Diagnostics Allocations Frequently Asked Questions

Test allocations: why do we need 'allocations'?

The current COVID-19 pandemic is unprecedented and has affected nearly all countries. Because of the extent of the pandemic, the needs and demand for tests is significant. Access to tests, particularly in low- and middle-income countries, have been limited. Because of this, the Diagnostics Consortium for COVID-19 was developed in an effort to secure critical volumes for countries with limited market access. In order to support all countries in an equitable way, an allocation process and principles are necessary.

Allocation principles: How are the allocation principles developed?

The allocation principles were developed based on ethical principles of equity, transparency, consistency, inclusiveness, and accountability. A WHO policy brief on Ethics and COVID-19 that provides guidance on resource allocation and priority-setting can be found here.

Allocation principles: Which products require allocation model?

Fortunately some diagnostic products, particularly manual molecular tests and sample collection kits (as of the October 2020), are not limited by availability or volume. Full funded country demands can therefore be met without the need for an allocation model. Constrained diagnostic products, however, require an allocation model to ensure equitable access to all eligible countries due to the limited volumes available for low- and middle-income countries. As of October 2020, these include tests from Abbott, Cepheid, and Roche. The constraints of antigen-based rapid diagnostic tests are still being understood; however, an allocation model will be developed along the same principles to ensure all countries have access to volumes in the near-term.

Allocation principles: I have seen a file with quantities for my country already defined, how were the allocations / minimum volumes calculated?

The quantities (also called allocations or minimum volumes) were calculated by country using a number of considerations, including the potential affected population, healthy system vulnerability and market access, epidemiological consideration, existing instrument footprint, and country capacity.

Country Eligibility: Why are certain World Bank classified High Income small islands included in the allocation?

All low- and middle-income countries are included and eligible to receive minimum volumes through the consortium. Some high income small island states have also been included, particularly those that are independent autonomous states without demonstrated market access.

Vulnerability: Why was the Universal Health Coverage index chosen as the vulnerability factor?

The Consortium has revised the proxy metric for the robustness of country health systems to use the Universal Health Coverage Service Coverage index. The UHC Service Coverage index takes a number of components into consideration, including reproductive, maternal, new-born and child health; infectious diseases; noncommunicable diseases; and service capacity and access. Each component includes multiple key health parameters to develop the national UHC Service Coverage Index. Lower UHC Service Coverage indices are linked to inadequate access and quality of basic healthcare, indicative of health

systems that would be more vulnerable to a COVID-19 epidemic. The UHC Service Coverage index is a publicly available metric with strong underlying data across the Consortium-eligible countries.

Epidemiology: How was epidemiology incorporated into the allocation model?

As we are several months into the pandemic, another important consideration for an allocation model is epidemiology. This was incorporated into the model using the number of cases per population forecasted by the WHO's Essential Supplies Forecasting Tool with data from the Imperial College's SEIR model to understand the epidemiological context of each country. Based on the cases per population, countries were put into quartiles and provided additional test quantities based on those countries most in need.

Countries with market access outside of the consortium: If countries are receiving test volumes for automated technologies, outside of the Consortium through either direct relationships with suppliers or from partners, how are these managed by the Consortium?

These volumes procured or accessed outside of the Consortium are taken into consideration, particularly if the supplier counts those volumes against the global Consortium stockpile. In these instances, the volume per country is compared with what would be their equitable allocation of the specific test. If the volumes accessed from outside of the Consortium are higher for the specific test than what would be their equitable allocation, those countries would not receive additional volumes for that test through the Consortium. If the volumes accessed from outside of the Consortium are lower for the specific test than what would be their equitable allocation, if requested those countries would receive additional volumes of that test through the Consortium, but not higher than their equitable allocation.

Suppliers' role: Are suppliers involved in the allocation process?

No, suppliers are not involved in the allocation process.

Testing (absorptive) capacity: Is the testing capacity in each country considered?

Yes. The Consortium does not allocate tests based on the number of devices per country (ie. does not provide the most tests to the country with the most devices). All Consortium partners, including WHO regional offices, shared country-specific instrument mapping and footprint information for each of the automated technologies in order to inform the allocation procedure. Furthermore, after the equitable allocation process is completed across all countries, the understood footprint for each country is reviewed. If a country is noted to be receiving more tests than their instrument footprint can run in a single month, then the allocation is reduced to that monthly capacity and the remaining volumes re-allocated to countries with remaining capacity per the guiding principles.

Minimum volumes: Is a minimum number of tests for each country considered?

Yes, minimum volumes for each test type would be provided in order to maximize operational and logistical considerations. The quantity of minimum tests distributed may vary by month depending on the total number of tests available, ideally increasing as the global Consortium stockpile per test type increases.

Total tests: Why can't I get more automated tests?

For these initial periods, the total volume of automated tests in the global Consortium stockpile may not fill the need for all countries. The Consortium is working hard with suppliers to increase the global Consortium stockpile for distribution to all eligible countries.

Interchangeability: A country has high demand for a specific platform but no minimum volumes available – can we just substitute one platform's volumes for another? How would this work?

While we recognise that countries may have preferences for specific platforms over others, limited supply availability means that not all preferences can be met. Allocations or minimum volumes are the result of a considerable planning and equitable allocation process that takes into account countries available testing platforms and available supplies.

If additional volumes of their preferred / demanded platforms are made available by manufacturers or left un-requested by other countries, the Consortium will make those volumes available through a reallocation process that will follow the same guiding principles as above.

Revisiting principle of Abbott OR Roche, but not both: Why can't countries receive both Abbott and Roche tests through the consortium?

The principle was instituted initially to ensure countries with both Abbott and Roche platforms, in particular, would not exceed their fair and equitable allocation of total automated tests. It was determined that countries with more platforms and/or more variety of platforms should not receive higher volumes than their equitable allocation. Additionally, focusing on one of the two platforms by country was considered due to training requirements and other operational considerations.

Upon re-allocation of un-requested volumes, countries might be able to receive the other test type, if available and in an equitable process, in order to best match unmet demand with available supply.

Revisions to allocation model: How will feedback on actual testing capacity in country be accounted for in the allocation?

The Consortium has received feedback from a few countries that they do not have the adequate functional machines, software, or technicians to run a given platform of COVID diagnostic tests. If a country is unable to use any of the automated tests they have been assigned due to technical issues, the Consortium will make its best effort to allocate tests from other platforms if volumes become available.

Additional information: How can new or updated information be shared for inclusion in subsequent allocation models?

The Consortium is eager and willing to receive and review new or updated information from countries regarding the instrument footprint or preferred tests. However, given the global supply scarcity for diagnostic tests, the Consortium acknowledges that allocation decisions must be made holistically.

Who can I contact if I have more questions?

Please email: COVID19Enquiry-Diagnostics@who.int.