



Treating Depression with Guided Digital Self- Help Programs

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RECOMMENDED

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Ambitious Impact Research Report

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Contributions: *The primary author for this report was Joel Christoph (AIM Research Program Fellow), supported by Juan Benzo (Research Manager). We are also grateful to the experts who took the time to speak with us, particularly Huw Evans from Kaya Guides and Joel McGuire from Happier Lives Institute.*

Ambitious Impact (AIM) *exists to enable more effective charities to exist worldwide. We strive to achieve this goal through our extensive research process and Incubator Program. We give talented potential entrepreneurs two months of cost-covered, intensive training designed by founders for founders. Our talented researchers and entrepreneurs identify evidence-based, high-impact interventions and help founders find a co-founder to launch the idea and reach scale.*

Note to readers: *Our research is geared toward AIM decision-makers and program participants. We attempt to find the best ideas for our incubation programs through these reports. Given our commitment to focusing on recommended ideas, reports on those not recommended for incubation can often be less polished.*

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Treating depression with guided digital self-help programs / Summary

Description

This report assesses a potential charity delivering a digital guided self-help program for adults with depression in low- and middle-income countries (LMICs). The model builds on the World Health Organization's (WHO) Step-by-Step program and the approach used by Kaya Guides, an AIM-incubated mental health nonprofit.

Depression is one of the leading causes of disability worldwide, affecting more than 300 million people. The burden falls disproportionately on LMICs, where access to care is extremely limited: the WHO estimates that around 75% of people who need mental health treatment receive no care at all, largely due to severe shortages of trained providers. As a result, most people with depression in these settings are left without effective support.

Expected impact

Cost-effectiveness: The intervention meets AIM's cost-effectiveness bar across all modeling approaches and countries assessed. Average cost-effectiveness is estimated at \$97 per DALY averted or \$25 per WELLBY.

Scale: Our modeling assumes the charity reaches 100,000 people at scale, resulting in approximately 25,000 program completers and an estimated 14,000 DALYs averted annually, including household spillover effects.

Potential for success

Evidence base:

There is strong evidence supporting guided self-help for depression:

- Kaya Guides demonstrates real-world feasibility of implementing WHO Step-by-Step in an LMIC context.
- Meta-analytic evidence indicates guided self-help achieves effects comparable to face-to-face psychotherapy, despite requiring far fewer resources.
- Five randomized controlled trials (RCTs) (total n = 2,210) of Step-by-Step in LMICs found statistically significant improvements relative to enhanced usual care.

As with much of the digital mental health literature, these studies face limitations related to attrition and reliance on self-reported outcomes.

Durability of effects: Evidence on long-term outcomes is limited. The Step-by-Step RCTs include only three-month follow-up data, although one study found effects increased over this period. Evidence from other guided self-help interventions suggests effects may persist for up to 12 months; beyond that, outcomes are either unstudied or no longer statistically significant. Longer-term estimates (e.g. 3–5 years) are based on evidence from psychotherapy more broadly, and their applicability to guided digital self-help is uncertain.

Theory of change: The proposed charity would deliver a five-session behavioral activation program via WhatsApp. Participants would complete short, structured modules independently and receive brief weekly check-ins by phone from trained lay counselors over the five-week program. A small supervisory team would oversee counselors and review flagged cases.

Neglectedness

Existing activity: Work on this intervention remains highly neglected. Kaya Guides is the first non-profit to implement WHO's Step-by-Step program.

Geographic fit: Based on disease burden, connectivity, cost considerations, and household size (as a proxy for potential spillover effects), the most promising countries are Pakistan, China, Nigeria, Bangladesh, Indonesia, Egypt, Brazil, Tajikistan, Ethiopia, and Malaysia. All meet our cost-effectiveness bar.

Relevance

Strategic value to AIM: This intervention is not expected to have high strategic value for AIM, as we have already supported the launch of a digital guided self-help provider (Kaya Guides) and several other charities focused on mental health (Happier Lives Institute, Canopie, and Vida Plena).

Fit for the CEIP: We expect this intervention to be attractive to potential co-founders. Useful backgrounds for co-founders or early hires would include technical skills for product development, training in psychology or mental health to support program design, outreach or marketing experience, and local knowledge to help adapt content appropriately to new countries, contexts, and languages.

Other

Expert views: Kenneth Carswell (WHO) provided implementation guidance and directed us to WHO resources on Step-by-Step. Huw Evans (Kaya Guides) shared practical implementation experience that informed our understanding, approach, and modeling throughout the report.

Implementation factors: The main implementation challenge is scaling. Kaya Guides serves as the primary proof of concept for this intervention, but remains relatively early-stage, having treated approximately 3,600 people to date. While the organization aims to reach 100,000 people by Year 5, evidence from other implementations of WHO's Step-by-Step program is similarly limited in scale. One of the largest rollouts to date is Thailand's national implementation in partnership with WHO, which launched in May 2025 and is also still in its early stages.

A related concern is talent. While we expect it to be feasible to identify strong co-founders for this intervention, scaling delivery requires recruiting and managing a large number of lay counselors and supervisors. Kaya Guides is currently attempting to double counselor headcount roughly every six months (around fourfold annual growth) to meet its target of 100,000 participants, but progress is constrained by HR and management capacity.

Treating depression with guided digital self-help programs / Crucial Considerations

What scale could a new organization reach?

We currently model a reach of 100,000 people at scale (equivalent to approximately 25,000 program completers) based on Kaya Guides' ambitions to reach this level by Year 5. However, there is significant uncertainty around how realistic this target is.

Kaya Guides was incubated in 2022 and launched its WhatsApp-based program in August 2023. Since then, it has grown from 700 to approximately 3,600 participants, though the feasibility of sustaining this pace remains uncertain due to HR and management constraints.

How durable are the effects of this intervention?

Our model applies a one-year duration of effects, though there is considerable uncertainty around how durable the effects are in practice.

The evidence base for long-term impacts is limited.

- The five RCTs on the WHO Step-by-Step program include only a three-month follow-up. One study found that effects strengthened over this period, with depression effect size increasing from SMD=0.48 post-treatment to SMD=0.61 at three months.
- Evidence from other guided self-help interventions suggests effects may persist for up to 12 months, but outcomes beyond this point are either unstudied or no longer statistically significant. One meta-analysis found effects declining to MD=-0.5 (barely significant) at 12 months, while another reported a 33% reduction in effect size between 6–9 months and 10–12 months (g=0.74 to g=0.49).
- HLI's meta-analysis of psychotherapy more broadly estimates effects lasting 3.48 years, or 5.36 when including some unusually long-term follow-up periods ([McGuire et al., 2024](#)).
 - HLI uses 3.48 years in its CEAs of Friendship Bench and StrongMinds.

Table 1 shows how cost-effectiveness estimates vary under different assumptions about the duration of effects and across the two modeling methods used in [our CEA model](#).

Table 1: Sensitivity analysis on duration of effects (average cost-effectiveness across modeled countries, \$/DALY)

Duration of effects	Method 1	Method 2	Average across methods
1 year (current model)	120	82	97
3 months (WHO Step-by-Step RCT follow-up)	481	326	389

6.5 months (minimum duration to meet our cost-effectiveness bar)	222	151	180
8 months (Mamukashvili- Delau's 2023)	180	122	145
1 year with decay (100% for first 6 months and 50% for second 6 months)	160	109	130
1 year with decay (Cuijpers, 2023) ¹	131	89	106
3.48 years (used by Kaya Guides)	35	23	28

Based on Table 1, effects would need to last at least 6.5 months for this intervention to meet our cost-effectiveness bar of \$220 per DALY across all three methods. Current evidence from WHO Step-by-Step trials only track outcomes over a three-month period, leaving a gap between observed effects and the duration required for strong cost-effectiveness. This reflects a lack of long-term evidence rather than evidence that effects do not persist.

Recruitment at scale

- **Recruiting lay counselors:** Kaya Guides reports that it has been able to successfully recruit lay professionals through local job advertisements, with many guides drawn from psychology students or women with master's degrees. However, scaling this model remains a challenge. Kaya Guides is currently attempting to double counselor headcount roughly every six months (around fourfold annual growth) in order to reach its goal of 100,000 participants by Year 5, but progress is constrained by HR and management capacity.
- **Recruiting participants:** Kaya Guides currently recruits participants through targeted Meta advertising, largely via Instagram. In its pilot, the organization was highly successful at recruiting its target population: 97% of participants who completed the baseline depression questionnaire met criteria for depression, and 82% scored in the moderate-to-severe range (Abbot, 2024). This suggests that targeted digital ads can be an effective recruitment channel for this population.

While digital delivery may make recruitment easier than in-person group therapy, scaling remains nontrivial. According to Huw Evans, Kaya Guides is currently bottlenecked by staffing and funding despite demand for its program. Vida Plena, which provides community-led depression treatment in Latin America, has also faced recruitment challenges. At the same time, experience from other large LMIC mental-health programs

¹ Cuijpers, 2023 found a 33% reduction in effect size from 6–9 months to 10–12 months ($g=0.74$ to $g=0.49$).

shows that high-volume recruitment is possible: StrongMinds reports reaching 240,000 people in Uganda and Zambia in 2023 ([StrongMinds, 2023](#)), and Friendship Bench reports serving more than 800,000 people across its programs ([Friendship Bench, n.d.](#)).

Our CEA assumes that a new charity could reach 100,000 people by Year 5, in line with Kaya Guides' scaling ambitions. However, this projection is uncertain. We assume that approximately 45% of recruited participants do not complete the first session², and only around 25% (25,000 people) complete all five sessions. To date, Kaya Guides has reached approximately 3,600 people since launching in August 2023. While this demonstrates early traction, it remains uncertain whether the organization, or a new entrant, can scale to this level within five years.

Recruitment information from WHO Step-by-Step RCTs:

- [Cuijpers et al., 2022a](#): "Recruitment of participants took place through advertising for the research project on several social media platforms, by posting and boosting posts on the official social media pages of the National Mental Health Programme on Facebook and Instagram. Additionally, outreach methods took place with the network of NGOs and UN agencies taking part in a mental health and psychosocial support taskforce whereby meetings were held in different regions with the Syrian community to introduce the project, followed by WhatsApp broadcasts that were sent by the organizations to their Syrian beneficiaries... As remuneration for completing all the questionnaires, users received \$20 phone credit."
- [Cuijpers et al., 2022b](#): As above - Participants were recruited through online advertisements and social media and received remuneration of \$20 phone credit.
- [Heim et al., 2021](#): Participants were recruited through social media (Facebook and WhatsApp), using advertisements developed by a communications and advertising company based on focus group testing. "A partnership was established with UNHCR to support dissemination of the posts to the Syrian community via their messaging strategy over WhatsApp and through their outreach volunteers. Organizations in the Mental Health and Psychosocial Support (MHPSS) taskforce were also approached to help disseminate the project among their beneficiaries, and a group of social workers from the International Medical Corps (IMC) have been trained to introduce the project in their outreach activities."
 - Participants do not appear to have received financial compensation for participation in this study.
- [Li et al., 2024](#): "Participants were recruited via (1) university daily news; (2) posters and leaflets on campus; (3) presentations by research staff; and, (4) referrals from the university counseling center [...] Participants received compensation for posttreatment and follow-up assessments (\$6 and \$12 US dollars, respectively)."
- [Buchert et al. 2024](#): "Participant recruitment was carried out in collaboration with Caritas Egypt, an NGO with a long track record in providing health services to refugees in the Alexandria metropolitan area. The NGO team reached out to potential participants, provided information on the study, and supported study processes onsite... Participants received a compensation of 150 Egyptian

² We think in reality more participants might complete their first sessions, as Kaya Guides data shows they have higher rates of early completion (see [more](#))

pounds (EGP; equivalent to 9 USD) for the post and the follow-up assessments, respectively.”

- **Recruiting supervisors:** At scale, we estimate a need for 17 supervisors. Based on Kaya Guides’ experience, we expect it would be feasible to recruit supervisors through local job advertisements. However, Kaya Guides has not reached a scale that requires more than one supervisor, so there is some uncertainty around how this would translate at a larger scale.

Based on this, our primary concern is HR and management capacity at scale rather than recruitment of lay professionals, participants, or supervisors. Our CEA assumes 15 HR/management staff (in addition to co-founders) at scale. This concern is informed largely by Huw’s comments, though we do not believe this level of senior staffing is implausible. For context, [Fortify Health](#) appears to have 10 people in leadership roles and a further 33 staff with senior or manager titles, while [Suvita](#) appears to have 17 non-ground staff and an additional 12 staff in senior roles (both figures include co-founders).

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1 Background

1.1 Context

Ambitious Impact (AIM) exists to increase the number and quality of effective nonprofits working to improve human and animal wellbeing. AIM connects talented individuals with high-impact ideas. We give potential entrepreneurs intensive training and ongoing support to launch ideas to scale. Our research team focuses on finding impactful opportunities.

As part of our 2025 research agenda, we reviewed wellbeing-focused global health as a cause area. In that context, we researched *Improving access to depression care through guided digital self-help*. This report provides an overview of our findings.

1.2 Introduction to the idea and problem

Depression imposes a huge global burden as one of the leading causes of disability worldwide. Over 300 million people are affected globally, with LMICs bearing the majority of this burden ([WHO, 2017](#)). Crucially, mental health treatment gaps are vast: WHO estimates that ~75% of people in need in LMICs receive no care ([WHO, n.d.](#)). This treatment gap is largely driven by a severe shortage of mental health professionals. Low-income countries have about 1.1 mental health workers³ per 100,000 people, compared with 2.4 in lower-middle-income countries and 19.3 in upper-middle-income countries. In contrast, high-income countries have around 67.2 per 100,000 ([WHO Mental Health Atlas, 2024](#)). The extremely limited specialist capacity in LMICs makes it difficult to scale mental health support ([Patel, 2018](#)). Moreover, in rural or poor areas, even if services exist, they may be geographically or financially inaccessible.

³ MHWs includes “psychiatrists, child psychiatrists, other medical doctors, nurses, psychologists, social workers, occupational therapists and other paid workers in mental health”

Cultural stigma around mental illness also dissuades people from seeking help ([Le, 2022](#)). Many individuals may not recognize depression as a treatable condition.

Guided self-help can provide a scalable approach designed to address specialist shortages, reduce stigma through private self-guided use, and expand access to evidence-based care. Guided self-help combines culturally-adapted digital therapy modules with light human support (brief weekly check-ins by trained lay counselors) to expand access to mental health care. Delivered via mobile technology (SMS, WhatsApp, or apps), it can reach large populations at low per-capita cost.

This model circumvents key barriers in LMICs: anonymity and convenience reduce stigma; automated content ensures fidelity; and minimal human guidance boosts engagement. The [WHO Step-by-Step](#) program exemplifies this approach: a digital course “designed to treat depression through an internet-connected device” with five 20-minute self-guided sessions (see Figure 1) focused on behavioral activation⁴, accompanied by weekly 15-minute phone support from trained non-specialists⁵ ([Carswell, 2018](#); [WHO, 2022](#)).

⁴ The intervention focuses on “behavioural activation as the central therapeutic component with additional components covering psychoeducation, stress management techniques (slow breathing), identifying strengths, positive self-talk, increasing social support and relapse prevention.” ([Carswell 2018](#))

⁵ “Guidance in Step-by-Step is provided by non-professional “e-helpers” and is limited to 15–20 minutes per week using telephone, synchronous online messaging or through a secure email system. Multiple contact approaches are provided to ensure users have choice and can use a method that suits their needs. E-helpers are university graduates without a professional qualification in mental health care, but with some experience of providing support to vulnerable people (e.g., volunteering, working in a community service). They are trained to provide structured guidance which covers a review of the previous session and any related questions, review of the user’s experience, putting the skills into practice and providing encouragement and support in using the program.” ([Carswell 2018](#))

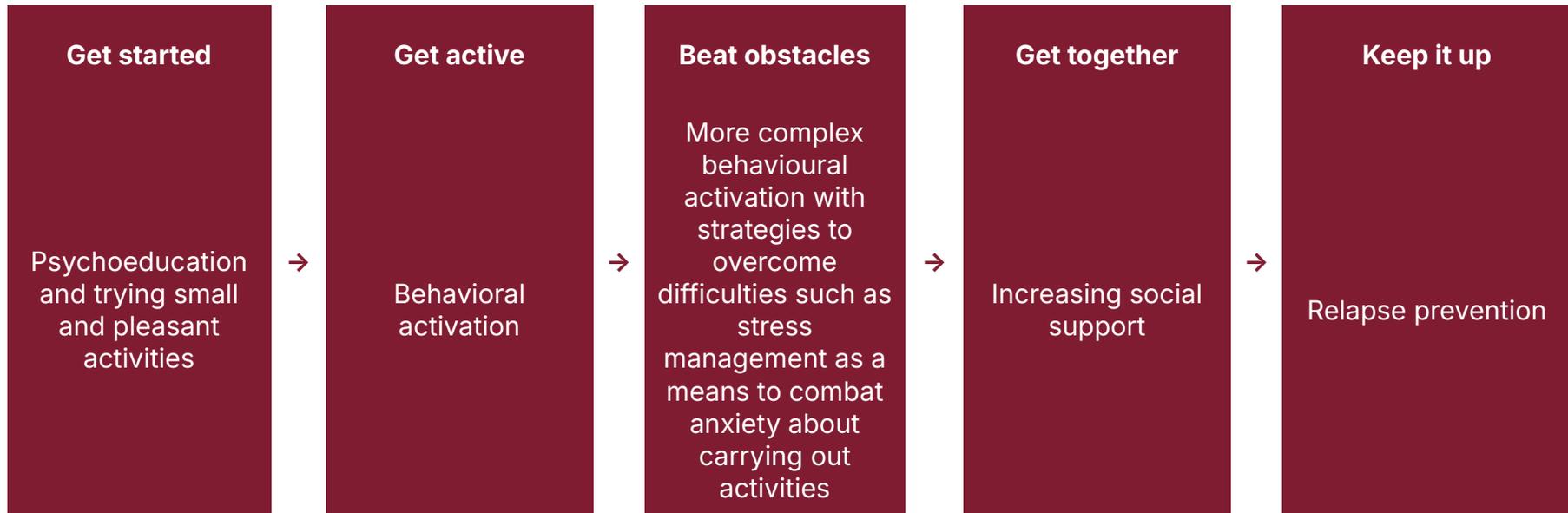


Figure 1: Outline of the five therapeutic sessions of WHO's Step-by-Step program (Carswell, 2018).

The Step-by-Step program has been adapted by the AIM-incubated organization Kaya Guides for the Indian context and delivered using WhatsApp, with content in Hindi. The program follows the same five steps outlined in Figure 1.

2 Theory of change

We envision a charity that would deliver a guided digital self-help program for adults with depression in LMICs, modeled on WHO's Step-by-Step program and Kaya Guides.

The core offering would be a five-session behavioral activation course delivered through a mobile platform such as WhatsApp or a lightweight web app.

Participants would work through short, structured modules on their own, with each session taking about 20 minutes. Each participant would be paired with a trained lay counselor who provides brief weekly check-ins by phone⁶ over the five-week program. A supervisory team would oversee counselors and review flagged cases.

This model would aim to close the large treatment gap by combining scalable digital content with minimal human support. Because most therapeutic work would be digital and standardized, the marginal cost per participant would remain low, and each counselor could support many users.

2.1 Barriers to Mental Health Care in LMICs

Mental health care in LMICs is limited by several barriers:

Structural barriers:

- **Specialist capacity is extremely low:** low-income countries have about 1.1 mental health workers per 100,000 people, and lower-middle-income countries about 2.4, compared to 67.2 per 100,000 in high-income countries ([WHO Mental Health Atlas, 2024](#)).
- **Minimal mental health budgets:** LMIC governments allocate very little to mental health—around 2% of total health spending on average ([WHO 2022](#)), and in many low-income countries less than 1% ([Patel, 2025](#)).
- **Cost of services:** a meta-analysis by Sarikhani found the second most common barrier to mental health service use in LMICs was cost (71% of studies reported this barrier) ([Sarikhani 2021](#)).

⁶ Kaya Guides model is to provide up to 8 contacts with counselors.

- **Distance and transportation barriers** were also cited ([Sarikhani 2021](#)).

Attitudinal barriers also delay service:

- **Stigma** around mental illness leads people to delay seeking help, lower access to care, and leads to suboptimal treatment and outcomes ([Sarikhani 2017](#); [Javed 2021](#); [Wainberg 2017](#); [Le 2022](#)). In a meta-analysis on the barriers to mental health service use in LMICs, social stigma was cited in 83% of papers ([Sarikhani 2017](#)).
- **Concerns about the effectiveness of services** delays treatment ([Sarikhani 2017](#)).
- **Cultural beliefs**, such as attributing mental health illness to spiritual causes ([Sarikhani 2017](#)).

Knowledge barriers

- Lack of knowledge about mental illnesses and available services delays the use of mental health services ([Sarikhani 2017](#)).

2.2 Approaches considered

For this report, we focused on digital self-help for depression in LMICs. We considered two approaches:

- **Digital unguided self-help interventions:** standalone apps without human support.⁷ Please see Annex 1 for our analysis of the evidence on guided vs unguided self-help.
- **Digital guided self-help:** structured digital content supplemented by brief support from trained lay workers (e.g., [WHO Step-by-Step](#)⁸, [Kaya Guides](#)).

We prioritized guided digital self-help for the following reasons:

- It has greater effect sizes and seemingly greater adherence rates (see [Section 3.2](#))

⁷ We still think it's possible that unguided self-help might be cost-effective and tractable, and this is an important area for deeper investigation.

⁸ WHO's Step-by-Step program is specifically designed for depression.

- There are 5 RCTs testing Step-by-Step in LMICs: WHO's Step-by-Step model has been tested in five trials across Lebanon ([Cuijpers 2022a](#), [Cuijpers 2022b](#), [Heim 2021](#)), Egypt ([Buchert 2024](#)), and China ([Li 2024](#)) in three languages (Arabic, Chinese, and English).
- In addition, we found one RCT in HICs/UMICs (Switzerland, Germany) in the Albanian language ([Heim 2024](#)), and a radio adaptation of Step-by-Step in Zambia in Tonga ([Clare 2025](#)).
- Kaya Guides, an AIM-incubated charity, piloted Step-by-Step in India ([Kaya Guides 2024](#)), and has thus far reached 3,600 participants (per Kaya Guides), showing feasibility in a new cultural and linguistic context. They are currently in the process of scaling. Separately, Step-by-Step was scaled up to 1,942 users in Lebanon ([Ramia 2025](#)).
- The CTO of Kaya Guides, Huw, reported that they could support a new charity on technical setup and platform adaptation, therefore saving substantial time and resources on product development.

2.3 Theory of change for this charity

We decided to focus on the ToC depicted in Figure 2. The core focus of the envisioned organization would be to identify adults with mild-to-moderate depression who lack access to care, deliver a guided self-help program that reduces their symptom severity through behavioral activation and skill-building, and thereby improve their wellbeing.

Figure 2 presents a high-level theory of change for guided self-help for depression delivered via WHO Step-by-Step on WhatsApp.

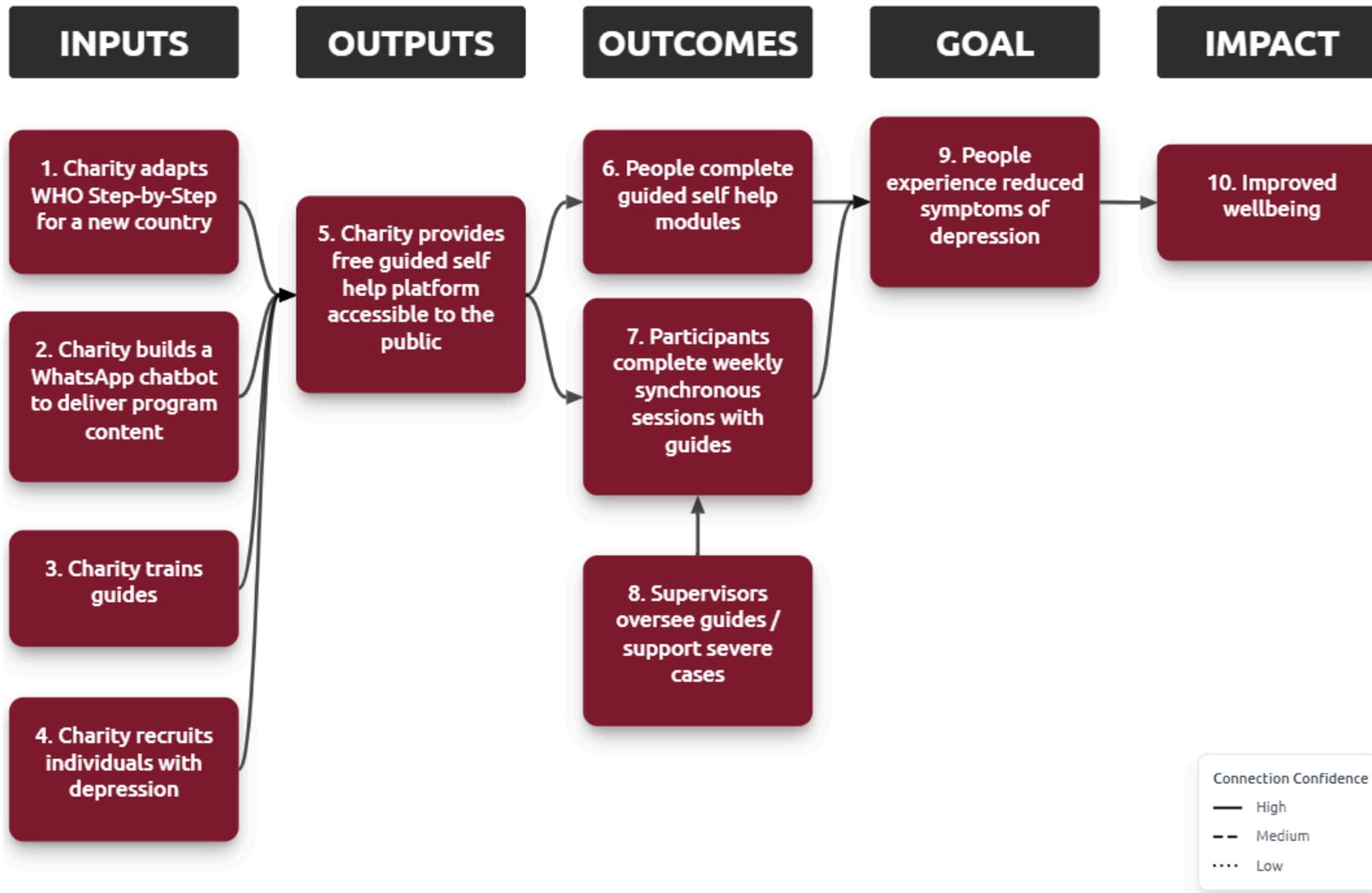


Figure 2: Theory of change for this charity ([view in full here](#))

2.4 Key assumptions and supporting rationale

The table below outlines each step in the theory of change and the assumptions required for that step to hold. For each assumption, we summarize the relevant supporting or contradicting evidence.

No.	Assumption	Evidence/reasoning
1→5	The charity can adapt Step-by-Step materials to the local context (culture and language)	<p>Step-by-Step has been adapted and delivered in multiple LMIC settings and languages:</p> <ul style="list-style-type: none"> • Hindi in India (Kaya Guides), • Arabic in Lebanon (UNHCR), three RCTs with displaced Syrians and general-population users (Cuijpers 2022a; Cuijpers 2022b), and China (Li 2024). • Arabic in Egypt (Buchert et al. 2024), • Chinese in China (Li et al. 2024) • Albanian in Switzerland and Germany (Heim 2024), • Tonga in Zambia (Clare 2025), • Thai in Thailand (WHO 2025), • Arabic in Egypt and Sweden (Woodward 2023) • Filipino in Macao, China (Garabiles 2019) <p>Note: Kaya Guides specifically recommended hiring a trained psychologist as a clinical director to maximize the chances that cultural beliefs and attitudes are adapted.</p>
2→5	The charity can build a WhatsApp chatbot to deliver program content	Kaya Guides has already built and deployed a WhatsApp-based Step-by-Step program in India. Their CTO reported that this platform can be repurposed for a new organization for a service fee, reducing development time and cost.
3→5	The charity can hire a sufficient number of lay professionals as guides	Kaya Guides reports successful hiring of lay professionals as guides through local job ads. Many of their guides are psychology students or women with master’s degrees. Note that we are concerned about a new charity’s ability to hire large numbers of guides at scale. Kaya Guides is currently trying to double counselor headcount roughly every 6 months (~4x per year) to reach their goal of recruiting 100,000 people by Year 5, but they are bottlenecked by HR and management capacity. For these reasons, we are only moderately certain that a charity could recruit enough lay professionals to reach scale within 5 years.
	Lay professionals can be trained to deliver effective 15-minute therapeutic sessions	There is program-relevant evidence that lay professionals can be trained to deliver short, structured therapeutic sessions. Randomized trials of the WHO Step-by-Step program trained non-specialist “e-helpers” with no prior experience delivering mental health treatment beyond basic health or psychology backgrounds. (Cuijpers 2022a ; Cuijpers, 2022b). In addition, Kaya Guides have been able to effectively train lay professionals to deliver 15-minute therapeutic sessions (Kaya Guides 2024).

		<p>There is also supporting evidence from analogous interventions showing that lay providers can deliver longer and more complex psychological treatments. Lay providers have delivered effective psychological support in multiple LMIC settings (HLI, 2025). Programs such as StrongMinds, Vida Plena, and Friendship Bench train lay counselors to run 60–90 minute group sessions across 6–8 weeks (StrongMinds, n.d., Vida Plena, n.d., Friendship Bench, n.d.). StrongMinds reported that “the majority of our depression group leaders are volunteers with low levels of education and literacy” (StrongMinds 2023). If lay counselors with limited education can deliver longer and more complex interventions, it is reasonable to expect they can deliver shorter and simpler Step-by-Step sessions. The charity will also hire supervisors with more therapeutic experience who can help the guides.</p>
<p>4→5</p>	<p>The charity can recruit enough individuals with depression at scale</p>	<p>Our cost-effectiveness model assumes the charity reaches 100,000 people by Year 5. This scale assumption is informed by Kaya Guides’ stated growth ambitions. We conservatively assume high attrition aligned with attrition observed in Kaya Guides’ implementation (see CEA for details).</p> <p>There is meaningful uncertainty around whether this scale is achievable within five years. Since launching in August 2023, Kaya Guides has treated approximately 3,600 participants. Additionally, Vida Plena, another AIM-incubated charity, has faced recruitment challenges in its in-person group therapy model. While we expect recruitment to be easier for a digital intervention than for in-person programs, these examples highlight the practical difficulty of scaling.</p> <p>However, there is evidence of underlying demand. Kaya Guides currently recruits participants primarily through targeted Meta advertising and reports being constrained by hiring capacity and funding rather than participant interest (<i>Huw Evans expert interview</i>).</p> <p>There is also indirect evidence from comparable LMIC mental health programs that high-volume recruitment is possible: StrongMinds reports reaching approximately 240,000 people in Uganda and Zambia in 2023 (StrongMinds, 2023), and Friendship Bench reports serving over 800,000 people across its programs (Friendship Bench, n.d.).</p> <p>Overall, we view recruitment at scale as the most uncertain assumption in the theory of change and a major execution risk. We therefore expect this to be a central focus for prospective co-founders.</p>
	<p>The charity can screen individuals for depression with high accuracy</p>	<p>Standard tools such as the PHQ-9 and the Cantril Ladder are widely used in LMIC settings and are straightforward to administer (Carroll et al., 2020). Kaya Guides and Vida Plena already use PHQ-9–based screening to identify individuals with probable depression, suggesting operational feasibility. Kaya Guides also started using the Cantril Ladder in February 2025.</p>

		In their pilot, Kaya Guides were very successful at recruiting their target population: “97% of people who completed the baseline depression questionnaire scored as having depression. 82% scored moderate to severe” (Abbott, 2024).
5→6 and 5→7	Individuals a) have access to smartphones, b) have internet service, c) have WhatsApp, d) have privacy (to complete self-guided modules and for 15 minute calls with guides), and e) individuals complete guided self-help modules and guide calls at high enough levels.	<p>Smartphone + Internet + WhatsApp access: Pew reports that in eight middle-income countries, a median of 73% of adults use WhatsApp (Pew 2024). Askyazi data from six Sub-Saharan African countries (Uganda, Ghana, Nigeria, South Africa, Ivory Coast, Cameroon) shows internet penetration of 43–75%, WhatsApp penetration among internet users of 80–98%, and overall population-level WhatsApp penetration of 10–50% (Askyazi 2025). This indicates that it would be possible to identify countries with high levels of access to this program. We can also prioritize countries with higher levels of access. However, we note that smartphone ownership and WhatsApp penetration may be lower among the poorest, which could affect reach.</p> <p>Privacy: Direct evidence is limited, but proxy evidence suggests feasibility. Kaya Guides (India) and multiple WHO Step-by-Step RCTs in LMICs were able to deliver 15-minute synchronous interactions, implying that many users can secure short periods of privacy. However, we note that privacy constraints may vary by household size, gender norms, and living arrangements.</p> <p>Completion rates are similar across RCTs (32.20%, 19%, 24%, 24.20%, 25.56%, see Section 3.2.5) and the Kaya Guides pilot program (27%, see Abbott, 2024 for details). More recently, Kaya Guides reported in an expert interview that participants completed an average of 4.5 calls.</p>
8→7	The charity can recruit enough supervisors, and the supervisors can oversee guides and support severe cases.	<p>We only require a total of 17 supervisors at scale. We think that it will be possible to recruit these supervisors via local job adverts as Kaya Guides has been able to do. In the future, Kaya plans to “promote supervisors from the counsellor pool”.</p> <p>This program structure (where supervisors oversee ~14 guides and provide support on severe cases) has worked well for Kaya Guides, so we expect that it could also work for a new charity. The charity could also have a separate on-call trained clinician for severe cases.</p>
6→9 and 7→9	The guided self-help program (when completed) leads to reductions in depression.	See Section 3.2 .
9→10	People with fewer depressive symptoms experience improved wellbeing.	It is clear that better mental health will improve wellbeing.

3 Quality of evidence

In this section, we assess the evidence base for WHO's Step-by-Step program. To do so, we discuss the evidence base for different types of therapy. We define these as follows:

- Face-to-face therapy (FTF): In-person (one-to-one or group) therapy sessions between a patient and a therapist (trained or a lay person). The type of therapy used in FTF sessions can vary greatly (relaxation therapy, exposure therapy, CBT, breath training, etc.).
 - Also termed "in-person therapy" and "individual therapy" (here, the therapy is delivered one-to-one).
- Self-help therapy: Therapy that uses self-directed tools (workbooks, apps, modules/sessions) to self-manage mental health issues. Self-help therapy can be guided (discussed below) or unguided, where one works through these tools alone at their own pace.
- Guided self-help (GSH): Working through self-directed tools with coaching from a therapist or trained lay person).
 - WHO's Step-by-Step program is a form of guided self-help. Kaya Guides has adapted it to the Indian context.
- Cognitive Behavioral Therapy (CBT): A type of psychotherapy that helps people manage their problems by changing negative thought patterns and behaviors. CBT can be delivered face-to-face, or through both guided and unguided self-help.
 - Behavioral activation is a component of CBT which increases participants' engagement in rewarding and meaningful activities and focuses on how these activities can improve mood and break the cycle of depression / poor mental health.
 - WHO's Step-by-Step program uses behavioral activation as its central therapeutic component ([Carswell et al., 2018](#))

3.1 Evidence on feasibility

Kaya Guides was incubated by AIM in 2022 and is the first non-profit implementer of WHO's Step-by-Step program.⁹ Since launch, Kaya Guides has:

- Reached a total of ~3,600 people. The estimated effect per person is 0.06–1.36 WELLBYs without spillovers (0.1–2.09 WELLBYs with household spillovers) and <0.01–0.14 DALYs without spillovers (0.01–0.22 DALYs with household spillovers).
- Created its WhatsApp-based program, which launched in August 2023. This creation process included many important steps:
 - Adapting the World Health Organization's guided self-help program (Step-by-Step) to India's context and translating it to Hindi.
 - Producing 40 videos in Hindi, in partnership with a youth media organization, for use across their guided self-help modules.
 - Building and launching a WhatsApp chatbot to deliver program content.

3.2 Evidence on effectiveness

3.2.1 Effectiveness of guided self-help compared to face-to-face therapy

Meta-analytic evidence suggests that guided self-help (GSH) with minimal human support can reduce symptoms about as effectively as face-to-face individual psychotherapy ([Karyotaki, 2025](#), [Cuijpers, 2010](#)). This is very promising, as individual therapy is much more costly and time-intensive than GSH, and there is a severe shortage of therapists in LMICs ([WHO Mental Health Atlas, 2024](#)). An overview of the evidence is below:

⁹ Clare et al. have also adapted the WHO Step-by-Step program into an unguided radio delivery method in Zambia ([Clare 2025](#)).

- A 2024 preprint network meta-analysis in *The Lancet* (not yet peer reviewed) comparing CBT delivery formats in LMICs found that guided self-help reduced depressive symptoms with effect sizes similar to individual FTF therapy. Guided self-help had an effect size of $g = 0.78$ (95% CI 0.47–1.09; $k = 12$), while individual therapy had an effect size of $g = 0.99$ (95% CI 0.68–1.29), and the difference between them was not statistically significant ([Karyotaki, 2025](#)).
- A 2010 comparative meta-analysis of 21 trials ($n=810$) found no meaningful difference between guided self-help and FTF therapy ($d = -0.02$, 95% CI -0.20 to 0.15), including at 3-, 6-, and 12-month follow-ups ($k=10, 9$, and 3) ([Cuijpers, 2010](#)).
 - However, this evidence has some limits: only six of the trials focused specifically on depression (the rest on anxiety disorders, panic, and phobia disorders), and all were conducted in high-income countries, potentially reducing generalizability to depression in LMICs.
- A 2019 meta-analysis of 155 trials ($n = 15,191$) found no statistically significant difference between GSH and individual therapy ([Cuijpers, 2019](#)).

3.2.2 Evidence on the WHO Step-by-Step program

We identified five randomized controlled trials evaluating the WHO Step-by-Step guided self-help program in LMICs.¹⁰ We describe the study setting, population, effects, and concerns in this section.

Study settings and populations

The existing evidence base is concentrated in three LMIC settings and populations. Three trials were conducted in Lebanon, one in China, and one in Egypt. Three focused on refugees, one on the general population, and one on

¹⁰ We identified one additional RCT conducted in a high-income country with Albanian refugees ([Heim 2024](#)). We did not include this study in our main analysis for three reasons. First, the trial did not include a true control group: the comparison arm received a “surface adaptation,” in which participants reviewed the intervention content and provided feedback on exercises, illustrations, and usability, while the intervention arm received a “deep adaptation” tailored to the target population. As a result, the comparison group was exposed to substantial therapeutic content. Second, the study did not measure depression directly, using the Kessler Psychological Distress Scale instead, which limits comparability with the other trials and prevents straightforward inclusion in our models. Third, the study was conducted in a high-income country, which reduces its external validity for LMIC implementation.

Chinese students (see Table 1). All studies assessed depressive symptoms using validated self-reported scales (PHQ-9 or HSCL-25) and compared Step-by-Step to enhanced usual care, with follow-up periods of three months.

Table 1: Study characteristics of RCTs evaluating WHO Step-by-Step program in LMICs

Study	RCT	Outcome measure	Country	Population	Age	Follow-up period	Control group	n
Cuijpers et al. 2022a	RCT	PHQ-9	Lebanon	Refugees	Adults	3 months	EUC ¹¹	569
Cuijpers et al. 2022b	RCT	PHQ-9	Lebanon	General Population	Adults	3 months	EUC	680
Heim et al. 2021	Feasibility RCT	PHQ-9	Lebanon	Refugees	Adults	3 months	EUC	138
Li et al. 2024	RCT	PHQ-9	China	Students	Adults	3 months	EUC	285
Burchert et al. 2024	RCT	HSCL-25 ¹²	Egypt	Refugees	Adults	3 months	EUC	538

Overall effects across randomized trials

All five studies conducted in LMICs found that Step-by-Step produced statistically significant improvements relative to enhanced usual care immediately post-treatment, and all but one found statistically significant improvements relative to enhanced usual care at three months (see Table 2). The effect sizes fall within—and sometimes below—the range seen in the broader guided self-help literature summarized in [Section 3.2.1](#).

Table 2: Effect sizes across studies immediately post-treatment and 3 months measured in SD effects on depression.

Study	Outcome measure	Population	SD immediately post-treatment	SD at 3 months ¹³
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¹¹ EUC = Enhanced usual care which across all studies was: “one page of basic psychoeducation and a referral list to evidence-based care, which was administered online right after allocation. Psychoeducation on depression and anxiety was delivered through the app or website. The text for the psychoeducational messages was taken from the first session of Step-by-Step to ensure identical information. After the psychoeducation, users received a list of primary healthcare facilities with non-specialised staff trained in evidence-based mental healthcare.”

¹² While the HSCL-25 is commonly used elsewhere as a measure of depression and anxiety, Burchert et al. treat it as a measure of overall psychological distress. We note that such a broader distress outcome measure may be less responsive to a depression-specific measure ([Wiebe 2003](#)), particularly in a trauma-exposed population with elevated PTSD risk, as in this study. Despite this, we chose to include Burchert (2024) in our analysis to remain conservative, as it reports the smallest effect size among the included studies. To reflect the measurement mismatch and population differences, we applied a slightly lower weight to this study's effect estimate in our pooled results.

¹³ Note that three months is the longest follow-up period for all of these studies.

Cuijpers et al. 2022a	PHQ-9	Refugees	SMD = 0.48 (95% CI: 0.26-0.7, p = <0.001)	SMD = 0.61 (95% CI: 0.37-0.85, p = <0.001)
Cuijpers et al. 2022b	PHQ-9	General population	SMD = 0.71 (95% CI: 0.45-0.97, p = <0.01)	SMD = 0.52 (95% CI: 0.22-0.82, p = <0.01)
Heim et al. 2021	PHQ-9	Refugees	Not reported in SDs, but statistically significant ¹⁴	
Li et al. 2024	PHQ-9	Students	g = 0.35 (95% CI: 0.12-0.59, p = 0.004)	g = 0.16 (95% CI: -0.07-0.4, p = 0.179)
Buchert et al. 2024	HSCL-25	Refugees	g = 0.23 (p = 0.021)	g = 0.22 (p = 0.022)

Questions about generalizability to the general population

The predominance of refugee-focused trials raises questions about generalizability to a broader population. Refugees may have higher baseline distress, potential comorbidities (e.g., PTSD), and different engagement patterns. This could either inflate or depress effect sizes; the direction is uncertain.

To explore this, we examined the effect sizes of two trials conducted concurrently in Lebanon by Cuijpers et al.: one among Syrian refugees and one among the Lebanese general population. The general-population sample showed a larger treatment effect (SMD = 0.71, p < 0.01), while the refugee sample showed a more moderate effect (SMD = 0.48, p < 0.001). See [Cuijpers et al. 2022a](#) and [Cuijpers et al. 2022b](#) in Table 2 for the corresponding results. This provides some supporting evidence that the treatment effects are similar among the refugee and general populations.

However, adherence patterns differed in the opposite direction: refugees completed the full program at higher rates (32.2%) than the general-population participants (19%). While this suggests that adherence may be lower outside refugee settings, Kaya Guides achieved a 27% full-completion rate among ~800 participants from the general population in their 2024 pilot ([Abbott 2024](#)), indicating that higher adherence in non-refugee contexts is feasible.

Overall, we conclude there is limited but compelling evidence that guided self-help is effective among the general population.

¹⁴ Note that the [Heim et al. 2021](#) study did include effect sizes, they just didn't include this in SDs. Instead they provided pre and post-treatments scores on the PHQ-9, which we later use in our cost-effectiveness analysis.

Risk of bias assessment

We also examined the risk of bias (RoB), using the [Revised Cochrane risk of bias tool for randomized trials - short version](#), and found some concern for all Mapping PHQ-9 Scovive RCTs. Please see our [RoB spreadsheet for details](#)¹⁵; we summarize the key points below.

Our assessment used the Cochrane risk of bias tool, covering the five principal domains summarized in Table 3.

Table 3: Risk of bias assessment overview for WHO Step-by-Step RCTs.

Domain	Key questions	Cuijpers 2022a	Cuijpers 2022b	Heim 2021	Li 2024	Buchert 2024
Randomization process	Was the allocation sequence random and concealed? Do baseline differences suggest risk of bias?	Low	Low	Low	Low	Low
Deviations from Intended Interventions	Were participants/personnel blinded? Were deviations balanced between groups? Was intention-to-treat analysis used?	Low	Low	Low	Moderate	Low
Missing outcome data	Were data available for all/nearly all participants? Could missing data depend on its true value?	Moderate / High				
Measurement of the outcome	Was the outcome measurement appropriate? Were outcome assessors blinded?	Moderate	Moderate	Moderate	Moderate	Moderate
Selection of reported result	Was the outcome pre-specified (check protocol/registry)? Evidence of multiple analyses or selective reporting?	Low	Low	Low / Moderate	Low	Low

We found low concern for bias arising from the randomization process, deviations from intended interventions (apart from in Li 2024), and selection of reported results. In practice, this means that participants were appropriately

¹⁵ Note that this risk of bias assessment was performed with the help of ChatGPT. Everything was double-checked and verified by the author.

randomized, the intervention was delivered largely as planned, and the reported outcomes were not selectively chosen to favor the intervention.

However, we identified more substantial concerns related to **missing outcome data** and **measurement of outcomes**, which are discussed in detail below.

Missing outcome data

Across all five WHO Step-by-Step trials, we identified substantial concerns related to missing outcome data, driven by consistently high attrition and low intervention completion rates. Post-treatment attrition ranged from 37% to 65%, and attrition at three-month follow-up ranged from 48% to over 80%, depending on the study. In all trials, fewer than one-third of participants completed the full intervention.

Several features of these studies suggest that participants who dropped out may have had different outcomes than those who remained, raising concern that attrition could bias the results. First, the intervention required sustained engagement over multiple weeks, yet adherence was low (19–32% completing all sessions across studies). Participants who experienced limited benefit, worsening symptoms, high distress, or low motivation may therefore have been more likely to disengage from both the intervention and outcome assessments. Second, qualitative process evaluations and author reports frequently cite reasons for dropout—such as perceived lack of benefit, intervention burden, competing life stressors, and technical barriers—that plausibly correlate with mental health status and treatment response. In multiple studies, authors explicitly identified high dropout as a primary limitation.

Some studies reported that observed baseline characteristics and initial symptom severity did not statistically predict dropout ([Heim, 2021](#); [Li, 2024](#)).

However, participants may have disengaged because the intervention was ineffective or their symptoms worsened—outcomes that are unobserved precisely because they dropped out.

To mitigate the risk of bias from attrition, all studies calculated missing outcome observations using multiple imputation based on prescores and prespecified

background characteristics (gender, age, education and symptom severity). This indicates that the effect sizes already take into account these attrition rates. In addition, attrition rates were broadly similar across treatment and control arms, with only modest differences (4.2%) between groups, reducing—but not eliminating—concerns about differential attrition bias.

Nevertheless, while high attrition is common in digital mental health interventions and partly expected, the magnitude and consistency of missing data across these trials introduce meaningful uncertainty. Specifically, if participants who benefited less (or worsened) were more likely to drop out, treatment effects estimated from completers may overstate true population-level effectiveness. For this reason, we judge the risk of bias due to missing outcome data to be moderate to high across all five trials. We gave a downward adjustment to our cost-effectiveness to account for attrition (see [CEA](#)).

Measurement of the outcome

All studies rely on outcome measures that are self-reported, and participants necessarily knew whether they were receiving the Step-by-Step intervention or control as the intervention involved active app use and weekly helper contact. This means that the impact of the intervention could be overstated due to social desirability bias.

Deviations from intended interventions

We also had some concern about bias due to deviations from intended interventions in [Li, 2024](#) as dropout rates were statistically higher in the treatment group. Moreover, the authors originally intended to perform an intention-to-treat analysis, but due to unexpectedly high dropout before completion of baseline assessment (only 77% completed the baseline assessment), they had to conduct a modified ITT analysis, including only participants who completed baseline measures which could also overstate the estimated treatment effect.

3.2.3 Duration of effects

We expect the effects of this intervention to last for over one year (but less than two years) effects gradually diminishing over time. This estimation is based on: RCTs of WHO Step-by-Step, RCTs on other guided self-help interventions, and estimates of the duration of effects of psychotherapy in LMICs from Happier Lives Institute.

Step-by-Step

All five RCTs of WHO Step-by-Step report effect sizes at three-month follow-up, as seen in [Table 2](#) above. The effects at three months differed between studies:

- [Cuijpers et al. 2022a](#) - Effects strengthened at the three-month follow-up, increasing from 0.48 to 0.61 SMD in PHQ-9 depression scores compared to enhanced usual care ($p < 0.001$).
- [Cuijpers et al. 2022b](#) - Effects slightly diminished at three months from 0.71 to 0.52 SMD ($p < 0.01$).
- [Li et al. 2024](#) - Effects at three months were no longer significant ($p = 0.179$).
- [Buchert et al. 2024](#) - Effects slightly diminished at three months from $g = 0.23$ to $g = 0.22$ ($p = 0.022$).

No studies of Step-by-Step had follow-ups longer than three months.

Other guided self-help interventions

For other digital guided self-help interventions, we find evidence suggesting that impacts last up to 12 months:

- [Mamukashvili-Delau's 2023](#) meta-analysis of 15 RCTs finds continued effectiveness of internet-based guided CBT at 6–8 months (SMD = -0.59). However, the major evidence gap is durability beyond 12 months.
- [Karyotaki et al.'s 2021](#) meta-analysis of 39 RCTs evaluating the promise of internet-based guided CBT compared to “treatment as usual” found effects declining to MD = -0.5 (not significant, 95% CI: -1.1 to 0.1) at 12 months.
- [Cuijpers, 2023](#) meta-analysis of CBT in guided, unguided, individual, and group settings showed a 33% reduction in effect size from 6–9 months to 10–12 months ($g = 0.74$ to $g = 0.49$). Beyond 12 months, effects are not statistically significant ([Mamukashvili-Delau, 2023](#): SMD = -0.12, $p > 0.05$).

Face-to-face therapy

Estimates of the duration of effects of psychotherapy vary greatly. HLI's meta-analysis of the impacts of psychotherapy in LMICs estimates effects last for 3.48 years, or 5.36 years when including some large outliers with very long-term follow-ups ([McGuire et al., 2024](#)).

- Kaya Guides uses 3.48 years in their cost-effectiveness analysis based on this.

3.2.4 Adherence rates

We estimate that only ~24.9% of people will complete all five sessions and that 45% of those recruited will not complete any sessions. This estimate is based on the average attrition rates seen in the five RCTs on WHO Step-by-Step. See Table 4 (blank cells indicate data was not reported in the original study).

Table 4: Completion rates in WHO Step-by-Step studies

Study	Number of sessions completed				
	1	2	3	4	5
Cuijpers et al. 2022a	71%		42%		32%
Cuijpers et al. 2022b	40%	31%	27%	24%	19%
Heim et al. 2021	46%	25%	22%	26%	24%
Li et al. 2024	54%				24%
Buchert et al. 2024	67%	50%	38%	37%	26%
Average	55%	35%	32%	29%	25%

3.3 Evidence on broader impacts and spillover effects

Household Spillover Benefits

We defer to HLI's estimate of household spillover effects of 16.24% ([HLI, 2025](#)), which is also in line with GiveWell's best guess for spillover effects of 15% ([GiveWell, 2023](#))

Productivity and Economic Benefits

Depression significantly impairs work performance and labor force participation. WHO estimates the global economic cost of depression and anxiety at \$1 trillion annually in lost productivity ([WHO, 2024](#)). Lebanon's Step-by-Step cost-effectiveness analysis found a greater than 75% probability of the intervention being cost-saving from a societal perspective when accounting for productivity gains ([Hana et al., 2024](#)).

Suicide Prevention and Self-Harm Reduction

Although the relationship between depression and other mental health problems and suicide is complex, it is clear that mental illness increases the risk of suicide considerably ([Song et al., 2020](#)). It could be the case that this intervention prevents suicide deaths, but we have not tried to quantify this in our modelling.

There may also be some reduction in self-harm as a result of this intervention, but we have not attempted to quantify this in our modelling.

4 Expert views

As part of our investigation, we consulted two experts familiar with this space: Kenneth Carswell (WHO) and Huw Evans (Kaya Guides).

Expert consultations confirmed the viability of guided self-help delivery models, emphasized the importance of human guidance (even when minimal), and validated both the disability weight choices and cost-effectiveness modeling. Kenneth Carswell (WHO) provided implementation guidance and directed us to WHO resources on Step-by-Step. Experience from Kaya Guides demonstrated the feasibility of achieving low per-person costs through digital delivery.

Kenneth Carswell (WHO)—Evidence-Based Digital Intervention (Step-by-Step)

WHO's strategy positions Step-by-Step as a freely available, evidence-based intervention that countries can adapt and implement ([Carswell et al., 2018](#)). The open-access model (contact: Psych_interventions@who.int for manuals and training materials) enables rapid scaling without licensing barriers. The development process deliberately created flexible architecture allowing implementation with varying guidance levels (fully self-guided, on-demand support, or structured weekly guidance) to match local resources and preferences.

Carswell emphasized that completion rates for Step-by-Step in routine (non-trial) settings show variability but remain comparable to RCT results in some implementations. In Lebanon, post-trial implementation maintained similar completion rates to the original RCT. An RCT of the WHO Sustainable Technology for Adolescents and Youth to Reduce Stress (STARS) intervention in Jordan demonstrated high completion rates, though the study is forthcoming. Carswell noted that one study of the 'WHO Doing What Matters' intervention achieved particularly strong completion rates among university students when offered for course credit, suggesting institutional integration may enhance engagement.

For quality assurance and supervision, Carswell directed attention to the [WHO/UNICEF EQUIP project](#), which provides frameworks for ensuring quality in

scaled implementations. He noted that feasible supervision ratios and caseloads tend to vary substantially by country context and must be determined through local implementation experience rather than universal standards.

Regarding persistence of effects, Carswell confirmed good evidence for 3-month follow-up effects across WHO interventions. For longer-term effects, he recommended consulting the extensive work by Cuijpers, Karyotaki, and colleagues, which provides the most comprehensive evidence on duration of effects for digital interventions.

Step-by-Step is currently being scaled nationally in two countries, Lebanon and Thailand. The Lebanon National Mental Health Programme scaled Step-by-Step nationwide as part of its mental health system, following the positive results from two randomized controlled trials ([MHI, nd](#)). This was the first case of post-research implementation. More recently, Thailand scaled Step-by-Step nationally through the “Tor-Tuem-Jai” digital mental health platform, launched in May 2025. The initiative targets individuals experiencing stress or depression and offers stepped levels of support based on symptom severity, with trained e-Helpers supporting people with more severe problems ([WHO 2025](#)). The platform uses both Doing What Matters in Times of Stress ([WHO 2020](#)) and Step-by-Step. Together, these cases show government-integrated implementation and demonstrate the feasibility of integrating WHO digital interventions into national mental health systems.

Huw Evans—Kaya Guides’ Implementation Experience

Huw emphasized that guided self-help is primarily a scaling and execution challenge rather than an effect-size problem. Most of the cost-effectiveness variation is driven by: (i) whether early teams avoid tech bottlenecks, (ii) caseload per guide (given high no-show overhead), and (iii) how quickly fixed costs are diluted as programs scale. A central tech platform like Kaya can make an AIM-incubated charity more viable by eliminating the need for a full in-house engineering stack and allowing new teams to focus on HR, clinical adaptation, and partnerships.

Kaya Guides would be excited about a “Kaya as a platform” model where new charities take on the business risk (market fit, local partnerships, hiring guides, cultural and linguistic adaptation, fundraising), while Kaya provides the core tech and possibly a paid service layer. Kaya has done the heavy lifting to build a functioning, low-friction WhatsApp-based Step-by-Step-style intervention, plus the surrounding tech and supervision systems, which a new charity could benefit from.

A typical launch trajectory involves Years 1–2 with two co-founders (clinical and operations), ideally with some technical capacity, expanding to a small central team and roughly 10 counselors. During this phase, teams focus on translation, adaptation, piloting, and scaling toward around 1,000 participants per year. Using Kaya can save roughly the cost of a senior technical hire and reduce early execution risk.

By Year 5 and beyond, a plausible target is approximately \$1 million per year to reach around 100,000 people served (roughly \$10 per enrolled participant), with variable program costs accounting for roughly 90% of the spending, and fixed and technical costs making up a decreasing share as scale increases. Kaya’s current costs are higher due to fixed costs, but marginal costs could fall to roughly \$5–7 per participant at scale.

Operationally, one guide can support roughly 400 intention-to-treat (i.e., enrolled) participants per year, but approximately half of a guide's time is lost to no-shows. As a result, scheduling, automation, and tooling (including potential use of generative AI) are key levers for efficiency. A safe rollout also requires local clinical expertise, robust supervision (approximately one full-time supervisor per 14 counselors), and clear self-harm escalation protocols.

Huw’s expected bottlenecks for a new charity in order of importance are: (1) Tech in the first 1–2 years (if not using an existing platform). Non-technical founding teams will otherwise need to raise something like USD 200k/year early on just to hire and retain developers, as seen in similar WhatsApp-based interventions (e.g., Respira); (2) HR and counselor scaling once tech is stable. Kaya has been trying to double counselor headcount roughly every 6 months ($\approx 4x$ per year) and is essentially growth-constrained by HR bandwidth and funding, not by demand; and

(3) securing long-run partnerships with large employers of counselors (such as government helplines) to enable large increases in scale.

5 Existing activity, funding, and geographic assessment

This section discusses whether this intervention is currently overlooked or underfunded, and where it could be most effectively delivered, based on disease burden, feasibility, and existing activity in this space.

5.1 Existing activity and funding

This landscape analysis confirms substantial neglectedness—Kaya Guides is the first nonprofit implementer of WHO’s Step-by-Step program.

Actors currently delivering this intervention

We narrowed our neglectedness assessment to actors currently delivering the WHO’s Step-by-Step program, and have identified only a handful of stakeholders:

- **WHO** - developed Step-by-Step program, provided technical support for Lebanon trials, but does not directly implement at scale. Makes materials freely available for adaptation.
- **Kaya Guides** (India) - an AIM-incubated nonprofit delivering WhatsApp-based guided self-help for depression. Operational since 2022, Kaya currently runs a small but rapidly growing programme with a dozen or so lay counsellors and aims to scale to very large participant numbers as funding and partnerships allow.
- **Thailand’s National Mental Health Programme** - launched Step-by-Step as part of the "Tor-Tuem-Jai" national digital platform in May 2025, representing the first government-led scale-up of WHO Step-by-Step with trained e-Helpers supporting users. Demonstrates feasibility of national-level implementation ([WHO, 2025](#)).

- **Ministry of Public Health, Lebanon** – ran a guided scale-up of Step-by-Step with WHO support, reaching 1,942 users. Demonstrates feasibility of uptake and delivery at scale ([Rambia, 2025](#)).
- **Zambia (radio adaptation)** – implemented an unguided radio version of Step-by-Step to expand reach ([Clare, 2025](#)).

Attention and Funding

Government funding

LMIC governments allocate very little to mental health—around 2% of total health spending on average ([WHO 2022](#)), and in many low-income countries, less than 1% ([Patel, 2025](#)).

Funding within the AIM network

The Mental Health Funding Circle is likely to fund this, and we also think that the Bloom Wellbeing Fund could be interested, but we imagine this would be at <\$200k per donor.

Other funding

We also conducted a shallow review of other potential funders for a digital guided self-help charity. Table 9 summarizes funders that have supported mental health programs in LMICs or adjacent delivery models. For each, we note grant sizes, the stage they might fund (seed vs. scaling), funding directed toward digital mental health interventions, and why they may be plausible funders for this model.

Table 9: Neglectedness—funding landscape

Funding organization	Health Spending	Typical grant size	Funding stage	Reasons to think they would provide funding
Mental Health Funding Circle	~\$560k per grant cycle	Smaller: \$20k–\$185k	Seed + early scaling	They've funded Kaya Guides for 185k in 2024, and other AIM charities

Grand Challenges Canada (GCC)	\$64.6m invested in mental health innovations	Medium/large: ~\$600k on average, ~\$3m for scaling	Seed + early scaling	GCC has funded StrongMinds and Friendship Bench. Could be a plausible funding pathway at the scaling stage.
Mulago Foundation	\$26m total in 2024 ¹⁶	Large, multi-year (1–2m over years)	Scaling	Has funded aligned LMIC mental health orgs (e.g., 2.8m for StrongMinds, 1.4m for Friendship Bench) and other scalable delivery models (e.g, 950k for Jacaranda Health—an AI app—and 975k for Shamiri (school-based mental health)).
Cartier Foundation	\$183m since inception ¹⁶	Unsure, likely large	Unclear exact size of funding	Have funded Gender Based Violence (e.g., Ujamaa Africa), and mental health programs (e.g., StrongMinds)
Dovetail Foundation	\$20–30m per year ¹⁶	Median: \$200k in 2023	Early + mid-stage scaling	Runs mental health-specific funding
Wellcome Trust	1.6bn euros in 2023/24 ¹⁶ (Wellcome Trust, 2024)	Large	Scaling / research	Focused on research partnerships at a larger scale
The Agency Fund	\$8.9m in 2025 ¹⁶ (Agency Fund, 2025)	Small (\$10k) to large (\$1m), with a median of ~\$200k	Seed + scaling	Runs mental health-specific rounds, previously funded Vida Plena (Agency Fund, 2023)
WAM Foundation	Not specified	Small (\$50k) to large (\$1.5m)	Seed + scaling	Funded Kaya Guides for \$333k in 2026

5.2 Geographic assessment

Link to our model:

[📄 2025 - W - #5 - Treating depression with guided digital self-help programs - ...](#)

We conducted a geographic assessment using a z-score across four criteria: purchasing power parity (20%) to prioritize lower-cost settings; internet use (10%) to exclude countries with very low connectivity; depressive disorders DALYs from GBD 2023 (50%) to reflect need; and household size (20%) to capture potential spillover effects.

¹⁶ Not mental health specific.

India was excluded from our geographic assessment, as this is where Kaya Guides is working and planning to scale. A future refinement could incorporate language homogeneity, since adapting Step-by-Step into multiple languages raises costs and complicates guide hiring.

The top 10 candidates were: **Pakistan, China, Nigeria, Bangladesh, Indonesia, Egypt, Brazil, Tajikistan, Ethiopia, and Malaysia.** Note that selecting 10 countries is an arbitrary cut-off; we expect this intervention to be cost-effective in additional settings.

6 Cost-effectiveness analysis

Link to our model:

[2025 - W - #5 - Treating depression with guided digital self-help programs - ...](#)

6.1 Results

We estimate that digital guided self-help for depression meets our bar for cost-effectiveness. Based on two modeling methods, both of which meet our cost-effectiveness bar, we estimate an average cost-effectiveness of \$97 per DALY averted (range: \$82-\$120) or \$25 per WELLBY (range: \$21-\$31) at scale. These estimates are robust to staffing and recruitment costs, with duration of effects emerging as the most decision-relevant uncertainty. Effects must persist for at least 6.5 months for the intervention to meet our cost-effectiveness bar across both methods and their average. Our results are broadly consistent with internal analyses by Kaya Guides and Happier Lives Institute.

Our CEA Model

The two methods are briefly described below and further detailed in subsequent sections.

1. **Method 1** - Mapping PHQ-9 scores to mild, moderate, or severe disability weights to estimate the DALY benefit of moving between different scores. We then converted DALYs to WELLBYs using Founders Pledge's moral weight (1 DALY = ~3.82 WELLBYs; [Founders Pledge, 2022](#)). See more in a [later section](#).
2. **Method 2** - Converting SD improvements in depression into WELLBYs using a similar method to [Happier Lives Institute](#). We then converted WELLBYs to DALYs using Founders Pledge's moral weight (1 DALY = ~3.82 WELLBYs; [Founders Pledge, 2022](#)). See more in a [later section](#).

This intervention meets our bar for cost-effectiveness across all countries modeled and all methods used. The average cost-effectiveness is expected to be \$97 per DALY averted or \$25 per WELLBY.

Table 4: Cost-effectiveness analysis results

	Method 1	Method 2	Average
Total costs at scale (2023 USD)	\$1,348,935		
Total benefits at scale (DALYs)	11,402	16,807	14,104
\$/DALY	\$120	\$25	\$97
Total benefits at scale (WELLBYs)	43,554	64,203	53,879
\$/WELLBY	\$31	\$21	\$25

Other models

Our cost-effectiveness estimates are more conservative than those used by Kaya Guides¹⁷, primarily because we assume a one-year duration of effects. Kaya Guides assumes longer-lasting effects with gradual attenuation, which leads to higher per-participant impact estimates (1.24 WELLBYs vs. 0.54 WELLBYs in our model).

6.2 Modeling choices

6.2.1. Costs

We estimate the costs for a program that reaches 100,000 people per year, where 'reach' includes all enrolled participants, regardless of whether they complete a session. This mirrors the intention-to-treat analyses used in the WHO Step-by-Step trials that inform our effect estimates and allows us to calculate

¹⁷ Note that Kaya Guides' CEA is not publicly available, but available upon request.

cost-effectiveness for all individuals reached, regardless of how many sessions were completed.

Costs are divided into fixed costs (largely independent of scale) and variable costs (which scale with the number of participants, guides, and supervisors). At scale, we estimate an average total annual cost of ~\$1.3 million.

Fixed costs

Fixed costs include staffing, engineering, and core operating expenses ([see CEA Costs sheet](#), Section 1). We modeled the costs based on Kaya Guides' costs in India which were adjusted to other countries based on PPP.

- **Staff salaries.** We assumed a team consisting of two co-founders and 15 additional staff at scale. This estimate draws directly from guidance from Huw Evans, the CTO of Kaya Guides, and is broadly consistent with other AIM-incubated charities operating at scale.
 - These staff would help with initiating the program, such as program development, as well as for operations of the program at scale.
- **Additional fixed costs include engineering costs and program development costs.**

In total, fixed costs at scale were approximately **\$601,000 per year** (discounted), with the majority of fixed costs coming from staff salaries.

Variable costs

Variable costs scale with the number of guides, supervisors, and participants (see CEA Costs sheet, Section 2). We estimate that the variable costs to reach 100,000 people are ~\$748,000 per year (discounted).

Guide and supervisor salaries + Support

- Guide salaries. We used salary ranges reported by Huw Evans and in Kaya Guide's internal CEA.
- Supervisor salaries. We assumed one supervisor per 14 guides, based on Huw's input.
- Support for guides and supervisors include recruitment + call costs.

Estimating the number of guides needed

To estimate the number of guides the charity would need, we followed the steps outlined below.

1. *Estimate the number of calls one guide can complete per year.*

Each participant call requires approximately 27 minutes (15-minute session plus ~6 minutes of preparation and ~6 minutes of documentation). We assume guides work 25 hours per week for 11 months per year, and apply a 30% overhead to account for no-shows and scheduling inefficiencies. Under these assumptions, a single guide can complete approximately **1,800 calls per year**.

2. *Estimate how many calls participants (people reached) require.*

Kaya Guides reported that participants complete an average of 4.5 calls out of a possible 8 with a counselor. Thus, for 100,000 people, this equals 450,000 calls. Note that this is much higher than the RCTs suggest: If we used the attrition data from the RCTs, this suggests that participants complete an average of 1.7 calls for a total of 170,000 calls.¹⁸

3. *Calculate the number of guides needed to support participants:*

Given that one guide can complete ~1,800 calls per year, the number of guides required is:

- $\sim 450,000 \div 1,800 \approx 245$ guides

We then multiply the number of guides (and supervisors, using the supervisor-to-guide ratio) by their salaries to calculate total variable costs.

¹⁸ **The module completion patterns from Step-by-Step trials and Kaya Guides data (see [Attrition Rates tab of CEA](#)) are as follows:** 24.9% complete five sessions; 4% complete four sessions; 3.4% complete three sessions; 3.1% complete two sessions; 20% complete one session; 45% complete no sessions.

If we assume that these sessions equate to the number of counselor calls, then: if we had 100 participants, this distribution would generate a total of 176 calls: 25 people \times 5 calls = 125; 4 people \times 4 calls = 16; 3 people \times 3 calls = 9; 3 people \times 2 calls = 6; 20 people \times 1 call = 20. This leads to a total of 176 calls required to support 100 people. Scaled to 100,000 participants, this implies approximately 177,000 calls per year.

Other variable costs

Other variable costs include costs for recruitment of staff, guides, and supervisors, and items such as API calls and voice calls (call costs are also adjusted for overhead such as other non-work calls being taken or spam calls, etc.)

6.2.2 Effects

For the CEA, we estimated effects in both DALYs and WELLBYs using two independent methods. This lets us cross-check assumptions and avoid relying on a single modelling choice.

Across our two methods, the average estimated effect per person was 0.14 DALYs (range, 0.11–0.17) and 0.54 WELLBYs (range, 0.44–0.64).

Method 1: Conversion of PHQ-9 scores to Disability Weight

This method uses disease-burden estimates directly ([see CEA, Effects tab, Section 1.1](#)) and follows these steps:

1. We took pre-post PHQ-9 scores for treatment and control groups in Step-by-Step studies.
2. We converted each PHQ-9 score into a disability weight (DW) using IHME/GBD categories ([see Conversion DW PHQ-9 tab of CEA](#)):
 - a. The PHQ-9 scores were: none = 0–4; mild = 5–9; moderate = 10–14; moderate-severe = 15–19; severe = 20–27¹⁹
 - b. These PHQ-9 bands were mapped onto GBD disability weights for depression (mild 0.145, moderate 0.39, severe 0.66), and we interpolated linearly between categories to obtain a DW for each PHQ-9 score.
3. With this conversion table (assuming a one-year duration of effect), we converted the pre-post changes to PHQ-9 scores to the DW reduction in both the treatment and control groups. We then took the difference between them, which gives DALYs averted per person reached. This was done for

¹⁹ We could not confirm how PHQ-9 severity bands were mapped to GBD disability weights in the original studies. We assumed the standard PHQ-9 ranges in which mild corresponds to 5–9 and applied the GBD disability weight for mild depression accordingly.

each of the 5 studies on the WHO Step-by-Step program ([see Effects WHO Step-by-Step tab of CEA](#)).

- a. Note: We also gave each study a different weight proportional to a) sample size and b) external validity (how closely the study population matches the proposed target population).
 - b. Note: Only $\frac{4}{5}$ of the studies on the WHO Step-by-Step used a PHQ-9 for depression (all except for Buchert, which used the HSCL-25). We only included studies with PHQ-9 here, but included Buchert in Method 2 of our analysis.
4. DALYs were then converted to WELLBYs using the Founders Pledge conversion ([Founders Pledge](#); 1 DALY = ~3.82 WELLBYs).
 5. We also applied an external and internal validity adjustment (which includes a discount for attrition rates). These were relatively small as they were testing the exact intervention (WHO Step-by-Step) that we are proposing. Another discount of 19% was applied to account for the gap between RCT completion rates and real-world completion in Kaya Guides' implementation ([see more](#)). **The adjusted effects were 0.08 DALYs per participant reached, or 0.30 WELLBYs per participant reached.** Note this is for intention to treat, and only ~25% of people actually complete all 5 sessions.
 6. Finally, we adjusted for household spillover effects (16.24%).²⁰

The final effect size per person reached using the first method including household spillovers was 0.12 DALYs, or 0.47 WELLBYs.

Method 2: Standard-deviation approach using similar methods to Happier Lives Institute

This method mirrors the approach used by the Happier Lives Institute.

1. We extracted standardized mean differences (SMDs) from Step-by-Step trials. ([see Effects WHO Step-by-Step tab of CEA](#))
2. We converted SMDs into SD-years, similarly to HLI's method ([Section 5 of HLI's Methodology](#)).

²⁰ We defer to HLI's household spillover effects of 16.24% ([HLI, 2025](#)), which is also in line with GiveWell's best guess for spillover effects of 15% ([GiveWell, 2023](#))

- a. This method multiplies the SMDs by the years the effects should last. We did this using a simplified assumption that the effects would persist one year without diminishing.
3. SD-years were converted into WELLBYs as per HLI’s methods, where 1 SD-year equals 2 WELLBYs. For more information on this, read [Section 5 of HLI’s Methodology](#).
4. WELLBYs were then converted into DALYs using Founders Pledge’s WELLBY–DALY conversion ([Founders Pledge](#); 1 DALY = ~3.82 WELLBYs).
5. We applied the same discounts as for Method 1. **The adjusted results with this method were 0.44 WELLBYs per person reached, or 0.12 DALYs per person reached.**
6. Finally, we adjusted for household spillover effects (16.24%).²¹

The final effect size per person reached using the second method, including household spillovers, was 0.18 DALYs, or 0.69 WELLBYs.

Downward adjustment to account for the gap between RCT completion rates and real-world completion in Kaya Guides’ program

We applied a 19.3% downward adjustment to reflect that Kaya Guides’ real-world overall completion rates were lower than completion rates observed in the RCTs (see Table 5). In 2025, early-session completion was higher for Kaya Guides (27% for session one; 51% for session two), completion of three sessions was similar, and the largest drops occurred at session four (–35%) and session five (–55%).

Table 5: Adjustment to account for the gap between RCT completion rates and real-world completion in Kaya Guides’ implementation.

Number of Sessions Completed	RCTs average	Kaya Guides	Percent Difference	Weight	Total Adjustment
1	55.47%	70.40%	27%	6.66%	1.79%
2	35.41%	53.30%	51%	13.32%	6.73%
3	32.31%	32%	-1%	19.98%	-0.19%
4	28.91%	18.90%	-35%	26.64%	-9.23%
5	24.90%	11.18%	-55%	34.00%	-18.41%

²¹ We defer to HLI’s household spillover effects of 16.24% ([HLI 2025](#)), which is also in line with GiveWell’s best guess for spillover effects of 15% ([GiveWell, 2023](#))

We considered various discount options: A 55% discount would be the most conservative approach, reflecting the 55% lower completion of all five modules in Kaya Guides, but this overstates the issue because partial completion still provides value and attrition is not uniform. A simple average of the five differences (-3%) understates the problem, since later sessions plausibly produce more of the therapeutic effect.

To balance these extremes, we applied a weighted average of session-level completion gaps. Early-session differences receive lower weight and later-session differences receive higher weight. The weights applied were: 1 session = 6.66%, 2 sessions = 13.32%, 3 sessions = 19.98%, 4 sessions = 26.64%, and 5 sessions = 33.4%. The overall downward adjustment was 19.3%.

6.2.3 Sensitivity analysis and Considerations

In this section, we run a sensitivity analysis of the two most uncertain parameters in our CEA: Staff recruitment costs and the duration of effects.

We found that variation in staff recruitment costs has only a modest effect on overall cost-effectiveness (see Table 6).

Table 6: Sensitivity analysis of staff recruitment costs—cost-effectiveness

	Method 1	Method 2	Average
Recruitment costs of: <ul style="list-style-type: none"> • \$99 per staff • \$27 per guide • \$36 per supervisor (Current model)	\$120.3/DALY	\$81.6/DALY	\$97.3/DALY
Recruitment costs of: <ul style="list-style-type: none"> • \$397 per staff • \$107 per guide • \$145 per supervisor (Increased staff recruitment costs pro-rated by salary)²²	\$122.1/DALY	\$82.9/DALY	\$98.8/DALY

²² In the current model, salary costs for staff are ~10x salary costs for guides, but recruitment costs are only 3x. Here we model a 4x recruitment costs for all staff.

We found that changing the duration of the effect substantially affects cost-effectiveness. Because we assume a one-year effect, shorter durations reduce cost-effectiveness proportionally (see Table 8).

Table 8: Sensitivity analysis on duration of effects—cost-effectiveness (\$/DALY)

Duration of effects	Method 1	Method 2	Average across methods
1 year (current model)	120.3	81.6	97.3
3 months (WHO Step-by-Step RCT evidence follow-up period)	481	326	389
6.5 months (required duration to meet our cost-effectiveness bar)	222	151	180
8 months (Mamukashvili-Delau's, 2023)	180	122	145
1 year with decay (100% for first 6 months and 50% for second 6 months)	160	109	130
1 year with decay (Cuijpers, 2023) ²³	131	89	106
3.48 years (used by Kaya Guides)	35	23	28

Based on Table 8, effects must last for at least 6.5 months for the intervention to meet our cost-effectiveness bar of \$220/DALY across all columns. This is 3.5 additional months longer than the current follow-up period in existing WHO Step-by-Step RCTs. Note that no studies have follow-up periods longer than three months, which reflects a lack of long-term evidence rather than evidence that effects do not persist.

We also consider ways in which our current modelling choices could be overstating or understating the expected cost-effectiveness of this intervention, which is highlighted in Table 9 below.

²³ [Cuijpers, 2023](#) found a 33% reduction in effect size from 6-9 months to 10-12 months ($g=0.74$ to $g=0.49$).

Table 9: CEA considerations

Reasons this intervention could be more cost-effective than modeled	Reasons this intervention could be less cost-effective than modeled
<ul style="list-style-type: none"> ● If the duration of the effects is longer ● If the household size is larger, the spillover effects will be greater ● We have not modelled reductions in self-harm and suicide or increases in productivity, which could meaningfully improve cost-effectiveness ● We have not modeled impacts for people who complete <5 of the sessions, but we may expect that they also see some symptom improvement 	<ul style="list-style-type: none"> ● If we cannot reach 100,000 people per year at scale ● The discount rates for internal and external validity could be much higher. This could lead to a big effect size difference. However, given the baseline cost-effectiveness, we do not expect this to push the intervention above our cost-effectiveness threshold. ● If the duration of effects is shorter ● If the household size is smaller

7 Implementation considerations

7.1 What operating this charity would look like

This proposed idea falls toward the 'exploit' end of the explore-exploit continuum. The intervention model is well-defined through WHO Step-by-Step and well-tested through implementation by Kaya Guides, with clear evidence of efficacy and established implementation protocols. Core uncertainties relate to scaling and optimization rather than fundamental viability.



Figure 3: Explore-exploit continuum

Core day-to-day activities:

- Recruitment and screening of participants through digital marketing and partnerships
- Training and supervision of lay counselors (10-day initial training, weekly ongoing supervision)
- Platform management and technical troubleshooting (WhatsApp Business API, chatbot maintenance)
- Monitoring completion rates, engagement metrics, and outcome tracking
- Partnership development with government health systems and local NGOs
- Crisis referral coordination and safety monitoring

7.2 Key operational factors

Overall, we judge guided digital self-help to be feasible for implementation, with low concerns regarding access to information, stakeholders, monitoring and evaluation, tractability, and the risk of harm.

The main constraint is scaling complexity: while the intervention itself is simple and well-specified, reaching large numbers of participants requires rapidly hiring, training, and supervising a large lay workforce, maintaining engagement and fidelity at scale, and managing operational and HR bottlenecks. Talent availability for early leadership roles appears adequate, but the limiting factor might be hiring and managing enough guides and supervisors fast enough as the program grows. As a result, execution risk is concentrated not in intervention design or evidence strength, but in operations at scale. Table 10 summarizes our high-level assessment of implementation concerns.

Table 10: Implementation concerns

Factor	Level of concern
Talent	Moderate
Access to information	Low
Access to relevant stakeholders	Low
Feedback loops / monitoring and evaluation	Low
Execution difficulty / tractability	Low
Complexity of scaling	High
Risk of harm	Low

Talent

We do not expect finding co-founders to be a bottleneck for this intervention.

The following backgrounds would be useful for co-founders or early hires:

- **Public health or psychology background:** Understanding of mental health interventions, familiarity with evidence-based approaches, and ability to train and supervise lay counselors.
- **Technical skills:** Having a founder with technical skills could help with product development and would decrease costs.
- **Digital product management:** Experience with messaging platforms, chatbot development, and user engagement optimization.

- **Operations and scaling expertise:** Ability to manage a distributed workforce, establish quality assurance systems, and optimize cost structures.
- **Outreach and Marketing:** Experience with outreach and recruiting participants.
- **Cultural competency:** Understanding of the target context, ability to adapt content appropriately, and language skills for localization.

However, scaling depends on hiring large numbers of guides and supervisors, which may be challenging. Kaya Guides is currently aiming to double its counselor headcount every six months (about 4× per year) to reach 100,000 users by Year 5, but HR and management capacity are the main bottlenecks.

Access

Information

Access to information is not a constraint. WHO Step-by-Step materials are freely available (contact: Psych_interventions@who.int). Training protocols and implementation guides exist.

Relevant stakeholders

We are also not very concerned about access to stakeholders. Key stakeholder relationships:

- WHO mental health team for technical assistance
- National mental health programs (e.g., DMHP in India) for integration
- Existing implementers (Sangath, Kaya Guides) for knowledge sharing
- Community health worker networks (e.g., ASHA in India) for delivery

Feedback loops/Monitoring and Evaluation

We are not concerned about feedback loops. There are clear outcome metrics (PHQ-9) which are sent to all participants and digital tracking enables real-time monitoring.

Tractability

Implementation is highly tractable, particularly if a new organization can access Kaya Guides platform. This would give a new organization a head start and their work could then focus on adapting content via translation and local clinicians and recruiting participants as soon as possible.

Complexity of scaling

We think that scaling could be the main bottleneck for a new organization. Although digital interventions scale faster than in-person delivery and fixed costs get amortized across users, we expect reaching a large scale will be difficult. Kaya Guides is our main proof of concept for this intervention, and they are still relatively new and small. All existing studies of WHO's Step-by-Step program have reached far fewer people than our target of 100,000.

Primary scaling challenges:

- Hiring and training sufficient lay counselors and supervisors—Kaya Guides' main bottleneck
- Maintaining intervention fidelity as the workforce grows
- Maintaining engagement through completion (requires A/B testing and optimization)
- Managing technical infrastructure for a growing user base
- Ensuring quality supervision at scale (1:14 supervisor-to-counselor ratios) (Implementers should utilize the WHO/UNICEF EQUIP competency assessment tools to standardize this supervision)
- Navigating partnerships with government systems at scale

Risk of harm

We identified minimal evidence of harm. The Lebanon trial documented one serious adverse event, which was assessed as unrelated to the intervention.

Potential risks include: inappropriate intervention for severe cases (mitigated through screening), suicide risk if not properly monitored (addressed through crisis protocols), and counselor burnout (managed through supervision and self-care support).

7.3 Remaining uncertainties

Several key uncertainties remain for this intervention.

First, the achievable scale of delivery is unclear. Our model assumes reaching 100,000 individuals per year²⁴ by Year 5 (measured on an intention-to-treat basis rather than program completion), informed by Kaya Guides' scaling ambitions. However, the feasibility of achieving this level of reach remains uncertain. The implementation of Step-by-Step by [Lebanon's Ministry of Health](#) and [Thailand's National Mental Health Programme](#) are the only examples that this could be implemented at a larger scale with government collaboration. However, it is unclear whether partnerships with government systems—such as those achieved in Lebanon and Thailand—can be secured, and whether such partnerships could enable substantially larger scale.

Second, there is uncertainty around the durability of treatment effects. Existing evidence on WHO Step-by-Step is limited to follow-up periods of three months, leaving open questions about longer-term outcomes.

Finally, expected completion rates at scale are unknown. Completion rates may improve or deteriorate as programs expand, and these changes could affect overall effectiveness.

²⁴ Based on Kaya Guides' attrition rates we estimate that recruiting 100,000 people will result in ~25,000 people completing all 5 guided self-help modules.

8 Conclusion

The decision board met in December 2025. It was made up of Morgan Fairless (AIM), Vicky Cox (AIM), Juan Benzo (AIM), and Martijn Klop (AIM). Samantha Kagel (AIM) provided notes for the meeting.

The board decided to recommend this idea. Arguments in favor emphasized the intervention's strong evidence base and cost-effectiveness. While the board noted concerns about long-term effects and high attrition rates, it concluded that average effects at scale should still be meaningful and cost-effective.

The board viewed this as a promising low-touch model that sits in a sweet spot—more effective than purely self-help approaches, but much more cost-effective than intensive interpersonal therapy. The intervention benefits from having trusted lay workers provide the therapeutic guidance.

The team discussed external validity, with Morgan questioning whether they should focus on refugees given the location of the RCTs. One board member expressed general skepticism about mental health interventions compared to global health, citing poor monitoring and evaluation across the field and concerns, and a lack of lasting change. However, he viewed this specific intervention more positively, noting that it may represent one of the most promising mental health delivery models currently available.

Annex 1

Guided vs. unguided self-help

A key consideration for this report was whether guided self-help (GSH) offers larger effects than unguided self-help (USH), because adding human support increases costs and could reduce cost-effectiveness. The evidence is mixed on this.

Two large meta-analyses conducted mostly in high-income countries suggest GSH outperforms USH. A 2019 network meta-analysis (155 studies, $n=15,191$) found GSH produced statistically significantly larger effects than USH and was comparable to individual, group, and telephone CBT ([Cuijpers, 2019](#)). Similarly, an umbrella review of 87 meta-analyses covering 1,683 RCTs (295,589 participants) found guided internet-based interventions had higher effect sizes for depression (SMD 0.65, 95% CI 0.59–0.71) than unguided interventions (SMD 0.46, 95% CI 0.30–0.62) ([Zhang, 2024](#)).

However, LMIC-specific evidence suggests that GSH and USH may have similar effect sizes. A 2025 meta-analysis of self-help interventions in LMICs (13 guided, 4 unguided arms) found no statistically significant difference between guided ($g = 0.75$, 95% CI 0.45–1.23) and unguided self-help ($g = 0.84$, 95% CI 0.58–0.92) ([Vavani, 2025](#)). A 2024 network meta-analysis preprint focused on LMICs reached similar conclusions: guided ($g = 0.78$, 95% CI 0.47–1.09) and unguided ($g = 0.75$, 95% CI 0.41–1.09) formats performed comparably, and neither differed statistically from individual therapy ([Karyotaki, 2024](#)).

Overall, evidence favors guided self-help, with the caveat that more recent LMIC evidence suggests guided and unguided formats may be similarly effective. The mechanisms for this are unclear, and further research would be helpful. Below we highlight each study referenced in more depth.

Evidence suggesting guided self-help outperforms unguided self-help:

Cuijpers (2019): A network meta-analysis of CBT delivery formats for adult depression (155 studies; 15,191 participants; 46 guided and 21 unguided self-help arms) found that guided self-help was more effective than USH. In addition, GSH

produced statistically nonsignificantly different effects from individual, group, and telephone CBT. All four formats were statistically significantly more effective than waiting list controls (SMD 0.87–1.02), care-as-usual controls (SMD 0.47–0.72), and unguided self-help (SMD 0.34–0.59). However, most studies (133/155; 85.8%) were conducted in Western countries, limiting generalizability to LMIC settings ([Cuijpers, 2019](#)). Some details are below:

- Unguided self-help showed a small, non-significant effect versus control (SMD 0.13, 95% CI –0.39 to 0.13).
- Guided self-help showed a stronger, statistically significant effect versus control (SMD –0.47, 95% CI –0.70 to –0.25).
- Individual CBT showed an SMD of –0.63 (95% CI –0.92 to –0.52) but was not statistically significantly different from guided self-help ([Cuijpers, 2019: Figure 3, Table 1, Appendix K](#)).

Zhang 2024: An umbrella review also supports stronger effects for guided self-help. Zhang et al. synthesized 87 meta-analyses covering 1,683 RCTs and 295,589 participants across a broad range of internet-based mental health interventions (including depression, anxiety, PTSD, addiction, suicidal ideation, stress, OCD, and personality disorders). For depression, **guided** internet-based interventions produced an **SMD of 0.65 (95% CI 0.59–0.71)**, which was **significantly larger** than the effect for **unguided** interventions (**SMD 0.46, 95% CI 0.30–0.62**) ([Zhang, 2024](#)).

Evidence suggesting guided and unguided self-help may perform similarly in LMICs

Vavani 2025: A 2025 meta-analysis of self-help interventions for depressive symptoms in LMICs (13 guided arms, 4 unguided) found no statistically significant difference between guided ($g = 0.75$, 95% CI 0.45–1.23) and unguided self-help ($g = 0.84$, 95% CI 0.58–0.92). The overall pooled effect was $g = 0.82$ ($p = 0.05$; 95% CI 0.63–1.01) ([Vavani, 2025](#)).

Karyotaki 2024: A 2024 preprint network meta-analysis in The Lancet (not peer reviewed) comparing CBT delivery formats in LMICs likewise found similar effect sizes for guided self-help and unguided self-help. ($k = 89$, $n = 13966$). Specifically,

compared to a control, the effect size for guided self-help was $g = 0.78$ (95% CI 0.47–1.09; $k = 12$), for unguided self-help $g = 0.75$ (95% CI 0.41–1.09; $k = 8$). Neither GSH nor USH were statistically different from individual therapy ($g = 0.99$, 95% CI 0.68–1.29) ([Karyotaki, 2024](#)).

Adherence rates

One main consideration we have is whether adding human support meaningfully improves adherence. Higher completion would justify the extra cost of guidance; if not, unguided self-help might be more cost-effective. The evidence is mixed.

An umbrella review of 87 meta-analyses of internet-based interventions ([Zhang, 2024](#)) reports that guided self-help shows higher adherence and lower dropout than unguided formats. In contrast, two earlier meta-analyses ([Cuijpers, 2010](#); [Cuijpers, 2019](#)) find no statistically significant differences in acceptability between guided and unguided self-help. We put more weight on the Zhang 2024 umbrella review, given its larger sample size.

More in-depth information on the evidence we reviewed is below:

Evidence that adherence to GSH is similar to face-to-face therapy:

- An umbrella review by Zhang et al. that covered a total of 87 meta-analyses, reporting on 1,683 randomised controlled trials and 295,589 patients, were included, looking at internet-based interventions for mental health outcomes (depression, anxiety disorders, addiction, PTSD, suicidal ideation, stress, OCD and various personality disorder), found that adherence (the percent of people who completed treatment in face to face programs was similar to guided self-help (83.9% vs 80.8%) ([Zhang, 2024](#)).

Evidence that GSH has greater adherence than USH:

Evidence in support that guided self-help has greater adherence includes an umbrella review by Zhang et al. (2024). This umbrella review of 84 meta-analyses examined adherence and dropout patterns in guided versus unguided internet-based interventions ([Zhang, 2024, Supplementary Table 5](#)). The findings from the umbrella analysis favor guided formats:

Dropout rates - Three studies reported comparative dropout:

- Study 1: 28% dropout in guided IBI vs. 74% in unguided ($p < .001$).
- Study 2: 11.7% in guided vs. 34% in unguided ($p < .003$).
- Study 3: Similar dropout across groups (25% guided vs. 29% unguided). ([Zhang, 2024, Supplementary Table 5](#)).

Adherence - Two studies compared treatment adherence:

- Study 1: 85% of guided participants completed the full intervention vs. 65% in unguided ($p < .001$); 85% of guided participants completed $\geq 80\%$ of modules vs. 67.5% in unguided.
- Study 2: Adherence was 76% in guided vs. 54% in unguided. ([Zhang 2024, Supplementary Table 5](#)).

They also report that: "71% of studies in the high-engagement group offered guidance compared with only 36% in the remaining studies, suggesting a link between human support and increased engagement... the presence of human support was associated with increased treatment adherence." ([Zhang 2024, Supplementary Table 5](#)).

This body of evidence indicates that guided self-help consistently shows **higher adherence and lower dropout** relative to unguided formats.

Evidence that GSH has similar adherence than USH:

However, evidence on adherence is mixed, with some analyses reporting no advantage for guided vs unguided self-help on adherence. In a 2019 network meta-analysis of CBT delivery formats for depression (155 studies; 15,191 participants), unguided self-help showed higher acceptability (i.e., lower dropout) than guided self-help: 24.3% vs. 1.6%, respectively ([Cuijpers, 2019](#)). However, all of these studies were in HICs. A second 2010 meta-analysis by Cuijpers et al. ($k = 21$; $n = 810$) found no statistically significant differences in dropout rates between guided and unguided self-help. Again, most of the studies analysed were conducted in high-income countries ([Cuijpers, 2010](#)).

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