Decentralized Evaluation of the UNFPA Country Programme for Egypt 2007-2011

Final Draft Report

January 2011

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<thead>
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<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AWP</td>
<td>Annual work plan</td>
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<td>BCC</td>
<td>Behavioral communications coordinator</td>
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<td>CCA</td>
<td>Common Country Assessment</td>
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<td>CO</td>
<td>Country Office</td>
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<td>CP</td>
<td>Country Program</td>
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<tr>
<td>CPAP</td>
<td>Country Program Action Plan</td>
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<tr>
<td>DAC</td>
<td>Development Assistance Committee (OECD)</td>
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<tr>
<td>EBPP</td>
<td>Evidence based population policy</td>
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<td>EFPA</td>
<td>Egyptian Family Planning Association</td>
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<tr>
<td>EMC</td>
<td>Evaluation Management Committee</td>
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<tr>
<td>FGC</td>
<td>Female genital cutting</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>FGM</td>
<td>Female genital mutilation</td>
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<td>FHI</td>
<td>Family Health International</td>
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<tr>
<td>FHM</td>
<td>Family health model</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<td>G</td>
<td>Gender</td>
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<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
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<tr>
<td>GME</td>
<td>Gender monitoring and evaluation</td>
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<tr>
<td>GOE</td>
<td>Government of Egypt</td>
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<td>GOTHI</td>
<td>General Organization of Teaching Hospitals</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>HSR</td>
<td>Health Sector Reform</td>
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<tr>
<td>ICPD</td>
<td>International Conference for Population and Development</td>
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<td>IDSC</td>
<td>Information and Decision Support Center</td>
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<td>IICPSR</td>
<td>Islamic Centre for Population Studies and Research</td>
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<tr>
<td>IP</td>
<td>Implementing Partner</td>
</tr>
<tr>
<td>MARPS</td>
<td>Most at risk populations</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MFP</td>
<td>Ministry of Family and Population</td>
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<tr>
<td>MLD</td>
<td>Ministry for Local Development</td>
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<tr>
<td>MOFP</td>
<td>Ministry of Family Planning</td>
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<tr>
<td>MOH</td>
<td>Egyptian Ministry of Health</td>
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<tr>
<td>MOR</td>
<td>Ministry of Religious Affairs</td>
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<tr>
<td>NCW</td>
<td>National Council for Women</td>
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<tr>
<td>NGO</td>
<td>Non government organization</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<tr>
<td>OJT</td>
<td>On the job training</td>
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<td>PC</td>
<td>Population Council</td>
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<td>PD</td>
<td>Population and Development</td>
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<td>PHC</td>
<td>Primary health care</td>
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<tr>
<td>PPS</td>
<td>Population policies and strategies</td>
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<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>RL</td>
<td>Religious leader</td>
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<tr>
<td>RR</td>
<td>Raedat Refyat</td>
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<tr>
<td>SH</td>
<td>Sexual Harassment</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>SOP</td>
<td>Standards of practice</td>
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<tr>
<td>THO</td>
<td>Organization of Teaching Hospitals</td>
</tr>
<tr>
<td>ToR</td>
<td>Terms of Reference</td>
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UNDAF  United Nations Development Assistance Framework  
UNICEF  United Nations Children’s Fund  
UNFPA  United Nations Population Fund  
VAW  Violence against women  
VCT  Voluntary Counseling and Testing for HIV infection  
YFC  Youth Friendly Clinics  

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Acknowledgements

This evaluation was undertaken by the UNFPA country office. We would like to thank the staff members of the UNFPA country office, particularly Ziad Rifai and Dawlat Shaarawy, for their assistance with this evaluation. We would also like to thank the members of the Evaluation Monitoring Committee (EMC), including Magdy Khaled, UNFPA, Roy Thompson, UNFPA, Hanan Girgis, IDSC, and Nevine El-Kabbage, UNICEF for their input into the evaluation methods. Finally, we would like to thank the Implementing partners for providing information about their projects and access to their staff, data and clients.

Note

The views expressed herein are those of the authors and do not necessarily reflect the views of the UNFPA Egypt country office management team.
Executive Summary

This project conducted an evaluation of the 8th UNFPA Country Programme for Egypt 2007-2011 in accordance with the Terms of Reference for the evaluation (UNFPA, 2010). The country program consists of projects reflecting three main themes: Population and development (PD), Reproductive Health (RH) and Gender (G). The evaluation was designed to answer 6 questions related to the country program goals. These questions and the associated results from the evaluation are discussed below.

The country program evaluation reviewed 11 projects related to the three program areas (PD, G, RH). The methodology for each project was developed using a desk review of project documents, consultation with the UNFPA staff of the Egypt Country Office and the Evaluation Management Committee (EMC) of UNFPA, as well as interviews with each of the implementing partners (IP). Geographic distribution of evaluation sites was considered so that sites in the Cairo area as well as upper and lower Egypt were included. Data were collected from focus groups, in depth and regular interviews. Service statistics were also analyzed for family planning utilization, youth clinic utilization and HIV testing.

The UNFPA Egypt Country Office works with a number of stakeholders and implementing partners including the Egyptian Ministry of Health (MOH), the Ministry of Family and Population (MFP), the General Organization of Teaching Hospitals (GOTHI), the National Council for Women (NCW), the Egyptian Center for Women’s Rights (ECWR), the Information and Decision Support Center (IDSC), the National Council for Childhood and Motherhood, the National Council for Human Rights, Family Health International (FHI), the Population Council (PC), and Azhar-IICPSR.

OECD/DAC criteria

The OECD/DAC criteria for development assistance include relevance, effectiveness, efficiency, impact and sustainability. The six questions that were the main focus of the evaluation relate mainly to effectiveness and impact of the country program and the results related to these factors are detailed below. All of the projects were relevant to the country program goals. Although most projects still need assistance, they should eventually develop sustainability because they are tied to government institutions as well as other stable Egyptian institutions such as Al Azhar. Further comments on sustainability are included below with the RH and Gender results. At the present time, the evaluation of sustainability is limited by the wide ranging political changes taking place in Egypt.

Findings

Reproductive Health

Family Planning Services

The first question for the evaluation related to the extent that the program intervention strengthened the family planning (FP) program within the MOH population sector to serve the family planning model. One project with the Ministry of Health as the implementing partner was reviewed for this question. Overall family planning services were of acceptable quality in the governorates of program intervention. However, work remains to be done with regard to integrating family planning with other services and improving the skills of providers. The team also investigated whether the use of FP services increased in areas of program intervention. Data from service statistics showed that utilization of family planning services did increase post intervention in the program governorates as compared to pre intervention.

HIV Testing

Question 2 was related to VCT services and asked if the capacity of health care providers was strengthened so that they could provide good quality health services. The training provided through UNFPA support did strengthen the capacity of health care providers to provide VCT services. Curricula, training materials, and IEC materials developed by FHI were efficient and useful. Work remains to be done in making providers more comfortable with HIV positive patients. At the central level, increasing the number of staff and strengthening their monitoring and evaluation skills is needed for a better program effectiveness. Services also need to be scaled up. Use of VCT services was low in most evaluated centers. An additional evaluation question, whether the target population for VCT services increased in governorates of program intervention, could not be answered due to data limitations.
Youth Friendly Clinics

The third RH evaluation area reviewed the development of youth friendly clinics (YFC). The evaluation focused on whether the YFC contributed to the sustainability and quality of RH services at the service delivery points. Two Implementing partners, the Egyptian Family Planning Association (EFP) and the Organization of Teaching Hospitals created Youth Friendly Clinics (YFC) in hospitals. The concept of YFC was new for the Egyptian population and continues to require promotion in communities. In general, the YFC concept was successful though utilization of the clinics was low, particularly in the teaching hospitals. The YFC clinics were valued by youth both for treatment and for information on reproductive health. There is high potential for the sustainability of these clinics.

Population and Development

The population and development evaluation question considered the extent to which gender analysis/disaggregated indicators were developed and used in policy dialogue and in gender program evaluation. Two projects were evaluated in this area, the first project was Gender Monitoring and Evaluation, implemented by NCW. This project was concerned with monitoring and evaluation of the National Gender Plan. The project performed exceptionally well and its impact is clearly seen in terms of ministerial decrees issued to force the implementation of gender projects as well as the unified standardized system for monitoring that has been adopted nationally. The second project focused on improving accessibility of population statistics and it is implemented by (IDSC). The project performed well and it has improved the quality of available data sources for better accessibility. The project needs to change focus and it has good capacity to contribute more in the area of capacity building related to improving the quality of data nationally.

Gender

Adolescent Health Education

The first question related to gender concerned an adolescent health project that aimed to build the capacity of adolescent beneficiaries as advocates for sexual and reproductive health and gender equity among their peers, especially vulnerable adolescents. This MOFP project established peer education projects in multiple governorates in Egypt. Further evaluation is needed to determine the efficacy of the projects in educating adolescents in RH.

Gender Based Violence

The second question related to gender asked if the strategies and activities designed to influence religious leaders and communities have been implemented successfully and are they likely to positively influence religious leaders/beneficiaries and media personnel knowledge and attitudes toward women and girls especially gender based violence (GBV). A first project, conducted by Al Azhar created a reference guide and training manual and implemented a training program for religious leaders on GBV. Although in its early stages, the program points to producing some attitudinal change in religious leaders that may lead to reduced GBV. RL who participated in the program reported that the training was useful to their work in communities and they requested more evidence based training.

A second project, conducted by ECWR, created a media package and other activities focused on assisting media personnel in being advocates for reducing sexual harassment of women. The media personnel interviewed for the evaluation found that the resources that were provided were very useful in reporting about sexual harassment. Learning more about the consequences of SH through the program motivated them to include material about SH in their writing and programming.
Summary of Recommendations for Cycle 9

Reproductive Health

The cycle 8 country outcomes and outputs related to reproductive health should be retained. Recommendations for developing the programming for these outcomes are detailed below.

1. Cycle 8 Outcomes

a. Family planning is a national priority and UNFPA must continue work in this area. Linking FP with other RH and FP services should come first. No further work is needed to strengthen FP since this has already been done, instead foster integration of services. Make all departments under primary care sit together and think about how to make integration work. MOH actors need to agree on common goals. Specific program foci should include targeting missed opportunities, FP discontinuation, management of side effects, and improving providers' counseling skills.

b. Scaling up VCT clinics and upgrading already established ones is a priority. Increasing the number of capable NAP staff is needed and training new VCT staff through establishing an OJT mechanism to work with the turnover challenge. Linking VCT with STIs should strengthen VCT services. In Sharm EL Sheikh clinic they have both services in the clinic; if this was the cause of increase in cases, then this might be tackling two points, first reducing the HIV stigma as clinics are offering other services and at the same time helping people clients with integrated services meet their needs. Actually this will require a very large budget for capacity building and securing human and financial resources but should be beneficial.

c. Adolescent and Young Adult Reproductive Health. The YFC concept worked to some extent and should be continued. Services in FP and RH are needed for youth. The information area is mandatory in such clinics as it attracts youth where we can support them with the required information. Having both in the same place hits two important targets. It is important though to increase the clinics working under EFPA since they have a better structure and to strengthen THO structure and clinics till they reach the required level. Further recommendations for supporting the reproductive health education for adolescents are discussed under gender.

d. Work with communities to reach vulnerable groups. UNFPA has worked with the MOH on its Family Planning and HIV projects and with the Egyptian Family Planning Association and Teaching hospitals in the three main RH projects that were reviewed. Through the peer education program, reviewed as a gender project, and the associated Y-Peer program they have also worked on RH issues with youth in communities. In terms of addressing population groups, UNFPA has addressed youth, women in reproductive age, and MARPS, but did not focus on men in the reviewed RH projects.

Further consideration should also be given to more involvement with communities. UNFPA through strengthening FP within Health Sector Reform is tackling increased utilization which affects the CPR and reduces fertility but a community component addressing RH issues among youth including males and females might be of significant value in the future. Addressing men at the community level will be crucial in the next decade. In Egypt women are already involved in several empowerment activities and they also visit health clinics to obtain services. Additional activities in the community targeting youth, men, and women in reproductive age as well will complement other UNFPA interventions at the service level. Note that they should be working in same communities though in different projects. This would increase the coherence within UNFPA.

2. Cycle 9 Outcomes

a) Maternal Mortality. A new outcome related to maternal mortality should be considered. The outcome would aim to reduce maternal mortality though strengthening the maternal mortality surveillance system. This will assist in locating areas where the need for additional prenatal care and obstetric services are needed.

b) Integrated Services. A new outcome would also move toward creating integrated FP/RH/MCH services by adding outcomes related to child growth and development. This might be done in collaboration with UNICEF and other related agencies.
Population and Development

The Cycle 8 outcomes and outputs should be retained. Recommendations for programming for these outputs are as follows:

Egypt has well established institutions that are working in the area of population related research and policy development. Among others there are Information Decision Support Center IDSC, the Central Agency for Public Mobilization And Statistics CAPMAS, which is responsible for the Census, the National Population Council (research wing of MoHP), the Cairo Demographic Center (research wing of CAPMAS), the Institute of National Planning (research wing of the Ministry of Planning), the National Council on Population and Development (NCPD) and the Population Council, in addition to range of other university’ research centers, UN agencies and NGOs. Most of these institutions are working in line with UNFPA mandate and most of them have been supported by the UNFPA at one time.

There is no shortage of institutions that are capable of producing high quality research in Egypt. Therefore, supporting activities related to publication of more research should not be a priority for the next cycle. However, support for new specialized surveys like SYP targeting Female Headed Households should continue. A survey on the welfare of the elderly in Egypt should also be considered.

There is huge need in the area of coordination between different actors in the area of population related information management and dissemination. There is decent volume of research going on and it is done by various bodies. However, it is not working with a unified plan and not using standardized methods. Supporting the creation of a national plan related to organizing the regulatory environment in the areas of social research ethics, data protection, privacy and dissemination should be a priority for next cycle. This includes institutionalization of a data management framework as well as capacity building for all government departments responsible for data collection.

Gender

The Cycle 8 outcomes and outputs should be retained. Recommendations for programming for these outputs are as follows:

Adolescent Reproductive Health Education.

Peer education has been a useful strategy for the health education of adolescents in many settings. The present cycle included a peer education project for providing RH education to male and female youth. The evaluation of this project raised some questions about current implementation of the project in some governorates and the need to evaluate the best way to implement these activities. It is not clear whether a true “peer education” program was running in some governorates and whether or not variations in the implemented programs enhanced or weakened the delivery of health messages. Further evaluation of this program is needed including surveys to assess the learning of the participating adolescents.

The UNFPA in thinking the way forward for Adolescent Reproductive Health Education should consider ways in which to conduct its activities within the mainstream activities of the MOE. The UNFPA can support the MOFP to suggest and advocate for the below strategies and activities to be conducted by the MOE.

It is also important that out of school adolescents be targeted. It is time that this project moved on to target these out-of-school adolescents by mainstreaming adolescent reproductive health education within the MOFP.

Gender Based Violence

The evaluations of the Al Azhar project on training of religious leaders showed that it has some potential to change the attitudes of RL and providing them with better communication skills. This program should be continued with the changes noted in the evaluation above including developing a stronger more evidence based training program.

It is worthwhile for UNFPA to direct some of its activities with NCW and IDSC to strengthen the routine documentation of GBV such as beating wives, sexual harassment etc. in health facilities and thus in MOH statistics as well as in police records, thus institutionalizing monitoring and measuring GBV and its causes. Preachers as well get in contact with these incidents as these sometimes show up in discussions of divorce or when reporting of mistreatment incidents for consultation.
The IIICPR and ECWR should work together on developing a sexual harassment curriculum in the RL guide. The ECWR can also develop kits for distribution to RL. As ECWR is headed by an activist lawyer, UNFPA can assist in getting ECWR involved in strengthening its wife beating training. The ECWR can also provide the personal status laws, which were requested by RL. After IICPSR efforts to sensitize preachers to combat wife beating are well underway, the ECWR could start another campaign against wife beating as well as review its available laws.

Create advocacy groups among preachers who would like to combat various forms of GBV at grass root level and link them with other stakeholders having similar activities e.g. NGOs, the MOH, MOFP, and NCW. Create alliances between trained preachers and MOH primary and secondary health care physicians as they are the two essential pillars for combating FGC at community level.

This project involved only the Islamic religious leaders. However, there is anecdotal evidence that Christian women as well suffer from various forms of GBV, the underlying causes of which may differ greatly from those for Moslem women. The UNFPA would do well to consider working with the Egyptian Church on a similar project addressing all population, RH and gender issues, especially GBV from a Christian perspective.

The evaluation on the use of media to combat gender based results showed that sensitizing media personnel can be an effective way to bring sexual harassment (SH) out into the open and increase understanding of its causes and harmful effects. The IEC materials developed in the SH project should also be emphasized in the adolescent peer education program and the information centers in the Youth Friendly clinics. These materials are also important for the RL training. Further advocacy is needed to enact laws against SH. Work with media personnel should be continued and monitoring of SH is needed in police records.

**Overall Summary**

We have summarized the most important recommendations for Cycle 9. An important overall goal for the next cycle should also be to develop an integrated M&E system within UNFPA to measure progress toward these goals. Monitoring indicators and project evaluations should be conducted and reported to UNFPA at regular intervals.

The UNFPA has accumulated a lot of experience on RH issues including family planning, reducing the TFR and reducing maternal mortality, developing a database for population policy and planning and gender based violence. All of these experiences should be documented and used in South to South collaboration on these issues. This is particularly important because USAID is now playing a smaller role in these areas.
1. Introduction

This project conducted an evaluation of the UNFPA Country Programme for Egypt 2007-2011 in accordance with the Terms of Reference for the evaluation (UNFPA, 2010). The fundamental objectives of the program were to advance human development, fight poverty and inequality, including the fight against HIV/AIDS and gender inequality. The country program consists of projects reflecting three main themes: Population and development (PD), Reproductive Health (RH) and Gender (G). The current country programme is the 8th. It is based on the Common Country Assessment (CCA) and aligned with the United Nations Development Assistance Framework (UNDAF) outcomes. Among the five identified outcomes to be achieved by 2011, UNFPA will contribute to three: (A) Improved performance and accountability of the Government in programming, implementing and coordinating actions, especially those that reduce exclusion, vulnerabilities and gender disparities, (C) Reduced regional human development disparities, including a reduction in the gender gap and the promotion of environmental sustainability, (D) Increased women’s participation in the workforce, political sphere and in public life and the fulfillment of their human rights.

1.1 Purpose of the evaluation

The purpose of the evaluation was to conduct an end of country program cycle evaluation to ensure substantive accountability of the investments made and to provide a basis for learning in order to improve the relevance and quality of future actions. The scope of the evaluation covers the ongoing country program cycle that began in 2007. The evaluation covered 11 projects that include the three technical areas (PD, RH & G). The output criteria broadly follow OECD/DAC guidance, namely relevance, effectiveness, efficiency, impact, sustainability, and management systems. In order to extract lessons learned and best practices, the evaluation scope covered overall program design, delivery, performance, alternative strategies, and the application of the rights based approach and mainstreaming in gender in development efforts. Using a mixed methods approach, the evaluation will assist the UNFPA country office in developing effective programming for the next cycle.

The UNFPA Egypt Country Office works with a number of stakeholders and implementing partners including the Egyptian Ministry of Health (MOH), the Ministry of Family and Population (MFP), the General Organization of Teaching Hospitals (GOTHI), the National Center for Women (NCW), the Egyptian Center for Women’s Rights (ECWR), the Information and Decision Support Center (IDSC), the National Council for Childhood and Motherhood, the National Council for Human Rights, Family Health International (FHI), the Population Council (PC), and Azhar-IICPSR.

1.2 8th Country Programme Outcomes and Outputs.

The 8th Country Programme has six outcomes, two each for the different areas (PDS, RH and Gender) and seven corresponding outputs.

Reproductive Health (RH)

Outcome (3): The sustainability and quality of reproductive health services at the national level and at service delivery points are improved.

Output (1): Capacity of the Government and non-governmental health organizations is strengthened in management, planning and monitoring.

Output (2): Capacity of health care providers is strengthened to provide high-quality reproductive health services, including voluntary counseling and testing and youth-friendly services, especially to vulnerable groups.

Outcome (4): The utilization of integrated reproductive health services is increased in Upper Egypt with a focus on underprivileged communities in rural areas.

Output (1): Primary and reproductive health care services strengthened within the framework of the Health Sector Reform.

Population and Development (PD)


Output (1): Multi-sectoral population policies and strategies revised to address poverty reduction, HIV prevention, youth RH and needs of vulnerable groups.
Outcome (2): Poverty reduction strategies are monitored to ensure progress and the integration of a gender perspective.
Output (1): Gender analysis and gender disaggregated indicators developed and used in policy dialogue.

**Gender (G)**
Outcome (5): Girls' and women’s rights to access information and services progressively fulfilled.
Output (1): Increased effective advocacy strategies in promoting sexual and reproductive health and gender equity, addressing men, women and youth.
Outcome (6): Incidence of all forms of violence against women is reduced.
Output (1): Community, religious leaders and media sensitized through active alliances to combat gender-based violence.

### 1.3 Evaluative Questions

Given these outcomes and outputs, the UNFPA country office identified six evaluation questions as the most important focal points for evaluation. These questions are:

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<th>Area</th>
<th>No.</th>
<th>Question</th>
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<tbody>
<tr>
<td>Reproductive Health</td>
<td>1a)</td>
<td>Did the program intervention strengthen the family planning (FP) program within the MOH population sector to serve the family health model?</td>
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<td></td>
<td>1b)</td>
<td>Did the utilization of FP services increase in governorates of program intervention?</td>
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<tr>
<td></td>
<td>2a)</td>
<td>Did the capacity of health care providers strengthen and provide quality VCT services as a result of program intervention?</td>
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<td></td>
<td>2b)</td>
<td>Did the target population use of VCT services increase in governorates of program implementation?</td>
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<td></td>
<td>3)</td>
<td>To what extent did the Youth Friendly Clinics (YFC) projects contribute to the sustainability and quality of RH services at the service delivery points?</td>
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<tr>
<td>Population &amp; Development</td>
<td>4)</td>
<td>How many gender analysis/disaggregated indicators developed and used in policy dialogue and in gender program implementation?</td>
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<tr>
<td>Gender</td>
<td>5a)</td>
<td>Is the UNFPA/MOFP Adolescent Health project successfully building the capacity of adolescent beneficiaries as advocators for sexual and reproductive health and gender equity among their peers, especially vulnerable adolescents?</td>
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<td></td>
<td>5b)</td>
<td>Have UNFPA/Egypt CP 2007-2011 strategies and activities to sensitize religious leaders and communities they serve been implemented successfully and are they likely to positively influence religious leaders/beneficiaries and media personnel knowledge and attitudes toward women and girls especially gender based violence (GBV)?</td>
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<tr>
<td>Over-arching</td>
<td>6)</td>
<td>On the basis of findings from questions 1-5, how can country program assistance be repositioned for enhanced impact?</td>
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### 1.4 Design and Coverage

**Reproductive Health**

Reproductive Health component of the CP is the biggest component where more than 50% of the CP total budget is allocated. There are six implementing partners for the RH component: the Ministry of Health (MOH), Family Health International (FHI), the Organization of Teaching Hospitals (GOTHI), the Egyptian Family Planning Association (EFPA), and Al Shihab. The MOH with its two sections (population/family planning and preventive) is the biggest partner spending almost 50% of the total budget of the RH. UNFPA RH projects are set to support health related services implemented by the government and NGOs.

To answer the above mentioned evaluation questions the following projects have been evaluated.
### Table 1: Summary of Reproductive Health (RH) projects

<table>
<thead>
<tr>
<th>ID</th>
<th>Project Name</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>EGY08P02</td>
<td>Strengthening Supply, Demand &amp; Utilization of Reproductive Health Care Services within the context of Health Sector Reform</td>
<td>Improving FP coordination within MOH, updating FP standards of practice and guidelines, implementing a comprehensive training package for service providers.</td>
</tr>
<tr>
<td>EGY08P03</td>
<td>Support to NAP for Voluntary Counseling &amp; Testing Services(VCT)</td>
<td>Developing VCT services in several locations</td>
</tr>
<tr>
<td>EGY8R44A</td>
<td>Support to VCT by FHI</td>
<td>Providing training in VCT counseling and testing</td>
</tr>
<tr>
<td>EGY08/P10</td>
<td>Adolescents RH Needs in Egypt</td>
<td>Establish Youth Friendly Clinics (YFC)</td>
</tr>
<tr>
<td>EGY8R51A</td>
<td>Support to YFC by FHI with EFPA and THO</td>
<td>Assistance with training in YFC</td>
</tr>
<tr>
<td>EGY08R54A</td>
<td>Support to Teaching Hospitals - Youth Friendly Services</td>
<td>Establish YFC in teaching hospitals</td>
</tr>
</tbody>
</table>

### Population & Development

The population and development PD component of the CP is the second largest after the RH. 25% of the total budget of CP is allocated to PD. There are four implementing partners: National Council for Women NCW, Information Decision Centre/IDSC, Ministry of Family & Population MFP and the Population Council. The NCW and IDSC are sharing the biggest percentage of the total budget (about 40% each). It worth mentioning that PD is the only component that has a national geographical coverage in almost all of its projects.

The nature of PD programs is different from RH because it is concerned with changing policies and availability of information for decision making. In addition, its activities have more to do with training personnel and liaising tasks between government departments as well as ensuring that the government is committed to conducting specialized surveys for proper planning and ensuring that gender is given appropriate attention in government policies and documents.

Broadly PD projects can be divided in to two sections including 1) projects that raise the capacity of counterpart’s staff and 2) projects that build a concrete base of information systems. The following table shows the details of each project and its main activities.

### Table 2: Summary of PD Projects

<table>
<thead>
<tr>
<th>ID</th>
<th>Project Name</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>EGY8P31A</td>
<td>Evidence Based Population Policies</td>
<td>Educate university students on PD issues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Media workshops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Train to monitor population program at governorate level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Train local planners on gender indicators</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Train to communicate information &amp; data accurately</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop training materials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Update PD database</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Produce annual population report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Update estimation of fertility levels</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Produce PD papers</td>
</tr>
<tr>
<td>EGY08P05</td>
<td>Gender M&amp;E</td>
<td>Train governorate planning personnel on PBB, GB &amp; M&amp;E</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Print reports/ advocacy materials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess gender plan process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Produce Gender Equality Index data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitate &amp; monitor gender plans implementation</td>
</tr>
</tbody>
</table>
Gender

The Gender component is smallest compared to the RH and PD. About 23% of the total CP budget is allocated to its projects. There are four implementing partners: National Ministry of Family and Population (MOFP) (33%), Population Sector/MOH (15%), National Council for Human Rights (NCHR) (9%), Azhar – IICPSR and Egyptian Centre for Women Rights (9%). In addition, 18% of the budget is allocated to FGM projects not reviewed here.

Three gender projects fall under this evaluation. The first project supported a peer education training program related to general and reproductive health. The second project developed a training manual and a training program for religious leaders (RL) regarding gender based violence (GBV). The third program created a guide for media to advocate against sexual harassment.

Table 3: Summary of Gender projects

<table>
<thead>
<tr>
<th>ID</th>
<th>Project Name</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>EGY08P08</td>
<td>Adolescent Health Program</td>
<td>Conducts peer education training programs for general and reproductive health</td>
</tr>
<tr>
<td>EGY8G27B</td>
<td>Reproductive Rights and Gender in the Context of Islam</td>
<td>Create a reference guide and training program for RL to advocate against gender based violence</td>
</tr>
<tr>
<td>EGY8G47A</td>
<td>Campaign against sexual Harassment</td>
<td>Create a guide for media and promote activities to advocate against sexual harassment</td>
</tr>
</tbody>
</table>

1.5 Evaluation Methodology

Each question was evaluated taking many aspects into account including design, resource allocation, timing and the impact of all these on the ability of the projects in achieving required outputs. Through evaluating activities the impact of the interventions were assessed and their contribution to achievement of desired outcomes. The methodology and sampling scheme are summarized in each project.

The methodology for each project was developed using a desk review of project documents, consultation with the UNFPA staff of the Egypt Country Office and the Evaluation Management Committee (EMC) of UNFPA, as well as interviews with each of the implementing partners (IP).

Sampling

Some UNFPA projects cover all governorates while others are limited to selected governorates or only Cairo. For the evaluation, a random purposeful sampling scheme was developed that focused on including projects that were important for the purpose of the evaluation. Geographic distribution was considered so that sites in the Cairo area as well as upper and Lower Egypt were included.

Data Collection

Data were collected from focus groups, in depth and regular interviews. Service statistics were also analyzed for family planning utilization, youth clinic utilization and HIV testing. Data collectors were trained by the consultants in field procedures, consent, interviewing techniques, and research ethics. Statistical procedures varied depending on the output required. Histograms and line graphs were used to show the progress and the impact of the interventions. Qualitative data, the core of this evaluation, gives an understanding of challenges facing projects and the reasons for success and more importantly the future prospects of these projects.

1.6 Confidentiality and Privacy Issues

The evaluation was conducted with consideration for the rights of the participants. All leaders in the implementing partners were included in interviews. Other participants including religious leaders, physicians, nurses, peers, clients and other
persons participated in interviews with their consent and their names were not included in any evaluation documents. Names were destroyed after analysis.

1.7 Evaluation team

Kathleen Ford, Project Leader was responsible for the overall scientific direction and management of the evaluation. Hala Youssef designed and conducted the evaluation of the reproductive health projects. Samar Gala designed and conducted the evaluation of the population and development projects and was responsible for data management and statistical analysis. Mahinez El-Helw designed and conducted the evaluation of the gender projects.

The evaluation team received support from the UNFPA Country Office in Cairo Country Representative Ziad Rifai PhD and Program Associate Dawlat Shaarawy. They were also supported by the UNFPA Evaluation Management Committee (EMC) including 'Magdy Khaled, UNFPA, Roy Thompson, UNFPA, Hanan Girgis, IDSC, and Nevine El-Kabbage, UNICEF.

1.8 Structure of the evaluation report

The evaluation report is built around the main evaluative questions. The questions cover three program areas: Reproductive Health (RH), Population and Development (PD), and Gender (G). Methods, results, conclusions, lessons learned and recommendations are presented for each question. Detailed results for each question are shown in Annexes 7-10.

2. Overall assessment

Relevance
The UNFPA mandate is working in line with ICDP, ICPD+5, MDGs and overall UNDAF goals and objectives. Furthermore, the GoE priorities and needs are the prime driving force for all UNFPA initiatives. However, working hard to match all the above mentioned mandates sometimes leads to overloading outcomes and outputs. Although this is not affecting the operational side of projects, in many times it gives a sense of under achievement and the volume of real impact is not fully reflected.

Effectiveness
Interventions could be described as effective when they reach and achieve its expected goals. Generally, there is a fine line between problems related to structural problems within government systems and flaws in projects’ design. For example, in the EBPP project the main goal is to make available data accessible and generate publications to influence policymakers.

The project has achieved its targets and a database has been created in a very high standard. However, obtaining data from some government departments, and quality of data remain as unresolved issue that made the intervention appear less effective.

On the other hand, UNFPA has supported FP and VCT services and the support has given tangible results and capacity of health personnel has been raised significantly and service users were satisfied. However, the overall utilization of the services has remained low as a result of inadequacy of promotional campaigns and other management issues related to government health system (cultural issues also contributed). Similar situation faced the Adolescent health project (more details in below sections). Broadly, there is some lack of effectiveness in some projects related to reproductive health and this is not entirely as a result of deficiency in projects’ design on the side of the UNFPA. However, more consideration should be made to ensure that projects are designed in a more holistic approach where gaps are filled by other credible partners.

Efficiency
Looking into efficiency is not in the scope of this evaluation as the evaluation is conducted before the end of the cycle and most projects has not spent all the allocated budgets yet.

Sustainability
The strategic choice of UNFPA to work with the government and enhancing existing systems, made the interventions have better potential for sustainability. However, sticking to this choice and adherence to its principles is adversely affecting the efficiency and the effectiveness of many projects. This is always a challenge and a compromise need to be made between
level of efficiency/ effectiveness and long term sustainability. A good example is the GME project; the project is fully funded by the UNFPA and situated in the NCW premises. The project managed to attract highly qualified staff and has its own autonomy which facilitated its work and helped to escape government bureaucracy. Although the political will enhanced the impact of the project, the activities performed at a national level and in very high quality. The project has managed to achieve one major sustainable result, the institutionalization of M&E system for the implementation of the GNP. Based on that, having some activities (or a major activity within some projects) that are fully funded by UNFPA is likely to enhance the sustainability of the whole project.

Regarding the RH context, the government commitment to the overall ICPD goals and the agreement with UNFPA is a strong base for sustainability. A well established infrastructure for RH services with good capacity is already in place. However, ensuring sustainability of quality services needs more effort and continuous support. This is more relevant in the case of YFC. More support is needed especially for the ones attached to THO as they struggle to attract youth and face major problems in terms of management and finance. Furthermore, a focus on supporting activities aimed at coordinating efforts between all stakeholders in the health sector will ensure long term sustainability.

Impact
UNFPA supported activities had a measurable impact on target populations and this is clearly described in the following sections of this report. However, the impact of these projects could not be supported by statistics in many activities. This is due to two major factors. First, the nature of some projects (i.e. activities related to behavior change in gender related projects and in some PD projects). Secondly, the lack of baseline data in most projects evaluated. There is a missed opportunity for capturing the real impact of interventions by not completing base line surveys before the start of most projects. Moreover, the internal UNFPA M&E system is not designed to capture timely progress in most activities. In addition, some programs’ indicators focus on activities rather than outcomes. On the other hand, some activities would have a bigger impact if were connected to other related smaller activities. For example, regular promotional campaign could have enhanced the YFC and VCT impact. More details about the impact of each intervention and the gender projects is described in the below sections.

3. Findings, Conclusions and Lessons Learned.

A. Reproductive Health

Introduction
The reproductive health program addresses the following Country Program outcomes:

Country Program Outcome 3: Sustainability and quality of reproductive health services at national level and at service delivery points improved.
Country Program Outcome 4: Utilization of integrated reproductive health services increased in Upper Egypt and with special focus on underprivileged communities in rural areas.

For the above listed projects, the UNFPA country office has identified 3 evaluation questions as the most important focal points for evaluation. These questions are:

Question 1
1a) Did the program intervention strengthen the family planning (FP) program within the MOH population sector to serve the family health model?
1b) Did the utilization of FP services increase in governorates of program intervention?

Question 2
2a) Did the capacity of health care providers strengthen and provide quality VCT services as a result of program intervention?
2b) Did the target population use of VCT services increase in governorates of program implementation?

Question 3
3) To what extent did the Youth Friendly Clinics (YFC) projects contribute to the sustainability and quality of RH services at the service delivery points?

Projects evaluated under this section cover 6 projects under the Reproductive Health (RH) component as follows:
1. Project RH EGY08P02: Strengthening Supply, Demand & Utilization of Reproductive Health Care Services within the context of Health Sector Reform
2. Project RH EGY08P03: Support to Voluntary Counseling & Testing Services
3. Project RH EGY08R44A: Support to VCT by FHI
4. Project RH EGY/08/P10: Adolescents RH Needs in Egypt
5. Project RH EGY/08R51A: Support to YFC by FHI
6. Project RH EGY08R54A: Teaching Hospitals - Youth Friendly Services

**Evaluation Methods**

*Design and tools*
The evaluation methodology consisted of a qualitative and a quantitative component. The qualitative component included desk reviews of project documents, annual work plans and analyzing data used from a variety of project reports, extensive interviews with IPs, UNFPA program officers, and providers and beneficiaries at service delivery points. Focus group discussions were also utilized to collect information from beneficiaries at service delivery outlets. Different interview guides were used for each category to ensure that standardized set of discussion points were tackled at each of the visited sites. Discussion points tackled two major issues including 1) services provided and 2) assessment of training and curricula. The quantitative component included service statistics and is described below under data collection.

*Sample*
Mapping of sites was conducted and random selection of sites was followed with upper/lower Egypt consideration. Sites covered for the evaluation included Alexandria, Menoufia, Ismailia governorates from Lower Egypt and Menya, Sohag, and Luxor governorates from Upper Egypt in addition to Sharm El-Sheikh governorate as an example of a Frontiers governorate.

*Data management*
For the qualitative data, the RH evaluator conducted interviews with IPs and UNFPA program officers whilst three skilled data collectors were hired to conduct in-depth interviews and focus group discussions at service delivery points. In one day training, data collectors were trained on the use of the interview guides. A schedule for the activity was developed, circulated to stakeholders and approved. Data collection was completed for all sites over a 7 day period. All interviews and FGDs were audio taped and transcribed. Stakeholders were in direct connection with data collectors for organizational matters and addressing any problems and delays. Oral consent was obtained from persons involved in interviews.

The quantitative part of data collection aimed at measuring changes in service utilization after UNFPA project interventions. Pre-post intervention service statistics were collected over three months from all RH evaluated projects. The quantitative data were analyzed by the evaluation team statistical consultant. Results were then discussed with IPs for validating the interpretation of findings.

*Obstacles*
Data pertaining to service statistics was obtained from all selected sites except for the most at risk population (MARPS) from VCT clinics. Project management thought that due to privacy issues, disclosure of such data was inappropriate. This affected the analysis of question 2b addressing the utilization of VCT centers by the target group.

**Results**

### 3.1 Evaluative Question 1a:

**Did the program intervention strengthen the family planning (FP) program within the MOH population sector to serve the family health model?**

To evaluate the two-subs under question 1, the RH project ID: EGY08P02 titled Strengthening Supply; Demand & Utilization of Reproductive Health Care Services within the context of Health Sector Reform was evaluated.

**Project description**
The project worked with the objective of strengthening Primary and Reproductive Health Care services within the frame work of the Health Sector Reform. Actual activities of the project started in 2008 and included coordination efforts among actors on FP services (Population sector and HSR), updating FP standards of practice and guidelines, and implementing a comprehensive training package for service providers. The above activities, piloted in three governorates; Qena, Sohag, and Alexandria, support the main target of improved quality of family planning services in Egypt. The project also addressed the need for enhancing a supportive supervision system empowered by the development of a clinical audit system.

Evaluation methods

Qualitative assessment was conducted to collect data through in-depth interviews and focus group discussions. From intervention sites, Sohag and Alexandria governorates were included representing 2 of the 3 pilot governorates with equal representation of Upper and Lower Egypt. From each governorate one district was randomly selected under which one or two PHCs were randomly selected to interview their providers.

In-depth interviews were conducted with the following project managers:
Dr. Magdy Khaled, UNFPA assistant representative who oversees all RH projects.
Dr. Atef El-Shitany, the MOH project director
Dr. Mohamed Helaly, the MOH project officer

To collect information about quality services provided, training outcomes and future needs, interviews were conducted with 2 district directors, 4 physicians, 4 nurses, 4 Raedat Refyat (RR), and 1 trainer.
To collect information about client’s satisfaction of services and understand their needs, two focus groups were conducted with FP clients, one from each governorate.

Findings. Detailed findings from this question are shown in Annex 8.

Conclusions

RH1. Integration of services. The process of strengthening the family planning (FP) program within the MOH population sector to serve the family health model has just started as evidenced by the extensive coordination efforts between FP sector and HSR, development of FP standards of practice, and training conducted. The FP program became a vertical program. Though project managers believed that was necessary to re-position FP within the HSR, yet this might result in the FP program going back to its previous independent status. Research, FP service needs, and clients’ needs in different communities were always in favor of integration of FP services with other reproductive health services. Since the challenge in FP services lies within addressing unmet need among clients (40% of FP clients), then integration of services would help to catch missed opportunities and help to decrease this unmet needs percentage. This vertical program should not continue because it might negatively affect the acceptability of FP services in communities. The policy of integration needs strengthening at the central level.

RH2. Supervision, assessment and auditing. The supervisory system is still missing a good management component and providers and supervisors requested management training. On the ground level, supervision combined with the implementation of a structured OJT plan was still missing. The absence of self assessment tools did not allow for the start of continuous service quality improvement. Again, vertical supervision would waste efforts and time of both clinic providers and supervisors. Clinic providers were to be visited several times under a vertical supervision system without having the time to focus on defects in providers’ knowledge and practices. On a related note, a clinical audit system required for service quality improvement has not been implemented. There is a need for management training and monitoring of its effectiveness to better improve the functioning of the clinics.

RH3. Gaps in knowledge of providers. FP counseling on methods side effects service and how to deal with them to decrease discontinuation rates was lacking in FP services. Also, insufficient knowledge about LAM criteria to avoid unwanted pregnancy postpartum was evident among some interviewed providers.

RH4. Monitoring and Evaluation. Some activities, including the sentinel system, were not linked to each other or were not in the initial project document. The sentinel system is an important monitoring and evaluation tool and it should have been included from the start. Moreover, measurable monitoring and evaluation indicators are not clearly planned for in the project.
RH5. MOH Priorities. Priorities inside MOH may impede or affect the progress and completion of project activities, the fact that needs to be given consideration in developing annual work plans to avoid delays in activities.

3.2 Evaluative Question 1b.

Did the utilization of FP services increase in governorates of program intervention?

To assess the utilization of family planning, service statistics over a three month period pre-intervention were compared to the same period post-intervention for new and recurrent FP clients in the three intervention governorates.

Findings

As shown in Figure 1, there was an increase in both new and recurrent FP clients in all governorates except in Qena governorate where the new FP clients’ caseload has decreased. Project managers explained that in Qena governorate, there was always a shortage in/absence of female physicians who are much demanded among Upper Egypt communities and this affected the utilization of services. On the other hand, an exceptional increase in caseload was encountered among new users in Alexandria clinics. This was explained by the fact that in Alexandria, district teams are stronger, open minded, and motivated. Also, female physicians are in abundance there, a factor that made the clinics more acceptable to women. In addition, the baseline number of clients in the Alexandria clinics was affected by the dilution of FP within the FHM. When FP services were strengthened, the caseload increased substantially.

Conclusions

RH6. Interventions conducted did improve the utilization of services despite the drop encountered in some areas due to the shortage of female physicians.

Lessons learned

- Integration and strengthening of FP services within FHM does not come from peripheral implementation of activities but necessitates policy formulation at the central level.
- Investment with MOH resources in the development of manuals and protocols, trainings, and sentinel system without external consultants has proved to be cost effective from the project’s managers within MOH.
- Decentralization of activities and efforts with district teams and their capacity building helped MOH central policy makers achieve better results at the peripheral level.
- Counseling skills on method side-effects and other related issues need repeated refresher training
- OJT helps fill the gaps after classroom trainings. Assessment tools are needed to monitor progress
- MOH priorities must be considered when developing goals.
- Results oriented management of projects and the development of an initial project monitoring plan is crucial to monitor and evaluate project results and achievements.
- FP utilization increases when more female physicians are available.
- Use of FP services increases when they are strengthened
Figure 1: Pre/Post Intervention FP services Utilization in MoH Clinics

Recommendations

- Work on the policy formulation process at the central level to institutionalize integration of services
- Create and produce a manual that describes a clear process for updating of manuals, SOP, and training curricula
- Arrange for training on ultrasound use
- Scale up of the intervention in clinics nationwide
- Develop a project monitoring and evaluation plan with measurable indicators before the start of the project
- Ensure effective implementation of the Clinical Audit System with its required tools and manuals and its scale-up. The manual should be completed, tested, and then continue its implementation in pilot governorates to be scaled up later.
- Put into action a structured OJT system that focuses on counseling skills among providers especially on management of FP method side effects
- Encourage providers to use self assessment tools and monitor their performance
- Give more attention to Integrated Reproductive health messages in community activities to ensure sustainability of knowledge sharing, acceptability and use of FP methods in target communities. There is a need to more involvement from community NGOs and CDAs.
- Create a budget line for development and printing of IEC materials.

Table 4: Overall answer to question 1a & 1b

Utilization of FP services has increased in UNFPA supported sites. However, the FP sector has been weakened as a result of its dilution within the FHM. Lack of female physicians has a negative impact on service utilization and is a key factor for attracting women to the services. The SOP manuals had a positive impact on quality of services although they are not accessible to all staff. The MoH is not supporting a clear plan for clinical audits. On the other hand, the supervisory system is not integrated within the larger RH system. More technical support is needed as well as regular OJT for staff.
3.3 Evaluative Question 2

2a) Did the capacity of health care providers strengthen and provide quality VCT services as a result of program intervention?

2b) Did the target population use of VCT services increase in governorates of program implementation?

To evaluate the two subs under question 2, the following RH projects were evaluated:

ID: EGY08P03: NAP Support to Voluntary Counseling & Testing Services
ID: EGY8R44A: FHI Support to VCT & YFC by FHI

Project description

Although Egypt is considered a low-prevalence country in HIV/AIDS, all predisposing factors for a larger epidemic are present. Moreover, the data indicate that a concentrated epidemic may already exist in certain at risk populations. In addition, the prevalence of other STDs in Egypt is not known precisely. The MOH has placed a strong emphasis on the prevention of HIV/AIDS and other STIs. Under the guidance of the National AIDS Program, and with the support of UNFPA and other international organizations, Egypt has established numerous sites for voluntary counseling and testing (VCT) for HIV, both mobile and standalone, with the objective of reducing the risk of HIV/AIDS and STI transmission. Three core areas were addressed namely; advocacy, policy development, and capacity building for health providers with special focus on enhancing counseling skills and promoting condom use.

Evaluation methods

The evaluation methodology included review of project documents, work plans, assessment reports, training curricula and checklists, developed samples of site visit reports, and IEC materials.

To answer question 2a, qualitative assessment was conducted to collect information through in-depth interviews and analyzing a sample of available self-administered client exit questionnaires.

In-depth interviews were conducted with the following project managers:
Dr. Ihab Abd El Rahman, NAP Project Director
Dr. Sherif Soliman, FHI Project Director
Dr. Sherif Kamhawy, FHI Program Officer
Dr. Waleed Kamal, Specialist at NAP

To collect information about quality services provided, training outcomes and future needs, in-depth interviews were completed in three governorates namely; Cairo, Luxor, and Sharm El Sheikh with three VCT counselors, one nurse, and four data managers as well as one STIs provider. Analysis was conducted with 82 client exit questionnaires collected in the three evaluated governorates.

To answer question 2b, that addresses the utilization of VCT centers by the target population, service statistics over a three month period pre-intervention were compared to the same period post-intervention for all clients disaggregated by sex in the three evaluated governorate sites. MARPs analysis was not feasible due to privacy of data as reported by NAP managers. They proposed the use of service statistics pre-post completed promotion campaign in Menoufia governorate instead as an indication of the increased utilization as a result of their various interventions. This data limitation made a proper answer to question 2b difficult to construct.

Question 2a: Did the capacity of health care providers strengthen and provide quality VCT services as a result of program intervention?

Findings.
The service statistics collected were analyzed and presented in the figures below. Figure 2 describes VCT clinic utilization disaggregated by sex during the years 2008 – 2010 in all evaluated sites. In general males visited clinics were more than females. However, in 2009 Luxor showed marked increase in female clients. This finding could not be explained because the type of client was not identified due to unavailability of data. In general there was a decrease in the caseload over the years.
This decrease was related by managers to the very rapid turnover of providers and a drop in the provision of awareness sessions. They stated that MARPs who were considered the target population showed an increase but the data was not disclosed due to privacy issues.

Detailed findings are shown in Annex 9.

**Conclusions**

NAP has made substantial efforts in reducing HIV risk among target communities in Egypt. Together with technical assistance from FHI, the capacity of providers and clinic staff to provide VCT service has increased and become adequate for HIV testing. Curricula and IEC materials required to strengthen training on HIV counseling skills and service provision were available but probably need a continuous program for their update and development of new IEC materials because of changing needs.

Among the deficiencies identified among providers’ performance, there was still some embarrassment among non-physician providers when dealing with VCT clients and fears from the blood samples among counselors and lab providers/nurses about transmission of infection. This necessitates that on-the-job training follow classroom training.

Generally, there is low utilization of VCT clinics and utilization showed a decrease from year to year except in Sharm El Sheikh. The trend could not be observed among the target population because data were not made available. Also, promotional campaigns had an immediate but not a sustained effect on the overall utilization of VCT services.

Clients reported satisfaction with the services but half of them would not discuss their visit with their spouses and one-third did not like the video they watched.

There is a gap between providers’ and staff reported competencies and level of service utilization that needs more investigation.

**Figure 2: Utilization of VCT services by sex in all clinics during the period 2008-2010**

The extent of monitoring and evaluation of UNFPA of NAP activities was not clear in this evaluation. Despite the fact mentioned above that there are well developed monitoring tools, the evaluators had no access to the data to better evaluate
activities and utilization of services. Also, progress reports have no data at all and communication with NAP staff to gain a better understanding of the preliminary results and its validation was not permitted.

**Lessons learned**
- There is still a lot needed to work on prevention and reducing the risk of HIV transmission within the Egyptian community.
- Dealing with VCT clients is not easy among non-medical staff and even among the medical staff, fear of infection is still evident despite training and the staff’s level of competence.
- Sustainability of services and increased utilization requires well maintained clinics, on-the-job training, awareness, and promotional campaigns among the target population and in the community at large.
- Awareness of project managers and staff of the benefits of monitoring and evaluation is essential for better outcomes.

**Recommendations**
- Scale-up and expanding VCT services to other governorates to cover wider geographical areas.
- Increase the number and strengthen and build the capacity of the NAP central level staff for better implementation of project activities. Also build their capacity in data analysis to monitor activities and improve outcomes.
- Upgrade NAP website to promote VCT and HIV/AIDS activities.
- To address rapid turn-over of VCT staff, conduct capacity building activities in the form of classroom trainings or on-the-job trainings of newly hired staff. More OJT is required for supervisors, providers and staff on client provider interaction, infection control procedures, and HIV stigma.
- Increase the demand for VCT Services by creating an enabling environment through these activities:
  - Involve stakeholders and other sectors as the education sector, adult education agency, NGOs, and partners/donors working on HIV in Egypt to spread HIV health messages in the community.
  - Identify innovative approaches to attract more MARPs
  - Target promotion in high risk group settings such as drug rehabilitation centers
  - Link STI clinics to VCT services to strengthen the referral
  - Address the issue of low condom use
  - Establish a mechanism for the provision of office equipment and supplies
  - Creating a maintenance program for the mobile units
- To improve coordination, M&E, focus on quality of intervention, working with and on a decentralized mode and structure. Hold more meetings among partners. It is important to have more inter-linkages and symmetries between projects and partners.
- Explore the idea of having an evaluation structure (firm) that continues to work with the CP – as opposed to pulling them in at the end of the cycle.
- Focus on VCTs for men and out of school youth
- Advertising campaigns are highly needed
- Work on stigma: HIV/AIDS needs to be addressed in a different way during awareness sessions and campaigns; e.g. link it to diseases of the era rather than sexually transmitted diseases. Add a focus on acceptance of HIV positive persons in communities.

**Table 5: Overall answer to question 2**

UNFPA interventions have contributed to strengthening the capacity of professional staff working in VCT clinics. Training manuals and IEC are developed and highly valued by the staff. Clients of the services are satisfied with the quality of the services provided. However, utilization numbers have decreased during the last three years apart from one site (Sharm-Elshiekh). Further support is needed in building a concrete M&E system. UNFPA has no clear policy on reporting and the M&E is not well designed and maintained. These factors adversely affected the quality of data available on utilization. On the other hand, coordination between different stakeholders is crucial for tackling underutilization of services in some sites. The area of HIV is still considered to be very sensitive by service users, professionals and government bodies. A comprehensive strategy for tackling the root causes of underutilization of services should be developed for the next cycle. This intervention is highly beneficial and needed and UNFPA is one of the few agencies working in this field.
3.4 Evaluative Question 3

To what extent did the Youth Friendly Clinics (YFC) projects contribute to the sustainability and quality of RH services at the service delivery points?

To answer this question, the following RH projects were evaluated:
ID EGY/08/P10: Adolescents RH Needs in Egypt (EFPA)
ID: EGY08R54A: Teaching Hospitals - Youth Friendly Services
ID: EGY8R51A: FHI with EFPA and THO

Project description.
The three projects worked toward the following objectives: 1) increase access to appropriate adolescent reproductive health services, 2) create awareness, and give adequate information on SRH and rights among the Egyptian youth, and 3) ensure its sustainability. The expected result was to ensure a comprehensive service provided in sustainable youth friendly clinics in different Egyptian governorates.

EFPA clinics (EGY/08/P10) provided RH services in 12 YFC situated in 8 governorates namely; Dakahlia, Menoufia, Ismailia, Qalyubia, Minia, Matruh, Aswan, and Red Sea. These services included counseling, health education, ANC and FP services.

THO youth friendly clinics (EGY08R54A0) included 9 located in 6 governorates namely; Cairo, Aswan, Sohag, Beheira, Menoufia, and Kalyuobia. These clinics offered RH counseling and referrals of ANC and FP clients to the related hospital clinics in addition to premarital counseling and assessments necessary to issue the health certificate recently required to complete marriage documents.

A community component to mobilize communities and encourage youth to use such services was included in the two above projects. To ensure sustainability in YFC clinics, managers decided to manage covering costs of service providers through their self-income.

The third project through FHI (EGY8R51A) gave technical assistance to the above two projects by producing FP and RH training manuals for providers working at YFC, RH of youth training manual for peers, and a monitoring and evaluation guide to support and strengthen RH services in the affiliated clinics. It also conducted assessments necessary to develop recommendations for service improvement and sustainability of such clinics.

Evaluation methods
The evaluation methodology included review of project documents, work plans, progress reports, curricula, and assessments conducted. Also, a qualitative research assessment component using in-depth interviews and focus group discussions was used.

Interviews were conducted with the following project managers:
Dr. Amr El-Ayat, director of EFPA and the youth project
Dr. Mohsen Makram, Head of Teaching Hospitals Organization and project director
Ms. Rabab Mansour, Youth and Gender officer at EFPA
Mr. Ahmed Malh, UNFPA project officer
Dr. Sherif Soliman, FHI project director In-depth interviews

To collect information about types and quality of services provided, training outcomes and future needs, EFPA YFCs at Menya and Ismailia governorates were randomly selected to equally represent Upper and Lower Egypt sites. For teaching hospitals YFC clinics at Menoufia and Sohag TH were randomly selected for the evaluation to represent Upper and Lower Egypt governorates. From all sites, in-depth interviews were conducted with a total of 5 physicians, 5 counselors, and 2 peers in addition to 5 focus groups with youth. FGDs were conducted separately with male and female youth. Youth participant’s age ranged from 17 – 25 years of age with a mode of 18. They were all secondary or university students.
Quantitative data were obtained from project directors to include service statistics of both EFPA and TH clinics’ utilization along the years of project activities in all clinics. It is important to note that detailed service statistics for TH were not available except for 2010. As per the project director reports, this is when they started to register their numbers correctly.

Findings
As shown in figure 3; utilization is increasing from year to year. The more the clinics were known, the more youth sought their services. Project managers and officers reported that proper monitoring and evaluation of work activities as well as on-the-job training for improving providers’ performance played an important role in the acceptability of clinics within their communities.

Figure 3: Number of youth below 25 years of age using EFPA Reproductive Health Centers

![Graph showing number of youth below 25 years of age using EFPA Reproductive Health Centers]

Source: EFPA 2010

Figure 4 shows variations among different clinics’ utilization of youth below 25 years of age. Actually many factors had a role in the utilization namely; variability of services, quality, providers’ performance, nearby schools, prepared communities, internet and computers, trips and entertainment, providers’ turn over, and adequate advertisement. Project managers believed that youth advocate for YFCs. Accordingly, improved utilization could be managed and corrected through monitoring, evaluation, and corrective actions.
Detailed findings are shown in Annex 10.

Conclusions.

FHI provided assistance through the production of well designed and comprehensive training manuals and IEC materials but their use was limited among providers especially in THO clinics.

EFPA clinics showed better quality of services provided to youth and wide range of activities compared to THO clinics. Providers showed more competencies in service provision and their clinics were appreciated by the young clients.

Information corners were a pivotal activity appreciated by youth in such clinics. Actually it was the most attractive service in such clinics to youth.

Peers in this evaluation showed that they were effective tools for YFCs. They advocated well for clinics and served the young clients well. They had innovative ideas and thoughts and were effective in reaching the need of clinics to be appreciated in their communities. Peers were not available with TH clinics.

A clear monitoring and evaluation strategy was essential to monitor quality of work, assess needs and properly plan for the future. This was followed by EFPA and not adequately followed by the TH clinics.

Utilization of EFPA could not be compared to TH clinics because the clients were different. EFPA clinics provided services to youth while the TH clinics provided services to premarital couples. Working hours in TH did affect clinic utilization and accordingly a lot of organization needs to be done within TH clinics.

Although research has always pointed to the need for offering services targeting youth, the concept of developing YFCs was new to the Egyptian community; it started only a few years ago. The new concept still needs a lot of support from leading organizations such as EFPA and TH. EFPA has achieved far more than TH in services for youth as a result of their proper system and consistent monitoring and evaluation, TH still needed a lot of organizational support to make its clinics effective in reaching youth needs.

Elements of sustainability were recognized, in terms of commitment and available capacity of infrastructure, yet the capability component needs a lot of modification especially at TH YFCs.
Lessons learned.

- If clinics are accessible and friendly youth will use them.
- Awareness sessions need to include both youth and parents to gain their support.
- Peers are important tools to advocate for YFCs.
- The information corner was the most attractive service to youth in YFCs.
- Provider turnover threatens the sustainability of clinics.
- OJT is an effective methodology for addressing performance defects.
- Media are important tools for bringing youth into the clinics.
- Organizational support is important for the success of the clinics.
- A well developed M&E plan would facilitate continuous and sustained improvement of services.

Recommendations

Promotion of YFCs was a substantial need through the development of a culturally sensitive and creative BCC strategy with involvement of all stakeholders including youth and religious leaders. The strategy should include strengthening of the advertising program already in action.

The establishment of YFCs was a pilot activity that could be considered as a model for further strengthening and expansion. Expansion in new effective clinics is highly recommended since acceptability of these clinics is on the rise. Secure funds to achieve sustainability of the clinics. Make computers available for the knowledge corner because it increased client flow and income. Ensure that the DSL for internet connections established in all youth clinics.

Peers proved to be an effective tool in approaching youth. This tool needs expansion through the involvement and training of more peers. Youth should advocate for clinics and support marketing plans by distributing IEC materials in the community.

A continuous process for updating training, manuals, brochures and other IEC materials needs to be in place. FHI staff could be more involved with technical assistance to THO and EFPA thus assist UNFPA with monitoring project activities.

Coordination efforts between TH central and peripheral levels needed to be in place through an effective monitoring and evaluation plan. A cross referral system between YFCs service providers and other specialties in same hospital was needed to enhance young clients’ use of clinics and increase knowledge about RH issues.

Motivation of service providers working in YFCs is needed. This can be done by increasing their financial remuneration and building their capacity with training/refresher training in the different areas of youth RH, including STIs, sexual health, and HIV/AIDS.

The development of a well-designed standardized M&E plan for YFCs and training of clinic staff on its appropriate implementation is badly needed. The plan should be strengthened and supported by a strong supervision system and on-the-job training. Supervision and monitoring of those clinics would be beneficial to track deficiencies in service provision and utilization and address them properly.

YFCs needed be further publicized in the local communities, particularly in places that young people tend to frequent such as youth centers, sporting clubs, churches, and mosques. In particular, cooperation was still needed to be enhanced with opinion leaders and influential bodies in the local communities, such as religious leaders.

Since youth friendly clinics act as an important venue for education messages, more of them need to be opened. As per the speech of Her Excellency Minister Moushira Khattab in the SYPE launch opening, several important points need to be addressed including early registration of births, importance of school enrollment, encourage communication between parents and youth, and open more clinics in frontier governorates.
Table 6: Overall answer to question 3

| The impact of UNFPA support given to EFPA, TH and FHI varies in its strength and quality between the three IPs. FHI has managed to provide quality technical support in the form of training manuals and IEC materials. This role could be strengthened to help the THO and EFPA improve their services. In addition, a system for updating and revision of these materials should be in place. Regarding the YFC services, the EFPA model (YFC is integrated with other reproductive health services) proved beneficial in attracting more clients. EFPA has a well organized system and provides quality services. YFC witnessed an overall increase in utilization each year. However, use of the services is low and more promotional campaigns are needed. YFCs attached to TH are struggling in attracting youth to the services and generally have poor performance. There is high staff turnover, a weak M&E system and other problems related to management and finance. Peers proved to be an effective tool for spreading RH messages. Finally, the information corners and the computer facilities associated with them appear to attract youth and could be enhanced and upgraded to attract more clients. |

B. Population and Development (PD)

Introduction
The population and development activities address Country Program outcomes 1 and 2.
Output (1): Multi-sectoral population policies and strategies revised to address poverty reduction, HIV prevention, youth RH and needs of vulnerable groups.
Outcome (2): Poverty reduction strategies are monitored to ensure progress and the integration of a gender perspective.
Output (1): Gender analysis and gender disaggregated indicators developed and used in policy dialogue.

3.5 Evaluative Question 4.
How many gender analysis/disaggregated indicators developed and used in policy dialogue and in Gender program implementation?
This question is expected to fulfill the outcome: poverty reduction strategies monitored from a gender perspective, enhanced national capacity to monitor progress towards achievement of ICPD/ICPD+5, MDGs.

Project Description
This evaluation covers two out of four projects under PD. These include 1) Gender Monitoring and Evaluation (GME), Implementing Partner National Council for Women (NCW) 2) Evidenced Based Population Policy (EBPP), Implementing Partner Information Decision Support Centre (IDSC).

Gender monitoring and evaluation activities focused on helping governorates to integrate the local gender plans in a governorate-level five year development planning process and to adopt a standardised M&E regime to assess progress. This was done through providing M&E training for planning officers and relevant personnel in the governorates. In addition, round table discussions with all government departments and stakeholders were organized by the project’s staff.

The Evidence-Based Population Policy project conducted four main activities: 1) create and update a population and development database, 2) produce an annual report reflecting progress in population policies, 3) conduct a population conference and 4) organizing advocacy and communication workshops.

This cycle the PD component projects have been influenced by two issues, the creation of the Ministry Family and Population and the process of decentralization and its impact on the government planning process.

Evaluation Methods
In order to better link the outcome/ output with the achieved results a consultation process has taken place with implementing partners and CO staff to determine the extent to which the target outputs are relevant to actual activities. In evaluating the two projects, interviews with project staff and clients, and review of project documents using content analysis were the main
sources of data. Interviews were conducted with projects’ directors, UNFPA staff and relevant stakeholders. Annex 4 and 5 include a list of documents reviewed and persons interviewed.

Findings

1. Gender Monitoring and Evaluation (GME)
   - The GME project has managed to successfully initiate a policy debate and has gone a step further in pushing for ministerial decrees to be issued to force implementation of the Gender National Plan. Based on that, the project is working towards achieving the institutionalization of gender monitoring and evaluation systems and to strengthen national efforts towards a more coherent, consistent implementation of the Gender National Plan.

2. The GME project is a successful project and its impact is clearly seen in terms of initiation of strong policy debate and building solid M& E system for assessing progress. Many factors have contributed to the success of this project. First, political will is agreed by interviewees to be a leading factor. Furthermore, the determination of the project’s staff and the readiness of recipients for change are additional factors. Having this project fully funded by UNFPA has enabled it to attract highly qualified staff and ensured high standards. The high management cost for this project is justified by the quality of the activities. This project can be considered sustainable. However, more needs to be done in the area of providing more training of trainers (TOT) and ensuring that some parts of the training activity can be continued with minimum project involvement.

3. The advisory role that the GME project provides is highly appreciated by the government planning officers. The GME project’s staff advises governorate planning managers on the best way of implementing the gender plans and gives them trouble shooting ideas. They also negotiate on behalf of them to ensure commitment towards implementing gender plans. However, the successful implementation of gender related projects depends on many factors. The character of the governor and his team came as the most important factor in addition to the governorate’s resources (some governorates are richer than others).

4. The process of developing the training materials for the GME project made it more relevant to the trainees’ work. The project’s staff together with the trainers assess the needs and develop training curriculum. The training materials are in the form of PowerPoint and contain all relevant material issues related to the training topic. In terms of impact of the training, it has helped to change the way the government monitors and evaluates projects. Before the start of the project there was no single unified standardised format for reporting. Now there is a standard format. In addition, the quality and validity of the information have improved. However, more needs to be done in developing guidance manuals and training materials to support planning officer between trainings. Furthermore, priority should be given to printing these manuals than printing annual and progress reports.

5. Some planning officers raised the issue of lack of accurate information about vulnerable and needy women within governorates at the Markaz level. This makes planning for new interventions difficult and loses focus on the most needy.

6. Decentralization is creating new needs for monitoring and evaluation. It will help governorates to have more control over resources and to decide their own priorities. This can be a driving force for more gender plans to be implemented. On the other hand, it shifts the focus of planning to new stakeholders.

7. Lack of resources led to some governorates giving priority to areas perceived to have more pressing needs than gender.

8. The issue of lack of innovative ideas for better development projects emerged in all interviews. Some governorates are trapped in old fashioned (handcraft style) projects for women.

Evidence Based Population Policy (EBPP)

9. For the EBPP project, the activities performed are geared towards ensuring that available data is harmonized and maintained for better accessibility, comparability and dissemination. In addition to production of reports and research papers, officials in local governorates were trained to use these materials. These products and activities were of high quality and were appreciated by government officials in the Cairo area as well as the governorates.
10. The process of developing the database and production of the annual reports has led to raising the capacity of project’s staff and included high caliber software programmers, researchers and trainers.

11. There were concerns noted about the accuracy of the data obtained from the government and other sources. Supplying the database with relevant information has not been a straight forward task due to lack of cohesive policies/regulations addressing issues related to data management. Moreover, the database remains a ‘project’ that is not yet part of a well-organized system for data collection and dissemination.

General.
12. The relevance of the projects’ expected output and desired overall CP/UNDAF outcomes is an issue that was discussed with both PD projects’ staff. They believe that the activities performed achieved part of the expected output/ outcomes expected. This was due to the fact that overall outcome and the expected outputs were too elaborate.

Conclusions
- The Gender Monitoring and Evaluation project (GME) helped to create an environment that respects women and generates commitment to implement gender plans. The M&E training was useful and of good quality.
- Governorates vary in the quality of planning and implementation of gender related projects.
- Innovative development programs for women are needed in some governorates.
- The EBPP database project and yearly population report contribute to the process of dissemination of information as well as initiation of policy debate on population issues.
- The staff of the EBPP is ready to be part of more challenging projects. Technically the database has a user-friendly interface and includes most available data sources as well as integrating GIS. Data harmonisation (1996-2006) census has helped creating comparable data. Furthermore, the developers are going in the right direction in making it web based as well as considering the needs of end users in the design.
- The main limitation of the EBPP issues has been data inaccuracy. It should be noted that the data are produced by different organizations and used by the project. Successful strengthening of information systems will require relevant, timely, and accurate data. Inaccuracy of some official data could be related to diverse sets of factors. Lack of capacity, lack of awareness about the importance of data and other factors related to government handling of data are all contributing factors to data inaccuracy. More effort is needed in the next cycle to address data accuracy problems.
- Better data is needed for vulnerable populations including women, youth and the elderly. There is a need for small scale specialized surveys focusing on vulnerable populations including women for better planning at lower levels.
- PD projects often had overlapping activities

Lessons learned
- The population and development interventions in this cycle has managed to make a mark in the contribution to Gender development as well as contributing to the building a base of information system and initiate policy debate on population and gender issues. Furthermore, the long-term impact of the Gender M&E project is clearly observed and it is a replicable model and there are a lot of good attributes that can be learned from this experience

- In order to design the next cycle’s overall projects, the existing design needs to be examined. The table 7 shows overall PD interventions this cycle by type of program (advocacy, capacity building, promotion of evidence based dialogue and Horizontal & vertical coordination /coordinate activities among stakeholders). Population Policies & Strategies PPS project ( not covered in this evaluation in early stages of implementation) and EBPP share the advocacy component of the PD. Producing publications is under the advocacy in PPS project as a relatively small activity while it is a major activity under promoting evidence based population policies section for the EBPP. Furthermore, both projects have population campaigns activities. There is a lot of overlap in these two projects. It is not clear whether these intersections are made according to a plan or each project works separately.

- The capacity building component consists of a relatively big training component for the three projects. The training targets different groups (sometimes same target group on different issues). The question here is how to get the most of the knowledge and experience gained this cycle to better quality of training for the next cycle. Furthermore which IP is in better position to deliver/ organize the training and what is the best process for developing the training curricula or is it possible to look at the training in population/ data issues as one component and divide its related tasks (activities) among IPs?.
The main issues in any training activity are well developed training curriculum, well trained trainers, choosing the right target group for training and locating a comfortable venue. For training management and organization, the GME project has extensive experience in organizing training nationally. Additional activity could be added to the GME project for organizing training in population issues. For developing curriculum, the EBPP project is in better position for adding an activity of curriculum development and be responsible for developing training materials in various population/data management issues as well as delivering TOT in these areas. For assessing the training needs and suggesting training target groups the new MOFP would be in a better position to perform this task. There are many other scenarios for better integrating these activities.

Promote evidence based dialogue/production of data relies on producing credible information and research to influence policy making. The three PD projects have activities related to this component. The GME project is supposed to generate a gender index but this has not happened. In the next cycle, an index for disparities in implementation of the National Gender Plan could be developed. The EBPP has taken good steps in this regard; a database has been established as well as the development of a consortium of experts for the research work and production of publications. However, the EBPP project is in the best position to be in the centre of this component and has the capability of generating relevant information needed on behalf of the other two projects.

GME and PPS are sharing the load of arranging vertical and horizontal collaboration between different stakeholders and government departments in gender and population issue respectively. This exercise proved beneficial in the case of the GME project. This is due to a number of factors including political will and a highly motivated project staff. The question here is, do these factors exist for the PPS? (It may be too early to evaluate). Is there a clear mandate that PPS wants to achieve? Furthermore, is there any possibility for some PPS tasks to be shared and organized by the GME staff?

Commitment towards gender projects is a first step in advancing women’s status Egypt. More effort is needed to realize these commitments. In doing so moving the M&E project to work with the Ministry of Local Development would of great impact as gender monitoring & evaluation is already mainstreamed. The focus for the next cycle should be on ensuring proper implementation of the proposed projects.

Recommendations

PD1. Continued support should be given to the Gender M&E project to increase staff and widen its umbrella. This will provide a focal point for training and vertical and horizontal networking for all PD projects.

PD2. A ranking for governorates based on performance and progress in implementing the National Gender Plan should be developed and used as a planning tool for all UNFPA projects (when relevant). High performing governorates with better resources should be given more training in developing better innovative projects (more help in project design and M&E). On the other hand, underperforming governorates should have more help in fundraising and other relevant support.

PD3. Development activities for women were outdated in some governorates and at times not implemented in others. Assistance in planning activities is needed.

PD4. The IDSC is producing quality products that aid in development. Exploring new ventures and cutting edge applications is one way of going forward for the IDSC future collaborations. Furthermore, innovative projects aimed at providing software applications geared at the private sector and different government departments need to be considered for the next cycle.

PD5. A project that addresses data inaccuracy needs to be incorporated in the plans for the next cycle. This will make the whole database exercise viable as well as it will help to develop a strong platform for the next census.

PD6. Data was sometimes lacking on vulnerable populations, including women, youth and the elderly. Activities that focus the government statistical system on collecting and disseminating such data through IDSC or other groups are encouraged. Support for surveys focused on vulnerable populations such as the Survey of Young People in Egypt should also be continued.
PD7. Activities that aim at improving collaboration between the main players in the area of data collection and dissemination at the national level need to be included in the plans for the next cycle. This will help in developing a unified platform for data collection and dissemination and consequently better informed policies.

PD8. PD projects should be reconfigured to allow better integration between projects. Each project could possibly have one focal outcome to achieve either in advocacy, capacity building or promotion of evidence based dialogue.

Table 7: Summary of PD projects

<table>
<thead>
<tr>
<th>Project</th>
<th>Evidence Based Population Policies</th>
<th>Gender M&amp;E</th>
<th>Population Policies &amp; Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>- Advocate University students on P &amp;D issues</td>
<td>- Train governorate planning personnel on PBB, GB &amp; M&amp;E</td>
<td>- Launch population campaigns</td>
</tr>
<tr>
<td>Building national capacities</td>
<td>- Media workshops</td>
<td>- Retreat</td>
<td>- Produce publications</td>
</tr>
<tr>
<td></td>
<td>- <strong>Train</strong> local planners on gender indicators</td>
<td>- Attend CSW</td>
<td>- Train NPC personnel</td>
</tr>
<tr>
<td></td>
<td>- <strong>Train</strong> information &amp; data accurately</td>
<td></td>
<td>- Train media personnel</td>
</tr>
<tr>
<td></td>
<td>- Attend IUSSP conference</td>
<td></td>
<td>- Assess NGOs capacity</td>
</tr>
<tr>
<td></td>
<td>- Develop training materials</td>
<td></td>
<td>on FP</td>
</tr>
<tr>
<td>Promote evidence based dialogue</td>
<td>- <strong>Update</strong> PD database</td>
<td>- Print reports/ advocacy materials</td>
<td>Assess data banks and available population reports</td>
</tr>
<tr>
<td>produce data</td>
<td>- <strong>Produce</strong> annual population report</td>
<td>- <em>Assess</em> gender plan process</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Update estimation of fertility levels</td>
<td>- <strong>Produce</strong> Gender Equality Index data</td>
<td></td>
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<tr>
<td></td>
<td>- Produce PD papers for national CNF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Horizontal &amp; vertical</td>
<td></td>
<td>- Facilitate &amp; monitor gender plans implementation</td>
<td>Hold meetings among MFP, NPC, MoH, IDSC at all levels</td>
</tr>
<tr>
<td>coordination/coordinate activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>among stakeholders/</td>
<td></td>
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</tbody>
</table>

Table 8: Overall answer to question 4

UNFPA support to the creation of gender disaggregated data and initiation of policy debate on population and gender issues has been successfully managed and activities have been executed to a high standard. The support given to the IDSC through the EBPP project has helped to improve the quality of available data for better accessibility and dissemination. Quality research publications have been produced. However, a recent study by same supported institutions revealed major problems facing policy makers on obtaining accurate data from its original sources. Data quality produced by various government agencies lacks accuracy and consistency. The support given to NCW through the GME project has contributed to significant change in the commitment to implementation the Gender National Plan. Some governorates struggle in implementing women’s projects that were agreed upon in the GNP due to lack of resources. At times, budgets are reallocated to other projects. Including representatives from funding institutions in round table discussions and providing more technical help in project management and design will help in advancing the progress of the GNP. On the other hand, looking at the PD component as a whole, more integration between various PD projects is needed for better and stronger impact. Overlapping and cross-cutting activities could be better managed and a clear strategic decision is needed on the number of projects and the size of each budget.
C. Gender.

Questions 5a and 5b are related to Country Program Objectives 5 and 6.
Outcome (5): Girls’ and women’s rights to access information and services progressively fulfilled.
Output (1): Increased effective advocacy strategies in promoting sexual and reproductive health and gender equity, addressing men, women and youth.
Outcome (6): Incidence of all forms of violence against women is reduced.
Output (1): Community, religious leaders and media sensitized through active alliances to combat gender-based violence.

Questions 5a and 5b were formulated to evaluate the gender outcomes.

3.6 Evaluative Question 5a
5a) Is the UNFPA/MOFP Adolescent Health project successfully building the capacity of adolescent beneficiaries as advocates for sexual and reproductive health and gender equity among their peers, especially vulnerable adolescents?
To answer this question, one project was reviewed, EGY08P08: Adolescent Health Program, an agreement with the Ministry of Family Planning.

Project Description
This evaluation focuses on the Ministry of Family Planning (MOFP) activities related to in-school adolescents. MOFP trains volunteers from 15 NGOs to become peer educators for in-school adolescents in sexual, reproductive health and gender equity. The program includes seven messages: early marriage, marriage between close relatives, personal hygiene, physiologic and psychological body changes, HIV/AIDS and sexually transmitted diseases, nutrition and Hepatitis C. According to the project manager, each year each NGO is supposed to cover two classes in two schools. The project started at the end of 2003 and continued until 2010

Methodology
Five of the 15 governorates currently implementing the project began in 2003. Most of these NGOs were based in Upper Egypt. Governorates that started early were selected for evaluation to allow for enough time for project effects on volunteer peer educators to be visible. According to an MOFP assessment, two out of the five NGOs have excellent performance, one NGO very good, one NGO good and one NGO satisfactory. As the evaluation aimed to assess effectiveness, the evaluation included one of the excellent NGOs and the satisfactory NGO in order to allow covering the range of performance and for comparison of factors affecting program effectiveness. Fayoum was chosen as one of the excellent NGOs and Mynia for satisfactory performance.

Content analysis was performed on project documents and IEC materials. Interviews were conducted with the MOFP project manager, the two NGO managers, one head master / manager of a grass root NGO participating with the Fayoum NGO, two peer educators from Fayoum and three peer educators and a parent from Myngia NGO. Observation of two in-school adolescent education sessions took place in two schools one rural and another urban.

The evaluation methods were reinforced with a quantitative questionnaire, which was filled out by 26 NGO volunteer educators from nine governorates attending a meeting at the MOFP offices in Cairo.

Findings. Detailed findings are shown in Annex 11.

Conclusions
1. The information being provided to adolescents on RH issues such as physiologic changes during puberty is inadequate. Some NGOs were avoiding addressing the message of physiologic changes due to perceived fear of resistance on the part of the school and community. It may also be out of educators’ personal embarrassment or lack of skills to run a session dealing with a sensitive issue with adolescents. This may be one reason why NGOs seek the help of doctors and / or religious leaders to give this message to school adolescents

2. NGOs vary in the form of implementation of the “peer educator” model. The Mynia NGO has been using an alternative strategy by training adolescents to deliver messages to their peers individually rather than through groups. Although, it may not be appropriate that NGOs improvise and perform a major strategic shift in implementation without seeking consultation from the project management, however, it is worth assessing the pros and cons of their alternative
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strategy. In addition, the age of educators is by far different from what could be considered adolescent peers, as around 42% of educators are 30 years of age or more, with some of them above 40.

3. **Bureaucratic obstacles and funding problems.** The implementing NGOs face bureaucratic obstacles from the MOE, which result in having to have papers through the MOFP and the MOE at the central level for each performed session. This also limits the choice of schools to those having connections with the NGO, which may result in the selection of the better off schools. Funds are needed to cover transportation costs for distant rural schools.

**Lessons Learned.**

1) It is important to closely monitor implementation of activities and use its findings to improve performance.

2) Education on core adolescent reproductive health issues such as the male and female reproductive systems and physiological changes during puberty need to be always followed-up, strengthened and strategies to remove shyness and embarrassment from educators need to be devised and followed up.

3) Resistance of communities and parents to RH education can be an obstacle to programs.

**Recommendations.**

1. The MOFP needs to study in depth whether physiological puberty changes are being addressed and how they are being addressed in order to identify lessons learned that would enable realization of this project output. Monitoring visits should concentrate more on peer educators addressing these issues in their presence to maximize the benefits of supervision and M&E in emphasizing the delivery of these messages. It is also important to add a project indicator that counts number of sessions on physiologic changes and reports it as a proportion of messages delivered. It seems that the project has either not sufficiently addressed and overcome community resistance to core RH issues or the educators are still not comfortable addressing these issues. Furthermore, without giving messages to adolescents about physiologic puberty changes and the reproductive system, other messages such as those of early marriage and STD including HIV/AIDS become similar to general information in public service announcements.

2. The UNFPA and the MOFP need to consider whether it is the methodology of peer education with its edutainment that is effective in delivering such messages to adolescents or the young age of the educator. Program sites should be reviewed for the details of program implementation and the merit of program variations. Surveys of students should be conducted to assess their level of knowledge.

3. Administrative and funding procedures should be reviewed for efficiency and impact on project activities.

3.7 **Evaluative question 5b:**

Have UNFPA/Egypt CP 2007-2011 strategies and activities to sensitize religious leaders and communities they serve been implemented successfully and are they likely to positively influence religious leaders/beneficiaries and media personnel knowledge and attitudes toward women and girls especially gender based violence (GBV)?

To answer this question, two projects were reviewed: EGY8G27B. Reproductive Rights and Gender in the context of Islam EGY8G47A. Campaign against sexual harassment

**Project1.** EGY8G27B. Reproductive Rights and Gender in the context of Islam

**Project Description.**

The project “Advocacy for Reproductive Health/Gender Issues in the Context of Islam”, having a national scope, implemented by the International Islamic Center for Population Studies and Research (IICPSR) — Al-Azhar University, seeks to advocate for the common grounds between Population Policies, Reproductive Health and Gender Issues and Islamic teachings, and then to apply this gained knowledge in religious activities in different settings.

The project’s first aim was to produce a preachers’ reference guide on these issues covering the socio-medical as well as the Islamic points of view and showing the commonalities. Training was conducted on the reference guide to a select group of 94 preachers of the Ministry of Religious Affairs (MORA) in four workshops taught by top level renowned professionals many
of whom have taken part in producing the guide. The trained preachers will be referred to in this evaluation as religious leaders (RL).

Step-down training was planned to be conducted by these RL to the rest of the MORA preachers including around 50 thousand preachers. On Fridays preachers perform the Friday prayer and speech and on Saturday they give religion lessons to the family about family issues.

**Evaluation Methods**

Interviews were conducted with the IIICPSR Project Manager and the First Undersecretary of MORA for Preacher Affairs. Content analysis of the gender section of the preachers’ reference guide was performed. In addition, in-depth qualitative interviews were conducted with a systematic random sample of 12 trained RL. Interviews were held at the UNFPA/Egypt office. The twelve selected RL came from 12 different governorates. At least one-third of them serve in rural areas. Five of them have conducted post-graduate studies ranging from a diploma to a doctorate degree. Their ages ranged from 27-49 years and they had worked with MORA for 2-14 years. Their work grade varied from third grade for half of them to first grade for one of them. Five of them have appeared on radio and television.

Because the evaluation question required assessing the likelihood of UNFPA activities positively influencing religious leaders and the communities they serve concerning knowledge and attitudes towards women and girls, especially gender based violence (GBV), the in depth interviews focused on the RL’s views about the training and the preachers’ reference guide; development issues RL address; whether training caused them to combat various forms of GBV; and the different forms of existent GBV. In addition, there were three direct question sections concentrating on female genital cutting (FGC), early marriage and wife beating. FGC had elicited the most debate during training of RL. Concerning early marriage, RL stated during training that they face a lot of debate and resistance by the public. (project manager interview) The issue of wife beating was also a focus because it is a significant phenomenon in Egyptian society. In addition, [wife] beating was mentioned by the undersecretary as one of two GBV issues where he wanted RL to change their attitudes.

**Findings.** Detailed findings are shown in Annex 11. A summary of findings is included here.

**Likely Effectiveness of Trained RL in Combating GBV:** Answer to Evaluation Question

RL and preachers are well situated to influence a good proportion of society, whether these are their immediate social network or the public they serve. As evident from interviews with RL, some of them perform marriage ceremonies or their announcement and the public resorts to them for issues concerning divorce, which is often related to FGC and/or other forms of GBV, such as wife mistreatment. Furthermore, the routine job activities they perform weekly include Friday prayer speeches attended by a big proportion of mainly male Egyptian Moslems as well as weekly religion lessons with men and women in which social issues are discussed. They have scheduled monthly visits to schools and youth centers. In addition, they give lectures and seminars during religious celebrations. They also sometimes take part in health education and behavioral change communication activities of the MOH, State Information Service (SIS) or NGOs.

According to RL, when preachers have the religious opinion backed up by religious evidence together with some medical background, they are capable of addressing population, RH and GBV sensitive topics and responding to concerns and counter arguments from the public. The training has given RL the courage to address these topics that used to be problematic and brought about quarrels in their religion lessons.

The undersecretary anticipates that training preachers can be very effective in combating FGC as people believe if they do not circumcise their daughters they are acting against Islamic teachings “haram”. This concept needs to change into “it is against Islamic teachings to circumcise”. Once the misconception that circumcision is being done as part of Islamic teachings changes to the concept that it is against Islam to perform it, the prevention of FGC would be straightforward. In this respect, the training succeeded in that all RL interviewed have not indicated that performing FGC is part of religion. Although, trained RL still have some misperceptions towards FGC and are not completely against it, however, it is evident from RL’s spontaneous responses that a few of them have already positively affected their wider family circle and prevented a few girls (at least 2) from having FGC.
For wife beating and violence, for which the common public believes that Islam allows it or even requests it, the undersecretary expects a lesser effect by preachers, halving the current prevalence of domestic violence. This is because he believes that some people would need the existence of a strict penal law. For other behaviors that are commonly perceived by all people as bad behaviors, he expects only a marginal effect, e.g. sexual harassment etc.

Because of the deeply rooted nature of the attitude towards wife beating, there were no debates presented by RL during training. This may be one of the reasons why the training was not as successful in changing the acceptability of such an act, especially in serious perceived errors. Religious evidence documented in the preachers’ reference guide, against wife beating should be strengthened and streamlined and the misconceptions of “nashez” and “kewama” should be well explained and emphasized in the guide and in refresher training in order for RL to well understand and assimilate them. This may have a big effect in changing the attitude of preachers towards wife beating and their current social acceptability of it. Through strengthened activities of preachers at community level, the attitude of Egyptian Moslem society towards wife beating and its acceptability would be expected to slowly change from being the right of a husband in Islam to being an action that Islam refuses and disallows.

For early marriage, the training has totally succeeded in changing attitudes of RL. For other forms of GBV, according to interviews RL are combating many of these problems and addressing them in their religious activities, some of whom have started to combat population, RH and GBV negative behaviors as a result of IICPSR training. It is premature to judge likelihood of the effectiveness of the RL’s activities in combating GBV. In addition, the design of the evaluation study does not allow this. However, with the implementation of the evaluation recommendations, and with national scale implementation, the project and its partner MORA are likely to build capacities of Islamic preachers in a way that increases the likelihood of effectively contributing to reduction of GBV, especially in FGC and wife beating.

Since December 2009, 150 MORA preachers are being trained weekly on eight subjects from the guide. These subjects include the chapters on gender issues including harmful practices such as FGC and other forms of violence. However, according to the undersecretary, wife beating is not being covered in depth. This may be due to the fact that MORA’s partner, MOFP, does not have women’s issues as part of its mandate, as those are of the NCW. UNFPA has to emphasize the need to stress wife beating in its preacher training. According to the project manager, MORA training serves as raising awareness about topics of the reference guide. The preachers receive a copy of the reference guide. At the time of start of the evaluation, all preachers of four Upper Egyptian governorates were trained amounting to around 16 thousand preachers.

Another unintended positive effect of the project is that the undersecretary and trained RL have requested more information about adolescent health from IICPSR. The IICPSR is currently producing the Adolescent Reference Guide using the same participative approach with funding from the Ford Foundation. This will address the needs of preachers in their activities with adolescents in schools and youth centers.

Conclusions.
1) RL have gone through GBV awareness raising and attitude change especially for early marriage and FGC. Misperceptions are still present, concerning FGC, which need to be addressed through a refresher training activity for the entire group of 94 RL who have been trained by the project. The reason and rational behind these misperceptions has to be first identified as a first step to address them, whether misconceptions were pre-existing or were somehow correlated to the training received (as some RL reported).

RL have to understand that there is no medical evidence substantiating the need for FGC for any girl. The medical problems requiring surgical intervention in the female external genitalia are extremely rare and would present symptoms for which the girl’s parents would seek a physician’s diagnosis. Therefore, RL need not be informed of such rare incidents. They should be told a direct message that “the medical profession is in consensus that no girl needs circumcision or beautification”. Thus there is no rational to refer the girl to a medical consultation for FGC. RL should also realize that uncovering the girl’s external genitalia in this case would be “كشف عورة”, because there is no medical need for it.

The RL misperceptions concerning the need for the doctor to decide whether a girl needs circumcision or not coupled with the financial greed or ignorance of a few Egyptian physicians would regress combating FGC and delay achievement of intended results. Almost three-quarters of FGC, among girls aged 0-17 years, has been conducted by physicians (DHS, 2008). Some physicians, as part of this society have the same wrong “cultural religious” concepts concerning circumcision, and thus
they perform FGC out of ignorance of religion and their medical profession. For another group of Egyptian physicians, FGC is performed out of material greed.

2) Wife beating may not have been given the adequate emphasis it needs during training because it may not have been conceivable that a religious preacher would accept such behavior. The attitude towards wife beating is deeply engrained in some sections of Egyptian society, including the trained RL, as being allowed or even required by Islam. Thus the training needs to put more emphasis on this phenomenon and on defining related concepts such as “nashez” and “kewama”, which have to be explicitly spelled out and explained in the guide. The guide needs to extract and refer to more texts from Koran and Sunna that would support the notion that Islam does not agree to wife beating as practiced nowadays or even immorizes it. The content of the guide concerning Islamic evidence on wife beating needs to be streamlined and made more succinct and to the point reaching strong definitive Islamic conclusions. It would be even more effective if theologians were able to reach a statement against wife beating with its current understanding as being “haram” in Islam.

Furthermore, the issue of wife beating should be included in the socio-medical chapter of the gender section of the preachers’ reference guide. This chapter should collect and document men’s perception of the rational behind wife beating as well as evidence on the patterns and severity of these violations and their consequences on Egyptian society. Writing this chapter should use authors who are anthropologists, sociologists, psychologists and activist in the field of GBV as well as stakeholders such as the National Council of Women and NGOs. This would lead to a more effective message on “wife beating” that would support and enable the theologians to extract from Koran and Sunna the appropriate texts against “wife beating”.

The importance of articulating well this section, with strong religious evidence, is not only important, because of the elusive nature of capturing this attitude, which many may be unconscious of its existence within them, but also because prevention of domestic violence came as a first priority for training among the grassroots preachers in the study “Knowledge, attitudes and practices of religious leaders on reproductive health/rights and gender issues in the context of Islam” conducted by Assiut University for the project. This also implies that Islamic preachers may be receiving many cases of domestic violence for religious consultation. Through a study of preachers’ experiences with wife beating, the section on GBV in the manual can be greatly enhanced, just as sections on FP have benefited from many years of experience in the field. It may be important as well to cover the legal and religious implications of wife beating on the husband.

3) The reference guide is quite comprehensive and adequate to cover preachers’ needs. However, especially for step down training, education of girls needs more information to help preachers convince the public. Women’s work needs to be addressed as well as some additions to sexual harassment, rape as well as inclusion of orfy marriage, especially as anecdotal evidence points to its increasing use to get around the age of marriage law and leads to many problems as well as loss of the girl’s rights in marriage. The Islamic view-point and religious information need to be added for sexual harassment and rape. It may be better to include more explanation of religious texts especially from the guide’s perspective as it will enrich preachers’ explanations to the public. A few RL have requested articulating the religious counter evidence and its relative weakness, especially for debatable phenomena such as FGC. (See details of suggestions in the findings section.) It is worth noting that RL have reported in this evaluation that they need information about divorce and personal status laws.

4) Given that not all trained RL have adequately adopted all the messages of the training in the preachers’ reference guide yet, especially for wife beating and FGC, refresher training is needed on these topics as well as on other topics requested by RL such as sexual harassment and orfy marriage. This would necessitate revisiting training content concerning the various misconceptions.

As for step-down training, some of the RL have stated the need for a physician to teach the medical part and the need for modern presentation equipment and training facilities. In addition, since the project has resulted in the institutionalization of the training on the reference guide to all preachers of MOR by top level specialized medical and religious professionals, it may not be worthwhile for the project to continue with its planned activities of step-down training. The project has to start thinking of other activities that would maximize the effectiveness of both its own trained RL and MORA trained preachers in combating negative perceptions and behaviors of the Egyptian Moslem public related to population, RH and gender issues, especially GBV.

Lessons Learned.

1. Training religious leaders is a good first strategy for reducing GBV. It is essential in order to change the wide spread social acceptability in Egypt of wife beating as a husbands right in Islam.
2. Both religious and social issues need to be considered to reduce wife beating.
3. Both religious and medical issues need to be understood properly before attitudes toward FGC change.

Main Recommendations.
1. Some attitudinal change has occurred among RL as a result of the training indicating that this may be a good method for reducing GBV.
2. Revise the training curriculum to provide stronger evidence for reducing GBV. Both religious and socio-medical issues need to be further developed to provide RL with adequate tools in teaching the public.
3. A revised curriculum and retraining on gender issues is needed, especially for FGC, wife beating, sexual harassment, orfy marriage as it relates to early marriage, education and work of women.

Further Recommendations for IICPSR are shown in Annex 11.

Project 2. EGY8G47A. Campaign against sexual Harassment

Project Description.
The project seeks to empower women to speak out against sexual harassment (SH) and demand their equal right to share in public space that will encourage them to speak out against other forms of inequality and violence. The Egyptian Center for Women’s Rights (ECWR) has been developing existing relationships as well as seeking new partnerships with media in order for their message to reach a wider audience and correct misconceptions about the phenomenon. The ECWR prepared kits for media to guide them in reporting events related to sexual harassment. The activities of the program included conferences, seminars, media kits, and campaign demonstrations.

Evaluation Methodology.
The ECWR project manager was interviewed. Media personnel exposed to ECWR campaign activities were selected for interview categorized by type of media channel, using simple random sampling with two individuals from each media channel, male and female. Sixteen media people were selected, to represent the various types of media channels as well as government, political party or private media. Because many individuals from the selected sample were too busy to be interviewed, repeated random selection was implemented to replace those who did not participate. Finally, in depth interviews were conducted with 12 of them, 3 males and 9 females. One of the sample respondents found that she was invited to an ECWR activity, which she had not attended. However, she followed up their work through their website. This case was removed from the analysis of the second part of the interviews. The evaluation is limited by the small number of interviews and the low participation of male media personnel.

Although the sample was intended to represent those media people who had been exposed to ECWR sexual harassment activities after the start of UNFPA activities, many had attended ECWR activities since the start of their sexual harassment campaign in 2005. This resulted in respondents being able to report on changes in media discourse regarding SH from the start of the campaign rather than changes in their own specific way of addressing the issue after being exposed to ECWR activities and media kits.

Findings. Detailed findings are shown in Annex 11.

Conclusions.
1. ECWR strategies for informing the media have successfully sensitized media personnel to the issues and motivated them to advocate against SH. They have been successful in encouraging women and society to speak out against SH.
2. To combat SH, strong studies are needed to increase the evidence base on the causes and consequences of SH.
3. More effort is needed on the part of ECWR and the media in order to pass laws adequately penalizing SH, which is likely to reduce the prevalence of SH in Egypt.

Lessons Learned.
1. Routine data collection and research studies are needed to continue shedding light on the SH problem and continuing the campaign against it.
2. The media are a good channel for presenting evidence about the harmfulness of SH to the public.

Recommendations.
1. The country program should continue to reach out to media personnel and provide them with up to date resources.
2. Documentation of the causes and consequences of SH in Egypt should continue.
3. More advocacies are needed to change the laws in Egypt regarding SH.

**Table 9: Overall answer for question 5**

The UNFPA support given to MOFP & NGOs to train advocates has not resulted in significant impact on target groups’ knowledge and abilities to pass RH and other sexual health messages. Sexual health issues are still considered as a taboo and this is a major underlying cause for not achieving the required results. On the other hand, the project is facing major problems in terms of finance and management. Furthermore, NGOs are adopting different strategies in implementing the “Peer Model”. Further assessment is needed to verify which models is the best to replicate.

Another project, conducted by Al Azhar created a reference guide and training manual and implemented a training program for religious leaders on GBV. Although in its early stages, the program points to producing some attitudinal change in religious leaders that may lead to reduced GBV. RL who participated in the program reported that the training was useful to their work in communities and they requested more evidence based training. A third project, conducted by ECWR, created a media package and other activities focused on assisting media personnel in being advocates for reducing sexual harassment of women. The media personnel interviewed for the evaluation found that the resources that were provided were very useful in reporting about sexual harassment. Learning more about the consequences of SH through the program motivated them to include material about SH in their writing and programming.

### 3.8 Evaluative Question 6

In this section, the report focuses on the question, Given these results, how should the UNFPA Egypt country program reposition itself for Cycle 9?

The recommendations below include some specific and general ideas for outcomes and outputs and associated programming for the next cycle. We recognize that developing new outcomes and outputs is a long process that necessitates further consultation with implementing partners and targeted groups.

**Area 1. Reproductive Health**
The country program goals for Cycle 8 related to RH and recommendations for Cycle 9 are included below.

**Table 10: Summary of RH Outcomes and Outputs.**

<table>
<thead>
<tr>
<th>Cycle 8 RH Outcomes and Outputs</th>
<th>Suggested activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 3.</strong> The sustainability and quality of reproductive health services at the national level and at service delivery points are improved.</td>
<td>Monitoring and evaluation of projects is institutionalized</td>
</tr>
<tr>
<td>Output 1. Capacity of the Government and non-governmental health organizations is strengthened in management, planning and monitoring.</td>
<td>Capacity building: training activities</td>
</tr>
<tr>
<td>Output 2. Capacity of health care providers is strengthened to provide high-quality reproductive health services, including voluntary counseling and testing and youth-friendly services, especially to vulnerable groups.</td>
<td>Training of staff developed, training program updated regularly</td>
</tr>
<tr>
<td><strong>Outcome 4.</strong> The utilization of integrated reproductive health services is increased in Upper Egypt with a focus on underprivileged communities in rural areas.</td>
<td>Training and refresher training is conducted on a regular basis</td>
</tr>
<tr>
<td>Output 1. Primary and reproductive health care services strengthened within the framework of the Health Sector Reform</td>
<td>Activities suggested in Output 2 of Outcome 3 above focused on Upper Egypt.</td>
</tr>
</tbody>
</table>
Additional Cycle 9 Outcomes and Outputs.

<table>
<thead>
<tr>
<th>Outcome 1.</th>
<th>Output 1.</th>
<th>Suggested activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality in Egypt should be reduced through the development of a surveillance system</td>
<td>A surveillance system for maternal mortality is designed</td>
<td>Expert Meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drafting of plans for implementation.</td>
</tr>
</tbody>
</table>

Outcome 2. Creating integrated FP/RH/MCH services by adding outcomes related to child growth and development.

Output 1. | Suggested activities
---|---
Initiate a planning process within the MOH for integrating services. | Support planning meetings |
| | Involve stakeholders such as UNICEF |

The cycle 8 country outcomes and outputs related to reproductive health should be retained. Recommendations for developing the programming for these outcomes are detailed below.

1. Cycle 8 Outcomes

a. Family planning is a national priority and UNFPA must continue work in this area. Linking FP with other RH and FP services should come first. No further work is needed to strengthen FP since this has already been done, instead foster integration of services. Make all departments under primary care sit together and think about how to make integration work. MOH actors need to agree on common goals. Specific program foci should include targeting missed opportunities, FP discontinuation, management of side effects, and improving providers' counseling skills.

b. Scaling up VCT clinics and upgrading already established ones is a priority. Increasing the number of capable NAP staff is needed and training new VCT staff through establishing an OJT mechanism to work with the turnover challenge. Linking VCT with STIs should strengthen to VCT services. In Sharm EL Sheikh clinic they have both services in the clinic; if this was the cause of increase in cases, then this might be tackling two points, first reducing the HIV stigma as clinics are offering other services and at the same time helping people/clients with integrated services meet their needs. Actually this will require a very large budget for capacity building and securing human and financial resources but should be beneficial.

c. Adolescent and Young Adult Reproductive Health. The YFC concept worked to some extent and should be continued. Services in FP and RH are needed for youth. The information area is mandatory in such clinics as it attracts youth where we can support them with the required information. Having both in the same place hits two important targets. It is important though to increase the clinics working under EFPA since they have a better structure and to strengthen THO structure and clinics till they reach the required level. Further recommendations for supporting the reproductive health education for adolescents are discussed under gender.

d. Work with communities to reach vulnerable groups. UNFPA has worked with the MOH on its Family Planning and HIV projects and with the Egyptian Family Planning Association and Teaching hospitals in the three main RH projects that were reviewed. Through the peer education program, reviewed as a gender project, and the associated Y-Peer program they have also worked on RH issues with youth in communities. In terms of addressing population groups, UNFPA has addressed youth, women in reproductive age, and MARPS, but did not focus on men in the reviewed RH projects.

Further consideration should also be given to more involvement with communities. UNFPA through strengthening FP within Health Sector Reform is tackling increased utilization which affects the CPR and reduces fertility but a community component addressing RH issues among youth including males and females might be of significant value in the future. Addressing men at the community level will be crucial in the next decade. In Egypt women are already involved in several empowerment activities and they also visit health clinics to obtain services. Additional activities in the community targeting youth, men, and women in reproductive age as well will complement other UNFPA interventions at the service level. Note that they should be working in same communities though in different projects. This would increase the coherence within UNFPA.

2. Cycle 9 Outcomes

a) Maternal Mortality. A new outcome related to maternal mortality should be considered. The outcome would aim to reduce maternal mortality though strengthening the maternal mortality surveillance system. This will assist in locating areas where the need for additional prenatal care and obstetric services are needed.
b) **Integrated Services.** A new outcome would also move toward creating integrated FP/RH/MCH services by adding outcomes related to child growth and development. This might be done in collaboration with UNICEF and other related agencies.

**Area 2. Population and Development (PD)**

The Cycle 8 Country Program Outcomes and Outputs are as follows:


**Table 10: Summary of PD Outcomes and Outputs**

<table>
<thead>
<tr>
<th>Outcome 1. Population policies and strategies are consistent and unified in addressing the needs of vulnerable populations</th>
<th>Suggested activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Output 1</strong></td>
<td>Institutionalization of unified mechanisms of data collection. Support the creation of cohesive, clear regulations with regard to data disseminations, privacy and protection issues.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome 2. Poverty reduction strategies are monitored to ensure progress and commitment towards implementation of gender related projects</th>
<th>Suggested activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Output 2.</strong> Disparities in implementation of poverty alleviation projects under the National Gender Plan are identified and underperformed regions are supported</td>
<td>Governorates are able to support the implementation of the National Gender Plan related project MLD have the capacity to plan and implement new projects under the new decentralized authorities</td>
</tr>
</tbody>
</table>

Recommendations for programming for these outputs are as follows:

Egypt has well established institutions that are working in the area of population related research and policy development. Among others there are Information Decision Support Center IDSC, the Central Agency for Public Mobilization And Statistics CAPMAS, which is responsible for the Census, the National Population Council (research wing of MoHP), the Cairo Demographic Center (research wing of CAPMAS), the Institute of National Planning (research wing of the Ministry of Planning), the National Council on Population and Development (NCPD) and the Population Council, in addition to range of other university’ research centers, UN agencies and NGOs. Most of these institutions are working in line with UNFPA mandate and most of them have been supported by the UNFPA at one time.

There is no shortage of institutions that are capable of producing high quality research in Egypt. Therefore, supporting activities related to publication of more research should not be a priority for the next cycle. However, support for new specialized surveys like SYP targeting Female Headed Households should continue. A survey on the welfare of the elderly in Egypt should also be considered.

There is huge need in the area of coordination between different actors in the area of population related information management and dissemination. There is decent volume of research going on and it is done by various bodies. However, it is not working with a unified plan and not using standardized methods. Supporting the creation of a national plan related to organizing the regulatory environment in the areas of social research ethics, data protection, privacy and dissemination should be a priority for next cycle. This includes institutionalization of a data management framework as well as capacity building for all government departments responsible for data collection.
The GME project should be given more support and have a new focus. The project should expand its implementing partners to include the Ministry of Local Development for extra support to the decentralization process as well as to provide technical support for new projects implemented under the National Gender Plan. In addition an activity that will help in the development of permanent forums and web based training activities is needed. Publication of specialized training material and manuals should also be considered.

Area 3. Gender (G)

The outcomes and Outputs related to gender for UNFPA Cycle 8 and recommendations for Cycle 9 are below.

Table 11: Summary of Gender Outcomes and Outputs.

<table>
<thead>
<tr>
<th>Cycle 8 Gender Outcomes and Outputs</th>
<th>Suggested activities</th>
<th>Outcomes and Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 5. Girls' and women’s rights to access information and services progressively fulfilled.</strong></td>
<td>Health education</td>
<td>Improve clinical services accessibility to youth, Include out of school youth</td>
</tr>
<tr>
<td>Output 1.</td>
<td>Peer education</td>
<td>Improve School RH curriculum</td>
</tr>
<tr>
<td>Increased effective advocacy strategies in promoting sexual and reproductive health and gender equity, addressing men, women and youth.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcome 6. Incidence of all forms of violence against women is reduced</strong></td>
<td>Training on GBV</td>
<td>Media on GBV Document causes and consequences of GBV</td>
</tr>
<tr>
<td>Output 1.</td>
<td>Facilitate collaborations between religious and other groups</td>
<td></td>
</tr>
<tr>
<td>Community, religious leaders and media sensitized through active alliances to combat gender-based violence.</td>
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<td></td>
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</tbody>
</table>

These country program outcomes and outputs should be retained from Cycle 8. Recommendations for developing associated programming are as follows.

1. Adolescent Reproductive Health Education.

Peer education has been a useful strategy for the health education of adolescents in many settings. The present cycle included a peer education project for providing RH education to male and female youth. The evaluation of this project raised some questions about current implementation of the project in some governorates and the need to evaluate the best way to implement these activities. It is not clear whether a true “peer education” program was running in some governorates and whether or not variations in the implemented programs enhanced or weakened the delivery of health messages. Further evaluation of this program is needed including surveys to assess the learning of the participating adolescents.

In November-December 2010, there were some suggestions presented to the Minister of Education concerning the removal or reduction of some reproductive health education in the schools. Apparently, the Minister did not accept the presented suggestions. However, this implies that there is a danger that such actions are discussed again and accepted. The UNFPA and MOFP would be well advised to adopt a proactive approach towards this issue instead of having to react later to decisions that may be taken by the Minister of Education, which may negatively affect the fulfillment of the adolescent’s reproductive health information needs. The Minister is fairly new and proper sensitization to the needs of adolescents for reproductive health information as a national priority is needed. This is valid whether the project will change strategy over the coming UNFPA country program or not.

The UNFPA in thinking the way forward for Adolescent Reproductive Health Education should consider ways in which to conduct its activities within the mainstream activities of the MOE. The UNFPA can support the MOFP to suggest and advocate for the below strategies and activities to be conducted by the MOE.

The first strategy would be to strengthen the skills of biology teachers in interactive and edutainment techniques as well as in the scientific material of the science syllabus for the reproductive system together with some pertinent socio-psychological messages about adolescents’ reproductive health can be also added. In this day and age major diseases such as Viral Hepatitis C affecting Egyptians as well as HIV/AIDS and sexually transmitted diseases should be added within the curricula of communicable diseases and the different modes of transmission of such diseases. It is also important to note here the need to add also information about Avian Influenza to the curricula as it is now endemic in Egypt.
Another synergistic strategy would be to similarly raise the capacity of school social workers who are available in mostly all schools to enable them to undertake the social aspects of adolescent reproductive health education sessions including nutrition as an extra-curricular activity. This would have the advantage of preparing existing school cadres accessible to students who could answer adolescent concerns.

It is also important that out of school adolescents be targeted. It is time that this project moved on to target these out-of-school adolescents by mainstreaming adolescent reproductive health education within the MOFP.

2. Combating gender based violence.

The evaluations of the Al Azhar project on training of religious leaders showed that it has some potential to change the attitudes of RL and providing them with better communication skills. This program should be continued with the changes noted in the evaluation above including developing a stronger more evidence based training program.

NCW is currently undergoing a project in the field of GBV. The Egyptian TV news reported a meeting in Suzan Mubarak’s Center for Women in Alexandria. The NCW reported that GBV was mainly caused by religious misconceptions in communities. It is worthwhile for UNFPA to direct some of its activities with NCW and IDSC to strengthen the routine documentation of GBV such as beating wives, sexual harassment etc. in health facilities and thus in MOH statistics as well as in police records, thus institutionalizing monitoring and measuring GBV and its causes. Preachers as well get in contact with these incidents as these sometimes show up in discussions of divorce or when reporting of mistreatment incidents for consultation.

The IIICPR and ECWR should work together on developing a sexual harassment curriculum in the RL guide. The ECWR can also develop kits for distribution to RL. As ECWR is headed by an activist lawyer, UNFPA can assist in getting ECWR involved in strengthening its wife beating training. The ECWR can also provide the personal status laws, which were requested by RL. After IICPSR efforts to sensitize preachers to combat wife beating are well underway, the ECWR could start another campaign against wife beating as well as review its available laws.

Create advocacy groups among preachers who would like to combat various forms of GBV at grass root level and link them with other stakeholders having similar activities e.g. NGOs, the MOH, MOFP, and NCW. Create alliances between trained preachers and MOH primary and secondary health care physicians as they are the two essential pillars for combating FGC at community level.

For further sustainability of advocating for the common grounds between Population Policies, Reproductive Health and Gender Issues and Islamic teachings, the IIICPSR should advocate for the review of syllabi of Azhar University and schools concerning the religious perspective towards controversial issues presented in the guide such as FP, FGC, and wife beating.

UNFPA could support MOFP to act as an advocate and catalyst to create linkages between preachers and social workers in schools for the MORAs activities of preachers to be well received as well as to be coordinated with the suggested MOFP activity with MOE on adolescent reproductive health education through MOE social workers and science teachers.

This project involved only the Islamic religious leaders. However, there is anecdotal evidence that Christian women as well suffer from various forms of GBV, the underlying causes of which may differ greatly from those for Moslem women. The UNFPA would do well to consider working with the Egyptian Church on a similar project addressing all population, RH and gender issues, especially GBV from a Christian perspective.

The evaluation on the use of media to combat gender based results showed that sensitizing media personnel can be an effective way to bring sexual harassment (SH) out into the open and increase understanding of its causes and harmful effects. The IEC materials developed in the SH project should also be emphasized in the adolescent peer education program and the information centers in the Youth Friendly clinics. These materials are also important for the RL training. Further advocacy is needed to enact laws against SH. Work with media personnel should be continued and monitoring of SH is needed in police records.
**Overall Summary** We have summarized the most important recommendations for Cycle 9. An important overall goal for the next cycle should also be to develop an integrated M&E system within UNFPA to measure progress toward these goals. Monitoring indicators and project evaluations should be conducted and reported to UNFPA at regular intervals.

The UNFPA has accumulated a lot of experience on RH issues including family planning, reducing the TFR and reducing maternal mortality, developing a database for population policy and planning and gender based violence. All of these experiences should be documented and used in South to South collaboration on these issues. This is particularly important because USAID is now playing a smaller role in these areas.

**Table 12:** Overall answer for question 6

UNFPA Egypt CP has many fronts to work on to enhance its initiatives, impact and improve the quality of interventions. Areas for improvement could be divided into three main activities including monitoring and evaluation, program design, and partnerships. For M&E, UNFPA needs to revisit its M&E system and go through an extensive consultation process with its own team and with IPs to build an effective monitoring system that is able to capture progress. This includes revision of IPs’ M&E systems for better linkage between the two. In terms of program design, this evaluation shows that supporting activities that bring all the stakeholders together is beneficial and it helps to get the best out of existing resources. Therefore, including fully funded coordination of activities within each component (RH, PD, G) would help to advance the overall component work. Furthermore, having it fully funded and supported by the UNFPA will ensure quality and sustainability. In partnerships and collaboration with different government agencies, UNFPA need to reshuffle its long term partnerships. This does not necessary mean changing IPs, but considering changing the type and level of support for existing projects.
Decentralized Evaluation of the UNFPA Country Programme for Egypt 2007-2011

Terms of Reference for the Evaluation Team

1. Background

UNFPA Country Program (CP) in Egypt 2007-2011 is the 8th programme. The first started in 1971, and the International Conference for Population and Development (ICPD) came in the middle of the 5th CP. Through these years UNFPA Egypt has assisted the Government of Egypt (GoE) and civil society organizations in addressing population issues. The 8th CP is consistent with the objectives of the ICPD Programme of Action, the achievement of the Millennium Development Goals (MDGs), as well as the principles of human rights, and recommendations of previous CPs evaluations. As of 2008, the CP was made to align with the UNFPA Strategic Plan 2008-2013. The fundamental objective of the CP is to advance human development; fight poverty and inequality. It also fully addresses the fight against HIV/AIDS and the promotion of gender equality. UNFPA is committed to support Egypt’s national development.

Based on the United Nations Development Assistance Framework (UNDAF, 2007-2011) for Egypt, the CP was adopted by the Executive Board in October 2006. According to an analysis of human and state capabilities, the UNDAF framework identified five outcomes to be achieved by the year 2011. The 8th CP contributes to three of the UNDAF outcomes, namely: strengthening the capacity of the state, reduction of regional disparities and increasing women’s participation in public life. This implies a focus on women’s rights, vulnerable groups and youth, using approaches that emphasize human rights and cultural sensitivity.

The Country Programme Action Plan (CPAP) was developed in close collaboration with national partners, the UN System and signed by the Egyptian Government and UNFPA Country Office (CO). Mainly through a cluster of projects, the CO provides technical and financial support to strengthen national capacities to collectively contribute to attain and facilitate the achievement of these development goals.

The CP is composed of six outcomes distributed evenly across UNFPA’s three main themes: Population and development (PD), Reproductive health (RH), and Gender (G). It is nationally executed under the overall coordination of the Ministry of International Cooperation. The CP has seven outputs responding to the six outcomes. A list of on-going projects, duration, total resources and implementing partners (IPs) is attached (annex I). The first year of the CP (2007) experienced some overlapping of projects with the 7th CP. Not all the current projects started on the first year of the cycle; most of the IPs have worked with the CO in the prior CPs.

Egypt is one of the most challenging countries for a population programme with population growing at 1.99% a year. The CP is supporting the government in continuing the development momentum and reducing the high population growth. In this context, the evaluation of the 8th CP presents an opportunity to assess UNFPA contributions and shortcomings over the programme cycle, and help UNFPA to improve its programming and strategic positioning. The findings and recommendations of this evaluation will be used as inputs to the 2012-2016 CPD within the context of the UNDAF.

Recently, some efforts have been made, in the course of implementation of the different projects (Each project is composed of multiple annual work-plans (AWPs)), to strengthen a results-based management

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system, use and update the results matrix regularly, and monitor results progress. However, shortfalls still exist due to the transition from activity-based to a result oriented programming.

2. Evaluation purpose

The purpose is to conduct an end-of-country programme cycle evaluation to ensure substantive accountability of the investments made, and as a basis for learning in order to improve the relevance and quality of future actions. Evaluation serves this dual purpose, through the provision of reliable evaluative evidence on the development results of the programme. According to UNFPA policies, evaluation is undertaken mandatory requirement, in the penultimate year of the on-going cycle to build the evidence-base of results achieved, to inform the design of the next cycle. UNFPA aims to compile a consolidated picture of the results and performance of CP projects and to help in gleaning insights and lessons from this evaluation.

3. Evaluation scope and objectives

The scope of the evaluation covers the on-going country programme cycle that began in 2007. As per annex I, the total number of projects varies from one year to another, all of them are managed centrally in Cairo, and some projects operate in selected governorates only. The list of projects in the annex is categorized according to technical area (PD, RH & Gender). Projects are funded from the regular resources for program funds. Some other projects were funded from other resources and are highlighted though respectively.

The outputs evaluation criteria proposed broadly follows OECD/DAC guidance, namely, relevance, effectiveness, efficiency, impact, sustainability, and management systems. In order to extract lessons learned and best practices, the evaluation scope should cover as well the overall program design, delivery, performance, alternative strategies & the application of the rights-based approach and mainstreaming gender in development efforts.

Both the FGM & FAO projects are part of our programme, but will be covered by another evaluation being programmed.

4. Evaluation questions

The CP evaluation should address a list of specific questions as well as a list of general questions.

Please refer to Annex II for the list of questions in the Evaluation Methodology Framework.

5. Methodology

Based on the CPAP (Part VII), the M&E planning and tracking tool, and the available data, the CO has compiled the attached Evaluation Methodology Framework (annex II) for the evaluators to review and use as appropriate.

It is proposed that the evaluation use a mixed methods approach to include some or all of the following:

- desk reviews
- group and individual interviews
- collection and analysis of quantitative primary and secondary data where appropriate
• use of field visits to validate preliminary findings
• triangulation of different data sources to add rigor to the validity of findings

The evaluators will be required to specify the precise methods of data collection and validation in the inception report.

The evaluation will adopt a participatory approach to the greatest extent possible, and involve a wide range of stakeholders. A list of UNFPA direct partners is attached (Annex III).

It is envisaged that this evaluation activity will be divided in three distinct phases:

Phase 1. Preparation: desk review/stakeholder mapping/inception meetings and an inception report
Phase 2. Implementation: data collection and validation/analysis/draft report/stakeholder meeting/final report
Phase 3. Communication: Management response/disseminate the report/follow-up implementation

6. Evaluation products (deliverables)

The required key evaluation products are:

• **Evaluation inception report** (a maximum of 10 pages) — an inception report should be prepared by the evaluators before going into the full fledged evaluation exercise. A two week period is estimated for completion of the inception report after contract award. It should detail the evaluators’ understanding of what is being evaluated and why, showing how each evaluation question will be answered by way of: proposed methods; proposed sources of data; and data collection procedures. The report should include a proposed schedule of tasks, activities and deliverables, designating a team member with the lead responsibility for each task and/or product. The report provides the evaluation managers and the evaluators with an opportunity to verify that they have reached a common understanding about the evaluation methodology and scheduling.
• **Draft evaluation report** — the draft report is required by stakeholders within five weeks after submission of the inception report. The EMC will review the draft report to ensure that the evaluation meets the required quality standards as per UNFPA evaluation guidelines.
• **Final evaluation report** (max 30 pages excluding annexes) – the required layout is attached in Annex IV. The final evaluation report is required two weeks following approval of the draft report by the ECM. The Arabic version of the report will be submitted one month after acceptance of the English version of the final evaluation report.
• **Evaluation brief and other knowledge products** (two-page evaluation brief & a presentation for the stakeholder workshop) one day event will be arranged by the CO. Evaluators will be the guest speakers to disseminate the CP evaluation report and facilitate discussion among stakeholders.

An indicative time-frame/Gantt Chart for the evaluation process is attached (Annex IV)

7. Evaluation team composition and required competencies

The team will be constituted of four members:
- Consultant team leader, with overall responsibility for providing guidance and leadership, and in coordinating the draft and final report
- Consultant team specialists, who will provide expertise in the core subject areas of the evaluation, and be responsible for drafting key parts of the evaluation document

In addition, support is envisaged through the provision of one research assistant to facilitate the initial desk review and one programme assistant to provide support in logistical and administrative matters.

The team leader must have a demonstrated capacity in the evaluation of country-wide programmes, as evidenced by previous work and demonstrable deliverables. All team members must have an in-depth knowledge of development issues in Egypt preferably in the three main themes: Population and development (PD), Reproductive health (RH), and Gender (G). While the team leader has the overall responsibility for compiling the report, each team member is responsible for providing detailed inputs for the topics and thematic areas within their specialist expertise. The division of labour will be spelled out in the inception report. The EMC will support the team in the final design of the evaluation, participate in the scoping mission, and provide ongoing feedback for quality assurance during the preparation of the inception report and the final reports. Depending on the needs, the EMC may participate in the main mission also, to be discussed and finalized during the inception phase.

As part of the process, resumés and references are required to be submitted to the CO, together with a clear statement from the prospective evaluators stating their independence from any organizations that have been involved in designing, executing or advising on any aspect of the intervention that is the subject of the evaluation. Previous experience with United Nations and field experience in the middle east are required.

8. Evaluation ethics

The evaluation team will follow UNEG norms and standards for evaluation and will adhere to the ethical Code of Conduct.

9. Implementation arrangements

The management structure for the evaluation is composed of the following:

- The Evaluation Management Committee (EMC) – will be co-chaired by UNFPA CO program manager and a representative from the national partners. ASRO M&E Advisor, and UNICEF/Egypt M&E officer will be members in the committee.
- The Evaluation Manager (EM) – will be the M&E focal point in UNFPA/CO.
- Evaluation Team – based on competitive selection of the four evaluators that will constitute the evaluation team.

The EMC and EM provide oversight to the evaluation process. The attached Gantt Chart (Annex IV) shows the responsibilities per party.

UNFPA CO will provide logistical support and arrange meetings and field visits as and when required by the team. UNFPA will also make available office space; the evaluators are however expected to bring their own laptops.
10. Time-frame for the evaluation process

30 working days over a period of two months.

Draft report has to be ready by year end.

11. Cost

The estimated budget to cover the whole evaluation process ranges from $50,000 - $60,000. Consultant fees will be calculated using UN daily base rates commensurate with qualifications and experience. For international consultants, travel costs will be incurred by the CO as per UNFPA regulations.

12. ToR annexes

- Annex I - List of on-going projects, duration, total resources and implementing partners
- Annex II – Evaluation Methodology Framework
- Annex III - List of UNFPA/EGY/CO direct partners & relevant websites
- Annex IV – Indicative time-frame for the evaluation process
- Annex V – Intervention Results Framework
- Annex VI – Background documents & important online Materials

Annexes are available upon request.

For additional Information regarding this consultancy, please contact:
Dawlat Shaarawy – shaarawy@unfpa.org
## Annex I Projects

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<tr>
<th>Partner</th>
<th>Project#</th>
<th>Implementing Partner</th>
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<th>2008</th>
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### Total

- **Sub-total**: 5,518,170
- **52%**
- **Sub-total**: 2,710,249
- **25%**
- **Sub-total**: 2,466,939
- **23%**

**Total**: 825,473, 2,216,688, 2,623,136, 2,970,061, 2,430,000, **10,695,358**

**umbrella**: 1,700,000

### Other Resources

- All Projects are managed centrally and implemented either at the national level or in selected governorates.

### Below Projects

- EGY08P04 University of Economics | 29,083
- EGY08P07 MoH/FP Sector | 127,807 | 6,731
- EGY08P09 FGM Free Village - UNDP | 56,187
- EGY08P11 CSIA | 58,688 | 13,536
- EGY03P09 Old IDSC | 575,051

**433,236**
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<th>Evaluation Question</th>
<th>Performance indicator</th>
<th>Data Source</th>
<th>Evaluation design</th>
<th>Sampling plan</th>
<th>Data collection instruments</th>
<th>Data analysis plan</th>
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<td>1a</td>
<td>Did the program intervention strengthen the FP services within the framework of HSR?</td>
<td></td>
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<td>Intervention Group: all governorates</td>
<td>Comparison group: all other governorates</td>
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<tr>
<td>1b</td>
<td>Did the utilization of FP services increase in governorates of program intervention?</td>
<td>% of Clients utilizing FP services</td>
<td>Facility service data</td>
<td>Quasi-experiment</td>
<td>Intervention Group: all governorates</td>
<td>Existing service records + evaluator validation visits</td>
<td>Histograms comparing intervention and control – Chi-Square contingency tests</td>
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<tr>
<td>2a</td>
<td>Did the capacity of health care providers strengthen &amp; provide quality VCT services as a result of program intervention?</td>
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<td></td>
<td>Intervention Group: all governorates</td>
<td>Comparison group: all other governorates</td>
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<td>2b</td>
<td>Did the target population use of VCT services increase in governorates of program intervention?</td>
<td>% of VCT clients</td>
<td>VCT service data</td>
<td>Quasi-experiment</td>
<td>Intervention Group: all governorates</td>
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<td>Histograms comparing intervention and control – Chi-Square contingency tests</td>
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<tr>
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<td>To what extent did the YFC projects contribute to the sustainability and quality of RH services at the service delivery points?</td>
<td>% of new YFC clients</td>
<td>Facility service data</td>
<td>Field assessment against benchmarks</td>
<td>Intervention Group: all governorates</td>
<td>Existing service records + evaluator validation visits</td>
<td>Histograms comparing intervention and control – Chi-Square contingency tests</td>
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<tr>
<td>4</td>
<td>How many gender analysis/disaggregated indicators developed and used in policy dialogue and in Gender program implementation?</td>
<td># of policies</td>
<td>IDSC/NCW records</td>
<td>Document review – content analysis</td>
<td>Visit to all YFC service delivery points</td>
<td>YFC service point assessment relative to benchmarks</td>
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<tr>
<td>5</td>
<td>Have the strategies developed through the program intervention to sensitize religious/community &amp; media to combat GBV been effective in contributing to reduce violence against GBV?</td>
<td>Progress in GEM &amp; GDI</td>
<td>Document review – content analysis</td>
<td>Desk study + Key informant discussions</td>
<td>Content analysis</td>
<td>Narrative description of causality</td>
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<td>On the basis of findings from 1-5 how to reposition CP assistance for enhanced impact?</td>
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Table A4: Evaluation Methodology Framework
Have UNFPA/Egypt CP 2007-2011 strategies to sensitize religious leaders and communities they serve as well as media people been effective in changing religious leaders/beneficiaries and media personnel attitudes towards women and girls / gender issues to the extent that they become an active alliances in combating GBV?
<table>
<thead>
<tr>
<th>Project No</th>
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<th>Exc. Agnc</th>
<th>Contact person</th>
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<td>RH</td>
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<tr>
<td>1 EGY08P01</td>
<td>Scaling up outreach to vulnerable women for vulnerability reduction in Cairo (Joint Program)</td>
<td>Al-Shehab Institution for Comprehensive Development</td>
<td>Ms. Reda Shoukry - Project Director 0127888462</td>
<td><a href="http://www.shehabinstitution.org/">http://www.shehabinstitution.org/</a></td>
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<td>2 EGY08P02</td>
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<td>Dr. Atef El Shitany - Project Director 0102501212</td>
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<td>Dr. Naas El Sayed (0123466685) Dr. Ihab Ahmed - Project Director (0123374111)</td>
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<td>5 EGY8R44A &amp; EGY8R54A</td>
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<td>Dr Cherif Soliman - Project Director -27950939</td>
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<td>Ms Ghada Barsoum - Project Director 25255965</td>
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<td>Nihad Abu El Komsan Project Director 0122305324, Rebecca Chiao (0102861476)</td>
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### Gantt Chart for UNFPA/Egypt 8th Programme Cycle Decentralized Evaluation Checklist Activities (CPE)

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<tr>
<td><strong>Gantt Chart</strong></td>
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<td><strong>Concept Note/Partners’ briefing</strong></td>
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<tr>
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<td><strong>Establishing Management Structures</strong></td>
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<td>Representative</td>
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<tr>
<td><strong>Bidding/Selection of Evaluation firm/Consultants</strong></td>
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<tr>
<td>RFP (TOR) &amp; Announcement</td>
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<td>Assessment of bids (CVs) and selection</td>
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<td>Contract Award</td>
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<td><strong>Identification of Background documents (existing)</strong></td>
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<tr>
<td>Inception Report</td>
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<tr>
<td>Briefing of evaluators</td>
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<tr>
<td>Desk review - documents to be consulted &amp; background</td>
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<td>Finalizing the evaluation design and methods &amp; review logic</td>
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<tr>
<td>Develop a feasible data collection plan</td>
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<tr>
<td>Prepare the detailed inception report (with evaluation matrix &amp; schedule of tasks)</td>
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<tr>
<td><strong>Conduction of the Evaluation exercise</strong></td>
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<td>Aug - Dec</td>
</tr>
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<td>Collection of data - undertake Visits to the field, interviews,</td>
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<td>Data analysis</td>
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<td>Debrief</td>
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<td>Prepare the draft report</td>
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<td>Finalize the evaluation report</td>
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<td>Translate the report into Arabic</td>
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<td>Disseminate the evaluation report</td>
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<td>Management Response</td>
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<td><strong>Promoting the implementation of the recommendations and use of evaluation results in present and future programming</strong></td>
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EM = Evaluation Manager  
EMC = Evaluation Management Committee
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<td>Briefing of evaluators</td>
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<td>Collection of data - undertake</td>
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Decentralized Evaluation of the UNFPA Country Programme for Egypt 2007-2011

Inception report

December 2010

Kathleen Ford
Hala Youssef
Samar Galal
Mahinez El-Helw

This document states the purpose of the evaluation, methodology, description of the evaluation management team and final report outline
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Introduction

This project will conduct an evaluation of the UNFPA Country Programme for Egypt 2007-2011 in accordance with the Terms of Reference for the evaluation (UNFPA, 2010). The fundamental objectives of the program are to advance human development, fight poverty and inequality, including the fight against HIV/AIDS and gender equality. The country program consists of projects reflecting three main themes: Population and development (PD), Reproductive Health (RH) and Gender (G).

Purpose of the evaluation

The purpose of the evaluation is to conduct an end of country program cycle evaluation to ensure substantive accountability of the investments made, and as a basis for learning in order to improve the relevance and quality of future actions. The scope of the evaluation covers the ongoing country program cycle that began in 2007. The evaluation will cover 11 projects that include the three technical areas (PD, RH & G). The output criteria broadly follow OECD/DAC guidance, namely relevance, effectiveness, efficiency, impact, sustainability, and management systems. In order to extract lessons learned and best practices, the evaluation scope should cover as well the overall program design, delivery, performance, alternative strategies, and the application of the rights based approach and mainstreaming in gender in development efforts.

The UNFPA works with a number of stakeholders and implementing partners including the Egyptian Ministry of Health (MOH), the General Organization of Teaching Hospitals (GOTHI), the National Center for Women (NCW), the Egyptian Center for Women's Rights, the Information Decision Center (IDSC), the National Council for Motherhood and Children, the National Council for Human Rights, Family Health International, the Population Council, and Azhar-IICPSR.
Evaluation questions

The UNFPA country office has identified six evaluation questions as the most important focal points for evaluation. These questions are:

1a) Did the program intervention strengthen the family planning (FP) program within the MOH population sector to serve the family health model?

1b) Did the utilization of FP services increase in governorates of program intervention?

2a) Did the capacity of health care providers strengthen and provide quality VCT services as a result of program intervention?

2b) Did the target population use of VCT services increase in governorates of program implementation?

3) To what extent did the Youth Friendly Clinics (YFC) projects contribute to the sustainability and quality of RH services at the service delivery points?

4) How many gender analysis/disaggregated indicators developed and used in policy dialogue and in gender program implementation?

5a) Is the UNFPA/MOFP Adolescent Health project successfully building the capacity of adolescent beneficiaries as advocators for sexual and reproductive health and gender equity among their peers, especially vulnerable adolescents?

5b) Have UNFPA/Egypt CP 2007-2011 strategies and activities to sensitize religious leaders and communities they serve been implemented successfully and are they likely to positively influence religious leaders/beneficiaries and media personnel knowledge and attitudes toward women and girls especially gender based violence (GBV)?

6) On the basis of findings from questions 1-5, how can country program assistance be repositioned for enhanced impact?

Evaluation Methodology

Each question will be evaluated taking many aspects into account including design, resource allocations, timing and the impact of all these on the ability of the projects in achieving required outputs. Through evaluating activities the impact of any intervention will be assessed and consequently the contribution to achievement of desired outcomes.
Each project has a methodology tailored to fit considering the strategic importance of the program, implementing counterpart and other relevant factors. The methodology was developed using a desk review of project documents, consultation with the UNFPA staff of the Egypt Country Office, the Evaluation Management Committee(EMC) of UNFPA and interviews with each of the implementing partners (IP). This methodology for questions 1-5 is summarized in Table 1. Question 6 will be answered by the team using the information gained from answering questions 1-5. An outline of the final report is shown in Appendix 2. The project visit and sampling plan is shown in table 2.

**Coverage**

The overall coverage of UNFPA supported projects varies. Some projects cover all governorates while others are limited to selected governorates or only Cairo. Table 2 shows the coverage of each project and selected sites. RH projects cover selected governorates. Regarding, YFC project the access is given to visiting all sites. However, time issues and availability of data collectors are other factors influenced the selection criteria of governorates. Regarding PD projects, all its projects have a national coverage.

**Sampling**

The sampling design is largely a random purposeful sampling. It is influenced by set of factors. Geographical location is the prime factor and in this sense we can say the sample is representative. For each project two sites will be selected (Upper Egypt and Lower Egypt) depending on the coverage of the project (see table 1). Within this frame many other factors affected the selection of the project e.g. age of the project and performance. Although it is purposeful sampling, every effort has been made to make it representative.

**Data collection and fieldwork procedures**

*Implementing partner consent and advance letters*

The consent of the implementing partner needs to be obtained before the start of the data collection, informing them of the whole process. Advance letters will be sent to sampled individuals, explaining the purpose of the evaluation and asking for their cooperation with interview. As a named respondent had been selected before the Interview, the advance letter was addressed to the selected respondent by name.

*Selection of data collectors and training*

Data collectors will be trained by the consultants in field procedures, consent, interviewing techniques, and research ethics. For RH projects there are two data
collectors while for Gender project the number of data collectors needed will depend on the final decision of number of sites

**Data Collection**

Fieldwork will take place 12-29 December. There are three types of data collection methods including two types of face-to-face interviews as well as focus groups. Table 1 shows number of people will be interviewed in each project. For the Gender projects, the interviews may be in-depth due to the nature of the projects (assessing attitude change). Focused Group Discussion (FGD) will also be conducted in collecting data in both RH and Gender projects. Interview guides and themes for qualitative interviews are developed for consistency.

**Data Analysis**

There are two main sources of information that will help in evaluating CP projects. Firstly, secondary data sources including the records kept by service providers e.g. family planning FP clinics, Youth Friendly Services YFC and Voluntary Counselling Test VCT services. The second source of information is validation visits. These will involve using participatory evaluation tools as well as performing focus group discussions, conducting in-depth interviews and content analysis of existing materials.

In terms of statistical procedures, they will vary depending on the output required. Excel and SPSS will be used to analyse the data. Histograms and Chi-square will be used to show the progress and the impact of the interventions. This will possibly be combined with a range of other tests where appropriate. Regarding qualitative data, it will help giving a better understanding of challenges facing projects and the reasons for success and more importantly the future prospects of these projects.

**Evaluation Team Roles and Responsibility**

Kathleen Ford – Head of Evaluation. Responsible for delegation of work to consultants, reviewing plans for evaluation, working with consultants to solve problems, reviewing
research progress, reviewing results from consultants’ work, consulting with UNFPA staff about evaluation issues, assembling, editing and writing portions of the final report, revising relevant sections of the final report with regard to UNFPA comments.

Hala Youssef – Reproductive Health Evaluator (Questions 1-3). Responsible for planning and conducting the evaluation of the reproductive health projects, reviewing the evaluation plans and research results of all other team members, providing consultation to other team members, drafting the section of the final report on reproductive health and contributing to the response of the team to question 6, revising relevant sections of the final report with regard to UNFPA comments.

Samar Gala – Statistician, Data Management and Population and Development Evaluator (Question 4). Responsible for planning and conducting the evaluation of the population and development projects, providing consultation to other team members, reviewing the evaluation plans and research results of all other team members, drafting the section of the final report on population and development and contributing to the response of the team to question 6. Responsible for statistical analysis and data management, revising relevant sections of the final report with regard to UNFPA comments.

Mahinez El-Helw – Gender Evaluator (Question 5). Responsible for planning and conducting the evaluation of the gender projects, providing consultation to other team members, reviewing the evaluation plans and research results of all other team members, drafting the section of the final report on reproductive health and contributing to the response of the team to question 6, revising relevant sections of the final report with regard to UNFPA comments.

Schedule of tasks and deliverables

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 December</td>
<td>Preliminary inception report compiled</td>
</tr>
<tr>
<td>Date</td>
<td>Activity</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------------------------------------</td>
</tr>
<tr>
<td>1-9 December</td>
<td>Meet with implementing partners</td>
</tr>
<tr>
<td>9th December</td>
<td>Finalize inception report</td>
</tr>
<tr>
<td>9-29 December</td>
<td>Data collection period</td>
</tr>
<tr>
<td>19th December</td>
<td>Debriefing meeting</td>
</tr>
<tr>
<td>31st December</td>
<td>Preliminary results available, power point presentation</td>
</tr>
<tr>
<td>15th January</td>
<td>Draft evaluation report</td>
</tr>
<tr>
<td>Two weeks after evaluation report is approved.</td>
<td>Final report</td>
</tr>
</tbody>
</table>

**Limitations**

The results will be limited by the availability of data in this time frame. While some of the projects have had several years of implementation, others are just getting started so the evaluation of impact will be limited. Furthermore, some of the issues related to reproductive health and gender are considered sensitive and issues related to obtaining reliable information might emerge.
List of Tables and Appendices

Table 1. Evaluation Matrix

Table 2. Sampling Plan

Appendix 1. Project Descriptions and Evaluation Plan

Appendix 2. Draft of Final Report
<table>
<thead>
<tr>
<th>#</th>
<th>Evaluation Question</th>
<th>Relevant Projects</th>
<th>Performance indicator</th>
<th>Data Source</th>
<th>Evaluation design</th>
<th>Sampling plan</th>
<th>Data collection instruments</th>
<th>Data analysis plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Did the program intervention strengthen the family planning (FP) program within the MOH population sector to serve the Family Health Model?</td>
<td>EGY8BP2 Strengthening Supply, Demand, &amp; Utilization of Reproductive Health Care, Ministry of Health/Family Planning Sector</td>
<td>Quality and extent of training</td>
<td>documents, interviews, focus groups</td>
<td>post test</td>
<td>physicians, nurses, district staff members</td>
<td>Interview guide</td>
<td>qualitative analysis</td>
</tr>
<tr>
<td>1b</td>
<td>Did the utilization of FP services increase in governorates of program intervention?</td>
<td>EGY8BP2 Strengthening supply, demand and utilization of reproductive health care services within the context of health sector reform</td>
<td>% of clients using FP services, quality and extent of training</td>
<td>facility service data, interview</td>
<td>pre-post test</td>
<td>Program officer, director, VCT counselors, STI providers, data managers</td>
<td>service records, interview guide</td>
<td>chi square, qualitative analysis</td>
</tr>
<tr>
<td>2a</td>
<td>Did the capacity of health care providers strengthen &amp; provide quality VCT services as a result of program intervention?</td>
<td>EGY8BP03. Support to VCT Services. MOH and FHI</td>
<td>Quality and extent of training</td>
<td>documents, interviews</td>
<td>post test</td>
<td>2 project sites, one VCT and one STI in Cairo, 2 physicians, 2 nurses, data manager</td>
<td>Existing service records + evaluator validation visits</td>
<td>national data on HIV testing, qualitative analysis</td>
</tr>
<tr>
<td>2b</td>
<td>Did the target population use of VCT services increase in governorates of program intervention?</td>
<td>EGY8BP04A. Support to VCT &amp; YFC. FHI and MOH</td>
<td>% of VCT clients</td>
<td>VCT service data</td>
<td>pre-post test</td>
<td>2 project sites, one VCT and one STI in Cairo, 2 physicians, 2 nurses, data manager</td>
<td>Existing service records + evaluator validation visits</td>
<td>national data on HIV testing, qualitative analysis</td>
</tr>
<tr>
<td>3</td>
<td>To what extent did the YFC projects contribute to the sustainability and quality of RH services at the service delivery points?</td>
<td>EGY8BP10 &amp; EGY8BP31A. Adolescents RH needs in Egypt. Egyptian FP association and FHI</td>
<td>number new YFP clients, training, youth acceptability</td>
<td>service data, interviews, focus groups</td>
<td>post test</td>
<td>Ismailia and Menya centers interviews physicals, nurses, clients, peers</td>
<td>checklist, interview guide</td>
<td>qualitative analysis</td>
</tr>
<tr>
<td>3</td>
<td>To what extent did the YFC projects contribute to the sustainability and quality of RH services at the service delivery points?</td>
<td>EGY8BP44A. Teaching hospitals. Youth friendly services. General organization of teaching hospitals.</td>
<td>quality and extent of training, number of clients</td>
<td>service data, documents, interviews</td>
<td>post test</td>
<td>Menoufia and Sohag hospital clinics, interview physicians, secretary, youth</td>
<td>checklist, interview guide</td>
<td>qualitative analysis</td>
</tr>
<tr>
<td>4</td>
<td>How many gender analysis/disaggregated indicators developed and used in policy dialogue and in Gender program implementation?</td>
<td>EGY8BP5 Gender monitoring and evaluation.</td>
<td>quality of training</td>
<td>NCW records</td>
<td>Document review – content analysis</td>
<td>Desk study + Key informant discussions</td>
<td>examination of documents</td>
<td>observe attention to gender in data reporting</td>
</tr>
<tr>
<td>5a</td>
<td>Is the UNFPA/MoH FP Adolescent Health Project successfully building the capacity of adolescent beneficiaries as advocates for sexual and reproductive health and gender equity among their peers, especially vulnerable adolescents?</td>
<td>EGY8BP8 Adolescent Health Program</td>
<td>quality and extent of training</td>
<td>documents, interviews, observation</td>
<td>post test</td>
<td>staff, peer educators, parents, urban NGO, rural NGO</td>
<td>interview guide</td>
<td>qualitative analysis</td>
</tr>
<tr>
<td>5b</td>
<td>Have UNFPA/Egypt CP 2007-2011 strategies and activities to sensitize religious leaders and communities they serve been implemented successfully and are they likely to positively influence religious leaders/beneficiaries and media personnel knowledge and attitudes towards women and girls especially GBV?</td>
<td>EGY8G27B. Reproductive Rights and Gender in the context of Islam</td>
<td>quality of preparation for training</td>
<td>records, interviews</td>
<td>post test</td>
<td>project sites</td>
<td>interview guide</td>
<td>qualitative analysis</td>
</tr>
<tr>
<td>5b</td>
<td>Have UNFPA/Egypt CP 2007-2011 strategies and activities to sensitize religious leaders and communities they serve been implemented successfully and are they likely to positively influence religious leaders/beneficiaries and media personnel knowledge and attitudes towards women and girls especially GBV?</td>
<td>EGY8G47A. Campaign against sexual harassment.</td>
<td>quality of media kits, quality of training</td>
<td>interviews, documents, focus groups</td>
<td>post test</td>
<td>media personnel</td>
<td>interview guide</td>
<td>qualitative analysis</td>
</tr>
<tr>
<td>6</td>
<td>On the basis of findings from 1-5 how to reposition CP assistance for enhanced impact?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Evaluation Matrix
<table>
<thead>
<tr>
<th>Component</th>
<th>project</th>
<th>Total coverage of the project</th>
<th>Sampling plan</th>
<th>People who will be interviewed (for each site)</th>
<th>time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>RH</td>
<td>EGY08P02: Strengthening Supply, Demand &amp; Utilization of Reproductive Health Care Services within the context of Health Sector Reform</td>
<td>3 Governorates</td>
<td>Service records available from three governorates: Alexandria, Qena and Sohag</td>
<td>Coverage in two governorates: Alexandria and Sohag 2 physicians 2 nurses 2 RR 1 district director 1 Focused group discussion will be held with FP</td>
<td>19-24</td>
</tr>
<tr>
<td></td>
<td>EGY08P03 : Support to Voluntary Counseling &amp; Testing Services EGY8R44A : Support to VCT &amp; YFC</td>
<td>17 governorates</td>
<td>Limited data available (the first three month from each year in three sites (Cairo, Sharm El-Sheikh and Luxor). Data available for Menoufia governorate in pre and post promotion campaign</td>
<td>Greater Cairo, Sharm-El Sheikh, and Luxor 2 VCT counselors 2 coordinators or data managers 2 exit interviews with users or samples of exit interviews already available in clinics 2 STI providers only in Cairo</td>
<td>19-24</td>
</tr>
<tr>
<td></td>
<td>EGY08/P10 : Adolescents RH Needs in Egypt EGY08R54A : Teaching Hospitals - Youth Friendly Services</td>
<td>12 Governorates</td>
<td>Service record data available EFPA: Ismailia, Menoufia and Menya, Aswan TH: Menoufia, Banha, and Sohag</td>
<td>EFPA: Ismailia and Menya TH: Menoufia and Sohag 2 physicians 2 peers (for EFPA only) 2 social workers (for TH only) 1 FGD with male and one with female youth in EFPA clinics (subject to availability, interviews could be done instead in TH)</td>
<td>19-24</td>
</tr>
<tr>
<td>PD</td>
<td>EGY08P05: Gender Monitoring &amp; Evaluation</td>
<td>29 Governorates</td>
<td>There is no quantitative information required for this project</td>
<td>New Valley, Qina, Suez, Sharqia, Matruh 1 planning officer in each governorate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EGY8P31A: Evidence base population policy</td>
<td>29 Governorates</td>
<td></td>
<td>Cairo</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Interview with IP, project director and potential users</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>EGY08P08: Adolescent health Program</td>
<td>15 Governorate</td>
<td></td>
<td>Fayoum and Menya Interview with IP, project director and 2 NGOs, peer educators in NGO, parents, observe day preparations for sessions and actual sessions FGD with adolescents after attending sessions To decide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EGY8G27B: Reproductive Rights and Gender Issues in the context of Islam</td>
<td>29 Governorates</td>
<td></td>
<td>Any 2 governorates or 2 of 3 governorates where MORA will start step down Training Interview with IP staff, MORA staff Interviews with 10-15 religious leaders</td>
<td>19-24</td>
</tr>
<tr>
<td></td>
<td>EGY8G47A: Campaign against Sexual Harassment</td>
<td>Metropolitan Cairo</td>
<td></td>
<td>Random sample of media personnel from project records Interview with IP, project director interviews with media personnel</td>
<td>19-24</td>
</tr>
</tbody>
</table>
Inception Report Appendix 1.

Description of projects with intervention plans.

09 December 2010
Q1a, b

Did the program intervention strengthen the family planning (FP) program within the MOH population sector to serve Family Health Model? Did the utilization of family planning services increase in governates of program intervention?

ID: EGY08P02. Strengthening Supply, Demand & Utilization of Reproductive Health Care Services within the context of Health Sector Reform
Implementing Partner: Ministry of Health/Family Planning Sector (MoH/FPS)

Project duration:
The project started in July 2007 to December 2010 where activities varied from year to year.

This question will be answered to fulfil the CP outcome: utilization of integrated reproductive health services increased in Upper Egypt and with special focus on underprivileged communities in rural areas. The desired output is that primary and reproductive health care services be strengthened within the frame work of the Health Sector Reform.

This question is part of the Reproductive Health component of the CP which is the biggest component where more than 50% of the CP total is allocated. There are six implementing partners for the RH component: the Ministry of Health MoH, Family Health International/FHI, Teaching Hospitals/GOTHI, Egyptian Family Planning/EFPA, Al Shihab. The MoH with its two sections (population/family planning and preventive) is the biggest partner spending almost 50% of the total budget of the RH.

Generally the RH projects are set to support services implemented by the government. Project EGY08P02 Strengthening Supply, Demand & Utilization of Reproductive Health Care Services within the context of Health Sector Reform is one of the biggest projects about 21% of RH budget is allocated to it.

The project started its activities in July 2007 based on the rationale of the Health Sector Reform (HSR) promoting the Family Health Model (FHM) as the new system of family based primary health care. Its main activities are: commission a study to document and explain the limited RH-impact of The FHM and recommend strategies to increase its effect, ensure that accredited and non accredited PHC centres are adequately equipped/supplied/furnished to deliver quality integrated RH services, improve knowledge and skills of medical staff in accredited and non accredited PHCs through training activities, strengthening the supervision system in accredited and non-accredited PHCs by establishing a sustainable system of the On-the-job training at the district level and strengthen the formal status and improve knowledge and skills of outreach workers to increase RH awareness, monitor behaviour change, and build confidence in the FHM at the community level.

Among the activities that designed to achieve the desired output are activities aiming at coordination between different FP actors, quality improvement of the service, creation of evidence-based FP system and institutionalization of RH.

In evaluating this project we want to determine if the program is strengthening the supply, demand and utilization of Family Planning Services. This will be done through extensive desk review of the project’s documentation. This includes among others training curricula, auditing documents, outcome indicators and administrative records. In addition, individual interviews will be carried out with physicians, nurses, RR and project’s directors as well as focus groups with FP clients. Furthermore, interviews will be conducted with district's staff members to determine their gains from UNFPA supporting activities and their needs for the future. Moreover, a field visit will be done to validate the collected information. Service utilization will also be assessed within the intervention governates.
2a,b. Did the capacity of the health care providers strengthen and provide quality VCT services in governorates of program intervention? Is the number of clients using VCT services increasing?

**EGY08P03 Support to Voluntary Counselling & Testing Services.**
**EGY8R44A. Support to VCT and YFC.**
**Implementing Partner. Ministry of Health, Family Health International.**

This question is related to the CP outcome sustainability and quality of reproductive health services at the national level and at service delivery points improved. The output that is expected to be achieved is: capacity of health care providers strengthened to provide quality RH services including VCT and youth friendly services, especially to vulnerable groups.

**EGY08P03 Support to Voluntary Counselling & Testing Services project is the second largest project within the RH about 17% of the RH total budget is allocated to it. Ministry of Health/Preventive Sector and Family Health International (FHI)-Egypt as a sub-contractor are the main counterparts. EGYBR44a also contributes to this effort including FHI and the MOH.**

Starting 2007, MOH Preventive department in cooperation with UNFPA and technical assistance from FHI started the second round of a series of activities to reduce the risk of HIV/AIDS, Hepatitis B&C, and STI transmission. Three core areas were addressed namely; advocacy, policy development, and capacity building for health providers with special focus on enhancing counselling skills and promoting condom use.

FHI lead the capacity building activity through training of cadre of service providers to ensure sustained provision of quality VCT/STDs services in 9 mobile VCTs, an in 5 fixed VCT and 5 STD centres in selected governorates. These centres were developed through UNFPA support to MOH in the previous cycle (2002 – 2006). A total of 55 service providers were trained in the following areas: VCT counsellor training, STI health care provider training, data management training. In addition to the above activities, a communication component was included for producing IE&C materials as a response to client needs and a monitoring and evaluation plan was developed. To ensure accurate monitoring of VCT services, FHI worked with NAP to standardize data collection forms for all fixed and mobile VCT sites that were used to monitor data collected at VCTs.

In evaluating this question the same set of methods that used to evaluate Q1a will be used (desk review, interviews and field visits). Interviews will be conducted at one VCT and one STI clinic in the Cairo area. The persons to be interviewed include program officers, directors, physicians, nurses, VCT counsellors, and data managers. If feasible, clients of HIV counselling will be interviewed. The number of clients using VCT services will be obtained for a three year period from the National AIDS program.
Q3. Did the YFC projects contribute to the development of sustainable quality RH service delivery points for youth in Egypt?

Project 1.
Title. EGY/08/P10 and EGY8R51A. Adolescent reproductive health needs in Egypt.
Implementing Partner. Egyptian Family Planning Association and Family Health International.

This question will be answered to fulfil the CP outcome: Sustainability and quality of reproductive health services at the national level and at service point improved. The primary output is that the capacity of health care providers to provide quality RH services will be strengthened. The well being of young people in Egypt is under threat due to several causes such as prevalent FGC, early marriage, lack of sexual reproductive health (SRH) information, and lack of access to services and gender inequality.

Project 1.
UNFPA with EFPA and FHI took the lead to increase access to appropriate adolescent reproductive health services, awareness and information on SRH and rights. Through strengthening already existing youth friendly clinics (YFC) affiliated to EFPA, it would increase accessibility and utilization of reproductive health services to youth.

The project started in 2007 and to ensure a sustainable and comprehensive approach, FHI conducted a baseline assessment of eight YFC in 4 governorates namely; Qalioubia, Dakahlia, Ismailia, and Menoufia supported by focus group discussions with target population (youth) to identify gaps and weaknesses in service delivery. Based on the assessment, FHI developed training materials to ensure a standardized service delivery approach is taken throughout all intervention clinics. Later in 2009, 4 more intervention sites were developed in 4 new governorates namely; Aswan, Qena, Minya, and Matrouh to offer RH services for youth with same project activities continued till 2010. EFPA and FHI continued to monitor the execution of activities through site visits, action plans, and continuous reporting to UNFPA.

The methodology for intervention will include desk review of project documents and work plans, meeting minutes, training curricula, number of trainees, clinic documents and monitoring and evaluation tools. Individual interviews will be conducted with the UNFPA program officer, and project directors at EFPA and FHI. In addition, youth health service providers and peers who received training will be interviewed Focus group discussions will be conducted with youth using the clinics. Service data will also be collected to examine the number of clients served.

Project 2.
EGY08R54A0. Youth Friendly Services
Implementing Partner. General Organization of Teaching Hospitals

Based on the need to offer quality reproductive health services for the Egyptian youth and based on EDHS findings that indicate the need for that. UNFPA aimed at increasing access to appropriate RH information and services for young people in collaboration with The General Organization for Teaching Hospitals and Institutions. The project would strengthen the capacity of youth friendly clinics located in teaching hospitals and established with UNFPA’s assistance in earlier cycles by enhancing service providers skills to provide RH services for youth through training on counseling, communication, and management of RH issues. The project would work in nine YFC in 6 governorates namely; Cairo, Aswan, Sohag, Beheira, Menoufia, and Kaluobia. Training of providers will follow the same training curricula used by EFPA. The selected sites would provide the following RH services; counseling, health education on several RH topics including nutrition, referral of cases of ANC, Post Natal care, and family planning in addition to immunization services and lab testing. The evaluation methodology will be similar to the methodology used in Project 1.
Q4: How many gender analysis/disaggregated indicators developed and used in policy dialogue and in Gender program implementation?

**RGY08P05. Gender monitoring and evaluation.**
Implementing Partner. National Council for Women (NCW)

**EGY8P31A. Evidenced based population policy.**
Implementing Partner. Information Decision Support Center (IDSC)

This question is expected to be achieved to fulfil the outcome: poverty reduction strategies monitored from a gender perspective, enhanced national capacity to monitor progress towards achievement of ICPD/ICPD+5, MDGs.

The nature of PD programs is different from RH as it is concerned more by changing policies and availability of information for decision making. In addition its activities are more to do with training personnel and liaising tasks between government departments. This particular output is supposed to be achieved through implementing two projects gender monitoring & evaluation and evidence-based population policy implemented by NCW and IDSC respectively.

Evidence-based population policy project is accomplished through conducting four main activities: create and update population and development database, produce annual report reflecting progress in population policies, conducting population conference and organising advocacy and communication workshops. The bulk of the budget of this project is devoted to the production and the update of the population database and the production of annual reports. The training activities and advocacy meetings are the smaller components of this project.

In evaluating this project content analysis and interviews will be the leading methods for data collection. Regarding the population and development database, review of the indicators and process of collecting them will be done. Furthermore, an analysis of the end users of project’s deliverables will be done i.e. users of the database and publications. On the other hand, the training and the workshops will be assessed through reviewing contents as well as interviewing some attendees.

Gender monitoring and evaluation project main focus is directing and helping government in evaluating projects as well as overseeing progress and commitments. The project main activities are promote participation and capacity building of relevant national institutions in monitoring and evaluation of poverty/gender programmes, organize advocacy meetings with planners and key decision-makers, coordination meetings with Ministry of Finance to ensure budgeting for plans, preparation for M and E Training for relevant personnel.

In evaluating this project interviews with stakeholders, data users and trainees will be the main method as well as reviewing training materials.

In the two projects the impact of the intervention will be analysed taking into account the contribution of the whole PD component compared to other CP components in terms of impact, budget and strategic importance.
5a Evaluation Question: Is the UNFPA/MOFP Adolescent Health Project successfully building the capacity of adolescent beneficiaries as advocators for sexual and reproductive health (SRH) and gender equity among their peers, especially vulnerable adolescents?

EGY08P08. Adolescent Health Program Implementing Partner. Ministry of Family and Population.

This question is concerned with the “Adolescent Health Program” which is under UNFPA CP output 6 and is being implemented by the Ministry of Family and Population (project number EGY08P08). The overall objective of the “Adolescent Health Program” is to educate adolescents about RH and offer them guidance to utilize necessary services. Also raise community awareness about adolescent related issues to ensure an enabling environment and support for adolescent RH, reproductive rights (RR) and eliminating gender based violence (GBV). The program builds the capacity of NGOs to promote RH information to in school youth through peer education sessions. It trains young volunteers of participating NGOs in methods of peer education through Training of Trainers (ToT) through the Y-PEER network. The project is being implemented in 15 Governorates: Cairo, Giza, Ismailia, Fayoum, Sohag, Assiut, Qena, Beni-Suef, Menia, Aswan, Marsa-Matrouh, North Sinai and three new governorates Sharqia, Bahira and 6 October. Each governorate has one NGO active with the project, targeting 2 schools (boys and girls), 2 classes per school per year. Two governorates have two NGOs (North Sinai and Aswan). These additional NGOs have performed summer activities during school year 2009/2010. The three new governorates have also not targeted schools yet but have performed either summer activities or seminars in a youth center. Performance indicators such as the following are being devised to measure whether adolescent beneficiaries (peer educators) have become effective advocators for SRH and gender equity among their peers:

This evaluation data will be gathered mainly through post test evaluation design to identify changes in knowledge, attitudes and skills of peer educators due to the project. Two NGOs will be selected one in a rural and one in an urban area, where interviews, FGDs and observation of male / female peer education sessions. The following are the sources of data: Additional evaluation data will include project document review, including IEC materials, Egyptian standards of peer education, training guides, interviews with MOFP and NGO program staff, peer educators, and focus groups with male and female school adolescents after attending the session or pre-/post session quantitative questionnaire.
5b Evaluation Question: Have UNFPA/Egypt CP 2007-2011 strategies and activities to sensitize religious leaders and the communities they serve as well as media people been implemented successfully and are they likely to positively influence religious leaders/beneficiaries and media personnel knowledge and attitudes towards women and girls especially GBV?

EGY8G27B. Reproductive Rights and Gender in the Context of Islam
Implementing Partner. International Islamic Center for Population Studies and Research (IICPSR) Al Azhar University.
EGY8G47A. Campaign against sexual Harassment.
Implementing Partner. Egyptian Center for Womens Rights.

Two projects aim to achieve the objectives that are addressed in the above evaluation question. The first “Advocacy for Reproductive Health/Gender Issues in the Context of Islam” (project number EGY8G27B), conducted since mid 2008, having a national scope, in partnership with the International Islamic Center for Population Studies and Research (IICPSR) — Al-Azhar University, with overall goal to ensure that Islamic preachers and graduating theologians are trained and oriented on the Islamic perception of reproductive health, rights and gender. The project aims in general to build the capacity of selected faith based partners with respect to understanding gender, reproductive health and population issues. The project also seeks to advocate for the common grounds between these issues and Islamic teachings, with respect to applying this gained knowledge in practice in different settings such as religious sermons. The project has so far produced a reference manual and training guide for religious leaders. They have trained religious leaders nationwide.

The evaluation data will be collected using a post test evaluation design but will aim to compare findings to available baseline like data. A sample of trained religious leaders from al-Azhar and MORA will be interviewed (different age groups/ regions / male/female). In addition, interviews with project staff from al-Azhar and MORA will be conducted. Use will be made of project documents, including KAP survey, monitoring and evaluation reports of project e.g. pre and post training questionnaire, and other studies if available. Content analysis of reference manual and training manual will be performed to judge the quality and effectiveness of messages. If there is any documentation on utilization of key GBV messages in preaching activities it will be analysed.

The second project “Campaign against Sexual Harassment” (project number EGY8G47A) is implemented by The Egyptian Center for Women’s Rights (ECWR) since 2009 with overall goal to advance women’s status in society by promoting a culture of respect and personal rights that begins with changing the social acceptability among both men and women of sexual harassment in the street. One of the strategies used is to sensitize media personnel preparing them to be advocates for combating sexual harassment.

The evaluation information will be collected using a post test evaluation design but will aim to elicit information about changes in mass media people’s attitudes and practices due to the project as well as media coverage. Project documents, including IEC materials, project monitoring reports e.g. media coverage reports, report on changes in discourse about sexual harassment, progress reports etc. will be reviewed. In depth interviews with a sample of media personnel working in all types of media channels will be conducted (government / private: allies / not allies: male /female)
Appendix 2. Outline of Final Report

Title Page
Table of Contents
Acknowledgements
List of acronyms

Executive Summary – draft author Kathleen Ford
2 pages
State objectives, methods, major limitations, most important findings, conclusions and recommendations

Introduction – draft author Kathleen Ford
3 pages
Describe program being evaluated, problems addressed by the projects, evaluation purpose, objectives, and key questions. Evaluation criteria and methodology employed to conduct the evaluation. Who was involved in conducting the evaluation and what were their roles. Structure of the evaluation report.

Findings and Conclusions
18 pages total
Reproductive Health Questions 1-3 – 6 pages – draft author Hala Youssef
Population and Development – Question 4 – 4 pages draft author Samar Gala
Gender Question 5. – 5 pages - Draft author Mahinaz El-Helw

Recommendations for reprioritizing the CP for enhanced impact 3 pages – draft author entire team

In each section, present the results in qualitative and quantitative forms and analyze the linkages between inputs, outputs and outcomes and, if possible impact. Discuss the relative contribution of stakeholders to achievement of results. Conclusions should be substantiated by the findings and be consistent with the data collected, and must relate to the evaluation objectives and provide answers to the evaluation questions.

Lessons Learned
3 pages
Reproductive health draft author Hala Youssef
Population and Development draft author Samar Gala
Gender – draft author Mahinaz El Helw
Summary – draft author Kathleen Ford

Based on the findings and drawing from the evaluators overall experience in other contexts, if possible provide lessons learned that may be applicable in other situations, include positive and negative lessons.

Recommendations

3 pages

Reproductive Health – draft author Hala Youssef

Population and Development - draft author Samar Gala

Gender – draft author Mahinaz El Helw

Summary – draft author Kathleen Ford

Formulate relevant specific and realistic recommendations that are based on the evidence gathered, conclusions made and lessons learned. List proposals for action to be taken (short and long term) by the person, unit or organization responsible for follow-up in priority order including suggested time lines and cost estimates (where relevant) for implementation.

Annexes

1) TOR for the evaluation
2) List of persons interviewed
3) Sites visited
4) List of documents reviewed
5) Data collection instruments
6) Web links
<table>
<thead>
<tr>
<th>#</th>
<th>Evaluation Question</th>
<th>Relevant Projects</th>
<th>Performance indicator</th>
<th>Data Source</th>
<th>Evaluation design</th>
<th>Sampling plan</th>
<th>Data collection instruments</th>
<th>Data analysis plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Did the program intervention strengthen the family planning (FP) program within the MOH population sector to serve the Family Health Model?</td>
<td>EGY08P02 Strengthening Supply, Demand, &amp; Utilization of Reproductive Health Care . Ministry of Health/Family Planning Sector</td>
<td>Quality and extent of training</td>
<td>documents, interviews, focus groups</td>
<td>post test</td>
<td>physicians, nurses, district staff members</td>
<td>Interview guide (1a.1 &amp;1a.2)</td>
<td>qualitative analysis</td>
</tr>
<tr>
<td>1b</td>
<td>Did the utilization of FP services increase in governorates of program intervention?</td>
<td>EGY08P02 Strengthening supply, demand and utilization of reproductive health care services within the context of health sector reform</td>
<td>% of clients using FP services, quality and extent of training</td>
<td>facility service data, interview</td>
<td>pre-post test</td>
<td>service records, interview guide (1b.1)</td>
<td></td>
<td>chi square, qualitative analysis</td>
</tr>
<tr>
<td>2a</td>
<td>Did the capacity of health care providers strengthen &amp; provide quality VCT services as a result of program intervention?</td>
<td>EGY08P03. Support to VCT Services. MOH and FHI</td>
<td>Quality and extent of training</td>
<td>documents, Interviews</td>
<td>post test</td>
<td>Program officer, director, VCT counselors, STI providers, data managers</td>
<td>interview guide (2a.1 &amp; 2a.2 &amp; 2a.3)</td>
<td>qualitative analysis</td>
</tr>
<tr>
<td>2b</td>
<td>Did the target population use of VCT services increase in governorates of program intervention?</td>
<td>EGY8R44A. Support to VCT &amp; YFC. FH and MOH</td>
<td>% of VCT clients</td>
<td>VCT service data</td>
<td>pre-post test</td>
<td>2 project sites, one VCT and one STI Cairo, 2 physicians, 2 nurses, data manager</td>
<td>Existing service records + evaluator validation visits (2b.1)</td>
<td>national data on HIV testing, qualitative analysis</td>
</tr>
<tr>
<td>3</td>
<td>To what extent did the YFC projects contribute to the sustainability and quality of RH services at the service delivery points?</td>
<td>EGY/08/P10 &amp; EGY8R51A. Adolescents RH needs in Egypt. Egyptian FP association and FHI</td>
<td>number new YFP clients, training, youth acceptability</td>
<td>service data, interviews, focus groups</td>
<td>post test</td>
<td>Menoua and Ismailia centers interviews physicians, nurses, clients, fg peers</td>
<td>checklist, interview guide (3.1 &amp; 3.2)</td>
<td>qualitative analysis</td>
</tr>
<tr>
<td>5a</td>
<td>Is the UNFPA/MOFP Adolescent Health Project successfully building the capacity of adolescent beneficiaries as advocates for sexual and reproductive health and</td>
<td>EGY08P08. Adolescent Health Program</td>
<td>quality and extent of training</td>
<td>documents, interviews, observation</td>
<td>post test</td>
<td>staff, peer educators, parents, urban NGO, rural NGO</td>
<td>interview guide</td>
<td>qualitative analysis</td>
</tr>
<tr>
<td>5b</td>
<td>Have UNFPA/Egypt CP 2007-2011 strategies and activities to sensitize religious leaders and communities they serve been implemented successfully and are they likely to positively influence religious leaders/beneficiaries and media personnel knowledge and attitudes towards women and girls especially GBV?</td>
<td></td>
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</tr>
<tr>
<td>EGY8G27B. Reproductive Rights and Gender in the context of Islam</td>
<td>quality of preparation for training</td>
<td>records, interviews</td>
<td>post test</td>
<td>project sites</td>
<td>interview guide (5b.1)</td>
<td>qualitative analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EGY8G47A. Campaign against sexual harassment.</td>
<td>quality of media kits, quality of training</td>
<td>interviews, documents, focus groups</td>
<td>post test</td>
<td>media personnel</td>
<td>interview guide (5b.2)</td>
<td>qualitative analysis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. On the basis of findings from 1-5 how to reposition CP assistance for enhanced impact?
تحليل الوضع الحالي للخدمات الصحية بعد التدخلات من قبل وزارة الصحة
التي تقدم لمنتفعات تنظيم الأسرة، من خلال المراكز الصحية التابعة للوزارة في بعض المحافظات في مصر وممولة من قبل صندوق الأمم المتحدة للسكان

دليل المقابلة المعمقة لمقدمي خدمات تنظيم الأسرة

المقدمة:
صباح الخير، أنا أحب أعرفكم بنفسي، أنا ... وأعمل مع صندوق الأمم المتحدة لتقييم التدخلات لتحسين خدمات تنظيم الأسرة في وزارة الصحة ونود أن نعرف آراء حضراتكم ومقترحاتكم بالنسبة للخدمة المتاحة حاليا وتدريبات القيادات التي حصلت عليها. فما أن حضرتكم قد حصلوا على النصائح الأولى للمراحل القادمة.

شروط المقابلة:

أحب أن أوضح لحضرتك أنه ما فيها رأى صح أو غلط، كل الآراء ه تكون مفيدة بالنسبة لنا. بعد إذنك هنمل الجلسة لذ عضان ما ننساه أي نقطة تمت أثناء النقاش من آرائكم المفيدة والمهمة.

النقاط الأساسية في المناقشة:

أولا: أسس خدمات تنظيم الأسرة:
1- أحب أن أعرف عن خدمات تنظيم الأسرة المقدمة في الوحدة بتاعتك؟
2- أيها وسائل تنظيم الأسرة الموجودة في الوحدة هنا؟ هل الوسائل دي موجودة بانتظام؟ بيميلوا أي عضان يتأكدوا من توافر الوسائل دائما؟
3- هل حصل أنه الوسائل ما كنتش موجودة في فترة؟ أتصرفوا أزاي؟
4- مين هي المنتفعة اللي ممكن تكلمها عن المبادعة و تنظيم الأسرة و امني؟ هل ممكن تكلموا الحوامل عن تنظيم الأسرة؟
5- من وجهة نظر حضرتك، أحب أنك تفهمي يعني أي مشورة معضوبة بالضبط؟ أيه هي الشروط الواجب توافرها في المشورة الجيدة؟ (مطلب التعمق)
6- أيه هي النقط اللي لازم تغطي أثناء المشورة مع كل و سلية؟ (يتم التعمق عن الأعراض الجانبية)
7- أيه هي فترة المبادعة المطلبي بين الولادة و بداية الحمل الذي يليه؟
8- أنتهت الست ممكن تحمل بعد الولادة و أنتهت ممكن تحصل حمل للولادة بعد الاجهاض؟
- 8. أيه رأيكم في استعمال وسائل تنظيف الأسرة قبل الأربعين على طول؟ هل هي لها أي فوائد أو أضرار؟ طيب أيه رأيكم في تركيب اللولب بعد الولادة على طول؟

- 9. أيه رأيكم في الرضاعة التنظيفية؟ تفكروا أنها ممكن تمنع الحمل أكيد؟ (هل فيه شروط؟ مطلوب التعمق)

- 10. مين بيشيرك على العمل بيع حضرتك؟ وهل حضرتك شافه أنه مفيد؟ ماذا؟ أزاى؟ أيه ممكن نخله أكثر افادة؟ هل حصل إنه حضرتك طلبت مساعدة من المشرفين؟ اتشرفت معالك أزاى؟ هل ممكن تحكي أي موقف؟

ثانيا: التدريب

- 11. حضرتك أخر مرة اخذت تدريب على تنظيم الأسرة مع وزارة الصحة كان امتي؟ مين كان حاضر معالك في التدريب ده (فريق الإدارة-المشرفين)؟

- 12. ايه هي المواضيع التي اتغطت أثناء التدريب؟ هل ايام التدريب غلبت كل المواضيع التي كنت محتج تعرفها أكثر؟ هل وقت المحاضرات كان مناسب؟ أسلوب التدريب كان يسمح بالنقاش أو المحاضرات فقط؟ هل كان في جزء عمل؟

- 13. بالنسبة للمدربين، هل كانوا متمكنين من المادة العلمية؟ هل كان التدريب العملي مفيد؟ ما زوج حضرتك تقول لي حاجتين أو ثلاثة استفدت من التدريب؟

- 14. بعد التدريب، هل حسيت أنك تغيرت في تقديمك للخدمة؟ ازاى؟ أيه الحاجات التي بقت احسن؟

- 15. هل حاولت أنك تقيم نفسك؟ ازاى؟ (أدوات التقييم)

- 16. هل حسنت أنه بعد التدريب الناس بقت يجي للوحدة أكثر من الأول؟ ازاى عرفت أنه ده حصل؟... يجب التعمق.

- 17. لو فيه تدريب ثاني، أيه المواضيع التي تتحب تعرفها أكثر؟ هل تحب التدريب يكون نظري ولا عملى ولا على رأس العمل؟ ريث طبنتي امثالة. يجب التعمق.

- 18. هل حضرتك تحب يقول حاجة زيادة عن اللي قولناه؟ ما هي مقترحاتك؟ (يرجى التعمق في هذه الأسئلة)

باشكر حضرتك على المعلومات القيمة...
تحليل الوضع الحالي للخدمات الصحية بعد التدخلات من قبل وزارة الصحة

التي تقدم لمنظمات تنظيم الأسرة، من خلال المراكز الصحية التابعة للوزارة في بعض المحافظات في مصر وممولة من قبل صندوق الأمم المتحدة للسكان

دليل المقابلة المتعارف على مدير الادارات الصحية

المقدمة:

صباح الخير، أنا أحب أعرفكم بنفسي. أنا … واعمل مع صندوق الأمم المتحدة لتقديم التدخلات لتحسين خدمات تنظيم الأسرة في وزارة الصحة ونود أن نعرف آراء حضرتك وتقرراتكم بالنسبة للخدمة الموجودة حاليا وتذكريات التي حصلت عليها. عشان ده حيسادنا كثير في تحديث الأولويات الراهنة القائمة.

شروط المقابلة:

احب أوضح لحضرتك انه مافش رأى صح أو غلط، كل الآراء هتكون مفيدة بالنسبة لنا.

بعد إذنك هنسجل الجلسة دي عشان ما ننساش أي نقطة تم عليها النقاش من آرائكم المفيدة والمهمة.

النقاط الأساسية في المناقشة:

أولا: أسس إدارة خدمات تنظيم الأسرة:

1. أحب اتعرف من حضرتك على خدمات تنظيم الأسرة المقدمة في وحدات الرعاية الصحية؟

2. إيه هي وسائل تنظيم الأسرة المتاحة من خلال الخدمة؟ هل الوسائل دي موجودة بالضبط؟ بيعملوا اي حضرة تتأكدوا من توفر الوسائل دائما؟ هل حصل ان الوسائل ما كنتش موجودة في فترة اتفقوا اراني؟

3. حضرة في رأيك، إيه هي فترة المباعدة المثلى بين الولادة و الحمل الذي يليه؟

4. حضرة في رأيك، إيه هي فترة الاتصال المثلى بين الولادة و الحمل الذي يليه؟

5. إيه رأي حضرة في تزويج اللولب بعد الولادة على طول؟

6. إيه رأي في الرعاية الطبية؟ تفكرت انها ممكن تمنع الحمل أكيد (هل فيه شروط؟)

7. ممكن نتكلم شوية عن الإدارة؟ إيه مفهوم حضرة للإشراف؟ ممكن حضرة تدلي مثال تطبيقي؟

الخدمة؟ هل عادكم خطة للاشراف بتعمل كل اداة؟ مين بيساعد في وضع الخطة؟ مين بنعرفها؟ هل حضرة صافية انها التخطيط مفيد؟

ازاي؟ اراني ممكن نخليه أكثر افادة؟
9- هل حصل أن حضرتك طلبت مساعدة من المشرفين؟ اتصلوا معانا أزاي؟ هل ممكن تحكي أي موقف؟

ثانيًا: التدريب

حضرتك آخر مرة اخذت تدريب على الإدارة والشرف مع وزارة الصحة كان متى؟ من كان حاضر معاك في التدريب ده؟

أيه هي المواضيع التي اتفقت أثناء التدريب؟ هل أيام التدريب غلبت كل المواضيع التي كنت تحتاج تعرفها أكثر؟ هل وقت المحاضرات كان مناسب؟ أسلوب التدريب كان يسمح بالنقاش أو المحاضرات فقط؟

بالنسبة للمتدربين، هل كانوا متمكنين من المادة العلمية؟ هل كان التدريب العملي مفيد؟ أهنت حضرتك تقول لي حاجتين أو ثلاثة استفدتهم من التدريب؟

بعد التدريب، هل حسيت أنك اتغيرت في أسلوب الإدارة والشرف أزاي؟ أي الحاجات اللي بقت احسن؟

هل حاولت أنك تقيم نفسك أزاي؟

هل حسبت أنك بعد التدريب سير العمل بقي احسن من الأول؟ أزاي عرفت أنه ده حصل؟... يجب التعمق.

لو فيه تدريب ثاني، أي المواضيع التي تحب تعرفها أكثر؟ وهل تحب التدريب يكون نظري ولا عملي ولا على رأس العمل؟

يا ريت تدبيرملة. يجب التعمق

هل حضرتك تطلب بقول حاجة زيادة عن اللي قولانه؟

(يرجى التعمق في هذه الأسئلة)

باشكر حضرتك على المعلومات القيمة....
تحليل الوضع الحالي للخدمات الصحية بعد التدخلات من قبل وزارة الصحة التي تقدم لمنشآت تنظيم الأسرة، من خلال المراكز الصحية التابعة للوزارة في بعض المحافظات في مصر والموكلة من قبل صندوق الأمم المتحدة للسكان

دليل المناقشة البورتية لمنشآت تنظيم الأسرة

المقدمة:

صباح الخير، أنا أحب أعرفكم بنفس، أنا...... وأعمل مع وزارة الصحة لتحسين الخدمات الصحية في مجال تنظيم الأسرة ونود أن نعرف أينكم ومقترحاتكم بالنسبة للخدمة الموجودة حالياً. عشان ده حساعنا كثير في تحسين نوعية الخدمة.

شروط الجلسة:

إحنا هنا جاين عشان نسمع بعض وعشان نناقش ها疑问 منكم تسمحوا لكل واحد يقول راي، ما فيش رأى صح وما فيش رأى غلط، كل آراءكم هتكون مفيدة بالنسبة لنا. بعد إذنكم هنسجل الجلسة دى عشان ما ننساه أي رأى من أرائكم المفيدة والمهمة.

النقاط الأساسية في المناقشة:

أولاً: المعرفة عن خدمات تنظيم الأسرة:

1. يا ريت كل واحدا تقول لنا هل اخترت الوحدة دي؟ وهل حدد ساعدها في اختيار المكان ده (الطبيب، الأهل-...)?

2. تعرفوا إيه هي وسائل تنظيم الأسرة الموجودة في الوحدة هنا؟ مين من الوحدة هنا عرفكم بها؟

3. طب تعرفوا الأعراض الجانبية مع كل وسيلة؟ والمخاطر تتصرفوا إزاى لما تحصل؟

ثانياً: الآراء والاتجاهات

4. إيه هو رأيكم في خدمات تنظيم الأسرة هنا؟ هل هي كافية؟ هل حسيتوا أنكم حصلتوا على كل المعلومات الخاصة بالوسائل؟ ايه اللي ناقش و كنتوا تحبوا تعرفوه؟
5. أثناء الحصول على الخدمة، كان مين موجود معاكوا في حجرة الكشف؟

6. إيه رأيك في استعمال وسائل تنظيم الأسرة بعد الأربعين على طول؟ هي ليها أي فوائد أو أضرار؟

7. إيه رأيك في الرضاعة التنظيفة؟ تتفكرلا أنها ممكن تمنع الحمل أكيد؟ هل حد بيشجعكم عليها؟ مين؟ هل سألتوا عليها النكاترة؟ قالوا لكم إيه؟ التعقم لمعرفة الشروط

ثالثا: الممارسات والمقترحات:

8. هل حد فوكو اه حب أزيد عن اللي قولناه؟ (يجب التعمق في هذه الأسئلة)

9. هل حد فوكو راح الادة بعد الولادة؟ امتي؟ إيه اللي حصل في الزيارة دى وما هي الخدمات اللي حصلتوا عليها(تنظيم أسرة - رعاية أم- تطعيم)

10. هل حد فوكو اه حصل في الزيارة هول كان في حاجة تحبوا الممرضة تقولها أو تعملها أثناء الزيارة وماعملتها؟ ممكن الزيارات دي بيحصل فيها إيه بالضبط عشان تخليك تنبليها؟ (يتم السؤال عن المشاهرة بالنغص)

بشكركم على المعلومات القيمة....
تحليل الوضع الحالي بعد التدخلات من قبل وزارة الصحة لتحسين الخدمات الصحية الخاصة بالمشورة والفحص الاختياري لفيروس نقص المناعة البشري و التي تقدم من خلال المراكز الصحية التابعة للوزارة في بعض المحافظات في مصر و الممول من قبل صندوق الأمم المتحدة للمسكان

دليل المقابلة المتميزة لخدمات المشورة والفحص الاختياري

المقدمة:
صبح الخير، أنا أتمنى أن أكنك نبضأ. أنا .... وأعمل مع صندوق الأمم المتحدة لتقييم التدخلات من قبل وزارة الصحة لتحسين الخدمات الصحية الخاصة بالمشورة والفحص الاختياري泻維روس نقص المناعة البشري ونود أن يعرف أراة حضارتك ومقرحاتكم بالنسبة للخدمة الموجودة حاليا والتدريبات التي حصلوا عليها. أشتقلب حسبا كثير في تطبيق الدوريات للمرحلة القادمة.

شروط المقابلة:
حبيب أوضح لحضرتك انه ماشي صح أو غلط، كل الآراء هتكون مفيدة بالنسبة لنا.
بعد إذنك هناك المقابلة دى عشان ما ننساش أي نقطة تمت أثناء النقاش من آرائكم المفيدة والمهمة.

النقاط الأساسية في المناقشة:
أولا: أسس الخدمات:

1. أحب أعرف من حضارتك ما 사람이 صح أو غلط، كل الآراء هتكون مفيدة بالنسبة لنا.

2. هل تجد صعوبة في التعامل مع مرض الأيدز؟ أيا؟ أيا أكثر حاجة لتبنيك؟ أيا يتعملون مع المرضى دول أو حتى المرضى من المناطق الجدوي؟

3. هل من خلال عملك يمكنك تطبيق خبر ممرضين للاستعمال بالاليد؟ أيا تتعاملون معهم؟ يعنى ينتقل لمهمة أيا بالطبع؟

4. من وجهة نظرة حضارتك، أحب أن أعلى يعني أن مرض الأيدز يدفع معالجة بالضبط؟ مرتاح أو المريض تؤثرها في المشورة الجيدة؟ ( gruntل التمثيل)

5. أيا هي النقطة التي تراكم أفراد المشورة مع كل ممتع أو منتفع؟ ( يجب التمثيل)

6. أيا حضارتك تشكك أنه الممتع يمكن أن يكون حل لمرض الأيدز؟ أيا حضارتك تعترف أيا هي الفترة الشباكية وما هي منتهي؟

7. أيا هي الرسالة الصحية الالهاء التي يجب توقيعها للعمل المستخدمين ليعدوا؟ ( يجب التمثيل لصرفزير للCTR، يعني في أن تكون

8. ما هو معنى نتيجة سلبية أو إيجابية للتحليل؟ أيا تقول له؟ نتائج التحليل المتوقع من هذه الخدمة؟ أيا يتضمن له سرية نتائج التحلي؟ حضارتك ممكن تديل مثل؟

9. أيا هو المشاكل التي يتفاوض حضارتك في تنفيذ هذه الدورة من الخدمات؟ أيا يجد صعوبة مع السنتين أكثر مثل؟ أيا حضارتك شابف أنه في أبوق على هذه الخدمة؟ أي أبوق و أيا؟

10. أيا الاخطار التي حضارتك يتفاوض تطور لتوافق مع الناس دي؟

11. من وجهة نظرة حضارتك أيا يزور المتبرعون على هذه الخدمة؟ أيا ممكن نخيل المجتمع يتفرع التعامل مع الناس دي بسهولة و سهولة؟

12. مئة يشترق على العمل بناء حضارتك؟ أيا حضارتك شابف أنه مفيد؟ أيا؟ أيا ممكن نخيل ايك افاده؟
هل حصل أنه حضرك طلبت مساعدة من المشرفين؟ اتصلوا معاه أراي؟ هل ممكن تحكي أي موقف؟

ثانياً: التدريب

حضرك آخر مرة اتخذت تدريبًا على المشورة والفحص الافتراضي لفيروس نقص المناعة البشري كان أمتى؟ مين كان حاضر معاك في التدريب؟

أيه هي المواضيع التي انتقطت أثناء التدريب؟ هل أيام التدريب عقب كل المواضيع التي كنت تحتاج تعرفها أكثر؟ هل وقت المحاضرات كان مناسب؟ أسلوب التدريب كان يماثل بالنقاش أو محاضرات فقط؟

بالنسبة للمدربين. هل كانوا متمكنين من المادة العلمية؟ هل كان التدريب النشبي مفيدًا؟ باركت حضرك نقول ل حاجتين أو ثلاثة استغاثتهم من التدريب؟

بعد التدريب. هل حسبت أنك اكتسبت في تقنيك الخدمة؟ أراي؟ أي الحواس التي بقت احسن؟ هل حاولت أنك تقيم نفسك؟ أراي؟

هل حسبت أنه بعد التدريب الناس بقت لجئي لعيادتك أكثر من الأول؟ أراي عرفت أنه ده حصل؟ يجب التعمق.

لو فيه تدريب ثاني. أي المواضيع التي تجب تعرفها أكثر؟ و هل تحب التدريب يكون نظري ولا عملي ولا على رأس العمل؟ يا ريت تدلي امثلة. يجب التعمق. هل حضرك تجب يقول حاجة زيادة عن اللي قولنها؟

(وجب التعمق في هذه الأسئلة)

باشكر حضرك على المعلومات القوية...
تحليل الوضع الحالي بعد التدخلات من قبل وزارة الصحة لتحسين الخدمات الصحية الخاصة بمرضى الأمراض المنقولة جنسياً و التي تقدم من خلال المراكز الصحية التابعة للوزارة في بعض المحافظات في مصر والممول من قبل صندوق الأمم المتحدة للسكان

دليل المقابلة المتعامدة لمقدمي الخدمات الصحية الخاصة بمرضى الأمراض المنقولة جنسياً

المقدمة:
صباح الخير، أنا أحب أعرفكم بنفسي. أنا .... وأعمل مع صندوق الأمم المتحدة لتقديم التدخلات من قبل وزارة الصحة لتحسين الخدمات الصحية الخاصة بمرضى الأمراض المنقولة جنسياً ونود أن نعرف آراءك حول خططنا، نحن نعتمد على الرأي العام من أجل تحسين الخدمات الصحية للأمهات الأكثر بحاجة. معًا، نحن جميعًا نعمل على تحسين الخدمات الصحية للأمهات أكثر بحاجة.

شروط المقابلة:
أحب أن أوضح لحضرتك أنه مافش رأى صريح أو غلط، كل الآراء تكون مفيدة بالنسبة لنا. بعد إذنك، نسجل الجلسة على السلام قبل أي نقطة تمت أثناء النقاش من آرائكم المفيدة والمهمة.

النقاط الأساسية في المناقشة:
أولاً: أسس الخدمات

1. تعرف ما عرض الآيدز؟ ما هو الوضع في مصر؟ هل تذكر عندنا حالات كثيرة؟
2. هل تجد صعوبة في التعامل مع مرضى الآيدز أو المعرضين له؟ كيف تتعامل معهم؟ هل تستخدم النصائح والنصائح باللغة الإنجليزية؟
3. تعرف ما هي الخطوات التي يتبعها في تشخيص ومعالجة مرضى الأمراض المنقولة جنسياً (أربعة خطوات يجب ذكرهم بحرف C)؟
4. من وجهة نظر حضرتك، أحب أنك تفهمي يعني إيه مشورة بالضبط؟ ما هي الشروط الواجب توافرها في المشورة الجيدة؟
5. ما هي النقاط التي لازم تعطي أثناء المشورة مع كل متعاط أو متتعاط؟ (جرب التعمق)
6. هل حضرتك تشع أنه المتعاط يمكن حامل لمرض الآيدز؟ هل حضرتك تشع أنه تمتع أثر من الفرق بين نساء ورجال؟
7. هل من خلال عملك تقابل كثير متعاطين للاصابة بالآيدز؟ أحب أنك تتيك أه عندهم المرض؟ أحب تتعاملهم، يعني نقول لهم إيه بالضبط؟ طيب من مصادر معلوماتهم؟

Counseling, Condom, Contact, Compliance
8- أيها الرسائل الصحية الهامة التي يجب توصيلها لهؤلاء المستخدمين لعيائتك؟ (يجب التعمق لمعرفة إن كان يقوم بعرض لاستخدام الواقي الذكري أم لا)

9- إن لم يذكر الواقي الذكري، اسألهم: هل حضرتك تتلألأ لمعرفة إن كان يقوم بعرض لاستخدام الواقي الذكري في هذه النوعية من الخدمات؟ هل يتعد صعوبة مع السنات أكثر مثلاً؟ هل حضرتك شايف إنه في أقبال على هذه الخدمة؟ ليه أو ليم؟

10- أيهما المشاكل اللي ي.Calendar حضرتك في تقديم هذه النوعية من الخدمات؟ هل يتعد صعوبة مع السنات أكثر مثلاً؟ هل حضرتك شايف إنه في أقبال على هذه الخدمة؟ ليه أو ليم؟

11- أيها الإخطار اللي حضرتك بتحتر خاطر ت تعرض لها أثناء التعامل مع الناس؟

12- من وجهة نظر حضرتك آناً نزود المترددين على هذه الخدمة؟

13- مين بيخبر على العمل بناء حضرتك؟ وهل حضرتك شايف إنه مفيد؟ أزاي؟ وهل عمك نحن أخطاء أو اعتقالات؟ هل حضرتك مروية؟ هل حضرتك تقول له تحكي أي موقف؟

ثانياً: التدريب

14- حضرتك أخر مرة اخذت تدريب على الأمراض المنقولة جنسيًا كان أمتي؟ مين كان حاضر معك في التدريب؟

15- أيهما المواضيع اللي اتغطت أثناء التدريب؟ هل إيم التدريب غطت كل المواضيع اللي كنت تحتاج تعريفها أكثر؟ هل وقت المحاضرات كان مناسب؟ أسلوب التدريب كان يسمح بالنقاش أو محاضرات فقط؟

بالمهندس للمهتمين. هل كانوا متمكنين من المادة العلمية؟ هل كان التدريب العملي مفيد؟ ياري حضرتك تقول لي حاجتين أو ثلاثة استفدت من التدريب؟

16- بعد التدريب، هل حسيت أنه اتغنت في تقديبك للخدمة؟ أزاي؟ هل الشعور اللي بقت احساس؟ هل حاولت أنك تقم نفسك؟ أزاي؟

17- هل حسيت أنه بعد التدريب الناس بقت نجحك لدانه أكثر من الأول؟ أزاي عندك؟ هل حصلت أنه ده حصل؟...

18- لوه فيه تدريب ثاني، أيهما المواضيع اللي تقربها أكثر؟ هل حضرتك تقربها أكثر؟ هل التدريب يكون نظري ولا عملي ولا على رأس العمل؟ با ريب تدين إثارة. يجب التعمق. هل حضرتك تقرب بقول حاجة زيادة عن اللي قولناه؟

(يجب التعمق في هذه الأسئلة)

19- باشكر حضرتك على المعلومات القيمة...

(يجب التعمق في هذه الأسئلة)
دليل المقابلة المتعمقة لمدخل بيانات خدمات المشورة والفحص الاختياري

المقدمة:
 صباح الخير، أنا أحب أعرفكم بنفسكم. أنا ...... وأعمل مع صندوق الأمم المتحدة لتقديم التدخلات من قبل وزارة الصحة لتحسين الخدمات الصحية الخاصة بالمشورة والفحص الاختياري. نقوم بتقديم المنصة المشورة والفحص الاختياري لفيروس نقص المناعة البشري ونود أن نعرف آراء حضرتك ومقترحاتكم بالنسبة لطبيعة عمل حضرتك وتدريبات التي حصلت عليها. عشان ده بيحسننا كثير في تحديد الأولويات للمرحلة القادمة.

شروط المقابلة:
 أحب أوضح لحضرتك أنه مايش رأي صح أو غلط، كل الآراء تكون مفيدة بالنسبة لنا. بعد إنك هنسجل الجلسة دي عشان ما ننساه أي نقطة تمت أثناء النقاش من آرائكم المفيدة والمهمة.

النقاط الأساسية في المناقشة:

أولاً: أسس العملين على حفظ البيانات وتدخلها على الكمبيوتر:

1. أحب أعرف من حضرتك تعرف أي عن مرض الإيدز؟ هل تفتكر في مصر فيه حالات كثيرة؟ هل تجد صعوبة في انك تعمل في هذا المكان وقد تتعامل مع مرضى الإيدز؟ ايه أكثر حاجة بتعمل أو بتعمل في هذا المكان؟

2. هل حضرتك شاف ان من هو Então على هذه الخدمة؟ تنتظر اي أسباب زيادة الأقبال أو قلة؟ هل حضرتك شاف انه في أخطار تحكير لها أثناء العمل في هذا المكان؟

3. عايز أعرف من حضرتك طبيعة عملك بالطلب؟ هل حضرتك يدخل البيانات فقط ولا كمان يقوم بعض التحاليل الإحصائية؟ هل يتعامل مع سجلات المرضى باسمهم و لا بالأكواد و الارقام؟

4. هل حضرتك مقدر مدى أهمية سرية البيانات التي بتعمل معاها؟ ايه اتسى بمحاولة على سرية نتائج التحاليل والمرضى؟ هل حضرتك تقدر تتعرف على المرضى من خلال بياناتك؟ طبيب ازا بتحاول على سرية؟ حضرتك ممكن تديني مثل؟

5. مين لي ممكن يطلع على البيانات لي عدنك؟ هل هناك اجراءات معينة لاخراج هذه البيانات؟
من بشرف على العمل بتاع حضرتك؟ و هل حضرتك شاف أنه مفيد؟ ازاي؟ ازاي ممكن نخلجه أكثر فاعلية؟
هل حصل أنه حضرتك طلبت مساعدة من المشرفين؟ تصرفا عوا معك أزاي؟ ممكن تحكي أزاي موقف؟

من وجهة نظر حضرتك أزاي زود المترددين على هذه الخدمة؟ أزاي ممكن نخلج المجتمع بقدر يتعامل مع الناس دي بسهولة و بساطة؟

ثانيا: التدريب

حضرتك أخر مرة اخدت تدريب على ادخال البيانات و التعامل معها كان الطريه؟ مين كان حاضر معك في التدريب ده؟

اي ه هي المواضيع التي اتغطت أثناء التدريب؟ هل ايام التدريب غطت كل المواضيع التي كنت محتاج تعرفها اكتر؟ هل وقت المحاضرات كان مناسب؟ أسلوب التدريب كان يسمح بالنقاش
او محاضرات فقط؟

بالنسب للمدربين، هل كانوا متمكنين من المادة العلمية؟ هل كان التدريب العملية مفيد؟ باريت حضرتك تقول لي حاجتين أو ثلاث استفدت من التدريب؟
بعد التدريب، هل حسبت انت اتغبرت في عملك؟ أزاي؟ اي الحاجات التي بقت احسن؟ هل حاولت انت تقيم نفسك؟ أزاي؟

لو فيه تدريب ثاني، اي المواضيع الي تحب تعرفها اكتر؟ و هل تحل التدريب يكون نظري و لا عملي و لا على رأس العمل؟ يا ريت تدلي امثلة. يحب التعمق. هل حضرتك تحب يقول
حاجة زيادة عن اللي قولناه؟
(يجب التعمق في هذه الأسئلة)

باشكر حضرتك على المعلومات القيمة...
استطلاع رأي الزوار لدى مغادرة مركز المشورة والفحص الطوع

التاريخ ________________

الرجاء اختيار نوع زيارة:
☐ زيارة متابعة
☐ زيارة متبقية

إذا رفض الزائر استطلاع الرأي، ما سبب الرفض ________________

نوع الجلسة:
☐ جلسة فردية
☐ جلسة تدريبية

ضع دائرة حول الإجابة المناسبة

<table>
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</tbody>
</table>

1. بصفة عامة تلقى طلبيت مرضاة في مركز المشورة والفحص الطوع.
2. رحب بي أحد العاملين بالمركز عند وصولي.
3. استقبلت مقابلة أحد العاملين بالمركز خلال نصف ساعة من وصولي.
4. توفر لي مكان للجلوس أثناء انتظاري.
5. تحدثت مع المستشار عن إجراء فحص فيروس الإيدز (سأوال يطرح في زيارات ما قبل الفحص فقط).
6. تحدثت مع المستشار عن إجراءات استلام نتيجة فحص فيروس الإيدز.
7. تحدثت مع المستشار عن مسائل متعلقة بنتائج فحوص سابقة أو حالية.
8. أشرفت المستشار بالراحة وأنا أتحدث إليه.
9. شعرت أن نتائج فحصي سرية ويتم محاولة محفظة.
10. أحسنت برحابة صدر المستشار تجاه كل تساؤلاتي وتمت الإجابة عليها.
11. حصلت في هذه الزيارة على أشياء عملية للتعامل مع ما بعد الإيدز والمصابين بالفيروس.
<table>
<thead>
<tr>
<th>محور</th>
<th>الملاحظة</th>
<th>عناية</th>
<th>ملاحظات إضافية</th>
</tr>
</thead>
<tbody>
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<td>2</td>
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<td>أنوى مناقشة نتائج فحصي مع شريكي/زوجي/زوجتي.</td>
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<td>2</td>
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<td>تعلمت حديثاً من شريط الفيديو الذي حرى عرضه في قاعة الانتظار أو من المطبوعات الموجودة بها.</td>
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<td>2</td>
<td>1</td>
<td>سوف أدل آخرين على هذه الخدمة.</td>
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</table>
تحليل الوضع الحالي للخدمات الصحية للشباب بعد التدخلات من قبل الجمعية المصرية للتنظيم الأسرة والمستشفيات التعليمية، من خلال المراكز الصحية التابعة لهم في بعض المحافظات بمصر والمملوكة من قبل صندوق الأمم المتحدة للسكان

دليل المناقشة المتعمقة مع مقدمي الخدمة

المقدمة:

صباح الخير، أنا أحب أعرفكم بنفسي. أنا ... وأعمل مع الجمعية المصرية لتحسن الخدمات الصحية المتقدمة للشباب ونود أن نعرف آراء حضرتك ومقترحاتكم بالنسبة للخدمة الموجودة حالياً والتدريبات التي حصلنا عليها. عشان ده حسناً لنا كثير في تحديد الأولويات للمرحلة القادمة.

شروط المقابلة:

أحب أوضح لحضرتك أنه ما فيتش رأى صح أو غلط، كل الآراء هتكون مفيدة بالنسبة لنا.

بعد إنذرك هنسجل الجلسة دي عشان ما ننساش أي نقطة قمت أثناء النقاش من آرائكم المفيدة والمهمة.

النقاط الأساسية في المناقشة:

أولاً: أسس الخدمات الصحية المقدمة

أولا: أسس الخدمات الصحية المقدمة:

1- عايدة أعرف من حضرتك إيه هي الخدمات الصحية الموجودة هنا في عيادتك؟

2- هل سمعتم عن الصحة الإنجابية؟ بدأً عند سن إيه و امتني تنتهي؟ إيه الجوانب الصحية التي لازم الشاب أو الشابة يهتم بها في الفترة دي أو يعرف معلومات عنها؟

3- إيه هو السن المناسب للزواج؟ إيه هو السن المناسب للحمل؟ ما هي أهمية تقديم خدمة صحة للعقيلين على الزواج؟

4- إيه هناره رعاية الحمل؟ السلف لازم توفر فيرا ولاية الحمل كام مرة؟

5- إيه هي فترة المباعدة المثلى بين الولادة والحمل الذي يليه؟

6- امتى السلف ممكن تحميل بعد الولادة وأمين ممكن يحصل حمل للست بعد الاجهاض؟

7- إيه هي وسائل تنظيم الأسرة للي حضرتك تعرفها؟ أمن وجهة نظر حضرتك، احبت انت تفهمن بمعنى ما مشورة بالضبط؟ إيه هي الشروط الواجب توافرها في المثورة الجهيد؟ (طعوم التعميق)

8- إيه هي النقاط التي لازم تغطي أثناء المشورة مع كل ولاية (تتم التعمق عن الأعراض الجانبية) إيه رايك في استعمال وسائل تنظيم الأسرة قبل الأربعين على طول؟

9- إيه رايك في الرضاعة النظيفة؟ تفكروا أنها ممكن تمنع الحمل اكيد؟ (الشروط)

10- إيه هو دور الرجل في الأسرة؟ ما هي أوجه المشاركة التي ممكن يعملها مع زوجته وأولاده في المنزل؟
من يشرف على العمل بتاع حضرتك؟ وهل حضرتك شافك أنه مفيد؟ ازاي؟ ممكن نخلله أكثر افادة؟ هل حصل انه حضرتك طلبت مساعدة من المشرفين؟ اتصلنا معالك ازاي؟ هل ممكن تحكي اي موقف؟

ايه هو رأيك في خدمات المقدمة هنا؟ هل هي كافية بالنسبة للشباب؟ ايه الي ناقص و ازاي ممكن نساعد في تحسينها؟

ايه رأي حضرتك في ختان الإناث؟

ثالثا: التدريب

حضرتك آخر مرة اخذت تدريب على تقديم خدمات الشباب كان متى؟ مين كان حاضر معالك في التدريب ده؟ ايه هي المواضيع التي اكتشفت اثناء التدريب؟

هل اياي التدريب غلطت كل المواضيع التي كنت محتاج تعرفها اكثر؟ هل وقت المحاضرات كان مناسب؟ أساليب التدريب كالتقه بالنفاش أو محاضرة فقط؟

بالنسب للمدربين، هل كانوا متمكنين من المادة العلمية؟ هل كان التدريب العملية؟ باريت حضرتك تقول لي حاجتين أو ثلاثة استفدتهم من التدريب؟

بعد التدريب، هل حسيت انك تغيرت في تقديمك للخدمة؟ ازاي؟ ايه الحاجات التي بقت احسن؟

هل حاولت انك تقم نفسك؟ ازاي؟ هل حسيت انه بعد التدريب الناس بتجي لعياداتك أكثر من الاول؟ ازاي عرفت انه ده حصل؟... يجب التعمق.

له فيه تدريب ثاني، ايه المواضيع التي تحب تعرفها اكثر؟ وهل ترب التدريب يكون نظري ولا عمل ولا على رأس العمل؟ يا ريت تدعي امثلاة. يجب التعمق.

هل حضرتك تحب يقول حاجة زيادة عن اللي قاولوا؟

(يرجى التعمق في هذه الأسئلة)

باشكر حضرتك على المعلومات القيمة....
تحليل الوضع الحالي للخدمات الصحية للشباب بعد التدخلات من قبل الجمعية المصرية لتنظيم الأسرة و المستشفيات التعليمية، من خلال المراكز الصحية التابعة لهم في بعض المحافظات. 

دبل المناقشة اليومية للشباب

المقدمة:
صباح الخير، أنا أحب أعرفكم بنفسي. أنا .... وأعمل مع الجمعية المصرية لتحسين الخدمات الصحية المقدمة للشباب وتود أن نعرف أرائكم ومقتراحاتكم بالنسبة للخدمة الموجودة حاليا. عسان ده حيساعدنا كثير في تحسين نوعيتها.

شروط الجلسة:
إحدنا هاجبين عشان نسمع بعض وعاشان كدة هتطلب منكم تسمحوا لكل واحد يقول رأيه. ما فيش رأى صح وما فيش رأى غلط، كل آراءكم هتكون مفيدة بالنسبة لنا.
بعد منظم هنسلج الجلسة دي عشان ما ننساش أي رأي من أرائكم المفيدة والمهمة.

النقاط الأساسية في المناقشة:
أولا: المعرفة عن الخدمات الصحية المقدمة:

1- هل سمعتم عن الصحة الإنجابية؟ سمعتوا عنها من من؟ بتبدأ عند سن أيه و أمتى تنتهي؟ أي الجهاد الصحية اللي لازم الشاب أو الشابة يهتم بها في الفترة دي?

2- أيه هو السن المناسب للزواج؟ أيه هو السن المناسب للحمل؟ هل تعرفوا آزاي الحمل بيحصل؟ (تعمق لتعرف هل عندهم المعلومات الكافية؟)

3- ما هي هامة تقديم خدمة صحية للمقبلين على الزواج؟

4- أيه هي هامة رعاية الحمل؟ النس لازم تروح لرعاية الحمل كام مرة؟

5- تعرفوا أيه عن الرضاعة الطبيعية؟ أمتى تبدا و تستمر لامته؟ ما الفرق بينها وبين الرضاعة الصناعيه؟

6- تعرفوا أيه هي وسائل تنظيم الأسرة اللي ممكن نستخدم عشان تمنع الحمل؟ عرفتوا عنها من فن؟ ما بيدد من العناية هذا عرفكم بيه؟

7- طلب تعرفوا الأعراض الجانبية مع كل و سيلة؟ والمفروض تتصوروا آزاي لما تحصل؟
هل سمعتم عن الممارسات الضارة في المجتمع؟ تعرفوا تدريجيًا أمثلة؟ سمعوكم عن الحاجات دي منين؟ لو من العبادة: قالوكوا ايه بالظبط؟ (مطلب التعمق)

ثانيا: الأراء والاتجاهات

- ايه هو دور الرجل في الأسرة؟ ما هي أوجه المشاركة اللي ممكن يعملها مع زوجته و أولاده في المنزل؟
- ايه هو رأيكم في خدمات المقدمة هنا؟ هل هي كافية؟ هل حسبتم اتكلم حصلوا على كل المعلومات اللي انتو تحتاجوا و تمت الإجابة على كل تساؤلاتكم؟
- أثناء الحصول على الخدمة، كان معنا موجود معكم ف الحجرة؟
- ايه رأيكم في الرضاعة النظيفة؟ تفكروا أنها ممكن تمنع الحمل؟ هل سألوا عليها الدكاترة؟ قابلوا لكم ايه؟
- ايه رأيكم في ختان الاناث؟
- ايه رأيكم في ضرب الستات؟

ثالثا: الممارسات والمقترحات:

- هل فيه حد فكم متزوج او إتجوز قريب؟ هل ذهبت لفحص ما قبل الزواج؟ و ايه اكتر حاجة عجبتكم في؟ كنتو تحبوا تعرفوا ايه اكتر؟
- حدي فيكم بدأ يستخدم وسيلة تنظيم أسرة؟ ايه هي؟ واللى ما استخدمت لحد دلوقتي؟ هل ناوية تستخدم؟ وايه اللحي ما بتاعها؟ هل انكلمت مع جوزها في الموضوع ده؟
- ايه اقتراحاتكم لتحسن الخدمات في العبادة دي؟ ازاي ممكن نخلو كل الشباب يعرفوا عن الخدمة في العبادة دي؟
- هل حدي فيكو يجب يقول حاجة زيادة عن اللي قولناه؟ (يرجى التعمق في هذه الأسئلة)

بنشكركم على المعلومات القيمه....
Interview guide
Planning managers
- Firstly tell me about the activities you were involved with NCW
- Can you talk about your role in the ministry
- Tell me about the women empowerment program (objective, implementation, impact)
- Tell me about the training, how many time you got that training (content, time,
- What did you learn
- Have you applied the knowledge
- Has the ministry really committed to implement women related projects
- What are the obstacles that NCW helped to tackle
- What are the new areas that need to be covered by NCW in the future
- What the decentralization can bring to the development of the governorates
- What the decentralization can bring women
- What the are the new needs after the decentralisation takes place

NCW director interview
Project structure and funding issues
- What is the administration structure of the project
- How is the resource distributed (priorities & limitation)
- What are the administrative issues that challenge this project
- In terms of resource allocation, what changes you wish to see

- Can you please provide summery of the budget divided into planned vs used for the period of 2007-2010

Gender Based Budgeting and M&E training
- Who designed the training material?
- What do you think about the quality of the training?
- Who provided the TOT
- Is the frequency and the length of the training are sufficient
- What areas relevant to the GBB & M&E are needed or lacking
- What is the best way to assess the quality of the training

What needed
  o Can you select a group of trainees for focused group discussion?
  o Can you please bring some training materials?
  o Can you please prepare a table showing number of trainings/trainees for the projects Covering the 2007-2010
  o Can you please provide examples of some budgets where GBB have been used
  o Please provide any materials that you see relevant (before & after budgets)

Round Table discussions & stakeholder meetings:
- Explain the selection process for attendees of the table discussion (role in the organisation, previous experience..)
• How is the discussion themes are selected

• Are attendees adhere to discussion topics
  
  o  Can you please select a groups of stakeholder & planners (we can discuss it when we meet
  
  o  Can you select individual planners for interviews
  
  o  Please bring any material you see relevant
Interview Guide
Evidence Based Policy project

**Population & development database:**
- Tell me about the population database (how it’s developed, managed and who using it)
- How the indicators are developed? (list of indicators)
- Resource issues
- Relationship with CAPMAS
- Data accuracy issues
- Training activities (do you train people in the usage of the database)
- Do you provide technical assistant to IDSCs within the governorates (building their own

**Production of annual report:**
- What is the process of selecting a topic for the report?
- Why you doing it? can other research institution do it?
- Who is involve in the update?
- How can you assess the impact?
- How do you see the future of it?

**Monitoring the performance of the population program training**
- Who are the participants of this training?
- How you assess the impact?
- Is it enough in terms of quality & quantity?

Population & development indicators training
- Participants
- What are the indicators
- Training quality and materials
- Impact assessments

What are problems & challenges?
What you want to do in the next cycle
Topic Guides for Adolescent Health Project

Interview with MOFP Project Manager:
1. Introduction of purpose of visit and evaluation
2. Overview of the work being done under UNFPA Adolescent Health Project
3. In depth on peer education
   - How is peer educator selected
   - What is done to prepare peer educator
   - Partners and their roles
   - Expectations from peer educators
   - Key messages to be delivered
   - Who are the target beneficiaries
   - How are activities followed up
   - Where are the activities taking place

Interviews with NGO Project Manager:
1. How do you run the project since 2003 and what activities do you conduct
2. What is the difference in implementation by time
3. How do you evaluate your achievements
4. How do you achieve the activities of the project
5. What successes have you achieved and what are the factors that helped you
6. What are the factors that are making it easier for you to implement
7. What are the challenges you face to undertake your activities: management, NCCM, Y-Peer, human resources, peer educators, finance, regulatory environment, partnerships, other, especially in the time being
8. How do you overcome these challenges
9. How many peer educators do you have (male/female), have you faced turnover of peer educators, what system do you have to smoothly replace leaving or growing peer educators. Are you depending on Y-Peer for training of new peer educators? Is this possible without the NCCM support or not?
10. What is the system you have to replace peer educators who leave you
11. If there is no NCCM nor Y-peer, will you be able to use your peer educators to train others
12. How do you find the support of NCCM and Y-Peer? Did this change since the start of the project?
   - Initial training
   - Continuous capacity building, and how frequent is it
   - Field visits to the NGO
13. Are you still in need of this support (financial, technical, administrative), Are you in need of other types of support
14. Can you perform the adolescent health education without the support of NCCM? How yes, why not?
15. Are there other activities performed for adolescents outside of project activities, what are these activities and do you receive support from another project
16. Is there a good response from adolescents to UNFPA project activities, what activities and what messages
17. On what basis do you select schools
18. Is there a positive response from schools and from MOE directorate?
19. How many schools have you thus far covered in the governorate? You have been functioning for 7 years with NCCM on this project, how do you assess your achievements regarding coverage of school adolescents in your governorate.

20. How do you see alternative strategies to more efficiently target all school adolescents, how would you design the activities and with which partners?
21. Do you perform activities with out of school children, how do you reach them and motivate them to attend?
22. Do you have a plan for sustainability of activities with adolescents, especially in school adolescents after the project?
23. How can you continue and what do you need in order to be able to continue project activities after the project?

Interviews with NGO Peer Educators:
1. Where did you hear about the project and what made you join?
2. Do / did you have any other activities with other NGOs?
3. Do these activities benefit you in any way?
4. What is the reaction of adolescents from your activities, do they benefit from it, does it address their information needs or do they have other needs for which we should develop our project?
5. What is your experience conducting education sessions with adolescents about physiological changes? What do you do if it is a co-ed school?
6. What is the reaction of those surrounding the adolescents, the parents, the schools and the MOE?
7. What are the challenges they face as peer educators?
8. How useful was the initial peer education? What other training did you obtain and how useful was it? Any suggestions.
9. Are they able to conduct peer education sessions in other activities of the NGO or in other NGOs? How yes? What enables you and the NGO to do this? / Why not? What is detaining you from that?
10. Have you ever thought of other target groups, e.g. out of school adolescents, and how would you be able to get an entrance to such vulnerable groups.
11. What are your long term plans for your career? Will you continue being a peer educator? For how long?
12. What do you intend to do and would your work as a peer educator benefit you, in what way?
13. Are the field visits conducted by the NCCM and the Y-peer beneficial to you?
14. Do you want these visits to increase or decrease, what changes are needed for these visits to be more beneficial?
أسئلة التعافر / بيانات شخصية

· تعرف على حضرتك
· عمرك كام سنة
· الحالة الزواجية
ما هو أعلى مؤهل حصلت عليه
· ما هي الوظيفة الحالية
· الدرجة الوظيفية
· مكان العمل الحالي
· مكان الإقامة الحالية: حضر/ريف بمحافظة
ماهى مدة عملك في مجال الدعوة
· الفنوات التي تقوم بالدعوة من خلالها
· عدد المساجد التي عملت بها

أسئلة عامة عن نشاطات التنمية
1. هل حضرتك متمسك لأى جمعية أهلية
2. ما هي نشاطاتك في هذه الجمعية
3. هل لديك نشاطات اجتماعية (أخرى) في مجتمعك المحلي؟ ما هي هذه النشاطات؟
4. هل لديك أهداف عامة في مجال الدعوة تريد تحقيقها أو منشى لمشاكل اجتماعية معينة متعلقة بقضايا السكان والصحة الإنجابية وقضايا النوع?

أسئلة عن التدريب
5. كيف تتعامل على النصيحة لهذه القضايا والمشاكل الاجتماعية في المجتمع المحلي؟
6. هل أفكارك المتبلطة تجاه هذه القضايا وهدفك في التدريس لهذه المشاكل بتعت من محاورك التدريب على دليل الدعوة، أم كانت لديك من قبل الدورة؟
7. ما الذي اكتسبته في الدورة؟ ما الذي استفدت منه في الدورة؟ إشرح؟ (في أيه ثاني)
· توجهات بالأمور إشر- 마련ات إشر
8. هل غيّرت أو طورت الدورة من بعض توجهات وقناطنك الشخصية في قضايا السكانية أو في مجالات الصحة الإنجابية أو في قضايا النوع إذكر
· كل ما غيّر وأشر أراها قبل وبعد الدورة
9. هل تعتقد أن أنتم المسجد لهم دور في تنمية المجتمعات المحلية؟
· قضايا النوع
· ما هو أهمية الإسلام به؟
10. ما هو مفهوم النطاق الاجتماعي؟
· متى أنواع العنف المبين على النوع التي قد تتعرض لها المجتمعات؟
11. ما هي أئمة المساجد لهم دور في التهيئة في إيه ثاني
· أنواع العنف المبين على النوع أو الحرماءن الحقوق التي تتعرض له المرأة والفتيان المصرية؟ إذكر جميعها - في أيه ثاني.
من وجهة نظرك لماذا تعتبر هذه القضايا نوعا من العنف ضد المرأة والفتاة؟

ما الآثار المجتمعية أو التنموية المترتبة على هذا العنف على النساء و الفتيات؟ إشرح كل منها تفصيلا.

و الآن سوف تعمق في موضوع موضوع (بالذات إذا لم يتعرض له رجل الدين تشظا)

الزواج المبكر

يا ترى عندك بنات ؟ ( بنات أخ / أخت ) جوزتها في سن كام ؟

فلا تقلق في أن تتمكن من أن تؤثرها فيه. و لاحظ ما إذا طلبت منك الموافقة في婚?

ما رأيك في كل نوع ؟ هل فيه من الأهدار لمصلحة الناقة و صحتها النفسية و الجسدية ؟ إشرح كل نوع

سوّب توحيدة، ثم تعودنا لوضعك في المجتمع المحلي. أنت أنتدأ عقاقة سوف تحدث، ماذا يكون تصرفك؟

هل قمت بهذا الدور فعلا من قبل ؟

هل تعرضت لهذا الموضوع في خطب الجمعة أو دروس الدين أو نشاطات أخرى ؟ إذكر الأنشطة ؟

ختان الإناث

بالنسبة لختان الإناث هل أنت من مؤيدين إجراء للقابات أم أنت المعارضين ؟

ما رأيك في التعامل مع هذه الظاهرة من خلال القانون؟ (مؤيد / معارض، في)؟

هل كنت تختين بناتك في السابق ؟ ( نادم / غير نادم)

هل تؤمن أن الختان في المستقبل؟

ما النصيحة أو الرأي الذي تشير به على من تسألك عن تخزين بناته في محجع عائلتك و أصدقاءك؟

إذا كان من المؤيدين لإجراء الختان ؟

ما هي أسباب رأيه؟ ( تريد أن نفهم ) انتقل إلأ مجموعة أسة أخرى

إذا كان من المناهضين لختان الإناث

هل زوجتك ووالدتك ووالدتها أيضاً رأيك أم لا إلتح رأتهم.

هل ترى أنه يمكن أن تلعب دور على مستوى العائلة و الأصدقاء للتصدي لهذه الظاهرة بين الذكور و الإناث ؟ إشرح كيف و متى يمكن ذلك و لماذا لا يمكن ذلك و في أي الحالات ؟

هل تعرضت لموضوع ختان الإناث في خطب الجمعة ؟ إشرح باختصار المنطق في الخطبة ثم إشرح باستفاضة ردوت أفعال الحضور ؟

هل تعرضت لموضوع ختان الإناث في دروس دينية للرجال ؟ إشرح باختصار المنطق في الدروس ثم إشرح باستفاضة ردوت أفعال الحضور ؟

هل تعرضت لموضوع ختان الإناث في دروس دينية للنساء ؟ إشرح باختصار المنطق في الدروس ثم إشرح باستفاضة ردوت أفعال الحضور ؟

هل في رأيك هذا كافي للقضاء على الظاهرة في مجتمع المحب؟
38. ما الذي يمكن لك عمله للقضاء على هذه الظاهرة؟
39. ما الذي يجب على الآخرين عمله للقضاء على الظاهرة؟

العنف الأسري
40. هل عمرك جالك أن يحتاج إلى رد فعل منك في حال شرب و يطلب منك التضحية أو التدخل لنكذم الزوج؟
41. هل من حق الزوج في الإسلام ضرب زوجته؟ اشرح تحديد كيف و متى يكون من حق الزوج ضرب زوجته في الإسلام؟
42. بماذا سوف تنتهي الأمر؟

Research Team: Lets put the scenarios together
43. هل ستتدخل لنصح الزوج وزوجته؟ ماذا سوف يكون نصحك للإثنين في سيناريوهات مختلفة؟
44. هل تعرضت لموضوع ضرب الزوجات في خطب الجمعة؟ اشرح باختصار المنطق في الخطب ثم إشرح باختصار ردود أفعال الحضور؟
45. هل تعرضت لموضوع ضرب الزوجات في دروس دينية للرجال؟ اشرح باختصار ردود أفعال الحضور؟
46. هل تعرضت لموضوع ضرب الزوجات في دروس دينية للنساء؟ اشرح باختصار ردود أفعال الحضور؟

47. هل في رأيك هذا كافي للقضاء على الظاهرة في مجتمعك المحلي؟
48. ما الذي يمكن لك عمله للقضاء على هذه الظاهرة؟
49. ما الذي يجب على الآخرين عمله للقضاء على الظاهرة؟
ما هو أعلى مؤهل حصلت عليه
مكان الاقامة الحالية:
حضر / داير في محافظة
ماهى مدة عملك فى مجال الدعوة
القنوات التى تقوم بالدعوة من خلالها
عدد المساجد التى عملت بها
هل حضرتك منضم لاى جمعية أهلية
ما هى نشاطاتك فى هذه الحمعية
هل لديك نشاطات اجتماعية (أخرى) في مجتمعك المحلى؟ ماهى هذه النشاطات وماالذى تريد تحقيقه من هذه النشاطات؟
كيف تعمل على التصدي لهذه القضايا والمشاكل الاجتماعية في المجتمع / المجتمعي المحلى؟
ما الذى اكتسبته فى الدورة؟ ما الذى استفدته من الدورة؟ إشرح؟ (فى أيه ثانى)
هل تعتقد أن أئمة المساجد لهم دور فى تنمية المجتمعات المحلية؟
ماهو مفهومك للنوع الاجتماعي؟
ماهى أنواع العنف المبنى على النوع التى قد تتعرض لها المجتمعات؟
ما أنواع العنف المبنى على النوع أو الحرمان من الحقوق الذى تتعرض له المرأة والفتاة المصرية؟ إذكر جميعها – فى ايه ثانى.
1) What role do preachers play in society?

2) What was the vision of MORA for preachers for the reference manual and its training manual on Population Policies, Reproductive Health and Gender Issues?

3) What was the knowledge and skills that you had intended the preachers to gain? What were the beliefs and attitudes that you wanted them to adopt?

4) We are focusing on the chapters related to gender issues and gender-based violence. So, what are the important concepts that you wanted preachers to come out with from this training?

5) After training of preachers of MORA at local level mosques, what are your views and expectations of the forms of use of what they have learnt in the training? What do you expect them to achieve with what they have learnt?

6) If we focus on gender issues and gender-based violence, how do you see the role of the preacher after the training in reducing the various forms of gender-based violence? What specific type of GBV, how will that role be played and with what effect (big / small)?

7) What are other activities that we need to undertake to enable them to effectively reduce the various forms of GBV in their local communities?

8) What are the complementary strategies and activities that are required from other organizations, government entities, NGOs in order to maximize the likelihood of achieving the intended effect of reducing GBV in the Egyptian society?

9) We would like to know what can be done in future to enhance what is being done by the project?
Topic Guide for Interview with
Al-Azhar Project Manager

1) How were the topics for Gender chapters chosen? What considerations were taken into account?
2) How was the reference manual produced?
3) What considerations were taken into account when producing the training manual?
4) What were the criteria for choice of religious leaders to be trained?
5) How was the reaction and discussion of participant religious leaders to topics of gender and gender-based violence?
6) What are the main benefits of the religious leaders?
7) How do you foresee religious leaders using what they have learnt from the reference manual training?

8) We have trained religious leaders. Then we are going to train preachers at grass-root level. In your opinion, what will be the effect of these activities on reducing gender based violence?
9) Do religious leaders at grass-roots level have enough knowledge and skills to implement advocacy activities? What do they need apart from the reference manual
أسئلة تعريف
ما هي أهم قضايا المجتمع التي تهتم بها وتنبأها في تغطيتك الإعلامية في الوقت الحالي؟

أسئلة عامة
1. ما هو فهمك وتعريفك للتحرش الجنسي؟
2. ماذا يهتم المجتمع بمعاناة المشاركين في الشارع أو مكان العمل ولا له فهم نائئ؟ ما هو؟
3. ما الأسباب وراء التحرش الجنسي؟
4. في رأيك من المستقبل فيه؟ أيه اللي يسببه؟
5. في رأيك ما هي العواقب والآثار المترتبة على التحرش الجنسي بالنسبة للنساء والأطفال؟
6. من وجهة نظرك ما هو رد فعل المناسب للنساء والأطفال تجاه التحرش الجنسي؟
7. كيف يمكن للنساء والذكور حماية أنفسهم من التحرش؟
8. أيه هو دور الناس الموجودين في حماية النساء والأطفال من التحرش في الأماكن العامة؟
9. ما الواجب عمله من جهة المدارس وأماكن العمل تجاه هذه الظاهرة؟
10. ما الواجب عمله من جهة الحكومة لحماية النساء والأطفال من هذه الظاهرة ولمنع حدوثها في الأماكن العامة؟
11. هل تعتبر أن الإعلام دور في التصدي لظاهرة التحرش الجنسي في الأماكن العامة؟
12. ما هو هذا الدور؟
13. ما هو دورك الشخصي كإعلامي للتصدى لظاهرة التحرش الجنسي؟
14. وما الذي قمت به وما نتائجه؟
15. هل تبدو عملية المستقبل وما هو؟
16. لو حصلت على تقرير عن التحرش الجنسي هل سوف تنشره / تحيطه على الراديو أو التلفزيون؟ ولماذا؟
17. هل المسؤول عن النشر سوف يوافقك على ذلك؟ ولماذا؟

أسئلة عن نشاطات المركز المصري لحقوق المرأة
18. ما هي الأنشطة / المناسبات التي قام بها المركز وحضرتها؟
19. ما رأيك فيها؟
20. هل يمكن أن تكون لهذه الأنشطة تأثير في عدم حدوث التحرش في الأماكن العامة؟
21. من وجهة نظرك ما هي الأنشطة المفيدة التي يمكن للمركز القيام بها للحد من هذه الظاهرة؟
22. هل استفدت من حضور أنشطة المركز؟ (وكيف استفدت؟ ولماذا لم تستفيد؟)
23. هل استخدمت ما تعلمت من حضور أنشطة المركز؟
24. ما أوجه الاستخدام؟ وما الأثر المرتبتة على الاستخدام (شخصي - اجتماعي - سياسي)
25. هل أخذت مواد إعلامية بالتحرش الجنسي من المركز؟
26. وهل تغطي احتياجاتكم في هذا الموضوع ك الإعلام؟
27. كيف تغطي ما هي أوجه النقص؟ وكيف تعالج؟
28. هل المواد الإعلامية التي تصدرها المركز المصري لحقوق المرأة كافية لتفطير احتياجات الناس العاديين؟
29. هل المواد الإعلامية التي تصدرها المركز المصري لحقوق المرأة كافية في تغطية الظاهرة عند واضعي السياسات ومتخذ القرارات؟
30. كيف تغطي ما هي أوجه النقص؟ وكيف تعالج؟
31. بعد المعرفة بالمواد الإعلامية للمركز هل تغير مضمونك الإعلامي عن ظاهرة التحرش؟ صفر ذلك؟
32. هل طريقة عرض الموضوع اختلفت؟ صفر ذلك؟
33. ما هي الاستراتيجيات التي استخدمتها لتضمين موضوع التحرش الجنسي في تقاريرك الإعلامية؟
34. هل غطيت موضوع التحرش الجنسي ضمن مناقشة مواضيع أخرى مثل الفقر، حقوق المرأة، العنف ضد المرأة، مواضيع أخرى أو الهام؟
35. هل تعتقد أن التعرض لموضوع التحرش الجنسي أصبح مقبول الخوض فيه من قبل الإعلاميين بشكل مفتوح؟ إذن ما كان في السابق
ما هو مفهومك وتعريفك للتحرش الجنسى؟

مش التحرش الجنسى معناه المعاكسات فى الشارع أو مكان العمل ولا له مفهوم تانى؟ ما هو؟

ما الأسباب وراء التحرش الجنسى؟

فى رأيك مين المتسبب فيه؟ أيه اللى بيسببه؟

 فى رأيك ما هى العواقب والأثار المترتبة على التحرش الجنسى بالنسبة للنساء والأطفال؟

من وجهة نظرك ما هو رد الفعل المناسب للنساء والأطفال تجاه التحرش الجنسى؟

كيف يمكن للنساء والفتيات حماية انفسهم من التحرش؟

ايه هو دور الناس الموجودين فى حماية النساء والأطفال من التحرش فى الأماكن العامة؟

ما الواجب عمله من جهة المدارس وأماكن العمل تجاه هذه الظاهرة؟

ما الواجب عمله من جهة الحكومة لحماية النساء والأطفال من هذه الظاهرة ولمنع حدوثها فى الأماكن العامة؟

هل تعتقد أن للإعلام دور فى التصدى لظاهرة التحرش الجنسى فى الأماكن العامة؟

ماهو دورك الشخصى كإعلامى للتصدى لظاهرة التحرش الجنسى؟

وما الذى قمت به وما نتائجه؟

هل تنوى عمل المزيد فى المستقبل وما هو؟

لو حصلت على تقرير عن التحرش الجنسى هل سوف تنشره / تذيعه على الراديو أو التليفزيون؟ ولماذا؟

هل المسئول عن النشر سوف يوافقك على ذلك ولماذا؟

أسئلة عن نشاطات المركز المصرى لحقوق المرأة

ما هى الأنشطة / المناسبات التى قام بها المركز وحضرتها؟

هل يمكن أن يكون لهذه الأنشطة تأثير فى عدم حدوث التحرش فى الأماكن العامة؟

من وجهة نظرك ما الأنشطة المفيدة التى يمكن للمركز القيام بها للحد من هذه الظاهرة؟
1) What are your activities under UNFPA?
2) You have been working on the sexual harassment issue since 2005, what is it you want to achieve from your project with UNFPA? What are your main objectives from your activities under UNFPA?
3) What UNDAF objectives do you believe you are addressing?
4) What are your main aims from conducting activities with media people?
5) Explain your activities with the media and what are your target groups and why are you targeting them?
6) How did the conference help in realizing your objectives with the media?
7) How do you monitor the media people that have been sensitized to sexual harassment? What do you expect from them?
8) Numbers and affiliations of media people sensitized through UNFPA project (take hard copies)
9) Did you get the lists of radio listening and call in statistics? (not asked)
10) Are there any mechanisms in Egypt to monitor sexual harassment (NCW, ECWR, the coalition ...etc)?
11) Existence of media alliance to combat sexual harassment? What is the coalition and what is its role.
12) How do you see your progress and achievements?
13) What challenges do you face management, HR, finance, political environment, partners etc.
Annex 4. Documents reviewed for the evaluation.

1) Reproductive Health

### Project
**UNFPA Egypt**

<table>
<thead>
<tr>
<th>Document</th>
</tr>
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<tbody>
<tr>
<td>UNFPA Country Program 2007-2011</td>
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<tr>
<td>UNFPA Strategic Plan</td>
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<tr>
<td>UNFPA Strategy and Framework</td>
</tr>
<tr>
<td>UNFPA country program evaluation 2003</td>
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</tbody>
</table>

**ID: EGY08P02 titled Strengthening Supply; Demand & Utilization of Reproductive Health Care Services within the context of Health Sector Reform**

**ID: EGY8R11a titled Strengthening CS system**

- Annual work plans 2007 - 2010
- Study on reproductive health impact of family health model pilots in Egypt
- Integrated Standards of Practice for Family Planning Health Services (ISOP) (Violet)
- System for ISOP update
- Sample steering committee meetings’ reports
- Sample task force meeting reports
- Sample Activity reports
- Trainees’ guides 2008
- Physicians, nurses, and RR training manuals and presentations
- Pre-service training manual
- RR work guide (orange)
- OJT outline
- TOT manual
- Questions and answers on FP
- Evaluation tools (questionnaires)
- Self-assessment tools
- Data collection forms used by RR
- Sample reports of mobile clinics
- Annual report 2008
- Sample training reports on FP regular courses
- Sample training reports on FP refresher courses
- Sample training reports on district planning
- Reports on community surveys conducted
- Lists of equipment procured for trained centers
- Sample sentinel report
- Assessment of the logistic systems of the contraceptive security system in MOH
- Required data sets for utilization of services

**ID: EGY08P03: NAP Support to Voluntary Counseling & Testing Services**

**ID: EGY8R44A: FHI Support to VCT & YFC by FHI**

- Annual work plans 2007 - 2010
- Training manual for VCT of HIV/AIDS in Egypt
- Sample IEC materials; brochures and books addressing information about HIV/AIDS disease, prevention, and nutrition
- Nursing manual for patients living with HIV/AIDS
- Monitoring and evaluation plans
Annex 4. Documents Reviewed

HIV/AIDS BBSS 2006
Training manual for STDs in Egypt
Progress reports
Meeting reports
Annual reports 2005 - 2009

**ID: EGY/08/P10: Adolescents RH Needs in Egypt (EFPA)**
Formative Assessment of Youth Reproductive Health Needs in
Menoufia and Ismailia Governorates, 2009
Annual reports
Required data sets for utilization of services

**ID: EGY8R51A: FHI with EFPA and THO**
FHI report on: Enhancing Voluntary Counseling and testing services for
HIV/AIDS and the detection and treatment of sexually transmitted
infection in Egypt 2007
Progress reports and quarterly for EFPA
Annual reports for THO
Sample posters

**ID: EGY08R54A0: Teaching Hospitals - Youth Friendly Services**
Annual work plans 2007 - 2010
Assessment of Youth Friendly Clinics in Teaching Hospitals in Egypt,
2008
Sample progress reports
Available data sets to reflect utilization of services

---

2) Population and Development

Food Crisis and Population Status in Egypt—EPDI (April 2009)
Egypt Country Evaluation Report, Addressing the Reproductive Health Needs and
Rights of Young People since ICPD – The Contribution of UNFPA and IPPF
Population Status in Egypt ICPD @ 15—EPDI, Evidence-Based Population Policy
Survey of Young People in Egypt, Preliminary Report—the Population Council (February
2010)
Annual Work Plan Cover and Table
Gender Monitoring and Evaluation of the National Plans (2008-2009)
Gender Monitoring and Evaluation NCW (July-December 2007)
Gender Monitoring and Evaluation NCW (January- December 2009)

- دليل الرعاة في مجالات السياسات السكانية و الصحة الإنجابية و قضايا النوع – جامعة الأزهر 2009
- موسورات السكان و التنميمليل
  (UNFPA, EPDI)
- حالة السكان في مصر: نحو تحقيق أهداف البرنامج القومي للسكان ديسمبر 2010
  (UNFPA, EPDI)
- المسح البعدي: التعداد العام للسكان والاسكان 2006
  (IDSC)  
  NCW

- الزيايات المليئونى لمحافظات جمهورية مصر العربية مارس - يوليو 2009
- البرنامج التدريبي الخاص ب: "مواردات البرامج و الأداء المستجيب للنوع الاجتماعي"
Annex 4. Documents Reviewed

Annual Work Plan Cover and Table
Gender Monitoring and Evaluation of the National Plans (2008-2009)
Gender Monitoring and Evaluation NCW (July-December 2007)
Gender Monitoring and Evaluation NCW (January-December 2009)

3) Gender

**MOFP**
1) IEC materials
2) Egyptian Y-Peer standards
3) Training of trainers for peer educators
4) MOFP publication, Adolescent Health Program: Stepping into a Healthy Future
5) Preliminary incomplete evaluation report of the NGOs working in the Adolescent Reproductive Health Program
6) Annual implementation plan for 2010, 2009, and 2008
7) Progress reports Jan-Nov 2010

**Azhar**
1) Preachers’ Guide in Population Policies, Reproductive Health and Gender Issues
2) Religious Leaders Training Manual
3) Study conducted by Assiut University for the project “Knowledge, attitudes and practices of religious leaders on reproductive health/rights and gender issues in the context of Islam”.
4) Monitoring and evaluation project tools
5) Annual implementation plan for 2010, 2009, and 2008
6) Progress reports 2009, and 2008

**ECWR**
1) IEC materials
2) Proposed laws for sexual harassment
3) Report on changes in media discourse about sexual harassment
4) Annual implementation plan for 2010, and 2009,
5) Progress reports 2009
Annex 5. Persons interviewed for the evaluation.

1) Reproductive Health (RH)

   a) Family planning

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Dr. Magdy Khaled</td>
<td>UNFPA assistant representative</td>
</tr>
<tr>
<td>Dr. Atef El-Shitany</td>
<td>MOH project director</td>
</tr>
<tr>
<td>Dr. Mohamed Helaly</td>
<td>MOH project officer</td>
</tr>
<tr>
<td>4 District directors</td>
<td></td>
</tr>
<tr>
<td>4 physicians</td>
<td></td>
</tr>
<tr>
<td>4 nurses</td>
<td></td>
</tr>
<tr>
<td>4 Raedat Refyat (RR)</td>
<td></td>
</tr>
<tr>
<td>1 trainer</td>
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b) HIV

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Dr. Ihab Abd El Rahman</td>
<td>NAP Project Director</td>
</tr>
<tr>
<td>Dr. Sherif Soliman</td>
<td>FHI Project Director</td>
</tr>
<tr>
<td>Dr. Sherif Kamhawy</td>
<td>FHI Program Officer</td>
</tr>
<tr>
<td>Dr. Waleed Kamal</td>
<td>Specialist at NAP</td>
</tr>
<tr>
<td>9 VCT counselors</td>
<td></td>
</tr>
<tr>
<td>3 nurses</td>
<td></td>
</tr>
<tr>
<td>12 data managers</td>
<td></td>
</tr>
<tr>
<td>1 STI provider</td>
<td></td>
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</tbody>
</table>

c) Youth friendly clinics (YFC)

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Amr El-Ayat</td>
<td>Director of EFPA and the youth project</td>
</tr>
<tr>
<td>Dr. Mohsen Makram</td>
<td>Head of Teaching Hospitals Organization and project director</td>
</tr>
<tr>
<td>Ms. Rabab Mansour</td>
<td>Youth and Gender officer at EFPA</td>
</tr>
<tr>
<td>Mr. Ahmed Malh</td>
<td>UNFPA project officer</td>
</tr>
<tr>
<td>Dr. Sherif Soliman</td>
<td>FHI project director</td>
</tr>
<tr>
<td>20 physicians</td>
<td></td>
</tr>
<tr>
<td>20 counselors</td>
<td></td>
</tr>
<tr>
<td>8 peers</td>
<td></td>
</tr>
<tr>
<td>20 focus groups</td>
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2) Population and Development

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanan Girigis</td>
<td>EBPP project manager, IDSC</td>
</tr>
<tr>
<td>EBPP project staff (12 employees)</td>
<td>Researchers , software programmers and administrator , Information Decision Support Center IDSC headquarters, Cairo</td>
</tr>
<tr>
<td>Ghada El-Sherif</td>
<td>GME project coordinator, National Council for Women NCW, Cairo</td>
</tr>
<tr>
<td>Mohamed Kamel</td>
<td>Manger of statistics department, Information Decision Support Centre Elshargiah governorate</td>
</tr>
<tr>
<td>Fatima Elkayat</td>
<td>General Manager, Information Decision Support Centre, Asut</td>
</tr>
<tr>
<td>Kareem Masoud</td>
<td>General Manager, Information Decision Support Centre, Red Sea</td>
</tr>
</tbody>
</table>

Suad Helme General Manager, Information Decision Support Centre, Alexandria
Magdy Mostafa and Ministry of local development for finance, administration and planning, First
Mohamed Farok. Undersecretary office, Cairo
Ahmed Rajab Planning officer, Elsharqia governorate
Adel Kadier Planning officer, Wadi el Gedid governorate
Selwa Farouq Planning officer, Gena
Abdel Elsatar Abdelaseem Planning officer, Elsoues

3) Gender

a) MOFP- Peer Education

Name Position
Dr. Azza El-Ashmawy, General Project Director
Adolescent Reproductive Health
Ministry of Family and Population

Dr. Ahmed Malah Y-Peer Network Coordinator
UNFPA

Dr. Afaf Zain El-Abdein Director of Fayoum NGO
El-Shabbat El-Moslemat

Dr. Magdy Mohamed Yousef, Director of Mynia NGO
El-Khashaba

Mr. Shoaib El-Shemy Head Master
El-Shemy Coed Preparatory School

4 Educators
1 peer educator
Questionnaires completed by 26 peer educators

b) Al Azhar – Training of Religious leaders

Name Position
Dr. Ahmed Ragai Ragab Professor of Reproductive Health
Project Manager
International Islamic Centre for Studies and Research

Dr. Salem Abdel Galil First Undersecretary of Ministry of Religious Affairs for Preacher Affairs

12 religious leaders

c) ECWR – Sexual Harassment and the media

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nehad Abul Komsan</td>
<td>Head of the Egyptian Center for Women’s Rights</td>
</tr>
<tr>
<td>12 Media personnel</td>
<td></td>
</tr>
</tbody>
</table>
Annex 6. Sites Visited

RH
Ministry of Family Planning Cairo office
National AIDS Program (NAP) Cairo Office
Family Health International Cairo office
Egyptian Family Planning Association (EFPA) Cairo Office
General Organization of teaching Hospitals (GOTHI) Cairo Office
Sohag FP project site
Alexandria FP project site
Cairo, Luxor and Sharam El-Sheikh HIV project sites
Menya Youth Friendly Clinic site
Sohag TH Youth Friendly Clinic site

PD
Information Decision Support Center IDSC headquarters, Cairo

Gender
Ministry of Family and Population
El-Shabbat El-Moslemat NGO, Fayoum Governorate
El-Shemy, Preparatory Coed School, Youssef El-Sediq District, Fayoum Governorate
El-Khashaba NGO, Mynia Governorate
Suzan Mubarak Preparatory School for Girls, Mynia District, Mynia Governorate
International Islamic Center For Studies and Research
Ministry of Religious Affairs
Egyptian Center for Women’s Rights
Offices of media personnel interviewed
Annex 7. 8th Country Program Outcomes and Outputs

**Question 1:**
1a: Did the program intervention strengthen the family planning (FP) program within the MOH population sector to serve the family health model?

To evaluate the two subs under question 1, the RH project ID: EGY08P02 titled Strengthening Supply; Demand & Utilization of Reproductive Health Care Services within the context of Health Sector Reform was evaluated.

**Initial assessment study**
The El-Zanaty assessment study conducted early in 2008 concluded that the Family Health Model (FHM) did not offer enough support to improve RH-services utilization including FP services during the transition phase from donor-supported to self-reliant programs resulting in inadequate coverage. Interviews with project managers and review of the different project documents, meeting minutes, and reports revealed substantial coordination between the FP sector and Health Sector Reform (HSR) in initiating project activities and defining the specific steps necessary for the process of strengthening the FP sector within FHM/HSR. The FP project director reported that it was important to go back to a vertical program to support the diluted FP services by having a separate room at the clinic, re-setting of the FP client flow, having a FP nurse dedicated to FP services, and eliminating any expenses paid by clients to receive FP services. Moreover, putting FP methods on the primary care essential drug list was important as it was not included in the FHM drug list.

**Manuals and standards of practice**
In an attempt to strengthen and place FP services in its correct position within the HSR, the process started with producing comprehensive FP Standards of Practice (SOP) guides that were written and reviewed by FP sector officials, with feedback and input from governorate and district supervisors. Though this activity could be seen as returning to verticality of programs, project directors thought it was important to begin the process by re-strengthening the FP component and then integrate it with other RH services and HSR. The FP sector with UNFPA funds printed 500 copies of the SOP guides that were distributed to donor agencies and partners working on family planning. The guide was also distributed to directors and supervisors nationwide. In pilot areas, only intervention clinics received a copy that was kept with the FP nurse but all providers received orientation on these standards. While interviews with providers at clinics revealed that the SOP guide was not used and sometimes not handy to them (because it was with the FP nurse), the MOH project director stressed that providers were only aware of the book if they were asked about the violet one (color mark). Also he ensured that during supervision visits, providers’ knowledge was tested and they were always referred to the correct information in the SOP.

MOH project managers reported that to support project activities and eventually FP services, other manuals/protocols were produced over the years including a TOT manual, ultrasound protocol, RR manual, as well as updating training manuals for physicians, nurses and RRs. A pocket guide for FP methods was produced also to be used by physicians. These manuals were distributed on a small scale in project intervention areas.

**Training activities**
Interviews with project managers and reviewing documents showed that to start training activities governorate and district supervisors received a TOT training course to increase their capability in conducting step-down training to FP providers. The TOT included a contraceptive technology update and exercises on presentation and training skills. A comprehensive training package for service providers including a strong counseling component was then implemented through five day mini training courses. FP providers who attended this training reported that trainers were central, governorate, and district supervisors which made for a good understanding between providers and supervisors of all relevant topics covered. The providers thought the training was useful in updating their knowledge and skills in service provision. They also believed that the caseload at their clinics increased as a result of the better FP services provided. Though all providers reported their satisfaction of the training, interviews revealed insufficient knowledge among nurses and RR in management of FP side effects. It is important to note that 3 criteria of effective LAM were well known by nurses but not by RR. FGDs with FP clients also indicated a lack of knowledge of the three LAM criteria. Clients were specifically asked if they were counseled for managing FP method side effects and they reported they did not discuss those issues with providers. Providers, especially nurses and RRs requester more practical and on-the-job training in order to master FP counseling skills and to continuously update their knowledge. Providers and supervisors requested management training. Although, MOH
project managers believed that ultrasound training was crucial and important to support FP services, the training needed a special budget and arrangements that need to be developed.

On-the-job training (OJT) is an effective approach to maintain the knowledge gained in classroom training and it identifies gaps in services that need strengthening. Though skills and human resources were available, the tools necessary for the implementation of OFT were not available. The provider interviews indicated that self-assessment tools were not available. Moreover, interviews with project managers confirmed that the necessary tools were to be produced in the near future and should be available by the end of 2011. Also, the structure of the OJT process was not available and a well developed manual was not available to providers.

**FP service provision**

Services provided at FP clinics as documented with interviews with providers and FGDs with FP clients included FP counseling and method provision. FP methods available included IUDs, OCs, injections, and condoms. Providers reported that methods were always available and secured for approximately 2-3 months in the future. Providers reported that they rarely faced method shortage for OCs and injections. FP clients participating in FGDs reported that they received FP counseling on how to use methods and their advantages and disadvantages, but they did not receive counseling on how to deal with side effects of methods. FGDs also revealed in-correct knowledge of criteria for LAM among FP clients. It is important to note that when clients were asked what they wanted to know more from providers, they requested information other RH issues rather than FP. This response indicates that integration of FP with other RH messages and services is appropriate for client needs. Project managers also pointed to the deficiency in availability of IEC materials needed for provision of adequate counseling within FP services.

**Supervision**

Providers reported that they receive useful supervisory visits and that whenever they face problems at the clinic, they request aid from their supervisors who willingly support them and provide solutions. Also, both supervisors and providers confirmed that facilitative and supportive supervision was followed. Still, supervisors pointed out that where the medical supervisor was not involved in supervision but only in training activities, FP supervision and OJT was not available.

**Delayed activities**

Interviews with project managers identified some activities that started but were still in progress or not completed and this included the clinical audit system. This system was designed to correct for the clinical gaps/incompetence identified during supervisory visits. For example, nurses were measuring blood pressure when they did not know the correct procedure for measuring it. This problem was observed in several clinical services including IUD insertion. Accordingly, the FP sector recognized the need to introduce a clinical audit system. Steps taken included policy formulation (creating the need among policy makers) to initiate the system and developing procedures required for an effective system. Due to other MOH priorities and activities, the human resources required for training and execution of the clinical audit system were not developed. This may be implemented by the end of 2011.

**Monitoring and evaluation of project activities**

In the year 2010 of the project a "sentinel system" monitoring project began. This project collected information from households in communities to monitor changes in knowledge and use of FP methods. These surveys generated large data sets to be used for monitoring and evaluation of FP activities. Communities selected for those sentinels were Alexandria, Sohag, Helwan, Cairo, and Giza. Not all sites were intervention sites but as per the project director reports, it was necessary to disseminate this important approach nationwide. Therefore, in addition to selected project sites, he expanded it to other sites near Cairo where he could follow-up at low cost. The sentinel was to be conducted at regular intervals to monitor the required changes. Currently, the FP sector has very rich database of information that was has been used whenever needed by the ministry to produce reports and to document program results.

Finally, an important finding revealed from interviews with project managers from both UNFPA and MOH and from reviewed reports and documents was the lack of a clear project monitoring plan and timely measured indicators to monitor and evaluate project activities.

D Question 2a.

Did the capacity of health care providers strengthen and provide quality VCT services as a result of program intervention?

To evaluate the two subs under question 2, the following RH projects were evaluated:
ID: EGY08P03: NAP Support to Voluntary Counseling & Testing Services
ID: EGY8R44A: FHI Support to VCT & YFC by FHI

Review of project documents revealed project activities started in 2007 including advocacy, policy development, and capacity building for health providers with a special focus on enhancing counseling skills and promoting condom use.

The evaluation of the previous UNFPA program cycle (2002-2006) indicated that evaluation of the quality of services provided at established centers was an initial crucial step for improvement of the VCT testing services. An assessment was conducted by FHI of 14 VCT mobile and fixed centers to identify strengths and weaknesses before developing the technical assistance plan. Based on findings, FHI then lead the capacity building activity through training of a cadre of service providers to ensure sustained provision of quality VCT/STDs services in nine mobile VCTs, five fixed VCT and five STD centers in intervention governorates. A total of 55 service providers were trained on VCT, STI provision of care and data management. Training curricula used were well developed and comprehensive. In addition to the above activities, a supportive communication component to produce IEC materials and to develop a monitoring and evaluation plan were put into action. To ensure accurate monitoring of VCT services, FHI worked with NAP to standardize data collection forms for all fixed and mobile VCT sites that were used to monitor HIV testing. Technical assistance was provided to coordinators, counselors, and health educators on data collection methodology and data entry.

Interviews with project managers revealed that VCT clinics whether fixed or mobile, offer services for HIV and hepatitis B and C. Sharm El Sheikh fixed center has integrated VCT and STI services. They also conduct awareness sessions to educate communities about the different diseases. Mobile clinics were more concerned with awareness sessions than with HIV testing. Project managers thought that service provision was adequate in VCT clinics based on the available resources. Project IPs and managers believed that those clinics needed renovation and supplies and most importantly, they face the problem of rapid turnover of providers... Managers and supervisors, being small in number, were doing their best to supervise and guide providers through on-the-job training on gaps and weaknesses in service provision.

At the clinic level, interviews with providers in VCT clinics revealed that counselors had good knowledge; they knew the virus (HIV), mode of infection transmission, incubation period, and the window period. Interviewed counselors reported that they provide clients with demonstrations of condom use and that they have acquired good communication skills from the training they received. Most of interviewed providers did not find any difficulty dealing with clients who may be HIV positive or HIV positive clients. Still, two providers reported they do not feel comfortable when dealing with HIV positive clients and they were uncomfortable drawing blood from them. Not all data managers interviewed received classroom training but as a result of on-the-job training they became competent in doing their job. Privacy of data is an issue in VCT clinics which was appreciated by the evaluation team. Providers felt satisfied with the level of supervision from the NAP staff. When asked about the training they received, providers wished to receive more training and especially OJT. Data managers requested to receive classroom training to learn more about HIV/AIDS and how to deal with clients because they felt embarrassed when receiving clients.

All providers interviewed agreed that training strengthened their counseling skills and service provision requirements but did not affect the level of utilization of VCT clinics. They believed that clients flow depends most upon the level of awareness among community members and the advertising campaigns conducted by the project. It is important to note that the interviewed STI provider was very...
knowledgeable and believed that frequent refresher training and advertising for services is of the utmost importance.

VCT clients’ satisfaction was analyzed through reviewing 82 client exit questionnaires collected from the clinics selected for this evaluation. The questionnaires were filled out by clients during 2010. Almost all clients were satisfied with the different services provided except for the following: 21% of clients marked they did not discuss testing, 50% of clients marked they were not planning to discuss their counseling visit with their spouse (equal percentages in all sites), 33% of clients marked that the video they watched was not useful (more in Luxor), only 8% of clients marked they will not recommend the center to others, and one client marked he/she was not given the chance to be heard and discuss his/her points. It is important to note that clients visiting Sharm El Sheikh Clinic wrote many positive comments in the form. The clients expressed their satisfaction with the service; wished those centers opened earlier to prevent HIV spread in Egypt; wished the ministry would make HIV treatment available to them, and reported that these clinics needed a media campaign strategy so that people would visit them when needed.

Question 2b: Did the target population use of VCT services increase in governorates of program implementation?

The service statistics collected were analyzed and presented in the figures below. Figure 1 describes VCT clinic utilization disaggregated by sex during the years 2008 – 2010 in all evaluated sites. In general males visited clinics were more than females. However, in 2009 Luxor showed marked increase in female clients. This finding could not be explained because the type of client was not identified due to unavailability of data. In general there was a decrease in the caseload over the years. This decrease was related by managers to the very rapid turnover of providers and a drop in the provision of awareness sessions. They stated that MARPs who were considered the target population showed an increase but the data was not disclosed due to privacy issues.

![Figure 1: Utilization of VCT services by sex in all clinics during the period 2008-2010](image-url)
Annex 9. Detailed Findings from Question 2a

Figure 2 compares utilization in fixed and mobile clinics in Cairo and Sharm El Sheikh Governorates.

It is clear that mobile clinic utilization was higher than fixed clinics in both governorates though Cairo fixed clinics showed more utilization across the years. Despite the very low utilization of fixed clinics as shown in the graph of Sharm El Sheikh, 2010 shows increased utilization. Providers and project managers reported that the caseload was not related to service provision but to campaigns and awareness in the community. Client satisfaction, as described above for Sharm El Sheikh Clinics, might explain the increase in utilization during 2010.

As shown in figure 3 below, the trend of utilization in Cairo is decreasing while a rise in utilization was observed in Sharm El Sheikh. This is consistent with findings in the above graph.
Service statistics analysis did not answer question 2b as numbers of MARPs (target group) were not disclosed by NAP. Still, broadly speaking, service utilization is on the rise in Sharm El Sheikh and this finding was supported by client satisfaction explained above.

The project is conducting promotion campaigns in different governorates to increase VCT clinic utilization. So far, the project has finished campaigns in Menoufia governorate and Figure 4 below describes how the campaign markedly increased utilization which then fell over time. Campaigns should be continuous to promote utilization of VCT services in Egypt.
Figure 4: Effect of campaigns on utilization of VCT services in Menoufia Governorate 2009-2010

**Question 3:**
To what extent did the Youth Friendly Clinics (YFC) projects contribute to the sustainability and quality of RH services at the service delivery points?

To answer this question, the following RH projects were evaluated:
ID: EGY/08/P10: Adolescents RH Needs in Egypt (EFPA)
ID: EGY08R54A0: Teaching Hospitals - Youth Friendly Services
ID: EGY8R51A: FHI with EFPA and THO

**Findings**

**FHI**

Interviews with project managers and reviewing project outputs showed that FHI has produced training manuals including FP and RH manuals for providers working at YFC, youth RH training manual for peers, and a monitoring and evaluation guide to support quality services were available. Also, a wide range of IEC materials used at clinics was provided by FHI to the evaluation team. These manuals and IEC materials were well prepared comprehensive ones and used in training activities as well as by providers in clinics. Despite their usefulness as reported by project directors and managers, the peers would like to update or change formats of the ones they use at regular intervals. They believed that using the same material repeatedly was boring to them and to their target groups as well.

**EFPA**

EFPA had a well formed project structure where clear roles and responsibilities of staff were defined. Besides the project director, youth and gender specialist, they had a monitoring and evaluation specialist who oversees all activities and reports timely and regularly to the project and then to UNFPA. A well developed monitoring checklist was used regularly to monitor performance and list needs of clinics. Clinics visited in this evaluation had a visible location and were easily accessible with a clearly placed sign carrying the name of the clinic. Clinic staff provided family planning (FP), antenatal care services (ANC), pre-marital counseling, in addition to RH counseling and selected laboratory services. An information corner was found in each clinic which has a library, video player and TV set, a printer, computer/s and a cassette recorder. YFCs had a good reputation as reported by peers and youth participating in focus group discussions for providing good FP and ANC services as well as a place to get gain good information and knowledge. Youth reported they visit such clinics mainly to use the internet and for reading a variety of books in the library. They appreciated the information they got about the physiology of reproduction, puberty changes and related problems.

Interviews with providers, including physicians, counselors, and peers showed that they had a very good amount of correct knowledge regarding RH issues. They are aware of the appropriate age for marriage and its reasons, importance of pre-marital counseling, ANC and FP counseling, different RH aspects, and harmful practices including FGC. Physicians are very knowledgeable about requirements of ANC and FP services. They know all FP methods, side effects, and how to manage them. All types of providers were outspoken and positive about offering youth RH services and information. They believed they had an important role in youth RH education.

Peers in particular were very impressive in their presentation to data collectors; they were university students or graduates and they were very willing to work with youth. They reported that in the beginning, youth were not responsive to them but now they are responsive and seek their help. They added that whenever they face problems with youth or if they were asked about issues that they were not confident about their answers, peers referred youth to the physician or counselor working with them. Peers were very proud of awareness sessions and wanted to do more with them they also believed that the presence of an experienced nurse or physician helped them convey the correct messages and information. They gave innovative ideas to attract youth during awareness sessions. Spreading health messages through plays where youth play the actors’ roles was very well received by youth. Finally, for improved quality of work, they requested data on RH issues suitable for presentation to aid them in their presentations and sessions.
All types of providers interviewed were satisfied with the training they have received. They thought it was useful and helped them improve their counseling skills. Peers still requested to have repeated refreshers especially on FGC, premarital and RH issues. Providers believed that not only training affects clinic utilization but also if parents were convinced; it affected the increased utilization of their clinics. That’s why, they recommended media campaigns directed to both parents and youth to make people in their communities aware of YFCs and to increase their use..

The evaluation showed a good sustainability criteria since clinics are already established EFPA branches and providers were either of the place or affiliated to MOH. Still, what threatened the sustainability of such clinics and as verified from providers’ and managers interviews was the fact that physicians’ turnover is high among YFCs. Since EFPA paid a form of small honoraria, the association cannot hire specialized physicians for their clinic, instead, MOH physicians are sent for limited periods of time to work at YFCs. This fact has pros and cons, since an MOH physician is trained and capable of providing quality service, but on the other hand could not stay for long since he/she was affiliated to another place/facility and this was not acceptable by clients. Also, providers who are originally MOH loose their benefits and thus were not willing to work in such clinics.

It was important to understand the perspective of youth themselves and how they perceived the clinics and services provided. FHI assessments showed that at the time they were done, youth were not well prepared to visit clinics but this evaluation showed that EFPA clinics were very appreciated and visited by youth. In both Minia and Ismailia, they knew about the clinic from their friends and awareness sessions conducted at schools. Youth attending FGDs had good information and reported YFCs as the source of their knowledge. They had a wide scope of information including RH and HIV related issues. They learned this information from awareness sessions conducted in the clinic. Still, topics known to males were different than topics known among females where the males were interested in pre-marital topics and reproduction while the females were interested in ANC, FP methods, and child care topics. Harmful practices and gender issues were tackled in YFCs, still, youth are in need of more knowledge. Among females, many issues are hidden and need to be tackled in awareness sessions. Female youth reported that the parents do not take them as friends and there were no discussions between them to differentiate between the right and wrong deeds. Youth showed their deep appreciation to the information corner. They specially like the good books about population problem, FGC, and others. Also, the internet availability was extremely appreciated. This finding was supported by project officers where they reported that if one of the computers was not working, it affected the utilization big time. Male youth thought the clinic would be very useful for their future wives. One youth said that when he and his future wife did his premarital counseling, he felt relaxed and relieved. Youth participating in discussions believed that those clinics were helpful but needed more advertising and expansion. For example, in Minia, youth requested another new clinic in addition since the available one in not centrally situated. Finally, youth requested more organization of trips, more info about pre-marital counseling, FGC, child care, and breastfeeding as a FP method. They also requested some privacy during counseling; there was no special room for counseling. Moreover, to increase clinics’ accessibility, youth who participated in FGDs recommended developing a website for YFCs.

It is evident from interviews and FGDs that there were awareness sessions conducted in communities to market for YFCs, yet there was still a substantial need for its increase. Project managers thought that community leaders and specifically religious leaders need more work to advocate for such clinics in the community. An important finding was resistance of RL to FGC messages in youth clinics as they believed it is linked to Islam. Also, the effort was needed to reach parents who actually were the tool to increase or decrease YFC utilization especially among female youth.

Interviews with project managers revealed that utilization of YFCs is affected by many factors. The most important factor was the location of the clinic and the distance between it and nearby schools. For example, project officers claim that the Ismailia clinic is utilized much more than Minia clinic as it is just in front of the secondary school. This was supported by youth reports as mentioned earlier.

The reputation of EFPA YFCs spoke for them, as shown in figure 1; utilization is increasing from year to year. The more the clinics were known, the more youth sought their services. Project managers and officers reported that proper monitoring and evaluation of work activities as well as on-the-job training for improving providers’ performance played an important role in the acceptability of clinics within their communities.
Figure 2, shows variations among different clinics' utilization of youth below 25 years of age. Actually many factors had a role in the utilization namely; variability of services, quality ones, providers' performance, nearby schools, prepared communities, internet and computers, trips and entertainment, providers' turn over, and adequate advertisement. Project managers believed that youth advocate for YFCs. Accordingly, improved utilization could be managed and corrected through monitoring, evaluation, and corrective actions.
Organization of Teaching Hospitals Clinics (THO)

THO project structure formation consisted of the central project director and financial assistants and supported by peripheral/local managers consisting of hospital administration and service providers. Clinics took the form of one room that offered services mainly for newly weds who sought the clinic to receive the health certificate required by official authorities for completion of marriage. Clinics were not included the teaching hospitals organogran (formal organization structure) which threatened its sustainability. Interviews with project directors showed that efforts had been taken to ensure sustainability of clinics. Starting in 2010 YFCs were integrated within the organogram of THs. Still, a monitoring and evaluation officer who was responsible for these clinics was not clearly defined in their organizational chart. Very few youth clients visit the clinic for counseling services and newlyweds were the main clients for such clinics. Interviews with providers and youth participating in FGDs reported that clinics in teaching hospitals did not have a clear label for people to know about their availability and there was not enough advertisement of such clinics in their communities. Moreover, the morning working hours of the clinics did not allow for proper utilization since youth were in schools or universities.

Interviews with providers of care showed that their knowledge is deficient in many RH related health issues. They do not use their training manuals or the IEC materials to refresh their knowledge or during offering the service. As per the trainings received, clinic staff reported it was good but was too brief. According to interviews, staff needed more information on how to effectively communicate with adolescents. The staff was not confident about their counseling skills and they requested more classroom and practical training.

Interviews with IPs and project managers revealed a weak monitoring and evaluation system with missing data which made tracking of problems and implementing solutions impossible. Project managers believed that working with newlyweds would result in more exposure and hence youth will follow but they did not have a clear plan for how to tackle this. Meanwhile, the UNFPA officers were not comfortable with this and requested from THO to work on developing an effective plan to bring youth into their clinics. On the clinic level, providers reported that YFC need a lot of upgrading, they need training, and a media strategy should be addressed to make clinics utilized by the youth population as currently, clinics were utilized only by newlyweds. After FHI conducted the clinics’ assessments, weaknesses were identified and starting late 2009, community activities that were initially...
conducted by TH were put to an end and a new marketing plan adopted by UNFPA started. The UN organization subcontracted a media agency to market for THO clinics but the output in terms of advertisements and marketing tools were still in process.

Youth attending FGDs from teaching hospitals had inaccurate RH information and reported the source of knowledge to be the Radio, TV, and relatives. They needed to know a lot about various topics under RH. They requested that TV ads spoke about the availability of YFCs.

Figure 3 describes the variation in utilization among the different teaching hospitals along the years. It is evident that in general, the highest utilization was in 2009 when the marriage certificate was a formal pre-requisite to complete marriage papers. This was mostly encountered in Banha hospital in Qalubia governorate where project managers believed it was the best YFC among all TH clinics since providers were committed and community activities there were effective. This was related to the fact that Banha was a small town and had only two hospitals where people preferred to receive services from the teaching hospital. The graph also showed a decrease in 2010, yet the data for 2010 was not complete. Utilization in Sohag and Menoufia might be showing some increase. Actually, there was no clear explanation for such findings as on the whole monitoring and evaluation at teaching hospitals for YFC was very weak.
5a) Is the UNFPA/MOFP Adolescent Health project successfully building the capacity of adolescent beneficiaries as advocates for sexual and reproductive health and gender equity among their peers, especially vulnerable adolescents?

**Project 1. EGY08P08: Adolescent Health Program Question 5a**

Visits to project sites.

Fayoum the MOFP Assessed Excellent NGO:

Administrative Issues.

In Fayoum, the selection of schools is determined by the availability of community leaders and or school heads among the MOFP contacts and the social network of those in charge of the NGO. This criterion for selection was to facilitate their entry and acceptability in the community and school. So far the Fayoum NGO has covered only three schools since 2005, as they take each school for two years in order to cover as many students as possible within a school.

The NGO has suffered from delays as a result of senior staff of the Directorate of Education and the bureaucracies. However, the Department of Community Education facilitates some of their work. The constraint they face is the inadequacy of financial funds. They receive only LE 5000 after implementation of all activities. These funds are especially important to finance transportation to rural schools.

Observation of the education session in Fayoum.

The observed adolescent education session was in the form of a number of quizzes reviewing various messages with an emphasis on Hepatitis C. The position of the tables was U-shaped, with 42 girls and boys sitting squeezed and adjacent to the walls.

The two female educators, aged 30 and 31, were faculty of the Faculty of Education. They had or they were studying for a doctoral degree. They coordinated the session activities fairly well and called each other with their titles “doctor”. To the evaluator they seemed very much like good school teachers using modern teaching techniques. These women cannot pass for “peers” to these school adolescents; they more likely represent the teacher figure.

The evaluator noticed that the educators avoided the mention of any sensitive information concerning the reproductive system, or if they did, they referred to it with embarrassment and with general rather than specific terms. The particular messages seemed just like what would be broadcast in a public service announcement on TV. Personal hygiene message was a general one of having to take frequent baths, as much as twice daily in summer.

When the two educators were asked about addressing physiologic puberty changes with adolescence in the education session, again the evaluator noticed facial expressions of embarrassment of the educators. They responded that delivering this message is not difficult but it is awkward “حِرْجَ” therefore they say it in the middle of other statements / messages “في وسط الكلام وينقلوها باستجابة” and they state it with modesty and shyness. They haven’t addressed the reproductive health issues in detail though they have addressed sexually transmitted diseases. They have not addressed the physiologic puberty changes as they are still in the general section [of health education] and have not taught before except FGC, early marriage and sexually transmitted diseases (STDs). They explained how they gave the STD message: “we quickly mention in the middle of talk that it can be
transmitted through illegitimate sexual relations, only, without details”. From the educators’ point of view, the parents of adolescents have not caused any problems.

The educators complained about the lack of teaching aides "وسائل إيضاح". They find that they benefit from the support and monitoring visits of the MOFP and the Y-peer. They benefit from the feedback they obtain based on observing the education sessions as well as the medical knowledge provided by the doctors of Y-peer. Before the training, they did not know about good nutrition, incorrect health behaviors, HIV/AIDS, Hepatic Virus C, and sexually transmitted diseases. They also benefited from training techniques that deliver information through games.

Headmaster
According to the interview with the Head Master who also heads the local community development association, in response to the question of how they address reproductive health topics in a coed school, he reported that they cannot address RH nor anatomy and physiology of the reproductive system for adolescents in the village. If the families knew, the whole activity could be stopped. This is why they do not address these issues at all or if they do they only point to it reservedly "ينوه عنه" and with great caution.

The head master reported that the project is of great importance to the need for awareness for adolescents about their health. He reported that after education sessions, the adolescents report that they benefit a lot from the sessions. However, again he also finds great resistance toward the program from MOE (Ministry of Education) districts, religious preachers, human rights organizations and other groups.

Mynia the MOFP Assessed Satisfactory NGO:

Administrative issues.
The NGO selects schools for the program where they have performed other activities. According to an educator and what the evaluator had witnessed, the schools bargain for services and favors from the NGO, such as making shade areas, painting a fence or growing trees. According to the NGO head, the difference in implementation in the current year compared to earlier years is the use of data in presentations, internet and other technological assets of the NGO. He reported using doctors in delivering medical information such as healthy nutrition. Two of his educators are doctors who have attended y-peer training.

The NGO faced a number of constraints including an inadequate supply of IEC materials, and inadequate funding. They receive LE 5000 and cover seven schools. However, it seems that these seven schools are over the lifetime of the project. Because this is a funded project, the Department of Community Education requests a share of the funds.

According to the Mynia NGO head, adolescents have a great need for information on RH. However, the messages are not presented from the religious perspective, while adolescents are requesting the religious point of view. According to the head of the NGO, the messages should therefore take on a religious motivation or a religious coloring "الوازع الدينى", reaching adolescents. For example he explained that they need the topic of bringing up children from the religious perspective and to incorporate the viewpoint of religion for example in the nutrition and other messages. The evaluator has reason to believe that the peer educators may have developed their own religious messages and are delivering them.

It is worth noting that the evaluator has received from the project management one booklet entitled “Adolescents and Youth: from a religious perspective” that discusses both the Islamic and the Christian viewpoints. It covers the topics that the head of the NGO was requesting.

He reported that the number of peer educators is hard to count but he has more than 120 students who are “school peers”, plus the volunteers and 2 physicians who have received the Y-peer training. This seems to be a result of difference in perception to “peer educators” as he has two ways of targeting in-school adolescents.

The method of implementing the adolescent peer education activities is the system designed by the project and he takes a whole class from the school. The NGOs alternative method is to select the best and brightest
students from the school, who are ready to receive and deliver the messages to others in the school. This select group of students is given the messages more in depth and more often. As reported, from 300 students he comes out with around 120 “school peers”, who are knowledgeable and willing to pass on the information to their school mates. He uses the school social worker to monitor whether they are actually telling their friends the messages or not. The head of the NGO finds this second approach to be better than training the whole class.

The NGO head requested that he be able to send more volunteers to peer education training. Educators also need more training on messages about safe use of the internet and innovative thinking so that they would be able to transfer the information to their peers. He finds the technical support of the MOFP and y-peer to be good but needs more of it to link the new educators to the old educators to learn from their experience.

A 16-year old excellent “school peer” in the second secondary form was interviewed. She has been doing volunteer work for four years and has previously participated with MOE, one classroom schools and another NGO. The benefits from the peer education training were that she learned better communication skills including entry points to talk to others, and the use of games. Her classmates benefit from her availability because some are too shy to ask questions in a group. For example, a girl getting engaged asked her about the disadvantages of early marriage. She also stated that they need more information about aggressiveness and violence, relationships between boys and girls and sexual harassment. A problem that she faces is that some girls consider talking about these issues to be impolite "طيب" and parents of her peers prevent their children from talking to adolescent “school peer” educators, as they consider them impolite girls. Parents also prevent their children from attending seminars. They talk about menstruation and RH issues in a humorous way and she uses descriptive examples. She thinks that the project can be sustainable if the in-school peer educators keep transferring the messages through their friends.

The two interviewed educators aged 29 and 30 years, both indicated that physiologic and psychological puberty changes have not been taught yet. There was another educator that gave this topic and now is not available.

Since the evaluator had seen that teaching about the physiologic and psychological puberty changes had been avoided in the Fayoum education session, she asked the head of the Myinia NGO if they delivered such a message. Because there did not seem to be any reservations, the evaluator asked the Myinia NGO to conduct its session about this message for girls. The management of the NGO had not expressed any concerns about presenting such a topic. It was reported to us that three educators had prepared a theatre drama about this topic and distributed the roles. However, even though the session started later than planned as the school girls had an examination, two of the educators did not show-up. One of them came towards the end of the session as she had a meeting at the political party she is working in. Only one educator gave the session and she had not had any previous y-peer training. The session was attended by 40 female students of the second and third preparatory.

The room was huge and the students were seated in rows. As the session was going to start, as many as 30 people entered the session such as community leaders and teachers etc. They insisted on presenting an introductory speech as if it was a ceremony. The evaluator refused to give a speech and thanked everybody and asked them to leave to start the session with the girls. Many other people kept coming in and out of the session and passing in front of the students. The school social worker attended the whole session.

The educator was not trained and the material presented was non-scientific; she spoke out of her own personal knowledge. Some of the information given was incorrect or just represented her own cultural background. The social worker intervened and corrected and reiterated one of the messages of the educator. The session at one point started to be just collecting questions about the topic from the girls and promising to cover them in later sessions.

To show what she meant by growth and puberty changes, the educator selected two girls opposite to each other in physical body measurements, one was tall and broad and the other was short and thin. The evaluator thought that this method of comparison in education could be detrimental to the psychology of the adolescent who was pointed out, in front of the whole class as being small and not grown up yet. When the evaluator explained to the educator, she indicated that she knew the “small” girl from before, meaning that she will not be negatively affected.

IEC materials.
The educators distributed several MOFP/UNFPA IEC publications. One of them is a very nice story book entitled: “Adolescents Talking”. The book would be interesting to adolescents as it is nicely written with nice drawings. The book depicts the life of three urban adolescents, thus it may not be appropriate to distribute in rural areas. The MOFP needs to develop another similar book for rural adolescents, for adolescents who work and study at the same time as well as for those who are only working, to help provide them with good role models and several road maps to a fruitful adulthood. These books would better be written in a participative manner involving persons with expertise in education, gender, psychology, anthropology and medicine.

In the distributed book, the evaluator noticed a phrase in the book about the menstrual cycle symptoms that the girl is feeling. The book states that the girl “sometimes feels strong depression” and does not want to tell her parents how she suffers. Before the menstrual cycle every month I [feel] choked “مختبأة شديد الأكتاف” and want to cry.” The book does not provide guidance on how to overcome feelings of depression of other problems such as a feeling of bloating. There are many methods for relief of menstrual symptoms. The book needs to give better information to adolescents about dealing with these symptoms.

Quantitative Survey with 26 NGO Educators:
The educators who completed the survey questionnaire at the Cairo meeting were previously trained in y-peer methodology. They came from 9 governorates and two thirds were female. The mean age of educators was 29 years; half of the educators were above 27 years of age, with 42% of them 30 years or more. Thus the age range of y-peer trained educators for adolescents is by far older than the adolescents they train.

When asked what messages they give to adolescents, only 13 (50%) mentioned giving messages on physiologic puberty changes. They also listed other messages that are not among the 7 project messages for adolescents. In response to a direct question, about one-fifth of the 26 educators had not given any messages about physiological changes of adolescents and if they did they cover it through doctors and/or religious leaders. Those who reported covering this issue, cover through using physicians (5), through religious leaders (3), and through both (6). Of the 12, who reported presenting the topic themselves, only one presents it alone while the rest include a physician and/or a religious leader. Three educators totally depend on doctors and/or religious leaders to present this material.

Eighty-five percent find that there are factors that affect their choice of training method. Thirty-nine percent find that the classroom space is a limiting factor, the students (23%), the training received (18%) and the school (14%). The general constraints facing them are: financial (47%), the schools (21%) and the MOE District, lack of training (13%), the adolescents (13%). Most of the educators (81%) have other volunteer work to do.

This question is related to Country Program Outcome 6.  
Outcome (6): Incidence of all forms of violence against women is reduced.  
Output (1): Community, religious leaders and media sensitized through active alliances to combat gender-based violence.

5b) Have UNFPA/Egypt CP 2007-2011 strategies and activities to sensitize religious leaders and communities they serve been implemented successfully and are they likely to positively influence religious leaders/beneficiaries and media personnel knowledge and attitudes toward women and girls especially gender based violence (GBV)?

Project 2. Detailed Results from Question 5b.

5b: Have UNFPA/Egypt CP 2007-2011 strategies and activities to sensitize religious leaders and communities they serve been implemented successfully and are they likely to positively influence religious leaders/beneficiaries and media personnel knowledge and attitudes toward women and girls especially gender based violence (GBV)?

To answer this question, two projects were reviewed: EGY8G27B. Reproductive Rights and Gender in the context of Islam EGY8G47A. Campaign against sexual harassment
Findings

Project 2. EGY8G27B. Reproductive Rights and Gender in the context of Islam

Findings
For gender issues and GBV, the undersecretary finds that there are two important points a preacher should know and relay to the public. First, there is no difference between man and woman in humanity before God. Second, there is no violence and beating in Islam. This is not just physical but also many other forms i.e. there should be no “oppression”. This refers to violence in all its forms, whether this oppression is in sexual relations, oppression in expenditure, oppression in giving dry orders etc.

The undersecretary reported that, this necessitates correcting the understanding of the concept of “kewama”, which does not mean the man is the “head” and even if it does, it does not mean that others below him are “his slaves”. The other issue, “beating”, in a specific Koran verse is not intended to address any wife actions that are not acceptable to the husband. It is only for a woman who is “nashez” i.e. “refusing sex without having any reason whether physical or psychological”. It is also just “symbolic” beating with a brush like plant, after having used other means of conveying the message. The undersecretary’s explanation of “nashez” will be used as a benchmark to compare the interviewed RL’s perceptions as to when a man is justified in “beating” his wife and how.

Advantages of Preachers’ Reference Guide:
The undersecretary highly regards the guide and the participatory, consensus building approach, which was used in producing it. All trained RL reported the guide to be very good and beneficial at many levels. The RL also stated many advantages of the guide related to specific topics and their importance. It is worth noting that they mentioned advantages related to the gender section of the guide spontaneously and sometimes after direct probing. See Endnote 1 for content analysis of the gender section of the guide.

According to RL, it is a reference that should be read and referred to by doctors and preachers alike; physicians would know about religious opinion and preachers would benefit from knowing the medical facts. The guide is comprehensive and written in a simple way, which makes understanding of medical issues easy for preachers. RL review the guide often to use in Friday prayer speeches and religion lessons. It uses a correct scientific approach. It is written by experts in the religious and medical fields. It is presented in an organized way and at the end of the guide it presents a summary and conclusion of the various messages. The guide includes the relevant Koran verses and hadiths, i.e. it does not mention anything without its religious evidence. The printing is also very good.

Enhancements to the Gender Section of the Preachers’ Reference Guide:
Due to the experience of the undersecretary in using the guide in training RL and preachers as well as responding to the public’s questions and remarks in issues related to population, FP, RH and gender issues, he finds that more social and medical evidence backed up with statistics from scientific research is needed. For example, he would like to have evidence on the morbidity and mortality associated with repeated pregnancy.

Important RL suggestions, presented below, for developing the guide as well as making it more beneficial for step-down training were each reported by one or two RL. A RL believed education of girls was a little short needing more information to help preachers convince the public. RL found the guide to cover well GBV but that it needs some additions to sexual harassment, rape as well as inclusion of orfy (not officially documented) marriage. As preachers, they reported not having the social and medical information regarding these issues. Furthermore, the religious information was reported not to be enough for these three topics. This lack of sufficient information was reported to be especially important for step-down training of other preachers. Content analysis of the guide has shown that sexual harassment and rape have not been addressed from an Islamic view-point. It has also shown that women’s work needs to be addressed in the guide as a woman’s right.

It was noticed that various UNFPA/ECWR IEC materials on sexual harassment produced for media people, found in the waiting room for the evaluation interviews, were taken by RL. This shows two things; the need of preachers for such information about current social and health issues in the Egyptian society as well as the good quality of the content of ECWR IEC material on sexual harassment.

RL find that more medical information is needed for the guide to become more complete as preachers refer to it to incorporate parts in their Friday prayer speeches and religion lessons. In the religious sections, a RL reported needing more in depth explanation of Koran verses and from different sources. The other issue here is that a preacher, as he talks to the public, would need to explain the text from the angle of his argument and to refute other explanations if confronted with debate.

RL find that the guide only presents the religious evidence that supports the positive attitude towards an issue. To make the guide more helpful in step-down training, the guide should contain all points of view concerning some of the topics, similar to comparative "feqh" studies, one should present both points of view with their evidence and then discuss. This would enable debate showing which evidence is stronger as well as argumentative confrontation with the opposite attitude, especially that of another preacher in step-down training. The content analysis showed that incorporating the other points of view with their evidence and their relative strength may be added in annexes, which would help avoid diluting the strength of arguments presented in the guide’s main text.

Another RL finds that for FGC, most of the information is medical as the religious content is written in only half a page, while a preacher needs a lot of religious evidence to back his point. The RL explains that this might have been because FGC from the religious perspective is considered from those issues that were not discussed historically "مسكوت عنه" and because the guide does not discuss the opposing points of view.

However, for FGC the project manager reported distributing two books about FGC to training participants. The book produced by WHO and reprinted by UNFPA contains a religious section where two religious scientists with opposing views discuss the FGC issue using religious evidence. The other distributed book was a Question and Answer Book for Imams on FGC produced by IICPSR and UNICEF.

In fact, the content analysis for the religious point of view section of FGC shows that it discusses the available current cultural beliefs pertaining to FGC and why it is performed. There is one paragraph that states that there is no religious evidence from Koran or Sunna for performing FGC. It goes on to state that the hadiths referenced to the prophet "do not have any correct reference source in mother-books (reference books) nor in Sunna". Through this paragraph, it is actually difficult to convince a RL who has studied the hadiths that are said to back-up the performance of FGC, especially those who have studied Comparative Feqh, without stating these hadiths and discussing them and their authenticity. It may have been also good in this respect to quote the statement of the Grand Mufty relating to the current religious ruling on FGC.

Although some professors teaching RL, especially the undersecretary, told trainees how to respond to questions and debates from the public, however, a RL finds it important to know ways of convincing the public in issues where they have strong views. As he reports, the guide is well developed to reach preachers but not to reach the public.

Benefits of Training on Preachers’ Reference Guide:
Trained RL gained self-esteem and self-respect. They realized the significance of their position as they have an important religious mission and role to play in society; they have a message to deliver. RL also benefited greatly from the knowledge and skills offered by the training.

According to RL, the topics were well taught by very high level physicians as well as very prominent religious figures and scientists in Egypt. RL gained scientific knowledge, both from the religious and the medical perspective. The training also collected and compiled Koran verses and hadiths, which no one can refute. For the medical side it gave them a lot of information they would not have known otherwise. They discussed topics that were far from them e.g. RH and how to address it. This improved medical and health information also benefited them a lot on a personal level. They valued being given very good books that address current issues. RL now knew about current social issues, which are important, as preachers need to always speak about existing problems.

RL have learned how to think in a more scientific way, to question their religious cultural heritage and to always base their views on logical reasoning. The training opened up their minds as they used to adopt the views of certain theologians they liked. The training developed their thinking about the topics studied. RL also gained discussion and debate skills and how to present in a scientific methodological way. They learned how to present
information in an organized way as their role is not only a matter of just telling people, it is a matter of convincing them from the first to the last word. RL made group work which made everybody express themselves and prepare speeches in their own styles.

The training gave RL a push to talk about the issues studied where previously they were hesitant. They are now not afraid to talk about these issues. They benefited the courage that preachers should have to talk about current problems, especially if recent community circumstances necessitate it. RL used to talk from the religious perspective only but after the training they can also talk from the medical perspective in such issues as FGC. They knew that as preachers they should not be limited to religious concepts but also open their minds to other horizons. They learned how to talk and explain in lectures and in Friday prayer speeches as there were working groupsthat prepared them concerning material that could be addressed in a lecture and in a Friday speech. They read and refer to the guide and they now know how to respond to the public with evidence and reasoning.

**Knowledge and Attitude towards Gender-Based Violence:**

In response to a question about the different forms GBV, RL’s spontaneous responses show that they have assimilated the general concept of GBV and are sensitized to its different forms. Moreover, their responses seemed to be out of experience with the communities that they serve. RL spontaneously mentioned 4 to 8 forms of GBV, with 8 out of 12 RL mentioning 6-7 forms. The GBV issues spontaneously reported were:

- Discrimination in treatment, preference of having a boy, neglect to vaccinate the baby girl, care more for boys than girls, denial of inheritance
- Not considering a woman as a human being, denial of education, or limiting a girl’s number of school years although she is doing well.
- Lack of experience due to constraints on the mobility of girls.
- FGC
- Deprivation from marriage, marriage without taking the girl’s consent is a big problem, wedding night mechanical breaking of hymen, early marriage resulting in non-legally documented marriages arranged by parents resulting in loss of rights of wife and children
- Lack of reproductive knowledge of girls due to shyness in talking to the mother and lack of knowledge of women about FP
- Repeated pregnancy without spacing forced by the husband and the mother-in-law
- Lack of sexual relations or does not satisfy his wife’s sexual desire. No foreplay as stated in Islam, “a kiss or talking and put several lines under ‘talk’”. It is more important to satisfy women’s emotional needs than to satisfy their needs for food and drink. Making a woman feel she is of value.
- Denying a sharing in decision-making, especially in rural areas. Most husbands do not ask wives their opinion about husband’s life and work. They do not consult their wives or as the saying goes “consult her and do the opposite شورها وخالفها”.
- Wrong understanding of kiwamah, beating of women, and mistreatment. Threatening to divorce.
- Limiting participation in the labor force.
- Because all these are rights of women that Islam كنّا when a woman is deprived of these rights, it means that violence is exerted against her.
- Sexual harassment and rape.

**Combating Negative Behaviors as a Result of Training:**

All interviewed RL are already conducting activities to combat many of the negative behaviors in society related to population, RH and GBV issues, many of which are a result of training. It is worth noting that the FP and population issue is being addressed by many RL interviewed (see Endnote 2 for a discussion of FP).

As a RL states, after the training they went back to their governorates, they started moving towards combating problems such as poverty, gender issues such as discrimination and harshness towards women and girls and forcing them into marriage etc. Among the other phenomena addressed were discrimination against girls e.g. denial of education, work, freedom of opinion and thinking, innovation and mobility, inheritance as well as dignity. As part of society, a RL witnesses many forms of injustice that women and girls go through and thus addresses them.
As for FGC, 6 out of 12 interviewed RL spontaneously mentioned that they are trying to combat it, or at least are talking about it to the public, as one of the negative social practices. Five out of these have started these activities after the training. As for wife beating and violence against women in general, 6 out of 12 interviewed RL spontaneously mentioned that they are addressing mistreatment “سب وضرب” of women, two of whom started addressing harshness “قسوة” and wife beating after the training. The one RL who is addressing violence against women is doing so from before the training; however the training has strengthened his knowledge and skills in that issue.

Changes in Attitudes of RL:
The initial attitude of at least some of the RL trainees was skeptical about the intentions of the trainers, as they may be coming with a forced and dictated foreign agenda. There was fear that they will be spoon fed something to convey to the public. These major concerns were especially regarding FP and FGC.

Albeit this negative resistant attitude, the training was able to change many of their perceptions and attitudes towards population, RH, gender issues and GBV. From spontaneous responses to questions about the training, the controversial issues of FP and FGC were the reported highest perceived attitude change. As a RL states, “gender issues, FGC, women’s rights and FP, these ideas were not there before training. Truthfully I was against these things and I essentially did not talk about it [in speeches or lessons]”.

Changes in Attitude towards FGC:
According to the project manager, during the training of RL, there were many discussions concerning FGC. As part of the training, the detailed anatomy and physiology of the female genital tract and external genitalia was explained and pictures and diagrams shown. The theologian faculty gave RL strong religious arguments against FGC. However, as reported by the project manager, by the end of the training there was still a margin of “ambivalence”, uncertainty and indecisiveness among RL concerning FGC. The project manager therefore plans to conduct a one day refresher training for FGC for RL at the governorates before they conduct the step-down training for local preachers.

Interviews with RL showed that training on the reference guide has resulted in a change of knowledge and attitude towards FGC of all interviewed RL, as is evident from both RL’s spontaneous as well as their direct responses. In the responses to several questions, e.g. benefits of training, social issues they are actively addressing, some RL spontaneously mentioned their new position on FGC as a result of training. There was a perceived complete change of attitude towards FGC. The training has addressed the deeply rooted cultural and religious values pro-FGC. Lack of prior proper religious and medical knowledge was spontaneously reported as causing their previous position. None of the RL spontaneously mentioned that performing FGC is part of religion, which is a good step forward in combating FGC. However, RL’s spontaneous reports indicated some misperceptions that will be discussed below.

In response to direct questions, it was evident that the actual change in attitude varied from currently becoming completely against FGC (2 RL), to becoming against FGC unless a trusted Moslem specialist physician finds cause for circumcising a girl (2 RL), to relegating the decision to circumcise to the doctor (8 RL), stating that FGC is a matter for the physician to decide and/or some girls need circumcision and some girls don’t.

According to responses to direct questions, all three groups of RL had changed their attitude towards FGC due to the training on the preachers’ reference guide. Again, none of the RL mentioned that FGC is related to religion. They neither said it is a must or it is "مستحب" ("مكرمة ولا ؟؟؟" krwa). This is a positive change of attitude for all RL attending the training on the reference guide. What still needs working on is that medically no girls need female circumcision. The misconceptions will be stated below.

In response to direct questions, the first misconception is that the girl may have physical or health problems for which the doctor may find that the solution is circumcision, if the girl does not get such problems then things can

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2 In many of the spontaneous responses of RL trainees, FP and population issues were brought up and are worthy of mention. See Endnote 2.

3 Responses to these questions concerning FGC will be referred to as spontaneous reports in contrast to reports in response to the direct questions section.
remain as they are. Second misconception is that immediate complications of FGC are due to the fact that the girl in the first place was not in need of circumcision. Third misconception relates to the MOH, as it is thought that MOH allows FGC in its facilities and criminalizes it in private facilities (one RL). These misconceptions should be understood and addressed through the preachers’ reference guide and training.

Spontaneously, many interviewed trained RL believe that girls need to have physical medical examination by a trusted specialized doctor to determine whether her case requires FGC. So although, some interviewed RL, have spontaneously reported being totally convinced against FGC, they still find FGC necessary for some girls. “Before the training I did not have a complete understanding of FGC in my mind. After the training, the trusted doctors had showed us the dangerousness of FGC on girls and females; maybe one has been convinced by it, complete conviction that it negatively affects many of the girls”.

This misunderstanding may have stemmed from something said in the training or from slides presented as a RL reported, “When we studied FGC from a medical perspective, it was stated that not all women are alike in this respect. There could be those who are diseased (not normal). And if you do FGC for a woman or girl [who does not need it] you cause her complications that are bad for the health. And God requests us to ask those who know. So after we knew the medical perspective there is no other opinion after knowledge / science”.

A few RL interviewed may not be so sure about their religious position on FGC and are thus relieved to throw the religious responsibility of giving advice against FGC to the public before God onto physicians. This may be why 2 RL had spontaneously reported that especially for step-down training the guide should show and discuss the relative strength of evidence for and against FGC.

Another RL spontaneously reported that after long discussions about FGC with the project manager, the project manager said to “throw it [FGC decision responsibility] on the back of the doctor” and that the RL became convinced to take this position. This may have been a last resort strategy used by the project manager in case a RL was not yet religiously convinced against FGC to enable them to answer questions from the public by directing them to the doctor.

The spontaneously reported changes in attitude of RL have resulted in some RL stating that they started to combat FGC. Due to the change in attitude towards FGC gained by the training, one RL made up his mind not to circumcise his daughter.

Addressing FGC with Family and Friends as well as with the Public:
Despite the difference in attitude towards FGC, a few RL from all three groups have spontaneously reported that they talk to their immediate family and friends, especially when the issue of circumcising a girl is eminent. Each group advises according to their convictions. However, the result of this advice was that finally girls were not circumcised, whether this was immediate or after seeking a physician’s consultation / advice.

RL from all three groups talk to their public about FGC. They addressed it as a point within the topic of children’s rights in Islam or the care of male and female children. A RL reported talking about it in a lesson, where he talked about male circumcision then went on with female circumcision. He made a point of not starting with saying “I will talk to you about female circumcision”. This way he talked in a natural way during the lesson. From all groups, RL find that they are able to convince the public with their point of view. Not all would be convinced, but the majority would be convinced.

Preachers receive divorce cases whether for consultation or for performing the divorce and are thus well situated to address GBV. As reported by a RL, they have thus seen how FGC sometimes affects sexual relations leading to divorce.

Wife Beating: Real Insight into Attitude is quite Intricate and Problematic
According to the project manager, there were no arguments concerning “wife beating” during training as RL are preachers who already know the religion and understand well the relevant Koran verses as well as due to the undersecretary’s good explanation of the issue “whereby there turns out to be no beating allowed”.

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As any one would expect, violent actions such as beating or hitting others is a negative behavior that all people do not accept and all religions ask us not to do such bad actions. This has been well articulated spontaneously by a RL in response to the question to what extent will he be able to convince other preachers with the messages of the preacher’s reference guide. He states that being against wife beating does not contradict any religious statements, all religious evidence is definitive and not speculative, the Koran and Sunna are clearly against it / tell us not to act in this way, so a person comes to the training ready to be convinced [100%].

Despite this positive attitude, another statement for that same RL shows how wife beating is so much unconsciously deeply rooted and justified as part of a man’s right in Islam. In a probing question related to benefits of training, whether there were other views that the training had changed, for example, violence between spouses, he stated that from before the training, he was actually against violence between spouses. He reported that they had studied feqh and studied the rights of a wife in religious feqh etc., so they knew that “the one who beats is not the best” and other texts etc. and that “to resort to beating, this would be the last method and this is only with the nashez woman. Until here, nothing is wrong in what he had expressed. However, he continues to explain his perception of the effective measures to sway the mind of the nashez woman to go back in what she has been saying or doing. This perceived minimal effective measure is that “she needs a whole troop of soldiers to back her off”.

In the wife beating section, as would be discussed later, he was from the point of view that beating is acceptable for crucial incidents, meaning that there was no real change of attitude contrary to what he had indicated.

The above explicit statements provide a clearly articulated example of how some interviewed RL would apparently seem to be against wife beating, but in actuality they approve of wife beating through their wrong interpretation of Islam. This shows that it may apparently seem straightforward and easy to convince RL and preachers against wife beating, however, a real change of attitude to this deeply rooted attitude in society that is being justified by the wrong interpretation of Islam, is difficult unless one is aware of the complex nature of this attitude.

Attitude towards Wife Beating:
The 12 RL were classified into 4 categories according to their attitude towards “wife beating”. In the first category, three RL believe that Islam is completely against wife beating. They were affirmative in their responses that Islam prohibits beating and that it is not the right of the husband. One of them defined “nashez” correctly, according to undersecretary’s definition, as “refuses sex with husband without reason”.

The second category (4 RL) is partially against wife beating. They also spontaneously reported that Islam is against beating or reported that Islam only stated beating that is not harmful and also after taking other measures. They have neither mentioned the specific instance for which this statement had been made or mentioned that this was for the “nashez” woman. The one who defined “nashez” defined it wrongly as the woman who has committed an act that may jeopardize the family or the future of children. The second category, in essence, is religiously and socially against beating but would understand it if it is not harmful, if after taking other measures or if it is for a grave mistake. RL of this category suggested having a penal law against husbands who mistreat their wives or reported that they would try to advise the husband against beating and if he continues in his bad behavior would advise the wife to complain in family courts as a last resort before asking for divorce.

The third category (2 RL) are of the attitude that wife beating in Islam is only for crucial and serious incidents. They did not react to the husband who beats his wife and says it’s his right as not being his right in Islam. In this case they responded by social concepts against beating e.g. "أعيب سماح". When asked directly about the right of a husband to beat his wife in Islam, then the RL would start to mention either “no, except in necessary cases, or "when beating is a must" to "عمرة الله وإصلاح البيت كنيرجة المرأة كما قال القرآن" or for “nashez” woman. They indicated the meaning of “nashez” as disobeyed her husband or as committing crucial incidents. A RL mentioned that people misunderstand this verse as meaning to have the right to continuously beat the wife. His concept is that beating is for disobedience.
The fourth category (3 RL) believe that wife beating is allowed in Islam for the “nashez” woman who is defined as disobedient. The “nashez” woman is defined as a woman who disobeys her husband’s orders. The twelfth RL allows beating for “nashez” woman but did not explain the concept. As found from the above, the concept of “nashez” is not correctly understood by RL as explained by the undersecretary: “refuses sex with husband without reason”. In summary, some RL indicated that beating is for nashez and explained the two strategies to use before resorting to beating. All explained that the beating is not in a way that harms the woman. Only one, from those RL that believed that beating is completely prohibited in Islam explained “nashez” correctly. Four RL who mentioned “nashez” had an incorrect and wide definition of “nashez”; two RL relate “nashez” to disobedience of women in grave matters that would have severe implications for the family and future of children, and one RL relates it to plain “disobedience”; the fourth quoted that if the wife does not comply with the saying “if he orders her, she obeys; if he looks at her, he becomes pleased and if he is not present, she protects his honor and money ….” she is then considered ”nashez”.

Addressing Wife Beating:
The topic of wife beating has been addressed by all RL in various instances in Friday prayer speeches, in religion lessons, in lectures and in wedding celebrations. As a RL reports, the preacher can play a role in combating wife beating as “people have strong religious feelings and often come to tell the preacher everything”. When a problem occurs, the husband comes and says what happened and that he had beaten his wife and the preacher then tries to resolve the problems between spouses in a religiously acceptable way. This is especially the case, if talk about divorce has occurred.

Content Analysis of Wife Beating Sections in the Preachers’ Reference Guide:
Unlike what RL have reported that only religious evidence backing up the guide’s position against a particular form of GBV is presented, the religious evidence that may be taken to backup wife beating is presented and explained. The Islamic evidence on “wife beating” needs to be streamlined and made more succinct and to the point reaching strong definitive Islamic conclusions. Strong Islamic evidence against beating and violence needs to be extracted from Koran and Sunna and presented in the guide, especially evidence opposing violence against women.

The guide misses presenting in depth explanation for two important concepts “nashez” and “kiwamah”. The undersecretary had emphasized the need for preachers and the public to correctly understand “kiwamah”. It is important to add more explanation of religious texts as the guide assumes that preachers have a similar common correct understanding, which may not always be true e.g. for “nashez”, which was not correctly defined by several interviewed RL.

As GBV in all its forms is still newly addressed by development efforts, the subtitle on “wife beating” can benefit from collecting more evidence on the patterns and severity of these violations and their consequences on Egyptian society as well as the men’s perception and rational for wife beating. Especially if Islamic evidence is still found to be indecisive regarding wife beating, then it would be more crucial to include adequate evidence on the magnitude of this problem and its consequences within the Egyptian context. It is worthwhile to include anthropologists, sociologists, psychologists and activist in the field of GBV and stakeholders such as the National Council of Women (NCW) and NGOs as authors in the review of this subtitle’s text, which would probably lead to a more effective message in combating “wife beating”.

Attitude towards Early Marriage:
Early marriage was defined by RL as marriage before the legal age of marriage at 18 years, before completing puberty and reaching complete maturity of the girl’s reproductive system, which exposes the girl as well as her children to health problems. RL emphasized the need for completed mental and psychological maturity before marriage where at a young age the girl cannot understand and carry home and family responsibilities as well as bring up children. RL find that due to early marriage divorce occurs because of this lack of mental and

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4 A good example of streamlining Islamic evidence, where there is seemingly controversial evidence, is that, which has been used for withdrawal and family planning in general.
psychological maturity and lack of understanding of family responsibilities. In addition, below age 18, the girl would not understand why she is leaving her own family to join another.

RL alerted that lay people may only consider apparent physical development, where at age 14-15 the body looks big but a girl cannot bear the burden of pregnancy, delivery, BF, and bringing up children. In short, she is still a child who has not fully matured. Therefore marriage should be after mental and psychological maturity, where intellectual and decision-making capabilities are well developed. The appropriate age for marriage should be considered by the girl’s guardian according to her status regarding complete mental and physical maturity. Even marriage at 18 should only occur if her guardian finds her to be mature enough, i.e. whenever she is completely mature above 18.

A RL reported that early delivery leads to deterioration of health and would also lead to a lot of children by age 35. One RL reported that in rural villages there is a knew awareness of the dangers of early marriage as they have seen it result in death and hemorrhage during delivery, as well as eclampsia and repeated spontaneous abortion as the uterus is not yet well developed. Early marriage has been reported as causing genital prolapse at a later age. RL reported that early marriage leads to a high proportion of divorce due to the lack of mental and psychological maturity as well as a lack of understanding of wife family responsibilities.

Many RL respect the law for appropriate age of marriage as it is defined by consensus of the medical profession to be 18 to allow for complete mental maturity as well as physical maturity of the reproductive organs. The law was also reported to be compatible with religious beliefs as religious feqh had differed in considering the age of marriage at 15 or 17. Now the law is 18, according to accepted medical knowledge.

One RL sees that marriage could occur after secondary school at 18. Another finds it should be between 18 and 25 and to wait until the girl finishes her education as she wishes. One RL finds the appropriate age of marriage to be 25 years after finishing university, even for girls who are not continuing their education. Another finds that even if a girl is not educated, marriage should not occur below 18 and to be between 18 and 20, so that her mental abilities are developed and not those of a child and to be able to bear the married life responsibilities. Another reports the appropriate age to be 22 for fully developed reproductive organs.

**RL Actions against Early Marriage Practices**

In response to the government’s age of marriage law, some Egyptian families resort to orfy marriage within the context of the family before the girl reaches the legal age of marriage. All religious aspects of marriage are conformed to including the publicization of the marriage. However, the marriage is not officially registered. The marriage is performed by a preacher or even the official mazoun (legally recognized person responsible for performing and registering marriages) who does not register the marriage when it occurs. It is usually intended by the two families that the marriage is to be registered after the spouses reach the legal age.

Eleven of the 12 RL are truly convinced of the problems that arise from early marriage due to lack of complete mental and physical maturity. They would thus advise against it and they would not take part in performing orfy marriages or publicizing them even within the context of family approval and knowledge. They find that even though this type of marriage is apparently religiously acceptable, however, since it is not legally documented, it does not protect the rights of the wife and children, especially if the husband divorces her or dies before documenting the marriage. It does not prove the legitimacy of children, inheritance, as well as the rights of wife and children to the financial support of the husband. Furthermore, the children are not vaccinated and maybe deprived of health care and education for the lack of a birth certificate. One RL went further to describe the unregistered orfy marriage even when it occurs within family consent and knowledge as “haram” as it does not protect the rights of the wife and children. This RL has witnessed such an early marriage ending in divorce ruining the future of the child wife and creating psychological, social and economic problems.

It was mentioned that some lay people believe that if a marriage is religiously correct then it is not important to have it officially documented. RL reported that from a religious perspective, people are supposed to obey those in charge of their wellbeing. Therefore as the laws are instituted for the benefit of the people based on the consensus of the knowledgeable medical professionals, these eleven RL fully respect such a law. They would thus advise people to wait for marriage after the legal age and would use the above mentioned problems and points of view to convince people.
There was only one RL out of 12, who finds that at any age (15, 16, 17) where a particular girl has become completely mature, if an appropriate husband to be proposes to marry, then the girl may get married if this marriage will not cause subsequent harm to her body, mentality and psychology as well as her education. This RL shares other RL views concerning the dangers of early marriage. However, his above reports indicate that he considers that complete physical and mental maturity could occur before the girl reaches the age of 18 years.

Addressing Early Marriage:
Although, many RL are convinced of the problems of early marriage and have mentioned their readiness to advise against it when asked, however, not as many addressed this issue in their preaching activities. In total, eight out of the 12 RL addressed early marriage in public. Six RL specified that they addressed early marriage in Friday prayer speeches and 2 RL in religion lessons as well. One RL mentioned addressing early marriage without further specification and another RL addressed it in MOH and MOFP seminars only.

One RL mentioned that he addresses of marriage a lot as his mosque is near to a university, as it is known that secretive marriage is a prevalent phenomenon among university students.

Likely Effectiveness of Trained RL in Combating GBV: Answer to Evaluation Question
RL and preachers are well situated to influence a good proportion of society, whether these are their immediate social network or the public they serve. As evident from interviews with RL, some of them perform marriage ceremonies or their publicization and the public resorts to them for issues concerning divorce, which is often related to FGC and/or other forms of GBV, such as wife mistreatment. Furthermore, as part of their routine job activities they perform weekly Friday prayer speeches attended by a big proportion of mainly male Egyptian Moslems as well as weekly religion lessons with men and women in which social issues are also discussed. They have scheduled monthly visits to schools and youth centers. In addition, they give lectures and seminars during religious celebrations. They also sometimes take part in health education and behavioral change communication activities of the MOH, State Information Service (SIS) or NGOs.

According to RL, when preachers have the religious opinion backed up by religious evidence together with some medical background, they are capable of bringing up population, RH and GBV sensitive topics and responding to concerns and counter arguments from the public. The training has given RL the courage to address these topics that used to be problematic and brought about quarrels in their religion lessons.

The undersecretary anticipates that training preachers can be very effective in combating FGC as people believe if they do not circumcise their daughters they are acting against Islamic teachings “haram”. This concept needs to change into “it is against Islamic teachings to circumcise”. Once the misconception that circumcision is being done as part of Islamic teachings changes to the concept that it is against Islam to perform it, thus the prevention of FGC would be straightforward. In this respect, the training succeeded in that all RL interviewed have not indicated that performing FGC is part of religion. Although, trained RL still have some misperceptions towards FGC and are not completely against it, however, it is evident from RL’s spontaneous responses that a few of them have already positively affected their wider family circle and prevented a few girls (at least 25) from having FGC.

For wife beating and violence, for which the common public thinks that Islam allows it or even requests it, the undersecretary expects a lesser effect by preachers, halving the current prevalence of domestic violence. This is because he believes that some people would need the existence of a strict penal law. For other behaviors that are commonly perceived by all people as bad behaviors, he expects only a marginal effect, e.g. sexual harassment etc.

Because of the obscure deeply rooted nature of the attitude towards wife beating, there were no debates presented by RL during training. This may be one of the reasons why the training was not as successful in changing the acceptability of such an act, especially in serious perceived errors. Religious evidence documented in the preachers’ reference guide, against wife beating should be strengthened and streamlined and the misconceptions of “nashez” and “kewama” should be well explained and emphasized in the guide and in refresher training in order for RL to well understand and assimilate them. This may have a big effect in changing the attitude
of preachers towards wife beating and their current social acceptability of it. Through strengthened activities of preachers at community level, the attitude of Egyptian Moslem society towards wife beating and its acceptability would be expected to slowly change from being the right of a husband in Islam to being an action that Islam refuses and disallows.

For early marriage, the training has totally succeeded in changing attitudes of RL. For other forms of GBV, according to interviews RL are combating many of these problems and addressing them in their religious activities, some of whom have started to combat population, RH and GBV negative behaviors as a result of IICPSR training. It is premature to judge likelihood of the effectiveness of the RL’s activities in combating GBV. In addition, the design of the evaluation study does not allow this. However, with the implementation of the evaluation recommendations, and with national scale implementation, the project and its partner MORA are likely to build capacities of Islamic preachers in a way that increases the likelihood of effectively contributing to reduction of GBV, especially in FGC and wife beating.

Relevance and Sustainability:
As part of the government’s efforts to address population growth, in response to MOFP’s initiative, the MORA has submitted its plans to train all its preachers using the IICPSR reference guide. The government has provided the budget for implementing this plan and the reference guide has been officially endorsed by the government as the source of training for MORA preachers on population and RH. It has also been included in the basic training that preachers would usually get once appointed by MORA.

This positive unexpected result is due to the high relevance of the project to Egypt’s current development needs. It is also due to the effective approach adopted to produce the reference guide in a totally participative manner that created a sense of ownership as well as due to the strong political commitment of the MORA First Undersecretary for Preacher Affairs, a primary partner of the IICPSR project.

Since December 2009, 150 MORA preachers are being trained weekly on eight subjects from the guide. These subjects include the chapters on gender issues including harmful practices such as FGC and other forms of violence. However, according to the undersecretary, wife beating is not being covered in depth. This may be due to the fact that MORA’s partner, MOFP, does not have women’s issues as part of its mandate, as those are of the NCW. UNFPA has to emphasize the need to stress wife beating in its preacher training. According to the project manager, MORA training serves as raising awareness about topics of the reference guide. The preachers receive a copy of the reference guide. At the time of start of the evaluation, all preachers of four Upper Egyptian governorates were trained amounting to around 16 thousand preachers.

Another unintended positive effect of the project is that the undersecretary and trained RL have requested from IICPSR more information about adolescent health. The IICPSR is currently producing the Adolescent Reference Guide using the same participative approach with funding from the Ford Foundation. This would address the needs of preachers in their activities with adolescents in schools and youth centers.

Further Recommendations for IICPSR

One role the IICPSR could play as a research organization is to conduct an effectiveness and impact assessment study of MORA training, this together with findings from this evaluation can help provide lessons learnt to make the guide and training program more effective in changing attitudes of RL as well as more supportive to prepare them to perform their intended role in their communities. If any step-down training has been performed during the evaluation duration, then it would be beneficial to conduct the above mentioned effectiveness study as a comparative study. In either case, effectiveness indicators related to changes in preacher attitudes towards critical population, RH and GBV issues need to be developed based on qualitative findings of project M&E activities, this evaluative study and the baseline KAP study. They need to measure changes in attitudes towards behaviors that are MORA objectives or that cater to Egypt / UNFPA priority development needs, especially concerning FP, FGC and GBV particularly wife beating.

The project may also devise and develop activities to backup and support project trained as well as MORA trained preachers to provide continuous support and monitoring and evaluation of their MORA planned activities in their communities. This would help preachers continuously gain from lessons learnt, exchange experience with other
preachers, and gain from experience of the top level religious and medical authors and trainers utilized in the IICPSR and MORA training.

Based on suggestions of the undersecretary, trained RL, and future studies with MORA trained participants as well as on practical experience due to preachers' activities develop further the reference guide. According to the findings of this evaluation develop the sections on education and work as well as on wife beating, FGC, sexual harassment, rape and orfy marriage. As the IICPSR has produced other books concerning specific topics that are included in the guide, especially FGC, it would be beneficial to refer to these books within the guide's text for more information. As the guide has been well received and owned by MORA, it would be far-sighted to routinely review the guide every few years according to current development issues.

Endnote 1: Content Analysis Preachers’ Reference Guide

The reference guide is jointly published by the International Islamic Center for Population Studies and Research, Al-Azhar University and UNFPA. It was first published in October 2009. It comprehensively covers all of Egypt’s development issues related to population and family planning, reproductive health and gender. These are common development problems facing other Islamic developing countries. The issues presented are discussed from two dimensions. The medico-social point of view, showing the medical and developmental consequences on individuals and society, is presented in a first chapter. The following chapter presents the same problem from a religious point of view presenting Koran verses and Hadith to support the presented religious view-point.

The guide is well written in simple easy to read language. Since the guide is addressed to Islamic preachers, in very few cases, meanings of Koran versus or Hadith are not explained in enough detail for a lay person to understand. Detailed explanations, even if put in a footnote, may provide further help to a preacher in explaining issues to his lay audience. This would also make the reference guide very useful and valuable to literate lay people, community leaders and NGOs as well.

The guide was written and/or revised by male and female experts from a variety of professional fields: Religion, Law and Shariaa, Medicine, Public Health and Demography as well as from all relevant stakeholder organizations. The authors are affiliated to Al-Azhar University, including its head, deans / former deans of other Islamic and Arabic Studies Faculties, deans / former deans of Law and Shariaa faculties in Cairo and Al-Azhar universities, Ministry of Religious Affairs (MORA), Head of Religion Committee of the Parliament as well as experts from the IICPSR. This approach to authorship has promoted consensus-building and ownership, which is likely to diminish any resistance to the contents of the guide from preachers.

At the end of the guide, there is a 37-page summary of all eight main topics with supporting Koran verses and Hadith, which provides preachers who have read the guide with a quick, succinct, reference to all the key messages. The topics addressed are the family, reproductive health, family planning, safe motherhood, breastfeeding, different forms of gender-based violence, HIV/AIDS prevention as well as protecting the health of adolescents and youth. Infertility treatment and abortion are also discussed in the guide.

All topics reviewed were well covered from different aspects and address the different concerns of people as well as present the various opposing religious interpretations and provide conclusive evidence and the final Islamic interpretation e.g. withdrawal as a family planning method. Content analysis of the guide from a gender perspective showed that the authors used gender sensitive language and advocated for the different health, reproductive health and rights as well as other rights of women and girls such as education, consent to marriage and the husband as well as inheritance. For example, withdrawal as a family planning method has to be approved by the wife to be practiced in order to observe woman's Islamic right to sexual fulfillment and child bearing decisions.

The Two Chapters Concerning Gender-Based Violence (GBV)

The chapter on the medical perspective covered the social aspects of GBV. Topics covered in this chapter were early marriage, deprivation from education, participation in decision-making, whether in the family sphere or in social and political activities and its effect on marginalization of women, which makes them unable to compete for high decision-making jobs.
In addition, forced / nonconsensual marriage, sexual harassment in public spaces including on streets, workplace and public transportation, rape, traditional wedding night practices (mechanical breaking of hymen), FGC with its long and short term consequences on women and their babies were also discussed in this chapter. It is worth noting that this chapter did not address wife beating and its consequences, as an important social phenomenon in Egyptian society.

The chapter on the Islamic view-point started successfully by addressing the concept of equal creation and status of women and men as human beings as well as before God. Albeit not under explicit sub-titles, the chapter covered the following issues as rights of women that Islam put forward: speech and debate, political participation, manage her own personal and financial affairs without guardianship, accept or refuse marriage from a particular man, may not be prevented from marrying her chosen husband, especially in case of previously married women, ending the marriage contract is a right of both women and men and seeking education is an Islamic duty for all Moslems (women and men).

This chapter goes on to discuss the gender concept and gender roles as humankind defined roles not religiously defined. The chapter finally discusses the current negative practices that are considered as violence against women: FGC, traditional wedding night practices (mechanical breaking of hymen), prevention of marriage especially after divorce, forced / nonconsensual marriage, maltreatment of wives and negative verbal and facial expressions, beating of wives, and prevention of inheritance of women.

Findings
Since the guide is addressed to Islamic preachers, in very few cases, meanings of Koran versus or Hadith are not explained in enough detail for a lay person to understand. Detailed explanations, even if put in a footnote, may help the preacher in explaining to his lay audience. This would also make the reference guide very useful and valuable to literate lay people and community leaders as well.

The right of women to work needs to be addressed in the guide. Sexual harassment and rape need to be addressed from an Islamic viewpoint as probably there exists Islamic teachings against these two negative practices. Orfy marriage as an important widespread social phenomenon with grave consequences for adolescents has not been addressed at all in the guide. It is especially important to address Orfy marriage from a socio-medical as well as an Islamic perspective as anecdotal evidence exists that it is now being used by families to get around the legal age of marriage.

For FGC, in the religious point of view section, it discusses the available current cultural beliefs pertaining to FGC and why it is performed. There is one paragraph that states that there is no religious evidence from Koran or Sunna for performing FGC. It goes on to state that the hadiths referenced to the prophet “do not have any correct reference source in mother-books (reference books) nor in Sunnaa”. Through this paragraph, it is actually difficult to convince a preacher who has studied the hadiths that are said to back-up the performance of FGC, especially those who have studied Comparative Feqh, without stating these hadiths and discussing them and their authenticity. It may have been also good in this respect to quote the statement of the Grand Mufty relating to the current religious ruling on FGC.

For wife beating, the religious evidence that may be taken to backup this negative behavior is presented and explained. The guide, however, misses presenting in depth explanation for two important concepts “nashez” and “kiwamah” related to wife beating. It is important to add more explanation of religious texts as the guide assumes that preachers have a similar common correct understanding, which may not always be true. The Islamic evidence on “wife beating” needs to be streamlined and made more succinct and to the point reaching strong definitive Islamic conclusions. Strong Islamic evidence against wife beating needs to be extracted from Koran and Sunna and presented in the guide.

Furthermore, the issue of wife beating should be included in the socio-medical chapter of the gender section of the preachers’ reference guide. This chapter should collect and document men’s perception of the rational behind wife beating as well as evidence on the patterns and severity of these violations and their consequences on

6 Presented in the guide under two sub-titles before and after “wife beating”. It is better to discuss all these issues together, under one subtitle, before the “wife beating” subtitle.

Egyptian society. Writing this chapter should use authors who are anthropologists, sociologists, psychologists and activist in the field of GBV as well as stakeholders such as the National Council of Women and NGOs. This would lead to a more effective message on "wife beating" that would support and enable the theologians to extract from Koran and Sunna the appropriate texts strongly opposing violence and "wife beating".

If the guide incorporates the opposing points of view with their religious evidence and relative strength, as is done in wife beating and as is needed for FGC, these may be added in annexes, which would help avoid diluting the strength of arguments presented in the guide’s main text.

In conclusion, the guide is very well prepared and quite informative for preachers and for the public in general. It could be widely distributed to NGOs as well as preachers. There is anecdotal evidence that a few charity NGOs, operated by families, refuse the government and donor discourse on the issues addressed in this guide. For these NGOs, receiving such a reference guide from Al-Azhar or even the Grand Mufty of Egypt, albeit without the UNFPA logo, would have good credibility, not different from their own perceptions and attitudes and may thus be used in their own development efforts in their local communities.

Endnote 2: Family Planning

We used to hear that the United Nations Fund interferes in Family Planning. There are very nice words in the preface of the guide “United Nations Fund is friend of religion”. We did not previously have this idea at all. United Nations Fund meant that the issues are forced on us e.g. limiting children. The training told us that it is not “limiting birth”, it is “Family Planning”, and Planning in religion is legitimate according to Koran and Sunna. “Friend of religion” means “not against religion” and that limiting and planning i.e. Family Planning is against abortion. The system of Family Planning is against preventing pregnancy. The system of Family Planning gives you the correct method for you to organize your life in the family and your life in society from a religious perspective and from a medical perspective.

The training changed RL’s concepts about FP from limiting number of children to organizing and planning their families. The issue was not concerned with FP but with the wider concept of population characteristics and development. RL reported benefiting from the training on FP.

It was understood during the training that limiting births was not the issue being requested and that it would not be forced with positive and negative incentives. The training taught them to think objectively away from FP being forced on Egypt. They understood that it is not against religion as they were shown that the Koran presents a basis for FP. Sunna allowed it “إجازته” and life necessitates FP. Because of breastfeeding rights, the rights of children to care, and the woman's rights as a wife as well as her right to preserve her health, for which some Foqahaa had allowed preventing pregnancy, FP is religiously allowed.

Another RL expressed that repetitive pregnancy without adequate spacing results in weakness of child and mother and not give first child the benefit and its right to breastfeeding. He also understood that the state wants to combat poverty through FP to safeguard the humanity and dignity of people and their human rights to a good living standard. Another RL reported that the emphasis during training was put on all dimensions and on the reproductive health and the care for the whole family and its standard of living and the development of all society.

A RL used to say that there was nothing in Islam called FP. If someone used to ask him, he used to tell her not to take [contraceptive methods] and to have children. But after the training things started to change “بدايات المسابل تتفتح معيا”. Another reported he had similar thoughts of FP as the common people, but changed his mind when he knew about population statistics, divorce, street children and causes of population density. Another RL saw no contradiction with Islamic concepts to think in a scientific organized way. Among the important concepts of population growth he learnt, is the right of each citizen to choose the number of children according to their own circumstances. For example, one of the circumstances to consider is the Islamic rule of not having girls and boys live in the same bedroom, this necessitates having a house that is spacious enough.
A RL reported that the training affected his own personal life. He benefited from knowing all the FP methods. He understood that necessity dictates that 2-3 children is enough as there are problems from expenditures on housing, education, food, etc.

However, this does not mean that all RL now have the concept of a small number of children. As one RL comments: “we used to make fun of Ablah Karima’s advertisements, now with a little reasoning “we get 7 children in 7 years or we get them in 14 years is better!!”.

A RL reported that when discussing FP with the undersecretary during training and there were RL who thought that “planning” is allowed in Islam but that limiting is forbidden (haram). The undersecretary told them to get any evidence that limiting is haram.

Addressing Family Planning

Seven RL spontaneously mentioned in response to several different questions that they address FP in their public preaching activities. Three had started this from before the training and four had probably started after the training on the preachers’ reference guide. Two RL are addressing FP through lectures and seminars with MOH, MOFP and State Information Centers.

A RL, performing three to four marriages per week, takes this opportunity to address FP as the marrying couple as well as many other people from society, are present in the mosque. He also takes the opportunity of a marriage ceremony and prepares a topic from the guide and talks about it and afterwards he gets many questions.

Project 3. Detailed Findings from Question 5b

EGY8G47A. Campaign against sexual Harassment . ECWR Project

Findings.

The media personnel included 9 females and 3 males; eight were journalists, one of whom writes in a website and another works also on TV, two are from national TV, one from a private satellite channel, and one from national radio.

The interviewed media personnel had attended several activities of the ECWR. The activities mentioned were the SH conference, the Arab harasser conference, the regional conference for combating SH, seminars, training on media focusing on women’s issues as well as Safe Street for All campaign. Most respondents were not able to pin-point the exact activities attended.

It was evident that the respondents were knowledgeable of the different aspects of SH and its consequences at personal and societal levels as well as on how to react to it. Their attitude has changed as almost all reported that girls or women, victims of SH, should report the incident to the police and take legal action. Furthermore, seven media personnel thought that people should help the harassed and get a hold of the harasser and take him to the police.

Role of schools, workplaces, government and media in combating SH

The interviewees made several suggestions concerning schools, workplace and the government. There should be awareness raising through Churches and Mosques. As for schools, theoretical and practical training and awareness raising on how to deal with SH incidents should take place at the student, teacher, social worker, supervisor and head master levels. Three respondents mentioned the importance of sex education starting at the primary school stage with appropriate messages for each age group. For workplaces, human rights organizations should pressure the government and workplaces to institute SH policies and laws to regulate the working relationship between employer and employee. It is also important to hold awareness raising sessions and training on how to deal with SH in the workplace. There should be a specialist unit to deal with women’s problems consisting of a social worker and a legal representative who can advice the woman when reporting problems.

The government should pass new laws to address the phenomenon of SH both on the street and in workplace. Harassment should be considered a serious offence. The role of the police needs to be activated and the police should react to SH and its incidents with the appropriate attention and a positive attitude. They should enforce the already available laws. There should be a specialized place for women and children in the police office to file their complaints away from criminals. Awareness of the police officers on duty on the streets of how to perform their duty in this respect should be raised. The police should be available on the streets wearing civilian clothes to be under cover in crowded areas and in school places. There should be lighting on the streets. Furthermore, the government has to address macro-level problems leading to SH, such as economic problems and lack of youth employment.

The Media has to continue to allocate space and time to discuss SH, its psychological reasons and consequences, how to protect our women, girls and boys and to present the issues to be resolved. There have to be public service announcements as well as information about the hotline. There is a political commitment to address women’s issues, including SH. The media has to continue exerting pressure until new laws are passed. Once there are laws in place, the media’s role will be to raise awareness about the laws from different angles so that youth know they cannot escape the penalty and girls and women know how to press for charges. The media has talked and should continue to talk about cases in which the harasser gets penalized.

Benefits of ECWR activities
The activities performed by ECWR were seen by media personnel as being very important. They were effective in shedding light on the important issue of SH. They were objective in their presentation. They produced good studies and good conferences. Their reports were scientific and they presented both regional and international reports. One of them reported the patterns of SH in different Arab countries. The ECWR knew when to come out with their reports and statistics. What they do goes beyond social activities for media personnel.

Media personnel also reported learning things that they did not know before exposure to the program. They gained awareness, information, results from studies and statistics that they needed to conduct their work as journalists. The media personnel’s information about SH was previously shallow; however with exposure to the program they realized that it affects both the economy and the reputation of the country. They learned about different points of view which widened their view of the issues and allowed them to rethink their positions. The activities changed their perceptions of the causes of SH. It used to be thought that the dress of girls and women was the cause for SH. However, statistics showed that even completed veiled women and older women have been sexually harassed. They did not know that government employees experience harassment. They were awakened to the fact that children also experience sexual harassment.

The activities of ECWR put media people in contact with specialized people working in the field who can provide them with important information for publishing. The phenomenon of SH became crystallized in their minds, motivated them to care about the issue and gave them the courage to act on their knowledge.

Important activities that ECWR can perform
As reported by a respondent, the ECWR has been doing many things and should keep pushing for new laws on sexual harassment. Others reported that ECWR needs to move more towards educating youth in schools, universities and clubs to raise their awareness and get them on board to combat SH. They need to be in the community to make direct contact with girls and raise their awareness. The ECWR should also go down to slum areas where this phenomenon often takes place. They should distribute instruction cards. They should also conduct workshops with influential sectors of society, who could use the ECWR information to combat SH. In addition the ECWR could routinely distribute their reports and training materials. They could put real SH cases they obtain on the net. ECWR should actually show more victims of SH as well as cases where people faced up to the problem and reported it. They should create a link between those harassed and psychiatrists and legal attorneys. The ECWR should activate more hotlines. They should also get the harassed in contact with the police station nearest to them and to have representatives available. The ECWR could partner with the Ministry of Interior to raise awareness about receiving and dealing with SH cases. They could also make public service announcements on TV, which would raise awareness for everyone. Raising the awareness of children is also needed.

Use of what they learned from ECWR activities
As the ECWR works through partnerships with media, their voices and messages reached more people. Only one person reported not utilizing what he gained from the activities. All of the others mentioned that they published reports based on what they had learned. Their reports became more in depth and informative. They made reports on the studies presented and opened discussions with viewers and listeners on what they see on the streets, giving women and girls practical instructions on how to react. One of the media people invited the head of ECWR to her program and used the ECWR proposed law and studies both in her programs and in her articles.

The written reports have influenced many talk shows to present the issue and discuss it. Thus people are more aware of the phenomenon and they are reacting differently towards it. Because of ECWR’s continuous efforts, the media keep publishing about SH. Slowly but surely there will be an effect on reducing SH in the long run.

**Effects of media personnel’s work**

The work of the media personnel has been reported to complement the work of ECWR. It is the channel through which its work reaches a larger audience. As a result of media efforts, people read, listen and view and thus have started to open up and discuss the issue. Many people had not realized the extent of the problem before. Now society allows women to talk about SH and society now accepts published reports about the issue. The people are more aware and there is a perceptible reaction.

Media personnel also used the information gained on a personal level to raise awareness among friends and relatives as well as children. They found that their contacts listened to them and told others and the youth behaved better. Their new awareness made female media personnel realize that it was not their fault that SH occurred. It also allowed them to better deal with the situation. When bombarded with accusations that women are to blame for SH, women media individuals were able to report that two-thirds of those completely veiled are also sexually harassed. Their reaction to harassers became different. A few media personnel used to be afraid to help others. Now they help others so that harassment stops.

**Effectiveness of efforts at community level**

The nature of the Egyptian society requires many strategies to work together on SH. For example, conferences, seminars, cultural events, and the religious influence are needed so that youth start to absorb the message, especially in slum areas. Recently there was a walk against SH in Cairo University. After youth participated in a march, it was difficult for them to harass girls. It also encouraged girls to report incidents to the police. Once women and girls start winning these cases, harassers will be afraid to commit such crimes. All these efforts can have a good effect but a penal law needs to be created.

**Direct Results of ECWR activities**

The ECWR played an important role in raising awareness among youth. The efforts of ECWR and the media have forced the officials to admit there is a problem and that it affects the economy. ECWR activities rang the alarm bell that activated discourse between people, civil society and decision-makers. It moved the people to request new laws. The ECWR’s statistical report made the Ministry of Tourism realize that SH was prevalent in a way that threatened tourism in Egypt. Later the ministry made a campaign against harassment of tourists, including SH. There is now a film on SH and the head of ECWR was a consultant to the director of production. The studies of ECWR have found out about certain places and certain times where SH occurs. As a result there is now an electronic geographic map of where SH occurs, which will alert girls and women. There is an open line with the police station so that they can be quick in their response.

**Received media kits, CDs and reports**

The materials basically covered media personnel’s information needs. They utilized the information and the pictures within the reports. When writing about SH, they referred to the materials and found them adequate. It would be beneficial to produce a book about SH that addressed more dimensions of SH. It would be good for TV, if there were video materials that showed reality. They could also show statistical data with animation to suit TV presentation. Others requested cartoons on SH. Yet others realize that they have to depend on many sources. The information received by journalists was strong enough that BBC and many other media outlets reported the data and this created a lot of discussion of SH.

The ECWR materials contain theoretical background information on SH. However, the various media channels need to also go to the field and interview real victims. It would be good if ECWR could recruit harassment victims

and let them present their cases. This could provide media people with real positive and negative case studies. They would like to have statistics about victims of SH from police reports. They would like to have information about how the police are dealing with SH cases. The efforts to combat SH need to involve more than media kits. There should be more emphasis on seminars, more presence on the streets and more recommendations for the government about how to combat the phenomenon.

Adequacy of information for policy-makers
Some have reported that the information is adequate for policy-makers. Others have made the following suggestions. Data must be collected routinely on the prevalence of SH. Reports have to be written in a way that caters to the needs of policy-makers and the implications of the problem, similar to what has been done for tourism. Data is also needed about the causes of SH and thus how to combat it. The emphasis till now has been on the consequences of SH.

The ECWR has made available the information needed. It is now the role of the government to reach out everywhere in schools, universities and youth centers. Others reported that we have now disseminated many studies and it is time for the law to be enacted. Parliamentarians need to have a comprehensive view of SH and the media needs to concentrate more their efforts on the parliamentarians.

Knowing about SH affects on knowledge of other difficulties on the street
Knowing about SH widened some media personnel’s perceptions of lack of safety on the streets in general. This limits mobility especially at night. There is no pavement to walk on and there are too many cars. There are general difficulties that were also uncovered, like crowding in transportation vehicles and the presence of crime on Egyptian streets including theft. There is also rape, poverty, beating, verbal offensiveness and begging as well as street children and drugs. Another important issue is stealing body organs, especially in slum areas. Knowing about SH made them realize that SH was another important dimension of domestic violence against women.

Changes in media content
Several years ago, due to lack of knowledge and the taboo against talking about sensitive sexual issues, especially if it would undermine Egypt’s reputation, there was no information to be found about SH on the street or in the workplace, even on the net. Thus earlier, there was no material for journalists to use in their writing. The ECWR provided such material. When knowledge increased, this increased the space journalists used to write and talk about SH. This material helped to break the silence.

The journalists used to think that the biggest reason for SH were the girls themselves. This changed when they read studies of SH. They used to think that SH was a small problem that should be kept quiet to preserve Egypt’s reputation. A media person reported that she did not know the word harassment. Another used to think it was only innocent teasing. It was thought that SH did not include verbal harassment. However, verbal SH is now known to have become more aggressive. Media personnel found it important that people know about these issues. The information made the media unable to keep quiet about SH. Now media personnel know they have to shed light on SH to shock people and make SH stop.

Media personnel wrote about SH in order to combat it. They have requested that the government take action to light streets and to have police everywhere. This media discourse has also motivated girls and women to report these cases.

Presentation style changes
A few years ago there was silence about SH. Now we talk clearly and openly without fear. A media person reported that SH was among the issues that she did not talk about before the ECWR activities began because it was impolite to do so, especially in government media. Another used to address the issue in a modest way. A journalist reported that she used to put SH in a small news item. If there was a study, she would minimize it to take the smallest space possible. Nowadays she writes on the topic in detail and if she finds a study, she not only publishes it but she also interviews a specialist to talk about the issue. Now she designates a big space for SH topics. Another reported noted that people like to read statistics and this enlarges the space the topic takes and makes people realize the importance of the problem. On TV, they used to get psychiatrists or sociologists to talk about SH, but now they know of others who are well informed about the phenomenon and can address it. Another reports that SH is on her mind so when she finds an opportunity, she presents it on TV.
Strategies used to incorporate SH in your media reports
A media person presents SH preventive as well as curative strategies. For example they show how mothers should bring up their children and observe them as well as how to teach them to protect themselves. Another addresses it in a simple way stating that SH could affect the women in your family. The repetition of the message can be effective. On the other hand if there is a problem they talk to the audience and assign a big space to highlight the issue. A private TV channel media person reports that when she sees a problem, she reports it. However, they can be viewed as making things look bad. Another uses incidents that occurred to attract people’s attention and then discusses SH. People are not attentive to dry material. Another does not talk about SH unless there is something that necessitates this. Another presents the problem in a general sense, then she talks about its causes and about how to resolve it, using materials from specialists. Another reports that she starts with an academic study and then brings in specialists to comment on the study. Finally, fieldwork is presented with humanely appealing cases. Another tries to present it in discussions/interviews or in an analytical report as this is appropriate for journalism and TV. On TV they present it in social programs and talk in a direct way and with freedom. Another plans to make a journalistic campaign about SH. In this case, all types of articles, interviews, and analytical work will be employed for this issue.

Covering SH within other topics or vice versa
All strategies are used to cover SH. Some discuss only one topic at a time, especially in news as they cannot discuss one topic under another. In the beginning, a media person used to talk about SH in a special topic in regards its relationship to tourism and rape. Now she talks about SH as harassment. It is presented as a separate topic as it is easier for people to grasp on TV or in journals. Another reported that usually everything is presented alone but sometimes SH of children is discussed and then they discuss violence.

SH is very much related to violence. Thus media people sometimes talk of SH as part of violence, which includes family violence as well as violence in the street and at work and sometimes when talking about violence they allude to SH. Five media people discuss SH as an important separate topic and sometimes within violence against women. SH is being discussed as part of violence against women, relations within the family, protection within the family and SH committed by relatives of the victim. SH is also addressed within topics about violence as SH is higher in slum areas. Slum area children are the most vulnerable to harassment, as well as to stealing their organs.

SH activities by media personnel exposed to ECWR activities and media kits
Among the 12 interviewees, three interviewees reported that they covered the activities of ECWR. Another two made one or two programs or cover SH when there is an incident. Among the rest, 7 interviewees (more than half) have become real advocates against SH. In addition to covering events, these persons opened several complete files on SH. They have adopted the issue of SH and wrote or spoke about it in each of its phases. They were among the first journalists to break the silence and to write about the topic in an expanded fashion making several files and investigative analytical articles. They focused on the SH phenomenon. They published studies about harassment of Egyptian employees and have conducted research and field work on the issue. They attend as well as make seminars and conferences about SH. They participate in demonstrations by legal NGO’s for SH and cover it.

One journalist has made a file for child harassment: how to protect children from it and how to treat it. One has made a web-page called the “club of rape and harassment victims”, where victims enter and participate. Another focuses in their website about SH. One interviewee has visited the hope home for care of rape victims and met with street girls and wrote a story about them.

One interviewee wrote a lot about SH, since the beginning of the campaign and all its stages and its laws. She advocated for more severe penalties for the harasser and wrote about the laws that are locked up in the drawers. She wrote about the campaigns “When you harassed how did you benefit?”. Another made programs about the proposed law and marketed them and also made a program with the NCW staff responsible for the complaints box. Another also follows news around the world concerning SH and disseminates it through the Egyptian media.
All media personnel indicated that they are motivated to continue to address SH issues until new laws are enacted and beyond. They all indicated that if they are given a good report on SH they will publish and/or disseminate it through radio and TV. Their supervisors will also encourage them to do so.

**The results of ECWR and media personnel’s activities on SH: Conclusion**

Ten years ago no journalist would have had the courage to talk about SH in any program or journal. Media personnel made people realize that SH is an important problem. Now people report harassment cases to the police. Women come to the magazine and tell their stories without fear. Earlier it was impolite for a girl to say that she was harassed. Now girls say that they have been harassed and say they want to report it and to bring justice. There has been a case where the harasser was penalized, which is a big step forward in encouraging others to report cases.

Although the attitude of men towards raped girls was negative, one of the girls from the home for the care of victims of rape married to a good man and her life is settled. This may indicate that that media were able to change the perception of a rape victim to this man.

There are several groups addressing SH, which has resulted in laws being proposed. The people’s parliament has been willing to discuss SH issues. These are positive effects of the media pressure that has been exerted on this issue as a result of ECWR ignition.
Annex 12: Findings Conclusions Recommendations Matrix

<table>
<thead>
<tr>
<th>ID.</th>
<th>Findings</th>
<th>Conclusions</th>
<th>Recommendations</th>
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</thead>
<tbody>
<tr>
<td>RH11</td>
<td>Assessment study conducted revealed diluted FP within FHM</td>
<td>Activities need to be undertaken to strengthen FP services then integrate it with RH services</td>
<td>Policy formulation of integrated services at the central level needs to be into action from top level policy makers to insure integration of FP with other RH services.</td>
</tr>
<tr>
<td>RH12</td>
<td>A comprehensive FP standards of Practice was produced and distributed in intervention clinics but not integrated with other RH standards SOP is not easy to use</td>
<td>The FP SOP needs to be more accessible in clinics.</td>
<td>Integrate SOP with the FH standards and initiate a process for timely continuous update. Develop an integrated pocket guide for feasibility of use.</td>
</tr>
<tr>
<td>RH13</td>
<td>Development of other manuals and curricula Ultrasound manual developed but not used</td>
<td>Material for continuous quality improvement is available for use with the exception of the ultrasound training manual</td>
<td>Develop a process for update. Prepare the logistics and implement an Ultrasound training for physicians and find a way to install machines in clinics.</td>
</tr>
<tr>
<td>RH14</td>
<td>Structure of OJT process was not available and a well developed manual was still behind the curtains.</td>
<td>Quality of FP service provision will not be under continuous quality improvement</td>
<td>Develop a full structured OJT system with the needed tools for its proper implementation</td>
</tr>
<tr>
<td>RH15</td>
<td>Integrated supervision is not on the ground</td>
<td>Waste of time and effort of both supervisors and providers</td>
<td>Conduct management training that teaches supervisors how to develop integrated supervision plans.</td>
</tr>
<tr>
<td>RH16</td>
<td>Sentinel system was created to measure FP knowledge and use in communities</td>
<td>A strong MOH database is available for monitoring and evaluation of FP activities in some communities,</td>
<td>Develop appropriate analysis plans to use data in producing reliable information to be used for decision making.</td>
</tr>
<tr>
<td>RH17</td>
<td>No use of self assessment tools</td>
<td>OJT and clinical audit could not be implemented</td>
<td>Develop self assessment tools and encourage providers to use them.</td>
</tr>
<tr>
<td>RH18</td>
<td>MOH priorities affected implementation of clinical audit.</td>
<td>MOH priorities can affect the implementation of activities</td>
<td>Consider MOH priorities in development of plans, try to complete the activity and scale up in next cycle.</td>
</tr>
<tr>
<td>RH19</td>
<td>No monitoring indicators</td>
<td>Project’s monitoring of activities is not</td>
<td>Develop a PMP with measurable simple</td>
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<tr>
<td>RH110</td>
<td>Family planning utilization decreased when program was weakened</td>
<td>Family planning utilization is related to the strength of services</td>
<td>Continue to support strengthening of FP services.</td>
</tr>
<tr>
<td>RH111</td>
<td>Women used more family planning services when female physicians were available.</td>
<td>Gender is an important factor in promoting use of FP clinics in Egypt.</td>
<td>Support the enrollment of females in medical schools and their training in FP.</td>
</tr>
<tr>
<td>RH21</td>
<td>Comprehensive training curricula and IEC are available</td>
<td>Capacity building activities need to be conducted regularly</td>
<td>Develop a process of update/ develop curricula and IEC based on need</td>
</tr>
<tr>
<td>RH22</td>
<td>Rapid turnover of providers was observed.</td>
<td>Sustainability and increased utilization will not be achieved without a consistent group of providers</td>
<td>Continuous capacity building activities and on-the-job training, incentives for staying with the program</td>
</tr>
<tr>
<td>RH23</td>
<td>Providers do not feel comfortable dealing with VCT clients because of fear of HIV transmission</td>
<td>Indication of stigma of the disease and lack of understanding of modes of transmission.</td>
<td>More training and work on reducing HIV stigma and understanding modes of transmission</td>
</tr>
<tr>
<td>RH24</td>
<td>Clients were satisfied with the service</td>
<td>Services are meeting clients’ needs.</td>
<td>Renovate clinics, Scale up and expand the service in other governorates</td>
</tr>
<tr>
<td>RH25</td>
<td>Use of HIV testing by MARP is not known because question 2 could not be properly answered</td>
<td>Utilization among target group could not be addressed.</td>
<td>Capacity building of NAP staff on monitoring and evaluation and its importance. Increasing the number of NAP staff is recommended</td>
</tr>
<tr>
<td>RH26</td>
<td>Increased utilization of VCT centers after promotion campaigns</td>
<td>Clinics are not known to people in communities</td>
<td>Increase promotion campaigns especially in target areas and develop a proper national media strategy</td>
</tr>
<tr>
<td>RH27</td>
<td>Monitoring and evaluation was not cleared at UNFPA for the NAP project</td>
<td>Evaluation and implementation of project activities is not streamlined</td>
<td>Explore the idea of having an evaluation structure (firm) that continues to work with the CP – as opposed to pulling them in at the end of the cycle</td>
</tr>
<tr>
<td>RH28</td>
<td>More activities are needed for addressing HIV infection in communities</td>
<td>More involvement of different stakeholders and partners is needed</td>
<td>Involvement of stakeholders and other sectors including the education sector, adult education agency, NGOs, and partners/donors working on HIV in Egypt to spread HIV health messages in the community. Innovative approaches to address stigma Involve men and out of school youth</td>
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<tr>
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<tr>
<td>RH31</td>
<td>Youth Friendly Clinics are underutilized</td>
<td>Activities need to be undertaken to increase use if the clinics are to continue.</td>
<td>Address the issue of low condom use</td>
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<td>Upgrade the NAP website</td>
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<td></td>
<td>A comprehensive BCC strategy needs to be in place with media messages promoting clinics placed in TV, radio, schools and other places where youth may see them.</td>
</tr>
<tr>
<td>RH32</td>
<td>FHI has produced training manuals and IEC materials</td>
<td>Manuals were comprehensive and useful</td>
<td>Develop a process or system to update manuals and IEC materials. Increase the involvement of FHI through technical assistance to TH and EFPA.</td>
</tr>
<tr>
<td>RH33</td>
<td>Peers proved to be effective tools</td>
<td>More peers are to be involved with YFC</td>
<td>Encourage youth cooperation as peers and provide them with the adequate training needed and tools. Include them with TH clinics</td>
</tr>
<tr>
<td>RH34</td>
<td>Sustainability of clinics affiliated to governmental structures</td>
<td>YFC will be always available to provide services</td>
<td>Strengthen the capacity of available service providers, support clinic needs, and expand to more clinics providing RH youth services. Try to reach out of school youth</td>
</tr>
<tr>
<td>RH35</td>
<td>Monitoring and evaluation deficient in TH clinics</td>
<td>As a result, improvement of services and effectiveness is lacking</td>
<td>Develop a strong M&amp;E plan with relevant measurable indicators</td>
</tr>
<tr>
<td>RH36</td>
<td>High turnover of providers in YFC</td>
<td>Sustained quality of services is threatened</td>
<td>Motivation of service providers working in YFCs is required by increasing their financial remuneration and building their capacity with required trainings</td>
</tr>
<tr>
<td>RH37</td>
<td>Knowledge corner is the most attractive service for youth at clinics</td>
<td>Identified youth needs which are internet access and knowledge gain in many topics</td>
<td>Secure funds to upgrade information corners by making computers with internet connections available and maintain the library supply with books. Probably an IT person is required for continuous maintenance and sustainability of this corner</td>
</tr>
<tr>
<td>RH38</td>
<td>Weak THO clinics</td>
<td>Clinics need strengthening</td>
<td>A cross referral system between YFCs service providers and other specialties in same hospital was needed to enhance young clients' use of clinics and increase knowledge about RH issues.</td>
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<td>ID.</td>
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<tr>
<td>PD1</td>
<td>M&amp;E training has made a positive impact on government activities related to gender programming.</td>
<td>Training and follow-up of M&amp;E is needed in gender programming.</td>
<td>This program should be continued with a focus on improving the quality of M&amp;E in underperforming governorates.</td>
</tr>
<tr>
<td>PD2</td>
<td>Commitment towards implementation of the national gender plan varies among governorates.</td>
<td>Support in needed in underperforming governorates.</td>
<td>Governorates should be recognized for good performance and supported in developing better performance.</td>
</tr>
<tr>
<td>PD3</td>
<td>Development activities for women are outdated in some governorates and not implemented in others.</td>
<td>New programs for women with quality M&amp;E need to be developed in some governorates.</td>
<td>A review and planning process needs to be conducted in governorates focused on projects for women.</td>
</tr>
<tr>
<td>PD4</td>
<td>The IDSC staff is very capable and is producing high quality products.</td>
<td>IDSC activities aid the development process.</td>
<td>Cutting edge activities in data dissemination should be developed in the next cycle.</td>
</tr>
<tr>
<td>PD5</td>
<td>Some data sources in the population data base are inaccurate.</td>
<td>Data quality needs to be improved.</td>
<td>A project that aims at addressing data inaccuracy problems needs to be incorporated in the next cycle’s plans.</td>
</tr>
<tr>
<td>PD6</td>
<td>Data was sometimes lacking on vulnerable populations including women.</td>
<td>Data on vulnerable populations, including women, need to be generated.</td>
<td>Needed are activities that will increase government attention to data on vulnerable populations and assistance with special data collection projects.</td>
</tr>
<tr>
<td>PD7</td>
<td>Overlap in activities was seen in IDSC and other statistical offices.</td>
<td>A more efficient system of data collection and dissemination is needed.</td>
<td>Activities that aim at improving collaboration between main players in the area of data collection and dissemination at the national level are needed.</td>
</tr>
<tr>
<td>PD8</td>
<td>PD projects have overlapping components.</td>
<td>Projects need a clearer focus.</td>
<td>A review of program components and the need for overlap should be conducted.</td>
</tr>
<tr>
<td>G11</td>
<td>The information the adolescents were receiving on puberty was limited in scope and coverage.</td>
<td>Education sessions on puberty were inadequate</td>
<td>Training of educators needs to be strengthened and monitored. Community and other resistance to RH messages need to be confronted.</td>
</tr>
<tr>
<td>G12</td>
<td>The &quot;peer model&quot; was implemented in different ways in different communities.</td>
<td>The role of peers as well as the age of trainers needs to be reviewed.</td>
<td>The differences in implementation of the project in study sites should be examined to study the effectiveness of variation in the</td>
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<tr>
<td>ID.</td>
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<tr>
<td>G13</td>
<td>The program faced problems with bureaucracy and funding.</td>
<td>Administrative mechanisms are causing delays in implementation.</td>
<td>Efforts should be made to streamline the operation of the project.</td>
</tr>
<tr>
<td>G21</td>
<td>Some RL have gone through some attitudinal change due to training.</td>
<td>Training of religious leaders may be a good strategy for stimulating change in violence against women.</td>
<td>Continue efforts to train religious leaders in issues related to GBV.</td>
</tr>
<tr>
<td>G22</td>
<td>Both religious and traditional beliefs influence views of FGC and wife beating.</td>
<td>Traditional beliefs of FGC and wife beating are difficult to change.</td>
<td>Strengthen both religious and socio-medical perspectives in the training curriculum to assist preachers in teaching the public.</td>
</tr>
<tr>
<td>G23</td>
<td>Not all trained RL have adequately adopted the messages of the training especially for wife beating and FGC.</td>
<td>Many trained RL may not be ready to provide step down training on GBV issues.</td>
<td>Develop a revised curriculum and retraining on gender issues.</td>
</tr>
<tr>
<td>G24</td>
<td>RL are already addressing the different forms of GBV.</td>
<td>Maximizing effectiveness of RL efforts to combat GBV is needed.</td>
<td>Devise and strengthen development systems to supervise and support RL and preachers in combating GBV and measure their effectiveness.</td>
</tr>
<tr>
<td>G221</td>
<td>Media personnel were receptive to the ECWR activities on SH and used the materials in their reporting.</td>
<td>The program was well designed for media personnel.</td>
<td>The program should continue to reach out to media personnel and provide up to date resources for them.</td>
</tr>
<tr>
<td>G222</td>
<td>Solid information on the causes and consequences of SH help to change attitudes.</td>
<td>Studies documenting the causes and consequences of SH are valuable.</td>
<td>Studies of the causes and consequences of SH should be supported.</td>
</tr>
<tr>
<td>G223</td>
<td>Parliamentarians are just starting to consider laws against SH...</td>
<td>More advocacy is needed on legal issues regarding SH.</td>
<td>Advocacy for laws regarding SH needs to continue.</td>
</tr>
</tbody>
</table>