

Allocation Mechanism for COVAX Facility Vaccines

Explainer for countries based on commonly asked questions

November 2020

Purpose of this document

This document aims to explain how COVAX vaccines will be allocated amongst participants.

It is:

- A simple explanation of the guiding principles underpinning the allocation of COVAX vaccines.
- A view on a process which is under development and subject to change as more information becomes available.
- A focused view on the allocation of vaccines.

It is not:

- An exhaustive description of how the allocation of vaccines will be carried out.
- A static view of exactly how the allocation mechanism will operate.
- A full explainer covering all aspects of COVAX (e.g., procurement, country delivery etc.).

Table of Contents

Allocation Phase 1	3
1) What is the difference between Allocation Phase 1 and Phase 2?	3
2) During phase 1, the so-called proportional allocation phase, how will the vaccine doses be allocated? How many vaccines will each participating country get?	4
Allocation Phase 2	5
3) During phase 2, the so-called weighted allocation phase, how will the vaccine doses be allocated? How many vaccines will each participating country get?	5
4) How will vulnerability and threat be assessed in practice?	6
5) If a country scores low in vulnerability and threat during phase 2, does this mean that the country would get no vaccine?	7
6) How can countries predict and prepare for the doses that they will get on phase 2 if the proposal is that the allocation may vary based on threat and vulnerability?	7
Allocation of Multiple Products	9
7) What will happen if there is more than one vaccine to allocate?	9
8) How will country preferences be accounted for?	9
Governance	10
9) How will the Allocation Mechanism for vaccines be governed?	10
Prioritisation	11
10) What is the relationship between the Allocation Mechanism and SAGE recommendations on immunization?	11
Humanitarian Buffer	11
11) What is the objective of the humanitarian buffer?	11

Questions and Answers
How will the Vaccine Allocation work in practice?

Allocation Phase 1

1) What is the difference between Allocation Phase 1 and Phase 2?

Phase 1: Proportional allocation up to 20% of total population

Countries receive doses proportionally to their total population given the ubiquity of the threat:

Countries progressively receive doses until all countries reach 20% of their total population (or less if they so requested).

The rate at which countries receive vaccines depends on country readiness and the availability of doses (not on threat and vulnerability).

The allocation moves on to phase 2 once all countries have reached 20% coverage (or less if they so requested).

Phase 2 may start ahead of this if available doses are unable to be allocated to some participants due to lack of readiness, funding or territory issues. However, these participants would be prioritised to get to their requested coverage as soon as possible.

Phase 2: Weighted allocation beyond 20% (if supply severely constrained¹)

Countries receive doses at variable rates, based on consideration of vulnerability and COVID-19 threat:

In the case of a severely constrained supply, the timing of country shipments would be based on a risk assessment based on Threat and Vulnerability.

Countries with a higher risk would receive the doses they need faster than others, although all countries will receive some doses in each allocation round².

Threats and Vulnerabilities will be based on metrics defined closer to the end of phase 1, potentially related to the country's vulnerability to severe disease and its healthcare system.

All countries will receive the total doses they have requested as rapidly as possible in phase 2.

¹ The criteria to establish whether supply is severely constrained will be communicated at a later date.

² An allocation round is when new volumes are made available by manufacturers for allocation to countries through global access mechanisms, and procurement and distribution are set up to deliver the products to countries.

2) During phase 1, the so-called proportional allocation phase, how will the vaccine doses be allocated? How many vaccines will each participating country get?

The quantity of vaccines received in phase 1 will be 20% of each participating country's total population, or the coverage percentage that participants have requested (whichever is lower).

The rate at which countries receive vaccines will be such that all countries will achieve the same coverage at the same time where possible³.

The allocation moves on to phase 2 once all countries have reached 20% coverage (or less if they so requested). Phase 2 may start ahead of this if available doses are unable to be allocated due to lack of readiness, funding or territory issues.

An example of how allocation phase 1 may look in practice given different coverage requests is illustrated in Exhibit 1.

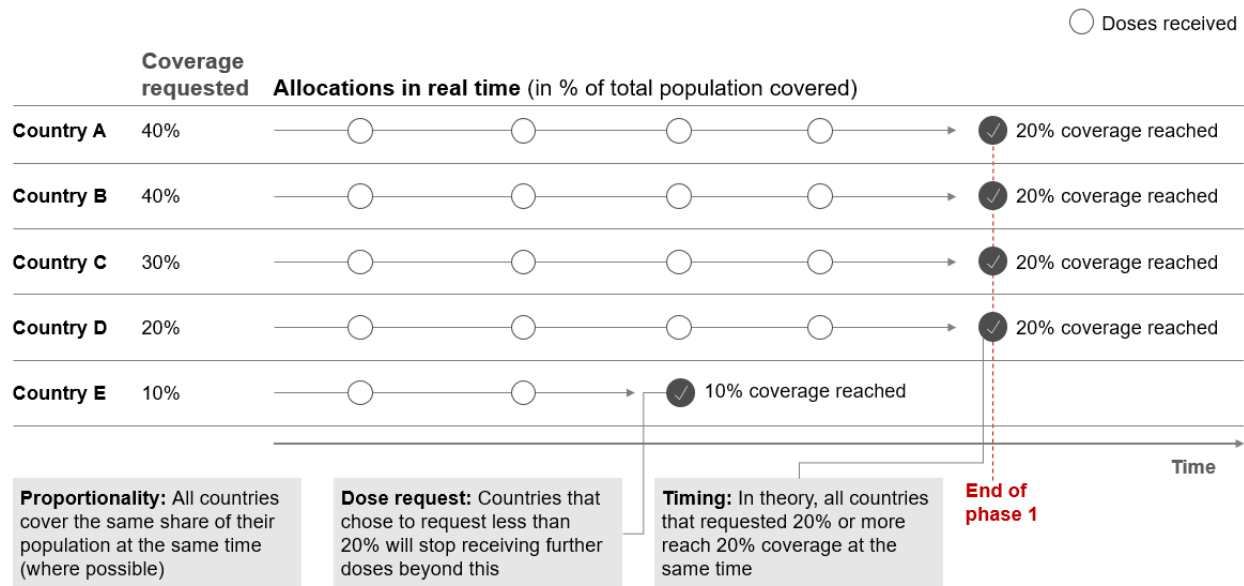


Exhibit 1: Example for multiple rounds of allocation with increasing supply

³ Some exceptions could be made where this is not practical (e.g., small countries where shipping doses to cover a low percentage of the population would not be logistically practical)

Allocation Phase 2

3) During phase 2, the so-called weighted allocation phase, how will the vaccine doses be allocated? How many vaccines will each participating country get?

The quantity of vaccines in phase 2 is based on the coverage percentage participants have requested beyond the initial 20%.

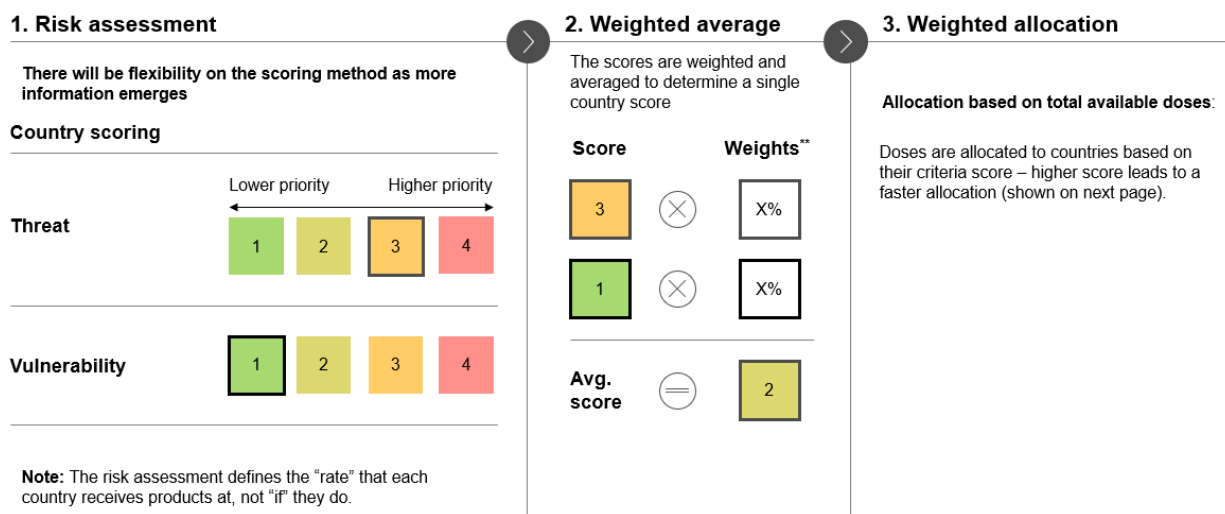
If there is no severe supply constraint, the rate at which participants receive vaccines is such that all countries will achieve the same coverage at the same time (up to their requested coverage) where possible (as in phase 1)³.

If there is a severe supply constraint¹, the rate at which participants receive vaccines will be adjusted based on an assessment of participant risk (threat and vulnerability);

- Participants with a higher risk rating will receive their doses relatively faster, but all countries will receive the total doses they have requested to access by the end of phase 2.
- At this stage, any delay in receiving doses for participants with a lower risk is imagined to be a matter of weeks rather than months.

Participants' risk assessment scores will be weighted and averaged to determine a single score. This score will inform each participant's rate of allocation in phase 2. This process is detailed in Exhibit 2.

Details of the criteria and their weighting is under development, though potential criteria are described in Table 1. More details will be released as they emerge.



** Details of each criteria and their weighting of each is under development. More details will be released as more details emerge.

Exhibit 2: Phase 2 - weighted allocation system (in the case of severely constrained supply)

An example of how allocation phase 2 may look in practice given different coverage requests and risk assessment scores is illustrated in Exhibit 3.

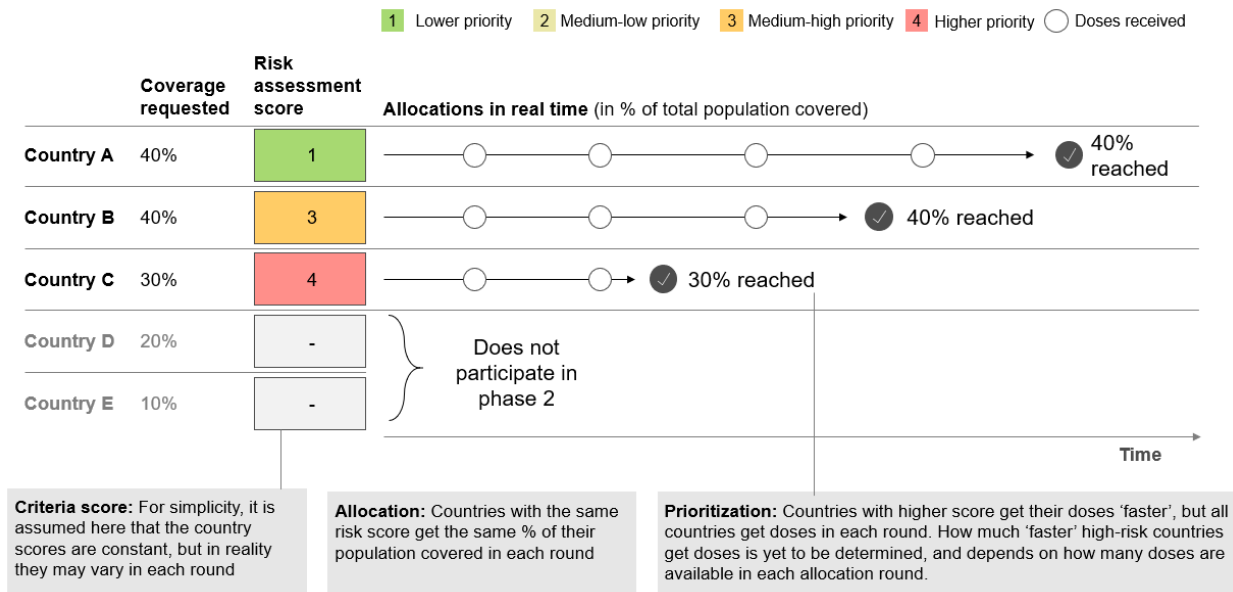


Exhibit 3: Example of weighted allocation under conditions of severely constrained supply

4) How will vulnerability and threat be assessed in practice?

Several potential parameters could be used to assess threat and vulnerability for countries. These are described in Table 1: Potential parameters to assess threat and vulnerability. The parameters will be reviewed closer to phase 2 as more information regarding the pandemic comes to light.

The numerical assessment will need to be accompanied by a qualitative assessment to make sure country context is considered.

Table 1: Potential parameters to assess threat and vulnerability

Criteria	Parameter	Reason for using
Threat	Effective reproductive number R_t and its trend	Indication of the current state and dynamic of the of the pandemic in a country (average number of secondary cases per primary case over time). Could be replaced or supplemented by other epidemiological parameters to interpret the dynamic of the epidemic in the country.
	Hemisphere location	Other respiratory viruses such as seasonal influenza will i) impact health systems functions and ii) increase the risk profile of target COVID-19 population groups Could be replaced or supplemented by other parameters indicating concomitant threats.
Vulnerability	UHC service coverage index	Combines several indicators of service coverage and health system vulnerability into one.
	Health system saturation	Indication of whether the country's health system is saturated, informed by metric such as % occupancy of hospital beds and % occupancy of ICU beds.
	High risk groups	Indication of what proportion of the population is at higher risk of severe disease.

Each country is given an overall risk score based on a weighted average of the parameter scores. This process is illustrated in Exhibit 4. The weighting used to generate an overall score is under development.

		1 Highest priority	2 Medium-high priority	3 Medium-low priority	4 Low priority	
Criteria	Parameter	Score		Weights		Overall score
Threat	Estimated Rt	1	⊗	X%		} 2
	Estimated trend in Rt over time	2	⊗	X%		
	Hemisphere location	4	⊗	X%		
Vulnerability	UHC service coverage index	3	⊗	X%		
	Health System saturation	1	⊗	X%		
	High risk groups	2	⊗	X%		

Exhibit 4: Potential risk scores based on sum of potential weighted parameter scores

The numerical risk assessment will need to be accompanied by a qualitative assessment to make sure country context is considered. The overall risk score will then inform each participants' rate of allocation in phase 2, as outlined in Exhibit 2.

5) If a country scores low in vulnerability and threat during phase 2, does this mean that the country would get no vaccine?

No, every country will get the vaccines they have requested through the COVAX Facility (provided supply and funds are available).

The score in the risk assessment will determine the rate at which countries will receive the doses, with countries with a higher risk assessment receiving doses at a faster rate than the others. The risk assessment defines only the *rate* at which countries obtain access to vaccines, not whether they do. Risk assessments will be conducted ahead of each allocation round.

6) How can countries predict and prepare for the doses that they will get in phase 2 if the proposal is that the allocation may vary based on threat and vulnerability?

The total amount of doses allocated in phase 2 will correspond to the amount requested by each country (minus the 20% already allocated in phase 1), provided funds are available.

Countries will know upfront the total number of doses they will receive and will be able to plan for the deployment of the vaccine to their populations.

As much as possible, the allocation rounds will be determined and communicated by COVAX well ahead of deployment to provide enough time for countries to prepare for each round.

In phase 2, supply from manufacturers will be more predictable than in phase 1, and there will be better visibility on what countries will receive.

Based on likely supply scenarios, the impact of threat and vulnerability on the timing at which a country receives doses in phase 2 is in the order of weeks rather than months.

Allocation of Multiple Products

7) What will happen if there is more than one vaccine to allocate?

Participants under the Optional Purchase Arrangement will receive options to purchase their pro rata share of each vaccine.

- These participants will be able to opt-out of certain vaccines.
- The Pro Rata Share is calculated by dividing the estimated number of doses required (the Total Participant Doses) by the total number of doses that the Facility intends to procure based on demand from all Participants (the Total Facility Doses).

For other participants, the allocation will strive to allocate products as soon as possible while accounting for:

- Country preferences based on product characteristics.
- Country readiness.

8) How will country preferences be accounted for?

Participants will be invited to express their preferences regarding the characteristics of the product they are allocated.

The allocation will strive to accommodate country preferences wherever possible, so that the products they are allocated match their preferred characteristics. However, it may not be possible to accommodate these at all times.

Governance

9) How will the Allocation Mechanism for vaccines be governed?

Two new bodies are directly involved in the Allocation of COVAX Facility Vaccines:

- The Independent Allocation Validation Group (IAVG).
- The Joint Allocation Taskforce (JAT).

These bodies will operate in tandem with the COVAX Facility governance.

9.1 Allocation governance structure

The JAT will receive relevant inputs from the Office of the COVAX Facility, WHO Allocation Unit, procurement agencies (UNICEF SD, PAHO RF, etc.), and participants. The JAT will prepare Vaccine Allocation Decision (VAD) proposals based on the allocation model, which would then be passed on to the IAVG.

The IAVG would then validate this proposal ensuring it is technically informed and free from conflict of interest. The validated VAD would then be passed on to the COVAX Facility, procurement agencies and self-procuring countries in order to be implemented.

This process is illustrated in Exhibit 5.

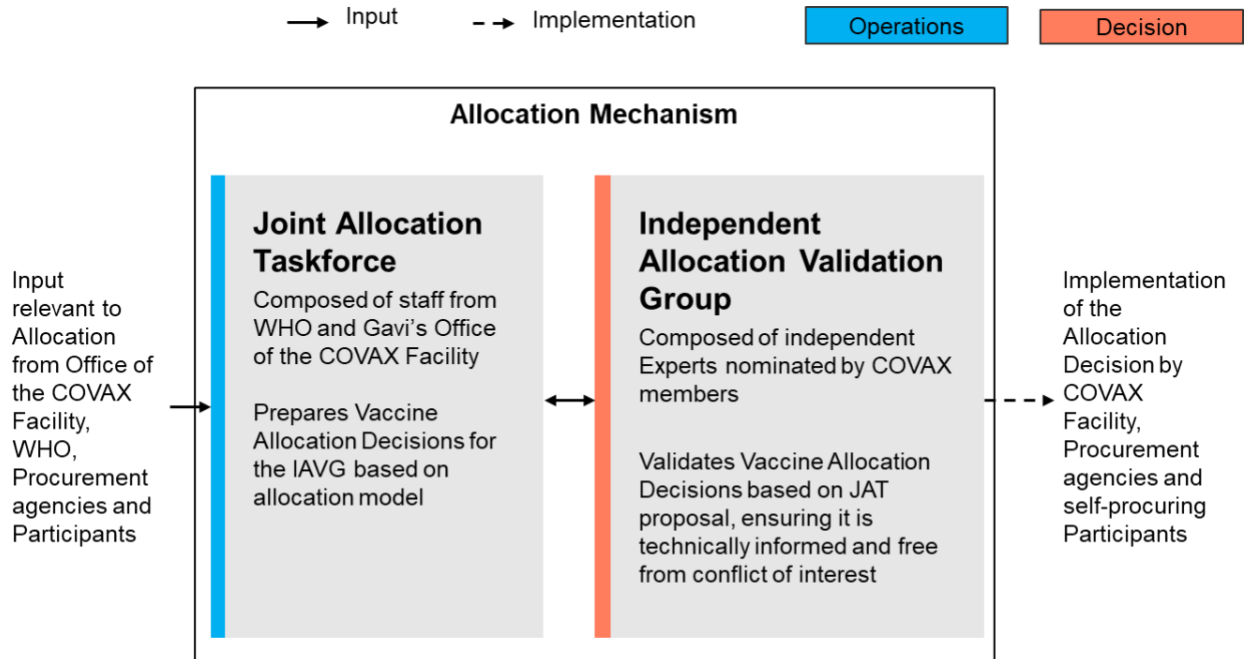


Exhibit 5: Allocation Governance Structure

Prioritisation

10) What is the relationship between the Allocation Mechanism and SAGE recommendations on immunization?

The Allocation Mechanism indicates how vaccines should be allocated *among* participants of the COVAX Facility.

The WHO SAGE recommendations advise on how vaccines could be used *within* countries, prioritising target populations based on context.

The Allocation Mechanism does not decide on behalf of countries which populations should be prioritised for immunization.

Humanitarian Buffer

11) What is the objective of the humanitarian buffer?

Given that some populations will not be covered by the global allocation of vaccines, there is a risk of an equity gap.

The objective of the humanitarian buffer is to cover populations that may not be covered through the main allocation mechanism for vaccines. Under this objective, potential populations to cover could include refugees, Internally Displaced People, asylum seekers etc.

The volume of this buffer would be 5% of the volumes supplied by the COVAX Facility (e.g., 100 million doses by end of 2021).

A technical working group has been convened to further detail the details of this buffer.