

Phone conversation between TB Reach (Suvanand Sahu, Team Leader, and Jacob Creswell, Technical Officer) and GiveWell (Elie Hassenfeld and Natalie Stone) on March 5, 2012

GiveWell: We could evaluate TB Reach in one of two ways: (1) review projects ourselves to fund, and (2) evaluate TB Reach, itself, and potentially move funding directly to you. At this point, (2) makes more sense. To that end, we have some questions about how TB Reach works.

First, would it be possible to see technical evaluations of your projects, including what data was used and how successful were the project was at detecting additional cases?

TB REACH: That would be possible. Our approach to evaluation is very simple. We look at the case detection numbers in the evaluation population before and after the project. When there is a control population, we look at that as a comparison to the evaluation population.

GiveWell: Could you share specific reports?

TB REACH: Yes, that should be possible. The analysis is done at the end of the project. Only 3-4 projects have actually ended. Our better projects have not yet ended. We do have interim data from many projects that leads us to believe things are going well.

GiveWell: Is the interim data for both wave 1 and wave 2?

TB REACH: Wave 2 has just started. No interim data yet from wave 2, only from wave 1. Interim data has to be interpreted with caution because of the possibility of seasonality in the results. We can send you the analysis of our interim reports which considered changes in notified cases. Wave 1 evaluation reports will be available in June. Wave 1 was projects done in 2011.

GiveWell: Could we see the 3-4 reports that are completed?

TB REACH: We'll see what we can send you. We'll send you 1-2 completed reports.

GiveWell: We're cautious about seeing a sample that could be unrepresentative. Can you either send all report or send details of how you selected the ones you send?

TB REACH: We will send details of selection.

GiveWell: Do/will evaluation reports look at 2012 results of wave 1 projects?

TB REACH: We will have evaluation reports for 2012 for the 11 wave 1 projects

towards the beginning of 2013 once they have come to an end. Of the 30 projects selected for funding in 2011, 29 were actually funded and implemented (the one that wasn't decided to change their plans). We extended 11 of the wave 1 projects into a second year. These are called 'year 2 of wave 1' grants. A few of them have plans for longer term funding. A few projects that have completely ended. The remaining are trying to get more funding. This is an area that we are still thinking about: how to sustain projects with results.

GiveWell: Are you focused on funding wave 3? How much funding do you need?

TB REACH: We are planning to launch wave 3 in the middle of this year. We anticipate even more applications in this wave, because there are currently few other sources of funding for projects like these. We estimate there will be \$15-20 million available for wave 3.

In wave 2, we had \$6-8 million of Xpert MTB/RIF orders (a new diagnostic technology) as part of case detection activities. We are part of an application to UNITAID to get funding for Xpert MTB/RIF for wave 3. In that case grants from TB REACH could be reserved for implementation rather than paying for tests.

From wave 1 to wave 2, there was a huge increase in number and quality of proposals, and more money available. We expect less money to be available for wave 3 (wave 2 was \$30 million), but expect number and quality of proposals to be higher. Our projection is that we'll get 400 or more applications (more than 300 in wave 2). If we hold them to the same criteria as we did in wave 2, we'll be looking at a funding gap of \$15-17 million even if we get the UNITAID funding.

GiveWell: Does your funding come exclusively from CIDA?

TB REACH: It's entirely from CIDA for funding grants. We get very little from DFID for non-grant purposes. The CIDA funding is earmarked for TB REACH. Our partners called for increasing TB case detection and the Stop TB Partnership got support from CIDA to set up the TB REACH initiative to address TB case detection via innovations. CIDA has made a 5 year commitment to support TB REACH and wants the TB REACH initiative be supported by other donors.

GiveWell: Why did funding fall for wave 3?

TB REACH: Wave 2 included extra money accumulated during the startup period. Wave 3 and Wave 1 are funds available on an annual basis from the CIDA 5 year grant.

GiveWell: We took a look at the 7 unfunded proposals you sent us. Do you know whether the 7 organizations that submitted these proposals received funding from other sources? Do you mind if we email the people from the proposals you sent us?

TB REACH: We don't know about all the projects. We think it's reasonable to assume they likely haven't gotten funding for the purpose in current funding climate. There was one in Bihar that we know has not received funding. There's been some discussions about them getting funding, but nothing has come through to date.

You are welcome to contact them directly. It would be good if you could copy us on the messages you send so we can see how they are doing as well. We don't have the capacity to follow up with all applicants beyond the usual feedback letters from the proposal review process.

GiveWell: If you got additional funding, would you use it on grants?

TB REACH: Yes, the short answer is that it would go towards grants. Currently all our grants go to case finding activities. We have had discussions about specific requests for proposals: TB in children, TB/HIV case finding, etc.

We're also interested in funding innovations beyond case detection based on the needs of global TB control and needs expressed by our partners, e.g. TB treatment, but the current CIDA funding is mandated to focus only on case detection so we need to mobilize additional funding for this to happen.

GiveWell: Is TB REACH a department of the World Health Organization, its own agency, or something else?

TB REACH: TB Reach is an initiative of the Stop TB Partnership. The Secretariat of the Stop TB Partnership is housed by the World Health Organization.

GiveWell: Does TB REACH have its own financials, including grants and admin costs?

TB REACH: The CIDA grant is for Canadian\$120 million, nearly \$100 million of which is for grants and about \$20 million of which is for monitoring and administering of grants including overheads.

GiveWell: Are there TB REACH financial docs available?

TB REACH: I'm not sure. Whatever is in the public domain we can send.

GiveWell: We were also wondering to what extent you can help us understand the impact of detecting additional cases of TB as opposed to other programs such as bed nets to prevent malaria?

TB REACH: We keep asking ourselves the same question. It's difficult to compare across health programs. We try to do this in terms of lives saved. We have calculations based on fatality rates for detected cases v. undetected cases, and

separate this for different groups, such as HIV positive people. This information is not difficult to provide. It would be difficult to provide the number of MDR cases prevented and the transmission of TB reduced.

GiveWell: How do you account for treatment quality improvement?

TB REACH: The additional cases detected by TB REACH projects are treated within the existing system for treatment in the respective national TB programmes. This ensures that additional cases detected because of TB REACH are well treated. A few TB REACH projects also have interventions to improve TB treatment quality but this is not an area of focus for the projects – the projects focus on case detection. The treatment success rates reported by the national TB programmes for the TB REACH evaluation population shows to us whether treatment outcomes have been maintained or improved.

GiveWell: Could you send assumptions and calculations?

TB REACH: Yes. The other thing that these projects have is infections prevented and early detection. We have a project finishing in Zimbabwe, where the percentage increase in TB detection was not much, and this project is not among the best projects on this measure, but it was able to decrease the delay in diagnosis from 3 weeks to a couple of days. These are the added benefits other than increased numbers of TB patients detected by the TB REACH projects.

GiveWell: If there are things at you fingertips that would help us understand these benefits, we'd appreciate them.

TB REACH: These are things that you come to understand qualitatively or from talking to people, benefits that are difficult to claim quantitatively.

GiveWell: In what ways is the Xpert MTB/RIF an improvement?

TB REACH: It is more accurate and more specific. It improves the quality of diagnosis. More cases will be detected. Sputum testing has been used for 100 years. Xpert MTB/RIF won't be standard tool anytime soon, but it's revolutionary and will detect many TB cases that are missed by sputum microscopy. There will be huge impact for people with HIV and children; people who generally can't be detected through sputum microscopy. There are lots of cases with low bacteria counts in the sputum which can be missed by microscopy, but detected by Xpert. However, there's only one manufacturer that produces it, and it's not cheap.

GiveWell: What happens to people who have TB but don't test positive through sputum testing?

TB REACH: If you have a high quality smear microscopy, you can detect about 60% of true TB cases. In most settings the remaining TB suspects are given wide

spectrum antibiotics, and told to come back for an X-ray. People are often lost from this group. With Xpert, you get an accurate diagnosis on the first visit and can get treatment started right away.

There are other barriers to TB testing which are also important in some settings. There aren't a lot of TB testing centers, the travel times to these can be long, and they often have short working hours. The costs to patients of getting to the testing center can be considerably higher than the cost of a Xpert test. Hopefully, costs to patients will be reduced by addressing these barriers.

GiveWell: Do you monitor the quality of TB treatment for the additional patients your programs detect?

TB REACH: We have not asked our projects to report on treatment outcomes but are now beginning to do so. However, treatment takes 6-9 months, and then it often takes another 3 months to get the results reported. We're looking at aggregate TB data. In town X there were 100 cases last year, and this year there were 130 cases. What we are interested to assess is that despite the increase of 30 cases the treatment success, as reported in the information system of the national programme, remains high in that town. We're not tracking individual cases. For certain projects, there will be specific treatment data on their cohort, but in general, it's at an aggregate level. But it's important to note that if a patient is not enrolled in the nationally recommended treatment plan, it's not counted as case detected.

GiveWell: We haven't found good literature on the difference in treatment quality between publicly-run treatment programs and private providers. Do you have information on the difference?

TB REACH: We don't recommend only publicly-run treatments, but do encourage public-private partnerships. However, notification and registry of cases must be to the national TB program, and private providers have to follow some rules such as providing free treatment.

We have a few articles on treatment regimens used in the private sector that we will send. Generally speaking, it is a completely mixed bag - drug quality is unknown and patients have to pay out of their own pockets which makes following 6 month treatment to the end less likely.

GiveWell: Do you have a list of all the projects you've funding that describes the type of activities?

TB REACH: We will soon be launching a website that will allow the public to look up where our grants are given by location, intervention, etc.

[Update: The website is up at <http://www.stoptb.org/global/awards/tbreach/>]