DOCUMENT ADMINISTRATION

VERSION NUMBER	APPROVAL PROCESS	DATE
1.0	MD: Nina Schwalbe, Policy and Performance	
	Reviewed by: GAVI Programme and Policy Committee	19 May 2010 22 October 2010 (Review of financial sustainability indicators)
	Approved by: GAVI Alliance Board	17 June 2010
		Effective from: 17 June 2010
		Review: Following the application of the pilot prioritisation mechanism to two rounds

Pilot Prioritisation Mechanism

1. Purpose

1.1. This pilot mechanism aims to inform GAVI's funding decisions in a resource constrained environment by enabling the ranking of country proposals recommended by the Independent Review Committee ("IRC") for New Vaccine Support ("NVS") and cash-based programmes and also informs the prioritisation of vaccines within GAVI's portfolio.

2. Scope

2.1. During the pilot phase (see Section 7.1 of this policy), funding decisions for the following vaccines will be subject to the NVS proposal prioritisation mechanism described here: hepatitis B and Haemophilus influenza (Hib) - containing vaccines; Yellow fever routine vaccines; Measles 2nd dose; Pneumococcal conjugate vaccines from GAVI-eligible countries; Rotavirus vaccines; and Meningitis A routine + catch-up and Yellow fever preventive campaigns.

2.2. NVS application windows for Japanese encephalitis (JE), human papillomavirus (HPV), rubella, typhoid vaccines will not be accepted during the pilot phase (see "Timeline for implementation and updates" section below).

2.3. During the pilot phase, funding decisions for existing cash-based programmes will be subject to the proposal prioritisation mechanism described here. However Health System Strengthening (HSS) proposals submitted through a new applications process – the Health Systems Funding Platform (HSFP) will not be subject to this mechanism.

3. Principles

3.1. The pilot prioritisation mechanism is designed to: (a) support nationally defined priorities; and also to be (b) objective; (c) transparent; and (d) feasible.

3.2. The pilot prioritisation mechanism aims to: (i) maximise health impact and value for money; (ii) reinforce financial sustainability of immunisation programmes; (iii) support countries with the greatest need; and (iv) promote equitable distribution of GAVI's resources among countries (as accorded by a maximum of one NVS proposal per round).

4. Criteria

4.1. The following criteria will be applied in a weighted index to rank IRC-recommended NVS proposals:

- Deaths averted per 1,000 vaccinated (as a proxy for "health impact");
- Cost per death averted (as a proxy for "value for money");
- Health share of government expenditure (as a proxy for "financial sustainability");

- Gross national income per capita (as a proxy for "need"); and
- A maximum of one NVS proposal per country can be approved per application round (as a proxy for "equity among countries" applied as a rule rather than an input to the index).

4.2. The following criteria will be applied in a weighted index to rank IRC-recommended cash-based proposals:

- Under-five mortality ("overall health burden") and DTP3 coverage ("system weakness") (which together serve as a proxy for "need"); and
- Health share of government expenditure (as a proxy for "financial sustainability").

5. Operational design

5.1. Weighting of objectives for NVS proposals: Health impact-30%; Value for money-30%; Financial sustainability-25%; Need-15%.

5.2. Weighting of objectives for cash-based programme proposals: System weakness-50%; Overall health burden-25%; Financial sustainability-25%.

5.3. Ties: The health impact indicator will be used to break ties for NVS, and DTP3 will be used to break ties for cash-based programmes. In the case of the latter, the lower DTP3 coverage would receive priority.

5.4. Unfunded proposals: Proposals that are not funded in a particular round will automatically go into the pool of new IRC recommended applications for the next application round. If in the next round, these proposals are still not funded, then countries will be asked to reapply.

6. Data sources

- GNI per capita (Atlas method) from the World Bank
- DTP3 coverage from WHO/UNICEF estimates
- Disease burden for vaccine preventable strains of Hib, pneumococcal disease and rotavirus diarrhoea from WHO
- Vaccine efficacy from the Weekly EPI Record, no.23(84) for rotavirus; and WHO and technical consensus for Hib and pneumococcal disease
- Average price per course over the period (2010-2015) from GAVI average weighted price projections
- General government expenditure on health as a proportion of total government expenditure from WHO National Health Accounts data
- Under five mortality from Inter-agency Group for Child Mortality Estimation

7. Timeline for implementation and updates

7.1. The pilot prioritisation mechanism will be in effect for two application rounds including the prioritisation of IRC-recommended proposals from October 2009.

7.2. Applications windows shall be prepared for Meningitis A routine and catch-up and Yellow fever preventive campaigns so these proposals can be requested, accepted and prioritised within the pilot prioritisation mechanism.

7.3. While the prioritisation mechanism is being piloted, GAVI will continue preparatory activities for JE, HPV, rubella, typhoid vaccines, and only open windows for these vaccines after the pilot, subject to funding availability and the finalisation of the GAVI strategy 2011-2015.

7.4. The subsequent iteration of this mechanism will be introduced once the pilot has been evaluated and possibly strengthened e.g. with the addition of a measure of Country Readiness added to the index to prioritise NVS applications and additional means of measuring Financial Sustainability.

8. Effective date and review of pilot mechanism

8.1 This pilot mechanism comes into effect as of 17 June 2010.

8.2 This pilot prioritisation mechanism will be reviewed and updated following the application of the pilot to two rounds. Any amendments to this policy are subject to GAVI Alliance Board approval.