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Elie Hassenfeld: Hey, everyone. It's great to see you. Thank you for being here. I'm Elie Hassenfeld, I'm GiveWell's co-founder and CEO. And as many of you probably know, GiveWell is an organization that does research to recommend organizations that accomplish a lot of good with their work internationally. We're really excited tonight to be joined by Dr. Buddy Shah. He's the CEO of the Clinton Health Access Initiative. Excited to hear from him. I also want to welcome my parents, Joan Blum and Dan Hassenfeld, they are visiting from the Boston area where I grew up. They don't usually get to come to these events, so it's really nice to have you here tonight. I'm really excited to talk with Buddy because, Buddy, I think we've known each other now for more than ten years, if I'm remembering correctly. Buddy was formerly the founder and CEO of an organization called IDinsight. It's a research organization for programs that are operating in low and middle income countries. Buddy and I started working together closely when GiveWell supported some of the work that IDinsight was doing when he was there. Buddy then came to work at GiveWell, and we worked very closely at GiveWell together for two years before Buddy was sadly recruited away to become the CEO of CHAI, the Clinton Health Access Initiative.

CHAI is, for those who don't know, is one of the largest global health organizations. It operates in more than 30 countries and runs a very wide variety of programming. One of the reasons I'm

really excited to talk to you, Buddy, and with all of you is because I think that- Buddy and I know each other very well, and I think that there's very little at a principles or methodology level that we disagree on. But I'm at GiveWell, you know, we do research to try to find the most cost effective programs. CHAI is a very large global health organization. And so one of the main things we want to talk about is if we agree on so much, you know, why is GiveWell not just doing what CHAI is? Why is GiveWell, you know, not *only* recommending money to CHAI, let's say? Or maybe why is CHAI not just doing programming that GiveWell would recommend? So we're excited to get into that a little bit. Uh, recently we've supported some work that CHAI is doing. We call this the "Incubator" at CHAI, where CHAI is developing programming that GiveWell could potentially support. Potentially very cost effective programming that doesn't already have a home, an organization delivering it somewhere else, you know, globally. I think this program that we've implemented and supported at CHAI is one of the more exciting programs that we've supported in the last couple of years.

And I just want to give one example of the work we're doing together. And then you'll get a chance to hear from Buddy, I promise. So one of the programs that CHAI is implementing via this incubator is a program called oral rehydration solution with zinc to treat diarrhea in young children. And diarrhea in high income countries is a nuisance, in low income countries it is still one of the leading killers of young children. More than 500,000 children die every year of diarrhea. And there's a treatment called oral rehydration solution that is cheap—In the work we're doing with CHAI, we estimate it's about $2.50 per child treated. It's effective—It reduces mortality from diarrhea by approximately 60%. And all in we estimate that it will cost less than $2,000 per death averted via this program. GiveWell has tried to find ways to

support this program for years, and it's only now via CHAI that we found a way to do it. We're not really sure why it's been so hard to find a way to support ORS. It's well known that it works; it's essentially like Pedialyte for those who have young children and ever use that. Some speculation is that, you know, maybe funders see it as boring and no longer needed, notwithstanding the fact that it still is not used ubiquitously across the entire world. Possibly it's hard to figure out how to deliver. Usually, you might expect people to come pick it up in a clinic when needed, and so it was hard to find a nonprofit partner we could support to deliver the program.

But based on some recent research, CHAI proposed a program that would distribute ORS to families with young children. They would also promote the use of ORS so people would know that it was effective, and that they should use it. And we finalized our support for this program recently and are excited to see what it can do. You know, we're optimistic, but consistent with our general approach of having rigorous evaluation so we know whether things will work or not, we're also supporting a randomized controlled trial via the Rand Corporation to try and assess the ultimate effectiveness of this program. If it looks good, it has the results that I described, we'll be excited to scale it up. And if it doesn't, you know, we'll move on to other things. And we're just excited to partner with CHAI on this type of work.

But now you've heard enough from me. I want to turn things over to Buddy. And I think maybe the high level question to start with is, you know, why is CHAI doing anything other than just implementing the most cost effective global health programs?

Buddy Shah: Not to evade the hard question, but maybe I'll just start by giving a flavor for what CHAI does overall and then get to that. So, you

know, CHAI was formed at the height of the HIV/AIDS epidemic 20 years ago. And during that time in the early 2000s, basically HIV, you know, before that, was a death sentence. If you get the diagnosis. And then pharma develops these amazing breakthrough antiretroviral drugs that almost overnight changed HIV from a death sentence basically to a chronic condition that you could live, then, into your 50s and 60s with. Now, basically, life expectancy is almost the same with someone who lives with access to treatment their whole life. The problem is that it was $10,000 per patient per year. And pharma obviously invested a lot of R&D money into the development of those drugs. And 90 plus percent of people dying were in markets where they simply couldn't afford, either individuals or the government, $10,000 per patient per year. And so the first part of what CHAI did was what we call market shaping. And that's basically pooling a bunch of capital from big governments like the government of South Africa or government of India, donor governments like the US, UK and multilateral institutions like the World Bank and the Global Fund. And then going to pharma and saying, hey, look, if we can guarantee you X hundred million dollars a year or X billion dollars a year, will you drive down the price of these lifesaving drugs close to your basically marginal cost of production, and then we'll help design intellectual property agreements so that it doesn't infringe on your profits in Western Europe or Japan or the US? And so CHAI did this kind of work, along with a lot of others, to help drive down the price of life saving drugs.

So that's the first pillar of what CHAI does, basically what we call market shaping, now across a range of other disease areas. The second part was realizing that just having high quality, low cost commodities was likely not enough to actually save lives. And so the second part of what we do is what we call being a trusted strategic partner to national governments. So CHAI works at the

invitation of either the head of state or the Minister of health in 36 countries around the world: Latin America, sub-Saharan Africa, India, and Southeast Asia, to basically design public health policies to figure out how do we procure these drugs? How do we build supply chains to get them out to rural communities that need them most? How do we figure out the financing and training of health workers? So that's the second component is basically, imagine CHAI teams in national capitals, in Nairobi, in Delhi, in Abuja, advising governments on all these public health policies.

And then the third part of what CHAI does, the third leg of the stool, is being an operational partner. Which is essentially ensuring that great plans on paper at the national capital level actually get executed well, either by the government health systems or by the private sector. So we don't actually tend to implement anything ourselves. We're not the ones hiring nurses or doctors and midwives, putting shots in people's arms or pills in their mouths, but instead figuring out at the subnational level, at the district level, at the village level, how do we support the government and private sector through training or setting up data systems to make sure that those great plans are actually translated into lives saved. And so those are the three things that we do. It started during the AIDS epidemic with with global market shaping to drive down the prices, advising governments, and then making sure that those plans actually translated into improvements in people's lives. So with that as grounding, you know, to answer the hard question, like, why isn't everything that CHAI does what GiveWell does? I think the first thing to say is just that we are trying to frankly, do like a lot more in the way that GiveWell thinks. You know, cost effectiveness analysis seems really boring, but we just had a pretty heated internal debate a couple of weeks ago based on a GiveWell blog post, which talked about one intervention: anti-malarial bed nets that saves kids' lives.

And there's the first order problem of like, okay, which interventions are going to save the most people's lives? So thinking about like, we could do bed nets or we could provide surgeries or we could do any number of other interventions. But then there's the deeper question of how do you actually do the most good? And so the blog post that incited so much internal debate at CHAI was this post that said even the same specific intervention—giving families anti-malarial bed nets—if you do it in Guinea versus Chad, right? Both countries with really high malaria incidence, anyone at face value, even analytical people would basically say this is an amazing thing to do. It's a proven intervention. Both Guinea and Chad have really high rates of malaria. And they're underfunded. There's no real difference. But if you go through the trouble of doing the deep analysis, you find out that it's eight times more cost effective in Guinea than in Chad. And that with your donation, you would literally save eight times as many lives by having thought through every last detail of the analysis.

Question: Because of the politics?

Buddy Shah: There's a whole host of considerations, I mean, baseline mortality levels, the existing coverage rates of nets in those places, the cost of delivery in those places. So there's like all these things that are seemingly banal but ultimately translate into being able to save eight times as many lives with the same level of investment.

And so the first thing I said before getting into reasons why we don't base everything on that, is that that mode of thinking is just revelatory, even for people that work and have worked in global health for their whole lives and for people who are generally highly analytical, like the whole CHAI team is a bunch of epidemiologists,

former business people, very analytical folks that think in terms of numbers. But having that wiring actually leads you to very different conclusions.

Question: [inaudible]

Buddy Shah: Uh, so yeah, that's a good question. I think we'll get to that, you know, so one reason why we don't do everything just based on- and there's a couple of reasons. I mean, just to start with, one of the core reasons, and there's content reasons and practical reasons. But the first content reason is CHAI, we try to be transformational, right? So there's certain problems which are not cost-effective today, but we think there's a pathway towards getting there. So you know, say with the AIDS example. There's a great blog post that's like what economists got wrong about the AIDS epidemic.

And there were basically three things. One was that they didn't fully factor in that you could dramatically reduce the cost of life saving AIDS drugs. And CHAI played some role in that along with others. The second was that George W. Bush and PEPFAR put billions of dollars into AIDS. That was unforeseen, and it wasn't as though that was trading off with something else. And so overall, there's some belief that under the right circumstances, if you dream big and you do certain things, you can get something that's not currently cost effective to, over time, be really cost effective. Now, the thing, the dynamic between GiveWell and CHAI that's been really valuable is that that's a very easy out to basically do whatever you want, right? It's like, well, if we just, like, transform the Nigerian health system or do XYZ, it's gonna be the most cost-effective thing ever. And the useful parlay between GiveWell and CHAI has been like, okay, that's plausible. Now, like, state all of your assumptions that would need to be true in order to get there.

How likely do we think each of those assumptions are? Let's model it. And then if it's a good bet, let's actually consider it. So I think that's the first bit though, is that there is this kind of like risk taking mentality for things that could be cost effective in the future.

Elie Hassenfeld: So let me ask you about the blog post that was revelatory or surprising. Why do you think among analytical people, the knowledge or the inclination to do that math or to do those calculations wouldn't already be happening? Why is that something that is, you know, why is that surprising? Why isn't that commonplace?

Buddy Shah: Yeah, it's a good question. So first of all, I'll answer like my own personal story before I came to GiveWell and then some conversations we've been having internally. I think the first is that a lot of people just don't, frankly, realize how big the difference is, right? So I helped to found IDinsight. Dan Stein our chief economist is here from IDinsight, and there's people that like all day, all we think about is evidence. What's the evidence of effectiveness? But that's just a different question from like, how much more good could you do with a certain investment than something else? It's more, does something work? And is it a good thing in general for the world to have versus is it the best possible thing you can do with your dollar? And that's just a fundamentally different question that I think very few people think about. And once you start thinking about it, the implications are much more, I guess, surprising than even I thought. So that's one.

I think the second is that, you know, people have passion areas, right? Not everyone's thinking about how do I do as much good as possible. You know, we have people on our team who are epidemiologists and their passion is to eliminate malaria. That's the thing that their life is devoted to. And when you say, hey, you

could actually save twice as many kids' lives if you did ORS-zinc or, you know, immunizations, they wouldn't have thought of it. And even when they do, they're kind of solving for something fundamentally different. So I think that's a second reason. And then I guess the third, just system-wide, if I look at the big players, there are just very few organizations where the question they obsess over is how do we do the most good possible. And I think, ultimately, organizations with really bright people get good at doing the thing that they're set up to do. And so if you're set up to generate evidence on a lot of things that could improve lives, you'll do that well. If you're set up to solve malaria, you have good people who try to do that. And if you're set up to figure out this question, how do we do as much good as possible? I think you'll get really good at that if you have the right team. And there's just not a lot of orgs that are centered around that question, I think.

Elie Hassenfeld: Yeah. And so I think one of the things that's been interesting to me over the 15 plus years of GiveWell's existence is that when we started, we were outsiders. We were the people who didn't know how the global health community, the global development community, large foundations and governments operated. And we wondered whether once we grew and got closer, we didn't know what we would find. And I think what we found is GiveWell has grown and now, with support from donors like you, is one of the largest private funders of global health and development programming globally. You know, we found that the approach we're taking, it might seem intuitive to some, but it's not commonplace in the sector. And so I think aside from the direct impact that the funds that we can direct have, hopefully we're also shifting how large organizations operate by taking the methodology on board. But I guess I wanted to come back to the "transformational" point. So GiveWell, you know, we talk about

cost effectiveness. And sometimes I think cost effectiveness means to people, you know, what number shows up in a spreadsheet.

And in the case that Buddy is describing, in one country you can save eight times as many lives as another with the same level of investment. But then the counterargument is the spreadsheet or the numerical, the quantification is missing something else that's really important that ultimately is getting, arriving at a more, a better, an answer that's closer to the actual truth, not the calculated figure. And, you know, you described some of the challenges that are associated with dealing with the claim of transformation. But I guess I'm curious, you know, how do you think about that, either at CHAI when you're deciding what programs to move forward with or, you know, via the engagement with GiveWell? I think you know that our attitude is not about follow the number in the spreadsheet. It's about have the most impact, whether it's short term or long term, whether it's calculated or not calculated. So how do you think about that at CHAI? Or how do you think we should engage differently with questions of transformation? Are we taking that into account appropriately?

Buddy Shah: Yeah. So, you know, to be honest, I think there's probably learning on both sides. From our end at CHAI, one of the things we've tried to do is make sure that you can't claim that you're doing something because it *could* be transformational at some point without having thought through and really interrogated all the assumptions along the way, and still making smart bets. But having that be well-calibrated based on what would need to be true for something to be transformational. And then I think, you know, through the GiveWell-CHAI incubator relationship, I do see that happening in certain ways. So, like one specific example is this whole idea of market shaping, which is there are certain drugs that are just really expensive today. But if you could make a grant that

would help an organization like CHAI basically do these price negotiations, drive down the cost, it could be much more cost effective in the future. And so, I mean, I think that the GiveWell team is thinking about those, and there's like a healthy debate and back and forth on just the conditions under which that's going to be true.

So that's one. I think the second is just like actually testing things that are not yet proven. Right? So even the zinc ORS example, GiveWell's funding of New Incentives, incentives for immunization, it was not fully clear ex ante that this would be really cost effective. But I think you guys did a good job of like placing the bet, investing in actually testing rigorously, is this going to be impactful? And owning that there's risk there. And if not then you have to move on to something else. And so I think things like that, which- and it's all about calibrating like how big of a risk to take. But basically, you know, spending money or making grants that set the stage for things that could be transformational, but with some real testing behind it so that you're not just doing it on a faith-based kind of move, but it's actually still grounded in that core GiveWell DNA of we have some real signal on whether this is cost effective.

Elie Hassenfeld: Got it. What are some of the other constraints? Or, constraints or reasons for how CHAI—and again, really a very large and I would say influential global health organization—decides which programs to choose, that isn't based on this explicit assessment of value for money. What else is going into that assessment?

Buddy Shah: Yeah, I mean, the first one that I said was like, okay, there's a reason to do other things. It could be more cost effective, as cost effective. But there's just a lot of other practical constraints. So one is government demand. We work at the invitation of national

governments. And so there's a lot that we do to support their priorities. Some of which are cost effective, some of which are not. And that's just, you know, a real part of… I wouldn't even call it a constraint. That's just part of what enables us to be effective. I also think that there's sometimes competing values, like there's this idea of sustainability, like, can we build a sustainable health system in the Democratic Republic of Congo? or in Malawi? And that's just really hard to model how much good an investment is going to do. You can write the model in a bunch of different ways. You can say, oh yeah, we'll help build this data system. We'll help do these trainings, we'll provide this technical assistance. But it's very hard to say, and it happens over a very long period of time. And so CHAI is taken, you know, almost like a… there's some values-driven approach of saying, all right, we are going to invest in that longer-term project, but we're going to try to be as rigorous about it as possible and be willing to say, you know, when we shouldn't be doing it because we're not actually building the system. So I think that both government demand to do things where you just have to respond, as well as some belief. Again, ultimately we would do it because of cost effectiveness reasons. But like if we could build the Nigerian health system to have the right data and have the right supply chains to get meds out to the people who need it, that's potentially over a long period of time, really cost effective. It's just very hard to say ahead of time whether it's going to end up being so.

Elie Hassenfeld: So in your experience, and I don't know how well you can answer this, but what are some of the priorities that are coming from governments, from ministries of health that are harder to say explicitly, oh, I know this is cost effective, but they're coming to you and asking for help or want your assistance implementing their programs?

Buddy Shah: Yeah, there are a lot, uh, I mean, two big ones that come to mind. One is, as in any country, oftentimes the political priorities also map to the groups that have influence or power. And so there's a lot of desire for building high quality tertiary hospitals, like specialist hospitals with different types of pediatric specialists and other forms of specialists. Now, in countries where the disease burden is just so heavily skewed to people dying, of kids dying of diarrhea, not being vaccinated, malaria, TB, HIV, you're just going to save a lot fewer lives from having an exceptional, you know, pediatric cancer specialist training program, or a tertiary hospital for something. But you also understand why the government wants it, both for political reasons and also because ultimately, they want to build a society where, you know, they have those kinds of expertise. And so that's one. It's just going to be nowhere near the amount of impact or cost effectiveness. But there's some case for doing it. I think the second are on things like non-communicable diseases—diabetes, cardiovascular disease—which affect people that are much older. Also tends to affect people who are better off. And again, you know, rightfully, there's a reason why the government would care about setting up those programs, even though they're going to save far fewer lives than things geared towards bigger killers.

Elie Hassenfeld: Okay. And I think last question. And then we'll turn it over to you all for Q&A. I'm curious what you've heard from- you know, CHAI is an organization that engages with donors from across the spectrum, many different types of donors. And I'm curious how engaging with GiveWell is similar and different from engaging with other donors that are out there. And I assume there are some things about engaging with GiveWell that are easier or better, perhaps, I hope, than engaging with large funders, maybe governmental funders. But then at the same time, I'm curious, you know, what is GiveWell doing that others aren't? Or what should

we be doing differently that takes on board some of what you're seeing from other groups in a similar position to us of researching and giving money?

Buddy Shah: Yeah. So I would say, on the positive side, which is easy, is like, it's just very, like, respectful and low overhead to work with GiveWell, which is great versus like these intensive and not directly tied to the impact case, kind of, you know, bureaucracy. That's true of other donors, but much more substantively, it's a space—and this has upside and downside—It's a space where you can be, like, intensely truth seeking. Right? So the team also has to get in the habit of not be pitching because pitching just doesn't work with GiveWell, because of the intensity of scrutinizing every single assumption. But that gives a lot of space for the programmatic teams to actually think about, engage with the question, not what is going to like, how are we going to sell this to the donor, but what's actually the program we would build that's going to save the most lives? And that's just a very freeing thing for teams to have where it's like actually like there are some constraints. But the main constraint is like, try to come up with a thing that's going to save the most lives and then test every assumption to see how likely we think that is.

Now, the flip side of that is that it's just really intense to try to get good answers to those questions. And it often means confronting things that you wouldn't normally think about. Right? Like going back to the anti-malarial bed nets in Guinea versus Chad. Normally you would just be like bed nets are evidence-based. They're cost-effective at saving lives. Let's just go out and, like, sell that rather than try to do the hard analysis of where is it going to do more good and design a program accordingly. And so, you know, it does force teams that might want to, they just might have a preset agenda, to have to answer a lot more questions and maybe

harder questions for something that they really believe in. And when you ask them like, okay, well, why do you think building a data surveillance system in the Democratic Republic of Congo is going to improve lives? If someone's been working on data surveillance systems in the Congo for ten years, like, what do you mean why? Because I know, and I've, you know, I've spent five years there. And so I do think that there's just often, there is a challenge of like the emotional appeal of doing important work and then having that checked just intensively by the GiveWell team for every assumption you have to make sure that it's rationally or empirically grounded.

And so that just takes getting used to, to be honest. And then things that GiveWell could be doing better. I mean, the teams have had conversations about this. And I think fundamentally it comes down to the risk taking. Like, are there things where GiveWell could take more risk that down the line could lead to things that are as cost effective? But I think we're already seeing a lot of signs of that, to be honest. And so it'll just be good to see how those progress and whether you can actually get good information on them. I think one potential thing is there's just a whole category of potential investments where it's always going to be hard to know how good of an investment that was. But I think by actually, you know, GiveWell is actually trying some of those. And so we'll be able to over a couple of years, see, you know, whether they were, in fact, and how that updates the kind of risk taking appetite for GiveWell.

Elie Hassenfeld: One of the things that comes through for me in this conversation, and it matches other things that we've heard over the years, is, we started the conversation with a GiveWell blog post that shows a pretty direct comparison between lives saved based on, you know, you can save eight times as many lives for the same cost and that

on some, on some level, seems like a very intuitive way to approach the problem we're facing. But we know that this isn't the conventional way that the organizations we engage with are thinking. It's not how they're analyzing the problem, it's not the question they're asking. They tend to ask a different set of questions. Once I had someone, I asked another organization CEO a similar question, and she said what was really hard for her team is that in engaging with funders, normally the work is about building relationships. And with GiveWell, of course the relationships matter, but it's not the core. The core is the data, the evidence, the information. That took a lot of getting used to. And I think one of the the challenges we have, in some ways it's a strength and in others, you know, it's a challenge we have to overcome, is finding the right language to engage with with all the groups that are out there so that we can fully understand what they're doing and why and make good decisions about about what to recommend. So thanks to Buddy for engaging in this conversation. Want to turn it over to you for questions. Feel free to ask about, ask me things. Ask Buddy. You can ask about what we talked about or GiveWell or global health in general. Really anything is on the table. Clarifications or, you know, hardball questions. At least, Buddy's happy to take them I'm sure. If he is, then I can skip. It'll be easier on me this time. But, you know, just, we'd love to hear from you. You know, whatever's on your mind, please just jump in.

Question: I'd love to hear a bit more concretely about the incubator and how it compares to other incubators like the Evidence Action Accelerator or Charity Entrepreneurship. And sort of concretely, once you research an idea and say, okay, this looks pretty compelling. To what extent do you have a team that's just sort of doing all that work, doing the geographic assessments, and then you connect with, say, the CHAI team in that country and they go do it? Versus, I don't know, connecting with experts who've been

implementing that intervention, and they go do it. Like how much is it in house versus out of house?

Buddy Shah: Yeah. So maybe I'll answer the second part of that and you can talk about other incubators. So there's a core CHAI incubator team who are really deep on the GiveWell cost effectiveness model and thinking about how to evaluate essentially what programs are going to be most cost effective. And they're also comprised of people that are just really plugged in to all of the geographic and programmatic experts at CHAI. And so they're talking to the HIV/AIDS team, the malaria team, the childhood deaths team, and the country leaders across the world. And basically the way that the idea sourcing has been working—and there's a long pipeline of ideas. You know, Elie talked about one which was ORS-zinc to stabilize kids with diarrhea. But there's a really long list. And we've been approaching it from like a bottoms-up and top-down part. So the core team is very analytical, and we're working with the GiveWell team around the global literature base and basically trying to see what's out there that hasn't scaled where there's real need based on existing evidence, and then trying to figure out is there a way to operationalize that in a way that's cost effective? And then we have basically sensitized the kind of GiveWell approach to identifying how do you save the most lives or do the most good per dollar spent with all of these technical experts across CHAI and country leads, and they're feeding ideas up, because a lot of the ideas that are happening aren't necessarily already in the academic literature or been rigorously evaluated, but they're coming up with ideas of programs that they run on maternal mortality or neonatal mortality, and then the core GiveWell incubator team at CHAI is then thinking about that program design and modeling okay, how cost effective it is, do we think it could be this cost effective? And if so, is this something that we would want to roll out and test or evaluate in a more

rigorous way to actually see how good it is? And so I think our process internally has been both of those, the kind of sourcing the best ideas from 36 country offices and 20 plus programmatic areas of expertise within CHAI, as well as looking at best buys that haven't been scaled and then going and talking to country leads and programmatic leads about whether, you know, why hasn't it happened so far, and is this something we could scale?

Elie Hassenfeld: I just want to point out one person in the room. So, Meika, I'm sorry to do this to you, but Meika is an excellent researcher from GiveWell and she is probably—sorry, Meika, it's going to be fine— she's probably the person who's the most expert on the GiveWell side on the details of the CHAI incubator work, so feel free to seek her out after if you want to really grill someone.

In terms of the, you mentioned a few different types of incubators. So one is CHAI. We've been talking a lot about them. We also supported a similar program, which we call the accelerator. I don't know why they're named different things. We just did what the organizations wanted I think. It's a very similar idea where this group Evidence Action, that we've supported for a long time, similarly tries to develop new programs that can serve people around the world. So there's, you know, there's different ways the two incubator/accelerators have played out. But the biggest difference, in my opinion, between the two organizations, CHAI is a gigantic global health organization, has offices all over the world, and that gives them the ability to do many different things in many different locations. Evidence Action is a much smaller organization, medium-sized organization, let's say. And they initially grew out of an organization called Innovations for Poverty Action, which was the group associated with Yale University that was very integral in the beginnings of the randomized controlled trial movement in development economics.

So the evaluation and evidence is in their name, literally. They're a smaller organization, so they don't have the same throughput that CHAI has, but also, you know, we work very closely with them. And then finally, you mentioned Charity Entrepreneurship. For those who don't know, this is an organization that supports entrepreneurs in founding mostly new organizations. And it's not just in global health and development, but it could be organizations across the spectrum of causes that are sort of broadly associated with effective altruism. And some of the organizations that come through that program that are aligned with what GiveWell is looking at are groups that we look at closely for funding. Historically, we've also supported some organizations themselves and with early funding, not literally getting off the ground, but very early stage. Buddy mentioned an organization called New Incentives. We gave New Incentives very early funding ten years ago. Now they've grown up to be a GiveWell top charity. We do tend to do less of that these days because of the existence of these other programs at CHAI, Evidence Action, and Charity Entrepreneurship, but that's also something that we consider in the right circumstances.

Question: Both of you interact with a lot of donors, how often when you're doing those interactions, do you push the evidence-based, "you should give more of your money to us because we're going to spend it better" conversation. How does that work? And how often do your donors give you the majority of their money versus not?

Elie Hassenfeld: I think we're going to answer this question very differently. So I feel very fortunate that at GiveWell, we tend to interact with donors who've found us, who know what we do. Now this is not always the case. There's plenty of donors that we meet who aren't

as interested in evidence. But I would say that the normal thing that I'm trying to do is to convince them to give more to GiveWell or programs that have some form of similar methodology behind them. And that's really all, you know, the only thing I do, I guess. It runs the gamut of what proportion of their giving comes through us from nearly 100% to a very small percentage, you know, on just the side. I'd say mostly, I mean, people do all sorts of things, but, you know, we could get a very large donation from a very, you know, a donor giving $100,000, let's say, a very large donation. And that could be, you know, a portion of a much larger portfolio. So anyhow.

Question: You proselytize to him? Try to say, hey, 100,000 isn't enough, you should be giving more.

Elie Hassenfeld: We certainly, I mean, we try to tell them, you know, we also have some great fundraisers here from GiveWell who can talk to you about how you can give more if you want. So, Erin is right here and Olivia is in the back. We have a lot of GiveWell staff who can help answer all the detailed questions. But I'll tell you what, what we try to do is help people understand what they can get if they give to GiveWell. And, you know, we try to be very clear about the fact that we think the impacts via donating through GiveWell are immense. But, you know, some people are more amenable to that sort of argument than others. And, you know, we try not to fight battles we don't think we can win.

Buddy Shah: Yeah, I mean, it is different being an operating NGO than I think being GiveWell. But we really do try in every conversation. There's often this moment of like meeting the donor where they are, and sometimes those are like very idiosyncratic terms. Right? There was a donor who was like, oh, I really care about, you know, kids' health in this part of the world using this type of technology, like, is there

stuff you could do? And the reality is, like, I will probably think of something that fits within that, versus saying no, but let me tell you about anti-malarial bed nets, which is going to save five times as many lives as that. But that's a starting point that I try to use to say, like, yeah, you know, this digital health product program kind of fits those parameters, but we're much more excited or really excited about these three other things which we think have a lot more impact potential. And I mean, I do think that that's just a natural reality between being an operating NGO versus, you know, GiveWell's got a pretty sweet position, like just thinking about, you know, what you think you're going to do the most good, and then you have the luxury of sticking to those guns, which is, you know, it's a different space.

Question: For either of you, have you had many situations where you have to, like, quickly, drastically, or you opt to drastically increase or decrease the investment, something based on political changes where it's like new president comes in and is like either actively courting more help from outsiders or actively indicating they're like, suspicious of Western influence and like, how do you… it seems so hard to model. How do you deal with a situation like that?

Elie Hassenfeld: Well, let me give the GiveWell answer really quickly, and then I think you'll have maybe a more interesting answer, which is, you know, when we support organizations, we put a lot of trust in them to decide how to respond to circumstances as they arise. I can't think of an example of what you're describing, but during COVID, organizations had to materially change their programs. In some cases, they couldn't keep running their programs, but they still had to pay overhead for their staff. In other cases, they had to shut down programs entirely. And, you know, we do a lot of work to try and quantify the impact that specific programs will have. But also

we have a high degree of trust in the organizations we support. And so, you know, our attitude is that we want to support organizations where we trust that as circumstances arise, they'll make good decisions about what to do to respond. And so many of your organizations and the programs span multiple countries. And so, you know, if they ran into a particular problem in one location, we'd be very happy to say, oh, well, you planned to do X in location Y, but if you think you should move—and we'd ask, you know, for more information and they tell us. But generally speaking, what I'd expect is we'd go along and support them in the change of plan.

Buddy Shah: Yeah. And for CHAI's side there's really two parts of the answer there. One is we work really hard to have robust relationships with the civil servants and the bureaucracy that just stays there and really is the core of executing programs, regardless of the administration. And so, you know, CHAI's been in these 30 plus countries for 20 years. There's been a lot of political changes in the parts of the world where we work. And the first part is being able to continually provide that kind of support and partnership regardless of the administration, which is really important. The second part, though, is that there are certain political windows that have huge potential for impact, right? So for instance, in Nigeria after the recent elections, they just named this guy Dr. Muhammad Ali Pate as Minister of Health. He was the former head of health, nutrition, and population for the World Bank, professor at Harvard, you know, is one of the foremost kind of global health experts, very politically savvy and technocratically thoughtful. He's worked with CHAI for years and was like, okay, we've got five years to make some huge changes in terms of maternal mortality, neonatal mortality, a few other things. These are my priorities. And, you know, I flew to Abuja the next week and really sat down. We don't— and we have existing programs. But it was also about—

Question:	That's him telling you? I have five years to get this done?
Buddy Shah:	Yeah. "These are my priorities. We've got a political window of opportunity here." And so, I mean, I think there is that style of responsiveness in addition to the steady state work that we try to do.
Question:	Yeah, so GiveWell is, I guess, much bigger than, you know, when it started. And I guess a lot more people have started to come around to GiveWell's way of thinking. Buddy now works at CHAI. How has, I guess, the world reacted to this? Like, have you been saturating opportunities? Have, you know, other organizations, like, has there been backlash against this because, you know, some organization is found to be not effective, they'll lose their jobs or something like that?
Elie Hassenfeld:	Yeah. So I think that GiveWell is really part of a movement that has gathered a lot of steam over the last 15 plus years. To be clear, I think a lot of this predates GiveWell, even. I think what's called the randomista movement from the Poverty Action Lab at MIT, Innovations for Poverty Action at Yale that I mentioned earlier. This starts in the mid to late 90s. The researchers associated with this movement won the Nobel Prize in economics a couple of years ago. Since then, you see this massive growth in the direction of more evidence and data. And this is true via GiveWell. It's true via someone like Buddy being the head of CHAI. And, you know, really, I think true across the board. One of the most interesting things that I think I've seen and I've been pleasantly surprised by is when we've made a mistake and funded something that doesn't work, the reaction has been positive and not negative, and I think everyone would have expected- I mean, when we were getting started, people would tell my co-founder Holden and me, "I mean,

this is crazy. Like, donors will never give this way," you know? And now, more than 15 years later, we just directed our two billionth dollar. In the last few months, it went out the door. And so not only is it true that donors care about this type of evidence, but they have the sophistication to say, "of course, things fail sometimes." You know, GiveWell has a big mistakes page up on our website. We make mistakes. We supported a program that was a top charity and the evidence wasn't strong enough. It's not a top charity anymore. And people get that. And so, I mean, what I think I see is more of this rapid movement in the direction of more evidence, more data, more sophistication. It's not commonplace yet, of course, but, you know, it still feels like we're just at the beginning of this path towards, you know, more sophisticated, more impactful giving globally, which is really exciting.

Buddy Shah: I completely agree with that.

Elie Hassenfeld: All the way in the back. Yeah.

Question: Hello. How do you see formation of new foundations and charities to pursue particular efforts versus directing money to existing organizations that want to expand their remit or so on, because there's often different, very different motivations for the two sides.

Elie Hassenfeld: So. Yeah, just I don't know if everyone heard, the question is how do we think about the creation of new organizations versus supporting existing ones to expand their remits slightly? I mean, I think by default we would prefer to support the existing opportunity, the existing organization, if we could. And so in some sense, the newer organization has a higher bar to clear to show that, you know, someone should start something new as opposed to just supporting the organizations that already exist. And then

you know what we've seen repeatedly over the last ten years, let's say, if not more is, unsurprisingly, there are still new ideas that are insufficiently covered, and whether those organizations are focused on incentives for immunization, focused on rolling out the HPV vaccine globally, focusing on lead regulation globally. I mean, there are needs that are not being taken up by existing organizations, and we're excited to support those, you know, where we can, with an appropriate degree of skepticism that any individual can, you know, lead the charge. But you know, of course, excited to support them when appropriate.

Question: I'm curious. What are some things that, like ORS, are really good ideas but don't have great implementation yet? And I'm also curious, like, what's one thing that sounds like it should be transformational but ends up not, you know, quite panning out when you do the calculations.

Elie Hassenfeld: I think there's two categories of programs that I would say fall into the ORS categories. So one is straightforwardly good programs that we have not found a way to support, even though there is some gap. The most obvious one is vaccine delivery. Roughly speaking, very roughly, 80 to 85% of children globally get their standard set of routine immunizations. That means that there's a large proportion of children who are not receiving routine immunizations that they should. And this has been hard for us to find a way to support. We now support it via an organization that Buddy mentioned, New Incentives, which provides very small cash incentives to encourage and incentivize caregivers to bring their children to the clinic to get immunizations. The reason this has been hard is that the vaccines themselves are paid for by, it's amazing, wonderfully, by this large institution called Gavi, which raises funds from governments around the world and the Bill and Melinda Gates Foundation. And so that's an example where we

know there's a gap. We haven't found a way to close it beyond the work we've done with New Incentives and an organization that does something similar in Pakistan called IRD. And then there's other categories of delivering basic commodities that we haven't found a way to do, malaria treatment, we've actually explored a little bit with CHAI. They helped us see that it wasn't sufficiently cost effective in the way we had imagined it, so we haven't moved ahead with it.

There's a whole other set of programs that are maybe very straightforward but not always known. And I think a good example of this is a program we supported via the Evidence Action Accelerator, which focused on screening and treating of syphilis in pregnancy. Syphilis is not something that people think a lot about in high income countries. There was a New York Times article a couple of weeks ago about the rise in the US, but globally more than about a million people are infected with syphilis during pregnancy. This can lead to very bad outcomes for children. And Evidence Action via its accelerator identified an opportunity to switch out the test that clinicians were using when people attended antenatal appointments from an HIV test alone to an HIV plus syphilis test, which was only marginally more expensive, and then ensured that penicillin was in stock. Penicillin, very cheap antibiotic to treat people, and so this is another example. This is not something that was widely known. It's not something that is thought about and talked about, but it's a program that via, I'd say on our side, research and learning about the programs that could be implemented. And then in partnership with organizations, what's feasible and practical in a given country led us to some really straightforward ideas of funding that I think have amazing impacts.

Buddy Shah: Yeah, I mean, I think there's a whole category of programs like that

where we basically know exactly what to do to deliver it, and then it's not getting delivered either because of a lack of resources or because actually the human behavior element is challenging to close that last gap. On the first bucket, one of the things we found within the incubator is that some of them are probably pretty straightforward. We can do, but they're just not as cost effective. So you're going to save fewer lives. And there's just, you know, to be blunt, there's a lack of funding globally for everything that is a good thing to do. So things like hepatitis C elimination or hepatitis B, you know, a couple hundred thousand people die of each of those per year. There's a birth dose for hepatitis B, which would save people's lives. For hepatitis C, there is a cure that affects more adults. But when you do the math, it's just, you know, there are other things that you would do before then, and there's just not enough money globally to do all the things, which is sad. And so I think, you know, crowding in more money and figuring out health financing is important.

Question: There is enough money, it's just not in the right places right now.

Buddy Shah: Yeah, exactly. So I think that's part of the project where it's like, how do you mobilize more dollars so that you can fund things less cost effective than what GiveWell does? And then I think the second is like some there just are tricky behavioral issues. Right. So for pediatric AIDS like CHAI has, one of our goals is ending pediatric AIDS deaths. 100 plus thousand kids still die a year of pediatric AIDS. And there's only about 55% of kids on treatment versus, you know, 80 to 90% of adults on treatment. And I think it is eminently solvable, but there's just the dynamics of the kids who slip through the cracks that don't get diagnosed. And then by the time they realize they're sick and have HIV, they're much older and harder to treat or get on treatment is, it's just a pretty challenging

and complex delivery program. And so, you know, I think there are things like that where it's like, well, we have cheap drugs, we have cheap diagnostics. This should be straightforward. When you meet the real world, I think some are just genuinely hard to solve. And others we actually know exactly how to solve. And we could if there are more resources.

Elie Hassenfeld: Alright, I think we have time for one more question. Uh, right there.

Question: This is a question more for Buddy, but I'm interested in GiveWell's perspective as well. So you talked a lot about, like, building out like, infrastructure and long term goals as part of CHAI. I'm just wondering, like, do you have an example of, like, a time where you put in a bunch of resources to something and you're able to build that infrastructure and it ended up working out. Or a time where that didn't work out, where you put a bunch of resources here and then like, the hospital didn't end up saving that many people or whatever.

Buddy Shah: Yeah, I think the best positive example, frankly, is from the early days of HIV, where CHAI invested a lot both in that market shaping, to negotiate down the prices of life saving drugs, and then that increased access dramatically, it also then crowded in new funding because, you know, people were much more willing-governments especially, from donor countries, to pay for drugs that were a couple hundred bucks or a hundred dollars versus a few thousand. And then also building supply chains because, you know, these are intense drugs. Patients have really intense side effects. You have to train the health workforce in a whole set of new ways of treating patients. You need to build cold chains to get refrigerated supplies to the last mile. You know, it's not an easy thing. And I think having stuck through that multi-decade project, we're now at a point where the drugs are under $50 per patient

per year, the diagnostics are under a dollar per patient. The supply chains are built out, the monitoring systems are built out. And in most of the countries you work, there's 90 plus percent of adults that are on treatment.

And then I think there's a lot of examples where we thought we would be able to build, you know, some kind of infectious disease data surveillance system. So we would have this amazing dashboard at the national level. We would see which subnational regions were having big outbreaks. You'd be able to target scarce resources to those regions. And that's just really hard, both because the technical solution is challenging to develop that good data surveillance system. But then even if you have a good technical solution, there's so much human behavior change in how a large bureaucracy, a ministry of health in a low income country that has a lot of other priorities can actually act dynamically based on that. And so it's not to say that we've given up on those kinds of system strengthening projects, and we do have some wins there. It's just that they're inherently challenging. And there's a lot of ways in which they can go wrong. And we've seen a number of those.

Elie Hassenfeld: I think that's great. Just want to thank Buddy for being here and joining us. You know, we're really grateful that we have the opportunity to work with groups like CHAI that are both outstanding intellectual partners and help us do our research better, but also outstanding implementation partners who can deliver great programming on the ground. So it's really a pleasure. We're really grateful for that. And of course, we're grateful for you all and your support both trekking out here tonight in the winter, but also your financial support over the years. Like Buddy said, we really feel like at GiveWell, we're in this incredibly fortunate position of having support from donors who say, essentially, we

trust you. Go figure out where to give money so that it does the most good, and we can stay focused on that goal and that goal alone without having to think too hard about challenging compromises that we would have to make. So we're incredibly grateful for that support. You've helped us deliver more than $2 billion now, which we estimate will save more than 150,000 lives around the world. So we're incredibly grateful for that. And you should, you know, thank you so much for your support.