At-A-Glance:
Primers on campaigns and financing

These primers are intended, in 10 minutes or less, to provide a high-level overview of the key characteristics of campaigns and their financing across five health domains: Polio, Vaccine-Preventable Diseases, Malaria, Neglected Tropical Diseases, and Malnutrition (Vitamin A Supplementation). The purpose is to provide experts in a particular health domain the opportunity to quickly understand the nuts and bolts of campaigns and their financing for the other domains.

The primers describe the health interventions delivered in each of the campaigns, in addition to noting general characteristics of the campaigns, such as their frequency, target population age, delivery methods, and points of delivery. The primers describe the key strategy and guidance documents that exist for the health domains, with select references to integration and campaigns included. The primers also cover the key players involved in coordination and advocacy for the health domains. Finally, the primers include a section on financing which describes the largest funders, the different funding mechanisms, and commodity procurement. This section also describes the key implementers of those funds, and concludes with a brief country case example, elicited from the interviews, related to campaign financing.

A challenge in describing the financing is that the flow of funds is elaborate, the landscape is fragmented, and the data on share of funding for campaigns are particularly scarce. The landscape of donors and implementing partners is quite complex and fragmented, and this summary representation certainly excludes some nuance and detail. We welcome any corrections to these primers, in addition your suggestions on improvements and how to strengthen them to support the understanding of non-experts on the various health domains.

Please send any feedback to the Health Campaign Effectiveness Coalition: campaigneffectiveness@taskforce.org.
Polio At-A-Glance: Primer on campaigns and financing  
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Overview
Since the launch of the Global Polio Eradication Initiative (GPEI) in 1988, the number of wild poliovirus (WPV) cases has been reduced by 99.9%. Despite recent confirmation of circulation of WPV in Malawi, WPV has been circulating in only two endemic countries (Afghanistan and Pakistan) for over five years, a sharp contrast to the 125 countries where it was present 30 years ago. Vaccine strains of poliovirus also need to be managed, with 1,113 cases of circulating vaccine-derived poliovirus (cVDPV) in 27 countries in 2020. Importation of the virus from another country is a continuing threat, with Malawi reporting an imported WPV case in 2022, 30 years since Malawi’s last case and five since Africa’s last case.

Achieving polio eradication means reaching 0 cases of WPV or cVDPV. Two of the three strains of WPV have been eradicated. The Emergency Committee under the International Health Regulations maintains that failure to achieve eradication continues to represent a “public health emergency of international concern.” To achieve eradication, interruption of transmission of all polioviruses is necessary. This has been pursued through a combination of routine immunization, National Immunization Days (NIDs), supplementary immunization activities (SIAs), introduction of Inactivated Polio Vaccine (IPV), introduction of monovalent and bivalent Oral Polio Vaccines (OPV), strong surveillance, and targeted (“mop-up”) campaigns to respond to outbreaks.

Non-polio activities have accompanied campaigns with the intention of increasing polio immunization coverage, for example through PolioPlus in which other interventions (e.g., Vitamin A capsules, bed nets, antimalarial drugs, soap, etc.) are delivered alongside the vaccine. GPEI infrastructure has also supported other functions beyond the polio-eradication agenda, including surveillance (with laboratory support) for other vaccine-preventable diseases, essential immunization activities, new vaccine introductions, emergency preparedness and response for various public health emergencies (e.g., COVID-19 Ebola), and health system strengthening. The Polio Transition Independent Monitoring Board has reported that 25-50% of staff time funded through the GPEI has been spent on non-polio activities.

Campaign Characteristics

<table>
<thead>
<tr>
<th>Targeted Diseases / Disorders</th>
<th>Poliomyelitis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions</td>
<td>Oral polio vaccine (OPV) and Inactivated polio vaccine (IPV) given by injection</td>
</tr>
<tr>
<td>Frequency</td>
<td>Regular intervals based on epidemiology and risk, as well as in response to outbreaks</td>
</tr>
<tr>
<td>Target population age</td>
<td>Typically 0-59 months</td>
</tr>
<tr>
<td>Delivery methods</td>
<td>Health workers, community health workers (volunteers paid stipend)</td>
</tr>
<tr>
<td>Points of delivery</td>
<td>National Immunization Days (NIDs) and Sub-National Immunization Days (SNIDs), Child Health Days, Supplemental immunization Activities (SIAs), and house-to house mop-up campaigns</td>
</tr>
</tbody>
</table>

Global Strategy and Guidelines
In the Polio Eradication Strategy 2022-2026, one of five strategic objectives is to “Expedite progress through expanded integration efforts with a broader range of partners in immunization, essential health care and community services.” Integration is defined as “joint efforts between the polio eradication programme and a range of partners with the objective of improving immunization outcomes in targeted geographies. Integration efforts are pursued through strengthened collaboration with other immunization programmes and context-appropriate strategies for delivering vaccines alongside primary health care and other services.” Some key integration activities include integrated service delivery for high-risk areas in the endemic countries, ensuring the success of the Gavi zero-dose strategy and leveraging multi-antigen campaigns, and accelerating the transition of polio-essential functions in areas where polio is already integrated. A non-polio-specific key performance indicator is: “% of campaigns for which microplans were developed via integrated planning workshops (inclusive of Expanded Programme on Immunization (EPI), maternal, newborn, child and adolescent health (MNCAH), communication and geographic information system (GIS)) in a

1 Zero-dose children are those who do not receive a single dose of diphtheria, tetanus and pertussis-containing vaccine.

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gender-responsive way.” The strategy also includes a decision-making framework to guide countries in evaluating integration opportunities and activities.

Integration was one of the three goals of the Polio Endgame Strategy 2019–2023, with a focus on: 1) Contributing to strengthening immunization and health systems to help achieve and sustain polio eradication; 2) Ensuring sensitive poliovirus surveillance through integration with comprehensive VPD and communicable disease surveillance systems; and 3) Preparing for and responding to future outbreaks and emergencies. The strategy specified campaign integration with other programs, mentioning nutrition, Water, Sanitation and Hygiene (WASH), and the Partnership for Maternal, Newborn and Child Health. An example of an integration-focused solution proposed to address challenges with the eradication agenda included:

“Pursuing synergies and cost-saving efficiencies between polio SIAs and other immunization campaigns. These consist of joint planning for multi-antigen SIAs, the harmonization of SIA calendars, and the development of guidance documents and processes, including support for the periodic intensification of routine immunizations (PIRIs). Joint campaigns will also identify concrete follow-up activities to link SIAs to immunization strengthening by using SIA microplans and independent monitoring data to identify and follow up on persistently missed children and drop-outs.”

The Strategic Action Plan for Polio Transition (2018–2023) includes WHO objectives and indicators on the use of polio assets for non-polio-specific activities, including strengthening immunization systems, which is tracked by indicators on measles vaccine coverage and government expenditure on routine immunization per newborn.

In the context of postponements of many campaigns during the COVID-19 pandemic, mostly polio and measles, GPEI developed an interim Programme of Work for Integrated Actions in the context of the COVID-19 pandemic (iPOW).

The iPOW identified critical actions to “drive synergies and materialize efficiency gains by building on initiatives accelerated by COVID-19 to ensure the successful resumption of all immunization activities and to explore opportunities to coordinate the delivery of other essential health services.”

Coordination and Advocacy

Rotary International launched a global effort to immunize the world’s children against polio in 1985, followed in 1988 by the World Health Assembly’s adoption of a resolution for the worldwide eradication of polio, which established GPEI. GPEI is a public-private partnership with six core partners – the WHO, Rotary International, the US Centers for Disease Control and Prevention (CDC), UNICEF, the Bill & Melinda Gates Foundation (BMGF), and Gavi, the Vaccine Alliance. GPEI’s eradication activities are implemented by the WHO and UNICEF in partnership with countries and Gavi.

Gavi joined the GPEI as the sixth core partner in 2019. On the request of the GPEI Strategy Committee, a framework for strengthened Gavi-GPEI collaboration was developed in 2019. The framework is underpinned by the goal of strengthening transparency and accountability and having a greater impact of investment for both initiatives. GPEI points to the development of the 2019-2023 strategy overlapping with Gavi 5.0 and IA2030, stating the “synchronous timing of these critical global health strategies provided a unique opportunity to pursue the kind of synergies targeted in this strategy’s Integration goal, through improved collaboration and efficiency to deliver broader impact.” GPEI’s strategy outlined mutual benefits for integration with immunization: 1) Polio sees integration as an opportunity to help reach eradication and address community fatigue in the endemic countries; and 2) Immunization benefits from polio eradication expertise, knowledge and presence to help reach zero-dose children. Polio eradication is among the disease-specific goals of the Immunization Agenda 2030 (IA2030).

Financing

- **GPEI Financing:** The BMGF is the largest private source of funding for the GPEI. It provides technical support and invests in research to enhance polio vaccines, surveillance, and outbreak response. The U.S. Government is the second largest donor to the GPEI. Most U.S. funding for polio is provided through CDC’s global immunization program (more than 70% in FY 2021). Additional polio funding is provided under the maternal and child health (MCH) program at USAID. In addition to supporting surveillance and lab activities, the CDC provides technical and
financial assistance for campaign planning and monitoring, social mobilization, and other activities. **USAID** provides technical support to country partners in campaign planning and implementation, social mobilization and communications efforts, and strengthening surveillance and monitoring systems. Rotary International is the third major source of funding for GPEI, fundraising from its 1.4 million members and beyond to support GPEI. Rotary International sets Challenge fundraising goals through End Polio Now to raise money for eradication, and the BMGF triples contributions. In addition to the U.S., the primary government contributors include the other G7 countries (Canada, France, Germany, Italy, Japan, United Kingdom) and the European Commission. Government loans given with the support of development bank loans also comprise some of the contributions to GPEI (e.g., Government of Pakistan/Islamic Development Bank Loan, Government of Nigeria/World Bank Loan). There are a large number of other contributors as well, such as non-G7 countries, private foundations, NGOs, corporations, and beyond.

- **5-year Budget:** The Financial Resource Requirements (FRR) provides an overview of the budget for activities planned by the GPEI. WHO, UNICEF, and national governments jointly prepare the budget that underpins the FRR. The 2022-2026 budget will be released in late April 2022, along with the new GPEI Investment Case. The GPEI budget for 2019-2023 comprised the costs for the WHO (62%) and UNICEF (38%), with immunization campaigns the largest single expense, absorbing nearly one third of the budget. Non-GPEI costs consisted of IPV (supported by Gavi) and the one-time cost of OPV stockpiles. In 2018, the Gavi Board exceptionally approved the use of core funding to support IPV through 2020. The Gavi Board also approved continued support for the 2021-2025 period, subject to availability of funding. Projects where GPEI collaborated with other health actors were not included in the budget. These projects were financed through other means, for example by the UNICEF-led Integrated Services Delivery Initiative, supported by the BMGF, and by Gavi Health System Strengthening/cash grants.

- **Commodities:** UNICEF works with vaccine manufacturers to procure OPV on behalf of national governments, the GPEI, and their own programmes. These vaccines are for both routine delivery and campaigns.

- **Key Implementers:** Countries are the implementers of polio campaigns and the GPEI partners (WHO, UNICEF, CDC, Rotary International, BMGF) provide technical support to the countries. The WHO coordinates the management and administration of the GPEI and provides technical and operational support to Ministries of Health. Indeed, polio eradication accounted for 20% (US$ 902.8 million) of the WHO annual budget in 2018-19. In addition to its procurement role, UNICEF also invests in supply chain infrastructure, and communication and social mobilization. Both UNICEF and the WHO pay allowances to health workers and volunteers supporting campaigns. In addition to supporting surveillance and lab activities, the CDC provides technical and financial assistance for campaign planning, implementation and monitoring, evaluation, social mobilization, and other activities. Rotary supports countries for social mobilization. The BMGF supports countries for various components of outbreak preparedness and response, including surveillance and polio campaigns.

- **Implementing Country Governments:** Financial contributions provided through WHO and UNICEF are supplemented by in-kind contributions within countries such as the time spent by volunteers, health workers, and others in the planning and implementation of campaigns. These contributions are estimated to have a dollar value approximately equal to that of international financial contributions.

- **Polio and vitamin A integration: the case of UNICEF Afghanistan:** Coordination of polio eradication is led by an Emergency Operation Center with representation from WHO, UNICEF, BMGF, CDC, and the Government of Afghanistan. All funding to support polio in Afghanistan is paid to WHO or UNICEF, and almost 75% of UNICEF’s polio program budget goes towards campaigns. In 2022, there will be six polio campaigns. Funding to UNICEF for vaccine procurement arrives from different donors at different times. In recent years, funding has come from the BMGF, CDC, Rotary International, the governments of Germany and Japan, and UNICEF’s own resources, among other sources. Most donors prefer to direct their funds to the FRR—the budget for activities planned by GPEI. Other donors contribute to the operational budget for campaigns to fund specific line items, such as logistics and social mobilization. A small number of donors (e.g., BMGF, Government of Canada, EU) are willing to fund both campaigns and integrated services. UNICEF and the WHO have different funding disbursement mechanisms to front-line workers, but there is standardization in the incentive structure. Out of the $30M budget in Afghanistan, only $4M (13%) is earmarked for integrated services. For integrated campaigns, funding for vitamin A supplementation sometimes comes from UNICEF Nutrition department budgets, and other times as an integrated package through GPEI. An Integrated Services Delivery platform was established two years ago for Mobile Health
& Nutrition Teams to deliver polio vaccination 1-2 times per month in remote areas with a bundle of nutrition services and antenatal care services.

Key Sources
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Vaccine-Preventable Diseases At-A-Glance: Primer on campaigns and financing  
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Reviewer: Alex Mphuru (UNICEF)

Overview

There is a long history associated with use of mass vaccination campaigns as a delivery strategy to rapidly raise population level immunity and reduce the number of those susceptible to vaccine-preventable diseases (VPD), beginning with inoculation against smallpox in the early 1800s (smallpox was eradicated in 1980). Campaigns are valuable in three main ways: 1) preventive campaigns accelerate disease control and fill immunity gaps including where people are missed by routine services, thus decreasing risk of outbreaks; 2) catch-up campaigns build population immunity rapidly for certain vaccines at the time of introduction by reaching a multi-age cohort; and 3) reactive campaigns respond to an outbreak. Campaigns, also known as Supplemental Immunization Activities (SIAs), deliver vaccination to all targeted individuals regardless of their vaccination status (prior history).

Campaign-style delivery is also used in Periodic Intensification of Routine Immunization (PIRI), where time-limited, intermittent activities/campaigns are used to administer routine vaccinations to under-vaccinated populations and/or raise awareness of the benefits of vaccination. Examples include Child Health Days/Weeks and National Immunization Weeks. PIRI activities focus on delivery of routine, rather than supplemental, doses; however, some SIAs have piggybacked on PIRIs to reach populations (e.g., Uganda HPV introduction with Child Health Days).

Campaign Characteristics

<table>
<thead>
<tr>
<th>Vaccine-preventable diseases (VPD)</th>
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<tbody>
<tr>
<td><strong>Targeted Diseases</strong></td>
</tr>
<tr>
<td>The most common antigens delivered through campaigns are: Cholera, Japanese Encephalitis, Measles &amp; Rubella, Meningitis A, Tetanus, Typhoid, and Yellow Fever. Other vaccines, such as HPV and Pneumococcal conjugate, may have one-time multi-age cohorts targeted with introduction.</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
</tr>
<tr>
<td>Oral vaccines (delivered through drops to the mouth) and injectable vaccines (delivered through the subcutaneous or intramuscular routes)</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
</tr>
<tr>
<td>Variable depending on antigen, for example: MR preventive (follow-up) campaigns every 3-5 years, and reactive campaigns; YF one-time mass introduction campaign with routine immunization follow-up, and reactive campaigns. Catch-up campaigns that are associated with vaccine introductions are expected to occur once.</td>
</tr>
<tr>
<td><strong>Target population age</strong></td>
</tr>
<tr>
<td>Variable depending on antigen, ranging from 9mo-14yo (MR), to 1-5yo (PCV), to 9mo-60yo (YF), to all &gt;1yo in hotspots (Cholera), to WRA 15-49yo (Tetanus)</td>
</tr>
<tr>
<td><strong>Delivery methods</strong></td>
</tr>
<tr>
<td>Trained vaccinators, health workers, community health workers, non-health community workers (volunteers paid stipend, typically for oral vaccines), school administrators</td>
</tr>
<tr>
<td><strong>Points of delivery</strong></td>
</tr>
<tr>
<td>Fixed post, mobile outreach, school-based, and Periodic Intensification of Routine Immunization (PIRI) such as Child Health Days/Weeks and National Immunization Weeks</td>
</tr>
</tbody>
</table>

As separate verticals, COVID-19 and polio vaccination are not covered in this note.  
HPV = Human Pappilomavirus; MR = Measles & Rubella; PCV = Pneumococcal; YF = Yellow Fever; WRA = women of reproductive age

Global Strategy and Guidelines

Immunization Agenda 2030: A Global Strategy to Leave No One Behind. With its development led by the WHO, IA2030 is the global immunization vision and strategy for the decade 2021 to 2030. There are several references to the importance of integration under IA2030’s strategic priorities. Strategic Priority #4 (Life-course and Integration) prioritizes cross-sector collaboration (including beyond the health sector) to integrate age-appropriate and catch-up vaccination into public and private health services, emphasizing the reciprocal benefits of receiving vaccines with other health interventions. Strategic Priority #5 (Outbreaks and Emergencies) calls for strengthened coordination of implementation of vaccination and outbreak preparedness, including strengthening integrated disease surveillance for epidemic-prone VPDs. It calls for a “coordinated and integrated approach” including the sharing of microplans and population data, and the coordination of SIAs across disease control programs. Strategic Priority #6 (Supply and Sustainability) emphasizes the importance of streamlining and aligning partnerships for immunization, PHC or integrated financing, and ensuring effective global collaboration. It highlights that coordination across different types of campaigns is generally poor, and underlines the need to take advantage of opportunities such as outreach and campaigns to provide multiple vaccines and other services. Strategic Priority #3 (Coverage and Equity) emphasizes learning from the Global Polio Eradication Initiative (GPEI) on how it addressed coverage and equity-related issues, including delivery of integrated campaigns.
Measles and Rubella Strategic Framework 2021-2030. This strategic framework, developed by the Measles & Rubella Initiative, points to the need for a combination of PIRI and SIAs in many countries to fill immunity gaps because of missed routine vaccination doses and the cancellation of planned SIAs due to COVID-19. Similar to IA2030, Strategic Priority #4 focuses on Life Course and Integration. In addition to “firmly embedding measles and rubella activities within immunization and other PHC programmes,” with respect to campaigns, the strategy states:

“Promote integrated delivery of vaccines and non-vaccine preventive interventions in preventive campaigns to create efficiencies and maximize impact. Where indicated and feasible, joint campaigns that combine preventive vaccination with other disease initiatives (such as for polio, yellow fever, cholera or meningococcal meningitis vaccination) or take place during World Immunization Week campaigns should be implemented. Where appropriate and feasible, other non-vaccine preventive interventions (such as vitamin A supplementation) may be included in such campaigns.”

Other institution-specific strategies. Institution-specific strategies also exist, for example the UNICEF Immunization Roadmap 2018–2030, and Gavi’s 2021-2025 strategy “Gavi 5.0.”

Several key guidelines documents are available, including WHO’s Planning and implementing high-quality supplementary immunization activities for injectable vaccines using an example of measles and rubella vaccines: field guide. This guide states that SIAs are an excellent platform to deliver additional public health and nutrition interventions, but notes that integration of multiple interventions may raise additional logistical challenges and the decision to integrate should be made on a case-by-case basis. The WHO Guidelines for Developing a National Immunization Strategy emphasizes that immunization is one of the possible entry points for strengthening PHC by integrating immunization services over the life course with other health interventions in areas such as human resources, surveillance, supply chain, data, and vaccine safety. The WHO is developing a guide, Considerations for Planning Integrated Campaigns: Immunization and Beyond. This guide will present the rationale for integrating health interventions during campaigns and will cover when and how to integrate campaigns.

Gavi, the Vaccine Alliance, is trying to encourage opportunities for integration through its funding guidelines. The most recent Gavi Vaccine Funding Guidelines (2021) emphasize that to be eligible for funding through operational support for campaigns, countries should “integrate campaign planning with other relevant campaigns or other PHC interventions (e.g., Vitamin A, deworming).” Further, “…all campaign requests must demonstrate how they are integrated into the broader primary healthcare agenda and provide justification if they are not.” Key changes in Gavi requirements highlighted in the Plan of Action for Measles/Measles-Rubella Campaign (2021) include:

“Countries are required to leverage all opportunities for integration with other health campaigns (vaccine and/or health interventions) in the planning, preparation, implementation, delivery, and/or monitoring & reporting phases of the campaign, to leverage synergies and complementarity across investments, reduce adverse impact on routine immunisation, and increase cost-efficiencies.”

The Campaign Plan of Action for JE, MenA, YF Campaigns (2017) also emphasizes integration, but without a strong statement on requirements.

Coordination and Advocacy

In addition to the role that the IA2030 partnership plays in coordination and advocacy, there are many other important actors. The Global Alliance for Vaccines and Immunization, now Gavi, the Vaccine Alliance, was established in 2000 with the goal of improving access to new and under-used vaccines for children living in the poorest countries in the world. Gavi’s core partners are the BMGF, UNICEF, WHO, and the World Bank. As an independent public-private partnership and multilateral funding mechanism, Gavi makes impact investments and pools demand for vaccines, sharing the cost that implementing countries pay for vaccines and supporting their delivery.

The Measles & Rubella Initiative (M&RI) is a partnership between the American Red Cross, the U.S. Centers for Disease Control and Prevention (CDC), UNICEF, the United Nations Foundation, and the WHO. In 2019, the M&RI supported 53 countries to implement measles campaigns.

The International Coordinating Group (ICG) on Vaccine Provision improves cooperation and coordination of epidemic preparedness and response, ensuring emergency stockpiles of cholera, meningitis, and yellow fever vaccines and managing and coordinating their provision during major outbreaks. Its partners include the International Federation of the Red Cross and Red Crescent Societies (IFRC), Médecins sans Frontières (MSF), UNICEF, and the WHO. UNICEF procures and ships vaccines and supplies on behalf of the ICG. IFRC and MSF support the vaccine logistics and roll out

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of immunization campaigns on the ground. WHO provides global advice and technical support to countries. Gavi finances ICG’s stockpiles of the three vaccines for Gavi-eligible countries.

The Strategic Advisory Group of Experts on Immunization (SAGE) is the principal advisory group to the WHO for vaccines and immunization and advises WHO on global policies and strategies.

Financing

In low-income countries, in aggregate, development assistance is the largest source of funding for immunization. Aggregated across all low- and middle-income countries, governments are the largest source of immunization financing, followed by development assistance for immunization, with the majority of that channeled through Gavi and the remainder disbursed by other development agencies. The biggest contributors to non-Gavi development assistance for immunization include the BMGF, UNICEF, WHO, NGOs, US foundations, the European Commission, and development banks. In addition to Gavi, a large share of development assistance for immunization flows through GPEI. A recent financial modeling study estimates 86.5% of government spending over 2000-2017 was allocated to routine immunization and 13.5% to SIAs; over that same period, 57.5% of development assistance was allocated to routine immunization and 6.1% to SIAs.

Gavi, the Vaccine Alliance

Gavi is the largest channel of external financing for immunization. Over three-quarters of Gavi’s funding is from donor governments and private organizations and individuals. In 2000-2021, the largest donor overall was the BMGF (18.8%), with the U.K. (13.9%), the U.S. (12.8%), and Norway (8.5%) as the top government donors. In addition to direct donations, the remainder of Gavi’s funding (23.6%) comes from the proceeds of the International Finance Facility-Immunisation (IFFIm) and the Pneumococcal Advance Market Commitment (AMC). The former provides “up-front” financing to Gavi using donor funding commitments to back the issuance of vaccine bonds in capital markets. The latter offers “up-front” funding commitments from donors to support accelerated access to pneumococcal vaccines. (This financial picture does not include contributions to COVAX AMC.)

Gavi’s co-financing policy is at the heart of its catalytic funding model. Countries co-procure a portion of their new vaccines and safe injection devices and as they progress on a trajectory of increasing GNI per capita, they increasingly take on higher levels of co-financing. Importantly, Inactivated Polio Vaccine (IPV) and all campaigns are exempt from Gavi’s co-financing requirements for vaccine support, with the exception of “Periodic Follow-up Campaigns” (e.g., measles or measles-rubella follow-up). Gavi also provides support through its Health Systems and Immunization Strengthening (HSIS) support framework, which includes health systems strengthening (HSS) grants, grants to fund one-time startup costs for new vaccine introduction, and grants to help fund operational costs for immunization campaigns. Campaign Operational Support (Ops) is offered to “provide an opportunity to strengthen routine immunisation services and to facilitate integrated delivery of immunisation with other health interventions.” One-off grants or complementary allocations are given to cover part of the operational cost of campaigns. Operational support for campaigns is provided at three funding levels based on country income status –$0.65, $0.55, or $0.45 per targeted person.

During Gavi Strategy 4.0 (2016-2020), expenditure on campaigns was 13% of total Gavi expenditure (8% for vaccine support and 5% for operational cost). Expenditure on outbreak response was an additional 5% (4% vaccine support and 1% operational cost).

Gavi operates in 5-year funding cycles, with a revised strategy and goals for each cycle. Gavi is moving towards an moving away from countries submitting separate applications for different types of support on an as needed basis, to submitting one integrated Full Portfolio Planning (FPP) request for all types of support, including HSS grants, Targeted Country Assistance (support to partners), and vaccine support.

Commodities

Approximately 80% of Gavi’s support is provided as commodities, almost all of which are procured centrally by UNICEF Supply Division. UNICEF Supply Division not only works with Gavi-eligible countries, but it also procures on behalf of some countries that were never eligible for Gavi support. It supplies vaccines to over 100 countries every year for routine immunization and outbreak response.
**Key Implementers**

Immunization campaigns are largely implemented by national immunization programs, the Expanded Programme on Immunization (EPI), supported by UNICEF and WHO who receive Gavi funds. UNICEF conducts vaccine procurement and shipment, and provides technical support on campaign planning and implementation in country focusing specially on social mobilization and cold chain. WHO provides global public health advice and technical support to countries, in addition to focusing on vaccine stockpile management, surveillance, preparedness and response to disease outbreaks. M&RI is also a key implementer of campaigns, also supported by Gavi and a range of other donors such as governments (Canada, Japan, Norway, U.K., U.S), private foundations (BMGF), industry (Merck Co. Foundation), corporates (The Vodaphone Foundation, the WNBA), and others.

**Funding flows for integrated campaigns: the case of Tanzania:**

Tanzania conducted an integrated Measles-Rubella (MR) and Inactivated Polio Virus (IPV) campaign in 2019, with funding coming from two different sources from Gavi. The Ministry of Health developed a consolidated campaign budget at the central level with support from WHO and UNICEF, with separate line items for each antigen (i.e., MR and IPV). WHO and UNICEF managed the funds, with MR funds channeled from Gavi to WHO and IPV funds channeled from Gavi to UNICEF. WHO and UNICEF had different ways of disbursing and managing funds. WHO paid direct to the health workers. UNICEF disbursed by direct cash transfer to the government, and the government disbursed to the subnational level. The vaccination team included 2 vaccinators (1 each for MR and IPV), 2 data recorders (1 each for MR and IPV), and 1 social mobilizer.

Tanzania conducted another integrated campaign funded by Gavi in 2014, with delivery of MR, Vitamin A Supplementation (VAS), and deworming (albendazole and ivermectin). MR and VAS delivery were planned together during the Gavi application process, and the government agreed to integrate VAS and NTDs later. The immunization and NTD programs held distinct budgets, and separately funded and managed campaign components (e.g., planning, supply chain, and data system), with integration focused at the service delivery level. Funds flowed vertically by program to the subnational level without any pooling.

**Key Sources**


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Malaria At-A-Glance: Primer on campaigns and financing
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Reviewer: Perpetua Uhomoibhi (Federal Ministry of Health, Nigeria)

Overview

Insecticide-treated nets (ITNs) have comprised one of the pillars for global malaria programs since the early 2000’s. A 2018 Cochrane Review confirmed earlier findings that ITNs reduce child mortality from all causes by 17%, save 5.6 lives yearly per 1000 children protected by ITNs, and reduce the incidence of uncomplicated episodes of the lethal Plasmodium falciparum malaria by almost half. Manufacturers delivered almost 2.3 billion ITNs globally from 2004 to 2020, with Sub-Saharan Africa receiving 2 billion nets. WHO recommends a strategy of achieving universal coverage of ITNs in malaria-endemic areas, meaning access to one ITN for every two household members regardless of age. By 2020, 34% of these households in Sub-Saharan Africa had achieved this goal compared with 1% in 2000, with reported percentage of the total population sleeping under a net increasing from 2% to 43% in the same period. However, the indicators for ITN access and use have declined since 2017. To achieve and sustain optimal coverage, WHO recommends that countries distribute free ITNs through mass campaigns and through local continuous distribution channels such as antenatal and immunization clinics. Mass campaigns are “the only proven cost-effective way to rapidly achieve high and equitable coverage.” The approaches to mass campaigns have evolved from leveraging already-established immunization and other health campaign platforms in the late 1990s, to currently more widespread “stand-alone” campaigns with ITNs only. This change followed in part an evidence-based shift in global strategies from targeting vulnerable populations (children <5 years and pregnant women) to universal coverage, along with new funding and procurement mechanisms. Countries generally conduct campaigns every three years, reflecting the average number of years that the net’s physical barrier and insecticidal properties remain effective. Campaign intervals can be longer or shorter based on local data on net conditions or coverage gaps, or in humanitarian emergencies. Mass ITN campaigns require significant human, financial and logistical resources. Key ITN mass campaign challenges include:

- conducting high-quality household registration to reach all targeted populations;
- ensuring early planning to accommodate supply chain challenges;
- distributing nets via fixed posts (the traditional method) versus house-to-house (a critical COVID-19 adaptation);
- incorporating digital tools to improve household registration, microplanning and logistics;
- considering gender as a factor for ITN access (i.e., by male versus female heads of household);
- determining effective ways to deliver different ITN types to mitigate evidence of insecticide resistance;
- reaching the hard-to-reach such as refugees and internally displaced persons;
- addressing the loss of nets, often due to problems with tearing;
- selecting the methods and timing of post-campaign evaluations (i.e., immediate post-campaign coverage assessments versus use of other scheduled population-based surveys such as the Malaria Indicator Surveys and Demographic and Health Surveys).

Seasonal malaria chemoprevention (SMC) has emerged as an important malaria prevention tool in areas of Sub-Saharan Africa with exclusively seasonal transmission. Targeting children ages 3-59 months, SMC involves administering treatment doses of longer-acting antimalarial medications to maintain protective drug concentrations in the blood through the peak malaria season. Community-level workers distribute sulfadoxine-pyrimethamine plus amodiaquine (SPAQ) in one dose daily over 3 days through three- to five-monthly cycles depending on transmission patterns. For each cycle, these workers directly observe administration of the first dose of SPAC and rely on a caregiver to complete the remaining 2 doses. Thirteen countries in the Sahel region have implemented SMC, with the number of children receiving at least one dose of SMC increasing from 0.2 million in 2012 to 33.5 million in 2020. Expansion of

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SMC to new areas in Nigeria in 2020 accounted for 11.8 million of these children. Studies have found that SMC can reduce the incidence of uncomplicated and severe malaria in target-age children by about 75%. Some countries are piloting an increase in the target ages and number of cycles for administering medications. Key SMC implementation challenges include:

- lack of detailed WHO guidance on field implementation;
- conducting effective microplanning to identify all target-age children;
- ensuring compliance of drug administration during each monthly cycle;
- implementing an adequate number of monthly cycles to match seasonal patterns;
- expanding beyond the Sahelian region;
- extending the age range for SMC up to 10 years (studies in progress);
- planning at least a year in advance;
- ensuring availability of drug supplies due to limited manufacturer supply base;
- accurately enumerating the target population;
- tracking drug supplies.

**Campaign Characteristics:**

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Malaria Campaigns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insecticide treated nets (ITNs), specifically long-lasting insecticidal nets (LLINs)</td>
<td>Seasonal Malaria Chemotherapy (SMC)</td>
</tr>
<tr>
<td>Frequency</td>
<td>Four doses / year</td>
</tr>
<tr>
<td>Target population age</td>
<td>Children 3-59 months</td>
</tr>
<tr>
<td>Delivery methods</td>
<td>Trained campaign distributors</td>
</tr>
<tr>
<td>Points of delivery</td>
<td>Fixed-site or household</td>
</tr>
</tbody>
</table>

*Given the high cost and complexity of IRS, this brief will focus on campaigns for ITNs and SMC.

**Global Strategy and Guidelines**

While WHO’s *Global Technical Strategy for Malaria 2016-2030* does not explicitly mention ITN campaigns, it seeks to “maximize the impact of vector control” by ensuring that “all people at risk of malaria are protected through the provision of, use and timely replacement of ITNs or through the regular application of IRS.” Chemoprevention including SMC is to be expanded and tailored to the local context, such as adjusting the number of SMC cycles according to the length of the transmission season. The *WHO Guidelines for Malaria—31 March 2022* provide the overall framework for ITN mass campaigns and SMC as described in the overview section above.

**Coordination and Advocacy**

**The Global Fund**: The Global Fund through its Secretariat works as a partnership between government and private donors, recipient countries and supported communities to “support catalytic, people-centered HIV, TB, and Malaria (HTM) investments tailored to maximize impact, equity, quality and build sustainability according to local context, based on country-owned plans and aligned with technical partner guidance.” For ITNs and SMC, its strategy for 2023-2028 highlights “an intensified focus on prevention,” with sub-objectives that seek to “ensure optimal effective vector control coverage” and “implement malaria interventions, tailored to sub-national level, using granular data and capacitating decision-making and action.” As a partnership, the Fund seeks to bolster country coordination mechanisms and empower the leaders of the affected communities by supporting community and civil-society-led activities.

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For Discussion Purposes Only
advocacy efforts. The Fund strives to maintain the affordability and availability of sufficient ITN and SMC supplies through its Pooled Procurement Mechanism, which aggregates order volumes and negotiates prices and delivery conditions with manufacturers.10

U.S. President’s Malaria Initiative: PMI is the U.S. largest program targeting malaria prevention and control. Led by USAID and implemented with the Centers for Disease Control and Prevention (CDC), PMI funds proven, cost-effective interventions in 24 countries in Africa and the Greater Mekong Sub-Region. Since its launch in 2005, PMI has delivered 421 million ITNs through mass campaigns and continuous distribution, and 127 million SMC treatments. Its strategy for 2021-2026 focuses, among other things, on reaching the unreached and strengthening community health systems, and “where beneficial,” advocates for “integrating malaria activities with maternal and child health, HIV/AIDS, tuberculosis, neglected tropical diseases, and Global Health Security activities” supported by the US Government.11

RBM Partnership to End Malaria: RBM’s Vector Control Working Group (VCWG) aims to “align RBM partners on best practices to reach and maintain universal coverage with effective vector control interventions.” The VCWG’s “Enhancing Impact of Core Interventions” workstream focuses on identifying gaps, clarifying policies on new ITN products, and ensuring efficient and effective delivery of ITNs. In 2019, RBM’s SMC Working Group organized a discussion platform for partners and national program to exchange experiences and lessons.

African Leaders Malaria Alliance: ALMA provides a forum for African countries to review program progress, provide management tools, establish End Malaria Councils, and identify lessons learned for effective national programs.

Alliance for Malaria Prevention (AMP), hosted by the International Federation of Red Cross and Red Crescent Societies (IFRC): As part of RBM, the 40 partners under AMP seek to support countries to “expand the ownership and use of ITNs which, along with timely diagnosis and effective treatment for malaria, is an essential component of the malaria control toolbox, and part of an integrated strategy to achieve malaria elimination“ under WHO’s global strategy. AMP trains and supports a team of nearly 20 technical assistance providers to help national programs plan, implement, and evaluate ITN mass campaigns. Through weekly calls, annual meetings and engagement of its Core Group, AMP identifies and documents best practices for ITN campaigns through its toolkit12 and tracks campaign schedules and progress.

Malaria Medicines Venture (MMV): MMV is part of UNITAID’s partnership with the ACCESS-SMC Consortium, helping improve SPAQ product availability and forecasting.13

SMC Alliance, hosted by the Malaria Medicines Venture (MMV): The SMC Alliance is a stand-alone working group attached to RBM, serving as a platform for gathering national programs, international technical partners, donors, research and implementing partners to promote progress with SMC programs. Its website tracks children targeted and reached by monthly treatment cycle.

Financing:

Governments: Financial contributions include direct and indirect funding (cash and in-kind). To support country planning, AMP provides a detailed template for countries to develop ITN campaign budgets.14 The Malaria Consortium provides an illustrative SMC Budget Planner covering planning, drugs, training, field implementation, supervision, and sensitization and advocacy.15

Global Fund Financing: The Global Fund provides 56% of all international financing for malaria programs, having invested over US$16 billion in malaria control programs as of April 2022. In 2020 it supported distribution of 188 million ITNs and covered 30 million children by SMC.16 The Fund receives most of its funding from the public sector, with 92% of total funding from donor governments, the remainder from the private sector, foundations, and other

financing initiatives. The Fund operates a 3-year funding cycle that corresponds with its donor replenishment periods. The current funding period is 2020-2022. It allocates its donor funds to countries which apply after a rigorous in-country consultation process and technical review. Each grant is implemented by Global Fund Principal Recipients (PRs), which can be governments, NGOs, community-based organizations, or a private sector entity. Each country’s Country Coordinating Mechanism select PRs with input from the Local Fund Agent in country. The PRs in turn allocate funding to sub-recipients, smaller organizations that implement ITN mass campaigns and SMC under the guidance of the national malaria program.

**U.S. President’s Malaria Initiative financing:** The U.S. Congress appropriated US$ 770 million to USAID for malaria in fiscal year 2020, which funds PMI. The U.S. is also the largest donor to the Global Fund. PMI allocates country-specific funding through the development of annual malaria operational plans (MOPs). USAID and CDC assign resident advisors to each country to advise on all target interventions, including the procurement, distribution, and evaluation of ITN campaigns and continuous channels and for SMC.

**Commodities:** The Global Fund and PMI fund the bulk of costs for ITNs and SMC medications, with each using various procurement avenues such as UNICEF, along with significant contributions from the Against Malaria Foundation (for ITNs), African Development Bank, the Islamic Development Bank, and PAHO, among others. Historically the World Bank and DFID have provided significant funding of commodities. Commodities are sourced from WHO prequalified suppliers.\(^\text{17}\)

**Key Implementers (illustrative):**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Funding</th>
<th>Technical and/or Policy Guidance</th>
<th>Procurement</th>
<th>Planning and Implementation Support</th>
<th>Monitoring &amp; Evaluation Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>National malaria programs</td>
<td>XX</td>
<td>XX</td>
<td>XX</td>
<td>XX</td>
<td>XX</td>
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<tr>
<td>World Health Organization (Headquarters and Regional Offices)</td>
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<tr>
<td>UNICEF</td>
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<tr>
<td>The Global Fund</td>
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<tr>
<td>President’s Malaria Initiative (USAID &amp; CDC)</td>
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<tr>
<td>Alliance for Malaria Prevention/IFRC (ITNs)</td>
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<tr>
<td>RBM Partnership to End Malaria</td>
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<td>UN Foundation</td>
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<tr>
<td>African Leaders Malaria Alliance (ALMA)</td>
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<tr>
<td>World Bank</td>
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<tr>
<td>Malaria Consortium</td>
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<tr>
<td>Population Services International</td>
<td>XX</td>
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<tr>
<td>Catholic Relief Services</td>
<td>XX</td>
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<td>XX</td>
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<td>XX</td>
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<tr>
<td>Against Malaria Foundation (ITNs)</td>
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<td>XX</td>
<td>XX</td>
<td>XX</td>
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<tr>
<td>World Vision</td>
<td>XX</td>
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<td>XX</td>
</tr>
</tbody>
</table>

Organization | Funding | Technical and/or Policy Guidance | Procurement | Planning and Implementation Support | Monitoring & Evaluation Support |
---|---|---|---|---|---|
Breakthrough Action (at the Johns Hopkins University Center for Communications Programs) | XX | XX | XX | XX |
Tropical Health (ITNs) | XX | XX | XX | XX |
PATH | XX | XX | XX | XX |
Malaria Elimination 8\(^{18}\) (Southern Africa) | XX | XX | XX | XX |

**Key funders of malaria campaigns: the case of Nigeria**

Outlined in the *National Malaria Strategic Plan (NMSP 2021-2025)*, the key interventions prioritized include LLIN campaigns as a main intervention for vector control, complemented by IRS and SMC for children from 3-59 months and intermittent preventive treatment of malaria in pregnancy (IPTp) for pregnant women. In 2022, ITN campaigns are planned in 14 states, with funding support from the Global Fund, PMI, and Malaria Consortium. Integrated delivery of LLIN and SMC is planned for two states (Taraba and Yobe) this year. Nigeria LLIN campaigns are delivered on a rolling basis with states grouped based on those that had their last campaign three or more years ago. SMC campaigns are performed in 4-5 cycles each year, depending on rainfall patterns and epidemiology.

The funding for these campaigns is largely donor driven, but state governments are responsible for counterpart funding for SBCC components, provision of warehousing and security for the commodities, and last mile distribution, etc. The National Malaria Elimination Program (NMEP) coordinates partners for state engagement and advocacy for buy-in and collaboration, macro and microplanning, trainings, and budgeting with the states. The budget is compiled, and funds are independently disbursed by the funders through their mechanisms. There is no co-mingling of funding, as the Global Fund and PMI support different states in the country. A World Bank and Islamic Development Bank IMPACT loan is intended to cover the non-Global Fund and PMI states, but disbursements have not yet commenced and thus the Malaria Consortium and GiveWell stepped in with support for LLIN and SMC campaigns in the interim in some of these states.

Global Fund funding goes to the NMEP or Catholic Relief Services, the two Principal Recipients, who then fund the campaigns in Global Fund-supported states. Global Fund procurement of commodities is through their online procurement platform, Wambo. PMI and Malaria Consortium funding goes to the implementing partners they engage who support campaign implementation.

The coordination platform to discuss integration, which is part of the country’s strategic plan, is the Integrated Vector Management (IVM) and Case Management (CM) technical working groups of the NMEP. The Mal-RMNCAH platform is for integration of malaria into other maternal and child services. There is malaria representation, and the group has funding support from the Global Fund and other partners. The CHIPS program (Community Health Influencers, Promoters and Services) is another coordination platform for integration discussions for community interventions.

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\(^{18}\) See [https://malariaelimination8.org/](https://malariaelimination8.org/).
Overview
Vitamin A Supplementation (VAS) is a life-saving intervention in countries with high levels of Vitamin A Deficiency (VAD), and “adequate intake of vitamin A for women and children” is one of six interventions in the package of Essential Nutrition Actions (ENAs). VAS is especially important for vulnerable children in the context of an infectious disease outbreak (e.g., measles). Global coverage of two annual doses of VAS had been stagnant around 65% of eligible children prior to the COVID-19 pandemic, and then experienced a precipitous decline in 2020 due to service delivery disruptions and suspension of mass campaigns (from 60% to 41%).

The delivery of VAS depends on mass campaigns and/or delivery through routine health services in facilities and the community. The delivery strategy for VAS has evolved over the last 15 years, with Child Health Days/Weeks (CHD) (see page 2) serving as a platform in a significant number of countries, and Supplemental Immunization Activities (SIAs) (i.e., campaigns) and polio eradication efforts also continuing to provide a platform.

The major sustainability focus among the nutrition community is integration into routine health services and leveraging CHDs. Nutrition partners agree that what is required is a mix of approaches – including campaigns – to ensure the best, and most equitable coverage. Few donors are eager to support VAS campaigns as a standalone activity and the opportunity for delivery through the polio eradication platform has wound down in many countries. Some countries continue to have standalone campaigns, but this is more the exception as compared with integrated campaigns delivering VAS. Finally, new efforts to fortify foods with Vitamin A are being offered alongside routine delivery to reduce dependency on supplementation.

Campaign Characteristics

<table>
<thead>
<tr>
<th>Targeted Diseases / Disorders</th>
<th>Vitamin A deficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Vitamin A capsule</td>
</tr>
<tr>
<td>Frequency</td>
<td>Every 4-6 months</td>
</tr>
<tr>
<td>Target population age</td>
<td>6-59 months (initial touchpoint targeted at 6 months of age, which poses challenging to align with EPI routine delivery which has touchpoints typically at 4 and 9 months)</td>
</tr>
<tr>
<td>Delivery methods</td>
<td>Health workers, community health workers (volunteers paid stipend)</td>
</tr>
<tr>
<td>Points of delivery</td>
<td>Child Health Days, routine health services, integrated SIAs (e.g., Polio, Measles), and standalone VAS campaigns in some countries</td>
</tr>
</tbody>
</table>

Global Strategy and Guidelines

The nutrition community follows **VAS guidelines** published by the WHO in 2011, in which there is no mention of campaigns. The guidelines reference delivery through routine health services, through biannual “special days” (i.e., CHDs) and distribution as part of the Expanded Programme on Immunization (EPI).

While there is no formal global strategy for VAS, the World Bank published **An Investment Framework for Nutrition** in 2017, costing scale up of nutrition interventions to reach the World Health Assembly’s 10-year targets for nutrition, and assuming the delivery platform for VAS specifically was to continue “either through mass campaigns or in health facilities.”

The nutrition community came together in 2016, convened by the Global Alliance for Vitamin A (GAVA), to collaborate on the declaration, **Vitamin A Supplementation Remains Vital in Sub-Saharan Africa**. The community committed to examining delivery models (especially in light of the phasing-out of polio campaigns) and identifying ways to better integrate VAS into routine delivery systems, including, but not limited to, the Expanded Programme on Immunization (EPI). The declaration commits to facilitating “the co-delivery of VAS with other high-impact interventions” and institutionalization in national health systems, including advocating for “a dedicated budget line for nutrition, and for activities within which VAS can be integrated, in domestic health budgets.”
A **GAVA Consensus Statement** on VAS delivery during COVID-19 encourages continued routine delivery and delivery through mass VAS campaigns or integrated campaigns (with appropriate precautions), and for countries to start planning for intensified, catch-up VAS delivery.

**Coordination and Advocacy**

The primary coordination mechanism for VAS is the Global Alliance for Vitamin A (GAVA), currently hosted and chaired by Nutrition International (NI). The three key alliance members are NI, Helen Keller International (HKI), and UNICEF. US Centers for Disease Control and Prevention (CDC) and the WHO join some discussions. GiveWell, Global Affairs Canada, and Sight & Life also contribute to partner coordination and advocacy.

**Financing**

- **Top Financiers:** The key players involved in financing for the nutrition sector (non-specific to VAS) include the Bill & Melinda Gates Foundation (BMGF), Children’s Investment Fund Foundation (CIFF), Foreign, Commonwealth & Development Office (FCDO), GiveWell, Global Affairs Canada (GAC), Power of Nutrition (PON), USAID, Vitamin Angels, and the World Bank. Financing from certain funders, such as USAID and the World Bank, is specific to the country context and where it fits into existing programs. Vitamin Angels’ support to VAS programs is funded by private contributions – corporate partners, grant-making organizations, individual philanthropists, and individual donors. Its biggest funders are Deworm the World via Evidence Action (deworming) and Kirk Humanitarian (VAS).

- **Commodities:** Most countries implementing VAS campaigns receive vitamin A capsules as an in-kind donation from the Government of Canada, a program which is implemented jointly by NI and UNICEF. The in-kind donation program supplies over 90% of capsule requirements. There has not been a major shift towards self-financing. Separately, GiveWell is a donor of capsules through HKI. Some countries have begun to include a budget line for VAS capsules. For example, Bangladesh, India, and Nepal do their own procurement.

- **Governments:** Beyond capsule donations, VAS financing supports program implementation (primarily from governments, but also including support from partners). For example, UNICEF is supported by GAC to work in 15 high-mortality countries. Countries are contributing significantly in most countries to programs, even if all capsules (the lesser cost) are provided as donations.

- **Key Implementers:** HKI, NI, and UNICEF are the key implementers of VAS campaigns, responsible for global coordination of financing, funding VAS campaign programmatic costs, and providing the supplies. NI and UNICEF Supply Division procure VAS supplies, and NI, UNICEF, and HKI provide technical and financial support to governments in complementary geographic regions.
  - NI and UNICEF Supply Division procure the global vitamin A requirements for program countries as in-kind donations. The program is primarily funded by the Government of Canada (Global Affairs Canada) to support procurement and distribution of donated capsules through polio SIAs, CHDs, and through routine systems where possible.
  - UNICEF Supply Division procures vitamin A capsules for country offices and partner programs that are not served by the in-kind contribution program, NI. This procurement for program country deliveries represents a relatively small but growing volume of total vitamin A procurement.
  - HKI’s work on VAS campaigns is primarily funded by GiveWell. HKI has also received funding in the last few years from the U.S. Government focused on integrating VAS with deworming.

- **Integrated SIAs:** Funding for VAS is sometimes contributed to immunization SIAs, particularly polio and measles in distinct budgets. This happens when VAS and vaccines are co-delivered.

- **Child Health Days/Weeks:** Child Health Days (CHD) now play a key role in VAS delivery, in contrast to standalone mass campaigns or polio or measles SIAs. CHDs are a campaign-type delivery modality, typically led by the nutrition program and which combine a number of interventions targeted for a certain age, such as VAS, Integrated Management of Childhood Illness (IMCI), and immunization. Countries that use this delivery platform typically plan for two CHDs per year. Some countries (E.g., Ghana, Kenya, Nepal, Nigeria, Philippines, Tanzania) have institutionalized these campaigns in their national strategies. Stronger coordination at the national level ensures a joint national budget with contributions of different partners for specific line items. Typically, District
Health Management Teams are responsible for planning CHDs, which includes the involvement of other health programs and inclusion of a line for CHDs in annual district budgets. Funding for CHDs in many countries has been inadequate, with countries finding it increasingly difficult to raise funds for this delivery modality. Nutrition partners are concerned this is not a sustainable way to ensure VAS delivery, and also consider this delivery platform challenging in that it is not ideally suited to reach older children (>2 years of age).

**VAS inclusion in MNCH Weeks: the case of Nigeria:** Since the maternal, newborn and child health (MNCH) platform was established in Nigeria in 2010, Global Affairs Canada has been the primary donor providing resources to procure vitamin A capsules. The Government of Nigeria (GoN) received these donations twice a year through NI and UNICEF to be able to deliver vitamin A during MNCH campaigns (i.e., MNCH Weeks). Vitamin Angels has also provided in-kind donations of the capsules to complement the GoN to improve access to VAS in underserved communities. In recent years, states have been expected to support the implementation of the MNCH week campaigns through payment of counterpart funding in addition to procurement of deworming tablets. However, the success of the MNCH Weeks has varied state by state, in part depending on challenges in the release of funds and weak governance and accountability mechanisms.

**Key Sources**

Neglected Tropical Diseases At-A-Glance: Primer on campaigns and financing

Authors: Annette Ozaltin and Alex Chekole (Results for Development)
Reviewer: Katherine Gass (Task Force for Global Health)

Overview

Of a diverse group of 20 neglected tropical diseases (NTDs) recognized by the WHO, there are seven Preventive Chemotherapy (PC) diseases targeted through mass drug administration (MDA) (i.e., “campaigns”), including:

- Schistosomiasis (snail fever) (SCH) control
- Soil-transmitted helminths (three types of intestinal worms) (STH) control
- Onchocerciasis (river blindness) (ONC) control
- Lymphatic filariasis (elephantiasis) (LF) elimination
- Trachoma (TRA) elimination

A combination of four drugs used to prevent or treat these seven NTDs, sometimes referred to as the “rapid-impact package,” is used for MDA. Approaches for combined delivery of PC were introduced in 2006, and there has been a gradual shift towards integrated management of NTDs. The PC diseases have attracted the most donor support, but the funding needs for PC access and delivery are typically different for each disease. These parasitic and bacterial infectious diseases are associated with high morbidity rates, but typically low mortality and thus these debilitating “diseases of poverty” are often neglected.

Campaign Characteristics

<table>
<thead>
<tr>
<th>Targeted diseases</th>
<th>SCH</th>
<th>STH</th>
<th>LF</th>
<th>ONC</th>
<th>TRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interventions</td>
<td>Praziquantel</td>
<td>Albendazole, Ivermectin</td>
<td>Albendazole, Ivermectin, Diethylcarbamazine</td>
<td>Ivermectin</td>
<td>Azithromycin</td>
</tr>
<tr>
<td>Frequency</td>
<td>1x per year</td>
<td>1-2x per year</td>
<td>1x per year</td>
<td>1x per year</td>
<td>1x per year</td>
</tr>
<tr>
<td>Target population age</td>
<td>School-aged children (SAC), adults</td>
<td>School-aged children (SAC), pre-SAC</td>
<td>&gt;2 or &gt;5 years typically (depends on drug combo)</td>
<td>Children &gt;90cm tall</td>
<td>Age 6 months and older</td>
</tr>
<tr>
<td>Delivery methods</td>
<td>Health workers, community health workers, non-health community members, school officials</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Point of delivery</td>
<td>School-based; community</td>
<td>Door-to-door; fixed-post primary health center</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Global Strategy and Guidelines

Global strategy is outlined in the WHO's *Ending the neglect to attain the Sustainable Development Goals: a road map for neglected tropical diseases 2021-2030.* Of the 20 NTDs prioritized by the WHO, 15 global disease strategies and 14 WHO disease guidelines and manuals also exist. The combined road map calls for a shift:

1. From siloed disease-specific programs that have limited interfaces with national health care systems and adjacent sectors…To holistic, cross-cutting approaches including integration across NTDs, mainstreaming in national health systems, coordinating with adjacent sectors and strengthening country capacity and global support.
2. From externally-driven agenda reliant on partner support and donor funding…To country ownership and financing with NTDs integrated in national health plans and budgets, and supported by partners and donors to overcome outstanding challenges.

The road map includes the below categories of cross-cutting themes:

- Integrating across NTDs: joint delivery of interventions that are common to several diseases
- Mainstreaming within national health systems: improving the quality of NTD management in the context of universal health coverage
- Coordinating among ecosystem stakeholders: working with other sectors within and beyond health on NTD-relevant interventions
- Strengthening health systems...
  - ...basic national systems: improving capacity to deliver interventions on the ground, e.g., supply chain, monitoring and evaluation
  - ...global and regional resources and expertise: extending overall support for NTD programmes, e.g., advocacy, funding
With respect to integration, the road map encourages balancing disease-specific and integrated approaches, providing the example that countries close to elimination may decide to retain a vertical structure to ensure adequate attention. Finally, the road map emphasizes domestic financing and mainstreaming: “NTDs must be accounted for in national health, development and poverty alleviation strategies and budgets and not only in NTD strategic plans.” Indeed, a target for 2030 is: “90% of endemic countries: with NTDs integrated into national health strategies/plans; including NTD interventions in their package of essential services and budgeting for them.”

**Coordination and Advocacy**

- The **London Declaration on Neglected Tropical Diseases** was a disease eradication program launched in 2012 by the WHO, the World Bank, the Bill & Melinda Gates Foundation, the world’s 13 leading pharmaceutical companies, and government representatives from the US, UK, UAE, Bangladesh, Brazil, Mozambique, and Tanzania. The London Declaration established the Uniting to Combat NTDs public-private partnership among bilateral donor governments, endemic country governments, and numerous stakeholders (NGOs, industry, private philanthropists, and academic institutions) to eradicate, eliminate, or control 10 NTDs by 2020. The drug donation programs are a cornerstone of the London Declaration Partnership.

- **Coordination of the NTD response is primarily led by WHO**, who convened NTD global partners for the first time in 2007 to bring a number of disease initiatives under an NTD “brand” to support funding, advocacy, and coordination. The WHO convened partners again in 2017 for a second global meeting focused on garnering commitments from donors. The **WHO Regional Office for Africa** is an important partner, particularly through administration of the Expanded Special Project for Elimination of Neglected Tropical Diseases (ESPEN), which is primarily focused on tackling the NTDs amenable to PC in Africa.

- The **WHO and The Task Force for Global Health** are the coordinators for the drug donation programs. The WHO coordinates for LF, SCH and STH, the International Trachoma Initiative for TRA, and the Mectizan Donation Program for ONC and LF. The latter two are programs of The Task Force for Global Health.

- **Uniting to Combat NTDs** plays another critical role. The coalition is a diverse and open global health partnership, with partners’ activities mainly including advocacy, donation of medicines, research and development, diagnostics, civil society and community engagements, and NTD program implementation. The **Neglected Tropical Disease NGO Network** is a major player, created in 2009 to give NGOs working on the five PC diseases a global forum and with membership exceeding 80 organizations today. The objectives of NNN are to be the unified NGO voice on issues to achieve NTD goals, in addition to supporting member engagement, learning, and sharing knowledge. The focus has expanded to a broader set of NTDs since.

- **Disease-specific multi-stakeholder coalitions** also provide coordination and advocacy support, including the Global Schistosomiasis Alliance (GSA), the STH Coalition, the Global Alliance to Eliminate Lymphatic Filariasis (GAELF), and the International Coalition for Trachoma Control (ICTC).

**Financing**

- **Top Financiers:** In addition to Ministries of Health and the pharmaceutical industry (drug donation), the largest funders of NTDs are USAID, the BMGF, the Children’s Investment Fund Foundation (CIFF), and The End Fund. The END Fund was founded in 2017 as a platform to engage public, philanthropic, and private contributors in investing in NTDs. Among the partners that have contributed to the END Fund are the Campbell Family Foundation, the Leona M. and Harry B. Helmsley Charitable Trust, the Shefa Fund, and the ELMA Foundation. Funding data is not consolidated across the diseases nor tracked systematically, and thus the quantum allocated for the NTDs amenable to PC and the corresponding share for MDAs is unclear.

- **Commodities:** Multinational pharmaceutical companies are critical donors and 13 were core members of the London Declaration on Neglected Tropical Diseases. This commitment stated that participating companies would meet a commitment to provide 14 billion treatments through 2020 to address 10 NTDs. Company donations are predominantly provided for MDA, but also include donated or discounted drugs for treatment, and may provide some support for delivery. Large-scale drug donations for MDA include contributions from Johnson & Johnson, GlaxoSmithKline, Merck, Pfizer, EMD Serono, EMS, and Eisai Co., Ltd. The WHO and The Task Force for Global Health facilitate these public-private partnership donation programs.

- **Development Assistance for Health:** Development assistance for health (DAH) for NTDs is provided primarily by the US Government (through USAID). The UK government (through DFID/FCDO) had been a major bilateral donor
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government, but the aid budget for NTDs was cut by 90% in 2021. The Government of Japan has made big investments in promoting access to and delivery of NTD drugs through funding the Access and Delivery Partnership (ADP) and contributing to the ESPEN project.

- **Multi-stakeholder Partnerships**: Commitments by governments, the private sector, and others have also been fostered through multi-stakeholder partnerships, such as the Onchocerciasis Elimination Program, the Accelerate Trachoma Elimination Programme, the Act to End Neglected Tropical Diseases | East & | West, the Global Programme to Eliminate Lymphatic Filariasis, among others.

- **Private Philanthropy**: Private foundations such as BMGF and CIFF are major donors, in addition to the Conrad N. Hilton Foundation, the Carlos Slim Foundation, the Queen Elizabeth Diamond Jubilee Trust, Mondo Sano, and others. GiveWell is also a major donor, channeling individual donations to NGOs such as SCI Foundation, Evidence Action, Sightsavers International, and The END Fund. Donors in the Middle East and the Gulf states (governments and private philanthropic donors) have played a long-time role in financing NTD programs. The Kuwait Fund for Arab Economic Development is one of the founding partners of the ESPEN project. The Reaching the Last Mile Fund was established by the Crown Prince Court of Abu Dhabi in partnership with the END Fund and with the support of the BMGF, DFID, and ELMA Philanthropies.

- **Key Implementers**: There are over 80 NGOs that are members of the NTD NGO Network, highlighting the number of large and diverse implementers. NGOs such as the Carter Center, FHI360, Helen Keller International, RTI, and Sightsavers International play a critical role in channeling funds provided by major donors for addressing NTDs. Implementation for Trachoma is primarily led by the Carter Center, Sightsavers International, Fred Hollows Foundation, World Vision, and others. These organizations raise funds to support program implementation. The Schistosomiasis Control Initiative (SCI) at the Imperial College London was established with a BMGF grant to focus on Schistosomiasis and STHs. The Imperial College London also receives funding from the UK Government, GiveWell, and others. The Filarial Programmes Support Unit at the Liverpool School of Tropical Medicine receives money from the UK government.

- **Development Banks**: The World Bank and the Islamic Development Bank (IsDB), for example, have provided loans and grants to address NTDs, although these have not always been a priority for Ministries of Finance. The World Bank has played an important role but is less engaged today. The World Bank established a trust fund in 1995, the *African Programme for Onchocerciasis* Control (APOC), managed by the WHO and with drug donation from Merck. The fund of $120M USD was to be spent over 12 years, initially with 75% of contributions from APOC to each of the 19 countries, with 25% matching from the governments. A sustainability model was established, focused on reducing APOC contributions by 25% every year over 5 years. Most countries were unable to establish this model for continued financing. The trust fund ended, with some APOC assets absorbed by the ESPEN project.

- **Fragmentation of funding and partners: the case of Ethiopia**: The NTD program in Ethiopia has historically been supported by donor financing. There are 18 key actors working on NTDs, with donors and implementing partners funding program components at the national and regional levels, but no budget line at the national level specifically for the NTD program. Separate donors inject funds into the Ministry of Health budget, and those funds are distributed to Regional Health Bureaus, and then further distributed to districts based on targets for NTD interventions. The various implementing partners have distinct planning and budgeting cycles and implementation timelines, and they hold their own distinct budgets at national and subnational levels. There is no platform for implementing partners to have coordinated and integrated planning or budgeting at the national or regional level, there is no pooling of funds, and a large portion of the NTD program is off-budget. 19 There are different MDA efforts focused on the dozen NTDs. Various groups are involved in NTD response, including the National NTD Task Force and various national NTD technical working groups, the National Trachoma Task Force, the Onchocerciasis and Lymphatic Filariasis and Leishmaniasis Technical Working Groups, the Schistosomiasis and Soil-transmitted Helminths Technical Advisory Group, and the NTD-WASH Task Force. The third national *NTD Strategic Plan 2021-2025*, aligning with the global road map, calls for “movement away from siloed, disease-specific programmes to mainstreaming into the national health system and intensifying cross-cutting approaches centred on the health needs of people and communities.” The five-year total cost for the 3rd NTD Strategic Plan is estimated at $353.16 million, with cross-cutting approaches representing 16.2% of the budget.

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19 Off-budget financing refers to expenditure that’s not funded through the government budget. Such financing tends to hide the amount, rationale, objective, and actual extent of government spending, borrowings, and debt.
Key Sources


Malpani, R. *Landscape of funding and financing opportunities for access and delivery of health technologies for neglected diseases*. Uniting Efforts for Innovation, Access and Delivery; 2020.

