Evaluation of UNFPA's Provision of Dignity Kits in Humanitarian and Post-Crisis Settings

Client:
United Nations Populations Fund

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TABLE OF CONTENTS

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Evaluation of UNFPA's Provision of Dignity Kits in Humanitarian and Post-Crisis Settings was produced to guide UNFPA's future provision of the dignity kit intervention in emergencies.

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LIST OF ACRONYMS

ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
CERF	Central Emergency Response Fund
CPRA	Child Protection Rapid Assessment
CO	Country Office
EF	Emergency Response Fund
FGD	Focus Group Discussion
GBV	Gender Based Violence
HQ	Headquarters
HRB	Humanitarian Response Branch
HRU	Humanitarian Response Unit
ICPD	International Conference on Population and Development
IDP	Internally Displaced Person
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
KII	Key Informant Interview
MISP	Minimal Initial Service Package
OCHA	Office for the Coordination of Humanitarian Affairs
PLWHA	People Living with HIV/AIDS
RH	Reproductive Health
SIPA	School of International and Public Affairs
TOR	Terms of Reference
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene

EXECUTIVE SUMMARY

In early 2000 the United Nations Fund for Population identified a gap in addressing women's needs in humanitarian response. As a result, the Fund began providing basic hygiene kits, but included items (such as panties and sanitary pads, where culturally appropriate) to meet the specific needs of women and girls with the purpose of facilitating their mobility and helping restore their dignity during times of crisis. These kits were branded 'dignity kits' and have become a significant part of UNFPA's role in humanitarian response. It has been more than a decade since UNFPA began to distribute "dignity kits," to displaced populations affected by conflict and natural disasters, and the role of dignity kits has grown organically. Though the intervention has enhanced UNFPA's presence in humanitarian emergencies, the experiences of various countries involved in the distribution of dignity kits have been captured largely anecdotally, and documentation of the diverse costs and benefits of procuring, assembling, storing and distributing dignity kits has been limited.

Project background

Observing that dignity kits have become a standard intervention for UNFPA and acknowledging that the provision of the kits comes at high financial and human resources costs to the agency, in 2010 UNFPA commissioned the first formal global assessment of dignity kits. Based on several years of experience participating in the Workshop for Development Practice from the School of International and Public Affairs at Columbia University (SIPA), UNFPA chose to enlist a team of SIPA graduate students in an assessment of the impact, costs and benefits, and the distribution challenges of dignity kits in emergency situations.

The overall objective of the assessment was twofold: to assess the usefulness and impact of UNFPA's dignity kits, and to carry out a cost/benefit analysis of UNFPA's engagement in the procurement, assembly, warehousing and distribution of the dignity kits. The team was asked to perform a 'global evaluation' including distributions in various types of emergencies, including natural disasters and armed conflict, and throughout UNFPA's five geographic regions: Asia and the Pacific, Eastern Europe and Central Asia, Latin America and the Caribbean, the Middle East and North Africa, and Sub-Saharan Africa. Within the usefulness and impact component, the team was asked to assess the process through which the contents of the kits are determined, as cultural sensitivity has been the main driver, which is reflected in the inclusion of headscarves in Muslim settings, wrap skirts in Africa, and other context specific items, which accompany the more regular hygiene items as soap, toothbrushes, toothpaste, underwear, sanitary napkins[1] and towels, among others.

Taking into consideration all of the provision components of dignity kits mentioned above, and the evolving reality of the data the team could acquire, the Columbia team found that three main areas emerged that could best house the data and structure the evaluation: impact, logistics and organizational competencies. These themes were created while closely aligning the evaluation questions to the Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) conceptual framework; the ALNAP indicator table is included at the end of this section to facilitate the visual representation of the matching ALNAP criteria and the assessment findings. The team worked closely with UNFPA staff at headquarters,

[1] Where considered culturally appropriate.

regional offices and country level to carry out the analysis and employed a mixed method, multi-phase approach which resulted in the findings and recommendations presented in this report.

Methodology

The assessment of dignity kits was carried out in four phases, starting with a desk review of the available literature on dignity kits, humanitarian interventions and logistics in emergencies, which supported the parallel development of tools used for data collection in the subsequent phases, including an online survey and semi-structured interview guides specific to stakeholder groups. The second phase included the submission and preliminary analysis of an online global survey, carrying out key informant interviews with stakeholders at Headquarters, regional level and the country level, the preparation of a focus group discussion (FGD) topic guide and extensive preparation for field research. The third phase included field visits to four case study countries –Colombia, Indonesia, Kyrgyzstan and Mozambique– selected by UNFPA as representative of four of UNFPA's five working regions, where key informant interviews (KII) with stakeholders as well as FGDs and Participatory Ranking Methodology(PRM)[2] activities with beneficiaries were performed. The following table summarizes the latest distribution of dignity kits in the case study countries; the data contained in the table provides an example of the broad variations in the intervention between countries.

Table 1 - Field Visit Details

	Colombia	Indonesia	Kyrgyzstan	Mozambique
Type of Emergency	Natural Disaster (2008 and 2010) and Internal Conflict (2008)	Natural Disaster (2010)	Internal Conflict (2010)	Natural Disaster (2010)
Amount of Money Received	2008: $90,000 2010: $86,100	$121,692	$45,000	$50,000
Number of Kits Distributed	Natural Disaster: 8,160 Internal Conflict 500	11,330	800	1,220
Target Beneficiaries	Women	Women, Pregnant Women, Post-Delivery Women, Babies	Women and Men	Women, Elderly, Disabled, Ill, Children Heads of Households

Upon return from the country visits, the SIPA team began the data analysis stage. The teams integrated findings from the literature review, 29 global survey responses, 116 KIIs, 25 FGDs, and 23 PRMs. Using a grounded theory approach and constant comparative methods, the teams allowed themes from the findings to emerge. Early on, the three themes of impact, logistics and comparative advantage emerged as relevant and were clearly informed by the ALNAP criteria. The three theme groups then met and formulated recommendations for UNFPA's provision of dignity kits in the future.

[2] See Methodology section, page 16 for further details.

Limitations

The SIPA team encountered several limitations for the assessment, many of which would have been present for any evaluation of this magnitude. The most salient were the potential selection bias due to the non-random selection of participants in KII, FGD, and field visits by UNFPA's staff at the different levels; a limited representation of the 5 working regions and the typology of emergencies; difficulty making comparisons across countries with significantly different contexts and characteristics; lack of access to external partners and suppliers which limited the extent of a comparative analysis; the limited baseline documentation of the program which required that the team rely on the anecdotal reports of stakeholders; recall bias of informants and beneficiaries; and finally, the ambiguity around the concept of dignity, which complicated the understanding of the intervention's objectives.

Findings

As previously mentioned, the team framed the findings in three thematic areas which encompass a wide spectrum of issues analyzed in this assessment of dignity kits. Within each theme challenges and opportunities are outlined, and a set of recommendations are presented for UNFPA to guide future decisions regarding the dignity kit intervention as a whole.

Organizational Competencies

The first theme is "*Organizational Competencies,"* which refers to the organizational strengths and best practices that UNFPA has in the implementation of the dignity kits intervention. Initially this section was conceptualized to address comparative advantage; however, given the lack of data from partner organizations and the vast array of costs per kit as function of their customization, the team found that they would better serve UNFPA if they focused on their strengths in humanitarian response and where they have shown to be effective. UNFPA differs from other organizations distributing non-food items in emergencies as the aid provided is customized to address the specific needs of the target population. Additionally, UNFPA has the potential to establish strong partnerships with community-based organizations and local authorities for the distribution of the kits, which serves the dual purpose of facilitating the interaction with the beneficiaries and building local capacity. Finally, UNFPA has the potential to strengthen the coordination with other UN agencies within the cluster system where activated, or under the leadership of the host government, to create synergies in the delivery of aid to the emergency affected population, avoid overlap, enhance the overall efficiency and effectiveness of the emergency response, and position itself as an advocate for the inclusion of women specific hygiene items.

UNFPA faces several challenges and opportunities regarding its core competencies for distributing dignity kits: first, the current overlapping distributions, as other organizations are delivering hygiene kits in humanitarian emergencies; the lack of clear definition of target populations; response time lags which potentially dilute the relevance of the kits upon distribution; the limited visibility of the kits as part of UNFPA's humanitarian response because of limited size of the intervention and as it may not be prioritized

by country offices (CO); and finally, findings show that dignity kits are more adequate in emergencies when they meet the needs of the target population as part of a broader integrated response.

To seize the opportunities for improvement, the team recommends that UNFPA continues strengthening the incorporation of dignity kits with other areas of UNFPA's core mandate in the dignity kits intervention by the inclusion of educational materials in the kits which address issues related to reproductive health (RH), gender based violence (GBV) and HIV prevention in the context of an emergency. Moreover, UNFPA must continue harnessing the good relationships with local government agencies and organizations to widen the space for advocacy and capacity building. In addition, UNFPA should continue strengthening coordination for the distribution of dignity kits as part of an integrated approach to humanitarian aid that allows for the fulfillment of the breadth of needs of the affected populations. Finally, we recommend that UNFPA consolidate its objectives in the area of visibility, with a cohesive policy that involves all the levels of operations.

Impact

The second area of thematic focus is "*Impact",* which for the purposes of this assessment refers to immediate outcomes obtained by the distribution of dignity kits. Given the wealth of information and the diversity of the countries analyzed, findings in impact are divided into two categories: consistent evidence of impact, mixed and limited evidence of impact, followed by opportunities and challenges

Regarding consistent impact outcomes, the kits have succeeded in fulfilling immediate hygiene needs of affected populations; in addition, the kits made female beneficiaries feel "remembered" in that kits specifically prioritized the hygiene needs of women. One beneficiary in Kyrgyzstan explained that receiving the kits made her feel "so happy I wanted to cry because people remembered us. When we had a difficult time others respected us". Dignity kits have also served the purpose of budget substitution, allowing families to purchase other important items needed in the emergency, such as food. In Indonesia women spoke of appreciating the kits in that they prevented her from having to make a decision between buying sanitary napkins for herself or food for her children.

The second category that emerged was mixed evidence of the impact. The results were inconsistent on the impact of dignity kits on beneficiaries' mobility and access to services such as food and water distributions, education and community activities. The majority of the evidence for this section comes from UNFPA staff at the global, regional and country levels. Though several high level UNFPA respondents noted that the purpose of the kits were to increase mobility, the data show limited support for this notion outside of a Muslim context. The issue of proper clothing, such as head scarves, in Muslim countries was noted as a significant factor in the impact of dignity kits in countries such as Indonesia, Sudan, Pakistan, Yemen, Syria and the Palestinian territories. However, other countries, such as Kyrgyzstan, explicitly rejected the notion that the kits contributed to their mobility.

In this same category, the use of dignity kits as an 'entry point' for other educational interventions varied across countries. Some Cos were using the intervention to introduce and begin programs surrounding issues in UNFPA's mandate, such as GBV, RH, psychosocial support and general hygiene. In some cases, largely in Latin America, the COs were quite successful at using the kits as entry point mechanisms to provide information on GBV, RH and HIV prevention. One CO staff member in Peru stated "UNFPA has a niche in gender; it's not just the kit, it's the information inside the kits". However, in several other

countries, especially in the 4 case study countries, these educational opportunities were either missed or were performed inconsistently; leaving beneficiaries asking for educational materials or trainings in UNFPA's area of expertise.

Next, gaps and opportunities for UNFPA are captured looking forward to increase the impact of the intervention. UNFPA faces challenges due to a general lack of clarity on the dignity kit intervention. Three questions became clear that would help guide the UNFPA to further clarify the scope and purpose of the intervention. These questions surround the issues of who is being served by the dignity kit interventions? Target populations have to be defined clearly for CO and implementing partners before distributions take place. The second question surrounds the notion of what dignity means both in theory and on the ground. If a purpose of the kits is to restore dignity, the term should be clearly defined or understood to help guide the intervention. Lastly, it was unclear what the primary objective of the dignity kit intervention is; the respondents from various levels within the UNFPA as well as partner agencies had varying responses.

To address these challenges, UNFPA should clearly define the primary objective of dignity kit provision and develop a theory of change in order to achieve measurable results that are sustainable for the early recovery of affected populations. In this vein, guidelines for effective needs assessments must be improved, as well as for conducting regular monitoring and evaluation activities. Consequently, as a vital priority, UNFPA must formulate and disseminate overall dignity kit distribution guidelines to standardize and advance the impact of the intervention worldwide.

Logistics

The third thematic area comprises findings related to the logistics of dignity kits provision, starting with some information about the funding of the kits, going on to the procurement phase through the distribution process, and closing with recommendations for more efficient processes. Regarding procurement, the team found that the procurement process can be burdensome for COs as they have to follow UNFPA's procurement guidelines which require thorough procedures; in this regard, COs agree on the importance of having Long Term Agreements (LTA) with suppliers, but very few are currently implemented. In general, procuring locally is strongly preferred, with the exception for when it is impossible to procure sufficient items in the local market. Regarding timeliness in procurement, there is a trade off in this aspect when it comes to the customization of the kits, as the possibility of having regionally prepositioned kits is debilitated. Finally, the team found that the average cost of kits is USD $22.18.

Regarding storage, there is mixed evidence about the cost significance of this activity, as well as in the preferences for warehousing, which can be either centralized or decentralized. Some countries do pre-position basic hygiene kits which are delivered in the first phase of the emergency, while they add the customized items for later distributions. The assembly of the kits, which is not a significant cost driver, is done through different modalities including UNFPA's own staff, local NGOs, and even CBOs; the latter is used as an opportunity to support livelihoods in the communities. Regarding transportation, costs are incurred at two points, making this phase one of the most costly of the dignity kits supply chain, which is worsened by the low availability of LTAs for transportation and the challenges in coordination with other aid providers. Finally, UNFPA COs commonly outsource the distribution of dignity kits to local partners, international NGOs and government agencies at the local level, making this phase not significantly costly; nevertheless, there are challenges in the coordination and integration of the intervention with other

provision of other types of kits and aid. There are also gaps in coverage and monitoring and evaluation of the distributions.

The SIPA team recommends that UNFPA address these challenges by the following: establish LTAs and supplier agreements; pre-position "core" hygiene items; enhance the coordination between NGO partners, UN agencies and UNFPA COs; engage in more robust monitoring and follow-up activities after the distributions; and very importantly, develop an "Emergency Procurement Plan" to facilitate the logistics of the intervention.

Conclusions

Based on the thorough analysis of the data collected and the findings described above, the SIPA team recommends a phased strategic decision process to the provision of dignity kits, rather than making the intervention a universal component of UNFPA's humanitarian response. The SIPA team recommends that thoughtful consideration be given to the position of dignity kit provision within UNFPA's overall humanitarian response strategy. At a minimum, three basic conditions should be met in order for any dignity kit intervention to be undertaken. First, dignity kits should be distributed only as part of an integrated, coordinated response. Second, the CO must be able to distribute dignity kits in a "timely" manner, as determined by the exigencies of the emergency. Third, dignity kit provision should serve as an entry point for UNFPA's broader programming on RH, GBV, HIV prevention and psychosocial support. Where dignity kit provision may not be appropriate given the absence of these conditions, the team recommends that UNFPA assume an aggressive role in advocating for the inclusion of issues related to its mandate in emergency response efforts.

ALNAP framework and research questions

Articulated throughout the report are key evaluation questions and recommendations on the provision of dignity kits, guided by the ALNAP criteria: appropriateness, coverage, connectedness, effectiveness, and impact. [3] These criteria have served as the basic framework to inform the evaluation's three main thematic areas -Organizational Competencies, Impact and Logistics- as well as the conclusions on UNFPA's provision of dignity kits in humanitarian and post-crisis settings.

Table 2. ALNAP criteria and research questions

Criteria	Key Questions[4]	Overall Findings	Recommendations
Appropriateness:	Are dignity/hygiene	➢ The majority of items	1. Conduct more systematic

[3] John Cosgrove et al. 2009. *Real-time Evaluations of Humanitarian Action – An ALNAP Guide (Pilot Version).* Action Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) Publication. As defined by ALNAP: *Appropriateness* is the tailoring of humanitarian activities to local needs, increasing ownership, accountability and cost-effectiveness accordingly; *Connectedness* refers to the need to ensure that activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account; *Coverage* is the need to reach major population groups facing life-threatening suffering wherever they are; *Effectiveness* measures the extent to which an activity achieves its purpose, or whether this can be expected to happen on the basis of the outputs. Implicit within the criterion of effectiveness is timeliness; *Impact* looks at the wider effects of the project – social, economic, technical, environmental – on individuals, gender- and age-groups, communities and institutions. Impacts can be intended and unintended, positive and negative, macro (sector) and micro (household).

[4] Reference Annex II – Terms of Reference, for key questions from UNFPA

Criteria	Key Questions[4]	Overall Findings	Recommendations
	kits responding to the needs of the affected populations? Are the contents of dignity kits appropriate and culturally sensitive?	included in dignity kits were considered useful and responded to the immediate hygiene needs of the affected population ➢ Dignity kits were not directly attributed to responding to immediate, more life-saving needs of affected population ➢ Dignity kits are tailored at the local level, most often following an informal assessment ➢ Contents of the kits are generally culturally appropriate and in line with most of the differentiated hygiene needs of affected population	needs assessment before deciding on contents of kits 2. Reduce lag time between needs assessment and kit distribution to ensure that items are contextually relevant and still meet the needs identified by beneficiaries
<u>Coverage:</u>	Who received dignity/hygiene kits, and how were beneficiaries selected?	➢ Dignity kits generally target women of reproductive age (These recipients are rarely the targets of gender-differentiated aid). However, the kits are also distributed to a variety of other groups ➢ Dignity kits are generally associated as kits that fulfill specific needs of women & girls in emergencies ➢ Beneficiaries are generally selected by community leaders, local organizations and implementing partners ➢ Kit distribution varied greatly across countries with reach falling anywhere between 25 and 60,000 kits ➢ The reach of kit provision was often restrained by limited quantities of kits – raising questions as to how /why certain women had been selected	1. Consider narrowing down target group – depending on objective of the distribution – to ensure better coverage 2. Formalize program guidelines with specific targeting criteria for distributing partners 3. Collaborate more closely with distributing partners to ensure comprehension and enforcement of target criteria 4. Coordinate distributions with other aid organizations to make reach more efficient and avoid overlap of coverage
<u>Connectedness:</u>	Did the provision of dignity kits support local capacities and market or income-	➢ Given that kits are procured locally whenever possible, the provision of dignity kits does support local markets	1. Depending on coverage and the level of customization determined for kit distribution, consider international

Criteria	Key Questions[4]	Overall Findings	Recommendations
	generating opportunities for affected communities?	to a certain extent ➢ In some cases, minimal income-generation activity resulted from the assembly of kits by local women's and youth groups (i.e. Haiti, Sierra Leone) ➢ Generally, there is little evidence to support the idea that dignity kits provide longer-term income-generating opportunities for affected communities ➢ In some circumstances, dignity kits were used as part of an integrated approach –i.e. used as an information vehicle to educate communities on issues relevant to UNFPA's mandate or were provided in conjunction with health service delivery	procurement for standard items that can be pre-positioned, especially for reoccurring emergencies 2. Establish a clear "program" theory and specify if income-generation is a core objective of kits and a necessary activity to connect short and long-term emergency response 3. Distribute dignity kits as part of an integrated response and systematically use as an 'entry point' intervention 4. Distribute kits in coordination with other agencies/organizations (through Cluster, if possible) to ensure kits are systematically delivered as part of package rather than a stand-alone intervention
<u>Effectiveness:</u>	Were dignity/hygiene kits delivered on time to serve their purpose? Was provision of dignity/hygiene kits coordinated with other agencies (Gvt, UN, NGO)? What were, for UNFPA, the financial and human costs of procuring dignity kits?	➢ The average time lapse between the needs assessment and distribution was three weeks ➢ Mixed results of COs achieving "timely"[5] delivery of kits following onset of emergency ➢ Coordination with other UN partners, NGOs, and governments varied across emergency events and with varied degrees of success ➢ The primary financial cost driver of providing dignity kits is transportation ➢ Other major costs included the opportunity cost (i.e. human resources, emergency funding, intended impact and	1. Conduct systematic needs assessment before deciding on contents of kits 2. Conduct more consistent M&E and follow-up to ensure improved logistics processes result in intended impact 3. Engage in key preparedness activities, especially in cases of reoccurring crisis (i.e pre-position "standard" items in kits) 4. Form LTA's with local/international suppliers and transportation partners 5. Streamline and disseminate

5 For further definition of "timeliness" for dignity kits provision, see Logistics section in the Findings chapter.

Criteria	Key Questions[4]	Overall Findings	Recommendations
		potential coverage) of kit provision in relation to other UNFPA programming	an Emergency Procurement Plan to all COs 6. Coordinate with existing UN agencies, international and nation NGOs, and the host government to increase logistics process efficiency
<u>Impact:</u>	Were women's hygiene needs met? Was women's dignity restored? Were women able to access other services as a result of using items in the kits?	➢ The kits generally meet women's hygiene needs ➢ The principal impact of the kits outside of meeting hygiene needs is budget substitution. Having the contents of the kits allows beneficiaries to free up money to purchase other 'essential' goods (i.e. food) in emergencies ➢ Benefits of dignity kits take on a multiplier effect because when distributed to women, items are shared and used by entire households ➢ Articulating how dignity kits restored dignity proved difficult for most informants; however, the restoration of dignity was generally operationalized as providing mobility for women or helping them feel 'remembered' ➢ There is mixed evidence on whether dignity kits help women access other services; kit provision was generally linked to access or mobility in Muslim countries ➢ In some cases (i.e. primarily in Latin America), access to additional information services is associated with the provision of dignity kits	1.Identify a primary objective for dignity kit provision and clarify targeting criteria to maximize impact on beneficiaries 2. Develop a clear theory of change and logical framework for dignity kits, in line with UNFPA's programmatic work in emergencies 3. Engage in systematic consultation with beneficiaries to clearly identify specific needs and to clarify which UNFPA intervention (kits or otherwise) will have the most impact

I. PROJECT BACKGROUND

There are over 43 million refugees and internally displaced persons (IDPs) in the world today.[6] These populations, displaced by natural disaster, violence and/or internal conflict, often flee volatile situations with nothing more than the clothes on their backs. People living under such conditions may lack necessities such as toothbrushes, underclothing, culturally appropriate dress, sanitary napkins and/or shaving kits. Lacking such essentials, displaced populations may, in addition to the loss of their homes and possessions, feel stripped more acutely of their basic human dignity. In an effort to help restore some of this dignity and assist in the maintenance of hygiene, UNFPA distributes "dignity kits"—commonly known as hygiene kits[7]—to men, women and children in countries experiencing humanitarian crises.

Since 2000, UNFPA has been providing and distributing dignity kits in emergency settings around the world. These kits were conceived of during a series of high-level discussions during the Sierra Leone and Liberia conflicts in early 2000. The Humanitarian Response Branch (HRB), in consultation with the then Geographic Divisions and Country Offices (COs), observed that none of the major international agencies in the sub-region were providing tangible, essential items that also fulfilled the basic needs of women and girls in refugee camps. This prompted UNFPA to begin procuring and distributing a small quantity of kits containing sanitary pads and other essentials, in order to encourage the mobility, comfort and dignity of women living in refugee camps.[8] Approximately 600 dignity kits were delivered as a pilot intervention to displaced Liberians seeking refuge in Ghana.

HRB's concern with the particular needs of women in refugee camps reflected a much larger evolution of UNFPA's mandate to incorporate reproductive health (RH) into its international humanitarian programs. In 1994, the International Conference on Population and Development (ICPD)—often referred to as the Cairo Conference— endorsed a new Programme of Action that "focused on meeting the needs of individual women and men rather than on achieving demographic targets."[9] This shift in population policy provided traditional development agencies like UNFPA with a platform to transition into humanitarian programming. The ICPD placed the provision of universal access to reproductive health (RH) services, including family planning, at the forefront of UNFPA's mandate (for more about UNFPA's mandate see 'Client Agency' in Annex I).

Since their inception, dignity kits have served as a tangible reflection of UNFPA's mandate to incorporate RH and women's needs more broadly into its agenda for humanitarian aid. Dignity Kits complement UNFPA's other humanitarian interventions, including the Minimum Initial Service Packages (MISP), GBV prevention and the distribution of Reproductive Health kits.[10] Furthermore, the dignity kits are now

[6] "2009 Global Trends" (United Nations High Commissioner for Refugees report, Division of Programme Support and Management, 15 June 2010), http://www.unhcr.org/4c11f0be9.html

[7] Hygiene kits and dignity kits are sometimes used interchangeably, but this is not always the case. In some instances, COs distribute both and differentiate between them by the process and extent to which local populations were consulted in the selection of the kit contents.

[8] UNFPA HRB informant, in discussion with authors, 1 December 2010.

[9] From UNFPA website, http://www.unfpa.org/public/icpd/pid/5065#intro.

[10] "Reproductive Health in Refugee Situations: An Inter-agency Field Manual" (United Nations High Commissioner for Refugees report, 1999), http://www.unfpa.org/emergencies/manual/index.htm.

covered by the CERF "life-saving" criteria - thanks to UNFPA's advocacy efforts – which means that they recognized by the humanitarian community for their life-saving benefits and can be funded through CERF. Although the intervention initially targeted only women, distribution of the kits has expanded to sometimes include men, youth and even entire households. As noted in the Terms of Reference, the provision of dignity kits often entails relatively high financial and human resource costs for an often-limited number of kits given UNFPA's financial constraints.

In 2011, UNFPA enlisted a team of ten graduate students from the SIPA at Columbia University to conduct an assessment of the benefits and costs of dignity kit provision. The SIPA team conducted a four-phase process of data collection that included engagement with, *inter alia,* UNFPA headquarters, regional and country staff, beneficiaries of dignity kit interventions, and government/NGO partners and organizations involved in humanitarian response. As part of this assessment, the SIPA team conducted field visits to Colombia, Indonesia, Kyrgyzstan and Mozambique. This report presents the team's main findings and analysis that respond to the evaluation questions spelled out in the inception report of this assessment. This document also provides recommendations for improving the effectiveness of dignity kit provision within UNFPA's broader humanitarian response mandate. These findings and recommendations will be presented to UNFPA, with the objective of informing UNFPA's internal decision-making as it relates to the provision of dignity kits globally. Please refer to Annex II for complete project Terms of Reference.

A. An Overview of Dignity Kit Provision

1. *What is a "dignity kit"?*

UNFPA has been involved in the provision of "dignity kits," also known as "hygiene kits," since the early 2000s. While hygiene kits are considered a standard humanitarian intervention outlined in the Sphere standards for humanitarian response, UNFPA recognized that standardized hygiene kits typically do not meet the specific hygiene needs of women. The idea of "dignity kits" was developed almost a decade ago to address the feminine hygiene needs of displaced women affected by conflict or natural disasters. Although dignity kits have not been established as a formal program by UNFPA and continue as a non-standardized intervention, dignity kits are nonetheless considered by many COs a regular intervention in humanitarian response. The intervention expanded organically over the years, as the kit contents and the populations served by dignity kits evolved to reflect field responders' understanding of the importance of customized local items to those affected by emergencies.

Unlike the standard hygiene kit, dignity kits contents are theoretically selected in consultation with local communities and customized to meet both the immediate hygiene needs of affected populations and facilitate women's mobility by providing them with items that women themselves prioritize for daily life. As such, dignity kits include culturally appropriate items that vary across countries and regions; examples include headscarves in Muslim countries, hair oil in West Africa, or *capulanas* in Mozambique (multi-purpose cloth used commonly throughout sub-Saharan Africa). Kit contents are also adapted according to the needs generated by the specific type of emergency; therefore, items may also vary according to distribution context. Kits also typically contain a number of standard hygiene items: the five most commonly included items are sanitary napkins, hand soap, toothbrush, toothpaste, and underwear.[11]

[11] For complete listing of kit items from global survey responses, see Annex XI.

2. Where are dignity kits provided and who do they serve?

In the decade since UNFPA first began distributing dignity kits, dignity kits have been distributed by more than 50 COs[12] spanning all five of UNFPA's global regions. Dignity kits are employed in response to both acute and protracted conflicts as well as a variety of natural disasters, including floods, earthquakes, volcano eruptions, and cold weather emergencies, just to name a few.[13]The target population for distribution has varied considerably across settings; although the most common target population has been women and girls of reproductive age, a wide range of specialized sub-groups have also been targeted for dignity kit distribution by various COs: men, adolescent boys, pregnant and lactating women, newborns, newlyweds, PLWHA, sex workers, physically handicapped individuals, and the elderly.[14] Dignity kit provision is generally a one-time single distribution of kits within a single emergency, although some COs have performed multiple rounds of distributions of kits.

The number of kits distributed per emergency also varies significantly, contingent on available funding and the costliness of kit items as well as the scale of the crises and other organizations' distribution of similar kits. Among COs who reported on their most recent dignity kit distribution, the average number of kits distributed falls around 7,500, but ranged from 200 (for a small emergency in Peru) to 100,000[15] (the latter in the case of Haiti, by far the most extensive dignity kit distribution to date). Average cost per kit according to global survey responses is generally between $10-20 USD, but ranged from as low as $3.85 in Guatemala for a small kit of only women's underwear and sanitary napkins to $89 in Peru, where the kit included winter clothing items for a cold weather emergency.

3. How are dignity kits funded?

A variety of funding mechanisms have been used for dignity kits, but the primary funding sources identified by COs are the CERF, ER, ERF, and regular CO funds,[16] described in greater detail here:

a. Central Emergency Response Fund

The Central Emergency Response Fund (CERF) is a humanitarian fund created by the UN in 2005 to provide timely funding for crisis response activities. In most situations, the CERF is the first seed funding available for humanitarian response activities undertaken by UN agencies and the International Organization for Migration (IOM). CERF funds of up to USD 500 million per year are available and are managed centrally by the Office for Coordination of Humanitarian Affairs (OCHA). The fund consists of an annual grant facility of up to USD 450 million and a loan facility of up to USD 50 million. Only interventions deemed 'life-saving' in the context of an emergency are eligible for CERF funding. The UNFPA successfully advocated for the designation of 'life-saving' criteria to the provision of dignity kits. As a result, programs to distribute dignity kits are eligible for funding under the CERF.

[12] Note: 54 COs were identified as countries who have distributed dignity kits according to an official list provided by UNFPA HQ; however, the SIPA team learned that not all of these countries have in fact distributed dignity kits, so the exact number is not known to the SIPA team

[13] For complete break-down of emergency typology from global survey responses, see Annex XI.

[14] For a complete break-down of kit target populations from global survey responses, see Annex XI.

[15] Based on global survey responses and key informant interviews.

[16] For full explanation of funding mechanisms, please see Logistics section, page 46.

b. The Emergency Fund

The Emergency Fund (EF) was established as a special fund within the UNFPA budget to provide humanitarian assistance in response to serious and immediate RH and GBV needs and to situations in which any of the following criteria apply: (a) regular country program funds are not available; (b) country program funds are not immediately available, but may become available in the future and reimbursed to the EF (with the approval of the government); (c) donor support for the UNFPA component of a Consolidated Appeal Process has been committed but funds are not yet in hand.[17]

The EF, which is a revolving fund of USD 3 million per year, is overseen by the Programme Division (HRB).[18] UNFPA COs can request funds from the EF in crisis situations involving the displacement of populations, loss of access to basic RH care, significant risk of gender-based violence (GBV) or where the basic needs of vulnerable populations are at risk.[19]

c. The Emergency Response Fund

An Emergency Response Fund (ERF) is a country-based pooled fund and an in-country funding mechanism for NGOs and UN agencies to respond to the short term emergency needs of communities suffering from humanitarian crises.[20] Overall management and oversight of the ERF is the responsibility of the Humanitarian Coordinator (HC), with day to day management and financial administration conducted by OCHA. The ERF is typically modest in size (less than USD 10 million) and ranges from small to medium-sized grants of less than USD 500,000. These grants are used primarily to fund the activities of NGOs. There are currently sixteen funds being managed by OCHA for Afghanistan, Colombia, Democratic Republic of Congo (DRC), Ethiopia, Haiti, Indonesia, Iraq, Kenya, Myanmar, Nepal, Occupied Palestinian Territory (oPt), Somalia, Sudan, Uganda, Yemen and Zimbabwe.[21]

Although our data is representative of only a snapshot of dignity kits in its entirety as an intervention, it is helpful to understand the diverse interpretation of the intervention's objectives by various COs and the extent to which dignity kits provision varies around the world.

B. Field Visits Background

In March of 2011, members of the SIPA team traveled to Colombia, Indonesia, Kyrgyzstan, and Mozambique to collect field data from UNFPA CO staff, internal and external partners, and other key informants. The team also conducted focus groups and participatory research activities with beneficiaries

[17] "2009 Emergency Fund Monitoring Report" (UNFPA report, 15 June 2010). The Consolidated Appeals Process is a tool developed by aid organizations in a country or region to raise funds for humanitarian action and to plan, implement and monitor their activities together.
[18] Ibid.
[19] Ibid.
[20] Unlike CERF funding, which is only available to UN agencies, NGOs are eligible for ERF funds.
[21] OCHA, Basic Facts about Country Base About Country Based Humanitarian Pooled Funds (February 2010); http://unocha.romenaca.org/Portals/0/Documents/20100205%20FCS%20Basic%20Facts%20for%20ERF%20and%20CHFs.v8.pdf

of the dignity kit intervention. The following provides a brief introduction to the context of the emergency, number of dignity kits distributed, and target beneficiaries in each of the countries the SIPA team visited.

- **Colombia:** There were two types of emergencies where the SIPA team collected field data from, the floods of 2008 and 2010, and the ongoing internal conflict afflicting the eastern region of the country. In December 2008, heavy flooding throughout many regions in Colombia affected over 660,000 people. In response to the emergency, CERF granted UNFPA HRB $90,000 toward distribution of dignity kits in Magdalena, Cesar, Santander, Bolivar, and Sucre with the help of local distributing partners. In total 5,160 kits were distributed to women in these areas in January 2009. In December 2010, flooding once again devastated regions of Colombia and over 10,000 families were affected. UNFPA requested $86,100 from CERF for the provision of dignity kits to more than 3,000 adolescent women, girls, pregnant women and women of childbearing age in the rural and urban areas of Sucre and Majagual, in the northern coast of the country. Colombia also has one of the largest populations of IDPs as a result of the ongoing internal conflict. In 2008, UNFPA distributed dignity kits through distributing partners to 500 displaced women in Tumaco. The funding for these dignity kits came from unused money specifically requested for dignity kit provision in 2008. (See Annex III for Colombia Country Report)

- **Indonesia:** On October 26th 2010, the Mount Merapi volcano, which is located north of Yogyakarta city in central Java, began erupting. Several eruptions occurred over the course of the following six weeks, progressively displacing an increasing number of people. UNFPA distributed over 10,000 kits to meet the hygiene needs of the women displaced. Altogether during the emergency, five different types of kits costing over $121,000 were distributed as part of the response: 3,000 basic sanitary kits, 6,750 hygiene kits, 425 pregnant woman kits, 625 post-delivery kits and 530 newborn kits. (See Annex IV for Indonesia Country Report)

- **Kyrgyzstan:** On June 10, 2010 conflict erupted between ethnic Kyrgyz and ethnic Uzbek in southern Kyrgyzstan following the contentious results of presidential elections in April. By June 13th violence in the region had subsided. In response to this humanitarian crisis and the health and hygiene needs of displaced women and families, UNFPA Kyrgyzstan received $45,000 from the EF and distributed approximately 800 hygiene kits and dignity kits to women in Osh and Djalal-Abad between mid-June and December 2010. (See Annex V for Kyrgyzstan Country Report)

- **Mozambique:** The latest provision of dignity kits occurred between November 2010 and March 2011 after the government declared a red alert in districts identified as high risk across the central provinces of Zambezia, Sofala, Tete and Manica.[22] Approximately 21,000 people were affected by the floods and UNFPA participated in the humanitarian response with the provision of 1,220 UNFPA dignity kits distributed in coordination with the cluster system and within a strong partnership with Instituto Nacional de Gestão de Calamidades (INGC)[23] and Ministerio da Mulher e Acçao Social (MMAS)[24], at different administrative levels. (See Annex VI for Mozambique Country Report).

[22] The last rollout of kits (about 90) was still to be delivered to the affected population while the SIPA team mission was in Mozambique.
[23] National Institute for Prevention and Mitigation of Disasters.
[24] Ministry of Women and Social Action.

II. METHODOLOGY

Chapter Summary

- **Description of the mixed-methods approach to assess the costs and benefits associated with UNFPA's provision of dignity kits.**
- **Research questions were drafted following the ALNAP framework for evaluating humanitarian response.**
- **Phases of research included: desk review, key informant interviews with UNFPA staff and staff from partner organizations, a global electronic survey for UNFPA COs that have distributed dignity kits, and field visits to four countries.**
- **Data analysis proceeded following a grounded theory approach, whereby all data sources were triangulated and reviewed by multiple researchers to identify significant themes that emerged from the findings.**

The ALNAP framework for evaluating humanitarian response played a key role in guiding the research questions for this evaluation.[25] ALNAP proposes five criteria for evaluating humanitarian response: appropriateness, coverage, connectedness, effectiveness and impact. Research and resource limitations specifically related to access to cost data prevented the SIPA team from fully investigating connectedness (for more on this see "Limitations"). Data that correspond to appropriateness, coverage and impact were collected through mixed methods and are presented in "Section B: Impact" of "Chapter IV: Findings." For the purposes of this evaluation, impact is defined as the *immediate* changes in quality of life experienced by beneficiaries as a result of the provision of dignity kits. These include changes in perceptions of "dignity," self-worth, agency and mobility (as measured by access to education, water and food distribution, social activities and/or income-generating capabilities). In the traditional language of causal pathways, these are considered outcomes rather than impacts. For further information on the development of this definition, please see Inception Report in Annex VII.

Data on effectiveness are presented in two sections of Chapter IV: timeliness is addressed in Section C: Logistics, and coordination in Section A: Organizational Competencies.

UNFPA tasked the SIPA team with conducting a cost-benefit analysis of UNFPA's provision of dignity kits. The team did not employ a formal cost-benefit process, but rather addressed the issue of trade-offs by drawing on elements of the ALNAP framework. Following the ALNAP criteria, appropriateness, coverage and impact were aggregated to serve as an approximation of "benefit" for the construction of an informal cost-benefit model. For the purposes of this evaluation, "costs" were considered as not only the direct costs of procurement, assembly, warehousing and distribution of dignity kits, but also the indirect human

[25] ALNAP. *Evaluating Humanitarian Action Using the OECD-DAC criteria: An ALNAP guide for humanitarian agencies.* Overseas Development Institute. March 2006.

resource costs in terms of the time and effort exerted by UNFPA CO staff involved in the provision of dignity kits. These costs fall under the ALNAP criteria of effectiveness and are presented in Section C of Chapter IV. Another "cost" considered in this model was the opportunity cost that UNFPA incurs by choosing to distribute dignity kits instead of an alternative intervention. These issues are discussed further in Section A: Organizational Competencies in Chapter IV.

A. Phases of Research

1. Desk Review and Tool Development

The research process began with a review of critical documents provided by UNFPA. Though formal documentation of the program is limited, documents included funding appeals, distribution reports, a regional report from Latin America and other miscellaneous documents related to the distribution of dignity kits. The SIPA team also reviewed SPHERE, ALNAP and UN guidelines pertaining to evaluation.

This preliminary research guided the SIPA team's tool development process. Tool development was iterative and involved extensive feedback from UNFPA and the SIPA team's faculty sponsor, Dirk Salomons, to ensure appropriateness and quality. The team prepared three main tools: a focus group discussion (FGD) guide[26], a key informant interview (KII) guide (semi-structured)[27], and a global survey (with closed and open-ended questions). The focus group guide included a participatory ranking methodology (PRM) sub-section.[28] PRM is a qualitative data collection method that elicits relative value from participants using a ranking process. Three members of the SIPA team were trained in PRM by the developer of the method; these three students then trained the team to conduct PRM in the field.

The KII guide was written to include a comprehensive set of questions covering impact, logistics and core competencies—thematic areas that were selected in consultation with UNFPA to address the research agenda. The master KII tool was then adapted to target specific categories of respondents: UNFPA HQ staff, UNFPA CO staff, implementing partners and other organizations distributing hygiene/dignity kits. Using a constant comparative approach to qualitative research, questions in the guide were adapted as needed over the course of the research process to further investigate emergent and relevant themes.

2. Key Informant Interviews and Global Survey

UNFPA provided a comprehensive list of key informants for the research project. Informants included UNFPA staff at the headquarters, regional and country level, as well as key personnel from partner agencies. In total, the SIPA team interviewed 116 people (12 UNFPA HQ personnel, 6 at the regional and sub-regional level, 44 at the country level and 54 external partner staff) primarily through Skype and phone calls as well as in person, where possible. For a complete list of participants, please see Annex X.

[26] See Annex VIII.
[27] See Annex IX.
[28] Ager et al. "Participative Ranking Methodology: A Brief Guide." Program on Forced Migration and Health, Mailman School of Public Health, Columbia Univeristy. 2010.

Concurrent with KIIs, the SIPA team designed and disseminated an electronic global survey[29] to UNFPA COs involved in the distribution of dignity kits. The survey was sent to a total of sixty countries and 32 responded, yielding a response rate of approximately 50 percent. Responses from the global survey were used to inform follow-up interviews with COs and to help identify preliminary themes for further investigation during the field work phase.

3. Field Work

The SIPA team visited four case study countries: Colombia, Indonesia, Kyrgyzstan and Mozambique. UNFPA selected the four countries based on a number of criteria, including regional diversity, recency of dignity kit provision and the capacity of the CO to host a SIPA team. At the time of writing of the inception report, the four selected countries were Georgia, Haiti, Indonesia and Mozambique. Due to security concerns in Haiti and the resettlement of IDPs in Georgia, these two countries were later replaced with Colombia and Kyrgyzstan, respectively.

Teams of two to three SIPA students visited each of the four case study countries. In-country research included KIIs, FGDs, and PRMs. KIIs were conducted with CO staff, implementing partners and other humanitarian aid agencies, including the Red Cross and Red Crescent National Societies, UNICEF, OCHA, WFP and UNHCR. Where necessary, interviews were conducted with the aid of a translator.

Each team conducted 4 to 11 FGDs in-country (25 focus group discussions in total). FGD participants were selected by distributing partners before the SIPA team arrived at the site, on the basis of having received a UNFPA dignity kit, and were comprised almost entirely of women (one FGD in Kyrgyzstan included 2 men who had received kits). As an exception to this, one FGD in Mozambique was conducted with male community members who had not been direct beneficiaries; though the FGD was conducted primarily as a courtesy to the local community, the discussion did yield some relevant findings on the broader impact of kits in the community.

FGD participants were selected by implementing partners, which presents a possibility of response bias (see Ch III. Limitations). FGDs were often held either on site at UNFPA or implementing partner offices. In some select situations, as in Colombia, for example, pre-selected sites offered limited privacy, so the SIPA team made additional efforts—with the assistance of partner organizations—to guarantee that FGDs and PRMs were held in sites that would not compromise beneficiaries' confidentiality. In all case study countries, all efforts were made to guarantee that respondents felt comfortable speaking in the site and to ensure privacy. FGDs were conducted by one member of the student team, with one to two other members acting as note-takers to ensure accurate data recording. Translators were used in all countries.

Visiting SIPA teams varied in their approach to PRM. Some teams embedded PRM activities within FGDs, while other teams conducted PRMs and FGDs separately with different groups of beneficiaries. The framing question for PRMs in all countries asked participants to collectively recall and rank—in terms of usefulness—the items in the kits that they had received. In addition, some countries asked participants to then add and rank additional items to form a hypothetical "ideal" kit. Following standard PRM data

[29] See selected results in Annex XI.

collection practices, all discussions around the ranking process were recorded, as were the final rankings. In total, the SIPA team conducted 21 PRMs with beneficiaries.

4. Data Analysis and Report Writing

Preliminary data analysis took place at the field level, as visiting teams were asked to present initial findings to the host CO. Upon return from the field, each country team presented its findings to the greater team, allowing the initiation of a process whereby country-specific findings from the case studies were reconciled with global survey responses, findings from KIIs, and then contextualized within the broader picture of UNFPA global dignity kit provision.

For analysis purposes the SIPA team divided into three thematic teams: Impact, Logistics and Organizational Competencies. These thematic areas were identified in early phases of research in consultation with UNFPA, and were selected with a specific view to facilitating the cost-benefit analysis and addressing the questions put forth in the terms of reference (see Annex II). The Organizational Competencies section was originally designated "Comparative Advantage," although with feedback from UNFPA and in view of limitations surrounding data collection on other agencies' provision of dignity kits, the title was renamed to hone in on findings specific to UNFPA. This section was intended to identify UNFPA's particular strengths and weaknesses, if any, in the provision of dignity kits, so that the cost-benefit findings (from Logistics and Impact, specifically) might be appreciated against the broader backdrop of UNFPA's role in humanitarian response.

To make the analysis as thorough and balanced as possible, each thematic team included a representative from each of the four case study countries. Thematic teams analyzed the KII, FGD and PRM transcripts and the global survey results. Primary data from FGDs and PRMs were prioritized for Impact analysis, whereas KIIs and global survey results strongly informed the development of findings for Logistics and Core Competencies. Importantly, Organizational Competencies draws upon findings from Impact and Logistics and attempts to make sense of these findings within the bigger picture of UNFPA's humanitarian response.

The SIPA team employed a grounded theory approach to data analysis. Grounded theory stresses the importance of iterative and flexible approaches to data analysis, whereby domains of data analysis are not pre-determined but are adapted to accommodate and reflect emergent themes from the data. Due to the breadth of the data, scope of the program and size of the team, this constant comparative approach led to the development of several sub-themes within each thematic area. These were presented on the basis of being both evident in the data and relevant to the larger questions put forth in the evaluation.

Recommendations were first written for each thematic section based on the findings of each thematic team. The team then came together as a whole and, using the informal cost-benefit model described above and taking into account UNFPA's "core competencies," developed overarching recommendations for UNFPA's dignity kit program.

III. LIMITATIONS

Chapter Summary

- **Ambiguity of transferring the term "dignity"**
- **Potential Selection Bias**
- **Limited Representation**
- **Limit to transferability of data due to the uniqueness of countries and events**
- **Lack of Access to External Partners and Suppliers**
- **Limited Documentation of Project**
- **External Validity**
- **Recall Bias**

The SIPA team acknowledges a number of constraints affecting the validity of research findings. Limitations of the project include:

- ***Ambiguity around the Concept of "Dignity."*** Within UNFPA, there is no uniform definition of dignity, making it difficult to elucidate what dignity means in the context of dignity kit provision. Moreover, among beneficiaries, the concept of dignity was difficult to convey as there was often no direct translation of the term; thus, proxies had to be used such as: *sense of self, sense of worth, feelings of esteem, etc*. Defining the notion of dignity thus proved to be a major challenge. Moreover, the quantification of elements that contribute to a person's sense of dignity is outside the scope of this evaluation. Instead, the SIPA team sought to assess outcomes such as access to clean water, education, food and other social activities. Further, in some country the dignity kits are referred to as "hygiene kits."

- ***Potential Selection Bias.*** Most of the interviews with UNFPA staff and external partners were conducted based on the contact list provided by UNFPA headquarters. The four countries for field visits were likewise chosen by UNFPA. Participants in the FGDs were selected by UNFPA or distributing partners. Further, the FGDs were typically held on site at the implementing partner's office or at UNFPA's office. These factors may have biased the sample of participants and responses used to inform the team's assessment. However, the participants were continually told that their responses were confidential and were encouraged to be as open and honest as possible.

- ***Limited Representation.*** Although four cases examined during our country visits range from political crisis (Kyrgyzstan) to natural disasters (Colombia, Indonesia, and Mozambique), the SIPA team did not have an opportunity to visit a camp setting. Additionally, with the exception of 6 conflict-related crises, most of the global survey responses and interviews pertained to natural disasters (flood, land-slides, earthquakes, tsunamis, volcano eruptions, etc.). There is only one case study for protracted crises and no field visits to Arab states due to time constraints.

- ***Comparisons Across Countries.*** Each country differs in terms of its unique economic and political context, the capacity of UNFPA COs and the type and scale of the humanitarian crisis experienced. This makes robust comparison across countries extremely challenging. Even among the four study countries, each country team modified their participatory ranking methodology (PRM) and FGD tool slightly to adapt to the particular in-country setting. Thus, simple comparison of crude quantitative and qualitative data can lead to inaccurate analysis.

- ***Lack of Access to External Partners and Suppliers*.** Data obtained from external partners involved in the distribution of dignity kits was limited, precluding a comprehensive analysis of the competitive landscape or an assessment of UNFPA's comparative advantage relative to other organizations. Rather, the SIPA team focused on identifying UNFPA's core competencies using internal data from the global survey, KIIs and FGDs. Core competencies should thus not be taken to imply any relative advantage in the provision of dignity kits, as data was insufficient to support such conclusions. Moreover, there was no access to the suppliers of dignity kit contents, except for one KII in Colombia. As a result, findings related to the logistics of dignity kit provision are limited to the perspectives of UNFPA staff.

- ***Limited Documentation on Intervention.*** The absence of an articulated program theory and lack of documentation related to past UNFPA dignity kit interventions hindered the SIPA team's ability to validate findings. As a result, findings are largely anecdotal. Moreover, lack of baseline data made it difficult to ascertain whether and how the dignity kit intervention has evolved over time, or to compare different dignity kit distributions within a country.

- ***External Validity.*** Data from the global survey was extrapolated in order to draw broader conclusions about dignity kit provision in humanitarian crises. However, the survey garnered a response rate of approximately 50% and, of these, there were a number of gaps in the information provided, as well as inconsistencies in how questions were interpreted by various COs. In some cases, CO respondents had insufficient knowledge or experience to respond to all of the questions, particularly those that related to logistics. Thus, findings may not be reflective of the experiences of all COs and may not be generalizable to all settings.

- ***Recall Bias.*** In all study countries, PRMs and FGDs were conducted months, if not years in the place of Mozambique, after the last distribution of dignity kits. As a result, beneficiaries may not have remembered the details of the dignity kits or their experience of the crisis as accurately as if these interviews were conducted immediately after their distribution.

IV. FINDINGS

Chapter Summary

Based on the collection of data through the different methods utilized by the team, findings are presented within three thematic areas:

- **Organizational Competencies**
  In reference to UNFPA's skills for dignity kits distribution and best practices observed, plus area recommendations.
- **Impact**
  Immediate outcomes observed across the countries are divided into consistent evidence and mixed evidence findings; gaps and challenges encountered and recommendations to address them.
- **Logistics**
  Findings related to funding, procurement, assembly, storage, transportation and distribution. Recommendations for improving the dignity kits supply chain processes.

In this section, we present findings and recommendations from three thematic areas: organizational competencies, impact and logistics. Data from each phase of research was aggregated and analyzed by thematic subgroups comprising 3 to 4 team members, in order to identify common themes and to develop recommendations. Thematic findings and recommendations were then discussed by the SIPA team as a group in order to ensure that linkages between thematic areas were adequately reflected. From these thematic findings flow the team's broad recommendations for UNFPA's dignity kit program.

A. Organizational Competencies

In this section, we analyze UNFPA's organizational competencies in the provision of dignity kits. For the purposes of this analysis, we define organizational competencies as the set of strengths and organizational "best practices" that characterize UNFPA's provision of dignity kits. The focus of this section is not to identify UNFPA's strengths *relative* to other humanitarian organizations; instead, it seeks to extrapolate internal best practices of the dignity kit program using data from the global survey, KIIS and FGDs/PRMs; in other words, we seek to identify what works and what doesn't in the context of humanitarian response given UNFPA's organizational capacity and mandate. Finally, we highlight possible niche opportunities for UNFPA to differentiate itself as a provider of humanitarian aid. UNFPA's core competencies with respect to the dignity kit intervention fall into three broad categories: dignity kits are customized and designed for women, UNFPA has strong partnerships with CBOs and government agencies, and UNFPA has the ability to coordinate with other UN agencies to conserve resources and distribute kits more effectively.

1. Customized aid primarily for women and girls of reproductive age

Though women constitute one of the most vulnerable groups during humanitarian crises, women's needs are often neglected or inadequately addressed. Through its dignity kit intervention, UNFPA has been able to

draw attention to these beneficiaries in emergency settings. While UNFPA is not the only organization distributing dignity or hygiene kits in an emergency, it has been able to distinguish itself by tailoring its program explicitly toward the needs of women and girls of reproductive age. For example, needs assessments are designed to identify the distinct needs and preferences of local communities, with a particular emphasis on the needs of women. For example, in several of the Arab states, hijabs and abayas were identified through a needs assessment as being very important for women, and the inclusion of these items enabled them to leave their shelter and access services. Similarly, some COs, such as Indonesia, incorporated the needs of pregnant women, women who have just given birth and lactating women, further strengthening UNFPA's niche as an organization that meets the needs of women. Moreover, the customization of kits distinguishes UNFPA's kits from more standardized kits, which may not be culturally sensitive or appropriate.

Testimonies

"The kits have been very important in filling a gap existing among humanitarian actors, as other organizations deliver hygiene kits but are not concerned with restoring women's dignity, and that it differentiates from all other interventions in being culturally sensitive." (KII, LAC)

"Flexibility of the dignity kits is that they adapt the contents to the actual population that you are helping, taking into consideration the cultural importance of the community. "(KII, Peru. 2011)

2. *Strong partnerships enable capacity-building of local organizations and government agencies*

UNFPA COs have been able to forge strong relationships with local organizations and government agencies, which has aided in the distribution of dignity kits. These key relationships serve a dual purpose for UNFPA. First, local organizations have established relationships with the community. By partnering with these organizations to conduct needs assessments with beneficiaries and distribute kits, UNFPA is able to conserve resources that would otherwise be required to build their ground presence. Given UNFPA's resource constraints in many countries, this would be a time and resource intensive task. In addition, local organizations have first-hand knowledge of the community and in some cases act as proxies for need assessments when a thorough rapid needs assessment cannot be conducted with beneficiaries. Second, UNFPA is able to build local capacity both in terms of responding to humanitarian crises and addressing issues that are core to UNFPA's mandate. For example, in many countries UNFPA also has been able to successfully partner with government agencies to identify vulnerable populations and distribute kits. These partnerships not only allow UNFPA to extend its reach, but also enable it to provide technical support in matters related to women's and reproductive health. In Indonesia, UNFPA works with the government to integrate dignity kits into the national contingency plan, helping to ensure the sustainability of their provision. The Indonesia CO has also been building capacity at the national and local levels for reproductive health and gender issues, thanks in part to the provision of dignity kits, in collaboration with government and civil society. Finally, integration of UNFPA's activities into the national sphere has the potential to increase the organization's visibility in humanitarian response.

Testimony

"UNFPA usually has an implementing partner – who has presence on the ground and capacity… they have ground presence that UNFPA does not have and we would have to devote a lot of resources to gain this ground presence otherwise. We also worked with NGO with government experience…. Both at central and district level—you usually have to work hard to develop these relationships but we were able to leverage on the NGOs relationship."
(KII, Sri Lanka. 2011)

3. Coordinating with other UN agencies to conserve resources and avoid duplication of efforts

When UNFPA was able to effectively and efficiently coordinate with other UN agencies such as UNICEF, UNHCR, UNDP, WFP or IOM, dignity kit distribution was more organized in terms of identifying and mapping out beneficiaries and avoiding duplication of efforts. For example, in Bangladesh, the UNFPA humanitarian focal point contacted other UN agencies to determine the worst affected areas during the flooding. Some of the UN agencies had already conducted a joint assessment with the government to identify the most vulnerable areas and populations. UNFPA was able to use this information to inform their own dignity kit distribution plan and did not have to use its restricted resources to map out affected beneficiary populations. In Yemen, UNHCR was distributing sanitary pads and communicated this to UNFPA through the cluster system so there would be no duplication of the delivery of this item among the beneficiary population, and thus the UNFPA did not provide them. Communication within the cluster also alerted UNFPA to the fact that no other organization was including panties in their aid delivery, and UNFPA identified the need to include this item in their dignity kit because the sanitary napkins UNHCR was distributing would be worthless without panties. In China, UNFPA and UNICEF communicated with one another to avoid overlap in aid distribution. Though some of the items being distributed by the two organizations were the same, both organizations distributed to different communities and communicated with one another during the distribution process.

Testimony

"This (coordination) dynamic is working especially since UNFPA cannot handle the whole logistics on its own, and don't have the operational needs at the field level to manage these services. UNFPA have to work through partnerships to do this. Inter-agency coordination to manage the humanitarian response is working very well. For example, IOM has done a rapid assessment in Namibia and UNFPA was able to define with them the contents of the kits. At the inter-agency level there is an awareness of what UNFPA is doing." (KII, Africa. 2011)

4. Gaps and Opportunities

a. Other organizations distribute hygiene items during humanitarian emergencies

UNFPA is not the only organization that distributes hygiene items to beneficiaries during humanitarian emergencies, and among these organizations its resources and capacity are relatively limited. Organizations such as UNICEF, International Red Cross and IOM distribute similar kits and have greater capacity to distribute on a larger scale than UNFPA. Unlike UNFPA dignity kits, however, these hygiene kits are typically standardized, containing basic items such as soap, toothbrushes and toothpaste. Because many of these organizations brand their hygiene kits and family hygiene kits, women are included in the beneficiary population by default. In some cases, UNFPA has distributed dignity kits in the same communities as other organizations distributing hygiene kits, but provision by other organizations was far more expansive in terms of the amount of kits distributed and the numbers of beneficiaries reached.

Testimony

"The issue of dignity kits even though it has been on the table for almost 10 years now, it has not actually picked up any momentum. You will still find that there are still so many humanitarian orgs who are either unaware of provision of dignity kits. It is not solely provided by UNFPA. UNFPA has more to offer than just offering dignity kits. If some other orgs or local NGOs could spend more time to provide dignity kits, then UNFPA could support them and do many other things that can help in maternal survival." (KII, West Africa. 2011)

b. Beneficiary Populations are not standardized

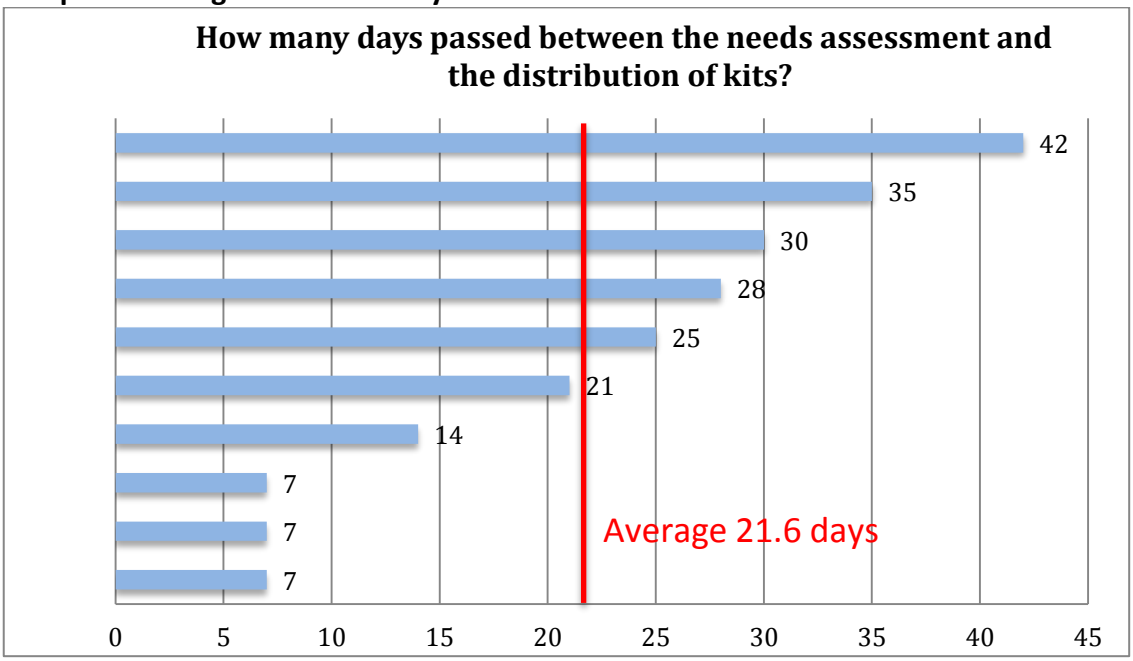
A wide range of beneficiaries have been targeted by UNFPA COs, with no streamlined, overarching criteria for identifying who is eligible to receive dignity kits in an emergency. In some cases, a wide net is cast, with broad categorizations used to determine eligibility, such as "affected communities", or "vulnerable people." In other cases, specific segments of women are targeted, such as pregnant or lactating women. This poses a challenge in terms of both impact and visibility, as there is no one beneficiary population that UNFPA will always target as part of its humanitarian response.[30] And visibility was limited when UNFPA targeted broad populations, as those populations were at times also targeted by other organizations. Moreover, UNFPA's coverage of these target populations was often low relative to organizations with greater resources.

Testimony

"I don't think they are highly branded. We haven't distributed that large enough of quantities for them to be visible… There is not strong branding but we don't really look at our response that way – and that's not what we prioritize when we responded." (KII. 2011)

c. The Average lag time to distribute kits after a needs assessment is 3 weeks

Graph 1: Average number of days between the needs assessment and distribution[31]



On average, there is a three-week lag time between the time that a needs assessment is conducted and the time dignity kits are distributed. UNFPA's customized approach to dignity kit provision means that it is often not the first organization on the ground distributing hygiene items to beneficiaries. In instances where UNFPA is the only organization distributing hygiene items, by the time the aid is delivered, beneficiaries

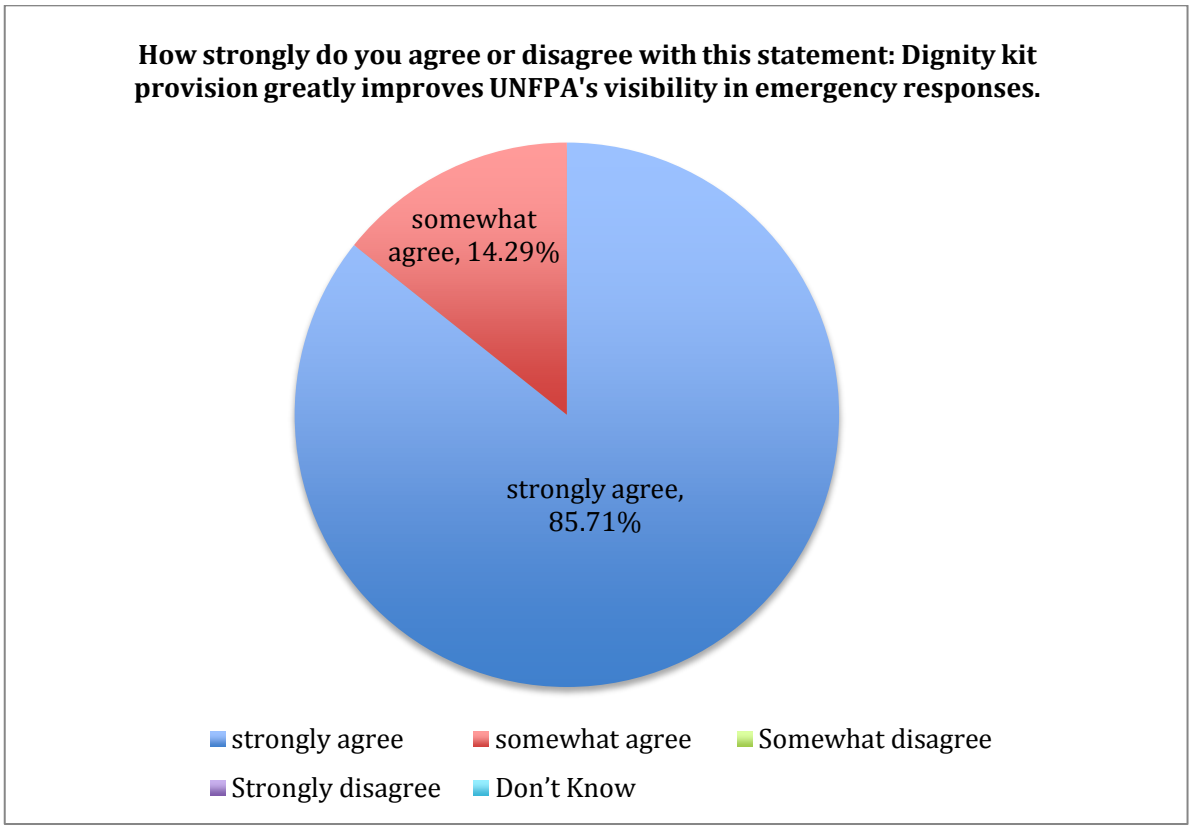
[30] For further detail, see "Who is served by the dignity kit program?" in the impact findings section of this report.
[31] From global survey (N=10)

may already have relocated or returned to their homes, and their needs may not be the same as when the needs assessment was initially conducted.

d. Dignity Kits Receive Limited Visibility

All COs responding to the global survey agreed that dignity kit provision greatly improves UNFPA's visibility in emergency response. KIIs with many UNFPA COs, however, revealed that visibility of the dignity kit program was not a priority in terms of the overall objective of dignity kits. In addition, for those COs that indicated that visibility was integrated within their overall response, communication strategies varied depending on the resources of the local UNFPA CO. Some COs had a dedicated communications team to promote UNFPA's dignity kit program, while others engaged the media on their own to try to gain visibility and create awareness of UNFPA's humanitarian response efforts.

Graph 2: Dignity kits and UNFPA's visibility in Humanitarian Response[32]



e. Provision of dignity kits is not a panacea in emergencies

Provision of dignity kits as an emergency response is effective only to the extent that it a) can adequately meet the needs of affected communities, b) it is coordinated within a broader, integrated humanitarian response, and c) embodies the core mandate of the distributing organization. Feedback from KIIs suggest

[32] From global survey (N=10)

that the role of UNFPA in humanitarian response remains modest. According to one key informant, UNFPA is not a "full-fledged" humanitarian organization and it is limited in what it can do.[33]

5. Recommendations

a. Dignity kits have the potential to strengthen UNFPA's core mandate by the inclusion of educational materials

Some countries indicated that educational materials related to reproductive and sexual health, hygiene, and GBV were included as part of dignity kit distribution. If this practice is standardized with all dignity kit distributions, UNFPA has the ability to link dignity kits more closely to its core mandate and increase its visibility in humanitarian settings. By distributing dignity kits to vulnerable women, UNFPA is establishing a relationship with this beneficiary population, which provides an entry point for UNFPA to further educate women about issues directly tied to the organization's core mandate. The educational aspect of dignity kits has the potential to increase UNFPA's visibility within communities, as well as to provide a platform for the organization to establish development programs in a community post-crisis. Education also offers UNFPA a unique advantage, as it has the opportunity to establish a niche by being the only organization providing education on sensitive issues related to women during humanitarian emergencies.

Where UNFPA is unable to distribute dignity kits due to lack of resources, education on reproductive and sexual health, hygiene, and GBV can still be provided to beneficiaries that would have received dignity kits. UNFPA's educational activities could be coupled with aid that other organizations are already providing. UNFPA can also build the capacity of local partners to educate beneficiaries on these issues. This training can be incorporated into a UNFPA's preparedness strategy and need not be limited to the onset of a humanitarian crisis. Capacity-building programs should incorporate monitoring and evaluation mechanisms in order to ensure the quality of the information that local partners are providing to the community.

Testimonies

"…We looked at the cost of a private consultation in a shelter (it was cheap – like 5 dollars) so we could have all these women being consulted by nurses and midwives…We wondered, what is more valuable: to give a bucket or to give a woman the chance of having an individual medical consultation where they could discuss issues that were pertinent… If we have limited resources we have to wonder what is the most useful for a woman…. We need to know what to prioritize since we have limited resources."(KII, Haiti. 2011)

"UNFPA is too small to really have full global impact, and to do as much as other agencies, UNCHR, WHO, UNDP and NGOs dedicated to humanitarian response, even private sector. Thus, this limits the impact it can have. It should be much bigger if it wants to be more operational." (KII, UNFPA HQ. 2011)

b. UNFPA's relationships with government agencies and local organizations provides an opportunity for advocacy

Given UNFPA's limited resources and human resources capacity in many countries, in circumstances where UNFPA does not have a clear organizational competency in terms of the beneficiary population it is

[33] SIPA team, Internal UNFPA Interview, 2011

targeting or in the provision of locally-appropriate dignity kits, resources may be better suited toward advocacy. In particular, UNFPA has a unique platform through which to advocate for the inclusion of sexual and reproductive health as part of all humanitarian response activities.

UNFPA has established relationships with many local and national governments, offering an opportunity to promote mainstreaming of gender into humanitarian response at the country level. In addition, UNFPA has the opportunity to leverage its position in the UN cluster system to advocate for GBV, psychosocial support and reproductive and sexual health education to be a standard component of the UN's response in humanitarian emergencies. Advocacy is less resource intensive and can provide tangible benefits to communities in terms of impact, as well as to UNFPA in terms of visibility.

c. Dignity Kit distribution should be coordinated as part of an integrated approach to humanitarian aid

In order for dignity kits to be impactful, UNFPA needs to coordinate its response with other UN agencies and international and local organizations. One important mechanism for enhanced cooperation is more active participation in the cluster system. While UNFPA co-leads with UNICEF the GBV Area of Responsibility under the Protection Cluster and is responsible for RH under the Health Cluster, it is less active in other clusters. Participation in the cluster approach enables UNFPA to leverage its financial and human resources and refine its role in humanitarian responses. Coordination also enables UNFPA to leverage existing knowledge gathered by other organizations in terms of mapping and identification of vulnerable populations. Finally, coordination helps avoid duplication of target populations and identifies gaps in aid distribution. Because UNFPA's dignity kit distribution is done on a much smaller scale and only distributed once, it needs to be coordinated within a broader humanitarian response in order to ensure that beneficiary needs are being met after dignity kit distribution. Dignity kits typically last for up to a month, emphasizing the need for this intervention to be coupled with a more sustainable response.

Testimony

"New strategies can be mainstreamed and have country and regional offices to do the operational work. But again they have limited capacity in humanitarian emergencies. Maybe just participate in cluster meetings and keep UNFPA mandate on the agenda. Which is very important as well. Try to do more coordination, outreach and advocacy at the levels and capacity development to CO. Then the CO can actually do the operational work and mainstream the different work into their regular development programs. Working with other agencies. UNFPA should make sure we are at the table at all of the meetings in country during disasters – sit with the clusters, planning meetings and make sure UNFPA's mandate is heard and incorporated into the response. (KII, UNFPA HQ Staff. 2011)

d. Integrate dignity kits into UNFPA's broader communication strategy

Given that all survey respondents agreed that dignity kit provision greatly improves UNFPA's visibility in emergency responses, communications about the program should be integrated into UNFPA's larger communication strategy during humanitarian emergencies. This communication strategy should be standardized across all countries, and should not compromise or take resources away from the dignity kit program itself. Improved visibility can also contribute to UNFPA's advocacy efforts, as government agencies and donors will be more aware of UNFPA's mandate and role in humanitarian emergencies.

B. Impact

Data generated from the four phases of research conducted by the SIPA team produced a "picture" of what UNFPA's provision of dignity kits looks like worldwide and what its impact is on beneficiary populations. The team's primary finding is that this intervention is characterized by high levels of variability, reflecting on the one hand UNFPA'S commitment to meeting local needs through the provision of culturally appropriate and locally procured items and on the other a lack of guidelines related to dignity kit provision.

The impact team began its analysis by identifying five domains within which to analyze the impact of the dignity kits on beneficiaries: value, usefulness, hygiene, mobility/access to services and dignity. Using a grounded theory approach to data analysis, the team then reviewed its findings (triangulating reviewers to validate findings) and adapted its analysis domains accordingly. Given limitations around the measurement of both value and usefulness in humanitarian settings (for more on this, see "Limitations"), the impact team found that the distinction between the categories of "value" and "usefulness" was practically negligible, and the two were merged for data coding purposes. At the same time, some unexpected or neglected themes emerged from our preliminary "coding": coverage/reach, target populations, budget substitution effects and the potential role of dignity kits as an entry point to communities (both sub-themes under value/usefulness).

In total the team identified eight sub-themes that organized the bulk of findings on the impact of dignity kits. With a view toward presenting findings in the most practically relevant way for the client, the eight sub-themes are organized into three categories: "Consistent evidence of impact," "Mixed and limited evidence of impact," and "Opportunities and challenges." For further explanation of how these findings correspond to the ALNAP criteria for evaluating humanitarian response, please see the Executive Summary.

1. Consistent Evidence of Impact

Constant comparative data analysis methods revealed three themes for which there was consistent evidence of the impact of dignity kits: kits fulfilled immediate hygiene needs, kit beneficiaries felt "remembered," and kits had a budget substitution effect.

a. Kits fulfilled immediate hygiene needs

Focus group participants and key informants from implementing partners in all four case study countries acknowledged that the items in the dignity kits met beneficiaries' immediate hygiene needs.

In many cases, kit contents filled a gap in which markets had failed or daily hygiene items were otherwise not readily available. Women affected by both floods and conflict in Colombia, for example, explained that they had lost everything and dignity kits provided them with items that they needed. In Kyrgyzstan, basic needs were identified by the Protection Cluster Rapid Protection Assessment Report.[34] The report showed that 40% of survey respondents in 3 of 4 locations expressed a need for hygiene items. The fact that this

[34] Kyrgyzstan Protection Cluster (2010). *Rapid Protection Assessment: Osh and Jalalabat Oblasts 30 June-3 July 2010.*

need was met by UNFPA's dignity kits was confirmed by beneficiaries who participated in FGDs there. One focus group participant articulated the belief that the hygiene items provided were not only necessary for their particular context, but that such items fulfill universal hygiene and personal needs: "If they [UNFPA] give these items to people in need they will not be mistaken, because people always need these items." This quote speaks to the appropriateness of these items in terms of meeting the hygiene needs of affected populations.

UNFPA staff and implementing partners were also nearly unanimous in their assessment that the kits were a means of temporarily meeting the hygiene needs of beneficiary communities. Results from the global survey showed that 63% (n=18) of COs that responded to this particular measure indicated from empirical observation that the main benefit of the kits was "improved hygiene." This is a significant finding in that it suggests 1) convergence of beliefs from both beneficiaries and UNFPA staff on the impact of the kits, and 2) overwhelming evidence that dignity kits primary' impact is in restoring hygiene needs, as compared to improving mobility or increasing access to services.

b. Kits made beneficiaries feel remembered

The second consistent theme that emerged from the data was the notion that dignity kits conferred to beneficiaries a feeling of being "remembered." Though the idea was articulated in different terms across countries and across focus groups, beneficiaries from the four case country studies were nearly unanimous in expressing the belief that the value of the kits was more than material. That is, many beneficiaries articulated a sentiment that even the actual experience of receiving a kit in a time of need was symbolically valuable because it meant that they were not forgotten. In Indonesia, one woman indicated that the effect of the kits was the feeling "that some people care about us…pay attention to us." In Kyrgyzstan, a participant explained that she felt "so happy I wanted to cry because people remembered us. When we had a difficult time others respected us". In Colombia, most beneficiaries had never received any other form of aid before and women expressed gratitude that the kits were distributed to women to meet women's needs, rather than strictly those of their husbands or children.

The Capulana is Vital:
How dignity kits can improve mobility

"Women don't leave the house without a* capulana*...You use it to cover your body, as a blanket in bed, to carry the baby, and most important it's a simple part of being a woman. One time, I met this woman. Many times women have to survive on lily fruit from the river when they are hungry. So they have to enter the river to get fruits, you know. Anyway, after receiving the* capulana *the woman was so satisfied that she got to eat. The* capulana *enabled her to go to the river to get the fruit and feed her family. Years later, the woman recognized me as the person who distributed the kit and offered me what little food she had….she had a sweet potato and gave it to me for giving her a* capulana *years before. " (KII, Mozambique. 2011)

The vast majority of staff from UNFPA COs and implementing partners echoed these sentiments, further strengthening evidence that the emotional impact of dignity kit distribution is a salient one and that this value—though difficult to measure or capture—should be considered in assessing the impact of dignity kits.

c. Kits as budget substitution mechanisms

The third effect of dignity kits that was consistently reported by beneficiaries and CO staff alike was the notion that kits provide a budget substitution function. There emerged a clear and consistent theme in

Indonesia, Colombia and Mozambique, and to a lesser extent in Kyrgyzstan, that women were particularly grateful for kits as a 'gift' or 'donation' that allowed them to shift their relatively small financial resources to purchase food for other basic necessities. In one Colombian focus group a participant explained, "The priority is to fill the stomach of the family. Not having to buy these daily items gives (us) the ability to eat more food." What is more, the kits allowed women to meet their own needs while also meeting the needs of their families. As one participant from Indonesia explained, receiving the kit allowed her to avoid making the difficult decision of whether to buy sanitary pads for herself or food for her children.

Interviews with other distributing COs suggest that this finding is particularly relevant in the Middle Eastern, South American and North African context, where it was frequently noted as an unintended consequence of the kits.

d. Limitations in assessing value or usefulness

The above findings illustrate three areas in which the distribution of UNFPA dignity kits have shown consistent impact across all four case studies (to varying degrees). Oftentimes, the findings were articulated by both beneficiaries, UNFPA staff and implementing partners alike; many of the findings have also been supported by KIIs with UNFPA staff from other COs.

There are, however, significant limitations to the above findings that must be noted. In particular, the SIPA team faced considerable challenges in attempting to measure notions of "value" or "usefulness" when working with populations that have lost everything. These challenges were highlighted by several instances in which beneficiaries expressed that though they valued and appreciated the majority of items in dignity kits, they would have been happy to receive anything at all. In Kyrgyzstan, for example, one participant described the inflated value of aid in humanitarian crises (in reference to an MSF kit that she had received prior to a UNFPA kit): "At that time they looked like gold because we didn't have anything."

Similarly, in Colombia, one beneficiary explained that even if all that they had received was candy, the women in her community would have "loved" it, as it would have been something when they had nothing. Putting this inflated measure of value into perspective, a woman from a different focus group in Kyrgyzstan commented, "We were so happy to get these things because we really needed them, but we cannot say that they changed our lives."

In addition, it should be noted that oftentimes the kits had a 'diluted' effect or utility for women specifically, given that most women chose to share items with their entire family. This effect might be considered positively or negatively. On the one hand it allowed women—who often play key roles in household management and daily life—to help their families/households in times of need. On the other hand, if UNFPA's objective is specifically to target women as vulnerable populations, then it becomes unclear if the distribution of household goods can achieve this directly when women have shown to share nearly every item in the kit.

2. Mixed and Limited Evidence of Impact

a. Mixed evidence of the impact of dignity kits on beneficiaries' mobility and access to services

Our research revealed inconsistent results on the impact of dignity kits on beneficiaries' mobility and access to services such as food and water distributions, education and community activities. Much of the evidence that we do have of this is indirect and comes from UNFPA staff at the global, regional and country levels. One UNFPA respondent who was closely involved with the origins and evolution of UNFPA's provision of dignity kits insisted clearly that the original purpose was "for the recipients to have access and to be mobile…People misunderstand it…The purpose [of dignity kits] is to ensure mobility."

Those key informants who mentioned the impact of dignity kits on improved mobility and access often did so with reference to Muslim country contexts. For example, a few UNFPA staff in Muslim countries mentioned that women could not leave the house in general without headscarves, hijabs or long-sleeves: "In the Muslim world it is important that women are covered. They can't operate without proper clothing." Some variation of this emphasis on the relationship between kit provision and mobility was also acknowledged by staff in Indonesia, Sudan, Pakistan, Yemen, Syria and the Palestinian territories.

Despite repeated suggestions of improved mobility from key UNFPA informants, the SIPA team found very limited evidence of this effect when speaking to beneficiaries in its four case study countries. The exception to this was in Mozambique, where limited anecdotal evidence indicates that provision of capulanas (see side bar above) may have improved mobility.

In Kyrgyzstan, by contrast, beneficiaries explicitly rejected the idea that dignity kits may have improved their mobility. When asked whether the contents of the kits allowed them to go to markets or food distributions, one woman replied: "even before we had these things we were not ashamed." In a separate focus group also in Kyrgyzstan, a beneficiary echoed this sentiment: "These items might have helped, but we were already outside, not being shy or ashamed". It is important to note here that Kyrgyzstan is also a predominately Muslim country, and so even though the bulk of anecdotal evidence around mobility comes from Muslim countries, even in those contexts the benefits of dignity kits cannot be assumed.[35] The juxtaposition of this program motivation and the real needs on the ground foreshadows our later recommendation to improve needs assessment processes so that dignity kits are designed to meet actual rather than perceived needs.

b. Dignity Kits have the potential to act as an 'entry point' for other types of interventions

Research revealed a potential for dignity kits to serve as an "entry point" to engage difficult to reach communities with the provision of other programs and services. Suggestions of this came from both beneficiaries and staff. Many beneficiaries and implementing partners across the four case study countries requested that UNFPA provide additional education or programming on issues relevant to UNFPA's mandate—GBV, RH, psychosocial support and general hygiene. In Colombia, for example, every single FGD group requested that if future distributions were to take place they should include basic hygiene and health education. In Kyrgyzstan, participants from multiple focus groups expressed that while they appreciated the dignity kits—which were targeted to survivors of GBV—they also would have appreciated broader psychosocial services related to their experiences with the conflict.

[35] UNFPA Appeal. (Aug 2010-Dec2010).*Family Supplies and Support to Promote Access to Assistance*, Protection Cluster, Request for Family Kits in Osh, Kyrgyzstan. The appeal directly aligned this idea that displaced persons "may be reluctant to leave their homes because of lack of basic hygiene supplies and clean clothing" with the dignity kits.

In some cases, COs did actually use kits as an entry point mechanism to provide information on GBV, RH, and HIV prevention. In Ecuador and Peru, dignity kits contained pamphlets on GBV and distributions were combined with two-hour information sessions that later allowed CO staff to do GBV work in vulnerable communities. Similarly in Darfur, kit provision was explicitly used to build positive relationships with communities that UNFPA later targeted for GBV programming—a sensitive issue they might have otherwise had difficulty breaching with a conservative community. As one CO staff member in Peru remarked, "UNFPA has a niche in gender; it's not just the kits, it's the information inside the kits".

In Uruguay as well as Peru, kits included educational games for HIV prevention, exemplifying another programmatic area in which UNFPA strategically employed the provision of dignity kits. In Yemen, kits included information for beneficiaries about where to access health services. These examples-combined with requests from beneficiaries for further education and services-suggest a critical opportunity for UNFPA to optimize the impact of dignity kit distributions by linking them to the provision of other services within its mandate.

3. Gaps and Opportunities

Field research, KIIs, and findings from the global survey indicate three key areas in which UNFPA's dignity kit program has clear scope for improvement. Underlying the three primary issues we have identified is a general lack of clarity on the form and function of dignity kit provision —what it does for whom and in which circumstances. As such we have framed our findings in this section as a series of three questions summarizing key gaps in knowledge around UNFPA's dignity kit intervention.

a. Who is served by the provision of dignity kits?

Our research uncovered a considerable range in the target groups served by UNFPA's provision of dignity kits. Research revealed no documented guiding principles around the question of whom dignity kits should target, though general documents on UNFPA's mission and mandate provide some suggestions. The notion of dignity as it appears in UNFPA's overall mission is linked to women and girls.[36] More broadly, UNFPA "is committed to assisting and protecting women, men and young people made vulnerable by natural disasters and armed conflicts."[37] UNFPA's website on the distribution of hygiene items in emergencies gives some indication that the intervention is targeted toward women: "UNFPA has taken the lead in organizing and distributing hygiene kits based on what local women have said they need."[38]

Among the four case study countries recipients included: pregnant women, post-partum women, women with newborn babies and women of reproductive age (Indonesia), women survivors of GBV (Kyrgyzstan), women and vulnerable groups (Mozambique), and women generally—with a preference for those who were most affected by floods or had not received any other aid (Colombia). Data from the global survey and

[36] UNFPA. "About UNFPA: Our Mission." Web. 24 April 2011; http://www.unfpa.org/public/about/
[37] UNFPA. "UNFPA-Columbia University School of International and Public Affairs Workshop in Development Practice 2010-2011: Terms of Reference." Unpublished document shared by UNFPA HRB.
[38] UNFPA. "Assisting in Emergencies: Food, hygiene and security." Web. 24 April 2011; http://www.unfpa.org/emergencies/food.htm

KIIs indicated that target groups have also included adolescents, newlywed couples, and families more generally (see Annex XII).

The implications of these wide and undefined targeting criteria are several. A lack of centrally defined criteria might not be a problem in itself, if dignity kits are designed to be a context specific intervention. There does, however, seem to be an association between a lack of criteria at the central level and a lack of specificity and clarity at the country and distribution levels as well. In cases such as Kyrgyzstan, the ambiguity of the practical meaning of the criteria led to broad interpretation, which in turn precluded any opportunity for UNFPA to serve a particular niche. Key informants from UNFPA and partner organizations in Kyrgyzstan reveal that the definition of survivors of GBV was translated in the field to mean "affected women"—more specifically, this was operationalized as women whose houses had been burnt or whose husbands had been killed. The broadness of the target group (in combination with an apparent lack of coordination) permitted duplication of efforts; some women who received UNFPA's dignity kits also received similar kits from UNICEF (which also specifically targeted survivors of GBV), MSF and Red Crescent.

The lack of explicitly agreed upon targeting criteria might also present challenges for translating this criteria to the distribution level. During field visits, the SIPA team observed some discordance between the populations the kits were intended to target and actual beneficiaries. In Mozambique, though the kits were called "women's kits" the kits did not always go to women, and specific sub-groups (including the elderly and disabled) were also targeted. Further, while the dignity kit program was designed as a response to severe flooding, some beneficiaries were deemed eligible only because they were considered "vulnerable," and not because they had been affected by the floods. In Indonesia, for example, the kits intended for women with newborn babies (2-3 months old) were often distributed to women with children up to 8 months old. Further investigation revealed that many of these instances could be attributed to miscommunication between UNFPA and distributing partners—a communication gap that might be addressed through the establishment and dissemination of clear targeting criteria.

Many times this discrepancy was the result of the limited quantity of kits available for distribution. CO respondents and distributing partners across the four countries consistently expressed that dignity kits did not reach all selected beneficiaries. Evidence was most prevalent in the cases of Mozambique and Indonesia. For example, UNFPA CO informants explained that dignity kits, much like other humanitarian interventions, rarely reached more remote areas like Chinde where some of the most "vulnerable" river communities lived. Even in resettlement centers where kits were intended for the most vulnerable people, several respondents from FGDs noted that they did not receive kits, paradoxically, because they belonged to the most vulnerable groups in the community (i.e. orphan child heads of household, widows, disabled, the elderly, and second or third wives in polygamist households). In both Indonesia and Mozambique, when faced with insufficient numbers of dignity kits, implementing partners took apart kit contents and distributed these items individually to beneficiaries for greater coverage.

Limited supply also led to feelings of jealousy and unfairness among women, as was the case noted by FGD respondents in Indonesia; this issue of coverage highlights the significant need to create and disseminate clear target group criteria for kit distribution.

When combined with the process by which distributing partners are chosen (based on previous relationships), the lack of clearly defined target criteria also means that the selection of individuals or communities for distribution is sometimes done in an unsystematic way. In Kyrgyzstan, for example, UNFPA

"selected" communities to receive dignity kits by default—that is, they chose as distributing partners those organizations with whom they had established working relationships, and thus the communities who received kits were often those whom those organizations had served before.

There was no indication that this process was informed by explicit needs assessments or efforts to prevent duplication with other organizations, though key informants noted that there was an effort by some partnering organizations to make sure that the benefits of kit distribution were shared equally by both ethnic communities. A similar process was described in Indonesia, where one distributing partner was identified by happenstance: when a UNFPA staff person drove past an individual from the partner organization on the road, (s)he stopped to offer to provide that organization with kits for distribution and subsequent arrangements were made.

In sum, evidence suggests that a lack of centrally defined target criteria (at the global level) or the lack of clear and specific targeting criteria (at the CO level) detracts from the ability of the dignity kit program to fulfill UNFPA's mandate or fulfill a certain niche in humanitarian response. In addition, the identification of beneficiaries is often guided by the discretion of implementing partners, which can result in misinterpreted or broadly interpreted beneficiary populations. This can be problematic both in terms of compliance with recognized humanitarian response standards—whereby agencies are encouraged to maintain fidelity to their particular mandates and coordinate efforts so that they are targeted and non-duplicative[39]—and in terms of measuring the effect of UNFPA's dignity kit intervention.

b. What does "dignity" mean in theory and on the ground?

Though the notion of dignity underlies humanitarian response generally, and UNFPA's dignity kit provision specifically, there is a lack of consensus on the meaning of the term or its operationalization in the field. Though some key informants suggested that the SIPA team not focus on this "language" issue, in fact over the course of the six month research process it became clear that the notion of "dignity"—however undefined or differently interpreted—was for many COs a very central one that informed the implementation of the intervention. For this reason—and in the absence of any other clear guidelines on the objectives of the intervention—we consider it an important issue to address.

When asked about the purpose of dignity kits, key informants almost always responded in some form that the intention of the kits was to restore dignity to beneficiaries. When asked to clarify or operationalize dignity, however, many UNFPA key informants were unclear about

Meaning of dignity to key informants

"Why are they called dignity kits? I even asked this as well."

"That is a tricky question. Dignity is difficult to measure though we have testimonies. Dignity is related to UNFPA's mandate."

Dignity is "a very loaded term…it's about women's rights."

"From a UNFPA point of view 'dignity kits' is a good way to describe them—they allow women to move around and provide them with a sense of self-esteem. It has served more than just the hygiene needs. It goes beyond that."

(KIIs, various countries. 2011)

[39] The Sphere Project. "Core Standard 2: Coordination and Collaboration." *The Sphere Project: Humanitarian Charter and Minimum Standards in Humanitarian Response*. p 23. 2011.

or unable to specify the meaning of dignity in the context of dignity kit provision. Some examples of this are included in the "Meaning of dignity to key informants" box.

Preliminary qualitative analysis of key informants' views on the meaning of dignity yielded several broad categories of meanings of dignity in the context of dignity kit provision: feelings of self-worth and self-respect, respect from peers, freedom from shame or humiliation, mobility, participation in social life, meeting basic needs, fulfilling human rights, and feminine identity. To some, the ad hoc evolution of dignity kits as a UNFPA intervention and the theory of local appropriateness behind them might not only permit but demand this broad range of interpretations of just what dignity is or how it might be restored. It is clear, however, that this flexibility is also a considerable challenge.

"The objectives of the dignity kit itself. Hmm, what can I say? I'm not sure."
(KII, 2011)

The final quote in the above box illustrates this. Though the respondent here indicates that dignity kits "go beyond" meeting material needs, (s)he—like most of the key informants with whom we spoke—was unable to specify exactly what non-material impact the kits have (or should have). An inability to identify and measure "dignity" in this context makes it extremely difficult for COs to effectively envision an appropriate program design (kit contents, distribution mechanisms, etc.) that can restore dignity. Furthermore, without any preliminary agreement on what dignity is or what its restoration would look like, it becomes almost impossible to monitor and evaluate programs that are designed specifically to restore dignity. This is just one example of the myriad ways in which practitioners defined and applied the concept of dignity.

c. What is the primary objective of UNFPA's dignity kit intervention?

The most fundamental challenge facing the effective and consistent implementation of UNFPA's provision of dignity kits is that there is a clear lack of consensus on the objectives of this activity. While dignity kits were first introduced as an ad hoc activity, over the course of ten years they have become a common intervention in UNFPA's humanitarian responses without benefitting from the development of a clear and consistent program objective (or corresponding logical framework). Key informants from UNFPA were asked to explain what they thought was the main objective behind the provision of dignity kits. For the most part, responses fell into three broad categories: the restoration of dignity, improved mobility and fulfillment of basic hygiene needs.

The table below illustrates just some of the diversity of responses that UNFPA practitioners provided on the objective of dignity kit distribution.

Table 3. Objectives of dignity kits

Restoration of dignity	"The principle objective is to return dignity to women who have lost everything in emergency situations, giving them the possibility to have access to basic hygiene items" "Giving opportunity to affected women to feel as human beings—as

	ladies. During emergencies they lose everything. For this reason, the main objective is to give them these things so that they should start to feel as human beings."
Improved mobility	"The objective of the kits is for the recipients to have access, to be mobile…People misunderstand it….The purpose is to ensure mobility." "[Kits] are important for women's dignity, comfort and mobility. Without them, women may be inhibited from carrying out daily tasks, and girls may miss out on school."[40] "The uniqueness of the kits is that they are tailored to respond to the religious needs of the targeted population. In Pakistan, for example, there is a need to cover the body to go out, to fetch water and other things women need to do on a daily basis to help their families."
Basic hygiene needs	"To prevent for example the outcome of disease. The needs of women's hygiene. In order to meet their demands, like having clean towels…washing clothes…and keeping children clean." "Both [hygiene kits and dignity kits] are for meeting immediate needs." "[Improved access] was not part of the objective at that time…This was particularly aimed at helping women get by."

It is important to note that though the responses have been presented according to three broad categories, there is clear overlap in practitioners' explanations, further indicating the lack of clarity on the precise purpose of the dignity kit program.

Finally, international humanitarian standards provide a basis for resolving the lack of clarity on the objectives of dignity kits, particularly on the matter of the distinction between the restoration of dignity and the fulfillment of basic hygiene needs. The revised SPHERE Project Handbook (2011), for example, provides a starting point for the discussion: "Dignity entails more than physical well-being; it demands respect for the whole person, including the values and beliefs of individuals and affected communities, and respect for their human rights, including liberty, freedom of conscience and religious observance."[41] In explicitly defining dignity as "more than physical well-being," The SPHERE Project implies an international standard whereby programs that aim to restore dignity must have an effect beyond the fulfillment of basic hygiene needs. Applied to dignity kits, this creates a space in which an important distinction should be made between the *primary* objective of dignity kits (to fulfill social and psychological needs) and hygiene kits (to meet basic health needs). Though these two objectives are not mutually exclusive, a kit that is designed with the explicit intention of restoring dignity to beneficiaries must go above and beyond the fulfillment of basic material or hygiene needs in accordance with accepted humanitarian values. To maximize and measure effectiveness, then, the UNFPA dignity kit intervention must identify a primary objective and articulate a logical framework for achieving that objective. Given that our findings indicate

[40] UNFPA. (2006). Women are the Fabric: Reproductive Health for Communities in Crisis;" http://www.unfpa.org/webdav/site/global/shared/documents/publications/2006/women_fabric_eng.pdf

[41] The Sphere Project. *The Sphere Project: Humanitarian Charter and Minimum Standards in Humanitarian Response*, 2011, 23.

significant variation in COs' interpretations of what this objective is, the SIPA team has identified this as an important gap in UNFPA's current implementation of the dignity kit intervention.

4. Recommendations

Building on the above findings, the SIPA team recommends a series of steps that UNFPA should take when considering future dignity kit interventions. This series of recommendations is meant to encourage open and experience-based reflection from key UNFPA stakeholders that would, ideally, result in an informed, clear and consistent vision for the global provision of dignity kits.

a. Identify a primary objective for dignity kit provision

Practitioners have identified a variety of objectives that they believe describe the overarching objective of the UNFPA's provision of dignity kits: the restoration of dignity, improved mobility and the fulfillment of basic hygiene needs. Additionally, our research indicates that dignity kits might be used as an entry point to access hard to reach communities with additional education and services that fall within UNFPA's mandate (such as the provision of GBV services or the promotion of reproductive health and rights). Given the number of directions UNFPA might take at this juncture, the SIPA team recommends the following component questions to facilitate the identification of a primary objective for the dignity kit intervention:

a. What is UNFPA's niche in humanitarian response and what role do dignity kits play in this?

b. What vulnerable or excluded populations that fall under UNFPA's mandate should be targeted by dignity kit provision?
c. Are dignity kits an immediate humanitarian response, or are they appropriate in early recovery or transition to development phases?

The discussions that emerge from these questions will help UNFPA identify a specific and actionable program objective. *The first recommendation, therefore, is to agree upon a program objective that clearly defines what dignity kits do for whom and in which contexts.*

b. Develop a theory of change

Once UNFPA has agreed on what it wants the global dignity kit program to accomplish, the SIPA team recommends that the agency build an appropriate theory of change that can contribute to the fulfillment of this objective. Not only are sound theories of change considered best practice to guide program implementation, but theories of change are typically articulated in logical frameworks, which in turn permit meaningful monitoring and evaluation by industry standards.[42] *The second recommendation is to develop a theory of change and translate it into a comprehensive logical framework that can guide practitioners in the implementation and evaluation of dignity kit provision.*

c. Improve needs assessments guidelines

[42] ALNAP. *Evaluating Humanitarian Action Using the OECD-DAC criteria: An ALNAP guide for humanitarian agencies.* Overseas Development Institute. March 2006.

Though UNFPA COs frequently indicated that they had conducted needs assessments in preparation for the distribution of dignity kits, reports suggest that needs assessments are often informal and haphazard. Furthermore, they may not be targeted enough to adequately address questions of what needs women (or other target populations) actually face, and how dignity kits might best be designed to address these needs.[43] As such, the SIPA team encourages UNFPA to develop centralized guidelines for conducting purposeful needs assessments that will allow COs to most effectively document and meet the needs of the local population. Importantly, the guiding questions behind an assessment will depend largely on many of the outcomes of many of the steps we have previously recommended. For example, if UNFPA chooses to target its program objective to use dignity kits as an entry point for introducing other services, the provision of kits will have to be based on an identification of priority needs for populations within UNFPA's mandate. *The third recommendation is that UNFPA should establish clear needs assessments guidelines to improve the appropriateness and effectiveness of dignity kit provision.*

d. Establish and disseminate overall dignity kit program guidelines

As our findings indicate, interviews with UNFPA CO staff revealed a general lack of clarity on the objectives and processes behind dignity kit provision. Once steps one through three have been realized, the results should be translated into clear and actionable guidelines for UNFPA COs. Guidelines should include:

a. Guidelines for performing needs assessments;
b. Criteria for defining target groups;
c. Criteria for identifying distributing partner organizations;
d. Best practices for improving coordination and avoiding duplication;
e. Procurement guidelines; and
f. Monitoring and Evaluation guidelines

The fourth recommendation is to establish and disseminate guidelines for UNFPA's global dignity kit program. If feasible, COs should be trained in these guidelines in order to establish broad organizational agreement on the purpose and implementation of dignity kit provision.

e. Conduct regular monitoring and evaluation

Monitoring and evaluation of humanitarian assistance is an accepted global standard. With steps one through four in place, UNFPA should have the foundation from which to realize the final recommendation: *to conduct regular monitoring and evaluation that is used to inform the ongoing improvement of UNFPA's global dignity kit intervention.*

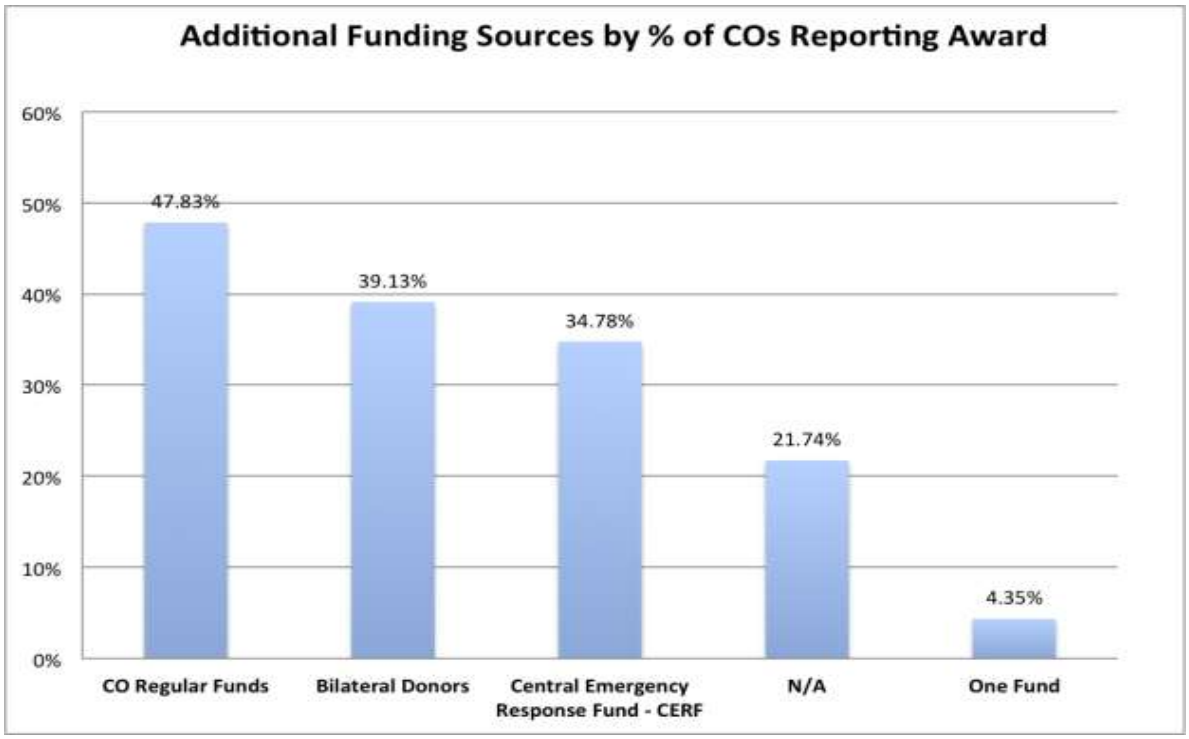
[43] In Kyrgyzstan, for example, the Protection Cluster's rapid assessment suggested that some women might be facing considerable information gaps in terms of where to access services, the status of conflict, etc. As a result, UNFPA procured hand-held radios for inclusion in the dignity kits. The SIPA team's research, however, revealed that many beneficiaries did not even remember that this (high cost) item had been included in the kit. When groups did remember to include the item in their PRM activities, it was consistently ranked at the bottom of the list, and women explained that the radios' primary value had been for entertainment value. This is an important example of a situation in which the rigor or specificity of the needs assessment did not yield cost-effective or impactful outcomes for either UNFPA or beneficiaries.

C. Logistics

In the vast majority of cases, the process of procuring UNFPA dignity kits begins with a needs assessment conducted shortly after the onset of an emergency. With few exceptions, COs do not engage in dignity kit procurement activities prior to the onset of an emergency. Yet evidence from select countries suggests that enhanced preparedness can lead to significant gains in efficiency in the distribution of dignity kits. By having mechanisms to facilitate procurement in place *prior* to the onset of a crisis, COs can avoid having to "re-invent the wheel" each time a crisis occurs.

Funding mechanisms and eligibility for dignity kit provision vary according to emergency and CO [for overview, see "An Overview of Dignity Kit provision," page13]. Although a direct assessment of funding sources was not undertaken as part of the team's assessment, a brief presentation of global survey data is useful to understand the diversity of funding mechanisms used in the provision of kits. The majority of distributing COs reported having received funding from UNFPA's EF to fund kits [n=24], while other significant funding sources included regular CO funds, bilateral donors and the CERF. A further breakdown by funding source from survey responses is depicted below:

Graph 3 – Global Survey Results on Funding sources (Excluding EF)[44]



This section highlights key findings related to the logistics of dignity kit provision at each stage of the supply chain: procurement, assembly, storage, transportation and distribution. A thorough analysis of survey and KII data yielded a number of best practices that we used to develop a series of recommendations aimed at improving the reliability and predictability of the supply chain. Given the often limited financial resources

[44] For breakdown of EF Award by Amount, see Annex XI.

for dignity kit provision, it is imperative that employed resources be used efficiently and effectively to achieve maximum possible benefit.

Research for this section is based on internal documents provided by UNFPA, KIIs and global survey data. A total of 18 UNFPA source documents were identified as relevant for inclusion. In addition, the team drew data from 116 KIIs and 29 global survey responses. To facilitate analysis, key quantitative data was organized by geographic region: Africa, South Asia, Central Asia, Arab States and Latin America (see Annex XIII). Qualitative data generated from key informant interviews was then analyzed with specific attention to the identification of major themes applicable to each stage of the supply chain.

1. Procurement

a. Procurement procedures can be cumbersome for COs

Procurement of dignity kits is highly decentralized and typically requires that the CO issue a Request for Quotation (RFQ), wherein written quotations are obtained from at least three suppliers.[45] For larger procurement contracts, UNFPA Emergency Procurement Procedures (EPP) require an Invitation to Bid (ITB) or Request for Proposal (RFP), a multi-phased process involving the formation of a local bid committee and approvals from the CO Representative and the Chief of the Procurement Services Branch (PSB).[46] RFQ solicitations must remain open for a minimum of 48 hours to allow suppliers to respond, whereas ITBs/RFPs must remain open for at least 5 calendar days. Moreover, the EPP requires that all procurement decisions be adequately documented by the CO. COs reported that fulfillment of EPP requirements can lead to significantly delays in the distribution of aid in an emergency. In some cases, COs were unaware of EPP requirements and/or lacked the technical capacity to procure in accordance with EPP rules.

It is also important to note that EPP were very recently adopted. Standard procurement procedures used in the majority of CO responses were overwhelmingly noted by informants to be even less flexible, and constrained the timeliness of response. One respondent indicated that in some instances the CO purposefully requested funding amounts below the $30,000 mark to avoid having to comply with standard procurement procedures and facilitate timely response, even if it meant being able to provide less coverage. It should be noted, however, that the use of RFQs and ITBs/RFPs is standard for UN agencies and these mechanisms are part of recognized Good Procurement Practices.[47] Nevertheless, UNFPA HQ should work closely with the PSB to understand how the EPP can be adapted to better reflect the reality of procuring in emergencies.

Best Practice:
Incorporate Pricing Flexibility into LTAs

In Sri Lanka, LTAs include a provision that enables suppliers to increase prices by 20 percent in the event that input prices change, thereby increasing the likelihood that a supplier will enter into an LTA.

[45] For procurement contracts valued between USD $5,000 to USD $99,999.
[46] For procurement contracts valued between USD $99,999 and USD $499,999.
[47] See the UN Procurement Practitioner's Handbook http://www.unicef.org/supply/files/UN_Practitioners_Handbook.pdf

b. Broad Support for Supplier Agreements, but Few Actually Implemented

Survey and interview data revealed that, while COs overwhelmingly favor the establishment of supplier agreements such as pre-qualified vendor lists or long-term agreements (LTAs), few had made any tangible steps toward establishing these agreements in their location.[48] Only two COs, Sri Lanka and India, reported having LTAs in place for procurement. In some instances, COs had scant knowledge of the supplier landscape and relied on Internet searches and phonebook queries in order to locate vendors following the onset of an emergency. Yet, a vast majority of survey respondents indicated that the establishment of LTAs would increase preparedness and facilitate a more rapid emergency response. This was validated by the experiences of Sri Lanka and India, where reduced costs and enabled UNFPA to access hard-to-reach communities. In Sri Lanka, the establishment of LTAs with both local and international suppliers has increased UNFPA's reliability, thereby strengthening its relationship with the Sri Lankan MOH.

c. Strong Preference for Local Procurement

COs reported a strong preference for local rather than international procurement. A number of COs indicated that international suppliers provided competitive bids for kit items compared to local suppliers; however, once shipping costs, customs and other taxes and fees were calculated into the total cost, international bids were considerably less attractive. COs also cited the timeliness of delivery and beneficiaries' familiarity with local products and brands as factors that favored local procurement. In a few notable cases as the 2010 earthquake in Haiti, COs procured internationally if the country was so devastated by the emergency that the local market was not functioning in the initial response phases. Local procurement resumed once local market capacity was restored.

d. Trade-off between Timeliness and Customization

There exists a trade-off between customization of kits to local needs and preferences and the timeliness of emergency response. This trade-off is driven by the fact that customization necessitates the completion of a needs assessment, and customized items may have longer production lead times than standardized items. In the sample of countries surveyed, the time required to conduct a needs assessment ranged from one to two weeks, and the time between the completion of the needs assessment and the distribution of kits ranged from one week to almost two months, with a global average of three weeks between the needs assessment and distribution. To mobilize kits more rapidly, Indonesia and Guatemala used a two-phased approach in which standardized kits were distributed in the immediate response phase and customized kits were distributed later, in the early recovery phase.

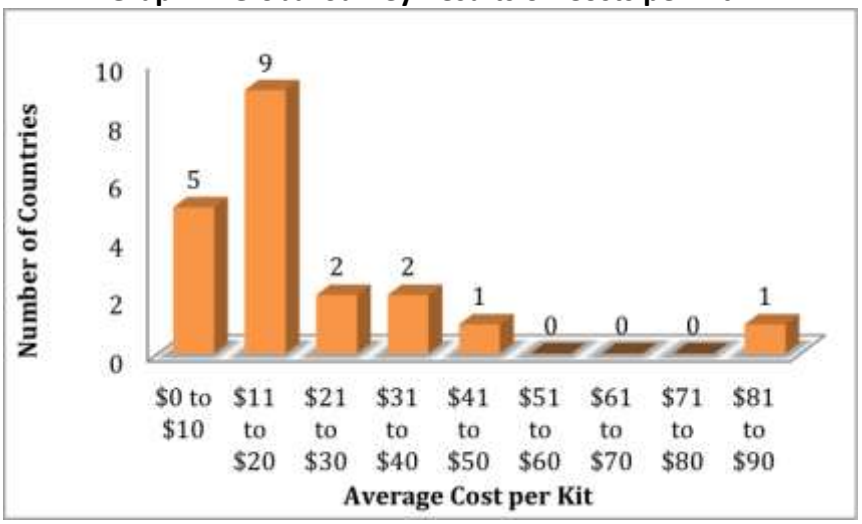
[48] Pre-qualification is a method whereby suppliers of particular goods or services are assessed against pre-determined qualification criteria, and only those suppliers who comply with the criteria are invited to bid. Pre-qualification ensures that bids are only received from suppliers who are able to comply with the requirements. An LTA is a written agreement between a UN organization and a supplier covering all the commercial terms applicable to the orders that may be issued against them for pre-selected goods or services: pricing, discounts, payment, delivery and packaging and any other relevant special as well as the general terms and conditions.

It is important to qualify these findings in light of standard "timeliness" in humanitarian response. According to the Sphere standards, the timeframe of response cannot be explicitly stated, as the life of an emergency can last days, weeks, months or even years.[49] However, Child Protection Rapid Assessment (CPRA) guidelines indicate that phase I response should occur within 72 hours of an emergency; phase II within two weeks, and phase III response within three to four weeks following the onset of an emergency.[50] It is also important to note that population needs change over this timeframe; SPHERE standards recommend that basic hygiene items be distributed in the first 72 hours of an emergency, with more comprehensive hygiene kits to follow in subsequent distribution phases.

By this standard, the majority of COs interviewed and surveyed for this report were unable to provide hygiene items in the immediate "timely" response phase for immediate response, but were generally successful in meeting the timeliness specifications of the early recovery phase. It is important to note, however, that a number of COs were unable to provide kits within this four week timeframe. Moreover, additional consideration should be given to the *relevance* of kits to the designated recipients to meet priority needs three to four weeks following an emergency event.

e. Average Cost of Kits

Graph 4- Global Survey Results on Costs per Kit[51]



Source: Own elaboration - Dignity Kits Global Survey, 2011.

The average cost per kit was USD $22.18 based on the responses of twenty out of twenty-nine COs that provided a global survey response to this question. The price per kit ranged from as low as USD $3.85 (for a basic kit containing only women's underwear and sanitary napkins) to as high as USD $89 (for a kit with winter clothing items in response to a cold weather emergency). Informants almost universally indicated the specialty items in the kits (clothing, radios, solar lamps, etc) were the most expensive items to procure. For example, in Kyrgyzstan, these items included nightdresses, vests, leggings and radios. The graph above

[49] Sphere Project, *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*, 2011, available at: http://www.sphereproject.org/component/option,com_docman/task,cat_view/gid,17/Itemid,203/lang,english/ [accessed 6 May 2011]

[50] Child Protection Rapid Assessment Guide, *Global Protection Cluster.* 11 January2011.

[51] Nine Countries did not provide the cost per kit for the last time they distributed kits.

displays the range of costs per kit. As shown, most of the kits cost less than USD $20.00, with the majority of kits falling in the USD $10.00 to $20.00 range.

Although hygiene kits distributed by other agencies appear to be less costly on average, it is difficult to assess the relative costliness of dignity kits to the standardized hygiene kits, as i) the SIPA team was unable to obtain exacting costing information from other distributing agencies;[52] and ii) hygiene kits generally do not contain the more costly specialty items customized to the local population found in dignity kits and therefore direct cost comparisons cannot be made.

2. *Storage*

Multiple Modalities for Storage: Our research uncovered a diversity of modalities for the storage of dignity kits, the most commonly reported being UN warehouses or warehouses managed by local NGOs.

Table 4: Global Survey Data Results for Storage (All Regions)

Site	Number of Offices Reporting Used Site for Dignity Kit Storage*
UNFPA Country Office Bldg	9
UN Warehouse	11
Local NGO Warehouse	10
Government Warehouse	5
School Bldg	1
Religious Bldg	1

*Note: Respondents reported using multiple sites for dignity kit warehousing, so tabulated results may add up to more than the number of survey responses.

a. Mixed Evidence as to the Cost Significance of Storage

Survey respondents frequently reported that no remuneration was provided for the storage of dignity kits; rather, warehousing was provided at no cost to UNFPA [n=19]. When costs were incurred for warehousing, the average cost to UNFPA for storage of the kits was approximately USD $7,000 per year.[53] A number of interview respondents reported using warehouses provided by organizations within the logistics cluster (primarily WFP or the UN Humanitarian Response Depot), and perceived this to be a good practice that reduced overall costs of kit provision. In other cases, COs reported using whatever warehousing was available closest to the disaster site in order to reduce transportation costs, even if fees were associated

[52] See Methodology and Limitations sections.
[53] Only three survey respondents reported costs for warehousing.

with the use of the warehouse. Other COs indicated that they had explored storage options in-country and found costs to be prohibitive to the establishment of safety stock.

b. Decentralized vs. Centralized Storage

At least one interview respondent reported difficulty in securing warehousing in more remote areas, as warehousing facilities operated by NGOs or UN partners tend to be centrally located near major cities. Indonesia, for example, pre-positions kits in a warehouse in Jakarta, from where they are deployed in the event of an emergency. However, transportation from the warehouse in Jakarta to other parts of the country has proven challenging. In order to reduce transportation lead times, the Indonesia CO is in the process of establishing decentralized warehouses throughout the country. In contrast, COs in Latin America and the Arab States reported exploring the possibility of establishing regional hubs to stock certain basic kit items and reduce overall storage costs.

c. Pre-positioning of Kits

Respondents indicated that the maintenance of a "safety stock" of pre-positioned kits in-country greatly improved the timeliness of the emergency response. In Guatemala, pre-positioning of kits allowed the CO to supply the first delivery of standardized generic kits within 5 days of an emergency, followed by a more customized kit in the weeks following the disaster. In Indonesia, pre-positioned kits were deployed from Jakarta within one week of the crisis. A few respondents mentioned that they had had safety stock of “core” kit items positioned strategically in Country sub-Offices, but that the amount stored in these spaces was inadequate to support response beyond that of a small localized disaster. Thus, the ability to pre-position kits is highly correlated with the ability to secure adequate storage capacity.

3. Assembly

a. Multiple Modalities Used

Global survey and interview data revealed that UNFPA COs employ a variety of modalities in the assembly and packaging of dignity kits. The two most common mechanisms used for the assembly of the kits were i) local/international suppliers [n=16] and ii) women’s/youth groups [n=11]. A number of COs reported using multiple modalities of package assembly simultaneously, commonly citing the exigency of the emergency as the reason for doing so.

b. Assembly Used as an Opportunity to Support Local Livelihoods

In a few instances, COs reported enlisting youth and/or women’s groups to assemble kits as an income generating activity, noting that the use of these groups generated a feeling of solidarity within the community. Interviews with key informants indicated that remuneration usually consisted of a daily stipend or a daily food allowance that was paid for by CO funds. The most notable use of these groups to assemble kits was in Haiti, where the CO employed 100 youth volunteers to assemble 90,000 kits in the aftermath of the 2010 earthquake. Although volunteers did participate in some educational seminars on issues related to reproductive health (and a small number later assisted in the distribution of contraceptives in the camps), it does not appear that comprehensive follow-up with youth volunteers continued after assembly completion. Thus, the role of dignity kits as an income-generating activity appears to be that of a temporary

budget substitution mechanism. A summary of groups employed in kit assembly and remuneration costs is shown below:

Table 5: Global Survey Results on Assembly (All Regions)

Group	Number of Offices Reporting Used Group for Kit Assembly	Number of Offices Reporting Remuneration of Group
UNFPA Staff	7	0
Women's Group/Youth Group	11	5
Local/Int'l Supplier	16	13
Local NGO	4	0
Religious Group	1	0
Other Volunteers	5	0

c. Assembly Not a Significant Cost Driver

The most frequently remunerated group for kit assembly was local and/or international suppliers, who provided assembled kits to the CO as part of the supply arrangement. All-inclusive contract agreements with suppliers that included procurement and assembly reduced overall costs compared to segmented contracts for each discrete phase of the supply chain. COs were, however, able to significantly reduce or avoid incurring assembly costs altogether through the use of local groups or government partners. Although exact costing data was not available, survey countries ranked assembly as the least expensive cost driver of procurement in more than half of the survey responses [n=16].

d. Inconsistent Quality Control

Suppliers frequently employed independent quality control systems to verify the quality of the goods supplied. Where assembly was not done by suppliers, quality control measures were inconsistent. KIIs revealed the need for robust, country-level quality control mechanisms to be built into contracts or outsourced to implementing partners.

Spotlight on Quality Control

"...we had a specific example of an issue with the soap which came from some country and it was put in our kit, internally we saw nothing wrong with it. But we got calls from our partners, because [it turned out] one of the soaps was a whitening soap [which women scrub on their skin to make it lighter]. They were outraged. They felt like UNFPA was supporting this idea that to be beautiful you need lighter skin." (KII, 2011)

4. Transportation

a. Costs Incurred at Two Points

Survey and interview data indicated that overall transportation costs were incurred at two points: i) the transportation of items from the supplier to the specified docking station and ii) transportation of the kits to community distribution sites. Transportation of kits to docking stations or warehouses was often done through a UN partner or by the contracted supplier. Similar practices were reported for the transportation of kits to community distribution sites, which was commonly done through either UN or local distributing partners. The average cost of transportation was USD $5,275, according to survey results [n=11].

Main Cost Driver of Procurement: Global survey responses from all regions consistently ranked transportation as the most costly element of dignity kit supply chain, which was corroborated by data from in-depth interviews. However, countries that utilized partner UN agencies or government partners to transport the kits reported very low or no costs associated with the transportation of kits.

Volatile Pricing Costs: Respondents noted that transportation costs often rose dramatically in the aftermath of the emergency for a variety of reasons: elevated fuel costs, damaged infrastructure and compromised road access, security considerations[54] associated with transportation in the case of conflict-affected zones, the remoteness of disaster-affected locations, and increased operating fees for transporters following an emergency. Timeliness, reliability of transporting partners and insurance costs were general cost considerations in solicitation of transportation carriers.

b. Few LTAs for Transportation

The majority of CO respondents disclosed that they had no pre-arranged agreements with other agencies or distributing partners for the transportation of kit items, but considered this to be a good practice that would reduce costs and delays in the event of an emergency. A small number of respondents [n=2] reported having LTAs for transportation, and indicated that coordinating these agreements with other UN agencies or partners could reduce costs to UNFPA. There was, however, a lack of consensus on the feasibility of pooled transportation LTAs; some respondents suggested that joint LTAs with other UN agencies, while attractive in theory, would be difficult to execute, as most other UN agencies have sufficient funding to secure transportation independently. Nonetheless, a number of respondents mentioned the possibility or desire to improve coordination with WFP for the transportation of kits, as is done in Mozambique.

"What I'm saying is that transport in the case of [this region], always takes up to 50% of your total budget so if you can save on transport, you can save your money." - KII 28 March 2011

[54] This was only noted specifically in the case of one interview, but the informant indicated that security and insurance costs in conflict zones are universally applicable.

c. Challenges in Coordination

A consistent challenge mentioned by interview respondents was the difficulty of coordinating transportation with other UN partners, particularly within the cluster framework, as UNFPA typically does not participate in Logistics Cluster meetings. One informant described a situation in which UNICEF was distributing hygiene kits in close proximity to where UNFPA dignity kits were to be distributed, noting that transportation could have been coordinated with UNICEF. However, UNFPA staff did not learn of this until after the distribution had already occurred and were therefore unable to coordinate with UNICEF in advance. Informants also described instances in which transportation had to be independently arranged or aggressively negotiated with UN partners due to disagreements on transportation routes or delivery timeframes. If these differences could not be resolved, COs were forced to arrange other modes of transportation, which contributed to delays in kit distribution.

Best Practice:

Long-Term Agreements with Partners for Transportation

In 2010, Mozambique signed an LTA for transport with WFP in country. The agreement is renewed on a year-to-year basis UNFPA has flexibility to decide which services to use.

5. Distribution

a. Outsourcing to Local Partners

The distribution of dignity kits is overwhelmingly outsourced to local implementing partners. In some cases, distribution arrangements are based on the UNFPA CO's existing relationships with community-based organizations (CBOS), including NGOs, faith-based organizations, health care providers and/or local government institutions. These organizations are often closer to the ground than UNFPA and are better acquainted with the needs of affected populations, having already established networks in the local community. COs reported a number of criteria used to select implementing partners for the distribution of dignity kits. Among these criteria was reputation, past performance, access to, and credibility with, local communities. In some cases, CBOs were able to access areas that would otherwise be inaccessible to UNFPA. In Kyrgyzstan, where ethnic tensions were high in the acute stage of the conflict, certain areas were inaccessible to UNFPA staff. UNFPA was able to reach affected populations in this community by leveraging its relationship with a local health center.

"From our experience we know that the active partnership with various organizations (NGOs or governmental sector) is a very cost-effective tool. Close collaboration has helped to increase effectiveness of the humanitarian program, they provided assistance in storage and transportation of kits, which allowed UNFPA to make savings on operational costs and channel these funds for purchasing additional hygiene items."

UNFPA staff. CO documents. 2008

b. Partnerships with International NGO's

Another strategy observed in several countries is the establishment of partnerships with the national Red Cross or Red Crescent, which in most cases already has the logistical infrastructure and experience to effectively deliver dignity kits. In several countries, dignity kits are targeted to the most vulnerable populations in places that are not being covered by other humanitarian agencies; the remoteness and difficulty of reaching these locations makes the Red Cross and Red Crescent an ideal partner, as they usually have broad territorial access and have volunteers at the local level that can initiate an immediate response and help gather information about populations in need. In Kyrgyzstan, one key informant noted that, during the crisis, the only cars seen on the road were those of the Red Crescent.

Best Practice:

Partnerships with well-established CBOs to distribute dignity kits

The Guatemala CO partnered with CBO *Equipo de Estudios Comunitarios y Acción Psicosocial de Guatemala* (ECAP) for the distribution of dignity kits and complementary activities. This CBO has experience working all over the Guatemalan territory and knew the population. Most of its staff is bilingual, fluent in Spanish and in the Mayan dialects spoken by beneficiaries. UNFPA had partnered with the CBO on a number of past occasions and found they were able to mobilize support quickly in the event of an emergency.

c. Partnerships with Government agencies at the local level

A number of countries have established partnerships with the government to distribute dignity kits, as is the case in Mozambique. There, the CO works in conjunction with the Instituto Nacional de Gestão de Calamides (INGC), a government agency that has established a strong preparedness strategy that involves coordination with all actors involved in emergency response. INGC connects humanitarian organizations with the corresponding line ministry to coordinate aid distribution.

d. Challenges in Coordination and Integration

An important factor in dignity kit distribution is the strength of coordination within the UN system. In countries where the cluster approach works efficiently, UN agencies and other organizations involved in the cluster approach can take advantage of synergies to make distribution more effective and to better address the needs of affected populations. Nevertheless, UNFPA faces challenges in this area, as dignity kits are not streamlined within the cluster system. Depending on the country, dignity kits can fall under a range of clusters, including WASH, Protection, Health and GBV. In Kyrgyzstan, where a distinction is made between hygiene kits and dignity kits, hygiene kits fall under the WASH cluster and dignity kits fall under the Protection cluster. Within the cluster system, knowledge about dignity kits is limited, which suggests that stronger advocacy is needed to educate stakeholders about the role of dignity kits in humanitarian response.

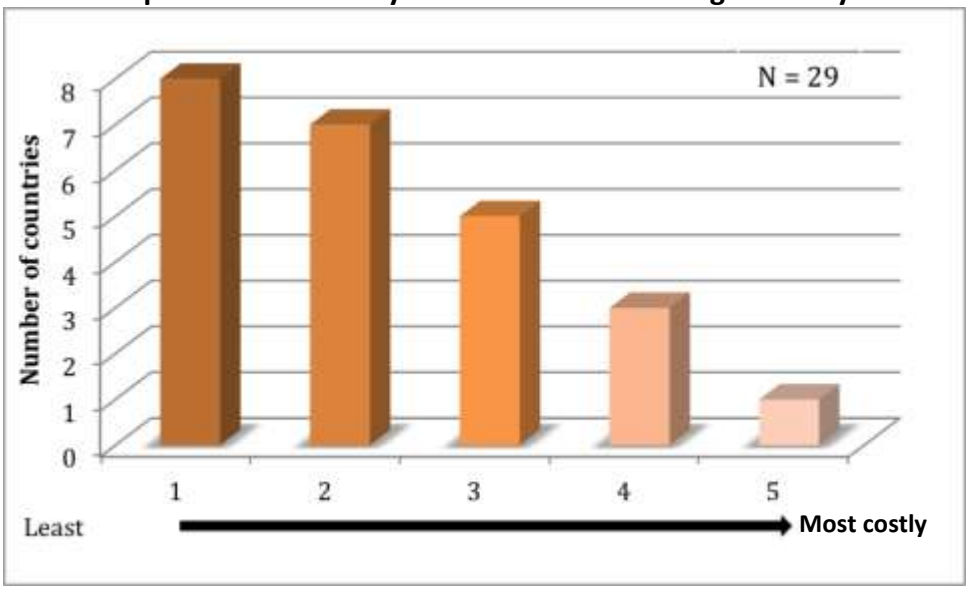
e. Challenges in Monitoring and Follow-Up

Despite the benefits of leveraging local partnerships, there is little, if any, monitoring of distribution activities during the crisis or follow-up with beneficiaries after distribution is complete. UNFPA has little oversight or control over the distribution process, making an assessment of the impact of dignity kit interventions difficult.

f. Distribution is Not a Significant Cost Driver

While distribution requires significant investment in time and effort (e.g., the establishment of strong partnerships with local organizations, coordination and negotiation with other UN agencies, etc.), distribution did not emerge as a significant cost driver. According to data from the global survey, only one country found the delivery of dignity kits to be the most costly element of the supply chain and eight countries found it to be the least costly.

Graph 5- Global Survey Results on Cost Ranking: Delivery[55]



g. Distribution coverage

COs distributed an average of about 7,500 kits per response. There was also a wide spread in the number of kits distributed, ranging from 200 to 100,000, contingent on the costliness of the individual kits and the amount of funding available for kit provision.

With the exception of outliers Haiti, Myanmar and Pakistan, most kit distributions met or were under the average number of kits per emergency, and in some cases far less, as some survey respondents reported

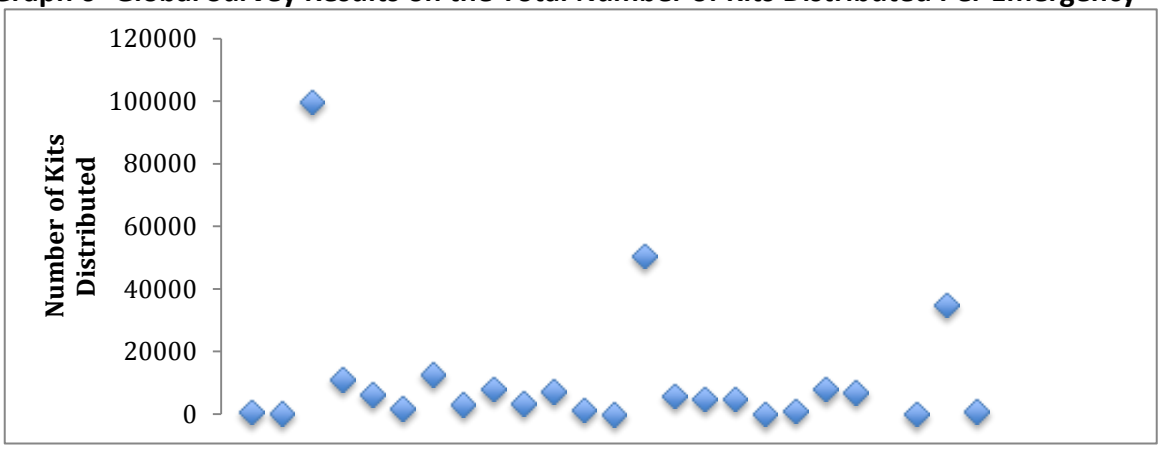
"If I were to manage an operation I would make sure to have people on the ground to make sure the kits are distributed to the people/places they are supposed to go.

-KII, 21 April 2011

[55] Seven countries did not provide a rank for this specific cost in the supply chain.

number of kits distributed per year, not per emergency. In general, coverage amount indicated by COs were usually insufficient to cover the amount of eligible beneficiaries.

Graph 6- Global Survey Results on the Total Number of Kits Distributed Per Emergency [56]



6. Recommendations

The following recommendations were derived from "best practices" employed by UNFPA COs globally in the provision of dignity kits, as well as from analysis of UN Good Procurement Practices. They are designed to establish more dependable, predictable procurement mechanisms that can be leveraged by COs to more rapidly and effectively respond in the event of an emergency as well as overall implementation effectiveness defined by the ALNAP criteria.

a. Establish LTAs and supplier agreements

COs are overwhelmingly in favor of the establishment of LTAs with suppliers; yet few countries have LTAs in place for the procurement of dignity kits. The reasons for this are unclear, but may have to do with human resource constraints and competing priorities. Wherever possible, the SIPA team recommends the establishment of LTAs with suppliers for the provision of dignity kits, particularly in countries subject to recurring crises, where the need for predictable and reliable procurement mechanisms is great.[57]. Evidence from our data suggests that the existence of an LTA can materially affect the reliability and credibility with which COs can respond to humanitarian emergencies.

A survey of the procurement process by the Arab States RO was done in Lebanon, OPT, Iraq, Jordan and Syria concluded that a local LTA is more beneficial than a regional LTA.[58] The decision to procure locally rather than internationally depends on, inter alia, organizational preferences, local market competitiveness and ease of entry of foreign goods into the local economy. Refer to Annex XIV for a decision tool proposed by the SIPA team that illustrates the key determinants of local versus international procurement.

[56] Five countries did not provide information for this question.

[57] Countries having dealt with repeated crises are also better positioned to negotiate LTAs with suppliers. They can, for example, use historical procurement data to estimate annual procurement needs, which may be required by suppliers in order to set up an LTA.

[58] Result highlighted by the Syria CO in an interview with the authors on 13 April 2011.

In countries not subject to recurring crises, the establishment of an LTA is recommended if the perceived benefits outweigh the administrative and labor costs involved in its establishment and maintenance. If the time and effort required to set up an LTA are unjustified given the anticipated benefits, then the SIPA team recommends more informal preparedness measures such as the establishment of a preferred vendor list. At any given time, COs should have a running list of at least three price quotations, fixed for six months to one year, so that at the onset of a crisis COs already know which suppliers are available, which products each offers and at what prices.

Best Practice:
Sign LTAs with at least two suppliers

Establish agreements with at least two suppliers to avoid being sole supplied. This will protect against any major disruptions in supply should one supplier be unable to meet requirements.

b. Pre-position "core" kit items

Countries that hold kits pre-positioned prior to the onset of a crisis were able to deploy dignity kits during the acute stage of the emergency. In Indonesia, pre-positioned kits shortened the lead-time to distribution during the 2010 Merapi eruption. In Kyrgyzstan, the CO was able to deploy pre-positioned hygiene kits within weeks of the eruption of the 2010 conflict. In contrast, dignity kits, which were not pre-positioned, were distributed several months later. The SIPA team recommends that, wherever possible, countries subject to recurring disasters keep a safety stock of core, non-perishable items in storage. These items should include, at a minimum, soap, toothbrush, toothpaste, sanitary pads, and panties. Core items can be supplemented with locally appropriate items following a needs assessment.

This strategy ensures that ex-post procurement activities focus only on those items identified as part of the needs assessment, thereby reducing the time needed to procure kit contents in the acute stage of a crisis. Should procurement of supplemental items be delayed for any reason, COs can opt to distribute core items immediately and follow this up with a second distribution of non-core, locally-appropriate items as soon as they become available, as was done in Guatemala and Indonesia. Pre-positioning of core items thus provides COs with added flexibility. It should be noted that, in countries with recurring disasters, past experience may be sufficient to determine kit contents without the performance of a formal needs assessment. If the items required in the context of a recurring emergency are well known, then the entire kit can be pre-positioned in advance. If appropriate, in recurring emergency settings, COs should seek to conduct "ex-ante" needs assessments, in which the contents of dignity kits are determined before the onset of an emergency. It should be noted that prime candidates for pre-positioning are countries with recurring natural disasters, particularly those with multiple weather seasons throughout the year. If, in the unlikely event the CO pre-positions but the disaster does not occur, most core items, with the exception of body soap, have a long enough shelf life that an inventory can be maintained for several years with proper inventory maintenance. COs can also arrange agreements with other local NGOs or UN agencies to ship items within the region as needed if items are not needed in-country during a given disaster season.

One potential barrier to pre-positioning is the availability of storage facilities. Ideally, suppliers would keep a safety stock of kit items that UNFPA could pull from in the event of an emergency; however, suppliers may be reluctant to do so as this requires that they assume the inventory risk. Alternatively, if UNFPA COs

lack storage capacity, it may be possible to piggyback on storage facilities used by other UN agencies, as has been done in a number of the countries surveyed. In other instances, UNFPA may need to rent or buy a storage space to house dignity kits. Additionally, pre-positioned inventory will need to be adequately monitored so that expired items are properly disposed of.

c. Enhance coordination between NGO partners, UN agencies and UNFPA COs

Better coordination between UN agencies has been shown to lower costs and increase the efficiency of emergency response, as demonstrated by UNFPA Mozambique's LTA with WFP for the transportation of dignity kits and UNFPA Kyrgyzstan's use of UNHCR warehousing capacity. Similarly, better coordination with NGO partners can strengthen program objectives by ensuring that dignity kits reach the intended populations. In Indonesia, for example, it was found that some women had received the wrong kits and, in some cases, kits were disassembled in order to achieve greater coverage. More robust communication between UNFPA and NGO partners about the objectives of dignity kits and their intended recipients may have helped alleviate some of these problems.

Prior to the initiation of distribution activities, UNFPA COs should clearly communicate program objectives, establish streamlined eligibility criteria and develop a distribution strategy jointly with NGO partners, as well as with other UN agencies. Where the Cluster response is activated, UNFPA should work to consolidate the number of clusters in which dignity kits are distributed in order to ensure adequate staff capacity to attend the relevant cluster meeting, in order to be able to leverage existing distributional arrangements and ensure a coordinated response. This will not only help minimize costs, but it will also help avoid duplication of effort and geographic overlap, which will lead to broader coverage of affected communities overall. The SIPA team recommends designating a member of the CO to represent UNFPA at Logistics Cluster meetings and to serve as a contact point for logistics-related issues.

A CO's ability to respond to an emergency can also be enhanced through coordination with other UNFPA COs. For example, systems should be put in place to enable the transfer of dignity kits from one country to another. This is standard practice in the distribution of essential medicines, for example; when a country experiences a stock-out, efforts are made to transfer inventory from nearby countries. A similar model can be applied to dignity kits, wherein countries with open borders but non-functioning local markets can request inventory from other COs in the region. While the financial repercussions of such an arrangement would need to be explored, one possibility is for the receiving country to reimburse the transferring country out of CERF or internal ERF funds.

d. Engage in more robust monitoring and follow-up of distribution activities

In the majority of countries surveyed, UNFPA does not directly distribute dignity kits; rather, this is done through partner NGOs and local civil society. This model leverages local knowledge of affected communities and enables UNFPA to access areas that might otherwise be inaccessible. At the same time, with no monitoring systems in place, UNFPA has little oversight over how and where dignity kits are distributed. In Mozambique, for example, child or woman-headed households were excluded from lists of affected households---even though these were some of the most vulnerable---as village leaders were responsible for selecting beneficiaries and consistently neglected to include these groups. The establishment of basic monitoring mechanisms, such as cross-checking lists of dignity kit recipients with lists of those affected, is recommended to ensure that programs are being implemented as intended.

e. Develop an Emergency Procurement Plan

The SIPA team recommends that every CO have an emergency preparedness plan in place that clearly outlines the processes and procedures for procurement in an emergency. At a minimum, the plan should include:

- UNFPA Emergency Procurement Procedures
- Information about available sources of emergency funding
- Details of any existing LTAs or supplier agreements
- Information about local NGOs and civil society
- Information about the supplier landscape (e.g. which suppliers are available, contact information, price quotes, etc.)
- Available transportation networks
- A contingency plan for international procurement should local markets fail
- Information about UNFPA's role in the cluster approach (e.g. which cluster meetings will be attended and who will attend)
- Information about the role of the UNFPA Procurement Services Branch (PSB) in providing support to COs in emergencies.
- Pre-existing arrangements to leverage resources and infrastructure of other UN agencies should the UNFPA CO's capabilities become compromised by an emergency.

Trainings should be conducted at least once a year on the emergency preparedness plan and should include NGO partners and, if possible, suppliers.

V. CONCLUSIONS

The SIPA team employed a mixed methods, multi-phased approach to assess the benefits and costs associated with UNFPA's provision of dignity kits in humanitarian and post-crisis settings. Given data limitations and the difficulties involved in quantifying benefits, a formal cost-benefit analysis modeling the magnitude of benefits relative to costs was beyond the scope of this assessment. Nonetheless, the team was able to identify a number of benefits and costs associated with the provision of dignity kits in humanitarian response. Dignity kits were found to have met the immediate hygiene needs of beneficiaries, helped beneficiaries feel acknowledged and remembered, and have a budget substitution effect. However, evidence from this assessment also indicates that dignity kit provision comes at significant cost, both in terms of direct costs such as procurement and transport and in terms of indirect costs such as human resource commitments and the opportunity costs associated with the provision of dignity kits in lieu of other UNFPA humanitarian interventions.

Dignity kits are distributed in a variety of settings, each with distinct challenges and opportunities relating to the distribution of aid. Dignity kits are distributed in acute and chronic/protracted crises; to displaced people in camps and resettlement centers as well as to residents in urban settings; and in response to both man-made and natural disasters. These differences make direct comparisons between and across countries difficult. As is common in humanitarian response, there are inherent constraints to measuring or quantifying the usefulness and value of a given intervention. For example, with respect to dignity kits, beneficiaries often reported finding all assistance useful when they have lost so much during an emergency.

With all of these considerations in mind, the SIPA team sought to answer the primary question posed in the terms of reference (ToR):

Given the costs and benefits, is it advisable for UNFPA to continue supplying dignity kits and under what circumstances? If so, what are the most appropriate and effective mechanisms to do so?

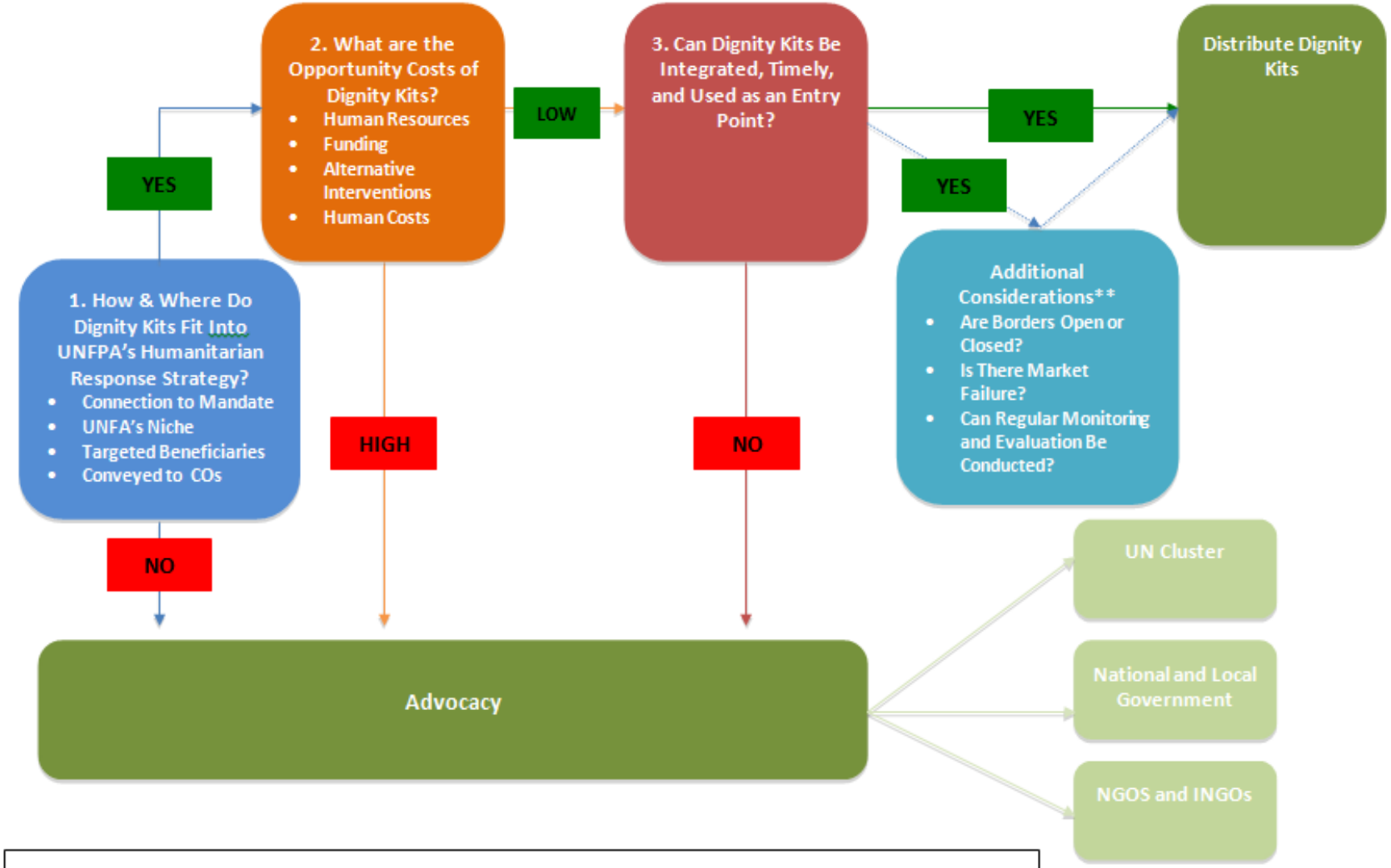
The SIPA team found mixed evidence of the impact and logistical effectiveness of dignity kit distributions, suggesting that the efficacy of supplying dignity kit is highly contextual.

In light of this, the SIPA team developed a series of recommendations aimed at identifying the conditions under which dignity kit provision is most appropriate, given UNFPA’s capacity and findings on the impact of kits on beneficiaries. The corresponding decision tool (see below) aims to enable a phased, strategic approach to determine under what circumstances dignity kits should be provided in emergency settings.

This tool is not to preclude UNFPA’s role in advocacy if dignity kits are provided during a given emergency, but rather to guide the decision processes of COs to establish if and when dignity kits are appropriate as an intervention.

GENERAL RECOMMENDATIONS: DECISION TREE

The purpose of this tool is to guide UNFPA's internal analysis of their dignity kit intervention. It provides strategic questions that UNFPA HQ and COs should consider before continuing with the intervention. The tool indicates that if the provision of dignity kits does not fit into UNFPA's greater humanitarian response objectives or comes at a high opportunity cost, UNFPA should discontinue its provision of kits and should, alternatively, further enhance its advocacy work in emergencies.



** Additional Considerations are extracted from analysis and recommendations in the Impact and Logistics sections of the final report. All specific recommendations in the findings sections that are directly related to dignity kit implementation should also be considered prior to dignity kit distribution.

A. Step 1

The SIPA team recommends that UNFPA first address the following three questions in order to proceed more effectively with the dignity kit intervention:

1. *How and where do dignity kits fit into UNFPA's core mandate and overall humanitarian response strategy?*

UNFPA has a unique mandate and a small but growing role in humanitarian response. The answer to whether or not dignity kits are a *crucial* component in the fulfillment of the UNFPA's humanitarian response logical framework—real or theoretical— will first require that *UNFPA HQ* articulate a clear vision for the future of UNFPA's role in humanitarian response. Specifically:

- In what phase(s) of recovery should UNFPA focus its distribution of kits?
- In what ways can UNFPA's provision of dignity kits fulfill a specific and important role in the broader picture of humanitarian response?
- Which populations should UNFPA humanitarian interventions target to appropriately fulfill its overall mandate, and are they best served by the provision of dignity kits?
- Can the purpose of the dignity kit intervention be effectively conveyed to COs and implementing partners in order to ensure a more consistent vision for the implementation of the intervention?

2. *What are the opportunity costs of providing dignity kits with respect to UNFPA's other humanitarian interventions?*

UNFPA might implement a number of appropriate humanitarian response interventions –such as the provision of psychosocial services for GBV or RH kits for health facilities – in fulfillment of its mandate. Working on the assumption of limited financial and human resources, however, *UNFPA* must assess the opportunity costs of dignity kit provision *vis a vis* other humanitarian response interventions. Component questions include:

- Does the dignity kit intervention best capitalize on UNFPA's unique strengths as an agency with a background in development and advocacy?
- How do the demonstrated impacts of dignity kit provision—met hygiene needs, a feeling of being "remembered," and budget substitution—compare against the demonstrated impacts of other humanitarian response interventions?
- Alternatively, can an evidence-based dignity kit intervention be developed moving forward so that its impact and cost-effectiveness is improved such that it becomes relatively cost-beneficial compared to other interventions?

3. Can dignity kits be integrated, timely, and used as an entry point?

Integration: In accordance with international humanitarian response standards, the SIPA team recommends that UNFPA only proceed with dignity kit provision if the intervention can be delivered in an integrated and timely manner. "Coordination and collaboration in humanitarian response" is one of the core Sphere standards for humanitarian response, as a means of achieving greater efficiency, coverage and effectiveness[59]. Consequently, for dignity kits to have a sustainable impact in addressing the needs of affected populations, their distribution must be integrated within the larger response framework of the government and other humanitarian response actors.

Timeliness: In times of emergency the needs of the affected population change in a rapid manner. The SIPA team's evidence indicates that in some cases, UNFPA dignity kit distribution has been characterized by considerable lag time between the performance of the needs assessment and the effective delivery of dignity kits to beneficiaries. In addition, other humanitarian actors have a greater capacity to provide a faster and larger scale response. As such, the SIPA team recommends that UNFPA make a strategic decision regarding the relevance of the contents of the kits to meet the priority needs of the target population; if by the time the kits reach their destination, needs have already evolved or the composition of the population has changed as displaced populations relocate, the impact and effectiveness of dignity kits will be diluted.

Entry Point: Given UNFPA's limited distribution capacity *vis a vis* other agencies, the fact that other agencies distribute similar kits, and the mixed impact of the dignity kits as evidenced through this assessment, the SIPA team believes that UNFPA COs should only distribute kits if they can be used as an entry point. In this sense, kit provision would be utilized to access communities that could be targeted for other programs and services that correspond to UNFPA's mandate (GBV prevention and response, or gender and hygiene education or RH, for example). Additional services can be provided in conjunction with kit distribution or serve as an entry point for later interventions and will require strengthened training of trainers (ToT) for local partners. These activities will enhance the impact of the intervention, making dignity kit provision more sustainable while enabling the strengthening of other UNFPA CO interventions and programs in the future.

B. Step 2

If, upon reflection, UNFPA has identified a crucial role for the provision of dignity kits within its broader humanitarian response, the intervention comes at a low opportunity cost and it can meet the three previously identified criteria, then UNFPA (pending context-specific needs assessments) can appropriately consider continuing with the distribution of dignity kits.

If, on the other hand, (as the decision tool indicates) the answer to any of these key questions is "undecided, "no" or the opportunity cost for a CO is "too high" in relation to other humanitarian interventions, then UNFPA should discontinue the provision of the kits. Though the pursuant recommendation falls outside the immediate scope of the SIPA team's ToR, our findings lead us to suggest that—barring dignity kit provision—UNFPA should further enhance its advocacy work as part of its humanitarian response strategy.

[59] The Sphere Project. Humanitarian Charter and Minimum Standards in Humanitarian Response. 2011 Edition.

This assessment indicates that the impact of dignity kits as a stand-alone intervention is generally limited and UNFPA can better leverage its core competencies to advocate for the inclusion of a gender sensitive perspective into the planning and implementation of emergency response. This includes advocacy for strategic interventions that protect vulnerable groups against GBV and meet their RH needs in emergency settings. More specifically, UNFPA might promote the inclusion of customized and women-specific items in other organizations' NFI kits, so that even if UNFPA itself is no longer a kit provider, it can continue to guarantee that the hygiene needs of women and other vulnerable populations are met.

ANNEX I – CLIENT AGENCY

United Nations Population Fund

UNFPA was created as a trust fund in 1967 under the administration of the UNDP. Originally called the United Nations Fund for Population Activities, UNFPA began operations in 1969 with the mandate of promoting policies to improve women's rights and reproductive and sexual health. Today, UNFPA works to promote "the right of every woman, man and child to enjoy a life of health and equal opportunity."[60] UNFPA's existing mandate is based on principles set forth in two international frameworks: The Programme of Action of the 1994 ICPD and the Millennium Development Goals.[61]

UNFPA has 140 COs in five regions: Eastern Europe and Central Asia, Asia and the Pacific, Latin America and the Caribbean, Middle East and North Africa, and Sub-Saharan Africa. Its country programs focus on three core areas of work: population and development strategies, RH and gender equality.

Population and Development Strategies: Country programs support data collection and analysis related to population and demographics. They also promote policy dialogue aimed at addressing population dynamics and demographic issues such as migration, ageing, climate change and urbanization.

Reproductive health: UNFPA engages in a broad range of RH activities. These include advocacy and support for family planning programs; maternal health; prevention and treatment of infertility; prevention and management of abortion, HIV/AIDS and sexually transmitted infections; promotion of sex education; information and counseling; and prevention of violence against women.

Gender equality: UNFPA country programs bring attention to issues of gender equality by addressing four key areas: fostering girls' education, women's economic empowerment, women's political participation and balancing of reproductive and productive roles. Engagement on these issues includes the involvement of men and boys.

In addition to these three thematic areas, UNFPA programs cut across broad development concerns that include the use of culturally-sensitive, rights-based approaches, support for adolescents and youth, responding to the AIDS epidemic and assisting in emergencies. In the context of emergencies, UNFPA provides assistance and protection for populations at risk, including refugees, IDPs, and populations made vulnerable by natural disasters, violence and armed conflicts.[62]

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[60] From UNFPA website, http://www.unfpa.org/public/home/about.

[61] The International Conference on Population and Development was signed in 1994 by 159 countries. It states that population and development are interdependent and therefore ensuring access to education and health, as well as gender equality, supports the achievement of development goals. The Programme of Action is a twenty-year program aimed at achieving the goals in the ICPD.

[62] From UNFPA website, http://www.unfpa.org/public/home/about.

ANNEX II – TERMS OF REFERENCE

UNFPA – COLUMBIA UNIVERSITY SCHOOL OF INTERNATIONAL AND PUBLIC AFFAIRS
WORKSHOP IN DEVELOPMENT PRACTICE 2010-11
Terms of Reference
Evaluation of UNFPA's provision of dignity kits in humanitarian and post-crisis settings

1. Background

The United Nations Population Fund (UNFPA) works with governments, non-governmental organizations (NGOs) and sister UN agencies to support programs that help women, men, and young people to plan their families and avoid unwanted pregnancies; to improve the safety of pregnancy and childbirth; to avoid sexually transmitted infections (STIs) including HIV; and to combat gender-based violence.[63] UNFPA also emphasizes the promotion of gender equality in order to improve health and advance development. The Program of Action adopted at the 1994 International Conference on Population and Development (ICPD), and the Millennium Development Goals, guide UNFPA's work.

UNFPA is committed to assisting and protecting women, men and young people made vulnerable by natural disasters and armed conflicts. This includes refugees, internally displaced persons, and people made homeless or vulnerable by conflicts and disasters.

The relationship between UNFPA's Humanitarian Response Branch (HRB) in New York and Columbia University began in 2003-2004, when the School for International and Public Affairs (SIPA) provided UNFPA with a team of graduate consultants to evaluate the agency's HIV/AIDS programming in Sierra Leone. In 2004-2005, a second SIPA team mapped HIV/AIDS and sexual and gender-based violence (SGBV) programming in Liberia. The success of these partnerships led UNFPA to request a SIPA team in 2005-2006 to consult on RH issues and programming in Sudan, and in 2008-2009 to evaluate UNFPA's humanitarian interventions in Nepal after the 2008 floods. In 2010-2011, UNFPA is once again keen on collaborating with Columbia University for an evaluation study of dignity kits.

UNFPA has been involved in the provision and distribution of "dignity kits", also known as "hygiene kits", since the early 2000s. Conflict and natural disasters can destroy homes and communities from one moment to the next. Forced to flee or find shelter, families and individuals suddenly find themselves without basic necessities – including hygiene supplies. The lack of sanitary supplies for menstruation can impede the mobility of girls and women – who are usually responsible for collecting water and firewood – or may cause them to experience discomfort, shame and isolation for several days each month. In the absence of appropriate

[63] See www.unfpa.org for more details.

supplies, women may be inhibited from carrying out daily tasks, and girls may stay home from school, increasing their likelihood of dropping out.

UNFPA has taken the lead in organizing and distributing dignity kits based on what local communities have said they need. Dignity kits have been provided and distributed by UNFPA in many different emergency settings in all regions of the world. Kits' contents are usually identified in direct consultation with women (or other community groups) IDPs or refugees, who as far as possible are also involved in the assembly (as an opportunity for income-generating activity) of the kits. Kits generally include basic hygiene items such as sanitary pads, women underwear, soap, toothbrush, toothpaste, shampoo and washing powder, but also some specific items requested locally (eg: oil for hair in West Africa; head covering in some Muslim countries; slippers for disaster areas; buckets to store water, etc.)

However, it has become increasingly evident that this type of interventions comes at a high cost for UNFPA. The procurement, assembly, warehousing and distribution of kits often entails relatively high financial and human resource costs, for an often limited number of kits given UNFPA's financial constraints. Numerous agencies (such as UNICEF, IOM and others) are now also involved in the provision of hygiene kits/supplies. Therefore, an Evaluation of the usefulness, comparative advantage and impact of UNFPA's provision of dignity kits, including, as far as possible, a cost/benefit analysis, is needed in order to assess whether UNFPA should continue providing dignity kits, and if yes what would be the most effective ways to do so.

2. Evaluation purpose

The proposed evaluation aims at:

1. Assessing the usefulness and impact of UNFPA's dignity kits, looking at whether the items contained in the kits are indeed helpful to women, girls and sometimes entire families, and do meet the objectives of giving them back some dignity. The evaluation will also aim at verifying whether the kits have been successful in facilitating women and girls' access to food and water distribution, school and community activities.
2. Carrying out a cost/benefit analysis of UNFPA's engagement in the procurement, assembly, warehousing and distribution of dignity kits. The evaluation will look into financial costs, procurement procedures and human resources requirements for dignity kits in a selected number of Country Offices; and will recommend whether continuing to procure dignity kits is advisable for UNFPA, and if yes what would be the most appropriate and effective options to do so (long-term agreements, pre-positioning in regional hubs, local procurement and distribution etc.)

The evaluation findings and recommendations will be used to inform an organizational decision on whether the practice of providing dignity kits should be continued and if yes, what would be the most effective modalities to do so.

Key stakeholders for this evaluation include:

- In UNFPA: Humanitarian Response Branch, Programme Division, Technical Division, Regional Offices, Country Offices.
- Externally: beneficiaries, implementing partners; governments, donors.

3. Criteria and key evaluation questions

The evaluation will make use of the ALNAP criteria for evaluating humanitarian action: appropriateness, coverage, connectedness, effectiveness, efficiency and impact. [64]
Preliminary questions are proposed below. The methodology will be further elaborated by the evaluation team:

Topic area	Evaluation questions	Level of inquiry	Proposed methods
Appropriateness:	Are dignity/hygiene kits responding to the needs of the affected populations Are the contents of dignity kits appropriate and culturally sensitive	1.Country 2.Country; regional	1. Survey/FGD/interviews with beneficiary populations (if possible or use of secondary data). 2. Survey/FGD/interviews with beneficiary populations 3. Desk review of regional reports (eg. Logistics study from Latin America and Caribbean Regional Office) HPN, and forced migration review
Coverage:	Who received dignity/hygiene kits, and how were beneficiaries selected	Country	Interviews with Country Offices (COs) and partner organizations Distribution reports if available
Connectedness:	Support provided to local capacities and market ,	Country	Interviews with COs and partners

[64] John Cosgrove et al. 2009. *Real-time Evaluations of Humanitarian Action – An ALNAP Guide (Pilot Version).* Action Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) Publication.

	income-generating opportunities for affected communities		Surveys/FGDs with beneficiaires Project reports
Effectiveness:	Where dignity/hygiene kits delivered on time to serve its purpose Was provision of dignity/hygiene kits coordinated with other agencies (Gvt, UN, NGO), What were, for UNFPA, the financial and human costs of procuring dignity kits	Country, Regional, HQ	Interviews with COs and partners Programme and distribution reports.
Impact:	Were women's hygiene needs met **Was** women dignity restored Were women able to access other services as a results of using items in the kits?	Country, Region	Survey, interviews, FGDs, literature review. Note: it might not be possible to directly attribute impact to the distribution of dignity kits but proxy indicators can help as outlined in RH literature. (??)

4. Methodology

The evaluation team will develop an inception report which will provide details on the approach and methodologies to be followed. The inception report should provide details on the following issues:

- Evaluation questions
- Indicator framework
- Details on how each case study will be organized and conducted
- Details on data collection instruments
- Types of data analysis to be conducted
- Proposed schedule of country visits
- A schedule of detailed outputs and dates in line with the work programme of deliverables scheduled below

The evaluation will be carried out in 3 main phases:

1) A global survey will be sent to all UNFPA Country Offices that have been involved in dignity kits (February 2011)

2) Key informant interviews (HQ, Regional Offices, selected COs, selected partner organizations) will be carried out in person or over the phone (February- early March 2011)

3) Field research in 4 countries where UNFPA has recently been involved in distributing dignity kits to populations affected by crises: Colombia, Kyrgyzstan, Indonesia and Mozambique. The following criteria were used in the selection of the countries:

    - Regional representation: At least 4 different regions should be represented.
    - Types of emergencies: both armed conflicts and natural disasters should be represented among the emergencies having affected the selected countries
    - Duration of the emergency (acute/chronic), in order to look into whether dignity kits are more useful in short term acute emergencies or in long-term chronic settings.
    - Innovative approaches – innovation/creativity in procurement of dignity kits will be another criteria to select countries for field evaluation
    - Distribution mechanism: e.g. through international and local NGOs, UN partners, government, etc.

5. Deliverables

The expected deliverables for the study include: a detailed work plan; inception report; draft report; final report; and presentation of key findings and recommendations at SIPA and UNFPA in May 2011.

6. Timeframe

The duration of the study will be about 6 months, tentatively from November, 2010 until May 2011:

- Desk review: November 2010-January 2011
- Global survey and phone interviews: February – early March 2011
- Field visits to the 4 locations: 12-27 March 2011 (exact dates to be discussed with COs and Columbia University team)
- Final write up and presentation: April-May 2011

7. Evaluation team composition and required competencies

The evaluation will be carried out by a team of graduate students from Columbia University's School of International and Public Affairs (SIPA), under the guidance of a SIPA faculty advisor

and an Evaluation Management team from UNFPA. The SIPA faculty advisor will have demonstrated prior experience in evaluation. Applicants should have some experience in:

- Reproductive health, gender and population data in humanitarian settings;
- Field research in development/humanitarian settings;
- Evaluation methods and data-collection skills;
- Excellent teamwork, communication, interviewing, analysis and writing skills.
- Spanish language skills (two team members);
- Ability to adapt to multiple types of terrain and demonstrate cultural sensitivity.

8. Evaluation ethics

The evaluation will be conducted in accordance with the principles outlined in the UNEG "ethical guidelines for evaluation".
Ethical consideration should include:

- respect to local customs, beliefs and practices; respect to people's right to provide information in confidence and ensuring that sensitive information cannot be traced to its source;
- informing interviewees in advance on what the interview ground rules are and obtaining their informed consent for participation;
- right to privacy and minimizing demands on time of the people participating in evaluation

9. Costs and logistics

Four field missions will be carried out in 2011 (March 12-27; dates to be discussed with Columbia University team, based on academic schedule). UNFPA Country Offices and UNFPA Humanitarian Response Branch (NY) will support in-country logistics. HRB will coordinate all country visits with the regional offices. The CU team will be required to purchase their own air-fare and visa. All in-country costs, including accommodations, local transportation, meals and translation costs for team members, will be covered by HRB/PD. A detailed logistics note will be made available to the Columbia team and UNFPA Regional and Country Offices.

Client contacts

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ANNEX III – COLOMBIA COUNTRY REPORT

I. Background

Colombia is a country that is afflicted by both natural disasters and internal conflicts. Heavy rains and flooding caused by the "La Niña" phenomenon annually affect the country. In certain regions, heavy flooding in 2008 and 2010 afflicted Colombia. In response to the emergency in 2008, CERF granted UNFPA HRB $350,000 to support the provision of sexual and reproductive health services to women affected by the floods in Chocó, Magdalena Medio and La Mojana; provide dignity kits to women and girls; train health practitioners and empower the affected population regarding their sexual and reproductive rights. During the most recent emergency in 2010, UNFPA Colombia requested $86,100 for the provision of dignity kits to more than 3,000 adolescent women, girls, pregnant women and women of childbearing age in the rural and urban areas of Sucre and Majagual, in the northern coast of the country.

Colombia also has one of the largest populations of IDPs as a result of the ongoing internal conflict, which started in the sixties with the rise of the ideologically motivated guerrillas, and has evolved to a fight over territory and resources between the guerrillas, the paramilitary forces and the government.[65] The situation of IDPs in Colombia is atypical, due to the characteristics of the conflict, which is one of low intensity that has been affecting the most vulnerable segments of the population for a very long period of time. IDPs are not living in resettlement camps, but rather have fled their villages and migrated to the cities. The living conditions in these cities have precarious conditions which the government, along with the international community, has tried to relieve but given they are constantly moving into homes of family or friends, they are difficult to identify. Tumaco is one city that has received a large number of IDPs, who currently live in illegally occupied areas of the city in makeshift settlements. In 2008, UNFPA also received money to distribute dignity kits to displaced women in Tumaco through distributing partners and reached roughly 500 women. The funding for the dignity kits came from the unused CO funds allocated towards dignity kits for flood-affected regions in 2008.

II. Introduction

In March 2011, UNFPA Colombia hosted a visiting team of three graduate students from Columbia University's School of International and Public Affairs (SIPA) to conduct a field assessment of the distribution of dignity kits in flood affected regions in 2008 and 2010, and distribution of kits to victims of the ongoing civil conflict in 2008. This visit was part of a global assessment of UNFPA's provision of dignity kits, which included concurrent field visits to the Republic of Kyrgyzstan, Indonesia, and Mozambique by other members of a larger student team.

65 The guerrilla and the paramilitaries fight each other and the government in their pursuit of territorial domination for drug trafficking purposes.

SIPA team members Shanon McNab, Dohini Patel, and Christine Saba traveled to Colombia for a period of two weeks beginning on 12 March 2011 and ending 27th March 2011. The team was hosted by UNFPA Colombia Country Representative Tania Patriota, and UNFPA HRB staff member Catalina Sierra. In total, the team spent three days in the regions of Sucre, three days in Barranca, and one day in Tumaco on the southern coast. The remaining two days were spent at UNFPA's main office in Bogotá. Five focus groups were held with beneficiaries of dignity kits in the affected regions (two in Sucre, two in Barranca, and one in Tumaco). Additionally, the team met with two representatives from the Kyrgyzstan Country Office (CO), eight partner NGOs and three other UN agencies. For a complete list of meetings held, please see Annex A. Preliminary findings from the field visit were presented to members of the Colombia CO on 25 March 2011.

III. Methodology

The SIPA team conducted field visits in Colombia, Indonesia, Kyrgyzstan and Mozambique. Field visits represent Phase III of the SIPA team's assessment of UNFPA dignity kits in humanitarian emergencies. Phase I consisted of desk research, interviews with UNFPA headquarters and tool development. Phase II involved the distribution of an online survey to all countries that have included dignity kits as part of their humanitarian response and phone interviews with select COs.

Field visits lasted from one to two weeks and were conducted in the month of March. CO staff developed the agenda for each field visit in consultation with SIPA team members. Prior to the field visits, the SIPA team worked with UNFPA headquarters staff to develop focus group (FG) guides and interview tools for use in-country. The FG guide was created to capture the experience of beneficiaries before and after receiving the kit, as well as to discern their overall impression of the value of the kit retrospectively. Participatory ranking methodology was used to explore notions of necessity and value regarding the contents of the dignity kits. SIPA team members applied these tools subjectively based on the country-specific context and, if necessary, tools were adapted while on the ground. Any such changes were communicated to the rest of the SIPA team via email.

Key informant interviews (KIIs) were conducted with key stakeholders involved in the distribution of dignity kits. KIIs included UNFPA staff, partner NGOs, other UN agencies and government officials. The selection of participants for both the FGs and the KIIs was done by COs in consultation with the SIPA team. The team's findings are limited by the fact that selection of focus group participants and KIIs was not random, leading to the possibility that samples were not representative of affected populations.

All three SIPA team members were present at each meeting, with one person responsible for conducting the meeting and two people manually documenting responses (no tape recorders were used). At the end of each day, meeting notes were compiled and uploaded to a shared network viewable by all team members.

IV. Findings

Participatory Ranking Methodology

PRM Ranking Activity #1

Question asked in each of the PRM activities: "Thinking of the health and hygiene needs of women in your community (not including men or children), can you please rank the items given to you in the UNFPA Dignity Kit in order of most valuable to less valuable?"

Background: The first PRM was conducted in a rural community with women aged mid-20's to late 40's of Mestizo Colombian decent. The women were affected by cyclical flooding that devastated their homes, land, domestic animals and overall health and wellbeing. The women received dignity kits within two months after the flooding took place, and roughly 8 months prior to the PRM activity. The implementing partners selected the women, and the entire activity took 45 minutes.

Limitations: The recipients were selected by implementing partners, not allowing for a random selection process. The women also did not immediately understand the notion of ranking items in terms of importance; rather they focused on the temporal order. The facilitator stopped the group to clarify, at which time the women re-ordered their items in accordance to their need. Lastly, the container that dignity kit items were distributed in was not included in the overall list of items.

Findings: The women in the PRM activity were grateful for all of the items in the list. Several were uncomfortable with having to rank the items as they deemed all of them important and did not want the lower ranked items to be viewed as not appreciated. The items that UNFPA adds in addition to a standard hygiene kit, such as clothing and combs, which are items that made the kit customized to the women's needs, were placed lowest in the overall ranking. This may suggest that the women appreciated these items but their basic needs are met with the standard items in a hygiene kit. The women acknowledged that they had seen or used all of the products that they were given and none of the items were considered unnecessary. The women did mention that a major health concern during the floods were vaginal infections; they requested that a type of vaginal soap or antibacterial cream be included in the future distributions for women in flood affected areas. They also asked that instead of sandals or flip flops, that UNFPA consider distributing boots, as they wade in water for months and the infections that they and their children were susceptible to by wading in water were often unmanageable.

Final Ranking of Dignity Kit Items	
1	Body soap
2	Toothpaste
3	Tooth brush

4	Deodorant
5	Body cream
6	Shampoo
7	Toilet Paper
8	Towel
9	Pads (sanitary)
10	Sandals
11	Panties
12	Brush
13	T-shirt
14	Comb

PRM Ranking Activity #2

Background: The second PRM was conducted in a village similar to the first PRM, with women aged mid-20's to late 40's but with both Mestizo Colombian and Afro-Colombian women. These women were also affected by cyclical flooding that devastated their homes, land, domestic animals and overall health and wellbeing. The women had received dignity kits approximately 2-3 months after the flooding took place. The implementing partners selected the women and this activity took 45 minutes.

Limitations: This PRM had the same limitations as the first PRM activity. Additionally, the overwhelming majority of Mestizo-Colombian compared to minority of Afro-Colombian participants may have muted the voices of the Afro-Colombian population. For example, the Afro-Colombians would have put the comb much higher in the ranking order but the Mestizo-Colombian group did not view combs as high on the list and therefore it's place may not be indicative of the Afro-Colombian needs.

Findings: The women in this activity also noted the overwhelming gratitude for each and every item that was included in the list. Similarly to above, they were hesitant to rank them as they used and shared each of the items in the kits. This group ranked the pads and panties, which were customized items placed by UNFPA, within the top five items in this list, suggesting that participants saw these items as necessary for their basic hygiene. As noted in the limitations, the Afro-Colombian women placed much more value on the comb than the Mestizo population – but due to the small number of Afro-Colombians that preference is not reflected in the activity. Lastly, these women also noted the increased incidence of vaginal infections during the flood season, and asked if a vaginal soap or medicine could be included in the future kits.

Final Ranking of Dignity Kit Items	
1	Toothpaste
2	Tooth brush
3	Pads (sanitary)

4	Panties
5	Towel (body)
6	Laundry soap
7	Body soap
8	Toilet paper
9	Flip flops
10	Body cream
11	T-shirt
12	Shampoo
13	Comb

PRM Ranking Activity #3

Introduction: The third PRM was conducted in a larger city, with women, aged early-20's to late 30's. The majority of whom were of Afro-Colombian and had been affected by the internal conflict and were internally displaced (note: a minority of women had not been displaced but were a part of a larger program to target Afro-Colombians living in poverty – and they had received kits). Many of the participants were living illegally on government land and had moved to Tumaco within the last year or two. The distributions were rolling, according to supply, thus the kits were not in response to a new wave of violence or migration, but rather funding was procured and the community in need was identified.

Limitations: The participants were chosen by the implementing partners, which left room for selection bias. They also were not victims of an acute crisis, rather when UNFPA had additional funds, the women were given the kits. Thus, these women could have been living in the city for years prior to receiving kits, which allowed for very different needs and perspectives across the group of women.

Findings: As with the women in the other PRM activities, the women expressed gratitude for the items and valued everything included in the kits. This group valued outer appearance more than the other two groups; being presentable and not looking dirty or smelling badly was very important to these women. They viewed this as a way of respecting oneself. Many of these women were living with their family members or friends since they left their home villages, and were not able to get employment as easily as they had hoped. Several women discussed that these items were items they buy on a consistent basis and even a month or two weeks of money being saved on not purchasing the items allowed them to buy clothing and food for their children, as well as pay for school tuition. The items lasted 15 days to 2 months, depending on the number of women in each household. When asked what items they would have added to the kits, they agreed on flip flops, perfume, bras, clothing and antibacterial soap to wash their hands. When asked if they could only receive 5 items, they agreed to toothbrush, tooth paste, deodorant, sanitary pads and toilet paper.

Final Ranking of Dignity Kit Items	
1	Tooth brush
2	Toothpaste
3	Soap
4	Deodorant
5	Panties
6	T-Shirt
7	Toilet paper
8	Pads (sanitary)
9	Body towel
10	Body lotion
11	Mirror
12	Shampoo
13	Brush
14	Cloth bag

Focus Groups

Background:

In total, the SIPA team conducted five focus groups in Colombia. Four of the focus groups were held in the flood affected regions of Mojana and Magdalena del Medio in northern Colombia, and the fifth focus group was held in Tumaco, a city that surrounds a region that is afflicted by violence from guerilla organizations.

Local UNFPA staff in conjunction with UNFPA partners in each of the regions organized the focus groups, and women were asked to participate in the focus group by local partners who had specific knowledge of which women received dignity kits. In some cases, specific women were chosen to participate in the focus group by local partners beforehand, while in other cases, women were chosen at random by local partners before the focus group began to participate in the activity.

The following table provides a brief composition of each of the focus groups to provide context and other relevant background information. It is important to note that the focus groups conducted with women from flood affected areas, the ethnic composition was primarily Mestizos or mixed, while in Tumaco, the ethnic composition of the participants were Afro-Colombian.

Focus Group 1	
City Conducted	Majagual
Type of Emergency Crisis	Flooding
Number of Participants	6
Estimate Age Range of Participants	Late 20s – Early 40s

Focus Group 2	
City Conducted	San Marcos
Type of Emergency Crisis	Flooding
Number of Participants	6
Estimate Age Range of Participants	Late 20s – Early 40s
Focus Group 3	
City Conducted	San Marcos
Type of Emergency Crisis	Flooding
Number of Participants	13
Estimate Age Range of Participants	Early 20s – Late 40s
Focus Group 4	
City Conducted	Garzal
Type of Emergency Crisis	Flooding
Number of Participants:	10
Estimate Age Range of Participants:	Late 20s – Early 40s
Focus Group 5	
City Conducted	Tumaco
Type of Emergency Crisis	Conflict
Number of Participants	7
Estimate Age Range of Participants:	Late 20s – Late 30s

Key Findings:

1. Aid was distributed to women on the village level

Women who were affected by the floods in both the regions of Sucre and Barranca were not forced to leave their communities due to the flooding. Women were able to stay in their homes with their family and there was no forced displacement. In contrast, the women who participated in the focus group in Tumaco were all internally displaced persons (IDPs), who fled the conflict in surrounding areas of the region and resettled in Tumaco.

In most of the communities where dignity kits were distributed, women indicated that they were notified beforehand that they were receiving aid especially for them and where to pick up this aid. The aid was typically distributed in a central location and women said that there was some sort of educational speech given prior to the distribution of the kits, but could not recall the topics that this speech covered.

2. Women were grateful for the kits and this was the first time aid was distributed specifically to them

In each of the focus groups, women expressed gratitude for the items in the dignity kits and articulated that this was the first time that they have received aid specifically for them as

women, and not for their family or children. This was the first time that they were given visibility in an emergency situation.

3. All the items in the dignity kit were useful and needed

Women indicated that all the items that were included in the dignity kits were necessary and were used in its entirety. The women expressed that all the items in the kit were of high quality and they recognized the majority of the brands of the items. The tables below provide a list of the items that women identified were included in the kit; the items highlighted in yellow are the among the five most important items that a majority of women identified out of all the items in the dignity kit.

Focus Group 1
Creolin
Deodorant
Laundry Soap
Panties
Plastic Bucket
Sanitary Pads
Shampoo
Toilet Paper
Toothbrush
Toothpaste

Focus Group 2
Body Soap
Condoms
Creolin
Deodorant
Laundry Soap
Panties
Plastic Bucket
Sanitary Pads
Shaving Cream
Shampoo
Sponges
Toilet Paper
Toothbrush
Toothpaste

Focus Group 3
Creolin
Deodorant
Dish Soap
Disposable Cloths
Panties
Plastic Bucket
Sanitary Pads
Shampoo
Soap
Toilet Paper
Toothpaste
Towels

Focus Group 4
Body Cream
Comb
Deodorant
Pair of Sandals
Panties
Sanitary Pads
Shampoo
Small Towel
Soap
T-Shirt
Toilet Paper
Toothbrush
Toothpaste

Focus Group 5
Body Cream
Body Soap
Face Towels
Laundry Soap
Panties
Sanitary Pads
Shampoo
Small Mirror
T-Shirt
Toilet Paper
Toothbrush
Toothpaste

4. Women shared items in the dignity kits with their family

All the women in each of the focus groups said that they shared items in the dignity kit with family members such as body soap, toothpaste, toilet paper, and shampoo. In cases where items were not useful to a woman or her family, the items were given to friends that who had use for it. Because women shared hygiene items in the kits with their family, the kit contents on average lasted about 15 - 30 days, instead of the intended two months. In no focus group women cited that they sold any of the items of the dignity kit, as all of them unanimously agreed that the items in the kit were too precious and necessary to do so.

5. Not having to buy the hygiene items provided in the kit allowed women to use money towards basic needs after the emergency

In each of the focus groups, women expressed that by receiving the items in the dignity kits they were then able to redirect money towards basic family needs, specifically buying food instead of personal hygiene items. In most of the villages where flooding occurred, hygiene items were available to buy after the emergency crisis, but were too expensive for the women to afford. For the focus group women in Tumaco, hygiene items were available to purchase also, but they could not afford them once they resettled in the city because they were too expensive also.

6. Women would like more information and education on administering basic first aid and reproductive health

In a majority of the focus groups, women indicated that they needed more information and educational training on reproductive health, family planning (particularly for adolescents), hygiene, emergency first aid, and general protection against infection and disease

Key Informant Interviews

Methodology:
Key informant interviews (KIIs) were conducted by the SIPA team members over the course of the two week data collection period in March 2011. The purpose of the interviews was to engage in a constructive dialogue with key stakeholders in the humanitarian response process in Colombia. The research aim was to identify key points of successful 'dignity' kit implementation as well as key challenges from the perspectives of a broad range of stakeholders. In total, fourteen KIIs were conducted: two with internal UNFPA staff (in two separate regions); nine with implementing partner agencies (including two government agencies); and three interviews with partner UN agencies.

Sample

The interview subjects were largely key heads of organizations involved in dignity kit implementation or in humanitarian response. Their experience level ranged widely, from one-two years in their current post to more than twenty years of experience working in communities affected by disaster or conflict. The interviews were arranged ahead of time by the UNFPA in-country contact, and the SIPA team did not have direct input into the interview subjects or the agencies to be interviewed.

Protocol

The SIPA team followed the same semi-structured interview guide for the majority of interviews (see annex). Occasionally, the guides were modified to cover topics more relevant to the particular interview subject or to fit more within their particular area of expertise. The interview guide for the Imperial del Arroz interview was heavily modified, as this actor was a supplier that had little knowledge of dignity kits as a UNFPA intervention in emergency response or of the overall humanitarian response context.

Prior to beginning each interview, each respondent was notified that their responses would be recorded and their participation in the interview was voluntary as well as confidential. Verbal consent was obtained from each respondent prior to the interview.

Limitations

The SIPA did not have direct consultations with key informants prior to the team's arrival, thus, it became evident during the course of certain interviews that some informants were not as informed about various areas of UNFPA's dignity kit response; interview guides were modified accordingly. In addition, the SIPA was not able to speak to all interview subjects as a result of time constraints. Finally, the team was unable to speak to various partner agencies involved in the distribution of hygiene kits, only those partners involved in dignity kit distribution.

Findings:

Overall, there was a general report of anecdotal evidence from distributing partner agencies of the dignity kits having been useful and highly valued by the beneficiaries and respondents felt universally that the kits met their principal objective of 'restoring dignity' to beneficiaries. A number of respondents indicated there was also an economic impact of the kits, as women were able to forego expenditures of such necessary and basic items and instead able to purchase food or other household necessities.

Most distributions occurred as a one-time single distribution and did not occur more than twice over the course of the delivery period. Most respondents indicated that the earliest a distribution reached the community after the onset of flooding was five weeks later, with an average lag time of approximately six weeks between disaster onset and delivery of aid. This lag time was often due to the administrative procurement processes as well as time to declare a situation an emergency. However, respondents indicated that the target areas were very

remote communities and chosen specifically due to their remote location or for not having previously received any form of state aid. The remoteness of the target locations contributed to this lag time.

Respondents also indicated that the scope of need was nearly always larger than what the agency was able to distribute. Even within small villages, there was a need to discriminate amongst recipients and determine 'the most in need' or 'most affected.' However, the target criteria for these recipients varied widely across the communities.

Many of the partner agencies also indicated that they included educational material or presented educational seminars on sexual or reproductive health issues to the women at the time of kit delivery, and felt this to be an important part of the overall dignity kit process and contribution to the overall impact of the dignity kits.

Due to capacity constraints, all of the procurement and distribution of dignity kits in Colombia was outsourced to partner implementing agencies. Several partner agencies reported that the strong coordination with UNFPA greatly facilitated the overall process and made for a symbiotic relationship between the partners. UNFPA interviews indicated that partner agencies were selected either for 1) their "solidarity" with the communities; or 2) their logical capacity. Although no long term agreements or collaborations were formed, these partnerships proved effective because the mission was clearly stated on the part of UNFPA and because the implementing partners had strong existing networks that facilitated the distribution process. A few agencies coupled the delivery of kits with other aid distribution with the goal of producing a more integrated response.

All procurement was done locally, either in a city nearest to the affected communities or in Bogotá. A number of respondents discussed the effect of the flooding on the prices of basic commodities in the aftermath of the flooding, as well as transportation costs. Many respondents indicated the need for better planning and preparation for natural disasters, particularly in disaster-prone areas. The most significant cost drivers in every case were considered to be the purchasing, packaging, and transportation of kits.

A number of agencies indicated that a strength of the dignity kit program was its gender-differentiated approach to aid, unique among what other aid agencies or government aid is provided in emergency response. In addition the customization of the kits was considered to be a significant value-added to the more generic kits distributed by the government or other agencies [*"the problem with universal kits is that it doesn't respect local culture."*] However, other partners disagreed, arguing that the most important aspect was the timeliness of the response.

Other general findings included:

- Frequent manipulation of aid by local politicians
- Waste generation of the kits was considered a major concern and the need for a more environmentally friendly kit

- Census taking and rapid needs assessment in the immediate post-emergency phase was considered a major issue in underestimating the amount of aid needed; census-takers often reported only one household having been affected when in fact several families were living in the same household
- Due to government sensitivities, the cluster approach and flash appeals were seldom activated; thus, most agencies coordinate independently and a very ad-hoc basis

V. Overall Findings

Impact

The overall impact of UNFPA's dignity kits in Colombia was evaluated along the categories of advocacy, value, education and reach. UNFPA in Colombia was highly successful, through its work with the World Food Program, in advocating for the inclusion of dignity kits in government supported (both financial and theoretical) aid. WFP and UNFPA worked closely to ensure that the dignity kits were included in the integrated approach to humanitarian crises. After effective lobbying, and testimonies from WFP staff who had distributed the kits and seen the response of beneficiaries, the Colombian government saw the value in the dignity kits and agreed to fund a portion of the costs of kit distributions as a part of their larger humanitarian response. As this inclusion and institutionalization of the kits is a global goal of UNFPA HRB, the government buy-in is a success for both UNFPA and WFP in the Colombian context.

There was a unanimous belief, among all of the beneficiaries interviewed as well as the distributing partners, that the items in the kits were all highly valued and needed. In each of the focus group discussions and the PRM activities, the women clearly stated that they needed all of the items that they received, that all items were of high quality and that they recognized the brands and the items. All groups suggested a few additional items that would have helped them following the floods or displacement, but would not have changed any of the existing items. An unexpected component of why women valued the kits was in what they could buy when they were given these hygiene kits for free. All groups mentioned one of the most important aspects of this distribution was that they did not have to spend the little amount of money they had on these hygiene items, and could instead buy food for their family. The findings show that not only were the specific contents in the kits valued, but also what they allowed women to purchase for the larger family unit when they didn't have to buy the items for their hygiene seemed almost more important to the women.

An overwhelming sentiment from key informants and implementing partners was the idea that the educational component of the distribution had a significant impact on the women in the communities. The partner agencies claimed to have provided all women receiving kits with basic education regarding hygiene, reproductive health, STD and GBV (the specific educational topics varied by partner). This was seen as a way to add to the value of the specific items in the kit, and to work with women to provide as much educational information as possible. Unfortunately, the women in focus groups or PRM activities did not corroborate the distributing partners claims of education provision. In fact, it was mentioned in every focus

group that the women needed and wanted educational packets or brief workshops that covered reproductive health, basic hygiene, or first aid. The educational component to the dignity kits may have been forgotten or conducted with other women who were not interviewed, however, it seemed clear that this is a focus for UNFPA that is not having the impact it was intended to have, if it was being provided at all.

The final component of impact was reach. UNFPA partner agencies clearly were targeting and reaching populations of women who were among the most vulnerable and who had not received aid from any other organization. However, the definition of the target population was vague and often up to the discretion of the implementing partner to target "the most vulnerable" in a community. The focus groups confirmed that the majority of women (less so for the IDP populations) had never received any aid before the dignity kit and if they had it had been in the form of food aid. UNFPA effectively reached out to communities that were very remote, and hard to get to especially during times of natural disasters. However, despite this reach, the time it took to deliver the kits was a factor that may or may not have played a role in the impact of the overall kits. For both the flood affected regions and IDP populations, the kits could have come at an earlier date, but the women noted that anything was better than nothing and the timing was not mentioned as a concern for the women. This may not be true as often in acute emergencies and should be further investigated to figure if the time to distribute kits could be reduced. Despite being able to provide kits to women in the most vulnerable areas, both the partner agencies and beneficiaries noted that there were never enough kits to give to all the women that they did reach. They noted that the impact may have been strengthened had they been able to distribute to every woman of reproductive age in the affected village. With budgets as a reality, the targeting process for most vulnerable populations may need to be standardized.

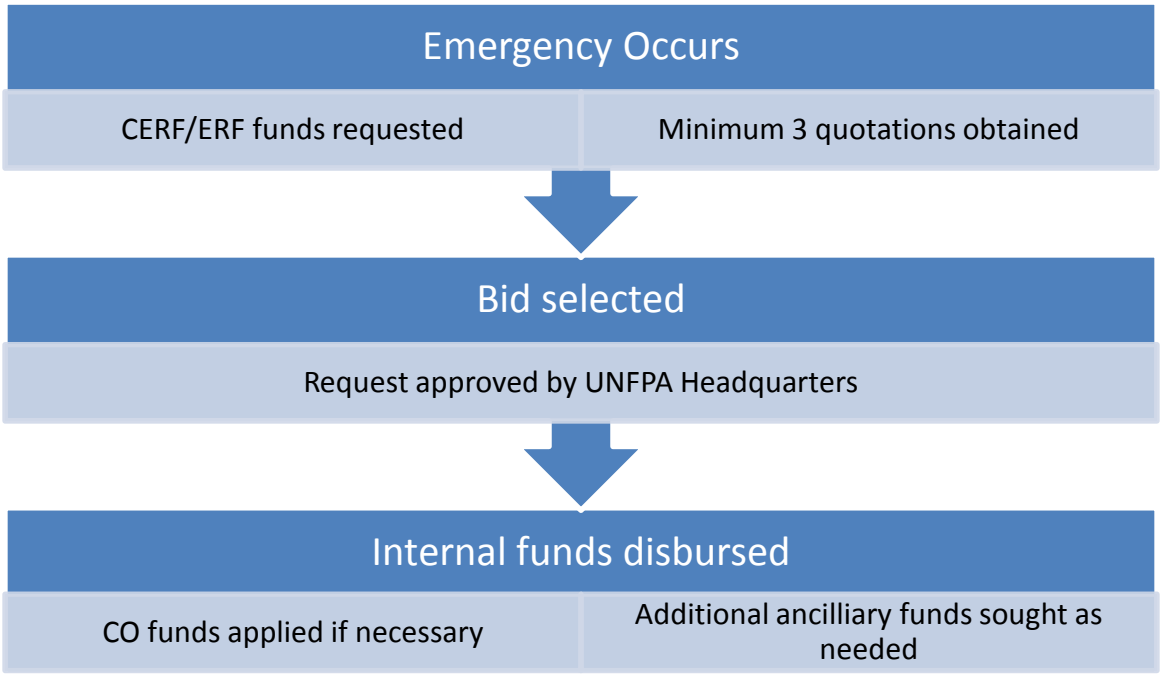
Procurement

UNFPA's procurement findings in Colombia fall into four broad categories: purchasing, assembly, distribution, and warehousing.

Purchasing: Discussions with numerous implementing partners indicated that purchasing of items was one of the most significant cost drivers of the procurement process. This was due in part to the use of local suppliers, who indicated that prices of certain items increase following a natural disaster. In addition, items within the kit varied in cost: the clothing items were the most expensive to procure. In addition, the packaging, such as the cloth bag, was also relatively costly.

Interviews indicated that the transition from plastic bags to cloth bags was made after several early distributions in 2008 where kits were being transported by boat and the bags burst open and several items were damaged. As a result, many of the subsequent kits carried items that were individually package-wrapped in plastic, generating a larger amount of trash in each kit.

Figure 1: International Bidding Protocol



Some respondents mentioned the idea of having some kit items procured in advance and then additional customized items added to the kit before distribution. Many respondents noted that this practice would expedite the distribution process in the immediate recovery phase. Although nearly all respondents indicated the importance of local consultation, the implementing partners have worked in the same areas year after year and noted the cyclical nature of the disaster response. Thus, kits are increasingly easier to procure as they develop ad-hoc preferred suppliers and vendors. No respondent indicated that items were not able to be procured in-country; although one supplier noted the products purchased from MNCs tended to be less price volatile than products procured locally; noting prices tended to fluctuate in the aftermath of an emergency.

A systematic bottleneck in purchasing indicated by many respondents was the need to adhere to standard procurement protocols required by the UN. Most implementing partners indicated that the longest time lag on the part of the UNFPA was the delay caused by the procurement standards, which require agency to secure three separate quotes and then gain approval of bid from UNFPA Headquarters and then the final funds disbursement. Respondents uniformly indicated there are no existing mechanisms to expedite this protocol in the face of an acute emergency.

Long term agreements (LTAs) were considered by several respondents to be a feasible solution to the issue of time delays in emergency response, but noted that they did not currently have such agreements in place. Another factor noted was that no partner agency (with the exception

of the Red Cross) maintained a safety stock of standard kit items due to the lack of warehousing capacity and its associated expense. As a result, no pre-positioning of kits occurred.

Assembly: Most assembly in the case of Colombia was done by the contracted supplier and kits arrived in communities pre-packaged. Most implementing partner agencies indicated there were extensive quality control systems in place to ensure the overall quality of the kits. This was later confirmed in the focus groups, where women stated that the items they received were of good quality and of known brands.

Distribution: Transportation was indicated by most agencies as the most significant cost driver in dignity kit response. This is due in large part to the remoteness of the locations and due to the security concerns of delivering kits in the indigenous communities.

One factor that facilitated the distribution process was utilizing agencies (WFP) with a strong logistics infrastructure. Implementing partners noted that the use of local partners in distribution allowed them to secure cheaper transportation because of local knowledge of the cheapest transport mechanisms, which allowed UNFPA to stretch allocated funds farther. In addition, agencies also had established transportation agreements, particularly in conflict-affected areas, which expedited the distribution process and enhanced the safety of transporters.

Figure 2: Distribution Figures by Region

Distribution	Type of kit distributed	Total number of kits delivered	Number of distributions	Needs Assessment	Other kit distribution
Site #1	Women's kit	2008:1000 2009: 2500 2010: 5000	1 1 1	✓	UNICEF 3,000 family kits Oxfam- # unknown **Red Cross:** 8,522 family kits (over 6 months, b/ween Sucre, Bolivar, Chocó)- divided by DK and FK
Site #2a	Women's kit	2009:60-70 2010:250	1 1	No	UNICEF
Site #2b	Women's Kit	2010: 200	1	✓	UNICEF
Site #3	Women's kit	2009:4,200 2010:	1	✓	None

Warehousing: Warehousing costs in the case of Colombia were negligible, as any warehousing costs were incurred by the implementing partner agency or the government. However, a few respondents did indicate the pre-positing would be possible if warehousing space could be allocated at a low-cost fixed fee.

Organizational competencies

UNFPA Colombia's organizational competencies fall into three broad categories: specifically targeting women as beneficiaries and providing customized kits, reaching beneficiaries in remote areas, and coordinating with international and local partners.

It was indicated during key informant interviews that UNFPA Colombia was the only organization distributing humanitarian aid specifically to women in both the context of natural disaster and protracted conflict. This gender-specific aid distribution differentiates UNFPA Colombia from other organizations in the country that distribute similar kits that contain hygiene items. In addition, by conducting needs assessments through local partners, UNFPA was able to customize kits to the specific needs of women in each of the regions where kits were distributed. Other organizations that distribute similar hygiene kits have standard items that are distributed to beneficiaries no matter where and what the context of the crisis is, leaving no room for customization. Though customization is a key strength in UNFPA's dignity kit, the time that it takes to customize the kit is a clear challenge for the organization.

The areas that UNFPA distributed aid to flood victims were very remote, and no other organization was distributing similar aid in these areas. UNFPA chose to target these remote areas in an effort to reach out to the poorest and most needy communities after the floods. Though the Colombian government and other international organizations such as IOM and the Red Cross distributed similar hygiene kits, these distributions were in more urban areas that were easier to reach. The one major drawback of distributing aid in remote areas is that distributions tend to be smaller in scale compared to distribution in areas that are more accessible and easier to reach. This leads to the challenge that not all women in a given community receive aid.

Given UNFPA Colombia's resource constraints, the organization relied heavily on coordinating with international and local partners to distribute kits and assess the needs of beneficiaries prior to distribution. These coordination mechanisms allowed UNFPA to effectively distribute aid within their limitations. For example, UNFPA partnered with WFP to distribute dignity kits and through this partnership, UNFPA was able to use WFP's strong logistical networks to save on costs and resources. UNFPA was also able to effectively partner with local organizations to conduct needs assessments in remote communities and distribute kits in these areas. The added advantage of partnering with local organizations is that they already have a presence in the community and already have built trustful relationships with community members. The one challenge of heavily relying on local partners, especially in terms of distributing dignity kits is that UNFPA has no oversight on how distribution is taking place and if it is being done the way

the organization intended it to be. Also, by distributing dignity kits through local partners, UNFPA's visibility to beneficiaries is diminished, since beneficiaries associate the aid with distributing partners and not the funding organization.

ANNEX IV – INDONESIA COUNTRY REPORT

I. Background

On October 26th 2010, the Mount Merapi volcano, which is located north of Yogyakarta city in central Java, began erupting. Several eruptions occurred over the course of the following six weeks, progressively displacing an increasing number of people. The Government of Indonesia initially called for people living within a five-kilometer radius of the volcano to evacuate but evacuation orders progressively spread to a twenty-kilometer radius. In total nearly 350,000 people were displaced from their homes and 353 were killed. UNFPA distributed over 8,000 kits to meet the hygiene needs of the women displaced. Altogether, five different types of kits were distributed as part of the response: basic sanitary kits, hygiene kits, pregnant woman kits, post-delivery kits and newborn kits.

II. Introduction

In March 2011, the Indonesia Country Office hosted three Columbia University students to conduct a field assessment of UNFPA's provision of kits in response to the Mount Merapi Eruption. Dorothy Louis, Yuka Karasawa and Laetitia Vaval travelled to Jakarta and Yogyakarta from March 13th to March 25th 2011. Their primary focal points were Mrs. Rosilawati Anggraini and Mrs. Leny Jakaria, both Humanitarian Officers in the Indonesia UNFPA Country Office. The team first spent three days in the capital Jakarta before travelling to the Yogykarta Province where the team spent one week and visited three districts (Sleman, Klaten and Magelang) affected by the Mount Merapi eruption.

Many types of natural disasters including earthquakes, tsunamis, floods, landslides, and volcano eruptions regularly affect Indonesia. In 2010 alone, UNFPA's humanitarian division responded to an eruption of Mount Sinabung in North Sumatra (August), flash floods in West Papua (October), an earthquake followed by a tsunami in Mentawai (October) and an eruption of Mount Merapi in Yogyakarta and Central Java Provinces (October). As a result of the frequency and magnitude of natural disasters affecting the country, the UNFPA Country Office has been engaged in numerous distributions of dignity kits since their inception in 2005 following the Tsunami in Aceh Province. UNFPA currently provides four types of kits during emergencies:

Hygiene Kit:

- Sarong, 1 piece
- Towel, 1 piece
- Bath Soap,1 piece, 80 grams
- Toothpaste, 75 grams
- Toothbrush, 1 piece
- Hair Shampoo, 5 sachets
- Sanitary Napkins, 3 packs at 10 pieces per package
- Underwear and Bra, 3 sets
- Slipper/Sandal, 1 pair
- Blanket, 1 piece
- Comb, 1 piece
- T-Shirt, 1 piece
- UNFPA canvas bag, blue color

Pregnant Mother/Maternity Kit:

- Cloth for Pregnant Women, 1 piece
- Long Cloth (*Jarik*), 1 piece
- Bra for Pregnant Women, 3 pieces
- Underwear (adjustable waist), 3 pieces
- Blanket, 1 piece
- Towel, 1 piece
- Bath soap, 1 piece, 80 grams
- Toothpaste, 1 piece 75 grams
- Toothbrush, 1 piece
- Hair Shampoo, 5 sachets
- UNFPA canvas bag, green color

Post-Delivery Kit:

- Blouse with Front Buttons for Breast Feeding, 2 pieces
- Long Cloth (*jarik*), 1 piece
- Post-Deliv. Sanitary Napkins, 3 pcks.
- Bra for breastfeeding, 3 pieces
- Underwear, 3 pieces
- Blanket, 1 piece
- Bath soap, 1 piece at 80 grams
- Toothpaste, 1 piece at 75 gram
- Toothbrush, 1 piece
- Hair Shampoo, 5 sachets
- Towel, 1 piece
- UNFPA canvas bag, orange color

Baby Kit (Newborn Kit):

- Cotton Diaper, 12 pieces
- Baby Cotton Clothes, 12 pieces
- Baby Gloves and Socks, 12 pieces
- Blanket, 1 piece
- Baby Hat (flannel), 1 piece
- Mosquito Net, 1 piece
- Baby Cloth (flannel, soft), 12 pieces
- Baby Soap, 1 piece at 80 grams
- Baby Powder, 1 piece at 50 grams
- Baby Towel, 1 piece
- Baby Oil (*telon*), 1 bottle, 50 grams
- UNFPA canvas bag, red color

III. Methodology

The SIPA team conducted field visits in Colombia, Indonesia, Kyrgyzstan and Mozambique. Field visits represent Phase III of the SIPA team's assessment of UNFPA dignity kits in humanitarian emergencies. Phase I consisted of desk research, interviews with UNFPA headquarters and tool development. Phase II involved the distribution of an online survey to all countries that have included dignity kits as part of their humanitarian response and phone interviews with select COs.

Field visits lasted from one to two weeks and were conducted in the month of March. CO staff developed the agenda for each field visit in consultation with SIPA team members. Prior to the field visits, the SIPA team worked with UNFPA headquarters staff to develop focus group guides and interview tools for use in-country. The focus group guide was created to capture the experience of beneficiaries before and after receiving the kit, as well as to discern their overall impression of the value of the kit retrospectively. Participatory ranking methodology was used to explore notions of necessity and value regarding the contents of the dignity kits. SIPA team members applied these tools subjectively based on the country-specific context and, if necessary, tools were adapted while on the ground. Any such changes were communicated to the rest of the SIPA team via email.

Key informant interviews (KIIs) were conducted with key stakeholders involved in the distribution of dignity kits. KIIs included UNFPA staff, partner NGOs, other UN agencies and government officials. The selection of

participants for the KIIs was done by COs in consultation with the SIPA team. The team's findings are limited by the fact that selection of focus group participants and KIIs was not random, leading to the possibility that samples were not representative of affected populations.

At least two SIPA team members were present at each meeting, with one person responsible for conducting the meeting and another for manually documenting responses. At the end of each day, meeting notes were compiled and uploaded to a shared network viewable by all team members.

During the visit to Indonesia, the SIPA team conducted thirteen key informant interviews with international organizations, governmental agencies and local partner organizations as well as eleven focus groups discussions across three districts of Yogyakarta Province (Sleman, Klaten and Magelang). Each focus group was technically composed of women having received a different type of kit (newborn, pregnant woman, post-delivery kit and hygiene kit).

The SIPA team met with the following key informants:

- **UNFPA**: Humanitarian program officer, Operations Dept.
- **Government of Indonesia**: Ministry of Women Empowerment and Child Protection (Jakarta & District Offices in Yogya), Ministry of Health (Jakarta & District Offices in Yogya)
- **International Organizations**: UNICEF, Plan International, UN-OCHA
- **Local Distributing Partner Organizations**: GP Anshor, Rifka Annisa, PKBI, Satu Keluarga dan Satu Saudara, Midwife Association

Four FGDs were conducted on March 17th in Sleman District, four were conducted in Klaten on March 19th and three were conducted Magelang on March 22nd.

IV. Findings

Participatory Ranking Methodology

Sleman District – March 17th 2011

PRM Sleman - Hygiene Kits

Ten women participated in this group. They received hygiene kits from the village head. The SIPA team asked this group to break up into three subgroups and asked that each subgroup draw the five items they needed the when they arrived at evacuation point.

Please rank the five items you needed the most when you arrived at the camp:

Rank	Sub-group A	Sub-group B	Sub-group C
1	Soap	Blanket	Milk for Children
2	Toothpaste	Detergent	Toiletries
3	Toothbrush	Soap	Equipment to Sleep (like a mat)
4	Underwear	Towel	Medicine
5	Bra	Toothbrush and toothpaste	Clothing

Please rank the items in the kits in order of their usefulness and importance:

Rank	Items	Rank	Items
1	Toiletries	5	Bra
2	Underwear	6	Pads
3	Blanket	7	Disagreement over sandals vs. sarong
4	Towel		

If you could choose five items to go in a kit for women of reproductive age, what would you include? The group came to a consensus on the following items: Toiletry items, a blanket, soap, a towel and underwear.

PRM Sleman Post-Delivery Kits

The SIPA team did not conduct PRAs with this group as it was difficult for them to do the activities with babies in their arms. The SIPA team did ask them to name five items they would include in a kit designed for women who have just given birth. The group responded with the following items: clothing, soap, underwear, a bucket to bathe their baby and a blanket.

PRM Sleman Pregnant Woman Kits

The SIPA team asked each sub group to draw pictures of items they needed when they arrived at the evacuation camp. The SIPA team then asked the entire group to rank the most useful items in the kits.

Please rank the five items you needed the most when you arrived at the camp:			
Rank	Sub-group A	Sub-group B	Sub-group C
1	Soap	Milk for Pregnant Mothers	Nutritious Foods
2	Milk for Pregnant Mothers	Nutritious Foods	Milk for Pregnant Mothers
3	Clothes	Clothing for Pregnant Mothers	Multivitamins
4	Bathtub (for Babies)	Padding	Hygiene Equipment
5	Baby Ointment	Clothes	Clothing for Pregnant Mothers

Please rank the items in the kits in order of their usefulness and importance:		
Rank	Items	Reasons
1	Underwear	Underwear is vital, cannot use second hand or dirty underwear so that's why it needs to be new. Underwear is also very personal and cannot be shared – it is needed in large numbers.
2	Toiletry Kit (plus Towel)	Since we have the clean underwear we would need to be clean or else there is no point in having the new/clean underwear…. Also the soap is very important b/c if we wash ourselves with water that is not necessarily clean the soap would be important

		to get rid of the dirt.
3	Clothing for Pregnant Mothers	Because it is comfortable –the clothing material absorb sweat…. Also clothing for pregnant women it should be more comfortable and not too tight.
4	Blanket	
5	Sarong	

PRM Sleman - Baby Kits

Six women with newborns (from one month to six months old) participated in this discussion). They received baby kits form the local health centers. It was difficult for them to participate in the PRM activities given that they were holding their babies. Hence, the SIPA team only asked the entire group to name which items were most useful in the kits. The group named the following items: blanket, soft cloths to wrap the baby, clothing, and diapers (cloth). Later, the SIPA team asked them to rank five items they would put in a kit for newborn babies:

If you had to pick 5 items to go in a kit for (specify here per what group received the kit – family, newborn, adolescent, etc.) what would you include?

Rank	Items	Reasons/Comments
1	Towel	
2	Cloth Diapers	Those types of diapers (cloth) can only use for a limited period of time (when the baby is only one or two months). Then they need baby pants.
3	Soft Cloth	Something to lay the baby down, use it as a blanket, to cover up the baby, wrap baby up
4	Blanket	To protect from the cold when they go out.
5	Ointment	To warm up the babies body's especially after the bath.
6	Soap	Every day they need to bathe their child.
6	Gloves	Gloves, to prevent the babies from scratching themselves. Some disagreed because of limited use, only good for 1 -2 months.
8	Headgear	To protect the head.
9	Mosquito Net	After they give a bath to protect from mosquitoes while the baby is sleeping

Klaten District – March 19th 2011

PRM Klaten Post-Delivery Kits

The distributing partners disassembled the kits due to limited quantities and women in this group received some of the contents but not the entire kits. As a result, the women in this group had not all received the exact same items. The SIPA team asked them to rank the five most important items they needed when they arrived at the evacuation camp. As they had not received the same kits, the SIPA team could not ask to rank items in the kits they received based on the usefulness.

Please rank the items you needed the most when you arrived at the camp:		
Rank	Items	Reasons
1	Oil	The camps are very cold, and this oil is used to keep babies warm.
2	Diapers	Babies can urinate in their pants and they need to change it.
3	Warm Clothes	In this region, it is very cold, clothes are needed to prevent diseases and to protect from dust.
4	Milk for Mothers	Because they are breast-feeding, they have to make sure the mothers have vitamins and good nutrition.
5	Milk for Babies	After a baby is born, the milk of the mother does not come directly: need to supplement

PRM Klaten Post-Delivery Kits (Group II)

Six pregnant women participated in this discussion. They all received post-delivery kits, by error it would seem, as they were all in the early stages of their pregnancies. On average, kits were distributed one week after these women arrived at the evacuation point. Some items were missing from the bag. Even though they did not use some of the items designed for post-delivery use, they have kept them for future use.

Please rank the items you needed the most when you first arrived at the camp:		
Rank	**Items**	**Reasons**
1	Clothing	They did not have anything so they needed to change clothes. Without it they would feel uncomfortable.
2	Food	Food is needed to have energy.
3	Clean Water	
4	Toiletry	Needed to feel clean, otherwise they would be dirty. *After further probing from SIPA team*: Feeling dirty would prevent them from interacting with each other and they would have no confidence.
5	Medicine	If they are sick, they need timely treatment in order to avoid prolonged disease.

PRM Klaten Baby Kits

All seven women in the group received the kits in a bag but there were variations in terms of the contents of each bag and in terms of the timing of the distribution. Some women received the kits one week after their evacuation and a few did after one month. They emphasized the importance of equal distribution of the items, and ensuring that everyone receives the same items. The SIPA team asked this group two ranking questions.

Please rank items that you needed the most when you first arrived at the camp:		
Rank	Items	Reasons
1	Diapers and Baby Pants	Babies urinate, need to change a lot, but in the second month baby pants are needed
2	Blanket for	Need something to protect the babies and keep them

	Baby	warm.
3	Baby Oil	Together with baby soap and baby shampoo. Without them the babies will not be clean.
4	Towel for the Baby	The towel is used to dry out the babies. If they stayed in the moist weather they might get sick.
5	Underwear for the Mother	Need to change underwear or else they would get sick

If you were to design a kit for women who have just had a baby, what items would you include:	
Rank	Items
1	Maternity pads
2	Diapers and baby pants
3	Breast-Feeding Bras
4	Jarik (huge cloth)
5	Towel
6	Toiletry items
7	Corset
8	Baby oil, ointment and powder

PRM Klaten Pregnant Women Kits

Eight women participated in this discussion; they did not receive the kits but items from midwives one week after taking refuge. The SIPA team asked them to break into two groups of four women and asked them to draw five items that they needed the most when they were displaced as pregnant women. The SIPA team then asked the entire group to come to a consensus regarding these items:

Please rank items that you needed the most when you first arrived at the camp:		
Rank	Items	Reasons
1	Underwear	If they don't change their underwear, they could get a disease. Preventing diseases is very important for pregnant women.
2	Bra	In the refugee camps it would be dirty if they didn't have a bra.
3	Shirt/Clothing	To change – they had not brought a change of clothes with them and if they had ash on their bodies it would become itchy.
4	Toiletry	It is important, otherwise they get itchy if they can't clean their bodies
5	Blanket	For pregnant women if they get cold it is important to prevent diseases and fever.

Magelang District – March 22nd 2011

PRM Magelang Pregnant Women Kits

Seven women participated in this discussion; all were pregnant when they received the kits from the evacuation camp coordinators. Some women came with newborn babies and one was still pregnant at the time of the discussion. In order to conduct the PRAs, the SIPA

team first divided them into two groups and asked them to rank the five most important items they needed when they arrived at the evacuation camp and to eventually come to a consensus as a whole group. Next, the SIPA team asked the whole group to rank the items in the kits. Finally, they listed which items they would put in an 'ideal' kit for pregnant women:

Please rank items that you needed the most when you first arrived at the camp:			
Rank	Items	Sub-group A	Sub-group B
1	Money	Blanket/Bed mats	Soap
2	Clean water	Cooking utensils	Milk for pregnant mothers
3	Milk for pregnant mothers	Baby accessories	Clothes
4	Bed, pillow and blanket	Milk for pregnant mothers	Bathtub (for babies)
5	Toiletry	Money	Baby ointment

Please rank the items in the kits in order of their usefulness and importance:	
Rank	Items
1	Clothes for pregnant women
2	Underwear
3	Towel
4	Toiletry
5	Blanket

If you were to design a kit for pregnant women, what items would you include:
Milk for Pregnant Mothers
Baby Ointment and Powder
Underwear
Toiletry
Clothes for Pregnant Women and Baby
(Money)

PRM Magelang Post-Delivery Kits

Nine women participated in this discussion; they all received post-delivery kits from the midwives one week after the eruption. The SIPA team asked two subgroups of four/five women to rank the five most important items they needed when they arrived at the evacuation camp and to come to a consensus as a group. Next, the SIPA team asked the whole group to rank the items in the kits in terms of their importance/usefulness. Finally, they listed the items they would put in an 'ideal' kit:

Please rank items that you needed the most when you first arrived at the camp:		
Rank	Items	Reasons
1	Clean Water	To take bath, to drink, to wash their clothes, wash before prayer
2	Food (Rice)	After you wash your hands, you are able to eat

3	Money	Money, because finding work is very hard, that is why money is most important.
4	Clothing	To change when the Merapi occurred they did not have time to bring clothing
5	Toiletries	To make sure their bodies are clean and also need detergent to wash their clothes

Please rank the items in the kits in order of their usefulness and importance:		
Rank	Items	Reasons
1	Blanket	At the evacuation camp it was very cold and windy.
2	Breast feeding shirt	If they don't have shirt to change, it will be difficult.
3	Underwear	To make sure they are clean, it is very important. It is humid in the camps and they needed things to change into.
4	Toiletry kits	They were debating between breast-feeding bras, pads, and toiletry kits. If they do not use breast-feeding bras, it is very impolite and uncomfortable, but the toiletries won because it is for their health and that way their breath won't smell.
5	Pads	To be prepared because they would need them at some point.

If you were to design a kit for pregnant women, what items would you include:	
Rank	Items
1	Milk for Baby
2	Milk for mothers
3	Ointment, Baby Powder
4	Disposable Diapers
5	Blankets for Babies

PRM Magelang Baby Kits

Eight women participated in this group. They had received different kits: Baby Kit (five women), Post-Delivery Kit (two women) and Hygiene kit (1 woman). They received complete kits, but said they received them too late when they were ready to go home. The SIPA team broke up the group into two subgroups and asked them to draw the five items they thought they needed the most for them and their babies when they arrived at evacuation point. The SIPA team then showed them the items in the baby kit and asked them to rank the five most important items as a group. Finally, they listed the items they would put in an 'ideal' kit:

Please rank items that you needed the most when you first arrived at the camp:		
Rank	Items	Reasons
1	Mattress	The need was not fulfilled by any other organization. This came in as #1 because they were not able to get it as opposed to smaller toiletry items, which were much more common within aid distributions.
2	Blanket	They could bring clothes from home but were not able to bring a blanket. Another adds that a mattress w/ out a blanket would be useless
3	Toiletry Kit	It makes them better, to maintain our health and it can be directly / immediately used.
4	Pampers	If the baby pees, it smells and is dirty.
5	Children's Clothing	Babies have to change all the time, only limited supply, and also important because of weathers, they need to change them a lot.
6	Ointment	To make sure the child is warm

Rank the five most important items in the baby kit		
Rank	Items	Reasons
1	Cloths	Multifunctional – can use as blanket, to wrap the baby and can also be used as mattress
2	Towel (for baby)	Important for babies to have their own towel s, and do not mix up with that of adults b/c of germs
3	Soap/baby Powder/Ointment	Important to take a bath, after bath, you put powder and put the ointment to make them warm…Important (Soap) to keep body clean so they don't stink, ointment for babies to stay warm and powder to reduce sweat. They think it makes the baby clean, smell nice.
4	Baby Pants	They suggested replacing diapers with pants – can be used by both young and older child.

Helping other mothers in the future, which items would place in the bag?	
Rank	Items
-	Baby Clothes/Clothes
-	Towel
-	Ointment, Baby Powder, Baby Oil, Soap, and Shampoo
-	Disposable Diapers
-	Blankets for Babies
-	Cotton buds to clean nose and ear of babies
-	Undergarments for the baby

Overall Ranking (based on frequency counts)

Most needed items (all)		
Hygiene kits	•Soap •Toothpaste •Toothbrush •Underwear •Bra •Blanket, •Detergent	•Milk for Children, •Equipment to Sleep (Mat) •Medicine •Clothing •Towel
Pregnant Women	•Food •Good Nutrition •Money •Clean Water	•Milk for Pregnant Women •Bed & Pillow & Blanket •Toiletry
Baby Kits	• Mattress • Blanket • Toiletry Kit	• Pampers • Children's Clothing
Post-Delivery	•Baby Oil •Clothing • Underwear • Diapers • Baby Pant	•Clean Water •Money •Milk for Children/ Pregnant Women • Towel

Most useful Items in the kits (all)		
Hygiene kits	• Toiletries • Underwear	• Blanket • Towel • Bra
Pregnant Women	• Underwear • Shirt/Clothing • Toiletry Kit • Blanket	• Blanket • Sarong • Towel • Bra
Baby Kits	• Clothes • Towel for Baby • Soft Cloth • Sarong • Blanket	• Soap & Baby Powder & Ointment • Baby Diapers
Post-Delivery	• Blanket • Women's Breast feeding Shirt • Underwear	• Breast Feeding Bras • Pads

Focus Groups

The SIPA team conducted a total of eleven FGDs with kit recipients in Yogyakarta Province. Each group was meant to only be composed of women having received one same type of kit to facilitate discussion on the contents. This, however, did not happen each time as a few groups ended up being composed of a mix of women who received different kits. In Sleman and Klaten the SIPA team was able to meet with women having received each type of kit, whereas in Magelang the SIPA team did not meet with women who had received the

hygiene kit. The FGDs were conducted in local health centers/clinics, locally called "puskesmas". The women had been notified and selected in advance by the director of each of the health centers.

Pregnant Woman Kit

These groups of women found that the kits were well suited to their special needs as pregnant women; all items were appropriate and useful. The SIPA team noted that every woman had received complete kits in Klaten and Magelang districts. On average, the kits were received one week following their evacuation and this was found to be a reasonable timeframe by the beneficiaries. The kits were shared with the rest of their families and therefore some items only lasted one to two weeks. Women underlined the importance of good hygiene while being pregnant and found that the underwear and toiletry items provided in the kits helped them in that manner. One group explained that by receiving these kits, they did not have to worry about going out to find these items and were able to save the money to buy other items that they would need once they would give birth. The women did not report any direct benefits related to mobility, access to services or restoration of dignity.

Post-delivery Kits

When the women arrived at the evacuation centers, they received some basic items from camp coordinators, but UNFPA's kits were the only aid they received under the form of a pre-packaged kit. Women reported receiving the kits about one week on average after having been evacuated. All items were deemed useful, and none was identified as being of no use to them. The team did learn however that in Klaten, some pregnant women had been given post-delivery kits. These women all received their post-delivery kits from the evacuation shelter coordinator but were only a few months pregnant at that time. As a result, some items were not suited (nursing bra, maternity pads, etc.) for immediate use and these pregnant women explained that they stored those items for future use. The SIPA team also recorded that some women had not received complete kits. As the team went through the contents of the kits with the group in Magelang, there were some differences noted in what the women reported having received. All items very found to be very useful and the women were extremely grateful to have received UNFPA's kits. While the kits were targeted at individual women, the team noted that all the recipients reported having shared the contents with the rest of their family. The toiletry items only lasted about a week or two as they were shared with several family members.

Baby Kits

This kit is designed for newborn babies and was received by the majority of beneficiaries about one week following their evacuation. The feedback was very positive, the majority of women reported that all items were very useful. Very few exceptions were recorded, with some women explaining that their babies were too old to use the gloves and cloth diapers provided. Most women expressed the fact that they had been able to keep their babies warm thanks to the blankets and ointments provided in the kits. While no direct link to mobility or access to services was provided, a group of women explained feeling calmer and more comfortable by having these kits.

Hygiene Kits

The SIPA team was only able to conduct one FGD with women having received this type of kit. This group of ten women found all items in the kit very useful and explained that they had shared these kits with their families. None of them received kits from other organizations. This resulted in many of the items (particularly the toiletry) running out in about one week. The group did not immediately make mention of any secondary benefits related to the kits (improved mobility, access to services, etc.) but after some

probing, they explained that the items help them interact with people and be more active. An additional benefit noted was the fact that they did not have to buy these items and were thus able to save some money.

Key Informant Interviews

The SIPA team conducted a number of interviews with different divisions of UNFPA (Operations Department and Humanitarian Department), partner UN agencies, governmental ministries, and international and local NGOs.

Both meetings with international organizations (UNICEF and Plan International) provided some insight as to how other organizations provide kits in Indonesia as a response to natural disasters. These KIIs particularly highlighted the importance of Long Term Agreements (LTAs) with suppliers to ensure effective and timely distributions. As explained, LTAs greatly decreased the time spent procuring items. As underlined by PLAN International, which is in the process of implementing LTAs, these agreements can be challenging to set up, as suppliers often require a guaranteed minimum number of orders in advance. UNICEF currently has LTAs in place with two suppliers and with a transportation vendor. As opposed to UNFPA's kits that only target one individual woman, both PLAN and UNICEF's kits were family/household kits (for use by 5 people) and contained higher quantities of items than UNFPA's.

The SIPA team also interviewed local implementing partners, which were all organizations that had distributed UNFPA's kits to affected populations during the Merapi eruption. Many of the local partners were in the process of being trained by UNFPA at the time of the eruption, and UNFPA utilized these open communication channels to distribute the kits. Local health centers and the Midwife Association distributed the pregnant woman kits, the post-delivery kits and the newborn kits as they had key access to these groups. The hygiene kits were distributed by local NGOs to women of reproductive age. Distributing partners were all extremely positive on the usefulness and comprehensiveness of the kits and found that the kits were one of the best forms of aid provided in response to the Merapi eruption. While the concepts of dignity did not really come up during the FGDs, several distributing partners believed that the kits provided the beneficiaries with a sense of pride and dignity.

All distributing partners underlined the fact that the amount of kits provided was not sufficient to meet the needs of the displaced populations and as a result the health centers were forced to disassemble many of the kits to ensure greater coverage.
Beneficiaries confirmed this during FGDs.

The SIPA team learned that UNFPA's visibility on the humanitarian scene remained quite limited in Indonesia. Other international organizations had very limited – if any – knowledge of the fact that UNFPA provided such kits during emergencies. UNFPA's lack of participation in the WASH Cluster (where most kit distributions fall under in Indonesia) was a primary reason for this limited visibility.

Overall Findings

Impact

Within the context of this evaluation, impact is "construed as the *immediate* changes in quality of life experienced by beneficiaries as a result of the dignity kit(s). These include changes in "dignity" and self-worth, changes in agency, and changes in mobility (measured by access to education, water and food

distribution, social activities or income-generating capabilities)."[66] With this in mind, the SIPA team has drawn the following key findings regarding the impact experienced by beneficiaries of UNFPA's distribution of kits following the Merapi eruption.

There was no observable long-term impact on the health conditions of beneficiaries, however the women emphasized that the kits met their immediate hygiene needs – and that of their families. Toiletry items and the clothes and underwear were all very helpful to stay clean.

Improved mobility was not a concept that came up automatically when the SIPA team spoke to the beneficiaries about the benefits of the kits. A few women explained being able to do more things and interact with people thanks to the kits but there was no consensus on this. The mobility of these affected women had not been directly hampered by their displacement and the kits therefore did not have any direct effect on their ability to leave their shelter and access services.

A notable benefit expressed by many of the beneficiaries was the fact that they no longer had to worry about finding the items UNFPA had given them. Women explained that they were able to save money by not having to buy these items and were instead able to buy other essential items. In this sense, the concept of "peace of mind" was more relevant than the idea of the direct restoration of dignity. This concept of dignity came up more often during KIIs than during the FDGs. While several key informants mentioned that the kits provided a "sense of pride" and dignity, the women in the FGDs spoke more about added confidence and comfort. In addition to the immediate benefits the kits provided, the women did express their immense gratitude for receiving the kits and appreciated that someone had thought of them.

Overall, the contents of the kits were valued and adapted to the needs of each particular target group; the items were culturally sensitive and appropriate.

Procurement

UNFPA distributed a total of 6750 Hygiene Kits (unit price: US $13), 425 Pregnant Woman Kits (unit price: US $14), 625 Post-Delivery Kits (unit price: US$ 23) and 530 Newborn Kits (unit price: US$ 22) as a response to the 2010 Mount Merapi eruption.

Indonesia follows UNFPA's procurement rules and the Country Office gathers bids from at least three vendors before purchasing the items. This process takes, on average, one week. UNFPA's humanitarian officers explained that LTAs could greatly reduce lead-time but that these agreements were challenging to establish, mainly due to the fact that suppliers required the total number of orders that will be placed within a year.

The main logistical challenge in Indonesia resides in transportation issues. It can be very costly and long to deliver kits to remote disaster-affected areas. Transportation is further complicated by the fact that Indonesia is comprised of over 15,000 islands. Pre-positioned kits are currently warehoused in Jakarta, but as a result of these logistical challenges, the CO is in the process of decentralizing these stocks of kits at

[66] SIPA Team, Inception Report: Evaluation of UNFPA's provision of Dignity Kits in Humanitarian and Post-Crisis Settings (6 February 2011), 17

regional levels. While stockpiling at the national level has already shorted response time, this is a very positive initiative that will further reduce both transportation costs and distribution times.

While the distribution channels currently used (local health centers and local NGOs) ensure key access to vulnerable groups, there are some opportunities for UNFPA to improve communication regarding the contents, the targets and the purpose of each kit. The SIPA team learned from the FGDs that some women had received the wrong kits and that kits had sometimes been disassembled to ensure greater coverage. Both UNFPA and these implementing partners could benefit from stronger communication to ensure the most efficient use of these specific, pre-assembled kits.

Organizational competencies

In Indonesia, one of UNFPA's comparative advantages rests on its unique target groups. UNFPA distributes kits to segments of the population (pregnant women, women who have just given birth, etc.) that no other organizations cover. In addition, UNFPA benefits from very strong relationships with partners at all levels: from national government ministries to grassroots organizations. As a result, UNFPA is able to reach vulnerable groups that no other organizations target. Also, the customization of the kits to the segmented needs of different groups, while being culturally sensitive, differentiates UNFPA from other organizations that also engage in kit distributions in Indonesia. Pregnant woman, newborn and post-delivery kits all fall directly within UNFPA's RH activities, while the hygiene kit falls under UNFPA's Gender focus. These kits are important and valued – especially since aid is not usually gender sensitive in Indonesia.

Focus Groups

The SIPA team conducted a total of eleven FGDs with kit recipients in Yogyakarta Province. Each group was meant to only be composed of women having received one same type of kit to facilitate discussion on the contents. This, however, did not happen each time as a few groups ended up being composed of a mix of women who received different kits. In Sleman and Klaten the SIPA team was able to meet with women having received each type of kit, whereas in Magelang the SIPA team did not meet with women who had received the hygiene kit. The FGDs were conducted in local health centers/clinics, locally called "puskesmas". The women had been notified and selected in advance by the director of each of the health centers.

Pregnant Woman Kit

These groups of women found that the kits were well suited to their special needs as pregnant women; all items were appropriate and useful. The SIPA team noted that every woman had received complete kits in Klaten and Magelang districts. On average, the kits were received one week following their evacuation and this was found to be a reasonable timeframe by the beneficiaries. The kits were shared with the rest of their families and therefore some items only lasted one to two weeks. Women underlined the importance of good hygiene while being pregnant and found that the underwear and toiletry items provided in the kits helped them in that manner. One group explained that by receiving these kits, they did not have to worry about going out to find these items and were able to save the money to buy other items that they would need once they would give birth. The women did not report any direct benefits related to mobility, access to services or restoration of dignity.

Post-delivery Kits

When the women arrived at the evacuation centers, they received some basic items from camp coordinators, but UNFPA's kits were the only aid they received under the form of a pre-packaged kit. Women reported receiving the kits about one week on average after having been evacuated. All items were deemed useful, and none was identified as being of no use to them. The team did learn however that in Klaten, some pregnant women had been given post-delivery kits. These women all received their post-delivery kits from the evacuation shelter coordinator but were only a few months pregnant at that time. As a result, some items were not suited (nursing bra, maternity pads, etc.) for immediate use and these pregnant women explained that they stored those items for future use. The SIPA team also recorded that some women had not received complete kits. As the team went through the contents of the kits with the group in Magelang, there were some differences noted in what the women reported having received. All items very found to be very useful and the women were extremely grateful to have received UNFPA's kits. While the kits were targeted at individual women, the team noted that all the recipients reported having shared the contents with the rest of their family. The toiletry items only lasted about a week or two as they were shared with several family members.

Baby Kits

This kit is designed for newborn babies and was received by the majority of beneficiaries about one week following their evacuation. The feedback was very positive, the majority of women reported that all items were very useful. Very few exceptions were recorded, with some women explaining that their babies were too old to use the gloves and cloth diapers provided. Most women expressed the fact that they had been able to keep their babies warm thanks to the blankets and ointments provided in the kits. While no direct link to mobility or access to services was provided, a group of women explained feeling calmer and more comfortable by having these kits.

Hygiene Kits

The SIPA team was only able to conduct one FGD with women having received this type of kit. This group of ten women found all items in the kit very useful and explained that they had shared these kits with their families. None of them received kits from other organizations. This resulted in many of the items (particularly the toiletry) running out in about one week. The group did not immediately make mention of any secondary benefits related to the kits (improved mobility, access to services, etc.) but after some probing, they explained that the items help them interact with people and be more active. An additional benefit noted was the fact that they did not have to buy these items and were thus able to save some money.

Key Informant Interviews

The SIPA team conducted a number of interviews with different divisions of UNFPA (Operations Department and Humanitarian Department), partner UN agencies, governmental ministries, and international and local NGOs.

Both meetings with international organizations (UNICEF and Plan International) provided some insight as to how other organizations provide kits in Indonesia as a response to natural disasters. These KIIs particularly highlighted the importance of Long Term Agreements (LTAs) with suppliers to ensure effective and timely distributions. As explained, LTAs greatly decreased the time spent procuring items. As underlined by PLAN International, which is in the process of implementing LTAs, these agreements can be challenging to set up, as suppliers often require a guaranteed minimum number of orders in advance. UNICEF currently has LTAs

in place with two suppliers and with a transportation vendor. As opposed to UNFPA's kits that only target one individual woman, both PLAN and UNICEF's kits were family/household kits (for use by 5 people) and contained higher quantities of items than UNFPA's.

The SIPA team also interviewed local implementing partners, which were all organizations that had distributed UNFPA's kits to affected populations during the Merapi eruption. Many of the local partners were in the process of being trained by UNFPA at the time of the eruption, and UNFPA utilized these open communication channels to distribute the kits. Local health centers and the Midwife Association distributed the pregnant woman kits, the post-delivery kits and the newborn kits as they had key access to these groups. The hygiene kits were distributed by local NGOs to women of reproductive age. Distributing partners were all extremely positive on the usefulness and comprehensiveness of the kits and found that the kits were one of the best forms of aid provided in response to the Merapi eruption. While the concepts of dignity did not really come up during the FGDs, several distributing partners believed that the kits provided the beneficiaries with a sense of pride and dignity.

All distributing partners underlined the fact that the amount of kits provided was not sufficient to meet the needs of the displaced populations and as a result the health centers were forced to disassemble many of the kits to ensure greater coverage. Beneficiaries confirmed this during FGDs.
The SIPA team learned that UNFPA's visibility on the humanitarian scene remained quite limited in Indonesia. Other international organizations had very limited – if any – knowledge of the fact that UNFPA provided such kits during emergencies. UNFPA's lack of participation in the WASH Cluster (where most kit distributions fall under in Indonesia) was a primary reason for this limited visibility.

Overall Findings

Impact

Within the context of this evaluation, impact is "construed as the *immediate* changes in quality of life experienced by beneficiaries as a result of the dignity kit(s). These include changes in "dignity" and self-worth, changes in agency, and changes in mobility (measured by access to education, water and food distribution, social activities or income-generating capabilities)."[67] With this in mind, the SIPA team has drawn the following key findings regarding the impact experienced by beneficiaries of UNFPA's distribution of kits following the Merapi eruption.

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The kits have also played an important role in introducing UNFPA to local implementing partners in Indonesia; they have opened the door for communication between local organizations and UNFPA. Relationships have been formed through the distributions and most, if not all, of the local NGOs the SIPA team met expressed their desire to form stronger ties with UNFPA, even outside the realm of emergencies. This differs from other major aid organizations that have not been able to forge such close relationships with local partners. In the case of Indonesia, these relationships have provided key access to affected populations, since the Government of Indonesia only welcomes international assistance depending on the scale of a disaster and did not do so following the eruption of Mount Merapi. By further increasing collaboration with these local channels, UNFPA will have the opportunity to develop access to key vulnerable groups in Indonesia.

The SIPA team has identified the lack of inter-cluster coordination as a challenge. UNFPA is active within the health cluster but not a part of the WASH cluster where many of the kit distributions of other organizations fall under. Due to human resources limitations, it has been difficult for UNFPA's humanitarian team to attend inter-cluster meetings or WASH cluster meetings in addition to the clusters UNFPA leads in times of emergencies. Nevertheless, coordination provides tremendous opportunities for UNFPA to reduce costs and to capitalize on existing strengths. Coordination in the areas of logistics and long-term agreements offer great potential for reduced costs and increased efficiency in the delivery of UNFPA's kits to affected populations across Indonesia.

ANNEX V – KYRGYZSTAN COUNTRY REPORT

I. Background

On June 10, 2010 conflict erupted between ethnic Kyrgyz and ethnic Uzbek in southern Kyrgyzstan following the contentious results of presidential elections in April. By June 13th violence in the region had subsided. A first report from UN OCHA on that date indicates that 75 deaths were already confirmed and looting continued to be rampant in Osh and Djalal-Abad cities.[68] By mid-June OCHA was operating on an estimation of 300,000 IDPs in the region;[69] a month later, approximately 75,000 people remained displaced.[70] Conflict, displacement, and the loss of business and homes have had a protracted effect on the region. Reports from November 2010 indicate that approximately 810,000 people continued to be in need of assistance as a result of direct or indirect effects of the events.[71] In response to this humanitarian crisis and the health and hygiene needs of displaced women and families, UNFPA Kyrgyzstan distributed approximately 800 hygiene kits and dignity kits to women in Osh and Djalal-Abad between mid-June and December 2010.

II. Introduction

In March 2011, UNFPA Kyrgyzstan hosted a visiting team of two graduate students from Columbia University's School of International and Public Affairs (SIPA) to conduct a field assessment of the distribution of hygiene and dignity kits during the 2010 civil conflict. This visit was part of a global assessment of UNFPA's provision of dignity kits, which included concurrent field visits to Colombia, Indonesia and Mozambique by other members of a larger student team.

SIPA team members Libby Abbott and Rikha Sharma Rani visited the Republic of Kyrgyzstan for a period of one week beginning on 11 March 2011 and ending 19 March 2011. The team was hosted by UNFPA Kyrgyzstan staff Azamat Bailanov, Reproductive Health Programme Associate, and Ramis Djailibaev, Finance Associate for Emergencies. In total, the team spent three days in Osh and two days in Djalal-Abad. The remaining two days were spent at UNFPA's main office in Bishkek. Five focus groups were held with beneficiaries of dignity kits in the affected regions (three in Osh and two in Djalal-Abad). Additionally, the team met with five representatives from the Kyrgyzstan Country Office (CO), eight partner NGOs and three other UN agencies. For a complete list of meetings held, please see Annex A. Preliminary findings from the field visit were presented to members of the Kyrgyzstan CO on 18 March 2011.

III. Methodology

The SIPA team conducted field visits in Colombia, Indonesia, Kyrgyzstan and Mozambique. Field visits represent Phase III of the SIPA team's assessment of UNFPA dignity kits in humanitarian emergencies. Phase

[68] ROMENACA Sub-regional Office for Central Asia. "Kyrgyzstan Civil Conflict: Situation Report #1." UN Office for the Coordination of Humanitarian Affairs (UNOCHA). 13 June 2010.
[69] ROMENACA Sub-regional Office for Central Asia. "Kyrgyzstan Civil Conflict: Situation Report #4." UN Office for the Coordination of Humanitarian Affairs (UNOCHA). 16 June 2010.
[70] Melissa Fleming. "75,000 people still displaced in southern Kyrgyzstan, one month on." UNHCR. 16 July 2010. Web. 16 April 2011. <http://www.unhcr.org/4c403946528.html>
[71] "Kyrgyzstan: Extended Humanitarian Flash Appeal Seeks $42 Milliion." UNOCHA. 24 November 2010. Web. 16 April 2011. < http://kg.humanitarianresponse.info/>

I consisted of desk research, interviews with UNFPA headquarters and tool development. Phase II involved the distribution of an online survey to all countries that have included dignity kits as part of their humanitarian response and phone interviews with select COs.

Field visits lasted from one to two weeks and were conducted in the month of March. CO staff developed the agenda for each field visit in consultation with SIPA team members. Prior to the field visits, the SIPA team worked with UNFPA headquarters staff to develop focus group (FG) guides and interview tools for use in-country. The FG guide was created to capture the experience of beneficiaries before and after receiving the kit, as well as to discern their overall impression of the value of the kit retrospectively. Participatory ranking methodology was used to explore notions of necessity and value regarding the contents of the dignity kits. SIPA team members applied these tools subjectively based on the country-specific context and, if necessary, tools were adapted while on the ground. Any such changes were communicated to the rest of the SIPA team via email.
Key informant interviews (KIIs) were conducted with key stakeholders involved in the distribution of dignity kits. KIIs included UNFPA staff, partner NGOs, other UN agencies and government officials. The selection of participants for both the FGs and the KIIs was done by COs in consultation with the SIPA team. The team's findings are limited by the fact that selection of focus group participants and KIIs was not random, leading to the possibility that samples were not representative of affected populations.

At least two SIPA team members were present at each meeting, with one person responsible for conducting the meeting and another for manually documenting responses (no tape recorders were used). At the end of each day, meeting notes were compiled and uploaded to a shared network viewable by all team members.

IV. Findings

Participatory Ranking Methodology
During the field assessment, the researchers conducted five focus group discussions (FGDs) with participatory ranking methodology (PRM) activities. Participants were primarily women who had received dignity kits during the 2010 distributions, though one FGD included two male beneficiaries and targeted beneficiaries who had received hygiene kits.[72] For each FGD/PRM, participants were selected and recruited by the community-based organization that had distributed kits to them on behalf of UNFPA. A translator was employed to translate between the researchers (who spoke English) and the participants (who spoke a mix of Kyrgyz and Uzbek).

To elicit information on the value and appropriateness of items in the kits, FGD participants were invited to complete two participatory ranking activities. First, participants were provided with blank note cards and markers, and asked to collectively remember each of the items included in the kits that they had received

[72] Note: The UNFPA Kyrgyzstan Country Office makes a distinction between dignity kits and hygiene kits. Dignity kits fall under the Gender Program and were distributed between September and December 2010, following an official appeals process. Hygiene kits fell under the Reproductive Health Program and were distributed in June 2010 in immediate response to the crisis. The items contained in the hygiene kits were pre-stocked items that remained from a 2008 earthquake response, and thus facilitated UNFPA's rapid response in June 2010. Contents of dignity kits and hygiene kits were similar (a significant difference being that the latter contained medicine) and target groups were similarly defined (women who had been affected by violence during the June events).

(kit contents differed across groups, but were the same within groups). Group participants named and drew each of the items they remembered so that each item was represented by one note card. Once participants had agreed upon a final list of items, the note cards were laid out on a central table around which participants were seated. Participants were asked, "Which of these items were most useful to you at that time [during the conflict and in the months that followed]?" They were subsequently requested to rank the items listed in order of usefulness so that the final list reflected the views of all participants.

After participants had agreed upon a ranking of the items received in the actual kits, they were asked to think of any items that they would have liked to include in a hypothetical kit: "If you could add anything to a kit like this that would be given to women like you in a situation like the one you experienced last year, what would you add?" Following the same process as above, participants drew new items on note cards, inserted these new items into the old list, and then ranked the items in order of usefulness. The results of the five PRM activities are presented below.

PRM Activity 1

The first PRM activity was conducted with eight women of mixed age and ethnicity (Kyrgyz and Uzbek) who had received dignity kits in Osh city. All of the women had been identified as participants by the community-based organization (CBO) that had distributed kits to them. Three of the women had been identified as beneficiaries because their husbands had been killed during the conflict; the other five women were selected because their houses had been burned.

This focus group and PRM activity was in fact a pilot exercise for the SIPA team. As such the PRM activity differed slightly from the four subsequent PRMs, as experiences from the first informed a revision of the guiding question and the activity guidelines. After participants listed the items included in their kits, they were asked to generate a list of the top five items included in their kits. They were then asked to name the top five items they would include in a hypothetical kit. These findings are presented below.

LIMITATIONS: The quality of these data are less reliable than those from subsequent PRMs, when the guiding question was clearer and activity protocols (listing and drawing items, etc.) were more closely followed. In addition, the dynamic of this group was particularly constrained. The head of the CBO that had organized the activity attributes the tension to the mixed ethnicities as well as the uncomfortable environment (the discussion was held in a very large and cold conference room). As with all groups, the PRM was conducted on the site of the distributing organization, which may have biased participants' responses.

FINDINGS: Participants repeatedly expressed their appreciation for the contents of the kits. Several participants noted that while other organizations were giving away food, no other organizations were giving away clothes, and in fact two of the clothing items were included in the final group ranking of items received in the kits.

	Actual Kit	Hypothetical Kit
1	Shoes	Underwear
2	Toothpaste/toothbrush	Shoes
3	Sleeveless jacket	Food for babies
4	Towel	Medicines for stress

5	Sanitary napkins	Bed clothes
6		Toothpaste/toothbrush

PRM Activity 2

The second PRM activity was conducted with seven women of mixed age and ethnicity (Kyrgyz and Uzbek) who had received dignity kits in Osh city either in late September/early October or late November/early December.[73] All of the women had been identified as participants by the community-based organization (CBO) that had distributed kits to them.

LIMITATIONS: As with all groups, the PRM activity itself involved less discussion than the activity is ideally designed to elicit. This was often because of the dominance of several women who articulated decisions, while other women seemed content with the resultant lists. In this case, women also articulated an ambivalence toward the notion of ranking: "We can't say what was more important and what was less. All were important." As with all groups, the PRM was conducted on the site of the distributing organization, which may have biased participants' responses.

FINDINGS: Participants from this group explained that soap was first on their list of items received because "at that time the markets were closed, and everybody had difficulty getting soap." Another participant noted that typically families buy household goods to last only one or two days, and thus did not have stores of goods when the conflict took place. Sanitary pads were also a much needed item; women reported that in their absence they had been using old cloth or rags to meet menstrual hygiene needs. When asked why the head scarf was listed last, participants responded that while locally these items are a part of everyday life, this meant that in fact they still had access to them (through friends, neighbors, mosques, etc.) and as such did not see them as a particularly necessary or important item for inclusion in the kits. In discussing the contents of their hypothetical kits, participants agreed that not getting sick was an important priority, which is why they had listed medicines as the most important item.
Many participants from this group had also received kits from Red Crescent.

	Actual Kit	Hypothetical Kit
1	Soap	Money
2	Sanitary pads	Medicines
3	Socks	Soap (body)
4	Rubber shoes	Shampoo
5	Sleeveless jacket	Toothpaste/toothbrush
6	Leggings	Towel
7	Head scarf	Sanitary pads

[73] Initially participants agreed that they had received the kits in the fall, but when recalling the contents of the kits participants remembered that they had really valued the socks at the onset of winter, and thus decided that they had received the kits in November or December.

8		Head scarf
9		Underwear
10		Bed clothes
11		Socks
12		Leggings
13		Rubber shoes
14		Sleeveless jacket

PRM Activity 3

The third PRM activity was conducted with seven women of mixed age and ethnicity (Kyrgyz and Uzbek) who had received dignity kits in Osh city in December. All of the women had been identified as participants by the community-based organization (CBO) that had distributed kits to them.

LIMITATIONS: As with group two, when group three was probed further about the logic behind their ranking, women responded that they had ranked the items simply because we had asked them to, but that in fact all the items had been important and useful to them at that time, suggesting a limitation to the ranking activity. As with all groups, the PRM was conducted on the site of the distributing organization, which may have biased participants' responses.

FINDINGS: Soap was noted as a necessary item "to keep the body clean," and one participant responded that as a result of not having body soap she had been forced to use dish soap to clean her body during the conflict. Speaking about both the real kits and the hypothetical kits, one respondent noted, "The most important thing is our health. To be healthy we need to be clean. That's why the most important things included in the kits were toothbrush, soap, etc." They also added that many women and families ran out of clothing and diapers for their children, and therefore would have benefitted from the inclusion of diapers to keep their children healthy and clean.

Many of the participants from group three also received kits from Red Crescent. They noted that they preferred the Red Crescent kits because they included more items and also met the needs of men and children.

	Actual Kit	Hypothetical Kit
1	Soap (body)	Soap (laundry)
2	Sanitary pads	Diapers
3	Shoes	Sanitary pads
4	Leggings	Bed clothes
5	Socks	Soap (body)
6	Head scarf	Winter coat
7	Sleeveless jacket	Sleeveless jacket
8		Head scarf
9		Socks
10		Leggings
11		Rubber shoes

PRM Activity 4

The fourth PRM activity was conducted with five women and two men from an Uzbek community in Djalal-Abad city. These beneficiaries had received hygiene kits (distinct from dignity kits in the Kyrgyzstan context) that were distributed in June in immediate response to the conflict. All participants were selected by the partner organization through whom UNFPA had distributed the kits.

LIMITATIONS: Because of the volume of items included in the real kit, the exercise was adjusted slightly so that in the second part of the PRM participants were simply asked to generate a list of the top five items they would include in a hypothetical kit. The presence of two men in this focus group may have influenced the inclusion of the razor in the final five items for the final kit. As with all groups, the PRM was conducted on the site of the distributing organization, which may have biased participants' responses.

FINDINGS: One participant explained the ranking of clothing items toward the bottom of the list: "Of course clothes were important but when you're not clean the hygiene items come first." The participants also agreed that the inclusion of men's items was important, as men had to go out and earn money to take care of their families.
Many of the participants in group four later received similar kits from other organizations, though they noted that they preferred UNFPA's kits because "they took into account all the needs of the people."

	Actual Kit	Hypothetical Kit
1	Medicine	Medicine
2	Diapers	Soap (body)
3	Soap (body)	Soap (laundry)
4	Soap (laundry)	Razor
5	Toilet paper	Shampoo
6	Sanitary pads	
7	Shampoo	
8	Razor	
9	Shaving brush	
10	Dish detergent	
11	Toothbrush/toothpaste	
12	T-shirt	
13	Children's pants	
14	Children's shirt	
15	Night dress	
16	Shorts	
17	Sanitary pads	
18	Q-tips	

PRM Activity 5

The fifth PRM activity was conducted with seven women of both Uzbek and Kyrgyz ethnicity who had received dignity kits in Djalal-Abad city. Participants reported receiving the kits a month after the conflict occurred (July 2010), although they later reported that they received the kits in October 2010, which more closely corresponds to when the organization might have received the kits from UNFPA. All participants were selected by the partner organization through whom UNFPA had distributed the kits.

LIMITATIONS: Like other groups, group five was somewhat ambivalent to the ranking activity. When asked to further explain why certain items were ranked in certain ways, participants simply responded that "all items were important." One respondent went so far as to say that it was "a sin" to describe one item or one kit as better than the other when they are recipients of help; this finding might illuminate the cultural reasons behind some of the challenges with the PRM activities. As with all groups, the PRM was conducted on the site of the distributing organization, which may have biased participants' responses.

FINDINGS: Participants in group five prioritized soap in their rankings because of the unusual circumstances (lack of water, dust from fires) that increased their need for hygiene items. Sanitary pads were also highly ranked, and one respondent reported using old cloths prior to receiving sanitary pads in the kit. The radio was ranked last because of its value only as a source of entertainment: "When we were clean and warm, then we would listen to the radio."
Participants from group five also received similar kits from UNICEF and Red Crescent.

	Actual Kit	Hypothetical Kit
1	Soap	Medicines
2	Sanitary pads	Soap
3	Toothbrush and paste	Sanitary pads
4	Pants	Toothbrush and paste
5	Rubber shoes	Antiperspirant
6	Slippers	Pants
7	Short socks	Rubber shoes
8	Head scarf	Slippers
9	Sleeveless jacket	Short socks
10	Long socks	Head scarf
11	Radio	Sleeveless jacket
12		Long socks
13		Radio

Focus Groups

The SIPA team conducted a total of five focus group discussions (FGDs). Participants were primarily women who had received dignity kits during the 2010 distributions, though one FGD included two male

beneficiaries and targeted beneficiaries who had received hygiene kits (see earlier note for an explanation of the difference between dignity and hygiene kits).

For each FGD, participants were selected and recruited by the community-based organization that had distributed kits to them on behalf of UNFPA. This, in combination with the fact that the discussions were held on the premises of the organization that had provided beneficiaries with kits, may have biased participants' responses about the kits. A translator was employed to translate between the researchers (who spoke English) and the participants (who spoke a mix of Kyrgyz and Uzbek). Key findings from the FGDs are presented below.

1. The contents of kits were valued and viewed as appropriate

Beneficiaries consistently commented on the high quality and appropriateness of the contents of the kits. In particular, women from three groups noted that the warm clothing was timely as many of them received kits when the weather was becoming cooler. One group was particularly impressed with the quality and contents, as their kits contained items (such as q-tips) that they had not previously used in their daily lives. In the words of one participant: "The person who bought [the kits] knew all of our difficulties and knew what we needed."

2. Articulating the value of kits in such difficult times is a challenge

Though participants appreciated they kits, they often articulated the view that in such difficult times, the value of the kits can be reduced or made less relevant:

> "Even in those living conditions I didn't need those things. I had lost my most important person." (FGD 1)
>
> "When people have bad living situations it is very difficult but can be solved. But when people lose their relatives, it can't be solved." (FGD 1)
>
> "During the events we weren't thinking about our hygiene." (FGD 2)
>
> "Even when we had the opportunity to keep clean we didn't want to because we had other problems" (FGD 2)
>
> "We were really happy to receive these things, but can't say that they changed our lives" (FGD 2)

By contrast, another respondent noted that the circumstances heightened the apparent value of the kits. In describing a kit she received from MSF, she noted "At that time it looked like gold because we didn't have anything."

3. The needs of children and men were not met

Several groups noted that the kits did not contain items for men or children in the family. One group added diapers to their hypothetical kits and another added food for babies; further discussion led to the suggestion of kids clothing in one group. Participants from the third FGD had also received kits from the Red Crescent, and indicated that they preferred those kits because they contained items for men and children.

4. Items were often available through informal support networks

Most focus groups confirmed that before receiving the kits they had been able to access similar items through networks of friends and family, or from places of worship. Participants also indicated that at the time of the discussion they were able to buy all items in the markets again.

5. Secondary effects

There was some indication of a purely symbolic and support function of kits: “We were very thankful that God didn’t forget about us. People still were taking care of us.” Several other respondents indicated the value of feeling like “a remembered person.” FGDs did not, however, yield any evidence of other secondary effects of kits. When asked specifically about whether the kits had improved their mobility in the community, a respondent from group two indicated that she was already moving about outside of her house by necessity, “not feeling shy or ashamed.” Respondents from the fifth group articulated similar sentiments:

> “Even before we had these things we were not ashamed.”
>
> “Even if we were wearing the same dress we were going outside because nobody was laughing at us.”

6. The role of needs assessments

Though some participants seemed to appreciate the symbolic value of needs assessments, there was also an opinion that the contents of the kits did not have to be tailored to local needs. A participant from the first group, for example, expressed the opinion that even when organizations do not have goods or services to offer, she appreciated when they came to ask her what had happened and what she needed. By contrast, a participant from group two noted that the kits did not necessarily have to reflect a needs assessment, as they had a universal value. This discussion followed shortly after a major earthquake in Japan: “In Japan for example you wouldn’t have to ask people about their needs. These kinds of things can be given without asking.” Similarly, a respondent from group five said, “God forbid there is another disaster, but if something happens send these same items and people will be happy.”

Key Informant Interviews

The SIPA team conducted a total of sixteen KIIs. These included interviews with five representatives from the Kyrgyzstan CO, eight partner NGOs and three other UN agencies. The key findings from these discussions are summarized below.

1. UNFPA is viewed positively by NGO partners

UNFPA was able to successfully implement a needs assessment, during which it sought input from NGO partners. In some cases, NGO leaders accompanied UNFPA to the local market to procure items. One NGO leader commented, "UNFPA was the only organization that asked their opinions." Other partners noted that UNFPA was constantly seeking their input.

2. UNFPA dignity kits were differentiated from those of other distributing organizations

UNFPA's participatory approach served to differentiate its dignity kits from those of other organizations, such that UNFPA's dignity kits are believed to have better addressed the unique needs of affected communities. One NGO leader gave the example of UNICEF distributing liquid soap in two liter cans that are usually used to hold oil. According to the leader, people thought that it was oil that they had received, not soap. Another NGO partner mentioned that items in the UNFPA kit were of better quality than what beneficiaries used prior to the crisis. This also helped to differentiate UNFPA's kits from those distributed by other organizations.

3. Criteria for determining "affected" people was broad and varied across partners

One NGO described eligibility as those people who had lost relatives, whose house was burnt or whose living conditions were "bad". Another NGO described the criteria for eligibility as those whose house had

burnt and who had no things, and women who had lost their husband. In some cases, the criteria for eligibility were established by UNFPA and in other cases they were established by NGO partners with buy-in from UNFPA.

4. Distribution mechanisms were not streamlined across NGO partners

Distribution through NGO partners was done informally, with no unified process for identifying beneficiaries or coordinating across geographic regions. For example, some partners distributed kits through territorial leaders who were tasked with determining which members of their community were most affected. Others distributed directly into communities, with identification of affected people done through observation or word of mouth. In some cases, distribution of kits was determined by the NGO partner's ability to access particular neighborhoods. One distributing partner in Djalal-Abad distributed kits to the area in which one of their staff lived, as this was one of the few areas that they could access. Areas to which NGO partners did not have immediate access were excluded.

5. "Equity" was an important consideration in determining beneficiaries

A number of NGO partners mentioned that their decision to distribute to certain groups of affected people was driven in part by the desire to be viewed as impartial and unbiased. For example, one NGO organization split the kits evenly between Uzbek and Kyrgyz communities, irrespective of how these groups were proportionately affected. Another UN agency representative noted that they had received complaints that only "rich" people were receiving kits (note that this was not referring explicitly to UNFPA kits, but to the distribution of kits more broadly). The desire to be viewed as "fair" weighed heavily on decisions about how to distribute dignity kits.

6. Distribution of dignity kits timely, but insufficient

There was a broad perception that UNFPA's distribution of kits was timely; however, key informants overwhelmingly felt that the size of the distribution was insufficient and that not all people in need received kits.

7. UNFPA Kyrgyzstan staff and NGO partners were unprepared to respond to a humanitarian emergency

Both UNFPA Kyrgyzstan staff and NGO partners described a lack of preparedness in responding to the crisis and expressed a strong desire for more comprehensive training on the kinds of responses available/necessary, procedures for flash appeals, etc.

8. There is room for increased coordination between UN agencies

There appeared to have been some coordination between UN agencies at the cluster level; however, kits were distributed through different clusters (e.g. WASH, health, protection), making effective coordination difficult. One UN agency noted that "there was no explicit effort to avoid duplication," but that agencies worked with different NGO partners to minimize this possibility.

Overall Findings

Impact

The impact of the dignity kit program can be framed in terms of primary and secondary effects. The primary effect of the kits, as articulated by beneficiaries, was the satisfaction of immediate hygiene needs. Respondents were almost universally happy with the contents and quality of the kits. Though customized clothing items were often discussed as most memorable by beneficiaries and were often raised as evidence

of the unique impact of UNFPA kits by UNFPA staff and partner organizations, PRM activities found that these items were often ranked at the bottom of the lists. This raises important questions about the impact of standardized hygiene items versus customized items more targeted toward local needs and the restoration of dignity.

Generally respondents also noted that would have liked more of each item in the kit. Partner organizations expressed the view that they did not have enough kits to reach the populations in need.

Focus group participants did not provide overwhelming evidence of any secondary effects of the kits, such as increased mobility or access to other services. A few respondents did note that the kits made them feel like a "remembered person," a secondary psychosocial impact that approximates the notion of dignity restoration that lies behind the dignity kit program theory. Key informants (both within UN agencies and other partner organizations) repeatedly noted that kits helped beneficiaries to "feel more human," though evidence of this effect in the target population was minimal.

Impact can also be measured by whom the program is able to reach. Dignity kits in Kyrgyzstan are officially targeted toward women who are perceived to be victims of gender based violence (GBV). Hygiene kits, on the other hand, were designed to target a broader group of "affected women"—women whose houses had been burnt or whose husbands had been killed during the crisis. In effect dignity kits and hygiene kits targeted the same populations, as women whose husbands were killed or whose houses were burnt were labeled victims of GBV.

More broadly, UNFPA identified the communities it was going to reach by default, without any explicit attention to overlap with other organizations. UNFPA's strategy was to identify partner organizations with whom it had worked in the past; after it had shared its individual criteria with them (victims of GBV or otherwise affected women), it was up to each respective organization to reach out to the women in the communities with which it normally worked. A substantial portion of participants from FGDs also received kits from other organizations such as Red Crescent and MSF.

Logistics

In Kyrgyzstan, the degree of funding and relatively small size of the distribution made local procurement attractive, enabling the CO to respond faster than other organizations. However, local procurement may not make sense in settings where procurement requirements are greater (trade-off between time required to procure and assemble locally versus additional time needed for international procurement). Thus, there is no blanket procurement approach (e.g. local versus international) that is appropriate for all circumstances. Procurement must take into account the specific country context, the size and scope of the distribution and internal resources and constraints.

The strength of UNFPA's immediate hygiene response was in its ability to capitalize on relationships with implementing partners. The SIPA team found that having pre-identified vendors suppliers would also enhance ability to respond quickly and effectively. UNFPA would also benefit from measures to increase preparedness and reduce procurement lead times in an emergency. Such measures include:

- Defining core items and keeping minimum safety stock on these items (e.g. soap, sanitary napkins, toothbrush/toothpaste, etc.).

- Negotiating pricing agreements with suppliers in advance - Prices and supplies fluctuate in emergencies. Establishing a list of vendors/suppliers and approximate prices might reduce the amount of time spent on the procurement process and thus improve UNFPA's ability to respond rapidly. In the event that suppliers are unwilling to fix prices, UNFPA may wish to consider guaranteeing a minimum purchase volume.

- Prequalifying vendors/suppliers (applying a variant of UNHCR model in which suppliers are pre-authorized to procure below for UNHCR-funded projects). UNFPA could buy directly from prequalified suppliers in the event of an emergency at pre-negotiated prices.

Organizational Competencies

The SIPA team was able to discern one clear organizational competency for UNFPA in the distribution of dignity kits, and this was in the kit itself. UNFPA's kit was more tailored to the needs of affected populations than kits distributed by other organizations. It should be noted, however, that this is only a competency to the extent that the more "customized" items created a material benefit over and above that of other, more standard kits. The inability to quantify this benefit and compare it to the added time and cost required by customization makes deriving a conclusion on this point difficult. What can be said is that there is a tradeoff between providing items that are locally appropriate and expanding coverage to more people.

Despite taking a more customized approach, UNFPA Kyrgyzstan was able to respond faster than many other UN agencies to the crisis. It is unclear whether this is representative of UNFPA's response in general, or whether this was a result of delays in the distribution of kits provided by other agencies (we know of at least one UN agency that suffered substantial delays). If representative, then one possible strategy is for UNFPA to provide immediate relief in the acute stage and then, given its limited resources, "hand over" response activities to other UN agencies with larger budgets and greater human resource capacity for more stabilized response.

The lack of a clear organizational competency for UNFPA leads to a number of questions that should be explored further. For example, beneficiaries targeted by UNFPA were similar, if not exactly the same, as those targeted by other UN agencies distributing dignity kits. Thus, UNFPA may expand its impact by narrowing its eligibility criteria to comprehensively reach a smaller sub-section of affected populations. Moreover, there are multiple organizations that distributed dignity kits in the most recent crisis in Kyrgyzstan. Given this, UNFPA may wish to divert its resources to less concentrated activities such as psychosocial support (identified in several KIIs as a gap), or traditional areas of strength such as GBV or RH support.

ANNEXE A

LIST OF FOCUS GROUP MEETINGS AND KEY INFORMANT INTERVIEWS CONDUCTED IN KYRGYZSTAN

5 Focus Group Discussions

- 3 Osh
- 2 Djalal-Abad

Key Informant Interviews

- 5 UNFPA CO staff
  - Meder Omurzakov, Azamat Baialinov, Ramis Djailibaev, Nurgul Kinderbaeva, Natalia Luzina
- 8 partner NGOs
  - Ensan Diamond, Sanaalash, Ukuk, NGO Mutakalim leaders, RHC, Kaniet, Red Crescent
- 3 UN agencies
  - UNICEF, UNHCR, OCHA

ANNEX VI – MOZAMBIQUE COUNTRY REPORT

I. Background

Even though Mozambique has experienced rapid economic growth and political stability during the last decade, a large proportion of the population lives in poverty[74] and is very vulnerable to disasters. The country remains prone to flooding and cyclones during the rainy season between November and March. In this context, UNFPA Mozambique started providing dignity kits during the 2007 floods and has continued to do so in 2008, 2010 and 2011, distributing them among women and in some cases other segments of the most vulnerable population, who live in the resettlement centers established by the government[75].

The latest provision of dignity kits occurred between November 2010 and March 2011 after the government declared a red alert in districts identified as high risk across the central provinces of Zambezia, Sofala, Tete and Manica.[76] Approximately 21,000 people were affected by the floods and UNFPA participated in the humanitarian response with the provision of 1,220 UNFPA dignity kits distributed in coordination with the cluster system and within a strong partnership with Instituto Nacional de Gestão de Calamidades (INGC)[77] and Ministerio da Mulher e Acçao Social (MMAS)[78], at different administrative levels.

II. Introduction

In March 2011, UNFPA Mozambique hosted a visiting team of two graduate students – Carolina Posada and Brittney Elise Bailey – from Columbia University's School of International and Public Affairs (SIPA). The Columbia team conducted a two-week field assessment of the distribution of dignity kits in Mozambique, with a particular emphasis on the distribution of kits during the 2008 floods in Zambezia province. This visit was part of a global assessment of UNFPA's provision of dignity kits, which included concurrent field visits to Colombia, Indonesia and Kyrgyzstan by others on the Columbia team.

In coordination with the UNFPA-Mozambique humanitarian focal point, Filipa Gouveia, the Columbia team visited communities and key informants across a few districts in Zambezia province: Quelimane, Morrumbala and Mopeia. The team also visited the Caia district in the nearby province of Sofala and conducted additional research in the Mozambican capital of Maputo. Mozambique was identified as one of the countries to conduct a field assessment of UNFPA's distribution of dignity kits, primarily because of the context of natural disaster in the Zambeze region, the country's capacity to handle natural disasters, as well as UNFPA- Mozambique's reputation for strong coordination with local and government partners in humanitarian response.

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[74] According to the latest Human Development Report, 79% of Mozambicans are multi-dimensionally poor. See: *Human Development Report 2010* —20th Anniversary Edition. The Real Wealth of Nations: Pathways to Human Development

[75] Some of the families have been living in the resettlement centers since the emergency response from the government established them in 2007 – 2008; some are newcomers, but most of the women and men who participated in the FGs and PRMs live there permanently.

76 The last rollout of kits (about 90) was still to be delivered to the affected population while the SIPA team mission was in Mozambique.

[77] National Institute for Prevention and Mitigation of Disasters.

[78] Ministry of Women and Social Action.

III. Methodology

The SIPA team conducted field visits in Colombia, Indonesia, Kyrgyzstan and Mozambique. Field visits represent Phase III of the SIPA team's assessment of UNFPA dignity kits in humanitarian emergencies. Phase I consisted of desk research, interviews with UNFPA headquarters and tool development. Phase II involved the distribution of an online survey to all countries that have included dignity kits as part of their humanitarian response and phone interviews with select COs.

Field visits lasted from one to two weeks and were conducted in the month of March. CO staff developed the agenda for each field visit in consultation with SIPA team members. Prior to the field visits, the SIPA team worked with UNFPA headquarters staff to develop focus group (FG) guides and interview tools for use in-country. The FG guide was created to capture the experience of beneficiaries before and after receiving the kit, as well as to discern their overall impression of the value of the kit retrospectively. Participatory ranking methodology was used to explore notions of necessity and value regarding the contents of the dignity kits. SIPA team members applied these tools subjectively based on the country-specific context and, if necessary, tools were adapted while on the ground. Any such changes were communicated to the rest of the SIPA team via email.

Key informant interviews (KIIs) were conducted with key stakeholders involved in the distribution of dignity kits. KIIs included UNFPA staff, partner NGOs, other UN agencies and government officials. The selection of participants for both the FGs and the KIIs was done by COs in consultation with the SIPA team. The team's findings are limited by the fact that selection of focus group participants and KIIs was not random, leading to the possibility that samples were not representative of affected populations.

At least two SIPA team members were present at each meeting, with one person responsible for conducting the meeting and another for manually documenting responses (no tape recorders were used). At the end of each day, meeting notes were compiled and uploaded to a shared network viewable by all team members.

The Columbia team conducted 4 FG discussions with approximately twelve to twenty-five people and twenty-one KIIs (with a total of 31 informants present) in Mozambique.

FG discussions were carried out in two districts of the Zambezia province: Morrumbala and Mopeia. UNFPA- Mozambique chose these two districts for the FG discussions because of their proximity to the Zambeze basin (which is prone to flooding and cyclones) and UNFPA's previous distribution of kits in this region. Also, the humanitarian focal point took into account the amicable relationship between government officials and community leaders in these two districts that would facilitate the presence of an external team in the region. The Columbia team conducted two FG discussions – disaggregated by gender- in the village of 24 de Julho, Mopeia. A third discussion with only women took place in Mopeia in the village of Zona Verde. The team had the opportunity to meet with a final group of women in the village of Pinda, Morrumbala.

Three of the four focus group discussions included a modified version of the participatory ranking methodology, where participants were primarily asked to rank items within the kits along with items that were not included in the kits (but that they found important in meeting their needs in an emergency). Participants were also asked about these items in relation to meeting their specific hygiene and health needs. The last focus group had the option of creating an "ideal" kit with only five of the items ranked.

The Columbia Team also conducted semi-structured and informal interviews with key informants at UN agencies, international and local NGOs and the Government of Mozambique. Informants were interviewed from the following list of organizations:

UN Agencies

- UNFPA
- UNICEF
- WFP
- Resident Coordinator Office of the UN
- The Protection Cluster

International/Local NGOs

- Mozambican Red Cross
- NAFEZA (Nucleo de Associações Femininas da Zambezia)

Government

- INGC – Central
- INGC/CENOE – Regional
- INGC – Province of Zambezia
- INGC – District of Morrumbala
- MMAS – Central
- MMAS/DPMASZ – Provincial
- MMAS/ SDSMAS – District

The UNFPA- Mozambique humanitarian focal point facilitated all meetings for the Columbia team in-country.

IV. Findings

Participatory Ranking Methodology

Due to the small number of FGs that the SIPA team performed in Mozambique, the PRM activities were carried out within each FG and were restricted to a classification of the items women had previously identified as needs in the FG.

PRM activity 1

The SIPA team conducted this PRM with women in a resettlement center for population affected by the floods. Women had been living in these centers for more than two years. Twelve women participated in

the PRM, ages between 15 and 60, who spoke Sena dialect. Two of the eldest women were especially vocal and seemed to have a leadership role within the group; two of the younger women also participated actively. The SIPA team asked the women to organize in order of importance the items they received in the kits, along with the sketches of the other articles they had mentioned as needs in the FG. To convey the meaning of "importance" in the ranking, the SIPA team referenced the district-level governmental official who was present in the PRM as the "most important" end of the spectrum, and one of the SIPA team members as the "least important".

Limitations: Given the large and varying number of women participating in the FG and thus in the PRM, it was difficult to get them all to participate. Because of the setting, women continued joining the group after the FG started but not everyone talked.

Ranking of items for Dignity Kits	
1	Capulanas[79]
2	Shoes
3	Clothes
4	Blankets
5	Plates
6	Pots
7	Cups
8	Vaseline
9	Toothbrush
10	Toothpaste
11	Soap
12	Underwear
13	Agricultural tools

PRM activity 2

This PRM activity was conducted with women between 15 and 60 years old who live in a resettlement center for population affected by the floods. The twenty-one women who participated spoke Sena dialect; two women in their 40's seemed to lead the discussion within the group and then speak for the group with the ideas they all had agreed upon. Two other of the eldest women expressed their feelings and opinions vividly, mostly about not having enough support from the community nor the government in their positions as widows. The SIPA team asked the women to classify the items they received in the kits and the sketches of their other needs starting with the most important for them, finalizing with the least vital.

Limitations: Not all the women in the group participated and only three of the women organized the items in order of importance, even though there was active discussion within the whole group about what should be included in the ranking. One of the elder women said that the toothbrush and toothpaste were also important, but the lead women had not included them because they had already received these items from other organizations.

[79] A capulana is a length of printed fabric used by women in Mozambique for clothing, for carrying their babies, as a blanket, as a sanitary pad, etc.

Ranking of items for Dignity Kits	
1	Capulana
2	Ointment
3	Soap
4	Underwear
5	Mosquito net
6	Tools for agriculture
7	Pot
8	Plate
9	Repellent/traps
10	Blanket

PRM activity 3

The SIPA team started the FG with about ten women from this resettlement center, but by the time the PRM activity was initiated there were twenty-six in the group. Age of participants went from mothers in their late teens that brought their babies to women in their sixties, some of whom were widows. Women spoke Sena but some seemed to understand Portuguese, so there was more direct communication between the SIPA team and the women, which made the interaction more vivid and active. The participants had internal discussions about the questions and then their conclusions were transmitted by two middle aged women. This group of women also seemed to be more familiar with the concept of focus groups, with sanitary pads (that were not provided those in other FGs) and stated that they wanted to use their own local women's association to help distribute the kits. Women were asked to rank the items they had identified as their most important needs, including the actual items in the dignity kits.

Limitations: Given the large number of items they kept adding, the SIPA team finalized the activity asking the women what they would prefer to get if they only had the chance to get five items; these condition changed the order of the preferences, raising doubts about the precision of the first ranking.

Ranking of items for Dignity Kits	
1	Plate
2	Pot
3	Agricultural tools
4	Bucket
5	Cooking oil
6	Blankets
7	T-shirt
8	Toothpaste
9	Toothbrush
10	Mosquito net

Ranking of items for Dignity Kits[80]	
1	Plate
2	Pot
3	Agricultural tools
4	Bucket
5	Cooking oil

[80] When asked to re-rank their "ideal" kit to only include 5 items, the women moved the capulana into this second list and replaced cooking oil.

11	Soap
12	Capulana
13	Shoes
14	Underwear
15	Sanitary pads
16	Cutlery

Focus Groups

The SIPA team conducted four FGs in two districts of Mozambique, covering three resettlement centers for population affected by the floods along the Zambeze River. Women participated in three of the FGs and one was done on an ad-hoc basis with men who had been gathered by the community leaders for the visit; even though only a few of these men had received dignity kits, the SIPA team considered their opinions and input important for the impact assessment.

The groups were organized by local INGC officials, who upon our arrival asked the community leaders in the resettlement centers to summon the women who had received dignity kits. Upon arrival at each location the accompanying government officials, UNFPA's humanitarian focal point and the SIPA team would introduce themselves to the community leaders. All beneficiaries were already waiting at a meeting point in each resettlement community. The SIPA team asked only the women who received the kits to stay for the FGs.

Limitations: Due to the setting and relations with the community, dismissing some of the women was considered inappropriate and thus the FGs were conducted with a larger group than planned. There was ambiguity about the meanings of hygiene and dignity; therefore, for questions related to hygiene it was explained as 'being healthy' and 'taking care of the body', while questions about dignity were not answered.

Focus Group 1	
Resettlement center:	24 de Julho
District:	Mopeia
Type of Emergency Crisis	Flooding
Number of Participants:	Twelve
Estimate Age Range of Participants:	15 – 60
Focus Group 2	
Resettlement center:	24 de Julho
District:	Mopeia
Type of Emergency Crisis	Flooding
Number of Participants:	16 (Men)
Estimate Age Range of Participants:	25 – 60
Focus Group 3	
Resettlement center:	Zona Verde
District:	Morrumbala
Type of Emergency Crisis	Flooding

Number of Participants:	21
Estimate Age Range of Participants:	15 – 60
Focus Group 4	
Resettlement center:	Pinda
District:	Morrumbala
Type of Emergency Crisis	Flooding
Number of Participants:	26
Estimate Age Range of Participants:	15 – 60

Key findings:

1. The target population are vulnerable groups

Even though dignity kits are mostly associated with women in emergencies in Mozambique, the kits have been provided to other segments of the most vulnerable population such as the elderly, the disabled, the ill and children heads of households. The selection of beneficiaries is being done by MMAS and INGC which target the intervention to people in dire need regardless of their gender.

2. Benefits are extended to the families and the community

The impact of dignity kits is spread out by the women who received the kits, as they share the contents with their children and husbands. Sometimes the benefits reach women in need that did not receive the kits themselves, though this is mandated by community leaders in order to extend the coverage of the intervention.

3. Coverage is limited

The population living in resettlement centers is extremely poor and in dire need of supplies and services throughout the year. Community leaders, who have a closer knowledge of the living conditions of every member of the community, choose the beneficiaries. Nevertheless, the women and men in the FGs feel that some of the most vulnerable people did not receive dignity kits and they want the quantity of kits to be increased.

4. The contents of the kits were highly appreciated and were found useful

Women beneficiaries said the kits had helped them improve their day to day lives and carry out their daily chores. They noted being more mobile as they are able to go to the farming areas, they can send their children to school, they can cook, they can clean their bodies and wash their clothes, and they can get water for the cooking, cleaning and for the latrines. Women say that as contents are shared with their families, the contents of the kits last from two to four weeks (soap and toothpaste specifically). The three most common “useful” items identified by the women in the FGs were capulanas, buckets and soap.

They value dignity kits enormously as they had never received anything directed especially to them in emergency responses and in some cases, the contents of the kits were the first items they owned; therefore the intervention seemed to improve their sense of self and their perception about their importance in the community. Thus, they were very thankful to the government, whom they perceive as the providers of the kits; they do not know of UNFPA and are not aware that UNFPA is the original source of the kits.

5. Benefits of the kits were only partially associated with the restoration of dignity

Women do not have a clear definition of dignity and they associate the benefits of the kits to an improvement in their daily lives and in their health rather than "dignity"; moreover, hygiene is identified with health and wellbeing rather than a concept in itself. Thus, for women the benefits of the kits include improving their ability to carry out their day to day activities and avoid illness. In contrast, men were more vocal in their definition of dignity as "something that a good man has, like a good home, good health and good food". Consequently, men believe that receiving the kits dignifies those who receive them.

6. The community wants to participate more actively in the distribution of the kits

Both women and men expressed their interest in participating in the delivery of the kits. Community leaders are vital to the intervention as they support the government in selecting the beneficiaries, they are the entry point to the community and they help in the distribution. Nevertheless, the community as a whole wants to help in the delivery of the kits recipients; they see this activity as a source for livelihoods that will further improve their situation.

7. Important unmet needs

A common element of all the FGs conducted was the need for cooking and kitchen utensils, clothes and shoes. Even though they all mentioned that they have received these items in the past from other organizations, they wish these goods were included in the dignity kits as these would make a difference in their daily lives- i.e. help them to carry out their daily activities and look after the family.

Men reported the following needs were essential to their hygiene and health: pants, shirt, soap, pots, blanket, toothpaste, toothbrush and items for shaving.

Key Informant Interviews

All of the informants unanimously agreed that UNFPA's distribution of dignity kits in Mozambique had a positive impact. This impact was generally associated with women. For instance, dignity kits were often referred to as "women's kits" and some government officials did not even know of the specific term of "dignity kits"; but rather the kits were commonly known as "kits femeninos" or as "basic needs kits". Government officials at the provincial and regional levels specifically stated that the main difference between the dignity kits and hygiene kits were that dignity kits responded to the needs of women in emergencies. Given the direct association with women, two items were commonly identified as the most useful and appropriate for fulfilling women's needs: the capulana and the buckets, in which the kits came. These items were also said to provide indirect benefits to the whole family.

Although considered a positive impact, particularly for women, the informants also identified potential limitations of the kits in this regard. There was concern that UNFPA kits only focused on women and girls, although many informants noted that this targeted distribution made sense given UNFPA's mandate and the overall lack of response to women in emergencies. Also, many informants from partner agencies addressed the need for other items (outside of the capulana and buckets) that might better fit the local context and needs of both men and women in emergencies i.e. clothing, pots and plates.

Most informants, especially government and NGO representatives at the local level, went into great detail about the positive and negative consequences of providing kits generally associated with the needs of

women. On the one hand, this provision of kits to women has fulfilled a "niche" need in humanitarian response. Dignity kits were viewed as a provision that takes care of women's unique needs in emergencies and as an intervention that fulfills an overlooked issue in humanitarian response. Also, UNFPA was identified as the only entity providing these specific, customized kits as part of humanitarian response in Mozambique.

Yet, on the other hand this customization of kits also sometimes led to reinforced gender and power dynamics among women and men and across communities. For instance, it was mentioned several times that many men were not excited about the idea that their women were receiving intimate items- underwear- from anyone else but them. Also, local informants stated that although the kits were targeted toward women, oftentimes men would go through the kits at the distribution centers and would then divide or sell certain items. Another example that came up quite often was the fact that target groups were identified by community leaders, who although they had a monopoly on local knowledge, also had their own agendas for including certain people on the lists of targeted groups. Local authorities from the government mentioned that some women from polygamist households would be left off of the list by their husbands. This was also the case for many households led by widows and orphans. The issue of coverage and reaching the most vulnerable and "needy" individuals in an emergency was one of the most common themes in discussions with key informants at all levels.

The general debate over coverage also touched on accessibility and logistics limitations. Many times the kits were not delivered to hard-to-reach areas that were identified as the most vulnerable parts of Zambezia (i.e. Chinde district). Also, distributions as late as February 2011 were barely made in the Morrumbala district because of missing contents (due to a reported traffic accident and bucket spill en route to Morrumbala). Lastly, there was a general lack of clarity on who was considered vulnerable and who should really receive the kits, given that many times vulnerable people received dignity kits even though they were not directly affected by the floods.

In terms of fulfilling the basic objectives of the kits, all informants were able to articulate an idea that the kits met two basic goals: hygiene needs and the restoration of dignity. The definition of dignity varied. Dignity was sometimes associated with mitigating the psychological effects of an emergency (for both men and women), providing a personal possession for those in need, giving power to a woman in a family and providing them with self-esteem, as well as improving health and helping someone to reconstruct the community.

Informants also mentioned several secondary effects of the kits that fulfilled other objectives outside of hygiene and restored dignity. For instance, many said that the kits improved a family's mobility (though this was especially stated in regards to women). Women could perform their daily activities, leave the house to go work in the lowlands, send children to school and use the money that would normally be spent on these items for other things. The capulanas, buckets and underwear were identified as the primary items that allowed women to fulfill these other needs. Also, almost every informant identified the capulana as a sign of normalcy and the most important item for women to fulfill hygiene and non-hygiene needs in an emergency.

Whether at the local, regional, national or international level, almost all informants expressed a need for some type of assessment or inclusion of beneficiaries in determining contents of the kits. This issue was usually mentioned within the context of cultural sensitivity and debates over items included in the kits. For

instance, some government officials wanted to know why toothbrushes were included in the kits when many communities, particularly in Zambezia, used a local root to brush their teeth. Others brought up the issue of including underwear, which were sometimes seen as an affront to a man's role in the family. Lastly, as previously stated in an assessment conducted by UNFPA's partner organization, NAFEZA, although sanitary napkins were more appropriate in terms of utility in emergencies (i.e. lack of clean water to wash cloths and lack of privacy during the floods), they were also seen as a culturally inappropriate addition to the kits in juxtaposition to the commonly-used cloths of capulana.

A common question from government officials and NGO representatives was – Is UNFPA conducting an assessment to determine kit contents? If so, how are they going about doing this? Are they providing community education on how to use the items along with/before the distribution of kits? In addition, many informants from international organizations and the government expressed the importance of distinguishing between types of emergencies (floods, droughts, etc.) and the severity of emergencies (red alert, etc.).

The main cost driver identified by almost all informants was transport. Interviewees familiar with the procurement process mentioned that insurance costs associated with transport could be very high for UNFPA. The fact that Mozambique has poor road infrastructure and perpetually faces high-cost seasonal weather means that transport costs will inevitably be high. Also, even with the WFP arrangement, many times because the kits are not distributed in large quantities or with bulk items, they require many smaller trucks for transport, which can be more expensive than large-scale deliveries. Some of the transport costs are offset by the recently-established long term agreement with WFP. Also, since UNFPA now utilizes the government contingency plan and UN emergency procurement procedures to determine how many kits to distribute by November of the previous year, some of the costs associated with transport and warehousing are lessened.

One consistent finding among all informants was that UNFPA-Mozambique's kit distribution served as a strong example of coordination among international, government and local partners. From procurement to distribution, the kits are integrated into the country's Contingency Plan, the UN's Joint Programme as well as the pilot One UN project. UNFPA receives funds for humanitarian response, including dignity kits, from the One UN fund. UNFPA- Mozambique also has a long term agreement with the World Food Programme (WFP) to warehouse and transport the kits to INGC, where the kits will then be delivered by the government. All informants mentioned the need to foster these current partnerships in order to facilitate the dignity kit intervention and to disseminate more information on the purpose of dignity kits in UNFPA's humanitarian response programming overall.

Informants from international agencies and at the local level also placed a particular emphasis on community education and the need for "training of trainers". Even though UNFPA's partners unanimously highlighted the positive impact of kits, they had trouble articulating specific knowledge about the purpose of the kits and how they fit into UNFPA's humanitarian response priorities. There were several suggestions to strengthen UNFPA partners' knowledge of the kits and to provide more education at the community level that could link kit provision to larger issues that UNFPA should address in emergencies (i.e. GBV sensitization, hygiene education, and reproductive health in emergencies). Also, many partners acknowledge never seeing a UNFPA logo on any of the kits that they helped to distribute. This meant that many times people (including local government representatives) were unaware that the kit intervention was directly associated with UNFPA.

Overall Findings

Impact

Dignity kits have a positive impact in emergencies as they are targeted to the most vulnerable population (mostly women), which is not the specific beneficiary of any other intervention; in addition, there is a valuable impact on women's self-esteem and their position in the community. Hence, women can be empowered and can better face some of the difficulties of an emergency while men perceive the importance of women as they are directly being taken into account by the government (the "provider" of the kits).

As women are the main recipients of dignity kits in Mozambique, they tend to extend the benefits of the kits to the rest of their families, having a greater reach. Another valuable characteristic of the dignity kits is that they are customized for women's needs and therefore include culturally sensitive goods that the women know how to use; a great example of this best practice is the inclusion of capulanas in Mozambique, which are very useful to women as they have several functions.

Based on the experience that Mozambican beneficiaries have had with the dignity kits, there is an improvement in their mobility and their ability to perform their daily activities. The women noted how this helps them indirectly support their homes and families by allowing them to go to the farming fields and send their kids to school.

In spite of all the positive effects observed in the communities, the provision of dignity kits is limited by the availability of funds and the inability to get to remote areas which are in dire need of aid; therefore, UNFPA Mozambique has the opportunity to improve its coverage to reach more of those who are forgotten by other interventions that do not target the most vulnerable segments of the population.

Another challenge that UNFPA Mozambique has to face is improving direct contact with the community by performing more frequent needs assessments. In addition, there was a consistent request for workshops and educational material that accompany kit distribution and will help the communities strengthen their knowledge about hygiene, health, GBV and disease prevention, which can be coupled with the offering SRH services.

Logistics

The CO in Mozambique has been able to establish very strong partnerships with implementing organizations such as INGC, MMAS, NAFEZA and CVM which have allowed the Humanitarian Response team to better identify the beneficiaries and reach them more easily. Nevertheless, these partnerships have to be fostered to improve communications, as well as strengthening processes and procedures to target exactly those people who need the kits the most.

Given that Mozambique is one of the pilot countries for the DELIVERING as ONE approach, the coordination level between UN agencies is effective, and though time consuming, has improved emergency response in the country. In addition, the Government of Mozambique has been able to establish a strong institutional structure for the prevention and mitigation of disasters, which includes a thorough planning of interventions and preparedness for emergencies along with the cluster approach. UNFPA seems to be highly integrated into this system. This allows the CO to plan the distribution of dignity kits effectively, starting with the allocation of funds through the ONE fund, the procurement of kits in a timely manner, the

prepositioning of kits in regional hubs through a newly established LTA with WFP for transportation and warehousing, and the final dispatch and distribution of the kits in conjunction with government officials working at the community level.

The SIPA team noted how the CO has been able to learn from its own experience throughout the years, and thus has adapted the procurement process accordingly to make it more efficient. The CO has done so by improving coordination and taking advantage of the strengths of partnerships in areas where UNFPA has low capacity, e.g. transportation, warehousing and distribution.

Organizational Competencies

UNFPA's CO in Mozambique has a core competency in emergency responses as its mandate directs its efforts to women, who are one of the most vulnerable groups of the population in emergencies. In a cultural environment where women have little value without a man, reaching women with an intervention can empower them to have a better position within the family and strengthen their capacities. In addition, dignity kits are the only kits that are culturally customized to the needs of the population, having an additional psychosocial value for the recipients who feel important and happy about themselves.

The continuous and effective use of the cluster approach in Mozambique provides the CO with a great opportunity to continue strengthening gender mainstreaming in emergency responses. As observed in the KIIs, gender sensitive interventions are still rare within emergency operations and UNFPA has the comparative advantage of having the knowledge and the mandate to modify this trend; no other organization has promoted the inclusion of programming with gender in mind, giving UNFPA an important place in the cluster system. This is also true about the Minimum Intervention Service Package (MISP) that is being promoted by UNFPA and which still requires a lot of work to be implemented fully during emergencies in Mozambique.

The CO faces the challenge of raising awareness about the importance of the kits within the cluster system, as many organizations see the intervention as a favorable but marginal one. UNFPA Mozambique has to work within the CO and in the cluster system to achieve a better understanding of the purpose of the kits and raise support for the intervention, which is already included in the Joint Programme but for which there is not enough knowledge or interest.

Evaluation of UNFPA's Provision of Dignity Kits in Humanitarian and Post-Crisis Settings

Inception Report

6 February 2011

Client: United Nations Populations Fund (UNFPA)

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Table of Contents

LIST OF ACRONYMS

ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
CERF	Central Emergency Response Fund
CO	Country Office
EF	Emergency Response Fund
FG	Focus Group
GBV	Gender Based Violence
HQ	Headquarters
HRB	Humanitarian Response Branch
HRU	Humanitarian Response Unit
ICPD	International Conference on Population and Development
IDP	Internally Displaced Person
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
KII	Key Informant Interview
MISP	Minimal Initial Service Package
OCHA	Office for the Coordination of Humanitarian Affairs
RH	Reproductive Health
SIPA	School of International and Public Affairs
TOR	Terms of Reference
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

The United Nations Population Fund (UNFPA) has been providing dignity kits to vulnerable populations in emergency settings for more than a decade, and the intervention has become a standard activity of the Fund in humanitarian emergency settings. The provision of dignity kits is thought to help women and other beneficiaries' access food distribution and other lifesaving activities, while simultaneously enabling them to retain their sense of dignity. While the intervention has enhanced UNFPA's presence in acute humanitarian emergencies, the experiences of various countries involved in the distribution of dignity kits have been captured largely anecdotally and have been very ad-hoc, and documentation of the diverse costs and benefits of procuring, assembling, storing and distributing dignity kits has been limited.

As part of its analysis of UNFPA's dignity kit program, the team from the School of International and Public Affairs (SIPA) at Columbia University will work closely with UNFPA staff at headquarters, regional and country level to analyze the benefits and challenges of dignity kit provision to beneficiaries. The SIPA team will also seek to understand and assess the direct costs and any comparative advantages associated with this intervention in terms of procurement, time and human resources. This will be done using a four-phase process of data collection that will include engagement with, *inter alia,* UNFPA headquarters, regional and country staff, beneficiaries of dignity kit interventions, and government/NGO partners and organizations involved in humanitarian response. At the conclusion of the project, the SIPA team will present its findings and recommendations to UNFPA's Humanitarian Response Branch and Evaluation and Strategic Planning Branch, with the objective of informing UNFPA's internal decision-making as it relates to the provision of dignity kits globally.

PROJECT BACKGROUND

There are over 43 million refugees and internally displaced persons (IDPs) in the world today.[81] These populations, displaced by natural disaster, violence and/or internal conflict, often flee volatile situations with nothing more than the clothes on their backs. People living under such conditions may lack necessities such as toothbrushes, underclothing, culturally-appropriate dress, sanitary napkins and/or shaving kits. Lacking such essentials, displaced populations may, in addition to the loss of their homes and possessions, feel stripped more acutely of their basic human dignity. In an effort to help restore some of this dignity and assist in the maintenance of hygiene, UNFPA distributes "dignity kits"—commonly known as hygiene kits—to men, women and children in countries experiencing humanitarian crises.

Since 2000, UNFPA has been providing and distributing dignity kits in emergency settings around the world. These kits were conceived of during a series of high-level discussions during the Sierra Leone and Liberia conflicts in early 2000. The Humanitarian Response Branch (HRB), in consultation with the then Geographic Divisions and Country Offices (COs), observed that none of the major international agencies in the sub-region were providing tangible, essential items that also fulfilled the basic needs of women and girls in refugee camps. This prompted UNFPA to begin procuring and distributing a small quantity of kits containing sanitary pads and other essentials, in order to encourage the mobility, comfort and dignity of women living in refugee camps.[82] Approximately 600 dignity kits were delivered as a pilot program to displaced Liberians seeking refuge in Ghana.

HRB's concern with the particular needs of women in refugee camps reflected a much larger evolution of UNFPA's mandate to incorporate reproductive health into its international humanitarian programs. In 1994, the International Conference on Population and Development (ICPD)—often referred to as the Cairo Conference— endorsed a new Programme of Action that "focused on meeting the needs of individual women and men rather than on achieving demographic targets."[83] This shift in population policy provided traditional development agencies like UNFPA with a platform to transition into humanitarian programming. The ICPD placed the provision of universal access to reproductive health (RH) services, including family planning, at the forefront of UNFPA's mandate (for more about UNFPA's mandate see 'Client Agency' in Annex I).

Since the program's inception, dignity kits have served as a tangible reflection of UNFPA's mandate to incorporate RH and women's needs more broadly into its agenda for humanitarian aid. For example, UNFPA incorporated dignity kits into the Minimum Initial Service Packages (MISP), which was established as a set of priority activities to be implemented in a coordinated manner by trained staff during the onset of an emergency.[84] Dignity kits typically contain basic hygiene items such as toothbrushes, toothpaste, sanitary

[81] "2009 Global Trends" (United Nations High Commissioner for Refugees report, Division of Programme Support and Management, 15 June 2010), http://www.unhcr.org/4c11f0be9.html

[82] Priya Marwah, Humanitarian Programme Specialist with UNFPA HRB, in discussion with authors, 1 December 2010.

[83] From UNFPA website, http://www.unfpa.org/public/icpd/pid/5065#intro.

[84] "Reproductive Health in Refugee Situations: An Inter-agency Field Manual" (United Nations High Commissioner for Refugees report, 1999), http://www.unfpa.org/emergencies/manual/index.htm.

napkins, underwear, towels, soap and, depending on the needs and cultural norms of affected populations, buckets, slippers and headscarves—items that at the time were not normally distributed in humanitarian aid settings. Although the intervention initially targeted only women, distribution of the kits has expanded to sometimes include men, youth and even entire households. Design of the kits typically incorporates input from local community groups and the contents are often customized to the needs of specific beneficiary populations. Procurement of kit contents and kit assembly are generally done locally rather than regionally or globally. Where possible, women and youth groups are employed or mobilized by UNFPA to assemble the kits. While this customized, participatory approach is believed to have helped ensure local buy-in and to have boosted the local economy, it is becoming increasingly evident that this type of intervention comes at a high cost for UNFPA. Procurement, assembly, warehousing and distribution of kits often entail relatively high financial and human resource costs, for an often limited number of kits given UNFPA's financial constraints.

The SIPA team will be conducting the first global evaluation of UNFPA's dignity kit program. UNFPA has identified four countries from which the global experience of dignity kit provision will be extrapolated. These are: Georgia (tbd), Colombia, Indonesia and Mozambique. These countries were selected on the basis of four key criteria:

1. Different geographical regions
2. Differences in the nature of the humanitarian setting
3. Ability to track beneficiaries
4. Capacity of COs to support the assessment

See Annex II for a description of dignity kit provision in each of the four study countries.

Funding Mechanisms for the Provision of Dignity Kits

Central Emergency Response Fund

The Central Emergency Response Fund (CERF) is a humanitarian fund created by the UN in 2005 to provide timely funding for crisis response activities. In most situations, the CERF is the first seed funding available for humanitarian response activities undertaken by UN agencies and the International Organization for Migration (IOM). CERF funds of up to USD 500 million per year are available and are managed centrally by the Office for Coordination of Humanitarian Affairs (OCHA). The fund consists of an annual grant facility of up to USD 450 million and a loan facility of up to USD 50 million. Only interventions deemed 'life-saving' in the context of an emergency are eligible for CERF funding. The UNFPA successfully advocated for the designation of 'life-saving' criteria to the provision of dignity kits. As a result, programs to distribute dignity kits are eligible for funding under the CERF.

The Emergency Fund

The Emergency Fund (EF) was established as a special fund within the UNFPA budget to provide humanitarian assistance in response to serious and immediate RH and GBV needs and to situations in which any of the following criteria apply: (a) regular country program funds are not available; (b) country program funds are not immediately available, but may become available in the future and reimbursed to the EF

(with the approval of the government); (c) donor support for the UNFPA component of a Consolidated Appeal Process has been committed but funds are not yet in hand.[85]

The EF, which is a revolving fund of USD 3 million per year, is overseen by the Programme Division (HRB).[86] UNFPA COs can request funds from the EF in crisis situations involving the displacement of populations, loss of access to basic RH care, significant risk of gender-based violence (GBV) or where the basic needs of vulnerable populations are at risk.[87] EF funding can be used to support a wide range of crisis response activities including rapid needs assessments, provision of hygiene kits and/or MISPs for reproductive healthcare, establishment of appropriate psychosocial support programs, recruitment of consultants, purchasing of equipment, and implementation of surveys and other data collection related to assessing and monitoring humanitarian needs.[88] Recently, EF guidelines have been revised to include funding for preparedness.

The Emergency Response Fund

An Emergency Response Fund (ERF) is a country-based pooled fund and an in-country funding mechanism for NGOs and UN agencies to respond to the short term emergency needs of communities suffering from humanitarian crises.[89] Overall management and oversight of the ERF is the responsibility of the Humanitarian Coordinator (HC), with day to day management and financial administration conducted by OCHA. The ERF is typically modest in size (less than USD 10 million) and ranges from small to medium-sized grants of less than USD 500,000. These grants are used primarily to fund the activities of NGOs. There are currently sixteen funds being managed by OCHA for Afghanistan, Colombia, Democratic Republic of Congo (DRC), Ethiopia, Haiti, Indonesia, Iraq, Kenya, Myanmar, Nepal, Occupied Palestinian Territory (oPt), Somalia, Sudan, Uganda, Yemen and Zimbabwe.[90]

RATIONALE FOR EVALUATION

Based on discussions with the client and an initial review of documents provided by UNFPA, the SIPA team has identified two main rationales for the project:

[85] "2009 Emergency Fund Monitoring Report" (UNFPA report, 15 June 2010). The Consolidated Appeals Process is a tool developed by aid organizations in a country or region to raise funds for humanitarian action and to plan, implement and monitor their activities together.

[86] Ibid.

[87] Ibid.

[88] Ibid.

[89] Unlike CERF funding, which is only available to UN agencies, NGOs are eligible for ERF funds.

[90] OCHA, Basic Facts about Country Base About Country Based Humanitarian Pooled Funds (February 2010); http://unocha.romenaca.org/Portals/0/Documents/20100205%20FCS%20Basic%20Facts%20for%20ERF%20and%20CHFs.v8.pdf

1. An evaluation of dignity kits has not been conducted by UNFPA since project inception.

UNFPA has been involved in the provision and distribution of dignity kits since the early 2000s. Dignity kits have been distributed by more than 100 COs in all five global regions to thousands of beneficiaries. There is growing awareness within UNFPA, however, that this intervention comes at a high cost. Despite anecdotal field reports, no formal internal or external evaluation of the impact and utility of dignity kits have been undertaken. Given the commitment of resources required by this intervention, an examination of costs and benefits is needed to evaluate the viability of dignity kit provision in various settings.

Moreover, it is important to understand the global experience of dignity kit provision to inform UNFPA's structuring of RH interventions in emergencies. Dignity kits have become a standard intervention for UNFPA COs, particularly in the acute phase of the emergency continuum. However, the institutional capacity of individual COs varies widely, as do procurement, assembly, storage and distribution mechanisms. It is critical to encapsulate and document the global experience of dignity kit provision in order to inform effective intervention points, and to streamline (where possible) elements of the supply chain. This could lead to important cost savings and gains in efficiency. UNFPA has engaged a SIPA team to conduct the evaluation and provide recommendations for continued procurement and provision of dignity kits as part of its humanitarian response efforts.

2. Dignity kits are important to UNFPA's institutional mission and branding.

In addition to UNFPA, several other UN agencies and international NGOs distribute hygiene kits in humanitarian settings, including the IOM and UNICEF. It is critical to understand where UNFPA is situated within this market system in order to identify its comparative advantage, if any, in dignity kit provision, both in terms of supply chain mechanisms and in broader distribution and impact. UNFPA's role in expanding the concept of hygiene kits to include items essential to women and girls is thought to have enhanced the organization's visibility and standing in a number of countries. UNFPA is one of the only UN agencies working within the cluster system that has a specific RH mandate, giving it a unique lens through which to operate in humanitarian settings (see Annex III for a breakdown of the UN cluster system). For example, UNFPA was among the first organizations to start distributing sanitary napkins to women in emergencies. Moreover, UNFPA attaches great importance to the distribution of dignity kits given its particular mandate.

OBJECTIVES OF EVALUATION

The SIPA team has been asked to conduct a multidimensional evaluation of dignity kits for UNFPA. The objective of the proposed evaluation is to:

1. Assess the usefulness and impact of UNFPA's dignity kit program. Specifically, the SIPA team will examine whether the items contained in the kits are valued by beneficiaries and achieve the objective of helping to restore dignity and maintain hygiene in displaced populations. To that end, the SIPA team will explore whether the kits have successfully facilitated access to food and water distribution, education, other essential services and/or income generating activities believed to be crucial to socialization and the preservation of personal dignity.

2. Document the costs of procurement, assembly, storage and distribution of dignity kits. The SIPA team will gather data about the various financial costs, procurement practices and human resource

requirements associated with the provision of dignity kits in diverse settings. In order to inform UNFPA's decision-making, the SIPA team will identify factors critical to choices surrounding procurement, assembly, storage and distribution mechanisms based on, *inter alia*, the typology of the emergency situation (e.g., a protracted versus acute crisis setting), available market mechanisms and accessibility of distribution channels.

The SIPA team's evaluation will incorporate the Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) criteria for assessing humanitarian interventions: appropriateness, coverage, connectedness, effectiveness, efficiency, and impact (for more on the ALNAP conceptual framework and its role in this evaluation see Annex IV).[91] Findings and recommendations will inform UNFPA's internal decision-making with respect to the provision of dignity kits.

DELIVERABLES

The expected deliverables for the study include:

- Work plan;
- Inception report;
- Presentation of preliminary findings at UNFPA COs in March 2011;
- Draft final report;
- Final report;
- Presentation of key findings and recommendations at SIPA; and
- Final presentation of key findings and recommendations at UNFPA HQ and Columbia University in May 2011.

Results from data collection will inform the creation of a decision-making tool aimed at helping countries determine whether or not the provision of dignity kits is appropriate in a particular situation.

LIMITATIONS OF THE EVALUATION

The SIPA team acknowledges a number of constraints to the scope of the project. These limitations will influence the team's ability to assemble the data needed to globally assess the benefits, challenges and mechanisms of dignity kit provision. Potential limitations of the project include:

- *Insufficient cost data.* The absence of cost data may limit the extent to which the SIPA team can provide a comprehensive analysis of costs and comparative advantage involved in the provision of dignity kits. Moreover, this evaluation will focus on ascertaining the *direct* costs associated with dignity kit provision in various settings (e.g. procurement, assembly, distribution/freight, etc.). Indirect costs such as overhead, indirect labor, input prices (e.g. oil) and environmental impact are beyond the scope of this evaluation.
- *Measuring quantifiable costs against qualitative benefits*. The quantification of elements that contribute to a person's sense of dignity is outside the scope of this evaluation. Instead, the SIPA

[91] John Cosgrove et al. 2009. *Real-time Evaluations of Humanitarian Action – An ALNAP Guide (Pilot Version).* Action Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) Publication.

team will assess (to the extent possible) outcomes such as access to clean water, education, food and other social activities.

- *Lack of baseline data*. Given this, the depth of the evaluation will be determined in large part by the robustness of data obtained from surveys and interviews with UNFPA headquarters, regional offices (ROs) and COs.
- *Applicability of findings*. Information obtained from the four study countries will, in combination with in-depth interviews with other selected countries, need to be extrapolated in order to draw broader conclusions about dignity kit provision in humanitarian crises. Challenges to this include the possibility of low response rates and the non-comparability of dignity kit programs and country contexts. As a result, recommendations arising from findings may not be generalizable across all settings.
- *Access to competitive/external information*. The SIPA team may not have unfettered access to cost and other data from key informants (e.g., governments, NGOs, other UN organizations, etc.); the degree to which key informants are willing to share information will affect the team's assessments of comparative advantage. Moreover, due to time constraints and geographic differences, the SIPA team will not be able to speak with all stakeholders involved in the provision of dignity kits and, as a result, data collection will necessarily be incomplete.

Where appropriate, and in consultation with UNFPA, adjustments may be made to methodology and scope to overcome these limitations.

PROPOSED METHODOLOGY

I. Research Question(s)

The SIPA team has created a series of research questions that reflect UNFPA's objectives for the evaluation of its dignity kit programs:

a. What are the various ways in which dignity kit programs are implemented by UNFPA COs?
b. To what extent, if at all, are the kits valued by beneficiaries?
c. What are the direct costs associated with distributing dignity kits?
d. Given the costs and benefits, is it advisable for UNFPA to continue supplying dignity kits and under what circumstances? If so, what are the most appropriate and effective mechanisms to do so?

A preliminary indicator framework has been developed to address the four overarching research questions outlined above.

Research Questions	Evaluation Questions	Assumptions/Risks	Level of Inquiry	Method	Indicator
What are the various ways in which dignity kit programs are implemented by UNFPA Country Offices?	How do UNFPA's dignity kits differ from hygiene kits distributed by other organizations?	Other international organizations (UN and non-UN) are willing to be interviewed or provide samples	HQ, ROs, COs, IOs	KII	Observation or qualitative analysis of stakeholders' descriptions of kits
	How is funding secured?		HQ, ROs, Cos	KII, DR	Qualitative analysis of discussions with stakeholders and review of appeals documents
	How are the kit contents determined?	Records of preliminary assessments are available	COs	GS, KII, DR	Qualitative analysis of stakeholders' reports and assessment records (if any)
	What are the contents of the kits?	Ability to recruit beneficiaries; Accurate recall; Global survey has a decent response rate	COs, field	GS, KII, FG	Tabulation of the variety of kit contents as reported in the global survey, key informant interviews, and FGs, and through direct observation
	How long do the contents of the kits last? How often, if at all, are they replenished?	Ability to recruit beneficiaries; Accurate recall by both COs and beneficiaries	COs, field	KII, FG	Qualitative analysis and cross-checking of field staff reports and beneficiary reports of content longevity
	Who is targeted to receive the kits?	Ability to recruit beneficiaries	COs, field, HQ	GS, KII, FG	Collection and analysis of HQ, CO and beneficiary responses
	Who uses the items?	Ability to recruit	Field	FG, KII	Qualitative

		beneficiaries; Accurate/unbiased recall from beneficiaries			analysis of beneficiary, CO staff and key informant responses
	How were beneficiaries selected?	Availability of documentation from previous distributions	COs	KII, DR	Qualitative analysis of key informant responses, CO staff responses and documents, if any
	How soon after the onset of the crisis were kits delivered to beneficiaries?	Ability to recruit beneficiaries, relevant records are available from CO staff	COs, field	KII, FG	Qualitative analysis of staff and beneficiary reports on the timing of distribution
	Was provision coordinated with other agencies? If so, with whom?	Willingness of partner organizations to be interviewed	ROs, COs, IOs	KII	Qualitative analysis of discussion with key informants
	To what extent do CO staff and/or partners engage in activities to sensitize beneficiaries about kit contents, how the contents are used, etc?	Actions were taken to sensitize beneficiaries about items in kits and how they are used	IOs, Cos, Field	KII, FG	Qualitative analysis of responses from CO staff, partner agencies and beneficiaries
To what extent, if at all, are the kits valued by beneficiaries?	What were beneficiaries using before the distribution of dignity kits to meet hygiene needs?	Ability to recruit beneficiaries; Ability to collect unbiased data from beneficiaries	Field, CO	FG, KII	Qualitative analysis of FGs, CO staff and participatory research activities (lists, group narratives, drawings, etc.)
	What were female beneficiaries using before the distribution of dignity kits to meet hygiene and menstruation needs?	(same)	(same)	(same)	(same)
	How long after the disaster did beneficiaries receive kits? What did they use to meet hygiene needs in the meantime?	(same)	(same)	(same)	(same)

	Do dignity kits respond to the hygiene needs of affected populations?	(same)	(same)	(same)	(same)
	How do stakeholders define "dignity"?	Ability to translate "dignity" into appropriate local languages	(same)	(same)	(same)
	To what extent, if at all, do kits contribute to the restoration of beneficiaries' dignity?	Ability to relay concept of dignity to recipients	(same)	(same)	(same)
	To what extent, if at all, do beneficiaries value the contents of the kit?		(same)	(same)	(same)
	Which items do beneficiaries view as "non-negotiable" (e.g most useful)?	Belief that the items in the kit were valuable in some capacity	(same)	(same)	(same)
	Were beneficiaries able to access other services (food, water, education and social activities) as a result of using items in the kits?	Beneficiaries able to link kit contents to accessing services, if at all	(same)	(same)	(same)
What are the costs associated with distributing dignity kits?	What are the direct and indirect costs associated with the procurement, assembly, storage and distribution of dignity kits?	Cost data is available and accessible	HQ, ROs, COs	KII, DR	Analysis of available cost data
	What are the key direct cost drivers?	(same)	HQ, ROs, COs	KII, DR	Analysis of available cost data
	Do direct costs vary according to the typology of the crisis? Other factors? If so, how?	(same)	COs	KII, DR	Comparative analysis of available cost data across countries and within various contexts
	What are the direct labor costs? (staff, hours, volunteers, etc.)	CO staff are willing to provide information about	COs	KII	Qualitative analysis of human resource

		human resource costs of distribution			costs
	What other UNFPA activities compete for the same funding?	UNFPA staff are willing to provide information about program and funding priorities	HQ, ROs, COs	KII	Qualitative analysis of key informants' responses regarding funding and programming priorities
Given the costs and benefits, is it advisable for UFNPA to continue supplying dignity kits and under what circumstances? If so, what are the most appropriate and effective mechanisms to do so?	Does UNFPA have a comparative advantage over other organizations (IOM, UNICEF, etc.) in the provision of dignity kits?	Availability of accurate and reasonably comprehensive data from previous data collection and analysis stages	Global	DR	Analysis of all qualitative and cost data

Key:

DR = Desk Review
KII = Key Informant Interviews
CO = Country Office
FG = Focus Group
GS = Global Survey
RO = Regional Office
IO = International Partner Organizations

II. Key Concepts and Definitions

Many of the concepts and terms that are central to this evaluation will be defined inductively over the course of research. As a starting point, we have proposed some broad and preliminary definitions:

***Beneficiary*:** At the outset, we are defining direct beneficiary as the man, woman, young person or child who physically receives a dignity kit (the identification/designation of beneficiaries is done locally by COs, so the categories of direct recipients will vary across sites). We will also be looking at the impact of the kits on the families of beneficiaries, whom we will treat as indirect beneficiaries.

***Dignity*:** At present, UNFPA does not have a working definition of "dignity" as it relates to the provision of dignity kits. We expect to develop a definition of dignity over the course of our research and field work. Chilton (2006) proposes a definition of dignity in the context of health outcomes as "a dynamic sense of worth that is socially and politically mediated." Importantly, she notes that dignity is both objective and subjective—a consideration that will likely inform our investigations of "dignity" in the field. Notably, Chilton lists agency and autonomy as essential components of dignity.[92] Agency is an important consideration in this evaluation, as we will not only be assessing agency as a component of dignity, but also perceived agency as a factor that mediates mobility and access to humanitarian services (food and water distribution, education, etc.).

***Costs/Benefits*:** There are a number of variables and costs associated with UNFPA's provision of dignity kits. We will look not only at the direct costs of procurement, assembly, warehousing and distribution for dignity kits, but also at direct but less tangible "costs" in terms of time, stress, efficiency, etc. that are incurred by UNFPA offices providing dignity kits during humanitarian responses. Another "cost" that will be examined in this evaluation is the counter-factual opportunity cost experienced by a beneficiary of not receiving a dignity kit, although the team recognizes the methodological limitations involved in soliciting this kind of information in the context of post-facto evaluation with no comparison group. All of these costs will be measured against "benefits," understood as both the material benefits of the kits (the usefulness of the contents, access to water and food distribution as a result, etc.) and the psychosocial benefits of the kits ("dignity").

Impact: The ALNAP criteria note the many possible definitions of impact, and suggest that it is most important to clarify the meaning of impact in ways that are specific to particular interventions or contexts and that enable practical implementation of an effective assessment.[93] In the traditional causal pathway, impact is conceived of as the distal and overarching changes to quality of life that have come about as the result of an intervention. It is not, however, within the scope of this evaluation to investigate these kinds of long term, sustained changes, especially given a lack of comparison group or baseline data. Following ALNAP's recommendation that a definition of impact be explicit, tailored and practical, we are clarifying that in the context of this evaluation, "impact" will be construed as the *immediate* changes in quality of life experienced by beneficiaries as a result of the dignity kit(s). These include changes in "dignity" and self-worth, changes in agency, and changes in mobility (measured by access to education, water and food

[92] Mariana Chilton, Developing a Measure of Dignity for Stress-Related Health Outcomes, Health and Human Rights, 9 no. 2 (2006), 209-233

[93] ALNAP (2009)

distribution, social activities or income-generating capabilities). In the traditional language of causal pathways these are considered outcomes rather than impacts. Thus, while the Terms of Reference (TOR) stipulates the need for an "impact assessment," time and resource constraints compel us to focus at the level of outcomes.

III. Phases of Research

a. Desk Review

The SIPA team will review critical documents provided by UNFPA. These documents pertain to the mission and programs of UNFPA in general as well as to the provision of dignity kits (although, as has been noted in the, formal documentation about dignity kit interventions in some countries may be limited). In addition, the team will review external sources and conduct informal interviews pertaining to humanitarian response practices, humanitarian principles and the specific country sites.

b. Initial Informant Interviews

The SIPA team will conduct semi-structured interviews with key stakeholders within UNFPA headquarters, ROs, COs and from other major international NGOs that are providing similar kits. Client contacts at UNFPA have prepared a list of recommended informants within UNFPA for the SIPA team to interview. This initial list may serve as the basis for "snowball" sampling. The SIPA team also plans to contact a number of International NGOs (INGOs) that have been engaged in the distribution of items similar to those found in UNFPA's dignity kits. Interviews with organization such as IOM and UNICEF will allow the SIPA team to document alternative strategies (in terms of procurement, distribution, etc.) for the provision of dignity kits. These initial interviews, in combination with the desk review, will provide the basis for a stakeholder and SWOT analysis.

c. Preparation for March Field Work

To prepare for March field work, the SIPA team will begin by conducting two broader phases of data collection with larger sample sizes. First, the SIPA team will conduct a global survey of UNFPA COs that have provided dignity kits. This brief survey will address research questions 1 and 3 (see Indicator Framework) by collecting descriptive data on the various logistical arrangements, practices and outcomes surrounding local provision of dignity kits. The survey will contain both structured and open-ended questions and the results will be used to inform the development of further data collection tools.

As a follow-up to this survey, a sub-sample of COs and ROs will be selected (with client input) for in-depth, semi-structured phone interviews. The objective of these interviews will be to explore in greater detail the variety of circumstances under which dignity kits have been provided (acute vs. protracted crises, circumstances with local market supply vs. no local market, etc.) and to begin to explore outcomes from the client perspective. Data derived from the survey and phone samples will complement field data collected from the four case study countries in March.

d. March Field Work

In mid to end of March, the SIPA team will travel to four pre-selected project sites for field evaluation. Teams of two or three students will travel to each country to conduct key informant interviews (KIIs) with UNFPA CO staff and other INGO staff involved in the distribution of dignity kits. In consultation with the CO, the team will conduct interviews, focus groups (FGs), and participatory research activities with former beneficiaries to address research question 2 (see Indicator Framework). Data entry and transcription will be ongoing during field work. Presentation of preliminary, country-specific findings and recommendations to the CO will be done by the Columbia team at the end of each field mission.

e. Data Analysis

Upon return from the field, the respective country teams will finalize data entry and transcription. Each team will be responsible for presenting initial findings and analyses before the team comes together to begin analyzing the field data. Data analysis will be a dynamic process involving inductive learning and constant interaction between country and thematic teams to guarantee a unified approach to the analysis that will lead to coherent, globally relevant results (see 'Team Organization and Work Plan' for a detailed breakout of country and thematic teams). The integration of data from the previous phases of research will contribute to addressing research question 4, which is in essence a supra-research question encompassing all of the factors explored in previous phases.

f. Report Writing

Following data analysis, findings from these subsequent phases of research will culminate in the development of a final report that will include the SIPA team's recommendations for UNFPA. The deadline for completion of the report will be May 2011. The team will present its findings and recommendations to UNFPA HQ staff and will participate in final workshop presentations at Columbia University in May.

IV. Methods and Tools

This evaluation will require a four-tiered data collection approach: short questionnaires to UNFPA COs that have distributed dignity kits, phone or personal interviews with global partners or competitor agencies, phone interviews with key COs and ROs within all five global regions, and in-country FGs, KIIs and participatory research activities in the final selected field sites. Each of these data collection methods will be adapted according to specificity and need or as suggested by the client. The data collection will be done by all ten members of the team over the course of the evaluation. UNFPA will provide a list of priority countries and relevant global partners to guide the sampling process. The starting point for all data collection methods will be derived from the aforementioned research questions (see under 'Research Questions').

Global Country Office Questionnaires: This method will allow for a global understanding of the experience of field offices in procuring, assembling and distributing dignity kits in a variety of humanitarian settings. The initial instrument will be an electronic questionnaire with both structured and open-ended questions to allow for global comparison (through structured questions) and to elicit greater detail and "expert information" during the initial stages of research (through open-ended questions). When completed, the tool will be sent to UNFPA COs that have distributed dignity kits. This survey will

collect the most information in terms of scope; it will be given to as many COs as possible and will be used to inform the following three data collection methods.

Global partner interviews: These interviews will be undertaken with both internal UN agencies such as UNICEF (which also distributes hygiene kits) and the United Nations Development Programme (UNDP), as well as global partners/competitors such as IOM, International Committee of the Red Cross, International Rescue Committee and CARE, all of whom distribute hygiene kits or are specialists in logistics and procurement. These semi-structured and open-ended interviews will allow for a broader understanding of what other similar services other organizations are providing, whether these are cost effective and what 'best practices' are being used by organizations that are efficient and effective at any of the steps in the distribution process (procurement, assembly, storage and distribution). This method will contribute to the final recommendations about UNFPA's comparative advantage in the global distribution of dignity or hygiene kits.

Select UNFPA Country Office and Regional Office phone interviews: After reviewing the data from the global questionnaire, the team will meet with UNPFA client contacts to narrow down a list of key COs with which to arrange phone interviews. The questions asked in the semi-structured phone interview will further explore themes uncovered through the global questionnaire, but the interviews will also progress organically, as this phase of research will still be largely exploratory. Data from these interviews will help identify themes or areas of further research when in-country. This method will also allow access to countries that have been distributing dignity kits for several years and would be able to contribute significantly to the team's overall understanding of challenges and successes, but that due to security considerations or other travel limitations will not be able to receive an in-country team (i.e. Pakistan, countries from the Arab States, etc.).

Focus groups/participatory research activities: When in-country, the team will conduct FGs with beneficiaries. Where possible, beneficiaries will be sampled to represent as many distributions as possible while also ideally covering an appropriate range of ages, sex, communities, etc. The guides for FGs will be created after doing a thorough review of numerous tools and evaluation guidelines used in humanitarian settings as well as more general development evaluations. Where possible, the SIPA team will sample recipients of the dignity kits that were distributed during the most recent disaster to minimize recall time and facilitate accurate participant reporting. The FG guide will be created to capture the experience of the recipients before and after receiving the kit, as well as to discern their overall impression of the value of the kit retrospectively. To this end, FGs will also include participatory research activities such as ranking and pile sorting to explore notions of necessity and value regarding the contents of the dignity kits. (Note: The SIPA team is exploring the possibility of securing a brief training in these participatory techniques before field travel). These data will be essential for assessing outcomes of the UNFPA dignity kit distributions.

Key informant interviews: Also while in-country, the SIPA team will conduct KIIs with UNFPA staff, partnering NGOs and any other group or individual that the local staff believes will provide insight to the process and outcomes of dignity kit distribution. The KIIs will target a range of individuals involved in the distribution of the kits, from local government officials to NGOs involved in distribution to the UNFPA country representative. It is important that the sample of informants also include individuals who do not view the provision of dignity kits favorably, so that the final evaluation reflects a variety of perspectives. The selection of participants for both the FGs and the KIIs will be done in collaboration with COs;

however, UNFPA staff will not be present when the interviews are conducted in order to ensure that the results of the evaluation are independent and valid.

The team will review and incorporate the following UN-specific evaluation documents before the inception report or any methodological tools are created. These documents will give substantive background to the requirements, guidelines and theory behind UNFPA's evaluation strategy, within which this evaluation will be received.

These evaluation documents are as follows:

1. UNEG Quality Checklist for Evaluation Terms of Reference and Inception Report;
2. UNEG Norms;
3. UNEG Standards for Evaluation;
4. Code of Conduct for Evaluators in the UN System;
5. Handbook on Planning, Monitoring and Evaluating for Development Results;
6. UNFPA Evaluation Policy;
7. UNFPA Evaluation Guidelines; and
8. UNEG Quality Checklist for Evaluation Reports.

All of the above will be undertaken with respect for the following humanitarian principles: humanitarian imperative, neutrality, impartiality, do no harm, respect for culture and custom and the participation of affected populations. Please refer to the proposed project timeline and budget in Appendices V and VI, respectively.

TEAM ORGANIZATION AND WORK PLAN

Project Management Arrangements

Each team member was assigned a specific functional role for optimal management of our project. The team functions and responsibilities are distributed as follows:

Faculty Contact: Libby Abbott	- Organize, plan and manage communication with faculty advisor (Professor Dirk Salomons) - Responsible for communicating Prof. Salomons' comments and recommendations to the team in a timely manner - Point of contact for comments or questions for Prof. Salomons - Initiate meetings with Prof. Salomons
Client Contacts: Brittney Bailey and Shanon McNab	- Organize, plan and manage communication with UNFPA HQ staff - Responsible for communicating client comments and guidance to entire team in a timely manner - Responsible for providing and managing client resources on SIPA team Google site - Initiate meetings with clients, prepare and finalize

	agenda prior to each meeting - Lead the conversation on behalf of the team during client meetings
Budget Officers: Carolina Posada Lopez and Yuka Karasawa	- Attend all budgeting meetings - Create first drafts of budget - Brief team on budgeting rules and regulations - Oversee budget and spending during the course of the project - Liaise with Columbia finance staff regarding reimbursement procedures/questions (each team member will be responsible for their own expense reimbursements)
Fundraising Officer: Laetitia Vaval	- Attend fundraising meetings - Brief team on fundraising meeting notes/agenda - Organize team to assist with fundraising events
Editor: Rikha Sharma Rani	- Provide final editorial review of all significant deliverables - Provide feedback to team about quality of work/writing to further enhance the quality of subsequent submissions
Group Coordinator/Scheduler: Dorothy Louis	- Schedule and inform team on meeting time and location via web-based scheduler - Coordinate with faculty and client contacts to ensure that as many team members as possible are available for meetings with clients and staff
Mediators: Christine Saba and Carolina Posada Lopez	- Listen to team members' concerns and frustrations - Coordinate among team members to work out frustrations, reconcile differing working styles - Speak to Jenny McGill about concerns if the team is unable to resolve conflicts internally - Receive any concerns/comments from team members and, if appropriate, raise these during weekly team meetings
Project Manager: Dohini Patel Associate Project Manager: Christine Saba	- Oversee the coordination of country/thematic teams - Ensure timely submission of deliverables - Ensure equal workloads for each member of team - Ensure fluency and coherence between the four country teams - Update team on relevant/important project components and decisions

Resource Manager: Rikha Sharma Rani and Carolina Posada Lopez	- Maintain all documents held in Dropbox and uploads final versions to the Google site - Ensure that files are saved in the appropriate folders and are easily located by the team - Ensure that team members adhere to the agreed upon naming convention - Ensure that all documents are ready for the teams when they leave for the field - Keeps running bibliography for the group

In terms of project content, the SIPA team has proposed the following matrix of country and thematic assignments. The team organized itself by breaking up into smaller country sub-groups. The size of the country teams was determined in relation to the size of the actual UNFPA CO (3 team members will travel to Indonesia as those are the largest country offices in our evaluation, and Colombia's team is still to be determined). Within these smaller country sub-groups, each team member was assigned one or more thematic areas of focus. These areas of focus were selected based on the objectives of the evaluation and the TOR. This focus will be particularly useful during the research phase, for the development of tools (interview guides, FGs, etc.) and throughout the data analysis stage. These thematic assignments will also facilitate communication between the SIPA team and UNFPA, as the latter will refer relevant information to the sub-group of students specializing in a specific area.

Thematic and Country-Specific Assignments

Note: Country-specific responsibilities pertain to the people who will be conducting field visits
Georgia (2 members), Mozambique (2 members), Indonesia (3 members), Colombia (~3 members)

	Mozambique	**Indonesia**	**Georgia**	**Colombia**
Supply Chain Includes knowledge of dignity kit procurement, assembly, storage and distribution processes	Carolina	Christine	Rikha	Laetitia
Impact Includes knowledge of effectiveness & usefulness of kits, effect on dignity, health, livelihoods and/or educational outcomes for beneficiaries	Brittney, Carolina	Shanon	Rikha, Dohini	Libby
Comparative Advantage Includes knowledge of 'best practices', contents of competitive kits and potential synergies with other organizations involved in dignity kit provision	Brittney	Yuka	Dohini	Dorothy

The above team organization will ensure that thematic information is captured and streamlined across all four focus countries. This is especially important in light of the project's broad scope and the need for global generalizability of results (the SIPA team's recommendations will not be restricted to the four countries of study, but rather applied globally). Each team member will conduct a literature review according to their respective country and thematic area. Outside of the thematic areas, a literature review will be conducted in the following areas. Note, some of these reviews will be conducted at two levels. The first level will serve to generate a holistic/broad understanding of the topic and the second will be to drill down to the country level.

1. Political risk and assessment of crisis (country-specific) – Country sub-group
2. Economic growth and development (country-specific) – Country sub-group
3. Gender-based violence (country-specific) - Country sub-group
4. Reproductive health (holistic and country-specific) - Shanon/Libby/Christine, country sub-group
    a. Interagency Working Group on Reproductive Health + SPHERE standards - Libby and Shanon
    b. Reproductive health in emergency settings, Cairo Conference - Christine
5. Funding mechanisms (holistic, country-specific) – Yuka, country sub-group
6. Cluster approach (holistic, country-specific) - Carolina, country sub-group

Field Work:

January: No planned travel

March: All team members

All field work will be conducted in March 2011. Two to three members of the SIPA team will travel to each of the following countries: Georgia (tbc), Colombia, Indonesia and Mozambique The duration of each trip will be approximately two weeks, with at least ten working days in-country. One or more staff members from UNFPA will accompany each SIPA country team.

ASSUMPTIONS AND RISKS

Critical Assumptions

- COs are responsive and cooperative.
- UNFPA HQ, ROs and COs are aligned with respect to the objectives of the SIPA evaluation.
- Minimum amount of data available on cost, procurement and distribution data pertaining to dignity kits is available and accessible.
- Key stakeholders, including beneficiaries and informants, are willing to participate in study.
- Discussions with beneficiaries and key informants will yield honest, accurate information.
- Translation of FG interviews, one-on-one interviews, questionnaires and surveys is accurate and unbiased.
- Selection of study countries is appropriate and purposeful.
- Countries selected for field visits and telephone interviews will represent various phases of an emergency and also represent conflict affected or natural disaster affected settings.

Critical Risks

Risk	Potential Impact on Ability to Deliver Output	Likelihood of Occurrence	Mitigation Techniques
Mozambique			
Difficulty finding relevant information about dignity kits due to the lag time between actual distribution of the kits and time of evaluation (beneficiaries are no longer in the area, staff involved is no longer stationed in Mozambique, etc.).	Medium-High	Medium	UNFPA HQ will select another country from the Africa region.
Georgia (tbd)			
Locating beneficiaries may be difficult	High	High	Assess impact to the extent possible by speaking with other organizations, NGOs, government agencies, etc.
Unstable political context and continued insecurity may hinder data collection.	High	Low	UNFPA HQ will select another country from the Caucasus region.
Language barrier/Poor quality translation.	Medium-High	High	Skilled and experienced translator will be used (based on recommendation from UNFPA).
Limited staff and resource in CO (~3 staff).	Medium	High	Presence of a UNFPA HQ staff member will minimize strain on CO. Design of field tools will take into account capacity/resources of CO.
Colombia			
Beneficiaries may have been relocated to different shelters, returned to their homes or are living with relatives, making it difficult to locate them.	Medium	Low	UNFPA CO will support the SIPA team in contacting beneficiaries.
Damaged infrastructure may affect the capacity of the team to visit the different locations.	High	Medium	SIPA team and client will define the agenda based on time and transportation constraints.
Security in the region may affect mobility of the team.	Medium	Medium	UNFPA CO will debrief the team about security measures and procedures.
Feedback and response rates from key informants limited due to ongoing crisis.	High	Medium	The SIPA team will pay special attention to the formulation of tools in order to minimize potential burden. UNFPA CO will support the SIPA team in contacting and motivating the participation of beneficiaries
Indonesia			
Language barrier/Poor quality translation	Medium-High	High	Skilled and experienced translator will be used (based on recommendation from UNFPA).
Research environment may not be conducive to an all-female SIPA group.	High	Medium	SIPA team will observe culturally-sensitive manner of dress. UNFPA country representative will brief team on cultural/religious norms to be observed.
General Risks			

Scope of evaluation too broad (both by country and theme).	High	High	SIPA team and client will define scope of evaluation in advance. SIPA team will break down into smaller sub-groups based on regional and thematic assignments.
Inability to transfer and convey the concept of "dignity" across cultures and languages.	High	Medium	SIPA team will conduct appropriate research and consult with key actors working in the field to mitigate any cultural distortion likely to occur.
Expectations from beneficiaries to be rewarded/compensated for their participation in the study.	Medium	Medium-High	SIPA team will fully disclose in consent forms that no compensation will be provided.
Unwillingness to discuss concepts related to RH, including notions of "dignity."			SIPA team will follow ethical standards of human subject research and provide full disclosure of the purpose of the study to minimize discomfort.
Findings and results might be too culturally specific to country contexts, and may lack transferability to a global level.	High	High	SIPA team will consult together to ensure that research tools are appropriate and comparable across countries. SIPA team will consult with faculty advisor and clients for feedback
SIPA team is limited to one field visit per country and country subgroups are small (2-3 students).	Medium	High	SIPA team will gather extensive information on local country context prior to field visit and review all relevant reports pertaining to dignity kits. SIPA team will arrange as many interviews/FGs as possible from NY to make most efficient use of time in the field.
Communication amongst team members in field will be challenging because of the different time zones (telephone, internet, etc.).	Low	High	Team members will communicate via the Google group site and over email if telephone communication is not feasible.

ANNEX I – CLIENT AGENCY

United Nations Population Fund

UNFPA was created as a trust fund in 1967 under the administration of the UNDP. Originally called the United Nations Fund for Population Activities, UNFPA began operations in 1969 with the mandate of promoting policies to improve women's rights and reproductive and sexual health. Today, UNFPA works to promote "the right of every woman, man and child to enjoy a life of health and equal opportunity."[94] UNFPA's existing mandate is based on principles set forth in two international frameworks: The Programme of Action of the 1994 ICPD and the Millennium Development Goals.[95]

UNFPA has 140 COs in five regions: Eastern Europe and Central Asia, Asia and the Pacific, Latin America and the Caribbean, Middle East and North Africa, and Sub-Saharan Africa. Its country programs focus on three core areas of work: population and development strategies, RH and gender equality.

Population and Development Strategies: Country programs support data collection and analysis related to population and demographics. They also promote policy dialogue aimed at addressing population dynamics and demographic issues such as migration, ageing, climate change and urbanization.

Reproductive health: UNFPA engages in a broad range of RH activities. These include advocacy and support for family planning programs; maternal health; prevention and treatment of infertility; prevention and management of abortion, HIV/AIDS and sexually transmitted infections; promotion of sex education; information and counseling; and prevention of violence against women.

Gender equality: UNFPA country programs bring attention to issues of gender equality by addressing four key areas: fostering girls' education, women's economic empowerment, women's political participation and balancing of reproductive and productive roles. Engagement on these issues includes the involvement of men and boys.

In addition to these three thematic areas, UNFPA programs cut across broad development concerns that include the use of culturally-sensitive, rights-based approaches, support for adolescents and youth, responding to the AIDS epidemic and assisting in emergencies. In the context of emergencies, UNFPA provides assistance and protection for populations at risk, including refugees, IDPs, and populations made vulnerable by natural disasters, violence and armed conflicts.[96]

[94] From UNFPA website, http://www.unfpa.org/public/home/about.

[95] The International Conference on Population and Development was signed in 1994 by 159 countries. It states that population and development are interdependent and therefore ensuring access to education and health, as well as gender equality, supports the achievement of development goals. The Programme of Action is a twenty-year program aimed at achieving the goals in the ICPD.

[96] From UNFPA website, http://www.unfpa.org/public/home/about.

UNFPA Humanitarian Response Branch

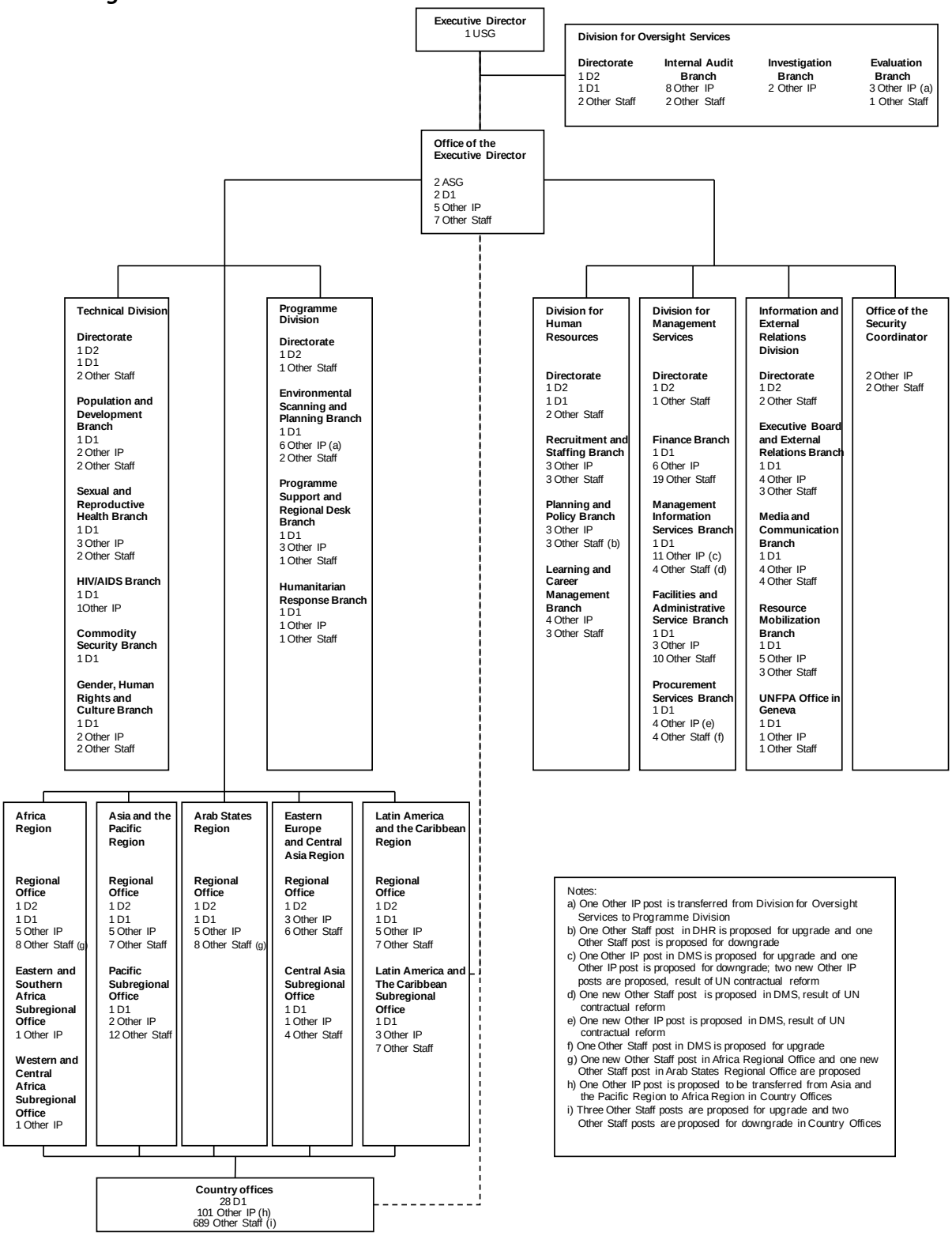
As part of the Programme Division of UNFPA, the Humanitarian Response Branch's (HRB) objective, according to the UNFPA Terms of Reference is "to advocate for the inclusion of the ICPD agenda in emergency preparedness, humanitarian assistance, recovery and transition frameworks, mechanisms and coordination for all bodies, and to ensure that emergency preparedness, humanitarian assistance, and recovery are mainstreamed and integrated within UNFPA Work". [97]

Based in New York, the HRB is composed of ten to fifteen program officers, each of whom has both a thematic and a geographic focus. HRB officers at headquarters work closely with ROs, SROs and COs to develop a regional strategy for emergency preparedness and humanitarian response, which informs which humanitarian interventions are undertaken in a region or country. The HRB oversees management of the Emergency Fund, one of the funding mechanisms for UNFPA's humanitarian response activities. There is an HRB office in Geneva, Switzerland, which focuses on reproductive health issues, advocacy and resource mobilization in partnership with the OCHA and the World Health Organization.[98]

[97] UNFPA Official Version "Programme Division TORs"

[98] Priya Marwah and Cecile Mazzacurati, Humanitarian Programme Specialist with UNFPA HRB, in discussion with the authors, 1 December 2010.

UNFPA Organizational Structure



Notes:

a) One Other IP post is transferred from Division for Oversight Services to Programme Division

b) One Other Staff post in DHR is proposed for upgrade and one Other Staff post is proposed for downgrade

c) One Other IP post in DMS is proposed for upgrade and one Other IP post is proposed for downgrade; two new Other IP posts are proposed, result of UN contractual reform

d) One new Other Staff post is proposed in DMS, result of UN contractual reform

e) One new Other IP post is proposed in DMS, result of UN contractual reform

f) One Other Staff post in DMS is proposed for upgrade

g) One new Other Staff post in Africa Regional Office and one new Other Staff post in Arab States Regional Office are proposed

h) One Other IP post is proposed to be transferred from Asia and the Pacific Region to Africa Region in Country Offices

i) Three Other Staff posts are proposed for upgrade and two Other Staff posts are proposed for downgrade in Country Offices

ANNEX II - PROFILES OF DIGNITY KIT PROVISION IN STUDY COUNTRIES

Republic of Georgia

The Republic of Georgia is located in the Caucasian region, surrounded by Russia to the north, the Black Sea to the west, Azerbaijan to the east and Turkey and Armenia to the south. The estimated population of Georgia is 4.6 million people and the country has the following demographic profile:

DEMOGRAPHIC PROFILE: REPUBLIC OF GEORGIA					
Population		Ethnicity		Language	
0–14 yrs	16.1%	Georgian	83.8%	Georgian	71%
15-64 yrs	67.6%	Azeri	6.5%	Russian	9%
65yrs +	16.4%	Armenian	5.7%	Armenian	7%
		Russian	1.5%	Azeri	6%
		Other	2.5%	Other	7%

Source: CIA World Factbook, https://www.cia.gov/library/publications/the-world-factbook/geos/gg.html.

From 2006 to 2007, Georgia's economy sustained GDP growth of more than 10 percent, stemming largely from foreign investment and government spending. In 2009, following a conflict with Russia in August of the previous year, the Georgian economy declined by 7 percent. High poverty rates and unemployment followed in the wake of the decline of the Georgian economy, causing people to emigrate from the country. The impact of emigration can be seen in Georgia's current population growth rate, which is a meager 0.325 percent.

Georgia was part of the Soviet Union from 1922 to 1991. After gaining independence in 1991 following the collapse of the Soviet Union, Georgia suffered a dramatic socioeconomic downturn. This was further compounded by civil war and a series of armed conflicts, resulting in more than 290,000 displaced people. The most recent conflict was in August of 2008, when Russia sent tanks and warplanes in response to a Georgian military offensive to recapture its breakaway province of South Ossetia.[99] A large number of civilians were reported to have died as a result of the military confrontation. This was the worst outbreak of violence in Georgia since 1992, when South Ossetia won de facto independence from Georgia. Peace was brokered between Russia and Georgia on 13 August 2008, but a major impact of the conflict was that it created a new generation of IDPs and refugees. Two years after the conflict, several hundred thousand

[99] Deborah Tedford, "Georgia-Russia Conflict Escalates Over Separatists," National Public Radio, 8 August 2008, http://www.npr.org/templates/story/story.php?storyId=93410345.

refugees and IDPs have yet to return home.[100]

UNFPA began providing development assistance to Georgia in 1993, but it was not until 1999 that a formal UNFPA office was established in the country.[101] UNFPA partners with WHO as the health cluster lead and United Nations Children's Fund (UNICEF) as the water/sanitation/hygiene (WASH) cluster lead in Georgia.[102] In May 2005, UNFPA's Georgia program was approved for funding and received a total of USD 4.3 million to be disbursed from 2006 to 2010.[103] Since 22 August 2008, UNFPA has had an active humanitarian program in Georgia focused on health and WASH. Specifically, it provides RH services and dignity kits ('family kits' and 'youth kits').

Dignity kits have been distributed to both women and men and have included items such as multivitamins, soap, shampoo, towels, toothbrush and toothpaste, underwear, sanitary napkins and shaving kits. Youth kits were distributed specifically to boys and girls and included additional items such as locks, combs and various informational materials on RH, HIV/AIDS, etc. The contents of the kits were determined through a needs assessment administered by UNFPA and conducted in collaboration with doctors.

In order to assemble and distribute the kits, UNFPA partnered with internally displaced women and youth, providing these groups with a modest source of income. Since the start of the dignity kit program in Georgia, UNFPA and its partners have distributed 11,000 family dignity kits reaching 44,000 IDPs in 130 facilities and collective centers in Tbilisi, ShidaKartli, KvemoKartli, Mtskheta-Mtianeti regions and in adjacent area villages. 2,100 families in Tserovani settlement also received dignity kits.[104]

[100] Kornely K. Kakachia, "Russia-Georgia: An Illusory Stability" (PONARS EurAsia Policy Memo No. 109, 2010), http://www.gwu.edu/~ieresgwu/assets/docs/pepm_109.pdf.

[101] From UNFPA website, http://www.unfpa.org.tr/georgia/index.htm.

[102] The cluster approach is a system that aims to coordinate the humanitarian response activities of UN and non-UN humanitarian partners. In 2005, the Inter-Agency Standing Committee designated 'cluster leads' in nine sectors or areas of humanitarian response.

[103] "Oversight Assessment of the UNFPA country office in Georgia" (Report No: GEO101, 14 October 2009), http://www.unfpa.org/exbrd/2010/annual_session/georgia_2009assessment.pdf.

[104] "Annual Report of the Humanitarian/Resident Coordinator on the Use of Central Emergency Response Fund (CERF) Grants" (Central Emergency Response Fund report, September 2007), ochaonline.un.org/OchaLinkClick.aspx?link=ocha&docId=1097460.

Republic of Indonesia

The Republic of Indonesia is located in Southeast Asia and is comprised of over 17,500 islands. The estimated population of the country is 243 million people, making it the fourth most populous country in the world. Indonesia is also home to the world's largest Muslim population.[105] The following table is a demographic profile of the country:

DEMOGRAPHIC PROFILE: REPUBLIC OF INDONESIA					
Population		Ethnicity		Language	
0–14 yrs	28.1%	Javanese	40.6%	Bahasa	6.7 million
15-64 yrs	66%	Sudanese	15%	Malay	10 million
65yrs +	6%	Madurese	3.3%	Madurese	9 million
		Minangkabau	2.7%	Javanese	70 million
		Betawi	2.4%	Minangkabau	7.5 million
		Bugis	2.4%	Balinese	3 million
		Banten	2%	OtherDialects	2 million
		Banjar	1.7%		
		Other	29.2%		

Source: Statistics Indonesia (Badan Pusat Statistik—BPS) and Macro International. 2008. *Indonesia Demographic and Health Survey 2007*. Calverton, Maryland, USA: BPS and Macro International.

The Indian Ocean earthquake occurred on 26 December 2004, with an epicenter off the west coast of Sumatra, Indonesia. The earthquake caused a massive tsunami that struck Indonesia and surrounding countries in Southeast Asia. The US Geological Survey estimated that over 167,000 people died in Indonesia alone. According to Oxfam figures, more women than men were killed in the disaster.[106] UNFPA provided dignity kits, medicines, medical equipment, contraceptives and safe delivery kits for distribution by government and NGO partners in Aceh and North Sumatra provinces. Working with the Ministry of Health, the National Family Planning Coordination Board and others, UNFPA focused on re-establishing basic reproductive health services and building local capacity in the region.[107]

[105] CIA World Factbook. https://www.cia.gov/library/publications/the-world-factbook/geos/id.html#.

[106] "Most Tsunami Dead Female – Oxfam," *BBC News,*26 March 2005, http://news.bbc.co.uk/2/hi/south_asia/4383573.stm.

[107] From UNFPA website, http://www.unfpa.org/emergencies/pacific/indonesia.htm.

The UNFPA Indonesia CO procured, assembled and coordinated the distribution of dignity kits. More than 200,000 kits have been distributed through various implementing partners, along with other basic supplies and information on reproductive health and hygiene. Efforts were made to promote safe access to basic services and to educate officials, care providers and camp managers about the need to protect women, youth and children against exploitation and violence. UNFPA also supported health promotion campaigns and a needs assessment to investigate the tsunami's disproportionate impact on women.

Republic of Mozambique

The Republic of Mozambique is located on the coast of Southeastern Africa, between South Africa, Malawi, Swaziland, Tanzania, Zambia and Zimbabwe. The estimated population of the country is 22 million people. The following table is a demographic profile of the country:

DEMOGRAPHIC PROFILE: REPUBLIC OF MOZAMBIQUE					
Age/% of Pop		Ethnicity		Language	
0–14	44.3%	African((Makhuwa, Tsonga, Lomwe, Sena, and others)	99.66%	Emakhuwa	26.1%
15-64	52.8%	European	0.06%	Xichangana	11.3%
65+	2.9%	Euro-African	0.2%	Portuguese (official)	27% (spoken)
		Indian	0.08%	Elomwe	7.6%
				Cisena	6.8%
				Echuwabo	5.8%
				OtherMozambicanlanguages	32%
				Otherforeignlanguages	0.3%

Source: - InstitutoNacional de Estatistica- INE.(2010). Gabinete Central de Recenseamento, Maputo: Mocambique. *Mozambique Demographic and Health Survey 2007*. Calverton, Maryland, USA: BPS and Macro International.

One of the poorest countries in the world at independence, Mozambique has emerged from decades of war to become one of Africa's best performing economies. Between 1996 and 2008, the country enjoyed remarkable progress, achieving average annual economic growth of 8 percent, while steadily increasing its human development indicators. Nevertheless, Mozambique remains one of the 20 least developed

countries in the world. The recent global food, fuel and financial crises coupled with devastating natural disasters have undermined Mozambique's recent economic progress.[108]

Mozambique gained independence from Portugal in 1975. From 1977 to 1992, the country was engrossed in a civil war between the Frelimo government and the Renamo movement. Approximately one million people died in the conflict and millions more became refugees or IDPs. In 1990, the Frelimo government enacted a new constitution that institutionalized free elections and a multiparty system. Two years later, the Rome Peace Accords were signed by the Frelimo party and the Renamo rebels (recognized as a legitimate party), which ended sixteen years of civil war.[109] Poor infrastructure networks, service delivery and high HIV/AIDS infection rates (currently 15 percent) further exacerbated the humanitarian emergency in Mozambique.

UNFPA has been present as a development agency in Mozambique for over thirty years. Originally, UNFPA projects in Mozambique were formulated at the organization's New York headquarters and then implemented by UNDP. In 1980, however, UNFPA initiated the Population/Census, Family Planning and Maternal Health programs in Mozambique, which commenced direct implementation of UNFPA programs in the country. Current programmatic areas of focus in Mozambique are RH, HIV/AIDS prevention and population and gender development. Nearly half of Mozambique's population is under the age of 15, making income generation and RH activities for youth particularly important.[110] As such, UNFPA emphasizes the needs of youth in these three areas.

UNFPA operates within the cluster system to distribute and fund dignity kits in Mozambique. The cluster approach was widely adopted in early 2007 in Mozambique to help support the government's emergency response efforts. UNFPA procured dignity kits from local partners and provided them as a component of the organization's emergency preparedness efforts in the lead up to rainy seasons as well as in post-disaster situations.[111]

In February 2007, Mozambique faced a series of natural and manmade disasters in which more than 163,000 people were displaced from their homes, primarily in the Zambezia, Tete, Manica and Sofala districts.[112] UNFPA provided dignity kits that were distributed by Mozambique Red Cross volunteers to over

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[108] Mozambique: Country Brief, World Bank, http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/MOZAMBIQUEEXTN/0,,menuPK:382142~pagePK:141132~piPK:141107~theSitePK:382131,00.html; "Human Development Report" (United Nations Development Programme report, 2009); Mozambique Country Profile, *BBC News*, http://news.bbc.co.uk/2/hi/europe/country_profiles/1063120.stm.

[109] Mozambique Country Profile, *BBC News*, http://news.bbc.co.uk/2/hi/europe/country_profiles/1063120.stm.

[110] Mozambique: Country Brief, World Bank, http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/MOZAMBIQUEEXTN/0,,menuPK:382142~pagePK:141132~piPK:141107~theSitePK:382131,00.html; Mozambique Humanitarian Country Team Inter-Agency Contingency Plan – 2008/2009 (November 2008).

[111] "Mozambique Disasters, Health Cluster Report: January-Jun 2007" (WHO report, 20 July 2007), http://www.who.int/countries/moz/publications/disasters_report.pdf.

[112] "Mozambique: Floods and Cyclone" (United Nations Humanitarian Flash Appeal, 2007), http://ochaonline.un.org/humanitarianappeal/webpage.asp?Page=1558.

35,000 families. Each kit contained a toothbrush, toothpaste, sarongs, soap, sanitary pads, a t-shirt and a backpack. The UNFPA Mozambique CO faced several challenges throughout the procurement and distribution process and many kits did not reach displaced persons until July of 2007.[113]

Republic of Haiti

The Republic of Haiti is located on the island of Hispañola in the Caribbean Sea. The estimated population of the country is 9.6 million people. Haiti is the poorest country in the western hemisphere. The following table is a demographic profile of the country:

DEMOGRAPHIC PROFILE: HAITI					
Population		Ethnicity		Language	
0–14 yrs	38.1%	Black	95%	French	N/A
15-64 yrs	58.5%	Mulatto and White	5%	Creole	N/A
65yrs +	3.4%				

Source: CIA World Factbook (https://www.cia.gov/library/publications/the-world-factbook/geos/ha.html) Cross-checked: Cayemittes, Michel, et al. 2007. *Enquête Mortalité, Morbidité et Utilisation des Services, Haïti*, 2005-2006. Calverton, Maryland, USA : Ministère de la Santé Publique et de la Population, Institut Haïtien de l'Enfance et Macro International Inc.

In 1804, after a prolonged struggle against French colonists, Haiti became the world's first independent black republic and the second independent nation in the western hemisphere.[114] Since then, the country has been plagued by political violence. After an armed rebellion led to the forced resignation and exile of President Jean-Bertrand Aristide in February 2004, an interim government took office to organize new

[113] International Red Cross; Operations Update/Flash Appeal Mozambique (28 Aug 2007).

[114] "To Heal Haiti, Look to History, Not Nature," *New York Times*, 21 January 2010, http://www.nytimes.com/2010/01/22/opinion/22danner.html.

elections under the auspices of the United Nations Stabilization Mission in Haiti. In May 2006, Haiti inaugurated its first democratically elected president and parliament.[115]

In addition to its volatile political history, Haiti has suffered a series of natural disasters. In September of 2008, Haiti was hit by hurricanes Fay, Gustav and Ike, as well as tropical storm Hanna—all occurring within less than a month. Approximately 800,000 people were affected, including an estimated 150,000 IDPs who moved to temporary shelters. In January 2010, Haiti was struck with yet another massive disaster. A magnitude 7.0 earthquake struck Haiti with an epicenter about 15 km southwest of the capital, Port-au-Prince. An estimated 2 million people were directly affected by the earthquake, which is considered by many to be the worst in the region over the last 200 years. Massive international assistance has been mobilized to help the country recover.[116]

UNFPA has been working in Haiti since 1970. However, it significantly expanded its humanitarian assistance efforts in the country after the 2008 hurricanes.[117] Since then, UNFPA has worked as part of the cluster system to provide dignity kits to displaced Haitians. Distribution of the kits to women and girls in temporary shelters was one of UNFPA's first interventions after the 2008 hurricanes. More than 7,000 kits were assembled by youth volunteers in Port-au-Prince and distributed to beneficiaries across several regions. The kits included items such as wipes, toilet paper, laundry detergent, toothbrushes, utensils, flashlights, batteries, sanitary napkins, condoms and informational leaflets about HIV/AIDS.[118] Similar kits were provided in the wake of the 2010 earthquake.

UNFPA has been working extensively under the WASH, health and protection clusters to deliver dignity kits along with emergency reproductive supplies specific to pregnant women. As of the end of March 2010, more than 25,000 dignity kits have been distributed and 150,000 are in the pipeline.[119] The contents of dignity kits have been adjusted in response to the recent cholera epidemic. Approximately 7,000 hygiene-cholera kits had been distributed to pregnant women and those living with HIV as of mid-November 2010.[120]

[115] CIA World Factbook, https://www.cia.gov/library/publications/the-world-factbook/geos/ha.html.

[116] Ibid.

[117] "Haiti Hurricane Season 2008: Internal Review of Lessons Learned" (UNFPA Humanitarian Response Branch internal report, May 2009).

[118] "Summary of information from LAC COs on assembling and distribution of Dignity Kits" (UNFPA report, 2009).

[119] From UNFPA website, http://www.unfpa.org/public/news/haiti.

[120] From UNFPA website, http://www.unfpa.org/public/home/news/pid/6897.

ANNEX III – GLOBAL CLUSTER LEADS MATRIX

Global Cluster Leads	
Sector or Area of Activity	**Global Cluster Lead(s)**
Food security	FAO
Camp Coordination/Management: IDPs (from conflict)	UNHCR
Disaster situations	IOM
Early Recovery	UNDP
Education	UNICEF International Save The Children - Alliance
Emergency Shelter: IDPs (from conflict)	UNHCR
Disaster situations	IFRC (Convener)*
Emergency Telecommunications	OCHA/WFP
Health	WHO
Logistics	WFP
Nutrition	UNICEF
Protection: IDPs (from conflict)	UNHCR
Disasters/civilians affected by conflict (other than IDPs)**	UNHCR/OHCHR/UNICEF
Water, Sanitation and Hygiene (WASH)	UNICEF
*** IFRC has made a commitment to provide leadership to the broader humanitarian community in Emergency Shelter in disaster situations, to consolidate best practice, map capacity and gaps, and lead coordinated response. IFRC has committed to being a 'convener' rather than a 'cluster lead'. In an MOU between IFRC and OCHA it was agreed that IFRC would not accept accountability obligations beyond those defined in its Constitutions and own policies and that its responsibilities would leave no room for open-ended or unlimited obligations. It has therefore not committed to being 'provider of last resort' nor is it accountable to any part of the UN system.**	
**** UNHCR is the lead of the global Protection Cluster. However, at the country level in disaster situations or in complex emergencies without significant displacement, the three core protection-mandated agencies (UNHCR, UNICEF and OHCHR) will consult closely and, under the overall leadership of the HC/RC, agree which of the three will assume the role of Lead for protection.**	
Cross-cutting issues	
Age	HelpAge International
Environment	UNEP
Gender	UNFPA/IMC
HIV / AIDS	UNAIDS

ANNEX IV - THE ALNAP AS A CONCEPTUAL FRAMEWORK

The ALNAP works to improve humanitarian performance through learning and accountability. ALNAP strategies for evaluating and establishing conceptual frameworks were suggested by both the client and the team's academic advisor. The following five component questions are proposed by the ALNAP to guide evaluations. A brief summary of the SIPA team's response has been included below.

First, an impact assessment must balance the priorities and interests of a range of different stakeholders. Is the objective of the assessment learning or accountability? Are the results intended for donors, UNFPA, wider academic research or affected people?

It is assumed that the purpose of this evaluation is to facilitate internal UNFPA decision-making processes, and that, as such, the evaluation should be implemented with the objective of better informing UNFPA staff.

Second, how should humanitarian impact be defined? Impact on what and over what timescale?

Due to time and resource limitations, "impact" will be measured at the outcome level. To the extent possible, the evaluation will examine the immediate effects of dignity kit distribution.

Third, how can impact be measured? What indicators are appropriate and against what baselines or comparison groups? How can it be proved that any observed or reported effects are actually caused by a particular intervention? What methods are appropriate to the given context and how will issues of data, baselines and timing be addressed?

This evaluation does not benefit from baseline data or a comparison group against which to measure impact and therefore will be limited to examining effect-level changes primarily through self-reporting. In this case, causality cannot be proven.

Fourth, how should data on impact be analyzed and interpreted, and what role should affected people play in this?

Because this evaluation is global and the contexts from which data is collected will vary greatly, quantitative and qualitative data will be analyzed to explore several important variables describing the context of the intervention. Consequently, interpretation of data will be highly dependent on context (acute response vs. protracted crisis, natural disaster vs. political crisis, etc.) and results will likely reflect some kind of appropriate typology.

Fifth, how can incentives and capacities be developed to enable and improve humanitarian impact assessment?

This question, though important, is beyond the scope of the SIPA team's evaluation.

ANNEX V – PROPOSED PROJECT TIMELINE

Weekly	Item (task/deliverable)	Responsibility
	PHASE I (November to mid-February)	
	• Desk research	
Nov. 15 - Feb. 13	Research on Supply Chain Management	Supply Team (Dorothy, Christine, Carolina, Rikha)
Nov. 15 - Feb. 13	Research on Impact	Impact Team (Brittney, Shanon, Rikha, Donhini, Carolina, and Libby)
Nov. 15 - Feb. 13	Research on Organizational Landscape	OL Team (Brittney, Yuka, Dohini, and Laetitia)
Nov. 15 - Feb. 13	Research Political risk and assessment of crisis (country-specific)	Brittney, Christine, Dorothy, and Rikha
Nov. 15 - Feb. 13	Research Economic growth and development (country-specific)	Laetitia, Yuka, Brittney, and Rikha
Nov. 15 - Feb. 13	Research Gender-based violence AND Reproductive Health	Libby, Carolina, Dohini, Shanon
Nov. 15 - Feb. 13	Research Interagency Working Group on Reproductive Health + SPHERE standards	Libby and Shanon
Nov. 15 - Feb. 13	Research Reproductive health in emergency settings + Cairo Conference	Christine
Nov. 15 - Feb. 13	Research Funding mechanisms (holistic, country-specific)	Yuka
Nov. 15 - Feb. 13	Research Cluster approach (holistic, country-specific)	Carolina
	• Interviews	
Jan. 17 - Feb. 13	Headquarter interviews (internal- UNFPA 0semi-structured and informal)	SIPA Team
Jan. 17 - Feb. 14	Headquarter interviews (other UN agencies and relevant orgs. –semi-structured/informal)	SIPA Team
Jan. 17 - Feb. 15	Contact country offices for resources	SIPA Team
	• Tool Development	
Dec. 10 - Feb. 12	Develop and send initial survey questionnaire	SIPA Team, by Country and Thematic Team
Dec. 10 - Feb. 13	Develop semi-structured and informal interviews	SIPA Team, by Country and Thematic Team
Dec. 10 - Feb. 14	Selection of data analysis tools	SIPA Team, by Country and Thematic Team
Dec. 10 - Feb. 15	Develop initial theory of change diagram (recommended)	SIPA Team, by Country and Thematic Team
Dec. 10 - Feb. 16	Develop initial SWOT analysis	SIPA Team, by Country and Thematic Team
Dec. 10 - Feb. 17	Develop initial stakeholder analysis	SIPA Team, by Country and Thematic Team

	• Work Plan	
Dec. 10 - Dec. 13	Edit first draft	SIPA Team
Dec. 9	Work plan Presentation	SIPA Team
Dec. 14	Provide feedback	SIPA Team
Dec. 6 - Dec. 11	Revise Timeline	SIPA Team
Dec. 6 - Dec. 16	Send to client and faculty contact	Shanon, Libby and Brittney
Dec. 17	Deliver final draft	SIPA Team
	• Inception report	
Dec. 17 - Jan. 20	Draft report	SIPA Team
Jan. 21 - Jan. 31	Edit draft	SIPA Team
Feb. 1	Send to client	Brittney and Shanon
	• Budget	
Dec. 11 - Dec. 17	Deliver final budget	Yuka and Carolina
	• Administrative Tasks	
Dec. 17 – Jan. 31	Complete 2 UN security modules	SIPA Team
Dec. 17 - Feb. 12	Purchase tickets (tentative)	SIPA Team
Dec. 17 - Feb. 12	Complete MISP module (highly recommended)	SIPA Team
	PHASEII (February to mid- March)	
	• Phone Interviews with Country Offices • Tool Development	
Feb. 13 - Mar. 11	Develop FGD	SIPA Team
Feb. 13 - Mar. 11	Develop KII	SIPA Team
Feb. 13 - Mar. 11	Develop phone interview guide	SIPA Team
Feb. 13 - Feb. 19	Select data analysis approach	SIPA Team
Feb. 13 - Mar. 11	Re-evaluate tools	SIPA Team
Feb. 20 - Mar. 11	Data analysis of Phase I data	SIPA Team
Feb. 13 - Mar. 11	Submit to country offices for feedback	SIPA Team
Feb. 13 - Mar. 11	Confirm back-translating	SIPA Team
Feb. 13 - Mar. 11	Develop a systems model	SIPA Team
	• Interviews	
Feb. 13 - Mar. 11	Phone interviews with Country Offices	SIPA Team
Feb. 13 - Mar. 11	Partner interviews (HQ)	SIPA Team
Feb. 13 - Mar. 11	Set up in-country interviews	SIPA Team
Feb. 13 - Mar. 5	Prepare for testing of FGD (with country office, etc.)	SIPA Team
Feb. 13 - Mar. 5	Roll-out pre-test of FGD	SIPA Team
	• Travel Preparation	
Feb. 13 - Mar. 11	Retrieve VISAs	SIPA Team
Feb. 13 - Mar. 11	Get vaccines	SIPA Team
Feb. 13 - Mar. 11	Clarify in-country logistics	SIPA Team
Feb. 13 - Mar. 11	Confirm country office UN ID	SIPA Team
Feb. 13 - Mar. 11	Confirm UN contracts	SIPA Team
	• Desk research	
Feb. 13 - Mar. 5	Ongoing background research	SIPA Team
Mar. 6 - Mar. 11	Revise literature review	SIPA Team

	PHASE III (mid-to end March)	
	• Field Visit	
Mar. 12- Mar. 28	Conduct FGD	SIPA Team
Mar. 12- Mar. 28	Conduct KII	SIPA Team
Mar. 12- Mar. 28	Maintain notes and disseminate within group	SIPA Team
Mar. 12- Mar. 28	Present in-country initial findings at UNFPA country office	SIPA Team
	PHASE IV (end March to mid-May)	
	• Data Analysis	
Mar. 28– Apr. 30	Conduct data entry	SIPA Team
Mar. 28– Apr. 30	Conduct data analysis	SIPA Team
Mar. 28– Apr. 30	Deliberate on findings	SIPA Team
	• Tool Development	
Mar. 28– Apr. 30	Develop additional cost-benefit matrices	SIPA Team
Mar. 28– Apr. 30	Conduct decision-modeling	SIPA Team
	• Final Report	
Mar. 30 – Apr. 5	Draft final report	SIPA Team
Apr. 6 – Apr.12	Send to faculty advisor	Libby
Apr. 19 – Apr. 21	Revise final report	SIPA Team
May 4 – May 10	Final paper due	SIPA Team
	• Presentation	
Apr. 21 – Apr. 24	Draft of Presentation	SIPA Team
Apr. 24 – April 28	Practice Presentation	SIPA Team
Apr. 28 – Apr. 29	Present final report to EPD Workshop	SIPA Team
May 11 – May 14	Present Brown-Bag for UNFPA	SIPA Team

ANNEX VI – PRELIMINARY BUDGET PROPOSAL

	CATEGORY		EXPENSES	CLIENT IN-KIND ESTIMATE
I.	TRAVEL			
	Air fare	Initial Budget	$ 10,363.10	
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
	US transportation to airport (up to $15 to JFK & LGA or $34 to EWR)	Initial Budget	$ 145.00	
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
	In-country local travel	Initial Budget	$ 1,500.00	$ 1,500.00
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
	Visas	Initial Budget	$ 235.00	
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
	Immunizations & Malaria Medication (up to $200 per person)	Initial Budget	$ 475.00	
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
	Airport taxes	Initial Budget	$ 91.00	
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
II.	BOARD			
	Lodging	Initial Budget	$ 7,200.00	$ 7,200.00
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
III.	PROJECT EXPENSES			
	Communications (up to $20 per person)	Initial Budget	$ 200.00	
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
	Office Expenses (including printing and photocopying - up to $20 per person)	Initial Budget	$ 200.00	
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
	Translation (if needed; subject to approval)	Initial Budget	$ -	
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
	Interpreter in the field (if needed; subject to approval)	Initial Budget	$ 860.00	$ 860.00
		Revised Budget	$ -	

	CATEGORY		EXPENSES	CLIENT IN-KIND ESTIMATE
		Final/Actual Budget	$ -	
	Other (subject to approval)	Initial Budget	$ -	
		Revised Budget	$ -	
		Final/Actual Budget	$ -	
IV.	TOTAL			
	TOTAL (incl. in-kind)	**Initial Budget**	**$ 21,269**	**$ 9,560**
		Revised Budget	$ -	$ -
		Final/Actual Budget	$ -	$ -

ANNEX VIII – FOCUS GROUP DISCUSSION GUIDE

Materials Needed:
Participatory Items (random items for ranking) OR
Choose from items available
Paper, pens, index cards

Focus Group Discussion Guide

Introduction/Disclaimer:

Good morning/afternoon. First of all, thank you very much for joining us today for this discussion. My name is _____ and these are my colleagues, _____ and _____. We are students from a university in the US working with the UNFPA here in (country). We are not employed by UNFPA. Instead we are here to try to help them better understand the health situation of women and families such as yourselves. For this reason we would like to talk to you to learn more about your experiences following (crisis/disaster), and specifically how you managed your health and the health of your families. Our conversation will last about two hours, and there will be a break in the middle.

During our conversation today, _____ here will take notes of what you say so that we can remember and understand all of the important information you will be sharing with us. It is important for you to know, however, that nothing you say will be recorded in association with your name. If at any point we plan to publicly release the results of our research we will not include anyone's name or any other identifying information such as age, gender, or origin. Please feel free to speak honestly and say what is on your mind.

DISCLAIMER: Specify what UNFPA actually is (in the event that beneficiaries do not know exactly what UNFPA is)

Just as we are here today talking to you, several of our friends/colleagues are in other countries around the world talking to other women and families who have experiences similar to yours. We hope that after talking to you and other people around the world, we will be able to help UNFPA understand how they might better serve people like you in response to future disasters. Although we hope that UNFPA will be able to improve its programs as a result of our conversation today, you and your community will not receive any direct benefit from participating in this conversation. We appreciate the time that you are giving to us to help people like you in the future. (*NOTE: This disclaimer is crucial – be sure to sit with the translator before the FGD starts to see if he/she understands this and if he/she feels that it is appropriate language in the context of the groups you will be meeting*).

Do any of you have any questions about this? Please feel free to speak or ask questions. Do you have any other questions? If you are comfortable, can we begin the discussion?

Before we start, we would like to set one ground rule. We know that many of you have experiences that you are interested in sharing, and we want to make sure we can hear from each and every one of you. Let's respect our fellow participants and when they speak, do not interrupt but let them finish first and then speak your mind. Also sometimes you might have a different opinion or different experience from someone else in the group. It is important to us to hear all kinds of different opinions and experiences, so please do not feel shy if you have something to different to say, and please also respect what other people in the group say. Do you agree with this rule?

Do you have any other questions before we begin?

FOCUS GROUP QUESTIONS CAN NOW BEGIN
OPENER:
To begin, I would like us to all share a little something about ourselves. First, please tell us what name we can call you. You do not have to use your real name if you don't want to. Please also tell us if you had to be one animal what would you be and why? (*NOTE: Students might want to go first to ease group shyness. Also, if animal question is*

inappropriate, students might begin by asking respondents to say something about their children, how many they have, etc.)

1) Now I would like to ask you about where you are from. Where did you live before (conflict/disaster)?

   PROBE: How far away is your home? How long did it take to get here? How did you get here (walk, car, buses, planes, boats, etc.)?

2) When you arrived here, can you tell me what it was like? [POTENTIALLY SENSITIVE]

   PROBE: What was the living situation? Were you with your family? How did you get your basic needs: food, water and shelter?

****Thank you for sharing this information. Now I would like to ask about the health needs you and your family had when you arrived in (camp/village/etc).

3) Think about when you first arrived in (here/camp/location). What things did you feel you and your family needed for your health?

4) Were you able to get these items?

   PROBE: How did you obtain the items? Were you able to buy any of these items locally?

5) Thinking about the items that you needed but could not get, can you tell me how you felt not having these items?

   PROBE: What effect did not having these items (*name specific items*) have on your life? Did not having these things affect your ability to go to food distributions? Water distributions? Community or social events? School? Work?

6) At any point after you arrived, did anybody ever ask you about the health of you or your family, or what you needed to improve your health? For example, did anyone ever bring you into a circle like this to ask you what you needed?

   PROBE: If yes, who asked you? What did they ask? Who else did they ask? Were the items you asked for provided?

Now, I want to ask you more specifically about your hygiene needs when you arrived. Hygiene means the things you do to keep clean. (*NOTE: be sure to discuss with translator whether there is a direct translation for "hygiene" and how it might best be translated into lay terms*)

7) Think about when you first arrived in (here/camp/location). What things did you feel you and your family needed to feel clean? What things did women specifically need?

8) Were you able to get these items?

   PROBE: How did you obtain the items? Were you able to buy any of these items locally?

9) Thinking about the items that you needed but could not get, can you tell me how you felt not having these items?

PROBE: What effect did not having these items (*name specific items*) have on your life? Did not having these things affect your ability to go to food distributions? Water distributions? Community or social events? School? Work?

10) At any point after you arrived, did anybody ever ask you about your hygiene or what you needed to improve your hygiene? For example, did anyone ever bring you into a circle like this to ask you what you needed?

    PROBE: If yes, who asked you? What did they ask? Who else did they ask? Were the items you asked for provided?

DIGNITY and HYGIENE KITS

Now we would like to talk about Dignity Kits (*or locally appropriate name or description*) distributed by the UNFPA (*show kit or picture of kit*).

11) Did you ever receive these kits?

12) What items were in the kits that you received?

    PROBE: Anything else? (*If you have actual kit, ask about each item – clearly document where women's answered differed. Ask why they think respondent A got a head scarf but respondent B didn't.*)

13) Which items in the kit did you think were most useful for you and your family?

    PROBE: Why?

14) Were there items in the kit that you felt were unnecessary?

    PROBE: Why do you think they were unnecessary?

15) Do you feel that the items were of high quality? Did you have any trouble using any of the items?

16) How long did the items in the kit last?

    PROBE: What did you do when items ran out? Were you able to replace them yourselves? Were you given more? If not, how were you able to meet the health and hygiene needs of you and your family?

17) Can you tell me about the process of receiving the kits? Specifically, how did you hear about them? Where did you go to pick them up and who in your household picked them up? Who else in your community received the kits?

18) Who used these items in your household?

    PROBE: Yourself? Children? Husband? Neighbors? Other relatives? etc.

    PROBE: Did you sell or trade any of the items in the kits? What did you do with items you did not need? Do you know if some people in the community sold items they did not need?

19) How did receiving these kits make you feel?

PROBE: Did receiving these kits have an effect on your day to day life? Did they in any way change the ability of you (and your family) to go to food and water distributions? Social or community functions? School? Work?

20) What are you and your family using today to meet your health and hygiene needs?

    PROBE: (*Ask about bathing, dental hygiene and personal upkeep (soap, combs). For women ask specifically about menstruation and undergarments.*)

    PROBE: Where and how do you get these items? Are these items available locally for purchase, or are you receiving these items from NGOs or Government agencies?

21) At any time in the process of picking up the kits, did you feel you were in danger or did you worry for the safety of your family member?

    PROBE: Did you express your concerns to anyone? Did you take any action to improve your safety? Was anything done to ease your fear?

**********Other Distributions**********

22) At any time after you arrived in the camp/village, etc. did any other organization give you a hygiene kit or dignity kit (*or local term/general description*)?

    PROBE: Which organization? What items were in those kits? How did you hear about those kits? Where did you go to pick them up and who in your household picked them up? Who else in your community received those kits? Did you receive those kits or any of the items in those kits more than once? What are the differences between the UNFPA kits and the other kits? Which was more useful? Which did you like more?

****

23) Thank you for sharing all of this important information with us. Now we would like you to imagine that you are in charge of giving kits like these to women and families like yourself in future disasters. If you had to pick 5 items to go in a kit for (*specify here per what group received the kit – family, newborn, adolescent, etc.*) what would you include? Why?
24) How do you or your community define “dignity”? [using whatever associated term based on CO context]

25) If you could give one message to the UNFPA about what programs women and their families in this community need for their health and hygiene, what would your message be?

26) This conversation has been really helpful for us and we appreciate your time. Before we end, we would like to know if there were any questions that you think we should have asked you that we didn’t? How would you have answered that question?

27) Do you have any questions for us?

Thank you again for sharing your time and this information. We look forward to using this information, in combination with the information we are collecting from countries all around the world, to help improve UNFPA’s dignity kits in the future. Please know that you have helped us to better serve women and families like yourself in the future.

ANNEX IX – KEY INFORMANT INTERVIEW GUIDES

A. INTERNAL PARTNER QUESTIONS

UNFPA HQ and Regional Offices

Below you will find a series of master questions for internal contacts that can be used for key informant interviews. The guide is meant to serve as a general list of key questions that should be addressed with each informant type, not as a literal guide to be followed step-by-step. We have broken the guide down into 3 main HQ groups + the Regional Offices across 3 categories that correspond to the major objectives of our project: 1) Impact & Usefulness, 2) Logistics, 3) Branding & Visibility. There are, of course, exceptions to these 3 categories, but the idea is to have a set of "essential" questions that can be included in a more tailored interview within the general informant type and objectives categories. You can also use the interview matrix, specifically the key issues section, to define which particular questions would be most relevant to ask depending on the interview.

Key UNFPA Branches:

HRB	***Humanitarian Response Branch-*** Will have the most to say at Headquarters about the specifics of the kits, especially in terms of the overall impact and usefulness of the kits and the logistical effectiveness behind their distribution
PSB/RMB	***Procurement Service Branch/Resource Mobilization Branch-*** Will have the most to say at Headquarters about procurement logistics and resource mobilization associated with the kits
PD/TD/MCB/ERB	***Program Division/Technical Division/Media & Communications Branch/External Relations Branch-*** Will have the most to say at Headquarters about the branding, visibility and overall perception of the kits
RO	***Regional Offices-*** The 5 regional offices will include humanitarian focal points that know specifically about the kits and have much to say about all aspects of our major evaluation objectives: impact, the overall visibility of the kits in regional priorities and emergency response as well as a bit on cost and logistics

Office	Informant Type	Background Questions	Objective 1: Impact and Usefulness	Objective 2: Logistics	Objective 3: Branding and Visibility	Closing Questions
HQ	PSB/RMB	YES	SOME	YES	NO	YES
	PD/TD/Media/ERB	YES	YES	NO	YES	YES
	HRB	YES	YES	SOME	YES	YES
RO		YES	YES	SOME	SOME	YES

Thematic Area	Target Group	Questions	Key Issues to Address
Background	All	A1 to A2	• **General Information about Interviewee** • **Whether or not person has worked directly on DK distribution**
Impact and Usefulness	RO	B1 to B7	• **Objective of said kit** • **Items found in dignity kits** • **Role of dignity kits for beneficiaries**
	HRB	B1 to B7	
	PSB	B1 and B6	
	PD	B1	
Logistics	RO	C1a and c, C4 to C8	• **Procurement of items/kits** • **Delivery of kits in emergencies** • **The monetary and human costs of dignity kits + cost drivers of provision** • **Coordination of delivery of kits with partner agencies**
	PSB	C1 to C9	
	HRB	C1, C2, C4, C5, and C7	
Visibility/Branding	All	D1, D5	• **Role of UNFPA in emergency settings** • **Possible uniqueness of dignity kits compared to other hygiene kits** • **Ways to increase the visibility of UNFPA's dignity kits**
	HRB	D1 to D3, D5	
	RO	D1, D2, D5	
	RMB	D1, D3, D5	
	ERB	D1,D3, D4, D5	
	PD/TD/MCB	D1, D4, D5	
	UNFPA Speechwriter	D1, D4, D5	
Closing Questions	All	E1, E2, E4	• **Alternative use of funding** • **Ability to address topics they find important that were not directly asked in interview** • **Possibility to establish other relevant contacts**
	RO	E1 to E4	
	PSB	E1 to E4	

STANDARD INTRODUCTION

**Note: Just an introduction guide*

Name of Interviewee _____

Date: _____Time: _____Interviewer: _____

Country/Location:_____

Good morning/afternoon. My name is _____ and this is_____(if 2 people present). Thank you for agreeing to speak with us. We are conducting an assessment of UNFPA's provision of dignity kits in emergencies. The purpose of this assessment is to evaluate the overall impact and usefulness of UNFPA's provision of hygiene kits and to make recommendations on how UNFPA can improve this type of intervention going forward. We are speaking with UNFPA staff to gain a better understanding of how these kits are perceived internally. Your responses will help inform our assessment. If you wish, any personal or sensitive information that you choose to share with us will be kept in confidence.

Do you have any questions? If not, we will now begin.

General Background:

A1. What is your current title and what are your main responsibilities at UNFPA? (All)

A2. Have you worked directly on dignity kits, and if so in which capacity? (All)

Objective 1: Impact & Usefulness

B1. In your opinion, what is the main objective of dignity kit provision? (RO, HRB, PSB, PD, etc.)

- How useful do you think the kits have been in fulfilling that (or these) objective(s)?

B2. Do you think that dignity/hygiene kits have met the hygiene needs of the affected populations? (RO, HRB)

B3. In your opinion, have dignity kits also helped beneficiaries access certain services? If yes, could you please explain how so? (RO, HRB)

If the following isn't mentioned, please follow up on some of these specific services/needs:

a. Food/water distributions
b. Education access
c. Healthcare services
d. Income Generating Activities
e. Social and community activities

B4. One of the objectives of dignity kits is to contribute to the restoration of dignity for people affected by emergencies. What does dignity mean to you in this context? (RO, HRB)

a. And to what extent do you think the dignity kits have been successful or not in achieving this objective? Any specific country examples?

B5. What feedback –if any – have you received from the COs regarding the impact or usefulness of dignity kits? (If yes) Have you documented this feedback? (If yes) Would you be willing to share this information with us? (RO, HRB)

B6. How would you weigh the perceived impact/usefulness of dignity kits in relation to their costs? (RO, HRB, PSB)

B7. How are the contents of dignity kits typically determined? (RO, HRB)

a. What does UNFPA do during a Rapid Needs Assessment?
b. How does UNFPA ensure that the contents of the dignity kits are appropriate and culturally-sensitive? (RO, HRB + Azza Karam – cultural advisor)

Objective 2: Logistics – for PSB and certain HRB

C1. Could you please tell us what you know about the procurement of dignity kits? (PSB, ROs, HRB)

- **a.** Do country offices have to adhere to any established procurement practices for the provision of dignity kits? (RO)
- **b.** What criteria are used to select suppliers?
- **c.** Does UNFPA sign long-term agreements (LTAs) with suppliers or are orders placed on an as-needed basis? (RO)
- **d.** How much decision-making authority is left to the CO? What is determined at the HQ level?

C2. Are dignity kits typically procured via local suppliers or is it more common to ship dignity kit items from regional or int'l stocks? (PSB, ROs, HRB)

- **a.** *If items are procured regionally/locally ask following:* Does the CO provide you with detailed information about bidding processes and cost comparisons amongst different suppliers on the ground? (PSB, HRB)

C3. Could you please rank the importance of these 3 factors in selecting a supplier: 1.Lead time; 2. Cost; and 3. Local vs. international supply? (PSB)

C4. Could you please identify what you think are the key cost drivers of the dignity kit program? (RO, PSB, HRB)

C5. Do you see any ways in which financial and human resources dedicated to dignity kits could be reduced without jeopardizing the usefulness of the kits? If so, how? (RO, HRB, PSB/RMB)?

a. Have there been examples of COs that successfully pre-positioned dignity kits? If yes, how exactly did they go about it?

C6. In your opinion what is the biggest challenge in procuring dignity kits? Are there any systematic bottlenecks that surround dignity kit procurement? (PSB, HRB, RO)

a. If yes, do you have any thoughts on how to overcome them?

C7. Was the provision of dignity kits coordinated with other agencies (i.e. government, UN, international and local NGOs)? (PSB, RO, HRB)

a. If yes, which agencies/organizations and in what way were activities coordinated? (PSB, RO, HRB)
b. How were these partnerships forged?
c. What role did UNFPA play in these partnerships?
d. What were some of the benefits and challenges of these partnerships?

C8. What are your thoughts on the timeliness of the delivery of kits? (PSB, RO)

C9. Are there any ways in which the overall procurement process could be improved? (PSB)

a. If yes, what role could HQ play in improving this process and helping COs provide kits more effectively? (PSB)

Objective 3: Visibility/Branding

D1. What is your perception of UNFPAs role in emergency response? (HRB, RO, PSB, PD, etc.)

D2. Do you think UNFPA's provision of dignity kits is different than what other organizations provide in emergencies? If so, how? (HRB, RO)

D3. How have dignity kits contributed to UNFPA's ability to secure funding for its emergency response activities? (RMB, ERB, HRB)

D4. What role do dignity kits play, if any, in UNFPA's positioning and brand equity? (PD/TD/MCB, ERB + UNFPA Speechwriter)

D5. Do you think that the visibility of UNFPA's provision of dignity kits could be improved? If yes, how so? (All)

a. Does UNFPA have communication material promoting dignity kits? If yes, could you please share these with us? (ERB)

Closing Questions

E1. If UNFPA did not distribute dignity kits in humanitarian settings, what alternate activities could UNFPA engage in with the funding that is currently allocated to dignity kit provision? (All)
E2. Do you feel there is something important we should have asked that we did not address? (All)
E3. Do you have any documentation that would help us understand UNFPA's provision of dignity kits, and that you would be willing to share with us? (All)
E4. Do you have any suggestions of other people we should contact at UNFPA? (All)
Thank you very much for your time. [Recap any information that was especially helpful] Here is our contact information. Please do not hesitate to contact us if you have any other questions.

B. UNFPA COUNTRY OFFICES INTERVIEW GUIDES:

STANDARD INTRODUCTION
**Note: Just an introduction guide*

Name of Interviewee _____Lubna _____
Date: _____Time: _____Interviewer: _____
Country/Location:_____
Good morning/afternoon. My name is _____ and this is_____(if 2 people present). Thank you for agreeing to speak with us. We are conducting an assessment of UNFPA's provision of dignity kits in emergencies. The purpose of this assessment is to evaluate the overall impact and usefulness of UNFPA's provision of hygiene kits and to make recommendations on how UNFPA can improve this type of intervention going forward. We are speaking with UNFPA staff to gain a better understanding of how these kits are perceived internally. Your responses will help inform our assessment. If you wish, any personal or sensitive information that you choose to share with us will be kept in confidence.

Do you have any questions? If not, we will now begin.

General Background:

A1. What is your current title and what are your main responsibilities at UNFPA?
A2. Have you worked directly on dignity kits, and if so in which capacity?
A3. Over the past 5 years, in which instances has your CO distributed kits? (Only ask this question if the respondent has not filled out the global online survey). Please specify:

- **The type of emergency; the target population; the types of kits distributed.**

Objective 1: Impact & Usefulness

B1. How did you determine which areas to target? Did you use a mapping system to monitor where the kits were being distributed?
B2: In your opinion, what is the main objective of dignity kit provision? How useful do you think the kits have been in fulfilling that (or these) objective(s)?
B3. Do you think that dignity/hygiene kits have met the hygiene needs of the affected populations?

- **Can you walk us through the needs assessment of the hygiene?**

- **Does UNFPA coordinate with other organizations for this type of assessment?**

B4. In your opinion, have dignity kits also helped beneficiaries access certain services? If yes, could you please explain how so? (At interviewer's discretion – this question was also on the survey).
If the following isn't mentioned, please follow up on some of these specific services/needs:

a. Food/water distributions
b. Education access
c. Healthcare services
d. Income Generating Activities
e. Social and community activities

B5. One of the objectives of dignity kits is to contribute to the restoration of dignity for people affected by emergencies. What does dignity mean to you in this context?

b. And to what extent do you think the dignity kits have been successful or not in achieving this objective?

B6. Have you documented feedback from your beneficiaries? If yes: How? Would it be possible for us to see this information?

a. Have you observed or heard about any unintended consequences?

B7. Do you think the perceived impact/usefulness of the kits outweigh their cost?

B8. How are the contents of dignity kits typically determined?

c. What does UNFPA do during a Rapid Needs Assessment? How long does this usually take?

Objective 2: Logistics – for PSB and certain HRB

C1. Could you please tell us what you know about the procurement of dignity kits?

a. Do you have to adhere to any established procurement practices for the provision of dignity kits? -> follow-up by asking for documentation
b. What criteria are used to select suppliers?
c. Have you signed long-term agreements (LTAs) with suppliers or are orders placed on an as-needed basis?
d. Does this protocol vary depending on the emergency response phase (rapid response vs. longer term response)

C2. How do you determine whether items should be locally procured? Is it more common to ship from regional or international suppliers?

C3. Could you please rank the importance of these 3 factors in selecting a supplier: 1.Lead time; 2. Cost; and 3. Local vs. international supplier/vendor?

C4. Could you please identify what you think are the key cost drivers of the dignity kit program? (transportation, warehousing, etc…)

C5. What was the average cost of one kit in the 3 most recent emergencies your CO responded to?

C6. In your particular country context what are/would be benefits of stockpiling items (standardizing) prior to emergencies? And what would be the challenges?

C7. Is there a monitoring system in place to verify the quality of items supplied?

C8. In your opinion what is the biggest challenge in procuring dignity kits? Are there any systematic bottlenecks that surround dignity kit procurement? (PSB, HRB, RO)

a. If yes, do you have any thoughts on how to overcome them?

C9. Was the provision of dignity kits coordinated with other agencies (i.e. government, UN, international and local NGOs)? (PSB, RO, HRB)

a. If yes, which agencies/organizations and in what way were activities coordinated? (PSB, RO, HRB)
b. How were these partnerships forged?
c. What role did UNFPA play in these partnerships?
d. What were some of the benefits and challenges of these partnerships?

C10. Are there any ways in which the overall procurement process could be improved?

b. If yes, what role could HQ play in improving this process and helping COs provide kits more effectively? If no particular answer: Do you think they should standardize procedures? Provide guidelines for procurement? Stockpiling?

Objective 3: Visibility/Branding

D1. How visible are UNFPA's kits compared to the kits of other organizations? (clarification: do you think UNFPA has done an effective job of branding dignity kits)

D2. Do you think UNFPA's provision of dignity kits is different than what other organizations provide in emergencies? If so, how? (At the discretion of interviewer – only if this hasn't been addressed already by interviewee)

D3. Does your country office engage the media in informing them on your interventions?

- If no: why not?
- If yes: could this be improved? Could HQ help?

Closing Questions

E1. If UNFPA did not distribute dignity kits in humanitarian settings, what alternate activities could UNFPA engage in with the funding that goes towards financing dignity kits?
E2. Do you feel there is something important we should have asked that we did not address?
E3. Do you have any documentation that would help us understand UNFPA's provision of dignity kits, and that you would be willing to share with us?
E4. Do you have any suggestions of other people we should contact in your country?
Thank you very much for your time. [Recap any information that was especially helpful] Here is our contact information. Please do not hesitate to contact us if you have any other questions.

C. IN COUNTRY EXTERNAL PARTNER INTERVIEW GUIDE

STANDARD INTRODUCTION

**Note: Just an introduction guide*

Name of Interviewee _____

Date: _____Time: _____Interviewer: _____

Country/Location:_____

Good morning/afternoon. My name is _____ and this is_____(if 2 people present). Thank you for agreeing to speak with us. We are conducting an assessment of UNFPA's provision of dignity kits (also referred to as hygiene kits). The purpose of this assessment is to evaluate the overall impact and usefulness of UNFPA's provision of hygiene kits and to make recommendations on how UNFPA can improve this type of intervention going forward. We are speaking with organizations that are familiar with UNFPA's provision of dignity kits in a post-crisis setting. Your responses will help inform our assessment. If you wish, any personal or sensitive information that you choose to share with us will be kept in confidence. The interview should take no more than 30 minutes, and you should feel free to interrupt us at any time.

Do you have any questions? If not, we will now begin.

ORGANIZATIONS THAT DISTRIBUTE HYGIENE KITS (ODK)

BACKGROUND

1. What is your current title and what are your main responsibilities in your position at [name of org.)? What emergency response activities does your organization engage in? What role does your branch/unit play in emergency response within the organization?

2. Which items are typically distributed by your organization after an emergency? Have you worked directly on dignity kits, and in which capacity?

HYGIENE KITS

3. When and where did [name of organization] first start distributing hygiene kits (in relation to the onset of a crisis/emergency)?
4. In the most recent instance of a conflict/and or natural disaster in which your organization distributed kits:
    a. How many kits did you distribute?
    b. Who did you distribute the kits to? Were any specific groups targeted (women, children, the elderly, etc….)?
        i. If No Group Targeted: Did you use any other selection criteria to determine who received the kits? (If no particular response, ask if location, size of household, proximity to disaster were determinants).
        ii. If Group Targeted: How did you decide to select this segment of the population?

5. What were the main contents included in the kits?
    a. How were these contents determined

b. To what extent are the hygiene kits standardized for a particular region/context or population?
c. To what extent was the local population involved in this process?
d. In your opinion what are the five most important items in a hygiene kit?
e. Can you give an approximation or the range of the cost per kit during this most recent emergency?

6. Have there been any past instances in which you think certain items should have been added to the kits but were not included? If yes, why are these items not included in your kits?

ORGANIZATIONS THAT DISTRIBUTE HYGIENE KITS (ODK) – ctd.

LOGISTICS

7. Can you please tell us about the procurement process of hygiene kits, from the moment a crisis/disaster hits to the actual distribution of the kits to beneficiaries?

8. How do you identify and select suppliers? E.g. Is it direct procurement or is there a competitive bidding process? [If a competitive bidding process, ask them to describe. Is it an open or closed tender? What selection criteria do they use?]

9. Is a procurement agent used?

10. Does your organization have a preference for local procurement, or is procurement primarily cost-driven?

11. What factors determine the total quantity of kits you procure?

12. On average, how long is the procurement process from the start of a crisis to the actual distribution?
    a. What is the average lead time for receipt of kit contents?
    b. Do country offices typically enter into long-term agreements with suppliers?
    c. Do you pre-package your kits? If yes, is this done in country or at the regional or global level?
    d. Do you see any ways in which your organization's procurement process could be improved?

13. In general, what tend to be the most significant cost drivers for your organization's provision of hygiene kits (i.e. transportation, warehousing, human resources, etc.)?

14. What are the biggest logistical challenges that your organization faces when it comes to the provision of hygiene kits (i.e. procurement, assembly, warehousing, transportation and distribution)?

15. Once you've finished procuring the contents of the kits, how are they assembled, stored and distributed?

IMPACT AND USEFULNESS

16. In your opinion, what is the main objective of your organization's provision of hygiene kits?

17. In what ways do you think the hygiene kits have met the hygiene needs of the affected populations?

18. What feedback -if any- have you received from beneficiaries on your hygiene kits? (Ask if willing to share docs.)

VISIBILITY AND PARTNERSHIPS

19. Has your organization ever provided hygiene kits in coordination with other partners?
    - If so which ones and in what capacity
    - What have been some of the challenging and beneficial aspects of this cooperation?

20. What do you know about UNFPA's role/activities in an emergency?

21. How (and when) did you first become aware of UNFPA's provision of dignity kits as part of its humanitarian response?

22. What is your general perception of UNFPA's provision of dignity kits?

OTHER ORGANIZATIONS (OO)

BACKGROUND

1. What is your current title and what are your main responsibilities in your position at [name of org)?

2. What emergency response activities does your organization engage in? What role does your branch/unit play in emergency response within the organization?

VISIBILITY AND PARTNERSHIPS

1. What do you know about UNFPA's role/activities in emergencies?

2. How (and when) did you first become aware of UNFPA's provision of dignity kits as part of its humanitarian response?

3. Has your organization partnered with UNFPA in the distribution of dignity kits? If so, in which ways?

4. From your experience, what if any, differences do you think there are between UNFPA dignity kits and hygiene kits offered by other organizations?

5. Do you think that the visibility of UNFPA's provision of dignity kits could be improved? If yes, how so?

IMPACT

1. One of the objectives of dignity kits is to contribute to the restoration of dignity for people affected by emergencies. What does dignity mean to you in this context?

2. What is your general perception of UNFPA's provision of dignity kits?

3. In your opinion, what is the main objective of UNFPA's dignity kits?

4. In what ways do you think the dignity kits have met the hygiene needs of the affected populations?

STANDARD CLOSING QUESTIONS

- Is there any additional information that you would like to share with us?
- Do you have suggestions of anyone else we can/should contact?
- Do you feel there is something important we should have asked but didn't?
- Do you have any documentation that would help us to better understand your organization's provision of dignity kits, and that you would be willing to share with us?
- If we have any further questions, may we contact you?

D. EXTERNAL PARTNER QUESTIONS

OTHER ORGANIZATIONS (OO)

OO are organizations that would potentially be able to provide valuable information on the perception of UNFPA's provision of dignity kits in post-crisis settings. OO includes humanitarian and development organizations and agencies such as the WRC, IMC, CERF, etc. that do not distribute dignity kits directly but can still inform our assessment (especially in terms of impact & overall visibility of kits).

The following questions are key questions to address when interviewing representatives at the above organizations. Please note that they are simply a general guide, and should be tailored for each interviewee. You can use the key issues section to define which specific questions would be most relevant to ask depending on the interview.

STANDARD INTRODUCTION

**Note: Just an introduction guide*

Name of Interviewee _____

Date: _____Time: _____Interviewer: _____

Country/Location:_____

Good morning/afternoon. My name is _____ and this is_____(if 2 people present). Thank you for agreeing to speak with us. We are conducting an assessment of UNFPA's provision of dignity kits (also referred to as hygiene kits). The purpose of this assessment is to evaluate the overall impact and usefulness of UNFPA's provision of hygiene kits and to make recommendations on how UNFPA can improve this type of intervention going forward. We are speaking with organizations that are familiar with UNFPA's provision of dignity kits in a post-crisis setting. Your responses will help inform our assessment. If you wish, any personal or sensitive information that you choose to share with us will be kept in confidence. The interview should take no more than 30 minutes, and you should feel free to interrupt us at any time.

Do you have any questions? If not, we will now begin.

Thematic Area	Questions	Key Issues to Address
Background	**B1:** What is your current title and what are your main responsibilities in your position at [name of org]? **B2:** What emergency response activities does your organization engage in? What role does your branch/unit play in emergency response within the organization?	• **Role and responsibilities of interviewee** • **General emergency response activities of org.**
Impact & Visibility	**B3:** What do you know about UNFPA's role/activities in emergencies? **B4:** How (and when) did you first become aware of UNFPA's provision of dignity kits as part of its humanitarian response? **B5:** One of the objectives of dignity kits is to contribute to the restoration of dignity for people affected by emergencies. What does dignity mean to you in this context? **B6:** What is your general perception of UNFPA's provision of dignity kits? **B7:** In your opinion, what is the main objective of UNFPA's dignity kits? **B8:** In what ways do you think the dignity kits have met the hygiene needs of the affected populations? **B9:** Do you think that dignity kits have helped beneficiaries gain access to other benefits beyond meeting basic hygiene needs? If yes, could you please explain how so? **B10:** From your experience, what if any, differences do you think there are between UNFPA dignity kits and hygiene kits offered by other organizations? **B11:** Do you think that the visibility of UNFPA's provision of dignity kits could be improved? If yes, how so?	• **Knowledge of UNFPA role in emergencies** • **Knowledge of UNFPA's DK** • **Perception of main objective of DK** • **DK ability to meet hygiene needs; other needs/ services outside of basic hygiene; women's needs, HOW?** • **UNFPA kits in relation to other hygiene kits** • **Ways to improve visibility of kits**

Closing	**B12:** Is there any additional information that you would like to share with us? **B13:** Do you have suggestions of anyone else we can/should contact? **B14:** Do you feel there is something important we should have asked but didn't? **B15:** If we have any further questions, may we contact you?	• **Request for additional info, suggested contacts, option for follow-up/contacts**

E. EXTERNAL PARTNER QUESTIONS

ORGANIZATIONS THAT DISTRIBUTE HYGIENE KITS (ODK)

ODK are organizations in which UNFPA could potentially partner with and learn from in the future regarding the provision of hygiene kits in post-crisis settings. ODK includes humanitarian and development organizations such as the IRC, UNICEF, IOM, ICRC, Care, Save the Children, Mercy Malaysia, Oxfam, World Vision, AmeriCares, Un Women, the WASH cluster[121], etc.
The following questions are key questions to address when interviewing representatives at the above organizations. Please note that they are simply a general guide, and should be tailored for each interviewee. You can use the key issues section to define which specific questions would be most relevant to ask depending on the interview.

STANDARD INTRODUCTION
**Note: Just an introduction guide*
Name of Interviewee _____
Date: _____Time: _____Interviewer: _____
Country/Location:_____
Good morning/afternoon. My name is _____ and this is_____(if 2 people present). Thank you for agreeing to speak with us. We are conducting an assessment of UNFPA's provision of dignity kits (also referred to as hygiene kits). The purpose of this assessment is to evaluate the overall impact and usefulness of UNFPA's provision of hygiene kits and to make recommendations on how UNFPA can improve this type of intervention going forward. We are speaking with organizations that distribute hygiene kits independently and/or partner with UNFPA to distribute kits in a post-crisis setting. Your responses will help inform our assessment. If you wish, any personal or sensitive information that you choose to share with us will be kept in confidence. The interview should take no more than 30 minutes, and you should feel free to interrupt us at any time.
Do you have any questions? If not, we will now begin.

Thematic Area	**Questions**	**Key Issues to Address**

Background	**A1:** What is your current title and what are your main responsibilities in your position at [name of org.]? What emergency response activities does your organization engage in? What role does your branch/unit play in emergency response within the organization? **A2:** Which items are typically distributed by your organization after an emergency? Have you worked directly on dignity kits, and in which capacity?	• **Role and responsibilities** • **General emergency response activities of org.** • **Whether or not person has worked directly on DK distribution**
Hygiene Kits	**A3:** When and where did [name of organization] first start distributing hygiene kits (in relation to the onset of a crisis/emergency)? **A4:** In the most recent instance of a conflict/and or natural disaster in which your organization distributed kits: 1. How many kits did you distribute? 2. Who did you distribute the kits to? Were any specific groups targeted (women, children, the elderly, etc….)? a. **If No Group Targeted:** Did you use any other selection criteria to determine who received the kits? (If no particular response, ask if location, size of household, proximity to disaster were determinants). b. **If Group Targeted:** How did you decide to select this segment of the population? **A5:** What were the main contents included in the kits? c. How were these contents determined (Sidenote: i.e. try to understand who makes the final call on contents and the role the COs are expected to play)? d. To what extent are the hygiene kits standardized for a particular region/country/context or population? e. To what extent was the local population involved in this process? f. In your opinion what are the five most important items in a hygiene kit? g. Can you give an approximation or the range of the cost per kit during this most recent	• **General information on the org's provision of dignity kits** • **Target groups and selection criteria, if applicable** • **Kit contents → how they have been determined? Are they standardized? Are they appropriate and relevant?**

	emergency? **A6:** What are the primary sources of funding that your organization uses to provide hygiene kits? **A7:** Have there been any past instances in which you think certain items should have been added to the kits but were not included? If yes, why are these items not included in your kits?	• **Funding mechanisms for kits**
Logistics	Note: These questions will be directed at procurement specialists at ODKs **A8:** Can you please tell us about the procurement process of hygiene kits, from the moment a crisis/disaster hits to the actual distribution of the kits to beneficiaries? 1. How do you identify and select suppliers? E.g. Is it direct procurement or is there a competitive bidding process? [If a competitive bidding process, ask them to describe. Is it an open or closed tender? What selection criteria do they use?] 2. Is a procurement agent used? [If answer is yes, ask which one they currently use.] 3. Does your organization have a preference for local procurement, or is procurement primarily cost-driven? 4. What factors determine the total quantity of kits you procure? **A9:** On average, how long is the procurement process from the start of a crisis to the actual distribution? *If standard time is given, follow up:* 1. What is the average lead time for receipt of kit contents? 2. Do country offices typically enter into long-term agreements with suppliers? 3. Do you pre-package your kits? If yes, is this done in country or at the regional or global level? 4. Do you see any ways in which your organization's procurement process could be improved? **A10:** In general, what tend to be the most significant cost drivers for your organization's	• **How are items procured?** • **Various decision factors in selecting suppliers** • **Logistical constraints/challenges** • **Cost drivers in the provision of kits (Transportation? Assembly? Warehousing?)**

	provision of hygiene kits (i.e. transportation, warehousing, human resources, etc.)? **A11:** What are the biggest logistical challenges that your organization faces when it comes to the provision of hygiene kits (i.e. procurement, assembly, warehousing, transportation and distribution)? **A12:** Once you've finished procuring the contents of the kits, how are they assembled, stored and distributed? **A13**: Have there been any evaluations of or reports on the procurement and distribution of your hygiene kits? If so, would you be willing to share some of this information with us? Note: These questions will be directed at procurement specialists at ODKs	• **Evaluations of supply chain process that can be shared with us**
Impact & Usefulness	**A14:** In your opinion, what is the main objective of your organization's provision of hygiene kits? **A15:** In what ways do you think the hygiene kits have met the hygiene needs of the affected populations ? **A16:** Do you think that hygiene kits have helped beneficiaries gain access to other benefits beyond meeting basic hygiene needs? If yes, could you please explain how so? **A17:** What feedback -if any- have you received from beneficiaries on your hygiene kits? 1. Has your organization ever conducted a formal evaluation of hygiene kits? (*Note: If yes, follow up to see if willing to share this info. with us*) **A18:** One of the objectives of UNFPA's dignity kits is to contribute to the restoration of dignity for people affected by emergencies. What does dignity mean to you in this context?	• **Appropriateness/usefulness of kits** • **Observed and perceived benefits of kits** • **Existing evaluations of hygiene kits** • **Understand ODK's definition of dignity during emergencies**
Visibility &	**A19**: Has your organization ever provided hygiene	• **Existing hygiene kits &**

Partnerships	kits in coordination with other partners? • If so which ones and in what capacity • What have been some of the challenging and beneficial aspects of this cooperation? **A20:** What do you know about UNFPA's role/activities in an emergency? **A21**: How (and when) did you first become aware of UNFPA's provision of dignity kits as part of its humanitarian response? **A22:** What is your general perception of UNFPA's provision of dignity kits?	**partnerships** • **Perception of UNFPA's provision of kits** • **Knowledge of UNFPA's emergency response activities**
Closing Questions	**A23**: Is there any additional information that you would like to give us? **A24:** Do you have suggestions of anyone else we can/should contact? **A25:** Do you feel there is something important we should have asked but didn't? **A26:** Do you have any documentation that would help us to better understand your organization's provision of dignity kits, and that you would be willing to share with us? **A27:** If we have any further questions, may we contact you?	• **Learn about potential new informants** • **Ask for any relevant documentation that could be shared**

ANNEX X – LIST OF INTERVIEWEES

UNFPA Country Offices
Bangladesh
China (2)
Colombia (3)
Ecuador
Georgia
Guatemala (3)
Guinea
Haiti (3)
Indonesia (2)
Kyrgyzstan (5)
Liberia
Mozambique (8)
Pakistan
Occupied Palestinian Territories (3)
Peru (2)
Philippines
Sri Lanka (3)
Sudan (2)
Syria
Tajikistan
Yemen

UNFPA Regional & Sub-Regional Offices
Asia – Pacific (2)
Africa
Latin America & Caribbean (2)
Eastern Europe/Central Asia
West Africa (Sub-Regional)

UNFPA Headquarters
Environmental Scanning and Planning Branch (New York)
Humanitarian Response Branch (New York) (9)
Media & Communication Branch (New York)
Office of the Executive Director (New York)
Procurement Service Branch (Copenhagen)

External Partners
International Organization for Migration
Mercy Malaysia
Plan International (Indonesia)
UNICEF (4 Headquarters; Indonesia, Mozambique)
UN-OCHA (Colombia, Indonesia, Kyrgyzstan)
Women's Refugee Commission
Oxfam

In-Country Partners

Colombia
CDPMM
Imperial Del Arroz
Department of Civil Defense
Red Cross (3) (HQ and regional)
Diakonía de la Paz
World Food Programme (3) (HQ and regional)
Acción Social
IRD
Pastoral Social
Pastoral de la Primera Infancia

Indonesia
GP Anshor
Klaten District Health Office
Magelang District Health Office
Indonesian Midwife Association (IBI)
Ministry of Health (RH sub directorate)
Ministry of Woman Empowerment & Child Protection (Jakarta and Jogjakarta)
PKBI Jogjakarta
Rifka Annisa
Satu Keluarga dan Satu Saudara
Sleman District Health Office

Mozambique

Office of the Resident Coordinator
INGC (National Disaster Management Institute) – Central
INGC/CENOE – Regional
INGC – Province of Zambezia
INGC – District of Morrumbala
MMAS (Ministry of Women and Social Action) – Central
MMAS/DPMASZ – Provincial
MMAS/ SDSMAS – District
Mozambican Red Cross
NAFEZA (Nucleo de Associações Femininas da Zambezia)
World Food Programme

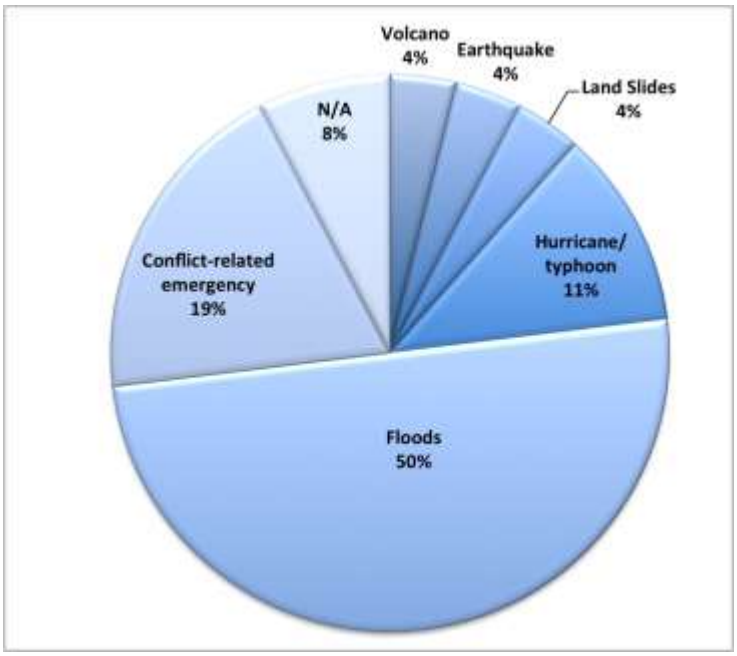
Kyrgyzstan

Ensan Diamond
Sanaalash
Ukuk
NGO Mutakalim leaders
RHC
Kaniet
Red Crescent

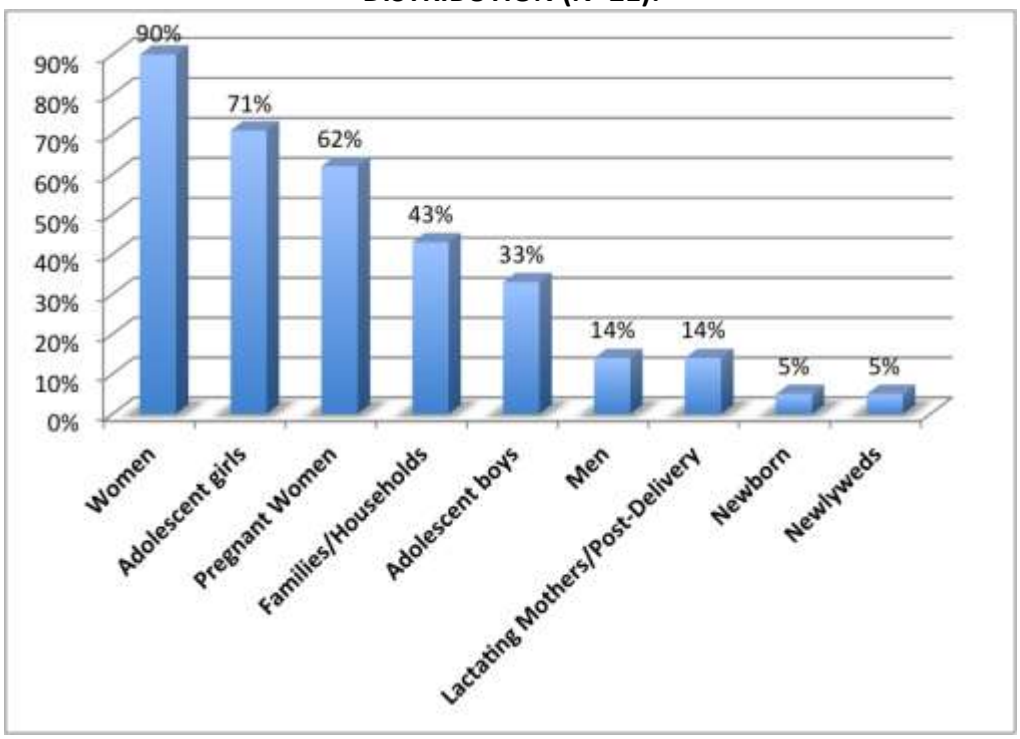
ANNEX XI – GLOBAL SURVEY RESULTS

GRAPH 1. EMERGENCY TYPOLOGY

Question: Please characterize the type of emergency in which the most recent distribution occurred for. (n=26)



GRAPH 2. PERCENTAGE OF COS THAT TARGETED THESE SUB-GROUPS DURING THEIR MOST RECENT DISTRIBUTION (N=21):



GRAPH 3. PERCENTAGE OF COS THAT INCLUDED THE FOLLOWING ITEMS IN MOST RECENT DIGNITY KITS (N=21)

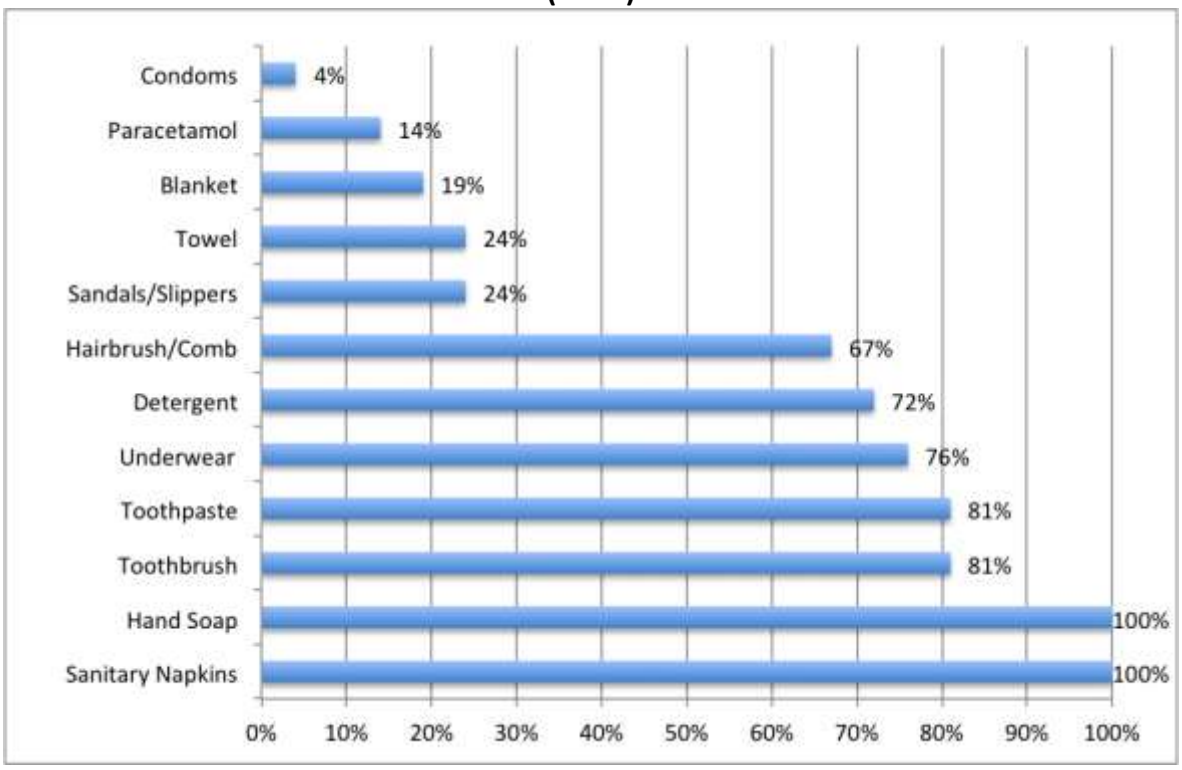
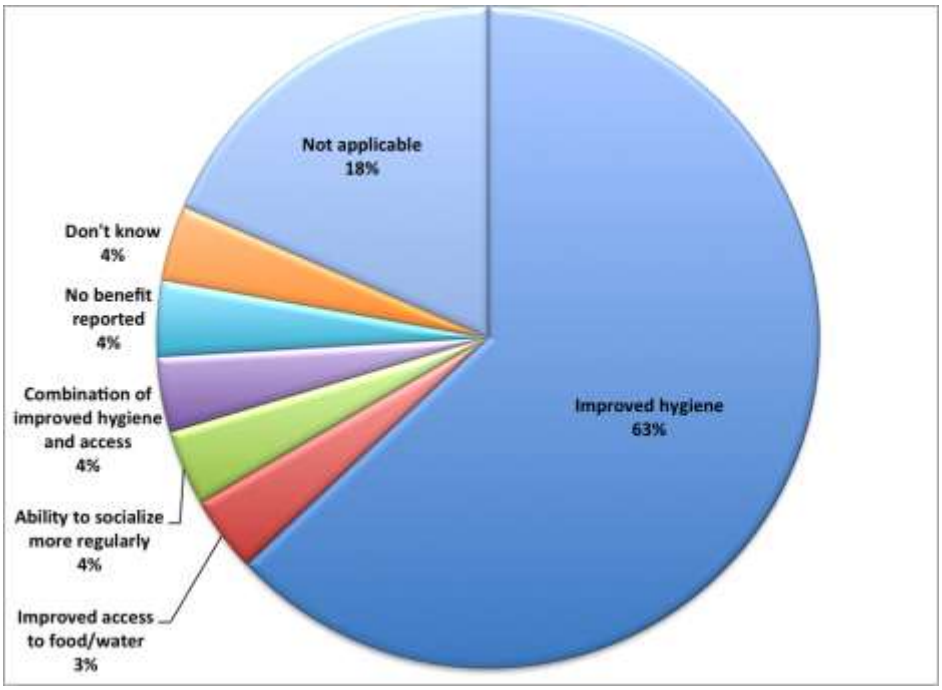


TABLE 1. DETAILED LIST OF KIT CONTENTS

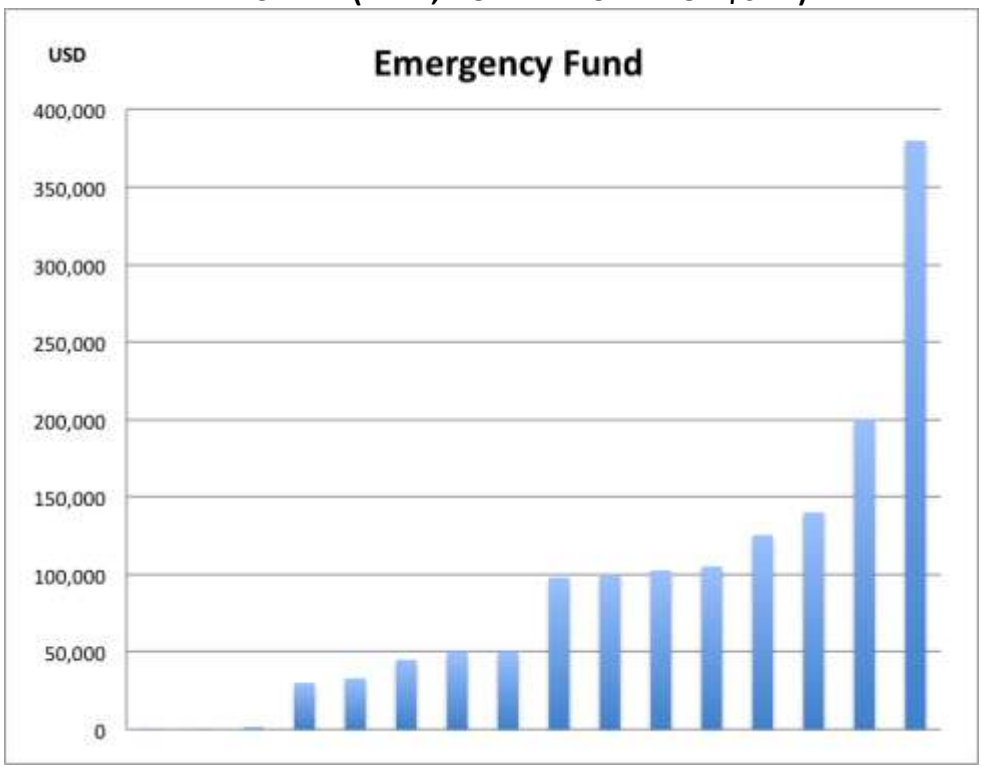
Kyrgyzstan	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Detergent, Underwear, Hairbrush/comb
Nepal	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Detergent, Underwear, Hairbrush/comb, Condoms, paracetamol, canvas, safety pins, shawl, peticoat, plastic jug, Brassiere , Nighty, ORS, Roller bandage
Haiti	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Detergent, Underwear
Indonesia	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Underwear, Hairbrush/comb, sandals, shirt, sarong, blanket etc
Pacific Sub-Regional Office	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Detergent, Underwear, T-Shirt, Sarong and Towel
Bangladesh	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Detergent, Hairbrush/comb, matches, tissues,mosquito coil, paracitamol tablet, cotton, candle, sandal, towel
Georgia	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Detergent, Underwear, Hairbrush/comb
Sri Lanka	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Detergent, Underwear, Hairbrush/comb

Philippines	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Detergent, Underwear, Shampoo, alcohol, nail cutter, tissue paper, slippers, toilet pot ("arinola"), water dipper, multi-purpose blanket ("malong"), bath towel, and face towel.
Lao PDR	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Hairbrush/comb
Namibia	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Detergent
India	Sanitary napkins, Hand soap, Underwear, Washing soap, comb, safety pin, printed sarees, salwar kamezz with dupatta, sindhor, old newspaper
Ghana	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Underwear, Hairbrush/comb, chewing sticks,safety pins, bath soap, washing soap,body cream, baby dresses, wrapping sheet for babies, blade, bathing towel, face towel
Rwanda	Sanitary napkins, Hand soap, Underwear, towels, hand bag, body lotion for baby, bucket, fabric, baby crib, blanket
Myanmar	Sanitary napkins, Hand soap, Detergent, Underwear, Hairbrush/comb
Albania	Sanitary napkins, Hand soap, Detergent, Underwear
Timor-Leste	NR
Mongolia	NR
oPT	Sanitary napkins, Toothbrush, Toothpaste, Hand soap, Detergent, Hairbrush/comb, Blanket, wet ones, lady slippers
Guatemala	Sanitary towels, toothbrushes, toothpaste, hand soap, detergent, underwear, brush / comb
Ecuador	Sanitary towels, toothbrushes, toothpaste, hand soap, brush / comb, hair brush, mirror, hand and body cream, wet towels and sandals. Kits of information material.
Nicaragua	Sanitary towels, toothbrushes, toothpaste, hand soap, detergent, underwear, brush / comb
El Salvador	Sanitary towels, toothbrushes, toothpaste, hand soap, detergent, underwear, brush / comb

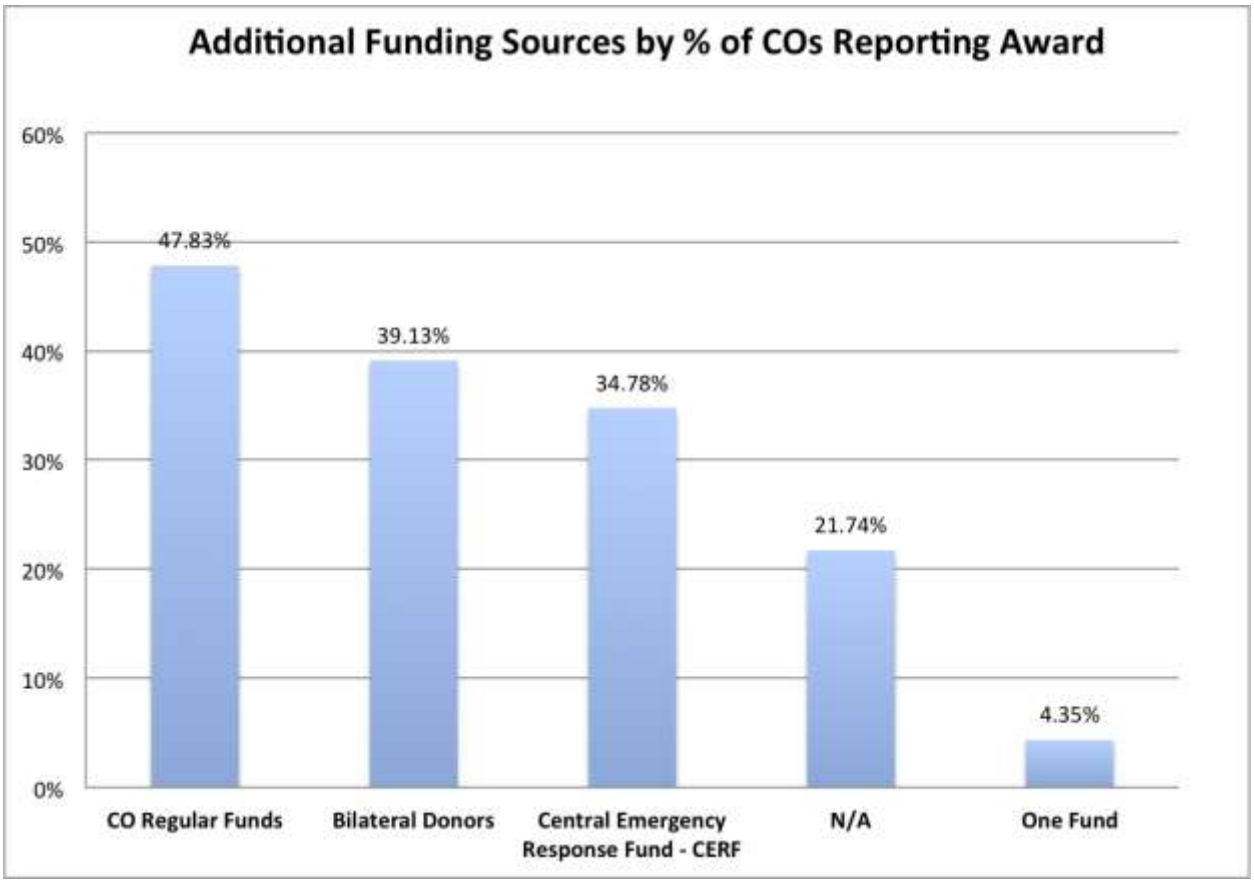
GRAPH 4- WHAT IS THE ONE MAIN BENEFIT RECIPIENTS HAVE REPORTED AS A RESULT OF THE DIGNITY KITS, IF ANY?



GRAPH 5. HOW MUCH FUNDING DID YOU RECEIVE FROM UNFPA'S EMERGENCY FUND SPECIFICALLY FOR DIGNITY KITS? IF NO FUNDING WAS RECEIVED FROM THE EMERGENCY FUND, PLEASE MARK 'NOT APPLICABLE.'(N=24, NOT APPLICABLE OR $0 =7)



GRAPH 6. WHAT OTHER SOURCES OF FUNDING DID YOU RECEIVE FOR DIGNITY KITS? PERCENTAGE OF COS THAT RECEIVED THE FOLLOWING SOURCES OF FUNDING IN MOST RECENT DIGNITY KITS (N=23)



ANNEX XII – TARGETED GROUPS

UNFPA COs and sub-regional offices provided specific information on who is targeted for the provision of dignity kits. As seen in the table below, a variety of groups receive the kits; however, it should be noted that the majority of respondents generally associate dignity kits with women and girls. UNFPA COs utilize implementing partners in consultation with local associations and community representatives to select target groups.

Country	Group Targeted
Indonesia	Women, Pregnant Women, Women w/newborns, Women post-delivery, Adolescent girls
Mozambique	Women, Disabled persons, the elderly, Vulnerable groups not always affected by floods
Colombia	Women
Kyrgyzstan	Women, Men, Adolescent girls, boys, Families/Households, Pregnant women
Nepal	Women, Men, Adolescent girls, Adolescent boys, Pregnant women
Haiti	Women, Adolescent Girls, Pregnant women
Bangladesh	Women, Adolescent girls, Pregnant women, Newlywed Couples, Lactating mothers
Georgia	Women, Men, Adolescent girls, Adolescent boys, Families/Households, Pregnant women
Sri Lanka	Women, Adolescent girls, Pregnant women
Philippines	Pregnant women, Lactating mothers
Lao PDR	Women, Adolescent girls, Families/Households, Pregnant women
Namibia	Women, Adolescent girls, Adolescent boys, Families/Households
India	Women, Adolescent girls, Pregnant women
Ghana	Women, Adolescent girls, Pregnant women
Rwanda	Women, Adolescent girls, Pregnant women
Myanmar	Women, Adolescent girls, Adolescent boys, Families/Households
Albania	Women, Families/Households
oPT	Women
Guatemala	Women
Ecuador	Women, Adolescent girls, Adolescent boys, Families/Households
Nicaragua	Women, Families/Households
El Salvador	Adolescent girls, adolescent boys
Mongolia	Families/Households
Pakistan	Women, Men, Pregnant women
Uganda	Women
Yemen	Women, Adolescent girls
China	Women of reproductive age, Elderly women
Peru	Women, Adolescent girls, Elderly women
Syria	Women
Tajikistan	Families/Households
Liberia	Women
Sudan	Women
Pacific Sub-Regional Office	Women, Families/Households, Pregnant women
West Africa Sub- Regional Office	Women of reproductive age

ANNEX XIII – KEY QUANTITATIVE DATA FROM THE GLOBAL SURVEY BY GEOGRAPHIC REGION

1. AFRICA

AFRICA						
	Central African Republic	Cote d'Ivoire	Ghana	Namibia	Rwanda	Uganda
Number of kits distributed	1000	3500	1495	3500	25	1000
Approximate cost per kit	24	600	11	20	90	9.5
Cost to UNFPA for storage			DK	DK		Not applicable
Cost to UNFPA for transportation	7000	DK	1000			900
Ranking of Cost Drivers						
Procurement	5	5	5	4		2
Storage	3	1	2	2		1
Transportation	4	1	2	2		1
Assembly	3	1	2	2		
Delivery	3	1	4	4		1

2. ARAB STATES

ARAB STATES				
	Opt	Syria	Yemen	Lebanon
Type of disaster	Conflict	Conflict		
Number of kits distributed	5000			
Approximate cost per kit	$32	$10	$17	
Cost to UNFPA for storage	n/a			
Cost to UNFPA for transportation	N/A			
Ranking of Cost Drivers				
Procurement	5			
Storage	4			
Transportation	3			
Assembly	2			
Delivery	1			

3. CENTRAL ASIA

CENTRAL ASIA				
	Kyrgyzstan	Georgia	Albania	Mongolia
Type of disaster	Conflict	Conflict	Floods	Floods
Number of kits distributed	800	Family: 11,000 Youth: 1800	6014	150

CENTRAL ASIA				
	Kyrgyzstan	Georgia	Albania	Mongolia
Approximate cost per kit	Type 1: $30 Type 2: $17	Family: $15.65 Youth: $12.45	Standard women's: $16.40	$26.16
Cost to UNFPA for storage	$700	99	n/a	99
Cost to UNFPA for transportation	$5,500	99	n/a	99
Ranking of Cost Drivers				
Procurement	4	2	n/a	5
Storage	2	1	n/a	1
Transportation	3	1	n/a	1
Assembly	1	1	n/a	1
Delivery	2	1	n/a	3

4. SOUTHEAST ASIA

SOUTHEAST ASIA					
	Pakistan	India	Sri Lanka	Nepal	Bangladesh
Type of disaster	Floods	Floods	Floods	Floods	Floods
Number of kits distributed	35000	7400	3250	399	2000
Approximate cost per kit	Type 1: $21 Type 2: $15 Type 3: $10	$9.98	$10.54	Women: $25 Male: $10 Pregnant: $10	$5.71
Cost to UNFPA for storage	n/a	n/a	n/a	No cost	99
Cost to UNFPA for transportation	n/a	$5,000	$19,200	No cost	$185.71
Ranking of Cost Drivers					
Procurement	n/a	4	5	5	5
Storage	n/a			1	2
Transportation	n/a		2	1	4
Assembly	n/a			1	3
Delivery	n/a		1	4	1

5. ASIA AND SOUTH PACIFIC

ASIA AND SOUTH PACIFIC						
	Indonesia	Pacific Sub-Regional Office	Phillipines	Lao PDR	Myanmar	Mongolia CO
Number of kits distributed	11330	6396	8178	10000		150

ASIA AND SOUTH PACIFIC						
	Indonesia	Pacific Sub-Regional Office	Phillipines	Lao PDR	Myanmar	Mongolia CO
Approximate cost per kit	13	14.6	18			26.16
Cost to UNFPA for storage	$7,000/year	n/a	98	n/a	n/a	99
Cost to UNFPA for transportation	depends on diaster	6,250	98	4000	n/a	99
Ranking of Cost Drivers						
Procurement	3	3	1	2		1
Storage	4	5	5	5		5
Transportation	2	1	3	1		1
Assembly	3	1	2	2		3
Delivery	3	2	4	4		1

6. LATIN AMERICA

LATIN AMERICA AND THE CARIBBEAN							
	Colombia	Ecuador	El Salvador	Guatemala	Haiti	Nicaragua	Peru
Number of kits distributed	7,147 (2010)	200(2009)	8,168 (2009)	5000 (2010)	100,000 (2010)	1,150 (2010)	
Approximate cost per kit	Standard kit ($25); Women's kit ($29)	$42	Women's kit ($3.85); family kit ($10.85)	$10	$30	$15	$89 (abrigo); $39 (higiene)
Cost to UNFPA for storage	N/A (no cost)	NR	N/A (no cost)	NR	$12,000	N/A (no cost)	
Cost to UNFPA for transportation	$7,000 (2010)	NR	$2,000	NR	N/A (no cost)	$400	
Ranking of Cost Drivers							
Procurement	3	2	2	5	5	2	
Storage	4	2	5	1	3	5	
Transportation	1	2	1	1	1	1	
Assembly	4	2	2	5	4	2	
Delivery	4	5	2	1	2	2	

ANNEX XIV – DECISION TREE FOR INTERNATIONAL OR LOCAL SUPPLY