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ODA eligibility of COVID-19 related activities

In follow-up to the discussions at the WP-STAT March 2021 meeting, the Secretariat has assessed the eligibility of the ACT-A Health Systems Connector pillar, and has investigated the possibility of valuing the donation of vaccine doses to developing countries.

The note is presented for discussion under item 7 of the draft annotated agenda. Members are invited to share their comments **by 25 June 2021**.

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ODA-eligibility of COVID-19 related activities

1. This note provides an update on ODA-eligibility of COVID-19 related activities. It presents an assessment of the eligibility of the COVID-19 Health Systems Connector (section I) and includes a proposal for counting the donation/sharing of vaccines to developing countries (section II). It also outlines next steps (III) and presents a summary of the workshop held with health experts on 3 June 2021.
2. **Members are invited to share their comments by 25 June 2021.**

I. ODA-eligibility assessment of the ACT-A “Health systems connector”

3. The WP-STAT has previously assessed three pillars of the Access to COVID-19 tools – Accelerator (ACT – Accelerator): the vaccine, diagnostics and therapeutics pillars, see the FAQs on line at https://www.oecd.org/dac/financing-sustainable-development/ODA-eligibility_%20of_COVID-19_related_activities_final.pdf. The “Health Systems Connector” (HSC) is a transversal pillar of the ACT-Accelerator and is co-convened by the Global Fund, the World Bank and WHO, with support from the Global Financing Facility for Women, Children and Adolescents (GFF). It aims to rapidly identify and address country-specific health systems bottlenecks to ensure readiness and enable rapid scale up and delivery of COVID-19 tools. It also seeks to accelerate availability and use of Personal Protective Equipment (PPE) and medical oxygen as crucial tools for protecting health workers and ensuring the resilience of the health system in LICs and LMICs¹. The HSC requires a total of USD 9.5 billion. The investment case as of 10 September 2020 was presented as follows:

- **Critical health systems enablers: USD 500 million**

The funding is needed to strengthen the COVID-19 response by addressing health system needs such as health workforce; data systems; public financial management; community responses and engagement, among others. Health system strengthening efforts are country specific, and the support through the Health Systems Connector will be implemented on a country-by-country basis. The adequate resourcing of those enablers is critical, through domestic, bilateral and multilateral financing.

- **Calculation of commodities: USD 9 billion (including USD 500 million for Innovation, Training, Policy, Guidance and Management Systems)**

The total costs of commodities is estimated at USD 15.8 billion. The assumption is that USD 6.8 billion will be covered by domestic resources, using the same assumptions as the Therapeutics Pillar, namely that the share assumed to be covered by domestic financing would be 80% for UMICs, 40% for LMICs and 0% for LICs. Estimates of the amounts needed solely for PPE and oxygen are based on the WHO’s costing model used to estimate a price tag for the response in developing countries. The number of health workers needed is estimated from WHO’s Health Workforce Estimator tool, and the overall costing tool accounts for constraints on the health worker and hospital bed supply. For oxygen, the resource needs estimate is calculated from the total need of severe and critical COVID-19 patients only, not taking into account the constraints of shortage

¹ <https://www.who.int/publications/m/item/urgent-priorities-financing-requirements-at-10-november-2020>

of health workers and lack of hospital beds at country level which will require additional investments for the oxygen to be used. Included are the costs of procuring and delivering portable oxygen concentrators, cylinders and pressure swing adsorption (PSA) plants with some limited operating costs and considering system constraints including the number of hospital beds and the number of health workers.

4. The detailed deliverables for the HSC can be found in the table 1 below.

Table 1: ACT-A Health Systems Connector deliverables

<i>In USD million</i>	Main deliverables	Target
Innovation & capacity building	Innovation, training, and management systems	50
	Innovation, training and management for O ₂	50
	Infection prevention and control (IPC) for health facilities	102
	Supply chain	198
	Global coordination costs	189
	Community response	100
	Clinical care	211
Delivery & Impact	Basic and full PPE procurement	6900
	O ₂ procurement	1600
	Total	9500

5. The investments made by ACT-Accelerator into strengthening health systems infrastructure and service delivery in LICs and LMICs will have positive long-term implications for global health (e.g. protecting the gains of recent decades in key diseases such as Tuberculosis). Indirectly, this will also benefit all countries, as inequalities reduce, future global health threats can be better managed.²

6. Although strengthening health systems and service delivery in LICs and LMICs will eventually benefit all countries, **the primary focus of the Health Systems Connector pillar of the ACT-Accelerator is on LMICs and LICs. It aims to support low- and middle-income countries to build the required capacity and support health systems to deploy new tools effectively and efficiently when available. Consequently, 100% of contributions to the Health Systems Connector pillar can be reported as ODA.** This case will be added to the FAQs online.

² https://www.who.int/docs/default-source/coronaviruse/act-accelerator/status-report-plan-final-v2.pdf?sfvrsn=ee8f682b_4

II. ODA-eligibility of the distribution of vaccines to developing countries

7. As of 9 June 2021, according to the UNICEF [COVID-19 Vaccine Market Dashboard](#), over 81 million of doses have been donated between countries/groups (this figure includes donations to developed countries as well). For example, France became the first country to donate doses of COVID-19 vaccines from its domestic supply to COVAX, with an initial commitment of 500 000 doses. Other DAC members that donated doses to developing countries include Australia, Japan, New Zealand, Portugal, and the United States.

8. During the workshop held on 3 June 2021 on ODA and COVID-19 (see summary in Annex), the question of whether and how to account in ODA the donation/dose sharing of vaccines to developing countries was discussed. The dominant view among participants to the workshop was the need to avoid overvaluing the cost of donations in ODA. Although all participants lauded the donor community for transferring their doses to developing countries, several expressed the view that these actions should not necessarily count as ODA, in particular because it was an ex post decision by the donors, with no original intent to benefit developing countries, but to protect themselves by ensuring access to enough doses for their population. In addition, there was a risk of diverting and inflating ODA.

9. Ordering and shipping vaccine doses for the specific use by developing countries would count as ODA. Donors' donation of excess vaccine doses could also be considered as a form of aid in kind, and on the basis of the Reporting Directives³, it would seem legitimate for members to include the related costs in their ODA.

10. Given the concerns raised on the risk of ODA inflation and of creating perverse incentives in counting donations in ODA, the recommendation during the workshop was to follow a careful and conservative approach in valuing the donations. The Reporting Directives instruct to use the market price for the calculation, where possible. This price would be difficult to determine, given that:

- The market for COVID-19 vaccines is complex, with different prices for different vaccines by different manufacturers.
- Prices are not all known to the public (given confidentiality restrictions from the part of manufacturers) and there are tier-pricing systems by some manufacturers, depending on the income status of the buying country.
- The dashboard illustrates that the market price range is large and the price is different when doses are distributed through COVAX or through bilateral agreements. The COVAX AMC price of USD 3 per dose reflects their ceiling price. As for the publicly reported prices for COVID-19 vaccines, the average price is at USD 13.12 per dose with high variability across products, suppliers and buyers. This is not considering the prices reported for private markets. The reported vaccine price per dose ranges from USD 1 to USD 40.

11. The market price is different when doses are distributed through COVAX or through bilateral agreements, but applying such a differentiation in calculating ODA could create negative incentives to use the multilateral system. Also, it would not reflect the reality in the field (developing countries would in any case receive the same number of doses, whatever the price used for the ODA calculation). Considering all elements, **the Secretariat recommends to value donations of vaccines in ODA by applying the**

³ The Directives indicate (see paragraph 174) that "Aid in kind, including food aid, should where possible be valued at prevailing international or national market prices for the goods in question at the time of the transfer. Where this information is not available, the amount reported should be calculated on the basis of the price paid by the official sector for the purpose of acquiring the goods for shipment to the recipient country.)"

price used by COVAX AMC i.e. USD 3 per dose⁴. Several participants in the workshop considered that, if it was decided to count donations in ODA, this price should be used as it was the lowest price available. The case of vaccine donations/sharing will be included in the FAQs.

III. Next steps

12. As regards members' preliminary reporting on 2020 ODA data, to the knowledge of the Secretariat, all members but one applied a 53% coefficient to their earmarked contributions to CEPI for its COVID-19 related work, as advised by the Secretariat (see FAQ 8 [here](#)).

13. The workshop provided useful insights on CEPI's work (see summary in Annex). While some participants were convinced that CEPI's work on R&D should count 100% in ODA, others were more sceptical given the global public good nature of the vaccines developed and the fact that, in practice, developing countries are still struggling to obtain doses. When assessing the ODA-eligible share for 2021 later this year (review planned for end 2021), the Secretariat will look into the details of the partnership agreements reached by CEPI, and the way they ensure that the investments address challenges specific to the partner countries. As indicated earlier⁵, it will also look at the updated figures for the allocation of doses to AMC versus non-AMC countries.

⁴ If COVAX changes its practice in future, the valuation of donations in ODA will need to be adjusted accordingly.

⁵ See DCD/DAC/STAT(2021)6.

Annex. Summary of the WP-STAT workshop held with experts on “Tracking R&D funding for COVID-19 in ODA”

As suggested by a member at the last WP-STAT meeting in March 2021, the Secretariat organised a workshop with health experts, economists and epidemiologists to discuss the ODA-eligibility of R&D and COVID-19 activities. The objective of the workshop was to draw on the knowledge of experts to inform the assessment of the ODA-eligibility of R&D for COVID-19 vaccines, therapeutics and diagnostics. Another topical question was how to count in ODA support to developing countries provided in kind, e.g. donation of vaccine doses.

20 experts from WHO, CEPI, OECD (experts on health of the Directorate for Employment, Labour and Social Affairs), the Bill and Melinda Gates Foundation, Gavi, UNICEF, think tanks and CSOs participated in the workshop. A high-level guest from WHO, Dr. Bruce Aylward, Senior Advisor to the Director-General of WHO and ACT- Accelerator Hub Lead, also participated in the discussion.

In the first session on Research and Development, the Secretariat described its assessment of the ODA-eligibility of CEPI’s work on R&D for a COVID-19 vaccine within COVAX. A successful vaccine will be a global public good (GPG), benefitting both developed and developing countries. At the same time, CEPI is a key enabler to secure that developing countries are not left behind. In line with the treatment of GPGs in ODA, only the share of contributions targeting developing countries should be counted in ODA. The ODA-eligible share for 2020 has been assessed based on the number of doses distributed to developing countries through the COVAX AMC facility out of the total number of doses (53%).

CEPI presented its role in COVAX in more detail. The key point in CEPI’s presentation was that their intent is to ensure equitable access to vaccines for developing countries (UMICs, LMICs, and LICs). The overarching principle in CEPI’s partnering agreements with pharmaceutical companies is that all manufacturing output corresponding to the CEPI-funded part of development are to be offered first to the COVAX Facility (this is the right of first refusal). Equitable access provisions are included in the partnering agreements.⁶ Beyond the ignition phase, CEPI can only fund research when it can secure the equitable access conditions (e.g. CEPI could not fund Moderna beyond the ignition phase for that reason). The vaccine target product profiles (TPPs) are designed with developing countries specific characteristics in mind.

After the presentations, the floor was opened to a discussion by experts on the following questions:

- 1) Is it possible to assert, conceptually, that R&D for COVID-19 vaccines, therapeutics and diagnostics have the economic development and welfare of developing countries as its primary objective?
- 2) If so, how could this primary objective be verified?
- 3) What mechanisms are put in place to ensure this primary objective is pursued?

Participants made insightful contributions to this debate that will be used by the WP-STAT in next steps of its work, in particular when assessing the ODA-eligible share of CEPI’s work for 2021:

⁶ <https://cepi.net/wp-content/uploads/2020/12/Enabling-equitable-access-to-COVID19-vaccines-v4-18Mar2021.pdf>

- **More investment in health is needed in this period**, and it is positive that a share of CEPI's work is recognised in ODA. More resources, also beyond ODA are needed too and should be better valorised.
- The COVID-19 crisis has a huge impact on developing countries that have limited ability to conduct research. There is an urgency to pursue R&D efforts to face emerging COVID-19 variants.
- **It would be possible to conceive COVID-19 research targeted specifically to partner countries** (e.g. heat stable formulations, delivery methods better adjusted to local logistic challenges), but this can be determined only on a case-by-case basis. If the focus on developing countries is reflected in budgets, an ODA coefficient can be calculated.
- **While some participants were convinced that CEPI's work on R&D should count 100% in ODA, others were more sceptical:**
 - **Some thought CEPI's work complies fully with the ODA definition. Every investment in CEPI has been assessed based on the criteria of speed, scale and access.** CEPI did not look at the vaccine as a GPG, but strived to develop a product that would meet the specific requirements of developing countries. As regards the metrics used by the Secretariat to assess the ODA-eligible share, i.e. the number of doses allocated to AMC versus non-AMC countries, it was noted that the proportion had changed since the inception of COVAX, and that in 2021 the share reaches 87% on that basis.
 - **Others emphasised the need for mechanisms to ensure that developing countries are indeed primarily benefitting from the investment for R&D, beyond intention.** The intent in the case of CEPI could be qualified as mixed, given that, despite the focus on developing countries, funds contributed to a system that largely benefitted developed countries so far; the COVAX Facility itself benefitted some developed countries. Also, although developing countries are part of trials for vaccine development, the location of trials may not be sufficient to demonstrate a primary objective to benefit these countries, which are still struggling to obtain vaccines for their populations.
- The Secretariat explained that the rules on ODA accounting were quite rigid, and that GPGs were not reflected in ODA unless there was a means to assess their contribution to developing countries. The TPPs described by CEPI justified counting at least a share of CEPI's work in ODA. The Secretariat would propose an updated metric to make the calculation of the share in 2021.
- **In wrapping up the session, the Chair recalled the accountability requirement that goes with ODA reporting. The details of the partnership agreements reached by CEPI, and the way they ensure that the investments will address challenges specific to the partner countries, should be verifiable and withstand public scrutiny.**

The second session was on the valuation of donation of vaccine doses. After a brief introduction of the topic by the Secretariat, UNICEF presented its [COVID-19Vaccine MarketDashboard](#) that includes valuable information on vaccine donations (through bilateral agreements and COVAX) and prices. The participants were then invited to discuss the following questions:

- 1) How can the contribution of leftover vaccine doses to developing countries (through COVAX or bilateral agreements) be valued in ODA?
 - Using prevailing international or national market prices? (what source?) or
 - Price paid by the official sector for the purpose of acquiring the doses in the first place? (e.g. contribution to COVAX)

The dominant view among participants was the need to not overvalue the cost of donations in ODA. The inputs will allow the WP-STAT to have a better-informed discussion on this topic in its forthcoming meeting.

- **Should it count as ODA?**
A few members recalled that the ODA rules clearly allowed such aid in kind to be counted in ODA. Donations should definitely be encouraged and counted in ODA. **However, although all participants indeed lauded the donor community for transferring their doses to developing countries, several expressed the view that these actions should not**

necessarily count as ODA:

- Donations of vaccines to developing countries, purchased with that donation as the intent, are clearly eligible. If donors experience a low level of domestic vaccination and provide doses that they could have used, it is clearly eligible (one participant suggested to possibly apply a coefficient based on the number of people vaccinated in the donor country to assess the level of concession of the donation).
 - However, if it is an ex post decision, several participants thought it should not count. Developed countries bought the doses for their own use but, given the lower attrition rate than expected, they have received far more doses than needed. The original intent of buying the doses has nothing to do with an objective to benefit developing countries. By signing so many contracts, they actually contributed to the lack of doses available to other countries.
 - There is no opportunity cost for the donor in handing over the doses to developing countries.
 - Participants also voiced the concern that the donation of excess vaccine doses, if counted in ODA, could replace much-needed ODA for e.g. health systems rather than representing additional investments.
 - There could also be perverse incentives in allowing providers to score ODA for their donation of vaccine in excess. Indeed this could encourage them to stick to bilateral deals, and discourage them to fund multilateral initiatives. This could also legitimise hoarding strategies that led to the current inequitable access situation.
- ***How should it be valued in ODA?***
Given the above concerns raised on the accounting of donations in ODA, **participants generally recommended a careful and conservative approach in counting excess vaccine doses in ODA, to avoid negative effects and inflation of ODA.**
 - The Reporting Directives instruct to use the market price for the calculation. This price is different when doses are distributed through COVAX⁷ or through bilateral agreements.
 - The market for COVID-19 vaccines is complex, with different prices for different vaccines by different manufacturers. Prices are not all known to the public (given confidentiality restrictions from the part of manufacturers⁸) and there are tier-pricing systems by some manufacturers. Instead, the price of vaccines allocated by COVAX-AMC should be used in the ODA calculation (USD 3), as it is the lowest price and it is well known.
 - ***Additional points made:***
 - Health systems in developing countries are not necessarily equipped to handle the doses received, and will struggle to make use of vaccine doses that are close to expire.
 - ODA reporting should be transparent on the topic of donations. The Secretariat clarified that it would not play a supervisory role in verifying the price of vaccine doses used to make the ODA calculation, or in verifying the expiry date of vaccines.
 - **In wrapping up, the Chair referred to the existing ODA rules as a basis for assessing the eligibility of these costs. He also called for common sense and stated that the donation of spoiled goods would obviously not count as ODA.**

⁷ COVAX dose sharing principles: https://www.gavi.org/sites/default/files/covid/covax/COVAX_Principles-COVID-19-Vaccine-Doses-COVAX.pdf.

⁸ It was suggested that partners in charge of investing in R&D should encourage transparency in pricing policy as part of their agreements.

