



## Lebanon: Cash Transfers for Sexual Reproductive Health and Rights (SRHR) within Protection

### Programming

<b>LOCATION</b>	Lebanon (Beirut)
<b>MODALITY &amp; SRHR OUTCOME</b>	Unconditional cash transfers (UCTs) SRH services
<b>TIMELINE</b>	September – December 2020
<b>TARGET POPULATION</b>	Women self-identifying as in need of SRH goods and services
<b>TRANSFER AMOUNT</b>	One-time, 103 USD
<b>MONITORING</b>	Post-distribution monitoring (PDM)
<b>DELIVERY MECHANISMS</b>	Cash-in-envelope
<b>REACH</b>	152 women

## Background

*This study is part of a larger multi-country study by CARE entitled “Cash and Voucher Assistance for Sexual Reproductive Health and Rights Outcomes: Learnings from Colombia, Ecuador, Lebanon and Somalia.”*

On August 4, 2020, an explosion in the port of Beirut left hundreds killed and thousands injured, damaged numerous neighborhoods – including hospitals and residential buildings – and left 300,000 people homeless.<sup>1</sup> The economic, social, and psychological tolls of the blast were added to an already strained population suffering from an economic crisis and the impacts of COVID-19. The Lebanese Red Cross reported in a post-blast study<sup>2</sup> that, of those surveyed, approximately 5% of respondents reported having family members who were pregnant or lactating and, of those households, 40% reported needing Maternal Child Health (MCH) services. A UNFPA report identified a decrease in SRH service availability due to facilities destroyed or damaged in the blast.<sup>3</sup>

Prior to the blast, the Interagency Sexual and Gender-based Violence (SGBV) Task Force conducted an assessment with 562 women and girls across the country on the SGBV impact since the beginning of COVID-19. This assessment found that 51% of respondents felt less safe in their communities and only 30% reported accessing health services.<sup>4</sup> Sixty-seven percent of respondents reported that the main barrier to accessing services was lack of money.<sup>5</sup>

## Program Design

CARE Lebanon’s post-blast Rapid Gender Analysis (RGA) recommended increasing access to SRH services for women and adolescents, while providing information on available services.<sup>6,7</sup> Recognizing the increased risks for Gender-Based Violence (GBV) and increased barriers to accessing SRH services related to COVID-19 exacerbated by the explosion,

CARE Lebanon identified the opportunity to use UCTs to enable better access to SRHR.

### IDENTIFYING NEEDS

CARE Lebanon is an active member of the GBV working group and coordinates closely with the health cluster. The NGO recognized that the majority of protection actors were focused on case management, but that there was a gap in the integration of SRH services. Access to these services seemed to be especially difficult given increased financial barriers after the blast. Responding to this gap, CARE Lebanon developed a pilot to offer one-time cash transfers with the support from the Sall Family Foundation to meet immediate SRHR needs among 152 women in post-blast Beirut.

In addition to the aforementioned analysis, the CARE Lebanon team applied the **Minimum Economic Recovery Standards (MERS)** benchmarking tool to ensure that the response took into consideration a holistic market in crisis approach due to the nature of the humanitarian crisis arising from the blast. Other steps included a brief market assessment on the costs of goods and services in the affected areas. Few organizations were focusing on standalone SRHR, rather it was part of GBV or protection programming. As a result, CARE had to do preliminary assessments. Newly adopted SOPs were used for

#### KEY PROJECT DATA:

- 327 cases assessed
- 152 women reached
- 62% head of household
- 66% Lebanese, 31% Syrian, 2% Palestinian, and 1% Ethiopian
- Age ranges: 3% >18 years, 36% 19-39 years, 39% 40-59, and 22% 60+

1 World Health Organization (WHO). (2020). **Lebanon Emergency Appeal 2020**.

2 IOM. (2020). **Multi-Sectoral Needs Assessment (MSNA)**.

3 UNFPA. (2020). **Primary Health Care Centers Assessment. Summary Findings. Post Beirut Explosion**.

4 Interagency SGBV Taskforce Lebanon. (2020). **Impact of COVID-19 on the SGBV Situation in Lebanon**.

5 Ibid.

6 UNFPA. (2020). **Primary Health Care Centers Assessment. Summary Findings. Post Beirut Explosion**.

7 CARE. (2020). **A Rapid Gender Analysis of the August 2020 Beirut Port Explosion: An Intersectional Examination**.

the intervention and the program monitoring framework for the blast response included this programming.

### TARGETING PARTICIPANTS

Participants were referred from several CARE Lebanon programs. The referrals came mainly through CARE's helpline, other partner organizations in country, and word of mouth. The helpline number was put on Facebook and CARE social workers also helped spread the information on how assistance could be received.

The baseline assessment conducted a vulnerability analysis for 327 potential participants, using scoring criteria outlined below. Scores ranged from 5 to 24, with an average of 13. Based on discussion with the team members, and taking into consideration the average sample score, any beneficiary with a score of 12 or above was considered eligible for the cash transfer. A total of 152 participants were selected.

### TRANSFER VALUES AND MECHANISMS

Each participant received 400,000 Lebanese Pound (LBP) (103 USD).<sup>8</sup> The transfer value was selected based on standards of practice by the SGBV Working Group. The CARE team also considered the fact that the average SRHR consultation cost was 100,000 LBP. With this information in mind, the transfer rate was set assuming that a recipient



may need at least one consultation, funds for transport, and follow-up consultations or goods.

Direct cash transfers through cash-in-hand were selected as the modality and mechanism. This was done to ensure inclusion of participants without bank accounts and to avoid reliance on the limited banking hours during COVID-19 lockdowns. Two delivery mechanisms were used for the cash transfers:

- On-site, in community centers (CARE's Social Development Centers and centers of partner Abaad)

#### SCORING CRITERIA:

- Age >40 or <18 (2 points), if <40 and >18 (1 point)
- Head of household (4 points)
- Pregnant or lactating (4 points)
- In danger/at risk of GBV level high (4 points), medium (1 point), low (0 points)
- Participant needs money for CMR, HIV/STI testing and treatment, clean and safe delivery-related services, antenatal or postnatal care, child healthcare, medical counselling, gynecology-related services (4 points)
- Cost of service (don't know (1 point), <100,000 LBP (1point), 100,000-200,000 LBP (2 points), 201,000-300,000 LBP (3 points), 301,000-400,000 (4 points), >401,000 LBP (5 points))
- Any safety concerns or physical barriers to accessing services (2 points)
- Men in household oversee the medical expenses and/or gender/social norms are a barrier to access SRH services (1 point)

- Door-to-door distribution for vulnerable individuals unable to reach on-site distribution

The actual delivery mechanism was selected by the participant to ensure confidentiality and safety. Participants were also allowed to send a representative to collect the transfer if preferred. Transfers were distributed by three female CARE staff (Program Officer, Cash Officer, and Outreach Worker) at the Social Development Centers or door-to-door at participants' home. Only 5% of the participants (seven people) chose the door-to-door option.

For the distributions at the Social Development Centers, CARE adapted its approaches to adhere with all precautionary measures to prevent the spread of COVID-19. The distribution consisted of four checkpoints:

- **CHECKPOINT 1:** At arrival, participants were asked to sanitize their hands before entering.
- **CHECKPOINT 2:** Awareness and information sessions on SRHR topics were conducted by volunteers or social workers for groups of eight women before they received the transfer.
- **CHECKPOINT 3:** Each participant received the cash transfer in a private room after their names were collected and copies of their identification were obtained.
- **CHECKPOINT 4:** CARE ran a help desk where individuals were welcome to stop for additional questions or information about other projects or services, including GBV and SRH services, prevention of sexual exploitation and abuse (PSEA), COVID-19 risk mitigation measures, and helpline numbers. The help desk also provided suggestion boxes for feedback and/or complaints (including PSEA complaints) and referrals to the midwife for additional information. The help desk was staffed by one dedicated CARE team member with full knowledge of the services provided internally and externally within the area of coverage. The help desk also ensured that beneficiaries on-site respected the precautionary measures for COVID-19. The help desk was set up so that individuals could not leave the Center without passing it, although it was not required that they stop at it.

Social Development Centers also had midwives who offered awareness sessions and information on locally available SRH services.

## Outcomes

A PDM survey was conducted with a representative sample of 116 participants (76%) within two to four weeks of receiving their cash transfer. The PDM survey included questions about overall satisfaction with the distribution process, the amount of money collected, and general questions about safety/ security and how the cash was utilized.

### DECISION-MAKING

Nearly half (48%) of respondents said that men oversee medical expenses in the home, and 3% stated that they independently make these decisions. When asked if they usually need permission to buy personal supplies or access SRH services, 26% of the women said yes. Of the 37% of participants who reported that they had previously borrowed money for SRH services, 61% said that they independently make the decision and 31% said they make the decision jointly with their husbands.

### TRAVEL TIME TO RETRIEVE TRANSFER

Half (50%) of respondents walked to the distribution site, 37% traveled by taxi, 8% traveled by private car, and 5% traveled by bus. For those who needed more than 25 minutes to arrive to site, the majority travelled by taxi (66%), bus (17%), or private car (17%). The time to reach the distribution site ranged from 0 and 90 minutes; the average of 17 minutes.

### SPENDING

The participants were asked to report how they spent their cash transfers, with the option to select more than one response. Sixty-four percent of respondents spent the

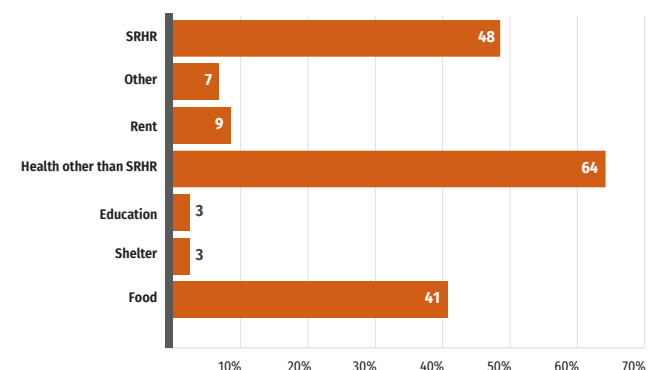
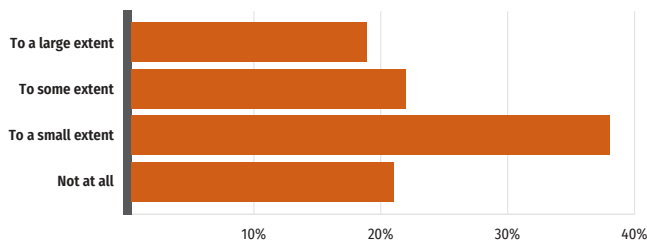


FIGURE 1: WAYS IN WHICH CASH TRANSFERS WERE UTILIZED



**FIGURE 2: INFLUENCE OF TRANSFER ON ACCESS TO SRHR SERVICES**

transfer on health services other than SRH; 48% on SRH services; 41% on food; and 9% on rent.

Forty-nine percent of respondents said that the SRH services cost them between 100,000-300,000 LBP; 23% spent more than 300,000 LBP; and 28% spent less than 100,000 LBP per month. Overall, respondents reported these services costing between 25% and 100% of the total amount of the transfer.

Nineteen percent of respondents reported that the funds helped them access SRH services to “a large extent” and 21% said the funds helped them cover other priority needs to “a large extent.” Importantly, 86% reported worrying about not being able to provide for their families’ the daily life necessities; this may help explain why transfers were spent on priorities other than SRHR.

## DISTRIBUTION

In the PDM, all participants reported that the distribution process made them feel safe, secure, and protected. All participants said that they thought the process was well organized and that they were satisfied with the process. Importantly, 79% said the funds did not cause conflict in the home. In two of the three sites, SRHR awareness raising sessions were held for approximately 15 minutes during distribution. The topics included CARE’s programs and different SRHR topics (e.g. Antenatal care (ANC), newborn care, healthy timing and spacing of pregnancies, and menopause).

## Facilitating Factors

There were a number of facilitating factors that enabled a rapid pilot to occur under difficult circumstances. First, although the CARE team had many new staff, they were well organized and committed. Existing CARE programs enabled CARE staff to identify appropriate women for referrals, and the CARE helpline and scoring system assisted in ensuring that the selected women reflected those in greatest need

of support. In addition, the team was able to implement a very flexible program, offering options of both distribution door-to-door (at home) or through the Social Development Centers, as well as offering participants the option of sending a representative. The flexibility allowed for a quick modification in delivery to ensure teams transferring funds were female staff.

## Challenges

Many challenges reflected in the enormous stressors facing Beirut at large impacted the project--the repercussions from the explosion on the health and wellbeing of communities, the economy, housing, and infrastructure coupled with lockdowns due to COVID-19. These factors led to delays in project start-up and put staff under considerable pressure to deliver a pilot against competing priorities. Moreover, many of the staff were new to CARE and had to find the time to work together, become familiar with CARE and the pilot, and develop new tools and program materials. In addition, with the frequently changing strength of the LBP, it was difficult to select a reliable transfer value. Finally, although the CARE-supported Social Development Centers were selected as a venue for distribution because women were already attending programs there, there was confusion as to exactly where the funds were being distributed in the building. There was not enough space to offer SRHR information sessions for all sites and this was further exacerbated by COVID-19 gathering limitations. Staff also expressed concerns about the lack of privacy when delivering the funds to each participant.

## Lessons Learned

Unrestricted cash transfers may be used for other unmet needs. The cash transfers were not spent on SRHR by nearly half the recipients – meaning that SRHR was either not a priority for some recipients, there were other competing priorities, or recipients were not well-targeted. In terms of priorities, it is likely that the economic situation for vulnerable communities in Lebanon deteriorated so significantly that many felt they had to prioritize family needs like shelter and food over SRHR. Gender and social norms contribute to nearly half of the recipients reporting men as decision-makers on health-seeking although, in all cases possible, CARE sought provide cash transfers directly to women including, in some cases, doing so without the

knowledge of the recipients' families due to safety concerns.

Scoring criteria can account for both protection and SRHR needs. In terms of targeting, it is worth noting that the scoring criteria considered integrated protection and SRHR needs, rather than SRHR needs alone, to facilitate meeting holistic needs of recipients. CARE staff suggested exploring other avenues, such as obtaining referrals from health providers for patients who would be more certain of facing financial barriers to meeting SRH needs. However, staff preferred to give UCTs that allowed the participants to prioritize their own needs.

CVA recipients may benefit from complementary services, such as information sessions, that address norms. It was also noted that women receiving cash transfers would benefit from longer and more frequent SRHR information and education sessions (complemented by dialogue sessions for addressing gender and social norms that hinder access to SRH), including referrals for specific services during distribution. During the SRHR information sessions provided prior to distribution, CARE staff noticed that the majority of women had never visited a gynecologist or midwife, either due to a lack of awareness or the means to do so. Although most married pregnant women in Lebanon do have a gynecologist, stigma and gender/social norms hinder access to care for other groups (such as unmarried and younger women and adolescents). Overall, a key takeaway of this pilot is that although SRHR had been identified as a major need prior to COVID-19 and then further exacerbated by the

port blast, it is critical to support ongoing engagement not only on SRHR awareness but also on addressing gender and social norms for more equal decision-making on household expenditures for meeting SRH needs when resources are limited.

Recipients may experience unanticipated costs that should be accounted for in cash transfers. The PDM highlighted that there were unexpected costs for women in receiving the funds, including transport costs if taking a bus or taxi, and time lost to collect the funds. This could have been averted by including the question in the needs assessment

Adaptability is key in meeting needs in complex environments. Although a partner was originally selected to refer participants in the program, the effort required to build that collaboration was not possible within the project timeframe. Instead, CARE's ongoing programming allowed for the targeted number of referrals, which worked well and demonstrated CARE's own referral mechanism through its helpline and coordinating capacity. During the beginning of the distribution, some women receiving the cash transfer felt discomfort in receiving funds from mixed gender teams; distribution was quickly revised to ensure that all CARE teams conducting distribution were women. Because of the multiple layers of crises and the complexity of the Beirut blast response, it was difficult to confirm if the targeted participants were receiving other support and if they were what it was.

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