Djibouti
Internal Appraisal 2014

1. Brief Description of Process

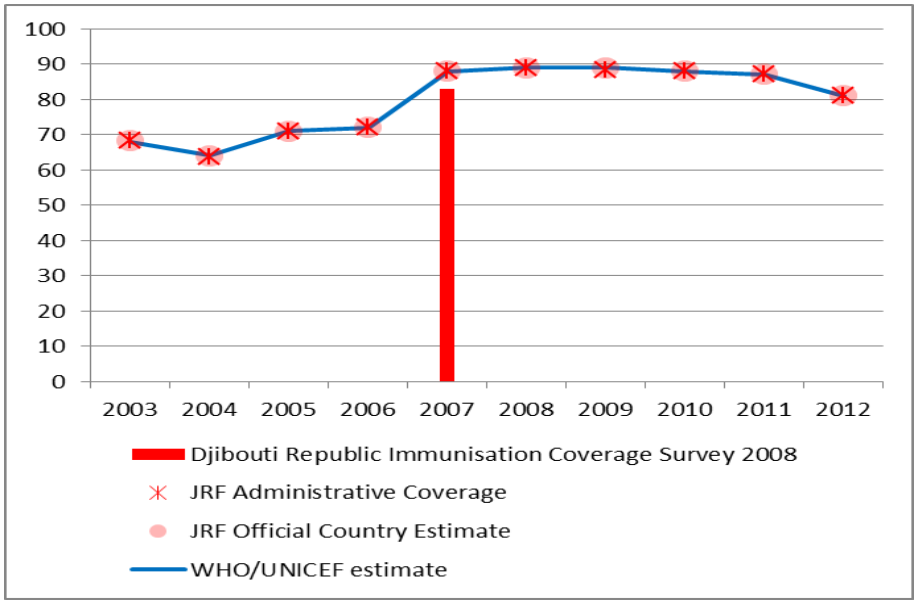
This Appraisal was developed by the EMRO Regional Head, Stephen Sosler, with support rom Diane Le Corvec, Programme Officer, and Isabelle de Zoysa, Technical Expert. It is based on the 2013 APR submitted by the country, and other relevant documentation.

2. Achievements and Constraints

Djibouti is a small country with an estimated population of 906,000 in 2011, of which 77% live in urban areas, and 54% live in the capital (UN Statistics). The rural areas are difficult to access and many who live in the rural areas are nomads. The country is situated in the horn of Africa and large migrant populations cross its territory.

Coverage targets were not achieved in 2013. Coverage stagnated for most antigens, reaching 82% for DTP3 (compared to 87% in 2011 and 81% in 2012, and a 2013 target of 92%), 86% for BCG (87%) in 2012 and target 93%) and 82% for measles (82% in 2012 and target 90%).

Concerns have been raised previously about the levelling performance of the immunization programme since 2010 (see Figure 1). The reasons given in the APR for poor progress in 2013 are similar to those given last year. Again, the programme suffered from a mid-year change in programme leadership, which led to a lull in implementation of activities. In addition, resources were insufficient to maintain adequate follow up and supervision, especially in more remote and hard to reach areas, and to deal with inadequacies in the cold chain.



Strong programme leadership and management remain critical as the country introduces new vaccines. PCV13 was introduced in 2012. Post introduction evaluation is currently planned for September 2014, as stated in the APR. Rotavirus vaccine introduction was planned for June 2013 but has been postponed for various reasons, including delays in setting up a new national cold room. This is now completed, as of June 2014, and training activities of front-line vaccinators are about to commence. Other priority activities noted are in the area of building

community systems, strengthening immunization services in peripheral health structures, and surveillance of target diseases (including acute flaccid paralysis, measles and neo-natal tetanus).

Sex-disaggregated data are not routinely available. The collection of such data in the future is planned, but no details are provided. The APR notes a strong commitment to gender equity evidenced by women in high levels of government (14% in 2012, according to UN Statistics), and parity in primary education, though the early drop-out rate is higher for girls than boys.

Important disparities were reported in 2012 between Djibouti city with 87% coverage and the other five regions: all but one with coverage below 80% with two regions less than or equal to 75% (HSS proposal presented earlier this year).

The HSS grant which was approved at the IRC meeting in February-March 2014 and should commence by late 2014-early 2015 intends to address key bottlenecks to improving immunization programme performance and addressing equity gaps. Identified bottlenecks in the HSS proposal were as follows:

- Nomadic populations accounts for 20% of the population and are hard to reach.
- The activities of mobile teams are irregular and sporadic, In part due to lack of resources, such as transportation, fuel and maintenance.
- Defective cold chain equipment at peripheral level.
- Centralised implementation of the EP and weak ownership at regional level.
- Irregular supervision at all levels.
- Lack of community engagement in vaccination services.
- Lack of integration of the vaccination services in the child health intervention package.

3. Governance

The ICC consists of representatives of the MoH, international partners (WHO and UNICEF), and NGOs including two domestic CSOs (Union Nationale des Femmes de Djibouti [UNFD], et Association Bender Djedid).

The APR states that there were four ICC meetings in 2013. Only the minutes of the ICC meeting of 17 May 2014 (and not 2012, as indicated) during which the APR was discussed are included. It should be noted that this document still includes comments from the WHO Representative. In particular, she questions the statement that the ICC endorsed the APR, as it was not given the chance to verify whether its comments were included the final version. The ICC also discussed plans for immunization week in May 2014 and for rotavirus introduction in June 2014 (and a post introduction evaluation in September 2014). Finally, it raised concerns about co-financing requirements and financial sustainability beyond 2015 and about the poor performance of the National Immunisation Technical Advisory Group (NITAG). The ICC felt that the planned development of a proposal for the introduction of IPV would be an important opportunity to review and galvanize the work of this group. It is not easy to tell from materials presented whether the CSOs were present and actively participated in the ICC meetings last year.

There is no HSCC in the country. The Permanent Secretary in the Ministry of Health (PS/MoH) appointed a technical committee in 2013 to prepare the GAVI HSS proposal, included all the major departments of the Ministry of Health, the UNFD, and key external partners (principally WHO, UNICEF, WB and UNAIDS). This committee will also be oversee the M&E of the HSS project.

4. Programme Management

Programme management is a weak area. The February-March 2014 ICC noted that the HSS proposal is aligned with the country's national health plan, the cMYP, and other reports provided, but that the cMYP is now somewhat outdated. No national EPI action plan was mentioned in the APR. One of the objectives of the HSS grant is to improve the leadership and managerial capacities of health system managers.

5. Programme Delivery

The last EVM was carried out in May 2011, leading to 38 recommendations in all areas, notably information system, inventory management and temperature control. As noted by the IRC in 2013, the status of implementation of improvements is not very clear. Although many recommendations seem to have been addressed, the improvement plan does not provide information about the planned date of completion (including the year). The next EVM was initially planned for summer of 2013, but is now planned for November 2014. The APR provides some unspecific comments about the strengthening of the cold chain through the installation of a new cold room, routine maintenance activities and training of staff.

The stock of pentavalent vaccine as of 1 January 2014 is the same as on 1 January 2013, at 57,126 doses. This seems high in relation to the estimated total number of doses needed. Similarly, the stock of PCV13 on 1 January 2014 is reported to be 116,150, which is very high.

There is an injection safety plan. All health facilities are equipped with adequate quantities of AD syringes and safety boxes. Immunization agents are trained and/or retrained on injection safety on a regular basis.
All health posts in the health regions are equipped with an incinerator. In Djibouti city, there is a sanitation unit in charge of collecting and destroying sharps and syringes.

The APR and the May 2014 ICC meeting minutes note that EPI target disease surveillance needs to be urgently stepped up. Currently the Hôpital General Peltier's paediatric department, in collaboration with the National Institute of Public Health, is conducting surveillance of suspected cases of meningitis and taking samples to isolate the responsible bacterial strains. The hospital is supposed to inform the NITAG if number of cases is found is substantial.

There is no specific pharmaco-vigilance program in the country. The lack of AEFI surveillance monitoring is a concern, notably with the introduction of rotavirus.

Action:

- Djibouti should report on progress in responding to the EVM recommendations and in planning the next EVM.
- Efforts should be intensified to strengthen EPI target disease surveillance.
- Consideration should be given to developing AEFI surveillance monitoring.

6. Data Quality

Administrative and WHO/UNICEF immunisation data are aligned.

A Pan-Arab Project for Family Health (PAPFAM) survey was conducted in 2012, but the results were challenged and are still not yet validated.

As previously mentioned in the APR 2012, the Health Information System (HIS) was restructured in 2012 and has benefited from new staff, equipment (with the installation of rural telephone in facilities, HIS data is now transmitted electronically from rural areas), and a more effective data collection, analysis and feedback process. Much remains to be done, however, to ensure timeliness and quality of data and the country plans to implement a DQS with WHO support. Another key objective of the HSS grant is to improve health information management at all levels of the health pyramid.

Action:

- Djibouti should consider doing a new independent coverage survey since the last one was conducted in 2008.

7. Global Polio Eradication Initiative, if relevant

The last clinically-confirmed case of poliovirus in Djibouti was reported in 1999. The APR reports that the country is intensifying its contribution to regional efforts to eradicate polio. Routine immunization is complemented by national immunization campaigns, with 2 waves reported in 2013. All the same, estimated OPV3 coverage in 2013 is stagnating at 82%.

The EMRO polio eradication initiative website indicates that the acute flaccid paralysis surveillance system in Djibouti has performed inconsistently over the last three years and did not achieve global certification standards in 2010. The country is working to strengthen surveillance measures, especially at community level, and identified 6 cases of AFP in 2013.

No specific information is provided in the APR about plans for IPV introduction.

8. Health System Strengthening

Not applicable as country just applied for 1st HSS grant with Gavi.

Djibouti's HSS grant was recommended for approval with clarifications by the February 2014 IRC, for a total of US$ 3,400,000. Djibouti is currently working to strengthen their budget and M&E framework; technical assistance was provided to help resolve clarifications. Once the clarifications are complete, the Gavi CEO will review for approval.

9. Use of non-HSS Cash Grants from GAVI

Djibouti carried a balance of USD 46,321 of ISS funds into 2013 and spent USD 21,034 on cold chain maintenance, supervision and training activities. It carries over USD 25,287 into 2014. The underuse of these funds for another consecutive year is a cause for concern, given the reference to limited resources to address priority needs in other parts of the proposal.

No reward is earned in 2013 since fewer children were vaccinated than the previous highest previous DTP3 achieved or target.

Of the funds (USD 100,000) made available for rotavirus introduction, USD 39,543 were used, mainly for setting up a cold room, leaving USD 60,457 carried over to 2014.

10. Financial Management

As mentioned above, the country's absorptive capacity seems to be weak at this time. Activities planned in support of the implementation of the HSS grant should serve to pinpoint areas that might need strengthening.

The FMA has recently been conducted (finalized and the report should be available soon.

11. NVS Targets

The country is revising its immunization targets to take into account the lack of progress in recent years. It is now planning for a DPT3 coverage of 90% in 2015 (revised downwards from 95%), that is a total of 25,485 children to receive the 3rd dose of DPT-HepB-Hib.

The country is also requesting 124,845 doses of PCV13 vaccine in 2015 based on the target coverage of 90%. The stock at 1 January seems high with 116,150 doses (this issue is currently under discussion with the countr)y. The planned wastage rate is 5%.

Finally the country plans to provide 25,486 children 2 doses of rotavirus vaccine in 2015, based on target coverage of 90%.

12. EPI Financing and Sustainability

The Government share of the EPI budget was 16% in 2013. The government has specified a budget line for immunization. This is used mainly to cover staff, other recurrent costs and equipment, but not for the purchase of traditional vaccines, which are paid for by UNICEF, JCV and UK Natcom. The Minister of Health has promised to negotiate an additional budget line for vaccines with his financial colleagues. Djibouti is encouraged to start allocating and progressively increasing funding for traditional vaccines from government sources.

Djibouti falls into the intermediate income group country. Djibouti met its co-financing requirements for the 2013 co-financing requirement ($43K), albeit with some delay. By year end of 2013, the country had not made any contributions towards its 2013 obligations for penta, rota and PCV.
The country is aware of the urgent need to develop financial sustainability strategies for increased mobilisation of funds for immunization, including for co-financing. It requests technical support from partners for the elaboration of such strategies.

13. Renewal Recommendations

Topic	Recommendation
NVS	Pentavalent vaccine: Renewal as requested. PCV 13: Renewal as requested. Rotavirus: Renewal as requested.

14. Other Recommended Actions

Topic	Action Point	Responsible	Timeline
Programme delivery	• Djibouti should report on progress in responding to the EVM recommendations and in planning the next EVM.	Country, with support from partners	2014
	• Efforts should be intensified to strengthen EPI target disease surveillance.	Country, with support from partners	2014-onwards
Data quality	• Consideration should be given to developing AEFI surveillance monitoring.	Country, with support from partners	2014-onwards
EPI Financing and Sustainability	• Djibouti should consider doing a new independent coverage survey since the last one was conducted in 2008.	Country, with support from partners	? (check with WHO/UNICEF)
	• Djibouti to ensure appropriate budget allocation for timely payment of co-financing requirements in coming years.	Country, with support from partners	2014-onwards