Comparative Study of the Effects of Different Cash Modalities on Gender Dynamics and People with Disabilities

Aleppo, Syria

Final Report

Prepared by Key Aid Consulting and Venture International for Dutch Relief Alliance (DRA)

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List of Acronyms

Acronym	Definition
CfW	Cash for Work
CSI	Coping Strategy Index
CVA	Cash and Voucher Assistance
CWG	Cash Working Group
DRA	Dutch Relief Alliance
FAO	Food and Agriculture Organization
FCS	Food Consumption Score
FGD	Focus Group Discussion
GBV	Gender Based Violence
FSP	Financial Service Provider
HH	Household
HHH	Head of Household
IP	Implementing Partners
KAC	Key Aid Consulting
M&E	Monitoring and Evaluation
MPC	Multipurpose Cash Transfer
MEB	Minimum Expenditure Basket
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PWD	People with disabilities
SADD	Sex and Disability Disaggregated
SJR	Syria Joint Response
SYP	Syrian Pounds
TdH	Terre des Hommes
VAWG	Violence against Women and Girls
WFP	World Food Programme

Executive Summary

In 2020, the Syria Joint Response (ZOA, Oxfam, Cordaid, Dorcas and Terre des Hommes) delivered Cash and Voucher Assistance (CVA) with a transfer value of 45,000 SYP per household per month over four months to approximately 14,300 beneficiaries in 3 neighbourhoods in northeast Aleppo city (Haydariyeh, Jabal Badro and Hanano) to cover food security needs. Partners used different modalities which included: vouchers, Cash for Work (CfW) and Multipurpose Cash (MPC). The objective of this study was to showcase the different effects of those different modalities on the most deprived and marginalised groups, in particular women and people living with disabilities (PWD) in order to inform more appropriate CVA programming.

The methodology mostly relied on a desk review and on the analysis of baseline and endline data, targeting female respondents. The study, however, presents important limitations, such as:

- While the selected neighbourhoods are close geographically and present similar economic conditions, the population composition in those different areas could have had an impact on the comparability of data across groups and modalities;
- The timing of the cash disbursements and different data collection exercises were impacted by the COVID-19 pandemic (which hit the country right after baseline data was collected) and the time required for partners to obtain government approvals;
- Due to those delays and the inflation rate in the country, the transfer value did not correspond to the needs it was meant to cover.

As such, the following findings arose under exceptional circumstances and the evolving context should be taken into account for future interventions.

Findings: Food security status

Food Consumption Score (FCS)

Overall, the targeted households' food security improved over time. This was illustrated by an increase in the FCS (+1,82***).[1] When disaggregated by modality, households that received vouchers reported a large improvement in FCS (+4,65***), compared with household that received CfW which reported a large decrease of -4,67*** in FCS. Households with PWD experienced a smaller improvement in FCS (+0,01) compared with households without PWD (+1,37).

Reliance on negative coping strategies

Using the Livelihood Coping Strategies Index (FCS Indicators Handbook), the study found that recipients reduced their engagement in negative coping strategies. Households reported the

[1] * P ≤ 0,05 (Less than 5% possibility that the results are due to chance), ** P ≤ 0,01 (Less than 1% possibility that the results are due to chance), *** P ≤ 0,001 (Less than 0,1% possibility that the results are due to chance).

largest reduction in the use of the following coping mechanisms: borrowing food (-55%***) and borrowing money (-30%***). Households that received vouchers reported the largest decrease in stress-related negative coping strategies (-34%***) and CfW recipients reported the largest decrease in crisis-related negative coping mechanisms (-19%***). MPC recipients reported a decrease in emergency-related negative coping strategies, such as, sending children to work (-14%***).

Expenditure patterns

All CVA recipients spent a greater proportion of their expenditure on health at endline (+5%***) and slightly less expenditure on hygiene (-2%**). Food-related expenditure patterns show a large increase in expenditure on staple foods (+13%**) and a decrease in the consumption of fruits and vegetables (-8%***). Households that received vouchers increased the priority they gave to food (+4%***), which is linked to the restricted nature of the modality, and health (+6%***) in their expenses. Households that received CfW reported an increase in health (+1%*), education (+2%***) and shelter expenditure (+1%***). CfW recipients diversified their food expenditure (staples, fruit and vegetable, and protein) more than voucher recipients.

As such, to improve food security indicators, voucher seems to be the most effective modality as the use of the transfer was limited to a basket of food items. Considering the changes in reliance on negative coping mechanisms and expenditure patterns for CfW and MPC recipients, however, it is expected that the non-restrictive modalities brought other positive outcomes (related to health and education for instance) which could not be measured as part of this study.

FINDINGS: PROTECTION OUTCOMES FOR WOMEN

Improved well-being

The majority of female respondents that received vouchers and MPC reported that their well-being improved since they started receiving the CVA (83% and 75% respectively). For CfW recipients, the question was misinterpreted and thus, the data could not be presented.

Level of stress

Female respondents reported a reduction in the level of tension within the household and in their self-assessed level of stress. At baseline, respondents reported an average stress of 2,75 and an average tension of 3,21 on a scale of 0 to 10. The majority of households for each modality reported that their levels of stress have 'decreased'. This was especially the case for recipients of unrestricted modalities (CfW = 98,65% and MPC = 93,21%). Comparatively, 80,24% of voucher recipients reported a decrease.

Decision making power

The percentage of female respondents that make household decisions alone remained the same at baseline (37%) and endline (38%). At baseline, 41% of female respondents reported that most decisions were made by a male household member, which decreased to 11% at endline. At baseline,

22% of female respondents reported that decision making was shared, which increased to 51% at endline. The share of female-only decision making increased at endline for voucher recipients by 25%. Comparatively, the percentage of shared decision making increased at endline for CfW recipients by 29% and for MPC recipients by 58%.

Levels of violence within the household

At household level, the majority of respondents said that there was no violence before the assistance (81%). Of the remaining respondents that experienced violence within the household before the assistance period, 56% reported a decrease in violence and 44% reported no change during the assistance period. CfW recipients reported the largest decrease in violence (18%).

Levels of violence within the community

Overall, 65% of the respondents reported no violence in the community before the assistance period. Of the remaining respondents that reported violence within the community before the assistance period, 46% reported a decrease in violence and 54% reported no change during the assistance period. When disaggregated by modality, 3% of the households that received vouchers, 14% of the households that received CfW and 18% of the households that received MPC reported a decrease in violence in the community since receiving the CVA.

As such, the study noted that all modalities had a positive effect on the reported level of stress and tensions among women by easing some of the financial burden faced by the recipient households. This was particularly the case for unrestricted modalities as recipients had the freedom to spend the grant to cover their priority needs.

FINDINGS: PREFERENCE AND SATISFACTION FOR WOMEN AND HOUSEHOLDS WITH PERSONS LIVING WITH DISABILITIES

Modality preference

Most female recipients were satisfied with their respective modalities and would not prefer to receive assistance through a different modality in the future. This was especially the case for CfW (95%) and MPC (96%) recipients. Households with PWD that received vouchers showed a stronger preference for a different modality (30%) than households without PWD (22%) as households with PWD particularly appreciate the flexibility to purchase items related to the disability status of the member with special needs. Modality preference is, however, also often linked to programme design-related decisions such as distance to travel to access the distribution point or waiting time to cash out the grant. As such, and considering that the partners made different decisions, this could rather be linked to how the chosen modality was distributed rather than the modality per se.

Satisfaction for households with PWD

Households with PWD report an average satisfaction of 7,66 out of 10. Comparatively, households without PWD reported an average satisfaction of 6,59 out of 10. Households that received CfW

were the most satisfied (8,44), then households that received MPC (8,34), and households that received vouchers (6,95).

Accessibility of delivery mechanism for households with PWD

Households with PWD rated the delivery mechanisms as 7,19 out of 10 on accessibility. Comparatively, households without PWD rated the delivery mechanisms as 6,39 out of 10 on accessibility. Households with PWD found the delivery mechanism for CfW to be the most accessible (8,36), then MPC (7,29) and vouchers (6,79).

Satisfaction with the assistance received among women and households with PWD and accessibility was higher for non-restrictive modalities such as CfW and MPC.

RECOMMENDATIONS

Based on the findings of the study and discussion with the SJR partners during a preliminary findings workshop, the research team has drawn conclusions and recommendations to improve CVA programming in the future. The conclusions and recommendations are grouped into three perspectives: Design, implementation, and monitoring and evaluation.

Table 1 Recommendations for design, implementation and M&E

Perspective	Recommendation
Design	1. Unrestricted cash assistance should be the default modality of assistance when the conditions for appropriateness are met. Vouchers should be considered if the key objective of a project is improved food security only.
	2. Conduct a Sex and Disability Disaggregated (SADD) gender and barrier analysis to cover the needs of different groups.
	3. Ensure women's and PWD's voices are heard in need, market and security assessments.
	4. When CfW is considered, additional MPC assistance should be considered for most vulnerable households not able to work.
	5. Combine cash assistance with food security awareness raising if increased food security if the main objective of the programme.
	6. Integrate non-food related expenditure in the transfer value calculation or in the voucher list of restricted items, especially when targeting women and households with PWD. These expenditures should be defined based on a needs assessment but could include: WaSH, shelter/NFI or education expenditures.
	7. In volatile economic contexts like Syria, the transfer value should be set in USD or adjusted according to the inflation rate.
	8. Incorporate gendered outcomes into the programme design.

	9.	Map and learn from existing humanitarian projects in the programme intervention areas with intended gender outcomes.
Implementation	10.	SADD gender and barrier analyses should be conducted routinely during the design and implementation phase (during each monitoring and evaluation exercise for instance).
	11.	Integrate equal access considerations when identifying service providers.
	12.	The appropriateness of e-payments should be informed by a feasibility assessment.
M&E	13.	Including behavioural changes should be an intended outcome with dedicated resources and time.
	14.	Do not limit data collection to between-household levels, but also consider the within-household individual levels.
	15.	Use indicators to track both intended and unintended outcomes (such as health, education or shelter outcomes).
	16.	Make use of the M&E tools and guidance included in CaLP updated Programme Quality Toolbox.

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I. Introduction

I.1. Humanitarian Context

With the Syria crisis entering the eleventh year, the conflict continues to drive large swaths of Syrians into neighbouring states. Over 5,5 million people have fled Syria, finding refuge in neighbouring countries mostly in Turkey (3,6 million), Lebanon (800,000), Jordan (600,000) and Iraq (240,000).[2] Before the conflict, 21 million people were living in Syria. Current estimates are approximately 18 million, with 6,5 million internally displaced of which 2,5 million are children.

The majority of Syrians are unable to meet basic goods and services as a result of conflict related insecurity and the economic and financial sanctions imposed on Syria by the international community.[3] The OCHA estimates that there are currently 13 million people in need of humanitarian assistance in Syria.[4] The COVID-19 pandemic exacerbated the socio-economic and other challenges faced in Syria. Neighbouring states closed their boarders to contain the spread of the virus. By the third quarter of 2020, 31,000 refugees had spontaneously returned to Syria.[5] In 2020, the number of food insecure people rose from 7,9 million in January to 9,3 million in December. The nationwide average prices of the WFP standard reference food basket increased by 13% from October 2020, reaching SYP 99,243. By the end of November 2020, food prices had increased by 75% since April 2020, and 251% year-on-year. This led to a serious deterioration of key household food security indicators and a dramatic decline in the purchasing power of Syrian households.[6] This is a result of the restrictions placed by the Government to curb the spread of COVID-19 which led to a loss of livelihoods, and a large increase in the exchange rate which drove up the price of food.[7]

There are also a number of 'silent' consequences due to the protracted conflict, this includes the stunting of child growth (affecting 674,000 children), widespread psychological trauma, and gender-based violence (GBV).[8] Safe and consistent access to crisis-affected communities is one of the most important challenges faced by in-country humanitarian actors. The delivery of aid is often

[2] 3RP Syria Crisis, "Regional Strategic Overview 2021 – 2022", December 2020.
[3] Emily Lyles, Hannah Tappis and Shannon Doocy, "Cash-Based Response Feasibility Assessment in Northern Syria (Center for Refugee and Disaster Response)," May 2016.
[4] OCHA, "Global Humanitarian Overview 2021 - Syria", February 2021.
[5] World Population Review, "Syria Population 2021", February 2021.
[6] WFP, "Syria Country Brief – December 2020".
[7] FAO, "Syrian Situation Report", June 2020.
[8] OCHA, "Global Humanitarian Overview 2021 - Syria", February 2021.

obstructed by active fighting and access to various areas is regularly restricted. The security situation remains unpredictable across the country, leading to logistical access constraints.[9]

I.2. Cash and Voucher Assistance in Syria

In line with global trends, cash and voucher assistance (CVA) has gained traction in Syria as a means to cover the basic needs of crisis affected households. This includes both conditional and unconditional cash transfers and restricted vouchers.[10] One of the enabling factors for this trend is the high acceptance of CVA within crisis affected populations. A cash-based response feasibility assessment in Northern Syria indicated an overwhelming preference for CVA among crisis-affected communities.[11]

Most assistance is, however, delivered through in-kind support, and both sectoral and multi-sectoral cash assistance is relatively small in scale. There are various barriers to the increased uptake of CVA in Syria. These include security issues and limited access due to on-going clashes and risks at checkpoints, beneficiary data protection concerns, and misappropriation of funds as a result of corruption and bribery.[12] Other challenges linked to the use of CVA in contexts like Syria include the highly politicised setting, unstable markets, the effect of international sanctions and the effects of a deepening economic crisis.[13]

The Damascus-based Cash Working Group (CWG) was reactivated in September 2018 to coordinate CVA assistance in Government-controlled areas and as a platform to share experiences and tools.[14] This study matches this geographical scope in order to better inform the CWG members' needs and expectations.[15]

Beyond CVA being heavily researched globally, there is also a trend to look more into the segregated effects of CVA on different groups. This has already started in Syria with a recent study from IRC in Raqqa.[16]

I.3. Brief Project Outline

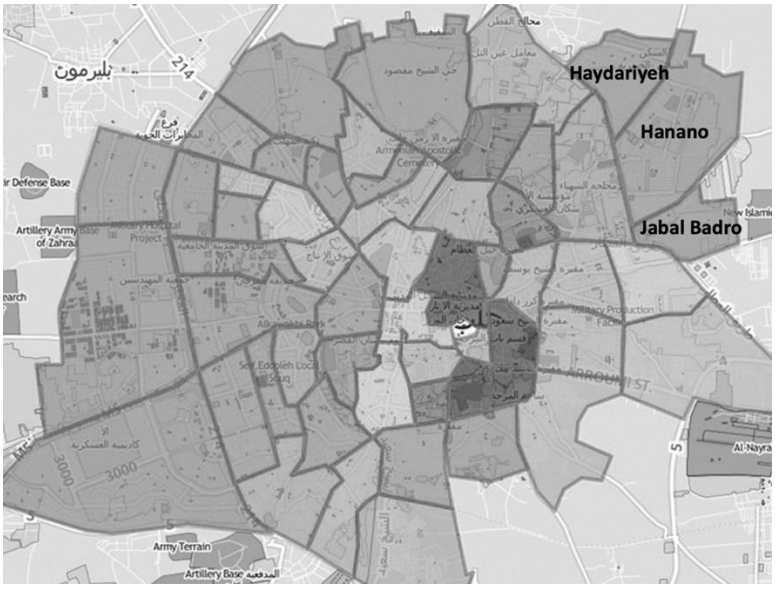
[9] Emily Lyles, Hannah Tappis and Shannon Doocy, "Stakeholders Analysis and Feedback on Cash Based Response Programming in South and Central Syria," December 2017.
[10] Doocy, Tappis, and Lyles, "Cash-Based Response Feasibility Assessment in Northern Syria," 2016.
[11] Doocy, Tappis, and Lyles, 'Cash-Based Response Feasibility Assessment in Northern Syria', 2016.
[12] Maillard, C., Juillard, H. "CTP in challenging contexts: Case study on CTP risks in Syria — government-controlled areas", 2018.
[13] https://www.chaberlin.org/en/event/cash-and-voucher-assistance-in-syria-opportunities-and-challenges/
[14] British Red Cross, "Feasibility Assessment Study for Cash Based Assistance in Syria - Summary Report V.1.20.", May 2016
[15] "To Coordination Cash Assistance on Government Controlled Areas and Strengthen through Capacity Building and Development of Sector-Wide Resources That Will Benefit All Cash Actors in Syria. It Consists of a Small Group of UN Agencies and NGOs.," n.d.
[16] IRC, 'Cash Transfers in Raqqa Governorate, Syria - Changes Over Time in Women's Experiences of Violence & Wellbeing', 2019.

The Dutch Relief Alliance (DRA) consists of 15 Dutch non-governmental organisations working together in the field of humanitarian assistance. The DRA, funded by the Dutch Ministry of Foreign Affairs, places people affected by disaster are at the centre of their humanitarian responses, thus saving lives, alleviating suffering, restoring dignity and contributing to resilience. Through collaboration, the DRA ensures that their responses are of high quality, timely, efficient and delivered through strong partnerships. A total of eight Joint Responses have been operational since 2015, among which is the Syria Joint Response (SJR), implemented by 5 partners.[17]

In 2019, four of the five SJR members (Oxfam, Cordaid, Dorcas and Terre des Hommes) led by ZOA delivered CVA to approximately 14,300 beneficiaries (i.e., 2,565 households)[18] in Aleppo Governorate to cover food security needs. Each partner distributed a monthly transfer grant of 45,000 SYP per household per month over four months, in their respective implementation areas.[19] This transfer value was calculated using an amount deliberately above the Minimum Expenditure Basket (MEB) amount agreed by the Syria Cash Working Group at the inception of the intervention (which was then set at 30,000 SYP).

Assistance was delivered in 3 neighbourhoods in northeast Aleppo city: Haydariyeh, Jabal Badro and Hanano.

Graph 1: Map of targeted neighbourhoods in Aleppo[20]



[17] https://aidstream.org/who-is-using/NL-KVK-41009723/3284
[18] Based on baseline and endline data, the average number of people per household is 5,58.
[19] ZOA, "SJR2019 - Cash Proposal - Concept Note," 2019.
[20] UN Habitat, "City Profile Aleppo", May 2014.

To cover food needs, partners used the following modalities for the following caseload:

Table 2: Partner distribution modality, location and number of households

Organisation	Area	Modality	Number of HH reached
Dorcas	Jabal Badro	Voucher	868
Terre des Hommes	Haydariyeh	Voucher	614
Oxfam	Hanano	Cash for Work	298
Cordaid	Hanano	Multipurpose cash	785

Aside from the CVA targeting crisis-affected households in Aleppo, SJR partners and the CWG have developed activities aiming at strengthening CVA in Syria through capacity building and strategic development of sector-wide resources funded by the Dutch Government.[21] This aimed at bringing higher quality and more appropriate CVA programming for beneficiaries, ensuring improved quality of future CVA interventions beyond the project. In response, SJR partners proposed the following to improve cash operations in Syria:

1. A comparative effects analysis led by ZOA,
2. In-depth market assessment in the implementation area led by Oxfam, and
3. Capacity strengthening and development tools led by Cordaid.

The expected result was that in-country humanitarian actors have access to relevant tools for comprehensive market assessments, are informed about market dynamics in the areas of implementation and are capable to extrapolate findings for improvement of CVA in similar contexts in Syria.

Overall, the timeframe of the study covered the four-month CVA implementation, with collation of a baseline and endline study. The project was delayed by the approval process to implement multipurpose cash transfer (MPC) and by the measures put in place by the Government to prevent the spread of COVID-19 in Syria. As a result, MPC cash distributions only started in June 2020 as per the below table, despite the fact that the baseline survey was disseminated from January to March 2020 depending on the partner. This is one of the limitations of the study, as explained in the limitations section.

Table 3: Project schedule

Partner	Baseline survey	1st distribution	2nd distribution	3rd distribution	4th distribution	Endline survey

[21] ZOA, "SJR2019 - Cash Proposal - Concept Note", 2019

Dorcas	8/Feb	1/Jun – 15/Jun	1/Jul- 15/Jul	1/Aug – 15/Aug	1/Sep – 15/Sep	4/Nov
Terre des Hommes	27/Jan	1/Jun – 30/Jun	1/Jul – 31/Jul	1/Aug – 30/Aug	1/Sep – 30/Sep	15/Oct
Oxfam	4/Mar	22/Jun	7/Jul	9/Aug	10/Sep	6/Oct
Cordaid	17/Mar	Combined with 2nd distribution	24 Sept	15/Oct	15/Nov	23/Dec

The COVID-19 pandemic also had an impact on the recipient households due to border closure across governorate, restriction on the opening times of local market and increased black market exchange rate (1 USD=1,800 SYP in May 2020 as opposed to 1 USD=900 SYP in December 2019) which led to a deterioration of the economic situation and an increase in market items prices.[22]

II. Purpose, Objectives and Scope

The research objective was to showcase the different effects of CVA modalities on vulnerable groups, in particular women and People with Disabilities (PWD) and to inform more appropriate CVA programming for those households. In addition, engagement with the government shows that, despite the existence of global comparative CVA studies, there is still widespread support for in-kind programming. As such, this research would provide a basis for data-led advocacy on the merits of different modalities specifically in Syria.[23]

The research aimed to determine the most effective modality to meet households' food needs and to explore the effect of different modalities on protection outcomes for women. Due to the short implementation time, longer term impact was not measured; therefore, the research team chose to measure the comparative effects of the selected modalities.[24]

The comparative study took place in the three geographical areas in Aleppo Governorate: Hanano, Haydariyeh and Jabal Badro neighbourhoods. The Aleppo Governorate has the highest number of people in need (2,5 million of which 40% are in acute need) of all governorates in Syria.[25] The three neighbourhoods are close in proximity (see Graph 1: Map of targeted neighbourhoods in

[22] WFP, "The Socio-Economic Impacts of the COVID-19 Pandemic in the Syrian Arab Republic (April – June 2020)", October 2020.
[23] ZOA, "Dutch Relief Alliance Extra funds facility 2019 Joint Response Proposal for extra funds Syria", 2019.
[24] Impact is usually defined as "positive and negative, primary and secondary long-term effects produced by a development intervention, directly or indirectly, intended or unintended." (OECD-DAC 2010). As such, impact implies a long-term vision whereas effects can be immediate.
[25] HNO, "HNO Syria 2019".

Aleppo) and share comparable socio-economic status (as discussed with partners during the inception phase).

The research questions and corresponding indicators are presented in Table 4 below.

Table 4: Study questions and indicators

Questions	Research indicators
1. What are the comparative effects of different cash modalities on food security status of targeted households?	• Number of meals a day • Food Consumption Score • Reliance on negative coping mechanisms • Expenditure patterns (as per different household types, including PWD)
2. What are the comparative effects of different modalities on protection outcomes for women, including experiences of violence against women and girls (VAWG) and other aspects of women's wellbeing?	• Improved well-being • Level of tension and stress reported within the households • Decision making on allocation of resources
3. What is the comparative satisfaction with different modalities for households with PWD?[26]	• Time usually spent by beneficiaries to cash out assistance • Transaction costs to access assistance • Social stigma associated with the assistance • Physical, financial and social barriers faced when accessing the CVA
4. How can the modality be shaped (from a design, delivery and monitoring standpoint) to maximise satisfaction and effects on improving food security and supporting access and safety for targeted households?	• Based on all above indicators, the research team professional judgement and experience and discussion with the SJR

III. Methodology

To answer the research questions, the research team compared the effects of three different modalities: vouchers, Cash for Work (CfW) and MPC. Implementing partners (IP) aligned their transfer values and distribution periods to ensure the results can be compared. A comparison was made in Hanano, Jabal Badro and Haydariyeh in Aleppo Governorate, of the pre- and post-distribution of assistance data to measure the effects on food security status and protection needs

[26] People living with disabilities will be defined as per those households described as such by consortium members.

coverage and analyse how each household (and as such each modality) performed over time against the agreed set of indicators.

To measure food security, the researchers used the WFP's Food Consumption Score (FCS). The FCS is a food security score calculated using the frequency of consumption of different food groups by a household during the 7 days before the survey. Weightings are used for each of the food groups depending on their relative nutritional importance, and then calculated into a final score. Depending on the final score, a household's FCS in Syria is determined as poor (<28), borderline (28-42) or acceptable (>42).[27] The study included eight food groups, each corresponding to different weightings (see Table 5).[28]

Table 5: Food Consumption Score items and weightings

Food group	Food items in survey	Weight
Cereals	Bulgur, rice, bread, tubers	2
Pulses	Pulses	3
Vegetables	Vegetables	1
Fruits	Fruits	1
Protein	Red meat, white meat, eggs	4
Dairy products	Dairy	4
Sugar	Sweets	0,5
Oil	Fats	0,5

The livelihoods coping strategy index (CSI) is a behavioural measurement used to answer this single question. It serves as an indicator of household food security. In the study, respondents were asked if they had engaged in eleven different negative coping mechanisms in the past 30 days.[29] The coping mechanisms differ in severity and are thus weighed differently. The table below shows how coping strategies were grouped in the analysis.

Table 6: Coping strategy index

Severity	Coping strategy
Stress	Rely on less preferred and less expensive foods
	Limit meals portion size and quantities of food eaten
	Borrow money

[27] FCS for Syria is reported based on an adjusted threshold due to high consumption of sugar and oil in the country.
[28] World Food Programme, "Food Consumption Analysis: Calculation and use of the food consumption score in food security analysis" (2008).
[29] The Livelihoods Coping Strategy Index asks households how many times in the past 30 days they've engaged in various negative coping mechanisms. In this study, participants were asked if they had engaged in each behaviour in the past 30 days (yes/no). The results reflect the number of times respondents indicated 'yes'.

	Borrow food, or rely on the help from a friend or relative
	Purchase food on credit
Crisis	Reduce number of meals eaten per day
	Sell household assets (radio, furniture, refrigerators, television, jewellery etc.)
	Sell productive assets or means of transportation
Emergency	Skip entire days without eating
	Withdraw children from school
	Send your children to work

Considering that the data for each modality was collected at different points in time and that the groups receiving different modalities were not homogenous,[30] the researchers are unable to statistically measure the comparative impact of each modality. The researchers were, however, able to measure performance against each indicator over time per modality (comparison pre-assistance and post-assistance for each modality) and comment on which modality seems to derive better results.

III.1. Desk Review & Inception Phase

The researchers started with an in-depth briefing with the consultancy manager to foster a broad and general understanding of the project background and the study's objectives. The purpose of the briefing was to present the study objectives, refined the study matrix included in the inception report and harness additional documents.

After the briefing, an extensive structured desk review of the SJR project documents, as well as documentation from the CWG on previous use of CVA, and contextual documentation, was conducted to inform the study framework and the situation analysis to be undertaken by the SJR members. The desk review harnessed both qualitative and quantitative data (e.g., PDM, end-line surveys, vulnerability profiles etc.).

After further discussion with ZOA and representatives of the SJR, the researchers produced an inception report presenting the study matrix, detailed methodology, revised timeframe, sampling strategy and the data collection tools. Upon the review of the draft inception report and feedback provided by SJR members, the research team integrated the feedback into a final inception report.

[30] Even though the selection criteria were the same for the different modalities, beneficiaries of different modalities come from different areas and, as such, the apparent effect of the modalities may actually be biased by external factors playing in some areas and not others. It is also assumed that it won't be possible to have homogenous groups which have the same average income, economic opportunities exposure to protection risks, etc.

III.2. Training

Following the inception phase, the researchers developed a two-day training targeting enumerators on the data collection methods and tools to be used so as to ensure alignment of data collection methodologies. Using adult learning principles as well as clear and user-friendly materials, the research team developed the first version of the training material set. It was reviewed by SJR members and their feedback was integrated in the final version which was delivered in person in Aleppo.

The training was participative in nature and required engagement of participants in exercises and working groups. The focus was therefore on "learning by doing", exposing participants to the process and the tools developed. The training was designed for participatory and exploratory learning. It contained a mixture of lecture style presentations, participatory group work, plenary discussions, structured tasks given out over the course of the workshop, as well as feedback given after each task.

III.3. Data collection & sampling

The research combined a pre- and post-test design. The researchers opted for stratified random sampling for each modality and selected area. The sampling also focused on women as respondents of the different surveys.

To select survey respondents, in female-headed households, the female head of household was invited to complete the survey. In male-headed households containing more than one eligible woman aged 18 to 59, a Kish grid was used to randomly select a respondent among the eligible women. To account for the fact that respondents may not be available on the data collection day, the research team asked all partners to randomly sample an extra 30% for each stratum.

The sampling for the baseline included 100% of the targeted households as the baseline questionnaire was administered during the targeting process alongside the targeting questionnaire which happened in Q1 2020. SJR partners were responsible to determine their targeting process hence the subsequent data collection method.

The study includes 3,991 households with 84% (n=3,356) of the households participating in the baseline study and 16% (n=635) participating in the endline study. This sample was, however, still representative. The study compares three cash modalities: voucher 64% of the respondents (n=2,559), CfW 12% of the respondents (n=472), and MPC 24% of the respondents (n=960). Depending on the location of the household, different modalities of CVA were distributed: Jabal Badro (voucher), Haydariyeh (voucher) or Hanano (CfW or MPC).

Table 7 Sample size for baseline and endline by partner, area and modality

Partner	Area	Modality	Baseline sample	Endline sample
Dorcas	Jabal Badro	Voucher	1200	168
TdH	Haydariyeh	Voucher	1028	163
Oxfam	Hanano	CfW	341	131
Cordaid	Hanano	MPC	787	173
Total			**3356**	**635**

The baseline sample is 70% female (n=2,361) and the endline sample is 98% female (n=620). Given the inconsistent representation of males at baseline and endline, and the fact that the study is interested in female respondents' perspectives, male respondents are excluded from the analyses. This allows to rule out the effect of gender bias on the results. Table 8 shows the final sample for each modality at baseline and endline, excluding male respondents. Table 9 shows that 41% (n=962) of baseline respondents identified as the Head of the Household (HHH) and at endline 62% (n=382) identified as the HHH. It's important to note when disaggregating by the gender of the HHH, the sample sizes are too small to draw conclusions or report on (e.g., male HHH that received vouchers = 0 and for MPC = 7), therefore the researchers only report on this disaggregation when the analyses are relevant, and the results are statistically significant. Table 10 shows the composition of household at baseline and endline.

Table 8: Sample size by modality at baseline and endline (excluding male respondents)

	Baseline	Endline
Voucher	1,568	329
CfW	206	129
MPC	587	162

Table 9: Average number of people per household by the gender of the household head

	Baseline	Endline
Female HHH***	962	382
HH with PWD***	502	185

Table 10: Average number of people per household at baseline and endline

	Baseline	Endline
Sample size	2,361	620
Age	42,07	43,22
Number of people living in the household	5,58	5,57
Number of women	1,70	2,32

Number of older people	0,28	0,41
Number of babies (under 2 years of age)	0,36	0,37
Number of children (2 - 18 years of age)	2,50	2,46
Number of PWD***	0,25	0,35

Table 11: Number of respondents by gender of household head per modality

		Baseline	Endline
Voucher	Female HH	731	328
	Male HH	793	0
Cash for work	Female HH	65	47
	Male HH	137	81
MPC	Female HH	166	7
	Male HH	400	147

To support data collection, the research team developed data collection tools, available in Annex VIII.2. These tools were integrated with those used by the SJR partners, hence why it did not include data about demographics (which was already part of the baseline, endline and PDM template used by the different partners).

SJR partners were responsible for the identification of the data collection team. Enumerators administered surveys on their own. Depending on the partner, the enumerators used mobile data collection tools or paper-based questionnaire which were then re-transcribed and translated into an Excel template produced by the researchers. Following the data collection, partners delivered a clean database in Excel format to the research team. This format was consistently used across partners.

The primary data collected by the SJR partners was sent once after day 1 of data collection and then every two days to the researchers so they could perform the pre-agreed checks to validate data and ensure consistent quality of it. Data was triangulated to ensure a rigorous analysis process. Ongoing monitoring and data collection was overseen by the research team (Key Aid Consulting and Venture International) to provide feedback during the implementation phase.

III.5. After the Implementation Phase: Comparative Analysis and Report Writing

Upon receiving clean databases from the SJR partners, the researchers analysed the data using descriptive statistics for each of the variables (e.g., modality type, location, gender, disability status, etc.).

The researchers compared the pre- and post-distribution data for each group receiving one specific modality and commented on how each group performed over the implementation phase against the set of indicators agreed upon. As mentioned previously however, the researchers were not be able to conclude with statistical significance of the comparative effects across modalities as it would have required homogenous groups receiving each modality which was not feasible in this context. Even though the selection criteria were the same for the different modalities, beneficiaries of different modalities came from different areas and, as such, the apparent effect of the modalities could have actually been biased by external factors playing in some areas and not others. It was also assumed that it was not possible to have perfectly homogenous groups which had the same average income, economic opportunities, exposure to protection risks, etc. As much as possible, research team drew upon trends emerging on comparative effects across modalities.
In order to test the statistic validity of the findings, the researchers ran t-test analyses for most analysis and especially for findings showing small differences across modalities or between baseline and endline. The significance of the statistical results is shown using a star system (see Table 12).

Table 12: How to interpret the p value

	P value	Interpretation
*	P ≤ 0.05	Less than 5% possibility that the results are due to chance
**	P ≤ 0.01	Less than 1% possibility that the results are due to chance
***	P ≤ 0.001	Less than 0,1% possibility that the results are due to chance

Data was triangulated to ensure a rigorous analysis process. A first draft of the final report using figures, maps, and graphs was produced and shared for comments by SJR partners in February 2021. This presentation was also a good opportunity to discuss recommendations in a collaborative manner.

Upon receiving feedback, the researchers produced the final version of the report. This final version of the report was presented during a webinar in March 2021 that was open to all cash working group members.

In addition, the final report, including advocacy messages for the government, was shared with the CWG and other actors to ensure that findings have a strategic impact on future programming.

III.6 Limitations

Different modalities were implemented in different neighbourhoods. While those neighbourhoods are geographically close and present similar economic conditions, the population composition, distance to the distribution points, markets and selected stores in the case of vouchers in those different areas (especially in terms of representation of internally displaced people, returnees and

host population) could have had an impact on the comparability of data across groups and modality.

Certain evaluation questions are related to the effect of the CVA on PWD. To answer these questions, the survey should have specifically targeted respondents with PWD, this was however not always the case. As the research team could not control the quality of the data collection in real time, but only received the data once the collection was over, this could not be corrected. As such, households with PWD are stored as a continuous variable (min 0 household member with PWD and max 5 members with PWD). It, however, cannot be assumed that an improvement in outcomes for a household implies an improvement for persons with PWD.

The timing of the cash disbursements and different data collection exercises was impacted by the COVID-19 pandemic and lockdown measures, as explained previously. As a result, the transfer value did not correspond to the needs it was meant to cover due to the inflation rate in the country and possible loss of income. Between the time when partners on the CVA amount and the time when the first disbursement happened, the official MEB had been revised to 75.000 SYP. The partners were however unable to revise the CVA amount and delivered 45.000 SYP. The changes measured before and after the CVA was distributed also correspond to a situation before/after COVID-19 (i.e., baseline data was collected before the pandemic hit the country and lockdown measures were put in place), so it is likely that COVID-19 has had a detrimental effect on households' ability to meet basic needs and it is difficult to isolate the COVID effects to come up with findings on the effects of the transfers per se.

Lastly, endline data was collected a few weeks after the last CVA disbursement (see Table 3). This had an impact on the food security indicators calculated as most of them were asking respondents to give an answer based on the last 7 days. As such, endline data was collected when respondents had already spent the CVA entirely and were readjusting to living without this (additional) source of income.

IV. Research findings

The study findings and the evidence to substantiate them are presented below. They are structured as a response to each evaluation question in turn.

IV.1. Comparative effects of different modalities on food security status

Section IV.1.1. Food consumption looks at the overall number of meals consumed per day and the FCS for households at baseline and endline. The FCS thresholds are used to categorise household's

food consumption as 'poor' (<28), 'borderline' (28-42) or 'acceptable' (>42) food consumption.[31] The FCS and relative thresholds for the three different modalities (vouchers, CfW and MPC) are presented. This analysis is then disaggregated for households with PWD and without PWD.

Section IV.1.2. Reliance on negative coping strategies looks at the overall negative coping strategies at baseline and endline. The eight negative coping strategies are grouped based on their relative severity: stress, crisis, emergency. Reliance on negative coping strategies is disaggregated for each modality and then for households with PWD.

Section IV.1.3. Expenditure patterns looks at the general expenditure patterns and food-related expenditure patterns for all households. Expenditure patters are then disaggregated by modality.

IV.1.1. Food consumption

Number of meals a day

The average number of meals for each household per day at baseline was 2,36 and at endline was 2,41.[32] The results show a small increase (+0,05) in the average number of meals eaten per household from baseline to endline. An increase in meals per day was reported across modalities: voucher (+0,06), then CfW (+0,08), and MPC (+0,02), however these increases are not statistically significant.

FCS for all households

The study results show an overall increase of 1,82*** in the FCS from 31,01 at baseline to 32,83 at endline (Table 13 shows the mean, median, and the standard deviation for FCS).[33] The FCS is calculated using the relative weightings of eight food groups.[34]

Table 14 shows the relative consumption of each food group. At baseline, respondents consumed a high percentage of fats and sugar, and a relatively low percentage of fruit and protein. High consumption of fats and sugars is characteristic of the diet in these regions of Syria.[35] The results show the largest increase in the consumption of vegetables (8%***), sugars (5%***) and fats (1%***). There was a reported decrease in the consumption of staples (-6%***), and pulses (-5%***).

[31] FCS for Syria is reported based on an adjusted threshold due to high consumption of sugar and oil in the country.
[32] Respondents were asked how many meals their household had eaten per day for the past 7 days
[33] The median is the middle number in the dataset and the standard deviation shows the dispersion of a dataset relative to its mean. The higher the standard deviation, the more dispersed the dataset.
[34] FCS = (starches*2) + (pulses*3) + vegetables + fruit + (meat*4) + (dairy*4) + (fats*.5) + (sugar*.5)
[35] World Food Programme, WFP Syria Country Office Quarterly Monitoring Report (2016).

Table 13: Mean, Median and Standard Deviation for FSC at baseline and endline

	Baseline	Endline
Mean***	31,01	32,83
Median	29,83	33,33
Standard Deviation	11,82	8,97

Table 14: Food diversity at baseline and endline

	Staple	Veg	Fruit	Protein	Pulses	Dairy	Fats	Sugars
Baseline	21%	18%	2%	3%	16%	6%	17%	17%
Endline	15%	26%	1%	2%	11%	5%	18%	22%
Difference	-6%***	8%***	-1%***	0%	-5%***	-2%	1%***	5%***

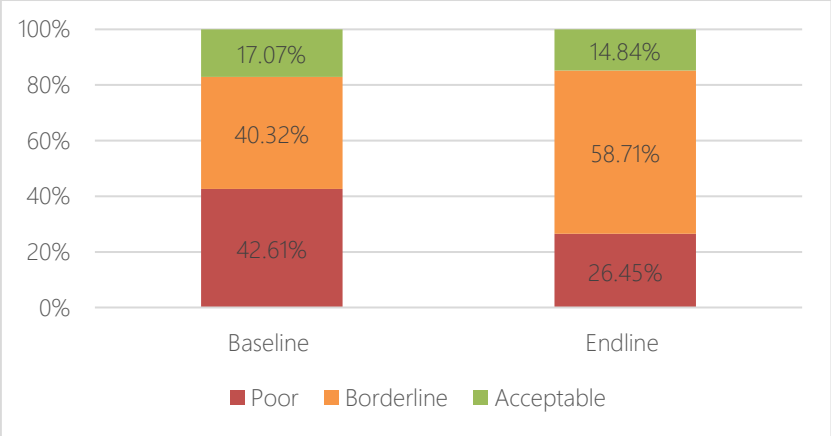
The FCS has thresholds for 'poor' (<28), 'borderline' (28-42) or 'acceptable' (>42) food consumption.[36] Graph 2 shows the percentage of household with poor, borderline and acceptable FCS at baseline and endline. Overall, households reported a decrease in poor food consumption (-16,16%) and an increase in borderline food consumption (+18,39%).

Results from a WFP survey shows a 38% increase in the national average rate of inadequate food consumption (poor and borderline combined) between December 2019 and November 2020. In December 2020, 52% of households in Aleppo reported inadequate (poor and borderline) food consumption. This indicates that project successfully targeted food insecure households as the households participating in this project experienced greater inadequate food consumption at baseline (82,93%) and endline (85,16%) compared to the average of the Aleppo Governorate.[37]

A nationwide increase in inadequate food consumption is the result of many factors, namely the increase in food prices, a wheat crisis as a result of the Syrian Government's loss of control over the country's richest wheat-producing regions, and an economic downturn as a result of the COVID-19 pandemic which lead to the loss of livelihoods.[38] These factors (e.g., increasing food prices) could have also limited the effects for the project.

Graph 2: FCS threshold for all households at baseline and endline[39]

[36] FCS for Syria is reported based on an adjusted threshold due to high consumption of sugar and oil in the country.
[37] WFP, "Syria Country Brief – December 2020".
[38] WFP, "Syria Country Brief – December 2020".
[39] World Food Programme, "Food Consumption Analysis: Calculation and use of the food consumption score in food security analysis" (2008).



FCS by modality

When disaggregated by modality, households that received vouchers reported a large improvement in FCS (+4,65***), compared with households that received CfW which reported a large decrease of -4,67*** in FCS (see Table 15).[40] This reduction in the FCS for CfW recipients seems however to be linked to contextual factors (such as how different geographic areas were affected by the pandemic, the repartition of internally displaced people and returnees, etc.) rather than the modality per se.

A WFP study comparing the effects of cash and vouchers in Ecuador similarly found that vouchers led to greater improvements in FCS (+15,6%) compared to multipurpose cash (+10,8%).[41] In terms of FCS thresholds, households that received vouchers and CfW maintained a borderline food consumption status (i.e., between 28 and 42).

Table 15: Average food consumption score per modality at baseline and endline

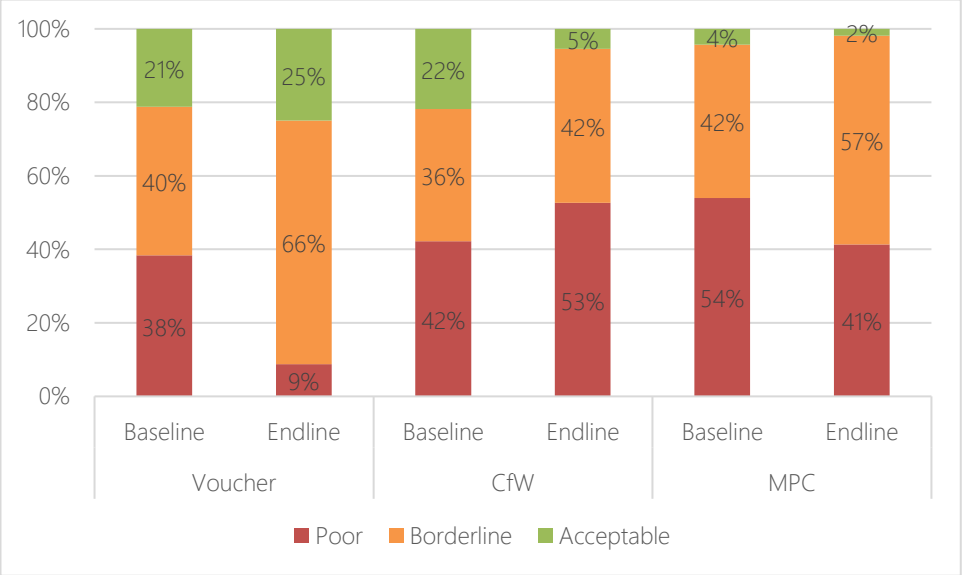
	Baseline	Endline	Difference
Voucher***	32,28	36,93	+4,65
CfW***	32,82	28,51	-4,67
MPC	26,98	28,23	+1,25

Graph 3 illustrates the change in FCS thresholds for each household disaggregated by modality. Households that received vouchers experienced the largest decrease in poor FCS (-29%) and an

[40] The FCS results for MPC were not statistically significant.
[41] Hidrobo, M., J. Hoddinott, A. Margolies, V. Moreira and A. Peterman (2012) Impact Evaluation of Cash, Food Vouchers, and Food Transfers among Colombian Refugees and Poor Ecuadorians in Carchi and Sucumbíos, Final Report. International Food Policy Research Institute and the WFP.

increase in acceptable FCS (+4%). Comparatively, households that received CfW saw an increase in poor FCS (+11%) and a decrease in acceptable FCS (-17%).[42]

Graph 3: FCS threshold for each modality at baseline and endline



The increase in FCS among voucher recipients is expected as the vouchers could only be used to buy food items. The decrease in FCS among CfW recipients matches the national trends according to a WFP survey which saw an increase in inadequate food security over the course of 2020. The WFP survey shows that in July 2020, nearly 13% of households reported poor food consumption and in December 2020 this had increased to 17%.[43] As mentioned previously, this could however be explained by the fact that CfW recipients might have been more hardly hit by the COVID-19 pandemic and lockdown measures.

FCS by households with and without PWD

At baseline, the FCS for households with PWD was 29,14 and at endline it was 29,15. Comparatively, the FCS for households without PWD was 31,11 at baseline and 32,48 at endline. Therefore, households with PWD experienced a smaller improvement in FCS (+0,01) compared with households without PWD (+1,37).

Table 16 shows the average FCS for households with PWD per modality. CfW recipients reported a higher baseline FCS compared with voucher and MPC recipients. In line with the overall FCS results, CfW recipients with PWD reported a decrease in FCS (-4,25).

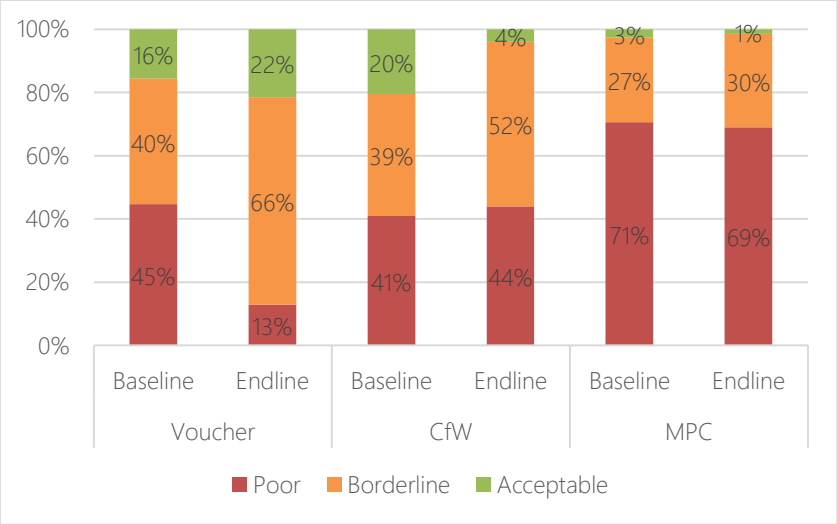
[42] The FCS results for MPC were not statistically significant.
[43] WFP, "Syria Country Brief – December 2020".

Table 16: Average food consumption score per modality at baseline and endline for households with PWD

	Baseline	Endline	Difference
Voucher	29,71	35,96	6,25
CfW	32,85	28,61	-4,25
MPC	24,84	22,88	-1,96

Error! Not a valid bookmark self-reference. shows the food security status for households with PWD per modality. Similar to the overall findings, households that received vouchers reported an increase in acceptable FCS (+6%). Households that received CfW reported a decrease in acceptable FCS (-16%). The results represent the between household effects of different modalities. To capture the effect of each modality on PWD, it is necessary to measure the within household differences.

Graph 4: Food security status for each modality at baseline and endline for households with PWD



IV.1.2. Reliance on negative coping strategies

Negative coping strategies for all households

Overall, **CVA recipients reduced their engagement in negative coping behaviours**.[44] Table 17 shows the eleven negative coping strategies measured in the study, which have been grouped according to their perceived severity (stress, crisis, emergency).[45] Households reported the largest reduction in stress related coping mechanisms: borrowing food (-55%***) and borrowing money (-30%***).

[44] The Coping Strategy Index asks households how many times in the past 30 days they've engaged in various negative coping mechanisms. In this study, participants were asked if they had engaged in each behaviour in the past 30 days (yes/no). The results reflect the number of times respondents indicated 'yes'.

[45] The severity categories are used to group the negative coping behaviors, weightings have not been used in the analysis.

This is not surprising as stress related behaviours are relatively easier to engage in (as shown by the high percentage of engagement at baseline compared to crisis and emergency coping strategies) and to reduce. Emergency coping strategies are considered to be more severe and therefore more challenging to engage in. As such, a 10% reduction in sending children to work at endline is remarkable.

Table 17 Engagement in negative coping strategies at baseline and endline

		Baseline	Endline	Difference
Stress	Less preferred***	97%	77%	-20%
	Limit portions***	70%	43%	-27%
	Borrow money***	86%	56%	-30%
	Borrow food***	75%	20%	-55%
	Purchase credit	82%	54%	-28%
Crisis	Reduce meals***	72%	39%	-33%
	Sell household assets	21%	10%	-11%
	Sell productive assets	11%	0%	-11%
Emergency	Skip days without eating	7%	2%	-5%
	Withdraw children from school	28%	12%	-16%
	Send children to work***	25%	15%	-10%

Negative coping strategies by modality

Table 18 shows household's engagement in negative-coping strategies at baseline and endline for each modality.[46] Overall, the results show that different modalities enabled households to avoid different negative coping strategies in response to food insecurity.

Voucher recipients reported a statistically significant decrease in all strategies. The large decreases were reported for stress-related coping strategies: consumption of borrowed food (-55%***), food purchased on credit (-42%***). A reduction in food related coping strategies is expected as the voucher assistance was restricted to food-related items. It is surprising, however, that voucher recipients reported a large reduction in crisis related coping strategies (selling of household's assets -16%***) and emergency related coping strategies (withdrawing children from school -14%***).

Households that received CfW reduced meals less at endline (-40%***) and reported a decrease in the consumption of less preferred food (+46%***). This might appear to contradict the CfW recipient's FCS which decreased by -4,67***. The FCS uses a composite scoring system for dietary diversity and nutrient intake (i.e., the number of different food groups eaten). Each food group is weighed according to its 'nutrient density', for example relatively less preferred food groups such

[46] all statistically significant results are bolded

as pulses or main staples have a greater weighting than more preferred food items such as fats and sugar.[47] Therefore, CfW recipients' consumption of more preferred foods does not necessarily contradict the decrease in FCS.

Households that received MPC reported a large decrease in stress-related negative coping strategies: consumption of borrowed food (-58%***) and limiting portion sizes (-24%***). They also reported a large decrease in emergency-related negative coping strategies: send children to work (-14%***) and withdrawing children from school (-21%***).

Table 18: Engagement in negative coping strategies by modality

		Voucher		CfW		MPC	
		Baseline	Endline	Baseline	Endline	Baseline	Endline
Stress	Rely on less preferred food	97%	**87%*** **	89%	**43%*** **	99%	**84%*** **
	Limit portions	74%	**51%*** **	59%	**31%*** **	62%	**38%*** **
	Borrow money	88%	**49%*** **	70%	**41%*** **	86%	81%
	Borrow food	75%	**20%*** **	47%	**12%*** **	83%	**25%*** **
	Purchase food on credit	84%	**42%*** **	60%	51%	85%	79%
Crisis	Reduce meals	74%	**47%*** **	62%	**22%*** **	71%	**38%*** **
	Sell household assets	18%	**2%*** **	33%	**19%*** **	25%	20%
	Sell productive assets	9%	**0%*** **	5%	**1%** **	20%	**1%*** **
Emergency	Skip days without eating	6%	**0%*** **	14%	**1%*** **	8%	9%
	Withdraw children from school	31%	**17%*** **	14%	8%	25%	**4%*** **
	Send children to work	27%	**19%*** **	14%	12%	23%	**9%*** **

Table 19 shows the negative coping strategies averaged and grouped according to their perceived severity. Household that received vouchers reported the largest decrease in stress-related negative coping strategies (-34%***), which is unsurprising as these items are closely related to food consumption and the vouchers were limited to food items. Therefore, adding a restriction to vouchers will unsurprisingly bias the reduction of coping strategies towards strategies that depend on commodities and services which can be redeemed against the voucher. CfW recipients reported the largest decrease in crisis-related negative coping mechanisms (-19%***). Finally, MPC recipients reported the largest decrease in emergency-related negative coping mechanisms (-12%).

Table 19: Engagement in stress, crisis and emergency negative coping strategies by modality

	Voucher		CfW		MPC	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Stress	84%	**50%*** **	65%	36%	83%	61%
Crisis	34%	**16%*** **	33%	**14%*** **	39%	19%

[47] WFP, "Food Consumption Analysis - Calculation and use of the food consumption score in food security analysis" 2008.

Emergency	21%	12%***	14%	7%	19%	7%

Negative coping strategies by modality for households with PWD

Table 20 shows the percentage of households that engaged in each negative coping strategies for households with PWD by each modality.

Table 20: Engagement in stress, crisis and emergency negative coping strategies by modality for households with PWD

	Voucher		CfW		MPC	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Stress	71%	75%	66%	66%	63%	70%
Crisis	18%	15%	22%	21%	24%	19%
Emergency	11%	10%	12%	13%	14%	10%

In conclusion, the study found that overall targeted households reduced their engagement in negative coping strategies. The largest reduction was reported for stress-related coping strategies. When comparing the different modalities, households that received vouchers reported the largest reduction in stress-related coping strategies, households that received CfW reported the largest reduction in crisis-related coping strategies, and households that received MPC reported the largest reduction in emergency-related coping strategies. The livelihoods coping strategy index is a multi-sectoral measure of food security, it is therefore unsurprising that households that received a multi-sectoral modality (i.e., MPC) reported the largest reduction in emergency-related negative coping strategies, which are considered the most challenging behaviours to engage in and reduce.

IV.1.3. Expenditure patterns

Expenditure patterns for all households

Households indicated their general expenditure patterns (see Table 21) and their food-related expenditure patterns (see

Table 22) at baseline and endline using proportional pilling.[48] Using Engel's law of consumption, the share of general expenditure should be interpreted as a proxy for income. The law demonstrates that when income rises, expenditure on non-food items increases more than expenditure on food, and as such, the relative share of expenditure on food decreases. Therefore, the share of a household's total expenditure on food indicates the household's level of vulnerability.

[48] Respondents were given a total of 20 stones and were asked to put a greater number of stones next to the type of expenses they prioritised the most over the last 30 days. The team then calculated the means for each time and transformed into a percentage i.e. in Table 21, respondents were spending on average 47% of their budget on food at baseline.

Such that the more vulnerable a household, the larger the share of expenditure on food.[49] CVA recipients spent a greater proportion of their expenditure on health at endline (+5%***) and slightly less expenditure on hygiene (-2%**), the remaining categories were not statistically significant.

Table 21: General expenditure patterns at baseline and endline

	Baseline	Endline
Food	47%	47%
Hygiene**	16%	14%
Health***	11%	16%
Education	9%	8%
Shelter	13%	13%
Livelihoods	3%	0%
Ceremonies	2%	0%
Other	0%	1%

Table 22: Food-related expenditure patterns at baseline and endline

	Baseline	Endline
Staple**	44%	57%
Fruit and Vegetables***	29%	21%
Protein	14%	16%
Livelihood inputs agriculture	6%	3%
Livelihood inputs non-agriculture**	6%	4%

Food-related expenditure patterns show a large increase in expenditure on staple foods (+13%**) and a decrease in the consumption of fruits and vegetables (-8%***). According to a Food and Agriculture Report in June 2020, consumers are buying fewer vegetables and fruit in markets, often buying items by the piece rather than in bulk in kilograms or boxes.[50] These results, appear to contradict the overall FCS results which saw a decrease in the consumption of staples (-6%***), and fruits (-1%***), and an increase in the consumption of vegetables (+8%***).

Expenditure patterns by modality

Table 23 shows that households that received vouchers increased the priority they gave to food (+4%***) and health (+6%***) in their expenses. The increase in the importance of food expenditure was explained by the fact that the vouchers are restrictive, and beneficiaries could only

[49] Zimmerman, Carle C. "Ernst Engel's Law of Expenditures for Food." The Quarterly Journal of Economics 47, no. 1 (1932): 78-101.
[50] FAO, "Syrian Situation Report", June 2020.

purchase food items. Households that received CfW reported an increase in health expenditure (+1%*), education expenditure (+2%***) and shelter expenditure (+1%***).[51]

Table 23: General expenditure for each modality at baseline and endline

	Voucher		CfW	
	Baseline	Endline	Baseline	Endline
Food	44%	48%***	45%	47%
Hygiene	15%	13%**	22%	16%
Health	11%	17%***	12%	13%*
Education	8%	7%	9%	11%***
Shelter	15%	13%***	11%	12%***
Livelihoods	4%	0%***	1%	0%
Ceremonies	3%	0%***	1%	0%***
Other	0%	1%	0%	2%

Table 24 shows that households that received vouchers and CfW increased their expenditure on staple foods by 20%*** and 5%***, respectively. CfW recipients diversified their food expenditure (staples, fruit and vegetable, and protein) more than voucher recipients.

Table 24: Food-related expenditure for each modality at baseline and endline

	Voucher		CfW	
	Baseline	Endline	Baseline	Endline
Staple	38%	58%***	49%	54%***
Fruit and Vegetables	32%	19%***	25%	27%**
Protein	12%	15%***	19%	17%*
Livelihood inputs Agriculture	9%	3%***	5%	1%***
Livelihood inputs Non-agriculture	9%	5%***	2%	0%

In conclusion, the restriction of vouchers to food commodities did not increase food diversification. While CfW grants allowed for dietary diversification, it's important to note that in distributing these restricted cash grants, recipients were aware that the purpose of the grant was to address food security needs. This could have influenced CfW recipient's expenditure choices, and responses in endline data collection.

[51] In the analyses below (Table 23 and Table 24), respondents are excluded if the total for all categories (food, hygiene, health, education, shelter Livelihoods, ceremonies and other) does not equal 20. Data for MPC is excluded from this analysis because the endline proportional piling data for all respondents (expect one) did not sum up to 20.

IV.2. Comparative effects of different modalities on protection outcomes for women

Section IV.2.1. Improved well-being looks at whether CVA recipients experienced an improvement in well-being as a result of the assistance. This analysis is disaggregated by modality.

In section IV.2.2. Level of tension and stress within the household, female respondents reported their self-assessed level of stress and the level of tension within the household at baseline. At endline, female respondents report on how their levels of stress have changed. Endline results are disaggregated by modality, and by the gender of the household head.

Section IV.2.3. Decision making on the allocation of resources looks at the share of decision making among female, males and both within the household. Decision making on the allocation of resources is disaggregated by modality. Female respondents indicate whether their decision-making power has increased since receiving the CVA. These results are disaggregated by modality.

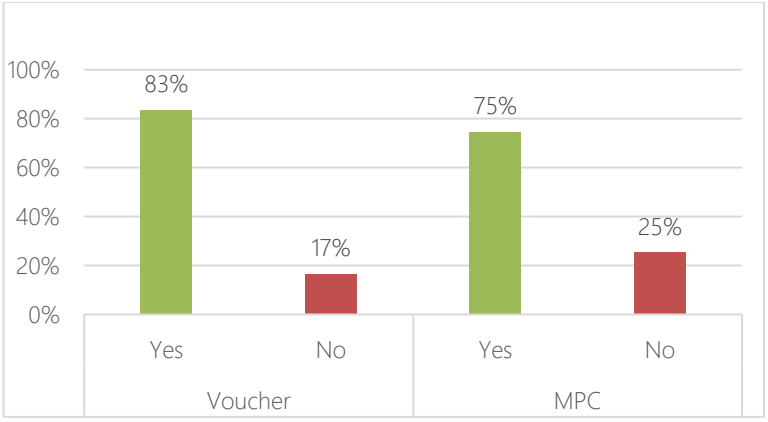
Section IV.2.4. Levels of violence looks at the level of violence within the household and the community at endline. Female respondents reported either no violence before the assistance period, a decrease, an increase or no change in violence during the assistance period. These results are disaggregated by modality.

IV.2.1. Improved well-being

Improved well-being by modality

Households were asked whether the CVA assistance that they had received improved their well-being. The majority of households that received vouchers and MPC reported yes (83% and 75% respectively). Most of the reasons given are related to an improvement in psychological comfort (as reported by the decrease in stress level in section IV.2.2.) but also by the ability to meet children's and the family's needs. Data for CfW recipients could not be analysed as the consultants noted an interpretation error in the way the question was phrased.

Graph 5: Improvement in well-being as a result of the CVA for each modality



IV.2.2. Level of tension and stress within the household

Level of tension and stress by modality at baseline

At baseline, respondents reported an average stress of 2,75 and an average tension of 3,21 on a scale of 0-10.[52] The most common reasons given to explain the reported level of stress were linked to the lack of income and livelihoods opportunity, health/disability of some household members or to the loss of a family member.

Table 25: Stress and tension level for each modality at baseline53

		Voucher	CfW	MPC
Stress	Mean	2,83	5,29	1,58
	Median	3	5	1
	Standard deviation	2,61	3,25	1,98
Tension	Mean	3,34	4,42	2,3
	Median	3	5	2
	Standard deviation	2,26	3	2,17

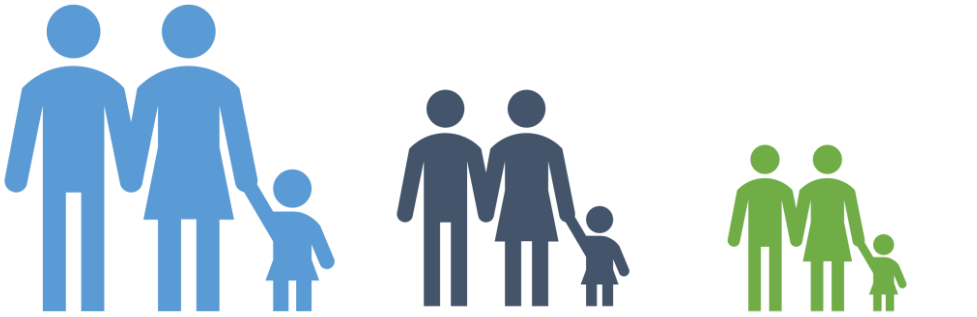
Level of stress by modality at endline

At endline, female respondents were asked whether their stress levels had increased, decreased or not changed since receiving the CVA. The majority of females reported that their levels of stress

[52] Respondents reported their self-assessed level of stress and tension at baseline (0 – 10) and how their level of stress had changed since receiving the CVA at endline (increase, decrease, no change). 0 = no stress at all; 10 = an extreme level of stress. Stress was assessed using categorical variables at endline (increase, decrease, no change).

[53] The median is the middle number in the dataset and the standard deviation shows the dispersion of a dataset relative to its mean. The higher the standard deviation, the more dispersed the dataset.

have 'decreased'. This was especially the case for unrestricted CVA recipients (CfW = 98,65% and MPC = 93,21%). Comparatively, 80,24% of voucher recipients reported a decrease.



99% of CFW recipients reported a decrease of stress within their households

93% of MPC recipients reported a decrease of stress within their households

80% of voucher recipients reported a decrease of stress within their households

Reasons for this reported decrease include gains in purchasing power brought by the CVA, ability to meet basic needs and in some cases, fewer disputes over how to prioritise expenses. Given that more CfW respondents reported a decrease in their stress level could be linked to the fact that their self-assessed level of stress was higher at baseline compared to households that received other modalities (as shown in Table 25). This difference at baseline could be linked to a sampling bias.

Level of stress by gender of the household head at endline

Table 26 shows the number of recipients in female and male headed households which reported an increase, decrease, or no change in stress as a result of the CVA.

Table 26: Level of stress at endline by gender of the household head and modality

	Voucher		CfW		MPC	
	Female HHH	Male HHH	Female HHH	Male HHH	Female HHH	Male HHH
Increase	2 (1%)	0	0 (0%)	1 (1%)	0 (0%)	0 (0%)
Decrease	263 (80%)	0	29 (62%)	43 (53%)	5 (71%)	138 (94%)
No change	63 (19%)	0	18 (38%)	37 (46%)	2 (29%)	9 (6%)

The overall reduction in reported stress levels is in line with findings from other recent studies in Syria, such as the one led by IRC in Raqqa, which showed that many women reported that receiving CVA assistance reduced household tension and provided a sense of personal relief. The study, however, also highlights that these decreases were rather short-term and that concerns for the future were very high and sometimes linked to reported longer-term depressive symptoms among

women.[54] In addition, several studies have reported an increase in household income is correlated with an increase in household harmony, as the extra income relieves stress. This finding is consistent regardless of the gender targeted for the cash transfer.[55]

IV.2.3. Decision making on the allocation of resources

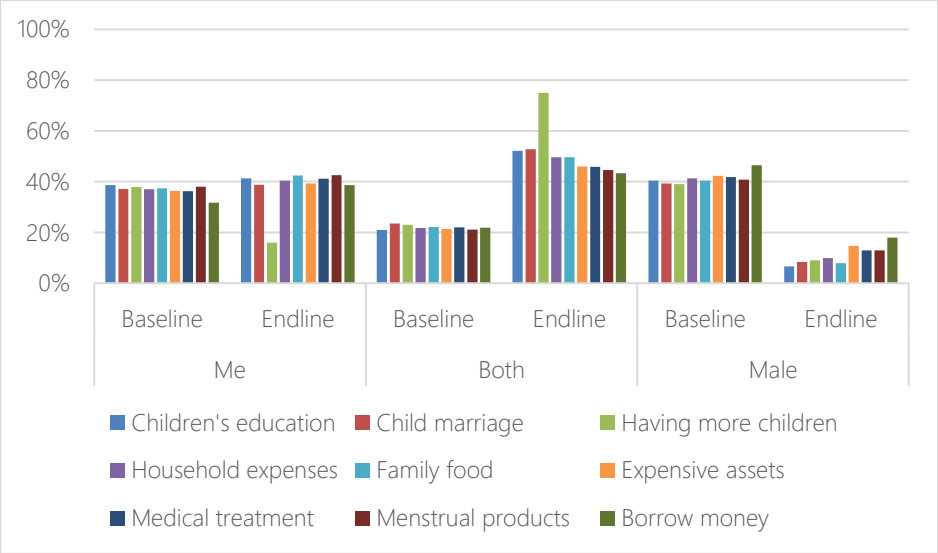
Female respondents were asked how decision-making power was shared among the household members on specific types of decision (e.g., children's education or family food).[56] They could either report that they were making the decision alone ('me'), that decision-making was shared with a male ('both') or that a male figure (e.g., husband or family member) was making the decisions ('male').

Decision making for all households

Graph 6 below show how decision making was shared at baseline and endline for all households.[57] Overall, the share of female decision making ('me') remained the same at baseline (37%) and endline (38%). Comparatively, the share of male decision making decreased from 41% at baseline to 11% at endline, and the share of shared decision making ('both') increased from 22% at baseline to 51% at endline. As females were not specifically targeted in the CVA distribution, these changes are considered to be due to chance.

Graph 6: Decision making for female respondents at baseline and endline

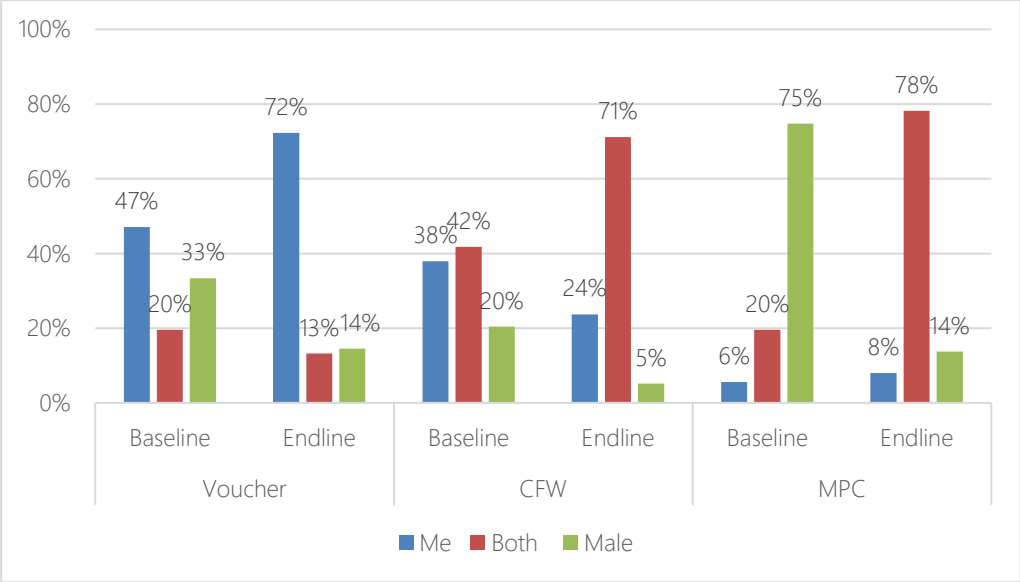
[54] IRC, 'Cash Transfers in Raqqa Governorate, Syria - Changes Over Time in Women's Experiences of Violence & Wellbeing'.
[55] CaLP, "Collected Papers on Gender and Cash Transfer Programmes in Humanitarian Contexts", 2018.
[56] Partners did not specifically target women as the main recipient of the CVA therefore a change in decision making power as a result of the CVA is not expected. This is coupled with the short length of the CVA.
[57] Respondents were asked who usually decides how to distribute the CVA received (me, me and husband/male family member, husband, male family member, other).



Decision making by modality

Graph 7: **Average share of decision making at baseline and endline for each modality** shows the average share of decision making at baseline and endline for each modality. The share of female decision making increased at endline for voucher recipients by 25%. Comparatively, the share of shared decision making ('both') increased at endline for CfW recipients by 29% and for MPC recipients by 58%. Given the brief length of the distribution period, it is uncertain how long any observed behavioural changes in decision making will last. It is, therefore, difficult to conclude on the effectiveness of a given modality on decision making. This is especially the case for restricted voucher assistance, which unlike other modalities (such as MPC and CfW) involves less decision making. It is possible that the respondents reported an increase in female and shared decision making at endline in an effort to boost the apparent success of the CVA.

Graph 7: Average share of decision making at baseline and endline for each modality



Decision-making power by modality

Female respondents were asked whether they have more decision-making power within their household as a result of the CVA. Overall, the larger majority of female respondents reported 'no' (83,55%). When disaggregated by modality, households that received vouchers reported the largest change in decision making power (22%), then CfW (12%) and MPC (9%).

Table 27: Increase in decision making as a result of the CVA

	No	Yes
Voucher	78%	22%
CfW	88%	12%
MPC	91%	9%

In line with the share of decision-making results, voucher recipients reported a large increase in female decision making at endline (+25%), as opposed to male decision making (-19%) and shared decision making (-7%). This increase in female decision-making power for restricted voucher recipients could suggest that food related decisions are gendered, such that females made decisions on how to spend the vouchers. This is reflected in the large increase in female decision making on family food for voucher recipients (+30%). Comparatively, female decision making on family food decreased for CfW recipients (-14%) and slightly increased for MPC recipients (+2%).

IV.2.4. Levels of violence

While cash is being increasingly used in acute emergency settings, there is a gap in evidence around the effect of CVA on VAWG.[58] In the endline study, the research team asked respondents to assess whether the level of violence within the household and community decreased, remained stable or increased within the assistance period.

Levels of violence within the household for all households

At household level, the majority of respondents said that there was no violence before the assistance (81%).[59] Of the remaining respondents that experienced violence within the household before the assistance period, 56% reported a decrease in violence and 44% reported no change during the assistance period.

Levels of violence within the household by modality

When disaggregated by modality, CfW recipients reported the largest decrease in violence (18%) (see Table 28). Most CfW recipients explain that the level of violence in the family decreased because 'the living situation improved'.

Table 28: Reported changes in levels of violence at household level per modality

	Increased	Decreased	No change	No violence before	Prefer not to say
Voucher	0,00%	4,85%	**9,39%**	80,00%	5,76%
CfW	0,00%	**17,56%**	3,05%	79,39%	0,00%
MPC	0,00%	7,56%	3,49%	83,72%	5,23%
Total	0,00%	8,21%	6,48%	80,88%	4,42%

Levels of violence within the community for all households

The study shows similar findings in terms of violence in the community. Overall, 68,22% of the respondents reported no violence in the community before the assistance period. Of the remaining respondents that reported violence within the community before the assistance period, 46% reported a decrease in violence and 54% reported no change during the assistance period.

[58] IRC, 'Cash Transfers in Raqqa Governorate, Syria - Changes Over Time in Women's Experiences of Violence & Wellbeing'.Setting the stage: What we know (and don't know) about the effects of cash-based interventions on gender outcomes in humanitarian settings", 2018.

[59] Respondents were able to indicate if the level of violence has increased, decrease, remained the same of if there was no violence before. Respondents that indicated that there was no violence before, it is assumed that this did not change during the assistance period (i.e., if there was no violence before and violence has increase, then the respondents should have indicated 'increased'.

Levels of violence within the community by modality

When disaggregated by modality, 3% of household that received vouchers, 14% of households that received CfW and 18% of household that received MPC reported a decrease in violence in the community since receiving the cash CVA (see Table 29). Three women recipients of MPC reported an increase in violence in the community since the start of the project. However, they explained their answer by the general context and "bad conditions" in the area where they lived.

Table 29: Reported changes in levels of violence at community level per modality

	Increased	Decreased	No change	No violence before	Prefer not to say
Voucher	0,00%	3,02%	**15,41%**	57,10%	24,47%
CfW	0,00%	**14,50%**	3,82%	81,68%	0,00%
MPC	1,73%	**18,50%**	9,25%	65,90%	4,62%
Total	0,57%	12,00%	9,49%	68,22%	9,69%

As such, CVA does not seem to have increased women's experience of violence as almost none of the recipients reported an increase at household or community level. The fact that there was no reported increase in the level of violence within the community could also indicate that the CVA was positively accepted and therefore the likely effectiveness of the targeting. Receiving vouchers seemed to have maintained to status quo (as seen in the higher proportion of women reporting no change) whereas a proportion of CfW and MPC recipients reported a decrease both at community and household level.

IV.3. Comparative satisfaction with the different modalities, specifically for people living with disabilities

Section **IV.3.1. Modality and delivery mechanism preference** looks at household's preference for a different modality, disaggregated by modality and by households with and without PWD. The PDM data is used to discuss households' preference for different delivery mechanisms.

Section **IV.3.2. Satisfaction with the CVA for households with PWD** looks at the average level of satisfaction for households with and without PWD. The level of satisfaction is disaggregated by modality for households with PWD.

Section **IV.3.3. Accessibility of the delivery mechanism for households with PWD** looks at the average accessibility of the delivery mechanism for households with and without PWD. The level of accessibility is disaggregated by modality for households with PWD.

IV.3.1. Modality and delivery mechanism preference

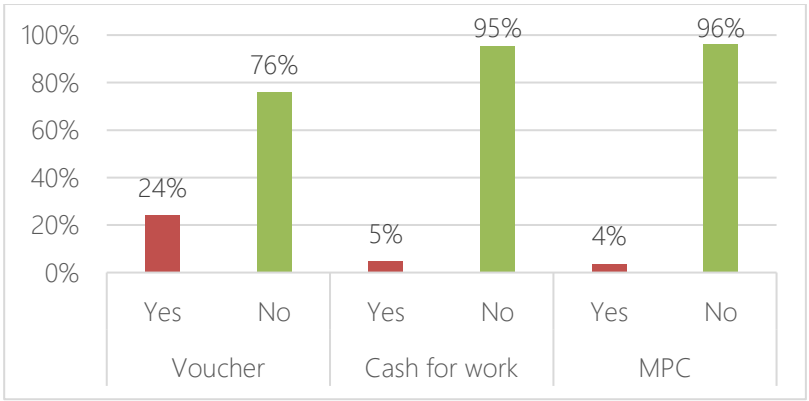
In terms of modality preference, respondents were asked whether they would prefer to receive their assistance through a different modality in the future.

Preference for a different modality by modality

Overall, most recipients were satisfied with their respective modalities and would not prefer to receive assistance through a different modality in the future.[60] This was especially the case for CfW (95%) and MPC (96%) recipients. Three of the six CfW recipients mentioned that the CVA should be distributed within Hanano as travelling time was important for some of them. Three of the five MPC recipients who would like to receive the CVA in a different way explained that they would prefer vouchers but without stating any specific reason.

For voucher recipients, 24% would prefer a different modality. The reasons given were that they would rather receive unrestricted cash CVAs or have include other items such as medicines, detergent or children's clothes included in the purchase list. Some respondents also mentioned that the shop where they could cash out the vouchers were distant and more expensive than the shops they usually go to.

Graph 8: Preference for a different modality in the future



Preference for a different modality for households with and without PWD

For voucher recipients, households with PWD showed a stronger preference for a different modality (30%) than households without PWD (22%) (see Table 30). Voucher recipients of

[60] The extent to which respondents are aware or understand the nature of alternative modalities is unclear. The survey question was asked as follows: "Would you prefer to receive cash in a different way in the future?" It could be the case that some enumerators gave examples of alternatives.

households with PWD explained that they would like to receive cash aid and be able to purchase non-food items (e.g., medical supplies, clothes, stationery and detergents).

Table 30: Preference for a different modality in the future

	Households with PWD		Households without PWD	
	Yes	No	Yes	No
Voucher	30%	70%	22%	78%
CfW	4%	96%	5%	95%
MPC	7%	93%	1%	99%

Satisfaction with delivery mechanism by modality

In terms of delivery mechanisms, the PDM data collected by the different IPs shows that 98% of CfW respondents reported that they did not face any challenges in accessing the CVA. 93% of the CfW respondents travelled for less than half an hour and 98% reported having to wait less than half an hour at the distribution point.[61]

For voucher recipients, 46% reported that the prices were higher than in other shops and showing slightly longer waiting time at the distribution point, with 57% of respondents reporting that the waiting time was acceptable, 20% reporting it was short or very short and 23% reporting it was long or very long.[62] An IP noted that voucher recipients were given timeslots, in accordance with the COVID-19 regulations and to make the distribution process more efficient, which were not adhered to. This in turn led to longer waiting periods.

IV.3.2. Satisfaction with the CVA for households with PWD

Households were asked how satisfied they were with the CVA on a scale from 0 (not satisfied at all) to 10 (very satisfied).

Satisfaction with CVA for households with and without PWD

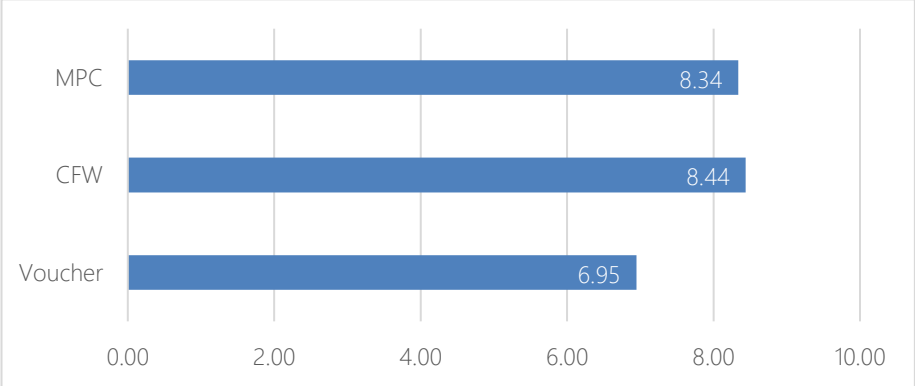
Households with PWD report an average satisfaction of 7,66 out of 10. Comparatively, households without PWD reported an average satisfaction of 6,59 out of 10.

Satisfaction with CVA for households with PWD by modality

[61] Oxfam, 'Cash for Work Distribution 2nd Payment - During Distribution Monitoring Survey Report (DDM)', 17 August 2020.
[62] Dorcas, 'Post Distribution Monitoring Report Activity: Food Vouchers – Jabal Badro Project: SJR Cash Project', 19 July 2020.

Graph 9 shows the level of satisfaction for households with PWD disaggregated by modality. Households that received CfW were the most satisfied (8,44), then households that received MPC (8,34), and households that received vouchers (6,95). Although the analysis is disaggregated by households with a PWD member, it is important to note that the question on satisfaction does not directly ask about the PWD household member. It is, therefore, difficult to interpret the effect of the different modalities on different members within the household (e.g., a member of the household engaging in CfW versus a household member that is not engaging in CfW but potentially benefiting from the household's increase in income).

Graph 9: Reported level of satisfaction with the modality for households with PWD



IV.3.3. Accessibility of the delivery mechanism for households with PWD

Households were asked how accessible the delivery mechanism was on a scale from 0 (not accessible at all) to 10 (very accessible).

Accessibility of the delivery mechanism for households with and without PWD

Overall, households with PWD rated the delivery mechanisms as 7,19 out of 10 on accessibility. Comparatively, households without PWD rated the delivery mechanisms as 6,39 out of 10 on accessibility.

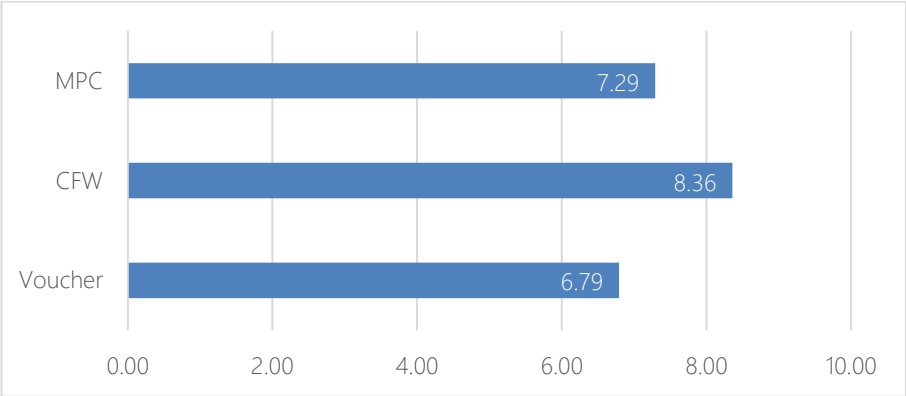
Accessibility of the delivery mechanism for households with PWD

When disaggregated by modality, households with PWD found the delivery mechanism for CfW to be the most accessible (8,36), then MPC (7,29) and vouchers (6,79). The accessibility of CfW could seem surprising as the condition to receive the CVA was to undertake work such as

gardening, restoring the water system or cleaning the streets. This is, however, linked to the fact that the household members who undertook the work were not the PWD.

The slightly lower score given by vouchers respondents could also be linked to the reasons given by some respondents who were willing to receive CVAs in a different way in the future, i.e., distance to reach the selected shops and the fact that they could not purchase items to improve the well-being of the household members with PWD.

Graph 10: Reported level of accessibility of the modality for households with PWD



V. Recommendations on how to maximise satisfaction and effectiveness of CVA for targeted households, and especially women and households with PWD

Based on the findings of the study and discussion with the SJR partners during a preliminary findings workshop, the research team has drawn conclusions and recommendations to improve CVA programming in the future. The conclusions and recommendations are grouped into three perspectives: Design, implementation, and monitoring and evaluation.

V.5.1 Design perspective

1. Unrestricted assistance should be the default modality of assistance when the conditions for appropriateness are met

As per the industry standard, when the conditions for appropriateness are met, unconditional and unrestricted assistance should be considered as the default modality of assistance. Recipients

showed a strong preference for unrestricted modalities and this was even more so the case for women and households with PWD. The freedom of choice associated with the absence of restriction allowed the recipients to access goods and services specifically meeting the needs of household members with PWD (such as eye treatment, hearing devices or medical consultations in general). Restricted assistance, be it through voucher or in-kind assistance cannot match the flexibility and granularity that unrestricted assistance offers to each household to prioritise its need. The list of restricted items available with vouchers often does not allow targeted households to access such tailored assistance. Voucher recipients requested the following non-food items: clothes, stationery, detergents, medicine and health supplies for disabled support and dippers.

In Syria however, the current low political acceptance of MPC might limit the use of unrestricted modalities. They should nonetheless be considered at programme design stage. CVA providers should assess how feasible and timely it will be for them to obtain official approvals to deliver MPC and make a decision based on a thorough analysis of the context (including the urgency of the needs to cover, the potential delays caused by difficult MPC approvals and the potential benefits brought by MPC to achieve the programme's outcomes).

Restricted assistance and vouchers in particular, can be considered if there is a higher imperative, for example in case of risks to public health. In that circumstance, the interest of the many should supersede the individual choice that unrestricted assistance can bring.

2. Conduct a SADD gender and barrier analysis to cover the needs of different groups

When aiming to cover needs of different groups, conduct a sex, age and disability disaggregated (SADD) gender and barrier analysis. This analysis should aim to capture the distinct needs and access constraints. The SADD should be conducted early on to inform programme design. In addition to the SADD, it could be useful to integrate secondary data on, for example, disability, using the Washington Group on Disability Statistics.[63] Secondary data can also be useful to reduce the opportunity costs borne to women, who often commit unpaid time to respond to surveys.[64]

3. Ensure women's and PWD's voices are heard in need, market and security assessments

Needs assessments should capture the gendered and disability-related determinants of food security. To capture this, it is essential that women's and PWD's voices are heard, during the need's assessment. This study found that women's' satisfaction with a modality depended on factors such distance to and waiting time at the distribution points, and, in case of vouchers, the impression that they can get the 'best deal' out of the assistance (i.e., that the selected shops offer competitive

[63] Washington Group on Disability Statistics
[64] Abebe Kabet, R., Juillard, H. "Better Gender outcomes in Food Assistance through complementary and multi-modal programming", December 2020.

prices compared to other local markets and shops). This is even more so the case for households with PWD and women with young children who can't always afford to travel long distance and wait for hours at distribution points.

When targeting these populations, CVA programme designers should pay specific attention to those factors to maximise access and satisfaction of the recipients. This could be done through qualitative interviews and FGDs with the specific target groups (for instance, with women only or PWD only) at needs assessment stage to really understand the priority needs, the determinant of satisfaction and barriers to access.

4. When CfW is considered, additional MPC assistance should be considered for most vulnerable households not able to work

To cover the needs of different groups and ensure that vulnerable groups are not further excluded, CfW should include a portion of assistance for households that do not have a member able to work. For example, households with PWD, mothers of young children, pregnant women, or households with elderly taking care of young children.

5. Combine cash assistance with food security awareness raising if increased food security if the main objective of the programme

When food insecurity is linked to a poorly diversified diet which may result from preferences for less nutritious food, explore combining unrestricted cash assistance with awareness raising session. If time is too short to trigger behaviour change, consider restricting a portion of the assistance to create stronger incentives for a diversified diet.

6. Integrate non-food related expenditure in the transfer value calculation or in the voucher list of restricted items, especially when targeting women and households with PWD

When cash is the most appropriate modality to cover food needs it is important to maximise the flexibility of cash by integrating non-food related expenditure in the calculation of the transfer value. Similarly, in the case of vouchers, the study showed that women and households with PWD who received a restricted modality were less satisfied with the assistance as they were unable to use the assistance to purchase specific items such as diapers or medical support for the PWD. If voucher is the only option possible, it seems important to include such items in the list. The situation analysis should allow to identify the priority needs of the target population.

These expenditures should be defined based on a needs assessment but could include: WaSH, shelter/NFI or education expenditures.

7. The value of the transfer should be adjusted according to the inflation rate

In volatile economic environments like Syria, CVA programme designers should also be aware of rapidly growing inflation rate and the devaluation of the set CVA value. As discussed in the study, by the time SJR partners started delivering the CVA, the amount of the MEB in SYP had already increased by almost 50%. It is therefore recommended to set the transfer value in USD, so that it is less vulnerable to inflation.

This inflationary risk should be included in the risk analysis presented to the donor in order to discuss a potential flexibility to adjust the CVA amount. In addition the exchange rate between USD and SYP should be monitored as part of market monitoring. The official USD-SYP exchange may not reflect the reality of the exchange rate used in the market, hence the importance to monitor it. The cash working group can be used to leverage buyer power with financial service providers so that the exchange rate they provide is as close as possible from the market one as opposed to the official one.

From the recipient perspective, inflation and exchange rate fluctuations impact the price of goods/services and therefore the ability of people to meet their basic needs. Therefore, the key objective for adapting cash assistance should be ensuring outcomes are reached for the people targeted, by stabilising their purchasing power. An associated objective is to ensure coherence of programming, i.e., avoiding changing the transfer value at each distribution, and harmonising and aligning transfer values within each sector/activity regardless of the currency of disbursement. As such, programmes should be designed from the outset to anticipate currency and liquidity shocks. They can make provision for extra cash based on a projected inflation rate (the Red Cross/Red Crescent transfer value tool which includes a budget line to calculate anticipated inflation during the project period). Another option is to include Crisis Modifiers in the budget which can be activated once defined thresholds have been reached.

8. Incorporate gendered outcomes into the programme design

When the goals of a CVA programme is to improve women's well-being, this should be specifically incorporated into the design phase. Outcomes for women's well-being should not be treated as an unintended consequence of the programme. In addition, when a programme includes intended gender outcomes, it is important to engage males in promoting gender equality. This could include curriculum-based interventions (e.g., Promundo Global: Program H)[65] or community activism approaches (e.g., Sonke's One Man Can).[66]

[65] Promundo Global: Program H
[66] Sonke's One Man Can

9. Map and learn from existing humanitarian projects in the programme intervention areas with intended gender outcomes

The purpose of this map is to improve coordination, develop synergies and maximise the use of modalities within the implementation areas. The map also serves to identify complimentary services (e.g., GBV services providers), create referral relationships and train staff to make referrals for CVA recipients who identify as GBV survivors.

It is useful to reflect on CARE's CVA and Gender Based Violence[67] design approach to meet their specific protection objectives:

- *"CVA in GBV prevention example: targeted cash transfers to families who risk placing girls in early marriages, such as conditional cash assistance to keep girls in school".*
- *"GBV risk mitigation in CVA examples: separate focus group conducted with women about their preference for the household recipient of a cash transfer or voucher, asking if targeting women might cause tensions in the family or any safety concerns".*
- *"CVA in GBV specialised response example: CVA as part of survivor care and assistance through case management, for example cash transfers to cover transportation costs, or conditional cash transfers (CCT) to encourage attendance at regular follow-up appointments".*

The importance and urgency of linking GBV and CVA have become even clearer with the COVID-19 pandemic, where GBV risks for women, girls and other vulnerable groups have increased due to mobility restrictions, loss of income opportunities, and increased care burdens. Overall, efforts to mitigate, prevent, and respond to GBV risks need to be mainstreamed. This includes:[68]

- Optimising the use of CVA to enhance the protection of rights holders;
- Mitigating any risks of violence that are (potentially) increased because of a CVA programme (safe programming and do no harm);
- Using CVA to reduce risks and potential exposure to violence (e.g. reduce the use of negative coping strategies);
- Enabling economic empowerment and resilience for at-risk community members;
- Considering complementary activities to make CVA gender-aware and gender transformative;
- Inclusion of CVA in GBV case management and referral services.

[67] CARE, 'Cash & Voucher Assistance and Gender-Based Violence Compendium: Practical Guidance for Humanitarian Practitioners', May 2019.
[68] Maja Tønning, 'Gender Based Violence and Cash and Voucher Assistance: Tools and Guidance' (Key Aid Consulting, October 2020).

A series of tools and guidance to better include gender equality in CVA is available here. In Northwest Syria, the Cash Working Group and the GBV Sub-Cluster also established a task force to build bridges between GBV and CVA actors.[69]

V.5.2 Implementation perspective

10. SADD gender and barrier analyses should be conducted routinely during the design and implementation phase (during each monitoring and evaluation exercise for instance)

The SADD context analysis should be conducted early on to inform programme design. It should then be conducted periodically to ensure that the programme remains relevant to contextual changes. For example, a periodic assessment during this project would have shed light on the disproportional effects of the COVID-19 pandemic on women or PWD.

11. Integrate equal access considerations when identifying service providers

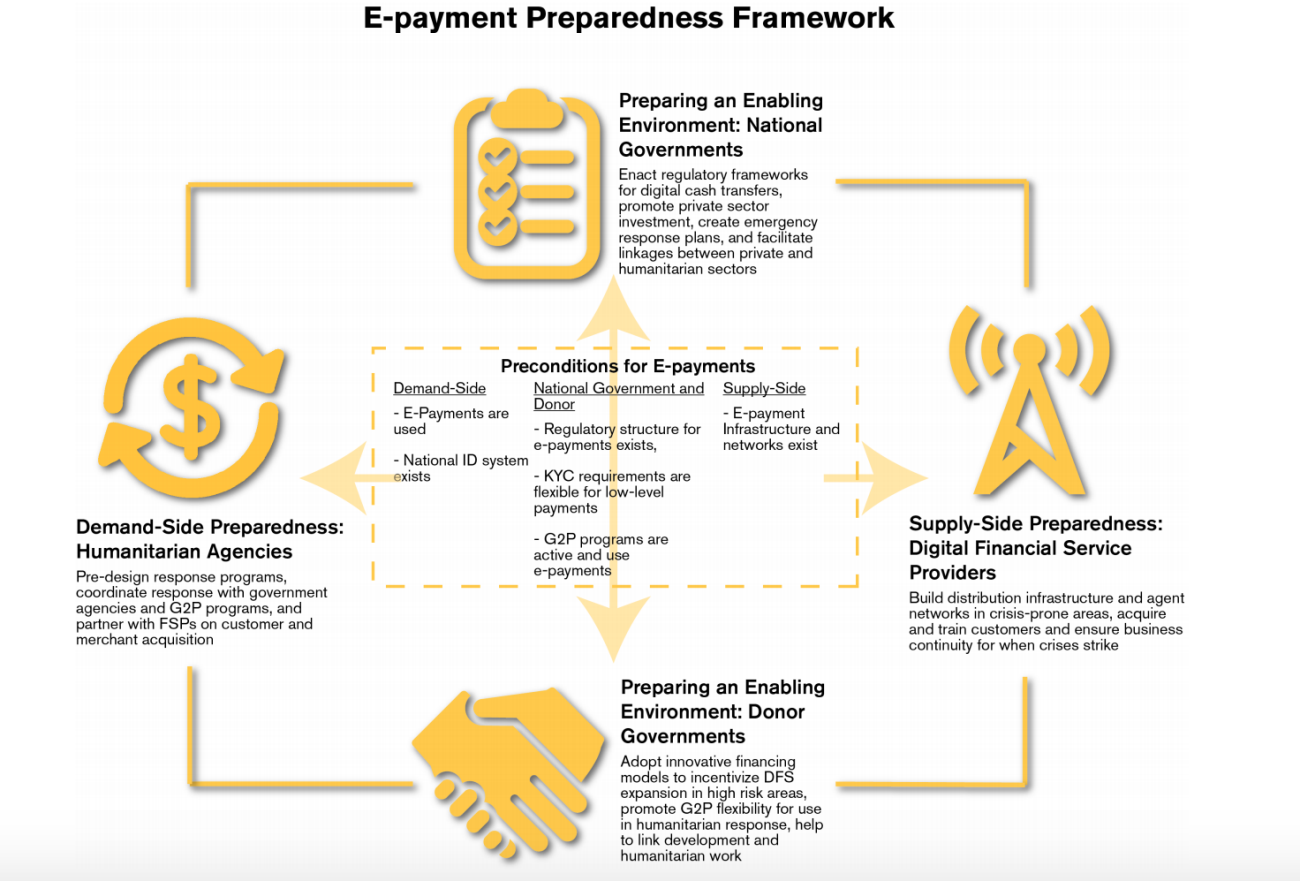
This study found that women's satisfaction with a modality depended on factors such as distance to and waiting time at the distribution points, and, in case of vouchers, the impression that they can get the 'best deal' out of the assistance (i.e., that the selected shops offer competitive prices compared to other local markets and shops). This is even more so the case for households with PWD and women with young children who can't always afford to travel long distance and wait for hours at distribution points. Therefore, it is important to integrate equal access considerations into the selection of service providers.

12. The appropriateness of e-payments should be informed by a feasibility assessment

From an implementation perspective, SJR partners have expressed an interest to move away from direct cash distribution and explore e-payments (e.g., RedRose's ONEsystem)[70] to simplify the delivery process. This could limit transport and queuing time at distribution points and as such, increase beneficiaries' satisfaction. Several pre-conditions however need to be in place before considering e-payments as a real option. The following figure presents the main elements of e-payment preparedness:

Figure 1: E-payment preparedness framework[71]

[69] Maja Tønning, 'Establishing a Cash Working Group and Gender-Based Violence Sub-Cluster Task Force - Northwest Syria Case Study' (Key Aid Consulting, December 2020).
[70] https://www.redrosecps.com/index.htm
[71] International Rescue Committee, 'Making Electronic Payments Work for Humanitarian Response', May 2016.



A feasibility assessment is thus required and could be completed in coordination with other CWG members.

V.5.3 Monitoring and Evaluation perspective

13. Including behavioural changes should be an intended outcome with dedicated resources and time

From an M&E perspective, the research team and SJR partners came to the conclusion that M&E questions need to be appropriate for the modality. For instance, the study reveals that expecting a behavioural change is unrealistic for short distribution periods. M&E exercises as part of voucher programmes should rather focus on other aspects of intervention such as satisfaction or ease to access distribution points and selected shops, monitoring of selected shops' prices and the potential update of the list of selected goods based on needs and priorities.

14. Do not limit data collection to between-household levels, but also consider the within-household individual levels

That a household reports a positive outcome as a result of the programme does not mean that these outcomes are equally experienced by all members within the household. To capture the within household effects of the program, it is important to collect data at the individual level. For gendered outcomes, collect data from both men and women within the household, separately, to identify how processes are perceived along gender lines. This should also be done to understand the effect of the program on households with PWD, with household members living with and without disabilities.

15. Use indicators to track both intended and unintended outcomes

Quantitative survey questions are often designed to capture the intended outcomes of a programme (such as health, education or shelter outcomes), leaving little opportunity to identify unintended outcomes. One way that unintended outcomes are overlooked is through limited disaggregation. For example, when identifying the outcome of a programme for women, it is important to remember that 'women' is not a homogeneous group, additional layers to the analysis, such as the gender of the household head, will allow for a more nuanced understanding on how the program is experienced within different groups of individuals. However, to disaggregate and draw conclusions at these levels, it is critical to have a large enough sample size. Quantitative data collection should be triangulated with qualitative in-depth interviews.

16. Make use of the M&E tools and guidance included in CaLP updated Programme Quality Toolbox

Most M&E challenges are not specific to CVA, but the unrestricted nature of the transfer can bring difficulties to monitor outcomes. This study highlighted for instance the effectiveness of vouchers to meet food security outcomes but also showed that CfW recipients priorities expenses differently and in a more diverse manner (to increase the share of their budget going to health or education for instance). This has probably brought positive outcomes to the targeted households, but those outcomes could not be captured in this study or the monitoring exercises undertaken by partners. The flexibility of unrestricted cash transfer can make it difficult to determine appropriate outcome indicators, as they may involve a combination of sector-specific and cross-cutting indicators. There are limitations on gathering accurate data on how cash transfers are spent. CaLP developed a tool focusing on monitoring and evaluating CVA (available here and specifically for MPC available here) which could be useful for future programmes. Similarly, the British Red Cross published a series of practical tools on their Cash Hub as part of the Cash in Emergencies Toolkit, which include a section on monitoring (available here). In addition, partners could consider other methods such as Most Significant Change and Outcome Harvesting to better capture all the outcomes of an unrestricted CVA programme.

Annexes

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Data collection tools

List of questions added to the targeting survey for baseline purposes

In the introduction of the interview, make sure that you present the objectives of the study, that respondents can answer the questions based on their own experience or based on people they know who have had similar experiences. Also highlight that answers will not affect their eligibility to receive further assistance nor the eligibility of anyone else, that they can skip questions at any time and that their answers are confidential.

1. How many meals a day have you and your household been able to eat in the last 7 days? I would like to ask you about all the different foods that your household members have eaten in the last 7 days. Could you please tell me how many days in the past week your household has eaten the following food items? For those items purchased could you let me know where they come from?

Food item	DAYS eaten in past week (0-7 days)	Sources of food (see Food item codes below)	
		Primary	Secondary
#.1 – Bulgur			
#.2 – Rice			
#.3 – Bread/wheat			
#.4 – Tubers			
#.5 – Groundnuts & Pulses			
#.6 – Fish			
#.7 – Red meat (sheep/goat/beef)			
#.8 – White meat (poultry)			
#.9 – Vegetable oil, fats			
#.10 – Eggs			
#.11 – Milk and dairy products (main food)			
#.12 – Milk in tea in small amounts			
#.13 – Vegetables (including leaves)			
#.14 – Fruits			
#.15 – Sweets, sugar			

Food source codes:

Purchase =1 Own production =2 Traded goods/services, barter =3 Borrowed = 4 Received as gift= 5 Food aid =6 Other (specify) =7

2. In the last 30 days, did you have to rely on the following strategy?

Strategy	Yes	No
Rely on less preferred and less expensive foods		
Borrow food, or rely on the help from a friend or relative		
Purchase food on credit		
Reduce number of meals eaten per day		
Limit meals portion size and quantities of food eaten		
Skip entire days without eating		
Sell household assets (radio, furniture, refrigerators, television, jewellery etc.)		
Sell productive assets or means of transportation		
Withdraw children from school		
Send your children to work		
Borrow money		

3. Can you tell us how you have prioritised your expenditures over the last 30 days?

   - Food
   - Hygiene
   - Health care, medicines
   - Education
   - Shelter/housing
   - Purchase of productive capital or means of transportation
   - Ceremonies (e.g. burial)
   - Other, please specify

4. Looking more specifically at food, and still using proportional piling, can you tell us how you have prioritised your expenditures over the last 30 days?

   - Dry Staple Foods (bulger, rice, lentils, oil etc.)
   - Fresh fruits and vegetables
   - Fresh protein (eggs, chicken, meat etc.)
   - Livelihood Inputs / Materials (Agriculture)
   - Livelihood inputs/materials (non-agricultural)

5. Over the past 30 days, who, within your household, has made the following decisions?

For married women:

Decision	Mainly husband	Both of us equally	Mainly me	Others
Children's education				
Marriage decisions for children				
Having more children				
General household expenses				
Food for the family				

Buying expensive household assets				
Buying medical treatment for health problems				
Buying of menstrual products				
Borrowing money/giving back money borrowed				

For unmarried women or female-headed households:

Decision	Mainly me	A male relative	A male relative and me equally	Others
Children's education				
Marriage decisions for children				
General household expenses				
Food for the family				
Buying expensive household assets				
Buying medical treatment for health problems				
Buying of menstrual products				
Borrowing money/giving back money borrowed				

6. On a scale of 0 to 10, how would you rank the level of tension within your household?(0 being no tension at all, 10 being very high level of tensions)
7. What are the main causes of tension?
8. On a scale of 0 to 10, how would you rank your personal stress level? NB: personal stress means the feeling of worry, anxiety, hardship, nervousness, tension linked to specific events or situations (for instance: displacement, loss of income sources and/or support system) (0 being no stress at all, 10 being very high level of stress)
9. What are the main causes of stress?

Household survey for end line

In the introduction of the interview, make sure that you present the objectives of the study, that respondents can answer the questions based on their own experience or based on people they know who have had similar experiences. Also highlight that answers will not affect their eligibility

to receive further assistance nor the eligibility of anyone else, that they can skip questions at any time and that their answers are confidential.

1. How many meals a day have you and your household been able to eat in the last 7 days? I would like to ask you about all the different foods that your household members have eaten in the last 7 days. Could you please tell me how many days in the past week your household has eaten the following foods?

Food item	DAYS eaten in past week (0-7 days)	Sources of food (see Food item codes below)	
		Primary	Secondary
#.1 – Bulghur			
#.2 – Rice			
#.3 – Bread/wheat			
#.4 – Tubers			
#.5 – Groundnuts & Pulses			
#.6 – Fish (eaten as a main food)			
#.7 – Red meat (sheep/goat/beef)			
#.8 – White meat (poultry)			
#.9 – Vegetable oil, fats			
#.10 – Eggs			
#.11 – Milk and dairy products (main food)			
#.12 – Milk in tea in small amounts			
#.13 – Vegetables (including leaves)			
#.14 – Fruits			
#.15 – Sweets, sugar			

Food source codes:

Purchase =1 Own production =2 Traded goods/services, barter =3 Borrowed = 4 Received as gift= 5 Food aid =6 Other (specify) =7

2. Overall, since you have started receiving the CVA, would you say that quality and diversity of the food eaten within your household has improved?
   - It has improved greatly
   - It has improved a bit
   - It remained the same
   - It got worse

3. Since you started receiving the CVA, did you have to rely on the following strategy?

Strategy	Yes	No
Rely on less preferred and less expensive foods		
Borrow food, or rely on the help from a friend or relative		

Purchase food on credit		
Reduce number of meals eaten per day		
Limit meals portion size and quantities of food eaten		
Skip entire days without eating		
Sell household assets (radio, furniture, refrigerators, television, jewellery etc.)		
Sell productive assets or means of transportation		
Withdraw children from school		
Send your children to work		
Borrow money		

4. Can you tell us how you have prioritised your expenditures over the last 30 days? Use proportional pilling
    - Food
    - Hygiene
    - Health care, medicines
    - Education
    - Shelter/housing
    - Purchase of productive capital or means of transportation
    - Ceremonies (e.g. burial)
    - Other, please specify
5. Looking more specifically at food, and still using proportional piling, can you tell us how you have prioritised your expenditures over the last 30 days and where those items came from?

Category	Location and name of store/vendor where they purchase item(s)
Dry Staple Foods (bulger, rice, lentils, oil etc)	
Fresh fruits and vegetables	
Fresh protein (eggs, chicken, meat etc)	
Livelihood Inputs / Materials (Agriculture)	
Livelihood inputs/materials (non-agricultural)	

6. How has your level of stress evolved since you started receiving the CVA?
    - No change
    - Increased - Why?
    - Decreased - Why?
7. Over the past 30 days, who, within your household, has made the decision regarding the following categories?

For married women:

Decision	Mainly husband	Both of us equally	Mainly me	Others
Children's education				
Marriage decisions for children				

Having more children				
General household expenses				
Food for the family				
Buying expensive household assets				
Buying medical treatment for health problems				
Buying of menstrual products				
Borrowing money/giving back money borrowed				

For unmarried women or female-headed households:

Decision	Mainly me	A male relative	A male relative and me equally	Others
Children's education				
Marriage decisions for children				
General household expenses				
Food for the family				
Buying expensive household assets				
Buying medical treatment for health problems				
Buying of menstrual products				
Borrowing money/giving back money borrowed				

8. Who usually made the decision about how to spend the CVA received?
    - Me
    - Me and my husband
    - A male relative (father, brother, uncle, etc.)
    - Me and a male relative
    - Other – please specify
9. Do you overall think that you have more decision-making power within your household because of the CVA?
    - Yes – please elaborate
    - No
10. Since you started receiving the CVA, has the level of violence in your household…?
    - Increased - Why?

- Decreased – Why?
- Remained the same - no change
- My household has never been violent
- Prefer not to answer

11. Since the beginning of the project, has the level of violence within your community…?
    - Increased - Why?
    - Decreased – Why?
    - Remained the same - no change
    - My community has never been violent
    - Prefer not to answer
12. Do you think your and your children's wellbeing has improved as a result of the CVA?
    - Yes - In what way?
    - No
13. Overall, how satisfied are you with the CVA provided? Please give a number from 0 to 10, 0 meaning not satisfied at all and 10 meaning extremely satisfied? If rating is under 5, please specify why?
14. How easy was it for you to access the CVA every month? Please give a number from 0 to 10, 0 meaning not easy at all and 10 meaning extremely easy. If rating is under 5, please specify why?
15. Would you prefer to receive cash in a different way in the future? If yes – please elaborate.