VIOLENCE AGAINST WOMEN AND GIRLS

AUTHOR: A. BANSAL, V. COX
Review: S. Hilton, M. Muntean

MAY 2023
Research Report: 
Large-Scale Global Health – Violence Against Women and Girls
(Community Activist Social Empowerment)

Author: Akhil Bansal and Vicky Cox
Review: Sam Hilton and Miriana Muntean
Date of publication: 2023
Research period: 2022

Thanks to Kylie Abel and Urszula Zarosa for their contributions to this report. We are also grateful to the experts who took the time to offer their thoughts on this research.

For questions about the content of this research, please contact Vicky Cox at vicky@charityentrepreneurship.com. For questions about the research process, please contact Sam Hilton at sam@charityentrepreneurship.com.
Executive summary

Nearly one third of women and girls aged 15 years of age or older worldwide have experienced either physical or sexual intimate partner violence (IPV) or non-partner sexual violence. Social empowerment has been identified as a promising approach to reduce and prevent violence against women and girls (VAWG), with evidence showing community activist social empowerment to be the most effective intervention.

There is relatively strong evidence that the identification, training, and utilization of local leaders to work as community-level activists against VAWG reduces the incidence of IPV. Taking the results of six RCTs into account, we find that the average relative reduction in IPV is 30.22% when using the community activist approach. However, we note that it is currently unclear how long these effects persist, as most follow-up surveys have been directly after completion of 12 to 48 month programs, rather than after any significant time has passed since implementation.

There is strong precedent for this work; Raising Voices’ SASA! toolkit\(^1\) is used by over 50 organizations, in more than 15 countries. These organizations are starting to see preliminarily promising results. For example, CEDOVIP reduced the prevalence of physical IPV from 25% to 9% four years later in an RCT in Uganda. This is compared to the slight increase in physical IPV in the control group which saw 21% prevalence at baseline and 22% at follow-up.

However, experts have mixed views on whether a new organization should be started in this space. This is because existing organizations are underfunded, and so starting a new organization could lead to competition for already limited funding. However, some experts did highlight that they were unsure whether this would actually create funding competition.

This intervention also doesn’t seem to be very cost-effective. Our cost-effectiveness analysis currently estimates a cost-effectiveness of $421.47 per DALY averted. However, we note that this model doesn’t capture some of the important impacts of this intervention – e.g. the economic benefits or the benefits of female empowerment and gender equality – and that DALYs may underweight two of the most significant health effects of IPV: pain and mental health problems.

---

\(^1\) SASA! is the largest and most commonly used community mobilization program developed by Raising Voices around the basis of an activist toolkit.
Moreover, this approach relies on the motivation, opportunity, and quality of the activists\(^2\) (rather than the co-founders) which we have less control over. This seems like an obvious potential path to failure. Hiring strong local staff and/or having a strong co-founder presence in the country of operations could potentially mitigate these concerns.

Overall, our view is that a new charity implementing the community activist social empowerment approach to preventing and reducing VAWG is not an idea worth recommending to future charity founders.

**Table of contents**

1. Introduction
2. Background
3. Theories of change
4. Geographic assessment
   4.1 Where existing organizations work
   4.2 Geographic assessment
5. Quality of evidence
   5.1 Evidence that a charity can make change in this space
   5.2 Evidence that the change has the expected health effects
6. Expert views
7. Cost-effectiveness analysis
8. Implementation
   8.1 Talent
   8.2 Access
   8.3 Feedback loops
   8.4 Funding
   8.5 Scale of the problem
   8.6 Neglectedness
   8.7 Tractability
   8.8 Externalities
9. Conclusion

References

\(^2\) However, we note that this is a limitation of any technical assistance intervention, and is to some extent mitigated by the toolkits and other resources that are made available by existing organizations.
1 Introduction

This report has been produced by Charity Entrepreneurship (CE). CE’s mission is to cause more effective charities to exist in the world by connecting talented individuals with high-impact intervention opportunities. We achieve this goal through an extensive research process and our Incubation Program. In 2022, our research process focused on the top highly scalable global health interventions.

*Violence against women and girls – Community activity social empowerment* was chosen by CE research staff as a potentially promising intervention within this category. This decision was the result of a five-month process designed to identify interventions that were most likely to be high-impact avenues for future charity entrepreneurs. This process began by listing nearly 300 ideas and gradually narrowing down, examining them in more and more depth.

In order to assess how promising interventions would be for future charity entrepreneurs, we use a variety of different decision-making tools, such as group consensus decision-making, weighted-factor models, cost-effectiveness analyses, quality of evidence assessments, case study analyses, and expert interviews.

This process was exploratory and rigorous, but not comprehensive – we did not research all 300 ideas in depth. As such, our decision not to take forward a charity idea to the point of writing a full report should not be seen as a view that the idea is not good.

2 Background

35% of women worldwide have experienced either physical or sexual intimate partner violence (IPV) or non-partner sexual violence globally. The majority of cases are intimate-partner violence, with almost one-third (30%) of women having been subjected to violence by their partner, and 7% by someone other than a partner ([World Health Organization, 2019](https://www.who.int/). These estimates do not include a number of issues, including sexual harassment, female genital mutilation, trafficking, or cyber-harassment ([UN Women, n.d.](https://www.unwomen.org/en)). It is also likely that this is an underestimation, due to chronic under-reporting.

The Global Burden of Disease, which includes information on IPV, but not VAWG more generally, reports it as the 19th leading burden of disease globally– it is responsible for 8.5 million DALYs and 68,500 deaths annually. In several countries, violence against women is in the top three-five leading causes of death for young
women aged between 15 and 29 (Mendoza et al., 2018). In addition to the direct harms of VAWG, it is a significant risk factor for other conditions – VAWG is responsible for 11% of the DALY burden of depressive disorders and 14% of the DALY burden of HIV in women (Institute for Health Metrics and Evaluation, 2019).

The rates of VAWG are alarmingly high worldwide and have also slightly increased over the last 30 years. This is despite gains in other areas of women’s health, such as maternal care (Spencer, Cagney, and Gakidou, 2021). Even worse, there are certain countries and regions of the world (e.g., several Asian countries) that have seen significant increases in the rates of VAWG over the last two decades (Borumandnia et al., 2020).

The health consequences of VAWG are significant; they can be immediate and acute, long–lasting and chronic, and/or fatal. Some of the most common health consequences of VAWG are summarized in the table below:

<table>
<thead>
<tr>
<th>Physical</th>
<th>Sexual and reproductive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acute or immediate physical injuries, including bruises, lacerations, burns, bites, and fractures</td>
<td>• Unintended/unwanted pregnancy</td>
</tr>
<tr>
<td>• More serious injuries leading to long–term disability, including injuries to head, eyes, ears, chest and abdomen</td>
<td>• Unsafe abortion</td>
</tr>
<tr>
<td>• Gastrointestinal conditions</td>
<td>• Sexually transmitted infections, including HIV</td>
</tr>
<tr>
<td>• Chronic pain conditions</td>
<td>• Chronic pelvic infection</td>
</tr>
<tr>
<td>• Death, including femicide</td>
<td>• Fistula</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental</th>
<th>Behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Depression</td>
<td>• Harmful alcohol and substance abuse</td>
</tr>
<tr>
<td>• Sleeping and eating disorders</td>
<td>• Having abusive partners later in life</td>
</tr>
<tr>
<td>• Stress and anxiety disorders e.g., PTSD</td>
<td>• Lower rates of contraceptive and condom use</td>
</tr>
<tr>
<td>• Self harm and suicide</td>
<td></td>
</tr>
<tr>
<td>• Fear</td>
<td></td>
</tr>
</tbody>
</table>

Violence against women and girls also has a large economic cost due to the lost economic productivity due to absenteeism and lost productivity and women. Survivors of violence also have increased utilization of public services (Bansal, 2022; Bansal, 2023).
3 Theories of change

This intervention includes the identification and training of local community leaders. The new charity would support these leaders with mentoring, training, toolkits, and other resources. This increases local knowledge about VAWG and positively changes social and gender norms, directly supporting survivors. Counseling and support is also provided to couples with known problems with IPV, with an aim to reduce and prevent VAWG.

The theory of change for a charity implementing the community activist approach is illustrated in this section. We consider the necessary activities and outputs by the new charity, as well as the mechanisms for change and required behavior change in both the activists and the community. We also highlight the key assumptions being made in this theory of change.

<table>
<thead>
<tr>
<th>Charity activities</th>
<th>Charity outputs</th>
<th>Activist COM change1</th>
<th>Activist behavior change</th>
<th>Community COM change</th>
<th>Community behavior change</th>
<th>Benefits</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning about the community, its current beliefs, and its needs</td>
<td>Ongoing support, training, mentoring, and monitoring and evaluation of intervention</td>
<td>Activists have the capability and motivation to: - Recognise VAWG, why it happens and the consequences - Raise community awareness of VAWG, why it happens and the consequences - Discuss power imbalances between men and women and promote gender equality - Teach couples to practice more gender equitable behaviors and how to manage tension and relationship conflicts in a non-violent way - Support survivors of violence and encourage them to get help</td>
<td>Activists speak out and take action against VAWG</td>
<td>Men and women have the capability and motivation to: - Challenge the acceptability of violence - Practice more gender equitable behaviors and manage tension and relationship conflicts in a non-violent way - Victims of violence speak out and seek help</td>
<td>Women and men speak out and take action against VAWG</td>
<td>Reduced incidence of VAWG (Physical, sexual, and mental)</td>
<td>Reductions in the physical effects of violence, eg. reduced injuries and chronic pain as a result of these injuries</td>
</tr>
<tr>
<td>Identifying community leaders</td>
<td></td>
<td></td>
<td></td>
<td>Community behavior change</td>
<td>Community behavior change</td>
<td>Benefits</td>
<td>Outcomes</td>
</tr>
<tr>
<td>Training and mentoring community leaders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Improved health effects (eg. reduction in rates of HIV)</td>
</tr>
<tr>
<td>Providing community leaders with toolkit and other resources</td>
<td>Monitoring and evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fewer unwanted pregnancies and the resulting complications (including abortions)</td>
</tr>
</tbody>
</table>

---

1 COM refers to the capability, motivation, and opportunity for change from the COM-B model for behavior change (The Decision Lab, 2021)
The key assumptions, corresponding to each step (i.e., “→”) in the theory of change, are:

<table>
<thead>
<tr>
<th>Charities can successfully identify the most promising community leaders to be activists</th>
<th>Community, activists, and other relevant stakeholders are on board with the intervention</th>
<th>Toolkits, support, and other resources are used</th>
<th>Community is willing to listen and engage with such a sensitive topic</th>
<th>Men and women have the opportunity and motivation to act despite other priorities, the fact that this is a sensitive topic, etc.</th>
<th>The intervention reduces anxiety, depression, PTSD, self-harm and interpersonal violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toolkits and other resources are appropriate to this community and cultural context</td>
<td>Activists have the opportunity to act despite other priorities</td>
<td>Activists are able to identify couples who are willing to get involved, and/or couples where intimate partner violence is a concern</td>
<td>There is no reactionary increase in VAWG</td>
<td>There is no reactionary increase in VAWG</td>
<td>The intervention reduces the number of unwanted pregnancies and the resulting complications (including abortions)</td>
</tr>
<tr>
<td>Scale: key uncertainty, high uncertainty, some uncertainty, low uncertainty, unconcerning.</td>
<td>The intervention reduces the physical pain caused by violence</td>
<td>The intervention reduces alcohol use disorder</td>
<td>The intervention reduces the rates of HIV</td>
<td>Impacts are long-lasting</td>
<td>Health services are adequate, accessible, and available for victims of violence</td>
</tr>
</tbody>
</table>
This theory of change is very similar to the SASA! model designed and implemented by Raising Voices and its partners.

The SASA! approach has four phases, with each phase addressing a different kind of “power”:

1. **Start**: Community activists interested in issues of violence, power and rights are selected and trained, along with staff from selected institutions (for example, police, religious leaders, health care, and so on).
   a. This phase fosters the “power within” the community activists to recognise VAWG and gender inequalities, and the ability to make positive change on this.

2. **Awareness**: Increasing the community’s awareness about VAWG, why it happens and what the consequences are.
   a. This phase encourages critical thinking on men’s “power over” women

3. **Support**: Strengthening skills and connections between different community members to work together and support each other.
   a. This phase illustrates the “power with” joining with others to make change.

4. **Action**: Taking actions and trying new behaviors to make positive change, and celebrating this change. Also strengthening actions to ensure sustainability.
   a. This phase shows the “power to” make positive change.

The theory of change for the SASA! approach is illustrated in Figure 1 below.
4 Geographic assessment

The geographic assessment is done in two stages. First, we look at where existing organizations are working and what they are doing. This information will later be used as an input in the formal geographic assessment as a measure of neglectedness (the greater the number of organizations already working in a country, the less neglected the problem is in that country and, therefore, the less promising it is to start a new organization in). Second, we conduct the formal geographic assessment with the aim of finding the top priority countries for starting a new nonprofit.

4.1 Where existing organizations work

We identified two organizations that are also working on the community activist social empowerment approach to reducing and preventing violence against women and girls: Raising Voices and the Centre for Domestic Violence Prevention (CEDOVIP).

Raising Voices developed the most commonly used community activist toolkit for this intervention: the SASA! activist kit, as detailed in the Theory of Change section above. Raising Voices does direct implementation work in Uganda, but outside of
this it mostly maintains the SASA! toolkit. They have provided technical support to over 50 organizations in 21 countries using SASA! in their communities. Raising Voices has partner organizations using the SASA! approach in the following countries: Mexico, Honduras, Nigeria, the Democratic Republic of the Congo, Cameroon, Liberia, South Sudan, Ethiopia, Malawi, Kenya, Tanzania, Uganda, Botswana, Namibia, South Africa, India, Bangladesh, Myanmar, Timor-Leste, Fiji, and Kiribati.

CEDOVIP is one of the organizations that has partnered with Raising Voices to implement the SASA! toolkit. They are currently working in Kenya, Botswana, Burundi, Ethiopia, Tanzania, and Uganda.

We have also decided to deprioritize countries where No Means No Worldwide (NMNW) is working, as although their intervention is slightly different (they are focused on self-defense training rather than community-based activism), they are one of the stronger organizations working to reduce violence against women and girls. NMNW works in Nigeria, Ethiopia, Uganda, Tanzania, Zambia, Zimbabwe, Namibia, Botswana, South Africa, and Mexico.

We also found a directory of organizations working on violence against women and girls from GBV Prevention Network. We included this in our geographic assessment, though weighted it lower as most of these organizations are likely not working on the community-activist approach.

Please note that this is a non-exhaustive exploration of all organizations working on violence against women and girls broadly, but we believe we have identified the main countries where we would not want to duplicate work by specifically focusing on Raising Voices and CEDOVIP.

4.2 Geographic assessment

To assess which countries could be promising for a new organization to work in, we completed a formal geographic assessment, taking into account the following factors:

- **Scale**: To understand the scale of the problem in a given country we use estimates of prevalence of IPV by country from the Lancet (Sardinha et al., 2022), and estimates of the total DALY burden and prevalence from IHME GBD 2019⁴ (Institute for Health Metrics and Evaluation, 2019). Countries with high prevalence and a higher number of total DALYs will be higher priority to work in.

- **Tractability**: We use various indexes to get a sense of how easy it will be to start a new charity working to reduce and prevent violence against women.

---

⁴ However, we believe that these numbers are undercounted as this only includes the relative risk of depression, anxiety, interpersonal violence, and HIV/AIDS. No other health effects are included.
and girls in a given country. We expect that implementation would be more
difficult in a country with high gender inequality, where the political system
is fragile, with less freedom, and where there is a lot of injustice, volatility,
and corruption.

- Gender inequality: The UN’s Gender Inequality Index which evaluates
inequalities across three dimensions: reproductive health, empowerment, and the labor market. This includes education, political involvement, workforce participation, maternal mortality rates, and birth rate (Gender Inequality Index, 2021).

- Fragility: The Fragile States Index evaluates the vulnerability of
countries to collapse by looking at indicators such as factionalized elites, economic decline, state legitimacy, and demographic pressures (Fragile States Index, 2022).

- Corruption: The Corruption Perceptions Index evaluates the level of
corruption in a given country by looking at indicators such as bribery in government, diversion of public funds, access to information on
government activities, and how positions of power are appointed (Corruption Perceptions Index, 2021).

- Rule of law: The Rule of Law Index evaluates the extent to which those
who govern a country are bound by law, government corruption, the
openness of the government to sharing information, whether
regulation is fairly and effectively implemented and enforced, how
well regulation ensures security and protects rights, and a country’s
civil and criminal justice systems (World Justice Project’s Rule of Law
Index, 2022).

- Freedom: The Freedom in the World Index evaluates the political
rights and civil liberties enjoyed by a given country’s population
(Freedom in the World, 2022).

- Neglectedness: We look at the number of existing organizations working in a
given country, and the ability of that country to solve its problems absent
charitable activities.

  - Existing organizations: We use our above stakeholder mapping of
charities doing similar work. This is an important consideration, as we
do not want to duplicate efforts and therefore would prioritize starting
a new organization in a country where this work is not already being
done.

  - GNI per capita: This is a proxy for how many resources that country/
individuals in that country have to find a solution to the problem.

Using these factors, our geographic assessment suggests that Angola is the most
promising country for a new charity to work in, followed by Zambia, Mozambique,
South Africa, and India.
5 Quality of evidence

5.1 Evidence that a charity can make change in this space

The most obvious examples that a charity can make change in this space are CEDOVIP, and any other organizations using Raising Voices’ SASA! toolkit. For example, an RCT of CEDOVIP’s program in Uganda found that their work reduced the past-year prevalence of physical intimate partner violence from 25% at baseline to 9% four years later. This is compared to the slight increase in physical IPV in the control group which saw 21% prevalence at baseline and 22% at follow-up (Abramsky et al., 2014). We also outline other RCTs which use the SASA! approach, or similar approaches, in the “Evidence that the change has the expected health effects” section below.

Another example of an organization that has successfully worked on reducing the incidence of intimate partner violence, and has successfully scaled quickly, is No Means No Worldwide (NMNW). By 2017, NMNW had reached 266,000 girls and 134,000 boys. It planned to scale to reach 428,000 girls and 150,000 boys through the intervention by 2021 (Hoeijmakers, 2019). It has also conducted seven large studies of its program. The results of these studies are as follows:

- **Sinclair et al., 2013**: Past-year prevalence of IPV was 24.6% at baseline and the effect size of the NMNW intervention was 17.1%
- **Sarnquist et al., 2014**: Incidence of IPV was 17.8% at baseline and the effect size of the NMNW intervention was 6.5%
- **Sarnquist et al., 2016**: Annual incidence of school dropout due to pregnancy decreased from 3.9% at baseline to 2.1% at follow-up
- **Keller et al., 2016**: Boys’ attitudes and behaviors related to gender-based violence improved as a result of the intervention; for example, at a nine-month follow-up after the intervention, 76% successfully intervened when witnessing verbal harassment vs. 38% in the control group
- **Baiocchi et al., 2017**: Past-year prevalence of IPV was 7.3% at baseline, and the effect size of the NMNW intervention was 3.7%
- **Decker et al., 2018**: Past-year prevalence of IPV was 15.2% at baseline, and the effect size of the NMNW intervention was 9.2%. This reduction was not seen in the control

---

5 NMNW implements a course over six weeks, taught at schools two hours per week, which has variants for boys and girls aged 10–20. 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. These courses enable girls to avert sexual assaults, and for boys to develop healthy gender relations and help prevent sexual assaults themselves (Hoeijmakers, 2019).
• **Edwards et al., 2021**: The incidence of sexual harassment decreased by 26% for girls in the IMpower group compared to the control group.

### 5.2 Evidence that the change has the expected health effects

We break this review into three sections: 1. Evidence that the intervention reduces violence, 2. Evidence that the intervention has positive impacts on health and well-being outcomes, and 3. Evidence on the impacts of violence on health and well-being outcomes.

**Evidence that the intervention reduces violence**

Our evidence review relies mostly on six RCTs evaluating 12–48 month community activist interventions in Africa. We focus on the reduction in the incidence of physical intimate partner violence (IPV) as a result of these interventions:

- **Abramsky et al., 2014**: A 48 month program run by CEDOVIP using Raising Voices’ SASA! activist toolkit in Uganda. The baseline prevalence of physical intimate partner violence was 25%, which decreased to 9% at follow-up, four years later (as soon as the program ended). This is compared to the slight increase in physical IPV in the control group (21% prevalence at baseline and 22% at follow-up).

- **Dunke et al., 2020**: A 24 month community-based couples intervention in Rwanda which is very similar to SASA! in implementation. The baseline prevalence of intimate partner violence was 49.8%, which decreased to 34.7% at follow-up, two years later (as soon as the program ended). This is compared to the slight increase in physical IPV in the control group (41.1% prevalence at baseline and 41.7% at follow-up).

- **Wagman et al., 2015**: A 24 month community-based mobilization intervention in Uganda which is very similar to SASA! in implementation. The baseline prevalence of physical IPV was 17%, which decreased to 15% at follow-up one (after 16 months), and 12% at follow-up two (after 35 months). This is compared to a baseline prevalence of 18% in the control group which only slightly decreased to 16% at both follow-ups one and two.

- **Ogum Alangea et al., 2020**: A 24 month Rural Response System program in Ghana. The baseline prevalence of intimate partner violence was 16.5%, which decreased to 8.3% at follow-up, two years later (as soon as the program ended). This is compared to the smaller decrease in physical IPV in the control group (14.6% prevalence at baseline and 10.9% at follow-up).

---

6 Developed by the Gender Centre, Rural Response Systems are community-based action teams selected by community members and the Gender Centre. They work together to undertake community sensitization and awareness raising, and work to change norms in the community, such as at community festivals, weddings, schools, religious groups and others. There are many similarities between this and the SASA! Program outlined in Raising Voices’ activist toolkit (Addo–Lartey et al., 2019).
• **Le Roux et al., 2020:** A 12 month, faith–leader–led community activist intervention in the Democratic Republic of the Congo. The baseline prevalence of intimate partner violence was 30.3%, which decreased to 16.6% at follow–up, one year later (as soon as the program ended).

• **Chatterji et al., 2020:** A 24 month program run by CEDOVIP using Raising Voices’ SASA! activist toolkit in Rwanda. The baseline prevalence of physical intimate partner violence was 31.7%, which increased to 34.7% at follow–up, two years later (as soon as the program ended). We also see an increase in IPV in the control group (19.7% at baseline and 21.4% at endpoint)
  - These negative impacts are said to be the result of not allowing sufficient time for adapting evidence–based programing to ensure cultural appropriateness and fidelity, as the intervention strategy of informal activism was not well suited to the Rwandan context and required considerable modification.

Taking all of these results into account, including negative impacts, the estimated relative reduction in violence due to a year of the program per participant is 16.49% when using the community activist approach. Note that it is currently unclear how long these effects persist, as most follow–up surveys have been directly after completion of 12 to 48 month programs, rather than after any time has passed since the intervention stops.

Evidence that the intervention has positive impacts on health and well–being outcomes

We find that three of the six RCTs outlined above also report on health and well–being outcomes:

• **Dunkle et al., 2020:** Although not the primary outcome, this study also looked at a few health–related exploratory outcomes (self–rated health, PTSD symptoms, depressive symptoms, and problematic alcohol use).
  - Both women and men in the intervention arm, versus control, were more likely to report ‘good’ or ‘excellent’ health at both 12–month and 24–month assessments.
  - Both men and women in the intervention groups, versus control, reported significantly fewer PTSD symptoms at both the 12–month and 24–month time points.
  - Both men and women in the intervention groups, compared with control group participants, reported significantly lower scores on the CES–D 10 short form measuring depressive symptoms, with improvements at both interim and final assessments.

---

7 Assessed using the [Center for Epidemiologic Studies’ Depression Scale](https://www3.ndsu.nodak.edu/depts/hmr/cepl assess/dep20guide.pdf) which is a self–reported measure in the range of 0–60. The score is the sum of the 20 questions and a score of 16 points or more is considered depressed.
There was no significant change in the level of problematic alcohol use reported by male participants, although there was a non-significant reduction.

- **Wagman et al., 2015**: A follow-up after about 35 months (~11 months after the intervention ended) found that the intervention was associated with a reduction in HIV incidence from 115 cases per 100 person-years in control vs 0.87 cases per 100 person-years in the intervention group.
- **Ogum Alangea et al., 2020**: Women in the intervention arm reported higher levels of depressive symptoms than women in control districts pre-intervention (mean depression score 19.6 vs 17.4). Post-intervention, a significant reduction ($p < 0.01$) was observed in the intervention arm (15.02) vs. the control arm (16.85). No reduction in depression levels were observed in men.

Abramsky et al., 2014 also reports on HIV risk via sexual concurrency. Men’s past year concurrency was approximately 50% lower in intervention communities, compared to control communities. Therefore, we may expect HIV prevalence to reduce as a result, but this is not reported directly.

**Evidence on the impacts of violence on health and well-being outcomes**

Reduction in violence against women and girls/intimate partner violence will have positive impacts on the physical effects of violence, e.g., reduced injuries and chronic pain as a result of these injuries, and also reductions in anxiety, depression, PTSD, suicide, alcohol use disorder, unwanted pregnancy and the resulting complications (including abortions), and HIV (Institute for Health Metrics and Evaluation, 2019; Ferrari et al., 2022; Rosenberg, 2022; Silverman and Raj, 2014; Ismayilova, 2010; Goemans et al., 2021). The hierarchy of evidence for these outcomes is as follows:

- Anxiety, depression, PTSD, self-harm and interpersonal violence, and HIV: Best evidence
  - This is based on the studies outlined above, and inclusion in IHME’s evaluation of the relative risk of intimate partner violence. IHME have a high burden of causal relationship required for relative risk to be calculated.

---

8 Sexual concurrency is the overlapping of sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner.
6 Expert views

We conducted three expert interviews with implementers from existing organizations for this report. All experts wished to remain anonymous, so we will just provide a summary of their views here.

Experts shared the view that social empowerment is the most promising approach to preventing and reducing the incidence of violence against women and girls. However, there was a mix of expert views on whether a new charity should be doing work in this space.

Experts generally thought that this space was underfunded, and so starting a new organization could lead to competition for already limited funding. As existing organizations are currently struggling for funding to scale, it may make more sense to fund the scaling of existing organizations, rather than starting a new one.
However, some experts also thought that there needs to be more innovation within the approach of social empowerment, and so a new organization could be a good way of achieving this. They also questioned whether a new organization would necessarily create funding competition.

Moreover, experts also stressed that the SASA! methodology is likely best implemented by women’s rights organizations with a strong activist spirit, prior experience in working on VAWG, and deep relationships with communities and local stakeholders. SASA! is also a long-term approach, requiring commitment to multi-year programming, which may be challenging for brand new organizations.

7 Cost–effectiveness analysis

We used an adjusted version of the cost–effectiveness analysis that was conducted for Akhil’s follow-up post on the EA forum “What you can do to help stop violence against women and girls”.

This models the costs of training local leaders to become activists, as well as the costs of developing and delivering the SASA! Toolkit, for example, and the cost of ongoing support for these activists. These cost estimates are based on the costs of running similar projects in Uganda and Rwanda (Michaels-Igbokwe et al., 2016; Torres-Rueda et al., 2020).

The benefits modeled are DALYs averted from depression, PTSD, alcohol use disorder, anxiety, physical effects e.g., injuries, abortion, unwanted pregnancy and resulting complications, HIV, suicide, and chronic pain. These impacts were modeled using three different approaches:

1. **IHME Data**: The IHME data on the prevalence and DALY burden of IPV was used to estimate the burden per individual per year affected by IPV. This data only included the relative risk of anxiety and depression, interpersonal/physical violence and HIV in its calculation of the DALY burden of IPV, which is likely an underestimation of the true burden of IPV.
   a. This estimate gave a figure of 0.06 DALYs per year of IPV.
   b. A weighting of 40% was assigned to this estimate because, although it is likely to be an underestimate, it is from a highly reputable and reliable source.

2. **Ferrari et al., 2022**: This is an estimate from a recent economic evaluation study of different IPV interventions.

---

9 We note that in one of the three cost estimates used, the community activists were volunteers. Instead of including a salary/stipend cost, this model instead included the opportunity cost of their time of attending training etc.
a. This estimate gave a figure of 1.60 DALYs per year of IPV.
b. A weighting of 20% was assigned to this estimate because the methods used to estimate this burden were not completely clear and had not been validated.

3. **Personal calculation of relative risks:** A personal calculation of the relative risk of different health conditions for women who have experienced IPV, versus the general population. This was then used to generate an estimate of the total health, DALY burden attributable to IPV.
   a. This estimate gave a figure of 1.13 DALYs per year of IPV.
b. A weighting of 40% was assigned to this estimate because, although it seems the most comprehensive of the three approaches, it has not been validated.

Using these costs and benefits, we estimate a cost-effectiveness of **$421.47 per DALY averted**, and $375.72 for a woman to live a year free from violence.

We note that this cost-effectiveness estimate is likely an underestimation; it doesn’t model the economic benefits, or the benefits of female empowerment and gender equality. Moreover, it is plausible that DALYs underweight pain and mental health struggles. WELLBYs would likely be a more appropriate measure, but not a lot of research has been done on this outside of high-income contexts.

8 **Implementation**

8.1 **Talent**

Community activist social empowerment is not a prohibitively complex area and operationally the intervention is relatively simple, so it should not be difficult to find talent capable of working on this issue. The main requirement for the co-founders of this charity would be that at least one of them should be a woman. It would be beneficial, but not necessary, to find a local co-founder; violence against women and girls could be a fairly sensitive topic that may be best approached by a local. A first hire could also fulfill these requirements.
8.2 Access

Information

Access to information is unlikely to be a barrier, though it has been difficult to find complete data. The data on the prevalence of intimate partner violence from the Lancet is quite spotty. It has no information for 41 countries, many of which have high gender inequality, so we may expect violence to be higher in these countries. IHME GBD 2019 has more complete data, but we believe that these numbers are undercounted as this only includes the relative risk of depression, anxiety, interpersonal violence, and HIV/AIDS. No other health effects are included. It has also been difficult to get a full picture of where existing organizations are working, as most organizations seem to be quite small and local. They have therefore been difficult to find via a Google search, and implementing organizations have been quite vague about where exactly the SASA! toolkit, for example, is being used. Instead, they mostly just focus on the number of organizations and/or countries that are using it/it is being used in.

A new organization can also learn a lot about implementation through Raising Voices’ toolkit and other similar interventions (e.g., Unite for a Better Life and Rural Response Systems).

Relevant stakeholders

Access to stakeholders is also unlikely to be a barrier, if approached thoughtfully. As this could be quite a sensitive issue, it should be approached carefully when trying to get relevant stakeholders on board.

8.3 Feedback loops

Feedback loops for this intervention will be quite long, as the intervention typically takes place over 12–24 months.

The impact of this intervention might also be difficult to measure. While a pre/post survey seems like an obvious, simple way to do this, this will be measuring women’s self-reported incidence of intimate partner violence. With self-reporting, there is some risk of social acceptability bias, where women may feel pressure to say that things have gotten better when they haven’t, or to even cover up how bad things are in the first place. This could be mitigated by using local interviewers, using interviewers of the same gender as the interviewee, conducting interviews privately, and by training interviewers on how to ask sensitive questions (e.g., WHO...
has advice on this and example questions for conducting a survey/questionnaire on violence against women and girls).

8.4 Funding

EA funding

Founders Pledge might be interested in evaluating and potentially recommending a new charity working on the community activist approach to reducing violence against women and girls, as a promising giving opportunity within women’s empowerment. Founders Pledge has conducted research on women’s empowerment, and has recommended No Means No Worldwide as the most promising organization to fund if you are specifically interested in funding an organization which works on averting sexual violence (Hoeijmakers, 2019). They do not feel confident to recommend it as one of the most promising organizations to support if you are interested in women’s empowerment more broadly, and also state that they recommend GiveWell’s top charities as organizations that are highly cost-effective in improving women’s and girls’ lives, but which do not focus directly on women’s empowerment.

Open Philanthropy may be interested in funding new organizations working in this space, given a cause area report on reducing violence against women and girls won their cause exploration prize (which was written by Akhil Bansal, one of the authors of this report) and given that Akhil has also been contracted by Open Philanthropy to do more research on "what you can do" in the space, where he recommends starting new organizations (Bansal, 2022; Bansal, 2023; Smith and Gertler, 2022).

GiveWell doesn’t seem to have researched violence against women and girls, or intimate partner violence. Therefore, they have not given any funding to charities in this space and are unlikely to give money to charities in this space in the future.

Non-EA funding

We expect that non-EA funding will likely be easier to get than EA funding, as women’s empowerment is a cause area that a lot of funders will be interested in. Basically all official development assistance (ODA) agencies have funding specifically for women’s empowerment. We think that a new organization working on the community activist social empowerment approach could be one of the most exciting giving opportunities for these agencies, as it puts the evidence base built by DFID’s “What Works” into practice (Kerr-Wilson et al., 2020).
However, experts have mentioned that existing organizations have been struggling to get the funding to scale. This is because a lot of the funders that are interested in funding organizations working to prevent and reduce VAWG are usually quite small, and so can only support these organizations up to a certain level of scale.

One of the strong reasons that this intervention could be so promising is the funding counterfactuals. A new organization would likely find it easier to secure non-EA funding, reducing concerns that it might redirect funding from GiveWells’ top charities, for example. Also, a lot of government development agencies and other funds support VAWG work, and shifting this funding towards social empowerment may present a high leverage opportunity. In this counterfactual scenario, the new charity’s impact could be significant.

### 8.5 Scale of the problem

Our current best estimate is that there are 5-10 top countries where this intervention looks very promising. We also think that this intervention should be quite scalable; Raising Voice’s activist toolkit accounts for community differences, so the approach should not need much adjustment when scaling from country to country.

### 8.6 Neglectedness

There seem to be large gaps for a new charity to fill. Although there are many groups working to stop VAWG, it is fairly neglected relative to the scale of harm that it causes. In addition, a lot of work may not be prioritizing interventions that have the greatest impact. Those that are working on the community activist social empowerment approach are still fairly small, and unlikely to scale to fill all gaps.

CEDOVIP is quite small, and unlikely to scale quickly to fill gaps. They are currently working in Kenya, Botswana, Burundi, Ethiopia, Tanzania, and Uganda.

Raising Voices is more meta, and they maintain the toolkit on how to implement this intervention, rather than doing work on the ground themselves.

Despite the availability of funding available for these interventions from ODAs following DFID’s “What Works” evidence collection and review, there hasn’t been an influx of new charities starting to work in this area. Therefore there is no reason to believe that these new charities will start now.
8.7 Tractability

This intervention relies quite heavily on the quality of the community level activists (rather than the co-founders). We have less control over this and so this could be a failure point. Hiring strong local staff and/or having a strong co-founder presence in the country of operations could potentially mitigate these concerns. Implementation also seems to have gone well in the RCTs reviewed in the quality of evidence section, which suggests that this can be done well.

Another potential barrier could be that countries where female empowerment interventions hold great promise may introduce legislation that restricts NGO activities (as has happened in Iran).

Other than these small concerns, implementation seems relatively simple, especially as you can learn from the existing resources (Raising Voices’ toolkit, Unite for a Better Life, and the Gender Centre’s rural response system).

8.8 Externalities

Positive externalities

Our cost–effectiveness analysis models the impacts of this intervention on the physical effects of violence, e.g., injuries and chronic pain as a result of these injuries, and also models the impacts on anxiety, depression, PTSD, suicide, alcohol use disorder, unwanted pregnancy and resulting complications (including abortions), and HIV. This intervention will also impact many other positive outcomes that are not currently modeled in our cost–effectiveness analysis. These positive externalities include:

- Women’s empowerment and gender equality
- Economic benefits: In 2016, the global cost of violence against women was estimated by the UN to be US$1.5 trillion, equivalent to approximately 2% of the global GDP (Puri, 2016). The economic cost seems to have two major contributing factors:
  - Lost economic productivity due to absenteeism and lost productivity: A study in Ghana (Merino et al., 2019) found that for women experiencing any form of violence, the total days of lost productivity was 26 days per woman in the past 12 months. This translated into nearly 65 million days at the national level or equivalent to 216,000 employed women not working, assuming women worked 300 days in


the year. Overall, the economy was estimated to lose output equivalent to 5% of its female workforce not working annually due to VAWG. Similar results have been shown in India and Uganda (Puri, 2016).

- Increased utilization of public services: Survivors of VAWG have increased utilization of public services, including health services, criminal and civil justice systems, housing aid and child protection costs, as well as specialist services. The European Institute for Gender Equality estimates that this incurs a similar (if not greater) economic cost than lost productivity (Walby and Olive, 2014).

- Other positive mental well-being impacts on sleeping and eating disorders, fear and stress, and self-harm.

Negative externalities

A potential concern of this intervention is that there may be a reactionary increase in VAWG in response to these programs. However, we note that the studies which have found this relationship are not evaluating community activity social empowerment, they are evaluating other interventions to reduce or prevent VAWG, and it is hard to know whether they generalize to this context.

There is also some concern that violence may shift from intimate partner violence to strangers. The community nature of this intervention should help to mitigate this.

9 Conclusion

Overall, our view is that a new charity implementing the community activist social empowerment approach to preventing and reducing VAWG is an idea not worth recommending to future charity founders.

References


Chatterji et al. (2020). Community activism as a strategy to reduce intimate partner violence (IPV) in rural Rwanda: Results of a community randomised trial. Available at: https://doi.org/10.7189/fjogh.10.010406 (Accessed 3 March 2023).


Dunkle et al. (2020). Effective prevention of intimate partner violence through couples training: a randomised controlled trial of Indashyikira in Rwanda. Available at: https://doi.org/10.1136/bmjgh-2020-002439 (Accessed 3 March 2023).


Le Roux et al. (2020). Engaging with faith groups to prevent VAWG in conflict-affected communities: results from two community surveys in the DRC. Available at:


Sardinha et al. (2022). Global, regional, and national prevalence estimates of physical or sexual, or both, intimate partner violence against women in 2018. Available at: https://doi.org/10.1016/S0140-6736(21)02664-7 (Accessed 3 March 2023).


