"No one has power over me"

The Impact of Integrating Cash Assistance into Gender-Based Violence Response in Northwest Syria

A Mixed-Methods Evaluation over Nine Months

Cover Image:
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Female refugee in Northwest Syria, carrying water across the refugee camp.

Full quote:
"It is safer. Cash assistance helped me pay off my debts, and no one asked me anymore. I felt that I am independent and stronger. No one has power over me." – IDP woman, Northwest Syria

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I. EXECUTIVE SUMMARY

"It is safer. Cash assistance helped me pay off my debts, and no one asked me anymore. I felt that I am independent and stronger. No one has power over me." – IDP woman, Jarablus

Traditionally, refugees and internally displaced persons (IDPs) have received aid in the form of in-kind assistance. Increasingly, however, cash and voucher assistance (CVA) is being used in humanitarian response to meet the diverse needs of those displaced by crisis and conflict.

Preliminary findings by the Women's Refugee Commission (WRC) indicate that CVA supports gender-based violence (GBV) prevention and response activities, yet humanitarian GBV programming does not comprehensively or consistently consider using CVA.[1] This is a critical gap, as refugee, internally displaced, and migrant women and girls face multiple risks and incidents of GBV before, during, and after crises.

As a complement to core aspects of survivor care and case management (CM), CVA—if appropriate in the context—may strengthen individuals' capacities to recover and enable access to services. CVA can, for example, help a GBV survivor cover the costs associated with fleeing an abusive relationship, such as rent, temporary shelter, transportation, food, and clothing. There also may be indirect pathways in which CVA could be used by survivors to reduce their exposure to GBV, such as decreasing their financial dependence on abusive partners or family members.

It is critical to not only identify the protective benefits of CVA, but also to ensure that any CVA-associated risks are mitigated during CVA delivery to GBV survivors so they can safely use CVA toward their recovery (for example, by tailoring the delivery mechanism, frequency, value, and duration of cash transfers). It is also critical to reduce recipients' exposure to further harm and optimize CVA when integrated in GBV CM approach.

There is little to no evaluation of the longer-term impacts of this type of programming in humanitarian settings. This and further evidence will shed light on remaining gaps in program design and lead to sustainable changes. From June 2021 to March 2022, WRC, with research partner the South Africa Medical Research Council (SAMRC), undertook a mixed-methods study to understand the potential of integrating CVA into comprehensive CM for GBV survivors in settings with acute humanitarian emergencies in Northwest Syria (NWS) and Colombia.

In NWS, drawing on the expertise of WRC and guidance and tools implemented by CARE Turkey, and in collaboration with local actors Ihsan Relief and Development (IRD) until October 2022 and Syria Relief and Development (SRD),[2] WRC sought to examine changes among internally displaced Syrian survivors in NWS in a cash assistance and in-kind assistance-integrated GBV case management program at three months and nine months into the program.

1 Tenzin Manell, Women's Refugee Commission, *Tackling the Integration of Gender-Based Violence Prevention and Response and Cash-based Interventions* (November 2018), https://www.womensrefugeecommission.org/wp-content/uploads/2020/04/genderandctpwrc.pdf.

2 Ihsan Relief and Development (IRD) took part in the project supporting the design of new Standard Operating Procedures, carried out assessments, survivor case management, and cash disbursement. In October 2021, the collaboration between CARE Turkey and IRD ended. All activities and findings reference the period between the beginning of the project and partnership with IRD through the new partnership with Syria Relief and Development.

KEY FINDINGS

- Integrated CVA-GBV CM not only reduced GBV and associated risks for survivors, but also improved economic capacity, personal well-being and the well-being of children, interpersonal relationships with family members, and interactions with the host community.
- In some cases, the value of the transfer was insufficient to address survivors' protection needs.
- The assistance allowed some participants to invest in an enterprise that then became a source of sustainable income.
- At nine months after the start of the program, participants still saw improved protection impacts, economic capacity, personal well-being, and asset outcomes, as compared to those at three months. However, some changes depreciated over time.

TOP RECOMMENDATIONS

- To support survivors' long-term recovery from GBV, strengthen the design, implementation, and reach of livelihoods support alongside cash-integrated GBV CM, either through a livelihoods component or referrals to active, effective livelihoods programming.
- CVA-integrated GBV CM programs should dedicate resources to reaching adolescent girls aged 10 to 19 years who have experienced or are at risk of exposure to GBV.[3] Consider launching awareness campaigns in internally displaced persons (IDP) camps where the program is to be implemented and challenging existing gender norms that are barriers to participation.
- Although it is GBV specialists who are directly responsible for GBV response, other actors, including multi-purpose cash assistance (MPCA) and livelihoods service providers, are responsible for ensuring their interventions do not increase risks of exposure to GBV. Proactively coordinating with GBV service providers will support cross-sectoral collaboration and inclusive referrals to meet survivors' recovery needs, as well as prevent and mitigate their falling back in to a cycle of violence.

3 The program model studied considered cash assistance integrated within GBV case management for 15 to 19 years old survivors; for those groups cash assistance was provided with the informed assent from the adolescent and informed consent of the care giver.

II. BACKGROUND

Traditionally, refugees and IDPs have received aid in the form of in-kind assistance. CVA is now a common tool in humanitarian response used to meet the diverse needs of those displaced by crisis and conflict, and its use is on the rise. Findings from the third Grand Bargain Cash Workshop in 2019 suggest an estimated 60 percent scale-up of total cash and voucher delivery from 2016 to 2018. Despite a push by several humanitarian actors since 2015, its use for protection outcomes—including to support the prevention of and response to GBV—trails behind its use in all other sectors.[4]

This is a serious gap, as refugees, internally displaced, and migrant women and girls face multiple risks and incidents of GBV before, during, and after crises.

While GBV prevention and mitigation are the responsibility of all humanitarian actors, GBV response is the responsibility of GBV specialists. CVA, while not always appropriate, can play a key role in the prevention of and response to GBV. It is essential to better understand how CVA can help prevent, mitigate, and respond to GBV. Building evidence on using cash transfers as well as vouchers is, therefore, much needed to strengthen the community of practice on responding to and preventing GBV.

Preliminary findings by WRC based on research from 2016 to 2018 indicate that, when appropriate, CVA supports GBV response activities; yet humanitarian GBV programming does not comprehensively or consistently consider CVA.[5] CVA as a complement to core aspects of survivor care and CM may strengthen an individual's capacities to recover and enable access to services—if appropriate in the context and for the case of individual survivors. CVA can, for example, help a GBV survivor to pay the costs associated with fleeing an abusive relationship, such as rent, temporary shelter, transportation, food, and clothing. However, identifying not only the protective benefits of CVA, but also ensuring that GBV survivors can safely use CVA toward their recovery is critical to ensure that recipients are not exposed to further harm. It is also critical to ensure that CVA is optimized when it is integrated within a GBV CM approach. Optimizing CVA may be achieved, for example, by tailoring the delivery mechanism, frequency, value, and duration of transfers.

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An awareness session was conducted by the mobile team, in Northwest Syria. During the session, the service provider communicates awareness messages about gender-based violence and child labor.

However, evidence on the effect that CVA has on protection- and GBV-related outcomes is limited. There is even less evidence on the longer-term outcomes of an integrated program on participants. The aim of this evaluation, undertaken by WRC and SAMRC through a mixed-methods study, is to understand the mechanisms and impacts of integrating cash into CM for GBV survivors in an acute humanitarian emergency setting (NWS). The program and evaluation seek to inform CARE Turkey's and in-country partners Ihsan Relief and Development's (IRD) and Syria Relief and Development's (SRD), understanding of the impacts of their cash-enhanced program model on the measures, tools, and effect sizes[6] over an extended period. This evidence can be used to inform scaled-up implementation and evaluation of this program model in the future.

4 Tenzin Manell and Holly Welcome Radice, "Leveraging Cash and Voucher Assistance in Gender-based Violence Prevention and Response" (2019; CALP Network blog), https://www.calpnetwork.org/blog/leveraging-cash-and-voucher-assistance-in-gender-based-violence-prevention-and-response/.

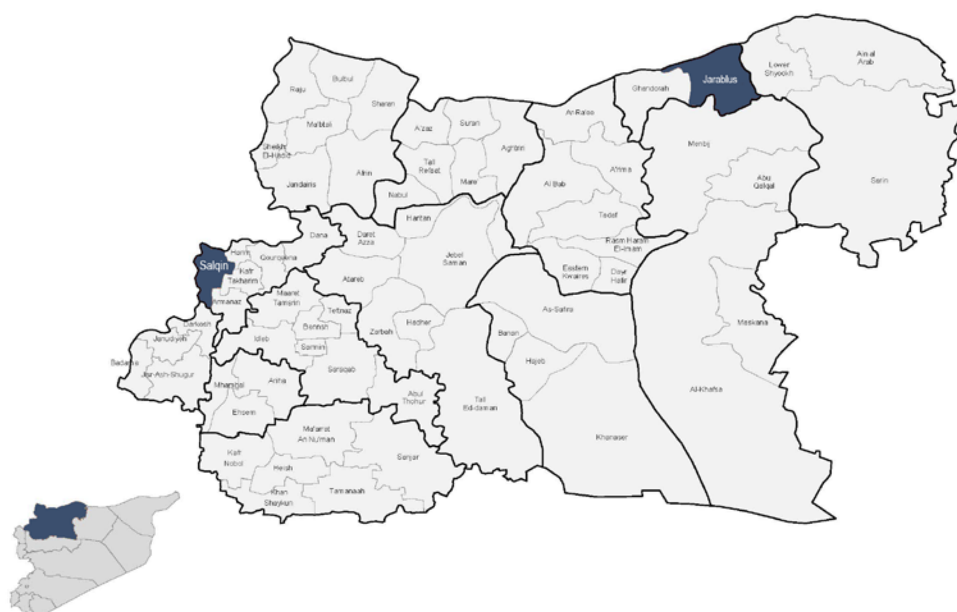
5 Tenzin Manell, Women's Refugee Commission, *Tackling the integration of Gender-based violence Prevention and Response and Cash-based Interventions* (November 2018), https://www.womensrefugeecommission.org/wp-content/uploads/2020/04/genderandctpwrc.pdf.

6 Effect size refers to the measure of the magnitude of the experimental effect.

III. CONTEXT: NORTHWEST SYRIA

Syria continues to be affected by the ongoing conflict that began over a decade ago. In NWS, humanitarian actors, including CARE Turkey and other GBV actors participating in the GBV Sub-Cluster, are operating in areas that are out of the government of Syria's control under UN Security Council Resolution 2585.[7] The lack of fully functioning local authorities means that GBV service providers cannot refer GBV survivors to local public care and support services due to the unavailability of quality services in these areas. Women and girls also contend with harmful social norms that normalize violence against women and girls and stigmatize survivors of GBV.

Idlib and Aleppo Governorates: Sub-District Level



NWS has the highest population of IDPs in Syria, hosting 2.8 million of 6.9 million total Syrian IDPs as of 2022.[8] In November 2021, there were significant movements of IDPs within Syria, amounting to 22,300 IDPs on the move, mostly concentrated in NWS; 88 percent occurred within and between Aleppo and Idleb governorates. Sub-districts in Idleb received the largest number of displaced people to date in November 2021, with around 2,000 IDP movements.[9] Many IDPs, particularly women and children, have been displaced multiple times.

Violence against women and girls in NWS predates the conflict and is rooted in harmful gender norms. GBV has been exacerbated by the conflict, COVID-19, drought, and acute poverty, as well as ongoing, and in some cases repeated, displacement. In UNFPA's *Voices from Syria 2022* report,[10] women and girls across all governates in Syria reported being subjected to physical violence, psychological and emotional violence, sexual violence, social violence (stigma and discrimination), forced and early marriage, systemic denial of economic resources and education, movement restrictions, and exploitation at work. This reality is paralleled by increased exposure to GBV risks linked to the COVID-19 pandemic, economic deterioration, and dwindling humanitarian resources.

7 http://unscr.com/en/resolutions/2165.

8 Cross-border operation for Northwest Syria 2022. UNHCR. April 2022, https://reporting.unhcr.org/document/2330

9 OCHA, Syrian Arab Republic IDP Movements (fact sheet, November 2021), https://reliefweb.int/sites/reliefweb.int/files/resources/idp-movements_202111_nov_fv_en.pdf.

10 UNFPA and Whole of Syria GBV AoR, *Voices from Syria 2022* (2022), www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/voices_from_syria_2022_online_version_final_draft.pdf?msclkid=d98553bbcfda11ec81a589bbfef10af4.

IV. PROGRAM DESCRIPTION AND EVALUATION

PROGRAM DESCRIPTION

This study is based on the program model implemented by CARE Turkey and its implementing partners, which was a cash- and in-kind assistance-integrated GBV CM program. The program model was informed by guidance in the GBV Compendium[11] and the WRC "Resources for Mainstreaming GBV Considerations in CVA and Utilizing CVA in GBV Prevention and Response" Toolkit.[12] It was contextualized to the implementation sites in NWS.

CARE Turkey had ongoing GBV response programming in the target communities of Jarablus and Salqin, which included GBV CM and GBV case workers who were already trained on GBV CM standard operating procedures (SOPs) by the GBV Sub-Cluster. Prior to the start of the program and the evaluation, four female case workers were trained on the "Standard Operating Procedures for Integrating Cash and Voucher Assistance in Gender-Based Violence Case Management for NWS" developed by CARE Turkey. Both the SOPs and the intervention were informed by a GBV risk assessment that CARE Turkey conducted during the design phase using the GBV Risk Matrix.

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Counseling and psychosocial support sessions for women and survivors of gender-based violence at a CARE-supported SRD center in Northwest Syria.

Given that all survivors targeted through this program were female, all case workers deployed to implement the program were women. Survivors voluntarily disclosed incidents of GBV to case workers at Women and Girls Safe Spaces (WGSSs). To ensure the safest program for survivors and in accordance with the SOPs, IRD, and later SRD, case workers assessed whether cash was appropriate for the case and, if so, case workers received cash and distributed it directly to survivors as cash in hand.

Each GBV survivor's case was individually assessed for cash referral. Survivors enrolled in GBV case management who were eligible for CVA received up to a maximum of US$500. However, there was no pre-defined total cash transfer value;[13] the transfer value was based on survivor's needs and the cash safety plan conducted with their case worker. The majority of survivors who received cash assistance received $150. The case worker worked with survivors to coordinate a suitable time to meet with the survivor in a consultation room at the WGSS to deliver the cash. When the WGSS was not feasible, an alternative location was arranged by the case worker in coordination with the survivor.

11 CARE International, *Cash & Voucher Assistance and Gender Based Violence Compendium: Practical Guidance for Humanitarian Practitioners* (2019), https://gbvguidelines.org/wp/wp-content/uploads/2019/07/CVA_GBV-guidelines_compendium.FINAL_.pdf.

12 Women's Refugee Commission, *Resources for Mainstreaming Gender-Based Violence (GBV) Considerations in Cash and Voucher Assistance (CVA) and Utilizing CVA in GBV Prevention and Response* (2018, rev. 2022), www.womensrefugeecommission.org/research-resources/mainstreaming-gender-based-violence-considerations-cash-voucher-assistance/.

13 The breakdown of transfer values received was as follows: 92 survivors received $150; 7 survivors received $300; 5 survivors received $385; 4 survivors received $140; 2 survivors received $120; 2 survivors received $350; 1 survivor received $100; 1 survivor received $125; 1 survivor received $135; 1 survivor received $265; 1 survivor received $290; and 1 survivor received $500.

In-kind support was provided in cases where the survivor preferred not to receive cash assistance. Case workers facilitated in-kind coverage of the costs of rent, temporary shelter, transportation, food, clothing, etc. The case workers provided survivors with referrals, after obtaining their consent, to external complementary services, based on service mapping of each site; these included other protection services such as awareness raising, structured life skills training, and recreational activities, as well as health services, mental health and psychosocial support services, legal assistance, and livelihoods programming. Case management follow-up included monitoring of assistance received by the survivor to ensure the survivor was not exposed to further harm.

It is important to have a clear distinction of roles and responsibilities of CVA and GBV specialists and, in many cases, it may not be appropriate for GBV case workers to handle cash transfers. In this context it was a deliberate choice for CVA to be delivered by the case workers rather than CVA actors. In NWS, the delivery mechanism that is most feasible, in addition to cash in hand, is through Money Transfer Agents (MTA). However, MTAs were not considered safe for survivors following a GBV risk assessment of CVA, due to risks of confidentiality and access to documentation being a barrier for many survivors. In contrast, cash in hand proved to be safe for both survivors and for case workers.

PROGRAM EVALUATION

Methodology

The objective of the research was to generate evidence on the use of CVA within GBV response programming in humanitarian settings. To that end, the research aimed to address the following research questions:

1. How might a cash assistance and in-kind GBV (C-IN-GBV) CM package affect protection outcomes, service access outcomes, and experiences of safety and well-being for displaced GBV survivors, and how might outcomes compare to GBV survivors in GBV cash management without a cash component?

2. How do displaced GBV survivors, C-IN-GBV CM program staff, and local partner organizations perceive, experience, and assess the design features of the cash or in-kind assistance component?

3. What are the implementation facilitators, barriers, and recommendations for improving the C-IN-GBV CM program?

Study Design

To evaluate the program and its implementation, the evaluation used mixed-methods research design, employing quantitative baseline and endline surveys, and qualitative in-depth interviews with both program participants and key informants. Quantitative surveys were conducted with all participants at baseline. The target sample was 120 C-IN-GBV CM program participants. Inclusion criteria were as follows:

- Adolescent girls aged 15–19 years or adult women aged 20–50 years

- Survivors of GBV or individuals at risk of exposure to GBV

- Individuals located in Salqin or Jarablus

The evaluation used three data collection tools: a baseline/endline questionnaire; an in-depth interview guide; and a key informant interview guide (for more information on the data collection tools, see Annex 1). In all cases, the WRC research team led development of research tools and provided off-site training and remote technical support to the local study team throughout the study.

The evaluation was set to end after three months, with endline qualitative interviews and quantitative surveys collected at that time. Due to challenges in working with the initial local partner, IRD, only 15 participants completed the quantitative survey at three months and data collection only resumed nine months after the start of the program. The research staff redesigned the evaluation to examine long-term impacts and compared participant outcomes at zero, three, and nine months from the start of the program. Due to the low number of participants who remained in the study at the nine-month follow-up, quantitative surveys and in-depth interviews were conducted with all remaining participants. Interviews were also conducted with 11 key informants at the end of the evaluation (for more information on the analysis and the Theory of Change, see Annex 1).

Challenges

The original evaluation was designed to be quasi-experimental, with 100 participants to be evaluated in the C-IN-GBV CM program and 100 participants in a GBV CM program (with no cash component) as a control. Due to challenges in recruiting and managing this volume of participants, the target sample was changed to 120 in the C-IN-GBV CM program and 30 in GBV CM. At baseline, 129 participants were evaluated, including 112 in the cash group and 17 in the control group. However, in October 2021, for reasons not directly related to the implementation of this program, the collaboration with IRD ended and CM ceased in over half the cases in the program. CARE Turkey identified SRD as a new GBV CM delivery partner to accept the remainder of the target cases and conclude the program evaluation. Only 22 cases were transferred, adhering to consent received in January 2022, all of whom were in the cash group. Shortly thereafter, the remaining participants were evaluated as part of the program, almost nine months from the start of the program. During the collaboration with IRD, the case workers were able to collect 16 endline surveys. With quantitative data at baseline, three months, and nine months, the evaluation of the program pivoted to examine longer-term impacts of the C-IN-GBV CM program, quantitatively comparing outcomes at three and nine months.

Adolescent girls' disclosure and access to GBV response services generally and CVA-integrated GBV response services was a challenge. Caregivers of adolescents did not allow them to go to the WGSSs where they could interact with case workers. This limited the program's ability to recruit adolescents into the program.

Limitations

This program evaluation experienced several limitations. The sample had a high level of attrition, which can be attributed to a few factors. Conducting this type of program evaluation in the NWS context can be difficult, especially in terms of reaching participants, as many are still on the move, have limited time and resources to participate in some programs, and may refuse to participate out of fear of being stigmatized by the family and/or the community. Moreover, depending on the political climate and migratory opportunities, large-scale movements in and out of NWS can occur over the course of a few months, which impedes follow-up in a program evaluation. In November 2021, tens of thousands of IDPs moved out of the Idleb governate into Aleppo. It is possible that program participants moved out of Idleb at that time, thereby becoming unreachable at follow-up and contributing to the sample's attrition. The cessation of IRD's services during the evaluation period may have also contributed to the sample attrition, as participants may not have wanted to continue in the program or evaluation due to the lack of support. Lastly, follow-up at nine months occurred during an increase in COVID-19 cases in February and March 2022. To protect both participants and program staff, interviews were conducted via telephone instead of in person, which deterred participation for some survivors during the endline evaluation due to the lack of privacy.

As a result of the attrition, the original evaluation methodology could not be implemented. Therefore, it is not possible to compare the changes in the outcomes between the intervention and comparison groups, removing the ability of the analysis to infer the program's impact. Furthermore, the empirical strength of the quantitative analysis is reduced due to the lack of statistical significance for many of the findings. This is attributed to the small sample size and reduced power in the data. Lastly, the generalizability of these findings is limited, due not only to the small sample size, but the specificity of the NWS context. Nonetheless, trends in the data have been interpreted to contextualize all findings reported, which can be helpful for the design of future research.

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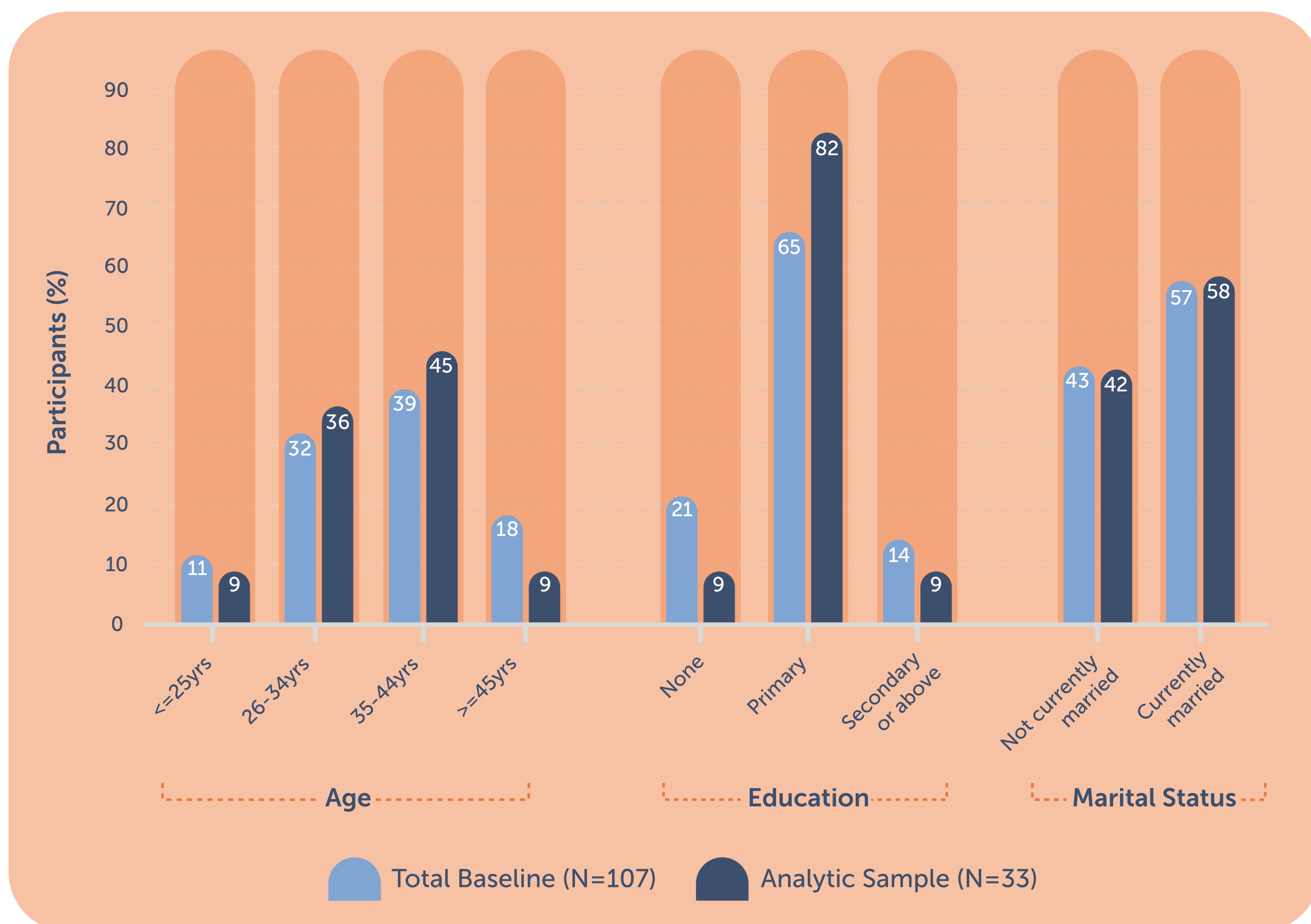
V. MIXED-METHODS FINDINGS: TRENDS OVER TIME FOR CASH PARTICIPANTS

DESCRIPTION OF THE SAMPLE: 0, 3, AND 9 MONTHS

At the start of the program, 107 participants were enrolled and evaluated in C-IN-GBV CM, nearly all of whom were cis-gendered heterosexual women 20 years and older – only 2 participants were adolescents, 16 and 18 years old. While adolescent girls were included in the program eligibility criteria and study design, no girls enrolled and were evaluated at follow-up. Adolescent girls' disclosure and access to GBV response services generally and CVA-integrated GBV response services is a challenge if their parents do not allow them to come to the WGSSs where they can interact with case workers.

At baseline, participants were mostly (39%) aged 35–44 years. Two thirds (65%) had received some primary school education and 57 percent were currently married. Over the course of the program, it was feasible to follow up with 33 participants: 15 at three months, and 21 at nine months (with three participants evaluated at both time points). Among the 33 participants who were followed up, the demographics were similar to the original baseline group; half (45%) were 35–44 years old, 82 percent had received some primary school education, and 54 percent were currently married. These 33 participants comprise the analytic sample in the study.

Figure 1. Description of Sample, Total Baseline and Analytic Sample



TRENDS OVER TIME: FINDINGS FROM THE QUALITATIVE AND QUANTITATIVE DATA

This evaluation leveraged findings from 20 qualitative interviews and 33 quantitative surveys to evaluate a variety of program outcomes. The qualitative data was used to determine perceptions of the cash and in-kind assistance integration. Both qualitative and quantitative data were used to examine changes among the participants in the cash group, across four outcome categories: GBV; economic capacity and professional life; personal well-being; and family and community affairs. Finally, the quantitative data was used to assess differences in these outcomes at three and nine months after the beginning of the program.

Overall, the qualitative findings serve as the primary analysis, and the frequency of these findings is described by the number of participants who reported these outcomes in parentheses (N). The qualitative findings are contextualized by the quantitative analyses of related outcomes among the 33 participants who were surveyed at three- or nine-months follow-up.

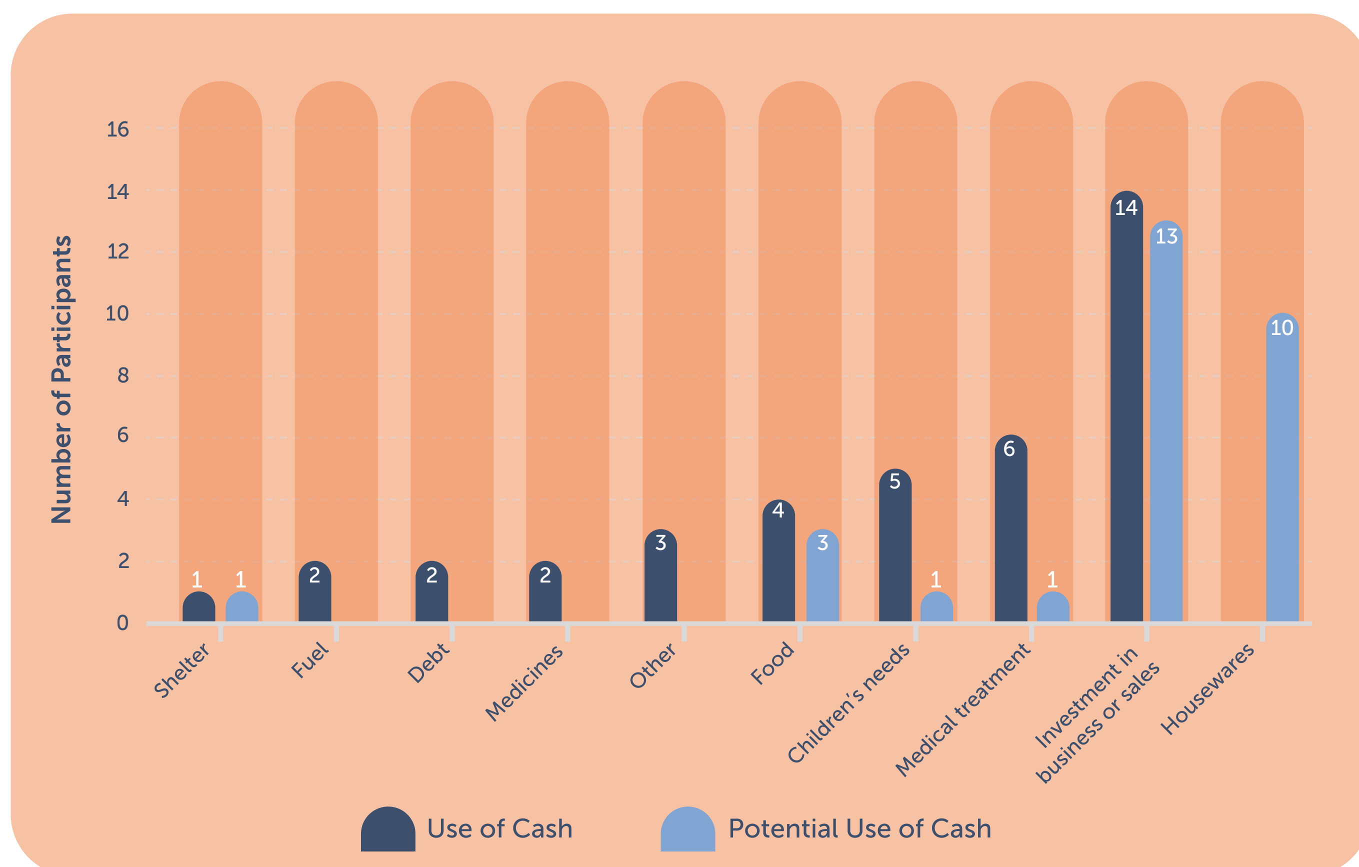
CASH OR IN-KIND ASSISTANCE

In the qualitative interviews (20), all participants reported that the cash or assistance in-kind was safe and easy to access. Only four participants opted to receive the assistance in-kind, which they all used as an investment, purchasing supplies or tools for an enterprise.

Nearly all (15) were able to make the decisions about how to use it on their own. If participants included others in their decision-making process, it was their children, parents, or siblings (5). One participant mentioned that her partner, who was emotionally abusive prior to the program, helped her make the decision to pay off their debts with the cash assistance, but she still felt that the cash assistance posed no risk to her. Shared decision-making was reported more among those who received cash (4); only one participant who used the in-kind assistance shared the decision-making (with her sister). Nearly all participants (18) stated that the assistance, whether cash or in-kind, or the income generated from the assistance, was insufficient to cover their basic needs and that they would have liked to receive more assistance.

The most common cash expenditure was investing in a microenterprise, which entailed purchasing sewing machines, textiles, hairdressing tools, and food or cosmetic items to sell (14). This was followed by expenditure on medical treatment (6), often for children, providing for children's other needs, such as purchasing clothes or paying for schooling (6), paying off debt (3), food (4), fuel (2), medicines (2), other items, such as clothes or a cell phone (2), and repairing shelter tents (1). When asked about what other expenditures they hoped to make, most participants prioritized supplies to help their enterprises grow (13) or larger housewares (10), such as refrigerators, mattresses, and washing machines. Others mentioned food (3), medical treatment (1), children's clothes (1), and walls to reinforce shelters against winter weather (1).

Figure 2. Assistance Expenditure and Potential Expenditure, NW Syria, N=20



CHANGES IN GBV

In the qualitative interviews, most participants (12) reported feeling safer after participating in the program. For the others (8), half felt their exposure to or risk of GBV changed somewhat, but that they were still vulnerable (4), and the rest felt that their safety and sense of security had not changed (3). However, these participants felt optimistic that their situations of violence could change in the future.

When reflecting on violence they experienced, just under half of the participants (9) felt that their situation of violence decreased, or that they were at less risk due to receiving the cash assistance as they no longer needed to ask husbands, family members, or others for money, which reduced conflict or exposure to situations that led to them being vulnerable and abused. One participant was able to purchase a cell phone which, she stated, helped decrease the likelihood of her being abused and harassed.

"It [the cash] was successful because it made me relieved. I became independent from people who abused me. I started earning my living on my own."
– IDP woman, Jarablus.

"Now it is a sum of money that has solved a current problem. It is not sustainable. The cash assistance was excellent. It supported a little, but it is not a sustainable solution. Violence may occur again, but not to the same degree, because I have been mentally supported and become stronger."
– IDP woman, Jarablus.

For others, the increase in safety was attributed to their improved confidence and mental fortitude; they felt that they could stand up for themselves and stop their abusers from inflicting any more violence against them. Some participants reported learning from the program how to navigate their relationships with their partners, resulting in less abuse and less quarreling. This was the same for parents, siblings, and extended family, as well, where participants were able to stop their patriarchal abuse.

"I was having a hard time with my husband and his family; they were beating me, insulting me, and I cannot leave my children. The IRD care worker talked to me and relieved me. She taught me how to deal with my husband, and she brought my attention to many things in life."
– IDP woman, Jarablus.

"I definitely changed for the better. I was afraid to face the music and speak up. Now, no, I am not [afraid]. I may be withdrawn, but just to take care of myself. They gave me many things so that I could come back stronger and know how to get back on my own feet."
– IDP woman, Jarablus.

In the quantitative data, there was also a trend toward reductions of GBV in the past three months, particularly of domestic (or family) violence, with a reduction from 84 percent to 64 percent. In addition, for participants who were married, physical violence decreased from 67 percent to 50 percent, economic violence decreased from 39 percent to 27 percent, and quarreling decreased from 94 percent to 69 percent. However, these changes were not statistically significant (p-value > 0.05) (see Figure 3).

CHANGES IN ECONOMIC CAPACITY AND PROFESSIONAL LIFE

Seventy-five percent (15) of participants invested the cash in a new or existing microenterprise. In the qualitative interviews, these participants mentioned demonstrably higher instances of self-reported self-reliance and empowerment than the rest of participants who were unable to do the same. Of the participants who were able to invest their assistance, 10 found that the income generated was not sustainable; they often ran out of supplies and could not generate enough income to purchase more. These women felt empowered in helping their families, being self-sufficient, and having a purpose in their community, but when businesses failed, they felt frustrated. Among these participants, nearly all wanted to find more or different supplies, invest more time in skill building, or receive more livelihood resources with which to create an economic opportunity for themselves. Sustainable income was framed by survivors as a key step on their road to recovery. For the five participants who continued to generate an income, they covered basic needs for their families to some degree and had an even stronger sense of self-reliance in comparison to their entrepreneurial counterparts whose enterprises did not survive.

"The best thing was, I got a sewing machine and it granted me an income...with God's grace.... It was positive on a personal level; I became stronger and independent."
– IDP woman, Salqin.

"The project did not succeed because our neighborhood is poor, and we are not well known here. No one will buy....I wanted to buy more products for my project, but the money wasn't enough, so I bought a small number of products. That's why the project did not succeed."
– IDP woman, Salqin.

Those who did not invest in any income-generating activity (5) spent their assistance on emergency purchases, particularly medical treatments (3), or pressing concerns, such as paying off debt (1) or purchasing fuel for the winter (1). For these participants, these expenditures addressed considerable physical health needs or, in the case of the participant who paid off her debt, decreased vulnerability to exploitation.

These changes in economic capacity were also demonstrated in the quantitative findings; for economic outcomes, there was a consistent pattern of improvement among the participants. Specifically, a higher proportion of participants reported, at either three months or nine months, earning money in the past month (baseline 18% to follow-up 45%), having savings (baseline 9% to follow-up 52%), and using fewer coping strategies (mean score baseline 27.9 to follow-up 18.2). These differences were statistically significant (see Figure 3).

Regarding household decision-making, there was only a statistically significant increase in the proportion of participants who reported total or equitable control over buying or selling expensive household products (baseline 24% to follow-up 64%). More participants also reported total or equitable control over decisions about children's education, children's marriage, medical treatments, and spending on menstrual products, although none of these were statistically significant (See Table 1).

Table 1. Changes in Household Decision-Making at 3 or 9 months, N = 33

Measure	Baseline (0 months)		Follow up (3 or 9 months)		
Household Decison-making (%)	N	%	N	%	p-value
Children's education	18	55	20	61	0.618
Marriage decisions for children	9	27	16	48	0.076
Buying or selling expensive household products	**8**	**24**	**21**	**64**	**0.001**
Medical treatment for health problems	29	88	32	97	0.163
Spending on menstrual products	28	85	30	91	0.451

Notes: Percentages are the number of participants who reported that they made decisions alone or equally with their spouse on the reported categories. **Bold** values indicate statistical significance.

CHANGES IN PERSONAL WELL-BEING

All participants stated in their qualitative interviews that their mental and psychological health improved because of the program—they were more resilient, confident, and hopeful, all of which was attributed to the combination of CM and cash assistance.

"I realized that life would not stop for me and that it would go on no matter the difficulties. Therefore, I had to keep up with it and fight to get my dream."
– IDP woman, Jarablus.

"I felt so relieved psychologically, that I started to speak confidently. It's a beautiful feeling to be able to prove yourself in life."
– IDP woman, Salqin.

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Within one of the training sessions of aerobic exercise sessions for adolescent girls within the Life Empowerment Program at one of the SRD centers supported by CARE in Northwest Syria.

"It gave me hope that goodness still exists in this world, and that they can do good. If you speak up, there are people who understand how you feel."
– IDP woman, Jarablus.

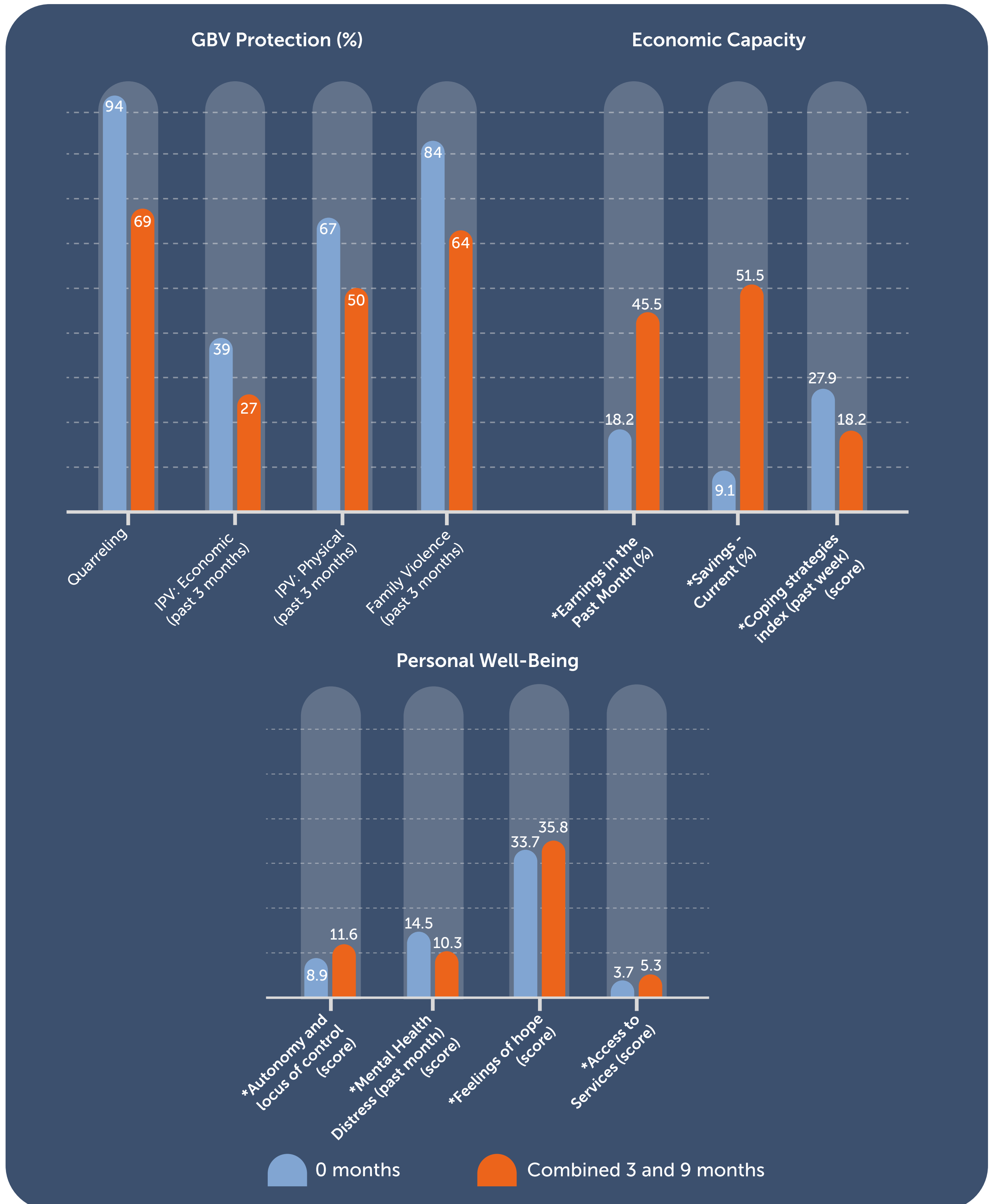
These findings were substantiated with the quantitative data, where there was a consistent improvement in a range of measures related to well-being and mental health. There were statistically significant increases (p-value<0.05) in the Adult Hope Scale[14] score (33.7 to 35.8) and the autonomy score (8.9 to 11.6), indicating better outlooks on the future, and a stronger sense of control. There was also a statistically significant decrease in mental health score (14.5 to 10.3), meaning that participants reported less mental health distress over the course of the program (see Figure 3).

Some participants (5) also saw improvements in their physical health, having used the cash transfer to pay for medical treatments and medicines, as well as supplies to stay warm during the winter months, such as blankets, gas for heating, and shelter repairs. This was reflected in the quantitative findings, as well, regarding access to services. The average number of services accessed increased over time (3.7 to 5.3), meaning that participants had access on average to two additional services at follow-up (see Figure 3). These increases predominantly happened with access to a pharmacy, sexual and reproductive health (SRH) services, counseling/psychological services, legal services, housing support/services, and livelihoods/employment services.

Despite the generally positive responses, some participants (7) continued to express feelings of distress in the qualitative interviews because of current health conditions in their family, ongoing risks of violence, social anxiety, continued mental health distress, and feeling unsupported without the continuation of CM services.

14 C. R. Snyder et al. (1991), "The will and the ways: development and validation of an individual-differences measure of hope," *Journal of personality and social psychology*, 60(4), 570–585, https://doi.org/10.1037//0022-3514.60.4.570.

Figure 3. Trends over time, GBV Protection, Economic Capacity, and Personal Well-Being Outcomes at Baseline and Endline (3 or 9 months), N = 33



Notes: * indicates statistically significant differences (p-value<0.05). GBV protection outcomes were assessed for participants who reported having partners at baseline, N=18 at baseline and N=16 at follow-up. Definitions of measures and methodology for calculations can be found in Annex 1. Mean scores are reported, Ns, standard deviations, and p-values can be found in Annex 2.

CHANGES IN FAMILY AND COMMUNITY AFFAIRS

During the program, many participants were able to improve their children's lives both materially and socially, as reported in the qualitative interviews. Some participants chose to use cash assistance to fulfill their children's basic needs, such as medical treatments (5), medicines (2), and schooling (1). After participating in GBV CM, participants found that they were able to improve their relationships with their children, communicating with them more and able to interact more positively. The cash assistance allowed two participants to address their children's needs despite the lack of support from their partners. For example, one participant was able to use the cash assistance to get her daughter tested for AIDS, even after her spouse objected.

"My family was positive toward me in all aspects, and the community in general, and my husband's family in particular, have changed their opinion about me, from a consumer woman to a productive one."
– IDP woman, Salqin.

Some participants felt that the program allowed them to improve their relationship to the rest of the community. There were several ways they described this, including becoming more sociable and trusting of community members, improving their perceived social standing as an independent and self-sufficient woman, or feeling empowered to help others in their community. For a few participants (3), their relationship to their community became slightly contentious—neighbors or others in their community were envious that the participant received the assistance, and they did not.

"It [the program] was so positive. I started helping people around me, for example, in the camp. I provide them with awareness. Therefore, I participated in a seminar in partnership with a medical staff. I gathered people and asked the specialists to raise awareness about Coronavirus."
– IDP woman, Jarablus.

DIFFERENCES AT 3 AND 9 MONTHS: A SECONDARY QUANTITATIVE ANALYSIS

When separating out the three- and nine-month follow-up results in the quantitative analysis, there were differential changes in the evaluated outcomes. Some economic capacity measures stayed consistent; similar proportions of individuals reported earning money in the past month, and currently had savings. However, the mean score for coping strategies was much higher at nine months than at three months (23.5 compared to 8.5).

With regard to personal well-being, mental health scores were higher at nine months compared to at three months (12.4 vs. 6.2), while autonomy and Adult Hope Scale scores were lower (12.3 to 10.8; 37.9 to 34.6, respectively) meaning that perceptions of autonomy, hope and mental health distress were better for those at the earlier follow-up time.

Access to services remained consistent (5 to 5.4), including in the following subcategories: access to a pharmacy, SRH services, legal services, counseling/psychological services, and housing support/services.

Despite some changes over time, these reported outcomes at nine months were still improved in comparison to baseline (not statistically tested, see Table 2).

Notes: These changes at 3 and 9 months were not statistically tested due to the small sample sizes. The impact change describes the change from 3 to 9 months after the start of the program, all outcome reported here were considered to be improved from baseline. For values at baseline, see Figure 3.

Table 2. Differences in GBV Protection, Economic Capacity, and Personal Well-being Outcomes at 3- and 9-Months Follow-Up, N = 33

Measure	At 3 months		At 9 months		Impact Change
	N/ mean	%/sd	N/ mean	%/sd	Impact Change
Economic Capacity					
Earnings in the past month (%)	7	47	10	48	↑
Savings (current) (%)	6	40	11	52	↑
Coping strategies index (past week) (score)	8.5	5.5	23.5	10.2	↓
Personal Well-being					
Autonomy and locus of control (score)	12.3	4.1	10.8	4.0	↓
SRQ20 (past month) (score)	6.4	5.0	12.4	4.67	↓
Hope scale (future scale) (score)	37.9	4.9	34.6	3.5	↓
Access to Services (score)	5	1.89	5.4	1.07	↑
Accessed a pharmacy (%)	15	100	20	95	↑
Accessed sexual and reproductive health services (%)	10	67	17	81	↑
Accessed legal services (%)	4	27	0	0	↓
Accessed counseling/ psychological services (%)	15	100	20	95	↑
Accessed housing support/services (%)	2	13	17	85	↑
Accessed livelihoods/ employment services (%)	3	20	14	70	↑

VI. DISCUSSION

Cash and in-kind assistance as part of GBV CM aims to help survivors recover from situations of violence. This mixed-methods program evaluation found that cash or in-kind assistance to support integrated GBV CM is a promising avenue to reduce GBV for IDPs in NWS. Across both qualitative and quantitative data, there was evidence that the combination of cash and GBV CM had improved women's lives in ways that directly and indirectly had the potential to reduce their experiences of violence. Although the quantitative findings were not statistically significant, **there were reductions in economic, physical, and domestic violence** for the sample, and the qualitative data substantiated these improvements. Many participants reported feeling safer and experiencing less violence, which they were able to achieve by using multiple pathways provided by the cash or in-kind assistance or the CM services to reduce their exposure to or risk of violence. However, there are insufficient livelihoods opportunities and MPCA providers, and those who are present lack a gender-transformative let alone gender-responsive approach. Many of the opportunities that exist are targeted toward heads of households, which means that programming is often designed to meet the needs of male heads of households. Much of MPCA is targeted to female heads of households, who do not have access to economic recovery opportunities as a bridge from meeting basic needs via MPCA to being self-reliant.

More often than not, GBV survivors are not explicitly included in the eligibility criteria for MPCA and livelihoods programming. In addition, many survivors lack documentation to access MPCA and livelihoods programming. Further, these programs would need to be integrated with GBV programming to meet the specific livelihood and cash requirements of GBV survivors. They would also have to ensure that referral pathways exist and can be activated, and that livelihood and cash interventions do not bring about unintended negative consequences for the safety of survivors, and that confidentiality, together with the other pillars of a survivor-centered approach, are achieved.

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An awareness session was conducted by the mobile team, in Northwest Syria. During the session, the service provider communicates awareness messages about gender-based violence and child labor.

GBV service providers have often been using cash for protection as a stopgap and to bypass the shortcomings of livelihoods and cash programming for GBV survivors. Without basic needs and livelihood gaps being addressed, GBV survivors will often not prioritize using cash transfers to access protection-related goods and services, but rather use them to cover basic needs and/or to invest in an income-generating opportunity. This situation leads to GBV survivors in essence triaging and then forfeiting their recovery from the incidents of violence that they have endured. The lack of integration and coordination between cash for protection, MPCA, and livelihoods may slow or prevent GBV survivors from leaving abusive situations within their households.

Although it could not address all their problems, **the cash or in-kind assistance was beneficial in reducing participants' exposure to GBV and vulnerable situations and improving their economic capacity during the program.** The majority of participants used the cash to invest in an income-generating activity, which allowed them access to more economic resources.

The quantitative findings showed significant increases in the number of cash participants who earned money in the past 30 days and had savings. Most notably, the **types and frequency of negative coping strategies decreased.** Participants linked their newfound financial self-reliance to a reduction in violence as they removed themselves from positions of vulnerability or exploitation from their abusers. Even participants who had to spend their assistance on emergency purchases felt safer; being able to purchase goods and services discreetly without relying on someone else or the approval of their spouses or families reduced potential conflict and resulting abuse.

However, for many, their enterprise was short-lived as they either ran out of supplies and capital or faced limited demand for their chosen business by nine months after the start of the program. Only **25 percent of participants who invested in a microenterprise became successful enough to cover their family's basic needs to some degree.** For program models that include development of sustainable livelihoods as part of their theory of change, this finding demonstrates the importance of including economic-strengthening components in the program package or having functional referrals to active effective livelihoods programming.

Psychological support and CM sessions were also associated with a **reduction in GBV, as many participants attributed their increased safety to their ability to manage conflict between their abusers, partners, or families and themselves.** Mental health distress decreased, evidenced by both the reduction in scores on the mental health questionnaire and in the qualitative interviews, where all participants discussed how **the program helped them process their trauma, cope with their families, and build resilience and self-esteem. Participants' sense of autonomy and control also improved** over the course of the program; several participants felt independent and self-sufficient with their enterprise, however short-lived. Improved self-esteem also contributed to participants' sense of protection, as they felt they were more able to advocate for and defend themselves in the face of abuse.

The combination of these services improved resilience to future instances of violence by developing participants' sense of self-reliance and self-esteem. Their outlook on life and the future also improved, as they felt more psychologically and economically equipped to tackle their problems. This was evident even for women who were still experiencing some mental health distress—they remained optimistic that things could get better.

The combination of CM services and cash assistance also improved the relationships between participants and their children, as participants were able to provide for their children financially, medically, and emotionally. This was also evident in the quantitative findings, as **more participants reported greater decision-making control over children's education, marriages, and medical treatments at the end of the program compared to the beginning of the program.** With increased decision-making power and greater self-reported self-reliance, some participants were able to improve their children's lives without having to engage their partner in the decisions, also reducing potential violence. As many mothers previously endured violence for the betterment of their children, improving their capacity to take care of them without their partner improved protection outcomes, enabling them to remove themselves from positions of vulnerability and/or exploitation. Conversely, mothers' tendency to dedicate new resources to children may decrease the possibility of participants to use more direct pathways of reducing GBV, such as relocating from a partner. In the qualitative findings, 20 percent of participants were able to address emergency issues regarding their children's health; some were able to keep their children from working and send them back to school. **With increased economic capacity, participants prioritized protecting their children from illness and exploitation, showing that the impacts of this program extend well beyond the participant alone.**

In addition, **participants were able to improve their social networks,** with increased time spent with other survivors, improved relationships with family, and better social standing in the community. Although some faced negative backlash and experienced jealousy for receiving cash assistance while others in their community did not, the program inspired many women to help other survivors by recommending the program, engaging with the community as enterprise owners, or empowering others through COVID-19 awareness campaigns.

Although the original design of the evaluation was not adhered to, the delay in follow-up with participants presented a unique opportunity to examine the program impacts for a longer period. Although the sample size was small, some changes were found to be sustained over time. This included employment, savings, and access to services, which remained relatively consistent at three and nine months.

For a number of other indicators, there appeared to be a reduction in improvements at the end of the evaluation. Survivors reported greater reliance on coping strategies at nine months than at three months, although participants at both time points still improved from baseline. This may signal a return to coping behaviors, such as borrowing money, which may increase participants' vulnerability to violence. As the cash assistance and the resulting increase in economic capacity were linked to reduced GBV exposure, if a participant's ability to maintain self-reliance and independence continues to dwindle, so may their protection from GBV. In addition, mental health, autonomy, and hope scores at nine months showed some reductions compared to those reported at three months; again, these scores at both time points were improved in comparison to baseline. This regression of impacts could be attributed to case closure, a reduction in resources, such as cash transfers, or increased financial and mental stress due to other contextual factors, such as the increase in COVID-19 cases in January 2022 or poor winter weather. However, deteriorating mental and psychological health may also reverse protection impacts if participants no longer have the mental fortitude to safely manage their relationships and reduce potential conflicts. These findings show that the impact of the program is most salient shortly after completion, and that some outcomes are harder to maintain, which may warrant consideration for extending program duration and increasing assistance, as many participants and key informants recommended in their interviews.

VII. PROGRAMMATIC AND OPERATIONAL LESSONS LEARNED AND RECOMMENDATIONS

Findings from Participants

Participants experienced several facilitators and barriers to their participation in the program. Time, transportation, distance of the WGSSs, spousal or familial permission, and community perceptions were all reported as barriers to participation. As for facilitators, the most common service mentioned was the private, confidential "Rest Assured" room for CM services, which ensured the confidentiality of the participants in the program. Nearly all participants recommended that more cash assistance should be provided to fulfill their access to needed protection services, meet their basic needs, and enable them to establish a sustainable income. Many participants also felt that more psychological support should be provided, either more frequently or for a longer period, and that these services should be expanded to reach more women.

Half of the participants stated that they attended courses at WGSSs on sewing, hairdressing, computer, or literacy skills, which often inspired their choices on what microenterprise to invest in.

All participants highly regarded the care and services they received from the case workers during the program. For some, the closure of their case brought about mixed feelings; they were both sad that their support had come to an end and assured that they were able to move forward on their own or that they knew who to reach out to if something else were to happen. Others felt that they still needed the support of CM and felt particularly distressed about the discontinued services. Overall, participants felt that the program helped them overcome some aspect of their trauma and were extremely grateful for the services.

Findings from Key Informants

As part of the qualitative methods, 11 key informant interviews (KIIs) were conducted with four caseworkers from implementing partners, four cash and GBV experts working in NWS, and three project staff members from CARE Turkey.

Many key informants discussed drivers of GBV in NWS. For example, women, when searching for economic opportunities, may become vulnerable to exploitation from credit sharks and landlords. Similarly, women who

rely on family members or spouses for financial support may also be at risk of GBV due to gender norms and the reduced economic capacity of male family members to support their families, which may lead to violent outbursts when women request certain items or services. This phenomenon was well documented in the participant interviews, where many women mentioned how the **cash assistance prevented violence from occurring by allowing participants to become independent from their abusers, thereby reducing their vulnerability.**

The aim of cash assistance within this program model was to achieve protection objectives. Nearly all key informants mentioned that the value transferred to program participants should be increased to better address all their needs, including basic needs and livelihoods goals. Survivors did not distinguish between their different sectoral needs—in other words, livelihoods, shelter, protection—in this recommendation, yet it points toward critical service gaps to ensure that survivors are able to access comprehensive support to meet their global needs to fully recover from GBV and to mitigate their future exposure to GBV risks.

Caseworkers highlighted specifically that the time between requesting and delivering cash or assistance to participants should be reduced. In this program, it took around 25–30 days to complete a cash assessment and delivery, at which point many participants were struggling financially and may have had better economic outcomes if the cash had been delivered sooner.

These programmatic and operational lessons learned, and recommendations draw from the evaluation findings and After-Action Review (AAR) workshops and interviews. See Annex 1 for a description of the AAR methodology.

#	Lesson	Recommendation
1	**Cash transfer currency and value –** Transfer value in some cases was insufficient to address survivors' protection needs; transfers delivered in US$ in some cases were well received while in others created a barrier for survivors who needed to travel extra distances to exchange currency.	• Consider distributing cash in the local currency so that survivors do not face risks of sexual exploitation and abuse related to traveling long distances to change money and access information about the current exchange rate. • Increase the transfer value range for diverse survivors and their protection needs in accordance with market assessments of protection-related goods and services and associated costs; ensure harmonization of cash for protection transfer value with minimum expenditure basket (MEB) and ensure referrals across sectors with attention to family size of the survivor, including the number and age of children in the household. • Transfer value should account for costs of transportation to reach CM, as well as the duration of participation in GBV CM.
2	**Cash timing, duration, and frequency –** Transfer value, duration, and frequency were insufficient to cover associated costs of participation, which became barriers for participants, including the costs of transportation and childcare; timing of the transfers was not always predictable.	• Transfer value and duration should account for costs of transportation to reach case management and duration of GBV CM. • Ensure predictable timing of transfers. • Transfer value should account for costs of childcare during participants' engagement in CM activities.
3	**Flexibility of GBV service provision –** Due to gender norms and security issues, survivors were sometimes blocked from attending GBV CM.	• Consider multiple service points and flexible timing of service provision to meet the needs of in-camp and out-of-camp survivors and for adolescents to meet demand and ensure access to a private space for safe disclosure. • To address supply side barriers to childcare provision, provide childcare during participants' engagement in CM activities (meetings with case workers, attending workshops, etc.).

	Lesson	Recommendation
4	**Segregation of duties and staffing –** Separate teams promote efficiency and narrow the delivery time between the assessment of survivors' needs and executing the cash referral.	• In order to streamline and better distinguish roles and responsibilities, more female staff are needed; capacity building of potential female staff is needed to facilitate recruitment and hiring of sufficient staff members and sufficient proportion of female staff to caseload.
5	**Psychological support needs to be intensified –** Despite survivors being positive about the quality of services received, greater emphasis on psycho-logical support, including length and breadth of services, will promote further favorable outcomes.	• To deal with the complexity of individual survivors' situations, psychosocial support needs to be provided more frequently and for a longer period of time. • Expand the program model to include additional Mental Health and Psychosocial Support (MHPSS) activities, for example survivor workshops and survivor network building, to increase peer-to-peer support.
6	**Lack of engagement with family members of survivors and their communities –** This was a gap and could have been an opportunity to engage survivors' family members, including male relatives, as well as community members about gender norms and attitudes for a gender-transformative approach.	• Incorporate program components to directly and indirectly engage male family members and community members in GBV prevention and mitigation; this may include awareness campaigns and addressing women's limited mobility, which in turn limits their access to services.
7	**Despite inclusive eligibility criteria, outreach to and delivery of services for marginalized groups of GBV survivors can be improved upon.**	• Increase opportunities for community-led and specifically survivor-led design and implementation of the intervention. • Co-develop with communities the outreach strategies for systematically including excluded, marginalized groups of survivors, including adolescent girls ages 10 to 19 and those with children, people with disabilities, and men and boys. • Allocate dedicated financial and human resources to enhance inclusion, including subgrants where needed to organizations with expertise. • Create new or expand existing safe spaces to improve access among excluded, marginalized groups of survivors; consider accessing services from survivors' diverse perspectives via a user's journey analysis. • Coordinate with legal service providers and proactively provide support to survivors to address gaps in their documentation to mitigate their exposure to GBV that they may face due to lack of legal documentation. • Consider mobile adolescent-specific awareness-raising activities and CM services, as well as peer-to-peer support systems, to explain to adolescent girls the services that are available.

	Lesson	Recommendation
8	**Expanding the scope and geographic reach, as well as the demographic reach, of complementary services will support survivors' long-term recovery from GBV.**	• Advocate for, design, and implement expanded market-based livelihoods programming; ensure as a minimum a gender-responsive approach and ideally a gender-transformative approach; include access to vocational and business training to support female participants and survivors. • Advocate for, design, and implement expanded CVA to GBV survivors in addition to cash for protection, including MPCA and CVA for SRH outcomes as designed with SRH specialists. • Strengthen SOPs and referral pathways between GBV service providers and MPCA, livelihoods, and SRH programming, accompanied by mutual capacity building and improvement of existing SOPs to ensure that GBV survivors are included and can access services. • Develop protocols between GBV service providers and MPCA and livelihood service providers that include data protection and information-sharing procedures for safe and confidential targeting and registration of survivors of GBV.
9	**Coordination of research efforts is key to increasing participation in data collection efforts and to raising the effectiveness and utility of evaluation findings.**	• Wherever possible, researchers should use existing data sets and establish data-sharing agreements that adhere to data protection best practices. • Data collection tools should be brief and contextualized.
10	**Confidentiality of survivors' cash recipient status** – Despite efforts to keep the transfers confidential, some program participants shared their eligibility for cash (or lack of eligibility) with each other, which created difficulties for case workers in managing survivors' expectations.	• Emphasize the importance of confidentiality regarding cash recipient status to survivors during the CM process.

VIII. CONCLUSION

Overall, this program evaluation finds promising evidence in support CVA-integrated GBV case management for IDP women in NWS. Women and girls across NWS continue to experience GBV in the wake of the country's internal conflict and it is paramount that humanitarian actors use a variety of modalities and approaches to address the confluence of needs experienced by survivors, including cash assistance to support protection outcomes for survivors when CVA is appropriate for their case.

Integrated cash or in-kind assistance in GBV programming has the potential to not only address emergent needs for GBV survivors, but affects their lives in extended, and sometimes sustainable, ways. Moreover, this program evaluation shines a light into a black box of longer-term changes of survivors in C-IN-GBV CM programs. The findings from this program evaluation provide key insights for future research and potential programming for cash and in-kind assistance to become a powerful tool in addressing the complex recovery of internally displaced GBV survivors in Northwest Syria.

ABBREVIATIONS

AAR	After-Action Review
CM	Case management
CVA	Cash and voucher assistance
C-IN	Cash and In-kind assistance
FGD	Focus group discussion
GBV	Gender-based violence
IDI	In-depth interview
IDP	Internally displaced person
IRD	Ihsan Relief and Development
KII	Key informant interview
MEL	Monitoring, evaluation, and learning
MHPSS	Mental health and psychosocial support
MPCA	Multi-Purpose Cash Assistance
MTA	Money Transfer Agents
NWS	Northwest Syria
SAMRC	South Africa Medical Research Council
SC	Sub-Cluster
SOPs	Standard operating procedures
SRD	Syria Relief and Development
SRH	Sexual and reproductive health
WGSSs	Women's and girls' safe spaces
WRC	Women's Refugee Commission

IX. ANNEX 1: METHODOLOGY

METHODOLOGY

The objective of the research was to generate evidence on the use of CVA within GBV response programming in humanitarian settings. To that end, the research aimed to address the following research questions:

1. How might a cash- and in-kind-GBV CM package affect protection outcomes, service access outcomes, and experiences of safety and well-being for displaced GBV survivors, and how might outcomes compare to GBV survivors in GBV cash management without a cash component?

2. How do displaced GBV survivors, cash assistance and in-kind GBV (C-IN GBV) CM program staff, and local partner organizations perceive, experience, and assess the design features of the cash or in-kind assistance component?

3. What are the implementation facilitators, barriers, and recommendations for improving the C-IN-GBV CM program?

STUDY DESIGN

To evaluate the program and its implementation, the evaluation used mixed-methods research design, employing quantitative baseline and endline surveys, and qualitative in-depth interviews with both program participants and key informants. Quantitative surveys were conducted with all participants at baseline. The target sample was 120 C-IN-GBV CM program participants. Inclusion criteria were as follows:

- Adolescent girls aged 15–19 years or adult women aged 20–50 years
- Survivors of GBV or individuals at risk of exposure to GBV
- Individuals located in Salqin or Jarablus

The evaluation used three data collection tools: a baseline/endline questionnaire; an in-depth interview guide; and a key informant interview guide (for more information on the data collection tools, see Annex 1). In all cases, the WRC research team led development of research tools and provided off-site training and remote technical support to the local study team throughout the study.

The evaluation was set to end after three months, with endline qualitative interviews and quantitative surveys collected at that time. Due to challenges in working with the initial local partner, IRD, only 15 participants completed the quantitative survey at three months and data collection only resumed nine months after the start of the program. The research staff redesigned the evaluation to examine long-term impacts and compared participant outcomes at zero, three, and nine months from the start of the program. Due to the low number of participants who remained in the study at the nine-month follow-up, quantitative surveys and in-depth interviews were conducted with all remaining participants. Interviews were also conducted with 11 key informants at the end of the evaluation.

DATA COLLECTION TOOLS

Women's Refugee Commission (WRC) research staff, South African Medical Research Council (SAMRC) research partners, and the CARE Monitoring Evaluation and Learning (MEL) team trained the implementing local partners, IRD and SRD, on quantitative and qualitative research methods, led the data collection efforts, and provided them with technical assistance when needed. All the data submitted was reviewed by the CARE MEL Team, SAMRC research partners, and WRC staff for quality assurance.

Questionnaire: WRC and SAMRC researchers conducted virtual inception workshops with CARE Turkey and partner country office teams and led activities designed to clarify the theory of change. Based on these workshops, and drawing on existing literature, WRC and SAMRC researchers compiled quantitative measures of protection and violence that were linked to the theory of change. All measures were taken from previous studies conducted by WRC or SAMRC: the questions included in the survey were adapted from validated scales and questionnaires, took an hour to complete, and assessed demographic information, GBV and other experiences of violence,[15] economic agency,[16] personal well-being,[17,18] and access to services. WRC shared the draft questionnaire with country office teams who reviewed and gave feedback on contextual fit. WRC then hired translators to translate the questionnaire into Arabic. WRC shared the translated versions with CARE MEL and cash for protection program staff, who reviewed the translations for accuracy and contextual fit. The questionnaire was programmed into KoboCollect and administered via mobile phones.

In-depth interview (IDI) guide: The IDI guide was based on IDI guides that were used in WRC's previous assessments of CVA-integrated protection programming. Prior to administration, the IDI guide was reviewed by CARE Turkey and partner country office teams for contextual fit. The IDI guide was then translated into Arabic. Research managers in each site piloted the IDI guide before data collection. Interviews were conducted over the phone with two SRD case workers, one who facilitated the interview, and another who transcribed the interview in Arabic. This approach was taken to avoid risks in recording participants.

Key informant interview (KII) guide: The KII guide was drafted based on KII guides that were used in WRC's previous assessments of CVA-integrated protection programming. The KII guide was reviewed by CARE Turkey and partner country office teams for contextual fit. The KII guide was then translated into Arabic. Research managers in each site piloted the KII guide before data collection. Interviews were conducted by SRD case workers, CARE MEL staff, and the WRC researcher over video conferencing platforms Zoom and Microsoft Teams. Interviews were conducted in either Arabic or English based on the preference of the key informant, audio recorded, and transcribed by the interviewer.

The quantitative survey was administered at all three time points, but the qualitative interviews were conducted at nine months only.

15 M. Beusenberg, J.H. Orley, & World Health Organization. Division of Mental, H, *A User's guide to the self-reporting questionnaire (SRQ / compiled by M. Beusenberg and J. Orley)* (1994: Geneva: World Health Organization), https://apps.who.int/iris/handle/10665/61113.

16 USAID, CARE, Technical Assistance to NGOs International, World Food Programme, & Feinstein International Center, Tufts University, *The Coping Strategies Index: Field Methods Manual* (2008), https://www.fsnnetwork.org/resource/coping-strategies-index-field-methods-manual.

17 C. R. Snyder et al., "The will and the ways: development and validation of an individual-differences measure of hope," *Journal of personality and social psychology, 60(4), 570–585* (1991), https://doi.org/10.1037//0022-3514.60.4.570.

18 World Health Organization, *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses* (2005), https://apps.who.int/iris/handle/10665/43309.

Figure 4. Theory of Change Developed for Program Evaluation

Inputs

- GBV case managtement services for displaced GBV survivors
- CVA for displaved GBV survivors intergrated within GBV case management
- Referrals to services for displaced GBV survivors within GBV case management

Outputs

- Participation of displaced GBV survivors in GBV case management services
- Increased knowledge of displaced GBV survivors of referral services
- Receipt of CVA by displaved GBV survivors

Outcomes

- Increased assets of displaved GBV survivors (as measured by e.g. access to capital, goods and services)
- Increased economic agency of displaced GBV survivors (Control of and decision-making abut capital, goods and services)
- Decreased self-blame of displaced GBV survivors

Impacts

Intended impacts

- **Decreased risk of future GBV for displaced GBV survivors**
- **Improvements in well-being displaced GBV survivors**

Unintended negative externalities

- **Decreased protection for displaced GBV survivors**
- **Increased GBV for displaced GBV survivors**

AFTER-ACTION REVIEW

Conducting an After-Action Review (AAR) for each completed project is a common practice of CARE and its partners. The AAR for this project adapted CARE's AAR methodology and took place through two hybrid (in-person and Zoom link) focus group discussions (FGDs) and one KII. FGDs were conducted with partner staff and led by CARE's senior cash and market technical advisor, with contributions from WRC's associate director for cash and livelihoods, and followed the same structure: welcoming and contextualization of the activity, discussion of key questions, and closing. Each FGD lasted for roughly 90 minutes and was simultaneously translated in Arabic and English.

Here below, the breakdown of FGD and KII participants:

	Date	Categories	No. of Participants	Age	Sex
1	20 April 2022	Partner - CARE Turkey	7	31-64	6F - 1M
2	26 April 2022	Partner - SRD	4	31-64	4F - 0M
3	27 April 2022	Partner - IRD KII	1	31-64	1F - 0M

Participants felt comfortable and willing to share their experiences and feedback with the facilitators, including identifying programmatic and operational lessons learned and recommendations.

QUALITATIVE ANALYSIS

Transcriptions were translated into English for analysis. Any notes and drawings were collected and translated into the local language. Qualitative data analysis comprised a multi-step analysis process. For all qualitative transcripts, analytic memos were created that were used to generate the initial findings and a codebook. The initial findings and the codebook, along with excerpts from the data, were shared in a co-analysis workshop with key project stakeholders, where methods of interpretation and feedback on the codebook were provided and the codebooks were refined.[19] The data was coded and assessed with Dedoose Software using a mixed-methods approach.

19 After the codebook was finalized, the data and codebook were uploaded and analyzed with deductive and inductive coding using Dedoose. Only five workshop transcripts were analyzed, as the participants in two workshops were confused by the questions, offered short responses, or did not speak at all (groups 4 and 5).

QUANTITATIVE ANALYSIS

For each outcome or impact, unadjusted differences from baseline to combined endline (at three and nine months) were calculated, using t-tests. For this, only findings with statistical significance were presented, the level of which was set significance 95 percent. Proportions of response were presented for three and nine months separately, if the outcomes changed more than 1 percent. All quantitative analyses were conducted using Stata SE 16.

ETHICS

This study received approval from the Allendale Investigational Review Board in Connecticut, United States. Participants and key informants were informed of the study's purposes, risks, and benefits and given the opportunity to provide written consent to participate in the study. Names and other identifying information were not collected from participants. All individuals or entities named in this report are named with their explicit consent. WRC provided an information sheet to each participant with WRC's contact information and directions for anonymous reporting channels. The recordings were subsequently deleted. Any names mentioned during the qualitative research data collection were deleted during transcription. All data collected for this report was stored securely on password-protected devices once uploaded and transferred to WRC, and data was not shared outside of the WRC evaluation team.

X: ANNEX 2

Differences in GBV and Protection, Economic Capacity, Personal Well-Being and Access to Services Outcomes among Cash Recipients, 0, 3 and 9 months, N = 33

Measure	Baseline		Follow-up		
	n/mean	%/sd	n/mean	%/ sd	p-value
GBV and Protection outcomes					
Quarrelling (%)	17	94	11	69	0.05
IPV: Economic (past 3 months; %)	7	39	4	27	0.458
IPV: Physical (past 3 months; %)	12	67	8	50	0.324
Family violence (past 3 months; %)	26	84	21	64	0.067
Economic Capacity					
Earning in the past month (%)	6	18	15	45	0.017
Savings (Current; %)	3	9	17	52	<0.001
Coping Strategies Index (Past Week) (score)	27.9	14.0	18.2	11.4	0.007
Household Decision-Making (%)					
Children's education	18	55	20	61	0.618
Marriage decisions for children	9	27	16	48	0.076
Buying or selling expensive household products	8	24	21	64	0.001
Medical treatment for health problems	29	88	32	97	0.163
Spending on menstrual products	28	85	30	91	0.451
Personal Well-Being					
Autonomy and locus of control (score)	9	5	12	4	0.024
SRQ20 (past month) (score)	14	3	10	6	<0.001
Hope Scale (Future Scale) (score)	34	5	36	5	0.024
Access to Services (score)	4	1	5	1	<0.001
Accessed a pharmacy (%)	27	82	32	97	-
Accessed sexual and reproductive health services (%)	20	61	25	76	-
Accessed legal services (%)	1	3	4	12	-
Accessed counselling/psychological services (%)	24	73	32	97	-
Accessed housing support/services (%)	1	3	19	58	-
Accessed livelihoods/employment services (%)	1	3	17	52	-

Measure	At 3 months		At 9 months	
	n/mean	%/sd	n/mean	%/sd
GBV and Protection outcomes				
Quarrelling (%)	-	-	-	-
IPV: Economic (past 3 months; %)	-	-	-	-
IPV: Physical (past 3 months; %)	-	-	-	-
Family violence (past 3 months; %)	-	-	-	-
Economic Capacity				
Earning in the past month (%)	7	47	10	48
Savings (Current; %)	6	40	11	52
Coping Strategies Index (Past Week) (score)	8.5	5.5	23.5	10.2
Household Decision-Making (%)				
Children's education	-	-	-	-
Marriage decisions for children	-	-	-	-
Buying or selling expensive household products	-	-	-	-
Medical treatment for health problems	-	-	-	-
Spending on menstrual products	-	-	-	-
Personal Well-Being				
Autonomy and locus of control (score)	12.3	4.1	10.8	4.0
SRQ20 (past month) (score)	6.4	5.1	12.4	4.7
Hope Scale (Future Scale) (score)	37.9	4.9	34.6	3.5
Access to Services (score)	5.0	1.9	5.4	1.1
Accessed a pharmacy (%)	15	100	20	95
Accessed sexual and reproductive health services (%)	10	67	17	81
Accessed legal services (%)	4	27	0	0
Accessed counselling/psychological services (%)	15	100	20	95
Accessed housing support/services (%)	2	13	17	85
Accessed livelihoods/employment services (%)	3	20	14	70

“No one has power over me”

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A Mixed-Methods Evaluation over Nine Months

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