



Summative Evaluation

Strengthening the Contraceptive Security System Project within MoHP/Egypt

2008 – 2013

Prepared By

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Gihan Shawky

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List of Acronyms

AWP	Annual Work Plan
CAPMAS	Central Agency for Public Mobilization and Statistics
CCA	Common Country Assessment
CCR	Contraceptive Coverage Rate
CP	Country Programme
CPAP	Country Programme Action Plan
CPE	Country Programme Evaluation
CPD	Country Programme Document
CPR	Contraceptive Prevalence Rate
CS	Contraceptive Security
CSP	Country Strategic Plan
DAC	Development Assistance Committee
DP	Development Plan
EDHS	Egypt Demographic and Health Survey
EPTC	Egyptian Pharmaceutical Trading Company
FIFO	First in First out
FP	Family Planning
GEM	Gender Empowerment Measure
GII	Gender Inequality Index
GNI	Gross National Income
HIO	Health Insurance Organizations
GoE	The government of Egypt
ICPD	International Conference on Population and Development
IDSC	Information and Decision Support Centre.
IMR	Infant Mortality Ratio
IP	Implementing Partners
LMIS	Logistic Management and Information System
MMR	Maternal Mortality Ratio
MoF	Ministry of Finance
MoHP	Ministry of Health and Population
MYFF	Multi-Year Funding Framework
ODA	Official Development Assistance
OJT	on-the-job training
PR	Progress Reports
PRCU	Primary Health Care Unit
RBM	Result Based Management

RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
SDP	Service Delivery Points
SP	Strategic Plan
TFR	Total Fertility Rate
ToC	Theory of Change
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

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Key facts Egypt

Land	
Geographical location	Northeast corner of the African continent (2)
Land area	1,001,449 square km (4)
Terrain	Much of the land is desert and only 6% of Egypt area is inhabited. The majority of Egyptians live either in the Nile Delta located in the north of the country or in the narrow Nile Valley south of Cairo. (2) (4)
People	
Population	81.4 million (Jan. 2012 est.) (6)
Urban population	43.6% (2012) (1)
Population Growth Rate	1.7% (2010-2015) (1)
Government	
Government	Republic; constitution adopted 2012
Key political events	Revolution in July 1952 Revolution in January 2011
Seats held by women in national parliament, percentage	2.2 (2012, national parliament) (1)
Economy	
GDP per capita 2011 PPP US\$	5,547 (2011) (1)
GDP Growth rate	5.1% (2010) (9)
Main industries	Yarn & textiles, Chemical, Food and Basic metallic (5)
Social indicators	
Human Development Index Rank	112 (1)
Unemployment	11.99% (2011) (6)
Life expectancy at birth	73.5 years (2012) (1)
Under-5 mortality (per 1000 live births)	22 (2004-2008) (1)
Maternal mortality (deaths of women per 100,000 live births)	66 (2010) (1)
Health expenditure (% of GDP)	1.7 (2010) (1)
Births attended by skilled health personnel, percentage	78.9 (2)
Adolescent fertility rate (births per 1000 women aged 15-19)	40.6 (2012) (1)
Condom use to overall contraceptive use among currently married women 15-49 years old, percentage	0.7 (2)
Contraceptive prevalence rate	60.3% (2)
Unmet need for family planning (% of women in a relationship unable to access)	9.2% (2)
Prevalence of HIV, among adults aged 15-49, percentage	<0.1 (2011, WHO) (8)
Adult literacy (% aged 15 and above)	72 (both sexes) (2010) (1)

Total net enrolment ratio in primary education, both sexes	97 (2010, UNESCO)(9)
Millennium Development Goals (MDGs): Progress by Goal(3)	
1. Eradicate Extreme Poverty and Hunger	On track ¹
2. Achieve Universal Primary Education	On track
3. Promote Gender Equality and Empower Women	Slow ²
4. Reduce Child Mortality	On track
5. Improve Maternal Health	On track
6. Combat HIV/AIDS, Malaria and other Diseases	On track
7. Ensure Environmental Sustainability	Insufficient information
8. Develop a Global Partnership for Development	Insufficient information

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¹ Very likely to be achieved,

² Possible to achieve if some changes are made

Executive Summary

The UNFPA Egypt country office, as part of its assistance to the Government of Egypt is supporting the project titled ‘Strengthening the Contraceptive Security System’ within Ministry of Health-Family Planning & Population Sector. The project targets the various pillars of CS, from commitment and coordination to policies and service delivery. It aims also to build the national capacity both at the central and local levels on logistics functions, logistics data & product selection. The project budget is 4.9 million Egyptian Pounds.

Purpose of project’s evaluation

The present evaluation assesses the extent to which the project effectively met its stated results. The evaluation seeks to provide implementing partners with practical recommendations for the consequent intervention. Also, it is to ensure substantive accountability for the investments made and to help improve the relevance and quality of future country office programming. This evaluation follows mostly UNFPA Handbook on How to Design and Conduct a Country Programme Evaluation (HB)

The Methodology

The evaluation criteria defines the broad aspects that are assessed in the analysis. Relevance, effectiveness, efficiency, sustainability, responsiveness and added values are the applied the criteria. The scope of the evaluation is focused on sixteen evaluation questions examining key components of the project, and assessing to what extent the project achieved its objective and contributed to UNDAF and CPAP outcomes and outputs.

The criterion of selection is geographical representation so one governorate in Lower Egypt and another in Upper Egypt were selected purposively. The consultant selected Sharkia and Assuit governorates, from the initial intervention governorates. The evaluation used a staged random sampling process to select the districts to be included in the evaluation.

Concerning the added governorates, the project coordinator mentioned that a little progress had been achieved in Menia, Sohag and Qena due to the security situation after 25th January revolution. However there is great progress in Cairo but there are some obstacles in Alexandria that affected the progress there. As a result of that the consultant selected Cairo and Alexandria.

Concerning districts’ selection, the consultant defined districts characterized by high population density and classified as middle or low- income district in each selected governorate. Two districts were randomly selected in Sharkia and Assuit governorates, one district in Cairo and another in Alexandria. In total, six districts are selected randomly³. The geographic distribution of evaluation sites is considered so that sites are distributed in the Cairo and Alexandria governorates as well as upper and Lower Egypt.

The evaluation draws on information from a desk review of project documents (refer to annex III), individual semi-structured interviews with officials in MoHP/FPS, UNFPA staff, representatives of EPTC, additional interviews in sampled governorates and focus group discussions with nurses and

³ Based on data collection extended for two weeks only, the data collection team cannot collect the details required data from more than 6 districts

beneficiaries. The combination of different types of information, data collection methods and data sources maximized the validity of the findings as same information were gathered from several sources (triangulation).

Finally the evaluation process is divided into six stages namely; desk review phase, developing design study, data collection, Preliminary findings and analysis, developing the evaluation Report and disseminating the results.

Evaluation scope

It covers the overall project, design, delivery, performance and management systems. The following criteria are discussed:

Main Findings

Relevance

This project is relevant to Egypt context, contributes to policies and strategies of UNFPA (UNDAF outcome 1, UNDAF output 3.3, CPAP outcome 3 and CP output3) and is relevant to the real needs of rights holders (demand side)

This project is relevant to Egypt context because it contributes to Egypt's efforts to meet ICPD goals and MDGs 1, 3 and 6. Egypt is signatory to both of ICPD and MDGs and has to implement policies to achieve these goals. Strengthening the contraceptive security system project in Egypt complements these efforts. It is also aligned with government priorities for funding and procuring contraceptive after USAID phase out, as well as policies to reach national goal of 2.1 as a replacement level fertility by the year 2017. In addition, the project contributes to UNFPA country program 2007-July 2013(CPAP outcome 3 and CP output3). Finally, its relevance towards the real needs of rights holders (demand side).

Effectiveness

Adequate finance and functional logistics system are two important aspects of RHCS program planning. Thus, different trainings were conducted to build the capacity of nurses, doctors, statisticians, storekeepers, and project team. It also strengthened the project team supervisory role and OJT through regular travels to the field, preparation of curriculum for trainings, materials for advocacy & coordination. Operations researches & assessment were conducted to build evidence to support decisions. The project met its objectives and the evaluation concluded that CS project is effective for the followings:

- The project supports MoHP in developing their capacities & establishing mechanisms to ensure ownership and sustainability of effects through promoting in-house expertise
- The multiple training conducted to nurses to maintain max / min stock level in PHCs, new methods, OJT to nurses and FP manger were effective. However training conducted to statisticians (Spectrum training) was not effective were statisticians in governorates did not forecast the required quantities of contraceptives in their governorate.
- The advocacy activities were effective in increasing budget for contraceptive procurement & attribute budget annual increase to the project meetings with the finance people in MoF.
- The generated data is sufficient and accurate to develop the key indicators that used to measure outputs and outcomes.

- The project benefits have not been efficiently achieved across all target governorates
- The coordination role of the project and meetings held among stakeholders namely, NPC, Pharmaceuticals and other MoHP Sectors were successful.

Efficiency

Based on Quarterly & annual implementation progress reports, AWP, it is indicated that the available resources (funds and staff) were managed efficiently where the consultant assured that cost have not been overrun or exceeded the planned budget. In addition to this, there were not cancelled activities. Actually revisiting, updating and upgrading TA8 started in 2009 and the activity was not completed due to the merging of NPC into the new ministry at that time, in 2010 the final certified Form of TA8 was disseminated. Besides all implemented activities are converted into outputs that constituted to achieve the project's key results, except Spectrum training for statisticians at governorates level.

Sustainability

The programme design incorporates sustainability factors as indicated in AWP and annual monitoring forms. The staff working in the project is the doctors of the MoHP/FPS and their work at the Ministry is related to and benefits from the success of the project. In addition the project supports in developing their capacities & establishing mechanisms to ensure ownership and sustainability of effects through promoting in-house expertise.

Responsiveness

UNFPA responded to project's request to purchase Implanon as it is a long term contraceptive and an expensive contraceptive so the procurement of Implanon is restricted to budget availability and funds can be allocated. Also the project trained 56 statisticians to build their capacity during 2012, it was responsive to a request from Head of FP department.

Added Values

The main project added value in the country context is:

- The project's key results achieved contributed to institutional change for the implementation of CS system.
- Introducing new methods of contraception; emergency contraception, local vaginal suppositories and the monthly injectable that got high acceptability by service providers and FP users.

The three new FP method mix could contribute in adding new FP clients as well as method shift due to less side effects compared to current FP method mix. Capitalizing on adding the three new methods in the FP method mix cafeteria could effectively reduce unmet needs and discontinuation rates.

- Achieving a sustainable funding mechanism and this funding can be increased to secure the increasing required resources. A condition for increasing such funding required that the Department of Contraceptives confirms and proves the financial need for this increase.

Learned Lessons

- The programme design has to incorporate sustainability factors.
- The Capacity-Building of employees and empowerment are the main success elements of any institutionalizing new systems.
- The importance of secured supply and high quality service to improve access.
- Division of role amongst partners is a must to ensure clarity of authority and accountability as well as better coordination of benefits for target PHCs.
- The availability of completed databases
- Establishing mechanisms to ensure the feeling of ownership among project's staff.
- Establishing project's monitoring system from the beginning.

Conclusions

Project's design:

- Project's design is realistic and relevant to Egypt context; the project was based on realistic assumptions . it contributes to Egypt's efforts to meet ICPD goals and MDGs 1, 3 and 6 where Egypt is signatory to both of ICPD and MDGs and has to implement policies to achieve these goals. It strengthens the contraceptive security system project in Egypt, as well as it is aligned with government priorities for funding and procuring contraceptive after USAID phase out, as well as policies to reach national goal of 2.1 as a replacement level fertility by the year 2017.
- The project results logframe is developed, following the RBM approach. Project AWP's incorporate activities that contribute to the project key result. A focus on the destination/result is an approach that maximizes benefits and results of medium-size projects.

Project's monitoring:

- The management role performed by UNFPA CO is considered one of the basis for the success of the program in achieving its objectives. Close follow up of the National Programme Associate to project team who follow up FP managers in health directorates, staff working in health units, & storekeepers, EPTC staff for following up the inventory level and the distributed quantities among governorates are basis of the good monitoring that contribute to achieved results
- The project result matrix gave the potential for strengthening the capacities of counterparts to monitor progress and cultivate a RBM approach; by end of each year the project's management computed project's key indicators, and develop the following AWP accordingly.
- Updating checklist, according to project's logistics system to monitor FP clinics in PHCUs and institutionalization in the quality standards of PHCs, and the three curricula developed by project team contributed to laying the groundwork for promoting in-house expertise and the practice of having follow-up tools. Furthermore these outputs are considered factors of system sustainability after phase out of the project.

Advocacy:

- Project contribution has been influential in the increased national budget for contraceptives procurement; the project management and the financial management in the population sector succeeded in negotiating with the Ministry of Finance about increasing budget allocations for the procurement of contraceptives. In addition, the path has been paved for future increment.

Management and performance in PHCUs:

- Division of role amongst partners in target governorates is a must to ensure clarity of authority and accountability as well as better coordination led to secured supply and high quality of service. In return access is improved.
- Incentives practice can be used to improve employees' performance; in 2012 the project's management and UNFPA staff approved to select best performers based on evidence of
 - Max-min stock level.
 - Counseling services to beneficiaries (through number of beneficiaries & collected feedback)
 - Promptness in providing the monthly data to central level.

Every quarter four Service Delivery Points (SDP) and two districts are selected to receive incentives to raise competition and improve their performance.

The project's success elements

The project strengthens and sustains the CS system in Egypt, because the project supports doctors working in the Department of Contraceptives, pharmacists and workers in the same Sector⁴ in MoHP/FPS in developing their capacities & establishing mechanisms to ensure their ownership and sustainability of effects through promoting their expertise. Also the project's management coordinated among different stakeholders to ensure data's accuracy through the availability of multiple sources of data.

Recommendations

All recommendations are aimed at ensuring the sustainability of the CS system. These recommendations are:

- **MoHP/FPS should plan for succession and create a second line of management in contraceptive Sector and in directorates of health to ensure the continuation of CS system.** Currently the head of department of contraceptives participated in developing guidelines for procurement's procedures of contraceptives & guidelines for logistics training for nurses' training, updating checklist, determining the required quantities of contraceptives, procuring future requirements and coordination with pharmaceutical companies. The Sector should assign a deputy to the post to ensure business continuity. The same at the governorate level, how far the system succeeds depends mainly on the FP manager in the directorate of health and his coordination between PHCUs, departments of health and directorate of health. So it is recommended to assign assistants to managers who can succeed them in case of promotion or separation. Hence the MoHP/FPS guarantees satisfactory performance .

⁴ The project's objectives are relevant to the nature of their work

- **To ensure achieving the project’s benefits efficiently across all target governorates, departments of contraceptives and family planning in MoHP/FPS have to coordinate together and follow up on the performance of FP managers in health directorates in managing the implementation of CS system in all PHCUs in the governorate.** FP managers in health directorates have been oriented on the project, its aim, CS system and the importance of coordination between health units and pharmacists (officials of contraceptive stores) in health departments and their relationship with pharmacists responsible for contraceptive stores in the health directorate. However there is a disparity in system’s performance between the various health units in the same governorate and between governorates.
- **To ensure Pharmaceutical Companies shoulder their social responsibility towards FP, department of contraceptives in MoHP/FPS has to strengthen their cooperation with them.** The project succeeded in cooperating with pharmaceutical in pricing the contraceptives with economic prices, supplying new methods and developing IEC materials for the new methods so the department of contraceptives in MoHP/FPS has to maintain this cooperation.
- **To ensure broader coverage for beneficiaries in reproductive age, FP Sector should guarantee scaling up of CS system and expanding it to non-intervention governorates.** This includes orienting FP managers on CS system and its importance to ensure secured supply and improved access. As the services providers and nurses in PHCUs in these governorates were already oriented by CS system and applied min/max stock level.??
- **To activate the initiative to strengthen NGOs role in RHCS, department of NGOs in MoHP should set criteria for selecting NGOs.** The project contracted the NGOs had a desire to participate in project regardless their capabilities so department of NGOs in MoHP should select NGOs according to the defining set criteria.
- **LMIS unit has to keep all data related to CS system** such as number of trainees & other training data and the required quantities of contraceptives at governorate level to have one source of information.
- **Donors’ close monitoring to all projects nationwide is highly recommended.** Continuous and almost daily follow up on the project team contributed to a higher level of efficiency and diligence.

Chapter 1: Introduction

In 1994, the International Conference on Population and Development set forth the goal of universal access to reproductive health services by 2015. Contraceptive security (CS) is an essential element in attaining this goal, as well as contributing to the achievement of the Millennium Development Goals.

Contraceptive security is achieved when couples have regular, reliable, and equitable access to a choice of contraceptive methods to meet their needs. The government of Egypt (GOE) initiated CS activities in 2003 to strategically prepare for the phase out of donated contraceptive commodities by 2006. Therefore CS has become a priority not only because of the health and economic benefits of family planning, but also because of changes in demographic trends, the demand for family planning (FP), and the ways development assistance is administered.

Reproductive Health Commodity Security (RHCS) is achieved when all individuals can obtain and use affordable quality Reproductive Health (RH) commodities of their choice when they need them. Reproductive Health (RH) commodity includes; equipment, pharmaceuticals and supplies for obstetric and maternal health care; the prevention, diagnosis and management of reproductive tract infections and sexually transmitted infections; and contraceptive supplies.

Since mid-2008, and in line with UNFPA mandate and the 2007-13 country programs, UNFPA Egypt Country office (CO) is supporting the project titled 'strengthening the contraceptive security system' with Ministry of Health/Population Sector. The project targets the various pillars of CS, from commitment and coordination to policies and service delivery. It aims also to build the national capacity both at the central and local levels on logistics functions, logistics data & product selection.

1.1 Purpose and objectives of the project evaluation

The purpose of this project evaluation is introducing a summative evaluation to prove that the Project effectively met its stated results. The evaluation seeks to provide implementing partners with necessary information for their future decision. Also, it is to insure substantive accountability for the investments made and to help improve the relevance and quality of future country office programming. This evaluation follows mostly UNFPA Handbook on How to Design and Conduct a Country Programme Evaluation (HB)

The evaluation's objectives are to:

- Assess how far the project has succeeded in strengthening the capacity of the contraceptive security system within MoHP and how sustainable could the achieved results be;
- Assess how far the project has succeeded in strengthening the capacity of the targeted duty bearer (FP staff at central, district and PHC level) and the sustainability of the achieved results;
- Assess how far the project has contributed in encouraging coordination among different stakeholders (Pharmaceutical, NGOs, other national bodies);
- Provide key findings, prepare conclusions, and present a host of clear and forward-looking options that lead to strategic and practical recommendations for the consequent intervention.

1.2 Scope of the evaluation

The evaluation covers the on-going project that started Mid 2008. It covers an analysis of the relevance, efficiency, effectiveness, and sustainability of the achieved results, as well as the added value of the intervention. The evaluation scope covers the overall project, design, delivery, performance and management systems as well.

The project was implemented in five governorates named and another five more governorates were added in 2011. The evaluation is applied in four governorates; two governorates from the first stage and two governorates from the extended governorates.

1.3 Evaluation methodology and process

1.3.1 Evaluation process

The evaluation process is divided to six stages as follows:

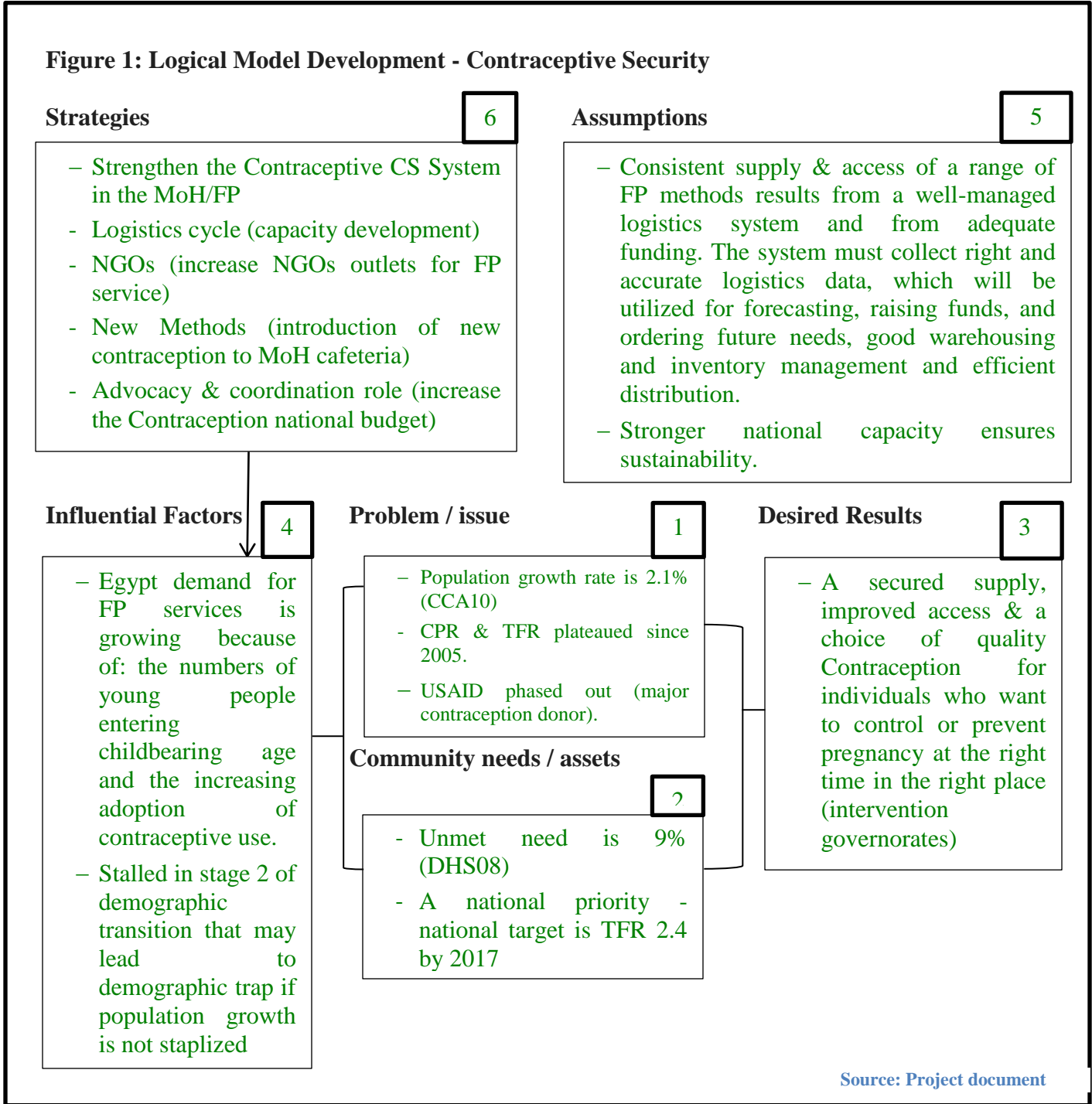
Table 1: The evaluation process

Stage	Description
Desk review phase	This phase started directly after signing the contract where the consultant reviewed the project documents, (see annex III), and continued through data collection and analysis.
Developing design study	This phase started after the consultant reviewed the project's documents and developed the evaluation design. Out of this phase a design report is submitted to UNFPA CO before conducting field work. the design report included; <ul style="list-style-type: none"> – Adjusted and refined evaluation matrix; – A work-plan to reflect timelines; – An agenda covering the field phase; – Validation mechanisms that enable the verification of preliminary findings where data should be collected during field work to answer evaluation questions were identified.
Data collection	It extended for three weeks, during the first week the consultant and her assistants interviewed officials in MoHP and stakeholders in Cairo governorate, however in the second week they collected data from Sharkia and Assuit governorates. In third week UNFPA staff and officials in EPTC and other officials in MoHP were interviewed and re-interviewed project coordinator
Preliminary findings and analysis	Based on a three-week field mission for the data collection and analysis phase, preliminary results was presented to the CO. UNFPA staff, reference group and key partners submitted their comments to the consultant. The consultant reviewed their comments and feedback.
Developing the Evaluation Report	Based on the comments and feedback, the consultant develops the final report using the template of the report in UNFPA evaluation handbook.
Disseminating the results	After submitting the final report to UNFPA CO, the consultant will prepare a power point presentation to disseminate the evaluation results.

1.3.2 Logical model of contraceptive security project

It is worth mentioning that reviewing the developed project’s logical model was the first and essential step in evaluating CS project before applying the evaluation methodology.

Figure 1: Logical Model Development - Contraceptive Security



The previous figure summarizes the project strategies and the main assumptions behind it to achieve the target results. Accordingly the project's activities focused on strengthen the logistics system, increasing the number of NGOs outlets that provided FP service, introducing new contraception to MoHP cafeteria and advocating & coordinating with MoF to increase the Contraception national budget, to achieve a secured supply, improved access & a choice of quality Contraception for individuals who want to control or prevent pregnancy at the right time in the right place in target governorates.

1.3.3 Evaluation criteria

The evaluation criteria defines the broad aspects of the CS project that are assessed in the analysis of to what extent it achieved its objectives and its contribution to UNDAF and CPAP outputs and outcomes. The following criteria are applied in this evaluation:

- **Relevance:** It measures the extent to which the objectives of the CS project are adapted to national needs and are aligned with government priorities as well as policies and strategies of UNFPA.
- **Effectiveness:** It measures the extent to which the objectives of CS project have been reached. The consultant looks at the degree of achievement of outputs and outcomes and the breadth and depth of outputs and outcomes
- **Efficiency:** The scope of the efficiency criterion is carried on the relation between CS project's inputs and outputs. It is a measure of how resources / inputs (funds, expertise, time, etc) are converted into results or the extent to which outputs and / or outcomes are achieved with the appropriate amount of resources / inputs (funds, expertise, time, etc).
- **Sustainability:** The continuation of benefits from CS project after its phase out.
- **Responsiveness:** The ability of the CO to respond to the changes and/or additional requests from MoHP.
- **Added values:** The main project's added value in the country context as perceived by national stakeholders.

In addition to previous criteria lessons learned also are assigned. They are both of good transferable practices to other projects or countries that have been observed during the evaluation analysis and the bad practices that the other projects have to avoid.

1.3.4 Evaluation questions based on evaluation criteria

The evaluation questions are used to refine the focus of the evaluation. They are at the core of CS project evaluation. Answers to these questions constitute the main body of analysis in the evaluation report and provide the main inputs that the evaluation offers for recommendations, added value and lessons learned.

It is worth mentioning that the interviewers will answer some of the following evaluation questions and the consultant will reach to the answer of the other questions during data analysis stage.

Relevance

To what extent the objectives of CS project are adopted to national needs (needs of RH to meet the needs of individuals who want to space or prevent pregnancy at the right time, national goal of reaching replacement level by 2017) and are aligned with government priorities for funding and procuring contraceptive after USAID phase out, as well as policies and strategies of UNFPA (UNDAF outcome 1, UNDAF output 3.3, CPAP outcome 3 and CP output3)?

- UNDAF outcome 1: By 2011, state's performance and accountability in programming, implementing and coordinating action, especially those that reduce exclusion, vulnerabilities and gender disparities, are improved.
- UNDAF output 3.3: Access to high quality family planning, maternal and child care services increased with improved utilization of primary health care / family health facilities.
- Expected CPAP outcome 3: Sustainability and quality of reproductive health services at national level and at service delivery points are improved.
- Expected CP output 3: Capacity of government and non-governmental health organizations strengthened in the areas of management, planning and monitoring.

Effectiveness

- To what extent were the expected output (key result) of the project achieved (both in terms of quantity and quality) in particular with ability to accurately forecast, adequately finance, technically procure, & properly distribute the project key result is to achieve a secured supply, improved access and an assured choice of quality contraceptives for individuals who want to space or prevent pregnancy at the right time?
- To what extent are the multiple trainings conducted effective, in particular the logistic one to nurses to maintain max/min stock level in PHCs, new methods, Statisticians, FP Manager?
- To what extent are advocacy activities effective to create budget line for contraceptive procurement & attribute budget annual increase to the project?
- What are advocacy activities that had been taken to create budget line for contraceptive procurement & attribute budget annual increase to the project was due to advocacy activities?
- Based on the developed indicators assess the quality & sufficiency of data generated and utilized on keys aspects of the project and used to measure outputs and outcomes, what are the indicators used to assess the quality & sufficiency of data generated and utilized on keys aspects of the project and used to measure outputs and outcomes.
- Analyze how have the achieved key results contributed to institutional change?
- Check whether the project benefits have been localized or widely spread across target governorates.
- Assess the coordination role of the project among stakeholders namely, NPC, Pharmaceuticals, NGOs, Private Sector & other MoHP Sectors?

Efficiency

- How appropriately and adequately are available resources (funds and staff) being managed and used to carry out activities?
- To what extent activities are converted into outputs.

Sustainability

- To what extent are the benefits of the intervention likely to continue beyond the project closure?

Responsiveness

- To what extent is the adequacy of UNFPA response to different levels need?
- What are these?

Added Value

- What is the main project added value in the country context as perceived by national stakeholders?
- Assess the added value of the supervisory role of the project & OJT that took place during the life of the project.

Lessons Learned

- What are lessons learned or good transferable practices to other programmes or countries have been observed during the evaluation analysis?

1.3.5 Methods for data collection and analysis

The evaluation depends mainly on both of qualitative and quantitative data. Concerning qualitative data a multiple methods of qualitative approach are used; desk reviews, focus group discussions, semi structured interviews (in-depth interviews) and field visits to answer the evaluation questions that have been stated in evaluation matrix (annex 5). The methods are applied as follows:

Table 2: Data collections methods

Data collection method	Documents or with whom	CRITERIA
Desk study	AWPs, assessment of national logistics, Project ToC, Project document, relevant research, trainings records, logistics management and information system (LMIS), Project Trip reports, Monitoring records, Minutes of meetings, relevant documents such as the budget line for contraceptive procurement in the annual contraceptive national budget, M&E framework indicators, Quarterly & annual implementation progress reports.	Relevance, Effectiveness, Efficiency and Sustainability
In- depth interview ⁵	UNFPA staff, project management in MOHP, FP manager in MoHP, officials in MoHP at local level, who is responsible of warehouse in PHCs & at the district level, worker who are responsible of LMIS (statisticians) at local & central level, other MoHP Sectors, representatives of pharmaceuticals companies, NGOs that provide FP services and private Sector.	Relevance, Effectiveness, Efficiency, Sustainability and added value

⁵ Through the evaluation's data collection 35 in-depth interviews were conducted

Data collection method	Documents or with whom	CRITERIA
FGDs ⁶	trained nurses at local level and beneficiaries (women benefited from the project) and Service providers in PHCUs.	Relevance and Effectiveness, added value and lessons learned.

Concerning the quantitative analysis in the evaluation, it depends mainly on the data provided from LMIS and quantitative indicators that extracted from this data. The consultant made sure from the accuracy of this data as there is coincide between data available at LMIS unit and TA8.

It is worth mentioning that the consultant evaluates the CS project and two qualitative researchers help her during data collection phase.

1.3.6 Sample Selection

The evaluation sample is divided to two parts; sample at the central level and sample of different stakeholders in target governorates. Based on CS project implementing plan⁷, the project started in five governorates and other five governorates were added in 2011.

Governorates' selection:

The consultant selects two random governorates, from the five governorates where the project was implemented in 2008 namely Sharkya, Menofia, Beni-Sueif, Fayoum and Assuit; the criterion of selection is geographical representation (i.e. one governorate in Lower Egypt and the second in Upper Egypt). They are Sharkia and Assuit governorates.

Concerning the added governorates, the project coordinator mentioned that a little progress had been achieved in Menia, Sohag and Qena due to the security situation after 25th January revolution. However there is great progress in Cairo but there are some obstacles in Alexandria that affected the progress there. As a result of that the consultant selects randomly one district in Cairo and another one in Alexandria, to study the reasons of differences in the performance between these two governorates although both of them are urban governorates and the project was implemented at the same time.

Districts' selection:

The consultant defined districts characterized by high population density and classified as middle or low-income district in each selected governorate. Then she selected two districts randomly in Sharkia and Assuit governorates and one district in Cairo and Alexandria governorate. Accordingly six districts are selected randomly⁸. Hence geographic distribution of evaluation sites is considered so that sites are distributed in the Cairo and Alexandria governorates as well as upper and Lower Egypt are included.

⁶ Through the evaluation's data collection 12 FGDs were conducted.

⁷ See section 3.2.1

⁸ Based on data collection extended for two weeks only, the data collection team cannot collect the details required data from more than 6 districts

Table 3: Sample sites

Governorate	Districts
Cairo	El-Basateen
Alexandria	El-Montaza
Sharkia	Hehia, Menia El-Kameh
Assuit	El-Fateh, Abou Teeg

Stakeholders' selection

Last but not least the stakeholder selection criteria can be summarized as follows:

- The sample included all type of stakeholders for each given output / outcome, i.e. IP, EPTC, NGOs, primary and secondary beneficiaries and UNFPA.
- For each output / outcome the sample included both stakeholders associated to on-going activities and with activities (AWPs) that have already been completed.

Table 4: The sample of Stakeholders

Geographical	Stakeholders
Central Level	<ul style="list-style-type: none"> – UNFPA Staff (National programme associate, and Rep Assistant). – Project Management in MoHP (project coordinator, LMIS manager, FP manager in MoHP, Dr. Hossam the Head of population sector, MoHP and project financial officer). – Manger of contraceptive department in MoHP. – Representatives of EPTC.
Sharkia, Assuit and Cairo governorates.	<ul style="list-style-type: none"> – Nurses and head of nurses working in the FP clinic in selected PHC in targeted districts to hold FGD with them. – Hold a FGD with women beneficiated from the project in each selected PHC in targeted district. – Conduct in-depth interview with service providers working in the FP clinic in selected PHCU in targeted districts – Conduct in-depth interview with a nurse and who is responsible of FP clinic in a NGO in selected governorates. – Worker who are responsible of warehouse in the PHCU, department of health in targeted district and directorate of health in selected governorates. – LMIS (statisticians) at the directorate of health in selected governorates – Conduct in-depth interviews with FP manager in directorate of health in selected governorates.

1.3.7 Evaluability assessment.

The evaluation depends on primary and secondary qualitative data and secondary quantitative data. Triangulation techniques are used to grantee the credibility and validity of findings, judgments and conclusions of the evaluation.

Triangulation implies double or triple checking the results of the data analysis by way of cross-comparing the information obtained via each data collection method (desk study, in-depth interview and FGDs).

In addition to the consultant and the two qualitative researchers held internal meetings during data collection and analysis phases to share and discuss preliminary findings / conclusions.

1.4 Structure of the report

The present report comprises an executive summary, six chapters, and four annexes.

- The **introduction** provides the background to the evaluation, objectives and scope, the methodology used including the evaluation process and the structure of the report;
- The **second chapter** describes Egypt and the development challenges faced by the country in the areas of development, poverty, population, FP, ICPDs goals, MDGs and gender. In addition to the role of external assistance to Egypt;
- The **third chapter** refers to the response of the UNFPA through its country programme to the national challenges faced by Egypt in reproductive health, population and gender equality. Furthermore UNFPA response to strengthen contraceptive security system project in Egypt;
- The **fourth chapter** presents the findings of the evaluation for each evaluation criteria;
- **Chapter five** discusses learned lessons;
- **Chapter six** encompasses recommendations.

Chapter 2: Country context

Egypt is located at the northeast corner of the African continent; it covers an area of 1,001,449 km² that is mostly desert (Sahara). Only 6 percent of Egypt's area is inhabited with a population of 81.4 million inhabitants in 2012, Egypt has the largest and most densely settled population among the Arab countries at 1356 persons⁹/km².

Administratively, Egypt is divided into 27 governorates; four Urban Governorates¹⁰, nine of these governorates are located in the Nile Delta (Lower Egypt), nine are located in the Nile Valley (Upper Egypt), and the remaining five Frontier Governorates are located on the eastern and western boundaries of Egypt.

2.1 Development challenges and National strategies

Egypt's population has witnessed a remarkable increase over the previous decades. In the second part of the second century, the population rose sharply from 35.3 million in 1970 to about 81.4 million in 2012, i.e. more than doubled in almost 40 years.

Globally, the population growth rate has decreased from 2.6 percent in 1960 to 1.7 percent in 2010. But Egypt is still growing fast, with an average of 3 children per woman. The population is extremely young, as more than a half (54.3 percent) of the nationals are under 25 years old and 31.7 percent are under 15. That is to say that 33.2 percent of the whole population is between 10 and 25¹¹. On other-words, this pattern is typical of countries that have experienced relatively high fertility in the recent past.

Egypt has made significant improvements in overall socio-economic development. According to the UNDP statistical update of HDI, Egypt ranked 112 out of 186 on the human development index (HDI) in 2012, up from a 116 ranking¹² in 2008. Figure 1 indicates that the development index has been continually increasing since the 1970s where the more recent estimates, however, show a slight slippage in the ranking. Hence the steady improvement has pulled Egypt from the low to the medium category of human development.

The HDI is calculated on the basis of life expectancy, literacy levels and per capita income. Literacy rates have risen and reached 71 percent in 2010, and the country has experienced improvements in health, education, sanitation and other social services¹³. Life expectancy is 73.5 years. The unemployment rate continues to grow reaching 11.99 percent in 2011; while child labor is 7% among seven to fourteen years of age. Maternal mortality is estimated at 66, infant mortality is 19/1,000 and child mortality under the age of five stands at 22/1,000.

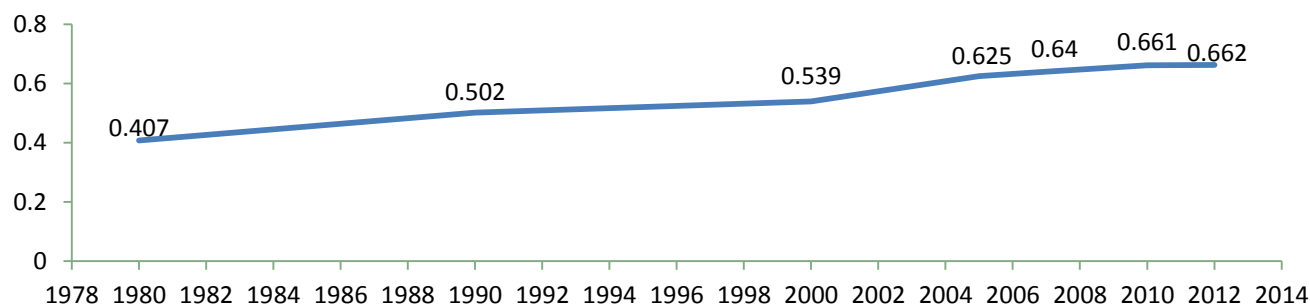
⁹ It is calculated from the available data.

¹⁰ They have no rural population

¹¹ These percentages are calculated based on: CAPMAS, Statistical Year Book (Jan. 2012), table 2-4 "Estimates of Midyear Population by age groups (2002 – 2011); http://capmas.gov.eg/pdf/Electronic%20Static%20Book_eng/population/untitled1/pop.aspx.

¹² Egypt ranked 116 out of 179 on the human development index (HDI).

¹³ Referring to Egypt's progress towards achieving MDG in 2010

Figure 2: Human Development Index in Egypt 1980-2012

Source: 2013 Human Development Report, UNDP.

The programme of Action of 1994 Cairo International Conference on Population and Development (ICPD) called upon all countries to take steps to provide universal access to a full range of safe and reliable family planning methods and related reproductive health services by 2015. Egypt is signatory of ICPD programme of Action and the Millennium Declaration.

There is a relationship between meeting the reproductive health needs and achieving MDGs; since family planning is critical for the health of women and their families, and it can accelerate a country's progress toward reducing poverty and achieving development goals, then universal access to reproductive health services, including family planning, is identified as one of the targets of MDGs.

It is worth mentioning that Egypt considers progress in CPR and TFR is a prerequisite for achieving its national population goal of achieving the replacement level (2 children/woman), i.e, TFR 2.1, by 2017 and its policy goal of reducing population growth.

The Family planning (FP) program has achieved successes; the Contraceptive Prevalence Rate (CPR) is up from 47.6 percent in 1991 to 60.3 percent in 2008. The Total Fertility Rate (TFR) has been slowly declining from 4.4 live born children per woman in 1988 to three in 2008, while the gap between the urban governorates and the rural ones has been reduced. The TFR has decreased because the 'average age at first marriage', the 'average age at first birth' and the 'contraceptive prevalence rate' have all increased. In spite of this and modern family planning methods are readily available in Egypt at low cost, a considerable proportion of women still have an unmet contraceptive need (9.2%)¹⁴.

The trend in population growth over the last few years indicates that Egypt has reached a plateau. This plateau can be attributed to many factors, including: the slowing down of fertility decline (total fertility rates (TFR) at 3.0); high adolescent fertility rate; unmet need is still around 10 percent; contraceptive discontinuation rate during the first 12 months of use is about 30 percent; and the gap between urban TFR (2.7) vs. rural (3.4) is still wide¹⁵.

EDHS 2008 indicated that some women who say they would prefer to avoid a pregnancy are currently using a family planning method, while others—those with unmet need—are not. Globally, women who

¹⁴ Egypt Demographic and Health Survey 2008.

¹⁵ <http://egypt.unfpa.org/english/search.aspx?searchterm=Common%20Country%20Assessment>

want to avoid pregnancy but are not using an effective method of contraception account for 9.2 percent of married women aged 15-49 years old. An analysis of the 2008 EDHS shows that if Egyptian women could successfully avoid births resulting from unintended pregnancies, the country's total fertility rate (lifetime births per woman) would decline from 3.0 children per woman to 2.4 and there are 14 percent of pregnancies in Egypt are unintended.¹⁶

Gender equality is one of the eight Millennium Development Goals as well as a human right. Yet discrimination against women and girls includes gender-based violence, economic discrimination, reproductive health inequities, and harmful traditional practices but it remains the most persistent form of inequality.

In spite of substantial improvements in female literacy rates, enrolment rates, labor force participation, and unemployment, there remains a gender gap in favor of males. Egypt's rank on gender empowerment measure, in the 2005 Human Development Report¹⁷, was 77 out of 80 countries with a value as low as 0.274 that decreased to 0.263 in 2008¹⁸. However the Gender Inequality Index¹⁹ (GII) was 0.590 in 2012 slowing down from the value 0.603 in 2005.

2.2 Advancement towards the Millennium Development Goals (MDG)

Since Egypt signed the Millennium Declaration a lot of progress has been made in all the related areas. Egypt shows that at the aggregated national level the country remains on track to reach the targets of the great majority of MDG indicators. The government has continued to give attention to critical areas of development, such as health and education, access to water and sanitation, as well as improving the livelihood of the most deprived segments of the population²⁰.

However, the pace of progress towards these targets varies among the goals; fast and sustained in child & maternal mortality and water and sanitation, at acceptable levels for education and poverty reduction, while somewhat more slowly in women empowerment and do not have sufficient information for the environment and global partnership for development.

Finally, 2010 MDG progress report²¹ showed that the disparities in development progress between Upper and Lower Egypt, between rural and urban areas and between women and men remain stark and demonstrate the need for greater and better targeted investments to address these differences.

2.3 The role of external assistance

Concerning external assistance in Egypt, net Official Development Assistance (ODA) is disbursement flows (net of repayment of principal) that meet the Development Assistance Committee (DAC) definition of ODA, by multilateral institutions, and by non-DAC countries to promote economic development and welfare in countries and territories in the DAC list of ODA recipients.

¹⁶ UNFPA, Arab State Regional office, Women's Need for Family Planning in Arab Countries, July 2012, <http://arabstates.unfpa.org/webdav/site/as/shared/ASRO%20website/Publication/family-planning-arab-countries.pdf>

¹⁷ 2005 Human Development Report, http://hdr.undp.org/en/media/HDR05_complete.pdf

¹⁸ 2008 Human Development Report, http://hdr.undp.org/en/media/HDR_20072008_GEM.pdf

¹⁹ International Human Development Indicators, <http://hdrstats.undp.org/en/indicators/68606.html>

²⁰ 2005 Country Common Assessment (CCS)

²¹ Egypt's Progress towards Achieving Millennium Development Goals 2010, Ministry of Economic Development, UNDP.

Table 5: The Top Ten Donors of gross ODA according to the average money they committed in 2010 -11.

Top Ten Donors of gross ODA (2010-11 average)		(USD m)
1	United States	212
2	France	196
3	Germany	183
4	Kuwait (KFAED)	147
5	Japan	141
6	Arab Fund (AFESD)	140
7	EU Institutions	102
8	United Arab Emirates	21
9	United Kingdom	17
10	Italy	16

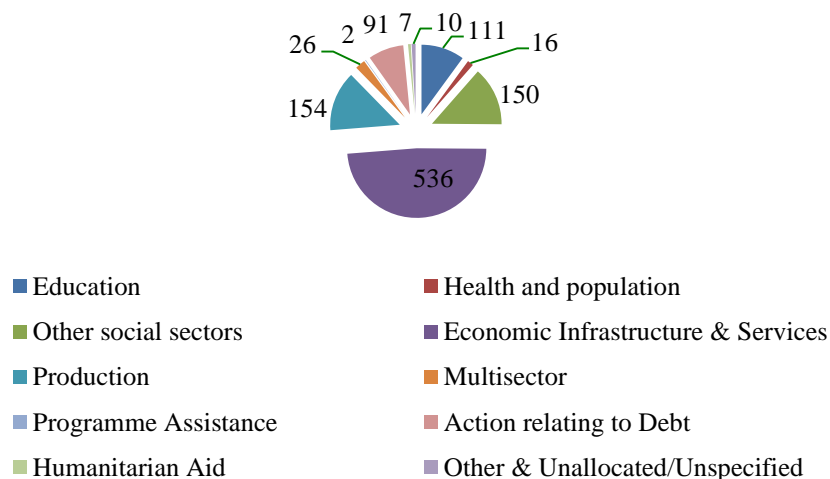
Here’s a look at **Egypt’s** top bilateral donors and the money they committed in 2010 – 2011(table 5), it is obvious that United States is the first country due to USD billion in U.S. military and development aid annually that had been received since 1979 and EU institutions were the seventh donor with 102 million USD. However Kuwait , Arabic country, came in the fourth rank with 147 million USD and United Arab Emirates was the eighth donor.

Source: [OECD - DAC, World Bank; www.oecd.org/dac/stats](http://www.oecd.org/dac/stats)

The distribution of bilateral ODA (2010-2011) is indicated in figure 3, almost 49 percent of ODA was directed to economic infrastructure & services followed by production sector and other social sectors (14 percent for each of them).

Hence health and population sector came at the seventh rank with 1.4 percent of bilateral ODA.

Figure 3: Bilateral Official Development Assistance by sector (2010 -2011), Egypt



Source: <http://data.worldbank.org/indicator/DT.ODA.ODAT.GN.ZS?page=2>

Concerning UNFPA’s assistance, UNFPA assists Egypt in developing capacity in data collection, support in using population data for policies and programmes to reduce poverty, ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect. In addition to supports Egypt in the analysis of population data to participating in national, regional and global policy dialogue and supporting demonstrative programmes for purposes of up scaling where Egypt need to be able to gather information about population, to track and analyze trends in order to create and manage sound policies and generate the political will to appropriately address both current and future population needs.

UNFPA’s seventh Country Programme (CP) for Egypt 2002-2006 focused on improving health status of couples and individuals, the advancement of gender equality and empowerment of women. The key lesson learnt from the implementation of seventh CP pointed to:

- Insufficient involvement of key stakeholders and national coordination mechanisms remain a major constraint such as coordination among RH providers and stakeholders, the need for active involvement of civil society in programme design and implementation.
- The need to integrate maternal health and family planning and strengthening advocacy programmes for and by youth and of the media.
- Support of religious leaders to new areas of interest such as Adolescent Reproductive Health and HIV prevention needs to be strengthened.
- A review of the previous national Information, Education and Communication (IEC) and advocacy strategies in Egypt stressed that the increase in levels of awareness were not matched with changes in behavior in spite of availability of IEC materials.
- Best practices that exist in Egypt indicate that creative, culturally sensitive approaches need to be developed to affect such a desirable change in behavior.

Also CCA (2005) indicated that Egypt was seeking to create a new social contract defined as an integrated rights based programme of action. This contract had ambitions and capabilities that the UNDAF (2007-2011) sought to address in order to achieve MDGs.

As a result of all the previous context of Egypt, UNFPA's eighth Country Programme for Egypt 2007-2011 consisted of three components; population and development, RH and gender (details in the following chapter). Egypt 8th CP had been evaluated²² in 2011 but CS project was not included in this evaluation.

²² <http://web2.unfpa.org/public/about/oversight/evaluations/document.unfpa?page=doclist&method=view&docId=78>

Chapter 3: UNFPA strategic response and programme

UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty. UNFPA vision is that every pregnancy is wanted; every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

3.1 UNFPA strategic response

UNFPA Strategic Plan reflected the lessons learned in the last SP implemented during the period 2004 – 2007 review process²³. The Plan provided the overall direction for guiding UNFPA's support to program countries to achieve their nationally-owned development objectives over the period 2008 - 2011 in the three inter-related areas of Population and Development, Reproductive Health and Rights and Gender.

It comprises of three interrelated frameworks (figure4):

- The Development Results Framework which outlines goals and outcomes for UNFPA in the three focuses areas and reflects UNFPA's mandate and experience. It has been designed to support countries to analyze the core issue of ICPD and as a guide for choosing which outcomes are most appropriate for UNFPA support in the specific country context²⁴.
- A Management Results Framework which shows what UNFPA will do to improve its management in order to support the implementation of the strategic plan through country programmes supported by the regional and global programmes²⁵.
- An Integrated Financial Resources Framework shows UNFPA's planned projected total income for the life of the strategic plan and how these funds are apportioned to the three primary organizational requirements, country programmes, global and regional programmes and the biennial support budget.

These core components of the Strategic Plan guide country programmes as they respond to country priorities. Global and Regional programmes also respond to country priorities by creating the infrastructure of support required by country programmes.

The global and regional programmes are presented to the Executive Board specifically to reorient the organization to be fully country focused and thus ensure that the work of UNFPA at the regional and global levels fully support country programme needs.

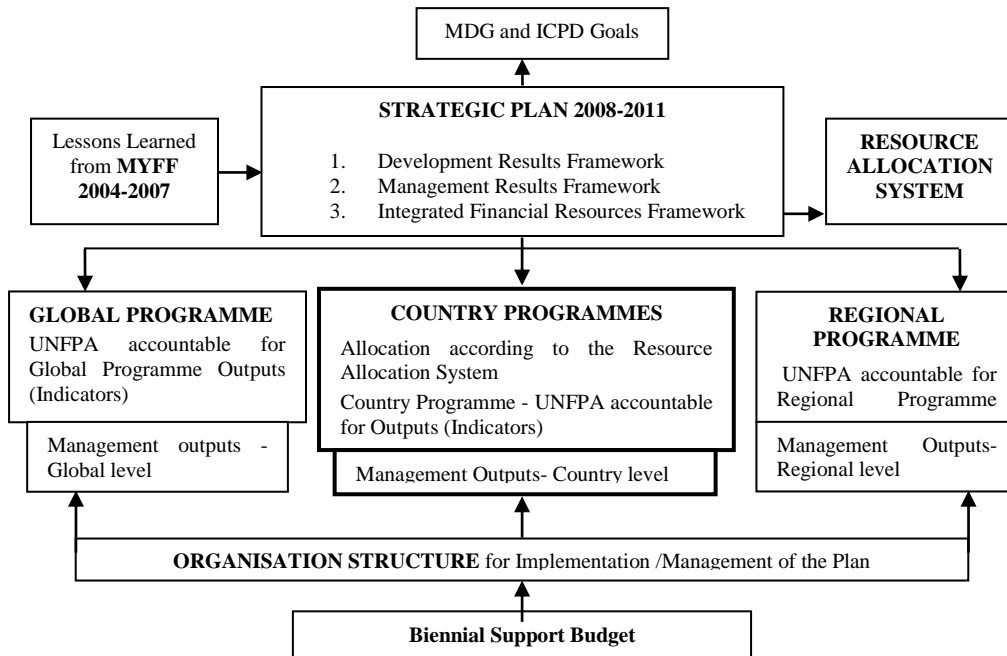
The Strategic Plan also lays out the organizational goals which represent UNFPA's core contributions of ICPD to the attainment of the Millennium Development Goals in the Development Results Framework.

²³ For details see draft 2008 – 2011 strategic plan, www.unfpa.org/exbrd/2007/annualsession/draft_strategic_plan_30may.doc

²⁴ for details see, UNFPA — Strategic plan and related matters, Second regular session 2007, 10 - 14 September 2007, New York, www.unfpa.org/exbrd/2007/secondsession/dpfpa_2007_17_eng.pdf

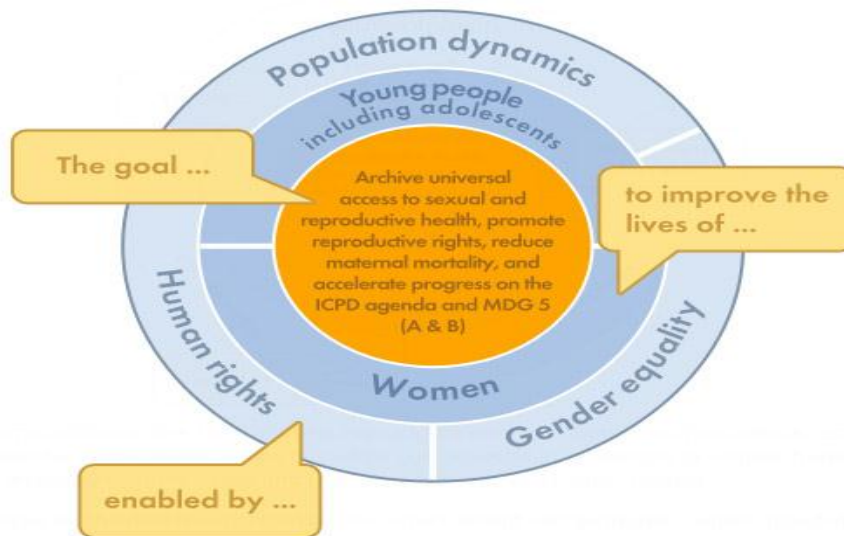
²⁵ for details see, UNFPA — Strategic plan and related matters, Second regular session 2007, 10 - 14 September 2007, New York, www.unfpa.org/exbrd/2007/secondsession/dpfpa_2007_17_eng.pdf

Figure 4: Linkages between the Strategic Plan and Component Frameworks and Programmes 2008 - 2011



In September 2011, following an extensive review of UNFPA’s recent work, as well as the changing context within which it operates, a new, more focused Strategic Plan was adopted by the Executive Board. It will guide the Fund’s work through 2013.

Figure 5: UNFPA Strategic Plan 2011 - 2013



The goal of the new plan is advancing the right to sexual and reproductive health by accelerating progress towards MDG5: to improve maternal health. Priority will be given to advancing two key MDG targets: to reduce maternal deaths and to achieve universal access to reproductive health, including family planning, as indicates in figure 5

At a Country level, the second United Nations Common Country Assessment (CCA) for Egypt in 2005 marked an attempt to provide an updated and comprehensive analysis of the national development situation from the perspective of the UN system in the country. This analysis had been undertaken by the United Nations Country Team (UNCT) in consultation with the Government of Egypt (GoE) and UN system partners in the donor community, research institutions and non-governmental organizations.

Depending on the results of 2005 CCA the country programme (CP) for Egypt was developed in October 2006 by UNFPA. CP would extend for five years during the period 2007 – 2011 and the proposed UNFPA assistance was \$18 million.

UNFPA's 8th Country Programme for Egypt 2007-2011 is aligned with the United Nations Development Assistance Framework (UNDAF) and its main thrust to eradicate poverty. The programme contributes to three UNDAF outcomes; they are

- Strengthening Government's capacity
- Reducing regional disparities
- Increasing women's participation in public life

The programme consists of three areas: population and development, reproductive health and gender, the 8th Country Program has 6 Outcomes, and seven corresponding outputs; the following table presents them according to each programme's component.

Table 6: The outcomes and outputs of the 8th Country Program

Component	Outcomes	Outputs
Population & Development	1. Population policies and strategies reflect a human rights-based approach to programme implementation.	1. Multi-sectorial population policies and strategies revised to address poverty reduction, HIV prevention, youth RH and needs of vulnerable groups.
	2. Poverty reduction strategies are monitored to ensure progress and the integration of a gender perspective.	1. Gender analysis and gender disaggregated indicators developed and used in policy dialogue.
Reproductive Health	3. The sustainability and quality of reproductive health services at the national level and at service delivery points are improved.	1. Capacity of the government and non-governmental health organizations is strengthened in management, planning and monitoring 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
	4. The utilization of integrated reproductive health services is increased in Upper Egypt with a focus on underprivileged communities in	1. Primary and reproductive health care services strengthened within the framework of the Health Sector Reform

	rural areas.	
Gender	<p>5. Girls and women’s rights to access information and services progressively fulfilled</p> <p>6. Incidence of all forms of violence against women is reduced.</p>	<p>1. Increased effective advocacy strategies in promoting sexual & reproductive health and gender equity, addressing men, women & youth.</p> <p>1. Community, religious leaders and media sensitized through active alliances to combat gender based violence.</p>

3.2 UNFPA response through strengthening the contraceptive security system project in Egypt

3.2.1 The contraceptive security system project

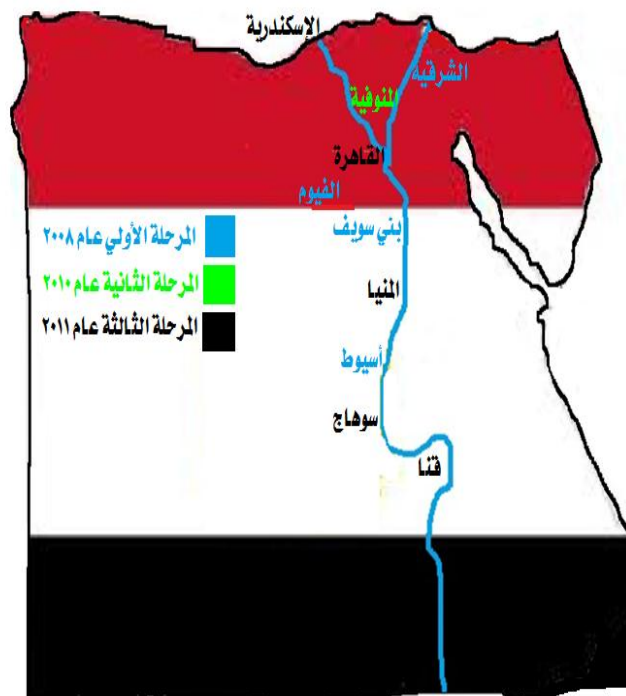
Based on this CP, strengthening the contraceptive security system project in Egypt was developed and implemented since 2008. The project is implemented by MoHP – Family Planning and Population sector.

Based on project documents the project started in 2008 in four selected governorates with two selected districts namely, Sharkya, Beni-Sueif, El Fayoum and Assuit.

In 2010 the project continued working at both national level and selected governorates; Menofia was added to them, to pilot new initiatives.

In 2011 the project continued working at both national level and selected governorates to pilot new initiatives and strengthen initiated activities. In addition to five intervention governorates, other five were included for nurses training on “Upgrading capacity building on logistic system”. The new governorates are Cairo, Qena, Sohag, Alexandria and Menya.

Since 2012 the project continued working at both national level and selected governorates to strengthen initiated activities. Ten governorates of intervention namely: Sharkya, Menofia, Beni-Sueif, Fayoum, Assuit, Cairo, Qena, Sohag, Alexandria and Menya.



Based on project’s AWP, this project would contribute to the following outcomes and outputs:

- UNDAF outcome 1: By 2011, state’s performance and accountability in programming, implementing and coordinating action, especially those that reduce exclusion, vulnerabilities and gender disparities, are improved.

- UNDAF output 3.3: Access to high quality family planning, maternal and child care services increased with improved utilization of primary health care / family health facilities.
- Expected CPAP outcome 3: Sustainability and quality of reproductive health services at national level and at service delivery points are improved.
- Expected CP output 3: Capacity of government and non-governmental health organizations strengthened in the areas of management, planning and monitoring.

There were several issues (determinants), based on contraceptive security strategic plan for Egypt 2006 - 2010, had been identified to be resolved or strengthened in order to achieve CS in Egypt; they are:

- Financial sustainability for funding and procuring contraceptive as USAID phased out their support for contraceptive since 2006.
- Collaboration and coordination to expand the quality standards to NGOs that provide FP services, and MoHP had to expand partnership with the private sector especially pharmaceutical.
- The lack of advocacy capacity at all levels to improve understanding of CS issues and to mobilize resources.
- Quality standards
- Logistics starting from proper forecasting the required contraceptive, logistic management and information system (LMIS) and conditions of storage of contraceptive.

The project is working on these issues to enhance the national capacity to plan and manage CS related issues including data management, forecasting, and procuring methods and to establish advocacy mechanisms to assist in ensuring financial sustainability for CS.

On other words, the project is strengthening FP services by focusing on CS and its key result is to achieve a secured supply, improved access and an assured choice of quality contraceptives for individuals who want to space or prevent pregnancy at the right time. To achieve this result the project focuses on logistics system, good warehousing and inventory management, efficient distribution and increasing the Contraception national budget.

There are two beneficiaries; primary beneficiaries are married women of child bearing age and their partners, and secondary beneficiaries are health service staff at target governorates / districts and service providers at primary health clinics (PHC), NGOs that provide FP services, pharmaceuticals companies and the management of IP.

3.2.2 The contraceptive security system project financial structure

In accordance with the approved UNFPA Egypt Country Programme, The GoE provides 10% of the cost of the project. It is worth mentioning that as a result of extending the CP till mid of 2013, the project also is extended till mid of 2013.

Table 7: Budget of the project during the period July 2008 – June 2013

Years	UNFPA (allocated resources)	GoE (estimation)	Total in EGP
2008	549070	54907	603977
2009	846260	84626	930886
2010	910000	101361	1011361
2011	986000	121200	1107200
2012	873608	87361	960969
2013	783000	87000	870000
Total	4947938	536455	5484393

UNFPA allocated resources is LE 4,947,938

Chapter 4: Main findings and analysis of the project

As mentioned before the evaluation scope covers the overall project, design, delivery, performance and management systems. The following criteria are discussed:

4.1 Relevance

This project is relevant to Egypt context, contributes to policies and strategies of UNFPA (UNDAF outcome 1, UNDAF output 3.3, CPAP outcome 3 and CP output3) and is relevant to the real needs of rights holders (demand side), as follows:

4.1.1 Egypt context

The objectives of CS project are adapted to national needs where the intervention main mandate is to strengthen FP services by focusing on CS where the project is working on the determinants that the contraceptive security strategic plan for Egypt 2006 -2010, had been identified²⁶ to enhance the national capacity to plan and manage CS related issues including data management, forecasting, and procuring methods and to establish advocacy mechanisms to assist in ensuring financial sustainability for CS.

In addition to this the project is designed under the assumptions; that consistent supply and access of a range of FP methods will be resulted from a well-managed logistics system and from adequate funding. The good warehousing, inventory management and efficient distribution of contraceptives will guarantee optimal use and reduce wastage of it. Also stronger national capacity will ensure sustainability. All these assumptions are considered logical.

Accordingly the projects' strategies are strengthening the contraceptive CS System in the MoHP/FP, logistics system, increasing NGOs outlets for FP service, introducing new contraception to MoHP cafeteria and advocating & coordination role to increase the contraception national budget.

So the project is aligned with government priorities to reach national goal of 2.1 as a replacement level fertility by the year 2017.

The consultant made sure that the project's staff advocated and coordinated with officials in MoF and increased the Contraception national budget which is aligned with government priorities for funding and procuring contraceptive after USAID phase out.

On the other hand, Egypt is signatory to both of ICPD and MDGs and has to implement policies to achieve these goals. In order to attain the goal of ICPD, of universal access to RH services by 2015, the role of RHCS is critical by improving access, broadening choice of quality contraceptives and services to ensure individuals who wish to choose, obtain and use RH commodities including FP needs at the right time and in right place.

Last but not least, RHCS is a prerequisite for improvement in SRH and for achieving the MDGs related to poverty reduction, gender equality and HIV/AIDS prevention. Also previous studies supported that in Egypt; a dollar invested in family planning saved 31 dollars in other expenses²⁷. As a result of that the

²⁶ Details in section 3.2.1

²⁷ UNFPA Global programme to enhance RHCS 2007 – 2011.

project can be considered as one of the efforts that the GoE are geared to achieve the goals of ICPD and MDGs.

4.1.2 Policies and strategies of UNFPA

Based on Semi structured interviews with project management in MOHP, officials in MoHP at local level and FGDs with trained nurses at local level, it is concluded that capacity of government health organizations is strengthened in the areas of management, planning and monitoring.

The consultant made sure that there were adequate contraceptives on the levels of health units, departments and directorates of health in the sampled governorates. The consultant also ensured that the sound storage methods were followed to maintain max/min stock level in PHCUs, methods of inventory, and recommendation of new methods and following the FIFO system when delivering contraceptives.

In return this contributed to UNDAF outcome 1, UNDAF output 3.3, CPAP outcome 3 and CP output3

4.1.3 Demand side of rights holders

Concerning demand side of rights holders, FGDs with beneficiaries assured that CS project met their needs as they mentioned when they visited PHC they found a choice of quality contraceptives and obtained good counseling in PHCs. Also the availability of quality contraceptives encourages women who stopped using contraceptives to come to PHCU and start to use them after discontinuation for one year at least and project's data confirms that.

On the other hand, although the project did not train nurses on counseling except for new methods, but through the OJT both of the director of PHCU and the doctors in FP clinic answered the nurse's questions regarding counseling. As a result, nurses are capable to provide good counseling. Accordingly the project is relevant to the real needs of rights holders (demand side).

4.2 Effectiveness

Adequate finance and functional logistics system are two important aspects of RHCS program planning. Thus, a variety of activities had been taken in several areas; building capacity of nurses, doctors, statisticians, project team and storekeepers, travel and supervisory role and OJT, researches / assessment & setting curriculum for training and advocacy & coordination. The main activities that are implemented as follows:

- CS national strategy framework was reviewed and updated.
- Forecasting required commodities and family planning clients using Spectrum at both national and governorate level; where forecasting is required for procurement planning to ensure that the right quantities of FP commodities are procured to prevent stock out, and to facilitate the mobilization of sufficient resources to meet the commodity requirement.
- Coordination among EPTC²⁸ and MoHP/Logistic unit were strengthened and obstacles eliminated.

²⁸ EPTC is a governmental company and responsible of storing and distributing contraceptives among all governorates in Egypt

- Logistics training at the PHCs level were conducted; nurses have to provide reliable information to districts and directorate offices on commodity requirements, inventory level and to warn of commodity shortfalls.
- TA8 was reviewed, updated, upgraded in cooperation with NPC; TA8 is a form used in documenting commodities used and users at a governorate level. It includes data about users by method, methods distributed and available printed material.
- A seminar was held to raise FP managers about CS issues and need to effectively use of available resources, to eliminate any obstacles between different stakeholders in the governorate.
- A series of activities to improve reports, increase information utilization²⁹ and customize it to inform decision makers were carried out. To this end, an assessment of the logistics system for contraceptives was conducted in 2010.
- Strengthening NGOs, Health Insurance Organizations and private sector role in CS.
- Three researches were conducted to utilize their results and recommendation to update plans and add interventions to CS programs.

The evaluation concluded that CS project is effective for the followings:

1. The project supports MoHP in developing their capacities & establishing mechanisms to ensure ownership and sustainability of effects through promoting in-house expertise

The Ministry of Health and Population implemented the project by doctors working in the Department of Contraceptives, assisted by doctors, pharmacists and workers in the same Department, since the objectives of the project are relevant to the nature of their work, thus creating their sense of ownership, developing their capacities especially in planning, advocacy, monitoring and reporting. Moreover, this project helps them to perform their work efficiently.

The project management attended RHCS workshop in 2011 where results based management and strategic priority setting were discussed, acted as trainers and project team attended language courses in 2010.

Furthermore the project management developed the following guides:

- A guideline for procurement's procedures of contraceptives.
- A guideline for logistics training for nurses' training.
- A guideline for forecasting process at national and governorate level using spectrum package. It summarized required data, process, periodicity of updating commodity forecasting yearly and test its consistency with commodities consumptions according to available data.

At national level the project management prepared the guides mentioned above and trained nurses, FP staff in target governorates and statisticians, which cemented the training and created their sense of ownership of the project. The Head of the Department of Contraceptives in the population sector and the project's coordinator re-designed the standard checklist used to evaluate the family planning clinic in health units so as to include all the CS standards. All doctors in the department responsible for the follow-up of family planning clinics in health units have been trained and this was applied in all the governorates

²⁹ To utilize the existing management information system

of the Republic. Furthermore, all pharmacists in the department were trained on store specifications, proper storage methods and following the FIFO system when delivering contraceptives to ensure these regulations are followed during their visits to PHCs nationwide. In addition to the project management facilitated the coordination between directorates of health with local units in districts to relocate of multiple stores with bad conditions.

For the LMIS unit, the capacity of unit staff and statisticians in directorates and health departments was raised. Moreover, the unit database at the population sector was developed to accommodate all the data available in the project and extract the required indicators. Statisticians at the directorate level in the targeted governorates by the project have been trained. Hence, databases for all data related to contraceptives and CS are now available.

At governorate level All FP managers in governorates targeted by the project who attended the workshop are familiar with all the CS logistics and the means to coordinate between different stakeholders in the governorate. Moreover, the capacity of all FP managers in health departments have been raised and they have become responsible for OJT to nurses and following up on them, with the purpose of assessing the needs of contraceptive units to maintain max/min stock level in PHCUs, methods of inventory, and recommendation of new methods and following the FIFO system when delivering contraceptives.

Table 8: Number of trainees according to training course and year

Training course	Year	No. of Trainees
Spectrum training	2009	39
	2010	30
Logistics training	2008	24
	2009	67
	2010	238
	2011	329
	2012	102
RHCS workshop	2010	1
	2011	3
	2012	28
New methods	2012	250
Building capacity the statisticians	2012	58
Total number of trainees		1169

All doctors in PHCUs, nurses and managers of health departments confirmed the increase in the number of female visitors of PHCUs to the extent that they demanded the appointment of an additional doctor and a nurse in the health unit / FP clinic. Beneficiaries confirmed that they feel now more attention from nurses & doctors in PHCU and get the adequate counseling that helps them choose contraceptives. Moreover, the doctor decides whether the contraceptive, they selected, is suitable for them or not and hence recommends the suitable contraceptive. She also informs them of the symptoms of a specific contraceptive. All this encourages them to continue visiting health units. Clients of the urban health unit in Al Fatah Center in Assiut pointed that family planning clinics in PHCUs in villages in which they live did not work regularly, thus they go to the districts to receive high quality of service.

Table 9A: Percentage of beneficiaries attending PHCs out of the total number of women in reproductive age in the targeted governorate within the period from 2009 till 2012.

	2009	2010	2011	2012
Assuit	44	56	57	66
Beni-suif	74	78	80	94
Alexandria	45	46	41	43
Sharkia	86	98	119 ³⁰	144
Fayoum	84	87	83	101
Qena	75	62	78	88
Sohag	42	44	49	63
El Menya	88	89	100	113
Menoufeya	69	79	84	110
Cairo	44	47	39	35

It is worth mentioning that the beneficiaries indicated in table 9A include those who visit PHC for the first time and the beneficiaries who frequently visit the PHCU (more than one time per year). Women in the second group are counted as new beneficiaries each time they visit the PHC. Hence, the percentages are relatively high and in recent years are greater than 100 because since 2011 the beneficiaries who have visited the clinic for the first time after discontinuation for one year at least, has been added to the number of beneficiaries.

However the results indicated that the percentage of beneficiaries in 2010 is greater than this percent in 2009 in the five governorates where the project started in 2008. The same result can be driven when comparing the results in 2012 with 2011 except in Alexandria and Cairo. This can be attributed to the obstacles the project had been faced in Alexandria³¹. Concerning Cairo the majority of districts are classified as high- income districts and women did not visit PHCs but they prefer to go to private doctors.

Table 9B: The percentage of beneficiaries who visit the PHCU for the first time & the beneficiaries who visits the PHC for the first time after discontinuation for more than one year out of total beneficiaries in the reproductive age in the targeted governorate within the period from 2009 till 2012

	2009	2010	2011	2012
Assuit	10.78	14.85	12.78	12.85
Beni- suif	24.96	28.83	24.94	26.13
Alexandria	16.47	17.43	14.56	14.19
Sharkia	19.22	21.60	22.92	23.36
Fayoum	26.01	28.52	24.78	24.80

³⁰ The percentage is greater than 100 because the majority of beneficiaries visited the PHC more than one time per year and they are counted as a new beneficiary each time she visits the PHC

³¹ See page 38.

	2009	2010	2011	2012
Qena	14.66	13.48	15.37	15.63
Sohag	12.32	14.42	15.08	15.09
El Menya	26.25	25.37	27.39	25.28
Menoufeya	15.78	19.17	18.38	18.72
Cairo	14.71	15.57	14.31	11.44

The beneficiaries indicated in table 9B include those who visit the PHC for the first time & the beneficiaries who visit the PHC for the first time after discontinuation for more than one year. Comparing the percentages in table 9A and 9B, you can realize that the majority of clients visit the PHC's more than one time per year. In return this indicates that the beneficiaries are satisfied with the service and this satisfaction encourages them to continue use the contraceptive and visit PHC frequently. As a result of that the PHC has a good reputation that encourages most of the women to use the contraceptive another time after stopping, which in turn increases the CPR.

It also turned out that the meeting, which was prepared by the project for the Family Planning manager in health departments as well as nursing staff, pharmacists and EPTC to determine the role of each of them and how to spend the required quantities of contraceptives from stores led to coordination between them and to overcoming all the obstacles that they face while obtaining contraceptives (53 Participants of the eleven governorates attended one day workshop for coordination between EPTC and MoHP/FP).

In addition to this the database at directorates of health is updated and completed, the statisticians in health directorates are familiar with the information system and collected all TA6 forms³² from PHCUs monthly, entered on the system and send it to LMIS at the central level monthly.

2. The multiple training conducted to nurses to maintain max / min stock level in PHCs, new methods, OJT to nurses and FP manger were effective. However training conducted to statisticians (Spectrum training) was not effective were statisticians in governorates did not forecast the required quantities of contraceptives in their governorate.

The multiple training conducted to nurses to maintain max / min stock level in PHCUs, methods of inventory, new methods and OJT to nurses was effective. Nurses followed this methodology to assess the needs of PHCU of contraceptives and to ensure that the stock in the health unit is enough for the period of two to three months. The data of LMIS indicated that stock in health units did not reach zero level (stock out) for any of the contraceptives since the application of this system. This result was assured from the data of stock level in sampled PHCs and departments of health

As for units where the inventory level falls for less than two months, the manager of the health unit identifies the cause and overcomes any obstacles. Also, storage methods of contraceptives followed by the nurse are reviewed periodically in order to ensure that contraceptives are arranged according to the expiration date so as to use the more recent first according to the expiration date (FIFO system). Thus, the project, along with the Department of Contraceptives, ensures maintaining them and avoiding any loss.

³² Details in page 43.

It also turned out that the Head of the Department of Contraceptives demanded the FP managers at directorate of health in the Republic to hold a training session for an hour and a half to train nurses on how maintain max/min stock level in PHCUs, methods of inventory and new methods during the periodical training sessions for them. This training is carried out all over Egypt to ensure the continuity and dissemination of this system in all governorates. It should be noted here that the success of this system in other governorates where the project has not been implemented depends on how serious this training is and how concerned the managers of Family Planning in health directorates and the Heads of Family Planning in Health Departments and Directors of health units are.

Moreover, FP managers in health directorates have been oriented with the project, its aim, CS system and the importance of coordination between health units and pharmacists (officials of contraceptive stores) in health departments and their relationship with pharmacists responsible for contraceptive stores in the health directorate. Managers succeeded in managing the project in Cairo and Sharqiya and to some extent in Assiut.

It was found that the family planning clinic was not working regularly in Assiut, for many reasons. For instance in the absence of the doctors or nursing staff in other clinics such as motherhood and childhood the physician and / or nurse of family planning works in these clinics. Moreover, doctors do not work on regular basis. However it was also found that there were miscommunication between the nursing staff in health units and pharmacists in health departments in Alexandria and those pharmacists were not committed to the work system. The Family Planning manager in the health directorate was unable to solve these problems because neither he nor his representative attended such training.

For the Spectrum training, statisticians in health directorates in all governorates of the Republic have been trained, but they did not apply this program because the annual needs of contraceptives are estimated centrally in the Ministry. This was affirmed by all statisticians who have been interviewed in the governorates of Cairo, Sharqiya, Alexandria and Assiut. Although there was refreshing exercise assigned to them by central level but they did not benefit from this training and they said they had to revisit the manuals for any application.

3. The advocacy activities were effective in increasing budget for contraceptive procurement & attribute budget annual increase to the project meetings with the finance people in MoF.

It has been indicated that the budget of the population sector in MoHP was fixed during the four years preceding the project. The increase in this item began since the financial year 2010/2011. The review of the budgets of 2008/2009, 2011/2012 and 2012/2013 showed that the item of raw materials, which falls under the item of goods among other items, is increased annually. The percentage of funds allocated to this item increased while the amount allocated to other items remained the same, thus its percentage increased. This indicates the success of the project management and the financial management in the sector in negotiating with the Ministry of Finance about increasing financial allocations for the procurement of contraceptives.

Table 10: The development of the amount allocated for the procurement of contraceptives in the budget of the sector of population:

Fiscal year	Allocated amount in the budget (EGP)	Additional subsidy from the Ministry of Finance
2009/2008	37,200,000	12,000,000
2010/2009	37,200,000	20,000,000
2011/2010	55,927,000	18,727,000
2012/2011	55,927,000	
2013/2012	80,927,000	25,000,000

This amount is expected to reach 100 million Egyptian pounds in the fiscal year 2013/2014.

It is worth mentioning that the name of the item allocated for the procurement of contraceptives was not changed (contraceptive procurement) because the budget items are fixed and apply to the whole country. The official responsible for the financial management of population sector in MoHP assured that the budget item for procurement of contraceptives, however, is linked to the budget of population sector in the Ministry, therefore it is accompanied by an authorization confirming that the item is allocated for the procurement of contraceptives.

He also confirmed that this item can be increased as long as the Department of Contraceptives confirms and proves the financial need for the procurement of contraceptives.

4. The generated data is sufficient and accurate to develop the key indicators that used to measure outputs and outcomes.

Based on project document, LMIS reports, M&E framework indicators and Quarterly & annual implementation progress reports, it can be proved that collected data is accurate as there is more than one source of data; PHCUs (TA6), reports of Directorate of Health in each governorates and TA8. In addition data is sufficient to compute the M&E indicators.

It is noted that trainees' data and the required quantities of contraceptives at governorate level are not available at LMIS unit, but number of trainees and other training data are available with project's management and the required quantities of contraceptives at governorate level are available at the head of contraceptive department.

It is worth mentioned other indicators, which can be utilized by the MoPH / population section, can be computed using the collected data.

In addition the project management monitored the implementation by developing the result matrix that presented the key results of CS; a secured supply that is measured by number of units with contraceptive methods between max/min stock level³³, improved access that measured by number of FP beneficiaries

³³ This number includes PHCs had the stock level between minimum and maximum for all contraceptives in the cafeteria during the 12 months of the year, e.g., the unit was not included in this indicator if the stock level of any contraceptive was less than the minimum or greater than maximum in one month even if there was not stock out in the PHC.

per 81 NGO per year and an assured choice of quality contraceptives for individuals who want to space or prevent pregnancy at the right time in the right place which measured by number of uptake of the new methods introduced in MoH contraception cafeteria during past 12 months.

The result matrix gave the potential for strengthening the capacities of MoHP/FP to monitor progress and cultivate a RBM approach.

Summative Evaluation of Strengthening the Contraceptive Security System Project in Egypt

The matrix results

RESULT INDICATOR	MoV	Baseline Year	2009 (2nd half)		2010		2011		2012	
			Target	Actual	Target	Actual	Target	Actual	Target	Actual
CS#1 No. of units with contraceptive methods between max/min stock level ³⁴ in 1395 SDPs in the 5 governorates (No of units have increased over the years)	LMIS-Assessment	2009	28 units (2%)	Avg# of SDPs 223 (16%)		Avg# of SDPs 257 (19%)	334 units (30% increase against year 10 actual)	Avg# of SDPs 329 (28%)	570 units (30% increase against year 11 actual)	Avg# of SDPs 369 (12% increase against year 11 actual)
CS#1.1 No. of units with contraceptive commodities between max/min stock level in 1298 SDP in the new 5 governorates (intervention started in 2011)						Baseline : Avg# of SDPs 197(15.4%)		Avg# of SDPs 223 (13% increase against year 10 actual)	158 units (30% increase against year 11 actual)	Avg# of SDPs 257 (15% increase against year 11 actual)
CS#2 No. of FP beneficiaries per 81 NGO per year in the five governorates	LMIS - Survey	2009		300 beneficiaries /NGOs/ year	25% increase against baseline	306 beneficiaries/ NGOs/10 (2% increase against 09 actual)	25% increase against 10 actual	337 beneficiaries/ NGOs/11 (10% increase against 10 actual)		366 beneficiaries/ NGOs/12 (19.6% increase against 10 actual)
CS#2.1 No of new outlets offering FP services										
CS#3 No. of uptake of the new methods introduced in MoH contraception cafeteria during past 12 months in 5 selected districts	TA 8 form-assessment	2009	zero uptake of 2 new methods		Assessment of pilot phase completed	authorization of the consultation committee of 3 new methods	100-200 beneficiaries	introduction of 3 new methods & assessment took place		
Yearly National budget for Contraceptive Procurement (in LE)			36,000,000		36,000,000		55,000,000		80,000,000	
EGY8R11A UNFPA Budget \$			164,000		154,000		140,000		145,000	
							(+ \$350K procurement)			

³⁴ This number includes PHCs had the stock level between minimum and maximum for all contraceptives in the cafeteria during the 12 months of the year, e.g., the unit was not included in this indicator if the stock level of any contraceptive was less than the minimum or greater than maximum in one month even if there was not stock out in the PHC.

The matrix results summarizes the key results of the project, results assures that the number of units with contraceptive methods between max/min stock level in 1395 SDPs in the main five governorates have been increased by 65% in 2012 against 2009. Also the number of FP beneficiaries per 81 NGO per year in the five governorates increased by 22% in 2012 against 2009. However the three methods were piloted in Menoufeya, so there is no available results in the matrix and the consultant verified the results that indicated in CS#3.

5. Building the capacity of service providers (nurses/doctors), strengthening the logistic functions has contributed to improve the performance of the supply side in the first five governorates. In addition to the beneficiaries are taking advantages of the benefits provided by interventions.

The project's information assure that the percentage of PHCUs which have FP methods stock between 2:3 months has been increased in Beni-suif, Sharkia, Fayoum and Menoufeya governorates during the period 2009 – 2012. However in Assuit governorate, it increased during the period 2009 – 2011 and decreased from 34% in 2011 to 32% in 2012 (table 12).

Table 11: Percent of PHCUs which have contraceptives stock between 2:3 months by governorate

Governorate	% of PHCUs which have FP methods stock between 2:3 months			
	2009	2010	2011	2012
Assuit	29	25	34	32
Beni- suif	10	13	15	16
Sharkia	9	10	10	23
Fayoum	10	13	15	25
Menoufeya	25	36	49	34
Alexandria		17	38	17
Qena		16	16	11
Sohag		6	8	7
El Menya		7	2	11
Cairo		49	52	44

Concerning Cairo, Qena, Sohag, Alexandria and Menya governorates this percent decreased between 2011 and 2012 except in Menya it increased from 2% in 2011 to 11% in 2012. This can be attributed to the fact that these governorates started the project in 2011 and as we mentioned before the project coordinator said that a little progress had been achieved in Menia, Sohag and Qena due to the security situation after 25th January revolution. In addition to this, there is miscommunication between the nursing staff in health units and pharmacists in health departments in Alexandria and those pharmacists were not committed to the work system that affected the progress there.

On the other side the number of beneficiaries increased in all governorates except Alexandria governorate, but there are positive results, they are:

- Number of frequent beneficiaries (who visits PHCU more than one visit in a year) increased.

- Results also indicated, starting from 2011, a great number of women who visited PHCU for the first time after one year of discontinuation has been increased.

These results assure that they are satisfied with the service. This result is a good indication that access is improved and women find a choice of quality contraceptives; each woman finds the most convenient contraceptive for her individual case.

Furthermore the consultant was assured that the supervisory role of the project & OJT that took place during the life of the project had a great effect in satisfying the real needs of rights holders (demand side).

6. The project benefits have not been efficiently achieved across all target governorates

The project started in 2008 in four selected governorates with two selected districts namely, Sharkya, Beni-Sueif, El Fayoum and Assuit. In 2010 the project continued working at both national level and selected governorates; Menofia was added to them, to pilot new initiatives. Since 2011 the project was working at both national level and ten selected governorates to strengthen initiated activities; namely: Sharkya, Menofia, Beni-Sueif, El Fayoum, Assuit, Cairo, Qena, Sohag, Alexandria and Menya.

As mentioned before not all the activities were implemented in Qena, Sohag, and Menya governorate.

There is also a disparity in system's performance between the various health units in the governorate of Assiut, and also in the cooperation and coordination between the nurse at the health unit and the pharmacist in charge of the store in the Department of Health in Alexandria.

7. The coordination role of the project and meetings held among stakeholders namely, NPC, Pharmaceuticals and other MoHP Sectors were successful.

The coordination and meeting held with NPC to revisit, update and upgrading TA8 was successful. The updated form of TA8 is very important to validate the collected data from PHCs.

A workshop was conducted in 2008 to strength the coordination between logistic unit and EPTC. Participants were logistic unit, FP program directors and medical department at governorate level, as well as EPTC staff at both central and local levels. As a result of that both partners identified obstacles that affect the program and developed required mechanisms they implemented. Furthermore, monthly meeting for a committee from head of department of contraceptives, project coordinator and EPTC staff is held to follow up the inventory level and the distributed quantities among governorates.

Furthermore DKT Pharmaceutical Company sponsored developing IEC materials for the new methods, and CID& DKT pharmaceutical companies sponsored conducting a series of training courses on new methods for Physicians and nurses. Also pharmaceutical companies supplied the three new methods as pilot in Menofeya.

However the initiative to strengthen NGOs, HIO and Private Sector role in RHCS started in 2010, The project had supplied number of seals and registers for the Private sector Initiative. Also the Initiative had supplied 2169 CuT 380 IUDs in the Private sector in twelve governorates named; Menoufeya, Fayoum, Sohag, Domeyatte, Assuit, Sharkia, Menya, Ismaillia, Suez, Luxor, Alex and Beni-sueif. In 2011 seven new FP outlets have been opened at Private hospitals at three governorates namely; Bani Seif, Sharkia and Assuit.

In addition to, two strategic committees (logistic committees) were convened to coordinate between the Pharmaceutical companies and the Central Administration of Pharmaceutical Affairs to discuss and solve obstacles of contraceptive registration of new contraceptives, and four committees at Sharkia and Bani Sueif governorates were conducted to advocate for FP Program and Opening FP new outlets at Private hospitals. Finally this initiative did not achieve its targets and was not successful in HIO and private sector; however the number of beneficiaries in NGOs indicated in result matrix.

4.3 Efficiency

The project is a medium project and its budget is LE 5,484,393. Based on Quarterly & annual implementation progress reports, AWP, it is indicated that the available resources (funds and staff) were managed efficiently as indicated in the following analysis.

As mentioned before, the project supports MoHP in developing their capacities and establishing mechanisms to ensure sustainability of effects through promoting in-house expertise. Besides the project management developed the training manuals and trained all the trainees. Recruitment of external consultants was in rare cases, such as recruiting a consultant for the implementation of three studies to have plans based on scientific basis & benefit from these studies to determine the method mix and identify the beneficiaries' preferences and reasons behind it.

As mentioned previously the statisticians in health directorates who have been trained on Spectrum package during 2009 – 2010 did not apply this program because the annual needs of contraceptives are estimated centrally in the Ministry because contraceptive procurement is budget based rather than needs based. However from the financial prospective, Spectrum training cost LE 147,622 which represented 2.6% of the project's budget.

Furthermore through reviewing the quarterly, annual implementation progress reports and AWP, the consultant assured that cost have not been overrun or exceeded the planned budget. In addition to this, there were not cancelled activities. Actually revisiting, updating and upgrading TA8 started in 2009 and the activity was not completed due to the merging of NPC into the new ministry at that time, at that time, in 2010 the final certified Form of TA8 was disseminated. Besides all implemented activities are converted into outputs that constituted to achieve the project's key results, except Spectrum training for statisticians at governorates level (as mentioned previously). Finally, no planned activities have been reformulated or partially redesigned.

4.4 Sustainability

The project is sustainable for the following:

- The project strengthens and sustains the CS system in Egypt, where the project sets logistics system. This system collects right and accurate³⁵ logistics data, which is utilized for forecasting, raising contraception national budget, and ordering future needs. It also sets conditions of good warehousing, facilitates relocating of multiple stores with bad conditions and grantees efficient distribution of contraceptives.
- The procurement of contraceptive is linked to the budget of population sector in the Ministry of Health and it is accompanied by an authorization confirming that the item is allocated for the

³⁵ There is more than one source of data; PHCUs (TA6), reports of Directorate of Health in each governorates and TA8

procurement of contraceptives only. This item can be increased as long as the Department of Contraceptives confirms and proves the financial need for the procurement of contraceptives.

- The programme design incorporates sustainability factors as indicated in AWP and annual monitoring forms where the staff working in the project is the doctors of the Ministry of Health and their work at the Ministry is related to and benefits from the success of the project.
- Revisit, update and upgrade checklist to monitor FP clinics in PHCUs and institutionalization in the quality standards of PHCs.
- As mentioned before the project supports MoHP in developing their capacities & establishing mechanisms to ensure ownership and sustainability of effects through promoting in-house expertise
- Documentation of project results detailing measures to sustain the results.
- Establishment of a Functional National Contraceptive Security Working Group to monitor CS in Egypt and assignment of RHCS focal point.

4.5 Responsiveness

UNFPA responded to project's request to purchase Implanon as it is a long term contraceptive and an expensive contraceptive so the procurement of Implanon is restricted to budget availability and funds can be allocated. Also the project trained 56 statisticians to build their capacity during 2012, it was responsive to a request from Head of FP department.

4.6 Added Values

The main project added value in the country context is:

- The project's key results achieved contributed to institutional change for the implementation of CS system.
- Introducing new methods of contraception; emergency contraception, local vaginal suppositories and the monthly injectable that has high acceptability by service providers and FP users.

The three new FP method mix could contribute in adding new FP clients as well as method shift due to less side effects compared to current FP method mix. Capitalizing on adding the three new methods in the FP method mix cafeteria could effectively reduce unmet needs and discontinuation rates.

- Achieving a sustainable funding mechanism and this funding can be increased to secure the increasing required resources. A condition for increasing such funding required that the Department of Contraceptives confirms and proves the financial need for this increase.

4.7 Learned Lessons

- The programme design has to incorporate sustainability factors.
- The Capacity-Building of employees and empowerment are the main success elements of any institutionalizing new systems.
- The importance of secured supply and high quality service to improve access.
- Division of role amongst partners is a must to ensure clarity of authority and accountability as well as better coordination of benefits for target PHCs.
- The availability of completed databases

- Establishing mechanisms to ensure the feeling of ownership among project's staff.
- Establishing project's monitoring system from the beginning.

Chapter 5: Conclusions

This concluding chapter assesses project's activities and achievements.

Project's design:

- Project's design is realistic and relevant to Egypt context; the project was based on realistic assumptions. It contributes to Egypt's efforts to meet ICPD goals and MDGs 1, 3 and 6 where Egypt is signatory to both of ICPD and MDGs and has to implement policies to achieve these goals. It strengthens the contraceptive security system project in Egypt, as well as it is aligned with government priorities for funding and procuring contraceptive after USAID phase out, as well as policies to reach national goal of 2.1 as a replacement level fertility by the year 2017.
- The project results logframe is developed, following the RBM approach. Project AWP's incorporate activities that contribute to the project key result. A focus on the destination/result is an approach that maximizes benefits and results of medium-size projects.

Project's monitoring:

- The management role performed by UNFPA CO is considered one of the bases for the success of the program in achieving its objectives. Close follow up of the National Programme Associate to project team who follow up FP managers in health directorates, staff working in health units, & storekeepers, EPTC staff for following up the inventory level and the distributed quantities among governorates are basis of the good monitoring that contribute to achieved results
- The project result matrix gave the potential for strengthening the capacities of counterparts to monitor progress and cultivate a RBM approach; by end of each year the project's management computed project's key indicators, and develop the following AWP accordingly.
- Updating checklist, according to project's logistics system to monitor FP clinics in PHCUs and institutionalization in the quality standards of PHCs, and the three curricula developed by project team contributed to laying the groundwork for promoting in-house expertise and the practice of having follow-up tools. Furthermore these outputs are considered factors of system sustainability after phase out of the project.

Fund raising:

- Project contribution has been influential in the increased national budget for contraceptives procurement; the project management and the financial management in the population sector success in negotiating with the Ministry of Finance about increasing budget allocations for the procurement of contraceptives. In addition, the path has been paved for future increment. .

Management and performance in PHCUs:

- Division of role amongst partners in target governorates is a must to ensure clarity of authority and accountability as well as better coordination led to secured supply and high quality of service. In return access is improved.
- Incentives practice can be used to improve employees' performance; in 2012 the project's management and UNFPA staff approved to select best performers based on evidence of
 - Max-min stock level.
 - Counseling services to beneficiaries (through number of beneficiaries & collected feedback)

- Promptness in providing the monthly data to central level.

Every quarter four Service Delivery Points (SDP) and two districts are selected to receive incentives to raise competition and improve their performance.

The project's success elements

The project strengthens and sustains the CS system in Egypt because the project supports doctors working in the Department of Contraceptives, pharmacists and workers in the same Sector³⁶ in MoHP/FPS in developing their capacities & establishing mechanisms to ensure their ownership and sustainability of effects through promoting their expertise. Also the project's management coordinated among different stakeholders to ensure data's accuracy through the availability of multiple sources of data.

It is worth mentioning that project's design, monitoring and management & performance in PHCUs are also main elements of project's success.

³⁶ The project's objectives are relevant to the nature of their work

Chapter 6: Recommendations

All recommendations are aimed at ensuring the sustainability of the CS system. These recommendations are:

- **MoHP/FPS should plan for succession and create a second line of management in contraceptive Sector and in directorates of health to ensure the continuation of CS system.** Currently the head of department of contraceptives participated in developing guidelines for procurement's procedures of contraceptives & guidelines for logistics training for nurses' training, updating checklist, determining the required quantities of contraceptives, procuring future requirements and coordination with pharmaceutical companies. The Sector should assign a deputy to the post to ensure business continuity. . The same at the governorate level, how far the system succeeds depends mainly on the FP manager in the directorate of health and his coordination between PHCUs, departments of health and directorate of health. So it is recommended to assign assistants to managers who can succeed them in case of promotion or separation. Hence the MoHP/FPS guarantees satisfactory performance.
- **To ensure achieving the project's benefits efficiently across all target governorates, departments of contraceptives and family planning in MoHP/FPS have to coordinate together and follow up on the performance of FP managers in health directorates in managing the implementation of CS system in all PHCUs in the governorate.** FP managers in health directorates have been oriented on the project, its aim, CS system and the importance of coordination between health units and pharmacists (officials of contraceptive stores) in health departments and their relationship with pharmacists responsible for contraceptive stores in the health directorate. However there is a disparity in system's performance between the various health units in the same governorate and between governorates.
- **To ensure Pharmaceutical Companies shoulder their social responsibility towards FP, department of contraceptives in MoHP/FPS has to strengthen their cooperation with them.** The project succeeded in cooperating with pharmaceutical in pricing the contraceptives with economic prices, supplying new methods and developing IEC materials for the new methods so the department of contraceptives in MoHP/FPS has to maintain this cooperation.
- **To ensure broader coverage for beneficiaries in reproductive age, FP Sector should guarantee scaling up of CS system and expanding it to non-intervention governorates.** This includes orienting FP mangers on CS system and its importance to ensure secured supply and improved access. As the services providers and nurses in PHCUs in these governorates were already oriented by CS system and applied min/max stock level.??
- **To activate the initiative to strengthen NGOs role in RHCS, department of NGOs in MoHP should set criteria for selecting NGOs.** The project contracted the NGOs had a desire to participate in project regardless their capabilities so department of NGOs in MoHP should select NGOs according to the defining set criteria.
- **LMIS unit has to keep all data related to CS system** such as number of trainees & other training data and the required quantities of contraceptives at governorate level to have one source of information.
- **Donors' close monitoring to all projects nationwide is highly recommended.** Continuous and almost daily follow up on the project team contributed to a higher level of efficiency and diligence.

Annex I: Terms of Reference

Summative Evaluation

Strengthening the Contraceptive Security System Project in Egypt

1. Background & Context

The system for obtaining adequate quantities of contraceptives and for delivering them to service delivery points (SDPs) constitutes a critical element of family planning (FP) program. Contraceptive Security (CS) is achieved when couples have regular, reliable, and equitable access to a choice of contraceptive methods to meet their needs. CS has become a priority not only because of the health and economic benefits of family planning, but also because of changes in demographic trends, the demand for family planning (FP), and the ways development assistance is administered.

UNFPA has been the lead UN agency promoting family planning and contraceptive security. In 1994, the International Conference on Population and Development set forth the goal of universal access to reproductive health services by 2015. CS is an essential element in attaining this goal, as well as contributing to the achievement of the Millennium Development Goals. As a promoter of best practices and coherent commitment to family planning, UNFPA has demonstrated results through the successful, multi-year Global Programme to Enhance Reproductive Health Commodity Security which, among other results, has increased the commitment of national governments to rights-based family planning by securing budget lines for contraceptives.

Although modern family planning methods are readily available in Egypt at low cost, a considerable proportion of women still have an unmet contraceptive need (9.2% DHS08). The FP program has achieved successes in the past & the Government of Egypt responds to enhance commitment and contribution to maximizing Egypt's contraceptive security by allocating a level of funding to make contraceptives available to all those who need and want them.

Since mid-2008, and in line with UNFPA mandate and the 2007-13 country program, UNFPA Egypt Country office (CO) is supporting the project titled 'strengthening the contraceptive security system' with Ministry of Health/Population Sector. The project targets the various pillars of CS, from commitment and coordination to policies and service delivery. The project facilitates building the national capacity both at the central and local levels on logistics functions, logistics data & product selection. The project strengthened the national capacity to maintain a monitoring mechanism that is evidence-based, analytical, & that focus on tracking planned results & supportive to the supervision process at different levels. On the other hand, the national budget allocated for contraceptive procurement is doubled since the project inception due to its advocacy activities. Finally, the project supported multiple studies and assessments, in an effort to generate evidence & identify gaps for remedial actions.

The project key result is to achieve a secured supply, improved access and an assured choice of quality contraceptives for individuals who want to space or prevent pregnancy at the right time in the right place in 5 governorates (five more governorates were added in 2011). It identified 3 indicators to measure progress over the years. Maintaining maximum/minimum stock level at the primary health care units in governorates of intervention was monitored on quarterly basis to track progress & effectiveness of trainings.

2. Purpose

The purpose of this evaluation is to provide the project partners with a summative evaluation of the effectiveness of the Project in meeting its stated result. This is to ensure substantive accountability for the investments made, to inform implementing partners for their future decision, and to draw lessons to improve the relevance and quality of future country office programming.

3. Objectives & Scope

The objectives of the evaluation are to:

- assess to what extent the project has succeeded in strengthening the capacity of the contraceptive security system within MoHP & the extent of sustainability of the achieved results,
- assess to what extent the project has succeeded in building the capacity of the targeted duty bearer (FP staff at central, district & PHC level) & extent of sustainability of the achieved results,
- assess to what extent the project has contributed in promoting coordination among different stakeholders (Pharmaceuticals, NGOs, other national bodies);
- present key findings, formulate conclusions, and provide a set of clear and forward-looking options leading to strategic and actionable recommendations for the next intervention

The scope of the evaluation is to cover the on-going project that started Mid-2008. Evaluator will analyze relevance, efficiency, effectiveness, and sustainability for the achieved results, as well as added value of the intervention. In order to extract lessons learned and best practices, the evaluation scope should cover as well the overall project, design, delivery, performance, management systems, alternative strategies & the application of the rights-based approach in the intervention. Please refer to the project annual work plans for detailed activities in Annex III.

4. Questions

The evaluation should answer the following overarching questions:

- I. Assess the present relevance of the project objectives toward the needs of MoHP/FP sector and final beneficiaries (married couples/WRA)?
- II. To what extent was the expected output of the project achieved?
- III. Has the project been efficient in converting its resources into results?
- IV. What are the prospects for sustainability of the achieved results?
- V. Assess the project design quality and internal coherence (needs and problems it seeks to solve)
- VI. What lessons learned or good transferable practices to other projects or countries have been observed during the evaluation analysis?

Please refer to the Evaluation Matrix Annex I

5. Methodology

UNFPA Evaluation [Handbook on How to Design and Conduct a Country Programme Evaluation \(HB\)](#)^I spells out the approaches and methodologies of conducting an evaluation & is recommended as one of the

main guiding documents to accomplish this project-level evaluation exercise. In the process of designing and conducting the evaluation, a set of tools is available in Part III of the Handbook. Tools are categorized into tools for structuring information, data collection & analysis. Please refer to page 6, part III/Toolkit to familiarize yourself, whenever the tool is required, a reference is made in the course of this ToR.

Based on the partners' needs, the evaluation matrix lists the required evaluation criteria and relevant questions. Consultant is expected to review & refine those questions. 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 project is required. For data collection, the evaluation will use a multiple method approach that could include desk reviews, group and individual interviews, and field visits. The consultant will use a variety of methods to ensure that the data is valid, including triangulation. The precise methods of data collection and validation will be detailed in the design report. The evaluation will have a participatory approach that involves a range of stakeholders.

6. Evaluation Process

The evaluation process will be conducted over a period of one month with a total of 25 working days; it can be divided in three phases each including several steps:

Phase 1: Desk Phase (1week): for desk review & production of Design Report

Phase 2: Field Work Phase (1 week): for data collection, validation, analysis & drafting of a set of preliminary findings, conclusions and recommendation (Preliminary results to be presented to the CO and Reference Group during a debriefing session on the last day of the field phase.)

Phase 3: Reporting Phase (2 weeks): for drafting & finalizing the evaluation report,

7. Expected Outputs

1. **Design report** (10 pages max) – Out of the design phase a design report should be submitted by the consultant before going into the full-fledged exercise. S/he reviews the evaluation questions, chooses the most appropriate methods for data collection and analysis, and selects a **sample of stakeholders (a stakeholder analysis is attached in Annex II)** to interview during the data collection and analysis stages. Evaluator to submit
 - o adjusted and refined evaluation matrix.
 - o a work-plan to reflect timelines as per ToR,
 - o an agenda covering the field phase (HB Part III Tool 7)
 - o validation mechanisms that will enable the verification of preliminary findings

Please refer to HB Part III Templates p.16 in UNFPA Handbook where a template of the report is presented.

2. **Debriefing Presentation** - Based on a two-week field mission for the data collection and analysis, preliminary results must be presented to the CO, RG & key partners during a debriefing session at the end of the field phase to formalize preliminary findings on the analysis undertaken. *Please refer to HB Part II p.18 & tool 14 in Part III*

3. **Final report** (25 pages max plus annexes) – Based on the sound analysis & preliminary findings in the draft report, conclusions should derive from findings and should explicit independent judgments; conclusions are the evaluator’s responsibility. Conclusions should be assembled by topic/area. Recommendations should derive from conclusions; Recommendations may be organized by area. Within each area, recommendations should be ranked by priority level, should be operational, with a time horizon, *with alternative options indicating the pros and cons*.

The report must mention to whom recommendations are addressed. Findings, conclusions and recommendations to be presented in the final report must be evidence-based. The evaluator should ensure use of triangulation techniques. Limitations and mitigation measures should also be stated. It must be noted that recommendations are valid only when they logically flow from conclusions, and that, in turn, the conclusions supporting this recommendation arise from findings that are based on reliable data, and sound methodology and analysis. Please refer to HB Part III P.22 where a template of the report is presented.

8. Management & conduct of the evaluation

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

- The Evaluation Reference Group (ERG) – will be co-chaired by UNFPA CO program manager and the project director from the national partners, and ASRO RHCS Regional Advisor will be members in the committee.
- The Evaluation Manager (EM) – will be the project manager from UNFPA/CO & M&E focal point.
- Evaluation consultant – based on competitive selection of one consultant for conducting the evaluation.

The ERG and EM provide oversight to the evaluation process. UNFPA CO & project team will provide logistical support and arrange meetings and field visits as and when required by the evaluator. UNFPA will also make available office space, the evaluator is however expected to bring own laptops. *Please refer to Overview in HB for an indication of the roles and responsibilities.*

The final draft report will be subject to the Evaluation quality assessmentⁱ by EM, ERG whose views must be reflected in the report to ensure transparency of the evaluation process.

9. Required competencies

The consultant should have solid understanding of evaluation methodologies, a proven expertise of research in social science relevant for the evaluation, & advance degree in his/her area of work. The consultant should be familiar with United Nations system, have at least seven years of experience in evaluation of development work, & possess proved written skills. In-depth knowledge of Reproductive Health, Family Planning & Contraceptive Security are required. The ERG will support the team in designing the evaluation, participate in the scoping mission, and provide ongoing feedback for quality assurance during the preparation of the design report and the final reports.

Interested consultants are required to submit proposal on their perception on how to respond to this evaluation and to submit their resumes and references to UNFPA Country Office (shaarawy@unfpa.org). In addition to a clear statement by consultant stating independence from any organizations that have been

involved in designing, executing or advising any aspect of the intervention that is the subject of the evaluation.

10. Evaluation Ethics

The evaluator must be independent and free of any conflict of interest due to either past or future involvement in the program/project being evaluated. Existence of any potential conflict of interest should be communicated in writing to the evaluation manager prior to signing of a work contract (see [UNEG Ethical Guidelines](#) for further clarification about conflict of interest)

11. Audience

The primary users of the evaluation are the MoHP/FP sector, UNFPA CO, decision-makers within national counterparts. UNFPA/HQ & international donors are users as well. Other national stakeholders, UN Agencies in Egypt and development partners are also seen as part of the audience of this report.

12. Fees

Consultant fees will be calculated using UN daily base rate according to qualification and experience. In principle, payment of installments is pegged to achievement of progress milestones stipulated in the relevant consultant contract.

13. Resources - please refer to Annex III

Annexes

Annex I – Evaluation Matrix

Annex II – Stakeholders Analysis

Annex III – Resources - Background documents & online material

Annex IV - Theory of Change

Annex II: Lists of Persons / institutions met

Day	Organization	Persons
18 – 20/5/2013		Desk Study
21-22/5/2013	MoHP	<ul style="list-style-type: none"> – Project Management in MoHP (project coordinator, LMIS manager, FP manager in MoHP, Dr. Sahar el Sonbaty, Dr. Hossam the Head of population sector, MoHP, three project members who conduct field visits and fill checklist and project financial officer). – Managers of other sectors in MoHP related to the core of the project.
23/5/2013	UNFPA CO	<ul style="list-style-type: none"> – UNFPA Staff (Mrs. Dawlat Shaarawy, Dr. Magdy Khaled).
25/5/2013	Cairo Governorate	<ul style="list-style-type: none"> – From (8-10) trained nurses at selected districts to hold FGD with them. – Hold a FGD with women benefited from the project in each district. – Conduct in-depth interview with two – three service providers in PHCs in each district. – Conduct in-depth interview with a nurse, service provider, responsible of FP clinic in a NGO in each district. – Worker who are responsible of warehouse in the PHC and district level. – LMIS (statisticians) at district level. – Conduct in-depth interviews with FP manager, LMIS manager, who is responsible of contraceptives inventory at the governorate level.
26/5/2013	pharmaceuticals companies	Representatives of pharmaceuticals companies
27/5/2013	Alexandria Governorate	<ul style="list-style-type: none"> – From (8-10) trained nurses at selected districts to hold FGD with them. – Hold a FGD with women benefited from the project in each district. – Conduct in-depth interview with two – three service providers in PHCs in each district. – Conduct in-depth interview with a nurse, service provider, responsible of FP clinic in a NGO in each district. – Worker who are responsible of warehouse in the PHC and district level. – LMIS (statisticians) at district level.

28-30/5/2013	Assuit Governorate	<ul style="list-style-type: none"> - Conduct in-depth interviews with FP manager, LMIS manager, who is responsible of contraceptives inventory at the governorate level. <hr/> <ul style="list-style-type: none"> - From (8-10) trained nurses at selected districts to hold FGD with them. - Hold a FGD with women benefited from the project in each district. - Conduct in-depth interviews with two – three service providers in PHCs in each district. - Conduct in-depth interviews with a nurse, service provider, responsible of FP clinic in a NGO in each district. - Worker who are responsible of warehouse in the PHC and district level. - LMIS (statisticians) at district level. - Conduct in-depth interviews with FP manager, LMIS manager, who is responsible of contraceptives inventory at the governorate level.
1-3/6/2013	Sharkia Governorate	<ul style="list-style-type: none"> - From (8-10) trained nurses at selected districts to hold FGD with them. - Hold a FGD with women benefited from the project in each district. - Conduct in-depth interview with two – three service providers in PHCs in each district. - Conduct in-depth interview with a nurse, service provider, responsible of FP clinic in a NGO in each district. - Worker who are responsible of warehouse in the PHC and district level. - LMIS (statisticians) at district level. - Conduct in-depth interviews with FP manager, LMIS manager, who is responsible of contraceptives inventory at the governorate level.

Annex III: List of documents consulted

1. CAPMAS, Statistical Year Book (Jan. 2012), table 2-4 “Estimates of Midyear Population by age groups (2002 – 2011); http://capmas.gov.eg/pdf/Electronic%20Static%20Book_eng/population/untitled1/pop.aspx.
2. CAPMAS, Statistical Year Book (Jan. 2012); http://capmas.gov.eg/pdf/Electronic%20Static%20Book_eng/population/untitled1/pop.aspx
3. Country Common Assessment (CCA) 2005; http://egypt.unfpa.org/english/Staticpage/7ebad37b-445e-4670-ad37-28ef1335f419/Common_Country_Assessment.aspx.
4. Draft 2008 – 2011 strategic plan, www.unfpa.org/exbrd/2007/annualsession/draft_strategic_plan_30may.doc18
5. 2008 Egypt Demographic and Health Survey Report.
6. Egypt 2010 MDG Report, UNDP; http://www.undp.org.eg/Portals/0/MDG/2010%20MDGR_English_R5.pdf
7. Egypt’s Progress towards Achieving Millennium Development Goals 2010, Ministry of Economic Development, UNDP.
8. Handbook on How to Design and Conduct a Country Programme Evaluation (HB), <http://www.unfpa.org/public/home/about/Evaluation/Methodology>
9. 2013 Human Development Report, UNDP; <http://www.undp.org/content/dam/undp/library/corporate/HDR/2013GlobalHDR/English/HDR2013%20Report%20English.pdf>
10. 2005 Human Development Report, http://hdr.undp.org/en/media/HDR05_complete.pdf
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12. International Human Development Indicators, <http://hdrstats.undp.org/en/indicators/68606.html>
13. Project’s Annual Work Plans 2008 – 2013.
14. Project’s Annual Monitoring form 2009 – 2012.
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16. Sixth Fifth Development Plan (2007–2012); <http://www.mop.gov.eg/english/sixth%20five%20year.html>
17. WHO, <http://apps.who.int/gho/data/view.country.8000>, 7th of May 2013
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19. <http://egypt.unfpa.org/english/search.aspx?searchterm=Common%20Country%20Assessment>
20. UNFPA, Arab State Regional office, Women’s Need for Family Planning in Arab Countries, July 2012, <http://arabstates.unfpa.org/webdav/site/as/shared/ASRO%20website/Publication/family-planning-arab-countries.pdf>

21. UNFPA country Program 2007 -2011 Evaluation, <http://web2.unfpa.org/public/about/oversight/evaluations/document.unfpa?page=doclist&method=view&docId=78>
22. UNFPA — Strategic plan and related matters, Second regular session 2007, 10 - 14 September 2007, New York, www.unfpa.org/exbrd/2007/secondsession/dpfpa_2007_17_eng.pdf
23. <http://data.worldbank.org/indicator/DT.ODA.ODAT.GN.ZS?page=2>
24. <http://www.indexmundi.com/facts/egypt/net-oda-received-per-capita>
25. <http://data.worldbank.org/indicator/DT.ODA.ODAT.GN.ZS?page=2>
26. <http://data.worldbank.org/indicator/DT.ODA.ODAT.XP.ZS>

Arabic list of documents consulted

- الخطة الإستراتيجية لضمان استمرارية توافر خدمات ووسائل تنظيم الأسرة 2006 – 2010
- الإستراتيجية القومية لضمان استمرارية توافر خدمات ووسائل تنظيم الأسرة 2009 – 2013
- المنهج التدريبي لإثراء كافتيريا الوسائل بأنواع جديدة
- تقدير الاحتياجات من وسائل تنظيم الأسرة باستخدام حزمة سبكتروم - دليل دورة تدريبية لبناء قدرات العاملين بالمحافظات
- دليل العقود والمشتريات
- المنهج التدريبي لضمان استمرارية وسائل تنظيم الأسرة
- أسماء وأعداد المتدربين في الدورات المختلفة خلال فترة المشروع

Annex IV: Evaluation Matrix

Evaluation Matrix				
CRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
Relevance	To assess the relevance of the intervention with the present national needs & the needs of different beneficiary groups (needs of staff working at PHCs, district-level, final beneficiaries < couples & WRA >)	Relevance towards the real needs of both duty bearer (supply side) & rights holders (demand side). Also whether the current UNFPA FP strategy in terms of CS is appropriate vis-à-vis the national strategy /policy	AWPs - assessment of national logistics - national documents/budgets/plan- UNDAF - UNFPA FP Strategy 2012 -2020	Study of documentation - Semi structured interview & FGD
Effectiveness	To what extent were the expected output (key result) of the project achieved (both in terms of quantity and quality) in particular with ability to accurately forecast, adequately finance, technically procure, & properly distribute :	Assess the project support to national partner in developing capacities & establishing mechanisms to ensure ownership and sustainability of effects through promoting in-house expertise	Project documents - trainings records	Study of documentation - Semi structured interview - Group discussion with beneficiaries & Service providers in PHCs
	Assess the worth of the supervisory role of the project & OJT that took place during the life of the project	To check the developed checklist used during field trips, also requests to relocate of multiple stores with bad conditions, in addition to the ongoing OJT to nurses	Project Trip reports	
	1- assess effectiveness of the multiple trainings conducted- in particular the logistic one to nurses to maintain max/min stock level in PHCs - new methods - Statisticians- FP Manager	Assess the results of those trainings and its contribution to improved performance of trainees	LMIS - Monitoring records	
	2- assess effectiveness of advocacy activities to create budget line for contraceptive procurement & attribute budget annual increase to the project	assess the background and timeline of the contraceptive national budget and attribute the increase of budget is due to the project meetings with the finance people	Minutes of meetings - relevant documents	

Summative Evaluation of Strengthening the Contraceptive Security System Project in Egypt

Evaluation Matrix				
CRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
	3- based on the developed indicators, assess the quality & sufficiency of data generated and utilized on keys aspects of the project	How the system is measuring progress- ensure meeting actual needs of target population/ /identifying constraints & determinants of risk. Also assess whether the generated information has reached & been utilized by the government	Project document - LMIS reports -M&E framework indicators- Quarterly & annual implementation progress reports - Implementing partners	
	Analyze how achieved key results have contributed to institutional change (Impact criterion can be considered here)	Analyze how building the capacity of service providers (nurses/doctors), strengthening the logistic functions have contributed to improved performance of the supply side. Examine to what extent end beneficiaries are taking advantage of the benefits provided by interventions & assess whether there have been any significant and tangible changes for them as a consequence of the interventions	UNDAF - UNCT - steering committee records - joint missions	
	Assess the coordination role of the project among stakeholders namely, NPC, Pharmaceuticals, NGOs, Private Sector & other MoHP Sectors	Assess worth of meetings held, recommendations implemented & results achieved as a result of these meetings	Beneficiary groups/ Other UN agencies	
Efficiency	Has the project been efficient in converting its resources into results?	Examine the relationship between what has been achieved and the costs of achieving it. (assess how inputs are converted into activates & the extent to which activities are being managed to ensure output delivery)	Quarterly & annual implementation progress reports - Atlas records - Donor	Analysis of planned and actual expenditures and activities

Summative Evaluation of Strengthening the Contraceptive Security System Project in Egypt

Evaluation Matrix				
CRITERIA	EVALUATION QUESTIONS	WHAT TO CHECK	DATA SOURCES	DATA COLLECTION METHODS
Sustainability	What are the prospects for sustainability of the achieved results? “to what extent are the benefits of the intervention likely to continue beyond the project closure?”	Assess whether factors ensuring ownership were factored into the design of interventions; & how the project has supported its partners and beneficiaries in developing their institutional and individual capacity to ensure the durability of outputs and outcomes;	Implementing Partner - Beneficiary groups -	Study of documentation - Semi structured interview
Added Value	What is the main project added value in the country context as perceived by national stakeholders?	Examine the explanatory factors behind a good degree of added value - What are the main comparative strengths of the partnership—particularly in comparison to other UN agencies?		Interviews with selected stakeholders
Lessons Leaned	What lessons learned or good transferable practices to other programmes or countries have been observed during the evaluation analysis?	assessing the impact of the different activities in order to identify best practices that should be replicated or scaled up		

Annex V: Stakeholder Analysis Matrix (HR-GE)

Who		What (role in the intervention)	Why (gains from involvement in evaluation)	Priority (how important to be part of the evaluation)	When (stage of evaluation to engage them)	How (stage of participation)
Duty-bearers with authority to make decisions related to the intervention (direct responsibility for the intervention)	FP/MoHP UNFPA/CO	Funders & GoE/MOHP FP - IP Project Management	to fulfill the accountability and learning functions of evaluation	High level of relevance to the evaluation	Preparation (TOR & selection of team) Inception/management response & dissemination	As a part of the audit information to give results validity
Secondary duty-bearers	Health Service staff at governorates/ districts & Service Providers at PHCs - Private hospitals	Secondary beneficiaries - trainees	Involve, feedback & assess performance improvement	High level of relevance to the evaluation	Primary research, Data collection & dissemination	As a part of the information
Rights-holders who one way or another benefit from the intervention	Health Service staff at governorates/ districts & Service Providers at PHCs	Secondary beneficiaries - trainees	Empower	High level of relevance to the evaluation	Primary research, Data collection & dissemination	As a part of the information
Rights-holders who one way or another benefit from the intervention	Couples & WRA	Primary beneficiaries (disaggregate: G, age, literacy)	feedback & ask for needs	High level of relevance to the evaluation	Primary research, & Data collection	As a part of the information
Rights-holders who are in a position disadvantaged by the intervention	Governorate with no intervention - NGOs - Private Sector					
Other interest groups	Other NGOs/ NPC/donors/ Pharmaceuticals	Secondary beneficiaries	Inform & consult	Low level of relevance to the evaluation	Dissemination	As a part of the information