**Report to the**
# GAVI Alliance Board
11-12 June 2013

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|---|---|
| **Subject:** | **Consent Agenda: Review of GAVI's pilot prioritisation mechanism** |
| **Report of:** | Nina Schwalbe, Managing Director, Policy and Performance |
| **Authored by[1]:** | Aurélia Nguyen, Director, Policy and Market Shaping, and Eliane Furrer, Senior Programme Officer, Policy |
| **Agenda item:** | 02g |
| **Category:** | For Decision |
| **Strategic goal:** | SG1 - Underused and new vaccines |

## Section A Overview

### 1 Purpose of the report

1.1 At the request of the Board, the Secretariat reviewed the experience with the pilot prioritisation mechanism since its approval in June 2010.

1.2 Based on recommendations from the Secretariat, the Programme and Policy Committee (PPC) proposed revisions to the prioritisation mechanism at its meeting on 29-30 April 2013. The Committee paper, which has relevant details, is attached to this paper.

### 2 Executive Summary – Update since the April 2013 PPC meeting

2.1 The PPC recommended that current indicators, as well as the weighting of objectives and the operational design of the mechanism will be maintained, with the exception of revisions to the health impact and financial sustainability indicators as follows:

(a) *Health impact*: Change from 'Ratio of average annual deaths averted to total population' (calculated through a standard formulae applied across all vaccines) to 'Ratio of future deaths averted to total population'– using outputs from a peer-reviewed, published impact modelling exercise.

(b) *Financial Sustainability of Immunisation Programmes*: Change from 'General government expenditure on health as a percentage of total government expenditure' (from WHO's National Health Account data) to a combination of two indicators:

[1] With contributions from Peter Hansen and Hope Johnson

1) Co-financing performance for GAVI supported vaccines in the last five years: *'Number of years for which a country has not fulfilled its co-financing commitment'* (from GAVI Secretariat based on annual monitoring reports from the Immunisation Financing & Sustainability Task Team). And:
2) *'Percentage of spending on vaccines used in routine immunisation financed with Government funds'* (from adjusted WHO/UNICEF Joint Reporting Form).

2.2 Given high correlation between the number of future deaths averted and a potential new indicator capturing morbidity (such as DALYs averted), the PPC advised against inclusion of an additional health impact indicator to capture morbidity. They noted that the value added of the latter was low in relation to the extra work required to include this dimension and the resulting complexity.

## 3 Recommendations

3.1 The Board is requested to:

**Approve** the revised prioritisation mechanism as attached to Doc 02g.

## 4 Risk and Financial Implications – Update

4.1 Risks and financial implications related to the review of GAVI's pilot prioritisation mechanism, are addressed in the PPC paper (attached).

**Report to the**
# Programme and Policy Committee
29-30 April 2013

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|---|---|
| **Subject:** | **Review of prioritisation mechanism** |
| **Report of:** | Nina Schwalbe, Managing Director, Policy and Performance |
| **Authored by:** | Eliane Furrer, Peter Hansen, Hope Johnson, Aurélia Nguyen |
| **Agenda item:** | 09 |
| **Category:** | For Decision |
| **Strategic goal:** | SG1 - Underused and new vaccines |

## Section A Overview

### 1 Purpose of the report

1.1 The purpose of this report is to share a review of the experience with the pilot prioritisation mechanism since its approval in June 2010 and to seek endorsement by the Programme and Policy Committee (PPC) of the proposed revisions to the mechanism for the post-pilot period.

### 2 Recommendations

2.1 The PPC is requested to:

**Recommend** to the Board that it approve the revised prioritisation mechanism attached as Annex 1 to Doc 09.

2.2 The Secretariat also requests the PPC to provide guidance on the potential inclusion of a health impact indicator which also captures morbidity, alongside the indicator of deaths averted into the mechanism at a later stage.

### 3 Executive Summary

3.1 In June 2010 the Board approved a Pilot Prioritisation Mechanism to inform GAVI's funding decisions in case available resources are not sufficient to approve all new proposals in a given application round. The Board requested the Secretariat to evaluate the pilot and suggest improvements to the mechanism for potential use in the future.

3.2 The objectives and operating guidelines were intended to apply beyond the pilot and are still in line with the GAVI Alliance Strategy 2011-2015. The Secretariat therefore recommends maintaining them for the revised mechanism. This implies that under funding constraints, proposals should

be prioritised that: (a) Maximise health impact; (b) Maximise value for money; (c) Reinforce financial sustainability of immunisation programmes; (d) Support countries with the greatest need; and (e) Promote equitable distribution of GAVI's resources among countries.

3.3 Based on previous Board discussions, lessons learned during the pilot phase and availability of improved data sources, revisions are suggested to the health impact and financial sustainability indicators:

(a) *Health impact*: Change from 'Ratio of average annual deaths averted to total population' (calculated through a standard formulae applied across all vaccines) to 'Ratio of future deaths averted to total population'– using outputs from a peer-reviewed, published impact modelling exercise. The new approach would rely on estimates of future deaths averted produced through the multi-agency process convened by the GAVI Alliance and Bill & Melinda Gates Foundation, and including WHO and leading academic and technical institutions from around the world. These impact projections have been peer-reviewed, will be in the public domain and get updated annually.[1]

(b) *Financial Sustainability of Immunisation Programmes*: Change from 'General government expenditure on health as a percentage of total government expenditure' (from WHO's National Health Account data) to a combination of two indicators:

1) Co-financing performance for GAVI supported vaccines in the last five years: *'Number of years for which a country has not fulfilled its co-financing commitment'* (from GAVI Secretariat based on annual monitoring reports from the Immunisation Financing & Sustainability Task Team). And:

2) *'Percentage of spending on vaccines used in routine immunisation financed with Government funds'* (from adjusted WHO/UNICEF Joint Reporting Form).

3.4 All other indicators, as well as the weighting of objectives and the operational design of the mechanism will be maintained. The recommended mechanism is described in Annex 1.

3.5 The PPC is also requested to provide guidance on the potential inclusion of a health impact indicator which captures morbidity, alongside the indicator of deaths averted into the mechanism at a later stage.

## 4 Risk implication and mitigation

4.1 Endorsement of the revised mechanism in itself mitigates the risks of ad-hoc decision making in case of funding shortfalls. Having a pre-agreed mechanism in place enables the Board to make funding decisions in a systematic, transparent and predictable way.

[1] Results from the modelling exercise will be published in the journal *Vaccine* in Q2 2013.

4.2 The current scope of the mechanism enables prioritisation among the new vaccine support (NVS) proposals submitted in new application rounds, but it does not extend to existing multi-year commitments and their extensions. In case of an unexpected, significant shortfall in resources, GAVI may also need to prioritise existing support. No mechanism is currently in place to undertake this type of prioritisation.

## 5 Financial implications: Business plan and budgets

5.1 Additional work associated with the development of a health impact indicator capturing morbidity would have to be added to the 2014 work plan and budget.

## Section B Content

## 1 Background

1.1 In June 2010 the GAVI Board approved a Pilot Prioritisation Mechanism to inform GAVI's funding decisions in a resource constrained environment. Developed under the guidance of a PPC-appointed task team, the pilot mechanism enabled the ranking of country proposals for new vaccine support (for rotavirus, pneumococcal and pentavalent vaccine proposals) and cash-based programmes recommended for approval by the Independent Review Committee (IRC).

1.2 The pilot mechanism was subsequently extended to new country applications for measles second dose, meningitis A, and yellow fever vaccine support[2]. The Board adopted the pilot mechanism to be in effect for two application rounds. While the prioritisation mechanism was used to prioritise funding for the IRC-recommended proposals from the October 2009 round[3], the favourable funding situation in subsequent years made application of the mechanism unnecessary.

1.3 This paper highlights lessons learnt with the pilot design over the past years since approval and recommends improvements to strengthen the mechanism for potential future use.

## 2 Review of lessons learned from the pilot mechanism

2.1 This short synthesis draws on a review of lessons learned from a test run of the pilot mechanism to the 2011 round of proposals that has been completed and is available to the PPC upon request. In summary, the main lessons learned are as follows:

[2] Report to the Programme and Policy Committee, 9 May 2011. The PPC also reviewed the Financial Sustainability Indicator for use in GAVI's Pilot Prioritisation Mechanism at its meeting in October 2010 (see Report to the PPC, 21-22 October 2010).

[3] Consistent with the mechanism, only one new IRC-recommended proposal per country per round was approved. Resources were sufficient to approve funding for eight NVS proposals. The three countries that had two IRC-recommended proposals were asked to choose which proposal they wished to see funded. The three de-prioritised proposals were automatically considered for funding in the 2011 round of NVS applications.

(a) The pilot prioritisation mechanism is feasible to apply and, consistent with the intention of the policy, is effective in systematically rank ordering approved proposals against the criteria adopted by the Board as part of the mechanism.

(b) A one-size-fits-all formula that prescribes how health impact is calculated through a single formula across vaccines and diseases with highly divergent characteristics (e.g. different transmission dynamics and age distributions of illness and death, different delivery strategies and target age groups) is a fundamental limitation.

(c) Adding additional vaccines to the mechanism is possible—as demonstrated by the inclusion of measles second dose, meningitis A and yellow fever to a mechanism originally set up for the hib component of pentavalent vaccine, pneumococcal and rotavirus vaccines—but this becomes increasingly complex as the number and variety of vaccines included increases.

(d) The range of scores produced by the pilot mechanism is wide, which reflects variable country, disease and vaccine characteristics.

(e) The distribution of scores by country and vaccine appears reasonable—clear themes emerge, but no single vaccine or country appears to be systematically disadvantaged to the point that their applications would never be funded.

(f) The scores are highly sensitive to disease burden, and to assumptions made about how the burden is estimated.

(g) To a somewhat lesser but still important extent, the scores are also sensitive to vaccine price.

(h) The scores reflect a “pro-poor” distribution, with the poorest countries tending to have favourable scores due to low gross national income per capita as well as burden of disease that tends to be higher than in wealthier countries (i.e. greater potential health impact).

## 3 Changes to the scope

3.1 The original mechanism enabled ranking of NVS *and* cash-based programme proposals. In subsequent meetings, the Board approved a separate approach for prioritising and allocating funds for cash-based programmes.[4] It is therefore recommended that the future prioritisation mechanism discussed here focus only on New Vaccine Support (NVS) proposals.

[4] Notably, the Board decided that the projected three-year rolling average share of expenditure on cash-based programmes within GAVI’s overall programmatic expenditure should be within the range of 15-25% of the total and approved a new HSS resource allocation method to establish the maximum potential amount of funding for each country (see minutes of Board meeting 16-17 June 2010 and 1 Dec 2010).

## 4 Objectives and operating guidelines

4.1 The Board approved five key objectives for the pilot prioritisation mechanism. Under funding constraints, proposals should be prioritised that:

(a) Maximise health impact;

(b) Maximise value for money;

(c) Reinforce financial sustainability of immunisation programmes;

(d) Support countries with the greatest need; and

(e) Promote equitable distribution of GAVI's resources among countries.[5]

4.2 The pilot was designed to support nationally defined priorities by comparing across proposals for different vaccines rather than enforcing a vaccine prioritisation from a "global" perspective. Additional guiding principles inform the selection of indicators and the operationalisation of the mechanism:

(a) *Objectivity*: implies reliance on evidence and published data. Data should be collected and/or verified by an independent party following standardised guidelines and techniques across all GAVI-eligible countries.

(b) *Transparency*: includes reliance on broadly available data and argues for simplicity. Data should be robust, reliable and their validity accepted by countries and partners.

(c) *Feasibility*: implies that the required data must be available and comparable across GAVI-eligible countries and updated on a regular basis; the entities charged with collecting, presenting, and assessing evidence must be ready and willing to do so; and the necessary procedures must be in place.

4.3 These objectives and operating guidelines were intended to apply beyond the pilot and are still in line with the GAVI Alliance Strategy 2011-2015. The Secretariat therefore recommends maintaining them for the revised prioritisation mechanism.

## 5 Proposed indicator revisions

5.1 Based on previous Board discussions, lessons learned during the pilot phase and availability of improved data sources, revisions are suggested to the health impact and financial sustainability indicators (see Table 1).

[5] Besides contributing to more equity among countries, increasing intra-country equity (i.e. equity in access to services within a country) is a key objective in GAVI's strategy. However, due to gaps in the quality and availability of data , there is currently no indicator that meets the criteria to be used for the purpose of prioritisation. However, countries with higher overall coverage levels are rewarded through higher scores against the health impact objective.

Table 1: Objectives and recommended changes to indicators

| Objective | Indicator | Weight |
|---|---|---|
| **Maximise health impact** | Change from "Ratio of average annual deaths averted to total population" (using standard formula across vaccines) to:<br>*Ratio of future deaths averted to total population from the first five years of vaccination* – using outputs from peer-reviewed impact modelling exercise | 30% |
| **Maximise value for money** | Cost per future death averted | 30% |
| **Reinforce financial sustainability of immunisation programmes** | Change from "General government expenditure on health as a percentage of total government expenditure" to:<br>1) Co-financing performance for GAVI supported vaccines in the last five years: *'Number of years for which a country has not fulfilled its co-financing commitment'.* And:<br>2) *'Percentage of spending on vaccines used in routine immunisation financed with Government funds'* | 25% |
| **Support countries with the greatest need** | Gross national income per capita | 15% |
| **Distribute GAVI resources equitably among countries** | | |

5.2 Recommended revision to health impact indicator

(a) When the pilot prioritisation mechanism was originally developed, published estimates of the likely future impact of the full portfolio of GAVI supported vaccines were not available. A formulae built from available data at the time was used to calculate the relative health impact of new vaccine proposals.[6] In light of the recent availability of a peer-reviewed set of impact projections for the full portfolio of GAVI support and the need to include in the prioritisation mechanism additional GAVI-supported vaccines with divergent characteristics, there is merit in revising the approach to calculating the health impact indicator.

(b) Moving forward, the estimates of future deaths averted produced through the multi-agency process convened by the GAVI Alliance and Bill and Melinda Gates Foundation, and including WHO and leading

[6] The formula was originally developed for the hib component of pentavalent vaccine, pneumococcal and rotavirus vaccines. The formula made sense for those three diseases—however, when need arose later to add measles second dose, meningitis A and yellow fever vaccines, it was with difficulty that these vaccines were added to the mechanism, given the divergent characteristics of the diseases and delivery strategies and the lack of comparability with the first set of vaccines included.

academic and technical institutions from around the world, would be used to calculate future deaths averted for use in the prioritisation mechanism. Results from this modelling exercise have been peer-reviewed and will be published in the journal *Vaccine* in late April, around the time of the PPC meeting. A copy of this manuscript is available upon request.

(c) This work will be updated annually. In the future, the most recent completed round of modelling will be used as the source for future deaths averted.

(d) There are several advantages to making this change. First, the estimates of health impact from the described approach—while still having substantial uncertainty that is not formally quantified—are more transparent and defensible than the estimates of average annual deaths averted used in the pilot mechanism. These estimates have been published following a peer review process and thus have been vetted to a greater extent than unpublished estimates like those used in the past and are available in the public domain. Second, using the outputs from the modelling exercise ensures greater consistency of assumptions and hence better comparability of results across vaccines. Third, since the GAVI Alliance and partners will be updating the modelling exercise every year, there will be an existing process of updating the estimates that can be used to keep the mechanism current, which minimises the need to invest additional resources in a parallel approach. This process is also inclusive, in that it involves a number of GAVI Alliance partners and stakeholder institutions. As the GAVI Alliance adds new vaccines to its portfolio of support, the vaccines will be added to the existing impact modelling exercise and therefore easily included in the prioritisation mechanism without delay or need to invest additional resources.

5.3 Recommended revised financial sustainability indicators

(a) When developing the pilot mechanism in 2010, one of the preferred indicators to assess financial sustainability was past co-financing performance. However, given relatively little experience with the co-financing policy (applied since 2008) and its pending review, the Board approved that such an indicator be added only after the pilot phase.

(b) At the same time the Board asked the Secretariat to reconsider the National Health Account indicator suggested as a proxy for financial sustainability in the pilot mechanism[7] with the PPC. After review of alternative options, the PPC decided that this indicator should be retained for the pilot phase, but that co-financing performance should indeed be explored as a potential alternative in the post-pilot prioritisation mechanism.[8,]

[7] '*General government expenditure on health as a percentage of total government expenditure' (GGEH % GGE)* from National Health Accounts data published by the World Health Organization

[8] Report to the Programme and Policy Committee, Review of Financial Sustainability Indicator for use in GAVI's Pilot Prioritisation Mechanism, 21-22 October 2010; and Meeting minutes.

(c) To respond to this request, the Immunisation Financing & Sustainability (IF&S) Task Team reviewed alternative indicators and assessed them against the principles of objectivity, transparency and feasibility. An ideal indicator would measure Governments' commitments to sustainably meet primary health care needs including spending on vaccines (GAVI supported or not) and the broader immunisation system. While several potential indicators exist, the IF&S Task Team is not recommending most of them due to severe limitations in data quality, lack of availability across all GAVI-eligible countries or data not being published systematically.

(d) Based on guidance from the IF&S, the Secretariat recommends that the following two indicators replace the current indicator and are used as composite measurement of financial sustainability of immunisation programmes:

- *Co-financing performance for GAVI supported vaccines in the last five years as measured by the number of years for which a country has not fulfilled its co-financing commitment* (i.e. the country being in default as per the GAVI Co-financing Policy)[9]. Data source: GAVI Secretariat based on annual monitoring reports from the IF&S Task Team.

- And: *'Percentage of spending on vaccines used in routine immunisation financed with Government funds'*. Data source: adjusted WHO/UNICEF Joint Reporting Form (JRF).

(e) Both indicators would contribute equally to an overall weight of 25% for this objective. Use of co-financing performance as an indicator in the prioritisation mechanism helps to underline the strategic importance GAVI places on a country's financial commitment to new vaccines and may act as an additional incentive for good co-financing performance. Inclusion of the second indicator allows capturing the Government's broader financial commitment to finance all vaccines in its national programme whether they are supported by GAVI or not. While there is a risk of self-reporting bias in JRF data, various Alliance partners are increasing their support to countries to improve expenditure tracking and data quality.

5.4 All other indicators, as well as the weighting of objectives and the operational design of the mechanism will be maintained. The recommended mechanism is described in Annex 1. The proposed Monitoring and Evaluation framework for the mechanism is available upon request.

5.5 The mechanism with the revised indicators suggested here was tested against the IRC recommended proposals submitted in the 2012 application

[9] A country enters into default when it has not fulfilled its co-financing commitment for a particular year by 31 December of that year.

round to assess ranking patterns. The outcome of this hypothetical exercise is shown in Annex 2.

5.6 PPC guidance on additional health impact indicator capturing morbidity

The PPC's guidance is requested on whether to include an additional health impact indicator capturing morbidity, alongside the indicator of deaths averted. The primary advantage of including a disability-related indicator—whether disability adjusted life years (DALYs) or other—is that such a measure would capture additional health impacts not captured in the deaths averted indicator. The primary disadvantage is that methodologies for calculating DALYs are complex. Their inclusion in the mechanism would make the mechanism more complex, and would potentially have resource implications. If the PPC advises that a disability-related indicator should be included in the prioritisation mechanism, the Secretariat would work with partners to convene a process to identify options for doing this.

## Section C Implications

### 1 Impact on countries

1.1 The presence of a pre-agreed and objective prioritisation mechanism improves visibility and transparency for countries about the key criteria that will be assessed to make funding decisions in case of limited resources. Supporting nationally defined priorities is at the heart of the mechanism. Country specific disease burden and coverage rates will drive the scores for the health impact indicator which enables a fairer assessment of the comparative strengths of different proposals, rather than enforcing a vaccine or country prioritisation from a "global" perspective.

### 2 Impact on GAVI stakeholders

2.1 All GAVI stakeholders benefit from a pre-agreed mechanism which – in conjunction with the financial outlook – facilitates strategic planning.

2.2 The mechanism provides assurance to GAVI donors that limited resources are focused on those programmes with the highest health impact and value for money.

### 3 Impact on Secretariat

3.1 The proposed approach to calculating deaths averted as part of the prioritisation mechanism would have limited impact on the Secretariat, since it would come from an existing cross-Alliance piece of work that is already updated annually. The recommendation approach is therefore an efficient approach that would not require additional resources. If the PPC wishes to add an additional measure of morbidity to the health impact criterion, this would need to be incorporated into the Secretariat's business plan for 2014.

## 4 Legal and governance implications

4.1 The recommendation in this report does not have legal or governance implications.

## 5 Consultation

5.1 The Immunisation Financing & Sustainability Task Team was consulted to provide guidance on alternative indicators to measure the financial sustainability objective. Additional feedback was sought from UNICEF (both Supply Division and Programme Division) on the feasibility of shortlisted indicator options.

5.2 The health impact estimates proposed for use in the prioritisation mechanism come from an established cross-Alliance process that many partners and stakeholders contribute to. The GAVI Secretariat and the Gates Foundation jointly convene the process, with critical technical inputs from WHO. Several other Alliance partners and stakeholders also participate, including the United States Centers for Disease Control and Prevention, the London School of Hygiene and Tropical Medicine, PATH, Harvard University, the Johns Hopkins University and others.

## 6 Gender implications

6.1 There are no gender implications.

## Section D Annexes

### Annex 1: GAVI Alliance Prioritisation Mechanism for New Vaccine Support

| VERSION NUMBER | APPROVAL PROCESS | DATE |
|---|---|---|
| 1.0 | Pilot Prioritisation Mechanism approved by: GAVI Alliance Board | 17 June 2010 |
| 2.0 | Prepared by: Nina Schwalbe, Policy and Performance | |
| | Reviewed by: GAVI Programme and Policy Committee | 30 April 2013 |
| | Approved by: GAVI Alliance Board | |
| | | Effective from: |
| | | Review: After use in a funding shortfall or at Board request |
| | | |

#### 1. Objectives

1.1. The GAVI Alliance Prioritisation 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).

1.2. Specifically the prioritisation mechanism is directed by five objectives to: (i) Maximise health impact; (ii) Maximise value for money; (iii) Reinforce financial sustainability of immunisation programmes; (iv) Support countries with the greatest need; (v) Promote equitable distribution of GAVI's resources among countries.

#### 2. Scope

2.1. Funding decisions for all vaccines included in the GAVI portfolio will be subject to the NVS proposal prioritisation mechanism described here.

2.2. NVS applications for Japanese Encephalitis and typhoid conjugate vaccines, as well as any other new vaccines added to the GAVI portfolio in the future will be subject to the prioritisation mechanism as and when application windows for these vaccines are opened.

2.3. Cash-based programmes (except from vaccine introduction grants and operational support for campaigns) are not subject to the prioritisation mechanism described here.

#### 3. Operating guidelines

3.1. The prioritisation mechanism is designed to support nationally defined priorities and be objective, transparent and feasible. These operating guidelines are reflected in the indicators chosen to measure each objective as well as in the process for application of the mechanism.

## 4. Criteria

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

- Ratio of future deaths averted to total population from the first five years of vaccination (as a proxy for “health impact”).
- Cost to GAVI per future death averted (as a proxy for “value for money”).
- Co-financing performance for GAVI supported vaccines in the last five years measured by the number of years for which a country has not fulfilled its co-financing commitment (i.e. the country being in default as per the GAVI Co-financing Policy) and ‘Percentage of spending on vaccines used in routine immunisation financed with Government funds’ (as proxies for “financial sustainability of immunisation programmes”).
- Gross national income per capita (as a proxy for “need”).
- 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).

## 5. Application of the mechanism

5.1. The Secretariat will maintain the prioritisation mechanism and apply it to each round of the new proposal Independent Review Committee for which there are insufficient resources available for the GAVI Alliance to fund all proposals recommended for funding from that round.

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

5.3. Ties: The health impact indicator should be used to break ties for NVS proposals.

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

## 6. Data sources

6.1. Estimates of future deaths averted from the impact modeling exercise jointly convened by the GAVI Secretariat and the Bill & Melinda Gates Foundation

6.2. Population data (total population, birth cohort) from UN Population Division

6.3. Immunisation coverage estimates from WHO/UNICEF best estimates

6.4. Average vaccine price per course over a five year period from GAVI average weighted price projections

6.5. Vaccine introduction grant and operational support for campaign amounts as per the latest GAVI policy

6.6. Co-financing performance for GAVI-supported vaccines in the last five years from GAVI Secretariat based on annual monitoring reports from the Immunisation Financing & Sustainability Task Team

6.7. Percentage of spending on vaccines used in routine immunisation financed with Government funds from adjusted WHO/UNICEF Joint Reporting Form

6.8. Gross National Income per capita (Atlas method) from the World Bank

## 7. Effective date and review of the mechanism

7.1. This mechanism comes into effect as of [DATE] and will apply to inform GAVI's funding decisions if and when necessary as described in section 5.

7.2. The need to update the prioritisation mechanism will be assessed after its use in a funding shortfall or as and when requested by the Board.

**Annex 2: Ranking of 2012 round proposals using the mechanism with revised indicators** (More details available on request).

| Proposal | Health Impact Score<br>Max=30;Min=6 | Value for Money Score<br>Max=30;Min=6 | Financial Sustainability Score | | | Need Score<br>Max=15;Min=3 | Total Proposal Score<br>Max=100;Min=20 |
|---|---|---|---|---|---|---|---|
| | | | Co-financing performance<br>Max=12.5;Min=2.5 | % of Gov funding for vaccines<br>Max=12.5;Min=2.5 | Combined | | |
| Measles SIA_Ethiopia | **30** | **30** | 12.5 | 2.5 | **15** | **15** | 90 |
| Men A_Gambia | **30** | **24** | 10 | 12.5 | **22.5** | **12** | 88.5 |
| Measles SIA_Nigeria | **30** | **30** | 12.5 | 12.5 | **25** | **3** | 88 |
| Rota_Mali | **24** | **30** | 12.5 | 5 | **17.5** | **9** | 80.5 |
| Measles SIA_DRC | **30** | **30** | 2.5 | 2.5 | **5** | **15** | 80 |
| Pneumo_Burkina Faso | **24** | **24** | 12.5 | 10 | **22.5** | **9** | 79.5 |
| Pneumo_Liberia | **18** | **18** | 12.5 | 12.5 | **25** | **15** | 76 |
| HPV_Rwanda | **18** | **30** | 12.5 | 5 | **17.5** | **9** | 74.5 |
| Rota_Burkina Faso | **18** | **24** | 12.5 | 10 | **22.5** | **9** | 73.5 |
| Pneumo_Afghanistan | **24** | **24** | 10 | 2.5 | **12.5** | **12** | 72.5 |
| Rota_Gambia | **12** | **18** | 10 | 12.5 | **22.5** | **12** | 64.5 |
| Pneumo_Nigeria | **18** | **18** | 12.5 | 12.5 | **25** | **3** | 64 |
| Rota_Eritrea | **12** | **18** | 12.5 | 2.5 | **15** | **12** | 57 |
| YF_Cameroon | **24** | **6** | 12.5 | 7.5 | **20** | **6** | 56 |
| Rota_Kenya | **12** | **18** | 10 | 10 | **20** | **6** | 56 |
| MR_Ghana | **18** | **12** | 12.5 | 5 | **17.5** | **3** | 50.5 |
| Measles SD_Tanzania | **6** | **12** | 12.5 | 7.5 | **20** | **12** | 50 |
| Pneumo_Nepal | **6** | **12** | 12.5 | 5 | **17.5** | **12** | 47.5 |
| MR_Senegal | **12** | **6** | 12.5 | 10 | **22.5** | **6** | 46.5 |
| Rota_Uzbekistan | **6** | **12** | 10 | 10 | **20** | **3** | 41 |
| MR_Cambodia | **6** | **6** | 12.5 | 7.5 | **20** | **6** | 38 |
| MR_Vietnam | **6** | **6** | 12.5 | 7.5 | **20** | **3** | 35 |