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THE IMPACT OF WOMEN FOR WOMEN INTERNATIONAL'S ECONOMIC AND SOCIAL EMPOWERMENT PROGRAM IN THE DEMOCRATIC REPUBLIC OF CONGO

Background

The Democratic Republic of Congo (DRC) has faced conflict and instability for over 25 years, exacerbating poverty and gender inequalities. Despite the abundance of valuable natural resources, DRC is one of the poorest, least-developed, and gender-inequitable places on Earth, ranking 179th out of 189 countries on both the Human Development Index and Gender Inequality Index¹ [1]. Almost 70% of the population live below the international poverty line of US \$1.90 a day, and over 6 million children under five suffer from chronic malnutrition [2][3].

Decades of conflict have claimed over 5.4 million lives and displaced millions more, primarily in the eastern provinces [4]. In South Kivu, continued insecurity and a lack of governance have challenged progress, disrupted markets, and destroyed assets. 90% of informal entrepreneurs in South Kivu live below the poverty line and the vast majority are women: women are 6.7 times more likely than men to be "survivalist" entrepreneurs, meaning they operate low-growth businesses [5].

Women's vulnerability to poverty is reinforced by a complex web of barriers. Women lack ownership of assets, personal income, and often do not receive inheritances. A married woman often needs her husband's permission to work, open a bank account, obtain credit, start a business, or travel [6]. 68% of women in South Kivu did not complete primary school, and the illiteracy rate for

¹ The Gender Inequality Index, calculated as part of the United Nations Development Programme's Human Development Report, is an index that reflects gender-based inequalities in reproductive health, empowerment, and economic activity.

SUMMARY OF FINDINGS*

Women for Women International's social and economic empowerment program:

- Increased women's savings, assets, and access to credit;
- Increased women's engagement with entrepreneurial work and net earnings;
- Improved women's mental health and household diet diversity;
- Improved women's agency, self-confidence and participation in household decision-making, and increased social support.

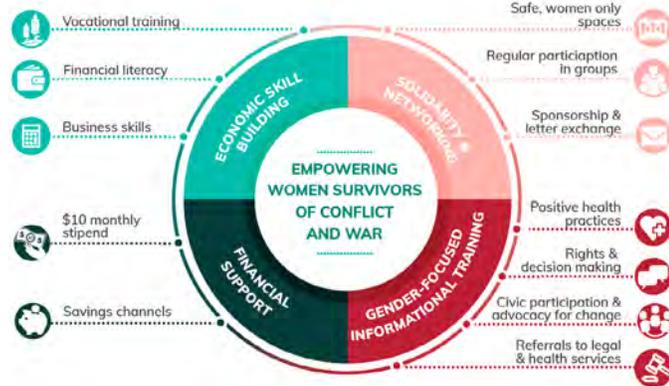
* Results are preliminary and may change after further analysis.

women aged 15 and older is 40% compared to 17% for men [2]. Women face discrimination and abuse stemming from harmful gender norms. In South Kivu communities, patriarchal "customary" norms take precedence over national legal protections for women. Women are not supposed to speak in front of men and are seen as second-class citizens. Conflict exacerbates these abuses and adds others, including the prolific use of rape as a "weapon of war" and the normalization of sexual violence against women (VAW) among the civilian population [7]. Almost half of the women in South Kivu have experienced physical violence and 35% have experienced sexual violence in their lifetime [2].

PROGRAM DESCRIPTION

Women for Women International (WfWI) works with the most marginalized women in conflict-affected countries to help them move from poverty and isolation to self-sufficiency and empowerment. WfWI has been implementing its Signature Program (Figure 1), an economic and social empowerment program, in North and South Kivu provinces in DRC since 2004.

Figure 1. Women for Women International Signature Program



This integrated, rights-based program aims to build women's self-reliance in every aspect of life: economic stability, health and wellbeing, family and community participation and decision making, and social networks. The bundled approach supports social and economic empowerment through:

- 1. Foundational training** in modules that include the value of women's work, ways to save money, ways to earn income and improve income-generating activities, basic business skills, ways to improve health and wellbeing, women's rights and prevention of VAW, strategies to make decisions and negotiate, civic action and advocacy, social networks, and safety nets;
- 2. Skill-building** in numeracy and a chosen vocational skill (e.g., agriculture, sewing);
- 3. Resource provision** in the form of a monthly cash stipend (US \$10), formal and informal savings vehicles (e.g., village savings and loans associations (VSLAs), microfinance institutions), and referrals to health, legal, and financial services; and
- 4. Connections** to other women through safe spaces for women to learn and share together, women-led social and economic groups, and a letter exchange with international supporters.

Over 12 months, participants are involved in two to five hours of programming weekly, delivered to groups of 25 women in community-based training centers. The program components are biweekly social empowerment training sessions (24 sessions), weekly numeracy classes during months three and four (6 sessions), weekly business skills training during months four through twelve (30 sessions), and intensive vocational skills sessions for months seven through nine (up to 50 hours over 12 weeks). Participants also receive training to set up their VSLAs, which then meet weekly.

WfWI also provides men's engagement programming (MEP) to encourage men to become active allies in support of women's social and economic empowerment and rights. As part of this trial, male community leaders were trained to share knowledge and then facilitated 16 weekly discussion groups with the women's male spouses, partners, or other household members on topics including women's economic empowerment, domestic violence, women's rights, and women's health. Couples identified by WfWI staff members as high-risk for disputes or violence were also invited to join one couples dialogue session, a two-hour session with up to 25 couples on topics such as roles and responsibilities in a marriage, women's rights (e.g., inheritance), civil registration, and making commitments to reduce household conflict.

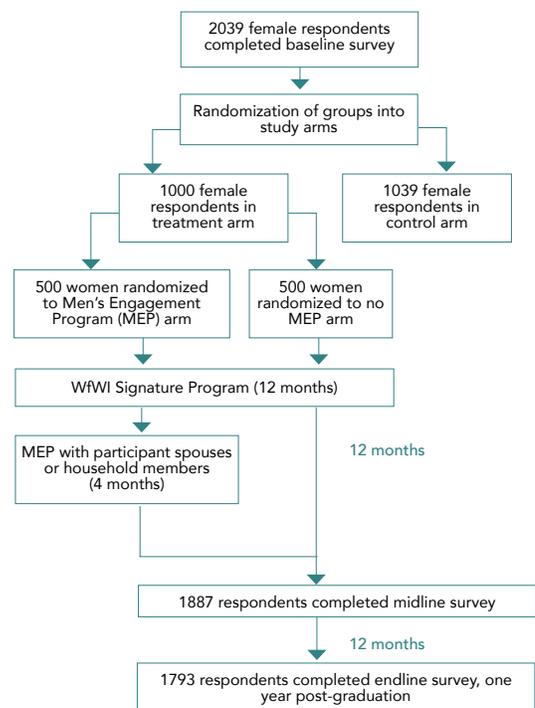
STUDY METHODS

WfWI worked with researchers at the University of Washington and University of Texas at Austin and the data collection firms Marakuja Kivu Research and the Innovative Hub for Research in Africa (IHfRA) to conduct a 24-month randomized control trial (RCT) in four communities in South Kivu province. The primary objective of the study was to measure the impact of WfWI's Signature Program on women's livelihoods, savings and assets, social empowerment, wellbeing, and social assets one year after program completion. Researchers also examined how men's engagement activities for male spouses, partners, and other household members impacted women's economic and social empowerment outcomes.

From July to September 2017, WfWI screened and recruited 2039 potential program participants in Kamanyola, Ciherano-Luciga, Nyangezi, and Mumosho to be research respondents.² All participants were given an explanation of the study and their participation in the research and were told they could decline participation or withdraw from the study at any time. Participants provided informed consent via signature or thumb print on a paper consent form, and then were interviewed for baseline.

Researchers assigned participants to training groups of 25 by location, which were cluster-randomized into treatment arms. 1000 women were randomly allocated to the treatment arm, and 1039 women were allocated to the control group (Figure 2). Women in the treatment group were further randomized into two arms: the MEP arm, where a spouse or male family member participated in men's engagement programming during the trial, or the no MEP arm.

Figure 2. Evaluation flowchart



² Standard eligibility criteria for participation in WfWI's program include: (1) experience with war/conflict (e.g. surviving violence, being displaced); (2) social vulnerability (e.g. poorer-than-average living conditions, facing restrictive traditional practices, or no or limited education); (3) economic vulnerability (e.g. extreme poverty, unemployment or limited to high risk or survivalist occupations); (4) motivation to participate in the full 12 month program; and (5) ability to participate (e.g. family support, adequate health). Those incapacitated because of poor mental health or very severe disability were ineligible as they could not fully benefit from the intervention. In this research study, an additional criterion was that women should be aged 18 to 55, and efforts were made to enroll only one household member in the trial to address spillover concerns.

The 1000 treatment arm participants started the Signature Program in August and October 2017. For the 500 participants in the MEP arm, male household members started four months of MEP part-way through the Signature Program. Control arm participants received no WfWI intervention during the trial period and were placed on a waitlist to receive programming after the study ended.

Study participants were interviewed three times: at baseline, midline (12 months after baseline, at completion of the Signature Program), and endline (24 months after baseline, one year after completion of the Signature Program). The endline survey had an 88% completion rate. At each data collection point, participants completed a 90- to 120-minute survey administered in-person in Kiswahili or Mashi by trained enumerators using the SurveyCTO platform and Android tablets. Marakuja Kivu Research led the data collection activities. In addition, 48 randomly selected individuals were interviewed in depth at endline, including 32 women who had been WfWI Signature Program participants and 16 men who were MEP participants.



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RESULTS

Baseline findings about study population

At baseline, the average study participant was 33 years old, and the average household had 6.4 members. 67% of the study participants were married or cohabitating with a partner. Only 14% of the study population had attained education higher than primary school, and 57% of the survey respondents were illiterate. 41% of respondents reported that they had worked for pay, profit, or gain in the past seven days. Across all respondents, average weekly earnings were \$1.57.³ 63% of women agreed that a man should have the final say on household decisions, and 62% of respondents agreed a man could beat his wife for refusing sex.

The communities in this trial faced conflict and insecurity, market instability, and a nearby Ebola outbreak. Nearly all respondents (98%) reported experiencing large increases in the price of daily goods in the past year. Many respondents also faced an illness of any household member lasting over one month (75%) and unemployment of a household earner for over one month (48%). In addition, 27% of respondents reported experiencing an incident of violence within her household and/or community in the prior 12 months. WfWI targets and serves an extremely marginalized type of population, and these baseline figures present a consistent picture of women who are living in extreme poverty, socially marginalized, and affected by conflict.

Study results

This section compares outcomes for the overall treatment group (both the MEP and no MEP arms together⁴) and the control group one year after the end of the program. For each outcome with statistically significant findings, the mean or prevalence in the treatment and control groups and the p-value of their difference are presented.⁵

³ All monetary results are reported in USD. The following exchange rates were used: 1600 CDF to 1 USD (2017 and 2018); 1696 CDF to 1 USD (2019).

⁴ Using this approach, all participants who partook in the WfWI Signature Program are included in the overall treatment group, including 500 participants in the MEP arm and 500 participants in the no MEP arm. There were not significant differences across outcomes between the MEP and no MEP arms—the reported results are driven by participation in the Signature Program.

⁵ Lower p-values indicate a higher level of confidence that the difference between the treatment and control groups is not due to chance. For example, a p-value lower than 0.05 indicates greater than 95% confidence and is considered very strong evidence. Likewise, a p-value between 0.05 and 0.10 indicates greater than 90% confidence and is considered moderately strong evidence.

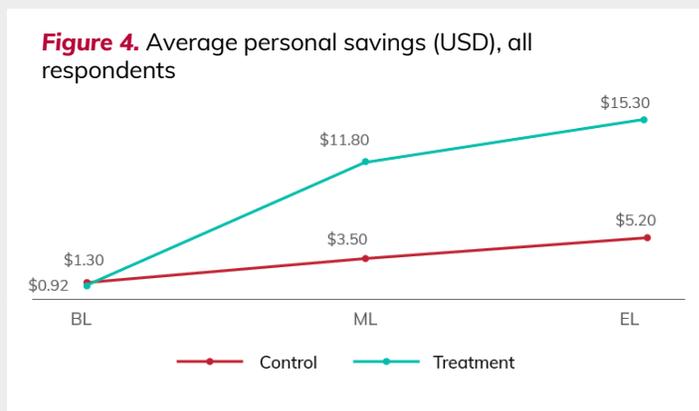
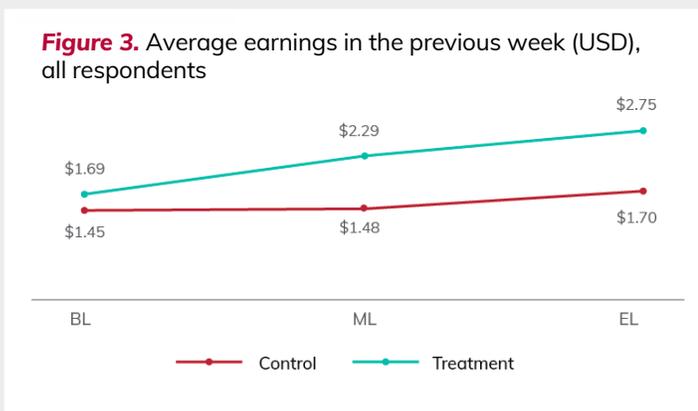
Women increased their income and shifted towards entrepreneurship. Women who had been through the WfWI intervention had weekly gross earnings 1.6 times higher than women in the control arm at endline (\$2.75 vs. \$1.70; $p < 0.01$) (Figure 3). This may be due to a shift towards more lucrative entrepreneurial endeavors: the treatment group had higher rates of self-employment by almost 40% (18% vs. 13%, $p < 0.01$). Women reported that the new skills gained from training allowed them to start new businesses: “[The important thing I’ve learned is] the skill I’ve acquired through weaving baskets. Today, I can go out here to Luvunge. If I have a little money, for example \$10, I can buy threads, weave, and sell. In addition, the WfWI program helped a lot in transmitting work intelligence.”

Though average earnings increased significantly, the share of women who reported any earnings in the prior week remained between 40% and 50% at each point in time and across treatment arms. This shows that the program may not lead to regular and/or increased earnings for all participants, but for those with gains, the program leads to significant positive changes.

Women reported increased personal and household savings, assets, and access to credit. The proportion of households with savings in the treatment arm was double that of the control arm (79% vs. 42%; $p < 0.01$) and the mean household savings were almost twice as high in the treatment arm (\$22.61 vs. \$12.19; $p < 0.01$). The program participants also had significantly higher valuations of household livestock at endline (\$70.36 vs. \$53.64, $p = 0.03$).

Women’s average personal savings also increased significantly due to program participation and sustained one year after the program; mean personal savings in the treatment group were \$15.30 vs \$5.20 in the control group ($p < 0.01$) (Figure 4). This three-fold difference in women’s savings suggests that (i) the overall increase in household savings is driven by the women’s increased amount of savings (since they both increase by about \$10) and (ii) women’s relative financial position in the household has improved.

The program also improved women’s financial inclusion. VSLA participation rates in the treatment arm were twice that of the control arm participants (79% vs. 38%, $p < 0.01$), providing a vehicle for savings outside the household and access to loans. The program also yielded higher rates of women’s formal land ownership (15% vs. 11%, $p = 0.01$).



Women reported feeling more in control of their lives, increased participation in household decisions, and improved self-confidence. When asked about feelings of control over one’s life, women in the treatment arm had locus of control index scores that were 10% higher than women in the control arm at endline (2.2 vs. 2.0 out of 4; $p < 0.01$). Interviews confirmed that women shared an increased sense of self-reliance and confidence in doing new things. According to one participant, “The big change that has taken place in my life is above all empowerment because today, I am able to take care of my children alone.” Another participant shared, “I did not know women could manage money. I used to expect everything from my husband. But now I hear nothing from him; I prefer to develop my own ways of feeding my children instead of waiting for the return of my husband.”

Overall, the program increased participation in household decision-making, measuring 0.15 standard deviations higher on the decision-making index ($p < 0.01$) one year after the program, when compared to women in the control arm.⁶ The decision-making index combined four questions asking who participates in specific household decision-making scenarios. In the qualitative research, some participants shared how decisions were made jointly in their homes or that some decisions were made solely by the participant, while others highlighted that in some households, decisions were still led by men.

Women’s rates of anxiety decreased, and household diets became more diverse. The survey included standard diagnostic tools for anxiety and depression (via self-report): the Generalized Anxiety Disorder Index (GAD-7) and Patient Health Questionnaire 9 (PHQ-9) [8][9]. The treatment arm participants had lower rates of mild, moderate or severe anxiety compared to the control group (51% vs. 58%, $p < 0.01$) (Figure 5), but similar rates of depressive symptoms across study arms at endline (57% vs. 60%, no significant difference).

In comparison to women in the control group, mean household diet diversity scores were significantly higher amongst women in the treatment group (8.4 vs. 8.1 out of 12, $p < 0.01$) (Figure 6). This was corroborated by qualitative data. For example, one woman shared: “I used to eat food without oil; now I can prepare my vegetables. I have salt or oil and a measure of flour we eat. I know how to vary the food today like beans, corn, sombe, and others, and the health of the family is improving.”

⁶ To contextualize this effect, note that decision-making participation increases with age, and the treatment caused decision-making index scores to increase by the amount equivalent to aging six years. Therefore, the program gave women in one year the same gains that they would have likely achieved in six years in the absence of the program.

Figure 5. Percent of participants with any anxiety diagnosis (GAD-7)

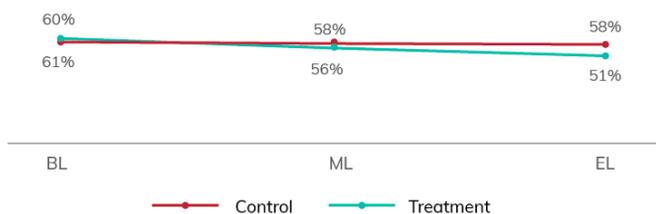
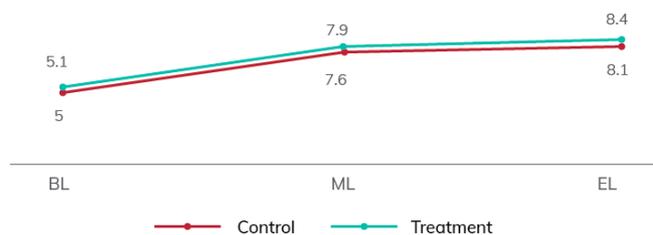


Figure 6. Average Household Diet Diversity Scores (0-14)



Women’s overall gender attitudes and rates of intimate partner violence did not change in the study timeframe. More women in the treatment arm held the attitude that women can be community leaders, compared to women in the control arm (93% vs. 84%, $p < 0.001$). However, women’s overall gender attitudes, when aggregated into an index, were not different between study arms.⁷ Additionally, the program did not impact the prevalence of reported experiences of intimate partner violence (IPV) in the past 12 months (30% of treatment arm participants vs. 32% of control arm participants, no significant difference). Qualitatively, some women reported experiences of physical, sexual and verbal abuse from their husbands and male partners. This is consistent with findings that interventions targeting women can have heterogeneous effects on IPV, leading to reductions for some women and increases for others [10].

Women increased participation in social groups and gained social support. Women in the treatment arm, compared to those in the control arm, had higher rates of participation in community-based social groups (94% vs. 77%, $p < 0.01$) (Figure 7) and more women had social support when in need: 55% vs. 42% ($p < 0.01$) of women reported having someone they could borrow money from in an emergency (Figure 8).

Figure 7. Percentage who belong to any social group

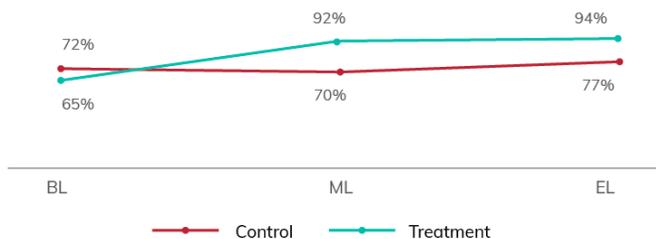
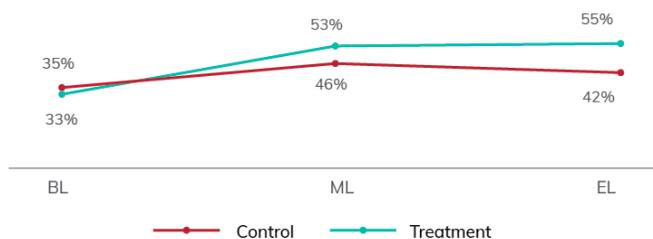


Figure 8. Percentage who have someone to borrow money from in the case of an emergency



Participants shared how they have become important members of their communities. One participant said, “Members of the community can borrow money from me without problems. Really WfWI [pushed me] forward! I became important in the neighborhood now, while I used to be the most neglected of us and no one could come close to me.” Another woman shared: “In my community, we say that WfWI makes us leave the ground, I am a model to women; a teacher who educates other women to become respectful to everyone.”

Overall, women’s outcomes were not significantly impacted by men’s engagement programming for male family members. The researchers analyzed the outcome differences between women in the MEP treatment arm and the women in the no MEP treatment arm. There were no statistically significant differences in any key outcome areas, including average earnings, savings, decision-making participation scores, gender attitudes, or IPV.

Though the survey data showed, on average, that the MEP treatment did not lead to additional improvements in women’s outcomes, qualitatively, some of the interviewed women described positive changes in their husbands or partners due to MEP. One woman reported, “There is huge change because before, he used to say he will marry another woman because I am a burden to him. However, now that he has realized that he can count me in, he now pays respect to me and consider me as a friend.” Some women highlighted reductions in their partners’ drinking habits, while some men reported that their relationships improved due to engagement with the MEP intervention. One man stated, “Today, honesty characterizes us, a good collaboration that exists between us.”

⁷ Example questions within the gender attitudes index included asking if participants agreed or disagreed that a male should have the final word on decisions in his home, or that a man could beat his wife for refusing to have sex.



Photo credit: Ryan Carter (2017)

Study limitations

The study was conducted in a fragile setting, and there was an overall 12% attrition rate at endline, much of which was caused by participants who were ill or migrated to new locations. However, this rate is not significantly different between study arms: 13% in the control group and 11% in the treatment group. Individuals in the treatment and control arms of the study lived in the same communities, and the research took place in communities with existing WfWI community advocacy activities. Therefore, respondents in the control group may have been exposed to elements of WfWI interventions, reducing the differences between treatment arms. 67% of women in the control group reported knowing someone in the WfWI Signature Program, and 12% reported receiving information or lessons from WfWI program participants over the course of this study.

For some outcomes, such as mental health and empowerment, Western survey tools may not have translated well to this context; further research is required to understand local definitions and manifestations of concepts such as depression, anxiety, and agency [11][12][13]. Lastly, social desirability bias, whereby participants learn the “right” answer to questions, can manifest in this type of study, particularly when questions are repeated multiple times over a long period. However, given that control group respondents were waitlisted to receive WfWI programming after this trial completed, it seems likely that a desire to please the enumerator would apply equally to treatment and control groups.

Reflections on results

This study demonstrates that an integrated social and economic empowerment program can improve the wellbeing of marginalized women in conflict-affected eastern DRC. These findings contribute to an extensive and growing evidence base on the success of “big push” bundled anti-poverty interventions such as graduation approaches, especially evinced by significant and sustained gains across a range of economic outcomes and indicators [14] [15]. However, to date, quantitative evaluations of graduation approaches have shown limited or mixed impacts on women’s empowerment outcomes [15][16]. The results from this study demonstrate that WfWI’s combined focus on poverty alleviation and gender transformation leads to gains across economic and social domains, including agency, participation in decision-making, anxiety, diet diversity, and social support. The gains seen from this

study demonstrate the effectiveness of an integrated approach even in a fragile and conflict-affected situation (FCAS) in which participants simultaneously faced poverty, ongoing conflict and instability, lack of governance and basic infrastructure, market shocks, an Ebola outbreak, and more.

Although this study did not seek to unpack the bundled program and interrogate which components are driving which change, WfWI believes the following integrated elements are critical to the success of this approach:

- 1. Building a women-driven program.** WfWI pledges to meet women where they are and does so by engaging with them to shape programming that is based on their stated needs and respecting the strength and resilience within them.
- 2. Laying economic foundations.** Women selected for the program have often missed out on formal education, so WfWI provides training on basic foundational knowledge including numeracy, saving money, goal-setting, and budgeting as well as vocational and business skills. In FCAS, savings and assets are essential both for coping with economic shocks and helping to start or grow businesses. The bundled approach helps women achieve economic self-sufficiency and withstand economic shocks.
- 3. Integrating gender-transformative programming into poverty alleviation efforts.** Women’s poverty in FCAS is compounded by deep-rooted gender norms that perpetrate gender discrimination. WfWI’s bundled approach supports building women’s social power with training on gender equality, rights and decisionmaking, leadership, communication, advocacy, and health and wellness.
- 4. Connecting women through networks.** There is power in women coming together to support one another. Group-based programming and VSLAs create social support networks for women, reducing isolation, providing comfort and safety in emergencies, and leading to opportunities for community engagement and collective action.

Marginalized women are resourceful and resilient agents of change. With the right financial, technical, and social support, women facing conflict, poverty, and oppressive gender norms can change their ways of working and earning money, improve their health and wellbeing, increase participation in their households and communities, and grow their power.

Recommendations for future programming to empower women

This study also provides a roadmap for WfWI's growth and for researchers, practitioners, and donors in the wider development community seeking to uplift women at the intersection of conflict, poverty, and gender inequality.

First, while the increase in average earnings from the WfWI Signature Program is substantial, it is important that programs look beyond averages to identify and support women who may need an additional boost to increase their earning potential. For low or moderate earners, more individualized tracking and tailored support by staff or mentors may be needed [16]. Further, methodologies that capture the complexity of irregular or seasonal earnings data are important to employ in research that seeks to understand the realities of micro-entrepreneurs; surveys relying on weekly or monthly recall to record the earnings of intermittent or seasonal workers can narrow a study's view of a population's earnings potential.

Second, there is limited research studying links between women's empowerment and mental health, especially in conflict settings [17]. This study found high rates of anxiety and depression among participants and provided promising findings in the reduction of the prevalence of anxiety symptoms, but not in reductions of participants with depressive symptoms. Mental health services are extremely limited in this setting, so programmers should consider a range of support strategies to promote improved mental health and address service gaps. These include training staff in psychosocial support and psychological first aid, employing screening tools and referrals to service providers where possible, teaching coping and support strategies, and leveraging targeted technical assistance to sensitize populations and provide services [18][19].

Third, this study showed that despite outcomes on the theorized pathway to violence reduction being impacted [20], reported experiences of intimate partner violence were not reduced. The program did not set out to reduce violence in its original design, and WfWI is convinced that intentional violence prevention programming that targets household members and community-level social norm change is needed going forward [21]. Significant research in the last decade has been dedicated to understanding strategies to reduce violence against women, and it is critical that practitioners begin to apply these tested approaches to poverty alleviation programs [22][23].

Fourth, the study finds that the examined level of men's engagement programming was not sufficient to lead to additional average gains for women participants of WfWI's Signature Program. Since this trial began in 2017, WfWI has improved and expanded its activities to engage with men, including training community and religious leaders, hosting community forums, and holding men's discussion groups, based on global evidence for best practices in terms of types of activities, duration of engagement, topics to be covered, and frameworks to employ [24]. More effective men's engagement programming is required to influence women's outcomes [25].

Finally, the results underscore the difficulty associated with shifting deeply engrained gender attitudes, even when many other social and economic indicators showed significant improvements. Individual attitudes about gender are intrinsically linked to gender norms; changing individual attitudes requires investment in shifting the beliefs, attitudes, behaviors, and norms across a community [26]. Since 2017, WfWI has increased community-oriented programming, such as training women as community advocates [27]. It is critical for programs seeking to empower women to foster an enabling environment that respects women's rights and encourages them to raise their voices.

Women in FCAS like DRC are often forgotten and risk being further left behind. They face multiple and intersecting barriers to their social and economic empowerment including extreme poverty, social exclusion and widespread gender discrimination. Bundled approaches that aim to promote women's social and economic inclusion must directly address these barriers by integrating gender-transformative programming into their approaches, directly investing in women's knowledge, skills, wellbeing and power and placing a strong emphasis on changing power dynamics in the household and community. This kind of approach is needed to ensure that women's economic and social empowerment is attainable and sustainable.

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Women for Women International works with the most marginalized women in conflict-affected countries to help them move from poverty and isolation to self-sufficiency and empowerment. WfWI has worked with over 500,000 women across eight countries since 1993. Further information about the project is available at: www.womenforwomen.org.

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