

FOR DECISION**GAVI Alliance Eligibility Policy****Background**

Since GAVI's inception, a simple metric has been used to define country eligibility: GNI per capita \leq \$1,000, initially using 1998 World Bank data. Within that overall eligibility, the Board decided that countries would need DTP3 coverage of at least 50% to access new vaccine support.

These policies have remained largely unchanged. GAVI revised the list of eligible countries only twice – it added Timor-Leste when it became an independent state in 2002, and it updated the list in 2004, using 2003 World Bank GNI per capita data. In 2006, GAVI decided to lift the DTP3 requirement for yellow fever mainly for programmatic reasons.

While the current policy has the strength of simplicity, it also has several weaknesses. Infrequent updates have resulted in many anomalies across countries. Some GAVI-eligible countries have experienced relatively rapid economic growth while others have stagnated. The income spread across GAVI-eligible countries has greatly widened and the highest income GAVI country is now better off than 23 GAVI-ineligible countries. Furthermore, the \$1,000 threshold has eroded greatly in real terms since its establishment in the year 2000. The current DTP3 filter employed to determine which countries can access NVS support (DTP3 coverage of 50% or higher) is now almost non-binding; i.e., all currently GAVI eligible countries except Somalia and Chad have coverage above 50%, according to the latest WHO/UNICEF coverage estimates for 2008. Finally, there are no policies to guide graduation, which has created uncertainty for, and potentially inhibited decision-making by, recipient countries.

The GAVI Board requested that the eligibility policy be reviewed and recommendations developed in 2009. The Programme and Policy Committee (PPC) took responsibility for developing a revised policy. The PPC appointed a time-limited task team¹ (known hereafter as the eligibility task team) to guide the analytical work, which was carried out by the Secretariat, with the support from the Results for Development Institute.

The review encompassed an assessment of the following:

1. metrics and threshold to define basic eligibility;
2. a process for future updates;
3. responsible management of the graduation process;
4. filters to determine which GAVI-eligible countries can apply for vaccine support;

This review did not include GAVI's co-financing policy, which will be reviewed separately in 2010. Definition and design of new or different types of financial and technical support that GAVI could offer countries were also not within the scope.

¹ The Eligibility task team was chaired by a World Bank expert and PPC member and made up of technical experts drawn from many of GAVI's constituencies (donors, WHO, technical institutes) as well as independent experts with an in-depth understanding of GAVI.

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The process

The analytical work, conducted between May and September, included assessment of the country eligibility criteria and graduation policies of 11 other international funding organisations. A summary of this assessment can be found in annex 2. It also included consultations with technical experts, 10 of GAVI's donors, 8 civil society organisations (CSOs), and 13 multinational and emerging WHO-prequalified vaccine manufacturers which currently provide 90% of the vaccine doses purchased by GAVI. Country consultations were conducted through the WHO Regional Committee Meetings as well as through GAVI's developing country Board Members. In addition, assessments of six countries were conducted: Albania, which became ineligible when the list was revised in 2004; Angola and Indonesia, which would likely become ineligible due to their increasing per capita GNI, and Guatemala, Morocco and the Philippines which are lower middle income countries that have never been eligible.

The eligibility task team met five times and the PPC was consulted three times during the process: at the outset to finalise the terms of reference for the consultants and the task team, subsequently to refine the scope of the analytical efforts and confirm the strategic objectives that should drive future eligibility policies, and at the end of the process to agree upon the recommendations to be taken forward for the Board's consideration.

Basic eligibility metric

Several possible indicators to determine GAVI eligibility were considered, including GNI per capita Atlas method, PPP-adjusted GNI per capita, poverty indicators, the United Nations Development Programme (UNDP) defined Human Development Index (HDI) and Human Poverty Index (HPI), under-five mortality rate (U5MR), DTP3 and measles containing vaccine (MCV) coverage, district-level DTP3 coverage, government spending on health, the share of public spending on health/routine immunisation from a country's own resources, and the World Bank's Country Policy and Institutional Assessment (CPIA) and IDA Resource Allocation Index (IRAI) - See annex 3.

GNI per capita is the most commonly used eligibility criterion among international funding organisations and the World Bank's Atlas method GNI per capita is almost always used over purchasing power parity (PPP) adjusted GNI per capita. The World Bank's GNI data are robust, comparable across countries, easy to understand and communicate, regularly updated, and publicly available. GNI per capita Atlas method was felt to be more readily understood by non-economists than PPP-adjusted GNI per capita and is therefore the more practical of the two measures for defining eligibility.

While poverty indicators are extremely important for monitoring and analytical purposes, no funding organisation uses them for eligibility decisions, most likely because of the lack of coverage issues—both lack coverage and lack of data in similar years.² Composite indices on the other hand, such as the CPIA, IDAI, HDI and HPI, were felt to be less transparent than individual indicators. They are composed of indicators that are not as relevant to GAVI's strategic objectives (e.g. adult literacy

² Only 18% of low income and 28% of lower-middle income countries have poverty indicators (e.g. population living on <\$1.25 per day; proportion of population within each income quintile) for any year since 2000.

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rate, fertility rate) and several of the measures used in such indices (e.g. adult literacy, probability of surviving, children under-weight, and poverty data) come from survey data from different years, making international country comparisons problematic for a given year. Finally, since many of these indices (including both the HDI and HPI) have standardised values for countries that fall between a specific range (e.g. 0 - 1.0), country values are relative and not absolute, making these criteria more difficult to use with absolute thresholds.

Tying GAVI support to measures of government spending on health, such as absolute public spending on health or the share of the national budget allocated to health, might penalise children/populations whose governments had skewed investment priorities, e.g. investing in defence at the expense of health. Finally, use of this indicator might not have the intended incentive effect, since health and/or immunisation officials are likely to be powerless to redress an imbalance among spending priorities.

Therefore, **the PPC recommends that GNI per capita Atlas method continue to be used as the indicator to define eligibility.**

Focusing on the poorest

At the June 2009 meeting, the PPC decided that **the primary driver of eligibility should be to focus on the poorest countries.** Focusing on the poorest countries enables GAVI to focus its efforts on those countries least able to pay, reach those countries that account for the majority of people living in poverty (see table 1), reduce disease burden (since poorer countries generally have higher burdens of diseases), and reduce mortality/contribute to MDG4 (since income and U5MR are strongly correlated).³

There was some debate around whether GAVI should focus its efforts not on the poorest countries, but the poorest people, implying that GAVI could provide support to poorer states or provinces in countries whose national income levels are higher. This idea was ultimately rejected mainly because it is inconsistent with the concept of fiscal federalism. In a federal-state system where states have responsibility for health services, it is the role of the federal government to offset the resource disadvantage of poorer states through intergovernmental transfers. There are also serious practical issues: insufficient data coverage of poverty indicators to identify the poorest people across all countries (see above) and there are no consistent data to define subnational eligibility.

Based on these issues and concerns, **the PPC recommends that subnational entities should not be separately considered for eligibility.**⁴

GAVI's financial situation and its bearing on eligibility

GAVI faces a significant resource mobilisation challenge to meet potential country demand for its portfolio of vaccines. At the Rotterdam Board Retreat in March 2009, the GAVI Board suggested considering more stringent eligibility programme filters and

³ Within the October 2009 PPC paper on eligibility, the Secretariat presented a mapping of the eligibility scenarios developed against the primary drivers identified by the PPC, and against other relevant GAVI Programme Funding Principles.

⁴ NB: Nothing prevents GAVI-eligible countries from focusing GAVI resources on particular states or regions, as both India and China have done so in the past. Since this kind of subnational support is already possible, it is not an eligibility issue per se.

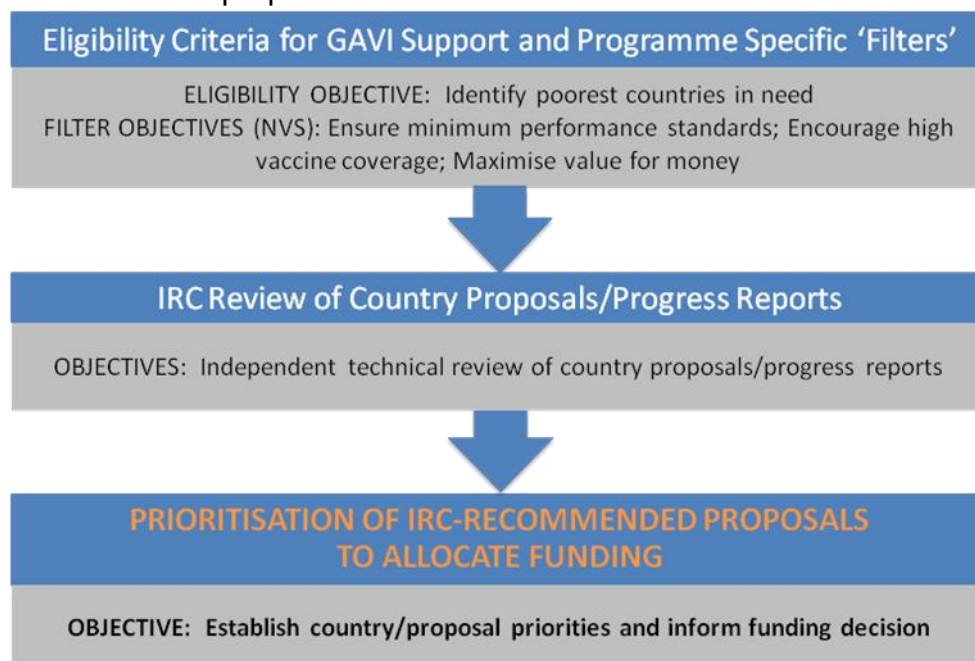
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perhaps higher co-financing to alleviate these pressures. In donor consultations related to this policy, many donors expressed a strong preference for focusing on the poorest countries. Given this backdrop, the PPC discussed in turn how GAVI's financial constraints should influence the eligibility options. The following points emerged from these discussions:

- There is much uncertainty surrounding medium- and long-term financial forecasts, particularly in terms of future revenues;
- Reducing the number of eligible countries may reduce GAVI's ability to mobilise resources;
- Splitting eligibility and resource allocation decisions would enable allocation decisions to take resource availability into account and to some extent would reduce the need to pursue severe contractionary options.

As a result of this discussion, the PPC agreed that overall eligibility criteria should determine which countries can apply for any kind of GAVI support, and programme filters should determine which GAVI-eligible countries can access vaccine GAVI support. They also noted that GAVI may wish to establish criteria to prioritise new IRC-recommended proposals and to inform funding allocation decisions separately from the eligibility policy (See Board doc #8, *Principles for Prioritisation*). This layered approach is illustrated in Figure 1 below:

Figure 1: Splitting eligibility, technical review of proposals and prioritisation of IRC-recommended proposals



Overall eligibility– choice of new thresholds:

Nine scenarios were considered for overall eligibility, including options that considered U5MR and DTP3 in addition to GNI per capita, but ultimately decided against using these additional indicators as eligibility criteria. Two preferred options were presented to the PPC, both of which use GNI per capita as the sole criterion; (i) GNI per capita \leq

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\$1,500; and (ii) GNI per capita \leq \$2,000⁵. In both scenarios, the threshold and the list of eligible countries would be updated annually, to account for inflation and changes in income. The PPC was unable to reach consensus on the two preferred options.

The status quo scenario is not considered a viable option, given the problems identified with the current policy (e.g. increasing disparities among countries), but it is included in the following table for comparison.

Table 1: Two proposed eligibility scenarios as compared to the status quo

Scenario threshold in 2011	Number of countries, 2011	Total Birth Cohort, 2011 [¥]	Percent Unimmunised children (2008 DTP3)	Share of World's Extreme Poor (<\$1.25/day)	Deaths averted 2011-2015**	Cases averted 2011-2015**	Cumulative GAVI vaccine programme costs [†]	
							2011-15	2011-20
Status quo	72	81.0m	86%	71%	4.99m	24m	\$4.79bn	\$10.11bn
GNI per capita \leq \$1,500	58*	74.4m	81%	77%	4.79m	22m	\$4.41bn	\$8.70bn
GNI per capita \leq \$2,000	65*	79.4m	82%	79%	5.01m	28m	\$4.63bn	\$9.11bn

* Estimate based on most recent World Bank data.

¥ UN Population Division projections

** GAVI estimate

† All NVS cost projections are in US dollars and are based on current demand and pricing projections for all GAVI-funded vaccines including the VIS portfolio (HPV, JE, Rubella and Typhoid) as of September 2009. The projections cover all eligible countries except for India, which has been excluded from most impact analyses because it will likely have a new budget cap of unknown size after 2011. (India's existing two-year commitment for pentavalent vaccine is included.). More details on these financial projections and associated sensitivity analyses are available on request.

The \$1,500 threshold is roughly equivalent to inflation adjustment of the current \$1,000 threshold, which was set in the year 2000. The finding that the \$1,500 scenario would result in a smaller share of the world's unimmunised children vis a vis the status quo is largely due to Indonesia's expected graduation; Indonesia accounts for about 4% of the world's unimmunised children. The vaccine industry consultations suggested that changes in the total GAVI birth cohort of this magnitude would probably not significantly affect price or supply.

The \$2,000⁶ threshold was selected as a round number for transparency (to avoid any appearance of favouring one country or another), while creating an option that maintains the size of the GAVI birth cohort (and thus the GAVI "market") roughly unchanged in 2011, at about 79 million. Although this raises the threshold, in real terms, by about 1/3 over its original level in the year 2000, it is worth noting that countries now face the challenge (and opportunity) of incorporating a considerably larger number of cost-effective vaccines into their immunisation programmes than when GAVI was first established. Potential immunisation costs are thus substantially

⁵ Alignment with the World Bank's Low Income Country Category upper threshold (\$975) was considered, but rejected, as being too contractionary in terms of the size of the GAVI birth cohort and the number of GAVI countries.

⁶ Alignment with the World Bank's Lower Middle Income Country Category upper threshold (\$3,855) was considered, but rejected, as being too expansionary given GAVI's resource constraints.

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higher, and more countries are likely to need assistance. Finally, the higher threshold of \$2,000 may improve GAVI's ability to mobilise resources.

The study team's estimates of vaccine impact (with India excluded) suggest that GAVI-funded vaccines would save about 220,000 more lives and avert 5.9 million more cases of disease between 2011 and 2015 if the eligibility threshold were set at \$2,000 as compared to if it were set at \$1,500.

The choice of the new eligibility threshold will depend on the Board's judgment as to whether to focus GAVI's expected resources on fewer countries, allowing these countries to introduce more vaccines more rapidly, or to spread them across more countries, with less rapid vaccine introductions. Another way to frame this is that the Board must weigh the benefits of reaching more children against the prospects of raising the necessary funds. Other considerations include of the impact of eligibility choices on the ability to mobilise resources, and the reaction of vaccine markets to a large versus more modest declines in the size of the GAVI market.

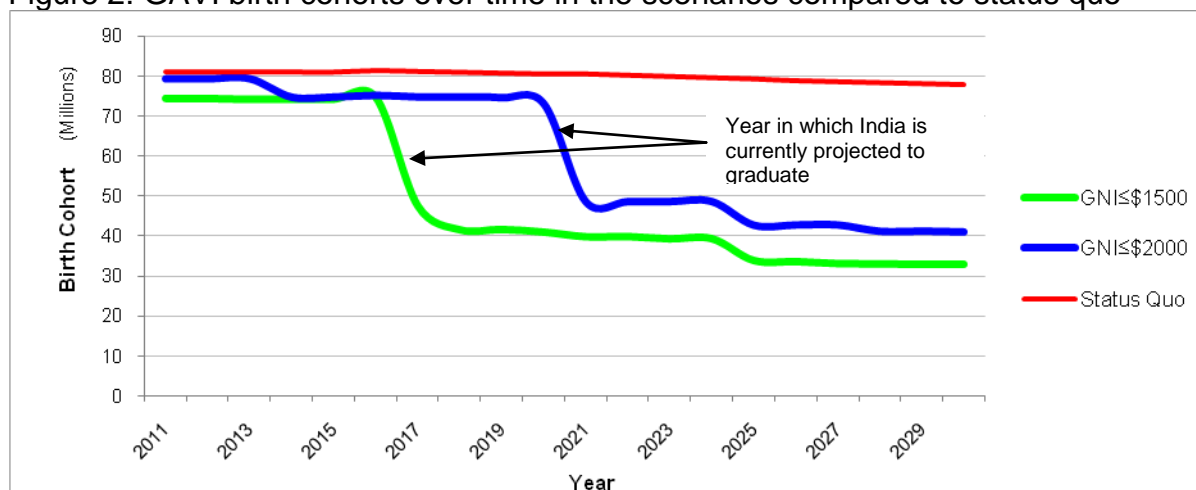
The PPC requests the Board to select either \$1,500 or \$2,000 as the threshold for the eligibility criteria.

Frequency of Updates

Rolling annual updates have the advantage of smoothing out the number of graduating countries over time, with an average of 1 country per year, instead of concentrating a large number in one year, as would be the case with updates every three or five years. In fact, most international funding organisation update and apply their eligibility threshold annually to adjust for inflation and economic growth in countries.

Simulations suggest that ten currently GAVI-eligible countries could lose eligibility in 2011 in the \$2,000 scenario, while three new countries could likely become eligible for GAVI support. As Figure 2 shows, the GAVI birth cohort would continue to fall after 2011, as some countries' incomes are projected to cross the threshold and graduated. In both the \$1,500 and \$2,000 scenarios, the most dramatic change to the GAVI birth cohort occurs when India graduates.

Figure 2: GAVI birth cohorts over time in the scenarios compared to status quo



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The rationale for annual updates and the operational implications have been discussed with the UNICEF Supply Division as well as vaccine manufacturers. UNICEF Supply Division would factor the implications of annual updates into demand forecasts. In the vaccine industry consultations, some manufacturers felt that annual updates could make demand less predictable. However, in further discussions, it was clarified that (i) GAVI will continue to make long-term predictable commitments; (ii) existing multi-year commitments will be honoured for graduating countries through 2015; (iii) graduation policies are being designed to maintain smoothness and predictability of demand⁷; (iv) annual updates smooth changes in demand compared to updates occurring once every 3-5 years. (v) Furthermore, it is assumed that most countries would continue to purchase vaccines after GAVI's support ends.

The PPC agreed that **the list of countries and the inflation-adjusted threshold for the GNI per capita scenarios would be updated on an annual basis.** The most recent World Bank GNI data would then be used to determine the list of eligible countries.

Programme filter for vaccine support:

At GAVI's inception, a 'programme filter' of DTP3 coverage $\geq 50\%$ was set to determine which GAVI-eligible countries could apply for new vaccine support. After the first year of operations, yellow fever vaccine applications were exempted from this filter on the grounds that the filter prevented yellow fever vaccine introduction in many of the highest-risk countries, which suffered frequent and costly epidemics. When the DTP3 filter was set at 50%, 21 countries⁸ were initially below the cut-off and thus ineligible for NVS funding. However, coverage improvements to reach the cut-off were fairly rapid in most countries (Table 2). Only Chad and Somalia still have DTP3 coverage below 50%. The current filter is therefore almost nonbinding and does not serve as an effective incentive to increase immunisation coverage.

Table 2. Countries and duration of exclusion from access to NVS due to DTP3 < 50% (Exclusion highlighted in grey)

Country	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Cambodia	49	59	60	54	69	85	82	80	82	91
Cameroon	48	53	58	63	73	73	80	81	82	84
Sudan	44	62	66	60	69	74	78	78	84	86
Timor-Leste	*	*	*	38	57	57	55	67	70	79
Djibouti	23	46	53	62	68	64	71	72	88	89
Mauritania	26	40	61	83	76	70	71	68	75	74
Burkina Faso	45	49	53	57	64	71	79	79	79	79
D.R. Congo	25	43	46	50	53	56	60	63	73	69
Guinea-Bissau	38	42	46	51	55	59	63	63	63	63
Mali	44	40	46	51	57	62	68	68	68	68
Sierra Leone	46	44	38	52	70	63	62	61	60	60
Afghanistan	35	31	44	48	54	66	76	77	83	85
Congo (the)	29	33	31	41	50	67	65	79	80	89
Haiti	43	45	46	48	50	51	53	53	53	53
Angola	21	31	42	47	46	59	47	44	83	81
C.A.R.	33	37	40	44	47	51	54	54	54	54

⁷ It is also assumed that most countries would continue to purchase vaccines after GAVI's support ends

⁸ including Timor Leste, when it joined GAVI later

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Guinea	43	45	46	46	49	51	68	71	75	66
Nigeria	23	24	24	25	35	44	54	54	54	54
Niger (the)	25	31	33	34	36	37	39	47	55	66
Chad	21	24	26	23	20	20	20	20	20	20
Somalia	36	33	33	40	40	30	35	35	39	31

* Timor-Leste is a new state that became GAVI-eligible in 2002.

Source: WHO/Coverage DTP3 coverage data for 1999 to 2008 as of 2008

NB: These may not reflect actual numbers published during a given year for a given country as WHO coverage data are sometimes adjusted retroactively.

Given the improving immunisation performance in so many GAVI countries, and the prospect of introducing more vaccines in the coming years, it makes sense to require a higher standard of performance in routine immunisation and to continue to encourage weak performers to improve immunisation coverage. A more stringent filter would ensure that countries achieve a minimum level of immunisation performance before introducing new, more expensive vaccines and thus enhance value for money. A higher coverage threshold would also push countries with weak immunisation performance to increase coverage. Since this will require greater efforts to include hard-to-reach groups, which tend to be poorer, a more stringent filter is likely to have equity benefits as well.

In deciding how much the filter should be raised, a number of factors were considered: (1) the WHO/UNICEF Global Immunisation and Vision and Strategy (GIVS) DTP3 goals to reach 90% DTP3 coverage; (2) evidence, although limited, of the positive relationship between introduction of new vaccines and DTP3 levels; (3) evidence that ISS support raised DTP3 levels, especially when DTP3 coverage was 65% or less; (4) the number of countries that would fall below the filter if it were set at different levels; and (5) the number that might be able to raise coverage levels above the filter fairly quickly with the incentive to do so and GAVI support.

After this review, **the PPC recommends that countries must have $\geq 70\%$ DTP3 coverage (WHO/UNICEF estimates) in order to apply for new vaccine support.**

Application of this filter would mean that 18 GAVI countries would not be able to apply for new vaccine support, according to 2008 DTP3 data⁹. Of these, 7 have DTP3 coverage between 65 and 69%, and five countries have coverage between 60% and 65%, and the remaining 6 are below 60%. Technical and/or financial support is likely to be needed to help the weaker performers achieve $\geq 70\%$ DTP3 coverage (different countries may require different types of approaches). As such, **the PPC recommends that GAVI explore strategies to provide enhanced technical and/or financial support to countries with DTP3 below 70%, with particular attention to the weakest performers.**

Epidemic Vaccines (Japanese Encephalitis, meningitis A and yellow fever)

Given that Japanese Encephalitis, meningitis A and yellow fever vaccines primarily target epidemic diseases, failing to introduce the vaccine in one country increases the

⁹ NB: 2009 DTP3 data, when available, would actually be used for the first year of the new policy

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risk to neighbouring countries.¹⁰ Moreover, these vaccines are or will be delivered in substantial part through immunisation campaigns, instead of or in addition to routine childhood immunisation. As a result, DTP3 coverage is probably not as relevant a predictor of success with these vaccines as it might be of vaccines that will be delivered primarily through routine immunisation. Thus, **the PPC recommends that the $\geq 70\%$ DTP3 filter should not apply to Japanese Encephalitis, meningitis A and yellow fever.**

India

The PPC recommends that subject to funding availability, a new budget cap be considered for India for the period 2012-2015 and then revisited thereafter. The level of the new budget cap will require further analysis. But on basic fairness grounds, the PPC recommends that no other country should receive support exceeding India's cap over the same time period. Thus the cap would be set at or above the amount of projected GAVI support for the GAVI eligible countries (other than India) expected to receive the most support in the absence of additional caps or other constraints. India's budget cap should be considered an upper limit, not a promise of support: other considerations, including the possible need to prioritise new proposals in times of constrained resources, may mean that actual support to India falls below the cap.

Implications for the pneumococcal vaccine pilot AMC

Changes in eligibility policy have implications for demand for pneumococcal vaccines from GAVI-eligible countries, and thus questions have been raised about an impact on the pneumococcal pilot AMC in two main aspects:

1. Since the allocation of shares of the AMC fund among participating firms is based on a peak demand of 200 million doses, there is a risk that the AMC fund will not be fully used if projected peak demand falls substantially below this benchmark.
2. Since in both scenarios demand falls, there is a risk that if vaccine manufacturers make 10-year supply commitments to meet peak demand there will be substantial excess supply in subsequent years.

Preliminary discussions with UNICEF Supply Division suggest that a change of this magnitude could probably be managed without serious consequences for the AMC, especially as these and other demand projections are subject to many other important sources of uncertainty.

One way to deal with a fall in projected demand from GAVI-eligible countries would be to allow graduated countries to continue to participate in some way in the AMC for some period after they become ineligible. For example, recently graduated countries could be required to finance the tail-price portion of the cost from their own resources. This would help these countries to continue pneumococcal conjugate vaccine programmes initiated with GAVI support while ensuring that doses available through AMC supply commitments could be used. Such an arrangement for pneumococcal conjugate vaccines specifically would also help to ease the challenges to the AMC mechanism posed by eligibility changes.

¹⁰ Although rubella is also an epidemic disease, the ETT does not recommend exempting this vaccine from the 70% filter because of the special risks posed by rubella immunisation when high coverage cannot be ensured.

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Under GAVI's current eligibility policies, NVS will represent between 60-70% of GAVI's annual expenditures for 2011-2015. Existing commitments account for the bulk of GAVI's projected expenditures in this time period. The two overall eligibility policy scenarios which the Board must select between would likely reduce GAVI's NVS expenditure projections by \$0.38bn or \$0.16bn respectively between 2011 (when the new eligibility policies are expected to take effect) and 2015, compared to continuing with the status quo. Therefore, the two eligibility scenarios would save 7% or 3% respectively on GAVI's total NVS expenditures between 2011 and 2015. These savings grow substantially after 2015.

Next steps

Following the Board decision, the GAVI Secretariat will plan for implementation of the new policy in 2011 (e.g. creating an operational manual). This will include extensive country consultations on implementation issues to take further account of countries perspectives on how the new policies are best made operational. GAVI will also work closely with UNICEF Supply Division and other technical partners to ensure new demand forecasts are revised to take account of eligibility policy changes.

ANNEX 1**GAVI Alliance Country Eligibility Policy***For Board consideration***1. Goal and scope**

- 1.1. This policy aims to create eligibility policies that are transparent, easy to understand and communicate, consistent with past operations, and support immunisation programme gains sustained to date
- 1.2. This policy covers basic eligibility, programme filters for accessing new vaccine support, and the process for future updates
- 1.3. This policy does not cover criteria for prioritisation and resource allocation

2. Principles

- 2.1. Eligibility policies focus GAVI support on the poorest countries
- 2.2. Programme filters are designed to (a) Ensure minimum performance standards; (b) Encourage high vaccine coverage; (c) Increase public health benefit per dollar invested

3. Definitions

- 3.1. GNI per capita atlas method: Gross national income (GNI) is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad. GNI per capita is GNI divided by mid-year population. GNI per capita in US dollars is converted using the World Bank Atlas method which smoothes exchange rate fluctuations by using a three year moving average, price-adjusted conversion factor.
- 3.2. DTP3 coverage estimates: Percentage of infants that received three doses of diphtheria, tetanus and pertussis (whooping cough) vaccine.
- 3.3. Eligibility threshold: Criteria set to determine which low and lower middle income countries are considered 'GAVI eligible', and which are either 'Graduated' and/or ineligible.
- 3.4. GAVI eligible countries: Countries whose GNI per capita are at least equal to or below the 'eligibility threshold'
- 3.5. Graduated countries: Previously 'GAVI eligible countries' whose GNI per capita exceeds the 'eligibility threshold' in the given year
- 3.6. Multi-year commitments: GAVI funding commitment covering the length of a country's comprehensive Multi-Year Plan (cMYP) or health sector plan – and extending up until 2015
- 3.7. Programme filters: Criteria set to determine which GAVI-eligible countries can apply for a particular type of support

4. Eligibility threshold

- 4.1. Countries with GNI per capita data of ≤[\$1,500 or \$2,000] are eligible for GAVI programme support.
- 4.2. Eligibility will not be considered for poorer states/provinces within higher income countries (i.e. no sub-national support for countries with GNI per capita above threshold).

ANNEX 1

5. Programme filters

- 5.1. Countries with DTP3 $\geq 70\%$ coverage are eligible to apply for new vaccine introduction support, except in the case of Japanese Encephalitis, meningitis A and yellow fever vaccines, for which GAVI sets no DTP3 coverage filters.
- 5.2. Cash based programs are not subject to a DTP3 threshold.

6. Timeline for implementation and updates

- 6.1. The new eligibility policy will apply in 2011 (based on 2010 World Bank GNI per capita data, released in July 2010).
- 6.2. The GNI per capita eligibility threshold will be adjusted annually for inflation.

7. Primary data sources

- 7.1. GNI per capita (Atlas method) from World Bank classifications
- 7.2. DTP3 coverage from WHO/UNICEF estimates
- 7.3. Eligibility threshold adjustment for annual inflation using World Bank deflators

ANNEX 2

Synthesis of Organisational Eligibility Policies

The Study Team reviewed the country eligibility criteria and graduation policies of 11 other international funding organisations to provide insights for GAVI's revision of its own policies: Asian Development Bank (ADB), African Development Bank (AfDB), Global Drug Facility (GDF), Global Environment Facility (GEF), The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), European Union (EU), Inter-American Development Bank (IDB), Millennium Challenge Corporation (MCC), United Nations Population Fund (UNFPA), The U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and the World Bank International Development Association (IDA) Credits. This short synthesis draws on detailed descriptions we prepared of these 11 organisations' practice, which are available upon request.

All organisations, except for PEPFAR and the European Union, use the GNI per capita (Atlas Method) as the criterion or one of the criteria for eligibility, with a defined threshold or income category classifications. Some organisations which consider low income and middle income countries for eligibility use the World Bank's classification (which is updated annually by the World Bank to keep the thresholds constant in real terms); others use an internally defined classification. Only the European Union uses purchasing power parity (PPP) GNI per capita instead of GNI per capita in the more traditional Atlas method to make country eligibility decisions (for its Structural Funds) within its member countries; some other organisations, including the World Bank, have considered using a PPP income indicator but ultimately decided to remain with the original GNI indicator. One reason for this is likely practical—the PPP income indicator and the Atlas income indicator result in fairly similar rankings across developing countries. Furthermore, GNI per capita (Atlas) is more readily understood by non-economists than GNI per capita in PPP terms. The nearly universal use of per capita income demonstrates the wide interest in using a country's general level of welfare/need in funding decisions. Poverty data are of much interest to many organisations, especially for monitoring progress at the country level and for analytical work, but there are practical problems with getting coverage across all, or nearly all, countries for similar points in time for their use in eligibility decisions. In addition to GNI per capita, some organisations such as the Global Fund and the Global Drug Facility have included a focus on vulnerable populations and disease burden in their criteria. In some cases where middle income countries can be eligible for funding, co-financing requirements are presented as part of eligibility criteria to ensure that these countries make a significant contribution towards their development program and that financing is more likely to be sustainable after the external support end.

The eligibility criteria are updated regularly, generally on an annual basis and in a transparent manner at many organisations, including the GFATM, AfDB, World Bank IDA credits, and the MCC. In the majority of cases, eligibility thresholds are updated annually to adjust for inflation. Most organisations also update the criteria in line with new application cycles. As needed, some organisations have revised their criteria to reflect changes in policy. For example, prior to Round 9, the GFATM changed its criteria for Upper Middle Income Countries (UMICs) so that "Small Island Economies" could be made eligible irrespective of their disease burden. The MCC can make changes to the list of country performance indicators it considers in its selection process and has made this process transparent.

ANNEX 3**Results from review of possible indicators**

Indicator / Indices / Measure	Description and Eligibility Task Team deliberations in context of broad eligibility criteria
GNI per capita Atlas method	Strongly correlated with poverty indicators and is viewed as the most robust measure of a country's general level of welfare/need. Also updated annually, widely available, simple and easy to communicate to countries.
The PPP-adjusted GNI per capita	Results in fairly similar rankings across low and lower-middle income countries as compared with the Atlas income indicator. The Atlas method measure is more readily understood by non-economists and is therefore the more practical of the two measures for defining eligibility. Also, nearly all funding organisations use the Atlas method.
Under five mortality rate	(e.g. U5MR>75 per 1,000 live births) could be used as a possible indicator to capture countries with a high child mortality and as a way to consider countries whose child health conditions are much worse than GNI per capita alone would suggest. Two of the nine scenarios considered the addition of U5MR but the ETT ultimately ruled these out. Updated yearly by UNICEF by September of each year. Point estimates also have confidence intervals.
WHO/UNICEF DTP3 and MCV coverage estimates	Data quality and the ability to manipulate estimates were seen as drawbacks but were deemed important for window filters to capture immunisation system performance. For measles coverage (MCV), there was some reluctance about pegging GAVI support to measles program performance which is largely outside of GAVI's control. Furthermore, while MCV ideally captures the health system's contact at the nine-month visit, it also includes campaign data.
District-level DTP3 coverage	(% of districts with >80% DTP3 coverage) was considered to measure geographic inequities but since it is only available as administrative estimates, data quality was again seen as an intractable problem. Potential for use as a filter instead.
Government spending on health	Considered as an indicator to encourage investment in health – However, tying GAVI support to this indicator might penalise children/populations whose governments had (skewed) investment priorities e.g. investing in defence at the expense of health. Furthermore, in these situations, MOH/immunisation officials are likely to be powerless to redress the balance among spending priorities so use of this indicator might not have the intended incentives effects.
Share of Routine Immunisation Financed by Government budget	Possible indicator of government commitment to immunisation. However, as new vaccines are adopted with GAVI support, the share of government commitment will inevitably decrease. Furthermore, mixed treatment in indicator of definition of "government budget".
Poverty indicators	(e.g. population living on <\$1.25 per day; proportion of population within each income quintile). Lack of coverage across countries in the same year makes these indicators difficult to employ to determine GAVI eligibility. Furthermore, GNI per capita is highly correlated with poverty indicators in low and lower middle income countries. No funding organisations have used poverty indicators for eligibility per se.
Human Development/ Poverty Indices	HDI/HPI provide UNDP-defined composite indicators of development/poverty but are based upon indicators related to other social services such as education). These indices were deemed to lack sufficient transparency for purpose of defining eligibility. Furthermore, their use of a relative scale is not suitable for a criteria designed to have a threshold.
Country Policy and Institutional Assessment (CPIA) or IRAI indicators	Were examined as performance indicators but were also deemed to lack sufficient transparency for purpose of defining eligibility.

ANNEX 4**Data sources and timing of updates**

	Indicator	Source	Timing
Broad Eligibility			
	GNI per capita (Atlas)	<p>World Bank (World Bank classifies all World Bank member countries, and all other economies with populations of more than 30,000 by income category).</p> <p>Non-member country states (such as Korea DPR) do not receive a point estimate but are classified as low income, lower middle income, or upper middle income. In addition, some member states do not have point estimates prepared because of data difficulties due to, for example, extreme economic turmoil or conflict. These countries are also only classified by category. For these countries, if the upper range of the category in which these countries are placed is below GAVI's threshold for that year, the country would be eligible. If the lower range of the category is above GAVI's threshold for that year, the country would be ineligible. If GAVI's threshold is within the category range, then GAVI will need an alternative point estimate.</p> <p>In this case, point estimates should be obtained from the UN Statistics Division's National Accounts Main Aggregates Database.</p>	<p>World Bank GNI per capita data are released in July for previous calendar year data. (World Bank may make data available on preliminary and confidential basis to GAVI at the end of May for initial review).</p> <p>The UN Statistic Division's site is updated every September to include data from the previous calendar year.</p>
Window Filters			
	DTP3 coverage for certain vaccines under NVS support and for cash-based windows	WHO website for WHO/UNICEF coverage estimates. Estimates are comprehensive but lacking for certain territories. Data are currently provided as a point estimate. If, in the future, data are provided as a range around the point estimate, then the point estimate should still be used.	WHO/UNICEF coverage estimates are released in July/August for previous calendar year data.
Inflator			
	Eligibility Threshold adjustment	Each year the World Bank adjusts its income category thresholds (low income, lower middle income, upper middle Income, high income) using an inflation adjustment in order to keep the categories constant in real terms. GAVI should use the same inflator that the World Bank uses for these adjustments.	World Bank releases in July each year.