CASH AND VOUCHER ASSISTANCE FOR
SEXUAL REPRODUCTIVE HEALTH AND RIGHTS

LEARNINGS FROM ECUADOR, COLOMBIA, LEBANON, AND SOMALIA
MARCH 2021
Acknowledgements

This report is a result of the extensive time and invaluable insights offered by CARE staff in Somalia (Puntland and Somaliland), Lebanon, Colombia, and Ecuador, as well as the Regional and Global staff for cash and voucher assistance and Sexual Reproductive Health and Rights in the data collection process and the writing of this report. Thank you also to the program participants who responded to all monitoring and evaluation activities that have allowed us to garner the learnings captured in this report.

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Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADRA</td>
<td>Adventist Development and Relief Agency</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>BHA</td>
<td>Bureau for Humanitarian Assistance</td>
</tr>
<tr>
<td>CMR</td>
<td>Clinical Management of Rape</td>
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<tr>
<td>CVA</td>
<td>Cash and Voucher Assistance</td>
</tr>
<tr>
<td>ECHO</td>
<td>Civil Protection and Humanitarian Aid Operations department</td>
</tr>
<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human papillomavirus</td>
</tr>
<tr>
<td>IAFM</td>
<td>Inter-Agency Field Manual for Reproductive Health in Crisis-Settings</td>
</tr>
<tr>
<td>ID</td>
<td>Identification</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
<tr>
<td>IUDs</td>
<td>Intrauterine devices</td>
</tr>
<tr>
<td>JRS</td>
<td>Jesuit Refugee Service</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitude, and Practices</td>
</tr>
<tr>
<td>KII</td>
<td>Key informant interview</td>
</tr>
<tr>
<td>KIT</td>
<td>Royal Tropical Institute in the Netherlands</td>
</tr>
<tr>
<td>LGBTQI</td>
<td>Lesbian, gay, bisexual, transgender, queer, and intersex</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MERS</td>
<td>Minimum Economic Recovery Standards</td>
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<tr>
<td>MISP</td>
<td>Minimum Initial Services Package</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MPC</td>
<td>Multipurpose cash</td>
</tr>
<tr>
<td>MSNA</td>
<td>Multi-Sectoral Needs Assessment</td>
</tr>
<tr>
<td>OFDA</td>
<td>Office of Foreign Disaster Assistance</td>
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<tr>
<td>PDM</td>
<td>Post-Distribution Monitoring</td>
</tr>
<tr>
<td>PNC</td>
<td>Post-Natal Care</td>
</tr>
<tr>
<td>PPFP</td>
<td>Postpartum Family Planning</td>
</tr>
<tr>
<td>PRM</td>
<td>Bureau of Population, Refugees, and Migration</td>
</tr>
<tr>
<td>PSEA</td>
<td>Prevention of sexual exploitation and abuse</td>
</tr>
<tr>
<td>RGA</td>
<td>Rapid Gender Analysis</td>
</tr>
<tr>
<td>SGBV</td>
<td>Sexual and Gender-based Violence</td>
</tr>
<tr>
<td>SOPs</td>
<td>Standard Operating Procedures</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>UCT</td>
<td>Unconditional Cash Transfer</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>USD</td>
<td>United States dollars</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, sanitation, and hygiene</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
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1. INTRODUCTION

CARE is committed to ensuring that projects with cash and voucher assistance (CVA) are designed with and for women and girls, addressing recipients’ needs, challenges, and opportunities. CARE has invested in research on how to make CVA work for women and girls through gender-sensitive approaches to framing processes and outcomes of the modalities.

As a widely accepted method of increasing access to services and improving autonomy, dignity, and resilience, programming with CVA has been integrated into numerous sectors to improve the lives of displaced communities, particularly the most underserved. To date, CARE’s CVA has primarily been used for food security and livelihood outcomes and multisectoral outcomes via multipurpose cash (MPC) transfers. Now, aligned with its strategic intent, CARE is investing in sectoral areas where CVA is less often used and that are of primary interest for women and girls, including gender-based violence (GBV) response and sexual and reproductive health and rights (SRHR).

The use of CVA to increase access to SRHR in humanitarian settings is not yet common. Increasingly, organizations like the United Nations Population Fund (UNFPA), World Vision, the Population Council, the United Nations Children’s Fund (UNICEF), and CARE are implementing pilots and small projects using CVA to increase SRHR access. Building on extensive experience with CVA and SRHR programming, CARE conducted a study to investigate how outcomes for the pilot initiatives using CVA for SRHR compare to global learnings, and to identify opportunities for strengthening and expanding pilots for long-term programming.
Study Objectives

The objectives of this study were to:

1. Explore whether the design and implementation of the pilot projects align with prior learning and available guidance on CVA for SRHR, CARE’s CVA priorities, and the definition of gender sensitive CVA.
2. Capture country-specific learning to assess whether the program design, early results, and expected outcomes, including selection of CVA methods and target group, were well-suited for the intended objectives.
3. Explore the learnings-to-date from the design and implementation of the pilots to capture country-based learning and any thematic learning across multiple contexts.
4. Capture learnings, positive practices, and early results to further inform CARE’s work using CVA for SRHR globally and to contribute to the nascent evidence on CVA for SRHR for both the SRHR and CVA communities of practice.

Methodology

The study reviewed programming in four contexts (Colombia, Ecuador, Lebanon, and Somalia). The initial study was undertaken by two consultants, one focused on Lebanon and Somalia and one focused on Colombia and Ecuador. Data collection included 25 remote key informant interviews (KIIs) with CARE staff at the global and country levels as well as staff from partner organizations, followed by After Action Reviews with each country team and a validation meeting. All activities were undertaken in either English or Spanish and transcripts were analyzed using data analysis software. Analysis was conducted both by country and across contexts to identify commonalities and thematic learning, mostly led by CARE technical advisors.

CVA for SRHR Outcomes

In March 2020, the Royal Tropical Institute in the Netherlands (KIT) convened a meeting to discuss the status of CVA for SRHR outcomes and identify gaps and opportunities for further programming and research. The KIT meeting highlighted the growing use of CVA. They identified that cash transfers for SRHR have been both conditional and unconditional, and vouchers have been used for services and transport.

Specific outcomes included a focus on safe delivery, family planning (FP), care for survivors of GBV, and sexual transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) care.

A literature review and presentation underscored the importance of linking demand-side financing (such as CVA for community members) to supply-side financing to ensure access to quality and timely healthcare. KIT’s review found few examples of CVA for SRHR programming in humanitarian settings, and few studies globally – even in stable settings – that had evaluated CVA’s direct impact on “the ability to perceive, ability to seek, ability to reach, ability to pay, ability to engage,” key to healthcare access according to the Levesque framework (see Figure 2). The few studies on this topic measured only the uptake in services, but did little to reflect on whether CVA informed other indicators of access. Lastly, the review found that conditional cash transfers do increase service utilization, arguing that increased demand must be met with sufficient, quality supply.

Similar findings were highlighted more recently by a United Nations High Commissioner for Refugees (UNHCR) report.

1 KIT. (2020). Evidence and feasibility of cash and voucher assistance for sexual and reproductive health services in humanitarian settings.
3 KIT. (2020). Evidence and feasibility of cash and voucher assistance for sexual and reproductive health services in humanitarian settings.
on key considerations for undertaking different types of CVA for health programming in humanitarian settings. The report explored both demand- and supply-side considerations and outlined the purpose and types of assessments and approaches for designing and monitoring CVA for health programs. The report raised points similar to those highlighted in the KIT review; some highlights include:

- The importance of simultaneously increasing access to and quality of supply;
- The importance of assessments in designing programs;
- The critical need to monitor how CVA is being used and what challenges and risks participants face;
- The fact that unconditional and unrestricted CVA for health may not achieve desired health outcomes when participants are unable to meet their other basic needs; and
- The importance of targeting and quality referrals to ensure participants are not selecting more affordable and lower quality providers.

These considerations are critical for organizations to review when planning CVA for SRHR approaches.

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4 UNHCR. (2020). The Role of Cash Assistance in Financing Access to Health Care in Refugee Settings and for other People of Concern to UNHCR.
5 Ibid.
6 Ibid.
Structure of the Report

This report is divided into four case studies, one for each country context. Each case study is further divided into the following sections:

- Contextual background;
- Program or project design;
- Outcomes;
- Facilitating factors;
- Challenges; and
- Lessons learned.

A final chapter examines themes common across the four different contexts. The findings included in this report primarily describe processes, with limited evidence of outcomes. CARE acknowledges that there is a need for more research, through stronger monitoring and evaluation mechanisms, to assess how CVA may enable improved access to SRH (sexual and reproductive health) services and SRHR outcomes for diverse communities.
## Summary Matrix of Interventions

### TABLE 1: SUMMARY OF INTERVENTIONS

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>MODALITY AND SRHR OUTCOME</th>
<th>TIMELINE</th>
<th>TARGET POPULATION</th>
<th>TRANSFER AMOUNT</th>
<th>MONITORING</th>
<th>DELIVERY MECHANISMS</th>
<th>REACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ecuador: Huaquillas, Manta, Quito, Lago Agrio, Tulcán, Guayaquil</td>
<td>Vouchers for SRHR goods and services</td>
<td>Phase 1: October 2019 – August 2020 Phase 2: September 2020 - August 2021</td>
<td>Migrants, refugees, asylum seekers, and vulnerable Ecuadoran nationals, focusing on women, adolescents, and the LGBTQI community</td>
<td>One-time, up to 50 USD</td>
<td>Satisfaction surveys</td>
<td>Paper vouchers</td>
<td>5,131 men, women, and gender non-conforming people</td>
</tr>
<tr>
<td>Colombia: Pamplona, Norte de Santander; Bucaramanga, Santander</td>
<td>Vouchers for SRH services; cash transfers for transport</td>
<td>December 2020 – June 2021</td>
<td>Migrants and refugees in transit or staying in Colombia, and Colombian returnees and other vulnerable host community members Focus on women, girls, and the lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) community</td>
<td>Up to 120 USD for SRH services; US$30 for transport</td>
<td>Post-distribution monitoring (PDM)</td>
<td>Paper vouchers; Remittance company</td>
<td>10,000 participants</td>
</tr>
<tr>
<td>Lebanon: Beirut</td>
<td>Unconditional cash transfers (UCTs) for SRH services</td>
<td>September – December 2020</td>
<td>Women self-identifying as in need of SRH goods and services</td>
<td>One-time, 103 USD</td>
<td>Post-distribution monitoring (PDM)</td>
<td>Cash-in-envelope</td>
<td>152 women</td>
</tr>
<tr>
<td>Puntland: Badhan</td>
<td>UCTs for maternal and child health (MCH) services and transport</td>
<td>September – December 2020</td>
<td>Pregnant women in last trimester of pregnancy</td>
<td>3 transfers in 3 months: Puntland 80 USD/month for 3 months and Somaliland 100 USD/month</td>
<td>Monthly PDM (3); pre/post knowledge, attitudes, and practices (KAP) survey; pre/post-focus group discussions (FGD)</td>
<td>Mobile money</td>
<td>70 women</td>
</tr>
<tr>
<td>Somaliland: Yubbe</td>
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</tbody>
</table>
### 2. ECUADOR: VOUCHERS FOR SRHR SERVICES

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>Ecuador (Huaquillas, Manta, Quito, Lago Agrio, Tulcán, Guayaquil)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODALITY &amp; SRHR OUTCOME</td>
<td>Vouchers for SRHR goods and services</td>
</tr>
<tr>
<td>TIMELINE</td>
<td>Phase 1: October 2019 – August 2020</td>
</tr>
<tr>
<td></td>
<td>Phase 2: September 2020 – August 2021</td>
</tr>
<tr>
<td>TARGET POPULATION</td>
<td>Migrants, refugees, and vulnerable Ecuadoran nationals with a focus on women, adolescents, and the LGBTQI community</td>
</tr>
<tr>
<td>TRANSFER AMOUNT</td>
<td>One-time, up to 50 USD</td>
</tr>
<tr>
<td>MONITORING</td>
<td>Satisfaction surveys</td>
</tr>
<tr>
<td>DELIVERY MECHANISM</td>
<td>Paper vouchers</td>
</tr>
<tr>
<td>REACH</td>
<td>5,131 men, women, and gender non-conforming people</td>
</tr>
</tbody>
</table>
Background

Ecuador is both a transit and destination country for refugees and migrants from Venezuela and elsewhere. As of July 2020, over 400,000 Venezuelans were living in Ecuador. Venezuelan refugees and migrants have considerable health, psychosocial, and economic needs. Within these groups, women, adolescents, and LGBTQI people face heightened risks of GBV, human trafficking, and sexual exploitation as well as challenges to earning an income while in Ecuador. Although the public health system in Ecuador is free to all regardless of migration status, not all health – and especially SRH services – are covered in the public system. Furthermore, safe access to available services without discrimination based on nationality, sexual orientation/gender identity, or age is a barrier to access and uptake of SRH services in Ecuador.

Program Design

Since late 2019, CARE Ecuador and two national partner organizations, Diálogo Diverso and Alas de Colibrí Foundation implemented a protection program, with support from Bureau of Population, Refugees, and Migration (PRM), using a case management approach that included vouchers for medicine and health services, mainly sexual and reproductive health, at public and private health facilities. Diálogo Diverso’s expertise is in supporting LGBTQI community members and Alas de Colibrí’s expertise is in supporting GBV and human trafficking survivors. The collaborative program worked to reach the most underserved populations among migrants, refugees, and Ecuadorian nationals, including LGBTQI individuals, survivors of GBV, adolescents, people engaged in sex work and transactional sex, people living with HIV and other STIs, and women who are pregnant or lactating. Eighty percent of the total amount of the humanitarian assistance was earmarked for refugees and migrants, with 20% targeted to host communities.

IDENTIFICATION OF NEEDS

The program was informed by a rapid gender analysis (RGA) undertaken in 2019 by CARE and partners to identify humanitarian needs and gaps concerning rights, SRH, water, sanitation, and hygiene (WASH), and shelter, and to make recommendations and guide CARE’s response. Some highlights related to health include:

- 57% of migrants said they need health attention; 84% had not received any recent healthcare.
- Women and members of the LGBTQI community disproportionately reported having unmet needs and required health services.
- There was high reported knowledge of contraceptive methods across groups, but there were significantly lower levels of knowledge among adolescents.
- Despite having knowledge, over half of men and women said they had no access to contraception. LGBTQI people were much less likely to have access to contraceptives.
- Barriers for health and health-seeking behaviors included lack of information and discriminatory and xenophobic attitudes of some health providers.
- Health professionals interviewed pointed to congested and over-burdened health centers and an increase in risky pregnancies and births (e.g. STIs such as syphilis in pregnancy; adolescent pregnancy).

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The program design for the SRHR vouchers was further informed by a desk review of secondary resources, consultations with target populations, an assessment of the changes in migratory routes in the region, recognition of the significant risks of GBV and the specific SRHR needs of the diverse groups, and the desire to, at minimum, implement the Minimum Initial Services Package (MISP) for SRH crisis settings and, ideally, comprehensive SRH services as guided by the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings.9,10

TRANSFER VALUES AND MECHANISMS

The three partners formed a health commission and developed agreements with health institutions, including government-run health facilities, private health providers, the Red Cross, pharmacies, and laboratories to establish a comprehensive referral system and coordinate access to health services, including general medical care, specialty consultations, laboratory tests, and medications. The health commission identified the estimated costs of SRH services, prioritized the services to be financed, defined the scope and limits of the program, and identified how to address urgent and priority health needs. Participants could access public or private providers, depending on the location and capacity of providers.

CARE designed Standard Operating Procedures (SOPs) to work through the process from identification to monitoring. These SOPs took into consideration the privacy of individuals, especially since these were highly vulnerable populations. The SOPs also defined what the voucher covered and who the target groups were.

The teams created five different vouchers for:

- Medical treatment or supplies
- HIV testing/STI screening
- Pregnancy tests/SRH screening
- Special tests and medical treatment (specifically for GBV survivors)
- Contraceptives

An in-kind SRH assistance of condoms and lubricants complemented the vouchers for some participants.

Each voucher had a maximum value based on the costs of goods and services determined in a local market assessment and taking into consideration cost-efficiency and the suggested pharmaceuticals, products, or services as suggested by the Ministry of Health (MOH).
TARGETING PARTICIPANTS
CARE and the partners disseminated information about health assistance through their social networks, though many participants learned of the program through word-of-mouth. Project participants were identified through different means including:

- Direct identification by CARE or partner staff through (e.g. through case management);
- Referrals from other organizations, including health centers; and
- Self-identification (e.g. potential participants came to CARE/partners’ offices seeking assistance).

When the potential participant arrived at the offices of CARE or the partners, the initial assessment was carried out by social workers with a diagnostic conducted to determine if the individual qualified for assistance. Persons or families were eligible for humanitarian assistance if they met at least one of the following criteria:

- Families in vulnerable conditions who have not received any assistance;
- Female-headed households with children and adolescents;
- Single women (e.g. women traveling alone);
- Families with a single parent (i.e. children who live with only the mother or father);
- Families with disabled persons or catastrophic severe illnesses;
- Women who were pregnant or breast-feeding;
- Unaccompanied minors;
- LGBTQI individuals or couples;
- Women survivors of GBV; or
- The elderly.

If an individual met any of the above criteria, they then needed to provide documentation in the form of a medical exam, prescription, or analysis signed by a certified medical professional; CARE and partners did not have medical personnel on site to evaluate needs. If an individual did not have such documentation (but met eligibility criteria), they were referred to the nearest health center with which CARE and partners had an agreement where the participant was able to obtain required documentation and return. Once documentation was provided, a social worker assessed the individual’s needs and generated a voucher for the participant to obtain the goods or services required along with a referral to either a public or private provider.

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11 Criteria were adjusted at the onset of the COVID-19 pandemic.
## TABLE 2: VOUCHER TYPE, TARGET GROUPS, AND MAXIMUM VALUES

<table>
<thead>
<tr>
<th>VOUCHER TYPE</th>
<th>TARGET GROUPS</th>
<th>VALUE</th>
</tr>
</thead>
</table>
| Medical treatment or supplies     | Consultations, procedures, and supplies not covered by public health or in previously prioritized cases from private providers  
                                    | For medicine, redeemable at pharmacies                                                                                                           | Up to 50 USD     |
|                                  | Venetuelans in transit and highly vulnerable Ecuadorians; prioritization for LGBTQI people, women survivors of sexual violence, women who were pregnant and/or breast-feeding, children and adolescents, and the elderly |                  |
| HIV Testing/STI Screenings       | Testing: rapid HIV, Hepatitis (B, C, E), STIs  
                                    | Examinations  
                                    | Consultations                                                                                                                                         | Up to 20 USD     |
|                                  | Venetuelans and Ecuadorians, especially LGBTQI people, women survivors of sexual violence, and people at risk of exposure to HIV or STIs                                                                    |                  |
| Pregnancy Tests/SRH Screening    | Laboratory and/or complementary tests, including pregnancy tests and pregnancy screening, or other pathologies related to SRH  
                                    | Examinations                                                                                                                                          | Up to 50 USD     |
|                                  | Venetuelans and Ecuadorians, especially women and LGBTQI populations; focus on women survivors of sexual violence and people at risk of exposure to HIV or STIs                                                   |                  |
| Special tests and medical treatment | Examinations, care, consultations, or other procedures, including clinical management of rape (CMR)  
                                      | Medication or medical treatment redeemable at pharmacies                                                                                           | Up to 150 USD    |
|                                  | Venetuelans and highly vulnerable Ecuadorians with special needs, especially LGBTQI people and women survivors of GBV, especially sexual violence, including family members affected by the situation |                  |
| Contraceptives                   | Contraceptives, including emergency contraception; mainly short acting methods (e.g. pills)  
                                    | For medicine, redeemable at pharmacies                                                                                                           | Two types:  
                                    | 1. Up to 6 USD  
                                    | 2. Up to 14 USD                                                                 |                  |
|                                  | Highly vulnerable Venetuelans or Ecuadorians (LGBTQI people, women survivors of sexual violence, people at risk of exposure to HIV/STIs, etc.)                                                               |                  |

The use of public or private service providers depended on the capacity of the service providers in the area. Sometimes the public service providers did not have the capacity for certain services; in these cases, participants were referred to private providers. Alternatively, if a participant sought services at a private SRH provider in the referral network, the participant delivered the voucher to the provider. The vouchers were paired with complementary services and distributions these included workshops with participants on sexual reproductive health, GBV prevention, sexual diversity, and human trafficking. Both public and private service providers received similar workshops to ensure inclusive services participants. The workshops were led from a gender and human rights perspective, emphasizing inclusivity in treatment. They included a discussion of concepts and approaches such as inclusive SRHR with a special focus on care for LGBTQI populations.
REDEEMING VOUCHERS

Vouchers for medical exams, consultations, screenings, and treatment could each cover up to three services. Each voucher was issued on an individual basis; if more than one family member qualified for a voucher, they would be issued additional vouchers. If the voucher recipient needed to have follow-up exams, they would be issued a new voucher. Social workers indicated the value of the voucher based on the costs of the needed service. The transfer value was determined in consultation with the organization’s social worker and service provider staff through email, a phone call, or an in-person visit. Once vouchers were filled out, they were signed and sealed by the organization staff. Vouchers were accompanied by a medical prescription for services. Both the original and copies of the vouchers were signed by the staff from the issuing organization and the service provider. Extremely vulnerable participants, as determined by social workers, were accompanied to the service provider by the organization’s staff.

For referrals to Cruz Vital (part of the Ecuadorian Red Cross) the SOPs were slightly different. Cruz Vital attendance was based on prior appointments. Cruz Vital accepted five means of communication: a toll-free call center, direct calls to the specific location (cell or landline), and messages or calls through either WhatsApp or Facebook Messenger (these final two options offered 24-hour services).

For laboratory tests, no appointments were necessary, but participants needed to call prior to arrival to understand the requirements for the test. For medical exams, organization staff needed to communicate some basic information including: the name of the organization; the Cruz Vital site where services were sought; whether the appointment was for general or specialized services; and the name and identification number of the participant. Once confirmed, the participant was told the time and place of the appointment at least 15 minutes prior to the appointment.

Test and screening results for participants were issued via email to the organizations’ medical personnel or social worker who relayed results to the participant or guardian. HIV test results were given to the organizations’ medical staff or social worker in a sealed envelope and only opened in the presence of the participant.

Vouchers for medicine were issued on an individual basis. Each of the three organizations signed an agreement with a parent company of the vendor pharmacy, SanaSana, which covered the various implementation areas. Specific locations of the pharmacy chain were identified where participants could redeem the vouchers.

The social worker supporting a participant’s case was required to contact the pharmacy using its preferred mode of communication. In the most critical cases organizational staff accompanied participants to the pharmacy; social workers determined whether or not participants needed accompaniment. Each voucher needed to be accompanied by the prescription, signed by the pharmacy staff, with a copy retained by the issuing organization.

MONITORING

Each voucher was registered in CARE Ecuador’s program registration system, a proprietary and personalized software with a biometric fingerprint component. The biometrics were not mandatory and were discontinued as part the project adjusted to the COVID-19 pandemic by shifting registration to remote. CARE’s registration system allowed data to be entered and extracted according to demographic variables (e.g. sex, gender, age, nationality, sexual orientation, etc.), migration status, and vulnerability criteria. These data points could be cross-referenced with the type(s) of assistance received, including the type of voucher, the location of service, and the date of care. Monitoring included the number of participants seen, number of vouchers, and services sought.

Participants also received a satisfaction survey about the services or goods accessed, the changes they experienced in their lives, their treatment by CARE and partners, and the relevance of workshops. Surveys asked whether the voucher was useful for recipients and about the quality of the services received (e.g. respect and non-discrimination, kindness, transparency, and efficiency). Most participants reported satisfaction with the services received. Participants were also made aware of a feedback mechanism for any concerns, questions, or complaints.
Outcomes

The SRHR component of the program, implemented from September 2019 to August 2020, reached 5,131 people with SRHR assistance. Of these participants, 57% were women, 41% were men, and 2% identified with other genders. Just over half of the participants were Venezuelan migrants (54%) and 46% were Ecuadorians. The majority were between 18 and 49 years of age with smaller numbers of participants aged 13 to 17 and 50 to 64. The majority of participants sought pregnancy tests, SRHR and STI screenings, HIV testing and and other SRH consultations. Additionally, condoms and lubricants were distributed during workshops and information sessions on SRHR topics.

The next most common voucher types for adults were condoms and lubricant followed by HIV/STI tests and medicine/specific tests. For adolescents, the most frequently sought services were medical supplies and treatments followed by medicine/specific tests and HIV/STI tests.

Prevention and timely detection of HIV/STIs was discussed with sexually active local and migrant men and women. Because of the oversaturated health system in Venezuela, these populations had not been able to access SRH services in their country of origin. Along with HIV and STI tests, participants received pre- and post-counseling based on the MOH’s algorithms. CARE and partners’ technical staff were fully trained on these counselling methods. The most commonly identified STIs were syphilis and HIV, with less common detection of human papillomavirus (HPV), herpes, and Hepatitis B and C.

Women and LGBTIQ individuals who survived sexual violence were able to access specialty consultations, such as neurology, gynecology, psychiatry, dentistry, and more. Additionally, they accessed specialized medications, such as anti-D or Rho (D)immune globulin injections to counteract blood incompatibility between mother and fetus to reduce pregnancy risk.

![Figure 4: Number of SRHR Vouchers Accessed, by Age](image)

Two hundred seven awareness sessions on SRHR and emotional health were delivered to 4,998 people (1,899 female; 3,042 male; 57 LGBTQI/no binary people). Additionally, mental health needs were addressed to develop response capacities in the face of “migratory grief” and other situations like discrimination and xenophobia to support coping and facilitate integration in Ecuador.

Within this framework, Alas de Colibri Foundation developed the campaign “Free and Safe Sexual and Reproductive Health,” which reached 1,064 people. The campaign provided prenatal check-ups, STI screening, and FP counseling, including contraceptive methods to support SRHR of affected communities. In addition, awareness events were developed to assist migrants, refugees, and the host community in preventing GBV, forced migration, to human trafficking and
to raise awareness of gender diversity, and children’s rights. Additionally, in coordination with UNFPA, CARE supported the development of information, education, and communication materials on SRHR and GBV (e.g. flipcharts, brochures on SRHR, and prevention of GBV in emergency contexts). Faced with the social isolation measures imposed due to COVID-19, collective activities were reprogrammed to be carried out virtually. CARE and its partners developed expertise in conducting virtual workshops and awareness events on GBV prevention and SRHR. Finally, CARE and the partners developed and delivered trainings on inclusive health center certification to 73 health providers.

The collaborative project contributed to strengthening the case management referral system of INGOs, national organizations, and public and private health providers. For example, coordination processes for referrals were agreed upon with the MOH, and similar coordination has occurred with other humanitarian assistance organizations. The program strengthened relationships among the members of the referral network creating a network aimed at improving access to services through vouchers. In addition, the project strengthened the national health system by increasing demand for national health system services. The program improved delivery of health services by training health providers on rights-based care, essential SRH services, and provision of quality, respectful care to a range of often hidden and underserved participants. The program supported participants in navigating the health system and in determining what health services they needed while sharing SRHR referral information during case management. CARE staff observed that the program increased services to SRH care for survivors of sexual violence and access to hormonal treatments for trans women. They also spoke of the project contributing to a quality approach to SRHR care by focusing on specific needs of individuals and linking them directly to quality referrals.

Facilitating Factors

The implementing agencies underscored the importance of the partnership between experienced organizations to enable a truly inclusive program to respond to the specific needs of diverse target groups. The establishment of a health commission was critical to designing the scope of the project, identifying key services and providers to include, and offering tailored care to individuals. In addition, staff and colleagues emphasized the importance of including refugees, migrants, and Ecuadorians in the target groups to reduce xenophobia, and the importance of including LGBTQI people to reduce discrimination and strengthen the care provided in the national health system. Partnership with the public and private sectors has been important to the process because it guaranteed coordinated and comprehensive care for the participants.
Challenges

There were several challenges that impacted the program. This included a national strike in October 2019 that interrupted and delayed all institutional agreements required for implementation. The selection of health providers and defining the voucher “life cycle” also proved challenging. The outbreak of the COVID-19 pandemic shifted strategies considerably and redirected project budgets into COVID-19 response. Systems and processes were updated in light of limited staff mobility and vouchers became electronic, with follow-up shifting to phone calls. Like many organizations, staff also began working remotely and coordination meetings went virtual. Finally, the lack of available comprehensive protocols for health providers made it difficult to ensure quality standards of care for referred services. Also important to the context was the impact of austerity measures impacting the Ecuadorian national health system a few months before the COVID-19 pandemic outbreak; this resulted in the departure of thousands of doctors and other health personnel causing enormous challenges for health care in Ecuador.13

Lessons Learned

A case management approach to SRHR vouchers can be beneficial. In general, organizations and health providers viewed the program as transparent and collaborative. The program findings showed that health vouchers are more impactful if they are part of a case management program that also includes legal and psychosocial support and provides SRHR information.

Including both host and migrant/refugee populations in a project can have impacts beyond meeting SRHR needs. Vulnerability criteria for the program included both migrant and refugee populations and vulnerable Ecuadorians. This contributed to reducing discrimination and xenophobic practices and complied with the principle of action without harm. The approach allowed the organizations to reach the most vulnerable people.

Relationship building at multiple levels is critical to project success. It was clear that there needs to be the same effort at building relationships among stakeholders in all program locations; during this program, more effort was focused on building relationships at the national level between CARE, referral partners, and the MOH.

Flexibility and contextual analysis are essential for appropriate and effective CVA for SRHR programs. In the context of the pandemic, the SRHR vouchers became even more relevant and more in demand. The increased demand was linked to increased challenges in access to healthcare, especially for Venezuelan migrants, due to the reduction of livelihood opportunities, increased economic needs, and an overwhelmed healthcare system. CARE and its partners were able to quickly adapt to virtual programming to allow continued programming during this health emergency.

### 3. COLOMBIA: VOUCHERS FOR SRHR SERVICES

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>Colombia (Pamplona, Norte de Santander, Bucaramanga, Santander)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODALITY &amp; SRHR OUTCOME</td>
<td>Vouchers for SRH services; cash transfers for transport</td>
</tr>
<tr>
<td>TIMELINE</td>
<td>December 2020 – June 2021</td>
</tr>
<tr>
<td>TARGET POPULATION</td>
<td>Migrants and refugees in transit or staying in Colombia, and Colombian returnees and other vulnerable host community members with a focus on women, girls, and the LGBTQI community</td>
</tr>
<tr>
<td>TRANSFER AMOUNT</td>
<td>Up to 120 USD for SRH services and 30 USD for transport</td>
</tr>
<tr>
<td>MONITORING</td>
<td>Post-distribution monitoring (PDM)</td>
</tr>
<tr>
<td>DELIVERY MECHANISMS</td>
<td>Paper vouchers; remittance company</td>
</tr>
<tr>
<td>REACH</td>
<td>10,000 participants</td>
</tr>
</tbody>
</table>
Background

As a result of Venezuela’s socioeconomic and political crisis, there have been massive migratory flows of people from Venezuela into Colombia. According to the Interagency Coordination Platform for Refugees and Migrants, as of May 2020 over 1.76 million Venezuelans had fled to Colombia with many continuing to walk to and across the Southern Border with Ecuador as caminantes. This situation is compounded by the collapse of the Venezuelan health system, which has resulted in many migrants and refugees arriving in Colombia with a range of unmet SRHR needs. Women and girls face sexual exploitation, and some engage in transactional sex during migration, particularly along border crossings and in major urban areas. Many Venezuelan migrants and refugees are subjected to other forms of exploitation, abuse, negative coping mechanisms, xenophobia, and various forms of violence, in particular GBV. More than 50% of refugees and migrants have irregular status and, therefore, have limited or no access to essential public services and the formal labor market. The COVID-19 pandemic exacerbated the vulnerabilities of these populations, as the Colombian government’s mandatory quarantine and border closures further limited access to services and income-generating activities while increasing protection risks.

CARE Colombia began direct operations in the country in 2019, focusing primarily on the needs of Venezuelan refugees and migrants in Pamplona, Norte de Santander and, later, Bucaramanga, Santander. CVA are primary modalities for CARE Colombia, particularly for its SRHR and protection portfolio. Working with populations on the move as was the case in this program, together with high levels of unmet SRHR needs resulted in a unique operating environment for a voucher intervention supporting SRHR programming.

This case study focuses on the design of the programming only. Due to the timing of the review, no substantive data on the user experience of the vouchers or outcomes could be captured.

Program Design

CARE Colombia had support from a variety of donors, including the Chubb Foundation, an anonymous donor, Abbott, and the Civil Protection and Humanitarian Aid Operations department of the European Union (ECHO), to provide this programming. Aspects of each of these projects aimed at addressing barriers to SRH services for migrants and refugees, especially those with lifesaving needs on the route of the caminantes, as well as vulnerable members of host communities.

IDENTIFYING NEEDS

The program design was informed by various needs assessments and analyses, including CARE’s 2019 and 2020 RGAs, a Profamilia evaluation of the unmet SRHR needs of migrant communities, from other MPC pilot programs, SRHR programming, and guidance from the Colombian CVA national working group. Consultations with migrants, building on CARE Colombia’s Women Lead in Emergencies program, were critical to identifying the overall gaps in SRHR needs for Venezuelan migrants in Colombia. These analyses were immediately applied to the planned CVA for SRHR programming launched in December 2020.

Given CARE’s commitments to localization and health systems strengthening, CARE Colombia sought to identify local...
government health actors with whom to collaborate to improve access to SRHR. However, the process was fraught with challenges due to:

- the limited availability of health providers offering SRHR services in target locations and surrounding rural areas, especially in humanitarian corridors;\(^{21}\)
- individuals with legal documentation being able to access services at only a few approved public health clinics with free services, where many faced xenophobic attitudes from providers. “Irregular migrants” without legal documentation avoid seeking services for a variety of reasons, including fear of deportation, lack of insurance coverage, and negative provider attitudes, including xenophobia; and
- the inability of public health facilities such as the public hospital in Pamplona to continue offering SRH services as a result of being overwhelmed by the COVID-19 pandemic further limited availability of SRH services.

Based on the identified barriers to access, CARE Colombia collaborated with a variety of actors through seven working groups to establish and strengthen four referral pathways to facilitate access to quality SRH services – particularly antenatal care, STIs, family planning, and CMR) – in project locations. Key actors included the Mayor’s Offices of Pamplona and Cúcuta in Norte de Santander and health organizations.\(^{22}\) These consultations helped to map out potential goods and services for SRH in the target areas and contributed to the first level of market analysis for the intervention. CARE Colombia then launched a bidding process to identify service providers.

Based on capacity and in line with the partnership model of the program, CARE Colombia selected CEDMI in Pamplona and Profamilia in Bucaramanga as clinical service providers for the program. Based on Colombia’s current regulations, CARE developed a partnership with the local Health Directorate to meet SRHR needs for vulnerable populations through rights-based approaches. SRH services were provided at either fixed points of service delivery—two static health facilities in Pamplona and one in Bucaramanga) or through mobile brigades.

**TRANSFER VALUES AND MECHANISMS**

The SRHR voucher intervention was designed to facilitate access to timely care for vulnerable individuals who lack access to lifesaving SRH services guided by the Inter-Agency Field Manual for Reproductive Health in Crisis-Settings (IAFM). Based on the needs analysis, participants could receive vouchers for a range of goods and services including:

- Antenatal care and follow-up;
- Postnatal care and follow-up;
- Family planning, counseling on contraceptive methods in line with WHO eligibility criteria and provision of contraception, including insertion and removal of IUDs (Intrauterine devices) and implants;
- Detection, diagnosis, treatment, and follow-up for STIs;
- Other general medical consultations including pregnancy testing;
- CMR and referrals for other services for survivors of sexual violence; and
- Prescription medications according to the list of medicines authorized by CARE.

CARE designed SOPs to guide the program. The programming was led by a monitoring framework that combined various projects and followed outcome, output, and process indicators for CVA and SRHR.

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\(^{21}\) Areas where migrants are allowed passage.

\(^{22}\) Local Health Directorate, hospital, Colombian Red Cross, Halu Foundation, Legal Option, IOM, UNFPA, and Humanitarian Civil Network
Paper vouchers were selected as the modality and delivery mechanism because CARE could secure quality service and because of the agreements (e.g., prices, number of people attended in relation to capacity to serve). The transfer value for the vouchers was defined through the market assessment on the costs of goods and services by the private service providers. The voucher amount varied by service and depending on the partner. Typical voucher values were 100 USD for antenatal checkups (for two ANC visits including relevant tests), 60 USD for diagnosis and treatment of STIs, 89 USD for subdermal implants, and 25 USD for IUDs. The program participants could receive up to two vouchers depending on the services needed (e.g., antenatal checkups). In addition, as the Colombian government offers free delivery services including emergency obstetric and newborn care for complications in pregnancy, CARE supports transportation and referrals to facilitate access to these services at public health facilities.

Participants could qualify for cash transfers for transport to health services within Pamplona to Bucaramanga and rural parts of Pamplona to Pamplona town, valued at up to 30 USD. These transfers were made through Efec
ty, a remittance company. Participants with identification (ID) that met Know Your Customer requirements in Colombia could use their ID to retrieve the money. For the participants who lacked valid ID, CARE set up an agreement with the FSP where a unique code would be provided to the participant and could be used in lieu of ID to retrieve the payments. Furthermore, participants could also qualify for other support from CARE and partners (e.g., MPC transfers, service delivery) based on assessment by CARE and partners.

TARGETING PARTICIPANTS

CARE nurses and CARE-trained community focal points led the identification and prioritization of project participants. Once the referral and voucher systems were established, CARE leveraged its existing programming with women’s and adolescent groups, community leaders, cultural and grassroots associations, humanitarian groups, and LGBTQI networks and local partners to raise awareness of service availability through awareness raising campaigns, radio and social media messages, collaboration with local governments, and, most importantly, through CARE-trained community focal points and staff. Priority groups for support included:

- Venezuelan migrants and refugees including *caminantes, pendulares*,23 asylum seekers and particularly “irregular” migrants, without access to health insurance;
- Colombian returnees and vulnerable members of host communities; and
- Populations disproportionately impacted by COVID-19, with an emphasis on women, girls, and LGBTQI communities.

MONITORING

Although participants were referred to health clinics for specific services, health providers screened for additional needs and referred them to other services if required. After participants received care, an estimated randomly selected 10% would be targeted with PDMs by phone two weeks after the voucher was delivered. The PDM assessed quality, timeliness, relevance, and access through an electronic survey on Kobo toolbox, usually conducted via telephone immediately after care and again two weeks to one month after services were rendered.

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23 Migrants who cross into Colombia and return to Venezuela.
Facilitating Factors

In addition, despite being a relatively new CARE country office, CARE Colombia’s in-house expertise on both SRHR and CVA enabled a strong integrated response. The integrated SRHR/CVA programming also leveraged other ongoing programming that strongly emphasized gender and inclusion (such as the Women Lead in Emergencies project and other protection programming) and facilitated identification, targeting, and accompaniment of individuals in need of SRH services.

Community participation was critical in program design, especially for prioritization of needs, development of communication strategies, and identification of the urgent need to train community leaders as focal points on SRHR. Strong collaboration across government institutions including the Mayors’ Offices, the Secretary of Health, Municipal Secretaries and key actors in health, humanitarian, and civil society networks was crucial to finding viable ways to enhance access to SRHR and complementary services. CARE Colombia linked its Women Lead in Emergencies project participants to this intervention, where women could act as focal points in their communities for SRH services through CARE and partners.

Challenges

The outbreak of COVID-19 forced critical adaptations in the project. These adaptations diminished the team’s ability to conduct in-person follow-up with participants. The aforementioned scarcity of service providers caused additional delays. Antagonism and xenophobia of some authorities and host communities toward migrants and refugees was exacerbated during the COVID-19 crisis. Moreover, challenges in targeting and reaching intended populations due to fears of deportation, further stigmatization, or discrimination were further compounded by quarantine measures.

Lessons Learned

Vouchers and complementary services can be critical at times of crisis when SRHR needs may be deprioritized. At the time of the study, the program was only in the early stage of implementation; therefore, the learnings only speak to planning and design. As COVID-19 resulted in further limitations on access to SRHR, vouchers enabled access to hard-to-reach and often deprioritized SRH services, including contraception and STI services. Demand in places like the albergues in Pamplona and from caminantes was so high that it sparked CARE’s partner in Bucaramanga to initiate service provision in Pamplona as well. This is particularly important for irregular migrants for whom legal status is a major barrier to access. Furthermore, addressing provider attitudes, including xenophobia, towards these groups is a critical complementary aspect of this programming.

Providing access to a full range of services aligns with a rights-based approach. One important takeaway is that although paper vouchers were provided for specific SRH services, CARE’s program design ensured that individuals who arrived at facilities were first screened to identify and be referred for other relevant services, facilitating access to a full range of services. Although this was more complicated for CARE and the health providers, it was instrumental in ensuring a rights-based approach to SRH, allowing access to a full range of services according to participants’ wishes.

24 These are shelters where the migrants can stay.
<table>
<thead>
<tr>
<th>LOCATION</th>
<th>Lebanon (Beirut)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODALITY &amp; SRHR OUTCOME</td>
<td>Unconditional cash transfers (UCTs) SRH services</td>
</tr>
<tr>
<td>TIMELINE</td>
<td>September – December 2020</td>
</tr>
<tr>
<td>TARGET POPULATION</td>
<td>Women self-identifying as in need of SRH goods and services</td>
</tr>
<tr>
<td>TRANSFER AMOUNT</td>
<td>One-time, 103 USD</td>
</tr>
<tr>
<td>MONITORING</td>
<td>Post-distribution monitoring (PDM)</td>
</tr>
<tr>
<td>DELIVERY MECHANISMS</td>
<td>Cash-in-envelope</td>
</tr>
<tr>
<td>REACH</td>
<td>152 women</td>
</tr>
</tbody>
</table>
Background

On August 4, 2020, an explosion in the port of Beirut left hundreds killed and thousands injured, damaged numerous neighborhoods – including hospitals and residential buildings – and left 300,000 people homeless.25 The economic, social, and psychological tolls of the blast were added to an already strained population suffering from an economic crisis and the impacts of COVID-19. The Lebanese Red Cross reported in a post-blast study26 that, of those surveyed, approximately 5% of respondents reported having family members who were pregnant or lactating and, of those households, 40% reported needing MCH services. A UNFPA report identified a decrease in SRH service availability due to facilities destroyed or damaged in the blast.27

Prior to the blast, the Interagency Sexual and Gender-based Violence (SGBV) Task Force conducted an assessment with 562 women and girls across the country on the SGBV impact since the beginning of COVID-19. This assessment found that 51% of respondents felt less safe in their communities and only 30% reported accessing health services.28 Sixty-seven percent of respondents reported that the main barrier to accessing services was lack of money.29

Program Design

CARE Lebanon’s post-blast RGA recommended increasing access to SRH services for women and adolescents, while providing information on available services.30,31 Recognizing the increased risks for GBV and increased barriers to accessing SRH services related to COVID-19 exacerbated by the explosion, CARE Lebanon identified the opportunity to use UCTs to enable better access to SRHR.

IDENTIFYING NEEDS

CARE Lebanon is an active member of the GBV working group and coordinates closely with the health cluster. The NGO recognized that the majority of protection actors were focused on case management, but that there was a gap in the integration of SRH services. Access to these services seemed to be especially difficult given increased financial barriers after the blast. Responding to this gap, CARE Lebanon developed a pilot to offer one-time cash transfers with the support from the Sall Family Foundation to meet immediate SRHR needs among 152 women in post-blast Beirut.

In addition to the aforementioned analysis, the CARE Lebanon team applied the Minimum Economic Recovery Standards (MERS) benchmarking tool to ensure that the response took into consideration a holistic market in crisis approach due to the nature of the humanitarian crisis arising from the blast. Other steps included a brief market assessment on the costs of goods and services in the affected areas. Few organizations were focusing on standalone SRHR, rather it was part of GBV or protection programming. As a result, CARE had to do preliminary assessments. Newly adopted SOPs were used for the intervention and the program monitoring framework for the blast response included this programming.

KEY PROJECT DATA:

- 327 cases assessed
- 152 women reached
- 62% head of household
- 66% Lebanese, 31% Syrian, 2% Palestinian, and 1% Ethiopian
- Age ranges: 3% >18 years, 36% 19-39 years, 39% 40-59, and 22% 60+

26 IOM. (2020). *Multi-Sectoral Needs Assessment (MSNA).*
29 Ibid.
TARGETING PARTICIPANTS

Participants were referred from several CARE Lebanon programs. The referrals came mainly through CARE’s helpline, other partner organizations in country, and word of mouth. The helpline number was put on Facebook and CARE social workers also helped spread the information on how assistance could be received.

The baseline assessment conducted a vulnerability analysis for 327 potential participants, using scoring criteria outlined below. Scores ranged from 5 to 24, with an average of 13. Based on discussion with the team members, and taking into consideration the average sample score, any beneficiary with a score of 12 or above was considered eligible for the cash transfer. A total of 152 participants were selected.

TRANSFER VALUES AND MECHANISMS

Each participant received 400,000 LBP (103 USD). The transfer value was selected based on standards of practice by the SGBV Working Group. The CARE team also considered the fact that the average SRHR consultation cost was 100,000 LBP. With this information in mind, the transfer rate was set assuming that a recipient may need at least one consultation, funds for transport, and follow-up consultations or goods.

Direct cash transfers through cash-in-hand were selected as the modality and mechanism. This was done to ensure inclusion of participants without bank accounts and to avoid reliance on the limited banking hours during COVID-19 lockdowns. Two delivery mechanisms were used for the cash transfers:

- On-site, in community centers (CARE’s Social Development Centers and centers of partner Abaad)
- Door-to-door distribution for vulnerable individuals unable to reach on-site distribution

The actual delivery mechanism was selected by the participant to ensure confidentiality and safety. Participants were also allowed to send a representative to collect the transfer if preferred. Transfers were distributed by three female CARE staff (Program Officer, Cash Officer, and Outreach Worker) at the Social Development Centers or door-to-door at participants’ home. Only 5% of the participants (seven people) chose the door-to-door option.

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SCORING CRITERIA:

- Age >40 or <18 (2 points), if <40 and >18 (1 point)
- Head of household (4 points)
- Pregnant or lactating (4 points)
- In danger/at risk of GBV level high (4 points), medium (1 point), low (0 points)
- Participant needs money for CMR, HIV/STI testing and treatment, clean and safe delivery-related services, antenatal or postnatal care, child healthcare, medical counselling, gynecology-related services (4 points)
- Cost of service (don’t know (1 point), <100,000 LBP (1 point), 100,000-200,000 LBP (2 points), 201,000-300,000 LBP (3 points), 301,000-400,000 (4 points), >401,000 LBP (5 points))
- Any safety concerns or physical barriers to accessing services (2 points)
- Men in household oversee the medical expenses and/or gender/social norms are a barrier to access SRH services (1 point)

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32 Exchange rate was 1 USD: 3,900 LBP
For the distributions at the Social Development Centers, CARE adapted its approaches to adhere with all precautionary measures to prevent the spread of COVID-19. The distribution consisted of four checkpoints:

- **CHECKPOINT 1**: At arrival, participants were asked to sanitize their hands before entering.
- **CHECKPOINT 2**: Awareness and information sessions on SRHR topics were conducted by volunteers or social workers for groups of eight women before they received the transfer.
- **CHECKPOINT 3**: Each participant received the cash transfer in a private room after their names were collected and copies of their identification were obtained.
- **CHECKPOINT 4**: CARE ran a help desk where individuals were welcome to stop for additional questions or information about other projects or services, including GBV and SRH services, prevention of sexual exploitation and abuse (PSEA), COVID-19 risk mitigation measures, and helpline numbers. The help desk also provided suggestion boxes for feedback and/or complaints (including PSEA complaints) and referrals to the midwife for additional information. The help desk was staffed by one dedicated CARE team member with full knowledge of the services provided internally and externally within the area of coverage. The help desk also ensured that beneficiaries on-site respected the precautionary measures for COVID-19. The help desk was set up so that individuals could not leave the Center without passing it, although it was not required that they stop at it.

Social Development Centers also had midwives who offered awareness sessions and information on locally available SRH services.

**Outcomes**

A PDM survey was conducted with a representative sample of 116 participants (76%) within two to four weeks of receiving their cash transfer. The PDM survey included questions about overall satisfaction with the distribution process, the amount of money collected, and general questions about safety/security and how the cash was utilized.

**DECISION-MAKING**

Nearly half (48%) of respondents said that men oversee medical expenses in the home, and 3% stated that they independently make these decisions. When asked if they usually need permission to buy personal supplies or access SRH services, 26% of the women said yes. Of the 37% of participants who reported that they had previously borrowed money for SRH services, 61% said that they independently make the decision and 31% said they make the decision jointly with their husbands.

**TRAVEL TIME TO RETRIEVE TRANSFER**

Half (50%) of respondents walked to the distribution site, 37% traveled by taxi, 8% traveled by private car, and 5% traveled by bus. For those who needed more than 25 minutes to arrive to site, the majority travelled by taxi (66%), bus (17%), or private car (17%). The time to reach the distribution site ranged from 0 and 90 minutes; the average of 17 minutes.

**SPENDING**

The participants were asked to report how they spent their cash transfers, with the option to select more than one response. Sixty-

![FIGURE 6: WAYS IN WHICH CASH TRANSFERS WERE UTILIZED](image-url)
four percent of respondents spent the transfer on health services other than SRH; 48% on SRH services; 41% on food; and 9% on rent.

Forty-nine percent of respondents said that the SRH services cost them between 100,000-300,000 LBP; 23% spent more than 300,000 LBP; and 28% spent less than 100,000 LBP per month. Overall, respondents reported these services costing between 25% and 100% of the total amount of the transfer.

Nineteen percent of respondents reported that the funds helped them access SRH services to “a large extent” and 21% said the funds helped them cover other priority needs to “a large extent.” Importantly, 86% reported worrying about not being able to provide for their families’ the daily life necessities; this may help explain why transfers were spent on priorities other than SRHR.

**DISTRIBUTION**

In the PDM, all participants reported that the distribution process made them feel safe, secure, and protected. All participants said that they thought the process was well organized and that they were satisfied with the process. Importantly, 79% said the funds did not cause conflict in the home. In two of the three sites, SRHR awareness raising sessions were held for approximately 15 minutes during distribution. The topics included CARE’s programs and different SRHR topics (e.g. ANC, newborn care, healthy timing and spacing of pregnancies, and menopause).

**Facilitating Factors**

There were a number of facilitating factors that enabled a rapid pilot to occur under difficult circumstances. First, although the CARE team had many new staff, they were well organized and committed. Existing CARE programs enabled CARE staff to identify appropriate women for referrals, and the CARE helpline and scoring system assisted in ensuring that the selected women reflected those in greatest need of support. In addition, the team was able to implement a very flexible program, offering options of both distribution door-to-door (at home) or through the Social Development Centers, as well as offering participants the option of sending a representative. The flexibility allowed for a quick modification in delivery to ensure teams transferring funds were female staff.

**Challenges**

Many challenges reflected in the enormous stressors facing Beirut at large impacted the project—the repercussions from the explosion on the health and wellbeing of communities, the economy, housing, and infrastructure coupled with lockdowns due to COVID-19. These factors led to delays in project start-up and put staff under considerable pressure to deliver a pilot against competing priorities. Moreover, many of the staff were new to CARE and had to find the time to work together, become familiar with CARE and the pilot, and develop new tools and program materials. In addition, with the frequently changing strength of the LBP, it was difficult to select a reliable transfer value. Finally, although the CARE-supported Social Development Centers were selected as a venue for distribution because women were already attending programs there, there was confusion as to exactly where the funds were being distributed in the building. There was not enough space to offer SRHR information sessions for all sites and this was further exacerbated by COVID-19 gathering limitations. Staff also expressed concerns about the lack of privacy when delivering the funds to each participant.
Lessons Learned

Unrestricted cash transfers may be used for other unmet needs. The cash transfers were not spent on SRHR by nearly half the recipients – meaning that SRHR was either not a priority for some recipients, there were other competing priorities, or recipients were not well-targeted. In terms of priorities, it is likely that the economic situation for vulnerable communities in Lebanon deteriorated so significantly that many felt they had to prioritize family needs like shelter and food over SRHR. Gender and social norms contribute to nearly half of the recipients reporting men as decision-makers on health-seeking although, in all cases possible, CARE sought provide cash transfers directly to women including, in some cases, doing so without the knowledge of the recipients' families due to safety concerns.

Scoring criteria can account for both protection and SRHR needs. In terms of targeting, it is worth noting that the scoring criteria considered integrated protection and SRHR needs, rather than SRHR needs alone, to facilitate meeting holistic needs of recipients. CARE staff suggested exploring other avenues, such as obtaining referrals from health providers for patients who would be more certain of facing financial barriers to meeting SRH needs. However, staff preferred to give UCTs that allowed the participants to prioritize their own needs.

CVA recipients may benefit from complementary services, such as information sessions, that address norms. It was also noted that women receiving cash transfers would benefit from longer and more frequent SRHR information and education sessions (complemented by dialogue sessions for addressing gender and social norms that hinder access to SRH), including referrals for specific services during distribution. During the SRHR information sessions provided prior to distribution, CARE staff noticed that the majority of women had never visited a gynecologist or midwife, either due to a lack of awareness or the means to do so. Although most married pregnant women in Lebanon do have a gynecologist, stigma and gender/social norms hinder access to care for other groups (such as unmarried and younger women and adolescents). Overall, a key takeaway of this pilot is that although SRHR had been identified as a major need prior to COVID-19 and then further exacerbated by the port blast, it is critical to support ongoing engagement not only on SRHR awareness but also on addressing gender and social norms for more equal decision-making on household expenditures for meeting SRH needs when resources are limited.

Recipients may experience unanticipated costs that should be accounted for in cash transfers. The PDM highlighted that there were unexpected costs for women in receiving the funds, including transport costs if taking a bus or taxi, and time lost to collect the funds. This could have been averted by including the question in the needs assessment.

Adaptability is key in meeting needs in complex environments. Although a partner was originally selected to refer participants in the program, the effort required to build that collaboration was not possible within the project timeframe. Instead, CARE’s ongoing programming allowed for the targeted number of referrals, which worked well and demonstrated CARE’s own referral mechanism through its helpline and coordinating capacity. During the beginning of the distribution, some women receiving the cash transfer felt discomfort in receiving funds from mixed gender teams; distribution was quickly revised to ensure that all CARE teams conducting distribution were women. Because of the multiple layers of crises and the complexity of the Beirut blast response, it was difficult to confirm if the targeted participants were receiving other support and if they were what it was.
5. SOMALIA: CASH TRANSFERS VIA MOBILE MONEY FOR MCH SERVICES

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>Puntland (Badhan Somaliland, Yubbe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODALITY &amp; SRHR OUTCOME</td>
<td>Unconditional cash transfers (UCTs) for maternal and child health (MCH) services and transport</td>
</tr>
<tr>
<td>TIMELINE</td>
<td>September – December 2020</td>
</tr>
<tr>
<td>TARGET POPULATION</td>
<td>Pregnant women in the last trimester of pregnancy</td>
</tr>
<tr>
<td>TRANSFER AMOUNT</td>
<td>Three monthly transfers</td>
</tr>
<tr>
<td></td>
<td>Puntland – 80 USD per month</td>
</tr>
<tr>
<td></td>
<td>Somaliland – 100 USD per month</td>
</tr>
<tr>
<td>MONITORING</td>
<td>Three 3 monthly post-distribution monitoring (PDM); pre/post knowledge, attitudes, and practices (KAP) survey; pre-post focus group discussions (FGD)</td>
</tr>
<tr>
<td>DELIVERY MECHANISMS</td>
<td>Mobile money</td>
</tr>
<tr>
<td>REACH</td>
<td>70 women</td>
</tr>
</tbody>
</table>
Background

CARE Somalia has used CVA in its programs for over ten years. This includes CVA for food security and livelihoods, nutrition, WASH, and education, as well as MPC transfers. Since 2018, with support from Office of Foreign Disaster Assistance (OFDA) (now the Bureau for Humanitarian Assistance (BHA)), CARE Somalia has been implementing a food security and Livelihoods, health, nutrition, protection and WASH program. With BHA support, CARE currently supports 19 MCH facilities across Somaliland and Puntland that target children and pregnant and lactating women (PLW).

Program Design

Drawing on its vast experience with CVA in other sectors and with support from the Sall Family Foundation, the CARE Somalia team developed a pilot project with the objectives of improving pregnant women’s access to at least three ANC visits and to delivery by skilled birth attendants. Target participants were pregnant women in their third trimester. Transfers were intended to cover costs related to safe deliveries and participants received three monthly cash transfers using mobile money through Telesom in Somaliland and Golis in Puntland.

IDENTIFYING NEEDS

The 2020 Somalia Demographic Survey underscored the high maternal mortality rate in the country (692 out of 100,000 live births) and pinpointed the biggest barriers to accessing MCH as: lack of money (65%), distance to health facility (62%), and lack of permission (42%). The survey also found that 79% of births take place at home, 31% of women had received ANC from a skilled health provider prior to their last birth, and 89% of women did not obtain postnatal care within two days of giving birth.

CARE staff at MCH facilities noticed a drop in the number of pregnant women doing ANC visits the further along they got in their pregnancy. To investigate further, CARE Somalia conducted a baseline MCH survey and FGDs on health knowledge, attitudes, and practices. The findings revealed that 48% of women preferred giving birth at home due for a number of reasons. In addition, spousal support influenced decision-making; in Yubbe, over 60% of women said their husbands made birth decisions. CARE Somalia designed a pilot project to address some of the financial barriers and support some of the MCH needs with CVA.

Transfer Values and Mechanisms

To ensure that the pilot was market aware, CARE Somalia utilized the MERS benchmarking tool. This provided guidance on what good market programming looks like and what to consider when developing the concept note. With this guidance, a targeted rapid market assessment was conducted in the two locations to determine the cost of ANC services and related costs for safe delivery. From the targeted market assessment, the transfer values were set at 100 USD and 80 USD for Yubbe and Badhan, respectively. These values were estimated to be the cost of the services not offered at the MCHs that were critical to safe pregnancy and delivery.

Although ANC, postnatal care (PNC), and normal delivery at MCH centers are free, the CVA aimed to cover transportation costs to the MCH centers and to referral hospitals as well as other comprehensive SRH services that are key for safe pregnancy, such as laboratory tests in the last trimester (e.g. syphilis screening, testing for anemia, etc.), ultrasounds, and blood transfusion in case of caesarean section. In addition, the transfer was intended to cover nutritious food, like

34 Ibid.
36 High costs at hospitals, lack of transport, distance to facility, concerns with privacy at the facility, lack of information, concerns with cleanliness and hygiene at the facility, perceived better care from Traditional Birth Attendants (TBAs)
37 Ibid.
fresh meat, poultry, fish, and vegetables available in the local market, particularly given the high rates of malnourished pregnant women in Somalia. In addition to the cash transfers, CARE also worked with two referral hospitals to cover costs for ten complicated pregnancies with a cap of 350 USD per participant.

The project adopted CARE Somalia’s CVA Standard Operation Procedures (SOPs) guidelines developed the COVID-19 pandemic to ensure the safety and wellbeing of CARE staff, partners and beneficiaries. Adjustments were made for participant selection criteria, transfer value selection, and monitoring.

CARE Somalia selected two health facilities for the intervention, one in Yubbe, Erigavo District, Somaliland and one in Badhan, Badhan District, Puntland. These locations were selected based on the following criteria: highly trafficked CARE-supported MCH facilities, facility proximity to the catchment populations, and ongoing engagement with communities through nutrition programming. Furthermore, there was an interest in comparing peri urban (Badhan) to rural (Yubbe) facilities. The selected facilities also had referral mechanisms for GBV survivors to access CMR and other relevant GBV services at hospitals with CARE-supported nurses and protection centers, case managers, and psychosocial counselors with longstanding relationships to the communities. Moreover, CARE has memorandums of understanding (MOUs) with both governments and strong relationships with the communities, including community health committees.

TARGETING PARTICIPANTS

Based on the available budget and the project objectives, 70 pregnant women were targeted (35 per location). Participants were identified using the ANC registers in consultation with healthcare staff and community leaders utilizing predefined selection criteria. As part of the project launch, CARE staff met with community health committees to orient them to the project goals, including offers of services.

Selection criteria focused on women who were:

- In last trimester of pregnancy;
- Considered malnourished;
- From a household where the head of household was unemployed/not working;
- Experiencing high risk pregnancies (geriatric/adolescent pregnancy, previous scarring, pre-eclampsia, diabetes, multiple births);
- Engaged in negative coping mechanisms such as selling firewood/charcoal (either the recipient or members of her household);
- Without any income or asset ownership;
- Recently the recipients of assistance from other sources.

Potential participants did not need to meet all of the selection criteria; women needed only to be pregnant and, preferably, in their last trimester. The other criteria were used for a scoring system; the higher the scores (indicating a greater fit with selection criteria) the higher the chances these women had to be selected as participants.

<table>
<thead>
<tr>
<th>TABLE 3: MENU OF OPTIONS FOR UTILIZING CVA FOR PREGNANT WOMEN</th>
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<tbody>
<tr>
<td>Transportation costs to hospital (roundtrip) and the MCH</td>
</tr>
<tr>
<td>Laboratory test in the last trimester</td>
</tr>
<tr>
<td>Ultrasounds (2)</td>
</tr>
<tr>
<td>Caesarean section delivery and basic emergency obstetric care (EmOC)</td>
</tr>
<tr>
<td>Blood transfusion</td>
</tr>
<tr>
<td>Allowance for fresh meat, poultry, fish, and vegetables</td>
</tr>
</tbody>
</table>
PROJECT ACTIVITIES

After selecting participants, CARE met with them as a group at each location. CARE had the mobile phone numbers of the women in the registers and the fact that mobile money is used a lot in these project locations made it easier to make the cash transfer. CARE received approval from each participant to receive cash transfers at their phone numbers in order to ensure safety, privacy, and ownership of the phones. The women attended the MCH twice a month where experiences and challenges were shared with other expectant mothers and staff. As part of ongoing programming, CARE-supported MCH centers continued to offer ANC services along with weekly education sessions. Topics for the awareness sessions included nutritious food, exclusive and complementary breastfeeding, the importance of delivery by skilled birth attendants, healthy timing and spacing of pregnancy, FP, and the involvement of husbands in ANC visits and during and after births. In addition to the ongoing engagement by project staff and participants through the MCH visits, an existing hotline for feedback on the project was shared with participants as a feedback mechanism.

The pilot also piggy-backed on the support CARE gives to the ANC mothers through the BHA funding where two midwives are paid incentives to be on-call overnight. This allowed for 24-hour care as typically, MCH facilities are only open during the day.

Outcomes

The first PDM included 70 respondents in-person at the facility or at home for those who had recently delivered. Sixty-nine participants responded to the second PDM and the endline KAP survey. Four FGDs were also conducted with women and adolescent girls. All findings were documented in the endline report.38

The monitoring results showed considerable positive changes from baseline to endline in MCH and SRHR attitudes and practices (See Table 4). There was a 48-percentage point increase in facility-based skilled birth attendance and a 38-percentage point increase in the perceived importance of visiting a facility before a birth. Awareness of methods to postpone pregnancy increased by 29-percentage points.

<table>
<thead>
<tr>
<th>TABLE 4: ATTITUDINAL AND BEHAVIORAL CHANGES FROM BASELINE TO ENDLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preference for delivering at a facility</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Perceived importance of visiting a facility prior to giving birth</td>
</tr>
<tr>
<td>Visits by pregnant women to health facility three or more times before giving birth (previous pregnancy at baseline; recent pregnancy at endline)</td>
</tr>
<tr>
<td>Awareness of methods to postpone pregnancy</td>
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<tr>
<td></td>
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<td></td>
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</tbody>
</table>

Joint decisions on FP in the household increased between baseline and endline KAP surveys. Men were directly included in the health information sessions, but some attended the with the women at their ANC visits and delivery. Men were, however, engaged during FGDs to inform program design (Figure 8).

KAP respondents (male and female) reported that participants were satisfied with the health system. The men interviewed in the FGD were a mix of project participants’ husbands and other community members. They reported a higher willingness to visit a facility for ANC services, a considerable change from baseline.

**DELIVERIES**

Ninety-four percent of participants delivered during the project period. Of those who delivered, 85% delivered at a facility – either the MCH facility or a referral hospital. Ten women who gave birth at night and/or were not able to reach the facility were able to call for in-person skilled birth attendance supported by midwives stationed at the MCH center. These outcomes are encouraging given that at baseline 54% of women in Badhan and 41% in Yubbe reported preferring home delivery.

In both Badhan and Yubbe, compelling stories of women who had never delivered at a facility were reported. One woman who had previously lost six babies during the last trimester and had previously delivered stillborn, was able to safely deliver her first live baby at a referral hospital in Somaliland.

**TABLE 5: LOCATION AND DELIVERY BY SKILLED BIRTH ATTENDANT DURING PROJECT PERIOD (DATA AS OF JANUARY 4, 2021)**

<table>
<thead>
<tr>
<th></th>
<th>Total Delivered</th>
<th>Basic and/or Comprehensive EmOC at Referral Hospital</th>
<th>Normal Delivery at MCH center</th>
<th>Birth at Home (Supported by Midwives/Skilled Birth Attendants Stationed at MCH Centers 24/7)</th>
<th>Births at Home with TBAs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Badhan, Puntland</strong></td>
<td>32</td>
<td>8</td>
<td>18</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Yubbe, Somaliland</strong></td>
<td>34</td>
<td>4</td>
<td>26</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

CARE staff reported that the pilot strengthened the referral system and greatly increased women’s confidence in contacting midwives and accessing health facilities. In addition, staff reported that the transfer relieved the heavy financial burden on families that had been exacerbated during the outbreak of COVID-19. Staff also reported that women attending the education sessions spoke of sharing information with other women who were not participants.
Facilitating Factors

There were a number of factors that supported such a rapid and effective pilot. The program was integrated into existing nutrition programs run through the facilities so the trust that had been established with communities and relationships that had been built with women, their husbands, families, and communities. In addition, it was helpful that a very clear need and gap in services and access had been established providing a clear target in terms of financial and transportation hurdles to accessing MCH. This was made even more important after the onset of COVID-19 when families were under even more financial constraints.

In addition, the modality and distribution of monthly mobile money transfers was well established within CARE’s programs and infrastructure, but also as a form of receiving money among communities since mobile money transfers are common in Somaliland and Puntland. The delivery mechanism is widely used and accessible for participants to receive and spend the transfers at no cost to themselves.

The pilot also leveraged existing MOUs and relationships with the MOH, referral hospitals, MCH staff, and community health committees. In addition, it worked with existing contracts for transport and the phone service. In the facility, the pilot expanded existing health education sessions to include SRHR, worked with facility staff to expand monitoring tools, and worked with midwives to widen their scope of work to be on call at night for deliveries.

Awareness sessions also created space for greater one-on-one engagement between project participants and health providers to build up trust between them, for providers to remind participants about upcoming appointments, and for ongoing feedback on the CVA and any other needs.

Challenges

Challenges were related to the limited amount of time allocated for the design and implementation of the pilot. The PDMs ideally would be conducted one month after the distribution; however, delays in start-up shortened the time between PDMS, resulting in survey fatigue among recipients. In addition, the pilot was conducted in two different government systems, requiring the same approval process in each location and in locations where mobility can be constrained by security concerns. Only 70 women could be enrolled due to funding limitations, despite the high need in the communities. Lastly, particularly in Puntland, the COVID-19 outbreak and related restrictions added difficulties for staff and participants related to mobility and ability to reach facilities or communities.

Lessons Learned

CVA for SRH should be combined with complementary services to address complex issues. The pilot revealed that CVA for SRH when complemented by ongoing community-level engagement and awareness raising is not only feasible but also extremely effective in improving positive health-seeking behaviors for SRH. In just three months, the pilot project in Somalia not only demonstrated increased uptake of the key project objectives (to ensure access to at least three ANC visits and skilled birth attendance), but also highlighted key attitudinal changes related to greater preference for facility-based delivery and the perceived importance of facility-based deliveries.

Despite being unrestricted, the cash transfers motivated the project participants to seek services at the MCH and reduced barriers to access like transport in seeking services, contributing to increased uptake in ANC services and delivery by skilled birth attendants. Ongoing engagement through educational sessions and strong monitoring through the PDM process had several benefits. This process revealed the perceived financial barrier of cost of services like ANC while the educational sessions provided a platform to dispel this misinformation and raise awareness of the availability of free services at the MCH center. Furthermore, ongoing engagement facilitated trust building between
participants and health providers, as demonstrated by pregnant women contacting midwives to assist even with home-based deliveries. Qualitative feedback also indicated that the unrestricted nature of the cash transfer supported women in birth preparedness and planning and in purchasing nutritious foods. Overall, this pilot indicates the potential for positive changes related to decision-making and that perceptions of SRHR can be achieved from an integrated program. These findings will need to be supported with further programming and integration of CVA within SRHR programming to sustain the attitudinal and behavioral changes.

Engaging stakeholders and community groups is key. Engagement of other household-level decision makers – including husbands and mothers-in-law – would be helpful given their role in delivery-related decisions. In addition, TBAs should be engaged to support through awareness raising on SRHR topics, addressing perceived and real financial barriers, and providing referrals. Staff also spoke of expanding the targeting to be more inclusive of women who had not yet accessed the MCH facility, including those who are seasonally mobile, who have disabilities, who lack permission to seek facility care, or who have negative perceptions of facility births and SRHR. It is also helpful to work through existing community platforms (like mother-to-mother support groups, female health workers, and other existing programming) for awareness raising on SRHR topics as well as on availability and location of free services. Finally, staff expressed that, although protection was considered in program design, it was not formally assessed, and protection staff should be engaged more to ensure considerations at every stage of the program.

Increasing demand requires simultaneous attention to supply availability and quality. The pilot also highlighted the concern that increasing demand requires simultaneous increases in service provision – through training and/or recruitment of staff and increasing supplies and equipment. Staff voiced concerns that facilities need to ensure they can welcome a growing number of women for deliveries. Moreover, midwives who were on-call 24/7 for women who went into labor at night relied heavily on their ability to have network connectivity. There were ongoing concerns about the lack of full range of needed services including services for emergency obstetric and newborn care, essential drugs during delivery, FP services (including long-action reversible contraceptives), HIV testing and counselling services and ultrasounds at the MCH.

There are opportunities for growth and expansion of CVA for SRHR programming. Staff also reported a desire to expand the program to cover transport costs for seeking CMR and to complement CVA for SRHR programming with psychosocial support. This desire was based on community’s, and especially women’s, needs. Additionally, the modality could be considered for FP and postpartum family planning (PPFP) opportunities and health considerations should be expanded for issues like high blood pressure.
6. CONCLUDING REMARKS

Discussion

CARE’s review of four distinct uses of CVA for SRHR outcomes in humanitarian contexts contributes considerably to a nascent knowledge base on the subject, especially focusing on process and design. The case studies demonstrate that the use of CVA for SRHR outcomes is feasible in sudden onset and protracted crises, although various elements will contribute to the potential reach, speed, and ultimate impact of the interventions. Based on the available evidence on the use of these modalities for SRHR outcomes, these case studies support existing knowledge, while highlighting some new findings. For CARE, the review has identified a few critical issues that need to be included in the design of interventions with CVA for SRHR outcomes to ensure that it is adheres to global promising practices and meets CARE’s ambition for gender sensitive in design and outcomes.

Partnerships: One of the most critical elements in each of the country contexts was the presence of partnerships with various actors, who could and did contribute to the robustness of the offering. In Ecuador, Colombia, and Somalia, teams worked public and/or private providers of healthcare, enhancing demand for and confidence in the services to which the populations were entitled. In Ecuador and Colombia, the teams leveraged the local expertise of national actors, such as the Red Cross and national NGOs, and governmental entities (local officials, health departments, etc.) to target and connect participants to SRHR services. In Ecuador, partnerships with two local organizations, Alas de Colibrí and Dialogo Diverso, helped identify high risk and marginalized populations in need of SRH services. In Lebanon, CARE acted as a clearing house on locally available providers of SRH services in Beirut. In Somalia, the intervention supplemented CARE’s efforts to strengthen the government health system.

Technical capacities: The case studies clearly demonstrate that where CARE and partners had existing capacity in health and CVA, the program design was stronger. Ecuador and Somalia are two of the CARE countries of presence with the
most CVA projects and the highest volumes of transfers across the CARE Confederation.\textsuperscript{39} CARE Lebanon’s team had been undergoing a month long capacity review on its CVA capacities and processes; when the blast occurred, this learning was fresh in their minds. The trend is similar for SRHR as well. CARE Colombia was exceptional in that the country program was relatively new in its operations; both CVA and SRHR were intentional areas of focus in building the team and for technical support because of gaps CARE had previously identified at the response level. CARE Ecuador and Somalia both have long-standing SRHR programming and in-country capacity. While CARE Lebanon has strong protection capacity, CARE is not seen as a “SRHR/health actor” in the country. Therefore, partnering with local health organizations may have been helpful in strengthening the intervention.

**Targeting:** Appropriate targeting is always a contentious issue for interventions with CVA. In CVA that seeks to contribute to health outcomes, targeting is even more challenging as no two people will have the same health needs. This was previously highlighted in UNHCR’s experience with modalities for health outcomes.\textsuperscript{40} In the case of the pilot in Somalia, the very narrow focus for participants aided in solid and simple targeting. In the three other contexts, the majority of potential participants were in unstable living conditions (Lebanon), in conditions of mobility and forced migration (Ecuador and Colombia), or extremely difficult to target as a result of other marginalized characteristics (e.g. GBV survivors, LGBTQI community members, etc.). In Colombia, Ecuador, and Lebanon, CARE used multi-layered approaches to sensitizing potential participants, their communities, peer agencies, government actors, and local agencies. It is not clear which of the methods, including mass outreach through social media, was most effective in spreading the word; this could be quickly studied by including the question “How did you hear of this programming?” in the PDM.

**Timeframe and consequent ability to adhere to general programmatic good practice:** CARE Lebanon had approximately one month to design and implement this intervention in response to a more “acute” emergency as a result of the Beirut Blast. The other contexts are protracted emergencies. This allowed the other three contexts to take additional steps for program design and planning, including monitoring, evaluation, and learning. Moreover, the additional time allowed for adherence to complementary interventions that are key to good practice:

**Community participation along the program cycle:** Community participation through assessments and program design (e.g. through FGDs and KAP assessments at registration for Somalia), were key to designing interventions responsive to the needs of affected communities. In Colombia and Ecuador, assessments raised the need for accompaniment by CARE-staff or trained community focal points, which became a critical factor for overcoming perceived barriers of discrimination by health staff related to legal status or other reasons.

**Strengthening existing systems and shifting social norms:** Furthermore, given the stigma around many SRH services and a lack of prioritization of using SRH services when decision-making on household expenditures is largely controlled by men, it is crucial for any SRHR programming to be complemented by addressing gender and social norms. In Somalia, where sufficient time was available for planning of the intervention, the cash transfers were complemented by small group awareness raising, discussion on gender and social norms within the household, and confidence building for women. This played a role not only in shifting attitudes around SRHR norms, but also built trust in the health system, particularly the midwives who were called upon for delivery support when women could not get to the facility. It is worth noting that the reality of programming for “people on the move” usually does not allow for sustained engagement to address complex issues. It is also important to acknowledge that lack of information on availability of free services was identified as a barrier, reinforcing the importance of updated, localized information through awareness raising and outreach addressed through the pilot programs.

**Rights-based approaches:** Adhering to principles of privacy and confidentiality through approaches like direct transfer of cash in Somalia and preferred delivery mechanisms for cash transfers in Lebanon were marks of good CVA for SRHR.

\textsuperscript{39} Based on internal CARE fiscal year 2020 data (July 2019–June 2020).
\textsuperscript{40} UNHCR. (2020). The Role of Cash Assistance in Financing Access to Health Care in Refugee Settings and for other People of Concern to UNHCR.
programming. Similarly, in Colombia and Ecuador, although the context required a restricted transfer, the vouchers enabled providers to screen and identify for other needs and services; this facilitated access to a broader range of services aligned with rights-based approaches. The disadvantage of this modality is in the inefficiencies in reconciliation, or aligning the redemption of vouchers for payment to vendors, adding burden to the field and program support teams and service providers.

**Adherence to CVA standards:** All four case studies demonstrated the importance of using frameworks that are good practice for CVA programming: SOPs and monitoring processes and satisfaction. Two of the projects used a market lens by applying the MERS, and all used SOPs designed specifically for the delivery mechanisms. Adapted market analysis – ranging from in-depth to “quick and dirty” – were used by the teams, which is a key step in using CVA. While this seems obvious to the CVA practitioners and SRHR experts systematically do similar assessments (e.g. mapping of service providers), the understanding of what market assessments need to look like are quite different among these two groups of specialists. In each of the contexts, the teams were accompanied by both CVA and SRHR technical advisors to backstop the assessment processes.

Linked to the assessments are the transfer values. For each context, these values were based on the best available information for SRH goods and services. The flexibility of the design, whether an “up to” value voucher or a cash transfer, allowed teams to meet the needs of the populations with few limitations. A common challenge in attempting to design such programming is that health needs are rarely considered in Minimum Expenditure Basket (MEB) calculations. As a result, the implementing agency needs to set the rate based on boutique market analyses. The transfer value can be different than the values used at coordination or national levels, and the result may require significant justification to peers and government. Such challenges are not insurmountable but add another layer to planning and design.

**Meeting holistic needs:** The case studies also underscore the importance of meeting the holistic needs of crisis-affected populations. In Ecuador, CVA support for SRHR was complemented by other sectoral interventions and referrals, including MPC transfers. Participants in Somalia also benefited from other CARE-supported interventions on food security, health, and nutrition. In Lebanon, CARE was supporting other larger protection needs of the affected population. This also demonstrates the importance of offering MPC (for and alongside often stigmatized SRH services). Furthermore, modalities that are less restricted also enable individuals to choose where and from whom to seek services.

**Addressing quality – the “supply” aspect of services:** In addition to improving “demand,” addressing barriers to access for SRH services, as undertaken in Ecuador, Colombia, and Somalia, it is critical that quality of services is ensured, such as technical competence of providers, respectful attitudes of health staff (including addressing xenophobia and ensuring dignity for all without discrimination based on sexual orientation, gender identity, age, or other characteristics), rights-based approaches, and availability of a full range of supplies. Beyond learning from these case studies, it is critical to ensure that health facilities are prepared to take on additional demand as a result of CVA interventions while maintaining quality services. Moreover, it is important for the humanitarian community to continue learning from CVA interventions that seek to improve quality of health services.

**Monitoring and evaluation:** In most of the programs, monitoring was limited and did not lend itself to a deep understanding of SRHR outcomes. Each intervention monitored, at minimum, a focus on satisfaction, use of the transfer, and the types of goods and services sought. Although all of the interventions used some form of gender-focused analysis to form the programs (e.g. RGAs), there was limited use of baselines to delve deeper into needs, opportunities, and challenges specific to the modalities and delivery mechanisms. The Somalia pilot had robust monitoring, though perhaps overwhelming for participants given the short timeframe. In the case of Lebanon, information on decision-making and transportation costs arose in the PDMs; this information could have been better collected at intake to influence the transfer values and sensitization. One area of improvement for monitoring is to involve service providers, to understand the extent

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of change in their knowledge, attitudes, and practices based on the awareness/training sessions that CARE provided. This will also be important to consider for participants in the medium to long term (e.g. health seeking behavior). In Somalia, another KAP study with the populations at a later date might help reveal longer term impacts. Lastly, though the outcomes of the programs were gender sensitive by design, there is only anecdotal evidence of the gender sensitivity of the processes. As this is a priority for CARE, the organization will need to find ways to ensure that it is a more integral part of design, implementation, and monitoring in the future.

How will these learnings transform CARE’s SRHR programming?

■ Create SRHR-specific guidance on how to assess, design, implement, and monitor in ways that align with standards of good practice on CVA and MISP/IAFM for SRHR, and that build on CARE’s gender-sensitive approach.

■ Bring communities of practice – CVA, SRHR, gender, and program support – together at the design and implementation stages to offer interventions that meet global and CARE good practices and that are efficient for participants and CARE staff.

■ Systematically use a “cash plus” or multi-modal response for any SRHR that includes CVA, with a strong emphasis on using social norms analysis (e.g., KAP).

■ Commit to a learning agenda that will inform how CARE uses CVA as complementary modalities to its broader health, equity, and rights ambitions.

■ Create learning spaces in CARE that allow for the exchange of ideas and experiences on CVA for SRHR in all of CARE’s four working languages (Arabic, English, French, and Spanish).

■ Explore SRHR programming with CVA that addresses both supply and demand.

CARE, as part of the humanitarian and development community, will also promote at global, country, and response levels:

■ The inclusion of market focused SRHR questions in interagency needs assessments and MEBs;

■ The inclusion of market-based approaches as part of SRHR response analysis;

■ Highlighting the needs and gaps in support of SRHR that could be covered by interventions with CVA; and

■ Systematic training for interdisciplinary teams on CVA for SRHR outcomes, ensuring a gender-sensitive approach to the use of the modalities in the sector.