



© 2019 Jennifer Bose/CARE

# Guidelines on Using Cash and Voucher Assistance for Sexual and Reproductive Health and Rights Programming





© 2019 Jennifer Bose/CARE

CARE International is one of the world's largest humanitarian organizations, fighting global poverty and working in over 90 countries. CARE's emergency response efforts are particularly effective because we view all of our programs through a unique gender perspective, putting women and girls at the center.

CARE's focus on women and girls gives us a unique lens on leveraging cash and voucher assistance (CVA) for more and longer lasting impact. CARE is **committed to ensuring** that projects with CVA are designed with and for women and girls, addressing recipients' needs, challenges, and opportunities. CARE has invested in significant research on how **to make cash work for women and girls** through a **gender-sensitive approach** that frames the processes and outcomes of the modalities. The organization aims to be "cash ready" to **achieve breakthroughs for women and girls** and to respond to **gender-based violence (GBV) with cash transfers and mitigate GBV risks in projects with CVA**.

Furthermore, CARE seeks to increase its use of CVA for one of its core areas of programming, **Sexual Reproductive Health and Rights (SRHR)**. This is in line with the **recommendations of the Inter-Agency Working Group on Reproductive Health**, which deems CVA a suitable option to ensure ongoing access to affordable and high-quality comprehensive sexual and reproductive health (SRH) care.

Given the cyclical nature of emergencies and the growing number of countries in fragile contexts, CARE works to: 1) enhance preparedness efforts on SRHR through capacity building of government, local partners, and other humanitarian actors, influencing policy on preparedness for SRH in emergencies and strengthening coordination mechanisms across actors; 2) enable agile, rights-based, people-centered, gender-sensitive emergency response efforts guided by the **Minimum Initial Service Package (MISP)** for SRHR in crisis-settings; 3) strengthen government health systems that have been weakened by protracted or chronic crises to deliver comprehensive SRHR services in fragile contexts in line with the **Inter-Agency Field Manual (IAFM)** for SRH in Crisis-Settings with a focus on unlocking access to the most stigmatized SRH services; and 4) cross-cutting approaches to support localization and gender and inclusive programming that is responsive to the needs and capacities of vulnerable and marginalized groups – such as adolescents – across all phases

of a crisis. With the goal of increasing access to and utilization of health services, in particular SRH, and guided by the IAFM including the MISP, CARE believes that provision of CVA for SRHR is critical to contributing to the safety, dignity, and resilience of women and girls in humanitarian settings. Therefore, strengthening the evidence base and sharing of guidance and learning on this topic is a high priority for CARE.

## CARE's Learning on CVA in SRHR Programming

In 2020, CARE completed a **multi-country review** of projects using CVA for SRH.<sup>1</sup> This review provided findings from four uses of CVA for SRHR outcomes in humanitarian contexts. It contributes considerably to a nascent knowledge base on the subject, especially focusing on process and design.

The case studies demonstrated that the use of CVA for SRHR outcomes is feasible in sudden onset and protracted crises, although various elements will contribute to the potential reach, speed, and impact of the interventions. For CARE, the review identified a few critical issues that need to be included in the design of interventions with CVA for SRHR outcomes to ensure that it adheres to global promising practices and meets CARE's ambition for gender sensitivity in design and outcomes.

### THE FINDINGS INCLUDED:

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

**Technical capacities:** The case studies clearly demonstrate that where CARE and partners had existing capacity in health and CVA, the program design was stronger. Ecuador and Somalia are two of the CARE countries with the most CVA projects and the highest volumes of transfers across the CARE Confederation.<sup>2</sup> CARE Lebanon's team had been undergoing a month-long capacity review on its CVA capacities and processes; when the 2020 Beirut explosion occurred, this learning was fresh in their minds. The trend is similar for SRHR as well. CARE Colombia was exceptional in that the country program was relatively new in its operations; both CVA and SRHR were intentional areas of focus in building the team and for technical support because of gaps CARE had previously identified at the response level. CARE Ecuador and Somalia both have long-standing SRHR programming and in-country capacity. While CARE Lebanon has strong protection capacity, CARE is not seen as a SRHR or health actor in the country. Therefore, partnering with local health organizations may have been helpful in strengthening the intervention.

**Targeting:** Appropriate targeting is always a contentious issue for interventions with CVA. In CVA that seeks to contribute to health outcomes, targeting is even more challenging as no two people will have the same health needs. This was previously highlighted in the United Nations High Commissioner for Refugees (UNHCR) experience with CVA modalities for health outcomes.<sup>3</sup>

---

1 CARE. (2021). **Cash and Voucher Assistance for Sexual and Reproductive Health: Learnings from Ecuador, Colombia, Lebanon, and Somalia.**

2 Based on internal CARE fiscal year 2020 data (July 2019-June 2020).

3 UNHCR. (2020). **The Role of Cash Assistance in Financing Access to Health Care in Refugee Settings and for other People of Concern to UNHCR.**

Irrespective of the modalities used to meet SRHR outcomes, targeting criteria should reflect individuals' vulnerabilities. When it comes to SRHR the challenge comes from the fact that, identifying these criteria as part of categorical targeting, may put these individuals at risks. Using proxy indicators is equally challenging due to the lack of relevant proxy to SRHR vulnerabilities.

The targeting mechanism should help to reach those in need of SRHR services. The traditional community-based, geographical, or **Proxy Mean Tests** mechanisms are ill-suited considering the individualized nature of services. The most appropriate mechanism is self-declaration and registration. To make sure the targeting is as comprehensive as possible, the outreach strategy ought to be as wide as possible. In Colombia, Ecuador, and Lebanon, CARE used multi-layered approaches to sensitizing potential participants, their communities, peer agencies, government actors, and local agencies. It is not clear which of the methods, including mass marketing through social media, was most effective in spreading the word. This could be quickly studied by including the question "How did you hear of this programming?" in post-distribution monitoring (PDM).

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

**Community participation along the program cycle:** Community participation through assessments and program design (e.g., through focus group discussions (FGDs) and knowledge, attitude, and practice (KAP) assessments at registration for Somalia), were key to designing interventions responsive to the needs of affected communities. Community participation starts at design stage when asking about the appropriateness of using CVA to meet SRHR needs. The attached Toolbox can be referred to for this.

Barriers to SRHR access are not only financial. In Colombia and Ecuador, even when receiving CVA and having the purchasing power to access SRHR services, assessments raised the need for accompaniment by CARE-staff or trained community focal points to enable access (e.g., to navigate the health system, ensure attendance at health services, and follow up), which became a critical factor for overcoming perceived barriers of discrimination by health staff related to legal status or other reasons.

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

**Rights-based approaches:** Adhering to principles of privacy and confidentiality through approaches like direct transfer of cash in Somalia and preferred delivery mechanisms for cash transfers in Lebanon were marks of good CVA for SRHR programming. Similarly, in Colombia and Ecuador, although the context required a restricted transfer, the vouchers enabled providers to screen for and identify other needs and services; this facilitated access to a broader range of services aligned with rights-based approaches. The disadvantage of using paper vouchers is in the inefficiencies in reconciliation, adding burden to the field and program support teams and service providers.

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

Linked to the assessments are the transfer values. For each context, these values were based on the best available information for SRH goods and services. The flexibility of the design, whether an “up to” value voucher or a cash transfer, allowed teams to meet the needs of the populations with few limitations. A common challenge in attempting to design such programming is that health needs are rarely considered in **Minimum Expenditure Basket (MEB)**<sup>4</sup> calculations. As a result, the implementing agency needs to set the rate based on boutique market analyses. The transfer value can be different from the values used at coordination or national levels, and the result may require significant justification to peers and government. Such challenges are not insurmountable but add another layer to planning and design.

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

**Addressing quality – the “supply” aspect of services:** Using a market lens to meet SRHR outcomes, programs can improve demand, addressing financial barriers to access SRH services and increasing the willingness to buy such services; this was undertaken in Ecuador, Colombia, and Somalia. Looking at supply is equally important to ensure that quality SRH services are delivered. This includes ensuring the technical competence of providers, respectful attitudes of health staff (including addressing xenophobia and ensuring dignity for all without discrimination based on sexual orientation, gender identity, age, or other characteristics), rights-based approaches, and the availability of a full range of supplies and services. Beyond learning from these case studies, it is critical to ensure that health facilities are prepared to take on additional demand as a result of CVA interventions while maintaining quality services. Moreover, it is important for the humanitarian community to continue learning from CVA interventions that seek to improve the quality of health services.

**Monitoring and evaluation:** In most of the programs, monitoring was limited and did not lend itself to a deep understanding of SRHR outcomes. Each intervention monitored, at minimum, with a focus on satisfaction, use of the transfer, and the types of goods and services sought. Although all of the interventions used some form of gender-focused analysis to inform the programs (e.g. Rapid Gender Analysis (RGA)), there was limited use of baselines to delve deeper into needs, opportunities, and challenges specific to the modalities and delivery mechanisms. The Somalia pilot had robust monitoring, though it may have been overwhelming for participants given the short timeframe. In Lebanon, information on decision-making and transportation costs arose in the PDMs; this information could have been better collected at intake to influence the transfer values and sensitization. One area of improvement is to also monitor the quality of services delivered to ensure that participants are satisfied with the services received and the attitudes of service providers. This could also increase understanding of the extent of change in service providers’ knowledge, attitudes, and practices based on the awareness and training sessions that CARE provides. This will also be important

---

4 The Global Health Cluster released guidance on this topic **Technical Note on the Inclusion of Health Expenditures in the Minimum Expenditure Basket and Subsequent Multi-Purpose Cash Transfer**

to consider for participants in the medium to long term. In Somalia, another KAP study with the populations at a later date might reveal longer-term impacts. Lastly, though the outcomes of the programs were gender-sensitive by design, there is only anecdotal evidence of the gender sensitivity of the processes. As this is a priority for CARE, the organization will need to find ways to ensure that it is a more integral part of design, implementation, and monitoring in the future.

Based on these learnings, CARE committed to facilitating more and quality use of CVA for SRHR programming. These commitments include a global learning agenda, guidance on CVA for SRHR, and facilitating communities of practice – CVA, SRHR, monitoring, evaluation, accountability, and learning (MEAL), and program support – to share and learn from and with colleagues throughout the CARE Confederation.



# GUIDANCE OVERVIEW

© 2020 CARE Ecuador

## Who is this guidance for?

The guidance is designed for CARE and partners who are involved in all stages of programming with CVA and SRHR, including assessment, design, implementation, monitoring, and evaluation—as well as those interacting with other agencies at the response and coordination levels. It provides prompt questions and topics and is meant to complement other resources on CVA, gender, and sectors.

## How is the guidance structured?

The guidance is structured along the project cycle and includes a section on national/response-level coordination. It is divided into five sections; each section has recommendations, guiding questions, and suggested tools connected to the theme according to the program cycle. These sections include the following categories:

**Preparedness:** These suggestions include actions that teams can take to be ready to design and implement SRHR programming with CVA as a viable response modality.

**Assessment and design:** These suggestions are relevant to planning and decision-making activities that are undertaken in the analysis and design stage of the SRHR programming to ensure that requirements for programming with CVA are present, planned, and budgeted for in projects with SRHR using CVA.

**Implementation and monitoring:** These suggestions are applicable to activities that are undertaken as part of the implementation of CVA, including critical monitoring. They are intended to help ensure that staff are provided with adequate training to implement and monitor SRHR projects with CVA.

**Evaluation and learning:** These suggestions are applicable to activities that are undertaken to evaluate and learn from

SRHR projects with CVA. It is worth noting that, although most evaluation activity occurs later in the program cycle, it should be considered at the outset as MEAL frameworks, plans, and tools are developed.

Response/national level: This section incorporates suggestions for how to promote the use of CVA for SRHR programming in the broader humanitarian response and national context, tool development, and staff capacity building.

## **Is there complementary guidance?**

**This guidance is also complemented by SOPs and models of FGDs during design and monitoring, questions for market assessment, KAP surveys, and PDM surveys to be adapted for individual contexts. These tools are available in a separate document. Annex I also has links to CARE and other agency resources related to the topic.**



## PREPAREDNESS PHASE

RECOMMENDATIONS	CONSIDERATION QUESTIONS	TOOLS
<p>Designate CVA and SRHR technical focal points.</p> <p>Ensure CARE and partner staff (including health providers, community focal points, etc.) have adequate capacity on SRHR and CVA.</p> <p>Participate in SRHR and CVA coordination mechanisms.</p> <p>Sign framework agreements with a Financial Service Provider (FSP), vendor or service provider (e.g. clinic, pharmacy).</p> <p>Contextualize SOPs that can support SRHR using CVA.</p> <p>Conduct a pre-crisis market mapping and analysis on SRH goods and services.</p>	<p>Are there gaps in capacity for either thematic area or in a certain phase of implementation? Does the self-assessment of CARE country office capacity identify complementary skills and gaps in CVA or SRHR? Can different partners build the capacity of other teams?</p> <p>Do teams participate actively in local Cash Working Groups and SRHR/health coordination? Does the MEB include SRH costs?</p> <p>Do CARE or partners have pre-established agreements with service providers (e.g. FSPs, SRH providers)?</p> <p>Do CARE or partners have SOPs that could serve as a model or from peer organizations? Do the SOPs include a risk assessment matrix and monitoring frameworks for CVA based on the delivery mechanisms and outcomes?</p> <p>Are there existing health system mappings available?</p>	<p><b>CaLP Fundamentals of CVA E-learning</b></p> <p><b>CARE EPP minimum standards</b></p> <p><b>CARE EPP Annex 5</b></p> <p><b>CARE Cash Working Group Coordination Tip Sheet</b></p> <p><b>UNFPA Coordination Tip Sheet</b></p> <p>Mercy Corps <b>Delivery Guide (Financial Service Provider Assessment Tool)</b></p> <p>Draft SOPs</p> <p>International Rescue Committee <b>Pre-Crisis Market Assessment</b></p>

## ASSESSMENT AND DESIGN PHASE

RECOMMENDATIONS	CONSIDERATION QUESTIONS	TOOLS
<p>Involve CARE cash and markets and SRHR technical advisors (e.g. global, regional, country).</p> <p>Adhere to CVA and SRHR standards<sup>5</sup> for needs assessments that lead to quality project design.</p> <p>As part of situation analysis capture the different components of CVA appropriateness and of the SRHR needs.</p>	<p>Where does capacity lay within the country, regional, and global teams? What gaps exist that the technical advisor (SRHR and CVA) can fill?</p> <p>Are there national/local standards for SRHR and/or CVA?</p> <p>Are there experiences from humanitarian or development contexts that could be adapted?</p> <p>Have tools been adapted to include questions related to markets for SRH services and supplies (e.g. costs, availability, quality)?</p>	<p>CARE guidelines</p> <p><b>CARE Gender-Sensitive CVA Guidelines</b></p> <p><b>CVA Modality Decision Tree</b></p> <p><b>GBV and CVA Risk Analysis Tool</b></p>

5 For CVA those could be the standards set by the Cash Working Group or captured in **CaLP programme Quality Toolbox**. For SRHR it will be the Inter-Agency Working Group on Reproductive Health in Crises (IAWG) **guidelines** such as the **Inter-Agency Field Manual (IAFM)**, and including **the Minimum Initial Service Package (MISP)** or SRH SWG standards.

## ASSESSMENT AND DESIGN PHASE (CONTINUED)

RECOMMENDATIONS	CONSIDERATION QUESTIONS	TOOLS
<p>Through the different assessments as part of the situation analysis, ensure appropriate assessment of team composition (gender, culture, and language-wise) and community consultation.</p> <p>Identify the most appropriate modality or combination of modalities as part of <b>a cash plus approach or complementary programming</b> approach.</p> <p>Decide on CVA feasibility to meet SRHR outcomes based on community preferences, market functionality, and availability and accessibility of <b>FSPs</b>.</p> <p>Calculate transfer value based on desired SRHR outcomes. Adjust transfer value ranges to accommodate the diversity of SRHR needs.</p> <p>Explore SRHR programming that addresses both supply and demand</p> <p>If working with partners, ensure that governance norms and accountability between partners is well-defined from the outset of the project.</p>	<p>How will community consultation be undertaken to ensure participation plans are appropriate and inclusive of various gender groups and other vulnerable and marginalized groups (e.g. related to disability, linguistics, and age) and their diverse SRHR needs?</p> <p>How can participation plans ensure CVA recipients are able to influence the program design and provide feedback on quality of SRH services to improve accountability?</p> <p>What considerations should be made with regard to the composition of staff teams conducting analyses and how this might influence results? For example, consider how the staff represent various gender groups and host/refugee communities.</p> <p>What are the critical markets for SRH commodities and services?</p> <p>Have market-based questions been included in the RGA design?</p> <p>How can needs, market, and gender analysis be conducted and integrated to ensure that results can inform design?</p> <p>How might the results of the RGA inform MEAL planning?</p> <p>Which modality or combination of modalities is more likely to meet the expected outcomes? Which modality is more efficient? Which modality is more accepted? Are there experiences in using either modality for SRHR outcomes in the context that can inform the decision?</p> <p>If using vouchers, which are more feasible: value, up to value, or commodity/service vouchers?</p> <p>What are the benefits of or drawbacks to using conditionalities with the transfers? Have the RGA and market assessments informed this decision?</p> <p>Has your program design and transfer value considered the need for transportation, decision-making, and gender and social norms change to access the support?</p> <p>Does the Cash Working Group have guidance on transfer values that can link to programming with SRHR?</p> <p>Does your program design consider meeting the holistic needs of the targeted population (e.g., beyond SRHR to facilitate the use of the transfer)?</p> <p>Have roles and responsibilities for the SRHR, CVA (e.g., relationships with service providers), and coordination (e.g., national health systems, humanitarian fora) been established in the partnership? Are they currently reflected in SOPs?</p>	<p><b>RGA</b></p> <p><b>CARE Gender Marker</b></p> <p>Market Assessments</p> <p>CARE Rapid Needs Assessment</p> <p><b>CVA &amp; GBV modality decision making tool</b></p> <p>KAP survey</p>

## ASSESSMENT AND DESIGN PHASE (CONTINUED)

RECOMMENDATIONS	CONSIDERATION QUESTIONS	TOOLS
<p>Ensure that the program has been designed to meet SRHR in Emergencies (SRHRiE) Minimum Commitments for gender and inclusion.</p> <p>Ensure that delivery mechanisms for CVA are responsive to the unique needs of vulnerable and marginalized subgroups of the target populations. Consider factors of marginalization and how this may hinder access to the CVA delivery mechanisms and SRH services. For example, lack of legal status may hinder an individual from receiving cash and/or SRH services.</p> <p>Ensure an inclusive approach to program design including timing of activities (e.g. registration, sensitization, and distribution of delivery mechanisms) and location of the activities and services to ensure everyone's access.</p> <p>Design targeted strategies for outreach and awareness-raising on CVA responsive to the unique needs of various gender groups.</p> <p>Design options for hard- to-reach populations and those gender groups with special needs.</p>	<p>How are you adapting those principles for CVA for SRHR programming? Are you reflecting on results and taking action based on the <b>SRHRiE Minimum Commitments</b>?</p> <p>How are you designing the CVA intervention to ensure SRH services are responsive to the unique needs of vulnerable and marginalized sub-groups? For example, are adolescents in your context eligible to receive cash assistance?</p> <p>Do we understand the gender and social norms around SRHR practices – such as marriage, pregnancy, family size, and pregnancy spacing – to inform CVA interventions?</p> <p>Do we know who the sub-groups and most vulnerable and marginalized groups are?</p> <p>Are there unique risks to people due to involvement in CVA based on their gender identity?</p> <p>Which factors are essential to ensure safer transfers to individuals based on their gender identity (e.g., amount, duration, frequency, or mechanism)?</p> <p>What accommodations need to be made to meet the needs of the most vulnerable and marginalized participants?</p> <p>How does your program design contribute to localization and power-shifting through your partnerships?</p>	<p>Needs Assessment</p> <p>RGA and Needs and Market Assessments</p> <p>FGD Design Phase</p> <p><b>Tip Sheet on Multi-Modal Responses</b></p>
<p>Analyze the gendered protection risks (e.g. safety and negative coping mechanisms) for all genders and their sub-groups (e.g. the elderly; people with disabilities; the lesbian, gay, bisexual, transsexual, queer, intersex, and asexual (LGBTQIA) individuals; etc.) at outset and throughout the program.</p>	<p>How can existing protection risks that may influence CVA design be explored and understood for all gender groups?</p> <p>How can protection risks arising from or exacerbated by CVA be explored and understood for all gender groups?</p> <p>What mitigation measures can be built into CVA program design and how might their effectiveness be monitored?</p>	<p><b>CVA Modality Decision Tree</b></p> <p><b>GBV Risk Analysis Tool</b></p>
<p>If you have not done so at the preparedness stage, ensure CARE and partner staff (including health providers, community focal points, etc.) have adequate capacity on SRHR and CVA.</p>	<p>Have the “soft components” been costed into budgets and plans of action?</p>	<p><b>CARE Guidance on Feedback and Accountability Mechanism (FAM)</b></p>

## IMPLEMENTATION & MONITORING

RECOMMENDATIONS	CONSIDERATION QUESTIONS	TOOLS
<p>Sensitize and create awareness of CARE CVA processes and resources and availability of SRHR services with all gender groups and their sub-groups among recipient communities.</p> <p>Co-create with targeted communities communication and engagement plans that promote SRHR, undertake reflective dialogue sessions to transform gender and social norms that hinder access to SRHR, and mitigate gendered protection risks (including appropriate mechanisms for feedback and complaints).</p>	<p>How well are information-sharing and two-way communication mechanisms working for all gender groups?</p> <p>Are accountability approaches – like the <b>Community Score Card</b> – in place to seek feedback on program quality on an ongoing basis?</p> <p>Is it feasible to select and train community focal points to accompany clients, particularly refugees and migrants, women, adolescent girls, LGBTQIA people, and other vulnerable and marginalized groups, to access health services?</p> <p>What adaptations are being made to the CVA/SRHR program in response to feedback received from various gender groups? Are you addressing gender and social norms not only among community members (e.g. women, girls, and other vulnerable and marginalized groups) but also among power holders (men, boys, community leaders, health providers, and government decision makers)?</p> <p>How safely can members of vulnerable and marginalized groups make complaints related to the CVA/SRHR program?</p> <p>Are providers trained on rights-based approaches to SRHR? Is the program team providing supportive supervision to ensure that providers are adhering to these standards?</p> <p>Are providers trained to counsel clients and refer them to other SRHR services? Are providers trained and aware of referral pathways for non-SRHR services?</p>	
<p>Select and validate targeting criteria for specific sub-groups (e.g. women of reproductive age, adolescents).</p> <p>Base registration processes on input from targeted individuals, applying accommodations as suggested by the communities.</p> <p>Where feasible and relevant, consider inclusion of baseline questions (related to access to services, gender and social norms, and other knowledge, attitudes, practices relevant to the theory of change or project goals) as part of the registration process.</p>	<p>Are the community committees' representative of all gender groups and sub-groups?</p> <p>Are the participants of the validation exercises representative of all gender groups and sub-groups?</p> <p>Have the recommendations from communities been applied for the registration process? What accommodations have been made to reach communities in a gender-sensitive manner?</p>	

## IMPLEMENTATION & MONITORING (CONTINUED)

RECOMMENDATIONS	CONSIDERATION QUESTIONS	TOOLS
<p>Track sex and age disaggregated data (SADD), ensure that systems are in place to register and analyze SADD, and train staff to fill the templates and report them. Ensure that health facility registers and/or other relevant monitoring tools record CVA interventions and other relevant referrals</p>	<p>What barriers do various gender groups experience in accessing the CVA program? How can you actively explore this with recipients?</p> <p>Have you utilized CARE’s SRHRiE Minimum Commitments for Gender and Inclusion on an ongoing basis to monitor and develop actions to ensure programming in gender-sensitive and more inclusive ways?</p>	<p>PDM</p>
<p>Monitor CVA distribution process and recipients’ satisfaction with the modalities used. Do so in real time using PDM; pay attention to outliers based on gender, age, and other characteristics. Ensure PDM not only assesses quality of CVA but also the process of CVA distribution to enable access to quality SRHR.</p> <p>Monitor the effectiveness of risk mitigation measures.</p> <p>Analyze actual SRHR outcomes against the expected outcomes or theory of change disaggregating by age, sex, and other factors of marginalization.</p> <p>Explore potential positive and negative unintended impacts on uptake of health services, perceptions of the health system, and gender relations (such as relating to transfer values not meeting multiple needs) as identified by recipients.</p> <p>Using monitoring results, update market analysis/ situation analysis and, if needed, take corrective measures.</p>	<p>What story does the data tell in terms of access, satisfaction, and contribution to outcomes? Are there concerning trends that need to be followed up?</p> <p>Has CVA improved access to life-saving SRH services in line with the MISRP (e.g. improved uptake of family planning services, emergency obstetric newborn care, or clinical management of rape services)? Has CVA improved access to comprehensive SRH services in line with the IAFM? (For example, improved uptake of antenatal care (ANC) and postnatal care (PNC) services)</p> <p>Has the intervention contributed to improved gender and social norm or to access to SRH services?</p> <p>How can protection risks be explored safely with recipients from various gender groups?</p>	<p>Safety Audit</p> <p>PDM</p> <p>FGD Monitoring</p>

## EVALUATION & LEARNING

RECOMMENDATIONS	CONSIDERATION QUESTIONS	TOOLS
<p>Ensure that learning from CVA for SRH is actionable and allows for program adaptation and updates broader practice.</p> <p>Seek learning from other CARE SRHR programs without CVA that demonstrate strong commitments to gender sensitivity, empowerment, and transformation.</p> <p>Involve CVA, SRHR, and gender specialists in the design and review of evaluation and learning from projects with CVA for SRHR.</p>	<p>Does the country office/CARE member partner have a learning agenda with SRHR and CVA? How can successful CARE SRHR programs be adjusted to include CVA? How effectively has the RGA been utilized in the SRH program or projects with CVA?</p> <p>What learning can partners (e.g. local organizations, civil society organizations (CSOs), government actors, private sector) offer from CARE or non-CARE related SRHR programming (e.g. use of technology)? This may include targeting, community participation, or social norms.</p> <p>Has an After-Action Review (AAR) or Rapid Response Review been committed to? Have colleagues from different specialties been invited to contribute?</p>	<p>AAR</p>
<p>Evaluate how relevant and effective the choice of CVA to deliver on SRHR outcomes was for various gender and age groups (e.g. elderly, youth, people who are LGBTQIA).</p>	<p>How can various types of participants inform the design of the evaluation/review to ensure their meaningful participation?</p> <p>To what extent did sub-groups achieve the expected outcomes and experience the process?</p> <p>How can protection-related unintended consequences be safely explored with CVA participants from various gender groups?</p>	<p>AAR</p> <p>CVA &amp; GBV Risk Matrix</p>
<p>Share findings with relevant stakeholders.</p>	<p>Do other agencies have similar or dissimilar experiences in using CVA for SRH? Are government and private sector service providers part of the learning process?</p> <p>What learnings can/should be converted into advocacy to change processes and systems to enhance the use of CVA for SRHR outcomes?</p>	<p>Learning Agenda</p>

## NATIONAL/RESPONSE LEVEL

RECOMMENDATIONS	CONSIDERATION QUESTIONS	TOOLS
<p>Include questions on market access and functionality on interagency SRHR needs assessments and MISP checklists.</p> <p>Include market-based approaches as part of SRHR response analysis and emergency preparedness plans.</p>	<p>What existing data is available that can inform CVA preparedness (e.g. demographic data, gender analysis)? Do we have sufficient information on SRHR access to consider SRHR in MEB?</p> <p>Are there existing health facility mapping or assessments to contribute to a market mapping (even if from pre-crisis)?</p> <p>Have financial barriers to accessing SRH services been assessed in inter-agency tools?</p> <p>What are the GBV risks associated with CVA for SRHR?</p>	<p>Pre-Crisis Market Mapping</p>
<p>Advocate for the inclusion of SRHR needs in MEBs.</p> <p>Conduct systematic training for interdisciplinary teams on CVA for SRHR outcomes, ensuring a gender-sensitive approach to the use of the modalities in the sector.</p>	<p>What are the policy considerations for CVA for SRHR that the coordination body could advocate to address?</p> <p>How can the existing knowledge and attitudes of staff related to the SRHR aspects of CVA be assessed? Are there trained staff and referral pathways as part of existing resources for GBV response?</p>	<p><b>MEB Toolkit</b></p> <p>Health Cluster Guidance</p>
<p>Highlight the needs and gaps in support of SRHR that could be covered by interventions with CVA.</p>	<p>What learning has been collected on CVA for SRHR? How can we leverage this learning for advocacy purposes? How can the coordination mechanism contribute to or advocate for national standards on CVA for SRHR?</p>	



# ANNEX I: RELEVANT RESOURCES

© 2019 Shantelle Spencer / CARE Sierra Leone

## CARE:

- [CARE shares cash and voucher assistance page](#)
- [Cash and Voucher Assistance Coordination Tip Sheet](#)
- [Minimum standards for cash and voucher assistance program quality](#)
- [Gender Sensitive Cash and Voucher Assistance: Guidance to Ensure the Approach in the Field](#)
- [Women lead in emergencies](#)
- [Gender Marker](#)
- [Rapid Gender Analysis guidelines](#)
- [CARE Emergency Toolkit: SRHR Page \(SRHRiE approach, SRHRiE Minimum Commitments for gender and inclusion\)](#)
- [Social Analysis and Action](#)

## EXTERNAL:

- [IASC Gender in Humanitarian Action Framework](#)
- [Protection Risks and Benefits Analysis Tool](#)
- [Cash and Voucher Assistance and Gender-based Violence Compendium: Guidance for Humanitarian Practitioners](#)
- [Cash and Voucher Assistance and Gender-based Violence Compendium: Training modules](#)
- [CALP Program Quality Toolbox](#)
- [The Minimum Economic Recovery Standards \(MERS\)](#)
- [Global Health Cluster Task Team on Cash-based Interventions](#)
- [UNFPA SRH CVA Tip Sheet](#)
- [IRC CVA for Health in COVID](#)
- [IAWG Minimum Initial Service Package for SRH in Crisis-Settings](#)
- [Inter-Agency Field Manual for SRH in Crisis-Settings](#)





**CARE USA**

151 Ellis Street, NE  
Atlanta, GA, 30303  
T) +1 (404) 681-2552  
info@care.org