

**Terms of reference for an external evaluation
of the tuberculosis control project in the South Ethiopian districts.**

ETHIOPIA



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Administrative Organisation in Ethiopia

Federal State (*Ethiopia*)



Region (*Southern Nations, Nationalities and Peoples Regional State*) – pop. 12 million



Zone (*Wolayta, Kembatta, Dawro*) – pop. 1.5 million



Woreda – District (*Damot Gale, Damot Pulasa...*) – pop. between 150,000 and 300,000



Kebele – pop. between 1,000 and 8,000

List of abbreviations used

AIR	Additional Incidence Rate
DOTS	Directly Observed Treatment Short -course
DU	Diagnostic Unit
EPTB	Extra-pulmonary
GHFs	Government Health Facilities
HF	Health Facility (including Diagnostic Units)
HW	Health Workers
IEC	Information, Education, Communication
MOH	Ministry of Health
NTCP	National Tuberculosis Control Programme
PDP	Pre-diagnosis period
PF	Project Field Facilitators
PTB-	Pulmonary negative
PTB+	Pulmonary positive
SNNPRS	Southern Nations, Nationalities and Peoples Regional State
TB	Tuberculosis
WHD	Woreda Health Department
WHO	World Health Organisation
ZHD	Zonal Health Department

I. THE ACTION AND THE ACTORS INVOLVED

A. BRIEF PRESENTATION OF THE ORGANISATION

1. Mission, objectives of the organisation

Inter Aide is a French non-governmental organization that specializes in the implementation of development programs. Its objective is to help the most disadvantaged families in the developing nations by helping them build the capacities to fulfill their fundamental needs. Currently, 60 programs are implemented in 8 countries.

There are several types of programmes, defined according to the families' needs:

- IN RURAL AREAS

- water and sanitation
- agriculture
- community health care, school health and sanitation, tuberculosis and AIDS prevention
- primary education

- IN URBAN AREAS

- access to employment: vocational training, microcredit
- education: early childhood education, prevention of school failure in primary school
- social: individual follow-up of the most underprivileged families

All Inter Aide's development programmes are implemented **in partnership with local organizations** (NGOs, community based organisations or beneficiaries' committees). Our aim is to strengthen our partners' capacities so that they can continue the activities on their own, start new activities and find adequate resources to do so. Thus the training component included in all our programmes is as important as the implementation itself.

Most of our local partners and field teams come from the areas of intervention (slums, remote/ destitute rural areas...); they are trained during the programmes' implementation.

All our programmes' direct beneficiaries are trained to master the necessary skills to ensure the sustainability of the project outcomes (water point management, agricultural techniques, health prevention behaviours, micro-enterprises, etc.). They also receive specific trainings enabling them to acquire and develop their capacities in the field of project management, decision-making and leadership.

2. Internal institutional organisation

Inter Aide's internal structure is built to ensure the efficient implementation and monitoring of development programs on the field.

It includes:

- **some 60 programs managers** based on the field are in charge of implementing the activities. The orientations of the projects are discussed at the field level, with a great autonomy of decision. All Program Managers are professionals (engineers, hydraulics specialists, agronomists, doctors, nurses, educators, business managers) with a two-year minimum contract. Wherever possible, we recruit local programme managers with high expertise and who are genuinely interested in staying in touch with the needs of the most disadvantaged and isolated communities.

- **8 "Country Directors"** set the strategies and coordinate a group of programs. They are former program managers and they spend at least a third of their time on the field. They provide the program managers with technical support, ensure monitoring and evaluation and continuity in the operating strategy and with the local and institutional partners.

- The headquarters team is composed of **14 persons** (equivalent to 12 full-time jobs): 3 in charge of human resources and recruitment, 7 in charge of financial management, 1 accountant, 1 secretary, 1 director and 1 person in charge of the dissemination of experiences and practices.

3. Experience in the country and in the field

As far as health is concerned, Inter Aide has conducted numerous actions since its creation, and in very disparate environments. Basically, these actions were centred on tuberculosis control, community health, AIDS prevention, reproductive health, and are conducted both in rural environments (Malawi, Ethiopia, Haiti) and in urban contexts (Bombay, Manila).

With regard to fighting tuberculosis, a certain number of operations have been carried out in the last two decades in very different environments. The first anti-tuberculosis project was initiated in Haiti in 1985 and took place over a period of about ten years. A project of the same type was launched in 1987 in the poorest slums of Bombay, first managed by a local partner in 8 dispensaries in the shanty towns in the north part of the city; it was then extended to become a reference project over the entire population of the urban district. This programme is currently conducted in partnership with the Municipality and the National Tuberculosis Control Programme. This action is centred on case finding and takes place in total collaboration with the healthcare system, by mobilizing a dozen of local NGOs. It relies on a strategy of strengthening the demand for healthcare by facilitating access to information about the disease and by simplified diagnostic procedures. This programme was the subject of an evaluation conducted with the support of F3E in 2004.

In Ethiopia, the first interventions started in 1987, with projects on water supply and primary health care, then it was progressively enlarged to tuberculosis control (1993 in Kindo Koysa then 2001 in Ofa), to support to familial agriculture (1994) and later to food security projects (2003). Located in the Southern Region of the country, the actions gradually focused on building up public-private partnerships by an increasing the involvement of institutional actors throughout all the sectors of intervention. Today Inter Aide is conducting project in rural environments in 4 specific fields:

1. Water supply, hygiene and sanitation and support for development of public water service (*5 programmes in 11 districts distributed over 4 zones*).
2. Familial agricultural support (*2 programmes* conducted in the areas of Wolayta and Kembatta)
3. Tuberculosis control (1 programme in 12 districts)
4. Reproductive health and family planning (1 programme conducted in 5 districts)

4. Overall budget

The total budget of the association was of **8,523,731 €** in 2008.

The portion related to Ethiopia is 13%. The portion related to the concerned field of operation (Health) is 27.40% in Ethiopia and 17% in all the countries combined.

5. Practice and internal organisation with regard to monitoring and evaluation

Monitoring and evaluation of the projects generally relies on 3 levels of intervention, promoting self-evaluation of the ongoing actions:

1. An integrated system of continuous data collection including:

- **Databases and maps** about the sites of intervention and the beneficiaries, providing an indispensable reference tool.
- **Continuous collection of indicators:**
 - *of the activities*
 - *of the operational results*
 - *of the structural results in the field of managerial capabilities*

2. Mechanisms for measuring the impact of the actions conducted

3. Mechanisms of supervision and technical support: relying on permanent exchange of information and several evaluation missions by the sector managers in charge of:

- *Monitoring the progress of the different activities*, their consistency, and respect for methodology and the schedule in order to facilitate the planning the subsequent activities.
- *Evaluating the efficacy* of the various activities and the quality of the selection process of the target groups.
- *Assessing the relevance of the strategies* and the need of revising them
- *Judging the quality of the synergies* between the different internal and external actors involved in the project, as well as the effective use of funds.

B. DESCRIPTION OF THE PROJET

1. The Ethiopian context

➤ General view



Ethiopia is one of the poorest and most populated nations of Africa, as well as a nation geographically and culturally isolated from the neighbouring countries, making Ethiopia a specific entity. Historical factors, such as the civil war that took place until 1991 and impeded the development of non strategic government services¹, explain why Ethiopia has the lowest urbanization ratio (90% of the population lives in rural areas), one of the highest population growth (3%) and is one of the most food insecure country in Africa. One of the consequences is that Ethiopia is ranked 7th in the world by the estimation of the number of TB cases.

The **Southern Nations, Nationalities and Peoples Regional State (SNNPRS)** is the result of the decentralisation process that took place in the recent years. This multiethnic entity of 11 million people presents violent socio-economic contrasts: Sidamo is considered as one of the most privileged rural areas of Ethiopia, whereas the districts of Wolayta, Kembatta and Dawro, less than 200 km away, have been hit by recurrent food shortages for the last 20 years. Decentralisation, with a gradual transfer of competences to the Regions, then to the districts (Woredas), has created the conditions for a renewal of institutional policies and mentalities.

Communicable diseases, including HIV/AIDS and malaria have been given priority by the health sector in Ethiopia which focuses its policy on increasing the number of health facilities while developing their capacities. The health system is nowadays progressively decentralised under the country's primary health-care strategy.

The primary health-care unit is the basic level of health care for Ethiopia and consists of a Health Centre with five satellite Health Posts, each serving theoretically 5 000 people. As from 2005, this network is progressively extended by the addition of Health Extension Workers (objective is to have two governmental health field workers for each kebele² by 2008). During the past year, further decentralisation to the woredas in major regions of the country has led to an increase in the transfer of health personnel from regions and zones to woredas.

However, implementing this policy proves to be difficult as observed in Wolayta, Dawro and neighbouring zone where the health supply is still quantitatively inadequate, with one health structure per 30 000 people on average on an area of more than 1.5 million habitants. **This reveals the inadequacy between the demand for care and the health supply.**

Tuberculosis is the second cause of adults' mortality in the AfroE (East Africa) WHO sub region³, next to HIV Aids⁴. Yet, the existence of a National TB Control Programme provides the structural and therapeutic resources to tackle this major health issue. Free TB treatments are theoretically available at all levels of the health system, so are diagnostic facilities and reporting formats.

¹ The health system was severely affected by this situation as there was usually only one health center poorly equipped per woreda at this time (representing a population between 70 and 300 000 habitants on average)

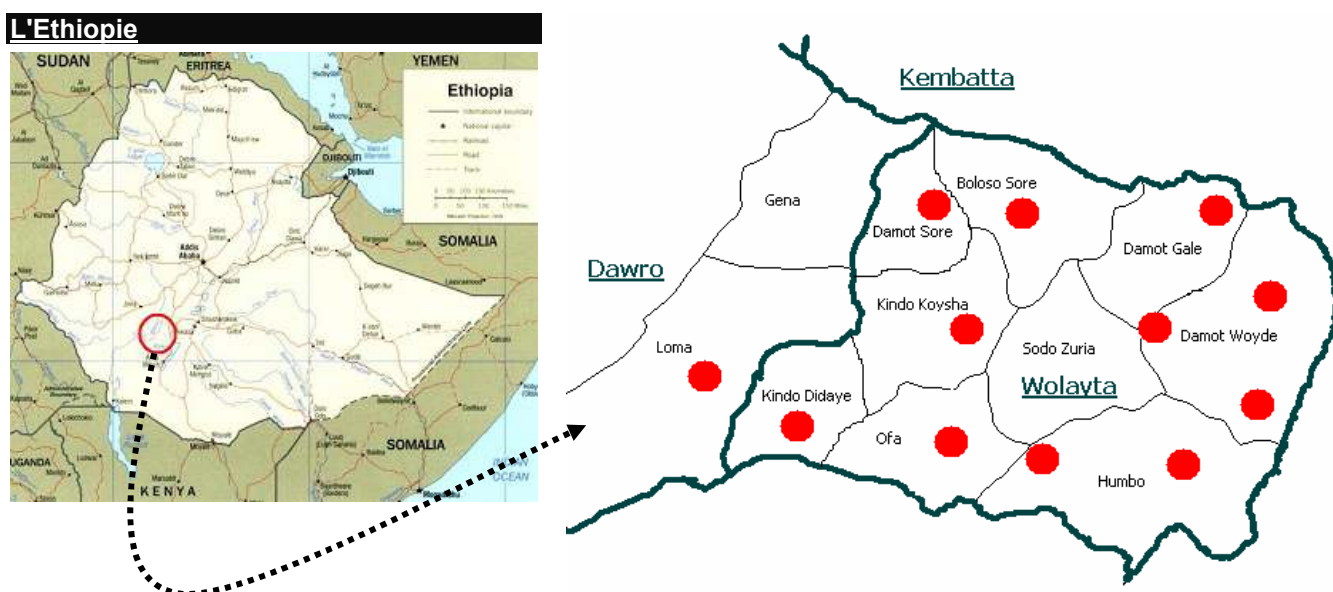
² The smallest administrative area of a district

³ Source : World Health Report 2004

⁴ Ethiopia belongs to the next-wave countries regarding HIV, but SNNPR presents one of the lowest national prevalence, with a 3.1% in rural areas.



➤ Regional focus



However, in 2003, only 10 health structures out of 30 were engaged in TB control in the whole area, due to a lack of trained staff, scarcity of lab technicians and absence of a real mobilisation of the health system. **There is thus a considerable under-utilisation of resources due to an acute problem of service delivery and access to care.** Consequently, the number of cases annually detected by the health system was around 70 per 100 000 pop/year, as opposed to a national notification rate of 141 in 2001⁵. This gap is all the most unfortunate because it leads to deaths and contaminations that could be avoided among the most vulnerable social groups.

TB mortality in Ethiopia has been reported at 79 deaths/100 000 pop/year. In other words, in the concerned area, about **1 100 deaths occur** every year in spite of the existence of a National TB Control Programme, making free TB treatments available at all levels of the health system.

The prevailing context of the selected area (Wolayta and Dawro Zones) is characterized by an **acute rural poverty**, high food insecurity and a lack of non institutionalised medium of information. The high incidence of tuberculosis appears therefore as the result of a combination of high human density, chronic food shortage and poor access to basic health information. In such a context, tuberculosis is devastating the family economy, depriving the families from their labour force, and consuming substantial resources in the search for care. In the Southern Region, the considered incidence is 2.2‰, and the prevalence of 4.4‰.

Regarding the institutional responses: the NT&LCP (National Tuberculosis & Leprosy Control Program) is a relevant tool but its operation is affected by a number of constraints frequently found in the implementation of national programs. With the introduction of the DOTS and its generalization, the problems moved from the observation towards the case finding.

The question today is less to secure the fidelity of the patients under treatment but rather to increase their number, and in particular those coming from the most vulnerable stratus. Indeed, the detection of new cases remains largely lower than the calculated incidence. Before any intervention, the incidence observed in the implied Woredas was around 0.7‰, which remains the standard in the whole Region, excepting in Wolayta Zone. The action started in the course 2003 enabled partially to fill the gaps, but has not been able yet to cover the entire area.

All in all, the deficiencies of the health system are to be found on:

- *The incapacity to produce and communicate clear and easy to assimilate information on the epidemic*, conveyed to the most vulnerable and isolated rural populations
- *An insufficient decentralization of the available health services*, being an essential condition to increase the case finding and to improve the case holding in the underprivileged zones
- *A diagnosis chain not efficient enough*, often slow, bureaucratic, not patient-friendly and sometimes repelled by sputum analysis

⁵ World Health report, 2005.

- *An inconsistent coordination*, being at the origin of a low visibility of the epidemiologic stakes, drug and reagents supplies' shortages and lack of reliable data and documentation

Last but not least, it is important to add a fifth factor independent from the health system but decisive: *the absence of mobilised intermediate actors* capable to ensure mediation between the medical services and the targeted communities. **In the Southern rural Ethiopia civil society is scarce or dormant.** Existing rural organisations are the consequence of governmental policy or churches' development rather than the result of emerging social initiatives⁶.

There is thus a lack of intermediate actors (or groups of actors) and this gap partially explains the problems of "access" as there is little possible mediation between institutions and local populations. In this context, the choice to intervene "in between" to build and link institutional partners' and civil society's capacities, notably through the empowerment of "social mediators", appears to be an appropriate approach to ensure the sustainability of the project results.

2. History of the action

Two initiatives in TB control carried out in the area provide strong foundations on which the proposed action is built on. Lessons drawn from these initiatives may be described as follows:

Period [1993 – 2002]

→ **The first TB control intervention in Koysha started in 1992**, as a result of empirical field observations showing a considerable number of suspected TB patients among the local populations. The first operational model was based on a classical approach encompassing the whole therapeutic chain: case detection, diagnosis, case holding and follow up were under the direct supervision of the project. To minimize the risk of patients drop out in an area where physical accessibility was particularly challenging, a TB centre was built in Bele to receive the patients during the two months of intensive phase of the treatment (DOTS strategy). Initially built for accommodating 40 patients at a time, the capacities of the centre were quickly overwhelmed in spite of a rigorous policy of admission, and had to be doubled to meet a growing demand. The therapeutic pick was reached in 1996 with nearly 400 patients cared for in the year. At this time, the ratio TB patients/project operator was set at about 8.

This experience confirmed one assumption: in a country where there is no alternative access to anti-tuberculosis chemotherapy (mainly due to the absence of a private health sector as such and the existence of a strict health regulation concerning TB drugs delivery), a rigorous DOTS strategy, with a success rate persistently above 85% and a sputum positive case finding rate close to 70%, can drastically reduce the incidence. Today, the observed incidence is set at 0.8‰ as opposed to [2.5-3‰] at the onset of the program. Such result means that the annual number of new cases detected in Koysha came down from 350 in 1997 to less than 150 in 2005. It is thus liable to consider that a highly significant drop in the risk of infection is achievable in the Ethiopian context. Similar observations recorded in Peru where an effective TB control program was carried out in the 90s, showed that in equivalent conditions of case finding and treatment success rate, the decline in the incidence had been close to 7% per year. It is important to mention that the strategy applied at this moment was fully supported by the Health Authorities, as they were providing the entire amount of TB drugs consumed within the project.

→ **A follow up survey conducted in the same area was made in 2005** to measure the mortality rate among former treated patients. 674 patients declared as cured or treatment completed between 2001 and 2004, were included in the survey. No information was available for 6.2% of them, and 8.3% had left the area. Among others, the post-treatment mortality rate was calculated at 3% only. This survey shows the durable impact of the treatment on the health status of all categories of patients.

Period concerned by the evaluation [2003- 2009]

→ **Later on, the most recent initiative was linked with a request from the Zonal Health Authorities**, asking for an extension of the scheme, based on an evaluation report from regional and zonal authorities⁷. In 2004, a pilot project started in 5 woredas to implement a revised strategy based on social

⁶ Excepted community groups and committees as a result of rare NGOs' intervention

⁷ Evaluation carried out in September 2003 by Regional and Zonal authorities in Ofa and Kindo Koysha woreda.

mediation and institutional support. This new approach was considering that in a context characterised by geographical isolation, illiteracy and poor accessibility, the most effective way to strengthen the response to the epidemic was to bridge the gap between the patients and the health system through acting on both demand and supply.

The central assumption was that sole a global strategy targeting both on patients and health professionals as well as on the possible social links between the two would generate the conducive conditions for an improved and sustained access both to diagnosis and care from the tuberculosis patients. On the demand side, the idea was to convey and promote simple and appropriate information about the disease and the availability of a free medical response, while referring suspects cases. On the side of supply, the focus was initially put mainly on improving the attitude of the health staff, shortening the diagnosis procedure and making the reporting system more effective, mainly through a coaching strategy consisting in accompanying the patients throughout the course of diagnosis and care. Later on, with the Lab Technicians shortage crisis, more attention was given to develop supportive mechanisms to the diagnosis at Health Facilities level by the provision of improved equipment and the reinforcement of the skills and implication of the technical staff through training inputs. Such a strategy pointed out that a referral system, facilitating dissemination of information and strengthening the efficacy of local health structures, could raise the case finding rate by 0.6‰ (e.g. from 0.7‰ to 1.3‰) in a single year. As a concrete result, the total number of TB patients registered and treated in the Government Health Facilities (GHF) raised by 50% (from 750 to 1035 cases detected and treated) and the defaulter rate dropped from 20 to less than 5% after one year only.

It can be derived from these experiences that early access to treatment can be significantly improved while limiting the defaulted rate by the combination of 3 key elements: making vulnerable populations aware and responsive to epidemiological stakes, setting up a referral protocol involving intermediate actors, ensuring close follow up and counselling to patients notably those discontinuing their treatment.

3. Summary of the objectives

Organised around 3 main priorities - access to information - access to care & treatment - improvement of health facilities performance -, **the project intends to facilitate a decentralised early access to free anti-tuberculosis treatment delivered by Government Health Facilities with the support of social mediators from the civil society.** This initiative is innovative by its double focus on demand for care and health supply. It relies upon the mobilisation of all the Government Health Facilities (GHF) and the setting-up of an efficient referral system between care seekers and service providers involving social mediators acting as community DOTS providers and *in fine* as information suppliers. This project aims to empower the target groups' own development capacities to generate an increase of detected and successfully treated patients by the health system, leading to a durable reduction of new contaminations, deaths and economical losses caused by tuberculosis. In addition, the potential for extension and replication of the scheme was particularly interesting.

The overall objectives of the project are in line with the main objective of the Ethiopia–European cooperation strategy to reduce poverty. They will contribute to:

- Build capacities of community and institutional actors to efficiently address communicable diseases and health related issues
- Reduce economical threat caused by communicable diseases on isolated and vulnerable families
- Secure health environment for the most vulnerable populations

The specific objective of the project is therefore:

- The capacities of community based and institutional actors to control tuberculosis epidemic among vulnerable families are durably reinforced

4. The beneficiaries

The action focus on the largest fraction of the rural population of the area. This population is equally exposed to a high risk of infection but unequally served in terms of access to treatment. All concerned beneficiaries are farming families, with the following economical status: 60% of the families belong to highly vulnerable category (facing an acute de-capitalisation process), 10% are in a capital accumulation process and 30% belong to an intermediary stratum. As most patients are in the economically productive age group, the priority age group is the [15-49], representing about 75% of the potential cases (with a distribution estimated as follows: [15-24] representing 30% - [25-34]: 27% and [35-44]: 19%). Genderwise, women and men are equally concerned by the scheme, with a sex ratio of nearly 1-1. Indeed, as tuberculosis affects women mainly in their economically and reproductively active years, the impact of the disease is also strongly felt by their children and families.

In quantitative terms, 10 000 families have been the direct beneficiaries (representing 60 000 people), as 10 000 tuberculosis' patients have been detected, diagnosed and treated over the period, with an equal access to care for women and men. As far as information dissemination is concerned, more than 100 000 families had been reached by the IEC scheme. Final beneficiaries can be described as the whole rural population, and particularly the 60% most vulnerable families, benefiting from a reduced risk of infection as well as an improved health system in its diagnostic and therapeutic dimensions.

5. Internal organisation and partnerships

➤ Internal organisation

Field activities' implementation, resources management and training, partnership and institutional collaboration are under the responsibility of one Ethiopian Project Officer, supported by one local Project Assistant. See the table below for the local implementation teams' staff.

The needs for technical and administrative permanent liaison with Regional and Zonal authorities and institutions require the presence of an Expatriate Country representative (on a part time basis).

General management, strategical orientations and supervision will be under the responsibility of a Regional Director (medical expertise) based in Europe. Short term missions are organised bi-annually for a total period of 15 days per year.

External evaluation will be carried out under the responsibility of an external consultant.

Management, supervision and co-ordination	Implementation teams (local staff)
<ul style="list-style-type: none">• 1 Project Officer (Ethiopian)• 1 local Project Officer Assistant• 1 Country Representative Expatriate (part time)• 1 Regional Director for evaluation and programming (about 15 days of mission per year from France)	<ul style="list-style-type: none">• 5 field supervisors• 31 field facilitators• 1 Administrative Assistant• 1 Driver• 2 lab technicians (support to Diagnostic Units)

➤ Other involved actors

Social mediators: These mediators were supposed to be persons with an eminent social position (elders, teachers, women and/or peasant association leaders...) or with a specific status of peer (former cured patient) able to influence attitudes and culturally-mediated perceptions. They are expected to act as an inter-link between care seekers and service providers. Their role may be described as relay actor ensuring patients' compliance on one side as well as facilitating adequate care seeking from patients suffering from a chronicle cough or other disabling symptoms, especially in the remote areas.

⇒ *The idea is to mobilise and empower the mediating resources of the context, under the shape of social actors having enough legitimacy to influence psychosocial and cultural perceptions and attitudes. At mid-term, the creation of sustainable links between key project stakeholders intends to find substitutes to project facilitators.*

Zonal Health Department, Woreda Health Department and GHFs

Wolayta Zonal Health Department, as co-signatory of the project agreement, has decided to extend the pilot project and expressed a request for operational support. On the operational ground, GHFs ensure the diagnostic and curative aspects and deliver DOTS treatment to the DOTS providers, collect and record data, fill in registers and activity reports, organise meetings with social mediators. On the management ground, ZHD ensure continuity of drug supply, organise training for health staff, compile, process and analyze data, receive operational and financial reports and conduct final evaluation.

⇒ *The role of the Health System is fundamental, as it is the only health service provider in the context. This absence of alternative, besides leaving care seekers with no other realistic option, makes institutional actors in a kind of monopolistic situation regarding health supply. The constant joint assessment of the project outcomes will thus permit a continuous process of self-evaluation under an external vision. This process will in turn allow the health system to measure its progress, finally resulting in improved capacities to ensure its service delivery mission.*

6. Budget

	Cofinancement 2002-2007	Cofinancement en cours 2008-2009	TOTAL
Budget en Euros	Réalisé 766 754	Prévisionnel 295 629	1 062 383
Plan de financement			
UE	302 921	216 565	519 486
MAE	276 470		276 470
ONG	177 368	79 064	256 432
Divers privés/Rec locales	9 995		9 995

7. Activities and results

7.1 Activities

The project takes place in 12 woredas of Wolayta and Dawro Zone, covering 5 000 Km² and with a global population of 1.5 million, most of them living in isolated and highly food insecure rural communities. Today, 30 public health structures are functional and there is no private health system as such in rural areas. Poor health supply and high potential demand for care represent the main structural imbalance of the context. Added to that, the distance from households to health structures and the social stigma attached to tuberculosis are the major obstacles to access to care, diagnosis and treatment. The project methodology is thus based on a double intention: acting on the demand for care, in alleviating the effect of the factors delaying appropriate care seeking, and acting on health supply in improving care-seekers' access to standard diagnosis and DOTS therapy within the health system. The methodological design aims at:

1. **Creating a communication network** able to provide clear and appropriate information to the target groups, promoting early and free access to treatment.
2. **Implementing a referral system**, through identification and training of intermediate actors (social mediators in rural zones), and setting-up coordination mechanisms between the project and the public health authorities.
3. Providing a selective support to Health Facilities, **in the field of diagnostic procedure, patients management and follow up, data collection - monitoring and reporting, as well as the promotion of services decentralisation.**

Translated into activities, this may be presented as follows:

1. Provide access to information

Access to information: the action relies on three different mechanisms to disseminate information to the remotest areas.

→ By **mass information campaigns** through the performance of dramas involving project staff and community actors to disseminate key messages on the epidemic, with the support of former patients as well as on HIV/AIDS prevention.

→ By **home to home visits** made by a team of field facilitators recruited and trained in each woreda. These facilitators will cover pre-determined geographical areas in permanent connection with local staff working in the concerned health structure. Their tasks will be to act on both demand for care and health supply. They will systematically visit families to provide a more consistent and adapted knowledge, while looking for suspects cases.

→ By the **mobilisation, training and empowerment of social mediators**, representing intermediate resource-persons with the capacities to durably relay reliable information and organise community conversation on tuberculosis as well as acting as DOTS providers for ongoing patients.

2. Facilitate access to care

Referral system: as mentioned above, this system will allow home based symptomatic patients to be referred to Diagnostic Units (DU), sole health structure entitled to officially notify new TB patients. This facilitating linkage between needs and resources will first be assumed by the project field staff until general awareness creation among the population as well as social mediating capacities are strengthened and effective.

3. Improve the health system performances

Provision of selective support: one has to keep in mind that the public health system is the only health service provider in the context, if we except traditional healers. No alternative system can provide competitive options. Facilitating access to care implies therefore the improvement of existing health supply. The main shortcomings of the health system have been jointly identified with the local governmental partners during a specific workshop to this extend in the field of: **diagnostic capacities, patients follow up and prevention of defaulters, data collection and monitoring**. The action proposes therefore to provide a temporary support to the weakest lab facilities through a specific project unit. Prevention of defaulters will rely upon the project facilitators then upon community DOTS providers, who will afterwards continue to act as a social link between vulnerable populations and public health systems, in order to shorten access to care and to ensure that patients' compliance generates a sustainable additional incidence rate (AIR) . Coordination, mobilisation and training of health staff will be ensured by the project coordinating unit.

7.2 Results

a. Relevant key information related to tuberculosis is durably integrated by target groups

3 main indicators have been selected to measure the dissemination of information on tuberculosis leading to a progressive impregnation of the target groups with new mental images of the disease.

→ The latency period :

The latency of pre-diagnosis period (PDP) is an indicator which corresponds to the time between the appearance of the first symptoms and the consultation in a health facility (period where the risk of contamination and economical loss is at the highest!). This indicator is systematically collected while recording the patients on the official Woredas Recording Book. It measures the level of awareness of the patients, as it can be assumed that the more rational the perception of the disease, the shorter the PDP.

Year	<1Month	2M	3M	4M	5M	6M	+6M	Total patients assessed
2006	328	295	241	146	93	90	85	1278
	26%	23%	19%	11%	7%	7%	7%	100%
2007	737	584	282	96	30	17	3	1749
	42%	33%	16%	5%	2%	1%	0%	100%
2008	994	804	302	74	33	16	17	2240
	44%	36%	13%	3%	1%	1%	1%	100%

The pre-diagnostic period corresponds to the time expressed in months (M) between the appearance of the first symptoms and the consultation in a health facility

Since this data has been recorded, there is a decreasing trend of the PDP within the concerned areas. It should also be notified that the first data was collected after 18 months of intervention and reflects therefore a reality already slightly modified by the action. The latency period observations reflect that:

- ☞ The number of patients diagnosed within 3 months or less after the symptoms' apparition increases from 68% in 2006 to 91% in 2007 and 96% in 2008.
- ☞ The PDP in 2008 shows an average of 41 days (1.38 month) against 44 days (1.46 month) in 2007 and 75 days (2.5 months) in 2006. Each diagnosed patient spends thus 34 days less being sick at home, which means less disability, less expenditure in search for care but also less expected mortality.
- ☞ This last assumption seems corroborated by the death rate figures, declining from about 7% in 2003 (first figures available in the area) to a [3 to 4%] range today, accrediting the idea that the patients are taken into care earlier and in a general better state

→ The defaulting rate

The defaulting rate gives an idea of the compliance of the patients, which may be forwarded as a sign of self conviction and adherence to the presentation of the disease.

Year	Case finding	# Defaulters
2003	1461	11 0.80%
2004	1562	12 0.82%
2005	1356	14 1.03%
2006	1600	17 1.06%
2007	1809	12 0.66%
Total	7788	66

The defaulting rate has been therefore extremely low from the beginning of the project, and has reached a minimum in 2008 that seems difficult to improve.

→ The observed incidence among lost patients

This indicator measures the probability of a lost patient to actually have the disease. The lost patients are those who do not attend the diagnosis unit after being referred by a field facilitator. The assumption is that **non TB cases should be less likely to visit the diagnosis unit because of their low self conviction, based on their own knowledge about the disease.**

Although the results of the survey are not completed, the first feed back concerning a quite important sample of lost patients clearly shows a lower incidence among lost patients, as testified by the following chart.

Year	Suspects	Referred	Screened	Confirmed
2007	100	83	53	35
2008	100	90	71	37

A 34% raise in the share of referred patients actually getting screened provides 6% of additional TB cases only. Put in another way, whereas the TB prevalence may be established at about 66% (35/53) of screened patients attending the DU, the value drops down to about 10% (2/19) on the sample of patients additionally screened thanks to an intensive coaching and counselling, considering of course that the actual prevalence within the referred group remains constant over the years.

b. Access to DOTS therapy is facilitated

The referral system developed through the action aims at facilitating the access for an increasing number of patients to the governmental health facilities. The facilitators' role is to encourage linkages between the health facilities and the targeted population. In addition to the mission of conveying information and training social mediators as described above, they also have to identify suspected cases within the communities, and then to refer them to the health facilities. Each agent is in charge of a given geographical area, with a continuous gliding dynamic in order to gradually cover new neighboured areas. The main indicators reflecting the effectiveness of this component are:

→ The yearly detected incidence of new cases

Year	PTB+		PTB-		EPTB.		Retr.		Total	Remark
2003	835	57%	359	25%	248	17%	19	1%	1461	3 quarters only for 10 Woredas
2004	921	59%	280	18%	319	20%	42	3%	1562	
2005	803	59%	331	24%	187	14%	35	3%	1356	
2006	886	55%	386	24%	284	18%	44	3%	1600	
2007	959	53%	440	24%	351	19%	59	3%	1809	
2008	1016	45%	687	31%	483	22%	56	2%	2242	
Total	5420	54%	2483	25%	1872	19%	255	3%	10030	

Case finding for 12 woredas from April 2003 up to end of 2008

10 030 represents the total number of cases registered in the whole project area over the period, out of which 97% are new cases. There is an increasing trend that is particularly visible in the last 2 years, where the case finding has progressed by almost 40%. Compared to the initial figures collected in 2003, the raise is much more spectacular, with a multiplying factor of 2.5.

The number of referred patients for the period within the 12 Woredas (taking into consideration the new administrative organization) was 3.777. Reduced to the number of facilitators (32 agents directly involved in the referral activity), the ratio references/operator corresponds to 118 per year. On the other hand, the same calculation carried out on the number of tuberculous diagnosed (1.807) amounts to 56 per year. One can therefore observe that the referral system effectiveness, in regards to the case finding activity, is 1 tuberculous for 2.1 patients, corresponding to 47% of effectiveness. This ratio is largely higher than our initial assumptions which counted on 1 tuberculous out of 5 patients (20%).

→ The rate of smear positive (contagious) patients

This indicator is essential to measure the effect of the project upon the global risk of contamination. As shown above, this parameter appears as less satisfactory, with a slight decline in terms of sputum positive patients. Part of the case finding increase in the last year is thus partly explained by an over

representation of negative cases. The reason behind this evolution is not clear, that might be linked with a deterioration of the requirement in the case detection, or a change in the epidemic pattern...

→ **The global observed incidence.**

It has been measured at 1.4‰, which means 2 times the initial value calculated in 2003 (0.7‰). The progress recorded through the period has been irregular, with a rapid increment in the first year, a stagnation from 2005 to 2006 followed by a noticeable raise in the 2 last years. In Damot Sore (2.22‰) and Boloso Sore, (1.78‰) , the detected incidence seems to be close to the actual figure that was assessed in the previous project in Koysha to be in a [2.2 – 2.5] ‰.

c. Performances of Health System to control and monitor tuberculosis are durably improved

The following chart displays the major indicators used to assess the effectiveness of a TB control system.

Year	Case finding	Cured		T.compl.		Died		Default.		Failure		TransfOut		Results	Success rate
2003	1461	654	48%	563	41%	103	7,5%	11	0,80%	5	0,36%	36	2,62%	1372	88%
2004	1562	748	51%	565	39%	101	6,9%	12	0,82%	2	0,14%	38	2,59%	1466	89%
2005	1356	686	51%	564	42%	58	4,3%	14	1,03%	2	0,15%	32	2,36%	1356	92%
2006	1600	776	49%	709	44%	54	3,4%	17	1,06%	4	0,25%	40	2,50%	1600	93%
2007	1809	823	45%	853	47%	75	4,1%	12	0,66%	6	0,33%	40	2,21%	1809	92%
Total	7788	3687	48%	3254	43%	391	5,1%	66	0,87%	19	0,25%	186	2,45%	7603	91%

→ **The treatment success rate (assessed with 18 months delay), the failure rate and the mortality rate .**

These indicators show the effectiveness of the global therapeutic control, far exceeding the WHO recommendations, with a success rate stable around 90%, a failure rate maintained at a very low level and a mortality rate constantly decreasing over the period.

→ **The decentralization of the health service delivery is effective.**

In 2008, the ratio of patients cared for in the peripheral health facilities was 46% as opposed to 54% in the Health Centres. This ratio appears as a confirmation of the effective decentralization of the health system, as initially 100% of diagnosed patients were treated at Health Centres level.

II. THE EVALUATION

A. JUSTIFICATION FOR THE EVALUATION

1. Origin of the request

The presented project is at an advance stage of its second phase (2003-2010), which constitutes the period to be evaluated. The first initiative of Inter Aide in Ethiopia on tuberculosis control began in 1993 with a direct intervention including all the dimensions of an epidemic control scheme: information, case finding, diagnosis, treatment provision in a closed environment and patient follow-up during the consolidation phase. This ambition of this first project cycle was to durably reduce the risks of contamination by identifying and treating the largest possible number of tuberculosis patients, and thus reducing the risks of contamination. At that time, the project had about forty operators available for managing a final total of 400 patients during a single year, with a constant reduction of the incidence observed, from 3% to less than 1%. In a second cycle, relying on the expertise acquired whole chain of tuberculosis control and the progressive implementation of a real national tuberculosis control policy, a complementary strategy has been designed, seeking to support the healthcare system in order to improve its ability to respond to the requirements of an effective epidemiological control program. The main idea was to design a more selective mode of intervention, based on the weaknesses and gaps identified in the existing system and extended over a much larger area so as to obtain lever effects to address a much larger population.

Today, this second-generation program needs to be evaluated from the angle of the effects produced and the perspectives offered, notably in terms of designing a new, more selective, form of support and allowing broader sanitary coverage. If the relevance of the strategic choices does not seem doubtful at first sight, it would be opportune to make an inventory of the methodological and organisational options that have been developed. **The program is indeed at a time where there is a need to draw lessons from the developed experienced and to integrate them into a new paradigm.**

2. Expectations and objectives for the ongoing project

Generally speaking, going from the first model of action to the second was based on a search for more efficacy notably as regard to the use of the invested resources. This increased effectiveness (or more precisely, efficiency) was obtained by identifying possible complementarities with the health system, by reducing the number of tasks directly managed by the project through a more selective operational approach, while broadening the geographical scope of the action (such "upscaling" being done while keeping the same means as in the previous action).

A central aspect of the evaluation objectives is then to help in the definition of a new model which would continue the process defined here-above. In other words, it consists in extracting from the ongoing experience the more relevant elements for the conception of a new operational model with an additional level of selectivity of the project activities (being selected based on their potential to improve the results of the health system) and to be deployed on a larger intervention area.

The objectives for the project are therefore:

- ***To evaluate the impact of the implemented measures within the partnership established with the healthcare structures and the health system in it whole on case finding.***

The project follows several key principles of action:

- **Acting on the healthcare demand**, which consists in ***conveying key information on tuberculosis to target population trough both mass communication campaigns and a close work with individual families.*** This dimension is strengthened by the use of liaisons or social mediators, ensuring a permanent access to key information on tuberculosis as well as counselling the local populations.
- **Acting on the healthcare supply**, which was initially developed in three directions: encouraging the decentralization of the services, strengthening the reliability of data collection and providing a support to the diagnostic structures in order to improve the patients' care and the diagnostic procedures. This last aspect has then been emphasized due to the intensity of the constraints exerted on laboratory activities (notably the lack of technicians and microscope equipment) on which a large part of the recruitment dynamics rely. The project scheme has therefore integrated technical assistance reinforced by training, equipment improvement, and pilot experimentations with sputum collection sites.

- **At the interface of these two principles, a referral system aiming at facilitating the access of suspected cases to Health Units** The referral system focuses on linking the target groups and the healthcare system, by referring suspected patients presenting indicative symptoms of chronic lung disease, and counselling in the diagnostic process while ensuring a monitoring throughout the whole treatment phase.

It is expected that this evaluation assesses, if possible, the relative effectiveness of each of the intervention components, by trying to isolate the methods and options that can be considered as having the greatest measurable impact on the core indicators, and more specifically on the case finding.

➤ ***To contribute in defining the outlines of a third-generation strategy on the basis of the preceding questions.***

At this level, the project has provided certain answers to the question of the poor efficacy of the healthcare system in the implementation of a tuberculosis control policy in the context under consideration. A large quantity of information and data allows today to better understand the areas where a supportive action seems the most likely to produce results. Some scenarios have been designed on possible forms that such action could take in the coming future. We expect the evaluation to confirm or refute the considered perspectives and to provide a logical opinion on the outlined anticipations.

➤ ***Find out the operational modalities for a larger scale intervention***

The tuberculosis control project relies on the concern of the effectiveness of the invested means as regard to the number of screened patients. Roughly assessed, the revision of the previous strategy has allowed facilitating the access to diagnostic and treatment for 3 times more patients while keeping the same constant means. The current experience was designed as regard to certain postulates related to tuberculosis control in the local context. It notably aimed at demonstrating the relevance of certain options, such as the decentralisation of access to care, the impact of an information access scheme, and the importance of rationalising the diagnostic procedure and bringing it as close as possible to the patients.

Today, the expertise acquired from a close and prolonged collaboration with health structures has considerably strengthened our knowledge of the health institutions and the areas where they have difficulties to respond to challenges marked by considerable socio-geographical constraints. This acquisition extends the movement toward lighter and more precise forms of action, involving a larger number of health structures while offering them flexible strategies entirely dedicated to a better efficacy of the case finding.

How to arrive at the adequacy between a strategy favouring flexibility and selectivity and an administrative and health apparatus culturally inclined to a normative attitude remains one of the major contributions we expect from this evaluation. In other words, it is a matter of proposing more targeted forms of action, and therefore focusing the resources of the system on methods selected for their potential to find new cases, to the detriment of a distribution favouring equality of access and uniformity of the mobilized means.

3. Expectations and objectives for the partners

The expectation from the partners' point of view concerns mainly the confirmation of certain methodological options that were experimented with in the scope of the ongoing operations. Of course, there is a difference in perception between the partners depending on their level of responsibility. Partners at the Regional or Zonal level are more focusing on overall epidemiological results and are favourable to an enlargement of the current geographical area covered by the intervention. At Woreda level, the actors have another type of expectation, more centred on increasing the mobilized resources by the project in their particular geographical sector.

B. PURPOSE OF THE EVALUATION

1. Fundamental postulates whose relevance will be assessed by the evaluators

- 📖 The first postulate issued at the origin of the action is **the existence of a consistent and appropriate national tuberculosis control programme whose application could be promoted in remote and isolated geographical areas**. This postulate was based on experience developed during the first project cycle, where a certain number of connections had been established with the Regional Tuberculosis Control Program's actors (RTCP). Overall, **the hypothesis was that there was a substantial inadequacy between a very high latent demand and a supply of services widely under-utilized**.
- 📖 The second postulate was based on the **conviction that the expertise acquired by Inter Aide during a first project cycle of nearly 8 years would allow the definition of a set of synergies and operational complementarities with the healthcare system**, with the perspective of a significant improvement of the case finding.
- 📖 The third postulate was based on the idea **that the dominant necessity was clearly to strengthen the case finding as compared to the other programme components** (dropout rate, treatment success rate, treatment failure, etc.) which were believed to be more easily controlled within the scope of the DOTS strategy. With this angle, only an action centred on both supply and demand for care was able to produce results regarding the access of patients to treatment.

2. Questions to be considered

The strategy put in place as per 2003 was focusing on a double objective: acting on demand and supply (demand for care and supply of health services) while setting up a mediation system to fill the vacuum of intermediate actors between the patients and the health system.

1. **Acting on demand was primarily aiming at facilitating the access to health information** in a rural set up where the lack of communication medium, illiteracy, scattered housing and historical isolation explain the absence of stable channels able to pick up and deliver appropriate, comprehensive and structured information to the remotest places. This improved access would in turn contribute to reduce the latency period stretching from the onset of symptoms to the start of the treatment, therefore limiting the economical burden of the disease upon vulnerable families. As a result, the pre-diagnostic period was considerably shortened over the years, to reach in 2008 a 93% share of patients diagnosed in the course of the 3 first months of the disease. Late diagnostics, occurring after more than 6 months of evolution, represent today 1.4% of the total cases only as opposed to 14% in 2006 and much more in the previous years.

The questions attached to this aspect of the project may be exposed as follows:

- ➡ **How far the steady decline recorded in the latency period testifies for an actual change in the mental perceptions about TB, and not for a simple consequence of the referral system itself, if we rely on the passive versus active detection rate ?**
- ➡ **How to measure through a quick assessment protocol the economic impact of such a reduction, notably as concerns the expenditure and other economical losses avoided by the referred patients?**
- ➡ **What kind of pedagogic and informative approach could be proposed to strengthen the educational impact of the action, besides the options selected by the project (house to house information, collective meetings...), notably with the objective of increasing the efficiency of the educational component?**

2. Acting on supply, part I. This component was developed later in the project design, as part of a global strategy to facilitate access to care (see above). One of the key constituent of a TB control program is the early access to diagnosis facilities. This access depends on qualitative and quantitative terms: physical access to diagnosis, capacities to provide a quick and adapted response to the demand, skills and commitment of the lab professionals, organisational modalities, availability of diagnosis equipment...

A study on lost patients was conducted in 2008 that allowed to identify a list of alleged reason for not attending the Health Units. Poor service was counting for as much as 26% of the answers, ranking second in the classification behind distance to the HF. Nevertheless, after excluding the 2 sites (out of 12) with the highest records (Damot Sore and Loma) this percentage falls down to 11%.

Therefore, the questions related to this aspect of the project could be formulated as follows:

- **To what extent the action had an impact on the duration of the diagnosis period ‘at the exclusion of other factors such as the opening of new DUs and alike...)?**
- **Is there a methodological way to assess the impact of the project on the quality of the service provided at DU level? What explains the rate of responses related to a poor service in specific areas, Damot Sore and Humbo notably?**
- **Assess the today situation in terms of diagnosis facilities and services, in separating the aspects already tackled by the project intervention (and identifying the most effective) from those that would require further attention and solutions.**
- **Finally, it is expected from the evaluation team to provide a global assessment of the articulation between the project and the Health system including the National TB Control Policy. This would entail the organisational, methodological and operational dimensions of compatibility between the project options and the national guidelines.**

3. Acting on supply, part II. One of the latest strategies applied in the target area was the concrete testing of on site sputum collection, through project staff specially trained to collect and fix sputum on microscopy slides. First available results on more than 863 patients registered on 12 collection sites showed a 14% rate of positive cases. Such a rate is lower than what is observed in within the referral system set up by the project, in which 35% of referred patients were diagnosed as TB cases, from which we can infer a 17% rate of positive cases. Such a result is thus actually promising as this activity eventually shows a little quantitative depreciation when compared to the ongoing, structured and proven referral system. This is even more convincing in a mechanism where the close distance from the patients’ houses reduces the chances for self selection. Adding on site sputum collection from trained staff to a simplified form of referral system might prove to be an efficient strategy for case finding.

The main question to be answered on this topic:

- **Validate the added value of the onsite sputum collection strategy. Determine the conditions under which this added value is optimal in terms of human resources involved, geographical location, efficacy in case finding and transportation mechanisms between collection sites and Diagnostic Units.**

4. Referral system. A recent study of the effectiveness of the referral system on the case finding issue showed that:

The intensification of the follow up and coaching of the suspects and referred cases decided and applied in 2007 and 2008 have significantly improved the ratio of patients reaching the DU and passing through a diagnosis procedure. This specific additional input allowed in 2008 to get 71% of all suspect cases to be screened in a diagnosis facility. Paradoxically, this increment, although quantitatively impressive, did not influence much the ratio confirmed TB cases/suspected cases, which remains more or less constant throughout the period, within a [35-41]% range. The chart below sums up the different stages of the referral system.

Year	Suspects (a)	Referred (b)	Confirmed (c)	Ratio (c)/(a)
2003	2801	1609	1038	37%
2004	3137	2214	1132	36%
2005	2643	2141	1072	41%
2006	4290	3386	1500	35%
2007	4534	3777	1578	35%
2008	4665	4260	1843	39%

For more readability, the same chart displayed on a referral basis of 100 cases:

Year	Suspects (a)	Referred (b)	Confirmed (c)
2003	100	57	37
2004	100	70	36
2005	100	81	41
2006	100	79	35
2007	100	83	35
2008	100	90	39

In other words, it does not appear that there is a clear correlation between the number of referred cases and the number of confirmed cases. A raise in the share of referred patients does not actually provide a significant increase in terms of additional TB cases. Those observations led to the assumption that suspect cases lost on the way during the referral process have less chance to have TB than the patients coming to the Diagnostic Facility. This crucial hypothesis, from an operational point of view, has been confirmed by a study targeting on lost patients on one side and screened patients diagnosed as non TB on the other. The analysis of the outcome is not yet completed, but the first results of a systematic follow up of lost cases tend to show a very low rate (probably less than 10%) of clinical deterioration over a period of 6 months, which practically cancels the suspicion of TB. This low prevalence is to be opposed to a 52% positive cases recorded among patients screened in the diagnostic facility after being referred.

This observation reveals that there is a kind of mechanism of self selection from the patients themselves, leading those with minor affection to renounce to come along the whole process. Another reason might be that, due to the educational input from the project, only the patients presenting a kind of adequacy between their own perception of sickness and the content of the information they receive are convinced enough about their clinical status to proceed.

It is thus reasonable to think that a strategy centred on detection and reference alone would be much more efficient than a strategy based on intensive counselling and follow up, as the clinical judgement of trained non medical staff and the self perception of the patients are adding their effects to improve the accuracy of the whole referral system.

Such a finding should not be interpreted only through the angle of active versus passive reference, with a traditional emphasis put on passive reference as the best option. A referral system seems to have a great impact on case finding in the context of the project, as testified by the doubling of the detected incidence in 5 years. But this impact is reinforced by the passive attitude of suspect patients who do not feel the need of undergoing the whole diagnosis process. Rather than an opposition between active and passive reference, the combination of an external active reference and a passive self selection mechanism seems the most effective way to stimulate case finding without overloading the fragile diagnosis system with negative patients.

The questions related to this aspect:

- **Validate or not the conclusions mentioned above concerning the referral system.**
- **Assess the impact of the system on the global case finding activity in the project area. Comparison with other areas might be useful but the reliability of the communicated data are still under question mark**
- **Assess the relevance of a future operational case finding system based on:**
 - 1/ a pre-selection of the sites through cartographic data reflecting the areas with high prevalence
 - 2/ Suspects tracing through trained staff from MOH
 - 3/ Sputum collection organised on a regular basis at field level.

5. Social mediation and intermediate actors involvement. The project ambition was to offset the low human resources invested per geographical area by the mobilisation of community actors acting as mediators. Those resource persons were expected to act as relay actors in order to ensure a form of continuous diffusion of messages and counselling support after the withdrawal of the project. Each facilitator had to build its own network of social mediators to extend his outreaching capacities. Those mediators are supposed to behave as referral actors as well as counsellors for patients under treatment.

- ⇒ **Propose an assessment of the impact and relevance of this specific strategy and suggest improvements and recommendations.**

6. Treatment outcomes. The evaluation conducted periodically on cohorts of former patients show quite outstanding results, notably as regards the death rate and the defaulter rate. The evaluation mission is expected to provide comments on:

- ⇒ **What is the most effective factor explaining the remarkable rate of compliance among ongoing patients? In this regard, and besides the facilitators, what are the respective roles of the social mediators and the health actors in this achievement?**

7. Global vision.

- ⇒ **What are the major lessons to be drawn from the ongoing project, major successes and prominent weaknesses?**
- ⇒ **How to design a new generation strategy, able to propose an operational support to the Health System while increasing the productivity of the human resources (in terms of number of detected patients per staff), enlarging the geographical scope of the intervention, gaining in terms of added value through more selective strategies, involving the health staff in a more consistent and relevant way?**

Evaluators are asked, in their proposal, to present the evaluative methodology they propose to apply, based on the questions presented here-above as well as their understanding of the problematic, the stakes and the objectives of the evaluation, which they will then further elaborate.

C. METHODOLOGY

1. For the preparation of the evaluation

A preparation meeting of the evaluation will take place between Inter Aide and the leading responsible of the evaluation, in the presence of the F3E. This meeting will take place at the Inter Aide headquarters in Versailles, France. It will specify the evaluative questioning and the evaluation methodology, on the basis of the terms of reference and the technical proposals that will have been selected.

2. For the evaluation mission

The evaluation will rely on **detailed study of the available documents**⁸ through the activity reports, the sector directors' mission reports, the investigation data and, especially, the entire system edified in the information framework of the project.

⁸ Available documents:

- Project documents
- Mission reports and internal analyses
- Programme results data base 2003-2009
- Analytical tables of the results in the district of Kindo Koysha (1995 – 2003)
- Study of the state of health of former patients after the treatment phase (Ofa Woreda – 2005)
- IEC and animation tools

It will rely on **interviews with the different stakeholders involved with the project**: the intervention teams, the direct beneficiaries, the local and institutional authorities, and the village actors involved to one degree or another in the project.

It will revolve around **discussions with the project managers** in Soddo and the sector managers in Versailles.

Finally, it will be based on **elements collected from multiple visits to the field**, including exchanges with the beneficiaries, the teams of facilitators and especially interviews with medical teams from the various healthcare structures. The advanced proposals consist of:

- A strategy of exhaustive study will be favoured, but as the area includes 12 woredas, integrate them all might be a lot. It would be preferable to visit between 6 and 8 of them, including sites having **divergent results** and presenting different **contexts of access to care and to diagnostic**, so that it would facilitate identifying factors of success.
- **Systematic** examinations and visits **of the diagnostic units**, which constitute one of the major challenges of the project, will be planned.
- **Meeting with the intermediate actors** in different areas would also offer an interesting observation to assess the socio-technical feasibility of setting up case finding channels within the communities.
- One to two **planned visits to the areas not covered by the action** but having the same conditions for exposure to the disease would probably be useful in light of collecting comparative data.
- **Interviews with the health authorities of the different Zones and the Region** are also imperative in order to identify the major tendencies regarding the benefits produced by the project, the flaws in the regional control policy and the working hypotheses for a third-generation programme.
- Possibly, planning a visit to private laboratories could bring a deeper perspective to the analysis

This methodology proposal is indicative. Evaluators are asked to include in their detailed proposals information regarding the evaluation methodology that they propose to use (evaluation steps, sampling elements, tools used, etc.) and possibly making other considered methodological proposals.

3. For the feedback session

A first feedback session will cover all the stakeholders locally involved in the project implementation: project operators, partners, local authorities and beneficiaries. It would take place in Soddo in the presence of the various participants, including representatives of RNTCP and the Health Minister of Awassa.

A meeting/feedback session will also take place in Addis Ababa with representatives of the European Delegation and the French Embassy, representatives of the Health Ministry, WHO, AFD as well as other donors and actors of the health sector.

A feedback session in closed committee will follow the submission of the provisional report; it will take place at the Inter Aide headquarters in the presence of F3E.

Following submission of the final report, **a final open feedback session** will be organized with F3E in the presence of the project donors and other interested organisations.

The role of the NGO and its partners

Inter Aide and its partners will facilitate the progress of the evaluation as much as possible by:

- ▶ Making all documents relating to the project, internal and external, narrative and financial, available either at headquarters or on the intervention sites.
- ▶ Submitting all the documents of the surveys
- ▶ Mobilizing all the logistical resources necessary for carrying out the mission
- ▶ Informing the actors concerned: health professionals, local authorities, donors, partner organisations
- ▶ Preparing the conditions for the feedback session

D. Resources

1. Human resources

A pair of evaluators will lead the mission, composed of a lead evaluator and an Ethiopian evaluator.

The expertise sought for the **lead evaluator, in charge of the evaluation**, is the following:

- ☞ Physician with an education, formal or acquired through experience, in biostatistics and epidemiology (CESAM [Centre d'Enseignement de la Statistique Appliquée à la Médecine et à la Biologie Médicale (Biostatistics Training Centre) level, for example]. In particular, the indicators relating to measuring a tuberculosis control programme must be mastered.
- ☞ If possible, having prior experience in the field of development: project direction and management, design, monitoring and/or evaluation of health actions, etc.
- ☞ Having proven skills in technical analysis and a personal framework for comparative measurement (efficacy and efficiency)
- ☞ Being able to listen and having good reasoning ability as well as being fluent in English.
- ☞ A prior knowledge of Ethiopia is preferable but not required.
- ☞ Expertise in conducting evaluations as an external evaluator
- ☞ Experience in the NGO field is desirable.

As for the **Ethiopian evaluator**:

- ☞ A profile of a health economist, sociologist or health professional with experience in social action around public health questions would be suitable (non-limiting list).
- ☞ If possible, having experience outside Ethiopia
- ☞ With the necessary understanding of the sociocultural context of the areas concerned.
- ☞ Having field experience in one form or another is indispensable: evaluation missions or consultancy, a fixed project manager position,
- ☞ Being fluent in English
- ☞ Expertise in conducting evaluations as an external evaluator

Inter Aide, in cooperation with the lead evaluator, could assist in identifying the Ethiopian evaluator through its contacts in Ethiopia.

2. Financial resources

- The evaluation budget is set at **25,500 € tax included** (direct costs) with a minimum of **47 working days** in total for the 2 evaluators, including a minimum of 34 days on the field in total for the 2 evaluators (see the distribution proposed above).
- The per diems for the 2 evaluators (in France and in Ethiopia) and travel (international, in France, in Ethiopia) are included in this budget.
- Contingencies (5% of the direct costs) will be calculated from the proposals received.
- The maximum amount of fees is set at 650 € tax included per person and per day

3. Schedule

As an indication, the planned schedule is the following:

The evaluation will take place **between September 2009 and October 2009** (*with a final feedback session currently planned in November 2009*) and will notably include

✓ Preparation in France for studying the available documents and meeting with the project coordinators	1 d
✓ International roundtrip travel (following of the reading of the documents).	2 d
✓ For the mission on site: <ul style="list-style-type: none">▫ secondary transportation,	1 d
<ul style="list-style-type: none">▫ visits to the sites of intervention	14 d
<ul style="list-style-type: none">▫ A feedback session, in particular with the teams, but also with the zonal and regional stakeholders	1 d
<ul style="list-style-type: none">▫ secondary transportation,	1 d
<ul style="list-style-type: none">▫ a broadened feedback session at Addis with the representatives of the health ministry, the WHO, the AFD and other donors involved in the health sector.	1 d
✓ writing in Europe, for production of a provisional report.	3 d
✓ preparing for the final session including a day in Versailles (provisional feedback session)	0.5 d
✓ production of the final report and its validation by Inter Aide and F3E.	2 d
✓ the final feedback session for the final report to F3E in Paris	0.5 d
<u>TOTAL</u>	<u>27 days</u>

4. Documents to be submitted

Several documents are expected from the consultants:

- Provisional evaluation report provided by October 2009 (report submitted at least two weeks before the feedback session).
- Final evaluation report and synthesis provided by November 2009 (report submitted at least two weeks before the feedback session).
- A methodological memorandum on the progress of the evaluation will be submitted to F3E by the consultants at the same time as the final evaluation report.
- A separate commentary note will also be addressed by the evaluators.