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Impact Evaluation of Holistic Women's Empowerment Program on Women's Agency, Decision-Making and Economic Empowerment: Baseline Research Brief

South Kivu, Democratic Republic of Congo

ABOUT WOMEN FOR WOMEN INTERNATIONAL

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 through our combined economic and social empowerment program.

Founded in 1993 in Bosnia-Herzegovina in response to atrocities committed against women during the Bosnian war, Women for Women International (WfWI) has worked with more than 495,000 marginalized women survivors of war in Afghanistan, Bosnia and Herzegovina, the DRC, Kosovo, Iraq, Nigeria, Rwanda and South Sudan.

WfWI builds women's self-reliance in every aspect of life: health and wellbeing, economic stability, family and community participation, and sustaining social safety nets. WfWI's one-year holistic social and economic empowerment training program is delivered to groups of 25 women and includes sessions on rights, life skills, numeracy, business practices, vocational training, an introduction to cooperatives, and a monthly stipend of \$10 (USD). Support is provided to link women to a savings tool, either by opening formal bank savings accounts or by helping them establish savings and lending groups.

WfWI also provides men's engagement programming (MEP) to engage men to become active allies in support of women's social and economic empowerment and rights. Male community leaders are trained to share knowledge and facilitate weekly discussion groups with the women's male spouses, partners, or other household members. Topics include women's economic empowerment, domestic violence, and women's health. High-risk couples also participate in couples dialogue sessions.

WfWI has been conducting its program in the North and South Kivu provinces of Democratic Republic of Congo (DRC) since 2004 and has reached over 98,500 women and 12,000 men.

IMPACT EVALUATION METHODOLOGY

WfWI is conducting an impact evaluation using randomized control trial (RCT) methodology to measure the causal impact of its one-year holistic empowerment training program. An RCT is a

study design that randomly assigns the study population into treatment and control groups. One group receives a program or intervention (treatment group) while the control group does not receive the program until after the study period.

Random assignment ensures that any difference observed between the two groups can be attributed to the program or intervention itself rather than other external or unobserved factors. As a result, RCTs are the most credible and reliable way to evaluate the effectiveness of a program or intervention.

In this study, 2,039 potential WfWI program participants were selected to be research respondents and were surveyed at baseline. One thousand women were randomly assigned to participate in the program, and the other women were randomly assigned to the control group (Figure 1). This study design further divided the treatment arm into two groups: half of the women participating in the program were also randomized to have a spouse or male family member participate in men's engagement programming during the trial.

The entire study is conducted over a period of 24 months to look at changes that occur over two years. The study baseline was completed in August 2017. The treatment arm participants entered the one-year training program in August and October 2017. The final data collection is scheduled for August 2019.

STUDY LOCATION: SOUTH KIVU, DRC

The DRC has grappled with wars, civil strife and multiple rebel movements since 1996. As a result, despite the abundance of valuable natural resources, the DRC is one of the poorest and least-developed places on earth, ranking 176 of 188 countries on the Human Development Index (HDI). 64% of the population live below the poverty line and over 6 million children under 5 suffer from chronic malnutrition.^{1,2} An estimated 30% of deaths are caused by preventable diseases such as diarrhea, malaria, or respiratory infections.³

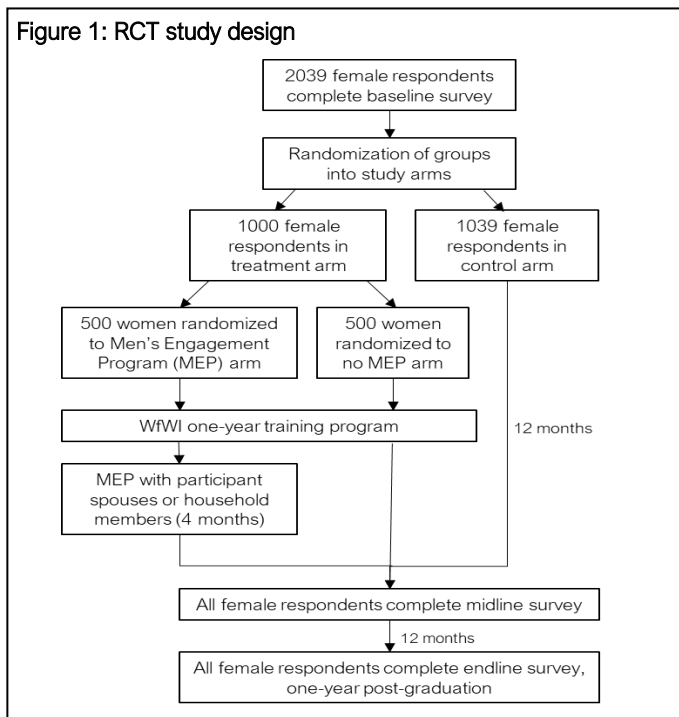
The DRC also scores poorly on measurements of gender equality. The DRC is ranked at 153 out of 159 countries on Gender Inequality Index (GII), an index that reflects gender-based inequalities in reproductive health, empowerment, and

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economic activity. Women represent less than 20% of the student body in universities. The literacy rate of the population aged 15 and older is 67% for women in comparison to 89% for men.⁴



In the eastern provinces, decades of conflict have claimed over 5 million lives and uprooted 2.8 million people from their homes.⁵ The constant conflict and lack of governance has led to extreme underdevelopment in South Kivu, DRC and families are susceptible to various economic shocks.

South Kivu has the highest rate of informal entrepreneurs in the DRC living below the poverty line (90%) and the vast majority are women.⁶ Women are 6.7 times more likely than men to be “survivalist” entrepreneurs, meaning they operate low-growth businesses.⁷



STUDY POPULATION

WfWI serves ultra poor and socially marginalized women. The average age of the female respondents in the study is 31 years old and the average household size is 6.4 people. 43% of the survey

¹ Human Development Report 2016: Democratic Republic of Congo. UNDP. http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/COD.pdf

² Democratic Republic of Congo: Nutrition Profile. USAID. (2018). <https://www.usaid.gov/sites/default/files/documents/1864/DRC-Nutrition-Profile-Mar2018-508.pdf>

³ Global Health – Democratic Republic of Congo. CDC. <https://www.cdc.gov/globalhealth/countries/drc/default.htm>

⁴ The World Factbook: Democratic Republic of Congo. CIA. <https://www.cia.gov/library/publications/the-world-factbook/geos/cg.html>

⁵ United Nations Office for the Coordination of Humanitarian Affairs (OCHA) (2015).

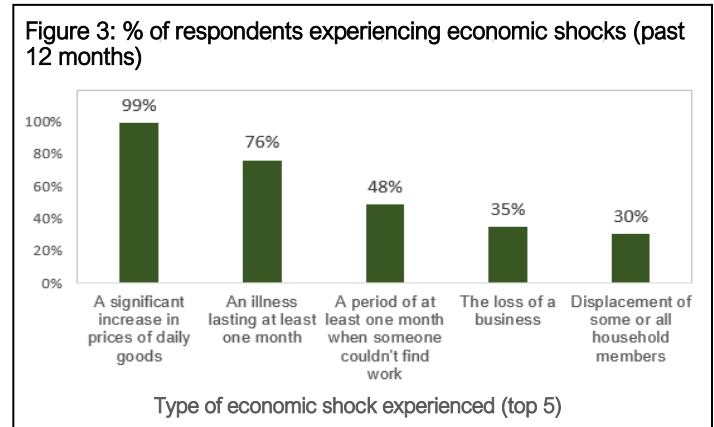
⁶ Adoho, F. M., & Doumbia, D. (2018). Informal sector heterogeneity and income inequality: Evidence from the Democratic Republic of Congo. The World Bank. <http://documents.worldbank.org/curated/en/984711517510605615/pdf/WPS8328.pdf>

⁷ Adoho, F. M., & Doumbia, D. (2018). Informal sector heterogeneity and income inequality: Evidence from the Democratic Republic of Congo. The World Bank. <http://documents.worldbank.org/curated/en/984711517510605615/pdf/WPS8328.pdf>

⁸ Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité (MPSMRM), Ministère de la Santé Publique (MSP) and ICF International. 2014. Democratic Republic of Congo Demographic and Health Survey 2013-14: Key Findings. Rockville, Maryland, USA: MPSMRM, MSP et ICF International.

respondents are literate and only 14% of women in our study sample attained education higher than primary school, as compared with the national rate of 48% for women’s primary school completion.⁸

Just under 40% of the households in our sample did not have any form of income in the previous 7 days and almost all of the survey respondents at baseline reported experiencing an economic shock that affected a household member in the past 12 months (Figure 3). The most common economic shocks were a significant increase in prices of daily goods, an illness lasting at least one month, and an unemployment period of at least one month.



STUDY LEARNING OBJECTIVES

Through the holistic women’s empowerment and men’s engagement programs, WfWI seeks the following changes in female participants: (i) improved self-confidence; (ii) improved knowledge of their rights, violence against women (VAW) and how to care for their health and well-being; (iii) greater influence in decision-making in the home and community (via includes negotiation and decision-making skills training); (iv) improved ability to be economically self-sufficient; (v) increased savings and access to credit; (vi) increased business management skills and assets; and (vi) improved connections to local and global networks for support and advocacy.

We aim to measure the causal impact of WfWI’s year-long holistic empowerment training program on women’s agency, decision-making, well-being, and health. With the inclusion of the men’s engagement treatment arm, we are additionally examining how training male spouses, heads of households, and community leaders affects women’s agency and decision-making. This study will provide evidence to confirm or modify some causal pathways in our program theory of change.

We are measuring impact across the following domains:

- *Economic empowerment*: access to secure and sustainable incomes, livelihoods, and savings, household consumption, and financial trust in spouse/partner.
- *Social empowerment*: women gaining control over their lives, decision-making power about important household issues, and attitudes about gender norms.

- *Social assets*: women's social networks, participation in groups and the community, and access to support when needed.
- *Well-being*: women's mental and physical health, children's health, household nutrition, and cognition.

STUDY INDICATORS AND BASELINE RESULTS

In this section, we present a subset of study indicators and results from the baseline survey, prior to any intervention.

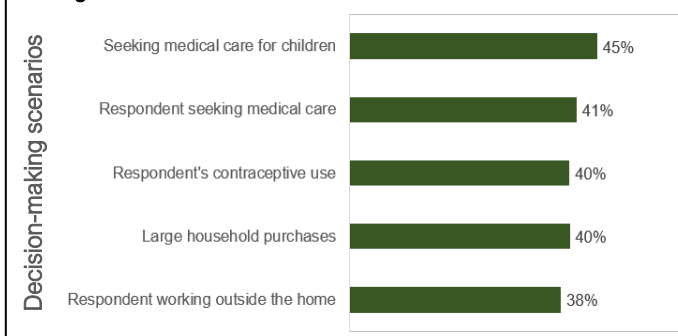
Economic Empowerment

- *Income-generating activities*. 41% of respondents said they participated in at least one income-generating activity in the past 7 days. The most common activities were agricultural wage labor, cultivating household plots, or petty trading.
- *Weekly earnings*. The respondents' average earnings in the previous 7 days from up to two main income-generating activities was \$1.57 (USD).
- *Time spent on unpaid domestic labor*. In this survey, unpaid domestic labor means work for the household that does not receive direct payment, such as caring for children, cooking, cleaning, fetching water or firewood, and buying food or other items. Respondents spent an average of 5.3 hours a day on unpaid domestic labor, compared to an average of 1.9 hours a day on paid labor, including cultivation of crops.
- *Household food consumption*. We asked questions about consumption and purchases of 22 food items to calculate the amount and value of food that the household consumed in the past 7 days. The average household spent \$7.61 (USD) in the past week on food.
- *Household non-food consumption*. Non-food consumption provides an estimate of household spending in a month across many typical expense categories, including necessities (e.g. rent, fuel, medical fees), routine expenses (e.g. clothing), large and non-routine expenses (e.g. home improvement, events, school fees), and luxury/comfort items (e.g. entertainment). Household spent an average of \$17.09 in the past month.
- *Total household savings*. The average amount of savings held by the household was \$1.72 (USD). 13% of respondents reported having some household savings; 9% of respondents reported having some individual savings.
- *Financial trust of spouse/partner*. Respondents were asked to participate in Modified Dictator trust games.⁹ A respondent was given some money and told to divide it between herself and a second player (not present for the game), where the amount she allocated to the second player would be doubled before being given to them. Respondents played this game twice: once where the second player was her spouse, and once where the second player was a stranger. We hypothesize that a respondent who trusts that her spouse will use their money for the good of the household will allocate a higher amount to her spouse than to a stranger, as money allocated to the spouse or stranger is doubled and therefore a larger sum of money enters the household if given to the spouse. 64% of respondents gave more money to their spouse than to a stranger at baseline.

Social Empowerment

- *Participation in household decision-making*. Respondents were asked about their participation in five household decisions: (1) whether the respondent can work outside the home, (2) large household purchases, (3) the respondent using contraceptive, (4) respondent seeking medical care, and (5) respondent seeking medical care for her children. Depending on the topic, 38% to 45% of respondents reported that they did not participate in the decision (Figure 4).

Figure 4: % of respondents who do not participate in decision-making



- *Respondent attitudes about gender norms*. 63% of respondents agreed that a man should have the final word about decisions in his home. 62% of respondents agreed that a man can beat his wife if she refuses to have sex with him.
- *Locus of control*. An important component of empowerment is feeling a sense of control about what happens in one's life. To measure this, we read four pairs of statements about feelings of control in one's own life to each respondent and asked them to choose the statement they agreed with the most. Respondents who select more statements expressing control demonstrate receive higher scores on the locus of control index. On average, respondents scored 2 out of the 4 on the index. The respondent selections are shown in Figure 5, per pair of statements.

Figure 5: Respondent responses to locus of control choices (%)



Social Assets

- *Access to safe place to sleep if needed*. 53% of respondents reported having a safe place to sleep if she felt unsafe in her household.
- *Access to money if needed*. 33% of respondents reported having a person who could give her money if needed.
- *Access to support when facing a problem*. 45% of respondents sought support from someone when facing a problem in the previous 4 weeks.
- *Social group involvement*. 69% of respondents were current participants in at least one social group. These groups include cultural or political groups, cooperatives, business groups, savings and/or credit groups, women's groups, religious groups, or any others.

Well-being

- *Respondent physical health*. 43% of respondents reported that they could not easily do vigorous activities,

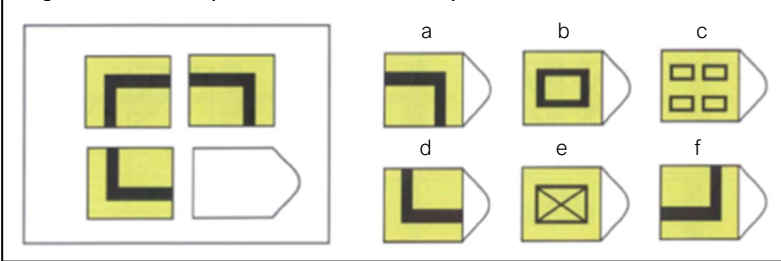
⁹ Dickhaut, J., & McCabe, K. (1995). Trust, Reciprocity, and Social History. *Games and Economic Behavior*, 10, 122-142.

such as running, lifting heavy objects, or carrying water. 24% of respondents reported they could not easily do moderate activities, such as working in the fields, sweeping, or walking 5 km. 36% of respondents faced difficulties in day-to-day tasks due to physical pain.

- **Health of children under five.** 76% of respondents live in a household with a child under five years of age. 73% of children under five in the respondents' households experienced diarrhea, a fever, and/or a persistent cough and difficulty breathing in the past two weeks.
- **Respondent self-reported levels of anxiety.** Using the self-reported Generalized Anxiety Disorder Index (GAD-7), 31% of respondents scored as having mild anxiety, 23% had moderate anxiety, and 6% had severe anxiety.¹⁰
- **Respondent self-reported levels of depression.** Using the self-reported Patient Health Questionnaire 9 (PHQ-9), 32% of respondents scored as having mild depression, 20% had moderate depression, 8% had moderately severe depression, and 13% had severe depression.¹¹
- **Nutrition in the household diet.** In the previous 7 days, the average household ate 5 out of 12 food groups. 51% of households had consumed fruits or vegetables, 31% had consumed eggs, and 51% had consumed meat or fish.
- **Respondent's cognitive abilities.** The lived stress of daily poverty has been shown to limit cognitive capacity due to exhausted mental resources.¹² We hypothesize that relieving some financial and social pressure may allow improved cognition. Respondents were asked to complete three tasks designed to measure cognitive abilities. The first task was a pattern recognition task, where respondents were shown eight Raven's Matrix puzzles (Figure 6). These puzzles display a pattern in which a part of the puzzle has a missing piece. On average, respondents correctly identified the missing piece in 3 out of 8 puzzles.

The second task was a memory task, where the surveyor would say a string of numbers and the respondent had to repeat it back in the correct order, increasing the length of the string with each question, up to 8 digits in length. Next, the surveyor would ask the respondent to listen to a string of numbers to repeat it back in the reverse order, increasing the length of the string with each question, up to 8 digits. Respondents could remember an average of 4 digits in sequence and 3 digits in reverse sequence.

Figure 6: An example of a Raven's Matrix puzzle



HYPOTHESIZED PROGRAM IMPACTS

The women in the treatment arm will graduate from the one-year training program in July and September 2018. Based on WfWI's theory of change, we hypothesize that program participation for women, and men's engagement program participation for male household members, may affect women in the following ways:

- Increased employment activities and increase in wages;



A data collector administering the study to a participant in South Kivu, DRC.

Photo credit: Eva Noble, 2018

- Increased time spent on income-generating activities;
- Increased role in household decision-making;
- Increased sense of control over one's own life;
- Greater financial trust between spouses in the household;
- Increased household savings, assets, and non-food consumption;
- Increased household food consumption and dietary diversity;
- Improved ability to manage economic shocks in the household;
- Increased participation in social groups within the community and more social support; and
- Improvements in respondent's physical health, mental health, and cognitive abilities and in children's health.

Through this RCT, we aim to learn about the impact of WfWI's one-year holistic empowerment training program across these domains.

Final Results from this RCT will be available in 2020.

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¹⁰ The Generalized Anxiety Disorder (GAD-7) questionnaire has 7 self-reported questions to measure psychological health during the previous two weeks. Citation: Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of internal medicine, 166(10), 1092-1097.

¹¹ The PHQ-9 scale is a set of nine questions designed to evaluate the presence and severity of depression in respondents. The questions target the frequency with which the respondents experience depressive behaviors such as feeling little interest or pleasure in doing things, or feeling tired or having little energy in the previous two weeks. Citation: Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The phq9. Journal of general internal medicine, 16(9), 606-613.

¹² Mani A, Mullainathan S, Shafrir E, Zhao J. Poverty Impedes Cognitive Function. Science 341(4169): 976-980. DOI: 10.1126/science.1238041.