

GiveWell Donor Event December 3, 2024

This transcript was automatically generated using software, with additional editing afterward, and may contain minor inaccuracies. If you have questions about any part of this transcript, please review the original video recording that was posted along with these notes.

Elie Hassenfeld: Hey everyone. Thanks for joining us today on this GiveWell webinar. I'm Elie Hassenfeld, I'm GiveWell's co-founder and CEO. It's great to be here with all of you. It's especially nice to be here with you on Giving Tuesday, which is today. So we're excited to talk to you about some of the things we've been working on with respect to charitable giving.

I am joined today by Julie Faller and Alex Cohen. They're two of our senior researchers. They're both here to give us more of an inside look into the details of some of the work that they've been leading.

Alex leads our cross-cutting team as a senior researcher. That means that his team focuses on methodological issues and issues that run across the gamut of all the programs that GiveWell looks at. It's his team that led work we call "red teaming" where they tried to find errors or mistakes in some of the recommendations that we had made on our Top Charities in the past, and I'm happy to talk more about that later today.

Julie leads grantmaking teams that focus on issues including water, nutrition, livelihoods, and vaccines. Julie is a senior program officer, and she's going to talk more about some of the work we've done in those areas this year. In what we talk about today, I'm going to ask Julie and Alex some questions. I'll probably answer some of those questions myself. In classic GiveWell style, we will probably skew a little bit negative in the takes that we have, to share some of the things that have been challenging or have gone wrong. We'll also share some of the successes that we've had. Hopefully it's informative and interesting.

Throughout, if you have questions, please use the Q&A button at the bottom of the zoom screen to ask questions. You can do that in text; they'll come to us, and then at the end of the hour we'll have some time to answer the questions that you have. Thanks again for joining us. And I'm going to turn it over now to Stephanie Stojanovic, our director of development.

Stephanie
Stojanovic:

Thanks, Elie. So before we get stuck into the meat of the research updates, we thought we'd kick things off in a slightly more engaging way with a data estimation exercise. If you haven't already, if you could join us at [menti.com](https://www.menti.com), or use the QR code, with your phone or with your laptop, and you can access the quiz with the code 81552499. So we'll just wait for more people to join on. We're seeing lots of thumbs up, which is suggesting that people have successfully logged in. So we'll give it another, maybe 20 seconds so that we can get maximum attendance. So a reminder that's Menti.com and use the code 81552499. Okay. Yes, the thumbs are going wild. So it looks like everyone is getting in. Okay, let's give it five more seconds. Great. All right, well, let's kick it off.

We've got four quick questions. The first is: According to the most recent data available from UNICEF, how many children under the age of five are there in Africa? And so this is the scale from 0 to 500 million. So remember the scale is in millions. Getting a big spread of answers here. Here's a little helpful hint. There are roughly 1.4 billion people in Africa. So what proportion of those are children under five? Good amount of answers coming in. They're still coming in thick and fast, so I'll keep the question open. We're seeing less little jumps in our graph here. So let's say we'll close the question in 5, 4, 3, 2, 1. And our answer is 210 million.

Next question: How many zero-dose children were there globally in 2023, according to the WHO? So that is: how many children have received zero doses of the recommended routine immunization?

Getting a good spread of answers again. So this is immunizations. Most of us have had measles, mumps, rubella, polio. Okay. Let's close the question in 5, 4, 3, 2, 1. And our answer is 15 million.

Third question: According to the WHO, how many people died of malaria in Chad in 2021? And this is in thousands. Our scale is from 0 to 50,000.

Take note of this question because it will become relevant later. Okay, let's have a look. Without scooping Alex too much later, don't feel bad if you get this one wrong, we're pretty uncertain about this one too. Okay, let's close this in 5, 4, 3, 2, 1. And our answer is 12,000. We have some accepted parameters there of course.

The last question is: According to the United Nations, how many gallons of water does the average person in Africa use per day for all household needs? That's for everything: drinking, cooking, cleaning and sanitation. And for our non-American friends, one gallon is roughly 3.8 liters.

We're having a much smaller spread on this one. Okay. Let's close this in 5, 4, 3, 2, 1. And the answer is 12 gallons. And here we just have a quick comparison between US use as well.

Thanks for playing. I will be back for another round of trivia later. But now I'm really pleased to pass the mic back to Alex, Elie, and Julie to get stuck into the research.

Elie Hassenfeld: Thanks, Steph, and thank you everyone for participating in that. I think some of these numbers are hard to come by, and I think it's good to see how challenging it can be sometimes to know what they are and where things stand.

Alex and Julie, I wanted to ask you a question about your work this year. What's something that you worked on that was very surprising or that you weren't expecting that happened this year in our research? Alex, let me turn to you first.

Alex Cohen: Let me share something surprising, or at least interesting, that I learned from a grant we made related to tuberculosis. So tuberculosis is a disease that's very dangerous, especially for young children. Without treatment, about 1 in 3 kids who develop active TB die from it. Making prevention easier for those kids can be especially impactful in countries like India where TB is still very, very common.

Until recently, though—this is the piece that I learned—preventing TB in a child who'd been exposed to someone with TB required giving them medicine for 6 to 9 months every day. It also required parents crushing the adult pills and mixing them with water. This was suboptimal because this tasted bad and made it hard to give to young kids. You get these chunks in the mixture that make it difficult to administer. Partially as a result of this, a lot of kids didn't complete the full course of treatment.

But there's a new treatment that only needs to be given once a week for three months. So instead of 200 doses, this is something like 13. And it also comes in a more child-friendly formulation that masks the bad taste and is more dispersible in water. So you don't get these hard chunks.

We recently made a grant to increase the uptake of this treatment to children in India. We think this is going to be an impactful way to prevent active TB, prevent deaths from TB. Then more broadly, I think for me at least, this is a reminder of how some of these important or these small, seemingly small programmatic details—in this case, test and dosage—can make a pretty big difference.

Elie Hassenfeld: Great. Thanks, Alex. Julie, I'm going to ask you the same question. First, I want to quickly answer a question that came in the Q&A: How many participants are on the call right now? About 270 people on this webinar right now, which is great. We really appreciate you joining us. Feel free if you have questions as we're talking to keep throwing them in the Q&A at the bottom, and we're happy to answer them when we have some time at the end. But Julie, over to you. What's something surprising from this year in research?

Julie Faller: We recently revisited our assessment of the impact of GiveDirectly's unconditional cash transfers program, which gives a one-time cash transfer of about \$1,000 to poor people living in five African countries. I was excited for us to revisit this work, because I had been concerned that we were underestimating the benefits of this program.

The surprise is that I was right about that, but for the wrong reasons. I had been concerned that we were missing potentially large benefits by not explicitly accounting for the program causing a reduction in child mortality. But it turns out that even taking these benefits into account, they're not a large proportion of the benefits overall. And that's because given that the program is relatively expensive and it doesn't target families who have young kids, you have to spend a substantial amount of money to prevent one child death.

But on the other hand, we now believe that we had been underestimating the spillover economic benefits to non-recipients. So that's to say that we hadn't adequately accounted for the fact that when someone receives cash transfers, they spend that money at local businesses and local markets. And that creates this sort of economic ripple effect that benefits those who don't get the cash transfers in nearby areas.

We still think that GiveDirectly's program is below our bar for funding, but accounting for these economic spillovers did make a substantial

difference to our overall estimate of the program's cost-effectiveness, and I think it's a good reminder that sometimes our intuitions about where the largest benefits of programs lie can be wrong.

Elie Hassenfeld: Thanks, Julie. One question that I had, and I'm curious if you can answer, is how we think about potential inflation in those effects. GiveDirectly gives cash to people. They spend it on things they need. It has these measured positive effects on the local economy. What effect does it have, if any, on prices, which would, I guess, negate some of the effect it's having on the economy?

Julie Faller: I'm going to kick that back to Alex, who is more steeped in the evidence on inflation specifically.

Alex Cohen: I think this is the number one question or a big question people should have about this. You give a large cash infusion to a bunch of people. In a small economy, shouldn't that cause prices to increase? In this case, our best guess is that these inflationary pressures are pretty low. That's based partially on this large study that tries to measure these price effects. So giving cash transfers to some villages, not others, and measuring the effect not just on consumption and health outcomes, but also price levels in those villages and surrounding villages.

The studies that we've reviewed on this don't find very large effects. Intuitively, we think that's for a few reasons. One of them is that these villages are maybe more open than you would expect. So there's more trade with other villages. It's not just getting a large cash infusion in a very small economy. They're connected with nearby villages. They're buying there. They're trading. That helps kind of lower the pressure here. But this is, I think, an open question, something that we're interested in keeping a lookout for and seeing more studies that come out on this topic.

Elie Hassenfeld: Thanks, Alex. I wanted to share something that I learned this year that was surprising to me. I was in Kenya this summer visiting some of the water programs that GiveWell has supported. We supported two kinds of water programs historically. One is called Dispensers for Safe Water, where people collect water from a source and put it into a, often a yellow jerry can. And then as they're leaving the water point, squirt some chlorine from this dispenser into the jerry can to clean the water and ensure it's safe. And then another type of water program we've supported is called in-line chlorination, where the water is automatically

chlorinated by a device before the person collecting the water ever receives it. You know, they turn a tap and they're getting clean, chlorinated water.

When we've looked at this in the past, one of the ways that I always thought about it is that the dispenser program, the one where you have to turn the device to get some chlorine, has this issue because each person that collects water has to remember or decide to take the chlorine in order for their water to be safe. And we know from monitoring data that only about 50% of people who collect water in places with chlorine dispensers are using it. And so we were really excited and are really excited about supporting in-line chlorination because we thought, I thought it removes this behavioral issue that people need to remember to take the chlorine themselves. It's just the chlorine is automatically there in in-line chlorination, which seems like a big benefit.

But as is often the case, reality is rarely as simple as it seems. And so when I was in Kenya, one of the things that I learned and saw was that there are taps that only function two days a week, so you might only be able to access water on, say, Tuesday and Friday. And because of that, people would turn the tap and collect water and store it for several days. And this is a problem because the chlorine dissipates over time. When we were there, we measured some of the water that was being stored and it had very low chlorine levels. This is an example of the kinds of issues that we're focused on, that the organization that runs the program is focused on, but it really demonstrates the need for ongoing attention and monitoring to identify issues and improve programs so they deliver the kinds of impacts that we're looking for.

Alex and Julie, I want to kick another question over to you. What are you worried about right now? What problems are keeping you up at night? Julie, why don't you take this one first.

Julie Faller: Yeah. So much keeps me up at night. But one work-related problem is that I'm really worried about the data that we rely on, including data about treatment availability. One recent example from a grant that we looked into shows the importance of having reliable data.

We were interested in potentially supporting HPV vaccination for adolescent girls in Malawi. We think getting more adolescents vaccinated against HPV could be highly cost-effective because it reduces

the risk of developing cervical cancer later in life. In this particular case, initially the estimates we found suggested that only about 13% of eligible girls were vaccinated in 2022; obviously there's a huge opportunity for improvement from a baseline of 13%. However, when we looked at updated data that was released for 2023, it showed that 68% of girls were vaccinated, which is substantially higher coverage than we'd been expecting.

So what explains, you know, 13 to 68%? It is a big difference. It seems like the estimate of low coverage was at least partially driven by a drop in vaccinations due to Covid, but because the program had been very close to our cost-effectiveness bar for funding when we assumed those much lower vaccination rates, it meant that if we were anywhere in the neighborhood of these higher vaccination rates, the program would be below our threshold for funding, and we ultimately decided not to fund that program.

Elie Hassenfeld: Alex?

Alex Cohen: Mine's another data issue that keeps me up at night. This is about burden of disease estimates. To decide which programs to fund, which countries to fund in, we rely a lot on burden of disease data. These tell us, for example, how many children are dying from malaria or diarrhea or other causes in a given country. But these data tend to be really, really noisy, really uncertain.

The example that I have in mind here is something we learned in Chad. Steph put up the estimate of the number of kids that died from malaria in Chad in 2021. That's not a random example. We recently noticed that in the data source that we use for most of our models, Chad's mortality rate is much lower than neighboring countries—surprisingly lower. And it's about two times lower than another commonly used data source.

We looked into this and found there's not really a strong reason to prefer one over the other. Both are relying on these very sparse and infrequent mortality surveys. So we think it's worth putting some weight on both. When we do this, we find that malaria programs in Chad look more cost-effective than we'd previously thought, which is leading us to reconsider grants to seasonal malaria chemoprevention and nets there. This is on my mind because I want to make sure that there aren't other examples of this where we're being misled by noisy data.

Elie Hassenfeld: Thank you. Alex. A third question I want to ask you is, sticking with the negativity theme here: What is a disappointing update that you had this year? I'm going to jump in and give my answer to that question first and then turn it over to you.

Something that was disappointing in a sense, but really, I'd say maybe more interesting is we spent more time looking into this question of the extent people who receive malaria nets use them for fishing. And you know, we still know, it's still the case that this is not a major issue, meaning malaria nets are mostly hung in houses. They prevent malaria cases and deaths from malaria. This is the case. And we knew this was the case previously because many surveys and monitoring and evaluation data demonstrate how nets are used. But we wanted to look more deeply into it to better understand the scope of the issue and how large it could be. And what we learned is that approximately, as best we can estimate, 1 to 2% of households use malaria nets for fishing. This is across all of the nets that are distributed.

In some hotspots, in some communities where small-scale fishing is very prevalent—they're very close to bodies of water—in these hotspots it could be as high as 50% of households, so about half of households using nets for fishing. You know, one of the challenges is it's not trivial to identify the locations ahead of time where we should expect nets to be used for fishing. That's something that we hope to learn more about and do more on.

But, overall, while we learned on one hand, the surprising fact to me, that in some places this is a very prevalent activity, we continued to reach the same bottom line, which is, in the scheme of the benefits that malaria nets provide, the small portion, let's say 1% of households that are using them for fishing, has only a very small diminishing effect on the overall positive impact that these nets have on people's lives around the world.

Alex, I'm going to turn it over to you. What's your answer to the question of a disappointing update from the year?

Alex Cohen: I'm going to give an example of a case where a grant idea turned out to be less promising than we thought. A question that we ask a lot is, can we layer different health programs? That is, could we combine two programs that are being delivered to the same people to provide them

more cost-effectively than if we delivered them separately? This kind of program has been surprisingly hard to find.

This is an example of that. We were considering funding seasonal malaria chemoprevention in South Sudan. At the same time, we noted that South Sudan has really low vaccination rates and thought, would it be possible to layer vaccine support on top of SMC campaigns? We knew at the outset that timing was going to be a challenge. SMC is given seasonally during the malaria season, while vaccination requires year-round support. But we thought that cost savings from leveraging the SMC infrastructure might justify that partial year support.

In this case, though, it didn't work out because there was less cost overlap than we expected. For example, vaccines require more advanced staff than SMC campaigns, so we couldn't just leverage the same personnel and have them deliver vaccines while they're delivering seasonal malaria chemoprevention.

We're planning not to move forward with this idea, but are considering whether to support vaccination in South Sudan in other ways, either with a standalone vaccination program or using vaccination as the base layer, so layering SMC on top of vaccines instead of vice versa.

Elie Hassenfeld: Great. We got a question that asked: What is the SMC campaign being discussed? Can you just briefly say what SMC is?

Alex Cohen: Yeah. Sorry about that. Seasonal malaria chemoprevention is giving medicines to prevent malaria during the rainy season when malaria is prevalent, doing door-to-door campaigns or getting people out in the community to deliver these medicines to prevent deaths from malaria.

Elie Hassenfeld: Thanks, Alex. Julie, how about you?

Julie Faller: I think my disappointing example has the same themes as yours, Elie and Alex, which is just that the world is complicated. My example is one where we funded an evaluation and ultimately it just wasn't as informative as we hoped.

Last year we funded an organization called MiracleFeet to run programs supporting clubfoot treatment. Clubfoot is a congenital condition where one or both feet twist inward, and if it's not treated, it can cause pain and also difficulty for people to move around. So MiracleFeet trains

healthcare workers to identify this and treat the babies who are born with this condition. We funded MiracleFeet to work in three countries: Chad, Cote d'Ivoire, and parts of the Philippines.

We suspected that there was some clubfoot treatment already happening in these places but were unsure about how much treatment was happening and what its quality was. So we also funded evaluators to go out to healthcare facilities and help figure out how many kids are being treated, so that we could then compare that baseline to a similar evaluation after Miracle Feet started working.

In two of those countries, Chad and Cote d'Ivoire, the evaluations went pretty well. And we feel like we have a fairly good understanding of what access to treatment there looked like. But we don't think that the survey in the Philippines will let us get an accurate picture of existing treatment, and that's because of some on-the-ground complexities. Doctors in the Philippines might work across multiple facilities, and patients might also be referred to different facilities at different stages of their treatment. This means that the data that was collected could have some double counting happening, but we're not sure how much. I think it's an example of how tricky it can be to rigorously measure impact, even if you have good intentions at the outset.

Elie Hassenfeld: Thanks, Julie. I hope the information we've shared in the first half of this has been helpful. I'm going to turn it back over to Steph in a minute for a little more of the data estimation. Just a quick reminder: If you want to ask questions, please use the Q&A button at the bottom. In the last 15 minutes or so of the hour, we're going to be answering those live. So if you have questions, please, please add them.

Stephanie Stojanovic: Well, we're back for trivia, although I guess I've always been here—I forgot to turn my camera off. I'll try to leave the next round.

We've compiled some of the most interesting fun facts that we were told as part of our grant investigations this year. We thought it would be fun to see if you could spot them in a multiple-choice trivia game. So let's fire up the menti again, code 81552499. We'll do ten quick seconds to get back into Menti for everybody. Okay. It looks like we're getting lots of people joining. Five more seconds. Okay.

Let's go to question number one. There are just three questions in this round. Which of the following foods or beverages is believed to reduce your body's ability to absorb iron?

We're interested in funding a number of programs to address iron deficiency and anemia via supplements and food fortification. So we're very interested in understanding if anything would stop iron absorption. Looks like answers are still coming in. No one thinks it's water. Oh. One person. Here we go. Okay, we'll close the question in five, four, three, two, one. And yes, 60 of you are correct.

The answer was tea. This is particularly important because we're looking at a number of programs in India, which is a high tea drinking geography. And some trials found that tea inhibited iron absorption by up to 85%, which of course we needed to incorporate. So that's a nice little fun fact.

Next fun fact: Malawi has lower rates of vitamin A deficiency compared to many other countries. What dietary habit is believed to contribute to this?

This is about our top charity, Helen Keller International, who delivers a vitamin A supplementation program. This program gives a small amount of vitamin A to children under five, which is shown in numerous studies to reduce child mortality. But of course it's not helpful to supplement children if they have enough vitamin A from their diets already. So why might that be the case in Malawi? Let's close the question in 5, 4, 3, 2, 1. There we go. And looks like the majority of people were correct again.

When we were talking to an expert to try to understand why vitamin A deficiency was low, they suggested that kids in Malawi might have enough vitamin A because they eat whole small fish.

Last question. What is a possible reason that certain communities in India avoid using chlorinated water?

We support a lot of water chlorination programs. We were worried about all of the usual stuff—people might not want to drink water because it smells and tastes like a swimming pool. But there was one cooking-related concern. What was it? Okay. These colors are very

similar. I'm having trouble figuring out which is which. Okay, we'll close the question in five, four, three, two, one.

The cooking-related concern we found was that a dish called Pakhala tastes different because chlorine impacts the rice fermentation process, which is making community adoption of chlorinated water challenging in Odisha.

Okay, so that's it. That's the final bit of trivia. I'll be back to facilitate the Q&A. So please do keep dropping your questions in the Q&A.

Elie Hassenfeld: All right. Thank you, Steph. We're back to hearing from Alex and Julie about things we've done this year. This second half of the Q&A is going to skew a little more positive.

Alex, what is a big win from this past year that you're excited about?

Alex Cohen: It feels so unfamiliar to be so positive. But we've got some good stuff I think. Since 2020, our grants to New Incentives have been significantly more cost-effective than we initially expected.

New Incentives provides cash incentives for caregivers in northern Nigeria that bring their kids in for routine vaccinations during the first year of life. We estimate that our grants to New Incentives have or will avert about 24,000 deaths. That's more than double our initial estimate of about 10,000 deaths.

We started funding New Incentives in 2020. That was when we made our first major grants. And at that time the program reached about 70,000 children. Today, it reaches about 1.8 million. That's something like 20% of all infants born in Nigeria each year. So it's reached this massive scale, and cost-effectiveness has actually improved over time. That's driven mostly by reductions in costs per child enrolled. We think that's dropped from about \$40 to about \$20. The main drivers of this are economies of scale. So as the organization is reaching more kids, those fixed central costs are lower. New Incentives has looked for ways to try to reduce costs over time, and devaluation of the naira the Nigerian currency has contributed too. So we're continuing to support New Incentives and planning to learn more over time about whether they keep up this same level of impact.

Elie Hassenfeld: That's great. Thanks, Alex. Julie, how about you?

Julie Faller: My good news is also about reaching more children, although on a slightly different scale.

So we recently got an update from the organization r.i.c.e., which helps support the implementation of kangaroo mother care in one hospital in Uttar Pradesh [India]. And kangaroo mother care is a program with strong evidence of its impact for low-birthweight babies. It basically involves skin-to-skin contact between the caregiver and the baby and also breastfeeding promotion and a couple other components.

We recently heard that the program is reaching more children than we had initially thought. In our original estimates, we thought the program would reach about 11 babies a week, and we're now seeing about 16 babies a week. What's particularly exciting about this is that half the participants aren't born in the hospital where the program operates. They're coming from elsewhere, suggesting that their outreach to smaller health care facilities is going well. This does mean that funding is being used faster than we planned, but we think it's a good problem to have. This kind of enrollment seems consistent with strong community engagement and trust.

Elie Hassenfeld: Thanks, Julie. We've been talking a lot about what GiveWell mostly does—we evaluate other organizations to determine whether or not we should recommend that donors direct funds there. What's something we did this year to evaluate ourselves or consider the quality of our own research? Alex, over to you.

Alex Cohen: At the start, Elie referenced some red-teaming work that we've been doing. The idea is that we've directed over \$1 billion to our Top Charities: seasonal malaria chemoprevention, insecticide treated nets, vitamin A supplementation, and New Incentives. We've done this based on a lot of research, but wanted to step back and pressure test our analysis and look for blind spots in our work. We did this red-teaming exercise last year.

Bottom-line takeaways are, first, we're confident that these are among the most impactful giving opportunities donors can choose. But we also identified several issues that we should follow up on. And we think these are things that could, as we follow up on them, cause us to make some grants that we wouldn't have otherwise, or not make grants that we would have otherwise.

I'll give a couple of examples here. I won't go through the whole report, but two examples are looking for other ways to support effective programs. We currently support campaigns to deliver vitamin A supplementation twice a year to children under five. Could vitamin A fortified foods be a more cost-effective way to increase vitamin A uptake in some areas?

The second example is understanding better how individuals might get interventions that we fund from other sources. So, for example, we fund net campaigns to deliver bed nets to households, but we may be underestimating the number of people that get bed nets from clinics. So, for example, while they're bringing their kids in to get vaccines, they may get nets while they're there. This means that we may overestimate the effect of nets campaigns, and it may also mean that we're missing opportunities to support bed nets in other ways, for example, through clinic distribution instead of or in addition to campaigns.

We're currently following up on these issues that we flagged. We've got a report up on our website about it and plan to report back next year on the extent to which these issues change our grantmaking.

Elie Hassenfeld: Thanks, Alex. Julie?

Julie Faller: Another example in this category: we recently examined whether we could have been overestimating the impact of some of the programs that we support because they target the same population of children each year. So with programs like medicines to prevent malaria, that seasonal malaria chemoprevention that Alex mentioned earlier, or vitamin A supplementation, usually these programs are carried out annually and they target children under five. This means that when we estimate impact for one year, for a cohort of kids who are under five, most of those kids are also part of the cohort that's treated the following year.

So the question was, if we averted a death in year one, would we be averting the same death in year two? Are we in some sense double counting the impact from year to year? After digging into this, we found that it's not as concerning as we feared.

This is for two main reasons. The first is that most child deaths occur in the first year or two of life. So the crucial impact happens in the early years of the interventions. And then the second is that while some kids

do stay at higher risk from year to year, there's also quite a bit of variation in which kids are the most vulnerable. One example is that malaria can flare up and down, and that causes different places to become hotspots over time.

The bottom line is that we're probably only overestimating impact due to this concern by about 10%, which is not nearly as bad as the 80% that we were initially worried about in the worst case. So I came away feeling a lot more confident in how we're evaluating these kinds of programs.

Elie Hassenfeld: Great, thanks, Julie. The sort of self evaluation that I was most excited about this year responds to a pretty common question we get, which actually also I think came in via the written Q&A. So thank you.

GiveWell Top Charities—the programs they run like distributing malaria nets, preventative malaria medication, incentives to help people get vaccinated, and vitamin A supplementation—these programs are great. They're very impactful. They do a huge amount of good per dollar donated.

The question is, if they're so good, why aren't others already funding them? Why aren't other grantmakers? Why aren't high-income country governments? Why aren't local country governments? This is a question that we have asked a lot. We ask it about every investigation, grant investigation we do. Is this program that we might support going to be supported by someone else? And if not, why not?

One example, just to give you a sense of why this might be the case, is the largest funder of malaria programs globally, an entity called the Global Fund. The Global Fund has a rule that of all of its malaria funding, it can give a maximum of 10% to any one country. But two countries, Nigeria and Democratic Republic of Congo, combine to account for 40% of the global malaria burden. So the burden they have surpasses the amount that this large funder is able to give them for malaria. This is a reason that these gaps might exist in some cases.

Nevertheless, this question is a hard one to answer. We supported a researcher named Justin Sandefur at the Center for Global Development to do a project talking to people locally in government and funders and elsewhere to try and understand whether and why these gaps exist in certain cases. Hopefully that will help us learn more about this important question that relates to our work.

Finally, Alex and Julie, I want to ask you just about something that you're excited about right now that you're working on, that you're looking forward to. And Julie, let me let me throw it to you first.

Julie Faller:

I am really excited about research that we're funding or considering funding. A big theme we've talked about today is how difficult it is to know what we want to know in order to make a funding recommendation. So I'm really excited about a request for proposals that we launched earlier this year.

We reached out to researchers in our network to ask for proposals for studies that could affect our grantmaking. And to do this, each of our teams collated high-priority questions. These were things like how does treating anemia affect people's functional outcomes? Or what spillovers should we expect from unconditional cash transfers to the broader community in poorer places that have less of that integration to trade that Alex talked about earlier?

We ended up receiving more than 180 expressions of interest, which was stage one of this process, and we advanced 25% of those to a request for full proposals. We're reviewing those proposals right now. These are live discussions. And we hope to make decisions about what research to fund by the end of January.

Elie Hassenfeld:

Great, Julie. Alex, what do you think?

Alex Cohen:

I talked about an example where we thought we could layer programs and it didn't work out. I want to talk about a case where we think it will work out. This one has to do with New Incentives again.

They reach a lot of kids each year in northern Nigeria, a part of the world with high child mortality, and provide vaccines. But we thought this was a great chance to provide other programs, too. So while kids are brought in by caregivers for vaccines, could they receive another program?

One that we've been investigating is ORS and zinc (oral rehydration solution is ORS). It helps prevent mortality by preventing severe dehydration for kids with diarrhea.

In this case, layering works well because we are leveraging the costs and the existing infrastructure. So the kids are there, the healthcare workers are there already. We have to pay the extra cost of the ORS sachets, but otherwise we can take advantage of what's already in place.

The other reason that this works, contra the seasonal malaria chemoprevention and vaccines example, is that the timing works well. So ORS is just a medical commodity that you can store at home until you need it, in the same way that we might keep Pedialyte or Tylenol on hand. So little risk of spoilage. Kids can get a three-month supply of sachets of ORS when they're at the vaccine appointment and use that in the case of severe diarrhea.

We're working with New Incentives to roll this out now, and plan to report out on whether it's as impactful as we think it will be.

Elie Hassenfeld: I think for me, the thing that I reflect on is, I've been at GiveWell a long time, just surpassing 17 years now at GiveWell. And the depth, the breadth, the scope of the research we're doing today surpasses anything we've done in the past.

If you had come to a Zoom like this, two years ago, we wouldn't have been able to talk about topics like funding researchers to do work to improve our future decisions; trying to layer programs on top of immunizations to prevent diarrhea; and really the full scope of things that we were able to talk about today, both in terms of their breadth, but also the depth and the knowledge that the team has. It's really exciting for me to think about how far GiveWell has come, even in the last few years, and then where we're heading next.

Thank you to Alex and Julie and the research team for all the work that makes that possible. And thanks to you all for your support and joining today.

In the last 15 minutes of this call, we're going to answer some of the questions that came in via the Q&A. If you have more, you know, please feel free to send them. Unfortunately, we won't be able to answer all of them. We've gotten a ton of great questions, so thank you, but we're happy to follow up after the call over email if you ask the question with your name and we have your email address. But now I'm going to turn it over to Steph to read off some of these questions. We'll do our best to answer them.

Stephanie Stojanovic: Great. Let's get started with the Q&A. We've got lots of questions coming through, so the first one I'll direct to Elie, which is: Does GiveWell work through NGOs, local organizations, or governments? Is there ongoing follow-up by people on the ground locally?

Elie Hassenfeld: So most of the funding that we direct goes through NGOs. The NGOs themselves work very closely with the government. So, for example, when we support a malaria net distribution, the organization that we've mostly supported, the Against Malaria Foundation, is in close communication with and working closely with the national malaria control program of that country.

Last year, we also supported a water program that was implemented by Evidence Action in coordination with the Indian government. And this is a program where the Indian government was largely the entity laying the infrastructure for the program, getting advice and getting monitoring and evaluation from Evidence Action—and so was working very, very closely with them.

Virtually all the programs that we support have additional monitoring data coming in after the fact. And that's monitoring data that's collected on the ground locally. So we know what's happening. In the example I gave earlier, we know from this local monitoring that about 50% of water that is chlorinated via the dispensers program, or about 50% of the water that people collect when they have access to a dispenser, is chlorinated. That's coming from that locally collected monitoring data.

Stephanie Stojanovic: Great, thanks, Elie. Let's keep powering through these. I'll direct the next question to Alex: How do you decide which programs to revisit, and how long do you expect an evaluation to hold true?

Alex Cohen: So we try to revisit programs once there's new information available that could change our bottom line. We published several intervention reports on programs that we think are promising. We also write short notes on programs that we're deprioritizing, but we revisit those when we get new information.

A few examples to share: Julie talked about GiveDirectly. That's a program that's been on our radar for a long time. And we got some new evidence on the size of spillovers, which prompted a reevaluation there, or was part of the reason prompting a reevaluation.

We'd written some early work on the effect of water chlorination programs that we revisited in light of some new evidence from Michael Kremer and coauthors on the effect of chlorination on mortality.

And then more on the deprioritized program side, we had initially looked into a radio program for contraception that seemed less cost-effective, partially because of high costs. An organization reached out to us and said that they could deliver the program much more cheaply. That prompted us to reevaluate as well. So when we get new information, we like to revisit these things.

Stephanie Stojanovic: We've heard a lot about data and quantitative evaluation, but we've been asked, and I'll direct this at Julie: How do you weigh qualitative factors between interventions giving an identical amount of quantitative good? What factors might break a tie?

Julie Faller: It's a great question. We consider a number of qualitative factors, factors that we call outside-the-model considerations. Those can include things like expert opinion: Does it seem like there is consensus that this intervention has a strong evidence base, or are there people who have skepticism or substantial concern about an evidence base? We also consider the organization's track record. Do we have evidence that they can implement this program and implement it well?

Before we make a grant, we often have a lot of uncertainty about whether the program will play out the way we hope it will, whether it will achieve the impact that we hope. So we might think about something like, how plausible is it that the organization's theory of change—that A leads to B leads to C—will actually create the impact that we hope? One last thing is will we be able to learn about whether we were right about our ex-ante predictions after we make the grant. All else equal, being able to learn more and being able to update our recommendations in the future makes an opportunity more attractive.

Stephanie Stojanovic: Thanks, Julie. The next question, and maybe Alex can answer this one: How does GiveWell, as an organization, decide on what is an appropriate threshold of cost-effectiveness below which you don't fund?

Alex Cohen: Our bar for cost-effectiveness is about 10x cash transfers. Setting that bar, I think of as comparing supply and demand. So we have funding coming in from donors. That's one side of the curve. And then we've got

a list of charitable giving opportunities. At the very top we've got a few things that are 50x, and then we work our way down.

We set a bar at a very rough level by thinking, you know, if we spent down our donations, what cost-effectiveness level would we be at? So if we get 300 million in donations and we think that the marginal dollar at 300 million is 10x, that's our bar. If we think the marginal dollar at that point is 5X, that would be our bar.

So it's about comparing the funding we have to the supply of funding opportunities out there. In practice, it's a very rough exercise because of uncertainty on funds raised and uncertainty about the universe of programs that are available, but that's the way I think about it.

Stephanie
Stojanovic:

Our next question is, do any GiveWell analyses look at the time requirement for the recipient to participate in the program, maybe via lost income? They said they looked at the New Incentive analyses and didn't see it. And they think that it could be a large effect there. Julie, what are your thoughts on this one?

Julie Faller:

Yes we do. We do typically think about the opportunity cost of time through the channel of lost income. I think for many of our health-related charity recommendations, we end up thinking that this isn't that big of a consideration, either because the time requirement for participants is pretty low (like if you think about something where commodities are distributed door to door) or because we think that there also could be time savings for preventative health commodities. So if you take time to get a vaccine but then don't have to take your child for treatment multiple times, if they get sick, then that could end up being a time savings.

I think that these things are likely to end up being a more substantively meaningful consideration for programs that are aimed at increasing livelihoods. You might think if you give a farmer an agricultural input, one thing that that farmer might do is use that input, but also substitute her labor away from casual day labor to farming her own land and sort of lose an income stream through that channel.

An example where we have thought about this and the opportunity cost of farmer time is through One Acre Fund's Tree seedlings program, where they distribute seedlings to farmers. And a question that we have and that we're hoping to learn about through research that we funded is

whether there will be an opportunity cost from farmers diverting away from other crops to take that time to plant and tend their trees.

Stephanie Stojanovic: Great. Well, we're getting through lots of questions here. We've been picking the details, so now we're going to jump out to a slightly bigger picture question, which I'll direct at Elie: What does the staff do to stay positive and motivated while working on such challenging and often depressing topics?

Elie Hassenfeld: I can only really answer this for myself as a staff member and also as a donor. The world we live in is deeply unjust. I think I—and I'm sure many of the people on this call—have what we have because we were lucky enough to win the birth lottery in a certain sense. I was born in a wealthy country to a comfortable family. And that enabled me to have what I have. Recognizing that where I've ended up is in some way a function of luck motivates me to want to do work to help people who are not in that position.

While thinking about these issues that relate to people suffering disability or young children dying is extremely depressing—it's really terrible—it's also incredibly motivating because our work and the support of donors like you gives us the opportunity to make these major, significant effects on people's lives around the world. I find that incredibly motivating to know that we have an opportunity to make that difference.

Stephanie Stojanovic: Let's get stuck back into some in-the-weeds questions, and I'll direct this one at Julie. How often do we encounter resistance to folks using the programs that we fund, such as chlorination and vaccines, based on skepticism of the evidence or worries about side effects?

Julie Faller: It's a good question. I think we do need to be concerned about this across all the programs that we fund. I think that the specifics of the program and the place where it's being implemented end up mattering quite a lot. Chlorine is a great example where we've got anecdotes of there being substantial community resistance in some places and much less in others. And we're actually actively considering funding research right now that we hope would let us get at understanding more of some of those drivers—what makes chlorine more or less acceptable to community members.

I think that it's really important to note that engagement with the community is a component of almost every—well, I don't want to overstate it—but it's a component of many programs that we fund.

That can look like talking to community leaders and explaining the program and getting their buy-in, that it is important and that they would endorse members in their community using it. It can look like holding community meetings, explaining to parents and caregivers, you know, what is this new malaria vaccine? What are its benefits? What are the potential risks, those kinds of things. And so community engagement happens not only when programs are rolled out, but also often on an ongoing basis.

Stephanie
Stojanovic:

Great. Let's end with a final question that I'll direct at Elie. How do you address concerns that charities that GiveWell funds are not getting to the root or systemic causes?

Elie Hassenfeld:

I think there are two things that are worth keeping in mind. The first one is that a lot of the programs that we support are aiming to avert deaths of young children in the earliest years of life, and we know that those are the years that are riskiest. If kids survive those years, they tend to live long, healthy, mostly happy lives. In that way, the programs we support have these long-run effects on people's well-being.

The other fact is that a major animating factor in GiveWell's work is humility, meaning we want to help as much as we can, but we also know there are limits to the extent that we can help. If we knew how to solve the root cause of poverty, we would direct money there immediately, as I'm sure other people would. But, you know, we are hesitant to believe that we have those answers. I should say: we know that we don't have that answer.

And so instead we aim to direct funds where we believe that those funds will do a lot of good, and we'll get information after the fact to determine how it went, so we can continue to learn and to improve. So that's how we think about it.

We are going to close here. I just want to thank everyone for joining today for the great questions, for your engagement, of course, for your support over the years. GiveWell would quite literally not exist without the support of our donors. And so we're extremely grateful for it.

We are going to follow up after this with a feedback form over email, and we'd really appreciate your thoughts on this event and how we could make it better in the future. So please do share. If you have any additional questions, don't hesitate to send them to info@givewell.org; that address is also on our website. Thank you again for joining and for your support. Have a great rest of your day and holiday season and be well. Take care.