 07/11/2023 - The revised International Health Regulations (IHR) were adopted in 2005 and entered into force in 2007 (available at: http://apps.who.int/iris/bitstream/10665/43883/1/9789241580410_eng.pdf). Under the IHR, States Parties are obliged to develop and maintain minimum core capacities for surveillance and response, including at points of entry, to early detect, assess, notify, and respond to any potential public health events of international concern. The IHR core capacity Index (tracking SDG .d.1) is computed from scores on 13 core capacities: (1) Legislation and financing; (2) IHR Coordination and National Focal Point Functions; (3) Zoonotic events and the Human-Animal Health Interface; (4) Food safety; (5) Laboratory; (6) Surveillance; (7) Human resources; (8) National Health Emergency Framework; (9) Health Service Provision; (10) Risk communication; (11) Points of entry; (12) Chemical events; (13) Radiation emergencies

[28] DHIS2 is an open source, web-based platform most commonly used as a health management information system developed by the University of Oslo. More information is available at https://dhis2.org/about/, accessed on 24/11/23

3.1.1 Relevance of WHO interventions in relation to needs and rights of most marginalized populations

Analysis of programme documents and WCO respondents' interviews reveal that the integration of gender equality and health equity analysis in WHO interventions and approaches has been limited. The evaluation could not identify interventions based on analysis of disaggregated data by sex, disability or rural/urban variables and their use in policymaking. The evaluation could also not identify efforts to analyse and address specific issues faced by girls, women, boys, men and people of diverse gender identities. Interventions promoting access to health services for people with different types of disability, either through specific programmes or integrating their needs transversally in programmes supported by WHO, have also been limited.

WHO respondents have argued that interventions strengthening the provision of PHC can help address such health inequities by improving access to health services. To this end, **barriers to health care and the needs of specific marginalized groups have been addressed to some extent** in WHO interventions, but they need to be strengthened.

An important barrier to accessing health care in the country is geographical distance and low primary care services coverage beyond Djibouti City. In some remote areas, distance to the nearest health facilities is compounded by the difficult terrain, requiring some outreach services to use camels to reach patients. Respondents from Ministry of Health have reported that in most regions several health centres were not operational due to lack of staff. So far, interventions by WHO on expanding health services coverage have focused on providing technical guidance and developing strategies, such as on MNCH and EPI, which may contribute to improving geographical coverage of specific programmes.

Financial barriers are more important in rural areas but remain overall less severe than in the rest of WHO Regional Office for the Eastern Mediterranean. The percentage of the population with household expenditures on health greater than 10% of total household expenditure was at 1.47%, and higher in rural than urban areas (1.65 and 1.43% respectively) in Djibouti. Although the Government of Djibouti adopted a universal health insurance policy in 2014, by 2019, the proportion of population covered by at least one social protection benefit was only 12.3%. **No significant WHO intervention on the implementation of UHC by reducing financial barriers to health care in Djibouti was documented in this evaluation**.

WHO GHO data show that women and girls are particularly impacted by a high rate of maternal mortality at 234 deaths per 100 000 live births in 2021, the highest rate in WHO Regional Office for the Eastern Mediterranean. Although recent population-wide data is not available, female genital cutting/mutilation (FGM/C) was extremely high at 93.1% at the last data point in 2006. **WHO has supported the national programme on RMNCH; however, specific work by WHO on FGM/C was not documented in the evaluation**. While sex disaggregated data may be available, for example in the weekly bulletins produced by the Institut National de Santé Publique de Djibouti (INSPD) on 35 priority diseases, gender analysis of such data is not conducted. This likely limits the ability of WHO to support health actors in identifying and addressing causes for gender differences in health outcomes.

Data from UNHCR[29] show that approximately 35 000 refugees and asylum seekers are registered in Djibouti and of these 68% are women and children.[30] The Government of Djibouti reports that over 137 000 migrants have transited through Djibouti in 2021, and 150 000 among "*populations flottantes*" are remaining in the country for an extended period.[31]

Both refugees/asylum seekers and migrants are granted access to free health services on par with the local population through conventions between UNHCR and the International Organization for Migration (IOM), respectively, and the Government of Djibouti. However, several UN respondents and a 2022 Report on Safe, Orderly and Regular Migration in Djibouti, highlighted that migrant populations remain highly vulnerable, especially those outside IOM centres, unaccompanied children and victims of human trafficking.[32] **WHO has worked on improving migrants' access to health, particularly by strengthening regional hospitals that are located on migration corridors and cater to the largest number of migrants** (See Box 1. below).

[29] See https://www.unhcr.org/countries/djibouti, accessed 24 November 2023.
[30] Ibid.
[31] *Rapport National Volontaire : examen de la mise en œuvre du pacte mondial pour des migrations sûres, ordonnées et régulières à Djibouti, République de Djibouti* (2022) (https://www.un.org/sites/un2.un.org/files/imrf-djibouti.pdf, accessed 24 November 2023).
[32] Ibid.

Box 1. Access to health care for "populations flottantes" and other vulnerable groups in the regions

Regional hospitals are on the front-line of providing care to refugees, migrants crossing Djibouti towards another destination, and "*populations flottantes*". According to the *Médecin chefs* interviewed for this evaluation, refugees and migrants benefit from the same rights to health care than the local population and are treated free of charge. Cross-border populations in Ali-Sabieh have free access to care in the regional hospital. In Arta, there are Yemeni refugees and Ethiopian migrants. In Obock, the Centre Médico-Hospitalier serves the refugee population located at the Markesi camp. The Tadjourah regional hospital is on the migration route to the Arabian Gulf countries and caters for an important flux of migrants. Regional hospitals resort to mobile teams to reach remote populations when funds are available. IOM together with the UNHCR provide support to public health facilities that cater for a large flux of migrants and for health centres neighbouring the villages of refugees. However, numerous *Médecins chefs* highlighted that the care of migrants and "*populations flottantes*" burdened their services and had a financial impact on the regional hospital.

All four regional hospitals' *Médecins chefs* reported receiving support from WHO, benefitting local, refugees and migrant populations. This included training health-care workers on acute choleriform diarrhoea and leprosy diagnosis, COVID-19 vaccination and detection/surveillance, support for routine immunization including outreach mobile teams for households in a five-kilometre radius around the health centres, provision of supplies, a cold room for polio vaccination and community mobilizers and hiring transportations for campaigns conducted in collaboration with UNICEF in Tadjourah. In Obock, WHO provided an ambulance to the health centre. WHO also supported the RMNCH programme in Obock with kits for malnourished children and kits for antenatal care. In Ali-Sabieh, WHO focused on the vaccination programme, and no other support in terms of supplies and equipment was reported. WHO does not directly liaise with regional hospitals to plan and provide capacity-building, but all interactions are conducted centrally through the Ministry of Health. This has been noted as a limitation in terms of timeliness and tailoring of WHO support to the specific conditions of each region.

Scant information is available on key populations in Djibouti. Data by UN agencies in 2019 showed HIV test positivity rates of 9.3% among female sex workers and 14% among men who have sex with men, compared to 1.2% in the general population. No data is available on HIV prevalence in other key populations, such as people who inject drugs, transgender persons and prisoners. The evaluation team met with five men who have sex with men, who access HIV prevention services through the Association "*Autres Regards*", supported by UNAIDS until it handed over its activities to WHO in 2022. They reported regular access to information, condoms and lubricants through a peer educator, and were referred to the Yonis Toussaint centre in case of sexually transmitted infections symptoms, where they received free diagnosis and treatment services. They explained, however, that many of their peers refused to access health services for fear of violence and discrimination and called for community peer educator services to be expanded to include HIV testing in the community, rather than only at a health centre level. The handover from UNAIDS requires WHO to support the continuity of UNAIDS' role, including on promoting the right to health of key populations and their access to HIV prevention and treatment services. **At the time of the evaluation, there were limited interventions by WHO relating to key populations.**

3.2 With Djibouti having the ambition of becoming an upper middle-Income country, what should WCO Djibouti focus on the coming years?

Djibouti's economic growth has come back to pre-COVID-19 levels, leading the country to apply to graduate to UMIC status. This offers opportunities for increased domestic investment in health, prioritizing the reduction of health inequalities and improving access to care. This is reflected in the National Development Plan (2020–2024),[33] which calls for achieving universal health coverage and improving health infrastructure for PHC and hospital services. Other contextual events that WHO may take advantage of to raise the agenda of health and UHC include the revision and development of the National Development Plan; the

[33] National Development Plan (2020–2024) Djibouti ICI, Republic of Djibouti (2020) (https://www.undp.org/djibouti/news/official-launch-national-development-plan-ndp-djibouti-ici#:~:text=The%20National%20Development%20Plan%202020,society%20organizations%20and%20development%20partners, accessed 26 January 2024).

revision of the current PNDS in view of developing the new one, and the revision and development of UNSDCF, all three plans coming to an end in 2024.

The relevance of WHO efforts may be enhanced by further focusing on strategic interventions to strengthen universal health coverage through a primary health care approach. As previously described, WHO has already repositioned itself to support health system strengthening and coverage. Looking forward, WHO may focus on addressing structural issues of the health system in Djibouti in a holistic manner, to achieve progress on UHC service coverage. Such issues include: The fragmentation of the health system. Parallel health provision systems co-exist such as the facilities managed by the Caisse Nationale de Sécurité Social (CNSS), the private for-profit sector and the para-public providers (army, gendarmerie, police and coast guards). Those do not directly report to the Ministry of Health or follow its norms, regulations and leadership.

a. The fragmentation of the health system. Parallel health provision systems co-exist, such as the facilities managed by the CNSS, the private for-profit sector and the para-public providers (army, gendarmerie, police and coast guards). Those do not directly report to the Ministry of Health or follow its norms, regulations and leadership.

b. The incomplete decentralization of the health system, contemplated in Law 48/AN/99/4ème L on the Public Health System orientation, is not implemented in Djibouti. This results in divergent inefficiencies in the management of health facilities.

c. The lack of community health workers' services. Currently, respondents from UN agencies, WHO and the Ministry of Health have reported that community outreaches are conducted with the support of community mobilizers; however, their function is linked to the delivery of specific programmes, especially at the time of emergency responses, and is not sustained to link communities to health services in a continuous manner.

WHO could also play a role supporting Djibouti to integrate a regional perspective on health. Given Djibouti's strategic positioning at important regional economic, political and migration crossroads, the WCO is well placed to engage with cross-border entities on addressing health governance, resources mobilization and cross-border collaborations in relation to migrant populations' health. So far, the WCO has not been mandated to engage with the Intergovernmental Authority on Development (IGAD) to promote its normative guidance, support capacity-building and mobilize resources for social protection. A WHO respondent at regional level considered that the African Union would also be an important interlocutor, as it holds an annual summit of heads of states, including on the health agenda. WHO respondents considered that such role, however, would need to be formalized and the WCO would need additional human resources and support from both WHO Regional Office for the Eastern Mediterranean and the Regional Office for Africa.

COHERENCE: To what extent are WHO interventions and positioning coherent and demonstrate synergies with interventions carried out by other partners and institutions in Djibouti?

This section explores the extent to which WHO interventions in Djibouti were aligned to country and regional partners' and institutions' policies and priorities, as well as to WHO GPW 13 and other sector-specific policies. It then considers the effect of the sociopolitical and economic landscape in Djibouti on the health sector and how this has affected the role of WHO and engagement with other health partners, as well as implications for the strategic positioning of WHO in Djibouti going forward.

Key findings

Coherence: The internal and external coherence of WHO interventions in Djibouti has been mixed.

Finding 5: WHO priority outcomes and outputs as outlined in the JPRM are well aligned to the GPW 13 as well as to the PNDS and the UNSDCF.

Finding 6: While the JPRM is a well-established planning process with strong buy-in from Ministry of Health and other actors, the absence of a valid CCS and of biannual CSPs hampers the effective prioritization of WHO support across its the different functions.

Finding 7: A hindering factor to the alignment of WHO interventions to national priorities is the lack of a budgeted operational plan to implement the PNDS.

Finding 8: Within the UNCT, the Health, Nutrition and Water and Sanitation Results Working Group, co-chaired by WHO and UNICEF, has worked well and there are examples of joint planning. However, collaborations can be improved within the UNCT by including non-resident agencies.

Finding 9: Coordination beyond the UN sector between WHO and funding agencies has been unequal and based on informal, bilateral discussions because the official platform, the Group of Health Partners convened by the Ministry of Health, has not been meeting regularly.

Finding 10: There are several avenues for WHO to support the leadership and coordination role of the Ministry of Health. However, the focus on providing technical assistance and direct implementation has not been conducive for WHO to play a more leadership and convening role, which represents its comparative advantage in relation to other agencies. This has led to some partners likening WHO to a small donor agency, further affecting the ability of WHO to fully realise the strategic role at the core of its mandate.

3.3 To what extent are interventions aligned to country and regional partners' and institutions' policies and priorities as well as to the GPW13 and other sector-specific policies?

Analysis of all documents and interviews with respondents showed that in the period covered by the evaluation **WHO JPRM aligns neatly with the articulation of country health priorities outlined in the PNDS and the UNSDCF**. The JPRM is the main operational document outlining WHO deliverables in Djibouti and is the outcome of a collaborative priority setting and planning process between WHO Secretariat and the Ministry of Health. Respondents from the Ministry of Health considered that priorities outlined in the JPRM were jointly developed with them and fully aligned to the national priority areas. The JPRM is well owned and widely referred to

by Ministry of Health counterparts as well as UNCT and other health partners. With support from WHO Regional Office for the Eastern Mediterranean in 2018 and 2022, WCO has further identified priorities to guide its work through a prioritization exercise of outcomes selected within the GPW 13. This prioritization exercise forms the framework within which the WCO has identified

its deliverables jointly with the Ministry of Health as captured in the JPRM and fully aligns to the WHO global results framework. The alignment between the WHO JPRM, country priorities and the UNSDCF is illustrated in Table 5 below.

With regard to the PNDS, under the UHC pillar, WCO priorities for health system strengthening via workforce development, health financing and essential medicines availability fully align with national objectives around equitable supply of care and good health sector governance. Under the emergency preparedness pillar, International Health Regulations (IHR) implementation as well as infectious diseases and emergency surveillance and response interventions align with the PNDS objectives on workforce capacity-building. Under the healthier populations pillar, there is alignment between the WCO outcomes on determinants of health, especially around NCDs, and advocacy for the implementation of Djibouti's Strategic Plan for Economic and Social Development (SCAPE) and the government's PHC approach. Finally, both the JPRM and the PNDS recognize the importance of strengthening health data information system management (DHIS2).

Within the UNSCDF,[34] the WHO JPRM addresses priority areas outlined under the effect 3 on health, nutrition, water and sanitation: maternal, neonatal and child health, immunization programme, COVID-19, treatment for HIV, TB and vector-borne diseases and surveillance systems on the plan. The only area not directly emphasized by WHO is the water and sanitation component, which falls under the lead of UNICEF. Despite the fact that nutrition is not clearly in focus in the UNSDCF, as there is no expected result or indicator on nutrition under effect 3, it is well captured in the interventions reported by the agencies on an annual basis.[35] As the UNSDCF framework is very broad, it does not outline specific joint intervention areas to be undertaken by the agencies in the framework of health and nutrition. However, multiple UN respondents reported that the Health, Nutrition and Water and Sanitation Results Group co-chaired by WHO and UNICEF has worked well as information sharing platforms to align activities within the mandate of each agency. In addition, the Health and Nutrition Results Inter-Agencies Working Sub-Groups have developed specific workplans to coordinate interventions and identify joint initiatives. The organogram presented in the UNDAF (2018-2022) also mentions the existence of an HIV/AIDS subgroup, but after the departure of UNAIDS from Djibouti in 2022, it seems that this has not been active.

[34] Djibouti Extension UNSDCF 2022–2024, UN Country Team (https://www.unfpa.org/sites/default/files/board-documents/main-document/DP.FPA_.2022.11%20-%20CPExt%20for%202022%20SRS%20-%20FINAL%20-%2014Jul22%20_7.pdf, accessed 26 January 2024).
[35] Rapport annuel Djibouti, UN Country Team, 2022, https://djibouti.un.org/sites/default/files/2023-05/UNCT%20Annual%20Report%202022_final_0.pdf

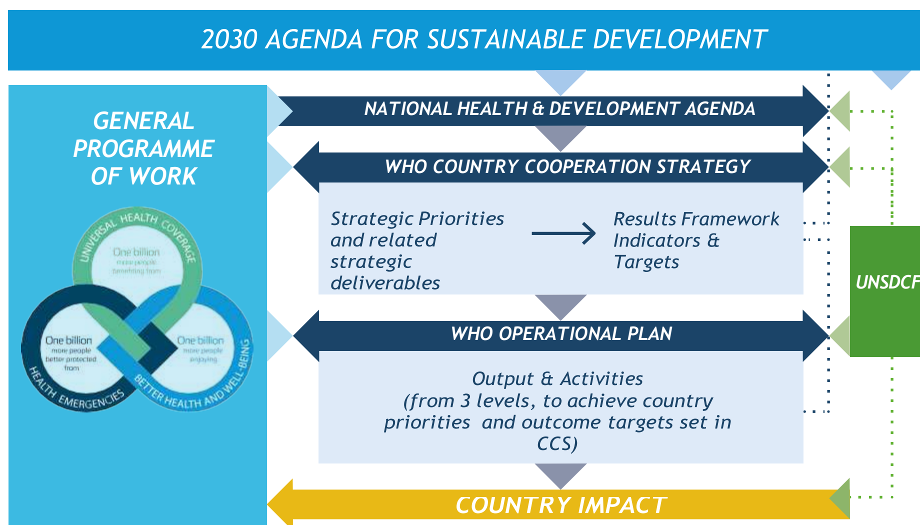
Table 5. Alignment of WHO priorities in Djibouti to strategic frameworks

WCO prioritization (2022-2023)	PNDS	UNSDCF Effect 3
Outcome 1.1. Improved access to quality essential health services - Strengthening operational planning framework of NHSP 2018-2022 - Strengthening management of human health resources - Strengthening access to health for population with financial barriers **Outcome 1.3. Improved availability of essential medicines, vaccines, diagnostics and devices for PHC** - Updating the national list of essential drugs and equipment Strengthening management of essential medicines for PHC	The **equitable supply of quality care** with qualified human resources, an adequate technical platform and quality essential medicines permanently available. **Good governance in the management of health services.** Strengthened through increased accountability of actors regarding the PNDS results.	National capacities to reduce maternal, neonatal and child mortality and to increase immunization.
Outcome 1.2. Reduced number of people suffering financial hardship - Strengthening health financing for UHC	**Adequate and sustainable financing is mobilized for UHC and social protection.**	
Outcome 2.1. Country health emergency preparedness - Strengthening implementation of the International Health Regulations - Development of the national plan for preparedness and response **Outcome 2.2. Emergence of high-threat infectious hazards prevented** - Strengthening national capacity for surveillance -Strengthening national capacity to respond to epidemics **Outcome 2.3. Health emergencies rapidly detected and responded to** - Strengthening national capacity for surveillance - Strengthening national capacity to respond to epidemics	The **equitable supply of quality care** with qualified human resources, an adequate technical platform and quality essential medicines permanently available.	The capacities of public and community services are strengthened to fight the COVID-19 pandemic and to ensure access of key populations to preventive care and treatment for HIV, TB and vector-borne diseases.
Outcome 3.1. Determinants of health addressed - Develop strategic plan for the reduction of NCDs risk factors - Implement a national multisectoral coordination mechanism **Outcome 3.3. Health in all policies and healthy settings** Advocacy during the development of the government's SCAPE	**Quality promotional, preventive and curative care services, focused on the PHC approach** and adapted to the epidemiological and socio-cultural context, are equitably available throughout the country.	Affordable access to safe and secure drinking water supply and sanitation.
Outcome 4.1. Strengthened country capacity in data and innovation - Capacity building of health workers on health data - Strengthening capacity for using health information - Capacity building for implementation of DIHS 2	**The health information system is strengthened** to ensure permanent availability of quality data for use at operational and strategic levels.	Capacity for planning, monitoring, surveillance and evaluation in the health sector are strengthened.

Sources: WHO JPRM, PNDS (2020-2024) and UNSDCF (Addendum 2022-2024)

While the JPRM is helpful for identifying WHO Djibouti's contribution to the global results framework, it is not sufficient to provide longer- term strategic direction for WHO in Djibouti because of the lack of a valid CCS since 2016 and a CSP to implement it. The CSP would outline the contribution of the three levels of the Organization on a biannual basis. Currently, although the Ministry of Health formulates technical assistance requests to WHO that can be directed to either the country office or the regional office, and sometimes referred to WHO headquarters, there is no single plan detailing the contribution of WHO headquarters, WHO Regional Office for the Eastern Mediterranean and WCO for Djibouti. The articulation of these different elements is well described in the WHO CCS Guide (2023), as shown in Fig. 2.[36] This framework clearly anchors a WHO country strategy in the analysis of health outcomes, to prioritize interventions where those are lagging. A WHO operational plan for Djibouti CCS would mobilize the full range of functions of WHO (leadership and convening, normative work, technical assistance, advocating for evidence-based health policies and supporting the monitoring of health trends) and would clearly outline contributions from the regional office and WHO headquarters.

Figure 2. CCS as a tool to implement the GPW 13 and guide WHO's strategic cooperation



Source: CCS Guide 2023, WHO

3.4. What has been the effect of the sociopolitical and economic landscape in Djibouti on the health sector and how has this complemented or affected the role of WHO, including engagement with stakeholders? What adaptations, refinements and strategic shifts are needed to improve the strategic positioning of WHO going forward?

3.4.1 Factors influencing the role of WHO role and engagement with other health stakeholders

Coordination of the health sector actors in Djibouti has been hampered by an inactive government-led official coordination mechanism, the lack of a diagnostic and mapping of health partners, including in health system financing, the lack of an operationalized PNDS and insufficient coordination and sharing of data among partners, including under a more sustained WHO leadership.

There is a shared diagnostic among health sector partners and actors within the Ministry of Health that the Ministry lacks coordination capacity and has exerted a weak leadership on health partners. On the side of international health partners, there are multiple, project-based initiatives with parallel planning, budgeting and reporting cycles and processes. This has sometimes led to inefficiencies, gaps and duplications in health interventions.

[36] Not published at the time of the evaluation.

The lack of operationalization of the PNDS has affected health sector partners' ability to align and coordinate. The lack of operational, budgeted plans to implement the PNDS has been an ongoing issue since at least since 2012. A 2012 WHO workshop discussing the implementation of the PNDS concluded that "the PNDS 2008-2012 is little used: its content is too detailed and it lacks clear priorities, operational planning for implementation and monitoring mechanisms."[37] It recommended adopting a light-touch review and development process for the following cycle and its operationalization; the same recommendations were formulated at the end of the current PNDS. For instance, a government respondent considered with regards to the current PNDS that "WHO must help reform the Ministry to have an annual planning framework and a clear budget." A root cause for the continued lack of implementation of the PNDS seems to rest in the insufficient government investment in the public health sector, as government health expenditure has been decreasing from 8.5% to 4.3% of general government expenditure between 2011 and 2020.[38]

Health partners lack visibility on the government's priorities, risking duplication in resources allocation while other priorities remain uncovered. Health partners may also compete with one another where mandates are not clearly understood and outlined among stakeholders. A UN agency respondent in Djibouti thus commented, "A multiplicity of private and public initiatives from foreign partners investing in the health sector require a strategic framework for achieving Universal Health Coverage, which is currently lacking." This was mirrored by an Ministry of Health respondent who noted that WHO may enable the government to play a leadership and coordination role for health partners: "WHO is the leader in health, and partners should get behind it, which is not the case. It seems like they are competing with each other." Respondents generally considered that WHO is well positioned by its mandate to convene actors in the health sector.

In addition to resources coordination, data coordination and sharing also remains a challenge. Although within the UNCT there are monthly meetings where agencies share data, there is no coordination from partners on supporting effective surveillance and health services monitoring. Ministry of Health respondents report that partners tend to focus on data collection and reporting for the disease areas they support. Funding partners may also request to include their indicators of interest in the DHIS2, resulting in burdening the already weak health data system.

The Groupe des Partenaires Santé (GPS) is the main health coordination mechanism in Djibouti. It is headed by the Ministry of Health and chaired by the Prime Minister's Office. It is meant to meet on a six-monthly basis. Despite WCO advocacy efforts, this mechanism has not been meeting in the past years. As a consequence, there is no mapping to identify all partners' interventions and no formalized information sharing between them and the Ministry. A donor agency respondent commented,

> *"We would like more sectoral coordination, and co-management of the coordination between the Ministry and WHO. We have no visibility on what others are doing. With all the funds that donors put in, it would be possible to have a significant impact in Djibouti if there was sectoral coordination".*

3.4.2 Coherence of WHO interventions with UNCT members

The UNCT has provided a useful platform for WHO to attempt to fill the coordination gap in the health sector among UN agencies. The Health, Nutrition and Water and Sanitation Working Group, co-chaired by WHO and UNICEF, has been meeting regularly monthly fostering information sharing, although it may not have acted as a catalytic mechanism to develop and finance joint projects. UN agencies respondents noted several examples of successful bilateral collaborations between WHO and other UNCT agencies. These include, for example, vaccination campaigns and management of severe malnutrition cases with UNICEF, provision of maternal, neonatal and child health care for migrants with IOM, or developing a one-health approach on zoonotic diseases with the FAO. Examples exist of WHO collaborating with non-resident UN agencies on health, such as with the International Labour Organization (ILO) on standards on health in the workplace and ongoing discussions with the International

[37] https://www.emro.who.int/fr/dji/djibouti-news/travaux-evaluation-pnds.html, accessed on 07/11/23
[38] Global Health Observatory, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/general-government-expenditure-on-health-as-a-percentage-of-total-government-expenditure, accessed on 24/11/2023

Atomic Energy Agency (IAEA) on cancer treatment. Since the departure of UNAIDS from Djibouti in 2022, it is unclear whether remote involvement might be maintained to pursue work through WHO. In general, WHO seems to serve as a relay to bring other organizations into the discussion and facilitate their contribution on health matters.

There are also examples where coordination has been unsuccessful, with agencies undertaking work that would traditionally be in the mandate of WHO. The sub-group on Nutrition, co-chaired by UNICEF and the World Food Programme (WFP), and in which WHO participates, has set up an annual joint planning based on the results of the annual food security surveys by WFP and the Integrated Food Security Phase Classification (IPC) led by the FAO. This allows the agencies to know what resources others have on nutrition and pool means to carry out certain activities. For example, agencies have pooled resources to conduct the Food Security and Nutrition Monitoring Survey[39] to complement the WFP funding.

3.4.3 Coherence of WHO interventions with other health partners

Beyond the UNCT, coordination of WHO with actors in health financing such as the Global Fund, GAVI, the Vaccine Alliance (GAVI), the World Bank and the *Agence Française de Développement* (AFD) **has been mixed**. Respondents from WHO in Djibouti as well as bilateral donors interviewed reported that discussions on alignment, developing collaborative projects or pursuing joint advocacy agenda have been challenging in the absence of a formal platform. WHO, however, has already engaged bilaterally in collaborations with non-UN agencies. For example, WHO is present on the Global Fund Country Coordination Mechanism, it has supported the government in developing its proposal to Global Fund and is also engaging with transitioning their funding from the United Nations Development Programme (UNDP) to the Ministry of Health as a principal recipient. Other donors such as GAVI, AFD and the World Bank are increasingly seeking avenues to align procedures and coordinate their funding to support national health objectives.

3.4.4 Whole-of-government, whole-of society approach

WHO has experienced challenges in Djibouti in terms of fostering a multisectoral response, especially engaging with the government beyond the Ministry of Health. There have been a few successful examples, however. WHO is working with the FAO and the ministries of agriculture and environment in the framework of one-health work on zoonosis as well as on antimicrobial resistance (AMR), and with Djibouti City municipality on addressing NCD risk factors. Crucially, WHO can play an advocacy role on raising the profile of the health sector to the Government of Djibouti to increase partner coordination, budget allocations and multisectoral policymaking. A UN respondent commented that:

> *The added value of WHO is the strengthening of the* Ministry of Health*. The WHO partnership with the Minister can greatly help his role in the Government. In Djibouti there is a lot of focus on the port, the economic ties with Ethiopia, the military bases and health is not a top priority. But the partnership with WHO gives more visibility to the health sector.*

With the support of the Special Programme on Primary Health Care at WHO headquarters and regional office levels, WHO has been able to convene a wider range of stakeholders in health governance, community mobilization and services delivery through conducting the National Health Symposium in 2022. Its purpose was to "bring out through a democratic debate of the living forces of the nation the health reforms to be carried out to accelerate achieving universal health coverage (UHC) in Djibouti by 2030." The Symposium provided an analysis of different components of the health system conducted by working groups on health services provision, medicines, human resources, financing, leadership and governance, and health information systems. The following uses were expected:[40]

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[39] Food Security and Nutrition Monitoring Survey Djibouti, WFP (2022), https://docs.wfp.org/api/documents/WFP-0000139124/download/ (accessed 7 November 2023).

[40] *Rapport National du Symposium National de la Santé « vers la couverture sanitaire universelle »*, Ministère e la Santé de la République de Djibouti (2022).

The recommendations of the *Etats Généraux* will be translated into a budgeted operational action plan which will serve to guide the work and interventions of all the actors involved in the reform of the health system. On this same basis, a new health policy can be prepared and promulgated. At this stage, it may be considered to organize a meeting of donors to mobilize the financing necessary for the implementation of the conclusions of the *Etats Généraux* under the leadership of the Ministry of Foreign Affairs and International Cooperation.

A wide range of actors participated, and debates were organized in Djibouti City as well as in the five regions. This was a novel approach in Djibouti, as many actors participated for the first time in discussions on health governance. Discussions were held in local languages, involving community leaders and civil society actors, among others. This initiative was successful in bringing new actors in the discussions and sensitizing the Ministry leadership on the use of participatory processes to gather information on the health system. However, opening a debate on the health sector also met with sensitivities and generated government resistance. The products of this work were not made public; thus, the recommendations did not result in specific change. In addition, AFD conducted a parallel review, which led to the new organizational chart for the Ministry of Health, but with no reference to the recommendations of the Symposium. Despite the challenges in buy-in and follow-up, the Symposium was an important attempt at broadening participation of different constituencies in a health sector reform. Other actions by WHO in terms of civil society and community engagement include the COVID-19 pandemic and the Essential Programme on Immunization (EPI) vaccination campaigns supported by WHO Regional Office for the Eastern Mediterranean. These campaigns have been the occasion of conducting microplanning involving local actors and communities, a novel approach in Djibouti according to WHO respondents.

3.4.5 Adaptations and strategic shifts needed to improve the strategic positioning of WHO

WHO and health partner respondents emphasized that a new positioning of WHO would require a strategic shift in the type of work conducted so far. Members of the UNCT and other partners in the health sector agreed that **WHO has largely limited its activities to direct support to service delivery and technical assistance, and this has not helped WHO to capitalize on its convening power, which represents a comparative advantage in relation to other agencies**. WHO has faced challenges as it often found itself in a “reactive” operational mode in response to the Ministry of Health requests. A funding agency, for example, reports that WHO provides Djibouti with operational support such as buying mosquito nets and “Although not duplicative of our effort, sometimes it is one more actor to coordinate with.” This type of engagement of WHO in Djibouti has led to a certain confusion about the role of WHO, some considering it as a “small donor” or comparing its work to that of a non-governmental organization. Another funding agency considered that “WHO acts as a donor, more than as a leader. And the volume of funding by WHO is modest.”

For this reason, **WHO may sometimes experience difficulties in its convening role, as it may enter in competition with other actors.** A UNCT respondent noted that “There is a tension between coordination and implementation with other actors – a tension to be managed.” WHO respondents indicated that there was a need to “change the narrative” on the role of WHO, taking advantage of the convening power of the Organization and the unique recognition it benefits from among the health sector partners. A Ministry of Health respondent also called for WHO to develop the full scope of its mandate in Djibouti, becoming more strategic and taking a leadership role among health partners: “We understand that WHO is not a donor. WHO must be closer to the Ministry, play a role of coordination and technical expertise, but the emphasis must be placed on the catalytic role. WHO is an organization that must take the leadership in health compared to other partners.”

EFFECTIVENESS: To what extent were WHO results achieved or are likely to be achieved and what factors influenced their achievement?

This section discusses the extent to which WHO programme outputs were delivered. It then explores the extent to which those outputs have contributed to progress towards health system outcomes and, in particular, the adoption and implementation by the national health system of interventions, programmes and services aimed at reducing the inequalities and exclusion related to

socioeconomic and environmental determinants of health. It also presents key factors that influenced WHO achievements. Lastly, the section discusses the added value of WHO regional and headquarters contributions to the achievement of results in Djibouti.

Key findings

Effectiveness: The extent to which WHO interventions achieved expected results has varied overtime, with a renewed dynamic in the current biennium (2022-2023).

Finding 11: The extent to which WHO has been able to carry out planned interventions has varied overtime. After a period where activities were limited in part due to challenges in the collaboration of WHO and the Ministry of Health, the COVID-19 pandemic marked a renewed engagement of WHO in Djibouti. The current biennium has seen a new dynamic, with many interventions and active collaboration taking place. Overall, however, the implementation of planned interventions has been slow.

Finding 12: The focus of WHO interventions in Djibouti has mostly been on the outcomes relating to improved access to quality essential health services and improved availability of essential medicines for PHC to a lesser degree under the UHC pillar, with less focus on addressing financial hardship and health financing. Under the health emergency pillar, work has focused on the "prevent" and "detect and respond" components, with less emphasis on the "prepare" component. Few interventions have taken place under the healthier populations pillar. Under the enabling/more effective and efficient WHO pillar, the focus has been on strengthening the country's capacity on health data and information systems, particularly on the implementation of the DHIS2.

Finding 13: The lack of recent actual data on national health outcomes impedes a comprehensive analysis of the WHO contribution to their achievement; however, some evidence exists on specific indicators. Thus, as part of this evaluation no evidence of the WHO contribution was documented on improved vaccination coverage indicators, which have been worsening, or on NCD and related risk factors, some of which have been improving. There is moderate evidence of WHO contributing to improved health system level outcomes on malaria and HIV treatment coverage. There is robust evidence of the WHO contribution to positive results on Reproductive Maternal, Newborn and Child Health (RMNCH) services, COVID-19 vaccination coverage, TB treatment coverage and surveillance data completeness.

Finding 14: Responding to the challenge of health service coverage in rural areas, WHO has contributed with UNICEF and GAVI to supporting an innovative model of outreach care delivery in Djibouti involving community mobilizers to deliver an integrated package of vaccination, antenatal care and nutrition services. This model has been effective in increasing access to health services where it was implemented, and the possibility of its replication at scale may be explored.

Finding 15: WHO contribution to address health inequalities has focussed on ensuring that "*populations flottantes*", or mobile populations, were taken into account, including in emergency and outbreak responses and on participating in innovative outreach activities to reduce geographic inequalities in access to health care.

Finding 16: Technical assistance support from WHO headquarters and WHO Regional Office for the Eastern Mediterranean have been critical in responding to Ministry of Health requests. However, requests from WHO Regional Office for the Eastern Mediterranean to participate in regional activities has sometimes hampered the effective delivery of planned activities in Djibouti.

While the JPRM is helpfully organized alongside the GPW 13 results framework, the lack of specific targets and baseline on outputs and outcome indicators for the country makes it difficult to assess effectiveness of WHO interventions. In this section, we relied on the reconstructed ToC to identify plausible contribution to health outcomes of WHO in Djibouti. Hence, this section is organized alongside the ToC pathways from interventions delivered by WHO, to outputs level changes (for example "new sectoral health strategies developed", "new technical guidelines in place") and outcomes framed in terms of health system level changes and access to health services. Health impact level analysis was not conducted as part of this evaluation given the limitations in data available as well as the scope of this exercise. Secondary data on WHO interventions and their contribution to output results was mainly derived from two sources: (i) the corporate reporting system, the OSC, which provides scant detail on interventions and their effectiveness; and (ii) the WHO Regional Office for the Eastern Mediterranean KPI tracking system, which provides useful narrative detail on progress against output level indicators designed at regional level to track GPW 13 outputs.

Both are described in the introductory part of this evaluation. Outcome data was mainly derived from the GHO, while the ToC model was used to identify plausible contribution of WHO to that data.

Photo credit: WHO
Environmental surveillance, Djibouti, 2021

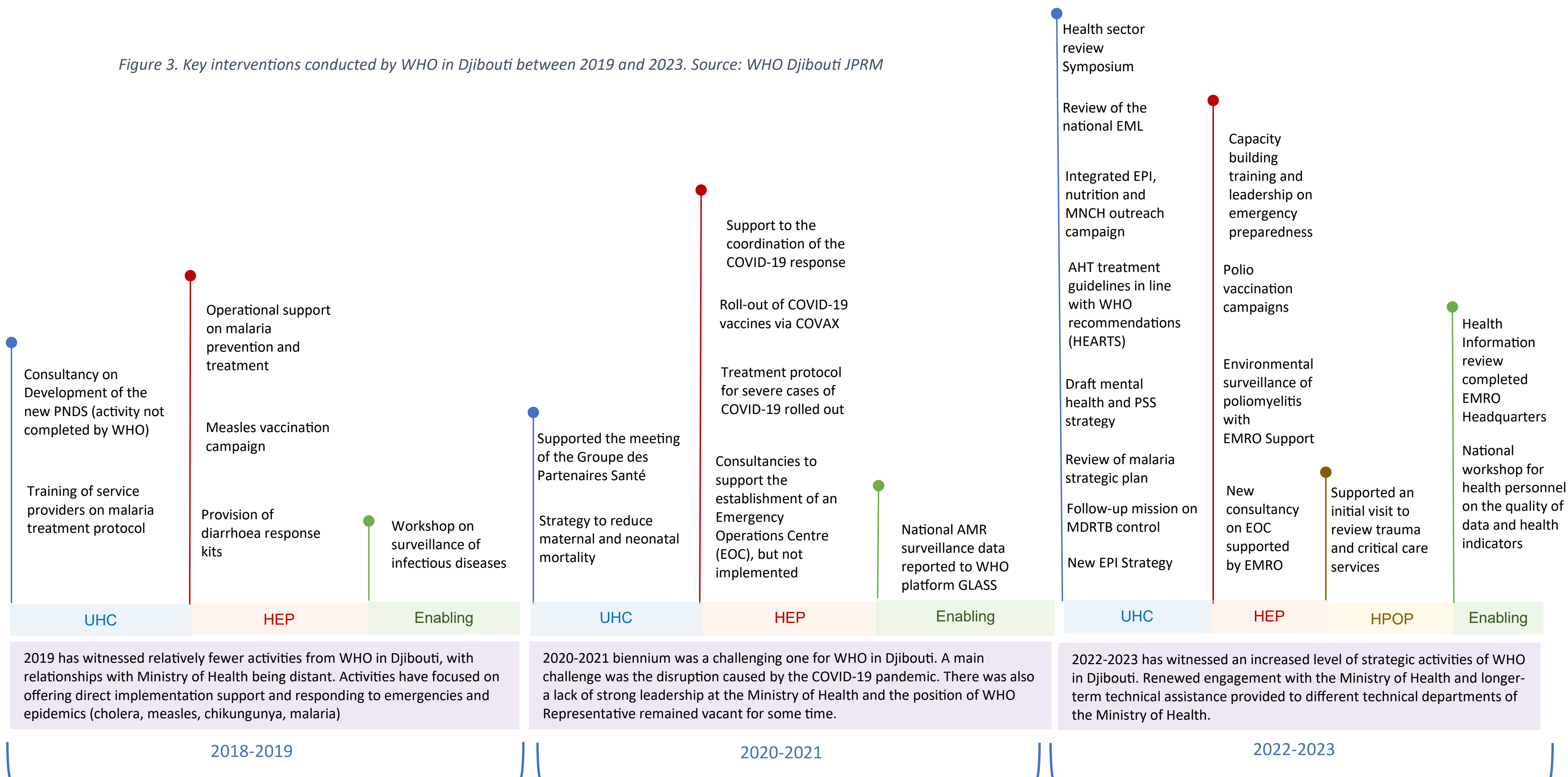
3.5 To what extent were programme outputs delivered and did they contribute to: (a) progress toward the stated programme outcomes; and (b) the adoption and implementation by the national health system of interventions, programmes and services aimed at reducing the inequalities and exclusion, related to socio-economic and environmental determinants of health?

3.5.1 Implementation of WHO interventions across the period 2019 – 2023

The ability of WHO to carry out planned interventions has varied overtime and by pillar, as illustrated in Fig. 3. Respondents from WCO and Ministry of Health officials aptly describe the evolution of WHO interventions. During interviews they often referred to the period pre-2016 as a time of stronger engagement and partnership with WHO in Djibouti. For example, a Ministry of Health respondent considered that “since 2016 there has been a lot of upheaval, and since then JPRM has not been what was usual.” In the 2018–2019 biennium, documents reviewed show that the engagement of WHO in Djibouti was characterized by small-scale activities, often in the form of direct implementation support in the context of disease outbreaks and emergencies. In

the 2020–2021 biennium, WHO has also met challenges in conducting planned activities, particularly as efforts were redirected to the COVID-19 response. However, this latter was unanimously praised by Ministry of Health and UNCT partners alike. **The 2022-2023 biennium has witnessed a renewed engagement of WHO on key thematic areas, especially under the UHC pillar** on improving the implementation of the EPI, polio eradication efforts, providing normative and technical guidance on HIV, malaria and TB, supporting the roll-out of the RMNCH strategy and providing continuous support to the development of the NCD and mental health programmes of the Ministry of Health. WHO has also been active in supporting the strengthening of the surveillance system, especially to the implementation of the DHIS2.

Figure 3. Key interventions conducted by WHO in Djibouti between 2019 and 2023. Source: WHO Djibouti JPRM



3.5.2 Output-level results in the period 2019–2023

The extent to which WHO has been able to contribute to GPW 13 outputs has varied among the different pillars. **Most efforts were undertaken in the UHC pillar** in the development of several new national strategies and technical capacity-building provision at different levels of the health system workforce. **Efforts under the health emergencies pillar have achieved good results**, especially on polio detection, outbreak communicable diseases and on the COVID-19 response. **Under the healthier populations pillar, efforts on addressing determinants of health have been more limited**. Good emphasis has been placed on streamlining existing national surveillance and health information management systems.

UHC pillar

In addition to the development of PHC strategies and comprehensive essential service packages (Output 1.1.1), WHO has largely focused on strengthening the health system to deliver on condition- and disease-specific service coverage results (Output 1.1.2), especially NCDs, mental health and psychosocial support, HIV/AIDS, tuberculosis and malaria. Realizations include the development of the NCD and mental health programmes through provision of normative guidance and technical support to the adaptation and roll out of the HEARTS and the Mental Health Gap Action Programme (mhGAP) technical packages, and the design of National Strategic Plans on NCD, Mental Health and Psychosocial Support and associated health workforce trainings. Complementing the Global Fund and in collaboration with UNICEF and IOM, WHO also supported the design of a new strategy on HIV, hepatitis and sexually transmitted diseases (STIs) 2023–2027, the mid-term review of the Tuberculosis National Strategic Plan and associated capacity-building of health-care providers on new treatment recommendations and laboratory diagnostic capacity. Similarly, WHO supported the review of the National Strategic Plan against Malaria in 2022, the realization of a therapeutic effectiveness study of antimalarial drugs, malaria diagnosis and treatment of migrants to maintain the downwards trend in malaria cases and advocated to the government to put in place high-impact recommendations for reducing malaria incidence.

Regarding health system financing reform (Output 1.2.1) and improving the analysis of information of financial protection and health expenditures (Output 1.2.2), progress has been limited. The Health Financing Strategy for UHC, for which WHO has been advocating, has not yet been developed and support to the National Health Accounts has not been implemented since 2016.

On the provision of authoritative guidance and standards on quality, safety and efficacy of health products, essential medicines and diagnostics lists (Output 1.3.1), WHO has conducted a review of the national List of Essential Medicines (EML) and continued to engage with the Ministry of Health to extend this work to essential diagnostic and treatment equipment. Although not captured in the JPRM, which only reflects the activities conducted with the Ministry, WHO has also provided technical assistance to the *Centrale d'Achats de Matériels et Médicaments* Essentiels (CAMME) that is responsible for storage and distribution of medical supplies and medicines in the country to improve the drug supply chain. There are continuing issues of regional hospitals being out of stock of essential medicines, and the CAMME is currently envisaging to establish regional stocks to facilitate the distribution locally.

Health emergencies pillar

In terms of the outputs relating to emergency preparedness (Outputs 2.1.1, 2.1.2), several planned activities have yet to take place, such as realizing a Joint External Evaluation to prevent, detect and respond to emergencies, or mapping risks and vulnerabilities. WHO has been active, however, on contributing to the "prevent"-related outputs, to the implementation of polio eradication plans within the Global Polio Eradication Initiative (GPEI) (Output 2.2.4). WHO supported the surveillance and investigation of polio virus in the environment by establishing two sentinel surveillance sites: in Arhiba and in the Douda Wastewater Treatment Plant, leading to the identification of a circulating, vaccine-derived polio strand.

Work on the “detect and response” component, and especially the output on responding to health emergencies (Output 2.3.2), has been a focus of WHO over the period. WHO has supported the country in detecting and responding to several outbreaks, including choleriform aqueous diarrhoea, chikungunya, measles, malaria and COVID-19. In addition to direct implementation support and provision of supplies, WHO has built capacities in the country to effectively detect and respond to emergencies. WHO also took the lead on all aspects of the COVID-19 response in Djibouti: supporting the coordination for the response; providing consultancy services on risk communication and community engagement; training and providing operational support to field epidemiologists as well as their supervisors; providing travel and point of entry protocols and standard operating procedures (SOPs); supplying diagnostic test reagents; acquiring isolation units and other hospital equipment; disseminating national COVID-19 therapeutic protocols; providing supplies for essential health services affected by COVID-19, particularly *Mutuelle nationale des hospitaliers* (MNH), NCDs and malaria; and supporting the vaccination campaigns by providing vaccines through the COVAX facility. WHO has also been active on malaria response outbreaks, providing specific technical assistance, such as conducting a study of therapeutic effectiveness of antimalarial drugs, training field epidemiologists and contributing to direct operations on providing antimalarial drugs and essential supplies.

Healthier populations pillar

On strengthening country capacity to address social determinants of health (Output 3.2.1), WHO planned to support the development of emergency and trauma care in general, and for the management of car crash victims in particular. However, progress on this has been limited. In relation to addressing risk factors through a multisectoral response (Output 3.3.1), planned work has included the implementation of the NCD STEPwise survey, which has been postponed after the completion of the national census.

Enabling pillar for a more effective and efficient WHO

WHO has worked on strengthening country capacity in data and innovation, with a focus on improving data, analytics and health information systems to inform policy and deliver impacts (Output 4.1.1). In Djibouti, two surveillance systems co-exist: one managed by the INSPD on mandatory notifiable diseases/neglected tropical diseases, which includes weekly monitoring of 35 diseases as part of an early warning system; the other system is the DHIS2 managed by the Direction de l'Information Sanitaire (DIS). WHO has been supporting the validation and reconciliation of data between the two systems by migrating the weekly monitoring data into the DHIS2 in line with regional normative guidance. WHO is also working to strengthen the DHIS 2 implementation. WHO Regional Office for the Eastern Mediterranean organized a regional capacity-building workshop in 2022 to which three Ministry of Health staff attended. WHO has also completed the efforts undertaken by the Global Fund to train staff to report data at regional hospital level, ensuring that data can be analysed to guide health management decisions and improve timely outbreak detection. Health surveys such as the Demographic Health Survey and the service availability and readiness assessment (SARA) have also been delayed by the national census process, thereby requiring shifting attention of a limited workforce on other survey activities.

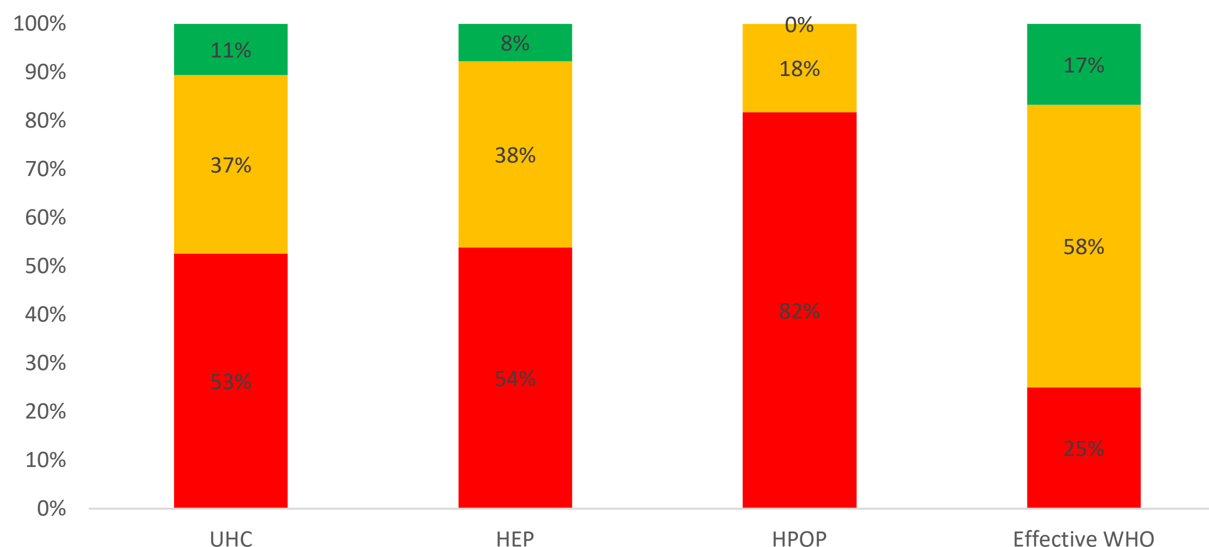
3.5.3 Extent to which planned outputs were delivered

Annual country reports to the regional office show the extent to which WHO has contributed to GPW 13 outputs through regional level output KPIs. KPIs are selected by the country office within a menu of regional indicators to reflect their priorities. Indicators are scored using a traffic-light system employing pre-defined thresholds at regional level: “green” indicating the completion of the indicator target, “yellow” corresponding to a medium threshold and “red” corresponding to no or limited achievements in relation to the indicator target. An example of such indicator is “Per cent of health centres that have

implemented UHC essential package of services", where the target corresponding to "green" is that at least 40% of health centres have implemented the UHC essential package of services in the country. Detail on these indicators is presented in Annex 6.

Fig. 4 shows that **in all three pillars (UHC, health emergencies (HEP) and healthier populations (HPOP), most indicators have scored "red", and the smallest proportion of indicators have scored "green". This data confirms that WHO has not been able to implement interventions to contribute effectively to selected outputs over the period considered**. The extent to which WHO has been able to contribute to GPW 13 outputs in Djibouti has varied among the different pillars. The UHC pillar is where more progress has been realized among the three billion pillars, with the lowest proportion of indicators scored as "red" (53%), a medium proportion scored as "yellow" (37%), and the highest proportion of indicators scored as "green" (11%). The health emergency pillar presents similar results although with slightly worse scores, with 54% of "red", 38% of "yellow" and 8% of "green" scores. By contrast, the healthier population pillar interventions showed little progress over the period, with 82% of indicators scoring "red", 18% scoring "yellow" and 0% scoring "green". The fourth strategic pillar, "effective WHO", which tracks WHO enabling functions, presents better results than the programmatic pillars, with 25% of indicators scoring "red", 58% scoring "yellow" and 17% scoring "green".

Figure 4. Indicator performance by strategic objective in WHO Regional Office for the Eastern Mediterranean KPI scores, from 2019 baseline to 2022



Source: WHO Regional Office for the Eastern Mediterranean KPI reports 2020-2022 (colour from red to yellow to green indicate the threshold of completion of the indicator target).

3.6. What factors influenced their achievement or non-achievement and to what extent has WHO demonstrated a reasonable contribution at the outcome or health system level?

Using the reconstructed ToC model (see Annex 4), it is possible to identify plausible contributions of WHO to outcome level changes. Annex 7 summarizes the evidence available on contribution of WHO to health system results.[41] Strength of evidence was assessed based on different elements, such as the intensity and scale of WHO intervention, the presence of other

[41] Unless otherwise stated, data presented in Annex 7 is extracted from the GHO, loc. cit. n. 2.

explanatory factors, the direction of change in health system indicators and how informants considered the role of WHO in changes documented. For instance, if an indicator showed a positive trend in the period but WHO had not conducted significant interventions in this area, strength of evidence was rated as low (for example on NCD outcomes). Conversely, if improvements in health services followed intense interventions from WHO and external respondents highlighted causal links between the two, strength of evidence was considered high, such as on tuberculosis (TB) treatment and maternal and neo-natal health services availability. While there were interventions by WHO throughout the period evaluated, a large part of WHO planned activities have taken place in the current biennium (see Fig. 4 above). **Contribution to outcome level results is still incipient in many areas, and efforts are generally posterior to the latest outcome data**. Therefore, indicator data available may not yet reflect the contribution of WHO at the time of the evaluation.

WHO sustained efforts over the two last biennia have likely contributed to improving health system outcomes on RMNCH, TB treatment, COVID-19 response and health data availability. On RMNCH, WHO has provided intensive support in the form of normative guidance, technical assistance, training and supply provision for the development and implementation of the National Strategy to Reduce Maternal and Neo-Natal Mortality. This support has been highlighted by Ministry and health partner respondents as a key contributor to the extension of availability of maternal and neo-natal health services in the regions. Through improved availability of RMNCH services, WHO efforts likely contributed to increasing the proportion of women (aged 15–49 years) whose needs for family planning are satisfied with modern methods from 47% to 49% between 2019 and 2020. Recent data on ANC uptake is not available on GHO. Maternal mortality, while still high, is on a decreasing trend from 257 to 234 per 100 000 live births between 2018 and 2020.

On TB treatment, WHO has supported the development of a screening strategy, evaluated the laboratory capacity gaps for multidrug resistant TB diagnosis, and built the capacity of the information and drug management systems. Those efforts have likely been instrumental to achieve the good results on TB treatment coverage in Djibouti. While TB remains a major issue in the country, with incidence per 100 000 population increasing from 212 to 240 between 2019 and 2022, Djibouti fares better than the regional average on TB treatment availability. WHO Regional Office for the Eastern Mediterranean had an average of 58% treatment coverage in 2021, compared to an estimated 80% in Djibouti, stable over the period 2019–2022.

WHO has contributed to a large extent to the COVID-19 response in Djibouti. COVID-19 vaccines were successfully rolled out via the COVAX facility – a coalition led by WHO, Gavi, the Vaccine Alliance and the Coalition for Epidemic Preparedness Innovations – with support from UNICEF. In 2023, 41% of the population had received at least a first course of vaccination, compared to 52% in WHO Regional Office for the Eastern Mediterranean. In addition, WHO may have contributed to limiting the number of deaths through supporting the roll-out of a standardized treatment protocol for severe cases. According to the WHO COVID-19 dashboard, Djibouti reported 15 690 cases and 189 deaths from COVID-19.

Lastly, WHO has supported the implementation of the DHIS2, building on the work by other partners on training data enumerators in health facilities and providing technical assistance to the Ministry of Health's Direction de l'Information Sanitaire. This likely contributed to improving surveillance data completeness. Although primary data availability for the UHC Service Coverage Index remains low, at 41% in 2019 as compared to 65% median value in WHO Regional Office for the Eastern Mediterranean, DHIS2 data completeness increased from 60% in 2022 to 80% in 2023.

On EPI, measles and polio immunization, while WHO renewed efforts in the current biennium are promising, no significant contribution could be identified to health system outcome indicators. WHO has provided direct support to vaccination campaigns and EPI in collaboration with UNICEF in the current biennium and has actively supported the country on detecting and responding to measles outbreaks. As a result of WHO preparedness work on polio with Ministry of Health, Djibouti was able to quickly detect and respond to circulating polio virus in the environment and declare a type 2 health emergency. Djibouti was the second country in the region after Egypt to respond to an outbreak using the new polio vaccine (noPV2). Despite efforts on immunization campaigns and outbreak prevention, detection and response, health system outcomes remain poor according to available data up to 2021. DTP3 vaccination coverage has declined from 85% to 59% in the period 2019–2021 and the coverage

of the measles second dose vaccine declined from 8% to 48% between 2019 and 2021, well below the regional average of 77% in 2021. Similarly, routine polio immunization coverage among 1-year-olds remains very low and declining from 85% to 59% between 2019 and 2021, compared to 83% in 2021 in WHO Regional Office for the Eastern Mediterranean. Respondents from health partners involved in supporting immunization programmes in Djibouti have considered that structural weakness of the public health system and community health services mean that the impact of investments on immunization coverage remains limited.

On both the UHC services coverage index and the IHR index, WHO interventions have been limited and have not had a plausible effect, while health system outcomes remain poor. WHO has conducted few interventions on strengthening UHC through a PHC approach, and those have not yielded tangible results. Such interventions include support to the development of the current PNDS and the conduct of the National Health Symposium. Both these activities have had a limited impact on operational plans and resources. WHO is now embarking with the Ministry of Health on an ambitious project to develop a health map for Djibouti as a building block for strengthening the health system. So far, however, bottlenecks remain to improve service coverage and the WHO contribution to these structural issues has not led to improved service coverage overall. UHC service coverage index in Djibouti declined from 45 to 44 between 2020 and 2021 compared to 57 in WHO Regional Office for the Eastern Mediterranean overall in 2021.

WHO has also not realized major interventions on emergency preparedness in Djibouti. The prepare dimension is reflected through the IHR index composed of an average of 13 core capacity scores. Djibouti performance has been low and declining on this indicator over time from 37 in 2018 to 31 in 2020 and is one of the lowest reported, well below global average of 65.

3.6.1 Factors influencing WHO effectiveness

In line with the data presented above, several respondents of the Ministry of Health commented that most activities planned in the JPRM had not been implemented. Several external factors may have contributed to this. Firstly, the collaboration between the Ministry of Health and WHO in Djibouti has sometimes been challenging. However, the WHO Representative and the current Minister have established a strong relationship, and numerous activities have taken place in the current biennium. Improvements in data sharing has also enabled more effective support on the part of WHO. Secondly, the Ministry has experienced high staff turnover which has hindered capacity development efforts by WHO. Thirdly, in the past years Djibouti has witnessed several emergencies and outbreaks, including COVID-19, chikungunya, acute watery diarrhoea, malaria, measles and floods which have required WHO to rapidly shift resources to support the response to those. Lastly, the lack of operational planning at the Ministry has hindered the ability of WHO to provide effective support. Although the Organization and the Ministry counterparts have attempted to bridge this gap with the JPRM mechanism, the lack of activities planned and implemented by the Ministry have limited the extent to which WHO could fulfil its workplans.

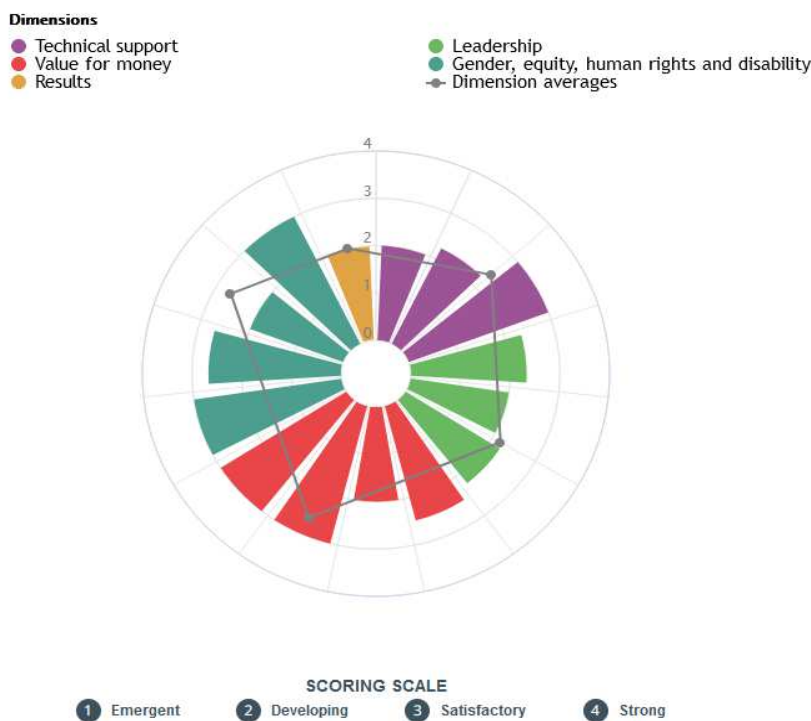
3.6.2 To what extent have WHO interventions contributed to addressing inequalities and exclusion related to socioeconomic and environmental determinants of health?

Evidence collected by the evaluation indicates that **WHO interventions have not focused on addressing inequalities and exclusion to a large extent, in contradiction to high scores attributed to the gender, equity, human rights and disability dimension in the technical Output Scorecard (OSC), which forms part of the corporate monitoring system**. The self-attributed score on the GEHR and the disability dimension is the highest (2.67 over 4) out of the six dimensions[42] (see Fig. 5 below). This dimension has often been given the highest possible score (4 out of 4) in individual output reports. Given that no rationale is provided for the scores in the output reports, it is difficult to interpret this result. However, as presented under the first

[42] Results report, Programme budget 2020-2021, WHO (2021) https://www.who.int/about/accountability/results/who-results-report-2020-2021/country-profile/2021/djibouti. Details on the OSC dimensions is provided in the Introduction section of this report.

evaluation question corresponding to the relevance criteria, scant analysis of health inequities and gender inequalities in health have been conducted by WHO in Djibouti. Interventions targeting marginalized groups such as key populations have been limited. Hence, available evidence does not support a score for this dimension between developing (2 out of 4) and satisfactory (3 out of 4).

Figure 5. Technical output scorecard for Djibouti in 2020



Source: Results report, Programme budget 2020–2021

Despite limited focus on integrating GEHR, some WHO interventions have contributed to improving health equity through increasing services coverage for "populations flottantes" and remote communities outside Djibouti City. For example, WHO reported that activities undertaken to mobilize communities for COVID-19 vaccination have effectively contributed to reducing the coverage gap between Djibouti City and the regions. A WHO respondent explained:

> *We have worked to engage communities in the planning of the COVID-19 response and vaccination campaigns. At first, the activities were concentrated in Djibouti City, so we opted to intensify the campaign in regions, where coverage ranged between 1 per cent and 10 per cent. We brought the communities together in the five regions to mobilize them on vaccination: the prefectures, local elected officials, imams, women's associations and community leaders. We engaged them in community dialogues, mobilization activities and microplanning exercises together with the health facilities. As a result, after a three-month campaign, the lowest scoring region has risen to 15 per cent vaccination coverage, and at present Tadjourah region is catching up with Djibouti City.*

WHO has also contributed to an initiative aimed at extending community health services delivery through an integrated vaccine, nutritional and antenatal care (ANC) outreach programme in collaboration with GAVI, UNICEF and the Ministry of Health. Box 3 presents more details on this intervention, which constituted an innovation in Djibouti.

Box 3. Integrated activities on maternal and child survival (vaccination, nutritional care and ANC)

The Ministry of Health Expanded Programme on Immunization (EPI) Programme, in collaboration with WHO, UNICEF and GAVI, initiated an integrated vaccination acceleration strategy in Djibouti city. The activity package consisted of vaccination, nutrition and prenatal consultations. The pilot phase of this intervention was launched for two weeks in June 2023 in five public health centres, and subsequently expanded to 15 health centres. Two hundred eight health workers, nursing students and community mobilizers were trained on delivering the services. Community mobilizers were tasked with raising awareness among community leaders, organizing door-to-door visits, referring children who were not on track on the vaccination schedule, malnourished children and pregnant women to the health centres. For families far from neighbourhood health centres, the referrals were managed through outreach sites.

At the end of the intervention, 14 923 children (55% of the expected number in the catchment area) were vaccinated, 662 ANC first visits (44% of expected number) were carried out, and 1514 (8.5% of expected number) children with malnutrition were identified through screening. A respondent that participated in the activity considered that, in the context of COVID-19, "the intervention package allowed people to regain confidence in the health system."

WHO and Ministry of Health participants mentioned several challenges to consider for scaling up this successful intervention. Those included: high costs related to the mobilization of high number of staff; the work being incentive-based; the need for decentralization of responsibilities for managing community mobilizers to *Médecins chefs* in the regions beyond the central Health Promotion Directorate; the lack of clear plans for institutionalizing the function of community health work (CHW) and cross-referral systems between them and the health facilities.

3.7 What has been the added value of WHO regional and headquarters contributions to the achievement of results in Djibouti?

With limited staff capacity at the WCO level, WHO Regional Office for the Eastern Mediterranean support has been instrumental in supporting technical assistance requests from the Ministry of Health. These include technical missions by WHO Regional Office for the Eastern Mediterranean staff, providing technical documentation, recruiting and funding international and national consultants, and mobilizing funding to support activities, especially during emergencies. **Technical focal points in the regional office have also provided regular online mentoring and supervision to WCO staff** including:

- Sharing global standard operating procedures (SOPs) vaccination guidelines and training material on the COVID-19 vaccination campaign, guiding WCO's coordinating role and the Ministry in the response during weekly meetings, the customization of SOPs and organizing a Strategic Committee at the Prime Minister level. The regional office was instrumental in improving the operational and microplanning, including locally on a six-monthly basis. WHO Regional Office for the Eastern Mediterranean also mobilized additional funding from GAVI to support the integration of other PHC services in the COVID-19 vaccination outreaches.
- Development of the first Maternal and Newborn Health Strategy (MNHS) for Djibouti.

- Technical support to the NCD component in the National Health Symposium and providing support to the WCO on the adaptation of the WHO Package of Essential Noncommunicable Diseases Interventions (PEN) and the HEARTS package.
- Development of the draft National Strategy on Mental Health, contributing to the adaptation of the mhGAP package in the context of Djibouti and supporting the Ministry of Health in developing a training plan for health workers on mental health and psychosocial support (jointly with WHO headquarters).
- On the Global Polio Eradication Initiative, WHO Regional Office for the Eastern Mediterranean supported Djibouti through country missions on environmental surveillance and vaccination with the new vaccine (noPV2) after the detection of polio virus in the environment. WHO Regional Office for the Eastern Mediterranean also mobilized funds to investigate suspected cases, conduct field supervision and visits to health posts by national focal points.
- WHO Regional Office for the Eastern Mediterranean has provided support to the implementation of the DHIS2 in Djibouti with an evaluation and four missions of international consultants in 2023, including two from the regional office, ongoing support and capacity building for the roll-out of the DHIS2 and a workshop on tracer indicators monitoring attended by three participants from the Djibouti Ministry of Health.
- Mobilization of funds for measles response through the World Measles Alliance.

However, certain requests by WHO Regional Office for the Eastern Mediterranean to participate in international events are not aligned with local priorities or integrated in workplans, and may have detracted WCO and Ministry staff from their planned activities. WHO Regional Office for the Eastern Mediterranean has organized several workshops, events and conferences inviting WCO staff or Ministry of Health stakeholders. Examples of this included in the Global System for Mobile Communication (GSM) financial and activity report are an annual workshop on UHC Coverage in Dubai in 2019, requesting the WHO Representative to accompany the Minister of Health to a visit at the WHO Regional Office for the Eastern Mediterranean office the same year, or supporting the participation of Ministry of Health staff to a training session on DHIS2 tracer indicators in Lomé in 2022. The contribution of these activities to the priorities of WHO in Djibouti has been limited according to both Ministry of Health and WCO respondents.

WHO headquarters support, where provided, has been relevant and well aligned to country priorities and is particularly beneficial when WHO Regional Office for the Eastern Mediterranean expertise is not available. Headquarters technical support has been obtained on a demand basis where adequate capacity was not available at the WHO Regional Office for the Eastern Mediterranean office. Technical support has been received from the PHC Special Programme on organizing the Symposium and on preparing for the National Health Map. The malaria therapeutic effectiveness study is also conducted with support from WHO headquarters and WHO Regional Office for the Eastern Mediterranean on a regular basis. Emergency responses have also benefitted funds mobilized by WHO headquarters.

EFFICIENCY. To what extent did WHO interventions deliver or are likely to deliver results in an efficient and timely way?

This section analyses the extent to which WHO interventions have reflected an efficient economic and operational utilization of resources, including in response to new and emerging health needs. It also discusses the extent to which results-based management systems have been adequate to ensure efficient operational and timely allocation of resources, as well as adequate measurement of results.

Key findings

Efficiency: The capacity of WHO to deliver results in an economic and timely way has varied.

Finding 17: WHO has used resources efficiently in Djibouti, maximizing its value added by seeking synergies and partnerships and refocusing its resources rapidly to respond to health emergencies, such as the COVID-19 pandemic.

Finding 18: There are instances where WHO interventions were not delivered efficiently. WHO has often engaged in funding direct implementation in Djibouti, a departure from its usual mandate in non-emergency contexts.

Finding 19: Human resources in the WCO are not adequate to deliver on the objectives of the Organization in technical areas such as health system strengthening as part of the PHC agenda, health financing, reducing barriers to health care to achieve UHC and in enabling functions such as monitoring and evaluation.

Finding 20: Overreliance on short-term consultancies has impacted WHO efficiency, hindering the continuity of technical support to the Ministry of Health and the follow-up of the JPRM implementation.

Finding 21: In the absence of a CCS, the planning process in Djibouti has been focused on operational aspects rather than achievement of results. In addition, the lack of a CSP means that the contribution of the three levels of the Organization is not made explicit.

Finding 22: 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 system, which relies on self-assessment by the WCO, is not well reported against. While the WHO Regional Office for the Eastern Mediterranean 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.

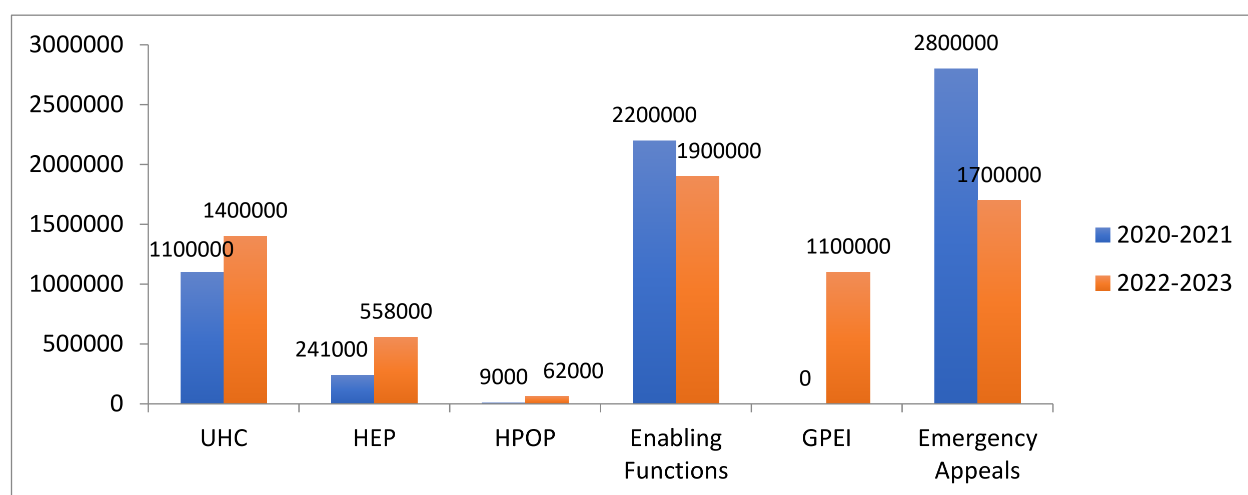
Finding 23: The programmes are well integrated at the WCO level, but there are programmatic silos at the regional level, which means that requests from the regional office sometimes hamper the ability of the WCO to focus on priorities defined in the country. Such issues have not been reported in relation to WHO headquarters support.

3.8 To what extent do WHO interventions reflect efficient economic and operational utilization of resources, including in response to new and emerging health needs that require adjustment or re-prioritization of interventions?

3.8.1 Efficiency in resources use

In line with findings under evaluation question 3 on effectiveness, WCO expenses distribution by strategic objective in the last two biennial show that **across the three billion pillars, UHC has concentrated most resources in the 2020–2021 and 2022–2023 biennia, while few expenditures were made under the healthier population pillar**. In addition to the core work on the three billion pillars, **expenditures from emergency appeals, especially the COVID-19 response, constitute a significant share**. The current biennium has seen an increase in expenditures under all three billion pillars, and polio eradication activities have also picked up. Fig. 6 shows the evolution of WCO expenses by different GPW 13 strategic objectives: the UHC pillar; the EP pillar; the HP pillar; the effective WHO pillar; the Global Polio Eradication Initiative (GPEI) and the emergency appeals.

Figure 6. Expenses in US$ by strategic objective in Djibouti WCO in the last two biennia



Source: WHO programme budget web portal [43] [44]

The Country Support Unit at WHO headquarters has developed a classification of WHO countries in terms of the type of support they require, depending on contextual factors such as the country income group and the presence of a humanitarian response. This classification ranges from A to E – A requiring the lightest level of support and E the most intensive level of engagement for WHO. Djibouti is classified as belonging to category D, corresponding to full technical support without field operations, meaning that the context does not require intense direct implementation.

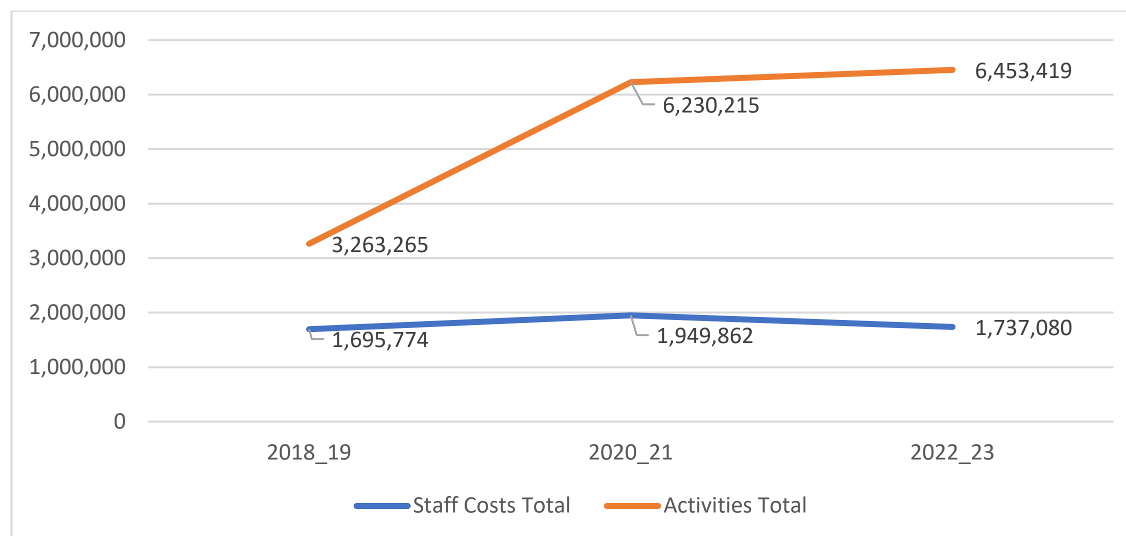
The budget analysis (Fig. 7) shows that **despite activities' costs having increased consistently, doubling across the three last biennia (from US$3.2 million in 2018–2019 to US$6.4 million in 2022–2023), staff costs have remained largely stable around**

[43] https://open.who.int/2022-23/home, accessed on 08/11/23

[44] In Figure 6, at the time of the evaluation (October 2023), expenditures for the 2022/2023 biennium were at 70% whereas the expenses for 2020/2021 were at 100%. Data from the previous biennium was not presented under to GPW13 framework, so it was not possible to provide trend analysis for the three biennia under consideration, including the 2018-2019 biennium.

US$1.7 million. Staff cost share has thus been decreasing from 34% to 21% of the total budget. While this evolution could reflect efficiency gains as it may show that WHO can achieve more with fewer human resources, it may also be relevant on several counts. Firstly, as mentioned above, WHO being a technical agency, it does not usually engage in direct activity implementation, which would warrant high activity costs. Secondly, it is expected that most of WHO value added would come from technical assistance provided by its staff. A low level of staffing to deliver activities may reflect the fact that WHO is largely dependent on external resources in Djibouti, such as consultants.

Figure 7. Evolution of staff and activity budgets over the period 2018–2023 in Djibouti WCO in US$



Source: WHO Global Management System45

3.8.2 Efficiency in delivering results through partnerships

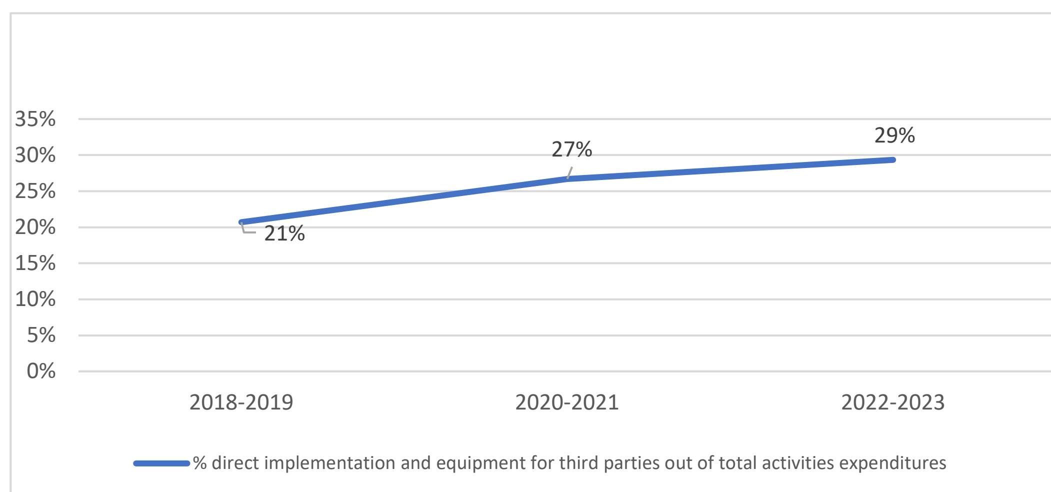
WHO in Djibouti has sought to maximize its value added to other health partners to achieve results. Respondents from UN agencies and donor agencies have recognized this complementary approach by WHO. Examples of resource-efficient contribution include the Global Fund adoption of WHO global normative guidance on malaria, HIV and TB treatment and adaptation to the Djibouti context to support the training of health workers. WHO has sometimes used its resources to complement other agencies interventions to achieve results, such as through the division of labour with UNICEF on child malnutrition. WHO has supported the management of severe, acute malnutrition cases with medical complications, while UNICEF addressed the uncomplicated cases of severe malnutrition. There are also instances where WHO has pooled funds with other agencies to deliver activities, for example for the delivery of integrated vaccination, nutrition and antenatal care outreaches with UNICEF.

[45] The analysis of financial data relies exclusively on information relating to the WCO, as no data was availed to the evaluation on expenses from Headquarters and RO related to the programme in Djibouti.

3.8.3 Efficiency and timeliness of financial resources allocation in relation to emerging needs

WHO has been responsive to emerging health issues, mobilizing and redirecting resources to areas of need. An example of this has been the COVID-19 response, where WHO was able to mobilize and redirect resources rapidly. Fig. 6 above shows the increase in emergency response-related expenditures in the 2020–2021 biennium corresponding to the COVID-19 response. **There are instances, however, where the choice of interventions to deliver results may not have been efficient**, such as engaging in funding direct implementation, purchasing medical supplies, ITNs and facilitating the logistics of the Ministry of Health during field missions outside emergency responses. For example, a Ministry of Health respondent explained that WHO funded the extension of essential mobile care, purchasing vehicles for the regions and providing fuel for movements locally. While the COVID-19 response justified direct operational support from WHO, as regards outside emergency contexts, WHO does not usually engage in direct implementation support. WCO respondents have provided a rationale for this given the fact that for some time donor funding was not directly channelled through the Ministry of Health; however, it was recognized that engagement in direct implementation was not an efficient use of WHO resources in the long run. Nevertheless, budget lines relating to direct implementation and equipment for third parties have been increasing over the three last biennia and have reached 29% of the WCO activity budget in 2022–2023, as illustrated in Fig. 8. This is excluding the budget line on medical supplies, which has covered a large share of COVID-19 related expenses.

Figure 8. Per cent of direct implementation and equipment for third parties out of total activities expenditures



Source: WHO Global Management System[46]

3.8.4 Efficiency in human resources allocation

WHO currently lacks adequate human resources to fulfil its ambitions going forward and offer stable support the Ministry of Health, as it largely relies on short-term consultants for key positions. This can affect continuity of the work and efficient planning and monitoring of activities. A Ministry respondent explained that “the problem is that our counterpart in WHO is not stable, there is no longer regular monitoring.” Other Ministry of Health respondents have noted that WHO has limited capacity to follow on and monitor planned activities, “once the plan [JPRM] has been signed by both parties, there is no monitoring of its

[46] The analysis of financial data relies exclusively on information relating to the WCO, as no data was availed to the evaluation on expenses from Headquarters and RO related to the programme in Djibouti.

implementation neither from the different directorates of the Ministry nor from WHO." This is further exacerbated by changing requests from the Ministry that have detracted attention from conducting planned activities.

The skills and experience of short-term consultants notwithstanding, reliance of consultants has also affected the type of work WHO is able to carry out. Ministry of Health respondents noted that **technical support for WHO has often been delivered in the form of short-term consultancies**. They have called for WHO to redirect resources to long-term technical support for the operationalization of plans and develop staff capacities. A Ministry of Health respondent commented: "We need to improve the monitoring and implementation of activities; ninety-five per cent of planned activities in the JPRM are not carried out. It's a waste of time to plan and hold series of preparatory meetings if planned activities are not financed."

Although the role of WHO is not to "finance" the implementation of activities, human and financial resources are needed to ensure the follow-up of planned activities, including empowering the Government/ Ministry of Health in identifying, planning and advocating at the highest governmental levels to budget appropriate resources where needed.

The current WHO representative has preferred recruiting technical national staff to complement the reduced number of international positions. This has been part of the strategy to develop capacities at country level, while improving efficacy of WHO work by bringing in talent with relevant contextual understanding and connections.

WHO has established a basic staff structure for the country offices in each category (A to D). In the case of an office in category D, such as Djibouti, total number of staff should expand from the eight staff currently employed to around 15 to 20. Enhanced staffing levels would allow the country office to take on additional responsibilities, including on its convening role and stewardship on health system strengthening and engagement with regional initiatives. To this end, the WHO representative has developed a new organigram, which has been approved by the Regional Director, that reflects the needed changes in capacities in the WHO office. It includes the position of the public health officer that would provide strategic support on health system strengthening beyond individual technical programmes. To date however, positions in the new organogram have yet to be recruited due to slow human resources processes in the regional office. In addition to core positions, the WCO or regional office could also raise funds for additional staff to cover new areas. For example, the PHC Special Programme hosted by WHO headquarters has supported the position of the PHC policy advisor in certain country offices.

3.9. To what extent are results-based management systems adequate to ensure efficient operational and timely allocation of resources and adequate measurement of results including in changing circumstances?

3.9.1 Planning

The planning process in Djibouti has been activity oriented, focused on operational aspects rather than achievement of results and contextual health outcome level measurements. A WHO respondent in Djibouti said:

> *We need to move away from implementation of activities and utilization of funds, it does not give us the bigger picture on what we are trying to achieve. Our strategic agenda may not be well understood, and this reduces accountability on improvements in health.*

In the absence of a CCS, the main results framework used in Djibouti is the GPW 13. This has resulted in "retrofitting" planned activities within the GPW 13 results framework rather than translating global outcomes and outputs to the Djiboutian context. The WHO Division of Data, Analytics and Delivery for Impact (DDI) has promoted a data-driven approach to planning through supporting an in-depth analysis of health outcome indicators at country level. This work is instrumental in ensuring that priorities

are established to accelerate progress on health indicators that are lagging, and that the GPW 13 framework is contextualized by identifying specific country-level targets at impact and outcome levels.

The issue of parallel planning processes is compounded by the reported fragmentation and lack of coordination at RO level. The WCO receives many ad hoc requests for participation in international events and demands for information from the regional office, which are not integrated nor aligned with the regular country planning. Respondents reported that some of these initiatives can interfere with planned activities in the context of limited staff availability at the country office and government level. Indeed, in a smaller country office such as Djibouti, one person may be the focal point for several thematic areas, covering, for example, NCDs, road safety and mental health areas, whereas in the RO there are departments dedicated to each of those areas and further divided in sub-expertise (such as dementia, substance abuse, nutrition). Lack of coordination between the different areas may create an overload when request from different departments reach countries or when areas that were not prioritized at country level were encouraged to be included in work plans, for example, on tobacco control. One WCO respondent commented:

> *At the country office level, we are cross-cutting and multitasking, we take on different hats, but at the regional level there are these sub-divisions … for example, dengue is located in neglected tropical diseases [NTDs)] and WHO health emergencies [WHE] programme. This can be redundant, so we have to make them come together to discuss. They need to collaborate before they collaborate with us.*

Crucially, a siloed approach based on disease areas at regional office level may hamper a health-system approach to addressing common issues among the programmes. One example of this is community-based health services, which is currently supported from the vaccination programme rather than benefitting from a strategy at health-system level. Such issues have not been mentioned in relation to WHO headquarters, which has mostly provided technical support when requested by the WCO through the regional office.

3.9.2 Monitoring and reporting

The monitoring of WHO outputs and outcome results in Djibouti has been weak, and monitoring data has not been used for guiding activities and resources allocation to a great extent, but mostly as an upward accountability mechanism.

The corporate reporting process, the OSC, does not reflect adequately the contribution of WHO in the country. OSC reports reviewed by the evaluation presented scant detail on interventions and their results as compared to the information collected through interviews with WHO and Ministry of Health staff. In Djibouti, WHO respondents' contributions reveal that the OSC process has not been carried out in a meaningful manner, in part due to lack of staff time dedicated to reporting. The OSC reports provide no justifications to the scores given, and some of the scores do not appear credible considering the results obtained. For example, the gender, equity and rights (GER) dimension has received very high scores under most outputs, while WHO contribution and focus on those areas appear limited. Another limitation of the OSC exercise is that its value for guiding the work of the country office is unclear, and it is mostly conceived as an upwards accountability process rather than used to generate reflections and improvements in interventions at country level.

As mentioned under evaluation question 3 relating to the effectiveness criteria, while the regional KPIs have been better completed than the OSC, they largely comprise disease or thematic based indicators, which mostly capture the technical assistance interventions of WHO but fall short of reflecting WHO convening and leadership functions. A WHO respondent commented that, “Strategic agendas and advocacy work is not well documented. We need to bring this together in performance indicators”. Functions of WHO on convening, fostering collaborations and partnerships, advocacy, or capacity-building are not well captured, yet are key to WHO advancing strategic agendas, such as supporting a PHC approach and ensuring adequate resources for UHC. For the same reasons mentioned above for the OSC, results of the WHO Regional Office for the Eastern Mediterranean KPIs do not seem to be a primary source of information used in the results-based management system of WHO in Djibouti.

SUSTAINABILITY: To what extent has WHO contributed towards building national capacity and ownership for addressing Djibouti's humanitarian and development health needs and priorities?

This section discusses the extent to which WHO has supported Djibouti's national longer-term goals and a resilient health system. It also analyses the extent to which WHO interventions supported national ownership for health system strengthening as well as national capacity to deliver on planned results in a sustainable manner.

Key findings

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.

Finding 24: WHO interventions on strengthening the health system have a high potential for bringing about sustainable change. However, the interventions have not clearly brought about change in the health system capacity, with the exception of work on improving surveillance and data management where results are emerging.

Finding 25: Although there are good practices and lessons to learn from the COVID-19 response, in general, WHO contribution to the resilience of the health system and responsiveness to external shocks has been limited.

Finding 26: The health sector is fragmented and poorly regulated; public health sector is highly dependent on donor funding; and the support from major donors is expected to decrease in Djibouti over the coming years. These aspects constitute hindering factors for sustainability of interventions aimed at supporting the health sector.

Finding 27: Funding agencies are increasingly seeking ways of encouraging national ownership and domestic funding of the health system. There are expectations from funding partners and the Government that WHO will increase its focus on sustainable financing of the health sector.

3.10 To what extent has WHO supported Djibouti's national longer-term goals and a resilient, shock-responsive health systems, including building national capacity in view of ongoing and future health needs?

3.10.1 Support to Djibouti's longer-term goals

WHO has contributed to lasting change in relation to the PNDS five strategic priorities described in Table 5. However, sustainability of these efforts is hindered by national structural limitations as well as limited capacity at both WCO and Ministry of Health levels. Overall, the operating model of WHO, based on strengthening national capacity to deliver improved health outcomes, is by nature likely to bring sustainable changes. Ministry of Health respondents have underscored the difference between WHO and other health partners in this respect, considering that WHO is first and foremost a technical agency and a close collaborator of the Ministry of Health. Strengths include equipment and supplies, health care staff meetings and surveillance systems. On essential medicines availability, WHO worked to build the capacity of the CAMME and supported the development of a national list of essential medicines in the current biennium. The extent to which those efforts are likely to lead to sustainable improvements in essential medicines availability is still unknown, given issues relating to the regulation and financing of the health sector. On qualified human resources, WHO has supported cascade training for health-care staff in different areas, such as neglected tropical diseases diagnostic and treatment, acute severe malnutrition case management, or

immunization. It is possible that these efforts are sustained; however, long-term outcomes depend heavily on the ability of the Ministry of Health to maintain effective support supervision of staff. WHO has also contributed to the implementation of the DHIS2 in Djibouti and has supported the national capacity to rapidly detect and respond to outbreaks of diseases, such as polio through environmental and case surveillance or measles through restarting the clinical investigation of eruptive fever cases. Results on these are likely to bring sustainable improvements to surveillance capacity in Djibouti.

Limitations include fragmentation of the health sector, poor health system financing, limited governance and high turnover of Ministry of Health staff. A hindering factor for the sustainability of WHO contributions to health outcomes in Djibouti is the high turnover of staff in the Ministry, which has limited the capacity-building efforts of WHO as Ministry counterparts moved on to other positions. In some incipient areas such as NCD and mental health, it is likely that changes obtained are not yet sustainable, as those programmes are largely dependent on the technical support of WHO. A respondent in Djibouti thus commented, “without WHO support, mental health is over”. In other areas such as malaria, TB and HIV, it is likely that the adoption of improved detection, diagnostic and treatment protocols are sustainable given that other partners of the health sector, such as the Global Fund, direct their support to programmes that adhere to the WHO guidelines. The fragmentation of the health sector and the lack of regulations applying to the different service provision mechanisms, within and beyond the Ministry of Health, have also been an important issue for health system governance. WHO and Ministry respondents report that the Ministry of Health has limited oversight and regulatory power over other powerful sectors of the health care system, such as the CNSS, which depends upon the Ministry of Labour, and the para-public service providers, such as police, gendarmerie, coast guards and army that depend upon the Ministry of Interior. So far, these issues have not featured prominently in WHO interventions.

3.10.2 Contribution to a resilient, shock responsive health system

Respondents from Ministry of Health and health partners, who commented on the COVID-19 response, unanimously acknowledged WHO leadership and good practice in the pandemic response. However, there is scant evidence that WHO interventions have contributed to strengthening the resilience of the health system and responsiveness to external shocks. The IHR core capacity index score of Djibouti is low and declining, and this is particularly true for the indicators on the prepare dimension. According to the JPRM and reports on WHO Regional Office for the Eastern Mediterranean KPIs, activities planned to develop an emergency preparedness plan and conduct drills have not been carried out, nor has the planned IHR Joint External Evaluation, which would provide recommendations on improving emergency preparedness. WHO respondents considered that the COVID-19 response in Djibouti provided examples of good practices to learn from when responding to other emergencies. These include the coordination mechanism of the response and the involvement of communities in conducting microplanning for vaccination. There is scope for WHO to discuss with the Ministry counterparts on how to build on and learn from those experiences to inform future emergency responses.

3.11. To what extent have WHO interventions supported national ownership for health system strengthening, as well as national capacity to deliver on and achieve the results as planned in the relevant national health policies and strategies? Is there evidence that the benefits will be sustained over time?

Public investment in the health system in Djibouti is low, and stakeholders from all categories of respondents highlighted the need for securing national ownership of the health agenda to accelerate progress on health-related SDGs that are lagging in Djibouti.

There are strong commitments on the part of the Government of Djibouti to address health inequities and progress on the UHC agenda. At the 1995 World Summit on Social Development held in Copenhagen, the Government of Djibouti committed to dedicating 20% of its national budget to health. Djibouti's strong economic growth in past years provides renewed opportunities for government investment in health, and external funding has more than doubled over the period: net disbursements of total official development assistance received for medical research and basic health sectors increased from US$4 million in 2011 to US$8.9 million in 2021.[47] Yet, domestic general government health expenditure was only 4.3% of general government expenditure in 2020, down from 8.5% in 2011.[48]

The national health programmes are highly dependent on donor funding, and some of the programmes in the Ministry do not have a specific budget line for activities, such as the NCD and mental health programmes. Similarly, whereas the Government has granted free access rights to health services to migrants, the cost of this policy is entirely supported by partners, and its sustainability is questionable in the context of a fragile and fragmented health system. The EPI programme depends on funding from GAVI, UNICEF and WHO. UNICEF fully funds the routine "traditional" vaccines, whereas WHO has funded the distribution of mosquito nets, both unusual activities outside emergency contexts.

Major donors have indicated that they would reduce their investment progressively. GAVI is initiating an accelerated transition phase from the end of 2023, with a perspective of gradually winding down its funding as of 2029. While in 2023, GAVI was taking charge of most costs of the EPI programme, it will reduce its support to 80% of the vaccination programme budget in 2024. The Global Fund has also indicated its plan to progressively reduce the share of its funding going forward, encouraging the Government to dedicate additional domestic resources to bridge the gap in a co-funding modality.

As Djibouti becomes a MIC, dependency on external funding of the health system may become increasingly difficult to justify. Major donors are interested in joining forces to accompany the transition of the health sector financing to increased public investment in health. An encouraging sign in this direction is the fact that the Government has been willing to reappropriate the funding of the Global Fund in 2023, whereas previously UNDP had been the principal recipient managing those funds in Djibouti. As part of this shift, the Global Fund and partners have focused on supporting the capacity of the Government to manage these funds and in going forward facilitate the transition to domestic funding for health.

Respondents have highlighted **that WHO is well placed to support dialogue with the Government of Djibouti on the topic of health financing.** Areas where the Ministry could benefit from technical support from WHO include the tracking of public/donor spending on health as well as in the development of a health sector financing strategy. A Ministry of Health respondent explained that "Documents such as a health financing strategy do not exist. The World Bank conducted an assessment of health system financing, but national health accounts must be done annually, which WHO previously supported. Next step after the World Bank study is the financing strategy to be developed with WHO."

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[47] See https://unstats.un.org/sdgs/dataportal/countryprofiles/dji#goal-3 (accessed 7 November 2023).
[48] The World Bank database, https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=DJ (accessed 8 November 2023). These figures may not capture Government investment in health that are not channelled through the Ministry of Health, for example, the NSS and para-public services providers.

4. 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 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 Ministry of Health. 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, planned WHO interventions experienced delays as human and financial resources were primarily redirected to respond to emergencies and outbreaks. Furthermore, the effectiveness of WHO contributions in Djibouti were limited by WRs turnover and the relationship with the Ministry of Health. Nevertheless, WHO support to 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 objectives. While the responsiveness of WHO to Ministry of Health needs and emerging requests has been particularly positive 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 sufficiently used to guide programming. While crucial in many technical areas, support from the regional office 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 Ministry of Health has been low, leaving them vulnerable in case of a reduction in external support. There is a need for reforms and regulations to reduce fragmentation, as well as supporting sustainable financing of the health sector alongside of planning a transition to increased domestic funding and national ownership of the health agenda.

5. Recommendations

The recommendations below were co-developed with members on the Evaluation Reference Group, including those from the Ministry of Health, UN agencies in Djibouti and WHO staff at the country and regional levels during an online workshop held on 23 November 2023.

Recommendations are classified between: High – those that should feed into the next planning cycle and must be addressed within this biennium; Medium – those that should be implemented in the next planning cycle (2 years).

Recommendations in italics are urgent.

Recommendation	**Lead** and supporting	Priority/urgency level
Recommendation 1. In the next 5 years WHO WCO and WHO Regional Office for the Eastern Mediterranean should prioritize health system strengthening interventions and develop a PHC approach as the overarching framework under which to implement programme-specific work.		
a. Ensuring that priority areas of support for WHO are identified based on an analysis of health indicator trends as part of JPRM and CCS processes	**WCO**/support from WHO Regional Office for the Eastern Mediterranean and DDI	High
b. Supporting a PHC approach through the development of a health map linked to other processes to maximize usefulness (for example, health regulations) to operationalize a basic service package at PHC level	**WCO**/Support from WHO Regional Office for the Eastern Mediterranean and headquarters PHC Special Programme	High
c. Supporting the institutionalization of community health services, building on the strategy currently developed with UNICEF with technical input from WHO	**WCO**/Support from WHO Regional Office for the Eastern Mediterranean and headquarters PHC Special Programme/UNCT	Medium
d. *Advocating for UHC implementation, particularly documenting, analysing and addressing barriers to health care for different marginalized groups***.** This should include providing technical assistance on the design and use of disaggregated data in planning and monitoring and survey exercises, commissioning studies to design interventions for marginalized groups and strengthening marginalized groups' networks and CSOs.	**WCO**/support from WHO Regional Office for the Eastern Mediterranean and Social Determinants of Health Unit	High
Recommendation 2. WHO future interventions should systematically address barriers to healthcare access and determinants of health		
a. Addressing barriers to accessing care, through supporting the institutionalisation of community-based health workers, including by learning lessons from the experience of the integrated outreach project on vaccination, antenatal care and nutrition as part of the development of the CHW strategy.	**WCO**/UNCT UNICEF	Medium

b. Supporting a review of the emergency preparedness response, including supporting the development and implementation of an operational plan detailing the roles and responsibilities of different public and para-public sectors. This may include negotiating the use of hospital facilities in the foreign military bases in case of major disaster.	**WCO**/support from WHO Regional Office for the Eastern Mediterranean, WHE	Medium
c. Addressing determinants of health, through documenting and analysing different factors of health inequalities and strengthening the capacity of the health system in responding to those. Health inequalities and the identification of gender dynamics and marginalized population groups needs should be integrated in a cross-cutting manner in all technical assistance by WHO to programmes, including in EPI, RMNCH, malaria, HIV and TB.	**WCO**/ support from WHO Regional Office for the Eastern Mediterranean / SDH Department	High
d. WCO to invest more resources to deliver interventions in the healthier populations pillar. NCD risk factors strategies should be supported based on results of STEPwise survey once conducted	**WCO**/ WHO Regional Office for the Eastern Mediterranean /NCD Unit	Medium
Recommendation 3 By March 2024 refine the reconstructed theory of change, as a basis to develop an evidence-based, theory of change-based CCS and related CSP.		
a. The CCS should be based on an analysis of health outcomes in country as well as health system level indicators with support from WHO headquarters DDI and in collaboration with Ministry of Health stakeholders, as a capacity building exercise.	**WCO**/support from WHO Regional Office for the Eastern Mediterranean and DDI	High
b. *The CCS development process should use a ToC process to clearly articulate the health system level changes WHO will contribute to, translating the GPW 13 outcomes and outputs into contextually relevant targets for Djibouti.* Intermediary changes should be identified (policy- and programme-level changes) as well as WHO interventions to support those.	**WCO/ WHO Regional Office for the Eastern Mediterranean / CSU**	High
c. This CCS should be used as a basis for communicating on the role of WHO to other health partners, addressing perceptions of WHO as a donor agency or NGO. Consider developing a two pager on the new CCS.	**WCO**	Medium
d. In line with the Organization's structure, a biannual CSP should be developed to outline the contribution of the three levels of the Organization in Djibouti.	**WCO/ WHO Regional Office for the Eastern Mediterranean /headquarters CSU**	High
Recommendation 4. WHO at country and regional levels should support the Ministry of Health in strengthening its leadership and coordination role.		
a. Working to address the bottlenecks to the operationalization of the PNDS, in terms of operational planning, budgeting and monitoring. WHO should support the Ministry in developing such planning and monitoring at all levels of the health system and provide long-term technical support to ensure the sustainability of these processes.	**WCO**/ Ministry of Health and health sector partners	Medium
b. *Supporting the review of the current PNDS and the development process of the new PNDS*. Support the Ministry of Health to initiate a wide-ranging engagement process with key actors in the health sector as well as with other Ministries to foster a multi-sectoral approach, strategies to tackle health regulations and increase harmonization and coherence of the health services providers under the leadership of the Ministry of Health	**WCO**/ Ministry of Health and health sector partners	High
c. Advocating to the Government for resources to be dedicated to this coordination role in the Ministry.	**WCO**/Government of Djibouti	Medium
d. Advocate for the Groupe des Partenaires Santé to be reconvened and reflect with Ministry of Health on how to maximize the usefulness of this platform.	**WCO**/ Ministry of Health	High
e. Engaging with donors in global platforms that can be activated at country level, such as the SDG3 Global Action Plan and IHP+. WHO Regional Office for the Eastern Mediterranean may liaise with other members of these platforms at regional level to explore potential partnerships at country level.	**WCO/ WHO Regional Office for the Eastern Mediterranean**	Medium

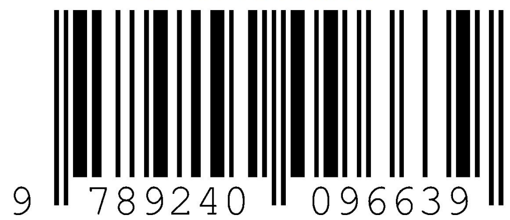
		/headquarters (for example SDG3 GAP Secretariat)	
f.	In the UNCT, by supporting health-related work of non-resident agencies. For instance, WHO can help leverage the support of non-resident UN-agencies such as UNAIDS, ILO and IAEA to achieving health priorities of Djibouti.	**WCO**/UNCT	Medium
Recommendation 5. WHO should improve its effectiveness by supporting a whole-of-society, whole of government approach			
a.	Seeking avenues to broaden participation of civil society and community actors in the governance of the health sector, in community mobilization and in services provision.	**WCO**/ WHO Regional Office for the Eastern Mediterranean PHC Programme	Medium
b.	Enabling multisectoral work on areas requiring collaboration between different Ministries, such as vector control, nutrition, emergency management. WHO to support Ministry of Health in consolidating/streamlining the many commissions and coordination bodies exist in Djibouti to improve their effectiveness.	**WCO**/ WHO Regional Office for the Eastern Mediterranean and corresponding departments and units in Headquarters (NCD, AMR, WHE)	Medium
Recommendation 6. Strengthen efficiency of WHO through improved allocation of financial resources, human resources and management systems			
a.	Engaging in a dialogue with the Ministry from the WHO regional office level to find a way forward on the question of implementing planned activities versus responding to short-term demands.	**WCCO/ WHO Regional Office for the Eastern Mediterranean**	Medium
b.	*WHO Regional Office for the Eastern Mediterranean to facilitate as soon as possible the implementation of a new organogram in line with the WHO Regional Office for the Eastern Mediterranean administrative review recommendations to ensure sufficient technical and administrative capacity in the office to deliver planned results***.** Improving WCO capacity on specific areas that have been identified (supporting the health reform based on a PHC approach, providing long-term technical assistance to Ministry of Health on the operationalization of the PNDS, strengthening M&E function, integrating GER in a cross-cutting manner, increasing civil society engagement) requires an urgent strengthening of capacity in WCO.	WHO Regional Office for the Eastern Mediterranean	High
c.	Djibouti WCO to continue prioritizing the recruitment of national staff as part of the new organogram.	WCO/support from WHO Regional Office for the Eastern Mediterranean	Medium
d.	WHO Regional Office for the Eastern Mediterranean to implement a country-focused, streamlined approach on supporting the WCO technical and business operation needs, inscribing its contribution in an integrated, three level plan (CSP). Options include holding coordination meetings of all officers involved with Djibouti and reviewing planned activities annually to ensure they align to CSP and are streamlined before requests are made to WCO; or having a focal point in RO to coordinate input from RO colleagues for Djibouti and track the implementation of the RO interventions in the CSP.	WHO Regional Office for the Eastern Mediterranean	Medium
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 KPI framework.			
a.	Design a monitoring framework that outlines indicator baseline and target values for Djibouti, in line with the global results framework and the regional KPI framework.	WCO/ WHO Regional Office for the Eastern Mediterranean /PRP and CSU	High
b.	Improve the quality of data and reporting by dedicating sufficient staff capacity to these tasks; and improve the use of monitoring data, by regularly analyzing progress on planned outputs and contribution to expected outcomes to guide planning.	WCO/ WHO Regional Office for the Eastern Mediterranean	Medium

c. The OSC reporting should be used as an occasion for critical reflection on the contribution of the WCO to cross-cutting issues such as gender equality; health equity, human rights-based approach and disability inclusion. Annual OSC process can be done through a workshop format involving all WCO staff (technical and administrative) and be directly linked to reviewing planning for the following year.	WCO/PRP	Medium
Recommendation 8. Together with other development partners WHO should actively support the Government on health sector reform.		
a. Supporting the Government in coordinating the development and implementation of a multi-sectoral health emergency preparedness plan.	WCO/ WHO Regional Office for the Eastern Mediterranean, WHE	Medium
b. Advocating for the Government to undertake required reforms to strengthen the leadership, coordination role and regulatory power of the Ministry of Health over all actors engaged in health services provision in collaboration with other key actors, such as the Ministry of Health, Global Fund and World Bank.	WCO/ Ministry of Health and health partners	Medium
c. Supporting the development and implementation of a health sector financing strategy, building on the existing situation analysis conducted recently by the World Bank on this issue.	WCO/ responsible unit for health financing in UHC; Ministry of Health and health partners	High

6. Lessons learned to be considered in other low- and middle-income countries (LMICs)

- The focus on delivering technical assistance and operational support to disease-based programmes at the expense of a health system strengthening approach hinders the realization of the contribution of the Organization in Djibouti, in particular the use of the full range of the Organization's functions on convening, fostering collaborations and partnerships, advocacy and capacity-building needed to deliver on its mandate.

- The Government and the Ministry of Health need more long-term, capacity-building type of technical assistance from WHO, while WHO has mostly worked through short-term consultancies of limited scope.
- A good example of a strategic intervention has been the participation of WHO in integrated outreach services combining vaccination, ANC and nutrition services. This intervention, conducted in partnership with UNICEF, has shown positive results and has proposed a model of service addressing the issues of availability and accessibility of health services. Pooling resources with other agencies on innovative approaches while focussing on its technical role within the partnership is a good way for WHO to maximize the impact of its work and efficiently use resources.
- A key issue hampering progress on health outcomes in Djibouti is the lack of annual budgets and operational plans to implement the national health plan, which is also outdated and needs to be reviewed to include regulation of the health sector. This has led to a reactive approach, short-term planning horizon in the Ministry, which has in turn impacted the ability of WHO to deliver on agreed priorities while responding to evolving requests from the Ministry.
- The lack of coordination of the health partners and funding agencies is the other bottleneck to the effective implementation of a UHC–PHC approach in Djibouti, and poor progress on the UHC agenda. There are expectations from all categories of stakeholders in Djibouti that WHO take a leading role in supporting the Government–Ministry to address these issues.
- In a context where domestic resources are growing and the Official Development Assistance (ODA) for health has been increasing in the last decade, low investment by the Government in the public health sector jeopardizes the sustainability of any progress on health outcomes in Djibouti, particularly as major donors are planning to reduce their contributions in the country. WHO has a role to play in raising the profile of health issues nationally as well as at regional level to increase sustainable funding for health, from domestic sources. WCO needs additional human resources capacity to deliver on this convening and stewardship role.
- Extending participation of all sections of society through a whole-of-society, whole-of-government approach has been challenging, as well as having been met with resistances despite the efforts of WHO. Despite the challenges encountered, in going forward WHO should pursue opportunities to promote greater civil society participation and multisectoral actions in health and promote efforts to analyse and address health equity and rights issues.
- The strategy to recruit and retain national staff in the country office has produced positive results in terms of facilitating relationships with national counterparts and taking advantage of contextual understanding and networks of the national staff.
- Lack of coordination between different departments at the regional level can impact negatively on the ability of the WCO to deliver planned objectives. A shift in perspective is needed from the RO to adopt a country-centred approach focussing on supporting the technical and operational needs of the WCO in a coordinated and synergetic manner.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