NORTHWEST SYRIA

Expanding The Evidence Base On Cash, Protection, GBV And Health in Humanitarian Settings

A comparison of individual protection cash assistance and dignity kits in Northwest Syria

The United Nations Population Fund (UNFPA) and the Johns Hopkins University (JHU) Center for Humanitarian Health have launched a collaboration to examine the role of UNFPA cash and voucher assistance (CVA) in the response to gender-based violence (GBV) response, sexual and reproductive health (SRH) access and protection for women and girls in humanitarian settings.

The two year-partnership (2021-2023) includes technical assistance, expanded monitoring and evaluation and research, focusing on approximately six countries where UNFPA has ongoing programs. This allows for an analysis of cash programming and outcomes across a variety of settings, with the goal of generating an evidence base on cash programming that can inform decision-making and humanitarian program design both within UNFPA and more broadly in the countries and sectors of focus. In order to examine cash assistance programming outcomes and impact pathways, the collaborative research uses a mixed-methods approach using both quantitative surveys and in-depth interviews with beneficiaries.

UNFPA Syria Country Office

UNFPA

JOHNS HOPKINS
CENTER for
HUMANITARIAN HEALTH

Evaluation Overview

The study was conducted in mid-2021 and included 431 women in Idleb Province that received either Individual Protection Assistance (a single unconditional cash transfer of US$100-120) or a dignity kit (hygiene items valuing approximately US $20) from UNFPA and its implementing partners in early 2021. Interventions were intended to provide immediate assistance and serve as an entry point for accessing services. Questionnaire-based interviews were conducted at intervention receipt and again approximately two weeks later; a sub-sample of IPA recipients also participated in qualitative interviews. Key findings were as follows:

- **Reduction in depression among IPA recipients (41.6%) was significantly greater than among those receiving dignity kits (16.4%) (p<0.001).**
- **The proportion of women reporting they no longer felt unsafe in their homes decreased significantly more among IPA recipients (11.9%) as compared to dignity kit recipients (3.7%) (p<0.001).**
- **Nearly all IPA recipients (98.6%) reported feeling safe receiving transfers and cash was the preferred modality for future assistance.**

Introduction

Over ten years of war and protracted humanitarian crises in Syria has taken its toll on local populations. As of 2021, 13.4 million people are in need of humanitarian assistance in Syria, including 6.7 million internally displaced people from the war that has been ongoing since 2011.[1] The COVID-19 pandemic, drought, and economic deterioration throughout Syria have all exacerbated these needs. In northwest Syria, where 97% of the population lives below the poverty line and 2.8 million people are displaced, humanitarian needs continue to outpace the response. The conflict and ensuing disruptions have caused **3.2 million people** to become **acutely food insecure**, while **3.1 million people need health assistance**, and **2.2 million people need shelter assistance**.[2] The situation in northwest Syria continues to pose serious protection concerns for the civilian population. A lack of resources has continued to cause people to resort to negative coping mechanisms, and gender-based violence (GBV) is a dominant feature of the crisis, affecting the lives of millions of women and adolescent girls.

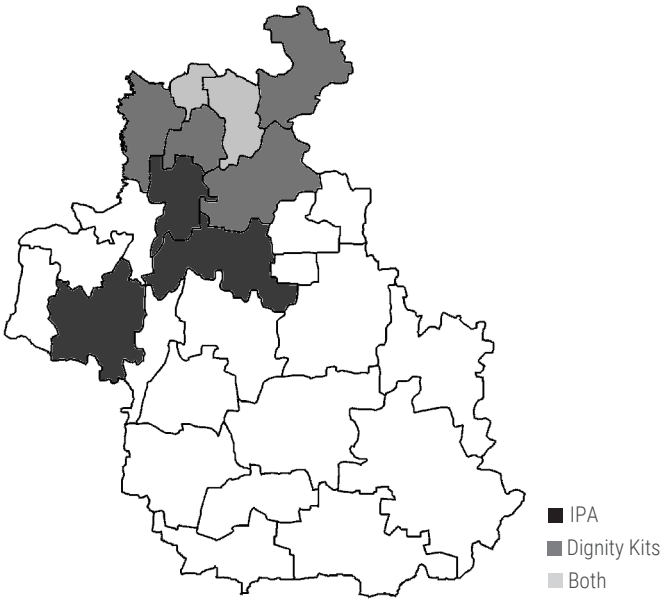
Traditionally, humanitarian aid to people affected by conflict and disaster has been delivered as in-kind aid – physical goods such as food staples. In contexts with functional markets, an alternative to in-kind aid is the provision of cash transfers directly. **Cash and voucher assistance may offer a number of benefits, including providing greater choice in how money is used to meet household needs, stimulation of local markets and greater cost-efficiency.**[3] Cash and voucher assistance has been successfully used in various humanitarian contexts to meet basic needs and can be restricted to certain types of spending (vouchers or conditional cash transfer), or given without conditions (unconditional or multipurpose cash transfer). **In 2020, an estimated US$6.3 billion was spent on cash and voucher assistance in humanitarian emergencies which translates to 19% of international humanitarian response spending.**[4] In northern Syria, cash is considered a acceptable and is a preferred modality to deliver aid.[5]

Given the cross-border approach of the humanitarian response in northwest Syria, UNFPA's program is implemented through established local Syrian NGOs.

Responding to the complex situation on the ground, UNFPA has been engaged in a long-term humanitarian emergency response providing lifesaving and life-sustaining Sexual Reproductive Health (SRH) and GBV services to those most in need through static and mobile service delivery points, including distribution of both in-kind and cash and voucher assistance. **UNFPA provides integrated SRH and GBV services to over one million women and girls in northwest Syria on an annual basis.** As part of 2021 programming in northwest Syria, UNFPA and its implementing partners worked in Idleb governorate to provide dignity kits and individual protection assistance (IPA), to those in need. In early 2021, UNFPA provided IPA assistance to 1,609 women and dignity kits to 11,074 women in Idleb; a secondary aim of both interventions was to provide information on locally available services and they were viewed as entry points for UNFPA-supported programming. IPA recipients were provided a single unconditional cash transfer of US$100-120 whereas dignity kit recipients approximately US$20 worth of hygiene and sanitary products, including items tailored to the needs of women and girls of reproductive ages. This evaluation was conducted to compare perceptions and outcomes between dignity kit and IPA recipients in Harim and Idleb Districts in Idleb Governorate with the aim of informing future UNFPA program decision making in Syria.

Methods

Figure 1: UNFPA Programming in Idleb



As part of routine programming in Idleb Governorate, UNFPA and its partners planned dignity kit distribution between January and March 2021 and IPA distributions between February and April 2021. Both groups also received information on locally available services, where the interventions were viewed as an entry point for UNFPA programming. In this evaluation, interviews were conducted when the intervention was received and again two to three weeks later, and changes in select indicators are compared between the pre/post-intervention periods. A short follow up period was identified because most participants were anticipated to use cash and dignity kit items immediately; in addition, the population is highly mobile. While all UNFPA program areas in Idleb were considered as potential study locations, Harim and Idleb Districts were selected due to the geographic overlap of dignity kit and IPA distributions and it was perceived as beneficial to have the two comparison groups residing in the same locations with access to similar services. An overview of intervention coverage in Idleb is presented in Figure 1.

At the time of study planning, a total of 2,908 IPA and 2,030 dignity kit recipients were planned to be served by UNFPA implementing partners between late February and April 2021. These figures served as the basis for sample planning and included IPA recipients in Harim district (sub-districts of Armanaz, Dana, Kafr Takharim and Salquin) and Idleb districts (Maaret Tamsrin sub-district) and dignity kit recipients in Harim district (Armanaz and Dana sub-districts) and Idleb district (Maarat Masrin district).

A total **sample of 440 participants** was proposed, including 220 in each comparison group, with an anticipated final sample of 400 (where 10% loss to follow-up is expected based on experiences with post-distribution monitoring). Only women with access to cellular phones were enrolled due to the need to conduct

follow-up interviews via phone. A stratified sample was used with 50% of the sample for each group allocated to Harim district and 50% to Idleb district (i.e. 110 women will be sampled in both intervention groups in each district). In Harim where programming encompasses multiple subdistricts the sample was further stratified by sub-district (i.e. for IPA transfer recipients, 25% of the sample in each of four sub-districts; for dignity kit recipients 50% of the sample in each of two sub-districts); within each sub-district, the sample was further stratified by community (i.e. if there are 3 communities, each was allocated 33% of the sample, 4 communities, 25% of the sample, etc.). Systematic sampling was used, where every nth recipient of a dignity kit/IPA in a particular location when data collectors were present were interviewed until the target sample size for the location is achieved (where n is the sampling interval and is determined by dividing the total number of recipients by the target sample size for the location).

It should be noted that due to set distribution timelines among UNFPA's implementing partners, which were contingent upon security considerations, it was not feasible to optimally match the comparison groups on key characteristics (e.g. camp vs. non-camp residence), however, **all participants were considered vulnerable by UNFPA criteria**. Of dignity kit recipients, 70% were displaced and 30% were from host communities, with priority given to pregnant women, nursing mothers, those with special needs, female-headed households and single women. IPA recipients were 90% displaced and 10% from host communities, with priority given to households headed by women or older adults, households with a disabled member or severe medical conditions, new arrivals without shelter, high-risk pregnant or lactating women without family support, and GBV survivors or those identified as at risk of GBV.

Data collection was conducted by Ihsan Relief and Development (IhsanRD), a UNFPA implementing partner. An in-person interview was conducted when either the cash assistance or dignity kit was received and the follow up interview was conducted via phone. The interviews were brief, averaging ~15-20 minutes in duration and focused on household economy, current needs, safety and access/use of safety resources, control/decision over money and perceptions/use of the intervention received. Oral consent was obtained prior to beginning interviews and data was collected on a secure tablet-based platform with numeric codes [in lieu of names] to ensure confidentiality. At the end of the post-intervention survey, IPA recipients (planned sample of 15-20) were invited to participate in an additional in-person qualitative interview to explore in more depth their participation/experience with cash assistance and its impacts on the household. Qualitative interviews were conducted by IhsanRD staff trained in qualitative methods and protection; interview transcripts were first produced in Arabic and later translated to English by IhsanRD staff.

Both de-identified quantitative and qualitative data were transferred from IhsanRD to JHSPH for analysis using a secure data sharing workspace. Quantitative analysis was conducted in Stata 13 and included descriptive statistics to summarize data (e.g. means, median, standard deviations) and examine patterns of change from pre- to post- for both groups. Chi-squared tests for comparison of proportions and t-tests for comparison of means were used in analysis, with p-values <0.05 considered statistically significant. Qualitative analysis was conducted using MAXQDA 2020, a software program qualitative interview data analysis to organize, code and analyze transcripts for key economic, health and safety themes associated with cash assistance.

Results

Baseline Demographic and Economic Characteristics

Baseline information collected included participant demographics, displacement status, income, and humanitarian assistance received in the prior month (Table 1, following page). Significant differences were noted at baseline between dignity kit and IPA groups for women's age, household structure and composition, residence location, and receipt of humanitarian assistance in the previous month. Dignity kit recipients were significantly younger than IPA recipients (mean age 31.7 vs. 37.0, p<.001) and were more likely to be living with a partner (77.1% vs. 47.5%, p<0.001) and less likely to be a female household head (16.8% vs. 55.8%, p<.001) compared to those in the IPA group. Both groups were similar in terms of household size (median of 6 in each group), and a median of one household member earned an income in both groups.

Table 1. Household Demographic and Economic Characteristics and Receipt of Humanitarian Assistance

		Overall (n=431)			IPA Recipients (n=217)		Kit Recipients (n=214)		p-value
		N	Point	(95% CI)	Point	(95% CI)	Point	(95% CI)	
Demographic Characteristics									
Women's Age (mean years)			34.3	(33.2-35.4)	37	(35.4-38.6)	31.7	(30.2-33.1)	**<.001**
Household size (mean)			6.7	(6.4- 7.0)	6.9	(6.3- 7.4)	6.5	(6.1- 6.9)	0.268
Female headed households		157	36.4%	(31.9-41.0%)	55.8%	(49.1-62.4%)	16.8%	(11.8-21.9%)	<0.001
Displacement status									
Displaced, living in a camp		299	69.4%	(65.0-73.7%)	39.6%	(33.1-46.2%)	99.5%	(98.6-100%)	<.001
Displaced, living outside a camp		112	26.0%	(21.8-30.1%)	51.2%	(44.4-57.9%)	0.5%	(-0.5-1.4%)	
Host community member		18	4.2%	(2.3-6.1%)	8.3%	(4.6-12.0%)	0.0%	(0.0-0.0%)	
Returnee (formerly displaced)		2	0.5%	(-0.2-1.1%)	0.9%	(-0.4-2.2%)	0.0%	(0.0-0.0%)	
Time in current location (displaced HH only)	< 6 months	25	6.1%	(3.8-8.4%)	7.1%	(3.5-10.7%)	5.2%	(2.2-8.2%)	0.562
	6-12 months	75	18.3%	(14.6-22.1%)	16.8%	(11.5-22.0%)	19.8%	(14.4-25.2%)	
	12+ months	309	75.6%	(71.4-79.7%)	76.1%	(70.1-82.1%)	75.0%	(69.1-80.9%)	
Household Economic Characteristics									
Monthly Income (USD)[1]	Median		26.1		26.1		26.1		---
	Mean		38.1	(33.4-42.8)	36.9	(30.8-43.0)	38.9	(32.2-45.7)	0.672
Top Quartile (≥58.8)		52	21.1%	(15.9-26.2%)	20.6%	(12.6-28.6%)	21.4%	(14.6-28.1%)	0.447
3rd Quartile (26.7-58.7)		51	20.6%	(15.6-25.7%)	23.5%	(15.2-31.9%)	18.6%	(12.2-25.0%)	
2nd Quartile (13.3-26.6)		56	22.7%	(17.4-27.9%)	25.5%	(16.9-34.1%)	20.7%	(14.0-27.4%)	
Bottom Quartile (<13.3)		88	35.6%	(29.6-41.6%)	30.4%	(21.3-39.5%)	39.3%	(31.3-47.4%)	
Current Debt (USD)[1]	Median		213.3		106.7		266.7		---
	Mean		881.4	(309-1453)	381.2	(2670-493)	1393.5	(241-2546)	0.082
	Any debt		84.7%	(81.3-88.1%)	83.9%	(78.9-88.8%)	85.5%	(80.8-90.3%)	0.636

		Overall (n=431)			IPA Recipients (n=217)		Kit Recipients (n=214)		p-value
		N	Point	(95% CI)	Point	(95% CI)	Point	(95% CI)	
Humanitarian Assistance									
Receipt of assistance (past month)[2]									
Any assistance		249	57.8%	(53.1-62.5%)	38.2%	(31.7-44.8%)	77.6%	(71.9-83.2%)	<.001
In-kind food		99	23.0%	(19.0-27.0%)	23.0%	(17.4-28.7%)	22.9%	(17.2-28.6%)	0.972
Cash transfer		80	18.6%	(14.9-22.2%)	2.3%	(0.3-4.3%)	35.0%	(28.6-41.5%)	<.001
Hygiene		45	10.4%	(7.5-13.3%)	5.5%	(2.5-8.6%)	15.4%	(10.5-20.3%)	0.001
Water/Sanitation		25	5.8%	(3.6-8.0%)	4.6%	(1.8-7.4%)	7.0%	(3.6-10.5%)	0.286
Non-food items		23	5.3%	(3.2-7.5%)	3.7%	(1.2-6.2%)	7.0%	(3.6-10.5%)	0.125
Highest Priority Unmet Need[3]									
Food		178	41.3%	(36.6-46.0%)	42.9%	(36.2-49.5%)	39.7%	(33.1-46.3%)	0.339
Debt Repayment		62	14.4%	(11.1-17.7%)	13.4%	(8.8-17.9%)	15.4%	(10.5-20.3%)	
Shelter		45	10.4%	(7.5-13.3%)	12.0%	(7.6-16.3%)	8.9%	(5.0-12.7%)	
Health Services		38	8.8%	(6.1-11.5%)	9.2%	(5.3-13.1%)	8.4%	(4.7-12.2%)	
Water/Sanitation		33	7.7%	(5.1-10.2%)	5.1%	(2.1-8.0%)	10.3%	(6.2-14.4%)	
Livelihoods		23	5.3%	(3.2-7.5%)	6.9%	(3.5-10.3%)	3.7%	(1.2-6.3%)	

[1] Amounts are in USD, using a conversion rate of 1 USD = 3750 SYP and 1 USD = 7.65 TYL; [2] Less than 5% reported receiving food vouchers, education, shelter, health or livelihoods assistance; [3] Less than 5% reported non-food items, education, hygiene or safety/security as a priority unmet need

Almost all participants (95%) reported that they were displaced and either living in a camp or a non-camp setting, however nearly all dignity kit recipients (99.5%) resided in a camp setting, compared to 39.6% in the IPA group (p<.001) (Figure 2). Length of displacement was similar between groups (p=.562), with 75.6% of participants displaced for more than a year, with an average length of displacement of one and a half years.

Dignity kit recipients reported higher levels of humanitarian assistance receipt in the preceding month, which is likely related to their concentration in camps which can be more easily targeted with assistance. Over 77% of dignity kit recipients reported receiving humanitarian assistance compared to 38% of IPA recipients (p<.001) (Figure 3). Overall, the most common types of assistance received were in-kind food assistance (23.0%) and cash assistance (18.6%); while food assistance receipt was similar between the two comparison groups, IPA recipients were significantly more likely than dignity kit recipients to report receiving [other] cash assistance prior to the UNFPA-supported transfer (35.0% vs. 2.3%, p<0.001).

To assess baseline socioeconomic differences, participants were asked to report household income in the past month and current debt. Incomes and debt amounts were reported either in US dollars (USD), Syrian Pounds, or Turkish Lira, and all amounts were converted to USD for analysis at a rate of 3750 Syrian pound per dollar and 7.65 Turkish Lira per dollar (local exchange rates at the time of data collection). **The average household income in the prior month was US$38.1** (CI: 33-43) and was similar between dignity kit and IPA groups (p=0.672). More than half of the participants in each group reported they were either unsure of how this income compares to a typical month or that their household has irregular income month-to-month. Overall, 84.7% of households reported that they had some debt, with a median of US$213 and a mean of US$881 (CI: 309-1,453). The average debt was higher in the dignity kit group (median $267, mean $1,394) than the IPA group (median US$107, mean US $381), however this difference was only marginally statistically significant (p=0.082).

Figure 2: Displacement Status by Group

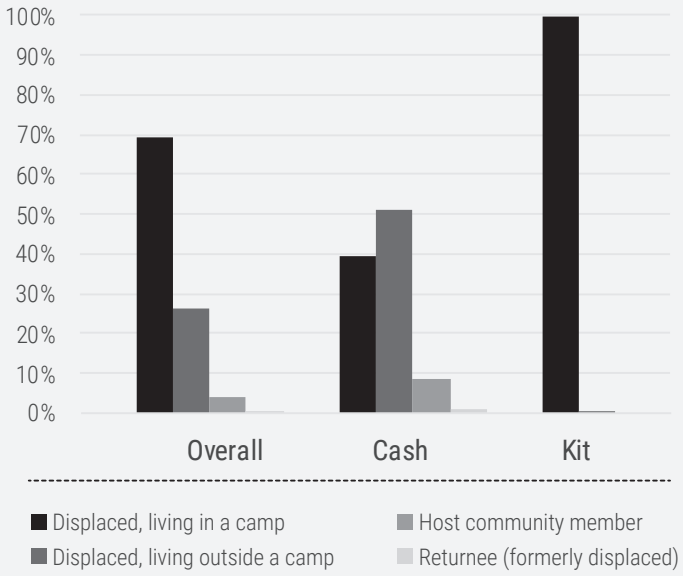
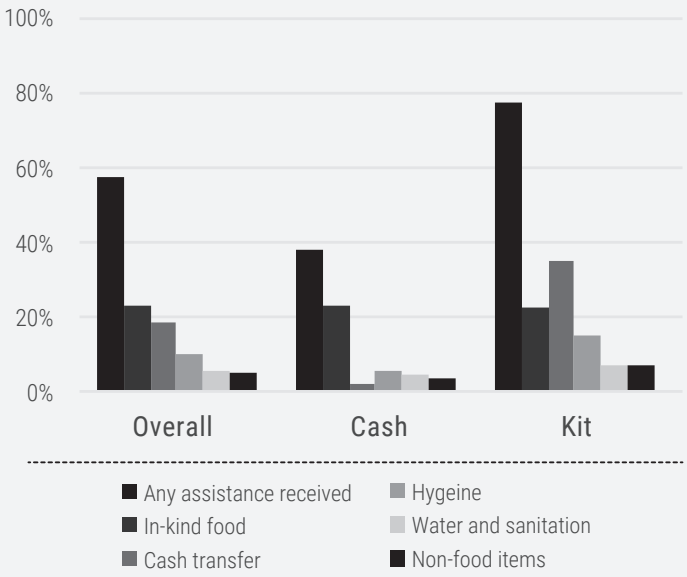


Figure 3: Humanitarian Assistance Receipt



Unmet Needs

Unmet needs were similar across both groups with **food being the most prominent unmet need**, reported by 41% of households (p=0.339). Other top priorities included debt repayment (14.4%), shelter (10.4%), health services (8.8%), water and sanitation (7.7%), and livelihood assistance (5.3%), with food, the top ranked unmet need being similar between groups (p=0.339). Unmet needs by group and survey period are presented in Figures 4 and 5 (following page). When asked to rank their top three unmet needs at baseline, three quarters of participants reported food as a key need, reflecting widespread food insecurity. This differed by group, with 80% of those in the IPA group reporting food as among their top three priorities, compared to 69% of those in the dignity kit group (p=0.006). Between baseline and the post-intervention survey, the proportion of IPA recipients that reported food needs decreased by 20%, while this proportion increased by 14% in the dignity kit group, suggesting that IPA recipients may have spent funds to address unmet food needs.

Debt repayment was second to food needs at baseline and was reported as among the three most important needs by half of participants, followed by shelter (31%), health services (30%), livelihoods (26%), and non-food items (22%). IPA recipients were more likely to report a need for hygiene items at end line than at baseline (16% vs 7%) whereas dignity kit recipients were less likely to need hygiene items at end line than baseline (11% vs 15%), suggesting cash transfers may not have been spent on hygiene needs. Needs for non-food items (NFIs) increased from baseline to end line in both groups (by 21% for IPA recipients and by 12% for dignity kit recipients), however the reason for this is unclear and could be attributable to reporting bias where respondents felt that reporting NFI needs could increase the likelihood of receiving future assistance.

Figure 4: Priority Unmet Household Needs (top 3 needs) Prior to Transfer Receipt

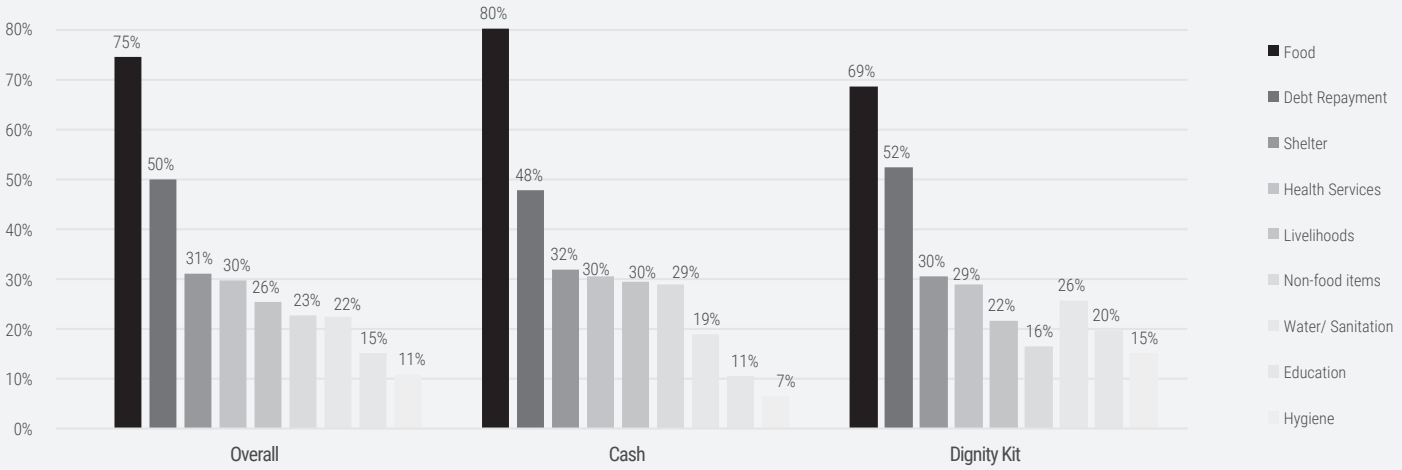
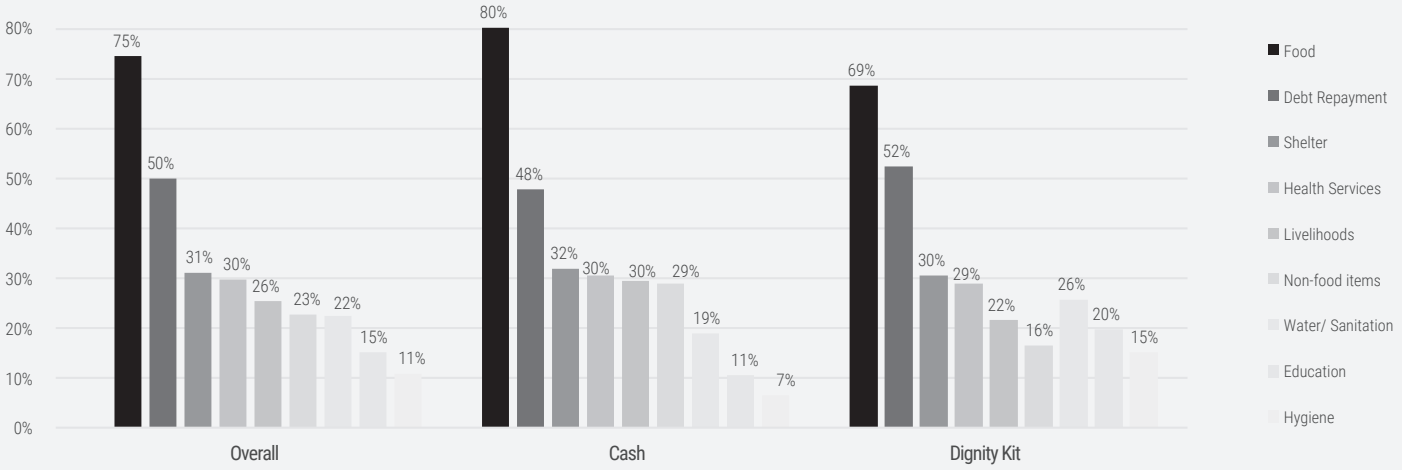


Figure 5: Household Needs (top 3 needs) After Transfer Receipt



Dignity Kit Perceptions

Perceptions and use of dignity kit items are presented in Table 2 (following page). Dignity kit recipients reported the most useful items included washing powder, shampoo, bath soap, dish washing liquid, and reusable pads. Most dignity kit recipients (77.8%) reported that there were no unnecessary items in the kit. The items that were most frequently reported as unneeded included a bath towel (5.3%), a comb (2.4%), dish washing liquid (2.4%), and shampoo (1.9%). Slightly over half (55%) of participants reported a need for additional items that were not included in the kit. Most participants kept all of the items in the kit for their own household, with 17.9% gifting some items to others outside the household and 2.9% reporting selling kit items. Among households reporting sales of dignity kit items (n=6), the average income from item sales was US$2.6 (CI: 2.1-3.5) and money from item sales was most frequently spent on food.

Cash Transfer Perceptions and Use

Overall, at least **73.2% of beneficiaries spent part of their cash transfer on food**, including 41.9% (CI: 35.2-48.5) that reported food was the largest expenditure and 31.3% (CI: 24.7-37.8) that reported food as the second largest expenditure. Debt was the second most frequent use of cash transfers, with 35.3% (CI: 28.9-41.8) and

16.9% (CI: 11.6-22.2) of households reporting as first or second highest expenditure type (52.2% total). Other frequent expenditure types, reported as among the two greatest expenditure categories included health (27.1% of households) and non-food items (24.6% of households). Expenditures in other categories including transportation, shelter, water and sanitation, education, and livelihoods were reported by <5% of households. Sharing of cash with other households was reported by 3.7% (CI: 1.2-6.3) of households; the mean amount shared was US $28.1 (CI: 13.3-43.5; median 26.1), or approximately one-quarter of the transfer value.

Table 2: Women's Perceptions of Dignity Kits (n=217)

	N	Point	(95% CI)
Perceived Usefulness of Items			
All needed items were not included in the kit	114	55.1%	(48.2-61.9%)
No unneeded items in kit	161	77.8%	(72.1-83.5%)
Most useful item[1]			
Washing Powder	59	28.5%	(22.3-34.7%)
Shampoo	36	17.4%	(12.2-22.6%)
Bath soap	22	10.6%	(6.4-14.9%)
Dish washing liquid	22	10.6%	(6.4-14.9%)
Reusable pads	22	10.6%	(6.4-14.9%)
Underwear	17	8.2%	(4.4-12.0%)
Among the three most useful items[1]			
Washing Powder	116	56.0%	(49.2-62.9%)
Shampoo	108	52.2%	(45.3-59.0%)
Dish washing liquid	87	42.0%	(35.2-48.8%)
Bath soap	75	36.2%	(29.6-42.8%)
Underwear	49	23.7%	(17.8-29.5%)
Reusable pads	44	21.3%	(15.6-26.9%)
Sanitary napkins	35	16.9%	(11.8-22.1%)
Items that were not needed			
Bath Towel	11	5.3%	(2.2-8.4%)
Comb	5	2.4%	(0.3-4.5%)
Dish washing liquid	5	2.4%	(0.3-4.5%)
Shampoo	4	1.9%	(0.0-3.8%)
Unused or unwanted Items			
Gifted to friends/relatives	37	17.9%	(12.6-23.1%)
Sold	6	2.9%	(0.6-5.2%)

[1]Other items that were included in kits but were not among the most useful items (reported by <5% as most useful and <10% as among top 3 included a hijab, bath towel, facial tissue, deodorant, razor, toothpaste, toothbrush, comb, baby wipes, flash light and backpack.

All the women (n=18) who participated in the qualitative interviews emphasized that cash was used to meet basic needs for the family. For example, one woman interviewed described the challenges in meeting her family's basic needs:

> ***"I wanted to buy food for the house like rice, sugar, bread, water, etc. but I had to leave the house where I used to live, so I moved into my husband's family house where five families lived. I could not live with them as my children were always hungry and the conditions were bad, so I had to rent a simple house using half of the cash value, while I used the remaining amount for paying some debts and for buying food for the house."***

As described above, a slight majority of IPA recipients (55%) were female head of households. One woman described the challenge of being the sole provider:

> ***"I am widow with little children; I have no supporter and I am responsible for the house expenses and everything. Moreover, my daughter suffers from an injury in her eye; she needs medicines and analyses; the cash help in a simple part of this. I have to take my daughter to hospitals and doctors but the transportations pose real challenges since I do not feel safe to get in others' cars. Safety is really important for this situation regarding my daughter's movement seeking the medical follow up. As I told you, we need everything; we get our needs through debts (food and children's needs); half of the cash was for repayment of debts, while the other half was used for my daughter's medicines."***

Table 3: Cash Transfer Use and Decision Making

Women from all Household Types (n=217)		
Mode of transfer	**Point**	**(95% CI)**
Hawala Agent	58.1%	(51.5-64.8%)
Cash in hand	41.9%	(35.2-48.5%)
Challenges in collecting transfer		
None	78.1%	(72.6-83.7%)
Needed male accompaniment	8.8%	(5.0-12.7%)
Travel time / distance	7.0%	(3.5-10.4%)
Transport costs	5.6%	(2.5-8.7%)
Other	2.4%	(0.3-4.5%)
Any problems with Cash transfer		
Tension with neighbors	0.9%	(-0.4-2.2%)
Tension with Husband	0.0%	--
Request to share with relatives	0.5%	(-0.5-1.4%)
Other	0.5%	(-0.5-1.4%)
Feels safe receiving cash	98.6%	(97.0-100.0%)
Cash Transfer Use		
Largest Expenditure		
Food	41.9%	(35.2-48.5%)

Women from all Household Types (n=217)		
Debt	35.3%	(28.9-41.8%)
Health	10.7%	(6.5-14.9%)
Non-food items	5.6%	(2.5-8.7%)
Second Largest Expenditure		
Food	31.3%	(24.7-37.8%)
Debt	16.9%	(11.6-22.2%)
Non-food items	19.0%	(13.4-24.5%)
Health	16.4%	(11.2-21.7%)
Women Living with their Partner (n=92)		
Husband was aware of transfer	84.7%	(79.8-89.5%)
Husband reaction was positive	97.8%	(95.7-100.0%)
Decision making on spending		
Woman	62.8%	(56.3-69.3%)
Both	30.2%	(24.0-36.4%)
Husband / male HH member	6.5%	(3.2-9.8%)
Other	0.5%	(-0.5-1.4%)

Most of the participants living with a partner (84.7%) reported that their husband was aware of the cash transfer and their reaction was reported as positive 97.8% of the time (CI 95.7-100%). One woman said, ***"It [cash] was of a very good effect on the family since we had something to cover the needs."*** Another woman described the positive reaction of her children, *"Imagine that when I bought them two kilos of apples, they danced with joy because they had not seen apples for a long time; I cried for the scene."*

The overwhelming majority (98.6%, CI: 97.0-100) of IPA recipients reported feeling safe receiving cash, and <1% reported tensions with their spouse, neighbors, or requests to share with relatives. **Over three-quarters of participants reported that there were no challenges in receiving their cash transfer.** The main challenges reported were the need for male accompaniment (8.8% of participants), travel time (7.0%), and transportation costs (5.6%) (Figure 6).

Many women participating in qualitative interviews detailed their positive experiences and feelings of comfort and safety when obtaining the voucher and then receiving the cash:

> ***"When they came to my house and gave me a voucher, I was very satisfied and comforted. Furthermore, during reception of the cash, I felt even safer as they took me in a car and picked me back to my house; the female staff members were kind with great welcome; they were happy as if the voucher was for them; their happiness was reflected on my feeling; the treatment was excellent."***

Among women living with their partner, the majority (62.8%) reported they were singular decision makers on transfer use and 30.2% reported joint decision making; only 7.0% of women reported they were not engaged as a primary decision maker on use of cash (Figure 7).

Figure 6: Difficulties reported in collecting cash transfer

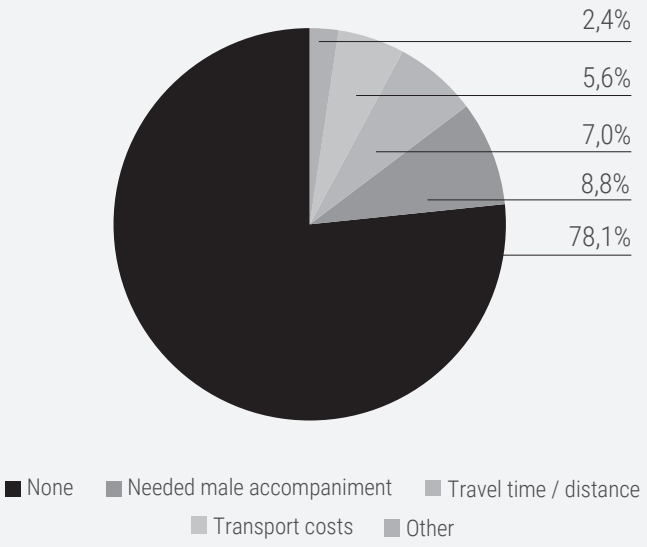
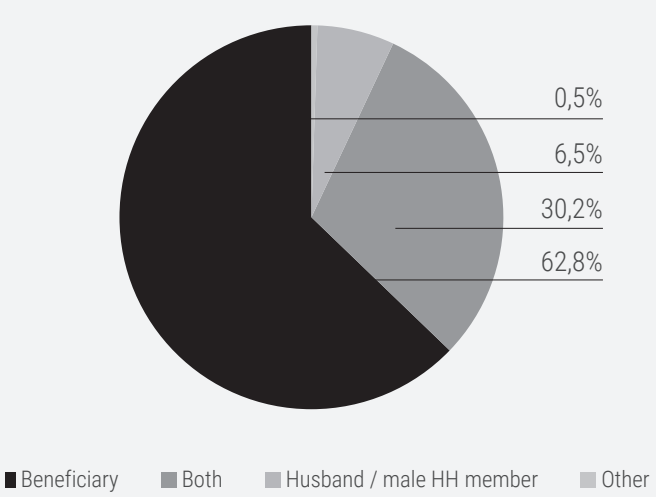


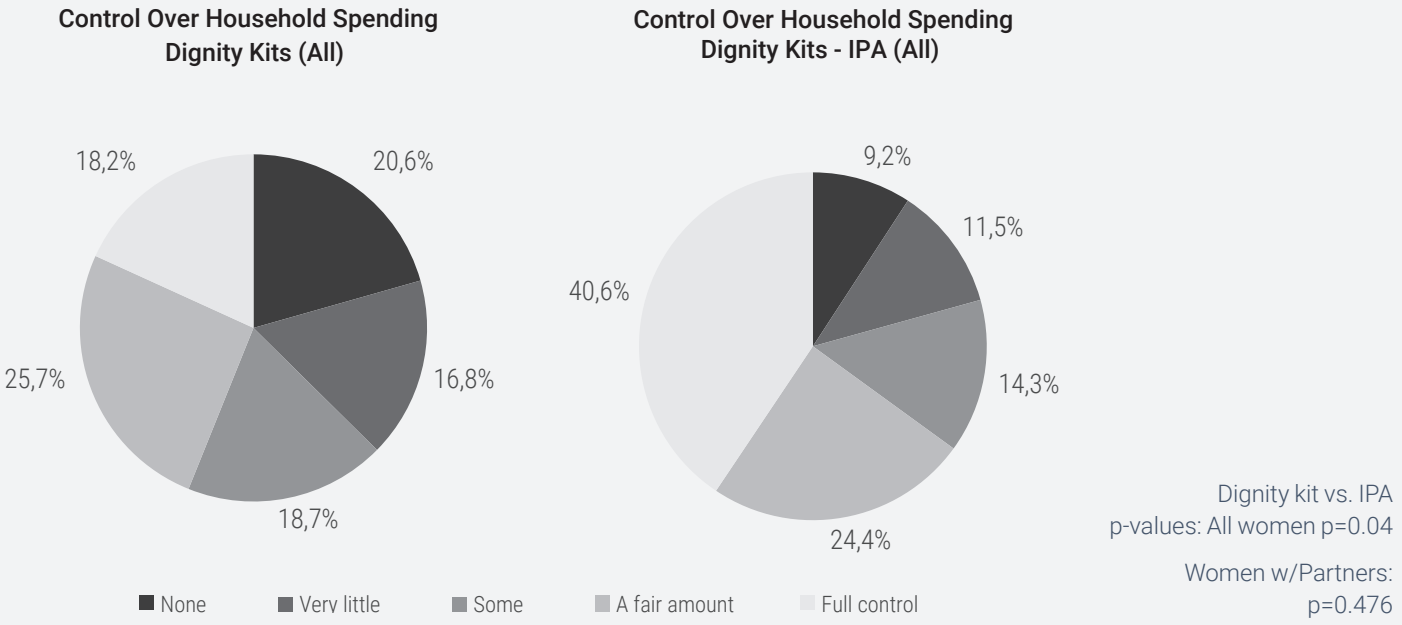
Figure 7: Decision-making on cash spending among women living with partner



Household Financial Decision Making

Prior to receiving dignity kits and cash transfers, women were asked to report their level of control over household spending decisions (on a five-point scale from no control to full control), and any anticipated consequences if household members disagreed with their spending decisions. Women in the dignity kit group were more likely to live with a partner (77.1% versus 43.7%), so these questions are reported both for all women in each group as well as among only those women living with a partner (Figure 8). In the IPA group, 65.0% of all women reported a fair amount or full control over household spending compared to 43.9% of those in the kit group ($p<0.04$). When considering only women living with a partner, 43.7% of those in the IPA group and 38.2% in the dignity kit group reported the same amount of control over household spending decisions, and the difference in responses between groups was not significant ($p=0.476$).

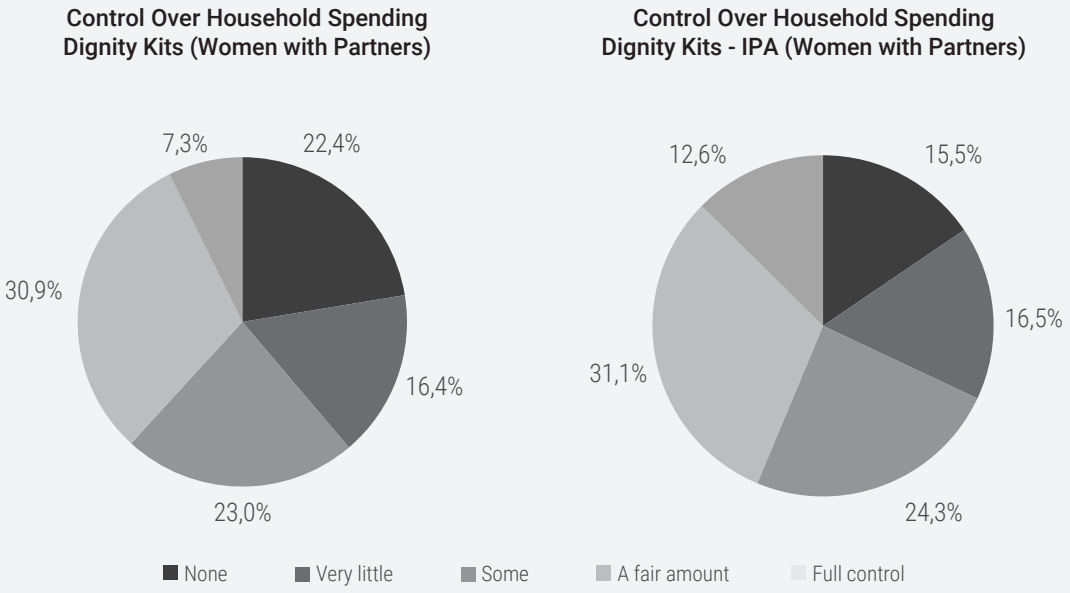
Figure 8: Pre-Intervention Decision Making by Intervention and Relationship Status



Dignity kit vs. IPA
p-values: All women p=0.04

Women w/Partners:
p=0.476

Figure 8 (cont) : Pre-Intervention Decision Making by Intervention and Relationship Status



Dignity kit vs. IPA p-values: All womenp=0.04

Women w/Partners: p=0.476

As noted above, **most participants (93.0%) reported either they were in charge of deciding how the cash would be used (62.8%) or that they jointly made decisions with their husbands (30.2%)**. Several women participating in the qualitative interview described their responsibility in making decisions for the family because their husband was either dead, missing or too ill to assist:

> ***"I did the task. I am responsible for my family. I am a widow living with only my children and I have no other relatives who can support me. I have no one to share the decision with."***

Women also described putting their needs secondary to their husband, children or other family members living in the household when making spending decisions:

> ***"I wanted to buy some private things for me, but there was not enough money after buying medicine for husband and clothes for children."***

As described above, the majority of women with a partner reported on the survey that their husband was aware of the cash, that they had fair amount or full control over spending of the cash with little tension, and disagreement or negative consequences related to cash spending was low. Through the qualitative interviews, women described how their families navigated decision-making and disagreements. One woman shared:

> ***"We consulted and made the right decision by arranging our priorities. The cash was for us – as I told you earlier – like a drop of water for our thirst, especially in the shadow of displacement and our poor conditions."***

Another woman interviewed decided not to involve her husband in spending decisions as to limit the stress this may cause him and potential conflict:

> ***"My husband did not know that we had that much amount of debts because I did not tell him about the exact debts value to avoid causing him more stress, so he wanted to delay the debts and buy medicines to treat himself. Nevertheless, as I told you, the owner of the supermarket told bad words and insisted to get his money back, so I had to repay the debts as priority and I used the little remaining cash to buy only two cartons of medicines. Later when I told my husband about how I had spent the cash and about the treatment of the supermarket salesman, he was very anxious; he even thought that I did not care for his health, so I had to***

tell him the truth and he understood my attitude."

Although women did not commonly report disagreements on spending decisions in the survey, women interviewed did report disagreements within the family on how to spend the cash. The disagreements described were always related to the multiple and competing needs of household members. As one participant describes:

"Honestly, at first there were some disagreements. Everyone identified one need: food, house rent, etc. my husband is a disabled person with no work, the house rent had not been paid for three months, my health condition was too bad, and the children wanted clothes and other school needs; everyone wanted to provide certain needs. However, when they understood that I was too tired, I took part of it and saw a doctor; he asked for an image that I could not even afford; I used part of it for food, especially with the coming of Ramadan since my house had nothing at all during our displacement conditions. There were some disagreements but we managed to solved them by setting priorities for everyone to cover part of the needs."

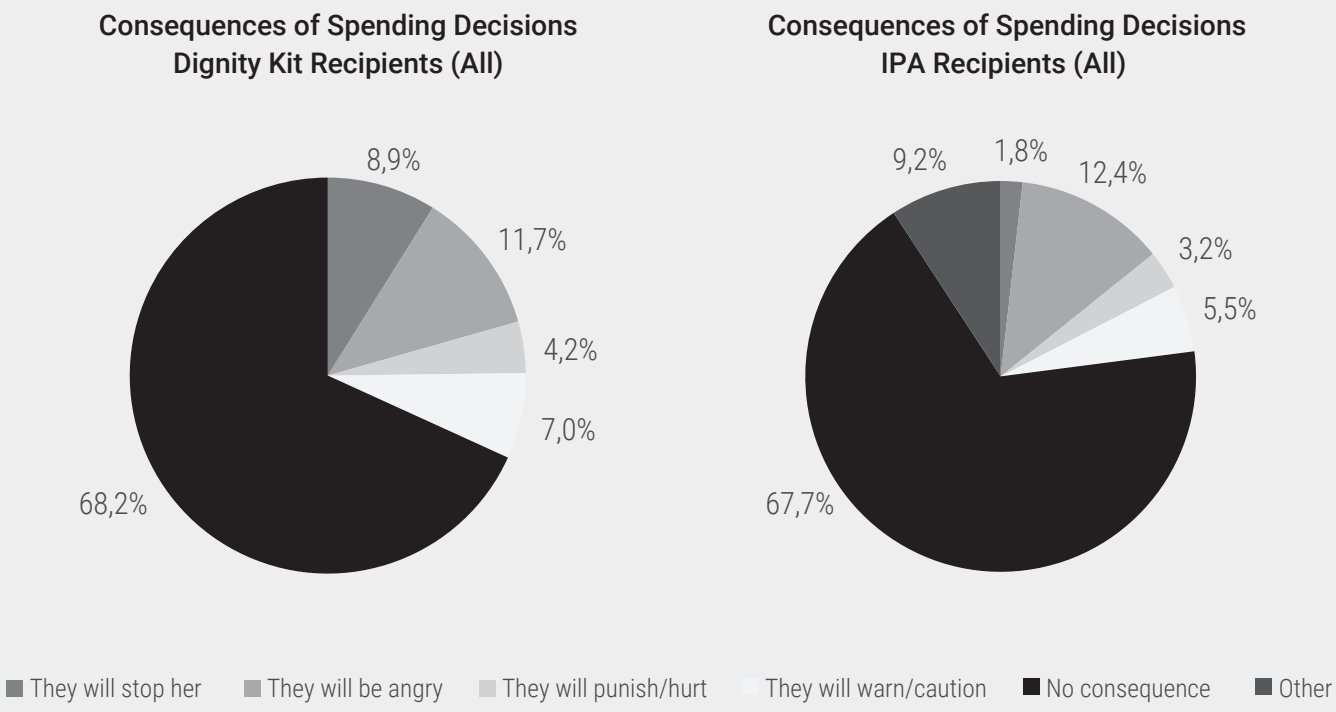
When asked about consequences if household members disagreed with spending decisions, the majority of women (60.2% of the IPA group and 65.5% of the dignity kit group) living with a partner reported that there would be no consequence. The next most common response was that family members would be angry, which was reported by 19.4% of IPA recipients and 12.1% of dignity kit recipients. A minority of women also reported that their household members would warn or caution them (8.7% of IPA and 7.9% of dignity kit recipients), would stop them from making certain spending decisions (2.9% of IPA recipients and 9.7% of kit recipients), or would punish or hurt them (5.8% of IPA recipients and 4.8% of kit recipients).

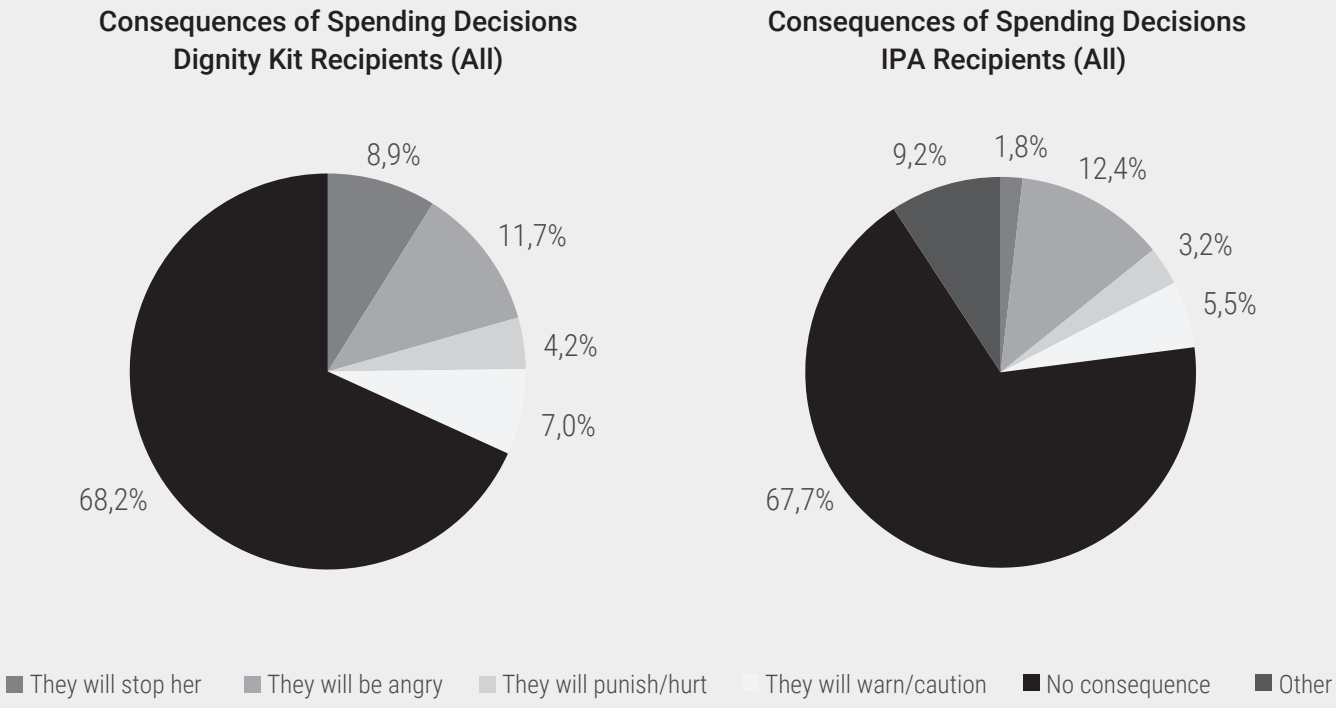
The difference in responses between groups among participants with partners was statistically significant with a p=0.04, with 8.4% more IPA recipients than dignity kit recipients reporting they would be yelled at or punished/hurt. Although, the majority of women reported no consequences if household members disagree with spending decisions on the survey, women interviewed described the ongoing impact of financial stress on family relationships:

The lack of negative consequences for spending decisions may have been related to married women deciding to accept the priorities of their husband for spending the cash, as one participant said:

"We had several needs and we did not know what to do with the cash; should we change the house, buy a battery and a solar panel for lighting the house, buy medicines for the children, or buy Eid clothes. Lots of disagreements occurred with my husband then, but when I knew that new problems would take place between my husband and the supermarket owner along with our own disagreements, I had to surrender my decisions."

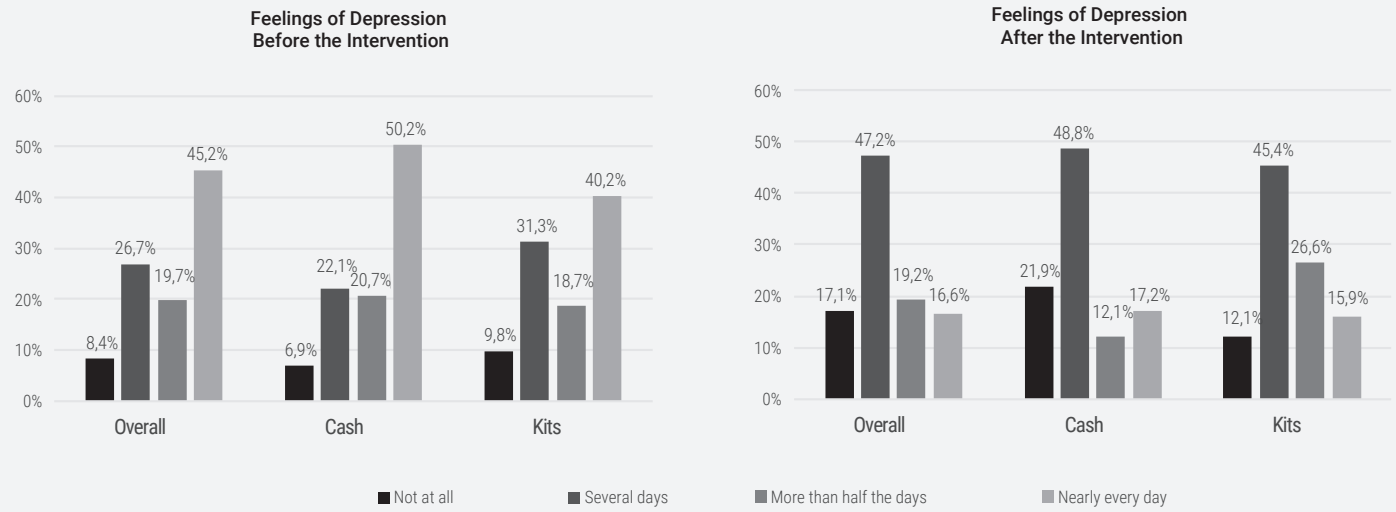
Figure 9: Post-Intervention Decision Consequences by Intervention and Relationship Status





Dignity kit vs. IPA p-values: All women p=0.04
Women w/Partners: p=0.476

Figure 10: Feelings of Depression Before and After the Intervention



Mental Health

Participants were asked to report how frequently they felt depressed or hopeless in the prior two weeks (on a 4-point scale from not at all to nearly every day) as well as whether they felt emotionally supported by people in their lives. At baseline, 70.9% of IPA recipients and 58.9% of dignity kit recipients reported feeling hopeless either more than half the time or nearly every day (Table 4 and Figure 10). The proportion reporting frequent depression decreased in both groups after the intervention to 29.3% in the IPA group and 42.5% in the dignity kit group. The magnitude of depression reduction was significantly greater among IPA recipients (41.6%) as compared to dignity kit recipients (16.4%) (p=0.001).

In qualitative interviews, one woman said,

> ***"When I received it [cash] and paid some of my debts, my psychological situation improved although I could not pay all of the debts, but little is better than nothing."***

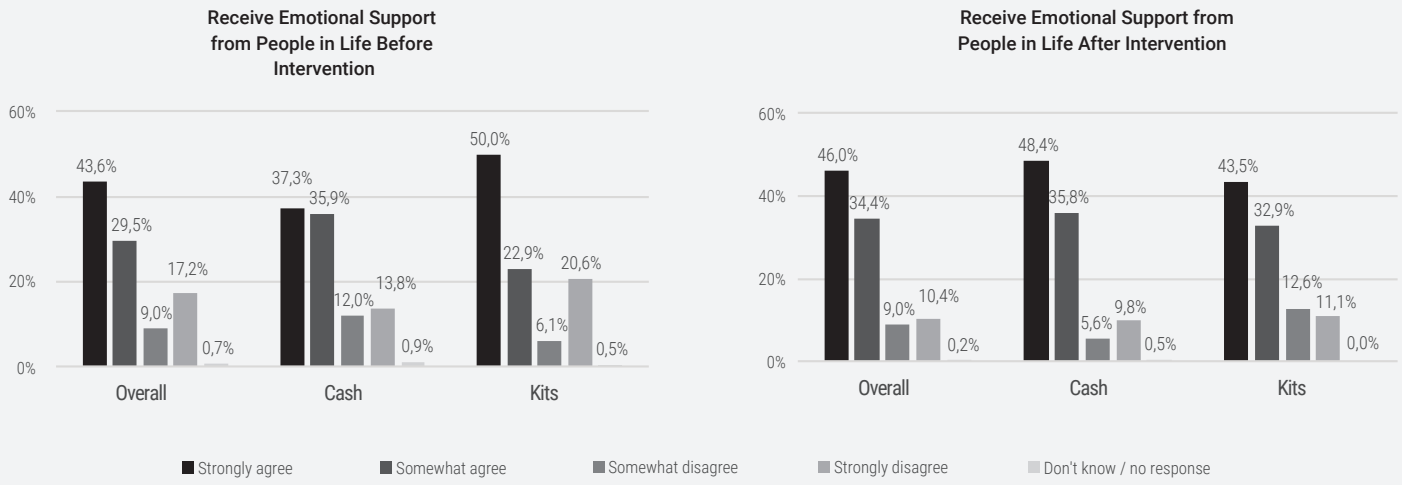
Relatedly, others described the impact of poverty and displacement on mental health for themselves and their family members. *"The lack of food and other needs had caused us problems and that had been reflected on our children who started to question the costs of their needs; this caused some psychological distress for me and for their father due to the harsh fact that the children had been anxious about costs of their needs at their early age."*

At baseline, 73% of both IPA and dignity kit recipients agreed they could get emotional support from people in their lives. This reported support increased to 84.2% for IPA recipients and 76.4% for kit recipients at end line (Table 4 and Figure 11). Changes in emotional support from baseline to end line were not significantly different between groups (p=.176).

Table 4: Women's Mental Health

	Overall			IPA Recipients (n=217)		Kit Recipients (n=214)		p-value
	N	Point	(95% CI)	Point	(95% CI)	Point	(95% CI)	
Prior to Receipt of Assistance								
Feelings of depression or hopelessness in last 2 week								
Not at all	36	8.4%	(5.7-11.0%)	6.9%	(3.5-10.3%)	9.8%	(5.8-13.8%)	0.068
Several days	115	26.7%	(22.5-30.9%)	22.1%	(16.6-27.7%)	31.3%	(25.0-37.6%)	
More than half the days	85	19.7%	(16.0-23.5%)	20.7%	(15.3-26.2%)	18.7%	(13.4-24.0%)	
Nearly every day	195	45.2%	(40.5-50.0%)	50.2%	(43.5-56.9%)	40.2%	(33.6-46.8%)	
Can get emotional support from people in life								
Strongly agree	188	43.6%	(38.9-48.3%)	37.3%	(30.8-43.8%)	50.0%	(43.2-56.8%)	
Somewhat agree	127	29.5%	(25.1-33.8%)	35.9%	(29.5-42.4%)	22.9%	(17.2-28.6%)	
Somewhat disagree	39	9.0%	(6.3-11.8%)	12.0%	(7.6-16.3%)	6.1%	(2.8-9.3%)	**0.002**
Strongly disagree	74	17.2%	(13.6-20.7%)	13.8%	(9.2-18.5%)	20.6%	(15.1-26.0%)	
Don't know / no response	3	0.7%	(-0.1-1.5%)	0.9%	(-0.4-2.2%)	0.5%	(-0.5-1.4%)	
After Receipt of Assistance								
Feelings of depression or hopelessness in last 2 weeks								
Not at all	72	17.1%	(13.5-20.7%)	21.9%	(16.3-27.4%)	12.1%	(7.6-16.6%)	
Several days	199	47.2%	(42.4-51.9%)	48.8%	(42.1-55.6%)	45.4%	(38.6-52.2%)	
More than half the days	81	19.2%	(15.4-23.0%)	12.1%	(7.7-16.5%)	26.6%	(20.5-32.6%)	**<.001**
Nearly every day	70	16.6%	(13.0-20.2%)	17.2%	(12.1-22.3%)	15.9%	(10.9-21.0%)	
Can get emotional support from people in life								
Strongly agree	194	46.0%	(41.2-50.7%)	48.4%	(41.6-55.1%)	43.5%	(36.7-50.3%)	
Somewhat agree	145	34.4%	(29.8-38.9%)	35.8%	(29.4-42.3%)	32.9%	(26.4-39.3%)	
Somewhat disagree	38	9.0%	(6.3-11.7%)	5.6%	(2.5-8.7%)	12.6%	(8.0-17.1%)	0.104
Strongly disagree	44	10.4%	(7.5-13.4%)	9.8%	(5.8-13.8%)	11.1%	(6.8-15.4%)	
Don't know / no response	1	0.2%	(-0.2-0.7%)	0.5%	(-0.5-1.4%)	0.0%	(0.0-0.0%)	
Pre/Post Assistance Change								
Feelings of depression or hopelessness in last 2 weeks								
Not at all		8.7%	(4.3-13.1%)	15.0%	(8.5-21.4%)	2.3%	(-3.7-8.2%)	
Several days		20.5%	(14.1-26.8%)	26.7%	(18.0-35.4%)	14.1%	(4.9-23.3%)	
More than half the days		-0.5%	(-5.8-4.8%)	-8.6%	(-15.6- -1.7%)	7.9%	(-0.1-15.8%)	**0.001**
Nearly every day		-28.6%	(-34.5- -22.8%)	-33.0%	(-41.4- -24.7%)	-24.3%	(-32.5- -16.0%)	
Can get emotional support from people in life								
Strongly agree		2.4%	(-4.5-9.0%)	11.1%	(1.8-20.3%)	-6.5%	(-16.0-3.0%)	0.176
Somewhat agree		4.9%	(-1.4-11.1%)	-0.1%	(-9.2-8.9%)	10.0%	(1.4-18.5%)	
Somewhat disagree		0.0%	(-3.9-3.8%)	-6.4%	(-11.7- -1.1%)	6.5%	(1.0-12.0%)	
Strongly disagree		-6.8%	(-11.3- -2.1%)	-4.0%	(-10.1-2.0%)	-9.5%	(16.4- -2.5%)	
Don't know / no response		-0.5%	(-1.3-0.5%)	-0.4%	(-2.0-1.1%)	-0.5%	(-1.4-0.4%)	

Figure 11: Emotional Support Before and After Intervention Receipt



Safety

Participants were asked whether they had been threatened or harmed by a household member as well as overall feelings of safety and any changes in household relationships between baseline and end line. At baseline, 9.7% (CI 5.7-13.7%) of the IPA group and 7.0% (CI 3.6-10.5%) of the kit group reported that they had been threatened or harmed by a household member in the prior year (p=0.31); these proportions were also similar when considering only women living with a partner (p=0.269).

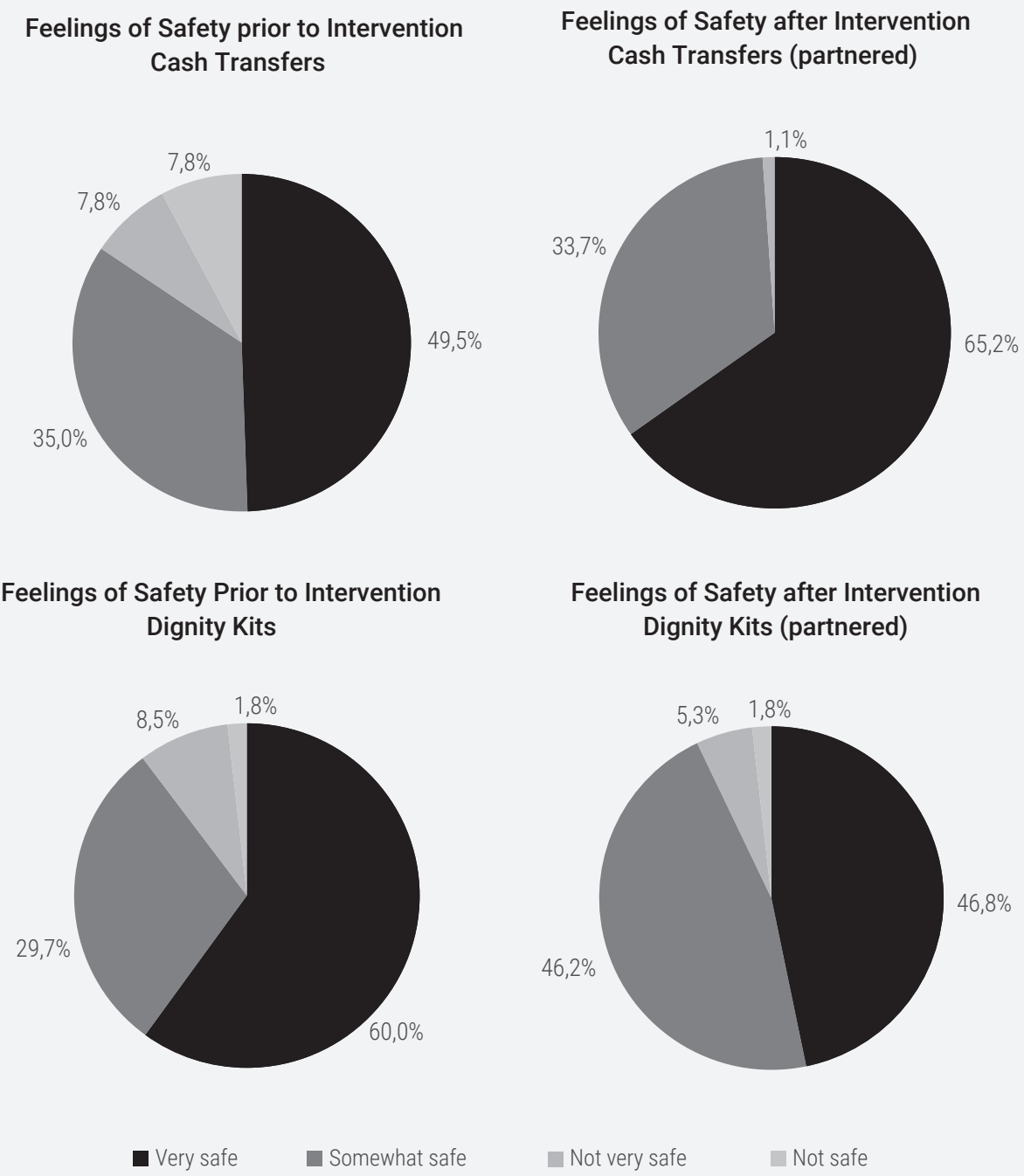
The majority of women reported feeling safe in their households at both baseline and end line, however, 16.6% of IPA recipients and 13.1% of kit recipients felt 'not very safe' or 'not safe' in their households at baseline (p=0.12) (Figure 12). At end line, this fell to 4.7% of IPA recipients and 9.7% of kit recipients which translates to reductions of 11.9% for IPA recipients and 3.4% for dignity kit recipients (p<0.001). T**he change in feelings of safety between baseline and end line was statistically significant, suggesting that receiving cash increased feelings of safety in the household.**

Similar results were observed among those living with a partner, where the number of people feeling unsafe in their home decreased from 15.6% to 1.1% in the IPA group and from 10.3% to 7.1% in the dignity kit group. The magnitude of change between groups from baseline to end line was significantly different (p<.001), with reductions in feeling unsafe of 14.5% and 3.2% in the IPA and dignity kit groups, respectively. Women described cash transfers as increasing feelings of safety in relation to both internal household dynamics and external factors:

> ***"When there is no money, the general atmosphere will be tense, the children will be anxious, and the father will be nervous. Therefore, the cash can reduce these disagreements."***
>
> ***"Yes, it makes me safe. It also makes me feel like I am able to satisfy the needs of my house and children (taking my daughter to the doctor). I can get food, medicine and clothes for my children; I can pay the house rent without being threatened by the house owner to make us leave the house."***

Women who reported feeling 'not very safe' or 'not safe' in their households at end line were asked whether they had taken any action to increase their own safety or that of their children. Of the 30 participants reporting feeling unsafe, only five (16.7%) had taken specific action, including planning a safe place to go (n=2), trying to keep their partner calm by acting like they agreed with him (n=1), developing a safety plan with a case manager (n=1), and participating in a job training program (n=1).

Figure 12: Safety Pre- and Post-Intervention by Intervention Type

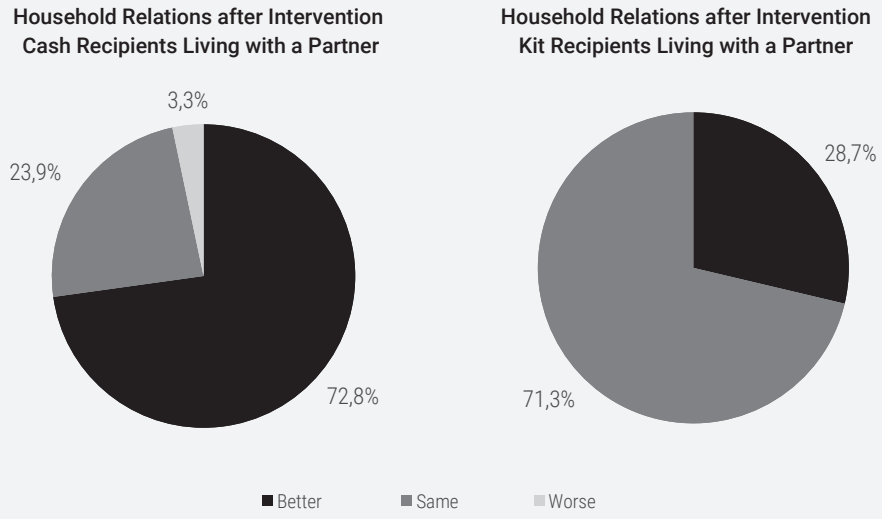


Dignity kit vs. IPA p-values: All women p<.001
Women w/ Partners: P<.001

Most IPA recipients reported better household relationships after the intervention (73.5% of all IPA recipients, and 72.8% of IPA recipients with partners), while only a minority of dignity kit recipients reported better relationships (28.0% of all kit recipients and 28.7% of partnered kit recipients) (Figure 13). It was uncommon for participants to report worsening household relationships after the intervention compared to before (3.3% of partnered IPA recipients and 0% of partnered kit recipients). The difference between groups before and after the intervention was statistically significant at p<.001 for both the whole group and those who were partnered.

Most women participating in qualitative interviews discussed how cash can reduce individual and household-level stress and family conflicts while improving relationships even if only for a short-period of time. **The women also noted the importance of support beyond cash assistance provided by case workers:** ***"They were very kind; I felt that I was talking to my sisters rather than NGO employees. My psychological situation got better."*** In addition to the kindness, one participant reported that a female NGO employee after she shared her family situation, reached out and visited her in-laws to support her in improving her relationship with them.

Figure 13: Change in Household Relationships after Interventions



Aid Preferences and Service Referrals

For future assistance, over 70% of both the IPA and dignity kit groups preferred that future assistance be given in cash rather than as vouchers or in-kind assistance, with no significant differences between groups (p=.125) (Figure 14). In addition, women suggested that the cash be provided on a monthly basis; or to give cash to start a small business or to buy a sewing machine so that women can make clothes at home and provide income. One interview participant said, *"I hope it can be more than $100. You can also vary the assistance by providing different assistance each time: one time for cash assistance, another time for*

Figure 14: Preferred Modality

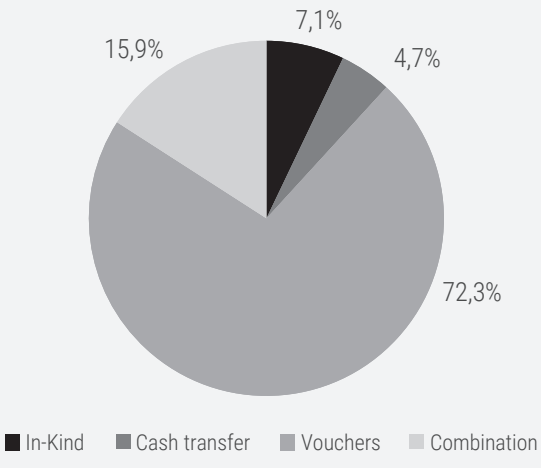
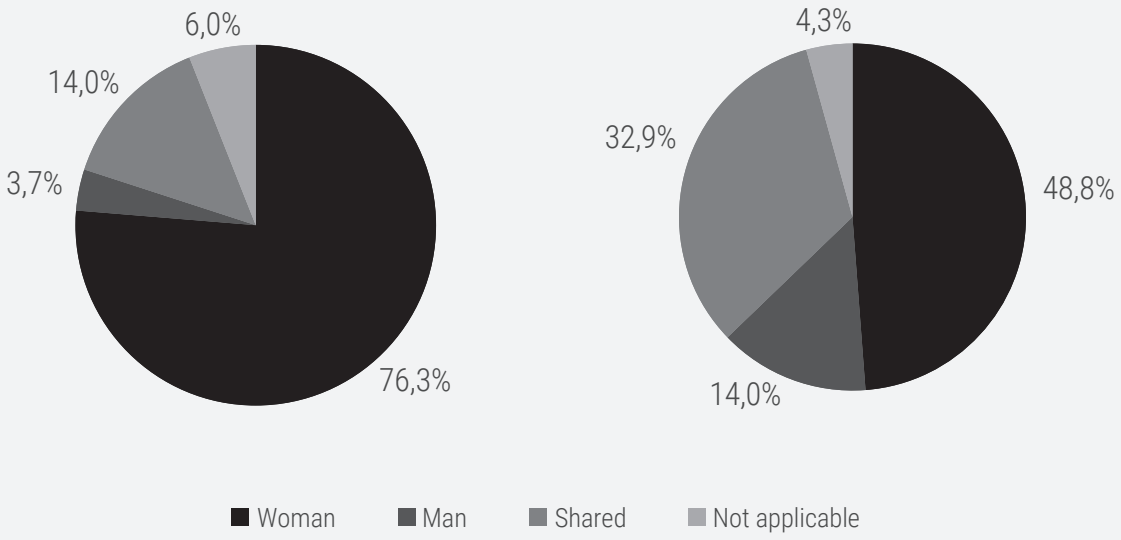


Figure 15: Preferences for Assistance



clothes vouchers, and another time for food so that it can be sufficient for the family."

Among IPA recipients, 76.3% (CI: 70.5-82.0%) preferred a woman to be the recipient, compared to only 48.8% (CI: 41.9-55.7%) of dignity kit recipients (p<.001) (Figure 15).

As a means of disseminating information about other services, providing IPA and dignity kits were similar, with approximately one-third (32.2%) of participants reporting they received information about other services at the time of the intervention, and this proportion was similar between groups (p=0.827). The most common requests for referrals in both groups included: health services (27.4% of those requesting referrals at baseline), livelihoods (15.7%), additional cash transfers (10.3%), psychosocial support (7.2%), and case management services (4.9%) (Table 5). Of those who reported receiving information, approximately two-thirds (67.6%) reported seeking the suggested services, and this proportion was similar between groups (p=.219 respectively), suggesting that both interventions can be appropriate methods of facilitating linkages to other services. One woman participating in the in-depth interviews provided a summary of the importance of cash and livelihood opportunities and services for her families well-being, *"if I get a job or monthly income, then even if I get food or medicine through debts, I know that I will repay the debts later since I have an income; I can take my daughter to the hospital without the help of others; even with all the responsibilities,* ***my psychology gets better when I know then that I can provide all my family needs.*****"**

Table 5: Requests for Referarals for Services

	Overall			IPA Recipients (n=217)		Kit Recipients (n=214)		p-value
	N	Point	(95% CI)	Point	(95% CI)	Point	(95% CI)	
Prior to Receipt of Assistance								
Participants requesting a referral (any service)	223	51.7%	(47.0-56.5%)	54.8%	(48.2-61.5%)	48.6%	(41.8-55.3%)	0.195
Health Services	61	27.4%	(21.5-33.3%)	26.9%	(18.8-35.0%)	27.9%	(19.1-36.6%)	0.074
Case Management	11	4.9%	(2.1-7.8%)	8.4%	(3.3-13.5%)	1.0%	(-0.9-2.9%)	
Livelihoods	35	15.7%	(10.9-20.5%)	16.0%	(9.3-22.6%)	15.4%	(8.3-22.4%)	
Additional Cash	23	10.3%	(6.3-14.3%)	12.6%	(6.6-18.7%)	7.7%	(2.5-12.9%)	
Psychosocial Support	16	7.2%	(3.8-10.6%)	5.0%	(1.1-9.0%)	9.6%	(3.9-15.4%)	
Other	77	34.5%	(28.2-40.8%)	31.1%	(22.7-39.5%)	38.5%	(29.0-48.0%)	
After Receipt of Assistance								
Participants requesting a referral (any service)	139	32.9%	(28.4-37.4%)	33.5%	(27.1-39.8%)	32.4%	(25.9-38.8%)	0.806
Health Services	34	24.1%	(17.0-31.3%)	11.1%	(3.7-18.5%)	37.7%	(26.0-49.4%)	**<.001**
Case Management	15	10.6%	(5.5-15.8%)	18.1%	(9.0-27.2%)	2.9%	(-1.2-7.0%)	
Livelihoods	15	10.6%	(5.5-15.8%)	13.9%	(5.7-22.1%)	7.2%	(1.0-13.5%)	
Additional Cash	33	23.4%	(16.3-30.5%)	30.6%	(19.7-41.5%)	15.9%	(7.1-24.8%)	
Psychosocial Support	8	5.7%	(1.8-9.5%)	4.2%	(-0.6-8.9%)	7.2%	(1.0-13.5%)	
Other	36	25.5%	(18.2-32.8%)	22.2%	(12.4-32.1%)	29.0%	(18.0-40.0%)	

Summary of Findings and Recommendations

This study examined the experiences of 431 women in Idleb Province of northwest Syria that received assistance as either IPA, a one-off unconditional cash transfer of US$100-120, or a dignity kit including US$20 hygiene items from UNFPA implementing partners in early 2021. The two interventions were intended to provide immediate assistance to women and their families while simultaneously serving as an entry point for additional services. Questionnaire-based interviews were conducted at intervention receipt and again approximately two weeks later; a sub-sample of 18 women that received IPA also participated in qualitative interviews that were intended to deepen the understanding of women's experiences with cash transfers.

Women receiving IPA differed in a number of important ways from those receiving dignity kits. As a group, IPA recipients were older, were more likely to live in a female-headed household and be without a partner and were more likely to live outside of a camp setting compared to those in the dignity kit group. IPA recipients were also less likely to have received any form of humanitarian assistance in the month prior to the intervention, which is likely related to residence outside camps. These underlying differences between groups warrant caution when interpreting results as these differences may confound a number of other variables. For instance, female household heads and women living outside camp settings described the additional challenges of awareness and safety in accessing available services without a partner to accompany them. Lack of childcare or safe places for their children when they need to

seek services was another factor that limited access to services. However, as head of household they may also be able to exercise greater decision-making power on how to spend cash within the household. Although women described their role in decision-making, they also described the stress they experience being the sole provider and responsible for making all the decisions to meet the needs of the children and other family members.

At both baseline and end line, the top unmet need in both groups was food, followed by debt repayment. Among those receiving IPA, food accounted for most of the cash transfer expenditure, and 20% fewer households reported food as among their top three needs at end line compared to baseline. Dignity kit receipt was associated with decreased hygiene needs between baseline and end line. The composition of the dignity kits was generally considered to be appropriate, with relatively few participants reporting specific items in the kits as unnecessary.

Among women in both interventions, **cash was by far the preferred modality to receive future aid**. Women who received cash reported that they had partial to full control of how the cash was used. **Nearly all cash transfer recipients (98.6%) reported feeling safe and the transfers rarely caused problems** between participants and their neighbors, relatives, or spouses. In fact, over **80% of women told their husbands about the cash transfer and reported overwhelmingly positive reactions**. Recipient preference, support provided by the NGO and the lack of difficulties reported in accessing and spending the cash demonstrates that future cash and voucher assistance is both feasible and safe. However, some challenges in accessing cash transfers were reported by 22% of the women, mostly related to transportation and the need for male accompaniment, which are key barriers to account for in future assistance.

Cash transfers had greater benefits in terms of mental health and safety as compared to dignity kits. While both groups reported reductions in feelings of depression and hopelessness during the intervention, the **reduction in depression among IPA recipients (41.6%) was significantly greater than among those receiving dignity kits (16.4%) (p<0.001).** Cash was also associated with increased feelings of safety in the household and better household relationships. **The proportion of women reporting they no longer felt unsafe decreased significantly more among IPA recipients (11.9%) as compared to dignity kit recipients (3.7%) (p<0.001).** One plausible explanation for the improved relationships and mental health benefit is that cash partially relieved financial stress, notably debt, and conflict caused by the multiple unmet household needs, while the dignity kits did not allow the same flexibility. Similarly, **cash allowed households to meet a broader range of needs for different household members which recipients appreciated.**

Cash was the preferred modality of assistance by >70% of both IPA and dignity kit recipients, which aligns with previous findings from northwest Syria on humanitarian assistance preferences. In practice, it is often logistical and contextual factors that determine which forms of assistance are most feasible. Findings from this study indicate that both dignity kits and unconditional cash transfers are appropriate forms of assistance and should be continued in northwest Syria, either as standalone or complimentary interventions. **Cash transfers may be more advantageous for supporting households to meet basic needs whereas dignity kits ensure that women and girls have access to hygiene and sanitary items that may not be prioritized when resources are limited.**

Both cash transfers and dignity kits were intended to be an entry point for services, and approximately one-third of women in each group received information about other services. Of those who reported receiving information, approximately two-thirds of women in both the IPA and dignity kit groups reported seeking the suggested services. Both the receipt of information about services and the number of people seeking services was similar between groups, suggesting that **both cash transfers and dignity kits are appropriate methods for facilitating linkage to services** and that provision of cash did not translate to increased referral use. This could be the result of a range of factors, including high levels of competing unmet needs, accessibility and perceptions of services (e.g. poor quality, service not available nearby), and other non-cost related barriers (e.g. need for male accompaniment or permission from family).

While the study findings clearly indicate cash is associated with a number of economic, health and

safety benefits for the recipients and their families, the short follow-up period limits the ability of this study to draw conclusions about longer-term and sustained benefits. As women in the qualitative interviews consistently stated, "*Any income or cash assistance reduces disagreements within the families and gives a sense of comfort. While when there are many unmet needs, problems will increase. Therefore, we requested providing the cash assistance on a periodic basis as most of families have children who cannot help or support and mothers cannot provide all of their needs.*" Acknowledging the immense unmet needs in northwest Syria, UNFPA and its partners should continue cash assistance and endeavor to expand programming, both by increasing the number of recipients and extending the time period that cash transfers are received.

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