

GiveWell Conversation with Operation Asha (Shelly Batra, President and Sandeep Ahuja, CEO)
March 17, 2011

Question 1:

We are particularly interested in understand the additional people treated by Operation ASHA. In other words, what would have happened if Operation ASHA were not in operation?

Answer 1: Operation ASHA is serving 4 million disadvantaged in six states of India, mostly in the urban slums but also now in peri-urban and rural areas. In these areas, we are the exclusive providers, that is, Operation ASHA is the only organization which is serving these people by TB education, intensive counseling, active case finding, complete TB treatment with default tracking to prevent MDR-TB. On an average, one patient, if untreated, infects 12 others in his lifetime. Thus we are breaking the cycle of spread of the disease. By preventing MDR-TB, we are also preventing spread of MDR-TB in the community.

Question 2:

Presumably there is some government treatment or other treatment available even if not as good as yours?

Answer 2: The government has a TB control program that is excellent as far as the TB hospital and diagnostics are concerned. What is typically missing are accessible DOTS centers open at convenient hours that a patient can reach with missing work and wages. Also, there is a great shortage of trained counselors to do active case finding, TB education, and to turn the tap off on India TB. To show our point, we started work in South Delhi in 2006. Before we started work the detection rate was 82/100,000. In 2009, or detection rate is 160/100,000 population. That means that the detection rate is increased by 100% because of our work in this area. Had we not been working in this area, half of the cases of TB would have been missed.

Question 3:

Is South Delhi all Operation ASHA or are there any other groups working in the South Delhi part of this graph?

Answer 3: In South Delhi, the government is one of the major players and there are other NGOs running a few centers as well. Operation ASHA caters to 40% of the patients in South Delhi, other NGOs 2% and the Government about 58%. Because of the long duration of TB treatment, and the need to retain patients for the full duration of treatment, most NGOs are not keen to do TB treatment, which is much more intensive and time-consuming as compared to those diseases which require a single or a few contacts. Operation ASHA utilizes community based health workers, our counselors, are relies upon counseling of patients and families to prevent missing doses, which could lead to the potentially fatal MDR-TB.

Question 4:

Does the 40% on this graph represent just the 40% that Operation ASHA treats?

Answer 4: Which graph does this question refer to? We will be happy to look at the graph and answer the question appropriately.

Question 5:

Where is this data coming from and how is it collected?

Answer 5: The data for operations is coming to us from our field staff. It is prepared by the counselor, checked by the Program manager and sent to the head office in Delhi. This data is also supplied to the government on a monthly basis, so it becomes part of the overall data. This is done for all of the areas we are working in. All data is verified by the government and cross checked with records in the diagnostic labs, TB hospitals and medical supply units that supply the box of medicine. Then the WHO also carries out independent analysis. This analysis is very

through. It includes random and surprise visits to our clinics, the labs, hospitals and medical supply units. The WHO also asks our counselors to take them to patient homes, in order verify that they do know where to find patients. Then counselors will be asked to step aside so that the WHO representative can speak to patients in private. During these conversations the representative not only verifies that treatment is happening, but that it is quality treatment.

Question 6:

So far what we have seen has been summary level data. We are interested in working on a more detailed level. How much of this data do you have that you can share?

Answer 6: We have a very stringent report system. We believe in total transparency, and have detailed data sets from the time we had started working. We can give you monthly data or annual data from one center, city, state, or the entire operations.

Question 7:

We'll prefer the monthly data. What's important for us is to be able to compare the data for Operation ASHA areas with other areas.

Answer 7: The data collected by the government is actually much less than what we are doing. It would be good to compare the data for Operation ASHA with others as you have suggested. We can study case detection rates for our centers vs. government centers in South Delhi or other areas.

Question 8:

Is that in the slide you sent with Government of India data?

Answer 8: That is from the government data, which is turned into slides. We could give you the details and you could cross check.

Question 9:

Do you also have these for treatment success and default rates?

Answer 9: Yes we have detailed data on our default rate and treatment success rate. Our overall default rate is about the lowest in the world (under 3%). In Delhi, where we are using biometrics to identify every dose taken by patients and more than 1700 transactions have been done; the default rate is down to 0.5%. The treatment success rate is also collected by the government and by us, and we can give you the data. About the cure rate and death rate, I don't think the government collects this data. We shall be sending you the government report for 2006.

Question 10:

Do you have previous years?

Answer 10: Sure.

Question 11:

In the government report, is that inclusive of Operation ASHA data?

Answer 11: The government data is inclusive of Operation ASHA data, as well as all NGOs that are working in TB treatment.

Question 12:

Can you send us the data you have for the same sets of treatment centers, specific data for each center?

Answer 12: Yes, we can do that. It is the same data analysis that we include in the annual report.

Question 13:

Can you send that annual report?

Answer 13: Yes, I would be happy to send the annual report. I can also send the government reports for 2007 and 2008.

Question 14:

Data like this is going to be very helpful to us. Operation ASHA going back to 2006, Operation ASHA going back to 2006, Operation ASHA specifically and then having the government data going back for comparison-whatever metrics are available. That is going to be very useful to us in our assessment. You don't need to put together charts for us-government reports or data you have internally are fine. We are happy to go through large amounts of data.

Answer 14: So you need the reports from us?

Question 15:

Yeah, I think the main thing we are going to follow up on is to get government figures for those same dates and also government figures for prior dates for South Delhi - those are the primary things we are looking for. Also, the annual report, and anything from the sample of your report system, that might be helpful too. Lastly, we've been talking about South Delhi but to the extent that we could look at data from East Delhi or other places, that would be helpful too.

Answer 15: I will look. We have the summary reports for all the cities. I think it would be interesting for you to look at these reports. We don't seem to have the government report for 2009. We've already sent you reports for 2008, 2010, but we will try to find the report for 2009 as well. We don't remember having taken a look at anything before 2007, but shall try and see if we can find it. We would be happy to flood you with as much data as possible.

Question 16:

Why do you think Operation ASHA could detect 170% above the expected detection rate?

Answer 16: The average expected prevalence for a city is 95 patients/100,000 population. Operation ASHA modus operandi is to empower communities to serve their own needs. We are using counselors who belong to the slums and villages they serve. These counselors carry out ACTIVE case finding to detect contacts of existing TB patients, they also carry out educational forums and each counselor is expected to visit 5 homes a day in order to educate about TB and encourage suspects to come forward for testing. An important point is that we have incentivized our staff and the counselors get an incentive of about 3.5 dollars for every patient they detect and enroll in the system. When we go to disadvantaged areas we can see patients and family living in cramped, unventilated shanties, malnutrition and other factors responsible for spread of the disease.

We are seeing the same problem in every city we are going to. So the expected prevalence is too low. We don't have enough data to show conclusively, but hopefully with the study with MIT, we will have many more answers once that is done in 1-1.5 years. Slum areas have a much higher prevalence and the detection rate is too low.

Apart from patients, our counselors are the ones that are benefiting from our program. 80% of our total costs go into salaries of our health workers and managers and they are all from disadvantaged areas.