



“We have a way
to start out
on our own”

The Effectiveness of Cash Assistance Integrated into Gender-Based Violence Case Management for Forced Migrants, Refugees, and Host Nationals in Norte de Santander, Colombia: A Quasi-Experimental Mixed-Methods Evaluation



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FROM THE AMERICAN PEOPLE

Full Quote:

"I feel more confident, because with the economic support, we have a way to start out on our own, with something of our own." – Colombian woman with disabilities, cash participant

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Cover Image Caption:

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Women participating in the GBV case management process during a workshop with CORPRODINCO, Ocaña

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I. BACKGROUND

Gender-based violence (GBV) is a pressing concern for forced migrant and refugee women, girls, and individuals with diverse sexual orientation, gender identity and expression or sex characteristics (SOGIESC). They face exposure to and incidents of GBV before, during, and after a humanitarian crisis. Humanitarian actors use a variety of approaches to prevent, mitigate, and respond to GBV, yet evidence gaps remain in informing comprehensive program models that improve the lives and protect the rights of GBV survivors as well as individuals at risk of GBV.

As a complement to core aspects of GBV case management, preliminary evidence finds that cash and voucher assistance (CVA) may strengthen survivors' capacities to recover from GBV and enable access to services. For example, CVA can help a GBV survivor to pay the costs associated with fleeing an abusive relationship, such as temporary accommodation and transportation, and to access legal assistance. There may also be indirect pathways in which CVA could be used by survivors and individuals at risk to reduce their exposure to GBV, such as decreasing their financial dependence on abusive partners or family members, and shifting power dynamics in intimate relationships.¹

As an alternative to traditional in-kind assistance, CVA has become an increasingly common tool across humanitarian response sectors to meet the needs of those displaced by crisis and conflict. In 2019, approximately 18 percent of humanitarian assistance globally was delivered via CVA,² and this proportion continues to grow. Despite a push by several humanitarian actors to increase the use of CVA within the protection sector to support protection outcomes, including to support the prevention of and response to GBV, CVA is the least used for protection outcomes out of all sectors.³

CVA has yet to be consistently considered in GBV programming for displaced survivors, and humanitarian actors have yet to systematically integrate CVA.⁴ As the use of CVA in GBV programming has not been robustly evaluated in humanitarian settings, not only is there limited evidence on the effects of CVA in GBV programming,⁵ but key aspects of CVA still need to be elucidated for safe and effective implementation, such as delivery mechanisms, frequency, value, and duration of transfers.

WRC has aimed to understand more about the specific dynamics of GBV case management and cash referrals for forced migrant, refugee, and host national GBV survivors, as well as to identify how best to address the needs of GBV survivors by including multipurpose cash assistance (MPCA) within a package of response services. Building on existing findings and tools,⁶ WRC, in conjunction with CARE Colombia and a national partner, CORPRODINCO, piloted an intervention from June 2021 to January 2022 to assess the integration of cash assistance into GBV case management to support survivors in forced migrant, refugee, and host communities in Ocaña, Norte de Santander, Colombia. Drawing from a quasi-experimental mixed methods study, this report summarizes the quantitative and qualitative findings and lessons learned from the joint program and evaluation over four months in support of CVA integrated into GBV programming, and shares recommendations for the way forward in this context.

1 Ana Maria Buller et al., "A Mixed-Method Review of Cash Transfers and Intimate Partner Violence in Low- and Middle-Income Countries," *The World Bank Research Observer*, 33(2) (2018): pp. 218–258. <https://academic.oup.com/wbro/article/33/2/218/5091868>.

2 The Cash Learning Partnership (CALP), *The State of The World's Cash 2020: Cash and Voucher Assistance in Humanitarian Aid* (2020), https://www.calpnetwork.org/wp-content/uploads/2020/07/SOWC2020_Full-report.pdf.

3 <https://www.calpnetwork.org/blog/leveraging-cash-and-voucher-assistance-in-gender-based-violence-prevention-and-response/>

4 Tenzin Manell *Tackling the Integration of Gender-Based Violence Prevention and Response and Cash-Based Interventions* (New York, Washington, DC, and Geneva: WRC, 2018). <https://www.womensrefugeecommission.org/wp-content/uploads/2020/04/genderandctpwrc.pdf>.

5 Melissa Meinhart et al., "Identifying the Impact of Intimate Partner Violence in Humanitarian Settings: Using an Ecological Framework to Review 15 Years of Evidence," *International Journal of Environmental Research and Public Health*, 18(3) (2021): 6963. <https://www.mdpi.com/1660-4601/18/3/6963>.

6 Tenzin Manell and Holly Welcome-Radice, *Utilizing Cash and Voucher Assistance Within Gender-Based Violence Case Management to Support Crisis-Affected Populations in Ecuador*, February 13, 2020. <https://reliefweb.int/report/ecuador/utilizing-cash-and-voucher-assistance-within-gender-based-violence-case-management>.

II. CONTEXT: OCAÑA, COLOMBIA

With the deterioration of the economic and political situation in Venezuela, a humanitarian crisis has spilled over into 16 countries across Latin America and the Caribbean, including Colombia. Colombia hosts 2.4 million Venezuelans as of 2021.⁷ Internal displacement and confinement escalated in 2019 caused by a variety of armed non-state actors competing for the income from narco trafficking, human trafficking, and illegal mining.⁸ Despite being increasingly overshadowed by the Venezuelan migration crisis, due to preexisting internal conflict, Colombia already has the second-largest number of internally displaced persons in the world after Afghanistan, with an estimated 8.5 million people in protracted displacement.⁷

Before entering Colombia, Venezuelan migrants and refugees are at risk of exposure to GBV and experience incidents of GBV; during the COVID-19 pandemic, exposure to sexual violence and other protection concerns increased for Venezuelans when the Colombian-Venezuelan border closed, and migrants and refugees pivoted to using irregular roads to enter Colombia.⁸

For both Colombians and Venezuelans, there are substantial risks of exposure to GBV and incidents of GBV in Colombia. The national and international conflicts enveloping Colombia have increased poverty and crime, in turn driving an increase in human trafficking. Women are particularly susceptible to human trafficking, as traffickers lure individuals with the promise of economic opportunity, such as jobs as street vendors, only to sexually exploit them.⁹

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

In 2021, over 115,000 cases of GBV—primarily physical and sexual violence—were reported to La Sistema Vigilancia en Salud Pública,¹⁰ Colombia's public health surveillance system. Of these cases, 77.9 percent were reported by women, and over 5,800 cases were reported by Venezuelans.

At the time of publication, there are no national statistics that disaggregate reports of GBV by individuals with diverse SOGIESC, resulting in limited information with which to estimate the incidence of GBV among this group. In Ocaña, forced migrant and refugee individuals with diverse SOGIESC face significant discrimination and violence from the broader community. Colombian lesbian, gay, bisexual, transgender, queer, questioning, and intersex (LGBTQI+) individuals also endure discrimination and violence from their community, due to deeply held religious values in their community which condemn their identities and sexualities.



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Women participating in the GBV case management process during an activity with CORPRODINCO and Save the Children, Ocaña.

7 United Nations High Commissioner for Refugees, Colombia, June 10, 2022. <https://reporting.unhcr.org/colombia>.

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

9 Adriana Marcela Pérez-Rodríguez, "Gender-Based Violence in a Migrant Context: A Case Study of Norte de Santander," *Humanitarian Exchange Magazine*, 80(5). <https://odihpn.org/publication/gender-based-violence-in-a-migrant-context-a-case-study-of-norte-de-santander/>.

10 Colombia Ministry of Health and Social Protection, "Integrated Information System on Gender Violence," June 10, 2022. <https://www.sispro.gov.co/observatorios/onviolenciasgenero/Paginas/home.aspx>.

III. PROGRAM MODEL AND EVALUATION

PROGRAM MODEL

The program model was a cash assistance-integrated GBV case management program, based on the [CVA and GBV Compendium](#)¹¹ and the WRC-International Rescue Committee-Mercy Corps [CVA-GBV Toolkit](#).¹² WRC, CARE, and CORPRODINCO contextualized the program model for implementation in Colombia, and CORPRODINCO executed the delivery of the program.

This program aimed to include adult women and men, aged 18 years or older, who were survivors of or at risk of GBV, including those with diverse SOGIESC and those living with a disability or disabilities. CORPRODINCO caseworkers were all female, and enrolled survivors who voluntarily disclosed an incident of GBV. Caseworkers assessed participants' need for cash assistance for protection, examining the economic drivers of their exposure to GBV risks, as well as the financial barriers to their recovery; this process took place according to the program's standard operating procedures, which were aligned with best practice guidance and tools. Survivors who met the program's eligibility criteria and were enrolled, were guided through the steps of the cash referral during GBV case management by their caseworker.

Each enrolled GBV survivor for whom cash assistance was deemed appropriate received up to three unconditional and unrestricted transfers within GBV case management, up to a total transfer value ranging from \$91 to \$274, depending on the needs of each survivor's case. Of the 100 survivors who received cash transfers integrated into GBV case management, 97 received three transfers with a total transfer value of \$274; two survivors received two transfers with a total transfer value of \$183; and one survivor received one transfer with a total transfer value of \$91. Cash transfers were delivered through the financial service provider [Efecty](#), which operates payment points from which survivors could pick up cash assistance at a time of their choosing. The program duration was approximately four months for each participant.

As part of GBV case management, caseworkers provided psychological counseling, information on and coordination of group workshops, and access to CORPRODINCO's legal service. Caseworkers also activated referrals to external services as relevant, including immigration status counseling; family commissioners of the Comisaria de Familia, an institution that handles complaints of domestic violence;¹³ sexual and reproductive health services; education; and livelihood support. Service mappings and referral pathways were updated regularly to reflect services available for referral.

11 CARE USA, Cash & Voucher Assistance and Gender Based Violence Compendium: Practical Guidance for Humanitarian Practitioners (Atlanta: CARE USA, 2019). https://gbvguidelines.org/wp/wp-content/uploads/2019/07/CVA_GBV-guidelines_compendium.FINAL_.pdf

12 Women's Refugee Commission, Resources for incorporating gender-based violence (GBV) considerations into cash assistance and vouchers (CVA) and the use of CVA in the prevention and response to gender-based violence, February 1, 2018. <https://www.womensrefugee-commission.org/research-resources/mainstreaming-gender-based-violence-considerations-cash-voucher-assistance>.

13 According to Law 1098 of 2006, the functions of this institution are to:

- 1) Guarantee, protect, restore and repair the rights of family members violated by situations of domestic violence.
- 2) Assist and guide children and adolescents and other members of the family group in the exercise and restoration of their rights.
- 3) Receive complaints and adopt the necessary emergency and protection measures in cases of crimes against children and adolescents.
- 4) Receive complaints and take protective measures in cases of domestic violence.
- 5) Provisionally define the custody and personal care, food quota, regulation of visits, and suspension of the life in common of the spouses or permanent partners, and fix the bonds of conjugal behavior in situations of domestic violence.
- 6) Practice rescues to avert dangerous situations in which a child or adolescent may find themselves, when the urgency of the case demands it.
- 7) Develop prevention programs on domestic violence and sexual crimes.
- 8) Adopt measures to restore rights in cases of child abuse and report the crime.
- 9) Apply the corresponding police measures in cases of family conflicts, in accordance with the powers conferred by the municipal councils.

PROGRAM EVALUATION: METHODOLOGY

The objective of the evaluation was to generate evidence on the use of cash assistance integrated within GBV response in a humanitarian setting. To that end, the research aimed to address the following research questions:

1. How might a GBV case management and cash transfer package affect protection outcomes, service access outcomes, and experiences of safety and well-being for displaced GBV survivors, and how might outcomes compare to those of GBV survivors in GBV case management without a cash component?
2. How do displaced GBV survivors, program staff, and local partner organizations perceive, experience, and assess the design features of the cash component?
3. What are the facilitators and barriers to implementation, and recommendations for improving GBV case management and cash program?

The study used a quasi-experimental design with two study arms: an intervention arm with 100 participants participating in the enhanced cash-GBV case management program, and a comparison group arm with 100 participants receiving GBV case management only, without the cash component. To evaluate the additional impact of cash, a mixed methods approach was employed. All 200 participants were surveyed at the beginning and the end of the program (hereafter referred to as baseline and endline, respectively). In addition, 60 participants—40 in the intervention arm and 20 in the control—were purposively sampled to complete an in-depth qualitative interview at the end of the program. Finally, 14 key informant interviews (KIIs) were conducted at the end of the program, with caseworkers, program staff, and local experts.

Using the quantitative data, a differences-in-differences analysis was conducted between the participants receiving the enhanced cash-GBV case management and those receiving the GBV case management intervention without cash, to examine differences in key impacts between these groups. This quantitative analysis was led by the WRC researcher and conducted by the research partner SAMRC. For the qualitative data analysis, the WRC researcher read all interviews, drafted analytic memos, conducted a co-analysis workshop with implementing partners, developed a qualitative code book, and analyzed the data using [Dedoose](#) version 9.0.46 software. For more information on the methodology, see the Annex.

CHALLENGES IN IMPLEMENTATION

Several challenges were faced during the program and evaluation. Originally, the program was to be implemented in Tibú, a municipality adjacent to the Colombia-Venezuela border that hosts Venezuelan migrants and refugees. However, Tibú has a heavy presence of armed groups and drug trafficking. Due to safety concerns for program staff, the program and evaluation implementation could not take place in Tibú, and the study site was moved to Ocaña.

GBV survivors, irrespective of displacement status and nationality, face challenges in seeking legal protection in Ocaña. Authorities at the federal department and municipal levels are under-resourced to effectively prevent and respond to the high prevalence of reported cases of GBV. In addition, knowledge gaps and attitudes held among the authorities leads to a prioritization of instances of physical and sexual violence, above other forms of GBV. Many survivors do not report abuse, not only due to the stigma they face as GBV survivors, but also due to a lack of trust in government institutions to assist them in seeking justice, protection, and support for recovering from GBV. Altogether, this creates a difficult operational context for program partners to support GBV survivors and individuals at risk, who are hesitant to disclose incidents and risks of violence and to access services.

Due to security and limited resources for program implementation, there was no designated office space for program staff in Ocaña. As a result, staff coordinated workshops in various locations across the municipality and provided participants with counseling at home in cases where it was safe to do so.

LIMITATIONS OF THE ANALYSIS

Several limitations were encountered during the program evaluation:

- The data collected were self-reported measures and, as a result, may be subject to reporting bias, especially related to sensitive topics such as GBV. The results presented here may underestimate the violence experienced by participants.
- The generalizability of these findings to other populations is limited due to the construction of the sample, which was not representatively sampled based on survivors in the area, and the specificity of the context of Norte de Santander.
- Due to the quasi-experimental study design, the analysis and findings therein can only infer causality of the cash integration on the study outcomes.

IV. QUANTITATIVE FINDINGS

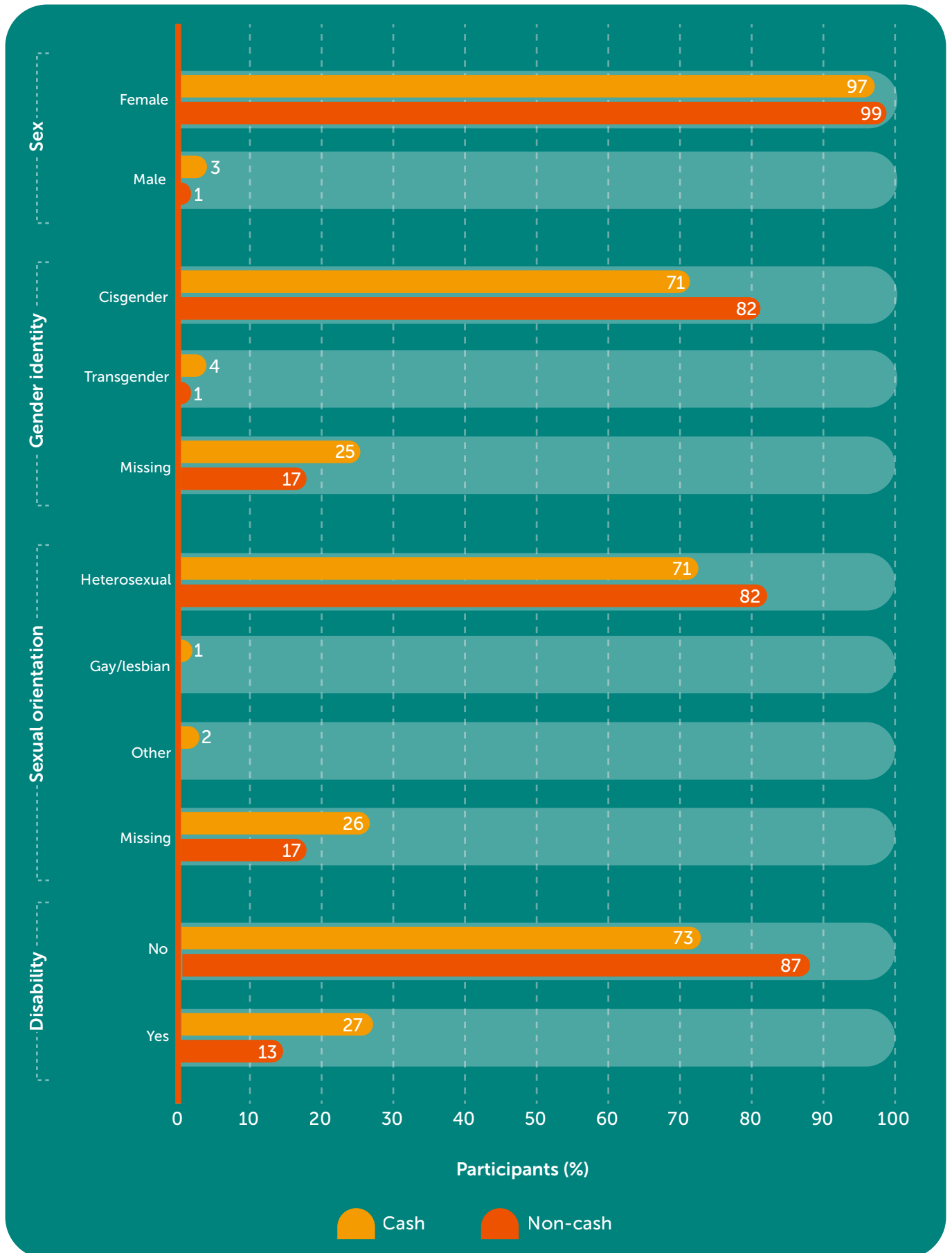
CHARACTERISTICS OF PARTICIPANTS

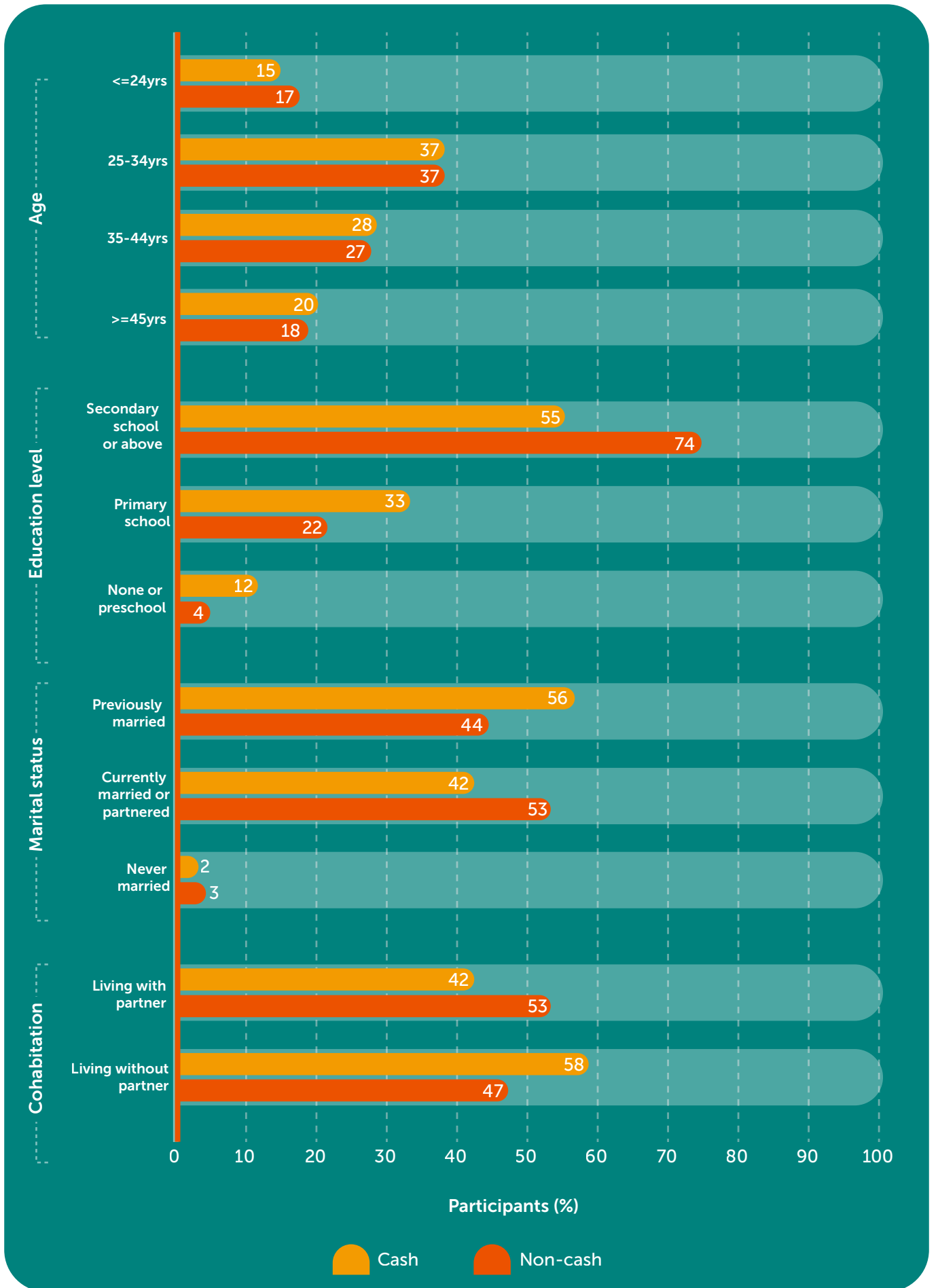
The study sample contained 100 participants in the cash group and 100 participants in the non-cash group. Figure 1 shows the proportions of each group by demographic characteristics. The composition of participants was similar between the two groups. By age, the largest age group was 25–34 years: 37 percent in both the cash and non-cash groups. By sex, most participants were female: 97 percent in the cash group and 99 percent in the non-cash group. By gender identity, 4 percent of the cash group and 1 percent of the non-cash group identified as transgender, while most participants identified as cisgender (71 percent in the cash group, 82 percent in the non-cash group); however, approximately a fifth of the total sample (17 percent in the cash group and 25 percent in the non-cash group) had missing data for this question. The majority of participants reported being heterosexual; however, there were missing responses for one fifth of the sample. In the cash group, 3 percent of participants reported being LGBTQI+, whereas all participants in the non-cash group reported being heterosexual. By marital status, in the cash group 42 percent were currently married and 56 percent were previously married, while in the non-cash group 53 percent were currently married and 44 percent were previously married. These proportions of participants who reported living with a partner at baseline were similar across groups: 42 percent in the intervention group and 53 percent in the comparison group. The level of education and disability status were the only demographic characteristics that had statistically significant differences between the two study groups (p -value = 0.011 in the cash group; 0.013, in the non-cash group). For both groups, most participants had received secondary education; however, the proportion of individuals who had done so was much lower in the cash group (55 percent) than in the non-cash group (74 percent). Of the cash group, 27 percent reported living with a disability, over twice as many as the non-cash group participants who reported living with a disability (13 percent).



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Women receiving candles during the International Day for the Elimination of Violence against Women, Ocaña.

Figure 1. Study sample characteristics of cash intervention and non-cash comparison groups (N = 200).





DIFFERENCES-IN-DIFFERENCES

In the quantitative evaluation, four sets of outcomes were examined: intimate partner violence (IPV) and protection, economic agency, well-being, and assets. The indicators within each category are outlined below.

Table 1. Four outcomes of interest for the quantitative evaluation.

<p>IPV and protection</p>	<p>4 dimensions of IPV were evaluated: emotional, economic, physical, and sexual violence. Participants reported on the frequency of violence over 3 and 12 months. The frequency of quarreling, family violence, and patterns in male controlling behaviors were also assessed.</p>
<p>Economic agency</p>	<p>7 aspects were analyzed: (1) employment; (2) money earned over the last 30 days; (3) current savings; (4) debt, (5) coping strategies (which was evaluated as an index); (6) household decision-making; and (7) feelings of autonomy and the locus of control (sense of agency regarding one's life).</p>
<p>Well-being</p>	<p>Overall mental health and feelings of hope; family and child well-being.</p>
<p>Assets</p>	<p>Access to services, healthcare, and legal services, over the past 3 months was assessed.</p>

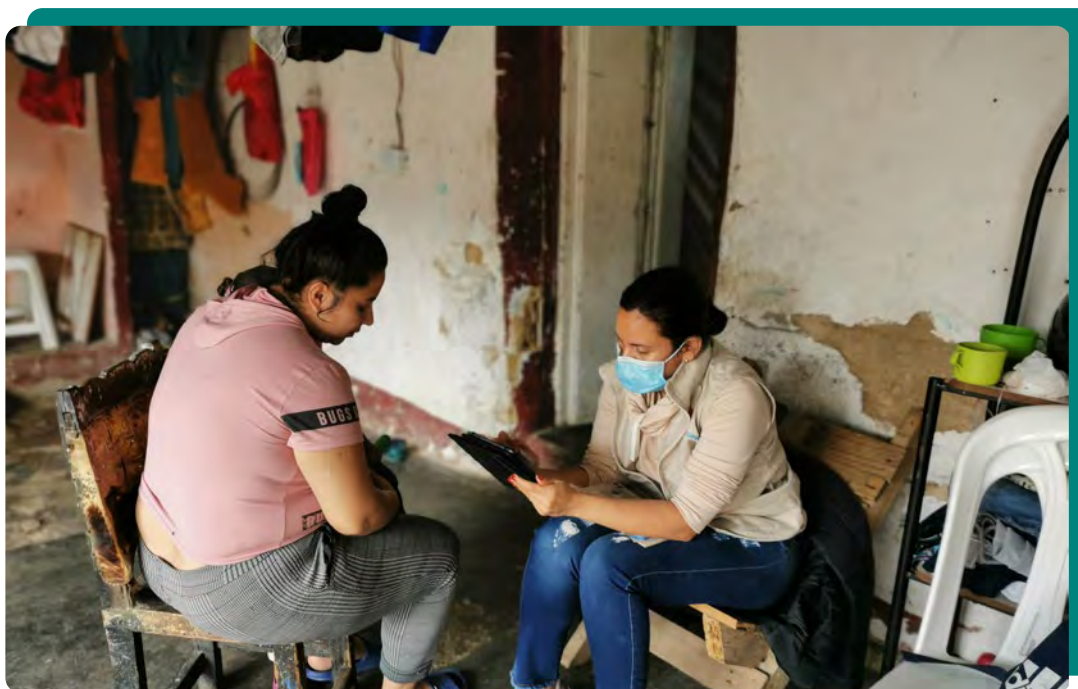
A differences-in-differences analysis was conducted for all outcomes to understand the impact of the cash intervention four months after the start of the program on participants in comparison to those who did not receive cash. For both the cash and non-cash groups, changes from baseline to endline were calculated, adjusted for age, sex, education, marital status, and disability status. Then, differences over time for the two groups were calculated and compared to examine how these groups diverged during the evaluation period. Due to the breadth of indicators included in this analysis, this report presents findings for all IPV and protection outcomes; for the other outcome categories, only findings with statistical significance are reported (p-value < 0.05).

IPV AND PROTECTION OUTCOMES

Overall, both cash and non-cash groups saw reductions in reported IPV and other protection outcomes. The cash group had statistically significant reductions for two more protection outcomes over time than the non-cash group, but the differences of those changes over time between cash and non-cash participants were not statistically significant for any IPV or protection outcome (see Table 1 and Figure 2). Both cash and non-cash groups saw **statistically significant reductions in the reporting of any IPV** (any emotional, economic, physical, or sexual violence) that occurred once or more in the past three months; **for the cash group, this outcome decreased by 22 percent** (p-value < 0.001) while **for the non-cash group, this outcome decreased by 13 percent** (p-value = 0.043).

Across the different types of IPV, the cash group had significant decreases in emotional IPV (19 percent; p-value = 0.002), economic IPV (19 percent; p-value = 0.002), and physical IPV (18 percent; p-value = 0.003). The cash group also had reductions in sexual IPV (7 percent), family violence (5 percent), and quarreling (12 percent). However, these changes were not statistically significant. By comparison, the non-cash group only had a statistically significant reduction in physical IPV, which decreased 12 percent (p-value = 0.024). There were reductions for other types of IPV for the non-cash group—emotional IPV decreased by 12 percent, economic IPV decreased 8 percent, and sexual IPV decreased 4 percent, but these changes were not statistically significant. Interestingly, the non-cash group saw an increase in one protection outcome, family violence, by 3 percent, but this change was not statistically significant.

Higher scores for perceptions of gender indicate more equitable gender attitudes. Both cash and non-cash groups had statistically significant increases in mean gender attitude scores by the end of the program. For the cash group, the mean score increased by 1.85 points (p-value = 0.005), and the non-cash group increased 2.53 points (p-value < 0.001). Self-blame for violence decreased among cash participants by 35 percent, which was 12 percent greater than was reported among non-cash participants (23 percent).



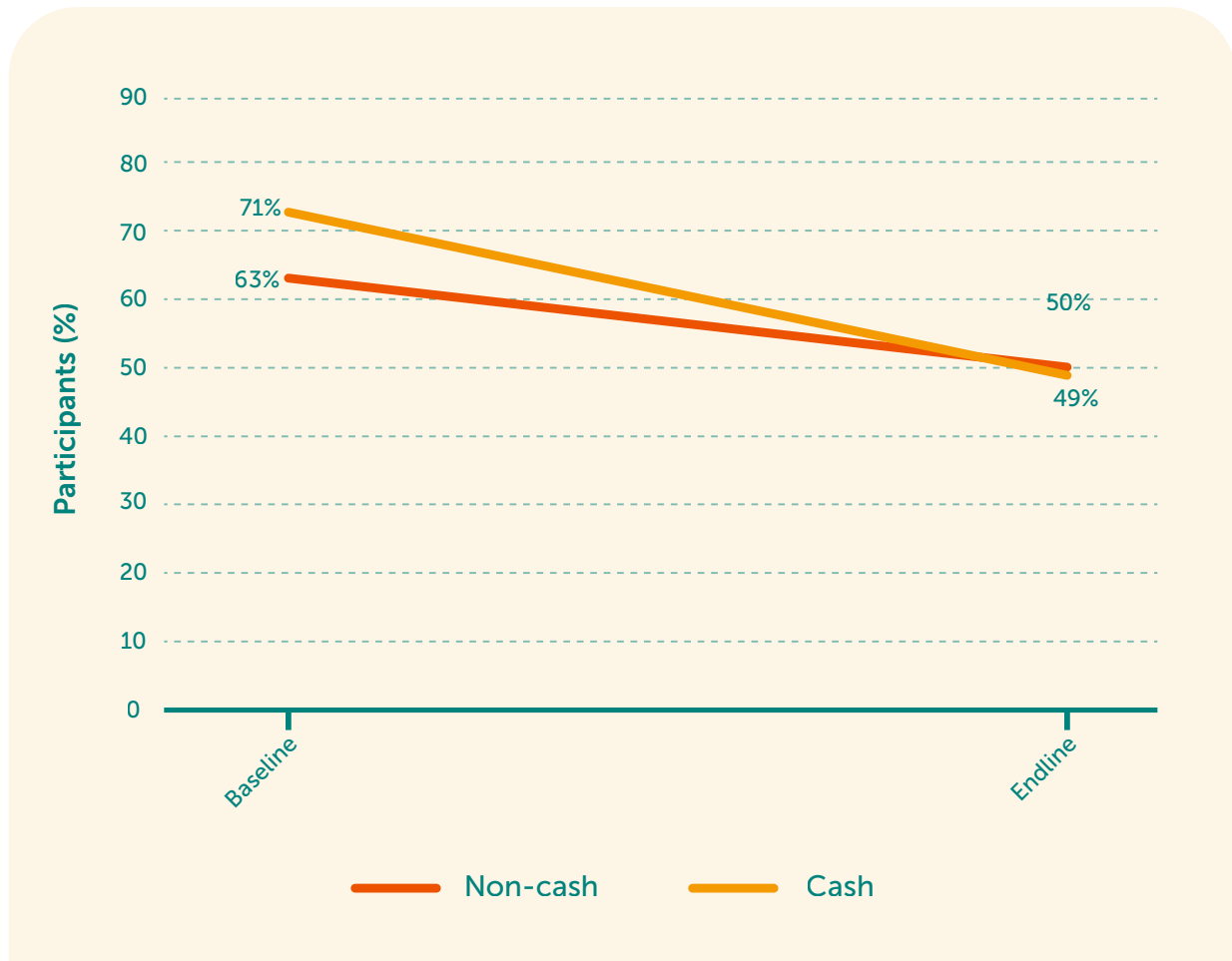
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Woman meeting with a CORPRODINCO case worker, Ocaña.

Table 2. Changes in IPV and protection outcomes over the evaluation period, cash and non-cash groups (N = 200).

Outcome	Non-cash group		Cash group		Difference between groups
	At baseline	Change over evaluation period	At baseline	Change over evaluation period	
IPV: Any occurrence of IPV (past three months)	63	<u>-13</u>	71	<u>-22</u>	-9 ↑
IPV: Emotional (past three months)	61	-12	67	<u>-19</u>	-7 ↑
IPV: Economic (past three months)	26	-8	36	<u>-19</u>	-11 ↓
IPV: Physical (past three months)	28	<u>-12</u>	37	<u>-18</u>	-6 ↓
IPV: Sexual (past three months)	10	-4	12	-7	-4 ↓
Family violence (past three months)	21	+3	37.8	-5	-8 ↓
Gender attitudes scale (score)	37.1	<u>+2.53</u>	37.4	<u>+1.58</u>	-0.68 ↑
Quarrelling	53	-2	71.7	-12	-10 ↑
Self-blame	46	-23	65	<u>-35</u>	-12 ↓

Notes: **Bold** indicates statistical significance (p-value < 0.05). Any IPV was categorized as a report of emotional, economic, physical, or sexual violence that occurred once or more in the past three months. For the gender attitudes scale, a higher score indicates more equitable perceptions of gender. All estimates were calculated using linear regression models for scored outcomes, or logit models for proportional outcomes, with robust standard errors, controlling for age, sex, education, marital or partner status, and disability status.

Figure 2. Changes in any occurrence of IPV in the past three months over the evaluation period, cash and non-cash groups, N=200



ECONOMIC CAPACITY OUTCOMES

There were statistically significant improvements for the cash group over the non-cash group over the evaluation period for four economic capacity outcomes: earning money for work in the past month, savings, coping strategies, and autonomy or sense of control (see Table 2 and Figure 3).

The cash group had a significant increase in the proportion of participants who reported earning money for work in the past month, 23 percent (p -value < 0.001), which was 29 percent higher (p -value = 0.002) than the change in the non-cash group. The cash group also had a statistically significant increase of 22 percent (p -value < 0.001) in the proportion of participants who reported having savings. This change was 26 percent higher (p -value < 0.001) than the change observed in the non-cash group which had a 4 percent (not statistically significant) decrease in this outcome.

Additionally, the cash group reported a decrease in the mean coping strategies score by 8.9 points (p -value < 0.001), which was statistically significant, and indicated using fewer coping strategies. This means the cash group, on average, decreased the use of one to two coping strategies for more than four days in the past week, compared to their reported frequency of coping strategy use at baseline. This decrease was 10.5 points (p -value < 0.001) more than the change in the non-cash group at endline; the non-cash saw an increase in the mean coping strategies score by 1.6 points. For comparison, the non-cash group engaged in one to two more coping strategies at least once in the past week compared to their reported frequency of coping strategy use at baseline. The increase in the coping strategies score for the non-cash group was not statistically significant over time.

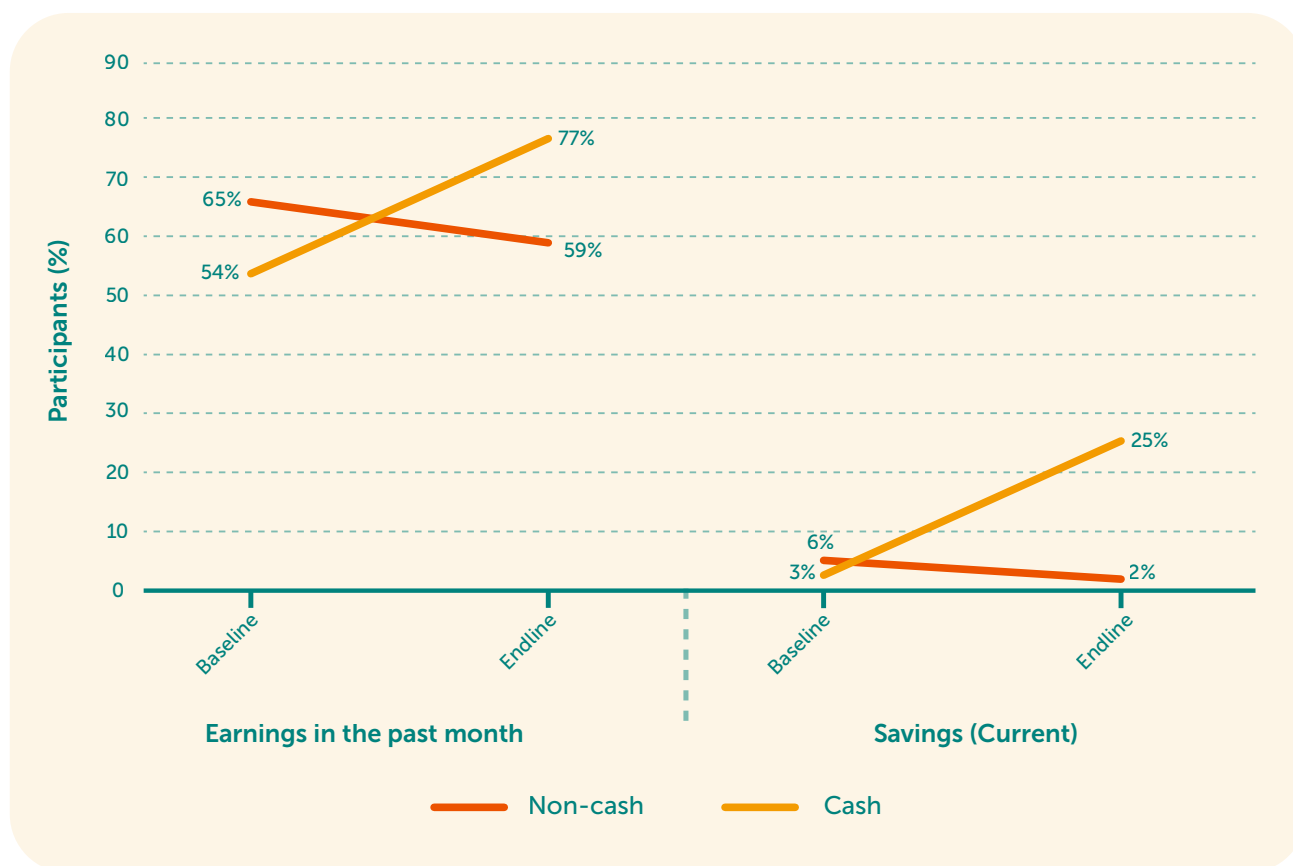
Higher scores for the autonomy scale indicate increased perceptions of one's autonomy and a greater sense of control in one's life. The cash group saw a statistically significant increase in their mean autonomy score over the evaluation period by 2.41 points (p-value < 0.001). This was 1.7 points higher (p-value = 0.029) than the change in the mean score reported by the non-cash group, which saw a 0.7-point increase by the end of the evaluation period; this change in the non-cash group was not statistically significant.

Table 3. Economic capacity outcomes over the evaluation period, cash and non-cash groups (N = 200).

Outcome	Change over evaluation period for non-cash group	Change over evaluation period for cash group	Differences between groups
Earning in the past month (%)	-6%	+23%	+29%
Savings (current) (%)	-4%	+22%	+26%
Coping strategies index (past week) (score)	1.6	-8.9	-10.5
Autonomy and locus of control (score, max = 20)	0.7	+2.4	+1.7

Notes: **Bold** indicates statistical significance (p-value < 0.05). The table presents the results of the differences-in-differences estimates. All estimates were calculated using linear regression models for scored outcomes, or logit models for proportional outcomes, with robust standard errors, controlling for age, sex, education, marital or partner status, and disability status.

Figure 3. Changes in earnings in the past 30 days, and current savings over the evaluation period, cash and non-cash groups, N=200



WELL-BEING AND ASSET OUTCOMES

Both cash and non-cash groups saw improvements in well-being outcomes. However, the cash group reported statistically significant changes across more outcomes over the evaluation period than the non-cash group. The cash and non-cash groups reported lower scores at endline than baseline on the mental health and well-being scale, meaning their mental health distress decreased over time. The cash group exhibited a decrease in their mean mental health score by 5 points (p -value < 0.0001), which was significantly larger (2.1 points, p -value 0.036) than the reduction in the control group, which saw a reduction of 2.9 points (see Table 3).

The cash group saw a statistically significant increase in the mean hope scores over the evaluation period by 3.3 points (p -value = 0.001), indicating an improved outlook for the future. The non-cash group also saw an increase of 1.2 points in this outcome over time, but this change was statistically significant. However, the 2.1-point difference between both groups was not statistically significant.

Though there were improvements for many other outcomes in this quantitative analysis, the asset outcome—access to services—reduced over time. The access to services score assessed participants' use of 15 different services in the past three months, including access to a hospital or clinic, pharmacy, sexual and reproductive health services, contraceptive methods, legal services, counseling/psychological services, housing support, livelihood or employment services, police, immigration or legal status services, protection services (such as a women's shelter, protection orders, the Family Police Station, and the Personeria¹⁴), and the Ombudsman's office. For the cash group, the access

14 The Personeria is part of the Public Ministry which is responsible for the protection and promotion of human rights, protection of public interests, monitoring the conduct of functionaries, and administrative control in the municipality.

to services score decreased significantly by 1 point (p-value = 0.001), which means cash participants, on average, accessed one less service at endline compared to at baseline. The non-cash group also reported a decrease in their access to services score, by 0.5 points. However, neither of these findings were statistically significant.

Table 4. Changes in well-being and assets outcomes over evaluation period, cash and non-cash groups (N = 200).

Outcome	Change over evaluation period for non-cash group	Change over evaluation period for cash group	Differences between groups
Mental health and well-being scale (past month) (score)	2.92	-5.03	-2.11%
Hope scale (future scale) (score)	+1.2	+3.29	+2.09
Access to services (score)	-0.48	-0.95	-0.47

Notes: **Bold** indicates statistical significance (p-value < 0.05). The table presents the results of the differences-in-differences estimates. All estimates were calculated using linear regression models with robust standard errors, controlling for age, sex, education, marital or partner status, and disability status.

V. QUALITATIVE FINDINGS

Sixty participants were sampled and interviewed for the qualitative analysis: 40 in the cash group and 20 in the non-cash group. The cash group comprised 18 forced migrant and refugee women from Venezuela (45 percent), one of whom was living with a disability. The rest of the cash group were Colombian nationals (55 percent), of whom three were transwomen (7.5 percent), and six were living with a disability (15 percent). In the non-cash group, half of the participants were forced migrant and refugee women from Venezuela, of whom two were living with a disability (10 percent). The rest of the participants were Colombian nationals, of whom one was a transwoman (5 percent) and four were living with a disability (20 percent).

Findings are reported by the number of participants associated with each in parentheses (N) and summarized on five areas of evaluation: the integration of cash, changes in GBV and other protection outcomes, economic capacity and professional life, personal well-being, and family and community affairs.

CASH INTEGRATION

Delivery

Most cash recipients found the cash delivery through Efecty to be easily accessible and fast and presenting no risk (31, 83 percent). Only seven participants had difficulties with the delivery mechanism. Most difficulties were reported as delays due to issues in the Efecty system, wherein participants were directed by program staff to collect their assistance; upon doing so, however, their information was not found in the Efecty system. The issue would be resolved in a few days, but some participants had to visit the Efecty distribution point several times before receiving their assistance. This difficulty only occurred among forced migrants and refugees (5). However, forced migrants and refugees who did not experience any trouble with the delivery mechanism regarded the distribution process as effective; many had anticipated some difficulty regarding their identification, which was required. Two participants in the cash group who are Colombian nationals reported that they had difficulties with Efecty staff. They reported that Efecty staff questioned them over where the cash assistance came from, and were impolite or even seemed displeased that the recipient was receiving assistance. One participant mentioned that the second tranche they received took a few months to process, and they would have liked to have collected the cash sooner per the design of the program. Three participants, two of whom were transwomen, reported concerns about the risk of robbery when collecting the cash. Overall, nine participants in the cash group experienced at least one issue with the cash delivery; however, all were able to access the cash assistance.

Use and Sufficiency of Cash

The majority of participants stated that they alone controlled the use of the cash assistance they were entitled to (23); some participants included family members in their decision-making process (10), such as parents, trusted spouses, siblings, and children; even in these instances, survivors made the final decisions themselves.



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Women participating in the GBV case management process carry out an activity on types of violence, Ocaña

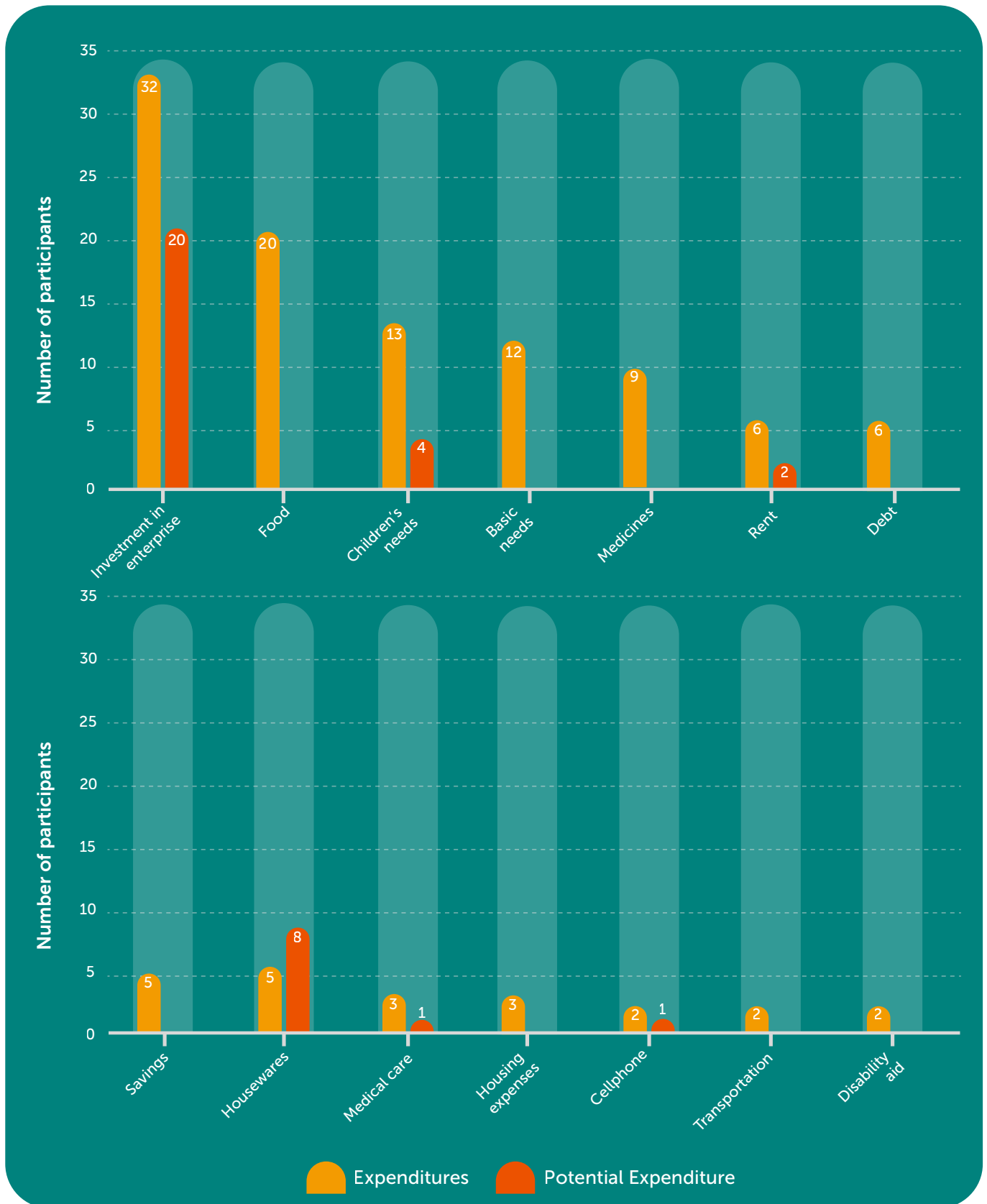
The most common expenditure among survivors was investing in a microenterprise. Cash group participants purchased a range of inputs, including carts to sell food items and tools for hairdressing (32) to generate an income. Other expenditures included food (20); personal items, cleaning supplies, utilities, or housing repairs (14); children's needs, such as milk and food,¹⁵ clothing, school supplies, and diapers (13); medicines for themselves, their children, or other family members (9); rent (6); debt repayment (6); savings (5); housewares (5); medical care for children or other family members (3); cellphones and cellphone repairs (2); transportation (2); and corrective devices, such as a cane or wheelchair, for themselves or a family members living with a disability (2). When discussing other items that they would have purchased with the assistance, participants mentioned inputs for income-generating activities (20), housewares¹⁶ (8), children's needs (4), rent (2), medical care (1) and a cell phone (1). See Figure 4 for both expenditures and potential expenditures.

Most participants—82.5 percent—felt that the cash transfer value was sufficient (33); only a few felt that transfer value could have been larger, and mentioned increasing the value to better aid larger families, establish a sustainable new enterprise, assist their recovery from GBV, and cover basic needs for more than three months (6). Overall, all participants in the cash group highly regarded the cash assistance as well as the help of CORPRODINCO staff in facilitating it.

15 One participant reported that she let her children choose what they wanted for dinner on the days she received cash assistance.

16 Housewares included stoves, refrigerators, heaters, and televisions; housing expenses included house repairs and utilities.

Figure 4. Expenditure and potential expenditure among cash recipients (N = 40)



CHANGES IN PROTECTION AND VIOLENCE

Nearly all participants felt safer and more secure after participating in the program (95 percent, n = 57). Only four participants from across both the cash and non-cash groups reported that they still faced some risks. Three participants, who were still living with their partners at the time of the interview, felt some risk of IPV. Of these individuals, one participant reported experiencing a conflict with her partner after he discovered she had received the cash assistance. As he "assumed the worst" of her, the participant endured emotional abuse as a result; with some intervention and explanation from the CORPRODINCO staff, the issue was later resolved.

Non-Cash Group

Non-cash participants attributed their increased safety to their improved awareness of their rights and orientation to the services available to aid them in instances of violence; many also felt safer knowing that they had support from CORPRODINCO's caseworkers, who were "just a phone call away." With their new-found knowledge and support, some survivors felt more confident and empowered to stand against future abuse. Two participants even reported being enabled to separate from or leave partners that they did not want to remain with.

"Yes, I feel safer, like I have someone who is going to do something for me, you know what I mean, yes. I don't feel alone like I used to, I used to go through things. I have had some very difficult moments at home, very difficult... You feel like there is someone who is supporting you."

– Cisgender Colombian woman living with a disability, non-cash participant

"No, I feel much, much safer. Why? Because I already have the necessary tools that the CORPRODINCO program and the professionals in this program have given me to be able to face any situation. So now I am sure of where I want to go, where I want to get to. So, I already have the certainty that I will be able to do it and that there is no turning back, 'not even to get a boost' [Spanish saying], so I want to continue moving forward more and more every day."

– Cisgender Venezuelan woman, non-cash participant

Cash Group

Participants in the cash group reported a greater sense of security against more specific threats of violence than the non-cash group and were able to utilize more resources to ensure their safety. Several participants in the cash group felt empowered to stand up against abuse through the lessons they learned in the self-esteem and GBV workshops led by CORPRODINCO, and reported feeling safer knowing that they could contact CORPRODINCO in an instance of violence against them.

Many also stated that cash assistance decreased their susceptibility to violence in other ways. For those who were selling goods in public areas, begging on the street, or engaging in survival sex/selling sex, cash assistance increased their economic capacity by providing them an opportunity to invest in a home-based income-generating activity. As a result, their exposure to exploitation and violence decreased. Several women, one of whom is transgender, also reported that they could now afford transportation around the city, and thus had reduced their exposure to risks of GBV they had previously experienced walking down the street.

For those in the cash group who were experiencing IPV or domestic violence, cash assistance reportedly enhanced their autonomy in addition to increasing their economic capacity; many participants were thus able to avoid conflicts by no longer needing to ask their abusers for money or goods, and support to access services; they were instead able to address their needs, as well as their children's needs, on their own. In addition, cash group participants reported using cash to cover the costs of transportation to physically reach legal services as well as to afford access to legal services, including to file lawsuits and claims against perpetrators of violence, which improved their safety. Two participants reported using cash assistance to pay rent to enable them to relocate away from their abusers. Overall, cash group participants reported decreases in physical, emotional, and economic violence.

"I am no longer exposed to what I was exposed to before when I was unemployed, because now with what the association [CORPRODINCO] has given me, I have a job, a secure job, a job where I have peace of mind, where I have security, where I don't feel bad, not mentally or emotionally... That has made me change, because not having a way to defend myself, to work on my own, excludes me, exposes me to uncomfortable situations! I mean, the tranquility and security that I already have with myself is great!"

– Cisgender Venezuelan woman, cash participant

"Before, I had to go out on the streets to work as a prostitute and I risked my life, because I worked on the street, there were drunks and people passing by. We transvestites get attacked a lot and so I have had many problems on the street, I have been shot, macheted, stabbed, and I risk my life by prostituting myself on the streets. Well now... I'm a stylist... Now I'm at home, cutting hair, with the support I received I rented a house and I'm at home, very calm!"

– Transgender Colombian woman, cash participant

"Well, it helped me, because [the cash] came at a good time. I was going through family problems, and suddenly this helped me to overcome it. I was able to look for a house to rent and get out of there. I am now over all that."

– Cisgender Venezuelan woman, cash participant

"Because of the violence, mostly verbal, I felt, I felt bad, I felt bad, like a little thing, and with the self-esteem workshop, it gave me the strength to stand up for myself and defend myself and not let them [the abuser] keep attacking me."

– Cisgender Venezuelan woman, cash participant

CHANGES IN ECONOMIC CAPACITY

Non-Cash Group

Most of the participants in the non-cash group did not report changes in their economic situations as part of the impact of the program (14). Thirty percent of the non-cash group (6) reported facing some difficulty in meeting their basic needs (3) or obstacles to reducing the financial stress they experienced from living in poverty (1), or wanted to increase their economic capacity by receiving training to develop an enterprise (4). These challenges were reported more often among the most marginalized survivors within the non-cash group, including one forced migrant, two people living with a disability, and one transgender woman (4), as compared to cisgender Colombian women in this group who were not living with a disability (2).

"It is not easy to be in a country, I repeat, being here is difficult and it is not easy to get a job because one is illegal! ... There are times when you have enough for one thing and not enough for another. Here, life is very limited, it is not the same when you are in your home country because you have more tools. Here, everything is more restricted..."

– Cisgender Venezuelan woman, non-cash participant

Cash Group

Participants in the cash group displayed notable improvements in their economic capacity, which many accomplished by investing in a new or existing enterprise to generate income and increase their economic resources (18). With the cash assistance received and/or the income generated from their microenterprise, many participants were able to cover their basic needs (20), reduce their stress associated with poverty (9), invest in a new or existing microenterprise (32), or supplement their income from another job (2). In addition, receiving cash assistance improved their decision-making control, as many participants who were previously dependent on a partner's income which their partner controlled, now managed the assistance they received on their own. The combination

of increased economic resources and autonomous decision-making, contributed to an improved sense of self-reliance and empowerment among participants; they felt they could move forward with a greater capacity to provide for themselves and their families, and with greater opportunities at their disposal.

"Thanks to that [the cash assistance], you can have more income, so you don't depend on a man anymore. I was dependent on him, because he was the one who worked and I stayed at home, so when I realized that I was alone, that I had no income at all, and I had two girls, that blocked me from going forward. Now thanks to you and the program, I've been able to overcome that, I can have my things now, I can work for my daughters."

– Cisgender Colombian woman, cash participant

"It was quite difficult. Before I began receiving this support, I used to spend most of my time at home. The time when I arrived here was hard because it was not easy at all. Coming from Venezuela to these parts and all that. It was hard for me to sell 'cocadas' [coconut candies] on the street and so on... The money that you have given me has helped me to get my own stuff, and to say that it is mine and that it stays there, it is not touched by anyone. It has helped me to go back and sell my products, and I have been able to get profits and depend on myself."

– Cisgender Venezuelan woman, cash participant

For cash group participants who did not invest in a microenterprise, cash assistance enabled them to repay debts, access emergency medical services, or address other pressing needs, such as making substantial home repairs.

CHANGES IN PERSONAL WELL-BEING

Non-Cash Group

Ninety percent of non-cash group participants reported improvements in their mental and psychological health (18). However, several participants—one of whom was a Colombian woman struggling with her disability, and one of whom was a forced migrant still living with her partner and experiencing interpersonal conflict—still felt some distress (2). The psychological counseling and workshops led by CORPRODINCO improved participants' self-esteem and resilience overall. During these activities they received information on their rights, reported feeling empowered as they recognized their self-worth, and were able to shape their own lives. Many participants noted that these improvements in their personal well-being were also the result of connecting with other survivors and being more social in a peer group, which made them feel less alone in their experiences with violence.

"I have become more self-confident, I have left my fear behind. I am becoming more participative, I am more social, and, well, I am committed to life, because if I have a weak point, I collapse. So, I want to move forward and not go backwards, so I am now able to face life in any situation that may arise."

– Cisgender Venezuelan woman, non-cash participant

Cash Group

Significant improvements in mental and psychological health, similar to the non-cash group, were noted among cash group participants (34). These changes were attributed not only to the psychological support provided by GBV caseworkers and the social support and information provided during the workshops, but also the mental relief and economic self-agency that the cash assistance enabled. Participants were able to decrease poverty-related stressors and reported gains in confidence in their new-found self-reported self-reliance.

Only two participants reported still experiencing some distress after receipt of cash assistance; this distress was related to the physical impacts of their abuse. Both were able to receive treatment.

"I feel more confident, because with the economic support, we have a way to start out on our own, with something of our own. Of course, it's up to us whether we want to start or not"

– Cisgender Colombian woman with disabilities, cash participant

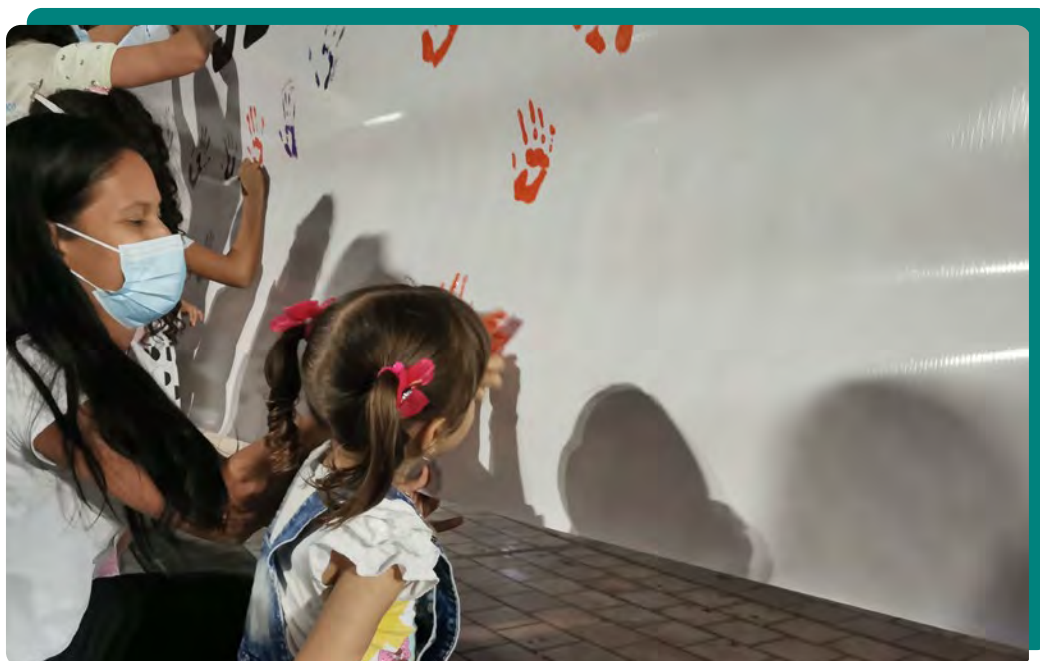
"I was feeling very frustrated, as if I was not capable of anything, that I wasn't a woman capable of moving forward on my own, that I always had to have someone beside me to get ahead. But the professionals have made me see that I'm capable and that I do have the abilities that any person can have, to move forward with my children, with my family, with a project [enterprise] like the one I have... I've seen myself, I've felt very calm, and I'm willing to fight and to move forward with everything."

– Cisgender Colombian woman, cash participant

CHANGES IN FAMILY AND CHILD WELL-BEING

Non-Cash Group

Several of the non-cash participants reported improved relationships with their children and enhanced well-being of their children due to their own improved mental health from counseling or the lessons shared from the workshops (3). Two participants in the non-cash group mentioned continued struggles with their children; one had difficult relationships with her children, while another had a daughter who was struggling with her mental health.



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Women participating in the International Day for the Elimination of Violence against Women, Ocaña.

Cash Group

Cash group participants were able to attend to the unmet needs of their family members, particularly their children. Fifteen participants reported improved physical or mental health among children under their care during the program; cash assistance allowed them to pay for emergency medical care and cover their children's basic needs. In addition, participants reported improved relationships with their children (22). For some, cash assistance enabled them to engage in income-generating activities that could be conducted from home or somewhere closer to home (instead of selling goods in public spaces), and thus they were able to spend more time with their children. For other cash group participants, their relationships improved as a result of tending to their own mental health via

psychological counseling; the at-home consultations sometimes included participants' children, which also improved their children's mental health. Only two participants who were looking for support through the program mentioned that they still had difficulties with their children or other family members at four months after the start of the program; one participant had a daughter struggling with addiction, while the other's daughter was experiencing IPV herself.

"Well, the positive thing is that I have felt calm, I felt good, thank God, because I have started a new stage of being able to work at home, to be able to do my things freely with my children, to be with my children at all times, because sometimes, sometimes, one has work outdoors and has to leave the children alone..."

– Cisgender Colombian woman, cash participant

"We have all received help, all of us, including my daughter. We have recovered because we have confidence in this group of women who have visited us in the house [i.e. the caseworkers] and told us about the events that have occurred to us, everything that has happened to us."

– Cisgender Venezuelan woman with disabilities, cash participant

The impact of cash assistance also extended to survivors' parents and siblings (11). Cash group participants were able to and chose to cover costs for medical care and medicines for their family members. In some cases, family members were engaged in survivors' income-generating activities as co-earners, a multiplier effect of cash assistance targeted to the survivor, improving both their and their family members' economic capacities. There was self-reported self-reliance among survivors with successful income-generating activities initiated due to their recipient status, which reduced their dependence, and thus their real or perceived burden on others and improved relations.

CHANGES IN COMMUNITY AFFAIRS

As previously discussed, both cash group and non-cash group participants noted that the workshops strengthened their social network by bringing them into contact and forging relationships with other survivors. This not only had positive personal impacts, but also inspired many participants to want to extend this support to others; participants hoped to find ways to help other GBV survivors through the program to empower them like themselves. Furthermore, the workshops also helped some forced migrants and refugee survivors feel less isolated than before, finding community around survivorship.

"You get to know many others, you become part of that group, that nucleus. At least, I feel at ease, I feel like I'm liberating myself and opening up my mind. In other words, I'm getting to know them."

– Cisgender Venezuelan woman, cash participant

"The positive effects that the project brought me were that there were many women who went out to get training and education. Analyzing them, I realized that in Ocaña there are many more women who need these recommendations, these routes, and this support. And that women continue to be strengthened because women have not been heard, not listened to by the competent entities."

– Cisgender Colombian woman living with disabilities, cash participant

"Well, it is very satisfying to be able to take part in the project. To be able to support, well, in the 'familias en acción' group, I have several families that have also been localized due to abuse, due to different situations. So, sometimes you feel that your hands are tied, but since the project became known, the program became known, it is very satisfying to have all this knowledge to apply it in our lives and to be able to help others."

– Cisgender Colombian woman, non-cash participant

However, there seemed to be a gap in the experience of community-building among transwomen survivors from both the cash and non-cash groups as compared with ciswomen survivors; transwomen reported feeling excluded from the workshops and had unfulfilled hopes of building community, as well as accessing opportunities to develop livelihoods skills and learn information tailored and pertinent to their identity (3). One participant mentioned the following when asked how she would improve in the program:

"They [program staff] should gather us all together more often... They should also gather us trans girls and give us talks on how to get tested [for sexually transmitted infections]... We should be included more."

– Transgender Colombian woman, cash participant



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Women participating in the GBV case management process during an activity with CORPRODINCO and Save the Children, Ocaña.

VI. DISCUSSION OF THE FINDINGS

Through its quasi-experimental mixed methods design, this program evaluation finds evidence for the effectiveness of integrated cash-GBV programming for Venezuelan migrants and refugees, and Colombians, in Ocaña, Colombia.

The quantitative analysis found significant reductions across more GBV and protection outcomes for survivors in the cash group—the cash group reported a decrease in any IPV occurring in the past three months by 9 percent more than the non-cash group, and reported a decrease in all other GBV and protection outcomes by 4–11 percent more than the non-cash group. While these differences between the cash and non-cash groups were not statistically significant, qualitative findings showed that cash assistance, in addition to GBV case management, was a powerful tool with which to reduce many participants' exposure to and risk of IPV, domestic violence, sexual exploitation, and GBV overall. **For IPV, the impact of cash on reducing IPV experience occurred indirectly; many participants simply avoided conflicts with their partners as they became more self-reportedly self-reliant and no longer had to ask their partner for money. Similar strategies were employed by survivors in the cash group to avoid family violence and conflict.** Only a few cash group participants used cash assistance to directly reduce their exposure to GBV by relocating away from their abusers. **For those who experienced risks of and exposure to GBV in the community and outside of their partnerships and families**—when they were begging in the street, selling goods in public areas, engaging in survival sex/selling sex, or being exploited when borrowing money from various sources—**cash assistance directly reduced their exposure by improving their economic capacity, reducing, or eliminating their reliance on risky coping strategies, and thus reducing their vulnerability to violence.**

The **improved economic capacity of cash recipients was significantly higher than non-cash participants** and substantiated by both quantitative and qualitative findings. During qualitative interviews, many participants reported using cash assistance to invest in a microenterprise, which generated some income. This finding was reinforced by the quantitative data; significantly higher reports of money earned for work in the past 30 days, increased savings at endline, and significantly lower reported use of risky coping strategies at endline were found among cash group participants as compared to non-cash group participants.

The cash assistance and income generated following investment in a microenterprise increased the protection of survivors in the cash group by reducing their exposure to risks of GBV they had faced on the street, and by enabling their pursuit of legal action through coverage of transportation to access legal assistance. Survivors in the non-cash group and cash group alike generally cited increased safety due to knowledge of support services and an increased sense of empowerment to defend oneself against abuse. **Overall, cash assistance provided survivors with more strategies to protect themselves against GBV than GBV case management alone, and facilitated their choice to decide how assistance received would best address their individualized protection needs.**

In both cash and non-cash groups, participants stated they felt safer against future risks of exposure to GBV as they were more knowledgeable about accessing services. Self-blame for violence decreased and gender equitable attitudes increased, which may instill longer-lasting resilience against GBV in the future. The reduced risks of exposure to GBV via improved economic capacity may also contribute to extended protection impacts. Even though GBV case management has finished, some survivors' continued access to income through their microenterprises developed with their cash assistance may continue to enhance their financial independence, thereby reducing their vulnerability to GBV.

The cash-GBV management program model also improved participants' mental health, well-being, and autonomy, compared to those in the GBV case management alone. Both groups saw improvements in these outcomes over time, but for participants in the cash group, these improvements were much greater and can be attributed to the cash assistance. While psychological counseling and group workshops were important for participants in both groups, **cash recipients experienced the added benefit of reduced poverty-related stress, as well as the increased self-reported self-reliance and empowerment, due to the cash assistance.** Participants in the cash group often mentioned the relief they experienced, knowing that they had the means to provide for their children and family members in moments of financial difficulty. This was further amplified for those who invested part of their cash

assistance in an income-generating activity that was successful; they felt they had an opportunity to continue to improve their lives and the lives of their loved ones. As the qualitative findings showed, cash assistance and income generated from a microenterprise benefited not only participants, but their children, siblings, spouses, and parents as well. Similarly, **the sense of autonomy among cash recipients can be attributed to the cash assistance; participants in the intervention group displayed greater control over decisions and showed themselves that, with opportunities, they can change their circumstances by themselves.**

Across the outcomes of interest, the impact of GBV case management on survivors is well demonstrated; so too are the ways in which the integration of cash assistance has amplified these changes. **Case management provided access to necessary psychological, social, educational, and legal services which improved outcomes for participants in both groups, but cash assistance provided participants with a greater number of pathways to enact self-directed changes, tailored to their needs.**

Though the quantitative differences between the cash and non-cash groups for GBV and protection outcomes were not statistically significant, it should be noted that the implementation of the program with the 200 GBV survivors only lasted four months. The short length of the evaluation period, too, may have diminished the changes observed for cash assistance on GBV outcomes, capturing the effects too soon. **Together, the findings from the quantitative and qualitative analysis provide evidence that cash assistance, when integrated into GBV case management, created a space for positive change—for participants to reduce their exposure to incidents of and risks of GBV more effectively than participating in GBV case management alone.**

VII. LESSONS LEARNED AND RECOMMENDATIONS

The following lessons learned and recommendations are informed by the evaluation and the after-action review (AAR) workshops and interviews (see Annex for methodology).

FINDINGS FROM PARTICIPANTS

Barriers and Facilitators to Participation

The most cited barriers to participation among participants both from the cash group and control group were lack of access to child or family care (17), work schedules or other time constraints to engage in GBV case management and other activities (13), and lack of access to and means to cover costs of transportation (9). A few participants mentioned that the location of workshops was hard to find, or that their physical health limited their mobility, and thereby their attendance at workshops. Participants who had a support system benefited from help with childcare and were able overcome that barrier, while for others, home visits from caseworkers were very beneficial.

Recommendations from Participants

Recommendations from program participants on how to improve the program model in the future included:

- Including livelihoods support for GBV survivors; many participants suggested this, and they referenced workshops for livelihood development. One participant went so far as to specifically recommend that the program conduct a market assessment to inform livelihood support for GBV survivors in this program.
- A physical safe space, such as an office, for service providers in Ocaña where survivors could safely and confidently access referral services; this was mentioned by a few survivors.

- Extending the duration and expanding the scope of the program to help more survivors in Colombia; every participant stated they hoped the program would continue. Both cash and non-cash group participants regarded this program as deeply necessary, providing assistance and opportunities to GBV survivors who greatly lack access to services.
- More focused workshops for transwomen to build community support and learn necessary information on sexual and reproductive health. Though the program only included a few transwomen, transwomen in both the cash and non-cash groups shared this recommendation.

Findings from Key Informants

Key informants reported on successes achieved and challenges faced during implementation. These included:

Successes:

- The program was successful in integrating cash assistance into GBV case management to support GBV survivors in their recovery and responsive to individual survivors' needs.
- The provision of services was robust and the delivery of cash through Efecty was effective. One key informant stated that CORPRODINCO was more effective than the police in assisting a participant during an instance of violence in the program.

Challenges:

- Some CORPRODINCO staff felt that the duration of the program was too short to provide sufficient support. Specifically, the delivery of workshops, psychological counseling, and legal services, while achieved, could have been more comprehensive with a longer duration, and thus outcomes would have been further improved.
- Some caseworkers felt that participants needed more guidance than was provided on managing cash assistance, and that with more implementation time, they would have been able to facilitate to a greater degree survivors' use of the cash assistance to escape their situations of violence in acknowledgment of survivors' common expenditure on other needs.
- CORPRODINCO staff reported that the resources for the program were limited in proportion to the number of survivors who needed support in the target area, and therefore could not stretch to meet the needs of all who needed support.
- Program staff noted that in some cases the transfer value was insufficient to address all of survivors' recovery needs, and that increasing the transfer value may better facilitate some survivors' leaving abusive situations.

REFERRALS TO LIVELIHOODS PROGRAMMING AND MPCA

Referral opportunities in this context are limited. There is an insufficient presence of providers of livelihoods and MPCA providers. Those which are present lack a gender equality approach, let alone a gender-responsive approach. Across MPCA and livelihoods programming in this context, more often than not, GBV survivors are not explicitly included in the eligibility criteria. Further, these programs would need to be integrated with GBV programming to meet the specific livelihood and cash requirements of GBV survivors and ensure that referral pathways exist and can be activated, and that livelihood and cash interventions do not bring about unintended negative consequences for survivors' safety. This would also help ensure that confidentiality, together with the other pillars of a survivor-centered approach, are achieved.

Without survivors' basic and livelihoods being addressed, GBV survivors will often prioritize their expenditure of cash assistance received for protection outcomes not on accessing protection-related goods and services, but rather on covering their and their family's basic needs and/or investing in an income-generating activity. This situation leads

to GBV survivors triaging their urgent needs, and in essence forfeiting their recovery from incidents of violence they have endured. The lack of integration and coordination between cash for protection, MPCA and livelihoods in this context may slow or stall GBV survivors from leaving abusive situations.

LESSONS LEARNED AND RECOMMENDATIONS FOR THE FUTURE

Table 5. Operational lessons learned and recommendations for scaling and institutionalization of successful approaches.

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

Table 6. Programmatic lessons learned and recommendations for scaling and institutionalization of successful approaches.

Lesson	Recommendation
<p>1</p> <p>To fully meet the protection needs of survivors, the program duration should be longer, additional program components should be added and the timing and location of these components should align with participants' availability and access needs for maximum efficacy.</p>	<ul style="list-style-type: none"> • Resource and implement a longer timeframe with a minimum of 18 months (to include a minimum of two months at the project launch for awareness raising and rolling case disclosure and three months of trauma counselling for survivors with a minimum of eight sessions). • Ensure that workshops and activities are scheduled with respect for participants' daily routines and duties to enhance participation and retention. • Provide childcare while participants are attending workshops/individual case management meetings. • Include costs of transportation in the transfer value and to ensure access to emergency shelter, when appropriate (or ensure survivors are referred to other organizations). • Provide demand-driven workshops specifically for LGBTQI+ survivors, including addressing navigation of accessing health services and support to foster social networks. • Ensure that program spaces are accessible for persons living with disabilities.
<p>2</p> <p>Spontaneous survivor-led peer empowerment can be systematized and resourced, including expansion of communication channels, for multiplier effects amongst survivors and the community at large.</p>	<ul style="list-style-type: none"> • Consider opt-in WhatsApp groups for: a. survivors to enhance solidarity and peer support among participants and to disseminate useful information about referral services and b. target communities to expand awareness about GBV and services; survivors may act as group facilitators.¹⁷ • In addition to individual-level assistance, resource survivor-led activities, for example through group cash transfers to survivor groups to resource survivor-developed solutions to survivor-experienced barriers to recovery from incidents of violence. • Increase opportunities for the design and implementation of the program model to be driven by survivors including survivor-led co-design and needs assessments, and survivor-led co-analysis workshops of assessment findings. • Build into the program model opportunities for survivors to continue strengthening social networks beyond the workshops, for example through recreational activities. • Increase access to safe spaces during and beyond program enrolment.

17 See Ladysmith, "Gender Data Kit." <https://genderdatakit.org>.

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

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

Lesson	Recommendation
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9	<p>Case identification and registration – identifying forced migrants/refugees and survivors with diverse SOGIESC was difficult; campaigns on GBV prevention and response and services for individuals at risk and survivors were helpful in reaching the target populations; some survivors who were sick encountered challenges accessing assistance.</p>	<ul style="list-style-type: none"> • Future programming should meet the needs of all survivors of GBV, including adolescents (including adolescents who are parents), the LGBTQI+ community, male survivors, and survivors who are displaced. • Expand outreach to survivors, including through door-to-door awareness of GBV services, information sharing at work sites and in marketplaces, and through engagement of community leaders. • At registration collect contact and identification information for an alternate cash recipient designated by the survivor who is a "safe choice" as an alternative to the process indicated in the SOP. • Strengthen the capacity of service providers to identify survivors of marginalized profiles safely and proactively, for example, refugees/migrants, adolescents, LGBTQI+ survivors, older persons, and survivors living with disabilities; ensure strong partnerships with organizations that have existing expertise in identifying and serving these populations.
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10	<p>Lack of engagement with family members of survivors – this was a gap and could have been an opportunity to engage survivors' current partners and family members in workshops on women's rights, gender norms and attitudes for a gender equality approach; this would especially benefit survivors who have remained in their partnership by choice.</p>	<ul style="list-style-type: none"> • Incorporate program components to support survivors' partners, children, and other dependents directly and indirectly, such as psychosocial support. Integrating program components that address secondary impacts would be not only positive for children of survivors but also for alleviating stress experienced by survivors-related to tension with their children. • Include a community-level component that influences a "new masculinity."
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11	<p>Psychosocial support and case management follow up – case management services, including psychosocial support, were highly effective; however, further follow up will ensure comprehensive support to survivors to meet their needs holistically.</p>	<ul style="list-style-type: none"> • Increase the number and duration of follow up visits to ensure needs are met timely and comprehensively, for example, follow up visits may be held once every week and then phasing down to once every two weeks for a longer duration of 6 months. • When first integrating CVA into GBV response, consider increasing the number of caseworkers on staff and decreasing the ratio of caseworkers to survivors as an enabler of comprehensive support and to support caseworkers with their learning curve while implementing the approach.
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12	<p>Retention of survivors – Some participants in the cash group did not continue with case management after receipt of the cash transfer.</p>	<ul style="list-style-type: none"> • Increase opportunities for design and implementation of the intervention to be driven by survivors to enhance retention. • Case workers should further emphasize the importance of all program components with participants.
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Lesson	Recommendation
<p>13 Coordination of research efforts is key to avoid duplication and reduce the burden on survivors of GBV and risks of retraumatization during data collection.</p>	<ul style="list-style-type: none"> • Wherever possible, researchers should use existing data sets and establish data sharing agreements that adhere to data protection best practices. • Data collection tools should be brief and contextualized.
<p>14 Confidentiality of survivors' cash recipient status – despite efforts to keep recipient status and transfer value confidential, some program participants shared their eligibility (or lack of eligibility) for cash with each other; this created difficulties for case workers in managing survivors' expectations.</p>	<ul style="list-style-type: none"> • Further emphasize the importance of confidentiality regarding cash recipient status to survivors during the case management process.

III. CONCLUSIONS

The integration of CVA into GBV programming to achieve protection outcomes in humanitarian settings is seldom evaluated using a robust study design. As such, there is little evidence on the impact of integrating CVA into GBV case management.

In this quasi-experimental mixed methods evaluation, there is new evidence that, when appropriately integrated into GBV case management, cash assistance can improve protection outcomes for survivors in humanitarian settings. In addition to survivors' increased access to services, counseling, and awareness of their rights provided through GBV case management, cash assistance provided alternative pathways to participants to reduce their experience of GBV, both directly and indirectly, by improving their economic capacity. Cash assistance offered participants the freedom to disengage from situations that exposed them to and put them at risk of GBV; this included survivors finding safer working conditions, shifting to home-based work, and eliminating financial dependence on their abuser. In addition, the impact of cash assistance extended to other facets of survivors' lives, with improved mental and psychological health, self-reported self-reliance, and empowerment. There were several ways in which the benefits of cash assistance extended to the lives of those around the participant, including to their children, grandchildren, siblings, and parents. Furthermore, for survivors who established successful income-generating activities and experienced improvements in their economic capacity, there may be sustainable effects. This could continue to extend beyond the duration of the program, but merits further study.

The findings and recommendations from this evaluation highlight areas of improvement for future cash assistance-integrated GBV case management delivery, and by extension CVA-integrated GBV case management delivery. Further research is necessary to optimize CVA-integrated GBV program models across diverse humanitarian settings, to leverage the potential of this approach to support GBV survivors in all their diversity in their recovery.

ABBREVIATIONS

AAR	After-action review
BHA	Bureau for Humanitarian Assistance
CORPRODINCO	Corporation of Professionals for Comprehensive Community Development
CVA	Cash and voucher assistance
FGD	Focus group discussion
GBV	Gender based violence
IDI	In-depth interview
IDP	Internally displaced person
IOM	International Organization for Migration
IPV	Intimate partner violence
KII	Key informant interview
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer or Intersex
MEL	Monitoring, evaluation, and learning
MPCA	Multi-Purpose Cash Assistance
SAMRC	South African Medical Research Council
SOGIESC	Sexual orientation, gender identity, gender expression and sex characteristics
SRH	Sexual and reproductive health
SRQ	Self Reporting Questionnaire
UNHCR	United Nations High Commission for Refugees
WRC	Women's Refugee Commission

IX: ANNEX

PROGRAM EVALUATION: METHODOLOGY

The objective of the evaluation was to generate evidence on the use of cash assistance within GBV case management in humanitarian settings. To that end, the research aimed to address the following research questions:

4. How might a GBV case management and cash transfer package affect protection outcomes, service access outcomes, and experiences of safety and well-being for displaced GBV survivors, and how might outcomes compare to those of GBV survivors in GBV case management without a cash component?
5. How do displaced GBV survivors, program staff, and local partner organizations perceive, experience, and assess the design features of the cash component?
6. What are the implementation facilitators, barriers, and recommendations for improving the GBV case management and cash program?

The study used a quasi-experimental design with two study arms: an intervention arm with 100 participants participating in the enhanced cash-GBV case management program, and a comparison group arm with 100 participants receiving GBV case management only, without the cash component. To evaluate the additional impact of cash, a mixed methods approach was employed. All 200 participants were surveyed at the beginning and the end of the program (hereafter referred to as baseline and endline, respectively). In addition, 60 participants—40 in the intervention arm and 20 in the control—were purposively sampled to complete an in-depth qualitative interview at the end of the program. Finally, 14 KIIs were conducted at the end of the program, with caseworkers, program staff, and local experts.

Using the quantitative data, a differences-in-differences analysis was conducted between the participants receiving the enhanced cash-GBV case management and those receiving the GBV case management intervention without cash, to examine differences in key impacts between these groups. This quantitative analysis was led by the WRC researcher and conducted by the research partner SAMRC. For the qualitative data analysis, the WRC researcher read all interviews, drafted analytic memos, conducted a co-analysis workshop with implementing partners, developed a qualitative code book, and analyzed the data using Dedoose software.

DATA COLLECTION TOOLS AND IMPLEMENTATION

WRC research staff, SAMRC research partners, and the CARE monitoring, evaluation, and learning (MEL) team trained the implementing local partner, CORPRODINCO, on quantitative and qualitative research methods and the data collection tools. CORPRODINCO led the data collection efforts and received technical assistance from the WRC research staff and the CARE MEL team as needed. All data collection was conducted in Spanish, and qualitative interviews were audio-recorded. Audio recordings were then transcribed into Spanish text and translated into English for analysis. All the collected data was reviewed by the CARE MEL team, SAMRC research partners, and WRC staff for quality assurance.

The data collection tools developed and used are as follows:

Quantitative

- **Questionnaire:** WRC and SAMRC researchers conducted virtual inception workshops with CARE Colombia and CORPRODINCO staff, and led activities designed to clarify the theory of change (see Figure 7). Based on these workshops, as well as drawing on existing literature, WRC and SAMRC researchers compiled quantitative measures of protection and violence that were linked to the theory of change. All measures were taken either from previous studies conducted by the WRC or SAMRC, or from studies in Colombia. The questions included in the survey were adapted from validated scales and questionnaires, and assessed demographic information, GBV and other experiences of violence,¹⁸ economic agency,¹⁹ personal well-being,²⁰ and access to services. WRC shared the draft questionnaire with CARE Colombia and CORPRODINCO staff who reviewed and provided feedback on how best to contextualize the tool. WRC hired translators to translate the questionnaire into Spanish, which was then shared with CARE Colombia and CORPRODINCO staff for a second review that focused on accuracy and contextual phrasing. The questionnaire was programmed into KoboCollect and administered via mobile phones; it took one hour to complete.

Qualitative

- **In-depth interview (IDI) guide:** The IDI guide was based on guides that were used in WRC's previous assessments of CVA-integrated protection programming in other contexts. Prior to implementation, the IDI guide was reviewed by program staff to contextualize the tool, which was then translated into Spanish and piloted by CORPRODINCO staff before data collection commenced.
- **KII guide:** The KII guide was drafted based on guides that were used in WRC's previously discussed assessments of CVA-integrated GBV programming. The KII guide was reviewed by CARE Colombia and CORPRODINCO staff to contextualize the tool, which was then translated into Spanish and piloted by CORPRODINCO staff prior to data collection.

The quantitative survey was administered at baseline and endline, while the qualitative interviews were conducted at endline only.

18 M. Beusenbergh and J. Orley, eds., *A User's Guide to the Self-Reporting Questionnaire (SRQ)* (Geneva: World Health Organization, 1994). <https://apps.who.int/iris/handle/10665/61113>.

19 Daniel Maxwell and Richard Caldwell, *The Coping Strategies Index: Field Methods Manual, Second Edition* (Atlanta: CARE USA, 2008). <https://www.fsnnetwork.org/resource/coping-strategies-index-field-methods-manual>.

20 C. R. Snyder et al., "The Will and the Ways: Development and Validation of an Individual-Differences Measure of Hope," *Journal of Personality and Social Psychology*, 60(4) (1991): pp. 570–585. <https://psycnet.apa.org/doiLanding?doi=10.1037%2F0022-3514.60.4.570>; Claudia García-Moreno et al., *WHO Multi-Country Study on Women's Health and Domestic Violence Against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses* (Geneva: World Health Organization, 2005). <https://apps.who.int/iris/handle/10665/43309>.

Inputs

- GBV case management services for displaced GBV survivors
- CVA for displaced GBV survivors integrated within GBV case management
- Referrals to services for displaced GBV survivors within GBV case management

Outputs

- Participation of displaced GBV survivors in GBV case management services
- Increased knowledge of displaced GBV survivors of referral services
- Receipt of CVA by displaced GBV survivors

Outcomes

- Increased assets of displaced GBV survivors (as measured by access to capital, goods and services, etc.)
- Increased economic agency of displaced GBV survivors (control of and decision-making around capital and goods and services)
- Decreased self-blame of displaced GBV survivors

Impacts

Intended impacts

- Decreased risk of future GBV for displaced GBV survivors
- Improvements in well-being for displaced GBV survivors

Unintended negative externalities

- Decreased protection for displaced GBV survivors
- Increased GBV for displaced GBV survivors

QUALITATIVE ANALYSIS

Transcriptions and any notes and drawings were translated from Spanish into English for analysis. Qualitative data analysis consisted of a multi-step analysis process. For all qualitative transcripts, analytic memos were created and used to generate the initial findings and a codebook. The initial findings and the codebook, along with excerpts from the data, were shared in a co-analysis workshop with key project stakeholders; during the workshop, methods of interpretation and feedback on the codebook were provided, and the codebooks were refined. Data was coded and assessed with Dedoose.

QUANTITATIVE ANALYSIS

Demographics for the sample were reported for age, sex, gender identity, sexual orientation, disability status, level of education, marital or partner status, and cohabitation status. For each outcome or impact, adjusted and unadjusted differences from baseline to endline were calculated, using either t-tests and linear regression models, controlling for age, education, marital or partner status, disability, and migrant status. Differences-in-differences analyses were conducted by intervention group, by which the changes in outcomes of the study were compared from baseline to endline for both cash and non-cash group participants. The differences between those groups at endline were then calculated. All estimates were calculated using linear regression models for scored outcomes, or logit models for proportional outcomes, with robust standard errors, controlling for age, sex, education, marital or partner status, and disability status. The level of significance was set to 95 percent. All quantitative analyses were conducted using [Stata](#) SE 16 software.

AFTER-ACTION REVIEW

Conducting an AAR for each completed project is a common practice of CARE and its partners.

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

Table 8. AAR overview

	Date	Categories	No. of Participants	Age	Sex
1	April 6, 2022	KII - former CARE Staff	1	31-64	1F - 0M
2	April 8, 2022	Partner - CORPORDINCO staff	5	31-64	5F - 0M
3	April 21, 2022	Partner - CARE staff	4	31-64	4F - 0M

ETHICS

This study was reviewed by and received institutional review board approval from the Allendale Investigational Review Board, located in Connecticut, United States. Participants and key informants were informed of the study's purpose, risks, and benefits, and were given the opportunity to provide written consent to participate in the study. Names and other identifying information were not collected from participants. All individuals or entities named in this report are named with their explicit consent. WRC provided an information sheet to each participant with WRC's contact information and instructions for anonymous reporting channels. Any names mentioned during the qualitative research data collection were deleted during data transcription. All data collected for this report were stored securely on password-protected devices once uploaded and transferred to WRC; data were not shared outside the WRC evaluation team. All recordings made during data collection were subsequently deleted.

“We have a way
to start out
on our own”

The Effectiveness of Cash Assistance Integrated into Gender-Based Violence Case Management for Forced Migrants, Refugees, and Host Nationals in Norte de Santander, Colombia: A Quasi-Experimental Mixed-Methods Evaluation



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