WHAT DOES GENDER-SENSITIVE CASH AND VOUCHER ASSISTANCE LOOK LIKE? 2.0

MULTI-COUNTRY STUDY

DECEMBER 2021

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Acknowledgements

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Acronyms

ATM	Automatic Teller Machine
COVID	Coronavirus Disease
CVA	Cash and Voucher Assistance
FGD	Focus Group Discussion
FSP	Financial Service Provider
GBV	Gender-based Violence
IDP	Internally Displaced Person
INGO	International Nongovernmental Organization
KII	Key Informant Interview
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
MEAL	Monitoring, evaluation, accountability, and learning
NGO	Nongovernmental organization
PDM	Post-distribution monitoring
PSEA	Protection from Sexual Exploitation and Abuse
RGA	Rapid Gender Analysis
SADD	Sex and Age Disaggregated Data
WFP	World Food Programme

Cover photo: Matilda Maindise with her two children (pink top and blue jersey) and her two orphaned little nieces, standing next to the groceries they recently redeemed using their WFP CVA card. Mashava, Masvingo Province, Zimbabwe. Photo credit: Vivian Ngonidzashe Munemo. © CARE 2021

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Woman withdrawing cash assistance from an ATM in Ecuador. ©CARE 2021

Study Overview

In 2019, CARE commissioned the study **"What Does Gender sensitive Cash and Voucher Assistance Look Like?"** to evaluate the extent to which CARE's programming with cash and voucher assistance (CVA) met the strategic intent. It guided the agency-wide definition and design of subsequent guidelines on gender sensitive CVA. In 2021, CARE again reflected on progress toward this ambition and commissioned a review to answer the question, "To what extent is CARE's use of CVA meeting the needs of women and girls in ways that represent the best possible outcomes by maximizing inclusion, effectiveness, and efficiency?". This study aimed to evaluate the experience of respondents receiving CVA, with an emphasis on the experience of women respondents.

Methodology

The study occurred between June and August of 2021 in **Ecuador**, **Ethiopia**, **Jordan**, and **Zimbabwe** using one-on-one interviews, focus group discussions (FGDs), and storytelling. In total, CARE conducted 28 interviews and 35 FGDs with 317 respondents. Women respondents comprised 71% of individual interviews, with men making up the remaining 29%. Of the 34 FGDs, 56% involved only women (166 total respondents). Thirteen individual testimonies were collected from respondents (nine women), with four of these testimonies videotaped (women only). Additionally, the participating CARE country offices completed a checklist based on CARE Gender sensitive CVA Guidelines; in addition to the previously mentioned countries, CARE the **Philippines** participated in the checklist review.

Discussion and findings

Recommendations presented in the 2019 CARE study remain valid. How successfully has CARE been able to meet these recommendations in the various contexts? The answer is mixed, but there is clear progress.

This study shows that CARE is improving on the process aspects of gender sensitive CVA. In terms of outcomes, the transfers did meet some of the needs of the target populations, especially women. However, across the board there were other needs that respondents and their communities had that the transfers did not meet. The cash plus approach1, when used, helped address underlying causes of gender inequity or for needs that cannot be met by CVA alone.

The CARE teams have excelled at talking to individuals from a variety of gender groups with various intersectional characteristics for this review. Interestingly, even with the inclusion of different gender groups in this study, there were relatively few points where opinions on and experiences of CARE's CVA programming diverged. Intersectionality – including related to civil status and sexual orientation – was explored more in this study and is something that CARE is committed to understanding better. This study confirmed that CARE staff and partners' treatment and feedback mechanisms were well-received across all gender groups.

The COVID-19 pandemic presented unique challenges and opportunities for CARE in its pursuit of gender sensitive CVA. CARE and partners expanded the ways in which they reached out to people in need through technology, allowing for CVA support even during periods of restricted movement/lockdown. Despite the obstacles, teams across these contexts managed to provide high-quality CVA support services and maintain loyalty to CARE's gender sensitive approaches.

Each context utilized Rapid Gender Analysis (RGA) to provide gendered understanding of needs, a critical step in designing gender sensitive CVA. Most of the RGAs included analysis on financial inclusion, technology, literacy, and numeracy. However, not all the contexts included these components, and none included market-based analysis. One of the obstacles making this analysis more systematic is that the existing RGA tools focus on sectoral outcomes rather than approaches. Without a cash or markets specialist participating in the scope of work for the RGA, a "market lens" is likely to be left out. This is a lost opportunity to deeply understand if market-based responses are feasible especially as CARE's work in urban areas grows.

The recommendation from 2019 of combining the specialties of gender and CVA is still in progress for achievement in most of the study areas. For market assessments overall, CARE teams are mostly complying on understanding gendered access, but need to improve on understanding price and functionality. These are critical at the assessment stage in order to tailor the transfer value (e.g., Is a top up for transportation needed?) and after transfers are made (e.g., Is there market distortion and where do women vs. men go if there is?). Failing to include these components will affect the degree to which country office programming with CVA demonstrates a logical link between the gender-specific needs identified for CVA and satisfies the diverse needs of CVA respondents.

Documented analyses of gendered risks specific to CVA across the study areas were low. Generally, CARE country offices have response-level risk analyses, which includes GBV risks. However, CARE's ambition and guidance suggests that all programming with CVA should do a formal analysis of GBV risks related to CVA. The organization led the development of tools and guidance on GBV risk mitigation in CVA and there are some strong examples of how this can be done. By incorporating this type of analysis with teams on the ground, it centers the conversation on the realities of the context, exploring what the real GBV risks and specific mitigation measures needed are.

This study highlighted yet again the important work of designing programming with CVA based on gendered analyses. The barriers and risks for women and other vulnerable groups are the same as those outlined in the 2019 study. Accompaniment for the most vulnerable populations remains especially important when normal procedures are

1 Cash plus or **complementary programming** refers to programming where different modalities and/or activities are combined to achieve objectives.

adjusted, such as during the COVID-19 pandemic. As a result, CARE must continue exploring how to ensure that people of all genders are sensitized to, have access, and benefit from CVA safely.

This study also re-emphasizes the critical importance of understanding and mitigating gendered risks during the implementation phase through monitoring data. Further work needs to be done to include gender indicators in programming with CVA; not all the countries in this study included these indicators. However, post-distribution monitoring (PDM), which all of the involved country offices used, can be easily adapted to add such questions. Most of the CARE study contexts did also include assessments of unintended consequences of the support, which can be analyzed with sex and age disaggregated data (SADD).

Monitoring data highlighted the positive – albeit seemingly temporary – impact of on shared decision-making at the household level during the time of the transfers. It would be interesting to see what sort of longer-term impacts would be reported by respondents; this would require a dedicated evaluation. There were some positive indications that the transfers contributed to women's improved budgeting and financial skills. It is possible that these might be more durable changes.

Findings from this study call for nuance in how we understand engaging different types of people in our design. The traditional approach of visiting a rural community, discussing needs, designing a project, and implementing it with the same people is less common than one in which discussions are held with "proxy" populations. Therefore, it may need to be made clear to crisis-affected people of all genders why and how CARE reached design decisions; this is necessary to ensure accountability to affected populations.

Clearly, all respondents were willing to discuss the needs and risks they faced in receiving CVA and the implementation and monitoring phases of a CVA project offer opportunities to analyze and pivot towards more gender sensitive processes – such as the selection of vendors, provision of transportation in transfer fees, adjusting delivery mechanisms – to reduce risk and burden for the most vulnerable people.

Generally, all gender groups were comfortable with the delivery mechanisms utilized. As expected, more women than men had issues with the delivery mechanisms; although this was a relatively small subset of respondents, attention to this issue is still required. Overall, respondents confirmed that CARE staff, partners, and FSPs assisted them when they had problems.

Regarding sensitization on processes, it was clear that men should be included even if women are the registered participants,[2] this was highlighted in the 2019 study as well.

At a global level, CARE committed to finding the tools and processes that field-based CARE and partner teams use to understand what is meant by gender sensitive CVA. Significant strides were made since 2019[3] in achieving this ambition. However, continual investments in capacity building, sensitization, and mentoring are needed to make gender sensitive CVA a reality for CARE's participants.

While the response-level recommendations were not prioritized for deep analysis in this study, the importance of those recommendations was reflected in the data. One positive point is that some of the RGAs were done in collaboration with other actors and co-led by CARE. The need for advocacy on the importance of a gendered approach to responses with CVA still remains.

2 This would apply to transfers destined for household use and not individual such as health or GBV response.

3 **Gender Sensitive Cash and Voucher Assistance**, **Cash and Voucher Assistance & Gender-Based Violence Compendium**, **Guidelines on Using Cash and Voucher Assistance for Sexual and Reproductive Health and Rights Programming**, **Better Gender outcomes in food assistance through complementary and multimodal programming tip sheet**, **Behavioral Design Checklist for Humanitarian Cash and Voucher Assistance Improving Outcomes for Women**

1.0 OVERVIEW

Fungai Mangoma and some of her 15 grandchildren whose lives have improved following the CVA program. Masvingo. Masvingo Province. Zimbabwe. Photo credit: Vivian Ngonidzashe Munemo. ©CARE 2021

1.1 Introduction: CARE's Gender Sensitive Approach to CVA

CVA has increasingly become a modality of choice for CARE's programming. In fiscal year 2020, CARE used CVA in 48 different contexts. CARE's strategic ambition for CVA aspires to have all projects with CVA be **gender sensitive**. CARE is committed to ensuring that projects with CVA are centered around women and girls, addressing their needs, challenges, and opportunities. As such, gender sensitivity frames the processes and outcome of the use of the modalities.

In 2019, CARE commissioned the study **"What Does Gender sensitive Cash and Voucher Assistance Look Like?"** to evaluate the extent to which CARE's programming with CVA met the strategic intent. The study drew directly from the experience of those affected by crisis in a range of operating environments: Haiti, Jordan, Malawi, Niger, and the Philippines. It guided the agency-wide definition and design of subsequent guidelines on gender sensitive CVA.

1.2 Study Objectives and Scope

Three years after establishing its strategic intent and two years after the 2019 study, CARE again reflected on its work with CVA. CARE commissioned a review to answer the question, "To what extent is CARE's use of CVA meeting the needs of women and girls in ways that represent the best possible outcomes by maximizing inclusion, effectiveness, and efficiency?"

The review included three components: 1) an analysis of CARE's CVA studies completed in 2020-2021 against its strategic ambition; 2) an assessment of engagement with CARE's CVA webinars, tools, and guidance (i.e., survey and review of downloads/views); and 3) field-based research on compliance with the CARE gender sensitive CVA guidelines. This third aspect is the focus of this report.

The primary focus of this study is to evaluate the perceptions of CARE CVA respondents against its gender sensitive approach. Trained data collectors – who are from and familiar with the contexts - completed data collection for the study. CARE adapted and streamlined data collection tools from the 2019 study. Key populations included in the study were: refugees, host populations, internally displaced persons (IDPs), vulnerable residents, and members of the lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) community.

TABLE 1: OVERVIEW OF CARE COUNTRY OFFICES PARTICIPATING IN THE STUDY

	ECUADOR	ETHIOPIA	JORDAN	ZIMBABWE
Expected Outcome(s) of CVA	Multipurpose	Multipurpose; livelihoods; food security	Multipurpose; livelihoods	Food security
Implementation Method	Direct and through partners	Direct	Direct	Direct as a partner
Context	Displacement; urban	Displacement; rural	Displacement; urban	Natural disaster; rural
Modality	Cash transfer	Cash transfer; voucher	Cash transfer	Cash transfer; e-vouchers
Delivery mechanism	Cardless Automatic Teller Machine (ATM)	Bank; paper voucher	Cash transfer; voucher	Cash transfer; voucher
Targeting approach	Case management	Community-based vulnerability	Case management	Community Based Targeting and Proxy Mean targeting
Location	El Oro and Manabí Provinces	Oromia region; West Hararge Zone	Amman, Irbid, Zarqa, Karak, Aqaba, Balqa, Ajloun, and Mafraq governorates	Masvingo District, Masvingo Province
Interview Location	El Oro- Huaquillas Canton; Manabí- Manta Canton	Xulo and Doba woredas; Kochere, Kurfa chele and Gemechis	Amman, Mafraq, Zarqa and Irbid	Mucheke, Mashava Mine, Masvingo
Length of programming with CVA in country	Since 2018	Since 2018	Since 2013	2015 to 2017, and 2021

1.3 Study Methodology and Tools

A summer graduate student intern coordinated the study with support from the Cash and Markets team; focal points led the study at the country offices. The study occurred between June and August of 2021. The team used three tools to collect data at the country level and included:

- **One-on-one household-level interviews** with men and women
- **FGDs** with women, men, and those with other gender identities (separately and in mixed groups)
- **Storytelling**, focusing primarily on women and allowing them to tell their stories with CVA in a way that demonstrated change or suggested ways in which more effective change could be made.

TABLE 2: DATA COLLECTORS BY COUNTRY AND GENDER

COUNTRY	NUMBER OF FEMALE DATA COLLECTORS	NUMBER OF MALE DATA COLLECTORS
Ecuador	2	1
Ethiopia	1	4
Jordan	1	2
Zimbabwe	2	2
Total	7	8

The team conducted 28 interviews and 35 FGDs with a total of 317 respondents during the study. Women comprised 71% of individual interviews, with men comprising the remaining 29%. Fifty-six percent of the 34 FGDs involved only women (166 respondents). In addition, the team collected thirteen individual testimonies from respondents (9 women), with four videotaped (women only). The team conducted all interviews in the local language and received informed/proper consent before interviews and videotaping. CARE **Ecuador** held FGDs specifically with LGBTQI community members and CARE **Zimbabwe**'s FGDs featured many women who identified as commercial sex workers and as chronically ill.

TABLE 3: RESPONDENTS BY TOOLS AND GENDER IN EACH CONTEXT

	ECUADOR	ETHIOPIA	JORDAN	ZIMBABWE	TOTAL
Individual interviews with men	1	3	2	2	8
Individual interviews with women	2	7	3	8	20
Women-only FGDs	**3** (19 respondents)	**4** (45 respondents)	**4** (16 respondents)	**8** (86 respondents)	**19** (166 respondents)
Men-only FGDs	-	**4** (32 respondents)	6 (39 respondents)	**2** (23 respondents)	**12** (94 respondents)
LGBTQI FGDs	**1** (5 respondents)	-	-	-	**1** (5 respondents)
Mixed FGDs	**2** (11 respondents; 6 women; 5 men)	-	-	-	2 (11 respondents)
Videoed storytelling	2	2	2	-	**4** (4 women)
Narrated stories	2	-	-	7	**9** (2 men & 7 women)

The study also included an internal review of the gender sensitivity of CVA design, implementation, monitoring, evaluation and learning. The internal review included an additional country office, the **Philippines**, along with the four countries that were a part of the country-level primary research (**Ecuador**, **Ethiopia**, **Jordan**, and **Zimbabwe**). The internal review sought to corroborate the findings presented by the study respondents. This review included key informant interview (KIIs) with country office research focal points and relevant staff members and a literature review evaluating the evidence provided during the interviews. The evidence was then evaluated against country office responses and the CARE Gender sensitive CVA Guidance.

1.4 Limitations

There were some limitations to the study including:

- **The coronavirus disease (COVID-19) pandemic**: The pandemic and associated restrictions were different in each of the contexts but impacted every context. While adjustments were made (i.e., using Zoom to conduct interviews) the pandemic posed a significant barrier for CARE staff and respondents.
- **Only a small number of CARE country programs were able to participate**: Only a select few country offices out of the 50 contexts where CARE utilizes CVA could be a part of the study because of limited budgets. Therefore, the results may not reflect all of CARE's programming and may be skewed towards programs that may be complying more rigorously to CARE's ambition. The findings are a snapshot across contexts.
- **Eid al-Adha holiday during study period**: The data collection phase and the internal review of CARE CVA processes occurred during the Muslim holiday of Eid al-Adha. During this holiday CARE Jordan was closed for a week, compressing the period for the data collection and analysis for the team.

2.0 STUDY FINDINGS

Mrs Primrose Mafuta being served by Cashier Rumbidzai Manyewe whom she is handing over her WFP CVA card that she uses to swipe for her family`s monthly groceries at the local shop in Mashava. Masvingo Province. Zimbabwe. Photo credit: Vivian Ngonidzashe Munemo. © CARE 2021

Findings of this study explore respondents' experiences and perceptions across the four elements of CARE's gender sensitive CVA definition. For each context, unless there were significant differences all findings are reported in a gender aggregated manner.

2.1 Responding to Unique Needs of All Genders: Respondent's Perceptions

A core principle of gender sensitive CVA is that it is adapted in dynamic ways addressing social and political gender norms that influence opportunities and barriers to access resources and services. Included within this principle is the commitment that CVA is analysis-based and conducted in a participatory manner. Components of gender sensitive CVA design include the type of modality used, targeting criteria, intended outcomes, the pick-up location, feedback mechanisms, and risk mitigation for respondents receiving CVA. Designing gender sensitive CVA means addressing protection risks respondents may face accessing and utilizing the assistance.

TABLE 4: EXPERIENCES OF CVA PARTICIPANTS IN DISTINCT PHASES OF PROGRAMMING

	ECUADOR	ETHIOPIA	JORDAN	ZIMBABWE
Participation in CVA design discussions, including on gender issues	x/y	x/y	y	x/y
Participation in discussions on needs and risks	x	x/y	y	x
Further opportunities for feedback and engagement requested by recipients	y	y	y	y

x – not confirmed by respondents; **y** – confirmed by respondents; **x/y** – mixed

In **Ecuador**, study respondents had received humanitarian assistance from CARE in the last six months; 90% of respondents were migrants from Venezuela. Of those interviewed, 80% were women. **Ecuador** was the only country included in the study that included a FGD specifically with LGBTQI community members.

Respondents confirmed that CARE staff interviewed them via voice calls or in person as part of the targeting process. Some also participated in sensitization sessions before receiving the CVA (e.g., on GBV or sexual and reproductive health). However, they indicated that they were not involved in discussions related to program design. Most respondents mentioned that the cash transfer covered their most immediate needs, which was the expected outcome of the support. Respondents mentioned different needs that they used the transfers for, demonstrating the flexibility of the modality.

Recipients interviewed in **Ecuador** had mixed opinions on card-less ATM, which was the delivery mechanism utilized by the program. While most respondents found the delivery mechanism easy to use, some women mentioned preferring to receive cash-in-hand. A few women also mentioned having issues with their ATM experiences. Some women also noted that they would have preferred to have the initial discussions with CARE and partners in person.[4] All respondents rated CARE **Ecuador**'s treatment of them as very good, with the exception of one respondent who expressed a small concern. Respondents would have liked to have more support, such as conversations or discussions in which to tell their stories, psychological talks, entrepreneurship workshops, and mutual aid groups to promote their integration into the community.

Interview respondents in **Ethiopia** were either IDPs (90%) or poor rural host communities in Xulo and Doba woredas affected by drought and locust crises. Eighty percent of interview respondents were women. There were mixed opinions on whether respondents had been sufficiently involved in the CVA design process. More men than women claimed to not have been oriented on the CVA processes. Furthermore, at least half of the **Ethiopia** FGD respondents, of both genders, did not know much about the targeting process. In the words of one FGD respondent, "We [weren't] involved in any discussions; they just called and informed us we are targeted to receive cash and finally they took our photos."

Most survey respondents in **Ethiopia** were satisfied with discussions and awareness sessions before disbursements and appreciated the assistance. All interviewees were satisfied with the delivery mechanism and many stated that they were treated respectfully by the bank's staff, who gave priority to the elderly and people with disabilities.

In **Jordan**, interviewees included both Syrian refugees and vulnerable Jordanians. All survey respondents, with the exception of one woman, stated that they had been interviewed and consulted before the distribution of transfers. Before the distributions, Syrian refugees were interviewed by social workers and participated in lectures and discussions. At the onset of the COVID-19 pandemic, these conversations were shifted to be phone-based or conducted via Zoom. The **Jordanian** Ministry of Social Development initially evaluated the eligibility of **Jordanians** who were selected as project respondents and their houses were filmed.

Respondents in **Jordan** considered all of the delivery mechanisms appropriate. In particular, the money exchangers were located near all respondents. All respondents stated that CARE instructed them on how to use the transfers and that they felt a degree of freedom in deciding on the use of the transfer. The most common concern noted amongst the interview respondents in **Jordan** was the amount of aid provided given varying household sizes.

Interview respondents in **Zimbabwe** were recipients of the World Food Programme (WFP)-managed Urban Social Assistance Project. Respondents were host country nationals in their normal places of residence from rural and peri-urban areas. In advance of the transfers, CARE and WFP jointly held door-to-door meetings sensitizing respondents about transfer modality, length of the program, and risks associated with CVA. Additionally, there were later FGDs on nutrition, women's empowerment, GBV, nutrition, and financial management.

4 Because of COVID-19 precautions, CARE Ecuador needed to adjust how assistance was provided. The team succeeded in shifting to continuing support remotely where required. This was critical to continue the pipeline of support to vulnerable populations and ensure a level of rigor in targeting while keeping all parties safe from COVID-19 transmission in one of the countries hardest hit by the pandemic starting in March 2020.

While respondents in **Zimbabwe** were informed and trained on some aspects of the program, their engagement in the CVA design was limited. Respondents stated that, prior to the transfer, they would have liked to be involved in the selection of vendors (where the e-vouchers were redeemed) and the locations of the mobile money cash-out sites. Respondents in **Zimbabwe** expressed a strong preference for the e-voucher delivery mechanism as opposed to mobile money.[5]

Two themes were mentioned in all contexts and gender groups. First, respondents knew other community members who could have benefited from the CVA. Second, respondents expressed a strong preference for CVA that could contribute to improved, dignified livelihoods sources. Across all contexts, respondents of all types stressed multiple needs that the transfers could not cover (e.g., psychological support (**Jordan**, **Ecuador**), health needs (**Jordan**, **Zimbabwe**). In **Zimbabwe**, **Ecuador**, and **Jordan** respondents mentioned a preference for multiple transfers. All respondents welcomed involvement in future design "based on our ideas, future plans, and inspired needs" in the words of one respondent in **Ethiopia**.

2.2 Responding to Unique Needs of All Genders: CARE's Perceptions and Practices

Critical to the success of gender sensitive CVA is CARE's commitment to including the approach in targeting and design. Doing so means adding CVA and gender sensitivity elements into the market and needs assessments and risk analysis. Components of CVA must also be included within the **Rapid Gender Analysis** (RGA) (e.g. financial inclusion, access to financial service providers (FSPs), technology, literacy, and numeracy).

All participating country offices in this study completed market assessments, needs assessments, and RGAs. Only two countries, **Ethiopia**, and **Zimbabwe**, conducted feasibility assessments. However, these assessments were not specific to their programming with CVA. All countries except **Zimbabwe** conducted their own assessments, they partnered with WFP for the assessments.

TABLE 5: MARKET ASSESSMENTS AND GENDERED RISK ANALYSES CONDUCTED BY THE COUNTRY OFFICES

	NEEDS ANALYSIS: MARKET ASSESSMENT			RISK ANALYSES		
Market Aspects:	Access	Functionality	Price	For CVA	For gendered concerns	GBV risks and mitigation
Ecuador	Yes	No	No	Yes	No	Yes
Ethiopia	Yes	Yes	Yes	Yes	Yes	Yes
Jordan	No	No	No	No	No	No
Philippines	*	*	*	Yes	No	Yes
Zimbabwe	Yes	Yes	Yes	Yes	Yes	Yes

*Partially conducted during a rapid needs assessment; reevaluated after the start of the CVA intervention

TABLE 6: RGA AND CONNECTION TO CVA AND MARKETS BY THE COUNTRY OFFICES

5 This was likely influenced by stabilization that restricted transfers offered as compared to losses in currency value through mobile money. The program shifted delivery mechanisms partway through programming.

	RGA: MARKET ASPECTS			RGA: OTHER CVA ASPECTS				
	Access	Functionality	Price	Financial Inclusion	Access to FSPs	Technology	Literacy	Numeracy
Ecuador	No	No	No	Yes	Yes	Yes	Yes	Yes
Ethiopia	*	*	*	Yes	Yes	Yes	Yes	Yes
Jordan	No	No	No	Yes	Yes	No	No	No
Philippines	No	No	No	No	No	No	No	No
Zimbabwe	Yes	Yes	Yes	No	No	No	No	No

*Varies depending on the regional focus of the RGA

Most of the CARE country offices involved in this study did not include all aspects of CVA and market analysis that align with guidance for gender sensitive programming with CVA. Of the five countries involved, only **Ecuador** described themselves as having an extensive logical link between the gender-specific needs identified for programming with CVA in their assessments. CARE **Ecuador** most strongly linked their assessments to needs for different gender groups, which was further corroborated by evidence provided. All other countries reported limited connections between the gendered needs of their respondents and their programming.

2.3 Recognizing Diversity within Gender Groups

During the design phase of CVA programming, all country offices disaggregated their data by sex. **Jordan** and **Zimbabwe** were the only two countries that included disability. Data was also disaggregated by sexual orientation (**Ecuador**), nationality (**Ecuador**, **Jordan**), ethnicity, education level, and indigenous or non-indigenous status (the **Philippines**). In the implementation and monitoring phases, country offices adapted and improved, utilizing sex, age, and disability disaggregated data (SADD).

2.3.1 Communication Plans and Feedback Mechanisms

In all involved countries, CARE teams engaged with various groups to develop appropriate communication plans/ strategies and feedback mechanisms. All the country offices collected information on how community members of various groups preferred to communicate and share feedback with program staff. **Ethiopia** and **Ecuador** collected this information from men, women, and people with disabilities. **Ecuador** also involved LGBTQI community members; and **Ecuador** and **Zimbabwe** included sex workers.

While country offices attempted to develop communication plans for diverse participants, during interviews it became clear that some were more successful than others. **Ecuador** and **Zimbabwe** were the only countries that described having communication plans that extensively utilized the preferences of diverse respondents. The other three countries recognize that they had room to improve in these areas and cited adequately (**Jordan** and the **Philippines**) or limitedly (**Ethiopia**) utilizing these preferences. In **Zimbabwe**, respondents confirmed that the feedback mechanism was accessible and used to solve issues that the respondents faced. Some respondents would have preferred to have in-person follow-up from CARE, but COVID-19 protocols precluded these types of interactions.

To inform CVA respondents about the programming, country offices used mixed gender groups, selection committees,

public validation/barazas (gatherings), community sessions through local partners/organizations, and social media. **Ecuador** and **Jordan** were the only countries that used gender specific groups. Countries' communication and feedback mechanisms included phone calls, hotline services (**Jordan**), WhatsApp, e-mail, Facebook, and, where possible, surveys and FGDs. While informing communities about CVA, CARE staff had the opportunity to train and provide resources to make the CVA programming more successful and gender sensitive. For example, in **Zimbabwe** this was used as an opportunity to disseminate messages about gender and nutrition; the teams in the **Philippines**, as a part of community orientation, emphasized risks and risk protection.

Respondents across all groups in **Jordan**, **Ecuador**, and **Ethiopia** indicated that CARE staff or partners treated them with respect and were responsive to their needs.

2.3.2 Targeting

To identify CVA recipients, CARE country offices used the results of their needs, market, and rapid gender assessments to help develop targeting criteria. In addition, they used vulnerability and targeting matrices, assessments based on case management, and other relevant studies conducted by CARE and others.

In **Jordan**, **Ecuador**, **Ethiopia**, and **Zimbabwe**, most respondents felt that the correct people were targeted. In **Ethiopia**, just two of the respondents reported that they would have preferred that their husbands received the transfer. Regarding sensitization on transfers, most male respondents reported not being well informed while no women reported feeling ill informed.

In **Jordan**, respondents expressed mixed perceptions on who was best positioned to receive the transfer. In general, respondents believe that heads of household should receive the transfer, no matter if they were male or female. However, some male respondents felt that their wives may not know where to go or would not be able to collect a transfer because of childcare duties.

2.3.3 Monitoring and Evaluation

Country offices most often used post-distribution monitoring (PDM) for monitoring CVA programming. Other tools included FGDs, exit interviews, and field observations. Monitoring for **Zimbabwe**'s programming was performed by WFP and included transaction reports, PDMs, feedback and accountability mechanism reports, and Gender and Accountability Focal Persons reports. Importantly, CARE did not have access to or collect the PDM data and was later granted access by WFP. This presented an obstacle for CARE to understand and mitigate any issues that were arising in the PDM data.

To develop indicators for monitoring, **Ecuador** used **the multipurpose cash guidelines** produced by the Grand Bargain's Cash Working Group and looked at satisfaction with the process. **Ethiopia** and **Jordan**, on the other hand, created their indicators based on initial assessments (e.g., the percentage of women who reported they were able to equally participate in household financial decision-making and the percentage of women who reported they were able to decide equally the expenditures of cash assistance). CARE **Jordan** also utilized assessments from other international nongovernmental organizations (INGOs) and nongovernmental organizations (NGOS,) including from the Cash and Basic Needs Working Group. The **Philippines** was the only study country that did not consistently have CVA indicators highlighting the experiences of women.

CARE teams monitored risks and their mitigation through PDM data. In **Ecuador**, this was complemented by FGDs and interviews. In **Ethiopia**, CARE collaborated with local partners to collect information. In **Jordan** and the **Philippines**, CARE used feedback mechanisms (e.g., phone-based survey, PDM) and FGDs.

2.4 Avoiding Exposing Recipients to Harm and Risk

Central to CARE's mandate is to do no harm, and that commitment is critical for gender sensitive CVA. Study respondents identified several risks specific to various gender groups, as seen in Table 7.

TABLE 7: PROTECTION RISKS IN PROGRAMMING WITH CVA

RISK	DESCRIPTION
Process (CVA registration, collection, delivery, and access)	Risks for women arise after collecting their transfers – such as robbery – and consequences for extended time away from household responsibilities due to long journeys to collection sites. Women's safety and security concerns also include a lack of knowledge and understanding of technology, illiteracy, language barriers, and the lack of required documentation. CVA risks during registration, collection delivery, and access may vary by gender identity and other vulnerable identity groups (e.g., LGBTQI community).
Communication mechanisms	Information-sharing and communication mechanisms need to be accessible and appropriate for various gender groups and vulnerabilities (related to literacy levels, language, and access to and use of technology) as this influences the accessibility of the transfer, engagement with the CVA project, and protection risks. This is also critical for ensuring that women can safely raise concerns related to Protection from Sexual Exploitation and Abuse (PSEA) risks.
Intra-household tensions and GBV	In some contexts, women's receipt of CVA can create additional tensions and increased risk of GBV in their households. For example, if the transfer value was not enough to cover essential needs in some contexts, women faced an increased risk of GBV at home. Additionally, if women's engagement with the CVA project threatened their ability to meet their household responsibilities due to time poverty, women might also face increased risks of tension and GBV.
Community-level tensions	In some contexts, women, and other vulnerable groups (e.g., youth and LGBTQI community members) may experience fear or harassment within their communities due to their receipt of CVA.
Protection Against Sexual Exploitation and Abuse (PSEA)	PSEA concerns associated with accessing humanitarian aid are relevant to CVA. Whether perceived or real, from any number of people and groups including FSPs Providers, CARE staff, or partners, these concerns present an enormous risk to CVA recipients and threaten their safe access to CVA.

2.4.1 Protection: CARE Practices

All countries, except for **Zimbabwe**, included assessments of the potential intended and unintended consequences of CVA programming. **Zimbabwe** did not include this evaluation as it was not a planned and prioritized activity of their partner/donor. In interviews, none of the country offices described themselves as extensively evaluating the risks for all gender groups. Three of five (**Ecuador**, **Ethiopia**, and **Jordan**) described conducting an adequate evaluation of protection risks. The **Philippines** included a limited evaluation of protection risks in their PDM.

2.4.2 Protection: Respondents' Experiences

The most significant risks and barriers in **Ecuador** were related to migratory status and gender stereotypes. These barriers included illiteracy, xenophobia, lack of knowledge of the context and locality, the work environment, and technological illiteracy. Some respondents felt that barriers were most burdensome for the elderly and people with disabilities. Some male and female respondents felt that women had more barriers than men; LGBTQI FGD respondents explained that their community also faced additional barriers. However, none of the **Ecuador** respondents indicated that the identified risks resulted in incidents for program respondents.

Women survivors who participate in workshops on psychosocial support mechanisms through art therapy, Guayaquil, Ecuador © 2021 CARE

All interview respondents in the **Ethiopia** stated that there were no barriers to accessing CVA for any respondents, including women, men, the elderly, and people with disabilities. Respondents highlighted that the elderly and people with disabilities got assistance and priority during receipt of CVA. Some respondents, mostly women, mentioned that access to the distribution sites and banks could have been more of a challenge for the elderly and people with disabilities, but they did not note any specific cases of this occurring. There were a couple of female FGDs that mentioned the attempts of local government officials to be overly involved in targeting.

Respondents in **Jordan** raised concerns about risks and barriers related to CVA both inside and outside the household. A few respondents believed that women may face risks from men in their households, such as men taking control of the finances and not including the women in decision-making. This risk was not reported by all respondents and respondents felt that it depended on household dynamics. A small number of women respondents stressed that "there are no challenges that cannot be solved, everything has a solution."

Reported barriers in **Jordan** were mixed depending on demographics (Syrians vs. Jordanians; men vs. women). The primary reported barriers were related to recipients' understanding of technology used for the transfers. Respondents also highlighted the possibility of participating women being exposed to exploitation, harassment, and robbery. While the majority of respondents said that there was no risk because an understanding of shared financial decision-making exists within households. Respondents said that risks are not the same for men, women, boys, girls, the elderly, and persons with disabilities. Views varied, but concerns highlighted included men taking the cash and not spending on household needs. Women, the elderly, and people with disabilities are at greater risk of exploitation. They also reported that those who experienced barriers in accessing the CVA distribution centers could be accompanied by other household members. Men and young people were considered to have fewer or no risks.

"With the cash support, I kept few amount [sic] and bought vegetables and started petty trade where I consume the profit. I have the morale and initiative to trade and work with greater capacity. In addition to this, I would like to receive additional cash support so as to increase my working capital and engage in income-generating activity. We started seeing changes since the CVA transfer."

- DAHABA, WOMAN RESPONDENT AND IDP IN WEST HARARGE

In **Zimbabwe**, respondents felt that women were more exposed to risks and had more barriers, as did chronically ill people. This was connected to cultural norms related to women's roles, which are seen as inferior to those of men. Respondents mentioned that many women do not have identification or phones, which present considerable barriers for them to participate fully and independently.

Another issue in **Zimbabwe** was that some vendors are located very far from the project participants' homes, exposing respondents, especially women, to more risks. Universally respondents felt that additional transfers for transportation would have helped. At the vendor level, various respondents noted that women received less respect from shop keepers than men, an observation reported by both women and men.

The issue of barriers to receiving assistance for chronically ill respondents or caregivers of chronically ill family members was highlighted across all genders and ages in **Zimbabwe**. In the FGDs, respondents demonstrated that this had spillover effects: illnesses caused absenteeism in sensitization sessions, resulting in participants missing out on key information.

Another interesting point highlighted by the respondents in **Zimbabwe** was that late payment to the vendors by the implementing agency caused inconveniences for respondents; this is notable as it came up in multiple FGDs.

2.5 Building on Social Norms Work

In addition to addressing the immediate needs of respondents, CVA programming also strives to foster positive and long-term gender impacts. Building on social norms work includes acknowledging existing dynamics in household decision-making and handling cash transfers; this is vital to ensuring sustainable gender impacts. Analysis of social norms enables an in-depth understanding of the safety and security issues related to the provision of CVA, bearing in mind the potential for CVA to create more risks and do more harm than good.

2.5.1 Experiences of CVA Respondents

In **Ecuador**, half of respondents indicated that CVA had not changed household decision-making related to finances. The other half of the respondents stated that there had been some positive changes related to financial decision-making and that they now feel more confident in making decisions related to household expenditures and felt supported and accompanied by CARE. Unfortunately, most respondents believe that such changes in household decision-making dynamics only occur when they receive the transfers and are not long-term. However, respondents who invested in income-generating inputs did expect to have fixed incomes in the medium- and long-term, which might positively contribute to gender relations and decision-making.

Past economic experiences positively impacted respondents' CVA experiences in **Ethiopia**, especially women. A majority of respondents said that women had experience handling cash and deciding on its use. Many were also traders and

IMPORTANCE OF INTERSECTIONALITY IN ANALYSIS

In Zimbabwe, gender norms strongly dictate that men are providers. When disability precludes men from taking that role, the entire household can be negatively impacted. Looking at social norms with an intersectional lens to inform gender sensitive CVA is an important step.

"As disabled person with a family of nine, it was difficult for me to support my family. I used to work as a mechanic but I couldn`t do that anymore following a car accident that left me paralyzed. With the assistance from the program, my family could now access nutritious foods that I was no longer able to provide them with.

"My family used to suffer discrimination due to my disability and limitations in providing them with a better life. Upon being paralyzed, I started mending shoes, but the money wasn't enough to support the family. Thanks to the food assistance program, I was able to redirect the little income from my shoe mending towards savings as we no longer needed it to buy us more food. These savings have enabled me to expand my shoe mending into shoe, sandals, and belt making.

"We decided to save up and invest in enhancing our shoe-making venture because we want to be self-resilient when this program leaves us."

– MOSES, MASVINGO, ZIMBABWE

businesswomen and, because of this, had prior experience handling money and generating income. In addition to previous life experiences, respondents were provided with training about gender and decision-making by CARE staff and government offices. These training courses further strengthened women's position in cash handling and decision-making.

There were generally positive cultural and attitudinal changes observed in the community within the households that received the transfers. Respondents noted an increase in joint financial decision-making in the household, though it seems that these decisions were already typically made jointly. However, women FGD participants shared contradictory perspectives; most women in the FGDs shared that if they were to use the CVA to earn income, this might have changed their roles within the household. Therefore, they concluded that the extent to which it altered household decision-making was not anticipated to maintain in the long-term, similar to findings from **Ecuador**.

Among respondents in **Jordan**, women's experience handling money varied. Both men and women indicated that some women had limited or no experience with handling money, while others had extensive experience. Equally there was no agreement on whether women or men were better placed in managing money. The responses suggested that the money management depended on the household members and not necessarily the gender.

On a positive note, women respondents in **Jordan** revealed that their financial management skills were enhanced while receiving the transfers. Women respondents said that CVA transformed household decision-making, allowing them to be more vocal and participate in household decision-making. They suggested that the CVA can contribute to a "lifestyle shift," with the head of the household adapting a more participatory style of decision-making. Women respondents stressed that, after receiving CVA, they gained experience managing the household expenses. Male respondents, on

the other hand, believed the CVA in the amount currently provided was insufficient for changing decision-making mechanisms. Some of the male respondents mentioned that the decision-making processes were already participatory. Unfortunately, regardless of gender identity, all respondents stated that any changes to household decision-making were short-term.

In **Zimbabwe**, there were mixed responses, depending on the respondent's sex and marital status, as to whether men and women held the rightful role to receive the transfers; there was no firm consensus in the data. The respondents claimed that gender stereotypes significantly impacted women's ability to manage money and be engaged in financial decision-making. There was agreement that women in **Zimbabwe** generally have less experience than men with handling money. Single women felt they had more barriers overall and female sex workers in **Zimbabwe** mentioned that their largely nocturnal schedules may make it difficult to fully participate in the program.

On a positive note, **Zimbabwe**an respondents – both men and women – noted that women's ability to budget has improved as a result of the project. Many respondents agreed that they were more involved in the decision-making on spending money since the transfers. However, widowed, single, and divorced women reported that the transfer was not enough to meet their needs when compared to other groups.

3.0 DISCUSSION

Catherine and Anxious Chitombo, part of a family of nine, stand with their groceries after redeeming their WFP Social assistance voucher from SPAR. Masvingo. Masvingo Province. Zimbabwe. Photo credit: Vivian Ngonidzashe Munemo. © CARE 2021

Recommendations presented in the 2019 CARE study remain valid. How successfully has CARE been able to meet these recommendations in the various contexts? The answer is mixed, but there is clear progress.

Two critical elements of CARE's gender sensitive CVA approach is that it focuses on process – the way programming with CVA is designed and delivered – and outcomes, especially focusing on outcomes that are important to women and frequently underfunded in humanitarian responses. This study shows that CARE is improving on the process aspects; most respondents across all gender groups were satisfied with how the projects were designed and implemented, though they also noted some needed improvements.

In terms of outcomes, the transfers did meet some needs of the target populations, especially women. However, across the board there were other needs that respondents and their communities had that the transfers did not meet. In the future, CARE can use this information to make clear to donors what respondents' true needs are and, hopefully, receive funding to meet these needs.

Another important element of CARE's CVA programming was the cash plus approach[6], which helps address underlying causes of gender inequity or for needs that cannot be met by CVA alone.

6 Cash plus or complementary programming refers to programming where different modalities and/or activities are combined to achieve objectives.

FIGURE 1: PRINCIPLES OF GENDER SENSITIVE CVA

CVA that works for women is gender-sensitive.	CVA that works for women is not only designed for them, but most importantly, with them.	CVA that works for women is based on robust gender analysis.
CVA that works for women is designed to sustainably transform gender roles and relations.	CVA that works for women is designed to increase their ability to manage their finances in the long term.	CVA that works for women is designed to protect them.

The CARE teams have excelled at talking to individuals from a variety of gender groups with various intersectional characteristics for this review. Interestingly, even with the inclusion of different gender groups in this study, there were relatively few points where opinions on and experiences of CARE's CVA programming diverged. While this study design precludes definitive assessment, this lack of difference of opinion may indicate that CARE's implementation of CVA is broadly gender sensitive for most respondents. Respondents pointed to few instances where particular groups experienced difficult access on a large scale. Respondents confirmed the general groups CARE pays special attention to for accompaniment throughout the process of receiving the CVA are the elderly and people with disabilities. Intersectionality – including related to civil status and sexual orientation – was explored more in this study and is something that CARE is committed to understanding better. This study confirmed that CARE staff and partners' treatment and feedback mechanisms were well-received across all gender groups.

The COVID-19 pandemic presented unique challenges and opportunities for CARE in its pursuit of gender sensitive CVA. CARE and partners expanded the ways in which they reached out to people in need through technology, allowing for CVA support even during periods of restricted movement/lockdown. During this period, CARE **Jordan** also expanded the types of delivery mechanisms used, which was well-received and seemingly contributed more towards a gender sensitive approach. At the same time, many respondents – mostly women – expressed a desire for more in-person support and direct transfers from CARE and CARE partner staff. Obviously, there was a difficult balance between maintaining safety for the teams while providing the type of support participants required. Despite the obstacles, teams across these contexts managed to provide high-quality CVA support services and maintain loyalty to CARE's gender sensitive approaches

Each context used RGAs to provide gendered understanding of needs, a critical step in designing gender sensitive CVA. Most of the RGAs included analysis on financial inclusion, technology, literacy, and numeracy. However, not all of the contexts included these components, and none included market-based analysis. One of the obstacles making this analysis more systematic is that the existing RGA tools focus on sectoral outcomes rather than approaches. Without a cash or markets specialist participating in the scope of work for the RGA, a "market lens" is likely to be left out. This is a lost opportunity to deeply understand if market-based responses are feasible especially as CARE's work in urban areas grows. CARE's teams are piloting additional tools that will help guide better integration of market-related questions in RGAs and are reviewing examples of where teams have successfully incorporated market-related considerations in RGAs.

The recommendation from 2019 of combining the specialties of gender and CVA is still in progress for achievement in most of the study areas. For market assessments overall, CARE teams are mostly complying on understanding gendered access, but need to improve on understanding price and functionality. These are critical at the assessment stage in order to tailor the transfer value (e.g., Is a top up for transportation needed?) and after transfers are made (e.g., Is there market distortion and where do women vs. men go if there is?). Failing to include these components will affect the degree to which country office programming with CVA demonstrates a logical link between the gender-specific needs identified for CVA and satisfies the diverse needs of CVA respondents.

Project participant, Amman, Jordan 2022 © Nadia Bseiso/CARE

Documented analyses of gendered risks specific to CVA across the study areas were low. Generally, CARE country offices have response-level risk analyses, which includes GBV risks. However, CARE's ambition and guidance suggests that all programming with CVA should do a formal analysis of GBV risks related to CVA. The organization led the development of tools and guidance on GBV risk mitigation in CVA and there are some strong examples of how this can be done. By incorporating this type of analysis with teams on the ground, it centers the conversation on the realities of the context, exploring what the real GBV risks and specific mitigation measures needed are.

This study highlighted yet again the important work of designing programming with CVA based on gendered analyses. The barriers and risks for women and other vulnerable groups are the same as those outlined in the 2019 study. Accompaniment for the most vulnerable populations remains especially important when normal procedures are adjusted, such as during the COVID-19 pandemic. As a result, CARE must continue exploring how to ensure that people of all genders are sensitized to, have access to, and benefit from CVA safely.

CARE Jordan was involved in both the 2019 and 2021 studies. Comparing the findings across the two studies reveals some interesting trends. It is worth noting that CARE Jordan prioritized an internal review of its team's capacities, ways of working, and processes connected to CVA in 2020-2021. In the 2019 study respondents expressed a preference for transfers provided closer to home and, in the current study, it is clear that the expansion of delivery mechanisms to include the exchanger companies was well received. This new delivery mechanism may have also alleviated some of the barriers experienced by women who were less tech-savvy. What is evident from the Jordan data is that the team must keep an eye on issues of intersectionality, as there was mixed feedback on who is best placed to receive transfers, manage money, or make decisions on the transfers among Jordanian and Syrian respondents. As a result, social norms and gender sensitization work as well as follow up with case managers will be critical to foment and augment the gender sensitive CVA approach. As CARE Jordan prioritizes transfers to women, they will continually need to be mindful of these different views to mitigate any risks of violence or harm to respondents. Encouragingly, the 2019 study found cases in which the transfers caused tensions in some the households, but this was not reported in this study as an experience of respondents and was only noted as a potential risk.

This study also re-emphasizes the critical importance of understanding and mitigating gendered risks during the implementation phase through monitoring data. Further work needs to be done to include gender indicators in programming with CVA; not all of the study countries included these indicators. However, PDM, which all the involved country offices used, can be easily adapted to add such questions. Most of the CARE study contexts did also include assessments of unintended consequences of the support, which can be analyzed with sex and age disaggregated data (SADD).

Monitoring data highlighted the positive – albeit seemingly temporary – impact of on shared decision-making at the household level during the time of the transfers. It would be interesting to see what sort of longer-term impacts would be reported by respondents; this would require a dedicated evaluation. There were some positive indications that the transfers contributed to women's improved budgeting and financial skills. It is possible that these might be more durable changes.

Findings from this study call for nuance in how we understand engaging different types of people in our design. CARE and peers are increasingly using CVA at scale and in urban areas. The traditional approach of visiting a rural community, discussing needs, designing a project, and implementing it with the same people is less common than one in which discussions are held with "proxy" populations. This is the likely explanation as to why so few respondents of any gender felt that CARE had engaged them in the design of CVA programming. Therefore, it may need to be made clear to crisis-affected people of all genders why and how CARE reached design decisions; this is necessary to ensure accountability to affected populations. Clearly, all respondents were willing to discuss the needs and risks they faced in receiving CVA and the implementation and monitoring phases of a CVA project offer opportunities to analyze and pivot towards more gender sensitive processes – such as the selection of vendors, provision of transportation in transfer fees, adjusting delivery mechanisms – to reduce risk and burden for the most vulnerable people.

Generally, all gender groups were comfortable with the delivery mechanisms utilized. As expected, more women than men had issues with the delivery mechanisms; although this was a relatively small subset of respondents, attention to this issue is still required. Overall, respondents confirmed that CARE staff, partners, and FSPs assisted them when they had problems. Having more than one delivery mechanism as an option was a useful approach in **Jordan**. However, there will always be a need to strike a balance between risk mitigation for respondents and CARE staff and partners and efficiency, as was also highlighted in the 2019 study.

There were some interesting findings on sensitization on processes. In **Ethiopia** in particular, men claimed to be less

Women participating in FGD, Ethiopia, © 2022 CARE

informed about the CVA process. It may be the case that women were prioritized as audiences since they are traditionally seen as CVA recipients. However, care must be taken to include men even if women are the registered participants,[7] this was highlighted in the 2019 study as well.

At a global level, CARE committed to finding the tools and processes that field-based CARE and partner teams use to understand what is meant by gender sensitive CVA. Significant strides were made since 2019[8] in achieving this ambition. However, continual investments in capacity building, sensitization, and mentoring are needed to make gender sensitive CVA a reality for CARE's participants.

While the response-level recommendations were not prioritized for deep analysis in this study, the importance of those recommendations was reflected in the data. One positive point is that some of the RGAs were done in collaboration with other actors and co-led by CARE.

In the 2019 study, CARE committed to advocating to others about the importance of a gendered approach to responses with CVA. CARE, as co-lead of the gender and cash sub-workstream of the Grand Bargain's Cash Workstream, collaborated with peers to encourage and equip the humanitarian sector to embrace and increase capacities in integrating gender equality and women's empowerment, as well as prevention and mitigation of and response to GBV, when using CVA in crises and humanitarian settings. Unfortunately, gender remains on the margins of discussions about CVA at the response-level; the **few response-level examples** have yet to yield significant cross learning. Nevertheless, the need for advocacy on the importance of a gendered approach to responses with CVA still remains. One such example is the expressed need to make CVA a part of durable solutions, especially for displaced and migrant women who, because of structural and cultural barriers, are less likely to have dignified livelihoods options. Additionally, it remains relevant in responses where few delivery mechanisms that are technology-heavy prevail; these study respondents reconfirmed women and especially the elderly and people with disabilities continue to need accompaniment using these systems, which frequently do not consider the needs of various gender groups in their design.

7 This would apply to transfers destined for household use and not individual such as health or GBV response.

8 **Gender Sensitive Cash and Voucher Assistance**, **Cash and Voucher Assistance & Gender-Based Violence Compendium**, **Guidelines on Using Cash and Voucher Assistance for Sexual and Reproductive Health and Rights Programming**, **Better Gender outcomes in food assistance through complementary and multimodal programming tip sheet**, **Behavioral Design Checklist for Humanitarian Cash and Voucher Assistance Improving Outcomes for Women**

ANNEX I: CARE RESEARCH FOCAL POINT AND INTERVIEW RESPONDENTS

NAME	POSITION	COUNTRY
Monica Tobar	Manager program quality and resource mobilization	Ecuador
Maria Belen Ayala	Monitoring and Evaluation Officer	Ecuador
Kasaye Ayele	Advisor: Financial Inclusion (PQL (Program Quality Learning))	Ethiopia
Rasha Mohammed	Gender and Program Design Manager	Jordan
Clayton Mafuratidze	Cash Lead/MEAL Specialist	Zimbabwe
Augustine Masomera	MEAL Advisor	Zimbabwe
Serkalem Getachew	Emergency Food Security, Livelihood, and Early Warning Advisor	Ethiopia
Amanuel Kassie	CVA focal person for humanitarian Programs	Ethiopia
Getu Temesgen	IGA/Income and Financial Service Advisor	Ethiopia
Sintayehu Mesele	Program Quality and Learning Coordinator	Ethiopia
Rasha Mohammed	Gender and Program Design Manager	Jordan
Hiba Sarhan	Quality and Accountability Coordinator Programs Quality Department	Jordan
Nour AlSaaideh	Director of Protection and Community Engagement	Jordan
Francelline Jimenez	Business Development Manager	The Philippines
Clayton Mafuratidze	Cash Lead MEAL Specialist	Zimbabwe
Augustine Masomera	MEAL Advisor	Zimbabwe
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