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REPORT ON THE EVALUATION

OF A PROJECT UNDER THE CZECH REPUBLIC'S DEVELOPMENT COOPERATION IN THE HEALTH SECTOR

Promoting cancer prevention among women in the Šumadija region

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Identification form

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EXECUTIVE SUMMARY

The project **Promoting cancer prevention among women in the Šumadija region** was implemented in Serbia from 2010 to 2012 by Caritas Czech Republic (CR) and Oaza Sigurnosti on the basis of a public tender. The total costs of 10,5 mil. CZK (552 632 USD) were funded by the Czech Development Agency (CZDA). From June to September 2015, an external evaluation was commissioned by the Czech Ministry of Foreign Affairs (MFA) and held by the Naviga4 evaluation team. The evaluation covered the whole project, its relevance, complementarity, impacts, sustainability till June 2015, and potential for future collaboration. The main purpose of the evaluation was to influence future direction and methods of implementing the Czech development cooperation in Serbia and/or the health sector. It was expected to form a part of the basis for the overall evaluation of the Development Cooperation Strategy of the Czech Republic for 2010 – 2017.

The key findings and conclusions are given below:

***High relevance*: the rural screening was a strategic step, in line with the needs of women / medical staff**

The project responded to a very high incidence rate of cervical cancer and an increasing mortality rate of cancer among women. The primary health services were not and still are not easily accessible in rural Šumadija region. Yet, a majority of women is eager to use a sensitive, low-threshold service such as the one piloted by the evaluated project. This project was in line with the priorities of the Development Cooperation Strategy of the Czech Republic for 2010 – 2017 and the strategic policy documents of Serbia related to early detection of cancer. It was well-timed before the launch of the national organized screening. It responded well not only to the needs of the women from rural areas, but also to the medical staff in Kragujevac, who received training and equipment necessary to perform the screening well. Only a national advocacy towards the Serbian Ministry of Health was missing.

***High efficiency*: good practice in the local multi-actor cooperation and screening cost-efficiency**

The cooperation with the local municipality, the medical institutions and the implementers was found very efficient. The entities naturally utilised their possibilities, such as access to the population or to the media. All actors worked as a team, in a synergy that contributed immensely to project outputs. The project was cost efficient. It utilised current equipment where available. Any purchases of equipment or vehicles were necessary for quality project outputs. The remuneration of medical staff during weekends was also necessary, as this was clearly above their standard duties. The direct costs of 2 000 RSD per screened woman (450 CZK, 17 EUR) was very reasonable taking into account the standard of GDP per capita. There is no evidence that any alternative with less funds or less time or with greater regard to local conditions would lead to the same outputs (4.292 women screened). Taking into account its 20 % of the total budget spent for remote management and field visits, Caritas CR could consider a full-time Serbian project manager (this was reported by Caritas CR as their current practice in case of projects with a certain budget), with international donor experience, who could have also engaged in on-going national advocacy.

***High effectiveness*: A sensitive, grass-root approach led to 52 % of all rural women screened in 2 years and in a high incidence rate of cervical cancer found at an early stage. This enabled timely treatment.**

The medical and project team was very dedicated. It went beyond the project plan and involved basically all villages of Šumadija region (50 instead of 40 planned) plus 3 districts of Kragujevac city. Personal invitation of

> *"The project shows why prevention is important. Cancer treatment (at a later stage) is not only more expensive, but it has also devastating psychosocial impacts."* Former project manager

an active volunteer or even medical staff, and comfortable, sensitive group screening "at their door steps" were among the key factors that contributed to exceeding the target of 4 000 by 292 women screened. Covering around 52 % of total rural female population in 2 years is evaluated as a big success. Personal results delivery and multiple follow-up by phone with the patient and her family resulted in relatively high follow-up rate (74 %) among women with positive results. As a part of remaining 26 % may have been further checked in other facilities, the number of women without follow-up is deemed low. Psychosocial support of families and addressing stigma in rural population may help in the future.

The high cancer incidence rate (330 cervical cancer cases per 100 000 women), which is far above the Serbian average, confirms both the relevance and effectiveness of the field screening. As mostly early stages were diagnosed (88 % of diagnoses, data may not be complete) and almost all women quickly started their cure, their likelihood of survival is high and the health expenses comparatively low. This is mainly thanks to a dedicated local medical and project team and partners that went beyond the project and ensured follow-up even for those with financial or social constraints. The conclusions about behaviour or attitudes of the target groups as of 2015 are described in impact.

***High impact*: More than 100 lives saved and more women screened after the project ended**

> "*You saved my life. The surgery was done 3 days after I learnt (screening) results. If it was not for the project, it would be too late (to get treated when symptoms occur).*" Cancer patient

The project has contributed to an increased awareness about the need for early detection of cancer among rural women, even though women still need more details about what they are eligible for and when. They also need more information about prevention, including HPV (human papilloma virus) and other risk factors. The project contributed to an equal access to health care by extending the target group and involving also vulnerable women, such as socially excluded Roma women in Kragujevac or women in rural areas without health insurance. The project contributed to behavioural changes among them – some continue screening and pay it from their pocket, knowing this is important. As the medical staff ensured that women got quickly treated, the project helped to save lives of more than 100 women. Thanks to the project, women started to trust doctors more and those without a gynaecologist could select one. The increased public awareness, a positive experience with screening and increased medical staff capabilities likely contributed to an above-average participation rate in the national cervical screening in the area served by Kragujevac medical facilities. Detection of cancer mainly at early stages (currently 99 % according to the National Screening Centre, data may be incomplete) enables timely intervention, higher likelihood of successful treatment, reduced negative psychosocial impacts and reduced health expenditures.

***Rather high sustainability*: benefits for insured women and doctors continue, but the vulnerable women are left out as rural screening does not continue. For 9 135 USD, about 12 women can learn about their cancer in time and increase their chances for survival!**

> "*I tell others to go immediately (for screening). If it wasn´t for the check-up, I would not even know (I had cancer). … You saved my life.*" Cancer patient

Even if most women in rural areas currently have a gynaecologist and organized screening is available in ambulances, only some have utilized this service since 2013 due to multiple barriers: low awareness about non-symptomatic cancer, about prevention and patients´ rights, low accessibility of health insurance and leaving out vulnerable women who may face higher risk of getting cancer, understaffed health centres, unclear coverage of cytology from health insurance and thus limited willingness of some doctors to increase the number of women screened, limited screening accessibility and productivity as well as patients´ experience with diverse quality of health care and thus hesitance to go for screening or treatment. Specifically, women

without health insurance are not invited for the organized screening and are thus left out. Even though the project and the medical staff as well as the current Kragujevac municipality head for health issues really own the project results and are still passionate for field screening, there is no institution which would be the driving force behind its continuation. Even though the Health Centre in Kragujevac expressed the interest to continue, this was not officially addressed and funding was not secured. If field screenings were done just one Sunday a month, 480 women can be screened for a total cost of 960 000 RSD a year (around 9 135 USD or 212 000 CZK). If the incidence rate remains as in the project, about 12 women could be diagnosed with cancer and could be saved for relatively low costs as mainly early stages of cancer are likely to be found. During the evaluation, multiple financing options were found. An „advocate“ was needed to explore them and drive a solution.

> "*We need quantity, quality and continuity.*"" Roma coordinator

***Rather high good governance*: high local participation, flexibility, national decision makers were missing**

The project was developed and implemented in a participatory way, with local decision makers. As it was a pilot project, the actors had not had similar experience. Thus flexibility of activities was necessary to achieve project objectives. However, the scheme of the project implementation (a tender) did not leave enough room for such flexibility. Thanks to the implementers´ accountability to target groups, the key change was solved outside of the original budget: follow-up screening costs were paid from the exchange rate surplus and unrealistic requirements for equipment were retrospectively adjusted with the CZDA. Yet, this shows a need for a systematic and more flexible solution (e.g. grants). Publishing results as a scientific article shows the commitment to inform about the success of the approach. An internal evaluation could have indicated for example the need to focus more on sustainability. More thorough national advocacy, planned at the formulation stage, could have been of a big added value (e.g. participation at national cancer conferences, in dedicated committees etc.).

High respect for human rights of beneficiaries and gender equality in access to health care

The project ensured an equal access not only to screening, but to treatment for vulnerable women. Women and girls were the main focus of the project. Men were reached out to indirectly via media and involved in treatment as necessary, which is reasonable. Evaluating awareness and attitudes of men to cancer is worth further research.

No major influence on environmental protection or climate change

Rather high project visibility in the Šumadija region, low visibility on the national level

The regional promotion of especially cervical screening via multiple communication tools and channels helped to raise awareness and visibility. Still, women learnt about screening mainly from volunteers or peers. Brochures were found rather complex for beneficiaries. While the implementer believed leaflets or posters would not make a difference, according to the evaluators, they can have a strong impact if displayed clearly at waiting rooms of doctors. The donor visibility was insured where possible. Target groups and beneficiaries mostly knew the project was "Czech", which is deemed sufficient. Yet, a distinctive logo could also help in promotion. The positive results could have been promoted more on the national and international levels, for which more capacities and structured activities in Belgrade would have had to be planned during the project formulation. Stronger visibility in the Czech media would also help to promote the Czech development cooperation among public.

High complementarity to the projects of the EU and JICA, yet, no special collaboration

The project complemented the efforts of the EU (European Union) and the JICA (Japan International Cooperation Agency), which worked with the same institutions on the national and regional levels. Even though there was no specific collaboration, the evaluated project basically supported the awareness, skills and attitudes of medical staff and rural women to take part in the organized screening. Simultaneously, the national screening programme

was prepared by the EU and the JICA. The complementarity to a small-scale screening support by Norway is not known. There is no evidence that synergies with other Czech projects were sought.

High potential for follow-up collaboration on field as well as on system level

All needs identified were found relevant except of in-vitro fertilisation, which the oncology expert of Naviga 4 sees as a far-away (and also expensive) step. Basic health care needs to be secured first. Opportunities are listed in recommendations.

Based on the above conclusions, following recommendations were drawn:

Recommendation	Addressee	Seriousness
Project and Serbian national level		
1. Advocate for state policy change to cover screening of uninsured women and replicate the field screening piloted by the evaluated project to reach out to vulnerable women at high risk of cancer	The Czech Embassy towards the Serbian Ministry of Health	1 – most serious
2. Further raise awareness about cancer prevention at schools and mobilize the public for screening	The Kragujevac municipality	2 – rather serious
3. Offer experts, capacity building or twinning for the following priority areas: • HPV testing / research in Kragujevac • National oncology data management for evidence-based policies • Revision of breast screening procedures to increase productivity • Training of doctors / medical trainees in tailor-made cancer treatment • Strengthening cancer patient associations, their services to patients, campaigning and advocacy	The CZDA with the Czech Embassy in Serbia	1 – most serious
Czech ODA system level		
4. Ensure thorough stakeholder mapping and key actor involvement during the whole project cycle	The CZDA (tenders), implementers (grants)	1 – most serious
5. Launch complex projects as grants to ensure enough flexibility	The CZDA	2 – rather serious
6. Include on-going advocacy to projects (evidence-based policy briefs, meetings with ministries, conferences etc.) where relevant to increase impacts and sustainability	The CZDA	2 – rather serious
7. Train Embassies in the project cycle management, including results-oriented monitoring	The MFA CR with the CZDA	1 – most serious
8. Request evaluation in all bigger development cooperation projects (with a budget above 10 000 000 CZK).	The CZDA with the implementers and with the MFA CR	1 – most serious
9. Consider the programme of mutual exchange of experts rather than expert sending; promote the programme among organisations involved in earlier ODA projects.	The CZDA	3 – least serious

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Separate Annexes:

- Presentation of the evaluation debriefing in Kragujevac
- Presentation of the evaluation findings, conclusions and recommendations in Prague
- Executive summary in the Serbian language

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1 INTRODUCTION

1.1 Context

The evaluation covered the project „**Promoting cancer prevention among women in the Šumadija region**“ in its whole scale and implementation period. Further, its impacts and sustainability till June 2015 were assessed.

Coordinator:	Czech Development Agency
Sector:	Health
Implementation period:	2010 – 2012
Project type:	Public contract
Implementer:	Caritas Czech Republic
Total funding from the Czech Republic's development cooperation budget:	10,5 million CZK

1.2 Evaluation purpose

The Ministry of Foreign Affairs of the Czech Republic (MFA), the department for development cooperation has commissioned the evaluation of the project specified above in April 2015. The evaluation was conducted from June to September 2015.

The **main purpose** of the evaluation was to obtain independent, objectively based and consistent findings, conclusions and recommendations that can be considered by the MFA in cooperation with the CZDA when deciding on the future direction and methods of implementing the Czech development cooperation in Serbia and/or the health sector. Specifically, the evaluation was expected to form a part of the overall evaluation of the Development Cooperation Strategy of the Czech Republic for 2010 – 2017.

The concrete **objectives** have been formulated as follows:

- To evaluate the work of the Czech Republic (CR) in the health sector based on the pilot oncology project „Promoting cancer prevention among women in the Šumadija region“, with an emphasis on its long-term impact and sustainability.
- To assess the options for further expansion of development cooperation or the establishment of bilateral cooperation outside the Czech development cooperation framework.
- To assess whether the project activities were linked to any other development cooperation activities of the Czech Republic and/or of other donors in the health sector in Serbia.
- To evaluate any cooperation with other development players in Serbia in the health sector.
- To evaluate or compare project activities with the relevant strategic documents covering the Czech Republic's development cooperation and the strategic documents of Serbia.

1.3 Evaluation questions

The evaluation questions were formulated by the MFA as follows. Some were re-grouped by the Naviga4 evaluation team according to the OECD/DAC evaluation criteria.

- To what degree did the evaluated project conform to the Official Development Cooperation Strategy of the Czech Republic 2010 – 2017 and the strategic policy documents of the partner country in the given sector? To what degree did the evaluated project fulfil the needs of its end recipients? (***relevance***)
- How were the project objectives achieved? What changes attributable to the project are evident in the behaviour or attitudes of the target groups? Which of the activities were the most effective with respect to achieving their objectives? (***effectiveness***)
- Within the evaluated project, how did cooperation with governmental and non-governmental entities proceed? (***efficiency***)
- In what way did the project implementer support local ownership of the project? In what way are local partners making use of the project results? (***sustainability***)
- What are the resulting and objectively verifiable impacts in relation to the intended impacts? What external effects had a positive or negative influence on the project results and impacts? Are there any barriers to the evaluation of impacts (e.g. with respect to the passage of time, insufficient information etc.)? Did the project activities or impacts affect any previously unintended target groups? Who is the resultant project owner? (***impact***)
- Is there evident potential for the establishment of bilateral cooperation outside the framework of development cooperation? Does the possibility exist for a different form of cooperation beyond Czech bilateral cooperation (e.g. engaging Czech organisations in the projects of other donors)? In what areas and by what method could such cooperation be supported? (***follow-up cooperation***)
- Can any system recommendations be derived from the evaluation results to amend the focus or increase the effectiveness of further development projects in Serbia or other countries and sectors? (***system***)
- Have the related activities of the evaluated project been sufficiently well elaborated and logically sequenced? Or, does the project proposal itself indicate the potential for failure with respect to the stated objectives (relevance, effectiveness, efficiency, sustainability and impacts)? (***intervention logic***)

1.4 Evaluation company

NAVIGA4 provides consultant services to the private and public sectors in the Czech Republic and abroad. International corporations, small and medium enterprises, ministries, regions, cities and municipalities form the majority of its clients. Its key business areas are: project and process management, monitoring and evaluation, communication strategies and analysis. Naviga4 has already conducted 3 evaluations for the MFA, including the evaluation of the Czech development cooperation project "**Promotion of prevention and early detection of breast and cervical cancer among women in the regions of Samegrelo and Shida Kartli II**" in Georgia in 2013.

2 PROJECT BACKGROUND

2.1 Women cancer in Serbia

2.1.1 Cervical cancer

The incidence rate of cervical cancer in Serbia is the third highest in the world[i]. The incidence of cervical cancer has been dropping from 27,3 / 100 000 in 2002 to 20,9 / 100 000 in 2008, which the Republic of Serbia explains as the benefit of "opportunistic screening" (around 20 % of women asked for the screening). Nevertheless, the latest estimates from 2012[ii] mention an increase to over 1500 new cases found annually, i.e. 30,2 in 100 000 women, which is double the world average. The age distribution of cervical cancer shows a peak incidence in women of 45 to 49 and of 70 to 74 years of age. Infection with human papilloma virus (HPV) is the most important risk factor for cervical cancer[iii]. The majority of new cases of cervical cancer (about 80%) found in underdeveloped Serbian regions is of later stages of the disease when the likelihood for survival is limited and the treatment is far more expensive than a surgery at an early stage. The mortality was more than 600 deaths a year in 2012, i.e. 7,7 / 100 000. Recently, peak morbidity from cervical cancer has shifted toward younger ages.

Primary prevention includes prevention of HPV infection (health education, vaccination), followed by screening (using the cytological cervical smear known as Pap test), early detection of asymptomatic forms of the disease and finally treatment of premalignant lesions, thus preventing their progression to invasive cervical cancer.

2.1.2 Breast cancer

Breast cancer is one of the most common causes of premature death of women in Serbia[iv]. According to the Globocan 2012 estimates, every year about 4 000 new cases of this disease are registered, i.e. 69 women in 100 000. Breast cancer is usually discovered at an advanced stage. Thus it is the third cause of death in women aged 45 to 64 years. The estimated mortality rate was 22 / 100 000 in 2012[1], which means that more than 2 000 women died from breast cancer each year. Both the incidence and mortality have been constantly growing.

Prevention focuses mainly on screening, early detection and treatment to increase survival.

2.1.3 National programs for early cancer detection

The **National Programs for Early Detection of Breast and Cervical Cancer** (referred to as organized screening) were launched in 2011 to reduce morbidity and mortality. It focuses on health education at schools, public promotion of healthy lifestyles, social mobilization of the population, good organization of screening, quality control in screening and appropriate data collection and processing. Specifically, the detection of cancer at an

[1] For comparison: In the countries of the EU, average annual incidence of breast cancer ranges from 57 / 100 000 (Greece) to 145 /100 000 (Belgium), mortality rate from 18,4 / 100 000 (Spain) to 31,1 / 100 000 (Ireland). While the incidence increases, there is an evident effect of early detection on reducing mortality.

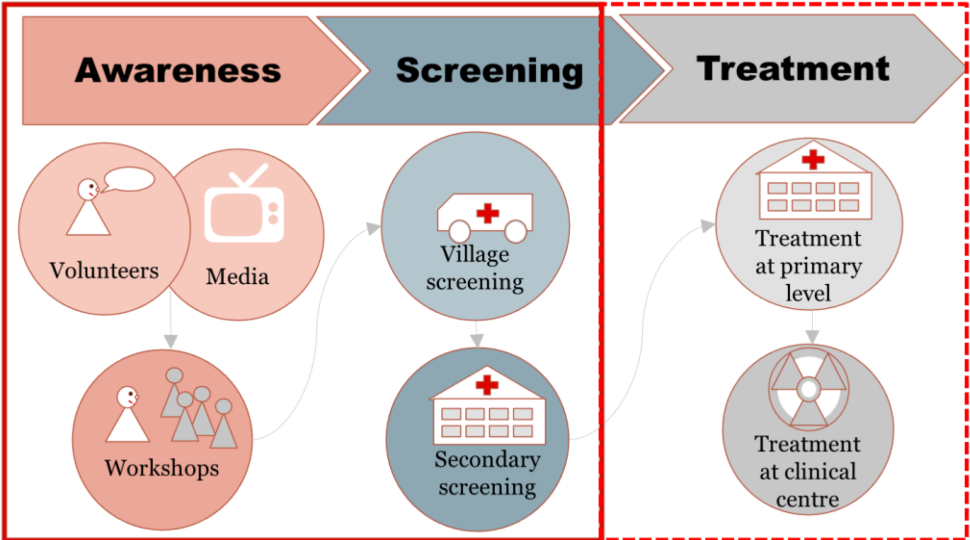
early stage enables treating it while curable and providing better quality of life for the patient. It also reduces the cost of treatment by both the national health insurance and the patient, which leads to inequality reduction[v].

The target population are women registered for the state health insurance: **women aged 25 to 64 years** are invited by gynaecologists for **cervical screening** using cytological cervical smear (Pap test) every three years after two negative findings within one year. The tests are to be done by gynaecologists and read by accredited cytological laboratories (e.g. at the Health Centre in Kragujevac). Follow-up is up to the gynaecologists. Similarly, **women aged 50 to 69 years** are invited for **breast screening** using mammography every 2 years. The invitations are done by gynaecologists, screenings are done by radiology technicians and readings by 2 radiologists. Follow-up is done by the secondary or tertiary health institution (e.g. at the Clinical Centre in Kragujevac). The programs aim to reach at least 75 % of all registered women. Nevertheless, the EU Delegation notes that the programmes´ full implementation is yet to be achieved to ensure an equal access for all citizens[vi].

2.2 Evaluated project

The evaluated project focused on **prevention of breast and cervical cancer among women aged 25 to 68 years in 50 villages of Sumadija region and Kragujevac city**. The project budget was 10,5 million CZK (552 632 USD[vii]) for the whole implementation period of 2010 – 2012. It was fully covered by the Czech Development Agency (CZDA) based on a public tender[viii].

The project approach towards cancer prevention among women in Šumadija region can be displayed as follows[ix]:



Graph 1: The project approach

After initial awareness raising among the women via volunteers, flyers, workshops, TV and radio trailers, manual breast screenings and cervical cancer screenings using Pap test was done during weekends in villages by mobile units with local medical staff. A few days later, women received their results and were invited for follow-up examinations at the Health Centre in Kragujevac if needed. While follow-up screening costs were generally not a part of the project, a fund was established to cover immediate expenses of women without health insurance. Simultaneously, Caritas CR as the Czech project implementer and local trainers trained Oaza Sigurnosti and local medical staff in several areas such as cytology or strategic planning. Treatment was not covered by the project

(see dotted line). It was, however, done often by the same medical staff in the Primary Health Centre, at the Clinical Centre in Kragujevac or in private clinics. The progress was monitored by the project medical staff and reflected in the project database.

The project logical framework has been reviewed for the evaluation purpose so that activities lead to relevant outcomes, which in synergy lead to the specific objective upon fulfilled assumptions and ultimately to the long-term purpose. Detailed explanation of the key adjustments, the original and the new frameworks are attached in Annex 7.7.

2.3 Key stakeholders

The key project stakeholders were identified during the evaluation as follows. Representatives of all of these stakeholders were involved in the evaluation.

Type	Key stakeholder
Donor	**The Czech Ministry of Foreign Affairs** – monitoring of the region, policy and programme development, commissioner of the evaluation
	The Czech Development Agency – coordinator of the Czech development cooperation, it identified and formulated the project, selected the implementer, monitored the progress and financed the project upon receiving progress reports, it was also involved in this evaluation
	The Czech Embassy in Belgrade – involved in the project identification, selection of the implementer, monitoring and evaluation, engaged in advocacy and networking when needed
Implementer	**Caritas Czech Republic** – main implementer, responsible for project implementation, monitoring and reporting upon a won public tender
	Oaza Sigurnosti Serbia – local implementer involved in project identification, formulation, implementation and evaluation, including its project staff, volunteers and external trainers
Partner	**(Primary) Health Centre in Kragujevac** (Dom zdravlje) – involved also in project identification formulation, implementation and evaluation
Target group	**Gynaecologists** and **nurses** of the Health Centre above, engaged in screening and follow-up
	Women in the rural areas of the Šumadija region involved in cancer prevention
Beneficiaries	**Population** of the Šumadija region and indirectly of other regions served by the health facilities of Kragujevac
Policy makers	**The Ministry of Health and Environmental Protection in Serbia** (further referred to as the Ministry of Health) – its Republic Expert Board (REB) is responsible for implementing national screening programs[x]
	The Institute of Public Health in Kragujevac – coordinates awareness raising and screening in the territory among health centres, local self-government and public[xi], updates data and report to the Office for the Prevention of Malignant Diseases.

Type	Key stakeholder
Policy makers (continues)	**The Institute of Public Health of Serbia at Dr Milan Jovanovic Batut** – its Office for the Prevention of Malignant Diseases (the National Cancer Screening Office) coordinates, organizes, monitors and evaluates the implementation of organized screening and provides technical support[xii].
	Kragujevac municipality – supported awareness raising about cancer, involved in the project promotion, monitoring and evaluation
Other key donors	**The European Union** (EU) **Delegation to Serbia** – health sector programme manager, involved in launching national cancer screening programs, a related EU project
	Japan International Development Agency (JICA) – another major donor involved especially in breast cancer screening
Others	**Local media** – involved in cancer prevention awareness raising as a part of this project
	Clinical Centre in Kragujevac – provider of tertiary health care for Šumadija and neighbouring regions, involved in related treatment of cancer patients[xiii].
	Oncologists Association of Serbia – awareness raising, networking
	Institute of Oncology and Radiology of Serbia – research, capacity building, awareness raising
	Associations of Cancer Patients: Budimo Zajedno in Belgrade, Ženski Centar DIVA in Kragujevac (in existence for 2 years) – psychosocial support, education, awareness raising

Table 1: Key project stakeholders

More details about the implementers are given below.

Caritas Czech Republic (www.charita.cz, further as Caritas CR) was established in 1999. It belongs to the biggest Czech civil society organisations (CSOs) 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 its international health and social projects. Caritas CR implemented in Georgia a similar project to the one evaluated in this report[xiv].

Oaza Sigurnosti Kragujevac (www.oazasigurnosti.rs, in English Oasis of Safety, further as Oaza Sigurnosti) was established in 2008. It is a local CSO committed to enhancing gender sensitivity and equality, fighting domestic violence, health promotion and advancement of women. Beside others, it has participated in the development of Social Welfare Development Strategy of the City of Kragujevac or the Strategy for Combating Domestic Violence of Gender Equality at the Ministry of Labour and Social Policy of Serbia. It has also engaged in several Czech and EU development cooperation projects.

2.4 Assumptions and risks

The project documents mentioned the following key assumptions: seamless cooperation at both the central government level and the local level. It was deemed fulfilled as Serbia belongs to the long-term partners of the Czech development cooperation. Further, several risks were identified before the project or during the evaluation:

Risk	Probability	Mitigation measures
Planned risks		
Potential cuts in financial resources allocated for project implementation in 2011 and 2012, caused by economic crisis, admission of Serbia to the EU etc.	Low – did not happen	The budget was approved for each year separately, still, the project partners worked on a long term basis. Project budget was not cut.
Local women's absence of interest in treatment (and in screening), or, on the contrary, an unexpectedly huge interest, which could not be satisfied within the project framework. Winter season was expected to encounter a lower interest.	High – did happen, mitigated well	An appropriate information campaign was launched together with other cancer prevention campaigns. Finally, interest in screening among women increased. Screening was organized according to their needs, no women was reportedly refused. Women were usually referred to their gynaecologists for further screening.
Additional risks		
Insufficient capacities of hospitals for screening (trained and experienced cytologists, radiologists and pathologists) and treatment of an increased number of women.	High – did happen, partially mitigated	Gynaecologists were trained in order to increase the quality and availability of the screening. Still, they remained overburdened. Capacities for treatment were not addressed, however, no case is known of a patient who would not be treated due to a lack of hospital capacities. Further, there was a lack of pathologists and radiologists at the time of the evaluation. This was addressed by the EU / JICA. Accessibility of treatment (chemotherapy, quality surgery) and tests (markers) remains an issue.
Inadequate resources and readiness of women to undergo treatment as soon as possible. The delay and the lowered likelihood of successful cure could also affect others around her.	Medium – did happen, mitigated well	Doctors followed upon the patients and contacted even their families to ensure follow-up. Still, there were likely some cases of patients hesitant to undergo further screening and treatment for example due to former experience with cancer.
Non-existence of financing mechanisms that would motivate health centres to continuously provide screening (as identified by the EC)	High – did happen, not addressed	Involved doctors reported they are not remunerated specifically for cytology. All kept screening their patients, though only some actively called them. Cytology is currently expected to be recognised. The project has not particularly advocated for this.

Table 2: Risk analysis

3 EVALUATION METHODOLOGY

3.1 Approach

The evaluation respected the Terms of Reference (Annex 7.8), the Code of Ethics and the Evaluation Implementation Standards of the Czech Evaluation Society[xv] and the OECD/DAC Evaluation Quality Standards[xvi].

The evaluation design was non-experimental and mostly one-shot (status at the time of the evaluation), as comparative baseline data or comparison group were not available. The effects and impacts were assessed using the contribution analysis, whereby the project theory of change was reviewed whether it was plausible and implemented as intended, whether expected changes happened and to what extent other factors influenced them. The evaluation was evidence-based, i.e. the evaluation team collected evidence related to evaluation questions and purpose. Such data were verified and triangulated with other sources and methods. A detailed set of evaluation sub-questions along with sources and methods formed an evaluation matrix.

Sampling of villages involved in prevention and diagnostics was purposive. Taking into account the evaluation budget and the accessibility of villages, 7 out of 50 villages were selected based on predetermined characteristics to maximise the variation: village size, % of total women who attended check-ups and other key variables (accessibility of a gynaecologist, availability of an active volunteer). This strategy aimed to minimize bias and foster triangulation and transparency in village selection. It sought for both confirming evidence (villages with high attendance rate at check-ups) as well as disconfirming evidence (villages with lower attendance rate). Additionally, a location in Kragujevac with high number of disadvantaged Roma families was also added. The list of selected villages was agreed with the project partners and the steering group. It is attached as the Annex 7.14.

The evaluation team approached informants sensitively and fully respected their rights and wishes, including anonymity. After the completion of interviews or focus groups, all informants were provided with space to answer any questions by the oncological specialist and provided with necessary information if needed, such as a contact to the nearest cancer patient association. Furthermore, the whole evaluation team was independent of the commissioning entity and all implementers of the Czech development cooperation projects. No member was involved in the preparation, review, selection or implementation of the evaluated project at any stage. None participated in the preparation of any project proposal, which the evaluated project competed with for funding.

3.2 Evaluation phases and methods

The evaluation comprised of an inception phase, 12-day field mission in Serbia and a synthesis / reporting phase.

The selection of **data collection methods** derived from the evaluation purpose and questions as well as the time available for the field mission and the evaluation budget. As the project documentation already provided quantitative data and only samples of updated medical data were available during the evaluation, the evaluation team focused mainly on explaining how and why the project worked and what were the factors that influenced its effects, impacts and sustainability. Therefore mainly qualitative methods were used aside of the desk review.

Thus the data collection methods included:

- ***Desk review*** of project documentation, relevant Czech and Serbian strategic papers and other key documents listed in the Annex 7.20.
- ***Semi-structured interviews*** with key informants in the Czech Republic as well as in Serbia, as identified during the stakeholder mapping. Group discussions were applied when useful, especially with the reference group and the project implementation team. Interpretation from / to Serbian language was applied whenever preferred by the informants. In total, 14 cancer patients were interviewed individually or in a group. The list of all interviews is available in the Annexes 7.3 and 7.4.
- ***Focus groups*** were conducted in each village with women involved in prevention and diagnostics and further with doctors and nurses involved in the evaluated project. To win the trust of potential participants, invitations were done by trusted individuals – either by local volunteers or by the project team in the case of doctors and nurses. The evaluation team stressed the importance to include representatives across ages and approach also those who did not take part in the check-ups to maximise the diversity and map the contributing and limiting factors. Nevertheless, the participation was influenced by the availability and interest of such women as well as by the established connections of the volunteers. In total, 7 focus groups were held with 52 women. The focus group with nurses was not held separately from the focus group with doctors, as only 2 nurses were available – thus 1 focus group was held with 10 doctors and nurses. All focus groups were interpreted from / to Serbian language. Participation was voluntary and not remunerated, only refreshments were provided. See the focus group guidelines in Annex 7.6 and a detailed list of focus groups in the Annex 7.4.
- ***Observation*** of village infrastructure and health premises involved in the project, including the approach of the staff, behaviour or patients and available equipment.
- ***Case studies*** of different women involved in the project were developed to demonstrate the complexity of motivations, effects and influences. Interviews, observation and medical data were available served as a basis for the case studies. See Annex 7.15 for all case studies.

As the data collection methods were mostly qualitative, **textual analysis** was mainly applied. Interviews, focus group discussions and case studies were coded thematically to distil the essential information. Tables or flowcharts were developed were deemed useful for comprehension.

A **reference group** with representatives of the MFA, the CZDA, the Czech Ministry of Health, the Czech Embassy in Serbia and the Czech Evaluation Society discussed the evaluation design. It commented and approved the inception and the final evaluation reports. The final evaluation report was developed in English. It was distributed to key stakeholders and published on www.mzv.cz to increase its accessibility and usability among key actors.

The **initial briefing** at the Czech Embassy in Belgrade was conducted only with the Development Cooperation Coordinator as other Belgrade-based entities were not directly involved in the evaluated project and were also not available at that point of time. The **final debriefing** was held with local stakeholders in Kragujevac, Serbia, and the **final presentation and discussion** with Czech stakeholders in Prague. See Annexes 7.11, 7.12 and 7.13 how the stakeholders´ inputs were reflected in this report. Presentations are attached separately.

The key **evaluation outputs** included:

- The inception report (not publicly available).
- The presentations from the final debriefing in Kragujevac and from Prague (published on www.mzv.cz).
- The final evaluation report (published also on www.mzv.cz[xvii]).

3.3 Evaluation team

The same lead evaluator, Ing. Inka Píbilová, MAS, and the oncology expert, MUDr. Václav Pecha, have already conducted an evaluation of a similar Czech oncological project in 2013. They have teamed up with an experienced methodologist of Naviga4, Mgr. Lukáš Bumbálek, and a local assistant evaluator, Tanja Menicanin, MA to address this evaluation. See Annex 7.5 for detailed personal profiles and job descriptions of the team.

3.4 Methodology limitations

The overview of key limitations is below, including the ways how they were addressed:

- Before the project was implemented, there were **limited oncological data available** and no national oncology registry existed. As baseline data were limited and as there was no comparison group identified, the impact assessment was based on a revised theory of change, real change mapping among key informants and evaluation of how the project (and alternatives) contributed to such changes.
- Further, the **project database was not updated** after the project end. Due to the data confidentiality, the evaluation team did not have a full access to the medical records of all women involved in the evaluated project. The evaluation team thus relied on the sample medical data provided by the doctors involved in the evaluated project. Aggregated information is expected to be produced by the end of 2015 by the Head of Gynaecology at the Health Centre in Kragujevac and published in a local medical journal.
- **Comparison of the project results with the results of the whole Šumadija region or with other regions was not reliable** as the National Screening Office used other methodology (% of women screened is based on the cohort of women with national health insurance, whereby those most vulnerable often do not have such an insurance) than the evaluated project (list of all female voters were used as basis, whereby some may actually live outside of the villages or region). Moreover, the regional and national cancer statistics compilation was still in progress.
- The evaluation was requested by the MFA and the Czech Embassy during the **main holiday season**. Therefore, the awareness raising at schools was not directly evaluated as the schools were closed. Remaining key stakeholders were involved according to their preferences. A potential risk of unavailability of women for focus group was addressed by the local partner, Oaza Sigurnosti, which managed to mobilize enough women via local volunteers. Focus groups were conducted close to the houses where women lived in order to minimise their travelling.
- The fact that **both relevant Project Managers have already left** Caritas CR did not affect the evaluation. They provided the data via phone / Skype. Current staff added evidence as necessary.

While the evaluation widened its scope beyond the concrete evaluated project and examined relevant information on breast and cervical cancer, other **health care issues in Serbia** were outside of its scope and budget. Thus the evaluation team does not deny that they may be other urgent health matters in Serbia that require attention. Similarly, the evaluation explored options for further expansion of development cooperation or the establishment of bilateral cooperation outside the Czech development cooperation framework only in breast and cervical oncology. A comparison of methods of implementation of this evaluated project with a similar project in Georgia (see Annex 7.17) further reveals that it is not just a method or an organisation that is particularly effective, but that the context matters and several external factors play an important role. Thus **replicating the project implementation methodology** elsewhere needs to be done with close attention to the specific context.

4 EVALUATION FINDINGS

4.1 Relevance

Relevance to the needs of target groups and beneficiaries

Oncology was identified in 2009 as a priority health issue in the Šumadija region by Oaza Sigurnosti and the Health Centre in Kragujevac. The medical staff had seen an opportunity to pilot especially cervical screening before the National Screening Programmes were launched. The Šumadija region was selected as this was their target area. The project was then formulated by the CZDA together with local partners. It was proposed in line with the regional policies on health protection of vulnerable groups[xviii].

The actors above decided to focus on women from rural areas as they were multiply marginalized in Serbia[xix]:

- 60 % were without education or with only an elementary education,
- 55 % were inactive or unemployed, remaining 45 % worked mostly in agriculture within their households,
- 9 % did not own health insurance, 14 % in case of supporting members of household,
- 24 % of those aged above 20 years checked their health annually at the gynaecologist (36 % in cities),
- 26 % of those aged between 20 and 69 years did a Pap test[2] in the last three years (42 % in cities),
- 7 % of those aged between 40 and 69 years have done a mammogram (13 % in cities).

> “*They were quite informed about cancer, but didn´t want to discover it.*“ Implementer

The focus groups with women in 2015 revealed that health prevention was not among their priorities as they took care of the family, household and mostly agricultural work. Many did not know why it was important. They also complained about a low access to primary health care at most villages. Most of them did not go for regular check-ups because of several reasons: no health insurance (due to a low income), bureaucratic ordering (at some doctors´, a visit cannot be agreed by phone and visit arrangements need to be done only at a certain time of the day), long waiting and inadequate transport to health facilities. Some have also mentioned corruption (e.g. doctors at public health centres refer them to their private clinics), which has been reported as widespread[xx]. At times, women did not want others to know that they visit a gynaecologist as others would assume they have a disease. The general situation slightly differed by village.

> “*We need to travel to a doctor 14 km just to make an appointment and then wait a long time. Or we can go to a private clinic and pay 8 000 dinars for a Pap test. This is 80 Euro!*“ Focus group with women

To address this, the project first informed the women about the importance of early cancer detection and then brought the gynaecological and manual breast check-ups to women´s doorsteps. Cervix was screened via accessible Pap test, breast check-up was done only manually due to a limited access to costly equipment (mammography, ultrasound). All interested women were checked regardless of their age or possession of health insurance. To address the needs of the medical staff, trainings and equipment were provided. The local medical staff was involved in the rural screening to gain an understanding of issues women face as well as hands-on experience with the check-ups and follow-up.

> “*We need prevention to save money (spent on expensive treatment).*“ Decision maker

[2] The Papanicolaou test (Pap test) is a method of cervical screening to detect pre-cancerosis and cancer in the cervix.

Relevance to the Czech strategic documents

Serbia has been a priority country of the Czech development cooperation (ODA) since 2004[3]. The new ODA Strategy for 2010 to 2017[xxi] proposed focusing on economic transformation, transfer of technological know-how and public private partnerships in Serbia, but kept social development including health among its priorities as previous projects were considered useful. Even before the new Strategy approval, as identified by the CZDA with Oaza Sigurnosti, supporting cancer prevention was included in the Development Cooperation Plan for 2010 and the Mid-term Overview for 2010 to 2012[xxii] among the two health sector priorities of Serbia.

Relevance to the Serbian strategic documents

The project was not formulated with the Serbian Ministry of Health, but it did reflect its legal framework related to cancer screening[xxiii]. According to the Regulations on the National Programs for Early Detection of Breast and Cervical Cancer, opportunistic screening, implemented in Serbia for many years, had had the following pitfalls:

- women's lack of information about the efficiency of cervical cancer prevention;
- low coverage of the target population of women through regular Pap examinations;
- lack of quality control, training and work quality control – interpretation of Pap smears;
- inadequate data collection and reporting, thus no real results;
- insufficient involvement of local governments in the activities to promote the health of women.

The Programs aim at reduction of women's mortality and incidence of cancer through awareness raising, strengthening screening capacities of health institutions, establishing a data collection and management system, establishing quality control and involving local authorities and civil society in the implementation of screening. The evaluated project was in line with the general as well as specific objectives of the Programs.

4.2 Efficiency

The overall project expenses of 10,5 mil CZK (around 390 000 EUR) were allocated between Oaza Sigurnosti and Caritas CR in the ratio of 80:20. For project expenses overview, see Annex 7.16.

The project team included 7 part-time members in Serbia and 2 part-time members in the Czech Republic, plus support staff (IT, accounting, PR in the CR). The oncological expertise was ensured mainly by Serbian medical staff and by an experienced Czech gynaecologist – oncologist from the Masaryk Memorial Cancer Institute. The expertise was crucial to ensure quality screening.

Further, a mobile gynaecological van and a small car for the project team were provided for transport to villages. A cytological laboratory was renovated and equipped to read Pap tests. Furniture, office equipment and latest literature were also given to the cooperating ambulances and the project office. Medical and project staff members were trained. One of the main outputs was that 2 new cytologists were able to use the new equipment, thus 10 out of 12 gynaecologists could perform cytology (reading Pap tests). Trainers were Serbian experts.

The production of promotional materials, brochure printing and a cheaper van purchase generated the biggest savings, which were used to renovate another ambulance, replace old equipment and buy a new microscope for cytology. No major delays were found.

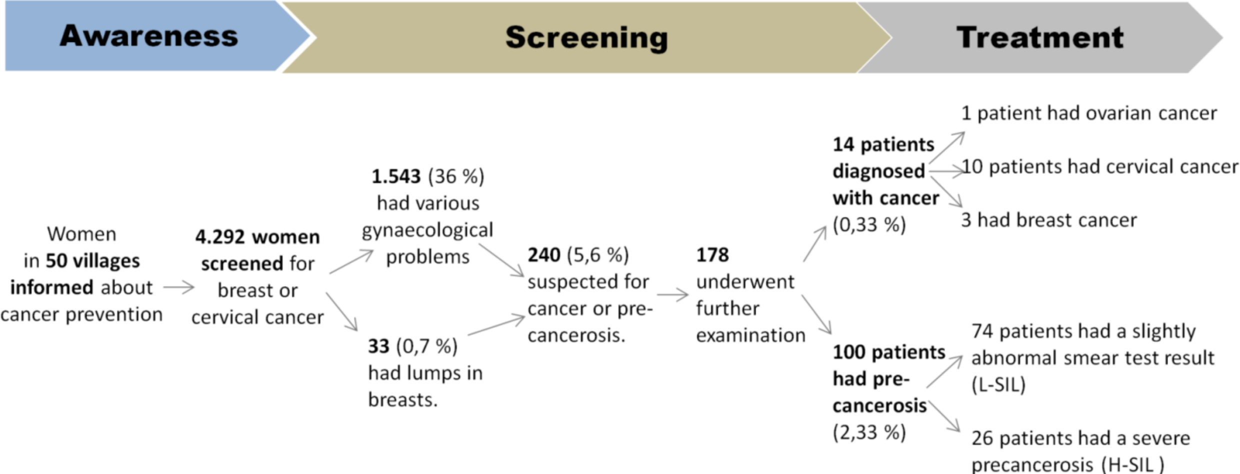
[3] The Czech ODA to Serbia in mil. USD: 7,8 (2008), 4,5 (2009), 3,58 (2010), 3,19 (2011), 2,38 (2012), 1,59 (2013), planned ODA volumes in the CZK: 19 mil. (2014), 17 mil. (2015), 14 mil. (2016), 4 mil (2017), according to the MFA, 1 USD = 24 CZK, http://www.mzv.cz/jnp/en/foreign_relations/development_cooperation_and_humanitarian/information_statistics_publications/index.html

Respondents reported that the key was the motivation of all medical and project staff members, who undertook field screening during the weekends, after their standard working hours. The remuneration was 15 000 RSD / day (around 125 EUR or 3 370 CZK) for an experienced gynaecologist[4] and 10 000 RSD / day (83 EUR or 2 250 CZK) for an experienced nurse. Two doctors and two nurses covered 2 villages in a day with an average number of 20,3 women screened per village. Together with the other direct expenses, the total costs for 1 day and 2 villages was about 82 650 RSD. Thus the **cost for field screening** (without follow-up examinations when necessary) was slightly above **2 000 RSD per woman** (450 CZK or 17 EUR). If a woman would be screened in this way every year (which is a high standard applied in the CR) from the age of 15 to 77[5], it would come to the cost of 126 000 RSD (around 1 183 USD) for her lifetime. This is far below the Serbian GDP per capita of 6 153 USD[xxiv], a commonly used informal threshold to assess cost-efficiency[xxv].

Cooperation among actors is elaborated under good governance.

4.3 Effectiveness

The key quantitative outcomes and objectives were reached as follows[xxvi]:



Graph 2: Key project achievements

Awareness

In total, **50 villages** (instead of 40 planned) **were involved in awareness raising about breast and cervical cancer**. There is no information about the total number of people reached. Promotion was undertaken at workshops in villages and through mass media, including newspapers, TV and radio. Aside of the original plan, reproductive health workshops were held at medical secondary schools. According to different informants, other campaigns focused mainly on breast cancer, while the project highlighted also the importance and relative easiness in addressing cervical cancer. The focus groups in 2015 revealed that **women knew they need to go for regular screening** to detect cancer at an early stage and get treated in time. Quite some also knew exactly

[4] Involved doctors reported a salary of around 500 EUR a month, an average gross monthly salary according to the WHO was between 613 and 833 EUR in 2010, see page 51, Evaluation of the organization and provision of primary care in Serbia, A survey-based project in the regions of Vojvodina, Central Serbia and Belgrade, WHO 2010, http://www.nivel.nl/sites/default/files/bestanden/Serbia%20final%20report.pdf
[5] Life expectancy as per the WHO (2013)

when they are eligible for a free screening and where. However, they were **mostly not aware of other prevention**: i.e. that HPV is the most important risk factor for cervical cancer and that it is sexually transmitted. They were also not informed about possible HPV vaccinations. They drew information mainly from relatives or neighbours, doctors and from the mass media.

Screening

An experienced Czech gynaecologist – oncologist from the Masaryk Memorial Cancer Institute trained 9 doctors in prevention and modern diagnostics (aside of Pap testing). Further, doctors were trained locally in PC and nanotechnology in medicine, cytology and ovarian cancer.

Oaza Sigurnosti found during an initial phase that posters promoting check-ups were not enough to attract women to screening. Thus NGO and village volunteers delivered **personal invitations to concerned women**. Out of 11 758 women in the 50 villages (according to the last electoral registry), 8 169 women were reportedly invited. Others were not present according to the implementer (due to a work abroad etc.).

> "*First check-up was a fiasco - five women came. Then we contacted local officers to recommend volunteers to go door to door. … Sometimes we called a teacher, priest´s wife or a nurse*" Implementer

> *"We really wanted to succeed. We could not do it here (in ambulances). (In villages) some women went to a gynaecologist for the first time after 30 years. We answered all questions."* Focus group with gynaecologists

Finally, 4 222 women were **screened** (versus 4 000 planned), i.e. **52 % of total women population over 2 years**. Additionally, 70 vulnerable, mostly Roma women were screened in Kragujevac. They stated that longer screening availability would boost the rate even further as some women need time to decide. From multiple resources it was reported that no woman was rejected screening. The project team and focus group members believed that women who did not join either did not have time or trust in such a screening, or they were ashamed or worried.

According to multiple actors, **factors that contributed to attending the screening** were trusted volunteers, a cohesive group of local women (e.g. a self-help group, an NGO or active women who took relatives and neighbours with them), workshop on prevention held before screening, adjusting the screening to local holidays, short waiting times, motivated and welcoming medical staff, free service "at the door steps", previous experience of others with the project screening and screening of local authorities too (e.g. doctors). Sanitary packages, provided to all participants, were believed effective especially with highly vulnerable population. In some villages, the screening was treated as a true event – women offered home-made cakes and chatted. Oaza Sigurnosti reported that some women feared that others would talk about them having cancer if they come for the screening, thus they were reportedly transported to other villages for screening. All actors highlighted that the approach described above was very effective in comparison to individual invitations to distant medical facilities, where women often feel uncomfortable and need to wait long hours for a check-up. The multiple campaigns on cancer prevention are believed to have helped too. Low screening ratio was in places with more scattered population, with a better access to doctors (i.e. women had other options for screening) and with migratory population (unavailable for screening).

> *"Many women are scared to learn (they have cancer). They need to be pulled by hand. Screening in a group and a little present helps."* Involved Roma woman

All patients received the results and potentially prescriptions within a few days personally in their village. **About three fourths of women who were advised further examinations actually followed up**. Approaching their family often helped, as reported by doctors. Doctors and implementers also reported that remaining 26 % of women were mostly afraid of treatment or went to seek a second opinion elsewhere. One of such patients confirmed to the evaluators a strong fear of doctors despite the knowledge of consequences[6].

The follow-up check-ups were originally not planned to be covered by the project. As around 6 women had no health insurance, Oaza Sigurnosti decided with Caritas CR to act quickly and covered further check-ups (around 100 EUR per person) from the surplus created thanks to budget transfer with a convenient exchange rate. Finally, **0,33 % of all screened women were diagnosed with cancer** (an incidence rate of 330 cervical cancer cases per 100 000 women), which is far above the incidence rate found via opportunity screening in Serbia (25,5 per 100 000 in 2009[xxvii]). **Most of the positive cases were detected in pre-cancerosis stages** (2,33 % of screened women), when it is relatively easy and cheap to cure.

Treatment

> *"We needed to call them every day to do biopsy… it was not only about discovering the disease, but also about treating it."* Gynaecologist

It was assumed that the project would contribute to improved treatment in long-term, but treatment as such was not covered by the project. Nevertheless, involved doctors followed upon their patients as a part of their standard duties and undertook about 100 surgeries. A few women were treated in private clinics.

Aside of the above activities, the local project team was trained in the EU project cycle management, Public Relations, strategic planning and advocacy. Oaza Sigurnosti then wrote a number or proposals and is currently implemented other EU projects, where it applies its experience.

4.4 Impacts

Focus groups with women from target villages confirmed that most **women understood the need for regular Pap-tests** and some were aware of breast screening options, but almost none knew exact conditions (age range, costs). Most of them registered to a gynaecologist, but not all knew their name. They also mentioned they started to trust doctors more.

Still, **fewer than half of the women** in focus groups **have gone at least through a screening of cervix** at a medical facility **after the project ended in 2012**. Some explicitly mentioned different pieces of advice by different doctors or delayed delivery of mammography results (even 2 months), which caused a certain distrust. Only a few manually check-up their breasts at home. On the other hand, several villages requested field screening continuation. A woman reported to pay herself for a cervical regular screening (300 RSD per visit), as she cannot afford the health insurance (estimated by her at 40.000 RSD per year).

> "*I would not have known I had breast cancer, if it wasn´t for this project… I will not give in!"* Cancer patient

The treatment of most of the women diagnosed with pre-cancerosis or cancer was still in progress during the evaluation. According to different

[6] The patient was scared to undergo a treatment. She was advised to contact the local Cancer Patient Association Diva after the interview with evaluators. A meeting with DIVA followed the next week. Current status is not known to the evaluators.

sources, **almost all women got treated, even socially excluded ones** (a fully updated database was not available).

See detailed case studies of patients in Annex 7.15. One case of death of cancer among patients was found as per a focus group with patients. Cancer patients met during the evaluation had insufficient information about reasons for their treatment, contraindications of medicines they had got or about recuperation.

"*(Follow-up) check-up is nothing bad, but the waiting in ambulances is killing me. I am waiting for a day to have enough courage to go. I know I need to go – my whole life is ahead of me.*" Cancer patient

Further, the project provided the first, hands-on rural experience for gynaecologists and their nurses. Thus during the evaluation, they could explain **new insights about rural women** and a lack of importance they put on prevention. The medical staff of the Health Centre involved in the project believed that especially their rural experience with screening, combined with the provision of equipment and training of 2 more cytologists helped them to have **above-average participation rate in the national cervical screening**, for which they were officially recognized by the National Screening Office. In Kragujevac (which serves an area bigger than Šumadija region), according to the National Screening Office[xxviii], 85 % of invited women[7] were tested (10.626) by May 2015 vs. the average of 56 % in Serbia. The incidence rate was high: 4.02 % of women had pre-cancerosis vs. 0.6% in Serbia and 0.04 % had cancer vs. 0.06 % in Serbia. The project success (early discovery and treatment of cancer) was mentioned in the article in the Serbian Medical Journal published in 2011 by the Head of Gynaecology and his colleagues from the Health Centre in Kragujevac [xxix], but the policy influence of this article is unknown.

4.5 Sustainability

"*Doctors say ultrasound is not working and expect us to come to their private clinic to pay 4.000 dinars (for the same!). They lie!*" Focus group with women

The local project supervisor – medical expert recommended at the end of 2012 a continuation of **preventive field examinations**, with the support of the National screening program. He believed this was "**the only way to ensure a reduction in the number of women with cervical cancer and diagnosis of pre-cancerosis in time**". During the evaluation, doctors urged to continue and some villages and Roma women actively requested field screening. Nevertheless, **the organized screening was conducted only in medical facilities[xxx] and no field screening continued due to a lack of funds**. This is despite the fact that financial sustainability was discussed with the municipality already in 2011.

"*I do not attend screenings (either). I went 3 times to the gynaecologist just to get an appointment. I had to wait for 6 months!*" Project team member

According to the focus groups in 2015, fewer women from villages attended regular screening than the field screening. The main barriers identified by involved actors were two-fold:

- **Barriers to public awareness:** Most women still do not know the non-symptomatic cancer and prevention measures. A lot of women also do not know their screening rights.

[7] Only women with valid health insurance were invited.

- **Institutional / Systematic barriers** include low accessibility of health insurance, limited screening accessibility and productivity[8], attitude of some doctors and patient work flow at some ambulances, negative experience of some patients with health care, not enough gynaecologists covered by national health insurance and not all women invited for screenings, only those insured.

The **equipment**, handed over by the project implementer to the Health Centre in Kragujevac, **has been kept for the original use** except of two cases. The gynaecological chair served in a new gynaecological ambulance for adolescents. The van was provided to the Red Cross on a quarterly basis for general health check-ups in villages. Otherwise, the van was utilised for distant travels of medical staff. There was no partnership agreement that would specify sustainability commitments. The prevention campaigns still continue (e.g. via January Cervical Cancer Week[xxxi]).

The evaluators estimated with the implementer that about **2 000 Serbian dinars per woman were needed to continue rural screening**. The Ministry of Health recommended looking into regional funds for awareness raising or funds of medical facilities, who could request additional money from the National Health Insurance Fund. Yet, the Municipality of Kragujevac mentioned that only minor funds were available for unique short-term projects (e.g. awareness raising among youngsters), not for activities funded by the state such as the organized screening. The Health Centre reported to have no funds for field screening. The medical staff believed that an additional gynaecologist and nurse could help, but this was not possible due to a national hiring cap. Private or international donations were also considered, but no concrete fundraising plan was in place.

4.6 Cross-cutting principles

Good governance

The project was developed by Oaza Sigurnosti and the Health Centre in Kragujevac, in consultation with the CZDA. Caritas CR won the project in a tender announced by the CZDA. The tender specified not only objectives and outputs, but also project activities. It also listed detailed specifications for equipment, as suggested by the Health Centre. The implementers later found that such a detailed specification was rather difficult to fulfil. This issue was solved retroactively with the CZDA. Implementers addressed necessary changes, such as the cost coverage of further check-ups. Upon the project start, the Municipality of Kragujevac was involved in identification of the whole women population and in media promotion. The Clinical Centre in Kragujevac helped to promote the project. The Ministry of Health was approached only during the project and met only once on an operational level with the project team. The reason for limited interest given by informants was missing involvement in project formulation.

The operations were managed by Oaza Sigurnosti, while Caritas CR ensured administration and financial contractual obligations of the CZDA as well as field monitoring and reporting. It was involved in revisions of publications, presentations and project database development, which was said to have been initially a challenge and finally did not to provide some data such as a number of uninsured women. Two project managers were involved – the second one spoke Serbian, which made communication with actors easier. The Kragujevac municipality head for health issues (currently the Professor of Gynaecology at the Clinical Centre in Kragujevac) supervised the project. Additionally, the Czech Embassy and the CZDA conducted 2 monitoring visits (half or full day)[xxxii]. They interviewed Oaza Sigurnosti and in one case also partner medical institutions. Due to administrative

[8] Mammography productivity at the visited facility in Kragujevac was only 2 persons per hour, max. 12 persons per day.

reasons, visits could not be conducted during weekends when field screening took place and when beneficiaries could be encountered. Covering treatment of women without health insurance and a lack of cooperation with the Ministry of Health were key issues discussed. The Embassy offered solutions (a Czech sponsor for the first issue and space and promotion of a roundtable for the second issue), still Oaza Sigurnosti finally found alternatives (additional funds generated through exchange rates for the first one, invitation of the Ministry to the conference in Kragujevac, which was not reflected by the Ministry). Aside of that, the CZDA and the Embassy was informed in details thanks to regular reports by the implementer. A study by the team mentioned above informed experts about the progress, but no project evaluation was done until now. Further, no collaboration was held with cancer patient associations (they have just recently developed and lack capacities).

Respect for human rights of beneficiaries, including gender equality

According to a number of studies[xxxiii], women in rural areas of Serbia suffer from multiple deprivations in comparison to men. They often possess no assets, nor own income. Therefore they have a more difficult access to health insurance, to medical or social service or education. According to Oaza Sigurnosti, their work lasts longer than 12 hours. Two thirds are believed to have suffered domestic violence. Due to these gender-related barriers and generally low health awareness[xxxiv], earlier research has already underlined that women are being the last in the families to access preventive care.

The project aimed to improve equal access to health care as one of the human rights. Actors underlined that inclusion of rural women including those without health insurance (between 10 %[xxxv] and 30 % according to Oaza Sigurnosti), of marginalized Roma women and of residents of a camp for internally displaced persons and youth (as proposed by Caritas CR) were important in this regard. The awareness raising workshops were directed solely on women except of workshops at medical colleges (it was believed that presence of men would not create a safe environment for women to pose questions). Men were likely reached by mass media; however, evaluating the outreach was beyond this evaluation. Further, the screening was adjusted to fit women´s needs (it was during weekends and outside of holidays). Above the planned project budget, follow-up check-ups of 6 women without health insurance were covered outside of the project budget. Family constraints were addressed together with the local volunteers (housing and lodging of children of a patient during her treatment in hospital). Immediate treatment was secured, which was highly appreciated by interviewed patients as this was not a common standard in public health care. Roma women especially highlighted fast treatment, which is in contrast to discrimination they reportedly face at public clinics (in contrast to private clinics).

Respect for the environment and climate

No influence on environmental protection or climate change was found during the evaluation.

4.7 External visibility

The Public Relations Manager of the Health Centre liaised with the local media throughout the project. A number of articles were published in local newspapers (some are still on-line as of August 2015[xxxvi]) and local radio and TV spots were broadcasted about the importance of regular cervical cancer screening. Further, an in-depth brochure on cervical cancer and project reports were published[xxxvii] in compliance with the visibility obligations of the CZDA. They are still available on the web. The project results were

> *“Thanks to the radio and TV coverage, the show-up rate increased (at screenings). We became like TV stars… Women started to look for us.“* Involved doctor

publicly announced at the Kragujevac Municipality in 2013 with the presence of press. A reference to project results can be found even in later media outputs[xxxviii]. The evaluation results were proposed by the involved doctors to be sent to media and promoted at the Week of Gynaecology in Kragujevac in June 2016.

The Czech PR activities included an article about the project on Caritas CR website[xxxix], a photo with a short project note was included in the Caritas CR calendar 2012 and a leaflet about Caritas CR in Serbia with case study of a patient was produced too (details about the distribution and use were not available). A recent bulletin of the CZDA[xl] briefly mentioned that (this) cancer prevention project in Serbia „evidently helped saving lives“. Nevertheless, other key donors, namely the EU and the JICA were not informed about the project approach and results until this evaluation.

Target group involved in focus groups was informed that the project was funded "by Czechs". Logos of the Czech development cooperation were placed on the provided equipment. No leaflets on cervical or breast cancer were found in involved gynaecological ambulances or in the ambulance of the general practitioner visited in one of the villages (leaflets were not produced by the evaluated project, but by the projects of the EU or the JICA).

4.8 Complementarity with other related projects

The health care reform in Serbia has been supported[xli] by several international donors, such as the World Bank, the EU - the European Agency for Reconstruction, UNICEF and a number of bilateral donors, mainly the CIDA, the Norad, the JICA and China. Yet, cancer has received a minor attention in comparison to other diseases such as tuberculosis[xlii]. The JICA and the EU were other key donors supporting cancer prevention (see Annex 7.9).

The above mentioned Programs have been developed in line with the recommendations of the World Health Organization. The EU has supported their development from 2009 to 2014 via its project[xliii] "***Support to the implementation of the National Program to Fight Cancer in Serbia***", which was financed by the Pre-Accession Instrument (IPA). It helped to establish the National Cancer Screening Office, trained more than 500 health care experts in early screening, equipped clinical centres with machines for clinical and cytological examinations and conducted a public campaign before the launch of the organized screening.

Further, JICA implemented The Project for ***Improvement of Breast Cancer Early Detection System*** from 2010 to 2012[xliv]. It provided mammographic units and other equipment to 39 medical institutions across Serbia. Further, it trained radiologists and radiographers for accuracy and quality control. The final report is unavailable, still, JICA[xlv] reported an expected increase of mammography exams in Serbia from 9,000 in the years 2008 and 2009 to about 330.000 per year from 2013 onwards, out of which 100.000 should be a contribution by JICA.

Oaza Sigurnosti has not directly communicated with the project manager responsible for this EU or JICA projects.

In 2013, the Health Centre in Kragujevac conducted also cervical cancer screening as a part of the project "***Support to Local Governments in the Decentralization of Social Services***". The project was implemented from 2010 to 2013 by the Standing Conference of Towns and Municipalities Subotica and Sombor towns and the Ada Sečanj, Backa Topola and Kanjiža municipalities[xlvi]. It was co-financed by the Norwegian government[xlvii]. It is not clear what the project results were with respect to cervical cancer and how it linked to the evaluated project.

Aside of cancer, another major health project funded by the Czech development cooperation aimed at ***Improving the Quality and Availability of Health Care at Arandjelovac Hospital***[xlviii], located in the second biggest city in

the Šumadija region after Kragujevac. It also serves rural population. There is no evidence of cooperation with this project or any other smaller health projects of the Czech Republic (see the full project list in Annex 7.10).

The Southern Moravian region from the Czech Republic has its own office in Kragujevac and has been involved in diverse development projects at partner towns and villages since 2003[xlix]. Between 2010 and 2012, ***3 health infrastructure projects were implemented in Šumadija region***, enabling primary prevention and not directly linked to cancer (see Annex 7.10 for a full list). Currently, the cooperation focuses on Czech language classes and student exchange. The current representatives of the region were not informed about the evaluated project. Due to staff changes, it could not be confirmed if any discussions about cooperation took place.

4.9 Further cooperation

The **local partner** suggested to the CZDA further awareness raising, replication of the project in other regions, medical training, improving palliative care and other health and social prevention in 2012. Yet, none of them were funded. The organisation is still interested in cooperation on these issues, but lacks funds to address them.

The most pressing needs in Serbia related to oncology, identified by multiple actors, are listed below. They may be further prioritized based on a needs assessment, which was about to be delivered by the Serbian Ministry of Health to the CZDA and the Czech Embassy as of August 2015.

- **Awareness raising among young people about reproductive health** and cancer prevention (including understanding HPV risks) and screening. This is necessary due to an early sexual life of Serbian youth and a lack of sexual education at schools. Good practices exist in Vojvodina as per the EU Delegation and are worth replicating.
- **Further awareness raising among general public** including men about cancer prevention is needed in collaboration with state and regional authorities so that all understand and exercise their health rights. This is especially relevant for **socially excluded localities and patients without health insurance** (the Roma coordinator estimated there are around 2.000 socially excluded Roma only in Kragujevac). Further, stigmatisation of patients is still an issue. Awareness raising (including the previous point) and psychosocial support of patients´ families can be addressed for example by Cancer Patient Associations active in the field. Yet, they need more funding and capacity building (relevant funds for capacity building or experts are still available in the mid-term ODA plan for Serbia by 2017). Czech associations can help them with their transitional experience (potentially via TRANS project funded by the MFA CR). The Kragujevac municipality expressed interest in (co-)funding innovative awareness raising projects too. Moreover, the Southern Moravian region from the CR may be interested in further support of prevention, but would need more details about the needs and possible Czech ODA support.

> *"Stigmatisation exists even within families. They think if you talk about breast cancer, you will get one."* Cancer patient association

- **Establishment of a strong cancer patient network in Serbia**. Such a network would be more effective not only in public awareness raising, but also in the psychosocial support of patients, advocacy and policy making. This is highly relevant as current patients need more medical information as well as psychosocial support. Again, Czech counterparts can help.
- **Management of screenings** including regional coordination, quality and productivity of screenings are key priorities of the National Screening Office. Other oncology

> *"Screening needs to be simpler. Send Pap tests to rural areas by post, women can do it themselves and send it back."* Oncology expert

experts also suggested exploring different screening options for rural, vulnerable population. The office expressed interest in capacity building, twinning or experts (which could be funded by the CZDA).

- **Enhancing quality, tailor-made oncology treatment**: the representatives of the Clinical Centre in Kragujevac expressed interests in the training of oncologists - surgeons and other specialists in latest methods. Ideally, they would be trained in the CR first and then supervised in Serbia. The Masaryk Memorial Cancer Institute gave a pledge to host trainees, but this was not realized. Current expert sending scheme does not enable such an exchange. University twinning was stated as another option.
- **Cancer prevention through HPV testing and vaccination**. The Serbian Ministry of Health suggested that the Czech ODA could fund research on types of HPV and potentially subsequent HPV vaccination in a selected region. Detailed oncology statistics would be very useful for evidence-based policy.
- **Health laws and regulations development and implementation**, including reformed health insurance, inclusion of private clinics, coverage of cytology, genetic testing, or medicines from the health insurance, measures to increase screening rates etc. Some actors were, however, sceptical, if relevant experts would be available from the CR.

Several actors also recommended to CZDA **replicating the project approach in other Serbian regions as well as in other Balkan countries**. Aside of oncology, the Ministry of Health was also interested in assisted reproduction (in vitro fertilisation), which was already discussed with the Czech Ministry of Health. Generally, there was a lack of knowledge about Czech ODA modalities available for Serbia (e.g. no Serbian informant knew about the expert sending scheme). For future collaboration, it is important to note that only 20 % of municipalities have screening facilities, which serve bigger areas. They are overburdened and suffer from unclear responsibilities (e.g. who does cytology, how it is covered[9]), lack of doctors and a hiring freeze[10].

5 CONCLUSIONS

***High relevance*: the rural screening was a strategic step, in line with the needs of women / medical staff**

The project responded to a very high incidence rate of cervical cancer and an increasing mortality rate of cancer among women. The primary health services were not and still are not easily accessible in rural Šumadija region. Yet, a majority of women is eager to use a sensitive, low-threshold service such as the one piloted by the evaluated project. This project was in line with the priorities of the Development Cooperation Strategy of the Czech Republic for 2010 – 2017 and the strategic policy documents of Serbia related to early detection of cancer. The project was well-timed. It piloted organized cervical cancer screening before the national organized screening was launched. It responded well not only to the needs of the women from rural areas, but also to the medical staff in Kragujevac, who received training and equipment necessary to perform the screening well.

While all activities were well-elaborated and meaningful, the project logical framework was inconsistent between activities – outputs – outcomes – impacts. Indicators were rather activity-based. Moreover, it has not included national advocacy (in Belgrade), through which it could have informed the decision makers and donors how to roll out the organized screening effectively. Ad hoc communication of the local implementer to the Serbian Ministry of Health was not effective to achieve this.

[9] Cytology costs is to be addressed by the end of 2015 according to the Ministry of Health.
[10] The Serbian Government introduced a hiring freeze in 2014 as a part of the fiscal consolidation approved by the International Monetary Fund program. See World Bank group – Serbia Partnership Program Snapshot April 2015, page 2, https://www.worldbank.org/content/dam/Worldbank/document/eca/Serbia-Snapshot.pdf.

***High efficiency*: good practice in the local multi-actor cooperation and screening cost-efficiency**

The cooperation with the local municipality, the medical institutions and the implementers was found very efficient. The entities naturally utilised their possibilities, such as access to the population or to the media. All actors worked as a team, in a synergy that contributed immensely to project outputs. The project was cost efficient. It utilised current equipment where available. Purchases of equipment or vehicles were necessary for quality project outputs. The remuneration of medical staff during weekends was also necessary, as this was clearly above their standard duties. The direct costs of 2 000 RSD per screened woman (450 CZK, 17 EUR) was very reasonable taking into account the standard of GDP per capita. There is no evidence that any alternative with fewer funds or less time or with a greater regard to local conditions would lead to the same outputs (4 292 women screened).

The role of Caritas CR was restricted mainly to project monitoring and reporting via distant cooperation and on-site visits, which accounted for 20 % of total expenses. It may have been more efficient to have a full-time manager in Serbia (this was reported by Caritas CR as their current practice in case of projects with a certain budget), who could have also engaged in on-going national advocacy.

***High effectiveness*: A sensitive, grass-root approach led to 52 % of all rural women screened in 2 years and in a high incidence rate of cervical cancer found at an early stage. This enabled timely treatment.**

The medical and project team was very dedicated. It went beyond the project plan and involved basically all villages of Šumadija region (50 instead of 40 planned) plus 3 districts of Kragujevac city. Personal invitation of an active volunteer or even medical staff and comfortable, sensitive group screening "at their door steps" were among the key factors that contributed to exceeding the target of 4 000 by 292 women screened. Covering around 52 % of total rural female population in 2 years is evaluated as a big success. Personal results delivery and multiple follow-up by phone with the patient and her family resulted in a high follow-up rate (74 %) among women with positive results. As a part of remaining 26 % may have been further checked in other facilities, the number of women without follow-up is deemed low. Psychosocial support of the families and addressing stigma in the rural population may help in the future.

The high cancer incidence rate (330 cervical cancer cases per 100 000 women), which is far above the Serbian average, confirms both the relevance and effectiveness of the field screening. As mostly early stages were diagnosed (88 % of diagnoses, data may not be complete) and almost all women quickly started their cure, their likelihood of survival is high and the health expenses comparatively low. This is mainly thanks to a dedicated local medical and project team and partners that went beyond the project and ensured follow-up even for those with financial or social constraints. The conclusions about behaviour or attitudes of the target groups as of 2015 are described in impact.

***High impact*: More than 100 lives saved and more women screened after the project ended**

The project has contributed to an increased awareness about the need for early detection of cancer among rural women, even though women still need more details about what they are eligible for and when. They also need more information about prevention, including HPV and other risk factors. The project contributed to an equal access to health care by extending the target group and involving also vulnerable women, such as socially excluded Roma women in Kragujevac or women in rural areas without health insurance. The project contributed to behavioural changes among them – some continue screening and pay it from their pocket, knowing this is important. As the medical staff ensured that women got quickly treated, the project helped saving lives of more than 100 women. Thanks to the project, women started to trust doctors more and those without a gynaecologist could select one. Increased public awareness, positive experience with screening and increased medical staff capabilities likely contributed to an above-average participation rate in the national cervical screening in the area

served by Kragujevac medical facilities. Detection of cancer mainly at early stages (currently 99 % according to the National Screening Centre, data may be incomplete) enables timely intervention, higher likelihood of successful treatment, reduced negative psychosocial impacts and reduced health expenditures.

***Rather high sustainability*: benefits for insured women and doctors continue, but the vulnerable women are left out as rural screening does not continue. For 9 135 USD, about 12 women can learn about their cancer in time and increase their chances for survival!**

Even if most women in rural areas currently have a gynaecologist and organized screening in ambulances is available, only some have utilized this service since 2013 due to multiple barriers: low awareness about non-symptomatic cancer, about prevention and patients´ rights, further low accessibility of health insurance and leaving out vulnerable women who may face higher risk of getting cancer, understaffed health centres, unclear coverage of cytology from health insurance and thus limited willingness of some doctors to increase the number of women screened, limited screening accessibility and productivity as well as patients´ experience with diverse quality of health care and thus hesitance to go for screening or treatment. Specifically, women without health insurance are not invited for the organized screening and are thus left out. Even though the project and the medical staff as well as the current Kragujevac municipality head for health issues really own the project results and are still passionate for field screening, there is no institution which would be the driving force behind its continuation. Even though the Health Centre in Kragujevac expressed the interest to continue, this was not officially addressed and funding was not secured. If field screenings were done just one Sunday a month, 480 women can be screened for a total cost of 960 000 RSD a year (around 9 135 USD or 212 000 CZK). If the incidence rate remains as in the project, about 12 women could be diagnosed with cancer and could be saved for relatively low costs as mainly early stages of cancer are likely to be found. During the evaluation, multiple financing options were found. An „advocate“ was needed to explore them and drive a solution.

***Rather high good governance*: high local participation, flexibility, national decision makers were missing**

The project was developed and implemented in a participatory way, with local decision makers. As it was a pilot project, the actors had not had similar experience. Thus flexibility of activities was necessary to achieve project objectives. However, the scheme of the project implementation (a tender) did not leave enough room for such flexibility. Thanks to the implementers´ accountability to target groups, the key change was solved outside of the original budget: follow-up screening costs were paid from the exchange rate surplus and unrealistic requirements for equipment were retrospectively adjusted with the CZDA. Yet, this shows a need for a systematic and more flexible solution (e.g. grants). Publishing results as a scientific article shows the commitment to inform about the success of the approach, but an internal evaluation could have indicated for example the need to focus more on sustainability. More thorough national advocacy, planned at the formulation stage, could have been of a big added value (e.g. participation at national cancer conferences, in dedicated committees etc.).

High respect for human rights of beneficiaries and gender equality in access to health care

The project ensured an equal access not only to screening, but to treatment for vulnerable women. Women and girls were the main focus of the project. Men were reached out to indirectly via media and involved in treatment as necessary, which is reasonable. Evaluating awareness and attitudes of men to cancer is worth further research.

No major influence on environmental protection or climate change

Rather high project visibility in the Šumadija region, low visibility on the national level

The regional promotion of especially cervical screening via multiple communication tools and channels helped to raise awareness and visibility. Still, women learnt about screening mainly from volunteers or peers. Brochures

were found rather complex for beneficiaries. While the implementer believed leaflets or posters would not make a difference, according to the evaluators, they can have a strong impact if displayed clearly at waiting rooms of doctors. The donor visibility was insured where possible. Target groups and beneficiaries mostly knew the project was "Czech", which is deemed sufficient. Yet, a distinctive logo could also help in promotion. The positive results could have been promoted more on the national and international levels, for which more capacities and structured activities in Belgrade would have had to be planned during the project formulation. Stronger visibility in the Czech media would also help to promote the Czech development cooperation among public.

High complementarity to the projects of the EU and the JICA, yet, no special collaboration

The project complemented the efforts of the EU and the JICA, which work with institutions on the national and regional levels. Even though there was no specific collaboration, the evaluated project basically supported the awareness, skills and attitudes of medical staff and rural women to take part in the organized screening. Simultaneously, the national screening programme was prepared by the EU and the JICA. The complementarity to a small-scale screening support by Norway is not known. There is no evidence that synergies with other Czech projects were sought.

High potential for follow-up collaboration on field as well as system level

This was evident on the field level (awareness, screening access and productivity, tailor-made treatment, psychosocial support) as well as system level (screening organisation, health reform, advocacy). All needs identified were found relevant except of in-vitro fertilisation, which the oncology expert of Naviga 4 sees as a far-away (and also expensive) step. Basic health care needs to be secured first. Twinning of ministries, oncological institutes, cancer patient associations and medical universities and further mutual expert exchange seem to respond to the current needs the most, according to informants. If funding is available, on-going field screening and also HPV testing would be very beneficial. Opportunities to engage in existing international oncology projects are minimal – almost all donors have left the sector in the recent years.

6 RECOMMENDATIONS

Recommendation	Justification	Addressee	Seriousness
Project and Serbian national level			
1. Advocate for state policy change to cover screening of uninsured women and replicate the field screening piloted by the evaluated project to reach out to vulnerable women at high risk of cancer	Equal access to cancer screening and treatment is necessary to diagnose cancer in early stages and reduce mortality rate. This has also proven more cost efficient than treatments of late stages of cancer, so ultimately it brings savings of the national health budget.	The Czech Embassy towards the Serbian Ministry of Health	1 – most serious
2. Further raise awareness about cancer prevention at schools and mobilize the public for screening	More in-depth knowledge, change of attitudes and behaviours are needed especially among young people and vulnerable population.	The Kragujevac municipality	2 – rather serious
3. Offer experts, capacity building or twinning for the following priority areas: • HPV testing / research in Kragujevac • National oncology data management	The mentioned areas were requested in Serbia and feasible for Czech institutions to cover. Development projects on good governance, twinning, expert exchange as well as private donations of Czech medical institutions (e.g. in	The CZDA with the Czech Embassy in Serbia	1 – most serious

Recommendation	Justification	Addressee	Seriousness
for evidence-based policies • Revision of breast screening procedures to increase productivity • Training of doctors / medical trainees in tailor-made cancer treatment • Strengthening cancer patient associations, their services to patients, campaigning and advocacy	case of a microscope for HPV testing) may be considered. The concrete possibilities need to be promoted among Serbian actors, who are expected to request concrete help. Any plans for collaboration need to take into account the activities of the Serbian Ministry of Health and the JICA or other donors.		
Czech ODA system level			
4. Ensure thorough stakeholder mapping and key actor involvement during the whole project cycle	National policy makers, cancer patient associations and other key stakeholders were omitted from the project planning. This has affected the good governance mechanisms, impacts and sustainability.	The CZDA in case of public tenders /implementers in case of grants	1 – most serious
5. Launch complex projects as grants to ensure enough flexibility	As the project was awarded in a tender, no details could be changed. Yet, if a project aims at changing attitudes and behaviour, it is rather complex and needs flexibility in implementation. Grants of the CZDA offer this flexibility.	The CZDA	2 – rather serious
6. Include on-going advocacy (evidence-based policy briefs, meetings with ministries, conferences etc.) to projects where relevant to increase impacts and sustainability	Stronger advocacy towards the Ministry of Health and the EU could have influenced the National Screening Programs. Advocacy has evidently brought system changes e.g. with respect to the Czech support of home care in Moldova.	The CZDA	2 – rather serious
7. Train Embassies in the project cycle management, including results-oriented monitoring.	The Embassy did not have detailed information about the Czech ODA project cycle management and lacked monitoring capacities.	The MFA CR with the CZDA	1 – most serious
8. Request evaluation in all bigger development cooperation projects (with a budget above 10 000 000 CZK).	The mid-term evaluation could have indicated the need for more structured advocacy and actions to remove barriers to sustainability.	The CZDA with the implementers and wit the MFA	1 – most serious
9. Consider the programme of mutual exchange of experts rather than expert sending and promote the programme among organisations involved in earlier ODA projects.	A short-term stay of a Serbian cytologist or radiologist at a Czech reputable cancer institute may help them learn high quality / productivity measures that can be then introduced to Serbia. None of the interviewed actors knew about the expert sending scheme. The expert contribution could have further enhanced impacts.	The CZDA	3 – least serious

7 ANNEXES

7.1 Abbreviations

CIDA	the Canadian International Development Agency
CR	the Czech Republic
CSO	Civil Society Organisation
CZDA	the Czech Development Agency
CZK	the Czech crown, currency, the exchange rate of 27 CZK = 1 EUR was used in this report unless stated otherwise
EC	the European Commission
EDF	the European Development Fund
ESO	the European School of Oncology
EU	the European Union
EUR	the Euro, currency, the exchange rate of 120 RSD = 1 EUR was used in this report
GDP	the Gross Domestic Product
HPV	human papilloma virus, an important risk factor for cervical cancer
ILO	the International Labour Organization
IOM	the International Organization for Migration
IRC	the International Rescue Committee
IT	Information Technology
JICA	the Japan International Cooperation Agency
LA	Local authorities
MFA	the Ministry of Foreign Affairs in the Czech Republic
Mio.	Million
NGO	Non-government organisations
NORAD	the Norwegian Agency for Development Cooperation
ODA	the Official Development Assistance
OECD-DAC	the Development Assistance Committee of the Organisation for economic cooperation and development
OSCE	the Organization for Security and Co-operation in Europe
Pap test	The Papanicolaou test, referred to also as the cytological cervical smear, is a method of cervical screening to detect pre-cancerosis and cancer in the cervix.
PC	Personal Computer
PR	Public Relations
RSD	the Serbian dinar, currency, the exchange rate of 120 RSD = 1 EUR was used in this report
TRANS	Transformation cooperation
TV	television
UNDP	the United Nation Development Program
USD	the United States Dollar, the exchange rate of the quoted sources were used in this report

7.2 Summary in the Czech language (shrnutí v češtině)

Projekt **Podpora prevence rakoviny u žen v regionu Šumadija** realizovala Charita Česká republika (ČR) a Oaza Sigurnosti v Srbsku v letech 2010 až 2012 jako veřejnou zakázku. Celkové náklady ve výši 10,5 mil. CZK (552 632 USD) financovala Česká rozvojová agentura (ČRA, anglicky CZDA). Od června do října 2015 proběhla externí evaluace projektu, kterou zadalo Ministerstvo zahraničních věcí (MZV, anglicky MFA) a kterou realizoval evaluační tým společnosti Naviga4. Evaluace se soustředila na celý projekt, jeho relevanci, komplementaritu, dopady, udržitelnost do června 2015 a potenciální budoucí spolupráci. Hlavním účelem evaluace bylo ovlivnit další směřování a metody realizace zahraniční rozvojové spolupráce (ZRS) ČR v Srbsku a/či v sektoru zdravotnictví. Předpokládalo se, že evaluace přispěje také k celkovému vyhodnocení Koncepce ZRS ČR pro léta 2010 až 2017.

Hlavní zjištění a závěry k evaluaci projektu jsou uvedeny níže:

***Vysoká relevance*: vyšetření ve vesnicích bylo strategickým krokem, v souladu s potřebami žen i zdravotního personálu**

Projekt reagoval na velmi vysoký výskyt rakoviny děložního čípku a rostoucí úmrtnost žen na rakovinu. Základní zdravotní péče v regionu Šumadija nebyla a stále není snadno dostupná. Ovšem většina žen touží využít nízkoprahových, citlivě provedených služeb jako jsou ty, které poskytoval hodnocený pilotní projekt. Projekt byl v souladu s prioritami Koncepce ZRS ČR na léta 2010 až 2017 a se strategickými dokumenty Srbska, které se týkaly včasného odhalení rakoviny. Projekt byl též dobře načasován, neboť byl po jeho ukončení zahájen organizovaný národní screening. Reagoval vhodně nejen na potřeby žen z venkovských oblastí, ale také na potřeby zdravotního personálu v Kragujevaci. Personál byl zaškolen a získal vybavení nezbytné ke kvalitnímu provedení vyšetření. Jediné, co chybělo, bylo zapojení srbského Ministerstva zdravotnictví a ovlivňování národní screeningové politiky.

***Vysoká efektivita*: spolupráce místních aktérů je ukázkovou praxí, náklady na vyšetření byly nízké**

Spolupráce mezi městem, zdravotnickými zařízeními a realizátory byla velmi efektivní. Subjekty přirozeně využívaly svých možností, jako byl přístup k evidenci obyvatel nebo k médiím. Všichni aktéři pracovali jako tým, v součinnosti, která nesmírně přispěla k dosažení výstupů. Projekt byl též hospodárný. Využil stávajícího vybavení, pokud bylo k dispozici. Zároveň bylo třeba nakoupit příslušné vybavení nebo vozidla, aby bylo možné dosáhnout kvalitních výstupů projektu. Bylo též nutné finančně odměnit zdravotnický personál, protože práce během víkendu byla zcela nad rámec jejich povinností. Přímé náklady ve výši 2 000 dinárů (450 Kč, 17 EUR) na jednu vyšetřenou ženu byly zcela přijatelné s ohledem na standardní měřítko hospodárnosti screeningu, tedy úroveň HDP na obyvatele. Neexistuje žádný důkaz, že by bylo možné dosáhnout stejných výstupů (4 292 vyšetřených žen) alternativním, levnějším či časově méně náročným způsobem. Charita ČR čerpala 20 % z celkového rozpočtu na pokrytí svých nákladů. Místo vedení projektu na dálku a několika návštěv mohla zaměstnat na plný úvazek srbského manažera projektu, který by měl zkušenosti s vedením projektů financovaných mezinárodními institucemi a který mohl průběžně ovlivňovat politiku příslušného srbského ministerstva. Charita ČR zmínila, že toto je již současná praxe u projektů s určitým rozpočtem.

***Vysoká efektivnost*: díky citlivému přístupu a zapojení komunity bylo během 2 let vyšetřeno 52 % všech žen na venkově. Četný nález rakoviny děložního čípku v raném stadiu umožnil včasnou léčbu.**

> *"Projekt ukazuje, proč je důležitá prevence. Léčba rakoviny (v pokročilém stádiu) je nejen dražší, ale má též ničivé psychosociální dopady."* Bývalý projektový manažer

Zdravotnický i projektový tým byly velmi zapáleny pro věc. Šly nad rámec původního projektového plánu a zahrnuly v podstatě všechny vesnice kraje Šumadija (50 místo 40 plánovaných obcí) plus 3 okrsky města Kragujevac. Mezi klíčové faktory úspěchu patřilo osobní pozvání žen aktivním dobrovolníkem či dokonce zdravotnickým personálem,

dále pohodlné a šetrné vyšetření, které je „hned u domu“. Díky tomu bylo vyšetřeno o 292 žen více, než byl původní plán ve výši 4 000 žen. Vyšetření 52 % všech žen na venkově za 2 roky je velkým úspěchem. Díky osobnímu předání výsledků vyšetření a četných telefonických rozhovorů s pacientkami i jejich rodinami se podařilo provést návazná vyšetření vysokého počtu pacientek (74 %), které měly pozitivní prvotní výsledky. Zbývajících 26 % s pozitivním nálezem mohlo být dále vyšetřeno v jiných zdravotnických zařízeních, tudíž počet žen, které se návazných vyšetření nezúčastnily, byl zřejmě nízký. V budoucnu může pacientkám a jejich rodinám pomoci psychosociální terapie a též osvěta na venkově řešící stigmatizaci pacientů s rakovinou.

Četný výskyt rakoviny (330 případů karcinomu děložního čípku na 100 000 žen), v Srbsku velmi nadprůměrný, potvrzuje potřebnost a účinnost screeningu ve vesnicích. Protože byla zjištěna především raná stádia (88 % diagnóz) a téměř všechny ženy se začaly rychle léčit, pravděpodobnost jejich přežití je vysoká a výdaje na léčbu poměrně nízké. Je tomu tak hlavně díky odhodlání lékařů, projektového týmu a Charity ČR, neboť šli společně nad rámec zadání a zajistili návazná vyšetření i těm ženám, které byly sociálně vyloučené a nemohly si návazná vyšetření finančně dovolit. Aktuální změny v chování nebo postojích cílových skupin jsou popsány níže v dopadech projektu.

***Vysoký dopad*: Zachráněno více než 100 životů a po ukončení projektu nárůst počtu vyšetřených žen**

> *"Zachránili jste mi život. Operovali mě 3 dny poté, co jsem dostala výsledky (vyšetření). Kdyby nebylo tohoto projektu, bylo by příliš pozdě na léčbu (až by se objevily příznaky)."* Pacientka s rakovinou

Projekt přispěl ke zvýšení povědomí žen na venkově o tom, že je třeba rakovinu odhalit včas. I tak ženy potřebují více konkrétních informací, na co mají nárok, v jakém věku a jak často. Potřebují též více informací o prevenci, včetně viru HPV (human papilloma virus) a dalších rizikových faktorů. Projekt posílil rovný přístup ke zdravotní péči, neboť cílovou skupinu rozšířil o ohrožené ženy, tedy sociálně vyloučené Romky v Kragujevaci a ženy na venkově bez zdravotního pojištění. Projekt též podpořil změny v chování žen – část z nich nadále navštěvuje prohlídky a sama si je platí, protože ví, že je to důležité. Neboť zapojení lékaři a sestry zajistili rychlou léčbu pacientek, lze tvrdit, že projekt pomohl zachránit životy více než 100 žen. Díky projektu ženy začaly více důvěřovat lékařům. Ty, které neměly gynekologa, si jej mohly vybrat. Zvýšené povědomí veřejnosti, pozitivní zkušenosti s vyšetřením a posílené kapacity zdravotnického personálu pravděpodobně přispěly k tomu, že zdravotnická zařízení v Kragujevaci v rámci národního screeningového programu vyšetřila nadprůměrný počet žen. Odhalení rakoviny včas (v současné době v 99 % případů podle Národního screeningového centra; data nemusí být přesná) umožňuje brzkou intervenci, zvyšuje pravděpodobnost úspěšné léčby, snižuje negativní psychosociální dopady a též snižuje celkové výdaje na zdravotní péči.

***Spíše vysoká udržitelnost*: přínosy pojištěným ženám a lékařům přetrvávají, ale zranitelné ženy jsou vynechány, neboť vyšetření na venkově nepokračují. Přitom za 212 000 Kč lze včas informovat asi 12 žen, že mají rakovinu, a tím zvýšit jejich šance na přežití!**

> *"Říkám ostatním, aby šly okamžitě (na prohlídku). Kdybyste mě nevyšetřili, ani bych nevěděla, (že jsem měla rakovinu)... Zachránili jste mi život."* Pacientka s rakovinou

I když nyní již většina žen na venkově má svého gynekologa a ač se mohou nechat vyšetřit, jen některé ženy z vesnic této možnosti od roku 2013 využily. Existuje několik překážek: nízké povědomí o nesymptomatické rakovině, o prevenci a právech pacientek, dále nízká dostupnost zdravotního pojištění, což vede k vyloučení zranitelných žen, které mohou čelit vyššímu riziku vzniku rakoviny, dále nedostatečné kapacity zdravotních středisek, nejasná úhrada vyšetření (cytologie) ze zdravotního pojištění, a tudíž i omezená ochota některých lékařů vyšetřit větší množství žen, dále též omezená dostupnost a produktivita screeningových zařízení, jakož i zkušenosti pacientek s různou kvalitou zdravotní péče, a proto nerozhodnost, zda vyšetření či léčbu postoupit. Ženy bez zdravotního pojištění nejsou zvány na organizovaný screening, a jsou tedy z prevence vyloučeny. Zdravotnický personál, projektový tým, ale i současná vedoucí sociálního a zdravotnického odboru města Kragujevac cítí

„vlastnictví“ výstupů projektu. Jsou stále nadšeni pro screening na venkově. Ovšem neexistuje žádná konkrétní instituce, která by přímo prosazovala další pokračování projektu. Dům zdraví v Kragujevaci vyjádřil zájem pokračovat, ovšem tento zájem nebyl smluvně podchycen a nebylo zajištěno financování. Pokud by vyšetření v terénu probíhalo i jen jednu neděli v měsíci, může být za rok vyšetřeno 480 žen s náklady ve výši 960 000 RSD (okolo 212 000 Kč nebo 9 135 USD). V případě, že by byla zachována stejná míra výskytu rakoviny jako v hodnoceném projektu, asi u 12 žen by byla diagnostikována rakovina. Mohly by být zachráněny za relativně nízké náklady, neboť je pravděpodobné, že by byla nalezena většinou raná stádia nemoci. Během evaluace bylo zjištěno několik možností financování. Je zapotřebí "obhájce", který by je blíže zkoumal a poté zajistil řešení.

“Potřebujeme, kvantitu, kvalitu a pokračování (vyšetření v terénu).“
Romský koordinátor

***Spíše vysoká míra řádné správy věcí veřejných*: významná participace lokálních aktérů, flexibilita, chyběly národní instituce s rozhodovací pravomocí**

Projekt byl připraven a zrealizován participativně, se zapojením místních samosprávných orgánů. Protože se jednalo o pilotní projekt, aktéři neměli dostatečné zkušenosti. Projekt potřebovali realizovat flexibilně, aby mohli dosáhnout vytyčených cílů. Nicméně realizace skrze veřejnou zakázku neposkytuje dostatečný prostor pro změny. Díky tomu, že realizátoři cítili zodpovědnost vůči cílovým skupinám, zasadili se o hlavní změny mimo původní rozpočet. Náklady na navazující vyšetření hradili z kurzového zisku a nerealistické požadavky na zařízení s ČRA zpětně upravili. Tyto komplikace však poukazují na nutnost systematického a pružnějšího řešení (např. využití dotací). Zveřejňování výsledků formou vědeckého článku ukazuje odhodlání informovat o úspěších. Ovšem interní evaluace v průběhu projektu by bývala mohla upozornit, že je třeba se více věnovat udržitelnosti (pokud to již nebylo zjištěno v rámci plánování a monitoringu). Velkou přidanou hodnotou by bývala byla i důkladnější práce s národními institucemi, a to již od fáze formulace projektu a dále skrze účast na národních konferencích o rakovině, ve specializovaných komisích aj.

***Vysoká míra dodržování lidských práv příjemců* a rovný přístup mužů a žen ke zdravotní péči**

V rámci projektu získaly ohrožené ženy rovný přístup nejen k vyšetření, ale i léčbě. Podpora žen a dívek patřila k hlavním cílům projektu. Muže projekt zasáhl nepřímo, a to skrze média. Dle potřeby se muži podíleli též na léčbě, což je považováno za adekvátní. Vyhodnocení povědomí mužů a jejich postojů k rakovině si zaslouží další výzkum.

Projekt se *nevztahuje se* k *ochraně životního prostředí* nebo *změně klimatu*

***Spíše vysoká viditelnost* projektu v regionu Šumadija, nízká viditelnost na národní úrovni**

Regionální propagace zejména vyšetření rakoviny děložního čípku prostřednictvím více komunikačních nástrojů a kanálů pomohla zvýšit povědomí o rakovině a viditelnost projektu. Ovšem ženy se o projektu dozvěděly zejména od dobrovolnic a známých. Brožury byly pro ženy z vesnic poměrně složité. Realizátor usoudil, že letáky či plakáty nebudou mít žádný vliv na posílení povědomí, podle evaluátorů však mohou mít významný dopad, pokud jsou umístěny na viditelném místě v čekárnách ambulancí. Vnější prezentace ZRS ČR byla zajištěna vždy, když to bylo možné. Cílové skupiny a příjemci většinou věděli, že projekt byl "český", což evaluátoři považují za dostatečné. Ovšem jasně odlišitelné logo projektu mohlo pomoci v propagaci. Pozitivní výsledky mohly být více propagovány na národní a mezinárodní úrovni. Pro tyto účely by bývaly musely být již během formulace naplánovány dostatečné kapacity a strukturované aktivity. Silnější vnější prezentace v českých médiích mohla též podpořit vnímání ZRS ČR u české veřejnosti.

Vysoká komplementarita s projekty EK a JICA, přesto neprobíhala konkrétní spolupráce

Projekt vhodně doplnil úsilí EK a JICA, které pracují s institucemi na národní a regionální úrovni. Nedošlo k žádné konkrétní spolupráci. Ovšem hodnocený projekt podpořil povědomí, dovednosti a postoje zdravotnických pracovníků a žen žijících na venkově a připravil je na účast v národním screeningu. Ten souběžně připravovaly EK a JICA. Není

známo, do jaké míry byl hodnocený projekt komplementární s norským projektem, který v malém rozsahu rovněž organizoval vyšetření. Součinnost s dalšími českými zdravotnickými projekty nebyla prokázána.

Vysoký potenciál pro návaznou spolupráci, a to jak v terénu, tak na systémové úrovni

Všechny zjištěné potřeby jsou hodnoceny jako relevantní kromě oplodnění in vitro, které vidí onkologický expert společnosti Naviga 4 jako vzdálený (a také drahý) krok pro srbské zdravotnictví. Dle tohoto názoru musí být nejdříve zabezpečena základní zdravotní péče. Příležitosti pro zapojení jsou uvedeny v doporučeních.

Na základě výše uvedených závěrů byla vypracována následující doporučení:

Doporučení	Adresát	Závažnost
Projektová a národní úroveň		
1. Zasadit se o změnu státní politiky, aby zajistila vyšetření nepojištěných žen a aby zavedla i v dalších regionech screening na venkově tak, jak ho pilotně provedl hodnocený projekt. Zapojí se tak i ohrožené ženy, u kterých je vyšší riziko rakoviny.	Zastupitelský úřad (ZÚ) směrem k srbskému Ministerstvu zdravotnictví	1 – nej-závažnější
2. Dále posilovat povědomí o prevenci rakoviny na školách a zmobilizovat veřejnost, aby se zapojila do screeningu	Město Kragujevac	2 – velmi závažné
3. Nabídnout experty, posilování kapacit a twinning v těchto prioritních oblastech: • Výzkum / testování typů HPV v Kragujevaci • Správa národních onkologických dat pro tvorbu politik • Revize postupů při vyšetření prsů s cílem zvýšit produktivitu • Školení lékařů / mediků v léčbě rakoviny na míru • Posílení sdružení pacientek s rakovinou, posílení služeb pacientům, osvěty a ovlivňování institucí	ČRA ve spolupráci se ZÚ	1 – nej-závažnější
Systémová úroveň ZRS ČR		
4. Zajistit zevrubné zmapování zainteresovaných stran a zapojení klíčových aktérů do celého projektového cyklu	ČRA (veřejné zakázky), realizátoři (dotace)	1 – nej-závažnější
5. Vést komplexní projekty formou dotací, a zajistit tak dostatečnou pružnost	ČRA	2 – velmi závažné
6. Zahrnout průběžné ovlivňování státních institucí (podklady pro politiky založené na faktech z projektu, schůzky s ministerstvy, konference aj.), pokud tak lze podpořit dopady a udržitelnost projektů	ČRA	2 – velmi závažné
7. Proškolit pracovníky ZÚ v řízení projektového cyklu, včetně monitoringu zaměřeného na výsledky	MZV ČR s ČRA	1 – nej-závažnější
8. Požadovat evaluaci všech větších rozvojových projektů (s rozpočtem nad 10 000 000 Kč).	ČRA s realizátory a MZV	1 – nej-závažnější
9. Zvážit program vzájemné výměny expertů spíše než jednostranné vysílání expertů; propagovat tento program mezi realizátory dřívějších rozvojových projektů.	ČRA	3 – nejméně závažné

7.3 List of interviews / group discussions in the CR

Form	Type of actor	Organisation	Name	Date
Interview	Gestor	CZDA, CR	Ivana Pejic Povolná, responsible for Czech ODA identification & monitoring in the Balkans	05/06/2015
Reference group meeting	Reference group member	Ministry of Health, CR	Eva Křemenová, health services department	05/06/2015
	Donor	MFA CR	Hana Volná, deputy director Dita V. Kubíková, responsible for evaluations, both from the department for Development Cooperation and Humanitarian Aid	05/06/2015
	Reference group member	MFA CR	Petr Kaiser, department of research and technology Pavel Baldík, department of the Southeast Europe	05/06/2015
Interview	Reference group member	Czech Evaluation Society, CR	Daniel Svoboda, independent expert	09/06/2015
Skype interview	Implementer	Caritas CR	Lukáš Voborský, former project manager	03/09/2015
Phone interview	Implementer	Caritas CR	Laura Kopecká, former project manager	03/09/2015
Phone interview	Other stakeholder	South Moravian region, CR	Tomáš Maluška, current head of external affairs	03/09/2015

7.4 List of interviews / focus groups and itinerary in Serbia

Form	Type of actor	Organisation	Name	Date
Belgrade				
Interview	Donor	The Czech Embassy	Dejan Zdrale, development cooperation coordinator	22/06/2015
Interview	Other donor	The EU Delegation	Dr. Maja Vuckovic-Krczmar, Health Programme Coordinator	22/06/2015
Group discussion	Key stakeholder	National Screening Office for Malignant Diseases, the National Institute for Public Health "Dr Milovan Jovanovic Batut"	Svetlana Vrga, Department for Development cooperation Verica Jovanovic, the Head of the National Screening Office Tamara Namnovic, responsible for cervical screening	23/06/2015

Form	Type of actor	Organisation	Name	Date
			Claudia Kravic, responsible for breast screening	
Interview	Key stakeholder	Association of Medical Oncologists Serbia / National Cancer Research Center	Sinisa S. Radulovic, M.D., Ph.D., CCPI, Spec Clin Pharm, Professor of Research, President of the Association, Scientific Director, National Cancer Research Center	23/06/2015
Group discussion	Cancer Patient Association	Budimo Zajedno - Stay Together	Jasmina Lukič, chairwoman, 4 cancer patients (anonymous)	23/06/2015
Šumadija region				
Interview by Skype	Local implementer	Oaza Sigurnosti	Mina Mijailović, project coordinator	01/06/2015 04/06/2015 17/06/2015
Group discussion	Local implementer	Oaza Sigurnosti, Srbsko	Mina Mijailović, project coordinator Vera Simić, director	23/06/2015
Interview and site visit	Local partner / target group	The Health Centre in Kragujevac	Dr. Dubravka Đurković, gyneacologist	24/06/2015
Interview	Local partner / decision maker	The Kragujevac Municipality, earlier the Health Centre in Kragujevac	Gordana Damjanović, currently the member of the City Council responsible for Health and Social sectors, earlier the PR Manager of the Health Centre in Kragujevac	24/06/2015
Focus group	Beneficiaries	-	6 Roma women from Kragujevac	24/06/2015
Interview	Beneficiary	-	Cancer patient from the Roma community	24/06/2015
Interview	Local partner / decision maker	the Kragujevac Municipality	Zoran Pavlovic, Roma coordinator	24/06/2015
Group discussion	Local implementer	Oaza Sigurnosti, Srbsko	Mina Mijailović, project coordinator Vera Simić, director Daniela Petrovic, field worker Snezna Gruic, lecturer Milavka Stivovic, field worker	24/06/2015
Focus group	Local partner / target group	The Health Centre in Kragujevac	Dubrovka Djurkovic, Mariana Boskurica, Spomenka Simonovic, Slavica Manojrovic, Vesna Pavlovic, Romana Sandro Dimitrijevic, Ivica Magdic, Yelena Stojanovic, Mirjana Arsenievic – gynaecologists involved in the project Sandra Dimitrijevic – nurses involved in the project	25/06/2015
Interview	Local Partner	The Health Centre in Kragujevac	Zoran Todorovic, Director, Professor at Medical College, Infectologist	25/06/2015
Interview and	Key stakeholder	Mammography unit in	Staff member (anonymous)	25/06/2015

Form	Type of actor	Organisation	Name	Date
site visit		Kragujevac		
Interview	Local partner	The Clinical Centre in Kragujevac	Alexander Zivanovic, Professor of gynaecology, surgeon at the Clinical Centre, earlier the Kragujevac City Council member responsible for health	25/06/2015
Focus group	Beneficiaries	-	9 patients from Gorne Komarovice	26/06/2015
Interview	Beneficiary	-	Cancer patient from Gorne Komarovice	26/06/2015
Focus group	Beneficiaries	-	2 patients from Cerovac	27/06/2015
Focus group	Beneficiaries	-	14 patients from Lužnice	27/06/2015
Interview	Beneficiary	-	Cancer patient from Lužnice	27/06/2015
Data review, planning of the second week				28/06/2015
Interview	Cancer Patient Association	Ženski Centar DIVA	Nataša Kračunovič, chairwoman	29/06/2015
Interview and site visit	Local partner / target group	The Health Centre in Bresnica, Kragujevac	Romana Dimitrijevic	29/06/2015
Interview and van visit	Local partner / target group	The Health Centre in Kragujevac	Dr. Dubravka Đurković, gynaecologist Nenad Sankovic, driver	30/06/2015
Interview	Volunteer / beneficiary	Ambulance in Dragobratje	Gordana Manojlovič, nurse and patient (screened by the project)	30/06/2015
Focus group	Beneficiaries	-	11 patients from Dragobratje	30/06/2015
Focus group	Beneficiaries	-	3 cancer patients from Gorne Jarošovice	30/06/2015
Interview	Beneficiary	-	Cancer patient from Gorne Jarošovice	30/06/2015
Focus group	Beneficiaries	-	7 cancer patients from Kragujevac	01/07/2015
Interview and site visit	Key stakeholder	Clinical centre in Kragujevac	Jasmina Nedovic, oncologist and 2 other doctors	01/07/2015
Debriefing	Multiple stakeholders	-	Mina Mijailović, project coordinator Vera Simić, director of Oaza Sigurnosti Dr. Dubravka Đurković, gynaecologist at the Health centre in Kragujevac Gordana Damjanović, City Council member/PR Nataša Kračunovič, chairwoman of Ženski Centar DIVA	02/07/2015
Interview	Decision maker	Ministry of Health	Predrag Sazdanovic, advisor to the Minister	03/07/2015
E-mail questionnaire	*Other donor*	*JICA Balkan Office*	*Ryuichi Ito, Natasa Blagojevic*	*No answer*

7.5 Evaluation team

The profiles of the evaluation team members are described below. All except the methodologist took part in the field evaluation mission.

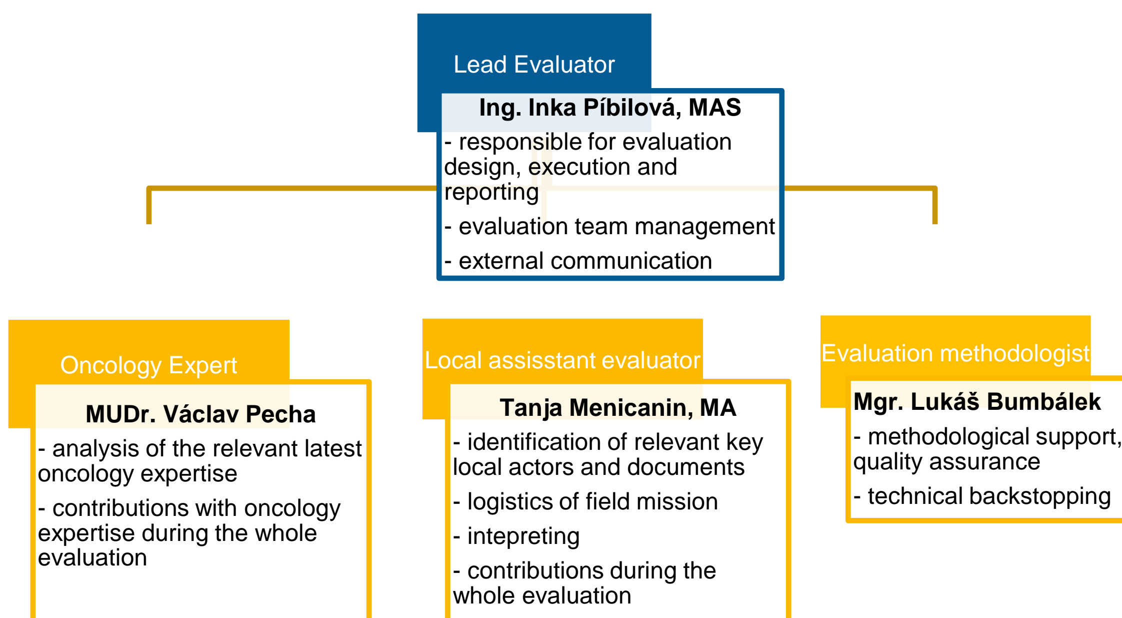
The lead evaluator Ing. **Inka Píbilová**, MAS, has been working in development cooperation on for more than 8 years and has conducted 17 evaluations of development and educational projects so far. She is a Board member of the Czech Evaluation Society and an active member of the International Development Evaluation Association – IDEAS. She regularly presents her research at international conferences, such as of the Wageningen University.

MUDr. **Václav Pecha** is an eminent Czech woman's oncologist and surgeon. He has been intensively involved in the field since the 70´s of the last century. He has cooperated with a number of international organisations specialized in oncology (Breast Centre Network, ESO etc.). He is an author of publications, trainer and further the co-funder and Chairman of the biggest Czech patient association, Mamma Help. MUDr. Pecha has experience from development cooperation in the health sector.

Tanja Menicanin, MA has been engaged in development cooperation in the Western Balkan for 17 years. She has gained project management, monitoring and evaluation experience in international organisations such as OSCE, IRC, IOM or ILO.

Mgr. **Lukáš Bumbálek** has more than 10 years of work experience with managing and evaluating EU-funded projects. Beside others, he has been involved in the water, health and sanitation programme evaluation in Bosnia and Herzegovina.

The roles within the evaluation team have been divided as follows:



7.6 Questionnaires and sets of questions used

Guidelines for focus groups with doctors / nurses

Location: Date:

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

1. Introduction: Name, age, job.

Check if all participated in the project!

2. How have you learn about the project? Do you know who funded the project we talk about? (*Effectiveness, visibility*)

3. What do you think were the biggest needs with respect to breast and cervical cancer prevention, diagnosis and treatment in Sumadija region before 09/2010?

4. What was unique about the project? (*Relevance, Effectiveness*)

5. We understood the project focused primarily on cervical cancer. Breast cancer examinations were conducted only by manual check-up, ovarian cancer only in follow-up. What do you think were the reasons for this approach? (*Effectiveness, Impact*)

6. About 24% of women who were recommended follow-up check-ups did not come or did not hand over their results. Is this correct? What do you think were the reasons? (*Effectiveness*)

7. Do you know what happened to the 14 patients who had cancer and with the 23 who had pre-cancerosis? How were they treated? What restrictions / limits appeared? What is their current status? (*Impact*)

8. Have you observed any increase in the interest in check-ups since 12/2012? Which check-us and in what extent? What do you think are the main reasons (even if there is not increase)? (*Impact, Sustainability*)

9. Have you observed any increase in cases of breast / cervical / ovarian cancer diagnosed in earlier stages? What do you think are the main reasons (even if there is no increase)? (*Impact, Sustainability*)

10. In case of higher interest: Do hospitals in Sumadija region have sufficient capacities for examinations and treatment of an increased number of women? (*Impact*)

11. How has the donated equipment been used? Do other hospitals / donors make use of it? (*Sustainability*)

12. *If time allows:* Do you think that both men and women are currently well aware of cancer and the importance of prevention? If not, what do you think is still needed? (*Impact, Relevance*)

13. *If time allows:* Do women have sufficient resources and are ready to undergo any treatment as soon as possible? What mostly limits them? Who cares about family and household during their ailment? (*Impact, Sustainability*)

14. *If time allows:* If there would be a possibility for future collaboration with the Czech institutions, what would be your priority area to collaborate on? Would you be interested to initiate the collaboration? (*Impact, Relevance*)

15. Do you have any other comments?

Guidelines for focus groups with women in villages

Location: Date:

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.

16. Introduction: Name, age, job.

Check:

- *10 women:*
  - *At least 2 should be between the age of 18 and 25*
  - *At least 1 should be between the age of 55 to 69*
  - *The rest can be of diverse age between 18 and 69*
- *A mix of those who went for gynec / breast cancer examinations during the project and of those who did not.*

1. How have you learn about the project? Do you know who funded the project we talk about? (*Effectiveness, visibility*)

2. Before the project started in 09 / 2010, what did you know about breast and cervical cancer? (*Relevance*)

3. What key messages can you remember from the awareness raising done by Oaza Svornosti and volunteers from 2010 to 2012? (*Effectiveness, how to live healthy, cancer can be treated if diagnosed early, when and where to go for check-ups…*)

4. Have you gone for check-ups at that time? What made you join? If not, what were the reasons? *Do you feel you were treated with sensitivity and care?* (*Effectiveness*)

5. *(If time allows:)What do you think motivates women best to go for screening? What stops them? (Relevance, Effectiveness, Impact)*

6. Have you been to a gynec / mammology check-up since 01/2013? If so, how many times? (each writes the number on a piece of paper, then the group discusses the reasons for a high number or a low number) (*Impact, Sustainability*)

7. What is the nearest place to go for a gynec / mammology check-up? What is the waiting time? Do you find this satisfactory or would you change it? If so, how? (*Impact, Sustainability*)

8. Do you know of any women in your village who have breast or cervical cancer or precancerosis? If so, are they being treated? Do they face any limitations? If so, what are these? How can they be overcome? (*Impact*)

9. Is there anything else you would like to share?

7.7 Original and reconstructed intervention logic

Key comments to the original intervention logic (project logical framework):

- The ***project purpose*** aimed to "improve the situation in cancer prevention among Serbian women" according to the ToR established by the CZDA, whereas the project proposal by Caritas CR narrowed it to breast cancer. The evaluators found it not clear what "improvement" is meant and what statistics was planned to be used to demonstrate a success. In practice, the local partner focused both on cervical and breast cancer specifically in Šumadija region as expected by the project title. They used a more specific indicator, which the evaluators considered appropriate:
    - *Increased % of the cases of breast and cervical cancer diagnosed in early stages out of a total number of new cases (compared to the baseline, which, however, was not available).*

- ***Specific objectives*** aimed at support of awareness and prevention and simultaneously at increased attainability of quality treatment. They overlapped with project outcomes, thus breaking the rule that the lower level of the logical framework should contribute to the higher one if relevant assumptions are met. Moreover, even if met, they would not necessarily mean that women would actually attend cancer screening, which is an essential step towards the project purpose. Out of the original 3 indicators, only the number of examined women in the region would be relevant in that case. Additionally, a % of women who followed upon initial positive results would show the project effectiveness. The indicators could be:
    - *Increased % of women who attend regular breast and cervical cancer screening out of a total number of women in the region (compared to the baseline, which was not available, or a total target of 4 000 women who were screened up to specified quality standards).*
    - *% of women who attended follow-up check-up upon recommendation.*

- ***Outcomes*** were two-fold: realized information and edifying campaign in the region (in 40 villages) and 4 000 local women with access to necessary information about breast cancer and to quality treatment. They referred to "outputs" (what is directly produced) rather than "outcomes" (the resulted behavioural change). On the outcome level, rather than measuring if the campaign was implemented (what if nobody understood the message?) and what was the number of seminars held (what if nobody joined?), increased awareness among women and increased knowledge/skills of seminar graduates seem to be more appropriate indicators of the outcome that can be defined as:
    - *Increased % of women who know that HPV can cause cervical cancer, that cancer can be cured if diagnosed at an early stage and who know when and where to attend regular screening (compared to a baseline e.g. at the beginning of workshops, which was not available, or a total target of 4.000 women)*

- *Increased number of doctors who perform screening according to certain quality standards (e.g. taking and reading Pap tests with a low error rate, compared to a baseline e.g. via self-assessment, as well as e.g. high satisfaction rate of patients).*

The original and the revised project logical framework:

	Original project description	**Project description proposed by evaluators**	**Original objectively verifiable indicators**	**Indicators proposed by evaluators**	**Original sources of verification**	**Sources of verification proposed by evaluators**
Purpose	Improvement of situation in prevention of breast cancer in Serbian women.	Early detection of breast and cervical cancer among women in Šumadija region and in long-term reduced mortality	Improvement of statistic outcomes concerning breast cancer treatment.	% of the cases of breast and cervical cancer diagnosed in early stages out of a total number of new cases	Serbian official statistic information published by official/competent authorities.	Regional oncology registry of the Public Health Institute
Objectives	1. Support of awareness and prevention of breast cancer in rural areas of the Šumadija region. 2. Increasing of attainability of quality and skilled treatment in the distant areas of the region.	1. Increased breast and cervical cancer screening among rural women in Šumadija region	Implemented media and public edifying activities. The number of realized special seminars. The number of examined women in the region.	% of women who attend regular breast and cervical cancer screening out of a total number of women in the region (or a total target of 4.000 women who were screened). % of women who attended follow-up check-up upon recommendation	PR and media summary of activities and references. Records of the implementing organization and medical records.	Project oncology database, patient documentation

	Original project description	**Project description proposed by evaluators**	**Original objectively verifiable indicators**	**Indicators proposed by evaluators**	**Original sources of verification**	**Sources of verification proposed by evaluators**
Outcomes	1. Realized information and edifying campaign in the region (coverage of 40 villages in the area) 2. 4 000 local women will gain access to necessary information about breast cancer and access to quality treatment.	1.1. Increased awareness about breast and cervical cancer among rural women in Šumadija region 1.2. Increased quality of cervical screening at the Health Centre in Kragujevac	Implemented media and public edifying activities. Number of realized special seminars. Number of examined women in the region.	% of women who know that HPV can cause cervical cancer, that cancer can be cured if diagnosed at an early stage and who know when and where to attend regular screening (or a total target of 4 000 women) Increased number of doctors who perform screening according to certain quality standards (e.g. taking and reading Pap tests with a low error rate, compared to a baseline via self-assessment, high satisfaction rate of patients etc.).	PR, overview of media activities and references, attendance of seminars. Records of the implementing organization and medical records.	Door-to-door survey among a sample of women pre and post the project, patient documentation, screening quality monitoring by a supervisor
Activities	1.1. Creation and distribution of propagation material 1.2. Promotion of the issue in media	A 3-digit numbering is recommended to refer to relevant outcome and objective.	Amount of distributed material Number of broadcast/ published contributions Number of meetings	Indicators are not required at this stage as activities may be adjusted on the way if they are found	Storage evidence, field monitoring Media monitoring Working evidence Attendance sheets and	No special comments

	Original project description	Project description proposed by evaluators	Original objectively verifiable indicators	Indicators proposed by evaluators	Original sources of verification	Sources of verification proposed by evaluators
	1.3. Face-to-face contact with target group representatives in field-work 1.4. Organization of special seminars for the public 1.5. Distribution of sanitary packages to the target group 1.6. Purchase of a private car for the project purposes 2.1 Supply and equipment of mobile clinic 2.2 Providing of slight adjustments in cytological laboratory 2.3 Skilled screening in the field and in hospital 2.4. Special seminar for 2 local doctors 2.5 Special seminars for the implementing team of the partner organization and involved specialists (doctors, nurses)		Number of seminars Number of packages Takeover of the equipment and its installation Number of examined women Information on the course progress Number of seminars, workshops etc.	ineffective to reach the outcomes and objectives.	programme Distribution list Car registration Completion certificate Photographic documentation Record of examined women Certificate on taking part in the seminar Attendance sheets	

7.8 Evaluation Terms of Reference

MINISTRY OF FOREIGN AFFAIRS OF THE CZECH REPUBLIC

ANNOUNCES

A TENDER FOR THE DELIVERY OF A SMALL-SCALE PUBLIC CONTRACT TITLED

„EVALUATION OF A PROJECT UNDER THE CZECH REPUBLIC'S FOREIGN DEVELOPMENT COOPERATION IN THE HEALTH SECTOR IN SERBIA“

AND INVITES BIDS

Information on the CONTRACTING AUTHORITY

Contracting authority: Czech Republic – Ministry of Foreign Affairs

Registration number: 45769851

Tax registration no.: The Ministry of Foreign Affairs is not a VAT payer

Registered address: Loretánské náměstí č. 101/5, Praha 1, PSČ 118 00

For substantive decisions and contractual matters the contracting authority is represented by:

PhDr. Hana Ševčíková, Director, Development Cooperation and Humanitarian Aid Department

Official responsible for organising the tender process:

Mgr. Dita Villaseca B. Kubíková, Development Cooperation and Humanitarian Aid Department

tel.: 224 18 2872, e-mail: dita_kubikova@mzv.cz

Subject of the public contract (NIPEZ 79998000-6 Coaching services)

The subject of the tender organised as an open tender is the evaluation of a project under the Czech Republic's foreign development cooperation in the health sector in Serbia (according to OECD-DAC[11] classification) with emphasis on long-term impacts and sustainability, as well as the potential for expanding development cooperation or the establishment of bilateral cooperation outside the development cooperation framework.

[11] Organisation for Economic Co-operation and Development - Development Assistance Committee

The specific project is: **„Promoting cancer prevention among women in the Šumadija region“**

coordinator:	Czech Development Agency
sector:	health
implementation period:	2010 – 2012
project type:	public contract
implementer:	Caritas Czech Republic
total funding from the Czech Republic's development cooperation:	10.5 million CZK

Principal stakeholders

Ministry of Foreign Affairs of the Czech Republic (MFA) – responsible within the framework of the Czech Republic's development cooperation for the conceptual management of development cooperation, including the programming of its bilateral components and the evaluation of results.

Czech Development Agency („CzDA“) has been active since 1st January 2008 as an implementation agency in the field of development cooperation, and in particular in the preparation and execution of bilateral development projects. It currently has responsibility for coordinating almost the whole range of bi-party development projects of a significant scale. The CzDA also oversees project evaluation.

Embassy of the Czech Republic in Belgrade represents the Czech Republic in Serbia, including in the field of development cooperation. Specifically, the tasks of coordinating and monitoring development coordination are the responsibility of a member of the embassy diplomatic staff specialised in development cooperation issues.

Implementer – Caritas Czech Republic implemented the project to be evaluated in the form of a public contract awarded by the CzDA following a tender.

Partner organisations – **Oaza Sigurnosti Serbia** is a local NGO concerned with the welfare of women in Serbia. Its activities include the protection of victims of domestic violence. **Dům zdraví Kragujevac** is a hospital and health clinic.

Final project beneficiaries – women aged 25 to 68 living in villages in the Kragujevac region at risk of cancer, patients already diagnosed with cancer, doctors and other local health workers engaged in this project.

Additional information on the project under evaluation

This development cooperation project was selected for evaluation due to the requirement for consideration of methods for additional Czech Republic development cooperation projects in the health sector. **Reports from previous evaluation cycles, including recommendations from a comprehensive assessment of the 2012-2013 evaluation reports and of the Ministry of Foreign Affairs evaluation system,** which took place in 2014, have been taken into account. The project was also selected with respect to the fact that evaluation of

development intervention in the health sector should be implemented **with an emphasis on long-term impacts and sustainability** as well as **the potential for expanding the scope of development cooperation or establishing bilateral cooperation outside the Czech Republic development cooperation framework.** The evaluation will also form part of the basis for the overall evaluation of the **Development Cooperation Strategy of the Czech Republic 2010 – 2017** [12]**.**

Objectives and purposes of the evaluation

The evaluation of Czech development cooperation projects is undertaken on the basis of **Act No. 151/2010 Sb.,** on Development Cooperation and Humanitarian Aid, the **Development Cooperation Strategy of the Czech Republic 2010 – 2017** (Government Decree No. 366 of 24th May 2010) and the applicable provisions of **Project Cycle Methodologies for Bilateral Development Cooperation Projects.**

The main **purpose** of evaluation is to obtain **independent, objectively based and consistent findings, conclusions and recommendations** that can be considered by the MFA in cooperation with the CzDA when deciding on **the future direction and method of implementation of development cooperation in a given country and/or sector.**

The objective of this specific evaluation is, on the basis of the pilot project in the health sector administered by the CzDA in the years 2010-2012, **to evaluate the work of the Czech Republic in the health sector with emphasis** on its **long-term impact and sustainability,** and also to assess the options for **further expansion of development cooperation or the establishment of bilateral cooperation outside the Czech development cooperation framework.**

Another important and expected result of the evaluation is assessment of whether the development activities represented by the project in question were **linked** with any other development cooperation activities of the Czech Republic and/or of other donors in the same sector. The contracting authority also welcomes evaluation of any cooperation with other development players in Serbia in the health sector, and evaluation or comparison of the activities of the project under evaluation with the relevant strategic documents covering the Czech Republic's development cooperation, or those of the partner country.

Evaluation shall be performed **in accordance with the internationally recognised OECD/DAC criteria, and other given criteria** (see below).

The contracting authority also expects, with respect to the specifics of a **public contract**, the evaluation team to **assess the intervention logic** in the context of the given sector. This should include analysis of key requirements and risks for achieving objectives, and where appropriate, analysis of methodological obstacles and constraints to evaluating project impacts. If the evaluation team find the intervention logic in the project documentation to be poorly or incompletely defined, the **reconstruction of the intervention logic** is expected as part of this evaluation work.

Principal evaluation questions

- To what degree did the evaluated project conform to the Official Development Cooperation Strategy of the Czech Republic 2010 – 2017 and the strategic policy documents of the partner country in the given

[12] Development Cooperation Strategy of the Czech Republic 2010 – 2017 is available at www.mzv.cz/pomoc

sector, and which of the activities were the most effective with respect to achieving their objectives? ***(relevance)***

- How were the project objectives achieved? What changes attributable to the project are evident in the behaviour or attitudes of the target groups? ***(effectiveness)***

- Within the evaluated project, how did cooperation with governmental and non-governmental entities proceed? From the perspective of achieving the objectives, which of the activities were most effective? ***(efficiency)***

- To what degree did the evaluated project fulfil the needs of its end recipients? Did the project activities or impacts affect any previously unintended target groups? Who is the resultant project owner? In what way did the project implementer support local ownership of the project? In what way are local partners making use of the project results? ***(sustainability)***

- What are the resulting and objectively verifiable impacts in relation to the intended impacts? What external effects had a positive or negative influence on the project results and impacts? Are there any barriers to the evaluation of impacts (e.g. with respect to the passage of time, insufficient information etc.)? ***(impacts)***

- Is there evident potential for the establishment of bilateral cooperation outside the framework of development cooperation? Does the possibility exist for a different form of cooperation beyond Czech bilateral cooperation (e.g. engaging Czech organisations in the projects of other donors)? In what areas and by what method could such cooperation be supported? ***(follow-up cooperation)***

- Can any system recommendations be derived from the evaluation results to amend the focus or increase the effectiveness of further development projects in Serbia or other countries and sectors? ***(findings concerning the system)***

- Have the related activities of the evaluated project been sufficiently well elaborated and logically sequenced? Or, does the project proposal itself indicate the potential for failure with respect to the stated objectives (relevance, effectiveness, efficiency, sustainability and impacts)? ***(findings related to intervention logic)***

OECD/DAC evaluation criteria

The findings and conclusions of the independent evaluation shall provide an overview of the activities of the Czech Republic in the **health sector in Serbia** over the evaluation period, including evaluation from the perspective of internationally recognised OECD/DAC evaluation criteria, i.e. relevance, efficiency, effectiveness and, **above all, sustainability and impacts**. Brief definitions of the OECD/DAC criteria are given below: [13]

Relevance – the extent to which the development activity is suited to the priorities and policies of the target group, partner (recipient) country and donor country, and donor.

[13] More on the application of OECD–DAC criteria in development cooperation project evaluations is available in the attached evaluation report outline and in OECD–DAC publications, such as "Evaluating Development Cooperation. Summary of Key Norms and Standards" and "Quality Standards for Development Evaluation" (available for download at www.oecd.org/development/evaluation). A thorough study of the Project Cycle Methodology for Bilateral Projects under the Czech Republic's Development Cooperation is also recommended (available at www.mzv.cz/pomoc).

Efficiency – degree of utilisation of input resources (scheduling, expertise, administration and management, finances etc.) relative to the results and objectives actually achieved. The activities performed are assessed as to their adequacy, effectiveness and efficiency. Where appropriate, alternative solutions can be proposed for achieving the stated results and objectives in a way requiring less funds, less time, or with greater regard to local conditions etc. Whether the desired objectives and outputs were realistically set can also be a subject for assessment. Assessment of the degree to which optimum use was made of financial resources to achieve the desired results is undertaken from both a quantitative and qualitative perspective.

Effectiveness – Theory of Change, the degree to which the development intervention objectives have been met.

Sustainability – the extent to which, or likelihood that, the **project's positive effects for the target group will continue after completion of activities and funding by the donor/implementer**. Sustainability should be assessed with an emphasis on assessing the importance that was placed during the project cycle on **motivation and cooperation with the recipients and local partners, sharing ownership** and identification of entities responsible for follow-up funding whilst objectively considering any obstacles.

Impacts – positive and negative, direct and indirect, and intended and unintended short- and long-term consequences of the project for the target group and in the partner country in general. For the impacts criterion, the evaluation must also thoroughly address **external influences of the environment in which the project was implemented, and specify obstacles that may objectively be considered to have an influence on these impacts.**

Other evaluation criteria

The evaluation is also to assess the project from the perspective of its **external presentation** (visibility) in the partner country and with respect to application of **cross-cutting principles of Czech development cooperation** defined in the Development Cooperation Strategy of the Czech Republic 2010 – 2017:

good (democratic) governance; respect for the environment and climate; respect for the human rights of beneficiaries, including equality between men and women. The evaluators should, in particular, assess whether and how the cross-cutting principles (or some of them as applicable) are directly associated with the sector focus of the evaluated project and activities; whether and how the contracting authority and/or the implementer have addressed the cross-cutting principles when formulating and implementing the project; whether in efforts to take cross-cutting principles into account during preparation and implementation of the project, the implementer (or the contracting authority during formulation of the project) encountered conflicting objectives, interests and values of the project beneficiaries/partner country, and how such situation was resolved. Regarding these aspects, the evaluation team should therefore be astute in collecting data and **ascertain the viewpoints of the project's final beneficiaries** (and, where appropriate, other relevant persons). When determining the opinions, feelings and experiences of the target group it is important to pay special attention to ensure inclusion of vulnerable members (as a rule women – and in the given case particularly women at risk of cancer, members of racial, ethnic and religious minorities, and the elderly). From the information obtained an overall conclusion should be drawn with respect to the individual cross-cutting principles as to the extent to which the evaluated project made use of existing opportunities and avoided undesirable situations.

Recommendations arising from the evaluation findings and conclusions

The evaluation report will give **specific and feasible recommendations, with added value, addressed by the evaluation team specifically to the MFA, the CzDA, the implementer or other relevant development**

cooperation parties. These recommendations should be adequately supported by specific findings and conclusions and focussed primarily on **system recommendations** for the potential future direction of development activities in the health sector in Serbia. The contracting authority will welcome, in particular, recommendations aimed at **increasing the sustainability and effectiveness of future similar development interventions, and especially** recommendations for implementing a **bilateral commercial follow-up** in the health sector. However, recommendations can also be **procedural** with respect to the given type of project, as well as **lessons learned of a broader nature** with respect to the management and implementation of development cooperation, or systemic lessons for the management of the evaluation process, provided that such lessons are sufficiently **specific, relevant and also applicable to the Czech Republic's development cooperation in other countries and sectors.**

Required outputs from the comprehensive evaluation with deadlines

Together with the contracting authority, progress in the evaluation will be overseen, in an advisory role, by a **reference group** comprising representatives of the Development Cooperation and Humanitarian Assistance Department of the MFA, the Southern and Southeastern Europe Department of the MFA, the Bilateral Economic Relations Department of the MFA, the CzDA, the Ministry of Health, the Embassy of the Czech Republic in Belgrade and the Czech Evaluation Society. Communication between the evaluation team and the reference group will be mediated by an authorised representative of the Development Cooperation and Humanitarian Assistance Department. Providing they remain impartial, reference group members will have the right to comment on the report submitted by the evaluation team.

- The contracting authority requires the submission of one **input evaluation report** and one **final evaluation report**. The final evaluation report will subsequently be published on the MFA website.
- The **input report,** with a structure and annexes in accordance with the attached mandatory outline[14], expands in detail on the evaluation methodology, describes the sets of evaluation questions and hypotheses formulated on the basis of a study of documents and interviews conducted in the Czech Republic, which are to be verified by a mission to the partner country. The input report also contains the **schedule** of the mission to the partner country, including a plan of meetings, interviews, focus groups, observations, scientific measurements, surveys, etc.
- The input report must be discussed with the contracting authority and the reference group and submitted to the contracting authority, both as a bound hardcopy publication and in electronic form, with comments incorporated **at least five working days prior to the team's departure for the evaluation mission** to the partner country.
- The form of the final evaluation report must follow the **outline of the evaluation report for Czech development cooperation**[15]; the report length will be a maximum of four A4 pages of executive summary and maximum 25 A4 pages (excluding annexes). Bearing in mind the stipulated scope, the contracting authority expects the final evaluation report to contain, in particular, the **key points of the evaluation, including the independent findings, conclusions and resultant recommendations**. **The mandatory annexes** shall state the sources of verifiable findings, quantitative facts, templates and

[14] Outline of the input evaluation report for development cooperation of the Czech Republic is an annex to this document.
[15] Outline of the final evaluation report for development cooperation of the Czech Republic is an annex to this document.

results of the evaluation of questionnaires, a table of processed comments from the reference group and implementer, a control list of obligatory requirements of the evaluation contract etc., - according to the list of mandatory annexes of the evaluation report.

- The evaluation report shall be in the **Czech language** (with an English summary), or, in the case of the evaluation team having an **international composition, in English (with a Czech summary)**. Annexes to the evaluation report can, where relevant, be kept in the language in which they were prepared.

- **A working version** of the final **evaluation report** must be submitted to the contracting authority for comments by **15th September 2015.** The contracting authority will collect comments from the reference group and pass them on to the author, who is required to process the content related comments (i.e. incorporate them into the body of the report, or reject them, with reasons, and in writing). If the project implementer is also invited to send comments, the evaluation team must also address the implementer's suggestions.

- The contracting authority expects the author to **present the evaluation report**, reflecting the comments of the reference group and the implementer, and where appropriate the implementer's local partners (i.e. in particular, the main **findings, conclusions and recommendations**), at a presentation and discussion organised by the Development Cooperation and Humanitarian Assistance Department of the MFA. Any additional major observations arising from the discussion will be incorporated as a **separate annex to the final version of the report.** The presentation date will be mutually agreed sufficiently in advance. Prior to the presentation the evaluation team shall also send a visual outline of the presentation (PowerPoint) to the contracting authority for approval.

- The **final version of the evaluation report**, including an overview of the method used to reflect all the written comments of the reference group and the implementer (and its local partners), and where appropriate other observations raised at the personal presentation of the report, must be submitted to the contracting authority by **30th October 2015,** which will subsequently be published on the MFA website. The final evaluation report must be delivered to the contracting authority in hardcopy, i.e. as **one bound copy, and in electronic form on a CD/DVD.**

Evaluation mission and further clarification of details for the author

- An examination of the results of projects in the partner (or recipient) country, in the form of an **evaluation mission**, is an obligatory part of the evaluation process. The **minimum** research period in the partner country is **5 working days** – depending on the nature of the project, geographic spread of the evaluated activities, local transport conditions in the partner country, the number of relevant authorities, etc. Specifically, however, it will depend on the methods selected by the author.

- During the course of the evaluation, the author will conduct **interviews** with representatives of the MFA, the CzDA, the Embassy of the Czech Republic in Belgrade, the project implementer, representatives of end recipients and partner organisations of the implementer in Serbia; also interviewed should be representatives of the state administration and local government (and other respondents as required).[16]

[16] However, during the evaluation mission in the partner country, this need not be limited to individual interviews – the methods for obtaining and verifying information are based on the evaluation team's methodological procedure.

- The author should start formulating the main focus of **findings, conclusions and recommendations** while still on the mission in the partner country. During the evaluation mission, the author will hold an **opening and closing briefing** for stakeholders (relevant authorities of the partner country, representatives of the project recipients, local implementation partners and implementer, the Czech Embassy in Belgrade etc.), at which the anticipated, and then the obtained findings and conclusions of the evaluation can be tested in discussion with these stakeholders, and initial feedback can be obtained. The presentation from the closing briefing (with minutes as applicable) should be included as an annex to the final evaluation report.
- The evaluators are also expected to hold detailed consultations with the **Embassy of the Czech Republic in Belgrade**. The evaluation team can contact the embassy with requests for logistical support or for mediating interviews at ministries and other authorities of the partner country. However, such assistance from the embassy should only be used where **absolutely necessary.**

Tender announcement and the receipt of bids

The tender, in the form of an open call for bids, is publically announced on the MFA website on **13th April 2015.**

Bids will be processed on the basis of selected project documents, which the bidders can request via the email address of the employee responsible for organisation of this evaluation contract.

The deadline for the receipt of tenders is **14.00 on 4th May 2015.**

Bidders are to submit bids by recorded delivery (or in person) in hardcopy and electronic form – e.g. on CD, to the following address:

Ministerstvo zahraničních věcí ČR

Odbor rozvojové spolupráce a humanitární pomoci

Loretánské náměstí 5

118 00 Praha 1

Bids shall be submitted in an envelope labelled with:

- the public contract name;
- the full name and address of the bidder;
- and marked **„DO NOT OPEN“.**

The contracting authority is entitled to reject bids sent by a different method (e.g. by fax or email), delivered to a different address or received after the closing deadline.

Bids may be submitted in the Czech, Slovak or English. Tenders in other languages will not be accepted.

Evaluation team

The evaluation can be conducted by a **team composed of several persons** (one of whom acts as team leader accountable to the contracting authority for all output) or a **legal entity** with an appropriate team of experts (one of whom acts as team leader for communication with the contracting authority).

The contracting authority consider the optimum team size to be 2-3 persons, comprising the **lead evaluator with responsibility** for the entire evaluation process and for submitting the agreed reports and whose expertise is primarily in evaluation methods; an **expert in healthcare or public health**, ideally specialised in gynaecological oncology and methods of preventing serious illnesses and/or communication of prevention with the public; and also possibly a **local expert** (or junior team member) with in-depth knowledge of the local environment.

Bids must include the following:

- the **methodological approach** of the evaluation team, including the work schedule (description of specific methodology, specifically proposed for the given comprehensive evaluation of development cooperation of the Czech Republic in Serbia);
- a firm statement of the **duration, in days, of the evaluation mission in the partner country** (not including the dates of arrival in and departure from the country);
- the **composition of the evaluation team**, i.e. the names and specialisation of the experts who are to participate the evaluation, including a **clear definition of their participation in the mission, or part of the mission** (what part, how many days), and including their planned roles in the production of the evaluation report;
- **CVs** of the evaluation team experts, with specific information on their education, skills and experience relevant to the evaluation;
- **a statutory declaration** on fulfilment of the qualification requirements (see below); prior to signing the contract, the bidder must be able to demonstrate fulfilment with applicable documents/certificates;
- **a statutory declaration of the bidder -** statement of truthfulness (see annex);
- **the bid price** stated both excluding and including VAT (for VAT non-payers just the one price accompanied by a declaration of the bidder that it is not a VAT payer). The contracting authority anticipates a contract value within an **indicative range of 315 000 – 350 000 CZK** excl. VAT;[17]
- the mandatorily completed **table calculating the cost of the evaluation** (see annex). Meal allowances in the table, budgeted per person and the number of days abroad, must comply with the relevant Czech legislation. We draw the bidder's attention to the fact that prior to releasing funds, the MFA, as the contracting authority, will request documentation of the scope of the delivered contract according to the individual items on the approved bid budget. In justified cases, and after prior approval from the

[17] However, the contracting authority does not intend this indicative range to serve as a strict definition of either a minimum or maximum price. The bid price must cover all of the evaluation team's costs, i.e. the time spent working in the office (document analysis, report writing, the incorporation of comments), the cost of the evaluation mission to the partner country (the remuneration of team members, airfares, local transportation, accommodation, meals, interpreting, telephone calls), the remuneration of team members for time spent on the final presentation, etc.

contracting authority, it is possible to shift costs between budget items to a maximum level of 10% of the total budget whilst maintaining the total bid price unchanged. If the total expenditure is in reality less than that budgeted in the bid submitted to the tender, the contracting authority will reduce the final sum payable by this difference compared to the bid price of the winning bidder. If on the other hand the actual costs are higher than those budgeted in the bid, this additional amount will not be paid by the contracting authority;

- a **statutory declaration of independence** signed by all members of the evaluation team. **All persons, or experts from the team of a legal entity, must simultaneously meet all of the following independence conditions** - these conditions apply **to all projects included in this comprehensive evaluation in the given country and the health sector.** The statutory declaration of independence is signed by all persons, or a legal entity and all the participating experts in its team.

Independence conditions applying to evaluation team members

- None of the evaluation team members has been involved in the preparation, selection or implementation of the projects to be evaluated at any stage. Furthermore, they have not been involved in the preparation of a project proposal which competed with the evaluated project in a tender.
- None of the evaluation team members is an employee or external associate of the project coordinator, and nor have they been during the period of the preparation and implementation of the evaluated project; none of the evaluation team members is an employee or external associate of the project implementer, and nor have they been during the period of the preparation and implementation of the evaluated project in the given country (Serbia) and sector (health).
- In addition to the conditions defined above, none of the evaluation team members has contributed to the implementation of projects of development cooperation of the Czech Republic in the country of the evaluated project (Serbia) in the year prior to evaluation, in the year of the given evaluation, and will not work on such projects in the given country in the year subsequent.

Qualification requirements of the evaluation team

- completion of higher education – applies to the evaluation team leader;
- at least four years of work experience – applies to the evaluation team leader;
- completed participation in at least one evaluation (in terms of the comprehensive evaluation of results) of a project, programme or similar intervention – applies to all members of the evaluation team;
- completion of at least one training course or higher-education subject on the theme of evaluation or project/programme cycle management, or on results-based management, or an executed evaluation as part of a dissertation or diploma work during university studies that was successfully defended and positively assessed – applies to any member of the evaluation team;
- English language skills for all members of the evaluation team who will participate in the mission to Serbia. Knowledge of Serbian by at least one member of the evaluation team would be welcomed. The bidder shall demonstrate foreign language ability by submitting a certificate confirming a language examination has been passed to at least B1 standard, or a declaration by the bidder that the relevant evaluation team member is proficient in the required language to a communicative level. In the case of a

declaration, the contracting authority is entitled to verify the language skills of team members prior to concluding an agreement.

Evaluation criteria (0 to 100 points in total)

The contracting authority has selected value for money as the assessment criterion for bids.

Individual sub-criteria have been defined as follows:

1. **Bid price** (prices excluding VAT are compared): **0-40 points**

The bid offering the lowest price is given 40 points. Other bids will be awarded points according to the formula: /value of lowest bid price/ x /40 points/ : /bid price of the given bidder/ = /number of points for the given bidder's bid/

2. **Professional quality, the specific targeting of the proposal and the feasibility of the evaluation methodology,** incl. schedule and procedure for the work and division of tasks within the evaluation team: **0-30 points**

Maximum points will be awarded to methodology that provides both a theoretical framework for the proposed methods and their limits, and specifically manages to combine the OECD/DAC evaluation criteria and the proposed methods – typically in the form of evaluation questions, the method for the identification and triangulation of data, etc. Strict compliance with the outline of the evaluation reports (input and final) and logical connections between findings, conclusions and recommendations with the stipulated specific and realistic evaluation questions is expected. The optimum methodology will also include a schedule of work, including a preliminary programme for the mission to the partner country, and the division of tasks and responsibilities among evaluation team members. These procedures must be proposed realistically. The contracting authority would welcome evaluations based on the **Formal Evaluation Standards** of the Czech Evaluation Society[18].

3. **Level of expertise and previous experience in** the area of **healthcare**: **0-20 points**

Maximum points will be awarded to the evaluation team whose members, together, possess sufficient expertise in the field of healthcare (and/or public health, in particular in the areas of gynaecological oncology and methods of preventing serious illnesses and associated work with the public in general). Expertise is understood to mean a combination of theoretical education and working experience. If the bidder's team has expertise in related areas, the bid will be awarded a proportion of the points based on the depth, breadth and transferability of the knowledge. The criterion of expertise and previous experience of the evaluation team in the given sector will be assessed on the basis of the tender documents submitted.

4. **The scope of previous experience of team members in developing and transforming countries**, and in particular those of **Eastern and Southeastern Europe,** and the experience of team members in the area of development cooperation: **0-10 points**

Maximum points will be awarded to the evaluation team whose members together can demonstrably offer extensive experience of work, research or similar visits to developing or transforming countries, including to any of the countries of Eastern and Southeastern Europe, or of development cooperation as an activity and

[18] See www.czecheval.cz

part of foreign policy, e.g. the planning, implementation, monitoring and evaluation of specific projects, or broader assistance programmes, work at the theoretical or research level of development cooperation etc. Experience directly from Serbia or other countries of the Balkans is an advantage. The criterion of prior experience of the evaluation team from developing countries and with the area of development cooperation will be assessed on the basis of the submitted bid documentation.

For sub-criteria 2 to 4 it may be that none of the bids will be awarded maximum points. The points are assessed by an expert evaluation committee.

Evaluation of bids

The received bids will be processed by the authorised administrator, who will examine the qualification criteria and then forward them to the evaluation committee, which will assess them and select the winning bid on the basis of the evaluation criteria. The result of the selection by the evaluation committee will be published by **29th May 2014** on the contracting authority's website.[19]

Final provisions

The MFA will not return bids for projects received on the basis of this announcement.

Annexes:

mandatory input evaluation report outline (version 2015)

mandatory final evaluation report outline for development cooperation of the Czech Republic (version 2015)

template statutory declaration by the bidder – statement of the truthfulness of the information provided (mandatory part of a bid)

template statutory declaration – independence statement of evaluation team members (mandatory part of a bid)

template table of evaluation costs for the calculation of the bid price (mandatory part of a bid)

[19] See www.mzv.cz/pomoc

7.9 Overview of other related health projects

According to the OECD/DAC, 50,937,812 USD have been granted as the Official Development Assistance (ODA) to Serbia to the sector Basic Health since 2000 (data may not be complete). Top basic health projects in Serbia funded by international donors[l] include the following 2 with an explicit focus on cancer:

Projects	Purpose	Donor	Organisation	Year	Amount	Type
Assessment of the status of the Serbian health sector with respect to cancer prevention and treatment	Basic health care	EU Institutions	EDF	2010	105 672 USD	ODA Grants
Assessment of the status of the Serbian health sector with respect to cancer prevention and treatment	Basic health care	EU Institutions	EDF	2011	71 061 USD	ODA Grants

The following projects of JICA have not appeared in the Open Data of the OECD/DAC[li], but were reported on the JICA website[lii].

Projects	Purpose	Donor	Organisation	Year	Amount	Type
The Project for Improvement of Breast Cancer Early Detection System (Grant Aid Project)	Basic health care	JICA	The Ministry of Health	June 2010 – August 2012	Not available	ODA Grants
Technical Training Course for Promotion of Management System of Mass Examination for Early Detection of Breast Cancer in Serbia (Country-focused Training)	Basic health care	JICA	The Ministry of Health	November 2010 – December 2010 and November 2011 – December 2011	Not available	ODA Grants

7.10 Overview of other Czech health projects in Serbia

Other Czech bilateral ODA projects focusing on basic health included in the Open Aid Data administered by the OECD/DAC[liii] and verified with the database of the Czech Ministry of Foreign Affairs[liv] were as follows in 2010 to 2012:

Projects	Purpose	Years	Donor	Implementer	Amount in USD[lv]	Amount in CZK[lvi]	Notes of evaluators	Source of information
Reconstruction of medical ambulance in Natalinci.	Basic health infrastructure	2012	Southmoravian Region, CR	Cooperating villages / towns	13 290	259 665		OECD/DAC, MFA, confirmed by the region
Help and care at home elderly, socially disadvantaged persons and invalids.	Basic health care	2012	Southmoravian Region, CR	Cooperating villages / towns	13 280	259 470		OECD/DAC, MFA, confirmed by the region
Organization of educational performance on current health issues - posture, obesity	Health education	2012	Southmoravian Region, CR	Cooperating villages / towns	9 070	177 221		OECD/DAC, MFA, confirmed by the region
Developing the quality of health of children and youth in the field of ultrasound diagnostics at the Health Center in Vranje		2012	MFA/ the Czech Embassy	The Health Centre Vranje - Dr. Uroš Trajković		294 000		MFA, missing in OECD/DAC statistics
Standardized hospital beds or beds for hemodialysis departments, University Hospital KBC DR D.Misovic		2012	MFA/ the Czech Embassy	University Hospital KBC DR D.Misovic		242 300		MFA, missing in OECD/DAC statistics

Projects	Purpose	Years	Donor	Implementer	Amount in USD[lv]	Amount in CZK[lvi]	Notes of evaluators	Source of information
Support for caring and improving women's health	Basic health care	2012	MFA/ the Czech Embassy	Committee for human rights – Majdanpek	12 495	244 125		OECD/DAC, MFA, CZDA
Improving the Quality and Availability of Health Care - Arandjelovac Hospital, including the supply of sterilization equipment for the medical centre Arandelovac and additional equipment	Basic health infrastructure	2010 – 2011	CZDA	Edomed a.s., BMT Medical Technologies	548 158 (per MFA)[lvii] (392 645 per OECD/DAC)	10 415 000 as per CZDA	Discrepancy in financial value between sources	OECD/DAC, MFA, CZDA
Purchase of a cardiograph (CTG) for a gynaecological department	Basic health infrastructure	2011	MFA / the Czech Embassy	Dom zdravlja "Savski venac", Belgrade		120 000		MFA, missing in OECD/DAC statistics
Delivery of medical equipment for the University Hospital Dr Dragisa Mišović in Belgrade	Basic health infrastructure	2010	CZDA	Caritas CR	36 830	699 770		MFA, CZDA, , missing in OECD/DAC statistics
Regeneration of Laparoscopic Equipment Used by General Surgery[20]	Basic health infrastructure	2010	MFA/ the Czech Embassy	University Hospital Dr Dragisa Mišović in Belgrade	20 526	390 000		MFA, OECD/DAC
Implementation of Czech medical devices in the area of vascular surgery – Serbian Clinical Centre (KCS)	Basic health infrastructure	2006 - 2010	Ministry of Trade CR	VUP Medical, a.s. (formerly Výzkumný ústav pletařský)		19 784 458 (2 000 000 in 2010)		MFA, missing in OECD/DAC statistics

[20] Project title as per the MFA, titles in alternative sources: Purchase of laparoscopic cameras for the KBC hospital (as per the OECD/DAC), Delivery of medical equipment for the University Hospital Dr Dragisa Mišović in Belgrade (as per the CZDA)

7.11 Comments to this report

Substantial comments are given below. Answers are provided either Czech or English, depending on the original language of the comment.

Substantial comments / závažné připomínky	Reflected by the evaluators / zohlednění evaluatorů
Caritas CR	
Strana iii, Executive summary (dalé pak v české mutaci textu, str. 27): „The role of Caritas CR was restricted mainly to project monitoring and reporting via distant cooperation and on-site visits, which accounted for 20 % of total expenses. It may have been more efficient to have a full-time manager in Serbia, who could have also engaged in on-going national advocacy.“ a) Prosíme o doplnění do věty či poznámky, že šlo o veřejnou zakázku, kde není výše osobní nákladů a jejich užití ze zákona definována. Naše nabídka byla předložena ČRA, která ji vyhodnotila jako vítěznou se všemi náležitostmi a náklady obsahujícími. b) Systém monitoringu vychází z tehdejších standardů CHČR. Později se systém monitoringu změnil a to především v přítomnosti tzv. Country Representative v zemích, kde se implementují projekty s určitým finančním objemem. c) S potřebností tzv. national advocacy se ztotožňuje, nicméně je otázkou zda by se Country Representative vůbec podařilo splnit tento úkol u takto administrativně a finančně náročného procesu ovlivnění změny národního zdravotního systému za poměrně krátké období implementace projektu a chybějící sektorové strategie ČRA pro onkologickou péči v Srbsku.	**Částečně zohledněno,** Informace, že projekt byl realizován jako veřejná zakázka, byla doplněna do úvodního odstavce ve shrnutí, ovšem ne přímo do odkazovaného odstavce, neboť s ním nesouvisí. V případě dotací, ale i v tomto případě (dle zadávací dokumentace veřejné zakázky) způsob řízení projektu nastavuje realizátor. Zaměstnání místního projektového manažera by bylo nejen levnější, ale též účinnější, neboť by tento manažer mohl jednak posílit interní procesy a dokumentaci, ale mohl též intenzivněji pracovat na tzv. „advocacy“ (nejen bilaterálně se srbským Ministerstvem zdravotnictví, ale též v rámci expertních skupin, konferencí, ve spolupráci s pacientskými asociacemi apod., na což místní partner neměl kapacity). Evaluátoři tedy trvají na tom, že projekt mohl být účinněji řízen přímo v Srbsku bez ohledu na to, zda by vypsán jako veřejná zakázka či dotace. Tento závěr ostatně potvrzuje nepřímo i Charita ČR vzhledem ke zmíněné změně v monitoringu.
Oaza Sigurnosti	
Caritas, Oaza Sigurnosti and the Health Centre had signed a Memorandum of Understanding and were partners. The Health Centre staff were perhaps the target group too. The Clinical Center was not a partner.	**Fully reflected.**

Daniel Svoboda, expert, member of the reference group	
Hodnocená zpráva přehledně shrnuje hlavní výsledky provedené evaluace a navrhovaná doporučení. Použité evaluační metody sběru dat byly odpovídající a jsou dostatečně popsány, zdůvodněny a doloženy v přílohách zprávy. Ačkoliv nejsou samostatně doloženy výsledky analýz dat, existuje poměrně jasný vztah mezi zjištěními a závěry, některá z navržených doporučení však považuji za problematická:	
Doporučení 3 (nabízet experty) částečně odporuje resp. duplikuje (twinning, výměna expertů) **doporučení 9** (nahradit vysílání expertů výměnou expertů).	**Částečně zohledněno.** V doporučení 3 jsou zmíněny současné modality ZRS ČR v souvislosti s konkrétním odborným zaměřením budoucí spolupráce. Doporučení 9 je systémové a zdůrazňuje požadavek na oboustrannou výměnu. Do zjištění bylo doplněno, že výměna expertů byla výslovně požadována.
U **doporučení 6** není jasné, jakým způsobem má ČRA zajišťovat nepřetržité advocacy.	**Částečně zohledněno**. Byly doplněny konkrétní aktivity, které mohou být doplněny do projektového dokumentu. Adresátem je ČRA, neboť projekty identifikuje a částečně formuluje. Předpokládá se, že v praxi může provádět tzv. advocacy realizátor v součinnosti se zastupitelským úřadem ČR, což je praxe v dalších projektech ZRS ČR (např. obdobný projekt v Gruzii).
Doporučení 8 na průběžnou a finální evaluaci všech projektů je zcela nerealistické: a) nelze zajistit formou „povinných“ interních evaluací, protože u nich hrozí formalizace bez jakéhokoliv reálného využití (byla by „klientem“ ČRA nebo realizátor?), nehledě na finanční a časová omezení – zejména u krátkodobých projektů; b) externí evaluace zadává MZV a nikoliv ČRA	**Částečně zohledněno**. Doporučení bylo upraveno – vztahuje se nyní na spíše větší projekty. Čistě formální provedení evaluace příliš přínosné není, ovšem interní evaluace nutně neznamená evaluaci nepřínosnou, zejména pokud má jít o proces „učení se“, tedy o formativní evaluaci. Naviga4 má zkušenosti s evaluacemi zadávanými realizátory či rozvojovými agenturami, které jsou schopny včas odhalit nutnost změny projektových aktivit s ohledem na efektivnost), nebo i nedostatečnou udržitelnost.
U **doporučení 9** je kromě dílčího rozporu s doporučením 3 nejasná druhá část doporučení „propagovat program u bývalých realizátor projektů“.	**Opraveno** na „propagovat program u bývalých realizátor**ů** projektů“. Jiný rozpor není znám. Dokud nebude program expertů změněn, i jen vyslání onkologa do Srbska má podle evaluátorů přínos.
Ačkoliv je v příloze 7.19 uváděno, že výsledky průzkumů jsou uvedeny v hlavním textu, uvítal bych alespoň základní statistiku výsledků/odpovědí rozhovorů a focus groups (viz otázky v příloze 7.6) v samostatné příloze. Citace jednotlivých příkladů odpovědí a případové studie velmi pomáhají k pochopení souvislostí a dopadů projektu, ale bylo by vhodné (kvalitativní) odpovědi alespoň částečně kvantifikovat.	**Nezohledněno**. Ze zadávací dokumentace vyplývá, že výsledky není třeba uvádět v příloze, pokud jsou v textu. Výsledky focus groups a interviews jsou zapracovány do textu s komentářem „většina žen“, „některé ženy“ apod. Konkrétní počet jednotlivých názorů evaluační tým nesledoval, soustředil se spíše na šíři názorů a ne/souhlas aktérů.

7.12 Minutes of the debriefing in Kragujevac

Promoting cancer prevention among women in the Šumadija region

2 July 2015

Participants: Gordana Damnjanovic, Maria Georgevic (Kragujevac municipality – key stakeholder and partner), Vera Simic, Mina Mijailovic (Oaza Sigurnosti - local project implementer), Dubravka Djurokovic (Health Centre in Kragujevac – local partner), Nataša Kračunovic (Women Center DIVA – breast cancer patients association in Kragujevac) Inka Píbilová, MUDr. Václav Pecha and Tanja Menicanin (evaluation team)

Excused: Dejan Zdrale (the Czech Embassy), Maja Vuckovic Krcmar (European Commission Delegation), Verica Jovanovic (the National Cancer Screening Office, Institute of Public Health of the Republic of Serbia "Dr Milan Jovanovic Batut")

Debriefing Goal

The goal of the evaluation debriefing was to share preliminary conclusions and recommendations and incorporate related feedback of the participants. Most time was spent on sustainability and future actions.

Presentation

See separate attachment for the key findings, preliminary conclusions and recommendations.

Key comments from the discussion

Ad slide 5, project design:

- Workshops were held in all villages with the exception of Cerovac, where the community is scattered. Thus an awareness raising workshop was held after the screening, i.e. on the occasion of the distribution of results.
- Work with media was an important element of the project – added in the presentation.

Ad slide 6, key results: The response to screening was enormous, more than 30 % of women from villages joined screening already in the first year after door-to-door campaign. With 52 % of all women above 18 years of age screened at the project end, the National Screening Programme had a great basis to build upon. This is confirmed by the results of the Programme.

Ad slide 10, barriers:

- Low accessibility of health insurance is a major issue. All pregnant women are insured since 2014, otherwise they are not. Not only work in agriculture (for a small income), but also work for employers who do not pay health insurance (or any salary) are problematic.
- Regarding limited screening accessibility, there are doctors who refuse taking appointments by phones, while others do use phones and proactively contact patients to come for the national screening. Nevertheless, quite some women still would not go due to other reasons.
- There was another barrier related to breast screening – patients waited upto 1 year for mammography before a new mammograph was donated by the Japan International Cooperation Agency – JICA about 2 years ago. Now patients wait 15 days to 2 months, depending on the urgency of the case. Nevertheless, there is also a problem of productivity as only about 2 women per hour are screened with the mammograph. The technicians need to perform also administrative tasks beside mammography as no administrative staff is available. This point was added to the presentation.

Ad slide 11, how to continue field screening or otherwise address the need to screen all women?

1) *Advocacy*
   - The Ministry of Health should arrange that the National Health Insurance Fund pays for cytology testing – currently it is not recognized in the payment system. Current gynaecologists should be officially recognized as cytologists (if they have adequate training).
   - The Ministry of Health should learn the details of the evaluated project and replicate it across Serbia.
   - The law enabling the private doctors to be paid by the National Health Insurance Fund is currently discussed in the Parliament. It is expected that they would be paid from 2016. This could reduce the burden of the state doctors.
   - Unlike internally displaced people or Roma, rural women working in agriculture are not recognized as a vulnerable group. Therefore they are obliged to pay health insurance if they own certain land, even if their income is below poverty line. It needs to be advocated that all women need to be screened – even those who do not have health insurance as it is far cheaper to cure them at an early stage than later.
   - See also point 3 below.

2) *Public awareness raising in Sumadija region*
   - The Municipality cannot fund the screening further as it cannot duplicate the national screening programmes, which are free of charge. Nevertheless, it can fund awareness raising campaigns that convince women to come for the screening. The projects can be upto 6 months long for the maximum of 300.000 RSD. They cannot be repeated.
   - Women Center DIVA – breast cancer patients association – has reported it has volunteers available to raise awareness not only on cancer, but also on reproductive health and other issues. It requires at least some incentives for the volunteers to travel to villages and a financial support for a coordinator. Former cancer patients could help also in answering questions of women who hesitate with screening. (Currently, only Red Cross conducts preventive check-ups in villages on a quarterly basis, but with a wider focus.)
   - Media campaigning needs to be strengthened especially with respect to cervical cancer, which is not present in media unlike breast cancer.

3) Cervical Cancer Screening in the field

- Awareness raising alone would not remove all barriers. It is still necessary to make screening as easy to access as possible.
- Current doctors cannot do field screening e.g. once a month, even if the car and equipment are available. During the field screening, they were able to check around 20 women on average. However, in the Health Centres, they are able to check even more than 40 women. These 40 women would be omitted and their check-up would have to be postponed. Taking into account the fact that one doctor can have even 7 000 patients, it is not feasible to go to the field as this would decrease his or her productivity.
- A solution would be to assign a new gynaecologist with a van to every region in Serbia to do the national screening (of cervical cancer). Nevertheless, there is a cap on hiring any staff in state institutions including health centres. Current doctors get older (their average age is 45 years) and would soon retire. Young doctors are often unemployed or they go abroad to work.

Ad slide 12: future collaboration with the CR:

- Media campaigning on cervical cancer mentioned above – exchange of experiences among NGOs, including cancer patients associations. This was added to the presentation.
- Data management project is currently being implemented, but all health care levels are not yet interlinked. There is a potential for tele-surgery for instance. A Czech expert may help with information systems.
- Cooperation between Medical Colleges would be useful. Prof. Zivanovic from the Clinical Centre teaches at the Kragujevac Medical College and can be involved in a twinning or teacher exchange project with a Czech institution, such as Masaryk Memorial Cancer Institute. This was added to the presentation.

Minutes were written by Inka Pibilova.

7.13 Comments from the discussion at the final presentation in Prague

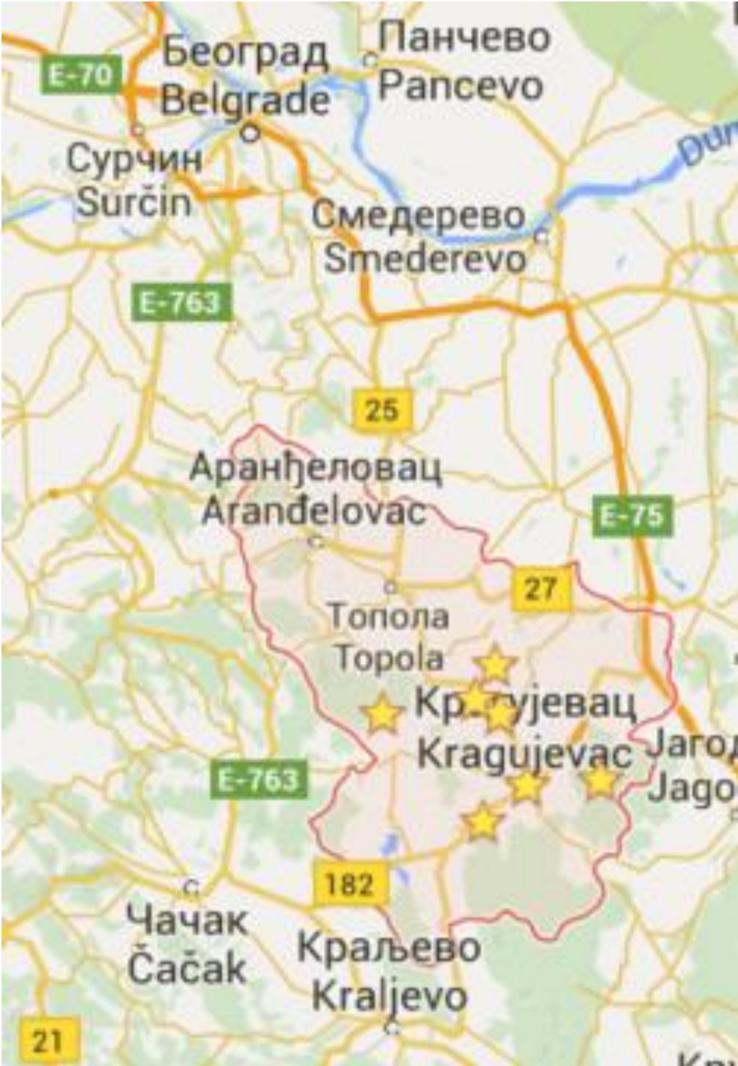
Substantial comments	Reflected by the evaluators
Add the MFA as one of the addresses of the recommendation 8	Fully reflected.
Add the word „programme“ to the recommendation 9	Fully reflected.

7.14 Overview of villages involved in the project

No. Name of village	No. Of women from electoral registry	No. of invited women	No. of examined women	%	Visit by evaluators
1. Stragari	337	337	178	53%	
2. Maslosevo	115	120	55	46%	
3. Ugljarevac	37	34	22	65%	
4. Mala Vrbica	50	49	22	45%	
5. Ramaca	85	85	48	56%	Visited due to an average examination rate and a long distance from Kragujevac and limited transport options
6. Kamenica	67	86	32	37%	
7. Gornja Sabanta	235	205	89	43%	
8. Donja Sabanta	171	123	61	50%	
9. Velika Sugubina	46	40	27	68%	
10. Velike Pcelice	102	93	54	58%	
11. Dulene	19	24	12	50%	
12. Desimirovac	514	474	264	56%	
13. Luznice	308	238	118	50%	Visited due to an average examination rate, an available cancer patient and an active volunteer as a key factor
14. Opornica	241	174	86	49%	
15. Gornje Jarusice	168	133	70	53%	Visited due to a medium examination rate, long distance from Kragujevac and limited transport options
16. Cumic	429	397	143	36%	
17. Grbice	203	180	90	50%	
18. Veliki Senj	95	82	46	56%	
19. Pajazitovo	90	73	26	36%	
20. Sljivovac	126	108	46	43%	
21. Poskurice	155	140	43	31%	
22. Cerovac	262	240	79	33%	Visited due to a low examination rate, a proximity / a good transport to Kragujevac and a cancer patient (who was finally unavailable)
23. Vlakca 196 128 45 35	196	128	45	35%	
24. Dobraca 118 96 50 52	118	96	50	52%	
25. Kutlovo 63 63 51 81	63	63	51	81%	
26. Rogojevac 96 96 37 39	96	96	37	39%	
27. Draca 220 185 116 63	220	185	116	63%	

No. Name of village	No. Of women from electoral registry	No. of invited women	No. of examined women	%	Visit by evaluators
28. Bukorovac 41 34 26 76	41	34	26	76%	
29. Jabucje	35	32	9	28%	
30. Prekopeca	28	22	12	55%	
31. Novi Milanovac 53	121	121	64	53%	
32. Divostin	151	151	68	45%	
33. Botunje	214	187	97	52%	
34. Dolnje Komarice	145	111	94	85%	
35. Gornje Komarice	54	64	62	97%	Visit due to the highest examination rate, a long distance from Kragujevac and limited transport options, an available cancer patient and an active volunteer as a key factor.
36. Korman	203	192	103	54%	
37. Trmbas	147	115	70	61%	
38. Jovanovac	358	301	140	47%	
39. Cvetojevac	239	219	123	56%	
40. Resnik	313	247	149	60%	
41. Zdraljica	373	280	114	41%	
42. Baljkovac	188	180	81	45%	
43. Dragobraca	704	630	469	74%	Visited as it was one of the biggest villages, with a relatively high examination rate, proximity / a good transport to Kragujevac, an available cancer patient and an active volunteer as a key factor.
44. Drenovac	108	95	38	40%	
45. Vinjista	112	110	61	55%	
46. Adzine Livade	11	10	7	70%	
47. Grosnica-selo 48	720	490	237	48%	
48. Marsic-staro selo	878	490	220	45%	
49. Erdec-staro selo	67	50	36	72%	
50. Koricani	2 000	35	32	91%	
51. Members of Roma community	unknown	150	70	n/a	Visited as a specific community and an available cancer patient

Map of the visited locations is below, locations are shown as stars:



7.15 Case studies

Following case studies were collected during interviews. Names were changed to secure anonymity.

Adrijana, a current cancer patient, born in 1967, is from a Roma community in Kragujevac. She speaks Roma and thinks her Serbian is not very good. She has a 14-year-orl daughter and an 11-year old son, who has a disability. Her husband left and does not support the family. Thanks to the Roma centre established by the Kragujevac municipality, she completed her primary education, received social benefits and apartment accessible for her son´s wheelchair. She knits socks for a living. Improved living conditions positively affected her son´s health. He first started walking, then attending school and even playing football.

Adrijana has already suffered from several health problems, including a heart attack. In 2011, she was invited to the field screening by the Roma coordinator and decided to join because of her children. She could not walk well, but thought she could be pregnant. When she learnt the positive result, she was afraid that children would lose her. So she appreciated that she could go immediately through the surgery. The Roma coordinator took care of her children during her 1-month treatment in the hospital. He also helped her get social benefits to cover their meals and medications. Now she can walk well. Currently, she suffers from other health problems, but is grateful that the project saved her life.

Biljana, a current cancer patient, was born in 1936. She lives alone, but her children take care of her. She felt something strange in her abdomen, but she kept postponing a visit to a doctor. Thanks to the encouragement of her neighbours she attended the field screening in her village. After she was diagnosed with ovarian cancer, she got a surgery within 3 days. She was back in a day and recovered well.

Casna, a current cancer patient, was born in 1968. Earlier, she worked in a factory and visited a doctor there. Then she lost her job and started working in agriculture within the family. Her doctor in the factory was not accessible to her any more due to a long distance and a lack of money for transport. She learnt that a Czech NGO wants to help women by providing free check-ups, so she helped to mobilize patients. She had some issues with her breast, but was told that it was due to breast feeding. Only when she saw in the TV how to check her breast for malignancies, she found something. As she worked the whole day, she did not manage to go to a doctor, even if it already started paining.

Then the field screening came, she got operated and got good results. Then she went through chemotherapy and had to pay 13.500 RSD. The depression started due to multiple challenges – there was not enough medication for side effects, it was too hot for her in the wig …. Then she started to cheer herself up. Her mother in law and family helped. Now after 4 years, she feels really well. Regular check-ups are smooth and within 15 days of waiting. She still takes up medication, which she has to buy as she is allergic to the one covered by the health insurance. She does not work that hard in the fields any more. She only feels a pity that her neighbours do not go for regular check-ups because they do not have similar pain as she had 4 years ago.

Dejana, a current cancer patient, was born in 1952. She did not go for regular check-ups as the doctor was far, bus connection was bad and there were always a lot of people waiting. She did not have any health problems, so she did not think going for a check-up is necessary. Dejana also had two difficult deliveries and a subsequent infection, so she preferred to see no doctors thereafter.

Grana was born in 1978. She lives with her husband and her 4 children. When she learnt about the field screening in 2011, she came as it was free of charge. Her PAP-test result was positive, so she went for a surgery in one month. During her stay in a hospital, her husband and mother in law took care of the children. She had no health insurance, but did not have to pay for the surgery thanks to the project. During her recovery, she already worked as normally. Now she still does not have health insurance, as she cannot pay 50.000 dinars a year. For her, education of children is a priority. Still, she does pay 1.000 dinars for regular check-ups. She is grateful the project give women a chance to get checked free of charge.

Jovana was born in 1970. She lives with her husband, 2 children and her parents. She is an economist, but currently employed. Thus she engages in farming and producing dairy products. She learnt about the feel screening from the nurse of the local general practitioner. She decided to go because of her children. She also had several relatives who suffered from cancer and still remembers how they suffered. Some died of cancer.

The field screening results were positive with respect to her breast as well as cervix. When she followed up at a private clinic, the ultrasound was not working. She had to wait for quite some time and eventually did not go for a follow-up. At a gynaecologist, she got scared as well, listening to the painful stories of other women, so she left. She said she had no one who could come to support her – she would not ask her daughter or another cancer patient in the village. Her mother died already.

7.16 Project expenses overview

Types of expenses	Oaza Sigurnosti	Caritas CR	Total expenses	Relative expenses
Human resources	1 940 684	1 024 371	2 965 055	28,24%
Office	306 234	0	306 234	2,92%
Travel	103 893	382 077	485 969	4,63%
Equipment	1 867 682	46 933	1 914 615	18,23%
Direct project expenses (mostly medical staff)	3 281 241	4 444	3 285 685	31,29%
Capacity building	437 416	0	437 416	4,17%
Other direct expenses	223 681	258 902	482 583	4,60%
Overheads	224 250	398 194	622 444	5,93%
Total	8 385 080	2 114 921	10 500 001	100,00%

Source: Internal financial documents of Oaza Sigurnosti and Caritas CR. They were not checked with their accounting systems.

7.17 Comparison of the approach in Serbia / Georgia

The evaluation team evaluated 2 oncological projects funded by the CZDA:

- Promoting cancer prevention among women in the Šumadija region, Serbia (2010 – 2012)
- Promotion of prevention and early detection of breast and cervical cancer among women in the regions of Samegrelo and Shida Kartli II in Georgia (2011 – 2013)[lviii]

Benchmarking is difficult as each country is in a completely different stage of development. Still, the evaluation team believes that the factors below had an influence on projects´ outputs, results, impacts and sustainability. Above all, a dedicated project team made of Oaza Sigurnosti, gyneacologists of the health centre in Kragujevac, as well as the involvement of the Clinical Centre and the Kragujevac municipality made the difference: women knew the doctors to follow-up with. For detailed findings and conclusions, see the reports.

Project / Area	Serbia	Georgia
External factors		
Health care system	**Relatively stable**, needs reform	Constant, major challenges
Health care financing	**Via national health insurance**, some citizens are excluded, reform is needed	National health insurance introduced only in 2014, most beneficiaries did not have health insurance during the project
National cancer screening programmes	**Started just after the project finished**	Implemented already during the project, but only in some cities, the launch in rural areas was delayed
Project design		
Identified and formulated by	The CZDA	The CZDA (health expert)
Funding	10,5 mil CZK, 100 % ODA grant based on a public tender (thus limited project design flexibility)	10,9 mil CZK, 100 % ODA grant based on a public tender (thus limited project design flexibility)
Implemented by	Caritas CR (coordination from Prague, 2 project managers changed) and a local NGO (consistent project management)	Caritas CR (coordination in Georgia, but frequent change of the project manager) and 2 local NGOs (consistent project management)
Local partners	**Local health centre and municipality**, MoU existed with the centre	Not officially, 1 of the implementing NGOs worked in the premises of a local hospital, where women got treated
Medical staff involved	**From the local health centre**	From Tbilisi with 1 exception
Advocacy to national authorities	The Ministry of Health informed after the project started, not involved, results presented on the regional level, not reflected on the national level	**The Ministry of Health and other key institutions** were officially involved, results presented on the regional level, not reflected on the national level
Efficiency	**Low screening costs, reasonable documentation and administration costs**, no internal evaluation, monitoring by the implementer and the CZDA	Low screening costs, inconsistent documentation, high administration costs, **planning, monitoring and evaluation by the CZDA health expert**
Effects and impacts		
Effectiveness	High, more women screened than planned (4.292) , a high incidence rate	Rather low, fewer women screened (3.244), still a high incidence rate
Impacts	**Most women diagnosed with cancer were treated in local hospitals** (a few with the project support), some women continue attending regular screenings, others are not aware of their rights	**Most women diagnosed with cancer were not treated** due to psychosocial reasons and low accessibility of treatment, women are not aware of their rights and mostly do not come for regular screenings
Sustainability	Unclear responsibility for rural screening, involved medical staff continues screening of rural women in the city, women trust them more and some do come, some villages still demand rural screening	Unclear responsibility for rural screening, even though women demand it

7.18 Photos of the project and the evaluation mission

Initial briefing at the Czech Embassy in Belgrade

Meeting at the National Screening Office

Meeting with patient association Stay Together

Review of project documents at Oaza Sigurnosti

Review of current status of cancer patients

Dr. Djurkovic with donated microscope

je ko mogao i imao, a u kutiji sa prilozima našlo se 67.870 dinara.

Ovo je četvrti put da "Bajka" organizuje završne predstave, a svaka od njih imala je i humanitarni karakter. Tako je novac od predstava prethodnih godina otišao stradaloj deci u Japanu i bolesnoj deci u Srbiji.

▶ Česi spasli 250 žena u Šumadiji

OD 4.000 žena iz šumadijskih sela, preventivnim pregledima grlića materice koje je finansirala vlada Republike Češke, kod svake dvadesete je otkriven sumnjiv nalaz koji je upućivao na dalja ispitivanja. Kod stotinu žena otkrivene su predkancerogene promene, a kod desetak i rak grlića materice, saopšteno je u Skupštini Grada Kragujevca nakon završetka projekta koji je Češka vlada donirala sa 400.000 evra.

- Žene sa sela retko odlaze na redovne kontrole. Može se reći da su ovim pregledima tim ženama spaseni životi - kaže dr Dubravka Đurković, ginekolog u Domu zdravlja u Kragujevcu i vođa ovog projekta. B. N.

Dr Đurković

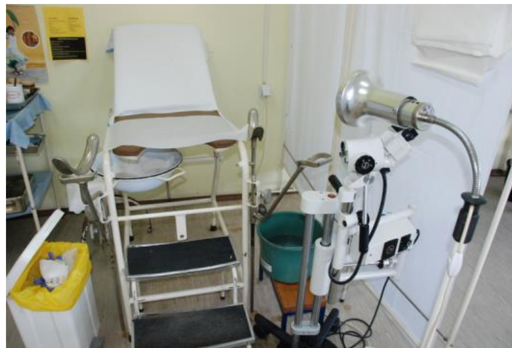
Example of an article about the project in local media, stating the donor was the Czech Republic

The bigger part of the team of medical staff, who were involved in the project and the evaluation

Mobile van used for screening

The displayed donors at the Health Centre in Kragujevac

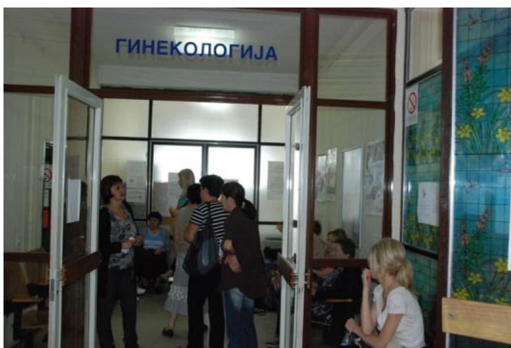
Dr. Dimitrijevic shows improvements made additionally from project budget savings



Donated microscope at Dr. Dimitrijevic´s ambulance in the Health Centre in Bresnica

Records of cancer patients were reviewed

Electronic database is being updated as well



Up to 50 women are check in one day at the Health Centre in Bresnica

The Health Centre in Bresnica from outside

Interview of a nurse at a village general practitioner

Interview of a cancer patient at a private space

Focus group with cancer patients in Kragujevac

Focus group with women involved in screening

Focus group with women involved in screening

Focus group with women involved in screening

Focus group with women involved in screening

Final meeting with the deputy minister of health

7.19 Checklist of mandatory requirements of the evaluation

General conditions	Fulfilled	When	Note
Use of min. 3 evaluation methods	Fulfilled	8 September 2015	
Completion of mission in the partner country	Fulfilled	3 July 2015	
Initial and final debriefing during the mission	Fulfilled	22 June, 3 July 2015	
Proper billing	Fulfilled	7 October 2015	
Revision of comments	Fulfilled	22 September 2015	
Final presentation	Fulfilled	1 October 2015	
Documents			
Inception report according to the mandatory structure (including the work timeline and mission in the partner country)	Fulfilled	19 June 2015	
Annexes to the inception report according to the mandatory structure	Fulfilled	19 June 2015	
Evaluation questions in the inception report	Fulfilled	19 June 2015	
Final evaluation report according to the mandatory structure			
Answers to the evaluation questions	Fulfilled	8 September 2015	
Reflection of the DAC criteria	Fulfilled	8 September 2015	
Level of fulfilment of evaluation criteria	Fulfilled	8 September 2015	
Reflection of cross-cutting principles	Fulfilled	8 September 2015	
Consistency of findings and conclusions	Fulfilled	8 September 2015	
Consistency of conclusions and recommendations	Fulfilled	8 September 2015	
Addressees given for each recommendation	Fulfilled	8 September 2015	
Compliance with the Czech Evaluation Society standards	Fulfilled	8 September 2015	
Range of max. 25 A4 pages (excluding Annex)	Fulfilled	8 September 2015	
Correct translation to the English language	Fulfilled	8 September 2015	
Mandatory Annexes to the final evaluation report – according to the mandatory structure			
List of abbreviations	Fulfilled	8 September 2015	
List of reviewed documents	Fulfilled	8 September 2015	At the report end
List of interviews and group discussions (focus groups) in the CR and partner country	Fulfilled	8 September 2015	
List of findings and recommendations	Fulfilled	8 September 2015	In the main text
Utilized questionnaires, overview of questions	Fulfilled	8 September 2015	
Results of surveys, factual findings	Fulfilled	8 September 2015	In the main text
Table reflecting (*key*) comments of the reference group, coordinator and implementer(s)	Fulfilled	8 September 2015	

General conditions	Fulfilled	When	Note
Executive summary in Czech language	Fulfilled	9 September 2015	
Evaluation Terms of Reference	Fulfilled	8 September 2015	
Overview and reflection of comments, which derived from the discussion during the presentation (if needed)	Fulfilled	8 September 2015	
Recommended annexes to the final evaluation report according to the mandatory structure			
Itinerary of the evaluation mission to the partner country	Reflected	8 September 2015	Included in the overview of interviews
Bigger tables and graphs	Fulfilled	8 September 2015	
The project logical framework (reconstructed if needed)	Fulfilled	8 September 2015	
The map of locations where the project was implemented	Fulfilled	8 September 2015	
Selection of photos from the evaluation mission	Fulfilled	8 September 2015	
Quotes of actors (e.g. target groups), case studies etc.	Fulfilled	8 September 2015	

7.20 Documents reviewed

- Project documentation
- Narrative and financial project reports of Caritas CR and Oaza Sigurnosti
- Monitoring reports of the CZDA and the Embassy
- List of trainers, villages, staff
- Media outputs attached to the project reports
- European guidelines for quality assurance in cervical cancer screening, http://bookshop.europa.eu/en/european-guidelines-for-quality-assurance-in-cervical-cancer-screening-pbND7007117/
- European guidelines for quality assurance in breast cancer screening and diagnosis, http://bookshop.europa.eu/en/european-guidelines-for-quality-assurance-in-breast-cancer-screening-and-diagnosis-pbND7306954/

Further documents that have been reviewed have been referenced in the text (see number).

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