
Evaluation of WHO's contribution in Djibouti

Annexes



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

Photo credit: WHO

Annex 1: Terms of Reference

Evaluation of WHO contribution in Djibouti

Terms of reference

I. Introduction

Evaluations of WHO contribution at country level are included in the biennial WHO organization-wide evaluation workplans, approved by the Executive Board. These evaluations focus on the outcomes/results achieved at country level using the inputs from all three levels of the Organization. They also assess WHO contributions towards public health needs of the country and the objectives formulated in WHO general programmes of work and key country-level strategic instruments, including CCS, biennial WHO WCO workplans and national health strategies. They document good practices and provide lessons that can be used in the design of new strategies and programmes in-country going forward. For the biennium 2022–2023, the WHO Evaluation Office has planned the evaluation of the contribution of WCO in Djibouti. This is a timely evaluation as WCO is undergoing rapid transition, is embarking on new processes of support to the Djibouti MoH and will aim to inform WCO planning going forward.

II. Country and health context

The Republic of Djibouti is one of the smallest countries in Africa, located at Eastern Africa and has an area of 23 200 km² with a moderate population density: 43 people per square kilometre.¹ The current national health system in Djibouti is defined by an inadequate health infrastructure for primary care and hospital services with COVID-19 having led to the weakening of the health system.² With a population of 1.1 million people in Djibouti, Table 7 below shows key population and health-related statistics.

Table 1: Djibouti key population and health statistics

Population ³	
Population (2023)	1.1 million
Population proportion 0-14 years	0.33 million
Population proportion 10-19 years	0.22 million
Population proportion over 65 years	0.055 million
Life expectancy at birth (2020)	61 (male); 66 (female)
Socio-economic indicators	
Gender inequality index	ND
Human Development index rank ⁴	0.524 (166/189)
Health (2020) ⁵	
Neonatal mortality rate	30/1000 live births
Infant mortality rate	48.4/1000 live births
Under 5-years old mortality rate	57.4/1000 live births
Maternal mortality ratio	248/100,000 live births

¹ Djibouti CCA.

² See [National Development Plan 2020-2024, Djibouti ICI](#).

³ State of World Population Report 2023, <https://www.unfpa.org/sites/default/files/swop23/SWOP2023-ENGLISH-230329-web.pdf> (accessed 24 July 2023).

⁴ Analysis of the business environment in Least Developed Countries: Djibouti 2023, <https://www.ioe-emp.org/index.php?eID=dumpFile&t=f&f=157927&token=1dc508a58a521bb32d56dbcaa81687bcf57ece0e> (accessed 24 July 2023).

⁵ Country profile, UN Women, <https://data.unwomen.org/country/djibouti> (accessed 24 July 2023).

Proportion of births attended by skilled health personnel	87.4
Antenatal Care Coverage (4+ visits) ⁶	22.6%
Total fertility rate	2.7
Health systems ^{7, 8}	
Physician density	0.22/1,000 population
Nurses and midwives' density	0.73/1,000 population
Births attended by skilled personnel	87.4%
(MCV2) measles immunization coverage among 1-year-olds (%)	48%
(POL3) Proportion receiving 3 rd dose of the polio vaccine	59%
UHC service coverage index	47
Health financing ⁹	
Per capita current health expenditure (US\$)	US \$105.22
General government expenditure on health as % of total government expenditure	52.74
Out-of-pocket expenditure on health as % of per capita current health expenditure	26.59

The Djibouti Vision 2035¹⁰ identifies the following to be the challenges in the health sector: populations find that health infrastructures are hardly operational, handicapped by the lack of equipment, ambulances, by the weak water and electricity supply; and the difficult access of rural populations to urban centres due to the lack of rural roads. Drugs supply is insufficient, community pharmacy stock is not regularly renewed and private pharmacies are not available in the regions. Solid wastes and the lack of sanitation in major towns deteriorate the populations' health. The Djibouti National Health Development Plan (2020 – 2024)¹¹ lays down five strategic priorities: (i) An equitable offer of quality care available for everyone and everywhere in the country and which meets the needs of the population, particularly the poorest and most vulnerable; (ii) The integration of quality promotional, preventive and curative care services centred on primary health care and adapted to the epidemiological and socio-cultural context of the country; (iii) Good governance in the management of health services strengthened through a increased accountability for the results of the PNDS at all levels of the health pyramid; (iv) Adequate and sustainable financing to ensure UHC and the social protection of vulnerable populations; and (v) An efficient health information system with quality data available and used in real time to facilitate informed and timely decision-making.

Djibouti benefits from WHO support through a cooperation strategy that seeks to address communicable diseases, including the three priority diseases (malaria, TB and HIV), and noncommunicable diseases to support maternal and/ child health, and to strengthen the health system according to the National Health Development Plan.

III. Evaluation object

WHO has supported health development in Djibouti over the past 50 years. Whereas the current UNSDCF¹² is valid until the end of 2024, the WCO does not currently have a CCS since the last CCS covered the 2013–2016 period. WHO is part of the UNSDCF, and its set of interventions are contained under the Health, Nutrition and WASH domain (inclusion), and the protection of vulnerable groups (institutions) of the 2022–2024 extension. As the current UNSDCF ends in 2024, there is an ongoing process by UNCT in evaluating the current UNSDCF and conducting a country case analysis in readiness for developing a new UNSDCF later this year. Key priorities for WCO in Djibouti between 2019 and 2023 have been on health system strengthening, supporting emergency response context, and health promotion. Another component of WHO work in Djibouti in the past four years focused on responding to the Covid-19 crisis and supporting surveillance and infection prevention, response and preparedness systems.

⁶ Country health dashboard, <https://idea.usaid.gov/cd/djibouti/health> (accessed 24 July 2023).

⁷ Ibid.

⁸ See [Djibouti: WHO and UNICEF estimates of immunization coverage: 2022 revision](#).

⁹ Loc. cit. n. 58.

¹⁰ Djibouti 2035 Vision.

¹¹ Djibouti National Plan for Health Development (PNDS) 2020-2024.

¹² Addendum to the United Nations Development Assistance Framework. UNDAF Expansion 2022-2024.

III.I. WHO Country Office key interventions

The main program interventions that WHO supported directly in Djibouti relate to enabling Djibouti to develop and implement Universal Health Coverage (UHC) and Primary Health Care (PHC) strategies after conducting the health sector review. Key focus areas included supporting Djibouti to:

- strengthen health system including disease control programmes, in particular EPI and malaria
- develop and implement strategies for Maternal, Neonatal, and Child health (MNCH), and Adolescent health including introduction of new vaccines;
- develop NCD and mental health psychosocial support strategies and action plans
- evaluate the burden of NTD and support leishmaniasis interventions;
- support the pharmaceutical system with the updating of its EML;
- comprehensive review of the health information system needs, and
- support the development of a one Health strategy including AMR through collaboration with the FAO.

The Country Office interventions also focused on polio outbreak and food insecurity–nutrition crisis response included: technical assistance (surge support) towards human resources; capacity-building; response coordination (campaign support); and surveillance strengthening (both environmental and AFP, including RRT deployment, quality review meetings; surveillance training of focal points, community engagement, data management, etc.). Furthermore, support went into development of case management of medical complications of severe acute malnutrition and integrated surveillance systems.

In addition, the WCO supported Djibouti to develop emergency care, including trauma care, as part of future development of road safety policies. The WCO also aided Djibouti to occupational health with the first protocol for occupational health and security, together with the ILO. Health promotion strengthening interventions in Djibouti included assistance on health promotion, including the Healthy Djibouti City initiative, and reinforcing the Health Promotion Department at MoH.

Since the onset of the Covid 19 pandemic, the WCO worked with the MoH and other stakeholders to: strengthen infection prevention and control; laboratories and diagnostics; case management and therapeutics; vaccination; risk communication, community engagement and infodemic management; surveillance outbreak investigation contact tracing; and essential health services and systems.

III.II. Djibouti WHO Country Office budget

The Table A2 below shows the biannual budget breakdown by category of interventions. BASE categories include four WHO core areas of mandate and focus: UHC, health emergencies, building healthier populations and WHO enabling functions (evaluation, compliance, audits, ethics, etc.). Emergencies refer to both COVID and non-COVID emergencies under the “outbreak, crisis response and scalable operations” budget line. The polio category comprises funds supporting polio elimination strategies. Major donors during the 2020–2021 and 2022–2023 programme budget period include GAVI, Germany, Italy, 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 (NPT).

Category	2018/2019			2020/2021			2022/2023		
	Allocated PB	Funds received	Utilization	Allocated PB	Funds received	Utilization	Allocated PB	Funds received	Utilization
BASE	5,086,900	4,083,568	3,891,895	4,706,500	4,461,879	3,673,853	7,827,800	7,332,118	3,874,071

Emergencies	1,250,000	850,533	821,457	5,744,800	5,229,966	4,224,832	4,944,972	2,164,805	2,105,218
Polio	ND	ND	ND	ND	ND	ND	1,423,000	1,264,275	1,089,045
Total	6,336,900	4,934,101	4,713,352	10,451,300	9,691,845	7,898,685	14,195,772	10,761,198	7,068,333

Table 2: WHO Country Office Funding information

III.III. Results-based monitoring system

Globally, each WCO reports towards a set of indicators linked to WHO's current Global Programme of Work and its Results Framework. The results-based monitoring system in Djibouti is thus linked to [WHO's Global Programme of Work 13 2019-2023 \(GPW13\) Results Framework](#) to reach the triple billion target.¹³ It reports against all GPW13 output indicators linked to the global 12 outcomes. Each output has key performance indicators and related definitions with a red-yellow-green rating to assess status. The full reporting framework will be shared during inception. Djibouti WHO Country Office mid-term review reports and End of Biennium assessment reports will also be available for review at inception stage.

IV. Evaluation purpose

The main purpose of the evaluation of WHO contribution in Djibouti is to:

- a. Enhance accountability for results towards external and WHO stakeholders (including, inter alia, governing bodies, Republic of Djibouti, Member States, donors and Djibouti partners, as well as the WHO Regional Director for the Eastern Mediterranean, the WHO Representative in Djibouti and the programmes in EMRO) through an impartial and comprehensive assessment of the results contributed by WHO work in Djibouti.
- b. Identify critical strategic shifts/direction for the Country Office going forward so that WHO is strategically positioned in Djibouti.
- c. Strengthen organizational learning for informed decision-making processes, particularly in the design, resourcing and implementation.
- d. Inform development of new strategic documents (UNSDCF and CCS).

The evaluation will be both summative and formative. Summative aspects will seek to achieve a better understanding of the types of results and achievements, both intended and unintended, stemming from WHO interventions. For the formative part of the evaluation, the goal is to identify lessons learned and core areas of work to the design and implementation of WHO interventions in Djibouti.

V. Evaluation objectives

This evaluation will build on an analysis of existing documents and data of relevance to the purpose of the evaluation, complemented with the perspectives of key stakeholders, to:

- a. assess the achievements against the objectives formulated in country-level strategic instruments and corresponding expected results developed in the WCO biennial workplans, while pointing out the challenges and opportunities for improvement;
- b. assess past successes, challenges and lessons learnt from WHO work, to support the WCO and partners in the development and resourcing of the next strategic instruments and operational planning mechanisms;
- c. Define WHO strategic shifts needed to improve strategic positioning of WHO going forward; and
- d. assess communication and coordination approaches among the three levels of the Organization and in-country stakeholders, to identify the strengths and areas for improvement of WHO's modalities of technical assistance as well as case studies that demonstrate strong co-ownership, collaboration and good use of funding.

¹³ See <https://www.who.int/about/general-programme-of-work/thirteenth> (accessed 1 February 2024). This uses a subset of 46 outcome indicators: 39 SDG indicators and seven Member State-approved indicators covering a range of key health topics.

VI. Evaluation scope

The evaluation will cover all development and humanitarian interventions undertaken by WHO (Djibouti WCO and supported by the Regional Office -EMRO, and headquarters) over the last three biennia (2019 – 2023), and as framed in the relevant strategic instruments (such as UNSDCF, UNDAF and any relevant national policies), as well as operational planning and reporting mechanisms covering activities which took place over this period. The geographical scope will include initiatives implemented across the country and any specific regional interventions, if any. This evaluation will focus mainly on the health sector, with cross-linkages to collaborating sectors such as finance, environment and education. The selected time frame not only corresponds to WHO's GPW13 period of implementation, but also corresponds to pre- intra- and post-COVID-19 phases of the response. The focus of the evaluation will be at both policy level and programme level, as well as specific operations (such as COVID-19 response).

VII. Stakeholders and users of the evaluation

Table A3 shows the role and interests of the main evaluation stakeholders and expected users of the evaluation.

Table A3. Preliminary stakeholders' analysis

Internal stakeholders	Role and interest in the evaluation
WCO Djibouti	The results of the evaluation will inform the design and implementation of the next country strategy as well as future interventions and strategic shifts to improve future contributions.
WHO Eastern Mediterranean Regional Office	The Regional Office has a direct stake in the evaluation in ensuring that WHO's contribution at country level is relevant, coherent, effective and efficient. The evaluation findings and best practices will be directly useful to inform other WCOs in the Region as well as regional approaches in health.
Headquarters management	Headquarters management is in charge of the strategic analysis of the content of country-level strategic instruments and their implementation and is responsible for promoting application of best practices in support of regional and country technical cooperation.
Executive Board	The Executive Board has a direct interest in being informed about the added value of WHO's contribution at country level and being kept abreast of best practices as well as challenges through the annual evaluation report.
External Stakeholders	
Government of the Republic of Djibouti	As a recipient of WHO's action, it has an interest in the partnership with WHO, and an interest to see WHO's contribution to health in-country independently assessed. Will be engaged at ERG, validation, stakeholder workshop, and use of evaluation.
Djiboutians including health care providers; para-public sectors such as the armed forces and CNSS	WHO's action in-country must ensure that it benefits all population groups, prioritizes the most vulnerable and does not leave anyone behind. The evaluation will look at the way WHO pays attention to equity and ensures that all population groups are given due attention in the various policies and programmes. Will be engaged during data collection as respondents.
UNCT (UNICEF, IOM, UNDP, UNFPA, UNHCR, FAO, WFP)	WHO as part of the UN Country Team contributes to UN strategic frameworks alongside other UN agencies. There is therefore an interest for the UN Country Team to be informed about WHO's achievements and be aware of the best practices in the health sector, a identify opportunities for partnership. Will be engaged as part of ERG or key informants during data collection.
Donors and partners (such as World Bank, USAID, French cooperation, AFD French development)	Donors (multilateral and bilateral agencies) and philanthropic foundations have an interest in knowing whether their contributions have been spent effectively and efficiently and if WHO's work contributes to their own strategies and programmes. Will be engaged through WHO publications on completion of the evaluation.

agency, ADB, Bill & Melinda Gates, IGAD, Africa CDC, GAVI, Global Fund, AU, China, Saudi etc)	Partners will be engaged at data collection stage in interviews.
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VIII. Gender, equity and human rights considerations

This evaluation will adhere to the UNEG norms and standards for evaluation and WHO guidance and policies, including the WHO Policy and Strategy on Health Equity, Gender Equality and Human Rights, 2023–2030 and the WHO Policy on Disability, WHO Evaluation Policy (2018), UNEG Guidance on Integrating Human Rights and Gender Equality in evaluations (2011 and 2014) and UNEG Guidance on Integrating Disability Inclusion in Evaluations (2022). The evaluation is expected to integrate gender, equity and human rights considerations in its conceptualization, design and analysis, ensuring that principles of “leave no-one behind” and “do no harm” are duly considered. This involves analysis of inclusion of human rights principles and alignment with SDGs as applicable to the subject of the evaluation, as well as appropriate ethical approaches and risk assessments in the design and execution of the evaluation.

IX. Evaluation questions

This evaluation will look at relevance, coherence, effectiveness, efficiency and cross-cutting issues. The key questions for this evaluation will be formulated based on the OECD–DAC criteria even though not all DAC criteria are included because not all criteria are equally important as regard to the purpose and objectives of this evaluation. Additional cross-cutting areas have been added to assess gender, human rights and equity considerations. The evaluation will be guided by the four key evaluation questions in Table A4 below.

Table A4. Key evaluation questions

Criterion	KEQs	Sub-questions
Relevance	1. To what extent are WCO's 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's objectives (including any adjustment of objectives), and interventions responded to Djibouti's beneficiaries' needs and rights, including those of the most marginalized populations, as well as the country's and partners' policies and priorities? 1.2 With Djibouti having the ambition of becoming a MIC, what roles should WHO play? 1.3 What should WCO Djibouti focus on the coming years?
Coherence	2. 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?	3.1 To what extent are interventions aligned to country (UNCDF) and regional partners' and institutions' policies and priorities as well as to WHO GPW13 and other sector-specific policies? 3.2 What has been the effect of the socio-political and economic landscape in Djibouti on the health

		<p>sector and how has this complemented or affected WHO's role, including engagement with stakeholders?</p> <p>3.3 What has been WHO's comparative advantage in Djibouti, especially in relation to other UN agencies, regional bodies and financial institutions, and what adaptations, refinements and strategic shifts are needed to improve WHO's strategic positioning going forward?</p>
Effectiveness	<p>3. To what extent were WHO results (including contributions at outcome and system level) achieved or are likely to be achieved and what factors influenced (or not) their achievement?</p>	<p>3.1 To what extent were programme outputs (including any adjustment) delivered and did they contribute to: (a) progress toward the stated programme outcomes (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?</p> <p>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?</p> <p>3.3 What has been the added value of WHO regional and headquarters contributions to the achievement of results in Djibouti?</p>
Efficiency	<p>4. To what extent did WHO interventions deliver, or are likely to deliver results in an efficient and timely way?</p>	<p>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?</p> <p>4.2 To what extent are the internal controls and RBM systems adequate to ensure efficient operational and timely allocation of resources and adequate measurement of results including in changing circumstances?</p>
Sustainability	<p>5. To what extent has WHO contributed towards building national capacity and ownership for addressing Djibouti's humanitarian and development health needs and priorities?</p>	<p>3.1 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 (including emergencies)?</p> <p>3.2 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?</p>

X. Methodology

The evaluation will be based on a rigorous and transparent methodology to address the evaluation questions in a way that serves the dual objectives of accountability and learning. We welcome proposals that include real time evaluation/learning approaches which are participatory, and utilization focused. The evaluation team should strive to provide immediate feedback to WCO, so that learning can be iterative, and improvements can be easily identified and absorbed.

X.I. Overall evaluation design and approach

The methodology described in this section is indicative and participating evaluators are expected to adapt and integrate the approach and propose adjustments needed to accomplish the initiative. These can include additions to the evaluation design, approaches to be adopted, appropriate sampling strategy, data collection and analysis methods, and an evaluation framework. The proposals should also refer to methodological limitations and mitigation measures.

The design of the evaluation will be non-experimental, utilisation focused, and theory based in assessing the effectiveness of the WHO interventions between 2019 and 2023 against their intended aims. With a strong focus on utilization, the approach of the evaluation will concentrate on engaging with the principal users of the evaluation process and report – WHO CO and RO, key stakeholders and focal points in national government ministries and departments, representatives at sub-regional and national level as far as possible, and UN partner organizations in Djibouti. Mixed data collection methods will be used as far as possible. Discussions with stakeholders from Djibouti will largely provide qualitative evidence. The evaluation team will draw from the available quantitative data from recent evaluations, progress reports and other sources. Participating evaluators can consider the “contribution analysis approach”, particularly around questions of effectiveness and other relevant approaches for stakeholder consultation that could generate useful qualitative and quantitative data on key issues. The evaluators will assess the options and describe in detail the suitable methods to meet the purpose, scope and objectives of this evaluation. The methodology will be further refined in the inception phase, based on the findings of the inception report and consideration of constraints posed. Participatory approaches will be adopted as far as possible, but given the potential access constraints, these may also include virtual means.

During the design phase the evaluation team will design the methodology which will entail the following:

- a. Develop a ToC for the evaluation of WHO presence in Djibouti. The ToC to frame the evaluation of WHO contributions in Djibouti will: (i) describe the relationship between the priorities of the relevant strategic instruments, the focus areas and the activities and budgets as envisaged in the biennial WCO workplans; (ii) clarify the linkages with the WHO General Programme of Work and programme budgets; (iii) describe how WHO Secretariat outputs would be expected to contribute to Djibouti health outcomes; and (iv) identify the main assumptions underlying it.
- b. Develop and apply an evaluation matrix¹⁴ geared towards addressing the key evaluation questions, considering the data availability challenges, the budget and timing constraints.
- c. Follow the principles set forth in the WHO Evaluation Practice Handbook, the UNEG Norms and Standards for Evaluation, and its Ethical Guidelines.
- d. Adhere to WHO cross-cutting strategies on gender, equity, disability, and human rights and include to the extent possible disaggregated data and information as well as gender balanced teams and gender- and disability-sensitive and human rights informed approaches for data collection. Include ethical considerations: confidentiality; no-harm to the respondents, use of the right protocols, especially if interviewing or conducting qualitative data collection with vulnerable/marginalized populations

¹⁴ An evaluation matrix is an organizing tool to help plan for the conduct of an evaluation. It forms the main analytical framework for the evaluation. It reflects the key evaluation questions and sub-questions to be answered and helps the team consider the most appropriate and feasible method to collect data for answering each question. An evaluation matrix guides analysis and ensures that all data collected are analysed, triangulated and used to answer the evaluation questions, as well as make conclusions and recommendations.

- e. Include ethical considerations: confidentiality; no harm to the respondents, use of the right protocols, especially if interviewing or conducting qualitative data collection with vulnerable/marginalized populations.

The methodology should demonstrate impartiality and lack of bias by relying on a cross-section of information sources (from various stakeholder groups) and using a mixed methodological approach to ensure triangulation of information through a variety of means. The evaluation of the WHO contribution in Djibouti will rely mostly on the following mixed data collection methods:

- a. Document review: This will include a wide range of key strategic documents, including but not limited to, general programmes of work, relevant programme budgets, WCO programme budget and workplans, budget, financial, audit and closure reports, annual programme reports and budgets, and relevant national policies and strategies. For humanitarian crises faced over the period under evaluation, documents may include the IHR, (such as joint external evaluation of IHR core capacities) and the IHR State Party Self-Assessment Annual Reports. Quantitative data from the WCO monitoring system to assess progress against key health indicators, including in the context of responding to the humanitarian and displacement crisis.
- b. Stakeholder interviews. Interviews will be conducted with external and internal stakeholders at WHO headquarters, EMRO and Djibouti Country Office levels. External stakeholders for this evaluation are: MOH officials and officials of other relevant governmental institutions; healthcare professional associations and other relevant professional bodies; relevant research institutes, agencies and academia; health care provider institutions; UN agencies; other relevant multilateral organizations; donor agencies; other relevant partners; non-State actors and civil society.
- c. Focused group discussions (FGDs) with a selection of male and female health services users, including migrant and refugees, and service providers to assess perceptions of WHO-supported services. Separate FGDs with male and female migrant and refugees can be conducted either directly by evaluators or, if budget allows, through collaboration with field partners.
- d. Mission in-country. Following the document reviews and initial stakeholder interviews, the country visit will be the opportunity for the evaluation team to develop an in-depth understanding of the perspectives of the various stakeholders around the evaluation questions and collect additional secondary data, particularly from external stakeholders and health service users. The visit will depend on prevailing security situation.
- e. Stakeholders' consultation. In addition to acting as key informants during the evaluation process, key internal and external stakeholders will be consulted at the drafting stages of the terms of reference, inception note and evaluation report, and will have the opportunity to provide comments.

X.II Triangulation

To ensure credibility and validity of evaluation findings, evaluators will triangulate emerging evidence. Evaluation evidence collected from different sources and/or by different methods will be compared to ensure that the data are valid, and conclusions and recommendations are solely derived from evidence.

X.III Validation workshop

Initial findings will be presented to stakeholders (ERG) in a virtual workshop to assess the validity/accuracy of the findings and their relevance to the Djibouti context and programmes at the end of the in-country visit (or remote field work). Stakeholders will be invited during the workshop to help the evaluator to identify and prioritize recommendations so that relevance, usefulness and usability of these can be maximized. The feedback will be documented, including where any divergent views arise from the findings. The conclusions will be based as far as possible on triangulated evidence.

X.IV Limitations

No major primary quantitative data collection is envisaged to inform this evaluation. The evaluation team will mainly use data (after having assessed their reliability) collected by WHO and partners during the time frame evaluated. Absence of a valid CCS between WHO and the Government of Djibouti would be a limitation and the evaluators should make reference to other available

strategic documents such as UNSDCF. Another limitation might be related to security fluctuations; this will be advised by WCO security teams. Where field travel will not be feasible for whatever reasons, remote data collection will be done using national consultant as enumerator.

X.V Ethical considerations

Due diligence will be given to effectively integrating good ethical practices and paying due attention to robust ethical considerations in the conduct of evaluation of WHO contribution in Djibouti. Evaluators are expected to outline in their proposal how they will adhere to ethical considerations, including: confidentiality and anonymity; do no-harm approaches; use of the appropriate ethical protocols; gender and human rights considerations in the conduct of interviews and FGDs with respondents and users of services, particularly if interviewing or conducting qualitative data collection with vulnerable/marginalized populations; data management and storage; and integration of appropriate cultural/language considerations.

XI. Evaluation phases, timelines, and deliverables

The evaluation is structured around five phases, which are summarized in Table A5 below.

Phase	Timeline	Tasks and deliverables
1. Preparation	July - August, 2023	Background research Draft and final TOR Evaluation team constituted
2. Inception	August, 2023	Desk review of existing literature Draft and final inception report Evaluation matrix Quality Assurance
3. Data collection and analysis	September, 2023	Document review Briefings HQ/EMRO/Djibouti WCO Key informant interviews with HQ and RO staff Country visit Data analysis Quality assurance
4. Validation and finalization	October, 2023	Draft and final evaluation report Quality assurance of report Validation workshop (virtual)
5. Dissemination and learning	November - December, 2023	Debriefings Dissemination via publication/internet Evaluation Brief Management response

Design phase

The design phase will start with a first review of key documents and briefings with WHO headquarters, EMRO and Djibouti WCO key stakeholders. During the design phase, the evaluation team will assess the various logical/results frameworks, if they exist, and their underlying ToC. The inception report will close this phase. Its draft will be shared with key internal stakeholders (at the three levels of the Organization) for their feedback. The inception report will be prepared following the evaluation office template and will focus on methodological and planning elements. Considering the various logical/results frameworks and the evaluation questions, it will present a detailed evaluation framework and an evaluation matrix. Data collection tools and approaches will be drafted as part of the inception report, alongside consent forms and ethical protocols.

Deliverable 1: Inception Report

Data collection and analysis.

This phase will include additional document review, key stakeholders' interviews at WHO headquarters and regional levels, and a country visit. Djibouti in-country mission will start with a briefing to the Djibouti WCO followed by key partners and will end with a debriefing with the same group at the end of the mission. During inception, WCO will advise the evaluation team as to the possible locations for field work, accounting for security and any movement and access restrictions.

Validation and finalization phase

This phase is dedicated to the in-depth organization of key findings and results, and identification of key lessons learned and recommendations. These will be presented in the draft evaluation report, which will be shared with key internal and external stakeholders and the joint Evaluation Management Group for fact-checking. Prior to the finalization of the recommendations, the WHO Representative (WR) in collaboration with the evaluation team lead might consider organizing a workshop with the main counterparts in-country to discuss the findings and conclusions of the evaluation team. A draft management response could also be presented at the workshop to ensure buy-in and commitment for all parties.

A final evaluation report, an evaluation brief and a short evaluation video will be prepared according to the WHO Evaluation Practice Handbook and implementation frameworks. The evaluation report, brief and video will provide an assessment of the results according to the evaluation questions and methodology identified above. It will include conclusions based on the evidence generated in the findings and draw actionable recommendations. Additional summary products could include infographics, visual summaries or video interviews with key Djibouti CO staff and stakeholders involved in the evaluation

Deliverable 2: draft evaluation report

Deliverable 3: final evaluation report, evaluation brief and evaluation video

Note: The revisions of any of the deliverables produced by the evaluation team will be accompanied by feedback on each comment provided. Note: The revisions of any of the deliverables produced by the evaluation team will be accompanied by feedback on each comment provided. This feedback will succinctly summarize if and how comments were addressed, and if they were not, it will justify why.

Management response and dissemination of results phase

The management response will be prepared by the Djibouti WCO prior to the finalization of the evaluation report. To ensure transparency as envisaged in the WHO Evaluation Policy and the UNEG norms and standards for evaluation, the reports of evaluations of the WHO contribution at the country level and their management responses will be made publicly available and summaries will be reported in the annual evaluation report to the WHO Executive Board.

XII. Evaluation Team

The evaluation will be conducted by two consultants with rich evaluation experience comprising a Team Leader/Senior Evaluator and one national junior evaluator.

The Team Leader/Senior Evaluator should demonstrate:

- Relevant professional qualification, preferably at the academic (master's or PhD) level.
- At least 10 years of experience in conducting evaluations, preferably in the areas of public health/economics or development, and experience in country-level programme evaluations, with a focus on North Africa.
- Demonstrated knowledge of public health and humanitarian programmes and country response to public health epidemics and NCDs, for example, COVID-19, HIV, TB, etc.

- Proven experience in conducting real-time evaluations, qualitative and quantitative data collection methods, analysis of data and experience in handling data limitations.
- Experience in evaluating incorporation of health equity, gender equality, human rights and other equity issues in programmes.
- Previous experience with evaluation for UN and/or other multilateral organizations.
- Strong interpersonal skills and ability to work with people from different backgrounds to deliver high quality products within a short time period.
- Excellent writing, analytical and communication skills in French and, preferably, Arabic. Should have good knowledge of English.

The national consultant will support the data collection at the country level as needed. In this capacity, the following skills should be demonstrated:

- Relevant professional qualification, preferably at the academic (Master's) level.
- At least 5 years of experience in conducting evaluations or data collection, preferably in the areas of public health/economics or development and experience in country-level programme evaluations.
- Demonstrated knowledge of public health and humanitarian programmes.
- Proven experience in understanding evaluation principles, collecting qualitative and quantitative data, analysis of data and experience in handling data limitations.
- Understanding of health equity, gender equality, human rights and other equity issues in programmes.
- Previous experience with evaluation for UN and/or other multilateral organizations.
- Strong interpersonal skills and ability to work with people from different backgrounds to conduct data collection in different settings.
- Excellent analytical and communication skills in French, Arabic and good knowledge of English.

XIII. Evaluation management

To ensure the independence and credibility of the evaluation, it will be conducted by an external independent evaluation team and managed by the WHO Evaluation Office in collaboration with the EMRO. The evaluation team will have appropriate knowledge and skills of the evaluand with relevant experience in performing similar evaluations involving organizational reform in multilateral or UN organizations.

The Regional Evaluation Officer will serve as the Evaluation Manager and will provide the necessary support to the evaluation team during the evaluation exercise (such as finalization of methodology, facilitation of the evaluation process, identification of relevant documents and stakeholders). WHO Country Office in Djibouti will facilitate access to data and relevant documents in a timely manner, provide logistic support during in-country mission and provide feedback on draft deliverables.

The WHO headquarters Evaluation Office will be part of the Evaluation Management Group and will support the RO in the management of the evaluation, including funding the evaluation and contracting of the consultants. Additionally, WHO headquarters Evaluation Office will provide overall quality assurance (both process and products) of the evaluation in adherence with UNEG norms and standards.

An Evaluation Reference Group (ERG) will be established to ensure the evaluation's relevance, accuracy and utility through a consultation and validation process. The ERG will include relevant staff from EMRO and Djibouti WHO Country Office, representatives from both the Government of Djibouti and MoH, implementing partners and UN agencies in Djibouti which the Country Office has closely worked with over the period under evaluation. The ERG will review the key deliverables (the terms of reference (TOR), inception report, the draft and final reports) of the evaluation, including validation of the technical findings.

XIV. List of documents

Below is a list (non-exhaustive) of documents that might be relevant during desk review:

- i. 13th General programmes of work of WHO
- ii. Programme budgets (2018/2019; 2020/2021; 2022/2023)
- iii. Djibouti WCO programme budget and workplans
- iv. Djibouti Budget, financial, audit and closure reports
- v. Annual/ Mid-term review, and End of Biennium programme reports and budgets (2018/2019; 2020/2021; 2022/2023)
- vi. Any donor-funded project specific reports, if available
- vii. Relevant national policies and strategies including vision 2035, National Development Plan 2020-2024; National Plan for Health Development
- viii. Djibouti UNDAF and UNSDCF addendum 2022-2024
- ix. Djibouti Common Country Analysis (CCA) report 2021
- x. International Health Regulations (IHR)
- xi. Any Joint External Evaluations

Annex 2: Respondents' list

WHO

HQ

Indrajit Hazarika, Country Support Unit
Kira Koch, PHC Special Programme
Sophie Genay-Diliautas, PHC Special Programme

EMRO

Amarnath Das, Compliance and Risk Management
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Gerald Sume, Immunization
Hicham El Berri, Non-communicable diseases programme
John Kissa, Immunization/COVID 19
MoHammad Nadir Sahak, IHP surveillance
Rosa Mae Acosta, Programme Planning, Budget, M&E

WCO

Abdoulkader Ali, Malaria Programme
Clémence Ayissi, Consultante Relais Communautaire
Fara-had Hassan Farah, External Relations Officer
Guy Feukwu, Consultant COVID-19 & Communication risques
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Gabriel Brun-Rambaud, Consultant en charge de programme VIH et tuberculose
Anastase Butsure, Consultant Nutrition

Government

MOH

Abdourahman Ali, DEPCI
Abdillahi Ayeh, Direction Promotion Santé
Ahmed Omar Abdallah, DEPCI
Alassane Abdoullaye, Ministère de la Santé
Amer Elmi Farah, PEV
Amina Farah Iltireh, Programme Lutte Contre le Sida
Daoud Ali Ahmed, Coordinateur Programme Élargie de la Vaccination
Farhan Ali, DG pharmacie et laboratoires (DMPLIP)
Fathiya Abdirahman Houssein, (DMPLIP)
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Fatouma MoHamed Houssein, Ministère de la Santé
Abdillah Elmi Gueddi, Programme National Nutrition
Gueidi Abdourahman Djama, Ministère de la Santé
Halima Daoud Ibrahim, Direction Santé Mère-Enfant
kadar Ismael boulaheh, Ministère de la Santé
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Samatar Kayad Guelleh, PNLP

Nour Abdourahman MoHamed, Direction Regional sanitaire
Youssef Ali Abdikamal, Direction Santé Prioritaire
Zahra Moussa Bouh, Direction Générale de L'Offre des Soins

Other government respondents

Hassan Abdourahman, Centrale d'Achats de Matériels et Médicaments Essentiels (CAMME)
Caisse Nationale de Sécurité Sociale (CNSS)
Houssein Youssef Darar, INSPD

Multilateral and donor agencies

UN

Aicha Ibrahim Djama, UNFPA
Beate Dastel, UNICEF
Georges Alfred Ki-Zerbo, WHO Representative to the African Union based in Addis

Harbi Omar, Resident Coordinator office

Jose Barahona, Resident Coordinator

Ricarda Mondry, FAO

Tanja Pacifico, IOM

Thomas and Daniel, UNHCR

Tony Byamungu, UNICEF

Other multilateral and donors

Amélie Joubert, The Global Fund

Daher Osman, Agence Française de Développement

Simona Schlede, European Union

Non-State Actors

Oumalkhaire Ahmed, Association Autres Regards

Health service providers

Médecins chefs

Abraham Mehdanie, Hôpital régional d'Ali-Sabieh

Hassan Ibrahim, Centre Médical – Hospitalier d'Obock

Yacoub Houssein, Centre Médical – Hospitalier d'Arta

Clinic

Abdourahman Moumin Douksie, Centre du Jeune Diabétique

Community Health Workers

Ayane Youssouf

Fatouma Djamal

Fatouma Hassan

Fardoussa MoHamed

Hibo Cheik

Kadra Awaleh

Koche Aich Osman

Maryma Hassan

Roda MoHamed

Saada Ismael

Safiya Ahmed

MoHamed Ai MoHamed, Secrétaire Général Ministère Santé Sarah Ali
MoHamed Houmed Bourhan, Ministère de la Santé
Omar MoHamed, Direction Information Sanitaire

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WHO background documents

Strategies and guidance

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- Ministère de la Santé (2020 – 2024) Plan stratégique du Programme National de lutte contre la Tuberculose
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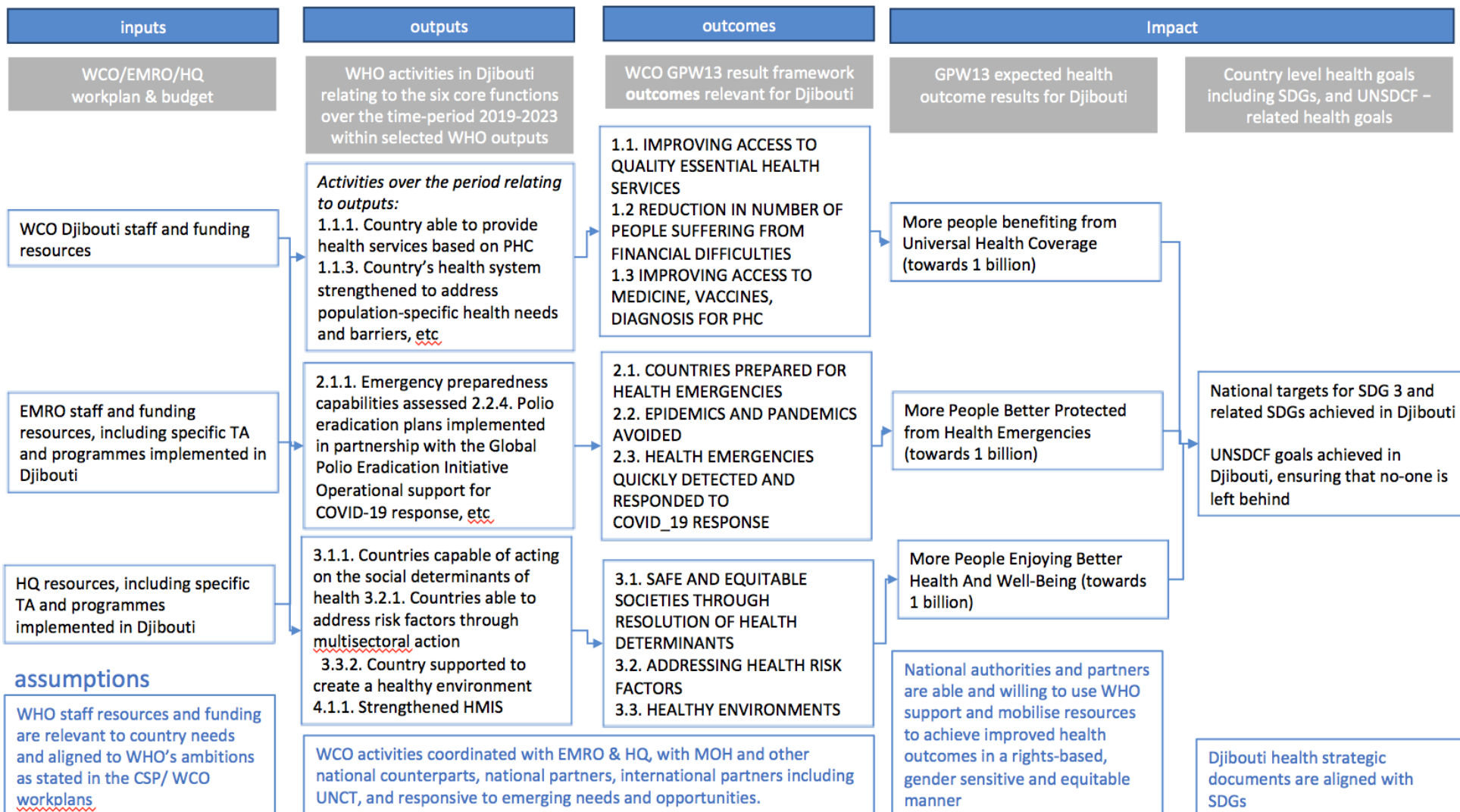
Annex 4: Theory of Change for WHO in Djibouti

Initial ToC process

The evaluation used a model of theory of change (ToC) to frame the analysis of the WHO contribution to expected results (outcomes and impact) in Djibouti. In the absence of an explicit logic model or ToC of the WHO contribution in Djibouti over the evaluation period, the evaluation team proposed a ToC that described the relationship between the priorities of the relevant strategic instruments, the focus areas and the interventions envisaged in the biennial WCO workplans; clarified the linkages with the GPW13 outputs and outcomes and expected results for WHO in Djibouti, and identified the main assumptions underlying the change pathways identified.

The TOC encompassed contributions from all levels of the Organization and all strategic areas of WHO in the country. This initial ToC was based on a review of documents provided during the inception phase, as well as interviews with the Djibouti WCO. It represented the evaluation team's understanding of the WHO intervention model in Djibouti to date and served as a basis to assess WHO contributions to its strategic objectives during the evaluation, by testing the expecting pathways against data collected and analysed through the evaluation. The evaluation ToC was primary linked to the evaluation questions and sub questions relating to effectiveness and sustainability. Identifying and testing assumptions was also useful to reflect on the questions relating to relevance and coherence. Lastly, the input section of the ToC was linked to the efficiency criteria. The initial ToC, comprising a diagram and a narrative part, is presented in Fig. 4.A and Box 4.A below.

Figure 4.A. Preliminary Theory of Change



Box 4.A 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 is able to perform those functions, then it will deliver a series of outputs aligned to its expected immediate/output-level results. Those outputs are delivered in partnership with the MoH counterparts, UN agencies such as UNICEF and FAO, and other implementing partners (UNCT, One Health and AMR). They include: strengthening the overall policy framework and MoH institutional capacity by supporting a health sector review and the development of the PNDS; the development of a national EML and sector-specific strategies and programmes (in maternal and new-born health, nutrition, NTDs, mental health and psychosocial support); supporting emergencies response and preparedness and direct implementation to the COVID-19 response; 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 will 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 GPW13 goals and national health goals and SDGs.

Revision process of the ToC following initial findings

The development of a revised ToC together with the Djibouti WCO was a central element of the formative dimension of the evaluation, focused on discussing potential strategic shifts going forward. At the end of the country visit, the evaluation team facilitated a participatory workshop with WCO staff. The evaluation team presented emerging findings and discussed potential implications for the WHO model of intervention. This served to develop a revised model of ToC that will feed into future strategic orientations, as well as form the basis for developing some of the evaluation recommendations.

The ToC discussion focused especially on one identified through the evaluation: the lack of an integrated approach on health system strengthening for PHC as a basis to strengthen the effectiveness of programme-specific technical assistance. The outcome of this work, which covers only one of the outcomes in the UHC pillar, is presented in figure 4.B below and the narrative part that follows.

Evaluation of WHO's contribution in Djibouti: Annexes

inputs	outputs		outcomes	Impact	
WHO resources at 3 levels	WHO enabling activities	Country outputs for Djibouti	GPW13 outputs relevant for Djibouti	GPW13 outcomes	Country goals in PNDS and UNSDCF
<p>WCO staff and funding resources, including adequate (long term, national) HR to support admin and program functions as per the EMRO review</p>	<p>Long-term TA to MoH on leadership capacity building, including on annual planning, budgeting and monitoring to implement PNDS and review of PNDS</p>	<p>Law on MoH attributions and amendments in order for MoH to play its leadership role on other HS actors</p> <p>Health map is available, describing the health system services and HR at 3 levels</p> <p>A PHC essential services package is in place</p> <p>Community health workers system is institutionalised</p>	<p>1.1.1 Country able to provide health services based on PHC HC that have implemented UHC essential package of services Implementation of the WHO PHC quality indicators</p>	<p>Outcome 1.1. Improved access to quality essential health services Average service coverage improves from 55.1 (2021) to xxx in xx</p>	<p>More people benefiting from Universal Health Coverage (towards 1 billion) Contribution to 1 billion: from -1.8% of population (2021) tp xx in xx.</p>
<p>EMRO staff and funding resources, including specific TA and programmes implemented in Djibouti</p>	<p>Mobilization and advocacy for coordination of Health Sector Partners</p>	<p>New PNDS is developed encompassing all health actors in the country through a whole-of-government, whole-of-society approach</p>	<p>1.1.2 Country enabled to strengthen the health system to deliver on condition- and disease-specific service coverage results Integration of CVD risk factors assessment and management at PHC level Adoption of the UNGA political declaration and multi-sectoral accountability framework Implementation of the mhGAP</p>		
<p>HQ resources, including specific TA and programmes implemented in Djibouti: PHC Policy Advisor Consultant for Health Map Deputy WR for advocacy</p>	<p>TA on health map development and developing an essential package of health services</p> <p>Capacity building of civil society organisations and membership networks</p> <p>TA on health financing strategy</p>	<p>Costed annual implementation plan to implement PNDS are in place and monitored</p>	<p>1.1.3 Country's health system strengthened to address population-specific health needs Adoption/update of WHO RMNH guidelines Implementation of community and facility-based interventions for NCH Achievement of the EMVAP targets Add here an indicator on outreach/friendly services for key populations, people with disabilities, people living with HIV, mobile populations, youth</p>		
<p>WCO will deliver the full range of functions required to fulfil its ambitions if it has adequate human and financial capacity and EMRO acts as an efficient, well-coordinated support office.</p>	<p>Normative guidance on adapting latest WHO technical recommendations and support to develop, fundraise for and monitor implementation plan</p>	<p>Programmes specific strategies and technical guidelines in place based on latest WHO norms and standards</p> <p>Civil society organizations and networks of marginalized groups are empowered and actively contributing in decision-making and services delivery</p>	<p>1.1.5 Countries enabled to strengthen their health and care workforce: Implementation of the health workforce strategic plan Add here indicator on % facilities fully staffed according to national guidelines</p>		
	<p>GPS is functional to coordinate health sector technical and financial partners</p> <p>UNCT and non-resident agencies are aligned and develop joint actions to deliver UNSDCF health results</p>	<p>HR for health policy clearly defining roles (admin/technical) at packages at each level</p> <p>Recruitment and training of health personnel on new guidelines, EML</p>	<p>Using a health system strengthening for PHC approach as a basis for programme specific work will improve the effectiveness of WHO's technical assistance.</p>	<p>Strengthening the health system to deliver a package of essential services will improve access to health services for all sections of the population.</p>	
	<p>If MoH has the capacity to implement the PNDS, this will lead to better coordination and effectiveness of public and donor financial and technical resources to deliver national objectives in health.</p>				

Revised ToC narrative

Input level

If WHO at the three levels has adequate human and financial resources, both technical and administrative/management capacity, and is 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.

Input level assumption: WHO in Djibouti has adequate human and financial capacity to deliver the full range of functions (technical assistance, advocacy, leadership and convening, and strengthening health information and research) and EMRO acts as an efficient, well-coordinated support office to realise country priorities.

This is linked to the following findings under evaluation question 4 on Efficiency criteria:

- Finding 3: Human resources in the WCO are not adequate to deliver on the ambitions 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 6: The programs are well integrated at the WCO level, but there are programmatic silos at the EMRO level, which means that requests from the regional office sometimes hamper the ability of the WCO to focus on priorities defined in country. Such issues have not been reported in relation to HQ support.

Output level

If WHO is able to perform the full range of its functions, *then* it will deliver a series of outputs aligned to its expected immediate/output-level results. Those outputs are delivered in partnership with the MOH (MoH) counterparts, UN agencies and other technical and financial partners in health, and civil society organisations and networks.

They include: strengthening the overall policy and regulatory framework and MoH institutional capacity to address fragmentation of the health system; improved coordination of health partners through GPS and UNCT; supporting a review and development of the PNDS and its implementation plans; supporting sector-specific strategies and programmes; advocating and fundraising for a strategy on community-based health care services; encouraging the development and engagement of civil society in health; and addressing gaps in HR for health.

Output level assumption: Supporting the capacity of the MoH to implement the PNDS will lead to better coordination and effectiveness of public and donor financial and technical resources to deliver national objectives in health.

This is linked to the following evaluation findings under evaluation question 2 on Coherence criteria:

- Finding 3: A hindering factor to ensure that WHO interventions align to national priorities is the lack of a budgeted, operational plan to implement the PNDS.
- Finding 5: 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 MOH, has not been meeting regularly.

Outcome level

If WHO will achieve those outputs, *then* it will 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; MoH enabled to strengthen the health system to deliver on condition- and disease-specific service coverage results; health system strengthened to address

population-specific health needs and increased availability of adequately trained health and care workforce. 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.

Outcome level assumption: Using a health system strengthening for PHC approach as a basis for programme specific work will improve the effectiveness and sustainability of WHO's technical assistance in programmes.

This is linked to the following evaluation findings under evaluation question 1 on Relevance criteria:

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

Impact level

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 GPW13 goals and national health goals and SDGs.

Impact level assumption: Strengthening the health system to deliver a package of essential services, including through community-based health services geared at the needs of marginalised groups, will lead to sustainably improve access to health services for all sections of the population.

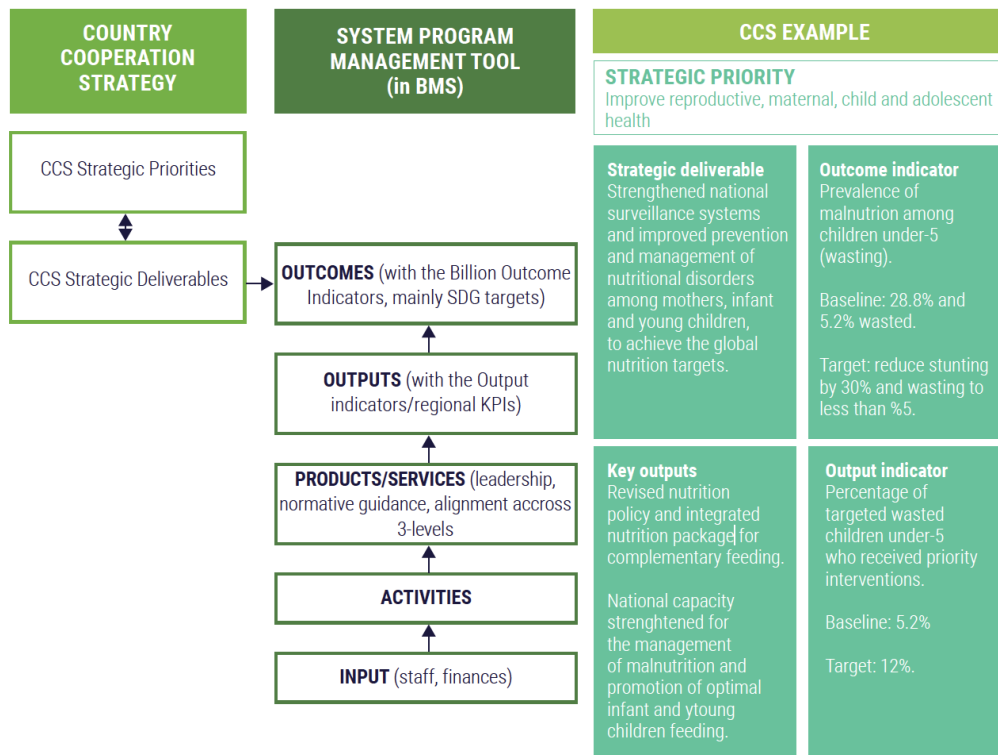
This is linked to the following evaluation findings under evaluation question 5 on Sustainability criteria:

- Finding 1: 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.

Next steps in using the ToC

Going forward, it is recommended that the WCO uses a theory of change process basing on the initial discussions held during the evaluation as part of the next strategic development process. The CCS guide 2023 advises that the selection of the strategic priorities at country level should be accompanied by a high-level theory of change to provide a feasible set of causal pathways through which WHO, in partnership with other agents, deliver GPW13 goals during the CCS. The objective of this high-level theory of change is to illustrate credible causal pathways linking outputs to impact. In line with the theory of change, the operational level should then be used to stipulate the key activities, products and services that need to be implemented to achieve the identified deliverables. Crucially, for the ToC to be useful, it should include a clear translation of outcome and output level statements from GPW13 into measurable indicators for the country, as illustrated in Figure 4.C below.

Figure 4.C. Integration of CCS in operational planning. Source: CCS guidelines 2023 (to be published), WHO



Annex 5: Evaluation matrix

Evaluation sub-questions	Indicator/measure	Main source of information
1. To what extent are WCO's 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's objectives (including any adjustment of objectives), and interventions responded to Djibouti's beneficiaries' needs and rights, including those of the most marginalized populations, as well as the country's and partners' policies and priorities?	<p>Presence of a situation analysis clearly identifying under-represented groups and social roles, relations, norms and inequalities in relation to gender, disability and ethnicity</p> <p>Evidence of WHO's objectives being designed based on a comprehensive health diagnostic inclusive of gender-related issues and covering all population (minorities, migrants) living in the country based on disaggregated data as available</p>	<p>Document review</p> <ul style="list-style-type: none"> - CCA - 2021 UNCT report - WCO plans and budgets <p>KII: WCO, RO, MOH and other Government stakeholders, Civil society actors, FGD with service users (to be confirmed)</p>
1.2 With Djibouti having the ambition of becoming a MIC, what roles should WHO play?	<p>Perception among partners about the role of WHO in the country</p> <p>Indication of role played by WHO in the development of the national health agenda</p>	<p>Document review</p> <ul style="list-style-type: none"> - UNSDCF addendum, Vision 2035, National development plan <p>KII: WCO and RO, MOH and other Government stakeholders, UNCT, WB and other donors, Civil society actors, FGD with service users (to be confirmed)</p>
1.3 What should WCO Djibouti focus on the coming years?	Availability of recommendations for future strategic direction co-created between the WCO team and the independent evaluation team	<p>Document review</p> <ul style="list-style-type: none"> - GPW13, PMDS, UNSDCF <p>KII: WCO, RO and HQ stakeholders, UNCT and other bi/multi-lateral partners, Government stakeholders, Civil society actors, FGD with service users (to be confirmed)</p>

2. 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 (UNCDF) and regional partners' and institutions' policies and priorities as well as to WHO GPW13 and other sector-specific policies?	<p>Level of alignment of health priorities identified in the relevant strategic instruments with</p> <ul style="list-style-type: none"> - Priorities of the National Health Plan and National SDG targets - GPW13 results framework - UNSDCF health goals - Regional initiatives 	<p>Document review</p> <ul style="list-style-type: none"> - GPW13, UNSDCF, national strategic documents, other donors strategic plans <p>KII: WCO, RO and HQ stakeholders, UNCT and other bi/multi-lateral partners, Government stakeholders</p>
2.2 What has been the effect of the socio-political and economic landscape in Djibouti on the health sector and how has this complemented or affected WHO's role, including engagement with stakeholders?	<p>Indication of evolution of WHO's role in the landscape of health sector actors over the period considered</p> <p>Indication of partnerships in relevant strategic instruments and opportunities for future partnerships</p>	<p>Document review</p> <ul style="list-style-type: none"> - CCA, other donors and UN situation analysis reports <p>KII: WCO and RO stakeholders, UNCT and other bi/multi-lateral partners, Government stakeholders, Civil society actors, FGD with service users (to be confirmed)</p>
2.3 What has been WHO's comparative advantage in Djibouti, especially in relation to other UN agencies, regional bodies and financial institutions, and what adaptations, refinements and strategic shifts are needed to improve WHO's strategic positioning going forward?	Explicit elements of WHO's comparative advantage identified	<p>Document review</p> <ul style="list-style-type: none"> - UNDAF and UNDCF, other donors strategic plans, WCO annual reports <p>KII: WCO, RO and HQ stakeholders, UNCT and other bi/multi-lateral partners, Government stakeholders, other external stakeholders</p>
3. To what extent were WHO results (including contributions at outcome and system level) achieved or are likely to be achieved and what factors influenced (or not) their achievement?		
3.1 To what extent were programme outputs (including any adjustment) delivered and did they contribute to: (a) progress toward the	Level of achievement for each priority in biennial WCO workplans	<p>Document review</p> <ul style="list-style-type: none"> - GPW13 and PB 2018-2023

<p>stated programme outcomes (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?</p>	<ul style="list-style-type: none"> - Identification of key results and best practices - Identification of added value of WHO contributions <p>Evidence that the WHO plans were based on a situation analysis clearly identifying inequalities and exclusion, related to socio-economic and environmental determinants of health</p>	<ul style="list-style-type: none"> - WCO budgets workplans and reports over the period 2019-2023 and other donor reports <p>KII: WCO, different Government stakeholders and UN partners, Civil society actors, FGD with service users (to be confirmed)</p>
<p>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?</p>	<p>Description of facilitating and hindering contextual factors influencing the contribution of WHO at country level</p>	<p>Document review</p> <ul style="list-style-type: none"> - GPW13 and PB 2018-2023 - WCO budgets workplans and reports over the period 2019-2023 <p>KII: WCO, RO and HQ, MOH and other Government stakeholders, Civil society actors, FGD with service users (to be confirmed)</p>
<p>3.3 What has been the added value of WHO regional and headquarters contributions to the achievement of results in Djibouti?</p>	<p>Indication of HQ/RO contribution to design and development of relevant strategic instruments</p> <ul style="list-style-type: none"> - Indication of HQ/RO contribution to specific activities in the country - Indication of participation of the country partners in regional or global initiatives/capacity development opportunities directly linked to priorities of relevant strategic instruments - Identification of added value from key results and best practices 	<p>Document review</p> <ul style="list-style-type: none"> - CSP, WCO reports <p>KII: WCO, RO and HQ stakeholders, MOH and UN partners</p>
<p>4. To what extent did WHO interventions deliver, or are likely to deliver results in an efficient and timely way?</p>		
<p>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</p>	<p>Availability of explicit linkages between relevant strategic instruments and work plans, budget allocations and staffing</p> <p>Evidence of intended or unintended (positive or negative) consequences of COVID-19 on the results</p>	<p>Document review</p> <ul style="list-style-type: none"> - WCO budgets workplans and reports over the period 2019-2023

<p>adjustment or re-prioritization of interventions?</p>	<p>Evidence of adaptability of WHO to the changing needs and demands of the country</p>	<p>KII: WCO, RO, HQ, MOH and UN partners</p>
<p>4.2 To what extent are the RBM systems adequate to ensure efficient operational and timely allocation of resources and adequate measurement of results including in changing circumstances?</p>	<p>Availability of monitoring mechanisms</p> <p>Availability and usefulness of monitoring reports on progress towards targets</p>	<p>Document review</p> <ul style="list-style-type: none"> - WCO budgets workplans and reports over the period 2019-2023 <p>KII: WCO, RO, HQ</p>
<p>5. To what extent has WHO contributed towards building national capacity and ownership for addressing Djibouti's humanitarian and development health needs and priorities?</p>		
<p>1.1 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 (including emergencies)?</p>	<p>Indication of whether WHO activities to support the COVID-19 response have contributed to strengthening the health system</p> <p>Perception of stakeholders on WHO's contribution to health system resilience and preparedness</p>	<p>Document review</p> <ul style="list-style-type: none"> - WCO activity reports, national frameworks on surveillance and emergency preparedness <p>KII: WCO, UNCT and other donors, MoH and other Government stakeholders (e.g. Ministry of Labour)</p>
<p>1.2 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?</p>	<p>Indication of key areas of national capacities developed</p> <p>Indication of changed practices among partners following WHO support and capacity development activities</p> <p>Indication of continued activities by national partners following end of WHO support</p> <p>Evidence of partners mobilising additional resources, networks and institutions to enhance the volume, scope and sustainability of triangular cooperation projects.</p>	<p>Document review</p> <ul style="list-style-type: none"> - National health policy and programme framework documents <p>KII: WCO, Government stakeholders, UNCT and other donors</p>

Annex 6: WHO Djibouti reporting to selected WHO Regional Office for the Eastern Mediterranean key performance indicators (2019–2022)

Output	KPI Definition	KPI baseline Status (Q4 2019)	KPI current Status (Q4 2020)	KPI current Status (Q4 2021)	KPI current Status (Q4 2022)
<i>UHC Pillar</i>					
1.1.1	Percentage of HCFs that have implemented UHC essential package of services				
1.1.1	Status of implementation of the WHO primary health care quality indicators				
1.1.2	Status of integration of cardiovascular risk factors assessment and management at primary health care level				
1.1.2	Status of adoption of the UNGA political declaration and multi-sectoral accountability framework				
1.1.2	Status of implementation of the mental health gap action programme				
1.1.3	Status of adoption/update of WHO reproductive and maternal health guidelines				
1.1.3	Status of implementation of key community and facility-based interventions for new-born and child health & development				
1.1.3	Status of achievement of the EMVAP targets				
1.1.5	Status of implementation of the health workforce strategic plan				
1.2.1	Status of development of the health financing strategy				
1.3.1	Status of National list of Essential Medicines				

1.3.1	Status of National list of Priority Medical Devices				
1.3.3	Existence of an institutional development plan for drug regulation				
1.3.3	Status of development of national control testing policy for medical products				
1.3.5	Status of national AMR surveillance reporting in GLASS				
HEP Pillar					
2.1.1	Status of implementation of simulation exercises using WHO tools and guidelines				
2.1.1	Status of country State Party Self-Assessment Annual Reporting (SPAR) on IHR implementation.				
2.1.2	Status of using findings from the IHR monitoring and evaluation framework to develop or update the national action plans				
2.1.3	Status of implementation of the Emergency Operation Centre				
2.2.2	Officially nominated rapid response teams at all levels (national, regional)				
2.3.1	Status of adaptation and implementation of the real-time early warning surveillance framework				
2.3.1	Status of completion of event risk assessments (rapid risk assessments/public health situation analysis for events) within recommended timeframe				
2.3.2	Percentage of medical commodities received from WHO Dubai platform				
2.3.3	Status of implementation of the surveillance system for attacks on healthcare (SSA)				
HPOP Pillar					
3.1.1	Status of the emergency care assessment and related roadmap				

3.2.1	Utilization of STEPS survey findings to develop evidence-based policies, and set national targets on NCDs				
3.2.1	Status of enforcement of total bans on advertising promotion and sponsorship of tobacco				
3.2.1	Status of introduction of the regional package of inter-sectoral policies and interventions into their national health systems				
3.3.1	Status of implementation of a surveillance mechanism (surveys) for reporting on drinking water safety				
3.3.1	Status of development and implementation of the national action plan on health resilience to climate change				
3.3.1	Status of implementation of the health impact assessment of air pollution				
3.3.2	Status of establishment of the needs, priorities and plans of action for HiAP				
3.3.2	Status of incorporation of environmental health into health city programmes				
3.3.2	Status of development and implementation of road map on healthy workplace and environmental systems in HCFs				
3.3.2	Status of the development and integration of a national school health service package into education system				
3.3.2	Status of integration of community engagement principles and activities in the Country Support Plan				
Enabling functions pillar					
4.1.1	Status of implementation of actions included in the health information system improvement plan based on the assessment findings.				
4.2.1	Status of fulfilment of the key strategic communication resources				

Evaluation of WHO's contribution in Djibouti: Annexes

4.2.2	Overall score of the managerial KPIs				
4.3.1	Percentage of the funds utilized out of the total available per Budget Center				

Annex 7: Contribution of WHO to key health system level outcomes in Djibouti

Sources: GHO and Djibouti JPRM

Outcome	Results achieved	Strength of evidence on WHO contribution	WHO contribution
Outcome 1.1. Improved access to quality essential health services	UHC service coverage index in Djibouti ¹⁵ declined from 45 to 44 between 2020 and 2021 compared to 57 in EMRO overall in 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.	low	WHO has conducted few interventions to strengthening UHC through a PHC approach, and those have not yielded tangible results. Such interventions include support to the development of the current PNDS. However, WHO did not accompany the process until the end, and according to both MoH and WHO respondents the current PNDS was largely not implemented. Another initiative by WHO was the conduct of the National Health Symposium, which was meant to inform a health sector review. Again, the results of this Symposium were limited, and recommendations were not made public or implemented. WHO is now embarking with the MoH 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 WHO's contribution to these structural issues has not led to improved service coverage overall.
	DTP3 vaccination coverage has declined from 85 to 59% in the period 2019-2021.	low	While WHO has provided direct support to vaccination campaigns and EPI in collaboration with UNICEF in the current biennium, the effect of previous efforts is not reflected at population level in 2021 data. Donors involved in supporting the EPI programme 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.
	Progress is registered on health system indicators relating to RMNCH: the proportion of women's (aged 15–49) need for family planning satisfied with modern methods increased from 47.40% to 48.90% between 2019 and 2020 and the proportion	high	WHO has provided intensive support to the RMNCH programme in the form of normative guidance, technical assistance, training and supply provision for the development of the National Strategy to Reduce Maternal and Neo-Natal Mortality. WHO's support has been highlighted by Ministry and health

¹⁵ Global Health Observatory, WHO <https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage>

<p>of women (15-49) who received antenatal care 4+ times increased from 7.1% to 25.7% between 2002 and 2012. Care-seeking for children with symptoms of acute respiratory infection also increased from 62 to 94.4% between 2002 and 2012.</p>		<p>partner respondents as a key contribution to the extension of availability of maternal and neonatal health services in the regions. However, stakeholders regretted that the child health component were not included within the same strategy and requested further support by WHO on this.</p>
<p>On malaria, ITN use improved until 2018 to above 30% of the population. However, this proportion has decreased to 19.4% in 2010 and Djibouti is now below the regional average</p> <p>On HIV, treatment coverage data is not available in the GHO. Global Fund data¹⁶ shows the number of persons treated has remained stable at around 2100 between 2019 and 2022.¹⁷ Estimated HIV prevalence has been decreasing to 0.7% in 2021, corresponding to 4000-5000 persons. HIV prevalence was estimated at 9% among female sex workers and 13% among men who have sex with men in the same year.¹⁸</p> <p>Tuberculosis remains a major issue in the country, with incidence per 100 000 population increasing from 212 to 240 between 2019 and 2022. The estimated proportion of TB cases with MDR TB among new cases in Djibouti was 3.4% in 2021.¹⁹ In terms of TB treatment, Djibouti fares better than the regional average, as EMRO had an average of 58% treatment coverage in 2021, compared to an estimated 80% in Djibouti, reported to be stable over the period 2019-2022 in the GHO. The Global Fund reports an increased number of people on treatment, from 1825 to 2151 between 2019 and 2022.</p>	<p>moderate</p> <p>moderate</p> <p>high</p>	<p>WHO provided normative guidance and technical support to develop disease specific strategies (HIV, Hepatitis and STIs, tuberculosis, malaria), complementing efforts by major funding partners such as the Global Fund and UNICEF. It is likely that through its support to implementing cascade trainings for health care workers to use updated guidance, WHO has contributed to improved diagnostic and treatment outcomes for these diseases.</p> <p>On tuberculosis treatment specifically, WHO has commissioned two consultancies on the management of multi-drug resistant TB cases, including on the implementation of new anti-TB drugs in line with the latest WHO recommendations. WHO supported the development of a screening strategy, evaluated the laboratory capacity gaps for multi-drug resistant TB diagnosis, as well as the information system and drug management. Those efforts have likely been instrumental to achieve the good results on TB treatment coverage in Djibouti.</p>
<p>NCD related mortality rate has been stable in the long term and decreased between 2017 and 2019, from 617 to 611/100 000 population. This is lower than the regional average of 650 in EMRO. While remaining below regional average, hypertension and diabetes indicators are worsening: age-standardized prevalence of hypertension among adults aged 30–79 years</p>	<p>low</p>	<p>Although WHO has undertaken promising work on NCDs and indicators show positive results compared to regional average; those cannot be attributed to WHO's interventions which are only recent and have not yet translated into services improvements. Also, the quality of data on NCDs has been questioned by respondents in WHO and MoH, with limited investment in reporting those in the DHIS2.</p>

¹⁶ Ibid.

¹⁷ The Global Fund data portal <https://data.theglobalfund.org/results>

¹⁸ Spectrum data quoted in the National HIV, Hepatitis and STIs strategy

¹⁹ Mission report on MDR TB, WHO EMRO (July 2023)

	increased from 26.8% to 34.2% between 2015 and 2019, and diabetes prevalence increased slightly from 8% (2010) to 8.1% (2014).		
Outcome 1.2. Reduced number of people suffering financial hardships	Data is captured by the latest (2017) indicator “population with household expenditures on health greater than 10% of total household expenditure or income (%)” at 1.47% overall, and higher proportion in rural than urban areas (1.65% and 1.43% respectively). Regional average is above 12%. Trend data is not available.	low	While financial hardship when accessing health care is relatively low compared to the regional average, the causal link to WHO's activities cannot be inferred given that there have not been significant interventions by WHO on this.
Outcome 1.3. Improved availability of essential medicines	Data on availability of essential medicines, vaccines, diagnostics and devices for primary health care could not be traced for Djibouti.	moderate	There is anecdotal evidence that WHO has contributed to addressing the gaps in essential medicines and supplies through direct support to MoH operations in some instances. Recently, WHO supported the development of a national essential medicines list (EML) and the reviewing of clinical guidelines to align to this. These efforts are however unlikely to have yet translated into better availability of essential medicines given that many challenges remain around stock outs and strengthening the management of medical supplies by the CAMME.
Outcome 2.1. Country health emergency preparedness strengthened	The prepare dimension is reflected through the International Health Regulations (IRH) index composed of an average of 13 IHR 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 (65).	low	WHO has not realized major interventions on emergency preparedness in Djibouti.
Outcome 2.2. Epidemics and pandemics prevented	The prevent dimension is captured by vaccine coverage of at-risk groups. 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% in 2019 to 59% in 2021, compared to 83% in 2021 in EMRO. The longer-term trend on polio vaccination coverage in Djibouti also shows that coverage is decreasing.	low	WHO has actively supported the country on preventing epidemics, and in detecting and responding to measles outbreaks; however, the weakness of routine immunization means that catch-up campaigns remain insufficient. As a result of WHO preparedness work on polio with the Ministry, Djibouti was able to quickly respond to the detection of polio virus, declare a type 2 health emergency. Djibouti was the second country in the region after Egypt to respond to an outbreak using the new vaccine (noPV2). Despite efforts by WHO and UNICEF, polio immunization coverage remains insufficient.
Outcome 2.3. Health emergencies rapidly detected and responded to	The detect and respond component is captured by the proportion of IHR events detected and responded to in a timely fashion. No data could be traced for Djibouti on this indicator. However, a key emergency events in the period considered is	high	WHO has to a large extent contributed to COVID-19 vaccination results in Djibouti. COVID-19 vaccines were successfully rolled out via the COVAX facility – a coalition co-led by WHO, Gavi, the Vaccine Alliance, and the Coalition for Epidemic Preparedness Innovations– with support from

	the COVID-19 pandemic. In this respect, according to the WHO COVID-19 dashboard ²⁰ Djibouti reported 15 690 cases and 189 deaths from COVID-19. 41% of the population had received at least a first course of vaccination, compared to 52% in EMRO.		UNICEF. 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.
Outcome 3.1. Determinants of health addressed leaving no one behind	Under determinants of health, child malnutrition remains a key issue in the country. In 2022, 18.7% of children under 5 were stunted (down from 21.5% in 2019) and in 2019, 10.6% of children under 5 were wasted (down from 13.9% in 2013). Child malnutrition is particularly acute in rural areas, where stunting is estimated at 42.3% or over double the national average. ²¹	moderate	WHO has focused on addressing complicated acute severe malnutrition in complement to the work of other agencies such as UNICEF of the management of malnutrition cases. Increased services availability and quality for these cases is likely to have contributed to some extent to the improvement of stunting and wasting outcomes.
Outcome 3.2 Risk factors reduced through multi-sectoral action	Trends on most NCD risk factors except alcohol use are worsening, although they remain better than regional average. For example, obesity in adults has increased from 10.2% to 12.2% between 2010 and 2016, compared to 19.5% in EMRO in 2016. It is noteworthy that obesity is higher in women (16.5% in women and 7.9% in men). For mental health, the key indicator which is reported is the suicide mortality rate (per 100 000 population). In Djibouti, it was higher than in the regional median, at 9.6% versus 5.8% in EMRO in 2019.	low	Work of WHO on NCD risk factors and health promotion has been limited in Djibouti and work on improving mental health services is only starting. Indicators are generally on a worsening trend, underscoring that WHO has not made a significant contribution in those areas.
Outcome 4.1. Strengthened country capacity in data and innovation	Primary data availability for UHC Service Coverage Index was 41% in 2019 as compared to 65% median value in EMRO. However, DHIS2 completeness increased from 60% in 2022 to 80% in 2023.	high	WHO has supported the implementation of the DHIS2, making it likely that it contributed to improving surveillance data completeness in Djibouti.

²⁰ <https://covid19.who.int/table>, accessed on 07/11/23

²¹ UN Country Common Analysis for Djibouti (2021)

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