

Integrating Cash Assistance into Gender-Based Violence Case Management to Support Survivors in Ninewa, Iraq

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Acknowledgements



The **Women's Refugee Commission** (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive improvements in humanitarian practice. To learn more visit www.womensrefugeecommission.org.

Women Empowerment Organization (WEO) is an independent, non-profit organization that aims to achieve gender equality and women's fair participation and inclusion in all aspects of life in Iraq. WEO plans to do so by empowering women economically and politically, ending all forms of Gender-based Violence, and advocating for policy development and reform that addresses gender equality and the national adoption and implementation of international resolutions and conventions. WEO works to prevent and respond to Gender-based Violence in Iraq with social and psychological counselling, legal assistance, and case management and advocates to increase women's legal protection. <https://www.weoiraq.org/>

Oxfam is a global organization that fights inequality to end poverty and injustice. Oxfam offers lifesaving support in times of crisis and advocates for economic justice, gender equality, and climate action. Oxfam demands equal rights and equal treatment so that everyone can thrive, not just survive. Oxfam has been working in Iraq since the 1990's with an expanding and contracting presence. Oxfam works in partnership with local communities, governments, civil society, and private sector organizations to deliver integrated and comprehensive humanitarian, development, and advocacy activities. www.oxfam.org/en.

Acknowledgments

This case study captures programmatic and operational learning from a joint intervention led by Women Empowerment Organization (WEO) and Oxfam in Iraq that integrated cash transfers into GBV response programming in Ninewa, Iraq. WEO and Oxfam thank Iraq Humanitarian Fund (IHF) for funding the intervention discussed.

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Cover photo: Distributing dignity kits in Najat Community Center, Mosul, Nineveh. © WEO

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Background



With support from the Swiss Agency for Development and Cooperation, the Women's Refugee Commission (WRC) and CARE are leading an initiative on behalf of the Global Protection Cluster Task Team on Cash for Protection (TTC4P) to expand access among field-level practitioners to the requisite knowledge, skills, guidance, and tools to integrate cash and voucher assistance (CVA) and gender-based violence (GBV) programming in humanitarian settings.

This and other case studies focusing on CVA for GBV outcomes in the Middle East and North Africa (MENA) accompany training materials, workshops, webinars, and podcasts that document programmatic and operational learning. Altogether, these resources contribute to local, national, and global learning on integrating CVA within GBV programming, as well as improved practice by a range of humanitarian stakeholders, including humanitarian and development professionals, national government agencies, and international donors.

This case study sheds light on the experiences of Oxfam and Women Empowerment Organization (WEO) during their partnership to implement the integration of cash transfers within GBV case management in Ninewa governorate, Iraq.



Distributing services maps leaflets in Mosul East side, Nineveh.



Operational Context



The political situation in Iraq remains unstable. Years of conflict have uprooted millions of people, eroded social cohesion, disrupted access to basic services, and destroyed livelihoods, which together have led to increased protection risks, including GBV. With weak central governance, limited progress toward economic recovery and development, and increasingly exacerbated gendered consequences of climate change, the situation is protracted and millions of people across Iraq remain in need of humanitarian assistance.

Iraq is simultaneously categorized as an upper middle-income country and at “very high risk” of a humanitarian crisis.¹ During the 2014–2017 conflict against the Islamic State of Iraq and the Levant (ISIL), nearly 6 million people were displaced, and despite the fall of ISIL, Iraq remains politically uncertain, fraught with social, ethnic, and sectarian tensions. Per Iraq Humanitarian Needs Overview (HNO) 2022, needs and vulnerabilities have deepened, with some 2.5 million people currently in acute need. Displacement is ongoing for 1 million Iraqis (45 percent of whom are children, 28 percent are women, and 15 percent are people with disabilities). Many encounter barriers to return to their locations of origin; over 60% of IDPs remain in need of humanitarian assistance, 30 percent of whom face acute needs.²

As of 30 September 2021, there were 1.1 million internally displaced people (IDPs) dispersed across 18 governorates in Iraq, with 76 percent living in private settings, 15 percent in camps and 9 percent in critical shelters (out of camps). Out of the 4.9 million returnees, 51 percent live in conditions of medium or high severity, facing a lack of livelihoods, basic services, social cohesion, and security.³ The proportion of out-of-camp IDPs in acute need increased from 36 percent to 45 percent in 2020–2021, while the proportion of returnees with acute needs increased from 28 percent to 38 percent.⁴ Loss of employment, accrual of debt, and increased expenditure on food are the main drivers of this increase.

The ongoing COVID-19 pandemic has intensified humanitarian needs, increasing socioeconomic vulnerabilities, generating loss of jobs and income,⁵ and amplifying protection issues in the face of inadequate or limited access to essential services, particularly in out-of-camp and unsafe returnee locations. Access to legal and community-based support is curtailed by movement restrictions, disruption of public services and other measures to mitigate the spread of COVID-19. IDPs in camp and return settings live in unsafe conditions and have inadequate or limited access to essential services. As a result, reliance on negative coping mechanisms and psychological trauma, stress and anxiety have increased.⁶

1 OCHA, *Iraq HNO 2020 report*, <https://reliefweb.int/report/iraq/iraq-humanitarian-needs-overview-2020-november-2019-enarku>.

2 <https://reliefweb.int/report/iraq/iraq-humanitarian-needs-overview-2022-executive-summary-enarku>.

3 IOM Displacement Tracking Matrix, <http://iraqdtm.iom.int/>.

4 OCHA, *Iraq HNO 2021 report*, <https://www.humanitarianresponse.info/en/operations/iraq>.

5 Ibid.

6 Ibid.



In addition, climate change is posing additional challenges to humanitarian needs. It has negatively impacted the quality of life, especially for women and girls. For example, in a drought situation, women and girls bear the increased burden of fetching water and facilitating other basic household needs from longer distances as water resources dry up. Increasing temperatures and seasonal variability in rainfall negatively affect agriculture, which reduces household income and food availability, and amplifies livelihood insecurity.

Iraq was ranked 123rd of 160 countries in the 2020 UNDP Gender Inequality Index. In this context of gender inequality, gender-based violence (GBV) is widespread and according to Iraq HNO 2022 nearly 0.9 million people are at risk of GBV, and 341,000 are in acute need of GBV services. Prevalent forms of GBV include domestic and sexual violence, exploitation and abuse (including by security and humanitarian actors), and forced marriage, including of children. According to the GBV Sub-cluster, the number of people reached with GBV-related activities has declined since the start of the pandemic because of the lockdown and funding restrictions. Case management and psychosocial support decreased by 25 percent in March and 50 percent in April 2020. Women and girls in Iraq are at increased risk of GBV and protection risks due to gender inequality, restrictive social norms, harmful traditional practices, and unequal education opportunities. Social stigma around GBV and especially sexual violence, fear of reprisal, insufficient coverage of GBV specialized services, and lack of awareness on available services continue to hinder many survivors to access specialized services, including health care, livelihood, safe shelter and legal services.⁷

Ninawa governorate is located in northern Iraq. Its largest city and capital, Mosul, was an ISIL stronghold, spurring mass displacement during the occupation of the city and its liberation. ISIL occupation disproportionately affected women,⁸ who suffered killing, kidnapping, trafficking, forced conversion,⁹ rape and sexual violence.¹⁰ Minority women were not the only victims; Women and girls of minority and majority religious communities were forced to marry ISIL members.¹¹ As of 2020, Ninawa governorate hosted more than 56 percent of new returnees from the camp closures ordered by the government of Iraq. Camp closures caused critical livelihood insecurity that disproportionately affected women and girls as families often came to rely on coping strategies such as early marriage to pay for rent, food, and basic needs. Furthermore, women and girls continue to face movement restriction related to gender norms which are compounded by lack of legal documentation. The need for GBV response continues to increase due to the fragile living conditions of most returnees and conditions in return areas not yet adequate due to limited access to basic services.

7 <https://policy-practice.oxfam.org/resources/gender-analysis-of-the-covid-19-pandemic-in-iraq-conducted-in-kirkuk-diyala-and-621007/>.

8 Report of the Iraqi Women's Network in 2014-2016, https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/IRQ/INT_CEDAW_NGS_IRQ_25070_E.pdf.

9 Arbil Declaration Regional Women's Security Forum on Resolution UNSCR 1325 in May 2015 <https://iraqi-alamal.org/?p=2009&lang=en>.

10 Amnesty International, *Escape from Hell, torture, Sexual Slavery in Islamic State Captivity in Iraq*, first edition Dec. 2014, <https://www.amnesty.org/ar/latest/news/2014/12/iraq-yezidi-women-and-girls-face-harrowing-sexual-violence>.

11 Report of the Iraqi Women's Network in 2014-2016, https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/IRQ/INT_CEDAW_NGS_IRQ_25070_E.pdf.

Intervention



Findings from Oxfam’s COVID-19 Gender Analysis¹² conducted in July 2020 made clear the urgent need to increase awareness of GBV and protection risks and to support access to services for GBV survivors. With the support of the Iraq Humanitarian Fund, Oxfam implemented the “Najat: Prevent and Mitigate Gender-based Violence and Protection Risks during the Covid-19 Pandemic” project from July 2020 until June 2021 in partnership with several Iraqi organizations: Kurdistan Relief Association in Kirkuk; VERA in Diyala; Baghdad Women Association in Anbar; and WEO in Ninewa.

The intervention, which took place during the COVID-19 pandemic, integrated cash assistance into GBV case management with the aim of supporting GBV mitigation and response. Women and girls at risk of GBV and survivors who were enrolled in the program often became aware of services through awareness-raising sessions. GBV survivors were provided with individual psychosocial support as part of GBV case management. Many survivors who were seeking to enter GBV case management due to their vulnerability and experiences of GBV aimed to improve their situation and stated their need to receive financial support, such as cash assistance and livelihood opportunities, in order to enhance their safety or recover from violence. Survivors saw cash assistance as key to accessing services they urgently needed, for example, multi-sectoral services, legal services, health services to address critical injuries, illness, or disabilities, and to cover the costs of transportation to access these services and safe accommodation/shelter away from their abuser.

Partners conducted awareness-raising sessions in the target communities, distributed leaflets and brochures on GBV prevention and available support services, provided case management to survivors, delivered psychosocial support, and distributed kits with basic items to GBV survivors. Partners ensured referral pathways for GBV survivors were activated, accessible, and used. Cash transfers (referred to as Cash for Protection per Oxfam’s standard operation procedure [SOP]) were integrated into the intervention as part of the case management process to ensure that the most vulnerable GBV survivors had the financial means to access the assistance they needed. The implementation of the integration of cash into GBV programming was new for Oxfam in Iraq, although many GBV actors had been emphasizing the need to provide cash to GBV survivors to increase their protection. Therefore, Oxfam developed a SOP to respond survivors’ needs and shared it with their partners to support joint implementation.

Based on Oxfam’s experience of providing cash to individuals with protection needs, SOPs were developed to adapt cash to the specificities of GBV response. To ensure the protection of GBV survivors, cash transfers were systematically integrated into and tailored through a GBV case management process, and provided alongside a range of other services. Post-

12 Gender Analysis of the COVID-19 Pandemic in Iraq: Conducted in Kirkuk, Diyala and Sulaimaniyah Governorates Oxfam Policy & Practice.



distribution monitoring (PDM), which is usually conducted by Oxfam’s Monitoring Evaluation Accountability and Learning team one month after cash distribution, was removed from the SOP in order not to breach the confidentiality of GBV survivors. Rather, monitoring the use of cash transfers by GBV survivors and following up with survivors remained the responsibility of the case managers. After developing the SOPs, Oxfam trained its local partners in Iraq on cash for protection as part of Oxfam’s overall protection response and strategic programming to prevent, mitigate, and respond to protection risks. The integration of cash transfers within GBV programming was used as another tool to enhance protection of women and girls and to mitigate risks associated with prolonged displacement, promote economic recovery, and build resilience of GBV survivors.

During the Najat project, Oxfam and its four partners provided cash for protection to 342 GBV survivors across four governorates (80 survivors in Ninewa, the site of this case study, 50 survivors in Diyala, 95 survivors in Anbar, and 117 survivors in Kirkuk). Survivors disclosed one or more of the following types of GBV: sexual assault, sexual harassment, physical assault: forced marriage; denial of resources, opportunities, or services; or psychological/emotional abuse. Cash was delivered via cash in hand and used by survivors to cover medical costs (except medical operations) not fully covered by the health sector; legal assistance and legal procedure costs not already provided; rent or any cost associated with moving to safety, including to shelters; and transportation to access such services.¹³

Assessment for cash transfer referrals and risk mitigation within case action planning

To mitigate potential risks related to the provision of cash to GBV survivors, cash was included as an integrated part of case management and only for survivors for whom cash referrals were appropriate. Oxfam’s partners’ case management team, including the WEO team, assessed GBV survivors’ eligibility for cash during the case management process. Cash transfers were not default assistance for all survivors who disclosed GBV during case management. Rather, GBV case managers systematically assessed in adherence with the “survivor-centered” approach whether cash transfer referrals were appropriate for individual cases. They activated referrals only for

13 These case typologies were defined in the SOP as follows: Rape: nonconsensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object. Sexual Assault: any form of nonconsensual sexual contact that does not result in or include penetration. Examples include attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. FGM/C is an act of violence that impacts sexual organs, and as such should be classified as sexual assault. Physical Assault: an act of physical violence that is not sexual in nature. Examples include hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. Forced Marriage: the marriage of an individual against her or his will. Denial of Resources, Opportunities or Services: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded. Psychological Emotional Abuse: infliction of mental or emotional pain or injury. Examples include threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.



Distributing services map leaflets in Mosul East side, Nineveh.

cases where cash transfers were considered supportive of the survivor’s recovery by both the survivor and their case worker.

In accordance with the WEO-Oxfam agreed SOP, WEO case managers assessed if each survivor’s case had economic drivers. If the survivor’s case did have economic drivers and the survivor had no safe access to financial resources, the case manager discussed with the survivor:

- » if and how the provision of cash could support the survivor’s needs;
- » how the survivor would cope once the cash assistance ends; and
- » any risks associated with the provision of cash and ways to mitigate them, which were included in the safety plan specific to the cash transfer (for example, the delivery mechanism, the transfer value, the frequency or duration of transfers); if there was a risk that the perpetrator might control the cash, the case manager would activate a referral for in-kind assistance instead of cash.

When the case worker deemed cash transfer referral to be appropriate, the cash transfer assessment form was completed and shared with Oxfam for approval. Oxfam and WEO proceeded together to complete disbursement of the cash to the GBV survivor.

Modality and delivery mechanism

According to the SOP, cash transfer referrals were classified into three categories according to risk level: high, medium, and low. See Table 1 for a detailed categorization of cases according to risk level with the associated cash disbursement period in order to address the risk level of the case.

Table 1. Categorization of cases and timeframe for cash disbursement

Risk level	Case description	Cash disbursement
High	Survivors who require immediate support, such as urgent referral for safe accommodation/shelter, or urgent medical or psychosocial support.	Within 24–72 hours
Medium	Survivors with specific characteristics related to age, gender, health, or others that heighten their vulnerability to violence, exploitation, and neglect.	Within 5–10 days
Low	Survivors who meet the eligibility criteria but do not require immediate assistance and are not considered at heightened vulnerability.	Within 2–3 weeks

All 80 survivors in Ninewa received more than one form of assistance (multi-modal assistance) in accordance with their case action plans and cash-specific safety plans, consisting of a combination of direct cash and in-kind assistance (kits with basic items¹⁴).

¹⁴ Kits contained soap (1 pack of 6 bars), 4 sanitary pads, 3 underwear, 2 hand sanitizers, 2 toothpastes, 1 toothbrush, and 1 moisturizer.

Timing and place of cash disbursement

The timing of the cash disbursement to survivors was based on the severity of their case. See Table 2 for a breakdown of the number of cases within WEO's 80 survivors case load according to risk level. When implementing the case action plan, WEO case managers agreed with the Oxfam gender team the best time and place for the survivor to receive assistance. WEO case managers accompanied Oxfam's gender officer to disburse the agreed tailored assistance to the survivors.

Table 2. Categorization of caseload by risk level and timeframe of cash disbursement

Risk level	# of survivors	Case load %	Cash disbursement
High	20	25	Within 24–72 hours
Medium	20	25	Within 4 days
Low	40	50	Within 1–2 weeks

Medium-risk-level cases were referred to specific services that were required for case resolution and for survivors' recovery, which was closely monitored. Low-risk-level cases were supported with standard monitoring. These survivors were vulnerable due to their family socioeconomic status, age, or severity of their condition, but did not require immediate assistance.

Cash disbursement

The process for cash disbursement started with the cash-for-protection form filled out by the WEO case manager working on the case based on information collected during the case management process. The form was then sent to Oxfam's gender officer and program manager for approval. Such segregation of duties was deemed key to protect individual's eligibility to receive cash transfers from potential abuse. All documents were anonymized to ensure the survivor's confidentiality.

Once a case was validated by Oxfam, WEO's case managers contacted the survivor asking them where and when would be safe to receive cash transfer(s) (without mentioning "cash" to avoid further risks). All survivors preferred to come to WEO's women's community center, where they felt safe and comfortable, to receive assistance.

WEO's case managers introduced Oxfam's gender officer (a female staff member) to the survivor without using the survivor's name and Oxfam's gender officer transferred the cash directly to the survivor. Payments were made in small bills. The survivor signed a receipt detailing their case number but without any personal or identifying data, the amount received, and the date of receipt. To respect the privacy of GBV survivors, the Oxfam team did not have access to survivors' case files. The process paid critical attention to the prevention of sexual exploitation and abuse (PSEA), ensuring there was segregation of duties between assessment, validation, and distribution of cash assistance. All staff were trained in PSEA, protection principles, humanitarian standards, and the core elements of CVA.

Timing of disbursement was sometimes delayed due to challenges in reaching the survivor recipient, either due to COVID-19 movement restrictions, distance between the survivor's home and services, security challenges, or the survivor's availability to meet at the identified location and time.

Transfer value, frequency, and duration

The transfer value for each survivor was based on the needs of their case and ranged from US\$50 up to a maximum of US\$200 received as Iraqi dinar. The exact amount was stipulated on a case-by-case basis upon recommendation from the survivor's WEO case worker to Oxfam's gender officer and in accordance with the SOP.

The rationale for and decisions on transfer value were documented with the survivor's case number, but no identifying personal data. All 80 survivors received one-off transfers. SOPs allowed for exceptional cases to receive up to three transfers.

Activities and services alongside cash referrals

Based on each survivor's case action plan, WEO referred cases to other service providers as relevant. These included referrals for health, vocational training and livelihoods, and food distribution. Accessing sustainable livelihoods opportunities was the most pressing need for GBV survivors; however, there were only limited options. This reality stresses the importance of addressing survivors' needs by addressing gaps in service delivery as this is critical to prevent further exposure to and incidents of violence. It is worth noting that GBV survivors who were eligible for cash referrals often required cash transfers to help them access services that were available but located far from their rural homes.

Monitoring

Considering the sensitivity of GBV, and to avoid breaching confidentiality, Oxfam and its partners chose to not conduct post-distribution-mechanism (PDM) as usually carried out for cash assistance by Oxfam's Monitoring Evaluation Accountability and Learning team. WEO case managers followed up with GBV survivors who received cash assistance as part of the case management process. During follow-up, the case managers assessed if the issue that originated the provision of cash had been addressed, if the other protection services had been provided, and if there was any risk emerging as a result of the provision of cash. The case manager also monitored the use of cash and continuously assessed the survivor's safety.



Distributing dignity kits in Najat Community Center, Mosul, Nineveh.

Findings



“I solved half of my problem by receiving the cash.”

– GBV survivor in Ninewa

As PDM data was not collected, the following findings were reported by project staff and case managers who were responsible for monitoring the use of cash transfer to reflect on the overall caseload. They have not been quantified or qualified via an M&E system.

Cash referrals assisted supported GBV survivors to cover the cost of transportation to access referrals included in their case action plans, which was necessary due to great distances between their homes and service provision. In addition, cash referrals resulted in improvements in their emotional well-being and confidence levels. According to case workers’ review of survivor files, this experience was shared by “almost all.” In addition, approximately half of survivors reported, according to their case workers, that they felt safe, happy, and were more emotionally stable, especially those who were able to continue paying the rent for their accommodation. Many survivors expressed to their case worker their concerns about the sustainability of these gains without access to livelihoods opportunities.

“I am currently safe after the sessions and paying my rent.”

– Widowed GBV survivor in Ninewa who was able to continue renting the accommodation she was living in away from her abusive brother

“I bought a hearing aid, and I can hear well now. I bought food and clothes for my children and paid my debts as well.”

- GBV survivor living with disabilities who was, prior to receipt and use of a cash transfer, verbally abused by her family because of her difficulty hearing



Lessons Learned and Recommendations



These programmatic and operational lessons learned, with corresponding recommendations, are drawn from the experiences and analysis of staff who led the project and partnership, as captured during several lessons learned-focused discussions facilitated by WRC.

Programmatic

Lessons learned	Recommendations
<p>Delivery mechanism</p> <p>Cash in hand was feasible and appropriate for survivors. Cash in hand was considered safe; other delivery mechanisms would have required survivors to travel long distances and incur transportation costs.</p>	<p>Continue to deliver cash assistance to survivors via cash in hand in this context, but ensure ongoing situational analysis to ensure safety, access, and inclusion.</p>
<p>Transfer value</p> <p>The largest transfer value in the SOP was US\$200 per survivor. However, some survivors' needs exceeded this amount. In addition to individual needs, the distance to and coverage of services in a survivor's given community differed widely, influencing not only the cost to access goods and services specifically, but also the cost of transportation.</p>	<p>Include protection goods and services and associated costs in market assessments to inform adequate and appropriate transfer values and, more broadly, SOPs that are context appropriate. This would also be helpful for inclusion/exclusion criteria and ensuring that assistance is delivered systematically and in adherence with humanitarian principles.</p> <p>In addition, increase the range of transfer values allowable for more flexibility and thus better meeting the variable and individual needs of GBV survivors; \$50–\$500 may be appropriate in Ninewa.</p>
<p>Transfer frequency and duration</p> <p>SOPs allowed for exceptional cases to receive up to three transfers. However, because the project duration was so short it was challenging to implement this procedure when appropriate.</p>	<p>Increase the duration to cover a minimum of three months and proactively research longer-term project durations (ideally longer than 6 months) to provide appropriate support for individual survivors' needs.</p>
<p>Referrals</p> <p>Survivors were able to access a variety of referral pathways to address comprehensive needs in a timely manner.</p>	<p>Continue strengthening referral pathways. They are already well organized and coordinated in Ninewa but can continue to be fine-tuned. Close collaboration between partners is key to quality care, achieving program goals, and achieving survivors' own goals for their recovery.</p>



Operational

Lessons learned	Recommendations
<p>Using existing best practice resources and adapting them for context</p> <p>While Oxfam adapted its organizational cash for protection resources, which draw on organizational best practice, field staff with both Oxfam and its partners were not familiar with global best practice guidance and tools that could have helped address “sticky” areas such as M&E of cash transfers to survivors (as compared with other cash recipients) and enabled Oxfam and WEO to include PDMs in the SOPs.</p>	<p>Use existing resources (including guidance, tools, training materials) and adapt them for context in addition to organizational best practices and guidance.</p> <p>Global rollout of existing resources needs to continue to raise awareness with field-based practitioners and ensure that these staff, already spread thin, are not reinventing the wheel and opportunities to contribute to building global evidence are missed. This requires dedicated resourcing.</p>
<p>SOPs</p> <p>Many lessons learned focus on SOPs:</p> <ul style="list-style-type: none"> » As case workers started to use the SOPs with survivors, they found that cash referrals were appropriate for some survivors who fell outside of the eligibility criteria. » In order to deliver cash disbursements on time, it is key that finance staff and staff in other, relevant “program support” functions, are able to process payments within the timeframe without bottle necks and in parallel to multi-purpose cash transfers, which have different parameters. » The anti-fraud and auditing requirements finance staff need to follow to be in compliance with donors can be at odds with a survivor-centered approach. 	<ul style="list-style-type: none"> » Develop the SOPs in close collaboration with CVA and GBV specialists based on situational analysis and pilot followed by fine tuning accountability, quality of care, effectiveness, and efficiency. A longer program duration allows for the opportunity to pilot and update SOPs as needed. » Detailed discussions among GBV and CVA specialists and finance staff and other program support functions should take place during the SOP development to identify where, how, and when usual ways of working may be at odds with a survivor-centered approach and problem solving reflected in the SOPs. » So as to not “reinvent the wheel,” work toward harmonized SOPs across service providers in the same operational context so that many donors and providers can uphold, institutionalize, and scale with efficiency. Such efforts should not overlook how costs and concentration and/or quality of services may differ across sites. » Reflect comprehensive referral pathways in addition to CVA within the SOPs to comprehensively meet survivors’ needs. » SOPs should be backed up by appropriate resources, including gender parity in hiring practices.
<p>Case identification</p> <p>As a new approach, case workers had some difficulty applying the SOPs with survivors at first. Case workers can benefit from coaching when the SOPs are first being used in practice, beyond a single SOP training.</p>	<p>Build coaching into the project work plan and resourcing.</p>

Lessons learned	Recommendations
<p>Case identification and follow-up during the COVID-19 pandemic</p> <p>Due to the increasing rate of COVID-19 infections during the project period, adaptations were required to the case identification, cash distribution, and follow-up steps of the process to protect the health and safety of survivors and of Oxfam and WEO staff. Survivors’ communities faced varying degrees of infection rates and lockdowns. Access issues included communication via phone with survivors by case workers, as many survivors did not have their own phones; finding suitable times and places for survivors to meet confidentially with their case worker; and the general security environment.</p>	<p>Prepare for future waves of infection to be able to adapt and pivot quickly to continue programming building on adaptations to date, including:</p> <p>Case workers conducted door-to-door activities such as awareness raising and information dissemination about resources available at the community center (not referring to GBV) while other activities such as sewing and psychosocial support activities, including meditation sessions, took place in the community center. Survivors texting their case workers “all clear” or similar messages to confirm it was a safe time for follow-up discussions over the phone.</p>
<p>Confidentiality and risk management</p> <p>Several challenges were faced when aiming to uphold confidentiality of GBV survivors:</p> <ul style="list-style-type: none"> » Due to connectivity issues and the short response time for CVA referrals for high-risk survivors, sometimes case workers conducted door-to-door case intake or follow-up when a survivor came to collect their cash transfer. Door-to-door visits took place only after prior, confidential communication between survivors and case workers about the date, time, and location that was suitable and safe for the survivor. In each of these occurrences, case workers ensured that that the perpetrator of violence was not in the home at the time of the visit. » In addition, they took care to avoid being noticed by neighbors and, if needed, pretended to carry out another type of service delivery. » Due to concerns about how to navigate PDMs with survivors about cash transfers, partners decided to not carry out PDMs, which undercut an opportunity to learn more about the results of the cash referral for survivors in their recovery. 	<p>Strengthen the segregation of duties further to ensure confidentiality and PSEA prevention so that the survivor only interacts with their case worker.</p> <p>The survivor should be informed to keep the confidentiality of details related to payment and case detail.</p> <p>Achieve gender parity among staff, including during disbursement of cash to be delivered through case workers.</p> <p>Ethical PDMs with GBV survivors are possible. See best practice guidance and tools.¹⁵</p>

15 Women’s Refugee Commission, *Resources for Mainstreaming Gender-Based Violence (GBV) Considerations in Cash and Voucher Assistance (CVA) and Utilizing CVA in GBV Prevention and Response*. womensrefugeecommission.org/research-resources/mainstreaming-gender-based-violence-considerations-cash-voucher-assistance. See also <https://oxfamilibrary.openrepository.com/bitstream/handle/10546/620602/rr-gender-profile-iraq-131218-en.pdf>.



Lessons learned	Recommendations
<p>Post-distribution monitoring</p> <p>It is critical and possible to carry out PDMs with survivors for CVA referrals. As GBV case workers have followed up with survivors on receipt and use of in-kind assistance, they can also follow up on receipt and use of cash referrals. This creates opportunities for efficiencies when survivors are receiving multi-modal assistance. It also ensures that only qualified case workers have access to survivors' data. Only data that has identifying information removed needs to be shared with non-case worker staff, and then, only when absolutely necessary.</p>	<p>Wherever possible, conduct follow-up in person in a safe and confidential location, rather than over the phone.</p> <p>Adapt global best practice tools for context.</p> <p>PDMs and other follow-up tools that track the progress of survivors' cases should have identifying information removed (for example, coded) and can be referenced by Oxfam's gender officer and WEO's case workers to understand the case progress.</p> <p>Ensure that local organizations, including those delivering GBV services, have time and resources to build a strong Monitoring Evaluation Accountability and Learning (MEAL) unit.</p> <p>Fund and implement longer-duration projects that integrate CVA and GBV response as an enabling factor for developing and implementing adequate M&E systems, including carry out PDMs, especially with survivors who receive multiple transfers.</p>
<p>Exit strategy</p> <p>To ensure that CVA referrals do not expose GBV survivors to further harm, it is essential to facilitate not only CVA referrals, but also safe, gender-responsive (if not gender-transformative) livelihoods referrals so survivors are able to achieve self-reliance.</p>	<p>A longer-term project duration can support more comprehensive support to survivors. In addition, while one case worker to 20 survivors is considered a benchmark for the delivery of quality care, organizations may consider an even smaller case load per case worker to enable proper follow-up.</p>

Next Steps



Oxfam and WEO will take forward the integration of CVA into GBV case management.

WEO will:

- » Systematically integrate CVA into its GBV programming either through implementation of the GBV program component and the cash referrals through partnerships or by building internal capacity on CVA delivery to deliver both programming components “in house.”
- » Continue to develop and/or strengthen SOPs based on lessons learned, including broader eligibility criteria, and strengthen case intake assessment.
- » Focus on monitoring and evaluation to build internal capacity and to contribute to strengthening the national, regional, and global evidence base.
- » Replicate and scale successful approaches ensuring that resources are appropriate to sustain good practices (including standard ratios of case worker to number of survivors and for geographic spread of caseloads). WEO’s current maximum capacity given current resources is 100 survivors, but with a few more staff could reach 300.

Oxfam will:

- » Continue to partner with local organizations to implement CVA-integrated programming.
- » Strengthen its tools based on lessons learned and existing resources, including the **CVA and GBV Compendium** and the **WRC-Mercy Corps-IRC CVA and GBV toolkit**, to facilitate stronger M&E.
- » Continue to emphasize PSEA prevention and risk mitigation training for its staff and its partners’ staff.
- » Share lessons learned from piloting, replicating, and scaling successful approaches, including to Oxfam teams across the MENA region.
- » Continue to engage in local, national, regional, and global coordination on CVA for GBV survivors.

Localization

The following recommendations from WEO and Oxfam offer opportunities to strengthen localization of CVA-integrated GBV response in Iraq.

- » Ensure that partnership assessments between local and international organizations include self-assessments and partner assessments so that training opportunities can be mutually identified and carried out to reinforce respective knowledge, skills, and attitudes; training should not be provided only once, but ongoing across the life cycle of a partnership and the program cycle.



- » Ensure that local partners' SOPs are appropriately and equitably resourced in project budgets so local organizations can not only be effective but also be prepared to scale successful approaches and increasingly lead projects in the future.
- » Donors should fund local organizations directly that have a track record of CVA-integrated GBV. INGOs that already have cash for protection specialization can perform the role of "coach" to train and accompany local partners in cash for protection, including development of SOPs, M&E systems, and documentation of successful approaches and best practices for CVA and GBV programming (separately and integrated) so local partners can fully implement CVA-integrated GBV response after "pilots."
- » Engage local partners from the beginning in the proposal and assessment phases, not only as implementers, and provide regular support.
- » When multiple local partners are part of a consortium and may be implementing programming in different and distances target sites, bring colleagues together on a regular basis across the project cycle so local partners can learn from each other's experiences (nuances, similarities, and differences), and have networking opportunities.
- » Strengthen the frequency of coordination efforts as well as participation of local organizations in the GBV and Cash Working Group Task Force to:
 - ◇ collaboratively develop a harmonized SOP that draws on best practice guidance and regional expertise (from the Task Force in Syria) and tackles division of roles and responsibilities, maintenance of survivors' confidentiality during the referral process, etc.;
 - ◇ secure resources to provide training and coaching to local organizations to complement their existing expertise so they can lead responses;
 - ◇ advocate with donors and INGOs on the dynamics of international and local organizations vis-à-vis donor fraud requirements that de-center local organizations and create dialogue as to how to address donors' and local organizations' concerns;
 - ◇ strengthen M&E capacity and CVA benefits analysis as well as risk mitigation knowledge and skills among practitioners;
 - ◇ advocate with donors to regularly consider and support CVA referrals within GBV response and stress that phased funding to the same partners in the same geographic site(s) can support deepening of partnerships, capacities, and elevation of local organizations; and
 - ◇ create opportunities for service providers to share their experiences.

Conclusion



The integration of CVA referrals into GBV case management and the coordinated delivery of CVA to GBV survivors, when appropriate, is lifesaving and enhances the safety and resilience of GBV survivors. It can support their access to legal services, psychosocial support, and medical treatment to help in their recovery from violence.

Stakeholders working in and funding work in this context should systematically take forward the integration of CVA within GBV response programming and tailor assistance as appropriate for specific survivors' cases.

Iraq's strong local organizations, as demonstrated in this case study and through Oxfam's experience with its other local partners, are ready to engage in the localization of integrated CVA-GBV response in this setting. The integration of cash into GBV case management can provide immediate support and enable lifesaving access to resources for GBV survivors, such as access to critical legal, health, and mental health services. The integration of cash assistance into GBV case management can support survivors in their recovery and contribute to their resilience and strengthen protection outcomes.



Acronyms and Abbreviations



CVA	Cash and voucher assistance
GBV	Gender-based violence
HNO	Humanitarian Needs Overview
IDPs	Internally displaced people
ISIL	Islamic State of Iraq and the Levant
MENA	Middle East and North Africa
PDM	Post-distribution monitoring
PSEA	Prevention of sexual exploitation and abuse
SOP	Standard operating procedure
WEO	Women Empowerment Organization
WRC	Women's Refugee Commission



