GAVI Alliance Programme and Policy Committee Meeting

16 April 2010
Teleconference

FINAL Minutes

The teleconference commenced[1] at 15:12 Geneva time on 16 April 2010. Seven members participated in the call. The PPC Chair decided with the assent of the present PPC members to proceed despite the lack of quorum since the teleconference was convened for "guidance" (as opposed to "decision").[2] Discussion followed:

1. Introduction to Prioritisation Framework Elements

The Chair of the PPC provided a brief summary of the prioritisation work to date and indicated the three areas where the Prioritisation Task Team (PTT) requests PPC guidance:

- Guidance on the principles of the prioritisation mechanism
- Guidance on the objectives of the prioritisation mechanism
- Guidance with regard to the criteria and indicators used for prioritisation, and specifically on the means of measuring the health impact and cost-effectiveness

The PTT Chair presented background information, including the composition of the PTT, the scope of its mandate, and on progress made thus far (Doc #1). Several points were emphasised:

- Defining which priorities are funded requires definition of the funding constraint. However, prioritisation should be considered separately from the approach or decisions about defining the overall funding envelope.

- Data limitations and the short time frame might make it difficult to create an ideal mechanism. Consequently the PTT is likely to recommend that a pilot mechanism be developed in the short term, and then evaluated and strengthened in 2011.

2. Proposed Principles and Objectives

- The mechanism should be a transparent, easily understood, and objective. Ideally, the next iteration of the mechanism should incorporate experience and feedback from countries to ensure the mechanism was sufficiently participatory.

[1] Attendees are listed in Attachment A
[2] The session was ratified as evidenced by the approval of these minutes during a quoriate session of the Committee on 18-19 May 2010.

- Health impact, value for money, financial sustainability, country readiness, need, and equity were seen as important objectives.

- It was noted that "equity" needs to be defined and referred to appropriately given the importance of this within GAVI's operating principles. Equity within this context, will likely be defined as means of improving the distribution of GAVI's resources across eligible countries, rather than *within*-country. However, this narrow definition has been proposed because it is difficult to measure equity objectively and transparently in a standardised fashion across countries.

- Principles and (at least a subset of) objectives should apply to the mechanism both NVS and cash-based proposals. However, the need to apply criteria differently was noted – E.g., the PTT might propose that countries with lowest DTP3 coverage would receive higher priority for cash-based support while countries with high DTP3 might receive priority for NVS applications.

3. Specific Means of Measuring Prioritisation Objectives

<u>Modelled outcomes versus existing published data for measurement of health impact and value for money</u>

- Ideally, measurement of health impact and value for money by vaccine should account for country and/or regional differences of disease burden. However, the feasibility of this approach will depend on trade-offs that GAVI is prepared to make between ease of understanding/familiarity and accuracy of measuring the desired objective.

- Using a model to assess health impact (deaths averted) and cost effectiveness (cost per death averted or cost per DALY) would provide greater accuracy to the prioritisation process by capturing country and vaccine specificities. Within the task team, WHO had recommended the use of a particular modelled approach.

- It is possible to use Under Five Mortality Rate (U5MR)– a proxy for a general measure of disease burden, and DTP3 coverage– a proxy for country capacity to effectively delivery new vaccines, could be used together as a weak proxy for both health impact and value for money.
    - These indicators are simple and easy to communicate and are produced by globally recognised third-party sources
    - However, U5MR and DTP3 do not enable GAVI to weigh cost-effectiveness in prioritisation decisions, and would not enable GAVI to discriminate between country-specific vaccine effects.

Other Indicators

- For transparency and simplicity, the number of indicators under consideration by the PTT has been kept small.
    - 'Financial sustainability' - the share of Government health spending in total Government spending (form National Health Accounts data).
    - 'Need' - GNI per capita data, Atlas method (from the World Bank).
    - 'Equity' in the distribution of GAVI resources- time of last GAVI commitment.
    - No indicator has been identified to measure 'Country readiness' in the short term and so this objective may only be measured in a future iteration.

- Given that some of these indicators are sub-optimal and reflect data available now, the PTT suggested using a pilot to cover the 2009 and potential 2010 rounds. In the longer term, GAVI could improve the mechanism in the by drawing upon new and better data expected to be available soon to more accurately measure the identified objectives (e.g. to measure country readiness).

4. Committee Consensus on Policy Guidance

- There was broad acknowledgement by PPC members on the importance and appropriateness of the proposed principles and objectives. However, PPC members stressed the importance of good communication around the prioritisation objectives and their measurement to ensure transparency and country participation.

- PPC members were comfortable with the emphasis placed on the health impact and value for money objectives and stressed the importance of considering both of them in the prioritisation mechanism.

- There was concern among some members that in the absence of a modelling approach, country-specific disease burden and cost-effectiveness might not be sufficiently taken into account. The PTT was encouraged to continue its analytical work on the applicability of a modelled approach to measure health impact and cost-effectiveness and compare the outputs of both options.

- PPC members were not comfortable with an approach to postpone a decision on the paused October 2009 proposals in order to spend more time to refine a prioritisation mechanism.
    - Additional delays funding decisions on the October 2009 proposals as this would risk undermining the Alliance's credibility.
    - Piloting a 'second best' prioritisation mechanism, albeit with the intention to review and strengthen said mechanism would resonate with GAVI's

philosophy to innovate and improve its processes as new evidence becomes available.

- PPC members were supportive of the idea that the proposed prioritisation framework would be considered as pilot for the short term. During this period, GAVI would integrate prioritisation within its operations such that the pilot would serve to signal a clear separation of IRC proposal recommendations from Board funding decisions. The pilot phase should be seen as a learning process which allows reviewing the mechanism and getting feedback from countries.

There being no other business, the meeting was adjourned.[3]

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Dr Gustavo Gonzalez-Canali, Chair

[3] NB: Ahead and after this teleconference, submissions from PPC members whom were unable to attend were passed onto the Committee and the Chair of Prioritisation Task Team (PTT).

Attachment A

Participants

Committee Members

- Gustavo Gonzalez-Canali, Chair
- Rama Lakshminarayanan, Prioritisation Task Team Chair
- Steve Landry
- Magid Al-Gunaid (in part)
- Anne Schuchat
- Mickey Chopra
- Susan McKinney

GAVI Secretariat

- Helen Evans
- Gian Gandhi
- Santiago Cornejo
- Stephen Nurse-Findlay
- Eliane Furrer

Regrets

- Suresh Jadhav
- Joan Awunyo-Akaba
- Olga Popova
- Paul Fife
- Jean-Marie Okwo-Bele
- Ashutosh Garg
- Nguyen Tran Hien
- Fidel Lopez-Alvarez (non-voting)
- David Salisbury (non-voting)