



“Community-based intervention to alleviate the different forms of violence against women and women's vulnerability to HIV”

in Ezbet El Haggana and El Marg communities,
Cairo, Egypt

January 2015-December 2017

April 2018 Evaluation
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“If I had not come to Shehab, I would have been lost by now.”

Al Shehab Institution for Comprehensive Development
United Nations Trust Fund to End Violence against Women

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Acronyms

BSS	Behavioral Sentinel Surveillance
CBO	community-based organization
DIC	drop-in center, where Al Shehab offers services
FGD	focus group discussion
FSW	female sex workers
IDI	in-depth interviews
IEC	information, education and communication
ISDF	Informal Settlement Development Facility
GARPR	Global AIDS Response Progress Reporting
GBV	gender-based violence
HIV	Human Immunodeficiency Virus
HIV/AIDS	HIV and AIDS, Acquired Immune Deficiency Syndrome
MENA	Middle East and North Africa
NAP	National AIDS Program
PLWHA	people living with HIV/AIDS
PWID	people who inject drugs
PWUD	people who use drugs
RRF	Results and Resources Framework
SDG	Sustainable Development Goals, international development agenda
STI	sexually transmitted infection
TOR	Terms of Reference, part of a contract
UNAIDS	United Nations Joint Programme on HIV/AIDS
VAW	violence against women
VCT	voluntary counseling and testing, as for HIV
VNR	Voluntary National Review, SDG progress report

Disclaimer: This Evaluation Report has been developed by an independent evaluation team. The analysis presented in this report reflects the views of the authors and may not necessarily represent those of the Al Shehab Institution for Comprehensive Development, its partners or the UN Trust Fund.

Evaluation participants in their own words:

“They arrive with visible blows but what is invisible is often the most traumatic in their history.” – health care provider

“Drugs are sold like potatoes in public.” – primary beneficiary

“If I had not come to Shehab, I would have been lost by now.” – primary beneficiary

“It is essential to have a measure that will enable us to know where we are from, what is the road traveled and therefore to place the awareness work in a process of continuous improvement.” - young man, 18 years old, in the community

Executive Summary

Al Shehab Institution for Comprehensive Development implemented a three-year community-based intervention to alleviate the different forms of violence against women and women's vulnerability to HIV from January 2015 through December 2017. This project is called the "Community-based intervention to alleviate the different forms of violence against women and women's vulnerability to HIV" and was implemented primarily in two poor areas, Ezbet El Haggana and El Marg. One of these neighborhoods has a large number of migrants, and drugs are widely available. The other neighborhood endures deep historic poverty.

The criteria and justification for the selection of El Haggana and El Marg communities could be described as follows:

- The two selected communities are belonging to the informal/slum areas that are representing to some extent the wider population on National level. At the time of the Census of 2006 informal/slum areas accounted for roughly a third of the built-up area and, remarkably, had become the residence of over 62 percent of Greater Cairo's population. According the Social Justice and Urbanism: A Map of Egypt" in 2010/2011 the informal sector produced 47% of the total housing stock in Egypt.
- The informal communities are among the most excluded and deprived areas. Al Shehab working experience and studies in Ezbet El Haggana as well as other national studies within informal areas indicated that women in communities such as El Haggana and El Marg suffer a disproportionately higher deprivation of education, literacy and income, violence and discrimination among other quality-of-life indicators, as compared to their counterpart within formal communities.
- The DHS (2008) data indicated that populations with low socio-economic status have limited access to services that could protect them from acquiring HIV/AIDS and have low knowledge about modes of prevention and transmissions. The selected communities are representing these groups of marginalized women.
- Al Shehab Institution's field experience with female sex workers and domestic workers shown that most of the beneficiaries who are visiting the drop-in center are frequently coming from those two communities and its surrounding neighborhoods.

The intervention proposed by Al Shehab Institution, included anti-violence programming with local women and men, vocational training for women, legal services, HIV education, HIV and STI testing, and healthcare referrals.

The primary beneficiaries of this community-based intervention were marginalized women from informal communities. Informal communities include female survivors of violence, female sex workers, women living with HIV/AIDS, and female domestic workers. The four groups of primary beneficiaries of this project struggle with low socio-economic status, high rates of illiteracy, unemployment, and structural forces that prevent their enjoying safe working conditions. Most of them face barriers to access medical, legal and economic services to improve their situations due to their low economic status, justified fear of stigma and discrimination, and/or low levels of awareness regarding the means of preventing the twin epidemics of HIV and Violence against Women (VAW).

The secondary beneficiaries of this project were: community-based organizations from Ezbet El Haggana, health professionals from private, non-governmental and governmental health care

providers in the local community, men, boys and religious leaders. The project intended to create a supportive environment that empower women and support their access to stigma-free services in order to expand their abilities to address the different forms of violence they experience every day. This evaluation assesses the success of efforts for both primary and secondary beneficiaries.

This evaluation has three aims:

1. To evaluate Al Shehab's entire pilot project addressing violence against women in terms of effectiveness, relevance, efficiency, sustainability and impact with strong focus on assessing the results at the outcome and project goals.
2. To generate key lessons and identify promising practices for learning by documenting cases of positive changes and key lesson learnt as a result of the project implementation, which can then be used in scale-up.
3. To assess changes in terms of knowledge and perceptions of the different target groups regarding violence and HIV/AIDS.

This evaluation will be useful to Al Shehab participants, staff and donors as the community leaders and Al Shehab determine their next steps to combat violence and HIV.

Data collection methods included:

- Focus group discussions (FGDs) with women living with HIV, domestic workers, local men and religious leaders.
- Structured in-depth interviews (IDIs) with female sex workers, women survivors of violence.
- Interviews with members of CBOs, community leaders and medical personnel.
- In-depth interviews with the staff at the drop-in center and the community-based center.

More than 110 people were consulted for this evaluation, including more than 65 primary beneficiaries as well as volunteers, community leaders, religious leaders, health care practitioners, and representatives of UN and government agencies. Data saturation was reached, meaning that no new information was shared during interviews and FGDs conducted at the end of the evaluation.

Primary beneficiaries consulted included 29 female sex workers, 10 PLWHA, 28 survivors of violence, and 11 domestic workers; some of the primary beneficiaries were members of more than one group. Focus group discussions and in-depth interviews were conducted. Twenty FSWs participated in two FGDs, and 9 FSWs were interviewed. Five women PLWHA participated in an FGD, and 5 were interviewed. Eleven domestic workers were interviewed. Some participants were members of more than one group: a domestic worker may also sell sex, and may also be living with HIV, and so in some cases a person may be surveyed about multiple facets of the program. For example, different questions will be asked of sex workers and domestic workers, but a woman who is both may have been asked all of the questions for both groups.

Secondary beneficiaries consulted included 16 volunteers and community leaders in two FGDs and 8 local men in another FGD. Five religious leaders of the 40 trained participated in another FGD. Three healthcare practitioners were interviewed in addition to the NAP manager. Eight people who use drugs (PWUD), including 5 PWID, also participated in a FGD.

Major limitations included the inability to implement survey methods due to literacy constraints and a lack of funding for incentives and transportation reimbursement for primary beneficiaries. Interviewees described high levels of violence in their lives; however, even so it may not be possible to ascertain the variety of violence experienced by women.

Most important findings with concrete evidence

Al Shehab's community-based intervention to alleviate the different forms of violence against women and women's vulnerability to HIV was very effective. Health, legal, psychological and anti-violence programs reached 1662 vulnerable women in Cairo, these women who were eager to access these services. Services were effective and benefited primary beneficiaries. Interventions with local men, religious and community leaders and NGOs were effective, and the interventions with primary and secondary beneficiaries built upon each other. The only aspect that was less effective was the vocational training.

The services offered by Al Shehab remain very relevant to the lives of primary beneficiaries.

Primary beneficiaries were emphatic about the ways Al Shehab has affected their lives and changed their behavior. They also described long-term effects within their families. Secondary beneficiaries were also enthusiastic, and offered examples of change. However, there is also a backlash against the anti-GBV programming, with some men and family members becoming more violent in response. It may be helpful to engage more family members and men more regularly, as some participants described resistance at home before good changes happened.

Al Shehab is efficient in its use of existing infrastructure, particularly in the health care system. Al Shehab could improve efficiency by partnering with more NGOs and referring beneficiaries to services provided by organizational partners, in order to ensure the sustainability of the different services that respond to ending VAW and tackling women's vulnerability to HIV. It was evident that working with different service providers, among governmental and non-governmental organizations to ensure women can enjoy quality services that improve their safety and well-being.

Drug use is also prevalent in the lives of the participants, and affects their vulnerability to GBV and HHIV. To improve effectiveness, it may be worthwhile to work with men in the community and to address drug use in particular among this target population. The gains of anti-GBV programming will be sustainable with repetition. Sustainability could be improved with more engagement with men and engagement with People Who Use Drugs (PWUD).

Police violence was described by all sectors of primary and secondary beneficiaries as a problem. As police violence is high, it will be important to engage the police, and this will require advocacy for policy change with the government to force the police to engage with

communities. However, giving the challenges Al Shehab faced to engage with the police. Working with police can be led by UN Women and the National Council for Women in Egypt.

In conclusion, Al Shehab's project to address the twin epidemic HIV and Violence against Women was effective but gains will not be sustained without further programming and continuation on larger scale. Programming could be improved upon in the next phase by repeated and sustained engagement at the individual and community level, and by working with perpetrators of GBV, meaning family members and men in the community. This can be realized by building and strengthening the partnership with a wide range of services providers on both community and national levels. In order to ensure sustainability of essential services that contribute significantly to the reduction of women's vulnerability to HIV and violence. As drug use affects everyone in some communities, and as some primary beneficiaries use drugs, it will be necessary to work with People Who Use Drugs (PWUD) to effectively combat violence against women. Thus, the implementation of proven-effective harm reduction approaches are recommended.

Key Recommendations

Effectiveness

Direct services are very effective: it is recommended (as stated by all interviewees among direct and secondary beneficiaries) to continue providing legal, medical, psychological and anti-violence services within the targeted communities.

Relevance

The former project did not include medical service. Most of women who participated in the focus group discussions, In-depth Interviews indicated the need to have gynecological services. Thus, it is recommended to include this service in both community center and the drop-in center in order to address women's vulnerability to both HIV and violence in a holistic manner.

Shehab should resume legal services and anti-violence programming. Primary beneficiaries described successes including securing identity papers for their children and completing divorce proceedings with the assistance of the lawyer. This program should be resumed.

Efficiency

For Al Shehab to be more effective in programs that address the twin epidemic (VAW & HIV), it will have to engage not only women and imams (religious leaders) but local men, in a programmatic fashion. This would be new for Al Shehab, but the men who have become more violent in response to women's empowerment need to be engaged, because if they remain unemployed, unable to fulfil community roles, they will continue to resent programs and advancements for women. The men are also underserved, and development programs should be designed to address and respond to men's needs and challenges as well. Al Shehab must continue to prioritize women, but must not let a few men's resentment derail the work with the women.

Sustainability

Models that address the nexus of VAW and HIV as well as the anti-violence programming must be repeated regularly and scaled-up for effects to be sustainable.

Promote a network of primary beneficiaries – the women who come to Al Shehab for services, and build their leadership and ability to advocate for their rights. This will require long-term capacity building.

Work with imams (representatives of religious leaders) with clear deliverables, for them to work with Christian clerics, and to use social media and new technology in order to influence on their constituencies as well as on the general population to promote equitable gender norms on both community and national levels.

Engaging men at the family and community level is important to the success of the anti-violence program and for programs that aim at reducing women vulnerability to both violence and HIV in the future. Men must start to understand that VAW is not only wrong nor illegal act, but that it hurts their families and the women they care about most.

Some Al Shehab participants have experienced a backlash at home as they have become more empowered. Considering this, it is important to work with their families, and with men in the community, to demonstrate that the women's gains are not a threat to the men or the family or the community, but instead an asset, healthier women means healthier families, and women with more earning power support their families.

Impact

Anti-violence programming was effective but needs to be resumed with regularity, rather than one-off programs.

Schedule DIC and programs in alignment with the schedules of the primary beneficiaries. Programs should be in the afternoons and evenings for some primary beneficiaries.

Vocational training was the least successful of programs. Beneficiaries reported not having professional level skills, except in some very specific instances. If vocational training is to resume, it should be in depth and involve only as many people can be sustained in hairdressing and food preparation in the community. A smaller program for fewer people who receive in-depth training and job placement assistance would be more effective. Handicrafts do not offer adequate economic opportunities to be included. If donors offer inadequate support for vocational programming, it may be better to wait for additional funding that would permit more in-depth training rather than to expend additional time, energy and small amounts of funding on an ineffective short-term vocational program. We would recommend to not add a component on the vocational training for the direct beneficiaries within this program. A specific program that aims at improving the economic status of the direct beneficiaries through vocational trainings, soft-skills trainings etc. should be designed separately to complement with the anti-violence programming.

Knowledge generation

To share information about Al Shehab's work, lessons learnt and best practice, consider publishing an academic paper and submitting information to health newsletters.

Other

It is important to work with other local NGOs and to refer participants to other service providers, rather than trying to offer all services. For example, some beneficiaries described a need for dental services, and this may present an opportunity to refer them to another NGO.

Beneficiaries suggested programs for children, because education services are lacking. This could begin with a nursery where children could stay when their mothers attended Al Shehab's programs. This could even be run by the women themselves.

NAP recommended expanding Al Shehab beyond Cairo, and can help work toward national coverage and also raise awareness and collaborate with a large number of medical service providers. Such expansion would depend on the new network of primary beneficiaries being able to travel and grow Al Shehab's work, first in other parts of Cairo and then in chosen locations in other cities.

It is strongly recommended that Al Shehab engage with the use of drugs, using proven effective harm reduction approach rooted in understanding of the drugs used in the local community. Drug use is extremely common in some areas where Al Shehab works and reported to be common in the families of Al Shehab's direct beneficiaries, and among some Al Shehab participants, affecting dramatically violence and vulnerability to HIV. Therefore, in order to comprehensively serve the beneficiaries, Al Shehab must address this facet of their lives, as this affects everyone. Using a harm reduction approach, accepting people "where they are at" with respect to drug use and other possibly dangerous activities and harmful behavior, is recommended for its proven effectiveness and to generate trust among the community. It may be worthwhile to start a support group for the women who use drugs and to encourage a local imam or other leader to work with men who use drugs.

Heroin is not the most common drug, but opioid overdose is a problem in the community; for this reason, it is recommended that naloxone be introduced and distributed, with trainings to use naloxone to reverse overdose conducted at regular intervals. Naloxone is on the WHO list of essential medicines but is not available in Egypt, so it will be necessary for UNAIDS, UNDP, WHO and other UN agencies to advocate for its importation, working with the Al Shehab community, and for naloxone to be distributed at the community level. These same groups should advocate for the introduction of proven-effective opioid substitution therapy in Egypt.



An Al Shehab participant selling goods at her kiosk

1. Introduction: Context of the Project

- a. Socioeconomic, demographic, geographic, and political context
- b. Explanation of how social, political, demographic and/or institutional context contributes to the utility and accuracy of the evaluation.

Geographic and political context:

Egypt has made important strides along a number of essential human development indicators over the past decade; however, economic growth has been moderate and unable to keep up with the growth of the population. As a result, it has a high unemployment rate of 12.8% and a burgeoning informal economy with insecure and precarious jobs. Since 2014, there have been many structural changes aimed at addressing the allocative inefficiency, such as cuts to energy subsidies, which are yet to be met with social security measures to protect people from ongoing economic shocks and inflation. As a result, many men and women lack the social protection necessary to live a secure and comfortable life, and face an array of issues related not only to finding employment, but finding and keeping decent work that is safe, financially rewarding, insuring the worker against emergencies and work-related injuries, etc.¹

The national, geopolitical context in Egypt vis-à-vis violence against women and women vulnerability to HIV/AIDS is vibrant. In 2015, Egypt witnessed two major changes in the areas of women's rights and HIV/AIDS national response. Foremost the government, worked to comply with the International Standards and to create supportive environment in order to promote women and girls' rights nationwide. By the end of April 2015, the National Council of Women launched the National Strategy on Combating violence against women under the auspice Primer Minister. It is five-year strategy (2015-2020) whose methodology is based on literature review, nationwide survey to better understand the current situation, SWOT analysis and the outcomes of workshops that were organized with wide number of stakeholders. For the first time the National Council for Women with numerous ministries worked collectively in structured manner to develop national strategy to address gender-based violence in Egypt. The strategy relies on 12 protocols signed between the National Council for Women and different ministries including Interior, Health, Education, Youth and Justice as well as with the Orthodox Church and several specialized councils including the National Council for Childhood and Motherhood and National Council for Human Rights. The strategy includes four main themes that shape the visions and objectives of the strategy. These themes are: 1) prevention, which deals with education, awareness raising and review of relevant laws. 2) Protection that deals with implementation of laws, raising awareness of them and encouraging women to report violence. 3) Intervention theme, which is concerning with service provision i.e. psychological, health services, women's shelters and referral system. 4) Prosecution and litigation.

In 2016 the Egyptian President Abdel Fattah El-Sisi declared that 2017 would be "the year of the Egyptian women", which indicated a strong political will at the highest level of government to improve the situation of women and girls nationwide. Consistent with this announcement has been the efforts by the NCW to develop a national vision and strategy on women

¹ World Bank, Egypt Country Overview 2015.

empowerment that will be aligned with Egypt's sustainable development strategy and the Sustainable Development Goals. This vision will in addition to the national strategy on Combating violence against women that was endorsed in April 2015. This built on NCW's ongoing efforts towards women's empowerment, such as the 2016 "Taa Marbouta" campaign, which refers to a letter of the Arabic alphabet that is the feminine conjugation in the Arabic language. The campaign was launched by the National Council for women, and focuses on utilizing the power of media to address misconceptions about gender roles, and enhance women's empowerment and participation in all spheres of life, including the political, economic, and social spheres. In 2017, The Government of Egypt takes different actions to alleviate the adverse impact of economic reforms, particularly on the poor and most disadvantaged segments of the population including those who are living in slum communities. Such efforts include expanding the social protection schemes such as Takaful and Karama cash transfer program. The Takaful program targets poor mothers conditional on their children getting health exams and/or demonstrating school attendance. Karama is a social protection program that targets poor elderly people and individual with disabilities. According to the World Bank, the Takaful and Karama program was initially rolled-out in Upper Egypt with a target of 1.5 million households. In June 2017, the program was scaled-up to reach 1.7 million household beneficiaries. This was complemented by announcing 2017 "Year of Egyptian Women" by Egyptian President Abdel Fattah El Sisi to improve the situation of women and girls nationwide. Despite the government's current efforts, high level of poverty and unemployment rate particularly among women, inflation caused by the currency floatation and significant increase in the food prices adversely affect the Egyptian households, especially the poor and vulnerable segments of population. We believe such harsh economic conditions will have adverse impact on women in particular. It would increase sexual exploitation, economic violence against women and depriving to access decent working conditions.

Regarding HIV/AIDS related situation. Egypt is experiencing financial challenge and availability of funding to sustain prevention and outreach programs that address the needs of Key Populations including FSWs. At present and due to the scarcity of funding, newly diagnosed People living with HIV are facing serious challenge to start ARVs. This is combined with increased fear among PLHIV that ARVs treatment would be stock out in six months.

Socioeconomic context:

Al Shehab Institution implemented this project in urban, marginalized, and informal communities, with partners from UNAIDS Egypt Country Office.

The first site was Ezbet El Haggana neighborhood, located in East Cairo with a population of approximately one million inhabitants in addition to more than 4500 refugee families from Sudan and Somalia (Al Shehab Institution survey in 2009 with WHO-EMRO). The second site was El Marg District, in North-East Cairo. Al Shehab did not provide services directly in this community, however, the organization targets women and girls who engage in sex work from this community and the surrounding neighborhood (East Cairo parts). Egypt's Informal Settlement Development Facility (ISDF) reports that in 2008, there were approximately ten informal areas in El Marg district, with tens of thousands of residents. These conditions have not been alleviated in the intervening years. Indeed, these neighborhoods are afflicted with structural factors like overcrowding and poor quality housing; inadequate infrastructure and services including sewage and access to clean water, an insufficient number of schools, inadequate electricity, and inadequate trash disposal. These are characteristics of "slums" and

residents of both target communities suffer from the hallmarks of slum dwelling. For example, too few schools lead to classroom overcrowding with class sizes reaching as many as 80 students. In this context, education is not up to par and literacy rates are low. The continuing lack of access to education compounds already trenchant problems including poverty, very high rates of unemployment, and a lack of decent jobs. These issues are compounded for young people.

Income-generating opportunities available to residents of the local communities are predominantly within the informal sector, and is therefore unstable labor, low income, and lacks social security and the minimum requirements of decent working conditions. Women within these communities are subject to discrimination and different forms of violence. For example, domestic violence against women reported in Ezbet El Haggana as a widespread phenomenon as the 2009 survey found that 62.6% of women had been subjected to domestic violence. Domestic violence against women includes physical abuse, emotional abuse, economic abuse, and sexual abuse. Batterers most likely are fathers and husbands, and they use threats, intimidation, isolation, and other behaviors to maintain power over their victims. Another significant finding in the Ezbet Al Haggana community that emerged from the survey is 48% of women represented in the sample are heading their families, which is relatively higher than the estimated national average of 13.4% (national figure obtained from: ICF International Demographic and Health Survey 2008). The majority of women in Ezbet Al Haggana community work mainly as domestic workers in wealthier areas nearby, where they are subject to different forms of violence, sexual harassment and poor health conditions.

The Al Shehab DIC has documented since 2006 that many people coming to the DIC from El Marg Districts and among women in Ezbet El Haggana do not have official documents like birth certificates and national identity cards. One reason for this problem is that many parents traditionally did and do not think it is necessary to issue such papers for girls. However, lacking access to such documents deprive women of the right to enjoy certain rights such as the right to education, access to health care services, and the right to access pension and literacy classes. Moreover, the absence of such documents denies women the ability to exercise their right to vote, to claim inheritance, to obtain credit or other financial services, and to establish a business. The lack of identity papers puts women at a disadvantage throughout their lives.

Drug use is easily observed on the streets of Ezbet El Haggana. Women from the Ezbet El Haggana neighborhood explained to evaluators that the area is so stigmatized for its slum conditions and the drug trade that they prefer to say that they come from elsewhere; usually saying that they come from other districts.

The communities of El Marg Districts and Ezbet El Haggana are not officially recognized, making even the neighborhood insecure. These neighborhoods could be razed or raided (for immigrants, for criminal activity including drugs.) Basic requirements for decent living conditions have fallen behind national averages, and these communities lag behind on many social indicators, creating further vulnerabilities and widening inequalities. These communities need services and attention beyond what Al Shehab can provide in order to attain the Sustainable Development Goals (SDGs) of the 2030 Agenda, especially related to Goal 3 on Health and Goal 5 on Gender Equity, including addressing VAW. Egypt's first Voluntary National Review offers few details about ways to achieve the SDGs, but corroborates the increase in

poverty and the increase in the population (page 23) and says “Much still needs to be done to combat violence against women and children, and gender equality is still at an early phase.” (page 43) Egypt will report its second VNR in 2018. In the interim, Al Shehab carries on its community-based work to improve the health and well being of women in these marginalized communities, supporting efforts to achieve Goals 3 and 5 on health and gender equality.

2. Description of the Project

Al Shehab Institution for Comprehensive Development implemented a three-year community-based intervention to alleviate the different forms of violence against women and women’s vulnerability to HIV from January 2015 through December 2017. This project is called the “Community-based intervention to alleviate the different forms of violence against women and women’s vulnerability to HIV.”

Marginalized women who experience (or are at risk of) violence and HIV transmission with a focus Ezbet El Haggana and El Marg communities in Cairo were the focus of the intervention, with attention to improved safety, health and reduced vulnerability through improved access to GBV and HIV services and increased understanding in the community. In Egypt and elsewhere, many studies have addressed HIV or violence against women, but this is the first evaluation of a project addressing the way violence affects women’s vulnerability to HIV in Egypt. This groundbreaking project was evaluated using qualitative and quantitative methods.

Al Shehab Institution implemented its “Community-based intervention to alleviate the different forms of violence against women and women’s vulnerability to HIV” with funding from the United Nations Trust Fund to End Violence against Women. The project worked to address these gaps and achieve an overall goal of supporting marginalized women who experience violence and/or HIV. The project’s objectives were to improve access and utilization of services for GBV and HIV to meet needs of particular groups who experience and at high risk of gender-based violence and HIV, and to increase understanding and support for gender equality and HIV response in the community. The project utilized a number of strategies, range from: promoting/providing services (psychological counseling, medical service, shelters); creating opportunity for women to exercise social and economic rights; capacity development for CBO and public health care providers; public outreach and awareness-raising; and collecting and analyzing data for the first time in Egypt on the interstice between HIV/AIDS and VAW.

Using Theory of Change terms, the long-term goal for this project is to reduce the effects of violence in the community, including the ways violence promotes the transmission of HIV. To address violence, it is necessary to understand the root causes of violence, including who commits violence, and who might influence people not to commit violence. To that end, AL Shehab engaged with women in the community to understand the levels and types of violence they experience, and also with men, including community leaders, to educate them about the effects of violence on the women and girls in their lives. Religious and community leaders worked to dissuade people who might commit violence. In addition, the project addressed structural violence, helping women with legal and health care services, as well as vocational training and education. This evaluation assesses the success of the aspects of this project.

The primary beneficiaries of this community-based intervention were marginalized women from informal communities. Informal communities include female survivors of violence, female sex workers, women living with HIV/AIDS, and female domestic workers. These segments of the population are frequently subject to different acts of violence including intimate partner violence, family violence, and harassment in public spaces, to name a few. Furthermore, women and girls are at significantly high risk to acquire HIV/AIDS. For example, female sex workers are amongst the key populations in Egypt and are highly vulnerable to both HIV and violence. Also, female domestic workers often work in unsafe environments without any legal protections from sexual violence and harassment within their workplaces as well as at their own households. The four groups of primary beneficiaries of this project struggle with low socio-economic status, high rates of illiteracy, unemployment, and structural forces that prevent their enjoying safe working conditions. Most of them face barriers to access medical, legal and economic services to improve their situations due to their low economic status, justified fear of stigma and discrimination, and/or low levels of awareness regarding the means of preventing the twin epidemics of HIV and Violence against Women (VAW).

The secondary beneficiaries of this project are: community-based organizations from Ezbet El Haggana, health professionals from private, non-governmental and governmental health care providers in the local community, men, boys and religious leaders. The project intended to create a supportive environment that empower women and support their access to stigma-free services in order to expand their abilities to address the different forms of violence they experience every day. This evaluation assesses the success of efforts for both primary and secondary beneficiaries.

Key partners: This project was implemented with the technical support from UNAIDS Country Office- Egypt.

3. Purpose of the Evaluation

a. Why the evaluation is being done

The final evaluation is required by the UN Trust Fund to End Violence against Women. At the beginning of this intervention, Al Shehab commissioned an external firm to conduct a baseline survey to measure the current knowledge, perceptions and experiences of violence among the primary beneficiaries prior to delivering this project, and to assess the perceptions of men, health workers and community leaders on how to best address the intersection between violence against women and HIV as well as to examine the current relevant national strategies in order to identify strengths and weaknesses, and to suggest ways to better establish link between the work on HIV and violence. As of 31 December 2017, the project was completed and closed. Now, Al Shehab would like to assess the extent to which each indicator was achieved and compare the results for the goal, each outcome and output against the findings of the baseline. The final evaluation assesses women's experience of safety, health and wellbeing (project goal), and societal perspective about gender equality, women's rights, intimate partner violence, acceptability of accessing HIV related information and service and acceptability of women's economic participation. Also, Al Shehab Institution would like to better understand and document the key successes, challenges and lessons learnt from this particular community-

based intervention, and to assess the relevance, effectiveness and management arrangements of the project.

- a. How the results of the evaluation will be used, decisions to be taken post-evaluation, and context of the evaluation
- b. What decisions will be taken after the evaluation is completed

The results and outcomes of the final evaluation will inform Al Shehab Institution how best to scale-up this intervention. This assessment is required to sustain the intervention and continue supporting women and girls within informal and marginalized communities with access to gender-based-violence and HIV services. In this context, the results of this evaluation will be used immediately to develop concept notes and full-fledged proposal(s) for resources mobilization and fundraising efforts. Based on the findings and results of this evaluation and end line survey, Al Shehab will revisit its strategy relate to women's and girls' empowerment as well as its program on women's vulnerability to HIV/AIDS in Egypt. On a strategic level, the final evaluation will support Al Shehab's Board of Trustees and programming unit to decide on the framework of the new proposal to scale-up this pilot project. On programmatic and service delivery level, the final evaluation will guide Al Shehab Institution to make informed decisions to improve the services at the drop-in center and the community center.

4. Evaluation Objectives and Scope

Timeframe: Duration of the project, 1st January 2015 – 31st December 2017.

Coverage: Women, girls, survivors of violence, female domestic workers men and youth, community-based organization and health services providers from Ezbet El Haggana. Female sex workers who come from East Cairo including Al Marg community and women living with HIV who come from different parts at Greater Cairo.

Target groups covered: the evaluation covered the target primary and secondary beneficiaries as well as broader stakeholders listed in the full-fledged project proposal. This includes: women and girls (female domestic workers, survivors of violence, female sex workers and women living with HIV), men and youth from the target community, community-based organizations, health care services providers (private, non-governmental and governmental services providers), religious leaders, National AIDS Program, National Council for Women, UN Women and UNAIDS Egypt country offices. Religious leaders were included instead of police; while the initial proposal included police, the police proved too difficult to engage, and so religious leaders were included instead.

Interventions covered by the evaluation are the following:

- Services provided for women and girls within the two centers (drop-in center and community service center). These services included: psychological, legal, listening supports as well as Voluntary Counseling and Testing (VCT) services.
- Handcraft and vocational trainings for the populations in question.
- Capacity development component for the community-based organizations and health care services providers.
- The referral system established between the project and services providers.
- Community-based awareness and advocacy campaigns to engage men and youth from the target community. This intervention includes: IEC awareness materials, door-to door campaigns, awareness sessions and interactive theatre activities.
- Policy paper on the intersection between VAW and HIV/AIDS
- Trainings for 40 religious leaders from Cairo.



Vocational training: Permission to take hair dressing training exam, hair dresser syndicate membership cards, and a certificate for the completion of the hair dressing course (names are not visible for a question of confidentiality)

Objectives of the Evaluation:

At the end of the three-year project, it is vital to assess the progress achieved by the project and the changes in perceptive, knowledge and even practice that occurred as a result of the project's different key activities.

The overall objectives of the evaluation were to:

1. Evaluate the entire project in terms of effectiveness, relevance, efficiency, sustainability and impact with strong focus on assessing the results at the outcome and project goals.

2. Generate key lessons and identify promising practices for learning by documenting cases of positive changes and key lesson learnt as a result of the project implementation.
3. Assess changes in terms of knowledge and perceptions of the different target groups regarding violence and HIV/AIDS.

5. Evaluation Team

Amal El Karouaoui, MPH, is an expert in gender and HIV, and is an expert on Egypt, having lived in Cairo for five years. El Karouaoui has expertise evaluating HIV programming throughout the MENA region. She was the Senior Evaluator, for undertaking the evaluation from start to finish and for managing the evaluation team under the supervision of evaluation task manager from the grantee organization (Al Shehab Institution), for the data collection and analysis, as well as report drafting and finalization in English and Arabic. El Karouaoui conducted all interviews and FGDs.

El Karouaoui analyzed data collected in the field and wrote the final report. Dr. Melissa Ditmore has been consulted by the evaluation leader to review the methodology used and the final report. Dr. Ditmore has worked with El Karouaoui on multiple evaluations of HIV programming in the MENA region.

Al Shehab staff were crucial partners for the evaluation team, both to help select Al Shehab participants, and facilitating introductions to participants among health care providers, religious leaders, and local men. Al Shehab's Director Reda Shoukra oversaw the evaluation team. Al Shehab staff Abdo abou el Ela facilitated introductions to key personnel, including current and former staff (health and legal practitioners) and arranged space for group discussions.

Nada Ayman, psychologist, offered support and counseling for people who were upset after the end of group focus or individual interviews.

The evaluation was conducted in February 2018, including all group discussions and interviews. The draft report was delivered in March 2018 and finalized in April 2018.

6. Evaluation Questions

The key questions answered by this evaluation include the following divided into five categories of analysis. The five overall evaluation criteria – relevance, effectiveness, efficiency, sustainability and impact - were applied for this evaluation. The questions specified by the UN Trust Fund to End Violence Against Women for this evaluation were as follows.

Effectiveness

1. To what extent were the intended project goal, outcomes and outputs achieved and how?
2. To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? How many beneficiaries have been reached?

3. To what extent has this project generated positive changes in the lives of targeted (and untargeted) women and girls in relation to the specific forms of violence addressed by the project? Why? What are the key changes in the lives of those women and/or girls? Please describe those changes.
4. What internal and external factors contributed to the achievement and/or failure of the intended project goal, outcomes and outputs? How?
5. To what extent was the project successful in advocating for policy change? If it was successful, explain why.
6. In case the project was successful in setting-up new policies (related to HIV & Violence against women), is the policy change likely to be institutionalized and sustained?

Relevance

1. To what extent were the project strategy and activities implemented relevant in responding to the needs of women and girls (direct beneficiaries)?
2. To what extent do achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?

Efficiency

How efficiently and timely has this project been implemented and managed in accordance with the project document?

Sustainability

How are the achieved results, especially the positive changes generated by the project in the lives of women and girls at the project goal level, going to be sustained after this project ends?

Impact

What are the unintended consequences (positive and negative) of the project?

Knowledge Generation

1. What key lessons learned can be shared with other practitioners on Ending Violence against Women and Girls?
2. Are there any promising practices? If yes, what are they and how can these promising practices be replicated in other projects and/or in other countries that have similar interventions?

In addition to above listed questions, at the end of end-line survey, Al Shehab will be able to answer the following questions specified in the TOR for the evaluation and quoted from there:

- To what extent did the project reach the targeted beneficiaries at the project different levels (goal, outcomes and outputs)?
- What are the internal and external factors contributed to the achievement, partial achievement or non-achievement of the intended outputs and outcomes?
- To what extent was the project successful in providing new information regarding GBV and HIV and in changes perceptions of the targeted audience in the implementing communities in comparison to the baseline data?
- To what extent did the project outputs and outcomes addressed the needs of the targeted population? And if some of the achieved results generated any positive change in the lives of some women and girls?
- What is the impact of the project on staff's ability and knowledge gain?

7. Evaluation Methodology

This evaluation has three aims:

1. To evaluate Al Shehab's entire project addressing violence against women in terms of effectiveness, relevance, efficiency, sustainability and impact with strong focus on assessing the results at the outcome and project goals.
2. To generate key lessons and identify promising practices for learning by documenting cases of positive changes and key lesson learnt as a result of the project implementation, which can then be used in scale-up.
3. To assess changes in terms of knowledge and perceptions of the different target groups regarding violence and HIV/AIDS.

A. Evaluation Design: qualitative and quantitative methods

This evaluation used both qualitative and quantitative methods, using only post-test without comparison group.

The researchers prepared a structured interview protocol for each group of primary and secondary beneficiaries. FGD protocols were also developed for each group. Then, the results of the qualitative study were reflected in a structured questionnaire used in the quantitative study to explore how common the issues or needs among the respondents. Protocols for the primary beneficiaries were pre-tested by a few numbers of people who have the similar characteristics as the sample population, in order to ensure that the respondents understood the questions correctly and examining whether the researchers were able to make the respondents feel free to answer the questions. Researchers adjusted the ways questions about personal experiences of violence were asked, using games and incorporating breathing exercises to discuss sensitive and difficult topics including experiences of violence.

The protocols were designed to investigate the meanings and understanding of experiences in safety, health and well-being among female domestic workers, women living with HIV, female sex workers and women's survivors of violence among the targeted communities, particularly Ezbet El Haggana and areas of East Cairo including Al Marg community, (Project goal indicator 1). First, safety indicates their experience of mental, physical, and sexual violence in their workplace and intimate partner violence. Additionally, it investigates what experience the project beneficiaries had within their community, with their partners in daily life and when they become victims of any forms of violence to report incidents. The study also probed whether they were willing to report incidents when they experienced any forms of violence, and what influences their decision-making to report or not to do so, as well as the extent to which the project equipped them to be able to report the forms of violence. Second, health was described as their needs for sexual reproductive health, HIV services (HIV testing and counseling, and condom provision), and mental health after experiencing any forms of violence. To assess the vulnerability to HIV, the study investigated their knowledge about HIV, condom use, and access to HIV testing and counseling and condoms, probe the stereotypes relate to intimate partner violence and its relation to vulnerability to HIV. The project's impact on women's ability to protect themselves from HIV and other sexually transmitted infections (STIs) was measured.

Third, wellbeing was defined as their experience of participating in household income, and being financially challenged.

A formative qualitative study included all the mandatory questions, with free-form open-ended questions about what was most helpful and what would improve Al Shehab's services for all participants, including vulnerable women, women living with HIV/AIDS, women in the trade classes, men, women in domestic work, women in sex work, and the imams who have been trained, in addition to Shehab's health care providers. This study included focus group discussions (FGDs) and opportunistic interviews at Al Shehab sites. FGDs for each group, one at each of Shehab's two urban locations, with a minimum of five participants in each. This enabled deep conversation. These discussions included vulnerable women in different categories of Shehab participants: women living with HIV, domestic workers and religious leaders.

B. Data sources

Data sources beyond the information collected by the evaluation team include UNAIDS webpage about Egypt, the baseline report produced by Al Shehab in 2015, and the policy brief about violence against women produced by Al Shehab in 2017. Al Shehab will be responsible for sharing relevant internal documents and the baseline study.

The main data sources are:

- The proposal and the Results and Resources Framework (RRF),
- The project's progress and annual reports,
- The project's monitoring, evaluation and knowledge management system,
- The project's direct beneficiaries, target groups and relevant stakeholders, and
- Relevant national strategic plans i.e. National Strategic Plan for HIV and National Plan to Combat Violence against Women.

Appropriate officials working on HIV were consulted.

Al Shehab facilitated introductions to religious leaders, health care practitioners, and drop-in centre attendees and other community-based intervention participants.

C. Description of data collection methods and analysis

Data collection methods included:

- Focus group discussions (FGDs) with women living with HIV, domestic workers and religious leaders
- Structured in-depth interviews (IDIs) with female sex workers, women survivors of violence
- Interviews with members of CBOs, community leaders and medical personnel
- In-depth interviews with the staff at the drop-in center and the community-based center

The mandated questions address effectiveness, relevance, efficiency, sustainability, impact, and the generation of knowledge. Questions added by the evaluation team included UN BSS indicators related to HIV, STIs, and violence indicators.

Religious leaders, all imams and professors, were asked what they did in response to the training; i.e. did they preach against violence against women? How did community members

respond? Also, they were asked how they respond to victims of violence and if this has changed because of the class.

More sensitive issues were addressed with sex workers and victims of violence, and in depth addressing their experiences, and how Al Shehab has helped them in their situations, as well as recommendations to improve services and expand access. During group discussions with primary beneficiaries, games were used to facilitate discussion of painful and violent experiences, and breathing exercises were incorporated. The games were successful in opening up discussion of sensitive and painful topics, and participants offered high levels of detail about their experiences during group discussions and interviews. During group discussions and interviews, Al Shehab's psychologist was on hand to assist with people who became upset while discussing adverse and traumatic events.

Interviews with the staff at the drop-in center and the community-based center were invaluable sources of information about the daily running of the centers and the obstacles faced in addition to the successes. Knowing and understanding obstacles allows potential solutions to be identified and suggested.

Over 110 people participated in the evaluation, from categories including primary beneficiaries (FSWs, domestic workers, female victims of violence), and local men in the community, religious leaders, health care practitioners, and government representatives. None of these categories had more than 30 people, and some categories were quite small; for example, only five religious leaders participated, or 20% of the 40 who participated in the anti-violence program. For this reason, the frequency of responses is useful, but no group is large enough for statistical analysis to offer more meaningful information. In most cases, the level of agreement on issues among participants was striking. For example, only one woman described not experiencing violence. This high level of agreement is described in greater detail in the findings.

Participatory techniques enabled freer discussion than might be expected with the interview and FGD guides. Participants largely stayed on topic, with only very few instances of the facilitator bringing people back to the topic. Evaluators believe this high level of staying on topic reflected the urgency of the topics for the stakeholders. Participants offered specific examples, including related to very sensitive topics like interpersonal violence, and were able to bring the discussion or interview to the aspects they found most compelling.

Interviews and FGDs were recorded and transcribed; only the senior evaluator has access to the recordings. All data was translated into English for this report to UNTF. Data from interviews and FGDs were categorized by topic and inputted into a spreadsheet categorized by topic, using the order for interview questions. As group discussions inherently strayed from the protocols, categorization by topic facilitated comparison across interviews and FGDs. Data was analyzed by frequency analysis (for example, how many people in which categories reported having experienced particular types of violence.) Quotes were inputted by theme. Some themes emerged organically in the interviews and discussions; for example, primary and secondary beneficiaries in all categories mentioned police, but only primary beneficiaries were asked about police and only in the last part of interviews and discussions. Unprompted topics were flagged as of particular importance, and issues brought up by large proportions of participants

were also flagged, as were responses that stood out for their singularity (e.g. notable violent incidents, a lack of violent experiences, and standout experiences not shared by others.)

Primary beneficiaries were asked to use a Likert scale (1-5, 5 = excellent, 3 = average, 1 = poor) to rate the programs in which they participated.

The existing UN instrument about interpersonal violence (asking for example has anyone slapped or hit you, and leading up to has anyone made you do something humiliating or that you did not want to do) functioned as a built-in scale to measure severity of violence experienced.

Two case studies are included demonstrating good outcomes in the community, one highlighting success with primary beneficiaries, the other starting with men and affecting women.

D. Description of sampling

Over 110 people were consulted for this evaluation, including primary beneficiaries, volunteers, community leaders, religious leaders, health care practitioners, and representatives of government agencies. The area covered was the two target neighborhoods of Cairo. Rationale for selection of participants included the identification of key people by al Shehab staff. These key informants included community leaders, former staff who were able to be reached, and target numbers of Al Shehab participants based on a small percentage of participants. The original aim was to survey 5 to 10 percent of participants, but a survey was not possible; considering this, numbers of interviews and FGDs were increased. A complete table of people and organizations consulted is in Appendix F.

Primary beneficiaries consulted included 29 female sex workers, 10 PLWHA, 28 survivors of violence, and 11 domestic workers; some of the primary beneficiaries were members of more than one group. Focus group discussions and in-depth interviews were conducted. Twenty FSWs participated in two FGDs, and 9 FSWs were interviewed. Five women PLWHA participated in an FGD, and 5 were interviewed. Eleven domestic workers were interviewed. Some participants were members of more than one group: a domestic worker may also sell sex, and may also be living with HIV, and so in some cases a person may be surveyed about multiple facets of the program. For example, different questions will be asked of sex workers and domestic workers, but a woman who is both may have been asked all of the questions for both groups.

Secondary beneficiaries consulted included 9 community leaders and volunteers in one FGDs and 8 local men in another FGD. Five religious leaders of the 40 trained participated in another FGD. Three healthcare practitioners were interviewed in addition to the NAP manager. Eight PWUD, including 5 PWID, were consulted in one FGD.

Time and resource constraints including a lack of transportation reimbursement for participants prevented the team from consulting more primary beneficiaries. Even so, data collected

reflected saturation, the point at which no new information is being gleaned and prior information is repeated.

E. Ethical considerations

This evaluation adhered to the UN Evaluation Group's Ethical Guidelines for Evaluation and exceeded their standards for the anonymity of Al Shehab participants for the serious nature of stigmatization of vulnerable women, especially including the poor, victims of violence and people who trade sex.

The safety and security of evaluation participants and the evaluation team was the paramount concern. The team planned to immediately leave any situation that seems dangerous or threatening, but fortunately this did not arise.

Amal El Karaouaoui conducted all interviews and facilitated all FGDs. She is an expert on the need and importance of confidentiality, and protocols to ensure anonymity and confidentiality of respondents. Written confidentiality agreements were required of the evaluation team.

Data was collected anonymously except in the case of health care practitioners and representatives of UN and government agencies. Only the senior evaluator and evaluation team member Dr. Ditmore have access to this data.

Data from FGD participants and interviewees was taken anonymously, and any names stated have been redacted and removed from digital data. Confidentiality was discussed at the beginning of FGDs and participants were reminded that these are private conversations that they must not share with others.

Safety of the team and participants is the paramount concern in any situation, including discussing difficult and sensitive topics. For participants who described traumatic experiences, for example, experiences of violence, Al Shehab staff were on hand to offer support, counseling and referral to any services required. These were the services they offered during the duration of the community-based intervention, and the Al Shehab psychologist is very experienced.

F. Limitations of the evaluation methodology

Sampling strategy was planned with less information than was needed to create a realistic strategy because evaluators had no information about the numbers of women served by the community-based intervention before visiting Al Shehab for the evaluation.

The evaluation team successfully used innovative means to open discussion about sensitive topics like violent experiences. However, even so it may not be possible to ascertain the variety of violence experienced by women.

The evaluation team proposed a survey but this was not done. The proposed survey was not possible due to literacy constraints and a lack of incentives or even transportation

reimbursement for primary beneficiaries. Numbers of interviews and FGDs were increased in order to reach and ultimately exceed the numbers of participants in the baseline study, as a survey was not feasible.

The evaluation team was surprised at the strong level of agreement among responses. This was the case for positive as well as negative assessments of programming. It must be considered that perhaps the people who felt most committed to participate in the evaluation were those who benefitted most from Al Shehab's work, but this would not explain the uniformity in negative assessments. Considering the uniformity in both positive and negative assessments, it may be that some programs were well suited for the two target communities, while one program was less well executed. It must be considered whether group discussions promote agreement among participants, but this would not address the high level of agreement among interviewees.

8. Findings and Analysis per Evaluation Question

Evaluation Criteria	Effectiveness
Effectiveness Q 1	To what extent were the intended project goal, outcomes and outputs achieved and how?
Response to EQ1 with analysis and key findings of the evaluation team	<p>Outcome 1 (target numbers of people reached, and accessing services) was achieved: 1662 FSW, female PLWHA, domestic workers and survivors of violence had improved access to GBV and HIV services and made use of the services. Output 1.1 was very successful. Psychosocial, legal and referral services were available and primary beneficiaries made use of the services.</p> <p>Output 1.2 was less successful, with only two women among interviewees "who were enrolled in this component" (reporting that they had benefitted materially from the vocational training program. The overwhelming majority said that they did not acquire professional level skills particularly those who enrolled in the cooking or hairdressing vocational trainings. In contrast, women who enrolled in the handicraft and sewing vocational training, illustrated that this workshop was beneficial by building on their existing capacities and supporting them to access different avenues for marketing and selling their products.</p> <p>In interviews, almost all the 35 interviewees described Al Shehab programming affecting</p>

	<p>their daily lives and even changing their behavior, speaking out against violence and harassment of women. What some referred to as “everyday violence,” meaning family and intimate partner violence and street harassment, is no longer acceptable to women who have participated in Al Shehab’s program.</p> <p>Output 1.3 was also achieved, demonstrated by the staff working in three (3) CBOs and two (2) healthcare services having greater understanding of the links between VAW and HIV, and the ways that violence and harassment affect women and girls. Their interviews demonstrated this, and at a higher level than that demonstrated previously in Al Shehab’s report of their anti-violence program retreat (2017). The most striking change described by healthcare professionals was that the women themselves changed how they acted with healthcare professionals, being more honest and open about their experiences of violence, and confiding in the healthcare providers when seeking care, especially after violent experiences. However, one reflected on the long-term psychological effects of ongoing harassment and violence, saying that “<i>the worst bruises are the ones you can’t see on the skin.</i>” A provider referred to the general overall acceptance of VAW in society, but that the new empowerment of the women to defend themselves and reject violent victimization and harassment even (perhaps especially) from their families had given some Al Shehab participants a new life.</p> <p>Outcome 2 is successful. Primary beneficiaries overall, all five (5) religious leaders, and some men in the community (all 17 community leaders, volunteers, and local men who participated in the evaluation, as well as the three (3) leaders of faith-based organizations consulted) have greater understanding of violence and HIV, including transmission in sexual violence, some people’s use of drugs to self-medicate after violent experiences, and police’s lack of attention to violence.</p> <p>Outputs 2.1 and 2.2 has strong and mixed results: The primary beneficiaries clearly demonstrated greater understanding of women’s vulnerability to violence, particularly non-physical psychological violence (which they categorized as ‘other’, and the intersection between HIV and violence. Women described not only physical violence but used “other” in the violence indicator to report psychological violence including bullying and intimidation, described by 3 women in in-depth interviews. The level of understanding is more complex among men, with religious leaders understanding, but not all the community members. One leader of a faith-based organization described talking about violence against women as counter to Islam, and another said, “We, as much as the imams [who participated in Al Shehab’s sessions], have learned so much with the Al Shehab sessions, and we have been able to talk to [young people, women and men] with moderate and fundamentalist imams to discuss and draw the best conclusion.” The imams and faith-based organization leaders reported that some men and conservative imams (not Al Shehab program participants) thought that “anti-violence programs give a lot of freedom to the women.”</p> <p>Outcome 3 and Output 3.2 was achieved, with religious leaders understanding the link between GBV and HIV and how GBV affects women’s and community lives. However, Output 3.1 was not realized: policy makers do not seem to have been reached, although a policy brief was drafted.</p>
Quantitative and qualitative evidence to support analysis	<p>Violence is a part of Al Shehab’s participants’ lives, and the participants described everyday violence and new responses to it, including recognizing violence, and standing up for themselves in different contexts. The women in FGDs, from all primary beneficiary groups, all described having learned more about what violence is, both at the personal level in their</p>

	<p>daily lives, as well as at the structural level. They also described discussing more issues with family and others, issues including HIV and health as well as larger questions about violence. These women described what could be called ‘consciousness raising’.</p> <p>Not a single participant reported not having experienced street harassment. Interpersonal violence, including family violence and IPV as well as street harassment were common, even described as normal, “normal street harassment” and “normal fighting”.</p> <p>Of the 35 women interviewed across all primary beneficiary groups, all described learning more about violence and seeing it more, including in their own lives. Domestic violence is not acceptable to these women now, but at some time for some of them DV was simply accepted as part of life.</p> <p>Only 2 of the 35 women interviewed, or less than 10 percent, said that vocational training had led to changes in their work. The successes built on existing businesses; for example, one woman improved her shop with a refrigerator from the program and started selling cool drinks. Another used the financial skills she learned in her existing business. No one else reported benefits from the vocational training. Vocational training was the only program that was rated poor by any participants (using the Likert scale.) The women explained that vocational training was less successful because they “did not acquire professional level skills” and were not able to generate income in hairdressing, cooking, or sewing. For example, one participant said “We didn’t practice enough the sewing to be professionals, I can make some personal stuff but can’t work with the skills I learned, I need more workshops and classes.” She said this about sewing, but these sentiments were expressed about each trade. If vocational programming is resumed, should be a long-term project with a small number of participants chosen for their ability to commit to regularly attending trainings. This longer program should be designed to deliver professional skills.</p> <p>Leaders and service providers all praised Al Shehab’s achievements. The NAP representative praised Shehab’s work with other service providers recommended its expansion. The five imams praised the overall work but especially the anti-violence programming in which they were directly involved.</p> <p>All five religious leaders demonstrated great understanding, at a surprising level, explaining how the women and girls are affected by violence beyond the immediate events, and they offered great suggestions for ways to move forward, included below in the recommendations. Foremost among the recommendations is resumption of the program, because only with repetition will the anti-violence messages be absorbed for the long term.</p>
Conclusion	<p>The program achieved the desired outcomes (anti-violence programming leading to greater understanding of the problem of VAW, vocational training workshops delivered) but the anti-violence programming has the greatest transformative impact with women and has potential to change the community as well. The engagement with religious leaders and men in the community has good implications for future generations to raise boys who will stand against VAW throughout their lives. The health care referrals have reduced institutional violence in the form of discrimination reducing access to health care.</p>
Other	<p>It is imperative that Shehab continue and sustain the different services that address the nexus between VAW and HIV. Women in FGDs demanded it and expressed their needs to these services. The most needed services are health care (rated excellent, 4.7 on the Likert scale used by 30 participants) and legal services (rated excellent, 5 by all 13 primary beneficiary participants), and the anti-violence program is also effective and needed (rated</p>

	very good, 4.5 by 20 primary beneficiary participants). All have had direct effects, improving health care access, getting official papers for girls, and reducing the overall level of violence in the community.
Effectiveness Q2	To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? How many beneficiaries have been reached?
Response to EQ2 with analysis and key findings of the evaluation team	Al Shehab demonstrated great success reaching the primary beneficiaries, and the overwhelming majority of women interviewed reported that Al Shehab had changed their lives, and that they had changed their behavior after participating in some Al Shehab programs. For example of the 37 primary beneficiaries interviewed at length about their experiences of violence, 33 said that the activities with Al Shehab changed their lives outside DIC hours, and 32 said they had incorporated what they learned in the workshops in their lives (only one person said no), for example one participant said that she <i>“changed the way she communicates and deals with her children”</i> ; the person who abstained when asked about violence in her life in the previous year later added that she felt stronger when facing violence after participating. Three people categorized some violence they had experienced as “other” and elaborated later that they had experienced psychological violence, which they learned about in the anti-violence program. Al Shehab also met or exceeded targets reaching secondary beneficiaries. Numbers reached are included below.
Quantitative and qualitative evidence to support analysis	<p>By the end of 2017, Shehab had reached 1662 women and girls including 349 survivors of violence, 247 domestic workers (highly exceeding targets), 859 FSWs, and 107 women PLWHA, and over 2000 local men and over 40 religious leaders and 7 NGOs in the target area had participated in Al-Shehab’s anti-violence activities.</p> <p>Five (5) imams/religious leader in a group discussion explained that they had gone through the Shehab anti-violence program and continue to preach against violence against women and girls, but that more is necessary, including with men and other religious leaders as well as with women. For example, they reported that conservative imams who were not part of Al Shehab’s project objected to women’s freedom. They described a backlash among a few traditional members of the community. The anti-violence program was effective, but will have stronger and more lasting effects if it is repeated, and repeated at regular intervals. They explained the effects of harassment and violence on women and girls, that this is real damage, and that men should not do this to women, especially in their families and their community. These messages were taken in by most, but a few very traditional people rebelled against this message.</p>
Conclusion	The women benefit from Al Shehab’s services in both short-term and long-term ways. Getting identity paperwork through the legal services of Al Shehab enabled people to access health care and the existing schools. Health care referrals lead to better care and increased health-seeking behavior. Women opened up about their lives and violent experiences with health care practitioners, enabling more thorough and appropriate care. Women found that they could articulate the effects of daily violence on them and advocate against VAW. Programming should be resumed, and eventually, expanded, so that more women will experience these benefits.
Other	
Effectiveness Q 3	To what extent has this project generated positive changes in the lives of targeted (and untargeted) women and girls in relation to the specific forms of violence addressed by the project? Why? What are the key changes in the lives of those women and/or girls? Please describe those changes.
Response to EQ1 with analysis and key findings of	The women nearly uniformly described increased awareness and understanding of violence in their communities, especially regarding family violence and street harassment, and

the evaluation team	<p>violence of a non-physical nature like psychological abuse. The project has changed their behavior in ways they see and report violence, and in ways visible to others including service providers. They became more forthright in their interactions with service providers, offering more examples and detail about violence they experienced.</p> <p>Three health care practitioners described changes in the ways the women approached them, becoming less meek and more confident in seeking health care and being more frank about their lives, rather than approaching with shame and embarrassment. They understood that the health care providers would treat them with respect, and this changed their behavior, understanding that they would not be blamed for their victimization or their choices regarding sexual behavior or drug use. The women are more likely to seek health care in the context of Al Shehab's referrals because they are treated better by service providers who meet these patients through Al Shehab.</p>
Quantitative and qualitative evidence to support analysis	<p>Overwhelmingly, the women described changing their behavior with their new understanding of violence, including addressing violence when they see it or experience it. Only two women said that they had not changed their behavior. They speak out against harassment, both through the theater program and in their families. Unfortunately, this has led to a backlash in some families and parts of the community. Even as many people have learned that harassment and VAW have longterm adverse effects on women and girls and the level of violence was reported to have declined, some traditional men and family members have responded to the anti-violence messages from Al Shehab and imams by beating members of their families. They seemed to be known personally to the imams and the community. While the backlash is unfortunate, it demonstrates that the women have changed and the community is changing and can change further. The traditional men and family members committing more violence are afraid of and against such change. While some may never change, but they may respond to ongoing social disapproval from community leaders if anti-violence programming is resumed at regular intervals.</p> <p>Three health care workers all described transformations in the ways women came to their offices, moving from embarrassment to actively seeking health services. Health literature documents that health care providers frequently stigmatize vulnerable, impoverished women, PWUD and FSWs. The women understood that they would not be stigmatized or discriminated against by Al Shehab services or when they were referred by Al Shehab to other practitioners, and so spoke more freely with health care providers and received more appropriate care.</p>
Conclusion	<p>The anti violence programming should continue, with clearer targets and involve more local men and community leaders as well as the women who come to Al Shehab's DICs. This will enable expansion of the effective anti-VAW education. The backlash is unfortunate but must be addressed; while the reactionary people committing violence may not be persuaded, it is imperative that they not be allowed to influence the community to accept VAW.</p> <p>The health care referrals enabled women who were otherwise turned away from care to access health services. This is an extreme reduction in institutional violence.</p>
Other	<p>For long-term effectiveness, it may be necessary to work with men and boys. Men and boys are the people who harass women in public, but those reached by the program learned that this harassment and violence adversely affect women and girls in their communities and in their families, and many absorbed this very meaningfully and changed their behavior. However, any gains could be lost with any rise in the influence of conservative people</p>

	promoting a backlash against the anti-violence program.
Effectiveness Q 4	What internal and external factors contributed to the achievement and/or failure of the intended project goal, outcomes and outputs? How?
Response to EQ1 with analysis and key findings of the evaluation team	<p>Internal: Al Shehab is most effective in face-to-face interactions with the primary beneficiaries and religious leaders and community members. Al Shehab has expanded to include primary beneficiaries as part of the staff and team: Primary beneficiaries have become excellent outreach workers and peer educators. This is excellent. They are the most effective at encouraging others to make use of Al Shehab's services. However, the evaluation team recognizes that Al Shehab would benefit from capacity building for the entire team, for monitoring and evaluation, data management, and more. As the primary beneficiaries are devoted to Al Shehab, a few who are educated may be capable of keeping some of the records and entering some of the data about participants and activities for monitoring and evaluation. Their ownership of the project could offer improvements. For example, the only information Al Shehab could share with the evaluation team were numbers of people reached, and even the baseline study was not shared before the lead evaluator arrived in the country. For this reason, the evaluation criteria could not match the baseline study, and evaluators grasped that Al Shehab personnel did not understand the importance of the comparison. The organization would benefit from some technical capacity building as well, especially with strategic planning, digital record keeping, and fundraising, so that the current funding gap may not recur, and so that records could be more easily shared.</p> <p>External:</p> <p>Structural violence was described by all types of interviewees and FGD participants. Structural violence included poverty, gender discrimination, lack of viable employment, and police problems. Gender discrimination was evident even within families, with women having to ask their brothers' permission to attend Al Shehab activities. The extreme level of poverty can inhibit people who do not live close to the DICs from seeking services, as transportation is not free.</p> <p>Everyone - primary beneficiaries, local leaders, health care providers, and others - says that the police present multiple problems, including as agents of violence, and not investigating victimization of women, especially vulnerable women. People from every category reiterated that the police do not investigate violence against women, and women who tried to report violence to the police described police demanding to know more about their actions than the violence they experienced.</p> <p>Drug use, particularly in Ezbet el Haggana where one participant said that "drugs are being sold in the street like potatoes," is problematic in that it is unaddressed and often for the women is self-medication in the absence of other assistance, and drug use by others seems to be a factor in violence, especially but not only within the family. Women described being beaten by family members and intimate partners who use drugs and sometimes being beaten by family members if the women themselves use drugs. Drug use is linked to the spread of HIV, both among FSWs and other women, sometimes related to coerced sex and rape by people who see them as appropriate targets of violence. Imams particularly stressed, in addition to the women of Ezbet el Haggana, that addressing drugs is a prerequisite for success in their community. Proven-effective, evidence based approaches are recommended, particularly harm reduction, based on the needs related to the types of drugs available and widely used.</p>

Quantitative and qualitative evidence to support analysis	<p>Police were cited as problems by all the categories of participants: the women themselves in 2 FGDs and 2 interviews, 5 five religious leaders and 3 health care workers. Evaluators were repeatedly told that police do not take reports or investigate VAW but instead interrogated women about why they were out. For these reasons, police were initially the focus of anti-violence programming, but police refused to engage with Al Shehab, while imams and community leaders were eager to engage.</p> <p>Primary beneficiaries, health care providers and imams described drug use as an extensive and problematic, especially in the Ezbet el Haggana community and in families. Two primary beneficiaries reported seeking Al Shehab's HIV programming because they have family members who inject drugs. 11 of 37 women interviewed – nearly one-third - referred to drugs as an external factor that affects Al Shehab's work. For some, drug use represents an added expense in poor families, but some drugs were used to subdue hunger; drugs and poverty are in this way related. 5 imams were very adamant that without addressing drugs, work in Ezbet El Haggana would be undermined.</p> <p>Advocacy was not undertaken. This may have been an issue of timing as the policy brief was completed just before the evaluation was undertaken, and political advocacy in a country where the government has recently closed a number of NGOs may be sensitive. However, as no advocacy strategy was offered, there may be a need for capacity building for advocacy.</p>
Conclusion	<p>Engagement with the police will be necessary because police were reported to inhibit the success of Al Shehab's programs, and it was widely reported that police do not take reports of or address VAW, instead policing victims of violence. Policy change may be required to force police to engage.</p> <p>Capacity building for advocacy may benefit Al Shehab and its participants. Advocacy was not undertaken, and advocacy will need to be well done and diplomatic in the current political context, which is hostile to some NGOs.</p> <p>Addressing widespread drug use in the community will be necessary to be effective because drug use seems to exacerbate interpersonal violence and to offer a coping mechanism for some victims of violence and stigma and discrimination.</p> <p>In addition to advocacy, the organization could benefit from capacity building on project monitoring and evaluation for Al Shehab staff and select primary and/or secondary beneficiaries</p>
Other	
Effectiveness Q 5	To what extent was the project successful in advocating for policy change? If it was successful, explain why.
Response to EQ1 with analysis and key findings of the evaluation team	The policy brief was written in December 2017, based on the experiences of the project. Recommendations are good, including developing a network to address VAW and stigmatization of PLWHA and key populations including members of key populations, and for this network to take on advocacy. However, policy was not changed during these three years. The brief noted that despite the availability of post-exposure prophylaxis for HIV, no rape victim had accessed this treatment in Egypt. One possible policy to address may be the

	provision of such treatment for survivors of violence, provided in healthcare settings without police reports being required. The policy brief was written just before the evaluation, which occurred in February and March 2018, and no advocacy had yet been undertaken.
Quantitative and qualitative evidence to support analysis	The policy brief was written in December 2017. However, at this time, it has not been presented to decision makers.
Conclusion	Policy change is a long-term goal and the current political situation with the closure of some NGOs by the government and the surveillance of NGOs with foreign funding, may not be immediately conducive to the changes recommended. Local policy and practices may be easier targets than national policy, but the SDGs may present opportunities as the VNR referred to the need to improve on health and gender equality.
Other	To change policy in 3 years is ambitious; policy change is a 5- or 10-year goal. Funding that concludes in three years will need to be extended or to have multiple donors in order to be effective for policy change. Policy change may be easier within local organizations, or if national level, with leverage presented by the SDGs. However, it may be possible to affect health care processes, for example, expanding the Al Shehab referral system to a larger region with support from NAP. Another example may be the introduction of OST and naloxone as they are on the WHO list of essential medicines. It may be possible with the help of UN agencies and NAP to work to secure easy access to post-exposure prophylaxis for HIV to victims of violence, particularly rape.
Effectiveness Q 6	In case the project was successful in setting-up new policies (related to HIV & Violence against women), is the policy change likely to be institutionalized and sustained?
Response to EQ6 with analysis and key findings of the evaluation team	Policy change was not achieved, or but others especially the National AIDS Program have noted Al Shehab's success ensuring access to healthcare for marginalized and vulnerable women, and recommended the expansion of their referral program around the country.
Quantitative and qualitative evidence to support analysis	Interviewees from NAP and 3 other organizations commented favorably on Al Shehab's success securing quality health care for women. Dr. Walid Kamal, the NAP manager, said "Al Shehab is one of the few NGOs that takes into consideration the changes that Egyptian society can experience, and the lack of funds (for example the end of Global Fund grant to Egypt.) They use existing infrastructure efficiently and key populations are part of its work team. They have easy access to FSWs, vulnerable women, and women and men PWIDs." For these reasons, Dr. Kamal recommended Al Shehab being involved in healthcare provision through a larger geographic area, ultimately reaching the entire country. While this is not a policy change, the unwritten policy to reject these vulnerable women from health care settings has been changed where Al Shehab works, and this enables them to access healthcare.
Conclusion	Change was not achieved at the government level, but Al Shehab is a role model for other NGOs working with PLWHA for its nonjudgmental approach and ability to secure quality services for its participants, and has influenced imams and other community and religious leaders to speak out against violence. While policy has not changed, people have changed in response to their work. These community members and primary beneficiaries should work in the next phase on policy advocacy.
Other	
Evaluation Criteria	Relevance
Relevance Q1	To what extent was the project strategy and activities implemented relevant in responding to the needs of women and girls (direct beneficiaries)?
Response to R Q1 with analysis and key findings of	The project was relevant to the lives of the primary beneficiaries and still is in many ways, including that they still need referrals to access health care, that violence while reduced or

the evaluation team	<p>different is still an everyday issue for the women. The women in interviews (37) and FGDs (42) cited benefits from all of Al Shehab's programs, and that the anti-violence project affected them at multiple levels, empowering them to fight VAW but also bringing a greater awareness of different kinds of violence. It is clear that each program offered much needed services to the women: The legal services and the health care (direct gynecological services and referrals to other providers) changed women's lives, enabling women and their children to register to receive health care and education, and to access life-saving medicines for HIV.</p> <p>The vocational training program was relevant but the implementation was unsuccessful. Regarding vocational training, only two women out of 23, or nearly 10%, described increased income – one through acquiring a mini-fridge, one working in a beauty salon – related to the vocational training. Impoverished women said that they can't apply what they learned because they remain overcome by debts and have no money to save or invest in a business. 12 primary beneficiaries interviewed criticized the program, saying, that the course was too short for the development of professional level skills, that they needed more time to practice the skills, that they learned but did not have the necessary equipment to benefit from their skills (sewing machines, kitchen equipment), and that there were not enough facilities for everyone to learn the skills (they had to share stations during the workshop and alternate). 2 explained that while they can sew for their own use, they did not learn enough in the short course to make a living sewing for others. Another said the same about the hairdressing workshop. One woman had an interesting and possible recommendation: for Al Shehab to have nursery where women could leave their children while women attend programs, and for some of the women to be hired to run the nursery. Three women interviewed referred to activities for children and places for children to be supervised while their mothers attended workshops; this could be explored.</p>
Quantitative and qualitative evidence to support analysis	33 women of 37 interviewed described changing their behavior in response to the anti-violence programming, and gave specific examples like legal assistance (13) with divorce or getting identity papers, and medical help, that demonstrated the ways Al Shehab directly affected their lives. Changes described by primary beneficiaries were both behavioral and psychological or internal. For example, one woman described sharing harm reduction methods with her son, including purchasing new syringes for him to be able to avoid HIV when injecting drugs, while another said she now fights back when her husband beats her. Another woman said, "I stand against the stigma of being married to a PWID man and being a domestic worker" when asked how the anti-violence program affected her.
Conclusion	All of Al Shehab's programming is highly relevant to the women's lives – they still need support to access health care, they still face daily harassment and GBV remains common, the lawyers can still assist with identity papers and more, and the women still need viable ways to generate enough income to support their large families (18 of 37 women interviewed support 4 or more people). Programming should be resumed.
Other	
Relevance Q2	To what extent do achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?
Response to RQ1 with analysis and key findings of the evaluation team	Violence and HIV are ongoing issues for the women reached by Al Shehab. In interviews, 35 of 37 women described violent experiences, while two women abstained from answering. The women have health issues that may go untreated or poorly treated without Al Shehab's health care and referrals: 19 of 37 interviewees reported having STI symptoms in the previous year, but only 10 reported seeking medical treatment, and without Al Shehab's referrals, the women may not receive quality care from other providers. 23 women

	<p>interviewed reported that they continue to experience constant street harassment and violence, even as their understanding of and responses to these incidents has changed, with some feeling strong enough to stand up to abusers in public (e.g. on the bus, “he touched me but I slapped him,” and in their families (one woman said that her husband “is no longer allowed to beat her”). The project remains necessary, even as the main goal and most of the outputs have been achieved.</p> <p>Shehab’s medical services and referrals to other services greatly improved the care of women PLWHA. Women, NAP, and health care providers all reported better outcomes with referrals from Al Shehab, especially for key populations and PLWHA. Women were sometimes denied care, especially those from stigmatized and impoverished communities, until they were referred by Al Shehab.</p> <p>11 of 37 women interviewed described a need to address drug use, corroborated by all 5 imams. Al Shehab could improve its relevance by introducing harm reduction services for PWUD.</p>
Quantitative and qualitative evidence to support analysis	<p>Women described the ways Al Shehab programs changed with outlooks and responses to violence, including fighting back against violence and frankly describing violent incidents to health care providers when they sought care. However, all but 2 of 35 interviewees described recent experiences of violence, ranging from street harassment to rape and attempted murder (for example, by defenestration, by choking, by other means). The two women interviewed who did not describe violent incidents did not say that they had not experienced violence, rather they were quietly thoughtful and did not answer the questions. It is clear that anti-violence programming, and making the links to HIV, remains highly relevant, because violence is still prevalent and provision of proven-effective HIV prevention has not been realized, even in the form of prevention for victims of rape.</p> <p>Only 2 women interviewed (of 37) changed their work with new skills and equipment (a refrigerator for an existing shop) from Al Shehab, but most need more vocational training to make a difference. People reported enjoying the classes and learning, but not learning enough to start a business or even to be hired by someone else; vocational programming was the only aspect of Al Shehab’s work about which participants voiced frustration. One woman said that she “learned the basics of hairdressing, but only uses them at home” for herself and her daughter. One said that 20 people in the sewing class was an obstacle, explaining that the class should be smaller and more intense, or longer term, in order for the women to hone professional level skills. One woman said that she learned to sew but did not have any money to buy a sewing machine. A longer-term class in which graduates would be given the equipment to start a business may see more success. Too few earn enough for the savings skills to be relevant for them: they have no money to save and are overwhelmed by debt. Only the woman who owns the shop described re-investing income in her small business. No one described saving money. Women support large numbers of family members, with 18 of 37 interviewees supporting 4 or more people. It is unlikely for handicrafts to generate the income needed to support a large family and generate savings – Al Shehab’s primary beneficiaries live hand-to-mouth.</p> <p>5 women living with HIV interviewed described receiving better medical care when Shehab refers them to services. Some reported having been denied services without Al Shehab’s referral (this is hard to quantify, because it came up in a FGD and other people agreed but did not say that they had this experience); this was corroborated by NAP and 2 health care providers.</p>

Conclusion	The project goals, outcomes and outputs, even those already achieved, remain extremely relevant to the women in the community. Services and programming should resume.
Other	Without a place like the DIC to meet and share information and new ideas, the current gains may not be sustained. The women need a place to offer support to each other, and Al Shehab has good standing in the community so that women and girls can gather there; families that did not accept their work have now encouraged their sisters and daughters to participate, as described in the case study below. The religious and community leaders may not keep promoting anti-violence messages as much without Al Shehab's encouragement. Without ongoing work, and considering the backlash against the antiviolence program from reactionary people, the danger is that the reactionary backlash could become stronger if the anti-violence work is not continued and even strengthened.
Evaluation Criteria	Efficiency
	How efficiently and timely has this project been implemented and managed in accordance with the project document?
Response to EQ with analysis and key findings of the evaluation team	<p>Al Shehab is able to use the existing health system infrastructure to obtain health services for their participants through referrals, especially regarding HIV. This is efficient. Primary beneficiaries reported that they were not offered services when they sought health care without a referral from Al Shehab.</p> <p>Al Shehab is very efficient in its work with primary beneficiaries, reaching over 1600 women, but Al Shehab is less efficient regarding paper deliverables like the policy brief and long-term goals, like advocating for policy change. For example, the policy brief was not written until the very end of the project, and advocacy had not been undertaken. The urgency of the need for health care is clear, but the policy advocacy is also important. One obstacle to effective information sharing and advocacy may be that the staff has one person who speaks English, and so communication with international agencies and donors is dependent on him. Many beneficiaries are unable to read, and the level of literacy in the neighborhood is low because there are too few schools in the target area. This means that Al Shehab generally cannot rely on primary beneficiaries to make good records or enter data about their work as peer educators. Finally, the current political situation in which many NGOs have been closed by the government makes advocacy sensitive. The level of capacity building needed is high, and the level of diplomacy and connections required for advocacy right now is definitely a compounding factor.</p>
Quantitative and qualitative evidence to support analysis	<p>NAP described being impressed with Al Shehab's ability to reach key populations in the struggle against HIV/AIDS, including FSWs, PWUD, and victims of violence, particularly in the face of newly constrained resources with the Global Fund leaving Egypt. Al Shehab reaches key populations by being part of their communities, and building trust by listening and offering services without judgment, and by being respected by health care providers so that they will treat people who they had rejected when they are referred by Al Shehab. Primary beneficiaries described knowing that they would not be judged by Al Shehab personnel, despite their participation in sex work or using drugs or being impoverished or uneducated.</p> <p>The numbers of primary beneficiaries reached – 1662 - and receiving services from Al Shehab demonstrates their effectiveness and efficiency in the field, and is reinforced by their effectiveness with community leaders like the imams (over 40 reached) and the 7 CBOs reached.</p> <p>The policy brief was drafted in December 2017, and therefore not used for advocacy prior to the evaluation in February 2018. Community leaders and primary beneficiaries should</p>

	work together to advocate for the recommendations in the policy brief.
Conclusion	<p>Al Shehab excels in its work with primary and secondary beneficiaries, as demonstrated by meeting and exceeding numeric deliverables like numbers of participants, and the efficient use of existing health care infrastructure via the referral system. NAP wanting to expand the referral system nationally is very high praise. The successful implementation of the anti-VAW work was also efficient, in part because of the partnerships with motivated community and religious leaders.</p> <p>Al Shehab could improve efficiency by partnering with more NGOs and referring beneficiaries to services provided by organizational partners.</p> <p>However, advocacy work was not efficient, but the timing considering the current government shutting some NGOs may be a factor.</p>
Other	The lack of efficiency in advocacy and writing can be addressed with some capacity building. The primary beneficiaries should be taught, with the community leaders, how to advocate for policy change, to develop talking points, to arrange meetings with policy makers, and the most diplomatic and skilled among them should be given paid roles to do this work.
Evaluation Criteria	Sustainability
	How are the achieved results, especially the positive changes generated by the project in the lives of women and girls at the project goal level, going to be sustained after this project ends?
Response to EQ with analysis and key findings of the evaluation team	<p>Because NAP recommends expanding Al Shehab's health referral system, this work may be sustainable if funding is secured.</p> <p>It is unclear whether the good results of the anti-violence program will be sustained without the work of Al Shehab continuing. Some women particularly young women, were allowed to come to Al Shehab but this took some time, as described in the family case study below.</p> <p>It remains important for influential members of the community continue to condemn VAW, including imams and community leaders. The end of Al Shehab's anti-VAW program and the current backlash against the anti-VAW messages may present an opportunity for reactionary people to mobilize against the anti-violence messages. The community and religious leaders may not reinforce the anti-VAW messages without Al Shehab's ongoing encouragement and involvement.</p> <p>Al Shehab has not addressed drug use, and it was not part of the interview and discussion guides, but primary and secondary beneficiaries described the high levels of drug use in the target communities. Drug use is also relevant to HIV and GBV and should be addressed – for example, women described violence, including rape, from family members when the family members used drugs or in some cases wanted money to buy drugs but there was no money. Primary and secondary beneficiaries described how without addressing drug use in Ezbet El Haggana, all progress is jeopardized, especially if the project is not continued. It was implied that without some of the services offered by Al Shehab, some women will turn to drug use, but this was not stated outright. It was clear that some participants use drugs and see Al Shehab as the one place where they can seek services without fear of judgment, but this is not possible to quantify with this data because drug use was brought up by evaluation participants and not part of the interview and discussion guides.</p>
Quantitative and	Volunteers, community leaders, religious leaders, and local men all agree that the theater

qualitative evidence to support analysis	<p>interventions and face-to-face interventions are effective, but to be sustainable they must be repeated multiple times. Repetition is key; this is borne out in other interventions in the literature.</p> <p>Women, men, and imams described drug use as a factor, particularly in Ezbet El Haggana. 11 primary beneficiaries interviewed of 37 described drugs as an external factor that affects Al Shehab's work, and this was corroborated by 5 imams.</p> <p>6 primary beneficiaries identified funding as an external constraint and an obstacle to the sustainability of Al Shehab's work.</p>
Conclusion	Anti-violence and HIV-prevention programming requires repetition, preferably monthly, to have lasting impact. It will not be possible to address GBV and HIV without addressing the use of drugs because this is a constant feature of the lives of the women and their families.
Other	
Evaluation Criteria	Impact
	What are the unintended consequences (positive and negative) resulting from the project?
Response to EQ1 with analysis and key findings of the evaluation team	<p>One unintended consequence was a backlash from family members who disapproved of the anti-violence campaign and the ways the primary beneficiaries were empowered to speak against violence and fight back. Women and imams and staff all reported traditional men and family members being threatened by the anti-violence campaign and beating their family members. A backlash against successful programs is normal, but must be addressed and fought at the community level. This means that community leaders should reinforce that VAW is wrong and that family members and community members who commit VAW are hurting their own communities.</p> <p>Another unexpected finding is that police were described as inhibiting success, both in terms of direct violence against FSWs and the random application of laws by police. Police were uniformly described by women, men, and religious leaders as problems rather than people to turn to for help. This is less about Al Shehab but demonstrates the need to force engagement from the police. Police refused even to meet with Al Shehab at the start of this project. No engagement has been possible because police refuse to engage.</p> <p>An unexpected finding but not one reflecting the project's impact is the high level of drug use in the lives of women and their families. This finding is important because GBV and VAW and HIV are all affected by drug use in the community, by the women and by their family members.</p>
Quantitative and qualitative evidence to support analysis	<p>All categories of primary beneficiaries and the local men and community leaders described the backlash, that some people had become more violent, beating family members.</p> <p>All 5 imams in the FGD said that some people "had become more violent," as in a backlash, and some were concerned about "the level of freedom afforded the women." This was corroborated by 1 woman interviewed who said, "Men's anger at the violence prevention workshops increases VAW," and again in FGDs, and by 2 health care practitioners. This may indicate a need for further discussion of women's rights with community and religious leaders, who can further explain to community members that their own violence is wrongheaded. One imam said that "There is always a way to introduce the subject [of VAW]" to the Friday sermon, and all were agreed that the work should continue and offered ideas like working with youth, and not be discouraged by the increased violence of some reactionary men.</p>

	<p>The 3 health practitioners also described a backlash in family violence against women who become more empowered. Health care workers also described the women's problems with police lack of attention to crimes against them, for example, women who tried to report rape were asked by police why they were out and the reports were not taken. These findings about police were elicited through FGDs with 20 FSWs and corroborated by the 5 imams and the 3 health care providers.</p> <p>11 women interviewees, nearly a third, in all categories of primary beneficiaries, and all categories secondary beneficiaries described being affected by drug use by the women and by others, including with regard to violence and vulnerability to HIV. For example, one woman interviewed reported that her husband beats her when he uses drugs. Most people were less explicit about direct experience with PWUD, for example 2 referred to the lack of security and not feeling safe in the neighborhood because of drug use rather than describing personal interactions or drug use. The 5 imams and the 3 CBOs and the 2 health care practitioners all confirmed drug use as a factor.</p>
Conclusion	Violence remains at high levels, even after a few years of anti-GBV work. Only 2 of 35 women interviewed did not describe experiencing violence in the past year, but they did not say that they had not experienced violence and instead became quiet and did not answer particular questions. Women reported constant street harassment, but also serious physical violence including rape, battery, and attempted murder. This is an ongoing struggle. To effectively address violence will require engaging the people who commit violence – in the future, Al Shehab should engage with community members, and advocate for engagement with the police, perhaps by going to the national level or the city level government. Also, it will be impossible to effectively address VAW without addressing drug use, especially in Ezbet El Haggana.
Other	Responding to this backlash and increase in some violence will require further engagement with men and other family members. These reactionary people will be the most difficult to persuade. However, it will be important to continue engaging men and especially boys, to improve the lives of women going forward. Boys are key because if their attitudes are formed against VAW, they can be part of a generational change to reduce VAW overall.
Evaluation Criteria	Knowledge Generation
KG EQ1	What are the key lessons learned that can be shared with other practitioners on Ending Violence against Women and Girls?
Response to EQ1 with analysis and key findings of the evaluation team	<p>Basic education and awareness raising about violence in the community is an important beginning, as demonstrated by the success of Al Shehab's workshops and community theater presentations in changing opinions, and with religious and community leaders speaking out to condemn VAW. These programs are easy to replicate, and the program structure is already in place. More work with community leaders and others remains critical in order to reinforce the anti-violence message. Reducing violence is a long-term project.</p> <p>Anti-GBV programs should prepare to respond to a backlash from community members who feel threatened by empowered women. Al Shehab is still planning its response, pending funding, working with community leaders including imams. It will be important to explain the ways GBV adversely affects the women and the family and the community.</p> <p>Anti-violence programming was successful because it engaged people who could be perpetrators of violence and/or harassment people as a class who may commit violence or who have influence to prevent others committing violence. For Al Shehab, this means</p>

	<p>continuing engagement with men and boys and trying again to engage with law enforcement.</p> <p>In locations where drug use is common, it is important for anti-violence and HIV-prevention programs to include PWUD.</p> <p>It will be necessary to work with the government to force the police to engage because they are the foremost source of violence against FSWs outside the family. Every imam, every health practitioner, the attorney, and many women reported that police did not try to address perpetrators of violence but instead policed women's behavior, for example police asking why they were at a place at the time, instead of asking for descriptions of perpetrators of violence.</p> <p>Institutional violence includes that women are not receiving high quality services when they seek them on their own, and Shehab is respected by other organizations enough to improve the care of their participants. Al Shehab's referral system should be expanded, and it is important to advocate for better services and respect for vulnerable women even when they approach without a referral from Shehab.</p>
Quantitative and qualitative evidence to support analysis	<p>Women described drug use by family members contributing to high levels of family violence, and women's own drug use contributes to their vulnerability to both violence and HIV. Others including community leaders (all 5 imams, 2 service providers, 3 leaders of faith-based organizations) and local men corroborated this information. When asked about external factors affecting Al Shehab's work, one imam said, "drugs as is the case of Ezbet El Hagana is a big element that causes violence."</p> <p>FSWs in FGDs described police violence inhibiting even vocational education through random application of laws and violence committed by police. While only a few women elaborated on this, over 30 FGD participants agreed and echoed that this is a problem. All five Imams echoed this in their FGD, emphasizing that police focused on women's behavior rather than investigating VAW. One imam explained that "When a woman who has been raped lodges a complaint, she is asked, 'why you were there, why were you out ?' instead of police looking for the rapist."</p>
Conclusion	<p>Combatting GBV is an ongoing struggle, and requires community leaders alongside women advocating for themselves. Basic education about what is GBV is the first step. The women's education program about violence, the community theater and religious leader sermons against VAW were key components of the basic education provided by Al Shehab.</p> <p>Harm reduction programming related to drug use is needed in some communities addressed by Al Shehab in order to effectively address GBV.</p> <p>Stigma and discrimination against vulnerable women occur in health care settings, but Al Shehab has effectively promoted access to care through its referral system. The referral system should be expanded with NAP.</p> <p>Policy change at the level of the police enforcement is needed so that the police will investigate VAW; it is necessary to engage with the police, but the police are resistant. The government will be needed to encourage police engagement.</p>
Other	<p>Harm reduction programming is recommended, including HIV and Hepatitis C prevention education, opioid substitution therapy, and distribution of naloxone.</p>
Knowledge Generation Q2	<p>Are there any promising practices? If yes, what are they and how can these promising</p>

	practices be replicated in other projects and/or in other countries that have similar interventions?
Response to EQ2 with analysis and key findings of the evaluation team	<p>Referrals from Shehab to other health care providers resulted in better care than when PLWHA and survivors of violence and vulnerable women sought care on their own. When women sought care on their own, they were not always cared for. However, when they first went to Al Shehab and were then referred to the existing health care service provider, they received care.</p> <p>Despite the backlash experienced by some women, anti-violence programming remains promising. All the women describe benefitting from anti-violence programming, even as this work is in beginning stages. Promising practices in the anti-violence program include community theater, working directly with community leaders and imams, and the workshops with the women to increase their understanding of violence including structural violence. Imams also recommended future anti-violence work.</p>
Quantitative and qualitative evidence to support analysis	<p>Participants, all 3 health care providers and NAP all acknowledged the greater access to care with Al Shehab.</p> <p>Many women described no longer accepting violence as part of life, and the FGD participants agreed that Al Shehab had elevated their expectations of a better life with less violence from family and community members. Women's awareness and understanding of violence has grown, but more work needs to be done, with imams and other community leaders. Men reached by Al Shehab's anti-violence programming generally respond positively. However, the good effects of the project will have short-term results if they are not reinforced. Fortunately, imams and community leaders all report being eager to do more.</p>
Conclusion	Health, legal and anti-violence programming should resume because they are promising. The most promising practice is Al Shehab's health care referrals, but it is the longest standing and thus has had the most time to demonstrate success and to build upon relationships with the health care providers. Therefore, as other programs continue, they may also develop greater success.
Other	Harm reduction programming with PWUD may also contribute to lasting success. There is currently no programming specifically for PWUD, and retention may be increased if such programming is created. The need is there, as clarified by imams, and all the participants from one area.

9. Conclusions

Evaluation Criteria	Evaluation Conclusions
Overall	<p>Al Shehab's community-based intervention to alleviate the different forms of violence against women and women's vulnerability to HIV was very effective. Health, legal, psychological and anti-violence programs reached vulnerable women in Cairo, these women who were eager to access these services. Al Shehab developed a policy brief but did not achieve policy change. As police violence is high, it will be important to engage the police, and this will require advocacy for policy change with the government to force the police to engage with communities.</p>
Effectiveness	<p>Services were effective and benefited primary beneficiaries. Interventions with local men, religious and community leaders and NGOs were effective, and the interventions with primary and secondary beneficiaries built upon each other. The program achieved the desired outcomes (anti-violence programming leading to greater understanding of the problem of VAW, vocational training workshops delivered) but the anti-violence programming has the greatest transformative impact with women and has potential to change the community as well. The engagement with religious leaders and men in the community has good implications for future generations to raise boys who will stand against VAW throughout their lives. The health care referrals have reduced institutional violence in the form of discrimination reducing access to health care</p> <p>The most needed services are health care (rated excellent, 4.7 on the Likert scale used by 30 participants) and legal services (rated excellent, 5 by all 13 primary beneficiary participants), and the anti-violence program is also effective and needed (rated very good, 4.5 by 20 primary beneficiary participants). All have had direct effects, improving health care access, getting official papers for girls, and reducing the overall level of violence in the community. The only aspect that was less effective was the vocational training.</p> <p>The women benefit from Al Shehab's services in both short-term and long-term ways. Getting identity paperwork through the legal services of Al Shehab enabled people to access health care and the existing schools. Health care referrals lead to better care and increased health-seeking behavior. The health care referrals enabled women who were otherwise turned away from care to access health services. This is an extreme reduction in institutional violence. Women opened up about their lives and violent experiences with health care practitioners, enabling more thorough and appropriate care. Women found that they could articulate the effects of daily violence on them and advocate against VAW. Programming should be resumed, and eventually, expanded, so that more women will experience these benefits.</p> <p>The anti violence programming should continue, with clearer targets and involve more local men and community leaders as well as the women who come to Al Shehab's DICs. This will enable expansion of the effective anti-VAW education. The backlash is unfortunate but must be addressed; while the reactionary people committing violence may not be persuaded, it is imperative that they not be allowed to influence the community to accept VAW.</p> <p>To improve effectiveness, it may be worthwhile to work with men and boys in the community. Men and boys are the people who harass women in public, but those reached by the program learned that this harassment and violence adversely affect women and girls in their communities and in their families, and many absorbed this very meaningfully and changed their behavior. However, any gains could be lost with any rise in the influence of conservative people promoting a backlash against the anti-violence program.</p> <p>Engagement with the police will be necessary because police were reported to inhibit the success of Al Shehab's programs, and it was widely reported that police do not take reports of</p>

	<p>or address VAW, instead policing victims of violence. Policy change may be required to force police to engage.</p> <p>Addressing widespread drug use in the community will be necessary to be effective because drug use seems to exacerbate interpersonal violence and to offer a coping mechanism for some victims of violence and stigma and discrimination.</p> <p>Policy change is an ambitious long-term goal and the current political situation with the closure of some NGOs by the government and the surveillance of NGOs with foreign funding, may not be immediately conducive to the changes recommended. Local policy and practices may be easier targets than national policy, but the SDGs may present opportunities as the VNR referred to the need to improve on health and gender equality.</p> <p>Change was not achieved at the government level, but Al Shehab is a role model for other NGOs working with PLWHA for its nonjudgmental approach and ability to secure quality services for its participants, and has influenced imams and other community and religious leaders to speak out against violence. While policy has not changed, people have changed in response to their work. These community members and primary beneficiaries should work in the next phase on policy advocacy. Capacity building for advocacy may benefit Al Shehab and its participants. Advocacy was not undertaken, and advocacy will need to be well done and diplomatic in the current political context, which is hostile to some NGOs.</p> <p>In addition to capacity building for advocacy, the organization could benefit from capacity building on project monitoring and evaluation for Al Shehab staff and select primary and/or secondary beneficiaries</p>
Relevance	<p>The services offered by Al Shehab remain very relevant to the lives of primary beneficiaries – they still need support to access health care, they still face daily harassment and GBV remains common, the lawyers can still assist with identity papers and more, and the women still need viable ways to generate enough income to support their large families (18 of 37 women interviewed support 4 or more people).</p> <p>The project goals, outcomes and outputs, even those already achieved, remain extremely relevant to the women in the community. Services and programming should resume. To improve relevance, Al Shehab could introduce harm reduction services for PWUD.</p>
Efficiency	<p>Al Shehab excels in its work with primary and secondary beneficiaries, as demonstrated by meeting and exceeding numeric deliverables like numbers of participants, and the efficient use of existing health care infrastructure via the referral system. NAP wanting to expand the referral system nationally is very high praise. The successful implementation of the anti-VAW work was also efficient, in part because of the partnerships with motivated community and religious leaders.</p> <p>Al Shehab could improve efficiency by partnering with more NGOs and referring beneficiaries to services provided by organizational partners.</p> <p>However, advocacy work was not efficient, but the timing considering the current government shutting some NGOs may be a factor. Al Shehab could improve efficiency by partnering with more NGOs and referring beneficiaries to services provided by organizational partners. The lack of efficiency in advocacy and writing can be addressed with some capacity building.</p>
Sustainability	<p>Anti-violence and HIV-prevention programming requires repetition, preferably monthly, to have lasting impact. It will not be possible to address GBV and HIV without addressing the use of</p>

	<p>drugs because this is a constant feature of the lives of the women and their families. Sustainability could be improved with more engagement with men and engagement with PWUD.</p>
Impact	<p>Primary beneficiaries were emphatic about the ways Al Shehab has affected their lives and changed their behavior. They also described long-term effects within their families. Secondary beneficiaries were also enthusiastic, and offered examples of change. However, there is also a backlash against the anti-GBV programming, with some men and family members becoming more violent in response. It may be helpful to engage more family members and men more regularly, as some participants described resistance at home before good changes happened. Violence remains at high levels, even after a few years of anti-GBV work. Only 2 of 35 women interviewed did not describe experiencing violence in the past year, but they did not say that they had not experienced violence and instead became quiet and did not answer particular questions. Women reported constant street harassment, but also serious physical violence including rape, battery, and attempted murder. This is an ongoing struggle. To effectively address violence will require engaging the people who commit violence – in the future, Al Shehab should engage with community members, and advocate for engagement with the police, perhaps by going to the national level or the city level government.</p> <p>Responding to the backlash against anti-VAW messages and the increase in some violence by reactionaries will require further engagement with men and other family members. These reactionary people will be the most difficult to persuade. However, it will be important to continue engaging men and especially boys, to improve the lives of women going forward. Boys are key because if their attitudes are formed against VAW, they can be part of a generational change to reduce VAW overall.</p> <p>Also, it will be impossible to effectively address VAW without addressing drug use, especially in Ezbet El Haggana.</p> <p>Vocational training had the least impact. Policy was also not affected, but Al Shehab may need to engage in a more long-term and well-planned way to affect policy change.</p>
Knowledge Generation	<p>Anti-violence programming is effective and should be adaptable for other locations. The most promising practice is Al Shehab's health care referrals, but it is the longest standing. Therefore, as other programs continue, they may also develop greater success.</p> <p>Combatting GBV is an ongoing struggle, and requires community leaders alongside women advocating for themselves. Basic education about what is GBV is the first step. The women's education program about violence, the community theater and religious leader sermons against VAW were key components of the basic education provided by Al Shehab.</p> <p>Harm reduction programming related to drug use is needed in some communities addressed by Al Shehab in order to effectively address GBV.</p> <p>Stigma and discrimination against vulnerable women occur in health care settings, but Al Shehab has effectively promoted access to care through its referral system. The referral system should be expanded with NAP.</p> <p>Policy change at the level of the police enforcement is needed so that the police will investigate VAW; it is necessary to engage with the police, but the police are resistant. The government will be needed to encourage police engagement.</p>

	Health, legal and anti-violence programming should resume because they are promising. The most promising practice is Al Shehab's health care referrals, but it is the longest standing and thus has had the most time to demonstrate success and to build upon relationships with the health care providers. Therefore, as other programs continue, they may also develop greater success.
Other	Harm reduction programming should be undertaken with PWUD, including HIV and Hepatitis C prevention education, opioid substitution therapy, and distribution of naloxone. Harm reduction programming with PWUD may also contribute to lasting success. There is currently no programming specifically for PWUD, and retention may be increased if such programming is created. The need is there, as clarified by imams, and all the participants from one area.

10. Key Recommendations

Evaluation Criteria	Recommendations	Relevant Stakeholders	Suggested Timeline (if relevant)
Overall			
Effectiveness	Direct services are very	Al Shehab, donors	Immediately

	<p>effective, for example in securing legal paperwork for clients and for providing extremely necessary gynaecological services (further evidence is elaborated below): There fore it is important to resume legal, medical, psychological and anti-violence services.</p>		
Relevance	<p>Shehab should resume gynecological services as soon as possible, and hire a gynecologist as this is the service the primary beneficiaries seek most often.</p> <p>Shehab should resume legal services and anti-violence programming. Primary beneficiaries described successes including securing identity papers for their children and completing divorce proceedings with the assistance of the lawyer. This program should be resumed.</p>	<p>Al Shehab, donors</p> <p>Al Shehab, donors</p>	<p>Donors should resume funding for gynecological services as soon as possible</p> <p>Donors should resume funding for the legal and anti-violence services as soon as possible</p>
Efficiency	<p>For Al Shehab to be more efficient in anti-violence programming, it will have to engage not only women and imams but local men, in a programmatic fashion. This would be new for Al Shehab, but the men who have become more violent in response to women's empowerment need to be engaged, because if they remain unemployed, unable to fulfil community roles, they will continue to resent programs and advancements for women. The men are also underserved, and need something. Al Shehab must continue to prioritise women, but must not let a few men's resentment derail the work</p>	<p>Al Shehab, local women, local men</p>	<p>This needs to be well thought out and planned for a year, and tested and adapted over 2 years.</p>

	with the women.		
Sustainability	<p>Anti-violence programming must be repeated regularly for effects to be sustainable.</p> <p>Promote a network of primary beneficiaries – the women who come to Al Shehab for services, in meeting and team-building activities as well as educational and health meetings, and build their leadership and ability to advocate for their rights. This will require long-term capacity building perhaps including literacy classes, and training for them to meet with legislators with the advocacy platform. Capacity building for advocacy will include working with the women to draft talking points, teaching them about policy making procedures, and rehearsing (building on the theater workshops!) advocacy meetings as well as anticipating questions from policy makers.</p> <p>Meet with imams to develop clear activities and deliverables, for them to work with Christian clerics, and to use social media and new technology.</p> <p>Effectively addressing violence requires engaging the people who commit violence, Al Shehab should engage with community members, and advocate for engagement with the police, perhaps by going to the national level or the city level government.</p>	<p>Al Shehab and primary beneficiaries, donors</p> <p>Al Shehab and primary beneficiaries</p> <p>Al Shehab, imams</p> <p>Al Shehab, imams, community leaders, primary beneficiaries, to work with the government agencies above the local police, to advocate for better police response to VAW</p> <p>Al Shehab, primary and</p>	<p>As soon as possible, and preferably monthly or at least quarterly</p> <p>3-year plan starting as soon as possible</p> <p>3 year plan</p> <p>3 year plan</p> <p>Resume as soon as</p>

	<p>Engaging men at the family and community level is important to the success of the anti-violence program in the future. Al Shehab has successfully explained to men how violence is harmful to women and girls, both in the form of immediate injury and long term problems. These programs help men start to understand that VAW is not only wrong, but that it hurts their families and the women they care about most. However, for this work to have lasting effects, it is important for it to be repeated regularly, at least quarterly, and for boys (the next generation) to be included.</p> <p>Some Shehab participants have experienced a backlash at home as they have become more empowered. Considering this, it is important to communicate with men and their families, and with men in the community, to demonstrate that the women's gains are not a threat to the men or the family or the community, but instead an asset, healthier women means healthier families, and women with more earning power support their families.</p>	<p>secondary beneficiaries</p> <p>Al Shehab, primary and secondary beneficiaries, donors</p>	<p>possible, with a 3-to-5 year plan</p> <p>Two months to plan, with 3-to-5 years programming</p>
Impact	<p>Anti-violence programming was effective but needs to be resumed with regularity, preferably monthly but at least quarterly, rather than one-off programs.</p> <p>Schedule DIC and programs in alignment with the schedules</p>	<p>Al Shehab, theater group, community leaders, imams, and donors</p> <p>Al Shehab, staff, primary beneficiaries</p>	<p>As soon as possible</p> <p>As soon as possible</p>

	<p>of the primary beneficiaries. Programs should be in the afternoons and evenings for some primary beneficiaries.</p> <p>Vocational training was the least successful of programs. Beneficiaries reported not having professional level skills, except in some very specific instances. If vocational training is to resume, it should be in-depth and involve only as many people as can be sustained in the trades (e.g. hairdressing and food preparation) in the community. A smaller program for fewer people who receive in-depth training and job placement assistance would be more effective. The program may need to help women acquire necessary equipment for example for hairdressing or seamstress work. Stipends may be required for women to be able to devote enough time to develop skills.</p> <p>If donors offer inadequate support for vocational programming, it may be better to wait and seek more funding to offer long-term training.</p>	Al Shehab, trainers, donors	If vocational training resumes, training programs should last 1-2 years for women to develop professional level skills
Knowledge Generation	To share information about Al Shehab's good work, consider publishing an academic paper and submitting information to health newsletters. The successful health referral system and anti-violence programming with community leaders should be more widely known and emulated.	Al Shehab, evaluation team	2 years if you start now
Other	It is important to form partnerships to work with	Al Shehab, donors, Ministry of Health	Immediately

	<p>other local NGOs in order to refer participants to other service providers, rather than trying to offer all services. For example, some beneficiaries described a need for dental services, and this may present an opportunity to refer them to another NGO.</p> <p>Beneficiaries suggested programs for children, because education services are lacking. This could begin with a nursery where children could stay when their mothers attended Al Shehab's programs. This could even be run by the women.</p> <p>NAP recommends expanding Al Shehab beyond Cairo, and can help work toward national coverage and also raise awareness and collaborate with a large number of medical service providers. NAP means that Al Shehab should open DICs in other cities. Such expansion would depend on the new network of primary beneficiaries being able to travel and grow Al Shehab's work, first in other parts of Cairo and then in chosen locations in other cities. This is a long term plan, not an immediate activity.</p> <p>It is strongly recommended that Shehab engage with the use of drugs, using proven effective harm reduction approach rooted in understanding of the drugs used in the local community. Drug use is extremely common in some areas where</p>	<p>Al Shehab, primary beneficiaries, donors</p> <p>NAP, Al Shehab, donors, health care providers, primary beneficiaries</p> <p>Al Shehab, community leaders, women PWUD, UNAIDS, donors</p>	<p>If adopted, preparations could be undertaken this year to open a nursery next year. This project would not be hard, but expanding would be expected by beneficiaries, and that could be difficult.</p> <p>Three years for the beginning. Do not expand too quickly.</p> <p>A support group may be possible quickly, but other efforts will require funding, so a one-year plan is recommended, to seek training in proven-effective harm reduction</p>
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	<p>Shehab works and reported to be common in the families of Shehab's beneficiaries, and among some Shehab participants, affecting violence and vulnerability to HIV. Therefore, in order to comprehensively serve the beneficiaries, Al Shehab must address this facet of their lives, as this affects everyone. Using a harm reduction approach, accepting people "where they are at" with respect to drug use and other possibly dangerous activities, is recommended for its proven effectiveness and to generate trust among the community. It may be worthwhile to start a support group for the women who use drugs and to encourage a local imam or other leader to work with men who use drugs.</p> <p>Heroin is not the most common drug, but opioid overdose is a problem in the community; for this reason, it is recommended that naloxone be introduced and distributed, with trainings to use naloxone to reverse overdose conducted at regular intervals. Naloxone is on the WHO list of essential medicines but is not available in Egypt, so it will be necessary for UNAIDS, UNDP, WHO and other UN agencies to advocate for its importation, working with the Al Shehab community, and for naloxone to be distributed at the community level. These same groups should advocate for the introduction of proven-effective opioid</p>	<p>Al Shehab, community leaders, women PWUD, UNAIDS, UNODC, UN Women, WHO, UNDP</p>	<p>methods.</p> <p>Start by asking the local women who use drugs who already come to Shehab what they need. If they think working with a local imam or other community leader will be useful, ask them to identify which imams may be good.</p> <p>Find out what harm reduction services are available in MENA.</p> <p>Naloxone is on the WHO list of essential medicines. This long-term project to introduce OST and naloxone to Egypt should be lead by UN agencies. This kind of advocacy can take years.</p>
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	substitution therapy in Egypt.		
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Case Study: Nafisa's Success Story with Al Shehab

Name: Nafisa

Age: 39 years old

Location: Cairo

Number of children: 6

Participated in: Psychological services, anti-violence programming, "Breadwinner Project" financial training, HIV awareness sessions

I am originally from El Matareya but live here for the last 35 years with my husband and 6 children, and I have a small kiosk here. I have a special relationship with people here, they reach out for me to solve domestic problems, and If I can't do it I refer them to Al Shehab, they are always there for us. I have referred so many women to benefit from the psychological

service and to attend the awareness sessions; it's for their own good by the end. Whenever I see a group of gathered women I tell them about the last awareness session I attended, I just came back from one of these gatherings; they were waiting for the bus and I told them about the violence session and that they cannot accept getting beaten from their husbands. They are always encouraged to attend the sessions too and they asked me when is the next one. I have referred more than 50 women to go and attend these sessions.

I started my journey with Al Shehab 3 years ago, I have benefited from the "Breadwinner Woman" project when I have been given products worth 5000 EGP to sell in my kiosk as well as a small soda fridge. I told them that I am interested in attending the different sessions they organize for women here. I have attended so many awareness sessions about violence, HIV and Hepatitis C and Sexual Harassment which raised my knowledge about these topics. Additionally, I do like the Psychological service and the support they give to whoever in need to. I always keep the awareness papers that I take from Al Shehab, I still remember the awareness messages related to GBV and domestic violence. I have heard stories about men who denied their wives from going to Shehab because they are afraid of their empowerment and knowledge getting raised. I believe the problem here is that Awareness sessions are restricted to women however Awareness doesn't reach parents and men who stop women empowerment. Parents here don't react if their daughter is beaten by her husband; however my point of view if the husband does it he has to be beaten to respect himself and it happened.

The awareness sessions that I attended changed my behavior. Before, we were afraid if we met a drug addict or an HIV positive patient or even touching a door handle, which was because of lack of knowledge. I was surprised that the Doctor working in a hospital few months ago is the one who urged me not to touch the door handle. For me, Awareness Sessions were not just a tool to get knowledge, I developed empathy towards people living with HIV. I really benefited from Al Shehab services, for example to lawyer; it's great to benefit from legal services for free and from the different awareness sessions they hold in the community.

I started to talk to young people taking drugs in the street instead of neglecting them and running away from them; I advise them privately to quit drugs for their own good and for their family and to grant a better future. People here – in the neighborhood- are used to make fun of those under drug effect in the street; this behavior saddens me, I talk to them and I ask them if they would be satisfied if someone did the same for them, I keep telling them that addiction is a disease that could reach anyone so no need to treat them badly and they apologized and deleted the picture they took of him and the guy is married now and quit drugs.

We need to create job opportunities for youth here to keep them busy, thus stay away from drugs and creating an alternative source of income, it shall help decrease the drugs problem in the neighborhood. I believe in the power of peers in solving the drugs problem. The whole community should embrace people following a different behavior instead of spreading stigma and discrimination against them.

Case Study: An Al Shehab Family

Family of 8: Mariam, an 18-year-old woman, her parents, her brother, and other siblings

Programs: anti-violence

My name is Mariam, I was born here but my parents aren't originally from Cairo; my mum is from Suez and my father came from Upper Egypt. I used to come to Shehab to watch the activities they do with my relative; I used to see Al Shehab volunteers in the streets. I had a very limited social life that is just between school and home.

I have always wanted to join them and It was disappointing that when I asked him to attend Al Shehab activities he refused and he was wondering why I would attend these stuffs and that it would be a waste of time and he didn't want me to deal with anyone. Before he attended these sessions and workshops he was very closed minded and stubborn. He was always taking me to school, either him or my mum. I was never allowed to go anywhere other than school, never allowed to visit my friends but after we started to go together for a year he left me here alone and left.

It was my 20-year-old brother who first volunteered here in the project, he was attending sessions about women and violence and he used to apply what he learned at home. I was never used to talk to him; I used to stay in my room and that's it. He started to open conversations with me about my life, my school; I felt the change and I loved it. I asked him where did he learn did stuff? He told me at Al Shehab, then I asked him if I can join him too.

He agreed to take me with him after he had seen what people are doing at Al Shehab and after he witnessed the change in his personality and that everyone is dealing respectfully. I started attending with him the sessions 3 years ago when I was only 16 years old; anything that we learned we did apply it on ourselves then at home. He started to accept my visiting my friends and hosting them at home and even hanging out in coffee shops. He was always commenting on my clothes; now he is convinced that it's a personal freedom; it was the same with his fiancée and his behavior changed also with her.

I have seen a change on myself too, I never had a social life and I would never talk to my mother even if something bad happened to me I was always afraid to speak about it. But now, I always share with her what I learned during the sessions so she could benefit too. When I attended the "Safe Cities" training I learned how to deal with my 10-year-old younger sister and how to raise her awareness towards specific topics. My father also refused to come to Al Shehab but eventually he came and watched what I am doing. He was convinced by seeing me doing something good for the community. He started to encourage me and was very proud of me. My family have seen a change in my personality towards them and toward others. At the beginning my family were against my acting work, but now they accept it and I am now acting in plays outside the neighborhood with the famous actor Mohamed Sobhi!

I have also seen change in the behavior of some of the young boys, among those who attended the plays some who used to harass girls in the street, they changed their behavior and stopped it. Even in schools among children, I have seen a baby boy denying his relative from sitting beside other boys, he is now letting her sit beside her classmates play and eat together. As for

the toktok drivers it was a true disaster, they used to harass girls and women physically; however, after they attended the SH Awareness sessions their behavior changed a lot.

I have also convinced five other girls to come with me and volunteer. Their parents too at first refused but eventually they conceded and let these girls attend too. What I truly consider a success is that Al Shehab organized a camp in Ain Sukhna for the volunteers about a year ago and my brother refused my participation because he still didn't change 100%. However, he participated himself and a couple of months after the camp he let me participate all alone in the next 3-day camp and he wasn't even there! I believe it's because he has seen how people deal with each other.

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Annexes

A. TOR

Terms of Reference (TOR)

Community-based intervention to alleviate the different forms of violence against women and women's vulnerability to HIV

End line Survey and final evaluation of the project

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Background and context

Description of the project that is being evaluated:

- a) **Name of the project and the organization:** Community-based intervention to alleviate the different forms of violence against women and women's vulnerability to HIV.
Organization name: Al Shehab Institution for Comprehensive Development
- b) **Project duration, project start date and end date:** Three-year project from January 2015 till December 2017.
- c) **Current project implementation status with the timeframe to complete the project:**
The project will be closed and fully-deliver its key activities by December 31st, 2017.
- d) **Main objectives of the project:** Marginalized women who experience (or are at risk of) violence and HIV transmission with a focus Ezbet El Haggana and El Marg communities in Cairo experience improved safety, health and reduced vulnerability through improved access to GBV and HIV services and increased understanding in the community.
- e) **Description of targeted primary and secondary beneficiaries:**
 - The primary beneficiaries of this project are mainly marginalized women from informal communities. Namely women survivors of violence, female sex workers, Women Living with HIV/AIDS and women domestic workers. Often this segments of the population are frequently subject to different acts of violence and are at

- significantly high risk to acquire HIV/AIDS. For example, female sex workers are amongst the key populations in Egypt and are highly vulnerable to both HIV and violence. Meanwhile, female domestic workers are working in unsafe environment, lacking any legal protections from being subject to sexual violence and harassment within their workplaces as well as at their own households. The four groups (primary beneficiaries of this project) are struggling with low socio-economic status, high rates of illiteracy, unemployment as well as inability to access safe working conditions. Most of them are not able to access different medical, legal and economic services to improve their situations due to their low economic status, fear of stigma and discrimination or low awareness regarding the means of preventing the twin epidemic (HIV & Violence against Women).
- The secondary beneficiaries of this project are: community-based organizations from Ezbet El Haggana, health professionals from private, non-governmental and governmental health care providers in the local community, men, boys and religious leaders. The project aimed at creating supportive environment that empower women and support them to access stigma-free services in order to expand their abilities to address the different forms of violence they are experiencing on daily basis.

Strategy and the results chain of the project:

There is limited evidence and interventions to address the twin epidemics Violence against Women and HIV. Numerous studies continue to show that women have weak knowledge in regards to both HIV and how to deal with potential or actual violence. The problem is that all such studies conducted in Egypt have focused on either HIV or violence, and rarely address the two together. This gap is not only limited to the research field, but also even in regards to the services available to vulnerable women and survivors of the two epidemics. NGOs working in this area have tended to focus on providing services in one area or the other, and a comprehensive approach that tackles both phenomena simultaneously is still missing.

In this context, Al-Shehab Institution is implementing a project titled "Community-based intervention to alleviate the different forms of violence against women and women's vulnerability to HIV" funded by the United Nations Trust Fund to End Violence against Women and Girls. The project intends to address these gaps and achieve an overall goal of supporting marginalized women who experience violence and/or HIV. The project's objectives are to improve access and utilization of services for GBV and HIV to meet needs of particular groups who experience and at high risk of gender-based violence and HIV, and to increase understanding and support for gender equality and HIV response in the community. The project utilizes a number of strategies, range from: promoting/providing services (psychological counseling, medical service, shelters); creating opportunity for women to exercise social and economic rights; capacity development for CBO and public

health care providers; public outreach and awareness-raising; and collecting and analyzing data for the first time in Egypt on the interstice between HIV/AIDS and VAW.

The project result chain:

Project goal: Marginalized women who experience (or are at risk of) violence and HIV transmission with a focus Ezbet El Haggana and El Marg communities in Cairo experience improved safety, health and reduced vulnerability through improved access to GBV and HIV services and increased understanding in the community			
Outcome 1	Female Sex Workers, Women and Girls Living with HIV, Domestic Workers and women and girls survivors of violence in two communities in Cairo have improved access to Gender-based Violence and HIV services and make more use of the services	Output 1.1.	Psychosocial, legal and referral services are available at the newly established community-based center and sustained in the drop-in center
		Output 1.2	Female sex workers and women living with HIV participate at the handcraft workshop and acquire professional and life skills: crochet, accessories and sewing, communication, marketing budgeting and saving
		Output 1.3	staff working in community-based organizations and health care services (Public, Private and NGOs-based health facilities) have increased knowledge of gender equality and understanding of intersection between VAW and HIV epidemics
Outcome 2	Men, boys and key affected women in the targeted communities have an improved understanding of gender equality, women's rights and how to prevent GBV and HIV transmission through changes in behavior to support gender equitable	Output 2.1	Understanding of women's vulnerability to HIV and violence is increased among men, boys, female domestic workers and female sex workers who participate in the awareness activity

	norms in Ezbet El Haggana and El Marg communities	Output 2.2	leaders within the targeted communities and among key affected women gained better understanding about the intersection between GBV and HIV and their support for the gender equitable norms increased
Outcome 3	Religious Leaders and policy makers demonstrate improved understanding and support for women vulnerable to violence and HIV through evidence-based policies.	Output 3.1	Policy makers understanding of women's vulnerability to HIV and violence in Egypt increased
		Output 3.2	Religious Leaders in Greater Cairo increased knowledge of women's vulnerability to HIV/AIDS and Violence

The geographical context and the geographical context of this project:

Al Shehab Institution is implementing this project in some urban marginalized (informal) communities. The first site is Ezbet EL Haggana community, which locates in East Cairo with population size estimated of one million inhabitants in addition to more than 4500 refugee families from Sudan and Somalia (Al Shehab Institution survey in 2009 with WHO-EMRO). The second site is El Marg District, which locates in North-East Cairo. Al Shehab is not providing services directly in this community, however, the organization targets women and girls who engage in sex work from this community and the surrounding neighborhood (East Cairo parts). According to Egypt's Informal Settlement Development Facility (ISDF) report in 2008 there are around 10 informal areas in El Marg district that are: El-Marg with the highest population that exceeds 91,222 inhabitants, El-Nozha 43,831, El-Andalus 60,445, El-Nakhl El-Sharqeya 23,008, Kafr El Shurafa 44,324, El-Zohoor 35,602, Baraket El-Hagg 27,012, Ard El-Muhagreen 135, Abu Seer 7,410 and Kafr El- Basha 8,258.

Main socio-economic and cultural context of the selected communities: Ezbet El Haggana and El Marg communities are informal areas corresponding to all of the standard elements qualifying it as a "slum", including different structural factors i.e. overcrowded and poor quality housing; inadequate provision of infrastructure and services; and insecurity. Both communities are suffering of the lack of/non function and poor quality of basic services i.e. access to clean

drinking water, sewage system electricity and garbage disposals. Limited educational facilities and the number of schools is significantly insufficient in comparison to the population sizes, is another underlying issue that the residents of the targeted communities are suffering of. It makes the pursuit of a basic education difficult for most families within the selected communities. For example, the classroom density can reach 80 students within the local communities. Residents of the targeted communities are subject to different economic and social problems. Such problems range from extreme poverty, lack of decent jobs, high rate of illiteracy and unemployment particularly among youth. The available working opportunities for the residents within the local communities are mainly within the informal sector that provides unstable labor, low income, lacking social security and the minimum requirements of decent working conditions.

Women within those communities are subject to discrimination and different forms of violence. For example, domestic violence against women reported in Ezbet El Haggana as a widespread phenomenon as the 2009 survey found that 62.6% of women are subject to domestic violence. Domestic violence against women includes physical abuse, emotional abuse, economic abuse, and sexual abuse. Batterers most likely are fathers and husbands, and they use threats, intimidation, isolation, and other behaviors to maintain power over their victims. Another significant finding in the Ezbet Al Haggana community that emerged from the survey is 48% of women represented in the sample are heading their families, which is relatively higher than the estimated national average of 13.4% (national figure obtained from: ICF International Demographic and Health Survey 2008). The majority of women in Ezbet Al Haggana community work mainly as domestic workers in the surrounding rich neighborhoods, where they are subject to different forms of violence, sexual harassment and ill-health conditions. Another form of violence against women is observed and documented among the beneficiaries who are coming from El Marg Districts and visiting AL Shehab Drop-in Center (that operates since 2006) is the absence of official documents (birth certificates and national IDs). There is also a high prevalence of this problem among women in Ezbet El Haggana. The high prevalence of this problem among women is because traditionally parents think it is not necessary to issue such papers for girls. Lacking access to such documents deprive women of the right to enjoy certain rights such as the right to education, health and the right to access pension and literacy classes. Moreover, the absence of such documents denies women's rights to exercise their right to vote, claim inheritance, obtain credits or establish a business.

For these communities a lack of secure tenure, official recognition, and the basic requirements for decent living conditions has resulted in falling behind national averages in many social indicators, creating further vulnerabilities and widening inequalities.

Key partners involved in the project:

UNAIDS, Egypt Country Office.

Purpose of the evaluation:

Why the evaluation needs to be done

The end line and final evaluation is required by the UN Trust Fund to End Violence against Women. At the beginning of this intervention, Al Shehab commissioned external firm to conduct baseline survey to measure the current knowledge, perceptions and experiences (prior to delivering this project) on violence among the primary beneficiaries, assess the perception of men, health workers and community leaders on how to best addressed the intersection between violence against women and HIV as well as to examine the current relevant national strategies in order to identify strengths and weaknesses to suggest ways to better establish link between the work on HIV and violence. By December 31st 2017, the project will be fully implemented and closed. Thus, Al Shehab would like to assess the extent to which each indicator was achieved and compare the results for the goal, each outcome and output against the findings of the baseline. The final evaluation and end-line will assess women's experience on safety, health and well-being (project goal), and societal perspective about gender equality, women's rights, intimate partner violence, acceptability of accessing HIV related information and service and acceptability of women's economic participation. Also, Al Shehab Institution would like to better understand and document the key successes, challenges and lessons learnt from this particular action, assess the relevance, effectiveness and management arrangements of the project. To take such findings into consideration while designing future interventions and programs that respond to marginalized women's and eliminate their vulnerability to violence and HIV.

How the evaluation results will be used, by whom and when

The results and outcomes of the end line and final evaluation will inform Al Shehab Institution in order to scale-up this intervention. It is very important requirement for sustaining the intervention and supporting women and girls to continue access to gender-based and HIV related services within informal and marginalized communities. In this context, the results of this evaluation will be used as soon as it is finalized to develop concept notes and full-fledged proposal(s) for resources mobilization and fundraising efforts.

What decisions will be taken after the evaluation is completed

Based on the findings and results of this evaluation and end line survey, Al Shehab will revisit its strategy relate to women's and girls' empowerment as well as its program on women's vulnerability to HIV/AIDS in Egypt. In order to develop Al Shehab strategic pathways based on the lessons learnt and findings of the evaluation.

On strategic level, the final evaluation will support AL Shehab Board of Trustees and programming unit to decided on the framework of the new proposal to scale-up this pilot project.

On programmatic and service delivery level, the final evaluation will guide Al Shehab Institution to take accurate decisions to further improve the quality of services delivered for women and girls at the drop-in center and the community center.

Evaluation objectives and scope

Scope of Evaluation:

- Timeframe: this evaluation will cover the entire project duration (January 2015-December 2017)
- Geographical coverage: women, girls survivors of Violence, female domestic workers men and youth, community-based organization and health services providers from Ezbet El Haggana. Female sex workers who come from East Cairo including Al Marg community and women living with HIV who come from different parts at Greater Cairo.
- Target groups to be covered: the evaluation needs to cover the target primary and secondary beneficiaries as well as broader stakeholders that are listed in the full-fledge proposal of this project. This will include: women and girls (female domestic workers, survivors of violence, female sex workers and women living with HIV), men and youth from the target community, community-based organizations, health care services providers (private, non-governmental and governmental services providers), religious leaders, National AIDS Program, National Council for Women, UN Women and UNAIDS Egypt country offices.
- Interventions to be covered by the evaluation are the following:
 - Services provided for women and girls within the two centers (drop-in center and community service center). This services include: psychological, legal, listening supports as well as Voluntary Counseling and Testing service.
 - Handcraft and vocational trainings for the populations in question.
 - Capacity development component for the community-based organizations and health care services providers.
 - The referral system established between the project and services providers.
 - Community-based awareness and advocacy campaigns to engage men and youth from the target community. This intervention includes: IEC awareness materials, door-to door campaigns, awareness sessions and interactive theatre activities.
 - Policy paper on the intersection between VAW and HIV/AIDS
 - Trainings for 40 religious leaders from Cairo.

Objectives of the Evaluation:

At the end of the three-year project, it is vital to assess the progress achieve by the project and the changes in perceptive, knowledge and even practice that occurred as a result of the project's different key activities.

The overall objectives of the evaluation are to:

- a. Evaluate the entire project in terms of effectiveness, relevance, efficiency, sustainability and impact with strong focus on assessing the results at the outcome and project goals.
- b. Generate key lessons and identify promising practices for learning by documenting cases of positive changes and key lesson learnt as a result of the project implementation.
- c. Assess changes in terms of knowledge and perceptions of the different target groups regarding violence and HIV/AIDS.

Evaluation Questions:

The key questions that need to be answered by this evaluation include the following divided into five categories of analysis. The five overall evaluation criteria – relevance, effectiveness, efficiency, sustainability and impact - will be applied for this evaluation.

Evaluation criteria	Mandatory Evaluation Questions
Effectiveness	<ol style="list-style-type: none"> 1) To what extent were the intended project goal, outcomes and outputs achieved and how? 2) To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? How many beneficiaries have been reached? 3) To what extent has this project generated positive changes in the lives of targeted (and untargeted) women and girls in relation to the specific forms of violence addressed by the project? Why? What are the key changes in the lives of those women and/or girls? Please describe those changes. 4) What internal and external factors contributed to the achievement and/or failure of the intended project goal, outcomes and outputs? How? 5) To what extent was the project successful in advocating for policy change? If it was successful, explain why. 6) In case the project was successful in setting-up new policies (related to HIV& Violence against women), is the policy change likely to be institutionalized and sustained?
Relevance	<ol style="list-style-type: none"> 1) To what extent was the project strategy and activities implemented relevant in responding to the needs of women and girls (direct beneficiaries)? 2) To what extent do achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?
Efficiency	<ol style="list-style-type: none"> 1) How efficiently and timely has this project been implemented and managed in accordance with the project document?
Sustainability	<ol style="list-style-type: none"> 1) How are the achieved results, especially the positive changes generated by the project, in the lives of women and girls at the project goal level, going to be sustained after the project ends?
Impact	<ol style="list-style-type: none"> 1) What are the unintended consequences (positive and negative) resulted from the project?
Knowledge Generation	<ol style="list-style-type: none"> 1) What are the key lessons learned that can be shared with other practitioners on Ending Violence against Women and Girls? 2) Are there any promising practices? If yes, what are they and how can these promising practices be replicated in other projects and/or in other countries that have similar interventions?

In addition to above listed questions, at the end of end-line survey, Al Shehab will be able to answer the following questions:

- To what extend did the project reach the targeted beneficiaries at the project different levels (goal, outcomes and outputs)?
- What are the internal and external factors contributed to the achievement, partial achievement or non-achievement of the intended outputs and outcomes?
- To what extend was the project successful in providing new information regarding GBV and HIV and in changes perceptions of the targeted audience in the implementing communities in comparison to the baseline data?
- To what extend did the project outputs and outcomes addressed the needs of the targeted population? And if some of the achieved results generated any positive change in the lives of some women and girls?
- What is the impact of the project on staff's ability and knowledge gain?

Evaluation Methodology:

a. Proposed evaluation design:

The evaluation and end-line study will utilize mix qualitative and quantitative methodology. The researchers will prepare a semi-structured questionnaire designed for each group for the qualitative study. Then, the result of the qualitative study will be reflected in a structured questionnaire used in the quantitative study to explore how common the issues or needs among the respondents. Both questionnaires for the qualitative and quantitative study will be pre-tested by a few numbers of people who have the similar characteristics as the sample population. In order to ensure that the respondents understand the questions correctly and examining if the researchers are able to make the respondents feel free to answer the questions.

The qualitative and quantitative study shall be designed to investigate the meanings and understanding of experiences in safety, health and well-being among female domestic workers, women living with HIV, female sex workers and women's survivors of violence among the targeted communities, particularly Ezbet El Haggana and areas of East Cairo including Al Marg community, (Project goal indicator 1). First, safety indicates their experience of mental, physical, and sexual violence in their workplace and in mate partner violence. Additionally, it investigates what experience the project beneficiaries had within their community, with their partners in daily life and when they become victims of any forms of violence to report incidents. The study will also probe if they are willing to report incidents when they experience any forms of violence, and what is more likely to influence their decision- making to report or not to do so, as well as the extend to which the project equipped them with to be able to report the forms of violence. Second, health will be described as their needs for sexual reproductive health, HIV services (HIV testing and counseling, and condom provision), and mental health after experiencing any forms of violence. To

assess the vulnerability to HIV, the study will investigate their knowledge about HIV, condom use, and access to HIV testing and counseling and condoms, probe the stereotypes relate to in mate partner violence and its relation to vulnerability to HIV. The project impact on women's ability to protect themselves from HIV and other Sexual Transmitted Diseases. Third, well-being is defined as their experience of participating in household income, and being financially challenged. Details may change upon more thorough design discussion with the evaluation consultant.

b. Data sources:

The main data sources are:

- The full-fledge proposal and the Results and Resources Framework(RRF),
- The project's progress and annual reports,
- The project's Monitoring, evaluation and knowledge management system,
- The project's direct beneficiaries, target groups and relevant stakeholders.
- Relevant national strategic plans i.e. National Strategic Plan for HIV and National Plan to Combat Violence against Women.

c. Proposed data collection methods and analysis:

- A structured survey to examine how the findings of the baseline study might have changed at the end of the project
- Focus group discussions (FGDs) with women living with HIV, domestic workers and religious leaders
In-depth interviews with female sex workers, women survivors of violence
- In-depth interviews (IDIs) with members of CBOs, community leaders and medical personnel
- In-depth interviews with the staff at the drop-in center and the community-based center
- Case studies to document some of the cases where women/girls benefited out of the provided services which lead to decrease of vulnerability

d. Proposed sampling methods:

Sampling and sample size will be specifically identified by the researchers (external evaluator). Yet, the sample of the study should consist of women, men, youth, community leaders, religious leaders and services providers (health services) who have been enrolled in the project during the course of implementation. For the qualitative study, the researcher will randomly sample women with a minimum number of 10 per each sub-group (female domestic workers, women living with HIV, female sex workers and women survivors of violence) who visited the drop-in center at least once from a contact list that an outreach team and the project staff recorded. Individual interviews will be conducted because the topics are personal and sensitive. Before the interview is conducted, the researcher will explain the purpose of the interview, what will be asked during the study and obtain a written consent from each interviewee. Also the researcher will record the conversation upon consent from the interviewees for transcription of the interview to be used in analysis. Also the researcher will assure the

confidentiality of the information. The researcher will use the results of the qualitative study to structure a questionnaire to understand how the issues and needs are common among the sample cluster. Again, the researcher will randomly sample women with a minimum number of 50 per each sub-group (female domestic workers, women living with HIV, female sex workers and women survivors of violence) who have visited the project's services. Al Shehab invites the respondents to the drop-in-center for the interview with a structured questionnaire. The respondents will be able to request to fill out the questionnaire by themselves or with assistance from the researchers/ Al Shehab staff.

Evaluation Ethics

The evaluation must be conducted in accordance with the principles outlined in the UN Evaluation Group (UNEG) 'Ethical Guidelines for Evaluation' <http://www.unevaluation.org/ethicalguidelines>.

It is imperative for the evaluation team to:

- Guarantee the safety of respondents and the research team.
- Apply protocols to ensure anonymity and confidentiality of respondents.
- Select and train the research team on ethical issues.
- Provide referrals to local services and sources of support for women that might ask for them.
- Ensure compliance with legal codes governing areas such as provisions to collect and report data, particularly permissions needed to interview or obtain information about children and youth. Store securely the collected information.

The evaluator(s) must consult with the relevant documents as relevant prior to development and finalization of data collection methods and instruments. The key documents include (but not limited to) the following:

- World Health Organization (2003). *Putting Women First: Ethical and Safety Recommendation for Research on Domestic Violence against Women*. www.who.int/gender/documents/violence/who_fch_gwh_0.1/index.html
- Jewkes, R., E. Dartnall and Y. Sikweyiya (2012). *Ethical and Safety Recommendations for Research on the Perpetration of Sexual Violence*. *Sexual Violence Research Initiative*. Pretoria, South Africa, Medical Research Council. Available from www.svri.org/Recommendations.pdf
- Researching violence against women: A practical guide for researchers and activists. November 2005 http://www.path.org/publications/files/GBV_rvaw_complete.pdf

- World Health Organization (WHO), 'Ethical and safety recommendations for researching documenting and monitoring sexual violence in emergencies' 2007, http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

Key deliverables of evaluators and timeframe:

No	Deliverables	Description of Expected deliverables	Timeline of each deliverable (date/month/year)
1	Evaluation inception report (Arabic and English)	<p>The inception report provides both Al Shehab and the evaluators with an opportunity to verify that they share the same understanding about the evaluation and clarify any misunderstanding at the outset.</p> <p>An inception report must be prepared by the evaluators before going into the technical mission and full data collection stage. It must detail the evaluators' understanding of what is being evaluated and why, showing how each evaluation question will be answered by way of: proposed methods, proposed sources of data and data collection/analysis procedures.</p> <p>The inception report must include a proposed schedule of tasks, activities and deliverables, designating a team member with the lead responsibility for each task or product.</p> <p>The structure must be in line with the suggested structure of the annex of TOR.</p>	31/01/2018
2	Draft evaluation report (Arabic and English)	<p>Evaluators must submit draft report for review and comments by all parties involved (Al Shehab, representatives of women, UNTF, UN Women and UNAIDS). The report needs to meet the minimum requirements specified in the annex of TOR.</p> <p>Al Shehab and key stakeholders in the evaluation must review the draft evaluation report to ensure that the evaluation meets the required quality criteria.</p>	01/03/2018

3	Final evaluation report (Arabic and English)	<p>Relevant comments from key stakeholders must be well integrated in the final version and the final report must meet the minimum requirements specified in the annex of TOR.</p> <p>The final report will be disseminated widely to the relevant stakeholders and the general public.</p>	15/03/2018

Evaluation team composition and required competencies

Evaluation Team Composition and Roles and Responsibilities:

The evaluation team will be consisting of 1 national consultant (senior Evaluator), statistician (for quantitative analysis) 3 to 4 evaluators (for data collection).

The senior evaluator will be responsible for undertaking the evaluation from start to finish and for managing the evaluation team under the supervision of evaluation task manager from the grantee organization (AL Shehab Institution), for the data collection and analysis, as well as report drafting and finalization in English and Arabic.

Evaluators team will be responsible for undertaking the field work and data collection from start to finish. The team will conduct in-depth interviews, focus groups discussions and structured survey with the direct beneficiaries and relevant stakeholder.

Required Competencies:

Senior Evaluator must have:

- Evaluation experience at least 5 years in conducting external evaluations, with mixed-methods evaluation skills and having flexibility in using non-traditional and innovative evaluation methods
- Expertise in gender and human-rights based approaches to evaluation and issues of violence against women and girls
- Specific evaluation experiences in the areas of ending violence against women and girls
- Experience in collecting and analyzing quantitative and qualitative data
- In-depth knowledge of gender equality and women's empowerment
- A strong commitment to delivering timely and high-quality results, i.e. credible

evaluation and its report that can be used

- A strong team leadership and management track record, as well as interpersonal and communication skills to help ensure that the evaluation is understood and used.
- Good communication skills and ability to communicate with various stakeholders and to express concisely and clearly ideas and concepts
- Country experience and knowledge: in-depth knowledge of the national context in Egypt is required.
- Language proficiency: fluency in English and Arabic is mandatory.

Management Arrangement of the evaluation

Name of the group	Roles and responsibilities	Actual name of staff responsible
Evaluation team	External evaluators/consultants to conduct an external evaluation based on the contractual agreement and the Terms of Reference, and under the day-to-day supervision of the Evaluation Task Manager.	External evaluators
Evaluation task Manager	Under the overall guidance of the senior management, the evaluation task manager will: <ul style="list-style-type: none"> • lead the development and finalization of the evaluation TOR in consultation with key stakeholders and the senior management; • manage the recruitment of the external evaluators; • lead the collection of the key documents and data to be share with the evaluators at the beginning of the inception stage; • liaise and coordinate with the evaluation team, the reference group, the commissioning organization and the advisory group throughout the process to ensure effective communication and collaboration; • provide administrative and substantive 	Project Manager of AL Shehab Institution for Comprehensive Development.

	<p>technical support to the evaluation team and work closely with the evaluation team throughout the evaluation;</p> <ul style="list-style-type: none"> • lead the dissemination of the report and follow- up activities after finalization of the report 	
Commissioning Organization	<p>Responsible for:</p> <ul style="list-style-type: none"> • allocating adequate human and financial resources for the evaluation, • guiding the evaluation manager, • preparing responses to the recommendations generated by the evaluation. 	<p>Senior management of AI Shehab Institution for Comprehensive Development. (1 Board Member, the Executive Director and Program Director)</p>
Reference Group	<p>Include primary and secondary beneficiaries, partners and stakeholders of the project who provide necessary information to the evaluation team and to reviews the draft report for quality assurance</p>	<p>Women representatives of the four main groups, youth representative, representatives from the community-based organizations and health service providers within the target community.</p>
Advisory Group	<p>The advisory group will review and comment on the draft TOR and the draft report for quality assurance and provide technical support if needed</p>	<p>Lorna Mesina-Husain-Programme Specialist, UNTF</p>

		<p>Cherine Aly- EVAW OIC- UN Women</p> <p>Abdel Razek Abu El Ela- Program Director- Al Shehab Institution for Comprehensive Development.</p>
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timeline of the entire evaluation process

Stage of evaluation	Key task	Responsible	Number of working days required	Timeframe (dd/mm/yyyy)
Preparation stage	Prepare and disseminate the TOR with key stakeholder and potential consultant	Commissioning organization and evaluation task manager	3	26/12/2107
	Recruitment of the external evaluator (s)		15	11/01/2018
Inception	Briefings of evaluators to orient the evaluators	Evaluation task manager	1	14/01/2018
	Desk review of key documents	Evaluation team	5	19/01/2018

stage				
	Finalizing the evaluation design and methods	Evaluation team	2	21/01/2018
	Preparing an inception report	Evaluation team	5	26/01/2018
	Review inception report and provide feedback	Evaluation Task Manager, Reference Group and Advisory Group	2	28/01/2018
	Submitting final version of inception report	Evaluation team	3	31/01/2018
Data collection and analysis stage	Desk research	Evaluation team	5	05/02/2018
	In-country technical mission for data collection (visits to the field, interviews, questionnaires, etc.)	Evaluation team	10	15/02/2018
	Analysis and interpretation of findings	Evaluation team	5	20/02/2018
	Preparing a draft report	Evaluation team	10	01/03/2018

Synthesis and reporting stage	Review of the draft report with key stakeholders for quality assurance	Evaluation Task Manager, Reference Group, Commissioning Organization Senior Management, and Advisory Group	5	06/03/2018
	Consolidate comments from all the groups and submit the consolidate comments to evaluation team	Evaluation task manager	2	09/03/2018
	Incorporating comments and revising the evaluation report	Evaluation team	4	14/03/2018
	Submission of the final report	Evaluation team	1	15/03/2018
	Final review and approval of the report	Evaluation Task Manager, Reference Group, Commissioning Organization Senior Management, and Advisory Group	3	19/03/2018
Dissemination	Publishing and distributing the final report	Commissioning organization led by the evaluation manager	5	25/03/2018

and follow-up	Prepare management responses to the key recommendations of the report	Senior management of commissions organization	7	01/04/2018
	Organize learning events (to discuss key findings and recommendations, use the findings for planning of following year)	Commissioning organization	3	15/04/2018

How to apply

Interested candidates should submit their full application by January 8th 2018 COB, mentioning “End-line and Final Evaluation” in the subject, to: abdo@shehabinstitution.org

Full application should include:

- a- Full financial and technical proposal
- b- Updated CVs for the key consultant(s): Principal Investigator(s) and Research Assistant(s).

Annexes

- 1) Key Stakeholders and partners to be consulted
 - National AIDS Program- Manager
 - National Council for Women- President
 - UNAIDS Country Manager

Sites to be visited:

- Ezbet El Haggana local community
- Al Shehab Drop-in Center at Nasr City.

- 2) Documents to be consulted

- The full-fledge proposal and the Results and Resources Framework(RRF),
- The project's progress and annual reports,
- The project's Monitoring, evaluation and knowledge management system,
- Baseline date of the project,
- The project's direct beneficiaries, target groups and relevant stakeholders,
- Relevant national strategic plans i.e. National Strategic Plan for HIV and National Plan to Combat Violence against Women.

3) Required structure for the inception report

1- Background and context of the project

2- Description of the project

3- Purpose of the evaluation

4- Evaluation objectives and Scope

5- Final version of the evaluation questions with evaluation criteria

6- Description of the evaluation team, including the brief description of role and responsibilities of each team member

7- Evaluation design and methodology

- a. Description of overall evaluation design
- b. Data sources (access to information and documents)
- c. Description of data collection methods and analysis (including level of precision required for quantitative methods, value scales or coding used for qualitative analysis; level of participation of stakeholders through evaluation process)
- d. Description of sampling (area and population to be represented, rationale for selection, mechanics of selection, limitations to sample) reference indicators and benchmarks, where relevant (previous indicator, national statistics, human rights treaties, gender statistics etc.)
- e. Limitations of the evaluation methodology proposed.

8- Ethical consideration: a) safety and security of participants and evaluation team, and b) contention strategy and follow-up

9- Work plan with specific timeline and deliverables by evaluation team (up to the submission of finalized report)

10- Annexes

- a. Evaluation matrix
- b. Data collection instrument (e.g. survey questionnaire, interview and focus group guides, observation checklist, etc.)
- c. List of documents consulted so far and those will be consulted
- d. List of stakeholders/partners to be consulted
- e. Draft outline of final report (in accordance with the requirement of UN Trust Fund).

4. Required Structure of the Evaluation Report

1. Title and cover page

- Name of the project
- Locations of the evaluation conducted (country, region)
- Period of the project covered by the evaluation (month/year – month/year)
- Date of the final evaluation report (month/year)
- Name and organization of the evaluators
- Name of the organization(s) that commissioned the evaluation
- Logo of the grantee and of the UN Trust Fund

2. Table of Content

3. List of acronyms and abbreviations

4. Executive summary

[A standalone synopsis of the substantive elements of the evaluation report that provides a reader with a clear understanding of what was found and recommended and what has been learnt from the evaluation. It includes]:

- Brief description of the context and the project being evaluated;
- Purpose and objectives of evaluation;
- Intended audience;
- Short description of methodology, including rationale for choice of methodology, data sources used, data collection & analysis methods used, and major limitations;
- Most important findings with concrete evidence and conclusions; and
- Key recommendations.

5. Context of the project

- Description of critical social, economic, political, geographic and demographic factors within which the project operated.
- An explanation of how social, political, demographic and/or institutional context contributes to the utility and accuracy of the evaluation.

6. Description of the project

[The project being evaluated needs to be clearly described. Project information includes]:

- Project duration, project start date and end date
- Description of the specific forms of violence addressed by the project
- Main objectives of the project
- Importance, scope and scale of the project, including geographic coverage
- Strategy and theory of change (or results chain) of the project with the brief description of project goal, outcomes, outputs and key project activities
- Key assumptions of the project
- Description of targeted primary and secondary beneficiaries as well as key implementing partners and stakeholders
- Budget and expenditure of the project

7. Purpose of the evaluation

- Why the evaluation is being done
- How the results of the evaluation will be used
- What decisions will be taken after the evaluation is completed

- The context of the evaluation is described to provide an understanding of the setting in which the evaluation took place

8. Evaluation objectives and scope

- A clear explanation of the objectives and scope of the evaluation.
- Key challenges and limits of the evaluation are acknowledged and described.

9. Evaluation Team

- Brief description of evaluation team
- Brief description of each member's roles and responsibilities in the evaluation
- Brief description of work plan of evaluation team with the specific timeline and deliverables

10. Evaluation Questions

- The original evaluation questions from the evaluation TOR are listed and explained, as well as those that were added during the evaluation (if any).
- A brief explanation of the evaluation criteria used (e.g. relevance, efficiency, effectiveness, sustainability and impact) is provided.

11. Evaluation Methodology

[The template below must be used for this section.]

Sub-sections	Inputs by the evaluator(s)
Description of evaluation design	<i>[please specify if the evaluation was conducted by one of the following designs: 1) post-test² only without comparison group; 2) pre-test and post-test without comparison group; 3) pre-test and post-test with comparison group; or 4) randomized control trial.]</i>
Data sources	
Description of data collection methods and analysis (including level of precision required for quantitative methods, value scales or coding used for qualitative analysis; level of participation of stakeholders through evaluation process, etc.)	[Please refer to the evaluation matrix (template Annex 4A)]
Description of sampling <ul style="list-style-type: none"> • Area and population to be represented • Rationale for selection • Mechanics of selection limitations to sample • Reference indicators and benchmarks/baseline, where relevant (previous indicators, national statistics, human rights treaties, gender statistics, etc.) 	
Description of ethical considerations in the evaluation	

² "Test" means project/intervention in this context.

<ul style="list-style-type: none"> • Actions taken to ensure the safety of respondents and research team • Referral to local services or sources of support • Confidentiality and anonymity protocols • Protocols for research on children, if required. 	
Limitations of the evaluation methodology used	

12. Findings and Analysis per Evaluation Question

[The template below must be used per evaluation question in order to provide direct answer to the question, key findings and analysis, and quantitative and qualitative evidence per evaluation question. Evaluators may add additional paragraphs/sub-sections in narrative format to describe overall findings and analysis if they wish.]

Evaluation Criteria	Effectiveness
Evaluation Question 1	To what extent were the intended project goal, outcomes and outputs achieved and how?
Response to the evaluation question with analysis of key findings by the evaluation team	
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	
Conclusions	
Others	

Evaluation Criteria	Effectiveness
Evaluation Question 2	<ul style="list-style-type: none"> • To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? • How many beneficiaries have been reached?
Response to the evaluation question with analysis of key findings by the evaluation team	
Quantitative and/or qualitative evidence gathered by the evaluation team to support the response and analysis above	
Conclusions	

Other	*For this specific question on beneficiaries, please complete the Beneficiary Data Sheet in Annex 4C.
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****Please repeat the same template per evaluation question.**

Instruction for Findings and Analysis

- Findings cover all of the evaluation objectives and the key evaluation questions agreed in the evaluation TOR and during the inception stage (inception report).
- Outputs, outcomes and goal of the project are evaluated to the extent possible (or an appropriate rationale given as to why not).
- Outcomes and goal include any unintended effects, whether beneficial or harmful.
- The report makes a logical distinction in the findings, showing the progression from implementation of the activities to the results (outputs, outcomes and project goal) with an appropriate measurement and analysis of the results chain, or a rationale as to why an analysis of results was not provided.
- Findings regarding inputs for the completion of activities or process achievements are distinguished clearly from the results of the projects (i.e. outputs, outcomes and project goal).
- Results attributed to the success/failure of the project are related back to the contributions of different stakeholders.
- Reasons for accomplishments and difficulties of the project, especially constraining and enabling factors, are identified and analyzed to the extent possible.
- Based on the findings, the evaluation report includes an analysis of the underlying causes, constraints, strengths on which to build on, and opportunities.
- An understanding of which external factors contributed to the success or failure of the project helps determine how such factors will affect the future initiatives, or whether it could be replicated elsewhere.

For evaluation questions related to lessons learned and promising practices

- Lessons and promising practices that contributes to general knowledge in the context of Ending Violence against Women, including innovative and catalytic methodologies/approaches.
- The analysis presents how lessons and promising practices can be applied to different contexts and/or different actors, and takes into account evidential limitations such as generalizing from single point observations.
- They are well supported by the findings and conclusions of the evaluation and are not a repetition of common knowledge.

13. Conclusions

[The template below must be used to provide conclusions organized per evaluation criteria, in addition to those for overall. Evaluators may add additional paragraphs/sub-sections in narrative format if they wish.]

Evaluation Criteria	Conclusions
Overall	
Effectiveness	

Relevance	
Efficiency	
Sustainability	
Impact	
Knowledge Generation	
Others (if any)	

Instruction

- The logic behind the conclusions and the correlation to actual findings are clear.
- Simple conclusions that are already well known are avoided.
- Substantiated by findings consistent with the methodology and the data collected.
- Represent insights into identification and/or solutions of important problems or issues.
- Focus on issues of significance to the project being evaluated, determined by the evaluation objectives and the key evaluation questions.

14. Key recommendations

[The template below must be used to provide recommendations per evaluation criteria.
Evaluators may add additional paragraphs/sub-sections in narrative format if they wish.]

Evaluation Criteria	Recommendations	Relevant Stakeholders (Recommendation made to whom)	Suggested timeline (if relevant)
Overall			
Effectiveness			
Relevance			
Efficiency			
Sustainability			
Impact			
Knowledge			

Generation			
Others (if any)			

Instruction

- Realistic and action-oriented, with clear responsibilities and timeframe for implementation if possible.
- Firmly based on analysis and conclusions.
- Relevant to the purpose and the objectives of the evaluation.
- Formulated in a clear and concise manner.

15. Annexes (mandatory)

The following annexes must be submitted to the UN Trust Fund with the final report.

- 1) **Final Version of Terms of Reference (TOR) of the evaluation**
- 2) **Evaluation Matrix** [see Annex 4A for the template] please provide indicators, data source and data collection methods per evaluation question.
- 3) **Final version of Results Monitoring Plan** [see Annex 4B for the template] please provide actual baseline data and endline data per indicator of project goal, outcome and output
- 4) **Beneficiary Data Sheet** [see Annex 4C for the template] please provide the total number of beneficiaries reached at the project goal and outcome levels.
- 5) **Additional methodology-related documentation**, such as data collection instruments including questionnaires, interview guide(s), observation protocols, etc.
- 6) **Lists of persons and institutions interviewed or consulted and sites visited**
[As appropriate, specification of the names of individuals interviewed should be limited to ensure confidentiality in the report but rather providing the names of institutions or organizations that they represent.]
- 7) **List of supporting documents reviewed**
- 8) **CVs of evaluator(s) who conducted the evaluation**

Annex 2A: Template for Evaluation Matrix

[illegible]

Annex 2C: Template for Beneficiary Data Sheet

		The number of beneficiaries reached	
Beneficiary group		At the project goal level	At the outcome level
Female domestic workers		247	247
Female migrant workers		0	0
Female political activists/human rights defenders		0	0
Female sex workers		959	959
Female refugees/internally displaced/asylum seekers		0	0
Indigenous women/from ethnic groups		0	0
Lesbian, bisexual, transgender		0	0
Women and girls in general		0	0
Women/girls with disabilities		0	0
Women/girls living with HIV and AIDS		107	107
Women/girls survivors of violence		349	349
Women prisoners		0	0
Others (specify)		0	0
Primary Beneficiary Total		1662	1662
Civil society organizations (including NGOs)	Number of institutions reached	NA	
	Number of individuals reached	NA	
Community-based groups/members	Number of groups reached	NA	5
	Number of individuals reached	NA	15
Educational professionals (i.e. teachers, educators)		NA	
Faith-based organizations	Number of institutions reached	NA	1
	Number of individuals reached	NA	48
General public/community at large		NA	
Government officials (i.e. decision makers, policy implementers)		NA	
Health professionals		NA	3
Journalists/Media		NA	
Legal officers (i.e. lawyers, prosecutors, judges)		NA	
Men and/or boys		NA	2142
Parliamentarians		NA	
Private sector employers		NA	
Social/welfare workers		NA	
Uniformed personnel (i.e. police, military, peace-keeping officers)		NA	
Others (specify)		NA	
Secondary Beneficiary Total		NA	

B. Evaluation Matrix

Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
Effectiveness	<p>c. To what extent were the intended project goal, outcomes and outputs achieved and how?</p> <p>d. To what extent did the project reach the targeted beneficiaries at the project goal and outcome levels? How many beneficiaries have been reached?</p> <p>e. To what extent has this project generated positive changes in the lives of targeted (a untargeted) women and girls in relation to the specific forms of violence addressed by t project? Why? What are the key changes in the lives of those women and/or girls? Please describe those changes.</p> <p>f. What internal and external factors contributed to the achievement and/or failure of t intended project goal, outcomes and outputs? How?</p> <p>g. To what extent was the project successful in</p>	<p>1. The project's objectives were to improve access and utilization of GBV and HIV services, and increased understanding and support for gender equality and HIV response in the community. Direct service provision (psychological counseling, medical service, shelters); opportunities for women to exercise social and economic rights; capacity development for CBO and public health care providers</p> <p>2. Numbers of health care workers attending capacity building sessions. Numbers of men and religious leaders reached. Numbers of primary beneficiaries accessing direct services: an increase is expected over the 3 years. Numbers of participants. Shehab records of participants.</p> <p>3. Interview, FGD and survey data is designed to evince information about changes in vulnerable women's experiences of violence</p>	<p>1. Outputs and outcomes should be visible in Shehab records of service provision, capacity building, and interventions with men and religious leaders. Outcomes should be apparent in data collected by evaluation team in interviews, surveys, group discussions, and so on. Questions were designed to elicit this information.</p> <p>2. Shehab records of activities and participants.</p> <p>3. Interview, FGD and survey data should evince information about changes in vulnerable women's experiences of violence and exposure to HIV.</p> <p>4. Questions in interviews about contributions to success or failure. Primary beneficiary information may elucidate more, but may require discussion with others to understand (eg consider gentrification, police efforts, local issues that may not be part of the programming.)</p> <p>5. Al Shehab staff can</p>

	<p>advocating for policy change? If it was successful, explain why.</p> <p>h. In case the project was successful in setting-up new policies (relate to HIV& Violence against women), is the policy change likely to be institutionalized and sustained?</p>	<p>and exposure to HIV during the duration of the project.</p> <p>4. Internal factors will come from staff and key informant interviews. External factors may be discovered in primary beneficiary information.</p> <p>5. Policy change should be documented by AI Shehab staff at local level, at services, and at government level. Local religious leaders may describe this in their interviews.</p> <p>6. If there was policy change, has it been implemented? Do the women feel these changes in their daily lives?</p>	<p>tell us about some policy changes. If policy changes occurred, local religious leaders and men may mention this too.</p> <p>6. Policy change will be discussed with AI Shehab staff, and if policy change affected the women, they will describe that in the FGDs and interviews.</p>
Relevance	<p>1. To what extent was the project strategy and activities implemented relevant in responding to the needs of women and girls (direct beneficiaries)?</p> <p>2. To what extent do achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?</p>	<p>1. Comparison to baseline; FGD and interviews questions for primary beneficiaries about needs and responses</p> <p>2. FGD and interviews questions for primary beneficiaries about ongoing need for services.</p>	<p>1 and 2. FGD and in-depth interviews with primary beneficiaries, survey; There may be insight from health care providers.</p>
Efficiency	<p>How efficiently and timely has this project been implemented and managed in accordance with the project document?</p>	<p>Staff interviews – are staff on top of the information? Is it easily accessible?</p> <p>Also observations of primary beneficiaries with staff – do they appreciate the services? Ask if services are useful to primary beneficiaries</p>	<p>Compare original proposal with project documentation including monitoring reporting, also observe AI Shehab staff</p> <p>Also FGD and Nasr City DIC observations</p>

Sustainability	How are the achieved results, especially the positive changes generated by the project in the lives of women and girls at the project goal level, going to be sustained after this project ends?	Lasting impact among men's attitudes; Violence survey trends between 2015 and 2018;	FGD with local men, interviews with religious leaders; survey of women about violent experiences;
Impact	What are the unintended consequences (positive and negative) resulting from the project?	Look for unexpected outcomes – ask during FGDs, ask staff. Statistical analysis outliers and odd correlations.	Some of this will be in interviews and FGDs with staff, men, religious leaders and primary beneficiaries. Some will require examination of survey correlations and data over the past three years.
Knowledge Generation	<ul style="list-style-type: none"> What are the key lessons learned that can be shared with other practitioners on Ending Violence against Women and Girls? Are there any promising practices? If yes, what are they and how can these promising practices be replicated in other projects and/or in other countries that have similar interventions? 	<p>Changes between survey and baseline in experiences of violence, and health practitioners' descriptions of changes in services sought.</p> <p>Changes in attitudes among local men and religious leaders.</p> <p>Activities mentioned by leaders and men as particularly effective, from examples they share.</p>	<p>Input from health practitioners, staff and religious leaders and other men should be corroborated by input from the primary beneficiaries (the vulnerable women.)</p> <p>Questions were designed to elicit changes in attitudes and experiences, and to highlight effective interventions.</p>
Evaluation Criteria	Evaluation Questions	Indicators	Data Source and Data Collection Methods
Effectiveness	<ol style="list-style-type: none"> To what extent were the intended project goal, outcomes and outputs achieved and how? To what extent did the project reach 	1. The project's objectives were to improve access and utilization of GBV and HIV services, and increased understanding and support for gender	1. Outputs and outcomes should be visible in Shehab records of service provision, capacity building, and interventions with men and religious

	<p>the targeted beneficiaries at the project goal and outcome levels? How many beneficiaries have been reached?</p> <p>3. To what extent has this project generated positive changes in the lives of targeted (a untargeted) women and girls in relation to the specific forms of violence addressed by t project? Why? What are the key changes in the lives of those women and/or girls? Please describe those changes.</p> <p>4. What internal and external factors contributed to the achievement and/or failure of t intended project goal, outcomes and outputs? How?</p> <p>5. To what extent was the project successful in advocating for policy change? If it w successful, explain why.</p> <p>6. In case the project was successful in setting-up new policies (relate to HIV& Violence against women), is the policy change likely to be institutionalized</p>	<p>equality and HIV response in the community. Direct service provision (psychological counseling, medical service, shelters); opportunities for women to exercise social and economic rights; capacity development for CBO and public health care providers</p> <p>2. Numbers of health care workers attending capacity building sessions. Numbers of men and religious leaders reached. Numbers of primary beneficiaries accessing direct services: an increase is expected over the 3 years. Numbers of participants. Shehab records of participants.</p> <p>3. Interview, FGD and survey data is designed to evince information about changes in vulnerable women's experiences of violence and exposure to HIV during the duration of the project.</p> <p>4. Internal factors will come from staff and key informant interviews. External factors may be discovered in primary beneficiary information.</p> <p>5. Poiiicy change should</p>	<p>leaders. Outcomes should be apparent in data collected by evaluation team in interviews, surveys, group discussions, and so on. Questions were designed to elicit this information.</p> <p>2. Shehab records of activities and participants.</p> <p>3. Interview, FGD and survey data should evince information about changes in vulnerable women's experiences of violence and exposure to HIV.</p> <p>4. Questions in interviews about contributions to success or failure. Primary beneficiary information may elucidate more, but may require discussion with others to understand (eg consider gentrification, police efforts, local issues that may not be part of the programming.)</p> <p>5. Al Shehab staff can tell us about some policy changes. If policy changes occurred, local religious leaders and men may mention this too.</p> <p>6. Policy change will be discussed with Al Shehab staff, and if policy change affected the women,</p>
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	and sustained?	be documented by Al Shehab staff at local level, at services, and at government level. Local religious leaders may describe this in their interviews. 6. If there was policy change, has it been implemented? Do the women feel these changes in their daily lives?	they will describe that in the FGDs and interviews.
Relevance	1. To what extent was the project strategy and activities implemented relevant in responding to the needs of women and girls (direct beneficiaries)? 2. To what extent do achieved results (project goal, outcomes and outputs) continue to be relevant to the needs of women and girls?	1. Comparison to baseline; FGD and interviews questions for primary beneficiaries about needs and responses 2. FGD and interviews questions for primary beneficiaries about ongoing need for services.	1 and 2. FGD and in-depth interviews with primary beneficiaries, survey; There may be insight from health care providers.
Efficiency	How efficiently and timely has this project been implemented and managed in accordance with the project document?	Staff interviews – are staff on top of the information? Is it easily accessible? Also observations of primary beneficiaries with staff – do they appreciate the services? Ask if services are useful to primary beneficiaries	Compare original proposal with project documentation including monitoring reporting, also observe Al Shehab staff Also FGD and Nasr City DIC observations
Sustainability	How are the achieved results, especially the positive changes generated by the project in the lives of women and girls at the project goal level, going to be sustained after this project ends?	Lasting impact among men's attitudes; Violence survey trends between 2015 and 2018;	FGD with local men, interviews with religious leaders; survey of women about violent experiences;
Impact	What are the unintended consequences (positive and negative) resulting from the	Look for unexpected outcomes – ask during FGDs, ask staff.	Some of this will be in interviews and FGDs with staff, men,

	project?	Statistical analysis outliers and odd correlations.	religious leaders and primary beneficiaries. Some will require examination of survey correlations and data over the past three years.
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Knowledge Generation

3. What are the key lessons learned that can be shared with other practitioners on Ending Violence against Women and Girls?

8. Are there any promising practices? If yes, what are they and how can these promising practices be replicated in other projects and/or in other countries that have similar interventions?	<p>Changes between survey and baseline in experiences of violence, and health practitioners descriptions of changes in services sought.</p> <p>Changes in attitudes among local men and religious leaders.</p> <p>Activities mentioned by leaders and men as particularly effective, from examples they share.</p>	<p>Input from health practitioners, staff and religious leaders and other men should be corroborated by input from the primary beneficiaries (the vulnerable women.)</p> <p>Questions were designed to elicit changes in attitudes and experiences, and to highlight effective interventions.</p>
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C. Results Monitoring Plan

A. Statement of Project Goal and Outcomes and Outputs	B. Indicators for measuring progress	C. Data collection method / source	D. Baseline data ENTER THIS DATA INTO THE ACTUAL NUMBER (Q1-Q2) COLUMN IN THE PROGRESS REPORT IN GMS	E. Date the baseline was collected (month, year) and/or notes	F. Target (expected results and date to be achieved, i.e. end of project or annual)	G. Timeline for follow-up data collection. Please specify month/year.
Project Goal: Marginalized women who experience (or are at risk of) violence and HIV transmission with a focus Ezbet El Haggana and El Marg communities in Cairo experience improved safety, health and reduced vulnerability through improved access to GBV and HIV services and increased understanding in the community	Perspective of women and girl beneficiaries about their safety, health, well-being and vulnerability to HIV/AIDS and GBV	Baseline: Quantitative: KAP survey.	86% of the female study sample reported that most Egyptian women experience violence. 66% of them reported that sexual harassment in the public sphere is the most common type of violence, followed by domestic violence (29%) and IPV is the most prevalent type. One third of the female study sample reported that bystanders witnessing incidents of violence against women in the public space do not intervene. 62% of the female study sample agreed that husband is justified to beat his wife in certain cases. (argue with the husband, burn the food, neglect the children, go out without husband permission, or refuse to have sex). 74% of female respondents, who have previously heard about HIV, reported that use of condom will decrease their vulnerability to HIV.	The data was collected August 2016		
	Perspective of service providers (medical and CBOs) within the targeted communities	Qualitative data: focus groups and in-depth interview with service providers				

	about women's health and vulnerability to HIV/AIDS and GBV					
	Percentage of women and girls surveyed that benefit from services in the two communities who report improved safety, health and reduced vulnerability	Quantitative: pre and post questionnaire to be filled with each beneficiary who accessed the different services to measure the number of women and girls who will report improved safety, health and reduced vulnerability.				
Outcome 1: FSWs, Women and Girls Living with HIV, DWs and women and girls survivors of violence in two communities in Cairo have improved access to GBV and HIV services and make more use of the services	Number of FSW, women and girls living with HIV, DW, and women survivors of violence accessing services related to HIV and GBV at baseline PS. This indicator was added at a later stage	Baseline: Quantitative KAP survey	39% of female participants, who have previously heard about HIV, know where to conduct HIV testing. 93% of women living with HIV know where to conduct HIV testing 57% of sex workers know where to conduct HIV testing 4% of women survivors of domestic violence know where to conduct HIV testing 13% of domestic workers know where to conduct HIV testing	The data was collected August 2016		
			58% of female participants, who have previously heard about HIV, have received information about HIV during the previous 6 months 75% of sex workers have received information on HIV during the past 6 months, followed by 67% women living with HIV, 47% of domestic workers and 41% of GBV survivors.			

			<p>42% of female respondents, had conducted HIV testing.</p> <p>71% of sex workers have conducted HIV testing</p> <p>4% of women surviving violence conducted HIV</p> <p>None of the domestic workers have conducted HIV testing</p>			
	Perspective of women who use services at the community-based center in relation to quality as well as privacy of services they received	Semi-structured Interviews with the services' users. The interviews will understand how the beneficiary/ies perceive quality and confidentiality of the services as well as what it did for her life needs				
	Percentage and frequency of female sex workers who have used VCT services during the project year in the past year.	Review of the community service records. data will be collected by Interviews with female sex workers who benefit of the project and will include information about condom use and knowledge of their HIV-status				
	Perspective of women who benefit of the referral system in relation to accessibility and geographical proximity of services they received	Interviews with some of services' users. The interviews will understand how the beneficiary/ies geographical proximity and accessibility of				

		the services as well as what it did for her life needs				
Output 1.1. Psychosocial, legal and referral services are available at the newly established community-	Number of beneficiaries who access quality services through service center and network of service providers and their satisfaction	The number of beneficiaries will be collected from the center records In-depth interviews with some beneficiaries to document some perceptions and experiences regarding provided services.				
	Percentage of outreached women have comprehensive knowledge of HIV	Quantitative, baseline survey	The majority of the female study sample heard about HIV/AIDS (90%), however only 11% provided correct information on ways of virus transmission. 39% provided accurate information on places to conduct HIV testing 74% of the female sample agreed that use of condom reduce transmission of HIV 6% of interviewed women had a comprehensive knowledge of HIV	The data was collected August 2016		
	Perception and insights of the staff at the new center regarding how well the service are working and any barriers are documented	Qualitative: in-depth interview with staff at new services				
Output 1.2. Female sex workers and women living with HIV participate at the handcraft workshop and	Number of products sold/marketed in the last six months	Quantitative data from the monitoring data.				
	The perception of sex workers and women	Qualitative data from the monitoring				

acquire professional and life skills: crochet, accessories and sewing, communication, marketing budgeting and saving	living with HIV/AIDS participating in the handcraft workshops on the skills they acquired	data.				
Output 1.3. staff working in community-based organizations and health care services (Public, Private and NGOs-based health facilities) have increased knowledge of gender equality and understanding of intersection between VAW and HIV epidemics	Number of CBO staff trained at least one time through awareness violence against women and HIV information, education, communication or behaviour change communication	Quantitative and qualitative data from the monitoring data		Mid-august with the full narrative report of the baseline		
	Number of health care providers who are trained violence against women and HIV information, education, communication or behaviour change communication	Quantitative and from the monitoring data Qualitative data, semi structured interviewed				
	Number of referral systems established between the project and community-based organizations and health care service providers	Quantitative and qualitative data from the monitoring data				
Outcome 2: Men, boys and key affected women in the targeted communities have an improved understanding of	Societal perspectives of gender equality, women's rights, intimate partner violence, and their acceptability of accessing to		<u>Intimate partner Violence (IPV)</u> 65% of study participants agreed that women should be beaten if they commit at least one of the following actions (argue with the husband, burn the food, neglect the children, go out without husband permission, or refuse to			

gender equality, women's rights and how to prevent GBV and HIV transmission through changes in behavior to support gender equitable norms	HIV-related information and services and women's economic participation		<p>have sex).</p> <p>Ps: we increased the weight of the male sample in the study to reflect accurate sex distribution (50%-50%)</p> <p><u>Gender equality</u></p> <p>48% of the study sample are gender insensitive</p> <p><u>Women economical participation</u></p> <p>41% of the study sample believes that women should stay home and not work and 38% of the sample believes that if women participate in the labor force they will neglect their domestic dwelling.</p> <p><u>Acceptability of accessing to HIV-related information and services</u></p> <p>The majority of the study sample heard about HIV/AIDS (92%), however only 6% provided correct information on ways of virus transmission.</p> <p>29% provided accurate information on places to conduct HIV testing</p> <p>Only 24% of the study sample had done HIV testing</p> <p>61% of the male sample agreed that use of condom reduce transmission of HIV</p>			
	Percentage of community leaders and Men reporting support for gender equitable norms, non-violence, and acceptability of accessing to HIV-related information and services in the target communities		<p><u>Intimate partner Violence (IPV)</u></p> <p>68% of the male study sample agreed that women should be beaten if they commit at least one of the following actions(argue with the husband, burn the food, neglect the children, go out without husband permission, or refuse to have sex).</p> <p>From the men who approves beating the wife, 79% approves it if the wife goes out without permission 77% if neglect the children and 47% if refuses having sex with the husband.</p> <p>Only one third of the male study sample agreed that a legislation addressing</p>			

		<p>domestic violence should be introduced and enforced.</p> <p><u>Gender equality</u> The majority of the interviewed men are gender insensitive (68%) and only 12% to be considered as gender sensitive.</p> <p><u>Women economical participation</u> 66% of the male participant believe that women should stay home and not work and 44% believes that if women participate in the labor force they will neglect their domestic dwelling.</p> <p><u>Acceptability of accessing to HIV-related information and services</u> The majority of the male sample heard about HIV/AIDS (94%), however only 2% provided correct information on ways of virus transmission. Only 19% provided accurate information on places to conduct HIV testing Only 4% of the interviewed men had done HIV testing 49% of the male sample agreed that use of condom reduce transmission of HIV</p>			
	<p>Percentage of women reporting support for gender equitable norms, non-violence, and acceptability of accessing to HIV-related information and services in the target communities [we added this indicator at a later stage]</p>	<p><u>Intimate partner Violence (IPV)</u> 62% of female study participants agreed that women should be beaten if they commit at least one of the following actions (argue with the husband, burn the food, neglect the children, go out without husband permission, or refuse to have sex). Ps: we increased the weight of the male sample in the study to reflect accurate sex distribution (50%-50%)</p> <p><u>Gender equality</u> 29% of the female study sample are gender insensitive</p> <p><u>Women economical participation</u> Only 17% of the female study sample believes that</p>			

			<p>women should stay home and not work and 32% of the sample believes that if women participate in the labor force they will neglect their domestic dwelling.</p> <p><u>Acceptability of accessing to HIV-related information and services</u></p> <p>The majority of the female study sample heard about HIV/AIDS (90%), however only 11% provided correct information on ways of virus transmission.</p> <p>39% provided accurate information on places to conduct HIV testing</p> <p>Only 42% of the female study sample had done HIV testing</p> <p>74% of the female sample agreed that use of condom reduce transmission of HIV</p>			
Output 2.1. Understanding of women's vulnerability to HIV and violence is increased among men, boys, female domestic workers and female sex workers who participate in the awareness activity	Number of men, boys, domestic workers, sex workers women survivor of violence reached through community outreach campaign	Qualitative and quantitative from monitoring data				
	% Of knowledge change among individuals participate in the community campaign regarding violence against women and women vulnerability to HIV	Pre and post questionnaire				
Output 2.2. leaders within the targeted communities and among key affected women	Number of female and male who participated in developing and training on the curriculum for	Quantitative information from the monitoring data				

gained better understanding about the intersection between GBV and HIV and their support for the gender equitable norms increased.	behaviour change communication or support community-based campaigns					
	Number of actions taken by trained female and male leaders within targeted communities to support gender equitable norms.	Qualitative information from the motioning data				
Outcome 3: Law enforcement entities and policy makers demonstrate improved understanding and support for women vulnerable to violence and HIV through evidence-based policies and increased knowledge in six police stations	Number and type of policies addressing VAW and HIV at a national level	qualitative data Analysis of the national strategy of HIV and VAW	<u>National AIDS Programme National Strategic Framework 2015 to 2020</u> The current HIV/AIDS national strategy for Egypt consists of four main pillars: prevention; testing, care, support & treatment; enabling environment; and coordination and management. Under each pillar there are set of strategic objectives and defined areas of work/target groups. Although the framework of the strategy clearly identified the objectives and expected results for the coming five years (2015-2020) and several target groups have been identified (people who inject drugs, sex workers, men having sex with men, prisoners, people living with HIV) yet addressing Gender based violence (GBV) as a cross cutting issue in all the introduced pillars and strategic objectives is not explored in the document. Although the strategy defines women living with HIV and sex workers as main target groups yet all objectives focus on prevention and care without			

		<p>addressing GBV as a structural driver of HIV. Furthermore, addressing male groups (whether drug inject or men having sex with men, or male prisoners) in the strategy focus from care, prevention and treatment perspective and gender transformative approaches are not introduce to better engage men in GBV prevention in HIV context. For example negative male perceptions and attitudes towards use of condom have a direct effect on increase vulnerability of HIV to other male or females.</p> <p><u>National Strategy of Violence Against women, 2015-2020</u></p> <p>in-depth interviews with official representative of the National Aids programmes (NAP) and National council for women (NCW)</p> <p>The national Council for Women (NCW) has issued a strategy on Gender Based violence in May 2015 for five years. The strategy was developed in participatory manner by representatives from different ministries and in the presence of some non-governmental organizations. Similar to the HIV strategy the national strategy on violence against women consists of four pillars: prevention, protection, interventions and legal prosecutions. Relationships between violence and HIV was not mentioned or referred to in the strategy documents. Target groups like women living with HIV, sex works, domestic workers or female migrants were not mentioned in the document. Sex work and trafficking were mentioned briefly in one of the document annexes, where sex work was defined as illegal without probing the relationship between GBV</p>			
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			and sex work or how female sex workers are usually subjected to violence from the state or the communities and the level of stigma they endure which increase their vulnerability and exposure to HIV.			
	Number of policemen who demonstrate more knowledge about GBV and women's vulnerability to violence and HIV and ability to apply this knowledge	pre and post surveys to be applied during the discussion sessions with policemen.				
Output 3.1. Policy makers understanding of women's vulnerability to HIV and violence in Egypt increased	Development of policy brief illustrate the intersection between HIV and VAW					
Output 3.2. Policemen inside 6 police stations in Greater Cairo increased knowledge of women's vulnerability to HIV/AIDS and Violence	Number of policemen who participate in the training sessions	Quantitative data from the monitoring system				

D. Data Collection Instruments and Additional Methodology Documentation

i. Violence and UN core indicator survey questionnaire

(for all women, or as many as possible)

[Adapted from the GARPR, UN core indicators, BSS, and more]

Location: (name of community area or DIC)

Demographics:

[All female]

Age (circle one)

<15

15-24

25-49

49<

Questions about migration:

Where were you born? OR Where is your home village? ASK TEAM WHAT WOULD BE THE BEST WAY TO ASK THIS.

How long have you been here in [NAME OF NEIGHBORHOOD]?

Where else did you live before coming here?

Are you married? If yes, go to next question.

If no: Have you ever been married?

How many people do you support? If zero, go to next question.

Who are they? [Circle all that apply.]

Parents

Children

Sisters and brothers

Other _____

What kind of work brings you to Al Shehab? [Try to discern domestic worker, sex worker, both, or other – ASK TEAM BEST WAY TO ASK THIS]

Do you have another job? If no, go to next question.

If yes: what is your other work? (e.g. trader, hair dresser, etc.)

UN Core Indicators

1.7 Do you know where you can go if you wish to receive an HIV test?

Where?

In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)

From where?

1.8 Did you use a condom with your most recent client?

1.9 Have you been tested for HIV in the last 12 months?

If yes:

I don't want to know the results, but did you receive the results of that test?

BSS STI question

Women:

Sometimes women experience a bad smelling genital discharge.

During the last 12 months, have you had a bad smelling genital discharge?

Sometimes women have a genital sore or ulcer.

During the last 12 months, have you had a genital sore or ulcer?

VIOLENCE INDICATORS

In the past 12 months, has anyone

By: Intimate Partner Client Police Community Family

1. Slapped you or threw something at you that could hurt you
2. Pushed you or shoved you
3. Hit you with a fist or something else that could hurt
4. Kicked you, dragged you or beat you up
5. Choked or burned you
6. Threatened you with or used a gun, knife or other weapon against you
7. Physically forced you to have sexual intercourse against your will
8. Forced you to do something sexual you found degrading or humiliating
9. Made you afraid of what this person would do if you did not have sexual intercourse with him/her

When/The last time this happened, were you intoxicated, drunk or high?

Did you participate in Al Shehab's project to address violence against women and vulnerability to HIV?

If yes – what activities did you participate in? What services did you receive?

Did these activities affect your life after DIC hours?

Did you learn things that changed your behavior? How or what changed?
 Did the project have long-term effects? Please give examples.
 Does it still affect your life? How?

Thank you for sharing your experiences with me.

ii. FGD guide: Domestic workers

Ask demographics: ages, whether they are migrants, marital status, and how many people they support – raise of hands for each is enough.

How often did you participate in Shehab’s anti-violence and HIV program? Was the project a regular part of your life? What did you do and what services did you receive?

Did you participate in Al Shehab’s project to address violence against women and vulnerability to HIV?

If yes – what activities did you participate in? What services did you receive?
 Did these activities affect your life after DIC hours?
 Did you learn things that changed your behavior? How or what changed?
 Did the project have long-term effects? Please give examples.
 Does it still affect your life? How?

What things outside Al Shehab affected the project?

[Prompts: police actions, gentrification, protests and civil unrest, etc.]

iii. FGD guide: Sex workers

Ask demographics: ages, whether they are migrants, marital status, and how many people they support – raise of hands for each is enough.

How often did you participate? Was the project a regular part of your life? What did you do and what services did you receive?

Did you participate in Al Shehab’s project to address violence against women and vulnerability to HIV?

If yes – what activities did you participate in? What services did you receive?
 Did these activities affect your life after DIC hours?
 Did you learn things that changed your behavior? How or what changed?
 Did the project have long-term effects? Please give examples.
 Does this still affect your life?

What things outside Al Shehab affected the project?

[Prompts: police actions, gentrification, protests and civil unrest, etc.]

iv. In-depth interview – sex workers and survivors of violence

Location: (name of community area or DIC)

Demographics:

[All female]

Age (circle one)

<15

15-24

25-49

49<

Questions about migration:

Where were you born? OR Where is your home village? ASK TEAM WHAT WOULD BE THE BEST WAY TO ASK THIS.

How long have you been here in [NAME OF NEIGHBORHOOD]?

Where else did you live before coming here?

Are you married? If yes, go to next question.

If no: Have you ever been married?

How many people do you support? If zero, go to next question.

Who are they? [Circle all that apply.]

Parents

Children

Sisters and brothers

Other _____

What kind of work brings you to Shehab? [Try to discern domestic worker, sex worker, both, or other – ASK TEAM BEST WAY TO ASK THIS]

Do you have another job? If no, go to next question.

If yes: what is your other work? (e.g. trader, hair dresser, etc.)

UN Core Indicators

1.7 Do you know where you can go if you wish to receive an HIV test?

Where?

In the last twelve months, have you been given condoms? (e.g. through an outreach service, drop-in centre or sexual health clinic)

From where?

1.8 Did you use a condom with your most recent client?

1.9 Have you been tested for HIV in the last 12 months?

If yes:

I don't want to know the results, but did you receive the results of that test?

BSS STI question

Women:

Sometimes women experience a bad smelling genital discharge.

During the last 12 months, have you had a bad smelling genital discharge?

Sometimes women have a genital sore or ulcer.

During the last 12 months, have you had a genital sore or ulcer?

VIOLENCE INDICATORS

In the past 12 months, has anyone

By: Intimate Partner Client Police Community Family

- Slapped you or threw something at you that could hurt you
- Pushed you or shoved you
- Hit you with a fist or something else that could hurt
- Kicked you, dragged you or beat you up
- Choked or burned you
- Threatened you with or used a gun, knife or other weapon against you
- Physically forced you to have sexual intercourse against your will
- Forced you to do something sexual you found degrading or humiliating
- Made you afraid of what this person would do if you did not have sexual intercourse with him/her

When/The last time this happened, were you intoxicated, drunk or high?

Did you participate in Al Shehab's project to address violence against women and vulnerability to HIV?

If yes – what activities did you participate in? What services did you receive?

Did these activities affect your life after DIC hours?

Did you learn things that changed your behavior? How or what changed?

Did the project have long-term effects? Please give examples.

Does it still affect your life? How?

How often did you participate? Was the project a regular part of your life? What did you do and what services did you receive?

Did you participate in Al Shehab's project to address violence against women and vulnerability to HIV?

If yes – what activities did you participate in? What services did you receive?

Did these activities affect your life after DIC hours?

Did you learn things that changed your behavior? How or what changed?

Did the project have long term effects? Please give examples.

Does this still affect your life?

What things outside Al Shehab affected the project?

[Prompts: police actions, gentrification, protests and civil unrest, etc.]

Thank you for sharing your experiences with me.

v. Interview guide: Health care practitioners

I would like to know a little about you and your work here. How long have you worked with women from these vulnerable communities?

What kinds of health services are most commonly sought here?

In the time you have worked with these communities, have you seen changes in that time?

Changes in what kinds of services people need, for example.

We are especially interested in experiences of violence endured by the women. Can you tell me whether violence and injuries from violence are part of your work?

[Prompts: regarding beatings, rape, abortion, other violence?]

Who do you think commits violence against these women?

[Prompts: family, husbands, boyfriends, police, others?]

In the time you have worked with these communities, have you seen changes in types of violence, or severity of injuries and need?

[if yes] Can you share any examples of this with me, recent patients, or changes over time.

What good outcomes can you tell me about?

Were there any bad outcomes?

Can you think of any external factors that would have affected the project?

[Prompts: police actions, gentrification, protests and civil unrest, etc.]

Thank you for your help. Is there anything else I should know? Is there anything else you would like to tell me?

vi. Interview guide: Religious leaders

Did you participate in Al Shehab's anti-gender-based violence programs?

Do you address violence against women and girls in your work?

Do you speak out? What kinds of messages do you promote?

[If yes] Can you tell me any examples of how people have responded?

What good outcomes can you tell me about?

Were there any bad outcomes?

Can you think of any external factors that would have affected the project?

[Prompts: police actions, gentrification, protests and civil unrest, etc.]

Thank you for your help. Is there anything else I should know? Is there anything else you would like to tell me?

vii. Interview/FGD guide: Local men

Do you think gender-based violence happens in your community?

What do you do then?

Did you participate in Al Shehab's anti-gender-based violence programs?

Have you seen changes – in your actions, in anyone's actions – regarding violence against women and girls?

[If yes] Can you tell me any examples of changes? Individuals, and the neighborhood, too, if you can share any examples.

What good outcomes can you tell me about?

Were there any bad outcomes?

Can you think of any external factors that would have affected the project?

[Prompts: police actions, gentrification, protests and civil unrest, etc.]

Thank you for your help. Is there anything else I should know? Is there anything else you would like to tell me?

viii. Introduction and Informed Consent

For all FGDs and interviews.

For survey:

Hello, my name is Amal El Karouaoui and I am working with Al Shehab Institute conducting a survey about Al Shehab's services addressing HIV and violence, particularly regarding vulnerable women, since 2015, We would greatly appreciate your participation and input. The survey usually takes between 20 and 45 minutes to complete. Whatever information you provide will be kept strictly confidential and not shared with others. Participation in the survey is voluntary, and if we come to any question you do not want to answer, please say so and we will go on to the next question. You may stop the survey at any time. However, we hope you will participate because your input and experiences are important.

At this time, do you want to ask me anything about the survey?

May I begin the survey at this time?

For FGDs:

Hallo, my name is Amal El Karouaoui and I am working with Al Shehab Institute conducting a group discussions about Al Shehab's services addressing HIV and violence, particularly regarding vulnerable women, since 2015, We would greatly appreciate your participation and

input. The group discussion takes about 90 minutes. Whatever information you provide will be kept strictly confidential and not shared with others.

Whatever information you provide will be kept strictly confidential and not shared with others. Participation in the discussion is voluntary, and if we come to any question you do not want to answer, please say so and we will go on to the next question. You may stop the survey at any time. However, we hope you will participate because your input and experiences are important.

At this time, do you want to ask me anything about the group discussion?

May I begin the discussion at this time?

For interviews:

Hello, my name is Amal El Karouaoui and I am working with Al Shehab Institute conducting a interviews about Al Shehab's services addressing HIV and violence, particularly regarding vulnerable women, since 2015, We would greatly appreciate your participation and input. The interview takes less than an hour. Whatever information you provide will be kept strictly confidential and not shared with others.

Whatever information you provide will be kept strictly confidential and not shared with others. Participation in the interview is voluntary, and if we come to any question you do not want to answer, please say so and we will go on to the next question. You may stop the interview at any time. However, we hope you will participate because your input and experiences are important.

At this time, do you want to ask me anything about the interview?

May I begin the interview at this time?

ix. Confidentiality agreement for Group Discussions

This will be discussed at the beginning of each FGD with all participants.

Procedures

You are being asked to participate in a focus group discussion.

The purposes of the focus group discussions is to learn about community members' experiences Al Shehab's programs, especially related to violence and HIV, what Al Shehab does that has benefited you and what would help you. You will be asked questions about experiences with violence, HIV, and Al Shehab's programming. Focus groups will take approximately 1.5 to 2 hours and will be facilitated by me. The focus groups will be recorded, for me to use to evaluate the anti-violence and HIV program.

Confidentiality

Your identity will be protected during this project. Only I will have access to information that could identify you personally. You will not be asked to provide any information that may allow others to identify you, including your name, date of birth, or address. While the focus group discussion will be audio-recorded, all information that may identify you will be protected.

All information collected will be kept confidential. Participants in the group discussion will also be asked to sign an agreement of confidentiality. Reports, publications and presentations will not contain any identifying information. The evaluation will be made available to you when it is published.

Withdrawal

The decision to participate in this discussion is entirely your own. You have the right to refuse to participate in any or all activities or to refuse to answer any of the questions. You can withdraw at any point during the focus group process. All identifying information related to your participation will be destroyed but information shared by you in the focus group up to the point of withdrawal cannot be separated nor destroyed.

Risks

There are no physical risks associated with this project. The focus group discussion may contain some questions that some may feel uncomfortable or embarrassing. However, you can refuse to answer any question that you feel uncomfortable with. Since focus group discussions involve a number of people, the researchers cannot guarantee absolute confidentiality or complete privacy. There is therefore a risk of disclosure that you have participated in this group and information that you may share in this group. However, to minimize the risk of breaching confidentiality, all focus group participants will be asked to sign a confidential agreement not to share any personal information from the focus group. Our discussion will include experiences related to health including HIV. The HIV status of individuals is not a topic that we are seeking to discuss, but we are aware it may be information that you may voluntarily wish to share. While we are not seeking to discuss individual's HIV status, people in the discussion group will understand that you have had some experience with HIV and sex work programs. It is possible that you may know the other participants through your activities with the Outreach Project. It is possible also that there may be someone in the discussion group who does not know about these activities, and who would learn them because of your participation in this discussion.

Benefits

This discussion is not designed to provide immediate benefits for the participants. However, information learned from this study will improve Al Shehab's outreach and other projects for vulnerable women in these communities and elsewhere.

Contact Information

You can contact me by email at a.elkarouaoui@gmail.com or coming to the Shehab office this week.

Confidentiality Agreement

(For focus group discussion participants)

I agree not to share any of the information that I hear in the focus group today with anyone who is not part of the discussion, unless I obtain permission from the facilitator.

Signature of Participant

Date

Signature of Witness

All participants will be offered a copy of the consent form.

F. List of Individuals and Organizations Consulted

Al Shehab Nasr City DIC staff and beneficiaries
Dr. Walid Kamal, National AIDS Program Manager

UNAIDS Egypt Country Office
UN Women Egypt Country Office

Primary beneficiaries:

Interviews

Women and girl survivors of violence (11)
Female sex workers (9)
Female domestic workers (11)
Female PLWHA (5)

Some interviewees were members of more than one category. For example, a domestic worker may also sell sex or live with HIV or be a survivor of violence. All PLWHA belonged to at least one other category.

Focus Group Discussions

20 FSWs in 2 FGDs
17 survivors of violence in 2 FGDs
5 women PLWHA

Secondary beneficiaries:

Health care practitioners (3) from government and NGO clinics
Representatives from 3 religious charities El Moufid, the Brothers of the Faith, and the Mountain of Mercy

FGDs in the community

9 volunteers and community leaders (8 women, 1 man)