Joint Appraisal report 2017

Country	Djibouti
Full Joint Appraisal or Joint Appraisal update	Joint Appraisal update
Date and location of Joint Appraisal meeting	8-13 October 2017 in Djibouti
Participants/affiliation	Ministry of Health, Gavi, WHO, UNICEF
Reporting period	1 January to 31 December 2016
Fiscal period	1 January to 31 December 2016
Comprehensive Multi Year Plan (cMYP) duration	2016-2020

1. SUMMARY OF RENEWAL AND EXTENSION REQUESTS

1.1. New and Underused Vaccines Support (NVS) renewal request(s)

Type of support (routine or campaign)	Vaccine	End year of support	Year of requested support	Target (population to be vaccinated)	Indicative amount to be paid by country	Indicative amount to be paid by Gavi
Routine	Pentavalent vaccine	2020	2016	23,716	US$ 8,000	US$ 24,000
Routine	PCV13 vaccine (existing presentation)	2020	2016	23,716	US$ 8,000	US$ 135,000
Routine	IPV (existing presentation)	2018	2015	23,716	US$ 0	US$ 55,000
Routine	Rotarix vaccine (existing presentation)	2020	2016	23,716	US$ 5,500	US$ 48,000

1.2. New and Underused Vaccines Support (NVS) renewal request(s)

Not applicable

1.3. Health systems strengthening (HSS) renewal request

Total amount of HSS grant	US$ 3,400,000
Duration of HSS grant (from... to ...)	2015-2019
Year/period for which the HSS renewal (next tranche) is requested	2017-2018
Amount of HSS renewal request (next tranche)	US$ 1,360,000

1.4. Cold Chain Equipment Optimisation Platform (CCEOP) renewal request

Already approved in 2017.

1.5. Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future	Programme	Expected application year	Expected introduction year
	EPI/MR	2018	2018

2. CHANGE IN COUNTRY CONTEXT SINCE LAST JOINT APPRAISAL

Despite concerted efforts by the Government and its partners to improve the immunisation system, several external factors have negatively impacted the expected outcomes.

In the past several years, massive numbers of refugees and migrants have arrived in the country, and they are using health services, including immunisation. This has put significant pressure on the entire health system, particularly in the regions. Many of the refugees and migrants live among host communities and receive public services in the same way that Djibouti citizens do.

In the fourth quarter of 2016, we recorded numerous cases of acute diarrhoea in the country, primarily in the north (Tadjourah and Obock). Investigations determined that these cases were imported by migrants from Ethiopia, where a similar outbreak had been ongoing for months. A dozen cases were recorded in early 2016 among migrants from Yemen, which is currently experiencing a cholera outbreak.

There are also regular population movements between Djibouti and its neighbours related to climate change. For example, in 2016 approximately 3,000 people, including children, arrived in Ali Sabieh, and there were some cases of measles. These populations gradually settled in the periphery of some cities, primarily the capital, which led to an increase in the number of non-immunised children, a resurgence of vaccine-preventable diseases (VPDs) and disruption of Expanded Programme on Immunization (EPI) indicators.

The Global Fund, one of the largest donors to the health system, reduced its contributions by more than half for the 2018-2020 period. However, the European Union is planning to provide up to 9 million euros to support nutrition and treatment for migrants.

The Government is continuing to increase its efforts to improve the health status of the population by increasing the national health budget. For the EPI in particular, government commitments have translated into the redeployment of new, more qualified immunisation workers and the construction of a new building to house the EPI within the health ministry.

Djibouti's reclassification from a low-income country to a middle-income country could affect Gavi funding by increasing the country's co-financing share.

3. PERFORMANCE OF THE IMMUNISATION SYSTEM IN THE REPORTING PERIOD

3.1. Coverage and equity of immunisation

The routine EPI has seen a reduction in immunisation coverage in the last two years (Figure 1). Although the WHO-UNICEF coverage estimates do not reflect this (lacking new data from a coverage study), data reported by the Ministry of Health (MoH) (administrative coverage data reported on the JRF) show a reduction in DTP coverage from 78% in 2015 to 68% in 2016 (Figure 2). This reduction in immunisation coverage is seen for most of the vaccines in the national immunisation programme (Penta, PCV and Rota: Figures 2, 3 and 4, respectively).

Figure 1: Target population for immunisation activities (source: 2016 DIS/MoH)

	Djibouti City	Interior regions	Total
Total population	576,688	415,947	992,635
Target population 0-11 months	13,264	9,567	22,831
Target population 0-5 years	65,742	47,418	113,160

The pentavalent dropout rate is high, thus coverage for the third dose is lower than for the first and second doses (Figure 5).

It is interesting to note that measles immunisation rates (first dose) have remained high over the past five years, likely due to strong demand for immunisation from families (Figure 6).

Figure 2: National DTP3 coverage in Djibouti, 2000-2016 (source: WEUNIC, JRF)

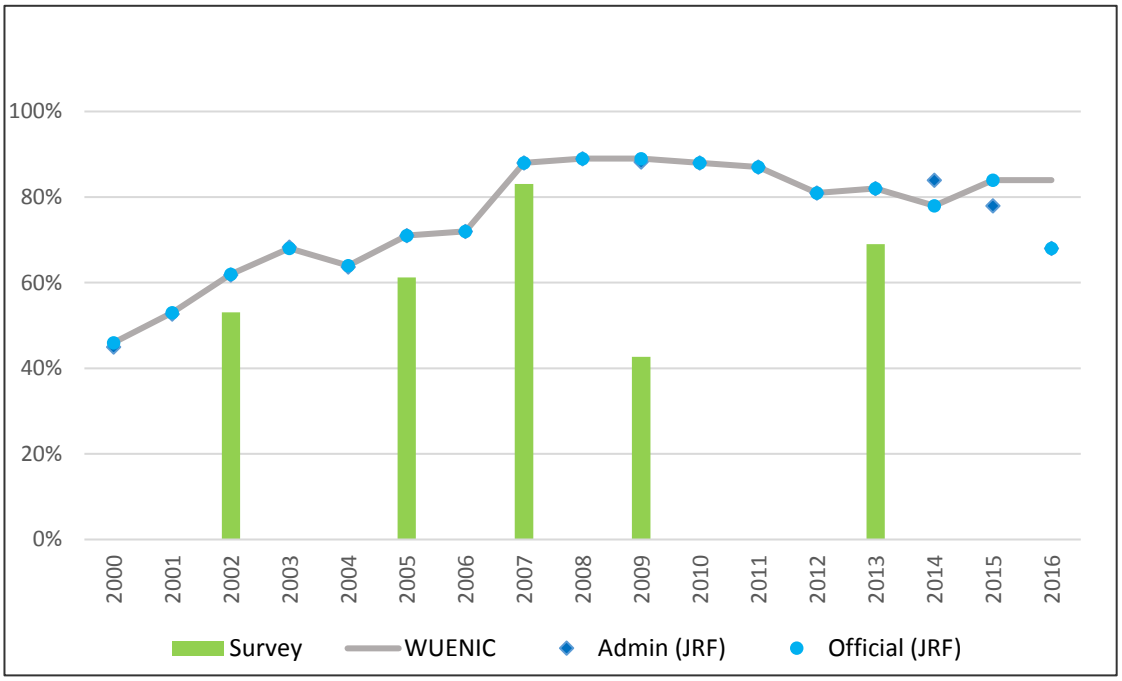


Figure 3: National PCV3 coverage in Djibouti, 2000-2016 (source: WUENIC, JRF)

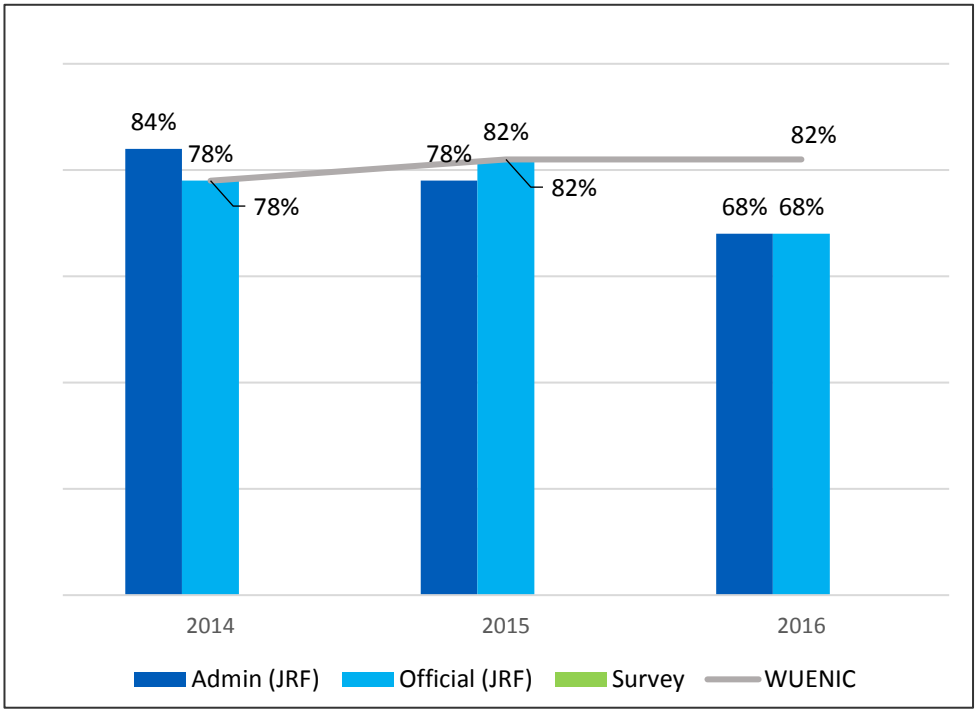


Figure 4: National Rota2 coverage in Djibouti, 2000-2016 (source: WUENIC, JRF)

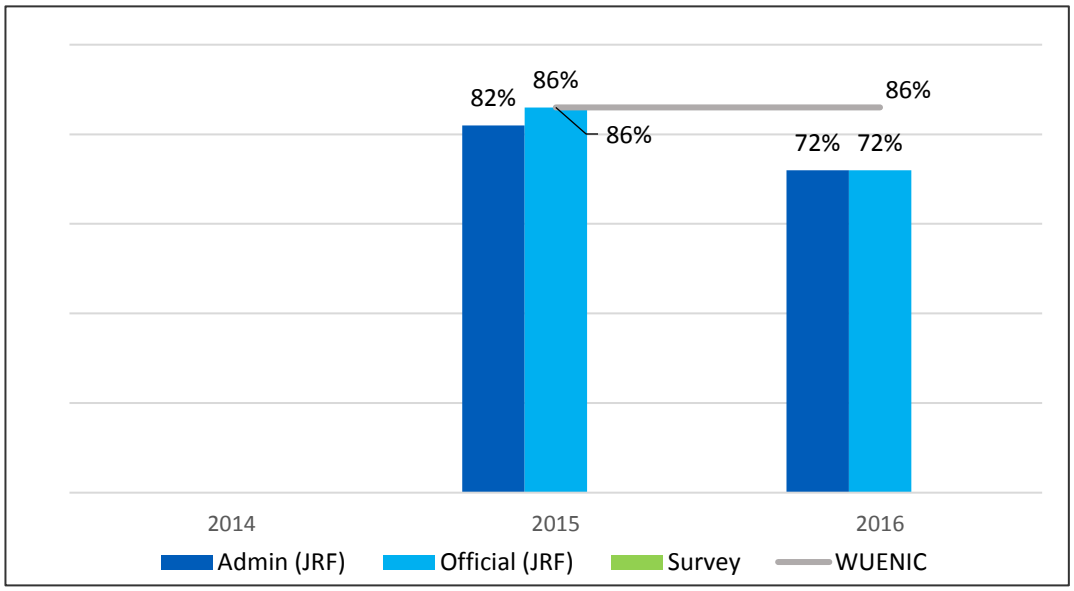


Figure 5: National Penta1, 2 and 3 coverage in Djibouti, 2000-2016 (source: WUENIC, JRF)

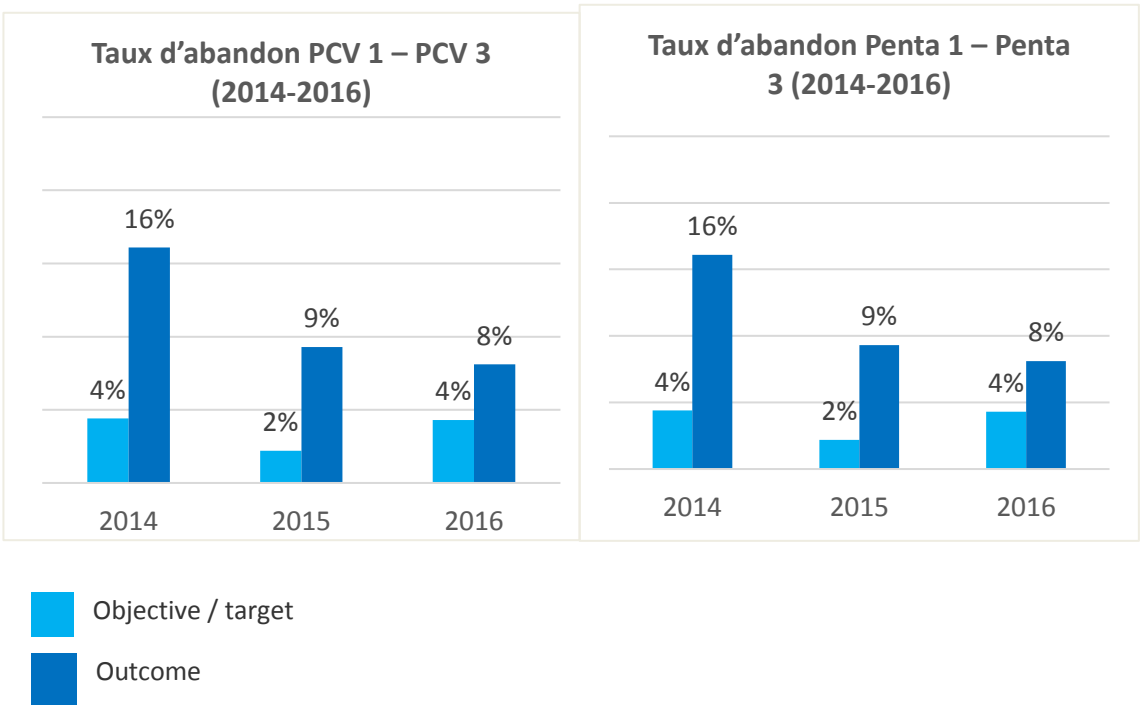
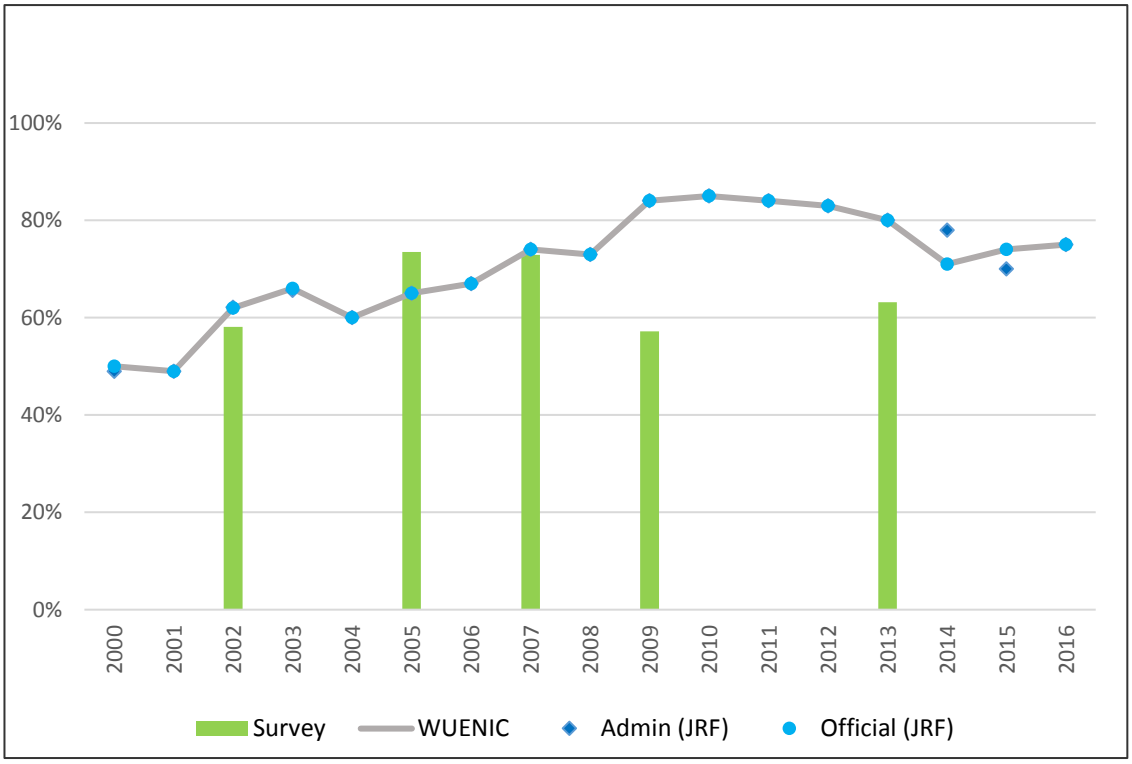


Figure 6: National MCV1 coverage in Djibouti, 2000-2016 (source: WUENIC, JRF)



The reduction in national coverage rates is primarily related to disparities between the capital and the health regions, as well as between urban, urban-suburban and hard-to-reach rural zones in the country's interior. Thus routine immunisation coverage has remained relatively stable in Djibouti City

at around 91% in 2016 (compared to 92% in 2015), whereas it has decreased in the majority of regions, mostly rural (Figure 8). DTP3 coverage dropped from 75% to about 50% in these five regions (Figures 7, 8, 9 and 10).

Figure 7: Percentage of districts reporting immunisation coverage below 50%, between 50% and 79% and above 80% in Djibouti, 2005-2016 (source: JRF).

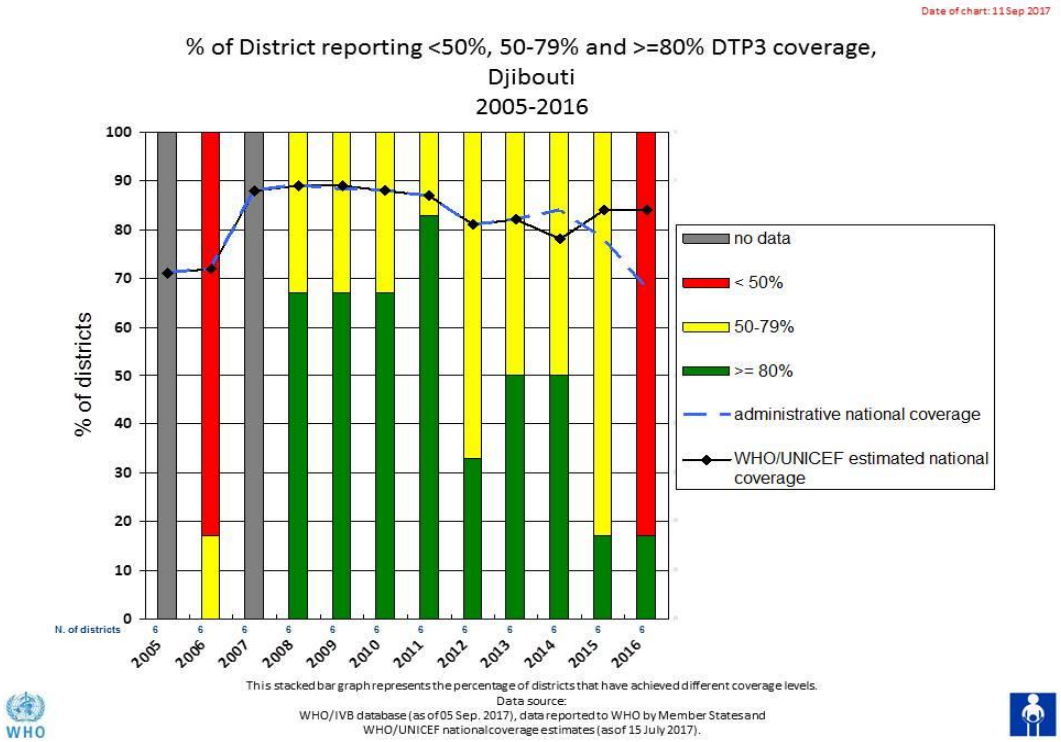


Figure 8: DTP3 coverage by health region, 2014-2016 (administrative data)

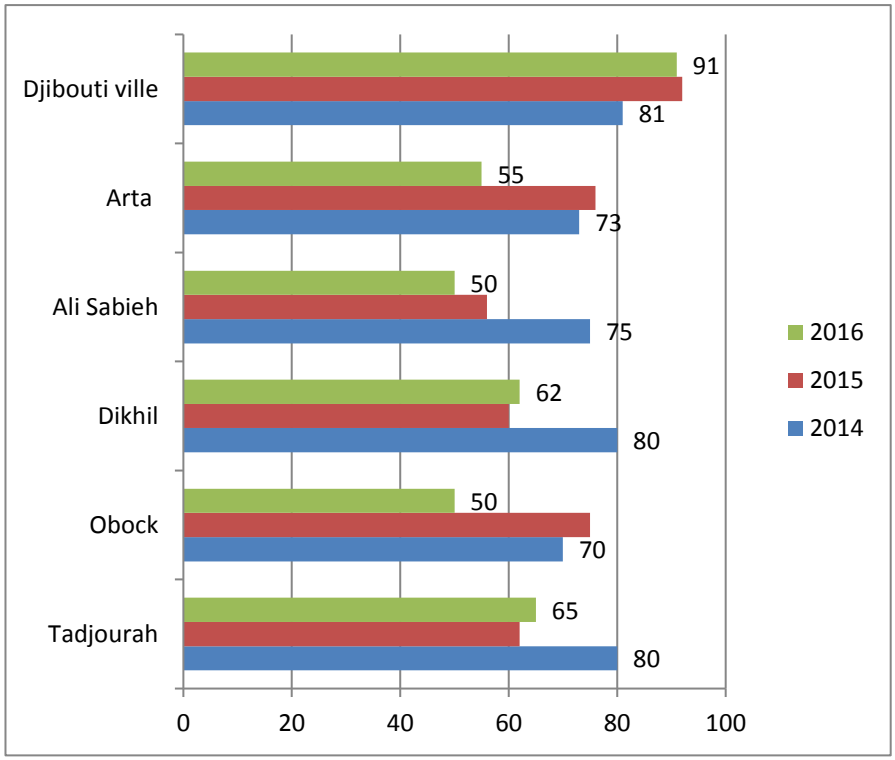


Figure 9: MCV1 coverage by health region, 2014-2016 (administrative data)

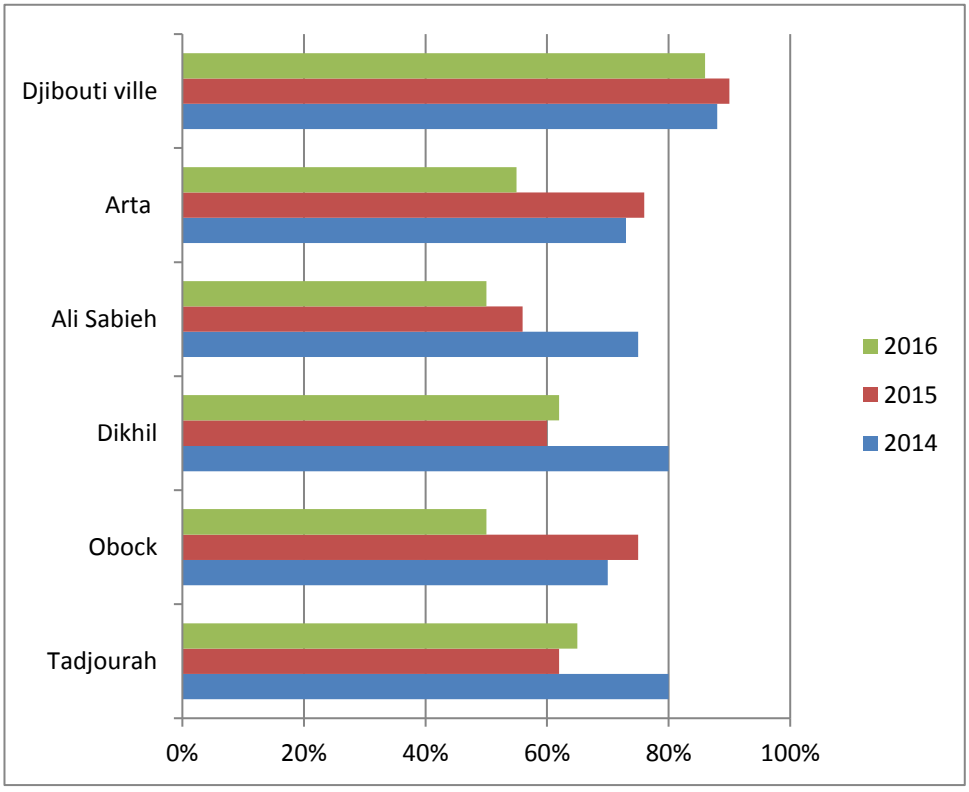
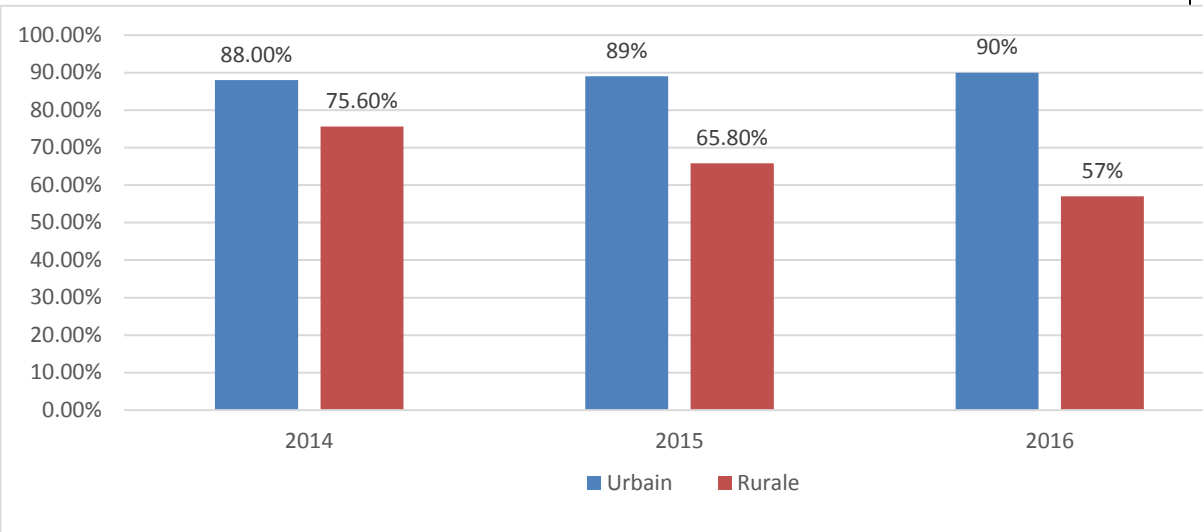


Figure 10: DTP3 coverage by rural zone (five regions) and the urban zone (Djibouti City), Djibouti, 2014-2016 (source: JRF)



There are several explanations for these reductions in immunisation coverage. In the past two years, many cold chain solar equipment items have broken down, resulting in an interruption of immunisation services in the rural regions of the interior. Another factor is increased population mobility. The influx of refugees from neighbouring countries experiencing conflict and nomadic populations (both local and from neighbouring countries) and the rural exodus to the suburbs of Djibouti City have created problems with both the denominator and a shortage of health cards for the population. Urban health centres are offering immunisation services to these mobile populations, who no longer use rural services.

Finally, poor quality data from primary health centres makes it difficult to interpret the data reported to the national level. While the health authorities in Djibouti City have undertaken a major effort, with strong results, regional centres still need to conduct a data quality analysis (DQA) and create a plan based on the results.

The MoH is concerned by this situation and has thus committed to strengthening the cold chain through Gavi's CCEOP, with technical support from UNICEF (the CCEOP submission was adopted in 2017). While waiting for the CCEOP plan to be established, the MoH received emergency assistance from Gavi to purchase cold chain equipment for immediate needs (23 solar and 5 electric refrigerators were received and installed in 2017).

3.2. Key drivers of low coverage/equity

Healthcare work force

While several factors explain the under-performance of the immunisation programme, human resources are the primary issue. The frequent turnover of trained immunisation workers, unequal distribution of workers between the capital city and the regions, and a lack of incentives for these workers may explain the disparities in immunisation coverage. Workers without adequate training in immunisation services struggle to effectively implement routine activities (managing vaccines and cold chain equipment, using good vaccine practices, reporting, etc).

The training curriculum for nurse health workers includes modules on immunisation, but knowledge assessments demonstrate a clear need for improvement. The EPI set up a plan for training and retraining workers to build their immunisation skills, but specialised training in vaccine management and logistics is necessary (similar to the LOGIVAC Centre training in Benin). Strengthening supervision is also critical for providing regular monitoring and rapid response.

Gavi support for the national human resources management policy is needed for capacity building (training/retraining, participation in regional and international workshops, short seminars) and for technical assistance to municipalities/zones with low immunisation coverage.

Supply chain

The last Effective Vaccine Management (EVM) assessment, in 2014, revealed significant gaps. An improvement plan based on its recommendations was developed but has only been partially implemented. There is a plan to boost implementation of these recommendations in year 3 (improving the cold chain, vaccine management and generator maintenance). There is also a plan to conduct an EVM assessment in 2018.

Demand generation/demand for immunisation

Immunisation is widely accepted by most of the country's population, but demand remains suboptimal. There are many dropouts between the first and third dose of the DTP vaccine, possibly due to a lack of understanding about the importance of immunisation in rural zones and suburban areas. To mitigate this, the EPI has developed a communication strategy with UNICEF support that focuses on specific populations (nomads, migrants, etc). This strategy is currently being implemented. A training plan for interpersonal communication (IPC) was developed, also with UNICEF support, and a series of "train-the-trainer" sessions is planned to begin shortly. Communication tools were updated, and new tools are being tested with the community. EPI administrative data do not currently provide a breakdown by gender; coverage data from the 2017 DHS-MICS may incorporate this factor.

The EPI is managed by the coordinator and his/her team. While the structure itself is in place, the EPI review found that there are no specific terms of reference for the various positions. Following the review, the EPI was restructured and made into an institution under the direction of priority health programmes. In addition, activity coordination was strengthened and the various entities were re-energised (ICC, NITAG, NLWG, etc). The EPI currently plays a central role in health system strengthening through the Gavi-HSS project.

Table 1: Activities established in 2016-2017 to address factors for low performance in the immunisation system

Objectives	Measures	Comments	Completed by October 2017
To improve the skills of logistics workers	- Train logistics managers in EVM - Organise technical visits/study trips to the EMRO region to share experience	Four people working in the EPI central storehouse	- Training for a pool of trainers, including the central warehouse team, in vaccine and cold chain equipment management
To improve storage conditions for vaccines and immunisation materials	- Set up shelves in three reserved rooms for storing immunisation materials - Set up an awning in front of the central storehouse in Einguella and in front of the PK12 storehouse	Two in Einguella and one in PK12	- Shelves in place in the storage areas of two storehouses - Awnings in place at the centra storehouse in Einguella and the PK12 storehouse (in progress) - Acquisition (in progress) of a centralised temperature monitoring system

Strengthen data management capacities (vaccine stock management)	- Acquisition of two computers (PCs) and a laptop - Acquisition of two printers - Acquisition of a copier and scanner - Training logistics specialists in working with software	Action to take for the two storehouses	- Both storehouses have received computers with accessories, including two printers, a photocopier and a scanner - Logistics specialists have been trained in the use of tools for managing and monitoring vaccines and supplies (SMT and DVD-MT)
Ensure vaccine storage equipment is safe	- Acquisition of electric regulators for about 20 pieces of equipment - Acquisition of thermometers (continuous temperature loggers)	- 20 pieces of equipment for the Einguella central storehouse - Plan for another 20 for districts in the interior	- Regulator is being installed - 100 fridge tags received and distributed to 50 community health centres (CHCs)/health posts and central storehouses - Acquisition of two CMTS (central temperature monitoring system)
Improve means of transport for vaccines and immunisation materials	- Acquisition of a refrigerated truck for transporting vaccines	This vehicle will be located in Einguella. Vaccines are transported to CHCs and district capitals	A refrigerated truck is being acquired
Monitor field activities in Djibouti City and districts	Organise supervision sessions throughout the year	Every year: 1 time every 2 months per district	Programme supportive supervision missions were conducted along with other joint supervision trips with other ministry directorates
Provide technical assistance to monitor, evaluate and train the logistics team	Recruit a national or international consultant for periodic logistics M&E	3 weeks, 2x/year. National or international consultant	A national assistant was recruited through UNICEF to strengthen programme logistics

3.3. Data

The weakness of the system for reporting immunisation activity data is due to both data quality and reliability issues. Until November 2016 there were two parallel data collection streams: the National Health Information System (SNIS) and the EPI. Each generated its own data, which were inconsistent with each other. It should also be noted that the irregularity of EPI supervision visits to immunisation workers led to a loss of motivation among these workers, which resulted in inadequate reporting (in terms of both quality and frequency). This insufficient reporting is another factor behind the reduced coverage rates.

In light of this, the MoH decided to strengthen the SNIS by establishing a specific directorate, the Directorate for Health Information (DIS), in October 2016. This new directorate centralises the

collection, management and analysis of all health-related data, including on immunisation. It does this through the monthly activity reports sent by the focal points, who themselves collect data from each health facility. The plan is for the DIS to provide the data to the EPI monthly, but a meeting to discuss and validate data internally at the MoH is planned twice yearly before the data are published.

There are possible gaps in this approach, such as data not being reviewed frequently enough (twice yearly rather than monthly; and not including data from mobile team activities). The EPI has studied the possibility of correcting these gaps with the DIS.

It should be noted that the DIS developed a plan for building health worker skills to improve the quality of data from health facilities. It deployed focal points with specific data analysis skills (academic backgrounds) to the regions in order to improve the system for collecting and analysing data and to provide decentralised training for health facility workers. The DIS also set up a plan for quarterly integrated supervision from the central level to the districts, and monthly supervision from regions to health posts.

In terms of the comparative advantages of the DHS for the Gavi-HSS project, there is a specific module for immunisation that includes the main key indicators, such as immunisation coverage for the following vaccines:

- DTP3;
- measles;
- BCG; and
- polio.

The DHS can calculate the dropout rates between the first and subsequent doses, thus measuring health system performance. In addition, these indicators are disaggregated by gender, wealth quintile, mother's education, rural/urban area, and birth order. This provides information on the relative equity of the health system and the impact of the Gavi-HSS project. Note that there was a proposal in the initial version of the HSS project to “conduct a survey/assessment of the impact of HSS funds on health indicators”. It is therefore necessary to contribute to the implementation of a DHS-MICS survey in 2018. The Gavi Secretariat has proposed exploring the possibility of financially contributing to a DHS.

A DHS-MICS survey was officially launched in early September 2017, and its final report is expected in the second half of 2018. This survey will collect quality disaggregated data using uniform indicators for the entire country.

It has been proposed that the knowledge and skills of workers in charge of district immunisation activities should be improved. Since the establishment of the medical sciences faculty and strengthening of the higher institute for health sciences (training for nurses and paramedics), there has been a significant increase in the number of medical staff in the country. District health centre human resources have been augmented by the influx of certified nurses. Although immunisation modules are part of the nursing curriculum, the EPI set up a training plan to strengthen the technical skills of immunisation workers (nurses and non-nurses). Supervision is strengthened by regular supportive monitoring of these workers.

To improve the quality of immunisation data and identify possible actions, the EPI and the DIS propose conducting a DQA. Gavi has offered to share examples of DQAs from other countries (terms of reference, budget, etc) and to fund this study.

3.4. Role and engagement of different stakeholders in the immunisation system

National coordination forum

The primary role of the ICC is to improve coordination between the various partners to ensure a better performance of the immunisation programmes and control of VPDs. The ICC conducts advocacy in order that cMYP goals remain national priorities as well as campaigns to mobilise resources.

The ICC plays a crucial role in checking that activities align with plans, and that they are purposefully and properly revised according to group consensus. This might include periodic meetings to discuss the status of activities and also supervision or data analysis functions to ensure that partners are using standardised tools and methods.

The ICC is also responsible for directing EPI interventions and mobilising the necessary funds to implement key interventions. It ensures activities are funded or determines the priorities if funding is insufficient. In addition, the ICC must ensure that the various donors and partners are contributing and assisting in making appropriate decisions to support the programme and ensuring that EPI interventions continue uninterrupted. The terms of reference for this body were updated in 2014, but it needs to be re-energised and to hold meetings more regularly. All immunisation actors are members of this community, including TFPs (WHO/UNICEF/USAID, etc) and other ministries (in particular Education, Women and Family, Waqf Fund and Budget). Civil society is also represented through the UNFD (Djibouti national women's union).

In addition to the ICC, which is the main entity for coordinating immunisation activities, there are other committees with specific roles in a variety of domains, such as:

- Gavi-HSS project steering committee, whose role is to monitor interventions supported by Gavi-HSS. This group meets once a month and reports to the ICC quarterly. In addition, the immunisation logistics working group (NLWG) is a subgroup of the steering committee responsible for monitoring vaccine supplies, the cold chain and logistics.
- The NITAG is a technical committee whose role is to advise the EPI on all scientific aspects related to immunisation activities. It is an independent committee that offers guidance to the MoH about advances in immunisation. The national certification committee is a subcommittee of national experts on polio and it meets every three months to ensure that all reported acute flaccid paralysis cases are classified and that all surveillance quality indicators are used properly in the country. This committee drafts an annual report that it submits to the EMRO regional certification office.

  All of the committees need to be re-energised, to include holding meetings on a regular basis to better guide the EPI and strengthen disease surveillance and response.
- Gavi will explore the possibility of providing support through the Leadership Management Coordination (LMC) programme for coordination and decision-making processes (ICC, NITAG, etc) and to share international experiences.
- A framework for dialogue and regulatory matters will be established between the EPI and the private and semi-public sectors. All stakeholders should be represented in these committees.

Civil society

Civil society plays a key role in communication and mobilisation activities, in particular during immunisation-related events (new vaccine introductions, supplementary immunisation activities, global vaccination week, etc). In 2016, civil society played an important social mobilisation role during the IPV introduction and switch from the trivalent to the bivalent OPV. However, a reduction in civil society involvement has been noted recently, which has translated into renewed interest and active participation in community-based activities. To sustain the effectiveness of its contribution towards boosting demand, the ministry has strengthened the Directorate for Health Promotion. It has been agreed that working conditions for community health workers (CHWs) will be improved so that they are re-energised.

Other donors

The country funds a majority of its immunisation costs, but donors other than Gavi also contribute, such as the World Bank, which contributes indirectly through its performance-based funding project. WHO and UNICEF provide financial as well as technical support. The limited number of potential donors in the country is another barrier to resource mobilisation.

Private sector

Collaboration with the private sector is not optimal. Through the EPI, the MoH provides vaccines to private structures that offer immunisation services, but information from these is not forthcoming. The EPI does not receive reports from the private sector in a systematic way and has no visibility on the immunisation schedule used by private actors.

These private health facilities do not have approved cold chain equipment and use domestic refrigerators. High wastage rates have been observed as well, due to not following the open-vial policy and to poor stock management more generally.

Administrative and VPD surveillance data are not sent on a regular basis.

It is strongly recommended that agreements be established with every private structure that provides immunisation services (eg, Global Fund), with clear commitments on data sharing, following the immunisation schedule and involvement in surveillance.

Cross-sectoral collaboration

Cross-sectoral collaboration between the MoH and other ministries is good. For example, the MoH works closely with the Ministry of Education in regards to school health, which can be seen through the immunisation activities that take place in schools.

4. PERFORMANCE OF GAVI GRANTS IN THE REPORTING PERIOD

4.1. Programmatic performance

The implementation of routine immunisation activities in 2016, with support from the Government and TFPs (WHO, UNICEF, Gavi), enabled immunisation services to restart in zones with low coverage, providing children with vaccines that many had not had access to for months due to the lack of a working cold chain. The purchase of 23 solar and 5 electric cold chain refrigerators through the Gavi-HSS project made it possible to offer immunisation services to children in the regions.

According to the cold chain and logistics inventory undertaken by the MoH in June 2016, only 60% of the cold chain was operational at the national level, and less than 50% was operational in the regions. The purchase of new equipment helped reduce that gap and enabled immunisation activities to start again in health facilities deprived of immunisation services, and thereby to protect the most vulnerable children. Following this inventory, and given the extent of the problem, the MoH seized the opportunity for the Gavi optimisation platform (CCEOP) to strengthen the cold chain.

Djibouti developed a proposal for Gavi, which was approved and covers the period from 2017 to 2019. The Gavi CCEOP will help the country to build up its cold chain to provide over 130,000 children under 5 years of age and pregnant women with access to quality vaccines for effective protection against deadly childhood diseases and other illnesses. Health worker skills were improved in vaccine management and cold chain equipment management by a pool of 10 trainers. In addition, 100 fridge tags were purchased and distributed throughout the country. Catch-up activities for a variety of antigens were conducted, reaching 3,004 children aged 0-23 months for Penta3 and 2,515 children aged 9-12 months for MCV1 in the five regions. This multiple-antigen campaign increased regional immunisation coverage by 16% for Penta3 and by 27% for measles. To boost demand, an immunisation communication strategy with a particular focus on hard-to-reach populations, was developed and is being implemented by the EPI Directorate for Health Promotion. CHWs have been re-energised by updated visibility and communication tools and a training plan for IPC. EPI focal points in CHCs were trained or retrained in the surveillance of VPDs to improve the surveillance system in the capital. As a result, four cases of acute flaccid paralysis were reported and investigated, compared to three cases per year in the past two years.

Note that some other year 2 activities are being executed. These include cold chain equipment installation and salaries for HSS project managers, which are being finalised with US$ 76,516 committed. Other activities include salaries for maintenance technicians, purchase of visibility equipment for community workers and cold chain maintenance, for which US$ 176,066 is being executed. To close out year 2 of the Gavi-HSS project, the remaining US$ 112,677 planned for laboratory equipment and a waste collection/transport truck with UNICEF must be disbursed, as must the US$ 67,563 for co-investment in equipment as part of the CCEOP.

It should be noted that the implementation delays in the two previous years have had an impact on the country attaining its goals. Nonetheless, the execution rate for years 1 and 2 is currently 87%.

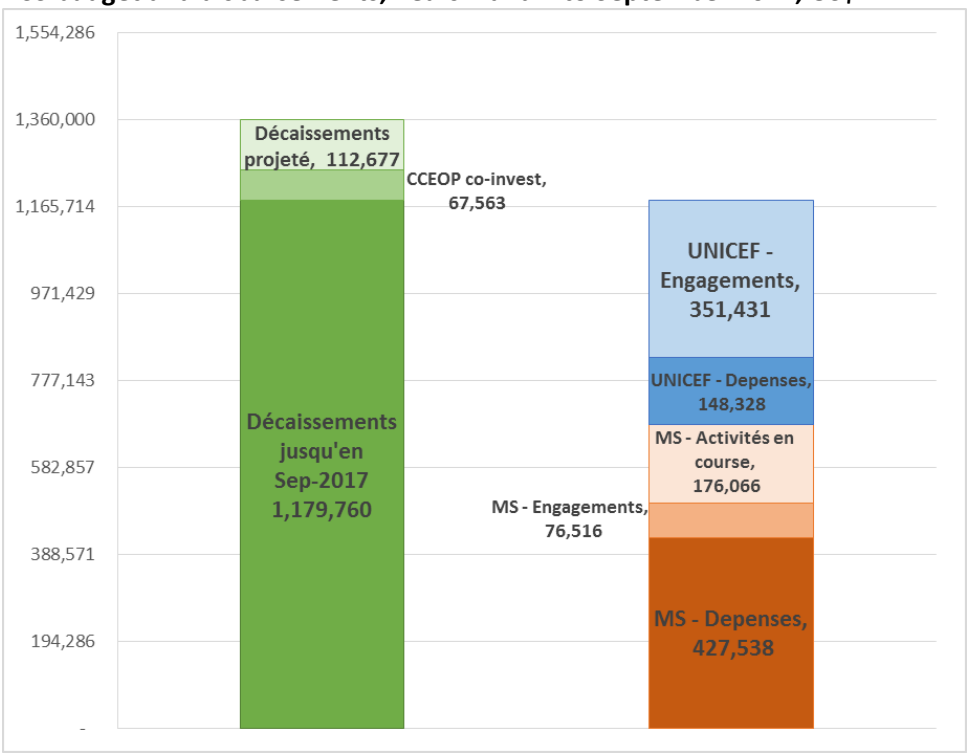
4.2. Financial management performance (for all cash grants, such as HSS, vaccine introduction grants, campaign operational cost grants, transition grants, etc.)

Figure 11: Financial status (September 2015-2017) - Gavi grants

Grant/Partner	Approved grant, years 1 & 2, US$	Disbursements, 2015-9/2017, US$	Expenses, 2015-9/2017, US$	Commitments 9/2017, US$	Projected ongoing activities for end of 2017, US$	Projected disbursements for end of 2017, US$	Projected grant balance end of 2017, US$
HSS							
Ministry of Health		680,000	427,418	76,516	176,066	-	-
UNICEF		499,760	148,328	351,432	-	180,240	-
HSS total	**1,360,000**	**1,179,760**	**575,746**	**338,000**	**176,066**	**180,240**	**-**
IPV VIG	100,000	100,000	50,663				49,337
Rota (remainder of DRHF funds)		7,538	2,963				4,575

Figure 12:

- **HSS budget and disbursements, Years 1 and 2 to September 2017, US$**



4.3. Sustainability (and if relevant, transition planning)

Financing of the immunisation programme: A majority of the funding for immunisation is provided by the country. Since 2016, a budget line item of US$ 51,000 has been allocated for co-financing new vaccines. The 2016 share of new vaccine costs has been paid and the 2017 share is being settled.

UNICEF covers traditional vaccines and all others (Rota, Penta, PCV, IPV) are covered by Gavi with the country's co-financing share.

Polio transition planning: The last case of confirmed identified polio was in 1999 and the country is in the pre-certification phase. The certification process is conditional on enhanced surveillance of acute flaccid paralysis and the operationalisation of certification committees.

The country introduced the IPV on 16 April 2016 and made the switch from OPV (trivalent to bivalent) on 30 April 2016. Djibouti conducts regular campaigns in addition to routine activities.

4.4. Technical assistance

Technical assistance from WHO enabled:

- conduct of the EPI review in 2016, which revealed the programme's main challenges and identified recommendations to improve it;
- development of the EPI's cMYP, including priority actions to improve routine EPI and immunisation data quality;
- setting up of independent monitoring during the 2016 polio immunisation campaign for improved performance and data quality;
- skills building of immunisation workers through their participation in training organised by the WHO Regional Office;
- enhancement of surveillance capacities for VPDs by training personnel and supplying materials and equipment for taking samples, transport and detection;
- recruitment of international technical assistance to support the EPI; and
- initiation of recruitment for national technical assistance to support the EPI.

No revisions to current WHO technical assistance activities are planned.

Technical assistance from UNICEF enabled:

- development and validation of an EPI communication strategy with a specific focus on special populations (nomads, refugees and migrants);
- training of CHWs and community actors (community liaisons, community-based associations);
- conduct of a complete inventory of logistics and cold chain equipment;
- recruitment of a national consultant to strengthen vaccine, logistics and cold chain management;
- support for developing the CCEOP submission to Gavi and the entire process, including the deployment plan;
- purchase and distribution of 100 fridge tags throughout the country;
- training of a pool of trainers (10 people) and 100 immunisation workers on cold chain maintenance and vaccine management; and
- purchase of two continuous temperature loggers and alarms for cold rooms (CMTS).

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Prioritised actions from previous Joint Appraisal	Current status
1. Increase immunisation coverage by organising campaigns for multiple antigens	- Multiple-antigen campaign organised in December 2016 and January 2017 for children not fully immunised in remote and hard-to-reach zones in regions of the interior (see outcome in section 4.1).
2. Strengthen cold chain management and maintenance and ensure the cold chain is functional throughout the country	- Capacity-building conducted on vaccine and cold chain maintenance by a pool of 10 trainers for more than 50 immunisation workers in the regions - Purchased and installed cold chain equipment (23 SDD and 5 electric refrigerators) per a deployment plan - Gavi CCEOP process: submission approved, deployment plan validated
3. Improve the quality of data collection, reporting and analysis	- Supportive supervision: qualified focal points deployed to improve data collection and analysis in interior regions; collection tools updated, harmonised, duplicated and distributed. - 19 computers and accessories purchased to enter collected data, 14 for CHCs in Djibouti City and 5 for medical hospital centres; for use with DHIS2, being validated. - Political commitment to improve health data through the establishment of the Health Information Service in the Health Information Directorate.
4. Deploy more mobile teams to reach remote populations	- MoH medical caravans organised regularly in regions and health posts (reports available)
5. Establish/strengthen disease surveillance (for measles, polio, rotavirus disease, tetanus)	- Training/retraining for focal points (14 head nurses, 28 IMCI focal points) and surveillance of EPI target diseases in the Djibouti City region - Training/retraining of 38 health workers and community liaisons in Djibouti City (four cases of acute flaccid paralysis reported and investigated in the first half of 2017)
6. Finalise and implement the communication strategy for access and equity	- Communication strategy developed by an international consultant with UNICEF support, finalised and validated during an ICC meeting; implementation is ongoing.
7. Improve the quality of routine immunisation services	- Revalorization of immunisation workers - Close collaboration between the various departments involved in immunisation; improved coordination - New EPI building totally covered by the MoH budget
8. Develop mobile strategies to reach the remaining 22% of the population that does not have access to vaccines	See point 4
9. Develop microplans for districts and health facilities to identify the zones and centres with the lowest immunisation coverage and design activities to remedy this	- Geomapping of all health facilities in the country is being finalised with WHO support - There are plans at the national level to update microplans and map hard-to-reach zones with special populations
10.	

Additional significant IRC/HLRP recommendations (if applicable)	Current status

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

Overview of key activities planned for the next year:

Following discussions during the Joint Appraisal and final approval from the MoH, ICC and Gavi, the following activities will be implemented during years 3, 4 and 5.

Key finding 1	Improve data availability, quality and analysis
Agreed country actions	1. Conduct a DQA/DQS 2. Train immunisation workers (IDE and other) on data collection, verification, analysis and transmission 3. Supportive supervision (centralised and decentralised) 4. Microplan and mapping 5. Conduct the DHS
Associated timeline	End of 2017 and 2018
Technical assistance needs	GAVI 1 WHO and UNICEF 2 WHO and UNICEF 4
Key finding 2	Improve coordination between partners and the MoH
Agreed country actions	1. Re-energise committees (regular meetings, set up a secretariat, review terms of reference, prepare meetings, etc). 2. Gavi will explore the possibility of providing support through the LMC programme for coordination and decision-making processes (ICC, NITAG, etc) and to share international experiences. 3. A framework for dialogue and regulatory matters will be established between the EPI and the private and semi-public sectors. All stakeholders should be represented in these committees. 4. The MoH will establish agreements with every private structure that offers immunisation services (eg, Global Fund), with clear commitments on data sharing, following the immunisation schedule and involvement in surveillance.
Associated timeline	2018
Technical assistance needs	Gavi-LMC
Key finding 3	Strengthen the supply and quality of immunisation services
Agreed country actions	Strengthen the practical skills of immunisation workers at all levels (training and monitoring) Develop and implement the Reach Every District approach

Associated timeline	2018
Technical assistance needs	WHO and UNICEF
Key finding 4	Increase community and individual demand for immunisation
Agreed country actions	1. Organise a training workshop for 30 trainers at the national and intermediate levels on IPC techniques and using educational materials. 2. Organise workshops to train/retrain health workers and community actors in the five health regions. 3. Train CHWs and community liaisons on the essential family practices package. 4. Organise educational talks in various structures (schools, young girl apprentice programmes, women's groups, development associations) by region, and distribute education materials. 5. Produce visibility, communication and monitoring materials for immunisation (create image boxes, posters, monitoring tools).
Associated timeline	2017 and 2018.
Technical assistance needs	UNICEF
Key finding 5	Strengthen surveillance and response capacities
Agreed country actions	1. Conduct active and community-based surveillance of VPDs, polio in particular 2. Strengthen laboratory surveillance of measles and rubella cases
Associated timeline	2018
Technical assistance needs	WHO/UNICEF

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

Process

- Joint preparation through conference calls to agree on objectives, Joint Appraisal dates, etc.
- Gavi shared the Joint Appraisal guidelines and report template.
- The MoH (EPI) presented a draft of the Joint Appraisal report, which was sent to Gavi prior to the appraisal mission
  The Joint Appraisal took place from 8 to 13 October 2017 per the MoH-validated programme with all stakeholders (MoH and TFPs WHO, UNICEF country and regional office, Gavi)
- Key discussions: immunisation coverage and equity; cold chain; data quality; private sector participation; demand and dropout rates; programmatic and financial management; year 3 plan and budget; technical assistance (PEF-TCA); field visit
- The completed work was presented to the ICC for comment and approval on 12 October 2017 at 3:00 pm.

8. ANNEX

Compliance with Gavi reporting requirements

	Yes	No	Not applicable
Grant Performance Framework (GPF) reporting against all due indicators	Yes		
Financial Reports			
Periodic financial reports	Yes		
Annual financial statement	Yes		
Annual financial audit report	Yes		
End-of-year stock level report	Yes		
Campaign reports		To be shared	
Immunisation financing and expenditure information		To be shared	
Data quality and survey reporting		No (2018)	
Annual desk review		No (2018)	
Data quality improvement plan (DQIP)		No (2018)	
If yes to DQIP, reporting on progress against it		No (2018)	
In-depth data assessment (conducted in the last five years)		No	
Nationally representative coverage survey (conducted in the last five years)		No (2018)	
Annual progress update on the Effective Vaccine Management (EVM) improvement plan	Yes		
Post-Introduction Evaluation (PIE)			--
Measles-rubella 5-year plan			--
Operational plan for the immunisation programme			--
HSS end-of-grant evaluation report			--
HPV-specific reports			--
Transition plan			--

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.

The country plans to conduct a DQA with Gavi support in 2018.