**A conversation with Jakob Svensson and Chuck Slaughter on July 31, 2014**

## Participants

- Dr. Jakob Svensson – Professor, Institute for International Economic Studies, Stockholm University
- Chuck Slaughter – Founder and CEO, Living Goods
- Jake Marcus – Research Analyst, GiveWell
- Natalie Crispin – Research Analyst and Financial Manager, GiveWell

**Note**: These notes were compiled by GiveWell and give an overview of the major points made by Mr. Slaughter and Dr. Svensson.

## Summary

GiveWell spoke with Mr. Slaughter and Dr. Svensson about the major drivers of the mortality reduction in the randomized controlled trial (RCT) of the Living Goods Community Health Provider (CHP) program in Uganda, about the baseline survey in that trial, CHP activity in the study areas before the program got started, and some problems with compliance to experimental protocol in the pilot study.

## Drivers of the reduction in mortality

The program could have led to a decline in mortality in a number of different ways. The major drivers of the decline could have also differed by cluster. It is impossible to pinpoint exactly what caused the decline with high confidence. In all likelihood, a combination of factors contributed. Mr. Slaughter believes that given the relatively low market share of Living Goods products the ability of the community health providers (CHPs) to target high-risk households, for instance households with pregnant women and children under 1, may have been a major factor. The CHPs received training on assessing at-risk cases.

## Baseline survey

BRAC Uganda conducted part of the baseline survey. That part of the survey did not produce usable data. The part of the survey conducted by Living Goods produced higher quality data.

The baseline survey contained a short section on mortality that asked the female head of the household if she had suffered the death of a child in the last year. The survey revealed higher mortality in the treatment area than in the control area but the difference was not close to statistically significant. In any case, the number of clusters randomized in the trial should make baseline imbalance unlikely.

## Community health provider activity before the intervention

There was a government program of community health workers that was theoretically active in villages where Living Goods' works before the Living Goods intervention. In practice this program was not active in these villages. Therefore, the trial can be best thought of as a comparison of CHPs using the Living Goods model to the absence of any community health worker program.

**Problems with compliance to experimental protocol in the pilot study**

The pilot study had some execution problems in the BRAC villages. The research team found that in some of the villages that were designated as control, BRAC had a CHP working there, and the opposite was also true – some treatment villages didn't have CHPs. This problem was fixed after the pilot study.