GiveWell IRC Immunization Concept Note_2024-08

Summary: GiveWell (GW) and International Rescue Committee (IRC) aim to increase cost-effective immunization in humanitarian settings, especially among zero-dose children (ZDC) and under-immunized children (UIC), by unlocking $40M+ in IRC funding opportunities. GW and the IRC will explore opportunities to research, scale up, and integrate immunization interventions with other interventions to increase programming cost-effectiveness and room for more funding. As an initial step, the IRC requests $150,000 to co-investigate funding opportunities alongside GW researchers.

Background:

- *Immunization:* IRC has active immunization programs in 16 countries. For example, the IRC is leading a $50M consortium to immunize ZDC in Ethiopia, Somalia, South Sudan, and Sudan (2021-2025). In the first six months of implementation, the consortium immunized ~300,000 children.[1] From a quick BOTEC, we estimate we are counterfactually immunizing a ZDC for ~$80 to $200 per child.[2]
- *Integrated care:* The IRC also has experience integrating immunization services with other interventions. For example, as part of its GW-funded malnutrition treatment work in Somalia, the IRC also provided routine immunization services.[3] These services accounted for ~56% of the program's overall CE.[4]
- *Cost-effectiveness:* The IRC is dedicated to the use of cost evidence to inform program prioritization and design. Its "Best Use of Resources" (BUR) team conducts cost research (~400 analyses to date) and provides input and recommendations across IRC's programming. For example, for the GW-funded malnutrition project, we estimate GW/BUR-IRC program design iteration increased program cost-efficiency by ~25%-100%.[5]

Objective: The primary objective is to co-create identify opportunities to increase immunization coverage in IRC focus areas, as part of a cost-effective scalable model to unlock $40M+ in IRC immunization funding opportunities for GW.[6] This objective may also have positive spillover effects by achieving learning value for GW and IRC, unlocking diverse immunization funding opportunities,

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[1] The Gavi REACH Consortium: Delivering Immunization Services to Zero-Dose Children in the Horn of Africa

[2] Gavi Reach BOTEC.

[3] International Rescue Committee — Acute Malnutrition Treatment in Burkina Faso, Chad, Democratic Republic of the Congo, Niger, and Somalia (January 2024)

[4] See 2024-03-28 [in vetting] GiveWell, Malnutrition treatment CEA (IRC standard protocol), 2023 shared with IRC.

[5] We estimate cost-efficiency gains of ~25% due to program design improvements (comparing initial GW proposal cost per child l to final GW proposal cost per child) and ongoing implementation improvements, including adjusting for attribution to GW/BUR (instead of, for example, economies of scale). However, IRC's average cost-per-child across malnutrition programming in 2016 was ~$300, so we think it is also possible that the original GW proposal underestimates the counterfactual cost-efficiency, since we believe it is highly likely the original proposal was already informed by cost-efficiency improvements that would not have otherwise occurred.

[6] $40M is based on a rough estimate of total immunization-only funding needs in IRC contexts.

informing and supporting government immunization policies, evolving global immunization strategies, and generally promoting more integrated funding and programming in PHC.

Qualitative funding case:

- *Counterfactual:* Among ZDC and UIC in humanitarian settings, there is low immunization coverage and high mortality rates.
- *Leverage:* IRC programming can leverage existing government infrastructure and donor funding that would counterfactually go underutilized.
- *Funding:* Major immunization funders generally do not fund this work because they primarily fund very short-term projects, government immunization services, and/or fund immunization-only interventions (i.e., no integration).
- *Spending flexibility:* GW funding flexibility allows the IRC to focus on the most cost-effective spending strategies, including (if deemed cost-effective) shifting spending to rapidly respond to unexpected outbreaks. Integrated programs spread fixed costs.
- *Effects:* Based on GW's [New Incentives CEA](#), immunization-only interventions can be effective and cost-effective. Integrated programs can increase demand for health services and have a greater health impact than the sum of their parts.[7] For example, in IRC's GW-funded Chad malnutrition work, IRC coupled malnutrition screening with immunization outreach programming. We estimate its cost per child admitted for malnutrition was roughly one-half to one-sixth the cost of nutrition-specific mass screenings.[8]

Key uncertainties / Qualitative case against: In general, targeting hard-to-reach populations in humanitarian contexts is relatively expensive compared to similar development programming. Coverage data may be hard to obtain or unreliable, particularly in ZDC and UIC, reducing the certainty of funding opportunities. GW may fund some immunization programming that Gavi, the Vaccine Alliance, the Bill & Melinda Gates Foundation, or another major immunization funder might have theoretically funded (note: the IRC does not currently have major immunization funding in its pipeline). However, the risk of not addressing outbreak prevention significantly outweighs the cost and funding issues, as preventing outbreaks in these vulnerable populations can save lives and reduce long-term health costs.

Proposal: As a first step, the IRC requests $150,000 to fund dedicated staff time to, in collaboration with GW, investigate funding opportunities. We expect this funding to increase the likelihood and quality of subsequent IRC funding opportunities. These funds will be used to cover costs for a Best Use of Resources cost analyst and Health Unit immunization program manager. At the end of six months, we expect to have a list of immunization-increasing programs that IRC could potentially implement (pilot for scaling) with additional funding. Programs will be selected based on maximizing for the number of vaccinations delivered to children under-2 (with potential optional consideration of benefits for children aged 2-5), as part of 'Zero-Dose Catch-Up policies at country-level. Vaccinations 'count' if they counterfactually would not have happened. For each program, information will be provided on:

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[7] For example, see [Habib et al 2017](#).
[8] Year 1: Cost per admission for admissions due to "advanced vaccination strategy": $53. Cost per admission for admissions due to "mass screenings": $97. Year 2: Year 1: Cost per admission for admissions due to "advanced vaccination strategy": $30. Cost per admission for admissions due to "mass screenings": $47.

- What is IRC's experience with this type of program? E.g. has IRC piloted or scaled the program before? Have other organizations implemented it before and what can we learn from their experiences?
- What population(s) would IRC suggest (locations[9], ages, etc.) targeting and why? Roughly, if the program was scaled up in the future, what are the other settings where this could be a useful approach (to get a rough sense of 'room for more funding')?
- What is IRC's estimate of current coverage rates for BCG, DPT1-3, PCV1-3, rota 1-3, and MCV1, and what are these estimates based on? (An input into GiveWell cost-effectiveness analyses)
- What is IRC's estimate of the change in vaccination coverage that this program would achieve? For many programs, this will be a rough guess. (An input into GiveWell cost-effectiveness analyses)
- What is IRC's estimate of either at-scale (GW guidance: "at-scale" should mean at least $5M+/year for 2-5 years in line with under-5 child mortality data, Global Burden of Disease) (a) cost per child in the target population, or (b) cost per counterfactually delivered vaccine? (An input into GiveWell cost-effectiveness analyses)
- What other interventions might be delivered alongside vaccines in this program?[10] (Possibilities for increasing both cost-effectiveness and room for more funding). For these "add-on" interventions, GW generally does not expect accompanying data, i.e. these can be a qualitative ideas longlist. If there are readily-available data already in existence, GW welcomes this as a "nice to have" accompaniment.
- Initial ideas for M&E to get more information on the questions above, including the expected contextual feasibility of implementing each idea. For example:
  - Baseline surveys of vaccination coverage and coverage/usage of other interventions that might be delivered alongside vaccination
  - Follow up surveys to track changes in vaccination and other intervention coverage and usage
  - Would this be a good program to test with an RCT?
  - Sketch of processes for monitoring to track program performance over time

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[9] "Location" geographical scope will depend on the intervention, as different interventions might be best implemented at the multi-country, country-level, or subnational level. Location should keep in mind the general scale/duration guidance below.

[10] See here for a rough IRC assessment of overall potential overlap between GW areas of interest and IRC programming. From Natalie, 2024-07-30: Not an exhaustive list, but interventions that are of particular interest are:
- Providing ORS/zinc to all households with young children
- Chlorine distribution to all households with young children
- PMC/SMC for malaria
- Breastfeeding promotion
- Vitamin A supplementation
- HPV vaccination

Others that are on our radar:
- malnutrition screening and treatment/referral
- deworming
- iCCM
- IPTp
- MDA with azithromycin

For all these deliverables, IRC will be expected to incorporate new external evidence into its deliverables. However, where the IRC already has external evidence available, GW would welcome the inclusion of external evidence into deliverables.

Communication standards / Ways of working

- Monthly meetings to assess status
- Simple two-page (max) status report and agenda (To accompany monthly meetings)
- Shared Google Drive Folder with living draft deliverables to promote high transparency and ease of collaboration (Note: there may be some confidential data the IRC will not be able to directly cite/share; we will state this to avoid ambiguity)

High-level timeline

Month	Main activities/deliverables
1 (mid-October goal, could be January to get the best staff person)	- Kickoff meeting(s) - Skeleton deliverable - Assessment of what data we have, but not the actual data (final)
2 December 2024	- Intervention longlist - Target population longlist
3 January 2025	Intervention shortlist mapped to specific populations
4 February 2025	Add-on interventions
5 Mid-March 205	Final deliverable compilation