SUBJECT:	**FRAGILE SETTINGS AND EMERGENCIES**
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1. Purpose

1.1 This paper is one of two papers (08a and 08b) for agenda item 08. The current paper (08a) presents PPC recommendations on principles for a new policy guiding Gavi's approach in fragile settings, emergencies, and situations involving displaced people. Paper 08b asks the Board to take a strategic decision with regards to potential engagement with lower-middle-income countries (LMICs) that are fragile or face protracted emergencies but whose eligibility for Gavi support cannot be exactly determined because a point estimate for Gross National Income (GNI) per capita is not available. Currently this question only arises in the case of Syria.

1.2 During its last meeting, the PPC was presented with findings from a review of Gavi's current approach to supporting immunisation in fragile and emergency settings and proposed changes going forward (see Appendix A). The PPC endorsed a set of principles to form the basis for an updated policy[1], and encouraged a clear separation between fragility, emergencies and displaced people, as is reflected in this paper.[2]

1.3 The PPC also recommended that the Board decide on how to engage with lower-middle-income countries that are fragile or face protracted emergencies. In those countries experiencing protracted emergencies that fall outside Gavi eligibility (e.g. Libya and Iraq[3]), the PPC recommended no Gavi engagement as they did not think it appropriate to reopen Gavi eligibility at this time. It was noted that PPC members representing the CSO and Research & Technical Health Institutes constituencies expressed support for Gavi engagement in these settings.

[1] Of note, this policy would not cover the individual institutional efforts of Alliance partners operating in fragile settings and emergencies. Throughout this document, 'Gavi' refers to the Alliance operating with Gavi funds and within the Gavi Alliance mandate.
[2] PPC members underlined that the process of the policy review had been faster than usual due to the perceived urgency of (re-)defining Gavi's approach in this area.
[3] Both currently upper middle-income countries

2. Recommendations

2.1 It is noted that "Doc 07" in the recommendation in paragraph 2.3 below refers to the report to the PPC for its October meeting. While the PPC endorsed the proposals for Gavi's approach to fragile and emergency settings embodied in the October PPC paper (and referred to in the official PPC recommendation below), it made some suggestions with regard to the framing and structuring - and in some cases, the specific wording - of the principles. The principles updated with the input received from the PPC are reflected in this (Board) document in sections 4.5, 5.3, and 6.4. Should the Board wish to approve these sections in this Board paper as the basis for the new policy to be developed, the recommendation language would be adjusted to reflect this.

2.2 The PPC recommended that, if endorsed by the Board at its December 2016 meeting, the new principles be applied with immediate effect to address urgent needs in affected countries as needed. The Secretariat will develop a formal policy for PPC and Board approval in May and June 2017, respectively, that would replace the existing policy.

2.3 The Gavi Alliance Programme and Policy Committee **recommended** to the Gavi Alliance Board that it:

Approve the principles for Gavi's approach to classifying and responding to fragile and emergency settings as embodied in sections 3, 4 and 5 in Doc 07, and **request** the Secretariat to operationalise these principles into a policy which will replace the 2013 Fragility and Immunisation Policy.

3. Background

3.1 Gavi operates in many of the most fragile settings, where health needs are often the greatest. Having an impact in these settings is critical for protecting vulnerable populations and for attaining global immunisation goals particularly around coverage and equity.

3.2 Gavi has had a 'Fragility and Immunisation Policy' in place since 2013. This policy recognises that protracted fragility can impede a country's ability to access and effectively utilise Gavi support, and that these settings demand a tailored and flexible approach. The policy stipulates a criterion for identification of fragility and currently 11 countries are classified as fragile.[4] While Gavi is not a "first response" humanitarian organisation, the policy also recognises the special needs of countries that experience emergencies, such as acute conflict or natural disasters, and enables flexibility in Gavi's engagement in these situations.

3.3 In 2016, the Gavi Secretariat undertook a review of the implementation of the 2013 policy and of the broader policy environment. Questions centered around three areas: 1) the experience to date with the current policy, 2) best practices in identification of fragility and in programmatic/operational approaches, and 3) the Alliance's role and means of action in fragile and emergency settings and

[4] Afghanistan, CAR, Chad, Cote d'Ivoire, DRC, Guinea, Haiti, Nigeria, Pakistan, Somalia and South Sudan.

with regard to displaced people. A Technical Expert Committee (TEC) was convened to help translate findings from the review into recommendations for the PPC and Alliance Board. A summary of all consultations can be found in Appendix B on myGavi.

4. Fragility

4.1 There are no universally agreed criteria to determine fragility.[5] Gavi's 2013 Fragility and Immunisation Policy identified 'fragile' countries based on a set of criteria with a strong immunisation lens (low coverage, large inequities)[6]. This was linked to the objective of the policy: "to improve vaccination coverage in a subset of countries with particularly challenging circumstances". In order to achieve this, the policy introduced the 'Country Tailored Approach' (CTA), which brought intensified engagement by the Gavi Secretariat and Alliance partners and enabled programmatic and process flexibilities to help improve coverage and equity. As fragility challenges are unique from country to country, Gavi's response in each case has been highly context-specific. Flexibilities applied to date (see Appendix C) were tailored to the local needs rather than a prescribed approach in each fragile country. These have included for example frontloading of an HSS grant (Chad), alignment of co-financing requirements with a country's fiscal year (Pakistan), and waiving of the coverage requirement for performance-based funding in HSS (Afghanistan). While it is difficult to draw universal lessons from context-specific approaches, fragile countries have welcomed the flexibilities, which have primarily been applied in programming and processes related to HSS grants. The review found that flexibilities have enabled targeted investments in areas with critical weaknesses while HSS utilisation rates have improved.

4.2 Since then, Gavi's operating model has evolved considerably in the wake of the new strategy for 2016-2020 which focuses on accelerating coverage and equity of all vaccines in *all* Gavi-supported countries. There is increased recognition of the imperative to move away from a 'one size fits all' approach, differentiate among countries and their needs, and tailor Gavi support to effectively respond to individual country contexts.

4.3 Under the Partners' Engagement Framework (PEF), the Board approved the principle of 'differentiation' and tiering of countries depending upon the scale and severity of immunisation-related challenges. Tier 1 and Tier 2 prioritise 20

[5] The OECD and the Fund for Peace (Fragile States Index), have developed sophisticated identification methodologies for fragility and levels of severity, based on different social, economic, and political factors. These organisations are increasingly moving away from fragile states 'rankings' towards a broader assessment of countries' exposure to different dimensions of fragility.

[6] The seven criteria included: three or more emergencies in past five years (OCHA appeal); listed in top two categories of Fragile States Index; complete devolution of health care system; large immunisation inequities; failure to fully access Gavi support; large unimmunised population of children; DTP3 coverage <70%.

countries[7] and include 9 out of 11 countries regarded as fragile per the current Gavi criteria. The differentiated approach allows for:

a) more focus on countries with the greatest and gravest needs through strategic engagement including with other co-investors;
b) sustained dialogue including annual Joint Appraisals (JAs) and in-country missions;
c) intensified technical support by Alliance partners under the PEF;
d) higher HSS allocations to low-coverage countries under the revised HSIS policy;[8] and
e) regular review and monitoring under the Alliance Accountability Framework, including systematic regional/global level review of progress in the 20 tier 1 and tier 2 countries.

4.4 In essence, the 'tailored approach' initially designed for fragile countries has been mainstreamed into Gavi's new operating model, with a strong immunisation lens.

4.5 Going forward, the following principles for Gavi's approach in fragile settings are proposed:

1. The current Gavi criterion for identification of fragility is proposed to be replaced by a reference to more objective, multi-dimensional and internationally accepted assessments by the Fund for Peace, World Bank and the OECD[9]. Any countries identified through this assessment that do not already feature among the 20 priority countries would be included in the tier 2 category to benefit from concerted attention and efforts of the Alliance. While endorsing this general principle, the PPC emphasised the importance of remaining cognisant of the special challenges that other countries may face, including at the sub-national level, and keeping the assessment of fragility (and application of flexibilities) dynamic and flexible.

2. In order to provide critical and time-sensitive support in line with the special needs of fragile countries, process and program flexibilities that currently apply to fragile settings are proposed to be continued, e.g., needs-based reprogramming, alignment of co-financing with a country's budget cycle, , interim funding to bridge old and new grants, alternative use of performance based funds, etc. These flexibilities are pro-actively identified and discussed in the Joint Appraisal process and operationalised by the Secretariat, and signed off by the CEO.

3. CSOs play a vital role in fragile settings and though Gavi's normal policy is to work with national governments to enlist participation of CSOs, the

[7] Tier 1: Afghanistan, Chad, DRC, Ethiopia, India, Indonesia, Kenya, Nigeria, Pakistan, Uganda. Tier 2: CAR, Haiti, Madagascar, Mozambique, Myanmar, Niger, PNG, Somalia, South Sudan (only Cote d'Ivoire and Guinea from the fragility list do not appear in the PEF 20)
[8] With the exception of India
[9] Criteria could include: Fund for Peace Fragile States top two categories 'Very high alert' and 'High Alert,' the OECD list of countries categorised as fragile in all dimensions, and the World Bank harmonised list of fragile situations.

new approach recognises that there may be specific situations when government and Alliance partners are unable to deliver immunisation services in certain areas/ populations. In such cases, it is proposed that direct engagement with CSOs would be considered, in full disclosure to the national government.

4. Countries in the accelerated transition phase (Phase 2)[10] may also face fragility related challenges and should also benefit from fragility-related flexibilities. If a Phase 2 country is assessed as fragile with sustainability concerns, the case would be brought to the Gavi Alliance Board for discussion.

5. Emergencies

5.1 Emergencies, such as natural disasters or man-made crises, can acutely threaten the immunisation programme in a country or region. 2015 saw a record number of seven WHO Grade 3 emergencies involving 12 countries (of these, seven were Gavi countries). With an emergency often comes increased vaccine-preventable disease mortality, and an increased likelihood of outbreaks. Sometimes a disease outbreak itself can be an emergency as was the case with Ebola.

5.2 Since the current policy came into effect in 2013, Gavi has responded to emergencies in five countries, with the aim to protect immunization systems and existing Gavi support: Central African Republic (CAR), Yemen, and the Ebola-affected countries Guinea, Liberia and Sierra Leone. For example, CAR was given a co-financing waiver during the peak of the war. As the government was unable to finance even the most basic costs of the EPI programme, the policy was invoked to enable reprogramming of CAR's HSS grant to help pay for salaries in order to avoid a collapse of the programme. Gavi also provided additional vaccines for an EPI catch-up campaign targeting a wider age range to reach large numbers of older children who had been missed.

5.3 The following principles for Gavi's approach in emergencies are proposed:

1. Gavi would continue to consider individual requests from countries experiencing an emergency, using WHO[11] and UN[12] classifications as reference points and early warning signs;

2. Programme and process flexibilities would be applied in response to special needs, e.g. additional vaccines targeting a wider age range, additional HSIS for campaign delivery of routine vaccines, a time-limited co-financing waiver, additional support for health systems recovery, etc. The CEO would approve flexibilities with financial implications as per the Programme Funding policy with reports to the Board;

[10] The final five years following a country's surpassing of the eligibility threshold during which Gavi support phases out.
[11] http://www.who.int/hac/donorinfo/g3_contributions/en/
[12] The Inter-Agency Standing Committee (IASC), which is a committee of UN and non-UN humanitarian organisations, classifies emergencies based on scale, complexity, urgency, capacity and reputational risk: https://interagencystandingcommittee.org/

3. Gavi funding during emergencies would complement funding from humanitarian response actors;
4. Gavi's programmatic response would be coordinated with other actors[13] through the appropriate mechanisms (e.g. the Health Cluster) and aligned with existing guidelines (e.g. Vaccinating in Acute Humanitarian Emergencies, WHO);
5. Direct engagement with CSOs when required in situations where the government and Alliance partners cannot reach certain areas or populations, in full disclosure to the government; and
6. Gavi will continue to participate in and support initiatives supporting CSOs wishing to procure vaccines in emergency situations, while acknowledging contractual constraints, Gavi's principle of working through governments, and its mandate specific to Gavi countries.

6. Displaced people[14]

6.1 In 2015, the world witnessed the highest numbers of displaced people on record[15]; 65 million, including over 21 million refugees as per UNHCR classifications[16]. The number of child refugees jumped by roughly 75 percent between 2010 and 2015. Gavi-eligible countries hosted over 6 million refugees in 2015, and some Gavi countries were among the top refugee-hosting nations world-wide (e.g. Pakistan 1.6 million, Ethiopia 700,000 refugees).

6.2 Several high level meetings[17] in 2016 recognised the extreme vulnerability of refugees and migrants and called on the international community to share the responsibility for supporting their needs. In February 2016, at the Ministerial Conference on Immunisation in Africa held in Addis Ababa, Ministers called on Gavi "to consider refugees and internally displaced populations as eligible recipients of Gavi support for vaccines and operational costs".

6.3 Under the current policy, governments can request additional doses of Gavi-supported vaccines to cover refugees residing in their country. However, they must co-finance such doses. A review of current and past situations in Gavi countries highlighted that this requirement has been a barrier for some governments otherwise willing to provide immunisation services to refugees. There could also be instances of refugees not being included in population projections for political reasons.

6.4 The following principles for Gavi's approach with regard to displaced people are proposed:

[13] See appendix D for a preliminary overview of partners in immunisation in emergencies
[14] Includes refugees and displaced people. **Refugees** are people fleeing conflict or persecution across an international border (UNHCR http://www.unhcr.org/refugees.html). Refugees are defined and protected under international law (in the 1951 Refugee Convention, the 1967 Protocol and in other legal texts). **Internally displaced people** (IDPs) have fled their homes but have not crossed an international frontier (http://www.unhcr.org/internally-displaced-people.html)
[15] UNHCR http://www.unhcr.org/figures-at-a-glance.html
[16] Refugees under UNHCR's mandate, total 21.3 m of which 5.2 m Palestinians registered by UNRWRA (UNHCR Sep 2016)
[17] World Humanitarian Summit May, UNGA and New York Declaration for Refugees and Migrants September 2016

1. Encourage governments to include refugee populations in their annual vaccine requests. To promote integration of refugees into regular programmes, continue to encourage co-financing of all doses, but if requested, waive this requirement for a limited initial period, proposed as 2 years. Simultaneously, more sustainable solutions would be explored.

2. Provide support directly to Alliance partners implementing immunisation services for refugees, when for political or other reasons it is not possible for a government to include refugees in their vaccination programmes. Determine cost-sharing arrangements on a case-by-case basis, ensuring that Gavi support does not displace other funding.

3. In case of government or partner implementation of immunisation services with Gavi-funded vaccines for refugees or internally displaced people (IDPs), consider providing additional HSIS if operational support normally provided by humanitarian response organisations is not available, recognising that the delivery of immunisation services to internally displaced persons or refugees can be challenging and costly.

7. Indicative overview of flexibilities

7.1 With the evolution of Gavi's model, Gavi has significantly expanded its capacity for responding in a tailored and flexible manner to challenges in different country contexts. As outlined above, many of these approaches used to be available only to fragile countries under the Fragility and Immunisation Policy, whereas they are now mainstreamed into the operating model for all countries. Table 1 below maps Gavi's approach against fragility-related challenges. It illustrates in column A what Gavi can do through its current model to address some of these challenges, while column B lists special flexibilities that would be additionally available to countries regarded as fragile under the new policy.

7.2 Table 2 below maps proposed principles for Gavi's approach in countries facing emergencies or displaced people against potential challenges encountered.

Appendices *(available on myGavi):*

Appendix A: Fragile settings and emergencies: Report to the PPC, 25-26 October 2016, Doc 07

Appendix B: Summary of consultations

Appendix C: Flexibilities applied in fragile countries to date

Appendix D: Preliminary overview of partners in immunisation in emergencies

Table 1: Gavi response to fragility

FRAGILITY	A: Tailored and flexible response through the current Gavi model (applicable to all countries):	B: Special flexibilities (incremental)[18] available to fragile countries:
a) Challenges to access and utilise Gavi support (e.g. low uptake of new vaccines, low HSS utilisation rates)	▪ **Country engagement**: intensified dialogue with Secretariat and partners under the PEF to identify needs, advocate for vaccine introduction, support readiness, support to identify and address coverage and equity challenges ▪ **NVS/HSS**: adapted review processes, e.g. in-country independent review ▪ **HSS**: one-time no-cost extension of HSS grant, one-time reprogramming	▪ **HSS**: no-cost extensions and reprogramming more than once as needed; interim funding to bridge old and new grants ▪ **NVS/HSS**: Alternative modalities for grant structure, e.g. separate HSS plans directly from different sub-national areas (Somalia)
b) Lower ability to achieve positive outcomes / return on investment of Gavi funds (e.g. poor planning and implementation of HSS grants, low quality campaigns)	▪ **Country engagement:** Programme Capacity Assessments, Joint Appraisal, sustained dialogue with Secretariat and partners to assess and respond to needs ▪ **TA**: intensified TA for HSS and NVS planning/proposal development for PEF priority countries	▪ **HSS**: More flexible use of HSS grants as needed, e.g. funding salaries in transitioning countries ▪ **Implementation model**: funding CSOs to support populations not reached by the government
c) Challenges to meet reporting requirements due to weak data systems, challenges to meet financial requirements due to other demands on resources (co-financing default, poor results monitoring, lack of data)	▪ **Country engagement:** intensified engagement by Secretariat and partners, e.g. financial modelling, advocacy, etc. ▪ **HSS**: Guidance on use of HSS grants for data improvements (as per data strategy), strengthening Leadership, Management and Coordination and other key strategic areas	▪ **PBF**: Flexible use of PBF payments (e.g. for data improvement in Afghanistan)

[18] Indicative examples. Other flexibilities may be required in fragile countries.

Table 2: Gavi response to emergencies and situations involving displaced people

EMERGENCIES:	**Special flexibilities (incremental)[19] available to countries facing an emergency:**
a) Disruption of routine vaccination (e.g. due to loss of vaccine supply or discontinuation of immunisation services) causing large numbers children to go un-immunised	▪ **NVS**: Replacement of destroyed vaccines ▪ **NVS**: Additional vaccines to cover expanded age range
b) Reduced ability to reach target population (e.g. government cannot access contested territories)	▪ **Implementation model:** funding CSOs to support populations not reached by the government
c) Changed/increased resource needs for rebuilding destroyed health systems and for implementation of Gavi grants (e.g. routine vaccines needing to be delivered in campaign mode)	▪ **HSS**: Reallocation of up to 50% of the total grant budget. Reprogramming of up to 100% of an HSS grant, repeated as needed, shorter term budget and work plans.[20] Additional HSIS support beyond country allocation of up to 50%, approved by the CEO, e.g. to rebuild health systems, cover increased operational cost of vaccine delivery
d) Reduced ability to co-finance due to competing financial demands	▪ **NVS**: Time-limited (prospective) co-financing waiver; application of this flexibility is reported to the Board
e) Reduced ability to access new vaccine support due to crisis-related drop in coverage below Gavi requirement of 70%	▪ **NVS**: Waiving the 70% coverage requirement for new vaccines in case of temporary coverage drop due to crisis
DISPLACED PEOPLE :	**B: Special flexibilities (incremental)[1] available to countries in a situation involving displaced people:**
a) Refugee/IDP immunisation needs	▪ **NVS**: Additional vaccines for refugees (normally co-financed by the government) ▪ **NVS**: If requested, time-limited co-financing waiver for vaccines for refugees while encouraging a long-term plan to support this population

[19] Indicative examples. Other flexibilities may be required in emergencies.
[20] The 2013 policy allowed for reprogramming of up to 50% of any remaining funds of an HSS grant subject to ICC and Executive Committee approval. This rule was found to be more restrictive than earlier common practice and also put an additional burden on Gavi's governance system. Secretariat operational guidelines now specify alternative ceilings both for non-emergency and emergency situations that would be incorporated in the update policy.

	▪ **NVS:** supporting partners to vaccinate refugees ▪ **HSIS**: support to cover increased operational costs of vaccine delivery in IDP or refugee situations (donor of last resort)