

# Expanding the Evidence Base on Cash, Protection, GBV and Health in Humanitarian Settings



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## Cash within GBV Case Management for Women and Adolescent Girls in Colombia

### EVALUATION OVERVIEW



In 2021–2022, the United Nations Population Fund (UNFPA) in Colombia piloted the integration of cash assistance as a tool within gender-based violence (GBV) prevention and response programming in five departments in Colombia (La Guajira, Norte de Santander, Arauca, Chocó and Nariño). Unrestricted cash transfers valued at US\$77 were provided for either one or three months to women enrolled in GBV case management. UNFPA and the Johns Hopkins Center for Humanitarian Health in the Johns Hopkins Bloomberg School of Public Health (JHSPH) conducted a mixed-methods evaluation of the cash assistance pilot with a focus on protection outcomes. The evaluation analyzed the impacts of the pilot on 200 women receiving cash assistance in three departments (La Guajira, Norte de Santander, and Arauca), where UNFPA cash recipients were predominantly Venezuelan (77%), and most of the Venezuelan cash recipients had arrived in Colombia within the past five years (65%). The mixed-methods

evaluation was intended to complement ongoing program monitoring and expand learning beyond current indicators to provide a more comprehensive understanding of the impacts of cash in responding to and preventing GBV-related needs and risks in the Colombian context.

The evaluation showed that there were greater positive impacts in some areas at endline for recurrent transfer recipients than for single transfer recipients, suggesting that longer-term assistance, when feasible, is beneficial.

#### Key findings were as follows:

- Feelings of safety from the interviewed GBV survivors and women and adolescents at high risk of GBV increased after they received the cash assistance. Overall, 46% of women and adolescents felt safe prior to cash transfers compared to 61% after

receiving cash assistance; the proportion that felt safe after the transfers was similar among those that received single and recurrent transfers. At endline, zero recurrent transfer recipients reported safety/protection as a priority unmet need compared to 16% of those who received a single transfer.

- A sizable proportion of cash recipients (30%) reported spending transfer(s) on services to improve their safety/personal situation, most often new accommodation, which was reported by 17% of cash recipients with no significant difference between the single and recurrent cash transfer groups.
- Cash transfer recipients reported improvement in household relationships following the transfers, and this proportion was significantly greater at endline among recurrent cash transfer recipients (80% vs. 65%,  $p=0.038$ ), suggesting the benefits of longer-term recurring transfers.
- Livelihoods was the area with the largest reduction in unmet needs. At baseline, 69% of respondents reported livelihoods as a priority unmet need (the

second most common unmet need after food).

At endline, only 7% of respondents reported livelihoods as a priority unmet need (a 62% reduction), including 11% of single transfer recipients and 3% of recurrent transfer recipients. Livelihood investment was the second most frequent use of transfers, reported by 52% of recipients, including 67% of recurrent transfer and 36% of single transfer recipients ( $p<0.001$ ). This suggests that recurrent transfers are more likely to contribute to sustainable gains in income to economic independence, thereby reducing the need for women and adolescent girls to engage in negative coping strategies in order to meet basic household needs.

- Significantly more recurrent cash recipients received service referral information compared to single cash recipients (51% vs 43%,  $p=0.021$ ). The overall care-seeking rate (37%) was similar between the two groups at endline; however, significantly more recurrent cash recipients sought psychosocial support than single transfer recipients, which again suggests that longer-term assistance may be more impactful.

## INTRODUCTION



Cash-based assistance has rapidly expanded and is widely used across a range of sectors to meet varied objectives in humanitarian settings. Cash-based approaches to providing humanitarian assistance to populations affected by disaster and conflict are generally perceived to be more efficient than in-kind assistance and more supportive of local economies, human agency, and recipients' dignity.<sup>1</sup> Approximately US\$5.3 billion in cash or voucher assistance was provided in 2021, accounting for 21% of total international humanitarian assistance.<sup>2</sup>

From 2021-2022, UNFPA in Colombia conducted a pilot program of cash transfers for GBV survivors and women and adolescents at risk of GBV ages 14+ years with immediate protection needs. During the pilot, UNFPA delivered 1,029 cash transfers in 2021 and 1,235 cash transfers in 2022. Transfers were provided for one or three months, through a remittance company (with the possibility of retrieving the cash at the counter location of the recipient's choice), and were unrestricted in nature, meaning that the women and adolescents could use them at their discretion to address unmet needs. UNFPA cash assistance targeted Venezuelan and Colombian women affected by the internal armed conflict and the Venezuelan migration crisis in five

departments of Colombia including Arauca, La Guajira, Norte de Santander, Choco and Nariño. Some of these women and adolescents in Colombia have faced twofold challenges, having migrated to Venezuela due to the armed conflict in Colombia and then having had to return to Colombia due to the political and economic crisis in Venezuela. Along the way, they have faced risks such as sexual abuse, exploitation, and human trafficking, among others. To help address some of these challenges, multipurpose monthly transfers were valued at US\$77 (370,000 Colombian pesos), based on the minimum expenditure basket as calculated by the Government, and were provided via an electronic transfer service provider in conjunction with case management services. This combined support contributes to the resilience and recovery of GBV survivors, helps to keep women and adolescents at risk of GBV safe, and promotes access to sexual and reproductive health services.

UNFPA gives cash as part of confidential, one-on-one GBV case management to survivors and women and adolescents at risk of GBV who face violence in Colombia, mainly from within their own households, but also from armed actors. UNFPA support to GBV survivors and women and adolescents at risk of GBV builds on the key role of GBV case workers who provide

each woman or adolescent with individualized services and case management. Cash assistance is considered as an option for cases of women who face financial barriers to obtain life-saving assistance, reach safety, and/or recover. Cash assistance can be discreet, flexible and dignifying, and the unrestricted nature of the transfers allows women to decide how cash is used. The program conforms, as do all GBV prevention and response interventions, to a survivor-centered approach and the guiding principles of response, safety, confidentiality, dignity and self-determination, and non-discrimination.

GBV case management care, as well as cash assistance, is mediated by informed consent as the first element that allows the survivor to establish the framework in which care is provided and the limits of confidentiality. In addition, the safety conditions are verified for the delivery of the cash, which involves assessing the risks that the receipt of cash may represent. When assessed as relevant, cash becomes part of an individual's case action plan, which is a coordinated follow-up to challenges the survivor is facing. The best option to receive and use the cash assistance is evaluated by the case worker together with each GBV survivor and woman or adolescent at risk of GBV. Emergency cash can enable survivors and women and girls at high risk of GBV to flee violent relationships and is an alternative to institutionalized shelter. Sometimes, specialized services come with a cost that can be a barrier for survivors (such as transport, legal, or medical costs), and cash

assistance can be a tool to overcome those barriers. A unique characteristic of the UNFPA GBV prevention and response program in Colombia is that the GBV case workers provide financial orientation and education to any GBV survivor or woman and adolescent at high risk of GBV. This was established based on the requests of many of the women and adolescents who wanted advice on how to handle budgets, as well as on investing in micro-livelihood activities that could help satisfy their basic needs. These women and adolescents were not used to overseeing money management in their households, and many of them were also unfamiliar with the cost of living in Colombia (especially the migrant GBV survivors and women and adolescents who were used to another currency in Venezuela).

UNFPA and the Johns Hopkins Center for Humanitarian Health in the Johns Hopkins Bloomberg School of Public Health (JHSPH) conducted a mixed-methods evaluation of UNFPA's cash assistance pilot program for GBV survivors and women and adolescents at high risk of GBV in Colombia with a focus on protection outcomes. The evaluation was intended to complement ongoing monitoring of case management and cash transfer activities with GBV survivors and women and adolescents at high risk of GBV and to expand program learning beyond current indicators to provide a more comprehensive understanding of the impacts of cash for protection in the Colombian context.

## METHODS

The evaluation aimed to elucidate the experiences of GBV survivors and women and adolescents at high risk of GBV who received cash through the cash transfer program, as well as to see how it contributed to their protection and determine if differences exist between those receiving a single cash transfer and those receiving three [recurrent] transfers. The evaluation was limited to the departments of La Guajira, Norte de Santander, and Arauca because they are more affected by the Venezuelan migrant crisis and likely to have greater similarities (Figure 1). Due to the small sample size, a more homogeneous sample was considered preferable; Nariño and Choco are located on the opposite side of the country, have few Venezuelan migrants, and were perceived as very different from the Northeast.

Data was collected on women receiving GBV case management with either a single transfer or recurrent cash transfers for three months, each valued at US\$77 monthly. A sample size of 200 was the largest feasible



**Figure 1: UNFPA-JHSPH study locations**



sample based on caseload (GBV survivors and women and adolescents at high risk of GBV having entered in the GBV case management process) and logistical considerations. The sample was distributed equally across departments (n=66-68 per department) and includes new cash recipients that agreed to participate. Participating women began receiving cash transfers between January and March 2022, with the target sample being met, as planned, gradually as enrolment into GBV case management continued in each department.

Women receiving UNFPA cash transfers completed a structured interview with trained GBV case managers when UNFPA cash was first received and again three weeks after receipt of the last cash transfer. Pre-cash surveys focused on household economy, women's income and economic activities, current needs, safety and access/use of safety resources, and control/decisions over money and were completed in approximately 30 minutes on average. Post-cash surveys included many of the same questions on household economy, women's income and economic activities, current needs, safety and access/use of safety resources, along with questions related to use and perceptions of cash transfers. The post-cash intervention survey was completed in approximately 45 minutes on average, due to extra questions on use and perceptions of cash assistance that were included.

All women who consented to participate were asked to provide their name and phone number during the pre-survey to allow for follow-up contact. Women's existing case management number codes were linked to the survey and the information was securely stored in a separate file and used only by the field team to contact the woman to complete the post-survey. The questionnaire-based interviews were conducted using the Kobo toolbox digital data collection application on a secure tablet and completed with eligible women only after the women provided informed consent. All complete pre-and-post surveys were uploaded to a secure server and records were then removed from the tablet. UNFPA/the implementing partner managed data collection and storage. Upon completion of each survey round, de-identified data was provided to JHSPH which then completed translation, data cleaning, and analyses. Quantitative data analysis consisted of descriptive summary statistics (e.g. means, median, proportions) and statistical testing (chi-square and t-test methods) for endline differences between women who received one transfer ("single cash" group) and those who received three transfers ("recurrent cash" group). Financial indicators were reported in Colombian pesos (COP) and converted to US dollars (USD) for analysis at a rate of 3,923 COP per USD (local exchange rates at the time of data collection).

At the conclusion of the post-intervention survey, both one-off and recurrent cash assistance recipients were asked if they could be contacted to participate in an additional qualitative interview to explore their experience with cash and protection assistance in more depth. A total of 20 women participated in qualitative in-depth interviews. Qualitative interviews were conducted approximately one month after cash transfer receipt with cash recipients purposefully selected based on sociodemographic characteristics and location. Qualitative interviews were conducted in-person in a safe and private location by GBV case workers with training in qualitative methods. Interview notes were uploaded to a secure server and transferred to JHSPH through the established data sharing agreement. Qualitative data analysis, led by a native Spanish speaking researcher, consisted of descriptive analysis using MAXQDA software to derive key themes and patterns for key protection outcomes associated with cash assistance. Data were analyzed and extracted in Spanish, and key quotes from survivors were subsequently translated into English for final presentation. Integrated findings reveal rich insights and knowledge about the perspectives and experiences of GBV survivors and women and adolescents at risk of GBV with cash protection assistance and case management support services in the context of Colombia.

## LIMITATIONS

A modest number of cash recipients were planned for enrolment in 2022, due to the nature of cash assistance within GBV case management which depends on the typically modest and unpredictable number of women in one-to-one case management. This limited the potential sample size, reducing statistical power and the ability to detect statistically significant differences between the comparison groups at endline. Second, during baseline data collection, cash recipients' background data was reported, but the planned intervention type (single or recurrent cash) was not indicated, thus, baseline similarities and differences between the two groups could not be assessed. It was also not possible to link baseline and endline observations, which precluded estimation and comparison of change over time for either intervention group. Third, issues with skip patterns in the electronic questionnaire resulted in no information being collected for some questions that were intended to be asked if a certain response was provided. This occurred for questions related to problems during cash transfer receipt and household relationships following transfer receipt, where skip patterns for the subsequent safety questions did not perform well, resulting in missing data. Finally, it was difficult to ascertain household structure and living arrangements without spending a significant amount of time on these questions, which, along with small sample size, precluded more detailed analysis on these topics.



## RESULTS



### BASELINE DEMOGRAPHIC AND ECONOMIC CHARACTERISTICS

Baseline information collected included distribution site location, recipient demographics, nationality, and year arrived in Colombia (Table 1). Cash recipients averaged 32.3 years of age and more than three-quarters were Venezuelan, of whom more than half (64.7%) had been in Colombia for less than five years. Recipient households had an average of 4.3 members and were largely (91.0%) female headed.

income in the past month than usual. Overall, 48.2% of households reported that they had debt, with a mean of US\$25.3 (CI: 16.5-34.0).

Only 23 (11.5%) cash recipients reported receiving humanitarian assistance from organizations other than UNFPA at baseline. Cash assistance, in-kind food aid, non-food items, and health assistance were each reportedly received by 2.0% of recipients; livelihood assistance was reported by 1.5% of recipients, and less than 1% of recipients reported receiving assistance in

**Table 1: Baseline Demographic Characteristics (n=200)**

		N	Point	(95% CI)
<b>Distribution Site Location</b>				
Arauca		66	33.0%	(26.4-39.6%)
La Guajira		66	33.0%	(26.4-39.6%)
Norte de Santander		68	34.0%	(27.4-40.6%)
<b>Demographic Characteristics</b>				
Women's age (mean years)		199	32.3	(30.9-33.8)
Household size (mean)		200	4.3	(4.0-4.6)
Female headed households		182	91.0%	(87.0-95.0%)
<b>Nationality</b>				
Colombian		47	23.5%	(17.6-29.4%)
Venezuelan		153	76.5%	(70.6-82.4%)
Time since arrival in Colombia (Venezuelan HHs)	≤ 5 yrs	99	64.7%	(57.0-72.4%)
	6 - 10 yrs	30	19.6%	(13.2-26.0%)
	11+ yrs	24	15.7%	(9.9-21.5%)

To understand recipient households' economic conditions, GBV survivors and women and adolescents at high risk of GBV were also asked about their living conditions, household income in the past month, and current debt (Table 2, following page). More than half of cash recipients lived in a house, apartment, or ranch (59.5%) while 22.5% were living in a single room in a house or apartment, and 6.5% reported living in substandard accommodations, including sheds, garages, tents, or other temporary structures. Most women (70.0%) paid rent for their housing, though 15.5% were staying as guests for free, 5.0% worked in exchange for rent, and 9.5% had another type of housing payment arrangement.

Average household income in the month prior to cash receipt was US\$51.2 (CI: 41.6-60.8). A large proportion (36%) of women said their household's income was irregular but more (39.5%) women reported having less

shelter, water and sanitation, hygiene, or education. Among the four recipients receiving non-UNFPA cash transfers, the average value was \$73.3 (median=\$95.6).

Baseline food security indicators among cash recipient households are presented in Figure 2. Most recipients (97.2%) reported their households had skipped meals in the last 30 days. Similarly large proportions of recipients' households ran out of food (88.5%) and went whole days without food (88.1%). Few (13.5%) recipients reported resorting to survival sex to be able to eat due to their condition of vulnerability.

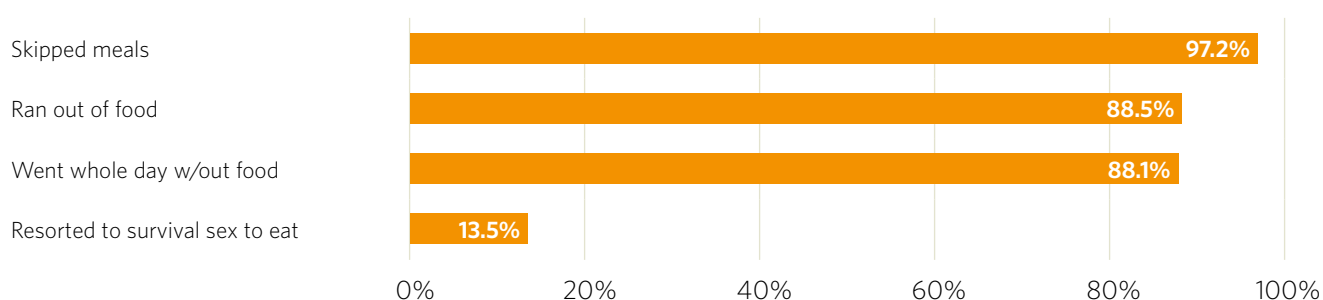
### SAFETY

Overall, the feeling of safety from GBV survivors and women and adolescents at high risk of GBV interviewed increased after they received the cash assistance (from

**Table 2: Baseline Economic Characteristics and Living Conditions**

		Overall (N=200)		
		N	Point	(95% CI)
<b>Household Economic Characteristics</b>				
<b>Monthly Income (USD)*</b>	Median	200	38.2	
	Mean	200	51.2	(41.6-60.8)
	Top Quartile (> \$51.0)	48	24.0%	(18.0-30.0%)
	3rd Quartile (\$38.2 - \$51.0)	18	9.0%	(5.0-13.0%)
	2nd Quartile (\$25.5 - \$38.2)	80	40.0%	(33.2-46.8%)
	Bottom Quartile (< \$25.5)	54	27.0%	(20.8-33.2%)
<b>Current Debt (USD)*</b>	Median	182	0.0	--
	Mean	182	25.3	(16.5-34.0)
	Any debt	93	48.2%	(41.1-55.3%)
<b>Living Conditions</b>				
<b>Housing Type</b>				
	House/apartment/ranch	119	59.5%	(52.6-66.4%)
	Single room in house/apartment	45	22.5%	(16.7-28.3%)
	Shed, garage, tent, temp. structure	13	6.5%	(3.1-9.9%)
	Other	23	11.5%	(7.0-16.0%)
<b>Housing Payment Type</b>				
	Pays rent	140	70.0%	(63.6-76.4%)
	Staying as guests for free	31	15.5%	(10.4-20.6%)
	Work in exchange for rent	10	5.0%	(2.0-8.0%)
	Other	19	9.5%	(5.4-13.6%)

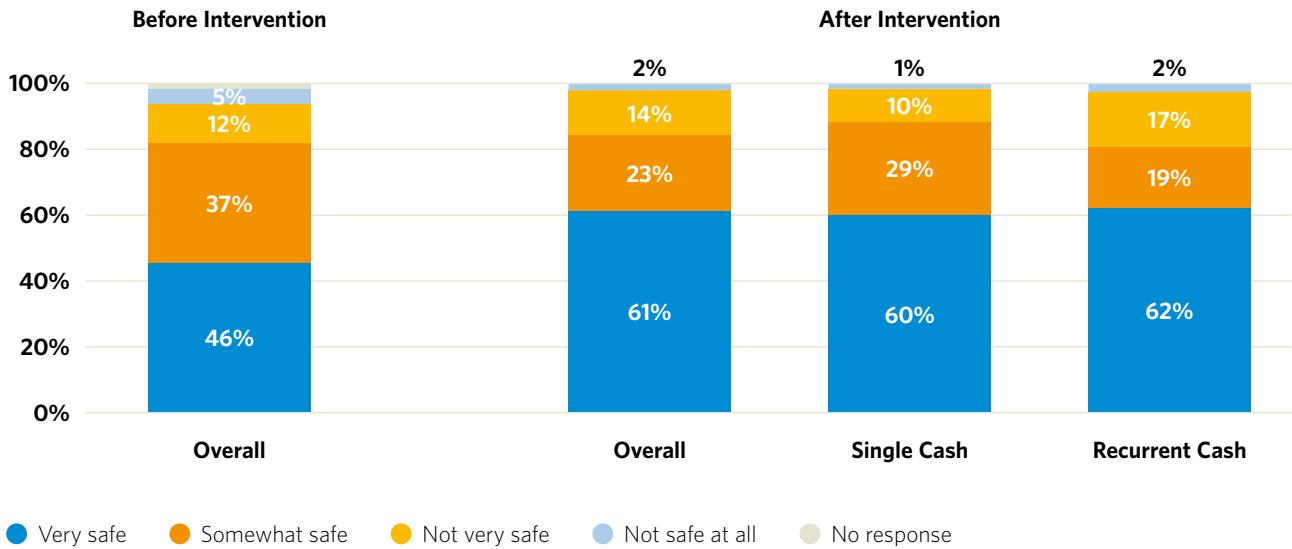
\* Exchange rate 3,923 COP/1 USD

**Figure 2: Baseline Food Security (past 30 days)**

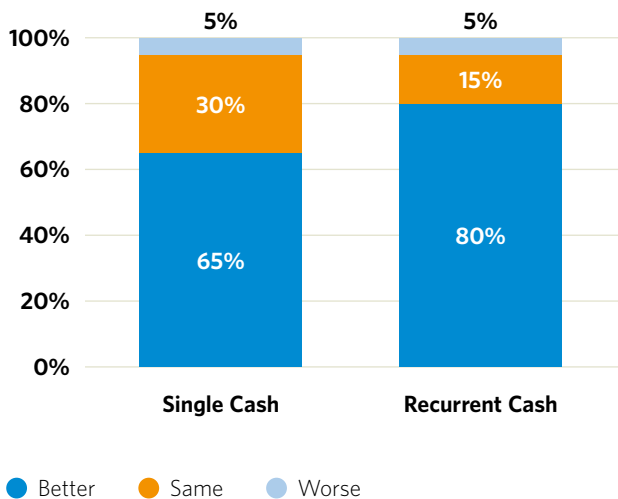
46% to 61% across all recipients). A similar proportion of single and recurrent cash recipients, 60% and 62%, respectively, reported feeling very safe at endline (Figure 3). Participants were asked whether they had been threatened or harmed by a household member as well as overall feelings of safety and any changes in household relationships between baseline and end line. At baseline, 54.0% (CI 47.0-61.0%) of cash recipients reported they had been threatened or harmed by a

household member in the prior year. Despite this, most women reported feeling safe in their households at both baseline and end line. Only 16.5% of cash recipients felt 'not very safe' or 'not safe' in their households at baseline and 15.4% felt this way at endline. At endline, more recurrent cash recipients (18.9%) reported feeling 'not very safe' or 'not safe' in their households as compared to 11.4% of single cash recipients, however, this difference was not significant ( $p=0.398$ ).

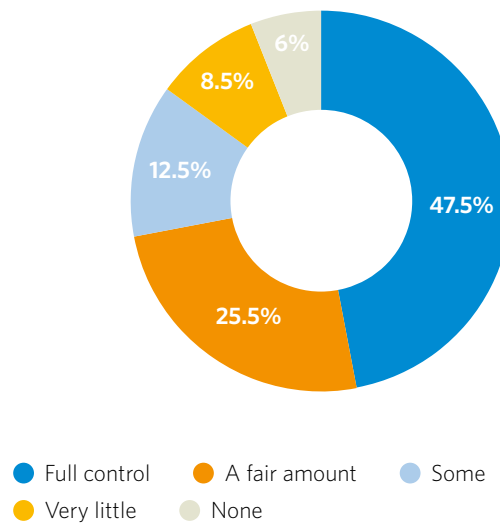
**Figure 3: Feelings of Safety Pre- and Post-Intervention**



**Figure 4: Change in Household Relationships After Interventions**



**Figure 5: Pre-Intervention Household Spending Control**



GBV survivors and women and adolescents at high risk of GBV described cash transfers as increasing feelings of safety in relation to both internal household dynamics and external factors. **One recipient stated,** “This allowed me to be [safer] by being more independent, not depending on others.”

**Another woman shared:** “I feel more safe, this has helped. I don’t have the need to be with someone who is always harming me to get my needs met. I can be on my own and eat what I want to eat, and not just what he brings. Because you know that sometimes women, we tolerate so much from men, the abuse from men because he puts a plate of food on our table and you don’t want to take that away from your children.”

**A woman who was formerly living in unsafe and precarious conditions shared:** “I feel more liberty and more relief because I have somewhere to sleep, I have a roof to live under.”

In the endline survey, women were asked whether they had taken any action to increase their own safety or that of their children. More than half (60.0%) of women had taken specific action, including trying to keep their partner calm by acting like they agreed (79.4%), talking with their children about leaving (61.9%), using community safe spaces (51.6%), creating a safe word (49.0%), packing a bag (47.1%), and developing a safety plan with a case manager (45.8%).

Most recurrent cash recipients (80.0%) reported better household relationships after the intervention, while a smaller proportion of single cash recipients reported better relationships (65.0%) (Figure 4). It was uncommon for participants to report worsening household relationships after the intervention compared to before (5.0% of cash recipients in each group). The difference between groups in reported change in relationships was statistically significant ( $p=0.038$ ), suggesting that recurrent cash is more beneficial than singular transfers.

## HOUSEHOLD FINANCIAL DECISION MAKING

Prior to receiving cash transfers, women were asked to report their level of control over household spending decisions (on a five-point scale from no control to full control), and any anticipated consequences if household members disagreed with their spending decisions. The majority (73.0%) of all women reported a fair amount or full control over household spending (Figure 5). When asked about consequences if household members disagreed with spending decisions, most women (92%) reported that there would be no consequence. The next most common response was that they would be angry with her (5.0%). Only two women reported that they would warn or caution her, one reported that they would punish or hurt her, and three recipients reported other consequences.

The majority (71.0%) of partnered cash recipients reported that they were singular decision makers on transfer use; this proportion was higher among recurrent cash recipients, but the difference was not statistically significant. An additional 26.3% reported joint decision making, and this proportion was greater, but not statistically significant, among single transfer recipients; only 0.5% of women reported they were not engaged as a primary decision maker on use of cash (Table 3). In qualitative interviews, women reported consulting with family members and partners around the decision-making process, and many of them reported that they ultimately felt that they had the agency to make the final choice on how to best utilize the cash transfer. Women reported that consulting with family members helped

them feel reassured and safe about how they were using the cash transfer. **One of them shared:**  
*"To say it this way, [my husband and I] each have the liberty to make our own decisions... I always share with him and he gives me his point of view, but beyond that he does not intervene in my decisions."*

Many of the women described the decision-making process as family-based and collaborative, where collective wellbeing and needs are prioritized over individual needs. While the assistance is planned by UNFPA to respond to individual needs, as part of GBV case management with the cash as integrated as support in individual case plans, the reality of the context and needs shows that for some of the GBV survivors and women and adolescents at risk of GBV the cash assistance is used based on collective household decisions. Several women reported that this process is also influenced by overarching social norms around family hierarchy. **As one of them stated:**  
*"When we [as a family] make a decision, we participate and agree: we are trying to achieve this goal. We all decide if we are in agreement or not. However, ultimately the entire weight of the decision is on the mother, because she is the mother. Still, I ask for their opinions and suggestions because they are my family, and we are a team."*

**Another woman shared:**  
*"[I told] my family which at that time included my dad, sister and my husband. We all decided to pay the rent, since we didn't have money to pay it and we all decided it was for our well-being. When we were in that situation, we were all looking for solutions, where to go... so when the help came, we decided to pay the rent."*

**Another woman noted:**  
*"In [my family] we always determine the priorities together. We classify expenses together by level of priority. So the most important things are taken care of and addressed."*

Several GBV survivors and women and adolescents at risk of GBV expressed that they were very isolated and did not have friends or loved ones to consult with around decision-making. Several others reported having left behind family members in Venezuela whom they did not want to burden by asking for support in decision-making.

**Table 3: Cash Transfer Receipt Decision Making**

Among Women Living with their Partner (n=38)					
Decision making	Single Cash		Recurrent Cash		p-value
Woman	61.5%	(41.5-81.6%)	91.7%	(73.3-110%)	0.160
Husband/male member	0.0%	--	0.0%	--	
Both	34.6%	(15.0-54.2%)	8.3%	(-10.0-26.7%)	
Other	3.8%	(-4.1-11.8%)	0.0%	--	

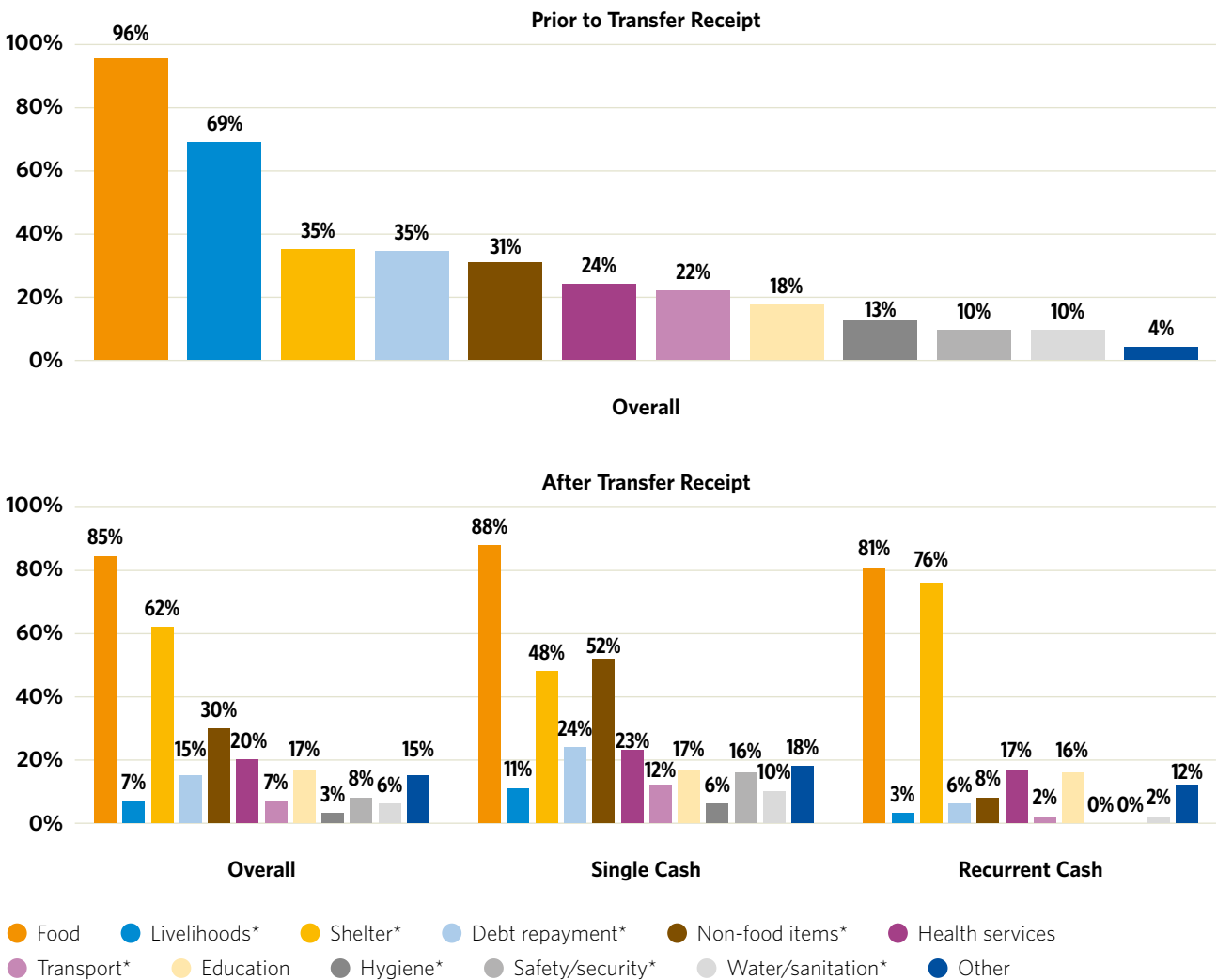


**One of the women shared:** *"I have family and we speak, but I didn't share this with them because of their situation they are living in [in Venezuela], they have a hard life, so I don't want to take their time."*

While the cash transfers intended to support the specific needs of the GBV survivor or the woman and adolescent at high risk of GBV as per her individual action plan, participants shared challenges with decision-making, particularly around prioritizing current and future needs, and family vs. individual needs. **One of them stated:** *"I had a lot of doubts on how to spend because I would ask myself, 'what if I spend this money and...'. The thing honestly is that here things are very expensive, and I was hoping to buy a lot more things but I didn't have enough. The money I got I had doubts about using it because I would say, 'Dear God, if later on I have needs and I don't have [money]...'"*

One woman shared that she used the cash-transfer in part to pay for an echocardiogram her obstetrician had ordered to make sure her baby was healthy, and which was a requirement for her to schedule her hospital birth. She shared mixed feelings – of joy learning that her results were normal, and regret having used that money on the echocardiogram when she could have utilized it to address other urgent needs. **She stated:** *"I had a lot of [needs] like I said, rent, food, a daughter who is in school. I wanted to stretch and stretch the money, but I couldn't. I had to get an echocardiogram which came back normal. If I had known that everything [with my health] was fine, I would have spent that money on something else because I ended up using it for the echocardiogram...when they did the echocardiogram I was happy because everything was fine and now we could schedule my [cesarean birth], which we couldn't have done without this."*

**Figure 6: Priority Unmet Household Needs (Top 3 Needs)**



\* Statistically significant difference in reporting need category across groups at endline

## UNMET NEEDS

Food was the most prominent unmet need at baseline, reported by 95.5% of households. Other top priorities at baseline included livelihoods (69.0%), shelter (35%), debt repayment (34.5%), non-food items (31.0%), and health services (24.0%). Overall baseline unmet needs are presented in Figures 6 along with endline unmet needs by group. At endline, food remained the most common unmet need, reported by 84.5% of cash recipients overall, reflecting continued widespread food insecurity creating risks for women and adolescents engaging in negative coping strategies to put food on their table. This did not differ by group, with 88.0% of those in the single cash group reporting food among their top unmet needs at endline, compared to 81.0% of those in the recurrent cash group ( $p=0.171$ ). In the qualitative interviews, many of the participants shared experiences of food insecurity and of need to make deeply distressing and difficult decisions to meet their family's needs – such as foregoing medical care or not eating to feed their children. **One of the women stated:** *“There were times I thought about not eating to be able to afford basic needs with my son and to go to the hospital.”*

Livelihoods was the second most prevalent unmet need at baseline and the sector with the largest reduction in unmet need. At baseline, 69% of respondents reported livelihoods as a priority unmet need compared to only 7% at endline, a 62% reduction. At endline, significantly more single cash recipients (11.0%) reported unmet livelihoods needs as compared to recurrent cash recipients (3.0%) ( $p=0.027$ ), suggesting that recurrent transfers may be more advantageous than single cash transfers for sustainable livelihoods investments.

Unmet shelter needs, which were the third most frequent unmet need at baseline, increased by 27% and were reported by 62.0% of all cash recipients at endline. Significantly more recurrent cash recipients (76.0%) reported unmet shelter needs at endline than did single cash recipients (48.0%) ( $p<0.001$ ). This may be linked to the fact that in Colombia, unsatisfied housing needs are defined as housing with more than three persons sharing a room (without kitchen, bathroom and garage), though it is uncertain if respondents were aware of this definition. The increase in shelter needs may also reflect more directly an overall lack of access to minimum living and sanitary conditions and/or increased awareness because of discussions during case management.

Debt repayment needs also decreased at endline and were reported by a significantly larger proportion of single cash recipients (24.0%) as compared to recurrent cash recipients (6.0%) ( $p<0.001$ ). While the overall proportion of households reporting non-food item needs was similar at baseline and endline, unmet needs for non-food items significantly differed between groups at

endline as reported by 52.0% of single cash and only 8.0% of recurrent cash recipients ( $p<0.001$ ). Transport, hygiene, safety/security, and water/sanitation needs were all reported by fewer households overall, and significantly more single cash households as compared to recurrent cash households at endline.

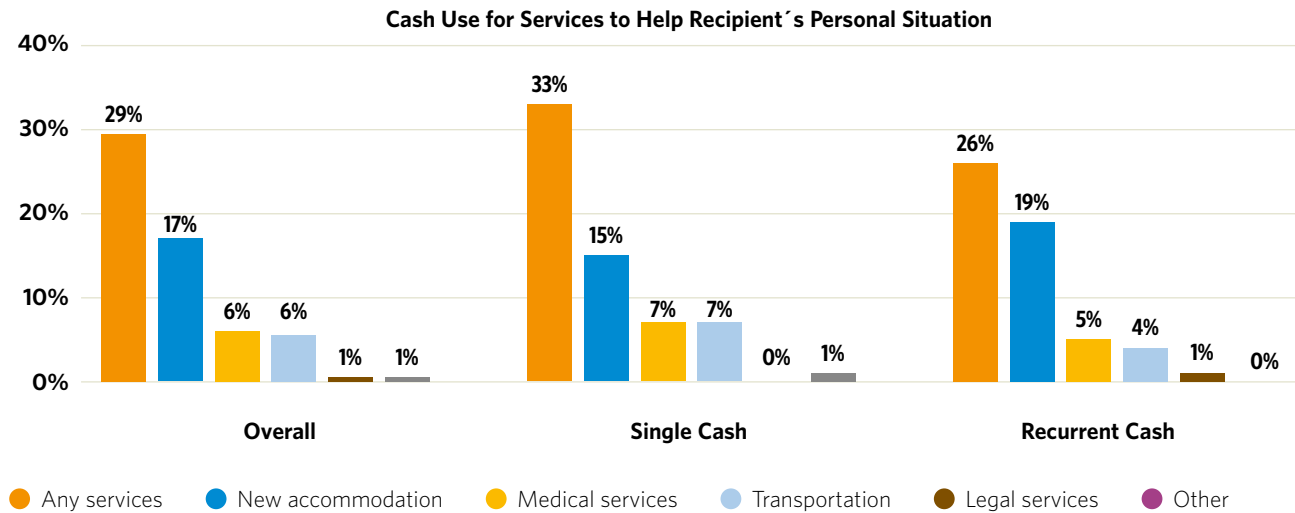
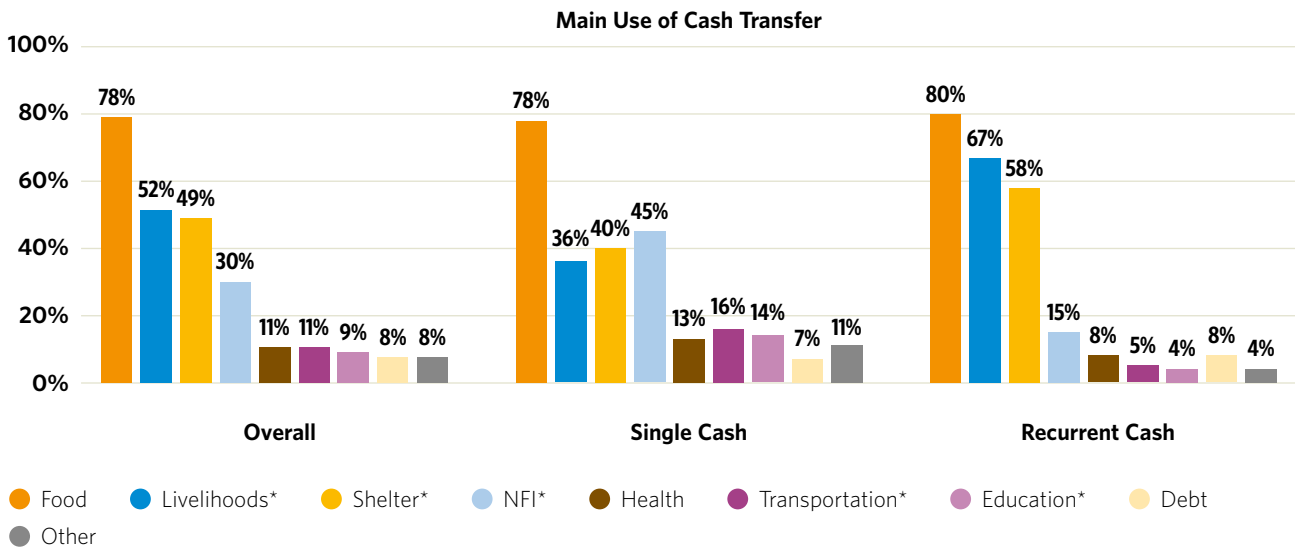
## Cash Transfer Use

Cash recipients reported spending an average of US\$58.0 (CI: US\$49.0-67.0) out of US\$77 of their cash transfer amounts, with the remainder held as savings for future needs and expenses. Single cash recipients reported spending a larger amount of their transfer (US\$63.8) as compared to recurrent cash recipients (US\$52.2), but this difference was not statistically significant ( $p=0.201$ ). Overall, 79.0% (CI: 73.3-84.7%) of cash recipients spent part of their transfer on food, including 78.0% of single cash and 80.0% of recurrent cash recipients (Figure 7).

Livelihoods was the second most frequent use of cash transfers, with 51.5% (CI: 44.5-58.5%) of all households reporting among their cash transfer expenditure types (36.0% of single cash and 67.0% of recurrent cash recipients,  $p<0.001$ ). Shelter was similarly common among cash expenditure types, reported by 49.0% of all cash recipients (40.0% of single cash and 58.0% of recurrent cash recipients,  $p=0.011$ ). Other frequent expenditure types included non-food items (30.0% of households), health (10.5%), and transportation (10.5% of households). Expenditures in other categories including education, debt repayment, and other types were reported by <10% of households. Sharing of cash with other households was reported by 13.0% (CI: 8.3-17.7%) of households; this was significantly more common among recurrent cash recipients (18.0%) than among single cash recipients (8.0%) ( $p=0.036$ ). The mean amount shared was US \$18.9 (CI: US\$11.3-26.5; median US\$12.3).

Women in both the groups expressed that the cash transfers were crucial in meeting basic needs for themselves and their families, and hence, crucial in responding to and preventing GBV related needs and risks. A sizable proportion of cash recipients (29.5%) reported spending the cash transfer(s) on services to improve their personal situation. The most commonly reported service on which cash transfers were spent was new accommodation, which was one of top three unmet needs at baseline. Spending on shelter was reported by 17.0% of all cash recipients (15.0% of single cash and 19.0% of recurrent cash recipients,  $p=0.316$ ), and participants in the qualitative interviews reported using cash transfers both to improve existing shelter and to find new living arrangements. Some of the women reported living in precarious and unsafe conditions, and the transfers facilitated their ability to secure new

Figure 7: Cash Transfer Expenditures



\* Statistically significant difference in reporting need category across groups at endline

homes, or to invest in improving their current living environments. For example, one woman reported using the transfer to purchase a door and zinc sheeting for her home. **Another woman noted:**

*"The cash assistance helped me rent in a safe location where my children wouldn't be attacked or vulnerable to situations that they are not to blame for."*

**Another woman stated:**

*"I decided to use it for rent because that's the reason I received the support, since I was in a very difficult and uncomfortable situation where I was living. My children were vulnerable, so this assistance gave me a safe place to be with my family."*

Several women reported using the money for rent payments and to avoid eviction. **A woman who received**

**recurrent cash transfers stated:** *"This was a big help for me because I was being evicted from my home. I am from an ethnic minority ... when I got this little bit of money, I was able to complete my rent payments and thank God I was able to stay here."*

**Another woman added:** *"I am really grateful because this honestly helped us so much for my rent and for food. In reality, we didn't have anything because we were evicted, we had to live in precarious conditions. This assistance was like a life vest."*

**Another woman said** *"Now we have more stability, my children can sleep in security. So as a mother I feel happy"*. The majority of women reported that the cash transfers were a source of empowerment and reassurance of future safety for themselves and their families.

**One woman explained:**

*"When you work for yourself you don't have to depend on any man. And if you don't depend on a man, then you don't have the pressure to stay with them because of what they give you, or to stay with them because you live with them. In other words, because of this, you grow, not just mentally but also economically, at work. I don't depend on any man to come and mess up my life."*

Many participants reported that receiving the cash transfers also allowed them to challenge traditional gender norms and to achieve more independence to accomplish their goals of gaining economic independence to keep themselves safe, to prevent GBV related risks and be able to access what they need.

**One woman explained:**

*"This is a way to generate my own income and to generate stability for my family, and I don't have to wait for a person whom I don't feel safe with. I don't have to cave to the pressure of that, or wait to see what they bring home. By generating my own income I don't have to [deal with] anyone coming to intimidate me. I don't need a man to move forward in my life."*

**Another woman shared:** *"When you are in a relationship, men think that because they give you things, or because they give you money, that they can do anything with you or get rid of you, so this is a way that we can both have some authority."*

Beyond meeting basic needs, many women shared in qualitative interviews that they used cash transfers to plan for the future. Participants had access to micro-livelihood support, as part of UNFPA coordination with local organizations, including training in specific production capacities and entrepreneurship skills. Many of the participants used part of the cash transfers to invest in their own small business ventures and cited the training support that they received as a key facilitator in this process. Most commonly, participants in qualitative interviews reported using part of their cash transfer to buy supplies and goods needed to jumpstart their ventures/business (including food service, beauty/cosmetic services, tailoring, and opening clothing stands). Women discussed these opportunities as a source of empowerment and reassurance of future safety for themselves and their families. This is done as part of the GBV case management process in which the GBV survivors and women and adolescents at immediate risk of GBV get access to comprehensive support, access to various services, in which their recovery process is enhanced, and they are supported in their healing and empowerment. As such, alongside the cash transfers, GBV case workers provide financial orientations to the GBV survivors and women and adolescents at high risk of GBV in order to provide advice on budget handling and investing in income-generating activities given that

most of the targeted women were not used to managing household income. Additionally, many had migrated from Venezuela and hence were less familiar or no longer used to Colombian prices and currency.

Using the cash transfers to support their business ventures also provided the women the flexibility to fulfill other family and role responsibilities.

**One woman shared:**

*"My dad is older and almost seventy years old, he needs oxygen. He is practically bed-bound. For me, it's hard to look for full time work, so now that I have my nail business I can work from my house, I can leave anytime my daughters need me, I can make my own schedule, and I even work out of people's homes. This is one of my biggest motivations."*

**Another woman shared:** *"I have a son who gets very sick because of the changes in weather, and that has been hard for me. I am still unemployed at this point. However, now that I can work selling food from my home, I try to make ends meet and that brings our family a lot of relief."*

Several women shared that they used the cash transfers in part to further advance their education. **One woman explained,** *"I want to study because I want to improve my quality of life... this is the first step for me to go to university and study social work, which is what I would like to pursue."*

**Another woman added,** *"At first I had doubts about how to use the payments but after some time, it was very clear. My objective, I had gone two years without studying, and I wanted to try to start again and it hadn't been possible to register in a university."*

**Cash Transfer Perceptions**

Fewer than one-third (31.5%) of all cash recipients reported that there were no challenges in receiving their cash transfer. The main challenges reported were safety (33.5% of participants), and travel time/distance (30.0%) and the proportion of recipients in reporting these concerns was similar in the single and recurrent transfer groups (Table 4, following page). These concerns were related to specific realities surrounding certain living locations of GBV survivors and women and adolescents at risk of GBV as well as their subsequent access to places to retrieve the cash. Due to displacement and migration from Venezuela, various women and adolescents in the target group live in informal settlements, which, even when they are within urban areas, are situated in the periphery and are difficult to access with less availability of and less space for public transportation. This can translate into significant challenges when it comes to reaching cash retrieval points that are most often located in city centers and formal neighborhoods.

**Table 4: Cash Transfer Receipt Process**

	Single Cash (n=100)		Recurrent Cash (n=100)		p-value
	Point	(95% CI)	Point	(95% CI)	
<b>Challenges and Concerns in collecting transfer</b>					
None	34.0%	(24.6-43.4%)	29.0%	(20.0-38.0%)	0.447
Safety	36.0%	(26.4-45.6%)	31.0%	(21.8-40.2%)	0.454
Travel time/distance	28.0%	(19.0-37.0%)	32.0%	(22.7-41.3%)	0.537
Need ID	12.0%	(5.5-18.5%)	17.0%	(9.5-24.5%)	0.315
Need male to accompany	9.0%	(3.3-14.7%)	4.0%	(0.1-7.9%)	0.152
Cash unavailable	5.0%	(0.7-9.3%)	6.0%	(1.3-10.7%)	0.756
Transport costs	9.0%	(3.3-14.7%)	0.0%	--	0.002
Other	24.0%	(15.5-32.5%)	38.0%	(28.3-47.7%)	0.032

The majority of participants reported feeling safe during the receipt of the cash transfers. While several qualitative participants acknowledged frequent exposure to community violence, they reported feeling reassured by the safety measures taken at the cash transfer sites (security guards, cameras, etc.). **As one woman explained,** “I generally didn’t see any type of danger. I simply picked up [my payment], put it away, and left.” Several of the women reported collecting the cash assistance in places they were familiar with close to home, selecting cash retrieval places with police presence or in a mall.

While UNFPA’s cash delivery mechanism provided for flexibility in the locations in which cash could be retrieved, several women did report concerns about their safety during receipt of their cash transfer, mostly linked to the informal settlement living situations described above. They often navigated this by asking family members for support. **In qualitative interviews, one woman shared,** “The place where I had to pick up the cash, specifically, is a grocery store, but it’s in a very dangerous area, there are people there who are waiting to do harm and to rob you. There was no safety there, my mom had to keep watch.”

Many women reported having to travel long distances to pick-up sites as well as issues with transportation as barriers to receiving the cash transfers. **A woman shared that she had to ask for a loan to be able to afford transportation to pick up the transfer:** “Yes, it [would have helped] to get independent transport. I had to ask for a loan and when I received the [cash-transfer], I was able to pay it back.”

The majority of women, irrespective of whether or not they experienced transportation challenges, felt that the program could be improved by providing transportation assistance for cash transfer delivery and receipt.

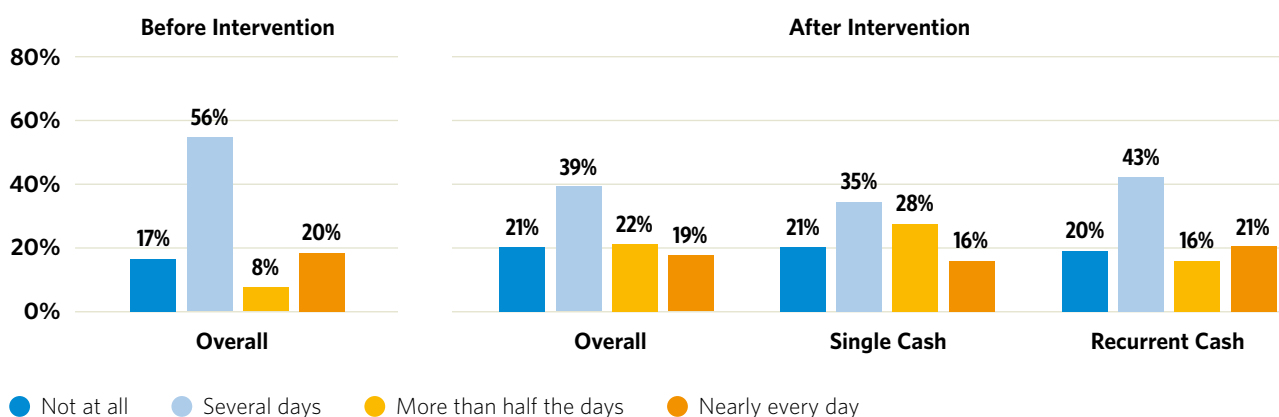
**One woman said,** “It would have been [helpful] if a pick-up ride was arranged, or if we received money for the taxi, really any sort of help like that would have helped.” Another woman added, “For me, it would be a big help if we could get support for transportation tickets, it would be important in the case that a [cash-transfer] is ready and one doesn’t have [money].”

### Mental Health

Participants were asked to report how frequently they felt depressed or hopeless in the prior two weeks (on a 4-point scale from not at all to nearly every day). At baseline, 27.5% of cash recipients reported feeling hopeless either more than half the time or nearly every day, 56% reported occasional feelings of depression and 17% reported no feelings of depression (Figure 6). At endline, the proportion reporting no feelings of hopelessness increased to 21% and feelings of occasional depression decreased to 39%; the proportion reporting frequent depression increased to 40.5% including 44% and 37% of single and recurrent cash recipients, respectively.

While there was no clear universal trend and the proportion of women reporting no depression was relatively constant, a large portion of women with occasional feelings of depression reported an intensification of symptoms (from several days monthly to more than half of the time).



**Figure 8: Feelings of Depression Before and After the Intervention**

### Service Referrals

Overall, 46.7% of cash recipients reported they received information about other services at the time of the intervention, and this proportion was significantly larger among recurrent cash recipients (50.5%) as compared to single cash recipients (43.0%) ( $p=0.021$ ). The most frequent type of service about which women in both groups received information was psychosocial support (81.7% of women who received information about any services), and this was followed by health services (29%) (Table 5).

Of the 93 women who reported receiving information, 74 (79.6%) reported seeking the suggested services, and this proportion was similar between groups ( $p=0.770$ ), suggesting that both interventions have the potential to be appropriate methods of facilitating linkages to other services. Interestingly, women in the single cash transfer group were significantly more likely to have sought specialized psychosocial support focused on recovery and/or empowerment, with several sessions being provided depending on the emotional needs of the GBV survivor (92% vs. 69%,  $p=0.013$ ). Women in the recurrent cash group were more likely to have sought health services, though this difference was not significant (30% vs. 16%,  $p=0.131$ ).

**Table 5: Referrals for Services After Receipt of Assistance**

	Overall (N=200)			Single Cash (n=100)		Recurrent Cash (n=100)		p-value
	N	Point	(95% CI)	Point	(95% CI)	Point	(95% CI)	
Participants who received information about nearby services	93	46.7%	(39.7-53.7%)	43.0%	(33.1-52.9%)	50.5%	(40.5-60.5%)	0.021
Psychosocial support	76	81.7%	(73.7-89.7%)	83.7%	(72.2-95.2%)	80.0%	(68.5-91.5%)	0.643
Health services	27	29.0%	(19.6-38.4%)	27.9%	(13.9-41.9%)	30.0%	(16.8-43.2%)	0.825
Livelihoods	9	9.7%	(3.6-15.8%)	14.0%	(3.2-24.7%)	6.0%	(-0.8-12.8%)	0.196
Safe spaces	8	8.6%	(2.8-14.4%)	9.3%	(0.3-18.3%)	8.0%	(0.2-15.8%)	0.823
Additional cash	7	7.5%	(2.1-13.0%)	7.0%	(-1.0-14.9%)	8.0%	(0.2-15.8%)	0.852
Food	6	6.5%	(1.4-11.5%)	2.3%	(-2.4-7.0%)	10.0%	(1.4-18.6%)	0.133
Legal services	6	6.5%	(1.4-11.5%)	9.3%	(0.3-18.3%)	4.0%	(-1.6-9.6%)	0.299
Shelter	3	3.2%	(-0.4-6.9%)	4.7%	(-1.9-11.2%)	2.0%	(-2.0-6.0%)	0.471
Other	9	9.7%	(3.6-15.8%)	9.3%	(0.3-18.3%)	10.0%	(1.4-18.6%)	0.910
Participants who sought services at suggested location(s)	74	37.0%	(30.3-43.7%)	38.0%	(28.3-47.7%)	36.0%	(26.4-45.6%)	0.770
Psychosocial support	60	81.1%	(71.9-90.2%)	92.1%	(83.1-101.1%)	69.4%	(53.6-85.3%)	0.013
Health services	17	23.0%	(13.2-32.8%)	15.8%	(3.6-27.9%)	30.6%	(14.7-46.4%)	0.131
Other*	9	12.2%	(4.5-19.8%)	13.2%	(1.9-24.4%)	11.1%	(0.3-21.9%)	0.788

\* Includes livelihoods, safe spaces, additional cash, food, legal, shelter, and other services

Women who received referrals and subsequently used the referrals described the impact on their health and wellbeing. Participants in the qualitative interviews mentioned receiving contraception as well as treatments for family members' health conditions including respiratory issues, blood pressure, and medication. Participants also shared that they used the cash transfers in part to cover the financial costs of these services.

**One of them stated:**

*"I only went to the psychologist once, and didn't go back because I had my baby with a cesarean and I wasn't able*

*to connect with her again. She helped me a lot, I was able to blow off steam, cry, talk, and she gave me a lot of good advice."*

**Another participant who received a psychology referral shared:**

*"Of course, the help has been really important, it helps you overcome difficult situations. It helps you gain strength because any person can get discouraged and depressed, so this has been really important."*

## SUMMARY OF FINDINGS AND RECOMMENDATIONS



### KEY FINDINGS

UNFPA Colombia GBV survivors and women and adolescents at high risk of GBV who received cash assistance in the provinces of La Guajira, Norte de Santander, and Arauca were predominantly Venezuelan (77%), and most Venezuelans had arrived in Colombia within the past five years (65%). Most cash recipients were in female-headed households (91%) and average household size was modest at 4.3 members. The surveyed GBV survivors and women and adolescents at high risk of GBV received the cash assistance for either one or three months as a component of the comprehensive support provided to them through the GBV case management process. The cash transfer(s) had a significant impact on improving the overall safety and security of GBV survivors and women and adolescents at high risk of GBV, especially for those who received cash on a recurrent basis. They felt safer, had improved relationships in their homes (which is where violence mainly occurs), and had reduced safety/security needs. A sizable proportion of cash recipients (30%) reported spending transfer(s) on services to improve their personal situation (most often new accommodation, which was reported by 17% of cash recipients).

In terms of their unmet needs at baseline, food insecurity was pervasive with the majority of participants reporting skipping meals (97%) and going entire days without eating (88%) in the past month; a significant minority (14%) reported resorting to negative coping mechanisms such as survival sex to be able to eat. Food was the most important unmet need at both baseline (96%) and endline (85%); other prominent unmet needs included livelihoods and shelter. Food was the most frequently reported use of cash transfers (79%) followed by livelihoods (52%). Investment in livelihoods was significantly more common among recurrent

transfer recipients as compared to single transfer recipients (67% vs. 36%;  $p < 0.001$ ), suggesting that recurrent cash transfers may be more likely translate to having the recipient gain more economic independence to stay safe from GBV risks through livelihoods investment and sustainable gains in household income. Recurrent cash recipients were also significantly more likely to report spending on shelter as compared to single cash recipients (58% vs. 40%;  $p = 0.011$ ).

Feelings of safety among the interviewed GBV survivors and women and adolescents at high risk of GBV increased after they received the cash assistance. Overall, 46% of women and adolescents felt safe prior to receiving the cash transfers, compared to 61% after receiving cash assistance. The proportion that felt safe after the transfers was similar among both the single transfer and recurrent transfers groups. At endline, 0% of recurrent transfer recipients reported safety/protection as a priority unmet need compared to 16% of those that received a single transfer.

Implementing cash transfers in GBV case management facilitates actionable personal case plans, access to services, and can also reduce financial access barriers to healthcare seeking. Significantly more recurrent cash recipients received information about nearby services as compared to single cash recipients (51% vs 43%,  $p = 0.021$ ), with referrals for psychosocial support (82%) and health (29%) being the most common. The overall rate of healthcare seeking (37%) was similar between single and recurrent cash recipients, however, there were notable differences in the proportions of single and recurrent cash recipients who sought psychosocial support (92% vs. 69%, respectively;  $p = 0.013$ ) and health services (16% and 31%, respectively;  $p = 0.131$ ).

While the majority of participants reported feeling safe during the receipt of cash-transfers, the most common

challenges reported in transfer receipt were safety concerns (34%) and travel times and distance (30%). The proportion of recipients reporting various concerns was similar between the single and recurrent cash recipient groups. Among women living with partners, the majority reported they were the sole decision makers on transfer use (70%), with an additional 26% reporting joint decision making (with similar proportions in the single and recurrent transfer groups).

## Conclusions and Recommendations

As cash transfers become increasingly mainstream in humanitarian settings, the approach is being adopted across numerous sectors with a diverse range of objectives, including meeting basic needs and reducing financial access barriers to a wide range of goods and services. For women who have experienced or are at risk of GBV, cash transfers are sometimes provided within the context of protection programming. Recent evidence reviews suggest the cash assistance has generally positive impacts, can be delivered safely, and is associated with decreases in domestic violence.<sup>3,4,5,6,7</sup> In qualitative interviews after receiving the cash transfers, women reported improvements in perceived safety stemming from the cash transfers, including through improvements in living conditions, food security, the strengthened ability to generate future income, and by enabling them to challenge gender norms that perpetuate GBV. These findings suggest that cash transfers may have resulted in reducing tension and therefore improved household dynamics. The qualitative analysis highlighted that cash transfers can respond to and prevent GBV-related risks and needs, and can also improve a collective sense of well-being and decision-making in the family system. There was no evidence that cash assistance reduced safety in either group, either at the time of or after disbursement, suggesting that integration of cash transfers in GBV case management is unlikely to have widespread unintended consequences in the Colombian context.

While cash transfers were a short-term intervention (one or three months) in this pilot program, they were integrated within the broader case management process, which is intended to provide individualized support to women who are at risk or victims of GBV. Recipients of recurrent cash transfers were more likely to have received service referral(s) and significantly more likely to have sought specialized psychosocial support, indicating that cash within the context of protection programming may have important benefits for healthcare seeking. In many instances, women may not know of services that are locally available; as such, additional contacts may help to facilitate these discussions and increase awareness of nearby providers.

Cash assistance can also enable women to better afford out-of-pocket costs of seeking care such as user fees and transportation. If program budgets permit, expanding both the period of transfer receipt and the number of recipients would both be beneficial strategies.

In its next program iterations, on a case-by-case basis, UNFPA Colombia will further address the concerns raised by some of the women over the travel distance and safety when collecting the cash assistance, particularly for women and adolescents living in informal settlements at the urban periphery. In this program, GBV survivors and women and adolescents at high risk of GBV were able to select a cash disbursement operated by the remittance agency (SuperGiros, which offers a large coverage in the targeted departments), be accompanied by a case worker if needed, or alternatively obtain the cash in hand directly from the GBV case worker on an exceptional basis. UNFPA Colombia will provide flexibility for cash transfers in future programming and consider increasing the transfer value for women who face higher costs in collecting the cash assistance. In addition, it will ensure more seamless communication to the women and adolescents that are at risk or victims of GBV about the options available to them, especially for those who may face access difficulties, limitations of movement, or have a disability.

Within the Colombian context, the addition of cash assistance to GBV case management for survivors and women and adolescents at high risk of GBV was associated with positive outcomes, including improved household relationships and increased receipt and use of referrals. In both cases, recurrent cash recipients had better outcomes at endline compared to single transfer recipients, indicating likely greater benefits of recurrent cash transfers. While the current global context is challenging and humanitarian needs far exceed funding that is available for humanitarian assistance, maintaining services for vulnerable groups such as GBV survivors or women and adolescents at high risk of GBV is critical. Cash transfers alone are insufficient to fully address the complex needs of this population sub-group; however, they are a useful tool within the context of case management that can support women in a variety of ways, including helping them to achieve their goals and safety plans set with case managers; meet basic household needs and reduce familiar tensions; and reduce financial barriers associated with accessing services. In the case of this evaluation, recurrent transfer recipients exhibited better outcomes single transfer recipients in some areas at endline, suggesting that longer-term assistance, when feasible, is beneficial. UNFPA and their Colombia implementing partners should also consider expanding the cash pilot program to include more GBV survivors and women and adolescents at high risk of GBV and geographic areas.

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