Evaluation of Gavi's contribution to reaching ZD and missed communities

Country Case Study: Djibouti

March 2024

Gavi The Vaccine Alliance

Ipsos

Contents

List of figures

List of tables

List of acronyms

AEFI	Adverse events following immunisation
C4D	Communication for Development
CCE	Cold-chain equipment
CCEOP	Cold-Chain Equipment Operations Platform
CDS	COVID-19 Delivery Support
cMYP (FR: PPAC)	Comprehensive Multi-Year Strategic Plans for immunisation
CSO	Civil society organisation
D4A	Data for Action
DEPCI	Directorate for Studies, Planning and International Cooperation
DIS	Directorate of health information
DPS	Directorate of health promotion
DRS	Regional health directorate; Direction regionale de santé
DTP1	Diphtheria, tetanus, and pertussis vaccine first dose
EAF	Equity Accelerator Fund
EMRO	WHO Eastern Mediterranean Regional Office
ENCV-D	National Survey for Vaccination Coverage
EPI	Expanded Programme on Immunisation
EVM	Effective Vaccine Management
FPP	Full Portfolio Planning
GPF	Grant Performance Framework
GNI	Gross national income
GVAP	Global Vaccine Action Plan (GVAP) 2011–2020
HPV	Human papillomavirus
HR	Human resources
HSS (Fr: RSS)	Health Systems Strengthening
IA2030	WHO Immunisation Agenda 2030
ICC	Immunisation Coordination Committee
IOM	International Organization for Migration
IRC	Internal review committee
IRMMA	Identifying, reaching, monitoring and measuring, or advocating (framework)
JA	Joint appraisal
MEL	Monitoring, evaluation, learning
MoH	Ministry of Health
MPM	Multidimensional poverty measure
NGO	Non-governmental organisation
NITAG	National Immunisation Technical Advisory Group
PEF	Partnership Engagement Framework
PENTA1	Pentavalent vaccine first dose

PHC	Primary healthcare
PND	National development plan
PNDS	National health development plan
PwC	Price Waterhouse Coopers
RI	Routine immunisation
SNIS	National Health Information System
TCA	Targeted Country Assistance
ToC	Theory of change
UGP	Unité de Gestion de Projets
UNFD	National Union of Women in Djibouti
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VPD	Vaccine-preventable diseases
WHO	World Health Organization
WUENIC	WHO/UNICEF estimates of national immunisation coverage
ZD	Zero-dose

1 Context

Health system context

Djibouti's health system faces the challenges of rapid urbanisation and growth of slums as well as increasing migratory pressure and the presence of large migrant and refugee populations. Located in the Horn of Africa, Djibouti shares borders with Eritrea, Ethiopia, and Somalia. It is divided into six regions: five inland regions and the capital city, Djibouti-ville. Djibouti has a population of around 1 million as of 2021, 78% of which reside in urban areas.[1] Urban expansion has been largely uncontrolled, resulting in a significant portion of the population living in precarious housing conditions and slums. Djibouti serves as an important transit country for trade and migrants due to its geostrategic position and the political and socioeconomic instability in the region. The country has refugee camps, where about 81% of refugees reside, while the remaining 19% live in urban areas.[2] The total number of registered refugees and asylum seekers in Djibouti was 36,656 in September 2022[3] but the overall population is difficult to estimate considering the nomadic communities that transit through the country.

Poverty, unemployment, socioeconomic and health indicators remain high despite external investments and increased income. There has been progress in social aspects; for example, Djiboutian households' access to electricity and education has improved along with a decrease in extreme poverty. The gross national income (GNI) per capita is of USD 3,300,[4] which is above the Gavi eligibility threshold. However, Djibouti still ranks low at 171st out of 191 with a Human Development Index of 0.509.[5] Around 18% of its population was predicted to be acutely food insecure and experience crisis (Infection prevention and control phase 3).[6] The adult illiteracy rate is 53% but is higher in cities than in regions.[7] To tackle these challenges, the government has developed long-term development plans: Djibouti Vision 2035[8] and the National Development Plan 2020–2024 (PND).[9] One of the strategies of Djibouti 2035 is to consolidate human capital through a comprehensive health policy aimed at prevention and education, and to promote gender equality.

Large health inequalities persist, and the availability and accessibility of quality healthcare is uneven, with access to public services remaining low or sporadic. Disparities in health coverage in different regions, and lack of sufficient human resources in health care, limit the provision of quality services. The Universal Health Coverage index has increased from 41 in 2015 to 44 in 2021 but remains relatively low. Maternal, neonatal, and infant mortality have declined but remain below the globally recognised targets. Coverage rates for preventable diseases through vaccination have been recorded at 70% for Penta 3, 72% for rotavirus and 60% for measles in 2020. Vaccine coverage has declined due to the COVID-19 pandemic, with diphtheria, tetanus, and pertussis (DTP3) coverage falling to 59% in 2022 from 85% in 2019 and diphtheria, tetanus, and pertussis vaccine first dose (DTP1) coverage at 70%

[1] Gavi. (2021). FPP Application. ***Gavi internal documentation.***
[2] Ibid.
[3] UNHCR. (2022). Djibouti Operational Update.
[4] Gavi. (2021). Gavi Djibouti Factsheet. ***Gavi internal documentation.***
[5] Countryeconomy. (2017). Djibouti - human development index - HDI 2017. Retrieved from countryeconomy.com website: https://countryeconomy.com/hdi/djibouti
[6] IPC. (2023). Djibouti: Acute malnutrition situation march - July 2023 and projection for August - December 2023 | IPC - integrated food security phase classification. Retrieved from www.ipcinfo.org website: https://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1156389/?iso3=DJI
[7] Gavi. (2021). FPP Application. ***Gavi internal documentation.***
[8] LDS. (2022). Vision 2035 – Ministère de l'economie des finances, chargé de l'industrie. Retrieved from Gouv.dj website: https://economie.gouv.dj/vision-2035-english/
[9] République de Djibouti. (2020). Plan national de développement 2020-2024.

down from 90%.[10] The immunisation of Penta3 in 2020 showed a disparity between urban and rural areas, with Djibouti-ville's 85% coverage compared to Arta and Tadjourah's 30%. The rates do not meet global immunisation benchmarks, rendering the country vulnerable to epidemics like the measles outbreaks in the past five years. Efforts to contain the COVID-19 outbreak have strained Djibouti's already overburdened health system. Many health resources were redirected to pandemic response, increasing the risk of resurgence of diseases neglected in the meantime. Vaccination campaigns were postponed, exposing thousands of children to vaccine-preventable diseases (VPD).

Over the past decade up to the COVID-19 pandemic, Djibouti's vaccination coverage rates, from BCG to MCV to DTP and others, have not met immunisation requirements. Coverage rates have plateaued, in part due to the climate and conflict migration that have led to changing populations and growing urbanisation. Recent data from WHO/UNICEF estimates of national immunisation coverage (WUENIC) shows a significant drop in vaccination coverage in 2016 before reaching a rate of 90% (DTP1), 85% (DTP3) and 83% (MCV1) in 2019. The 2020 Expanded Programme for Immunisation (EPI) data showed a significant drop in vaccination rates compared to the 2014 survey, with only 34% of children having received all their vaccines before their first birthday. Coverage rates were catastrophically low in 2021 with about 80% of zero-dose (ZD) children concentrated in Djibouti-ville.[11] More than half of ZD children and non-vaccinated children live in Djibouti-ville and in refugee camps across the country. Migrant children, refugees and nomadic populations pose significant challenges to immunisation efforts. Their constant movement make it hard to determine the population size in the area served by a clinic, necessary for calculating the coverage rate. Dire living conditions and poverty, sometimes in remote areas not easily serviced by public services, mean that access of unvaccinated children born at home and living far from health facilities is especially complex. The issue of vaccine coverage and growing populations of ZD children and missed communities has been further exacerbated by the COVID-19 pandemic. The number of ZD children increased by 12% in 2019, 141% in 2020, 25% in 2021, and has stayed relatively stable since the end of the pandemic (0.2% change) in 2022.[12]

Gavi support

Since 2014, Djibouti implemented Gavi grants with a first Health Systems Strengthening (HSS1) grant from 2014–2021. This grant focused on strengthening the health system through the expansion of health services, including those in hard-to-reach populations; reinforcement of vaccine supply chain and cold chains; and improvement of health data management, as well as governance. No activities under 4.0 were specifically dedicated to reaching ZD children[13] although all contributed indirectly to strengthening the system that would deliver services to those specifically intended beneficiaries under 5.0/5.1. Some technical assistance was allocated in 2018/2019 to develop and prepare an urban strategy to reach under-immunised children who represent a large proportion of ZD children in Djibouti. Unfortunately, this did not materialise in a finalised strategy with the arrival of the COVID-19 pandemic. Djibouti also received a COVID-19 Delivery Support (CDS) grant from 2020 to 2022 (likely to be extended to 2025[14]) to ensure an effective delivery of COVID-19 vaccines during the pandemic. Remaining unused amounts were said to be reprogrammed to activities that help reach ZD children such as a polio campaign[15] and a

[10] WUENIC. (2023). WHO/UNICEF estimates of national immunization coverage. Retrieved from www.who.int website: https://www.who.int/teams/immunization-vaccines-and-biologicals/immunization-analysis-and-insights/global-monitoring/immunization-coverage/who-unicef-estimates-of-national-immunization-coverage
[11] Country KII
[12] WUENIC. (2023). WHO/UNICEF estimates of national immunization coverage. Retrieved from www.who.int website: https://www.who.int/teams/immunization-vaccines-and-biologicals/immunization-analysis-and-insights/global-monitoring/immunization-coverage/who-unicef-estimates-of-national-immunization-coverage
[13] Gavi. (2021). Pro-equity mapping. ***Gavi internal documentation.***
[14] Country KII
[15] Country KII

refocusing of activities on community engagement, while the Full Portfolio Planning (FPP) application was being developed and approved. Targeted Country Assistance (TCA) funding was provided to World Health Organization (WHO) and United Nations Children's Fund (UNICEF) for activities such as the effective vaccine management (EVM) assessment and improvement, development of the Comprehensive Multi-Year Plan (cMYP) and Communication for Development (C4D), specific vaccine (inactivated polio vaccine–IPV) and measles, mumps, rubella–MMR) proposal development, and general support to strengthening routine immunisation (RI) and the EPI.

Djibouti was a pilot country for FPP application process in 2021. After more than 12 months of application development, the Internal Review Committee (IRC) approved the application in May 2022 and first funds were disbursed into accounts in March 2023 with implementation starting in June 2023. This current evaluation does not have additional data and visibility on disbursement and implementation. Under the FPP, Djibouti is receiving and will receive HSS2 (2022–2026) and Equity Accelerator Funds (EAF) (2022–2025) with the aim to ensure immunisation of all ZD children and unvaccinated children living in the country within three to five years, especially those living in Djibouti-ville, its surrounding slums and the hard-to-reach areas. More specifically, TCA funds (2022–2026) will contribute to achieving objectives 4 and 5 specifically around reinforcing the governance, management and use of data and funds. The figure and table below provide a broad summary of Gavi support over the years that have contributed to strengthening the health system and improving vaccine coverage as well as reaching ZD children and missed communities.

Figure 1.1: Summary of Gavi support to Djibouti

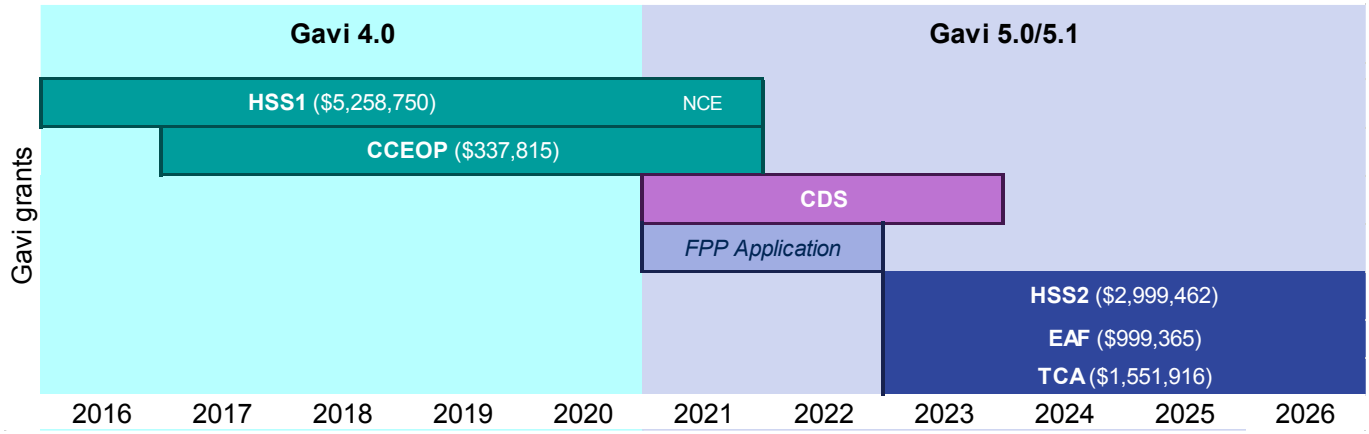


Table 1.1: Summary of Gavi support for ZD children and missed communities

Gavi support	*Amount allocated under 4.0*	*Amount allocated under 5.0*[16]	*Amount disbursed under 5.0 (June 2023)*
HSS	$3,669,404	$2,999,174	No data available
TCA	Received for WHO and UNICEF but no clear data available. $13,757 in 2015 under the New Vaccine Support grant[17] $311,032 or $551,298 in 2017 $618,029 in 2018	$1,673,709	No data available
EAF	N/A	$999,771	$278,841

[16] Gavi. (2021). FPP Application. ***Gavi internal documentation.***
[17] Gavi. (2016). Joint Appraisal Update Report. ***Gavi internal documentation.***

Key stakeholders

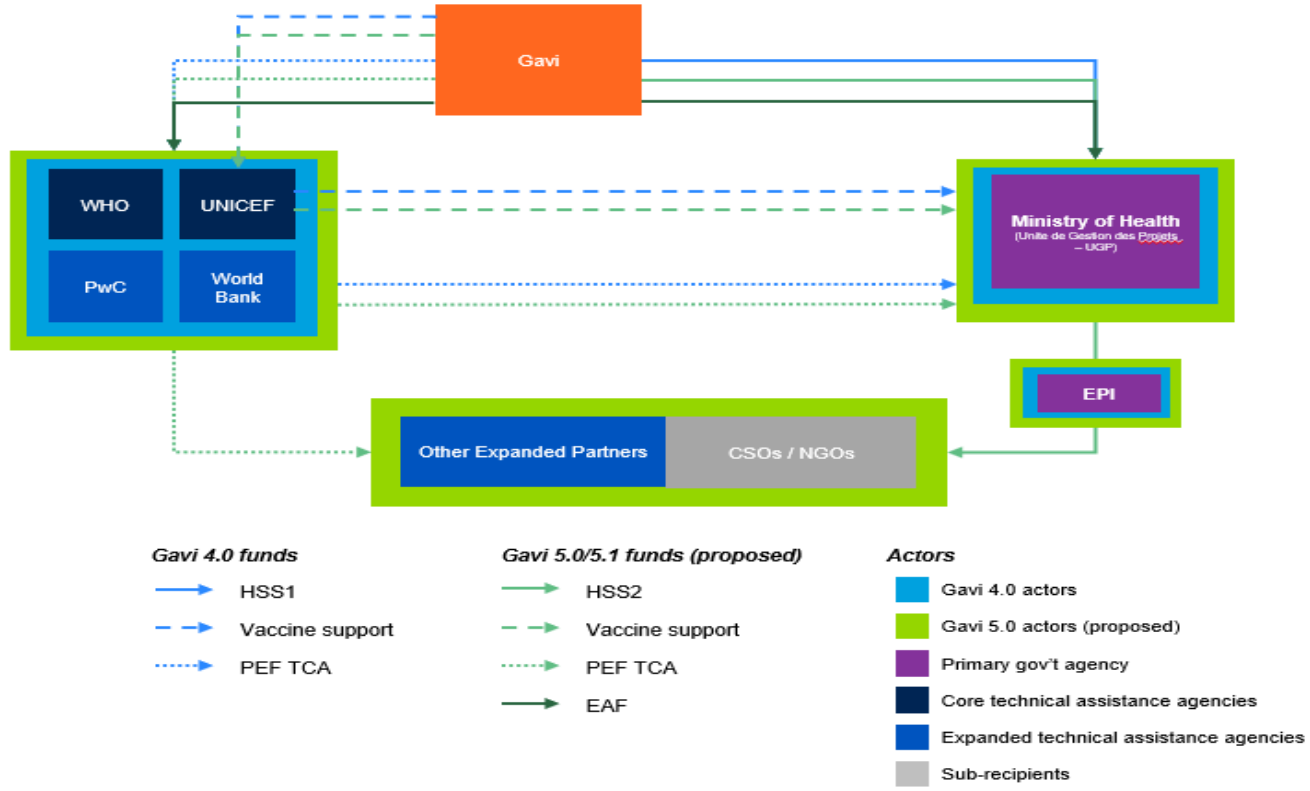
Key stakeholders under Gavi 4.0 and 5.0/5.1 remain relatively similar with the Ministry of Health (MoH) and core Alliance partners, WHO and UNICEF, being main receivers of Gavi support. Figure 2 below provides an overview of relationships between different actors under Gavi 4.0 and 5.0/5.1.

Under Gavi 4.0, HSS1 funding management and disbursement support was allocated directly to the MoH and subsequently to different departments within it. Disbursed funds were managed by the Project Management Unit (*Unité de Gestion des Projets*, UGP but previously known as Directorate for project management) dedicated to Gavi funds, World Bank funds, and funds from the Bank of Islamic Development. Each fund within the UGP had its own procedures, which were not explicitly detailed in any documents provided to the evaluation team.[18] The HSS grants are managed and supervised by the Directorate for Studies, Planning and International Cooperation (DEPCI)[19] and EPI whose approval are needed for disbursement. All technical assistance support was provided directly to core Alliance partners, although small and ad hoc support was provided to the World Bank and Price Waterhouse Coopers (PwC) for technical assistance concerning fund and financial management. WHO and UNICEF follow their own procedures for the allocation and disbursement of their share of funds.

Under Gavi 5.0/5.1, HSS2 support continues to be allocated directly to the MoH with UGP's coordination. Partnership Engagement Framework (PEF) TCA funding similarly is disbursed to WHO (USD 828,921) and UNICEF (USD 760,390) with small set amounts going to the World Bank for an assessment supporting the preparation for accelerated transition (USD 11,910) and to the MoH for an EPI Data manager and the commissioning of an external audit for the EPI programme (USD 72,488).

[18] PwC. (2018). Programme Capacity Evaluation.
[19] Gavi. (2016). Joint Appraisal Update Report. ***Gavi internal documentation.***

Figure 1.2: Key actors in Djibouti under Gavi 4.0 and Gavi 5.0/5.1 implementation stakeholders



Implementing actors under the MoH included the Expanded Vaccination Programme (EPI), Health Promotion Department (DPS), various regional health directorates (DRS), Health Information System Department (DSIS), Department of Planning for International Cooperation and Studies (DEPCI), and Planification Department (DP). Community and civil society organisations (CSOs) did not play a role within Gavi 4.0 support and did not receive funding. Under Gavi 5.0/5.1 grants, CSOs, non-governmental organisations (NGOs), and other expanded partners such as International Organization for Migration (IOM) and United Nations High Commissioner for Refugees (UNHCR) may benefit from support, but these have not been decided on in the FPP application and budget.

Implementation was coordinated through various committees, mainly the Immunisation Coordination Committee (ICC) and the Committee for Inter Agency Coordination (CCIA), but also the Health Partners Group, and the National Immunisation Technical Advisory Group (NITAG). ICC, the national coordination forum, aims to improve partnership between actors and ensure a better performance of the immunisation programmes and control of VPDs. ICC also conducts advocacy so that cMYP goals remain national priorities as well as campaigns to mobilise resources. The ICC directs EPI interventions and mobilises the necessary funds to implement key interventions. Members include WHO, UNICEF, USAID, Ministries of Education, Women and Family, and National Union of Women (UNFD), the National Union of Women in Djibouti. The ICC acts as the Gavi HSS project steering committee.[20] The NITAG is a technical committee responsible for advising the EPI on all scientific aspects related to immunisation activities.[21] Other technical committees such as the National Commission on Communisation, the National Savings and Credit Union and the National Logistics Working Group have very varied levels of implication and engagement.

[20] Gavi. (2017). Joint Appraisal Update Report. ***Gavi internal documentation.***
[21] Ibid.

Country ZD theory of change

The Djibouti theory of change (ToC) developed for Gavi 5.0/5.1 grants under the FPP shows the intended causal pathway to ensure that Gavi funds reach ZD children and missed communities. The main shifts in the new approach revolve around: (1) better data management and understanding of the population whether that is through monitoring and surveillance work or mapping of specific communities (nomadic, refugees, urban poor, etc.) to develop targeted responses; (2) stronger human resources to ensure appropriate and adequate coordination and management of actors for a unified mobilisation for advocacy; and (3) a dedication to better involve civil society.

Table 1.2: Key objectives of Djibouti ToC

Key objectives	
1	Establish favourable conditions for the introduction of new vaccines
2	Ensure equitable availability of and access to quality vaccination services for 80% of ZD and unvaccinated children, particularly migrant and refugee children, nomads and those living in remote communities
3	Increase the use of vaccination services, particularly for specific groups (migrants, nomads, displaced people, and refugees) by improving ownership, understanding and confidence in vaccines
4	Improve effective vaccine management from 56% to 70% composite score
5	Strengthen governance, management, and use of EPI data for better decision-making and improvement of EPI performance
6	Strengthen the governance, leadership and management of the programme during the accelerated transition phase and ensure the self-financing and sustainability of the programme by 2026
7	Strengthen the programme management unit by covering operational costs for the first three years in order to achieve a smooth transition with the country

Apart from Objective 1, that indirectly addresses barriers and issues in terms of reaching ZD children and missed communities, all other objectives echo those of Gavi's 5.0/5.1 ZD agenda and continue in line with objectives under Gavi 4.0 on health systems strengthening. Key challenges and risks identified in the Djibouti ToC included:

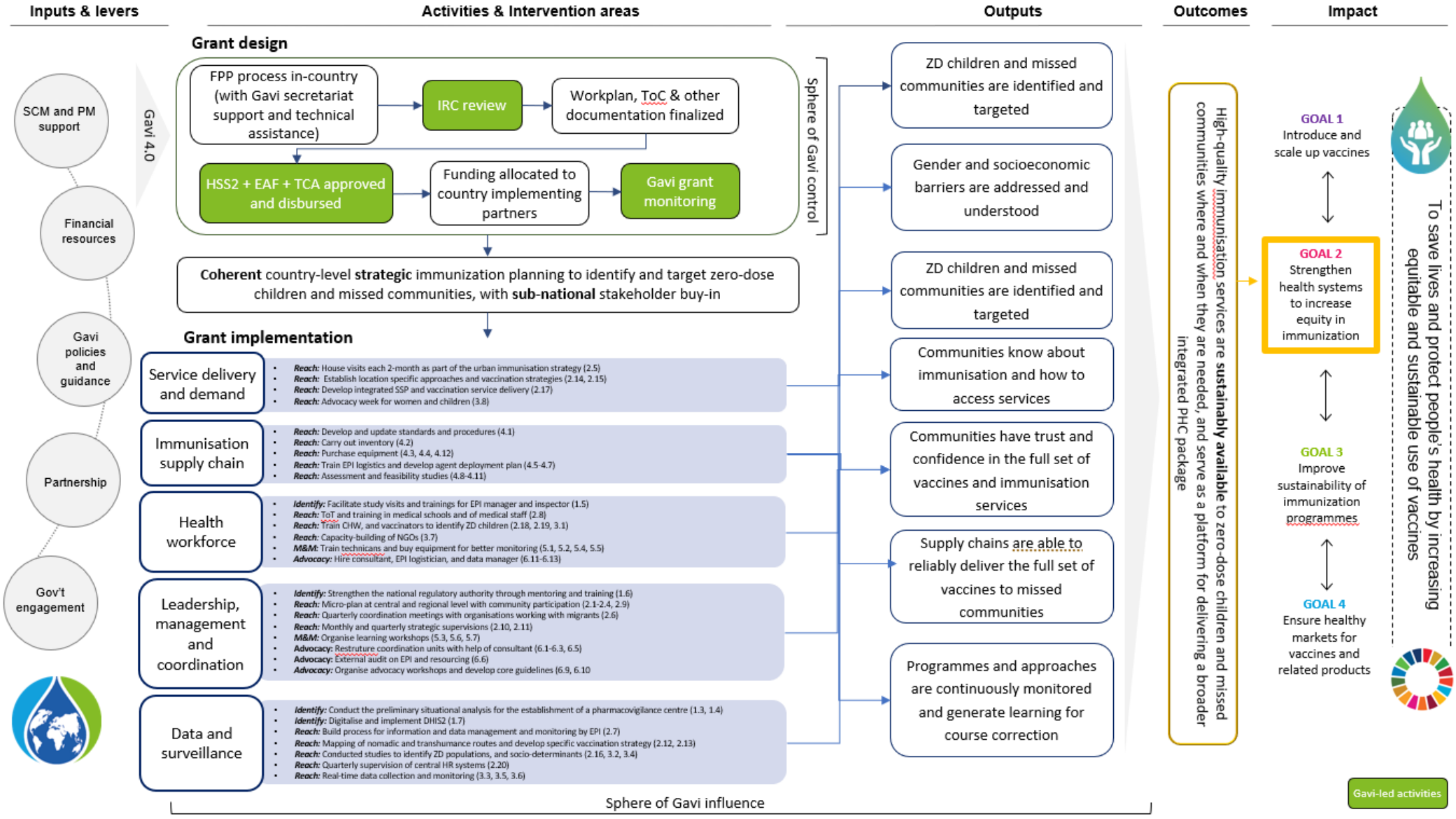
Lack of reliable and high-quality data that can undermine real-time, effective and efficient surveillance, monitoring, and targeted decision-making.

Extremely hard-to-reach mobile communities who are difficult to track and engage through conventional community outreach approaches and require additional intensive resources to support consistently and continuously

Immunisation human resources that lack strong technical, financial and operational capacities at every level and for each actor group from the EPI to core partners to government stakeholders to CSOs and private sector, from national level to sub-national level, which in past years were subject to high rates of turnover

Lack of leadership and prioritisation of immunisation at government level to push forward the EPI, particularly as the country is going through accelerated transition out of Gavi eligibility

Figure 1.3: Djibouti theory of change for Gavi 5.0/5.1



Data collection timeline

Data collection activities included the following:

- **Initial introductory call** with the Djibouti project manager (June 2023)
- **Document review** (April–September 2023) (list of documents in Annex)
- **Semi-structured interviews** with nine stakeholders: five operational stakeholders and four strategic stakeholders, three of which are no longer involved with Gavi support in Djibouti (June–August 2023)
- **Validation call** with the Djibouti senior country manager (September 2023)

Although the cut-off for the evaluation's primary and secondary data collection was in September 2023, please note that documentation and inputs from stakeholders interviewed were limited to mainly pre-2023 work. As a consequence, the case study does not cover country work conducted between March – December 2023.

2 Findings

Objective 1: Relevance and coherence of Gavi's ZD agenda

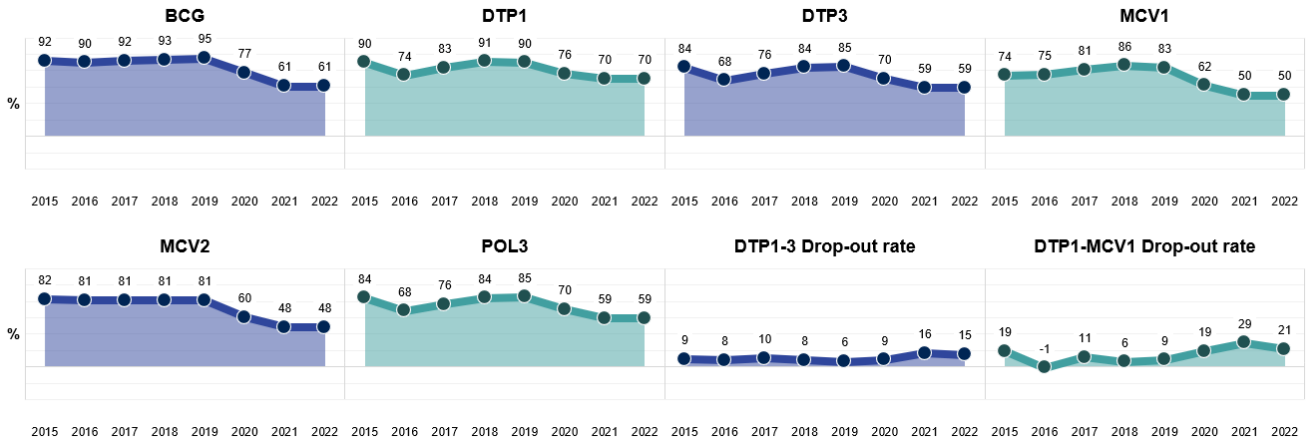
EQ1. How relevant is Gavi 5.0/5.1's focus on ZD children and missed communities to countries' needs?

Summary of findings	• The prioritisation of reaching ZD children and missed communities is an important health focus enabling better strategies catered to Djibouti's constantly evolving population and urban growth as a result of conflict-related and climate-related migration. • Quality and availability of reliable data on ZD children, and routine immunisation (RI) more generally, is a major issue in Djibouti that compromises effective and evidence-based decision-making. • ZD children and missed communities are concentrated in and around Djibouti-ville and Tadjoura, mainly in urban slums and remote rural areas. • Although the ZD agenda is pertinent, it remains largely driven by Gavi funding levers and the Alliance at global level rather than being country-led and advocated for by key actors at national level, who are willing to use the ZD metric but consider coverage and securing of HSS gains as their main priority and vision. • The identifying, reaching, monitoring and measuring, or advocating (IRMMA) framework supported the development of a clear pathway to reaching ZD children and missed communities with a heavy emphasis on 'Identify' and 'Reach' to improve governance, leadership, data collection, and programme monitoring, which were previously identified as key weaknesses in achieving HSS objectives.			
Strength of the evidence	1	2	3	4
Rationale for this judgement	The evidence comprised of multiple data sources and data types but stakeholder triangulation was limited and could not include qualitative inputs from government and frontline implementors. Documentation shared with the evaluation team and inputs from stakeholders interviewed were largely limited to mainly pre-2023 work.			

Djibouti faces a range of health challenges stemming from external factors such as climate change, conflict in neighbouring countries, and high exposure to infectious diseases, as well as internal factors such as ineffective decentralisation, weak human resources and capacity, and lack of sustained development. The COVID-19 pandemic along with civil conflict in Ethiopia have exacerbated strains on Djibouti's health system in the past three years: draining limited resources, adding pressure on ill-adapted infrastructure, and changing the profile of vulnerable populations. Djibouti's National Plan for Health Development (PNDS 2020–2024) outlined the country's approach to address health challenges and reinforce primary healthcare (PHC). Main government health objectives are to reduce mortality, morbidity, and malnutrition. After malaria, tuberculosis, and HIV/AIDS, addressing VPDs remained a high priority for managing transmissible diseases. Equity is the top strategic priority in terms of reaching set objectives. Context-sensitivity, good governance, effective financial management, and better health monitoring are subsequent strategic and cross-cutting priorities. Elections in 2016, which brought in the arrival of a new Health Minister and a new EPI manager, re-emphasised the country's eagerness to prioritise immunisation objectives and dedicate more attention and resources to holistic and context-appropriate interventions for immunisation (see Annex 3 for list of national policies).

Reaching ZD children and missed communities is a priority health focus for Djibouti that supports more targeted and responsive strategies to respond to Djibouti's population growth and complex demographics. Number of ZD children has substantially increased between 2015–2021. DTP1 coverage substantially declined, and the target population is growing. The COVID-19 pandemic led to a visible drastic decrease in RI as healthcare workers dedicated to RI and the EPI prioritised work and resources towards managing the pandemic, and demand was stunted by vaccine hesitancy. Vaccination coverage before the pandemic was already plateauing (see figure 4 below). Data in the Grant Performance Framework showed that DTP1 coverage targets were consistently not met even when targets were reduced.

Figure 2.1: Select vaccine coverage (WUENIC) in Djibouti, %, 2015–2022



Quality and availability of reliable data on ZD children, and routine immunisation more generally, is a major issue in Djibouti, that compromises effective and evidence-based decision-making. ZD children represented about 70% of under-immunised children.[22] However, identifying their location and specific barriers is challenging given that missed communities and ZD children often have limited interactions with public services and are part of undocumented and highly mobile communities. As is repeated throughout data quality assessments and confirmed by the most recent National Survey on Vaccination Coverage (ENCV-D) and the Gavi monitoring, evaluation, and learning (MEL) team, there is not enough survey data available on ZD prevalence by demographic, ethnic and other socioeconomic characteristics. Health data quality is not sufficient even with the recent introduction of DHIS2 and Data for Action (D4A) to enable timely and efficient steering of the EPI, particularly when the data is stored with the Directorate of Health Information (DIS).

ZD children and missed communities are concentrated in and around Djibouti-ville and Tadjoura, mainly in urban slums and remote rural areas. Mass migration of people with unknown vaccination status, noted over the past five years, has led to heightened risk of epidemics and VPD outbreaks, particularly in various pockets of Djibouti-ville. The ENCV-D 2021 found that children living in urban areas are less likely to start the vaccination schedule series than those living in rural areas. However, they are more likely to complete the vaccination series started.[23] Migrant and nomadic populations following pastoralist routes and driven by climate have limited interactions with the public health systems. The ZD agenda is highly pertinent to address barriers to vaccination and challenges that are resource-intensive and complex. It responded to a need to rethink the immunisation strategy, in under-vaccinated or unvaccinated populations who may not have permanent addresses, recognised documentation, and limited access to public services. The 'Identify' strategy under Gavi 5.0/5.1 was considered relevant in

[22] Gavi MEL team. (2023). Djibouti ZD Analysis. ***Gavi internal documentation.***
[23] MoH. (2021). National Survey for Vaccination Coverage ENCV-D.

helping the country establish a plan to better map out migrant, refugee, and nomadic communities, within which ZD children and missed communities reside, particularly given data issues.

Although the ZD agenda is pertinent, it remains largely driven by Gavi funding levers and the Alliance at global level rather than being country-led and advocated for by key actors at national level, who are willing to use the ZD metric but consider coverage and securing of HSS gains as their main priority and vision. Stakeholders reported that the ZD agenda was important but achievements and gains under 4.0 to reinforce the health system needed to be secured, prolonged, and expanded on, particularly given the slow implementation of HSS1. Progress made with Gavi 4.0 grants were perceived to be pivotal in growing and solidifying the role of the EPI and infrastructure that enables it to carry out RI and the ZD agenda. Those involved strategically and operationally in the implementation Gavi grants reported that they understood the rationale for wanting to focus on reaching ZD children but their main priority remained 'all under-immunised' and restoring coverage. Main priorities within the National Vaccination Programme remain to: (1) increase RI vaccination coverage to at least 90% and in at least 80% of all districts; (2) reduce mortality of measles by 90% compared to 2000 levels; (3) eliminate polio, and extend vaccination offer through the EPI. Reaching ZD children is mentioned as an opportunity and an avenue to achieve those objectives but is not a priority area of its own.[24] A Djibouti ZD analysis elaborated by Gavi's MEL team in March 2023 estimated that a focus on restoring objectives compared to ZD improvement coverage, if Djibouti reached Gavi 5.0 targets by 2025, could potentially have a larger effect on estimates of future deaths averted. In terms of ZD categorisation, Djibouti is a fragile country with generalised challenges and in the ZD category of low concentration and low coverage. District-level PENTA drop-out rates were only weakly correlated with ZD rates so it was not clear how past targeting efforts (related to PENTA3) would align with ZD targeting related to Pentavalent vaccine first dose (PENTA1). This made and still makes steering the EPI and health interventions extremely challenging. The ZD agenda was reported to be more of 'a donor priority'.

Gavi 5.0 activities tailor zero-dose solutions in the wider framework of health systems strengthening:

- For pastoralist, mobile, nomadic populations, a tailored strategy and mapping of migration and pastoralist routes will be conducted to identify ideal vaccination approach and points
- For hard-to-reach populations, coordination will be reinforced with UNHCR and IOM to enable outreach to refugee, displaced and migrant communities who may be left out of formal legal systems
- For remote rural populations, mobile teams and strategies will be reinforced and expanded to increase the reach of health centres
- For the peri-urban and the urban poor, increased monitoring, outreach and home visits will be conducted in Djibouti-ville and its surroundings
- A new mapping of ZD children and missed communities will be conducted by UNICEF in the first year of Gavi support under 5.0/5.1 to gather more accurate data that would guide decision-making and improve microplanning at regional level.

The IRMMA framework supported the development of a clear pathway to reaching ZD children and missed communities with a heavy emphasis on 'Identify' and 'Reach' to improve governance, leadership, data collection and programme monitoring, which were previously identified as key weaknesses in achieving HSS objectives. The ToC proposed within the FPP was validated by informants and provided adequate activities aligning with the gap analysis, according to the most recent IRC report available to the evaluation team (May 2022). Djibouti suggested a tailored

[24] MoH. (2021). Review of National Vaccination Programme.

approach to deliberately identify, reach, monitor and track, under-vaccinated population groups, thanks, in part, to Gavi 5.0/5.1 funding levers such as the EAF. Stakeholders reported that the IRMMA framework helped structure their approach and organise a coherent workplan.

EQ3. How coherent is Gavi's ZD agenda with other international and national actors' focus?

Summary of findings	• The Gavi 5.0/5.1 strategy, in particular its principles, is coherent with national level immunisation plans and health plans such as PNDS 2020–2024, the cMYP 2011–2015, and recommendations of the EPI Evaluation 2021 and the National Survey on Vaccination Coverage 2020. • There are no indicators around DTP1 and PENTA1 specifically in national policies and health plans but objectives and recommendations targeted towards reaching ZD children highlight alignment on the need for specific approaches to improve equity. • The Gavi 5.0/5.1 strategy is well aligned with core partners' strategies, which is facilitated by close working partnerships, and overarching alignment with Immunisation Agenda 2030 (IA2030). • However, coherence of coordination, collaboration, and leadership within the government is a key area of improvement and focus, which funding levers under 5.0/5.1 aim to address.			
Strength of the evidence	1	2	3	4
Rationale for this judgement	The evidence comprised of multiple data sources and data types but stakeholder triangulation was limited and could not include inputs from non-Alliance partners, private sector or government. Documentation shared with the evaluation team and inputs from stakeholders interviewed were largely limited to mainly pre-2023 work.			

The Gavi 5.0/5.1 strategy, in particular its principles, is coherent with national-level immunisation plans and health plans such as PNDS 2020–2024, the cMYP 2016–2020, and recommendations of the EPI Evaluation 2021 and the National Survey on Vaccination Coverage 2020. The overarching goals of national health policies and strategies related to vaccination and immunisation (from cMYP to the PNDS) are oriented towards objectives of increasing and maintaining RI coverage at 90%, reducing mortality and morbidity by eliminating polio and tackling measles, and extending and strengthening EPI services nationally to introduce a full package of vaccines. These mirror Gavi 5.0/5.1 goal of introducing and scaling up vaccines. To do so, national plans focus on cross-cutting principles such as equity to 'leave no one behind', integration of services to improve PHC and sustainability of immunisation programmes, and innovation to ensure healthy markets for vaccines. Documents highlight major needs for better data collection, surveillance, and monitoring and stronger leadership and coordination for adequate appropriation of the EPI and vaccination programme.

There are no indicators around DTP1 and PENTA1 specifically in national policies and health plans, but objectives and recommendations targeted towards reaching ZD children highlight alignment on the need for specific approaches to improve equity. National efforts in recent years collected data, analysed the needs, and developed recommendations to reduce the number of ZD children within a larger context of improving coverage. Indeed, more reflection is given to decentralisation and accountability of stakeholders at all levels of the health pyramid, community engagement and involvement of CSOs, and better use of data and innovation to improve equity. The ENCV-D 2020 attempted to better identify ZD children (16.5% of children) and define the barriers to their vaccination given the great lack of visibility and reliable data on this population group. These fed into larger national-level discussions of immunisation stakeholders to better guide decision-making. Partners

and stakeholders across different sectors adhere to the definition of ZD as confirmed unanimously in qualitative interviews but this could not be confirmed for local, national, sub-national actors. Recent documents such as the ENCV-D still refers to zero-dose in two different ways (completely unvaccinated and missing PENTA1).[25]

The Gavi 5.0/5.1 strategy is well aligned with core partners' strategies, which is facilitated by close working partnerships, and overarching alignment with IA2030. Alliance informants in Djibouti reported that the ZD agenda is coherent with their own organisations' agendas. Both UNICEF and WHO's country mandates include explicit support to the EPI and targeting of areas where most ZD children reside.[26] WHO, UNICEF and World Bank are not consistently explicitly focused on reaching ZD children but their multisectoral strategies are aligned with wider global immunisation strategies, from the previous Global Vaccine Action Plan (GVAP 2011–2020) to IA2030. They collaborate to support the EPI and MoH with technical assistance to achieve PNDS targets on various fronts, from programmatic to operational and financial. Under Gavi 4.0, UNICEF provided technical assistance for health worker training and provided the bulk of assistance in ensuring that Djibouti would have stronger vaccine management, cold chains, supply chains, C4D and D4A. WHO provided assistance to equip the EPI through training and development of systems for monitoring and supervision. Efforts have been made to improve coherence of Gavi funding vis-à-vis other donors. For example, an assessment was conducted by WHO Eastern Mediterranean Regional Office (EMRO) in 2022 to optimise Gavi and Global Fund support and listed the major blocks hindering the acceleration of the prevention, control, and elimination of communicable diseases through integration. In 2023, USAID and the government of Japan also supported WHO and UNICEF in vaccination intensification campaigns through mobile strategies to reach ZD children[27].

Table 2.1: Health financing by source

Donor/ source	Main aims of health spending
Government	Co-financing of vaccines
Gavi	Immunisation
World Bank	Support to financial and project management, health financing diagnostics
PwC	Support to financial management
Global Fund	Support to HSS and cold-chain interventions under their malaria grant. Unsure of the status since 2018
WHO	Support to EPI and planning
UNICEF	Support to logistics, supply chain, cold chain, and EVM, C4D, D4A
USAID	Support to strengthening the CSOs' capacity and constructing maintenance facilities
Japan	Support to health more generally, not only related to immunisation

Coherence of coordination, collaboration and leadership within the government is a key area of improvement and focus, which funding levers under 5.0/5.1 aim to address. Implementation partners comprised mainly of the EPI, WHO and UNICEF maintain tight and strong working relationship. Inputs from the MoH are more limited but they are actively involved in coordination and participate by providing their different inputs during meetings. There is limited participation from the private sector. Coordination and technical working groups such as the ICC and the NITAG were meant to meet on a quarterly basis to steer and align activities and planning. However, the reality was reported to be quite

[25] MoH. (2021). National Survey for Vaccination Coverage ENCV-D.
[26] UNICEF. (2018). Partenariats por les enfants 2018-2022. In https://www.unicef.org/djibouti/media/256/file/Partenariats%20pour%20les%20enfants%202018–2022.pdf.; WHO EMRO. (2013). Programmes Djibouti. Retrieved November 1, 2023, from World Health Organization - Regional Office for the Eastern Mediterranean website: https://www.emro.who.int/fr/dji/programmes/
[27] UNICEF. (2023). Intensification de la vaccination de proximité au profit de la santé de la mère et l'enfant. Retrieved November 1, 2023, from Unicef.org website: https://www.unicef.org/djibouti/recits/intensification-de-la-vaccination-de-proximit%C3%A9-au-profit-de-la-sant%C3%A9-de-la-m%C3%A8re-et-lenfant

different. Coordination with other national actors, especially with government, has been inconsistent in the past years due to how the EPI is embedded within the MoH. Operational and strategic informants under 4.0 indicated that mobilisation of various actors on EPI was low unless Gavi initiated certain actions or discussions. Roles and responsibilities, especially in terms of leadership beyond support, were not well understood and appropriated, which made engagement and development of the FPP application quite tedious according to informants involved in the drafting.

Regional technical support from Alliance partners was not able to work in French, which limited their ability to communicate and provide relevant assistance. The MoH is fragmented into different departments and the EPI struggled to navigate across departments to own its programming. Although the MoH chairs coordination meetings, it holds very little decision-making power to facilitate quick decisions and actions. Data-related activities are under the remit of the DIS, planning under DEPCI and community activities under the regional health directorates (DRS). Financial management is owned by the UGP but needs to be approved by DEPCI and Health Promotion Departments. Well-triangulated evidence points to complex dynamics that limit how the EPI can operate or lead on the immunisation agenda within the MoH. Feedback was provided at various points in time on how the organogram for the EPI did not accurately reflect the reality of dynamics between actors in-country: personalities and individuals played a key role in facilitating coordination and coherence between actors, which implied the lack of clear and effective mechanisms to guarantee the coherence of actors around a same agenda and ZD strategy without depending on certain individuals.

EQ2. How relevant are the Gavi funding levers to the needs of countries with regard to reaching ZD children and missed communities?

Summary of findings	• Gavi support was and is essential to help Djibouti meet its vaccination needs, given the country's high dependency on external resources. Without Gavi funding levers, the EPI programme would not be able to sustain itself, drive change, meet IA2030 targets, or exist independently. • As such, Gavi 5.0/5.1 funding levers and funding channels were considered relevant and appropriately designed to meet the country's significant needs and aligned with wider public health priorities. • Funding levers were not as responsive as informants had hoped for given long delays in approval but they were nonetheless considered adaptable and accessible to address changes in evolving contexts. • At country level, the hefty and resource-intensive IRC review process for the FPP application potentially hampered the responsiveness of Gavi funding. • The use of funding levers under Gavi 5.0/5.1 are directed at overarching objectives of the ZD agenda but, in the details, there are risks that activities funded may not be sufficient or appropriate to reach objectives. • Aspects of CSO engagement, including how they will be utilised, are not well defined: specific CSOs have not been identified, community approaches were not detailed in the application, and funding channels have not been clarified.			
Strength of the evidence	**1**	**2**	**3**	**4**
Rationale for this judgement	Stakeholder triangulation to include government and frontline participants could not be included. Data triangulation was also limited by homogenous sources and scattered evidence inconsistently recorded. Documentation shared with the evaluation team and inputs from stakeholders interviewed were largely limited to mainly pre-2023 work.			

Gavi support was and is essential to help Djibouti meet its vaccination needs, given the country being highly dependent on external resources. Without Gavi funding levers, the EPI programme would not be able to sustain itself, drive change, meet IA2030 targets, or exist independently. The COVID-19 pandemic and measles outbreaks in recent years highlighted the fragility of the Djibouti resources dedicated to vaccination and immunisation. Evidence showed that the EPI programme was and still is highly dependent on partners' and donor support in terms of financing. Government funding covered the salaries of health agents and maintenance of basic infrastructure. All purchasing of traditional vaccines were procured through UNICEF. Only 7% of Djibouti's government budget was allocated to health[28], still largely below the 15% Abuja goal. Total health expenditure was approximately 2% of the country's gross domestic product (GDP)[29], a decrease from 2015 primarily due to reductions in national health expenses.

Given the current trends in health expenditure, financing of the PNDS 2020–2024 that is estimated to cost about USD 348.5 million presents a significant challenge, as highlighted in the country's FPP application. In 2019, co-financing was expected for PENTA, Pneumococcal vaccine (PCV) and Rotavirus (RV) at around USD 27,000. PwC in their Programme Capacity Evaluation of 2018 assessed that co-financing targets were too low for a country in transition and all vaccines were still bought by UNICEF even though the government should be actively contributing to purchases. In 2021, Djibouti was the last country to pay their co-financing obligations. There were significant worries about it

[28] Gavi. (2021). FPP Application. ***Gavi internal documentation.***
[29] World Bank. (2023). World Bank Open Data. Retrieved November 1, 2023, from World Bank Open Data website: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=DJ

defaulting on its co-financing agreements despite heavy reliance on external donors for immunisation. However, as of January 2022, Djibouti is in an 'accelerated transition' with the goal of achieving self-financing by 2026. The patchy evidence and worried feedback from informants interviewed showed that Gavi funding levers remain relevant to help the country meet the needs of ZD children and missed communities. In its current state, informants reported that it would not be possible to sustain the ZD agenda and HSS objectives without them. These levers encourage the prioritisation of ZD children, without which there would be a risk that the government would turn to other priorities and be disengaged on the matter, particularly without reinforced advocacy.

As such, Gavi 5.0/5.1 funding levers and funding channels were considered relevant and appropriately designed to meet the country's significant needs and aligned with wider public health priorities. Informants interviewed reported that funding levers were adequate to meet Djibouti's needs and support it in carrying out the ZD agenda in line with national health priorities and with wider public health priorities. The HSS funding lever is relevant for cross-cutting health strengthening activities and maintaining focus on improving coverage and sustaining RI. Support will be dedicated to reinforcing coordination between stakeholders and government actors and planning at sub-national level. The TCA funding lever is considered essential for Djibouti given large gaps in capacity over the years with high staff turnover. TCA will be dedicated to reinforcing the capacity of national actors from the EPI to CSOs and DRS. Specific areas of focus are on data management, logistics and communications. The EAF funding lever is focused on generating the evidence-base to make more effective decisions in reaching ZD children, in particular migrant and refugee communities. The table below provides a summary of the main aims of Gavi 5.0/5.1 funding levers.

Table 2.2: Grant ceilings of Gavi 5.0 funding levers and main aims

Funding lever	Grant ceilings ($)	Main aims of funds in-country
HSS	3,000,000	Improvement of coordination, microplanning, vaccination campaigns, and integration of EPI with other entities; Training of health workforce, bi-annual supervision at regional level; Mapping of nomadic routes and elaboration of targeted vaccination strategy for nomads; Integration of communications strategy Recipient: MoH
EAF	1,000,000	Identification of ZD children and reinforcement of an Urban Immunisation Strategy; Elaboration of advanced strategies at regional level; Monthly supervisions at district level; Expansion of mobile vaccination teams dedicated to migrants and refugees; Training of community agents for identification of ZD children Recipient: MoH
TCA	4,665,931	Commissioning of assessments, evaluations, audits and targeted studies; Development of targeted vaccination strategies such as the introduction of human papillomavirus (HPV) vaccine; Digitalisation of health data collection, analysis, and synthesis; Training of vaccinators; Develop a digital community feedback mechanism; Reinforcement of CSO capacity; Logistics training of healthcare workers and EPI; Preparation for accelerated transition; Recruitment of international consultants Recipients: WHO, UNICEF, World Bank

Some informants involved in the FPP application development and in the operationalisation of Gavi 4.0 expressed approval for the increase in additional funding available but there was confusion in terms of

what would fit under each lever with pressure coming from Gavi technical teams to have their funding implemented. Feedback from informants involved in the FPP planning process was that requirements and new approaches were introduced too quickly and the sheer amount of information and processes to assimilate was too much for staff who were already stretched managing the pressure put on them by the COVID-19 pandemic.[30] At country level, one stakeholder articulated the experience as being pulled in all directions to meet Secretariat and funding lever requirements while forgetting the core purpose of what these funding levers are aiming for: i.e., ensuring that all children in Djibouti are vaccinated by 2025. Informants explained that the intention, thought and theoretical design of funding levers were appropriate and catered well to allowing countries to develop strong strategies to reaching ZD children and missed communities. However, the splitting of funding levers, separating EAF from HSS, was reported to increase risk of duplication, and ineffective use of resources, simply so that they could fit their activities within the application format.

Funding levers were not as responsive as informants had hoped for given long delays in approval, but they were considered adaptable and accessible to address changes in an evolving context. Programme execution and fund utilisation was deemed reasonable by the IRC, although monitoring data and progress against microplans was not available. Regular workplan reviews at national level led to built-in financial variance analysis for each activity with written justification of delays, realignment of activities and budget and cancellation of activities.[31] Remaining amounts on HSS1 in November 2019 were reprogrammed for completing urban strategy activities and prioritising urban immunisation activities, which would have contributed to the ZD strategy in Djibouti-ville. TCA funding was also provided the opportunity to be reprogrammed, in particular for support dedicated to WHO in 2017. The evaluation team did not find evidence of reviews and workplan adjustments in terms of timings, decisions made, rationale for reprogramming, nor amounts to assess responsiveness and timeliness of funding approval and allocation.

For funding levers under Gavi 5.0/5.1, the FPP application process took 22 months to complete with approval from the IRC granted in May 2022. Gavi funding was allocated to UGP in March 2023, 10 months after IRC approval and activities started in June 2023. The considerable time elapsed from FPP kick-off in 2020 to allocation was frustrating for informants interviewed and said to contribute to inefficient timing and challenges in resourcing, planning, and implementation, which undermined the responsiveness, flexibility, and accessibility of Gavi funds. The Joint Appraisal (JA) mission in October 2023 may reveal more evidence to generate findings in year 2 of the evaluation.

At country level, the hefty and resource-intensive IRC review process for the FPP application potentially hampered the responsiveness of Gavi funding. Informants flagged that there were high risks that situational analyses and country context may have changed in the space of two years. Annual health budget approvals were extremely tedious and political. Delays in allocation, approval, and disbursement from Gavi to MoH impedes on the EPI's already weak capacity to appropriately advocate for funding. These delays can have negative repercussions on EPI planning, which could be further exacerbated in a country where planning capacity is low and microplanning is inconsistent or unavailable at all levels from national to regional to district. To enable UGP to disburse funds in a timely manner, requests for funds from various implementors would need to take place at least six months beforehand. The unpredictability of when Gavi funds would be approved, allocated and disbursed could lead to delays in implementation and procurement that are strictly subject to the decisions of administrators, policy-makers and ministers.

[30] Also fed back to secretariat in FPP step-back slides (Gavi, February 2022)
[31] Gavi. (2017). Monitoring mission reports. ***Gavi internal documentation.***

The use of funding levers under Gavi 5.0/5.1 are directed at overarching objectives of the ZD agenda but, in the details, there are risks that activities funded may not be sufficient or appropriate to reach objectives. Details of how to address demand and supply-side barriers were not provided and the IRC felt that activities did not provide sufficient or appropriate drivers to reach objectives. Community-level interventions were broadly defined but did not specify implementation. Gender transformative interventions were not described and no gender-related barriers to equity were identified in the most recent equity assessment. A strong multi-partner collaboration is mentioned in the FPP application but little evidence is provided to support that claim. The IRC highlighted concerns around absorption due to the frontloading of the budget where more than 50% of funds are planned to be spent within the first year of support. Informants indicated that the lack of granularity and details in response was related to the lack of data and evidence that would be generated within the first year of support. For example, a study is commissioned on the social determinants and behaviours of missed opportunities, a mapping of CSOs, and data gathering for the elaboration of targeted strategies for migrants and nomads.

Aspects of CSO engagement, including how they will be utilised, are not well defined: specific CSOs have not been identified, community approaches were not detailed in the application, and funding channels have not been clarified. Although additional community and CSO partners under the new Gavi 5.0/5.1 support and strategy have not been explicitly included, country stakeholders reported that there was an active process of identifying the right expanded partners. Numerous CSOs exist, such as associations of women and youth like the UNFD and the Bender Djedid Association, for example, and were supposed to receive funding under Objective 1 of HSS1; but there is no clear documentation and financial reporting on which organisations concretely did carry out implementation of activities with Gavi funding. One major challenge reported by informants throughout qualitative interviews is the lack of technical capacity within civil society which is not strong enough in the health domain, and not sufficient in the immunisation sector to support targeted interventions. In terms of relying on non-traditional partners to reach ZD children, preliminary conversations with IOM and UNHCR have been encouraging in terms of considering outreach to migrant and refugee populations.

Objective 2: Operationalisation of the ZD agenda

EQ4. To what extent have Gavi 5.0/5.1 funding levers, processes and guidance enabled countries to focus their Gavi support towards reaching ZD children and missed communities?

Summary of findings	• The lengthy and burdensome FPP application guidance and processes could not be completed with existing resources and did not enable a strong appropriation of the strategy, which may lead to operationalisation risks later on. • Core implementation partners worked closely with the EPI and MoH but their leadership, coordination and technical capacity was limited and insufficient to accompany the application development process. • Weak human resource capacity combined with a lack of operational leadership and poor-quality data undermined evidence-based decision-making and application design. • The FPP application reflected the ZD agenda and requirements with a large dedication to strengthening operationalisation capacity through technical assistance but there were risks to implementation related to a lack of clear engagement of civil society partners and gender-related barriers to vaccination. • Although over 10% of combined HSS, EAF, TCA, and CDS reprogrammed funding are said to be allocated to expanded partners and CSO engagement, there is no evidence on which organisations these would be, what activities they would lead on, and how these would be implemented.
Strength of the evidence	1 | 2 | 3 | **4**
Rationale for this judgement	Data and stakeholder triangulation was possible but data is scattered and inconsistent in reporting and documentation. Stakeholder insight from the MoH and UGP could not be included. JAs did not consistently report on specific allocation, disbursement, and utilisation of funds disaggregated by grant, partner, and activity. Budget sheets were not available to the evaluation team to track the effective operationalisation of funds and grants over time. Documentation shared with the evaluation team and inputs from stakeholders interviewed were largely limited to mainly pre-2023 work.

The lengthy and burdensome FPP application guidance and processes could not be completed with existing resources and did not enable a strong appropriation of the strategy, which may lead to subsequent operationalisation risks. Djibouti started its FPP application process, combining requests for HSS, EAF and TCA funding in July 2020, with discussions starting as early as January 2020. The IRC approval was granted in May 2022, 22 months after FPP kick-off. Disbursement of HSS funds arrived in January 2023 (8 months), and EAF funds in February 2023 (9 months) according to the Monitoring and Performance Management (MPM) data but informants interviewed indicated that funding was only disbursed in March 2023, with activity implementation starting in June 2023. As a pilot country for the FPP process, Djibouti informants reported that requirements, guidelines and tools evolved throughout the application process, making it confusing for the team to understand the process and its requirements. Funding lever requirements, the application kit and the review process gave thorough details but were very dense. Informants reported that French documentation was lacking and/or delayed, which made engagement and consultation of other actors at country level arduous and unclear.

Core implementation partners worked closely with the EPI and MoH but their leadership, coordination and technical capacity was limited and insufficient to accompany the application development process. This combination of factors contributed to making the application development

laborious and burdensome for in-country stakeholders. They did not have the bandwidth, technical capacity and time required to dedicate to a very complex application process. Completing the FPP necessitated technical expertise in public health, financial management and grant development. Negotiation and facilitation tact were needed to lead active and in-depth consultations with a wide range of informants, who were themselves still absorbed in managing the day-to-day of COVID-19. Djibouti's EPI team, MoH and core partners did not have the ability to lead and complete the application process on their own. As such, an external consultant was recruited to assist. The FPP process was useful in terms of bringing together a wide range of informants. However, there is a high risk of poor appropriation and ownership of the plan submitted.

Weak human resource capacity combined with a lack of operational leadership and poor-quality data undermined evidence-based decision-making and application design. Evidence strongly pointed to issues in data quality and availability. This included context data, such as health and demographic data, programmatic data, and financial data. Digitalisation of processes and the introduction of D4A and DHIS2 with the support of University of Oslo and UNICEF have been highlighted as major efforts to support appropriate health data monitoring and data sharing. However, introducing those systems required strong guidance and support on technical, financial, and institutional capacities. The CSOs did not have the skills to undertake certain activities and the mapping of potential expanded partners at national level. Consequently, it was challenging to design an FPP application based on rigorous, reliable, and up-to-date data.

At macro-level, the Grant Performance Framework (GPF) provided very limited grant performance data. Data was missing on cumulated funds expended between 2016–2020, funding allocated directly to CSOs, and percent of work plan activities executed. At national level, data is held at the DIS where the EPI team needs to request access to RI data. The quality of monitoring at regional and district level varied significantly. It is not clear to the evaluation team (and as is evident in PwC audit reports from 2018) whether financial reporting and monitoring has been up to par, enough to give informants and the EPI team significant visibility on the progress and process of grant allocation and disbursement. The lack of reliable data implied a more challenging FPP application process, more uncertain decision-making, and poorer advocacy for grant design and development. The heterogeneity of contextual, programmatic, and financial data quality, availability and collection hints at both issues and risks in grant design and implementation.

The FPP application reflected the ZD agenda and requirements with a large dedication to strengthening operationalisation capacity through technical assistance but there were risks to implementation related to a lack of clear engagement of civil society partners and gender-related barriers to vaccination. The application somewhat met requirements on IRMMA criteria, gender, CSO engagement, and demand generation:

- **Single ToC:** Activities articulated within a single ToC under Gavi 5.0/5.1 grants are dedicated to better identifying ZD children and missed communities.

- **Identify:** 'Identify' was developed based on very limited triangulated data. Quality of available country-level data, especially specific to ZD children and missed communities, was variable and lacking. The majority of activities under 'Identify' are dedicated to vaccination intensification campaigns, pharmacovigilance, and improvement of digitalisation for better surveillance. There are no specific activities dedicated to identifying ZD children and missed communities under this category.

- **Reach:** 'Reach' activities focus on coordination between stakeholders including community actors and expanded partners, microplanning, training, supervisions, identification of ZD children, and Effective Vaccine Management (EVM). Most activities dedicated to reaching ZD children and missed communities, including identifying them, were categorised under this part of the framework. Activities lacked specificity and detail on how to address demand-side barriers, particularly through community-level interventions demand generation. In the first year of support, studies are commissioned to map out ZD children and missed communities, for example, along pastoralist nomadic routes. These aim to build a better understanding of the socioeconomic determinants and behaviours around vaccination, which may include gender-related ones. Tailored activities addressing supply-side barriers, especially through TCA, catered to improving human resources, equipment, planning, monitoring and surveillance, and data collection and analysis. The integration of UNICEF-supported innovative strategies for mobile data collection and digitalisation of immunisation data at all levels was recognised as essential for better integrated PHC. For activities addressing demand-side barriers, the lack of reliable data may be a reason why these lack specificity. Large investments are made for microplanning at national, regional and district levels.

- **Monitor and measure:** 'Monitor and Measure' strategies are heavily focused on digitalisation, data surveillance and monitoring, which sensibly build on gains of Data for Action (D4A) and DHIS2 under Gavi 4.0 grants. However, there are no clear outputs and follow-up activities to those with learning outputs largely limited to studies that would all be conducted in 2023, year 1 of implementation, by external international consultants.

- **Advocate:** 'Advocate' activities were focused on improving coordination, effectiveness, and leadership of the NITAG and the EPI, which were key learnings under Gavi 4.0 grants. Other costs cover EPI and UGP operational costs.

- **Gender:** Gender transformative interventions were not detailed. A situation analysis in 2018 indicated that there was "*no proof of discrimination based on gender, national origin or socioeconomic status was observed during the situation analysis".* No gender disaggregated data was on ZD children was available.

- **Demand generation:** To address demand-side barriers, most activities suggested are to identify barriers first through studies and engage community networks through community relays, CHWs, CSOs, and entities working with target populations, such as IOM and UNHCR, to reach ZD children. However, details on strategy and implementation are missing.

- **Sub-national targeting:** Sub-national targeting focuses on key priority ZD children and missed communities: migrants, refugees, nomads, and peri-urban missed communities around Djibouti-ville mainly.

- **CSO engagement:** Although over 10% of combined HSS, EAF, TCA and CDS reprogrammed funding are said to be allocated to expanded partners and CSO engagement, there is no evidence on which organisations these would be, what activities they would lead on, and how these would be implemented. According to the MPM, a total of USD 7.32 million of funds are allocated towards targeted investments to reach ZD children between 2016 and 2023: USD 3.25 million from CDS, USD 480,000 from EAF, USD 2.04 million from HSS, and USD 1.55 million from TCA. Under TCA, expanded partners of technical experts would most likely include PwC and the World Bank. IOM and UNHCR will also benefit from Gavi support in their role to reach out to target missed communities such as migrants and refugees, most likely through allocation of funds via UNICEF. The World Bank and University of Oslo will be receiving TCA for their support on digitalisation and financial

management. Community-based approaches for social mobilisation rely on community relays and community health workers. CSOs are not described or named explicitly in relation to certain activities. Dedicated budget allocated to UNICEF is aimed at contracting NGOs to support community engagement and outreach to zero-dose and missed communities but, apart from one training, it is not clear what this would entail. Informants interviewed reported that CSOs in Djibouti did not have the operational, programmatic, technical and financial capacity to manage large Gavi funds. A first step would be to map out CSO actors and capacity before they could be confident in allocating the management of funds and activities.

Objective 3: Contribution of Gavi 4.0 pro-equity and ZD grants

EQ5. How have Gavi grants initiated under Gavi 4.0 with continued implementation in 5.0/5.1 contributed to the delivery of the ZD agenda at the country level?

Summary of findings	• Activities under 4.0 enabled the possibility of undertaking the ZD agenda with Gavi 5.0/5.1 grants through health systems strengthening; however, those were not sufficient.			
Strength of the evidence	**1**	**2**	**3**	**4** (circled)
Rationale for this judgement	Data and stakeholder triangulation was limited. Monitoring and recordkeeping on progress against initial plans was inconsistent and scattered which made triangulation and validation challenging.			

Given the lack of consistent and reliable reporting on activity progress and indicators under Gavi 4.0, the evaluation team is not able to meaningfully assess the contribution of Gavi 4.0 inputs towards the ZD agenda in Djibouti and its ToC. GPF 2016–2020 data is missing across all indicators mapped to Gavi 4.0 activities. Where data does exist, it is not always available for all time points. JA reports and multi-stakeholder dialogue reports are not available after 2019, making it extremely challenging to assess progress, completion and success of activities made in the past three years, in parallel to the COVID-19 response. Where reporting indicators are available, comparability is not always possible given reporting in different formats, and lack of traceability of progress.

Activities under 4.0 enabled the possibility of undertaking the ZD agenda with Gavi 5.0/5.1 grants through health systems strengthening; however, those were not sufficient. A pro-equity intervention mapping study in 2022 did not identify any pro-equity interventions in Djibouti. Given an overall weakness in the health system in Djibouti and very mobile populations and unreliable data, the activities under 4.0 were pivotal in providing a strong base to initiate the ZD agenda. Progress made with Gavi 4.0 grants were perceived by interviewees to be essential in growing and solidifying the role of the EPI and infrastructure that enables it to carry out RI and the ZD agenda. This included activities to reinvigorate and reinforce the supply chains and cold-chain equipment (CCE) as well as the training of health staff to vaccinate children. The reinforcement of governance, financial and programme management assistance provided by PwC and others were essential for the development of 5.0 activities, whose operationalisation rely heavily on those being completed. The establishment of coordination units, although these need to be strengthened, was essential to provide the EPI with management and collaboration spaces to carry out activities.

Contribution claim 1: ZD children and missed communities are targeted and identified.

Gavi support enabled activities under 4.0 grants did not sustainably create new partnerships, including engagement with communities, CSOs, and expanded partners	
Claim assessment	
Confidence and strength of evidence: 4	Evidence shows that HSS1 activities, including the revitalisation of the ICC, reinforced the partnership between the EPI, WHO, UNICEF, the government, as well as other UN and international entities orbiting the sphere of immunisation such as IOM and UNHCR. However, there is not enough evidence to demonstrate the effectiveness of the ICC and other coordinating or technical advisory groups and there is no evidence on partnerships with communities, civil society and potential local expanded partners. Supporting evidence includes: • Although relatively irregular, ICC meetings coordinated the actions and planning of actors involved in immunisation and informed other informants of the progress on immunisation and vaccination. • Technical assistance was provided by WHO, UNICEF and PwC to reinforce the EPI and MoH's financial and programmatic management capacities. • Positive feedback on collaboration and implementation between core partners demonstrating keenness to work together and investment in the ZD agenda across Alliance partners. • Alliance partners policies and strategies embed into one another and disseminate and articulate the ZD agenda to other informants. • JA report of 2018 mentioned engagement of partners, including networking with private sector, but no more detailed evidence was provided or mentioned in interviews.
Alternative explanations	
Djibouti does not seem to have a strong CSO network capable of carrying forward specific outreach activities to hard-to-reach communities – perhaps it is only nascent or does not have the capacity for absorption of Gavi support. Additionally, the elections and the ministerial restructuring in 2016, which saw the restructuring of the EPI team, led to the need to reforge relationships and partnerships. The overstretched teams during the pandemic did not prioritise the maintenance or creation of partnerships for the ZD agenda objectives.	

Gavi support enabled activities under 4.0 grants that helped better understand socioeconomic barriers preventing appropriate vaccination of all children but did not show presence of any gender-related barriers	
Claim assessment	
Confidence and strength of evidence: 3	Evidence showed that informants had gained a stronger grasp of the issues affecting certain hard-to-reach communities in Djibouti through assessments and better health monitoring as well as discussions on the stagnation of vaccine coverage. Discussions with informants, including during JAs, demonstrated insightful thinking around how missed communities may benefit from improved vaccination strategies. However, informants and recent studies reached the conclusion that there were no gender-related barriers to vaccination in Djibouti. Supporting evidence includes: • Equity analysis conducted in 2018 showed strong rationale around the need to better target nomadic, migrant, and refugee communities, as well as rural remote, and fed into the contextual development of the FPP application. • The elaboration of a draft urban immunisation strategy was started but not completed due to reprioritisation needs with the arrival of the pandemic. • Context analysis in mission reports and various country-level documentation pointed to concerted thinking around socioeconomic barriers. • JA report of 2018 reports active searches for EPI lost opportunities in peri-urban areas. • PEF TCA in 2021 was dedicated to updating microplanning guides for unreached and marginalised populations through innovative strategies but it is not clear whether those activities took place.
Alternative explanations	
Data quality is a major issue highlighted repeatedly throughout the years and consistently across evaluations and assessments conducted by PwC, WHO, Gavi teams and Secretariat. Socioeconomic and demographic data, linked with health data, is non-existent (as is shown in the incompleteness of data in GPF). It may be that this type of data is not collected consistently and methodically or, alternatively, that if it is hosted somewhere, it has not been analysed and shared.	

Contribution claim 2: Health systems sustainable reach all zero-dose and under-immunised children and their communities with a full range of vaccines as a first

Gavi support enabled activities under 4.0 grants that triggered detailed microplanning involving communities and key sub-national actors	
Claim assessment	
Confidence and strength of evidence: 3	Evidence shows that microplanning was accounted for in workplans and in the Gavi grant applications. However, evidence on the quality of those microplans and whether those successfully took place as intended is lacking. Evidence also highlighted that supervision and monitoring at regional/district level is not always consistent or recorded. Certain evidence explicitly indicates that microplans did not include a focus on hard-to-reach populations, which is something that is emphasised in the FPP as something to carry out in Gavi 5.0 grants. No evidence could be found on the monitoring of these microplans or any mention of indicators within those related to tracking Penta1 coverage. Supporting evidence includes: • Gavi reports and data quality assessments highlighted the lack of consistent and standardised supervision and monitoring visits. • Reports showed the EPI team's limited remit and struggles to lead on immunisation planning which may hint at challenges to implement microplanning at district or regional level.
Alternative explanations	
Operational informants and documentation indicated weak technical capacity around vaccination management for logistics and supply chains but also around health planning. Given the EPI's limited ability to lead on its immunisation remit due to various factors outlined in previous sections, it may be that integrating microplanning into general health planning at sub-national level encounters resistance or lack of follow-up.	

Gavi support enabled activities under 4.0 grants contributed to building health workers capacity around reaching ZD children and missed communities

Claim assessment	
Confidence and strength of evidence: 3	Training for health workers and training of trainers took place throughout the implementation of the HSS1 grant and Cold-Chain Equipment Operations Platform (CCEOP) grants under Gavi 4.0. WHO and UNICEF provided technical support to reinforce the capacities of the EPI, review processes and structure. PwC provided technical assistance on financial management and programme management at national level. No evidence was available on whether a national strategy and review of health human resources was conducted as planned. It was also not clear whether activities around the development of normative documents and human resources (HR) management tools were conducted. Capacity building of health workers seemed to be broad and not focused on reaching ZD children and missed communities under HSS1. Supporting evidence includes: • In 2017 and 2018, revisions to incentives for vaccinators was conducted to better motivate and engage volunteers supporting the EPI. • Mobile vaccination teams were reinforced in 2017, which would enable teams to reach further and address supply-side barriers. • Training sessions were provided to various levels of healthcare staff in 2019. • Directors and managers from various central and district-level health structures received HR management training in 2019. • WHO and UNICEF supported the development of monitoring and surveillance tools such as supply chain monitoring logs and the integration of D4A and DHIS2. • WHO and UNICEF supported the elaboration of C4D plans and measles action plans.
Alternative explanations	
The EPI has limited control over HR and enforcement of data and information systems, which sit under the DIS in the MoH. Overstretched vaccination teams during the pandemic would have made mobilisation and incentivisation of health workers, including community health workers and liaison agents, very challenging.	

Gavi support enabled activities under 4.0 grants that foster the development and use of tailored accurate monitoring and data systems	
Claim assessment	
Confidence and strength of evidence: 2	Evidence points to very clear problem identification around data availability, quality and consistency or comparability. Issues around data and monitoring were at the foreground in numerous reports and assessments, highlighting the difficulty of making evidence-based decisions for EPI in the Djibouti context. These resulted from various factors including weak technical capacity at national and sub-national level, lack of monitoring tools and enforcement of data quality, and limited data sharing and reporting or accountability at all levels. Supporting evidence includes: • PwC conducted spot-checks and evaluations in 2018 and since then have provided support to UGP at national level for better recordkeeping and management. • WHO conducted a data quality assessment in 2019 outlining a plan of action for data improvement but the evaluation team was not provided updated on the implementation of recommendations and any follow-up conducted. • Monitoring and surveillance tools were said to be developed but these were not shared with the evaluation team. • WHO and UNICEF supported the development of monitoring and surveillance tools such as supply chain monitoring logs and the integration of D4A and DHIS2 with University of Oslo. Training was provided to different health centres.
Alternative explanations	
Improvement of data quality availability may be supported by other donors and the DIS may have invested additional resources or efforts into improving monitoring and surveillance, particularly as it pertains to health beyond immunisation.	

Contribution claim 3: Supply chains are able to reliably deliver the full set of vaccines to missed communities.

Gavi support enabled activities under 4.0 grants that build, expanded, and rehabilitated vaccination supply chains and trained health workers to for EVM management.
Claim assessment

Confidence and strength of evidence: 3	Significant efforts were made under the CCEOP grant to rapidly revamp the vaccination supply chains in Djibouti before the pandemic with collaboration with other donors such as USAID, WHO and UNICEF. Technical assistance activities, particularly from UNICEF, were dedicated to improving vaccine supply chain management (CCE real-time monitoring systems, inventory, etc.). Evidence is missing from the frontline operational sub-national level. Evidence was also missing about the development of procedures, rules and regulations, standards, and protocols for supply chain management. It is not clear whether gains were sustained in time or if processes were monitored. Supporting evidence includes: • Vehicles and fuel as well as equipment and other materials were purchased to support various health facilities across the country under HSS1 and CCEOP which was disbursed and implemented from 2016–2019. • Staff in healthcare centres were trained on EVM, cold-chain management, and recordkeeping.
Alternative explanations	
It may be that other donors would have contributed to the expansion of supply chains and training, although UNICEF would have been the leading actors on the matter. More evidence is needed on whether these are reaching certain hard-to-reach areas and 'the last mile', although most ZD children are located within reach from health centres in Djibouti and demand-side barriers relate to other factors.	

Contribution claim 4: Programmes and approaches are continuously monitored and generate learning for course correction

Gavi support enabled activities under 4.0 grants that encouraged partners to share learning and embedded those in the development of new activities and strategies	
Claim assessment	
Confidence and strength of evidence: 3	Very little evidence was visible in terms of integrating learning but evidence suggested that reflections, discussions and consultations took place between informants to improve and rethink vaccination activities and strategies, particularly for grants under Gavi 5.0. The FPP application process led by an external consultant helped bring together learning and embed those effectively in the new activities. Supporting evidence includes: • Monitoring and supervisions at sub-national level were conducted but evidence provided is not detailed. JA document shows activities conducted in 2017 and 2018. • Global Development Support was contracted to help prepare the documentation of lessons learnt but no records of this activity could be found. • PwC conducted audits and assessments in 2018 and has been providing technical support to improve recordkeeping at UGP, which is visible in their recent tracking documents shared. • The urban immunisation strategy started in 2018, although not finalised, took shape and is often referred to, allowing thought-provoking strategizing on how to better reach the peri-urban and mobile populations that are not consistently identifiable nor legally recognised. • Initiative to use D4A was an innovative way to pilot a new approach to data collection and monitoring but those successes are yet to materialise and there was limited feedback on this in the evidence collected this year. • The ICC met infrequently and irregularly in the past years before COVID-19 but it may have been reinvigorated after the pandemic with clear activities designed into Gavi 5.0 grants to reinforce its coordination role.
Alternative explanations	
Lessons learnt, good practices and data are not regularly and formally recorded or shared due to core informants (EPI, WHO, UNICEF) meeting on a daily basis and limited engagement of other actors or stakeholders in the ICC. As such, it may be that those are shared on an ad hoc organically.	

Gavi support did not lead to activities under 4.0 grants explicitly encouraging local and national level leaders to advocate for the ZD agenda
Claim assessment

Confidence and strength of evidence: 4	The pro-equity mapping of 4.0 activities did not show any relevant activities in Djibouti. Some small actions were taken to identify barriers for mobile communities such as the elaboration of the urban immunisation strategy and planned activities to upgrade microplans to actively include recording of data on hard-to-reach communities. However, explicit advocacy for the ZD agenda did not take place and no evidence was provided. Supporting evidence includes: • JAs and PEF TCA workplans showed intention to address some ZD agenda priorities of identifying and generating data and evidence around ZD children and missed communities.
Alternative explanations	
The ZD agenda was not a priority under Gavi 4.0 grants. It may be that advocacy took place informally and organically, particularly during the development of the FPP application and through JA visits.	

A further assessment against the Gavi ZD agenda contribution to these outcomes will be done during the next phase of the evaluation, through secondary data analysis, by reviewing the assumptions, analysing enforcement and monitoring data, and further investigation through qualitative interviews. This will provide more reliable evidence as to the likely and expected contributions of Gavi-supported activities towards ZD agenda outcomes. The lack of evidence does not mean that contribution from activities supported under 4.0 have not taken place.

Table 2.3: Mapping ZD-related outputs to pro-equity interventions implemented under Gavi 4.0

ZD-related outputs	Indicators of change over 2016–2020 period	Pro-equity interventions programmed/implemented	Plausible contribution of Gavi (insufficient evidence, partial, full)
ZD children and missed communities are identified and targeted	8% DTP drop-out in targeted areas – not sure in targeted areas 70% DTP1 coverage in targeted areas[32] – no GPF data 11% DTP drop-out[33] 59% Geographic equity (DTP3 coverage)[34] – no GPF data 7,135 No. of ZD children[35] 17% Percentage of districts or equivalent administrative area with Penta3 coverage greater than 80% Difference in Penta3 coverage between the highest and lowest wealth quintiles – no GPF data Difference in Penta3 coverage between the highest and lowest wealth quintiles – no GPF data Penta3 coverage difference between the children of educated and uneducated mothers/care-takers – no GPF data Difference in Penta3 coverage between children of urban and rural residences – no GPF data	Djibouti did not have any pro-equity activities under 4.0 according to the mapping study. Digitalisation of data collection to improve monitoring and surveillance capacity (D4A tool through UNICEF and DHIS2 through University of Oslo) Draft Urban Strategy developed for Djibouti-ville but disrupted by the pandemic **1.19 Organise additional vaccination activities to cover unvaccinated or incompletely vaccinated children in difficult-to-access areas** — Completed 2018 **1.20 Organise active searches for EPI lost to follow-up in the peri-urban areas of Djibouti city with the participation of the community** — Completed 2018 **1.24 Assessment of the capacities of civil society actors** — No data to confirm completion **1.30 Decrease in drop-outs** — Completed **1.7 Develop incentive (motivation) measures to achieve better performance in the field of vaccination** — Completed 2017 **1.7 Improving performances of mobile team (HSS – DRS & EPI)** — Completed 2017	Insufficient evidence

[32] https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/djibouti
[33] https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/djibouti
[34] https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/djibouti
[35] WUENIC 2023

ZD-related outputs	Indicators of change over 2016–2020 period	Pro-equity interventions programmed/implemented		Plausible contribution of Gavi (insufficient evidence, partial, full)
	Percent of districts with updated microplans that include activities to raise immunisation coverage – no GPF data	**3.1 Develop a national strategy for the development of HR for health**	No data to confirm completion	
		3.2 Strengthen administrative management capacities at the central level and regions	Completed 2019	
		3.3 Support for the establishment of an agent motivation mechanism based on performance	Completed 2017	
		3.4 Fuel for DRHF	Completed	
		3.4 Train 5 central directors and 5 managers of different health structures in HR management	Completed 2019	
		3.7 Establish a monitoring and evaluation mechanism for the use of different staff performance evaluation tools	Completed 2019	
		3.8 'Support to HR for the development of normative documents and health human resources management tools'	No data to confirm completion	
		3.9 Provide the sub-directors of the health regions with the necessary human and material resources	Completed 2018	
		5.1 13% of the budget to be granted to the execution management for the management of project financing	No data to confirm completion	
		5.2 Focal point of the RSS/GAVI project	No data to confirm completion	
		5.2 Salary of HSS Gavi focal point (UGP)	Completed	
		5.3 International assistant for the RSS/GAVI project	No data to confirm completion	
		A functional adverse events following immunisation (AEFI) surveillance system in place	Completed 2017	
		A functional surveillance system for VPD in place	Completed 2018	
		A functional vaccine regulatory and pharmacovigilance response system in place	No data to confirm completion	

ZD-related outputs	Indicators of change over 2016–2020 period	Pro-equity interventions programmed/implemented		Plausible contribution of Gavi (insufficient evidence, partial, full)
		Elimination of maternal and neonatal tetanus validated	Completed 2018	
		ICC improvement	Completed 2017	
		Improved outbreak response capacity at central and regional levels	Completed 2018	
		Improved performance of the EPI	Completed	
		Improved technical and managerial capacity of NEPI staff	Completed	
		National immunisation policy adopted	Completed 2018	
		New legal framework and financing mechanism adopted by the Government of Djibouti	No data to confirm completion	
		Strengthen quality vaccination campaigns with vaccination coverage> 90%	No data to confirm completion	
		The capacity of immunisation staff at all levels to use the DQA and other collection and analysis templates is reinforced	Completed 2018	
		The epidemiological surveillance of VPD, including the production of weekly bulletins is reinforced	Completed 2018	
		The Guide for Integrated Disease Surveillance and Response is developed	Completed 2018	
		The introduction plans and guidelines for the introduction of vaccines (HPV and MMR) are developed	Completed 2018	
		The national action plan for the elimination of measles and rubella is done	Completed	
		The supplementary immunisation activities are done with high quality and vaccine coverage >90%	Completed	
		The surveillance of AEFI is reinforced	Completed	
		The technical capacity of EPI staff at all levels in practical EPI and the approach	Completed	

ZD-related outputs	Indicators of change over 2016–2020 period	Pro-equity interventions programmed/implemented	Plausible contribution of Gavi (insufficient evidence, partial, full)
		Reach every district, Reach every child (RED/REC) is reinforced **Timely implementation of cMYP activities** — No data to confirm completion	
Gender and socioeconomic barriers are understood and addressed	Country addressing gender-related barriers support – no GPF data Percent of gender work plan activities executed – no GPF data	Djibouti did not have any pro-equity activities under 4.0 according to the mapping study. No gender barriers identified. **1.18 Carry out a study on the population's perception of health and the provision of health services, particularly by mobile teams** — No data to confirm completion **1.33 Urban strategy** — Partially completed **1.5 Establish a reporting system for adverse events and incidents relating to vaccination** — No data to confirm completion **The mapping of the areas covered by each health facility in charge of vaccination is done and the targeted population, including special populations, distances and localities** — No data to confirm completion	Insufficient evidence
Communities know about immunisation and how to access services	Percent of functional health facilities providing RI services – no GPF data Percent of demand work plan activities executed – no GPF data Country implementing tailored plans to overcome demand barriers – no GPF data	Djibouti did not have any pro-equity activities under 4.0 according to the mapping study. Adoption of RED and REC strategies UNICEF and EPI-enabled communications strategy to reach out to communities **1.10 Strengthen individual, family and community attitudes and practices favourable to health** — Completed 2018 **1.11 Establish a partnership, network with the private sector to strengthen the actions of the vaccination programme** — Completed 2018 **1.14 Update the communication for development strategy for vaccination** — Completed 2017	Partial evidence.

ZD-related outputs	Indicators of change over 2016–2020 period	Pro-equity interventions programmed/implemented		Plausible contribution of Gavi (insufficient evidence, partial, full)
		1.15 "Support for the development of communication and awareness materials on health promotion"	Completed 2018	
		1.16 Train/retrain all nurses in 1st level health structures on IMCI	Completed 2018	
		1.17 Strengthen health structures with equipment enabling SONUB/SONUC activities	Completed 2018	
		1.25 Selection is the contractualisation of the 7 actors of civil society	No data to confirm completion	
		1.26 Training of civil society actors	No data to confirm completion	
		1.27 Implementation of the operational work plan	No data to confirm completion	
		1.3 Develop, adapt and promote the use of good practice guidelines to improve the quality and safety of services offered in terms of vaccination	No data to confirm completion	
		1.4 Develop actions strengthening the commitment and active involvement of the population relating to vaccination	No data to confirm completion	
		1.9 Develop the integrated health communication strategy and implement it	Completed 2017	
Supply chains are able to reliably deliver the full set of vaccines to missed communities	Closed Vial Wastage (DTPcv) – no GPF data Stock availability at health facility levels – no GPF data Effective Vaccine Management Score (composite score) – no GPF data 88% CCE expansion in existing equipped sites	Djibouti did not have any pro-equity activities under 4.0 according to the mapping study. EVMA report in June 2018		Partial evidence
		1.1 Provide regional sub-directors with 7 4x4 vehicles	Completed 2016	
		1.12 Ensure regular maintenance and upkeep of the solar cold chain at the health region level	Completed 2016	
		1.13 Train 60 health and vaccination workers from health regions on cold-chain maintenance	Completed 2017	

ZD-related outputs	Indicators of change over 2016–2020 period	Pro-equity interventions programmed/implemented		Plausible contribution of Gavi (insufficient evidence, partial, full)
	0% CCE extension in unequipped existing and/or new sites	**1.2 Provide all CHCs and health posts with 2 motorcycles**	No data to confirm completion	
		1.23 Train Directorate of Medicine, Pharmacies, and Laboratories (DMPL) officials on the registration of medicines and vaccines in another country	No data to confirm completion	
		1.8 Fuel for vehicles (HSS – DRS)	Completed	
		1.8 Provide mobile equipped means of transport with fuel and ensure maintenance of 7 acquired vehicles	Completed 2018	
		4.0 CCE (EPI)	Completed	
		4.1 Conduct a mapping study of the supply chain of vaccines and drugs	No data to confirm completion	
		4.2 Organise a drug and vaccine price survey	No data to confirm completion	
		4.3 Revise the legal and regulatory framework for vaccine and medicine legislation	No data to confirm completion	
		4.4 Establish adequate procedures and conditions for cold-chain logistics for vaccines with the technical support of a consultant	No data to confirm completion	
		4.5 Strengthen the cold chain for the conservation of vaccines at different levels of the health system (periodically assess needs and cover them)	Completed 2017	
		4.6 CCE maintenance (EPI)	Completed	
		4.6 Provide 2 refrigerated trucks for transport and 30 solar freezers for the storage of vaccines and essential perishable products	Completed 2017	
		4.7 Establish appropriate procedures and conditions for cold-chain logistics for vaccines with the technical support of a consultant	No data to confirm completion	
		4.8 Renovate cold-chain logistics and the electrification system of health structures	Completed 2017	
		4.9 Strengthen the capacities of DMPL staff involved in the pharmaceutical regulatory authority	No data to confirm completion	
		5.10 preventative cold-chain management	Completed	

ZD-related outputs	Indicators of change over 2016–2020 period	Pro-equity interventions programmed/implemented		Plausible contribution of Gavi (insufficient evidence, partial, full)
		Deployment of CCE and installation (CCEOP – MoH)	No data to confirm completion	
Programmes and approaches are continuously monitored and generate learning for course correction	EPI management capacity – no GPF data	Djibouti did not have any pro-equity activities under 4.0 according to the mapping study.		Partial evidence
		1.21 Strengthen active surveillance of EPI target diseases, particularly acute flaccid paralysis (PFA), at all levels	Completed 2017	
		1.22 Train the 60 vaccination workers on management tools, on the monitoring of EPI activities and monitoring of vaccination coverage	Completed 2017	
		1.28 Forum for the annual review of civil society actors	No data to confirm completion	
		1.29 Revitalisation of VPD surveillance (HSS – EPI)	Completed	
		1.31 M&E	Completed	
		1.6 Conduct supervision actions to support local teams in achieving better quality and safety of care relating to vaccination	Completed 2018	
		1.6 Monitoring visit to improve quality of care (HSS – EPI)	Completed 2017	
		2.1 Establish an SNIS (national health information system) data quality control mechanism (SARA)	Completed 2017	
		2.1 Supplies for DIS	Completed	
		2.10 Organise quarterly coordination meetings between stakeholders (SIS-PEV-INSPD, etc.)	No data to confirm completion	
		2.11 Strengthen activities and means of early detection, reporting, analysis and response	No data to confirm completion	
		2.12 Ensure the regularity of supervision at the level of health structures every month on the reporting of register data	No data to confirm completion	
		2.13 Ensure ongoing training/retraining of service providers on the importance of data quality	Completed 2017	
		2.14 Have the necessary equipment for the DHISIS database	No data to confirm completion	

ZD-related outputs	Indicators of change over 2016–2020 period	Pro-equity interventions programmed/implemented		Plausible contribution of Gavi (insufficient evidence, partial, full)
		2.15 Train SNIS staff on data analysis and use	Completed 2018	
		2.16 Create a geo-referencing database and train staff on GIS	No data to confirm completion	
		2.17 Ensure the maintenance of SNIS computer equipment	No data to confirm completion	
		2.2 Provide the SNIS with two 4X4 vehicles to ensure regular monitoring and control of reported data	No data to confirm completion	
		2.3 Improve data collection tools	Completed	
		2.3 Review and duplicate level 1&2 routine data collection tools by integrating new indicators	Completed 2016	
		2.4 Fuel for DIS	Completed	
		2.4 Strengthen the means of communication (Fax, ADSL, Telephone) to increase the rate of completeness and promptness	No data to confirm completion	
		2.5 Organise an annual data validation workshop and use of data for decision-making	No data to confirm completion	
		2.6 Train and retrain (annual) programme and management staff on monitoring and evaluation	Completed 2018	
		2.7 Establish a reference manual on the monitoring and evaluation system for SNIS	No data to confirm completion	
		2.8 Strengthen the SNIS on the means of analysis and dissemination of routine data	No data to confirm completion	
		2.9 Decentralise the system by establishing health information units at the regional level	No data to confirm completion	
		3.5 Develop and adopt by consensus the tools for evaluating staff performance at different levels of the health system	Completed 2019	
		3.6 Test and validate the different staff performance evaluation tools	No data to confirm completion	
		5.1 Financial management (UGP)	Completed	
		5.4 Organise quarterly coordination meetings each year between the different programmes on monitoring RSS activities	No data to confirm completion	

ZD-related outputs	Indicators of change over 2016–2020 period	Pro-equity interventions programmed/implemented		Plausible contribution of Gavi (insufficient evidence, partial, full)
		5.5 Carry out a survey/evaluation of the impact of RSS funds on health indicators	No data to confirm completion	
		5.5 Survey on vaccination coverage (EPI)	Ongoing	
		5.6 External audit	Completed 2018	
		5.9 fuel for EPI vehicles	Completed	
		5.9 Maintenance of EPI vehicles	Completed	
		A plan for improving data quality is produced	Completed 2018	
		Data improvement activities	Completed	
		Data quality audit (TCA)	Completed 2019	
		Data quality self-assessment (HSSI)	Completed 2019	
		The laboratory surveillance for measles and rubella is reinforced	Completed 2018	
		The mid-term review of the Comprehensive Multi-Year Immunisation Plan is done	Completed	

3 Annex

Table 3.1: List of documents reviewed

Source	Document title	Year
WHO, UNICEF	WUENIC 2023	2023
Gavi	MPM Data 2023	2023
Gavi	Djibouti Country Hub 2021 (https://www.gavi.org/programmes-impact/country-hub/eastern-mediterranean/djibouti)	2021
Gavi	FPP Application for Gavi 5.0 including country documents, pre-screening report, and IRC report	2022
Gavi	HSS1 Application for Gavi 4.0 including country submission, pre-assessments, Secretariat docs, and old IRC reports	2014
Gavi	Grant Performance Framework 2016–2020	2021
Gavi	Joint Appraisal Update Report	2015
Gavi	Joint Appraisal Update Report	2016
Gavi	Joint Appraisal Update Report	2017
Gavi	Joint Appraisal Update Report	2018
Gavi	Joint Appraisal Update Report	2019
Djibouti	Annual Progress Report 2014	2014
Gavi	Co-financing Information Sheet Djibouti	2019
Gavi	Targeted Country Assistance Plan Djibouti	2019
Gavi	Targeted Country Assistance Plan Djibouti	2020
Gavi	Targeted Country Assistance Plan Djibouti	2021
R. Belt et al.	Improving Equity in Urban Immunisation in LMICs: A qualitative document review (R. Belt et al., 2023)	2023
R. Haydarov et al.	Evidence-based engagement of the Somali pastoralists of the Horn of Africa in polio immunisation: Overview of tracking, cross-border, operations, and communication strategies (R. Haydarov et al., 2016)	2016
WHO	Accelerating the prevention, control, and elimination of communicable diseases through integration: Optimising support from Gavi and the Global Fund (EMRO WHO, Sept 2022)	2022
S. Okiror	Lessons learnt from interregional and interagency collaboration in polio outbreak response in the Horn of Africa (S. Okiror, May 2021)	2021
Gavi	Djibouti ZD Analysis	2023
Gavi	Djibouti Country Summary	2018
Gavi	Djibouti Country Summary	2017
Gavi	Djibouti Country Summary	2016
Gavi	Djibouti Country Risk Matrix	2020
Gavi	Djibouti Country Risk Matrix	2015
Gavi	Djibouti Country Team Plan	2018
Gavi	Djibouti Country Team Plan	2020
Gavi	Djibouti Country Team Plan	2022
Gavi	Djibouti Monitoring Mission	2017
Gavi	Djibouti Monitoring Mission	2016
WHO	Djibouti 21st EMRO Working Group on Gavi	2015
Gavi	Gavi decision letters	2022
Gavi	Gavi approval letter	2017
Gavi	Gavi approval letter table	2022
Gavi	Gavi approval letter table	2021
Gavi	Partnership Framework Agreement	2014

Gavi	Cadre de performance	2016
Gavi	Cadre de performance	2016
PwC	Djibouti Evaluation de la Capacité Programme Subventions de Gavi	2018
PwC	Rapport de spot-check RSS Gavi à Djibouti	2022
Gavi	Djibouti TCA budget sheet	2017
Gavi	Djibouti TCA budget sheet	2018
Gavi	PEF TCA Workplan 2017–2018	2018
WHO	Plan d'amélioration des données 2019–2020	2018
UGP	UGP Gavi HSS disbursement and utilisation tracker	2021
UGP	UGP Gavi Urban Immunisation disbursement and utilisation tracker	2021
UGP	Etat financier tracker	2020
Gavi	Terms of reference for Gavi HSS implementation	2016
Gavi	HSS1 NCE memo	2020
Gavi	HSS1 NCE memo	2021
MoH	Djibouti National Vaccination Coverage Survey	2020
MoH	Djibouti Family Health Survey	2012
MoH	Djibouti Immunisation Coverage Survey	2008
UNICEF	Djibouti MICS	2006
MoH	Djibouti Family Health Survey	2002
UNHCR	Djibouti Operational Update	2022
Gavi	Gavi Djibouti Factsheet	2021
Gavi	Pro-equity mapping	2021

Table 3.2: List of academic sources

Source	Document title	Year
Countryeconomy	Djibouti - human development index - HDI 2017. Retrieved from countryeconomy.com website: https://countryeconomy.com/hdi/djibouti	2017
IPC	Djibouti: Acute malnutrition situation march - July 2023 and projection for August - December 2023 | IPC - integrated food security phase classification. Retrieved from www.ipcinfo.org website: https://www.ipcinfo.org/ipc-country-analysis/details-map/en/c/1156389/?iso3=DJI	2023
LDS	Vision 2035 – Ministère de l'economie des finances, chargé de l'industrie. Retrieved from Gouv.dj website: https://economie.gouv.dj/vision-2035-english/	2022
République de Djibouti	Plan national de développement 2020-2024	2020
UNICEF	Partenariats por les enfants 2018-2022. In https://www.unicef.org/djibouti/media/256/file/ Partenariats%20pour%20les%20enfants%202018–2022.pdf.	
UNICEF	Intensification de la vaccination de proximité au profit de la santé de la mère et l'enfant. Retrieved November 1, 2023, from Unicef.org website: https://www.unicef.org/djibouti/recits/intensification-de-la-vaccination-de-proximit%C3%A9-au-profit-de-la-sant%C3%A9-de-la-m%C3%A8re-et-lenfant	2023
WHO EMRO	Programmes Djibouti. Retrieved November 1, 2023, from World Health Organization - Regional Office for the Eastern Mediterranean website: https://www.emro.who.int/fr/dji/programmes/	2013
World Bank	World Bank Open Data. Retrieved November 1, 2023, from World Bank Open Data website: https://data.worldbank.org /indicator/SH.XPD.CHEX.GD.ZS?locations=DJ	2023
WUENIC	WHO/UNICEF estimates of national immunization coverage. Retrieved from www.who.int website: https://www.who.int/teams/immunization-vaccines-and-	2023

	biologicals/immunization-analysis-and-insights/global-monitoring/immunization-coverage/who-unicef-estimates-of-national-immunization-coverage	

Table 3.3: List of stakeholders

ID	Position	Organisation	Categorisation	Remote vs in person interview
1	Senior country manager	Gavi	Strategic	Remote
2	EPI manager	MoH	Operational	Remote
3	WHO focal point	WHO	Operational	Remote
4	UNICEF Chief of Health	UNICEF	Strategic	Remote
5	Senior country manager previous	Gavi	Strategic	Remote
6	UNICEF focal point	UNICEF	Operational	Remote
7	WHO regional	WHO	Strategic	Remote
8	EPI manager previous	MoH	Operational	Remote
9	FPP consultant	External	Operational	Remote

Relevant national policies

Plan National de Développement (PND) 2018

Plan National de Développement Sanitaire (PNDS) 2020–2024

Comprehensive Multi-year Plan for Immunisation (cMYP) 2011–2015 and 2016–2020

Our standards and accreditations

Ipsos' standards and accreditations provide our clients with the peace of mind that they can always depend on us to deliver reliable, sustainable findings. Our focus on quality and continuous improvement means we have embedded a "right first time" approach throughout our organisation.

3 Thomas More Square
London
E98 1YW

t: +44 (0)20 3059 5000

www.ipsos.com/en-uk
http://twitter.com/Ipsos...

ISO 20252

This is the international market research specific standard that supersedes ISO 26362/MRQSA and incorporates IQCS (Interviewer Quality Control Scheme). It covers the five stages of a Market Research project. Ipsos was the first company in the world to gain this accreditation.

Market Research Society (MRS) Company Partnership

By being an MRS Company Partner, Ipsos endorses and supports the core MRS brand values of professionalism, research excellence and business effectiveness, and commits to comply with the MRS Code of Conduct throughout the organisation. We were the first company to sign up to the requirements and self-regulation of the MRS Code. More than 350 companies have followed our lead.

ISO 9001

This is the international general company standard with a focus on continual improvement through quality management systems. In 1994, we became one of the early adopters of the ISO 9001 business standard.

ISO 27001

This is the international standard for information security, designed to ensure the selection of adequate and proportionate security controls. Ipsos was the first research company in the UK to be awarded this in August 2008.

The UK General Data Protection Regulation (GDPR) and the UK Data Protection Act (DPA) 2018

Ipsos is required to comply with the UK GDPR and the UK DPA. It covers the processing of personal data and the protection of privacy.

HMG Cyber Essentials

This is a government-backed scheme and a key deliverable of the UK's National Cyber Security Programme. Ipsos was assessment-validated for Cyber Essentials certification in 2016. Cyber Essentials defines a set of controls which, when properly implemented, provide organisations with basic protection from the most prevalent forms of threat coming from the internet.

Fair Data

Ipsos is signed up as a "Fair Data" company, agreeing to adhere to 10 core principles. The principles support and complement other standards such as ISOs, and the requirements of Data Protection legislation.

About Ipsos Public Affairs

Ipsos Public Affairs works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. Combined with our methods and communications expertise, this helps ensure that our research makes a difference for decision makers and communities.