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PROJECT EVALUATION REPORT

OFFICIAL DEVELOPMENT COOPERATION PROJECT OF THE CZECH REPUBLIC WITH

GEORGIA

Promotion of prevention and early detection of breast and cervical cancer among women in the regions of Samegrelo and Shida Kartli II.

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naviga4

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CZECH REPUBLIC
DEVELOPMENT COOPERATION

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Project name in Czech and English: Podpora prevence a včasného odhalení rakoviny u žen v regionech Samegrelo a Shida Kartli II. Promotion of prevention and early detection of breast and cervical cancer among women in the regions of Samegrelo and Shida Kartli II.	Sector: Health
Gestor: Czech Development Agency	Implementing agency: Caritas Czech Republic
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Total amount spent in CZK from the Czech ODA: 10.918.200 CZK (estimate as per the valid contract)	Total amount in CZK including co-financing: 10.918.200 CZK (estimate as per the valid contract)
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SUMMARY

The „**Promotion of prevention and early detection of breast and cervical cancer among women in the regions of Samegrelo and Shida Kartli II.**“ project was implemented from April 2011 to December 2013 by Caritas CR under the supervision of the Czech Development Agency (CZDA) with the budget of 10.918.200 CZK (approx. 908.200 GEL or 548.400 USD). The evaluation was implemented by Naviga 4 s.r.o. from May to September 2013 (before the project ended). The evaluation objective was to assess the implementation and provide evidence-based conclusions, lessons learned and recommendations for future decision making about the focus of Czech ODA in Georgia and elsewhere.

Relevance

The project derived from the needs of the Georgian health system as well as the priorities of the Czech ODA. It was **rather relevant.** As one of the few, it has focused on prevention and early diagnosis of breast and cervical cancer in rural areas, thus it was complementary to the National Screening Programme (NSP), which has been implemented in urban areas. However, it was very ambitious with respect to the number of regions involved and the expectations that it would link to secondary and tertiary health care. It has insufficiently reflected, especially, regional disparities in screening and treatment options. Partners maintained communication with state actors – Ministry of Labour, Health a Social Affairs of Georgia (MoLHSA) National Screening Centre (NSC) and from 2013 also with National Centre for Disease Control (NCDC). Regional facilities included in NSP or those with equipment and specialists for secondary check-ups were not involved.

> ***„People do not go to hospitals for prevention, especially if the hospitals are far. The mammologist (during the project) came to their door steps.***“
> Doctor, Shida Kartli

Efficiency

The project efficiency was **rather low.** The Georgian side has not co-financed the total budget of 10,9 mil. CZK. Inconsistent documentation (e.g. internal overview of expenses, database of screened women) limited the evaluation, as well as the possibility for the project implementing organisation to properly manage costs and thus insure their optimisation. Based on the analysis of actual expenditures in 2011 – 2012, high administrative costs have been identified (personnel costs for the project management and coordination, travel costs of the project team and other administrative costs) reaching 45% and 54% respectively of the total expenditure. Based on the direct costs of mobile clinics regardless of administration costs, unit costs would be 918 CZK (46 USD) per screened woman and 96.104 CZK (4.867 USD) for a confirmed diagnosis. The implementing agency has not reallocated the provided funds, reflecting these unit costs and the insufficient number of screened women by the end of 2012 (3.244 versus the target of 8.500, Caritas CR estimated the number of women to 9.000 including those “pre-screened”, however, this could not be validated). Cooperation with the CZDA expert from identification, via monitoring to Evaluation was assessed by the implementing agency and the project partners as positive. The absence of Project Coordinator of Caritas CR in Georgia from spring 2012 to spring 2013 negatively influenced the project. Local partners were not fully informed and have not taken part in strategic decision-making, which is assessed negatively. Internal evaluations are appreciated, though their reliability is lower due to inconsistent data.

Effectiveness

> ***„The project created an atmosphere of trust, as all diagnoses were confirmed. Other initiatives did not help us, even though almost everybody has cancer here.”*** Woman, Chitatskari

Project effectiveness was **rather low** concerning the number of women screened and the limited possibilities to influence treatment (due to the recent situation in Georgian health system and the capacities of oncocentres)**.** The project managed to show that the number of women screened from rural areas of Georgia can be considerably increased if enabling conditions are put in place, especially sufficient awareness, active ambulances and accessibility of services. Quantitative indicators on the activity level will probably be fulfilled (144 awareness raising activities, 150 peer trainers, 27 involved ambulances and trained personnel). Awareness raising is estimated to reach 1630 persons by the end of 2013. However, half of the awareness raising activities are planned for the last year of implementation, whereby women interested in check-ups are not directed to concrete facilities. In total, only 3.244 women instead of 8.500 (supposedly 9.000 women including pre-screening as per Caritas CR). Even though Caritas CR perceived the target number as overestimated (the call of the CZDA was probably based on 3 years of mobile clinic operations, whereas Caritas CR have undertaken the first level check-ups only until the end of 2012), the logical framework was not revised. Proactive follow-up supported the participation of 64% women (303 of 474), which is above the average of 50% at the NSP and thus can be assessed as rather effective. In total, 31 cases of cancer (16 breast, 14 cervical, 1 combined) and 48 cases of precancerosis (32 breast, 16 cervical) were diagnosed. The incidence rate of 1,18% in 2011 and of 0,58% in 2012 from the total number of women screened in mobile clinics was much higher than at the NSP in 2011 (0,065%). Based on the preliminary analysis of the CZDA expert on health, dated 12 May 2013, 17 so called „old ambulances“ involved since 2010 gradually experienced diagnoses of earlier stages of both types of cancer from 33% in 2010 to 76% in 2011. In 2012, only 5 diagnoses were found and a similar analysis was not done in the “new ambulances”. Based on the above mentioned analysis, „the National strategy for prevention and early diagnosis of breast and cervical cancer in rural areas“ is to be developed by August 2013. Approval by MoLHSA is still uncertain due to the reforms in the Health system and other priorities. Data on tuberculosis screening and diagnosis have not been collected and thus cannot be evaluated.

Sustainability

> ***„This project was the most realistic from all health projects (in our regions). It was timely and useful... Women*** **are now in a hopeless situation.** ***We progressed in 2 years and diagnosed early stages of cancer. We must not forget such progress, therefore the project has to continue***“. Doctor, Samegrelo

Project sustainability is **low**, as it relies on uncertain approval of the above mentioned strategy and existence of accessible screening for the target population. The Georgian health system, however, is going through big changes and thus the extension of oncological screenings and treatments for rural population is delayed. Ambulance doctors can exercise only limited check-ups and the target population lacks information about alternatives. Therefore the number of screened women significantly decreased in 2013 despite an increased demand. Insufficiently sustainable mechanisms for cancer screening and treatment (especially low involvement and capacities of regional oncocentres) would with doubts lead to long-term increase of probability of patients´ survival. Overall, the exit strategy is not clear. There are no agreements on which institution is accountable for sustaining outputs, results as well as all impact. No negotiation e.g. with local authorities or

regional oncocentres was held on the further financing of mobile clinics. They were not much involved in the project and did not have financial or other ownership.

Impact

Project impact on the awareness of the target population is assessed as **rather high**. Impact on the national level can only be assessed after 2014, when the health system reforms and the current strategy (dis)approval will bring their effects. Awareness raising is estimated to reach 1630 persons directly and min. 5.000 indirectly. As per Caritas CR, 65% of 31 cases of cancer and 4% of 48 cases of precancerosis were treated, which is above the national level (25%), but still alarming. During the project, minimum 5 patients died; some got partially inappropriate or insufficient treatment (treatment was not covered by the project), which has probably led to cancer relapse. Complete statistics, however, are not available. The evaluation team noted a high interest of ambulance doctors and nurses in cancer and motivation in patients´ follow-up, but low awareness on accessible screening and treatment including prices. The approach to prevention leading to increased demand for screening was highly appreciated by MoLHSA. If the proposed strategy is partially reflected in the NSP, the project can have a wider impact.

> ***„Earlier, cancer was perceived as fatal. Now women know, that if cancer is diagnosed early, it can be successfully treated.“***
> Doctor, Shida Kartli

> ***„I am married and have a child. I am a chemistry teacher. At a mobile clinic 2 years ago, I was diagnosed with cervical precancerosis. I do not know the exact diagnosis. They recommended treatment in a hospital, but I preferred my gynaecologist. The insurance covered treatment, but not the 10-day stay which cost me 300 GEL*** *(181 USD)****. I have similar complaints today. When I heard about the Czech team, I hoped to be checked.***“ Woman, 26 years, Jikhashkari

Other criteria

Visibility of Czech ODA in assessed as **rather high**. Key national institutions (MoLHSA, NCDC, NSC) as well as the target group were informed about the project and the donor. Logos of Czech ODA were displayed in the offices of the implementing agency, its partners as well as in 4 out of 6 ambulances visited. Other organisations, such as UNFPA, have not been informed about the project by June 2013. The project TV spot was reportedly screened on regional television. Nevertheless, the project produced only one media output in the Czech Republic and no other in Georgia.

Respect for human rights and gender can be identified as **high**. The project respected equal access to health care. It has concentrated on all women in given regions, both local and internally displaced, regardless of their age (in contrast to NSP). Most women interested in services received these. Men were usually not directly involved, still they have indirectly influenced check-ups and treatment follow-up. Several women would appreciate a project on men, e.g. on prostate cancer.

Good governance is assessed as **rather high**. Involvement of MoLSHA and other relevant Georgian institutions as well as of the CZDA expert on health is positive. Nevertheless, it was also possible to improve the cooperation with regional oncocentres, local authorities and other institutions.

The project **was not concerned** with **environmental protection and climate change**.

Recommendation	Type / level	Main addressee	Level of importance[1]
1. Focus on sustainability till the end of 2013: - Inform the target group about screening and treatment options after project end, including concrete health facilities and prices, while take into account current health system reform and launched national health insurance. - Finalize project database including data on stages of cancer, treatment and actual status of patients, then finalize project statistics and provide these to relevant actors, who can follow-up on the project. - Handover each activity/outputs to local institutions and have an agreement on project continuation if possible. - Strengthen cooperation with other organisations in the sector in order to reflect project outputs in their work (especially awareness raising, involvement of primary health care and the need of treatment).	Project	Caritas CR with Tanadgoma and CPC	1
2. Launch a coordination group focusing on cancer (breast and cervical) under the MoLHSA, which would coordinate activities of different institutions, donors and implementing organisations as well as support sharing of experiences, successes and challenges.	Project	MoLHSA with NCDC and NSC	2
3. Require budget by items and sustainability plan before or shortly after project launch (as a part of the first interim report), including contractual obligation of sustainability by local partners (state actors, local authorities), strengthening of their capacities **and co-financing**.	Process / System	CZDA	1
4. Launch **more effective monitoring and internal evaluations**: - Revise the project logical framework if needed so that it reflects the reality (as a part of an interim report). - Conduct results-oriented monitoring[2] by CZDA and the Czech Embassy. - Launch internal project evaluations above a certain budget, follow their clear Terms of Reference, results and follow-up on recommendations.	Process / System	CZDA with MFA and the Czech Embassy	1
5. Introduce a **holistic, complex approach to the fight against cancer with a focus on treatment –** follow-up by a project **in Samegrelo region** supporting patient care from prevention, to wide-scale screening, mainly to treatment, to active follow-up and psychosocial care. Include urban clinics, which provide free screening and further treatment. Ensure a cobalt radiotherapy machine in Kutaisi. Besides the training of specialists also direct supervision. Additionally, experience sharing with National Oncological Registrar in the CR. Coordinate everything with the Georgian government.	Czech ODA in Georgia	CZDA with MFA	3

[1] Scale: 1 most important – 3 least important

[2] See e.g. http://ec.europa.eu/europeaid/how/ensure-aid-effectiveness/monitoring-results_en.htm

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1 INTRODUCTION

Evaluation of the „ **Promotion of prevention and early detection of breast and cervical cancer among women in the regions of Samegrelo and Shida Kartli II.**“ project followed the Terms of reference of the Tender on Czech ODA project evaluation launched by the Ministry of Foreign Affairs (MFA) of the Czech Republic (CR). The contract was awarded to Naviga 4 s.r.o. and the evaluation was conducted from May to September 2013, i.e. before the planned project end in December 2013.

1.1 Evaluation Objectives

The evaluation objective was to provide to the main actors of the Czech Official Development Assistance (ODA), namely Ministry of Foreign Affairs of the Czech Republic (MFA) and the Czech Development Agency (CZDA) enough evidence-based conclusions and recommendations of the above mentioned project based on OECD-DAC evaluation criteria, further *lessons learned* and recommendations for future focus of the Czech ODA in Georgia, including the eventual continuation of the evaluated project. A further evaluation objective was to provide Czech ODA stakeholders with enough necessary information for decision making about other projects of a similar focus. The evaluation could also provide process recommendations or lessons learned with respect to management, implementation and evaluation of the Czech ODA.

Evaluation questions approved by the Reference group are attached as no. 7.9. It is expected that the contract authority, CZDA, the Czech Embassy in Georgia, as well as the implementing agency, project partners and other stakeholders in Georgia including MoLHSA will use the evaluation outputs in order to support prevention and early detection of cancer on the national level. Therefore this report has also an English version.

2 PROJECT BACKGROUND

2.1 Health care and breast and cervical cancer in Georgia

Georgia belongs to one of five project countries of the Czech ODA. Its population is officially 4,4 million, though some sources state a number up to 1 million smaller. Monthly income per capita was 218 GEL (around 130 USD) in 2012 as per Geostat, the national statistical unit. As per UN, 18% of population lives below poverty line of 1 USD at 2010 purchasing-power parity, unemployment is around 15,1% (2011) as per the World Bank.[3]

The Georgian health system went through a number of reforms after the collapse of the Soviet Union. It is criticised for low accessibility for low-income citizens, low quality, lack of basic equipment as well as for low utilisation of some facilities due to non-existent referral system between Primary Health Care practitioners and specialists.[4] [5] Frequent errors in diagnostics, often inappropriate treat-

[3] http://data.worldbank.org
[4] Chanturidze, et al. 2009. “Georgia: Health system review.” Health Systems in Transition.
[5] World Bank Project (see next page):

ment due to the omission of international standards and dominant focus of the private sector on profit maximisation even at the expense of patients are also problematic. The public budget covers only 22% total health expenses as per the World Bank (2011). As per the same source, citizens pay 89,2% health expenses out-of-pocket (payments for doctor visits, medication etc.). Despite the introduction of health insurance for people below the poverty line, only 36% of the Georgian population has a form of health insurance as per USAID[6]. Prevention is minimal according to the World Bank, citizens prefer direct purchase of medication without consulting doctors, and eventually they directly contact specialists rather than Primary Health Care practitioners.[7] Currently, further reform and partial de-privatisation are being launched, general health insurance is being re-launched as of 1 June 2013 and the Primary Health Care is being strengthened.[8]

Breast and cervical cancer is the most frequent cause of death of women in reproductive age according to UNFPA[9]. Comprehensive national statistics on breast and cervical cancer do not exist as the National Cancer Registry was cancelled in 2008; however, it is now being rebuilt as per NCDC and UNFPA. Since 2007, the National Screening Programme (NSP) ensured cancer diagnostics – first in Tbilisi and, since 2011, also in other regions. Besides that, a number of other programmes have been operating. As per UNFPA[10], in 2011, 5 screening programs including NSP screened 13.912 women for breast cancer (88 diagnosis found, i.e. 0,63%, whereby 78% in early stages I. and II.) and 14.372 women for cervical cancer (9 diagnosis found, i.e. 0,065%, data on stages are unavailable). Participation of women in secondary screenings is problematic, reaching to only 50% of those invited. As per UNFPA, this is due to dysfunctional mechanisms, lack of personnel and incorrect contact with patients. As per NCDC, the number of women screened just in NSP rose by 104% with respect to breast cancer and by 60% with respect to cervical cancer in 2012. The population from outside Tbilisi accounted for 55% (17.562 women) and 63% (27.315 women) respectively. The NSP struggles with insufficient demand – according to MoLHSA it was not able to spend the planned budget for screenings. The Ministry is currently considering program decentralisation and a handover to local authorities.

Treatment of cancer takes place in regional centres and in Tbilisi. Whereas surgery and chemotherapy are relatively accessible, the availability of biopsy and radiotherapy is very limited. According to the Czech Embassy in Tbilisi, 70% of oncological patients need radiotherapy, but only 4% receive it. Thus only 18% of women with breast cancer have a chance to survive the next 5 years[11]. Several patients do not trust the diagnosis and the treatment; therefore they use international health services if possible. As per a MoLHSA representative, the new national health insurance should cover amongst others also cancer treatment up to 12.000 – 15.000 GEL (up-to 9.000 USD) and therefore at least

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http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/01/09/000350881_20130109102252/Rendered/PDF/NonAsciiFileName0.pdf

[6] http://www.ghi.gov/documents/organization/175130.pdf

[7] See above mentioned project of the World Bank.

[8] Tamari Rikhadze: An overview of the health care system in Georgia: expert recommendations in the context of predictive, preventive and personalised medicine, The EPMA Journal 2013, 4:8 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3621519/

[9] eeca.unfpa.org/public/cache/offonce/pid/10107;jsessionid=A59CF451930340EAF83847B455A848F2.jahia01

[10] UNFPA Standard Progress Report 2011, GEO2R21A, Support to Breast and Cervical Cancer Prevention, údaje zahrnujú National Screening Centrem Tatishvili Medical Centre, Tbilisi Cancer Centre, Gudushauri Medical Centre a Tbilisi Baneology Resort.

[11] http://eurasianet.org/node/64789 As a benchmark, the average in low income countries is 40% (World Bank).

partially address the inaccessibility of treatment. Promiscuity is also linked to cervical cancer and prevailing sexual behavioural patterns. Only 26% of married women use contraception, whereas the average abortion rate of 3,1 per women is almost at the top world-wide.[12]

The incidence of tuberculosis has reduced from 210 (2003) to 125 (2011) new cases per 100.000 citizens as per the World Bank[13]. According to the National Centre for Tuberculosis and Lung Diseases[14], there are about 6.000 cases of tuberculosis per year, out of which 4.000 are new. Drug resistance appears in 10.3% of new and 31.1% of repeated cases.

2.2 Basic project description

The „ **Promotion of prevention and early detection of breast and cervical cancer among women in the regions of Samegrelo and Shida Kartli II.**“ project (CzDA-GE-2011-2-12191) was implemented from April 2011 to December 2013 by Caritas CR under the supervision of the Czech Development Agency (CZDA). A total budget of almost 11 mil. CZK (approx. 908.000 GEL or 548.000 USD) was awarded based on a tender. The project followed previous Czech oncological projects implemented since 2009, mainly the pilot project of the same name implemented in 2010 with the budget of 7,2 mil. CZK. The detailed Terms of Reference were prepared by CZDA based on the previous experiences of the implementing agency and local partners and in collaboration with other institutions. Caritas CR provided technical assistance during implementation.

The evaluated project focused on prevention and early detection of breast and cervical cancer among women living in regions with high percentage of internally displaced people (IDPs), Samegrelo and Shida Kartli, and further in the Tserovany settlement. Primary target group included women is rural areas. A secondary target group included Primary Health Care Practitioners (further referred as doctors) and nurses in rural ambulances and peer trainers. Project progressed bottom-up in contrast to the National Screening Programme (NSP) implemented top-down by the National Screening Centre (NSC) and regional subcontractors. The project logical framework with outputs is shown in the attachment 7.7.

The first project objective concerned an **increased awareness of both men and women** about a healthy lifestyle, symptoms of cancer that require a medical check-up or services provided by Georgian health system. Awareness raising activities were held throughout the entire project. In line with the needs of the target population, 90 of 144 planned awareness raising activities were held in 27 villages and their catchment areas. Further, peer trainers from the communities were trained to informally spread awareness and support interest in screening. The project utilised a number of newly developed brochures as well as a TV spot, which was screened at ambulances, as well as on regional television channels.

The second project objective was **effective early detection of breast and cervix cancers of the target population** already at the Primary Health Care level, i.e. in rural ambulances. The project continued with 17 „old“ ambulances in 16 villages, where activities were launched in 2010 as a part of a previous project and where ambulance personnel were expected to work independently from 2012

[12] Reproductive Health Survey, 2005
[13] http://data.worldbank.org/indicator/SH.TBS.INCD/countries/GE?display=graph
[14] http://www.tbgeo.ge

onwards. Further, 11 „new“ ambulances or villages were identified (see attachment 7.16) and could benefit from mobile clinics only in 2012. Doctors[15] from the ambulances were trained as well as nurses who come from the communities and knew the health status of the population. These personnel disseminated information materials, conducted pre-selection and engaged in free screenings in mobile clinics. Patients with a positive diagnosis were sent for free screening at regional oncocentres (in Zugdidi and Gori). A side output was the training of doctors and nurses in tuberculosis diagnostics. Caritas CR informally negotiated a budget increase for mobile clinics to operate also in 2013; however, without success.

The third project objective was a **pro-active follow-up of patients with a positive diagnosis**. Women with cancer or precancerosis were treated within the region or were sent to Tbilisi. Doctors in ambulances were to actively follow up further check-ups and treatment of their patients and eventually support palliative care. Based on medical reports, a project databases was developed to enable results analysis and the assessment of the project´s success. Psychosocial assistance was to be provided by self-help groups facilitated by a psychotherapist. The overall patient flow is shown below.

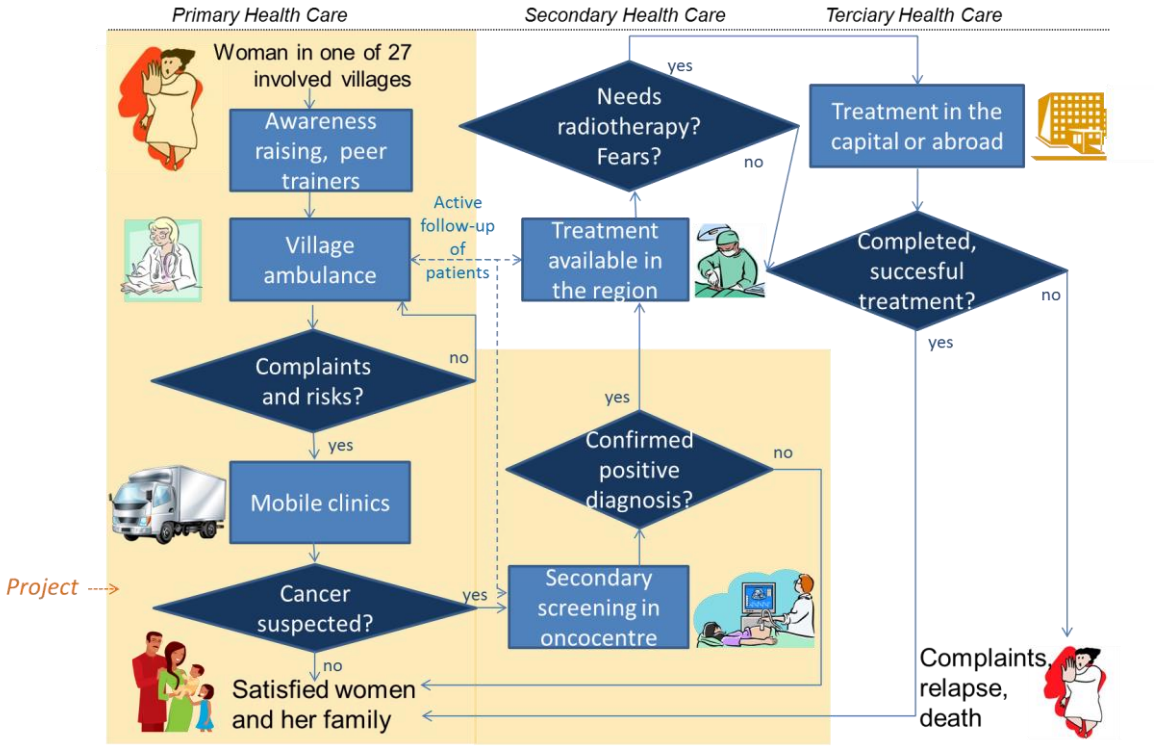


Image 1: Flow of patients involved in the project

The last objective was **development of** a **national strategy on prevention and early diagnosis of breast and cervical cancer in rural areas**. Thus a working group of representatives of key institutions was formed at the beginning of 2013, including MoLHSA, project partners and the CZDA expert. An analysis of project success was conducted, based on which the strategy is now being formulated.

With respect to the project logical framework, it is important to note that the English version uses the term „results“, which seems to be more appropriate looking at the number of objectives and their phrasing. Some indicators do not have target values, thus their non/achievement cannot be

[15] Femininum is used (in the Czech language) as the project engaged 26 female doctors and only 1 male doctor.

assessed. Indicators are stated also with respect to activities, which is in contrast to the logical framework form of the CZDA. Already after the project launch, Caritas CR found it impossible to reach above all the number of screened women; however, it has not officially applied for revision of the logical framework. Therefore the evaluation team used the original indicator as guidance [16], though it has considered including women pre-screened in ambulances. As the evidence of pre-screened women was insufficient and only women checked in mobile clinics were reported, the evaluation report provides two types of data: evidence-based numbers of screened women and an estimate of screened women including pre-selection. The evaluation team just added a few indicators, which are included in the analysis of the CZDA expert on health or which are directly linked to implementation and focus on outputs/results (number of persons reached through awareness raising, see the attachment 7.14).

2.3 Key assumptions and risks

During the formulation of the Project Terms of Reference, the gestor assumed a stable political and economic situation in Georgia, consistent health system reform (though decreasing capacities of newly privatised regional oncocentres affected secondary check ups and treatment), willingness of the government to take over the developed model (this depends on the current health reform), effective functioning of peer trainers (this is a project activity, not an external assumption), adequate utilisation of equipment (equipment of project partners was used) and all-year-round accessibility of target areas. Further, following identified risks reflect well the reality as per the evaluators.

Risk	Mitigation measures
Cooperation with and support of state and international actors – MoLSHA and UNFPA.	Regular meetings of Caritas CR with actors did not take place, since 2011 Caritas CR did not involve UNFPA after consideration and cooperated informally with MoLHSA on several activities. Since 2013, the latter was engaged in the working group.
Interest and capacity of ambulance personnel to engage in the project, provide information and learn.	New ambulances were selected according to their demonstrated interest and capacity to participate in the project. During the evaluation, the personnel showed great motivation to continue.
Real interest of target group in early cancer detection and thus in participation in check-ups, despite taboo and stigma around cancer.	Effective awareness raising and functional check-up system as per pilot project contributed to such an increased demand that was above the project capacities. Stories of successful treatments helped too.
Poor communication and activity overlaps among a higher number of project partners.	Regular communication of all actors was conducted rather bilaterally.
Financial inaccessibility of secondary health care (treatment) for some patients.	Mitigation measures were not mentioned in the Terms of reference – treatment was not a project component.
Incomplete or distorted data used for medical records of patients.	Again not mentioned in the ToR, but both Caritas CR and CZDA conducted monitoring.
Mobility of internally displaced persons.	Not mentioned in the ToR – not a part of the project.

Table 1: Risk management

[16] As almost 2.000 women were checked-up in mobile clinics in 9 months of the year 2010, the evaluation team considers it realistic to check 8.500 women in 3 years, provided that mobile clinics would have operated also in the third year of implementation or at least continuously the first 2 years instead of 6 months per year.

2.4 Implementing agency and local partners

Caritas CR, established in 1999, belongs to the biggest Czech non-governmental organisations in the social and health sectors as well as in development cooperation and humanitarian assistance. Mainly post-Soviet countries, Serbia, Cambodia or Mongolia are among the targets areas of international health and social projects. Caritas CR implemented the pilot project in Georgia , related to the evaluated one. The main role of Caritas CR in the evaluated (as well as the pilot) project was coordination of local partners and activities, monitoring of indicators and budget as well as reporting to the CZDA.

Cancer Prevention Centre (further as CPC) has been focusing on cancer prevention since 2000 and has also provided palliative care services since 2004. Within the project, it has trained the ambulance personnel, operated mobile clinics and contributed to the strategy draft.

Tanadgoma (the full name is Tanadgoma - Center for Information and Counselling on Reproductive Health) has focused on awareness in the area of reproductive health since 2000. Since 2009, it has also engaged in cancer prevention and operated a mobile clinic. Tanadgoma has 5 branches, one in Zugdidi, in the region of implementation, Samegrelo. Within the project, it has concentrated on awareness raising and psychosocial care of patients. It has also operated mobile clinics in Tserovany and Berbuky.

3 EVALUATION METHODOLOGY

The methodology derived from the Evaluation Terms of Reference, approved evaluation questions, desk review and initial interviews with stakeholders. After the approval of methodology by the reference group, an eight-day evaluation mission followed. It concentrated on collection of evidence (so called „evidence-based“ approach), its verification and triangulation with other sources, methods and evaluators, further analysis and development of answers to evaluation questions. the overview of meetings with involved stakeholders is attached under 7.4 a 7.5. Final phases included a debriefing with key stakeholders in Georgia (representatives of the Czech Embassy, Caritas CR, CPC, Tanadgoma, MoLHSA, NCDC and the CZDA expert), drafting a final report, including comments of the reference group, implementing agency and local partners, presentation and finalisation of the report in Czech and English languages.

3.1 Methodological tools

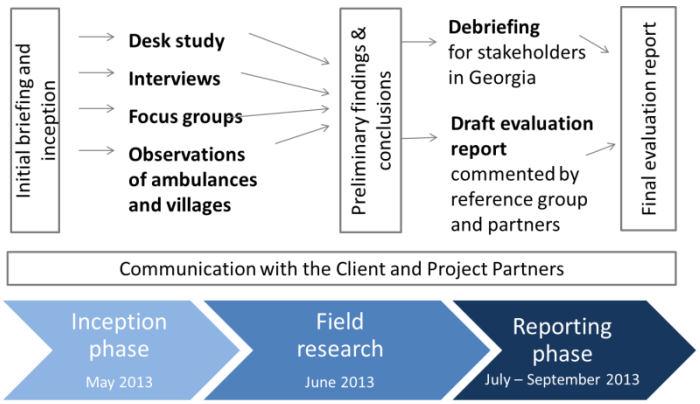


Image 2: Evaluation phases and methodological tools

The overview of evaluation phases and different methodological tools is shown above.

The basic sources of information included project documentation and other relevant courses, mainly studies, annual reports of other institutions and others (see list in attachment 7.3).

Semi-structured interviews were held with key stakeholders in Georgia as well as in the Czech Republic. In 10 cases, group discussions were used rather than interviews, especially when dealing with the implementing agency, local partners and peer trainers.

The evaluation team visited 6 out of 28 involved ambulances. It has randomly selected 2 villages from each region, one from the first and one from the second phase of implementation – Chitatskari and Jikhashkari in Samegrelo region, Khetulbani and Dzevera in the Shida Kartli region (Mejvriskhevi was disregarded due to a festival and thus a restricted opportunity to assemble target group). At the end of the evaluation mission, the evaluation team visited 2 ambulances involved in the IDP settlement in Tserovani and consulted also a third ambulance, which was not involved in the project. Observation of the ambulance (see guidelines in attachment 7.12), interviews with a doctor and a nurse (in total 12 persons plus 6 persons in the non-participating ambulance), peer trainers (in total 13 persons) a patients (in total 5 persons, more in the focus group) were held at each visited location. Women from local communities had the chance to comment of the project in focus groups (see guidelines in attachment 7.11), whereby recruitment was done by ambulance personnel. In total, 31 women participated in the focus groups, whereby some of them were not involved in the project, which was in line with the evaluation methodology. In this way, opinions of women with diverse approaches to prevention could be reflected. Other conditions were that women had not participated in any other, similar focus group (though they could have been involved in KAP survey - Knowledge, Attitudes, Practices[17]) and had lived in the implementation area for at least a year.

To get at least some limited data from other ambulances, 2 focus groups were held with doctors (16 participated out of 28 involved in the project) and nurses (14 participated out of 28) from the ambulances. Personnel from both phases of implementation were included. In order to reflect the hierarchical differences between doctors and nurses as well as different type of work with communities, focus groups with nurses were held separately from doctors (see guidelines in attachment 7.10). the focus groups were held in regional centres (Gori and Zugdidi), always one with doctors and one with nurses. Participants received travel reimbursements.

Beside the above, in order to better understand the functioning of the Secondary and Tertiary Health Care system, visits were paid to cooperating regional oncocentres (see guidelines in attachment 7.13) and to other health facilities involved in National Screening Programme in the area of implementation or to those providing a form of treatment (including e.g. radiotherapy, see overview of interviews in attachment 7.5). Observations and exploratory interviews took place here.

[17] The surfy was implemented by Tanadgoma in 2011 and 2013.

3.2 Evaluation team

Lead evaluator Inka Píbilová, working in development cooperation on a long-term basis, an expert on oncology MUDr. Václav Pecha and a local expert, logistician and interpreter Elene Margvelashvilin participated in the evaluation mission. MUDr. Václav Pecha is an eminent Czech woman's oncologist. He has been intensively involved in the field since the 70´s of the last century. He cooperates with a number of international organisations specialized in oncology (Breast Centre Network, ESO etc.). He is an active surgeon, author of publications, trainer and further the co-funder and Chairman of patient association Mamma Help. MUDr. Pecha has experiences from development cooperation in the health sector. The evaluation team was supported by the methodologist Ondřej Štefek and the analyst Petr Krucký, who analysed the project cost-efficiency.

3.3 Methodological limits

The evaluation was conducted during the project implementation, whereby some key outputs (mainly the national strategy, final version of the internal analysis, survey among patients, final data on check-ups and treatment as well as a number of awareness raising activities) would be delivered only after the evaluation mission. This affected the options of the evaluation team to accurately evaluate these outputs.

Data on patients needed for the evaluation of effectiveness and efficiency were inconsistent and incomplete (the number of pre-screened women was just estimated by the implementing agency, no evidence was available), therefore any analyses deriving from these have limited reliability. Inconsistent documentation required a more in-depth data analysis and cross-checking of data from a large number of actors. The final version of data included in this report was validated by Caritas CR and its project partners.

Impacts and sustainability could be evaluated mainly because the mobile clinics did not operate in 2013. However, the evaluation was done mainly in qualitative terms due to unavailability of comprehensive data on check-ups outside of the mobile clinics. Treatment statistics were also not available, and therefore medical impact could not be evaluated.

4 EVALUATION FINDINGS

4.1 Relevance

The project was relevant both for Georgia and the CR. Georgia is one of 5 project countries of the Czech ODA, whereby health care is one of 6 sectors of cooperation.[18] The project focused on breast and cervical cancer, which are the main cause of death of women of reproductive age in Georgia and they are still connected to stigma and taboo. Additionally, in line with the request of MoLHSA, the project focused also tuberculosis (see. chapter 2.1).

[18] See Czech ODA Strategy for 2010 – 2017 at http://www.MFA.cz/pomoc/.

Samegrelo (regional capital Zugdidi) **and Shida Kartli** (regional capital Gori) regions were selected by CZDA and the implementing organisation, reflecting the increased number of internally displaced people, who are exposed to potential higher risk of cancer due to stress. Another reason was the possibility to build on previous Czech humanitarian and development projects in health care, especially the previous nine-month project implemented in 2010 by the same leading agency and local partners (budget of 7,2 mil. CZK, approx. 326.000 USD). Women – patients as well as doctors and nurses in ambulances have assessed the relevance as high during the evaluation due to low awareness on general disease prevention and perceived high mortality on cancer.

During the project, **central institutions** responsible for prevention and treatment of breast and cervical cancer **were engaged** – namely the ministry of health (MoLHSA, cooperation on the basis on a short Memorandum of Understanding), National Centre for Disease Control and Public Health (NCDC) and National Screening Centre (NSC), which implements the National Screening Programme (NSP) at a number of locations. These institutions were involved mainly in 2013 in drafting the strategy for prevention and early detection of breast and cervical cancer in rural areas. Based on the pilot project, the evaluated project continued working with branches of the newly privatised National Cancer Centre (NCC), however, it has provided necessary equipment and some specialists from Tbilisi. The Secondary Health Care level has proven to be the weakest point especially in Zugdidi, where free mammological screening is not available. Treatment is limited here; therefore patients need to travel especially to Kutaisi and Tbilisi. In Gori, the private clinic Gorimed is involved in the NSP and even ensures some treatments. Moreover, the region borders with Tbilisi, therefore women can use the services available in the capital city. These **regional differences** (existence of NSP subcontractors, equipment and sufficient specialists) thus influenced follow-up check-ups and treatment in the project.

Analysis developed by CZDA expert on health in May 2013 compares the results of the National Screening Programme (NSP[19]) and the project. It underlines the importance of prevention and preselection of risk groups, which reportedly leads to earlier detection of both types of cancer. However, as NSP does not apply selection and screens all women of a certain age, it is not a relevant benchmark. In any case, both initiatives were complementary. **Whereas NSP concentrated on urban population and engaged Secondary Health Care level** (see more in chapter 2.1)**, the evaluated project focused on women in rural areas, who had been neglected so far, whereby it used the Primary Health Care level**. The option of free screening within NSP after the evaluated project end was key, whereby NSP was expected to reflect experiences from the project.

> ***„People do not go to hospitals for prevention, especially if the hospitals are far. The mammologist (during the project) came to their door steps.***“ Doctor, Shida Kartli

Beside others, following **institutions** worked in Georgia in the same field:

[19] As a part of the NSP, free breast screening is available only for some from 40 to 65 years of age, cervical screening for women from the age of 25; however, free services are often not accessible or promoted. In other cases, such services cost around 120 GEL as per representatives of concerned facilities. NSP screened all interested women of the given age, whereas the evaluated project preferred women with complaints, genetic predispositions and others interested without any age limitation.

Selected organisation	Activities related to breast and cervical cancer, eventually TBC
John Snow, Inc. (USAID)	Training of doctors, reportedly also in Samegrelo region
UNFPA	Cancer programme especially in Tbilisi in cooperation with NSC, education and awareness raising, screening and treatment guidelines development, currently drafting National Screening Strategy, earlier also operated mobile clinics[20]
World Bank	Improved access to health care in rural areas, increased quality including training of ambulance personnel, strengthened treatment of TBC etc., the project took plane in Gori and Tbilisi beside others, it was not implemented in Zugdidi[21]
European School of Oncology	Training of specialists, development of recommended guidelines
Hipocrate – mobile clinics	Operating beside others in Shida Kartli, as per the data of NCDC screens only 320 women per month with mammographs, however, mobile clinics did not cooperate with ambulances and did not actively follow up on patients
„First Lady“ Sandra Elisabeth Roelofs – mobile clinics	Operating in both regions, the evaluation team did not manage to get data on the number of women screened or ways of working
ADRA ČR - mobile clinics	In 2009 Czech mobile clinics operated with Tanadgoma[22]
UJP Praha a.s. (IAEA Vienna)	Czech supplier of 1 cobalt radiotherapy machine to NCC Tbilisi

Table 2: Selected organisations operating in the same field

According to the available data, some of these activities were co-financed by Georgian local authorities and Tbilisi city. Awareness raising covered by the state took place in the television and other media. None of the institutions above was involved in drafting the above mentioned strategy, reportedly due to time constraints as per Caritas CR. The **whole sector is rather fragmented, without a unifying strategy and coordination**.

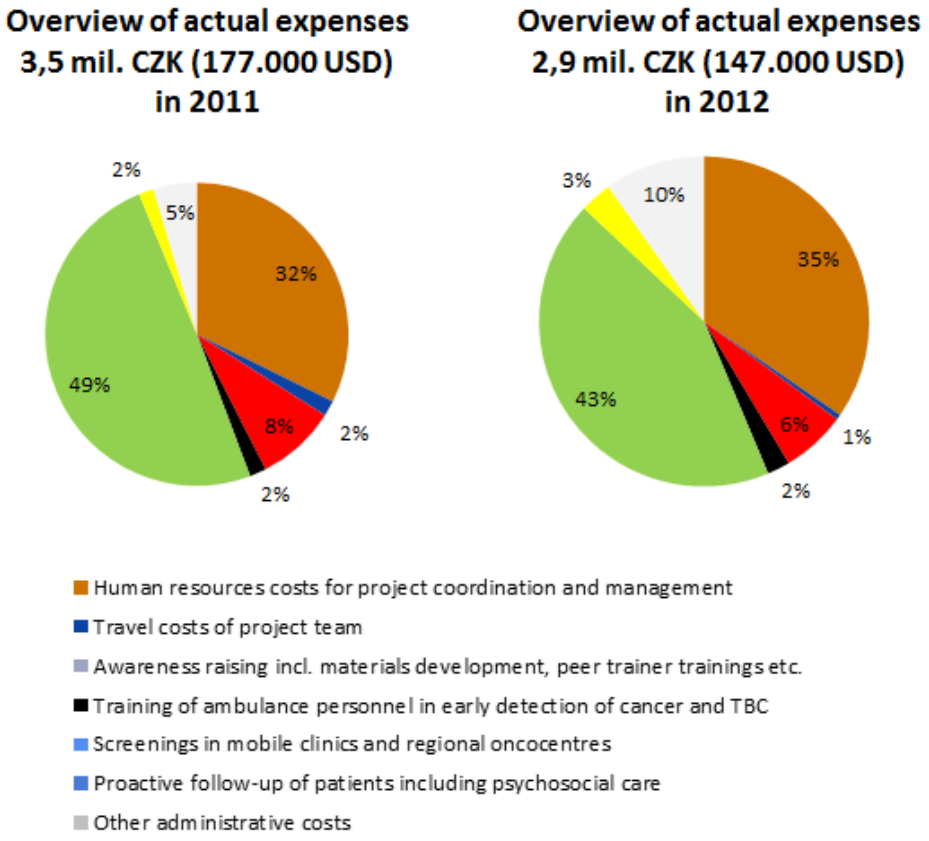
MoLHSA noted that beside insufficient awareness raising, lack of qualified personnel and equipment (especially mammographs, as there are only 26 of them in Georgia including mobile ones as per the ministry, moreover, some are not functional), the need for more motivation and work with ambulance personnel, the need for launching a referral system between the three levels of health care system and for the National Cancer Registry are among the challenges. Even NCDC confirmed the need to increase the number of functional mammographs, enhance awareness and strengthen cooperation among institutions. Further, engaged doctors and local partners have confirmed the necessity to supply equipment, support education and integration of different levels of the health care system at all levels. NSC agreed that it was not able to cover rural areas, that identified cases were in later stage and the treatment was insufficient (as per Caritas CR, treatment is ineffective in up to 75% of cases).

4.2 Efficiency

The total project budget was 10.918.200 CZK (approx. 552.400 USD)[23], 100% funding was provided by CZDA. Local partners provided mobile clinics, whereby the project covered only their operating costs.

[20] http://www.georgianews.ge/society/2148-united-nations-population-fund-unfpa-mobile-health-services-for-refugees--hopefully-they-are-not-abandoned-.html
[21] http://www.worldbank.org/projects/P040555/health-sector-development-project?lang=en
[22] See Annual report of ADRA CR in 2009 www.adra.cz/file/54

The overview of actual expenses of 2011 and 2012 was used as a basis for evaluating cost-efficiency. For the purpose of the Evaluation, expenses were split into seven main groups (for detailed budget split, see attachment no. 7.15).



Graph 1: Overview of actual expenses in 2011 and 2012

In 2011, about 3,9 mil. CZK (200.000 USD) and in 2012, about 3,5 mil. CZK (179.000 USD, about 82% of plan) were spent. For 2013, about 3 mil. CZK (154.000 USD) remained available. Based on graph no. 1 with an overview of actual expenses in 2011 and 2012, it is apparent that total **administrative costs** related to the project implementation, including personnel costs for the project management and coordination, travel costs of the project team and other administrative costs form **45% and 54%** of total costs **respectively**. One of the main reasons of such a high ratio is a high number of partners, their administration costs (especially of Caritas CR) and costs related to their coordination. Many expenses were incurred repeatedly by several partners – cleaning, accounting, logistics etc.

Regarding other items, it is worth mentioning the financial incentives for ambulance and oncocentre personnel (about 100 GEL / pers. / month), which encouraged collaboration, women mobilisation as well as subsequent care. However, the payments were necessary as per CZDA expert and implementing agency, even though they have probably affected sustainability.

Certain changes in timing and types of activities occurred during the project. Psychosocial care was piloted in Tserovani and for practical reasons also in Tbilisi. In 2013, mobile clinics did not undertake primary screening for financial reasons, however, the number of awareness raising events increased, patients were proactively followed-upon, a survey of impact on patients was conducted, a trip to the CR was held, strategy was drafted and dissemination of results at a conference is being planned. The

[23] As the evaluation was finalized efore the project end, final sum was not available.

budget for 2013 of about 3,5 mil. Kč (180.000 USD) is, however, rather high taking into account the expected outputs and the benchmark with previous years. Caritas CR representatives have not provided documents with an updated overview of expenses in 2013 to the evaluation team during the drafting of the evaluation report. Therefore it is not possible to assess the cost-efficiency of the last year of implementation.

The implementing agency **has not reallocated the received funds** in 2013 **towards an at least partial increase in the number of screened women** towards 8.500[24] for example by decreasing administrative costs or costs of other above mentioned activities. However, according to the data from 2012, it was possible to organize an additional visit of a mobile clinic and screen 20 or more women for about 18.277 CZK (925 USD), which is about 900 CZK (46 USD) per person. An alternative for secondary screening in cooperation with mobile clinics and NCC regional branches could theoretically be also cooperation with local clinics with necessary equipment, especially mammographs, e.g. Guli in Zugdidi and Gorimed in Gori. Fees for all screening procedures are over 1.200 CZK per person here if the patient does not fall under the criteria of the free NSP. Special cooperation e.g. on secondary check-ups would have to be negotiated. This approach could also contribute to higher sustainability.

Cost analysis is difficult due to inconsistent and incomplete documentation (reporting of unit costs, or evidence of the number of screened women) as well as limited availability of total expenses in at least a part of the year 2013. The offer of Caritas CR included only a budget by phases (activities), whereby no link was available to the budget by item, which was used for planning and expenses consolidation (reporting of expenses to CZDA was not required in the contract with the implementing agency). The implementing agency has not provided the budget by activity; therefore it cannot be assessed if the contracted budget split was adhered to. **Inconsistent documentation also limited proper cost management and thus cost optimisation.**

On-going monitoring of the project was done by Caritas CR, the expert CZDA and partially also by the Czech Embassy in Tbilisi. The launch of the health records and reporting enhanced the good governance, but the outputs are inconsistent. According to the Czech Embassy, the absence of a project coordinator in Georgia from spring 2012 to spring 2013 negatively affected especially the cooperation with other institutions, as well as field monitoring. Coordination from the CR was assessed as insufficient by the evaluation team. During the evaluation, the new employees of Caritas CR had limited knowledge about the project, which has affected the collection of indicators and other data. Local partners did not have a comprehensive overview of the project, for example the total budget or interim reports, and did not involve in strategic decision making e.g. about the main changes in the total project budget[25]. Engagement of Georgian employees was also complicated due to the fact that some project documents were in the Czech language. The CZDA health expert provided direct support not only to the implementing agency and the partners, but also to the ambulance staff, which was highly appreciated by the implementing organisations. Monitoring reports of the expert contained a number of specific findings and recommendations for the project. He also conducted an internal evaluation of the data from the „old“ ambulances in May 2013[26] and planned an evaluation

[24] According to Caritas CR, te indicator was fulfilled as 9.000 women were checker including pre-screeing.

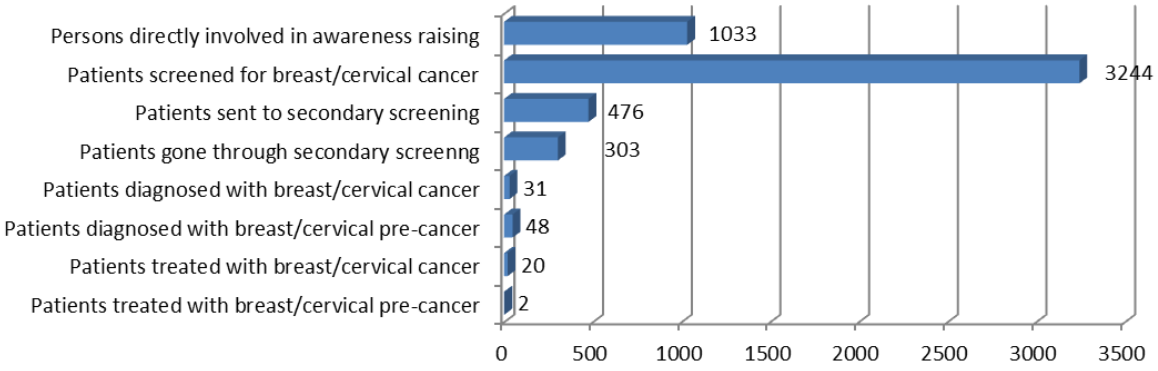
[25] To establish effective partnerships, see also FoRS Code on Effectiveness, page 2, part 3. Partnerships (Istanbul principles no. 6 and 7): http://www.fors.cz/user_files/fors_code_on_effectiveness_en.pdf

[26] Jan Voříšek: Analysis of Czech Cancer Screening and Early Detection Project, especially in comparison to Georgian National Cancer Screening Programme as Input to National Strategy Development, 14 May 2013

of ambulance staff attitudes. The evaluation of impact on patients was planned by Tanadgoma for summer 2013.

4.3 Effectiveness

Find below the graph of main (evidence-based) quantitative project indicators; followed by written description of objectives (results) achievement from both a quantitative and qualitative perspective. A detailed overview of the indicators is in attachment 7.14.



Graph 2: Women involved in prevention, diagnosis, treatment of breast / cervical cancer (by IV/2013)

Objective (Result) 1: Awareness Raising

Tanadgoma trained **98 peer trainers** by April 2013, and it plans to train 52 more by the end of 2013. It estimates that 41% of peer trainers are actively engaged in awareness raising. Among these are often teachers or other women motivated to work for others. Other peer trainers were interested rather in obtaining more information for themselves and their families (see examples below). No systematic coordination of peer trainers took place.

„I live without a husband. I have a daughter, who works in Tbilisi. I sell fruits and vegetables that I produce. I am a fighter. Two years ago, (thanks to the project) they detected pre-cancer, when I complained about abdomen pains. Gradually, they removed all my female organs. The surgery cost 1.200 GEL and was covered by the health insurance for the poor. As a peer trainer, I encourage women to get screened, sometimes I even accompany them. When I go for regular check-ups, I always take a woman with me and on that occasion, I suggest her to get screened herself.“ Woman, 49 years, peer trainer, Dzevera

Further, Tanadgoma organised **90 awareness raising events** (54 more are planned by the end of 2013), in which **1033 persons p**articipated (the events are expected to reach 1630 persons by the end of 2013). According to the available documentation, the participants as well as the Czech Embassy, the sessions were interactive and helped to develop an understanding that prevention is important. They also stimulated the women´s interest before the arrival of mobile clinics. Tanadgoma further estimated that 5 types of promotion brochures reached about 5.000 men and women; the regional television spot about 3.000 persons, though this data could not be verified. As per the evaluation team, the awareness raising tools were well adjusted to the target group. Half of the awareness raising events are being put in place in the third year of implementation, as takeover of subsequent check-ups by ambulances was expected. Nevertheless, the ambulances cannot perform most

check-ups and at the same time, mobile clinics do not operate anymore, thus the effect of awareness raising is diminished. Women at all focus groups demanded an overview of screening and treatment options including prices.

At the project beginning, stigma and taboo was notably associated with cancer, including check-ups. Thanks to awareness raising, engagement of doctors and nurses, recommendations of other women, regular visits of mobile clinics and reliability of diagnosis, a **high demand** for check-ups was recorded after the first few months of operating mobile clinics**.** The fact that **check-ups were free of charge and easily accessible** played a key role.

"Some women have not been to a gynaecologist for even more than 15 years, they were even afraid of the gynaecological chair. It was up to us to prepare them psychologically." *Doctor, focus group in Zugdidi*

"The project created an atmosphere of trust, as all diagnoses were confirmed. Other initiatives did not help us, even though almost everybody has cancer here." *Woman, focus group in Chitatskari*

„A single mother with two children has never been to a gynaecologist. I had to literally drag her to the mobile clinics. The found cervical cancer. Treatment was fully covered by insurance. Today she is healthy and working." Nurse, *focus group in* Samegrelo

Objective (Result) 2: Early detection of cancer

Specialists from CPC trained personnel of 28 village ambulances on prevention, check-ups and follow-up on positive diagnosis, based on internally developed materials. Subsequently, the personnel pre-selected patients and assisted during check-ups at mobile clinics. **According to MoLHSA, the approach to capacity building thus differed from to those of other donors**, who provided 2-3 week courses without further supervision.

In 2011 and 2012, mobile clinics visited each village about 6 times. During a visit, on average 20 persons were screened, which is close to the maximum capacity. Women and ambulance personnel appreciated the very good organisation and sensitive attitude of the specialists. In 2013, no visits were held for financial reasons. In total **3.244 women were screened**[27]**, 476 of them were sent to secondary check-ups**. Therefore the planned indicator of 8.500 patients screened on the primary level was not reached. Several women went only through a partial check-up - gynaecological or breast, therefore no clear conclusions can be made about the fact that more women were finally suspected for cervical rather than breast cancer (66%). Mobile clinics did not have always a mammograph, which diminished the reliability of screenings. As per the findings of the evaluation team, some women in Khetulbani village did not know about the project and therefore were not screened. Others could not attend the check-ups offered as monthly periods due to menses. During the evaluation, ambulances and local partners confirmed interest of tens of patients in (follow-up) check-ups in mobile clinics, even from neighbouring villages.

[27] Women who have gone through preselection by ambulances are not included in this number (record tracing is problematic, documents showing evidence are being prepared, Caritas CR estimates around 9.000 women). As per the oncologist, MUDr. Václava Pecha, preselection is not suitable as it may omit especially early stages of cancer, which are most likely to be successfully treated.

Additionally, besides cancer, the project trained ambulance staff in **tuberculosis** diagnostics. However, ambulances did not collect data on the number of patients screened and treated. At the same time, several national initiatives on tuberculosis took place. Therefore it is not possible to assess the effectiveness of the training. The focus group with nurses in Zugdidi mentioned a rather decreasing number of new cases, while the group in Gori noted an increasing trend due to high drug resistance. Detection of tuberculosis was complicated by low access to an X-ray.

Objective (Result) 3: Pro-active follow-up of patients with positive diagnosis

Secondary check-ups were recommended to 474 women suspected to have cancer, whereby **64% (303)** of them have **actually participated in them**. This is more than 50% in NSP according to the UNFPA[28]. As per the focus groups, the main reasons for nonparticipation include a fear of diagnosis and subsequent expensive treatment far away from home. However, patients, doctors and nurses often did not know the diverse possibilities and costs of treatment; they have just based their opinions on experiences of their relatives and friends. The fact that the population is not accustomed to preventive check-ups was also mentioned. On the other hand, secondary check-ups uptake was encouraged by personal invitations for concrete dates by ambulance staff. The consistency still differs ambulance by ambulance.

In total, **31 cases of cancer were detected,** out of which 16 concerned breast, 14 cervix and 1 and combined case; **and further 48 cases of pre-cancer**, out of which 32 concerned breast and 16 cervix. The cancer incidence of 1,18% from the total number of women screened in mobile clinics in 2011 (decreased from 2,73% in 2010 in the same villages) and even 0,58% in 2012 is far above the rate of NSP in 2011 (0,065%). According to the May 2013 analysis of CZDA health expert, gradually the 17 so called „old ambulances“ involved since 2010 detected **earlier stages** of both types **of cancer from 33% in 2010 to 76% in 2011**. As in the 11 „new ambulances“, mobile clinics operated only for 6 months in 2012 and only 5 diagnosis were made, one cannot expect a similar progress, though data on stages were not available during the evaluation.

The accuracy of diagnoses cannot be assessed based on the documents provided. Women personally shared they often did not know the exact diagnosis which was confirmed also by the CZDA expert. The project introduced health records, a project database, on-going communication of doctors and patients and monitoring by the implementing agency and CZDA. Nevertheless, it did not have a direct influence on treatment. Patient follow-up was affected by the lack of communication between national, regional facilities and village ambulances. Thus doctors were informed only informally.

Tanadgoma started a pilot of **psychosocial assistance** in 2011 in Tserovany and in contrast to the original plan also in Tbilisi, for practical reasons with Women Winners Club and NSC. Despite travel reimbursement, it was reportedly difficult to convince patients to join at the beginning. The 10-week therapy was, however, highly appreciated by NSC, which confirmed a big change among patients. Tanadgoma plans to scale-up the therapy to the Samegrelo region by the end of 2013. Gori is not involved sued to smaller capacities and the difficulty of mobilising patients who prefer to stay anonymous.

[28] According to the final report from the 2010 project, the participation was 100% (302 persons), which however, seems unlikely.

Objective (Result) 4: Drafting national strategy for prevention and early detection of breast and cervical cancer in rural areas

In 2013, a working group was launched to draft the strategy. Besides the implementing agency, local partners, CZDA health expert as well a national institutions– MoLHSA, NCDC, NSC and partially even the Czech Embassy were involved. By June, 2 meetings took place, where activities of each institution were presented together with preliminary results of the evaluated and pilot project from 2010. In August 2013, draft finalisation is expected, whereby project outputs will be disseminated among relevant actors at a conference in autumn 2013. Though MoLHSA expressed a strong interest in suing the evaluated project outputs (especially prevention), acceptance of the strategy is unclear due to the general health insurance launched on 1 July 2013 and due to other big reforms of the health system by the end of 2013.

Purpose: Increase the probability of survival of target population with breast and cervical cancer and TBC

Based on a relatively low number of positive cancer diagnosis and limited data on treatment and deaths (as well as unavailability of comprehensive statistics on patients suffering from tuberculosis), it cannot be concluded if the probability of survival was increased. Indicators related to the project purpose cannot be assessed as the National Cancer Registry does not exist since 2008. Generally, the effectiveness was negatively affected by frequent changes in Georgian health sector and insufficient capacities of involved oncocentres.

4.4 Sustainability

Sustainability was not planned in detail in project documentation. It was based on the acceptance of the **national strategy** for prevention and early detection of breast and cervical cancer in rural areas and on the launch of functional Primary Health Care by the state or the insurance companies. Nevertheless, strategy approval is **very uncertain** due to lower engagement of Georgian institutions (the meetings are coordinated by Caritas CR and the membership is not settled) and current major changes in the health system. As per ambulances and local partners, **screening accessibility was low** in 2013 after mobile clinics stopped operating.

> „***You gave us hope. If you leave, it will be a big disappointment for us***.“ Doctor, Samegrelo
>
> **„First we begged women to come for check-ups*. Now they begged us to continue (with mobile clinics)***.“ Doctor, Shida Kartli (from the new ambulance)
>
> ***„This project was the most realistic from all health projects (in our regions). It was timely and useful... Women* are now in a hopeless situation*. We progressed in 2 years and diagnosed early stages of cancer. We must not forget such progress, therefore the project has to continue***“. Doctor, Samegrelo

In focus group, **women confirmed they do self-examination and are interested in preventive check-ups with adequate equipment** (PAP tests, mammograph, ultrasound) and specialists. Beside mobile clinics, however, except of a few patients in Tserovany, they did not know about other free options, namely the NSP. Women also feared high prices and low accessibility of check-ups and treatment. This aspect should be partially addressed by the general health insurance, which is expected to cover

the treatment up to 12.000 – 15.000 GEL as per MoLHSA, but women still did not have this information. A relatively high interest in prevention derived from interviews with **peer trainers**, however, this differs as per their personality and experiences. Even trainers did not know where to send interested women for screening.

During the evaluation, doctors confirmed they can **identify risk groups**. They became more confident with respect to check-ups and that they are more trusted by patients. Thanks to established contact with oncologists, some doctors have informally used consultations by phone. Nevertheless, they **screen patients on a limited scale** – in case of complaints, they can manually check their breasts, but that is totally insufficient for early cancer detection. Further, during the evaluation, doctors did not feel very confident to conduct gynaecological check-ups, so gynaecological chairs from the pilot project were not used in visited ambulances. Administration of the gynaecological tests and financing are an issue.

„Without a follow-up check-up in adequate facilities, pre-selection is only a waste of money.“ Doctor, Shida Kartli

Sustainability of results and impacts depends also on the accessibility and quality of **Secondary Health Care in regional centres**. Some patients complained about a low quality of the Georgia health care – they would appreciate *„one centre, where we know the doctors and which we can rely on“*. Regional oncocentres were involved in the evaluated project only to a limited extent, moreover, they did not possess equipment for breast screening and enough specialists. Most specialists involved in the project came from Tbilisi and used brought-in equipment for screening. A private clinic in Guli provides screening with reportedly the only mammograph in Zugdidi. However, the check-ups were done only on a limited basis and for 50 GEL as reported, because the clinic is not involved in the NSP. Gynaecological check-ups and ultrasound are more accessible in Zugdidi, however have to be paid. Surgery and other treatments are limited reportedly due to bureaucracy. In Gori, Gorimed hospital has all the equipment and specialists available and is involved in the NSP. Nevertheless, it has not promoted free services despite the fact that the mammograph was used only at the half of its capacity. The price for complex breast and cervical screening for those who do not fulfil the criteria of NSP was above 100 GEL.

Active follow-up of patients and their support during the treatment has also proven difficult. As self-help groups were created in the area of implementation only in 2013 except of Tserovany, their sustainability is a question. Further, doctors expressed doubts that the new general health insurance would significantly increase the accessibility of care due to high level of bureaucracy, the necessity to travel to suppliers, lengthy waiting and abuse by clinics. Doctors and nurses thus asked for the continuation of the evaluated project.

Sustainability of outputs is limited. **Training sessions** have not been accredited (similarly to e.g. the trainings of UNFPA) and have not been handed over to regions in a compact form. Further trainings depend on the availability of funds. The implementing agency is consolidating the **project database** and is ready to share it with Georgian national institutions. The project health records are not being maintained as mobile clinics do not operate anymore.

Overall, it is not clear which institution would be accountable for sustaining outputs, results and eventual impacts. Neither the agreement between CZDA and Caritas CR, nor the contracts with local partners, or the Memorandum of Understanding with MoLHSA specify these commitments. There

are no clear responsibilities of each institution and no further funding. Negotiations were not held e.g. with local authorities or regional oncocentres with respect to fundraising, besides that these institutions were not involved in the project very much and did not have a financial or other ownership. The evaluation team thus perceived a frustration among target groups deriving from the exit of the provided support. The project sustainability thus depends mainly of the health reforms.

1.1 Impact

The project has directly reached 1033 persons through awareness raising, whereby an increase to 1630 is expected by the end of 2013. Thus about **1,5% of population** of involved villages will be reached[29]. Further, it can be assumed that the project will indirectly reach out to min. 5.000 family members. The ambulance staff confirmed a change in attitude of a number of patients. At the focus groups, women expressed their big interest in health issues; nevertheless, they were concerned about the screening and treatment difficulties.

„Earlier, cancer was perceived as fatal. Now women know, that if cancer is diagnosed early, it can be successfully treated.“ Doctor, Shida Kartli

As per the implementing agency, **65% women diagnosed with cancer and 4% women diagnosed with pre-cancer were actually treated**; however, the data are incomplete. The treatment depended on available funds (from health insurance or own resources), trust in concrete doctors and facilities, accessibility of facilities and previous experiences. The evaluation has also identified some cases of inappropriate or inadequate treatment, either too costly, consuming procedures, or missing radiotherapy[30], which is likely to have led at least in some cases to cancer relapse. Several patients have admitted that they do not comply with recommended treatment due to financial reasons, especially with respect to recommended drugs. According to doctors, at least 5 patients died during the course of the project on one hand and several women were successfully treated on the other hand.

„I am married and have a child. In the past, I was operated due to breast cancer. The treatment cost me 120 GEL, the remaining 1150 GEL were covered from the insurance. (Thanks to the project) I was also diagnosed with cervical cancer two years ago. (At our village clinics) they checked me and sent me for radiotherapy in Kutaisi. But my husband is handicapped due to the war and our family income of 239 GEL is not enough to cover even the basic needs. We use bank loans. I do not know what will happen to me, but I feel that the complaints are worsening.“ Woman, 42 years, Chitatskari

[29] An estimate of total population of 68.690 was used from the analysis of CZDA health expert.

[30] In Georgia, according to the MoLHSA, there are only 2 linear radiotherapy machines at the University hospital in Tbilisi and 1 functional cobalt radiotherapy machine at NCC. It was not possible to find out if 2 further cobalt radiotherapy machines reportedly from the Soviet era were functional.

„I am married and have a child. I am a chemistry teacher. At a mobile clinic 2 years ago, I was diagnosed with cervical precancerosis. I do not know the exact diagnosis. They recommended treatment in a hospital, but I preferred my gynaecologist. The insurance covered treatment, but not the 10-day stay which cost me 300 GEL *(181 USD)**. I have similar complaints today. When I heard about the Czech team, I hoped to be checked.**“* Woman, 26 years, Jikhashkari[31]

A **big shift in attitude of doctors and nurses** towards patients happened, as reported by the implementing agency and local partners. One nurse mentioned an improvement in palliative care as she applies pain killers in a better way. During the evaluation, a big interest in providing quality care and enhancement of knowledge was identified not only among the staff of the involved, but also of the neighbouring ambulances.

The approach to prevention, resulting in a **high demand for check-ups** was highly appreciated by MoLHSA during the final evaluation debriefing. The representative expressed great interest to **use these experiences for the NSP**. Based on experience sharing, other institutions may be inspired. Nevertheless, no such case was identified during the evaluation, not even at Caritas Armenia, which considered a similar project in 2012.

4.5 External project visibility in Georgia

Caritas CR presented the project to MoLHSA in January 2013 and subsequently involved in the preparation of the strategy also other national institutions – NCDC and NSC, who were aware of the project. **Other organisations**, for example UNFPA, were not informed about the project until July 2013, when experience sharing took place at UNFPA. Training, best practice guidebooks and other outputs are planned to be shared by the implementing agency at the project conference in autumn 2013. The project collected one **media output** in the CR as per Caritas CR[32]. A project spot was reportedly screened on regional television in Georgia. Other media outputs were not identified despite a press release on the occasion of signing the Memorandum of Understanding with MoLHSA.

Target group involved in focus groups was informed in 4 out of 5 visited villages about the concerned “Czech project”. An exception was a group created only upon the arrival of the evaluators – some women did not know about the project at all. Logos of Czech ODA were displayed in offices of the implementing agencies and its partners as well as in 4 out of 6 visited ambulances. They were also placed on mobile clinics. Some ambulances had also brochures available. The ambulances have not displayed any posters promoting cancer prevention (e.g. breast self-examination) or tuberculosis prevention, which could have supported the visibility even further.

[31] The note of the oncologist from the evaluation teams: According to the description, this was likely an error in treatment. As health records are not available, the hypothesis cannot be confirmed. The team recommended immediate free screening at a concrete clinic in Zugdidi.

[32] http://www.rozhlas.cz/radio_cesko/exkluzivne/_zprava/cesko-pomaha-s-prevenci-a-vcasnou-diagnostikou-rakoviny-v-gruzii--1038237 from 28 March 2012, visited 3 July 2013

4.6 Cross-cutting principles of the Czech ODA

Respect for human rights and gender

The project focus is directly linked to the respect to human rights, namely the equal access to health care. Both the target groups and the involved institutions have appreciated during the evaluation, that the project focused on all women in the given regions, both on local and on internally displaced ones and what is more, regardless of their age. Pre-selection and waiting lists were perceived as fair tools, determining the women´s order for check-ups. Husbands and families had an indirect influence of passing the check-ups and treatment. Nevertheless, the persons reached by awareness raising are not disaggregated by gender, therefore it cannot be assessed to which extent men were included, though individual interviews show a rather minor involvement. Only one male doctor worked among all involved ambulance staff. A number of patients and even doctors noted that some women were discouraged from the check-ups due to the fact that the mammologist was a man, though others confirmed his high sensitivity. Several women as well as representatives of local partners would appreciate a project focusing partially even on men, e.g. on prostate cancer.

Good governance

The principles of good governance are reflected across the project. The project was **identified** by CZDA upon consultation with MoLHSA, NCC, CSC, UNFPA and partners of the pilot project. Specific villages were selected by the implementing agency, local partners and the CZDA expert based on technical and practical criteria. However, regional oncocentres and local authorities, who provide funds to economically deprived citizens, were not involved in the selection process. The **tender** (as opposed to a grant) was chosen by the CZDA due to clear objectives, outputs and procedures.[33]

The CZDA and the implementing agency cooperated with national institutions (MoLHSA, NCDC and NSC) especially during the project identification and formulation and further within the established working group. Until now, the group has been still getting acquainted with the project and no decisions have been made on the strategy. It is not planned to function after the project end. **Limited cooperation with other institutions** was already mentioned in the subchapter on sustainability. Regional oncocentres and local authorities were not involved in decision making despite the fact that they have available equipment and specialists, eventually even funds for treatment.

> ***„The project was beneficial for the patients, but not for us. We did not get any equipment. Our specialists left. Nevertheless, we should be the ones providing complex services including treatment to the patients.***“ Representative of the oncocentre in Zugdidi

Environmental protection and climate change

The project did not have any influence on environmental protection and climate change.

[33] In future, according to the valid public procurement law, it would be necessary to write the terms of reference in a way so that bids from more applicants are received. In the case of just one bid, the tender will have to be cancelled.

5 EVALUATION CONCLUSIONS

Relevance

The project was rather relevant both taking into account the needs of the Georgian health system in 2010 as well as the priorities of the Czech ODA. The project was one of the few to focus on breast and cervical cancer in rural areas and was thus complementary to the National Screening Programme, which has been implemented in urban areas. Through community work and ambulance staff, the project has strengthened the prevention, which was limited till then, as well as diagnostics and indirectly even treatment. It was very ambitious with respect to the number of regions involved and the expectations that it would link to secondary and tertiary health care, which would be functional by 2013. It has insufficiently reflected regional disparities in screening and treatment options. Partners maintained communication with state actors –MoLHSA, NSC and from 2013 also with NCDC. Regional facilities included in NSP or those with equipment and specialists for secondary check-ups were not involved. Cooperation was coordinated with other implementing agencies (UNFPA etc.) only since 2013. A replication of the approach seems to be limited due to local specifics as well as premature.

Efficiency

The project efficiency was **rather low.** The total budget of 10,9 mil. CZK (approx. 552.400 USD). Was fully funded by CZDA, local partners provided mobile clinics. The Georgian side has not co-funded the project, even if local authorities financially contribute to cancer prevention and treatment (e.g. via NSP or contributions to the poor). Inconsistent documentation (e.g. incomplete reporting of administration costs, unit rates or the number of screened women) limited the evaluation as well as the possibility to properly manage costs and thus insure their optimisation. Based on the analysis of actual expenditures in 2011 (3,9 mil. CZK) and 2012 (3,5 mil. CZK), high administrative costs related to project implementation (personnel costs for the project management and coordination, travel costs of the project team and other administrative costs) have been identified, reaching 45% and 54% respectively of the total expenditure. This is because of a higher number of project partners and high overhead costs of Caritas CR. Derived from direct costs related to mobile clinics, it can be stated that the tax payer paid 918 CZK (46 USD) per screened woman and 96.104 CZK (4.867 USD) for a positive diagnosis[34]. The implementing agency has not reallocated the provided funds, reflecting these unit costs and the insufficient number of screened women by the end of 2012 (3.244[35] versus the target of 8.500). The cooperation with CZDA health expert during identification, implementation and evaluation was assessed positively. The launch of the health records and reporting enhanced the project management, but the outputs are inconsistent. Partial internal evaluation is also appreciated, though their reliability is lower due to inconsistent data. Local partners were not fully informed about the project, e.g. the total budget, and have not taken part in strategic decision-making, which is assessed negatively. According to the Czech Embassy, the absence of a Project Coordinator of Caritas CR in

[34] As a benchmark – The Analysis of the CZDA expert, MUDr. Voříšek, from 12 May 2013 shows the following costs: 36 EUR per screened woman and 2.805 EUR per cancer diagnosis. The costs of NSP are according to the NSC 22 GEL for complex breast screening and 28 GEL for gynaecological screening, still this comparison is not very relevant due to other methodology and the inaccessibility of NSP calculation, therefore it could not be checked which budget items were included.

[35] According to Caritas CR, 9.000 women were pre-screened, still the evaluation team has not received any evidence confirming the same.

Georgia from spring 2012 to spring 2013 negatively influenced especially cooperation with other institutions as well as monitoring of field work including data quality.

Effectiveness

Project effectiveness was **rather low** due to lower number of screened women and limited possibilities to influence the treatment (conditioned by the current situation in the Georgian health system and the capacities of oncocentres)**.** The project managed to show that in case of sufficient awareness raising, the proactive attitude of ambulance staff and accessibility of services, the number of women screened from rural areas of Georgia can be considerably increased . Quantitative indicators of the activity level will probably be fulfilled (144 awareness raising activities, 150 peer trainers, 27 involved ambulances and trained personnel). However, half of the awareness raising activities are planned for 2013, whereby those interested are not directed to concrete facilities. This lowers the effectiveness. In total, only 3.244 women were screened instead of 8.500 (Caritas CR estimated 9.000 women including those pre-screened, however, the number could not be verified). Proactive follow-up supported the participation of 64% women (303 of 474), which is above the average of 50% at the NSP and thus can be assessed as rather effective. The incidence rate of 1,18% in 2011 and of 0,58% in 2012 from the total number of women screened was much higher than at the NSP in 2011 (0,065%). Based on the analysis of the CZDA expert on health, dated 12 May 2013, 17 so called „old ambulances“ involved since 2010 gradually experienced diagnoses of earlier staged of cancer from 33% in 2010 to 76% in 2011. In 2012, only 5 diagnoses were found and a similar analysis was not done. Based on the analysis, „the National strategy for prevention and early diagnosis of breast and cervical cancer in rural areas“ is being developed by August 2013. Approval by MoLHSA is still uncertain. Data on tuberculosis have not been collected and thus no conclusions can be made about them.

Sustainability

Project sustainability is **low**, as it relies on uncertain approval of the above mentioned strategy and existence of accessible screening for target population. However, health reform is currently being put in place; extensit of cancer screening and treatment to rural population is thus delayed. Ambulance doctors can exercise only limited check-ups and the target population lacks information about alternatives (e.g. in clinics, which are involved in NSP). Therefore the number of screened women significantly decreased in 2013 despite an increased demand. Insufficiently sustainable mechanisms for cancer screening and treatment (especially low involvement and capacities of regional oncocentres) would with doubts lead to long-term increase of probability of patients´ survival. In overall, the exit strategy is not clear. In overall, there is no clear exit strategy. There are no agreements on which institution is accountable for sustaining outputs, results as well as all impacts. No negotiation e.g. with local authorities or regional oncocentres was held on further financing of mobile clinics. Moreover, they were not much involved in the project and did not have financial or other ownership.

Impact

The project's impact on the awareness of the target population is assessed as **rather high**. Impact on the strategic level can only be assessed in 2014 when the (dis)approval of the strategy development and the health system reforms will bring their effects. Awareness raising is estimated to reach 1630 persons directly and min. 5.000 indirectly (4,5% of target population in target villages). As per Caritas CR, 65% of 31 cases of cancer and 4% of 48 cases of precancerosis were treated, which is above the national level (25%) reported by Caritas CR, but still alarming. During the project, a minimum 5 pa-

tients died; some got partially inappropriate or insufficient treatment, either too costly and challenging treatments, or missing radiotherapy (treatment was not covered by the project), which has probably led to cancer relapse. Complete statistics, however, are not available. The evaluation team noted a high interest of ambulance doctors and nurses in cancer and motivation in patients´ follow-up, but low awareness on accessible screening and treatment including prices. Nevertheless, these are the main arguments for patients´ absence, and therefore need to be urgently addressed. The approach to prevention leading to increased demand for check-ups was highly appreciated by MoLHSA. If the strategy is partially reflected in the NSP, the project can have a wider impact.

Other criteria

Visibility of Czech ODA in assessed as **rather high**. Key national institutions and the target group were informed about the project and the donor. Logos of Czech ODA were displayed in offices of the implementing agency, its partners as well as in 4 out of 6 visited ambulances. Still, other organisations, such as UNFPA, have not been informed about the project until July 2013 and media visibility could have been improved. The project produced one media output in the Czech Republic[36]. Project spot was reportedly screened in the regional television in Georgia, but media responses were not recorded.

The **respect to human rights of the beneficiaries including gender** can be indicated as **high**. The project enabled equal access to health care. It focused on all women in the given regions, local and internally displaced ones, regardless of their age (in contrast to NSP). Most interested women received the services . Men were usually not directly involved (records of awareness raising events did not include statistics by gender), still they have indirectly influenced check-ups and treatment follow-up. Several women would appreciate a project for men, e.g. on prostate cancer.

G**ood governance** is assessed as **rather high**. Involvement of MoLSHA and other relevant national institutions in both the project formulation and in the last year of implementation during strategy drafting. Nevertheless, it was also possible to improve the cooperation with regional oncocentres, local authorities and other institutions.

The project did **not** directly **affect** the **environmental protection and climate change**.

[36] http://www.rozhlas.cz/radio_cesko/exkluzivne/_zprava/cesko-pomaha-s-prevenci-a-vcasnou-diagnostikou-rakoviny-v-gruzii--1038237 from 28 March 2012, visited 3 July 2013

6 RECOMMENDATIONS

Recommendation	Justification	Type / level	Main addressee	Level of importance[37]
1. Focus on sustainability till the end of 2013: - Inform the target group about screening and treatment options after project end, including concrete health facilities and prices, while taking into account current health system reform and launched national health insurance. - Finalize project database including data on stages of cancer, treatment and actual status of patients, then finalize project statistics and provide these to relevant actors, who can follow-up on the project. - Handover each activity/outputs to local institutions and have an agreement on project continuation if possible. Strengthen cooperation with other organisations in the sector in order to reflect project outputs in their work (especially awareness raising, involvement of primary health care and the need for treatment).	According to the findings of the evaluation team, the target group especially does not know about the screening (free or paid) and treatment possibilities where they live or in the neighbourhood. Patients do not sufficiently know their rights. There is a notion that screening and treatment are expensive, but even the village ambulances could not provide more information about the charges. As a result, patients do not go through the full treatment or do not undergo new screenings (e.g. in case of relapse). Inconsistent data limit the reliability of analyses, which are provided to relevant actors. In overall, there is no clear exit strategy. There are no agreements on what institution would be responsible for sustaining outputs, outcomes and ultimately impacts.	Project	Caritas CR with Tanadgoma and CPC	1
2. Launch a coordination group focusing on cancer (breast and cervical) under the MoLHSA, which would coordinate activities of different institutions, donors and implementing organisations as well as support sharing of experiences, successes and challenges.	Nowadays, there is no formal coordination among institutions. In some villages involved in the evaluated project, Greek clinics were independently operating. Projects from other regions are not centrally shared and coordinated.	Project	MoLHSA with NCDC and NSC	2

[37] Scale: 1 most important – 3 least important

Recommendation	Justification	Type / level	Main addressee	Level of importance[37]
3. Require a budget by items and a sustainability plan before or shortly after project launch (as a part of the first interim report), including contractual obligation of sustainability by local partners (state actors, local authorities), strengthening of their capacities **and co-financing**.	The offer of the implementing agency included a budget by phases (activities), whereas expenses reporting used the budget by items. Neither the project terms of reference, nor the offer included a sustainability plan. There were no commitments to sustainability in the agreements of the CZDA with Caritas CR, or in the agreements with local partners or in the Memorandum of Understanding with MoLHSA. Relevant regional institutions were not involved in the project. Co-funding was missing.	Process / System	CZDA	1
4. Launch **more effective monitoring and internal evaluations**: - Revise the project logical framework if needed, so that it reflects the reality (as a part of an interim report). - Conduct results-oriented monitoring[38] by CZDA and the Czech Embassy. - Launch internal project evaluations above a certain budget, follow their clear Terms of Reference, results and follow-up on recommendations.	During the implementation, the implementing agency found it unrealistic to achieve required indicators, especially the number of patients screened. However, it but did requested in a written form an eventual revision of the project logical framework. Interim reports did not clearly indicate insufficient achievement of indicators. Internal analysis in 2013, written by the CZDA expert, has focused rather on the effects of the pilot project and activities in 2011.	Process / System	CZDA with MFA and the Czech Embassy	1
5. Introduce a **holistic, complex approach to the fight against cancer with a focus on treatment –** followed up by a project **in the Samegrelo region** supporting patient care from prevention, to wide-scale screening, mainly to treatment, to active follow-up and psychosocial care. Include urban clinics, which provide free screening and further treatment. Ensure a cobalt radiotherapy machine in Kutaisi. Besides the training of specialists also	It is crucial to ensure that women diagnosed with cancer are treated correctly – for early stages, radiotherapy is necessary, however, its is almost inaccessible in Georgia (only in Tbilisi, in Kutaisi it is supposedly not operating). Alternative chemotherapy is inappropriate and costly. Therefore a functioning radiotherapy machine in Kutaisi with qualified staff is a top priority. Further, it is important to link rural	Future project	CZDA with MFA	

[38] See e.g. http://ec.europa.eu/europeaid/how/ensure-aid-effectiveness/monitoring-results_en.htm

Recommendation	Justification	Type / level	Main addressee	Level of importance[37]
direct supervision. Additionally, experience sharing with National Oncological Registrar in the CR. Coordinate everything with the Georgian government.	ambulances with urban clinics, which cater for prevention and treatment (private clinics in Guli, the republic hospital in Zugdidi, eventually involved oncocentres as per the decision of the NCC´s future). More mammographs are needed in Zugdidi. To avoid false diagnosis and inappropriate treatments, direct supervision of specialists is necessary. Patients registrar and follow-up care need to be strengthened. The National Cancer Registrar in the CR is quite unique even in the EU. Everything needs to be coordinated with the Georgian government.			

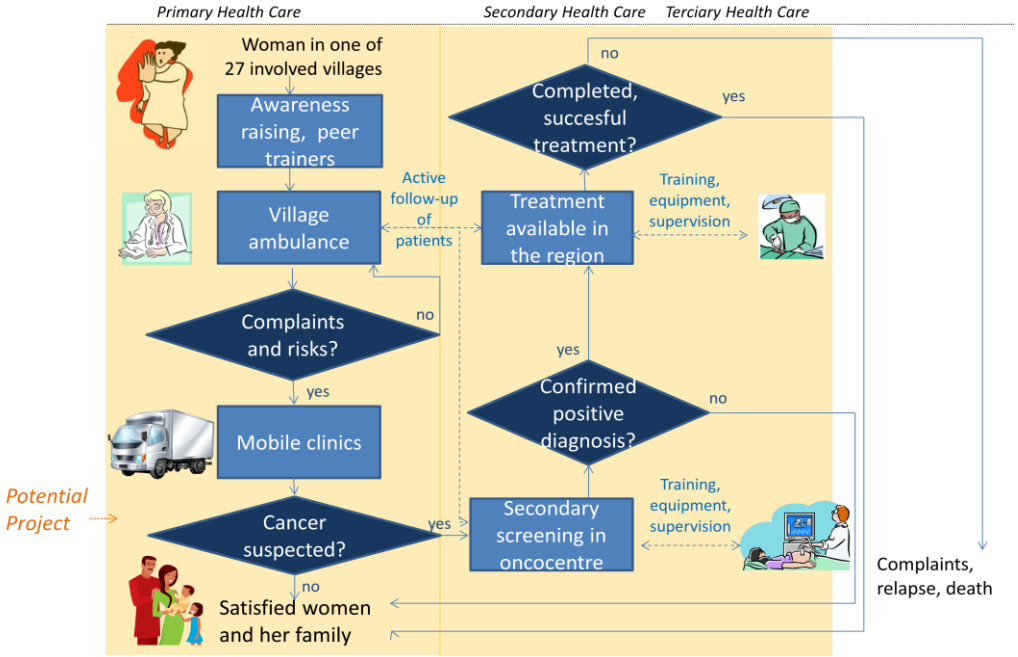


Image 3. Potential future direction of the Czech ODA in the health sector in Georgia

7 ATTACHMENTS

7.1 Abbreviations

CPC	Cancer Prevention Center
CZK	Czech crown
CR	Czech Republic
CZDA	Czech Development Agency
ESO	European School of Oncology
EUR	Euro
GEL	Georgian Lari
IDPs	Internally Displaced Persons
MoLHSA	Ministry of Labour, Health and Social Affairs of Georgia
MZV	Ministry of Foreign Affairs CR
NCC	National Cancer Center
NCDC	National Center of Disease Control and Public Health
NSC	National Screening Center
NSP	National Screening Programme
ODA	Official Development Assistance
OECD/DAC	Development Assistance Committee of the Organisation for Economic Co-operation and Development
s.r.o.	Limited company
Tanadgoma	Center for Information and Counseling on Reproductive Health „Tanadgoma“
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USD	United States Dollar
WB	World Bank

7.2 Czech Summary

(see separate full report in the Czech language)

7.3 List of reviewed documents and sources

Documents

- Jan Voříšek: Analysis of Czech Cancer Screening and Early Detection Project, especially in comparison to Georgian National Cancer Screening Programme as Input to National Strategy Development, from 14 May 2013
- Chanturidze, et al. 2009. “Georgia: Health system review.” Health Systems in Transition
- Strategy for Official Development Assistance of the CR for 2010 – 2017
- Memorandum of Understanding between CZDA and MoLHSA (without signature)
- Monitoring reports of CZDA health expert from September 2010, November 2011, July 2012, November 2012
- Monitoring reports of the Czech Embassy from 21.4.2010, 19.5.2010, 16.6.2010 and 15.03.2013
- Offer of Caritas CR including annexes
- Assessment of mid-term reports of Caritas CR (by MUDr. Voříšek) – 2 reports of 2011, 2 for 2012
- Mid-term reports of Caritas CR including annexes - 2 reports of 2011 and 3 of 2012, further an annual report of 2012
- Budgets per year and expenses for 2011 and 2012 (internal documents of Caritas CR)
- Project database of screened women
- Tamari Rikhadze: An overview of the health care system in Georgia: expert recommendations in the context of predictive, preventive and personalised medicine, The EPMA Journal 2013
- UNFPA Standard Progress Report 2011
- UNFPA Standard Progress Report 2011
- Annual Report of Adra CR 2009
- Terms of Reference for the evaluated project including annexes
- Terms of Reference for the previous oncological projects in Georgia
- Final report of the previous, pilot project of Caritas CR with annexes
- Minutes of the first and second meeting of the working group related to the national strategy
- Report from the business trip of Daniela Králová – Formulation mission to Georgia: preparazion of the project „Promotion of prevention and early detection of cancer “ on 5 -13 December 2009
- Minutes of the UNFPA workshop from July 2013
- Tables with achieved indicators provided by Caritas CR and partners

Internet sources

- http://ec.europa.eu/europeaid/how/ensure-aid-effectiveness/monitoring-results_en.htm
- http://data.worldbank.org
- http://www.ghi.gov/documents/organization/175130.pdf
- http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/01/09/000350881_20130109102252/Rendered/PDF/NonAsciiFileName0.pdf
- http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3621519/
- http://data.worldbank.org/indicator/SH.TBS.INCD/countries/GE?display=graph
- http://www.georgianews.ge/society/2148-united-nations-population-fund-unfpa-mobile-health-services-for-refugees--hopefully-they-are-not-abandoned-.html
- http://www.worldbank.org/projects/P040555/health-sector-development-project?lang=en
- http://www.rozhlas.cz/radio_cesko/exkluzivne/_zprava/cesko-pomaha-s-prevenci-a-vcasnou-diagnostikou-rakoviny-v-gruzii--1038237
- http://fors.cz/user_files/kodex_efektivnosti_fors.pdf

- http://www.rozhlas.cz/radio_cesko/exkluzivne/_zprava/cesko-pomaha-s-prevenci-a-vcasnou-diagnostikou-rakoviny-v-gruzii--1038237
- http://ec.europa.eu/europeaid/how/ensure-aid-effectiveness/monitoring-results_en.htm
- http://www.unfpa.org.tr/georgia/rh-doing.htm

7.4 Overview of interviews in the CR

(only in the Czech version)

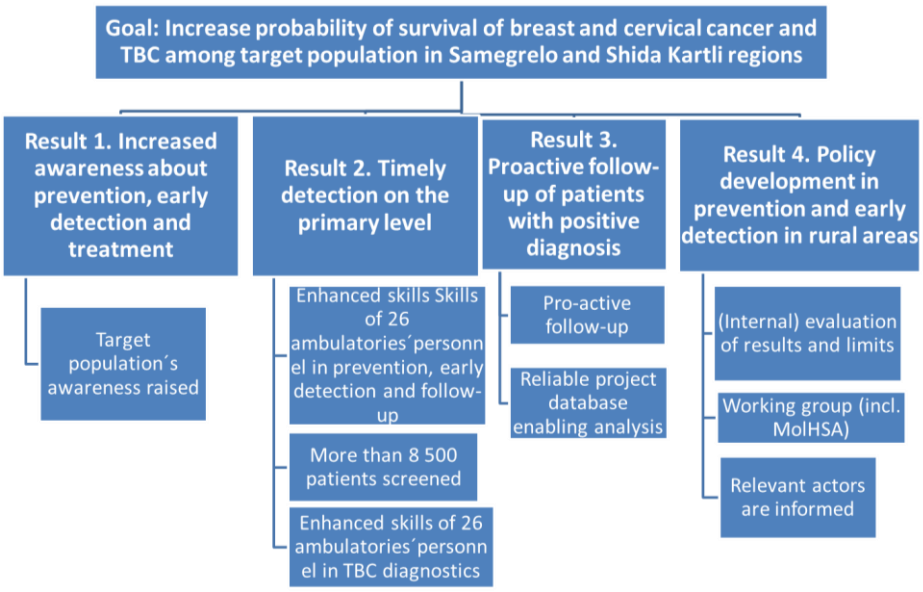
7.5 Overview of interviews, focus groups and visits in Georgia

(only in the Czech version)

7.6 Evaluation Timeline

Activity	Dates
Reference Group meeting	12. 6. 9:00
Mission in Georgia 16.6. Arrival 17.-18.6. Tbilisi 19.-20.6. Zugdidi and Samegrelo region 21.-22.6. Gori and Shida Kartli region 23.6. Tserovani 24.6. Tbilisi 25.6. Departure	16. – 25. 6.
Draft evaluation report	18. 7. 2013
Presentation of the evaluation and its outputs	3. 9. 2013
Final evaluation report including reflected comments	30. 9. 2013

7.7 Project theory



7.8 Evaluation Terms of Reference

(only in the Czech version)

7.9 Evaluation Questions

(only in the Czech version)

7.10 Guidelines for focus groups with doctors / nurses

Location:
Date:

Check at entry to the room:
Name and village (sign the list!) Total No.:
How long on the job in your village? (min. 3 months) Gender:
When did the project start in your village? (min. 3 pers. from old and 3 from new ambulances)
Statistics available (to be filled in the table provided)

Introduction, explanation of the purpose of external evaluation, outputs, users, confidentiality.

Questions:

1. How frequent was breast / cervical cancer and TBC in your village before 2011? *(Relevance, check data!)*

2. What were project´s key achievements in your point of view? *(Effectiveness / Impact)*

3. How has perception of cancer and TBC changed among women and men? What contributed to this? *(Effectiveness – Goal 1: Awareness raising)*

4. Looking at no. of patients screened, treated and followed upon *(see data provided)*, what helped in encouraging them to go for screening / treatment /check-ups? *(Effectiveness – Goal 2: Early detection and Goal 3: Proactive follow-up)*

5. What were the obstacles? How were these addressed by the project? *(Effectiveness – Goal 2: Early detection and Goal 3: Proactive follow-up)*

6. How will the activities continue from 2014 onwards? What is in place (*screening, registrar, your further education in breast/cervix cancer, enrolment in the National Screening Programme…*); what concrete support is still needed and by whom? How will it be funded? (*Sustainability*)

7. Do you have any other comments or recommendations?

7.11 Guidelines for focus groups with women in villages

Location:
Date:

Check at entry to the room:
Name and village (sign the list!) Total No.:
How long in the village? (min. 1 year)
Participated in the outdoor awareness raising activity? (both groups are needed)

Introduction of the project (check that participants know about it and can distinguish it from others) and the purpose of the evaluation, explanation of the purpose of external evaluation, outputs, users, confidentiality.

Questions:

1. What do people think about breat and servical cancer in your village? *(Relevance)*

2. Do you know of anybody who has personally benefited from the Czech project? (prevention, screening, treatment) *(Effectiveness – Goals 1: Prevention, Goal 2: Early detection, Goal 3: Proactive follow-up / Impact)*

3. What do you think motivates women to go for screening? *(Effectiveness – Goals 1: Prevention, Goal 2: Early detection)*

4. What prevents them from getting screened? *(Effectiveness – Goals 1: Prevention, Goal 2: Early detection)*

5. What do you think motivates women to get treated? *(Effectiveness – Goal 3: Proactive follow-up / Impact)*

6. What prevents them from getting treated? *(Effectiveness – Goal 3: Proactive follow-up / Impact)*

7. Do you have any recommendations of comments? *(All)*

7.12 Guidelines for visits of ambulances

Village: Region: Date:
Name of the doctor: Specialisation: Age: Gender:
Living at location:
Name of the nurse:
Total village population:
Total IDP population:
Number and type of other doctors in the ambulance:

Equipment:

- Gynecological chair
- Water
- Electricity
- Registrar (forms, cards)
- Brochures (5 types)
- Project training materials
- Logo of “CR helps”
- Access to internet (at least at home)

Introduction, explanation of the purpose of external evaluation, outputs, users, confidentiality.

Questions:

1. Since when do you work here? What is you background / personal history?

2. How frequent was breast / cervical cancer and TBC in this village before 2011? *(Relevance)*

3. What other projects related to breast / cervical cancer and TBC were implemented in the village (even before, or after 2011)? Who implemented them? What exactly was done? *(equipment provided, awareness raising etc.) (Relevance)*

4. When did the project on breast / cervical cancer and TBC start and how did you get to know about it (who decided about village inclusion)? *(Relevance)*

5. What was your role within the project? *(Effectiveness, good governance)*

6. What were project´s key achievements in your point of view? *(Effectiveness / Impact)*

7. How has perception of cancer and TBC changed among women and men? How have outdoor sessions / peer trainers / nurses / mobile clinics… contributed to this? *(Effectiveness – Goal 1: Awareness raising)*

8. How many patients were screened, treated and followed upon? *(Effectiveness – Goal 2: Early detection and Goal 3: Proactive follow-up)*

9. What helped in encouraging the patients to go for screening / treatment /check-ups? *(Effectiveness – Goal 2: Early detection and Goal 3: Proactive follow-up)*

10. What were the obstacles? How were these addressed by the project? *(Effectiveness – Goal 2: Early detection and Goal 3: Proactive follow-up)*

11. Is there any communication between you and the onco-specialists? If so, how, how often and with how many? What is the communication about?

12. What were the main costs involved in the project? How were these covered? Can it be done more efficiently? (*Efficiency*)

13. Is there any psychosocial care provided? (e.g. psychotherapist, self-supporting groups) (*Effectiveness – Goal 3: Proactive follow-up)*

14. How would you assess the cooperation with CPC, Tanadgoma and Caritas CR? (*Good governance*)

15. How will the activities continue from 2014? What is in place (screening, registrar…), what concrete support is still needed and by whom? How will it be funded? (*Sustainability*)

16. Do you have any other comments / recommendations?

7.13 Guidelines for visit of regional oncocentres

Town:	Region:	Date:
Name of the staff:	Position:	Age: Gender:
Hospital:		
Department:		
No. of oncologists:		
Other staff:		

Equipment:

- Mammography
- Ultrasound
- Cytology
- PAP smear
- Coposcopy
- Biopsy
- Mobile clinic
- Logo “CR helps”
- Presentations/training materials
- Brochures (5 types)

Introduction, explanation of the purpose of external evaluation, outputs, users, confidentiality.

Questions:

1. Since when do you work in the centre (as oncologist/gynaecologist etc.)? What is you background / personal history?

2. What key issues related to breast / cervical cancer have you encountered in the last 3 years (2010 and 2013) in this region? Is the region somehow specific to other regions in Georgia? *(Relevance)*

3. What other projects related to breast / cervical cancer and TBC were implemented in the region (even before, or after 2011)? Who implemented them? What exactly was done? (equipment provided, awareness raising etc.) *(Relevance)*

4. How do you keep yourself up-to-date with the developments in cancer research / approach to prevention, screening, care? Are there any trainings? By whom? How useful are they? Do you use internet? *(Relevance, Effectiveness)*

5. When did the project on breast / cervical cancer start and how did you get to know (who decided about region/village inclusion)? *(Relevance)*

6. What were project´s key achievements in your point of view? *(Effectiveness / Impact)*

7. How have you personally benefited from the project? What have you learnt at the trainings / through the cooperation? *(Effectiveness – Goal 2: Early detection, Goal 3: Proactive follow-up / Impact)*

8. Has perception of cancer changed among women and men in the last 3 years? How? (can you give us an example?) What do you think has contributed to this? *(Effectiveness – Goal 1: Awareness raising - outdoor sessions / peer trainers / nurses / mobile clinics)*

9. Can you provide us with annual data for the region (screening, diagnosis, treatment/follow-up) ideally split by village? *(Who collects such data?)* Can you observe any trends (e.g. between intervention and other areas, most frequent treatments done…)? *(Effectiveness – Goal 2: Early detection and Goal 3: Proactive follow-up)*

10. What helped in encouraging the patients to go for screening / treatment /check-ups? *(Effectiveness – Goal 2: Early detection and Goal 3: Proactive follow-up)*

11. What were the obstacles? How were these addressed by the project? *(Effectiveness – Goal 2: Early detection and Goal 3: Proactive follow-up)*

12. Is there any communication between you and the ambulance doctors? If so, how, how often and with how many? What is the communication about? Do you provide them with copies of screening/other documents?

13. What were the main costs involved in the project? How were these covered? (by project, by clients, by state / private insurance companies) Can it be done more efficiently? (*Efficiency*)

14. Is there any psychosocial care provided? (e.g. psychotherapist, self-supporting groups) (*Effectiveness – Goal 3: Proactive follow-up)*

15. How would you assess the cooperation with CPC, Tanadgoma and Caritas? (*Good governance*)

16. Are you a part of the National Screening Programme? How have you benefited? How has the project been integrated in this if at all? Do you think some (cluster) villages can become a part of NSP too? Why/not? (*Sustainability*)

17. What would continue and what would change if the project finishes by the year end? How will the screening/treatments/training of doctors and oncologists… be financed? Is any official handover planned? What concrete support is still needed and by whom? (*Sustainability*)

18. Do you have any other comments / recommendations?

7.14 Indicators achievement as per revised logical framework

Area	Indicator	Per log-frame	Added	Target value	2010 (prev. project)	Achieved in 2011	Achieved in 2012	Planned in 2013	Achieved Jan. till April 2013	Achieved 2011 - April 2013	Comment
Purpose: Increase probability of survival of patients with breast and cervic cancer and TBC in Samegrelo and Shida Kartli	No. of diagnosed cases in target areas	x		increase	-	N/A	N/A	N/A	N/A	**N/A**	No data
	No. of diagnosed cases in stage I and II	x		increase	-	N/A	N/A	N/A	N/A	**N/A**	No data
	No. of fatal cases within 1 year of diagnoses	x		decrease	-	N/A	N/A	N/A	N/A	**N/A**	No data
	No. of patients going though treatments (incl. pre-cancer)	x		increase	-	35,82%	41,67%	0	0	**36,71%**	Achieved (data incomplete)
Result 1 Awareness increase concerning prevention, screening and early detection of breast and cervix cancer among target population	Min. 144 awareness activities in the field	x		144	54	36	36	72	18	**90**	Planned to be achieved
	No of persons reached through awareness raising activities (outdoors)		x	-	616	410	420	800	203	**1033**	-
	Min. 150 peer trainers trained	x		150	48	60	38	52	0	**98**	Planned to be achieved
	No. of peer trainers actively engaged in awareness raising		x	-	?	25	21	-	15	**61**	-
	Estimated no. of materials distributed	x		-	N/A	2000	2000	2470	1000	**5000**	-
	No. of persons reached using DVD + TV spot (estimate)	x		-	N/A	1200	1200	2400	600	**3000**	-
Result 2 Effective	Ambulances involved in the	x		26	16	16	11	N/A	27	**27**	Achieved

early detection of breast and cervix cancers of target population at local level	project										
	No. of mobile clinic visits		x	-	N/A	97	66	N/A	163	**163**	-
	No. of Primary Health Care Physicians gone through the training on prevention, early detection and follows up of the breast and cervix cancer	x		-	N/A	0	11	N/A	11	**11**	Achieved
	No. of staff caspable of basic screening of breast and cervix cancer (gone through mobile clinics)	x		52	N/A	32	22	N/A	54	**54**	Achieved
	Min. 8.500 patients screened on breast/cervix cancer in 2011 - 2013 (on the primary level)	x		8500	1.956	2034	1210	N/A	N/A	**3244**[39]	Not achieved
	Out of these, no. of patients screened by mobile clinics		x	-	1.956	2034	1210	N/A	N/A	**3244**	-
	No. of patients referred to secondary screening	x		-	355	324	152	N/A	N/A	**476**	No target
	No. of staff gone through the TBC training		x	-	-	54	N/A	N/A	N/A	**54**	-
	No. of patients screened for TBC		x	-	-	N/A	N/A	N/A	N/A		No data
	No. of patients diagnosed with TBC	x		increase	-	N/A	N/A	N/A	N/A		No data
	No. of patients treated with TBC		x	increase	-	N/A	N/A	N/A	N/A		No data
Result 3 Appropriate and pro-active follow-up of new cancer	No. of women gone through secondary screening on breast / cervix cancer	x		-	302	205	98	N/A	N/A	**303**	No target
	Default rate (women not gone		x		?	63,27%	64,47%	N/A	N/A	**63,66%**	-

[39] According to caritas CR upto 9.000 including those pre-screened, detailed overview of women was not available.

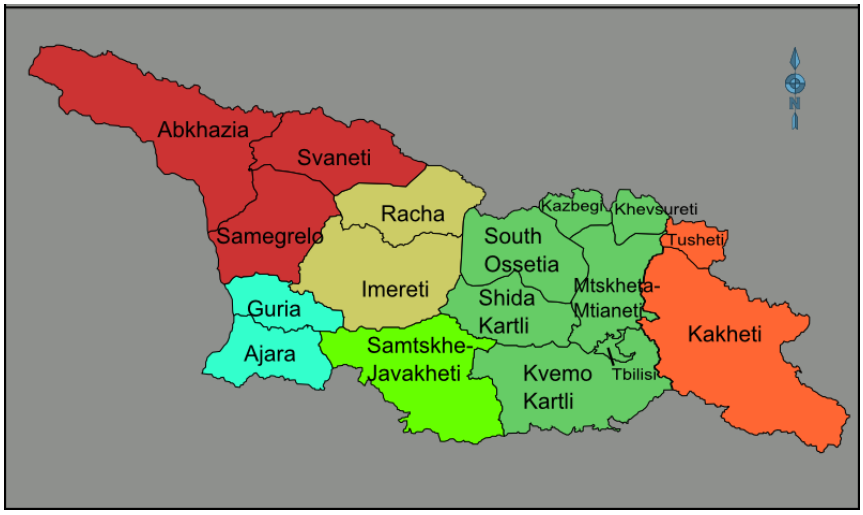
cases, pre-cancer patients and treated patients	for secondary check-up/total no. of women sent)										
	No. of women diagnosed with breast / cervix cancer	x		-	22	24	7	N/A	N/A	**31**	No target
	No. of women diagnosed with pre-cancer	x		-	125	43	5	N/A	N/A	**48**	No target
	Rate of early cancer diagnosis (stage I and II) vs. total no. of diagnosis		x		33% (not verified)	76% (not verified)	no data	N/A	N/A	**-**	-
	No. of patients benefiting from psychosocial assisstance		x	increase	-	32 only in Tbilisi	20 incl. Tbilisi	10	N/A	**?**	-
	No. of patients treated with breast or cervix cancer	x		increase	N/A	15	5	0	N/A	**20**	Not achieved
	Default rate (women not gone through treatment/total no. of women diagnosed with cancer)		x		N/A	37,50%	28,57%	N/A	N/A	**35,48%**	
	No. of patients treated with pre-cancer		x	increase	N/A	2	0	N/A	N/A	**2**	-
	Default rate (women not gone through treatment/total no. of women diagnosed with pre-cancer)		x	increase	N/A	95,35%	100,00%	N/A	N/A	**95,83%**	-
Result 4 Policy development concerning appropriate, comprehensive system of cancer prevention and early diagnose in rural areas	Existence of (internal) evaluation	x		-					done	**-**	Planned to be achieved
	Relevant actors have access to accurate and actual statistical data		x	-				in process		**-**	-
	Existence of functional strategy	x		-				in process		**-**	Planned to be achieved

7.15 Overview of budget items for the purpose of efficiency analysis

(only in the Czech version)

7.16 List and map of ambulances

Map of all reagions of Georgia as per http://en.wikivoyage.org

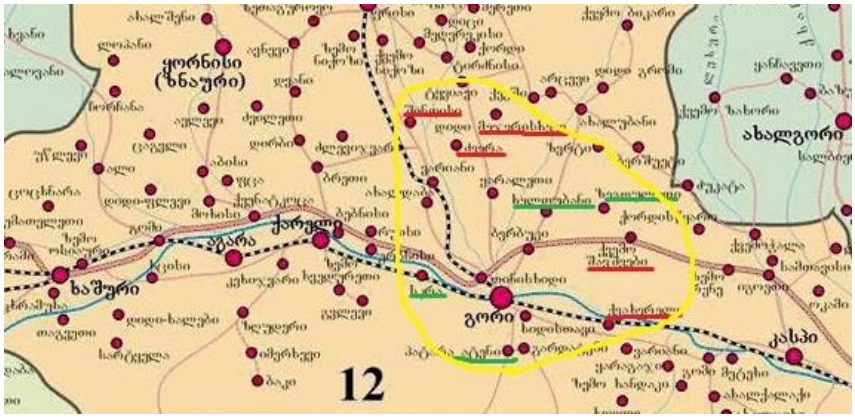


Samegrelo *(regional city Zugdidi, 5 hours away from Tbilisi):*

Old ambulances *(mobile clinics 2010 - 2011):* Caishi, Chitatskari [40] , Ingiri, Achalkakhati, Darcheli, Ruchi, Chkhoria, Korccheli, Achalsofeli and Narazeni

New ambulances *(mobile clinics 2012):* Akhali Abastumani, Octomberi, Jikhashkari[34], Anaklia, Koki

Shida Kartli *(regional city Gori, 1 hour away from Tbilisi):*



Old ambulances *(mobile clinics 2010 - 2011):* Khetulbani[34], Ateni, Skra, Zegduleti, Kurta and Akhalgori

New ambulances *(mobile clinics 2012):* Shavshvebi, Dzevera[34], Qvakhvreli, Mejvriskhevi, Shindisi

+ Tservani[34] was replaced by Berbuki

[40] The evaluation mission visited these villages.

7.17 Selected photos from the evaluation mission

(only in the Czech version of the report)

7.18 Table of incorporated comments by the reference group, gestor and implementing agency

(will be included in the final version of the report)