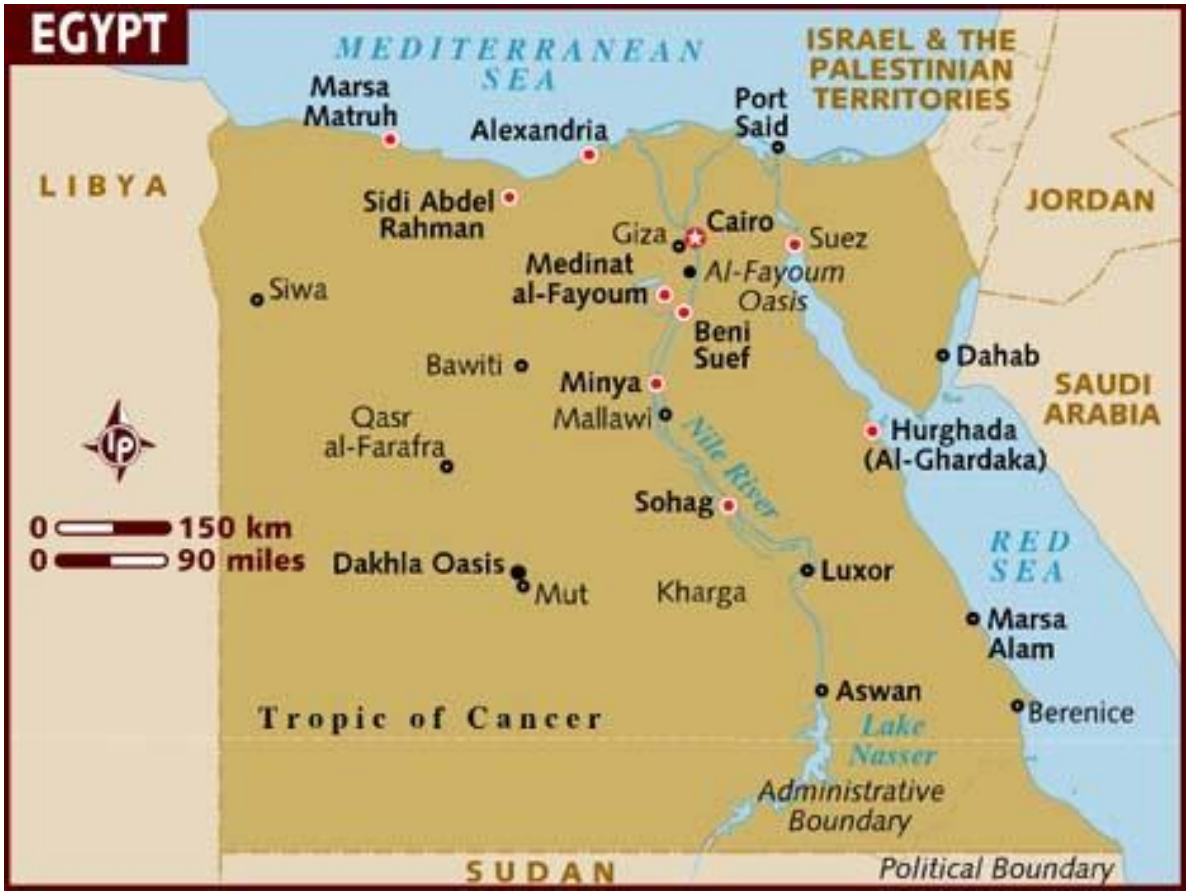
Evaluation of the UNFPA 9th Country Programme Egypt (Mid 2013-2017)

Final Report – Sixth & Terminal Draft

Date: 04 May 2017

Figure 1: Egypt Country Map



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ABBREVIATION AND ACRONYMS

A	
ADB	African Development Bank
ADR	Assessment of Development Results
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
AR	Annual Report
ARR	Assistant Resident Representative
ASRH	Adolescent Sexual and Reproductive Health
ASRO	Arab States Regional Office
ATLAS	Enterprise resource planning system, for the recording and consolidation information at global corporate level for all country offices
AUC	The American University in Cairo
AWP	Annual Work Plan
B	
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
BP	Best Practices
BLESS	Bishopric of Public Ecumenical and Social Services – Coptic Orthodox Church
C	
CAPMAS	Central Agency for Public Mobilization and Statistics
CBA	Cost-Benefit Analysis
CBO	Community-Based Organization
CCA	Common Country Assessment
CCM	Country Coordinating Mechanisms
CEFRS	Center for Economic and Financial Research and Studies
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CO	Country Office
COAR	Country Office Annual Report
COP	Community of Practice
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
D	
DAC	Development Assistance Committee (OECD)
DEX	Direct Execution (by UNFPA)
DHS	Demographic and Health Survey
DMT	Decision Making Tool
E	
ECGBVS	Egypt Economic Cost of Gender-Based Violence Survey

ECOSOC	Economic and Social Council of the United Nations
EDHS	Egyptian Demographic and Health Survey
EFPA	Egyptian Family Planning Association
EmONC	Emergency Obstetric and Newborn Care
EQ	Evaluation Question
ERG	Evaluation Reference Group
ET	Evaluation Team
EU	European Union
F	
FACE	Funding Authorization Certificate
FAO	Food and Agriculture Organization of The United Nation
FAPPD	Forum of Arab Parliamentarians for Population and Development
FBO	Faith-based Organization
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
G	
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GHI	Global Health Initiative
GNI	Gross National Income
GOE	Government Of Egypt
H	
H4+	UNFPA, UNICEF, the World Bank, WHO and UNAIDS (now UNH6)
HDI	Human Development Index
HIV/AIDS	Human immunodeficiency virus infection and acquired immune deficiency syndrome
HLPF	High-Level Political Forum
HMIS	Health Management Information System
HQ	Headquarters
HR	Human Resources
I	
IB	Institutional Budget
ICPD	Conference on Population and Development
IDI	In-Depth Interview
IDSC	Information and Decision Support Center
IE	Impact Evaluation
IFAD	International Fund for Agriculture Development
IFMSA	International Federation of Medical Students Association
ILO	International Labour Organization
IMF	International Monetary Fund
INGO	International Non-Governmental Organization
IP	Implementing Partner
IT	Information Technology

J	
JPO	Junior Programme Officer
K	
KII	Key Informant Interview
KM	Knowledge Management
L	
LAS	League of Arab States
Logframe/LFA	Logical Framework Analysis
M	
MCV	Mystery Client Visit
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MENA	Middle East and North Africa
MH	Maternal Health
MMR	Maternal Mortality Ratio
MOHP/FP	Ministry of Health and Population/Family Planning
MHTF	Maternal Health Thematic Funds
MOIC	Ministry of International Cooperation
MOP, M & AD	Ministry of Planning, Monitoring and Administrative Development
MOSS	Ministry of Social Solidarity
MOU	Memorandum of Understanding
MOY	Ministry of Youth
MP	Member of Parliament
MTR	Mid-Term Review
N	
NCCM	National Council for Special Needs
NCW	National Council for Women
NEX	National Execution
NGO	Non-Governmental Organization
NOA/NOB	Norwegian Funding Codes on Atlas System
NPAP	National Population Action Plan
NPC	National Population Council
NPS	National Population Strategy
NSPP	National Strategic Population Plan
O	
O/C	Outcome
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OEE	Organization Efficiency and Effectiveness Report
OIC	Officer In Charge
O/P	Output
OR	Other Resources
P	
PA	Personal Assistant

PA/D	Policy Advocacy/Dialogue
PBF	Performance-Based Financing
PD	Population and Development
PHC	Primary Health Care
PLHIV	People living with HIV
PM	Prime Minister
PMO	Project Management Office
PMU	Project Management Unit
PSA	Population Status Report
Q	
QCPR	Quadrennial Comprehensive Policy Review
R	
RB	Regular Budget
RBM/GAR/DBR	Results-based Management
RC/CR/CR	Resident Coordinator
RCT	Regional Centre for Training
Rep	Representative
RH	Reproductive Health
RL	Religious Leader(s)
RO	Regional Office
RR	Regular Resources
S	
SA	Situation Analysis
SCVAW	The Strategy to Combat Violence against Women
SDP	Service Delivery Point (s) (hospitals, health units)
SDS	Sustainable Development Strategy
SFD	Social Fund for Development
SGBV	Sexual and Gender-Based Violence
SIDA	Swedish International Development Cooperation Agency
SIS	Standard Information System
SMART (indicators)	Specific, Measurable, Achievable, Realistic and Timely
SP	Strategic Plan
SPR	Standard Progress Report
SRC	The Social Research Centre
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SSC/S-S	South-South Cooperation
SWOT	Strengths, Weaknesses, Opportunities, Threats
SYPE	Survey of Young People in Egypt
T	
TA	Technical Assistance
TD	Technical Division
TF	Task Force
TFR	Total Fertility Rate

TM	Team Member
TL	Team Leader
TOC	Theory of Change
ToR	Terms of Reference
U	
UH	University hospital
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNHCR	High Commission for Refugees (of UN/United Nations High Commissioner for
UNIC	United Nations Information Center
UNICEF	United Nations Children's Fund
UNRC	United Nations Resource Centre
UNV	United Nations Volunteers
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
UPR	Egypt Universal Periodic Review
V	
VAW	Violence Against Women
VCT	Voluntary Counseling and Testing
W	
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization
Y	
YFC	Youth Friendly Clinics
YPLHIV	Young people living with HIV
YRH	Youth and Reproductive Health

STRUCTURE OF THE COUNTRY PROGRAMME EVALUATION REPORT

The Country Programme Evaluation (CPE) report is composed of five chapters as follows:

1) ***Chapter 1: Introduction*** (covers the purpose, objectives, scope, methodology and process of the evaluation);

2) ***Chapter 2: Country Context*** (contains population development challenges in Egypt, status of national strategies and the role of ODA);

3) ***Chapter 3: UN/UNFPA Strategic Response and Programme*** (provides an overview of UNFPA role among other UN agencies, the UNFPA programme response to country needs, previous cycle and 9th cycle intervention logic constructed by the evaluation team (ET) and main results, and ends by an overview of the CP's financial structure);

4) ***Chapter 4: Findings*** (contains the findings of the evaluation team according to the CP programme areas matched with the evaluation criteria, in addition to overall assessment of the CP, and observations and findings on the current CO monitoring and evaluation system); and

5) ***Chapter 5: Conclusions, Recommendations and Lessons Learned*** (offers a set thread of strategic, cross-cutting programmes, humanitarian response, and M&E conclusions and relevant recommendations tied to the findings of the evaluation questions and criteria addressed in chapter 4. Chapter 5 ends with some salient lessons learnt from the 9th Cycle).

The chapters are preceded by: final report cover page, Egypt map, listing of evaluation team, acknowledgments, table of contents, acronyms list, the current report structure, tables & figures lists, key facts table, and an executive summary.

After the report chapters, eighteen supplemental, illustrative annexes contain the following: TORs, ERG list, CO organogram, outcomes/outputs of previous vs. current CP outputs, CPE projects map, list of Atlas projects by year, ninth cycle KM products (by component), details of the country programme financial structure, documents consulted, detailed CPE methodology and process, CPE methodologies (by component), interview guides, classification of interviews, interviews agenda, FGD minutes and key persons interviews, bi-lingual online survey tool, full online survey results, and evaluation matrix.

The main report is 65 pages (compliant with the UNFPA revised evaluation quality assessment (EQA) criteria); whereas full report size added to annexes is 243 pages, including 51 Illustrative tables and figures (i.e. 13 tables and 38 figures, respectively). The report includes the EQA annexes required at minimum and more to assure substantiated, evidence-based analysis, results and recommendations.

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KEY FACTS TABLE

Land	
Geographical location	Northern Africa, bordering the Mediterranean Sea, between Libya and the Gaza Strip, and the Red Sea north of Sudan, and includes the Asian Sinai Peninsula (1) (5) (6)
Land area	Total: 1,001,450 sq km land: 995,450 sq km water: 6,000 sq km (1) (5) (6)
Terrain	vast desert plateau interrupted by Nile valley and delta (1)
People	
Population	91,000,000 (2016) (4) (5)
Urban population	43.1 (2015) (2) (8)
Population growth rate	2.51% (2016 est.) (1) (2016) (7)
Government	
Government	Presidential Republic
Key political events	*July 23, 1952* beginning of revolution led to a republic being declared on 18 June 1953 and all British troops withdrawn on 18 June 1956 *January 25, 2011*, beginning of revolution that resulted in resignation of longstanding president Hosni Mubarak *June 30, 2014* majority protests resulting in removal of then president, Mohamed Morsi
Seats held by women in national parliament (%)	14.9% (2016) (4)
Economy	
GDP per capita	$11,800 (2015 est.) (1)
GDP growth rate	4.2%(1)
Main industries	textiles, food processing, tourism, chemicals, pharmaceuticals, hydrocarbons, construction, cement, metals, light manufactures (1)
Social Indicators	
Human Development Index Rank	108 (3)
Unemployment	13% (2016) (7)
Health Expenditure (% GDP)	5.6% (2014) (2)
Life Expectancy at birth (females/males, years)	73.1/68.7 (2010-2015) (2) (5)
Under-5 mortality (per 1000 births)	21.8 (3)
Maternal mortality ratio (deaths per 100,000 live births)	45 (3)
Infant mortality rate (per 1 000 live births)	19 (2010-2015) (2) (6)
Condom use to overall contraceptive use among married women 15-49 years old percentage	0.5% (2014) (2)
Contraceptive prevalence rate	58.5% (2014) (2)
Unmet need for family planning	12.6% (2014) (2)
HIV prevalence adult (% ages 15-49)total	0.1(3)
Refugees and others of concern to UNHCR	256384 (mid-2015) (2)
Violence against women ever experienced (%)	33.7%(3)
Millennium Development goals (MDGs) Progress by Goal[1](9)	
1-Eradicate Extreme Poverty and Hunger	Difficult to achieve
2-Achieve Universal Primary Education	Difficult to achieve
3-Promote Gender Equality and Empower Women	Ratio of girls to boys in primary and secondary on track, other Difficult to achieve
4-Reduce Child Mortality	Under 5 mortality rate on track, other difficult to achieve
5-Improve Maternal Health	Antenatal care coverage on track achieved, others difficult to achieve
6-Combat HIV/AIDS, Malaria and other diseases	HIV/AIDS insufficient information, others on track
7-Ensure Environmental Sustainability	Insufficient information
8-Develop a global Partnership for Development	Insufficient information

(1) CIA World Factbook, https://www.cia.gov/library/publications/the-world-factbook/geos/eg.html. Accessed November, 2016
(2) UN Data, http://data.un.org/CountryProfile.aspx?crName=egypt
(3) http://hdr.undp.org/en/countries/profiles/EGY. Accessed November, 2016
(4) Central Agency for Public Mobilization and Statistics (CAPMAS), www.capmas.gov.eg. Accessed September 2016.
(5) CAPMAS. Egypt 2016 Statistical Abstract, June 2016.
(6) CAPMAS. Egypt in Figures 2016, March 2016.
(7) CAPMAS. Egypt: Important Data, 1/10/2016.
(8) CAPMAS. Statistical Year Book 2016, Issue No. 107, September 2016.
(9) Ministry of International Cooperation (MOIC). Egypt National Review Report for Input to the 2016 HLPF, 2016.

[1] UNDP. Egypt's Progress towards Millennium Development Goals. http://www.eg.undp.org/content/egypt/en/home/library/mdg/egypt_s-progress-towards-millennium-development-goals-2015.html. Accessed November 2016.

EXECUTIVE SUMMARY

PURPOSE

This report is the result of the evaluation of the UNFPA 9th Cycle country programme (CP) in Egypt, covering the period mid-2013-2017. Its purpose is to demonstrate accountability to stakeholders on performance achieved. The primary audiences are UNFPA senior management, executive board, donors, national partners, and CP managers. Most of the program partners especially the Government of Egypt (GOE) are part of the evaluation process either as sources of data (primary/secondary) or through representation in the evaluation reference group (ERG).

The CP has three components with a total budget of USD14 million from both regular budget (RR) and other resources (OR): (a) ***youth and reproductive health—YRH***; (b) ***gender equality—GE***; and (c) ***population and development—PD.***

OBJECTIVES AND SCOPE OF THE EVALUATION

The overall objective of the country programme evaluation (CPE) is to provide an independent assessment of the effectiveness and relevance of UNFPA Egypt 9th country programme and to inform on the design of next program. Furthermore, the CPE is expected to highlight important lessons to enrich the knowledge base of UNFPA for learning in order to improve the quality of future actions. The specific objectives cover two analyses, a) CP focus areas namely reproductive health, youth and adolescents (YRH), gender-based violence (GBV), and population and development (PD), b) CO strategic positioning within Egypt's development community and national partners, and they are:

- Assess relevance of the CP and progress in the achievement of outputs and outcomes against what was planned (effectiveness) in the country programme action plan (CPAP), as well as efficiency of interventions and sustainability of effects
- Assess responsiveness of the CO to changes/additional requests from national partners caused by an evolving country context as well as by the influx of Syrian refugees to the country
- Assess the added-value of UNFPA CP to the national partners and to the development community in Egypt and the UN country team (UNCT)

The scope of the evaluation covered the activities (including soft activities) planned and/or implemented during the period mid-2013-mid 2016, with extensions towards end of 2016 within each programme component.[2] Some interventions are conducted at the central level; others target specific governorates, namely Assiut, Sohag and Greater Cairo. In addition to the three programme focus areas, the outputs to humanitarian needs are evaluated. Although not in the terms of reference (TORs), the evaluation team found some merits into providing inputs to an overview of the going M&E system and influences on CP programming at CO.

METHODOLOGY

The evaluation was structured around two categories of criteria: (i) the standard OECD/DAC evaluation criteria of relevance, efficiency, effectiveness and sustainability for the assessment of the three programme components;[3] and (ii) the criteria of coordination, value-added and comparative advantage for the analysis of the strategic positioning of UNFPA in Egypt. The methodology used is mixed method (both quantitative and qualitative) to enhance rigor

[2] Beyond CPE TORs.
[3] Impact is not covered in the CPE due to limited CP timeline.

and robustness of results. Purposive/illustrative sampling technique was utilized over the stakeholder map provided by CO, the ERG and key informant interviewees.

The data collection tools used by the evaluation team consisted in: (i) detailed review of all documentation available regarding the CP and main public policies (5,500 pages of hard and soft copies, files and documents, approximately); (ii) semi-structured interviews and group meetings with main stakeholders (including implementing partners—IPs, NGOs, private sector, academic institutions, ministries, consultants etc.) (300 face-to-face key informants and phone interviews); (iii) focus group meetings and key persons interviews with beneficiaries (5 FGD; 23 KPIs; 152 participants); (iv) mystery client visits (under *Youth* component: 3 MCVs; 2 to YFCs and 1 to HIV drop-in center); and (iv) bi-lingual online surveying tool, with composite assessment of overall CP evaluation criteria (53% response rate). Besides Greater Cairo (Cairo and Giza Governorates), field visits were conducted respectively to Assiut, Sohag and Alexandria. Phone interviews were concluded, as well, with: Damietta, Menoufia, and Menya governorates.

Triangulation was ensured through systematic cross-checking of data and information sources on the one hand, and data collection tools, on the other hand. Specific attention has been paid to the formulation of evidence-based findings by rigorously relating all findings to the supporting facts and data displayed in annexes and footnotes, in general, and to the evaluation matrix in particular. The revised quality assurance (QA) criteria was observed at all stages of the CPE (pre-, during-, and post-completion).

During the course of the evaluation, the team faced some methodological constraints, consisting mainly in information gaps in the programme documentation and in the limited availability of some stakeholders for in-depth interviews during the holiday season and some additional requests for interviews beyond the approved CP agenda, which all more than doubled the field phase period and pushed CPE report delivery date. The team was also challenged by the unavailability of full stakeholders' map and limited logistical support. At times, the evaluation team was denied access to documents that were thought of importance, however worked on cross-validating available sources to complete the assessment. The evaluation team managed to mitigate the other serious challenges to a large extent by using "snow-balling" interviewing/purposive sampling techniques, conducting some meetings through phone interviews, arranging most appointments and in some instances counting on IPs' support to bringing governorate officers to for interviews in their Greater Cairo headquarters.

MAIN FINDINGS

Relevance: The orientation of the 9th Cycle CP is highly relevant to government policies, IPs, the public and aligns to SP 2014 acceptably. The outputs of the focus programme areas are tied to UNFPA's strategic outcomes and UNDAF's. There are, still some instances in which the current CP could have aligned better to needs; namely, had it relied on results of updated knowledge products generated by UNFPA and others, previous cycle CPE results, and concluded wider consultations with stakeholders especially with the launch of SP 2014 that did not lead to a CPAP amendment. CO was responsive at varying degrees to shifted needs caused by major political challenges and regime changes (especially at the anti-FP Moslem Brotherhood rule), and to needs of IPs, including humanitarian assistance to Syrian refugees for mainstreaming YRH and GBV components. CO's responsiveness beyond the yellow, low middle-income country color grid stipulated by SP 2014-17 was evidenced (e.g. contraceptives procurement under YRH, and provision of capacity building through the GBV and PD components).

Efficiency: Although generally satisfactory and remarkable progress is achieved by CO during the 9th Cycle, massive contextual changes (human, financial and technical) led to efficiency challenges on programme focus and implementation. Efficient record keeping on: project activities, documents, deliverables, knowledge products, and beneficiaries documentation suffers shortcomings. Delayed fund transfers, pressures for milestones' delivery, periodic changes in annual work plans (AWPs) with consequences on implementation, and noneconomic financial spending, inappropriate selection of some IPs were noted. Problematic contractual effectuation, reliance on external

consultancies with mismatched credentials to tasks contracted, inconsistent reporting by IPs without feedback, and a tendency to focus on financial expenditures than results and sustainability were evidenced. Staff turnover with inadequate handover, over-worked staff at CO, without capacity building budget, were common during the 9th Cycle reflecting on efficiency of outputs and expected outcomes delivery cross-cutting the CP programme areas.

Effectiveness: Progress under the YRH, GBV and PD components was marked during the 9th Cycle. Examples worth noting are: YFCs, M3loma initiative support, protocol on school health, contribution to DHS (2014), SYPE (2014), completion of Caesarian section study, DMT tool translation, establishment of "safe motherhood committee" to decrease maternal mortality at both central and local levels, PSA completion, and increase in contraceptives use in the target governorates at Assuit and Sohag; preparation and launch of GBV costing study, production of medical protocol, passage of FGM law amendment in 2016 to criminalize FGM, the FGM strategy; launch of NPS, EP, NPAP, composite indicators, population observatory, provision of national population census sampling expert, participation in the launch of the national population and governors' population days.

On the other hand, CP effectiveness remains a key area for improvement. Worthy of attention is the following: training given at central-level for Family Planning did not cascade to governorate levels, DHS or SYPE were not used as knowledge inputs to influence policy and decision making, in GBV upscaling of training nationwide over rode effective sustainability at service delivery points, and no referral system is put in place yet. NPC staff not engaged in drafting or launch of NPS, nor were they involved in the generation of KM products, leading overall to additional resource needs to realize outputs and outcomes. Lack of coordination and knowledge management between initiatives, needs assessments unavailable in general, and finally the integration of the humanitarian component into YRH and GBV was not evidenced. There was an absence of coherence and long-term intervention planning and implementation. This includes institutionalization and data utility towards the generation of shared knowledge feeding into programming. Growing needs to build local and central capacities sufficiently, and M&E systems were found either incomplete or non-existent risking outcomes non realization.

Sustainability: Overall, sustainability and ownership have been rather questionable aspects in CO operations under the 9th programme cycle. Sustainability and ownership depended mainly on the strength of IPs structures and NGOs than being a planned for actionning by the CO. Political commitment and personal interest of the IPs in effecting planned activities was the success factor than an institutional or programming requirement for an exit and sustain strategy. The CO had little to contribute to on sustainability and ownership, while IPs required additional capacity building and knowledge transfer from CO to sustain CP interventions. Capacity building interventions were not evaluated and national strategies remain un-operationalized. Some examples show CO focus on training and /or capacity building rather than institutionalisation, greatly affecting sustenance. Without planning for exit strategies relating to interventions at the outset, no sustenance can likely to be attained on CP results.

Strategic Positioning: UNFPA's new mode of engagement introduced in SP 2014 is widely accepted by main stakeholders (IPs and donors), with reasonable achievements realized on value-added upstream activities leading to increased OR funding. KM products need to move towards wide dissemination followed by operationalization (e.g. GBV costing study, baseline assessment of the health sector, caesarian section study, DHS and SYPE etc.). Although a relatively non-outgoing CO, the Office was acknowledged by different stakeholders for what it delivers in light of its small staff number. That is to say, its potential can be better enhanced with quality staff growth. It was found the comparative strength of CO lies in having a focused mandate (i.e. the central focus of RH in the bull's eye), while other UN agencies are overlapping leaving space for joint programming (e.g. UNICEF, UNWomen, UNHCR etc.). Over the 9th Cycle, CO's presence and contribution was witnessed in key UNCT coordination Task Forces (e.g. the active chairing of the Youth and Gender Task Forces and representation in the UNDAF M&E Task Force), with indications for visibility improvement. For example, targeting Ta'a Marbouta campaign, generation of policy briefs and secondary analyses from KM products etc., improved results reporting and focus on yielding community-based interventions, same for overall programme coherence. Insufficient investments were expended

on south-south, triangular cooperation, and recourse to RO technical backstopping. Policy dialogue enhancements under the current country transitory context and in line with the new mode of engagement are emphasized to generate results beyond conferences holding and MOUs signatures.

Composite Assessment of Evaluation Criteria: A single composite indicator for eighteen numeric descriptors were derived. These came from responses of online survey designed by the evaluation team to arrive at a relative assessment responses participated in by anonymous stakeholders who were involved with CO's 9th Cycle CP. The overall assessment of the evaluation criteria based on respondents was a *satisfactory* CP performance. Doable areas of improvement are contained in the recommendations to improve performance beyond the satisfactory level.

Monitoring and Evaluation: Given the fact that the UNFPA M&E policy has been recently introduced (2013), the evaluation team found CO's M&E function at its infancy stage: under-staffed, under-placed in the organogram, un-supported, unbudgeted for, suffering from conflicts of interest, under-capacitated, unable to align focus programme areas sufficiently to the late coming SP 2014. All of this came with heightened expectations to deliver M&E reporting and expertise to CO, RO, HQ, and IPs, given the aforementioned limitations. Recently, the RO is offering support to the CO through offering capacity building, participation in regional peer reviewing, and advice to strengthen CO's M&E system.

MAIN CONCLUSIONS

The CPE conclusions are categorized in *five* groupings: (i) ***strategic***; (ii) ***cross-cutting programmatic***; (iii) ***programmatic***; (iv) ***humanitarian response***; and, finally, (v) ***M&E-related***. Summary of main conclusions are:

Strategic: the CO continues to be a trusted partner by IPs and the donor community, and was able to expand OR during the 9th Cycle. The CO was also an active player in the UNCT through its multiple chairing and memberships in TFs. South-South and triangular cooperation remain areas of high value to IPs that have strong improvement potential. The unstable political context in the country rendered the 9th Cycle atypical, with incoherent CP programme areas. The new mode of engagement of UNFPA in Egypt required consultations, amendments to the CPAP, and programming that were undertaken to some extent yet not fully. During the CP Cycle, the CO did not generate a strategic stakeholders map, is spreading thin with growing number of IPs linked to smaller interventions necessitating further prioritization, affecting its comparative strength, value addition and image. A need for capacity-building requirements beyond the current yellow color grid new mode of engagement expressed for a continued niche and results delivery were concluded.

Cross-Cutting programmes: It was concluded that the national execution (NEX) modality was more effective in country institutions shielded from periodic political changes in top management. Technical backstopping from RO is requested occasionally, either to align to the bull's eye programmatic distribution more closely or relating to other aspects of programme implementation which may go beyond the SP2014 business model. Activity-based reporting is weakly tied to programmatic outputs. Community-based interventions and capacity-building programming are not strong enough due to lack of prioritization and limited periodic field reviews. Data and statistics produced insufficiently transformed into informative knowledge products; and lack of record keeping and handover mechanisms affected programme performance to some extent. Geographic targeting to Greater Cairo, Assiut and Sohag was not based on an updated CCA focused on CO mandate at a period of massive changes. This influenced office priorities and directions.

Programme Areas: (i) YRH: A. *RH:* The CPE concluded a lack of coordination between MOHP/FP internally among different sectors with other stakeholders like universities. Similar conclusions relate to lacked investments in knowledge management and gender mainstreaming in RH activities to be able to provide specific advocacy for specific evidence based interventions. Work needs to be centralized with ministry of health; B. *Youth:* central-level interventions are more focused. In addition, the recommendations that came from the youth and adolescents

evaluation were not taken into consideration yet and there is need for conducting an impact assessment of long running community-based interventions (namely, Y-peer and youth-friendly clinics). High relevance of some youth interventions performed without supporting advocacy for national youth policy were also concluded; (ii) GBV: yellow level categorization needs to be revisited for GBV interventions as they still require technical support. The built capacity of the national health system is weak as it was up-scaled nationwide with a focus on greater outreach rather than sustainability. The comparative strength of UNFPA in reproductive health is not felt by all IPs due to lack of coordination; and (iii) PD: Comprehensive and integrated policy solutions are not considered in NPS implementation and roll-over despite NPS launch since 2014. Knowledge products are performed and capacity building are undertaken by external consultants who hardly engage or invest systematically in internal capacities of NPC. Delays on both sides, IPs and CO, relating to AWPs, ARs, financial, and administrative issues affected performance.

Humanitarian response: CP humanitarian programming is insufficiently aligned to the 3RP strategy and shift to the new mode of engagement to link with the RH and GBV components.

M&E-related: The M&E system at CO is mainly activity-/process- not results-based. The function is neither independent nor insulated from conflicts of interest. The M&E function is currently fragmented between PMOs, M&E Focal point and AR, without dedicated budget, staffing or clear mandate. Regional M&E peer mechanism proved a good learning tool availed by RO.

MAIN RECOMMENDATIONS

The recommendations are organized in the same *five* categories, mentioned above. They are summarized as follows:

Strategic: Continue with active participation in the UNCT, enhance visibility and develop fund-raising strategy equally for all programme areas, including multi-year humanitarian response. Boost bilateral and multilateral learning, capacity-building activities and networks through partnered work with RO and HQ. The cyclicality of SPs has to be sequenced enabling COs sufficient time to adjust to new strategic orientation passed from HQ (i.e. new SPs to be issued half-way through cycles to enable sufficient time for understanding, pre-planning and programming into the following cycle). Continue with NEX modality and build national IP capacities to handle it efficiently. CO to conclude rigorous organizational capacity assessments to potential and current IPs, as a pre-requirement. Construct strategic stakeholders map that is updated prior to the start of every cycle. Programmatic consolidation into the bull's eye and balancing components as per SP relative weighted distribution focusing on results, ensuring sufficient consultations with stakeholders on new corporate strategic orientation to align programming planned activities and implementation at both ends (CO and IPs).

Cross-Cutting Programmatic: Population situation analyses (PSAs) should be "the" priority tool for CO programming, while CCAs should be used as a complementary means prepared for UNDAF purposes, than specifically for UNFPA purposes. The PSA should be expanded to offer guidance on geographic targeting in the current CP penultimate year. Engage more academic institutions and think tanks with partners further (through competitive grants and scholarship awards) to generate knowledge products from surveys and statistics (e.g. DHS and SYPE) funded through CO CP. Build a properly up-kept data-base of knowledge products, beneficiaries, program and project records and documents, and digitized tracking systems in CO (complete, comprehensive institutional memory archiving system) for operationalization.

Programmatic (i) RH: UNFPA should facilitate the establishment of a national reproductive health coordinating committee at MOHP to facilitate among directorates relating to curative care, RH in primary and secondary centers. Engage the education system and private sector in developing sustainable interventions so as to increase the quality of RH services on the national level. Also, involve the private sector to negotiate long-term solutions like affordable FP pricing; ensure gender-mainstreaming in RH component. And, expand activities in the FP sector in the upcoming

cycle based on demonstrated success. Focus upcoming cycle on central-targeting refraining from the periphery. Advocate for building central level capacity on planning, decision making and technical skills to develop an efficient policy;(ii) Youth: Apply the recommendations of "Evaluation of UNFPA support to adolescents and Youth 2008-2015 report" to be followed by an impact assessment for the sub-components mainly Y-Peer and YFCs. Expand social media and HIV/AIDS activities working with key populations in sustainable manner taking into consideration documentation of the developed expertise in previous years; (iii) GBV: Continued technical support for SGBV interventions as they are still in their inaugural stages. Advocate for SGBV services at MOHP while instituting a sustainable M&E tracking system. Develop linkages with other interventions and components, to effectively utilize RH as an umbrella to address SGBV; and (iv) PD: Expand funding allocations to PD component to reflect its importance as an environment enabler and as per SP 2014 relative distribution (immediate corrective action required for 2017 to align results within Cycle). Enhance capacity of CO to offer technical and policy advice to IPs and fill-in gaps while supporting IPs fund-raising strategies for integrated interventions that cannot be supported solely by CO. Refine geographic targeting to have a balanced mix between quick-wins and challenging governorates to show results. And, exit strategies to be contained in project documents designs with full capacity-building tracking and training effectiveness assessments performed for all CP components.

Humanitarian Response: Focus humanitarian response programming on Livelihoods and Social Cohesion component of the 3RP, including time, length and funding, while shifting focus to resilience and medium-term sustainability. This should be accompanied by technical training awareness to CO.

M&E-related: Establish an independent M&E function directly reporting to the CO Representative led by a senior M&E officer and assisted by a JPO. The former is ideally funded through IB, or RR. A CP-based M&E plan to be budgeted from OR for CO and IPs capacity building and results-oriented planning and reporting. This has to be in line with UNDAF MTR, SP 2014, CPE 2009, and CPAP 2013. Establish an incentive system and training programs for IPs to utilize Atlas and SIS (MyResults) for real-time reporting and learning.

LESSONS LEARNED AND SUCCESS STORIES *(identified as unintended results of the CP evaluation)*

YRH

1.Learning from M3loma's success story

The M3loma social media platform focusses on sexual and reproductive health rights targeting young people. The page of Facebook has about 1.5 million "likes." Half of the people who have "liked" the page are Egyptians while the rest are from other countries, mainly from the Arab region. The success story of M3loma is linked to the design of the message and social media campaigns designed to attract young people. The message design was careful to target average young Egyptians who may feel embarrassed or ashamed to access pages that discuss sexual and reproductive health. The message also covered wider health issues that respond to the needs of young people. The daily inquiries through different resources range from 20 to 30 per day mainly on the facebook page. Most of the questions posed related to sexual and reproductive health which gives an indication of the platform to present itself as a reference for reproductive health for youth.

2.Gender mainstreaming in reproductive health programmes

The programmes designed to target women and reproductive health assume that it has gender mainstreaming in its structure. However, it is not always the case. Gender inequality was important factor affected the programmes for maternal health and family planning. It affected the mid-wives' trainees who could not practice delivery because their husbands banned them from contraceptives use. It also affected the beneficiaries who follow their husbands wishes whether to use contraceptive or not. Husbands even decide on the tool to be used.

Implementing successful gender mainstreaming programme in reproductive health seems to require considering gender factors in different levels of the project design, implementation and monitoring. It will also require men involvement and further analysis for those factors to combat them in the project design.

GE

3.Learning from FGM PMU at NPC

Efforts and effectiveness of the FGM PMU shows that ample time is required, over many years, to strengthen advocacy, build and integrate capacities and mechanisms that requires direct involvement and physical presence in the field. In the face of GBV issues that require a mindset/cultural change (not only of the existing culture of acceptance of GBV, but for victims themselves to overcome taboo and stigmatizations and report incidences and protect themselves), the model presented by the FGM PMU at NPC is one that needs to be replicated. There has to be a focus on hiring good technical staff that are committed, building their capacity, building a team culture and supporting their institutionalization, not just within a certain institution, but within a higher level of government. It is also, an effective example of models that can be utilized at the community level for change. However, it has to be re-emphasized that this comes with the understanding that such models require time and effort to fully materialize into behavioral and practice changes.

PD

4.Packaging factors for a successful national population strategy

Launching a national population strategy is a major achievement, intent to bring about sustained impact when carefully crafted, consulted, is measurable and feasible. Reality checks have proven that this may not be the case. A number of success factors require thorough study: 1) the presence of a supportive political (regime) and context; 2) a strong strategic institution higher-up in the state administrative apparatus who is able to engage and budget for implementation; 3) the presence of strong political will of the higher echelon of the implementing agency fairly sustained; 4) engagement, consultation and coordination within the cadres of the lead agency and the different layers of government (central and local) and partners (private sector, civil society, and development partners) is essential for data generation and utilization in decision making (early warning and corrective actions mechanisms); 5) building the capacity of the lead agency's in-house staffers upon conducting a comprehensive organizational capacity building assessment. This should lead to the development of an integrated utility-based M&E "system"[4] at the output, outcome and impact levels spanning the central and local levels at the outset; 6) developing and implementing a comprehensive advocacy and media campaigns based on evidence-based reports and knowledge products and effectiveness measurement; 7) prepare and conclude an M&E plan drafted at the outset to ensure alignment, ownership and accountability; and 8) CO has to have a similarly stabilized human, financial and technical resources to support an intervention with such national (and eventually local) scale and impact. The realization of items 1 to 5 above are imperative to the pre-launch of the national strategy (rather than *ex post*). Item 8 should sustain until the term of a pre-planned exit strategy expires and impact assessment is concluded to measure effects.

5.Learning from CAPMAS success story

Despite the short relations between UNFPA and CAPMAS, focused interventions and achievements are promising. A strong leadership, higher-up in the state administrative apparatus subjected the organization to voluntary organizational capacity assessment by OECD/Paris 21+. A vivid multi-stakeholder policy dialogue was initiated to collect data and construct complex SDG indicator with a pledge for the issuance of an annual SDG tracking report with continuous refinements to assume international leadership and inform decision making. With the return of

[4] M&E systems are commonly mistaken for performance indicators.

staffers from expatriate training, they were asked by their institution to offer TOT to their colleagues to expand excellence and learning circles, giving a success model to the other state administrative units. CAPMAS is now working with solid strides towards operationalizing Egypt's debut national statistical strategy.

CHAPTER 1: INTRODUCTION

1.1 Purpose and Objectives of the Country Programme Evaluation

This CPE was commissioned by the Egypt UNFPA CO, in compliance with the guidelines for the preparation and implementation of Country Programme Evaluations as contained the UNFPA Evaluation Handbook (2013) and the respective Evaluation Quality-Assurance measures (revised/final version). The purpose is to conduct an end of CP evaluation (CPE) to demonstrate accountability to stakeholders on performance achieved. The primary audiences are UNFPA senior management executive board, donors, government partners, and CP managers. Most of the program partners especially the Government of Egypt (GOE) are part of the evaluation process either as sources of data (primary/secondary) or through representation in the evaluation reference group (ERG).[5]The overall objective of the CPE is to provide an independent assessment of the effectiveness and relevance of UNFPA Egypt 9th country program and to inform the design of the next program. Furthermore, the CPE is expected to highlight important lessons to enrich the knowledge base of UNFPA for learning in order to improve the quality of future actions. The specific objectives cover two analyses, a) CP focus areas namely RH, GBV PD and young people, and b) CO strategic positioning within Egypt developing community and national partners and they are:

- Assess relevance of the program and progress in the achievement of outputs and outcomes against what was planned (effectiveness) in the country program action plan (CPAP), as well as efficiency of interventions and sustainability of effects;
- Assess responsiveness of the CO to changes/additional requests from national partners caused by an evolving country context as well as by the influx of Syrian refugees to the country
- Assess the added-value of UNFPA program to the national partners and to the development community in Egypt
- Assess alignment of CPAP with the UN Development Assistance Framework (UNDAF) and role of UNFPA country office as an active contributor to the coordination mechanism of the UN country team[6]

1.2 Scope of the Evaluation

The scope of the evaluation is to cover outputs implemented from mid-2013 to third quarter 2016 with ministries/institutions/NGOs involved in the CP implementation. Some interventions are implemented at the national level; others target specific governorates namely Assiut, Sohag and Greater Cairo. The CPE will cover the three outputs of the CPD 2013-2017 in addition to one output selected from UNFPA SP on PD. Also, contributions of the outputs to humanitarian needs are covered in the evaluation.

1.3 Methodology and Process

1.3.1 EVALUATION METHODOLOGY AND APPROACH

1.3.1.1 EVALUATION CRITERIA AND QUESTIONS

The evaluation followed the OECD/DAC criteria: Relevance, Efficiency, Effectiveness and Sustainability to analyse and evaluate the focus areas namely RH, PD & GBV, in addition to analysis of CO strategic positioning

[5] See Annex 2 for ERG members consulted.
[6] See Annex 1 for TORs.

with regard to responsiveness, added value and coordination with UN country team in Egypt. The DAC criteria have become the standard in evaluating projects and programs from a results-based perspective. Missing from the criteria for this evaluation is the 'impact' criteria, as it is too early to assess at this point in time. While in practice, the general criteria can be adapted to include a range of sub-questions, Annex 11 (on methodology) provides general definitions for each criterion.

The evaluation questions were selected through a series of discussions between the evaluation team, and after receiving feedback from the evaluation reference group (ERG).[7] A set of evaluation questions were laid in the CPE TOR. These were refined in a series of meetings by the evaluation team and merged within and upon finalization of field work; e.g. evaluation question 3 on effectiveness was merged into reflecting relevant components under reflective sub-headers, and same for evaluation questions 5, 6, 7 and 8 on value-added, comparative strength and UNCT coordination under the new mode of engagement implemented in the current CP to reflect the status of UNFPA strategic positioning. The key consideration at the several rounds of discussions, was which questions would allow a full coverage of the six evaluation criteria. The rounds of discussions, included a more refined approach that narrowed down the number of and sharpened the questions chosen.[8]

Below is the list of refined questions by the evaluation team for the CPE, were earlier in the design report and approved by the ERG. Annex 18 contains a more detailed table (evaluation matrix) with issues covered for each question, and salient findings are also contained.

Table 1: Evaluation Questions

Main Questions		Evaluation Criteria				
		Relevance& responsiveness	Effectiveness	Efficiency	Sustainability	Strategic Positioning
1 Relevance	To what extent are the interventions of UNFPA Egypt CP 2013-2017 (1) relevant to the needs of the intended beneficiaries (women and young people); (2) in line with the government priorities; and (3) aligned with UNFPA policies and strategies? (4) to what extent has the CO been able to respond to changes in national needs and shifts caused by major political changes?	X				
2 Efficiency	To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country program?		X	X		

[7] Design report was presented on 06 December 2016 to ERG, feedback received during the meeting and within a week after the meeting for incorporation into the design report and field phase concluded.
[8] See Annex 11 for the evaluation questions refinement criteria.

3 Effectiveness	3) To what extent has UNFPA CP support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into national systems, positioned on the national agenda, improved capacity nationally and locally through interventions, used institutionalized legal and policy instruments, use of data and evidence, including improving emergency preparedness for SRH and GBV in Egypt? (component dependent)	X	X	X	X	X
4 Sustainability	To what extent has the CP been able to support its partners and beneficiaries in developing capacities and establishing mechanisms to ensure ownership and sustainability of achieved results?		X		X	
5 Strategic Positioning	To what extent was the CO able to shift to new mode of engagement focusing on upstream interventions (policy advocacy, knowledge management and internal CO capacity), able to generate value-added, effectiveness of its role in UNCT coordination and comparative strength?	X	X	X	X	X

1.3.1.2 METHODS AND TOOLS FOR THE DATA COLLECTION AND ANALYSIS

The evaluation team ensured its independence and impartiality by relying upon a systematic triangulation of data sources and data collection methods and analytical tools.[9] The evaluation was completed through a combination of three sub-activities that were carried out to ensure a mixed method qualitative and quantitative data collection and analysis.[10]

Qualitative data was collected by using a number of methods including:

- A critical desk review
- Review of project activities against CPAP outputs, and UNDAF and strategic plan outcomes/outputs against objectives and performance indicators.
- Key Informant Interviews (KIIs) and in-depth, semi-structured interviews with representatives from IPs, politicians, CSO coalitions and networks, community leaders, religious leaders, GOE staff, other stakeholders and beneficiaries.
- Phone interviews were also utilized as a time and cost saving method, to conduct interviews and secondary interviews, as necessary.
- Field visits and meetings with project partners in the intervention areas, including: Cairo, Alexandria, Assiut, Sohag. Phone interviews were concluded with Damietta, Minya, and Menofiya.

9 See Annexes 14, 9, 11, 15, 16, and 17.
10 See Annexes 2, 13, 9, 18, 10, 4, 8, 3, 7, 5, 12, 15, 17, and 11.

- Focus Group Discussions (FGDs)[11]and mystery client visits.

These methods have been selected because they allowed the evaluation team to gain a better understanding of the partner and beneficiary perspective through targeted discussions and better triangulation for enhanced results validity and methodological robustness.

Quantitative data collection methods consisted of:

- Desk Reviews: Review of data sourced from the project on indicators.
- Collection and review of secondary data
- Review of data from available surveys and other studies.

Mixed Method collection method consisted of:

- Conclude on-line survey with the projects stakeholders to cross-validate evaluation question results quantitatively, qualitatively and anonymously[12]

The data collection tools used by the evaluation team consisted in: (i) detailed review of all documentation available regarding the CP and main public policies (5,500 pages of hard and soft copies, files and documents, approximately); (ii) semi-structured interviews and group meetings with main stakeholders (including implementing partners—IPs, NGOs, private sector, academic institutions, ministries, consultants etc.) (300 face-to-face key informants and phone interviews); (iii) focus group meetings and key persons interviews with beneficiaries (5 FGD; 23 KPIs; 152 participants); (iv) mystery client visits (under *RH* component: 3 MCVs; 2 to YFCs and 1 to HIV drop-in center); and (iv) bi-lingual online surveying tool, with composite assessment of overall CP evaluation criteria (53% response rate).

Besides Greater Cairo (Cairo and Giza Governorates), field visits were conducted respectively to Assiut, Sohag and Alexandria. Phone interviews were concluded, as well, with: Damietta, Menoufia, and Menya governorates.[13]

Table 2: Overall Classification of Interviews

Institutions	Number of Persons[14] [15] [16]			
	YRH Component[17]	GE Component[18]	PD Component[19]	Total[20]
UNFPA				
UNFPA Country Office	5	6	8	18
UNFPA Regional Office	1	1	2	4
DONORS & UN ORGANIZATIONS				
UN Agencies (UNHCR; UNICEF; UNWomen; UNDP/UNCT)	3	1	5	9
Country Donors (SIDA; Japan; & Norway)	2	1	3	6

[11]It was envisioned early on that the FGD approach may not be applied over the PD component due to limited number and to the high-level central meetings due to component's political sensitivity and high-ranks of interviewees, which included ministers, sub-ministers and senior officials. However, key persons interviews and group meetings were held together with key informant interviews, critical document reviews and a mixed-method survey tool constructed for all CP components. Look Annex 16.
[12] Annex 16 for survey tool.
[13] See Annexes 10-17.
[14] See Annexes 13-14.
[15] GE & PD Components interviewees including humanitarian component.
[16] PD component interviews inclusive of strategic positioning interviews (total of 10 interviews; 6 females (60%) and 4 male interviewees (40%). However, strategic positioning criteria is among the EQs and responded to by all online survey respondents).
[17] 52 female versus 14 male interviewees. See Annex 14.
[18] 47 female versus 29 male interviewees. See Annex 14.
[19] 47 female versus 33 male interviewees. See Annex 14.
[20] 146 female (40% of total) versus 222 male (60% of total) interviewees. Total interviewees including FGDs is 368.

GOVERNMENT				
Central Government	8	8	33	51
Regional/Decentral Government	4	4	4	12
INGOS				
Implementing Partner (CARE)	0	3	2	5
COMMUNITY BASED ORGANIZATIONS				
Implementing Partners	9	14	1	24
Youth Network	6	0	0	6
BENEFICIARIES				
Trainees	45	25	20	70
End line beneficiaries of service	30	42	0	72
Others				
Private Sector & Consultants	0	0	4	4
TOTAL	**113**[21]	**105**	**82**[22]	**300**

1.3.1.3 SELECTION OF THE SAMPLE OF STAKEHOLDERS

The sampling framework of the CPE was based on illustrative/purposive sampling at the central and local levels based on the stakeholders' map provided by CO initially. Key informant interviews were also used on series of rounds and through "snow-balling"[23]for further validation of findings until no additional insights were captured. Interviews were re-validated from different sources, and using FGD[24], additional cross-validating interviews and/or survey tools. Team consultations on findings received from interviewees were consulted further for data analysis, synthesis and reporting. Conflicting opinions on issues elicited from interviews or FGDs were eliminated (pre-test analysis), and upon receipt of validating survey results on evaluation questions (EQs). Selection of interviewees was guided by in-depth interviews with key IPs at the central levels to cascade and guide further samples selected at the local level.[25] The goal is to ensure that the wide range of interventions and stakeholders are covered in a meaningful manner to feed into strategic and programmatic conclusions. The selection of stakeholders to be interviewed was based on the importance of their respective contributions to components interventions. The evaluation team relied on the CO, ERG and IPs recommendations, and follow on through "snow-balling."[26]The selection of key interventions in each component ensure that a range of stakeholders were represented as partners and beneficiaries based on the nature of each component. It also ensured that some of the most successful and the most challenging interventions, in terms of implementation, were selected, to ensure a complete picture of supportive and constraining factors emerged, as well as substantial lessons learnt that can feed into the CPE.

1.3.1.4 LIMITATIONS AND RISKS

Risks:

1. The volatile political situation in the last five years may have affected respondents' willingness to fully share their insights and opinions.

Design Limitations

1. In light of the limited time available for primary data collection, the selection of specific key informants and beneficiaries for individual interviews, FGDs, and other data collection, approaches was targeted

[21] This figure is inclusive of 2 meetings under the humanitarian component, and 2 donor meetings.
[22] This figure is inclusive of 3 female meetings under the humanitarian component. In addition, this figure is exclusive of iterated KPI. Total number of interviews including iterations is 100. See Annex 11.
[23] Based on recommendations and references received from a key informant(s) that were essential to the evaluation, CO, and ERG.
[24] For YRH and GBV large components who had local level work.
[25] Illustrative, purposive snow-ball effect until no further insights were received.
[26] See Annex 14 for a full listing of persons interviewed, and Annex 13 for the overall and component disaggregated classification of interviewees.

opportunistically and built upon information generated through pre-field phase document reviews, with reliance on secondary data available

2. The activities that were evaluated were implemented between 2013 and 2016, a period that has witnessed immense changes in Egypt. In addition, the activities cover some socially sensitive topics, creating the possibility of selection bias. This may apply to in-person interviews, FGDs and survey.
3. There is a known tendency among respondents to under-report socially undesirable answers and alter their responses to approximate what they perceive as the social norm (*halo bias*). To mitigate this limitation, the Evaluation Team provided the respondents with confidentiality and anonymity guarantees.

Implementation Limitations

1. Given the large number of stakeholders – direct and indirect beneficiaries- it was a major challenge in the relatively short time allotted for this evaluation to interview all participating stakeholders (it would have been the ideal situation). This is added to data gaps in acquiring detailed trainees/beneficiaries list. To address these limitation, the Evaluation Team conducted interviews with carefully selected illustrative samples of assisted beneficiaries to ensure balance participant feedback is obtained. In addition, interviews were supplemented with online surveys as a means to collect further mixed method feedback within the short timeline allotted for the evaluation that eventually extended.
2. Field phase extended to 6 weeks beyond the planned 2 weeks period, laying pressures on the evaluation team to synthesize and cross-validate while in the field. Additional interviews from CO were requested beyond the field period which extended the field phase further, due to the profile of the interviews and the evaluation team's involvement in the logistics of (re-)scheduling most meetings.
3. As a number of interviewees were unavailable due to staff changes, holidays season, and cultural sensitivities involving the subject matter, the Evaluation Team was not able to cross-check information through direct interviews or observations in few instances. To mitigate this limitation, the team conducted extensive desk review of reports, other relevant materials that was collected or made available ensuring the validity of sources and further cross-validation through phone interviews to ensure results integrity.
4. There were cases, the CO was unaware, or unable to connect evaluators with key persons. That connection was provided through IPs, detracting from the professionalism or "official request" to meet introducing the ET. IPs also recommended other key persons to interview. While these nominations are undoubtedly trustworthy, there may be a slight bias in their selection, on the side of IPs.
5. Scheduling team appointments and logistics at the local level were inadequate, leading, in some cases, IPs bringing their local branch staff for interviewing to the central level, where the evaluation team assembled.
6. Also, many persons interviewed were new in their posts, and had clearly not received sufficient handover from their predecessors on UNFPA partnership. This affected access to documents, data and overall institutional memory.

Results Limitation

1. The evaluation team was well-aware that it may be too early to observe the effects generated by some outputs of the 9th Cycle Programme (e.g. changes in behaviour, culture or mindset) which require time to be reflected on, and will be completed by end of 2017.

1.3.2EVALUATION PROCESS

1.3.2.1 OVERVIEW OF THE PROCESS OF THE EVALUATION

The evaluation was planned to be conducted over a period of five months with a total of 116 working days; it was planned also to be divided into three phases each including several steps, as per the table 2 summarizing the 3 CPE phases:[27]

[27] See Annex 10 for details on evaluation phases.

Phase 1: **Design phase (6 weeks)**
Phase 2: **Field phase (originally planned for 3-4 weeks; and ended up with 2-6 weeks)**
Phase 3: **Synthesis Phase (2-4 weeks)**

Table 3: CPE Milestones

	Phase / Deliverables	Timeline (start and end)
1	Design Phase – design report& ERG-CO presentation[28]	Mid Oct.-End Nov 2016[29]
2	Field phase-simultaneous work on evaluation matrix and findings	Dec. 13-Feb. 2, 2016[30]
3	Synthesis Phase-simultaneous with field phase	1-31 Jan.., 2017
	1st draft submission of completed filled evaluation matrix, detailed response to EQs and online survey, provisional findings, conclusions and recommendations	Second week of Feb.-17
	Final evaluation report	fourth week of Feb. 2017[31]

1.3.2.2TEAM COMPOSITION AND DISTRIBUTION OF TASKS

The evaluation team consisted of:
1-Ms. Doha Abdelhamid, Team Leader and PD Specialist
2-Ms. Ghada El-Sherif, Team Member and GBV Specialist
3-Mr. Amr Awad, Team Member and YRH Specialist

Neither the TL nor TMs were involved in the design or implementation of any UNFPA interventions during the 9th Programme Cycle.

[28] An ERG meeting was held on 05 Dec. 2016 based on members availability, whereby the ET put forward before the ERG a full presentation of the Design Report based on CO request; this is taken in place of final presentation due to extended field phase with consequent more than doubling of consulting days going beyond the contracted period.
[29] Original start date was beginning of August 2016, leading to shifted time schedules and compression of evaluation period from 5 months to 4.
[30] The field phase extended to 6 weeks. See section 1.3.1.4.
[31] This extends the evaluation period to 6 months, instead of the contracted 5 months which did not cover for the extra-worked consulting days. Presentation will not be concluded except in case of need due to extended consultation, design and field work beyond the contracted period.

CHAPTER 2: COUNTRY CONTEXT

2.1 Development Challenges and Country Strategies[32]

Egypt spans North Africa and Asia, bordering the Mediterranean Sea to the north, the Gaza Strip and Israel to the northeast, the Gulf of Aqaba and the Red Sea to the east, Sudan to the south and Libya to the west. Its total land area is slightly under one million km2. The climate ranges from moderate along the coast and Nile delta through arid and semi-arid, to desert extremes in the western and eastern deserts.

Administratively, Egypt is divided into 27 governorates, over 300 districts, 166 regions, and 217 cities and 4,617 villages.33 Territorial administration has been strongly hierarchical. Governors and executive counsellors were appointed by the central government, while elected councils had little autonomy and limited capacity to hold appointed counsellors accountable. In particular, vertical fiscal dependency between units and control of sector budgets by line ministries constrain local council budgets and limit their ability to raise their own revenue.

Box 1: Key Development Challenges

Over the past three decades, Egypt has made progress in addressing issues of child mortality, life expectancy and education. However, poverty and income inequality remain the most pressing challenges to development, as 25% of Egyptians live below the poverty line and mostly concentrate in rural Upper Egypt. The government budget deficit reached 12.6% in fiscal year 2013-2014, reflecting long-standing structural challenges that have been exacerbated by the difficult political transition, with the resulting cyclical factors pushing the government debt-to-GDP ratio to 95.5%. There have been improvements in public health and education services, but regional gaps and deficient service quality require continued government effort.

Source:http://effectivecooperation.org/wp-content/uploads/2016/10/Egypt_10-10.pdf
Accessed November, 2016

Egypt is low middle income country; GNI per capita is $3,050 (WB 2014)33, it is the most populated in the Middle East. Egypt is at a stage of demographic transition with a marked "youth bulge," a period in which the proportion of youth under the age of 30 in 60% and 40% between the ages of 10 and 29 (SYPE, 2009 and 2014).[34]

Egypt could not achieve most of its targets toward the MDGs. For MDG 5: Egypt achieved its target to the coverage of Antenatal care, however it could not achieve its targets in maternal mortality rates, contraceptive prevalence rates or unmet need for family planning[35]. In addition to that, Egypt is one of the countries who presented moderate resistance for the commitments to the ICPD plan of action.

Public policies continue to not fully reflect the needs of young people, including their social, economic and reproductive health needs.[36] According to the Demographic Health Survey (EDHS 2014), the Family Planning indicators deteriorated, such as decline in contraceptive prevalence rate, negative shift in method mix from Long-Acting to Short-Acting that allows higher discontinuation rate, decreased utilization of public sector services by beneficiaries, and increased unmet need. HIV/AIDS rates is below 1%, however different socio-behavioural studies showed concentrated epidemics among men who have sex with men and intravenous drug users up to 6% in 2014. Egyptian youth received inadequate information about puberty from parents and health professionals, so they turn to sources, that may not be reliable[37]. Egypt still did not adopt sexuality education to be mainstreamed at national

[32] Challenges and strategies are discussed further by Component in Chapter 4: Findings, EQ1.
[33]World Bank http://data.worldbank.org/country/egypt-arab-republic
[34]Survey on Young People: http://egypt.unfpa.org/Images/Publication/2015_06/6be3baf2-61e3-4de4-bc9b-221f5180cd18.pdf
[35]UNDP Egypt's Progress towards Millennium Development Goals, 2015.
36 UNFPA CEPAP 2013-2017
37 Population Council, Reproductive health for Young People in Egypt. 2012.

education system and SRH services for young people are limited. While the maternal mortality ratio is well below the regional average (45 women of 100,000 die from pregnancy-related causes), the opposite is true for adolescent birth rates (43 births per 1,000 women aged 15-19).

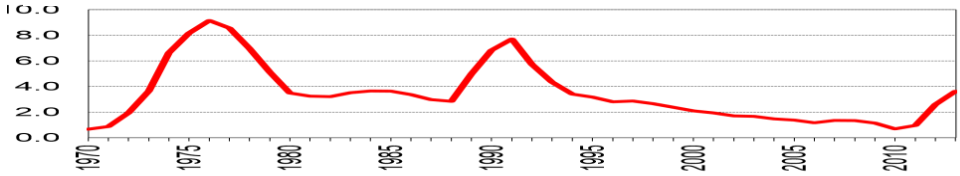
Egypt is a signatory of the Convention to Eliminate Discrimination against Women (CEDAW), and there are laws that support equality, however, implementation of laws and policies is weak, particularly regarding SGBV issues. Gender equality and women's empowerment stalled in terms of improvement for women and overall rural development. Egypt had a gender development index of 0.868. Nonetheless, in terms of gender inequality, it ranked 131 out of 155 countries. Nearly 44 per cent of adult women reach secondary education compared to 61 per cent for men. Agriculture is the sector providing most female employment, with an increase in women participating in contract farming38. One out of 3 women are exposed to violence and 92% of the women are mutilated according to DHS 2014[39].There have been some positive changes in the recent years that support women's empowerment, including a law on sexual harassment which passed in 2014, and an increase in the number of female parliamentarians from approximately 2% in 2012 to 14.9% in 2016. While the political will exists with the current administration for improvements in the status of women, there is still much to achieve to meet the needs of the female population.

Egypt recently has affirmed its commitment to the population issues according to the remarks of the Minister of foreign affairs in special session to discuss implementation of the Programme of Action of the International Conference on Population and Development Beyond. It also reflected the commitment of Egyptian government to the review process of ICPD. In February 2016, Egypt launched its national sustainable development strategy. Egypt Vision 2030, constitutes the national umbrella through which the Sustainable Development Goals will be implemented in Egypt. In December 2015, a national inter-ministerial committee, established by Prime Ministerial Decree was established to follow up on the implementation of the SDGs, and ensure proper alignment and integration of the SDGs with Egypt's sustainable development strategies and priorities.

2.2 Role of External Assistance

Egypt is currently one of the top 10 countries receiving Official Development Assistance (ODA). Net ODA received (% of GNI) in Egypt was 1.20 as of 2014. Its highest value over the past 49 years was 22.52 in 1975, while its lowest value was 0.15 in 1969.[40]

Figure 2: Trends in Aid to Egypt Since 1970 (USD billion, 2013 prices and exchange rates, 3-year average net ODA receipts)



38 Abdelali-Martini, M. (2011), 'Empowering Women in the Rural Labor Force with a Focus on Agricultural Employment in the Middle East and North Africa (MENA)', Expert Paper Expert Group Meeting of UN Women in cooperation with FAO, IFAD and WFP -Enabling rural women's economic empowerment: institutions, opportunities and Participation, presented in Accra, Ghana. Paper EGM/RW/2011/EP.9, September 2011

[39]Demographic Health Survey, 2014

[40] OECD. http://www.oecd.org/countries/egypt/ accessed November 2016.

Between 2005 and 2010, Egypt received US$ 6.9 billion in net ODA, while from 2011 onwards the amount increased to US$ 11.3 billion. Between 2005 and 2008, net ODA averaged 0.9 per cent of GNI and 3.3 per cent of total government spending, while between 2009 and 2013 net ODA decreased slightly to 0.8 per cent of GNI, but between 2009 and 2012 it slumped to 1.4 per cent of total government spending.

As figure 4 shows, in the year 2013-2014 in particular, the top 5 donors included the United Arab Emirates, Germany, Turkey and EU institutions and the United States, respectively, reflecting political changes and alignments both in the region and in Egypt. Figure 5 illustrates the distribution of assistance by sector.

Table 3 below shows ODA receipts for the current CP period (as data is available).[41] The percentage of current cycle allocations (USD millions) represents 0.25% of the value of the net ODA for the year 2013.

Figure 3: Top 10 Donors for Gross ODA in Egypt 2013-2014 (average), USD million

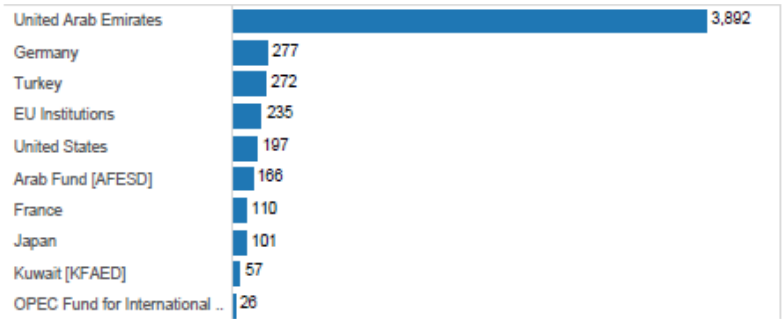


Figure 4: Bilateral ODA by Sector 2013-2014.

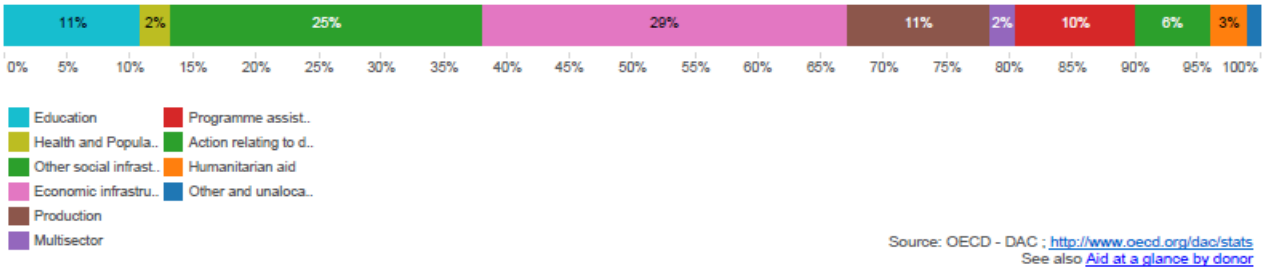


Table 4: Receipts for Egypt 2012-2014

	2012	2013	2014
Net ODA (USD million)	1,806.8	5,508.2	3,532.2
Net ODA/GNI (%)	0.7	2.1	1.3
Gross ODA (USD million)	2,635.5	6,442.8	4,505.0
Bilateral share (gross ODA) (%)	58.3	94.8	86.9
Net Private flows (USD million)	3,432.0	2,536.0	3,192.7
Total net receipts (USD million)	5,698.3	8,344.8	7,469.9

[41] Ibid.

CHAPTER 3: UN / UNFPA STRATEGIC RESPONSE AND PROGRAMME.

3.1: UN AND UNFPA STRATEGIC RESPONSE

UNFPA mandate complements many other UN agencies. Both UNFPA and UNICEF are mandated to work in the area of adolescents and young people. UNFPA work adjoins this of UNAIDS from the perspective of young women involved in sex work. UNFPA, UNICEF and UNWomen share the mandate of working on FGM. According to ICPD, RH is the sole playground of UNFPA. In September 2011, following an extensive Mid-Term Review of UNFPA's global portfolio and in light of the changing context within which UNFPA operates, a revised and more focused global UNFPA Strategic Plan 2014-2017 was adopted, with "SRH and reproductive rights placed squarely at the centre of the work of the organization,"[42] to advance towards the focus MDG5 – 5A and 5B. This corporate plan was complemented with a new business model. At this juncture, the 9th programmatic cycle had already begun in Egypt, with the UNDAF and UNFPA CP already drafted, and in effect.

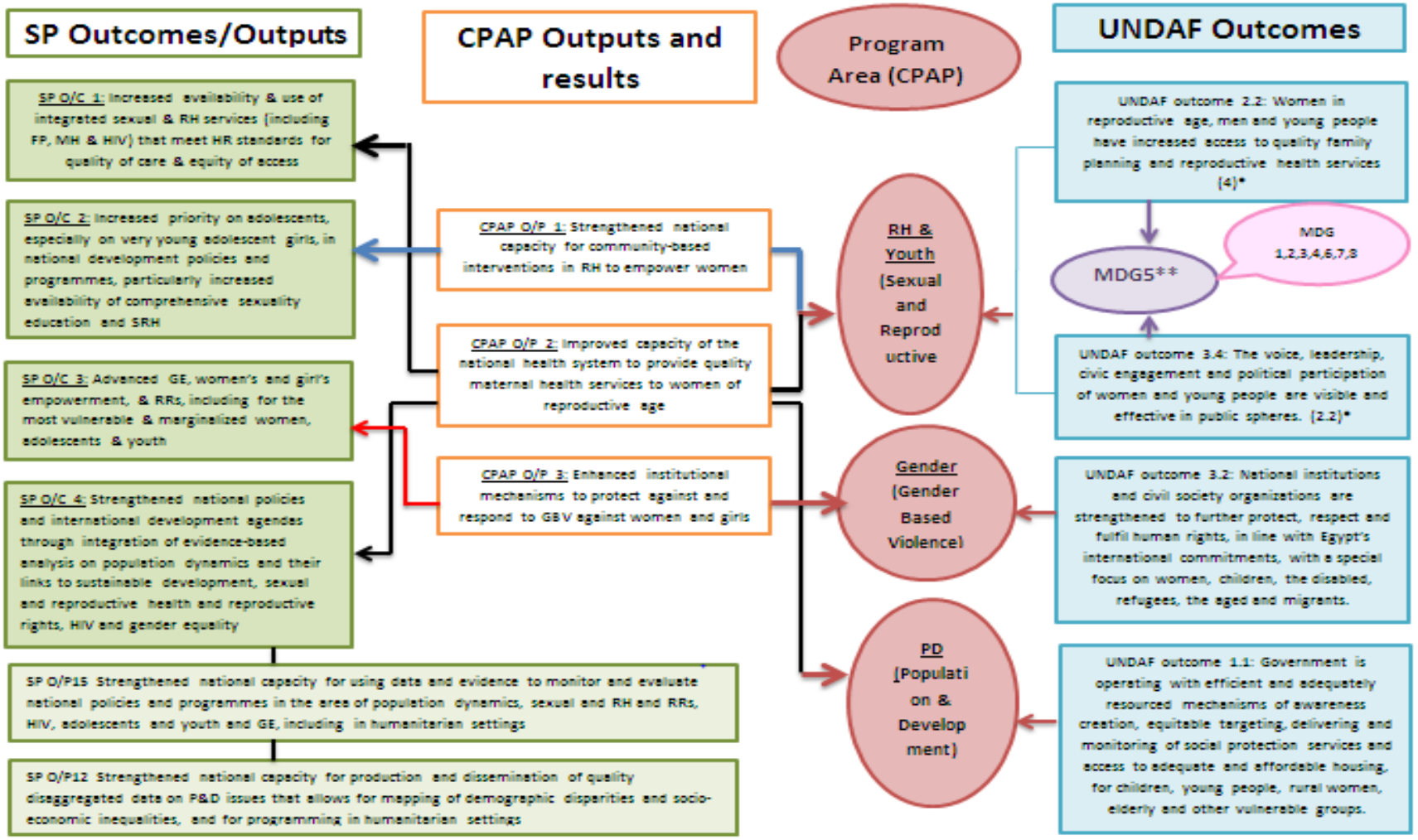
Ground work for the UNDAF had already begun in 2010, prior to the revolution, and had included priority areas identified in the Situation Analysis.[43] These included; institutional and human resource development; Primary health services especially in poor areas, and including assistance in dealing with Hepatitis C; Population challenges in all aspects, including supporting the rights of the elderly and the handicapped; and, facilitation of the achievement of the MDGs,[44] to which the UNFPA CPAP directly contributed through its stated outputs.

Figure 6 presents the intervention logic at the programmatic level and illustrates how the three main outputs of the CPAP contribute directly to the four outcomes of the SP, and how the UNDAF outcomes, are translated through the program areas (SRH, GBV, PD) to link with the SP outcomes. Intervention level AWPs, as well as UNFPA direct execution (DEX), spell out the activities by which the CPAP outputs are expected to be reached under each of the program areas.

The deviation from the SP comes in the form of direct technical support interventions implemented by UNFPA (full-package, red-grid). The business model of the SP categorized Egypt as a "yellow level" category, a lower-middle income country, with medium ability to finance its own programs; and, therefore, UNFPA support should be focused on "advocacy and policy dialogue/advice, and knowledge management."[45] However, the current programme interventions were drafted in 2013, prior to completion of the SP, and have strong capacity building and service delivery interventions. In fact, Outputs 1 and 2 of the CPAP focuses on strengthening capacities and explicitly focuses on capacity building at the community level. *It remains to be seen whether the classification was just, and taking into consideration the economic aftermath of the January 2011and 2013 revolutions, or whether findings from this cycle will indicate a need to phase out such interventions at the end of the current programme*.

[42]UNFPA Strategic Plan 2014-2017, p.4.
[43]In 2010, the UNCT decided that the Situation Analysis would act in the place of the usual Common Country Assessment, due to the in-depth scope and efforts; and wide range of both stakeholder and topic coverage within the document. The Situation Analysis was primarily led by Ministry of International Cooperation and UNDP Egypt.
[44] UNDG. 2010 Resident Coordinator Annual Report Egypt.
[45] UNFPA Strategic Plan, 2014-2017. Annex 14 and Annex 9.

Figure 5: Country Programme Intervention Logic



* UNDAF Outcome number according to "Planning Matrix for Monitoring and Evaluation -Progress Review Sept 2016".

** MDG 5a and 5b on maternal mortality and reproductive health are the central focus. Meanwhile, improving maternal health has a number of broader developmental impacts for the other MDGs.

3.2 UNFPA Response Through the Country Programme

3.2.1. Brief description of UNFPA previous cycle strategy, goals and achievements

The previous cycle strategy focused on Reproductive Health, Population and Development, and Gender. The largest portfolio was ***RH***, allocated more than 50% of the total budget, and with six main implementing partners, to support and enhance services to government institutions and major NGOs. The evaluation of the previous CP shows that within this component, there was a noticeable increase in demand for family planning services, and the quality of service was acceptable, with room for further improvement. There was a noted need to integrate family planning services with other programs, and to further enhance the skills of the providers. Work with persons living with HIV, showed UNFPA did contribute to strengthening the capacity of health providers to provide Voluntary Counselling and Testing (VCT), and that related material production was efficient and useful. There was room for greater improvement in advocacy for patients, and making service providers more comfortable working with HIV positive patients. There was stated need for more effective M&E in this program. Findings from the program on youth friendly clinics (YFC) show that while YFC were valued by youth, and there is high potential for sustainability, the clinics were under-utilized due to the novelty of the concept, requiring greater promotion. The focus of the ***PD*** program, allocated approximately 25% of program funds, was on IP capacity building and production of data for evidence-based policies, through two main projects focusing on gender plan monitoring and evaluation, and improving accessibility of population statistics. The former showed exceptional achievements of goals, including the establishment of a uniform national M&E system for gender plans and associated ministerial decrees to force implementation. The latter showed effective improvement in available data sources for enhanced accessibility by stakeholders. The ***Gender*** component was the smallest, allocated approximately 23% of the budget, and focusing on advocating campaigns and training material, with some training for youth and religious leaders. The results showed that a network of peer youth education for RH was indeed established and youth capacities built, the effectiveness of this network needed further evaluation. Religious leaders were satisfied with the training, and there was an indication of some behavioral changes. There was a stated need for more training material that is evidence based. Materials for media campaigns on sexual harassment were positively received by media personnel, and there was a reported positive effect on reporting on such issues in programming.

The results of the previous cycle were integrated into the current cycle, with some changes, as highlighted in sections below on intervention logic. Annex 4 provides a tabular format comparing the outputs of the current cycle to the previous cycle.

3.2.2. Current UNFPA COUNTRY PROGRAMME

The UNFPA CO response to the identified unmet needs, national development priorities and plans, UNFPA development and implementing partners' pledges for Egypt came through four Programme areas as reflected in the CPD 2013-17; they are: RH; MH; and GE. P&D was mainstreamed into the MH component. The following lines represent the intervention logic derived by the CPE evaluation team (ET) that reflects their understanding of the respective 9th Cycle Programme Components (RH, youth and adolescents, GBV, and P&D). This involved an in-depth desk/document review of annual work plans, quarterly reports, annual reports, CPDs, CPAPs, earlier evaluation studies, and many other reports, resources and conduction of CO interviews.

3.2.2.1 THE INTERVENTION LOGIC IN THE REPRODUCTIVE HEALTH AND RIGHTS (RHR) COMPONENT

RH component is a cumulative experience as many programmes continue from previous cycle. It follows outcomes 1,3 and 4 in the CPAP and this is translated into two outputs in the CPAP.

Output 1: Strengthened national capacities for community-based interventions in reproductive health to empower women and young people and Output 2: Improved capacity of the national health system to provide quality maternal health services to women of reproductive age

Which is linked mainly to UNDAF outcome 2.2. and to lesser extent to outcome 3.4 (as shown in the preceding figure 6) and is directly implemented through AWPs with MoH, Al Shehab Institute for Comprehensive Development, Etijah NGO and UNFPA direct implementation. The above initiatives are achieved through:

Support establishment of 30 model urban primary healthcare units redesigned and refurbished to become youth friendly. Create linkages between youth civic engagement in Egypt and youth sexual and reproductive health and reproductive rights, in line with UNFPA regional youth strategy. To be achieved through building capacities of youth centres, mainly in Assiut and Sohag, with the active engagement of civil society, to accommodate the needs of young people by providing a safe space where young people can work on self-development, peer development and community development.

Develop a social media strategy (inclusive of internet platforms, mobile applications and accessibility to other interactive platforms) with the aim of empowering young people through providing them with adequate information on reproductive health and rights and linking them to volunteering and capacity building opportunities, in addition to supporting career counselling. Support the Youth Peer Education Network (Y-PEER) geographical expansion, as well as, the extension of membership and outreach channels. Support the development of Behaviour Change Communication (BCC) strategy for married couples to make informed decisions to achieve healthy pregnancy outcomes. An assessment will be conducted to understand the role of socio-cultural influences, where the findings will be used to inform the development of the BCC strategy. A prospective impact evaluation (IE) is planned to be conducted to measure the true impact of the intervention. The pilot will cover a limited number of communities to be scaled up based on the IE results.

Geographically; the intervention is expanded beyond the main targeted governorates in the CPAP (Assiut and Sohag) as Y-PEER network will be expanded to work on national level, Shihab is covering Cairo and Alexandria and Etijah AWP extend to have different activities online through m3loma and also targeting NGOs in Sharkia governorate.

In the previous country program, the youth components focused on building the capacity of the governmental and non-governmental entities to support access of young people to SRH. The services were provided through local NGOs rather than governmental. Also, the capacity building focused on the management, planning and monitoring. In the current cycle; the current cycle tried to adopt national ownership by supporting the governmental to establish and support the youth friendly clinics. The capacity building is more toward community based interventions. In addition, there was expansion at the level of the youth network and the local NGOs to national levels.

Output 2*: Improved capacity of the national health system to provide quality maternal services to women of reproductive age*

linked with UNDAF outcome 2.2, which is cross-cutting with the UNDAF outcome and CPAP output above, and implemented by AWPs with; MOHP and population council, in addition to grant to Agha Khan foundation.

The planned interventions aim to strengthening the capacity of the regulatory body in the Ministry of Health and Population (MOHP), as well as, the medical syndicate in Sohag and Assiut to ensure operationalizing existing regulations while reinforcing the accountability of regulatory bodies overseeing physicians and malpractices. Support the Maternal and Child Health department at the Ministry of Health and Population in building cadres of

nurse-midwives to assist in home-deliveries, in response to the needs in rural Upper Egypt. Introduce the optimization of health workforce for effective family planning services through support of capacity building programs implemented by the MoHP with the aim to have at least one trained/specialized nurse on FP stationed in every service delivery point in the target areas. The intervention aims to address the high turnover of doctors that negatively affects the FP service provision in Egypt.

Support the revision of the contraceptive method mix in terms of clients' need and system capacity. Support the expansion of the monitoring system of service delivery through upgrading available applications on beneficiaries, LMIS, indicators on quality of service and effectiveness of supervision.

Support the production of national surveys such as the Survey of Young People in Egypt (SYPE) and DHS and policy papers to ensure evidence-based programming and policy making. In addition to promoting websites and social media platforms for dissemination of information to target audience, to conduct small scale opinion polls and knowledge assessment and initiate events and relevant celebrations to ensure wider dissemination of information.

Build the capacity of national relevant institutions to work with available data, produce policy briefs for advocacy purposes and to initiate informed and results based decision- making.

Geographically the main intervention is happening is Assiut and Sohag with the ministry of health and targeting the staff of MoHP at those governorates and at central level. SYPE and DHS are more products.

The output of this cycle is mainly continuation for output 2 and 3 in previous cycle. The main change is the focus on the targeted two governorates (Assiut and Sohag). The design of those intervention also preceded by baseline assessment to identify the intervention priorities in the two governorates.

3.2.2.2 THE INTERVENTION LOGIC IN THE GENDER EQUALITY (GE) COMPONENT

The Gender Equality (GE) component in the CPAP follows SP Outcome 3, and is specifically articulated, with a focus on GBV and FGM/C, under Output 3 of the CPAP:

> **Output 3**: ***Enhanced institutional mechanisms to protect and respond to gender-based violence against women and girls***

which is linked directly to UNDAF Outcome 3.2 (as shown in figure 6) and, is directly implemented through the AWPs: NCW (PGEG09); Al Azhar (PGEG08); BLESS (PN5890); NGOs Coalition (PN6186); National Population Council (PGEG02); and UNFPA execution Sexual Harassment Unit at Ain Shams and Assiut University.

And; **Output 2*: Improved capacity of the national health system to provide quality maternal services to women of reproductive age***

linked with UNDAF outcome 2.2, which is cross-cutting with the UNDFAP outcome and CPAP output above, and implemented by AWPs RCT with MOHP (PN6174) and Curative care (PGEG15).

These Outputs will be achieved through (a) generating evidence and analyzing the effects of gender-based violence on women's and girls' reproductive health, wellbeing and social and economic participation; b) advocating for the adoption of National Strategies to Combat Gender-Based Violence FGM and the enactment of protection legislations associated with them (c) integrating GBV health services in all public Service Delivery Points (SDPs) by developing medical protocols and services referral frameworks and strengthening capacity of service providers on management of gender-based violence; (d) building capacities of religious leaders to combat gender-based violence through raising the awareness of communities; (e) combating medicalization of female genital mutilation/cutting by creating awareness and raising capacities of among judiciary, prosecutors, forensics experts,

service providers and supporting community-led initiatives, and (f) addressing sexual harassment through the support of community service organizations advocacy, building alliances and school interventions with engagement of men and boys, and supporting the institutionalization of Anti-Sexual Harassment units in Universities. [46]

The planned interventions aim to strengthen institutional mechanisms from central policy level down to the community level through awareness raising, training, and advocacy. In this way, the program outputs provide comprehensive tools that will generate evidence-based policies, viable mechanisms for action, and building the relevant capacities to manage such mechanisms, in order to facilitate the process of institutionalization. This will be further supported by community-led initiatives that will provide on-the-ground support for the understanding and implementation of such mechanisms.

Geographically, the interventions initially focused on Cairo and Giza as essential locales for central counterparts, as well as Assiut and Sohag based on their identification as the poorest two governorates in Egypt. However, there has been scaling up to other governorates, particularly for the integration of GBV services in SDPs, and creating referral networks.

In the previous country program, gender was mainstreamed into the RH components through reproductive health and maternal health strategies, and the PD component in a strategy for nationwide gender planning, monitoring and evaluation. The previous cycle also had a small gender focused program[47]. It included as one of its strategies, awareness raising of Muslim religious leaders (RL) on reproductive rights. It has continued with this strategy focusing on awareness raising and capacity building for Muslim RL on GBV in particular, and has also included Christian RL. The previous cycle also had an awareness strategy that included a campaign against sexual harassment, and awareness raising for protection entities (judicial and police personnel). This cycle continues this awareness strategy by continuing to target protection personnel, and has included a new component on service delivery through its Medical Protocol program. In this way, it has comprehensively included strategies of prevention (awareness campaigns), protection (police and judiciary capacity building) and intervention (medical protocol and referral) for victims of GBV/FGM/C.

3.2.2.3 THE INTERVENTION LOGIC IN THE POPULATION AND DEVELOPMENT (PD) COMPONENT

PD was not a standalone Component in the 9th CP Cycle.[48] In order to align with the new corporate strategic direction, CO responded by linking the PD programmatic Component consequent to the SP 2014[49] namely to *SP Outcome 4*[50]. In addition, further links forged with two strategic outputs: first, *SP Output 12*; and, second, *SP Output 15* (see figure 6).[51] The consequent key results and activities that followed were mainstreamed into *CPAP Output 2* (same as YRH & GBV). The intervention strategies used to realize the expected outcome (SP O/C 4) and outputs focused on *upstream work. During the 9th Programme Cycle*, PD engaged in strategic partnership with NPC;[52] CAPMAS;[53] and the Governorates.[54] Main activities involved advocacy (NPS, EP, NPAP, plan & messages, documentary films on communities that succeeded in improving population characteristics, and calendar landmark national population day) and partnership building (NEX, & south-south and triangular cooperation, dissemination and capacity building), NPS and NPAP formulation and launch, instituting M&E/RF (population observatory) &

[46] UNFPA. Country Programme Action Plan between the Government of Egypt and UNFPA, 1 July 2013 –December 2017. P.11
[47] Ford, Kathleen, et.al. UNFPA Egypt Country Program Evaluation 2007-2011. January 2011
[48] neither in the CPD nor CPAP.
[49] i.e. at a later date to the original starting date of the CPD & CPAP.
[50] Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality
[51] NPC AWP 2016 & CAPMAS AWP 2016.
[52] The mandated executive arm of government charged with population dynamics and research-related issues.
[53] the supreme national data & statistics organ.
[54] the sub-national executive arm.

coordination modality, information and data ecosystems at the national level for tracking population dynamics and the SDGs (with focus on Goals 1 to 5 and 17)[55] and ICPD priority 16 indicators through dialoguing and awareness raising, and targeted media campaigns for BCC. In addition, activities in the field of knowledge management included updated population situation analysis, policy briefs, summative and baseline assessments for family planning and health services, benefit-cost analysis of FP in Egypt, debut composite indicators at the disaggregated governorial level. Geographical targeting planned for advocacy, policy dialogue/advice, and knowledge management, was supported by capacity building. However, the implementation of the EP is targeted centrally and NPAP for a set of governorates as per CPAP targeting, i.e. nationwide with focus on Greater Cairo; Assuitt and Sohag governorates. Special emphasis to women, youth and adolescents to be given at all levels. *Under the current and previous Programme Cycles*, PD continues to contribute to *UNDAF Outcome 1.1*.[56]

Although PD was second in rank on funding allocations in the 8th Programme Cycle, it was sublimed at the beginning of the 9th Programme Cycle mainstreamed under CPAP Output 2 on Maternal Health.[57] In the 8th Cycle, PD possessed two outcomes adjoined to couple of O/Ps. They revolved around developing institutionalized human-rights and evidence-based approaches at the national level, policy dialogue and knowledge products cross-cutting gender, poverty reduction, HIV prevention, YRH and the needs for vulnerable groups, similar to the main thrusts of PD under the 9th Programme Cycle. Major PD partners under the 8th Cycle comprised: MOHP, NPC, NCCM, NCW, IDSC, NCHR, NGOs and other institutions; whereas, in the current Cycle those were focused on: NPC, CAPMAS, and the Egyptian Parliament, same for a list of indirect stakeholders (e.g. Ministry of Education, Ministry of Planning, Ministry of International Cooperation, Ministry of Culture, MOSS, Ministry of Youth, SFD, NCCM, National Council for Special Needs etc.). Key activities continued from the previous cycle were: 1) the launch of a NPS & EP, developing an M&E system, and coordinating efforts for NPS; 2) improving accessibility of population statistics implemented earlier by IDSC[58] to NPC; and 3) continuation with population advocacy and media campaigning activities (e.g. media messages and TV spots), as well as knowledge products produced earlier (e.g. PSA and policy briefs[59]) by IDSC to Baseera, CEFRS[60] and others.

3.2.3. THE COUNTRY PROGRAMME FINANCIAL STRUCTURE[61][62]

The UNFPA 9th cycle (2013-17) total earmarked allocations stood at US$14 million compared to US$18 million in the previous cycle (i.e. years 2007-11). The amount of **US$13,034,674** was budgeted till end of Q3-2016.This is split between three country programme areas under the 9th CP Cycle is as follows: a) **US$7,435,360 (57%)** for RH, youth and adolescents; b) **US$4,728,801(36%)** for GBV; and c) **US$870,513 (6.68%)** for P&D. Figure 1 annex 8 shows the budget per year for each of the programme areas. In addition, **US$337,848** were allocated for program coordination activities.

Over the 9th Cycle period, total regular budget (RB) funds amounted to **US$10,401,347**, compared to **US$7,803,034**which came from other funding resources (OR). Figure 2 displays budgeted amount and the respective budget utilization amounts for RR and OR per each year in the 9th cycle, matched with corresponding percentages as illustrated in table 1.

[55] Although CAPMAS work plan was signed on the 4th quarter of 2016, it will be touched upon lightly to reflect initial steps towards the achievement of SP O/P 12 towards the end of the current CP.

[56] Government is operating with efficient and adequately resourced mechanisms of awareness creation, equitable targeting, delivering and monitoring of special protection services and access to adequate and affordable housing, for children, young people, rural women, elderly and other vulnerable groups (NPC AWP 2014 & 2016)—see Figure 6.

[57] sub-O/P 2.4, CPD/CPAP 2007-11 and CPD/CPAP 2013-17.

[58] Information and Decision Support Center; the Cabinet of Minister's Think Tank and data processor.

[59] Other policy briefs were produced along the Composite Indicators Governorates Atlas for Assuitt, Beheira, Ismailia, Mynia, Sharkeya, Sohag, and Giza.

[60] Nassar, Heba, and Jasmin Fouad (February 2015). Family Planning in Egypt is a Financial Investment: Benefit-Cost Analysis of Egypt Family Planning Program, 2014-2050, CEFRS, Cairo University.

[61] All raw data on financial figures provided in this section are from CO Atlas system.

[62] See Annex 8 for detailed graphic analytics of the CO CP financial structure

In addition, between mid-2013 and mid-2016, total expenditure amounted to **US$12,150,019** as disaggregated by programme area in table 2. Furthermore, budget and expenditure with respect to source of funding are shown in figure 3. There is a noticeable downward trend of RR budget, and alternatively expense outlays as the 9th cycle matures.
Moreover, partnered donor funding came from Norway on the main, followed by USA, and Japan, *inter alia*. Norway (NOA50, NOA52) assumes the highest rank of funding provisions to UNFPA, with 44% of the total donors'-based funds for the total program cycle. Main focus of Norwegian funding is on: enhancing reproductive health and rights, combating gender violence in Egypt, and population and development. Figure 4 shows the share of each prime donor in 9th programme cycle funds. Follows is Figure 5 portraying donor funds growth trends during years 2015 to 2016.

As for Japan funds (representing 6% share of total donors funding), they were directed to MoH for training and assessments, and RCT and providing women and adolescent girls safe spaces for Syrian refugees in Egypt, under the humanitarian response. USA funds (representing 8% share of total donors' funds) were geared towards several projects, including reproductive health and SGBV in Egypt, establishing youth friendly health services, and activities in the Syria regional refugee and resilience plan (3RP). On the other hand, the European commission - with 6% of donors' funds- had their availed outlays directed to lifesaving comprehensive obstetric and neonatal care services, and multi-sectoral gender based violence (GBV) prevention and response services for Syrian refugees and Egyptian host communities, Egypt. Other donors--including UNICEF, UNDP, UN Women, UNV, UNAIDS and WHO-- hit 36% share of donors' funds directed to the 2013 Survey of Young People in Egypt (SYPE), scaling-up outreach to vulnerable women in Cairo, and JP Egypt Women's Empowerment over the 9th Programme cycle.

CHAPTER 4: FINDINGS

This chapter is split into three sections: 1) findings by focus programme components responding to evaluation questions and criteria (relevance; efficiency; effectiveness; sustainability; and UNFPA strategic positioning) using

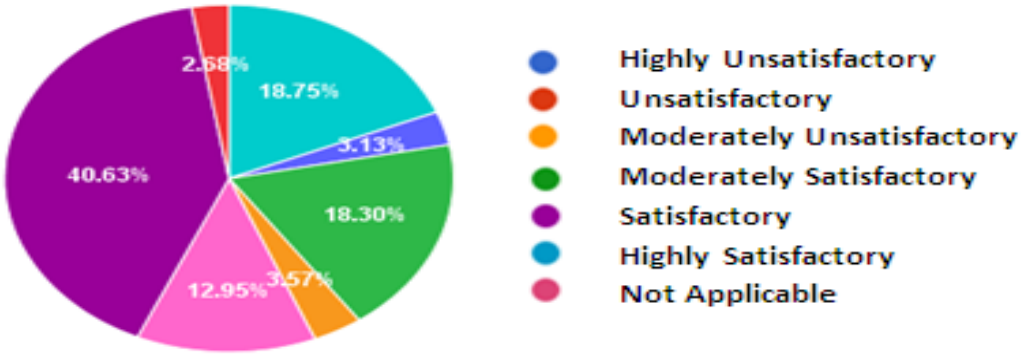
triangulated methodology;[6364] 2) overall composite country programme assessment based on online anonymous respondents' views; and 3) an overall assessment of the M&E function at CO during the 9th Cycle. The three focus programme areas are treated equally in the coming pages to reflect into upcoming CP programming, while setting aside funding allocations as sole credence criteria.

4.1 Relevance

EQ1: *To what extent are the interventions of UNFPA Egypt CP 2013-17 (1) relevant to the needs of the intended beneficiaries (women and young people); (2) in line with the government priorities; and (3) aligned with UNFPA policies and strategies? (4) to what extent has the CO been able to respond to changes in national needs and shifts caused by major political changes?*

Summary: The orientation of the 9th Cycle CP is highly relevant to beneficiaries, government, aligns to SP 2014 to some extent and is responsive to shifts in needs due to political changes. There are, still, some instances in which the current CP could have aligned better to needs; namely, had it relied on results of knowledge products, previous cycle CPE results, and concluded wider consultations with stakeholders. CO was responsive at varying degrees to shifted needs caused by major political changes.

Figure 6: Online survey EQ1 answers percentages (overall)



Online Survey Trends

***CP relevance to intended beneficiaries:** 51.8% of respondents thought UNFPA 9th Cycle CP interventions are relevant, and 16.1% as highly satisfactory to the intended need of beneficiaries.

***CP relevance to government priorities**: The majority of respondents (44.6%) believe that UNFPA's CP move satisfactorily in line with government priorities, 21.4% as highly satisfactory, and 17.9% as moderately satisfactory.

***CP relevance to UNFPA policies and strategies:** Most respondents (42.9%) think 9th Cycle CP aligned with UNFPA policies and strategies, 25% highly satisfactory, and 10.7% as moderately satisfactory, while 14.3% do not know.

***CO response to changes in national needs and shifts caused by major political changes** under current CP: The majority of respondents (28.6%) chose moderately satisfactory, 23.2% satisfactory, 19.6% do not know, 12.5% highly satisfactory, and 6.1% highly unsatisfactory.

[63] Summary findings for each component under each evaluation question/criteria is available in Annex 18: Evaluation Matrix. For purposes of consistency and only for EQ3, references are given to respective findings of sub-questions.
[64] See Annex 17 for full online survey results, including an analysis of explanatory comments and remarks of respondents for each evaluation question and sub-question.

Youth and Reproductive Health Component

Planning for reproductive health component was based on the findings of the national surveys and data available; mainly DHS (2014) and human development report (2008).[65]In addition to the needs assessment research which was conducted specifically for the health needs of Assiut and Sohag in 2014.[66] Annual planning was done in collaboration with Ministry of Health team according to the national strategic priorities. The Ministry of Health reported joint planning in agreement with the UNFPA and confirmed the relevance of UNFPA programmes at government level.[67] There was no participation for end beneficiaries at planning stage, trainers or team of the directorates in Assiut and Sohag. The contribution of the current CPAP extended to very fundamental participation in two national surveys which are DHS, 2014 and SYPE, 2014. UNFPA support created evidence through those surveys to assess the national needs for youth and reproductive health. UNFPA also provided support to the development of National study on the epidemiology and reasons behind the high caesarian section in Egypt.[68] UNFPA was fully engaged in the development of the strategic plan for family planning with the ministry of health, the Ministry acknowledges UNFPA's role and ensures its involvement in the next strategic plan as well.

The responsiveness of the reproductive health programmes was positively perceived among the different key informants. Ministry of health witnessed high turn-over among senior management in different directorate.[69] Accordingly, this change in management exposed the agreed planning to amendments; to which UNFPA was able to adopt in highly responsive way. However, this amendment of plan came on the price of the alignment with the global UNFPA strategic plan for 2014-2017. Egypt is entitled for advocacy and knowledge management according to the mode of engagement of UNFPA strategic plan. In the current CPAP; the main budget spent under the reproductive health was assigned to services delivery.[70] The high responsiveness of UNFPA CO also affected the utilization of the other knowledge resources for example; the main recommendations of the needs assessment research conducted in Assiut and Sohag were not put in action.[71]

Youth component activities were designed according to the survey of young people conducted in 2009, and the second report done in 2014 following same beneficiaries. Despite the fact that, there is no national strategy for young people, ministry of youth policy includes three pillars; political, social and economic empowerment for youth. The mandate to respond to young people health needs is divided among different stakeholders, namely the ministry of youth, ministry of health, media and civil society. UNFPA youth component was aligned mainly with the UNFPA global strategic views for young people. The youth programmes tried to expand and diversify its activities to ensure multispectral approach. Youth friendly clinics moved inside ministry of health to ensure ownership of the programme. Y-Peer worked to expand their network nationally and their activities to cover new aspects including gender issues and humanitarian component.[72] HIV/AIDS related activities continued to be implemented by the civil society, which was highly relevant at the moment taking into consideration the reluctance of the government to adopt harm reduction approach required for concentrated epidemic in Egypt.[73]

Youth component evolvement and approach in the current cycle was not examined against evidence. Youth friendly clinics, previously evaluated, showed different challenges facing the clinics and its ability to attract young people among other challenges.[74] Youth and adolescents programme have been evaluated by UNFPA evaluation office among other four countries. However, the recommendation in the report were not considered yet in the report. The

[65]Data from DHS and HDR utilized in the different AWPs proposals; and online survey.
[66]Assessment was conducted by external consultant in 2014
[67]Interviews with key informants of Ministry of Health
[68]Mentioned studies included other partners like population Council and WHO.
[69]IDIs with key informants in MoH.
[70]UNFPA changed their original plans and bought contraceptive commodities to MoH per request of MoH.
[71]Comparison between the recommendation and current activities of CPAP
[72]Y Peer manual for FGM and new structure.
[73]Bio behavioral survey for HIV/AIDS and UNDAIDS CO.
[74]Population council study – mysterious client and FHI assessment for EFPA Youth friendly clinics.

findings of current evaluation affirm the previous evaluation results. In addition to that, The impact of long running programme like Y-peer approach has not been assessed in the last two cycles, Specially with the new expansion to new topics is not examined against evidence to ensure its relevance to humanitarian contexts or gender issues.[75]

Gender Equity Component

Although the Egyptian Constitution provides equality for both sexes, many aspects of the law, and a number of traditional and patriarchal cultural practices and beliefs, enable gender based violence (GBV) in all its forms to be a tolerated social norm. And while gins have been made in some legislation and in opening political dialogue, more needs to be done to capitalize on those efforts.

The Social Research Centre (SRC) at the American University in Cairo (AUC) published a report in 2008 linking domestic violence to certain women's empowerment indicators. The study was a pilot, and findings indicated that women of all social backgrounds were vulnerable to GBV.[76]Since 2011, the discourse on violence against women has changed dramatically to focus on issues of sexual harassment and violence in the public sphere, and a number of organisations became active and vocal on the front of SGBV. In June 2014, a law was passed that for the first time specifically defined sexual harassment and related legal consequences. That same year, the Egypt Universal Periodic Review (UPR) 2014 report garnered 171 recommendations for action to be taken by Government of Egypt (GOE), and 25 of those recommendations pertained to the area of women's rights in particular, including combating aspects of violence and training for police and judiciary.[77] In 2015, the Egypt Demographic Health Survey stated three in ten ever married women age 15-49 years in Egypt have ever experienced some form of spousal violence with 25 percent saying they were subjected to physical violence. And, around 9 in 10 women age 15-49 have undergone female genital mutilation.[78]

The severity and importance of the situation was highlighted in the current 9th CP, by defining Gender Equity as a standalone component where previously related interventions had been aligned under Population Development (PD) and Reproductive Health (RH) components. Gender equality is recognized in the UNFPA strategic plan as a crucial enabling component to meet its 'bull-eye' target, and the component is generally relevant to the overall reproductive health rights of women.

As gender issues lend themselves to a myriad of programming, the key to assessing relevance is to examine the types of interventions, partners and activities, and whether they are the most relevant to create multiplier effects and reach results. While the CPAP continually identifies and asserts the governorates of Assiut and Sohag as primary focus geographical areas due to extremely high levels of poverty, interventions are implemented in other governorates, with no evidence of pre-planning, needs assessment or baseline interventions. And, none of the interventions included a component or activity that would allow collation of data in manner that effectively contributes to CPAP and UNDAF indicators. Furthermore, an assessment of the GBV capacities of the CO and IPs was conducted in 2013, and pointed to need to strengthen various mechanisms, and a need for greater strategic level

[75]No evidence provided on that.

[76] El Sheneity, Sahar and Mulki Al- Sharmani. Combatting Violence against Egyptian Women: Empowerment and Domestic Violence. Social Research Centre, AUC, 2008. Cairo. http://dar.aucegypt.edu/handle/10526/2931. Accessed November 2016.

[77] Universal Periodic Review. UPR Info. Egypt Recommendations. http://www.upr-info.org/database/index.php?limit=0&f_SUR=52&f_SMR=All&order=&orderDir=ASC&orderP=true&f_Issue=All&searchReco=&resultMax=300&response=&action_type=&session=&SuRRgrp=&SuROrg=&SMRRgrp=&SMROrg=&pledges=RecoOnly. Accessed December 2016.

[78] Ministry of Health and Population [Egypt], El-Zanaty and Associates [Egypt], and ICF International. 2015. Egypt Health Issues Survey 2015. Cairo, Egypt and Rockville, Maryland, USA: Ministry of Health and Population and ICF International. https://dhsprogram.com/pubs/pdf/FR313/FR313.pdf. Accessed December 2017.

advocacy at MoHP to ensure that the institution is aware of how SGBV issues can relate to the Ministry's overall programming.[79]There is no evidence these findings being incorporated into the programming and AWP's.

Regarding responsiveness of the CO, most IP's disagree as to the extent thereof. While some partners for smaller scale interventions report a slow but supportive response, other partners with larger scale interventions report that there was more a focus on reaching milestones, rather than meeting challenges associated with government turnover, and sensitivity of the topics at hand.

With a focus on gender equity and the impact of SGBV on reproductive health, the most directly relevant interventions are the JP FGM partnerships, the production of the Medical Protocol and the associated trainings for service providers, as well as the GBV costing study. And although the UNFPA SP specifically categorizes Egypt as a 'Yellow level" country and designates activities at the strategic advocacy and knowledge management levels, implementing partners have indicated that without direct interventions, the government would not have the funds or technical ability or direction to implement SGBV activities.

Population and Development Component

The 9th Cycle CP 2013-17 came after two revolutions, a regime that was against the principles of PD (Moslem Brotherhood), growing population, declining economic growth and political instability. This Cycle is considered atypical, and hence surrounded by expanded social, economic and political challenges. CP 2013-17, including PD as a supreme enabler, was formulated on a set of key documents; namely, CPD 2013; CPAP 2013; UNDAF 2013-17 based a Situation Analysis (2010)[80]; MDG Progress Reports (2016); Vision 2030: Sustainable Development Strategy—SDS (2014); and SP (2014).The following lines give special reference to PD which is an enabler component as per SP 2014-17 focused mainly on central-level policy advocacy and KM interventions.

Population issues and dynamics are multi-dimensional (i.e. population increase, population distribution, and population characteristics), which are the crux of PD component. They continued to be one of the major challenges facing development efforts in Egypt. In 2010, population growth rate stood at around 2% with more than 90% of the population living on less than 10% of the land, putting excessive pressures on natural resources, as well as education, health services and employment opportunities. Former President Mubarak launched the past NPS in 2008 and established a Ministry of State for Family and Population in March 2009. During the period 2008-2010, the most important achievement of NPC was activating the National Strategic Population Plan (NSPP) for the period up to 2012.[81] Nationally, MDG progress reports showed: Improved maternal health was not achieved due to regional disparities and inefficient health care and FP services (MDG 5).[8283] Related to PD, Vision 2030 contained 4 pillars of importance handling the health,[84] education sectors, social justice, transparency and efficiency of government institutions.[85] The third UNDAF strategic framework report was built on the results of the CAA, UNFPA CO 9th Cycle CP (2013-17) was tied to 4 key strategic outcomes where PD tied to Outcome 1.1.[86] PD came at the forefront to: "support the elaboration and dissemination of evidence-based information and data on vulnerable populations,

[79] Guenena, Nemaat. Assessment of GBV capacities of UNFPA Country Office and Implementing Partners. December, 2013.
[80]Also taken as the Common Country Assessment (CCA).
[81]Handoussa, Heba (2010). Situation Analysis (SA/CCA): Key Development Challenges Facing Egypt.
[82]global partnership for development and aid effectiveness.
[83] MOIC. SDGs: Egypt National Review Report for the Input to the 2016 High-Level Political Forum (HLPF) for Sustainable Development, pp. 49-51.
[84] The vision for the health sector stated: "All Egyptians enjoy a healthy, safe, and secure life through an integrated, accessible, high quality, and universal health care system capable of improving health conditions through early intervention, and preventive coverage. Ensuring protection for the vulnerable, and achieving satisfaction of citizens and health care employees. This will lead to prosperity, welfare, happiness, as well as social and economic development, which will qualify Egypt to become a leader in the field of healthcare services and research in the Arab world and Africa. The 8 programs involved are: adopting inclusive healthcare coverage; improving the quality of health care service provision; enhancing preventive and health care programs; improving health sector governance; decentralize health services provision; developing information and technological infrastructure to support health care systems; developing human resource management in the health sector; and developing the pharmaceutical sector.
[85]MOP/MOP,M, & AR. Vision 2015-2030: SDS, 2014.
[86]See Effects Diagram for details of UNDAF-CP (2013-17) outcomes.

specifically young people and rural women, for programming and policy making purposes,"[87] which ties with all previously mentioned documents. In addition, CPD (2013) affirmed the same deteriorating national poverty trends, contraceptive prevalence issues, maternal health, FGM/GBV. CPD excerpted lessons learned from CPE 2011,[88] leading to the design of the 9th Cycle CP. Aspects of relevance were systems enhancement, advocacy and evidence-based policy dialogue at the central level, while capacity development and community-based interventions aimed to focus on needy governorates targeting: Assiut and Sohag. The mentioned national development priorities in CPD were summarized as: (a) poverty alleviation through pro-poor growth and equity; (b) quality basic services; and (c) democratic governance through decentralization, civic engagement and human rights; and PD challenge was reflected under the MH component, Output 2.[89] Furthermore, the CPAP mid 2013-17 signed between MOP&IC and UNFPA CO elaborated government needs based on lessons learned after then:[90] 1) to develop a population data base and a yearly population report (PSA); 2) production of a number of operations research and studies to promote evidence-based interventions and to assist policy making (KM); 3) a need for improved M&E interventions to better analyse development progress; and 4) baseline surveys to capture interventions (DHS & SYPE). PD was reflected in CPAP to respond government needs as mainstreamed in output 2.[91] SP 2014 came with improvements to the positioning of PD responding to government needs, by reflecting the reduced Component under the CP to a supreme enabler encompassing all components resulting in its linkage to SP O/P 15 and SP O/P 12 so as to strengthen national capacity to produce and use disaggregated quality data and evidence to M&E national policies and programmes in the areas of PD, YRH, HIV, GE, including in humanitarian settings.[92]There is no evidence that CO documents were consulted or dialogued publicly. Having said that and upon the strategic directives of HQ, PD was re-linked and expanded to the new strategic objectives within the SP to comply within the 2-year alignment period. PD AWPs, ARs 2014, 2015, and 2016 align UNFPA SP Outcome 4 and SP Outputs (12 & 15), lesser so or, better said, looser to CPAP Output 2 and to the UNDAF one-size-fits-all outcome 1.1. As much as the original CPD/CPAP, no evidence of consultation or CPD/CPAP amendments between CO and GOE post SP 2014 was neither found, which infers missed collaboration opportunities and improved accountability.

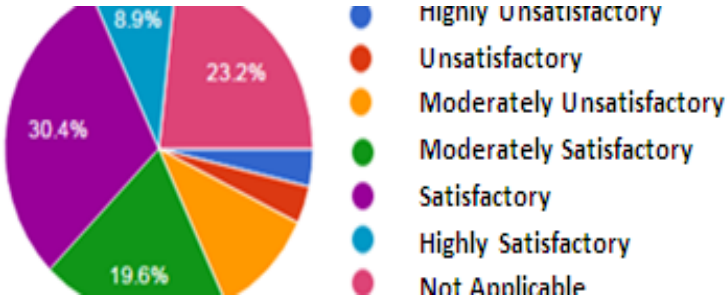
4.2 Efficiency

EQ2: *To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country program?*

Summary:Although generally satisfactory, the absence of a strong commitment to the monitoring and evaluation function at CO during the current cycle characterized by massive contextual changes (political, human and intermittent CO leadership) led to efficiency drawbacks on programme implementation. Efficient record keeping on project activities, documents, deliverables, knowledge products, beneficiaries, periodic changes in AWPs, PMOs staff changes, reliance on external consultancies and mismatched credentials for tasks required, focus on financial expenditures than results and sustainability, problematic contractual effectuation on the side of IPs, and over-worked staff at CO with zero capacity building budget were not uncommon efficiency markers influencing input-output optimization during the 9th Cycle.

[87]UNDAF (2013-17). Achieving MDGs+ with Inclusive Growth, Freedom, Social Justice and Dignity.
[88]UNFPA CO CPE 2009.
[89]Improved capacity of the national health system to provide quality maternal health services to women of reproductive age.
[90] No evidence received relating to wide consultation beyond the IPs and signatory institutions.
[91]CPAP O/P 2: Improved capacity of the national health system to provide quality maternal health services to women of reproductive age.
[92]See Effects Diagram; NPC AWPs 2015 & 2016; and CAPMAS AWP 2016.

Figure 7: Online Survey EQ2 answers percentages



Online Survey Trends: * **Overall,** the majority of respondents (30.4%) were satisfied, followed by 23.2% who do not know, and 19.6% who thought UNFPA was moderately satisfactory making good use of its human, financial and technical resources in achieving the results of its 9th Cycle CP.

***Human:** Although most responses (28.6%) did not know, equally 28.6% thought CO human capacity as satisfactory, and 12.5% as highly satisfactory. The majority of comments affirmed the inconsistency of the technical and human quality of UNFPA CO staff.

***Financial:** The financial competence of the CO is by far one of the satisfactory (37.5%) resources available, and 8.9% of respondents consider it highly satisfactory. And, 28.6% do not seem to be able to respond to this question.

***Technical**: The majority of responses thought UNFPA CO technical competence as satisfactory (39.3%), 26.8% did not know, and 7.1% thought it unsatisfactory which is equally as highly unsatisfactory (7.1%).

Youth and Reproductive Health Component

Youth and reproductive health programmes represent about 57% of the total budget of CPAP[93]. This budget is managed technically by two staff at the level of NOA and NOB[94]. The holders of those two positions changed each in the current cycle once which associated with vacant periods. The monitoring system also changed for UNFPA in the current cycle[95]. As mentioned earlier, limited staff number affected sufficient monitoring of the activities that were implemented in Assiut and Sohag governorate, without physical presence of UNFPA in those locations. The previous issues created challenge for UNFPA to conduct sufficient follow up for the different activities among different work plans and to handle the high weight of the work[96]. However, UNFPA team managed to conduct high rates of delivery in the current cycle. They also managed the financial support to the different partners within the limitation of the system[97].

The ability to provide technical support was perceived differently among different implementing partners[98]. Some partners perceived the role of UNFPA as monitoring role for the approved annual work plans activities only with minimal role in technical support. The implementing partners for youth component reported that; technical team were usually late to review quarter reports and knowledge products produced as part of the annual plan activities. In other cases; implementing partners for youth component reported no response at all from the country office team.

[93]Financial analysis provided by UNFPA CO.
[94] UNFPA Organogram 2015 and 2016
[95]SIS system entered into action late 2014.
[96]Number of the reported quality check visits to the governorates was relatively low.
[97]Progress report 2013/14/15.
[98]Interviews with Implementing partners; and online survey.

Other partners reported valuable technical input from UNFPA staff in the process of design and implementation of the different work plans specially for RH component. Worth mention is that, the UNFPA CO staff; counted largely on, the UNFPA regional office and headquarter for technical support and advice as needed specially for designing the indicators for each project, in addition to the assistance of external consultant to support the implementing partners where required.

Although the CPAP is a five years' plan with the different implementing partners, the financial and technical systems, require quarter reporting from the different implementing partners and an annual work plan. Different implementing partners showed dissatisfaction about the current system. They complained that current system's requirements, delayed implementation for almost four months of each year. It also creates annual gaps between the different work plans, which affect the sustainability of the project and the ability to serve the beneficiaries in timely manner. The gap usually covers the time for report/annual plan submission, review, response and funding transfer. Different implementing partners felt the need for annual approved plan and more flexible system for technical and financial reporting[99]. Another reported challenge was the youth groups worked under umbrella of Etijah, as it created pressure on both sides to facilitate the work. Etijah is local NGO which needs to comply with legal and administrative rules and culture in their activities. Meanwhile, Y-Peer and M3loma do not have legal status and want to keep their autonomy away from Etijah supervision. The legal status of Y-Peer and M3loma need to be discussed to ease such pressure. Tasks, expectations and responsibilities need to be clearly identified.

The organogram of the country office does not have monitoring and evaluation function. The function is distributed between the assistant representative and a programme associate in the office[100]. UNFPA staff exerted effort to develop monitoring process within available time and resources for example there is midwifery assessment for trained midwives in Sohag in Sept 2016. The monitoring system for UNFPA covered identification of lessons learnt and success stories in the annual reviews especially for youth component. However, there is area of improvement to ensure proper story writing and beneficiary tracking systems and to add qualitative information in the quarter reports. Also, to create participatory monitoring can lead to more efficient corrective actions. There is no accessible database for the beneficiaries who received the services of UNFPA in the last cycle, except for the direct activities implemented by NGOs that worked with youth component (Shehab and[101] Etijah). Such situation created difficulty in proper sampling for the different interviews and focus group discussions.

The current work load and function distribution need to be reconsidered at CO to improve the ability of the staff to provide proper monitoring and to strengthen the monitoring function in the office. The CO team is required to strengthen the linkage with the technical team in the regional office to benefit from the technical support they can provide.

Gender Equity Component

The Gender Equity component is managed by a (former) PMO (NOB), the FGM Coordinator and a part time Gender consultant. It comprises approximately 37% of the Budget of the CO for the current programme cycle. There has been a steady increase in budget allocations during the program cycle from US65,100 in mid-2013, to US771,824 in 2014, and US 1,993,863 in 2016.[102] In some cases, IPs reported that the budget was not necessarily in proportion to task at hand.[103]

[99]Mainly governmental partners requested that.
[100]Interview with Programme Associate responsible for M&E. See section 4.7: M&E at UNFPA CO.
[101]Some lists are available for Y-Peer and MoH but its not complete and do not have basic contacts.
[102] Financial documents provided by Evaluation Manager.
[103] For example, The RCT capacity building programs, targeting doctors and nurses at a national level was allocated 557,868 over 3 years. The budget for the humanitarian program implemented by CARE (267,107) and AMU had resource allocations of (270,251) totaled $537,355[103] for interventions that were planned for only one year, and for which implementation was late to start, leaving only 6—8 months for implementation.

Follow up with IPs on implementation is weak. Many IPs have submitted no quarterly reporting[104] and; those reports submitted are not uniform formats, with some as long narrative, some in short form, and some in table form.[105] And, within those, reporting is process/activity based, not results based against indicators in the AWPs. IPs have stated that there is no feedback on reports, or comments. More importantly, they do not feel that any of the challenges, information, or feedback is used in AWPs or planning for upcoming year.

Financial liquidity for projects is affected at the end of every quarter, with up to a four-week delay reported by IPs before cheques are available from UNFPA CO, and end of year processes often leave partners without signed AWPs and related funds up until March of the new fiscal year. These delays affect implementation and result in actual operational time being reduced to 7-8 months out of the year.

Some technical support through the CO is through consultants. In cases where IPs hire consultants directly, there is no evidence of involvement or follow-up by UNFPA. While all IPs have greatly applauded the role and involvement of the former PMO, they feel she was over stretched, and are concerned about replacement staffers. Expenditures of GE interventions reflect between 89-100% which is not consistent with quality of outputs of all the interventions. There is a tendency to tie results to financial expenditures by IPs, as opposed to results and outcomes that feed into indicators, and sustainability of results.

The efficiency of the GE component can be further strengthened with better planning for interventions, and allocating the appropriate level of financial and human capital resources to the planned interventions. There is also a need for more effective monitoring of interventions and incorporating feedback from IPs. Overall planning, adherence to reporting deadlines and financial allocations needs to take into account lag times in activity. Reporting is not regular, or uniform between IPs, and is process based.

Population and Development Component

Till end of 2015, the PD component was managed by an expatriate JPO, and now by a Programme Associate (G7) who holds a postgraduate degree in PD. According to SP 2014-17, PD work comprises 15.4% of corporate programming. During CP 2007-11, PD represented 24% of CP, while in CP 2013-17 it represented 6% only[106] and was mainstreamed under output 2 in CP without clear indicators. PD interventions implemented at NPC was performed through a non-institutionalized PMU composed of 3 consultants, 2 of which appeared in CO organogram and the third recruited via NPC[107][108] The PMU staff relay the AWP to CO for approval. Delays in signature of AWPs were noted.[109] However, fund transfers are timely within 7-10 days to a special project account opened at the Central Bank of Egypt. PMU staff acquire coaching from CO to complete the FACE form and audit requirements. As much as there were delays on AWP, IP counterpart financial and administrative matched delays led to fund transfer from a quarter to the other to enable payments due or contracts signature of independent consultants recruited under the project delaying timely delivery.[110] This led to numerous AWP amendments throughout the financial year, and delays in activities realized an efficient manner. In addition, end of year fund returns experienced were not uncommon. Audit reports for high-risk (government) IPs are responded to on timely manner and satisfactorily to CO with supporting documents.[111] Furthermore, a systematic financial filing system is held, however other project documentation relating to program delivery not backed up and lost nor a complete data-

[104] NCW on strategy, Al Azhar, AMU
[105] AWP Progress reports BLESS, NCW/CAPMAS, RCT.
[106] Analysis of evaluation team based on financial figures received from CO. See section 3.2.3 and Annex 8.
[107] Key informant interviews, NPC& CO.
[108] See Annex 3: CO Organigram, October 2016. HQ BOA auditors requested removal from organigram to align with corporate rules and procedures (KII, CO).
[109] NPC AWPs for 2014, 2015, and 2016; and CAPMAS AWP 2016.
[110] NPC Quarterly progress reports.
[111] NPC Key informant interviews; 2013 and 2015 audit reports; and sample response.

base of beneficiaries is available,[112]for updates and sharing between IPs and CO. Neither party seemed interested on this endeavour while activities are reported against CP output 2 with mismatched activities that are tied to financial expenditures than SP O/P 15 to which PD is tied for NPC. Moreover, worth noting that IPs fiscal year accounts' closure mismatch with CO's financial year beginning and end dates. This causes issues with contracting programme consultants and hence start and end of tasks. Some reviewed resumes of contracted consultants by IPs show a mismatch between credentials and the TORs for which they are contracted. At times, consulting contracts were rather implemented through the DEX modality to avoid bureaucratic delays at IPs. Corrective measures were recently taken on the side of an IP to improve efficient delivery.[113] This could have been defrayed if GOE IPs subject themselves to organizational capacity assessments prior to signature of cooperation MOUs. Light touch assessments are "sometimes" conducted by CO. Conversely, CAPMAS[114] has signed an AWP with CO (with delays beyond Q4-2016 beginning), though has subjected itself voluntarily to an OECD organizational capacity assessment, without being asked by CO. Despite signed AWP, CAPMAS was not assessed, though its organizational strength was shown in its efficient completion of deliverables on time. In PD, *inter alia*, there is a tendency to tie results to financial expenditures by IPs, as opposed to results and outcomes that feed into indicators, and sustainability of results. CO follow up on delivery of activities is at arms-length and is reliant mostly on IP reports which are merely copied into corporate quarterly and annual reports.

Both IPs noted pressures imposed by CO for meeting milestones. More encumbrances were fathomed by one IP who suffered from the consequences of the unstable political environment, compared to the other. While the CO takes reactive stance to IP requests in the AWP than offer technical and policy advice on related subjects, this seemed non-problematic with IPs with stronger organizational capacity and leadership stability who seemed more aware of their needs. This emphasizes the importance of concluding an organizational capacity assessment for IPs prior to partnership to identify and agree collaboratively on needs on sound and solid basis.

Nevertheless, the responsive stance of CO to the requests of IPs came at a price. NPC is standing at the moment with a launched NPS in November 2014 under the patronage of the H.E. the President of Egypt and presence of the Former PM, together with a related 5-year executive plan (2015-30) un-cascading fully to targeted grass roots.[115] An LE290 million to execute the NPS were returned to the Ministry of Finance upon abolishing the Ministry of Population in October 2015, leaving an ambitious national strategy matching with Vision 2030 time profile and objectives unfunded.[116] PD supported the development of a set of primary and secondary indicators to the output level with envisioned results measurement to the outcome and impact levels.[117] This does not seem to link clearly to the pillars of the strategy with further required for operationalization and up-scaling nationwide at the governorial level to generate data, results that can be monitored and evaluated, which poses questions on expenditure efficiency and ability to realize development outcomes eventually as the situation stands at the moment. Once an integrated multi-sectoral population-related database exists and is operational, this will serve component objectives enhancing efficiency, especially supporting the NPS' M&E system.

Not until recently,[118] a newly appointed RO backstopping Data and Policy Advisor (and Former Minister of Population, H.E. Prof. Dr Hala Youssef) to advice the now PD Associate and avail regional experience, South-South experience in the field through partnered relations, lessons learned and good practices. The CO organogram undermines its human capital.[119] With no budget for training and reliance on online learning on generic leadership

[112]Evaluation team review of incomplete and/or untraceable beneficiaries' lists provided by IP to CO for the first time.
[113]NPC key informant interviews.
[114] As mentioned in intervention logic section, implementation of work with CAPMAS started in Q4-2016, while discussions for cooperation started in previous quarter.
[115] National Population Strategy 2015-2030; executive plan 2015-2020; and NPC key informant interviews.
[116] NPC and Baseera key informant interviews.
[117]Observatory Indicators Manual (undated).
[118]13 November 2016.
[119] UNFPA CO organigram 2015 and 2016, CO key informant interviews. Most CO employees are placed at levels below the credentials held.

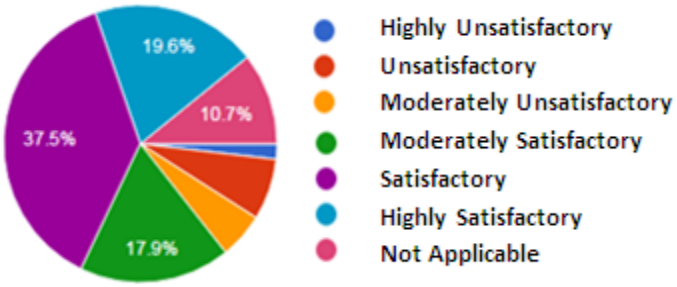
or soft skills training,[120] staff limited number and work overload prevents them from expanding their knowledge on most-up-to-date issues in their areas of specialization, leaving IPs unguided with the logic for the activity-based interventions and renders them (IPs) as well non-cognizant of strategic aspects (e.g. SPs, RBM, TOCs, Logframe analyses, outcome mapping etc.) to which they should align. SIS/My results proved to be an addition in the same direction, with reporting sections laying out challenges and lessons learnt, though without in depth analysis. The importance of the PD area has attracted OR funding during 2015-16, and expected to continue to do so till end of the 9th Cycle with more tangible results shown.[121]

4.3 Effectiveness

EQ3: To what extent has UNFPA CP support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into national systems, positioned on the national agenda, improved capacity nationally and locally through interventions, used institutionalized legal and policy instruments, use of data and evidence, including improving emergency preparedness for SRH and GBV in Egypt?

***Summary**:* Although achievements under the three focus areas were noted in the 9th Cycle, CP programme effectiveness remains a key area for possible improvement. An absence of cohesion and long-term intervention planning and implementation, including institutionalization and data utility towards the generation of shared knowledge helpful in programming and implementation is yet to be evidenced in the three components. Local and central capacities are yet far from being built. Laws and strategies without policy advocacy programming and behavioural change do not yield sufficiently. Humanitarian component is unsustained and hardly mainstream YRH and GBV components.

Figure 8:Online Survey EQ3 answers percentages



Youth and Reproductive Health Component[122]

Integration on national systems and agenda[123]

The logic of CPAP intervention for reproductive health components is in line with the *national strategic needs*. DHS data indicated the need for interventions to decrease the disparity in family planning utilization and maternal mortality especially in Upper Egypt. The implementation of the activities in both Assiut and Sohag responded to such need and matched the national strategic view. The intervention developed was expected to respond to this gap.

[120] CO files; key informant interviews, and Annex 3 for CO Organigram. CO are cadred to levels below their degrees, experience and hence remuneration potential.
[121] Key informant interview and signed partnership agreement 2015-17.
[122] YRH Component findings summary are as follows: RH component is integrated in the national agenda, but not with UNFPA global strategy. There is lack of planning skills and coordination interests among different directorates at MOHP which hindered taping different opportunities like: unified work plans for the ministry toward RH and initiating partnerships with the private sector. The collective challenges faced is strongly linked to KM system to provide strategic evidence-based advocacy guidance. There is also confounding gender factor affect ensuring embedding to practice or knowledge into the system on long-term basis. Y-component initiated activities in the current cycle to position its activities in national agenda. However, still majority of the component activities are not positioned in the national systems. There is perception of the effectiveness of community-based interventions (Y-Peer and YFCs). However, there is lack of evidence to support this perception. There also no clear process for target identification or assessment of effectiveness of the newly developed tools and expansion especially for Y-Peer and YFCs. M3loma social media platform, HIV/AIDS drop in centers represent success story for community-based intervention to empower young people. However, there is no documentation of the experience.
[123] This corresponds to EQ3 in Annex 18. Summary findings for sub-question available.

The annual work plans were always developed through series of meeting and dialogue with the different directorate to ensure the integration of UNFPA supported activities on the national agenda[124]. The feedback of interviews with MOHP key informants reported high effectiveness of UNFPA programme to the MOHP needs regarding capacity building. One of the achieved results was the effective role of "safe motherhood committee" to decrease maternal mortality in central and governorates level. Another collective achievement in the family planning sector was, the increased utilization of contraceptives in Assiut by 2.6% and 0.6% in Sohag.[125] One of the main reported gaps is weak management and planning capacity of ministry of health. Another challenge was the structure of ministry of health in relation to the mandate of UNFPA. The components of reproductive health scattered between different directorates within the ministry without proper cooperation between them. Another challenge faced the current cycle is the limited ToR of nurses. Nurses cannot provide emergency health services to women in delivery or insert family planning methods. There is also reported challenge in work force distribution in rural areas as many health centers have low number of nurses which affect their ability to perform their tasks. These structural challenges and others hindered the effectiveness of UNFPA programme.

As indicated earlier youth do not have national strategic plan, and the youth mandate is scattered between different sectors mainly Ministry of Youth, Health and Education[126].UNFPA CO exerted efforts to integrate some of the activities into the national system mainly the Youth Friendly Clinics (YFCs) through Ministry of Health. Also, the work on HIV/AIDS matched with priority of the national AIDS program to focus on harm reduction for key population[127], although the interventions happened mainly with non-governmental sector. Other initiatives such as peer-education programmes are kept out of the national system and were not integrated or positioned in the national agenda[128].

The capacity assessment was done partially for the different partners. The lack of full assessment according to UNFPA guidelines led to putting all the partners as high risk partners and conduct annual audit on their spending[129]. The different partners' ability to push the agenda on national level witnessed noticeable effort with high potential; however, there were no clear evidence for the contribution of UNFPA CPAP to advocate the national agenda directions yet.

There is tendency in UNFPA CO to shift their activities by collaborating with the Ministry of Youth to upstream their interventions. Such strategic direction seems to be good opportunity however; it needs to be examined against evidence. Proper capacity assessment for the Ministry of Youth against UNFPA mandate. Also, the possibility for partnership with different youth components seems to be a challenge to be assessed and approved by Ministry of Youth.

Improving national health system to provide high quality maternal health services to women of reproductive age[130]

UNFPA CPAP contributed to the capacity building of the central level in ministry of health and service providers at the district levels mainly; doctors, nurses and midwives to improve their skills to support safe deliveries, surveillance system and family planning counselling and utilization. The quality of the materials and training developed were highly appreciated by both partners and government as it matched the global standards[131]. Also,

[124] Different resources confirm the previous data include UNFPA staff, MOHP staff and different strategic documents.
[125] MOHP data, 2016.
[126] Interview with key informants in ministry of Youth and lack of access to the national strategy.
[127] National AIDS programme global fund proposal.
[128] Y-Peer is not recognized by law and it has to work through other NGO which create difficulty to integrate them. The feedback is coming from MoY and IPs.
[129] Confirmed by both sides UNFPA team and partners.
[130] This corresponds to EQ3a in Annex 18. Summary findings for sub-question available.
[131] FGD with different trainees in Assuit and Sohag.

beneficiaries recognized the great added value for such material. The assessment of the effectiveness of those different projects varied. Capacity building of family planning reported positive effectiveness and encouraged women to use different and proper contraceptives[132]. The feedback from the beneficiaries and service providers indicated high effectiveness for the interventions. UNFPA supported development of the "Decision Making Tool" (DMT) to support family planning counsellors. This activity was adopted by the ministry of health to take it to the national level. However, the service providers indicated difficulty to utilize the DMT as women come to the FP center with prior decision on the contraceptive tool they want. Some women receive advice from family member while others use social media and internet to decide their contraceptive method. One of the interesting findings that women count on FP centers for different sexual and reproductive health topics like: premarital counselling, sexuality and GBV. Such advantage can be utilized to integrate additional reproductive health services in the FP centers and/or stronger referral system with other services.

On the other hand, the assessment of the midwifery training showed gaps on the effectiveness of the training as more than half of the trained midwives did not practice deliveries for different reasons include; gender, cultural barriers and unsuitable selection for the trained midwives[133]. The reported gap in effectiveness is associated with lack of knowledge management, participatory monitoring and in depth data analysis. The challenges faced the effectiveness of the reproductive health program were noticed by other partners[134]. Midwifery training was conducted since 2004 with support from other donors. The challenges faced the effectiveness of the programme existed before UNFPA involvement. The request of the Ministry of Health to support the programme indicates weak monitoring of the evaluation system in the ministry. The effectiveness of the programme is also affected by structural challenges in the Ministry of Health. The majority of interviewees highlighted the lack of meaningful participation of the curative care directorate and university hospitals. They also reported the lack of structure or body to coordinate between the different levels of health services (primary, secondary and tertiary).

The gender factor was highlighted as a cofounding factor to the effectiveness of the RH component. Many of the trained midwives did not practice delivery because their husbands prohibited them. Also, those midwives could not visit delivering woman late at night. Another gender component was the selection of contraceptive methods. Some beneficiaries refuse certain contraceptives methods believing that it will affect their wright or libido. Such findings indicate the importance to consider adding male/husband's involvement and a gender component for the RH programme in the upcoming CPAP.

Strengthening local capacity of community-based interventions in reproductive health to empower women and young people[135]

The level of *capacity building* can be divided in terms of effect into two types. Capacity building conducted through NGOs and youth network, and capacity building of governmental staff to gain better skills. In both cases training was the dominant tool to build the capacity at local level.

In the case of NGOs and youth network, there was direct training for local NGOs and young people on different topics mainly peer education, reproductive health national views and extended to gender covering female genital mutilation. The reported numbers of trained/counselled youth were large according to annual progress reports but there was lack of evidence of the ability of the different training to improve the knowledge of the young people[136]. Also, due to lack of strong monitoring system, there was risk for Knowledge, Attitude and Practice (KAP) gap[137].

[132] FGD with service providers in Assiut and Sohag.
[133] FGD with midwives confirmed with UNFPA CO assessment.
[134] IDI with key informants in district level and strategic partners.
[135] This corresponds to EQ3b in Annex 18. Summary findings for sub-question available.
[136] Analysis of pre- and post-tests were not accessed to identify the knowledge change.
[137] KAP occurred as a minority of the trained youth adopted new behavior as result of this training. This finding was reported from different interviews related to Y-Peer.

This situation applies for youth friendly clinics, Y-Peer and IFMSA. On the positive side, different success stories were reported by youth programmes on the effectiveness of their initiatives. Also, the social activities of M3loma initiative was highly recognized by different partners and analysis of the utilization and the growth of the viewers (1.5 million likes for the Facebook page only) strongly indicate the ability of the programme to attract young people[138]. The capacity of small NGOs was also built through the two main IPs in CPAP.

The Youth component is perceived to be successful in empowering young people. Y-Peer provided important platform for young people. The feedback on the ability to utilize the members of Y-Peer is strong. Almost all the programmes of CPAP utilized Y-Peer and its team at certain point of the current CPAP[139]. However, the quality of target identification was a challenge. Y-Peer tried to expand their scope to target youth, adults, women and community leaders. However, such expansion did not match with the tools available by the team. Diversity was a necessity to expand the Y-Peer portfolio but the identification of specific youth groups is also important to avoid programme effect dilution. Y-Peer developed a new manual for FGM which is based on peer education techniques[140], however the effectiveness of such tool was not examined. The drop-in centers for HIV/AIDS have strong structure and beneficiaries reported strong positive effect of the center to face challenges facing them on daily basis. It's extended from protecting themselves from HIV/AIDS to combat gender-based violence and empowerment[141].

Building the capacity of Ministry of Health staff was managed mainly by the central level of the Ministry, with minimal involvement of the directorate management level[142]. The trainers were coming directly from central level, hence the capacity at local level improved through this structure, however it affected the ability to create cadre at directorate level. It also hindered the development of a local network from relevant partners working on RH[143].

Strengthening national capacity to use data to monitor and evaluate national policies and programs in the three CP focus areas, including in humanitarian setting[144]

Data was created on the national level for youth and reproductive health by direct support of UNFPA through funding the production of the DHS and SYPE. Data were used at very basic levels for the formation of the AWPs. No evidence for in-depth analysis or communication tools like info graphs to be used for advocacy purposes and/or community mobilization. Also, no evidence that national capacity in the MOHP or youth partners were strengthened to monitor national policies and programmes. This role was perceived to be led by the National Population Council (NPC) according to the UNFPA team. However, implementing partners of YRH reported that they are not required to coordinate with NPC[145]. The perception is that each directorate within MoHP is accountable for their own work plan and NPC do not have authority to play the coordination role.

One of the findings is that crude data found in national surveys need further analysis to identify the strategic direction of UNFPA interventions. One of the examples is maternal mortality data; most of the death cases are reported in university hospitals referred from private clinics[146]. In spite of that, no focus on university hospitals or private doctors were given. Another finding is that, although the highest number of maternal mortalities happened in Assiut; still big portion of these cases are referred from other governorates[147]. Another example is the

[138] M3loma Facebook page, last access December 15, 2016.
[139] Counselors for M3loma, trainer for Etijah and trainers for GBV are/were Y-peer members.
[140] Revise for the FGM manual of Y-Peer and comparison with Y-Peer manual for peer education.
[141] FGD with FSW visiting Shehab drop in center in Cairo and Alexandria.
[142] According to the head of directorates in Assiut and Sohag.
[143] IDIs with different key informants at district level.
[144] This corresponds to EQ3d in Annex 18. Summary findings for sub-question available.
[145] Interviews with key informants in MOHP central.
[146] Data provided by paper prepared by Assiut health directorate.
[147] Ibid 41

discontinuity of contraceptives reported in DHS or the sources used to access different types of sexual health for young people in Egypt which need to be analyzed further to develop strategic interventions for it[148].

Strengthening the surveillance system was an effective initiative supported by the UNFPA team. It helped MOHP to have better tracking for each case of maternal mortality. Data developed through this system was crucial to prioritize the intervention areas[149]. Such initiative need to be replicated in the FP sector. Family planning (FP) is still highly counting on paper filing system which limits the utilization of the existing data[150]. Another important source of qualitative data is the service providers whom were not involved in advising and evaluating national policies for FP.

Youth groups are changing very fast in terms of access to information and needs. There is collective instrument to monitor national policies on youth which might be beyond the scope of UNFPA. The work on continuous use of data is perceived as crucial factor for the success of youth programmes. The data also depends on the environment of providing the service. For example, there was important experience in analyzing social media data coming from M3loma which showed high need to work on sexual health. While data from YFCs highlighted self-hygiene, nutrition and fertility as examples of priority needs[151]. SYPE round table discussion provided important data on the needs for female genital mutilation with young people among other issues. In most of youth programmes there was data at certain level but it was not stored in structured method due to lack of KM system[152].

Different interviewees highlighted that, lack of proper data mostly affected the ability of UNFPA to prioritize youth interventions. The opinions about priorities for youth interventions varied greatly even within the same team of IP who worked with UNFPA. There was agreement that youth issues need to be tackled through a multi-sectoral approach but, there was lack of evidence-based data utilization to prioritize certain interventions and link those sectors together. Lack of data also affected the suggested approach and age group. Some interviewees believed that UNFPA should focus entirely on sexual health for adolescents and young people, while others believed the scope should focus on health services for young couples like pre-marital counseling, and postpartum counseling[153].

Gender Equality Component[154]

Improving the capacity of national health system to provide high-quality maternal health services to women of reproductive age[155]

The extent to which the *CP contributed to improving the capacity of the national health system to provide high-quality maternal health services to women of reproductive age was found to be not significant.* The country program,

[148] DHS 2014
[149] MOHP central level meeting with Dr. Khalid Otify
[150] Reported by the counselors of family planning.
[151] Interview with Dr. Ghada Izz El Din and data presentation from MoHP interview.
[152] Data include results of small surveys, pre- and post- tests and tacit knowledge depend on the programme.
[153] This part was based on analysis and response of different interviewees on using data and evidence.
[154] GE Component summary is as follows: While the overall vision for interventions in the GE component is comprehensive in its attempt to apply the 3P paradigm of Prevention, Protection, Prosecution; there is an absence of cohesive vision and long-term planning of interventions and in implementation, which includes institutionalization of interventions. Furthermore, weak collaboration between the program components, results in ineffectual results. The constant up-scaling of interventions, without needs assessment or baseline studies, and in contrary to governorates stated in the CPAP, dilutes the effectiveness and outcomes of interventions. There is a seeming discontent between how interventions are planned, and the actual time and effort required to reach stated outcomes and indicators in the CPAP. As importantly, there is a weakness/non-existence of M&E at the intervention level to feed into reporting that aligns with CPAP indicators.
[155]This corresponds to EQ3a in Annex 18. Summary findings are: while the development of the Medical Protocol Guideline and the associated content of training was extremely successful in providing unprecedented content and quality, the up-scaling diluted the presence of sufficient numbers of staff within each service delivery point. Furthermore, the efforts to date of institutionalization within decision makers to ensure that the Protocol is adopted and implemented.

as noted by MOH and the Regional Centre for Training (RCT), has made a significant contribution with the development of the Medical Protocol/Guidelines for Management of Victims of Gender Based Violence (including sexual violence).[156] UNFPA played a critical role in the coordination and funding of the Supreme Consultative Committee which was key in the development of the Protocol,[157] directly meeting its target for output 3.2 in the CPAP results framework in ensuring the development of the Protocol.[158] Both doctors and nurses who received training on the implementation of the protocol have unanimously remarked that it was the first detailed training of its kind, and was greatly needed in the field. In particular, the Head of the Forensic Medicine Sector at Ministry of Interior, received accolades for his training on evidence gathering and use, and overall professional and personnel support to the program.[159] The content of the Medical Protocol was then adapted by the IP[160] to conduct trainings for service providers in public health service delivery points.

The training program itself initially targeted Greater Cairo, Assiut and Sohag as pilot governorates, and was designed to focus on these governorates in phases that included a GBV needs assessment, TOT of service providers to ensure a critical mass of capacity, and training for CSOs on a GBV referral system.[161] In practice, there was a national up-scaling of the training, which was not well planned, and has weakened the effectiveness of the training. There was no assessment of hospital capacities conducted prior to training, or even a rapid assessment of the number of SGBV cases at these hospitals to reflect priority in need or catchment areas, although the rapid assessments conducted for 26 hospitals in the three pilot governorates, were used as a reference. Up to the third quarter of 2016, 1024 trainees in 313 public hospitals had been targeted.[162] However, nurses and doctors were not necessarily selected from the same hospitals to provide support and complementarity in service provision, nor was there awareness raising for hospital administrators. Due to small numbers of selected trainees from each hospital, there are gaps in service delivery when they migrate. In fact, evidence shows that for a follow-up forensic workshop in Cairo and Sharkeya, approximately 40% of those who had received the initial training in the previous year, did not attend. [163] Nor is the nature of the pre-post test administered by RCT conducive to assessing capacity building.[164] In addition, interviewees have questioned whether Curative Care is the correct sector for the program affiliation. Suggestions were made to move it to the Reproductive Health or Family Planning Divisions where the history of UNFPA collaboration is institutionalised, and where training and advocacy can build on a decade of previous experiences for more effectiveness.[165]

While the development of the Medical Protocol/Guideline and the associated content of training was extremely relevant and successful in providing unprecedented content and quality, the upscaling diluted the presence of sufficient numbers of staff within each service delivery point. Furthermore, the efforts to date of institutionalisation within MOH are insignificant, and require more prominence and commitment at senior levels of

[156] UNFPA, Ministry of Health, Regional Center for Training. Medical Protocol/Guidelines for Management of Victims of Gender Based Violence (including sexual violence). Service Provider's Manual. November, 2014.
The Protocol isbased on World Health Organisation guidelines that had been adapted to the Egyptian cultural and legislative context, and is all-encompassing in its coverage of management and assistance to victims of all categories of GBV, including domestic violence and rape.
[157] The committee was established and included various actors including the Ministries of Interior, Justice, Health, as well as relevant national institutions and UN agencies.
[158] UNFPA. Country program Action Plan between Government of Egypt and UNFPA: 1 July 2013-31 December 2017. CPAP Results and Resources Framework, Outcome #3, output indicator 3.2.
[159] Key person interviews with doctors and nurses with training recipients from Cairo, Giza, Domiat, Menofiya, Assiut;
Interview, MOH Directorate, Assiut Wednesday December 28, 2016; Interview, Curative Care MOH Central, Thursday, 22 December 2016.
[160] Regional Center for Training (RCT) was both a main partner in the development of the Protocol and the implementing IP for service delivery training. They are situated in the Faculty of Medicine, Ain Shams University, Cairo.
[161] AWP RCT, 2014,2015,2016.
[162] As stated in quarterly reporting and documentation by RCT.
[163] Interviews, RCT, Wednesday, 21 December 2016; Interview, Curative Care MOH Central, Thursday, 22 December 2016. Review of list of attendees for follow-up workshop. The IPs and other trainees also stated that the selection criteria for the trainees was not effective and included interns and personnel close to retirement, i.e. those most likely to not be around for long-term.
[164] Reviews of paperwork show had written scores for 30 questions for each participant. There are no indicative scores of acceptable increases in knowledge, or any parameters to evaluate knowledge enhancement. Further, documents are not collated or any further steps designed based on results or feedback.
[165] Interviews, MOH Directorate, Assiut, Wednesday December 28, 2016; Key person interviews with doctors and nurses.

administration/decision makers to ensure that the Protocol is adopted and implemented. It may be more effective in the future to focus efforts in certain governorates, and in certain hospitals to ensure that a comprehensive system is in place, and is indeed institutionalised within service delivery points. This includes commitment from administration personnel down to medical staff, with knowledge products advocacy, training, awareness raising and sensitization for complementary and cohesive capacity building. It is also essential that there is an effective M&E system in place to track trained service providers, and to provide follow-up or knowledge enhancement sessions, as necessary, with advancement in data, forensic procedures and general medical knowledge in the field of SGBV.

Strengthening local capacity of community-based interventions in reproductive health to empower women and young people[166]

Community based interventions are being implemented through BLESS, Al Azhar, Sexual Harassment Units at Assiut and Ain Shams Universities; the JP on FGM; These initiatives aim to create awareness on GBV and its impact on women's health for greater prevention and protection.

In so far as building capacities for religious leaders, the implementation has not yet begun at Al Azhar, while at the Bishopric of Public Ecumenical and Social Services – Coptic Orthodox Church (BLESS), over 6,000[167] religious leaders from Coptic, Catholic and Evangelical churches are receiving capacity building.

A review of the training material, developed in house by BLESS, indicates that the focus is on FGM, more so than GBV in general, and is quite clinical in nature. Furthermore, the messages received in one four-hour session, are further diluted as they are passed from RLs who attend the awareness sessions to the Servers (*khodam*) who are then responsible to insert GBV messages in their service to the community. The structure of the church activities allows for the dissemination of these messages through prayer meetings, youth groups, various counselling, and home visits. It would be of greater effectiveness to overall capacity building if there were structured tools or specific messages agreed upon to assist in disseminating knowledge to congregations. This recommendation was noted in the CPE 2007-2011[168] and was accepted by management, and to date, there is no evidence it has been implemented.

The capacities of the Sexual Harassment Units were strengthened by the support of the UNFPA in situating the Units within the respective University frameworks, giving credence and visibility to the Units; and in the provision of initial technical support to establish protocols of procedures, awareness raising, and suitable messaging. Since the beginning of the 2016-2017 academic year, each Unit has logged 5 complaints, with one of them from a male student in Assiut. The Assiut Unit is further strengthened by the fact that it is situated within the university Human Rights Centre, which is already established, with full time staff, and commitment of Faculty members on its committee. This is not reflected in the Ain Shams Unit, which has part-time staff, and is dependent on student volunteers for implementation. Furthermore, since changes in the grant mechanism regulations changed during the establishment of the unit,[169] UNFPA was unable to support maintaining staff at the unit, and is still waiting for the university to nominate and fund personnel seconded to the unit, so they can be trained and to ensure that the Unit

[166] This corresponds to EQ3b in Annex 18. Summary findings are: The JP FGM program has been effective in raising awareness and enhancing community involvement in activities to combat FGM through its school-based model. Improving the data collection methodology would contribute further to reporting on related indicators and evidence-based policies. Again, the training of RL was up-scaled to other governorates than stated in the CPAP, without effective planning, or linkages to other GE program components. Technical capacities of religious leaders and SH Units require more cohesive technical input (including M&E methods) and messaging to ensure that they meet the targets of the program, as well as uniform application of the interventions to all partners involved.

[167] This number is based on reporting in quarterly reports, and reflects accumulated numbers.

[168] In the CPE 2007-2011, there were three recommendations regarding more focus on streamlining religious messages, unifying training material and curricula, and focus on M&E of messages. Of particular reference is recommendation "G24: Revise and strengthen development systems to supervise and support RL and preachers in combating GBV and measure their effectiveness."

is operational for reasonable hours to receive complaints. This lack of uniformity in application, despite the fact that both units are supported by UNFPA, has led to ineffectiveness of the Ain Shams SH Unit.

Capacities of the NGOs working on the FGM in Upper Egypt on the school based model have been strengthened through technical activities and networking. The support provided allows the NGOs to conduct home visits, and have a visible presence in the communities, allowing parents to also reach out to them for more information. Since 2015, through the school based model,[170] 48 schools have been targeted in Assiut, Sohag, Quena, Minya and Luxor. The success of the community work is built on sustained relationships with the NGOs through NPC, and the physical presence of the Field Coordinator in Upper Egypt, allowing for quick response time and constant contact. And while there are no formal evaluations conducted at the community level, impact of the activities implemented are measured by the outputs of activities, such as messages and productions by students that reflect an understanding; and home visit discussions. And, while not all parents who refer back to the NGO may be fully convinced of abandoning FGM, they are at a minimum accepting dialogue on the subject.

Improving the data collection methodology would contribute further to reporting on related indicators and evidenced based policies. Technical capacities of religious leaders and SH Units require more cohesive technical input (including M&E methods) and messaging to ensure that they meet the targets of the program, as well as uniform application of the interventions to all partners involved.

Overall, the existing structures at BLESS and the JP FGM, and Assiut SH Unit have been strengthened for GE related community based interventions. Technical capacities of religious leaders and SH Units require more cohesive technical input (including M&E methods) and messaging to ensure that they meet the targets of the program, as well as uniform application of the interventions to all partners involved.

Contribution to enhancing institutional mechanisms to protect against and respond to GBV against women and girls[171]

The UNFPA through the Joint Programme on FGM, has successfully contributed to enhancing and mainstreaming *institutional mechanisms* to protect against GBV. Although the FGM JP is seen as UNDP led initiative, with the majority of its funding and support from the European Union, the UNFPA is viewed as having enhanced policy dialogue and advocacy for amendments to legislation which culminated in the amendment of the FGM law from Misdemeanor to Felony by parliament in August 2016.[172] It is important to note, that the initiative to amend the law came about during a training for judges, conducted by UNFPA. As stated by the IPs, the role of UNFPA in coordination was critical, and in fact was "the missing puzzle piece that brought together all the work that had been completed, and ongoing to date."[173] The Appeals Court in Dakahlia condemned parties involved in one FGM Case, and District Court in south Cairo raised by a mother, paving the way for families to report cases. And, in 2015, the

[170] The School Based Model allows dissemination of awareness on the rights of the girl- child, and on the health dangers and consequences of FGM. Activities within the school focus on awareness raising through arts, sports and Human Rights Camps, and they are complemented by awareness raising for parents and community in the catchment area.

[171] This corresponds to EQ3c in Annex 18. Summary findings for are: The JP on FGM has contributed exceptionally well in enhancing institutional mechanisms to protect against GBV. Direct advocacy of the programme has resulted in amendments that Criminalize FGM in law with harsher penalties. To a much lesser extent have been efforts towards response to GBV. To date, the GBV units have not been adopted by MOH or activated in hospitals, and there is still a need for a strong referral system to be put in place.

[172] On August 31, 2016, the *Egyptian* People's Assembly approved the *amendment* of article 242 of the Penal Code. Under the new amendment, individuals committing this crime will be punished with a period of imprisonment of between five and seven years. The article also punishes, with a penalty of imprisonment for between one and three years, any individuals who escort the victims of such crimes to the perpetrators. Furthermore, the amendment punishes the crime with up to 15 years' imprisonment if the act of FGM leads to the death of the victim or a "permanent deformity."

[173] FGM PMU Coordinator. Interview, NPC, Wednesday, 14 December 2016.

FGM Abandonment Strategy 2016-2020 was completed and launched been developed with clear actions and accountability of partners, including expected results and sources of data collection.[174]

The Egypt Demographic and Health Survey-DHS 2014 showed a 13% decrease in prevalence of FGM, from 2008, in girls aged 15-17 years. While this cannot be directly attributed to the activities of the JP in this programme cycle, it does lend credence to the activities conducted by the FGM/PMU at the central and decentral levels, as the main champions to eradicate the phenomenon in Egypt.[175]

To a much lesser extent, have been efforts towards response to GBV. To date, the GBV units have not been adopted by MOHP or activated in hospitals. There is only one focal point for the entire program at MOHP central (and one in each governorate), who essentially provides support to RCT in their implementation of the training, and no copy of the database compiled at RCT for its own records on trained persons. This does not support efforts to strengthen MOHP mechanisms or supervision over GBV response service delivery, as stated in the AWPs. Since the output indicator in the CPAP focuses on the number of service delivery points that have "adopted" the Medical Protocol, the baseline/target remains nil too date.[176]

Strengthening capacities for referral systems dealing with SGBV did not occur, as there is no such framework for such systems that exist. CSOs interviewed have indicated that they each received only one awareness session which focused on detailed presentation of the medical protocol, and a list of service providers trained in their governorates. There was an expressed need for more training on psychosocial support for victims of SGBV (this was also echoed by doctors and nurses in key person interviews). Furthermore, the CSOs have indicated that since the service has not been activated, they cannot refer victims to specific service delivery points. There is a need for effective advocacy at the decision-maker level, akin to that which established the committee and the adoption of the Medical protocol/Guideline, for the adoption of GBV units in hospitals.

Strengthening national capacity to use data to monitor and evaluate national policies and programs in the three CP focus areas, including in humanitarian settings[177]

The extent to which the CP has *strengthened the national capacity for using data and evidence* remains weak. The FGM PMU acknowledges a strong coordination role by the CO during the development of the FGM Abandonment Strategy, and it continues to support the monitoring of the Strategy, particularly in resource mobilization. While the programme has shown good use of data as evidenced by the detailed data and information, feeding to the overall Strategy action plan,[178]there is still an expressed need by the network of NGOs for further M&E training and data gathering.[179]At the national level, entities have access to research and have the funds and mechanisms for outreach, however the raw data on GBV exists at the local/grassroots level, and technical assistance is required to manage this data.

In the case of CAPMAS, the technical support offered by the international consultant for the Egypt Economic Cost of Gender-Based Violence Survey (ECGBVS) 2015, has been well absorbed and integrated, and the staff are confident that they can replicate the process, given their existing technical, personnel capacity and supporting

[174] Ministry of State for Population, United Nations Egypt, European Union. The National Abandonment Strategy 2016-2020. 2016. The Strategy is prefaced with historical evidence and data of FGM in Egypt, including challenges and; includes SMART indicators, clear activities and targets.
[175]Egypt Demographic and Health Survey. English. https://dhsprogram.com/pubs/pdf/OF29/OF29.pdf. Accessed December 2017.
[176] UNFPA. Country program Action Plan between Government of Egypt and UNFPA: 1 July 2013-31 December 2017. CPAP Results and Resources Framework, Outcome #3, output indicator 3.3.
[177]This corresponds to EQ3d in Annex 18. Summary findings are: The extent of building national capacities for using data and evidence to monitor and evaluate national policies and programmes particularly relating to gender equality is **insignificant to date**. Data stemming from interventions is often not processed past the raw data stage. There is no secondary analysis or documentation that utilises the information. Furthermore, data is not collected or collated in a manner that allows it to be shared across interventions, or in a format that can be easily adapted or updated.
[178] The document contains detailed history and data on FGM programing, and how that relates to current Strategy programming.
[179] Key Person Interviews, NPC Network of NGOs. January 24, 26, 2016.

organizational leadership. Moreover, adjustments they would like to implement which would align the Survey to the SDGs and DHS,[180] reflect an-depth level of analysis and design for future data collection mechanisms and implementation.[181] However, there has not been any follow-through as originally stated in the related AWP to produce secondary documents and policy briefs to utilize this data in M&E of national policies related to GBV in an effective manner. There is a need to expedite the development of such secondary material to further enhance the use of GBV related data in the monitoring of the relevant strategies, and a need to integrate this data in feedback and monitoring of the various associated strategies and programs.

The Strategy to Combat Violence against Women (SCVAW), led by NCW, was drafted with technical direction and support of an external consultant, and there is no evidence of capacity building for staff at NCW, or involvement of the planning or monitoring departments during this phase.[182] Upon completion, the Strategy stands as in-actionable,[183] and yet another consultant is working with NCW to develop an action plan for the Strategy, with weak collaboration between the two There is no evidence of training or efforts to contribute to NCW capacity to use data or monitor the Strategy.[184]

More importantly, there is stated evidence from IPs that there is no/very weak linkage between data and programs of the gender equality component in the CP[185]. There is also weak collaboration between national institutions and NGOs, resulting in a wide gap of knowledge and information sharing for evidence based policy making. What's more, the majority of data or databases resulting from program activities/outputs is not collected at UNFPA, but rather remains at the various IP institutions. And at these partner institutions, data is not collated or analysed, and there is no monitoring on its further use or contribution to monitoring of national programs.

Data stemming from interventions is often not processed past the raw data stage. There is no secondary analysis or documentation that utilises the information. Furthermore, data is not collected or collected in a manner that allows it to be shared across interventions, or in a format that can be easily adapted or updated. Recommendation 7 in the previous CPE 2007-2011,[186] clearly stated a need for "activities that aim at improving collaboration between main players in the area of data collection and dissemination at the national level; and it was partially accepted by management. And although the focus of the recommendation was NPC and IDSC at the time, the substance is valid to programming activities as a whole. Despite this, there is no evidence of efforts at the program level to share data/material/technical capacities between IPs.

CO contribution to improved emergency preparedness and response to SRH and GBV in Egypt[187]

In lieu of improvements to *CO's humanitarian assistance contribution to an improved emergency preparedness and response for the GBV in Egypt*, the following was noted: In 2013, UNFPA was one of several UN and other

[180] In tandem with YRH and PD components.
[181] Technical Coordinator GBV Costing study, CAPMAS. Interview, CAPMAS, Thursday 15 December 2016.
[182]Director of International Cooperation and External Relations Department, Planning Department Manager, Monitoring Department Manager. Interviews, NCW, Thursday, 15 December 2016.
[183]The National Council for Women. The National Strategy for Combating Violence against Women 2015-2020. 2015. The National Strategy for Combating Violence against Women reads more as a wish list for various ministries, some of whom have included activities that are outside their mandates. Furthermore, the indicators are not SMART. This assessment was stated directly by NCW staff, as well as other partners interviewed during the evaluation. Review of the Strategy for the CPE also shows that there is no related M&E plan, and the activities and timelines within are generally not specific targeted.
[184]Director of International Cooperation and External Relations Department, Planning Department Manager, Monitoring Department Manager. Interviews, NCW, Thursday, 15 December 2016.; Interview, Gender Consultant, Wednesday, 21 December 2016.

[185] Interviews with IPs in the GE component indicate that they are unaware of other projects under this component, and there is no exchange of the data or knowledge produced to be used across the program by various partners.
[186] Ford. K. et al. Decentralized Evaluation of the UNFPA Country Programme for Egypt 2007-2011. Final Draft Report. January 2011
[187]This corresponds to EQ3f in Annex 18. Summary findings are: While there has been a regional shift in focus of programming to adapt from emergency response to include 3RP planning, the associated CO programming is still focused on short-term interventions. Further, focus on coping and available response and support structures for refugees should be incorporated in the core knowledge disseminated.

organisations that contributed to the "Joint Assessment for Syrian Refugees in Egypt"[188] which outlined several recommendations on actions, including SGBV. Egypt also has its own strategic Regional Refugee and Resilience Strategic plans (3RP).[189] The 3RP strategies aimed to present a strategic shift in dealing with prolonged refugee crisis, and providing "durable and multi-faceted resilience-based" responses. Given this, the CO humanitarian assistance component currently consists on contributions to pooled funds for activities implemented through UNHCR[190], and CARE operated Safe Spaces. A similar contract for safe spaces was signed with the Arab Medical Union (AMU), however with a late start and inefficient and ineffective implementation, the program was put on hold by UNFPA CO in 2016.[191]

The activities conducted at Safe Spaces meet the objectives of the Resilience: Livelihoods and Social Cohesion component in particular raising awareness on SGBV and providing psychological support. A total of 1,500 women are already registered in the databases of two out of three safe spaces, with approximately 380 of them being repeat visitors. However, there was no indication of information reaching beneficiaries through sessions on referral systems in case of SGBV, or for general medical services, or service delivery points that are refugee friendly. This, despite the fact that the program has also funded medical equipment to public hospitals. Yet, there is no data on refugee access or selection criteria for these hospitals.

A review of the PowerPoint presentation on SGBV/RH created by CARE[192] shows an all-encompassing awareness session (information on definitions, types of harassment, violence, emergency contraception) but no coping mechanisms, especially for female refugees, context specific information on types of available assistance etc. The material was developed by a consultant for CARE, without input from UNFPA.[193] Interestingly, the issue of FGM awareness was raised as critical by beneficiaries. Coming from a culture where FGM is not practiced, the Syrian community found itself pressured by the Egyptian community towards the practice, and were able to find support and knowledge on the topic through the awareness sessions conducted at the safe spaces.[194]

While Safe Spaces reported by CARE and the beneficiaries themselves, has been extremely significant to the mental wellbeing of the Syrian women; there is no sustainability plan, or linkages with data, material or trainers from other GE or RH component programs. Despite a regional shift in focus of programming to adapt from emergency response to include 3RP planning, the associated CO programming is still focused on short-term interventions. The Humanitarian program and indeed the Humanitarian Coordinator are contracted on an annual basis.

The UNHCR regional report for 2016 shows that the Livelihoods component has received the least funding, with only 13% of the necessary funds acquired, and yet is critical "to expand opportunities to cope with, recover from and transform in response to crisis."[195] It would be more effective if the program at UNFPA takes into consideration more cohesive planning, and includes linkages to other GBV and RH activities presented at the SGBV sub-group, which UNFPA is a member of, to further substantiate the activities of this component.[196]It would also enhance

[188] UNHCR. Joint Assessment for Syrian Refugees in Egypt. November 2013. UNHCR had registered 125,499 Syrian refugees by end of 2013. That number is close to 116,031 registered by end of 2016. https://data.unhcr.org/syrianrefugees/country.php?id=8

[189] UNHCR. Egypt Regional Refugee & Resilience Plan in Response to the Syrian Crisis. 2015-2016 and 2016-2017. http://www.3rpsyriacrisis.org. Accessed December 2016., January 2017.

[190] According to interviews with UNHCR, these activities are mainly focused on SGBV case management for refugees.

[192] CARE, Final Violence against Women presentation. PowerPoint. Provided by CARE Women's Initiative Manager.

[193] Health and GBV material were developed under the project by CARE, the sessions on social empowerment utilize material developed in collaboration between USAID and CARE: CARE, USAID. Training Manual: Women's Empowerment Program, Combatting Gender Based Violence Program. 2015. Arabic

[194] Reported by focus group participants in both safe spaces.

[195] UNHCR. Regional Quarterly Update.:3RP Achievements September 2016. Dashboard. http://www.3rpsyriacrisis.org/wp-content/uploads/2016/12/Regional-3RP-Dashboards-September-2016.pdf. Accessed January 2017.

[196] UNHCR. Minutes of meetings. Egypt-SGBV Sub working Group: Syrian, African, Iraqi Refugee Response in Egypt.

effectiveness if, in addition to the community support programs (focused on health, psychology), there is also an economic empowerment/access to employment component.

Population and Development Component[197]

Strengthening national capacity to increase availability and use data to monitor and evaluate national policies and programs in the three CP focus areas, including in humanitarian setting[198]

UNFPA support to NPC came through SP 4, SP O/P 15, and CP O/P 2. CO succeeded in supporting NPC towards the following: NPS, Executive Plan (EP-cross-ministerial), NPAP (governorial), Composite Indicators/Population Atlas, media advocacy, coordination, training activities and KM. NPS strategy was launched in 2014 in the presence of PM, under auspices of the President of the Arab Republic of Egypt. Advocacy expended by UNFPA and NPC led to incorporating FP and RH in Vision 2030, with a matched profile to NPS. Other advocacy work supported by UNFPA and NPC related to youth, as it fell among the pillars of the NPS. Dialogue between youth and policy makers with the support of UNFPA, NPC and the Ministry of Youth concluded. Needless to say, PD was an enabler for policy advocacy and dialogue in compliance with the new mode of engagement.

A further success came through national state budget funding approval of LE290 million to the NPS and EP, in May 2015. Early on, UNFPA recognized the importance of developing a robust M&E system that collects data based on indicators to ensure NPS goals are realized, which had mostly qualitative indicators. To move effectively towards constructing a grounded M&E system, UNFPA commissioned a consultancy to perform a *needs assessment* for the NPC M&E system, in Q4-2015. Cooperation with MOP, M, & AD, and more recently GIZ is expected operationalize the M&E system through building the necessary data-base and automated system, linking the center to the periphery, provide software and hardware technical assistance and training. UNFPA, so far, has offered consultancy to sketch data-flows.

In order to transform the NPS and EP/NPAP into a doable evidence-based tool, CO supported an initiative to develop an indicators manual, namely the "Population Observatory." A set of primary (32—need to be collected) and secondary (52--available) indicators were derived. The Observatory indicators are mainly to the output level with work for linkage to the outcome and impact levels. Several rounds for refinements were taken through consultancy supported by UNFPA. The task achieved after then was to cascade the NPS/EP at both the central and local levels, *coordination* activities, to which NPC is mandated. This was also successfully supported by UNFPA, in 2015-16. To implement the five-year EP/AP of the NPS, 4 workshops were conducted between NPC and line ministries, NGOs and the Ministry of Planning, in addition to internal coordination meetings between NPC planning and monitoring departments, at the central level. At the local level, 53 persons were trained on the development of composite indicators.[199]

In Q4-2015, Composite indicators, with UNFPA CO support, were completed and 8 policy briefs concluded for priority governorates most in needs of support (i.e. Assuit, Sohag, Sharkeya, Beheira, Menya, and Ismailia), expanding reach beyond the 3 target governorates in CP. Meetings with governors concluded and training delivered. Composite indicators are 13 and are accompanied by traffic-lights governorate maps that work to "district" level

[197] Under PD effectiveness relates to a single SP O/C, and 2 O/Ps, namely: SP O/P 15 with NPC; and SP O/P 12 with CAPMAS. The results are varying as the text and relevant footnote summaries show.

[198] This corresponds to EQ3d in Annex 18. Summary findings are: Summary of the effectiveness of SP O/P 15: CO is succeeded in supporting NPC towards the following: NPS, Executive Plan (EP-cross-ministerial), NPAP (governorial), Composite Indicators/Population Atlas, with cross-cutting media advocacy, coordination, training activities and KM. Many effectiveness challenges continue to threaten the realization of the global outcome and output; e.g. the M&E system is not yet operational at both the central and local levels; no plans for updating Composite Indicators; interventions are extending beyond the 3 target governorates and lesser than nationwide; media advocacy and events do not follow a strategy or translate to results; coordination is devolved; reliance on external consultancy and devolution of PMU; and training needs assessment or training effectiveness study performed with signs of ineffectiveness; a single PSA was produced end of 2016 without policy briefs, instead of annual as per CPAP.

[199] UNFPA Annual reports, IP progress reports, KIIs, and online survey.

lower effects. Giza governorate was added due to prevalence of child marriage, which is relevant to GBV component. NGOs, the private sector, MOSS, and the Food Bank participated in the realization of this programme. Training curricula was developed and 20 MOP/NPC staffers were trained on composite indicators. No MOUs signed with governorates to sustain; governorates extend beyond targeted in CPAP; the overall political situation led to many changes in governors during the 9th Cycle reflecting on continuity; and capacities at the NPC branch level and facilities offered varied. No up to date data base is developed yet nor NPC branches linked to the central HQs. In Q3-2015, Among Composite Indicators intervention, 5 communities were piloted for awareness raising on population issues at the governorate level, under the Population Characteristics Program, representing a further subset. The yielded results were: 27 workshops for 520 participants (in Al Darb Al-Ahmar and Ezbet Kheir Allah in urban Cairo, Manshyet Dahshour in Giza at Badrashin District, and Mohamadeyat in Assuit at Abnoub District) addressing women and youth through improving their leadership and communication skills, changing attitudes towards the shape and size of family and disseminating relevant messages to targeted communities. UNFPA has also supported the publication of Composite Indicators pamphlet and maps' generation in hard and soft format, in July 2016, with the arrival of the new Rapporteur, H.E. Prof. Dr. Tarek Amin.

In addition, UNFPA supported the provision of 2 Core leadership trainings to 28 NPC participants including staff from the 3 target governorates in Q2-2015. The first was on leadership skills, while the second on strategic planning. Those trainings were planned to build capacity in second and third-liners at NPC and was supported by the then Minister of Population, H.E. Prof. Dr. Hala Youssef. The second training topic was surprising and was geared to senior managers at NPC. Assessments performed by trainers is that those who earned poor initially earned poorer when they participated in the training, while those scored high in pre-test, earned higher. Scoring was mainly on timely attendance of workshops and assignments delivery.[200] While in Q4-2016, workshops and coaching sessions were delivered by UNFPA consultants to Assuit, Sohag and Giza Governorates with NPC Branch, Governor and regional council (for Assuit) trained them on how to collect secondary indicators. In some cases, secondary indicators were found difficult to measure, contrary to what was originally expected, and were moved to primary indicators (hard to measure indicators, or phase 2 indicators). The other 3 red-spot governorates were involved, again, beyond the scope of the target governorates yet aligned with the nationwide approach, which is still incompletely fulfilled.

Relating to *advocacy and media* key activities included: 1. UNFPA developed a media plan for NPC, in 2015. It produced a documentary film (10 minutes) for a model village. The movie shows a village that succeeded to improve population characteristics (health, family planning, education, literacy and the environment) to offer an Egyptian sustainable development model with the potential of up-scaling. The film is used for awareness raising on the engagement of local communities in improving population characteristics. It was intent to be used by NPC for advocacy and fund-raising purposes. UNFPA supported 2 more media spots and a competition on Radio Masr and promoting FP awareness during 2016; 2. a large media conference was held with the support funding from UNFPA. A pamphlet publication containing the main media messages of the NPS was publicized and handed to the media for advocacy purposes, in Q2-2016; 3. a conference attended by CAPMAS President and Governors (195 participants) displayed examples of primary Observatory indicators that were put under an initiative called "Mogtam3na Masry" targeting priority 86 districts developed based on Composite Indicators, in Q3-2016; and in Q3-2016, UNFPA supported the first national population day on 31 July 2016 attended by PM Eng. Sherif Ismail. It advocated for the NPS, Observatory, and independent evaluation. The event was attended by 200 participants. Accordingly, this conference has impacted in the sense that H.E. Deputy Minister of Health and Population for

[200] KIIs and incomplete excel sheet account, NPC. See Annex 15. Only pre-test performed was for this training. Only post-tests performed are Core leadership training and Mogtm3na Masry. Both performed by trainers. Other activities are called "workshops" and accordingly not assessed and long end beneficiary lists of names are incomplete for possible cross-validation. Other lists were provided during field phase from several sources in key informant interviews at NPC. They were incomplete and could not be validated due to electronic data loss and lack of collation of systematized information on training activities in a single data-base. This mismatched lists from CO during desk review phase. According to NPC KII: "we never received this request [for trainees and end beneficiary lists] before from UNFPA and we never thought it is a requirement."

Population Issues, H.E. Prof. Dr. Maissa Shawky, is invited to all Governors Meetings in the Cabinet of Ministers and presented progress and achievements on NPC/NPS and Composite Indicators, inter alia, in Q3-2016. It has to be admitted that the effect of UNFPA interventions through advocacy and media have not been assessed for BCC to assert their effective ability to realize outcomes. However, short-term, limited interventions with this scale can hardly be envisioned to do so without a comprehensive advocacy and media strategies that are resourced.

On the *KM* domain, CO developed 6 PSAs in previous CPs.[201] By end 2016, one PSA was completed and now available on UNFPA during the 9th Cycle. NPC decided to develop a separate initiative on its own "Official PSA" in-house through its Research Department and external consultants.[202] A CBA for FP in Egypt was also developed in 2015.

In order to assess effectiveness of CO PD interventions towards the realization of global outcomes, additional aspects provide a fuller picture: a. the M&E indicators are in place, but system is not with lacked capacities (human investments, automated system, software, hardware, pilot-testing, bugs handling, report formatting, data protocols and assignment of responsibilities etc.; b. Observatory Indicators are not assigned to the 5 pillars of the NPS; c. results of coordination meetings, training and workshops is the delivery of NPAP 5-year plans for ministries at the central level showed setting their indicators for delivery is their business-as-usual indicators than population related; d. results of coordination meetings, training and workshops is the delivery of annual governorate executive plans based on the format developed for the previous NPS (2009-12);[203] e. "evaluation" is understood still as the monthly follow up of executive and regional meetings; f. Planning, Monitoring, and Evaluation Departments are 3 silos that do not share data or reports; g. selected potential core leaders are dissipated and training discontinued; g. in CP 2013-17, a PSA is to be produced per year. So far, a single was produced and developing a couple of PSAs (CO vs. NPC PSAs), is deficient from efficiency and effectiveness perspectives; h. the devolution of the NPC PMU casts issues interventions sustenance and should be addressed without delay; i. the non-involvement of the NPC staff in drafting of NPS and EP reflects on ownership and engagement of key interventions; j. quarterly and annual reporting on the side of NPC/PMU is on activities tied CP O/P 2, with delinks to SP O/C 4, O/Ps and sub-output indicators. No results reporting; k. no data base for indicators in place as branches are not connected electronically to the HQ so exchange of data takes place on paper format TA8 and others through desk reviews/collection than field, and l. a complete trainees or training materials data base is non-existent, the vast majority of training do not have pre- or ex post assessment of training, and trainees interviewed expressed dissatisfaction with training offered with respect to depth and breadth of training materials, relevance of subjects, duration, trainers, and lack of handouts or agenda.

On the one hand, there has been delays noted on the side of UNFPA in finalization of AWPs and quarterly funds transfers, and on the other hand, NPC financial procedures delayed the effectuation of activities. All ended in delays and several AWP amendments affecting delivery levels and effectiveness. In addition, the media spots that were developed did not engage NPC media and production department nor had it followed a comprehensive media strategy influencing effectiveness. No training effectiveness or a consistent record on training and trainees is available. More serious, at many instances patch training is confused for capacity building. Indeed, building a robust and operational M&E system require quality data, equipment and, most important, qualified staff. This is lacking so far and influence effectiveness towards the realization of global outputs and outcome. The elements for a good M&E system were expended by UNFPA during the 9th Cycle, what is missing is the comprehensive vision on how to integrate the pieces of the puzzle efficiently and effectively (i.e. NPS, EP, NPAP, Composite Indicators, design media campaign and support implementation, full-fledged M&E system linking branches to center, use of KM in decision making, involvement of research department in production of research than procurement, rely mainly on

[201] Those were launched by H.E. Prof. Dr. Magued Osman and his expert team; they were: first, on RH; second, on Demographic Dividends; third, on Food Security; fourth, on ICPD; fifth, on Towards Achieving the Goals of the National Population Strategy; and sixth, on A Way Forward for Marginalized Brackets (women, youth, and the elderly).
[202] Key informant interviews, NPC.
[203] The outgoing coordination Director resigned and the current coordination Director is without staff to fulfill the required coordination duties (KII, NPC).

NPC staff supported by external consultants, training for statistical department on production and participation in knowledge products, and training department on capacity building and assessment).

To date and after the passage of 2 years since NPS launch and withdrawal of budget allocation (LE290 million) due to abolishing the Ministry of Population, NPS has not generated population monitoring reports and the population growth rate has not abated. It is yet to be seen in the final year of the current CP corrective actions to operationalize NPS in an integrated manner at the macro-(intra-ministerial), meso-(regional) and micro-levels (governorates). This success formula is likely to bring about lessons learnt for documentation, learning and new strategic partnerships. A standalone NPS is necessary but insufficient, and an M&E system should have been planned, formulated and tested prior to launch looming around effectiveness realization and successful development outcomes.[204]

Interventions in PD contributed to enhanced data availability and use on emerging population issues locally and centrally[205]

Despite its limited duration since inception, UNFPA-CAPMAS relations turned to be a success story.[206] With links to SP O/C 4 and SP O/C 12, both CO and CAPMAS signed an AWP after the beginning of Q4-2016. UNFPA pledged the offering of a sampling consultant to support CAPMAS in the March 2017 National Population Census through two mission to develop innovative sampling techniques for the 10-year census. UNFPA support was highly appreciated. In addition, UNFPA funded a successful one-day, multi-stakeholders workshop at CAPMAS attended by CAPMAS President, General Abou Bakr El-Guindi, the Minister of International Cooperation (and now Investment as well), Prof. Dr. Sahar Nasr, and the Deputy Minister of Health and Population for Population, Prof. Dr. Maissa Shawky. The purpose is to open a policy dialogue on developing SDG indicators. The CAPMAS President pledged the issuance of an annual Egypt SDGs Tracking Report. This workshop was followed by a 4-day working workshop for the sub-ministerial level to dialogue the details concerning the hardships in measuring some SDG indicators, and the division of roles.

Both interventions with CAPMAS are excellent as they tend to extend from the output to the outcome and, perhaps, impact levels, as well. The Census is held every 10 years, and while SDGs tracking is annual it still matches with the NPS and Vision 2030 time profiles and feeds into both of them. Those interventions are highly effective and the organizational capacity is likely to sustain. Moreover, a smaller intervention offered to CAPMAS was funding the training travel costs of 2 CAPMAS officers to US Census Bureau to learn on sampling techniques. The topic and course were chosen by CAPMAS. Upon return, CAPMAS leadership requested the trainees to provide TOT to other CAPMAS-colleagues to expand knowledge circles, learning and excellence.

In addition, during the interviews it was found that CAPMAS subjected itself voluntarily to an organizational capacity assessment.[207][208] CAPMAS is currently fund-raising for its debut national statistical policy, which represents an opportunity for more effective and sustainable results over the long-term to CO and other development

204 See lessons learnt and success stories, chapter 5.

[205]This corresponds to EQ3e in Annex 18. Summary findings for PD effectiveness towards the realization of SP O/C 4, SP O/P 12 in the 9th Cycle is as follows: The achievements realized resulting from the short-term relations between CAPMAS and UNFPA is highly effective and represent a success story. This is represented in the following: A debut national policy dialogue on developing SDGs with wide stakeholders; the provision of 2 visits by an international statistical expert for sampling for the every 10-year National Population Census is highly effective; and funding travel of 2 CAPMAS staffers to the US Census Bureau on sampling techniques to provide TOT to their colleagues and associates upon return is both efficient and effective. On the other hand, UNFPA did not seem to recognize the importance of the Population and Public Services Sector which is mandated for population statistics; CO has not forged yet the highly-strategic partnership between NPC and IDSC, as stipulated in CPE 2007-11 management response, same for CAPMAS in the needed domain of mobilizing the first national statistical policy for Egypt with expected impacting results on national data, statistics, utilization and dissemination.

[206] See lessons learnt and success stories, chapter 5.

[207]Report Evaluating the National Statistical System in Egypt (13-17 September 2015).

[208]As mentioned earlier, website review vs no organizational capacity assessments were concluded prior to forging cooperation links with NPC and CAPMAS, respectively. According to UNFPA auditors, both IPs are high risk organizations with expected spot checks at least once a year.

partners. With its strong leadership,[209] the organization did not suffer the political turmoil resulting from the two revolutions, promises achievement and sustenance of results towards outputs and outcomes. CAPMAS needs seem higher than what UNFPA can offer.[210] Further cooperation can be forged with IDSC, the Cabinet's think tank, to be a strategic partner to the other 2 (NPC and CAPMAS) in the production of CP/PD-related knowledge products that are widely disseminated to the public and passed to highest national decision making organs in Egypt. CPE (2007-11) has already recommended cooperation between NPC and IDSC, but this was postponed due to the fluid political situation in the aftermath of the revolutions.

The expected effectiveness benefits of the UNFPA, NPC, CAPMAS, and IDSC is immense, as it will provide backbone strategic strength between the 4 organizations on policy advocacy and KM at multiple layers nationwide. However, it has to always be kept in mind that the PD component is an enabler for other CP components as well. Under the current Cycle, the 3 focus programme areas are parallel-tracked with little synergies, if none. The PD agenda for the coming 10th Cycle with those strong strategic players will need to involve calculated inputs and benefits from the other 2 components, YRH and GE, in order to boost strategic effectiveness of the CP and strengthen visibility.[211]

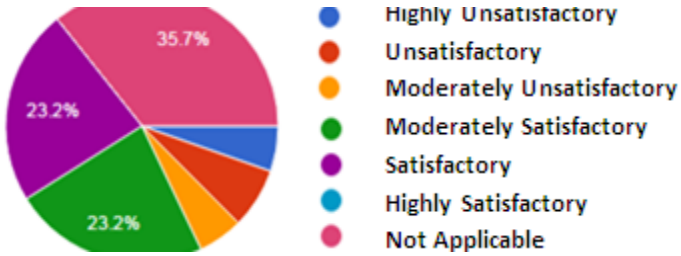
As mentioned previously, both NPC and CAPMAS suffered during the 9th Cycle from delayed UNFPA AWPs and pressures imposed due to milestones, than setting a full working strategy related to outcome effects, taking effectiveness of interventions. It may also be more effective if funds are transferred on annual basis to IPs to partially solve delays and enhance delivery rates. The involvement of PD in the humanitarian component was not envisioned, however, still, funding statistics on capturing the effective size and characteristics of the different refugees in Egypt via CAPMAS-NPC-IDSC may have triggered knowledge products that would inform national and local policy formulation, implementation and perhaps may have filtered into the NPS vulnerable strata.

4.4 Sustainability

EQ4: *To what extent has the CP been able to support its partners and beneficiaries in developing capacities and establishing mechanisms to ensure ownership and sustainability of achieved results?*

Summary: Overall, sustainability and ownership have been questionable aspects in CO operations under the 9th Cycle programme. Sustainability and ownership depended on the main on the side of IPs and NGOs. Political commitment and personal interest was the success factor than an action planned for by CO. CO had little to add on sustenance and ownership, while IPs required additional capacity building and knowledge transfer from CO to yield positively on the interventions offered under the current CP

Figure 9:Online Survey EQ4 answers percentages



[209] at the rank of Deputy Prime-Minister who attends Cabinet Economic Group meetings.
[210] CAPMAS expressed need of a resident statistical expert, for which CO responded by 2 senior expert one-week each, which is effective from CO's perspective. Being a donors magnet, CAPMAS secured a resident statistical expert through JAICA.
[211] See EQ5.

Online Survey Trends

*The foremost majority that were unable to assess UNFPA's capacity to support partners and beneficiaries sustained capacity and ownership resulting from UNFPA interventions (33.9%) and inform that no impact measurement on sustenance was invested by UNFPA in partners or beneficiaries has been taken; while others stated that youth health facilities, as an example, is under current evaluation, implying generating information on effectiveness and sustainability aspects. A skeptic key informant from a local/community branch of NPC poses that investing in capacity building activities in an IP's (NPC local branch) human resources as implemented by UNFPA have started in May and June 2016 only, with questionable, value-additions on sustained CO interventions.

Youth and Reproductive Health Component

"UNFPA monitoring is only accountable for outputs with contribution to the outcome level" as stated by different CO staff. Measurement of sustainability opportunities came late in the reporting priorities taken into consideration linkage of sustainability to outcomes rather than outputs. Efforts to sustain interventions for medium range in the RH component exist. Training of the MOHP cadres helps in continuation of the skills in the working place[212]. Such sustainability is linked to the presence of those trained staff in their working place without turn over and with improved work environment. There was no reported sustainability plan from MOHP to continue such activities[213]. Passing knowledge to peers in the work place requires time and commitment which is not perceived to exist. In-depth analysis for the weak skills of health staff showed that, the gap is expected to remain due to low education system and turnover in health facilities and ministry. To create sustainable intervention; there should be involvement from Ministry of Higher Education, medical schools, nursing schools and private sector to ensure creating qualified cadres aware of RH problems in Egypt and possess the skills to respond to the needs of beneficiaries.

NGOs working on the youth component have sustainability plans, however they expressed uncertainty of the success opportunities for such plans[214]. The main reason explained is the lack of financial resources to mainstream their activities with the local NGOs. Y-Peer and YFCs responded that "we will not be able to continue without UNFPA financial support", However IFMSA and M3loma thought they can manage to have financial resources from other sources. Passing knowledge for youth component mostly was not systemically assessed despite there was still quality periodic checking[215].

Gender Equity Component

Apart from Assiut University, FGM PMU, and to a lesser extent, BLESS; ownership at the relevant institutions is weak, and there is little evidence to show mainstreaming or institutionalisation or capacities, and mechanisms. None of the interventions, or the CP as a whole, have exit strategies. On the whole, UNFPA interventions are regarded as parallel projects within the institutions, with duties being over and above that of the regular duties of the appointed staff. Without the intervention being properly adopted and instituted, there is simply no sustainability. UNFPA only has one or two staff as focal points for its projects, which is often not reflective of the amount of work to be completed (RCT, NCW strategy monitoring, NPC Population Strategy) leading to over exertion of IPs and weaker implementation. When the intervention is supported by consultants and/or has a high level of UNFPA execution, the result is lack of integration and ownership of capacities and tools within the respective institutions (e.g NCW Strategy, MOH ownership of Service Provider training); and the likelihood of sustainability is very low.

[212]MoHP FP directorate key informants interview
[213]All interviews with MoHP
[214]Interview with Shehab and Etijah NGOs.
[215]Cascade of Y-Peer were not systemically assessed.

Furthermore, there is not sufficient planning, or time for capacity building and institutionalization of mechanisms, to allow for sustainability.

For IPs, where the capacities are already strong (Assiut University, CAPMAS, &BLESS) and the structure is in place, institutionalization and sustainability are high, given that the discourse is accepted and the decision makers agree with the philosophy behind the intervention.

Population and Development Component

Despite the fact that UNFPA CO invested in upstream activities[216]during the 9th CP Cycle, it is by far from sustenance of the interventions executed. UNFPA embarked on launching the NPS, EP, NPAP, pledged to develop an M&E and ICT system linking HQ and branches, delivered on a set of composite indicators to cascade to the grass-root level, and is reported to have delivered on capacity building investments to its main national counterparts. On paper, this is true. In reality, this is not particularly the case. The mere fact concerning the confusion relating to basic definitions such as, policy advocacy, capacity building and knowledge management reflects on the scope and nature of interventions offered to IPs.[217] In short, there are no project documents and hence no logical frameworks or exit strategies.

While almost all of the interviewees do not seem to recognize receiving UNFPA training *per se*, probing questions with trainees at NPC have affirmed their dissatisfaction with what they were offered as dubbed "capacity building" with respect to depth, relevance and value.[218] None has known if this training was UNFPA's or came through other donor funding (a visibility issue). Almost all informants did not know of UNFPA, its CP, or the interventions and technical support areas offered in partnership in general.

No training needs assessment were concluded prior to training delivery by UNFPA consultants. Patchy training on leadership skills, strategic planning, policy briefs writings, mostly not pre- or post-tested to respond to needs, relate to the NPC/NPS M&E system nor have those trainings been assessed by CO for content analysis and/or impact on skills development or impact on improved work delivery for target beneficiaries during the 9th Cycle. There exist no invested efforts to file a complete, validated lists of external beneficiaries who attended any of UNFPA/NPC workshops in a systematic, meaningful or traceable manner, with some attribution of some permanent staff trainings to the joint project.[219] NPC Training and Human Resources Development Department, if recourse to, was for mere logistic support, hall booking, refreshments, etc.[220] In addition, due to the fact that many NPC branches are short-staffed or may not have vehicles for monitoring data. Data collected by the Statistics Dept. on births, deaths and contraceptive coverage is performed through desk correspondence than field inspection and is delayed due to the unavailability of intranet for the entire organization. CO did not invest in the Stats, HR, Research, Evaluation, Media Production, or IT Departments. It picked rather the Planning, Monitoring, and Coordination Departments from the list mentioned. Without pecuniary incentives, many external consultants' contracts and deliverables were delayed. Adding PMU devolution at end of 2016 would paint the full picture for sustainability in the PD Component. Starting 2017 (and earlier), other donor organizations are now offering generous contributions to NPC in order to support a fully-automated integrated M&E system at both the central and local level, to complement UNFPA's initial efforts to sustain (unintended).

[216]As aligned with corporate new mode of engagement/business model (UNFPA SP 2014).
[217]Key informant interviews, NPC, and evaluation team documents reviews.
[218] Aside of key informant interviews, a ppt on workshop on M&E of the NPS executive plan by one of the training consultant was sampled; in addition to some NPC internal reports
[219] Many scattered reports made available to the evaluation team from CO and NPC; and key informant interviews.
[220] Several key informant interviews.

The NPS or EP are not mobilized on the ground to date, after a 2-years launch.[221]The coordination effort expended by CO to bring about line ministries representatives to put 5-year pledges did not work well. After completion of exercise, NPC (rather than CO) found that representatives inserted their business-as-usual operations in the population plan, were not specifically the concerned officers in their line ministries charged with population issues, some retired, and others informed that the national budget is for a single year while the 5-year is of mismatched time profile so they cannot promise what they cannot guarantee.[222]This is reflective of the importance of sequencing and planning thoroughly strategic interventions collaboratively between CO and implementers for aid effectiveness purposes, engagement and ownership of interventions leading to sustained capacity built both at the national and local levels. Upon launch of NPS on 2014--without NPC staff consultation, disregarding the list printed in the official document--organizational members were faced with a contained set of hard-to-measure qualitative document and indicators towards 2030, which required effectuation at the cross-ministry (horizontal integration) level, and between central ministries and the 27 governorates (vertical integration).[223] Excessive efforts are still underway by CO and IP to transform the NPS to a measurable endeavor for results through the Population Observatory. So far, two years have elapsed since NPS inception, and scattered results cannot be assessed to sustain until dry-runs of the full set of (primary and secondary) population indicators are tested, automated information system up, running and generating meaningful reports and results for decision making and public accountability. Another initiative funded by UNFPA was the construction of the Population Atlas traffic-lights color grids reflecting status of progress at the governorate and district levels nationwide.[224] With soon outdating data,[225] this launched initiative requires continuous (annual or biennial) updated feeds to sustain. No plans or signs on this are evidenced. This initiative stands with different indicators than those derived in the NPS/Population Observatory.[226] Partnerships are built with all ministries and governorates. And, the selected 8 most needy governorates under the Composite Indicators interventions had no signed MOUs or cooperation protocols with the relevant governorate. Under a highly unstable political environment (frequent governors, ministers, and leadership echelons in government), coordination and sustenance is very fragile. Strategic partnership between NPC and MOHP is fortified during the CP period to build a population characteristics data-base, without direct relations to UNFPA interventions. The consultancy contract funded by UNFPA for data work flows (than design) of the M&E information system was delayed by NPC and CO did not sign a new AWP till 15 January 2017. In addition, media interventions are sporadic, short-lived and without behavioral change assessment indicating sustained results.[227] As for CAPMAS, the two officials who were trained via UNFPA funding returned to train colleagues and pass statistical skills acquired through foreign training, sample consultancy has reflected on 2017 Census methodology, and wide advocacy dialogue on SDGs and the relevant indicators measurement is spurring with sustained annual SDGs reporting envisioned. Capacity building does not seem to be bearing fruition in the case of NPC due to lacked programming and implementation meeting capacity needs via a targeted manner. Political changes played a marked role in the case of the particular institution, contrary to the other. The mere logic that the NPS, EP and NPAPs milestones have been delivered translate into auto-sustainability realization is faltered from both programmatic and strategic stances.

[221]NPS 2015-2030; and key informant interviews at NPC. PD Associate handed over late 2015-early 2016, after two years of CP initiation from a departing JPO.
[222] KIIs at NPC.
[223] NPC Ministries population plans (2015-2020) and Annual 27 Governorates population plans (2014/15) and 2015/16); and online survey.
[224] Prof. Dr. Tarek Amin presentation on "Population Distribution Composite Atlas Nationwide 2016."
[225] Population Atlas/Composite Indicators were launched in 2016 with HDI data of 2010 and DHS of 2014. MOHP/NPC/UNFPA 2016.
[226]M&E Manual/Population Observatory, pre-final version.
[227]Key informant interviews at NPC.

4.5 Strategic Positioning

EQ5: *To what extent was the CO able to shift to the new mode of engagement focusing on upstream interventions,, able to generate value-added, effectiveness of its role in UNCT coordination and comparative advantage?*

Summary: UNFPA's new mode of engagement is widely acceptable by stakeholders, with reasonable achievements realized on upstream activities leading to increased OR funding. Although a relatively timid CO, the Office was acknowledged by different stakeholders in light of its small staff number that its strength lies in having a focused mandate, while other UN agencies are overlapping, leaving a room for joint programming. Over the 9th Cycle, CO's presence and contribution was witnessed in key UNCT coordination Task Forces, with room for visibility improvement and revisited evidence-based geographic targeting, enhanced reporting, programme coherence and improved results generation on community-based interventions. Insufficient investments were expended on south-south, triangular cooperation, and recourse to RO technical backstopping.

Figure 10: Online Survey EQ5.1 answers percentages

Figure 11: Online Survey EQ5.4 answers percentages

Online Survey Trends

***Shift to new mode of engagement:** The majority of respondents do not seem aware of UNFPA's new strategic orientation (35.7%). The following category of respondents find UNFPA's new mode of engagement as satisfactory (23.2%), to moderately satisfactory (23.2%). A fractional percentage (6.1%) regard it highly unsatisfactory.

***Comparative Strength and UNCT Coordination:** Almost all respondents to this questions were in strong support of UNFPA's technical and financial edge. On its human capacity, respondents believe that CO staff is friendly and fairly skilled despite of shortage in staff. Advocacy on population issues and dealings with strategic partners appropriately enables the filling of gaps on the social agenda of the GOE. Some respondents commended its contextualized solutions reflected in population advocacy, RH, GBV, FGM, YFS initiatives and Syrian refugees' humanitarian response. More responses emphasized the ability of UNFPA to select highly competent execution teams in the field. Furthermore, respondents see UNFPA CO as a natural extension for the collaboration on its agenda and the NPC. Moreover, others highlighted its strength as convener of youth-focused interventions and broker for high-level (policy) technical interventions. Finally, an area of comparative strength for UNFPA CO lies in its multi-partnership building relations with myriad national and international organizations (i.e. UN and non-UN).

* **Value-added:** The locus of responses hovers around not knowing exactly. Respondents who were positive of *UNFPA's added value* in the country context the organization (UNFPA) funds relevant existing or upcoming projects needed by IPS; its specialization in RH and population issues leading to the handling of gender issues; both technical and pecuniary assistance related to population issues; qualitative inputs into instituting activities that would be supplemented by the capacity of IPs; support given in building national capacities in statistics, data, population and censuses; focus on upstream activities is unique; public awareness activities on population issues; developing practical protocols and guidelines; and coordination activities among different institutions and ministries specifically in the field of youth and adolescents.

* **UNCT Coordination:** The majority of respondents (30.4% as satisfactory and 8.9% as highly satisfactory) believed that the *coordination performed by UNFPA and UNCT* was satisfactorily effective to boost the CP implementation and achieve better results. The reasons posed by respondents contained: UNFPA was able to coordinate UNCT around a pivotal strategy for GBV, population strategy, and youth and adolescents through consultations; was able to forge coordination links between UNFPA and NPC; played a critical role in UNCT; intensifies its efforts in realizing its planned results. The second category of respondents in line (26.8%) were unable to judge this coordination. Others were also on the downside in UNFPA's ability to coordinate.

Shift to New Mode of Engagement

SP 2014 stipulated to the migration to the *new mode of engagement* giving a transitionary period of 2 years with focus on upstream activities, effective financial management, regionalization, innovation, expansion of non-core funding and programmatic coherence, with emphasis on the NEX modality.[228] As a matter of fact, CO staff is compact and small to deliver on impacting operations and for meeting the expectations of IPs towards a thorny development issues relating to the components of its CP. Aside of being under-staffed and despite of sparring training activities offered to IPs and collaborators, it does not seem to have a clear capacity building program or budget to invest in updating the technical skills of its staff.[229] Online, voluntary generic, than specialist training is made available. With over-worked staff and lack of internal, comprehensive M&E system, no signs of CO human investments seem substantive. For Egypt, the move to upstream activity necessitates heavy capacity building investments to tackle policy advocacy, formulation and implementation and KM, which affirmed as timely and much needed, with innovative means to supply contraceptives at GOE expenses through mass purchase and competitive domestic private sector engagements.[230] During the 9th CP Cycle, UNFPA invested in producing Baseline assessment of the Health system, SYPE and DHS 2014, GBV Costing survey, same as and publishing a National Population Strategy—NPS (2015-30), matching with the Country's Vision 2030, funded the NPS indicators Observatory, initiated policy dialogue on data collection and construction of SDGs indicators with ministerial and sub-ministerial stakeholders.[231] UNFPA CO has also contributed to the generation of a caesarean section study, 2015 CBA, and 2016 PSA as knowledge products of strategic national policy utility for the implementation of the NPS and its action plan (2015-17). The Composite Indicators/Atlas is currently operational and highly-valued tool funded by UNFPA CO and launched in 2016 yet without plans for updating[232]In general, many of UNFPA KM products were not followed through towards utilization, and policy advocacy activities revolved around holding conferences attended by political figures and/or signatures of MOUs beyond which momentum is lost.

Although unknown to the majority, if not all,[233] the new mode of engagement and business seems to be received positively by national counterparts (IPs) as much as the UNCT and donors, as a rather focused niche and scoping activity to the added value of UNFPA CO in Egypt. It is believed to offer a better focused modality for programming for results. Other informants strongly believe the bull's eye should be centred around PD, with equally-spaced RH, MH, GBV, youth & adolescents, and human rights at the fringes of the outer circle. In a nutshell, the majority of key informants emphasized the fragmentation of the current programme, which would at least amalgamate and mainstream its main components (YRH, GE, and PD) under the single umbrella (the bull's eye single focus area with unitary higher goal) within which lie different sub-components yielding to focused, effective outputs for a single outcome, and with clear exit and sustain strategy. PD expanded its portfolio upon the adoption of the new mode of engagement in 2014 and linked it to SP outputs and outcomes, yet still marginal looking at percentage of programme funding in the current and previous cycle. YRH and GE components question sustainability, mainstreaming into each other and the adoption of an integrated approach to the humanitarian response. Because of this, as much as the other components, it lacks strong programme logic and results-focused, than activity-focused interventions.[234] South-South and triangular cooperation is faint, while OR funding has successfully grown during the current CP. Humanitarian activity engagement has expanded, while coherence remained same.[235] Despite emphasis on fortifying M&E functions under the new mode of engagement, the CO foregone its M&E Associate on October 2016 to be its PD Associate.[236]The three components lack the operationalization of effective M&E

[228] See also QCPR 2016.
[229] See response to EQ2 (Efficiency).
[230] Recalling Egypt is entitled to policy advocacy and KM only under the new mode of engagement.
[231] See Annex 7 for listing of excerpted KM products by component during the 9th Cycle.
[232]Qualified by responses to EQ3 & EQ3e (Effectiveness) and EQ4 (sustainability); and online survey.
[233]Key informant interviews, and online survey.
[234]Key informant interviews.
[235] See overall responses to EQs.
[236]See other report sections on M&E, and UNFPA CO organogram in Annex 3.

systems at IPs. Given austerity measures, The CO is inadequately staffed by continuously learning staff of special profile,[237] and does not recourse frequently to accessible peer-mechanisms enabled through RO. RO should also take the extra-step to engage CO PMOs into peer-learning and exchange. Staff rotation and capacity building activity ample budget and continuous learning should gain the necessary attention at CO in order to build this extra-step on the technical expertise[238] of its staff and enhance its image as "the" (rather than "a") specialist player in YRH, GE and PD.

Comparative Strength, Value-Added and UNCT Coordination

Comparative Strength and UNCT Coordination

The majority of key informants (development partners and IPs) expressed repeatedly the *comparative strength* of UNFPA as an organization and the Cairo CO is in its clear-eye focus on YRH, GBV and PD, in general, which makes it distinctive from any other UN agency. Its new strategic orientation (SP 2014) has fortified both its niche and focus in the eyes of all interviewed.[239]The CO's work in the field of FP and MH is recognized both by GOE and peer UNCT members and donors, same for FGM Abandonment strategy, medical protocol and others. Cross-cutting and overlapping areas of operation are in gender, youth and adolescents, that is reflected in UNFPA's joint programmes and programming (e.g. UNDP, UNICEF, UNWomen, SIDA, Norway, Japan, UNHCR etc.). A focus on the bull's eye new UNFPA modality was commended by donors, UNCT and GOE. Another focus area that was heavily emphasized related to the need for expanding the PD component, while emphasizing the supremacy of policy advocacy, knowledge management production, and heavy investments in building the capacity of national stakeholders at both the central and community levels for the institution of sustainable mechanisms for national population and statistical strategies, that are tied to national plans and the SDGs given the special atypical CP following revolutionary mode and political changes.[240]This synchronizes with upstream work. Although UNFPA CO does not Chair or Co-Chair any of the UNCT/UNDAF coordination 5 thematic working groups, it chairs actively both the Youth Task Force (TF), by the UNFPA CO Representative and youth officer, Gender Task Force, by the Assistant Representative and Former GBV Officer, and plays an important role in the M&E Task Force through the participation of the CO M&E Focal Point and PD Associate. UNFPA CO Representative is also Acting UNRC since joining CO.

Added-Value and UNCT Coordination

The *UNCT coordination meetings* minutes made available to the evaluation team were for the period of 2015-2016, avail the continued participation of UNFPA in all UNCT meetings.[241] Those represented 16 meetings from beginning of 2015 till October 2016. Some key activities and contributions were noted from the UNCT meetings minutes for 2015-16, were as follows:

First, on Tuesday, 21 April 2015 meeting the following is quoted: "As other countries around the world (Bangladesh, Cambodia, Ecuador (being established), Nepal, Somalia & Sri Lanka), the UNCT Egypt decided to establish a Youth Consultative Group in response to the Secretary General's Action Plan for Young people with UNFPA CO input to the full drafting of its TORs and partnership with ILO who would offer mentoring to the CG."[242]Second is on Wednesday, 29th June, 2016 in UNCT meeting: "Dr Magdy Khaled proposed to revitalize the UN Youth task force. The purpose is to have an internal mechanism to lead and coordinate among agencies to

[237]See EQ 2; almost all staff are placed in job levels lower than their credentials, experience record and potential.
[238] Key informant interviews.
[239]See also online survey responses.
[240]Key informants' interviews with UN agencies, donor organizations and the GOE; and online survey.
[241] Special acknowledgement to Mr. George Nalenga, UNCT RC Office at UNDP and ERG Member for availing UNCT minutes to the evaluation team.
[242]Minutes, United Nations Country Team, Tuesday, 21st April 2015, IOM, Zamalek.

position youth agenda, advocacy… It was also recommended that UNFPA collaborates with UNIC to prepare for the international youth day scheduled to take place on 12 August 2016 to show how we as UN can work together, planning and coordinating the activities so that they don't overlap."[243]And third, on 10 August 2016 UNCT meeting: "Youth Working Group: Mr Bodiroza (UNFPA), shared that the UNDG in Amman adopted the strategic framework for young people, setting the priority for the next few years. The First meeting of the Task Force took place on 7 August 2016. A number of agencies discussed how to organize the International Youth Day. UNFPA called for better coordination with the UN Communication Group to ensure commonly celebrated UN Days are properly coordinated. It was pointed out that there are number of lessons learned including starting the planning for such event earlier."[244]

UNFPA CO also plays a key role as chair of the Gender Task Force based on the special request of the GOE, and is represented on UNDAF M&E Task Force to improve programmatic coherence throughout the UNCT in Cairo and focus on reporting on programmatic and projects results delivery of UN agencies operating in Egypt and their partners.[245] Donor agencies voice the need to demonstrate results in the upcoming cycle.[246] Added, to participation documented in minutes, many key informants show an appreciation for the coordinated work between CO and IPs. They voiced high-technical quality collaboration. This was matched by a similar appreciation on the side of UN agencies, UNCT and donors. The missing link that donors voiced was strong cascaded impacts by CO to the local/community level compared to the central level. Geographic targeting to Assiut and Sohag was voiced that it needs to be revisited each programme cycle (and component) for wider impact assessment—i.e. look for success-mix between quick wins as much as most needy (e.g. Qena, Behera and Fayoum were proposed). It is also believed that at times of political change, policy advocacy cannot be neglected and should assume frontal position, especially with the newly focused bull's eye modality. NEX was appraised by donors, UN agencies and some IPs for increased ownership and engagement; however, others who suffer from bureaucracy where indifferent about the modality's ability to realize results.

As for South-South cooperation, on January 2016, with RO funding and recommended contacts from CO, a high-level parliamentarian delegation assembled in Amman, Jordan, together with regional counterparts in line with the post-ICPD agenda, SDG 2030 Agenda, and population forced migration issues in the Arab region due to conflicts and wars resulting from Arab Spring. This resulted in the official launching of the "Forum of Arab Parliamentarians for Population and Development"—FAPPD, a General Assembly meeting and the declaration of Amman Statement. The conferees have elected unanimously a renowned Egyptian MP (who was formerly Head of NCCM), as Forum Chair and adopted a 2-year work plan, while acknowledging the efforts of UNFPA's both Offices and the League of Arab States (LAS) for technical and financial support.[247]Nothing tangible on the side of CO was reported beyond this point. Room for improvement on this domain, same for triangular cooperation, in line of SP 2014 strategic direction, is achievable by closer collaboration with RO. Triangular cooperation was forced during the 9th Cycle through UNFPA HQ support to Y-Peer (Itijah) and the Arab world.

Additional S-S relations came recently through the joint cooperation between CO and CAPMAS, whereby the latter's staff was enabled to go to training visit to the US Census Bureau and the availing of an international sampling expert to support methodological robustness and validation aspects pertaining to the 2017 national population census, and the GBV costing study. [248] Moreover, peer review mechanism with ASRO is currently in place for the

[243]Draft Minutes, United Nations Country Team, Wednesday, 29th June 2016, 10.30-12.00, ILO premises, Zamalek.
[244]Draft Minutes, United Nations Country Team, Wednesday, 10 August 2016, 10.30-12.00, UNFPA Premises, Maadi.
[245]Several key informant interviews within the UNCT, UN agencies and donors; and Prof. Bodiroza presentation to UNCT 2016.
[246] Key informant interviews, multiple donors; and quarterly progress reports; SP 2014; Egypt United Nations Assistance Framework 2013-17 Independent Review, May 2016; and QCPR 2016; and online survey.
[247] General Assembly of the "Forum of Arab Parliamentarians for Population and Development" (FAPPD), Amman, Jordan 26-27 January 2016.
[248] CAPMAS AWP 2016, and key informant interviews, CAPMAS and CO.

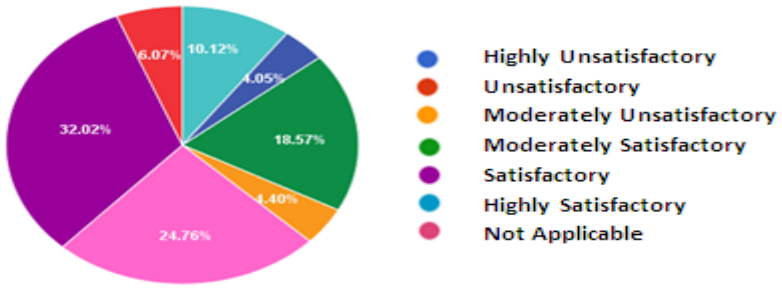
CO's M&E focal point and PD Associate that is expected to leverage knowledge networks and learning in both PD and M&E to be fostered in the upcoming 10th Cycle.[249]

UNFPA CO has a room for improvement relating to its *visibility*. UNFPA CO staff is seen as reactive, than proactive by IPs and development partners. Having said that a strong impetus is acknowledged since the arrival of newly coming Representative, adding to the CO's marked presence of the Chair of the Gender TF in UNCT coordination team, who is currently Assistant Representative and Formerly GBV PMO, especially upon the successful launch of the widely-covered "Taa-Marboota" campaign to empower Egyptian women socially, economically and politically.[250]

4.6 Composite Assessment of Evaluation Criteria

Based on responses received from the respondents, an overall composite assessment of the evaluation criteria was derived by the ET. The result of the composite assessment of responses to the evaluation criteria brought the CO CP portfolio performance over the 9th Cycle as ***satisfactory***. *It is yet for CO to decide whether to retain the same performance level to the 10th Cycle or to assume a higher performance standing overall.*

Figure 12: Online Survey Overall Performance Composite Assessment



4.7 Monitoring and Evaluation at CO during the 9th CP Cycle

As a key informant puts it in one of the CPE interviews: "*what you cannot measure, you do not manage*." The M&E system aims at measuring progress towards input, activities, outputs and outcomes as planned in the country programme. The monitoring of inputs and activities refers to day-to-day monitoring tasks carried out by programme officers at CO, in particular: budgets and expenditures follow-up; supervision of activities implementation. The M&E of outputs and outcomes is also directly associated with the CP contribution to UNDAF. Finally, the M&E system also encompasses the monitoring of risks and assumptions which directly relate to the country context.[251] The evaluation component corresponds to the evaluation function within the CO and encompasses the process of planning, conducting and using the results of evaluation exercises. An effective M&E system is therefore both a cornerstone and a precondition for fulfilling UNFPA corporate strategy towards: 1) strengthening results-based management, 2) putting in place a culture of measurement of results, 3) using evidence of results to inform decision-making, 4) improving measurability to ensure accountability of results and learning, and 5) strengthening national and local M&E systems, in turn.

The analysis performed by the evaluation team laid under covered the evaluation period of CPE program 2013-17. For the assessment of the CO M&E system, the data collection methods utilized consisted of documents review (UNDAF MTR, CPD, CPAP, AWP, ARs, SP, & M&E planning matrix) and semi-structured interviews, with CO staff, RO M&E Advisor, and counterpart IPs. UNCT members and donors contributing funding to the CP were also

[249]Key informant interviews at RO and CO.
[250]Key informant interviews with UNCT, CO, GOE, IPs, and donor agencies.
[251] UNFPA Guide "Assessing the country office monitoring and evaluation system."

interviewed. The findings are based on the sources made available to the evaluation team.[252] The ET trusts the findings arrived at based on the available information are adequately informative to feed into the upcoming Programme Cycle and synchronizes with many of the EQs findings. The findings in this section are not uncommon to many UN organizations.[253] Findings are sectioned in nine key areas as follows, and, extend to the following chapter 5.

I.CP Design:

1.The 9th Cycle CP was built on a CCA that was prepared for UNDAF in 2010, when conditions have completely changed after two revolutions. No real needs assessment was conducted prior to the design of the current CP was adopted (CPD and CPAP)

2.Insufficient consultations were held for the preparation of the 9th Cycle Programming to ensure appropriate interventions, indicators, activities, outputs, outcomes and impact, while engaging key stakeholders in tandem

3.When SP 2014 was passed for migration by CO within 2 years, PD was not vehemently in CPAP, and new upstream requirements were required. This was an opportunity to consult key stakeholders and amend CPD and CPAP document in the presence of GOE. This has not happened.

4.CO picked CPE 2011 recommendations selectively and has not followed through the implementation of an M&E system contained among the recommendation and further documented in the CPAP

6.CO infringed compliance with the new SP 2014: the percentage distribution of focus programme areas (GBV vs. PD); the yellow color grid with upstream activities (PA/D and KM; Egypt getting full-range); links to SP O/Cs and SP O/Ps for RH and GBV; performance indicators; S-S and triangular cooperation; regionalization and globalization; links to academic institutions; possibilities for use of Opportunity Fund etc.

7.Forging links with private sector and NGOs was weak, against SP guidance

II.Focus Programme Area Design:

1.No programme or project documents are in place at CO

2.Incomplete TOCs or intervention logic developed for the three component areas, added to humanitarian response

3.Delays in AWPs and milestones framed mainly by IPs

4.Milestones or lower-level activities are taken as indicators, and insufficiently tied to outcomes

5.No documentation on design of humanitarian component, sustainability or effectiveness of interventions

III.Programme Implementation:

1.No proper organizational capacity assessment of IPs

2.Funds earmarked to IPs returned with promises for re-transfer unfulfilled

3.Activities mistaken for outputs, void of clear links to outcomes

4.Misunderstanding of terminology (activities for outputs and outcomes capacity building for training; policy advocacy for 1-month media campaign; raw data collection for KM etc.)

5.Spreading thin with IPs, other partners, beneficiaries, and no stakeholders mapping all delinked to SP results

6.Focus on funds disbursement, than results achievement

IV.Reporting:

1.Monitoring:

a.No evidence of full data-base of beneficiaries/trainees at IPs and CO ready for each component prior to programming exercise

b.Reports from IPs received by phone or handwritten

c.Inadequate field visits and hence reliance on IP programme reporting

d..Activity-based reporting

e.Activities contained in AWP not fulfilled or no evidence of them (e.g. training of policy, judges and religious leaders)

f.Delays in reporting to HQ noted

2.Evaluation:

a.Project evaluations not performed

b.No impact assessments on BCC or training concluded, testing on effectiveness, sustainability or impact

c.Financial/Accounting audits are not replacement for organizational capacity assessment or project evaluation of high-or low-risk IPs

d.No Best Practices (BPs) or Community of Practice (CoP) in place for peered-learning from successes and failures in programme M&E with HQ or ASRO

e.No evaluation of geographic targeting (selected governorates) was concluded (MTRs)

V.Capacity Building:

1.No budget for M&E/RBM or capacity building for staff

2.Training on M&E not cascaded to CO staff

3.Online training is ineffective in Egyptian context

4.Training to IPs on routine financial accounts bookkeeping, expending procedures, FACE forms filling and dispatch, does not

VII.Leadership/High-Level Commitment:
1.On 29 April 2016, UNFPA Executive Director instructed as follows: "… UNFPA's relevance in 2030 era will depend on **achieving high level impact results**" and "… Country Representatives to raise the bar … commitments to move forward selected specific **indicators impacting the LIVES OF PEOPLE**"
2.The new CO Representative (arriving in August 2016) expressed interest in elevating the M&E function at CO (in compliance with SP 2014). Actions not yet taken.

VIII.Role of RO:
1.An M&E Regional Advisor position was opened in RO since 2008, with high turnover
2.Since August 2016, the newly arriving M&E RO Advisor has initiated two trainings and a regional peer review mechanism for M&E cross- fertilization, alignment and learning in which CO is active
3.Key findings by RO M&E Advisor overarching in ASRO were as follows: inadequate choice of indicators (advocacy and KM); inadequate/common understanding of indicators (meta-data); over-reporting; non-availability of supporting documentation; inadequate data collection and reporting systems (IP-based); inadequate data-quality control/assessment; and inadequate collaboration between program and M&E staff

IX.Building An M&E Culture (Scope and Reach):
1.In order to align IPs to a performance measurement culture and adopt RF/M&E systems that are owned, CO has to initially start its own exercise first and fast, then pass on to IPs (in the final CP year-2017) to be equipped for 10th Cycle
2.Both SIS/MyResults and Atlas can be used for reporting by IPs. No capacity building or incentives given to IPs to use those ***real-time*** reporting tools

CHAPTER 5: CONCLUSIONS, RECOMMENDATIONS AND LESSONS LEARNT

CONCLUSION	ORIGIN	RECOMMENDATION	PRIORITY LEVEL	ADDRESSEE	ORIGIN	TIMEFRAME
STRATEGIC						
C1.STRATEGIC CONSULTATIONS & NEW MODE OF ENGAGEMENT: Political instability rendered the 9th Cycle atypical. A new mode of engagement and business model was passed after Cycle beginning. A two years' shift period was set as deadline for migration to the new strategic mode. In a politically turbulent environment, organizations with unchanged leadership fared better with NEX modality's ownership.	**EQ1; EQ5**	**R1**.Multi-layered targeting for mitigating effects of political changes required. The sequencing of SP, CPDs and CPAPs should be revisited, with SP arriving mid-cycle. While the majority of stakeholders are accepting the new mode of engagement generally, wider consultations are to be undertaken and robust steps towards focusing the bull's eye, with added capacity building to move to policy advocacy and knowledge management across CP components. Build capacity for adoption of national ownership NEX modality as per SP 2014 for organizations (IPs) in need of more capacity investments and falls under frequent leadership changes	**HIGH**	**UNFPA CO; UNFPA HQ; GOE; IPs**	C1	**SHORT**
C2.STAKEHOLDERS' MAPPING & SHIFT TO NEW MODE OF ENGAGEMENT: CO has not generated strategic stakeholders map for the 9th Cycle, is spreading operations thin requiring improved prioritization affecting its comparative strength and value addition. Evidence show most stakeholders unaware of the new strategic orientation of UNFPA towards the bull's eye and mode of engagement, which classifies Egypt as a yellow country. The new mode of engagement (i.e. policy advocacy and knowledge management, with added capacity building however) is found	**EQ1; EQ3; EQ4; EQ5**	**R2**.A complete stakeholders mapping exercise on clear criteria and rigorous assessment. Joint planning, consultation, consensus to aligned priorities, implementation and progress to be fortified with IPs in the 10th Programming Cycle for better results, enhanced accountability and documented lessons learned	**HIGH**	**UNFPA CO; MOFA; MOIC; IPs; DONORS; UNCT**	C2	**SHORT**

acceptable to stakeholders, especially at the central level						
C3.ADVERSE SELECTION: CO is an organization with relevant mandate for Egypt and focused on RH, GE and population issues. Its visibility is not among its strongest areas, with more focus on lower-level, activity-based interventions. Despite this, the growing size of funds raised in OR, with shrinking RR, during the 9th Cycle affirm relevance of UNFPA mandate and stakeholders trust	**EQ2; EQ5**	**R3**.Enhance CO working partnerships with stakeholders through enhancing results, limiting conferences, workshops and launching events that are not followed through for documented tangible results. The newly reinvigorated political commitment for population issues in development lays additional responsibility on UNFPA to deliver more quality results on its agenda visibly. With clearly focused programming towards results and strong fund raising strategy in place, RR contraction has limited effect on CO capacity to deliver	**HIGH**	**UNFPA CO**	C3	**SHORT**
C4. SYNERGETIC, COORDINATED ACTIONNING: CO has been fairly active player in UNCT and partner with other UN agencies and donors in the 9th Cycle, through the Chairing and participation in key UNCT Task Forces. Despite achievements, CO South-South and triangular cooperation and learning opportunities can be improved	**EQ5**	**R4**.CO participation in TFs and WGs is a two-way stream. This enhances CO visibility, demonstrates results, and adds credits to the knowledge bank within the organization. In addition, South-South and Triangular cooperation should work to the effect of enhanced peer-to-peer continuous learning, knowledge exchange, and accountability. These activities are requisites to developing sustainable, living knowledge hubs likely to be easily replicated and up-scaled. UNCT is an access-ready channel, inter alia. PSA should be the favored document for CP programming	**MEDIUM**	**UNFPA CO; RO; HQ; UNCT; IPs**	C4	**MEDIUM**
C5.RESOURCE MANAGEMENT: Humans are the most precious resource to an organization. Despite of this, CO staff are left with insufficient capacity building budget to fortify continuously their human and technical skills. They are being undermined/down-scaled in the current organization structure, under-staffed and overworked. Capacity building availed is	**EQ2; EQ3**	**R5**.If budget limitation precludes expanded capacity building of CO staff, encourage recruitment of local interns to enable more time for PMOs to acquire online training. This is indispensable to keeping the CO with this niche as the population expert. The CO organization structure and arrangements to be revisited to reflect staff credentials and standing experience. A multi-year capacity	**MEDIUM**	**UNFPA CO; HQ; RO**	C5	**MEDIUM**

online on generic subjects, such as leadership training, security, soft skills, and lesser so on technical issues		building budget to be allotted in line with PAD to enhance efficiency				
CROSSCUTTING PROGRAMMES						
C6.PROGRAMMATIC CONSOLIDATION: Programme areas are parallel-tracked, lack a good focus on the bull eye's and do not synergize for improved outcomes. No analytical lessons learnt sufficiently drawn within Cycle to refocus programming in this direction or towards results. Under work pressures, CO staff working in silos with limited technical backstopping from RO and HQ	**EQ2; EQ3; EQ5**	**R6**.10th Cycle programming should revolve around a single outcome relating to RH with sub-components to GE, PD, FP, MH, and humanitarian response to translate the bull's eye effectively. Joint programming, cross-mainstreaming and implementation should be encouraged. Technical backstopping from RO and HQ encouraged and reported on. Documentation of learning and knowledge acquired	**HIGH**	**UNFPA CO; RO; HQ**	C6	**SHORT**
C7.INSTITUIONAL/ORRGANIZATIONAL/OPERATIONAL: No rigorous organizational capacity assessments are conducted to IPs prior to signature partnership agreements. Spot check audits are not a replacement to capacity-related aspects such as bureaucratic delays or blockade. Organizations with stronger internal systems, technical competence and stabilized leadership tend to deliver better on programmatic results. Activity-based reporting loosely tied to programme outputs.	**EQ2; EQ3; EQ5**	**R8**.Improved exercises for the selection of strategic partners is required. This should normally start with a proper, mandatory organizational capacity assessment through partnered collaboration, and perhaps be a multi-donor exercise covering a set of defined aspects of interest. A shift of focus towards performance audit—than the current financial audit and budget disbursements--should be encouraged. Reporting should be results-focused, than activity based. This may necessitate intensive capacity building on RBM and log-framing to PMOs and IPs.	**HIGH**	**UNFPA CO; MOIC; IPs; UNCT; DONORS**	C7	**SHORT**
C8.DATA COLLECTION FOR COMMUNITY-BASED INTERVENTIONS: Community-based interventions are not strong enough due to lack of direct intervention and capacity building activities based on robust data collected. Field presence, than external consultants is required for rigorous assessments of priority actions, interventions	**EQ3**	Develop linkages between UNFPA interventions based on reliable data sources and updated studies for proper targeting on real needs then prioritize to ensure programme interventions and capacity building activities are aligned to produce effective results	**HIGH**	**UNFPA CO**	**C8**	**SHORT**

targeting, and bottlenecks. Targeting was not based on updated CCA prepared in 2010 prior to two revolutions and changing political, social and economic conditions that followed						
C9.KNOWLEDGE MANAGEMENT AND PRODUCTS: During current CP, there is a tendency to collect useful empirical data to inform on programmatic targeting that is unutilized (e.g. DHS, SYPE)	**EQ3, EQ4**	**R9.** Generate knowledge management strategy and action plan covering the following: 1) access to existing knowledge internally (i.e. organizational tacit knowledge) and externally; 2) create widely accessible expert system of analytical data, knowledge and lessons learnt; 3) encourage researchers, academic institutions and think tanks (through competitive grants and scholarship awards) conclude in-depth analysis of statistics compiled and collated by CO to inform RH, GE and PD policy making	**HIGH**	**UNFPA CO; academic institutions and think tanks**	C9	**MEDIUM**
C10.OPERATIONAL: Record up keeping and handover mechanisms are inadequate at CO and partnering IPs	**EQ2; EQ3; EQ4**	**R10**.Financial records, AWPs, ARs, SIS reports, KM products, project files, periodic reports, project background and progress documents currently inadequately kept at CO and IPs have to be synchronized into an efficiently documented automated system by both parties. Since January 2017, IPs are enabled access to SIS, and earlier in 2016 to Atlas. These tools are not known to IPs who may be willing to use if offered training, incentive to use and required to do so for improved effectiveness, swift implementation early warnings, and mutual accountability	**MEDIUM**	**UNFPA CO; IPs**	C10	**MEDIUM**
PROGRAMMATIC (YRH)						
Youth Component						
C11.CENTRAL-LEVEL TARGETING: CO has clear comparative advantage working on central level for the YRH component	**EQ5**	**R11.** Focus upcoming CPAP-related YRH component on work with MOHP at central level, and avoid work on peripheral level. Conduct impact assessment on Sohag and	**HIGH**	**UNFPA CO; MOHP**	C11	**SHORT**

		Assuit experiences to develop advocacy messages				
C12.COMMUNITY-BASED EVIDENCE HARVESTING: Despite appreciated community-based interventions relating to youth (Y-Peer and youth-friendly clinics (YFCs)). No evidence is available to substantiate this perception. In spite UNFPA evaluation for youth and adolescent programme, recommendation were not taken into consideration. Also, M3loma social media platform, HIV/AIDS drop in centers represent a success story for community-based interventions that empowers women. Documentation of this experience is nil	**EQ3**	**R12.** Implement the recommendation of UNFPA evaluation for Youth and adolescent programme. Conclude impact assessment of Y-Peer network, especially the legal status, M&E, sustainability; same for YFCs to assess their effectiveness. Expand social media activities. Document experience of drop-in centers and M3loma.	**HIGH**	**UNFPA CO**	C12	**MEDIUM**
C13.POLICY/NATIONAL-LEVEL SUPPORT: Youth component relevance is not examined against national policies, however efforts to improve relevance expended through working with civil society	**EQ3**	**R14.** Help support youth policy to be drafted and instituted at the national level	**HIGH**	**UNFPA CO**	C13	**MEDIUM**
Reproductive Health						
C14.COORDINATION AND PRIVATE-SECTOR INVOLVEMENT: Lack of planning and coordination among MOHP directorates hindered tapping opportunities from the private sector for affordable pricing policy for FP and investing in areas like post-partum contraception, digitalization and FP filing	**EQ3**	**R15**.Encourage MOHP establish a coordinating organ for all directorates led by the Ministry, while UNFPA acts as Secretariat, to have clear mandate and regular coordinating meetings. The objective is to coordinate among directorates on issues relating to curative care, and mainstream RH in primary and secondary tertiary centers.	**HIGH**	**UNFPA CO; MOHP**	C14	**SHORT**
C15.SUCCESS DEMONSTRATION AND DOCUMENTATION: FP showed success	**EQ3**	**R16.**Expand activities of FP sector counselling services based on precedent success	**MEDIUM**	**UNFPA CO; MOHP**	C15	**MEDIUM**

in terms of effectiveness to be expanded and built-upon						
PROGRAMMATIC (GE)						
C16.OPERATIONAL: There is an attempt to shift mode of engagement, to focus on upstream interventions. However, while there is initially enthusiastic involvement at the level of institutional decision makers, it generally loses momentum and weakens once a "launch event" or signature of MOU occurs. And, there is subsequent weak follow-up by the CO	**EQ5**	**R16.**There is a need for stronger strategic level advocacy to ensure that commitment to interventions and or methodologies/ideologies, transcends personal relationships and reaches institutional commitment for effective institutionalization. Capacity building can be considered a program in itself, defined to provide evidence of behavioral change	**HIGH**	**UNFPA CO, IPs**	C16	**SHORT**
C17.INSTITUTIONALIZATION/SUSTAINABILITY/M&E: While strong contributions to protection SGBV mechanisms are notable through the JP FGM, there are no significant contributions to active GBV response mechanisms in place. There is a greater need for more cohesive planning and advocacy for training, networking and service delivery	**EQ3**	**R17.**Strongly advocate for the adoption and mainstreaming of the SGBV services at MOH, in the most relevant sector, and ensure an M&E system is in place. Ensure that upscaling of interventions is phased, and vertical integration is systemized prior to horizontal expansion	**HIGH**	**UNFPA CO**	C17	**SHORT**
C18.GENDER MAINSTREAMING IN RH: The comparative strength in reproductive health is recognized by some IPs, although they have not felt its impact in the GE Component. The UNFPA mandate and its focus on RH, is an opportune way to tackle SGBV advocacy, service provision, with no other organisation dealing with this issue at such a scale	**EQ6, EQ7**	**R18**.Develop linkages between UNFPA interventions that are occurring in the same geographic locations, and ensure that messages are aligned (this includes development of curricula for RLs and other partners), and sufficient awareness exists in the community of services and interventions	**HIGH**	**UNFPA CO, IPs**	C18	**SHORT**
C19.CATEGORIZATION OF EGYPT IN SP: SGBV interventions are still in their inaugural stage; there is a stated need by IPs for direct technical support and interventions	**EQ1**	**R19:** The designation of Egypt in the UNFPA SP as "yellow category" requires reassessment for this particular GE component to allow for continued technical support	**MEDIUM**	**UNFPA HQ**	C19	**MEDIUM**
PROGRAMMATIC (PD)						

C20.EXPANDED PROGRAMMATIC/STRATEGIC WEIGHT: Despite heightened importance under the new business model, PD component is an orphaned, miniscule component delinked and not consulted in the CPD and CPAP. None of PD stakeholders were found aware of changes consequent to the color grid system, and this has not reflected on allocated budget and magnitude of achievements during the 9th Cycle	**EQ3; EQ4; EQ5**	**R20**.Expand the PD component to reflect its strategic importance as an emphasized environment enabler in SP 2014[254] to enable it deliver on policy advocacy and KM agenda	**HIGH**	**UNFPA CO; MOIC; MOFA; IPs; UNCT/UNDAF**	C20	**SHORT**
C21.MULTI-TIERED RESULTS FOCUS: At NPC, Insufficient planning of an assortment of interventions with lack of focus on integrated results that cascade down to the lowest level and lower effects through the 27 governorate branches. NPS was launched in 2014 and up-to-date neither the monitoring and evaluation or the integrated information system with NPC branches are operational to produce NPS progress reports	**EQ3**	**R21**.Follow the full results chain in programming for proper project planning, and decide with IPs which gaps can be supported comprehensively. Assist IPs in finding partners and donors based on the strategic stakeholders' map completed and UNCT network to implement better integrated results-oriented solutions	**HIGH**	**UNFPA CO; NPC; IPs**	C21	**SHORT**
C22.GEOGRAPHIC TAREGTING ALIGNMENT: Evidence from IPs on mal-alignment of geographic targeting. For NPC, Fayoum, Beheira, Qena and others were identified as more potent for improved results	**EQ2; EQ3**	**R22.**A refined selection criteria for geographic targeting should be implemented in the 10th Country Programme Cycle. A mix of quick-win and highly challenging, most needy governorates to be considered. This will improve results and demonstrate success faster for replication and up-scaling	**HIGH**	**UNFPA CO; RO; IPs**	C22	**SHORT**
C23.INSTITUTIONAL/ORGANIZATIONAL/OPERATIONAL: At NPC and CAPMAS: Delays in AWP preparation, signature and push for milestones delivery, matched with government legal, financial and fiscal cycles bureaucracy were debated issues	**EQ3**	**R23**.Closer consultation and coordination on interventions multi-year programme, annual planning and implementation to be observed and conceded upon. Considering different agreed mechanisms and pre-set timetables	**HIGH**	**UNFPA CO; NPC; CAPMAS; IPs**	C23	**SHORT**

[254] As per SP 2014: YRH=73.3% of programme funding; GE=11.6%; and PD=15.4%, respectively. In Egypt CP: 1) CP 2007-9: YRH=52.8%; GE=16.7%; and PD=23.6%; and 2) CP2013-7: YRH=72%; GE=22.8%; and PD=does not exist, with expenditures till end of Q4 relative to other components equaling 6.68%). See SP 2014, p. 19, and section 3.2.3 of this report.

between CO and IPs leading to numerous AWP amendments and pressures		enable countering institutional bureaucracy on IPs and CO sides				
C24.OWNERSHIP AND ENGAGEMENT: At NPC, PD interventions are reactive (than responsive) to IPs requests. Knowledge management products are prepared by external consultants, than jointly involving IP staff leading to reduced capacity built, with little engagement of permanent staff, and media campaigns sporadic not having strategic vision, an eye on effectiveness, sustenance or BCC measurement	**EQ2; EQ3; EQ4**	**R24**.CO should act as an honest knowledge broker who is able to advice and pair technical assistance needs of IPs. Engage permanent wider circle of NPC staff in drawing comprehensive planning & implementation of interventions in the 10th Cycle, added to identification of effective knowledge products and media plans. Fund the plans (either through own funds or partnered funds), support research endeavors, and produce policy briefs and relevant materials through training of the NPC staff.	**HIGH**	**UNFPA CO; NPC; IPs**	C24	**SHORT**
C25. SEQUENCING & SUSTAINABILITY OF INTERVENTIONS: While NPS 2015-2030 is a medium to long-term strategy, it is yet in the process of materialization towards outputs and lesser so towards outcomes monitoring than evaluation. By design, an M&E system was conceded and is yet to be fully implemented after the elapse of 2 years since launch	**EQ 3; EQ 4**	**R25**.Proper sequencing of interventions and exit strategies sustenance for interventions should be contained at initial stages of project formulation with a clear theory of change and logical framework constructed together with stakeholders sequencing interventions more effectively to sustain. Completed project documents according to accepted norms should be a binding, yet remain as living document/contract between partners ensuring interventions are properly planned, implemented and sustained	**HIGH**	**UNFPA CO; IPs**	C25	**MEDIUM**
C26.CAPACITY-BUILDING PROGRAMMING AND EFFECTIVENESS EVALUATION: At NPC, training courses have not yielded marked results in institutional capacity building. No record keeping of beneficiaries, complete training materials content, or reporting. Capacity building needs assessment was not performed, and training effectiveness has not been tested	**EQ3**	**R26**.A proper archiving system has to be maintained at CO and IPs, enabling project formulation, implementation, expansion, lessons learned drawn, replication, upscaling, tracking and handover in case of staff changes at both ends. Conclude rapid capacity assessment of IPs to identify SWOTs, and implement a separate training effectiveness exercise at NPC.	**MEDIUM**	**UNFPA CO; NPC; IPs**	C26	**MEDIUM**

HUMANITARIAN RESPONSE						
C27.TARGET ALIGNMENT TO RH AND SGBV: CP Humanitarian programming is insufficiently aligned to the 3RP strategy and shift to new mode of management. SGBV programming not strong enough, as well as linkages to RH and GBV networks, IPs and programmes that can provide services and support. The reason for the non-involvement of PD as policy enabler is unclear	**EQ3**	**R27.**Humanitarian programming should be focused and aligned with the Livelihoods and Social Cohesion component of the 3RP, including time and length and funding. Shift to focus on resilience and medium-term sustainability. This should be accompanied by technical training and awareness to CO for focused 10th Cycle component mainstreaming	**MEDIUM**	**UNFPA CO; 3RP partner agencies**	C27	**MEDIUM**
MONITORING AND EVALUATION						
C28.STRENGTHENING CO M&E FUNCTION: Similar to many UN organizations, the M&E system used by the CO is process- not results-based. There is a conflict in terms of the definitions utilized by the CO regarding activities/inputs and outcomes/results, leading to reporting on activity level. The M&E function is neither independent nor insulated from conflicts of interest, while the 9th CP has not aligned closely to SP 2014 new strategic orientation. PD stood alone once SP 2014 came into effect, and the humanitarian component was not sufficiently programmed, monitored or evaluated in the 9th Cycle. Regional peer mechanism proved good learning tool availed through RO support to CO. M&E currently fragmented between PMOs, M&E Focal Point and AR.	**EQ1; EQ2; EQ3; EQ4; EQ5**	**R28.**With the new mode of engagement, the RB M&E framework must be operationalized. The various tools dedicated to results-based monitoring should be re-engineered by the users. CO staff (and IPs) should be trained accordingly, and a high-level ***fully-independent*** officer away of programming is recruited to report directly to the CO Representative. An evaluation plan and mid-term reviews should be defined for all programme components and ring-fenced, with a budget allocated at the start of each programme cycle, as per widely-accepted good practice.[255] A capacity-building plan to CO on RBM prior to the 10th Cycle exercise to be executed. In parallel, another training plan to IPs on RBM, project formulation, implementation, M&E, online usage of Atlas and SIS, together with an incentive mechanism designed. Ensure components' progress reports from IPs tied to SP outputs and outcomes starting terminal 9th Cycle year	**HIGH**	**UNFPA CO; RO; HQ IEG; MOIC; IPs**	C28	**SHORT/MEDIUM**

[255] Five to ten percent of total CP portfolio size. With large portfolios, economies of scale are expected, however with smaller-sized portfolios and at stages of inception and strategization, the ceiling is normally the picked option. The senior M&E Officer should be supported by an able team (JPO level etc.). The Senior M&E Officer is best and optimally funded from IB, though if inaccessible then the second-best scenario would be recourse to RR. His/her M&E Team and operations are to be funded through OR.

Lessons Learned and Success Stories *(identified as unintended results of the CP evaluation)*

YRH

1.Learning from M3loma's success story

The M3loma social media platform focusses on sexual and reproductive health rights targeting young people. The page of Facebook has about 1.5 million "likes." Half of the people who have "liked" the page are Egyptians while the rest are from other countries, mainly from the Arab region. The success story of M3loma is linked to the design of the message and social media campaigns designed to attract young people. The message design was careful to target average young Egyptians who may feel embarrassed or ashamed to access pages that discuss sexual and reproductive health. The message also covered wider health issues that respond to the needs of young people. The daily inquiries through different resources range from 20 to 30 per day mainly on the facebook page. Most of the questions posed related to sexual and reproductive health which gives an indication of the platform to present itself as a reference for reproductive health for youth.

2.Gender mainstreaming in reproductive health programmes

The programmes designed to target women and reproductive health assume that it has gender mainstreaming in its structure. However, it is not always the case. Gender inequality was important factor affected the programmes for maternal health and family planning. It affected the mid-wives' trainees who could not practice delivery because their husbands banned them from contraceptives use. It also affected the beneficiaries who follow their husbands wishes whether to use contraceptive or not. Husbands even decide on the tool to be used. One of the women said to the FP center "I want this contraception because it will make me fat and my husband does not like me to be skinny as I am now".

Implementing successful gender mainstreaming programme in reproductive health seems to require considering gender factors in different levels of the project design, implementation and monitoring. It will also require men involvement and further analysis for those factors to combat them in the project design.

GE

3.Learning from FGM PMU at NPC

Efforts and effectiveness of the FGM PMU shows that ample time is required, over many years, to strengthen advocacy, build and integrate capacities and mechanisms that requires direct involvement and physical presence in the field. In the face of GBV issues that require a mindset/cultural change (not only of the existing culture of acceptance of GBV, but for victims themselves to overcome taboo and stigmatizations and report incidences and protect themselves), the model presented by the FGM PMU at NPC is one that needs to be replicated. There has to be a focus on hiring good technical staff that are committed, building their capacity, building a team culture and supporting their institutionalization, not just within a certain institution, but within a higher level of government. It is also, an effective example of models that can be utilized at the community level for change. However, it has to be re-emphasized that this comes with the understanding that such models require time and effort to fully materialize into behavioral and practice changes.

PD

4.Packaging factors for a successful national population strategy

Launching a national population strategy is a major achievement, intent to bring about sustained impact when carefully crafted, consulted, is measurable and feasible. Reality checks have proven that this may not be the case.

A number of success factors require thorough study: 1) the presence of a supportive political (regime) and context; 2) a strong strategic institution higher-up in the state administrative apparatus who is able to engage and budget for implementation; 3) the presence of strong political will of the higher echelon of the implementing agency fairly sustained; 4) engagement, consultation and coordination within the cadres of the lead agency and the different layers of government (central and local) and partners (private sector, civil society, and development partners) is essential for data generation and utilization in decision making (early warning and corrective actions mechanisms); 5) building the capacity of the lead agency's in-house staffers upon conducting a comprehensive organizational capacity building assessment. This should lead to the development of an integrated utility-based M&E "system"[256] at the output, outcome and impact levels spanning the central and local levels at the outset; 6) developing and implementing a comprehensive advocacy and media campaigns based on evidence-based reports and knowledge products and effectiveness measurement; 7) prepare and conclude an M&E plan drafted at the outset to ensure alignment, ownership and accountability; and 8) CO has to have a similarly stabilized human, financial and technical resources to support an intervention with such national (and eventually local) scale and impact. The realization of items 1 to 5 above are imperative to the pre-launch of the national strategy (rather than *ex post*). Item 8 should sustain until the term of a pre-planned exit strategy expires and impact assessment is concluded to measure effects.

5.Learning from CAPMAS success story

Despite the short relations between UNFPA and CAPMAS, focused interventions and achievements are promising. A strong leadership, higher-up in the state administrative apparatus subjected the organization to voluntary organizational capacity assessment by OECD/Paris 21+. A vivid multi-stakeholder policy dialogue was initiated to collect data and construct complex SDG indicator with a pledge for the issuance of an annual SDG tracking report with continuous refinements to assume international leadership and inform decision making. With the return of staffers from expatriate training, they were asked by their institution to offer TOT to their colleagues to expand excellence and learning circles, giving a success model to the other state administrative units. CAPMAS is now working with solid strides towards operationalizing Egypt's debut national statistical strategy.

[256] M&E systems are commonly mistaken for performance indicators.

ANNEXES

ANNEX 1: TERMS OF REFERENCE

1. Context

Egypt is a low middle income country; GNI per capita is $3,050 (WB 2014)[1], it is the most populated in the Middle East. Egypt is at a stage of demographic transition with a marked "youth bulge," a period in which the proportion of youth in the population increases significantly compared to other age groups. 61% of the population is under the age of 30 and 40% between the ages of 10 and 29 (SYPE, 2009 and 2014)[2].

The youth bulge will become a demographic dividend, where economic benefit arising from increase in the ratio of working-aged relative to dependents can be harnessed. However, if a large cohort of young people cannot find employment and earn satisfactory income, the youth bulge will become a demographic issue, because a large mass of frustrated youth is likely to become a potential source of social and political instability. In Egypt, youth (15-24) unemployment rate is 34% (HDR, 2015)[3]. The dynamic population provides both latent productive capacity and increasing consumer demand. The technological aspects in Egypt are limited, all elements of the innovation pillars got low scores including R&D activity (GCR, 2016)[4].

Egypt's political transition culminated in the election of a parliament, which held its first session in January 2016. The economic outlook since the July 2014 Presidential election looks optimistic. Assumptions expect economic growth to average 4.2% in 2016 onward as political stability improves and economic reform progresses. Yet economic recovery remains fragile due to high inflation rate, budget deficit, high outstanding public debt to GDP ratio; and a rising unemployment rate.

Actually, Egypt has made advances along a number of human development indicators, but economic growth has been moderate, insufficient to absorb the rapidly growing population and labour force. Child mortality, life expectancy, primary and secondary school enrolment, and literacy rates have improved in the past thirty years, while average per capita income growth has been around 2% per year since 1980 resulting in an increase in poverty rates.

In the course of implementing the current UNFPA CP, Egypt has faced the consequences of two consecutive revolutions; where the political landscape reflected instability and anxiety that generated on-going protests, increased violence and strikes by segments within the society. That in-turn, impacted some of the gained development results as the political and social unrest resulted in change of strategic directions in many areas and affected the national priorities. According to Demographic Health Survey (EDHS 2014)[5], the Family Planning indicators deteriorated, such as decline in contraceptive prevalence rate, negative shift in method mix from Long-Acting to Short-Acting that allows higher discontinuation rate, decreased utilization of public sector services by beneficiaries, and increased unmet need.

1World Bank http://data.worldbank.org/country/egypt-arab-republic
2Survey on Young People: http://egypt.unfpa.org/Images/Publication/2015_06/6be3baf2-61e3-4de4-bc9b-221f5180cd18.pdf
3UNDP Human Development Report: http://hdr.undp.org/en/countries/profiles/EGY
4Global Competitiveness Report: http://reports.weforum.org/global-competitiveness-report-2015-2016/economies/#economy=EGY
5Demographic Health Survey: http://dhsprogram.com/Publications/Publication-Search.cfm?ctry_id=10&country=Egypt

Egypt is aiming through the recently launched *Egypt 2030 Sustainable Development Strategy*, to raise Gross Domestic Product (GDP) to >10% in 2030, up from the 4.2%, and to reduce the budget deficit to 2% from 11%. The strategy is aligned with the 2030 Agenda for Sustainable Development. Reinforcing the role of youth in sustainable development, the president of Egypt declared 2016 is the year of youth. Based on indicators, an overview of Egypt needs/challenges and interests/capacities is found under Annex A.

2. Background

In close collaboration with Government of Egypt and based on a situation analysis, the United Nations Development Assistance Framework (UNDAF, mid 2013-2017) was developed where five priority areas were identified for interventions by UN. At the same time, UNFPA Egypt Country Office (CO) developed its 9th country programme (CP), in consultation with national partners. The program aims to expand the possibilities for women and young people to lead healthy and productive lives, by tackling reproductive health, gender and population needs and working with implementing partners to accelerate progress in addressing those needs.

The CP is composed of three outputs that are measured by ten indicators, in addition to one output selected from UNFPA global Strategic Plan 2014-2017 (SP) and the relevant indicators. The CP contributes to four UNDAF outcomes in three priority areas, and its focus areas are reproductive health (RH), young people, population and development (PD) and gender based violence (GBV). The CP works to strengthen health systems/duty bearers to fulfil their obligations on the supply side, and assists community members/rights holders to claim their rights on the demand side. Also the program works to support knowledge generation to supply decisions makers with evidence. The geographical focus of the grass root interventions is Upper Egypt namely Assiut and Sohag. The CP estimated budget is $14 million from both regular and other resources.

To mention, the SP was developed in the course of implementing the CP, where a new business model was introduced to respond to the changing environment in program countries, to improve focus and coherence of UNFPA work, and to deploy resources to where most in need. The model classifies countries based on their ability indicator (GNI per capita) to finance their own development, and the countries social needs indicators (MMR etc.) where the modes of engagement (the how) with national partners were defined. Egypt was classified as yellow country where the focus must be on upstream interventions, namely 1) Advocacy and Policy dialogue/advice 2) Knowledge management. In 2014, Egypt CO had to align its 9th CP strategies to the new modes of engagement, while guaranteeing the achievement of same CP outputs, where the focus was on aspects of change linked with capacity development and service delivery interventions according to the program design and Theory of Change at the time of CP development.

The purpose of this evaluation is to conduct an end of country program evaluation (CPE) to demonstrate accountability to stakeholders on performance achieved. The primary audiences of this evaluation are UNFPA senior management, executive board, donors, government partners, and CP managers. Most of the program partners especially the government are part of the evaluation process either as sources of data (primary/secondary) or through representation in the evaluation reference group (ERG).

3. Objectives and Scope of the Evaluation

The overall objective of the CPE is to provide an independent assessment of the effectiveness and relevance of UNFPA Egypt 9th country program and to inform the design of the next program. Furthermore, the CPE is expected to highlight important lessons to enrich the knowledge base of UNFPA for learning in order to improve the quality of future actions. The specific objectives cover two analyses, a) CP focus areas namely RH, GBV PD and young people b) CO strategic positioning within Egypt developing community and national partners and they are:

- Assess relevance of the program and progress in the achievement of outputs and outcomes against what was planned (effectiveness) in the country program action plan (CPAP), as well as efficiency of interventions and sustainability of effects;

- Assess responsiveness of the CO to changes/additional requests from national partners caused by an evolving country context as well as by the influx of Syrian refugees to the country

- Assess the added-value of UNFPA program to the national partners and to the development community in Egypt

- Assess alignment of CPAP with the UN Development Assistance Framework (UNDAF) and role of UNFPA country office as an active contributor to the coordination mechanism of the UN country team.

The scope of the evaluation is to cover activities implemented from mid-2013 to mid-2016 with ministries/institutions/NGOs involved in the CP implementation. Some interventions are implemented at the national level, others target specific governorates namely Assiut, Sohag and Greater Cairo. The CPE will cover the 3 outputs of the CPD 2013-2017 in addition to one output selected from UNFPA SP on PD. Also contributions of the outputs to humanitarian needs are covered in the evaluation.

4. Evaluation Criteria and Evaluation Questions

UNFPA Handbook on How to Design and Conduct a Country Program Evaluation(HB) spells out the approaches and methodologies of designing and conducting an evaluation, and is considered as the main guiding document to accomplish this evaluation. In the process of designing and conducting the evaluation, a set of tools and resources are available in Part III of the Handbook that support the evaluators as well as a number of templates recommended to be used throughout the different phases of the evaluation.

The evaluation will follow OECD/DAC criteria: Relevance, Efficiency, Effectiveness and sustainability to analyse and evaluate the focus areas namely RH, PD & GBV, in addition to analysis of CO strategic positioning with regard to responsiveness, added value and coordination with UN country team in Egypt.
Below is the list of indicative questions, the final list will be formulated by the evaluation team in the design report. The total number of Evaluation Questions (EQs) should be limited to ten maximum (the selection will be made in the long list of questions under Effectiveness criteria).

Relevance:

1. To what extent are the interventions of UNFPA Egypt CP 2013-2017 (1) relevant to the needs of the intended beneficiaries (women and young people); (2) in line with the government priorities; and (3) aligned with UNFPA policies and strategies?
2. To what extent has the CO been able to respond to changes in national needs and shifts caused by major political changes?

Efficiency:

3. To what extent did the intervention mechanisms (organizational procedures) foster or hinder the achievement of the program outputs?

4. To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country program?

Effectiveness:

5- To what extent has UNFPA support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into the national systems and are positioned on the national agenda?

a) To what extent has the CP contributed to improving the capacity of the national health system to provide high-quality maternal health services to women of reproductive age?

b) To what extent have the interventions supported by UNFPA in the field of reproductive health (RH) contributed to (or are likely to contribute to) improved access and utilization of maternal health and family planning services, including deprived communities?

c) To what extent has the CP contributed to strengthening the national capacities for community-based interventions in reproductive health to empower women and young people?

d) To what extent has the CP contributed to creating demand and raising awareness on RH services through utilization of social media platforms?

e) To what extent has the CP contributed to enhancing the institutional mechanisms to protect against and respond to gender-based violence against women and girls? (In particular by helping to build the national capacity to implement laws and policies that curtail harmful practices i.e. FGM/C)?

f) To what extent has the CP strengthened national capacity for using data and evidence to monitor and evaluate national policies and programs in the areas of population dynamics, sexual and reproductive health and reproductive rights, HIV, adolescents and youth and gender equality, including in humanitarian settings?

g) To what extent have the interventions supported by UNFPA in the field of population and development (PD) contributed to an increased availability and use of data on emerging population issues at central and local levels?

h) To what extent has CO humanitarian assistance contributed to an improved emergency preparedness and response for SRH and GBV in Egypt?

Sustainability:

6. To what extent has the CP been able to support its partners and beneficiaries in developing capacities and establishing mechanisms (for example: youth friendly services) to ensure ownership and sustainability of achieved results?

UNFPA Added Value:

7. What are the main UNFPA comparative strengths in Egypt, particularly in comparison to other UN agencies?
8. What is the main UNFPA added value in the country context as perceived by national stakeholders?

9. To what extent was the CO able to shift the mode of engagement and focus on upstream interventions?

UNCT Coordination Mechanisms:

10. To what extent is the UNFPA CO coordinating with other UN agencies in inter-agency overlapping activities?
11. To what extent was this coordination effective to boost the program implementation and achieve better results?

5. Evaluation Methodology and Approach

Methods for Data Collection: The evaluators are expected to review and refine the evaluation questions and develop the evaluation matrix. For data collection, the evaluation will use both primary and secondary data that could include desk reviews, group and in-depth interviews, and field visits.
Validation mechanisms: The evaluation team will use a variety of methods to ensure that the data is valid, including systematic triangulation of data sources and data collection methods. The precise methods of data collection, analysis and validation will be detailed in the design report.
Selection of the Sample of the Stakeholders: The evaluation will adopt an inclusive approach that involves a range of stakeholders to generate diverse views on the program performance. The evaluation team will consider both UNFPA direct and indirect partners including beneficiaries of the program to participate in the evaluation, a stakeholders' map will be handed to the team.
Evaluability assessment, Limitations and Risks: The team needs to explain data gaps and describe factors that restrict access to sources of information. In case of lack of sufficient results framework, setting ad-hoc proxy indicators that can be used as a reference to establish the degree of progress and success of the intervention is required.

6. Evaluation Process and Expected Deliverables

The evaluation will be conducted over a period of five months with a total of 116109 working days; it can be divided into three phases each including several steps:

Phase 1: Design phase (1.5 months):
For desk review, mapping of stakeholders (Annex B refers), analysis of intervention logic, refining the evaluation questions in the evaluation matrix[6], development of data collection tools/ interview guides and analysis strategy, development of a concrete work plan for the field visits, and ends with production of the Design Report[7] (20 – 30 pages maximum). The design report provides clarification on methodology, tools, division of labour among the evaluation team, a work-plan to reflect timelines as per ToR, agenda for the field phase, and validation mechanisms to enable verification of preliminary findings.

Phase 2: Field phase:
For data collection, validation, analysis and drafting a set of preliminary findings, conclusions and recommendation, preliminary results are to be presented (power-point presentation) to the CO during a debriefing session at the end of field phase.

Phase 3: Synthesis Phase:

Based on the sound analysis of the preliminary findings, conclusions will be derived from findings and need to be assembled by homogeneous "clusters". Recommendations will be derived from conclusions; recommendations may be organized by clusters (strategic and programmatic). Within each cluster, recommendations need to be ranked by priority level, with a time horizon. The report must mention to whom recommendations are addressed.

For submission of the 1st draft final report for comments by evaluation reference group, a 2nd draft final report incorporating feedback follows. Based on the 2nd draft a presentation is to be disseminated in a seminar, to be shared with key counterparts for comments. The final evaluation report[8] taking into account all potential comments is the last deliverable with a maximum of 70 pages plus annexes.

All deliverables will be drafted in English. Final CPE (e-copy) will be disseminated to all partners and will be posted on UNFPA evaluation database along with the management response[9] to the CPE recommendations and the CPE final quality assessment (EQA[10]) by Egypt CO.

Indicative Timeframe

	Phases/Deliverables	Timeline (start and end)
1	Preparatory Phase (drafting/ Finalization of ToR/ constitution of ERG/preparation of documents)	Jan-Apr 2016
	Recruitment of evaluation team	May-July 2016
2	Design Phase – design report	Aug-Mid Sept 2016
3	Field phase – complete evaluation matrix and ppt Presentation	Mid Oct 2016
4	Synthesis Phase 1st draft final report (Mid Nov)-2nd draft final report (1st week in Dec)-Presentation- Final evaluation report (last week in Dec)	Mid Nov-Dec 2016

7. Required Skills and Experience

The evaluation team will be composed of a team leader and two national experts. The selection of the evaluation team will be based on ensuring a consortium of experts specialized in UNFPA focus area and in evaluation.

Education:

Masters in relevant field of social science, health, development studies and human rights or comparable field

Experience (team leader)

1. At least 10 years of directly relevant professional experience in conducting and managing project and program evaluations of development aid at country/field level.
2. Expertise in one UNFPA programmatic areas is required, such as reproductive health/maternal health, including knowledge of themes relevant to: Family planning, human resources in the health sector, and gender issues or Population/demography focus area
3. Knowledge of United Nations system, demonstrated capacity for strategic thinking and policy advice, familiarity with UNFPA or United Nations operations will be advantage.
4. Fluency in English, knowledge of Arabic

5. Excellent oral and written English

Responsibility (team leader)

- Have the overall responsibility for the production of the draft and final evaluation reports Responsible for the evaluation of one focus area (either RH, GE, or PD)
- Lead and coordinate the work of the evaluation team
- Responsible for the quality assurance of all evaluation deliverables.
- Debrief the findings, and present in the dissemination workshop

Experience (team members)

- At least 5 years of experience in conducting evaluation of projects
- Solid understanding of evaluation methodologies, a proven expertise of research in social science
- Expert in one of UNFPA thematic areas, namely sexual and reproductive health, population/demography or gender issues
- Proven drafting skills in English
- Ability to provide deliverables on time
- Responsibility (team members)
- Prepare the design report in accordance with UNFPA standards
- Evaluate the UNFPA's contribution to the relevant thematic areas of the CP
- Participate in the debriefing meetings and deliver quality reports on time.

The team must be committed to respecting deadlines of delivery outputs within the agreed timeline, and be able to work in a multidisciplinary team and multicultural environment. The division of labour is to be spelled out in the design report.

The work of the evaluation team will be guided by the Norms and Standards established by the UN Evaluation Group (UNEG). Team members will adhere and sign on the Ethical Guidelines for Evaluators in the UN system and the code of conduct.

Duration of Contracts and Remuneration

Indicative distribution of workdays among the team of experts will be as follows:

	TL	Expert 1	Expert 2
Design phase	8	5	5
Field phase	15	15	15
Reporting phase	22	12	12

Total days	**45**	**32**	**32**

Payment of fees will be based on the delivery of outputs, as follows:

- Approval of the design report 20%
- Approval of the draft final evaluation report 50%
- Approval of the final evaluation report 30%

Daily subsistence allowance will be paid per nights spent at the place of the mission following UNFPA DSA standard rates. Travel costs will be settled separately from the consultant fees.

Application process

Interested candidates can apply by submitting a UN Personal History, resume and a short cover note explaining why they are well suited to undertake the evaluation to Egypt.jobs@unfpa.orgby 5 June 2016. In addition, to a clear statement by candidates stating their independence from any organization that have been involved in designing, executing or advising on any aspect of the interventions subject of the evaluation.

The UN terms and conditions will govern the engagement of consultants, including fee and remuneration levels.

8. Management of the evaluation

The management structure for the evaluation is composed of:

1. **Evaluation Manager (EM):** Under the overall guidance of UNFPA Representative for Egypt, the M&E associate will act as the evaluation manager to oversee the entire process of the CPE. The EM will support the team in designing the evaluation; will provide ongoing feedback for quality assurance during the preparation of the design report and the final report. Supported by the Regional M&E adviser, the EM will:

- Prepare the terms of reference for the evaluation
- Identify potential evaluators and share with the Evaluation office for pre-qualification
- Compile a preliminary list of background information on both the country context and
- UNFPA CP
- Constitute an evaluation reference group
- Prepare a first stakeholders mapping (Annex B) of the main partners relevant to the CPE and the country overview (Annex A)

2. **Evaluation Reference Group (ERG):** will be composed of representatives from national partners, country and regional offices. The ERG will provide guidance and comments on implementation and the main deliverables of the evaluation, and advice on the quality of the work done. The ERG is responsible for:

- Contribute to the selection of the evaluation team Provide comments on the design report

- Facilitate access of evaluation team to information sources/interviewees to support data collection
- Provide comments on the main deliverables of the evaluation
- Advise on the quality of the work performed by the evaluation team

Quality Assurance:

Each phase of the evaluation will go through a rigorous quality assurance mechanism for validation as follows:

- Design phase: the report will be approved by the evaluation manager, after contribution from the Regional Office, the evaluation reference group and the Evaluation Office adviser/HQ.
- Field phase: the evaluation manager will be responsible to ensure that the data collection is in accordance with the approved design report.
- Synthesis phase: the final report will be reviewed by the EM, ERG, M&E regional advisor, and the evaluation office to ensure credibility of the evaluation findings, soundness of conclusions, alignment of the recommendations to the findings and conclusions as well as feasibility of the recommendations.

Resources

Initial list of documents to be reviewed by the evaluation team

1) Online

a) UNFPA Egypt Country Program Document and Country Program Action Plan:

http://egypt.unfpa.org/english/publication/80d3a855-255e-4a9c-bf13-f8ca7732a81bhttp://egypt.unfpa.org/english/publication/2bb00f8e-d5ca-4a50-9cdd-bb5ce8f8d7d9

b) UN Assistance Development Framework: http://www.moic.gov.eg/MopRep/MIC/UNDAF%202013-2017--.pdf_1214201522131AM.pdf

c) UNFPA Strategic Plan: http://www.unfpa.org/strategic-direction

d) UNFPA 8th CP Evaluation: add the link

e) How to Design and Conduct a Country Program Evaluation at UNFPA http://www.unfpa.org/admin-resource/how-design-and-conduct-country-programme-evaluation-unfpa

2.Background Documents (to be handed to the evaluator prior inception)

- List of Atlas projects for the 9th CP
- Copies of annual work plans for the 9th CP
- Country office annual reports during the cycle Resource Mobilization Strategy
- CP Reviews (quarterly and annual) during the cycle Trip and monitoring reports during the cycle

- CP Products: strategies- manuals – curricula – researches
  Annual budget and expenditure reports during the cycle
  Problem analysis and interventions logic

Evaluation Report outline

Annexes (to be handed to the evaluator prior inception)

A. Country Overview

B. Stakeholders Map with online links
C. Ethical Code of Conduct for UNEG/UNFPA Evaluations
D. Evaluation Matrix
E. Design report outline
F. Structure of Final Report
G. Tips for PPT on evaluation dissemination
H. Evaluation Quality Assessment template and explanatory note
I. Management response template

Online Resources relevant to UNFPA program areas

Ministry of Planning, 2015-2016 Development Plan:
http://www.mop.gov.eg/plan/Plan2016.aspx?ModID=2&MID=31

Ministry of Planning, Sustainable Development Strategy:
http://www.mop.gov.eg/EGYPT'SVISION.html

Egypt's Progress towards MDG
http://www.mop.gov.eg/MopRep/Final%20MDG%20English.pdf_107201520545PM.pdf

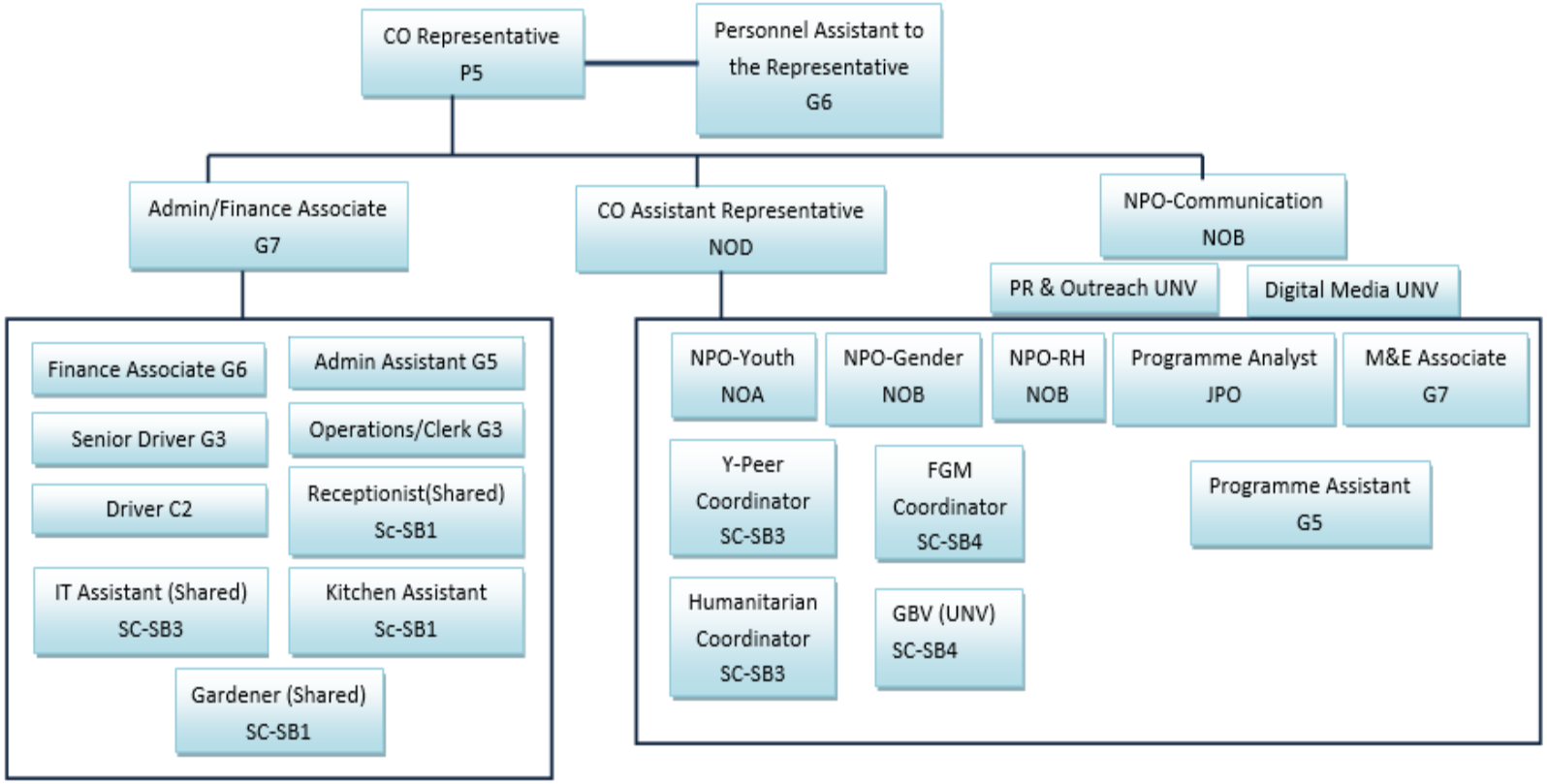
2030 Agenda: https://sustainabledevelopment.un.org/

ANNEX2: EVALUATION REFERENCE GROUP (ERG)

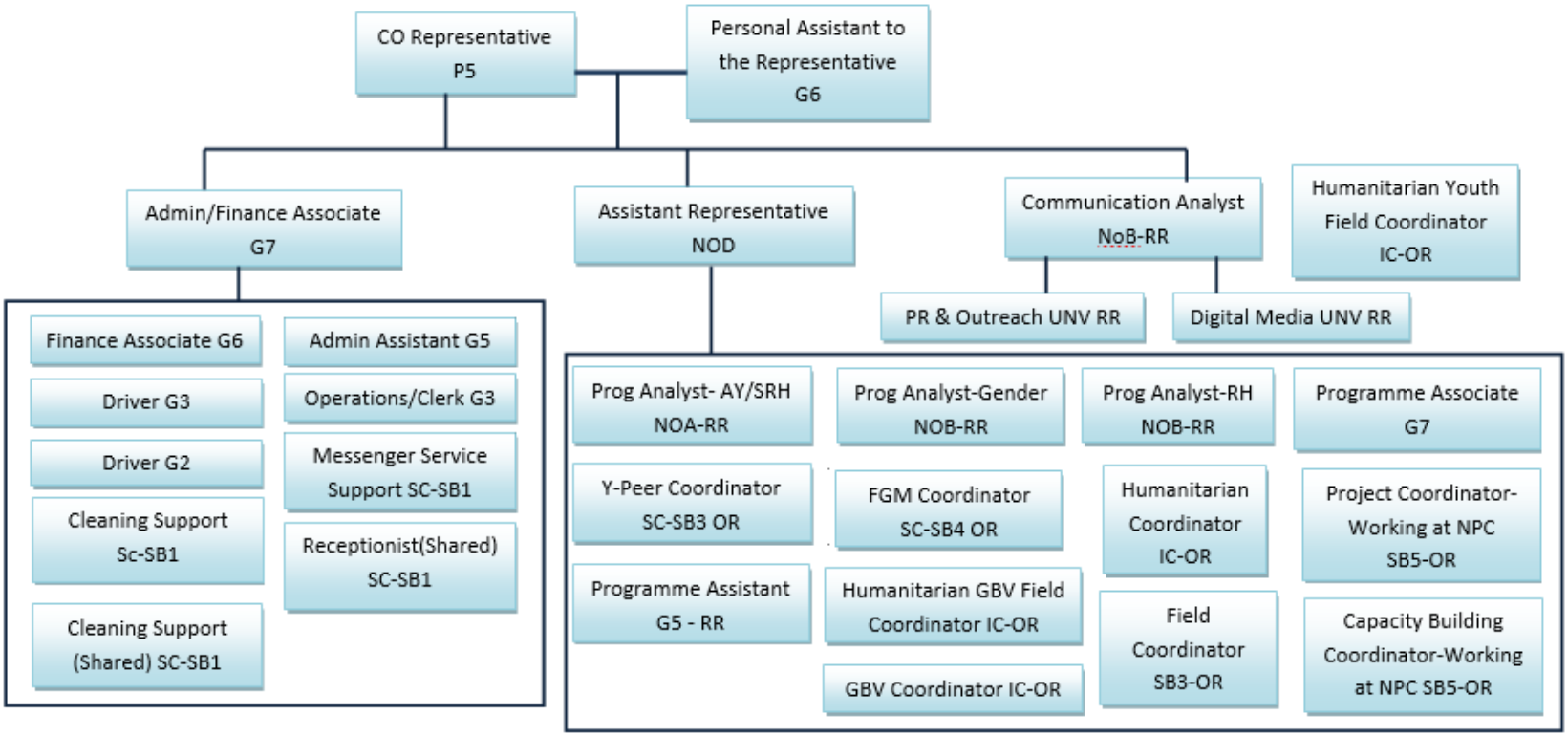
Name	Position	Institution
Dr Aleksandar Sasha Bodiroza	UNFPA Representative	Egypt Country Office
Ms. Dawlat Shaarawy	Evaluation Manager	Egypt Country Office
Mr. Georges Nalenga	M&E Specialist	Office of UN Resident Coordinator
Mr. Moataz Yeken	Senior Advisor to the Minister	Ministry of International Cooperation
Ms. Randa Hamza	Senior Advisor (Alternate/members with Mr. Yeken)	Ministry of International Cooperation
Ms. Sally George	Senior Advisor (Alternate/members with Mr. Yeken)	Ministry of International Cooperation
Dr. Mohsen Fathy	General Manager/Family Planning	Ministry of Health & Population
Dr. Olugbemiga Adelakin	Regional M&E Advisor	UNFPA Arab States Regional Office
Prof. Dr. Tarek Amin	Rapporteur	National Population Council

ANNEX3: CO ORGANOGRAM

May 2015



October 2016



ANNEX 4: OUTCOMES/OUTPUTS OF PREVIOUS VS. CURRENT CP OUTPUTS

Programmatic Areas	Outputs of previous cycle (2007-11)	Outputs of Current cycle (2013-17)
Reproductive Health	**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 (Egypt CPD 2007-2011)	*Access to sexual and reproductive health services for young people(RH)* Output 1: Strengthened national capacities for community-based interventions in reproductive health to empower women and young people. *Maternal and newborn health (MH)* Output 2: Improved capacity of the national health system to provide quality maternal health services to women of reproductive age (UNFPA Egypt CPD 2013-2017)
Gender Equality	**Outcome 5:** Girls' and women's rights to access information and services progressively fulfilled. **Output 1:** Increased number of effective advocacy strategies that promote 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 2:** Community, religious leaders and media are sensitized through active alliances to combat gender-based violence.	**Output 2**: Improved capacity of the national health system to provide quality maternal health services to women of reproductive age **Output 3:** Enhanced institutional mechanisms to protect and respond to gender-based violence against women and girls

	(Egypt CPD 2007-2011)	(UNFPA Egypt CPD 2013-2017)
Population Dynamics	**Outcome 1**: Population policies and strategies reflect a human rights-based approach to programme implementation. **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 2**: Gender analysis and gender disaggregated indicators developed and used in policy dialogue. (Egypt CPD 2007-2011)	No specifically individually stated output for PD, but linked to **Output 2**: Improved capacity of the national health system to provide quality maternal health services to women of reproductive age (UNFPA Egypt CPD 2013-2017)

* UNFPA Egypt CPD 2013-2017 has stated Outputs not Outcomes.

ANNEX 5: CPE PROJECT MAP

Donors	Implementing Agencies	Other partners	Beneficiaries
GENDER BASED VIOLENCE			
Strategic Plan outcome 3: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth. (*Gender equality and reproductive rights advanced particularly through advocacy implementation of laws and policy*)			
CPAP output 2: Improved capacity of the national health system to provide quality material services to women of reproductive age.			
RCT (PN6174)*			
UNFPA, Norway, Joint Program UNDP, Multi-partner TF, Japan, European commission, USA	Regional Centre for Training (RCT)	Ministry of Health MOH)	Doctors and nurses in public hospitals in all governorates CSOs in respective governorates

			Female beneficiaries receiving services
Curative care (PGEG15)*			
UNF UNFPA, Norway, Joint Program UNDP, Multi-partner TF, Japan, European commission, USA PA	Curative Sector - MOH	N/A	MOH central and directorates Female beneficiaries receiving services
CPAP Output 3.1: Enhanced institutional mechanisms to protect and respond to gender-based violence against women and girls.			
NCW (PGEG09)			
UNFPA, Norway, Joint Program UNDP, Multi-partner TF, Japan, European commission, USA	National Council for Women (NCW)	Central Agency for Population and Mobilizations Statistics (CAPMAS)	Decision makers at the national level
Al Azhar (PGEG08)			
UNFPA, Norway, Joint Program UNDP, Multi-partner TF, Japan, European commission, USA	Al Azhar	N/A	Muslim Male and Female RL in Greater Cairo, Assiut and Sohag (Upper Egypt)
BLESS (PN5890)			
UNFPA, Norway, Joint Program UNDP, Multi-partner TF, Japan, European commission, USA	BLESS	CSD	Christian Male and Female RL in Greater Cairo, Assiut and Sohag (Upper Egypt)
NGOs Coalition (PN6186) (Activity stopped)			
UNFPA, Norway, Joint Program UNDP, Multi-partner TF, Japan,	NGOs Union against Harmful Practices Against Women and Girls	N/A	School aged children and families in catchment areas of selected schools

European commission, USA			
Anti-Sexual harassment University Units			
UNFPA, Norway, Joint Program UNDP, Multi-partner TF, Japan, European commission, USA	UNFPA Execution	University of Ain Shams University of Assiut	University Board, university students in Ain shams (Greater Cairo) and Assiut (Upper Egypt)
POPULATION AND DEVELOPMENT			
Strategic Plan output 15**:** Strengthened national capacity for using data and evidence to monitor and evaluate national policies and programmes in the areas of population dynamics, sexual and RH and RRs, HIV, adolescents and youth and gender equality, including in humanitarian settings.			
CPAP Output2: Improved capacity of the national health system to provide quality material services to women of reproductive age.			
NPC*(EGY09PDC)*			
UNFPA, Norway (NOA52), Multiple donors (ZZJ29EGY)	National Population Council (NPC)	Parliamentarians	The National Population Council Personnel. Decision makers at the national level. Poor and vulnerable population (nationally).
Strategic Plan output 12: Strengthened national capacity for production and dissemination of quality disaggregated data on population and development issues that allows for mapping of demographic disparities and socio-economic inequalities, and for programming in humanitarian settings **(CAPMAS AWP 2016**)			
CPAP Output2: Improved capacity of the national health system to provide quality material services to women of reproductive age.			
CAPMAS*(EGY09PDC)*			
UNFPA, Norway	UNFPA CO, CAPMAS	Baseera,Ministry of International Cooperation	Decision makers at the national level. CAPMAS Staff.
SEXUAL AND REPRODUCTIVE HEALTH			

Strategic Plan outcome 1: Increased availability & use of integrated sexual & RH services (including FP, MH & HIV) that meet HR standards for quality of care & equity of access			
CPAP Output 2: Improved capacity of the national health system to provide quality maternal health services to women of reproductive age			
Maternal Health Services*(EGY09MRH)*			
UNFPA, Norway, European Commission, Japan, USA, Multi donor	Ministry of Health and Population- Family Planning Sector (MoHP/FP)	Population Council	MoHP personnel at central, governorates, districts levels.
Maternal Health Services*(EGY09MRH)*			
UNFPA, Norway, European Commission, Japan, USA, Multi donor	MoHP/MCH	Researchers	SDPs at (government, NGOs, Private Sector, Hospitals) Ra'edat Refayat
Maternal Health Services*(EGY09MRH)*			
UNFPA, Norway, European Commission, Japan, USA, Multi donor	Aga Khan NGO, UNFPA CO	WHO, UNICEF, World Bank	WRA in the intervention governorates
ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH			
Strategic Plan outcome 2: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and SRH			
CPAP Output 1: Strengthened national capacity for community-based interventions in RH to empower women and young people			
SRH for young people*(EGY09YRH)*			
UNFPA, Norway, UNDP, Multi partner TF	Youth & Dev. Consultancy Institution	UN Agencies	Selected YFC personnel & youth centers personnel
UNFPA, Norway, UNDP, Multi partner TF	Population Council, MoHP/School Age Health Dept, El Shehab Institution for Comprehensive Development	YPeer, IMFSA, Ma3looma	Selected Peer-educators

UNFPA, Norway, UNDP, Multi partner TF	UNFPA CO	Ministry of Youth and Sports	MARPs (F sex workers) & M partners/ G. keepers

*GBV projects fall under both CPAP output 2 and 3

ANNEX 6: LIST OF ATLAS PROJECTS BY YEAR

		2016		2015		2014		2013		US$	Percentage from the total budget
Projects	**IP**	**Budget**	**Expendit-ures**	**Budget**	**Expendit-ures**	**Budget**	**Expendit-ures**	**Budget**	**Expendit-ures**	Budget	
Population & Development											
EGY09PDC	NPC	87,926	87,395	129,888	129,887	124,455	123,922				
EGY9U202	CAPMAS	22,971	22,965								
	UNFPA	261,196	241,776	103,432	103,668	76,945	76,582	63,700	59,665		
		372,093	352,136	233,320	233,555	201,400	200,504	63,700	59,665	870,513	7%
Gender Based Violence											
EGY09GBV	Azhar	22,400	17,994	55,618	55,617	5,036	5,036				
EGY9U503	NCW	124,952	124,778	288,194	288,053	50,558	50,558				
	BLESS			151,136	150,814						
	Currative	20,000									
	RCT	235,326	224,401	216,076	212,593	94,451	91,439				
	Care (hum)	247,367	216,102	44,340	44,333						
	AMU (hum)	270,251	250,844								
	UNFPA	947,618	819,153	539,184	512,582	236,079	231,585	65,100	64,162		

FGM ZZJ29EGY											
	NPC	*109,040*	*108,144*								
	Azhar	*60,443*	*60,443*								
	BLESS	*74,338*	*71,961*	63,415	63,094	49,748	45,940				
	Coalition			32,886	31,809	89,506	88,449				
	Ypeer			11,000	9,712						
	UNFPA			378,293	377,804	246,446	246,471				
		2,111,735	1,893,820	1,780,142	1,746,411	771,824	759,478	65,100	64,162	4,728,801	36%
Maternal Health											
EGY09MRH	MoHP - FP	41,834	41,832	178,528	178,480	87,531	86,152				
EGY9U202	MoHP - MCH	269,485	269,471	591,941	586,332	452,304	451,883	177,521	170,360		
	RCT			44,543	43,719						
	POPCOUNCIL	100,002	56,393			270,776	218,213				
	YDCI	5,000	4,769								
	UNFPA	535,872	397,182	559,678	549,530	1,031,763	1,025,407	393,171	344,136		
		952,193	769,647	1,374,690	1,358,061	1,842,374	1,781,655	570,692	514,496	4,739,949	36%
Youth											
EGY09YRH	GDSACH	35,869	35,869	47,657	47,657	93366	63,158				
EGY9U601	POPCOUNCIL	156,162	138,455	116,227	115,500						
	SHIHAB	201,797	199,939	71,563	71,529	70,809	68,755	17,980	18,941		
	YDCI	250,635	210,716	411,164	388,854	230,069	230,059				
	UNFPA	166,693	135,633	220,601	216,517	447,024	439,133	157,795	144,017		
		811,156	720,612	867,212	840,057	841,268	801,104	175,775	162,958	2,695,411	21%

	Total	3,436,021	3,015,603	3,388,152	3,338,027	2,815,598	2,741,637	699,492	638,323	**13,034,674**	
Program Coordination											
EGY09PCA		86,500	60,266	101,279	101,195	150,069	149,998			649,307	

ANNEX 7: NINTH CYCLE KM PRODUCTS (BY COMPONENT)

GBV	PD	RH
الدليل التدريبي لمدربي مثقفو الاقران حول قضية تشوية/قطع الاعضاء التناسلية للاناث(المعروفة بعادة ختان الاناث)	Benefit- cost analysis of Egypt family	
الدليل الارشادي و البروتوكول الطبي للتعامل مع ضحايا العنف القائم علي النوع الاجتماعي(متضمنا العنف الجنسي)	الاستراتيجية القومية للسكان 2015-2030	Baseline assessment of the public health system management at district level in Assiut and Sohag
The Egypt economic cost of Gender Based Violence survey(ECGBVS) 2015	الخطة الاستراتيجية 2014-2017	Demographic and health survey 2104
كلنا مسؤولون خليك ايجابي	PB Assuit MSA	Panel survey of young people in Egypt 2014
	PB Behera MSA	Situation analysis for mHealth Intervention
	PB Ismalia MSA	C-Section epidemiology in Egypt
	PB Mynia MSA	Users of Implanon in Assiut
	PB Sharkia MSA	Family Planning in Egypt is a Financial Investment, Benefit-Cost Analysis of Egypt Family Planning Program, 2014 – 2050
	PB Sohag MSA	
	Policy B Giza MSA	
	Media messages guide	

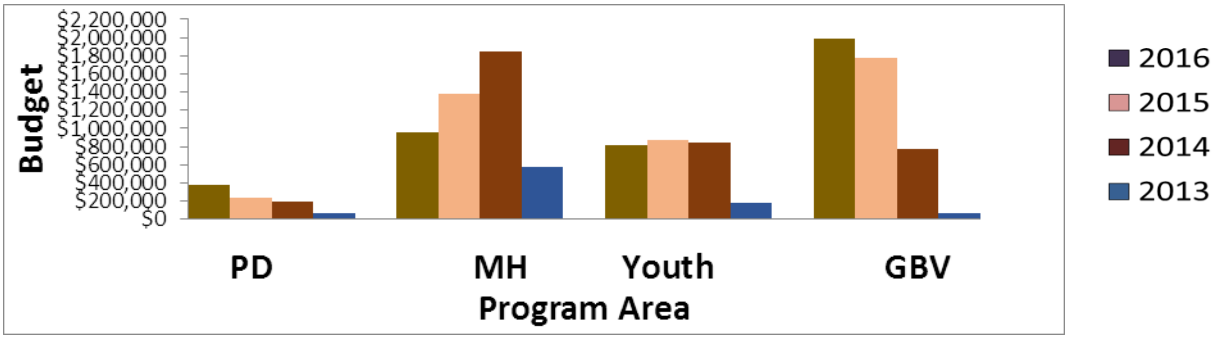
	Monitoring Guide	

Source: UNFPA CO 2016.

ANNEX 8: DETAILS OF THECOUNTRY PROGRAMME FINANCIAL STRUCTURE[257]

The UNFPA 9th cycle (2013-17) total earmarked allocations stood at US$14 million compared to US$18 million in the previous cycle (i.e. years 2007-11). The amount of **US$13,034,674** was budgeted till end of Q3-2016.This is split between three country programme areas under the 9th CP Cycle is as follows: a) **US$7,435,360 (57%)** for RH, youth and adolescents; b) **US$4,728,801(36%)** for GBV; and c) **US$870,513 (6.68%)** for P&D. Figure (1) shows the budget per year for each of the programme areas. In addition, **US$337,848** were allocated for program coordination activities.

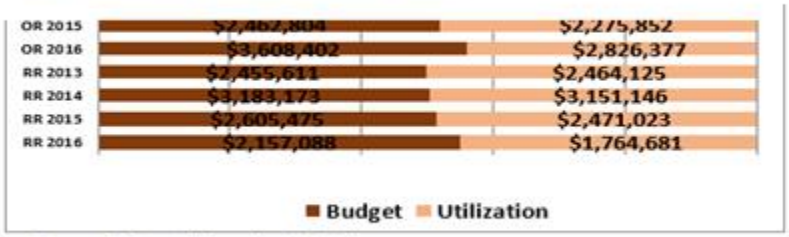
Figure 1 Program Areas Budget per years 2013, 2014, 2015 and 2016



Source: Extracted from summary of evaluation list of projects.

Over the 9th Cycle period, total regular budget (RB) funds amounted to **US$10,401,347**, compared to **US$7,803,034**[258]which came from other funding resources (OR). Figure (2) displays budgeted amount and the respective budget utilization amounts for RR and OR per each year in the 9th cycle, matched with corresponding percentages as illustrated in table 1.

Figure 2: Regular Resources(RR) and Other Resources (OR) budget and Utilization, per year



Source: Extracted from Funds Ceiling.

Utilization Percentage	
OR 2013	99.0%
OR 2014	94.3%
OR 2015	92.4%
OR 2016	78.3%
OR 2013	100.3%
RR 2014	99.0%
RR 2015	94.8%
RR 2016	81.8%

Table 1: RR and OR budget utilization, percentages

In addition, between mid-2013 and mid-2016, total expenditure amounted to **US$12,150,019** as disaggregated by programme area in table 2under. Furthermore, budget and expenditure with respect to source of funding are

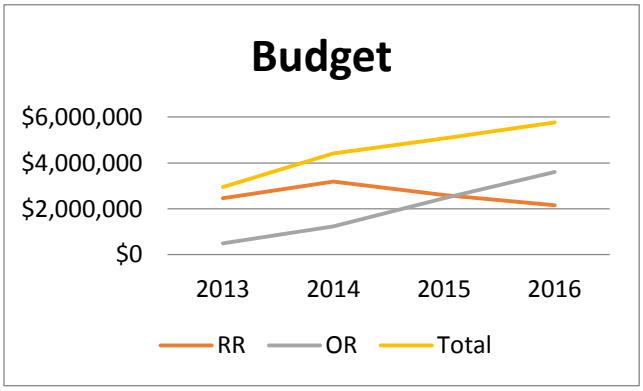
[257] All raw data on financial figures provided in this section are from CO Atlas system.
[258] Question mark on this figure. Some figures on disaggregated levels do not match aggregated level. Provided by CO from Atlas.

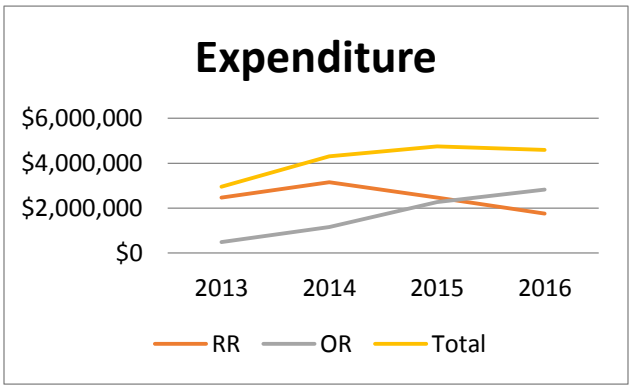
shown in figure 3. There is a noticeable downward trend of RR budget, and alternatively expense outlays as the 9th cycle matures.

Table 2: Total budget and expenditure for each program area per years, 2013,2014,2015,2016

	2016		2015		2014		Mid-2013	
Program Area	**Budget**	**Expenditures**	**Budget**	**Expenditures**	**Budget**	**Expenditures**	**Budget**	**Expenditures**
Population & Development	372,093	352,136	233,320	233,555	201,400	200,504	63,700	59,665
Gender Based Violence	1,993,863	1,785,518	1,780,142	1,746,411	771,824	759,478	65,100	64,162
Maternal Health	952,193	769,647	1,374,690	1,358,061	1,842,374	1,781,655	634,392	574,161
Youth	811,156	720,612	867,212	840,057	841,268	801,104	175,775	162,958
Program Coordination	86,500	60,266	101,232	101,148	150,070	149,999	325,400	322,716
Total	4,215,805	3,688,179	4,356,596	4,279,232	3,806,936	3,692,740	1,264,367	1,183,662

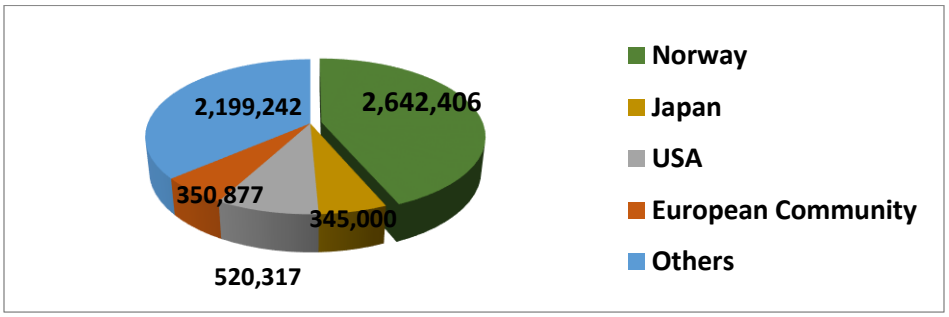
Figure 3: Budget and Expenditure from Regular Resources, Other Resources budget; by year





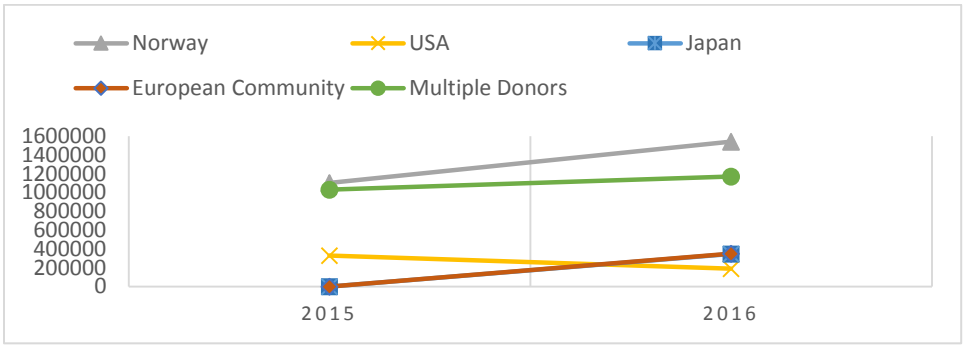
Moreover, partnered donor funding came from Norway on the main, followed by USA, and Japan, *inter alia*. Norway (NOA50, NOA52) assumes the highest rank of funding provisions to UNFPA, with 44% of the total donors'-based funds for the total program cycle. Main focus of Norwegian funding is on: enhancing reproductive health and rights, and combating gender violence in Egypt. Figure 4 shows the share of each prime donor in 9th programme cycle funds. Follows is Figure 5 portraying donor funds trends during years 2015 to 2016.

Figure 4: Allocated budget by Other Resources



Source: Extracted from Annual Financial Reports (2014, 2015, 2016)

Figure 5: Donors Budget Trend



Source: Extracted from Annual Financial Reports 2014, 2015, 2016.

As for Japan funds (representing 6% share of total donors funding), they were directed MoH and providing women and adolescent girls safe spaces for Syrian refugees in Egypt. USA funds (representing 8% share of total donors' funds) were geared towards several projects, including reproductive health and SGBV in Egypt, establishing youth friendly health services, and activities in the Syria regional refugee and resilience plan (3RP). On the other hand, the European commission -with 6% from the donors' funds- had their availed outlays directed to lifesaving comprehensive obstetric and neonatal care services, and multi-sectoral gender based violence (GBV) prevention and response services for Syrian refugees and Egyptian host communities, Egypt. Other donors--including UNICEF, UNDP, UN Women, UNV, UNAIDS and WHO-- hit 36% share of donors' funds directed to the 2013 Survey of Young People in Egypt (SYPE), Scaling up outreach to vulnerable women in Cairo, and JP Egypt Women's Empowerment over the 9th Programme cycle.

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RH documents Reviewed		
Folder	**Subfolder**	**Documents**
Annual reports		2014 Annual Report, pdf 2015 Annual report, pdf
Annual Workplans for the 9 cycle	2013-2014 Workplans	Shehab, pdf Shehab Extension UDCI, pdf MCH, pdf MOHP-FP MOHP YFC, pdf
	2015 workplans	Shehab, pdf CARE, pdf ETIjah, pdf MCH, pdf Pop Council, pdf School age department MOH AWP, pdf
	2016 Workplans	Shehab AWP, pdf AMU AWP, pdf CARE AWP, pdf EtijahAWP, pdf FP AWP, pdf MCH, pdf AWP Pop Council, AWP School age department MOH AWP, pdf
Country Programme Documents		Signed CPAP, pdf Strategic plan 2014-2017, pdf

		UNFPA Egypt CPD, pdf CPD Arabic, pdf
CP products		DHS 2014 SYPE panel 2014 Baseline Assessment Assiut & Sohag
Evaluation Report Outline		Country Programme Evaluation 2007-2011, pdf
Financial reports		Financial reports 2015/2016
Progress Reports		MOH FP 2014 QQ2, Elijah Q1,2,3 2015l Pop Council Q4 2014
Trip Reports		
		CP Products Marix, excel
		Maternal health assessment chart
		Letter to Evaluators July 2016,word
		UNFPA projects by Department, excel
		ToC for maternal mortality
		Detailed TOR,pdf
GBV documentation Reviewed		
Folder	**Subfolder**	**Documents**
Annual reports		2014 Annual Report, pdf 2015 Annual report, pdf
Annual Workplans for the 9 cycle	2013-2014 Workplans	NCW AWP, pdf RCT AWP, pdf
	2015 workplans	BLESS AWP,pdf NCW AWP, pdf Al Azhar AWP, pdf RCT AWP, pdf NGOs Coalition AWP, pdf
	2016 Workplans	BLESS AWP, pdf NCW AWP, pdf Al Azhar AWP, pdf RCT AWP, pdf Curative Care AWP, pdf
Country Programme Documents		Signed CPAP, pdf Strategic plan 2014-2017, pdf UNFPA Egypt CPD, pdf CPD Arabic, pdf
CP products		Medical protocol manual, Arabic, pdf YPeer FGM manual Arabic, pdf We are all responsible, Arabic, pdf

	Economic Costing Study on GBV, Arabic, pdf
Evaluation Report Outline	Country Programme Evaluation 2007-2011, pdf
Progress Reports	BLESS 2015, Q1,Q2,Q3, Excel RCT 2015, Q1,Q2,Q3,Q4 Word.doc
Trip Reports	Trip Report Marga Orzonoas, word Trip report Assiut, July 2016, Word
	CP Products Marix, excel
	Final GBV Assessment by Nemat Genina, word
	Final revised EQA template 20 April 2016, word
	GBV prevalence edited, pdf (chart)
	Letter to Evaluators July 2016,word
	UNFPA projects by Department, excel
Documents received by email	Detailed TOR,pdf
	Planning matrix for Monitoring and Evaluation, Excel
	UNDAF 2013-2017
	2013 Annual Report, PDF
	2016 Annual Planning, pdf
	2016 Q1 Monitoring, pdf
	2016 Q2 Monitoring, pdf
	Norwegian contribution agreement
	Norwegian presentation-utilization of funds March 2016
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	JP narrative report for Jan –December 2015
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	UNTITLED document- report from Nazra on CSO workshop on medical protocol

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	Agenda for workshop for Judges June 5, 2016. Arabic
	PPT on legal framework to combat GBV(purpose not stated) Arabic
	Azhar GBV manual
	Ain shams University – protocol for SH Unit and university president decree for establishment
	Assiut University – protocol for SH Unit and university president decree for establishment
	Referral forms for victims of GBV (2 samples)
	Selection criteria for TOT recipients in RCT training
Documents received in hard copy	Medical protocol guidelines for management of gender based violence (including sexual violence) Arabic/English
	Powerpoint presentation from CAPMAS on GBV costing survey –introduction and sampling (not dated). Arabic
	GBV Costing survey Steering committee minutes, June 22, 2015. English
	GBV Costing survey, progress report on field work. (not dated) (describes sampling and survey training). CAPMAS. Arabic
	GBV Costing survey, progress report on field work. March-July October 2015. CAPMAS. Arabic
	GBV Costing survey, progress report on field work. March-October 2015. CAPMAS. Arabic (overlap in dates with report above)
	RCT annual report 2015 GBV services integration in health care
	GBV portfolio – short summary of GBV portfolio (4 pages) not strategic

	Joint program indicators and results chain on FGM/C

List of documents Reviewed for PD and Overall Programming							
Folder	**Sub-folder**	**Sub-Sub-Folder**	**Sub-Sub-Sub Folder/Document**	**Sub-Sub-Sub-Sub Folder/Document**	**Sub-Sub-Sub-Sub-Sub Folder/Document**	**Sub-Sub-Sub-Sub-Sub-Sub Folder/Document**	**No. of Pages**
CP							
	Dawlat DocS						
		Annual Reports					
			2014 Annual Report-UNFPA Egypt.pdf				021
			2015 Annual Report-Egypt(1).pdf				046
			2016 Annual Planning-Egypt.pdf				016
			2016Q2 Monitoring-Egypt (1).pdf				012
			Reporting on Specific interventions and results financed				013
		Country Program Documents					
			CDS (Center for Development Services)				
				Cape Trip report.pptx			010

				Report.pdf (Baseline Assessment of the Public Health Management at District Level in Assiut & Sohag, Egypt)			036
				Travel Report-Assiut Week1.doc			018
				Travel Report Akhmeem.doc			009
				Travel Report Cape Town1.doc			002
			mHealth				
				Discussion Guide_Females IDIs & FGDs			008
				Discussion Guide_Males_Reporoductive			007
				Family Planning.doc			010
				Discussion guide Influencers.doc			006
				RH&FP_UNFPA_Inception_Report.1821			012
				SBCC.doc (TORs/Situation Analysis for MHealth Intervention on Social Behavior Channge Communication (SBCC) in Assuitt and Sohag)			005

			9th CP MonitorinfMidSept14 .xlsx				014
			CCA+SA Report final pdf version.pdf (Key Development Challenges facing Egypt, 2010)				148
			CP Products Matrix.xlsx				001
			CPAP-trip report May 13.doc				004
			M&E CO FrameworkAug13.xls x				004
			Notes.xlsx				008
			Planning Matrix for Monitoring and Evaluation				006
			Signed CPAP 2013.pdf				030
			Travel Report.doc				002
			UNDAF 2013-17.pdf				103
			UNFPA Egypt_CPD.pdf				007
			UNFPA Strategic Plan 2014-17.pdf				024
			UNFPA_PROJECTS_BY _DEPT_16383.xls				001

			Workplan Indicators 2016.pdf				004
			برنامج التعاون المشترك بالعربي				007
		Financial Reports					
			Budgets and Expenditures by Programme Cycle Outputs 2014.pdf				002
			Budgets and Expenditures by Programme Cycle Outputs 2015.pdf				003
			Budgets and Expenditures by Programme Cycle Outputs 2016.pdf				004
			Budgets and Expenditures by SP Outcomes and Outputs 2016.pdf				003
			Project Monitoring Fund codes 2015.xlsx				006
			Workplan Amounts, Budgets, Budget Utilization 2016.pdf				016
		ToC					
			GBV Prevalence edited.pdf				001

			Maternal Mortality.pdf				001
			ToC-Problem+intervention design.pdf				005
			TOC Unmeet1-details.pdf				003
		Evaluation Report					
			Evaluation Country Program 2007-2011.pdf				163
		Contraceptive Security Evaluation.pdf (summative evaluation)					066
		CP Performance Final (internal assessment).doc					014
		Evaluation plan CPD EGY as					001

		Apr15.docx					
		FINAL Revised EQA template April 2016					008
		Letter to Evaluators July 2016.docx					010
		Management Respose.pdf					013
		PD					
			Annual Work Plans for the 9th Cycle				
				2013-2014 work plans			
					Gender		
						NCW AWP.pdf	009
						RCT AWP.pdf	007
					PD		
						NPC AWP.pdf	004
					RH		
						Al Shehab AWP 2014.pdf	005
						Al Shehab AWP Extension.pdf	005
						AWP YDCI1.pdf	018
						AWP YDCI2.pdf	006

						MCH AWP 2013-2014.pdf	027
						MOHP AWP 2014 Amendment.pdf	002
						MOHP-FP AWP 2014 with Annexes&local training workshops	039
						MOHP-Youth Friendly Services AWP 2014	009
				2015 Work plans			
					Gender		
						BLESS_AWP 2015.pdf	002
						Elazhar_AWP_2015.pdf	003
						NCW_AWP_2015.pdf	002
						NGOs Coalition_AWP 2015.pdf	002
						RCT_AWP_2015.pdf	003
					PD		
						NPC_AWP 2015_Amendment_1.pdf	001
						NPC_AWP 2015_Amendment_2.pdf	001
						NPC_AWP 2015_Amendment_3.pdf	001
						NPC_AWP 2015_Amendment_4.pdf	002
						NPC_AWP 2015_Amendment_5.pdf	001
						NPC_AWP 2015_Amendment_6.pdf	001
						NPC_WP2015 (1).pdf	010

					RH		
						Alshehab_AWP_2015.pdf	009
						CARE_AWP_2015.pdf	009
						ETJIAH_AWP_2015.pdf	010
						FP_AWP_2015.pdf	003
						MCH_AWP-2015.pdf	003
						Population Council_AWP_2015_1.pdf	010
						School Age Dep_AWP_2015.pdf	006
				2016 work plans			
					Gender		
						Alazhar_AWP_2016.pdf	003
						BLESS_AWP 206.pdf	002
						Curative Care_AWP2016.pdf	002
						NCW_AWP_2016.pdf	003
						RCT_AWP_2016.pdf	004
					PD		
						Amman statement.pdf	002
						CAPMAS Workplan 2016.rtf	004
						Egypt_Census_long_form_sampling.pptx	019
						NPC_WP2016.pdf	010
						Recommendations on sampling Methodology	023
						بيان عمان 2016	002

						مشروع القانون الاساسي لمنتدي البرلمانيين العرب للسكان والتنميه	006
						ملخص تقرير خبير العينات	005
					RH		
						Alshehab_AWP_2016-2017.pdf	003
						AMU_AWP_2016.pdf	003
						CARE_AWP_2016.pdf	004
						ETIJAH_AWP_2016.pdf	004
						FP_AWP_2016.pdf	003
						MCH_AWP_2016.pdf	003
						Population Council_AWP_2016.pdf	003
						School Age Dep_AWP_2016.pdf	003
			Products				
				Benefit-cost analysis of Egypt family.pdf			070
				Documentary Film.docx			001
				Draft PSA.docx (Baseera/UNFPA/NPC, Population Status in Egypt, 2016)			198
				Media messages guide.pdf			024
				الخطه الاستراتيجيه التنفيذيه (وزارة السكان)			162
				PB Assuit MSA.pdf			010
				PB Behera MSA (1).pdf			009
				PB Ismailia MSA.pdf			009

				PB Mynia MSA.pdf			010
				PB SharkiaMSA.pdf			009
				PB SohagMSA.pdf			011
				Policy B GizaMSA.pdf			010
				2017-2014 .pdf الخطه الاستراتيجيه(NPC)			049
				دليل المرصد السكاني 2014- 2017docx			035
			Progress Reports				
				Copy of مؤشرات الخطه 2.xslx			012
				EGY9U202_April- June2014 narrative.docx			003
				EGY9U202_July- September 2014 narrative.docx (Completion of ICPD Action Plan Project)			007
				EGY9U202_July- September 2014.docx			001
				Indicators map.pdf			002
				Milestone indicators manual results based (002)			002
				PGEG02_Q1-2015 Progress report.xlsx			001
				PGEG02_Q1-2016 Progress report.xlsx			001
				PGEG02_Q2-2015 Progress report.xlsx			003

				PGEG02_Q2-2016 Progress report.xlsx			001
				PGEG02_Q3-2015 Progress report.xlsx			001
				PGEG02_Q4-2015 Progress report.xlsx			001
				RESULTS PROGRESS TO DATE Aug 8th 20…			002
				Sustainability of 2015 Work Plan Results			004
				Travel Report Amman.doc			002
Egypt National Review Report, Sustainable Development Goals, Ministry of International Cooperation, July 2016.							059
						Total	2,140

ANNEX10: DETAILED CPE METHODOLOGY AND PROCESS

10.1. EVALUATION METHODOLOGY AND APPROACH

10.1.1 EVALUATION CRITERIA AND QUESTIONS

The evaluation followed the OECD/DAC criteria: Relevance, Efficiency, Effectiveness and Sustainability to analyse and evaluate the focus areas namely RH, PD & GBV, in addition to analysis of CO strategic positioning with regard to responsiveness, added value and coordination with UN country team in Egypt. The DAC criteria have become the standard in evaluating projects and programs from a results-based perspective. Missing from the criteria for this evaluation is the 'impact' criteria, as it is too early to assess at this point in time. While in practice, the general criteria can be adapted to include a range of sub-questions, the below box provides general definitions for each criterion.

Definitions of Evaluation Criteria

Relevance
The extent to which the objectives of a development intervention (UNFPA country programme) are consistent with beneficiaries' requirements, country needs, global priorities and partners' and donors' policies. Note: Retrospectively, the question of relevance often becomes a question as to whether the objectives of an intervention or its design are still appropriate given changed circumstances (responsiveness).

Efficiency
A measure of how economically resources/inputs (funds, expertise, time, etc.) are converted to results.

Effectiveness
The extent to which the development intervention's objectives were achieved, or are expected to be achieved, taking into account their relative importance.

Sustainability
The continuation of benefits from a development intervention after major development assistance has been completed. The probability of continued long-term benefits. The resilience to risk of the net benefit flows over time.

Coordination with the UNCT
The extent to which UNFPA has been an active member of, and contributor to the existing coordination mechanisms of the United Nations Country Team.

Added value
The extent to which the UNFPA country programme adds benefits to the results from other development actors' interventions.

Source: adapted from:
OECD. Glossary of Key Terms in Evaluation and Results Based Management.2010. http://www.oecd.org/dac/evaluation/2754804.pdf. Accessed November 17, 2016. And UNDP. Independent Evaluation Office. Handbook: How to design and conduct a country programme Evaluation and UNFPA. P.45-47

The evaluation questions were selected through a series of discussions between the evaluation team, and after receiving feedback from the evaluation reference group (ERG).[259] A set of evaluation questions were set out in the CPE TOR. These were refined in a series of meetings by the evaluation team and merged within and upon finalization of field work; e.g. evaluation question 3 on effectiveness was merged into reflecting relevant

[259] See Annex 2 for ERG Members consulted.

component, and same for evaluation questions 5, 6, 7 and 8 on value-added, comparative strength and UNCT coordination under the new mode of engagement implemented in the current CP to reflect UNFPA strategic positioning. The key consideration at the several rounds of discussions, was which questions would allow a full coverage of the six evaluation criteria. The rounds of discussions, included a more refined approach that would narrow down the number of questions chosen. The refinement criteria included;

1) Excluding questions that would be repetitive, or that would be answered through other questions (example: it would be difficult to address relevance of UNFPA CO CP2013-2017, without addressing Q2 on the extent to which has responded to changes caused by major political changes)
2) Excluding questions that would have evaluability issues (such as Q5d, on social media platforms, where there would be issues of data analysis, and triangulation)
3) Ensuring that each component of the CP would be covered, particularly under the sub-questions of Evaluation Question 5.
4) Ensuring that the questions would cover program interventions that had indeed been implemented during the evaluation period Q3 2016, and that activities would be significant enough to feed into findings and conclusions (example: humanitarian assistance has not been significant enough to draw detailed conclusions, although covered)

Below is the list of refined questions by the evaluation team for the CPE. Table 1 contains the original questions contained in the CPE design report, and approved by the ERG; while a more detailed table with issues to be covered for each question and salient findings is contained in Annex 5 (evaluation matrix with findings).

Table 1: Evaluation Questions[260]

Main Questions		Evaluation Criteria					
		Relevance& responsiveness	Effectiveness	Efficiency	Sustainability	UNCT Coordination	Added Value and comparative advantage
1 Relevance	1)To what extent are the interventions of UNFPA Egypt CP 2013-2017 (1) relevant to the needs of the intended beneficiaries (women and young people); (2) in line with the government priorities; and (3) aligned with UNFPA policies and strategies? (4) to what extent has the CO been able to respond to changes in national needs and shifts caused by major political changes?	X					
2 Efficiency	2)To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country program?		X	X			

[260]The matrix includes the set of original EQs. In Chapter 4, EQ3 (a-f) have been merged into EQ3; and EQs 5, 6, 7 & 8 were merged to EQ5 reflecting UNFPA strategic positioning. The evaluation matrix in Annex 18 and Chapter 4's findings reflect responses to all evaluation questions and criteria covered.

3 Effectiveness	3)To what extent has UNFPA support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into national systems and are positioned on the national agenda?	X	X		X		
	(a) To what extent has the CP contributed to improving the capacity of the national health system to provide high-quality maternal health services to women of reproductive age?		X		X		
	(b) To what extent has the CP contributed to strengthening the local[261] capacities for community-based interventions in reproductive health to empower women and young people?		X		X		
	(c)To what extent has the CP contributed to enhancing the institutional mechanisms to protect against and respond to gender-based violence against women and girls? (In particular by helping to build the national capacity to implement laws and policies that curtail harmful practices i.e. FGM/C)?	X	X		X		
	(d) To what extent has the CP strengthened national capacity for using data and evidence to monitor and evaluate national policies and programs in the areas of population dynamics, sexual and reproductive health and reproductive rights, HIV, adolescents and youth and gender equality, including in humanitarian settings?	X	X	X	X	X	X
	(e)To what extent have the interventions supported by UNFPA in the field of population and development (PD) contributed to an increased availability and use of data on emerging population issues at central and local levels?	X	X				
	(f) To what extent has CO humanitarian assistance contributed to an improved emergency preparedness and response for SRH and GBV in Egypt?	X		X			
4 Sustainability	4)To what extent has the CP been able to support its partners and beneficiaries in developing capacities and establishing mechanisms (for example: youth friendly services) to ensure ownership and sustainability of achieved results?		X		X		
5 UNFPA Value Added	5)To what extent was the CO able to shift the mode of engagement and focus on upstream interventions (Strategic advocacy, Knowledge management and the internal CO capacity)?	X	X	X	X		

[261] Amended from "national' to "local", to better highlight that interventions are occurring at a de-centralized level, and are reliant on community-based initiatives. This is not to exclude national capacities, that may result from groups, coalitions or others working together to amalgamate results at the national level.

6 UNFPA Value Added	6) What are the main UNFPA comparative strengths in Egypt, particularly in comparison to other UN agencies?					X	X
7 UNFPA Value Added	7)What is the main UNFPA added value in the country context as perceived by national stakeholders and UNCT coordination team "visibility/NEX"?	X				X	X
8 UNCT Coordination	8)To what extent was this coordination (national stakeholders and UNCT) effective to boost the program implementation and achieve better results?		X			X	X

10.1.2 METHODS AND TOOLS FOR THE DATA COLLECTION AND ANALYSIS

The evaluation team ensured its independence and impartiality by relying upon a systematic triangulation of data sources and data collection methods and tools. The evaluation was completed through three sub-activities that were carried out simultaneously: qualitative and quantitative (mixed method) data collection and analysis.

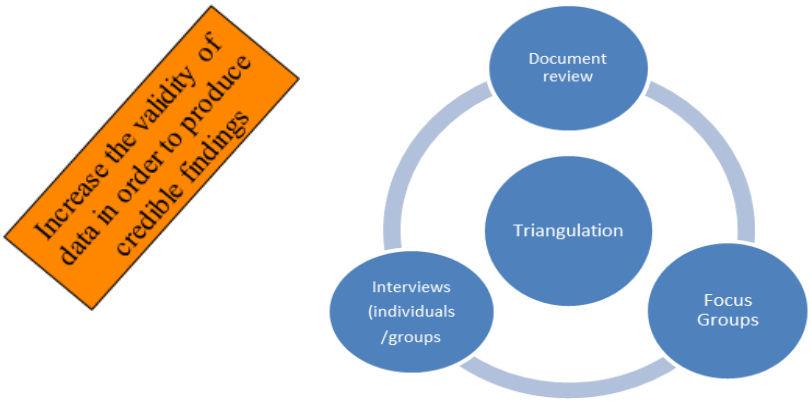
Qualitative data was be collected by using a number of methods including:

- A critical desk review of materials related to CPAP 2013-2017 and other relevant documents, as well as any relevant material that will be provided by UNFPA CO such as quarterly and annual reports, management reviews, budget information, data on achievement outputs, CPAP outputs deliverables and publications, etc. The Evaluation Team also reviewed documents that relate to, Gender Based Violence, legislation and policies regarding GBV and FGM/C, RH in the areas of interventions, as well as relevant advocacy policies and products. This review extended to documents external to the projects that were identified by the team through its own research or through informants which have a bearing on the evaluation questions.
- Review of project activities against CPAP outputs, and UNDAF and strategic plan outcomes/outputs against objectives and performance indicators.
- Key Informant Interviews (KIIs) and in-depth, semi-structured interviews with representatives from IPs, politicians, CSO coalitions and networks, community leaders, religious leaders, GOE staff, other stakeholders and beneficiaries. It is possible because some activities address sensitive, even taboo issues, interviewees may be intimidated by structured interviews and formal interviewing techniques. Accordingly, the team used semi-structured interviews, a more appropriate and valuable technique, because that allowed beneficiaries to present and explain points freely. Where necessary for triangulation, secondary interviews were conducted.
- Phone interviews were also utilized as a time and cost saving method, to conduct interviews and secondary interviews, as necessary.
- Field visits and meetings with project partners in the intervention areas, including: Cairo, Alexandria, Assiut, Sohag. Phone interviews were concluded with Damietta, Minya, and Menofiya.

- Focus Group Discussions (FGDs) with beneficiary service providers, CSOs and their social workers, and if permissible and socially acceptable, with direct beneficiaries to obtain qualitative information to strengthen our analysis and understand the project and results achieved within the given context in Egypt.[262]

These methods have been selected because they allowed the evaluation team to gain a better understanding of the partner and beneficiary perspective through targeted discussions. The team members were able to guide the discussions according to the responses received and reactions, and able to note other areas that require further research that were raised in discussions, as well as allowed for better triangulation for enhanced validity of data, as shown in Figure 1. The site visits and phone interviews enabled the team to have access to the target beneficiaries and communities, and for sites visited to physically and visually assess any infrastructural/administrative achievements that have been gained through the interventions.[263]

Figure 1: Enhancing Validity of Data



Source: Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA. P.87

Quantitative data collection methods consisted of:

- Desk Reviews: Review of data sourced from the project on indicators.
- Collection and review of secondary data from the analysis of the legal framework for Reproductive Health, Gender based Violence and population Development laws and policies, and access to information.
- Review of data from available surveys and other studies.

Mixed Method collection method consisted of:

- Conclude on-line survey with the projects stakeholders to cross-validate evaluation question results quantitatively, qualitatively and anonymously[264]

10.1.3 SELECTION OF THE SAMPLE OF STAKEHOLDERS

The sampling framework of the CPE was based on illustrative/purposive sampling at the central and local levels based on the stakeholders' map provided by CO. Key informant interviews were also used on series of rounds and through "snow-balling"[265]for further validation of findings until no additional insights were captured. Interviews

[262]See Annex 15 on FGD minutes.
[263]See Annex 12 for interview guides.
[264] Annex 16 for survey tool.
[265] Based on recommendations and references received from a key informant(s) that are essential to the evaluation.

were re-validated using FGD[266] and survey tools.[267] Team consultations on findings received from interviewees were consulted for data analysis, synthesis and reporting. Conflicting opinions on issues elicited from interviews or FGDs were eliminated (pre-test analysis), upon receipt of validating survey results on evaluation questions (EQs). Selection of interviewees was guided by in-depth interviews with key IPs at the central levels to cascade and guide further samples selected at the local level.[268] The goal is to ensure that the wide range of interventions and stakeholders are covered in a meaningful manner to feed into strategic and programmatic conclusions. The selection of stakeholders to be interviewed was based on the weight of their respective contributions to components interventions. The Evaluation Team (ET) ensured that the main key targeted groups are represented, including government partners (e.g. MOH, CAPMAS, NPC, NCW); NGOs/CSOs, and INGOs (e.g. CARE, YPEER and others that have partnered with UNFPA on the CP interventions). In addition, UN agencies such as UNDP, UN Women, UNICEF, WHO, UNHCR and UNCT who have both contributed to the development of the UNDAF and contributed to JP interventions. Other Donors were selected based on their contributions to the CPAP such as Norway and Sweden (SIDA). And where possible, and as indicated in the AWPs, beneficiaries and trainees at the various levels were also sampled purposively.

The selection of key interventions in each component ensure that a range of stakeholders were represented as partners and beneficiaries based on the nature of each component. It also ensured that some of the most successful and the most challenging interventions, in terms of implementation, were selected, to ensure a complete picture of supportive and constraining factors emerged, as well as substantial lessons learnt that can feed into the CPE.

10.1.4 EVALUABILITY ASSESSMENT, LIMITATIONS AND RISKS

Risks:

2. Some of these threats included the volatile political situation in the last five years which may affect respondents' willingness to fully share their insights and opinions, the biases that may result from the selection of interviewees and from the recall process (the program started in 2013, which may affect the accuracy of recall information), the maturation of beneficiaries, the possibility of multiple interventions and the unavailability of interviewees due to the political environment, high turnover, and the sensitivity of the issues that the project addressed.
3. Physical travel risks due to recent events of flooding in Upper Egypt, expected planned protests against current economic conditions.

Design Limitations

4. In light of the limited time available for primary data collection, the selection of specific key informants and beneficiaries for individual interviews, FGDs, and other data collection, approaches was targeted opportunistically and built upon information generated through pre-field phase document reviews. As such, there was initially a reliance on the accuracy and comprehensiveness of the secondary data as a starting point for the evaluation.
5. The activities that were evaluated were implemented between 2013 and 2016, a period that has witnessed immense changes in Egypt's social, economic and political life. In addition, the activities cover some socially sensitive topics, creating the possibility of selection bias. This may apply to in-person interviews, FGDs and survey.

[266] For YRH and GBV large components.
[267] For PD and other CP components.
[268] Illustrative, purposive snow-ball effect until no further insights were received.

6. There is a known tendency among respondents to under-report socially undesirable answers and alter their responses to approximate what they perceive as the social norm (*halo bias*). To mitigate this limitation, the Evaluation Team provided the respondents with confidentiality and anonymity guarantees.

Implementation Limitations

7. Given the large number of stakeholders – direct and indirect beneficiaries- it was a major challenge in the relatively short time allotted for this evaluation to interview all participating stakeholders (it would have been the ideal situation). This is added to data gaps in acquiring detailed trainees/beneficiaries list. To address this challenge, the Evaluation Team conducted interviews with carefully selected illustrative samples of assisted beneficiaries to ensure balance participant feedback is obtained. In addition, interviews were supplemented with online surveys as a means to collect further mixed method feedback within the short timeline allotted for the evaluation.
8. Field phase extended to 6 weeks beyond the 2-4 weeks period, laying pressures on the evaluation team to synthesize and cross-validate while in the field. Additional interviews from CO were requested beyond the field period which extended the field phase further, due to the profile of the interviews and the evaluation team's involvement in the logistics of (re-)scheduling most meetings.
9. As a number of interviewees were unavailable due to staff changes, holidays season, and/or cultural sensitivities involving the subject matter, the Evaluation Team was not able to cross-check information through direct interviews or observations in few instances. To mitigate this limitation, the team conducted extensive desk review of reports, other relevant materials, and field phase has ranged between 2-6 weeks.
10. in many cases, the CO was unaware, or unable to connect evaluators with key persons. That connection was provided through IPs, detracting from the professionalism or "official request" to meet introducing the ET. IPs also recommended other key persons to interview. While these nominations are undoubtedly trustworthy, there may be a slight bias in their selection, on behalf of the IPs.
11. Scheduling team appointments and logistics at the local level were inadequate, leading, in some cases, IPs bring their local branch staff for interviewing to the central level, where the evaluation team assembled.
12. Also, many persons interviewed were new in their posts, and had clearly not received sufficient handover from their predecessors on UNFPA partnership. This affected access to documents, data and overall institutional memory.

Results Limitation

2. The evaluation team was well-aware that it may be too early to observe the effects generated by some outputs of the 9th Cycle Programme (e.g. changes in behaviour, culture or mindset) which require time to be reflected on.

10.2 EVALUATION PROCESS

10.2.1 OVERVIEW OF THE PROCESS OF THE EVALUATION

The evaluation was planned to be conducted over a period of five months with a total of 116 working days; it was planned also be divided into three phases each including several steps:

Phase 1: **Design phase (6 weeks):**

For desk review, mapping of stakeholders, review of intervention logic, refining the evaluation questions in the evaluation matrix, development of data collection tools/ interview guides and

analysis strategy, development of a concrete work plan for the field visits, and ends with production of the Design Report (20 – 30 pages maximum). The design report provides clarification on methodology, tools, division of labour among the evaluation team, a work-plan to reflect timelines as per ToR, agenda for the field phase, and validation mechanisms to enable verification of preliminary findings. The design phase duration is subject to the furnishing of the full documentation required for its conduct (e.g. full direct and indirect stakeholders map, full Programme documentation, logistical support, etc.)

Phase 2: **Field phase (originally planned for 3-4 weeks; and ended up with 3-6 weeks)**:

For data collection, validation, analysis and drafting a set of preliminary findings, conclusions and recommendation, preliminary results are to be presented (power-point presentation) through a stakeholders' workshop due to over extension of field phase.

Phase 3: **Synthesis Phase (2-4 weeks)**:

Based on the sound analysis of the preliminary findings, conclusions were derived from findings and need to be assembled by homogeneous "clusters". Recommendations were derived from conclusions; recommendations may be organized by clusters (strategic and programmatic). Within each cluster, recommendations were ranked by priority level, with a time horizon. The report mentions to whom recommendations are addressed.[269]

Table 2: CPE Milestones

	Phase / Deliverables	Timeline (start and end)
1	Design Phase – design report& ERG-CO presentation	Mid Oct.-End Nov 2016[270]
2	Field phase-simultaneous work on evaluation matrix and findings	Dec. 13-Feb. 2, 2016[271]
3	Synthesis Phase-simultaneous with field phase	1-31 Jan.., 2017
	1st draft submission of completed filled evaluation matrix, detailed response to EQs and online survey, provisional findings, conclusions and recommendations	Feb.-17
	Final evaluation report	fourth week of Feb. 2017[272]

10.2.2 TEAM COMPOSITION AND DISTRIBUTION OF TASKS

The evaluation team consisted of:

The Team Leader (Ms Doha Abdelhamid) who served as the chief point of contact with UNFPA CO and provided direct technical and management oversight for all components of the evaluation. She interfaces directly with the

[269] See Chapter 4: Conclusions and Recommendations.

[270] Original start date was beginning of August 2016, leading to shifted time schedules and compression of evaluation period from 5 months to 4.

[271] Subject to provision of full and complete stakeholders map by UNFPA. See methodology and sampling section. ERG meeting was held on Dec. 6, 2016 with a week period for receipt of comments for incorporation and taking by the ET prior to the field phase, and while stakeholders maps is being complemented for field phase starting

[272] This extends the evaluation period to 6 months, instead of the contracted 5 months which did not cover for the extra-worked consulting days.

Evaluation Manager and is responsible for: 1) the coordination and management of the evaluation process; 2) the presentation of key findings, conclusions, recommendations, and lessons learned during the debriefing session prepared jointly with Team Members; 3) the preparation and submission of the workplan as well as the draft and final reports with assigned inputs from Team Members; and 4) reviews the content to assure the quality of deliverables submitted. The Team Leader ensures that the team works together as a unit, that the data collected covers all evaluation questions and consults with the Evaluation Manager on the mitigating strategies in case of any encumbrances in the field, logistics, etc. She will also be responsible for the evaluation of the P&D component.

The Team Members will assist the Team Leader with the preparation of the deliverables and delivery of the evaluation of respective and cross-respective Country Programme components. They will contribute to the successful completion of assigned tasks by the TL for the implementation of the evaluation methodology in timely manner. They will be responsible for 1) the collection, triangulation and analysis of the data resulting from the evaluation process, 2) make the necessary time available for Team meetings, discussions and implementation of work requests 3) submit assigned quality deliverables relating to their individual areas of expertise, and 4) provide input and substance to the preparation of the evaluation deliverables including the work plan, the draft evaluation report, the debrief to UNFPA CO and the completion of the final evaluation report. Team Members are composed of a Reproductive and Health Specialist (Mr Amr Awad), and a Gender Based Violence Specialist (Ms Ghada El Sherif), same for the Team Leader who acts as well as a P&D Specialist.

Neither the TL nor TMs were involved in the design or implementation of any UNFPA interventions during the 9th Programme Cycle.

10.2.3 RESOURCES AND LOGISTIC SUPPORT

The UNFPA CO provided the Evaluation Team with logistical assistance in the following:

1) Providing essential documents, reports and data to the team.
2) Coordinating some meetings with CO PMOs and stakeholders.
3) Drafting and delivering the initial evaluation introductory letter to stakeholders.
4) Feedback on final list of evaluation interviews, and coordinating and organizing the agenda of interviews, including setting up of a number of meetings.
5) Organization of travel, transport and accommodation requirements out of Cairo, in close coordination with the TL & TMs, in line with CO regulations and safety measures.
6) Providing a meeting room for the ET at the CO, including internet access, and printer. Photocopying and incidental expense reimbursement while on duty
7) Final report editor and RA.
8) No translation services are required, as this was handled jointly by the TL and TMs (bi-lingual documentation, interviews in Arabic and English and online survey).

10.2.4 WORKPLAN

Table 3: Provisional Workplan

Main Activities Field Mission	M 2	M 3				M 4				M 5			
	4	1	2	3	4	1	2	3	4	1	2	3	4
Delivery of the design report													
Approval of the design report													
Completion of the agenda for in-country meetings and interviews													
Preparation of the interviews and adjustments in the agenda													
In-depth study of AWP, previous evaluations, etc. (secondary sources)													
Data collection													
Data analysis, triangulation (teamwork)													
Presentation preliminary results to CO													
Delivery of first draft of evaluation report													
Comments from the CO													
Delivery of final evaluation report													

ANNEX 11: CPE METHODOLOGIES (BY COMPONENT)

11.1. YOUTH AND REPRODUCTIVE HEALTH COMPONENT METHODOLOGY

Evaluation of the YRH component mostly involved qualitative methods. As indicated in the methodology section in the body of the report, sampling was meant to be illustrative, based on the stakeholder mapping provided by the UNFPA CO.

Document Review:

- A review of the Y-Peer manual for FGM.
- A review of the Assessment of health series in Assuit and Sohag.
- Review of the Arabic translated decision making tool for family planning.
- Review of the results of DHS in relation to Reproductive health and youth.
- Review of the SYPE result and outcomes meeting related to them.
- Review of the quarter reports from IPs and annual report of UNFPA.
- Review of the databases for beneficiaries (when exist).
- A review of capacity building and training manuals utilized in the training of direct beneficiaries, including; training materials for doctors and nurses at MoHP and public hospitals.

The material review assessed the quality of materials, and the overall relevance of content to meeting the goals of improve access of women and youth people to reproductive health, including appropriateness of messages delivered.

Key Informant Interviews: Interviews were conducted with key stakeholders including:
UNFPA Country Programme Officers, Government stakeholders included central level family planning and MCH directorates) of ministry of health. Also there were meetings at in Assiut and Sohag with members of the same directorate on governorate level. Interviews with implementing partners among NGOs (Shehab and Etijah). Meeting with school health department in the ministry of health. Meeting with one grantee in Aswan (Agha Khan). Meeting with strategic partners include Population council, WHO, UNICEF and UNHCR. The consultant also interviewed ministry of health representative taken into consideration their mandate and its relation with UNFPA. Finally, there was phone interview with Y-Peer focal point in Assiut which could not happen physically due to time constrains.

Focus Group Discussions (FGD): FGDs were be held with direct beneficiaries of the HIV/AIDS programme in Cairo and Alexandria. Another FGDs were with the trainees in Assiut and Sohag which included doctors and nurses trained through FP programme. Midwives trainer through the maternal health programme. Finally focus group discussion with different members of Y-Peer team.

Site visits: Site visits were conducted in Greater Cairo, Assiut, Alexandria and Sohag. It included; visits to 2 drop in centers in Cairo and Alexandria. Visit to 2 youth friendly clinics in Assiut and Sohag. The visits happened formally in the case of the drop-in center and using mystery client in the case of youth friendly clinics.

Online Survey Tool: Abi-lingual evidence-based, user-friendly quantitative and qualitative survey tool was designed to respond to the EQs. A two-weeks period was allowed for survey completion, however

due to CO's request for additional meetings and the Christmas/New Year's holidays which delayed the conclusion of meetings, the survey was extended for additional week. The anonymous tool enabled the surveyed respond freely and useful insights were gained and used for triangulating analysed data collected through documents and key informant interviews for all CO CP components. The tool proved to be a useful analytic tool and was funded by the CO to build a mixed method compliant with evaluation quality criteria and to triangulate FGDs and KPIs.

Table 1: YRH Component Interviews Conducted

Institutions	Number of Persons
UNFPA	
UNFPA Country Office	5
UNFPA Regional Office	1
UN and international agencies	
UN Agencies	3
International Organizations	2
Government	
Central Government	8
Regional/Decentral Government	4
Community Based Organizations	
Implementing Partners (NGOs)	9
Youth Network	6
Beneficiaries	
Trainees	45
End line beneficiaries of service	30
Total YRH Component	112

11.2. GENDER EQUITY COMPONENT METHODOLOGY

Evaluation of the GE component mostly involved qualitative methods. As indicated in the methodology section in the body of the report, sampling was meant to be illustrative, based on the stakeholder mapping provided by the UNFPA CO.

Document Review:

- A review of the status of the National Strategy to Combat GBV, FGM strategy and other pertinent documents
- A review of the Medical Protocol and its adoption (supportive policies) and implementation at MoHP
- A review of capacity building and training manuals utilized in the training of direct beneficiaries, including; training materials for doctors and nurses at MoHP and public hospitals; training materials for judges and police personnel; manual on GBV in Islam developed by Al Azhar and

materials used at BLESS for training of religious leaders; SH Unit materials integrated at the Universities of Assiut and Ein Shams; GBV costing survey quality and dissemination to date.

The material review assessed the quality of materials, and the overall relevance of content to meeting the goals of combatting GBV, including unity in messages delivered.

Key Informant Interviews: Interviews were conducted with key stakeholders including:
UNFPA Country Programme Officers, and other Donors including UNHCR and SIDA. Government stakeholders included CAPMAS, NCW, NPC (central and Assiut) MoHP (central and directorates in Assiut), RCT (Director, Lead Trainer and Project Administrator), NAZRA, University of Assiut and Ein Shams, and BLESS and CARE. For specific JP interventions on FGM/C, interviews will be conducted with relevant UN Agencies. While it was not possible to get in touch with Judges who were trained, it was possible to talk to the Head of Forensic Medicine at Ministry of Interior who was heavily involve in their training program for Judges and prosecutors as a trainer. Meetings were not held with Al Azhar, as repeated calls and requests for contact were unanswered. However, the evaluator did access a copy of the manual produced by the IP on GBV in Islam.

Focus Group Discussions (FGD): FGDs were be held with direct beneficiaries of the humanitarian program and students at the two universities. While it was not possible to have focus group discussions with recipients of capacity building and NGO networks, ad series of key person interviews were conducted in persona and by telephone. These included doctors and nurses trained by RCT, religious leaders trained by BLESS, NGOs working with NPC on FGM, NGOS receiving information on referral networks.

Site visits: Site visits were conducted in Greater Cairo, and Assiut, and included University visits to the SH Units, in Cairo and Assiut, visits to 2 safe spaces under the humanitarian program. The GBV units have not been activated yet and so it was not possible to see any in practice. A review of interventions and reporting indicated that it was no necessary to visit Sohag, as there was no GBV units to visit, and it would be more time and cost efficient to conduct the KPIs by telephone.

Online Survey Tool: Abi-lingual evidence-based, user-friendly quantitative and qualitative survey tool was designed to respond to the EQs. A two-weeks period was allowed for survey completion, however due to CO's request for additional meetings and the Christmas/New Year's holidays which delayed the conclusion of meetings, the survey was extended for additional week. The anonymous tool enabled the surveyed respond freely and useful insights were gained and used for triangulating analyzed data collected through documents and key informant interviews for all CO CP components. The tool proved to be a useful analytic tool and was funded by the CO to build a mixed method compliant with evaluation quality criteria and to triangulate FGDs and KPIs.

Table 2: EG Component Interviews Conducted

Institutions		**Number of Persons**

UNFPA		
UNFPA Country Office		6
UNFPA Regional Office		1
Total		**7**
DONORS		
UN Agencies (UNHCR)		1
Country Donors (SIDA)		1
Total		**2**
GOVERNMENT		
Central Government		8
Regional/Decentral Government	Assiut	4
Total		**12**
INGOS		
Implementing Partner (CARE)		3
Total		**3**
COMMUNITY BASED ORGANIZATIONS		
Implementing NGOs: FGM Project	Assiut, Quena, Port Said, Fayoum	5
RCT project	Cairo, Giza	5
SH Units/Gender	Cairo, Assiut	4
Total		**14**
BENEFICIARIES		
Trainees:		
Doctors and Nurses	Cairo, Giza, Domiat, Menofiya, Assiut	14
Religious Leaders BLESS	Cairo, Assiut, Minya	11
End line beneficiaries of service:		
Students	Cairo, Assiut	10
Syrian women	Cairo	29
Recipients of Referral network Information	Cairo, Giza	3
Total		**67**
TOTAL GE COMPONENT		**105**

11.3.POPULATION AND DEVELOPMENT COMPONENT METHODOLOGY

Evaluation of the PD component used mixed method (quantitative and qualitative) for rigor and robustness of triangulated evidence-based findings. As indicated in the methodology section in the body of the report, sampling was illustrative/purposive based on "snow-balling," based on the stakeholder mapping provided by the UNFPA CO and recommendations from met stakeholders for key informants that have been involved in PD interventions during the CP period (GOE, IPs, Ministers, NGOs, trainees, contractees etc.) or their mere position, though recent, engages them with UNFPA CO programme cycle, such as donors and UN agencies.

Document Review:

- A review of the status of the National Population Strategy, Action Plan and other pertinent documents
- A review of the Population Atlas, its adoption and implementation at NPC and its branches

- A review of Population Observatory and other results-based documents
- A review of branch annual plans, and Ministries Annual Plans
- UNDAF, QCPR, AWPs, ARs, OEE, CPD, CPAP, CPE 2009, Quarterly reports and Annual reports of IPs, UNCT Meeting Minutes etc.
- A review of capacity building and training manuals, if any, utilized in the training of direct beneficiaries, including; training materials for NPC staff.
- Knowledge products produced, including Population Situation Analysis; CBA; media messages, TV spots and documentaries
- Policy Advocacy presentations (re. CAPMAS), and other national statistics (rural Egypt; OECD organizational capacity assessment etc.)

The material review assessed the quality of materials, and the overall relevance of content to meeting the goals of the NPS, including unity in messages delivered.

Key Informant and Group Interviews: Interviews were conducted with key stakeholders including: UNFPA Country Programme Officers, RO M&E Advisor and other Donors including UNCT, Norway, Japan, UNWomen, UNHCR and SIDA. Government stakeholders included H.E. the President of CAPMAS and Team, H.E. the Deputy Minister of Health and Population, NPC Rapporteur, key personnel, assortment of staffers (central, Giza, Assiut, and Sohag) and PMU Team, H.E. the Former Minister of Population, H.E. the Minister of Culture; H.E. the Minister of Planning, Monitoring and Administrative Development, IDSC, and CARE. Meetings with Baseera and private consultants were also concluded. Trainees were met among the key informant interviews.

Online Survey Tool: Abi-lingual evidence-based, user-friendly quantitative and qualitative survey tool was designed to respond to the EQs. A two-weeks period was allowed for survey completion, however due to CO's request for additional meetings and the Christmas/New Year's holidays which delayed the conclusion of meetings, the survey was extended for additional week. The anonymous tool enabled the surveyed respond freely and useful insights were gained and used for triangulating analyzed data collected through documents and key informant interviews for all CO CP components. The tool proved to be a useful analytic tool and was funded by the CO to build a mixed method compliant with evaluation quality criteria and to triangulate due to the high-level centrality of the policy component and high-ranks met (e.g. ministers, deputy ministers, heads of government organizations, first undersecretaries, general directors, etc.) which would disable the conclusion of FGD.[273]

Phone Interviews and Site Visits: Phone interviews proved to be a handy means for interviewing, especially used with donors and for follow on calls for cross-validation of some findings. A site visit was concluded to Nasr City Safe Space under the Humanitarian component. NPC's Giza, Assiut, Sohag branch came to meet the TL & PD Specialist due to issues in organizing field visits, which was convenient for quick analysis of findings and preclusion of political risks of single-female travel in traditional societies and the logistics entailing such travel.

[273] See Annex 14.

Table 3: PD Component Interviews Conducted

Institutions	Number of Persons	Iterations
UNFPA		
UNFPA Country Office	8	14
UNFPA Regional Office	2	3
International Organizations - Donors		
UN Agencies (UNICEF, UNHCR, UNWomen, UNDP/UNCT)	5	6
Country Donors (SIDA, (Japanese, & Norwegian Fund)	3	3
Government		
Central Government	33	37
Regional/Decentral Government	4	4
INGOS		
Implementing Partner (CARE)	2	2
Community Based Organizations		
Implementing Partners	1	1
Private Sector		
Consultants	4	10
BENEFICIARIES		
Trainees	20	20
Total PD Component	82	100

ANNEX 12: INTERVIEW GUIDES

12.1. GENERAL INTERVIEW GUIDES

General Introduction and Closing - 1. Human connection

- Spend a few minutes to understand how the interviewee is today. Is the interview convenient or problematic in any way? Is s/he really busy and we should make the interview shorter than agreed?
- Explain briefly something about yourself, where do you come from, other interviews you are doing that also frame this present interview, etc.
- Thank the interviewee for the time dedicated to this interview.

2. Inform the interviewee of the objective and context of the interview

- Purpose of the evaluation - Clarify briefly the purpose of the evaluation.

- Confirm the time available for the interview.
- Stress the confidentiality of the sources or the information collected.
- Explain what the objective of the interview (context) is. This not only shows respect, but is also useful for the evaluator, as it helps the interviewee to answer in a more relevant manner.

3. Opening general questions: refining our understanding of the interviewee's role

Before addressing the objectives of the interview, the evaluator needs to ensure that s/he understands the role of the interviewee vis-à-vis the organization, the programme, etc., so as to adjust the questions in the most effective way.

4. Ending the interview

- If some aspect of the interview was unclear, confirm with interviewee before finishing. Confirm that nothing that the interviewee may consider important has been missed:

  "Have I missed any important points?"

- Finish the interview, confirming any follow-up considerations - e.g., if documents need to be sent and by when, if the evaluator needs to provide any feedback, etc.
- Mention when the report will be issued and who will receive it
- If relevant, ask the interviewee for suggestions/facilitation about other key persons (referred to during the meeting) that could also be interviewed.
- Thank the interviewee again for the time dedicated to this interview.

12.2 Reproductive Health and Rights

Key Informant Interview Guide for Implementers of the Programme

Use General Introduction - Purpose of the evaluation

I am (we are) part of a three persons team to evaluate UNFPA's 9th Country Programme of Assistance to the Government of Egypt (2014-2017) to help UNFPA plan the next country programme. It is an independent evaluation and this is a confidential interview to understand how well UNFPA has positioned itself with the communities and national partners to add value to the country development results and to draw key lessons from past and current cooperation and provide clear options for the future. We will be talking to many stakeholders including beneficiaries and visiting Cairo, Alexandria, Assiut and Sohag.

Core interview: objectives of the interview guide transformed into questions

1. **Objective:** Rationale for the project and activities undertaken (needs assessments, value added, targeting of the most vulnerable, extent of consultation with targeted people, ability and resources to carry out the work, gender sensitivity)

Possible questions:

a. How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population?

b. Who was consulted regarding the design?

c. What other actors have been involved, how does this activity contribute to that of others?

2. **Objective: Relevance of the project/activities to the UN priorities, government policies, local structures, to changes in the political and institutional situation**

Possible questions:

a. How well does the UNFPA Egypt CP 2013-2017 (in the component area) (1) relevant to the needs of the intended beneficiaries (women and young people); (2) in line with the government priorities; and (3) aligned with UNFPA policies and strategies?

b. How well is the work designed to achieve the outcomes/results in the CPAP? (to build the capacity of the IPs, CSOs, etc., service providers in both RH and GBV, provide support to the YFC and provide commodities to the targeted health facilities), to increase demand by women for RH services, to improve RH knowledge of youth)

c. Has UNFPA adapted the programme and activities to respond to changes in the institutional environment (e.g. restructuring of the Ministry of Health)?

3. **Objective: Effectiveness of the approaches/activities/projects used to improve access to high quality RH and FP services and for the most vulnerable. Possible questions:**

4. To what extent has UNFPA support helped to ensure RH and the needs of young people are appropriately integrated into the national systems and are positioned on the national agenda?

a. What are the indications that the approach is working or making progress toward goals established for 2017 (e.g. anecdotes which provide illustrations of positive, negative or unintended effects, or quantitative and qualitative evidence) (numbers being reached, products produced/purchased and the extent of impact, evidence of usage of knowledge, increasing networks, etc.)

b. What are the barriers/challenges to increasing demand and access to services, and how are they being addressed?

c. Are the capacities in place among stakeholders to be able to carry out the activities/project without support from UNFPA?

d. Are financial resources available?

e. Will the results of the project last after is it over?

f. (for UNFPA) is there an exit strategy?

5. **Objective: Efficiency of use of UNFPA resources (partners, staff, money, global experience)**

Possible questions:

a. To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country program?

b. Did your work receive the needed support from UNFPA in terms of advice, staff inputs, money or technical assistance, what were the strengths and weaknesses?

c. Did you receive any other donor support in connection with the UNFPA work? Did UNFPA promote greater connections and resources from the government or national actors?

5. **Objective: Functioning of coordination mechanisms**

Possible questions:

a. Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping?

b. Are there gaps in the population needs which would not have been identified by the UN system, collectively?

c. To what extent was this coordination effective to boost the program implementation and achieve better results?

6. **Objective: The value of UNFPA work to national development**

Possible questions:

a. How big of a difference is UNFPA making in RH in Egypt, what contributes to its effect, what detracts?

b. Can UNFPA input be improved or strengthened?

c. What are the main UNFPA comparative strengths in Egypt, particularly in comparison to other UN agencies?

d. What is the main UNFPA added value in the country context as perceived by national stakeholders?

7. **Objective: Interviewee recommendations**

UNFPA Egypt - Reproductive Health and Rights -

Focus Group Interview for M3looma, Y-Peer Members, Scouts and Youth

Opening general questions: refining our understanding of the interviewee's role

I am part of a three person team to evaluate UNFPA's 9th Country Programme of Assistance to the Government of Turkey (2014-2017) to help UNFPA plan the next country programme, we are looking at how effectively UNFPA has helped young people to understand the issues in health.

Can we introduce ourselves? Can you explain what activities you have participated in? What has been the purpose of these activities?

Core interview: objectives of the interview guide transformed into questions

1. **Objective: Rationale for the project and activities undertaken Possible questions:**

a. Please describe the groups you are trying to reach through your participation in the activities and why you think it is important for RH?

2. **Objective: Relevance of the project/activities to the UN priorities, government policies, local structures, to changes in the political and institutional situation**

Possible questions:

a. How well does the activity/work fit in with the youth and Y-Peer activities/needs across Egypt?

b. What effect do you think the work should have, with which groups?

3. **Objective: Effectiveness of the approaches/activities/projects used to improve access to high quality RH and FP services and for the most vulnerable. Possible questions:**

a. Can you provide examples of success of the approach/activity (theatre-based approach) both long term and short term?

b. How useful are these activities to communicate the RH messages? To what extent you think the messages can change the behaviour of young people.

c. Can the youth network carry on the work without UNFPA? What will help the youth network to carry on the RH work on its own?

4. **Objective: Efficiency in the use of UNFPA resources (partners, staff, money, global experience)**

Possible questions:

a. Did your work receive the needed support from UNFPA?

b. Did the youth network receive any other support in connection with the UNFPA work and who provided this support?

a. Do you work with other UN agencies and/or can you say how well the activities are coordinated, overlapping or gaps identified?

b. What are the challenges face you as youth group to be more efficient in improving access of youth to RH services?

5. **Objective: The value of UNFPA work to national development**

Possible questions:

a. How big of a difference is UNFPA making in RH in Egypt, what contributes to its effect, what detracts?

b. Can UNFPA input be improved or strengthened?

7. **Objective: Interviewee recommendations (collect recommendations and review them)**

12.3 GE Component

Interview Guide

The following questions are only guiding questions, and by no means exclusive. They are simply a way to guide the discussion and allow the interviewee to think of relevant associated information. Please note, that the questions, while noted in English, are asked in colloquial Egyptian Arabic. This may require further elaboration or expansion, or rephrasing of the question.

General Guiding Questions for IPs:

1. Briefly describe the nature of your partnership with UNFPA (this is an opportunity to assess the perspective of the IP on the partnership interventions, vis a vis information from documents and CO)
2. How involved was (institution) in the development of the AWP/Workplan?
3. How does the AWP link with the overall mandate and activities of (institution)?
4. To date, the results have shown, (brief description of particular results). In your opinion what was the most facilitating factor for these results / or hindering factor for lack of?
5. Could there have been a different plan/intervention, or in the order of implementation order of activities to facilitate this process?
6. Has there been a need to change the approach of the intervention (due to conditions on the ground, feedback, political /economic conditions? (this will also open dialogue on nature of reporting, monitoring of activities).
7. How flexible was the UNFPA in responding to this need?
8. What in your opinion is the main value in your partnership with UNFPA as an institution?
9. Are you aware of other projects on GBV conducted by UNFPA? Do you collaborate in anyway? (FGM with NPC, Al Azhar manual on GBV)?
10. Have you worked with other UN agencies? What do you think is the main difference in their approach, from UNFPA?
11. How well do you see the collaboration between different UN agencies in implementing programs on gender equity/gender based violence?

Guiding Questions for NPC, in addition to relevant questions above:

1. What role did UNFPA play in the development of the FGM Strategy?
2. How do you think that role can be expanded upon, reinforced?

3. Given that this is a JP, how active to you see the UNFPA, vis a vis other UN partners? Other Donors?
4. Do you think UNFPA has a continued role in the programme? If so in what light?

Guiding Questions for RCT, in addition to relevant questions above:

1. How are trainees selected? And how is the training material developed?
2. What is the relationship between RCT and MOH?
3. Is the current mode of operations efficient in terms of time? Use of resources?
4. How many doctors and nurses have been trained so far? What is the average attrition rate in training?
5. How sustainable do you feel this training is? Will the work continue in hospitals?
6. Is the institutional will in place for such work
7. Do you feel the right beneficiaries are being targeted?

Guiding Questions for Al Azhar/BLESS Focal Points, in addition to relevant questions above:

1. What, in your opinion, is the role of preachers regarding GBV in Egyptian society?
2. How was the material for GBV prepared and presented to trainees? What were some of the main messages included within?
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. How do you see the role of RLs after the training in reducing the various forms of gender-based violence? What specific type of GBV will the focus be on, how will that role be played?
5. Are you aware of any complementary strategies and activities implemented by UNFPA on GBV, or any other organizations? Have you benefited from any of these activities (seminars, material, etc.)?
6. What are other activities are necessary to support RL and preachers to enable them to effectively reduce the various forms of GBV in their local communities?

12.4Population and Development

The following questions are only guiding questions, and by no means exclusive. They are simply a way to guide the discussion and allow the interviewee to think of relevant associated information. Please note, that the questions, while noted in English, are asked in colloquial Egyptian Arabic for Egyptian interviewees and in slang for English speakers. This may require further elaboration or expansion, or rephrasing of the question.

General Guiding Questions for IPs:

12. Briefly describe the nature of your partnership with UNFPA (this is an opportunity to assess the perspective of the IP on the partnership interventions, vis-a-vis information from documents and CO)

13. How involved was (institution) in the development of the AWP/Workplan?
14. How does the AWP link with the overall mandate and activities of (institution)?
15. To date, the results have shown, (brief description of particular results). In your opinion what was the most facilitating factor for these results / or hindering factor for lack of?
16. Could there have been a different plan/intervention, or in the order of implementation order of activities to facilitate this process?
17. Has there been a need to change the approach of the intervention (due to conditions on the ground, feedback, political /economic conditions? (this will also open dialogue on nature of reporting, monitoring of activities).
18. How flexible was the UNFPA in responding to this need?
19. What in your opinion is the main value in your partnership with UNFPA as an institution?
20. Are you aware of other projects on PD conducted by UNFPA? Do you collaborate in anyway?
21. Have you worked with other UN agencies or donors? What do you think is the main difference in their approach, from UNFPA?
22. How well do you see the collaboration between different UN agencies in implementing programs on population policy advocacy, KM, and capacity building?

Guiding Questions for NPC, in addition to relevant questions above:

5. What role did UNFPA play in the development of the NPS and its implementation?
6. Was an automated M&E system operationalized, generating data and guiding national population policy?
7. How do you think that role can be expanded upon, reinforced, and coordinated nationally and at the community level?
8. Have you received any UNFPA training? How do you rate this experience? How far did it add to your work and in which ways?
9. Which interventions have been most effective at the national and local levels?
10. Given this, how active do you see the UNFPA, vis-a-vis other UN partners and donors? Other Donors?
11. Do you think UNFPA has a continued role in the upcoming programme cycle? If so, which are the highest priority gaps within UNFPA's mandate you think the organization has an edge in?

Guiding Questions for CAPMAS, in addition to relevant questions above:

8. How far valuable the support UNFPA has offered so far?
9. What were the impression of trainees? And how is the training passed to others?
10. What is the relationship between the policy advocacy activities and national SDG reporting?
11. How sustainable the new sampling methodology?
12. Is the current mode of operations efficient in terms of time? Use of resources?
13. Is the institutional will in place for data quality improvements and integration of national databases to inform population policy making? What actions have been taken?

Guiding Questions for Donors, in addition to relevant questions above:

7. What, in your opinion, is the role of foreign assistance in joint programming?
8. What major changes are undergoing in programming for the upcoming UNDAF Cycle?
9. What is your opinion of UNFPA participation and contribution to the UN Family in Egypt?
10. How different is this different from other sister UN agencies?
11. What added value accrue in policy advocacy and KM accrue from the involvement of UNFPA in UNCT?
12. What is the quality of UNFPA reporting?
13. How do you assess the ongoing cooperation (TFs, WGs, or funding)?
14. How far do you think this will change in the upcoming cycle?
15. What are the SWOTs of UNFPA?

Guiding Questions for CARE, in addition to relevant questions above:

1. How far UNFPA successful in supporting work on Syrian refugees?
2. Is UNFPA visible and follows on service delivery to Syrian women and children?
3. How innovative was UNFPA approach in partnership with CARE? Targeting, reach and niche?
4. Interview with coordinators, facilitators and Syrian women on how effective are the SS in offering UNFPA-tagged services, how far appreciated and sustainable?

Guiding Questions for MOIC and Ministers, in addition to relevant questions above:

1. Which interventions do you recall of UNFPA?
2. Has there been reporting and knowledge sharing?
3. How the political situation and reinvigorated interest in the population issue translated into partnerships for the population cause nationwide or locally?
4. What, in your opinion, UNFPA should have focused on in the current cycle, and what to focus on in the upcoming cycle?
5. Would you be interested to foster cooperation and accountability?

ANNEX 13: CLASSIFICATION OF INTERVIEWEES

OVERALL

Institutions	Number of Persons			
	YRH Component	GE Component	PD Component	Total
UNFPA				
UNFPA Country Office	5	6	8	18
UNFPA Regional Office	1	1	2	4
DONORS				
UN Agencies (UNHCR; UNICEF; UNWomen; UNDP/UNCT)	3	1	5	9
Country Donors (SIDA; Japan; & Norway)	2	1	3	6
GOVERNMENT				
Central Government	8	8	33	51
Regional/Decentral Government	4	4	4	12
INGOS				
Implementing Partner (CARE)	0	3	2	5
COMMUNITY BASED ORGANIZATIONS				
Implementing Partners	9	14	1	24
Youth Network	6	0	0	6
BENEFICIARIES				
Trainees	45	25	20	70
End line beneficiaries of service	30	42	0	72
Others				
Private Sector & Consultants	0	0	4	4
TOTAL	**113**	**105**	**82**	**300**

Youth and Reproductive Health Component

Institutions	Number of Persons
UNFPA	
UNFPA Country Office	5
UNFPA Regional Office	1
UN and international agencies	
UN Agencies	3
International Organizations	2
Government	
Central Government	8
Regional/Decentral Government	4
Community Based Organizations	
Implementing Partners (NGOs)	9
Youth Network	6
Beneficiaries	
Trainees	45
End line beneficiaries of service	30
Total YRH Component	113

GE Component

Institutions	Number of Persons
UNFPA	
UNFPA Country Office	6
UNFPA Regional Office	1
DONORS	
UN Agencies (UNHCR)	1
Country Donors (SIDA)	1
GOVERNMENT	
Central Government	8
Regional/Decentral Government	4
INGOS	
Implementing Partner (CARE)	3
COMMUNITY BASED ORGANIZATIONS	
Implementing Partners	14
BENEFICIARIES	
Trainees	25
End line beneficiaries of service	42

TOTAL GE COMPONENT	105

PD Component

Institutions	Number of Persons	Iterations
UNFPA		
UNFPA Country Office	8	14
UNFPA Regional Office	2	3
International Organizations - Donors		
UN Agencies (UNICEF, UNHCR, UNWomen, UNDP)	5	6
Country Donors (SIDA), (Japanese Fund)	3	3
Government		
Central Government	33	37
Regional/Decentral Government	4	4
INGOS		
Implementing Partner (CARE)	2	2
Community Based Organizations		
Implementing Partners	1	1
Private Sector		
Consultants	4	10
BENEFICIARIES		
Trainees	20	20
Total PD Component	82	100

ANNEX 14: INTERVIEWS AGENDA

YOUTH AND REPRODUCTIVE HEALTH COMPONENT

Date	Name	Position
2nd November	Maha Wanis	Reproductive Health officer
3rd November	Nihal Said	Youth officer
3rd November	Gehad Khalil	Y-Peer Coordinator
13th December	Dr Nahla Roushdy	Head of MCH Directorate – MOH
13th December	Dr Samia Abdel Hakm	Senior Specialist, General Administration for Maternal and Child Health

14th December	Dr Gamal El Kashef	Ministry of health – Head of School Health Department.
14th December	Dr Khalid Bakry	Project coordinator
15th December	Heashm El Rouby	Etijah CEO
15th December	Souad Hamed	Deputy Programs Manager - Etijah
18th December	Dr Mohsen Fathy	Manager of FP Sector
18th December	Dr Amal Zaki	
18th December	Dr Nahla Abdel Tawab	Population Council International – Country director
19th December	Khaled Oteify,	Manager of MCH Directorate
19th December	Abdo Abo El Ela	Shehab NGO – Programme manager
19th December	Reda Shokry	
20th December	Omima Yousif	Assiut health directorate – MCH manager in Assiut
20th December	15 midwives trained in the last 4 years.	FGD with midwifery
20th December		2 Visit to YFC First visit was meeting with service provider and second visit used mystery client by designing a case asking for consultation.
21st December	Dr Somia Antar	FP department manager in Assiut directorate
21st December	15 midwives trained in the last 4 years and years before.	FGD with midwifery group programme.
21st December	Dr Marina	IDI with doctor trained in FP
21st December	6 nurses from different FP planning centres in Assiut	FGD with Nurses trained on FP
22nd December		2 Visits to YFC – Sohag First visit was meeting with service provider and second visit used mystery client by designing a case asking for consultation.
22nd December	Wahib Layla Nabil Wahib Omnia	FGD with the Y Peer team.
25th December	Amal Abdelwahed	Agha Khan – project manager
26th December	Mohammad Salah.	Y peer Assiut focal point
27th December	Shehab- Alexandria drop in center	FGD with beneficiaries. FGD consists of 12 women who received different services or referred through the drop in center.
28th December	Mr Yousif Werdany	Ministry of youth – Department of projects
29th December	"Ghada Ezz El din	M3loma advisor

29th December	Weaam Metwally.	Member of the youth advisory panel representing UNICEF
January	Sherif Ahmed	Humanitarian coordinator, UNFPA CO
January 10th	Dr Ramez Mahani	WHO – EMRO Women and reproductive Health Coordinator
January 11, 2017	Olugbemiga Adelakin	UNFPA Regional Office M&E Advisor
January 11, 2017	Dawlat Shaarwy	M&E focal point, Evaluation Manager PD PMO UNFPA CO
January 13	Dr Ashraf Azer	UNHCR

GENDER EQUITY COMPONENT

Date	Name	Position
Wednesday, 14 December 2016 2pm	Ms. Mona Amin	NPC FGM PMU Coordinator
Thursday, 15 December 2016	Dr. Naglaa El Adly	NCW Director of International Cooperation and External Relations Department
	Shaimaa Naim	NCW Planning Department Director
	Asmaa Boghdady	NCW Monitoring Department
Thursday 15 December 2016 1pm	Wafaa Magued	Technical Coordinator GBV Costing study
Monday,19 December 2016 1pm	Ahmed Saad	Social Worker CEWLA (participant CSO in referral network workshop)
Tuesday, 20 December 8.30am	Amal El Mohandes	Nazra for Feminist Studies Deputy Director and Director of Women human Rights Defenders
	Salma Shash	Nazra for Feminist Studies Researcher at Women human Rights Defenders
Tuesday, 20 December 10 am	Abdu Aboul Ella reception Centre	Al Shehab programs Manager at Nasr City (participant CSO in referral network workshop)
Tuesday, 20 December Noon	Sahar Waheed,	Banati Head of psyco-social Department (participant CSO in referral network workshop)
Wednesday, 21 December 2016 9am	Dr. Safaa El Baz	RCT Director
	Dr. Bahaa Shawkat	RCT lead Trainer-consultant
	Ms. Ashagan Farid	RCT Administrative Coordinator
Wednesday, 21 December 2016 2.30pm	Ms. Nehad Aboul Komsan	Gender Consultant (GBV National Strategy, SH Units)

Thursday, 22 December	Dr. Heba Gabr	GBV project coordinator in curative Care Sector, MOH
Monday 26 December 9.30am	Dr. Hend El Helaly	SH Unit Ain Shams Coordinator
	Islam Amin, Osama Mahir 5th year medical students, volunteer Amany Abdelal, Doa El Sayed Psychologist volunteers	Representatives SH Unit
Tuesday 27 December 9.30am	Naglaa El Adly NCW (follow up call)	
2.pm	Nahed Talaat	BLESS project coordinator
3pm	Veronica Overlid	Gender Consultant UNFPA CO
Wednesday 28 December, 2017 Assiut Governorate	Dr. Ahmed Abdou Gease	President of the University of Assiut
	Christine Fikry	SH Unit Coordinator, and Head of Centre for Human rights Assiut University
	KPI Students SH units	6 students from different faculties 3 females, 3 males
	KPI doctors Dr. Mohamed Khalaf Tawfeek, Assiut Dr. Hesham Ahmad El-Sayed, Assiut	Doctors trained on medical protocol delivery (organized through RCT)
Assiut MoH Directorate	Dr. Fawzya Dakhil Kassem	Hospitals General Director (also attended doctors training)
	Ms. Nabila Fekry Hashem	Director of Nursing
Monday, January 2, 2017 11.30am	Nahed Talaat (Follow-up call)	BLESS Project Coordinator
Monday, January 2, 2017 12.30 pm	Ashgan Farid (Follow-up call)	RCT Project Administrator
Tuesday, January 3, 2017	Nahla Abdel Gawad	Safe Space Coordinator, Nasr City
	Marwa Salah	CARE Women's Initiative Manger
	Focus Group	Focus Group with Syrian women 15 women, ranging in age from 18-70, living in Egypt average 2-4 years
Wednesday 4 January, 2017	KPI;s doctors and nurses Nurses	RCT doctors and Nurses, Trainees from Cairo, Giza

10am-1pm	1) Howayda Bihkheet 2) Mona Hassanien 3) Asmaa AboulFoutouh Doctors 1) Dr. Nermeen Nabil 2) Dr. Mona Mohamed 3) Dr. Riham ElBindary	
Wednesday 4 January, 2017 2.30pm	Elsa Bousquet	UNHCR Protection Officer (Child/SGBV)
Thursday 5 January, 2017 11am-1pm	Jacqueline Isaac	Safe space Coordinator, Maadi
	Marwa Salah	CARE Women's Initiative Manger
	Focus Group	Focus Group with Safe Space users 14 women, ranging in age from mid-20' to late 40's, living in Egypt average 2-4 years, including Syrian, 2 Yemini, one Egyptian and one Somali
Monday January 9, 2017 1pm	Sherif Ahmed	Humanitarian coordinator, UNFPA CO
Wednesday January 11, 2017 10am	Olugbemiga Adelakin	UNFPA Regional Office M&E Advisor
Wednesday January 11, 2017 Noon	Dawlat Shaarwy	M&E focal point, Evaluation Manager PD PMO UNFPA CO
Repeated interviews, follow-up	Germaine Haddad	UNFPA CO Resident Representative, former GBV PMO
	Veronica Overlid	Gender Consultant UNFPA CO
	May Sallab	FGM coordinator UNFPA PMO
Saturday January 14, 2017	**Cairo:** Father Farig Father Jonah Father Seraphim Father Isheyaa Father Ibram **Minya:** Father Bafly Father Ezra: Father Andreaos **Assiut**: Father Christopher Father Ibram Father Wessa	BLESS Religious Leaders Assiut, Cairo, Minya
Monday January 16, 2017	**Nurses and doctors trained:**	RCT Trainees Domiat and Menofiya

	Menofiya: Ms Hanem Tiba Ms Iman Haikal **Domiat** Dr Riham Saad Dr. Heba Youssef	
Wednesday January 18, 2017 11.30am	Nada Sabet	Noon Company Director
Wednesday January 18, 2017 2.30pm	Izabella Eriksson	Counsellor Embassy of Sweden in Cairo (SIDA)
Sunday January 22, 2017 11.30am	Akmel Gamal	FGM Project Field Coordinator for Sohag, Quena, Luxor, Aswan
Tuesday January 24, 2017 1.00 pm	Dr. Hisham Abdel Hamid	Head of Forensics Department, Ministry of Interior
Tuesday January 24, 26 2017 1.00 pm	KPI's NGO Network of NPC working on FGM Adel Ghazali Raafat Alfy Samir Abdel Baki Mohamed Hegazi	 Project Manager NGO for the Development of Southern Egypt – Quena Project Manager Caritas Egypt- Assiut Project Manager NGO for Enhancing Community Participation in Fayoum – Fayoum Project manager Port Fouad For Family and Childhood Development – Port Said

POPULATION AND DEVELOPMENT COMPONENT

Date	Name	Position
05 October 2016	Ms Dawlat Shaarawy	EM and P&DO, UNFPA CO
06 October 2016	Dr. Sasha Bodiroza	UNFPA Representative, UNFPA CO
06 October 2016	Ms Dawlat Shaarawy	EM and P&DO, UNFPA CO
Sunday 27 November 2016 09:45AM-01:30PM	Ms Dawlat Shaarawy	EM and P&DO, UNFPA CO
Sunday 27 November 2016 01:45-03:30PM	Ms Eman Awad	UNFPA Finance & Admin Associate

Monday 28 November 2016 09:00AM-06:30PM	Mr Sherif Ahmed	Humanitarian Coordinator, UNFPA CO
	Ms Nihal Said	Adolescence & Youth sexual and reproductive health Analyst, UNFPA CO
	Ms May El-Sallab	FGM Coordinator, UNFPA CO
	Ms Germaine Haddad	Assistant Resident Representative & Acting Gender/GBV Officer, UNFPA CO
Tuesday 13 Dec. 2016	Mr. Kawamoto Yosuke	Focal Point Japanese Fund Donor Organization
Sunday 18 Dec. 2016 09:30-11:30AM	Mr Tor Haug	Counsellor/Acting Ambassador Donor Organization
Monday 19 Dec. 2016 10AM	Ms Gillian Wilcox	UNICEF Deputy Representative
Monday 19 Dec. 2016 11:00AM-06:30PM	Ms Dawlat Shaarawy	EM and P&DO, UNFPA CO
Wed. 21 Dec. 2016 09:00AM-10:00PM	H.E. Dr. Maissa Shawky	Deputy Minister for Population, NPC
	H.E. Dr. Tarek Amin	NPC Rapporteur
	Ms. Dalia Hassan	UNFPA Coordinator
	Dr Gamal El Khatib	UNFPA M&E Consultant
	Ms. Abeer Samy	Finance Consultant
Sunday 25 Dec. 2016 09:00AM-01:00PM	Mr. Motaz Yeken	Senior Advisor to the Minister of MOIC
	Ms. Randa Hamza	Senior M&E Advisor, MOIC
	Ms. Sally George	Senior M&E Advisor, MOIC
Sunday 25 Dec. 2016 02:30-10:00PM	Dr. Essam Madkour	GD of Coordination and International Agreements, NPC
	H.E. Dr. Atef El-Shitany	Sr Advisor and Former Rapporteur, NPC
Monday 26 Dec. 2016 09:00-04:00PM	Dr. Hussein Abdelazziz	Sr Advisor to CAPMAS President on Census
	Gen. Aboubakr El-Gendy	CAPMAS President
	Dr. Ghada Abdallah	Sector Head of CAPMAS President's Office
	Dr. Yosr Abdelfattah	Head of SDG Unit
	Ms. Amira Gamaleldin	Head of Economic Statistical Sector
	Mr. Taher Hassan Saleh	Under Secretary of Central Dept. of Population and Services Statistics
	Ms Pacinthe Mahmoud	International Relations Coordinator/CAPMAS-UNFPA
	Dr. Soad El-Dawy	Senior Advisor to CAPMAS President
	Dr. Hoda Mostafa	Head of International Relations Sector
Wed. 28 Dec. 2016 09:00AM-10:00PM	Ms. Safaa Noureledin	GM at Statistics Dept. (F2F), NPC
	Mr. Hanaa Hamido (Phone Interview)	GM at Stats Dept. , NPC

	Mr Abdou Shenawi (Phone Interview)	GD of Stats Dept, NPC
	Dr. Neveen Nagui	IT Dept., NPC
	Dr. Gamal El-Khatib	UNFPA M&E Consultant
	Ms Dalia Hassan	UNFPA Coordinator
	Ms Abeer Samy	Finance Consultant
Thursday 29 Dec. 2016 10:00-11:00AM	Ms Gillian Wilcox	UNICEF Deputy Representative
Saturday 31 Dec. 2016 12:00-1:00PM	H.E. Helmy El-Namnam	Minister of Culture
Sunday 01 Jan. 2017 10:00AM-10:00PM	Mr. Samir Abouraya	GD of Planning, NPC
	Mr. Mostafa Deghedy	GM of Monitoring Dept., NPC
	Ms Mona Khamies	Sr Specialist at Training and HRD Dept., NPC
	Mr Abdelfattah Sayed (Phone Interview)	GD of Training
	Dr. Sherif Gamal	GD of Research
Tuesday 03 Jan. 2017 11:00AM-12:00 Noon	H.E. Dr Ashraf El Araby	Minister of Planning, Monitoring, and Administrative Development
	Ms. Nahla Tarek	Researcher, Follow Up Specialist, Minister's Office
Tuesday 03 Jan. 2017 12:30-02:00PM:	Ms Nahla Hossam	Field Supervisor, Safe Spaces, Nasr City--NGO
	Ms Basma Qadour	CARE EGYPT
	Ms Ghofran El-Homsy	CARE EGYPT
Wednesday 04 Jan. 2017 10:00-11:30AM	Mr Michael Schaadt,	Head of UN Coordination Office, Office of UN Resident Coordinator UNDP
Wednesday 04 Jan. 2017 02:00-02:35PM	Ms Elsa Bousquet	Child/GBV, UNHCR - Donor Organization/Partner
Thursday 05 Jan. 2017 09:15-09:30AM	Dr Tarek Amin	NPC Rapporteur
Thursday 05 Jan. 2017 10:00AM-06:00PM	Mr. Ahmed Kamal Amin	Giza Governorate Branch Director
Thursday 05 Jan. 2017 10:00AM-06:00PM Thursday 05 Jan. 2017 06:00-07:00PM	Mr. Hamdi Nadi Ahmed Hassan	Sohag Branch GM/Dep. GD and IT Specialist
	Ms Wafaa Hamdy (Phone Interview)	GD Sohag Branch
	Mr Mohamed Abdou Bekheit	Assuitt Branch GD
	Ms. Amal Abdelgabbar	General Director of Art Production

	Dr. Yehia Abdelaal	Deputy Director of Media and Dissemination Dept. Director
	H.E. Dr. Maissa Shawky	Deputy Population Minister, NPC
Monday 09 Jan. 2017	Ms Dawlat Shaarawy	EM and P&DO, UNFPA CO
Monday 09 Jan. 2017 Wed. 11 Jan. 2017 09:00AM-08:00PM	H.E. Dr. Tarek Amin (Phone Interview)	NPC Rapporteur
	Dr Adelakin Olugbemiga	RO M&E Advisor
Wed. 11 Jan. 2017 09:00AM-08:00PM Sunday 15 Jan. 2017 09:00AM-10:00PM	Dawlat Shaarawy	Evaluation Manager & PD Associate
	Dr. Hanan Gerguis	Operations Manager, Baseera - Private Sector Consulting
Sunday 15 Jan. 2017 09:00AM-10:00PM Monday 16 January 2017 02:00-02:15PM	H.E. Dr. Hala Youssef	RO PD Advisor & Former Population Minister
	H.E. Dr Hala Youssef (Phone Interview)	RO Data and Policy Advisor
Wednesday 18 January 2017 02:00-03:00PM	Ms. Izabella Eriksson	SIDA (Counsellor, Swedish Embassy, Zamalek)—Phone interview Donor Organization/Partner
Sunday 22/01/2017 09:00AM-08:00PM	Dr Yasir Gamal	Monitoring GM, NPC
Sunday 22/01/2017 09:00AM-08:00PM Monday 23/02/2017 08:15AM-12:00Noon	Ms Dalia Hassan	UNFPA Coordinator, NPC
	Dr Gamal El-Khateeb	UNFPA Consultant, NPC
	Ms Abeer Samy	UNFPA Finance Consultant, NPC
	H.E. Dr. Maissa Shawky	Deputy Population Minister
	Dr Fatma El-Zahraa Geel	Information Analysis and Research Director IDSC, Cabinet of Ministers
Monday 23/02/2017 02:30-04:45PM	Mr Jorg Schimmel (Phone Interview)	Officer in Charge (OIC) and Deputy Country Director - UNWomen
Tuesday 24/01/2017 03:30-07:00PM	Dr. Ghada Mohsen	GM of Population and Development IDSC, Cabinet of Ministers.
Sunday 29/01/2017 5:30-6:15 PM	Dr Tarek Amin (phone interview)	NPC Rapporteur
Thursday02/02/2017 10:00 AM-12:00NOON	Ms Eman Awad	UNFPA CO Finance and Administration Associate
	Ms Gina Shoukry	UNFPA CO Finance Associate

ANNEX 15: FGD MINUTES, KPIS AND MCVS

15.1 Youth and Reproductive Health Component

Debriefing on Focus Group Discussions and Key Person Interviews

Focus Group Discussion - Midwifes trained in Assiut and Sohag (35 midwife trained in the last three years)

Objectives of the Focus Group

To assess their perceptions of the midwifes on the quality of the training and its effectiveness to support women deliveries in their prospective working areas.

Methodology

General challenges cause maternal mortalities in Assiut and Sohag, Quality and accessibility of the training to the midwives, knowledge change, Ability to practice the training contents, challenges face midwifes on daily basis to support women delivery, Support from the ministry of health, relationship with medical doctors and private systems, recommendations to decrease maternal mortality and support the midwives.

Summary of Discussions

- The training was important for some of the trained midwives. Some of them complaint about its length of the training. Others believe that the importance of the training is to provide them with license to practice but they do already.
- All participants confirmed the quality of the training materials and they all confirmed they were ready to deliver after the training.
- Women faced challenges to promote home deliveries because doctors warn women about home delivery.
- Most of the women who die during delivery usually follow up with private doctors. Still if midwife involved at any stage, she will be blamed.
- More than half of the trainees never delivered a woman after the training. About quarter did very few cases since the training. The midwives who already used to deliver before the training continued their work.
- The midwives did not deliver for different factors:
    - The refusal of family member (mainly husband)
    - Negative image of the task of the nurse/midwife in the communities.
    - Presence of private doctors' clinics do the task.
    - Nurses are occupied with other work in the health unit and incapable to do that due to work load.
- There was complaint about the availability of the tools to support them to deliver. Also some of them indicated lack of legal permission to deliver women in the health units.
- Lack of administrative support to help midwives to visit the women at home for delivery. Nurse has to ask for day off to go help delivering woman at home.
- Women never asked before about their opinion about the training or their ability to practice home deliveries with anyone.
- Some of nurses selected for the midwifery training were also selected for registry training or surveillance training and they have to do all those tasks at once while other nurses do not do any other tasks.

- Midwives do not know any other activities like family planning or youth programme.

Debriefing of Key Person Interviews on FP Trainings for Doctors and Nurses (3 doctors, 4 Nurses)

Objectives of the Focus Group
To assess their perceptions on the FP counselling and activities, and its practical application at the service delivery centers.

Methodology

Continuous challenges facing family planning in Assiut and Sohag, sources of knowledge for women about contraception, Quality of the training and knowledge products, acceptability of women of family planning services, utilization of the services, challenges face health providers to support women, Integration with other services, monitoring of the services, recommendations.

Summary of Discussions

- Women come mainly come to insert the contraceptive tool with previous decision.
- Families in Assiut and Sohag still prefer male child over females and will not use contraceptive tools before having male.
- Economic factor for the price of contraceptive play important factor. It's the reason women come to the FP clinics.
- Side effects of contraception control the decision of the women. Misconceptions about certain contraceptives play important role. "women avoid IUD because it hurts their back or ask for implant because it helps them to gain/lose weight"
- Introduction of Implanon was good addition. There were some side effects for Implanon for some women include bleeding and weight gain/loss.
- Women depend on social media and peers to decide about their tool.
- Counselling associated with family planning is the comparative strength for the family planning project.
- "Women come to us for advice about different topics like their sexual health with their husbands, mental health, violence and we even had pre-marital sex".
- Referral system is partially existing but need to be strengthen and integration is existing in some centers only.
- We do not know UNFPA but we know USAID and WHO.
- The main technical resource used on daily basis is the "green book" refer to (Global family planning handbook for health providers) of WHO.
- The training we had was very useful and improved our skills a lot.
- Decision making tool is good, but women get bored often. They prefer casual chatting.
- There is need for communication campaigns to help women know about contraceptives. It has to be innovative and include media and social media.

- Awareness for contraception for "non gravida" is important as it will decrease fertility in noticed way.
- Involvement of private sector include doctors and pharmaceutical companies will help a lot.
- Doctors sometimes give inaccurate advice to the woman.
- The filing system is paper based and follow up with women have challenge.
- Family planning team are not aware of the activities happening with the maternal health.

Debriefing of Key Person Interviews
Y-Peer (Core team, Alumni and Focal Point(s)) – 5 persons

Objectives of the Focus Group
Assess the perception of Y-Peer team for the effectiveness of Y-Peer network, efficiency, sustainability and networking with other youth activities.

Methodology

Assessment of the progress of Y-Peer in the current cycle, target identification process, priority interventions for the programme, perception of the effectiveness of the progrmme, efficiency of current structure (legal status and management), possible option for sustainability, quality of monitoring and evaluation system, coordination and joint work with other teams, Working with government and positioning Y-Peer in national agenda. Recommendation to improve the outcomes of Y-Peer.

Summary of Discussions

- Y-Peer expanded their activities in the last cycle to cover new governorates and new topics.
- Y-Peer target beneficiaries up to 45 years old.
- "It depends on the context; sometimes we target all the community".
- We tailor our message to match with the audiences.
- "In some cases, we do quick assessment for the community to identify our target" but not in systematic way.
- "We believe that social media activities are very important. We still work on our social media strategy".
- The interviewees have different views about the priority areas for Y-peer interventions. Some ideas suggested were; drug addiction, women empowerment, FGM, sexuality education and HIV/AIDS.
- The effect of Y-Peer varies according to the audience.
- No documented M&E system for the cascaded activities of the programme.
- Y-Peer team think they are not ready to sustain their activities without UNFPA support.
- Y-Peer team do not coordinate activities with other NGOs. However, they sporadically inform about other initiatives like M3loma in their campaigns.

- Others components of the youth programme use Y-Peer team for their activities as counselors or trainers.
- There is no space for streaming Y-Peer in national agenda. There are no intentions to focus on that.
- The main recommendations were:
    - Improve internal structure of Y-Peer.
    - Strengthen monitoring and evaluation.
    - Develop social media strategy and action plan.
    - Develop plan for fundraising.

Focus Group Discussion – Commercial sex workers and women beneficiaries visiting drop in centers (3o women)

Objectives of the key person interviews

To assess the effectiveness of HIV/AIDS component of UNFPA country programme. Assess the satisfaction of the beneficiaries for the services offered by the drop in center.

Methodology

Accessibility of the center, source of knowledge about the center, perception for the quality of the counselors, perception for the quality of services provided, perception for the quality of the referral system, impact of the training for the women, knowledge change, behavior change. Recommendations.

Summary of Discussions

- Most of the women were hesitant to visit the center in the beginning.
- The accessibility to the center is easy and doable for the women without any stigma.
- The strength of the center is the skills of the team working in the center and their ability to listen to the beneficiaries.
- Beneficiaries believe that drop in center offered them safe space to communicate and have social support.
- The services provided by the center are very important and efficient.
- The referral to other centers was good but women feel they need more services like medical and financial support.
- Women think that legal services and counselling was the most important and efficient for them.
- Many of the beneficiaries considered the visit to the center turning point in their lives and it helped some to protect themselves sexually and even to find alternative economic opportunities.
- There were different reported success stories for the women in the center to be captured.

- The knowledge of the women about HIV/AIDS increased along with other topics like gender based violence.
- The main recommendation is to extend the services to other centers in Cairo and Alexandria to ensure coverage of more areas.

Mystery client visits (MCVs)

Two visits to the youth friendly clinics in Assiut and Sohag.

Objective

The case assessed the following criteria:

- Ability to access the service.
- Anonymity and confidentiality.
- Affordability.
- Counselor skills in probing and proving advice in non-discriminatory way.
- Counselor knowledge and ability to counsel to the client.
- Referral to other services.

Mystery client case:

- "Female 23 years old with irregular menstrual cycle. She complains about pain during each menstruation. With probing the case suggest having pre-marital relationship with her fiancé".

Main Findings:

- The health provider was not available in the first visit in Assiut.
- Both centers were part on health center. One room was assigned for the purpose of serving as youth friendly clinic.
- The client revisited later at 11:30 and the health counselor asked her to buy examination from "tazkra" to be able to consult with her and asked her to register herself.
- The client was the only person coming to receive counselling in the two centers.
- The counselors were knowledgeable about the topic and suggested her to improve her nutrition and explained the biology of menstrual cycle and possible solutions to ease the pain.
- Health counselor recommended the client to seek medical care in the clinic.
- Counselor avoided providing any advice or probing question related to sexual health.
- The main advice was the couple to come for pre-marriage counsel.
- Other advises from the counselor was mainly to avoid sexual contact with her fiancé and try to conclude the marriage.

Conclusion:

The service lacked confidentiality and free access. The health counselor was able to provide medical advice but she was not skilled to provide sexual health counselling. The finding applies for both visits. Sohag counselor used more advisory language to be considered judgmental.

One visit to drop in center in Shehab "Cairo – Nasr City"

Objective

The case assessed the following criteria:

- Ability to access the service.
- Anonymity and confidentiality.
- Affordability.
- Counselor skills in probing and proving advice in non-discriminatory way.
- Counselor knowledge and ability to counsel to the client.
- Referral to other services.

Mystery client case

"Female 24 years old complain about exposure to violence from her partner. The client works as waitress in café and she was forced to have sexual relationship with one of the clients. With probing the case suggest have multiple sexual encounters with other clients"

Main Findings:

- The location and the venue of the services was accessible and counselors was immediately available.
- The client was not asked to pay any fees or reveal identity.
- Counselors opened the discussion in friendly way and showed empathy with the client.
- Counselor explained the different possible services that can be provided through the center.
- Probing question were raised to identify possible risks.
- Additional service especially legal and medical were proposed for the client if wanted with clear referral structure to other resources.
- Counselor referred the client for psychosocial support session after initial counselling.
- Client was asked to fill questionnaire to assess their knowledge about HIV/AIDS followed by brief awareness session.
- Counselors were available for questions and showed high knowledge about HIV/AIDS and gender topics.
- Client was briefly introduced about other projects in the NGO mainly vocational training.
- Client was provided with emergency contact if case she needed additional help and was invited to visit the center again for awareness and social activities.

Conclusion

The center provided accessible, confidential, affordable and efficient service to the client. There was no hinting or indication for any judgmental or discriminatory language. The team in the center showed professionalism and empathy to the client.

15.2 Gender Equity Component
Debriefing on Focus Group Discussions and Key Person Interviews

Debriefing of the Focus Group Discussions on Humanitarian Response with Syrian Displaced Women (29 women)

Objectives of the Focus Group
To assess their perceptions of the women on safe spaces and the services and information provided

Methodology
Refugee community is facing a myriad of challenges affecting their resilience and integration local communities. They have suffered trauma and psychological abuse during their presence in the conflict in Syria, as well as while trying to relocate. They are also vulnerable to issues of SGBV: *Extent that psychosocial support and activities have provided support, SGBV knowledge and coping mechanisms, support networks*.

Summary of Discussions

- The Spaces provide a home away from home where women can hear their native language and venture out of the house. The majority had no interactions outside immediate family. The safe spaces have tremendously improved their disposition.
- Many are here on a daily basis. The majority of activities are led by Syrian women who have expertise in a craft.
- Having the spaces child-friendly is a huge bonus and allows more frequent participation.
- Many didn't think of the trauma that the children have gone through as well, but can see differences after they have play sessions, art sessions, field trips.
- Introduction to activities such as jewelry making, knitting, sewing and cooking allow practice, new skills, and enable women to use outputs in own homes
- Would like more funding for materials for these activities so that they can produce larger quantities for sale, income
- Sessions on parenting and preventing child abuse were extremely enlightening, would like more of these session, especially if they can also be tailored to dealing with teenagers
- The parenting sessions have helped in dealing with some of the trauma that children faced during the war in Syria
- Psychotherapy and drama therapy sessions were uplifting, allowed women to release grief from trauma. They would like more of these sessions.
- They received information on nutrition and health that were informative.
- They received some awareness sessions on GBV, helped understand different types of GBV.
- Particularly interested in FGM. This is not a cultural practice and any neighbours were pressuring women to conduct FGM on daughters, especially girls born in Egypt.

- They do not feel comfortable approaching public service delivery points. They are mis-treated and ignored most of the time.
- There has been no awareness on networks or service delivery points that can assist refugees.
- When there are incidences in the community, they all band together, try to raise money together, and/or through NGOs, to try and deal with them. Reception and support at UNHCR is inhumane, making people wait for hours with no end support.

Debriefing of Key Person Interviews on SGBV Training for Doctors and Nurses (8 doctors, 6 Nurses)

Objectives of the key person interviews *(in lieu of focus groups since numbers were smaller)*
To assess their perceptions on the SGBV and forensics training, and its practical application at the service delivery points

Methodology
There is major gap in the services provided to SGBV victims and survivors. Hospitals and staff are not professionally equipped to deal with victims or correctly collect forensic evidence to be used in prosecution of perpetrators: *Type of new knowledge acquired, appropriateness, change in attitude.*

Summary of Discussions

- The information provided was excellent, well thought out, and well planned. The number of days was sufficient for the content.
- Dr. Hisham provided excellent forensic knowledge.
- Doctors do not know nurses from their respective hospitals who received the training and vice versa
- No enough doctors trained from each hospital. There is not enough to cover shift work or absence of trained doctors.
- There is a need to consider the high turn over rate of doctors under the Ministry due to rotations, internships, job placement and retirement.
- The administration at the hospital has to be on board with the overall idea of the service delivery, and support its doctors and nurses in training.
- While some doctors and nurses indicated that there is an urgent need to activate the units, other stated that the numbers of SGBV cases were too low to warrant an entire unit at this point in time.
- The lack of activation of the units is a detriment to the training efforts. Not only will some information be forgotten, but staff will be lost without the opportunity to practice. There is no guarantee that the next posting will have such a unit.
- While it was good to focus on OB/GYN doctors in training, there should also have been focus on psychologists and psychiatrists.

Debriefing of Key Person Interviews with NGOs on Referral Networks Associated with Medical Protocol and Service Delivery Points (6 persons from 3 NGOS)

Objectives of the key person interviews *(in lieu of focus groups since numbers were smaller)*
To assess their perceptions on the referral networks on SGBV

Methodology
There is a wide gap in referral systems related to SGBV victims*: NGO capacity, type of information received and relevance to SGBV referral network, selection of partners, knowledge about services*

Summary of Discussions

- The training was not on a referral network, it was on the content of the Medical Protocol.
- There is no referral network in place, no guides or information were provided on similar NGOs working in the field or friendly service delivery points.
- The workshops were conducted a year ago, and have not heard back since.
- Those who attended from the NGOs did not inform others in their organizations about the workshops. The main reason is that the units were not active at the time, and therefore not relevant to the work on hand.
- Need more training on psychological support for victims of SGBV.
- Need more community awareness on rights of women, so they know they have the right to seek help and get their rights
- Need to break the culture of victim-blaming in Egypt.
- Given that many of the clients of these NGOs are sex-workers, women and children at risk, and with the status quo operations at police stations and prosecutors, the NGOs do not feel fully confident that they would encourage victims to report cases. However, having forensic evidence collected at the hospitals is a first step of support.

Debriefing of Key Person Interviews with Religious Leaders Trained by BLESS (11 Priests)

Objectives of the key person interviews *(in lieu of focus groups since numbers were smaller, and some were individual interviews)*
To assess the information received on GBV, and tools and mechanisms utilized to disseminate the information to the community.

Methodology

Religious dialogue is one of the effective ways to combat SGBV at the community level: *knowledge gained, tools/curricula provided for dissemination, methods of dissemination to community, changes in behavior*.

Summary of Discussions

- The training focused a lot on FGM, but the actual content is not well recalled.
- Church sermons are well monitored and focus on the word of Christ and bible messages. Other cultural messages are discussed during various church activities such as youth groups, counselling, home visits etc.
- In the past few years, discussions, have focused on sexual harassment in the public sphere, and respect.
- Priests who attended the training have passed a summary of the content to (khodam) who then deliver the messages to the community.
- There was no disseminated content at the awareness sessions that were conducted.

Debriefing of Focus Group Discussion with Students from Ain Shams University (2 Male Medical Students, 2 female Graduate Students)

Objectives of the Focus Grou*p*
To assess technical input received by the SH Unit, and the role of students.

Methodology
One method to combat sexual harassment is by targeting students at Universities: *messages received, support to disseminate messages, uniformity in messages, sustainability of student support/volunteerism, changes in behavior*

Summary of Discussions

- Security personnel involved in a lot of harassment.
- After the revolution 2011, there is a lot of change in the thought process of students. There is no longer a fear of authority that used to exist. So more are willing to note harassment by professors or staff.
- Social media is a great way to gain support from peers, and as an outlet for issues.
- It was a great learning experience to be involved in creating messages for dissemination, and to see those messages on posters, and in slogans.
- There are messages aimed at male students, at female students, and at the community at large.
- There is a need for greater awareness on campus for the unit, and what it does.
- There is a need for more activities, more budgeting

- Need to link with activities of first year students, during their "introduction week." This would be a great deterrent if they learn about the Unit right away, and understand risks if they are involved in harassment.
- Right now, all the students are volunteers, so during exams there are no activities, and no one is really available for the unit.
- There has been no involvement of other students, in lower years, from many other faculties. Not sure how activities will be run once these students graduate.

Debriefing of Focus Group Discussion with Students from Assiut University(3 Male Students, 3 Female Students, different faculties)

Objectives of the Focus Group

To assess technical input received by the SH Unit, and the role of students.

Methodology

One method to combat sexual harassment is by targeting students at Universities: *messages received, support to disseminate messages, uniformity in messages, sustainability of student support/volunteerism, changes in behavior*

Summary of Discussions

- Students received Sexual Harassment awareness sessions, presented by professors
- They have been briefed on types of sexual harassment, and procedures in place for grievances
- Discussions that occurred in the Q&A were very informative, and showed that the professors were listening.
- The ability to discuss the ways some professors treat male and female students differently was empowering, and knowing that it was okay to feel that some treatment was not okay.
- It is good to know there is a policy that can be applied to professors and administrative staff too.
- Some students have complained collectively about security personnel harassing female students verbally, and the university took action. There was also a collective complaint about some passenger cars that would park outside some faculties that had late classes, and harass and intimidate female students, and again the university took action, a d increased security in those areas.
- Not the same students are active in the activities that create awareness and outreach on campus. It is a faculty and administration led initiate, and the students get involved with direction.
- Messages are clear, and the students find them acceptable.

Debriefing of Key Person Interviews with NPC Trainees at central head-quarters and branch governorates (Cairo, Giza, Assuit, and Sohag) (20 persons)

Objectives of the key person interviews *(in lieu of focus groups since numbers were smaller, and some were individual interviews)*
To assess relevance and effectiveness of trainings and workshops offered during the 9th Cycle country programme given inability to generate comprehensive, consistent lists of trainees with contact details.

Methodology
Capacity building at the central level was in a number of areas; namely, core leadership training, preparation and drafting of policy briefs, composite and population observatory indicators, and other community initiatives, such Mogta3mna Masry. Discussion about knowledge gained, quality of training, trainers, training assessment, tools/curricula provided for dissemination, and changes in behavior.

Summary of Discussions

- Core leadership training promised a "hypothetical" good opportunity for second and third liners (i.e. young leaders at NPC) to assume higher positions and to prepare them for this assumption
- Core leadership training was backed strongly by the then H.E. the Minister of Population and Head of NPC
- Core leadership training was split into two rounds of sessions and ended by conflicts between participants, has not given sufficient knowledge on leadership and was discontinued without sharing reasons. It went out of control of trainers and dissatisfaction expressed
- Core leadership program and members are dissipated. They are not recognized by NPC leadership for engagement
- No agenda or hand out materials in any training provided by UNFPA
- No pre- or post- assessment of training
- None of the participants knew it is UNFPA training. They were never told and no banners carry UNFPA logo
- Quality of trainers and attitudes are not always up to standard
- Mogt3mna Masry training is ambitious, yet yielded in no behavior changes same as others
- Training needs of NPC are diverse and unmet

- No training needs assessment concluded. Only needs assessment concluded was by UNFPA consultant on M&E capacity and results were not shared
- Training and HR Dept. at NPC is not involved in pre- or post-assessment that are normally performed by the trainers themselves, results of which do not change training modality or content
- Training and HR Dept., if involved in UNFPA training, arranges logistics, such as hall bookings, refreshment, and not involved in content analysis, or pre- and post-tests.
- Training is not in depth. At a number of times, training duration had to be reduced as content was completed in half the training duration, and governorate directorate representatives wanted to leave
- Policy briefs training was arranged for and delivered by in-house staff
- Observatory indicators and composite indicators were initiated by in-house staff
- Core leadership training not in UNFPA mandate, although needed within a comprehensive framework for building capacity of staff to enhance overall performance
- There should be focus on NPC staff in UNFPA training initially, to be followed by focused training strategy for end-beneficiaries
- There is no dissemination of NPC training courses and most staff do not know about it
- Due to differing competence in NPC branches, some branches are in more need for training than others. This can be arrived at if and when a comprehensive needs assessment is concluded at the central and local levels
- There is no follow-on training offered
- In depth M&E training on different methodologies is highly needed so the features of a real system evolve
- Training is not used to motivate staff
- UNFPA training was converted to workshops and was not assessed; and if so, by trainers themselves. No involvement of training and HR Dept.
- External training at IDSC on M&E was in depth and does not compare with what is being offered by UNFPA with respect to quality and content. IDSC training developed a community of practice for continued learning and of high-value
- Training effectiveness was not considered and is of high need, in light of receipt of different training from different donors
- No coordinated human resource development strategy at NPC, especially staff body gathers diversified backgrounds and some are with high school degrees and others with highest postgraduate degrees yet in different subjects that do not relate to their NPC jobs
- Comprehensive capacity building strategy needed for NPC to deliver on M&E for NPS, EP, NPAP etc.

ANNEX 16: BI-LINGUAL ONLINE SURVEY TOOL

The UNFPA Country Office is undertaking an independent Country Programme Evaluation for its 9th Cycle in Egypt. The main purpose of this evaluation is to assess the results and performance of the

Country Programme over the period 2013-2017 and to generate findings, recommendations and lessons for the upcoming Country Programme to be implemented starting 2018. The purpose of this survey is to collect clear/precise, quantitative and qualitative evidence from key stakeholders on UNFPA's programme portfolio (reproductive health, youth and adolescents; gender-based violence; and population and development) over the study period. Your feedback is important to us, so please give the necessary attention to your responses. Thank you very much for participating in this survey.

All data, information and/or views elicited through this survey are treated with the necessary confidence.

يطلق صندوق الأمم المتحدة للسكان بمصر دراسة لتقييم برنامجه القطري في دورته التاسعة بمصر. الهدف من هذا الاستبيان هوتقييم نتائج وأداء البرنامج القطري خلال الفترة 2013-2017 وتوليد النتائج والتوصيات والدروس المستفادة للبرنامج القطري القادم لتنفيذها بدءا من 2018. والغرض من هذه الدراسة هو جمع المعلومات والآراء بدلائلكمية ونوعية واضحة / دقيقة من الشركاء الرئيسيين فيما يتعلقبملف برنامج صندوق الأمم المتحدة للسكان (الصحة الإنجابية والشباب والمراهقين، والعنف القائم على نوع الجنس، والسكان والتنمية) خلال فترة الدراسة.ردود الفعل الخاص بك مهم بالنسبة لنا، لذا يرجى مراعاة الدقة اللازمة لإجاباتكم. شكرا جزيلا على المشاركة في هذا الاستطلاع.

سيتم التعامل مع المعلومات التي سوف تدلي بها بخصوصية تامة، لن يتم استخدام اسمك أو اسم الجهة التابع اليها في أي وثيقة خاصة بهذا الاستبيان.

(البيانات سرية ولا تستخدم في غير أغراض البحث العلمي)

A. Title/Post

B: Governorate

C: Institutional Affiliation:

1. International Organisation: UN
2. International Organisation: Non-UN Agency
3. International Financial Institution
4. NGO/CSO
5. Private Sector
6. Government
7. UNFPA Staff: CO
8. UNFPA Staff: RO
9. Other

Relevance الملاءمه

Q1: To what extent are the interventions of UNFPA Egypt country program (CP) 2013-2017

Q1: الي اي مدي تتسق تدخلات البرنامج القطري لصندوق الامم المتحدة للسكان 2013-2017 مع

(Q1a) relevant to the needs of the intended beneficiaries (women and young people); please substantiate your choice with evidence

(Q1a) يتسق مع احتياجات الفئات المستهدفة (المرأة والشباب) ؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q1b) in line with the government priorities; please substantiate your choice with evidence

(Q1b) يتسق مع اولويات الحكومة؟ يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q1c) aligned with UNFPA policies and strategies? Please substantiate your choice with evidence

(Q1c)يتسق مع سياسات واستراتيجيات صندوق الامم المتحدةالسكان؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q1d) to what extent has the country office (CO) been able to respond to changes in national needs and shifts caused by major political changes? Please substantiate your choice with evidence

(Q1d) إلي اي مدي مكتب صندوق الامم المتحدة للسكان بج.م.ع. قادر علي الرد علي الاحتياجات القومية المتغيرة وتوابع التغيرات السياسية؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1

مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

Efficiency الكفايه

Q2: To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country program? Please substantiate your choice with evidence

Q2: إلي اي مدي كان صندوق الامم المتحدة للسكان قادر علي الاستخدام الجيد لموارده البشرية والمالية والفنية في الوصول للنتائج المحددة مسبقا في البرنامج القطري لصندوقالامم المتحدة السكان؟ يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q2a) To what extent has UNFPA made good use of its human resources in pursuing the achievement of the results defined in the country program? Please substantiate your choice with evidence

(Q2a) إلي اي مدي كان صندوق الامم المتحدة للسكان قادر علي الاستخدام الجيد لموارده البشرية في الوصول للنتائج المحددة مسبقا في البرنامج القطري لصندوق الامم المتحدة السكان؟ يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1

مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q2b) To what extent has UNFPA made good use of its financial resources in pursuing the achievement of the results defined in the country program? Please substantiate your choice with evidence

(Q2b) إلي اي مدي كان صندوق الامم المتحدة للسكان قادر علي الاستخدام الجيد لموارده المالية في الوصول للنتائج المحددة مسبقا في البرنامج القطري لصندوق الامم المتحدة السكان؟ يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q2c) To what extent has UNFPA made good use of its technical resources in pursuing the achievement of the results defined in the country program? Please substantiate your choice with evidence

(Q2c) إلي اي مدي كان صندوق الامم المتحدة للسكان قادر علي الاستخدام الجيد لموارده الفنية في الوصول للنتائج المحددة مسبقا في البرنامج القطري لصندوق الامم المتحدة السكان؟ يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

Effectiveness الفعاليه

Q3: To what extent has UNFPA support helped to ensure reproductive health (RH) and the needs of young people, gender based violence (GBV) issues, and population and development (PD) are appropriately integrated into national systems and are positioned on the national agenda? Please substantiate your choice with evidence

Q3: إلي اي مدي كان صندوق الامم المتحدة للسكان داعما لكل من برامجه في مجالات الصحة الانجابية واحتياجات الشباب، والعنف ضد المرأة، والسكان والتنمية، بحيث يتم ربطهم بالانظمه القومية ووضعها القضايا المصاحبه لتلك المجالات علي الاجنده القوميه؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q3a) To what extent has the CP contributed to improving the capacity of the national health system to provide high-quality maternal health services to women of reproductive age? Please substantiate your choice with evidence

(Q3a)إلي اي مدي اضاف البرنامج القطري لصندوق الامم المتحدة للسكان لتحسين طاقات نظام الصحة القومي حتي يتمكن من تقديم خدمة صحية عالية الجودة للأم في سن الانجاب؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q3b) To what extent has the CP contributed to strengthening the local capacities for community-based interventions in reproductive health to empower women and young people? Please substantiate your choice with evidence

(Q3b)إلي اي مدي ساهم البرنامج القطري لصندوق الامم المتحدة للسكان في تقوية الطاقات المحلية للتدخلات علي ذات الساحة (المحلية) في شأن الصحه الانجابية بهدف تمكين المرأة والشباب؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q3c) To what extent has the CP contributed to enhancing the institutional mechanisms to protect against and respond to gender-based violence against women and girls? (In particular by helping to build the national capacity to implement laws and policies that curtail harmful practices i.e. female genital mutilation/cutting (FGM/C)? please substantiate your choice with evidence

(Q3c)إلي اي مدي استطاع البرنامج القطري لصندوق الامم المتحدة للسكان ان يساهم في تقويه الاليات المؤسسية للحماية ضد ومواجهة ظاهرة العنف ضد المرأه والفتيات؟ (وخاصه القدره علي مساندة بناء الطاقات المحليه لانفاذ القوانين والسياسات التي تواجه الممارسات الضاره مثل ختان الفتيات؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q3d) To what extent has the CP strengthened national capacity for using data and evidence to monitor and evaluate national policies and programs in the areas of population dynamics, sexual and reproductive health and reproductive rights, HIV, adolescents and youth and gender equality, including in humanitarian settings? Please substantiate your choice with evidence

(Q3d)إلي اي مدي استطاع البرنامج القطري لصندوق الامم المتحدة للسكان من تدعيم الطاقات القومية لاستخدام البيانات والادلة في متابعة وتقييم السياسات والبرامج في مجالات التغيرات السكانية، الصحه الجنسية والانجابية، وداء نقص المناعة، والمراهقين والشباب والمساواة بين الجنسين، بالاضافة لبرامج الدعم الانساني؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q3e) To what extent have the interventions supported by UNFPA in the field of population and development (PD) contributed to an increased availability and use of data on emerging population issues at central and local levels? Please substantiate your choice with evidence

(Q3e)إلي اي مدي ادت التدخلات الداعمة للسكان والتنمية والمقدمة من خلال صندوق الامم المتحدة للسكان اسهمت في زيادة اتاحة البيانات واستخدامها للموضوعات الحديثة/الصاعدة في شأن السكان علي المستوي القومي والمحلي؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

(Q3f) To what extent has CO humanitarian assistance contributed to an improved emergency preparedness and response for SRH and GBV in Egypt? Please substantiate your choice with evidence

(Q3f)إلي اي مدي كان الدعم الانساني المقدم من مكتب صندوقالأمم المتحدة السكان بالقاهرة قد ساهم في تحسين القدرة علي مجابهة الازمات الطارئة واظهر القدرة علي الرد علي قضايا الصحة الانجابية ومواجهة العنف ضد المرأة؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

Sustainability: الاستدامه

Q4: To what extent was the CO able to shift the mode of engagement and focus on upstream interventions (Strategic advocacy, Knowledge management and the internal CO capacity)? Please substantiate your choice with evidence

Q4: إلي اي مدي كان مكتب صندوق الامم المتحدة السكان قادر علي الانتقال الي النظام الجديد للمشاركه من خلال تدخلات تتصل بتدعيم الاستراتيجية، وادارة المعرفة والقدرات الداخلية لمكتب صندوق الامم المتحدة السكان بالقاهرة؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

UNFPA Value-Added: الاضافه والميزه النسبيه

Q5: To what extent has the CP been able to support its partners and beneficiaries in developing capacities and establishing mechanisms (for example: youth friendly services) to ensure ownership and sustainability of achieved results? Please substantiate your choice with evidence

Q5 : إلي اي مدي كان البرنامج القطري لصندوق الامم المتحدة للسكان قادر علي مساندة الشركاء والمستفيدين في بناء القدرات وفي تأصيل الاليات (مثلا: الخدمات الصديقة للشباب) لتأكيد الملكية واستدامة النتائج التي تم التوصل اليها؟يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

UNFPA Value-Added: الاضافه والميزه النسبيه

Q6: What are the main UNFPA comparative strengths in Egypt, particularly in comparison to other UN agencies?

Q6 : ما هي مواطن قوة مكتب صندوق الامم المتحدة للسكان بالقاهرة مقارنا بمنظمات الامم المتحدة الاخرى؟

UNFPA Value-Added: الاضافه والميزه النسبيه

Q7: What is the main UNFPA added value in the country context as perceived by national stakeholders and UNCT coordination team “visibility/NEX?”

Q7 : ما هي الاضافة النوعية التي يقدمها مكتب صندوق الامم المتحدة للسكان بالقاهره كما يراها الشركاء الوطنيون وممثلي منظمات الامم المتحدة (مضافا للصورة الذهنيةللصندوق وأليه التنفيذ القومية)؟

UNCT Coordination: التنسيق مع منظمات الامم المتحده العامله في ج.م.ع

Q8:To what extent was this coordination (national stakeholders and UNCT) effective to boost the program implementation and achieve better results? Please substantiate your choice with evidence

Q8 : إلي اي مدي كان التنسيق (بين الشركاء علي المستوي القومي ومع فريق منظمات الامم المتحدة) قادر علي دعم تنفيذ برنامج صندوق الامم المتحدة للسكان والوصول لنتائج افضل له؟ يرجى إضافة الأدلة المؤيدة لاختياركم

highly satisfactory 6	Satisfactory 5	moderately satisfactory 4	moderately unsatisfactory 3	unsatisfactory 2	highly unsatisfactory 1
مرضي كليا 6	مرضي 5	مرضي جزئيا 4	غير مرضي جزئيا 3	غير مرضي 2	غير مرضي كليا 1

Evidence الأدلة

Q9: Please list your recommendations to improve on the UNFPA country programme specifying the focus area to which you wish to see improved (i.e. sexual and reproductive health, youth and adolescents; gender-based violence; or population and development). Please be as clear as possible with you recommendation and why it is necessary

Q9: يرجى وضع قائمة بالتوصيات لتحسين اداء البرنامج القطري لصندوق الامم المتحدة للسكان ذاكرا المجال التي تود ان تراه افضل اداءا (اي الصحه الجنسية والانجابية، او الشباب والمراهقين، او ممارسات العنف ضد النوع، او السكان والتنمية). الرجاء توضيح توصياتك ومدي اهميتها

Q10: Please inform of the lessons learnt drawn from the current UNFPA Country Programme that would inform the upcoming Country Programme starting 2018

Q10: يرجي الافادة بالدروس المستفادة من البرنامج القطري لصندوق الامم المتحدة للسكان الحالي (2013-2017) للاستفادة منها في اعداد البرنامج القطري التالي بدءا من 2018

Q11: Additional Comments/Remarks

Q11: أية تعليقات / ملحوظات إضافية

ANNEX 17: FULL ONLINE SURVEY RESULTS

Institutional Affiliation :

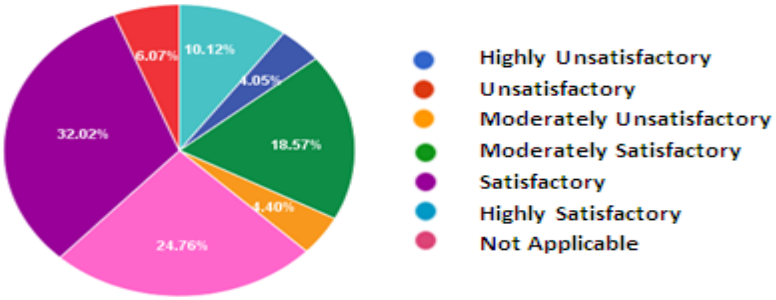
Figure 1: Institutional Affiliation Distribution

Table 1: Number/Percentage of respondents per institution

Institution	Frequency	Percent
Government	36	64.29%
UNFPA Staff: CO	2	3.57%
UNFPA Staff: RO	1	1.79%
International Organization: Non-UN Agency	3	5.36%
International Organization: UN	8	14.29%
NGO/CSO	3	5.36%
Private Sector	1	1.79%
Other (consultants)	2	3.57%
Total	56	100.00%

OVERALL PERFORMANCE

Figure 1: Overall Performance Satisfaction-Level Percentages

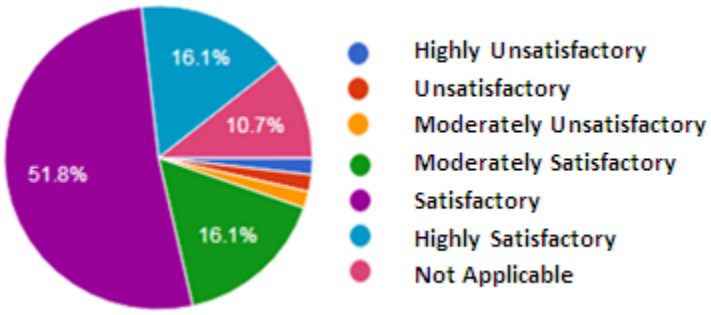


Overall performance is satisfactory (32.02%); followed respondents who cannot judge (24.76%); and moderately satisfactory (18.57%).

1. Relevance

Q1a : To what extent are the interventions of UNFPA Egypt CP 2013-2017 (a) relevant to the needs of the intended beneficiaries (women and young people);

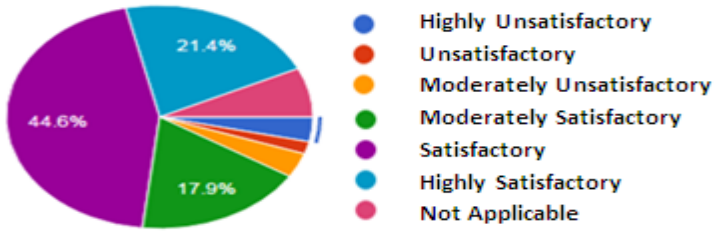
Figure 2: EQ1a answers percentages.



*Indeed, 51.8% of respondents thought UNFPA 9th Cycle CP interventions are relevant, and 16.1% as highly satisfactory to the intended need of beneficiaries. Many respondents provided their relevant evidence of the relevance of the CO CP agenda to national priorities, such as: matches with NPS 2015-2030; a spot on Safe Cities target group; GBV, FP including contractive security; NCW in GBV; youth and gender programs needed; national reach; funding census and surveys relating to sustainable development, gender and youth; with NPC, a focus on NPS and its operational plan, advocacy activities and two media campaigns focusing on FP, added to capacity building activities to technical staff; meeting needs on RH, labour market skills, and Syrian refugees (SGBV).

Q1b : To what extent are the interventions of UNFPA Egypt CP 2013-2017 (b) in line with the government priorities;

Figure 3: EQ1b answers percentages.



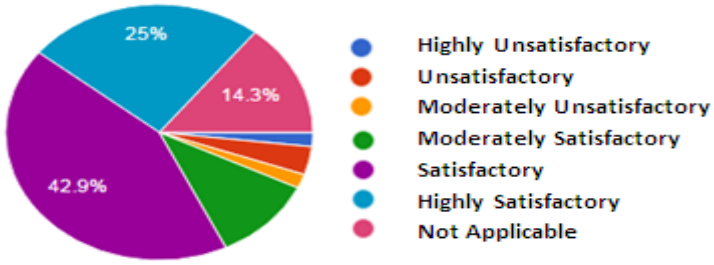
* The majority of respondents (44.6%) believe that UNFPA's CP move satisfactory in line with government priorities, 21.4% as highly satisfactory, and 17.9% as moderately satisfactory.

*In many respects UNFPA CP is aligned with government priorities, especially with respect to the population issue that had its NPS launched in 2014, several Presidential announcements addressing it, the support given to CAPMAS relating to tracking SDG indicator and census is aligned to GOE's Vision 2030, in alignment with the Presidential youth forum, UNFPA outputs are linked to GOE strategic plans, aligns with needs and policies of the Ministries of Health and Justice, young people especially in the aftermath of two revolutions, projects related to FGM and GBV are aligned with government priorities (despite fluctuating interest), SGBV, and to NPC NPS especially in pillars relating to gender and youth. Problematic areas mentioned touched on interventions impacts given the small amount of moneys invested by UNFPA CO which require demonstrating tangible results, and the great need to implementation mechanisms for

population programs and M&E that is impaired and inadequate. Some respondents acknowledged the quick responsiveness of CO to government requests, for example, Implanon, RH products, in addition to strengthening MH surveillance.

Q1c : To what extent are the interventions of UNFPA Egypt CP 2013-2017(c) aligned with UNFPA policies and strategies?

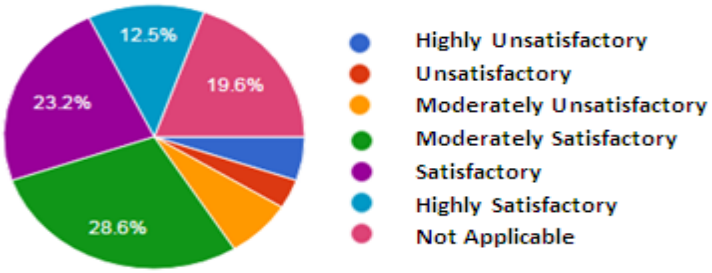
Figure 4:EQ1c answers percentages.



*Most respondents (42.9%) think 9th Cycle CP aligned with UNFPA policies and strategies, 25% highly satisfactory, and 10.7% as moderately satisfactory, while 14.3% do not know. Many respondents affirmed the alignment of UNFPA policies and strategies with GOE strategies, yet some wished to clarify that implementation realities may be different as the focus on strategic levels may or may not cascade to the grass root level. In addition, the CP is aligned to the 17 principles of its establishments and due to austerity measures on core fund limitation, the CO was able to elicit the interest of donors to raise a growing OR portfolio (and new donors such as the EU); having said that, some respondents from CAPMAS forwarded that UNFPA policies and strategies are at times limiting to meeting the needs of the newly-established, high-impacting SDG unit at the national statistical arm. Another respondent from NPC thought advocacy interventions are necessary but insufficient to CO's investments in to the NPS. Moreover, a different response confirmed that UNFPA's strategic interest with early marriage, FGM, FP, adolescent health initiative in Egypt in collaboration with the school age department of MOHP, and the NPS match strategically with its strategies and that of GOE's.

Q1d : To what extent are the interventions of UNFPA Egypt CP 2013-2017(d) to what extent has the CO been able to respond to changes in national needs and shifts caused by major political changes?

Figure 5: EQ1d answers percentages.



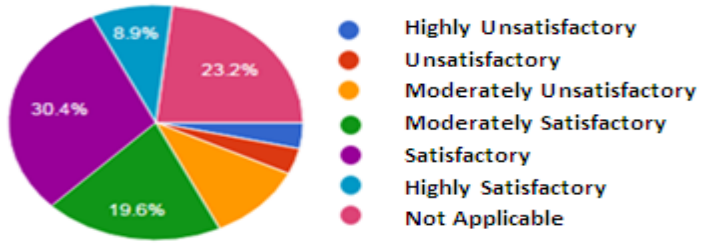
* the majority of respondents (28.6%) chose moderately satisfactory, 23.2% satisfactory, 19.6% do not know, 12.5% highly satisfactory, and 6.1% highly unsatisfactory. With this spectrum respondents' remarks

came as follows: mixed responses were received: the majority thought CO was able to respond to changes in political situation and was responsive. It was acknowledged that during the Moslem Brothers (MBs) era, there was little to be done by the CO, however the response to violence against women during the revolutions is marked, supporting the preparation and launch of the NPS, gender empowerment, and sustainable development goals are key. In other responses, reservations evolved, e.g. YFCs in 3 governorates were to be up-scaled yet funding was stopped against plans, and others noted that AWP seem like a taboo to CO against opportunities for better performance and results alignment.

2. **Efficiency**

Q2 : To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country program?

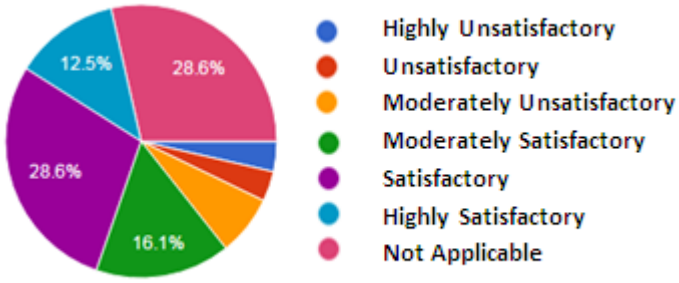
Figure 6: EQ2 answers percentages.



Online Survey: Overall, the majority of respondents (30.4%) were satisfied, followed by 23.2% who do not know, and 19.6% who thought UNFPA was moderately satisfactory making good use of its human, financial and technical resources in achieving the results of its 9th Cycle CP. To illustrate further, while many respondents were unable inform they do not have access to knowledge on this subject through UNFPA, others offer a mixed vision about the technical competence of CO in taking such decisions as to hire external consultants to implement interventions that may lack shared/owned goals by implementing partners. Others see its special relations with NPC as successful due to partnered initiatives to serve social needs, such as FGM. A respondent from a international organization believes that CO should allocate larger funding allocations for bigger programs especially for youth to demonstrate success related to government. Special acknowledgments were given to the financial management of the CP components. Furthermore, a respondent thought CO's performance efficiency differed along the years, while noting the current national turbulent circumstances at the behest of two revolutions, the CO remained static, understaffed and enforced its rigid plans that lost sharing an overarching vision with IPs. On the other hand, an opportunity taken by CO came in the form of responsiveness to meet Syrian refugee needs especially in relation to SGBV.

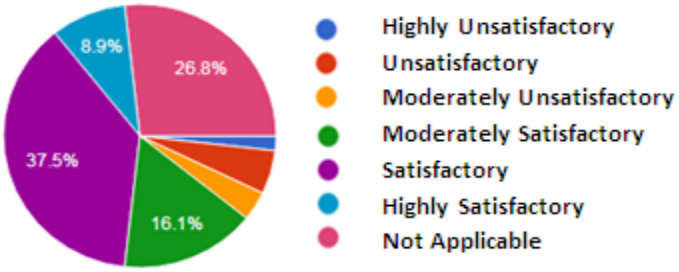
Q2a : * Human: Although most responses (28.6%) did not know, equally 28.6% thought CO human capacity as satisfactory, and 12.5% as highly satisfactory. The majority of comments affirmed the inconsistency of the technical and human quality of UNFPA CO staff.

Figure 7: EQ2a answers percentages.



Q2b : * Financial: The financial competence of the CO is by far one of the satisfactory (37.5%) resources available, and 8.9% of respondents consider it highly satisfactory. And, 28.6% do not seem to be able to respond to this question. The majority of respondents were quite satisfied with the competence of CO in managing its financial resources and found it rather effective in achieving results; some respondents thought the system may be improved if IPs new funding allocations for the entire program cycle than on year-by-year basis for effective planning and implementation; other commented on the possible adversity which may occur in the financial cycle dependent on approving PMOs. A respondent sees that the flexibility in earmarking resources to support UNFPA's humanitarian component was outstanding (SGBV).

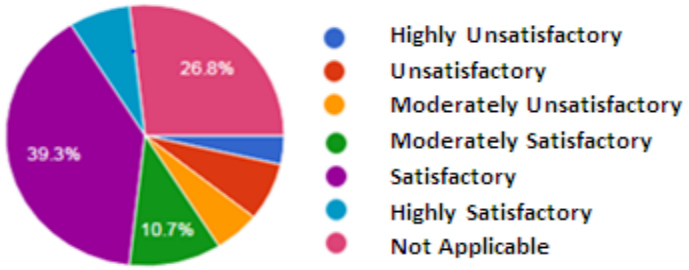
Figure 8:EQ2b answers percentages.



Q2c : * Technical: The majority of responses thought UNFPA CO technical competence as satisfactory (39.3%), 26.8% did not know, and 7.1% thought it unsatisfactory which is equally as highly unsatisfactory (7.1%).

Many responses remarked that the technical competence of CO staff is idiosyncratic, and recourse to external consultants is quite common due to this limitation which necessitates investing in IPs more.

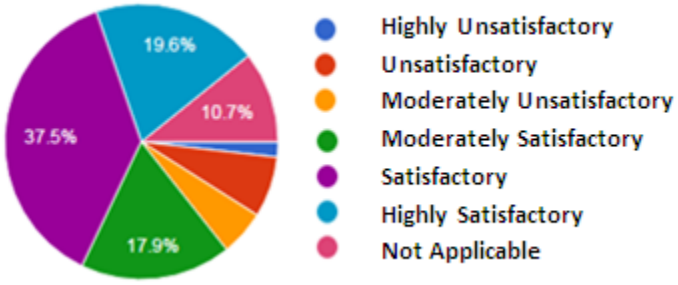
Figure 9: EQ2c answers percentages.



3. **Effectiveness**

Q3 :what extent has UNFPA support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into national systems and are positioned on the national agenda?

Figure 10: EQ3 answers percentages.

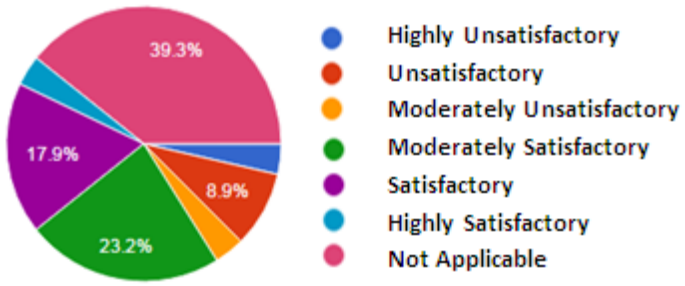


* A sweeping 37.5% of responses affirmed that UNFPA CP support in the different focus areas managed to appropriately integrate the respective domains of operation into national systems and are positioned on the national agenda. In addition, 19.6% of respondents see such efforts by CO as highly satisfactory. Only 10.7% did not know or thought it inapplicable.

* The evidence for positive selection revolved around the following: UNFPA is considered a partner in all population policy aspects, same for RH, MH, FGM, GBV and PD. Further evidence came in the form of criminalization of FGC and addressing harassment in criminal law. Despite of acknowledgment of the launch of the NPS and the offering of UNFPA TA to this national agenda item, respondents stated that results on the population challenge remain mediocre and CO is unable to understand that strategies are not stand-along exercises, as they require tools, systems and heavy human capacity building to sustain. Indeed, CO was highly commended for the GBV costing study.

Q3a : To what extent has the CP contributed to improving the capacity of the national health system to provide high-quality maternal health services to women of reproductive age?

Figure 11: EQ3a answers percentages.



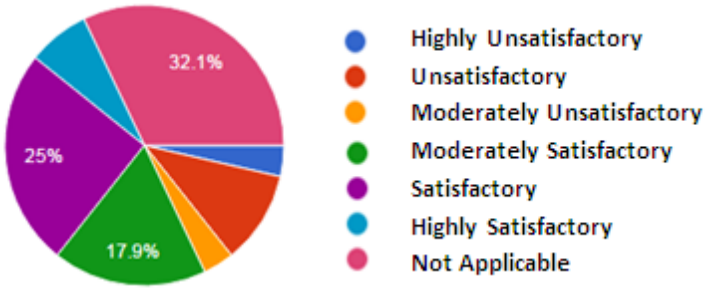
*A majority of 39% were unable to depict whether the UNFPA CP managed to improve the capacity of the national health system to provide high-quality maternal health services to women at reproductive age, while 23.2% sees this as moderately satisfactory, and 17.9% as satisfactory.

*Respondents informed that improvements in the capacity of the national health system in this regard is handled by the MCH department of the MOHP, where there is underground work to develop standard procedures for GBV victims, midwifery training is delivered. The capacities built bear fruition through the last DHS 2014, whereby indicators of mother and child have improved, reduction in post-natal maternal and child mortality.

*A further contribution that adds immensely to the build-up of national capacity relating to maternal health is contained in the development and launch of the national population strategy and observatory addressing population issues over the past 2 years. UNFPA funding of the NPS is a valuable undertaking towards this.

Q3b : To what extent has the CP contributed to strengthening the local[274] capacities for community-based interventions in reproductive health to empower women and young people?

Figure 12: EQ3b answers percentages.



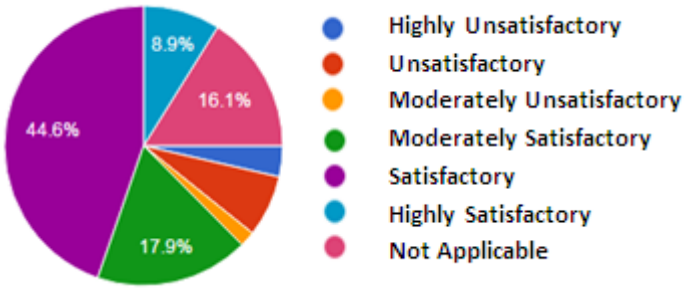
*The majority of respondents (39.3%) do not seem to know, 17.9% thought it satisfactory, 23.2% as moderately satisfactory. The varied results reflected different opinions and trajectories, e.g. many respondents saw the interest of CO in implementing local-level capacity building interventions at the community level favouring a tilt to investments on the national level. Developing indicators may be

[274]Amended from "national' to "local", to better highlight that interventions are occurring at a de-centralized level, and are reliant on community-based initiatives. This is not to exclude national capacities, that may result from groups, coalitions or others working together to amalgamate results at the national level.

necessary, however building capacities is more sufficient to sustaining an in-built, embedded M&E system. Capacity building efforts at the local level in the area of RH did not realize tangible results, and such interventions is regarded by some as a mere portrayal of an untrue democratic image. A clear statement came from a respondent read as: "UNFPA was always reluctant to support community based initiatives and said they were not one of their priority areas." On the other hand, a different respondent proposed to make use of success stories implemented by capacitated leaders in government and community leaders in household empowerment and FGM and outreaching villages, building local capacities and creating community awareness of population challenges etc.

Q3c : To what extent has the CP contributed to enhancing the institutional mechanisms to protect against and respond to gender-based violence against women and girls? (In particular by helping to build the national capacity to implement laws and policies that curtail harmful practices i.e. FGM/C)?

Figure 13: EQ3c answers percentages.



*A majority of 44.6% believed that the UNFPA CP led to enhancing satisfactorily the institutional mechanisms to protect against and respond to gender-based violence against women and girls, 17.9% thought it was moderately satisfactory, 16.1% did not know, while 8.9% thought it highly satisfactory.

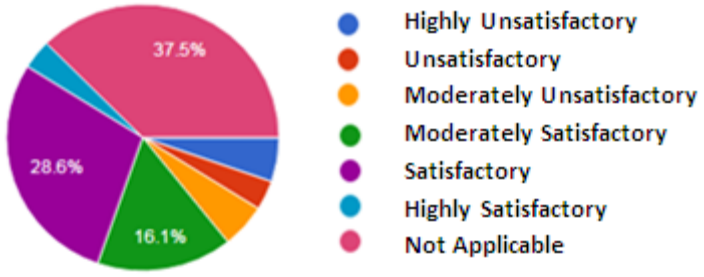
*The majority of respondents seem cognizant of the work performed by UNFPA and acknowledge it. Evidence given were as follows: the implementation of special programs through the family empowerment project through a number of NGOs locally (e.g. in Assuitt); the support given by UNFPA to NPC in the field of FGM/C is highly valuable, some capacity building workshop were offered effectively; printed materials such as brochures and illustrative posters were good tools; and some of the remarkable efforts expended by UNFPA relate to supporting NCW on changing the social culture represented in the norms encouraging FGM, and the Taa Marboota campaign. A couple of respondents were positive about the capacity building activity supported by UNFPA in the field of FGM, however they added by posing that training for legal authorities and the ministry of interior is moving slowly, aside of financial support, perhaps build capacity in students through more introductions on RH and the laws criminalizing the adverse phenomenon.

*On more respondent was quite satisfied with UNFPA CO support to the development of YFS initiative and clinics in Egypt, which were thought to enhance the institutional mechanism to protect against GBV,

and also helped in building the national capacity to enforce laws and policies curtailing the harmful practice of FGM/C

Q3d : To what extent has the CP strengthened national capacity for using data and evidence to monitor and evaluate national policies and programs in the areas of population dynamics, sexual and reproductive health and reproductive rights, HIV, adolescents and youth and gender equality, including in humanitarian settings?

Figure 14: EQ3d answers percentages.

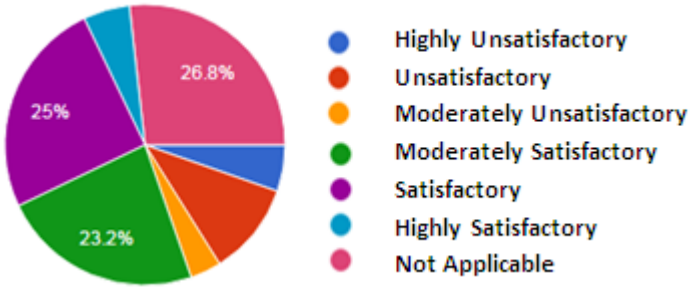


* The sweeping majority of respondents (37.5%) did not know the correlation between the effects of the CP and national capacity for using data and evidence to monitor and evaluate national policies in CO 9th Cycle focus areas, while 28.6% thought it was satisfactory. For a fuller picture, only 5.4% thought it highly unsatisfactory.

* A number of responses acknowledge that void in place due to the lack of an M&E system generating evidence for population policies. NPC's AWP contained the establishment of an M&E system within the organization to follow on the implementation of the previously UNFPA-supported NPS. The lack of an M&E system was identified as a gap in the post ICPD evaluation. Working on M&E system came in 2015 leading to the development of composite indicators (Population Atlas) in 2015. In 2016, the Atlas was rolled-out in almost all governorates by NPC. The work on developing a results-based framework (RBF) for the NPS resulted in the derivation of Phase I indicators, and the mapping of secondary and primary indicators allowing for Observatory Phase I implementation.

Q3e :To what extent have the interventions supported by UNFPA in the field of population and development (PD) contributed to an increased availability and use of data on emerging population issues at central and local levels?

Figure 15:EQ3e answers percentages.



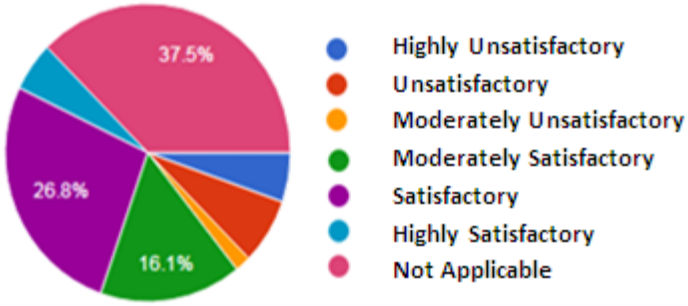
* The top category of responses (26.8%) did not know, most probably to the recent collaboration between UNFPA CO and CAPMAS intent to hike during the last CP year (2017) onwards. Next in line was a 25% and 23.2% of respondents thought UNFPA CO contribution to increasing the availability and use of data on PD issues at both the central and local levels as satisfactory and moderately satisfactory, respectively; while 10.7% thought those data and statistics as unsatisfactory for different reasons.

* On the upside, respondents acknowledged the efforts of the CO in contributing to DHS, SYPE and SDGs at the national statistical level. Others affirmed the contribution of UNFPA to the development of the NPC Observatory despite the fact of miniscule technical and financial contribution. Others mentioned that two capacity building workshops for NPC Sohag Branch were offered to staffers and partner organizations in the governorate relating to the newly launched Population Observatory were found useful. In addition, some respondents stated that UNFPA is competent in delivering specialist research and census on PD issues.

* Many of the respondents on the downside see they are unaware of CO's PD contributions, or state that scattered efforts on the PD front render it ineffective (i.e. lack of provision of advocacy tools to media personnel or personal interests preclude national ownership).

Q3f : To what extent has CO humanitarian assistance contributed to an improved emergency preparedness and response for SRH and GBV in Egypt?

Figure 16: EQ3f answers percentages.



*Most respondents (37.5%) were not aware of UNFPA CO's interventions for improved emergency preparedness and response for SRH and GBV in Egypt; 26.8% were satisfied with services provided; and 16.1% were moderately satisfied; and 7.1% thought it unsatisfactory.

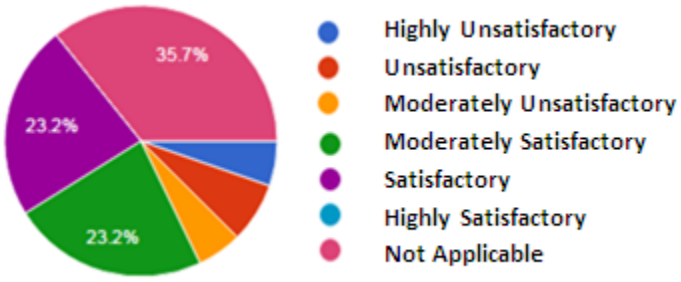
*Most respondents provided evidence that there is a marked impact by UNFPA CO in the humanitarian, namely the Syrian refugees program, whereby a number of safe spaces were open to refugees. An additional

advantage of the CO Syrian refugees program is its ability to build the capacity of NGOs to deliver to end beneficiaries (refugees).

4. **Sustainability**

Q4 : To what extent has the CP been able to support its partners and beneficiaries in developing capacities and establishing mechanisms (for example: youth friendly services) to ensure ownership and sustainability of achieved results?

Figure 17: EQ4 answers percentages.



Online Survey: *The foremost majority that were unable to assess UNFPA's capacity to support partners and beneficiaries sustained capacity resulting from UNFPA interventions (33.9%) and inform that no impact measurement on sustenance was invested by UNFPA in partners or beneficiaries has been taken; while others stated that youth health facilities, as an example, is under current evaluation, implying generating information on effectiveness and sustainability aspects. A skeptic key informant from a local/community branch of NPC poses that investing in capacity building activities in an IP's (NPC local branch) human resources as implemented by UNFPA have started in May and June 2016 only, with questionable, sustained intervention value-added.

*Most survey respondents (28.6%) see that the UNFPA 9th Cycle CP has been able to support its partners and beneficiaries satisfactorily to develop their capacities and establish mechanisms to ensure owners and sustainability of achieved results, in general.

*Those respondents who responded favourably to UNFPA's sustained interventions for better results emphasized the importance that the beneficiary organization has embedded capacity for change that has to match UNFPA's willingness to effect change to realize sustained value additions for better results. Other respondents believed that UNFPA's capacity to provide sustained interventions is marked more glaringly at the national level (i.e. compared to local/governorate levels). More respondents trust the UNFPA CO managed to support the development of youth-friendly clinics within MOHP health facilities and upgraded health-providers' capacity, though aspects of sustainability remain needy of additional effort to fortify. Sustenance issues do not seem to have been addressed at the outset on formulating MOHP's joint programme interventions.

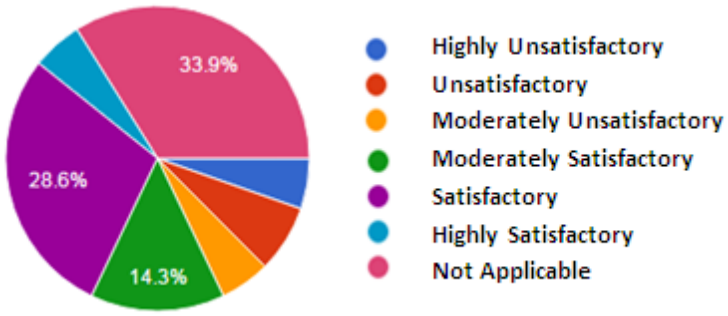
*On the downside, an NPC respondent thought UNFPA CP was unable to fulfil on this mandate who retorted by mentioning UNFPA's lack of focus resulted in a tendency to flip among activities and priority

agenda issues in case one has not achieved its planned results within a specified time frame. This was seen as conflicting with diligence and alleged commitment responsive to needs of partner organizations (IPs).

UNFPA Value-Added

Q5 : To what extent was the CO able to shift the mode of engagement and focus on upstream interventions (Strategic advocacy, Knowledge management and the internal CO capacity)?

Figure 18: EQ5 answers percentages.



* The majority of respondents do not seem aware of UNFPA's new strategic orientation (35.7%). The following category of respondents find UNFPA's new mode of engagement as satisfactory (23.2%), to moderately satisfactory (23.2%). A fractional percentage (6.1%) regard it highly unsatisfactory.

*On the upside, those who believe on the importance of the adoption and continuation with UNFPA's new mode of engagement see that despite many lost opportunities by the CO to contribute to many windows for upstream interventions, yet still the CO was able to have its contribution to the calendar-marked population day, engagement of medial people and to NPC's scientific day with marked political commitment elicited by Ministerial- and Governorial-levels to population issues. In addition, UNFPA was successful in partnering with NPC in launching the national population strategy (NPS), awareness creation stakeholders workshop on SDGs for collecting indicators and fortifying the national statistical system for periodic SDG reporting mechanisms. Moreover, interventions rendered by UNFPA to NPC were upstream, same for the ability to establish youth- and adolescent-friendly clinical services intent to sustain.

*On the other hand, some respondents affirmed that upstream activities offered by UNFPA (to NPC) require implementation mechanisms to go hand in hand with upstream/soft activities.

Q 6: What are the main UNFPA comparative strengths in Egypt, particularly in comparison to other UN agencies?

*Almost all respondents to this questions were in strong support of UNFPA's technical and financial edge. On its human capacity, respondents believe that CO staff is friendly and skilled despite of shortage in staff. Advocacy on population issues and dealings with strategic partners appropriately enables the filling of gaps on the social agenda of the GOE. Some respondents commended its contextualized solutions reflected in population advocacy, RH, GBV, FGM, YFS initiatives and Syrian refugees' humanitarian response. More responses emphasized the ability of UNFPA to select highly competent execution teams in the field. Furthermore, respondents see UNFPA CO as a natural extension for the collaboration on its agenda and the NPC. Moreover, others highlighted its strength as convener of youth-focused interventions and broker for high-level (policy) technical interventions. Finally, an area of comparative strength for UNFPA CO lies in

its multi-partnership building relations with myriad national and international organizations (i.e. UN and non-UN).

Q 7: What is the main UNFPA added value in the country context as perceived by national stakeholders and UNCT coordination team "visibility/NEX"?

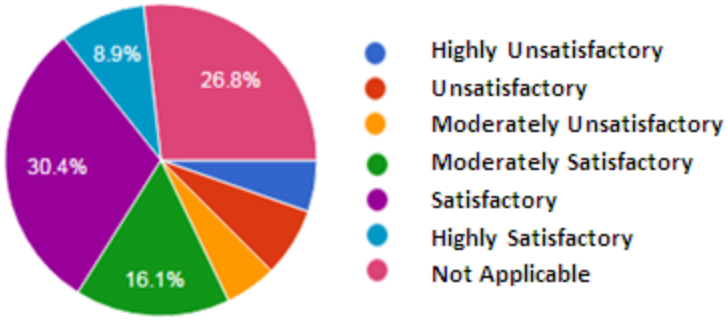
* The locus of responses hovers around not knowing exactly. Respondents who were positive of UNFPA's added value in the country context the organization (UNFPA) funds relevant existing or upcoming projects needed by IPS; its specialization in RH and population issues leading to the handling of gender issues; both technical and pecuniary assistance related to population issues; qualitative inputs into instituting activities that would be supplemented by the capacity of IPs; support given in building national capacities in statistics, data, population and censuses; focus on upstream activities is unique; public awareness activities on population issues; developing practical protocols and guidelines; and coordination activities among different institutions and ministries specifically in the field of youth and adolescents.

*Skeptics and those respondents who do not believe that UNFPA was able to provide any value-added to national stakeholders elaborated by stating that UNFPA is an ineffective organization, mostly unheard of heard of (i.e. lacks visibility), and critically assesses its performance by advocating its vertical interventions that leads to fragmentation of programming, and therefore a lack of vision and overall focus.

UNCT Coordination

Q8 : To what extent was this coordination (national stakeholders and UNCT) effective to boost the program implementation and achieve better results?

Figure 19: EQ8 answers percentages.



* The majority of respondents (30.4% as satisfactory and 8.9% as highly satisfactory) believed that the coordination performed by UNFPA and UNCT was satisfactorily effective to boost the CP implementation and achieve better results. The reasons posed by respondents contained: UNFPA was able to coordinate UNCT around a pivotal strategy for GBV, population strategy, and youth and adolescents through consultations; was able to forge coordination links between UNFPA and NPC; played a critical role in UNCT; intensifies its efforts in realizing its planned results;

* The second category of respondents in line (26.8%) were unable to judge this coordination. Others were also on the downside in UNFPA's ability to coordinate. Reasons forwarded were: attributed to lack of

coordination and coherence of the UN system in general; unsatisfactory coordination with national partners; and the inherent competition among UN agencies renders coordination inadequate.

Listening to Respondents' Voices

A. Recommendations

1) Increasing interventions related to PD
2) Emphasize youth and adolescents' health issues
3) GBV and development should be key areas of focus
4) Reproductive and sexual health domains are key
5) Full agreement with GOE on a major project with key strategic partners. Focus should be on bigger-sized initiatives, and no project to fly without a comprehensive M&E plan
6) Develop baselines to assess effectiveness and impact of policy dialogue and advocacy interventions
7) Technical staff at IPs have to be engaged in capacity building efforts as this sustains interventions
8) Increasing number and quality of highly, technically competent staff at CO
9) Offering bridge finance for gaps needed through technical and financial offering to IPs
10) More delegated authority to UNFPA field consultants
11) Supply more resources to upstream activities to turn them into comprehensive capacity building programs and flexible implementation procedures to meet the needs of beneficiaries
12) Some UNFPA projects tarnish the image of the organization in the pursuit of personal interests
13) Investing in educational and capacity building scholarships and awards abroad and in reputed institutions in Egypt. Workshops drawing on international expertise to transfer know how is needed
14) A launch workshop is needed upon start of any program while inviting all concerned stakeholders for transparency, engagement and exchange of practical views on implementation
15) More technical and financial support is required to build NPC's capacity as a strategic partner to UNFPA
16) Strengthening FP programs and continuation of GBVs work
17) PD is a key focus area to gain high scores in the upcoming cycle
18) Support for censuses and statistical surveys relating to youth, gender (GBV), RH and FP, the implementation of the national statistical strategy, and the generation of SDG data
19) The alignment between UNFPA CP and national priorities has to be clear
20) Implementation of CP should be through permanent technical departments at NPC
21) Building the capacity of researchers at NPC is required
22) Expand work on SRH, especially FP

23) While investing in an NPS, similar investments are to take place for improving population characteristics. This necessitates more efforts to build capacity
24) Developing an integrated data base for HR in NPC
25) More studies on women empowerment and adequate funding to realize results
26) Increasing technical support through the preparation of policy briefs and advocacy materials (knowledge products)
27) Capacity building of MOHP personnel on sustaining interventions and M&E
28) Creating new programs to support the implementation of NPS
29) NPC to work with RO on capacity building interventions through peered programs leading to behavioral changes and communication to avoid GBV, FGM according to WHO policy paper issued in March 2015
30) A sustained M&E mechanism for all interventions offered by UNFPA CO
31) Faster financial processing to respond to NGOs needs
32) Communications among the different institutions working on the same project for better coordination and results
33) Regular meetings with IPs and CO to get updated with developments
34) Societal awareness on GBV nationwide, while piloting on most needy governorates
35) CO PMOs are not team players and working in silos. Complementarity, innovation and self-criticism is required for improved results
36) Expanding youth and adolescent clinics including HR development, guidelines upgrading and data base development
37) Support for coordination activities, M&E for population issues, support to the establishment of population observatories, data bases and researches

B. Lessons Learnt

1) Strategies on their own are necessary but insufficient, they need to be actioned
2) Working with adolescents and youth between 12 and 25 years require expansion
3) Working with locales on health and environmental awareness should gain attention of CO in upcoming Cycle
4) Forging links with effective NGOs in local communities is beneficial
5) Setting internal controls in NGOs partnered with should be enforced
6) Fragmentation of programs in many sectors is futile and unable to realize meaningful results
7) UNFPA needs to improve project documentation and archiving system (at UNFPA and IPs)
8) Building capacity of permanent IPs staff to tackle interventions should win the day. Non-permanent staff reduces sustainability of interventions
9) Egypt is undergoing many changes. Work planning needs to be on biennial basis to accommodate for unusual conditions experienced and constant political changes
10) Budgetary allocations should reflect IPs needs (flexibility)
11) Work planning should be exercised at an ample time in advance of year start up
12) Sustainability of interventions required

13) Continuation of GBV program and tying it to national sustainable development (SDS)
14) CO Team is able to identify needs accurately
15) Capacity building is needed to strengthen youth statisticians in population census, sampling, data dissemination, participation in international workshops in health and population, and the drafting of a national statistical policy
16) An implementation team needs to be developed at NPC
17) Staff participation in activities should be from the outset to the onset
18) Projects operate in isolation of permanent departments in IPs
19) Enhance utilization of UNFPA funds through designing comprehensive interventions that are not mixed with others' moneys
20) No lessons learnt at the local level for NPC as no interventions were taking place with UNFPA during 2016
21) Early planning, time management and proper utilization of resources to avoid end of year pressures to deliver on AWP milestones
22) Coordination at the social level on wide ranging population issues
23) Developing strategic partnerships with government, than spreading thin
24) Ensure sustainability of interventions
25) Continue diversifying OR resources
26) Focus on humanitarian component
27) Increase UNFPA visibility
28) Clearer definition of roles with other UN organizations thematic areas
29) Studying political and economic conditions (context) prior to the embarking of CPs and studying the absorptive capacity for proposed interventions
30) Increasing awareness relating to healthy life styles, and develop a d-base for emerging problems relating to youth and adolescents to inform on strategic orientation
31) Selectivity in consultants recruited for work in the civil sector

ANNEX 18: EVALUATION MATRIX[275]

RELEVANCE			
Evaluation Question (EQ) 1: **To what extent are the interventions of UNFPA Egypt CP 2013-2017 (1) relevant to the needs of the intended beneficiaries (women and young people)[276]; (2) in line with the government priorities; and (3) aligned with UNFPA policies and strategies? (4) to what extent has the CO been able to respond to changes in national needs and shifts caused by major political changes?**			
Assumptions to be assessed	**Indicators**	**Sources of information**	**Methods and tools for data Collection**
1.The interventions were designed based on baseline studies, situational analysis that identified the needs for these specific interventions; and the geographical locations are either those most in need, or those where similar UNFPA interventions have taken place, and therefore enhance the results. 2.GOE development plans have outlined these population needs, and the interventions support the stated plans. 3.The interventions are aligned with the UNFPA strategic plan and the organizational mandate. 4. The UNFPA is responsive to changes at the national level	1. A participatory approach involving all relevant stakeholders is documented in the design of the CPAP 2. Evidence of alignment with national policies 3.Outputs in the CPAP relate to Outcomes in the UNFPA Strategic Plan 4.Changes in programme design or interventions reflect needs of national stakeholders	-UNFPA Strategic Plan -UNDAF for Egypt (2013-2017) -CPAP 2013-2017 -GOE strategic Development Plans (Ministry of International Cooperation (/MDGs/SDGs); Ministry of Planning Development Plans, 2030 Agenda) -Baseline, mapping, context reports/ studies on RH, GBV, PD	-Document review -Interviews with UNFPA CO Programme Officers & RO -Interview with legislative body -Interviews with Key GOE officials (MOIC; MOH; NPC; CAPMAS; NCW; etc.) -Online survey

[275] EQ3a-f was merged into EQ3; and EQs 5,6, 7 & 8 were merged into EQ5. Same findings hold.
[276]Relevant to the needs of intended beneficiaries as reflected by policy makers

To what extent are the interventions of UNFPA Egypt CP 2013-2017:
(1) relevant to the needs of the intended beneficiaries (women and young people);

*Online Survey:
*Indeed, 51.8% of respondents thought UNFPA 9th Cycle CP interventions are relevant, and 16.1% as highly satisfactory to the intended need of beneficiaries. Many respondents provided their relevant evidence of the relevance of the CO CP agenda to national priorities, such as: matches with NPS 2015-2030; a spot on Safe Cities target group; GBV, FP including contractive security; NCW in GBV; youth and gender programs needed; national reach; funding census and surveys relating to sustainable development, gender and youth; with NPC, a focus on NPS and its operational plan, advocacy activities and two media campaigns focusing on FP, added to capacity building activities to technical staff; meeting needs on RH, labor market skills, and Syrian refugees (SGBV).

(2) in line with the government priorities;

*Online Survey:
* The majority of respondents (44.6%) believe that UNFPA's CP move satisfactory in line with government priorities, 21.4% as highly satisfactory, and 17.9% as moderately satisfactory.
*In many respects UNFPA CP is aligned with government priorities, especially with respect to the population issue that had its NPS launched in 2014, several Presidential announcements addressing it, the support given to CAPMAS relating to tracking SDG indicator and census is aligned to GOE's Vision 2030, in alignment with the Presidential youth forum, UNFPA outputs are linked to GOE strategic plans, aligns with needs and policies of the Ministries of Health and Justice, young people especially in the aftermath of two revolutions, projects related to FGM and GBV are aligned with government priorities (despite fluctuating interest), SGBV, and to NPC NPS especially in pillars relating to gender and youth. Problematic areas mentioned touched on interventions impacts given the small amount of moneys invested by UNFPA CO which require demonstrating tangible results, and the great need to implementation mechanisms for population programs and M&E that is impaired and inadequate. Some respondents acknowledged the quick responsiveness of CO to government requests, for example, Implanon, RH products, in addition to strengthening MH surveillance.

(3) aligned with UNFPA policies and strategies?

*Online Survey:
* Most respondents (42.9%) think 9th Cycle CP aligned with UNFPA policies and strategies, 25% highly satisfactory, and 10.7% as moderately satisfactory, while 14.3% do not know. Many respondents affirmed the alignment of UNFPA policies and strategies with GOE strategies, yet some wished to clarify that implementation realities may be different as the focus on strategic levels may or may not cascade to the grass root level. In addition, the CP is aligned to the 17 principles of its establishments and due to austerity measures on core fund limitation, the CO was able to elicit the interest of donors to raise a growing OR portfolio (and new donors such as the EU); having said that, some respondents from CAPMAS forwarded that UNFPA policies and strategies are at times limiting to meeting the needs of the newly-established, high-impacting SDG unit at the national statistical arm. Another respondent from NPC thought advocacy interventions are necessary but insufficient to CO's investments into the NPS. Moreover, a different response confirmed that UNFPA's strategic interest with early marriage, FGM, FP, adolescent health initiative in Egypt in collaboration with the school age department of MOHP, and the NPS match strategically with its strategies and that of GOE's.

(4) to what extent has the CO been able to respond to changes in national needs and shifts caused by major political changes?

*Online Survey:

* the majority of respondents (28.6%) chose moderately satisfactory, 23.2% satisfactory, 19.6% do not know, 12.5% highly satisfactory, and 6.1% highly unsatisfactory. With this spectrum respondents' remarks came as follows: mixed responses were received: the majority thought CO was able to respond to changes in political situation and was responsive. It was acknowledged that during the Moslem Brothers (MBs) era, there was little to be done by the CO, however the response to violence against women during the revolutions is marked, supporting the preparation and launch of the NPS, gender empowerment, and sustainable development goals are key. In other responses, reservations evolved, e.g. YFCs in 3 governorates were to be up-scaled yet funding was stopped against plans, and others noted that AWP seem like a taboo to CO against opportunities for better performance and results alignment.

YRH

Annual planning was done in collaboration with Ministry of health team according to the national strategic priorities. The Ministry of health reported joint planning in agreement with the UNFPA and confirmed the relevance of UNFPA programmes at government level277. UNFPA was fully engaged in the development of the strategic plan for family planning with the ministry of health, the Ministry acknowledges UNFPA's role and ensures their involvement in the next strategic plan as well. There was no participation for end beneficiaries, trainers or team of the directorates in Assiut and Sohag.

No national strategy for young people, ministry of youth policy includes three pillars; political, social and economic empowerment for youth. UNFPA youth component was partially aligned mainly with the UNFPA global strategic views for young people.

There was lack of alignment with the global UNFPA strategic plan for 2014-2017. Egypt CO is entitled for advocacy and knowledge management according to the mode of engagement of UNFPA strategic plan. In the current CPAP; the main budget spent under the reproductive health were assigned to services delivery278.

The responsiveness of the reproductive health programmes was positively perceived among the different key informants. Ministry of health witnessed high turnover among senior management for different directorate279. Accordingly, this change in management exposed the agreed planning to amendments; to which UNFPA was able to adopt in highly responsive way

GE

RC Situation analysis in 2010, multiple stakeholder participation. Identified gaps in data,

The Social Research Centre (SRC) at the American University in Cairo (AUC) published a report in 2008 linking domestic violence to certain women's empowerment indicators. The study was a pilot, and findings indicated that women of all social backgrounds were vulnerable to GBV.280 Since 2011, the discourse on violence against women has changed dramatically to focus on issues of sexual harassment and violence in the public sphere, and a number of organisations became active and vocal on the front of SGBV. In June 2014, a law was passed that for the first time specifically defined sexual harassment and related legal consequences. That same year, the Egypt Universal Periodic Review (UPR) 2014 report garnered 171 recommendations for action to be taken by Government of Egypt (GOE), and 25 of those recommendations pertained to the area of women's rights in particular, including combatting aspects of violence and training for police and judiciary.281 In 2015, the Egypt Demographic Health Survey stated three in ten ever-married women age 15-49 years in Egypt have ever experienced some form of spousal violence with 25 percent saying they were subjected to physical violence. And, around 9 in 10 women age 15-49 have undergone female genital mutilation.282

CPAP Gender Outputs:

Output 3: Enhanced institutional mechanisms to protect and respond to gender-based violence against women and girls

[277]Interviews with key informants of Ministry of Health

[278]UNFPA changed their original plans and bought contraceptive commodities to MoH per request of MoH.
[279]IDIs with key informants in MoH.
[280] El Sheneity, Sahar and Mulki Al- Sharmani. Combatting Violence against Egyptian Women: Empowerment and Domestic Violence. Social Research Centre, AUC, 2008. Cairo. http://dar.aucegypt.edu/handle/10526/2931. Accessed November 2016.
[281] Universal Periodic Review. UPR Info. Egypt Recommendations. http://www.upr-info.org/database/index.php?limit=0&f_SUR=52&f_SMR=All&order=&orderDir=ASC&orderP=true&f_Issue=All&searchReco=&resultMax=300&response=&action_type=&session=&SuRRgrp=&SuROrg=&SMRRgrp=&SMROrg=&pledges=RecoOnly. Accessed December 2016.
[282] Ministry of Health and Population [Egypt], El-Zanaty and Associates [Egypt], and ICF International. 2015. Egypt Health Issues Survey 2015. Cairo, Egypt and Rockville, Maryland, USA: Ministry of Health and Population and ICF International. https://dhsprogram.com/pubs/pdf/FR313/FR313.pdf. Accessed December 2017.

which is linked directly to UNDAF Outcome 3.2 (as shown in figure 5—intervention logic) and, is directly implemented through the AWPs: NCW (PGEG09); Al Azhar (PGEG08); BLESS (PN5890); NGOs Coalition (PN6186); National Population Council (PGEG02); and UNFPA execution Sexual Harassment Unit at Ain Shams and Assiut University.

And to a lesser extent;

Output 2: Improved capacity of the national health system to provide quality material services to women of reproductive age

linked with UNDAF outcome 2.2, which is cross-cutting with the UNDAF outcome and CPAP output above, and implemented by AWPs RCT with MoH (PN6174) and Curative care (PGEG15).

Related to SP outcome 3; Advanced Gender equality, women's girls' empowerment, and reproductive rights, including for most vulnerable and marginalized women, adolescents and youth.

Relevance of SGBV programme is high, indirect relevance of M&E of NCW strategy, sexual harassment units, indirect.

PD

The 9th Cycle CP 2013-17 came after two revolutions, a regime that was against the principles of PD, growing population, declining economic growth and political instability. This Cycle is considered an outlier, and hence is surrounded by expanded social, economic and political challenges. CP 2013-17, together with its different components including PD, was formulated on a set of key documents; namely, CPD 2013; CPAP 2013; UNDAF 2013-17 based a Situation Analysis (2010)283; MDG Progress Reports (2016); Vision 2030: Sustainable Development Strategy—SDS (2014); and SP (2014).

Population issues and dynamics are multi-dimensional (i.e. population increase, population distribution, and population characteristics), which are the crux of the PD component which focuses on the provision of an enabling environment. They continued to be one of the major challenges facing development efforts in Egypt. In 2010, population growth rate stood at around 2% with more than 90% of the population living on less than 10% of the land, putting excessive pressures on natural resources, as well as education, health services and employment opportunities. Former President Mubarak launched a NPS in 2008 and established a Ministry of State for Family and Population in March 2009. During the period 2008-2010, the most important achievement of NPC was activating the National Strategic Population Plan (NSPP) for the period up to 2012.284 Nationally MDG progress reports showed: Egypt was not able to eradicate poverty and hunger especially in Upper Egypt and urban areas' pockets (MDG 1); challenged by high girl school dropout rates, early marriage, and low economic and political representation (MDG 3); Improved maternal health was not achieved due to regional disparities and inefficient health care and FP services (MDG 5); same for MDG 6,285 7,286 and 8.287288 Related to population dynamics, Vision 2030 contained 4 pillars of importance handling the health,289 education sectors, social justice, transparency and efficiency of government institutions.290 The third UNDAF strategic framework report was built on the results of the CAA, UNFPA CO 9th Cycle CP (2013-17) was tied to 4 key strategic outcomes; namely outcomes 1.1; 2.2; 3.2; and 3.4.291 PD came at the forefront to: "support the elaboration and dissemination of evidence-based information and data on vulnerable populations, specifically young people and rural women, for programming and policy making purposes,"292 which ties with all previously mentioned documents. In addition, CPD (2013) same deteriorating national poverty trends, contraceptive prevalence, maternal health, FGM/GBV. CPD excerpted lessons learned from CPE 2009,293 leading to the design of the 9th Cycle CP. Aspects of relevance was the emphasis placed on systems enhancement, advocacy and evidence-based policy dialogue at the central level, while capacity development and community-based interventions will focus on needy governorates targeting: Assiut and Sohag. The mentioned national development priorities in CPD were summarized as: (a) poverty alleviation through pro-poor growth and equity; (b) quality basic services; and (c) democratic governance through decentralization, civic engagement and human rights; and the population dynamics challenge was reflected under the MH component, Output 2.294 Furthermore, the CPAP 2013-17 signed between MOP&IC and UNFPA CO elaborated government needs based on lessons learned: 1) to develop a

[283]Also known as the Common Country Assessment (CCA).
[284]Handoussa, Heba (2010). Situation Analysis (SA/CCA): Key Development Challenges Facing Egypt.
[285] Combat HIV/AIDS, malaria and other major diseases.
[286] Environment sustainability.
[287]global partnership for development and aid effectiveness.
[288] MOIC. SDGs: Egypt National Review Report for the Input to the 2016 High-Level Political Forum (HLPF) for Sustainable Development, pp. 49-51.
[289] The vision for the health sector stated: ‘‘All Egyptians enjoy a healthy, safe, and secure life through an integrated, accessible, high quality, and universal health care system capable of improving health conditions through early intervention, and preventive coverage. Ensuring protection for the vulnerable, and achieving satisfaction of citizens and health care employees. This will lead to prosperity, welfare, happiness, as well as social and economic development, which will qualify Egypt to become a leader in the field of healthcare services and research in the Arab world and Africa. The 8 programs involved are: adopting inclusive healthcare coverage; improving the quality of health care service provision; enhancing preventive and health care programs; improving health sector governance; decentralize health services provision; developing information and technological infrastructure to support health care systems; developing human resource management in the health sector; and developing the pharmaceutical sector.
[290]MOP/MOP,M, & AR. Vision 2015-2030: SDS, 2014.
[291]See Effects Diagram for details of UNDAF-CP (2013-17) outcomes.
[292]UNDAF (2013-17)L Achieving MDGs+ with Inclusive Growth, Freedom, Social Justice and Dignity.
[293]UNFPA CO CPE 2009.
[294]Improved capacity of the national health system to provide quality maternal health services to women of reproductive age.

population data base and a yearly population report; 2) production of a number of operations research and studies to promote evidence-based interventions and to assist policy making; 3) a need for improved M&E interventions to better analyse development progress; and 4) baseline surveys to capture interventions. PD was reflected in CPAP to match government needs as sub-output 2.4.[295] SP 2014 came with improvements to the positioning of PD reflecting government needs, by reflecting the reduced focus programme area under the CP to a supreme enabler encompassing all components resulting in its linkage to SP O/P 15 and SP O/P 12, namely to strengthen national capacity using data and evidence to M&E national policies and programmes in the areas of PD, YRH, HIV, GE, including in humanitarian settings; and strengthening national capacity for the production and dissemination of quality disaggregated data on PD that allows mapping demographic disparities and socioeconomic inequities, and for programming in humanitarian settings.[296] It is standard practice that all documents above are heavily consulted either by the public, concerned government signatory authorities, UNFPA CO, MOFA, MOIC/MOP, IPs, and beneficiaries.[297] Having said that and upon the strategic directives of HQ, PD was re-linked and expanded to the new strategic objectives with CPD or CPAP to align within the 2-year alignment period. PD AWPs, ARs 2014, 2015, and 2016 align UNFPA SP Outcome 4 and SP Outputs (12 & 15), lesser so or, better said, looser to CPAP Output 2.4 (with zero baseline for an M&E system) and to the UNDAF one-size-fits-all outcome 1.1. No evidence of consultation or CPD/CPAP amendments between CO and GOE post SP 2014 was found. Also, original activities such as very limited number of knowledge products, NPS, building M&E systems, and a procrastinated intervention for and limited support to the population census and advocating SDGs indicators development and reporting. Despite its added strength under the new business modality, PD is, in as much as other components in the CP, disintegrated and fragmented from being a part of an all-encompassing Country Programme. A lack of a holistic approach to the development of the CP under the new business model resulted in reduced impacting of PD interventions down from 24% of CP 2007-11 total programme funding to around 6.2% currently). Irrespective of their strategic positioning and high-national impact over population issues in Egypt, none of the IPs under this component has undergone a rigorous organizational assessment to identify capacity gaps and needs.[298] In addition, IPs are unaware of the new strategic orientation of UNFPA. They have amended AWPs based on partnered collaboration, however IPs hardly knew of the re-orientation of SP 2014 which may imply some missed opportunities on both sides, e.g. additional investments in policy dialogue, building partnerships, capacity building etc. Moreover, PD may have had the opportunity to help generate quality statistics or population support through the NPS to Syrian refugees,[299] which did not happen to date.

Findings:

1-UNFPA CO CP 2013 is highly relevant to the needs of intended beneficiaries (women and young people); in line with government priorities; aligned with UNFPA policies and strategies; and was able to respond to identified national population dynamics gaps, needs, and major political shifts.

2-Despite of this, a classical approach parallel-tracked system approach was adopted in CP programming. Strategic changes at UNFPA central level has cascaded to CO, yet not to engage GOE in CPD/CPAP amendments.

3-PD aligns with CPAP output 2.4; SP O/C 4; SP O/Ps 12 & 15; UNDAF O/C 1.1.

4-The PD response according to the new mode of engagement relates to policy advocacy/dialogue and the generation of knowledge products.

5-The PD component and interventions did not respond to the humanitarian crisis of Syrians, yet responded to needs at the central level mainly through M&E and data needs.

[295]% of facilities with monitoring system that supports service delivery.

[296]See Effects Diagram; NPC AWPs 2015 & 2016; and CAPMAS AWP 2016.

[297]CPAP 2013-17, pp.13-14; NPC AWPs 2014, 2015, 2016; and CAPMAS AWP 2016; key informant interviews at NPC and CAPMAS.

[298]UNFPA CO key informant interview.

Efficiency			
Evaluation Question (EQ) 2: **To what extent has UNFPA made good use of its human, financial and technical resources in pursuing the achievement of the results defined in the country program?**			
Assumptions to be Assessed	**Indicators**	**Sources of information**	**Methods and tools for data Collection**
1.Financial resources have been suitably allocated and disbursed to relevant components, in ratio with expected interventions. 2. The necessary technical and human resources exist in the CO that enable implementation of the SP and CPAP. 3.The M&E of the CPAP interventions is on time, and feedback and lessons learned are clearly integrated in annual program reviews.	1.Financial resources are available, in a timely manner, for interventions. 2. Organizational structure and capacity building programmes for CO staff match expected technical skills. 3. Monitoring and evaluation is results based, and reflects appropriate challenges and amendments. 4. M&E is periodic and uniform across all program components.	-UNFPA CO organogram, Annual plans and reports, M&E matrix -Quarterly and annual progress reports from IPs.	-Document Review -Interviews with UNFPA CO & RO Programme Officers and management. -Interviews with IP focal points, project managers -Online survey
*Online Survey: * Overall, the majority of respondents (30.4%) were satisfied, followed by 23.2% who do not know, and 19.6% who thought UNFPA was moderately satisfactory making good use of its human, financial and technical resources in achieving the results of its 9th Cycle CP. To illustrate further, while many respondents were unable inform they do not have access to knowledge on this subject through UNFPA, others offer a mixed vision about the technical competence of CO in taking such decisions as to hire external consultants to implement interventions that may lack shared/owned goals by implementing partners. Others see its special relations with NPC as successful due to partnered initiatives to serve social needs, such as FGM. A respondent from an international organization believes that CO should allocate larger			

[299]"… population dynamics—is an important area of work for UNFPA. The support provided to the preparation and analysis of censuses and other population-based surveys is a critical means of ensuring that women, adolescents, and youth are at the centre of sustainable development policies, and that programmes have the evidence needed to improve SRH services. Helping national stakeholders understand and plan for the implications of emerging population issues such as migration, urbanization and ageing for the SRH needs of women, adolescents and youth is a key area for UNFPA" (SP 2014, p. 6).

funding allocations for bigger programs especially for youth to demonstrate success related to government. Special acknowledgments were given to the financial management of the CP components. Furthermore, a respondent thought CO's performance efficiency differed along the years, while noting the current national turbulent circumstances at the behest of two revolutions, the CO remained static, understaffed and enforced its rigid plans that lost sharing an overarching vision with IPs. On the other hand, an opportunity taken by CO came in the form of responsiveness to meet Syrian refugee needs especially in relation to SGBV.

2a) Human

*Online Survey:

* Although most responses (28.6%) did not know, equally 28.6% thought CO human capacity as satisfactory, and 12.5% as highly satisfactory. The majority of comments affirmed the inconsistency of the technical and human quality of UNFPA CO staff.

2b) Financial

*Online Survey:

* The financial competence of the CO is by far one of the satisfactory (37.5%) resources available, and 8.9% of respondents consider it highly satisfactory. And, 28.6% do not seem to be able to respond to this question. The majority of respondents were quite satisfied with the competence of CO in managing its financial resources and found it rather effective in achieving results; some respondents thought the system may be improved if IPs new funding allocations for the entire program cycle than on year-by-year basis for effective planning and implementation; other commented on the possible adversity which may occur in the financial cycle dependent on approving PMOs. A respondent sees that the flexibility in earmarking resources to support UNFPA's humanitarian component was outstanding (SGBV).

2c) Technical

*Online Survey:

* The majority of responses thought UNFPA CO technical competence as satisfactory (39.3%), 26.8% did not know, and 7.1% thought it unsatisfactory which is equally as highly unsatisfactory (7.1%).
* Many responses remarked that the technical competence of CO staff is idiosyncratic, and recourse to external consultants is quite common due to this limitation which necessitates investing in IPs more.

YRH

Although the CPAP is a five years' plan with the different implementing partners, the financial and technical systems, require quarter reporting from the different implementing partners and an annual work plan. Different implementing partners showed dissatisfaction about the current system. They complained that current system's requirements, delayed implementation for almost four months of each year. It also creates annual gaps between the different work plans.

Youth and reproductive health programmes represent about 75% of the total budget of CPAP300. This budget is managed technically by two staff at the level of NOA and NOB301. The organogram of the country office does not have monitoring and evaluation function. The function is distributed between the assistant representative and a programme associate in the office.

[300]Financial analysis provided by UNFPA CO.
[301] UNFPA Organogram 2015 and 2016

There was noticed different indicators in the AWPs which are not result based. None of the staff except the M&E focal point had training on results based management.

GE

Quarterly finances are late, and end of year wrap up leaves IPs without funds as late as march of following year. Some AWPs are not signed until May of the operational year, leaving only 7 months for implementation.

Technical support always through consultants, not the CO.

No uniform reporting on interventions. Some IPs have not submitted any progress plans to date. Those who have, it is indifferent formats. Some are Excel sheets, some are narrative. And within those reports, the reporting is not against indicators in the AWPs. IPs have stated that there is no feedback on reports, or comments. More importantly, they do not feel that any of the challenges, information, is used in AWPs or planning for upcoming year.

Review of reports shows they are process and activity based, not results based.

PD

1-Delays experienced in AWPs preparation and signatures combined with progress delays on the side of IPs and wasted funds, leading to numerous AWP amendments

2-Financial documents and filing are kept on record efficiently at IPs, while other project documents and complete training materials do not follow suit, especially complete and traceable beneficiaries/trainees' data base. There is no clear evidence on expenditure efficiency through matched inputs and outputs as training lists of beneficiaries are conflicting and such trainees are untraceable.

3-Technical assistance through external consultants moaned by IPs. Sporadic training confused for capacity building, which is defiant to SP2014 yellow grid

4-CO staff gets insufficiently funded specialist training opportunities. Training available is mainly on leadership and soft skills online training, added few others. No training budget in light of austerity measures may affect the technical edge of staff vis-à-vis other organizations. Hence, under-utilized human capacities

5-CO is reactive to IPs requested activities bidding for more focus on behavioral changes/outcome and impact level results to enmesh with CPAP and SP more effectively

5-OR has been supportive of much of the PD component activities over the 9th Cycle (especially 2015 onwards).

Effectiveness

Evaluation Question (EQ) 3:
To what extent has the UNFPA support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into the national systems and positioned on the national agenda?
(overall assumptions and indicators to keep in mind while assessing this question)

Assumptions to be Assessed	Indicators	Sources of information	Methods and tools for data Collection
1.The programs in the CP are relevant and timely to the national development agenda, and therefore the political will exists to integrate the CPAP outputs into national systems	1.Relevant Policy, laws, mechanisms are instituted at the relevant national institutions. 2. Policy dialogue is active on the related RH, PD, GBV topics.	-Baselines, national plans, documentation highlighting relevant needs. -Institutional mandates of partners.	-Document Review -Interviews with Key GOE officials -Interviews with UNFPA CO & RO POs -Online survey

	3. The partner institutions selected for partnership with UNFPA undergo capacity assessment and have the mandate to support the integration of issues in national systems and on the national agenda.		

Online Survey:

* A sweeping 37.5% of responses affirmed that UNFPA CP support in the different focus areas managed to appropriately integrate the respective domains of operation into national systems and are positioned on the national agenda. In addition, 19.6% of respondents see such efforts by CO as highly satisfactory. Only 10.7% did not know or thought it inapplicable.
* The evidence for positive selection revolved around the following: UNFPA is considered a partner in all population policy aspects, same for RH, MH, FGM, GBV and PD. Further evidence came in the form of criminalization of FGC and addressing harassment in criminal law. Despite of acknowledgment of the launch of the NPS and the offering of UNFPA TA to this national agenda item, respondents stated that results on the population challenge remain mediocre and CO is unable to understand that strategies are not stand-along exercises, as they require tools, systems and heavy human capacity building to sustain. Indeed, CO was highly commended for the GBV costing study.

YRH

Reproductive health component activities were institutionalization of different mechanism within ministry of health. Youth component have only youth friendly clinics which was institutionalized in the ministry of health.

There was continuous dialogue with policy makers but it was not evident it led to specific results. Also, there was structural challenges in the government hinder such efforts. Youth component did not have policy dialogue.

The capacity assessment was done partially for the different partners. The lack of full assessment according to UNFPA guidelines led to putting all the partners as high risk partners and conduct annual audit on their spending.

Evaluation Question (EQ) 3:

To what extent has the UNFPA support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into the national systems and positioned on the national agenda?

(a) To what extent has the CP contributed to improving the capacity of the national health system to provide high-quality maternal health services to women of reproductive age?

Assumptions to be Assessed	Indicators	Sources of information	Methods and tools for data collection
1. The capacity of MoHP allows for the integration of the outputs of the capacity building programs (i.e. capacity building is targeting the correct beneficiaries, the content is relevant, the content is acceptable and	1. Reported improvement in the quality of MRH services by service providers and beneficiaries.	-Baseline or needs assessment of existing capacity prior to interventions -MoHP development agenda or goals (that includes targeted RH and GBV interventions) -Beneficiaries of RH services	-Document review -Interviews with CO RH program Manager -Key person interviews at MoHP -Interviews with capacity trainers -focus group with trainees

readily applied at the institutional level-central and/or decentral) 2. There is monitoring of quality of capacity building and integration of skills achieved into service delivery	2. Capacity building programs are targeted through systematic and comprehensive coverage.	-Population strategy and executive plan	-Focus groups/survey with beneficiaries (if possible) -Online survey

*Online Survey:

*A majority of 39% were unable to depict whether the UNFPA CP managed to improve the capacity of the national health system to provide high-quality maternal health services to women at reproductive age, while 23.2% sees this as moderately satisfactory, and 17.9% as satisfactory.

*Respondents informed that improvements in the capacity of the national health system in this regard is handled by the MCH department of the MOHP, where there is underground work to develop standard procedures for GBV victims, midwifery training is delivered. The capacities built bear fruition through the last DHS 2014, whereby indicators of mother and child have improved, reduction in post-natal maternal and child mortality.

*A further contribution that adds immensely to the build-up of national capacity relating to maternal health is contained in the development and launch of the national population strategy and observatory addressing population issues over the past 2 years. UNFPA funding of the NPS is a valuable undertaking towards this end.

YRH

Family planning is success story in terms of service improvement while maternal health component was not optimal in terms of effectiveness according to midwifery assessment and different interviews.

Lack of knowledge management affected the ability to conduct comprehensive and lack of on-going monitoring delayed the corrective actions. Capacity building was for the cadres of MoH but not for the peripheral directorate management

GE

UNFPA played a critical role in the coordination and funding of the Supreme Consultative Committee which was key in the development of the Protocol,[302] directly meeting its target for output 3.2 in the CPAP results framework in ensuring the development of the Protocol.[303]

In particular, the Head of the Forensic Medicine Sector at Ministry of Interior, received accolades for his training on evidence gathering and use, and overall professional and personnel support to the program.[304]

The training program very relevant, no such services exist. It initially targeted Greater Cairo, Assiut and Sohag as pilot governorates, in AWP. Was planned as systematic and in phases that included a GBV needs assessment, TOT of service providers in the Reproductive Health (RH) and Family Planning (FP) Divisions to ensure a critical mass of capacity, and training for CSOs on a GBV referral system.[305] In practice, there was a national upscaling of the training, which was not well planned, and has weakened the effectiveness of the training. There is no documented evidence as to why this upscaling occurred, or why there was a switch from RH and FP to the Curative Sector as focal partner at MOH. There was no assessment of hospital capacities conducted prior to training, or even a rapid assessment of the number of SGBV cases at these hospitals to reflect priority in need or catchment areas. Up to the third quarter of 2016, 1024 trainees in 313 public hospitals had been targeted.[306] However, nurses and doctors were not necessarily selected from the same hospitals to provide support and complementarity in service provision, nor was there awareness raising for hospital administrators. Furthermore, since the trainings were held separately for doctors and nurses, they are not aware who was selected from their respective hospitals. In addition, only a small number of personnel was selected from each hospital (1-4 maximum), leading to gaps in service providers when these personnel are no longer affiliated to these respective hospitals. For a follow-up forensic workshop in Cairo and Sharkeya, approximately 40% of those who had received the initial training in the previous year, were unable to attend the follow-up session due to job position rotations, promotions, retirement and general absence from the public health service system, and did not have a replacement to send. 307 Nor is the nature of the pre-post test administered by RCT conducive to assessing capacity building.[308]. Interviewees have questioned whether Curative Care is the correct sector for the program affiliation. Suggestions were made to move it to the Reproductive Health or Family Planning Divisions where the history of UNFPA collaboration is institutionalized, and where training and advocacy can build on a decade of previous experiences for more effectiveness.[309] No data base copy at MOH, only at RCT, and only one focal point at MOH for entire program.

Evaluation Question (EQ) 3:
To what extent has the UNFPA support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into the national systems and positioned on the national agenda?
(b) To what extent has the CP contributed to the strengthening of local capacities for community-based interventions in reproductive health to empower men and young people?

Assumptions to be	Indicators	Sources of information	Methods and tools for data

[302] The committee was established and included various actors including the Ministries of Interior, Justice, Health, as well as relevant national institutions and UN agencies.
[303] UNFPA. Country program Action Plan between Government of Egypt and UNFPA: 1 July 2013-31 December 2017. CPAP Results and Resources Framework, Outcome #3, output indicator 3.2.
[304] Key person interviews with doctors and nurses with training recipients from Cairo, Giza, Domiat, Menofiya, Assiut;
Interview, MOH Directorate, Assiut Wednesday December 28, 2016; Interview, Curative Care MOH Central, Thursday, 22 December 2016.
[305] AWP RCT, 2014,2015,2016.
[306] As stated in quarterly reporting and documentation by RCT.
[307] Interviews, RCT, Wednesday, 21 December 2016; Interview, Curative Care MOH Central, Thursday, 22 December 2016. Review of list of attendees for follow-up workshop. The IPs and other trainees also stated that the selection criteria for the trainees was not effective and included interns and personnel close to retirement, i.e. those most likely to not be around for long-term.
[308] Reviews of paperwork show had written scores for 30 questions for each participant. There are no indicative scores of acceptable increases in knowledge, or any parameters to evaluate knowledge enhancement. Further, documents are not collated or any further steps designed based on results or feedback.
[309] Interviews, MOH Directorate, Assiut, Wednesday December 28, 2016; Key person interviews with doctors and nurses.

Assessed			**collection**
1.Local networks exist that can be capacitated 2. The geographical selection of CSO was based on a needs assessment 3.There is a baseline of both the number of community based organizations targeted, and an assessment of their technical capacities and achievements pre-intervention.	1.Local capacities strengthened in targeted areas, against pre-intervention assessment 2.Coordination committees formulated with trained members at local level composed of relevant parties 3.Signed protocols (central-local levels)	-Needs assessments for CSOs -Targeted CSOs -Young people involved in interventions -Government committees at local level	-Document reviews - Key person interviews with government staff (local/central), CSO staff and project focal points -Focus group discussions with young people targeted in interventions -Online survey

*Online Survey:

*The majority of respondents (39.3%) do not seem to know, 17.9% thought it satisfactory, 23.2% as moderately satisfactory. The varied results reflected different opinions and trajectories, e.g. many respondents saw the interest of CO in implementing local-level capacity building interventions at the community level favoring a tilt to investments on the national level. Developing indicators may be necessary, however building capacities is more sufficient to sustaining an in-built, embedded M&E system. Capacity building efforts at the local level in the area of RH did not realize tangible results, and such interventions is regarded by some as a mere portrayal of an untrue democratic image. A clear statement came from a respondent read as: "UNFPA was always reluctant to support community based initiatives and said they were not one of their priority areas." On the other hand, a different respondent proposed to make use of success stories implemented by capacitated leaders in government and community leaders in household empowerment and FGM and outreaching villages, building local capacities and creating community awareness of population challenges etc.

YRH

For Youth component, the reported numbers of trained/counselled youth was large according to annual progress reports but there was lack of evidence of the ability of the different training to improve the knowledge of the young people or to assess capacity building310. There was no systematic needs assessment done different youth interventions like Y-Peer, IFMSA and youth friendly clinics. Social activities of M3loma initiative was highly recognized by different partners and analysis of the utilization and the growth of the viewers (1.5 million like for the Facebook page only) strongly indicate the ability of the programme to attract young people311. The capacity of small NGOs was also built through the two main IPs in CPAP. Youth component is perceived to be successful in empowering young people. The quality of target identification was a challenge for Y-Peer and youth friendly clinics. There were no local committees developed and there was one protocol with school health department in the MoH.

GE

No evidence of pre-assessment for selected CSOs, or mapping. No evidence of why geographical locations were selected.

No Capacity building at Al Azhar (reported by FGM Coordinator, no reports form this project), BLESS, over 6,000 (quarterly reports) religious leaders from Coptic, Catholic and Evangelical churches are receiving capacity building. PowerPoint material focus is on FGM, quite clinical in nature. RLs are gathered in each parish, and given a 4 hour seminar on FGM. The RLs then give this information to Khodam in their church to disseminate through community services (home visits, youth groups, prayer groups). Religious leaders who had attended awareness sessions in 2015 could not recall the specific content, and had not had any other follow-up sessions since; and admit that in their dissemination, there is more focus on sexual harassment in the public arena. Messages pertaining to FGM and gender violence are discussed more in pre-marital and marriage counselling sessions. No reported structured messages to deliver, no uniform material. Accepted Recommendation in CPE 2007-2011 for such material but there is no evidence it has been implemented. A review of the Manual by Al Azhar shows a comprehensive manual. It is critical that the messages are resulting from the manual are well crafted, and that training for Muslim RL ensures unity in the messages and methods of delivery.

SH Units, legal framework and operational protocol within universities. The capacities of the Sexual Harassment Units were strengthened by the support of the UNFPA in situating the Units within the respective University frameworks, giving credence and visibility to the Units; and in the provision of initial technical support to establish protocols of procedures, awareness raising, and suitable messaging. Since the beginning of the 2016-2017 academic year, each Unit has logged 5 complaints, with one of the complaints at Assiut coming from a male student, and one complaint following formal grievance procedures At Assiut University there is funding for continued technical support for the first year, and the Unit is further strengthened by the fact that it is situated within the university Human Rights Centre, which is already established, with full time staff, and commitment of Faculty members on its committee. Ain Shams Unit has part-time staff, and is dependent on

student volunteers for implementation. Changes in the grant mechanism regulations changed during the establishment of the unit and there was no financial or technical support provided past the initial start-up, preventing effective capacity building.

Capacities of the NGOs working on the FGM in Upper Egypt on the school based model have been strengthened through technical activities and networking. The support provided allows the NGOs to conduct home visits, and have a visible presence in the communities, allowing parents to also reach out to them for more information. Since 2015, through the school based model, 48 schools have been targeted in Assiut, Sohag, Quena, Minya and Luxor. The success of the community work is built on sustained relationships with the NGOs through NPC, and the physical presence of the Field Coordinator in Upper Egypt, allowing for quick response time and constant contact. There are no formal evaluations conducted at the community level, impact of the activities implemented are measured by the outputs of activities, such as messages and productions by students that reflect an understanding; and home visit discussions. Not all parents who refer back to the NGO may be fully convinced of abandoning FGM, they are at a minimum accepting dialogue on the subject.

Evaluation Question (EQ) 3:
To what extent has the UNFPA support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into the national systems and positioned on the national agenda?
(c) To what extent has the CP contributed to enhancing institutional mechanisms to protect against and respond to gender-based violence against women and girls? (in particular by helping build the national capacity to implement laws and policies that curtail harmful practices i.e FGM/C)?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
1. Combatting GBV is on the political agenda 2. Relevant institutions that can implement mechanisms to protect against GBV are partners in interventions 3. The mechanisms developed or augmented under the interventions are relevant to the institutions, and can be activated with the given capacitates 3.There is a basic monitoring system of related policies/laws, that notes challenges in implementation. These challenges are addressed through the interventions.	1. National policies and mechanisms to combat GBV, in particular FGM/C, in place, and adopted by the relevant institutions. 2. Police, judiciary, forensics experts are targeted with relevant awareness and capacity building to support anti-GBV legislation 3.The GBV medical protocol is validated and adopted by MoHP 4.The referral system is adopted by MoHP by ministerial decree and there is a clear methodology for its activation, and monitoring	-Policies/laws on GBV issues, in particular FGM/C -National Council for Women, Population Council advocacy reports on GBV related issues -MoHP, central and directorates that have implemented referral systems and medical protocol -Training materials, policy guidelines etc. -Judges and police capacitated -Beneficiaries of training -Trainers at MoHP -Beneficiaries of services possible	-Document review -Interviews with CO GBV POs - Key person interviews with IPs -Interviews with trainers -Focus group discussions with various stakeholder beneficiaries of training -Online survey

[310] Analysis of Pre and post tests were not accessed to identify the knowledge change.
[311] M3loma Facebook page, last access December 15, 2016.

	5.Focal points are appointed at MoHP central and directorates that support the capacity building process 6.Targets, selection criteria, and definitions exist for capacity building at the start of these interventions		

*Online Survey:

*A majority of 44.6% believed that the UNFPA CP led to enhancing satisfactorily the institutional mechanisms to protect against and respond to gender-based violence against women and girls, 17.9% thought it was moderately satisfactory, 16.1% did not know, while 8.9% thought it highly satisfactory.

*The majority of respondents seem cognizant of the work performed by UNFPA and acknowledge it. Evidence given were as follows: the implementation of special programs through the family empowerment project through a number of NGOs locally (e.g. in Assiut); the support given by UNFPA to NPC in the field of FGM/C is highly valuable, some capacity building workshop were offered effectively; printed materials such as brochures and illustrative posters were good tools; and some of the remarkable efforts expended by UNFPA relate to supporting NCW on changing the social culture represented in the norms encouraging FGM, and the Taa Marboota campaign. A couple of respondents were positive about the capacity building activity supported by UNFPA in the field of FGM, however they added by posing that training for legal authorities and the ministry of interior is moving slowly, aside of financial support, perhaps build capacity in students through more introductions on RH and the laws criminalizing the adverse phenomenon.

*On more respondent was quite satisfied with UNFPA CO support to the development of YFS initiative and clinics in Egypt, which were thought to enhance the institutional mechanism to protect against GBV, and also helped in building the national capacity to enforce laws and policies curtailing the harmful practice of FGM/C.

YRH

Data was created on national level for youth and reproductive health by direct support of UNFPA through DHS and SYPE. Data were used at very basic level for formation of the proposals related to AWPs. No secondary analysis or in depth correlation was developed to develop advocacy messages.

No evidence policy amendments based on data.

No advocacy tools were developed based on existing data.

Reproductive health component trained the statisticians in the maternal health department for better monitoring and data tracking. No other initiatives for health or youth component.

UNFPA created/participated in different knowledge products for health components (DHS, SYPE, Caesarian section study, DMT tool translation) Youth component developed peer education manual for FGM.

GE

Results from JP FGM:

1. On the occasion of the National Anti-FGM Day on 14 June 2015, launch of National FGM Abandonment Strategy
2. The results of the 2014 Egypt Demographic Health Survey (DHS), launched in May 2015, verified the decrease in FGM prevalence rates, among girls in 15-17 age group, from 74% in DHS 2008 to 61% in DHS 2014-312 while not necessary a direct result of this CP activities, speaks to effectiveness of long term planning, focused capacity building, community awareness, and advocacy in an intervention.
3. Appeals court in Dakhalia condemned parties involved in one FGM Case, and District Court in south Cairo raised by a mother, paving the way for families to report cases.
4. In August 2016, FGM law amended to criminalize FGM from misdemeanor to Felony. This was a result of discussions taking place in training sessions to judiciary on FGM.
5. Establishment of 2 Sexual harassment units in universities of Assiut and Ain shams, with established legal protocols and procedures within university framework.

As stated by the IP's, the role of UNFPA in coordination was critical, and in fact was "the missing puzzle piece that brought together all the work that had been completed, and ongoing to date."[313]

As reported by NGOs, strengthening capacities for referral systems dealing with SGBV did not occur, as there is no such framework for such systems that exist. CSOs interviewed have indicated that they each received only one awareness session which focused on detailed presentation of the medical protocol, rather than indications of a referral system. There was an expressed need for more training on psychosocial support for victims of SGBV (this was also echoed by doctors and nurses in key person interviews). Furthermore, the CSOs have indicated that since the service has not been activated, they cannot refer victims to specific service delivery points.

More importantly, GBV units hospitals not adopted or activated to date. There is no formal M&E system for these units in place. MoH service providers in governorates have not reported providing services using the skills gained. Only one focal point at MoH, no copy of the trainee database. Most communications, verbal by phone.

Evaluation Question (EQ) 3:
To what extent has the UNFPA support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into the national systems and positioned on the national agenda?
(d)To what extent has the CP strengthened national capacity for using data and evidence to monitor and evaluate national policies and programs in the areas of population dynamics, sexual and reproductive health and reproductive rights, HIV, adolescents and youth and gender equality, including in humanitarian settings?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
1.Data is available, relevant to be used in policy making 2. Data collection mechanisms exist, and institutions are mandated 3. There is a clear monitoring system that indicates how data is used in the M&E of policies and programs 4. Up-to-date products available on population status issued periodically 5. Advocacy networks on population issues available	1.Amendments are made to policies, programs based on evidence from data 2. Advocacy tools developed using data 3.Capacity building programs on the use of data, tracking, M&E 4.No. of researches and policy briefs (knowledge products) 5.No. of PSAs during CP period compared to previous	-Existing relevant surveys -Surveys, research completed under UNFPA interventions -documented policy dialogue that includes evidence from surveys -national strategies and executive plans at central and local levels	- Key person interviews at CAPMAS, NPC, Parliament and other key informants -Interviews with CO GBV POs -Online survey -Interviews at the governorate level (health & education directorates; and NPC at local offices)

[312]Egypt Demographic and Health Survey. English. https://dhsprogram.com/pubs/pdf/OF29/OF29.pdf. Accessed December 2017.
[313] FGM PMU Coordinator. Interview, NPC, Wednesday, 14 December 2016.

*Online Survey:

* The sweeping majority of respondents (37.5%) did not know the correlation between the effects of the CP and national capacity for using data and evidence to monitor and evaluate national policies in CO 9th Cycle focus areas, while 28.6% thought it was satisfactory. For a fuller picture, only 5.4% thought it highly unsatisfactory.
* A number of responses acknowledge that void in place due to the lack of an M&E system generating evidence for population policies. NPC's AWP contained the establishment of an M&E system within the organization to follow on the implementation of the previously UNFPA-supported NPS. The lack of an M&E system was identified as a gap in the post ICPD evaluation. Working on M&E system came in 2015 leading to the development of composite indicators (Population Atlas) in 2015. In 2016, the Atlas was rolled-out in almost all governorates by NPC. The work on developing a results-based framework (RBF) for the NPS resulted in the derivation of Phase I indicators, and the mapping of secondary and primary indicators allowing for Observatory Phase I implementation.

GE

GBV costing study highly praised by CAPMAS. Effective process with international consultant. Also, noted changes to survey of it was to be conducted again which would align the Survey to the SDGs and DHS. This reflects an-depth level of analysis and design for future data collection mechanisms and implementation.[314] No secondary documents or policy briefs as originally stated in the related AWP 2015, 2016.

Review of FGM strategy shows well developed, SMART indicators. Contains history and data related to FGM in introduction, as well as relevant baselines, methods of collection, actors.

The Strategy to Combat Violence against Women led by NCW, was drafted with technical direction and support of an external consultant, and there is no evidence of capacity building for staff at NCW, or involvement of the planning or monitoring departments during this phase.[315] Upon completion, the Strategy stands as in actionable. As stated NCW is "at a complete loss of how to monitor the strategy, need much more support"[316] and yet another consultant is working with NCW to develop an action plan for the Strategy, with weak collaboration between the two There is no evidence of training or efforts to contribute to NCW capacity to use data or monitor the Strategy.[317]

Repeated statements by IPs that there is no/very weak linkage between data and programs of the gender equality component in the CP[318]. For example, the content of FGM training for RLs and GBV in Islam manual, was not developed in collaboration with the FGM/PMU or NCW, or CAPMAS. Any trainings and evidence collected by the FGM project, training of Religious Leaders, or on GBV training for service delivery points is not effectively shared between the respective projects, for more significant and cohesive efforts between IPs. What's more, the majority of data or databases resulting from program activities/outputs is not collected at UNFPA, but rather remains at the various IP institutions. And at these partner institutions, data is not collated or analyzed, and there is no monitoring on its further use or contribution to monitoring of national programs.

PD

1-UNFPA support to NPC is under SP 4, SP O/P 15, and CP O/P 2.
2-NPS strategy launched in 2014 in the presence of the then PM, Eng. Ibrahim Mahlab, and under the auspices of the President. Advocacy expended by UNFPA and NPC led to the incorporation of FP and RH in Vision 2030, with a matching profile to the NPS. Other advocacy work supported by UNFPA and NPC related to youth as it fell among the pillars of the NPS. Dialogue between youth and policy makers with the support of UNFPA, NPC and the Ministry of Youth, however this was somewhat timid due to the overall restrictive environment. Needless to say, PD was an enabler for policy advocacy and dialogue

[314] Technical Coordinator GBV Costing study, CAPMAS. Interview, CAPMAS, Thursday 15 December 2016.

[315]Director of International Cooperation and External Relations Department, Planning Department Manager, Monitoring Department Manager. Interviews, NCW, Thursday, 15 December 2016.

[316]The National Council for Women. The National Strategy for Combating Violence against Women 2015-2020. 2015. The National Strategy for Combating Violence against Women reads more as a wish list for various ministries, some of whom have included activities that are outside their mandates. Furthermore, the indicators are not SMART. This assessment was stated directly by NCW staff, as well as other partners interviewed during the evaluation. Review of the Strategy for the CPE also shows that there is no related M&E plan, and the activities and timelines within are generally not specific targeted.

[317]Director of International Cooperation and External Relations Department, Planning Department Manager, Monitoring Department Manager. Interviews, NCW, Thursday, 15 December 2016.; Interview, Gender Consultant, Wednesday, 21 December 2016.

[318] Interviews with IPs in the GE component indicate that they are unaware of other projects under this component, and there is no exchange of the data or knowledge produced to be used across the program by various partners.

3-In May 2015 an Executive Plan for the NPS was also approved, the allocation of LE290 million of state budget was earmarked to support the implementation of the NPS. UNFPA recognized the importance of developing a robust M&E system that would collect data based on indicators to ensure the goals of the NPS are realized, which mostly has offered qualitative indicators and budgeting was lumpsum.

4-In Q4-2015, Composite indicators, with UNFPA CO support, were completed and 8 policy briefs concluded for priority governorates which are most in needs of support; they are: Assiut, Sohag, Sharkeya, Beheira, Menya, and Ismailia. Meetings with governors concluded and training delivered. Composite indicators are 13 and are accompanied by traffic-lights governorate maps that work to the lower effects at the district level. Giza governorate was added due to the prevalence of child marriage. NGOs, the private sector, MOSS, and the Food Bank participated in the realization of this programme. Training curricula was developed and 20 MOP/NPC staffers were trained on the composite indicators. No MOUs signed with governorates; governorates extend beyond targeted in CPAP; political situation at the governorate level led to many changes in governors; and capacities at the NPC branch level and facilities offered are varied. No data base is developed yet nor NPC branches linked to the central HQs. In 2016, UNFPA has also supported the publication of Composite Indicators pamphlet and maps' generation in hard and soft format.

5-In Q4-2015, UNFPA funded a needs assessment for the NPC M&E system. Main findings were as follows: there is a major overlap between the tasks and responsibilities of the Monitoring versus the Evaluation Department with lots of duplicated efforts; monitoring is focused on collating raw data in percentage form of planned activities with no quality assurance or validation of activities, outputs, outcomes or impact assessment; the evaluation department is mistakenly called the corrective action (in Arabic "Takweem" than "Takyeem") which is a combined function for both M&E; and a near complete absence of performance indicators in all M&E actions and is based on subjective assessment than a proper evaluation. To date, this has not changed much while the M&E system is awaiting budget and mobilization. Luckily cooperation with MOP, M, & AD, and GIZ may operationalize the M&E system through building the necessary data-base, linking the center to the periphery provide software and hardware technical assistance and training. UNFPA, so far, has offered consultancy to sketch data-flows.

6-In order to transform the NPS and EP/NPAP into a doable policy instrument able to generate data feeding into a decision-making M&E on population issues, NPC supported an initiative to develop an indicators manual, namely the Population Observatory. A set of primary (32—need to be collected) and secondary (52--available) indicators were derived. The Observatory indicators are mainly to the output level with work for linkage to the outcome level. Several rounds for refinements were undertaken through consultancy supported by UNFPA.

7-In order to implement the NPS/EP at both the central and local levels, coordination activities, to which NPC is mandated, were also supported by UNFPA, in 2015-16. To implement the five-year EP/AP of the NPS, 4 workshops were conducted between NPC and line ministries, NCCM, NGOs and the Ministry of Planning, in addition to internal coordination meetings between NPC planning and monitoring departments, at the central level. At the local level, 53 persons were trained on the development of composite indicators who learned how to use these indicators for planning and monitoring. The annual collection and data utilized for monitoring purpose will continue that data is collected in a timely manner and is validated.

8-In Q3-2015, Among the Composite Indicators governorates 5 communities were piloted to do more awareness raising on population issues at the grass root level with the support of UNFPA, under what is called the Population Characteristics Program, which is a further subset. The yielded results were: 27 workshops for 520 participants (in Al Darb Al-Ahmar and Ezbet Kheir Allah in urban Cairo, Manshyet Dahshour in Giza at Badrashin District, and Mohamadeyat in Assuit at Abnoub District) addressing women and youth through improving their leadership and communication skills, changing attitudes towards the shape and size of family and disseminating relevant messages to targeted communities.

9-In Q2-2016, a large media conference was held with the support funding from UNFPA. A pamphlet publication containing the main media messages of the NPS was publicized and handed to the media for advocacy purposes.

10-In Q3-2016, a conference attended by CAPMAS President and Governors (195 participants) displayed examples of primary Observatory indicators that were put under an initiative called "Mogtam3na Masry" targeting priority 86 districts developed based on Composite Indicators.

11-In Q3-2016, UNFPA supported the first national population day on 31 July 2016 attended by PM Eng. Sherif Ismail. It advocated for the NPS, Observatory, and independent evaluation. The event was attended by 200 participants. Accordingly, this conference has impacted in the sense that H.E. Deputy Minister of Health and

Population for Population Issues is invited to the Governors Meetings in the Cabinet of Ministers and presents progress and achievements on NPC/NPS. She presented Composite Indicators and samples and is now communicating with Governors for procedural steps for implementation.

12-In Q4-2016, workshops and coaching sessions to Assuit, Sohag and Giza Governorates with NPC Branch, Governor and regional council (for Assuit) to expose them on how to collect secondary indicators. In some cases, secondary indicators were found difficult to measure, contrary to what was originally expected, and were moved to primary indicators (hard to measure indicators, or phase 2 indicators). The other 3 red-spot governorates were involved.

13-In 2015, UNFPA developed a media plan for NPC. It produced a documentary film (10 minutes) for a model village. The movie shows a village that succeeded to improve population characteristics (health, family planning, education, literacy and the environment) to offer an Egyptian sustainable development model with the potential of upscaling. The film is used for awareness raising on the engagement of local communities in improving population characteristics. It was intent to be used by NPC for advocacy and fund-raising purposes. UNFPA supported 2 more media spots and a competition on Radio Masr and promoting family planning awareness during 2016.

14-UNFPA supported the provision of 2 Core leadership training to 28 NPC participants including staff from the 3 target governorates in Q2-2015. The first was on leadership skills, while the second was on strategic planning. Those trainings were planned to build capacity in second and third-liners at NPC and was supported by the then Minister of Population, Dr Hala Youssef. The second training topic was surprising and was geared to senior managers at NPC. Assessments made by consultants who offered that training is that who earned poor initially earned poorer when they participated in the training, while those who scored high in pre-test, earned higher. Scoring was mainly on timely attendance of workshops and assignments delivery.

15-In 2016, One PSA was developed during the 9th Cycle. Launched on UNFPA website, than NPC. Not approved by NPC. NPC decided to develop its own PSA in-house through its Research Department and external consultants. A CBA for FP in Egypt was developed in 2015.

16-Assessment:

a.M&E indicators are in place, but system is not with lacked capacities (human investments, automated system, software, hardware, pilot-testing, bugs handling, report formatting, data protocols and assignment of responsibilities etc.

b.Results of coordination meetings, training and workshops is the delivery of NPAP 5-year plans for ministries at the central level showed setting their indicators for delivery is their business-as-usual indicators.

c.Results of coordination meetings, training and workshops is the delivery of annual governorate executive plans based on the format developed for the previous NPS (2009-12)

d.Evaluation is understood still as the monthly follow up of executive and regional meetings

e.Planning Dept, Monitoring Department, and Evaluation Department are 3 silos that do not share data or reports. This is ineffective and need to be merged into one.

f.Selected core leaders are dissipated and training discontinued

g.In CP 2013-17, a PSA is to be produced per year. So far, a single was produced and is suffering problematic adversities. Developing two parallel PSA for same period by UNFPA, on the one hand, and NPC on the other, is deficient with respect to efficiency and effectiveness, and may generate conflicting and confusing opinions influencing the overall policy dialogue over the population issue in Egypt, which both organization are supportive of.

h.The devolution of the NPC PMU casts issues relating to communications and sustenance of interventions that UNFPA having immediate importance.

j.The non-involvement of the NPC staff in the drafting of the NPS and EP influence the efficiency, effectiveness and sustainability of the long-term intervention.

j.No data base for indicators in place, branches are not connected electronically to the HQ so exchange of data takes place on paper format TA8 through desk reviews/collection than field collection, some NPC branches do not have staff or facilities, the active NPC coordination manager departed leaving the department currently with a manager without staff capacities who is supposed to uptake the coordination function, coordination is said now to participate by presence in executive and regional meetings at the governorate level, the statistics department works on desk reviews of data on birth, death and contraceptive coverage rates and produce reports which are a mere listing of tabulated figures (without analysis or policy directions); the HR Department is not involved in the delivery of training or assessment and if involved at all they would do hall or tea break bookings, a complete trainees or training materials data base is non-existent, no pre- or ex post assessment of

training, and trainees interviewed expressed dissatisfaction with training offered by UNFPA with respect to depth and breadth of training materials, relevance of subjects, duration, trainers, and lack of handouts or agenda. On the one hand, there has been delays noted on the side of UNFPA in finalization of AWPs and quarterly funds transfers, and the other hand, NPC financial procedures delayed the effectuation of activities. All ended in delays and several AWP amendments affecting effectiveness. In addition, the media spots that were developed did not engage NPC media and production department nor had it followed a comprehensive media strategy influencing effectiveness. No training effectiveness or a consistent record on training and trainees is available. More serious, at many instances patch training is confused for capacity building. Indeed, building a robust and operational M&E system require quality data, equipment and most important qualified staff. This is lacking so far and influence effectiveness towards the realization of global outputs and outcome. The elements for a good M&E system were expended by UNFPA during the 9th Cycle, what is missing is the comprehensive vision on how to integrate the pieces of the puzzle efficiently and effectively (i.e. NPS, EP, NPAP, Composite Indicators, design media campaign and support implementation, full-fledged M&E system linking branches to center, use of KM in decision making, involvement of research department in production of research than procurement, rely mainly on NPC staff supported by external consultants, training for statistical department and training department on production and participation in knowledge products).

17-To date and after the passage of 2 years after the launch of the NPS and withdrawal of budget allocation (LE290 million) to the abolishing of the Ministry of Population, the NPS has not generated a single monitoring report and the population growth rate has not abated reflecting on the effectiveness of this intervention and its sequencing towards results delivery. It is yet to be seen in the final year of the current CP immediate corrective measures to operationalize the NPS in an integrated at the macro-(intra-ministerial), meso-(regional) and micro-levels (governorates). This success formula is likely to bring about lessons learnt for documentation, learning communities of practices and new strategic partnerships.

Evaluation Question (EQ) 3:

To what extent has the UNFPA support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into the national systems and positioned on the national agenda?

(e)To what extent have the interventions supported by UNFPA in the field of population and development (PD) contributed to an increased availability and use of data on emerging population issues at central and local levels?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
1.Data is collected and collated. 2.Knowledge products generated feeding population policies/strategies 3.M&E systems exist for tracking Strategies	1.Link between data generated at the grass root level and national programming 2. Quality, quantity of data collected, relevance to PD issues (population, HDIs, SDGs etc.)	-National Surveys -National development programs or plans -participatory dialogues concluded -Composite HDIs for target governorates	-Document review -Key person interviews at CAPMAS, Population Council, National Council for Women, Ministry of Planning -Online survey -key person interviews at the governorate level (Giza, Assiut, and Sohag)

*Online Survey:

* The top category of responses (26.8%) did not know, most probably to the recent collaboration between UNFPA CO and CAPMAS intent to hike during the last CP year (2017) onwards. Next in line was a 25% and 23.2% of respondents thought UNFPA CO contribution to increasing the availability and use of data on PD issues at both the central and local levels as satisfactory and moderately satisfactory, respectively; while 10.7% thought those data and statistics as unsatisfactory for different reasons.
* On the upside, respondents acknowledged the efforts of the CO in contributing to DHS, SYPE and SDGs at the national statistical level. Others affirmed the contribution of UNFPA to the development of the NPC Observatory despite the fact of miniscule technical and financial contribution. Others mentioned that two capacity building workshops for NPC Sohag Branch were offered to staffers and partner organizations in the governorate relating to the newly launched Population Observatory were found useful. In addition, some respondents stated that UNFPA is competent in delivering specialist research and census on PD issues.
* Many of the respondents on the downside see they are unaware of CO's PD contributions, or state that scattered efforts on the PD front render it ineffective (i.e. lack of provision of advocacy tools to media personnel or personal interests preclude national ownership).

PD

1-UNFPA supported CAPMAS through SP O/C 12
2-AWP 2016 was signed after the beginning of 4th quarter 2016. UNFPA pledged the offering of a sampling consultant to support CAPMAS in the March 2017 National Population Census through two mission. One of the missions is to develop the long form for a high precision single stage stratified sampling, that will be followed by another validation mission after the statistics are collected. Both technical assistance were short-term (one week). CAPMAS had originally requested a resident statistical advisor, who is now offered by JAICA. In UNFPA's effort to support the national statistical agency, it was found the Population and Public Services sector was not communicated with which may influence the longer-term effect partnership effectiveness. Having said that, this particular Sector was involved in the preparation of the NIDI Survey commissioned by UNFPA.
3-In addition, UNFPA funded a one day multi-stakeholders workshop at CAPMAS attended by CAPMAS President, General Abou Bakr El-Guindi, the Minister of International Cooperation (and now Investment), Dr Sahar Nasr, and the Deputy Minister of Health and Population for Population, Dr. Maissa Shawky. The purpose is to open a policy dialogue on developing SDG indicators. The CAPMAS President pledged the issuance of an annual Egypt SDGs Tracking Report. This workshop was followed by a 4-day working workshop for the sub-ministerial level to dialogue the details concerning the hardships in measuring some SDG indicators, and the division of roles.
4-Both interventions with CAPMAS are excellent as they tend to extend from the output to the outcome and perhaps impact levels, as well. The Census is held every 10 years, and while SDGs tracking is annual it still matches with the NPS and Vision 2030 time profiles and feeds into both of them. Those interventions are highly effective and the organizational capacity is likely to sustain
5-A smaller intervention offered to CAPMAS was funding the training travel costs of 2 CAPMAS officers to US Census Bureau to learn on sampling techniques. The topic and course were chosen by CAPMAS. Upon return, CAPMAS leadership requested the trainees to provide TOT to other CAPMAS-colleagues to expand knowledge circles, learning and excellence.
6-CAPMAS subjected itself voluntarily to an organizational capacity assessment by OECD/Paris 21+. With its strong leadership (at the rank of Deputy Prime-Minister who attends Cabinet Economic Group meetings), the organization did not suffer the political turmoil resulting from the two revolutions and promises achievement and sustenance of results towards outputs and outcomes. CAPMAS needs are higher than what UNFPA can offer.
7-Same as NPC, CAPMAS suffers from delayed UNFPA AWPs and pressures imposed due to milestones.

8-Further cooperation can be forged with IDSC, the Cabinet's think tank, to be a strategic partner to the other 2 (NPC and CAPMAS) in the production of knowledge products that are widely disseminated to the public and passed to highest national decision making organs in Egypt. This tri-lateral relationship would enhance the effectiveness of the PD component.

9-In previous CPE (2007-11), Recommendation 7 (PD7): "Activities that aim at improving collaboration between main players in the area of data collection and dissemination at the national level are needed." This recommendation was partially accepted, with 3 key actions followed: 1. Enhance coordination between IDSC and NPC for data dissemination and reporting. This was postponed due to the fluid political situation which is now reversed and requires action on the side of UNFPA for the 10th Cycle; 2) promote the utilization of database and indicators handbook with relevant stakeholders. This was completed; and 3. Produce policy briefs based on population reports together with NPC. This was not completed, though expected to take place before the closure of 9th Cycle without NPC involvement which reduces effectiveness.

10-The expected effectiveness benefits of the UNFPA, NPC, CAPMAS, and IDSC is immense, as it will provide backbone strategic strength between the 4 organizations on policy advocacy and KM at multiple layers nationwide. However, it has to always be kept in mind that the PD component is an enabler for other CP components. Under the current Cycle, the 3 focus programme areas were parallel-tracked with little synergies, if none at all. The PD agenda for the coming 10th Cycle with this strong strategic players will need to involve inputs and benefits from the other 2 components, YRH and GE, in order to boost strategic effectiveness of the CP and organizational profile/visibility in a substantive manner.

11-The involvement of PD in the humanitarian component was not envisioned, however funding statistics on effective size and characteristics of the different refugees in Egypt may have triggered knowledge products that would inform policy formulation, implementation and perhaps may have filtered into the NPS vulnerable brackets of the population in need of support.

Evaluation Question (EQ) 3:
To what extent has the UNFPA support helped to ensure RH and the needs of young people, GBV issues and population and development are appropriately integrated into the national systems and positioned on the national agenda?
(f)To what extent has CO humanitarian assistance contributed to an improved emergency preparedness and response for SRH and GBV in Egypt?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
-TNA assessment conducted -Quality training delivered suffices demand and is sustained -Safe Spaces sufficient, effective, responsive and sustainable -Humanitarian component mainstreamed in CP and complies with UNFPA mandate	1.UNFPA possesses qualified, sufficient staff to deliver on humanitarian component 2.Protocols signed (MOH and others) 3.Evidence generated from the national level affirming policy direction towards Syrian response (compared to other refugees)	-Reports and monthly coordination committee meeting minutes -Training materials & artwork to physicians & nurses and from (CARE/RCT/Y-Peer responses) -site observation	-Document review -Site visits (Cairo & Giza) -Key person interviews (CO; Safe Spaces staff; Y-Peer; sampled doctors and nurses trained) -Online survey -GOE & Donors interviews (MOIC; UNHCR; EU; Japan; US; UNICEF)

	4.Relevant, quality training is delivered and meets required demand		

*Online Survey:

*Most respondents (37.5%) were not aware of UNFPA CO's interventions for improved emergency preparedness and response for SRH and GBV in Egypt; 26.8% were satisfied with services provided; and 16.1% were moderately satisfied; and 7.1% thought it unsatisfactory.

*Most respondents provided evidence that there is a marked impact by UNFPA CO in the humanitarian, namely the Syrian refugees program, whereby a number of safe spaces were open to refugees. An additional advantage of the CO Syrian refugees program is its ability to build the capacity of NGOs to deliver to end beneficiaries (refugees).

YRH

High demand for reproductive health among the refugees.

The referral system was not activated and linkage with equipped hospitals does not exist

No sustainability plan.

GE

High turnover in CO of Humanitarian officer, with no evidence of handover.

Late start to safe centers, and only one year of implementation,

No sustainability plan in place.

Egypt also has its own strategic Regional Refugee and Resilience Strategic plans (3RP).[319] Livelihoods and social cohesion focus on community integration, and psychological well-being of refugees, long term.

Maadi safe space data base has 1000, 800 repeat

Madinet nasr safe space has database 500, 380 repeat

PowerPoint of GBV very comprehensive, in awareness and definition, no coping mechanisms. No evidence from FG on referral or other services. Emergencies or medical support dealt with through community or NGOs that do outreach in their communities.

Observed leadership of activities (jewelry making and crochet, by Syrian Women. Both Spaces have support by Syrian women. Considered "mothers of the space."

FGDs show psychosocial support provided was critical to their mental health, and networking with other Syrian refugees has improved their overall outlook and allowed them to slowly start integrating with the community around them. And while the arts and psychotherapy activities gained more mention than other activities during the focus groups, parenting and prevention of child abuse sessions resulted in very positive feedback, and a request for more follow-up sessions. The beneficiaries also indicated that they would like to have more funding for purchase of materials to assist in the trainings they take (jewellery making, sewing, knitting, etc.) that would allow them to produce larger quantities, for the possibility of sale for income.

Sustainability

Evaluation Question (EQ) 4:

To what extent has the CP been able to support its (implementing) partners and beneficiaries in developing capacities and establishing mechanisms (for example: youth friendly clinics) to ensure ownership and sustainability of achieved results?

[319] UNHCR. Egypt Regional Refugee & Resilience Plan in Response to the Syrian Crisis. 2015-2016 and 2016-2017. http://www.3rpsyriacrisis.org. Accessed December 2016., January 2017.

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection
1.The established mechanisms supported by UNFPA are in place and capacity of the partners and beneficiaries were built. It also assess the sustainability and ownership of achieved results is part of the process.	1.The sustainability plans that partners like MOHP and trained NGOs have been developed during planning process. 2.Partneships with key stakeholders are active and influential 3. Partners capacities have been developed with a view to increase their ownership of the UNFPA initiated interventions. 4. Life skills education and peer education interventions are sufficiently followed up and passing knowledge has been systemically assessed.	-Document review -Trained beneficiaries -Government key officials -Representative of implementing partners	Document review for the sustainability plans or components in the work plans IDI with key informants in and partners Beneficiaries survey and FGDs -Online survey

2.UNFPA contributed to develop a functional integrated information system for formulation, monitoring and evaluation of national and sectorial policies	5.Disaggregated data produced, analyzed and utilized at national and sectorial levels, on a periodic basis 6. Number professionals and units trained to apply integration methods and tools 7. In-depth, policy-oriented studies released 8. Functionality of information systems set in place 9.Large-scale population surveys conducted and disseminated 10. Database for monitoring established.	UNFPA P&D section AWPs and SPRs - P&D project reports - MOSS staff and publications	Annual reports from MOSS, NCEA TS, need assessment, evaluation and monitoring reports - Planning and programming documents (MOSS, SDCs) issued during the reference period - Inputs to and deliverables of the information systems - Interviews with MOSS, NCEA TS and municipalities' staff to review the implementation modalities of P&D component and achievements -Online survey
3.Institutional capacity to prevent and protect women affected by GBV has been established	1.Number of institutions received capacity building on GBV 2.Number of beneficiaries that benefited from the services and expressed satisfaction about provided services 3.Public campaigns on GBV implemented and assessed	-Document Review -NCW -MOH	-Document analysis -Semi-structured interviews with NCW, MOH

*Online Survey:

*The foremost majority that were unable to assess UNFPA's capacity to support partners and beneficiaries sustained capacity resulting from UNFPA interventions (33.9%) and inform that no impact measurement on sustenance was invested by UNFPA in partners or beneficiaries has been taken; while others stated that youth health facilities, as an example, is under current evaluation, implying generating information on effectiveness and sustainability aspects. A skeptic key informant from a local/community branch of NPC poses that investing in capacity building activities in an IP's (NPC local branch) human resources as implemented by UNFPA have started in May and June 2016 only, with questionable, sustained intervention value-added.

*Most survey respondents (28.6%) see that the UNFPA 9th Cycle CP has been able to support its partners and beneficiaries satisfactorily to develop their capacities and establish mechanisms to ensure owners and sustainability of achieved results, in general.

*Those respondents who responded favorably to UNFPA's sustained interventions for better results emphasized the importance that the beneficiary organization has embedded capacity for change that has to match UNFPA's willingness to effect change to realize sustained value additions for better results. Other respondents believed that UNFPA's capacity to provide sustained interventions is marked more glaringly at the national level (i.e. compared to local/governorate levels). More respondents trust the UNFPA CO managed to support the development of youth-friendly clinics within MOHP health facilities and upgraded health-providers' capacity, though aspects of sustainability remain needy of additional effort to fortify. Sustenance issues do not seem to have been addressed at the outset on formulating MOHP's joint programme interventions.

*On the downside, an NPC respondent thought UNFPA CP was unable to fulfil on this mandate who retorted by mentioning UNFPA's lack of focus resulted in a tendency to flip among activities and priority agenda issues in case one has not achieved its planned results within a specified time frame. This was seen as conflicting with diligence and alleged commitment responsive to needs of partner organizations (IPs).

YRH

No sustainability plans with the government partners, but there are sustainability plans with implementing NGOs.

The ownership of the programmes working with government depend on the leadership of the directorate and varies for different directorates.

There is no systematic assessment for passing knowledge to peers in different components but it's perceived to be happening.

GE

No exit or sustainability plans with partners or related to CPAP.

- UNFPA interventions, regarded as projects within the institutions, particularly in the case of NCW, Curative Care training, with duties being over and above that of the regular duties of the appointed staff. Without financial incentives, and without the intervention being properly instituted, there is no sustainability.
- UNFPA only has one or two staff as focal points for its projects, with reliance on consultants to do the work. The end result is that the consultant completes the assignment, often working parallel to staff, with no internal gains. Furthermore, there is not sufficient planning, or time for capacity building and institutionalization of mechanisms, to allow for sustainability.
- The number of staff/focal points, and the financial allocation to projects does not reflect the amount of work that needs to be conducted. (RCT, NCW strategy monitoring, NPC Population Strategy) leading to over exertion of IPs and weaker implementation.
- Focal points do not always have the support of their respective institutions or that of other partners/actors, regardless of any MOUs or agreements initiated by UNFPA. Political willpower and commitment is tied to institutional decision makers. Those who do have support of higher decision makers, are active in implementation and vested in the intervention success.

- Campaigns on GBV include a wide Ta'aa Marboutah campaign on women's empowerment. However, according to the implementing partner, this campaign is stalled. And according to donors it needs a stronger and vision to take it to the community level. So far, it too broad and targeting only higher level actors. There is no community knowledge or public debate around it.
- Campaign on FGM included: Airing of Enough FGM Media Campaign produced by UNFPA and other UN Partners on Nile Satellite channels during the month of Ramadan at Prime Time hour within the MOHP Media campaign funded by the Ministry of Health & Population; and contribution for FGM episode within the context of reproductive health for airing of radio contest on Radio Masr Network (wide listenership)during the month of Ramadan which dedicated on 14 June 2016 all day programs for advocating FGM abandonment on the National Anti-FGM Day.
- Prevention mechanism effective to date, discussed in achievements of FGM project above.

PD

1-UNFPA CO intervention to develop an NPS is a remarkably sustainable policy advocacy tool for the period 2015-30, subject to its ability to generate informed results feeding into decision making and empowerment of NPC staff

2-Ownership and engagement insufficiently existed in the preparation of the NPS was remarked to be rectified through heavy capacity building, technical support and higher visibility of UNFPA as an advocator and supporter of population issues

2-CO to support an organizational capacity assessment to be performed for NPC to identify gaps and deliver tangible results

3-A comprehensive data-base for end beneficiaries and proper records of training beneficiaries neither exist at NPC nor CO

4-CAPMAS is transforming training acquired by staff through UNFPA CO funding to a sustained, passed skill-development TOT opportunity for its staff

5-CO intervention to CAPMAS through availing a sampling expert for 2017 population census will sustain effects for coming 10-years, until the following census is due (according to international norms)

UNFPA STRATEGIC POSITIONING

Evaluation Question (EQ) 5:
To what extent has the CO aligned with new mode of engagement, able to generate value added and comparative advantage?

Evaluation Question (EQ) 5a:
Value Added: To what extent was the CO able to shift the mode of engagement and focus on upstream interventions (strategic advocacy, knowledge management and internal CO capacity)?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for data collection

1.Basic societal, economic and health and factors leading to increased vulnerability of youth and women, and other marginalized groups are identified, and addressed through evidence based policies and prevention measures.	1.Programs are planned at macro level, with focus on advocacy for institutional policies 2.Policies and protocols in place to combat GBV, provide equitable access to RH services 3.Data is generated to support evidence-based policies	-Data on key programming issues -Policy documents regarding RH Policy documents regarding GBV -Policy and strategy documents on P&D -Knowledge management products and policy briefs	-Document review -Interviews with key personnel at MoHP; NPC and governorates -CO Representative, POs, and RO -Interviews with key persons involved in GBV strategy -Online survey

*Online Survey:

* The majority of respondents do not seem aware of UNFPA's new strategic orientation (35.7%). The following category of respondents find UNFPA's new mode of engagement as satisfactory (23.2%), to moderately satisfactory (23.2%). A fractional percentage (6.1%) regard it highly unsatisfactory.

*On the upside, those who believe on the importance of the adoption and continuation with UNFPA's new mode of engagement see that despite many lost opportunities by the CO to contribute to many windows for upstream interventions, yet still the CO was able to have its contribution to the calendar-marked population day, engagement of medial people and to NPC's scientific day with marked political commitment elicited by Ministerial- and Governorial-levels to population issues. In addition, UNFPA was successful in partnering with NPC in launching the national population strategy (NPS), awareness creation stakeholders workshop on SDGs for collecting indicators and fortifying the national statistical system for periodic SDG reporting mechanisms. Moreover, interventions rendered by UNFPA to NPC were upstream, same for the ability to establish youth- and adolescent-friendly clinical services intent to sustain.

*On the other hand, some respondents affirmed that upstream activities offered by UNFPA (to NPC) require implementation mechanisms to go hand in hand with upstream/soft activities.

YRH

The ability of CPAP to plan at macro level was partially achieved. In reproductive health component; CPAP activities were created through partnership at central level with ministry directorates. Also the overarching goal of UNFPA to decrease national fertility rate was a meeting point with the country leadership views320. Family planning activities (especially DMT) had cumulative experience and political support to be upstream intervention which is being extended on national level.

Youth component could not be up streamed due to lack on inclusion in national policies.

Monitoring data were not properly collected in disaggregated way.

No knowledge §management system in place but there was documentation of some success stories in the reporting system

GE

Advocacy for issues:

- While there is initially enthusiastic involvement at level of institutional decision makers, it generally loses momentum and weakens once a "launch" event or signature of MOU occurs. There is weak or no follow-up on advocacy or policy dialogue (reported by almost all IPs).

Knowledge management

- Production of some knowledge material, albeit late, is effective (GBV costing Study, Medical Protocol)

Knowledge management is weak in producing usable secondary materials such as policy briefs. Further, information is not shared across the GE component. Data is not collected or collated at the intervention or community level, to support evidence-based policy. Data if it exists, is in the form of lists, not collated, or disaggregated. More importantly, UNFPA does not provide any guidance to its IPs on how to collate or disaggregate data, so databases, if they exist, are not uniform or matching in indicators or data collection, across the GBV program.

PD

1-Tangible achievements realized on upstream activities, yet gaps exist in staff size and investments, counterpart needs, programmatic coherence, M&E, effectiveness of interventions, regionalization, innovation.

2-During the 9th Cycle, CO was successful in its fund-raising strategy and was able to expand its Other Resources (OR) to fund its programmatic interventions, despite reduced RR translates into an appreciation of the value-added and niche of the CO, programmes and staff

3-The new mode of engagement widely accepted by multi-stakeholders, with qualification: PD to play a key role in an exceptional environment with high political changes; and assist GOE in procurement of contraceptives from national funds or domestic private sector			
Evaluation Question (EQ) 5b: **Value Added: What are the main UNFPA comparative strengths in Egypt, particularly in comparison to other UN agencies?**			
Assumptions to be Assessed	**Indicators**	**Sources of information**	**Methods and tools for data collection**
1.The UNFPA country office has actively contributed to UNCT working groups and joint initiatives	1. Evidence of active participation in UN working groups 2. Evidence of the leading role played by UNFPA in the working groups and/or joint initiatives corresponding to its mandate areas 3.Evidence of exchanges of information between UN agencies 4.Evidence of joint programming initiatives (planning) 5. Evidence of joint implementation of programmes 6. OR budget trends in tandem with new UNFPA strategic direction for partnership building	-Minutes of UNCT working groups - Programming documents regarding UNCT joint initiatives - Monitoring/evaluation reports of joint programmed and projects -UNFPA strategic plan	-Documentary analysis - Interviews with UNFPA CO staff - Interview with the UNRC - Interviews with other UN and non-UN agencies -Online survey

[320]Interview with UNFPA country representative and decrease of contraception use in Assiut and Sohag.

*Online Survey:
*Almost all respondents to this questions were in strong support of UNFPA's technical and financial edge. On its human capacity, respondents believe that CO staff is friendly and adequately skilled despite of shortage in staff. Advocacy on population issues and dealings with strategic partners appropriately enables the filling of gaps on the social agenda of the GOE. Some respondents commended its contextualized solutions reflected in population advocacy, RH, GBV, FGM, YFS initiatives and Syrian refugees humanitarian response. More responses emphasized the ability of UNFPA to select highly competent execution teams in the field. Furthermore, respondents see UNFPA CO as a natural extension for the collaboration on its agenda and the NPC. Moreover, others highlighted its strength as convener of youth-focused interventions and broker for high-level (policy) technical interventions. Finally, an area of comparative strength for UNFPA CO lies in its multi-partnership building relations with myriad national and international organizations (i.e. UN and non-UN).

YRH
There was joint research rather than joint activities. Study of caesarean section, DHS and SYPE.
Youth interagency group did not meet regularly and there was no joint work plan

GE
Name: Social, Economic and Legal Empowerment of Egyptian Women Joint Programme
Duration: January 1, 2014 – December 31, 2017
Funders: SIDA, EU, Norway, US
Total fund: US 6,156,553 (SEK 49,900,000)

PD
1-UNFPA in general, and CO, specifically is seen by stakeholders as a focused UN organization with a clearly focused mandate on population issues
2-Overlapping mandates of many UN organizations leaves room for expanded partnerships, in which UNFPA was successful during the 9th CP Cycle
3-UNFPA CO played key role in a number of UNCT coordination Task Forces (TFs); e.g., leading the Youth Task Force by the CO Rep, lead the Gender TF by the AR based on acknowledgment and request of GOE, and participation in the key UNDAF M&E TF by the M&E Focal Point

Evaluation Question (EQ) 5c:
Value Added: What is the main UNFPA added value in the country context as perceived by national stakeholders and UNCT coordination team "visibility/NEX/DEX"?

Assumptions to be Assessed	Indicators	Sources of information	Methods and tools for data collection

1.UNFPA country program provided added value to the national strategic plans. National stakeholders can identify the comparative advantage and specific added value for the country program.	1.The number and quality of technical support provided by UNFPA to different stakeholders include national strategic plans. 2.The level of contribution of UNFPA country programme to support the selected thematic areas in comparison to other agencies. 3.The number and quality joint programme that led by UNFPA in the programme thematic areas.	-stakeholders and UN agencies. -Strategic and technical documents. -Programme baseline and assessments. -IPs	-Document reviews Interviews with the different stakeholders, and CO Representative, POs, UNRC, and donors. Document review for technical and strategic tools. -Online survey

*Online Survey:

* The locus of responses hovers around not knowing exactly. Respondents who were positive of UNFPA's added value in the country context the organization (UNFPA) funds relevant existing or upcoming projects needed by IPS; its specialization in RH and population issues leading to the handling of gender issues; both technical and pecuniary assistance related to population issues; qualitative inputs into instituting activities that would be supplemented by the capacity of IPs; support given in building national capacities in statistics, data, population and censuses; focus on upstream activities is unique; public awareness activities on population issues; developing practical protocols and guidelines; and coordination activities among different institutions and ministries specifically in the field of youth and adolescents.

*Skeptics and those respondents who do not believe that UNFPA was able to provide any value-added to national stakeholders elaborated by stating that UNFPA is an ineffective organization, mostly unheard of (i.e. lacks visibility), and critically assesses its performance by advocating its vertical interventions that leads to fragmentation of programming, and therefore a lack of vision and overall focus.

YRH

- UNFPA is part of the development of the plans of each directorate in ministry of health among other partners.
- Strong NGOs and government sector counted on their resources or using consultant rather than UNFPA resources.
- UNFPA participated in different joint researches but not programmes in reproductive health and youth component.

GE

- FGM Abandonment strategy well developed, clear SMART.
- Medical Protocol/Guidelines, first of its kind.
- Excellent support on GBV costing study, albeit not followed up with strategic documents.
- SGBV heavily championed by UNFPA. Integrated programming under the multi-partner trust fund encompasses all aspects of FGM, harassment, Social empowerment campaigns (FGM and Taa'Marboutah), as evidence in reporting to Trust Fund.

PD

1-UNFPA has been active and contributing constructively to UNCT meetings and forging partnerships among the UN family (e.g. proposing the Youth Consultative Group with support mentoring from ILO; contributions to the International Youth Day and proposals for coordination with UN Communication Group; Youth TF and Gender TF chairing, and participation in UNDAF M&E TF by CO Rep, AR, and M&E Focal Point, respectively)

2-Donors and UN agencies voiced CO need to focus on results reporting for JPs, and revisit geographic targeting given knowledge and edge at community level

3-South-South and Triangular Cooperation: Partnership between RO & CO towards launch of Arab Parliamentarians Forum for Population and Development; active participation of CO M&E Focal Point in ASRO's peer mechanism for learning, implementation and alignment in evaluation. Triangular cooperation through Y-Peer network (HQ and Arab region); and participation of 2 CAPMAS staffers in US Census Bureau statistical training.

4-Good visibility with quite a room for improvement. Taa Marboota was helpful to improve reactive image of CO despite appreciated technical competence

Evaluation Question (EQ) 5d:
UNCT Coordination: To what extent was this coordination (national stakeholders and UNCT) effective to boost the program implementation and achieve better results?

Assumptions to be Assessed	Indicators	Sources of information	Methods and tools for data collection

1.UNFPA country programme led to improved coordination, responsiveness, cooperation for partnership building among UN organizations, IFIs and key government institutions to meet UNFPA country programme results	1.Number and size of partnered programs in the 9th cycle 2.Satisfaction with partnership building in UNFPA programme 3.Documented, replicated and up-scaled initiatives in UNFPA partnered relation 4.Number of SSC and triangular cooperation initiatives	Direct stakeholders: UN agencies, UNRC, CO, RO, IFIs, key government institutions (NPC, CAPMAS, MOIC, MOSS, Baseera etc.)	Document review of UNFPA and UNDAF documents Interviews with key partners: donors and government -Online survey

*Online Survey:

* The majority of respondents (30.4% as satisfactory and 8.9% as highly satisfactory) believed that the coordination performed by UNFPA and UNCT was satisfactorily effective to boost the CP implementation and achieve better results. The reasons posed by respondents contained: UNFPA was able to coordinate UNCT around a pivotal strategy for GBV, population strategy, and youth and adolescents through consultations; was able to forge coordination links between UNFPA and NPC; played a critical role in UNCT; intensifies its efforts in realizing its planned results;
* The second category of respondents in line (26.8%) were unable to judge this coordination. Others were also on the downside in UNFPA's ability to coordinate. Reasons forwarded were: attributed to lack of coordination and coherence of the UN system in general; unsatisfactory coordination with national partners; and the inherent competition among UN agencies renders coordination inadequate.

YRH

Y-Peer can be example of triangulated programmes. Its initiated and supported by HQ. It has representative in different offices and there was south to south cooperation with other Y-Peer members. The implementation of Y-Peer happened in majority of governorates in Egypt using standard materials developed by UNFPA HQ. Y-Peer Egypt managed to tailor the materials developing new manual for FGM. Y-Peer face challenges in monitoring their effect and ensure sustainability.

GE

- Active in discussions and taking lead on GBV interventions.
- FGM project, strong coordination of an already active mechanism, has strengthened efforts and effectively boosted program implementation.
- Donors have reported weak results monitoring and reporting by UNFPA, leading to ineffective reflection of results chain. Also, Missing link at community level, where interventions needed to stir public debate and contribute with stronger evidence to national dialogue.
- IPs report weak reporting to partners on UN activities on related topics, and weak or no linkages made between interventions in other agencies (FGM aside)

PD

Response contained in previous EQ7