**Greater than the Sum of the Parts?**

**Evidence on Mechanisms Operating in Women’s Groups**

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**Abstract:** Women’s groups are a popular approach to promoting women’s and girls’ empowerment. Yet, whether and how creating and supporting women’s groups and delivering interventions through them offers unique benefits compared to individual-based interventions remains an open question. We review the experimental and quasi-experimental literature on women’s livelihoods and financial groups, health groups, and adolescent groups, and analyze the causal mechanisms through which these models improved outcomes for women and girls in low and middle-income countries. We distinguish between mechanisms that leveraged groups as a platform for intervention delivery and mechanisms that leveraged interactions among group members. We conclude that the primary benefit of group models is to offer a platform to reach many women at once with resources, information, and training. Nonetheless, some evidence suggests that group models can achieve positive impacts by fostering or harnessing interactions among group members, which would be harder or impossible to achieve through individual-based interventions. We offer some suggestions regarding the implications of these findings for programming and future research.

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Women’s group models are gaining increasing attention as policymakers, donors, and advocates seek effective strategies to promote women and girls’ empowerment at scale. In communities around the world, women organize and support one another through women’s groups. Some examples include savings groups, self-help groups (SHGs), mothers’ groups, community mobilization groups, and adolescent groups for girls. Groups serve as spaces where women socialize, build connections, and work toward economic or political goals. In addition, they offer an entry point for development organizations to reach large numbers of women at once to deliver interventions. Do group-based models offer unique benefits when compared to equivalent interventions implemented outside groups? In this paper, we shed light on this question by reviewing the evidence on women’s groups and analyzing key mechanisms that operate within group-based interventions.

Previous literature has highlighted the potential of certain group models to enhance women’s empowerment and other development outcomes. A recent evidence review focused on savings groups identified positive impacts on a range of individual and household-level outcomes, such as investment in income-generating activities, food consumption, resilience, solidarity with group members, and self-confidence [(Gash 2017)](https://sciwheel.com/work/citation?ids=7172334&pre=&suf=&sa=0). However, it found moderate effects along other dimensions, such as women’s decision-making power, social capital, and poverty. Likewise, a systematic review found that SHGs, a collective approach based on small voluntary groups that gather to reach financial goals, were successful in achieving impacts in women’s social, economic, and political empowerment, but not psychological empowerment [(Brody et al. 2015)](https://sciwheel.com/work/citation?ids=8483022&pre=&suf=&sa=0). Qualitative evidence synthesized in Brody et al. (2015) suggested that financial independence, solidarity, social networks, and respect from family and community members, may have been important mediators for achieving women’s empowerment.

Our review makes two main contributions beyond existing syntheses. First, we review women’s groups broadly, rather than a specific type, and thus are able to draw out commonalities in the impacts of different types of groups in low and middle-income countries. Second, and arguably, more importantly, we focus much of our discussion on the causal mechanisms operating within groups. Our aim is to better understand how groups generate positive impacts for women by identifying group-specific mechanisms that are harder or impossible to harness through individual-based interventions. We define mechanisms as the underlying pathways for the measured impacts, as articulated in the evaluation. In some cases, researchers empirically tested mechanisms; in other cases, they provided only suggestive or anecdotal evidence. Drawing from these various pathways, we analyze causal chains to better understand the centrality of the group structure in generating positive outcomes for women.

We focus on studies that have a strong research design to identify the impacts of group models on women’s outcomes. Specifically, we review evidence from randomized evaluations and natural experiments. In randomized evaluations, researchers estimate an intervention’s impacts using random variation in which people participated in, or were eligible to participate in, an intervention. With natural experiments, researchers use naturally occurring variation in who participates in an intervention (from, e.g., policy changes, gradual rollout of programs, cutoff rules for eligibility) that lends itself to isolating the causal effects of the intervention.

Based on [Biscaye et al.’s (2014](https://sciwheel.com/work/citation?ids=8579353&pre=&suf=&sa=0)) framework, we define group-based models as sharing three common features: (i) voluntary membership; (ii) members’ contribution of time, labor, money, or other assets; and (iii) regular face-to-face interaction among members. We further classify groups into livelihoods and financial groups, health groups, and adolescent groups. This review does not include less-studied group types like natural resource management groups or political groups and only focuses on studies that investigate the impact of groups on indicators of women’s and girls’ empowerment.

In our conceptual framework, we put forward two distinct potential benefits of groups relative to non-group models. The first hypothesized benefit of groups is that they function as a *platform for intervention delivery.* Groups may allow access to financial resources, information, or training to many people at one time and place. As a result, groups may facilitate the efficient implementation of certain types of interventions that would otherwise not be feasible if delivered individually, for instance, due to high costs. The second hypothesized benefit unique to group models is the *interaction among group members*. For example, groups facilitate peer interactions that may lead to positive effects through mechanisms like mutual accountability, moral support, or social networks. This distinction, by emphasizing two conceptually different benefits of groups, helps address the question regarding whether group-based approaches offer benefits for women that go beyond content and resource delivery, and if so, which mechanisms might be most critical.

We assess to what extent the available quantitative evidence is consistent with each of these two potential benefits. We do so by distinguishing between group-specific mechanisms that leverage groups as a platform for intervention delivery (for example, access to information and access to financial resources) and mechanisms that leverage interactions among group members(for example, moral support, mutual accountability, and social networks).

We present three sets of overarching takeaways. First, the primary benefit of group-based models appears to be the ability to reach large groups of women at once with resources, information, and training; that is, groups offered a *platform for intervention delivery*. Despite considerable heterogeneity in the programs delivered through groups, many led to modest improvements in women’s wellbeing. These improvements were mostly confined to downstream outcomes related to the core function of the group. For example, livelihood and financial groups (e.g., microcredit groups, savings groups, and self-help groups) increased women’s participation in economic activities by giving them access to financial resources including credit or assets. Increased access to financial resources, in our framework, is an example of a mechanism that leverages groups as a platform for intervention delivery. Similarly, health groups for women of reproductive age constituted a platform to disseminate health-related information to many women at once. In turn, this mechanism increased the adoption of better health practices and behaviors within the home.

Second, women’s groups usually did not generate impacts outside their core function. Livelihoods and financial groups, for instance, were effective in increasing women’s access to financial services and resources, but this mechanism did not always translate to increases in women’s household decision-making power. Intentional program design, through which content related to gender-specific issues was delivered, was important for effecting changes in outcomes like soft skills, violence against women, decision-making, aspirations, self-efficacy, or support for gender-equitable norms. Livelihoods groups sometimes reduced intimate partner violence (IPV), but only when they included training modules or gender dialogue sessions aimed explicitly at reducing IPV.

Third, in some cases, group-based models also generated positive impacts through interactions among group members, harnessing pathways beyond those stemming from content- and resource-delivery. There is evidence of groups helping create or strengthen women’s social networks, i.e., social ties and interactions that can persist when groups dissolve. New and stronger social networks were sometimes a mechanism that led to increased political participation, risk-sharing, and adolescents spending less time in risky settings, among other findings. A small number of studies found that social networks within livelihoods and financial groups helped enforce mutual accountability, which led to positive economic outcomes. There is also anecdotal evidence that group members provided moral support to one another. However, the studies we analyzed did not consistently measure moral support and did not directly link it to positive downstream outcomes.

Taken together, these findings have important implications for future research and policy. We found that the main advantage of groups is that they function as a platform to deliver programming to many women at once: while this suggests that groups can deliver benefits at a lower cost per person, more research is needed to understand the overall costs of group models, including fixed costs to create groups, coordination costs for participants to travel to scheduled meetings, and possible indirect costs like the exclusion of marginalized groups. To date, researchers have tended to measure the impact of groups by comparing them to a control group where no intervention took place but not to another treatment group that offered an individual-based intervention. This design (as well as the lack of systematic information on costs) does not allow us to assess to what extent delivering an intervention through groups is more cost-effective than delivering an intervention individually. Therefore, our review calls for additional research investigating this aspect further.

Our second finding, which emphasizes the importance of complementary programming to generate impacts outside the core function of groups, also calls for future research on cost-effectiveness. While providing complementary programs within existing groups may still be cost-effective relative to other service delivery models, adding in extra programming may alter the cost-effectiveness of implementing women’s groups at scale.

Third, our review suggests the need for a deeper understanding of how to leverage interactions among group members to achieve positive outcomes. Consistently measuring social relationships with more standardized metrics will help elucidate the impacts of women’s groups. From a policy perspective, programs should experiment with strategies for building and leveraging social relationships and networks within women’s groups, such as exploring digital interactions or testing different group compositions and meeting frequencies.

The remainder of the article is organized as follows. In the next section, we define and classify group-based models. We then present our conceptual framework on two potential benefits of groups and distinguish between group-specific mechanisms that leverage groups as a platform for intervention delivery and mechanisms that leverage interaction among group members. We then discuss the evidence on mechanisms operating within livelihoods and financial groups, health groups, and adolescent groups. In a final section, we summarize key overarching lessons and highlight avenues for future research and programming.

# **Definitions and Conceptual Framework**

## ***Definition of Women’s Groups***

The definition of group-based models we use closely follows that in [Biscaye et al. (2014)](https://sciwheel.com/work/citation?ids=8579353&pre=&suf=&sa=0). To be included in our analysis, groups must have the following three common features: (i) voluntary membership; (ii) member contribution of time, labor, money, or other assets; and (iii) regular face-to-face interaction among members. We classify groups into the following three categories based on their activities carried out and stated goals: (i) livelihoods and financial groups; (ii) health groups; (iii) adolescent groups.

*Livelihoods and financial groups.* These models intend to address women’s economic constraints by providing access to financial resources. In some cases, they include complementary interventions such as skills training, dialogue groups, and participatory learning targeted to women. Examples of models for women’s livelihoods and economic groups include microcredit groups, savings groups, and self-help groups (SHGs).

Microcredit groups are group-based microcredit interventions led by microfinance institutions (MFIs) where women generally share collateral in order to have access to credit, such as in joint-liability programs, and gather regularly for repayment.

Savings groups can be of two types. Rotating Credit and Savings Associations (ROSCAs) are informal, self-managed savings groups, where members save a fixed amount every week, which is then collected in a communal “pot.” Each week, one group member takes home the entire pot. The saving cycle continues until all members have received the pot once [(Beaman, Karlan, and Thuysbaert 2014)](https://sciwheel.com/work/citation?ids=7061335&pre=&suf=&sa=0). Village Savings and Loan Associations (VSLAs) models are similar to ROSCAs, but differ in that they require external facilitators, usually non-governmental organizations (NGOs), in order to spread. The external facilitator trains local women on how to form and manage groups that, once formed, become self-managed. Compared to ROSCAs, VSLAs are characterized by more flexible features. Groups are composed of self-selected women, who contribute a specific amount of savings during regular meetings to a communal pool,

constituting a loan fund. Members can apply for loans, to be paid back with interest and at a rate decided by the group, purchase group-based investments, or generate insurance funds for emergencies [(Allen and Panetta 2010)](https://sciwheel.com/work/citation?ids=8483032&pre=&suf=&sa=0).

SHGs are a common type of group in India, often supported by the government or NGOs. For example, the state of Bihar supports SHGs for poor, rural women through its Jeevika program. Their main purpose is similar to that of savings groups, i.e., to offer women a way to save and access credit. SHGs are often connected to external financial institutions to secure funds. However, the goals of SHGs are not necessarily confined to credit and savings. Other activities include the promotion of opportunities for income-generating activities and insurance [(Biscaye et al. 2014)](https://sciwheel.com/work/citation?ids=8579353&pre=&suf=&sa=0).

*Health groups.* The goal of women’s health groups is to convey health-related information. The majority of health groups that we analyze in this paper are related to maternal and neonatal health, targeted towards women of reproductive age, and facilitated by local women or trained health workers. Through participatory learning and action (PLA), groups can promote healthy behaviors around birth and encourage access to healthcare for delivery and antenatal visits. Dissemination of health-related information and PLA can also occur through other types of groups such as livelihoods groups, microfinance groups, and SHGs. In addition, health groups can serve as a base for collective action to improve health-care quality, with communities monitoring the health-care system and holding health workers accountable for their performance.

*Adolescent groups.* Most adolescent group programs aim to provide young girls access to a safe space where they can meet and interact with other girls in their age group. This is expected to help girls broaden their social networks, receive moral support, access mentorship, and protect their time (for example, girls may spend more time learning with their peers than on domestic chores). Apart from enabling access to peer networks, adolescent groups can be used to deliver hard and soft skills training programs to young girls. In this review, we include adolescent group programs only if they take place outside of schools and therefore participation is voluntary, or if in school, group interactions are facilitated by a trained adolescent peer.

## ***Conceptual Framework on Group-Specific Mechanisms***

This article puts forward two distinct potential benefits of groups relative to non-group models. We assess the extent to which each benefit is present, based on the available quantitative evidence. The first hypothesized benefit of groups is that they function as a *platform for intervention delivery.* Groups allow access to financial resources, information, or training to many people at one time and place. As a result, groups may allow for the efficient implementation of certain types of interventions that would otherwise not be feasible if delivered individually (for instance, due to high costs). The second hypothesized benefit unique to group models is the *interaction among group members*. For example, groups facilitate peer interactions that may lead to positive effects by activating mechanisms like mutual accountability, moral support, soft skills, or “power within,” defined here as support for gender-equitable societal norms, less acceptability of IPV, aspirations, or self-efficacy [(Kabeer 1994; Rowlands 1997)](https://sciwheel.com/work/citation?ids=8483030,8483031&pre=&pre=&suf=&suf=&sa=0,0).

Distinguishing between mechanisms that *leverage groups as a platform for intervention delivery* and that *leverage interactions among group members* provides insights on the key advantage of the group model: When delivering an intervention through a group, is the interaction and community-building among the members an important reason for positive impacts? Or are the impacts mostly because of the intervention itself (e.g., information, resources), with the group structure incidental to impacts? That is, this framework helps address the question of whether group-based approaches offer benefits for women that go beyond content and resource delivery, and if so, which mechanisms might be most critical.

Our definition of a mechanism is more inclusive than some social science literature. We classify as mechanisms intermediate outcomes that serve as signals that a specific pathway is working. In some cases, researchers show that these intermediate outcomes led to improvements in other downstream outcomes. In other cases, these intermediate outcomes are valuable per se and researchers treat them as outcomes in their own right. We still call them “mechanisms” because they are hypothesized channels for “bigger” downstream outcomes, even if researchers do not have power to assess those or did not measure them. For example, social networks are often treated as a stand-alone outcome of groups but are also a hypothesized channel for other downstream outcomes (e.g., political participation [(Prillaman 2017)](https://sciwheel.com/work/citation?ids=7061443&pre=&suf=&sa=0)). As such, we provide relevant details on the research design and related outcomes when describing the evaluations.

The following tables list and define the mechanisms we refer to throughout the paper. The tables classify them in two groups: mechanisms that leverage groups as a platform for intervention delivery (access to financial resources, economic inclusion, and risk sharing; access to information; “power within;” soft skills; hard skills) and mechanisms that leverage interaction among group members (social networks; mutual accountability; soft skills; collective action and mobilization; “power within”). In some cases, whether a mechanism leverages groups for intervention delivery or stems from interactions among group members is ambiguous. For instance, groups may achieve “power within” through intentional programming like gender dialogues aimed at changing group members’ attitudes. Interactions among women participating in groups may also incidentally improve “power within.” Similarly, soft skills may be the direct result of skills trainings or may be the indirect result of group interactions, which enhance members’ communicative ability, their deliberative efficacy, or their ability to cooperate. The analysis highlights these distinctions on a case-by-case basis.

*Table 1. Mechanisms that leverage groups as a platform for intervention delivery*

|  |  |
| --- | --- |
| **Mechanisms** | **Definition and examples** |
| Access to financial resources, economic inclusion, and risk-sharing | Access to resources including credit, assets, grants, and other financial resources |
| Access to information | Access to health information |
| “Power within” [(Kabeer 1994; Rowlands 1997)](https://sciwheel.com/work/citation?ids=8483030,8483031&pre=&pre=&suf=&suf=&sa=0,0) | Support for gender-equitable societal norms; less acceptability of intimate partner violence; aspirations; self-efficacy |
| Soft skills | Ability to negotiate, communicate, deliberate; life skills |
| Hard skills | Technical skills including financial management, business management, and agricultural skills |

*Table 2. Mechanisms that leverage interactions among group members*

|  |  |
| --- | --- |
| **Mechanisms** | **Definition and examples** |
| Social networks | Social ties and interactions, both inside and outside groups, which possibly persist when groups dissolve; perceived moral and material support from group members, other members of the community, friends or family; active participation in the community and membership in groups or organizations, when part of an index measuring social capital or social networks |
| Mutual accountability | Accountability to peers, social pressure, peer monitoring, and risk pooling as ways to encourage desirable behaviors, e.g. to repay loans in microfinance groups or accumulate savings |
| Soft skills | Ability to negotiate, communicate, deliberate; life skills |
| Collective action and mobilization | Working collectively to achieve common goals (either group- or community-specific) |
| “Power within” [(Kabeer 1994; Rowlands 1997)](https://sciwheel.com/work/citation?ids=8483030,8483031&pre=&pre=&suf=&suf=&sa=0,0) | Support for more gender-equitable societal norms; less acceptability of intimate partner violence; aspirations; self-efficacy |

# **Review of the Evidence on Impacts of Women’s Groups and Associated Mechanisms**

In this section, we review the evidence on each group type, focusing on understanding the causal pathways generated by livelihood and financial groups, health groups, and adolescent groups. We structure the analysis around whether the mechanisms and underlying explanations for the observed changes are related to the resources and content delivered in the groups (i.e. leveraging groups as a platform for intervention delivery), or attributed to peer interactions and social exchanges facilitated by the groups (i.e. leveraging interactions among group members). Table A1 in the Appendix reports the studies included in the review and summarizes each intervention’s details, group type, evaluation design, main findings, and mechanisms examined.

## ***Livelihood and Financial Groups***

Women experience limited economic opportunities relative to men in many contexts. For example, 59 percent of women have access to bank accounts in low- and middle-income countries compared to 67 percent of men [(Demirguc-Kunt, Klapper, and Singer 2017)](https://sciwheel.com/work/citation?ids=7963946&pre=&suf=&sa=0). Women’s ability to earn income can also be affected by social norms related to women’s work, mobility, and other issues. Meanwhile, opportunities to control household resources can be constrained by women’s relatively lower levels of bargaining power in the home [(Laszlo et al. 2017)](https://sciwheel.com/work/citation?ids=7301723&pre=&suf=&sa=0).

Women’s livelihoods and financial groups aim to improve women’s livelihoods and financial opportunities by leveraging the group to provide access to financial resources that would have been challenging to offer to low-income individuals at the individual level due to cost and logistics. Women’s livelihoods and financial groups may also offer additional benefits beyond financial outcomes. Women may learn leadership and other soft skills by administering a group or build connections in the community by forming relationships in the group. They may also increase their confidence and sense of their own ability to take on income-generating activities. Furthermore, training and other services added on to livelihoods and financial groups may lead to other impacts in women’s lives.

### *Leveraging livelihoods and financial groups as a platform for intervention delivery*

*Access to financial services and economic outcomes*

Livelihoods and financial groups have been an effective way to provide access to financial services, often leading to positive but not transformative business outcomes.As highlighted inprevious reviews of microcredit interventions [(Loiseau and Walsh 2015)](https://sciwheel.com/work/citation?ids=8818012&pre=&suf=&sa=0), access to microcredit groups led to positive but not transformative impacts on women’s entrepreneurship, business creation, and the expansion of existing businesses. For example, access to joint-liability microcredit in Mongolia increased the probability of women’s entrepreneurship by nine percentage points compared to 39 percent for the comparison group [(Attanasio et al. 2015)](https://sciwheel.com/work/citation?ids=7061332&pre=&suf=&sa=0). Likewise, access to joint-liability microcredit loans in India increased investments in small businesses and led to an increase in size for preexisting businesses, although access to the loans did not lead to increases in income on average [(Banerjee et al. 2015)](https://sciwheel.com/work/citation?ids=7061357&pre=&suf=&sa=0).

Similarly, two studies on savings groups found that VSLAs and SHGs had moderate impacts on women’s labor supply. A randomized trial of a VSLAs program for sexual violence survivors in the Democratic Republic of Congo found that, while both treatment and control groups saw a reduction in paid hours worked between baseline and follow up, women who participated in VSLAs experienced a smaller reduction. This effect, however, was significant only at the ten percent level [(Bass et al. 2016)](https://sciwheel.com/work/citation?ids=4193926&pre=&suf=&sa=0). One study on SHGs in rural India found that women were five percent more likely to be involved in non-agricultural employment compared to the five percent of women in comparison villages [(Desai and Joshi 2014)](https://sciwheel.com/work/citation?ids=8579375&pre=&suf=&sa=0).

However, there is mixed evidence that access to financial services in groups increases household economic well-being overall. In Burundi, access to VSLAs led to a 22 percent increase in average per capita consumption expenditures from a base of US$32 for the comparison group, and to an increase in the asset index score by 0.22, which is roughly equivalent to one extra head of cattle for each household [(Annan et al. 2013)](https://sciwheel.com/work/citation?ids=8483014&pre=&suf=&sa=0). Another VSLA in the Democratic Republic of Congo, implemented in conflict-affected communities among sexual violence survivors, increased household per capita food consumption by 25 percent and the number of animals for breeding [(Bass et al. 2016)](https://sciwheel.com/work/citation?ids=4193926&pre=&suf=&sa=0). Other studies found impacts on only some, but not all, measures of expenditures or assets [(Ksoll et al. 2016; Baro et al. 2013; Beaman, Karlan, and Thuysbaert 2014)](https://sciwheel.com/work/citation?ids=7061340,8482994,7061335&pre=&pre=&pre=&suf=&suf=&suf=&sa=0,0,0). A study on access to VSLAs in Malawi found some evidence of increased total expenditure and size of the house (a measure of assets), but no effects on food consumption or gross asset count [(Ksoll et al. 2016)](https://sciwheel.com/work/citation?ids=7061340&pre=&suf=&sa=0). Likewise, three studies found that microcredit groups had mixed impacts, with effects on either expenditure [(Attanasio et al. 2014)](https://sciwheel.com/work/citation?ids=8579439&pre=&suf=&sa=0) or assets [(Banerjee et al. 2015; Hoffmann et al. 2017)](https://sciwheel.com/work/citation?ids=7061357,7900659&pre=&pre=&suf=&suf=&sa=0,0), but not both. Finally, other studies on microcredit groups, SHGs, and savings groups found no positive impacts on measures of household economic well-being [(Angelucci, Karlan, and Zinman 2015; Karlan, Thuysbaert, and Gray 2017; Prillaman 2017; Joshi, Palaniswamy, and Rao 2015)](https://sciwheel.com/work/citation?ids=7061409,7062047,7061443,8482995&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&sa=0,0,0,0).

*Decision-making*

Livelihoods and financial groups did not consistently have impacts on women’s decision-making power in the family. Five out of the fifteen studies we analyzed had impacts on decision-making. Some examples of programs with positive impacts include microcredit, VSLAs, and SHGs. One study found that access to group microcredit in Mexico increased the proportion of women who stated that they participated in decision-making by 0.8 percentage points. While this number may seem small, most women already had high levels of decision-making ability at baseline, so there was very little room for improvement [(Angelucci, Karlan, and Zinman 2015)](https://sciwheel.com/work/citation?ids=7061409&pre=&suf=&sa=0). An evaluation of women’s VSLAs in Ghana, Malawi, and Uganda found small but positive impacts on women’s decision-making measured through control over household food expenses, children’s education expenses, and business expenses if the household operated a business [(Karlan, Thuysbaert, and Gray 2017)](https://sciwheel.com/work/citation?ids=7062047&pre=&suf=&sa=0).

Three studies on women’s SHGs in India also found positive effects. The first evaluation found that women with access to the groups were three to six percent more likely to have the final say in family planning, children’s schooling, and family medical care [(Desai and Joshi 2014)](https://sciwheel.com/work/citation?ids=8579375&pre=&suf=&sa=0). A second study of SHGs in India reported positive effects on women’s decision-making related to consumption, daily tasks, and children’s education, but not political decision-making in the household [(Prillaman 2017)](https://sciwheel.com/work/citation?ids=7061443&pre=&suf=&sa=0). A third study evaluated SHGs combined with additional programming Women’s SHGs plus gender transformative group learning sessions, which focused on empowering women economically and exposing them to topics related to gender norms and discrimination, increased group members’ self-reported independent decision-making [(Jejeebhoy et al. 2017)](https://sciwheel.com/work/citation?ids=7061456&pre=&suf=&sa=0).

Meanwhile, ten of the studies that measured women’s decision-making in the family did not find positive impacts. These included group microcredit in India [(Banerjee et al. 2015)](https://sciwheel.com/work/citation?ids=7061357&pre=&suf=&sa=0) and Ethiopia [(Tarozzi, Desai, and Johnson 2015)](https://sciwheel.com/work/citation?ids=8483008&pre=&suf=&sa=0); SHGs in India [(Joshi, Palaniswamy, and Rao 2015)](https://sciwheel.com/work/citation?ids=8482995&pre=&suf=&sa=0); the Saving for Change savings group program in Mali [(Baro et al. 2013; Beaman, Karlan, and Thuysbaert 2014)](https://sciwheel.com/work/citation?ids=8482994,7061335&pre=&pre=&suf=&suf=&sa=0,0); a study on the impact of switching from microcredit to SHG models in India [(Hoffmann et al. 2017)](https://sciwheel.com/work/citation?ids=7900659&pre=&suf=&sa=0); and combined models such as SHGs plus anti-violence against women modules [(Holden et al. 2016)](https://sciwheel.com/work/citation?ids=7061453&pre=&suf=&sa=0) group savings and microfinance plus family coaching [(Ismayilova et al. 2018)](https://sciwheel.com/work/citation?ids=7061338&pre=&suf=&sa=0).

Among programs that did and did not affect women’s decision-making, there was considerable overlap between the different programmatic models, locations, metrics used and initial levels of women’s decision-making power. Researchers did not consistently discuss what prevented livelihoods and financial groups from impacting women’s decision-making power. When they did so, the explanations they provided were not consistent across studies. In India, the lack of effect of microcredit dispensed through SHGs was attributed to the relatively short time horizon of the program evaluation [(Hoffmann et al. 2017)](https://sciwheel.com/work/citation?ids=7900659&pre=&suf=&sa=0). However, another microcredit program in India found no effects on women’s decision-making power three years after the program inception [(Banerjee et al. 2015)](https://sciwheel.com/work/citation?ids=7061357&pre=&suf=&sa=0). One study on savings groups in Mali found that the quantitative and qualitative evaluations produced discordant results. While there were no statistically significant results on women’s decision-making power in the quantitative analysis, the qualitative research pointed to some effects [(Baro et al. 2013)](https://sciwheel.com/work/citation?ids=8482994&pre=&suf=&sa=0). However, in another study of a program against IPV delivered through SHGs in India, both the quantitative and the qualitative evaluations concluded that there was a lack of an effect on women’s decision-making power and control over income: in this case, the authors suggested that this may have been due to male backlash [(Holden et al. 2016)](https://sciwheel.com/work/citation?ids=7061453&pre=&suf=&sa=0). The role of cultural factors in preventing increases in women’s decision-making power also emerged as a potential explanation in Burkina Faso. Here, women participating in group savings and microfinance integrated with family coaching may have wanted to maintain the perception of men’s role as main providers [(Ismayilova et al. 2018)](https://sciwheel.com/work/citation?ids=7061338&pre=&suf=&sa=0).

Taken together, this calls for further research to understand why some programs enhanced women’s decision-making and others did not. Measurement challenges may have contributed to the lack of a clear takeaway when it comes to decision-making. One study noted that the Demographic and Health Survey (DHS) decision-making modules researchers used were likely not fully capturing complex intra-household dynamics [(Ismayilova et al. 2018)](https://sciwheel.com/work/citation?ids=7061338&pre=&suf=&sa=0). Researchers who specialize in women’s economic empowerment frequently cite measurement challenges related to household decision-making, which raises the question of whether inconsistent impacts on decision-making indicators might be partially attributed to metrics construction [(Martinez-Restrepo and Ramos-Jaimes 2017; Diaz-Martin, Glennerster, and Walsh 2018)](https://sciwheel.com/work/citation?ids=7301702,7278880&pre=&pre=&suf=&suf=&sa=0,0). Measuring women’s decision-making power is part of the broader challenge of quantitatively capturing multifaceted concepts such as women’s agency and empowerment. Reassuringly, researchers can rely on recent methodological advances in future evaluations [(Alkire et al. 2013; Malapit et al. 2019; Ewerling et al. 2020; Maiorano et al. 2021; Jayachandran, Biradavolu, and Cooper 2021)](https://sciwheel.com/work/citation?ids=2564466,7292133,10685361,10685365,10685370&pre=&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&suf=&sa=0,0,0,0,0).

*Complementary interventions and non-economic outcomes*

Besides increasing access to financial resources, livelihoods and financial groups can be used to deliver complementary interventions such as training, leveraging groups’ economies of scale. Trainings offered through livelihoods and financial groups have covered a range of topics, like health education [(Flax et al. 2014; Hamad, Fernald, and Karlan 2011; Karlan, Thuysbaert, and Gray 2017; De La Cruz et al. 2009; Spielberg et al. 2013b)](https://sciwheel.com/work/citation?ids=2210338,8482985,7062047,8483033,8483019&pre=&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&suf=&sa=0,0,0,0,0), family coaching sessions [(Ismayilova et al. 2018; Annan et al. 2013)](https://sciwheel.com/work/citation?ids=7061338,8483014&pre=&pre=&suf=&suf=&sa=0,0), and gender transformative learning sessions [(Kim et al. 2007, 2009; Pronyk et al. 2006, 2008; Gupta et al. 2013; Jejeebhoy et al. 2017)](https://sciwheel.com/work/citation?ids=7061356,6069278,2882101,4413154,3842807,7061456&pre=&pre=&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&suf=&suf=&sa=0,0,0,0,0,0). Intentional program design that went beyond sole access to financial services was important for achieving moderate impacts in non-economic domains. Among the numerous non-economic impacts researchers measured, we here discuss in detail two widely-analyzed ones: “power within” and IPV.

Only livelihoods and financial groups with trainings and other add-on programming in addition to financial services measured “power within.” Often, the complementary programming had the explicit goal of supporting gender equality. The ability to generate changes in “power within” through complementary programming appears to be connected to the dosage, i.e., the number of content-related sessions implemented. Adding eight gender dialogue sessions to VSLAs in Côte d’Ivoire reduced the acceptance of wife-beating from 4 percent to 2.9 percent, particularly among couples with high attendance [(Gupta et al. 2013)](https://sciwheel.com/work/citation?ids=3842807&pre=&suf=&sa=0). However, this finding should be interpreted with caution since high-attendance couples might have characteristics that differentiate them from the other participants, and these could potentially explain the positive effects on attitudes. An evaluation of SHGs plus a series of 24 two-hour gender-transformative group learning sessions in India found that participants in the program were more likely to disagree with the notion that a husband has the right to exhibit controlling behavior over a wife or to reject the idea that women should be subservient to men [(Jejeebhoy et al. 2017)](https://sciwheel.com/work/citation?ids=7061456&pre=&suf=&sa=0). A study of the Gram Varta program in India, which contained twenty participatory health education sessions implemented in SHGs, had impacts on women’s self-confidence in refusing sexual intercourse and demanding a condom [(Subramanyam et al. 2017)](https://sciwheel.com/work/citation?ids=7061450&pre=&suf=&sa=0).

Meanwhile, three programs that did not have impacts on “power within” through intentional programming tended to implement fewer sessions. One program combined SHGs with a series of six sessions with content related to reducing violence against women in India but did not have impacts on attitudes about gender norms [(Holden et al. 2016)](https://sciwheel.com/work/citation?ids=7061453&pre=&suf=&sa=0). Another program in Burkina Faso, which consisted of group savings and microfinance plus family coaching delivered monthly over a period of five months, also did not find changes in beliefs about gender equality [(Ismayilova et al. 2018)](https://sciwheel.com/work/citation?ids=7061338&pre=&suf=&sa=0). The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) program, which combined microfinance with ten HIV and gender equity trainings and additional community mobilization activities in South Africa, did not change the percentage of women who disagreed with a series of six statements affirming traditional gender roles [(Kim et al. 2007; Pronyk et al. 2006)](https://sciwheel.com/work/citation?ids=7061356,2882101&pre=&pre=&suf=&suf=&sa=0,0).

Reducing violence against women only occurred when groups served as a platform for complementary interventions expressly aimed at reducing violence. The impacts were fairly large when achieved, but not all programs had impacts. The IMAGE program in South Africa introduced HIV and gender equity trainings along with community mobilization sessions into microcredit groups [(Kim et al. 2007, 2009; Pronyk et al. 2006, 2008)](https://sciwheel.com/work/citation?ids=7061356,6069278,2882101,4413154&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&sa=0,0,0,0). Two years after the completion of IMAGE, access to the program reduced IPV by more than half. Access to gender dialogue sessions on household and relationship dynamics within VLSAs in Côte d’Ivoire reduced economic abuse among women: the program reduced the odds of experiencing physical abuse by more than half among women who attended at least 75 percent of sessions relative to VSLA members who did not have access to the program [(Gupta et al. 2013)](https://sciwheel.com/work/citation?ids=3842807&pre=&suf=&sa=0). Married women in SHGs that implemented a gender-transformative group learning program in India, along with complementary programming engaging husbands, experienced a 27 percent reduction in physical violence [(Jejeebhoy et al. 2017)](https://sciwheel.com/work/citation?ids=7061456&pre=&suf=&sa=0). Nonetheless, women in the treatment group also experienced an 18 percent increase in emotional violence, from 76 to 90 percent, and engaging husbands did not lead to any additional impacts. Likewise, another study in India that focused on mobilizing SHGs to reduce violence against women, along with complementary programming aimed at engaging men, did not achieve any impacts [(Holden et al. 2016)](https://sciwheel.com/work/citation?ids=7061453&pre=&suf=&sa=0).

Overall, the evidence suggests that complementary programs only reduced IPV when they simultaneously improved non-economic outcomes like women’s decision-making power [(Jejeebhoy et al. 2017; Kim et al. 2007, 2009)](https://sciwheel.com/work/citation?ids=7061456,7061356,6069278&pre=&pre=&pre=&suf=&suf=&suf=&sa=0,0,0), social networks [(Jejeebhoy et al. 2017; Kim et al. 2007, 2009; Pronyk et al. 2006)](https://sciwheel.com/work/citation?ids=7061456,7061356,6069278,2882101&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&sa=0,0,0,0), and/or “power within” [(Jejeebhoy et al. 2017; Kim et al. 2007, 2009; Pronyk et al. 2006; Gupta et al. 2013)](https://sciwheel.com/work/citation?ids=7061456,7061356,6069278,2882101,3842807&pre=&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&suf=&sa=0,0,0,0,0). When complementary interventions failed to achieve changes in these non-economic areas, reductions in IPV were milder. Family coaching sessions integrated into livelihoods groups in Burundi increased women’s financial autonomy but did not change decision-making power or “power within” at the twelve-month follow-up survey. This led to a reduction in emotional forms of violence, but not in more severe forms like physical violence [(Ismayilova et al. 2018)](https://sciwheel.com/work/citation?ids=7061338&pre=&suf=&sa=0). Similarly, a program in India designed to mobilize women’s SHGs against violence against women did not change “power within,” household decision-making, or women’s mobility, and did not lead to a reduction in violence against women. Researchers posited that a lack of program fidelity or measurement error could explain the lack of results, in addition to the program alone being insufficient to change gender norms [(Holden et al. 2016)](https://sciwheel.com/work/citation?ids=7061453&pre=&suf=&sa=0).

### *Leveraging interactions among group members through livelihoods and financial groups*

There is strong evidence suggesting that livelihoods and financial groups encouraged the formation of social networks and/or leveraged existing social networks to support economic and non-economic outcomes. Studies that measured social networks found that they played a role in generating positive impacts for women, including but not limited to consumption and business creation [(Attanasio et al. 2015)](https://sciwheel.com/work/citation?ids=7061332&pre=&suf=&sa=0), risk-sharing [(Feigenberg, Field, and Pande 2013; Feigenberg et al. 2014)](https://sciwheel.com/work/citation?ids=7061324,7061394&pre=&pre=&suf=&suf=&sa=0,0), and political engagement [(Prillaman 2017)](https://sciwheel.com/work/citation?ids=7061443&pre=&suf=&sa=0). When social networks led to positive economic outcomes, researchers highlighted that social networks within groups helped enforce mutual accountability among group participants [(Attanasio et al. 2015; Feigenberg et al. 2014; Feigenberg, Field, and Pande 2013; Giné and Karlan 2014; Dupas and Robinson 2013)](https://sciwheel.com/work/citation?ids=7061332,7061394,7061324,8579827,7061413&pre=&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&suf=&sa=0,0,0,0,0). Other studies that measured social networks treated the networks as an outcome in their own right rather than a mechanism leading to additional impacts. Among these, two found evidence of increased social networks [(Jejeebhoy et al. 2017; Karlan, Thuysbaert, and Gray 2017)](https://sciwheel.com/work/citation?ids=7061456,7062047&pre=&pre=&suf=&suf=&sa=0,0), two provided only qualitative evidence not substantiated by quantitative findings (Bass et al. 2016; Kim et al. 2009), and two evaluating the same savings program did not find that it had an effect on social networks [(Baro et al. 2013; Beaman, Karlan, and Thuysbaert 2014)](https://sciwheel.com/work/citation?ids=8482994,7061335&pre=&pre=&suf=&suf=&sa=0,0).

One study directly tested the impact of group models by evaluating access to group versus individual microcredit programs in Mongolia. The study found that access to group loans increased the likelihood of a woman owning a business and had a moderate effect on food consumption, while access to individual loans had no impact on either of these outcomes. The positive economic outcomes were attributed to group dynamics that fostered mutual accountability, though social networks were not directly measured [(Attanasio et al. 2015)](https://sciwheel.com/work/citation?ids=7061332&pre=&suf=&sa=0). Two studies of a group microcredit program in India found that increasing the frequency of the groups’ meetings from monthly to weekly increased women’s social capital over the short and long term [(Feigenberg, Field, and Pande 2013; Feigenberg et al. 2014)](https://sciwheel.com/work/citation?ids=7061324,7061394&pre=&pre=&suf=&suf=&sa=0,0). More than a year after the end of the intervention, clients who had weekly meetings saw each other outside of group meetings 37 percent more often compared to clients who had monthly meetings—an increase from 5.5 to 7.5 interactions over the previous thirty days. More frequent meetings also led women to be more willing to engage in risk sharing with other group members [(Feigenberg, Field, and Pande 2013)](https://sciwheel.com/work/citation?ids=7061324&pre=&suf=&sa=0). This evidence suggests that finding ways to strengthen social relationships within groups may play a role in helping group members achieve positive economic results, and in some cases, meeting frequency may contribute [(Feigenberg, Field, and Pande 2013; Feigenberg et al. 2014)](https://sciwheel.com/work/citation?ids=7061324,7061394&pre=&pre=&suf=&suf=&sa=0,0).

Another study of microcredit in the Philippines found no significant difference in repayment rates between individual- and group-liability loan structures [(Giné and Karlan 2014)](https://sciwheel.com/work/citation?ids=8579827&pre=&suf=&sa=0). In centers with individual credit, loan repayments were still made in groups, suggesting that the peer pressure of repaying within groups may have been sufficient to sustain high repayments even without contractual group obligations. Across individual- and group-liability offerings, individuals with strong social networks had higher repayment rates, also highlighting the importance of social relationships. Nonetheless, it was not possible to disentangle whether social relationships activated peer pressure to repay, since researchers could not rule out whether individuals with stronger social networks were also more trustworthy and thus more likely to repay [(Giné and Karlan 2014)](https://sciwheel.com/work/citation?ids=8579827&pre=&suf=&sa=0).

Savings groups and VSLAs are also centered on the operating assumption that mutual accountability can be achieved through frequent meetings and peer enforcement. One study tested different informal savings methods to increase health investments (“piggybank”-style individual savings boxes that were either difficult or easy to access, ROSCAs, or health funds within ROSCAs). Researchers found that providing social pressure to make deposits in the ROSCA-setting increased health investments [(Dupas and Robinson 2013)](https://sciwheel.com/work/citation?ids=7061413&pre=&suf=&sa=0). Researchers described mutual accountability as an inherent feature of VSLAs in Malawi [(Ksoll et al. 2016)](https://sciwheel.com/work/citation?ids=7061340&pre=&suf=&sa=0) and savings groups in Mali [(Beaman, Karlan, and Thuysbaert 2014; Baro et al. 2013)](https://sciwheel.com/work/citation?ids=7061335,8482994&pre=&pre=&suf=&suf=&sa=0,0). One study found that savings groups can beneficially affect economic outcomes (savings) by generating change in time preferences [(Beaman, Karlan, and Thuysbaert 2014)](https://sciwheel.com/work/citation?ids=7061335&pre=&suf=&sa=0), a potential alternative channel for groups to lead to better self-discipline.

There is limited but consistent evidence that social networks formed in women’s SHGs increased women’s community and political participation in India, but evidence from other countries did not support this finding. Through a geographic regression discontinuity design, one study found that women who had access to networks of other women via SHGs were more likely to be politically active [(Prillaman 2017)](https://sciwheel.com/work/citation?ids=7061443&pre=&suf=&sa=0). The researcher found that this was a result of women leveraging the economic networks of SHGs to enhance their political coordination. The resulting gender-based coordination and mobilization, along with enhanced political knowledge, civic skills, and confidence, in turn, translated into higher political action of women. Another study found that women with access to SHGs were more likely to know where to express public grievances, had a higher willingness to act on public grievances related to drinking water, and reported greater satisfaction with the state of public services. Researchers implemented a public goods game and found that women in communities with SHGs exhibited greater cooperative behavior [(Desai and Joshi 2014)](https://sciwheel.com/work/citation?ids=8579375&pre=&suf=&sa=0).

However, it is unclear to what extent these results would generalize to other contexts. Access to financial groups did not lead to increased community mobilization in four other countries [(Beaman, Karlan, and Thuysbaert 2014; Karlan et al. 2017)](https://sciwheel.com/work/citation?ids=7061335,7061408&pre=&pre=&suf=&suf=&sa=0,0). A study of the Savings for Change savings group program in Mali found no impacts on women’s engagement in the community or voting behavior [(Beaman, Karlan, and Thuysbaert 2014)](https://sciwheel.com/work/citation?ids=7061335&pre=&suf=&sa=0). Likewise, a study of VSLAs in Ghana, Malawi, and Uganda did not find impacts on community participation [(Karlan et al. 2017)](https://sciwheel.com/work/citation?ids=7061408&pre=&suf=&sa=0). Yet, as outlined above, women in Benin assigned to receive access to microcredit and health education in women-only groups had higher social capital than women in mixed-gender groups (a metric that included some components of community mobilization, such as participation in local groups, village meetings, and influence in the village). Without further information regarding which part of the index drove the measured increases, it is possible that women with access to the women-only groups also exhibited greater political participation and influence in the village [(Karlan, Thuysbaert, and Gray 2017)](https://sciwheel.com/work/citation?ids=7062047&pre=&suf=&sa=0).

Several studies evaluated social networks as outcomes rather than mechanisms for achieving other outcomes. Researchers in Benin evaluated the impact of offering microfinance plus health education in either mixed gender or women-only groups and found that women in the mixed-gender groups had lower social capital after the intervention, measured through membership in local groups and support networks along with participation in village meetings and influence in the village [(Karlan, Thuysbaert, and Gray 2017)](https://sciwheel.com/work/citation?ids=7062047&pre=&suf=&sa=0). However, there were no differences according to an index measuring the number of people with whom women had financial relationships. Participation in SHGs plus gender-transformative group learning sessions in India increased women’s perceived social support, including friendships and having someone to turn to in times of trouble. The program also improved “power within,” decision-making authority, financial literacy, and reduced physical violence [(Jejeebhoy et al. 2017)](https://sciwheel.com/work/citation?ids=7061456&pre=&suf=&sa=0).

In the Democratic Republic of Congo, a VSLA program for sexual violence survivors did not increase women’s social ties or women’s participation in groups (Bass et al. 2016). Similarly, a group-based microfinance program in South Africa, when not combined with gender training, did not increase women’s ties in the community, measured through their social networks, their sense of community support, and their perception of solidarity during a crisis (Kim et al. 2009). These two studies that did not find impacts, however, identified qualitative evidence that social networks were strengthened in ways that were not measured or substantiated quantitatively (Bass et al. 2016; Kim et al. 2009).

Finally, two evaluations of the Savings for Change savings group program in Mali found that women did not report improved social capital as a result of access to the groups [(Beaman, Karlan, and Thuysbaert 2014; Baro et al. 2013)](https://sciwheel.com/work/citation?ids=7061335,8482994&pre=&pre=&suf=&suf=&sa=0,0). By and large, while many papers discuss social networks as an outcome or critical mechanism of economic and livelihoods groups, more research is needed to understand how to trigger social network effects for positive results.

## ***Health Groups***

Reducing maternal and child mortality and morbidity is a policy priority in most low- and middle-income countries. Most maternal and neonatal deaths occur in poorer communities, often as a consequence of complications that would be preventable with appropriate health practices within the home and basic health care usage [(World Health Organization 2018)](https://sciwheel.com/work/citation?ids=7290344&pre=&suf=&sa=0). According to the World Health Organization (WHO), lack of information on how to access health facilities and lack of knowledge of danger signs during pregnancy are factors that prevent women from seeking care around childbirth in low-income countries.

Women’s health groups aim to address this public health priority by conveying health-related information. In settings with weak local health care systems, health groups may also create fruitful synergies between the demand side (patients) and supply side (providers) of health care, through community-based monitoring of health providers. In doing so, health groups may lead to additional benefits outside their core function, for example, by stimulating community mobilization and collective action at the local level.

### *Leveraging health groups as a platform for intervention delivery*

Health groups were an effective platform to convey health-related information. The majority of health group interventions analyzed in this review focused on providing information on maternal and newborn health. Through participatory learning facilitated by local women or trained local health workers, group gatherings delivered information related to healthy behaviors around birth and encouraged access to health care for antenatal visits and delivery. Health information was also disseminated by leveraging existing livelihood groups, whose original purpose was not related to health, or delivered to adolescents through in-school peer-support groups or health promotion curricula.

When tested, participants’ health knowledge generally increased as a result of access to health information through groups. Studies find increased knowledge on correct key infant feeding practices [(Flax et al. 2014)](https://sciwheel.com/work/citation?ids=2210338&pre=&suf=&sa=0), on danger signs of diarrhea and dietary modifications for children with diarrhea [(Hamad, Fernald, and Karlan 2011)](https://sciwheel.com/work/citation?ids=8482985&pre=&suf=&sa=0), on malaria [(De La Cruz et al. 2009)](https://sciwheel.com/work/citation?ids=8483033&pre=&suf=&sa=0), on physical health issues [(Leventhal et al. 2016)](https://sciwheel.com/work/citation?ids=4059023&pre=&suf=&sa=0), and on HIV [(Spielberg et al. 2013a)](https://sciwheel.com/work/citation?ids=7061334&pre=&suf=&sa=0). However, one study found that participatory learning through SHGs had mixed effects on knowledge related to nutrition, diseases, domestic hygiene, sanitation, sexuality, and contraception [(Subramanyam et al. 2017)](https://sciwheel.com/work/citation?ids=7061450&pre=&suf=&sa=0). The program increased women’s contraception use but appeared not to improve adolescent girls’ knowledge about sexuality and contraception. Surprisingly, the program seemed to adversely affect knowledge about domestic hygiene practices.

Though encouraging health care usage was often one of the purposes of women’s health groups, there is mixed evidence on the effectiveness of groups in increasing access to formal health care. In India, a program combining mothers’ groups with home visits had an overall positive impact on accessing health care for antenatal care and delivery [(Acharya et al. 2015)](https://sciwheel.com/work/citation?ids=7919341&pre=&suf=&sa=0). In Pakistan, antenatal care promotion and maternal health education through groups increased women’s contact with lady health workers during pregnancy by 18 percentage points (relative to a comparison group average of 26 percent) and institutional delivery by 10 percentage points (relative to a comparison group average of 44 percent), but not antenatal checkups in a health facility [(Bhutta et al. 2011)](https://sciwheel.com/work/citation?ids=539038&pre=&suf=&sa=0). In Nepal, women’s groups promoting maternal and child health increased the likelihood of receiving antenatal care, visiting a health facility in event of illness, and delivering in a facility, although this effect did not translate into increased agency for health-seeking in the long run [(Manandhar et al. 2004; Gram, Morrison, et al. 2018)](https://sciwheel.com/work/citation?ids=180263,7061452&pre=&pre=&suf=&suf=&sa=0,0). In Nepal, women’s groups had large effects on antenatal care attendance but did not increase institutional delivery [(Sharma et al. 2016)](https://sciwheel.com/work/citation?ids=8482986&pre=&suf=&sa=0). Women’s groups were successful in increasing antenatal care attendance in rural Nepal for women who, at baseline, did not adhere to best health practices [(Wade et al. 2006)](https://sciwheel.com/work/citation?ids=436021&pre=&suf=&sa=0).

However, in several other studies focusing on health groups, increases in health care utilization were not achieved. Most studies evaluated intention-to-treat effects using aggregate data at the administrative-unit level. In some cases, researchers attributed the lack of a positive effect to low group participation. This occurred due to low population coverage (i.e., a small number of groups per community), and/or contextual factors preventing women from attending group meetings, like social norms or climatic conditions. An intervention in Bangladesh, where only nine percent of women of reproductive age were group members at endline, did not affect health care usage around birth [(Azad et al. 2010)](https://sciwheel.com/work/citation?ids=5990870&pre=&suf=&sa=0). A similar study in Malawi, where only ten percent of newly pregnant women attended the groups, did not find effects on institutional delivery [(Colbourn et al. 2013)](https://sciwheel.com/work/citation?ids=3278255&pre=&suf=&sa=0). Women’s groups did not affect antenatal care, institutional deliveries, or postnatal checks in urban India, where population estimates revealed that groups reached only eight percent of reproductive-age women [(More et al. 2012)](https://sciwheel.com/work/citation?ids=7919533&pre=&suf=&sa=0). Yet, a lack of significant effects on health care usage occurred also when interventions achieved higher participation. This was the case in two participatory women’s group programs or participatory learning through SHGs in India [(Tripathy et al. 2010; Houweling et al. 2013; Tripathy et al. 2016; Subramanyam et al. 2017)](https://sciwheel.com/work/citation?ids=743370,8482987,8483000,7061450&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&sa=0,0,0,0), in women’s groups in Bangladesh [(Fottrell et al. 2013)](https://sciwheel.com/work/citation?ids=8482997&pre=&suf=&sa=0), and in a malaria education intervention in Ghana delivered through microfinance groups [(De La Cruz et al. 2009)](https://sciwheel.com/work/citation?ids=8483033&pre=&suf=&sa=0).

There is more promising evidence of information delivered through health groups leading to better health practices and behaviors within the home, as opposed to increased access to health care.In groups where the focus was maternal and child health, researchers measured changes in health behaviors in home-care practices like hygiene during home delivery and best practices with the newborn (thermal care and breastfeeding). A women’s group intervention in India increased the likelihood of exclusive breastfeeding for the first six months after delivery, delaying the newborn’s first bath, and being attended by a delivery assistant who washed hands, used a clean new blade to cut the newborn umbilical cord, and applied nothing on the umbilical cord stump [(Acharya et al. 2015)](https://sciwheel.com/work/citation?ids=7919341&pre=&suf=&sa=0). Positive effects on similar delivery and newborn practices were achieved in other women’s group interventions in India [(Kumar et al. 2008; Roy et al. 2013; Tripathy et al. 2016; Nair et al. 2017)](https://sciwheel.com/work/citation?ids=5990909,7920435,8483000,4456711&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&sa=0,0,0,0), Bangladesh [(Baqui et al. 2008; Fottrell et al. 2013)](https://sciwheel.com/work/citation?ids=7919755,8482997&pre=&pre=&suf=&suf=&sa=0,0), Pakistan [(Bhutta et al. 2011)](https://sciwheel.com/work/citation?ids=539038&pre=&suf=&sa=0), and Nepal [(Wade et al. 2006)](https://sciwheel.com/work/citation?ids=436021&pre=&suf=&sa=0). Other interventions achieved significant effects in some, but not all, home-care practices that researchers measured [(Tripathy et al. 2010; Houweling et al. 2013; Manandhar et al. 2004)](https://sciwheel.com/work/citation?ids=743370,8482987,180263&pre=&pre=&pre=&suf=&suf=&suf=&sa=0,0,0).

In turn, teaching better health practices within the home generated positive effects on health, including saving women’s and children’s lives. The majority of health groups had large impacts on at least one primary health outcome. In line with the content of health groups, the most investigated outcomes were neonatal mortality and, to a lesser extent, maternal mortality and morbidity. Researchers found that women’s groups were effective in reducing neonatal or infant mortality in many contexts, including India [(Tripathy et al. 2010, 2016; Kumar et al. 2008; Roy et al. 2013)](https://sciwheel.com/work/citation?ids=743370,8483000,5990909,7920435&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&sa=0,0,0,0), Nepal [(Manandhar et al. 2004)](https://sciwheel.com/work/citation?ids=180263&pre=&suf=&sa=0), Pakistan [(Bhutta et al. 2011)](https://sciwheel.com/work/citation?ids=539038&pre=&suf=&sa=0), Bangladesh [(Fottrell et al. 2013)](https://sciwheel.com/work/citation?ids=8482997&pre=&suf=&sa=0), and Malawi [(Colbourn et al. 2013)](https://sciwheel.com/work/citation?ids=3278255&pre=&suf=&sa=0). These effects were often large in magnitude: for example, women’s groups decreased neonatal mortality by 38 percent in Bangladesh, compared to the neonatal mortality rate in comparison areas of 30 deaths per 1000 live births [(Fottrell et al. 2013)](https://sciwheel.com/work/citation?ids=8482997&pre=&suf=&sa=0). A systematic review and meta-analysis analyzing studies conducted in Bangladesh, India, Malawi, and Nepal found a 20 percent reduction in neonatal mortality [(Prost et al. 2013)](https://sciwheel.com/work/citation?ids=743288&pre=&suf=&sa=0).

Other studies found mixed results. A study on women’s groups in India identified an effect on maternal morbidity (defined as complications during pregnancy, labor, delivery, and postpartum) but not on neonatal mortality [(Acharya et al. 2015)](https://sciwheel.com/work/citation?ids=7919341&pre=&suf=&sa=0). A study in Bangladesh, which analyzed the impact of women’s groups separately from the impact of home visits, found that only home visits were successful in reducing neonatal mortality [(Baqui et al. 2008)](https://sciwheel.com/work/citation?ids=7919755&pre=&suf=&sa=0). In Guinea-Bissau, women’s groups reduced maternal mortality but had no effect on under-5 mortality [(Boone et al. 2016)](https://sciwheel.com/work/citation?ids=7919189&pre=&suf=&sa=0).

Taken together, these results suggest that women’s groups may be an effective way to encourage easily-adoptable health behaviors within the home that, in turn, can lead to sizable impacts on health. High participation in group meetings was an important factor to achieve positive health effects.

When group-based interventions intended to reduce depression, researchers evaluated effects on mental health outcomes. Group interpersonal psychotherapy in rural Uganda decreased depression and dysfunction [(Bolton et al. 2003)](https://sciwheel.com/work/citation?ids=743031&pre=&suf=&sa=0), group counseling in Tanzania delivered in a psychosocial support group reduced depression [(Kaaya et al. 2013)](https://sciwheel.com/work/citation?ids=4140398&pre=&suf=&sa=0), while one study in Bangladesh evaluating participatory women’s groups did not find effects on mothers’ postpartum psychological distress [(Clarke et al. 2014)](https://sciwheel.com/work/citation?ids=4268187&pre=&suf=&sa=0).

### *Leveraging interactions among group members through health groups*

In settings with weak local health care systems, health groups may create constructive synergies between the demand side and supply of health care through community-based monitoring of health providers. Interventions delivered through health groups may leverage the group structure to stimulate community mobilization and collective action at the local level. Given their collective nature, these mechanisms are inherently related to groups and could not be harnessed through health interventions delivered at the individual level. Yet, we identified mixed evidence regarding the ability of health groups to increase collective action and community mobilization.

Two studies of health care system monitoring programs found that they were effective in increasing group members’ community mobilization and engagement in health care delivery [(Bjorkman and Svensson 2009; Gullo et al. 2018)](https://sciwheel.com/work/citation?ids=8483029,7461185&pre=&pre=&suf=&suf=&sa=0,0). In Malawi, a health monitoring intervention found that women who actively participated in the program experienced improvements in an index measuring participation in various types of community groups [(Gullo et al. 2018)](https://sciwheel.com/work/citation?ids=7461185&pre=&suf=&sa=0). The intervention facilitated the formation of interactive local groups where women from the community could discuss issues related to maternal and newborn health with health workers and government officials. The intervention was also associated with improvements in perceptions about the quality and equity of negotiated spaces. However, there was no effect on collective efficacy, which measured women’s confidence in how well community members and health workers could come together to bring about change. Similarly, a study in Uganda found that a community health monitoring program enabled community members to act collectively to hold health service providers accountable. The intervention consisted of a series of meetings where focus group discussions ensured that women and members from other marginalized groups had the opportunity to voice their concerns [(Bjorkman and Svensson 2009)](https://sciwheel.com/work/citation?ids=8483029&pre=&suf=&sa=0).

In other cases, health groups were not successful in generating a base for collective action. A health promotion curriculum for adolescents in Tanzania, while positively affecting adolescent’s self-efficacy and deliberative efficacy on HIV-related topics, did not positively impact collective efficacy at the neighborhood level [(Carlson, Brennan, and Earls 2012)](https://sciwheel.com/work/citation?ids=7061348&pre=&suf=&sa=0). Another study anecdotally highlighted the difficulty of achieving collective action through health groups in India. While women were generally open to acquiring new information, they seemed less willing to engage in collective action [(More et al. 2012)](https://sciwheel.com/work/citation?ids=7919533&pre=&suf=&sa=0).

Three studies suggest that community monitoring health groups can increase women’s involvement in the community, though the effects were not sustained in the long term in one case. A health community monitoring intervention in Malawi increased women’s participation in various types of community groups [(Gullo et al. 2018)](https://sciwheel.com/work/citation?ids=7461185&pre=&suf=&sa=0). Another study of a participatory learning and action program in Nepal found that the presence of health groups increased women’s participation in groups unrelated to the intervention [(Gram, Morrison, et al. 2018)](https://sciwheel.com/work/citation?ids=7061452&pre=&suf=&sa=0). However, another study of a similar intervention in Nepal did not find similar effects in the long run: when resurveyed after more than ten years, women residing in clusters originally assigned to treatment were not more likely to participate in groups [(Gram, Skordis-Worrall, et al. 2018)](https://sciwheel.com/work/citation?ids=7061451&pre=&suf=&sa=0). These results should be interpreted with caution, as the authors mention low statistical power among the limitations of their study. In India, there was some suggestive evidence that participatory learning and action through SHGs increased women’s involvement in the community, measured through the probability of being acquainted with health staff and other officials. However, these results were not statistically significant when including control variables, and there was no effect on other indicators of community and political engagement, such as voting or attendance to public meetings [(Subramanyam et al. 2017)](https://sciwheel.com/work/citation?ids=7061450&pre=&suf=&sa=0).

Despite this evidence, researchers did not investigate to what extent social networks and moral support were crucial mechanisms that made health groups effective in achieving positive outcomes. One study in India highlighted that women’s existing social networks helped extend the beneficial effects of health groups to the rest of the community. Women shared the health knowledge acquired in group meetings with non-participant women belonging to their social network. This, in turn, increased immunization in the whole community (Janssens 2011). However, it is unclear whether spillovers occurred due to the group nature of the intervention or whether information delivered individually (e.g., through home visits) would have generated similar benefits. Some researchers argued that, in a group counseling intervention in Tanzania, both social networks and moral support by members of the networks might have been important pathways to achieve mental health impacts, but evidence on this was only anecdotal and not based on systematic or rigorous evidence [(Kaaya et al. 2013)](https://sciwheel.com/work/citation?ids=4140398&pre=&suf=&sa=0). Future research efforts should quantitatively explore whether social networks and moral support operate as mechanisms within health groups.

## ***Adolescent Groups***

Targeting group programs towards adolescents is important given the unique set of challenges that adolescent girls face. Adolescent girls are at a juncture in their lives where they are at risk for early marriage and pregnancy, which can potentially increase dependence on men [(Dupas 2011)](https://sciwheel.com/work/citation?ids=3794285&pre=&suf=&sa=0). Teen pregnancy and early marriage are also likely to hinder girls’ human capital investment and future participation in the labor force [(Field and Ambrus 2008; Bruce and Hallman 2008)](https://sciwheel.com/work/citation?ids=7656780,8483035&pre=&pre=&suf=&suf=&sa=0,0). Given all these factors, interventions targeted at girls during this crucial period in their lives may have greater returns than interventions later in their lives [(Heckman and Mosso 2014)](https://sciwheel.com/work/citation?ids=8483036&pre=&suf=&sa=0).

Most adolescent group programs we analyze in this section aim to provide young girls access to a safe space where they can meet and interact with other girls in their age group. Apart from enabling access to peer networks and providing a safe-space, adolescent groups have served as a platform for delivering hard and soft skills training programs. The Empowerment and Livelihoods for Adolescents (ELA) program implemented by the NGO BRAC, for example, provides vocational and life skills trainings to young girls to increase their economic status and personal agency. This program has been evaluated in several contexts, including Uganda, South Sudan, Sierra Leone, and Tanzania. Other safe space programs for adolescents have included life skills and negotiation skills trainings to improve socio-economic outcomes for adolescent girls.

### *Leveraging adolescent groups as a platform for intervention delivery*

Adolescent group programs, which often served as a platform to deliver hard and soft skills trainings to girls, consistently led to economic gains or increased school enrollment. Improvements in girls’ soft and life skills appeared to be an important part of this process. Studies conducted in Uganda [(Bandiera et al. 2020)](https://sciwheel.com/work/citation?ids=7999358&pre=&suf=&sa=0), Bangladesh [(Buchmann et al. 2018)](https://sciwheel.com/work/citation?ids=7061458&pre=&suf=&sa=0), and South Sudan [(Buehren, Chakravarty, et al. 2017)](https://sciwheel.com/work/citation?ids=7061375&pre=&suf=&sa=0), found that safe-space programs for adolescents, when bundled with skills training programs, were associated with better economic outcomes. However, since soft skills trainings were often combined with hard skills trainings, it is difficult to disentangle the precise cause of the increase in income-generating activities.

In Uganda, the ELA program led to a large increase in the likelihood of engaging in income-generating activities [(Bandiera et al. 2020)](https://sciwheel.com/work/citation?ids=7999358&pre=&suf=&sa=0). In South Sudan, the impacts of the ELA program were limited to geographic areas that were unaffected by conflict [(Buehren, Chakravarty, et al. 2017)](https://sciwheel.com/work/citation?ids=7061375&pre=&suf=&sa=0). This finding suggests that more specific programming might be necessary in conflict-affected regions to bring about desired outcomes on income-generating activities [(Buehren, Chakravarty, et al. 2017)](https://sciwheel.com/work/citation?ids=7061375&pre=&suf=&sa=0). In Bangladesh, an empowerment training program increased the likelihood of adolescent girls being engaged in income-generating work by 21 percentage points compared to a mean of 26 percent in the control group [(Buchmann et al. 2018)](https://sciwheel.com/work/citation?ids=7061458&pre=&suf=&sa=0). This empowerment program, called *Kishoree Kontha*, occurred in a safe space setting and provided educational support and social competency training to adolescent girls. On the other hand, an evaluation of the ELA program in Tanzania did not find that the safe space program combined with skills training affected economic outcomes. Qualitative comparisons between this study and the others suggested that the lack of impacts could be attributed to implementation challenges [(Buehren, Goldstein, et al. 2017)](https://sciwheel.com/work/citation?ids=7061358&pre=&suf=&sa=0). Despite this, adding a microfinance component to the adolescent safe space programs increased the likelihood of girls having savings at informal institutions (ROSCAs) in this same setting.

Results from two studies show that training programs delivered in safe spaces can lead to increases in education outcomes. In Zambia, negotiation training in after-school safe spaces for adolescents led to a ten percent increase in school enrollment in grades after the transition to secondary school (10th and 11th grade) [(Ashraf et al. 2020)](https://sciwheel.com/work/citation?ids=7061401&pre=&suf=&sa=0). In Bangladesh, *Kishoree Kontha* increased the likelihood of being in school for girls aged 15, but not for older girls [(Buchmann et al. 2018)](https://sciwheel.com/work/citation?ids=7061458&pre=&suf=&sa=0).

Soft and life skills training programs delivered in adolescent groups led to increases in “power within” among adolescent girls in most programs that measured it. However, future research should determine whether these impacts can persist in the long term and whether they can occur in areas disrupted by conflict or disease. The evaluations that measured “power within” most consistently treated it as a direct outcome of the skills training programs. An evaluation of the *Kishoree Kontha* program found that it increased adolescent girls’ developmental assets such as truth-telling, seeking advice from parents, and good time use [(Scales et al. 2013)](https://sciwheel.com/work/citation?ids=7061397&pre=&suf=&sa=0). Another evaluation of the *Kishoree Kontha* program found a marginally significant long-term impact on an empowerment index measuring gender attitudes, mobility, contraception, and decision-making power for girls who were 10 to 17 years old at program launch [(Buchmann et al. 2018)](https://sciwheel.com/work/citation?ids=7061458&pre=&suf=&sa=0). For the subsample of older girls who were 15 to 17 years old, the long-term impact on the empowerment index, while large, was not statistically significant. The Girl Empower program in Liberia, a safe space program that provided life skills training to girls aged 13-14, improved girls’ attitudes about gender equity and IPV [(Özler et al. 2020)](https://sciwheel.com/work/citation?ids=8047845&pre=&suf=&sa=0).

In India, a program that delivered a psychosocial training intervention based on a resilience curriculum improved adolescent girls’ emotional resilience, self-efficacy, and social-emotional assets. The intervention also reduced anxiety and improved psychosocial wellbeing. However, it did not have a detectable effect on depression. Researchers noted that this study did not include follow-up surveys at different time points and therefore, it is not certain if the effects of the intervention were sustained in the long term. Additional qualitative work indicated that improvements in psychosocial assets could potentially enable girls to advocate for themselves to stop early marriage, stay in school, and achieve their goals [(Leventhal et al. 2015)](https://sciwheel.com/work/citation?ids=7061349&pre=&suf=&sa=0). In a refugee camp in Ethiopia, a safe space and life skills program to combat IPV improved girls’ attitudes regarding rites of passage, such as beliefs about the highest grade girls should complete in school, the acceptability of girls to work outside the home after marriage, and the appropriate age for marriage and having children. Girls who received the program also had greater odds of believing a girl should get married and have her first child after age 18 [(Stark et al. 2018)](https://sciwheel.com/work/citation?ids=7061326&pre=&suf=&sa=0).

Studies of the ELA programs found impacts on “power within” in some contexts. In Uganda, the ELA program had long-lasting effects on girls’ views of the ideal age of marriage and the most suitable age to start childbearing for women. However, it is not entirely clear if impacts on all aspects of “power within” can be sustained in the long-term: the effects of ELA on most other aspirations-related outcomes, including questions about gender roles and duties, were most prominent two years after the intervention but seemed to fade out after four years [(Bandiera et al. 2020)](https://sciwheel.com/work/citation?ids=7999358&pre=&suf=&sa=0). In Tanzania, girls who received the ELA program along with a microfinance component experienced a marginally significant increase in perceptions about gender roles [(Buehren, Goldstein, et al. 2017)](https://sciwheel.com/work/citation?ids=7061358&pre=&suf=&sa=0). The ELA program in Sierra Leone led to sizable improvements in attitudes towards gender norms, measured through an empowerment index capturing girls’ opinions on the division of roles between men and women within the household. However, a positive effect occurred only in areas least affected by the Ebola virus and was marginally significant only for younger girls, i.e. those who were between 12 and 17 years old at baseline [(Bandiera et al. 2019)](https://sciwheel.com/work/citation?ids=7061430&pre=&suf=&sa=0). In conflict-affected South Sudan, researchers evaluating the ELA program failed to find impacts on “power within,” and even found negative effects on perceptions about gender roles [(Buehren, Chakravarty, et al. 2017)](https://sciwheel.com/work/citation?ids=7061375&pre=&suf=&sa=0).

Despite a lack of impacts on “power within,” two safe-space programs combined with skills training helped mitigate, to some extent, the adverse effects of an external shock on school enrollment and other outcomes. In Sierra Leone, the ELA program coincided with the 2014 Ebola outbreak. The Ebola-related disruption caused an overall increase in adolescent out-of-wedlock pregnancy, which may have occurred because of the increased time girls spent around men. This impact on out-of-wedlock pregnancy was completely reversed in highly-disrupted areas that were assigned to the ELA program [(Bandiera et al. 2019)](https://sciwheel.com/work/citation?ids=7061430&pre=&suf=&sa=0). Similarly, girls in communities highly affected by Ebola who did not have access to ELA clubs experienced a 16 percentage point drop in enrollment from a 51.9 percent average at baseline. In the treatment group, however, this drop was halved to an 8.1 percentage point fall [(Bandiera et al. 2019)](https://sciwheel.com/work/citation?ids=7061430&pre=&suf=&sa=0). Access to the ELA program allowed girls to combine school and work and reduced the likelihood for girls to focus exclusively on income generation in areas severely affected by Ebola. However, these effects were not observed in areas of Sierra Leone less affected by Ebola, and the reason for this somewhat puzzling pattern is unclear.

In South Sudan, a safe-space program offering skills training helped mitigate the negative effects of conflict on school enrollment. Conflict-affected areas that did not receive the program experienced a 6.8 percentage point decrease in girls’ school enrollment, while in conflict-affected treatment areas, this negative effect seemed to be partially mitigated [(Buehren, Chakravarty, et al. 2017)](https://sciwheel.com/work/citation?ids=7061375&pre=&suf=&sa=0).

Adolescent group programs had limited impacts on unwanted sex and IPV. The ELA program in Uganda decreased the share of girls who reported unwanted sex, but the same program did not achieve similar impacts in Sierra Leone, Tanzania, or South Sudan [(Bandiera et al. 2020; Buehren, Goldstein, et al. 2017; Buehren, Chakravarty, et al. 2017; Bandiera et al. 2019)](https://sciwheel.com/work/citation?ids=7999358,7061358,7061375,7061430&pre=&pre=&pre=&pre=&suf=&suf=&suf=&suf=&sa=0,0,0,0). One study in Bangladesh measuring the impact of a safe-space program combined with a training program for communication and negotiation skills found that it decreased the risk of physical IPV among young women between the ages 15 and 19 who received the curriculum in mixed gender groups [(Naved et al. 2018)](https://sciwheel.com/work/citation?ids=7061342&pre=&suf=&sa=0). The Girl Empower safe-space program in Liberia did not reduce sexual violence, despite the positive impacts on girls’ “power within” outlined above [(Özler et al. 2020)](https://sciwheel.com/work/citation?ids=8047845&pre=&suf=&sa=0)

Adolescent groups had mixed impacts on life cycle choices and changes, such as marriage, contraceptive use, and pregnancy. Qualitative analysis of the *Kishoree Kontha* program revealed that the impact of empowerment programs for girls may be confined to domains in which they are able to exert agency. Providing adolescent girls tools for negotiation through training programs seemed to have been an effective strategy to help them overcome barriers related to income-generating activities, but not other areas like marriage or pregnancy. *Kishoree Kontha* did not lead to any changes in rates of early marriage, although this was one of the goals of the program [(Buchmann et al. 2018)](https://sciwheel.com/work/citation?ids=7061458&pre=&suf=&sa=0).

Other studies, however, did find effects on reported rates of early marriage. In Ethiopia, a life skills and safe space program for refugee girls between ages 13 and 19 was associated with a decrease in self-reported child marriage among girls who were married at baseline. However, the reason for this is unclear; it could be due to actual changes in marital status or under-reporting caused by social desirability bias [(Stark et al. 2018)](https://sciwheel.com/work/citation?ids=7061326&pre=&suf=&sa=0). In Uganda, while marriage rates for adolescent girls in the comparison group rose between baseline and follow-up, this effect was almost entirely prevented among girls who received the ELA program, and there was a reduction in adolescent pregnancy [(Bandiera et al. 2020)](https://sciwheel.com/work/citation?ids=7999358&pre=&suf=&sa=0). Likewise, the ELA program in Sierra Leone reversed the increase in pregnancy rates caused by the Ebola outbreak and increased older girls’ and women’s use of non-condom contraceptives [(Bandiera et al. 2019)](https://sciwheel.com/work/citation?ids=7061430&pre=&suf=&sa=0).

### *Leveraging interactions among group members through adolescent groups*

Group meetings alone, even without additional programming, may have offered minor benefits to girls. However, more research is necessary to disentangle the role of programmatic components from that of the safe space alone. Only one study in Zambia separately identified the effects of the safe space program from the effects of the negotiation training embedded within the safe space program. Although the effects of the safe space on school enrollment were never statistically different from zero, researchers could not statistically reject that the safe space and negotiation treatments had the same positive effect on average [(Ashraf et al. 2020)](https://sciwheel.com/work/citation?ids=7061401&pre=&suf=&sa=0). Another study on the ELA program in Uganda found that while the life skills training was an important mediator of economic empowerment, a portion of the effect still remained unexplained. Researchers attributed part of the effect to the safe space itself, although they did not test this directly [(Bandiera et al. 2020)](https://sciwheel.com/work/citation?ids=7999358&pre=&suf=&sa=0).

Evidence from five studies suggests that safe-space programs can strengthen adolescent girls’ social networks. However, it is unclear to what extent these findings hold in areas affected by conflict or an epidemic. The ELA program in South Sudan increased girls’ likelihood to have a place in their community, other than home or school, where they could meet other girls, but only in communities unaffected by the conflict [(Buehren, Goldstein, et al. 2017)](https://sciwheel.com/work/citation?ids=7061358&pre=&suf=&sa=0). The ELA clubs in Sierra Leone shifted girls’ leisure time away from spending time alone, with men, other friends, or volunteering. Additional findings revealed that the program helped protect girls’ social ties that were disrupted by the Ebola outbreak. In highly-disrupted villages, the program curbed the loss of business and credit ties, friendship ties for younger girls, and ties for discussing intimate topics for older girls [(Bandiera et al. 2019)](https://sciwheel.com/work/citation?ids=7061430&pre=&suf=&sa=0). In Tanzania, the ELA program increased the likelihood of girls talking to their friends about business only when a microfinance component was added to the safe space program (Buehren, Goldstein, et al. 2017). Finally, a study in a refugee camp in Ethiopia found that a safe space and life skills program strengthened social networks. Girls in the intervention were more likely to report having friends their own age and having a trusted non-family adult in their life. However, social network strengthening did not lead to the desired decrease in IPV [(Stark et al. 2018)](https://sciwheel.com/work/citation?ids=7061326&pre=&suf=&sa=0).

# **Concluding Remarks: Overarching Lessons and Open Questions**

In this review, we found that women’s groups had positive impacts on women’s economic and broader lives by operating as a platform for providing access to information and services, such as financial services and skills trainings, for several women at one time and place. This was the most consistent finding regarding mechanisms operating within groups. Leveraging groups as a platform for intervention delivery may come with substantial economies of scale when the groups already exist. For example, a study on the Jeevika program in India documented that scaling up SHGs from 8 thousand to 5.7 million beneficiaries reduced the per-capita cost of the program from $37 to $13 [(Siwach, Paul, and de Hoop 2020)](https://sciwheel.com/work/citation?ids=10754403&pre=&suf=&sa=0). However, if an intervention requires forming new groups, then high start-up costs could compromise cost-effectiveness. In addition, taking into consideration the costs associated with women’s time and effort to coordinate a mutually feasible time to meet will be critical to have a more comprehensive understanding of the cost-effectiveness of this model.

More comprehensive data on costs and alternative research designs can help clarify the extent to which groups may be preferable to individually-focused approaches to intervention delivery. The need to shed light on whether or not groups are more cost-effective than individual-based models has also been advocated in a recent commentary on women’s groups in India [(Raghunathan and Desai 2021)](https://sciwheel.com/work/citation?ids=10778368&pre=&suf=&sa=0). The studies we analyzed in this review did not explicitly investigate how the costs and benefits of group models compare to those of similar interventions delivered outside groups. An exception is a recent study in India which found that delivering nutritional information through groups had similar impacts to delivering information through home visits, but the group model entailed considerably lower costs and was thus more cost-effective [(Grantham-McGregor et al. 2020)](https://sciwheel.com/work/citation?ids=10686486&pre=&suf=&sa=0). Understanding whether this finding applies to other contexts, services delivered, and group types is a promising avenue for future research.

Intentional program design was important for having impacts outside the core function of the group. For example, effects on IPV occurred when livelihoods groups served as a platform for complementary interventions expressly aimed at changing this outcome. Researchers assessed changes in “power within” only in evaluations of explicit empowerment programming whose content aimed at changing attitudes or aspirations, but the evidence was mixed. The success of these programs in changing “power within” appeared to be sensitive to dosage and context: programs were ineffective when they implemented small numbers of sessions or in disease or conflict settings. Complementary programming within women’s groups may affect the cost-effectiveness and delivery of programs at scale. Therefore, viability for scaling these models should be investigated further. Besides cost-effectiveness, open questions remain on the optimal way of bundling multiple interventions within women’s groups or aligning groups with complementary community programming.

Our review finds that the key benefit of using groups — or at least the one backed by quantitative evidence — is economies of scale, not social connections and team spirit, which is another hypothesized benefit. That said, studies discussed in this review show that, to some extent, women’s groups can leverage interactions among members to bring about change. While not uniformly reported in the studies, evidence suggested that women’s groups served to strengthen or leverage social networks to catalyze political participation [(Prillaman 2017)](https://sciwheel.com/work/citation?ids=7061443&pre=&suf=&sa=0), increase risk-sharing [(Feigenberg, Field, and Pande 2013; Feigenberg et al. 2014)](https://sciwheel.com/work/citation?ids=7061324,7061394&pre=&pre=&suf=&suf=&sa=0,0), and reduce the amount of time that adolescents spent in risky settings [(Bandiera et al. 2019)](https://sciwheel.com/work/citation?ids=7061430&pre=&suf=&sa=0). Despite this promising evidence, how to leverage social networks for specific impacts remains an open question.

In our analysis of the literature, there is suggestive evidence that groups build moral support, one of the pathways through which social networks may operate. Evidence outside of group-based interventions highlights that moral support might be an important mechanism to achieve positive outcomes. A business training program study identified improved business outcomes when women attended the training with a friend compared to attending the training without a friend, and the researchers determined that peer support was a primary mechanism for the improved outcomes [(Field et al. 2016)](https://sciwheel.com/work/citation?ids=7300118&pre=&suf=&sa=0). Another study from Bangladesh found positive impacts from studying with friends [(Hahn et al. 2017)](https://sciwheel.com/work/citation?ids=8483040&pre=&suf=&sa=0). In light of these findings, further research should consistently measure women’s perceived moral support within groups, and test how it can bring about change in women’s lives.

A small number of studies in this review found that social networks within livelihoods and financial groups helped enforce mutual accountability, which was linked to positive economic outcomes. Additional studies on peer effects, which are not focused on groups so are outside the scope of this review, suggest that mutual accountability can exist without a formal group structure. In India, people saved more when another member of their community knew about their savings progress [(Breza and Chandrasekhar 2019)](https://sciwheel.com/work/citation?ids=8483039&pre=&suf=&sa=0). Another study in India found that borrowers were more likely to repay when their peers repaid even without joint liability loans: these peer effects arose from the regular interactions facilitated by the microfinance institution [(Breza 2012)](https://sciwheel.com/work/citation?ids=8483012&pre=&suf=&sa=0). These findings suggest that the frequency of interactions and the presence of group members that already have strong community relationships can be important components in activating mutual accountability. Further research is needed to better generate specific recommendations about meeting frequency and group composition, along with how these dynamics might translate on digital platforms.

To conclude, group models can serve as an entry point to reach many people at once with resources, information, or training, and bring about positive changes in women’s and girls’ lives. Future research should further investigate whether, and how, women’s groups can be greater than the sum of the parts by leveraging the interactions among members of a group to achieve broad development outcomes.

# **Notes**

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# **Appendix A. Studies Included in the Review**

*Table A1: Description of included studies*

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| **Author-Year** | **Years, country, and study design** | **Sample size and treatment arms** | **Group type** | **Hypothesis/Research Question** | **Main Findings** | **Mechanisms Examined** | |
| **Platform or group-based** | **Type of mechanism** |
| Acharya et al. 2015 | 2007-2011  India  RCT | ~12,000 women  T: Media messages on maternal and newborn care and community mobilization (home visits and mothers' groups held once a month) C: Media messages on maternal and newborn care | Health | The impact of women's groups to provide health information on health care usage, health behaviors among mothers, maternal, and neonatal mortality. | The program increased the likelihood of exclusive breastfeeding for the first six months after delivery by 8.6 percentage points and increased the likelihood of the birth being attended by a delivery assistant. Researchers identified a 0.81 percentage points drop in maternal morbidity (defined as complications during pregnancy, labor, delivery, and postpartum) relative to a baseline average of 4.45 percent in the comparison group, but did not find impacts on neonatal mortality. | Platform | Access to health information |
| Angelucci et al. 2015 | 2009-2012  Mexico  RCT | 6,786 households  T: Access to group lending (loan amounts having to be agreed upon unanimously C: Treasurer collects payments at each weekly meeting); 2) no intervention | Livelihoods and financial | The impact of a group-lending program on women's decision- making power, micro-entrepreneurship, income, consumption, social status, and subjective well-being. | The program had a small positive effect on household decision making power, but no effects on most other outcomes, including income, consumption, and wealth. Women's participation in household financial decision making increased by 0.8 percentage points relative to a control group average of 97.5 percent. | Platform | Access to financial resources |
| Annan et al. 2013 | 2010-2012  Burundi  RCT | 1,595 eligible households in 77 self-selected groups  T 1: VSLA + Healing Families and Communities discussion sessions T 2: VSLA C: No intervention | Livelihoods and financial | The impact of VSLAs, alone and combined with family counseling on consumption, assets, and expenditure. | VSLAs led to a 22 percent increase in average per capita consumption expenditures from a base of US$32 for the comparison group and to an increase in an asset index score by 0.22, or one extra head of cattle for each household. For children, VSLA, when combined with family counselling, increased spending on clothing by 42 percent, compared to 27 percent increase among those who participated in only the VSLA intervention and a 16 percent increase among those in the control group. | Platform | Access to financial resources |
| Ashraf et al. 2019 | 2013  Zambia  RCT | 2,366 8th grade girls (41 schools)   T 1: Negotiation training in after-school safe space T 2: After school safe-space with role model C: No intervention | Adolescent | The impact of a safe space + negotiation training program on adolescent girls' educational outcomes, including school enrollment and dropouts. | The negotiation training program decreased school dropouts and increased a human capital index, which included school enrollment. For girls in grade 10, the negotiation training program increased enrollment by 3.5pp (7 percent). The estimated effect of the safe space program alone of 2.7pp (5.5 percent) was not statistically distinguishable from 0. | Platform | Soft skills |
| Researchers could not statistically reject that the safe space and negotiation treatments had the same positive effect, on average. | Group-based | Social networks |
| Attanasio et al. 2014 | 2008-2009  Mongolia  RCT | 1,148 women in 40 villages  T 1: Joint-liability loans through women's groups (group lending group)  T 2: larger loans with collateral if possible but no group activities (Individual lending group) C: No intervention | Livelihoods and financial | The impact of joint-liability and individual-liability microcredit programs on entrepreneurship and consumption. | The joint liability program increased the probability of women’s entrepreneurship by 9 pp (compared to 39 percent in the control group) and increased average food consumption by 14.2 percent (or USD 18.46). The individual-liability program did not have a significant effect on consumption. | Platform | Access to financial resources |
| Researchers attributed the positive outcomes of group-lending (relative to individual lending) to group dynamics that fostered mutual accountability, but did not directly measure social networks. | Group-based | Mutual accountability |

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| **Author-Year** | **Years, country, and study design** | **Sample size and treatment arms** | **Group type** | **Hypothesis/Research Question** | **Main Findings** | **Mechanisms Examined** | |
| **Platform or group-based** | **Type of mechanism** |
| Azad et al. 2010 | 2005-2007  Bangladesh  RCT | 18 clusters (with a mean population of 27, 953)  T: women's groups facilitated by a local "peer" facilitator  C: No intervention | Health | The impact of a group-based health information provision intervention on health care usage | The program did not affect health care usage around birth | Platform | Access to health information |
| Bandiera, Buehren, Burgess, et al. 2020 | 2008-2012  Uganda  RCT | 4,800 girls aged 14-20 (150 communities)  T: Empowerment and Livelihoods for Adolescents (ELA) group: safe space + skills training  C: no intervention | Adolescent | The impact of safe space + skills training adolescent groups on girls' engagement in income generation, teenage pregnancy, early marriage, and engagement in unwanted sex. | The program increased girls' engagement in income generating activities (by 4.9pp, or 48 percent), reduced teen pregnancy (by 3.8pp, or 34 percent), delayed marriage/cohabitation (by 6.9pp, or 53 percent), and decreased girls' likelihood of having sex against their will (by 5.3pp, or 17 percent). Soft skills acquisition appeared to be an important part of the process. | Platform | Soft skills |
| Researchers attributed part of the effect, which was unexplained by other program components, to interaction through the group, but they did not test this directly. | Group-based | Social networks |
| Bandiera, Buehren, Goldstein, et al. 2018 | 2014  Sierra Leone  RCT | 4,700 women  T: ELA groups: safe space + skills training (girls aged 17 or above), with microfinance (18 or older).  C: No intervention | Adolescent | The impact of safe space + skills training adolescent groups on school enrollment, out-of-wedlock pregnancies, engagement in unwanted sex, and contraceptive use in a region disrupted by the Ebola crisis. | The program reversed a 10.7pp (93 percent) increase in the likelihood of pregnancy in areas highly disrupted by Ebola: It led to a 7.6 percent decrease in out-of-wedlock pregnancies from a baseline mean of 9.1 percent. In highly disrupted areas, girls experienced a 16 pp (or 32 percent) drop in enrollment, which was halved to an 8.1 pp fall. | Platform | Soft skills |
| Banerjee, Duflo, Glennerster et al. 2015 | 2005  India  RCT | 6,863 households  T: Group-lending microcredit program with joint liability C: No intervention (delayed intervention) | Livelihoods and financial | The impact of a group-lending program on entrepreneurship, income, health, education, and household decision making power. | Access to group-lending increased investments in existing businesses by INR 391 (over a control mean of INR 280), but access to the loans did not have significant impacts on income on average. The program did not have significant effects on health, education, or women's household decision-making power. | Platform | Access to financial resources |
| Baqui et al. 2008 | 2003-2005  Bangladesh  RCT | 24 clusters (with a population of 20,000 each)  T1: Home-visits only. Female health workers made antenatal and postnatal home visits T2: Community group. Birth and newborn-care preparedness and care seeking from qualified providers were promoted through group sessions C: No intervention | Health | The impact of a community group-based health intervention on neonatal mortality | The home care intervention had positive effects on delivery and newborn practices; for example, the likelihood that a clean cord-cutting instrument was used increased from 49 percent at baseline to 72 percent at endline, and this difference was statistically significant. However, the community group intervention did not have statistically significant effects on neonatal mortality or health practices. | Platform | Access to health information |

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| **Author-Year** | **Years, country, and study design** | **Sample size and treatment arms** | **Group type** | **Hypothesis/Research Question** | **Main Findings** | **Mechanisms Examined** | |
| **Platform or group-based** | **Type of mechanism** |
| Baro et al. 2013; Beaman, Karlan, and Thuysbaert 2014 | 2009-2012  Mali  RCT | 6,000 households in 500 villages  T: Saving for Change. Twenty women voluntarily form a group that meets weekly and collects savings from each member in a communal pool. When a woman needs a loan, she proposes the desired amount to the group, and repays the loan with interest  C: No intervention | Livelihoods and financial | Impact of the savings group program on food consumption, income, expenditure, health, education, social networks, and women’s household decision-making power. | The program increased food consumption by 3 percent over a control mean of USD 3.83. The program did not have statistically significant effects on income, expenditure, health, education, or household decision making. Program effects on women's social networks were also statistically insignificant. | Platform | Access to financial resources |
| Bass et al. 2016 | 2012  Democratic Republic of Congo  RCT | 301 women in 66 groups  T: Village Savings and Loans Associations (VSLAs)  C: No intervention (waitlisted) | Livelihoods and financial | Impact of a savings group intervention on food consumption, social networks, and participation in community groups. | The program increased food consumption by 25 percent and increased the number of animals available for breeding by 1.5 more animals for breeding, relative to 4 animals on average in the control group, but this difference was only marginally significant. While both treatment and control group saw a reduction in paid hours worked between baseline and follow up, women who participated in VSLAs experienced a smaller reduction of 18 percent, relative to the control group reduction of 31 percent. This effect was significant at the ten percent level. | Platform | Access to financial resources |
| The effect of the program on women's social ties and participation in groups was statistically insignificant. | Group-based | Social Networks |
| Bhutta et al. 2011 | 2006-2008  Pakistan  RCT | 16 clusters (~47,000 households)  T: Education on antenatal care delivered through group sessions C: No intervention | Health | The impact of antenatal care promotion and maternal health education through groups on health care usage | The program significantly increased women’s contact with lady health workers during pregnancy by 18 percentage points (relative to a comparison group average of 26 percent) and institutional delivery by 10 percentage points (relative to a comparison group average of 44 percent), but not antenatal checkups in a health facility | Platform | Access to health information |
| Björkman et al. 2009 | 2005-2006  Uganda  RCT | ~5,000 households per round  T: Community health monitoring groups; encouraging participation through a series of meetings (community meeting, a staff meeting, and an interface meeting) C: No intervention | Health | The impact of community-based monitoring groups on the quality and quantity of primary health care provision, health utilization and health outcomes | The community health monitoring program enabled community members to act collectively to hold health service providers accountable. For instance, one year into the project, treatment facilities were significantly more likely to have suggestion boxes (no control facility had these, but 36% of the treatment facilities did). A year after the first round of meetings, researchers also found a significant reduction by 33 percent in under-5 mortality in treatment communities. Healthcare utilization also improved; for example, utilization for general outpatient services was 20 percent higher in the treatment compared to the control facilities. | Group-based | Collective action and mobilization |
| Bolton et al. 2003 | 2002  Uganda  RCT | ~220 individuals; 30 villages  T: Group interpersonal psychotherapy for depression  C: No intervention | Health | The impact of group interpersonal psychotherapy on depression and dysfunction | The program had significant impacts on the severity of depression and dysfunction. It reduced depression severity by 17.47 points in the intervention group and 3.55 points in the control group, and dysfunction by 8.08 in the intervention group and 3.76 points in the control group. | Platform | Access to health information |
| Boone et al. 2016 | 2008  Guinea-Bisseau  RCT | 146 clusters (~11,000 women; ~9,000 children)  T: Community health clubs, with training for community health workers and traditional birth attendants to promote facility-based delivery.  C: No intervention | Health | The impact of group-based community mobilization on under-5 and maternal mortality | Women’s groups significantly reduced maternal mortality from 6.15 per 1,000 births in the control group to 2.04 in the treatment group, but had no effect on under-5 mortality | Platform | Access to health information |

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| **Author-Year** | **Years, country, and study design** | **Sample size and treatment arms** | **Group type** | **Hypothesis/Research Question** | **Main Findings** | **Mechanisms Examined** | |
| **Platform or group-based** | **Type of mechanism** |
| Buchmann et al. 2018 | 2007  Bangladesh  RCT | 15,464 girls  T 1: Kishoree Kontha, Empowerment program offered in a safe space, consisting of educational support and social competency training T 2: Conditional incentive. Cooking oil incentive conditional on being unmarried (for girls < 18) T 1 + T 2: Empowerment program + incentive C: No intervention | Adolescent | The impact of an adolescent girls' empowerment program and an incentive conditional on delayed marriage, alone and when combined, on schooling, engagement in income generation, age of marriage and childbearing. | Girls who received the incentive were at least two years were 24 percent (8.9pp) less likely to be married under 18, 15 percent (4.8pp) less likely to have given birth under 20, and 25 percent (7.0pp) more likely to be in school at age 22.  The empowerment program did not decrease child marriage or teenage childbearing. However, girls eligible for the empowerment program were 11 percent (3.0pp) more likely to be in-school at age 22. The empowerment program also increased girls' engagement in income generation by 0.5SDs | Platform | Soft skills, Access to financial resources |
| Buehren, Chakravarty, Goldstein et al. 2017 | 2011-2013  South Sudan  RCT | 4,044 at baseline; 2,273 girls at endline  T: Adolescent Girls Initiatives. Safe space + skills training C: No intervention | Adolescent | Impact of a safe space + skills training program on participation in income generation, financial and saving behaviors, social networks, and girls' control over their own bodies in a conflict-affected region. | In conflict affected areas (but not in other areas), the program significantly increased the probability of being engaged in income generation by 9.6pp (14.1 percent) and the probability of being self-employed by 9.4pp (15.6 percent). The program significantly impacted the probability of having savings by 8pp (16.8 percent). | Platform | Soft skills |
| Treated girls who were not affected by the conflict were 9.4pp (22.4 percent) more likely than girls in control communities to have a place other than home or school, where they could meet friends and 4.4pp (5.7 percent) more likely to have help outside their family. | Group-based | Social networks |
| Buehren, Goldstein, Gulesci et al. 2017 | 2009  Tanzania  RCT | 5,454 baseline, 3,179 follow-up  T 1: ELA. Safe space + skills training T 2: ELA program + microcredit C: No intervention | Adolescent | The impact of a safe space and skills training program on income generation, entrepreneurship, saving behaviors, and social networks. | The program did not have significant impacts on most economic outcomes. Adding a microcredit component to the safe space program significantly increased the likelihood of girls having savings at informal institutions by 2.8pp, relative to 2 percent at baseline. | Platform | Access to financial resources |
| Adding a microcredit component to the safe space program significantly increased the likelihood of girls talking to their friends about business by 6.6pp. | Group-based | Social Networks |
| Carlson, Brennan, and Earls. 2012. | 2004-2006  Tanzania  RCT | 724 adolescents  T: Young Citizens program. A health promotion curriculum delivered in groups C: No intervention | Health | The impact of a health-promotion curriculum on adolescents' knowledge and efficacy to promote HIV/AIDS community competence | The curriculum for adolescents, offered in groups, positively affected adolescent’s self-efficacy and deliberative efficacy on HIV-related topics. | Platform | Access to health information |
| The program did not positively impact collective efficacy at the neighborhood level. | Group-based | Collective action and mobilization |
| Clarke et al. 2014 | 2009-2011  Bangladesh  RCT | 6,275 mothers  T: Participatory groups focusing on maternal and child health; health strengthening activities (training of traditional birth attendants) C: Only health strengthening activities, no groups | Health | The impact of participatory women’s health groups on mothers' postpartum psychological distress | The program did not have significant effects on mothers’ postpartum psychological distress. | Platform | Access to health information |

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| **Author-Year** | **Years, country, and study design** | **Sample size and treatment arms** | **Group type** | **Hypothesis/Research Question** | **Main Findings** | **Mechanisms Examined** | |
| **Platform or group-based** | **Type of mechanism** |
| Colbourn et al. 2013 | 2008-2010  Malawi  RCT | 61 clusters; ~50,000 births  T 1: Women's groups and quality improvement of health care centers T 2: Quality improvement of health care centers T 3: Women's groups only C: No intervention | Health | The impact participatory women’s groups, along and combined with a health centers' quality improvement intervention on maternal, neonatal and perinatal mortality | The combination of groups and the quality improvement program decreased neo-natal mortality; the neonatal mortality rate was 22 percent lower in groups that received this combination. Only ten percent of newly pregnant women attended the groups and the researchers did not find significant effects on institutional delivery. | Platform | Access to health information |
| De La Cruz et al. 2009 | 2004-2006  Ghana  RCT | ~700 participants  T 1: Malaria education curriculum delivered in groups T 2: Standard diarrhea education delivered in groups C: No intervention | Health | The impact of a malaria education program and a standard diarrhea education program, when integrated with group-based microfinance on health knowledge | The malaria education program significantly impacted knowledge related to malaria: 48.4 percent of those in the malaria education group were able to identify groups most vulnerable to malaria compared to 39.2 percent in the standard group and 37.7 percent in the control group. However, the program did not impact health care usage. | Platform | Access to health information |
| Desai and Joshi 2013 | 2007  India  RCT | 1,410 women, 80 villages  Self-help groups: Membership-based organizations that provided education, access to finance, and linkages to wider development programs Control group: No intervention | Livelihoods and financial | The impact of women's self-help groups on women's household decision making power and collective action | The program improved women's decision-making power about family planning, children’s schooling, and family medical care by 3-6 percent. | Platform | Access to financial resources |
| Treated women were 4 percent more likely to be aware of bribe-payments within the village and this effect is significant was marginally significant. Treated women were 40 percent more likely to know where to report grievances related to drinking water and 60 percent more likely to make a complaint, relative to 24 percent and 21 prior to program implementation. | Group-based | Collective action and mobilization |
| Feigenberg et al. 2014 | 2006-2008  India  RCT | **Fiegenberg et al., 2013** 3,205 women  T: Microfinance groups with weekly meetings and repayment schedule C: Microfinance groups with monthly meetings and repayment schedule  **Fiegenberg et al., 2014 (longer term clients)** 739 women  T 1: Microfinance groups with weekly meetings and repayment schedule T 2: Microfinance groups with weekly meetings and monthly repayment schedule C: Microfinance groups with monthly meetings and repayment schedule [all groups moved to fortnightly meetings and repayment schedule in the 2nd loan cycle] | Livelihoods and financial | The impact of increasing the frequency of microcredit group meetings on women's social networks and risk sharing | Clients who had weekly meetings saw each other outside of group meetings 37 percent more often in the short term compared to clients who had monthly meetings—an increase from 5.5 to 7.5 interactions over the previous thirty days. These impacts persisted more than a year after the start of the program: weekly repayment assignment was associated with an increase in social contact of 0.59 standard deviations relative to monthly repayment assignment. More frequent meetings also led women to be more willing to engage in risk sharing with other group members | Group-based | Social Networks; Mutual Accountability |

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| **Author-Year** | **Years, country, and study design** | **Sample size and treatment arms** | **Group type** | **Hypothesis/Research Question** | **Main Findings** | **Type of mechanism** | |
| **Platform or group-based** | **Type of mechanism** |
| Flax et al. 2014 | 2011-2012  Nigeria  RCT | 390 participants  T: Learning sessions in microcredit groups C: Microcredit groups | Health | The impact of a breastfeeding promotion intervention integrated into microcredit on mothers' breastfeeding practices | Women in groups that met at least weekly had higher odds (5.6 times the odds) of exclusive breastfeeding up to 6 months relative to the control group and had 5.8 higher odds of having correct knowledge of best breastfeeding practices. | Platform | Access to health information |
| Fottrell et al. 2013 | 2009-2011  Bangladesh  RCT | 25,321 participants  T: Participatory learning and action cycle with women’s groups and health system–strengthening initiatives C: Health system–strengthening initiatives | Health | The impact of a participatory women’s group intervention on neonatal mortality and healthcare usage. | The program significantly decreased neonatal mortality by 38 percent, compared to the neonatal mortality rate in comparison areas of 30 deaths per 1,000 live births. However, there were no significant effects on healthcare usage. | Platform | Access to health information |
| Gram, Morrison, et al. 2018 | 2014-2015  Nepal  RCT | 1,309 pregnant women  T 1: women's groups practicing Participatory Learning and Action (PLA); T 2: PLA + unconditional cash transfers  T 3: PLA + unconditional food transfers:  C: No intervention | Health | The impact of participatory learning and action groups, with and without unconditional cash and food transfers, on women's agency related to health seeking, household chores, work, and participation in groups outside the community. | The PLA program didn't impact several other measures of agency related to health seeking, household chores, or working outside the house. | Group-based | Social networks |
| The PLA program increased an index measuring participation in groups unrelated to the program by 0.53 points, on an 8 point scale. | Platform | Access to health information |
| Gram, Skordis-Worrall, et al. 2018 | 2001-2003  Nepal  RCT | 4,030 mothers  T: PLA facilitated monthly group meetings in which members explored issues around pregnancy, childbirth and newborn health;  C: No intervention | Health | The impact of participatory learning and action groups on women's household agency and participation in groups in the long run (ten years after program implementation) | When resurveyed more than ten years, women residing in clusters originally assigned to treatment were not more likely to participate in groups unrelated to the program. The program did not have an impact on agency in the household. | Group-based | Social networks |
| Gupta et al. 2013 | 2010-2012  Cote d'Ivoire  RCT | 934 women  T: Eight sessions of gender dialogue groups for members of VSLAs and their male partner/family members C: Only VSLAs | Livelihoods and financial | The impact of adding gender dialogue sessions to self-help groups on intimate partner violence against women and attitudes towards intimate partner violence. | Adding eight gender dialogue sessions to VSLAs in Côte d’Ivoire significantly reduced the acceptance of wife beating from 4 percent to 2.9 percent. The program significantly reduced the odds of reporting physical abuse by more than half among women who attended at least 75 percent of sessions. | Platform | “Power within” |
| Hamad, Fernald, and Karlan, 2011 | 2007-2008  Peru  RCT | 1,855 clients and 598 children  T: Health education offered in microcredit groups C: Microcredit groups only | Health; Livelihoods | The impact of health education integrated with group-based microfinance on health knowledge | The health education program significantly impacted participants' health knowledge related to diarrhea among children. For example, the percentage of participants able to detect at least one danger sign of diarrhea increased from 85.3 percent in the control group to 90 percent. The percentage of participants able to name on dietary modification for children with diarrhea also increased from 74.3 percent in the control group to 82.7 percent. | Platform | Access to health information |

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| **Author-Year** | **Years, country, and study design** | **Sample size and treatment arms** | **Group type** | **Hypothesis/Research Question** | **Main Findings** | **Type of mechanism** | |
| **Platform or group-based** | **Type of mechanism** |
| Hoffmann et al. 2017 | 2012-2014  India  RCT | 8,988 households across 333 villages  T: Jeevika program. Access to low-cost credit through self-help groups C: No intervention | Livelihoods and financial | The impact of access to credit in self-help groups on household decision-making and consumption | The program did not have significant impacts on household decision making power or consumption among women | Platform | Access to financial resources |
| Holden et al. 2016 | 2014-2015  India  RCT | 7,500 individuals   T 1: Strengthen existing and nascent women’s SHGs T 2: SHG + VAW group: SHG strengthening plus violence against women (VAW) module for SHG members T 3: Life skills module with men and boys: training and community mobilization to increase men's understanding of VAW T 1 + T 3: SHG strengthening + Life Skills with men T 1 + T 2 + T 3: SHG strengthening, life skills and VAW interventions C: No intervention (but existing women's groups in operation) | Livelihoods and financial | The impact of adding community mobilization, life skills, and intimate partner violence education components to self-help groups on decision making power, control over income, attitudes towards gender norms, or gender-based violence. | The program did not have significant effects on women's decision-making power, control over income, attitudes towards gender norms, or gender-based violence. | Platform | "Power within" |
| Ismayilova et al. 2018 | 2014  Burkina Faso  RCT | 360 unmarried women   T 1: Trickle Up. VSLAs, livelihood planning and household management training, seed capital grants, and one-on-one mentoring and coaching on livelihood development  T 2: Trickle Up+. Economic intervention plus family coaching with all household members  C: Delayed intervention | Livelihoods and financial | The impact of a group-based economic intervention, alone and in combination with family counselling, on intimate partner violence, women's decision-making power, and attitudes towards gender. | 12-months after program implementation, there were no significant intervention effects on gender equality beliefs, decision-making power, and physical violence. However, women reported a significant reduction in emotional violence from their spouses in both intervention arms. | Platform | Access to financial resources |
| Janssens 2011 | Program active since 1992, 1993 and 1998  India  Quasi-experimental (RD) | 1,191 participants  T: Women’s groups including literacy trainings, savings and credit groups, health education C: No intervention | Health; Livelihoods and financial | The impact of a group-based women’s empowerment program in India on child immunization | Existing social networks helped extend the beneficial effects of health groups to the rest of the community. Women shared the health knowledge acquired in group meetings with non-participant women belonging to their social network. This, in turn, increased immunization in the whole community: the probability of receiving a DTP, measles, and tuberculosis vaccine increased by 16.2 percentage points, 8.1 percentage points, and 18.2 percent, respectively. | Group-based | Social networks |

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| **Author-Year** | **Years, country, and study design** | **Sample size and treatment arms** | **Group type** | **Hypothesis/Research Question** | **Main Findings** | **Type of mechanism** | |
| **Platform or group-based** | **Type of mechanism** |
| Jejeebhoy et al. 2017 | 2014-2015  India  RCT | SHG members and their husbands belonging to a total of 140 SHGs from 28 villages  T 1: Gender transformative group learning sessions with self-help groups (SHG) members on economic empowerment, gender discrimination, notions of masculinity and violence against women T 2: Gender transformative group learning sessions with women, corresponding learning sessions to husbands, and interactive text messages to husbands C: No intervention, only SHGs | Livelihoods and financial | The impact of a gender transformative training program, with and without the engagement of husbands, offered in women's SHGs, on women's decision-making power, experiences of violence, social networks, and gender attitudes. | Adding gender transformative group learning sessions to SHGs increased group members’ self-reported independent decision-making, gender attitudes, and decreased physical intimate partner violence. For example, women who received the program were 6.3 pp more likely (relative to a base of 15 percent) to reject the idea that women should be subservient to men. Married women who received the program, along with complementary programming engaging husbands, experienced a 7pp (relative to a base of 26 percent) reduction in physical violence. However, women in the treatment group also experienced an 18 percent increase in emotional violence, from 76 to 90 percent, and engaging husbands did not lead to any additional impacts. | Platform | "Power within" |
| Adding gender transformative group learning sessions to SHGs increased group members’ social networks. SHG members who received the program scored 1.9 in comparison to 1.5 by those in the control arm on an index measuring confidence about access to peer support | Group-based | Social networks |
| Joshi, Palaniswamy, and Rao 2015 | 2009  India  Quasi-experiment (RD) | 2,875 households from 160 villages  T: Odisha Rural Livelihoods Projects. Creation and strengthening of community level institutions or SHGs at the village level + provision of community investment funds for livelihood projects C: No intervention | Livelihoods and financial | The impact of self-help groups on economic outcomes, such as consumption and expenditure, women's household decision making power, and mobility. | The program did not have significant effects on economic outcomes, such as consumption and assets, or women's decision-making power. However, women in self-help groups were 17.8 percent more likely to go alone to an SHG meeting. | Platform | Access to financial resources |
| Kaaya et al. 2013 | 2001-2004  Tanzania  RCT | 331 (but only ~180 women interviewed at follow-up)   T: Psychosocial support group with counseling facilitated by birth attendants and healthcare worker C: No intervention | Health | The impact of group-based counseling on depression among women | The group counseling program significantly depression. 60 percent of women in the intervention group were depressed post-intervention, relative to 73% in the control group | Platform | Access to health information |
| Karlan et al. 2017 | 2009-2011  Ghana, Malawi, Uganda  RCT | 15,221 households from the three sites   T: VSLAs: group-based commitment savings, a process for members to request loans from the group, and a social or emergency fund financed C: No intervention | Livelihoods and financial | The impact of VSLA groups on household business outcomes, women's household decision making power, consumption, and community mobilization. | The program had a 0.06 SD positive impact on an index of business outcomes, but no significant impact on assets. The program also had a significant positive impact of 0.06 SD on an index measuring women's household decision making. The program had no significant impact on women's participation in the community. | Platform | Access to financial resources |

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| Karlan, Thuysbaert, and Gray 2017 | 2007  Benin  RCT | Microfinance group members in 138 villages  T 1: Microcredit lending groups with mixed gender + health education T 2: Women-only groups + health education T 3: Mixed gender groups without health education C: Women-only groups without health education | Health; Livelihoods and financial | The impact of health education offered in microfinance groups, with varying gender compositions, on health behaviors, knowledge, and social capital. | The program improved health-related knowledge, but did not improve behaviors. | Platform | Access to information |
| Women in villages assigned to mixed-gender groups had significantly lower levels of social capital, compared with villages assigned to female-only groups. These women scored 0.0171 SDs lower on a metric that included some components of community mobilization, such as participation in local groups, village meetings, and influence in the village. | Group-based | Collective action and mobilization |
| Kim et al. 2007; Kim et al. 2009; Pronyk et al., 2006; Pronyk et al., 2008 | 2001-2005  South Africa  RCT | 1,408 participants from 4 villages  **Pronyk et al., 2006 and 2008; Kim et al., 2007:** T: IMAGE intervention, with group-based microcredit and a gender-focused participatory training on understanding HIV infection, gender norms, domestic violence, and sexuality C: Delayed intervention  **Kim et al., 2009:** T: IMAGE intervention, with group-based microcredit and a gender-focused participatory training on understanding HIV infection, gender norms, domestic violence, and sexuality T 2: Microcredit intervention alone minus IMAGE training (matched villages) C: Delayed intervention | Livelihoods and financial | The impact of a training intervention added to microfinance groups on violence against women, gender attitudes, social networks, and household decision-making power | After 2 years, both the microfinance-only group and the IMAGE group showed economic improvements relative to the control group. However, only the IMAGE group had significant effects on intimate partner violence. Levels of physical and sexual IPV were 55% lower among IMAGE participants compared with controls. The program did not significantly impact household decision making and "power within". | Platform | Soft skills, "Power within" |
| The microfinance program, when not combined with a gender training, did not increase women’s ties in the community, measured through their social networks, their sense of community support, and their perception of solidarity during a crisis | Group-based | Social networks |
| Ksoll et al. 2016 | 2009-2011  Malawi  RCT | 46 villages  T: VSLA groups  C: Delayed intervention | Livelihoods and financial | The impact of a savings group intervention on expenditure, assets, and food consumption. | Researchers found some evidence of increased total expenditure and size of the house (a measure of assets), but no effects on food consumption or gross asset count. The average number of rooms per dwelling rose by 0.16 from a control group mean of 2.77 and total expenditure rose by 4.2 percent (3.7pp). | Platform | Access to financial resources |

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| Kumar et al., 2008 | 2004-2005  India  RCT | 39 clusters (~3,900 women)  T 1: Essential care. Package of essential newborn care delivered via collective meetings and two antenatal and two postnatal household visits T 2: Essential care plus. Package of essential newborn care plus use of a liquid crystal hypothermia indicator delivered via collective meetings and two antenatal and two postnatal household visits C: No intervention | Health | The impact of group-based interventions delivering essential care packages on neonatal mortality | Compared with the control group, neonatal mortality rate was reduced significantly by 54 percent in the essential newborn-care intervention and by 52 percent in the essential newborn care plus. | Platform | Access to health information |
| Leventhal et al. 2015; Leventhal et al., 2016 | 2013  India  RCT | **Resilience curriculum (Leventhal et al., 2015):** 57 schools  T: Girls First Resilience Curriculum (RC). Psychosocial training through 23 classroom-based group training sessions C: No intervention  **Resilience + health curriculum (Leventhal et al., 2016):** 76 schools T 1: Girls First Resilience Curriculum (RC). Psychosocial training through 23 classroom-based group training sessions T 2: Girls First Health Curriculum (HC). Adolescent physical health intervention T 1 + T 2: RC+ HC C: No intervention | Health; Adolescent | The impact of a psychosocial intervention, alone and when combined with a health intervention, on girls' self-efficacy, socio-emotional assets and emotional resilience | The psychosocial training intervention based on a resilience curriculum, in addition to the health intervention, improved adolescent girls’ emotional resilience, self-efficacy, and social-emotional assets. The program significantly increased girls' score on the self-efficacy, emotional resilience, and socio-emotional asset indices by about 3.6 points, relative to control group averages of 31.9, 22.2, and 33.2 respectively prior to program implementation. The health intervention alone did not have similar effects. | Platform | "Power within" |
| Manandhar et al. 2004 | 2001-2003  Nepal  RCT | 28,931 participants  T: participatory women's groups C: No intervention | Health | The impact of a group-based participatory intervention on healthcare usage and neonatal mortality rates | The program significantly reduced the neonatal mortality rate from 36.9 per 1,000 live births to in control clusters to 26.2 per 1,000 live births in the treatment group. Women in the treatment group were 25 pp more likely to visit antenatal care centers at least once, relative to 30 percent in the control group. Institutional deliveries also increased significantly from 2 percent in the control group to 7 percent in the treatment group. | Platform | Access to health information |
| More et al. 2012 | 2006-2009  India  RCT | 18,197 births  T: Participatory learning health groups C: No intervention | Health | The impact of participatory health groups on healthcare usage and collective action | Women’s groups did not affect antenatal care, institutional deliveries, or postnatal checks. | Platform | Access to health information |
| The program did not significantly impact women's capacity for collective action | Group-based | Collective action and mobilization |

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| Naved et al. 2018 | 2012-2013  Bangladesh  RCT | Baseline: 2,666 women, Endline: 2,670  T 1: Women's groups. SAFE intervention (community mobilization, health and legal services, and training and advocacy on gender and violence) in women's groups. T 2: Mixed gender groups: SAFE intervention with women's and men's groups  C: only community mobilization and health and legal services, but no groups | Adolescent | The impact of a gender training program to reduce intimate partner violence, offered in women-only and mixed gender groups, on the risk of intimate partner violence. | the SAFE intervention in women-only groups had no impacts on intimate partner violence. However, for women the subgroup of women between the ages 15 and 19 who received the intervention in mixed gender groups experienced a statistically significant 19.2 pp reduction (relative to a base of 59.2 percent) in the risk of physical intimate partner violence. | Platform | "Power within" |
| Ozler, Hallman, Guimond et al. 2020 | 2016  Liberia  RCT | 56 communities  T 1: Girl Empower. Life skills training, caregiver sessions, savings start-up; T 2\_ Girl Empower Plus. Girl Empower plus participation incentive payment to caregivers C: No intervention | Adolescent | The impact of a life skills program that engaged adolescents' caregivers, alone and when combined with. cash transfers, on violence against adolescent girls and their gender attitudes | 2 years after the program, there were no effects on sexual violence, schooling and psychosocial wellbeing, However, the program had positive effects on gender attitudes, life skills, and sexual and reproductive health. The effects of both GE and GE+ were above 0.2 SD for all three indices, and as large as 0.37 SD for the SRH index in GE+ | Platform | Soft skills |
| Prillaman 2017 | 2016  India  Quasi-experiment (RD) | 7,770 women   T: Women's self-help groups for informal savings and credit C: No intervention | Livelihoods and financial | The impact of women's self-help groups on political participation, social networks, collective action, income, and consumption. | Access to SHGs had no positive impacts on measures of household economic well-being, measured through income and consumption. | Platform | Access to financial resources |
| Women who had access to networks of other women via SHGs were more likely to be politically active and their political participation, measured through an index, increased by 0.16 from a control group mean of 2.4 This was a result of women leveraging the economic networks of SHGs to enhance their political coordination. For example, women in SHGs reported having 0.85 more friends in the village relative to a control group average of 2.16 friends. | Group-based | Social networks, Collective action |
| Roy et al. 2013 | 2005-2008  India  RCT | 41,191 births  2005-2008: T: Local women’s groups  C: No intervention  After 2008:  T: Local women’s groups including education on women’s and children’s health issues C: Meetings on maternal and neonatal health | Health | The impact of participatory learning and action groups on neonatal mortality in the long run | Both programs significantly decreased neonatal mortality. The first decreased neonatal mortality from 41.3 per 1,000 live births to 34.2 per 1,000 live births, while the second decreased this rate from 61.8 per thousand live births to 40.5. | Platform | Access to health information |

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| Scales et al. 2013 | 2009-2010  Bangladesh  RCT | 1,000 girls   T 1: Basic. Social competency training (peer education on reproductive health and rights, life skills, and literacy support) T 2: Livelihood: social competency + financial competency training T 3: Full: social competency + financial competency + nutrition incentive (4 liters of cooking oil every 3 month if marriage was delayed);  C: no intervention | Adolescent | The impact of an empowerment training program on adolescent girls' developmental assets, such as truth-telling, seeking advice from parents, and good time use | The basic program significantly increased girls' development assets by a score of 0.80, or an average improvement of 22 percent in the amount of developmental assets experienced. Participants in the Livelihoods and Full intervention packages had smaller, although still significant and notable, gains in their developmental assets, despite more intervention components. | Platform | Soft skills, "Power within" |
| Sebert Kuhlmann et al. 2017) | 2014  Malawi  RCT | 2,230 participants  T: Groups to bring community members and health workers together with local government officials to discuss concerns/priorities  C: No intervention | Health | The impact of health groups bringing community members and health workers together on participation in community groups and collective action. | Women who actively participated in the program experienced statistically significant improvements in an index measuring participation in various types of community groups by 0.68 points. | Platform | Access to health information |
| There was no significant effect on collective efficacy, which measured women’s confidence in how well community members and health workers could come together to bring about change. | Group-based | Collective action and mobilization |
| Sharma et al. 2016 | 2007-2012  Nepal  Quasi-experimental (DiD) | 1,236 participants  T: Groups comprising health promotion activities (engaged family members, including husbands)  C: No intervention | Health | The impact of a participatory community-based maternal health promotion intervention focusing on women’s groups on maternal health services uptake | The program significantly increased women’s likelihood of attending for antenatal care at least once during pregnancy, but did not increase institutional delivery | Platform | Access to health information |
| Spielberg et al. 2013 | 2006-2009  India  RCT | 677 SHG members; 998 girls  T: SHG members and their adolescent daughters and daughters-in-law received the Learning Games curriculum (Financial and Health Games) C: SHG members and their daughters and daughters-in-law who were recruited to participate, but did not ultimately receive the Learning Games | Health | The impact of financial and health games in self-help groups on health knowledge and behaviors | Participants’ health knowledge significantly increased due to access to health information through groups. For example, among participants, the odds of knowing that condom-use can prevent HIV increased by 2.9 times relative to the control group. Women in the treatment group were also 3.1 times more likely than women in the control group to confirm the use of a clean needle when they were getting shots. | Platform | Access to health information |
| Stark et al. 2018a | 2015-2016  Democratic Republic of Congo  RCT | 869 adolescent girls  T: Life skills session for girls, with provision of safe spaces, building life skills and social assets, engaging girls in relationships with mentors plus similar sessions for caregivers  C: Only life skills sessions for girls | Adolescent | The impact of engaging caregivers in a life skills program on violence against adolescent girls | The program had no significant impact on sexual violence or any other outcomes for girls. | Platform | Soft skills |

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| Stark et al. 2018b | 2015-2016  Ethiopia  RCT | 919 adolescent girls  T: Life skills session for girls, with provision of safe spaces, building life skills and social assets, engaging girls in relationships with mentors plus similar sessions for caregivers  C: No intervention | Adolescent | The impact of a life skills training program that engaged caregivers on violence against adolescent girls and gender attitudes | The program had no significant effects on violence against adolescent girls, but improved gender attitudes and social support. For example, Girls in the program increased the odds of girls believing that women should be married one year later by 1.88 times. | Platform | Soft skills |
| Subramanyam et al. 2017 | 2015  India  RCT | 180 villages  T: Gram Varta. Participatory learning and action approach implemented in existing self-help groups with structured meetings to identify problems related to health and strategies to address these problems C: Existing self-help groups | Health | The impact of a participatory learning program implemented in self-help groups on health knowledge, healthcare usage, community and political engagement, and self-confidence. | Participatory learning through SHGs had mixed effects on knowledge related to nutrition, diseases, domestic hygiene, sanitation, sexuality, and contraception, and did not have significant effects on health care usage. The program did not have significant effects on community and political engagement. The program improved women’s self-confidence; women were 15pp more likely to believe that a woman is justified in refusing sex in certain circumstances. | Platform | Access to information |
| Tripathy et al. 2016 | 2009-2012  India  RCT | 30 clusters (estimated population 156,519)   T: Participatory learning and action groups focused on improving healthcare seeking behavior Control group: No intervention | Health | The impact of participatory women's groups on neonatal mortality and health care practices at home | The program significantly reduced neonatal mortality: neonatal mortality rate during this period was 30 per 1,000 livebirths in the intervention group and 44 per 1,000 livebirths in the control group. The program also improved home care practices. For instance, the proportion of infants being wrapped within 10 minutes increased significantly by 1.6 times, relative to the comparison group. | Platform | Access to health information |
| Tripathy et al., 2010; Houweling et al. 2013 | 2005-2008  India  RCT | 36 clusters; surveillance of a population of 228,186  T: Participatory women's groups focusing on maternal and child health C: No intervention | Health | The impact of participatory women's groups on neonatal mortality | 3 years after the start of the program, neo-natal mortality decreased significantly by 32 percent lower in intervention clusters | Platform | Access to health information |
| Wade et al. 2006. | 2001-2003  Nepal  RCT | 5,400 participants  T: Participatory women's groups C: No intervention | Health | The impact of a participatory health group intervention on delivery and newborn health-related practices | The program led to significant improvements on delivery and newborn practice. For example, 41.7 women in the treatment group, relative to 34.7 percent in the control group, exhibited good practices related to discarding the colostrum and 32.5 percent, relative to 12.8 percent in the control group, exhibited good practices related to boiling the blade used to cut the umbilical cord. 36 percent of the women in the treatment group exhibited good attendance in antenatal care visits relative to 12.5 percent in the control group. | Platform | Access to health information |

*Notes*: T=Treatment Group; C=Control Group; VSLA=Village Savings and Loans Association; SHG=Self-Help Groups; PLA=Participatory Learning and Action. Refer to the main text for descriptions of group types. Refer to Table 1 for a classification and definition of mechanisms that leverage groups as a platform for intervention delivery (“Platform” in the table) and Table 2 for a classification and definition of mechanisms that leverage interactions among group members (“Group-Based” in the Table).