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# Women's Empowerment Cause Area Report

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## Executive Summary

### 1. Women's empowerment

One hundred and four countries still have laws preventing women from working in specific jobs; only 56% of women giving birth in Africa deliver in a health facility; and at least 35% of women worldwide have experienced some form of physical or sexual violence. These are just some of the challenges that women and girls around the globe face today.

In this report, we focus on women's empowerment, by which we mean improving the lives of women and girls. We researched charity programmes aimed at women's empowerment to find those that most cost-effectively improve the lives of women and girls. As a heuristic for finding the most cost-effective interventions, we chose to focus on programmes aimed at low- and middle-income countries.

### 2. Our process

We used a top-down approach to select charities. First, we categorised women's empowerment in low- and middle-income countries into twelve subfields. We then reviewed literature and interviewed twenty experts in these subfields. This yielded a shortlist of eleven promising interventions across subfields, including the graduation approach to combat extreme poverty, empowerment-self-defence courses to prevent sexual violence, and interpersonal group therapy to treat depression.

With this shortlist, we began evaluating charities. We started with a longlist of 163 women's-empowerment charities and narrowed it down to a shortlist of 15 charities based on our intervention research and a quick scan of organisational strength. We then compared the shortlisted organisations using more detailed information on both cost-effectiveness and strength of evidence. By our criteria, four charities especially



stood out. For each of those, we investigated organisational strength and plans, which led us to recommend three and provisionally recommend the fourth.

### 3. Charity recommendations

#### StrongMinds

**What do they do?** StrongMinds implement Interpersonal Group Psychotherapy (IPT-G), training laypeople to treat women suffering from depression in Uganda.

**Is there evidence the intervention works?** Evidence for the efficacy of IPT-G in low-resource settings comes from two randomised controlled trials (RCTs) and StrongMinds' own quasi-experimental impact assessment.

**Is the intervention cost-effective?** We estimate that StrongMinds prevent the equivalent of one year of severe major depressive disorder for a woman at a cost of \$200–\$299, with a best guess estimate of \$248.

**What are the wider benefits?** There are indications of improvements in employment, nutrition, physical health, housing, and children's education.

**Are they a strong organisation?** They have a good track record and a strong focus on generating evidence. They are transparent about their mistakes and are committed to continuous improvement.

**Is there room for funding?** StrongMinds could productively use an extra \$5.1 million in funding through 2020.



## Bandhan's Targeting the Hardcore Poor programme

**What do they do?** As part of their Targeting the Hardcore Poor (THP) programme, Bandhan provide women living in extreme poverty in India with a productive asset, a savings account, business training, mentoring, consumption support, and information on education and health. They also work with the Indian government and other NGOs to scale up their model.

**Is there evidence the intervention works?** A high-quality long-term RCT supports the effectiveness of Bandhan's THP programme. Additional evidence gathered in different contexts suggests that the 'graduation approach' adopted by Bandhan can effectively address extreme poverty.

**Is the intervention cost-effective?** We estimate that Bandhan's THP programme doubles a participant's consumption for one year at a cost of \$41–\$134, with a best guess estimate of \$62. This suggests that Bandhan's programme can bring about nominal gains in consumption of about \$1.77 for each \$1.00 donated. Adjusting for purchasing power, this is equivalent to gains of \$7.27 for each \$1.00 donated.

**What are the wider benefits?** There is some evidence that the programme improves food security, physical health, and subjective well-being.

**Are they a strong organisation?** Bandhan is a specialised organisation with a good track record. They are careful to maintain high-quality delivery of their programme; they are committed to evidence; and they have been transparent throughout our analysis of their programme. One point for improvement, however, is that their website lacks up-to-date information.



**Is there room for funding?** The key impediment preventing Bandhan from scaling up is funding, as they have all the required infrastructure and capacity in place. Another \$24 million would allow them to reach an additional 60,000 households over the coming six years.



## No Means No Worldwide [provisional]

**What do they do?** No Means No Worldwide (NMNW) train instructors to teach their ‘IMpower’ courses to both boys and girls, to help prevent sexual assault. They also work with large NGOs and governments to scale these courses up.

**Is there evidence the intervention works?** Evidence suggests that NMNW’s IMpower intervention reduces the incidence of sexual violence in several settings and for girls at different ages. This evidence comes mostly from two RCTs and two quasi-RCTs.

**Is the intervention cost-effective?** We estimate that NMNW prevent a sexual assault for \$9–\$757, with a best guess estimate of \$62 per case averted.

**What are the wider benefits?** There is evidence that NMNW’s programme decreases negative gender attitudes among boys and reduces rates of pregnancy-related school dropouts.

**Are they a strong organisation?** NMNW are exceptionally committed to generating evidence; are transparent about their performance and motivations; and have a good track record supporting IMpower implementation.

**Is there room for funding?** NMNW could productively use an additional \$7 million in funding through 2021.

**Why is our recommendation provisional?** Based on the current evidence, we feel confident recommending NMNW to donors with a specific focus on averting sexual assault. Depending on the results of an independent evaluation of NMNW’s IMpower programme, which are currently under review, we may either recommend NMNW more generally to donors interested in women’s empowerment; keep recommending them only to donors with a focus on averting sexual assault; or decide not to recommend them at all.



### Other highly impactful charities

We also recommend charities that are highly cost-effective in improving women’s and girls’ lives but do not focus directly on women’s empowerment. We discuss these organisations, including those recommended by our research partner GiveWell, in other research reports on our [website](#).



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## 1. Overview of Women’s Empowerment

One hundred and four countries still have laws preventing women from working in specific jobs;<sup>1</sup> only 56% of women giving birth in Africa deliver in a health facility;<sup>2</sup> 214 million women of reproductive age in low- and middle-income countries<sup>3</sup> want to avoid pregnancy but are not using a modern contraceptive method;<sup>4</sup> and at least 35% of women worldwide have experienced some form of physical or sexual violence.<sup>5</sup> It should come as no surprise that the United Nations includes “achieve gender equality and empower all women and girls” as one of its 17 Sustainable Development Goals (SDGs).<sup>6</sup>

<sup>1</sup> “Women, Business and the Law - Gender Equality, Women Economic Empowerment - World Bank Group,” World Bank, accessed October 19, 2018, <http://wbl.worldbank.org/>.

<sup>2</sup> “Adding It Up: Investing in Contraception and Maternal and Newborn Health, 2017,” Guttmacher Institute, June 21, 2017, <https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017>.

<sup>3</sup> Low-income Countries are defined by the World Bank as those with a Gross National Income per capita of less than \$1,025. Middle-income countries are defined as those with a Gross National Income per capita between \$1,026 and \$4,035. See also <https://blogs.worldbank.org/opendata/new-country-classifications-2016>

<sup>4</sup> “Family Planning/Contraception,” World Health Organization, accessed October 19, 2018, <http://www.who.int/en/news-room/fact-sheets/detail/family-planning-contraception>.

<sup>5</sup> Claudia García-Moreno et al., *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence* (Geneva, Switzerland: World Health Organization, 2013).

<sup>6</sup> “Sustainable Development Goal 5: Gender Equality,” UN Women, accessed October 18, 2018, <http://www.unwomen.org/news/in-focus/women-and-the-sdgs/sdg-5-gender-equality>.



## 1.1. Our focus

In this report, we focus on women’s empowerment, by which we mean improving the lives of women and girls. We researched charity programmes aimed at women’s empowerment to find those that most cost-effectively improve outcomes (rather than outputs)<sup>7</sup> that directly affect women and girls, including self-reported measures such as subjective well-being.

Not all programmes that target women or girls fit this definition of women’s empowerment. For instance, many programmes targeting women aim mainly at reducing child mortality, rather than improving maternal health. For such programmes, given the scope of our inquiry, we looked at how losing a child affects the mother rather than at the child’s death itself.

Our definition also implies that we didn’t directly aim to reduce gender inequality, which could in principle be done just as well by limiting opportunities for men as by improving opportunities for women. Generally, however, programmes that improve women’s lives also reduce gender inequalities.

Lastly, charities that cost-effectively improve the lives of women and girls without targeting women’s empowerment were not included in this report. We refer to our and our research partner’s research on them in the [final section](#).

As a heuristic for finding the most cost-effective interventions, we chose to focus on women’s empowerment in low- and middle-income countries. Women and girls in these countries face the most severe problems, such as extreme poverty and lack of access to maternal care, as we’ll discuss in the next section. Moreover, the comparative paucity of resources currently dedicated to these problems makes it more likely that extra resources could be directed cost-effectively. For instance, the average health expenditure among the 47

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<sup>7</sup> For more on the difference between outcomes and outputs, see <https://founderspledge.com/research#looking-for-outcomes>



least-developed countries in the world in 2015 (according to WHO ranking) was only about \$70 per person, or \$160 adjusted for purchasing power.<sup>8</sup> This contrasts with the average \$2,800 spent per person (or \$3,400 adjusted for purchasing power) on health in 56 countries belonging to the World Bank high-income group.<sup>9</sup>

## 1.2. Twelve subfields of women’s empowerment

In our research, we categorised women’s empowerment into twelve subfields. In this section, we provide a quick and non-exhaustive overview of each subfield.

### Economic empowerment

According to the World Bank’s most recent estimates, 736 million people (roughly 10% of the world population) live in extreme poverty, which means they live on less than \$1.90 a day, already adjusted for differences in purchasing power among countries.<sup>10</sup> About 85% of the extreme poor live in Sub-Saharan Africa or South Asia<sup>11</sup> and about 75% live in rural areas.<sup>12</sup>

We did not find evidence of more women being in extreme poverty than men. However, there is a gender gap among people in the primes of their lives: among those between the ages of 25 and 34, 122 women live in poor households for every 100 men.<sup>13</sup> Moreover, women make up 55% of the world’s unbanked: 1.1 billion women remain outside the formal financial system.<sup>14</sup> Lastly, women do a disproportionate amount of unpaid

<sup>8</sup> “Global Health Expenditure Database,” accessed November 2, 2018, <http://apps.who.int/nha/database/Select/Indicators/en>.

<sup>9</sup> “Global Health Expenditure Database.”

<sup>10</sup> “Poverty,” World Bank, accessed October 11, 2018, <http://www.worldbank.org/en/topic/poverty>.

<sup>11</sup> “Poverty.” World Bank

<sup>12</sup> “Rural Poverty Reduction | Policy Support and Governance | Food and Agriculture Organization of the United Nations,” accessed October 11, 2018, <http://www.fao.org/policy-support/policy-themes/rural-poverty-reduction/en/>.

<sup>13</sup> Ana Maria Munoz Boudet et al., “Gender Differences in Poverty and Household Composition through the Life-Cycle : A Global Perspective” (The World Bank, March 6, 2018), <http://documents.worldbank.org/curated/en/135731520343670750/Gender-differences-in-poverty-and-household-composition-through-the-life-cycle-a-global-perspective>.

<sup>14</sup> Asli Demircuc-Kunt et al., “The Global Findex Database 2014 : Measuring Financial Inclusion around the World” (The World Bank, April 15, 2015), 59, <http://documents.worldbank.org/curated/en/187761468179367706/The-Global-Findex-Database-2014-measuring-financial-inclusion-around-the-world>.



labour: they devote 1–3 hours more per day to housework than men and spend 2–10 times the amount of time per day on care (of children, elderly, and the sick).<sup>15</sup>

### Gender-based violence

According to a 2013 report by the World Health Organization, 35% of women worldwide have experienced physical intimate-partner violence, sexual intimate-partner violence, and/or non-partner sexual violence at some point in their lives.<sup>16</sup> Most of this is intimate-partner violence, with almost one-third (30%) of women having been subjected to physical and/or sexual violence by their partner,<sup>17</sup> and 7% of women having been sexually assaulted by someone other than a partner.<sup>18</sup>

In addition to experiencing the immediate trauma of assault, women who have been assaulted by a partner suffer from higher rates of several physical and mental health problems. For instance, they are more than twice as likely to experience depression, and, in some regions, are 1.5 times more likely to acquire HIV.<sup>19</sup> Women who have been sexually assaulted by a non-partner are 2.3 times more likely to have alcohol-use disorders and 2.6 times more likely to experience depression or anxiety.<sup>20</sup> We should note that as these are correlations, they do not prove causality, but they do provide some evidence for it.

<sup>15</sup> “World Development Report 2012 : Gender Equality and Development,” 80, accessed October 18, 2018, <https://openknowledge.worldbank.org/handle/10986/4391>.

<sup>16</sup> García-Moreno et al., *Global and Regional Estimates of Violence against Women*.

<sup>17</sup> K. M. Devries et al., “The Global Prevalence of Intimate Partner Violence Against Women,” *Science* 340, no. 6140 (June 28, 2013): 1527–28, <https://doi.org/10.1126/science.1240937>.

<sup>18</sup> García-Moreno et al., *Global and Regional Estimates of Violence against Women*.

<sup>19</sup> García-Moreno et al.

<sup>20</sup> García-Moreno et al.



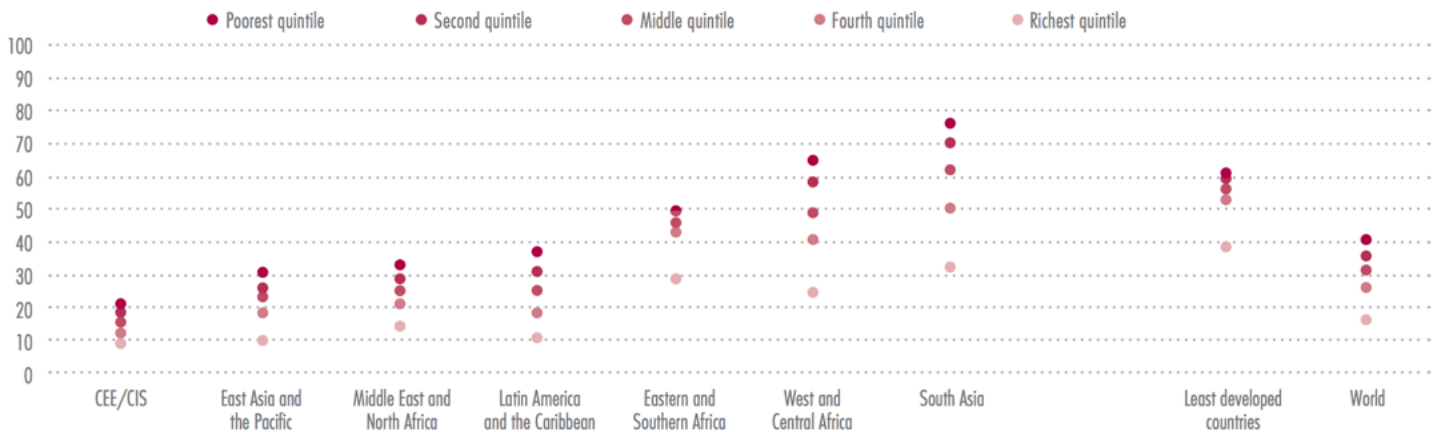
## Child marriage

Worldwide, more than 700 million women alive today were married before their 18th birthday. More than one-third of them (about 250 million) married before they turned 15.<sup>21</sup> Boys are also married as children, but girls are disproportionately affected. In Niger, for instance, 77% of women currently aged 20–49 were married before age 18 in contrast to 5% of men in the same age group.<sup>22</sup>

There are large differences between regions and income groups: child marriage is most prevalent in countries in South Asia and Sub-Saharan Africa, and low-income households are generally more affected (Figure 1).

Figure 1.

Percentage of women aged 20–49 years who were married or in union before age 18, by wealth quintile and by region



Source: “Ending Child Marriage: Progress and Prospects,” UNICEF DATA, 2014

<sup>21</sup> “Ending Child Marriage: Progress and Prospects,” UNICEF DATA, July 22, 2014, <https://data.unicef.org/resources/ending-child-marriage-progress-and-prospects/>.

<sup>22</sup> “Ending Child Marriage.” UNICEF DATA





Child marriage is declining in relative terms, but the regions where child marriage is most prevalent also show the largest population growth. This means that if progress doesn't accelerate, the number of child brides in the world might increase rather than decrease.<sup>23</sup>

## Maternal health

In 2015, 216 women died of causes related to pregnancy and childbirth per 100,000 live births. This is down 44% from the 385 per 100,000 in 1990. However, it falls far short of the Millennium Development Goal 5a target of a 75% reduction. The Sustainable Development Goal for 2030 is 70 per 100,000, requiring a 68% reduction from 2015.<sup>24</sup>

There are wide disparities in maternal health care across regions. For instance, only 56% of women giving birth in Africa deliver in a health facility, compared with 91% in Latin America and the Caribbean (Figure 2).<sup>25</sup> In Sub-Saharan Africa, a woman's lifetime risk of dying in pregnancy or childbirth is 1 in 36, compared with 1 in 4,900 in high-income countries.<sup>26</sup>

<sup>23</sup> "Ending Child Marriage." UNICEF DATA

<sup>24</sup> "Executive Summary" Lancet Maternal Health Series, accessed October 19, 2018, <http://www.maternalhealthseries.org/resources/>.

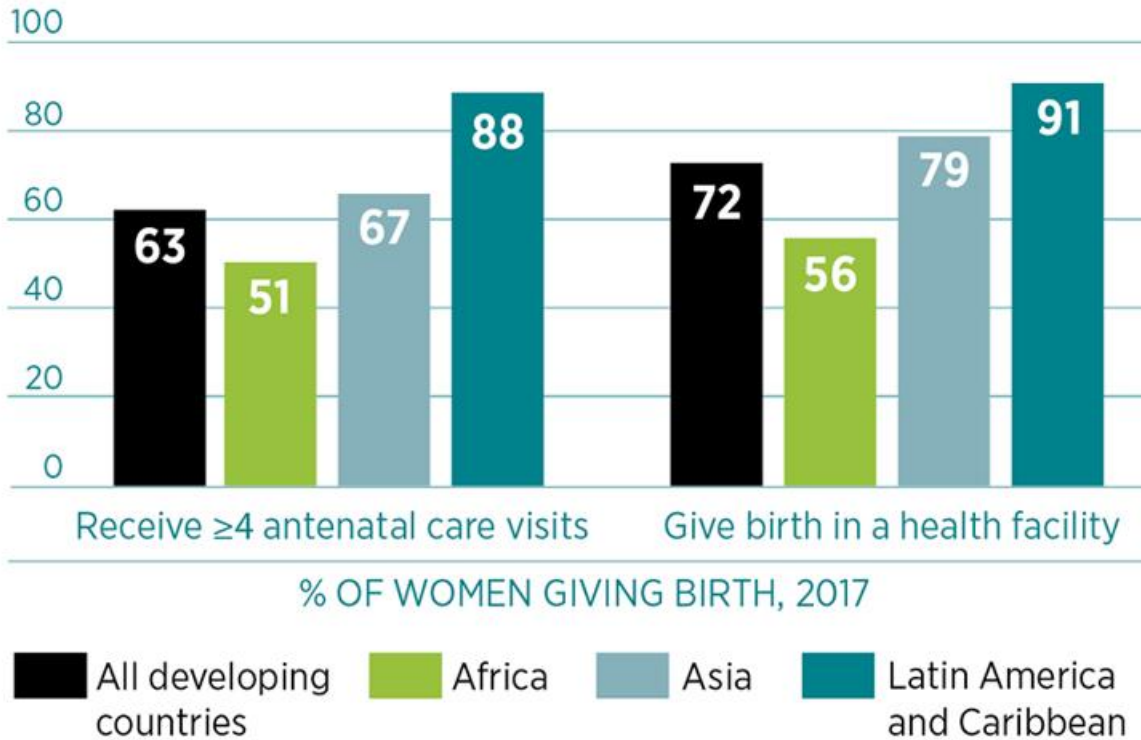
<sup>25</sup> "Adding It Up." Guttmacher Institute

<sup>26</sup> "Executive Summary." Lancet Maternal Health Series



Figure 2.

### Regional differences in maternal health care



Source: "Adding It Up: Investing in Contraception and Maternal and Newborn Health," Guttmacher Institute, 2017

In 2017, an estimated 308,000 women in low- and middle-income countries died from pregnancy-related causes. These deaths were largely preventable: providing all pregnant women with the level of maternal health care recommended by the World Health Organization could reduce maternal deaths in these countries by 64%.<sup>27</sup>

<sup>27</sup> "Adding It Up." Guttmacher Institute

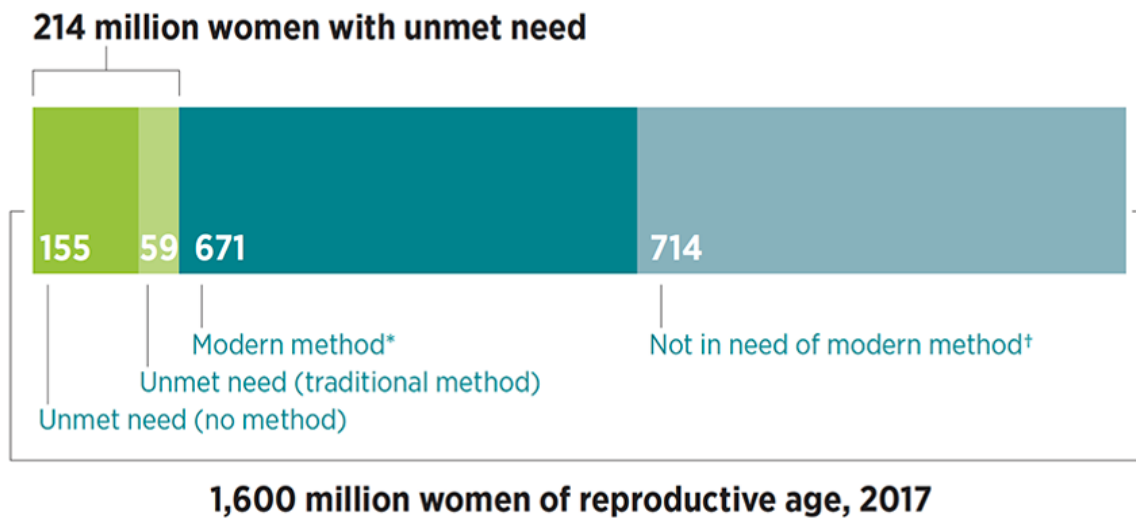


## Family planning

In low- and middle-income countries, 214 million women of reproductive age who want to avoid pregnancy are not using a modern contraceptive method.<sup>28</sup> This includes 155 million who use no contraception and 59 million who rely on traditional methods (Figure 3).<sup>29</sup>

Figure 3.

### Contraception use and need in low- and middle-income countries



\*Modern methods include female and male sterilization, hormonal methods, IUDs, male and female condoms, modern fertility awareness-based methods, lactational amenorrhea method, emergency contraception and other supply methods.

†Includes women who are unmarried and not sexually active, are infecund, want a child in the next two years, or are pregnant/postpartum with an intended pregnancy.

Source: “Adding It Up: Investing in Contraception and Maternal and Newborn Health,” Guttmacher Institute, 2017

<sup>28</sup> “Family Planning/Contraception.” World Health Organization

<sup>29</sup> “Adding It Up.” Guttmacher Institute



Disparities among countries in rates of unmet contraceptive need follow economic lines. The proportion of women aged 15–49 whose need for family planning is satisfied with modern contraception is lowest (49%) in low-income countries, compared to 69% in lower-middle-income countries and 86% in upper-middle-income countries.<sup>30</sup>

Current use of modern contraception already prevents an estimated 308 million unintended pregnancies per year among all women of reproductive age in low- and middle-income countries. However, of the estimated 206 million pregnancies in these countries in 2017, 43% were unintended.<sup>31</sup>

According to a report by the Guttmacher Institute, if all unmet need for modern contraception in low- and middle-income countries were satisfied, there could be an approximate 75% decline in unintended pregnancies (from 89 million to 22 million per year), unplanned births (from 30 million to 7 million per year) and induced abortions (from 48 million to 12 million per year).<sup>32</sup> This could prevent an estimated 76,000 maternal deaths each year.<sup>33</sup> In addition, there is some evidence that contraception has indirect benefits in the form of education and economic empowerment for women and girls.<sup>34</sup>

<sup>30</sup> “Adding It Up.” Guttmacher Institute

<sup>31</sup> “Adding It Up.” Guttmacher Institute

<sup>32</sup> “Adding It Up.” Guttmacher Institute

<sup>33</sup> “Adding It Up.” Guttmacher Institute

<sup>34</sup> “Reproductive Choices to Life Chances: New and Existing Evidence on the Impact of Contraception on Women’s Economic Empowerment,” Center For Global Development, accessed October 19, 2018, <https://www.cgdev.org/publication/reproductive-choices-life-chances-new-and-existing-evidence-impact-contraception-women>.



## Education

Worldwide, 58 million children of primary school age are out of school. More than three-quarters of these live in sub-Saharan Africa and Southern Asia and more than half of them are girls.<sup>35</sup> Four hundred ninety-three million women are illiterate, accounting for almost two-thirds of the world's 774 million illiterate adults.<sup>36</sup>

Girls from the poorest households are being left behind educationally. If recent trends persist, universal completion of primary school by children in the poorest fifth of households in sub-Saharan Africa will not be achieved until 2069 for boys and until 2086 for girls.<sup>37</sup> For universal completion of lower secondary school, the projections are 2090 for boys and 2111 for girls, respectively.<sup>38</sup>

For an in-depth look at education as a cause area, see our upcoming report on the subject.<sup>39</sup>

## HIV and other STDs

In 2016, HIV globally accounted for 2.41% of all disability-adjusted life years (DALYs),<sup>40</sup> a composite measure of morbidity and mortality caused by diseases.<sup>41</sup> Health loss due to HIV is approximately equal for men and women.<sup>42</sup> However, there are multiple other women's-empowerment subfields that influence how HIV impacts women's lives, such as sexual violence, child marriage, and maternal health.

<sup>35</sup> "The World's Women 2015," United Nations Statistics Division, accessed October 19, 2018, <https://unstats.un.org/unsd/gender/chapter3/chapter3.html>.

<sup>36</sup> "Teaching and Learning: Achieving Quality for All | Global Education Monitoring Report," accessed October 19, 2018, <https://en.unesco.org/gem-report/report/2014/teaching-and-learning-achieving-quality-all>.

<sup>37</sup> "Teaching and Learning: Achieving Quality for All | Global Education Monitoring Report," 97.

<sup>38</sup> "Teaching and Learning: Achieving Quality for All | Global Education Monitoring Report," 97.

<sup>39</sup> This will be published on our website at <https://founderspledge.com/research>

<sup>40</sup> "GBD Compare | IHME Viz Hub," accessed October 19, 2018, <http://vizhub.healthdata.org/gbd-compare>.

<sup>41</sup> "WHO | Metrics: Disability-Adjusted Life Year (DALY)," WHO, accessed October 19, 2018, [http://www.who.int/healthinfo/global\\_burden\\_disease/metrics\\_daly/en/](http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/).

<sup>42</sup> "GBD Compare | IHME Viz Hub."



Many other sexually transmitted diseases (STDs) affect women more than men. Human papillomavirus (HPV) for instance, is relatively harmless for men, but can cause cervical cancer in women, leading to 266,000 deaths each year.<sup>43</sup> Overall, STDs apart from HIV account for 0.58% of all female DALYs worldwide compared to 0.44% of all male DALYs.<sup>44</sup> Even accounting for the fact that men suffer 16% more DALYs in total,<sup>45</sup> this is a significant difference.

### Health (other)

Several diseases only affect women, and others disproportionately affect them. Pregnant women, for instance, are at a higher risk of contracting malaria and developing a severe form of the disease.<sup>46</sup>

An example of a disease that only affects women is obstetric fistula, an abnormal opening between a woman's vagina and her bladder or rectum that is often caused by prolonged obstructed labour. Women that are affected by it suffer not only physically, but also mentally and socially: they undergo incontinence, shame, social segregation, and health problems.<sup>47</sup> The WHO estimate that more than 2 million young women are currently living with untreated obstetric fistula in Asia and Sub-Saharan Africa.<sup>48</sup>

### Legal and political empowerment

Legal discrimination against women is still widespread, making progress in other subfields of women's empowerment more difficult. For instance, 104 countries still have laws preventing women from working in

<sup>43</sup> "Sexually Transmitted Infections (STIs)," World Health Organization, accessed October 19, 2018, [http://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-\(stis\)](http://www.who.int/news-room/fact-sheets/detail/sexually-transmitted-infections-(stis)).

<sup>44</sup> "GBD Compare | IHME Viz Hub."

<sup>45</sup> "GBD Compare | IHME Viz Hub."

<sup>46</sup> "Malaria," World Health Organization, accessed October 19, 2018, <http://www.who.int/news-room/fact-sheets/detail/malaria>.

<sup>47</sup> "10 Facts on Obstetric Fistula," WHO, accessed October 19, 2018, [http://www.who.int/features/factfiles/obstetric\\_fistula/en/](http://www.who.int/features/factfiles/obstetric_fistula/en/).

<sup>48</sup> "10 Facts on Obstetric Fistula." WHO



specific jobs; 59 countries have no laws on sexual harassment in the workplace; and in 18 countries, husbands can legally prevent their wives from working.<sup>49</sup>

Similarly, a very large political gender gap remains. Only 22.8% of all national parliamentarians were women as of June 2016, a slow increase from 11.3% in 1995.<sup>50</sup> As of January 2017, only 18.3% of government ministers were women, and as of October 2017, only 11 women were serving as Head of State and 12 were serving as Head of Government.<sup>51</sup>

### Slavery and human trafficking

According to the International Labour Organisation, in 2016, about 40.3 million people were enslaved, including 24.9 million in forced labour and 15.4 million in forced marriage.<sup>52</sup> Of the 24.9 million people trapped in forced labour, 16 million were exploited in the private sector in areas such as domestic work, construction, or agriculture; 4.8 million people were victims of forced sexual exploitation; and 4 million people were in forced labour imposed by state authorities.<sup>53</sup> Women and girls are disproportionately affected, accounting for 99% of victims in the commercial sex industry, and 58% in other sectors.<sup>54</sup>

Much less is known about the scale of human trafficking. According to the US Department of State, in 2016, 66,520 victims of human trafficking were identified by global law enforcement.<sup>55</sup> Women and girls make up

<sup>49</sup> “Women, Business and the Law - Gender Equality, Women Economic Empowerment - World Bank Group,” World Bank, accessed October 19, 2018, <http://wbl.worldbank.org/>.

<sup>50</sup> “Facts and Figures: Leadership and Political Participation,” UN Women, accessed October 19, 2018, <http://www.unwomen.org/what-we-do/leadership-and-political-participation/facts-and-figures>.

<sup>51</sup> “Facts and Figures.” UN Women

<sup>52</sup> “Forced Labour, Modern Slavery and Human Trafficking (Forced Labour, Modern Slavery and Human Trafficking),” International Labour Organization, accessed October 19, 2018, <https://www.ilo.org/global/topics/forced-labour/lang--en/index.htm>.

<sup>53</sup> “Forced Labour, Modern Slavery and Human Trafficking (Forced Labour, Modern Slavery and Human Trafficking).” International Labour Organization

<sup>54</sup> “Forced Labour, Modern Slavery and Human Trafficking (Forced Labour, Modern Slavery and Human Trafficking).” International Labour Organization

<sup>55</sup> “Trafficking in Persons Report 2017,” United States Department of State, accessed October 19, 2018, <https://www.state.gov/j/tip/rls/tiprpt/2017/>.



71% of all detected human-trafficking victims,<sup>56</sup> and they are most often trafficked for marriage and sexual slavery.<sup>57</sup>

### Gender-biased sex selection

Around 126 million women are believed to be “missing” around the world due to gender-biased sex selection,<sup>58</sup> which occurs in some regions because people prefer sons to daughters for socio-economic or cultural reasons. Since the 1990s, some areas have seen up to 25% more male births than female births.<sup>59</sup> For instance, estimates from India suggest that some 10 million gender-biased sex-selective abortions took place between 1981 and 2005, amounting to 5% of the female population younger than 15.<sup>60</sup>

In the past, gender-biased sex selection consisted mostly of neglecting or killing female infants. However, since the early 1980s, ultrasounds and other technologies have enabled parents to detect the sex of a foetus during prenatal screenings; those who prefer sons can now abort female fetuses. This has accelerated sex-ratio imbalances at birth in parts of the world.<sup>61</sup>

### Female genital mutilation

The WHO estimates that more than 200 million girls and women alive today have undergone female genital mutilation (FGM) in the countries where the practice is concentrated. Moreover, an estimated 3 million girls

<sup>56</sup> “Global Report on Trafficking in Persons,” UNODC, 2016: 7, accessed October 19, 2018, <https://www.unodc.org/unodc/data-and-analysis/glotip.html>.

<sup>57</sup> “Global Report on Trafficking in Persons,” 10.

<sup>58</sup> “Gender-Biased Sex Selection,” UNFPA, accessed October 19, 2018, <https://www.unfpa.org/gender-biased-sex-selection>.

<sup>59</sup> “Gender-Biased Sex Selection.” UNFPA

<sup>60</sup> “Gender-Biased Sex Selection in India: A Review of the Situation and Interventions to Counter the Practice,” GOV.UK, accessed October 19, 2018, <https://www.gov.uk/dfid-research-outputs/gender-biased-sex-selection-in-india-a-review-of-the-situation-and-interventions-to-counter-the-practice>.

<sup>61</sup> “Gender-Biased Sex Selection.” UNFPA

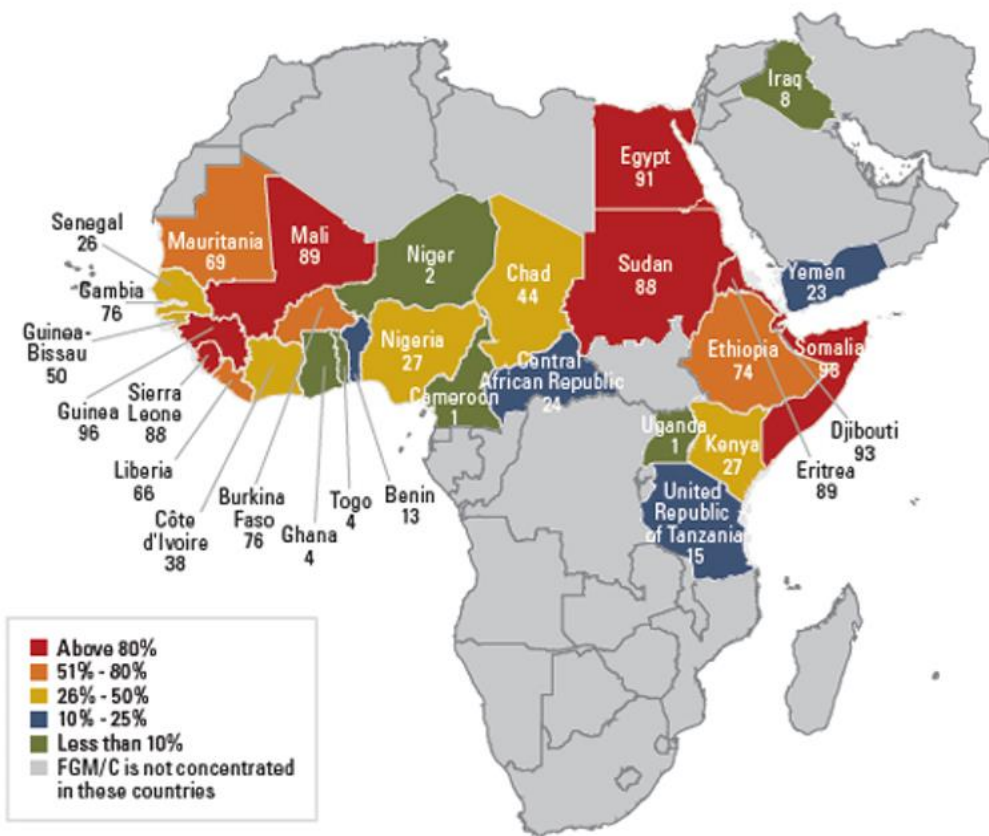




per year are at risk of undergoing female genital mutilation.<sup>62</sup> FGM has been documented in 30 countries, mainly in Africa, as well as in the Middle East and Asia (Figure 4).<sup>63</sup>

Figure 4.

Percentage of girls and women aged 15 to 49 years who have undergone FGM, by country



Source: United Nations Children's Fund and Geeta Rao Gupta, "Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change," *Reproductive Health Matters* 21, no. 42 (2013): 184–90

<sup>62</sup> "Female Genital Mutilation (FGM)," WHO, accessed October 19, 2018, <http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/>.

<sup>63</sup> "Female Genital Mutilation (FGM)." WHO



## 2. Our Process

We take a top-down approach to select charities, starting at a high level by gaining an understanding of the field. Next, we survey the academic literature on interventions that may be effective in the field. We then search for charities that implement these interventions and recommend them according to various criteria including internal monitoring, track record, and room for funding.

We use several heuristics to identify the most promising interventions and charities. However, we remain open to investigating interventions and charities ‘bottom-up’ when they fall outside the scope of these heuristics, whenever there are other reasons to believe they stand out. For instance, if we discover (e.g., via an expert) a charity that implements an intervention that we have not shortlisted, but this charity provides its own evidence for the cost-effectiveness of the intervention, we include it in the initial list of organisations considered for recommendation.

Below, we describe the steps in our research process in more detail, as we applied them to our investigation of women’s empowerment.

### 2.1. Step-by-step overview

Early on, we decided to focus on low- and middle-income countries, as explained in the previous chapter. We then reviewed literature and interviewed 20 experts<sup>64</sup> in relevant subfields of women’s empowerment. The aims at this stage were:

- forming an overview of the field and relevant subfields

<sup>64</sup> See the [acknowledgements section](#) for a list of the experts we consulted



- identifying which subfields were likely to contain the most evidence-based, cost-effective interventions
- selecting the most promising interventions within subfields

After we reviewed all subfields, we decided to focus most of our intervention review on economic empowerment, preventing gender-based violence, and child marriage. We committed less time to the other subfields for several reasons:

- Our initial review of the subfield uncovered few or no interventions that were supported by high-quality evidence (in the case of legal and political empowerment, slavery and human trafficking, gender-biased sex selection, and female genital mutilation).
- Experts we consulted considered it more likely to find cost-effective donation opportunities in other subfields (in the case of maternal health, family planning, education, and HIV and other STDs).
- We found little evidence on outcomes, as opposed to outputs<sup>65</sup>, of interventions in the subfield (in the case of education).
- Our research partner GiveWell<sup>66</sup> was an expert in the subfield and/or was building further expertise, and we thought it unlikely that we would find donation opportunities better than or equivalent to their current or near-future top charities within our timeframe for this research project (in the case of maternal health, family planning, HIV and other STDs, and health (other)).
- We have other existing or upcoming research reports in which interventions in the subfield are evaluated (in the case of education and health (other)).

<sup>65</sup> For more on the difference between outcomes and outputs, see <https://founderspledge.com/research#looking-for-outcomes>

<sup>66</sup> <https://www.givewell.org/>



We did not fully exclude any subfields. Rather, we focused our intervention review mostly on the three most promising areas, but were open to interventions and charities in other areas, for instance when experts referred us to them, or when charities themselves provided evidence for their intervention.

Our intervention review, based on expert input and a review of the literature, yielded a shortlist of the most promising interventions within the subfields:

- Economic empowerment
  - Graduation approach<sup>67,68</sup>
  - Unconditional and conditional cash transfers<sup>69,70</sup>
  - Demand-driven job services for young women<sup>71,72</sup>
  - Savings products for poor women<sup>73,74</sup>
  - Economic self-help groups<sup>75</sup>

<sup>67</sup> Abhijit Banerjee et al., “A Multifaceted Program Causes Lasting Progress for the Very Poor: Evidence from Six Countries,” *Science* 348, no. 6236 (May 15, 2015): 1260799, <https://doi.org/10.1126/science.1260799>.

<sup>68</sup> Oriana Bandiera et al., “Labor Markets and Poverty in Village Economies,” *The Quarterly Journal of Economics* 132, no. 2 (May 1, 2017): 811–70, <https://doi.org/10.1093/qje/qjx003>.

<sup>69</sup> “Cash or Condition? Evidence from a Cash Transfer Experiment | The Quarterly Journal of Economics | Oxford Academic,” accessed November 1, 2018, <https://academic.oup.com/qje/article-abstract/126/4/1709/1922509?redirectedFrom=fulltext>.

<sup>70</sup> Johannes Haushofer and Jeremy Shapiro, “Household Response to Income Changes: Evidence from an Unconditional Cash Transfer Program in Kenya,” (November 15, 2013): 57.

<sup>71</sup> Mayra Buvinic and Megan O’Donnell, “Revisiting What Works: Women, Economic Empowerment and Smart Design,” n.d., 68.

<sup>72</sup> “Do Labor Market Opportunities Affect Young Women’s Work and Family Decisions? Experimental Evidence from India | The Quarterly Journal of Economics | Oxford Academic,” accessed November 1, 2018, <https://academic.oup.com/qje/article-abstract/127/2/753/1823744?redirectedFrom=fulltext>.

<sup>73</sup> “Mindful Saving: Exploring the Power of Savings for Women | Center For Global Development,” accessed November 1, 2018, <https://www.cgdev.org/publication/mindful-saving-exploring-power-savings-women>.

<sup>74</sup> “Reducing Barriers to Savings in Rural Malawi | The Abdul Latif Jameel Poverty Action Lab,” accessed November 1, 2018, <https://www.povertyactionlab.org/node/1821>.

<sup>75</sup> “Economic Self-Help Group Programs for Improving Women’s Empowerment - The Campbell Collaboration,” accessed November 1, 2018, <https://www.campbellcollaboration.org/library/women-empowerment-economic-self-help-programmes.html>.



- Gender-based violence prevention
  - Empowerment self-defence courses<sup>76,77</sup>
  - Group training and community mobilisation<sup>78,79</sup>
  - Mass media campaigns<sup>80</sup>
  - Unconditional and conditional resource transfers<sup>81,82</sup>
  
- Child marriage
  - Unconditional and conditional resource transfers<sup>83,84</sup>

<sup>76</sup> Michael Baiocchi et al., “A Behavior-Based Intervention That Prevents Sexual Assault: The Results of a Matched-Pairs, Cluster-Randomized Study in Nairobi, Kenya,” *Prevention Science* 18, no. 7 (2017): 818–827.

<sup>77</sup> Charlene Y. Senn et al., “Secondary and 2-Year Outcomes of a Sexual Assault Resistance Program for University Women,” *Psychology of Women Quarterly* 41, no. 2 (June 2017): 147–62, <https://doi.org/10.1177/0361684317690119>.

<sup>78</sup> “Prevention of Violence against Women and Girls: What Does the Evidence Say? - The Lancet,” accessed November 1, 2018, <https://www.thelancet.com/action/showFullTableImage?tableId=tbl1&pii=S0140673614617037>.

<sup>79</sup> “3ie Impact Evaluation Report 24-3ie:International Initiative for Impact Evaluation | Evaluating Impact, Informing Policy, Improving Lives,” accessed November 1, 2018, <http://www.3ieimpact.org/en/publications/3ie-impact-evaluation-reports/3ie-impact-evaluations/3ie-impact-evaluation-report-24/>.

<sup>80</sup> “A Mass Media Experiment to Reduce Violence Against Women in Rural Uganda | Innovations for Poverty Action,” accessed November 1, 2018, <https://www.poverty-action.org/study/mass-media-experiment-reduce-violence-against-women-rural-uganda>.

<sup>81</sup> Melissa Hidrobo, Amber Peterman, and Lori Heise, “The Effect of Cash, Vouchers, and Food Transfers on Intimate Partner Violence: Evidence from a Randomized Experiment in Northern Ecuador,” *American Economic Journal: Applied Economics* 8, no. 3 (July 2016): 284–303, <https://doi.org/10.1257/app.20150048>.

<sup>82</sup> “Conditional Cash Transfers and the Reduction in Partner Violence for Young Women: An Investigation of Causal Pathways Using Evidence from a Randomized Experiment in South Africa (HPTN 068) - Kelly N Kilburn et al. - 2018 - Journal of the International AIDS Society - Wiley Online Library,” accessed November 1, 2018, <https://onlinelibrary.wiley.com/doi/abs/10.1002/jia2.25043>.

<sup>83</sup> “Cash or Condition? Evidence from a Cash Transfer Experiment | The Quarterly Journal of Economics | Oxford Academic,” accessed November 1, 2018, <https://academic.oup.com/qje/article/126/4/1709/1922509>.

<sup>84</sup> “Empowering Girls in Rural Bangladesh | The Abdul Latif Jameel Poverty Action Lab,” accessed November 1, 2018, <https://www.povertyactionlab.org/evaluation/empowering-girls-rural-bangladesh>.



- Other subfields
  - Group-based antenatal care<sup>85,86</sup>
  - Interpersonal group psychotherapy<sup>87,88</sup>
  - Reducing costs to staying in school<sup>89</sup>
  - Quotas for women in village councils<sup>90</sup>

With this shortlist, we began evaluating charities. We made a longlist of 163 charities that target women’s empowerment; work in low- and middle-income countries; seem open to using and/or generating evidence; and are large enough to productively absorb significant funding from our donors. This longlist was assembled using the UK government’s database of registered charities in England and Wales<sup>91</sup>; charities we had encountered while reviewing subfields and interventions; charities recommended by other charity-research organisations (for instance our research partner GiveWell<sup>92</sup>); grantees of philanthropic organisations that are largely aligned with our purpose (for instance the Bill and Melinda Gates Foundation<sup>93</sup>); as well as suggestions by experts.

<sup>85</sup> “Analyses Confirm Effect of Women’s Groups on Maternal and Newborn Deaths - The Lancet,” accessed November 1, 2018, <https://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2813%2961082-X/fulltext?code=lancet-site>.

<sup>86</sup> “Effect of Women’s Groups and Volunteer Peer Counselling on Rates of Mortality, Morbidity, and Health Behaviours in Mothers and Children in Rural Malawi (MaiMwana): A Factorial, Cluster-Randomised Controlled Trial - The Lancet,” accessed November 1, 2018, [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)61959-X/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61959-X/fulltext).

<sup>87</sup> Cuijpers, P. et al., “Interpersonal Psychotherapy for Depression: A Meta-Analysis | American Journal of Psychiatry,” accessed November 2, 2018, <https://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2010.10101411>.

<sup>88</sup> Judith Bass et al., “Group Interpersonal Psychotherapy for Depression in Rural Uganda: 6-Month Outcomes: Randomised Controlled Trial,” *The British Journal of Psychiatry* 188, no. 6 (June 1, 2006): 567–73, <https://doi.org/10.1192/bjp.188.6.567>.

<sup>89</sup> Esther Duflo, Pascaline Dupas, and Michael Kremer, “Education, HIV, and Early Fertility: Experimental Evidence from Kenya,” n.d., 71.

<sup>90</sup> “Impact of Female Leadership on Aspirations and Educational Attainment for Teenage Girls in India | The Abdul Latif Jameel Poverty Action Lab,” accessed November 1, 2018, <https://www.povertyactionlab.org/evaluation/impact-female-leadership-aspirations-and-educational-attainment-teenage-girls-india>.

<sup>91</sup> <http://beta.charitycommission.gov.uk/charity-search/>

<sup>92</sup> <https://www.givewell.org/>

<sup>93</sup> <https://www.gatesfoundation.org>



We narrowed down the longlist to 15 charities using the following criteria:

- They implement one of our shortlisted interventions and/or cite evidence of the effectiveness of their intervention themselves.
- They specialise in such an intervention (i.e., they spend a large amount of their budget on it) and/or it seems likely we would be able to recommend restricted donations to the implementation of such an intervention.
- They work directly with beneficiaries and/or assist other organisations in doing so (i.e., we excluded pure research and policy interventions from this report due to time constraints).
- They are open to using and/or generating evidence; focus on cost-effectiveness; and have strong organisational quality and transparency, insofar as we could assess from their website and the information experts shared with us.

The 15 charities we selected were:

1. Bandhan's 'Targeting the Hardcore Poor' programme
2. StrongMinds
3. Village Enterprise
4. No Means No Worldwide
5. Fistula Foundation
6. Operation Fistula
7. Trickle Up



8. The BOMA Project
9. Development Media International
10. Women and Children First (UK)
11. Jacaranda Health
12. Bridges to Prosperity
13. Promundo
14. HealthRight International's Maternal Mental Health Project
15. Organisation that preferred to remain anonymous

We reached out to all these charities and asked them to provide further evidence for the cost-effectiveness of their programmes, so that we could perform preliminary cost-effectiveness analyses. HealthRight International and an organisation that preferred to remain anonymous were unable to provide us with enough data to perform an analysis.

We compared the remaining 13 organisations using more detailed information on both cost-effectiveness and strength of evidence. Four charities stood out by our criteria.<sup>94</sup> For each of those, we investigated organisational strength and plans. We decided to recommend Bandhan, StrongMinds and Village Enterprise and to provisionally recommend No Means No Worldwide, awaiting results from a large independent evaluation of their programme.

<sup>94</sup> We should note here that we made a mistake in our cost-effectiveness analysis of Bridges to Prosperity, which led us to deprioritise them at a point in the research process where we shouldn't have done so. See also Appendix II.





## 3. Charity Recommendations

In this chapter we discuss the charities we decided to recommend to our community members wishing to support women’s empowerment. We recommend StrongMinds, Bandhan’s ‘Targeting the Hardcore Poor’ programme and Village Enterprise, and we provisionally recommend No Means No Worldwide. Each of these charities excels at improving the lives of women and has strong evidence to support their effectiveness.

### 3.1. StrongMinds

#### Summary

**What do they do?** StrongMinds implement Interpersonal Group Psychotherapy (IPT-G), training laypeople to treat women suffering from depression in Uganda.

**Is there evidence the intervention works?** Evidence for the efficacy of IPT-G in low-resource settings comes from two randomised controlled trials (RCTs) and StrongMinds’ own quasi-experimental impact assessment.

**Is the intervention cost-effective?** We estimate that StrongMinds prevent the equivalent of one year of severe major depressive disorder for a woman at a cost of \$200–\$299, with a best guess estimate of \$248.

**What are the wider benefits?** There are indications of improvements in employment, nutrition, physical health, housing, and children’s education.

**Is it a strong organisation?** They have a good track record and a strong focus on generating evidence. They are transparent about their mistakes and lessons, and are committed to continuous improvement.

**Is there room for funding?** StrongMinds could productively use an extra \$5.1 million in funding through 2020.



## What do they do?

StrongMinds use Interpersonal Group Psychotherapy (IPT-G) to treat women suffering from depression in Uganda. IPT-G is a model of therapy that focuses on the individual's relationships with others. StrongMinds' vision is "for every African woman suffering from depression to have access to mental health treatment, which enables her and her family to lead healthy, productive and satisfying lives."<sup>95</sup>

StrongMinds' programme is implemented by Mental Health Facilitators (MHFs) from the community. MHFs are laypeople with a high-school diploma who have undertaken two weeks of training from a certified IPT-G expert. MHFs are supervised by a professional Mental Health Supervisor. At full capacity, each MHF treats 350–400 patients each year.

Each therapy group has 12 members on average and meets for 90 minutes each week for 12 weeks. Patients with severe depression or suicidal tendencies are referred to a government clinic for further treatment, which may include medication.

To date, the primary target population of the programme has been women older than 15. These women are typically married, have 2–5 children and manage a family income of \$2–5 per day. Starting in 2019, in collaboration with the NGO BRAC-Uganda, StrongMinds will also treat adolescent girls age 12 and over. Around 5% of their patients are men, but they prioritise women due to higher rates of depression<sup>96</sup> and evidence that they respond better to IPT-G.<sup>97</sup>

<sup>95</sup> "Strongminds History," StrongMinds, accessed December 5, 2018, <https://strongminds.org/strongminds-history/>.

<sup>96</sup> Kessler, Ronald C. "Epidemiology of women and depression." *Journal of affective disorders* 74.1 (2003): 5-13.

<sup>97</sup> Bolton, Paul et al. "Interventions for depression symptoms among adolescent survivors of war and displacement in northern Uganda: a randomized controlled trial." *Jama* 298.5 (2007): 519-527.



As of September 2018, StrongMinds had treated over 30,000 women with depression,<sup>98</sup> with a target of reaching over 130,000 women by the end of 2020.<sup>99</sup> Total expenditure in 2017 was around \$2 million.<sup>100</sup>

### Is there evidence the intervention works?

Evidence indicates that interpersonal psychotherapy is an effective treatment for depression, with effect sizes comparable to cognitive behavioural therapy.<sup>101,102</sup> A meta-analysis in 2011 looked at 38 RCTs and concluded that “IPT deserves its place in treatment guidelines as one of the most empirically validated treatments for depression”.<sup>103</sup> However, the evidence is much stronger in high-resource settings than in low-resource settings. Of the 38 RCTs included in the meta-analysis, only two were conducted in Sub-Saharan Africa. Similarly, a 2017 systematic review found only three RCTs on IPT-G conducted in low- and middle-income countries that met the review’s eligibility criteria.<sup>104</sup>

As the effectiveness of mental-health interventions is likely to depend on the target populations, the indirect evidence we consider for StrongMinds’ intervention largely consists of two RCTs conducted in Uganda. We consider StrongMinds’ own quasi-experimental impact assessment as direct evidence.

<sup>98</sup> StrongMinds, “2017 Quarter 2 Summary,” 2017, 1.

<sup>99</sup> StrongMinds, “Strategic Operating Plan 2017-19,” 2016. with StrongMinds

<sup>100</sup> StrongMinds IRS Form 990, 2017

<sup>101</sup> Donker, Tara et al. “Internet-delivered interpersonal psychotherapy versus internet-delivered cognitive behavioral therapy for adults with depressive symptoms: randomized controlled noninferiority trial.” *Journal of medical Internet research* 15.5 (2013): e82.

<sup>102</sup> Lemmens, LHJM et al. “Clinical effectiveness of cognitive therapy v. interpersonal psychotherapy for depression: results of a randomized controlled trial.” *Psychological medicine* 45.10 (2015): 2095-2110.

<sup>103</sup> Cuijpers, P. et al., “Interpersonal Psychotherapy for Depression: A Meta-Analysis | American Journal of Psychiatry.”

<sup>104</sup> Daisy R. Singla et al., “Psychological Treatments for the World: Lessons from Low- and Middle-Income Countries,” *Annual Review of Clinical Psychology* 13, no. 1 (2017): 149–81, <https://doi.org/10.1146/annurev-clinpsy-032816-045217>.



### Indirect evidence of StrongMinds' effectiveness

The first study was an RCT in 2003 which examined the impact of a 16-week IPT-G intervention on 284 people in southwest Uganda.<sup>105</sup> The study found significant reductions in levels of depression in the treatment group ( $p < 0.0001$ ), with mean depression scores on the diagnostic test decreasing by 13.91 in the intervention group compared to the control group, and both groups starting at around 24 (out of a possible 42).<sup>106</sup>

Six months after the intervention ended, 14 of the 15 groups continued to meet without their group leaders. Individuals in these groups remained largely depression-free. Individuals who did not continue to meet partially relapsed, but mean depression scores remained significantly below the control group. Figure 5 shows the decline, as measured by the depression section of the Hopkins Symptoms Checklist (a method which correlates well with other standard measures of depression and with clinical judgement of change in depression over time).<sup>107</sup>

<sup>105</sup> Paul Bolton et al., "Group Interpersonal Psychotherapy for Depression in Rural Uganda: A Randomized Controlled Trial," *JAMA* 289, no. 23 (June 18, 2003): 3117–24, <https://doi.org/10.1001/jama.289.23.3117>; Judith Bass et al., "Group Interpersonal Psychotherapy for Depression in Rural Uganda: 6-Month Outcomes: Randomised Controlled Trial," *The British Journal of Psychiatry* 188, no. 6 (June 2006): 567–73, <https://doi.org/10.1192/bjp.188.6.567>.

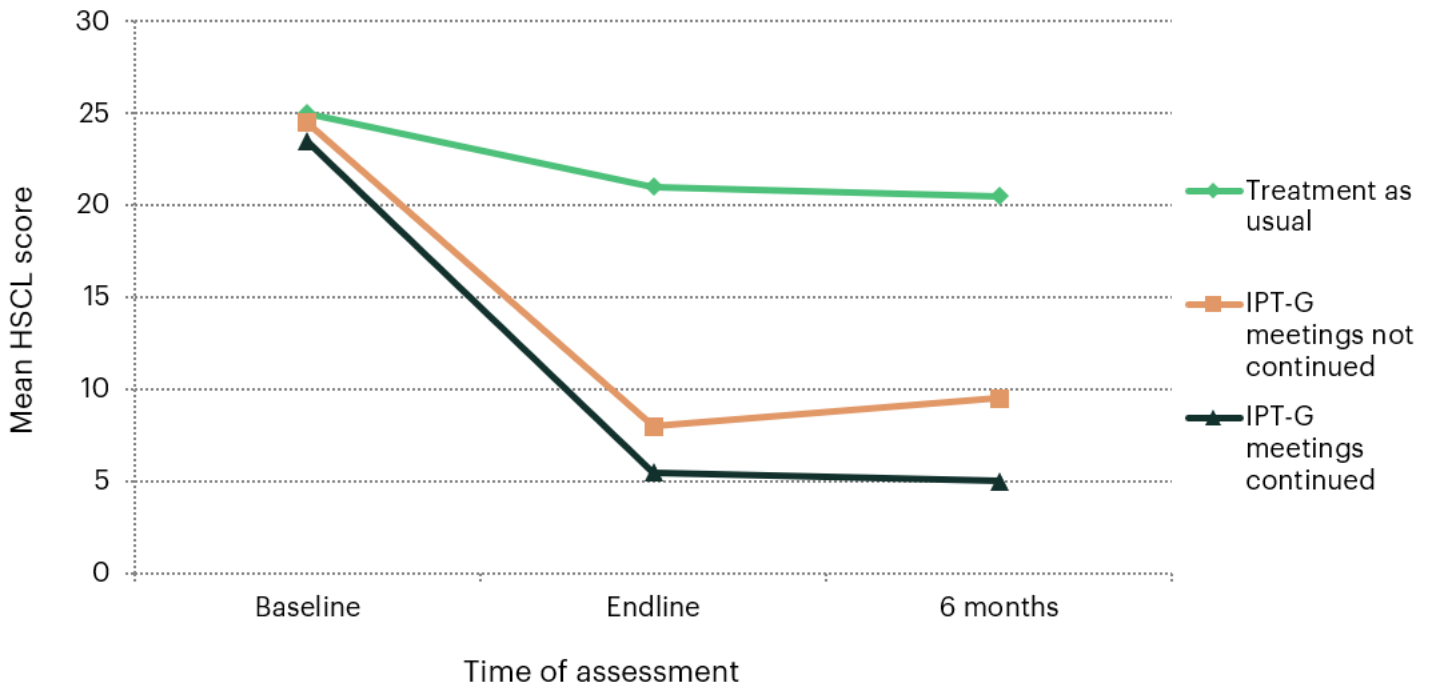
<sup>106</sup> At baseline 86% of participants in the intervention group met modified diagnostic criteria for major depressive disorder and 94% of those in the control group met these criteria. See Bass et al., "Group Interpersonal Psychotherapy for Depression in Rural Uganda," June 1, 2006, 569.

<sup>107</sup> Bass et al., 568.



Figure 5.

Outcomes for IPT-G 6 months after intervention<sup>108</sup>



Source: Judith Bass et al., “Group Interpersonal Psychotherapy for Depression in Rural Uganda: 6-Month Outcomes: Randomised Controlled Trial,” *The British Journal of Psychiatry* 188, no. 6 (June 1, 2006): 567–73

A second RCT was conducted by the same researchers in 2007. It studied the impact of a 16-week IPT-G intervention carried out by World Vision in northern Uganda.<sup>108</sup> The treated population was a group of 300 adolescents aged 15–17 who were survivors of war and displacement. Treatment outcomes were measured using a locally developed diagnostic tool, different from that used in the first study. IPT-G again resulted in a statistically significant ( $p=0.05$ ) reduction in depressive symptoms: the mean effect in the treatment group,

<sup>108</sup> Paul Bolton et al., “Interventions for Depression Symptoms Among Adolescent Survivors of War and Displacement in Northern Uganda: A Randomized Controlled Trial,” *JAMA* 298, no. 5 (August 1, 2007): 519–27, <https://doi.org/10.1001/jama.298.5.519>.



compared to the control group, was a 9.79-point reduction on a 105-point scale in depressive symptoms.

Interestingly, the improvements were driven by girls, with no significant impact found for boys (although the study was not powered to detect impact at the gender level).

These two studies represent moderate evidence for the efficacy of the StrongMinds intervention. Both studies have relatively high external validity as they were administered in Uganda, where StrongMinds operate, and the treatment effect was most significant in women, the primary population StrongMinds treat. On the other hand, the second RCT targeted only displaced people and survivors of war, a different group than StrongMinds generally target. There are two main areas of uncertainty that apply to both RCTs:

- Neither of the studies reported programme costs, making it impossible to assess cost-effectiveness. We therefore use StrongMinds' own quasi-experimental impact assessment to estimate cost-effectiveness.
- The long-term benefits of intergroup psychotherapy are highly uncertain. While most of the treatment group in the first RCT remained depression-free after six months, it is unclear whether this would persist over a longer period. In our cost-effectiveness analysis we used a study by Reay et al. in Australia<sup>109</sup> and StrongMinds' own impact evaluation to estimate the long-term effects of StrongMinds' intervention.

#### Direct evidence of StrongMinds' effectiveness

StrongMinds have conducted multiple impact evaluations on the effectiveness of their programme. Their highest-quality evaluation, a quasi-experimental pilot study including 270 women, formed the basis of our [cost-effectiveness model](#) of StrongMinds. At the end of the 12-week intervention, there was on average a

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<sup>109</sup> Rebecca E. Reay et al., "Trajectories of Long-Term Outcomes for Postnatally Depressed Mothers Treated with Group Interpersonal Psychotherapy," *Archives of Women's Mental Health* 15, no. 3 (June 1, 2012): 217–28, <https://doi.org/10.1007/s00737-012-0280-4>.



4.5-point (16%) out of a possible 27 points reduction in PHQ-9 depression survey scores in the treatment group compared to the control group.<sup>110</sup>

Limitations of the study include:

- **The existence of social desirability bias.** The outcome variables were initially intended to be based on post-treatment assessment of PHQ-9 scores, which found that 95% of women were depression-free following the treatment. However, the post-assessment outcomes were found to be subject to social desirability bias. Social desirability bias occurs when respondents answer questions in a manner that will be viewed favourably by the questioner. To mitigate this effect, StrongMinds revised their estimate down to 85%.<sup>111</sup> We have accounted for this in our cost-effectiveness model.
- **The composition of the control group.** The control group was not randomised: it consisted of patients who declined group therapy as they preferred to receive individual therapy instead, which they did after the study was finished. This way of forming a control group could lead to bias if a preference for individual therapy is correlated with the responsiveness of the patient to treatment. The direction of this potential bias is unclear, however, and the control group had similar baseline characteristics to the treatment group. These two factors reduce our concerns about the composition of the control group, though they don't fully account for them.
- **No control data for the longer-term follow-up.** StrongMinds carried out follow-up evaluations that show reduced rates of depression after 18 and 24 months.<sup>112</sup> However, these follow-ups didn't

<sup>110</sup> StrongMinds, "Impact Evaluation: End of Phase Two Impact Evaluation for the Treating Depression at Scale in Africa Program in Uganda," July 2015, 17.

<sup>111</sup> StrongMinds, "Follow Up Evaluations for Phase 1 & Phase 2," 2017, 2.

<sup>112</sup> StrongMinds, 2.



include control groups, so it is unclear what long-term effects the programme had, compared to no intervention.

While the study has several limitations, results align closely with the RCTs discussed above. Together, the indirect and direct evidence constitute reasonably strong evidence that StrongMinds' intervention substantially reduces depression.

### Is the intervention cost-effective?

Our rough [model](#) suggests that the StrongMinds intervention prevents a woman from the equivalent of living with severe major depressive disorder for one year for \$200–\$299, with a best guess estimate of \$248. The model includes explanations for each step of the analysis.

The most widely-used metric for measuring the health benefits of a programme is the disability-adjusted life year (DALY): the more DALYs a disease causes, the greater the disease burden it creates. DALYs account for the premature death (mortality) and years lived with disability (morbidity) that a disease causes. One DALY can be thought of as one lost year of healthy life—a more damaging disease receives a higher DALY weight. Our model suggests that StrongMinds averts a DALY for \$304–\$454, with a best guess estimate of \$377.

### What are the wider benefits?

In addition to an impact on rates of depression, StrongMinds' impact evaluation suggests a positive impact on different aspects of daily life for those who no longer suffer from depression.<sup>113</sup> These benefits were not included in the cost-effectiveness analysis, as we don't have enough evidence to reliably estimate the effect size, and we expect most of the impact of the intervention to come from direct relief of depression.

<sup>113</sup> StrongMinds, "Impact Evaluation - End of Phase Two Impact Evaluation for the Treating Depression at Scale in Africa Program in Uganda," 2015, 3.





Furthermore, as StrongMinds measured for 46 different indicators, we would expect some—though far from all—of the measured effects to be explained by non-programme-related variation.

Statistically significant ( $p=0.05$ ) benefits measured at the end of treatment include:

- Job satisfaction increased by, on average, 1 point on a 5-point scale.
- The percentage of families who had not consumed meals over the last 24 hours fell from 53% to 14%.
- The percentage of families sleeping in protected shelters increased from 65% to 83%.
- Use of medical care in the past month decreased from 58% to 42%.
- The percentage of children missing a day of school in the past week decreased from 43% to 33%.
- The percentage of women reporting the presence of someone in their lives they could rely upon for support with personal problems increased from 64% to 98%.

A follow-up evaluation, 18 months after the end of the programme, suggests some further benefits, while other benefits eroded.<sup>114</sup> Further benefits included:

- Reported self-employment increased from 17% directly after treatment to 45%.
- Employment continuity increased—yearlong work increased from 35% to 66%.
- The percentage of women reporting poor attention at work fell from 44% to 19%.

Self-reported nutrition, children’s schooling, and shelter indicators had eroded 18 months after treatment, effectively declining to their pre-treatment levels. StrongMinds believe that the erosion of these benefits may be due to wider macroeconomic forces in Uganda, and potential data-collection issues.

<sup>114</sup> StrongMinds, “Follow Up Evaluations for Phase 1 & Phase 2,” 3–4.



## Is it a strong organisation?

StrongMinds appears to be a transparent and self-improving organisation which is contributing to the global evidence base for cost-effective treatment for mental health.

First, they have a strong commitment to monitoring and evaluation. StrongMinds have published the impact assessments of their pilot study online. They also sought funding to carry out an RCT of their intervention, which proved to be difficult to find. As an interim measure, they are currently working on establishing a formal control group in Uganda consisting of several hundred women with depression, which they plan to use to evaluate the longer-term impact of their programme.<sup>115</sup>

Second, StrongMinds has good norms of transparency. They publish quarterly updates on their performance and finances and share yearly financial statements on their website. Furthermore, they shared all required information for us to do this evaluation.

They have also shown a commitment to continuous improvement and learning from mistakes. For instance, when finding out about a potential social-desirability effect affecting the results of their impact evaluations, they revised these results downward substantially, and have since used only external data collectors.

Furthermore, after receiving feedback they announced that they will start including average PHQ-9 score reductions in the main metrics section of their quarterly reports, in addition to the (less informative) ‘depression-free’ statistics they were reporting on so far.<sup>116</sup>

<sup>115</sup> Private correspondence with StrongMinds, 22 August 2018.

<sup>116</sup> StrongMinds, “2018 Quarter 2 Report,” 5.



## What is their strategy?

StrongMinds' ultimate goal is to treat two million African women suffering from depression by 2025. Having treated more than 30,000 women up until mid-2018, they plan to scale up and treat 130,000 women in Uganda and either Tanzania, Malawi or Zambia (into which they will expand in 2019) by 2020. They plan to accomplish this through two scalable pathways, which they are pursuing in parallel.<sup>117</sup>

The first pathway involves partnering with large international NGOs such as BRAC Uganda in order to implement the StrongMinds model. The second pathway involves 'virally expanding' through what StrongMinds calls the Peer Therapy Group model: they train graduates of the therapy groups to become volunteer facilitators themselves. The overall cost per patient in Peer Therapy Groups is very low because the group leaders volunteer. On the other hand, there is a risk of decreased effectiveness, as the volunteers receive a less-intensive training on IPT than the Mental Health Facilitators that lead the regular StrongMinds groups.<sup>118</sup> Overall, we expect this trade-off to balance out positively in terms of cost-effectiveness, given the large cost reductions. However, as StrongMinds expand further we will monitor their outcome measurements for both types of groups to see if any significant differences emerge.

StrongMinds are actively seeking to expand the evidence base for their intervention by establishing a formal control group, and they intend to carry out an independent randomised controlled trial if they can secure funding.

<sup>117</sup> StrongMinds, "Strategic Operating Plan 2017-19," 4.

<sup>118</sup> Private correspondence with StrongMinds, 26 September 2018.



### Is there room for funding?

StrongMinds estimate that they could productively spend an additional \$5.1 million in funding over the course of 2018–2020. Much of StrongMinds’ current funding is limited to 2018, which makes it more difficult to plan ahead.<sup>119</sup> As of August 2018, their remaining funding gaps for each of the coming three years are:

- 2018: \$500,000
- 2019: \$2,000,000
- 2020: \$2,600,000

As we mentioned in the previous section, StrongMinds also explored the possibility of carrying out an independent RCT of their project. This would be conducted in collaboration with global research organisation J-PAL. However, they could not secure the estimated \$1 million in funding necessary and were forced to put the plan on hold. This potential study is not included in the projected funding needs cited above.<sup>120</sup>

### What are the main uncertainties?

The two most important sources of uncertainty in our analysis of StrongMinds are:

- Self-reported mental-health diagnoses are subject to social-desirability bias. We believe StrongMinds has taken reasonable steps to mitigate this bias, and we have accounted for it in our cost-effectiveness model. Nevertheless, there remains a possibility that the intervention is less cost-effective than we expect given our current information.

<sup>119</sup> Private correspondence with StrongMinds, 22 August 2018.

<sup>120</sup> Private correspondence with StrongMinds, 22 August 2018.



- The long-term efficacy of IPT-G is highly uncertain and plays an important role in our cost-effectiveness analysis. We have based our estimation in part on a high-income-country study which may have limited external validity for this intervention.



## 3.2. Bandhan's 'Targeting the Hardcore Poor' programme

### Summary

**What do they do?** As part of their Targeting the Hardcore Poor (THP) programme, Bandhan provide women living in extreme poverty in India with a productive asset, a savings account, business training, mentoring, consumption support, and information on education and health. They also work with the Indian government and other NGOs to scale up their model.

**Is there evidence the intervention works?** A high-quality long-term RCT supports the effectiveness of Bandhan's THP programme. Additional evidence gathered in different contexts suggests that the 'graduation approach' adopted by Bandhan can effectively address extreme poverty.

**Is the intervention cost-effective?** We estimate that Bandhan's THP programme doubles a participant's consumption for one year at a cost of \$41–\$134, with a best guess estimate of \$62. This suggests that Bandhan's programme can bring about nominal gains in consumption of about \$1.77 for each \$1.00 donated. Adjusting for purchasing power, this is equivalent to gains of \$7.27 for each \$1.00 donated.

**What are the wider benefits?** There is some evidence that the programme improves food security, physical health, and subjective well-being.

**Are they a strong organisation?** Bandhan is a specialised organisation with a good track record. They are careful to maintain high-quality delivery of their programme; they are committed to evidence; and they have been transparent throughout our analysis of their programme. One point for improvement, however, is that their website lacks up-to-date information.



**Is there room for funding?** The key impediment preventing Bandhan from scaling up is funding, as they have all the required infrastructure and capacity in place. Another \$24 million would allow them to reach an additional 60,000 households over the coming six years.

### What do they do?

Bandhan were set up in 2001 specifically to alleviate poverty and empower women.<sup>121</sup> As part of their THP programme, they provide women living in extreme poverty in India with a productive asset, a savings account, business training, mentoring, consumption support, and information on education and health. They also work with the Indian government and other NGOs to scale up their model.

Bandhan’s intervention is an adaptation of what is commonly referred to as the ‘graduation approach’ to tackling extreme poverty. This holistic approach typically consists of six components (Figure 6) spread across 1.5–2.0 years, which aim to enable people to sustainably lift themselves out of extreme poverty:<sup>122</sup>

1. Transfer of a productive asset, such as livestock
2. Skills training to manage the productive asset, such as business training
3. Consumption support for the participant and their family, such as cash or food
4. Regular coaching, for instance to reinforce skills and build confidence
5. Health education or access to healthcare
6. Support to set up a savings account and/or be part of a savings group

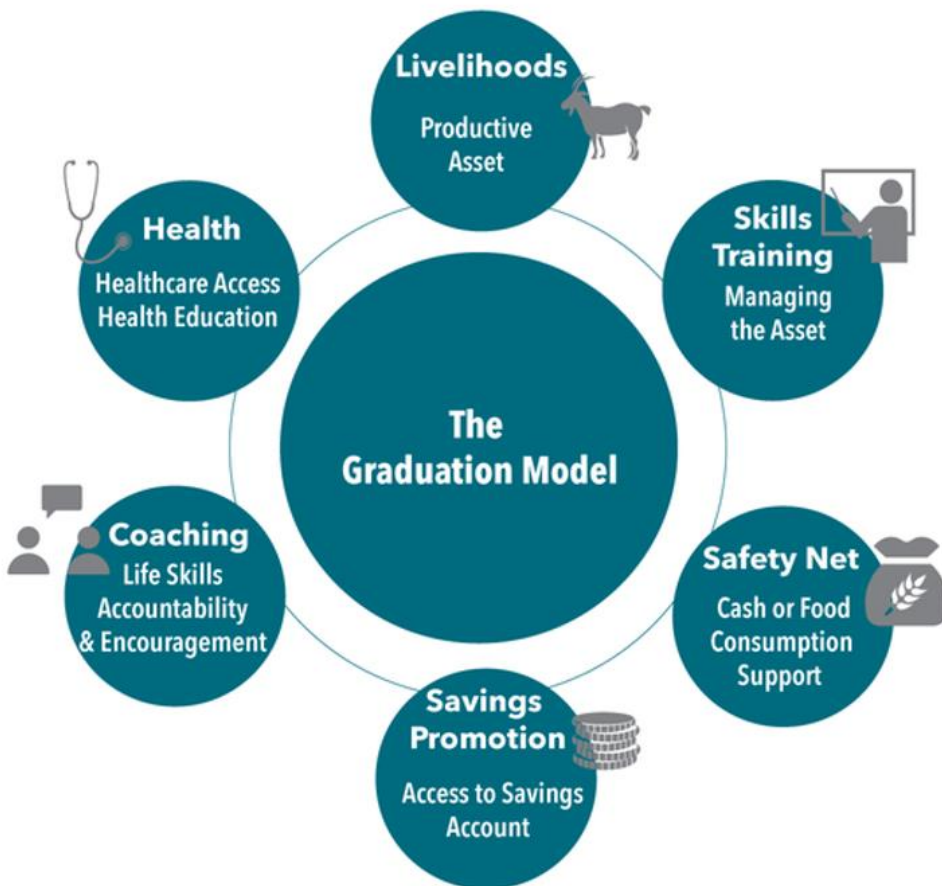
<sup>121</sup> “Bandhan Development Program,” Bandhan, accessed October 4, 2018, <http://bandhan.org/>.

<sup>122</sup> “The Ultra Poor Graduation Model,” Innovations for Poverty Action, September 18, 2015, <https://www.poverty-action.org/impact/ultra-poor-graduation-model>.



Figure 6.

Components of the graduation model



Source: "The Ultra Poor Graduation Model," Innovations for Poverty Action, 2015

Bandhan's THP programme was part of the six-country graduation study discussed in our evidence review below, and their model (Table 1) has remained similar to the standard graduation approach tested there. It





has had only minor updates over the years, such as increasing the number of enterprise options for beneficiaries as the economic context in India changed.<sup>123</sup>

Table 1.

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#### Outline of the implementation of Bandhan's programme

Months	Implementation Phase
1-4	Market analysis and beneficiary selection
5-8	Asset transfer (mix of farm and non-farm)
6-9	Enterprise training to manage the asset Temporary consumption support
9-15	Bank account opening and regular savings encouragement
6-24	18 months of weekly mentoring to develop the asset Education and health information
23-24	Graduation training and linkage to microfinance and government programmes

Source: Private correspondence with Bandhan, 11 July 2018

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<sup>123</sup> Private correspondence with Bandhan, 2 October 2018.



Bandhan’s programme specifically targets woman-headed households living in extreme poverty: before participating in the programme, beneficiaries earn an average of about ₹2000 per month<sup>124</sup>, which is equivalent to about \$1.25 per person per day in 2017 US dollars.<sup>125</sup>

From initial implementation in 2006 through October 2018, Bandhan have directly provided its THP programme to more than 72,000 women across 10 states in India.<sup>126</sup> They have also piloted, and are working to scale up, the implementation of their intervention by state governments and other NGOs, with Bandhan providing technical assistance and monitoring. Most notably, in April 2018 the government of Bihar announced plans and a budget for the implementation of Bandhan’s model for 100,000 households.<sup>127</sup> This happened after the start of an (ongoing, as of December 2018) RCT by research organisation J-PAL on a 2,000-household pilot of the Bihar government’s implementation of Bandhan’s intervention. On completion, this will be the first scientific evaluation of a government-run graduation programme.<sup>128</sup>

### Is there evidence the intervention works?

A high-quality long-term RCT supports the effectiveness of Bandhan’s THP programme. Additional evidence gathered in other contexts also suggests that the graduation approach adopted by Bandhan can effectively address extreme poverty. In this section, we first discuss the available external evidence for the graduation approach, and then discuss the RCT on Bandhan’s programme.

<sup>124</sup> Private correspondence with Bandhan, 30 July 2018.

<sup>125</sup> “Conversion Rates - Purchasing Power Parities (PPP) - OECD Data,” OECD, accessed October 4, 2018, <http://data.oecd.org/conversion/purchasing-power-parities-ppp.htm>.

<sup>126</sup> Private correspondence with Bandhan, 2 October 2018.

<sup>127</sup> Private correspondence with J-PAL, 3 July 2018.

<sup>128</sup> Private correspondence with J-PAL, 3 July 2018.



### Indirect evidence of Bandhan's effectiveness

Most external evidence for the effectiveness of the graduation approach comes from a six-country RCT published in *Science* in 2015.<sup>129</sup> This study included a sample of 11,000 households spread over Ethiopia, Ghana, Honduras, India (Bandhan's THP programme), Pakistan, and Peru.<sup>130</sup> The graduation programmes that were tested differed in several ways, including size of productive asset transfers, type of consumption support (cash or food), and whether it merely encouraged savings or mandated them.<sup>131</sup>

Directly after the two-year intervention, statistically significant ( $p < 0.1$ ) though small (mostly around 0.1 standard deviations of the control group) impacts were found on all 10 outcomes measured by the study.<sup>132</sup> At one-year follow-up, impacts on eight of those persisted, including consumption, income, assets, savings, food security, and mental health.<sup>133</sup> The average overall effect size on consumption was 0.1 standard deviation, with a p-value of less than 0.01, both directly after the intervention and at the one-year follow-up.

<sup>134</sup> This led the authors to conclude:

“The Graduation program’s primary goal, to substantially increase consumption of the very poor, is achieved by the conclusion of the program and maintained 1 year later.”<sup>135</sup>

This conclusion is corroborated by an RCT of NGO BRAC's graduation programme in Bangladesh, which took place around the same time. The study included almost 7,000 woman-headed households and also showed small (0.2 standard deviations of the control group) but statistically significant ( $p < 0.01$ ) effects on

<sup>129</sup> Banerjee et al., “A Multifaceted Program Causes Lasting Progress for the Very Poor.”

<sup>130</sup> Banerjee et al., 6.

<sup>131</sup> Banerjee et al., 4.

<sup>132</sup> Banerjee et al., “A Multifaceted Program Causes Lasting Progress for the Very Poor.”

<sup>133</sup> Banerjee et al., 10.

<sup>134</sup> Banerjee et al., 10.

<sup>135</sup> Banerjee et al., “A Multifaceted Program Causes Lasting Progress for the Very Poor.”



consumption at two-year follow-up.<sup>136</sup> More importantly, this latter RCT provides some evidence of long-term effects of the graduation approach. At the five-year follow-up, seven years after the start of the programme, the effect on consumption was still significant at a similar effect size.<sup>137</sup> However, half of the initial control group had undergone treatment by then, so the analysis was done by estimating a counterfactual for that part of the group, which reduces the strength of the evidence somewhat.<sup>138</sup>

Finally, an RCT of Village Enterprise’s intervention provides additional evidence that the graduation approach alleviates extreme poverty effectively. Village Enterprise’s model, however, is meaningfully different from the standard graduation model, as discussed in the [section describing their programme](#). Hence, this RCT provides weaker evidence than, for instance, the RCT on BRAC’s programme mentioned above. We discuss the Village Enterprise RCT more in detail in the [section on direct evidence for Village Enterprise’s programme](#).

#### Direct evidence of Bandhan’s effectiveness

The most important direct evidence for the effectiveness of Bandhan’s THP programme is an RCT that was run as part of the six-country graduation study,<sup>139</sup> with follow-ups at 5.5 years<sup>140</sup> and 8.5<sup>141</sup> years after the end of the intervention. This is a high-quality study that provides support for the long-term impact of Bandhan’s programme in helping women escape poverty.

<sup>136</sup> Oriana Bandiera et al., “Can Basic Entrepreneurship Transform the Economic Lives of the Poor?,” SSRN Scholarly Paper (Rochester, NY: Social Science Research Network, May 18, 2013), <https://papers.ssrn.com/abstract=2266813>.

<sup>137</sup> Bandiera et al., “Labor Markets and Poverty in Village Economies.”

<sup>138</sup> Bandiera et al., 5.

<sup>139</sup> Banerjee et al., “A Multifaceted Program Causes Lasting Progress for the Very Poor.”

<sup>140</sup> Abhijit Banerjee et al., “The Long Term Impacts of a Graduation Program: Evidence from West Bengal,” *Unpublished Paper, Massachusetts Institute of Technology, Cambridge, MA*, 2016.

<sup>141</sup> As of October 2018 no paper is available yet, but Abhijit Banerjee and Esther Duflo have kindly shared the preliminary findings with us, for which we are grateful.



The study had a sample size of 1,000 households at baseline, of which more than 90% remained in an 8.5-year follow-up survey.<sup>142</sup> We have no major concerns about the study quality.

Importantly, only 52% of the households that were randomised into the treatment group participated in the intervention.<sup>143</sup>

“According to Bandhan, the implementing organization, 35% of households declined the offer, for two unrelated reasons: First, in some villages, a section of villagers held the (erroneous) belief that Bandhan was a Christian organization trying to convert beneficiaries, and acceptance of the livestock constituted agreeing in some way to participating in Christian rituals. Second, some wives were worried that their husband would mishandle the asset and they would lose face in front of their village. A further 13% were deemed ineligible by Bandhan because they were participating in microcredit or self-help group activities.”<sup>144</sup>

The study applied a so-called ‘intent-to-treat’ (ITT) analysis.<sup>145</sup> This means that outcome data on all selected participants was included in the analysis, irrespective of whether they participated in the intervention or not. Given that almost half of the ‘treatment group’ didn’t receive treatment, it’s likely that the study underestimates the actual effects of Bandhan’s programme.

The RCT found small-to-moderate (0.2–0.4 standard deviations of baseline measurements) and statistically significant ( $p < 0.01$ ) effects on consumption, which are larger at the 5.5- and 8.5-year follow-ups than they were directly after the study and at the one-year follow-up.<sup>146</sup> There are also significant effects on asset

<sup>142</sup> Private correspondence with Abhijit Banerjee and Esther Duflo, 31 August 2018.

<sup>143</sup> Banerjee et al., “A Multifaceted Program Causes Lasting Progress for the Very Poor,” 7.

<sup>144</sup> Banerjee et al., 7.

<sup>145</sup> Banerjee et al., 7.

<sup>146</sup> Private correspondence with Abhijit Banerjee and Esther Duflo, 31 August 2018.



( $p < 0.01$ , 0.2–0.8 SD) and income ( $p < 0.1$ , 0.1–0.8 SD) indices, which remain at the 8.5-year follow-up as well.<sup>147</sup> This robust long-term evidence for the effectiveness of an intervention is quite uncommon in international development.

### Is the intervention cost-effective?

Our rough [cost-effectiveness model](#) suggests that Bandhan’s programme doubles a participant’s consumption for one year at a cost of \$41–\$134, with a best guess estimate of \$62. The model includes explanations for each step of the analysis.

The average monthly income of new participant households in 2018 was around ₹2,000,<sup>148</sup> or about \$27.43. Taking this as an estimate of consumption, and given an average family size of three,<sup>149</sup> our best guess estimate suggests that Bandhan’s programme can bring about nominal gains in consumption of about \$1.77 for each \$1.00 donated. Adjusting for 2017 purchasing power,<sup>150</sup> this is equivalent to gains of \$7.27 for each \$1.00 donated.

### What are the wider benefits?

Evidence suggests that Bandhan’s program improves subjective well-being: the long-term RCT found statistically significant improvements in indices that measure mental health ( $p < 0.01$ , 0.1–0.3 SD) and stress ( $p < 0.05$ , 0.1–0.2 SD). Both improvements had increased further by the 5.5- and 8.5-year follow-ups compared to directly after the intervention and at the one-year follow-up.<sup>151</sup> In addition, the RCT on

<sup>147</sup> Private correspondence with Abhijit Banerjee and Esther Duflo, 31 August 2018.

<sup>148</sup> Private correspondence with Bandhan, 30 July 2018.

<sup>149</sup> Private correspondence with Bandhan, 17 July 2018.

<sup>150</sup> “Conversion Rates - Purchasing Power Parities (PPP) - OECD Data.”

<sup>151</sup> Private correspondence with Abhijit Banerjee and Esther Duflo, 31 August 2018.



Bandhan’s programme showed statistically significant long-term improvements in indices that track physical health ( $p < 0.05$ , 0.1–0.2 SD) and food security ( $p < 0.01$ , 0.1–0.4 SD).<sup>152</sup>

The impact on nutrition and subjective well-being are consistent with the wider benefits the six-country graduation study reported on.<sup>153</sup> In that study, however, no overall longer-term statistically significant improvement in physical-health-related outcomes was found.<sup>154</sup>

### Is it a strong organisation?

Bandhan is a specialised organisation with a good track record. They put a lot of effort into guaranteeing the quality of their programme; they are committed to evidence; and they have been transparent throughout our analysis of their programme. One point of improvement, however, is that their website is lacks up-to-date information.

According to their research partner, J-PAL, Bandhan have remained committed to the evidence-based graduation model throughout their 10 years of implementing the THP programme: they haven’t compromised on any essential parts of it.<sup>155</sup> They have only incrementally extended their programme in the past 10 years, as they were careful not to overshoot, and to guarantee quality.<sup>156</sup> Furthermore, according to J-PAL, Bandhan have been a strong implementing partner for J-PAL’s studies.<sup>157</sup>

<sup>152</sup> Private correspondence with Abhijit Banerjee and Esther Duflo, 31 August 2018.

<sup>153</sup> Banerjee et al., “A Multifaceted Program Causes Lasting Progress for the Very Poor.”

<sup>154</sup> Richard Sedlmayr, Anuj Shah, and Munshi Sulaiman, “Cash-Plus: Poverty Impacts of Transfer-Based Intervention Alternatives,” CSAE Working Paper Series (Centre for the Study of African Economies, University of Oxford, 2017), Table A38, <https://ideas.repec.org/p/csa/wpaper/2017-15-2.html>.

<sup>155</sup> Private correspondence with J-PAL, 2 October 2018.

<sup>156</sup> Private correspondence with Bandhan, 2 October 2018.

<sup>157</sup> Private correspondence with J-PAL, 2 October 2018.



Bandhan have also been very forthcoming in answering the questions that arose during our analysis of the programme. However, public information on the programme is limited: their website<sup>158</sup> hasn't been updated for several years. Bandhan have said they are working on this, and aim to update the website by the end of 2018.<sup>159</sup>

### What is their strategy?

Bandhan aim to scale-up their program in India,<sup>160</sup> where millions of woman-headed households still live in extreme poverty.<sup>161</sup>

As of October 2018, 30,000 families participate in Bandhan's THP programme, and Bandhan are working with multiple state governments and other NGOs as potential future implementing partners.<sup>162</sup> They also intend to scale up their own implementation of the THP programme, as current evidence of cost-effectiveness is limited to their own implementation of the program, and it cannot be assumed that different implementers could replicate this result. They currently have long-term funding commitments to directly implement their THP programme for 25,000–30,000 families every two years.<sup>163</sup> Any further scale-up of the direct implementation of their THP programme depends on new funding becoming available.<sup>164</sup>

<sup>158</sup> "Bandhan Development Program." Bandhan

<sup>159</sup> Private correspondence with Bandhan, 2 October 2018.

<sup>160</sup> Private correspondence with Bandhan, 2 October 2018.

<sup>161</sup> "Socio-Economic Caste Census-2011," SECC 2011 accessed October 5, 2018, <http://secc.gov.in/stateSummaryReport>.

<sup>162</sup> Private correspondence with Bandhan, 10 October 2018.

<sup>163</sup> Private correspondence with Bandhan, 30 July 2018.

<sup>164</sup> Private correspondence with Bandhan, 2 October 2018.





## Is there room for funding?

The key impediment preventing Bandhan from scaling up the THP programme is funding, as they claim to have all the required infrastructure and capacity in place.<sup>165</sup> Another \$24 million would allow them to reach an additional 60,000 households over the coming six years.<sup>166</sup>

More specifically, Bandhan could support another 20,000 households, at a cost of \$400 per household for a two-year programme. That means they would be able to run three programme cycles over the coming six years at \$8 million each.

Running a two-year cycle at maximum efficiency requires at least 800 households and committed funding for the whole cycle.<sup>167</sup> Of the \$320,000 required, Bandhan are likely to be able to secure \$170,000-\$195,000 themselves. For this reason, we recommend our members to make any intended donation to Bandhan's Targeting the Hardcore Poor programme below \$150,000 via our donor-advised fund. There, we'll combine it with other donations intended for Bandhan and transfer to them as soon as we reach the required \$125,000-\$150,000 threshold.

## What are the main uncertainties?

Most of the uncertainty in our analysis of Bandhan's THP programme is due to the lack of recent direct evidence of the effectiveness of Bandhan's programme: a large part of our evaluation is based on an RCT with

<sup>165</sup> Private correspondence with Bandhan, 2 October 2018.

<sup>166</sup> Private correspondence with Bandhan, 30 July 2018.

<sup>167</sup> Private correspondence with Bandhan, 14 September 2018.



multiple longer-term follow-ups, for which implementation began 10 years ago. However, Bandhan's programme has remained largely the same and consistent with the evidence-based graduation approach over the years, and it targets people at similar levels of poverty.<sup>168</sup> Bandhan have made only minor adaptations, for instance to account for changes in market conditions that affected which business options they deemed most appropriate for beneficiaries.<sup>169</sup> This partly allays our concerns about the lack of recent direct evidence in favour of their programme.

<sup>168</sup> Private correspondence with Bandhan, 6 September 2018.

<sup>169</sup> Private correspondence with Bandhan, 2 October 2018.



### 3.3. No Means No Worldwide [provisional]

#### Summary

**What do they do?** No Means No Worldwide (NMNW) train instructors to teach their ‘IMpower’ courses to both boys and girls, to help prevent sexual assault. They also work with large NGOs and governments to scale these courses up.

**Is there evidence the intervention works?** Evidence suggests that NMNW’s IMpower intervention reduces the incidence of sexual violence in several settings and for girls at different ages. This evidence comes mostly from two RCTs and two quasi-RCTs.

**Is the intervention cost-effective?** We estimate that NMNW prevent a sexual assault for \$9–\$757, with a best guess estimate of \$62 per case averted.

**What are the wider benefits?** There is evidence that NMNW’s programme decreases negative gender attitudes among boys and reduces rates of pregnancy-related school dropouts.

**Are they a strong organisation?** NMNW are exceptionally committed to generating evidence; are transparent about their performance and motivations; and have a good track record supporting IMpower implementation.

**Is there room for funding?** NMNW could productively use an additional \$7 million in funding through 2021.

**Why is our recommendation provisional?** Based on the current evidence, we feel confident recommending NMNW to donors with a specific focus on averting sexual assault. Depending on the results of an independent evaluation of NMNW’s IMpower programme, which are currently under review, we may either recommend NMNW more generally to donors interested in women’s empowerment; keep recommending them only to donors with a focus on averting sexual assault; or decide not to recommend them at all.



## What do they do?

No Means No Worldwide (NMNW) train instructors to teach their ‘IMpower’ courses to both boys and girls, to help prevent sexual assault.<sup>170</sup> They also work with large NGOs and governments to scale these courses up. Their vision is “a rape-free world”.

Their flagship intervention, IMpower, is a 6-week, 2-hours-per-week course taught at schools, which has variants for boys and girls aged 10–20. The course was developed in 2009 by NMNW founder Lee Paiva as a way to enable girls to avert sexual assaults, and for boys to develop healthy gender relations and help prevent sexual assaults themselves. Girls are taught mental, verbal, and physical skills to stay safe; and boys learn to challenge rape myths, ask for consent, and intervene if they observe predatory behaviour.<sup>171</sup>

So far, NMNW have worked in Kenya and Malawi to test and refine their programme. They have done so in collaboration with non-profit and implementing partner Ujamaa Africa and research partners at Stanford University.<sup>172</sup> This led to seven studies of the programme, five of which have been published and two of which are currently under review.<sup>173</sup> We discuss this research in our section on the evidence supporting NMNW’s programme below.

NMNW want to scale up their programme to other countries globally, including Uganda and the United States in 2019, and to train a cohort of ‘Master Trainers’ who will train instructors at their implementing partners. They will also continue to build evidence supporting their programme, for instance by creating a standardized

<sup>170</sup> Sexual assault is defined here as and is used by NMNW to refer to ‘physically forced or otherwise coerced penetration of the mouth, vagina, or anus, using a penis or other body part or any object’

<sup>171</sup> “IMpower,” No Means No Worldwide, accessed October 1, 2018, <https://www.nomeansnoworldwide.org/impower-1/>.

<sup>172</sup> “Stanford GBV Prevention Collaboration,” Stanford GBV Prevention Collaboration, accessed October 1, 2018, <https://stanfordgbvprevention.wordpress.com/>.

<sup>173</sup> “Research,” No Means No Worldwide, accessed October 1, 2018, <https://www.nomeansnoworldwide.org/research/>.



monitoring-and-evaluation system for their implementing partners, and by running a study on their new programme targeting Native American populations in the United States.<sup>174</sup>

From 2010 through 2017, NMNW’s IMpower programme was taught to roughly 400,000 young people—266,000 girls and 134,000 boys.<sup>175</sup> During this period, total direct expenditure on IMpower programming by all organisations involved amounted to an approximate \$2 million.<sup>176</sup>

### Is there evidence the intervention works?

Evidence suggests that NMNW’s IMpower programme reduces the incidence of sexual assault among the populations it targets. This evidence comes mostly from four studies—two RCTs and two quasi-RCTs—carried out directly on NMNW’s programme. There is limited external evidence on the impact of empowerment self-defence (ESD) courses such as IMpower.

Below, we briefly discuss the available external evidence, and then discuss the four studies that provide direct support NMNW’s intervention.

#### Indirect evidence of NMNW’s effectiveness

We identified six RCTs that evaluate the effect of ESD or similar courses on the incidence of sexual violence. All of these were conducted on college campuses in the United States and Canada. The first five studies

<sup>174</sup> Private correspondence with NMNW, 17 July 2018.

<sup>175</sup> Private correspondence with NMNW, 16 August 2018.

<sup>176</sup> Private correspondence with NMNW, 16 August 2018.



found little or no impact on the incidence of sexual assault at 2-to-6-month follow-ups<sup>177</sup>. The sixth study, by Senn et al. in 2017, however, found a significant reduction up to one year post-intervention.<sup>178</sup>

The last study differs in meaningful ways from the first five and evaluates the ESD course that most closely resembles the IMpower intervention in terms of content, duration, and spread of sessions. More specifically, the first five courses studied had a total duration of 3–7 hours, did not all contain a physical-defence component, and were taught in one or two sessions, sometimes with a booster session three months later. The intervention reported in Senn et al. (2017), on the other hand, was a 4x3-hours ESD course including a physical-defence component, similar to the 6x2-hours IMpower intervention. It is plausible that these differences account for a large part of the difference in outcomes, so we see the Senn et al. (2017) study as the most representative of NMNW’s programme. However, we believe the other studies provide a weak reason for lower confidence in the results of Senn et al. (2017).

Senn et al. (2017) randomly provided 900 first-year female students at three universities in Canada with either a 4x3-hour ESD course, or brochures on sexual assault (the standard practice) as a control. At the one-year follow-up, the incidence of completed sexual assault within the past year was lower in the treatment group (5.2%) than in the control group (9.8%), at a p-value of 0.02. The incidence of attempted sexual

<sup>177</sup> Kimberly A. Hanson and Christine A. Gidycz, “Evaluation of a Sexual Assault Prevention Program,” *Journal of Consulting and Clinical Psychology* 61, no. 6 (1993): 1046–52, <https://doi.org/10.1037/0022-006X.61.6.1046>; Kimberly Hanson Breitenbecher and Christine A. Gidycz, “An Empirical Evaluation of a Program Designed to Reduce the Risk of Multiple Sexual Victimization,” *Journal of Interpersonal Violence* 13, no. 4 (August 1, 1998): 472–88, <https://doi.org/10.1177/088626098013004004>; Christine A. Gidycz et al., “The Evaluation of a Sexual Assault Risk Reduction Program: A Multisite Investigation,” *Journal of Consulting and Clinical Psychology* 69, no. 6 (2001): 1073–78, <https://doi.org/10.1037/0022-006X.69.6.1073>; Christine A. Gidycz et al., “The Evaluation of a Sexual Assault Self-Defense and Risk-Reduction Program for College Women: A Prospective Study,” *Psychology of Women Quarterly* 30, no. 2 (June 1, 2006): 173–86, <https://doi.org/10.1111/j.1471-6402.2006.00280.x>; Lindsay M. Orchowski, Christine A. Gidycz, and Holly Raffle, “Evaluation of a Sexual Assault Risk Reduction and Self-Defense Program: A Prospective Analysis of a Revised Protocol,” *Psychology of Women Quarterly* 32, no. 2 (June 1, 2008): 204–18, <https://doi.org/10.1111/j.1471-6402.2008.00425.x>.

<sup>178</sup> Senn et al., “Secondary and 2-Year Outcomes of a Sexual Assault Resistance Program for University Women.”



assault was also lower in the treatment group (3.4%) than in the control group (9.3%), at a p-value of less than 0.001.<sup>179</sup>

The study provides evidence that ESD courses similar to IMpower can reduce the incidence of sexual violence in some contexts. However, the context of this study and its target group—students at Canadian universities—are arguably relevantly different from the context and target groups of NMNW’s intervention so far—mainly 10-20 year-old primary-school and high-school students from Kenya and Malawi. On the other hand, Senn et al. (2017) finds a very similar effect size to the Baiocchi et al. (2017) study of NMNW’s intervention discussed below, which also records similar baseline rates of sexual violence. All-in-all, we consider Senn et al. (2017) to provide weak but positive evidence for IMpower’s potential impact, with by far the largest part of the evidence coming from the four studies discussed below.

One more way in which the Senn et al. (2017) study is useful for this report is that it assessed the retention of the effects of the ESD course on the incidence of sexual assault: it included follow-ups at 6, 12, 18, and 24 months, and asked participants to provide dates with their reports of assault. It finds that most of the intervention’s effects occurred during the first 6 months post-intervention, and that after 1 year there is no longer a difference in ongoing incidence of sexual assault between the treatment and control groups (Figure 7).<sup>180</sup> At the 18- and 24-month follow-ups the total effect on incidence is no longer statistically significant ( $p=0.10$  and  $0.13$ , respectively).<sup>181</sup> We use this information in our cost-effectiveness analysis of NMNW below. Its implications are attenuated by the fact that Senn et al. (2017) did not include a booster session,

<sup>179</sup> Senn et al., 155.

<sup>180</sup> Senn et al., 156.

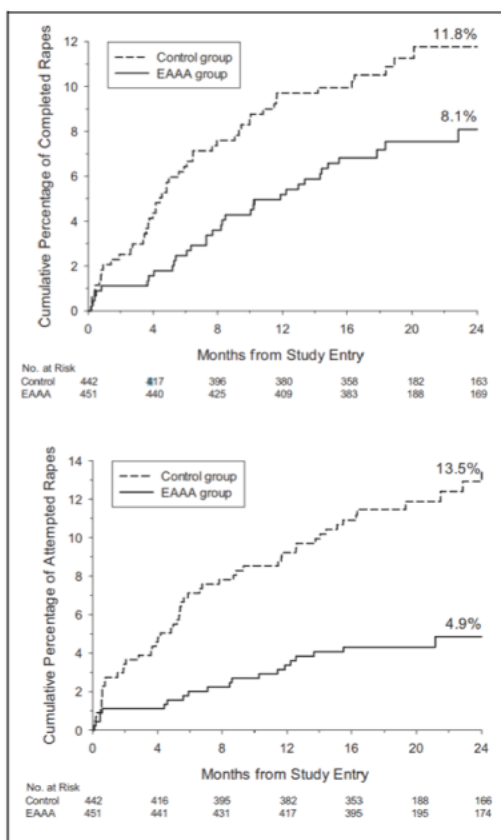
<sup>181</sup> Senn et al., 155.



whereas the IMpower programme typically has one between 3 and 12 months after the programme is taught.<sup>182</sup>

Figure 7.

Cumulative sexual assault incidence over time in Senn|et al. (2017)



Source: Charlene Y. Senn et al., "Secondary and 2-Year Outcomes of a Sexual Assault Resistance Program for University Women," *Psychology of Women Quarterly* 41, no. 2 (June 2017): p. 156

<sup>182</sup> Private correspondence with NMNW, 20 September 2018.





### Direct evidence of NMNW's effectiveness

Four studies provide direct evidence of the impact of the IMpower programme on the incidence of sexual violence. Here we provide the main characteristics of each (Table 2) and discuss their limitations in some detail.

The first study is a quasi-RCT run by Sinclair et al. in a Nairobi slum in 2013. It indicates a very large effect size, which can be partially explained by the high baseline prevalence of sexual assault. We put less weight on this study than on Baiocchi et al. (2017) and Decker et al. (under review), discussed below, mainly because of this exceptionally high baseline rate; the smaller sample size; the non-randomised assignment of participants to treatment and control (it is not clear on which basis they were assigned); and the risk of bias due to the authors' direct involvement in developing and implementing the intervention: Jake Sinclair, the first author, is co-founder of implementing organisation Ujamaa and married to Lee Sinclair (now Paiva), who is the second author, founder of NMNW, and main developer of the IMpower intervention.



Table 2.

Studies of NMNW’s programme

Study	Type	Sample	Metric <sup>183</sup>	Baseline	Effect size	P-value
Sinclair et al. (2013) <sup>184</sup>	Non-randomised	522 secondary school students	Past-year prevalence	24.6%	17.1%	<0.001
Sarnquist et al. (2014) <sup>185</sup>	Non-randomised	2,406 secondary school students	Incidence	0.178	0.065	<0.001
Baiocchi et al. (2017) <sup>186</sup>	Cluster-randomised	5,686 primary school students	Past-year prevalence	7.3%	3.7%	0.03
Decker et al. (under review) <sup>187</sup>	Cluster-randomised	5,199 primary and 1,445 secondary school students	Incidence and past-year prevalence	-	-	-

The second study, Sarnquist et al. (2014), has a larger sample size and lower baseline incidence (as prevalence provides a lower bound to incidence<sup>188</sup>), and the first author is not directly involved with NMNW or Ujamaa. However, data collection was still done by Ujamaa, and NMNW and Ujamaa were both heavily involved in designing and reviewing the study. As in Sinclair et al. (2013), schools were not randomly

<sup>183</sup> Here past-year prevalence measures the percentage of participants who suffered from at least one case of sexual assault in the past year, whereas incidence measures the number of cases of sexual assault per person-year as measured in the past year.

<sup>184</sup> Jake Sinclair et al., “A Self-Defense Program Reduces the Incidence of Sexual Assault in Kenyan Adolescent Girls,” *Journal of Adolescent Health* 53, no. 3 (2013): 374–380.

<sup>185</sup> Clea Sarnquist et al., “Rape Prevention through Empowerment of Adolescent Girls,” *Pediatrics*, 2014, peds–2013.

<sup>186</sup> Baiocchi et al., “A Behavior-Based Intervention That Prevents Sexual Assault.”

<sup>187</sup> We are unable to refer to the exact results of this study here, as the paper is still under review. We can however say that the (provisional) results are consistent with those of the other studies.

<sup>188</sup> Past-year prevalence measures the percentage of participants who suffered from at least one case of sexual assault in the past year, whereas incidence measures the number of cases of sexual assault per person-year as measured in the past year.



assigned to treatment or control, and the basis for the assignments is not clear. We put the least direct weight on this study of all four, mainly because it doesn't provide a baseline comparison to test for selection effects (Sinclair et al. (2013) does and finds no significant difference); and because it has much higher attrition (22%) than Sinclair et al. (2013) (6%). However, we do use the study's estimate of incidence effect size as an input for our cost-effectiveness analysis. This is because this was the only published study to report directly on incidence, which enables us to directly estimate the cost per case of prevented sexual assault. Furthermore, the effect size estimate seems plausible given the estimates of prevalence effect sizes in the two other published studies.

Third, we looked at Baiocchi et al. (2017), the largest published study and the only study conducted outside of Kenya, in Malawi. This was a cluster-RCT done solely on primary schools, which meant a much lower baseline prevalence and—likely—incidence, and hence less potential to reduce incidence. The attrition rate (9%) is of less concern, and the report lists similar baseline-treatment and control-group data, though a statistical comparison test is not provided. Most of the authors were not directly involved with Ujamaa or NMNW, but data was again collected by implementer Ujamaa, creating a risk for bias that the study itself notes:

“[A] challenge this study faces is that the course instructors (from both the intervention and SOC arms) were also tasked with deploying the survey to the same students they instructed.”<sup>189</sup>

The most important difference between this study and the other three, however, is that it evaluates the IMpower intervention when it is implemented for both the girls, for whom the incidence of sexual assault was measured, and their boy classmates, who received the male version of IMpower but were not included in the

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<sup>189</sup> Baiocchi et al., “A Behavior-Based Intervention That Prevents Sexual Assault,” 825.



study sample. Given the lower effect size and weaker statistical significance than the girls-intervention-only studies, this study doesn't provide evidence for the added value of the boys' intervention. It doesn't provide strong evidence against it either though, as the weaker outcomes could be explained by a lower baseline incidence at primary schools.

Last, we considered Decker et al. (under review), a large cluster-RCT on the girls-only intervention in Kenya.<sup>190</sup> As the study is still under review at the time of writing, we cannot refer to its specifics, but we can say that findings were consistent with the evidence found in the other three studies, and hence strengthened the case for NMNW's intervention.

Each of these four studies separately has too many limitations to serve as sufficient evidence for the effectiveness of the IMpower programme in reducing the incidence of sexual assault. Taken together, however, they provide strong enough evidence to conclude that the girls' component of IMpower has an effect. Three important remaining limitations/uncertainties should be noted here:

- In all studies, data was collected by implementing organisation Ujamaa, and Ujamaa and NMNW were heavily involved in the research process. This creates a relatively high risk for bias, the effect of which is unlikely to nullify overall effectiveness, but could influence the reliability of effect-size estimates.
- More generally, the other individual limitations of the studies and large variation in effect-size estimates make it hard to estimate overall effect size, which has a large influence on our estimates of cost-effectiveness.

<sup>190</sup> We thank the authors for providing a manuscript while the study was still under review.



- These studies provide no direct evidence for the effectiveness of the boys’ component of IMpower in reducing the incidence of sexual violence, and NMNW intends to make this component up to 50% of its programming in the long term.<sup>191</sup> There is some evidence of other benefits of the boys’ intervention though, which we discuss in the section on wider benefits below.

### Is the intervention cost-effective?

Our rough [cost-effectiveness model](#) suggests that NMNW’s intervention averts a sexual assault for \$9–\$757, with a best guess estimate of \$62 per case averted. The model includes explanations for each step of the analysis.

### What are the wider benefits?

NMNW’s intervention may have additional benefits beyond reducing the incidence of sexual assault. Two studies on NMNW’s programme, described below, provide evidence of such benefits. We did not include these when analysing cost-effectiveness, as there is not yet strong enough evidence for the effects to estimate effect sizes reliably, and we still expect most of the benefits to come from reducing the incidence of sexual assault.

The first study, Keller et al. (2017), is a quasi-RCT on 1,500 secondary school boys in Nairobi who were taught NMNW’s boys’ version of the IMpower intervention.<sup>192</sup> It found:

<sup>191</sup> Private correspondence with NMNW, 17 August 2018.

<sup>192</sup> Jennifer Keller et al., “A 6-Week School Curriculum Improves Boys’ Attitudes and Behaviors Related to Gender-Based Violence in Kenya,” *Journal of Interpersonal Violence* 32, no. 4 (2017): 535–557.



- A large (1.61 standard deviations) and statistically significant ( $p < 0.0001$ ) improvement in gender attitudes of the boys, as measured via a questionnaire, which did not decrease significantly at 4.5- and 9-month follow-ups.
- Of the boys who reported witnessing verbal harassment (50%), physical threatening behaviour (40%), or physically/sexual assault behaviour (30%) in the nine months after the intervention, more than twice as many boys in the treatment group reported successfully intervening compared to the control group (approximately 70% vs. 30%, respectively), also significant at  $p < 0.0001$ .

There are limitations to self-reported data, but the study provides some reason to believe that NMNW's boys' intervention achieves its goals.

The second study, Sarnquist et al. (2017), is a quasi-RCT on 68 secondary schools with 3,700 girls in Nairobi. Approximately half of the schools received the girls' programme and the other half received both the boys' and girls' programme.<sup>193</sup> The study found:

- Yearly pregnancy-related dropout at the one-year follow-up had decreased by nearly half, from 3.9% to 2.1%, with no significant difference in the control group ( $p = 0.029$ ).

This second study has multiple limitations, most notably that it is difficult to collect reliable data on pregnancy-related dropout. Hence, we don't put a lot of weight on it, but it does indicate that NMNW's intervention might have additional, indirect benefits.

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193 Clea Sarnquist et al., "Evidence That Classroom-Based Behavioral Interventions Reduce Pregnancy-Related School Dropout among Nairobi Adolescents," *Health Education & Behavior* 44, no. 2 (2017): 297–303.



## Are they a strong organisation?

No Means No Worldwide stand out in its commitment to generating evidence. In the less than 10 years of their existence, six large studies of their programme have contributed significantly to the evidence base on interventions that prevent sexual assault. More studies are underway and planned, including one on the IMpower intervention for boys, and a large independent RCT as part of the UK Department for International Development’s *What Works to Prevent Violence Against Women and Girls* programme.<sup>194</sup>

NMNW have also been very responsive to our questions, and transparent about performance, plans, and motivations. For instance, when asked about how they chose what to research exactly, they acknowledged that these choices were largely driven by funding considerations, even though they hope they can make such decisions more independently in the future.<sup>195</sup>

We have reservations about how NMNW sometimes communicate the impact of their programme. For instance, on their website they claim a cost-effectiveness of \$7.44 per rape prevented.<sup>196</sup> The underlying calculation is based on several studies in which 50% of girl participants claim to have used the skills learned to prevent sexual assault in the year after the programme.<sup>197</sup> However, the actual incidence of sexual assault in these studies shows a 4–17% reduction compared to the control group, which indicates a lower cost-effectiveness.<sup>198</sup>

NMNW have a good track record of delivering the IMpower intervention to approximately 400,000 boys and girls<sup>199</sup>, and of working with implementer Ujamaa in Kenya and Malawi. They recently hired new leadership-

<sup>194</sup> Private correspondence with NMNW, 17 August 2018.

<sup>195</sup> Private correspondence with NMNW, 17 August 2018.

<sup>196</sup> “About,” No Means No Worldwide, accessed October 1, 2018, <https://www.nomeansnoworldwide.org/about/>.

<sup>197</sup> Private correspondence with NMNW, 28 June 2018.

<sup>198</sup> See also our [cost-effectiveness model](#)

<sup>199</sup> Private correspondence with NMNW, 16 August 2018.



team members with extensive experience in the development sector<sup>200</sup> to help them scale the programme to other countries.

### What is their strategy?

NMNW's long-term goal is to end sexual violence globally. They are beginning to scale up globally, having tested the IMpower program extensively in different contexts in Kenya and Malawi. They regularly receive requests from nonprofits and governments who want to implement their programme<sup>201</sup>, but are selective in their choice of partnerships in order to protect the quality of programme implementation<sup>202</sup>.

Their plans through the end of 2019 include:<sup>203</sup>

- Expanding to Uganda in collaboration with 4–5 local implementing partners
- Starting a programme targeting Native American communities in the United States, and setting up an evaluation of this programme
- Developing a standardised monitoring and evaluation system for their implementing partners
- Training a team of 'Global Master Trainers' that will train IMpower instructors at implementing organisations

From 2018 to 2021, NMNW plan to train 2,450 IMpower instructors and reach approximately 428,000 girls and 150,000 boys through the intervention.<sup>204</sup> They plan to expand further, both to other countries in Sub-

<sup>200</sup> "About." No Means No Worldwide

<sup>201</sup> Private correspondence with NMNW, 28 June 2018.

<sup>202</sup> Private correspondence with NMNW, 17 August 2018.

<sup>203</sup> Private correspondence with NMNW, 17 July 2018.

<sup>204</sup> NMNW, "Scaleup Deck," 17 April 2018, 8.





Saharan Africa (likely Namibia or Mozambique) and to new geographies (including India), and are currently exploring potential partnerships with organisations in these countries.<sup>205</sup>

### Is there room for funding?

NMNW expect they could productively use an additional \$7 million over the next three years to execute on the plans detailed above.<sup>206</sup> More specifically, NMNW's remaining funding needs for each year are (as of July 2018):

- 2018: plans have been fully funded
- 2019: \$1,500,000
- 2020: \$2,500,000
- 2021: \$3,000,000

### Why is our recommendation provisional?

Based on the current evidence and NMNW's organisational quality, we feel confident recommending NMNW to donors with a specific focus on averting sexual assault. However, mainly due to the limitations mentioned in our analysis of the evidence, we do not recommend NMNW to donors interested in women's empowerment more broadly.

The results of a large, independent RCT of both NMNW's girls' and boys' interventions are due later in 2019.

This study, part of the UK Department for International Development's *What Works to Prevent Violence*

<sup>205</sup> Private correspondence with NMNW, 17 July 2018.

<sup>206</sup> Private correspondence with NMNW, 17 July 2018.



programme, is likely to reduce our current uncertainty about the programme’s effectiveness. We have hence decided to await these results before making a final decision, which could be either to recommend NMNW alongside the other organisations in this report, if the results confirm our current estimates; to recommend them to donors with a specific focus only (as we do at this point), if the results are slightly worse than expected; or to not recommend them at all, if the results are much worse than expected.

### What are the main uncertainties?

The main sources of uncertainty in our analysis of NMNW are:

- There are limitations to the studies that provide direct evidence for NMNW’s intervention, as discussed above.
- We lack direct evidence on the long-term effects of the IMpower intervention, which adds uncertainty to our cost-effectiveness estimate.
- NMNW does not directly implement the IMpower intervention itself. This makes it hard to estimate how many girls and boys are taught the course as a direct consequence of funding NMNW. However, NMNW’s indirect model could be a positive: it could allow NMNW to leverage resources at other organisations and governments to be deployed more cost-effectively. We have hence decided not to discount our best guess estimate of the cost-effectiveness of NMNW’s programme, but to make negative and positive adjustments to our conservative and optimistic estimates. We use the full implementation cost of the IMpower intervention (including contributions from NMNW) as a proxy for NMNW’s cost to make a new course happen.



### 3.4. Other highly impactful charities

In this report, we considered only charities directly aimed at women’s empowerment. However, many other charities improve the lives of women very cost-effectively. The charities we recommend in other research reports on our [website](#) often improve outcomes for women at a cost-effectiveness comparable to the charities we recommend in this report, even when taking into account that women are only half of their target group. There are also reasons to think some of the problems these charities work on, such as preventing malaria, disproportionately affect women.<sup>207</sup>

Hence, we suggest that donors who do not specifically prefer charities that directly target women’s empowerment also consider the charities we recommend in our other reports, including those based on research by our research partner GiveWell.<sup>208</sup>

<sup>207</sup> Athena P. Kourtis, Jennifer S. Read, and Denise J. Jamieson, “Pregnancy and Infection,” *The New England Journal of Medicine* 370, no. 23 (June 5, 2014): 2211–18, <https://doi.org/10.1056/NEJMra1213566>.

<sup>208</sup> <https://www.givewell.org/>



## Appendix I. Limitations

This research report has the following main limitations:

- Time constraints prevented us from considering policy or research interventions, which may include some great donation opportunities.
- We only considered programmes that directly affected outcomes for women. We excluded programmes targeting indirect measures, for which we would need much more expertise in a subfield to judge their potential. For instance, we did not look extensively at programmes that target self-reported changes in norms among men that may result in better outcomes for women.
- We established a threshold for the quality of evidence, and excluded charities whose programmes did not meet that threshold, rather than trying to account for a lack of evidence in our cost-effectiveness analyses.
- To some extent, we had to make value judgements to compare programme outcomes across subfields, even though we tried to account for this as described in Appendix II.

These limitations should be taken into account when interpreting our research and the resulting recommendations.



## Appendix II. Challenges, Lessons and Future Research

The main challenges in doing the research for this report were the lack of high-quality evidence in many subfields, and comparing outcomes across subfields.

First, during our overview of the different subfields, we found that high-quality studies on interventions, especially on their long-term effects, are sparse. However, we observed large variation across subfields and found that evidence may be improving. For instance, two research collaborations that are likely to soon generate useful evidence on gender-based violence are the UK Department for International Development's What Works to Prevent Violence Against Women and Girls programme<sup>209</sup> and Innovations for Poverty Action's Intimate Partner Violence Initiative.<sup>210</sup>

Second, a major challenge was determining how to compare the cost-effectiveness of charities that target very different primary-outcome measures, such as consumption and mental health. We consulted best practices, experts, our own intuitions, and those of several other people to make sure our recommendations were not just guided by our own values but would apply more widely. Furthermore, we decided to present cost-effectiveness estimates in terms of the primary outcomes, so that readers can decide for themselves which of the recommendations to prioritise.

In addition to multiple internal lessons to improve our research process, we learn from any mistakes we inevitably make in an investigation like this. We like to share such mistakes publicly, for transparency and accountability, and so others can learn from them as well. In the research for this report, we made a mistake in the cost-effectiveness analysis of one of the charities we investigated, Bridges to Prosperity. This led us to

<sup>209</sup> "What Works," What Works to Prevent Violence Against Women and Girls, accessed October 19, 2018, <https://www.whatworks.co.za/>.

<sup>210</sup> "Intimate Partner Violence Initiative," Innovations for Poverty Action, February 27, 2017, <https://www.poverty-action.org/program-area/health/intimate-partner-violence-initiative>.



deprioritise them at a point where we shouldn't have, and we only became aware of this error when it was too late to include them in our further analysis. To avoid similar mistakes in the future, we plan to improve the way we review cost-effectiveness analyses internally.

In future versions of this report, we might be able to address some of the limitations detailed in [Appendix I](#) and update current content. We plan to revise our recommendations and update room-for-funding data on our recommended charities at least yearly.

We encourage critical readers to send any feedback they have on this report to [research@founderspledge.com](mailto:research@founderspledge.com).



## Appendix III. Updates to Our 2017 Evaluation of StrongMinds

Our evaluation of StrongMinds is an update of the evaluation of their programme for our Mental Health report last year<sup>211</sup>. The most important changes are:

- We updated our [cost-effectiveness model](#), using StrongMinds' most recent costing data.
- We updated the information on StrongMinds' room for funding for the coming three years.
- We incorporated StrongMinds' most recent plans, such as their expansion to a new country; their plans to establish a formal control group for their programme; and their plan to start reporting on mean PHQ-9 reductions as a main metric.

Overall, these changes did not significantly change our view of StrongMinds. Our slightly lower cost-effectiveness estimate still implies they are a highly cost-effective organisation; the results of their programme have been consistent with our expectations. They've shown commitment to improving their programme and the evidence supporting it; and they still have much room for funding and the ability to scale up.

<sup>211</sup> "Research," Founders Pledge, accessed October 1, 2018, <https://founderspledge.com/research>.



## Appendix IV. Village Enterprise

In our initial research of this problem, we identified Village Enterprise as an organization implementing a highly effective solution. Though they are not currently one of our recommended funding opportunities in this space, you can read our initial review below. We'll continue to update this report as we get new information.

### Summary

**What do they do?** Village Enterprise provide business and financial-literacy training, seed funding, mentoring, and access to business savings groups to people living in extreme poverty in Sub-Saharan Africa.

**Is there evidence the intervention works?** A recent high-quality RCT provides evidence that supports Village Enterprise's programme. There is also some external evidence that the 'graduation approach' on which Village Enterprise's model is based effectively addresses extreme poverty.

**Is the intervention cost-effective?** We estimate that Village Enterprise double a participant's consumption for one year at a cost of \$157–\$367, with a best guess estimate of \$250. This suggests that Village Enterprise's programme can bring about nominal gains in consumption of about \$0.99 for each \$1.00 donated. Adjusting for purchasing power, this is equivalent to gains of \$2.18 for each \$1.00 donated.

**What are the wider benefits?** There is some evidence that the programme improves subjective well-being.

**Is it a strong organisation?** Village Enterprise are a strong organization, and routinely account for evidence and cost-effectiveness in decision-making. They have strong monitoring and learning processes and are outstandingly transparent and accountable.





**Is there room for funding?** They could productively use an extra \$28 million in funding through 2021.



## What do they do?

Village Enterprise provide people living in extreme poverty in Sub-Saharan Africa with business and financial-literacy training, seed funding, mentoring, and access to business savings groups. They directly implement their programme in East Africa and work with large NGOs and governments to replicate and scale up their model throughout the continent. Their vision is “a world free of extreme poverty, where people have the economic means to sustain their families”.<sup>212</sup>

Like Bandhan’s intervention, Village Enterprise’s intervention is an adaptation of the graduation approach. See our [section on Bandhan’s programme](#) for a short description of this approach. Village Enterprise’s programme similarly targets the extreme poor—people living on less than \$1.90 a day, already adjusted for differences in purchasing power among countries.<sup>213</sup>

Village Enterprise implement a lighter version of the graduation approach, and mostly focus on supporting business level rather than at the individual or family level. They provide training that focuses mainly on business skills and financial literacy, and coach participants as they set up their business. Entrepreneurs typically work together in groups of three to set up one business, and 10 of these groups then pool their resources to form a Business Saving Group (BSG)—a self-managed form of microfinance.<sup>214</sup> There are four concrete differences to the standard graduation approach previously outlined:<sup>215</sup>

1. Village Enterprise provide seed funding for starting a business, rather than an in-kind productive asset
2. They do not provide healthcare access or health education

<sup>212</sup> “Strategy,” Village Enterprise, accessed October 1, 2018, <http://villageenterprise.org/about-us/strategy/>.

<sup>213</sup> “What We Do,” Village Enterprise, accessed October 1, 2018, <http://villageenterprise.org/what-we-do/>.

<sup>214</sup> “What We Do.” Village Enterprise

<sup>215</sup> Private correspondence with Village Enterprise, 5 October 2018.



3. They do not provide direct consumption support
4. Their intervention lasts for only one year, although the BSGs tend to continue long after that

Seventy-three percent of the entrepreneurs Village Enterprise supports are women.<sup>216</sup>

So far, Village Enterprise have worked mainly in Kenya and Uganda, but they are looking for NGOs and governments that could scale up their intervention in other countries, as part of their new division ‘Village Enterprise Extend’.<sup>217</sup> As of October 2018, the first Extend pilot is underway in the Democratic Republic of the Congo.<sup>218</sup> Since their founding in 1987, Village Enterprise have helped found 43,000 businesses and have trained more than 169,000 East Africans,<sup>219</sup> mostly in the past 10 years.<sup>220</sup>

### Is there evidence the intervention works?

A recent high-quality RCT provides evidence that supports Village Enterprise’s programme. There is also external evidence that the graduation approach on which Village Enterprise’s model is based effectively addresses extreme poverty. In this section, we first go into the available external evidence for the graduation approach, and then discuss Village Enterprise’s recent RCT.

#### Indirect evidence of Village Enterprise’s effectiveness

For a discussion of the six-country RCT and BRAC’s RCT that provide evidence of the short- and long-term impacts of the graduation model, see our [section on indirect evidence for Bandhan’s programme](#). The 5.5- and 8.5-year follow-ups of Bandhan’s graduation programme provide further supporting evidence of a long-

<sup>216</sup> Private correspondence with Village Enterprise, 11 October 2018.

<sup>217</sup> “What We Do.” Village Enterprise

<sup>218</sup> Private correspondence with Village Enterprise, 11 October 2018.

<sup>219</sup> “What We Do.” Village Enterprise

<sup>220</sup> “History & Mission,” Village Enterprise, accessed October 1, 2018, <http://villageenterprise.org/about-us/history-mission/>.



term impact on consumption. We discuss these in more detail in the [section on direct evidence for Bandhan’s programme](#).

Village Enterprise’s intervention differs in some relevant ways from the standard graduation model implemented by Bandhan and addressed in the six-country graduation study and in BRAC’s RCT. Consequently, even though there is evidence that the standard graduation approach has a long-term impact in some contexts, we do not extensively rely on this evidence in our assessment of Village Enterprise’s programme.

#### Direct evidence of Village Enterprise’s effectiveness

In evaluating Village Enterprise, we put most weight on a recent high-quality RCT of its programme in Uganda.<sup>221</sup> This study tested Village Enterprise’s full intervention, as well as an unconditional cash-transfer equivalent to the cost of Village Enterprise’s full programme, and that programme without the savings components.

The sample included 5,800 households at baseline, of which 1,200 received the full graduation-approach intervention. We have no major concerns about the quality of the study. A minor concern is that no baseline group comparison was made for outcomes such as consumption. However, the study does contain a baseline comparison of other variables, which shows no statistically significant differences between control and treatment groups on, for example, household size, years of schooling of the household head, and multiple indicators of housing quality.<sup>222</sup>

<sup>221</sup> Sedlmayr, Shah, and Sulaiman, “Cash-Plus.”

<sup>222</sup> Sedlmayr, Shah, and Sulaiman, 19.



The study found significant effects on consumption ( $p < 0.05$ , 4% increase relative to baseline<sup>223</sup>), assets ( $p < 0.01$ , 17%) and productive cash inflows ( $p < 0.05$ , 7%) at a pooled follow-up between zero and two years after the program ended.<sup>224</sup> However, evidence does not indicate that benefits persist over time: at 0-to-1-year follow-up, all three financial indicators showed statistically significant improvement ( $p < 0.1$ ), but at 1-to-2-year follow-up, only assets still showed such improvements ( $p = 0.059$ ), and the effect size of all three had decreased by about half.<sup>225</sup> This has a major influence on our cost-effectiveness estimate (see next section).

### Is the intervention cost-effective?

Our rough [cost-effectiveness model](#) suggests that Village Enterprise's programme doubles a participant's consumption for one year at a cost of \$157–\$367, with a best guess estimate of \$250. The model includes explanations for each step of the analysis.

Average monthly per capita consumption of new participants is about 52,000 Ugandan schillings, or \$20.64.<sup>226</sup> Our best guess estimate suggests Village Enterprise's programme can bring about nominal gains in consumption of about \$0.99 for each \$1.00 donated. Adjusting for 2017 purchasing power,<sup>227</sup> this is equivalent to gains of \$2.18 for each \$1.00 donated.

<sup>223</sup> The Sedlmayr; Shah and Sulaiman (2018) paper doesn't separately mention standard deviations of the control group or at baseline, so we report percentage increases here instead.

<sup>224</sup> Sedlmayr, Shah, and Sulaiman, "Cash-Plus," 25.

<sup>225</sup> Sedlmayr, Shah, and Sulaiman, Table A2.

<sup>226</sup> Sedlmayr, Shah, and Sulaiman, Table 1.

<sup>227</sup> "PPP Conversion Factor, GDP (LCU per International \$) | Data," World Bank, accessed November 5, 2018, <https://data.worldbank.org/indicator/PA.NUS.PPP?locations=UG>.



## What are the wider benefits?

In addition to effects on consumption, assets, and productive cash inflows, the RCT on Village Enterprise’s programme reported statistically significant improvements in subjective well-being ( $p < 0.05$ )<sup>228</sup>, which increased in the 1-to-2-year follow-up compared to the 0-to-1-year follow-up.

## Is it a strong organisation?

Village Enterprise are a strong organization, and routinely account for evidence and cost-effectiveness in decision-making. They have strong monitoring and learning processes and are outstandingly transparent and accountable.

In addition to the RCT<sup>229</sup> we discuss above, Village Enterprise are having another RCT conducted on their programme as part of a Development Impact Bond (DIB).<sup>230</sup> The DIB is a funding mechanism in which investors get paid based on outcomes achieved, in Village Enterprise’s case improvements in consumption and net assets of the programme participants.

Furthermore, Village Enterprise emphasises monitoring and evaluation,<sup>231</sup> and are among the most transparent and accountable charities we have found. Their [website](#) contains clear information on everything they have done, do, and are planning to do, including financials and regular progress updates.

<sup>228</sup> Sedlmayr, Shah, and Sulaiman, “Cash-Plus,” Table A8. The paper doesn’t separately mention baseline values or variability, so we could not infer an effect size from it.

<sup>229</sup> “Randomized Controlled Trial,” Village Enterprise, accessed October 1, 2018, <http://villageenterprise.org/our-impact/rct/>.

<sup>230</sup> “Development Impact Bond,” Village Enterprise, accessed October 1, 2018, <http://villageenterprise.org/our-impact/development-impact-bond/>.

<sup>231</sup> “Monitoring and Evaluation,” Village Enterprise, accessed October 1, 2018, <http://villageenterprise.org/our-impact/monitoring-and-evaluation/>.



## What is their strategy?

In 2019–2020 Village Enterprise plan to train another 45,000 entrepreneurs, of which 33,000 will be women. In 2021, they intend to significantly scale up through their partners as part of Village Enterprise Extend, and to train 125,000 entrepreneurs, of which 91,000 will be women. From 2019 to 2021, they could therefore reach about 1,100,000 people in poverty, counting both entrepreneurs served and their families.<sup>232</sup> By 2025, they aim to have helped create one million small businesses, which implies training three million entrepreneurs and impacting 20 million people living in poverty.<sup>233</sup>

Village Enterprise currently operate in Kenya and Uganda and will scale up their direct programming in those countries. The main countries they are investigating for scale-up through Village Enterprise Extend are the Democratic Republic of the Congo (where they are already running a pilot), Ethiopia, Mozambique, and Malawi.<sup>234</sup>

In addition to scaling up, Village Enterprise have started to adapt their programme to specific populations, such as youth and refugees. For instance, they are currently piloting a programme for refugees in Northern Uganda.<sup>235</sup> They plan to continue this work in the coming years.

## Is there room for funding?

Village Enterprise have met their funding needs for 2018, but expect they could productively use an additional \$28 million in 2019–2021. Their projected budget for 2019–2021 is \$34.5 million, of which they

<sup>232</sup> Private correspondence with Village Enterprise, 11 October 2018.

<sup>233</sup> Private correspondence with Village Enterprise, 11 October 2018.

<sup>234</sup> Private correspondence with Village Enterprise, 5 October 2018.

<sup>235</sup> Private correspondence with Village Enterprise, 5 October 2018.



have secured \$6.5 million already.<sup>236</sup> More specifically, for each of the coming three years their remaining funding gap is:

- 2019: \$2,000,000
- 2020: \$4,000,000
- 2021: \$22,000,000

By far, the largest part of their funding needs is for scaling up through Village Enterprise Extend, in which they plan to invest \$18 million in 2021. The second largest part is for core programming in Kenya and Uganda, in which they plan to invest \$2.5 million, \$3.0 million, and \$3.5 million in 2019, 2020, and 2021, respectively, and for which they have already secured \$3.5 million.

### What are the main uncertainties?

Most of the uncertainty comes from a lack of evidence of long-term impacts. Bandhan’s and BRAC’s long-term studies have only limited external validity for Village Enterprise’s programme, and we even have some weak indication from Village Enterprise’s own RCT that there may be little long-term impact: the 1-to-2-year follow-up results are worse than those at 0-to-1-year follow-up. We have, however, accounted for this in our cost-effectiveness analysis, which is the main reason why our cost-effectiveness estimates for Village Enterprise are lower than those for Bandhan.

Another limitation relates to Village Enterprise’s plans to scale its programme to other Sub-Saharan African countries via partners. We lack information on Village Enterprise’s ability to select and work with partners and the extent to which their current programme’s results will generalize to these other countries. However, for

<sup>236</sup> Private correspondence with Village Enterprise, 11 October 2018.





the coming two years Village Enterprise Extend is only a small part of Village Enterprise’s budget.

Furthermore, we believe their organisational quality and emphasis on monitoring and evaluation warrants some confidence in their ability to scale via this pathway and adjust their plans when necessary.