



“Case management integrated with cash transfers is one of the best responses we can use”

An Operational Learning Brief on Integrating Cash Assistance into Gender-Based Violence Programming in Ocaña, Colombia



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Cover Image Caption:

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Cash-GBV Case Management Program participants taking part in a participatory activity identifying types of GBV, Ocaña

Full Quote:

“Cash is a vehicle that can help many women improve their living conditions. With [gender-based violence] case management, we can identify the most appropriate moment to deliver cash and when women are in the right circumstances to receive it, avoiding exposing them to risk. Case management integrated with cash transfers is one of the best responses we can use to overcome gender-based violence.” – Angelica Rios, psychosocial professional and project lead for CORPRODINCO

Mission statements:

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TABLE OF CONTENTS

I. INTRODUCTION	4
II. OPERATIONAL CONTEXT AND STAKEHOLDERS	4
III. CHALLENGES FACED DURING IMPLEMENTATION: SAFETY, SECURITY, AND THE EXISTING PROTECTION SYSTEM	5
IV: METHODOLOGY	6
V. PROGRAM MODEL	7
Story of a Colombian Cis Woman Survivor Who Received Cash-GBV Case Management	8
Story of a Colombian Survivor with Diverse Sexual Orientation and Gender Identity Who Received Cash-GBV Case Management	9
VI. LOCALIZATION	16
VII. CONCLUSION	17
ACRONYMS AND ABBREVIATIONS	18

I. INTRODUCTION

With support from the United States Agency for International Development (USAID) Bureau for Humanitarian Assistance, the Women’s Refugee Commission (WRC), CARE, and the *Corporación de Profesionales para el Desarrollo Integral Comunitario* [Corporation of Professionals for Comprehensive Community Development – CORPRODINCO] partnered to deliver gender-based violence (GBV) case management to 200 survivors in Ocaña, Colombia. As part of this project, they evaluated the outcomes and impacts for the 100 survivors who received GBV case management integrated with cash and voucher assistance (CVA) and the 100 who received GBV case management only (no cash). Click [here](#) to read the evaluation report.

II. OPERATIONAL CONTEXT AND STAKEHOLDERS

With the deterioration of the economic and political situation in Venezuela, a humanitarian crisis has spilled into 16 countries across Latin America and the Caribbean, including Colombia. Colombia hosts 2.4 million Venezuelans as at 2021.¹ Internal displacement and confinement escalated in 2019, due to a variety of armed non-state actors competing for income from narco-trafficking, human trafficking, and illegal mining.² Despite being increasingly overshadowed by the Venezuelan migration crisis, the preexisting internal conflict in Colombia has ensured that the country has the second-largest number of internally displaced persons in the world (after Afghanistan), with an estimated 9.2 million people experiencing protracted displacement.³

Before entering Colombia, Venezuelan migrants and refugees risk exposure to, and experience of, GBV. During the COVID-19 pandemic, Venezuelans suffered increased exposure to sexual violence and other protection concerns when the Colombian–Venezuelan border closed, and migrants and refugees pivoted to using irregular roads to enter Colombia.

For both Colombians and Venezuelans, there are substantial risks of exposure to, and incidents of, GBV in Colombia. The national and international conflicts enveloping Colombia have increased poverty and crime, in turn driving an increase in human trafficking. Women are particularly susceptible, as traffickers lure them with the promise of economic opportunity, such as jobs as street vendors, only to sexually exploit them.⁴

For Venezuelan migrants, particularly women and girls, GBV risks are magnified by discrimination, lack of legal status, and their work in the informal sector—where they face a lack of protection against hostilities from some host community members. In addition, forced migrant and refugee women have reduced access to services, including state-run health care, due to a lack of documentation.

1 Office of the United Nations High Commissioner for Refugees, *Colombia: Latest updates*, retrieved June 10, 2022, <https://reporting.unhcr.org/colombia>.

2 Human Rights Watch, *The War in Catatumbo: Abuses by Armed Groups Against Civilians Including Venezuelan Exiles in Northeastern Colombia*, 2019, www.hrw.org/sites/default/files/report_pdf/colombia0819_web_0.pdf.

3 Unidad para la Atención y Reparación integral de las Víctimas, www.unidadvictimas.gov.co/es/registro-unico-de-victimas-ruv/37394.

4 Adriana Marcela Pérez-Rodríguez, “Gender-based violence in a migrant context: a case study of Norte de Santander,” *Humanitarian Exchange Magazine*, no. 80 (March 2022): pp. 21–25, odihpn.org/publication/gender-based-violence-in-a-migrant-context-a-case-study-of-norte-de-santander/.

In 2021, over 115,000 cases of GBV (primarily physical and sexual violence) were reported to the *Sistema de Vigilancia en Salud Pública*,⁵ Colombia’s public health surveillance system. Of these cases, 77.9 percent were reported by women and over 5,800 were reported by Venezuelans.

At the time of publication, there were no national statistics that disaggregate reports of GBV by individuals with diverse sexual orientation, gender identity and expression, and sex characteristics (SOGIESC), meaning that there is limited information to estimate the incidence of GBV among this group. In Ocaña, forced migrant and refugee individuals with diverse SOGIESC face significant discrimination and violence from the broader community. Colombian lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) individuals also endure discrimination and violence from their community due to deeply held religious values that denounce their identities and sexualities.

“Women I spoke with were not aware of the different types of violence. They said they didn’t know that psychosocial violence was violence. They didn’t know that if they were mistreated, it was violence. Thanks to this [program and] study, women know the law.”

– Adielia Hoyos Salgados, GBV caseworker, CORPRODINCO

“We need to support the capacity-building for national authorities. In Ocaña, operations are not adequate.....We need to mediate for these women. The resistance from the institution to gender violence is still strong.”

– Laura Lozano, GBV caseworker, CORPRODINCO

III. CHALLENGES FACED DURING IMPLEMENTATION: SAFETY, SECURITY, AND THE EXISTING PROTECTION SYSTEM

Several challenges arose during the program in Norte de Santander, Colombia:

- Originally, the program was to be implemented in Tibú, a municipality next to the Colombian–Venezuelan border that hosts forced Venezuelan migrants. However, Tibú is rife with armed conflict because of its proximity to the border. Due to safety concerns for program staff and their previous experiences in Tibú, where GBV and gender-transformative programming was met with resistance, implementation of the program and evaluation was moved to Ocaña.
- The GBV survivors and at-risk individuals targeted by the intervention struggle to meet their basic needs and live in unsafe, often remote places in Ocaña, far from the reach of service providers. To bring service delivery closer, mobile GBV case management was delivered where it was safe to do so. Although this adaptation was built on security analysis, it increased security risks for program staff. Program participants also received cash to cover the costs of transportation to centrally located and safe meeting points.



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Cash-GBV Case Management Program participant participating in an activity identifying types of GBV, Ocaña

5 Colombia Ministry of Health and Social Protection, *Integrated Information System on Gender Violence*, Observatorio Nacional de Violencias de Género, retrieved June 10, 2022, www.sispro.gov.co/observatorios/onviolenciasgenero/Paginas/home.aspx.

- There is a lack of institutional knowledge, skills, and will to support both survivors and program staff—resulting in gaps in the activation of referral pathways. This hindered survivors’ safety and recovery and created an operational risk for program staff who were bridging the gap in service provision caused by the absence of strong institutions.
- The lack of integration and coordination among cash for protection, multipurpose cash assistance (MPCA), and livelihoods in this context can slow or stall GBV survivors’ escape from abusive situations. If survivors’ basic needs and livelihoods are not addressed, they will often have to spend the cash assistance intended for protection outcomes on covering their individual and family basic needs and/or investing in an income-generating activity, rather than accessing protection-related goods and services. This situation leads GBV survivors to prioritize their urgent needs at the expense of their recovery from incidents of violence.
- GBV case management follow-up on programming and referrals, including referrals to cash assistance, was challenging. GBV programming in Ocaña is insufficient to meet the needs of GBV survivors and individuals at risk of exposure. This means that existing service providers are overstretched in an attempt to fill the gaps.
- While several humanitarian-led coordination mechanisms are operational⁶ at the country level and across many of Colombia’s departments, persistent gaps remain in the protection system, especially in Ocaña. Greater coordination with and engagement of local government is critical to an effective protection system, including the engagement of the Municipal Ombudsman’s Office.
- Due to COVID-19, state-run and civil society-led care services were often offered virtually, which was a barrier for survivors who did not have access to electricity and the internet. However, some authorities, such as the Prosecutor’s Office and the Judicial Branch, were easier to reach because of their ability to work online, facilitating access to rights.
- In this context and others, many GBV survivors are hesitant to disclose incidents of violence and are disheartened by the shortcomings and failures of official reporting channels, such as the police, particularly the criminal investigation unit. In addition, survivors do not always wish to denounce their aggressor for fear of reprisal in situations where they are economically dependent on their abusers. Furthermore, survivors might choose to only disclose certain aspects of their experiences of violence due to stigma and social and cultural norms.

IV: METHODOLOGY

This learning brief focuses on operational and programmatic learning and the resulting recommendations for advancing CVA-integrated GBV case management in Ocaña, with implications for uptake in other settings in Colombia, as well as across Latin America and the Caribbean. It draws on operational findings discussed in the evaluation report,⁷ in addition to a three-part series of after-action review (AAR) workshops and key informant interviews (KIIs) conducted with five CARE Colombia and five CORPRODINCO project staff between April 6 and 21, 2022.

The AAR for this project adapted CARE’s methodology and took place through two hybrid (in-person and Zoom) focus group discussions (FGDs) and one KII. FGDs were conducted with partner staff and led by the CARE senior cash and market technical adviser, with contributions from the WRC associate director for cash and livelihoods. ALL FGDs followed the same structure: welcoming and contextualization of the activity, discussion of key questions, and closing. Each FGD lasted for approximately 90 minutes and was simultaneously interpreted in Spanish and English.

6 These include the humanitarian country team, the Interagency Group for Mixed Migration Flows, gender-based violence sub cluster working groups at the national and local levels, and the Money Transfer Group.

7 Women’s Refugee Commission, CARE, CORPRODINCO, *The Effectiveness of Cash Assistance Integrated into Gender-Based Violence Case Management for Forced Migrants, Refugees, and Host Nationals in Norte de Santander, Colombia: A Quasi-Experimental Mixed-Methods Evaluation* (2002), www.womensrefugeecommission.org/wp-content/uploads/2022/06/Effectiveness-Cash-Assistance-Integrated-Gen-der-Based-Violence.pdf.

Table 1. AAR overview

	Date	Categories	No. of participants	Age (years)	Gender
1	April 6, 2022	KII — former CARE Staff	1	31–64	1 woman
2	April 8, 2022	FGD — CORPRODINCO staff	5	31–64	5 women
3	April 21, 2022	FGD — CARE staff	4	31–64	4 women

V. PROGRAM MODEL

The program model was a CVA-integrated GBV response case management program, based on the GBV Compendium⁸ and the WRC *Resources for Mainstreaming GBV Considerations in CVA and Utilizing CVA in GBV Prevention and Response Toolkit*.⁹ WRC, CARE, and CORPRODINCO partners contextualized the program for implementation in Colombia and CORPRODINCO, as the local national partner, executed the delivery of the program on the ground.

This program aimed to include both adult men and women aged 20 years and older and adolescent boys and girls aged 15–19 years who were survivors of, or at risk of, GBV, including those who might identify as LGBTQI+. CORPRODINCO caseworkers (all female) enrolled survivors into the program after they disclosed their exposure to GBV. Caseworkers then evaluated which participants to select to receive cash assistance and notified selected participants of the process to access this assistance. As part of the case management, caseworkers also provided psychological counseling, information on and coordination of group workshops, and access to the CORPRODINCO legal service. They also made referrals to external services to further address survivors’ needs, for example, sexual and reproductive health (SRH) services, immigration status counseling, family commissioners, and education and livelihoods training. Service mapping and referral pathways were updated regularly to reflect the available services for referral.

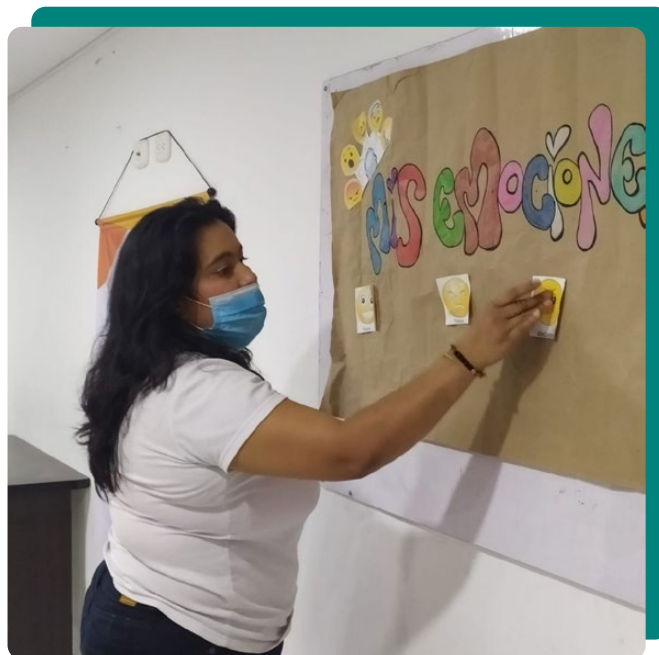
During the program, numerous referrals were made for GBV survivors to access these services, including child protection case management for 30 survivors, food security assistance for 43 survivors, SRH services for seven survivors, protection orders for 25 survivors, and state-run safety nets for three survivors.

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

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

Each GBV survivor enrolled, for whom cash assistance was deemed appropriate, received up to three unconditional and unrestricted transfers within GBV case management, up to a total transfer value of \$91 to \$274, depending on each survivor’s needs.¹⁰ Of the 100 survivors who received cash transfers integrated into GBV case management, 97 received three transfers with a total transfer value of \$274, two survivors received two transfers with a total transfer value of \$183, and one survivor received one transfer with a total transfer value of \$91. Cash assistance was delivered via Efecty, which operates payment points from which survivors can pick up the CVA at a time of their choosing.

To learn more about program implementation and evaluation findings, click [here](#).



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Cash-GBV Case Management Program participant participating in an activity identifying types of GBV, Ocaña

Story of a Colombian cis woman survivor who received cash-GBV case management

Carolina,¹¹ a survivor of GBV, was displaced after armed groups entered her village, forcing her and many other members of her community to flee. She relocated to an informal settlement in Ocaña, where she was living in a makeshift shelter.

After taking part in one of CORPRODINCO’s community GBV awareness campaigns, Carolina began to see that the risks of and exposure to GBV, including intimate partner violence, should not be her norm. She no longer wanted to be a victim.

She reached out to CORPRODINCO to enroll in GBV case management and, with her caseworker, she assessed her recovery needs as a survivor. Based on the targeting survey that informed program eligibility criteria and the prioritization of cases for cash referrals in the project standard operating procedure (SOP), her caseworker offered a referral to cash assistance, which Carolina accepted. Psychosocial care, survivor workshops, and home visits with her GBV caseworker helped her reflect on her experiences and identify the best path forward. She received three cash transfers totaling \$274, and was able to settle some of the debts she had acquired to meet her basic needs, including food and menstrual health products for herself and her daughter. In addition, Carolina chose to use part of the cash assistance she received to start a microenterprise—a barbecue cart. As her business grew, she continued to refine her business plan and began to make enough profit to save some money and improve her shelter. During GBV case management, Carolina reported that she was overcoming the consequences of GBV, which she had suffered throughout her life, especially during displacement. Psychosocial support paired with cash assistance improved her outlook, hope, and sense of autonomy and helped Carolina convince herself that she could overcome her situation of poverty.

¹⁰ The exchange rate used is 4.052 Colombian pesos = 1 US dollar.

¹¹ All names have been changed.

Story of a Colombian survivor with diverse sexual orientation and gender identity who received cash-GBV case management

While participating in a GBV awareness campaign, Miranda¹² thought about her childhood. Mistreated and neglected, she lived through ongoing psychological violence from her mother and close relatives due to her sexual orientation, and because she did not identify with the male gender she was assigned at birth. Miranda left home and lived on the streets, where she experienced incidents of GBV, including physical violence. She was targeted for her sexual orientation, gender identity, and gender expression.

Miranda wanted to become a stylist. To pursue her dream, she engaged in risky coping strategies, including survival sex/selling sex. With the income she earned, she invested in her business. However, Miranda suffered sexual violence while engaging in survival sex/selling sex and faced ongoing discrimination. She had no clients, her premises were vandalized several times by homophobic and transphobic neighbors, and she received death threats. Eventually, Miranda was forced to leave the city she had called home.

Having moved to another unknown and equally discriminatory city, Miranda again engaged in risky coping strategies to make ends meet, including survival sex/selling sex. She managed to open a new business, but the COVID-19 pandemic forced her to close her salon and move in with her mother during lockdown. Facing mounting debt, lack of food, and continual abuse from family members and members of her community, Miranda began engaging in survival sex/selling sex yet again to survive.

After participating in the GBV campaign, Miranda sought out CORPRODINCO to access services as a survivor of GBV. When she started receiving psychosocial care, Miranda dealt with unfounded guilt, gained confidence, and recovered self-esteem. Based on the targeting survey that informed program eligibility criteria, the prioritization of cases for cash referrals in the project SOP, and the high risk she faced for engaging in survival sex/selling sex as a coping strategy, her caseworker offered a referral to cash assistance, which Miranda accepted. She received three cash transfers totaling \$274, which she used to set up a new business with better products and equipment. Thanks to the income obtained from her venture, she feels safer from future risks of exposure to GBV and has an improved outlook on the future.

Prior to receiving cash assistance, Carolina, Miranda, and the other GBV survivors who received cash-integrated case management discussed with their GBV caseworker how this assistance could be used to support their recovery. If their caseworker decided that cash assistance was appropriate, a specific safety plan was co-developed that thoroughly mitigated GBV-exposure risks associated with cash assistance to ensure that they were not exposed to further harm. In addition, caseworkers provided survivors with information on referral pathways to government and civil society service providers so that survivors would know where to access services in case receiving cash assistance presented a risk after receipt.

Some survivors chose to go to Efecty alone to collect their cash transfer, while others accepted offers by caseworkers to accompany them, and others went with a trusted partner or to Efecty branches where they were familiar with the branch employees. Some survivors who went to collect the cash alone reported that doing this individually made them feel safer and freer. Most cash recipients found cash delivery through Efecty to be easily accessible, fast, and risk free.

12 All names have been changed.

After receiving cash assistance, survivors met with GBV caseworkers once or twice, including in their homes if it was safe to do so, and sometimes contacted them via text message to follow up on the cash assistance received. Within 15 days of receiving cash assistance, GBV caseworkers conducted a post-distribution survey to monitor survivors’ use of cash assistance and their safety. If survivors reported that they had used cash assistance to invest in a microenterprise, caseworkers observed their activity.

“We need a space where women can feel safe. ... Women take time to feel supported and by the time they do, the project closes. I think that to generate a bigger impact, we need a longer project.”

– Laura Lozano, GBV caseworker, CORPRODINCO



© CARE 2021
GBV awareness workshop, Ocaña

“We need a project with a phase of awareness-raising and orientation on their rights because women don’t know their rights. ... We need to give them time to give their informed consent. ... Not everyone needs the same amount of money. If we are given the time to get to know their cases, we’ll know how much to distribute.”

– Angelica Rios, psychosocial professional and project lead for CORPRODINCO

Operational lessons learned and recommendations for scaling and institutionalization of successful approaches

Lesson	Recommendation
<p>1 COVID-19 pandemic and safety considerations created challenges in coordination and service delivery.</p> <p>While inception workshops, training sessions, and other coordination touch points were planned to be in person, everything had to be shifted and program management was carried out virtually. The lack of a physical office limited CORPRODINCO's visibility as a service provider in this setting and thus full use of its services among survivors in the community. This constrained survivors' and caseworkers' rapport compared with fully in-person service delivery. Caseworkers adapted service delivery, carrying out home-based visits when safe to do so and conducting case follow-up over the phone whenever it was not possible to do so in person.</p>	<ul style="list-style-type: none">• Wherever possible, key coordination moments of program management should take place in person, especially when launching integrated programming wherein aspects of integration are new to all or some of the partners.• Wherever safety and security allow, a physical, safe, and appropriate space is needed to ensure use of services, promote voluntary disclosure, and ensure a safe space and confidentiality.• Home visits and using virtual communications, as needed, are an asset.
<p>2 The Efecty delivery mechanism worked well.</p> <p>However, diversifying delivery mechanisms will enhance choice for survivors.</p>	<ul style="list-style-type: none">• In addition to Efecty, employ cash-in-hand and other context-feasible delivery mechanisms, such as mobile money.• Ensure that survivors receiving cash are familiar with technology new to them in one-on-one meetings with caseworkers before distribution.
<p>3 The SOPs were strong and adapted from global guidance, but there is room for improvement around data protection and data management.</p>	<ul style="list-style-type: none">• Strengthen how data protection and data management are addressed, including further detail on how long data should be stored.• Train SOP users for longer on data protection policies and procedures.• Shorten the SOPs to improve usability.• Build in linkages with local government service providers with buy-in from and training of authorities.• During the design phase, visit the implementation site(s) and carry out a risk assessment for staff and program participants.

Programmatic lessons learned and recommendations for scaling and institutionalization of successful approaches

Lesson	Recommendation
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1

To fully meet the protection needs of survivors, the program duration should be longer, additional program components should be added, and the timing and location of these components should align with participants' availability and access needs for maximum efficacy.

- Resource and implement a longer time frame, with a minimum of 18 months (to include a minimum of two months at the project launch for awareness-raising and rolling case disclosure, and three months of trauma counseling for survivors, with a minimum of eight sessions).
- Ensure that workshops and activities are scheduled with respect for participants' daily routines and duties to enhance participation and retention.
- Provide childcare for participants attending workshops/individual case management meetings to ensure their participation and full attention during service delivery.
- Include transportation costs in the transfer value and ensure access to emergency shelter, when appropriate (or ensure survivors are referred to other organizations).
- Provide demand-driven workshops specifically for LGBTQI+ survivors, including addressing navigation of health service access and support to foster social networks.
- Ensure that program spaces are accessible for persons living with disabilities.

2

Spontaneous survivor-led peer empowerment can be systematized and resourced, including expansion of communication channels, for multiplier effects amongst survivors and the community at large.

- Consider opt-in WhatsApp groups, to a) enhance solidarity and peer support among survivors and to disseminate useful information about referral services;¹² and b) target communities to expand awareness about GBV and services, with survivors possibly acting as group facilitators.¹³
- In addition to individual assistance, facilitate survivor-led activities, for example through group cash transfers to survivor groups, in order to resource survivor-developed solutions to barriers to recovery.
- Increase opportunities for the design and implementation of the program model to be driven by survivors, including survivor-led co-design and needs assessments, and survivor-led co-analysis workshops of assessment findings.
- Build opportunities into the program model for survivors to continue strengthening social networks beyond the workshops, for example through recreational activities.
- Increase access to safe spaces during and beyond program enrollment.

¹³ See [Gender Data Kit](#).

¹⁴ Ibid.

Lesson	Recommendation
<p>3 Strengthen coordination with, and the capacity of, local authorities to directly and indirectly contribute to the program model to enhance their engagement. While CARE and CORPRODINCO coordinated with relevant actors in Ocaña, coordination could be improved to ensure that referrals comprehensively meet survivors’ needs.</p>	<ul style="list-style-type: none"> • Strengthen coordination mechanisms and rapport between civil society organizations, including local, national, and international nongovernmental organizations and national authorities. • Advocate at the federal level for greater allocation of funds to localities to effectively prevent and respond to GBV, including integrated protection and economic assistance programming. This should include advocacy on increasing transfer values to meet the protection needs of diverse GBV survivors. • Provide training to local authorities on GBV and the integration of CVA into GBV response that includes a focus on tailored and timely support. • Develop and continuously update and roll out an advocacy strategy to influence duty bearers and enhance their responsiveness to shifting contexts and ongoing survivor needs in real time.
<p>4 Survivors’ awareness of their rights and the legislation that protects them is extremely limited; greater emphasis on awareness-raising with survivors and across the community at large is needed to better support survivors after case closure.</p>	<ul style="list-style-type: none"> • Integrate training activities about survivors’ rights, existing laws, and legislation in their favor into workshops with survivors, in collaboration with the Secretariat for Women and the Ombudsman’s Office.
<p>5 Tailoring the transfer value to meet survivors’ individual protection needs was key. However, increasing the transfer value ceiling will more thoroughly meet survivors’ protection needs, including transportation and childcare costs.</p>	<ul style="list-style-type: none"> • Continue to offer a tailored transfer value within a designated range, which should be informed by a protection market assessment of protection-related goods and services. • Increase the transfer value, duration, and frequency range for diverse survivors and their protection needs in accordance with market assessments of protection-related goods and services and associated costs; ensure harmonization of the cash for protection transfer value with the Minimum Expenditure Basket (MEB) and ensure referrals across sectors, taking into account the size of the survivor’s family, including the number and age of children in the household. • The transfer value and duration should account for transportation costs to reach GBV case management meetings and the duration of the case management. • Provide childcare during participants’ engagement in case management activities (meetings with caseworkers, workshops, etc.)

Lesson	Recommendation
<p>6 SRH needs, in particular access to contraception, remain unmet or partially met—stronger presence and referral to SRH service providers is an important complement to this program model.</p>	<ul style="list-style-type: none">• Strengthen referrals and work closely with health organizations, hospitals, and pharmacies.• Depending on an increased presence of service providers, either integrate a SRH component directly into the program model or leverage existing referral pathways.• Ensure harmonization of the cash for protection transfer value with the MEB and advocate for health to be adequately reflected within the MEB, with potential top-ups for SRH; eligibility should include diverse women and girls, and individuals with diverse SOGIESC.• Advocacy and coordination should continue with the Ombudsman’s Office and the General System of Social Security in Health.
<p>7 Expanding the geographic scope, demographic reach, and complementary services delivered will support survivors’ long-term recovery from GBV.</p>	<ul style="list-style-type: none">• Advocate for, design, and implement expanded market-based livelihoods programming; ensure as a minimum, a gender-responsive approach and ideally a gender-transformative approach.• Livelihoods support should include livelihoods case management and tailored capacity-building that could include numeracy, literacy, business planning, vocational training, and job placement to support survivors’ full recovery from incidents of violence and to achieve self-reliance.• Strengthen SOPs and referral pathways between GBV service providers and MPCA and livelihoods programming, accompanied by mutual capacity-building and improvement of existing SOPs to ensure that GBV survivors are included in eligibility criteria and can access services.• Develop protocols between GBV service providers and MPCA and livelihood service providers, including data protection and information-sharing procedures for safe and confidential targeting and registration of GBV survivors.
<p>8 While referral pathways were identified during the program design and included in the SOPs, they were not used to their full potential, in particular referrals to cash to meet basic needs, livelihoods, and legal assistance. GBV caseworkers accompanying survivors to access legal assistance was effective and well received.</p>	<ul style="list-style-type: none">• Systematically use referral pathways to increase access for survivors to services (including SRH), MPCA to meet basic needs, livelihoods, and legal assistance.

Lesson	Recommendation
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<p>9</p> <p>Case identification and registration: identifying forced migrants/refugees and survivors with diverse SOGIESC was difficult. Campaigns on GBV prevention and response and services for at-risk individuals and survivors were helpful in reaching the target populations. Some survivors who were sick encountered challenges accessing assistance.</p>	<ul style="list-style-type: none"> • Future programming should meet the needs of all GBV survivors, including adolescents (including adolescents who are parents), the LGBTQI+ community, male survivors, and survivors who are displaced. • Expand outreach to survivors, including through door-to-door awareness of GBV services, information-sharing at work sites and in marketplaces, and through engagement of community leaders. • At registration, collect contact and identification information for an alternate cash recipient designated by the survivor, who is a "safe choice", as an alternative to the process indicated in the SOP. • Strengthen the capacity of service providers to safely and proactively identify survivors with marginalized profiles, for example refugees/migrants, adolescents, LGBTQI+ survivors, older persons, and survivors living with disabilities; and ensure strong partnerships with organizations that have existing expertise in identifying and serving these populations.
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<p>10</p> <p>Lack of engagement with family members of survivors: survivors' current partners and family members could have been engaged in workshops on women's rights, gender norms, and attitudes for a gender-transformative approach. This would especially benefit survivors who have chosen to remain in their partnership.</p>	<ul style="list-style-type: none"> • Incorporate program components to support survivors' partners, children, and other dependents directly and indirectly, such as psychosocial support. Integrating program components that address secondary impacts would be positive not only for children of survivors but also for alleviating stress experienced by survivors related to tension with their children. • Include a community-level component that influences a "new masculinity" that engages male adolescents, youth, and adults to prevent and mitigate risks of GBV.
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<p>11</p> <p>Psychosocial support and case management follow-up: case management services, including psychosocial support, were highly effective. However, further follow-up will ensure comprehensive support for survivors to meet their needs holistically.</p>	<ul style="list-style-type: none"> • Increase the number and duration of follow-up visits to ensure needs are met timely and comprehensively, for example, follow-up visits may be held once every week and then phased down to once every two weeks for a longer duration of six months. • When first integrating CVA into GBV response, consider increasing the number of caseworkers and decreasing the ratio of caseworkers to survivors to enable comprehensive support and support caseworkers with their learning curve while implementing the approach.
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<p>12</p> <p>Retention of survivors: some participants in the cash group did not continue with case management after receiving the cash transfer.</p>	<ul style="list-style-type: none"> • Increase opportunities for intervention design and implementation to be driven by survivors in order to enhance retention. • Caseworkers should further emphasize the importance of all program components with participants.
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Lesson	Recommendation
13	Coordination of research efforts is key to avoid duplication and reduce the burden on GBV survivors and risks of retraumatization during data collection. <ul style="list-style-type: none">• Wherever possible, researchers should use existing data sets and establish data sharing agreements that adhere to data protection best practices.• Data collection tools should be brief and contextualized.
14	Confidentiality of survivors’ cash recipient status: despite efforts to keep recipient status and transfer value confidential, some program participants shared their eligibility (or lack of eligibility) for cash with each other; this created difficulties for caseworkers in managing survivors’ expectations. <ul style="list-style-type: none">• Further emphasize the importance of confidentiality regarding cash recipient status to survivors during the case management process.

“Cash is a vehicle that can help many women improve their living conditions. With [GBV] case management, we can identify the most appropriate moment to deliver cash and when women are in the right circumstances to receive it, avoiding exposing them to risk. Case management integrated with cash transfers is one of the best responses we can use to overcome gender-based violence.”

– Angelica Rios, psychosocial professional and project lead for CORPRODINCO

VI. LOCALIZATION

The Grand Bargain’s localization commitment universally recognized that international actors have not included national and local humanitarian counterparts in the design and implementation of effective programming. Local actors are frequently excluded from decision-making on the design and implementation of GBV programming and do not receive adequate training on innovations, such as CVA. This leads to programming and research that does not have the buy-in of key stakeholders, such as women-led service providers and women’s rights organizations. As CVA-integrated GBV case management is an emergent practice, local GBV service providers have yet to be meaningfully engaged in integrated programming. An absence of local capacity and leadership in the analysis of integrating CVA into GBV case management can undermine the effectiveness of this integration.

Local actors have a unique and essential role to play in leading service delivery and generating evidence on the integration of CVA into GBV programming. In Colombia, there is a robust women’s movement and many civil society actors; the majority of these actors focus on human rights rather than service delivery. Resourcing of and partnership with local organizations, such as CORPRODINCO, yields a number of benefits including:

- ensuring that the tools, processes, and learning are contextualized and thus appropriate;
- ensuring that research design integrates the experience, issues, and concerns of local GBV services providers and women’s movements; and
- facilitating dissemination of the study results via local organizations and movements, and capacity-building in new and emergent approaches to integrating CVA as a tool within GBV case management.

Future cash-integrated and CVA-integrated GBV programming that supports GBV survivors in their recovery should leverage the aforementioned opportunities to efficiently and effectively provide quality services and to generate and continue to take up evidence-based practice in this context and in others across Latin America and the Caribbean.



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Commemoration during the 16 days of activism to end GBV campaign of lives lost because of GBV, Ocaña

VII. CONCLUSION

The situation in Colombia remains dire for GBV survivors and at-risk individuals. While there are advances in the protection system and referral routes, there is far from universal clarity and systematic collaboration among service providers to effectively prevent, mitigate, and respond to GBV. Internal armed conflict in Colombia persists, as do the effects of the Venezuelan migration crisis, which has exposed women, girls, and individuals with diverse SOGIESC to heightened risks of and exposure to GBV.

Through their cash-integrated GBV case management program model, CARE and CORPRODINCO supported GBV survivors to build their economic capacity for decision-making in support of their recovery from GBV and to strengthen their resilience. Working with local government institutions, such as the Women’s Secretariat of Ocaña, was critical to expanding upon civil society leadership to lay the groundwork for future scaling of successful approaches co-designed by survivors, civil society, and local government.

Integrating CVA into GBV case management, where appropriate, saves and improves the lives of survivors. Stakeholders working in and funding work in this context should systematically promote the integration of CVA into GBV response programming to support outcomes for survivors, and tailor assistance as appropriate to the specific cases of survivors.

Going forward, CARE Colombia will institutionalize learning, scale up successful aspects of the approach, and replicate and adapt the program model for other sites in accordance with the specific context and security situation. Cross-border departments, such as Nariño, and other areas affected by conflict and migratory waves are priority sites. CARE Colombia will continue to share learning across CARE operations in Latin America and the Caribbean, including peer-to-peer capacity-building by leveraging the [Cash and GBV Compendium Training](#).

For its part, CORPRODINCO will also institutionalize learning and scale up successful aspects of the approach, replicating as well as adapting the program model to the specific context and security situation of other sites, and share lessons learned with diverse stakeholders. CORPRODINCO will continue to address evidence gaps when it comes to integrating CVA into GBV programming for GBV outcomes.

ACRONYMS AND ABBREVIATIONS

AAR	After-Action Review
CORPRODINCO	Corporation of Professionals for Comprehensive Community Development
CVA	Cash and Voucher Assistance
FGD	Focus Group Discussion
GBV	Gender-Based Violence
KII	Key Informant Interview
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
MPCA	Multipurpose Cash Assistance
MEB	Minimum Expenditure Basket
SOGIESC	Sexual Orientation, Gender Identity and Expression, and Sex Characteristics
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
USAID	United States Agency for International Development
WRC	Women’s Refugee Commission

“Case management integrated with cash transfers is one of the best responses we can use”

An Operational Learning Brief on Integrating Cash Assistance into Gender-Based Violence Programming in Ocaña, Colombia.

