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ADDRESSING DISABILITY IN ETHIOPIA THROUGH COMMUNITY-BASED REHABILITATION AND HOSPITAL-BASED PHYSIOTHERAPY SERVICES:

AN EVALUATION OF THE MAIN PROJECT EFFECTS OVER THE PAST NINE YEARS (1994 – 2005)

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retro Viral
BoLSA	Regional Bureau of Labour and Social Affairs
BSc	Bachelor of Sciences
CBM	Christopher Blind Mission
CBR	Community Based Rehabilitation
CRDA	Christian Relief and Development Association
CSA	Central Statistical Authority
CSRPP	Civil Service Sector Programme
DPO	Disabled Persons Association
€	Euro
EDRP	Emergency Demobilization and Reintegration Programme
EPRDF	Ethiopian People's Republic Democratic Front
F3E	Fonds pour la promotion des Etudes préalables, Etudes transversales et Evaluations
FMoE	Federal Ministry of Education
FMoFED	Federal Ministry of Finance and Economic Development
FMoH	Federal Ministry of Health
FMoLSA	Federal Ministry of Labour and Social Affairs
GoE	Government of Ethiopia
GDP	Gross Domestic Product
HBPR	Hospital Based Physical Rehabilitation
HC	Health Centre
HEP	Health Extension Package
HI	Handicap International
HICES	Household Income, Consumption and Expenditure Survey
HIV	Human Immunodeficiency Virus
HSDP	Health Sector Development Program
ICRC	International Committee of the Red Cross
ILO	International Labour Organization
IMC	International Medical Corps
JICA	Japan International Cooperation Agency
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
NEPAD	New Partnership for Africa's Development
NGO	Non Governmental Organization
ODA	Official Development Assistance
PHCU	Primary Health Care Unit
POC	Prosthetic and Orthotics Centre
PRSP	Poverty Reduction Strategy Paper
RA	Rehabilitation Agency
RaDO	Rehabilitation and Development Organization
SNNPR	Southern Nation Nationalities People's Region
$US	American Dollar
TOR	Terms of Reference
TPLF	Tigrean People Liberation Front
USAID	United States Agency for International Development
VVAF	Vietnam Veterans of America Foundation
WDH	World Development Indicators
WHO	World Health Organization
WTP	Willingness to pay

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EXECUTIVE SUMMARY

1. Ethiopia, with a population close to 69 million, is the third most populous country in Africa. The gross national product is barely over 100 US$ and the high prevalence of poverty is associated with low growth and low productivity of subsistence agriculture. In addition, during the last twenty five years, the country has been suffering from external and internal conflicts that have precluded major foreign investments. The major burden of diseases is malaria, acute respiratory infections, nutritional deficiency diseases, tuberculosis, diarrhoeal diseases, maternal and perinatal complications. Ethiopia is also confronting to the HIV crisis; in 2002 the HIV/AIDS prevalence among the adult population has been estimated at 6.6 percent.

2. After critically evaluating health conditions in the country, Ethiopia has launched a Health Sector Development Program for implementation over a period of twenty years. As a result health care delivery system has undergone important restructuring within the last few years alone, including a rapid decentralization process and the reorganization of the health care delivery system.

3. The present pattern of service provision includes the following features:

Health services are poorly distributed and under-utilized;
Quality of care suffers from inadequate infrastructure, scarcity of trained health personnel and shortage of drugs and pharmaceutical supplies;
Public funding is inadequate;
Capacity for planning and management is weak.

4. Reaching the Millennium Development Goals (MDGs) is not without leading and daunting challenges related to:

The high level of poverty that poses a threat to the population health and well-being;
The rapid population increase that the country is experiencing;
The low socio-economic status of women that endangers their health and the health of their children;
The HIV/AIDS epidemic that presents additional challenge to the health sector;
The human resource deficiency of the health sector, both in terms of quality and quantity;
The low national spending on health.

5. The purpose of the 5-week evaluation was two-fold: (i) to assess the effects in relation to two community-based rehabilitation pilot projects implemented from 1994 to 1996 with the Ministry of Labour and Social Affair's staff; (ii) to assess the effects in relation to hospital-based physical rehabilitation services implemented for an 18-month period between 1998 and 2000 in partnership with RaDO, a local NGO, before a hand over to the Ministry of Health and; (iii) to generate information and a set of strategic recommendations for future HI involvement in Ethiopia.

Evaluation methods included reviewing facility data, project documents and literature and a field work data collection based on key informant interviews, observations, focus-group discussions, and semi-structured interviews. In the absence of a monitoring system and complete data, efforts were made to gather as many perspectives as possible. The views collected might be considered reasonably representative though this small scale evaluation does not offer statistics, nor can generalization easily be made about the findings.

6**. The disability context**: The 1994 official Census counted nearly one million persons suffering from disabilities but to date these statistics are inaccurate. Although not well documented, major causes contributing to disability in Ethiopia are malnutrition and complicated deliveries. The war-wounded disabled people are estimated at 22,000 persons and the increased burden of labour on children, road traffic accidents and cardiovascular disease may add to the burden of physical disabilities. In 1999, the government has produced a rehabilitation national policy and other directives to protect the physically

disabled. However this is at a high level of generality rather than representing a detailed plan of action. In addition successful implementation suffers from budget constraints and from a long chain of inter-linked decisions between the Federal government, regional offices and other ministries.

There are a number of organizations and agencies involved in rehabilitation services for persons with disabilities but their scope of activities and coverage are limited. Moreover collaboration and coordination remain poorly developed. Currently the main focus in terms of physical rehabilitation is via the 5-year World Bank financed program aimed at supporting regional referral centres for the provision of physiotherapy care and the manufacturing of different orthopaedic appliances.

Very recently on the policy level there are ongoing efforts to develop the physiotherapist profession. But concerns remain: due to limited availability of physical rehabilitation departments and instructors, the students may not be well prepared for practical work; yet it is not clear how the newly graduates will be integrated into the public health structure in the absence of policy and budget support.

7. The main findings for Community-based Rehabilitation projects: Handicap International encouraged a greater level of grassroots activities and acted as a catalyst for the development of CBR activities in Nazareth and Asella. In addition the organization gave attention to staff training needs, provided them with an unique opportunity for broadening their skills and worked in the best interest of disabled persons by integrating some of them into day to day activities.

Over the years most activities, perceived as being brought from the outside have been problematic to sustain and the capacity of the CBR services has declined because of inadequate budget, staff, and technical support. Limited ownership and integration within the institutional framework from the onset made the project very vulnerable to changes. The decentralisation and the civil service reform have had a dramatic impact on the project opportunities as they affected the transfer of competences from federal to regional levels. To date the project does not fulfil anymore its initial objective: the limited activities are mostly found in urban settings and the main focus of the Ministry of Labour and Social Affairs is on the establishment of referral centres under the World Bank support.

As disability goes beyond non-access to goods and services and encompasses social exclusion in terms of inadequate or unequal participation in social life, the beneficiaries have almost lost hope in relation to their integration into socio-economic life. Although they appreciate the support of the CBR workers, they expect little from the project. As a matter of fact, their survival depends on staying close and sharing resources among family members and friends.

8. The main findings for Hospital-based Physical Rehabilitation services: The project increased the visibility of physical rehabilitation: workshops were built for the manufacturing of local appliances, physiotherapy units were developed within the hospital infrastructure and health staff and technicians were provided with a 3-month basic physiotherapy care. However, these efforts proved difficult, if not impossible, to sustain over the long-term. To date the capacity of the HBPR services have declined because of inadequate budget, staff, and materials. The cost recovery scheme introduced under Handicap International and RaDO did not function as almost all revenues generated by the hospitals had to be transferred to the government Treasury.

The policy vacuum and a set of interrelated factors mainly explain why implementation and collaboration between the other segments of the health system and the trained staff remained weak. In a situation where there are considerable budget constraints and well-established infectious disease priorities, it is difficult to implement effective interventions for prevention or treatment of physical disabilities. In addition the project, while highly vulnerable to structural changes like decentralization and civil reform, was developed from a merely technical point of view and did not fully acknowledge the complexity of the health system.

Overall beneficiaries were satisfied with the services provided but most of the respondents recognised the project limitations in terms of equipment and skills. While the majority of disabled people are living in rural settings, there is a strong urban bias as access to hospital services is constrained by transport costs and extra costs related to the hospitalisation. Ultimately with the health financing reform to come, the issue of who will pay for physical rehabilitation services over the long term remains a question mark with the efficiency-equity dilemma likely to confront health professionals in the future.

9. Key lessons learned: Although HI and RaDO actions had merit, their foundations were not sufficiently rooted in a solid understanding of how health care system evolved, what factors shaped these evolutions, and what constraints faced the disabled persons to access the services. This must be set within the NGO context in 1996. Since then HI has gradually moved from an interventionist approach to more development-oriented practices.

It is essential that HI realizes that the type of project implemented in the past was over ambitious in terms of geographic coverage and scope of activities given a relatively short time frame and the local context realities whereby changes perceived as being brought from the outside are problematic to sustain. However the question of sustainability should be seen as a shared responsibility with the project stakeholders.

In Ethiopia the response so far to physical disabilities is minimal. The prevention and control of infectious diseases remain high on the agenda and the health professionals struggle with tiny health budgets against the huge burden imposed by conditions such as HIV, malaria and obstetric complications. Trauma resulting from traffic accidents and cardiovascular diseases may become an important public health problem but for the time being among donors and policy makers controversy exists on the priority that a disability programme deserves in the competition for scarce resources.

While political commitment and a responsive institutional framework are no doubt essential preconditions for successful integration, an analysis that provides a more comprehensive understanding of the impact of disabilities is seriously lacking even though the ongoing survey carried out by the World Bank may provide a more accurate picture on the burden of disability and its economic consequences. For the time being the consequences of these shortcomings is that there is no strong impetus for developing policies to curb physical disabilities

10. Recommendations:

In the future, more comprehensive steps for project design must be taken so that they reflect HI's development-oriented practices.

The problem of disability needs to take into account the national context and the building of strategic alliances in order to ensure a greater involvement of partners and disabled people and to increase project sustainability. However, sustainability is understood as a shared responsibility among all stakeholders.

The fact that physical disabilities are not perceived as a major threat to the public health and to the development of the country makes the policy environment little favourable to the integration of physical rehabilitation into the health system. Considering the above, it may be more appropriate for Handicap International to get back to what most of the stakeholders value the NGO for, i.e. technical support to physiotherapy care. The different alternatives should be carefully evaluated against a framework for partnership with institutional stakeholders, ICRC or Médecins du Monde.

Advocacy, in collaboration with the MoLSA, other NGOs and the civil society through Disabled Persons Associations, is needed to put the problem on the agenda, and to influence and lobby for decisions. These advocacy efforts should also target multilateral and bilateral donors as part of MDGs and poverty reduction strategies.

1. COUNTRY CONTEXT

Ethiopia, situated in the Horn of Africa, shares borders with Sudan, Kenya, Eritrea, Djibouti and Somalia (Annex 1). With a population close to 69 million in 2003, it is the third most populous country in Africa. In particular, the urban population is growing at a fast rate due to large-scale migration for search of better employment. As a multi-ethnic society, it comprises about 80 ethnic groups. Christianity and Islam are the main religions: 51% of the population are Orthodox Christians, 33% are Muslim, and 10% are protestants (GoE and FMoFED, 2002).

The country has a wide geographical diversity with 40 percent of the total area consisting of highlands above 1500 meters. The average Ethiopian household is comprised of 4.8 persons and approximately 85% of households rely on agriculture for their main source of livelihood. Coffee is the main export of the country.

Ethiopia holds a long-standing history, diverse cultural heritage, and good resource potential for development. Yet a significant proportion of the population lives in absolute poverty. Forty percent and 37 percent of the rural and urban population respectively fall below the poverty line of US$ 1 per day (GoE and FMoFED, 2002). The prevalence of poverty in Ethiopia is associated with low growth and low productivity of subsistence agriculture. In addition, regional disparities have been exacerbated by security, climate and market access (Tigray, Afar and Somali regions are among the poorest).

Agriculture productivity is highly vulnerable to external shocks, as droughts, and the country has become synonymous with food shortages. Devastating famines in 1973–74 and 1984–85 called for significant public attention and there were smaller-scale but still serious shortages in 1991 and 1994. To date more than 50% of Ethiopians remain food insecure, particularly in northern and eastern rural areas.

During the last twenty-five years, the country has been suffering from external and internal conflicts that have precluded major foreign investments. After the fall of the emperor Hailé Selassié I in 1974, Ethiopia became a socialist State, under the *Derg*[1] regime with the leadership of Colonel Mengistu Hailé Mariam. Opposition to the Mengistu regime involved various ethnic-based regional movements who conducted the war of liberation against the socialist regime. These various opposition parties formed a coalition and became the Ethiopian People's Republic Democratic Front (EPRDF) and overthrown the *Derg* regime in 1991. In 1995, the Federal Democratic Republic of Ethiopia was proclaimed and Meles Zenawi, the Tigrean People Liberation Front (TPLF) leader, formed a new government.

Ethiopia has introduced a parliamentary federal government administering nine regional states and two administrative councils (Addis Ababa and Dire Dawa), subdivided into 560 *Woredas* (districts). These, in line with the country's decentralized policy, represent the basic units of planning and political administration. Under the *Woredas* there are *Kebele* which are the lowest level of administration.

By the turn of the 1990s, economic policies, protracted civil war and recurring drought left the country in a severe crisis characterized by severe macroeconomic instability, increased food insecurity and social crisis with millions of displaced persons, refugees, demobilized soldiers, and unemployed

[1] Socialist Party

people. In particular, the war between Ethiopia and Eritrea, which began in 1998, resulted in the internal displacement of an estimated 350,000 Ethiopians from border areas, and nearly twice that number in Eritrea. Following the end of the 2-year war, the proliferation of landmines and unexploded ordnance in areas close to the border, the destruction of houses and public buildings, the lack of economic opportunities as a result of the closed border all represented significant obstacles to return.

Over the last ten years Ethiopia has been undertaking economic reforms and introduced a free-market economy. Nevertheless the gross national product of the country is barely over 100 $US. The Ethiopian households' average annual expenditures in 2000 was estimated at 5.401*Birr*[2] of which 60 percent was spent on food and only about 1.1 percent on health and medical care (GoE and FMoFED, 2002).

Domestic savings are too low to meet the country's investment needs. As a result, the level of foreign borrowing and foreign aid increased significantly during the 1990s. To date foreign aid continues to play a significant role in government spending and revenues. During the period 1992-2002 Official Development Assistance (ODA) has been high, at about 14% of Gross Domestic Product (GDP). While donors have sharply increased their focus on governance issues in the past years, the proportion of food aid represents more than one third of the total ODA grants. Non food aid is going to public investment, especially infrastructures and education.

2. BACKGROUND: HEALTH IN ETHIOPIA

2.1. GENERAL TRENDS

Females constitute almost half of the total population of Ethiopia. The crude birth and death rates are estimated at 40 and 12.6 per thousand, respectively with a rate of natural increase of 2.7% per annum. Life expectancy at birth stands at 48 years and the total fertility rate is high at 5.6 (WHO, 2003). Having large families is considered important, particularly in the subsistence economy, where everyone's labour contribution counts. The illiteracy rate stands at 62 percent of males and 77 percent of females respectively (DHS, 2000).

The 2001 national Welfare Monitoring Assessment shows that episodes of illness are highest among the rural population (CSA, 2001). The ten causes of morbidity are communicable diseases, including malaria, acute respiratory infections, diarrhoeal diseases, and tuberculosis. Nutritional deficiency diseases, maternal complications and HIV infection add to the public health burdens. In 2002, the HIV/AIDS prevalence among the adult population has been estimated at 6.6 percent.

Though there is some indications for improvement in the survival of Ethiopian children within the last 15 years, Ethiopia is among the countries with the highest under-five mortality. The Infant and Child Mortality Rates of the country are 112 and 169 per 1,000 live births respectively, indicating that almost one in every six new born dies before the age of five.
Based on the limited data available, the Maternal Mortality Rate (MMR) of Ethiopia is estimated to be 850 per 100,000 live births (WDI, 2005). The high MMR is related to high fertility rate, early and frequent pregnancies, and lack of timely access to adequate emergency obstetric care.

A summary of key indicators is provided in Table 2.1.

[2] 1 Ethiopian Currency Unit; the exchange rate for $US 1 is approximately 8.6 Birr.

Table 2.1. Summary of key indicators

Indicators	
GDP per capita ($US)	100
% of population living below $1 a day (1992 – 2002)	46%
Life expectancy at birth	48 years
Infant mortality rate (death/1,000 live births)	112
Maternal Mortality Ratio (death/100,000 live births)	850
Total Fertility Rate	5.6

Source: WHO/UNICEF (2003) and World Bank (2003)

Additionally, a huge gender gap in life's opportunities and access to services exist at the root of the high maternal mortality, poor women's general health and limited access to health. Women have fewer opportunities for education and earn lesser income compared to men. Customary laws may also discriminate against women, for example preventing the ownership or inheritance of property.

Despite efforts made by the Government (GoE) to ensure basic social services, only 51% of Ethiopians have geographical access to medical services, and it is much lower for rural residents due to the tendency of health institutions and professionals to concentrate in urban locations. DPT3 immunization coverage is 52% and the antenatal coverage rate stands at 34% (FMoH, 2003a). Household expenditures on medical care and health vary widely among the different regions but average annual expenditures in 2000 were 5.309 *Birr*. The findings of Household Income, Consumption and Expenditure Survey (CSA, 2001) showed that the cost of health care is highest in public hospitals and lowest in health posts.

Ethiopia's overall development strategy is based on the Poverty Reduction Strategy Paper (PRSP). The PRSP is the over-arching national planning document, placing poverty eradication as the central goal of the GoE. It provides a framework for the development of detailed sector-wide plans and investment programmes.

According to a recent study, an estimated 300 Non Governmental Organizations (NGOs) operate in the health sector. Although regulatory provisions have been made to encourage their activities, the legal procedures and specific requirements for their licensing and operation entail cumbersome agreements which pose serious constraints to NGO daily work. In general the NGO participation in health policy and national program formulation is very limited (CDRA, 2004). The report points out to their heterogeneity in terms of program priority, level of experience and expertise, profile of target population, source of funds and scope of geographic coverage.

2.2. THE HEALTH SECTOR DEVELOPMENT PROGRAM

Ethiopia has launched a Health Sector Development Program (HSDP) for implementation over a period of twenty years. The HSDP responds to a number of problems identified in the coverage and quality of health services. It is broken down into four successive five-year plans, the objectives being (i) to increase access and coverage to health care, along with utilization; (ii) to improve service quality through training and an improved supply of necessary inputs; and (iii) to strengthen management of health services at Regional levels.

As stipulated in the HSDP, the health care delivery system of Ethiopia has undergone important restructuring within the last few years alone. As part of the national health care reform, a four-tier system has replaced the previous six-tier system (Box 2.1).

Box 2.1. The four tier health system delivery

1. **First level care provider:** Primary Health Care Unit (PHCU) with one health centre (HC) and five satellite health posts. The PHCU focus is on preventive, promotive and basic curative health services.

2. **First referral level for PHCU:** District hospital. Equipped with the capacity of 50 beds, it is planned to serve between 100,000 - 250,000 populations and to provide curative, preventive and rehabilitative services.

3. **Third level health care delivery unit**: the Zonal hospital has the capacity of 100 beds and serves as referral for District hospitals. Zonal hospital is expected to provide curative and rehabilitative services, and it operates as training and research institution.

4. **Regional specialized hospitals** are situated at the top of the health service delivery system. With a capacity of 250 beds, they provide all specialized clinical services and serve a population of 1 million.

The Health Extension Package (HEP), a new initiative included in HSDP II, started on a pilot basis using the existing Primary Health Workers. The health extension service is provided as a package focusing on preventive health measures and targeting households particularly women and mothers at peripheral levels.

One of the key targets of the second phase of the HSDP was to increase health service coverage from 52% in 2001/02 to 65% by the end of 2005. The facility expansion over the past years can be seen as a positive development. However, it is not clear whether this increase has been associated with needed material and human resource inputs to provide good quality health services. Anecdotal evidence points out that some newly built facilities are hardly functional due to lack of personnel.

2.3. THE MAJOR INITIATIVES IN THE HEALTH SECTOR

2.3.1. The decentralization process

Ethiopia has gone through two stages of decentralization with the first stage involving the decentralization of functions from the centre to the regions. The primary objectives of the political, administrative and economic decentralization policy are (i) to increase local participation and ownership in the planning and management of government services; (ii) to improve efficiency in resource allocation; and (iii) to improve accountability of government and public service to the population.

The adoption of Federal state has created regions with significant autonomy in the health sector. The health system comprises of (i) Federal Minister at Federal level; (ii) Regional Bureaus at Regional level; and (iii) District or *Woreda* offices at the basic level.

Since July 2002, Ethiopia has embarked upon an ambitious program of decentralization with the primary responsibility for health service delivery. Regional Health Bureaus are the highest executive level in the health system, with a trend to increasingly decentralize decision making and management of government services to the *Woredas* which are now receiving block grants to ensure key public service functions.

The rapid decentralization has however highlighted issues related to rebalancing allocations, lack of clarity on responsibilities and expenditure assignments. In general, institutional capacity at the *Woreda* level for planning and implementation of health programs and other programs is a matter of concern since budget execution rate is below 70%. Problems in planning and implementing investment plans, and difficulties in utilizing donor funds are cited as the main reasons for low underspending (World Bank and FMoH, 2004).

2.3.2. The Civil Service Reform program

Introduced in February 2002, it aims to create a civil service, which is both efficient and sufficiently competent. The Civil Service Sector Programme (CSRPP) has five subprograms: (i) expenditure management and control; (ii) human resource management; (iii) service delivery; (iv) management systems; and (v) ethics. These sub-programs are expected to improve budgetary processes and financial management, two issues that were raised during the HSDP I review (FMoH, 2003a).

Overall the key challenges for the GoE in the CSRPP implementation is to ensure a regional and *woreda*-level focus, maintain coordination across line ministries, and create incentives among civil servants.

2.4. CHALLENGES FOR THE HEALTH SECTOR

2.4.1. LIMITED HUMAN RESOURCES

Despite efforts to train more health professionals, the health manpower base supporting health services is very limited. Ethiopia is one of the most disadvantaged countries in the world with a ratio of doctors to population estimated at 1:35,603[3]. Another serious gap is in the category of midwifes nurses. Many health staff operate in urban areas and rural areas face a continuous shortage of skilled human resources. In addition the phenomenon of brain drain among physicians is widespread, with many of them leaving to Botswana and South Africa.

A qualitative research revealed that four structural reasons were affecting the performance of health workers: (i) the ongoing transition toward a mixed model of public and private service delivery; (ii) weak institutional framework unable to absorb the changes linked to this transition; (iii) limited accountability and the erosion of professional norms; and (iv) the impact of HIV/AIDS (Lindelow et al., 2005).

The official salaries of health workers have been recently increased to be more or less in line with the minimal cost of living. However there are other issues, including difficult working conditions in the public health sector, lack of career development, and fear of HIV/AIDS that affect job satisfaction among health professionals, forcing many of them to leave the public health facilities. As the private sector expanded over the years, it has attracted health staff. Another alternative is to work in both the public sector at mornings and private sector later in the day.

While some regions have adapted the staffing norms to their own requirements, more than 25 types of health workers are currently documented, with some confusing overlap among the different job categories (e.g. 10 nurse categories). In addition a new health extension worker category has been introduced as a result of establishment of the HEP. Given this large number of health worker categories the evaluation of performance and quality of curricula is difficult to control.

2.4.2. FINANCIALLY CONSTRAINED

2.4.2.1. Low health care spending

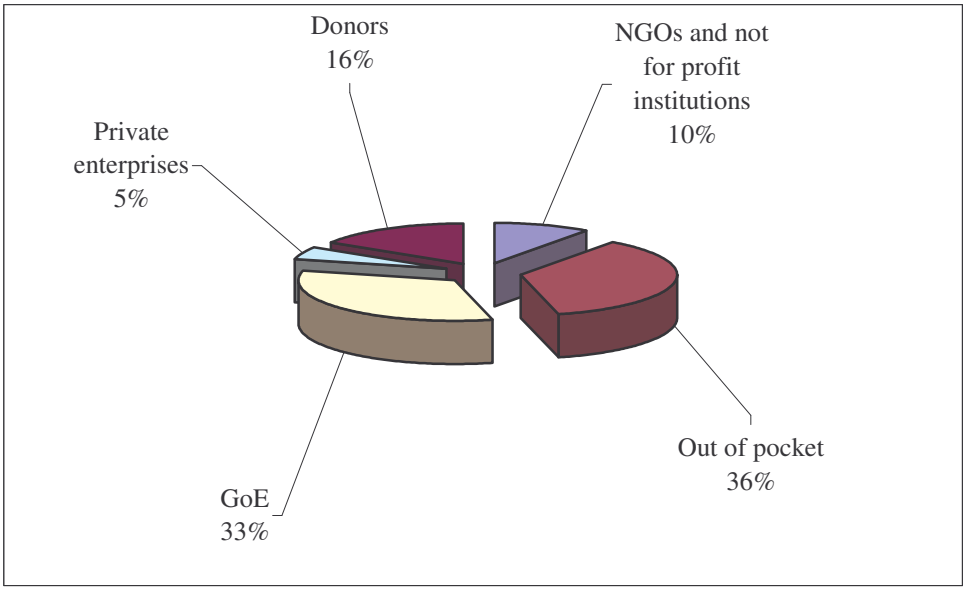
Although no definite answer exists to the question as to how much a country should spend on health, recent policy-oriented work suggests that a developing country spending less than an estimated $US 80 per capita per year would fail to achieve its main health targets (WHO, 2000).

[3] The WHO recommends a doctor/population ratio of 1/10,000.

Ethiopia's per capita allocations and spending on health are low. While more than 55% of the health budget is allocated to wages, the country is spending 5.7 percentage of its GDP on health, with a large share of public money being allocated to hospital care[4]. Per capita health expenditures in 2002 were estimated at $US 4 and are significantly lower than the Sub Saharan Africa average of $US 42 (MoH, 2003b).

As shown in Figure 2.1, the funding of health care is shared between the public and private sectors.

Figure 2.1. Ethiopia health spending: sources of financing, 1999-2000



Source: National Health Accounts, 1999/2000

Out of pocket spending, including direct payments to private practitioners, traditional healers and private pharmacies, represents the largest share of health spending. Transportation costs represent also a significant portion of out-of-pocket expenditures for health care. For instance, a Country Status Report on Health and Poverty revealed that cost of transportation was highest for GoE hospital as opposed to PCHUs (World Bank and FMoH, 2004).

As a result of increased out-of pocket and donor spending, the contribution of GoE to public health expenditures has been declining from 41% in 1995-1996, to 36% in 1996-1997, and then to 33% in 1999-2000.

While NGOs and not for profit institutions are covering 10 percent of national health expenditures, donor resources in the form of loans and external assistance are an important source of financing, particularly for capital expenditures. During the HSDP implementation, external assistance to the

[4] In 2000/01, the GoE spent 178 million *Birr* on recurrent expenditure in the country's 80 public hospitals; while it spent only 142 million *Birr* at the primary health care level (FMoH, 2003a).

health sector has increased significantly from 63 million *Birr* in 1997/98 to 437 million *Birr* in 2000/01 (FMoH, 2003a).

2.4.2.2. Cost recovery scheme: almost symbolic

Ethiopia has implemented cost recovery for the past 50 years. At both GoE and NGO facilities, users pay for registration, medical certificates and diagnosis. Fees, from 2 to 5 *Birr*, are charged for routine diagnostic procedures, including outpatient registrations, consultations, and laboratory tests. Higher fess are charged for prescription drugs and inpatient surgical procedures. Most facilities exempt treatment of tuberculosis, family planning, childhood immunization, ante-natal, and post-natal care (FMoH, 2003b). GoE policies on fees also defined entitlements to full or partial exemption from payments. Patients are exempted if they obtain a free paper from their *kebele* certifying that they are too poor to pay. Eligibility for free health care services is targeted to individuals with a monthly income of less than 105 *Birr*. Persons qualifying for full exemptions include the disabled.

When initially introduced fees recovered a significant portion of the total costs but today the scheme has become obsolete. According to a fee waiver and exemption survey conducted by the FMoH, about 66% of users obtained exemptions (FMoH, 2003b). More recently a new policy that distinguishes between exemptions (as specific services regarded as public health priorities) and waivers (aimed primarily at the poor) is being discussed at FMoH level.
The fees collected at point of delivery are not reinvested but remitted to the Federal Ministry of Finance and Economic Development (FMoFED). As a proportion of GOE health expenditures, a steadily decline in fee remittances to the FMoFED has been observed from 16% in 1986 to less than 6% in 1995-97 (World Bank and FMoH, 2004).

In 1998 the cost scheme has been reviewed and a Health Care Financing Strategy adopted. Core concepts were the generation of health-facility revenue from user fees, revolving drug funds (Special Pharmacies), risk-sharing schemes and donations. However the financial law of 1997, which requires all revenues to be remitted to FMoFED, did not allow the full implementation of the cost recovery scheme. At the time of writing, a new regulation has been passed which will authorize health facilities to retain hundred percent of the fees to provide revenues to meet operating expenses. At first the funds raised will be considered additional to the GoE budget but over the medium term hospitals are expected to gain financial autonomy and will merely depend on user fees to sustain service delivery.

The intention is to improve the quality and quantity of health services. This objective is based from a research conducted on the willingness to pay (WTP) for health care. The study showed that perceived quality was an important determinant both of patients' provider choice and of their willingness to pay for services and drugs. In particular 47% of the households surveyed considered the quality of service delivery at hospital out-patient department to be below average. Nevertheless they were willing to pay higher process if quality was improved (FMoH, 2001b).

3. EVALUATION BACKGROUND

3.1. GENERAL BACKGROUND

This report is based on a 4-week field mission to Ethiopia that took place from 23 January to 25 February 2006. The evaluation, commissioned by Handicap International (HI), is co-funded by HI and

the *Fonds pour la promotion des Etudes préalables, Etudes transversales et Evaluations(*F3E)[5]. Handicap International is a French non-governmental organization that was established in 1982 with the aim of providing access to care and improving the living conditions and the autonomy of people with disabilities.

The NGO involvement in Ethiopia started in 1987, with major strategies and activities related to capacity building, project funding and lobbying to create an enabling environment for the participation of the disabled in the socio-economic development of Ethiopia. From 1994 to 2000 two major projects were implemented: the Community-Based Rehabilitation (CBR) project took place from 1994 to 1996 in Nazareth and Asella, two cities located in the Oromiya region; the hospital-based physical rehabilitation project was covering eleven hospitals located in five different regions during the 1998-2000 period and was implemented in collaboration with a local NGO, the Rehabilitation and Development Organization (RaDO). Both projects were handed over to FMoLSA and FMoH respectively.

Since 2000, HI has not implemented a specific project on physical rehabilitation, even though the organisation has been approached on a number of occasions. For instance ICRC has been very keen, and still is, to build a partnership for strengthening physiotherapy care at POC level. There were also attempts to contribute to the design of the 2-year national curriculum aimed at physiotherapist-assistant training but the FMoE's willingness for a genuine NGO participation has been somehow limited. While acting as a chairman for the National Forum of NGOs working with disabilities, the current NGO activities, based in the Somali region, are focussed on food security. Another project with an important HIV/AIDS component is expected start during the course of 2006.

3.2. OBJECTIVES OF THE EVALUATION

3.2.1. Overarching purpose

The purpose of the evaluation is two-fold: (i) to assess the effects in relation to two projects implemented for an 18-month period between 1996 and 2000 and handed over to GoE institutions; (ii) to generate information and a set of strategic recommendations for a potential HI involvement in disability. Based on the Terms of Reference (TOR) (Annex 2), the output of the evaluation is the production of one document including recommendations and a 10-page synthesis in both English and French.

The two projects aimed at increasing the recognition of physical rehabilitation services among health service providers and the population. Similarly HI anticipated that both projects would participate to the formulation of a national policy for physical rehabilitation services and to the recognition of physiotherapists as professionals. The table below provides a summary of the two projects.

Table 3.1. Summary of HI projects

Project Title	Duration	Key components	Location	Implementing Partner	Technical expertise and support	Total Cost (€)	Source of Funding
CBR	1994 - 1996	Technical support to a CBR pilot project: (i) development of outreach	Nazareth Asella	Rehabilitation Agency (RA) under Ministry	4 expatriates (mainly physiotherapist	635 000 €	GoE (50%) CRDA Dutch

[5] The F3E is an associative consulting firm specialized in evaluation and training.

		for physiotherapy care and provision of appliances, vocational training, income generating, awareness clubs; (ii) training of CBR staff, including technicians.		of Labour and Social Affairs (FMoLSA)	and orthopaedic technicians) 2 national staff		Embassy Caritas Holland HI
HBPR services development	03/1999 - 08/2000	3-month basic training course for health workers and technicians Provision of basic physiotherapy care for in-patients and out-patients Production of orthopaedic appliances	11 hospitals[6]	Local NGO (Rehabilitation and Development Organization: RaDO)	2 expatriates (mainly physiotherapist and orthopaedic technicians) 3 national staff	774 000 €	GoE (8%) European Union (65%) HI (27%)

The main results were summarized as follows:

For the CBR projects:
2 functional orthopaedic workshops;
12 CBR workers trained;
7 orthopaedic technicians trained;
Awareness-raising sessions and information for disabled persons and community members.

For the HBPR services:
11 functional physiotherapy departments and orthopaedic workshops;
16 nurses trained and 16 health assistants trained in basic physiotherapy;
45 orthopaedic technicians trained;
2.133 in-patients benefited from physiotherapy;
Provision of 701 basic appliances;
Awareness raising sessions and information for health professionals.

The 3-month curriculum for the training included basic physical therapy and manufacturing of simple orthopaedic appliances (Handicap International document, unknown date). The 18-month period implementation focused at construction or renovation of workshops, establishment of a physiotherapy department , training and quarterly follow-up.

For the HBPR, HI and RaDO stopped their support in 2000 and handed over the physiotherapy and workshop units to the hospitals[7]. The findings of the internal evaluation carried out in 2000 showed that both institutional and financial sustainability remained a key issue for both projects (Handicap International, 1999/01). As a matter of fact the challenges for the hospitals have been to offer the trained staff and technicians satisfactory working conditions and to continue addressing the needs without financial external support. For the CBR projects, there is little information available but the TOR states that the hand over to the Regional Bureau of Social Affairs (BoLSA) proved problematic in terms of transfer of responsibilities and financial hand over.

[6] Namely Axum and Maychew for Tigray; Jimma, Nekempt, Mettu for Oromiya region; Dire Dawa in the Regional Council; Bahir Dar, Debre Tabor, Woldiya for Amhara region; Sodo and Hossana for SNNPR (Southern Nation Nationalities People's Region).
[7] GoE-owned hospital are under the FMoH.

It is well worth mentioning that RaDO is no longer working on disabilities even though the main objective for the local NGO foundation was to serve disabled populations. The lack of funding opportunities in this field forced RaDO to search for more attractive sources of funding. To date the main NGO involvement is related to refugees through UNHCR support.

3.2.2. Analytical approach

In the absence of a baseline survey, an impact evaluation was not feasible. The comparison between project beneficiaries and non-project beneficiaries, as a case control, would have required another approach, a different timeframe and a monitoring system in place. Looking at the objectives of the evaluation, which was to provide HI with lessons learned and a set of strategic recommendations, an analysis of effects was agreed upon between Handicap International, the F3E and the international consultant.

For the analysis to be performed, several broad questions were asked about both projects:

What is the context?
How does it affect the projects?
What are the main effects for each intervention?
As any understanding of the project effects has to begin with an understanding of the major causes, how these shape interactions within the overall project?
Are these effects sustainable?
What lessons are to be learned from each project and from an examination of its strong and weak points?

3.3. THE DISABILITY CONTEXT IN ETHIOPIA

3.3.1. Some facts

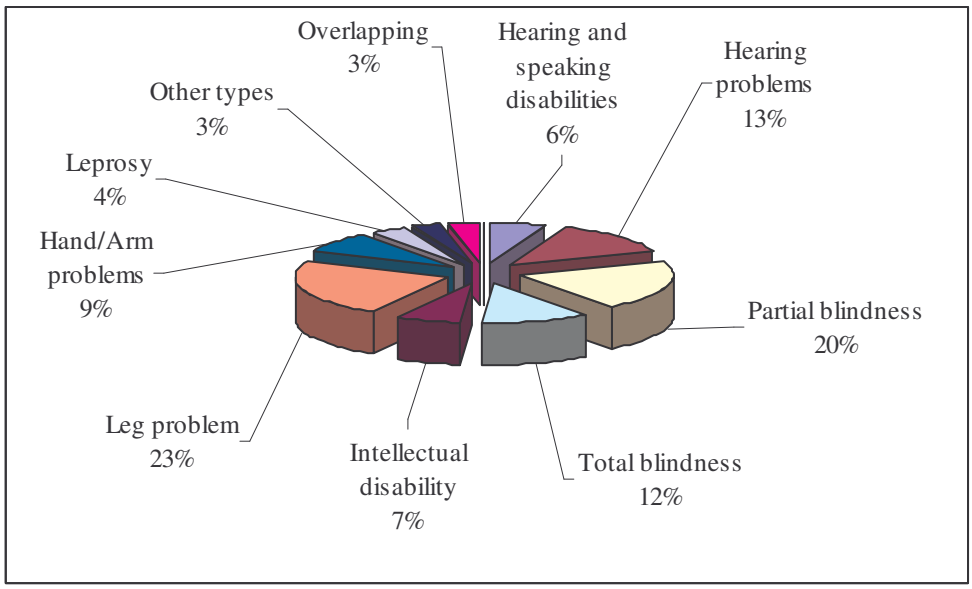
According to the National Programme of Action for Rehabilitation of Persons with Disabilities (FMoLSA, 1999), a disabled person is "any person unable to ensure by himself or herself a normal life as a result of deficiency in his or her physical or mental capabilities". The 1994 official Census counted nearly one million persons suffering from disabilities in the country. Because the current FMoLSA records on disabled people are limited, no accurate and definite figures can be given but according to WHO estimates, 10% of the population in developing countries are disabled. More recently a survey carried out by the World Bank should allow for a more accurate picture on disabilities in Ethiopia.

Disability can cause household impoverishment through income losses and medical expenses. However understanding the economic burden of disabilities for households in Ethiopia has not been documented.

ICRC estimates the war-wounded disabled people to approximate 22,000 persons, the highest percentage of them living in Tigray and Afar regions and in the area of Gondar (ICRC, 2004). Other major causes contributing to disability are malnutrition and complications during delivery. Although not documented, the increased burden of labour on children who perform heavy domestic workloads to earn income for daily may cause disability problems. More recently traffic accidents are increasingly responsible for physical disabilities. According to FMoH service statistics, accidents are among the fourth reason for in-patient admission and the fifth mortality cause (FMoH, 2001a). In addition, a significant number of hemiplegic's cases resulting from stroke may call from increased attention on the association between chronic diseases and disabilities. However, the absence of firm data to substantiate this permits only speculation.

The Figure 3.1. shows the prevailing types of disability in the country.

Figure 3.1. Types of disability in Ethiopia (1994)



Source: Wa'el International Business and Development Consultant, 2000, Country Profile Study on Persons with Disabilities, Ethiopia (*cited in Country Profile on Disability, JICA, 2002).*

3.3.2. Current policies

A Rehabilitation department (RA) under FMoLSA has been created and later restructured following the present Federal GoE structure. A Department for Rehabilitation Affairs has replaced the RA with structures extending to the Regions. Each Region has a Labour and Social Affairs Bureau, which is responsible for policy implementation and social matters, including disability-related welfare.

In 1999, the GoE has produced a rehabilitation national policy and other directives to protect the physically disabled and ensure their equal participation and benefits including the right to employment. However this is at a high level of generality rather than representing a detailed plan of action. In addition successful implementation suffers from budget constraints and a long chain of decision-making, with many inter-linked decisions between the Federal GoE, regional offices and other ministries such as Ministry of Health.
Government disability policy encourages also the development of representative organizations of persons with disabilities. In 2002, ILO initiated a national Forum of Organizations Working on disabilities. Across the country, five Disabled People's Organizations (DPOs) have emerged, especially in main cities. However, there is a need to strengthen their capacity and to support this trend in more remote areas (Help for Persons with Disabilities Organization, 2004).

3.3.3. Disability, exclusion and vulnerability

Remote rural areas, urban slums and conflict zones, households with disabled and poor health status due to disability are among the characteristics commonly associated with chronic poverty (Bloom, 2004). An Ethiopian study on gender and disability found that disabled women face disadvantages arising from both their disability and their gender, in many cases compounded by poverty (Tirussew, 2001). In particular, they were more likely than others to be:

Extremely poor or destitute;
Illiterate, often with little or no schooling;
Without vocational skills;
Unemployed;

Often without access to public services;
Unmarried, often with little family or community support;
Socially isolated due to stigma, myth and fear;
Subject to abuse and violence.

According to the Ethiopian Herald (April 2004), physically disabled women face difficulty in getting available information and cannot prevent abuses against them. They are the most vulnerable to various hazards including HIV/AIDS and face stigma and discrimination.

But disability goes beyond non-access to goods and services and encompasses social exclusion in terms of inadequate or unequal participation in social life. This distinction is important in that it modifies the focus of interest from the link between poverty and ill-health to the link between the social gradient and health.

3.3.4. What are the services available?

The social system, which was more or less working during the socialist period, could not be kept up after the liberation. According to the 1994 Population and Housing Census, the majority of disabled were found in rural areas. To date although there is little data to support this, anecdotal evidence suggests that disabled persons, especially those living in rural settings, have restricted access to social services.

After the end of the war with Eritrea, the World Bank, in collaboration with FMoLSA, initiated a 5-year regional programme, known as Emergency Demobilization and Reintegration Programme (EDRP) with a view to demobilize soldiers. The focus has been extended to physical disabilities and to date five Prosthetic and Orthotics Centres (POC)[8], under FMoLSA and with ICRC expatriate technical support, serve as referral centres for physiotherapy care and the manufacturing of different orthopaedic appliances. Part of the project consisted in implementing training programme, both for orthopaedic technicians and physiotherapist assistants. ICRC has been participating in the training course in prosthetics and orthotics entirely financed by the World Bank. The course for physiotherapist assistants has been under the responsibility of both FMoLSA and the Federal Ministry of Education (FMoE).
As of August 2005 and in partnership with FMoLSA, the NGO Vietnam Veterans of America Foundation (VVAF) has opened a new physical rehabilitation centre in Bahir Dar. The centre offers, by means of an USAID grant, physical therapy sessions and prosthetic limbs, braces and wheelchairs free of charge, mainly to war victims. Coping with the demand from the town, extending the services to rural areas and sustaining the activities over the long term are seen as key challenges. Aside from ICRC and VVAF, there are a number of organizations and agencies involved in rehabilitation services for persons with disabilities but their coverage is limited. Moreover collaboration and coordination are poorly developed although recent efforts to share information through sectoral meetings have emerged under ICRC leadership.

The major foreign and national[9] NGOs with specific programs for the disabled are the following:

[8] The POC are located in the following towns: Asella (Oromiya), Arba Minch (SNNPR), Makele (Tigray), Dessie (Amhara), Harar (Somali), and Addis Ababa.
[9] Thirteen NGOs, with a special focus on CBR, are registered.

The Christian Blind Mission
The German Leprosy and Rehabilitation Association
African Leprosy and Rehabilitation
Centre Mekane Yesus Church
Save the children UK
Swedish Save the Children (Rädda Barnen)
The United Abilities Company
Menschen für Menschen
Cheshire Foundation Ethiopia.

The International Labour Organization (ILO) is also supporting the development of income generating activities, legislation and DPO's involvement.

3.3.5. A growing interest for the physiotherapist profession?

Little literature exists regarding the physiotherapist profession in Ethiopia. In the past a number of ad hoc training courses provided by NGOs attempted to fill the gap. The problem is that neither the FMoE nor the FMoH have formally approved such type of training. Subsequently trained health workers were not included within salary scale supplements and career structures.

Very recently on the policy level there are ongoing efforts to develop the profession. The training courses formally accredited by the FMoE are presented in the Box 3.1.

Box 3.1. The main accredited courses for physiotherapy care

In Makele, Tigray Region: A 2-year diploma training under the Tigrean Disabled Association and Doctors for Africa, an Italian NGO;

In Gondar university: A 3-year degree course, Bachelor of Sciences (BSc) degree; under FMoH and FMoE; 80 students are expected to graduate in July 2006;

At POC level in Addis Ababa: a 2-year training for physiotherapist assistants under FMoLSA, previously funded by the GoE and to date the EDRP/World Bank, in collaboration with ICRC. The objectives are to train professionals with proper skills according to nationally and internationally recognized standards, and to promote the long-term sustainability of physical rehabilitation services.

Despite the progress made towards the recognition of the profession, the new professional category of physiotherapist is not yet included within the cadre of health workers identified as necessary within the health system framework. In addition several concerns remain: first due to limited availability of placements and instructors, the students may not be well prepared for practical work.

Second it is not clear yet how the newly graduates will be integrated into the public health structure in the absence of policy, functional physiotherapy departments and budget support. The first batch of students will probably be employed by the various POCs, the major specialized hospitals and the few NGOs. Beyond, a supply and demand imbalance may arise and create serious unemployment problems. In addition, ICRC's Head of Project expressed a specific concern related to the low performance of the physiotherapist assistants trained at the POC centre in Addis Ababa. In his opinion the assistants can not perform physiotherapy adequately unless provided with on-going support and follow up.

4. METHODOLOGY

Following a tender and selection procedure, a team of two individuals, one international consultant acting as team leader and one national consultant, carried out the evaluation. It was a multi-

disciplinary team with expertise in public health, health economics and socio-anthropology. The team worked closely together, especially during the methodology preparation and the field work.

The evaluation's approach was to conduct a joint team exercise, throughout a multi-phase process:

First phase: site selection and preparatory work;
Second phase: document search and review;
Third phase: evaluation design and development of specific tools;
Fourth phase: field work;
Fifth phase: presentation of results.

4.1. FIRST PHASE (6-WEEK)

4.1.1. Site selection

Due to the limited evaluation timeframe, it was not possible to cover all project sites, which included eleven hospitals based in five different regions. In order to build a balanced picture of HI assistance in Ethiopia, and to encompass a wide range of situations, the selection of sites, under the responsibility of HI team in Addis Ababa, took into account three types of criteria: (i) a balanced geographical distribution so that northern, eastern, western and southern parts were included; (ii) the representation of operating and non operating rehabilitation hospital services and; (iii) the inclusion of CBR projects.

4.1.2. Preparatory work

Prior to the international consultant's arrival, the national consultant facilitated the preparation of the fieldwork by spending six weeks in organizing the logistics, disseminating information concerning the evaluation and gathering background information. He visited the six selected sites, met with key individuals and identified potential data collectors in each of the sites. Open interviews were carried out with Regional Health Bureaus (RHB) officials, hospital's medical directors, and trained physiotherapists and technicians. The 6-week schedule of activities is presented in Annex 3. Nevertheless completing and crosschecking the information proved necessary as there were conflicting views, no recording of interviews and important gaps in what had been collected. In addition the assistant was unable, for unknown reasons, to perform the context analysis and present a summary, a task that was carried out by the team leader.

4.2. SECOND PHASE

This phase took place upon the arrival of the international consultant. The preliminary data gathered through the interviews helped to complete the stakeholders analysis (Annex 4). Stakeholders "are people, groups, or institutions which are likely to be affected by a proposed intervention, either negatively or positively, or those which can affect the outcome of the intervention" (Rietbergen-Mc Cracken and Narayan, 1998). Due to the multiplicity of actors involved in the two projects, conducting a stakeholder analysis was critical to (i) understand the social and institutional context; (ii) understand who has been affected by the projects and who influenced them and; (iii) identify stakeholders' interests in, importance to, and influence over the projects.

In order to get a thorough understanding of the health and disability contexts, the approach the international consultant took was to identify and track back additional key documents in relation to official statistics, policy and planning documents. Following a briefing held with the HI team and the national consultant, the search and review of documents were finalized by visiting the University of Addis Ababa, World Bank and FMoH's libraries. Other documents were also searched using the Web site. The bibliography referred to in this report is attached in Annex 5.

4.3. THIRD PHASE

4.3.1. Evaluation design

This is an exploratory and descriptive evaluation, with primarily employed qualitative methodologies of key informants interview, focus group discussions, observations and review of relevant documents. The practical aspects of the evaluation, including limited timeframe in each site, did not allow for a quantitative study design.

The diversity of different actors involved in each project resulted in a methodology combining observations through hospital visits, analysis of hospital records and questionnaire content, which allowed for focussed discussions on disability, access to health care, limitations, opportunities and perspectives for the disabled. The questionnaires for key informants were open and broad in order to incorporate the views of respondents (Annex 6).

Focus Group Discussions (FGDs) were conducted with trained health staff, technicians and CBR-workers. Guidelines for topics to be discussed were developed to direct the discussion process (Annex 7). Although FGDs are neither objective nor representative, the approach has many advantages to elicit views that may not be obtained easily through individual interviews. The participative nature of the discussion allowed the evaluation team to explore and contrast the view of the different participants. Having a social researcher familiar with the technique undoubtedly facilitated the FGD implementation.

The qualitative information gathered was substantiated with data collected in a series of beneficiary's interviews conducted with individuals who were previously admitted at the HBPR services. As shown in Annex 8, a semi-structured questionnaire was developed and translated in Amharic before the fieldwork began. Purposive sampling was utilized to attain the stated objectives: the selection of patients from the hospital records included different criteria based on sex (male, female, and children), location (urban and rural), and type of disabilities. For patients aged than 18 years, the accompanying carer was interviewed. For the CBR project, the following criteria were applied (i) being a disabled and; (ii) having benefited from the project.

The Table 4.3. below provides a summary of the main techniques used for data collection.

Table 4.3. Techniques and tools used for data collection

Function	Method	Tool used	Type of Data collected	Total completed
Representatives in Addis Abeba (from MoH, MoLSA and NGOs)	Key informant interview	Open	Qualitative	12
Representatives in the field (local administration, health centres, BoLSA and NGOs)	Key informant interview	Open	Qualitative	14
Medical director and/or Hospital administrator	Key informant interview	Questionnaire	Qualitative	5
	Observation	Hospital visit	Qualitative	4
Trained health staff Trained technicians	FDG	Guidelines	Qualitative	2 plus three individual interviews
Beneficiaries of HBPR services	Observation	Hospital records	Quantitative	4
	Individual interview	Semi-structured questionnaire	Quantitative	27
Function	Method	Tool used	Type of Data collected	
CBR coordinator	Key informant interview	Questionnaire	Qualitative	2
Trained CBR workers/technicians	FGD	Guidelines	Qualitative	2

CBR offices	Observations	Visit	Qualitative	2
Beneficiaries of CBR activities	Observation	CBR records	Quantitative	2
	Individual interview	Semi-structured questionnaire	Quantitative	50

4.4. FOURTH PHASE: FIELD WORK

The fieldwork, lasting 25 days, primarily involved training data collectors, collecting data and analysing them. For the most part the field schedule was completed on time. A division of labour among the two evaluation team members was agreed but opportunities to discuss and develop ideas as a result of progressive reflection were ensured throughout the fieldwork.

A rescheduling of activities was arranged following the sudden death of the father's national consultant: another person was recruited for the 2-day data collection in Nazareth and the team leader held the interviews in Sodo and carried out the last working days in Addis Abeba. on her own.

A significant amount of time was spent on explaining the evaluation's objectives to the different stakeholders in order to minimize misunderstanding and circumvent expectations. The general experience of the team with the persons interviewed was positive. The local GoE administration offices, the health centres and local NGOs provided a great deal of help, especially to identify disabled patients who previously benefited from the HBPR services.

4.4.1. The evaluation itinerary

The combination of the site criteria led to the following itinerary: Nazareth and Asella for the CBR project; Aksum, Jimma, Dire Dawa, Sodo for the HBPR services. Access to northern and eastern areas was by plane; the remaining was by road, a trip that proved enlightening as it allowed the team to capture the reality of rural areas and the constraints posed by the terrain. The detailed programme of activities is attached as Annex 9.

4.4.2. Training interviewers

In each site two persons, one male and one female, were identified during the first phase for collecting data on patients and community members. Upon arrival of the evaluation team on the area, one half day was spent on training. The general topics covered included:

How to contact respondents, introducing the evaluation objectives;
How to handle aspects of the interview without causing bias;
Ways of dealing with likely problems and difficult situations;
Methods for probing inadequate answers;
Procedures for recording responses.

4.4.3. Data collection

4.4.3.1. Key informants: open questionnaire

The national consultant conducted a total of eight interviews, mainly in Addis Ababa. A summary of key information was verbally recorded for feedback to the team leader. For the RHB, BoLSA and hospital management representatives, the discussions, held in English, lasted from half and hour to one hour. The participants were informed about the purpose of the discussion and the confidentiality of their views and opinions. In addition interviews were conducted with local administrators and NGOs

representatives. In total thirty three individuals were interviewed. In the absence of RBH officials, two questionnaires were self administered and later faxed back to HI office[10].

4.4.3.2. Focus group organization, composition, and implementation

A total of four FGDs were carried out. In each of the HBPR location, except in Dire Dawa and Sodo[11], a FGD was held with trained technicians, nurses and health assistants. For the CBR projects, trained CBR workers and technicians participated to the FGD. The composition of the groups was based on two criteria: (i) previous trainees; and (ii) promotion of group dynamics through specific training on disabilities.

The evaluation team ensured that the participants were willing to actively participate in the group discussion. The FGD varied between three and five participants. The low number can be explained by the fact that previously trained individuals left their job or were removed to other locations.

The discussions were semi-structured, following a prepared interview guide, which served as a checklist for the topics discussed. They were held at the physiotherapy department during afternoon hours or at the CBR-project office. In the introduction, the participants were informed about the purpose of the discussion, the importance of open participation, and the full confidentiality of the information disclosed during the FGDs. The discussions were held in Amharic or local dialect. In that case one of the data collector acted as a facilitator. Each session lasted approximately from one hour to two hours and was manually recorded.

4.4.3.3. Beneficiaries: semi-structured questionnaire:

Interviewees were chosen purposively for their previous involvement in the projects. Out of four HBPR sites visited, data were collected using semi structured pre-tested questionnaires in Axum and Jimma[12]. Trained data collectors conducted a total of 27 semi-structured interviews. Most of the data collectors had completed secondary school, spoke basic English, and were residents of the area. This helped to find houses difficult to locate. In order to minimize potential biases all were recruited outside project's staff. For the CBR projects, a different semi-structured questionnaire was used and a total of fifty individuals interviews were conducted. The CBR coordinators in Nazareth and Asella provided the evaluation team with their own staff for data collection but the evaluation team leader opted to select individuals external to the projects. During the data collection, the team divided in two groups, each one comprising one data collector and one evaluation member. The inclusion of the latter proved useful to check for discrepancies, and to review the completed questionnaires in the field with the interviewers.

4.4.3.4. Observations

[10] From Dire Dawa and Makele

[11] For HBPR services in Dire Dawa hospital, out of nine trained individuals only one trained technician is still working there. The situation is similar in Sodo. Instead the evaluation team conducted informant interviews.

[12] The physiotherapy department in Dire Dawa closed down in 2003 and the unit in Sodo had limited activities with incomplete records for patient address. Both sites were excluded from the data collection due to the lack of beneficiaries.

A visit was conducted in the four selected HBPR sites. The visit included in-patient ward, physiotherapy department and orthopaedic workshop. It provided a valuable insight on the physical aspects of the building, and on the way the work was organized and managed.

4.4.5. Data analysis

4.4.5.1. Key informant interviews

The process of analysis identified dominant themes for each open question. As the newt step, these issues were contextualized within the broader institutional system and structure.

4.4.5.2. Semi-structured interviews

The sample in each location was too small to allow for a statistical analysis. The purpose of the patient interview was rather to create a useful picture of the benefits and limitations facing different disabled persons in their attempts to gain access to HBPR and CBR services.

Each questionnaire had a unique identifying number to avoid mixing of site location. From the questionnaire records, data were first translated into English and later analysed using the three grouping of questions: respondent's profile; exposure to health services as a beneficiary; and beneficiary's current situation as a community member.

4.4.5.3. Focus group transcription and analysis

All FGDs were transcribed in English, providing a full record of each of the discussions. Through the process of analysis, the discussion transcripts were synthesized. This was done by identifying key themes, focusing on issues that were mentioned frequently or consistently, and that received particular emphasis.

4.4.6. Writing the report

In parallel to the field work and before the team split up, the team leader drafted the first version of the report, bearing in mind the main findings that were extracted from the data analysis. This first version was intended merely to synthesize the analysis of effects, to clarify the key issues at stake and to develop recommendations. It also proved very helpful as a basis for discussion and agreement before leaving the country. Ultimately it helped to prepare the feedback to stakeholders and to HI team.

4.5. FIFTH PHASE: THE WORKSHOP

At the end of the mission, a feedback session, which involved exchange and debate with key stakeholders, was convened in Addis Ababa. The workshop was organized to present the main findings and to discuss and debate how best to design a future HI strategy in the field of physical rehabilitation. Out of the 23 individuals who were sent an invitation, sixteen attended the workshop but nobody represented the FMOH. Expectations regarding a future strategy were high, sometimes disconnected from the reality or over-ambitious compared to the NGO capacity and mandate. They highlighted the difficulties to design a strategy relevant to the needs and to the context. The minutes are summarized in Annex 10.

4.6. CONSTRAINTS

4.6.1. MEETING WITH HEALTH OFFICIALS

It must be realized that health officials have extremely tied and busy agendas. In particular the RHB representatives seem to move from one workshop to another seminar. The medical directors are usually involved in a wide spectrum of activities, acting as a physician or a surgeon, manager, and

teacher. Although the question remains whether the domain of disability is of any interest to them, the many priorities they are facing in their daily activities is a grim reality one has to work with.

4.6.2. PATIENT INTERVIEWING: OPPORTUNISTIC AND LIMITED

As previously pointed out, the lack of baseline data and time constraints made the selection of beneficiaries opportunistic in the sense that we interviewed only those who directly benefited from the project. This purposive sampling did not allow the inclusion of disabled who did not access the services, or the comparison of these different groups. This may have potentially limited the range of effects obtained from the projects. In Dire Dawa the HBPR services resumed three years ago and in Sodo the few beneficiaries were not registered with their address, a situation that forced us, in the light of the one and half day data collection, to disregard the search for beneficiaries.

The results can be fairly assumed to represent the observations and opinions of those who took part, but due to the opportunistic nature of the sampling, it is difficult to extrapolate the findings to similar settings in Ethiopia.

4.6.3. INCOMPLETE DATA

The availability of data is something an evaluation cannot know before-hand. In the initial evaluation proposal, assumptions were however raised on the possible difficulties in tracking back beneficiaries of the HBPR services. The assumption proved partially true. Firstly the patient database at physiotherapy departments, although well maintained, does not include in most cases the detailed patient address. In the absence of systematic follow up and monitoring, identifying and searching for beneficiaries in the previous years proved to be problematic and time consuming as the evaluation team used different networks, including local administrations, health centres, local NGOs, and community members. In one instance, the team walked a 2-hour distance to a village but did not find the names they were given. Secondly, the two and half days scheduled per site underestimated the time needed for the patient search, which explains the limited number of interviews conducted with beneficiaries. In retrospect, it would probably have been useful to have allowed an additional day in each physical location visited.

Although the identification of CBR beneficiaries proved easier because of the CBR workers were able to identify the houses, hard data from HI files on the CBR projects were limited, which proved problematic to understand the project background and the institutional changes. The information collected was in some instances contradictory and had to be triangulated with additional interviews from the individuals previously met during the preparatory work. Ultimately the overall timeframe for the evaluation did neither allow to meet with ILO nor with the DPOs.

4.6.4. THE UNINTENTED EFFECTS OF BEING A FOREIGNER

Although the team made clear the exact objectives of the semi-structured interview, expectations from the disabled and their caretakers may have gone far beyond that, raising hope because a foreigner had visited them. In that sense it may have introduced a potential bias during the interview. Nevertheless the fact that the team leader was involved in data collection gave the opportunity of visualizing the resource-poor settings in which the disabled persons operate and the barriers they face in accessing services.

5. MAJOR FINDINGS FOR THE CBR PROJECT

5.1. IN NAZARETH

5.1.1. Background to the project

With approximately 1 million inhabitants, Nazareth, at 2-hour drive from Addis Ababa, is the capital city for the Oromiya region. The CBR project is under the regional BoLSA responsibility and has an office with a workshop centre. As for the health sector, the regional office for Oromiya is located in Addis Ababa. According to the GoE guidelines, the Regional Bureau has the responsibility for supervising, monitoring and evaluating the social activities, like CBR projects.

Handicap International has been involved in both Nazareth and Asella from 1994 to 1996. The NGO phased out at the time of FMoLSA restructuring process in 1996, while the GoE was dealing with difficult reforms and transitions, including the institutional framework change. In particular community based activities were influenced by the decentralization process. This challenge has had a dramatic impact on the project opportunities as it affected the transfer of competences from the RA to regional FMoLSA offices. The split between federal and regional levels led to fragmented and diluted responsibilities with no clear leadership for the project's hand over. The latter was given the responsibility for the project but without real ownership and resources. The CSRP was another element which impacted on the implementation of CBR activities as the health manpower was either reduced or transferred.

Internal factors within HI also contributed to weaken the 2-year project. First HI did not succeed to build a strong institutional collaboration and partnership. The project as such was never "institutionalised" and remain loosely. Second there had been a missed opportunity for developing a clear exit strategy from the onset. Ultimately monitoring and follow-up mechanisms were poorly developed and did not allow for satisfactory results, especially for income generating activities and repayment of loans

Currently two staff are allocated to the physiotherapy section and seven technicians are working on the production of orthopaedic appliances. Four of them are disabled persons Nine individuals forms the management team, a relatively high number for administrative and support staff compared to the low level of activities. Out of the 9 CBR workers[13], only four remain. Approximately 500 disabled are registered under the CBR project.

For the past years the main CBR activities have been limited to the provision of appliances, mostly in Nazareth and outskirts. The HI vehicle has been allocated to the Zonal administration who did not use it due to their inability to pay for the 21,000 *Birr* taxation to customs. The outreach activities[14], as initiated under HI auspices, slowly collapsed and to day are virtually non-existent. The workshop for the manufacturing of low cost aids and devices, albeit functional, has been downsized due to the lack of budget support for purchase of raw materials, maintenance and repair of machines and equipment. As one respondent put it "*it is empty house*". The BoLSA is very aware of the existing weaknesses but so far has been unable to address them.

5.1.2. Current project situation

This section reports the findings of one FGD held with five CBR project members previously trained with HI support. The detailed and contextual information provided by the participants helped to better understand the status of current activities and problems in Nazareth. The section is organized as follows: we describe the challenges as identified by CBR staff themselves and discuss the reasons why these problems have arisen.

[13] Also called social rehabilitation workers.
[14] Mobile workshop, vocational training, income generating activities.

5.1.2.1. Shortage of human and financial resources:

Following the CSRP, the number of field work staff has been reduced. Today the lack of manpower is affecting daily work, especially the leather and metal workshops. The situation is even more critical in relation to the recurrent costs. Indeed the focus group participants acknowledge that the lack of financial support is a major problem. In the past year, the budget for running costs has been reduced from 1,000 to 400 *Birr*. This has had serious implications on transport costs for home visiting, maintenance of equipment and repair. All commented that the demand for appliances is hardly met from the project: the equipment in relation to the production of orthopaedic appliances requires maintenance and repair as opposed to the strongest wood and leather machines[15].

Another illustration, and how this has unintended effects, is provided by the cost recovery scheme. Initiated by HI, the objective was to generate additional revenues through income generating activities so that poor patients will benefit from free appliances. With the shrinking public resources, the workshop has been asked to produce more wooden made furniture's. The revenues generated are thus increasingly covering the recurrent costs.

5.1.2.2. What about the activities initiated by HI?:

All respondents acknowledged that HI laid the foundation for awareness raising and change of attitudes toward people with disabilities. Overall they felt that the technical support helped them to gain credibility, especially with an expatriate presence. They were also positive about the 6-month training as it added knowledge in the field of physiotherapy and disability. The provision of a 6-month supply from raw materials benefited directly to the disabled because more appliances could be produced. For their part the disabled trained felt also very satisfied to provide support to other handicapped.

While the project made a positive contribution in terms of training or equipment, it proved insufficient for sustaining most of the activities. The respondents were critical at the way handing over has been worked out. According to them HI did not prepare sufficiently for the hand over, paid little attention to coordinating and lobbying with other GoE structures and NGOs, and underestimated the phase out period. All respondents pointed out to the inadequate timing due to internal structural changes that affected indirectly the project. In that respect HI may have underestimated the importance of context analysis.

According to the respondents, awareness campaigns, conducted with school students, proved helpful in changing attitudes towards disabilities. Bringing the disabled to the CBR centre to see the services provided helped also to gain legitimacy. But the limitations of these approaches have become apparent: because they were not a GoE initiative, FMoLSA officials paid little interest in it. Small scale income generating activities suffered from a lack of proper design and accountability, including monitoring and follow-up mechanisms. To date, the provision of low cost aids and devices has its own limitations in the absence of follow up, vocational training or other supports. As one trained technician put it -*"we have made people with disabilities to be a walking beggar"*.

5.1.2.3. The social sector and the community workers: a forgotten area ?:

[15] Most of them have been provided by the NGO Rädda Barnen.

The discussion reveals a high level of distrust and frustration with the social system. The staff insists that a serious attention to social aspects, including disabilities, is needed. "*Even though everything looks nice on paper, implementation work is limited; social matters and ourselves are ignored compared to the health or education sectors."* They described FMoLSA as lacking dynamism and credibility, with limited expertise and power.

While they complain that disabilities are not considered as an issue, the lack of opportunities for follow up, supervision and training is a source of frustration and affects both their motivation and self-esteem. Their dedication is not valued and the current FMoLSA structure hardly takes their voice into account. According to the majority of respondents, the FMoLSA has not understood what the CBR activities were about and that they had needed more guidance and support.

The lack of accreditation from the previous HI training was also perceived as a key issue. This must seen within the observable trend in the current FMoE focus which tends to favour diploma, degree and master levels. In an absence of an accredited system, the community workers, although with significant field knowledge, are not recognized as technical staff.

Some of the recommendations in relation to the activities are expressed in Box 5.1

Box 5.1. Recommendations from the CBR staff, Nazareth.

Before a training is initiated, it should be accredited.
Budget allocation should be improved in order to implement outreach activities and to cover the costs of maintenance and repair.
The FMoLSA should strengthen CBR's implementation capacity.
NGOs can assist in implementing but should not be held with the main responsibility.
GoE should take full responsibility for disabled persons.
HI should "keep up" its name and support again the development of physical rehabilitation.

5.1.3. Beneficiary perspectives

5.1.3.1. Profile:

Out of the 25 interviewees, 15 were from Nazareth town and the rest from Mojo, a locality at 30-minutes drive from the CBR office. Sixteen respondents were male and nine were female. Seven individuals under 16 years old were included. The age varied between 9 and 75 years old and the household size from 2 to 8 family members. Two were orphans living with their relatives. While most of the females respondents were single, five individuals under 18 were found illiterate. Most of the households exhibits low-asset ownership levels and support from the relatives is the main source of income.

5.1.3.2. Exposure to the CBR project as a beneficiary:

Physical disability was the main problem, either from accident, polio, or neurological cases. Two children were suffering from mental retardation since their birth, most likely due to complicated delivery. In most cases, appliances in the form of wheelchairs, crutches and metal braces were the commonest form of support. Counselling was also frequently described. Usually the support for appliances did not include follow-up and in some cases, appliances were not used because they were not fitting properly or because people did not know how to use them. Based on our observations, many appliances were old and in poor shape. For wheel chairs, there was a fear to use them extensively due to the lack of repair and maintenance.

Most of the appliances were delivered free because beneficiaries were considered too poor to pay. The services were helpful in increasing daily life autonomy, relationships with the community members and facilitating access to education, especially for children. However, the project did not increase access to employment and when hard times strike, it is often family and friends that constitute the ultimate safety net for disabled persons.

5.1.3.3. Current beneficiary situation as a community member:

The majority of respondents were still facing problems in their daily life. In both sites, the disabled made fatalistic comments and gave up with hope for a better future as they feel excluded from socio-economic life. The demand for new appliances and vocational training is high, reflecting the need for increased new equipment and job opportunities. Indeed access to employment is seen a major problem and as one respondent commented: "*I go to school to receive education but for what future?"*.

While some interviewees have observed positive changes in attitudes within their community, the social ties in the neighbouring were described as strong and of great help. They also acknowledged the dedication and hard work of the CBR worker: " *The home visits have brought some hope and we can share our concerns with somebody".* At the same time they are realistic in terms of follow-up and do not expect much from the CBR centre. The team's overall impression was of a community whose survival depends on staying close and sharing resources among family members and close friends.

5.2. IN ASELLA

5.2.1. Background to the project

With an estimated population of 70,000 whose main economic activity is agriculture, Asella is a small Zonal town in the highlands of the Oromiya region, at a 4-hour car drive from Addis Ababa. As of 1999, 4.346 persons from the 11 *Woredas* were registered as disabled (Unpublished data, CBR office,1999).

The CBR project is under the responsibility of BoLSA/Oromiya in Addis Ababa. In 1994 Handicap International initiated Disability Awareness Clubs, provided training to CBR workers and technicians, and supported the production of low cost aids and devices. In addition the project covered the running costs for outreach visits which included mobile workshops. During that period, there were 11 CBR workers deployed in 11 *Woredas* and assisted with CBR aids paid under the Peasant Associations. With the decentralisation and the CSRP, the CBR aids were dissolved and to date only four CBR workers remain. As for Nazareth, it is not clear who had been the counterpart to HI and how the phase out took place. It seems that the project phased out at the time decentralization was introduced and BoLSA given autonomy.

Since HI had transferred the project to the BoLSa, the situation has deteriorated and virtually all activities collapsed, including the workshop that closed down in October 2005. As a matter of fact the CBR project does not exist anymore. But the town has been fortunate enough to attract the attention of politicians and FMoLSA's decision makers for the construction of a regional POC under EDRPs' World Bank project. The construction started in 2001 and was completed in 2005. While all the 13 CBR project staff have been allocated to the centre, total staff number in the near future is expected to increase up to 51 members.

The POC is a very impressive building although the two separated wings for the physiotherapy department and the orthopaedics workshop are not very convenient. ICRC provides equipment and materials for the appliances and technical support with one full-time based expatriate prosthesis maker. Prosthesis are manufactured using the ICRC polypropylene technology for various upper and lower limb amputation levels. According to ICRC's head of project, there were clear signs of increasingly deliberate FMoLSA efforts to support the POC which may stem from the EDRP/World

Bank support and high visibility from capital investments. This situation, which is in sharp contrast to the CBR project in Nazareth, should call for caution: the expansion of physical infrastructure and the capacity both in terms of recurrent budgets and staff to render the centre functional may create an imbalance and a threat to financial sustainability.

Since its opening a year ago, the POC is not fully operational yet due to the lack of skilled manpower in the field of physiotherapy and manufacturing of appliances. Currently the main activity consists of the provision of appliances, albeit on a low scale. This suggests that the role of physiotherapy care from the very beginning and in parallel to the manufacturing of appliances has been seriously under-estimated.

For ICRC expatriate staff, the more critical objectives are to increase the production, the quality of physiotherapy care and the collaboration between the two units. The lack of qualified human resources is particularly acute for physiotherapists. Although three physiotherapist-assistants, trained from the POC in Addis Ababa, are currently employed, their performance remain unsatisfactory.

Admittedly the 2-year course, although accredited, is a failure and there is now a plan to review it and upgrade those already trained. A physiotherapist graduated from Gondar university will be recruited in June but ICRC expressed some concerns in relation to this training which may not be of satisfactory due to the shortage of placement for instruction and qualified teachers.

Too often the design and implementation of policies are all about allocation resources and distributing power. The choice of Asella for a referral POC for the Oromiya region, therefore, seems political. The fact that the town has been favoured may not reflect the choice for a referral centre. Asella is far away from many areas within the Oromiya region, a geographical location which appears inappropriate and questions the feasibility of reaching intended beneficiaries. The risk that the nature of services offered will not be responsive to the needs of disabled persons. For instance the rate of new cases for POC at national level, estimated at 25%, indicate a low utilization of the services.

ICRC acknowledged this problem and developed a strategy which may prove difficult to sustain over the long term: with the POC acting a referral centre for the Oromiya regions, transport costs will be paid for the disabled person and one caretaker on the basis of 10 *Birr* per 100 kilometres. Food and lodging will also provided as the centre has a 12 bed capacity to accommodate users. The services are free of charge except for the 2 *Birr* registration fees.

5.2.2. The CBR workers: what future?

Only two CBR workers remain who were trained under HI. They previously worked at *Woreda* level but have now been appointed to the POC, one as a social worker supervisor and one as a technician. In general they keep very good memories on HI support. They were attending workshops and seminars, exchanged ideas and experience and exposed to a gratifying environment which increased their motivation. In addition they highly appreciated the awareness clubs as a powerful tool to change community's attitudes.

The return to routine activities after HI left has been difficult as there was no interest from BoLSA in providing financial support to the activities. This adversely affected the ability of the project to deliver to its full potential and ultimately most activities gradually collapsed. As one individual commented: "*HI introduced nice ideas but none of them were sustainable"*. Although they could not explain the reasons for HI withdrawal, they objected about what they view as a premature hand over and a too short commitment.

To date they feel very happy of being integrated within the POC but at the same time they see the lack of outreach services for rural communities. A new type of community worker was recently created, termed Development Agents, to provide community outreach. Trained and deployed at *Woreda* level, the issue is still the same: who will pay for their activities and related running costs?.

5.2.3. Beneficiary perspectives

5.2.3.1. Profile:

The total number of beneficiaries interviewed was 25, of whom 10 were from Asella town and the remaining from rural areas, in particular Sagure, a 30 kilometres distance district. Fourteen respondents were male and eleven female. While age ranged between 9 and 46 years old, the household size varied between one and eleven members. At the time of the interview, twenty one respondents were single, suggesting that most of the adults interviewed had not opportunity to get married because of their disability. The literacy rate indicates that nine individuals received secondary education and four attended tertiary education. As a matter of fact different churches-faith based provide support to disabled orphans and facilitate access to education. The informal sector and the support from relatives constitute the main source of income.

5.2.3.2. Exposure to the CBR project as a beneficiary:

The main disability problem consisted of neurological cases, peripheral nerve damage, spasm and joint stiffness. Some cases seem related to increased burden of labour during childhood. Two amputees (from car accident and ergotism[16]) and two club-footed persons were also reported. In relation to project activities, the provision of orthopaedic appliances was reported for fifteen cases. Two individuals benefited from physiotherapy care, four from counselling and one respondent mentioned awareness raising sessions. Three respondents underwent vocational training. Eighteen respondents received the support before 2003. The expenses varied from 7 to 1.500, the latest amount being related to hospital costs following a car accident. In general those who did not pay appreciated the free support they received.

Twenty one respondents felt that the CBR support had been helpful in terms of increased autonomy and access to education as well as increased participation to social events. However the activities did not facilitate access to job employment. There were complaints on the low quality of appliances, the lack of qualified technicians for the manufacturing of appliances and the absence of proper follow up. Two respondents had mixed feelings: although they acknowledged that the appliances were helpful, they criticized the fact that they were not "*modern"*.

5.2.3.3. Current situation as a community member:

On the day to day activities, eighteen respondents experienced difficulties, mostly in relation to their appliances. First these are often painful and are not always used. Second the lack of proper follow up is problematic as most of them are old or in need of repair. The fact that some have a short time life span is mainly due to the poor pavement conditions. Third people noticed that, over the past years, the project support for new appliances became tighter. Surprisingly very few were aware of the existence of a POC in town. The limited access to employment was another factor that made people depressed and without hope for a better future. There is no evidence to suggest a gender differential in the responses.

[16] Ergotism is caused by the chemicals in the fungus called "ergot". Consumption of foods contaminated with ergot may lead to gangrene in serious cases.

The set of recommendations the disabled gave in relation to the CBR project are noteworthy. While sustainability was raised as an issue on three occasions, ten respondents pointed out the need for increased empowerment and access to jobs through income generating activities. The expansion of CBR activities to the rural areas was also an area of concern. One respondent stated that the GoE should take action so that the problem of disabled persons is given due attention. Ten individuals raised the need for advocacy and equal rights. While they were aware of the DPO progress made in Addis Ababa where "*all NGOs concentrate",* they wish to form an association in order "*to raise their voices".*
In their opinion the activities should remain free as most disabled persons cannot afford to pay for services. In theory, a paper giving exemption from user fees, obtained from the *Kebele,* provides the disabled with free services. In two occasions people recommended to facilitate what is perceived as a very bureaucratic, time-consuming and difficult process, as most disabled cannot not access physically the *Kebele*. Ultimately a strong recommendation stands for improving the quality of appliances through better materials.

5.3. DISCUSSION OF THE KEY EFFECTS FOR THE CBR PROJECTS

5.3.1. Pioneering activities in the field of CBR

Handicap International encouraged a greater level of grassroots activities and in a way acted as a catalyst for the development of CBR activities in its widest sense. In addition the organization gave attention to the staff's needs, provided them with an unique opportunity for broadening their skills and worked in the best interest of disabled persons by integrating some of them into day to day activities.

5.3.2. But a lack of integration within an institutional framework

Since 1996 most of the activities initiated by HI have gradually collapsed. Based on the project synthesis which had been the only document available (Handicap International, 2005b) and from the analysis of interviews, this situation has three potential explanations: the lack of a clear exit strategy either from HI or from the FMoLSA, the limited conceptual thinking on how "imported" activities could be best sustained and the result of unclear lines of responsibility between federal and regional and leadership from the FMoLSA. The first kind of issue is not new. Experience in developing countries suggests that establishing a vision for the hand over of a project early is critical. Perhaps short-term funding and the complexity of the field made it difficult for HI to determine strategic aspects, including phasing out. Second the major emphasis placed on new activities seemed disconnected from the institutional context, with no clear strategy and mechanisms for ensuring at least some sustainability. Initiating innovative activities, such as outreach, vocational training and income generating certainly had its own merit but may require systems in place to sustain them and a longer-term capacity building.

For the third, shortage of resources is blamed for the problem of limited activities but the real causes are seen as beyond the lack of budget and having to do with the existing policies for the social sector. These policies are often perceived as weak and unfair. Until now, although the GoE has a plan for Development Agents who will be gradually replacing the CBR workers, it is not clear what will their role, responsibilities and future in the absence of financial support for daily activities. The perceived unfairness has eroded the confidence of CBR workers in GoE policies and is a source of permanent frustration.

5.3.3. None of the projects fulfil their initial objective

In both locations activities are mainly concentrating in urban setting at the expense of serving rural areas. The scope of activities has been drastically reduced to the provision of orthopaedic appliances and occasionally to counselling. In Nazareth, the level of CBR activities is clearly linked to the high dedication of the persons in post. The current project is still alive because a few individuals at

grassroots are fighting for some activities to take place. As such the project is highly vulnerable: if to morrow those individuals, especially the CBR workers, leave, the project is likely to disappear. In Asella, the project has been absorbed into the POC activities and has lost its main CBR focus.

5.3.4. The issues at stake

Within the current institutional context, social affairs receives little attention as compared to health, education or rural development sectors. For instance the Poverty Reduction Program document does not even mention the sector. As a matter of act it is the EDRP, via the POC construction, which has been influential in raising the FMoLSA visibility. As a side-effect of Asella's POC, the workshop has been closed and increased human and resources are allocated to the centre while CBR activities are no longer valued, nor are they perceived as sustainable.

This phenomenon is reflected in the limited budget allocated to recurrent costs in Nazareth. The implications are many: decreased quality, ceased production of appliances, resort to the income generating revenues to finance the day to day activities, adverse environment, distrust and frustrations.

5.3.5. A very precarious life for the disabled persons

A number of problems arise from the way CBR activities are provided. The lack of support has direct effects on the disabled: while proper follow up is poor, many appliances are not used because they are old or in need or repair. While their quality has been questioned, those in need of new appliances are unlikely to get it through the project.

Although the disabled persons appreciate the dedication and hard work of the CBR workers, there is no reliance on the project to improve their current conditions and to incorporate them into society as a whole. In addition, the distribution of social services are biased towards urban areas despite the fact that the overwhelming majority of the disabled is residing in rural areas. All this combination of factors have led to cynicism in relation to this type of project. In fact meaningful support does not rest with the public services but with social networks, including family and close friends.

5.3.6. Summary of project's effects in relation to objectives and results

A schematic view of the direct and indirect effects of the projects is shown in the table below.

Table 5.1. Analysis chart in relation to CBR-project's effects

Objectives	Results	Positive effects	Negative effects	Causes	Possible impact
Increase the recognition of functional rehabilitation among the population	2 functional orthopaedic workshops	HI pioneered activities in the field of disability	One workshop has been closed down The other workshop drastically downsized its activities Limited access to maintenance and repair of appliances Limited access to new appliances	No ownership No real interest from RA/BoLSA Social support policy for disabled is weak in implementation No budget support Failure of cost recovery scheme Attention and resources focused on POC	Low utilization of services Low quality of orthopaedic appliances Increased exclusion of disabled persons Little empowerment Limited access to socio-economic integration Limited sustainability
	12 CBR agents trained	The project provided an opportunity for developing new skills The project facilitated the participation of disabled people The fact that CBR were trained facilitated their integration into Asella's POC and served as career development.	Most of the CBR workers have left the projects Limited disabled follow-up	CSRP reform with transfer of and reallocation of staff No recognition Lack of motivation in the absence of a supportive environment	
	7 orthopaedic technicians trained	The project provided an opportunity for developing the skills their skills The project facilitated the participation of disabled people Increased personal satisfaction The fact that technicians were trained facilitated their integration into Asella's POC and served as career development.	Most of the technicians have left the project Limited production of appliances	CSRP reform with transfer of and reallocation of staff Lack of budget for the production of appliances No recognition Lack of motivation in the absence of a supportive environment	

	Outreach activities and awareness-raising sessions for disabled persons and community members carried out	The HI has encouraged the development of grassroots activities for the disabled	Most activities have collapsed The needs of disabled are not addressed The project do no reach rural areas Strong urban bias	Limited strategic planning in terms of hand over Premature phased out Lack of institutional ownership Lack of institutional support Priority given to high visibility project versus CBR The rural disabled command little political support.	

6. MAJOR FINDINGS FOR THE HBPR SERVICES

6.1. IN AXUM, REGION 1

Axum town is situated in the Northern part of Ethiopia, close to the Eritrea border. The town, with its 40,000 inhabitants, is considered to be the holiest city in Ethiopia and is an important destination for Ethiopian Orthodox Christians.

It is part of the Tigray Region which comprises a population of 4 million inhabitants and has the highest level of poverty ratio at 61 percent. Makele, the regional capital, is located at a 3-hour drive from Axum. Axum itself is at 3-day drive from Addis Ababa. The evaluation team reached the town by plane, a 5-hour journey.

6.1.1. General trends

Compared to all the regions, Tigray displays a relatively high level of health performance. For instance the immunization coverage and the proportion of pregnant women with attended deliveries are significantly higher than the national average. Despite the progress it remains however with relatively high stunting and underweight rates.

The region has placed a strong emphasis on community-based approaches and accounts for the largest number of frontline workers across the country. The staffing standards for the health centres have also been revised, with attempts to allocate qualified staff to rural areas. The current 1994 data report on 90,742 persons suffering from disabilities but this outdate figure should be interpreted with caution.

6.1.2. The physiotherapy department: a real priority for hospital managers?

The St Mary Axum Zonal hospital has a 120-bed capacity. At the time of the visit the occupancy rate was estimated at 70% of current capacity. The hospital offers a wide range of services from internal medicine, dental care, psychiatry to surgery. Out of the list of services offered, physical rehabilitation is not mentioned but two drawings displaying physiotherapy care on the top of the major entrance building suggest that the services are available.

According to the medical director, in the current position for the past five years, key hospital priorities are communicable diseases, including HIV/AIDS. The increasing neurological cases like stroke were also mentioned as a concern.

The hospital has no financial autonomy. It receives a global state budget for inpatient activities but operations budget are reported insufficient to cover the running expenses of service delivery. Most of the revenues generated through user fees are not kept at hospital level and thus are not reinvested to improve services. In accordance with the national policy, they are remitted to the Regional Finance Bureau who forward them to the FMoFED. The medical director admitted that the hospital lacks the capacity to cope with increasing numbers of free patients, and the drugs to treat them. As a consequence the majority of patients visiting the facility contribute little. However unofficial charges at health facilities for basic materials such as syringes, IV fluids or gloves together with side payments are well-documented (Lindelow et al, 2005). These practices, although outside the scope of this evaluation, appear to be widely practised at public hospitals and may add to the barriers for accessing health service.

Due to lack of financial support to meet its running costs, the workshop build by HI and RaDO closed down in 2002. The physiotherapy department albeit functional does not seem of main interest to the medical director. He feels that the current health assistant has limited ability to treat patients adequately.

The current department records highlight the following characteristics:

Total of patients as of 2005: 264;
Main area of residence: Axum town and surroundings;
Main reasons for visiting the unit: car accident, fall and hemiplegia;
Most beneficiaries are from the in-patient departments;
There is neither monitoring system nor patient follow up.

6.1.3. Staff trained: limited integration into the health system

The aim of the discussion was to generate insights into the nature and sources of benefits and limitations in the daily work of trained health staff, and their perspectives on physical rehabilitation services. The key points summarized in the table below are reported on basis of salience.

Table 6.1. Summary of main issues.

Topics	Trained health assistant as physiotherapist	Trained technician
Selection process	Three disabled persons selected Previous experience in Sudan but not real training Two nurses were also trained but left the job	Four individuals among electricians, plumper, or gardener were selected and trained (one died and one retired). Two are left.
Motivation	Good opportunity for improving skills	Learning new skills
Benefits	Increased theoretical and practical knowledge Increased relationships with patients Increased relationships between physiotherapists and technicians Opportunity for private home-care for chronically ill or patients who have undergone surgery Increased career development for two trainees who were sent to training in Makele.	Personal satisfaction to see improved patient's conditions Recognition from patients because orthopaedic appliances are a real benefit to people Increased skills for practicing private activities
Limitations	The unit is not recognized as an important service by hospital managers Lack of financial support Lack of recognition from the health structure Lack of salary supplement Limited collaboration during polio campaign days Limited referrals from chronic patients like HIV/AIDS Lack of awareness from doctors Lack of supervision (i.e. the medical director never visited the unit) High turn over of hospital administrators is detrimental to the project.	Because the electricity bill for the workshop was high, the hospital administration decided to close it down in 2002 Lack of attention from hospital managers Lack of opportunities to practice their new skills although there is demand Lack of salary supplement and career development
Recommendations	Upgrading course for staff as they did not receive any training in the past 6 years. Financial assistance for equipment and material. Increased awareness on the importance of HBPR services for hospital managers.	Increased awareness on the importance of HBPR services for hospital administrator.

The comments points out that the project gave the opportunity to develop their professional skills. As of December 2005, two trained HI physiotherapists were somehow promoted to the accredited 2-year course organized by the Tigrean Disabled Veterans Association in Makele. However there is no guarantee that the trainees will be returning to their previous position.

The discussion indicates a level of distrust and frustrations with the hospital management. These frustrations are rooted in a number of more specific complaints. Their current work is associated with low compensation, and shortages of essential equipment and material. In particular, the lack of budget support for the unit and the closure of the workshop are sources of frustration for the remaining trained individuals and affects their motivation, which in turn may affect their performance.

6.1.4. The beneficiaries

6.1.4.1. Profile:

As highlighted in Section 4, to reach a geographically dispersed group such as "the disabled" proved highly problematic as within the hospital records, there was no detailed information on their location. In addition, some of the beneficiaries, as identified, changed their place of residence. In the 2-day time allowed for data collection, a total of fourteen semi-structured questionnaires were carried out. In addition two in-depth interviews were undertaken with caretakers of disabled persons. Although this number is not representative of the beneficiaries who received physiotherapy care at the hospital unit, some common trends can be identified.

Of the fourteen respondents, six were from Wkrow and Tataimaychew and the rest from Axum town. Wkrow is a small town accessible from a 45-minute local transport from Axum. Tataimaichew is a scattered *Woreda* whose walking distance to households varies between 30 minutes and 3 or 4 hours. Eight respondents were male and six were female. Age ranged between 14 and 65 years old. The average household size was 3 persons; this relatively small size can be explained by the fact that many of the respondents in Axum town were single and living in their own without any family or relatives to support them. With regard to educational status, five were illiterate. Only one respondent was working at the time of the interview. Half the respondents were beggars concentrating near St Mary church in Axum where they form a community because "*it is the only way to survive as a disabled*". By contrast, in rural areas where family and other social networks continue to be strong, there seem to be less risk of exclusion.

6.1.4.2. Exposure to health services as a patient:

The main disability problem was associated with trauma from car accident and polio. Three respondents became hemiplegics after a stroke. They benefited from the HBPR services, mostly in the form of crutches or walking aids. The disabled who were beggars in Axum obtained free services with a *Kebele* exemption letter.

There was however a differential in accessing the services. For those living in rural areas, there is evidence to suggest that distance to hospital imposes a substantial cost on them and that this may reduce demand for physiotherapy care. First the walking distance to access the main road is considerable and makes almost impossible for persons with heavy disability like hemiplegia to access the hospital services Second the local transports, often overcrowded, can hardly accommodate space for a person with disability.

Consuming hospital care services can also be time intensive. For relatives it is difficult to give up long periods of work, especially during harvest time. Their opportunity costs – in terms of travel, work foregone etc. - may remain very high. Financial barriers also interact with physical distance and opportunity costs and are likely to delay decisions for care and follow-up: even when free, the rural disabled pointed out the difficulties they face to access public hospital services because of travel costs.

Some respondents who knew about the exemption system said it was too complex. Moreover, the exemption paper does not cover transport to the hospital, informal hospital charges and food. People also said it was not worth seeking treatment as a free patient because there were no drugs for their illnesses. In this case, they turn either to private health care or traditional healers. Ultimately the search for patients living in Tataimaychew found that rural households are not as well informed about the system as disabled living in Axum are.

While the HBPR services were perceived as helpful in terms of increased autonomy and social interactions, four respondents complained about the lack of attention to their problems and the fact that appliances can seldom be purchased in Axum because the workshop is not fully operational.

6.1.4.3. Patient's current situation as a community member:

Eleven respondents reported obstacles in their daily life. The two most frequently cited were the lack of job opportunities and referral system for complicated cases. Overall getting employment opportunity is a serious problem in Ethiopia and evidence suggests that this situation is even worse for disabled persons. The respondents feel excluded as the place in the society is closely linked to the social role of employment or work.

6.2. IN JIMMA, REGION 4

Jimma, a 7-hour road journey west from Addis Ababa, is the second largest city for Oromiya Region, the most populated of Ethiopia with an estimated 24 million population. According to 2005 projection data, Jimma town itself comprises 151,697 inhabitants and a total of thirteen *Woredas*[17]. The main economic activity is subsistence farming. Although the region has various resources including coffee crops and hydroelectric power, it is still under-developed.

6.2.1. General trends

The RHB office for the Oromiya Region is located in Addis Ababa. The main health priorities are communicable diseases (including HIV, TB and malaria) and maternal and child health. In general the region is disadvantaged in terms of skilled health manpower: less than one doctor is available per 55,000 people and there is one nurse per 10,000 people. Midwifery skills are particularly lacking with less than one midwife per 100,000 people. Jimma University opened a 3-year course for a physiotherapy degree but the course had been cancelled due to the lack of skilled teachers.

The 1994 Population and Housing Census registered 333,653 persons with disabilities. An association for the disabled has recently been created in Jimma town. The discussion held at BoLSA suggests that, while many disabilities go under-reported, economic perspectives for disabled persons are extremely limited within a highly competitive work environment. Even though opportunities remain, especially for daily labor, the disabled cannot access this category of work.

The NGO Cheshire Foundation, while actively involved in CBR projects, provides also special support for wheelchairs, crutches and prosthetic appliances through its own network. Collaboration with the HBPR seems limited.

6.2.2. The physiotherapy department: still functioning albeit with difficulties

Jimma specialized hospital, near to the University compound, provides comprehensive specialist services, and serves as a centre for post basic training. It has more than 200-bed capacity but the current occupancy level suggests an excess capacity. According to the medical director HIV/AIDS, chronic diseases such as diabetes and trauma resulting from road accidents are increasingly putting an extra-burden on the hospital capacity.

The very high admission rates may also reflect other factors: low population health status; limited capacity of health staff at peripheral had - whether in terms of knowledge, skills or resources- to

[17] Data on population collected at the Office for Statistics, Jimma local administration.

manage illnesses, and refer patients to the hospital; "pull" factor because of the most skilled physicians and a better supply of equipment and drugs.

Faced with overwhelming demand, the hospital is being renovated and new compounds are under construction. In addition, the hospital confronts difficult changes: new patterns of diseases such as diabetes, cardio-vascular diseases and HIV/AIDS, continuing budget constraints and internal brain drain in terms of human resources[18].

These changes have important implications for how hospital care is provided, since new types of care require new configuration of buildings, people with different skills and new ways of working. The competing pressures facing hospital managers as they struggle to respond to these complex challenges are huge. Over the past months, the hospital drastically cut down on the large number of OPD visits and non-emergency cases.

Handicap International and RaDO trained two nurses and four technicians, opened a physiotherapy department and built an orthopaedic workshop. The 4-bed physiotherapy department is still functional and staffed with the two nurses previously trained.

The main department characteristics are as follows:

Total of patients seen on a daily basis: 25 to 30; Patients are mainly from in-patient departments; Main reasons for visiting the unit: trauma from injuries and traffic accidents; the treatment of hemiplegic patients is also common; Disabilities from unknown causes are widespread; There is no monitoring system and limited collaboration with BoLSA and the Cheshire CBR project.

In 2002, the Jimma University appointed, under a 2-year New Partnership for Africa's Development (NEPAD) contract, a Nigerian physiotherapist to the unit. Because of his dedicated and strong commitment work, the unit was able to survive and to fully develop. In particular he provided for increased space, equipment, material and subsequently better opportunities to apply and upgrade the nurses' skills. There were plans to extend the unit into a specific hospital department but disagreements arose between the university and the physiotherapist and made this project failing.

The orthopaedic workshop closed down three years ago, officially due to budget constraints. In our analysis, it is probably more attributable to limited interest from the hospital management team[19]. For instance, a large POC centre, which is likely to serve the same objective than the workshop although in a larger scale, is currently under construction within the hospital compound. This project is externally funded and supported by a German NGO, Menschen für Menschen, who sent four hospital staff to Tanzania for further technical training. As it was not possible to meet with the NGO for detailed information, it is unclear to which extent the collaboration between the POC and the physiotherapy department will be worked out but uncoordinated efforts may lead to duplicated services.

[18] There is evidence that staff is leaving hospital services to work in the private sector and with NGOs.
[19] Including the medical director and the administration manager.

Undoubtedly the growth in capital investment will increase the hospital recurrent costs. Yet it would be important to ensure that the recurrent budget would be adequate to keep up with facility expansion. Typically a hospital requires 30-40% of the capital investment in recurrent costs every year. However, these extra-costs seem to go largely unnoticed from the hospital management team, leaving the hospital with a large stream of recurrent costs that could easily endanger attempts at financial sustainability. According to the hospital management team, the current hospital budget is already insufficient to cover all the expenses incurred[20]. At the time being, it is estimated that 70% of in-patients receive free services and as elsewhere in Ethiopia, almost 100 percent of the revenues generated through user fees are accounted for as general government.

6.2.3. Staff trained: what remains so far?

Handicap International and RaDO trained two full-time nurses in basic physiotherapy and four technicians. The two nurses are still working in the unit but there is only two trained technicians left. The table 5.2. summarizes the main issues that arose during the FGD.

Table 6.2. Staff's views.

Topics	Trained nurses	Trained technicians
Selection process	Competitive selection with internal advertising: out of 15 applicants, seven were screened and two selected.	Already working for the general maintenance workshop Purposive selection of four individuals Agreed to be trained on a voluntary basis
Motivation	Additional skills Increased salary	Additional skills Contribution to improve disabled patient's situation
Benefits	Change from in-patient routine ward Increased satisfaction from improved patient's conditions Improved relationships with patients Opportunity for a 2-year support from a Nigerian physiotherapist: upgrading their skills, extending services to OPD department Increased recognition and collaboration with doctors and surgeons	Increased skills (as their first formal training) Improved relationships with patients Improved relationships with physiotherapists Increased satisfaction Increased work opportunities (e.g. on a contractual basis for other hospital services)
Limitations	During the first two years, they were requested to work on part-time basis while still on duty for in-patient services and within the context of increased demand. Lack of financial support for purchase of materials and equipment Lack of supervision Lack of proper attention from the hospital management team Lack of incentives leading to lack of motivation Increased demand in the context of limited HR and financial capacity Lack of accreditation.	Worked as an extra job for 4-year while increased workload Time-consuming to the expense of their other duties High turn-over of hospital administrators and limited understanding of the workshop's objectives from the administration Lack of supervision Lack of financial incentives Lack of financial support for the purchase of raw materials Two trained technicians left (one resigned; the other has been transferred to the University)

[20] Estimated at 11 million *Birr* per year.

Recommendations	The FMoH and FMoE should accredit the training so that health staff can receive proper benefits in accordance with GoE salary scale. Rather than providing a 3-month training in 11 different hospitals, a joint-training would have been more relevant. The already trained health workers as physiotherapists should be considered for further degree training	Increased awareness of their training skills among hospital administrators Proper supervision Increased collaboration and understanding between administrative matters and related-health issues Increased salary in relation to performing extra-jobs.

The nurses clearly stated that they would quit, soon or later, their work on the public health sector to pursue opportunities in the private sector. The main reason was the limited recognition from the public health system combined to the salary differentials as opposed to ward duty nurses who benefit from hardship allowances or bonuses.

Although financial rewards were not the only issue, the discussions underlined how health workers make constrained choices, both in their day-to-day professional activities and in their career. Implicitly the nurses recognized that the work at the physiotherapy department was less stressful than the in-patient wards and allowed them escaping workload, routine and night duty. In addition, fear of AIDS seems to make the health profession at hospital less attractive than it used to be.

6.2.4. The beneficiaries

6.2.4.1. Profile:

A total of 13 beneficiaries have been interviewed, of whom 6 were female and 7 were male. Five respondents were from rural areas and the rest from different *Kebeles* of Jimma town. Age ranged between 4 and 40 years old. Out of eight adults, four were single and one was separated. Most of the urban residents had received secondary education. In relation to the main source income, eight received support from the family, three worked in the informal sector and two were formally employed. After becoming disabled two respondents lost their formal job.

6.2.4.2. Exposure to health services as a patient:

All the respondents suffered from physical disabilities, including paraplegia, hemiplegia, back pain and leg or arm problems from accidents or unknown causes. A variety of physical rehabilitation services were provided including massages, traction, exercises, infra-red light, crutches, and walking aids. In addition, some of them received psychological counselling and home visits. A young boy has been referred to Addis Ababa because his case was beyond the unit's capacity.

Out of the 13 respondents, nine received the physiotherapy treatment for free, either from the *Kebele* exemption or from exempted categories such as health staff. Some of them paid a 3 *Birr* amount for the physiotherapy session and a 40 *Birr* for the purchase of crutches. The remaining paid for other hospital costs, including drugs and additional treatment or transport.

The majority of respondents highly appreciated the physiotherapy care they received. In particular they were very grateful to the Nigerian physiotherapist for his full support. In general, the services helped in different aspects, including social integration, increased autonomy in daily life and psychological support. For few respondents, there were mixed feelings: in some instances, the benefits were marginal in relation to the costs incurred and clinical cases were too complicated to be treated at the hospital level. One individual mentioned staff negative attitudes and preferential treatment based on the ability to pay.

6.2.4.3. Patient's current situation as a community member:

Out of 13 respondents, seven were still experiencing obstacles in their daily life. The problems include the lack of job opportunities, limited autonomy and stigma associated to their disability. Some felt that the physiotherapy department could not provide much help for complicated cases and pointed out the lack of proper follow-up.

The main beneficiaries' recommendations included:

Improved equipment and materials;
Extension of physical rehabilitation services to peripheral levels;
Increased staff skills and competence;
Decreased waiting time to access physiotherapy treatment;
Increased economic support for the disabled;
Increased financial support to the physiotherapy department

6.3. IN DIRE DAWA, SPECIAL COUNCIL

Dire Dawa Administrative Council is located in the eastern part of Ethiopia and consists of sixteen administrative *Kebeles* with a total population of 342,000 (2005 projections). The main economy activity of pastoralists and agro-pastoralists is livestock raising supplemented by subsistence farming. The major market centre for the Special Council is Dire Dawa town. Recurrent drought is a major problem and sixty percent of the mortality under five is attributable to severe and moderate malnutrition.

6.3.1. General trends

Although trauma from car accidents are among the ten top diseases, physical rehabilitation has been a neglected area for various reasons, including major attention given to the burden of communicable diseases. The collaboration between the RHB and BoLsa is currently limited, even for the monitoring of disabilities. In fact there is no system in place and current data are subject to caution.

According to 2004 data (BoLSA, personal communication), there are 394 disabled in Dire Dawa town, of whom 176 are registered as beggars but the 1994 data registered 4226 disabled persons for the entire Council. The NGO Christopher Blindness Mission (CBM) is addressing the needs of blind persons. Another NGO, Cheshire Service, is involved in CBR activities. Both have started successful income generating activities, especially in relation to animal husbandry.

6.3.2. The physiotherapy department in Dill Chora Hospital: closed down in 2003

Dill Chora Zonal Hospital, with a 210-bed capacity, offers medicine and surgery services, including surgery, orthopaedic, and ophthalmology. Fees represent small amounts and are not reinvested to improve services. Based on the discussion, an estimated 90% of the patients are eligible to free services because of the high poverty level of the population. Despite the provision of free hospital care, the medical staff reported that many patients were having insufficient cash to cover food expenses.

Patient case mix and mortality data at the hospital suggest that the burden of HIV/AIDS is high, with approximately 70% of in-patients diagnosed as HIV-positive. Currently the hospital has 500 out-patients under Anti Retro Viral (ARV) treatment course, a programme that has been implemented since April 2005 using resources from the Global Fund and the Bush Initiative.

The local authorities pointed out to a significant demand for appliances with disabled patients being referred to Harar's POC. Although the workshop built by HI and RaDO is still opened, the production

of orthopaedics appliances has stopped in 2002 following a major argument on the cost-recovery scheme. At the beginning, the workshop has managed to retain 100% of their proceeds, to deposit it in a separate account and to use the surplus for priority activities when decided by the management committee. The lack of transparency gradually undermined the process and led to the collapse of the scheme. The physiotherapy department has been more or less functional until 2003 and then closed down mainly due to the CSRP process and transfer of staff trained to health stations.

6.3.3. Staff trained: only one technician left

Four nurses and five technicians received the HI training course, the latter group on a volunteer basis. To date only one trained technician could be identified and interviewed. While the rest has been transferred to other sectors, the nurses have either been moved to different health facilities or allocated to HIV/AIDS counselling.

The discussion revealed that the training made a positive contribution by providing the technician with new skills. The comments pointed out to increased satisfaction to directly relieve the discomfort of the disabled by producing prosthesis appliances. These skills could even be used in the private sector but the respondent feels that although demand is there, it will be unethical to engage in private profit practices. In his opinion the project suffered from two weaknesses. First there was little interest from local health authorities that, having not initiated the project, felt limited ownership for it. Second, the cost recovery scheme was not well thought through and did neither benefit the workshop nor the patients. Recommendations included improved coordination between the RHB, the hospital managers and the services, and improved supervision and follow up.

6.4. IN SODO, SNNPR

6.4.1. General trends

Sodo is located in the southern region of Ethiopia, at a 7-hour drive from Addis Ababa. The region has an estimated population of 14.9 million. Population density, one of the highest in the country, is putting pressure on agricultural lands. The poverty head count ratio exceeds 50 percent and health indicators are among the lowest compared to other regions. Overall the region is facing a lack of health infrastructure and limited availability of qualified health providers and managers. Human resources development, including the opening of three nursing schools, maternal and child health and communicable diseases are key priorities for the RHB of Awassa. Chronic illnesses such as diabetes are increasingly reported and disabilities from traffic accidents are of special concern. While the newly specialized hospital will serve as a referral facility, many churches-faith related NGOs are actively involved in health care provision. In 1994 the number of persons with disabilities in SNNPR was estimated at 174,941.

The population of Sodo is estimated at 75,000. Data on disabilities either from the Zonal Health Bureau or Social Affairs are not available but the NGO World Vision estimates that, out of the 22,000 food aid beneficiaries, 20% are disabled. According to International Medical Corps (IMC), patients physically disabled are referred to Arba Minch' s POC, 100 kilometres south.

The newly opened Christian Mission hospital which acts as a private hospital also includes a physiotherapy department. The facility is staffed with 150 beds and specialized health professionals including one plastic surgeon, one orthopaedic surgeon and one physiotherapist. In the future the hospital will provide surgical treatment for children's disabilities and fistula.

6.4.2. The physiotherapy department in Sodo Hospital: virtually non-existent activities

The Sodo General Hospital has a 150-bed capacity and acts as a Zonal hospital. The building is in a relatively good condition but high turn over of qualified staff, including physicians, surgeons and nurses, is a key constraint. The medical director himself is a surgeon and dedicates most of his time to clinical and surgical cases. While car accidents and injuries are commonplace, the hospital is also confronted with the HIV/AIDS crisis. As in the other hospitals, user fees are reported to contribute little to the recurrent budget. The hospital is now seeking to open private rooms for patients who can afford to pay in order to meet some of their running costs. Nevertheless the common reactions to medical cases seem to be delaying treatment because of difficulties in obtaining cash to meet treatment costs, including drugs, IV fluids, catheter, and gloves.

The overall feeling is that the physiotherapy department, since its opening, has attracted little attention from the hospital managers. The hospital workshop, repaired under HI and RaDO auspices, is still open but has stopped producing walking aids or prosthetics appliances due to the lack of referral cases from doctors. At the time of the interview it was found that the medical director, in the position for one year, was not really aware about the HBPR services.
As a surgeon, he seldom refers patients to the unit. From his point of view, the ability of the health assistant is inadequate and limited, especially in relation to anatomy and physiology.

6.4.3. Staff trained: one health assistant and one technician left

Out of the eight staff trained (three health workers and five technicians), six were assigned to different working places and hospital wards soon after the training. As in other project sites, the interviews with the trained health assistant and technician indicate a high level of distrust and frustration with the public health system. The staff commented that from the very beginning, the project did not receive full support from the hospital management. As a result, procedures and practices related to the unit have been poorly enforced. Soon after the end of the technical support, the unit room, rehabilitated and equipped from the project funds, closed down and was reopened with the arrival of an orthopaedic surgeon. Unfortunately the surgeon left the hospital and since then the unit is almost non functional. The workshop is outside the hospital compound, an inconvenient situation which hinders visibility and recognition.

Currently the physiotherapy department consists of one nicely equipped room. The unit is closed but opens once in a while when the trained health assistant, who is on part-time duty in the in-patient surgery ward, receives an order from the doctors. The records do not indicate the patient address but, over the past years, an average of eight to ten disabled patients from car accidents or injuries have received physiotherapy care on a monthly basis. The high turn over of physicians and the fact that very few are aware of, or interested in physiotherapy are major constraints. There are also pressures from hospital managers to reallocate this room for the expansion of the medical ward.

The staff complain of being "*abandoned*" and demoralized. Instead of bringing benefits, they see the support of HI and RaDO as a waste of time and resources. They view the need for physiotherapy unmet, partly because doctors do not pay much attention to physical rehabilitation but also because the hospital managers are not providing adequate support in terms of interest and collaboration.

Interestingly, both individuals pointed out that nowadays professionalism and integrity have been steadily undermined. In their opinion, financial aspects are the main appeal to hospital staff, take precedence about ethics and are increasingly seen as accepted features of the hospital system. They feel that, because physiotherapy care does not bring additional resources to the hospital, it is a forgotten service.

According to the respondents, the limited RaDO follow-up after the training was insufficient to build credibility in such a new area as physiotherapy. They insist that, without a deep commitment from administration and physicians, a similar type of project is likely to fail.

6.5. DISCUSSION OF THE KEY EFFECTS FOR THE HBPR SERVICES

6.5.1. Increasing the visibility of physical rehabilitation

Handicap International and RaDO played a critical role in introducing the concept of physical rehabilitation at hospital level and in promoting physiotherapy departments and orthopaedic workshops. They were the main project drivers and indeed the project reflected both organizations' interests in having a stake in the development HBPR services. Nevertheless this commitment had its own limitations. From the onset there was a risk that rapid expansion of the physical infrastructure, including building workshops, and the establishment of such vertical activities, could not be sustained in the longer term. Perhaps spill over effects were anticipated by covering many regions. However, given the complexity of the health system and the vast territory, it might be argued that the geographic implementation, which included eleven hospitals, did not match with the reality and had been over ambitious, especially in relation to proper follow up.

In addition the 18-month timeframe is questionable: starting with an almost new concept in the absence of a conducive policy environment would certainly require a longer-term commitment in order to gain legitimacy.

6.5.2 But in isolation from the health care system and other actors

The main objective of the project was to pave the way towards the integration of physical rehabilitation into a national policy. However the move to make disability an issue that cuts across sectoral boundaries has made little progress. As a matter of fact the HBPR services remained isolated and failed to become integrated within the wider hospital system.

By 2006, none of the sites visited had gained sufficient support from the different stakeholders within the health system to become fully operational. Perhaps the HBPR services in Jimma are a notable exception for the following reasons: (i) it is a specialized hospital with orthopaedic surgeons; (ii) a foreign physiotherapist, appointed there for 2 years, gave the impetus to develop the services and raise the unit's credibility. The services are targeted at in-patient care with little referral from out-patient consultations and concentrate mainly on curative aspects, not preventive. At some expense the workshops were constructed or renovated and equipped. The buildings and the equipment are there but do not match to the intended objectives of local appliances manufacturing. This situation is not only relevant to the four sites visited but has been reportedly portrayed for the other seven-supported hospitals.

Several issues are noteworthy in this analysis. First, the implementation of health policy is influenced by many contextual factors, including the macroeconomic situation, the political system, societal values, and the institutional structure of the health system. Both HI and RaDO may have underestimated the macro-dimensions of the health sector, the dynamics of the actors within the health system, the review of risks and assumptions, and the development of a thorough exit strategy. As reflected in HI documents, the initial project proposal was designed from a purely technical point of view. Little attention was focused on understanding the broader context and the complex institutional environment in which HBPR services were going to operate. This, however, must be set within the NGO context in 1996. Since then HI has gradually moved from an interventionist and technical approach to more development-oriented practices.

Second it is not clear, from the interviews, whether the health authorities at that time had a coherent vision of how they wanted the HBPR services to fit into their plans and how these were to be articulated within the overall health system. As we have noted, most hospitals are attempting to keep up their health care delivery system driven in large part by shrinking budgets. Thus, projects using funds from external donors are attractive, no matter how sustainable they are. Although medical directors were involved in the process, it remains to be seen if the arrangements made were

sufficiently robust in terms of commitment as merely getting approvals is no guarantee of success. In addition there were no clear guidelines of whom will supervise the staff trained, which led to little accountability from both hospital managers and staff.

Third the fact that the HBPR services were not attached to surgical wards but were essentially designed to function as autonomous units made collaboration and integration more difficult. Ultimately, in most sites coordination and collaboration with external development partners, health care levels and local institutions like MoLSA's decentralized offices, were poorly developed and made the project disconnected from important actors who could have played a role in lobbying for the services.

6.5.3. Vulnerable to the changing nature of actors and environment

Within the health sector the policy environment has been affected not only by broader public sector reform, but also by a series of specific reforms which have typically included reorganization of the FMoH and decentralization, the broadening of financing options and liberalization of the private sector, among others. While such changes have potentially opened up the policy environment to many new actors, and introduced a range of new policies and procedures, reforms have put huge pressures upon health system and health staff. With the decentralization and the CSRP, key staff were moved on. In general there is no institutional memory of the past project activities at hospital management or ward levels. As a result, the support to the staff trained has eroded and a certain disinterest rather than real commitment is commonplace.

The hospitals are characterized by a high burden of disease and injury. At the same time, the capacity of health systems to respond to increased needs is critically reduced by the erosion of national capacity for health financing and provision. Ultimately the picture of hospitals has changed over time. One important trend is observable in the current focus of hospital activity: the HIV/AIDS epidemic has taken off rapidly and has become a major burden which absorb most of the attention of health professionals. Moreover the significant level of financial resources made available through the Global Fund and other mechanisms are somehow diverting scarce human resources away from general health services.

6.5.4. Not seen as a priority

Given the scarcity of resources in the country, health problems are not given equal importance. For the past years the focus of health policy in Ethiopia has been on delivering cost-effective and high impact interventions, including preventive infant and child care, and management of maternal, neonatal and childhood illnesses. The intersectoral aspects of health care are recognized to include population, food security, safe water, safe waste disposal, and environmental health.

The health policy documents closely reflects international donor expectations of a developing-country policy, a trend even stronger with the MDGs. Obviously physical rehabilitation is not in the agenda, which renders its implementation extremely weak. However the variety of information collected as part of this evaluation points to a disturbing situation in relation to disabilities. In particular there seems to be an increase of trauma related to car injuries. Although not given a priority at the time being, road accidents may become an important contributor to the burden of disease in the future and place an additional strain on the health services. The need to monitor this trend and to develop preventive aspects in relation to the main causes of disabilities is still unmet.

The exclusion of physiotherapy care is further reinforced by the fact that cost recovery for the services, if practiced, represents a negligible additional source of funding for health care delivery. In addition hospital managers want to take pride in having modern hospitals with up-to date equipment and users who are able to pay but physical rehabilitation do not bring in much visible and high technology equipment and disabled are entitled to free services..

6.5.5. A lack of recognition from the health system

The training raised much expectations in terms of salary's supplement and career development but the lack of recognition for the work performed has been a continuous source of frustration. According to the FMoH and FMoE regulations, yet there is no system of accreditation and a 9-month training is the minimum requirement for a salary supplement. In addition it may appear presumptuous to be recognized as a fully physiotherapist professional with a 3-month basis training whose implementation has neither been monitored since 2000.

Although the project provided the staff with new skills, not all the individuals trained had opportunity to use the skills taught. In Aksum, a positive effect has been the opportunity given to the two trained individuals for the 2-year training course in Makele. Similarly technicians were trained but the employment practices in the hospital were such that neither effective supervision nor incentives existed in the system to back up the training and give an incentive for their extra-work.

6.5.6. Poor collaboration between hospital managers, doctors and staff trained

The health structure is hierarchical in nature and this hierarchy can be observed in practice. In fact, few hospital managers had even visited the physiotherapy department. Tensions between the hospital managers and the staff trained persisted over the years. To day a mutual distrust is apparent. There may have been a capacity in terms of skills, but training alone has been insufficient because of a more serious lack of hospital system capacity to address the real problems. On the staff side there is a feeling of ongoing battle to get basic material and equipment, a situation that has worsened over the years. As observed, the current activities are closely linked to the motivation of the person in the post. Although nurses and health assistants are still very much dedicated to providing physiotherapy care, they complain of being underpaid, demoralized, and poorly supervised. As a matter of fact all painted a bleak picture of the public sector. These experiences are now convincing some of the staff from leaving the public sector.

While a recurrent complain has been on the lack of attention and support from hospital managers and doctors, medical directors expressed serious doubts about the health assistants performance which may, in part, explain the limited prescriptions for physiotherapy care. This scepticism is further reinforced by the fact that the basic training was neither followed by supervision nor upgrading course. From what has been observed and discussed, indeed the care provided is basic and can hardly address the needs of complex pathologies. The role of frequent re-training to sustain efforts in hospitals was probably underestimated.

6.5.7. General beneficiary's satisfaction but a strong urban bias

When available the services have improved relationships between the health staff, the technicians and patients. Overall the level of satisfaction regarding the HBPR is good, especially in Jimma but most beneficiaries recognize that the services are limited in terms of skills and supplies.

As for the HBPR beneficiaries, it is difficult to do a trends analysis over time because the readily available data obtained from the records are not presented using the same format and categories. Moreover, in some places, only partial information is available because of virtually non-existent activities. Although our findings should not be seen as representative in a quantitative sense, they raise important issues.

Determinants of the use of physical rehabilitation services are multifaceted; among these are physical and financial barriers and limited hospital capacity to respond to complicated cases. This reveals only part of the picture; another aspect is the utilisation of services by those living in remote areas. The HBPR has a clear trend in favour of the urban population compared to the people in rural settings who

have to bear the costs of illness – other than narrowly defined treatment costs – such as transport, food and lodging for the carers and who have limited awareness on the services available.

6.5.8. Who will pay for the services?

While actual charging practices at the hospital are not publicly advertised, entitlements to exemptions are realized but are of little benefit as they do not cover all the costs, particularly if the drugs for in-patient care are not available at the public health facilities and have to be purchased from a private pharmacy. In two occasions, there were also reports of discrimination against disabled persons with a waiver certificate by hospital staff.

As demonstrated with the cost-recovery scheme, the project made some attempts to build a system for sustainability. Nevertheless there was a limited understanding of the broader financing context as the fees collected were not reinvested but remitted to the FMoFED. In the future, with the evolving health financing strategies, the risk is that many hospitals managers may not be interested in granting exemptions because of their growing dependence on user fees revenues to meet their non-salary expenses. Then what is at issue is how the services will be financed in the longer-term and who will subsidize the costs incurred by the disabled.

6.5.9. Summary of effects in relation to objectives and results

The Table below presents the main effects of the HBPR services.

Table 6.3. Analysis chart in relation to objectives, results, and effects

Objective	Results	Positive effects	Negative effects	Causes	Possible impact
Facilitate the integration of physical rehabilitation services into a national policy	Physiotherapy departments and orthopaedic workshops are functional in X hospitals.	HI and RaDo laid the foundation for HBPR	Most of the services are not fully operational	Weaknesses in the project design: technical approach versus context analysis Ambitious coverage versus limited understanding of health system constraints Short project timeframe Lack of ownership Insufficient institutional support	Limited legitimacy and credibility No sustainability Low coverage Low utilization services No institutional memory
			The HBPR services are not part of the health care system	No inclusion into national policy Function as autonomous departments with unclear line of accountability. Do not bring neither high-tech equipment nor important revenues --→ Limited interest	
			The services have been vulnerable to reforms and changes within the health system	Decentralization and CSRP with high turn over of key staff	
			The HBPR services are not among the top health priorities in the policy agenda	Hospitals are burdened with HIV/AIDS and communicable diseases Other priorities attract human and financial resources The services serve an already excluded population with "little voice"	
			The hospital managers and doctors have little trust into the services.	Insufficient training, follow-up and supervision	
			The services are mostly limited to in-patients	Lack of awareness among providers Limited awareness and collaboration with other NGOs, health care levels and institutions	
			Urban bias	High costs to access hospital services Limited awareness	

	Trained technicians in production and maintenance of orthopaedic appliances	The staff trained have developed new skills	The skills taught can not be applied	Lack of financial support	No technical sustainability Low coverage No financial sustainability
		The skills improved their relationships with patients.	The staff trained did not benefit from financial rewards	No training accreditation	
		The project facilitated the participation of disabled people	Cost recovery has failed to generate sufficient revenues	Lack of understanding from hospital managers Limited accountability	
Increase the recognition of trained physiotherapists as professionals	Nurses and health assistants have been trained	The staff trained have developed new skills	The staff have limited means to practice their new skills.	Lack of institutional support No budget available Limited credibility from the doctors	No technical sustainability Low quality of physiotherapy care
		Two staff were sent for further training to Makele	The 3-month basic training for physiotherapy has never been accredited	Too basic to be integrated	
		The project facilitated the participation of disabled people			
		Increased relationships with patients.			
		The users recognize the need and are satisfied.	The staff trained did not benefit from financial rewards	No training accreditation	
		On policy level (MoE, University of Gondar) there is increased recognition of the profession. To some extend the project may have contributed to this.	Their skills are limited in the absence of upgrading training	Staff trained work in isolation with no supervision	
	Awareness raising and information sessions conducted		Limited awareness on the services within the hospital itself	Lack of interest High turn over of staff	Low utilization of services Low coverage
			Little knowledge of HBPR among health care levels, other NGOs and local FMoLSA institutions	Lack of information sharing Lack of coordination	
			Little knowledge of HBPR in rural areas	Lack of coordination with health facilities at peripheral level	

7. LESSONS LEARNED AND RECOMMENDATIONS

The detailed analysis of the effects leads to emerging lessons. The recommendations are intended to assist in the orientation for future HI involvement.

7.1. THE IMPORTANCE OF THE INSTITUTIONAL CONTEXT

Over the past ten years, health and hospital systems in Ethiopia underwent fundamental structural changes. In particular decentralization and civil sector reform programme set in motion a number of long-term changes that greatly affected the health sector. In addition there are multiple barriers to utilizing hospital services in terms of transport costs and fees.

Although HI and RaDO actions had merit, their foundations were not sufficiently rooted in a solid understanding of how health care system evolved, what factors shaped these evolutions, and what constraints faced the disabled persons to access the services. As reflected in HI documents, the initial project proposal was designed from a purely technical point of view but this must be set within the NGO context in 1995. Since then HI's practices have gradually moved from an interventionist to a more developmental approach.

In the future, more comprehensive steps must be taken so that they reflect HI's development-oriented practices From an early stage, HI should not absorb only on the technicalities of the project but also be aware of the policy environment and context. In particular a contextual analysis taking into account the institutions' strengths and weaknesses is critical.

7.2. QUALITY VS. QUANTITY

Undoubtedly there is a high unmet need for disabled persons, especially in rural areas but the problem of disability in Ethiopia is vast, has a larger dimension than poverty, and goes beyond a single NGO capacity. Therefore it is essential that HI realizes that the type of project implemented was over ambitious and for a too short commitment. Further the findings reveals that, while sustainability is a shared responsibility from all stakeholders, changes perceived as being brought from the outside are problematic to sustain. Ultimately the influence of disabled people in terms of actual planning of services is very limited and few monitoring data were available to document project implementation, limiting the potential of retrospective evaluations to contribute to programme improvement.

The problem of disability needs to be addressed realistically, taking into account the national context, as implementing change might be difficult in the absence of a supportive policy environment. In the future it is essential that HI realizes that pragmatism should prevail. The needs "should lead to the building of strategic alliances in order to ensure a greater involvement of partners and disabled people and to increase project sustainability. However, sustainability is understood as a shared responsibility among all stakeholders. A monitoring system should also be considered as a key element of project design from the outset.

7.3. A HOLISTIC APPROACH: TOO SOON

As stated at the outset, integrated services for the disabled persons offered an opportunity for favouring physical rehabilitation. Nevertheless the results in this regard are disappointing as both projects helped little to design a national policy. The evaluation shows that there are serious challenges facing the integration of physical rehabilitation into the health system. It also points out to the needs for a series of steps in order to ensure the inclusion of physiotherapists in the health workforce. Delivery of physical rehabilitation requires a high degree of commitment at all levels. In Ethiopia with relatively dissatisfied public sector health workers, such commitment cannot be taken for granted. The problem of disability needs to be addressed realistically, taking into account the national context as implementing change might be difficult in the absence of a supportive policy environment.

As far as can be ascertained from those interviewed, the GoE commitment to addressing the needs of disabled persons is weak and explicit moves to integration have not taken place. In addition public health practitioners have to make hard choices about how to make best use of scarce resources.

While political commitment and a responsive institutional framework are no doubt essential preconditions for successful integration, an analysis that provides a more comprehensive understanding of the impact of disabilities is seriously lacking. The consequences of these shortcomings is that both the burden of disability and its economic consequences are unknown. Therefore there is no strong impetus for developing policies to curb physical disabilities and under the severely constrained health system, implementation is likely to remain weak.

The fact that physical disabilities are not perceived as a major threat to the public health and to the development of the country makes the policy environment little favourable to physical rehabilitation. The major programmatic recommendation emerging from this evaluation is that in attempting to integrate physical rehabilitation into the health system, it will be necessary to analyse three questions: why to integrate, what to integrate, and at what level of care.

7.4. INSTITUTIONAL SUPPORT TO FMOLSA: THE CASE FOR DONOR ASSISTANCE

The MoLSA has developed a national policy on disabilities but there appears to be little articulation on how such policy commitments are to be translated into action. There is a need to strengthen the planning and management capacity of the local government officials who are responsible for overseeing the implementation of the policy. Similarly lines of accountability between local government, the services, and the community entail further development.

A number of stakeholders have requested HI to assist and capacity build the MoLSa at national level. Although Handicap International has successfully provided this type of support in other developing countries, the institutional context in Ethiopia is not encouraging the role of NGOs in this type of long-term commitment. For the time being technical assistance under bilateral aid would appear more appropriate.

7.5. POSSIBLE ALTERNATIVES

7.5.1. Building partnerships

The findings reveal that the greatest institutionalised opportunity for physical rehabilitation is through the POCs. Currently the main POC operational activity consists of the provision of appliances, suggesting that the role of physiotherapy care from the very beginning and in parallel to the manufacturing of appliances has been seriously under-estimated. The ICRC willingness for a partnership with Handicap International is strong as the latter could play a strong role in mentoring the newly graduated physiotherapists at POC level, in part to create an enabling environment for practice. Although one may argue that this approach is too restrictive, the development of good practices in the field of physiotherapy care and at POC level may be the most realistic given the current resource-constrained environment. Nevertheless support to the POCs raises a key issue, that while the political commitment is there, to sustain activities after the initial boost from World Bank is not ensured with the risk that the POCs become “white elephants”.

Other types of partnerships could be built upon taking into account the value of HI in the field of physiotherapy. On the one hand, the work at the highest referral level of hospital care, such as regional level where implementing physical rehabilitation will be linked to orthopaedic or surgical wards, could be considered. For instance the RHB of Awassa, which seems very dynamic and has a well-established collaboration with a number of NGOs, is looking for developing a working environment in the field of physiotherapy in the newly regional hospital. On the other hand, the Regional Counselor of

the French Embassy pointed out to a potential collaboration on a surgical project with the NGO *Médecins du Monde*.

***The future HI strategy must be framed within the local context and experience. Considering the current trend, Handicap International could focus on getting back to what most of the stakeholders value the NGO for, i.e. technical support to physiotherapy care. The approaches highlighted above are far from perfect but possibly the most feasible within the current institutional set up. These alternatives require to be carefully evaluated against a framework for partnership with institutional stakeholders, ICRC or* Médecins du Monde.**

7.5.2. Acting as a catalyst

Physical disability has not emerged yet as a national priority. Although there is a limited evidence-based and sound data of the changing disease patterns, Ethiopia may be experiencing a "double burden of disease" (persisting infectious diseases co-existing with emerging non-communicable diseases). However, this is not reflected in current health planning. Generating the essential commitment of donors and policy-makers to disability prevention and control would require community-based data on prevalence, impact and costs to convince them that it is a relevant problem.

Among the factors that shape whether an issue rises to the attention of policy-makers is the presence of a clear, measurable indicator to mark the issue because it has a powerful effect of giving visibility to that which had remained hidden, serving not just as monitoring purposes, but also as catalyst for action. A second factor depends on the presence of individuals and organizations committed to the problem and how their work at micro-level could be used to inform and influence health policy and practice at macro-level. May be the natural starting point is measures to raise awareness amongst policy-makers of the importance and threat from physical disabilities.

In that sense, Handicap International should embark on an effort to mobilize policy-makers, UN agencies (WHO, ILO, UNICEF) in service of disabilities. Advocacy, in collaboration with the MoLSA, other NGOs and the civil society through DPOs, is needed to put the problem on the agenda, and to influence and lobby for decisions. These advocacy efforts should also target multilateral and bilateral donors as part of MDGs and poverty reduction strategies.

ANNEX 1. MAP OF ETHIOPIA

ANNEX 2. TERMS OF REFERENCE

EVALUATION EXTERNE : APPUI ET RENFORCEMENT DU DEVELOPPEMENT DE LA READAPTATION FONCTIONNELLE EN ETHIOPIE, 1994 – 2004

A/ Présentation des projets d'appui au développement de la réadaptation fonctionnelle en Ethiopie

1) Contexte / Situation
Cette évaluation a pour cadre l'Ethiopie, pays peuplé de 70 Millions d'habitants.
En matière de santé, la couverture de la population est de 51%. Moins de 5% de la population handicapée a accès à des services de soins en terme de réadaptation fonctionnelle. Handicap International intervient en Ethiopie depuis 1987. Les projets menés ont d'abord été orientés vers la réadaptation à base communautaire (RBC) pour les personnes handicapées (développement des activités de réadaptation, de réintégration socioprofessionnelle et de sensibilisation; microprojets générateurs de revenus). Ces projets ont été à l'origine de l'élaboration d'un projet national de prévention des handicaps physiques, par la mise en place d'unités de réadaptation dans 11 hôpitaux, projet développé en partenariat avec la RaDO, ONG éthiopienne, (Rehabilitation and Development Organisation), de 1996 à 2000.

Ces 2 projets avaient un objectif général commun qui était d'améliorer les conditions de vie de la population habitant dans les zones ciblées en développant des services de réadaptation de proximité pour les personnes handicapées et en diminuant le risque de séquelles invalidantes pour l'ensemble de la population. Tous deux s'inscrivaient dans une même dynamique qui avait pour ambition de faire reconnaître par la population et les professionnels de la Santé, l'importance du processus de réadaptation fonctionnelle, de la période d'hospitalisation au retour au sein de sa communauté.

2) Acteurs impliqués
Les personnes handicapées physiques et leurs familles habitant dans les zones ciblées par le projet
Les personnes hospitalisées
Le personnel du Ministère des Affaires Sociales et des 11 hôpitaux affectés sur ces projets et qui ont suivi les formations.
Les cadres de la « Rehabilitation Agency » basés en capitale et au niveau des régions concernées (qui ont piloté le projet depuis sa conception jusqu'à son évaluation).
Les Directions des bureaux régionaux et zonaux du Ministère de la Santé et les Directions des 11 hôpitaux.
Le personnel de la RaDO.
Handicap International qui a apporté un appui technique, financier, méthodologique et organisationnel
B / Evaluation des Effets actuels de ces projets

1) Justification
Suite à l'expérience acquise en Ethiopie, nous sommes favorables à étudier une nouvelle stratégie d'intervention mais il nous apparaît nécessaire aujourd'hui de pouvoir évaluer les effets de ces projets vis-à-vis du contexte éthiopien actuel avant de se lancer à nouveau dans une phase plus active.

Plusieurs options (en termes d'évolutions stratégiques) sont possibles afin de re-positionner Handicap International dans le champ de la réadaptation fonctionnelle :
Une approche technique d'expertise qui reposerait sur les compétences acquises et mobilisables par Handicap International pour renforcer les compétences des professionnels éthiopiens de la réadaptation.
Une approche systémique qui reposerait sur la capacité d'Handicap International à appréhender le système de réadaptation fonctionnelle dans son ensemble. (ensemble des acteurs médicaux, sociaux, de réadaptation, professionnels, communautaires et associatifs…) dans une perspective de structuration et d'amélioration de l'offre de service de réadaptation.

Deux hypothèses pour lesquelles nous attendons de l'évaluation d'apporter des éléments d'analyse sont formulées:
Une approche uniquement régionale créerait un déséquilibre, des disparités régionales dommageables.
Une approche systémique est essentielle pour développer et améliorer les services de réadaptation pour les personnes handicapées et diminuer les risques de séquelles invalidantes pour l'ensemble de la population; une approche purement technique ne suffit pas.

Objectifs
L'objectif principal de cette évaluation est de mesurer les effets indirects obtenus plusieurs années après leur clôture.

Objectif pour les deux projets
L'objectif principal est de mesurer les effets indirects obtenus plusieurs années après la clôture des projets principaux développés par la Rehabilitation Agency et le Ministère de la Santé en collaboration avec Handicap International au niveau des communautés (personnes handicapées, leurs familles, associations locales), des services et structures de réadaptation fonctionnelle (hôpitaux, centres, ateliers), des instances dirigeantes et des pouvoirs publics (Ministère des Affaires Sociales, de la Santé et de l'Education, les directions des onze hôpitaux, facultés de médecine, etc)
Objectifs pour l'ONG demandeuse
Réaliser l'évaluation des effets d'une dizaine d'années d'intervention dans le secteur de la réadaptation fonctionnelle en Ethiopie permettrait à Handicap International de :

Avoir une vision plus macro des résultats obtenus, confronter et croiser ces résultats avec le contexte actuel ainsi que les perspectives en la matière et, en tirer les conséquences pour pouvoir mieux définir une stratégie future permettant de répondre à l'objectif général: Améliorer la qualité et l'accès des services de réadaptation aux personnes nécessiteuses.
Recueillir et structurer les bénéfices d'une telle expérience afin de pouvoir en faire profiter d'autres programmes concernés par cette même problématique
Dans le cadre de son rôle d'appui/conseil actuel, apporter aux autorités éthiopiennes concernées par le secteur une base de réflexion s'appuyant sur une étude apportant une vision large et complète de la situation actuelle.

2) Objet de l'évaluation
a) Période
L'évaluation portera sur les effets des deux projets mis en œuvre de 1994 à 2000.

b) Questions.
Les questions suivantes sont données à titre indicatif et leur liste n'est pas exhaustive. L'évaluateur devra s'en inspirer et en rechercher de nouvelles pour parvenir à apprécier au mieux chaque niveau de cette l'évaluation

Questions relatives à la population éthiopienne :
Au niveau de la population habitant dans les zones ciblées par les projets : Quel est le niveau de connaissance et de compréhension de l'utilité des services développés ? Types de services et pour quoi ? Quel est le regard porté par la population sur les bénéficiaires de ces services ? Ce regard s'est il modifié au cours des dernières années ? Si oui, quelles sont les raisons de ces changements ?

Au niveau des personnes handicapées et de leurs familles : Comment perçoivent-elles la création de nouveaux services de réadaptation développés dans leur intérêt ? Ce soutien a t-il apporté des modifications importantes dans leur vie quotidienne ? Si oui, quels types de modifications ? Si non, quels ont été les obstacles à ces modifications ?

Au niveau des personnes ayant été hospitalisées : Ont-elles participé, subi ou été indifférentes aux soins de réadaptation fonctionnelle ? Ces personnes considèrent-elles ces soins comme faisant pleinement partie de leur traitement ? Souhaiteraient-elles voir se développer ce type de soins ?

Questions relatives au personnel travaillant dans les structures et services de réadaptation fonctionnelle développés par les 2 projets
Au niveau des professionnels de la réadaptation formés : Comment considèrent ils leur activité professionnelle ? En quoi cette profession leur semble différente ou pas des autres ? Ont ils eu des difficultés à se faire reconnaître en tant que professionnel dans une nouvelle discipline ? Ressentent-ils le besoin, l'envie ou la nécessité de défendre leur activité professionnelle auprès de leurs supérieurs ? Ces personnes bénéficient-elles aujourd'hui d'une reconnaissance officielle ou non officielle de leur statut de professionnels de la réadaptation ? Sont-elles demandeuses d'une autre forme de reconnaissance ? Souhaitent t-elles poursuivre dans le secteur de la réadaptation et suivre des formations complémentaires ?

Au niveau des Directions des hôpitaux et des responsables de projets RBC : Les Directions des hôpitaux sont ils aujourd'hui mieux préparés à recevoir du personnel spécialisé en réadaptation fonctionnelle ? Si oui, en quoi le sont-ils ? Si non, que leur faudrait-il pour se sentir mieux préparé ? Quels sont les types de difficultés ressentis par ces responsables de service ou de structures ? Sont-ils en lien avec le fait qu'ils travaillent dans un secteur peu connu ? Que pensent-ils qu'il serait nécessaire de faire pour apporter des solutions à ces difficultés ?

Au niveau des autorités zonales et/ou régionales des Ministères de la Santé et des Affaires Sociales : Les autorités locales ayant été impliquées dans ces 2 projets sont-elles aujourd'hui plus actives dans le développement d'un tel secteur dans leur région ? Si oui, de quelles façons cela se traduit-il ? Si non, pourquoi ? Comment perçoivent elles aujourd'hui le développement de la réadaptation fonctionnelle ? Perçoivent-elles ce secteur comme prioritaire ou non au sein de la santé publique ? Si oui, que font-elles pour parvenir à lui donner plus d'importance ?

Questions relatives aux responsables des instances dirigeantes
Vis-à-vis du développement d'une politique nationale en faveur des personnes handicapées : Quels sont les freins et les obstacles du développement d'une telle politique au niveau national ? En quoi ces 2 projets ont favorisé ou ont empêché le développement de cette politique ?

Vis-à-vis du développement de l'intégration du secteur de la réadaptation fonctionnelle au sein d'une politique nationale de santé publique : Quels sont les freins et les obstacles du développement de l'intégration du secteur de la réadaptation fonctionnelle au sein d'une politique nationale de santé publique ? En quoi ces 2 projets ont favorisé ou ont empêché le développement de cette intégration ?

Vis-à-vis du développement d'un programme national de formation des professionnels de la réadaptation fonctionnelle : Existe t-il une réelle volonté des instances dirigeantes au niveau national pour favoriser la reconnaissance des formations et des nouveaux professionnels ? Quelles sont les perspectives d'avenir dans ce domaine ? Peut-on espérer observer un profond changement ou un signe d'espoir dans un proche avenir ? En quoi les formations de professionnels de la réadaptation développées à des niveaux basiques ont-elles favorisé le développement d'un programme national en terme de formation diplômante ?

Public cible
Seront consultés prioritairement les bénéficiaires indirects concernés par l'évolution de l'offre de soins en Ethiopie avec et/ou impliqués dans la mise en place des services de réadaptation (représentants des autorités zonales et / ou régionales des ministères de la Santé et des Affaires sociales, et des instances dirigeantes concernées
Seront ensuite consultés les bénéficiaires directs des activités mises en œuvre (personnes hospitalisées ayant reçu des soins de rééducation et/ou des aides techniques et / ou appareillages, personnel ayant bénéficié des formations dans les structures et services de réadaptation mis en place dans le cadre des 2 projets, personnes handicapées et leur famille, directeurs des hôpitaux, etc…)

c) Résultats attendus
Apporter des éléments de réflexion permettant de clarifier le rôle et la place de Handicap International dans le développement futur du secteur de la réadaptation fonctionnelle d'une part en mesurant les effets directs et indirects des activités mises en œuvre dans le cadre des 2 projets développés en terme quantitatifs et qualitatifs et d'autre part en émettant des recommandations au regard des conclusions de l'évaluation, afin, le cas échéant, de préparer les bases d'un accompagnement futur et d'une nouvelle stratégie d'appui conseil en terme de réadaptation.

d) modalités
D'une façon générale, cette évaluation sera réalisée de façon participative afin de favoriser au maximum l'implication des acteurs dans cette étude

3) Méthodologie
a) Lors de la mission d'évaluation
L'équipe d'Handicap International en Ethiopie s'assurera de mettre à disposition une sélection de documents clés à l'expert consultant.

Un état des lieux sera réalisé par une personne recrutée localement, spécialement à cet effet. L'objectif de cet état des lieux sera de récolter toutes les informations nécessaires à la compréhension / actualisation du système de la réadaptation dans le pays, et ainsi, de repérer les acteurs locaux et internationaux actifs dans le domaine.

Lors de la mission d'évaluation proprement dite, et *pendant toute la durée de l'expertise (),* cet assistant secondera l'expert consultant afin de lui faciliter le bon déroulement de sa mission :
Organiser l'identification, et le recrutement des enquêteurs et des traducteurs sur le terrain et participer à leur formation complémentaire
préparer le planning prévisionnel de l'expert consultant
coordonner l'organisation logistique
Aider le consultant expert dans sa compréhension d'un système (et d'un pays) complexe.

Rôle de l'expert consultant:
Prendre connaissance des documents nécessaire à la compréhension du contexte et relatifs aux sujets à aborder ;
Proposer et/ou adapter les outils et méthodes d'évaluation correspondant aux résultats attendus (en restant vigilant aux délais à respecter pour une traduction des documents nécessaires à l'évaluation en anglais et en amharique pour les enquêteurs si nécessaire) ;
Concevoir et mettre en œuvre avec l'appui de l'assistant la formation des enquêteurs à la démarche et aux outils d'évaluation retenus par l'évaluateur en adéquation avec leurs qualifications initiales .
Rencontrer les partenaires et interlocuteurs pressentis
Saisir et traiter les informations collectées par les équipes d'enquêteurs et transmises par l'assistant
Coordonner le déroulement des enquêtes
Rendre compte en fin de mission sur place des premiers éléments d'analyse et des recommandations envisagées
Secteur géographique et déroulement de la mission
L'évaluateur interviendra sur 4 sites à visiter (en rapport avec les projets développés) : Gonder-Axum, Dire Dawa – Jijiga, Sodo-Arba Minch et Nazreth-Asela.
La durée des visites sur chaque site sera variable en fonction des temps de déplacements et du nombre d'interlocuteurs à rencontrer.
b) Lors de la restitution
Au terme du travail d'évaluation proprement dit, l'expert consultant devra rédiger :
- Un Aide mémoire qui servira de support à une restitution en présence de quelques interlocuteurs clés, organisée à Addis Ababa). L'objectif sera de rendre compte des premiers éléments d'analyse et de recommandations.
- Un premier rapport présenté au siège de Handicap International, en présence de représentants du F3E.
Un rapport Final (rédigé en anglais) qui intégrera les dernières remarques.

4) Ressources
1 consultant chargé de la mise en œuvre et de la coordination de l'ensemble de l'évaluation assisté d'un homologue local recruté spécifiquement pour l'évaluation. Ce binôme sera assisté de 8 enquêteurs (2 par site) et de traducteurs.
Tous travailleront sous la responsabilité de la Directrice de Programme HI.
Le profil de l'expert consultant recherché est :

Compétences requises :

Connaissance et expérience confirmée de l'évaluation de projets de développement, compétences dans le domaine de la Santé Publique, sont exigés.
Bonne connaissance du milieu du Handicap concernant les domaines « Réadaptation Fonctionnelle » et « Droits et Politiques en faveur des personnes handicapées », Expérience confirmée de gestion de projet de développement à l'étranger dans le secteur du Handicap et des problématiques s'y référant sont fortement souhaités.
Bon niveau d'anglais écrit, lu et parlé.

Autres Compétences désirées : Connaissance de l'Ethiopie, bonnes capacités d'adaptation et d'écoute d'un environnement culturel différent, bonnes capacités rédactionnelles en anglais de façon prioritaire ou en français.

Le profil de l'assistant

5) Calendrier de l'évaluation
L'évaluation devra avoir lieu fin septembre / début octobre. Sa durée sera de 30 jours travaillés (*2 jours d' analyse documentaire, 22 jours terrain, 5 jours pour la rédaction rapport et 1 jour pour restitutions en France*).

La remise du rapport provisoire devra intervenir 2 semaines après la fin de la mission terrain. *Au moins deux déplacements au siège HI Lyon sont à prévoir avant départ et pour restitution au retour* . Le rapport final, incluant les commentaires et remarques de HI et du F3E devra être transmis au plus tard 2 mois après la fin de la mission ; soit fin juillet ou fin août

ANNEX 3. SCHEDULE OF ACTIVITIES THE PREPARATORY WORK

Weeks	Activities
Week 1	Document review Interview with contact persons: Ato Yiberta Taddesse, RaDO Mr Jo Naglas, ICRC Miss Solonne Chuppin, POC Ato Yohannes Tadesse, MoH Ato Tigabu G/Medhin, CBR network
Week 2	Document Review Interview with contact persons Ato Desalgn Samuel, MoE Ato Assefa Ashengo, MoLSA Ato Almstehay Maru, ex- CBR worker in Nazreth Travel to Axum: contacting the Medical Director, the trained nurses and the hospital administrator Travel to Gondar: contacting the physiotherapist training coordinator, University
Week 3	Travel to Jimma: contacting the Medical Director, the trained nurses and the technicians
Week 4 and 5	Travel to Nazreth and Assela: contacting the project coordinators Travel to Awasa: contacting the RHB
Week 6	Travel to Sodo: contacting the hospital medical director, the trained physiotherapists and the technicians. Report preparation

ANNEX 4. STAKEHOLDER ANALYSIS: IDENTIFICATION OF PEOPLE AND GROUPS, THEIR INTEREST, IMPORTANCE AND INFLUENCE

Stakeholder Groups	Interest at stake in relation to project or priority concerns of stakeholders	Importance of stakeholders for success of projects U= unknown 1 = little importance 2 = some importance 3 = moderate importance 4 = very important 5 = critical player	Degree of influence of stakeholder over projects U = unknown 1 = little influence 2 = some influence 3 = moderate influence 4 = significant influence 5 = very influential
HBPR services			
Federal Ministry of Health	Increased service delivery for the disabled	4 (for approval of project)	1
Regional Health Bureaux	Achievement of targets	4 (for project design)	2
	Increased service delivery for the disabled		
	Increased access for disabled persons		
Medical Director	Control over resources	5	4
	Access to additional resources		
	Increased bed-capacity		
	Increased hospital services		
	Increased hospital reputation		
	Availability of trained personal		
Hospital Administrator	Control over resources	5	5
	Access to additional resources		
Nurses and health assistants[21] trained	New learning opportunities	5	4
	Increased understanding of disabled needs		
	Increased range of skills		
	Improved collaboration with doctors		
	Recognition from the patients		
	Recognition from the public health system/structure		
	Career development		
	Salary increase		
Technicians trained	Increased understanding of disabled needs	4	4
	Increased range of skills		
	Recognition from the patients		
	Recognition from the public health system/structure		
	Career development		
	Salary increment		

[21] The nurses have at least two years of formal training after secondary school. Health assistants typically have one year of formal technical training.

Handicap International	Promote the recognition for these services among health professionals and beneficiaries	4	4 (during the 18-month implementation period) 1 after hand-over
RaDO representative	Promote the recognition for these services among health professionals and beneficiaries	5	5 (during the 18-month implementation period) 1 after hand-over
CBR Project			
Ministry of Labour and Social affairs/Rehabilitation Agency	Increased technical, logistical and financial support	5	4
Regional BoLSA	Control over resources Increased availability of resources	5	5
CBR coordinator and workers	Opportunity for learning new skills	4	4
	Increased recognition from the institutional structure		
	Increased recognition from the beneficiaries		
Trained technicians	Opportunity for learning new skills	4	4
	Increased recognition from the beneficiaries		
Handicap International	Increased the recognition of functional rehabilitation among the population	5	5 (during the implementation period) 1 after hand-over

ANNEX 5. BIBLIOGRAPHY

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ANNEX 6. QUESTIONNAIRE FOR KEY INFORMANT INTERVIEW

Head of BoLSA

Before starting the interview, the interviewer will introduce himself/herself and present the purpose of the interview. He/she will also mention (i) the objective of the 1-day workshop in Addis Ababa and; (ii) the fact that the information will remain confidential and will only be used for analysis of results. The interview should not take more than one hour.

Region Name: …….
Respondent Name': ……..……..
Position: …….
Time spent in this position ……...
Date:……..……...
Place of interview: ……
Name of interviewer: ……

B01. Based on the regional assessment, what are the key priorities in relation to disability?

B02. How has the current national policy integrated the need of disabled persons?

B03. In your understanding, what does disability encompass?

B04. What is the type and magnitude of disability in the region?

B05. What are the existing services available to disabled in the region?

B06. Where are located those services?

B07. Who is delivering them (INGOs, local NGOs, GoE, associations, others)?

B08. How does BoLSA collect data on disability? (on the causes, location, etc.)?

B09. How does BoLSA monitor the implementation of projects targeting disability?

B10. In your opinion, what should be the strategy to minimize disabilities?

B11. What is the type of network and links between the BoLSA and other stakeholders such as Federal Ministry of Health and Federal Ministry of Education?

B12. What is the current status of CBR project previously supported by Handicap International and the Rehabilitation Agency?

B13. To what extent had the BoLSA been involved in each phase of project design (including needs assessment, implementation, monitoring and evaluation)?

B14. To what extent the BoLSA benefited from the project?

B15. Which type of constraints did the BoLSA face in implementing this project?

B16. What would be your main recommendations for a similar type of project?

CBR Project Coordinator

Before starting the interview, the interviewer will introduce himself/herself and present the purpose of the interview. He/she will also mention (i) the objective of the 1-day workshop in Addis Ababa and (ii) the fact that the information will remain confidential and will only be used for analysis of results. The interview should not take more than one hour.

Name of the respondent: ……...
Position: …….
Time spent in this position ……...
Date:…….……...
Place of interview: ……
Name of interviewer: ……

C01. What is the type of support the project is currently providing to disabled persons?

C02. Who are the target beneficiaries?

C03. What is their profile in terms of socio-economic status?

C04. What are the main strategies used to implement the project?

C05. What are the main partners involved in the project?

C06. Can you describe the main changes from the project beginning up to date? (in terms of objectives, human and financial resources, etc…..)

C07. To what extent has the project benefited from HI support?

C08. What are the main constraints in implementing this type of project?

C09. What would be your main recommendations in relation to a similar type of project?

HEAD OF REGIONAL HEALTH BUREAU (RHB)

Before starting the interview, the interviewer will introduce himself/herself and present the purpose of the interview. He/she will also mention (i) the objective of the 1-day workshop in Addis Ababa and; (ii) the fact that the information will remain confidential and will only be used for analysis of results. The interview should not take more than one hour.

Region Name: ……
Respondent Name': ……..……..
Position: …….
Time spent in this position ……...
Date:…….……...
Place of interview: ……
Name of interviewer: ……

RHB01. How is the health structure organized in the Region?

RHB02. Based on the regional assessment, what are the key priorities in relation to health?

RHB03. How has the current health policy integrated the need of disabled persons?

RHB04. What is the type and magnitude of disability in the region?

RHB05. What are the existing physical rehabilitation services available in the region?

RHB06. Where are located those services?

RHB07. Who is delivering them (INGOs, local NGOs, GoE, associations, others)?

RHB08. How does the RHB collect data on disability? (on the causes, location, etc.)?

RHB09. How does the RHB monitor the implementation of projects targeting disability?

RHB10. In your opinion, what should be the strategy to minimize disabilities?

RHB11. What is the type of network and links between the RHB and other stakeholders such as Ministry of Social Affairs and Federal Ministry of Education?

RHB12. What is the current status of the previous Handicap International (HI)/RaDO project?

RHB13. To what extent had the RHB been involved in each phase of project design (including needs assessment, implementation, monitoring and evaluation)?

RHB14. To what extent the RHB benefited from HI projects?

RHB15. Which type of constraints did the RHB face in implementing this project?

RHB16. If a similar type of project was to be implemented in the future, what would be your main recommendations?

HOSPITAL MANAGEMENT TEAM (Medical Director and/or Administration Manager)

Before starting the interview, the interviewer will introduce himself/herself and present the purpose of the interview. He/she will also mention (i) the objective of the 1-day workshop in Addis Ababa and (ii) the fact that the information will remain confidential and will only be used for analysis of results. The interview should not take more than one hour.

Name of the respondent: ……...
Position: …….
Time spent in this position ……...
Date:…….……...
Place of interview: ……
Name of interviewer: ……

Hospital's name: ……
Bed-capacity: ……
Number of patients hospitalised at the time of the visit: …….
Type of hospital: ……..
Type of services offered: ……
……..
……..

HM01. What are the main health priorities targeted within the hospital?

HM02. What are the main financing sources for the hospital? (GoE budget, user fees, cost-recovery)

HM03. What are the current physical rehabilitation services offered in the hospital?

HM04. Who are the stakeholders involved in implementing this rehabilitation project?

HM05. What is the current demand for physical rehabilitation services?

HM06. What is the current situation with the physiotherapy department?

HM07. How is the department integrated into current hospital services?

HM08. To what extent had the hospital been involved in project design? (needs assessment, implementation, monitoring and evaluation…..)?

HM09. To what extent did the hospital benefit from HI project?

HM10. Which type of constraints does the hospital face in implementing this type of project?

HM11. In our opinion, what should be the strategy to minimize disabilities?

HM12. In your opinion, what should be the role of the respective ministries (Labour and Social Affairs, Education and Health) in addressing disabilities?

HM13. What are the hospital future plans regarding the HBPR services?

HM14. If a similar type of project was to be implemented in the future, what would be your recommendations?

ANNEX 7. INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSIONS (FGD)

Trained CBR workers and technicians

Before starting the FGDs, the interviewer will introduce himself/herself and present the purpose of the interview. He/she will also mention (i) the objective of the 1-day workshop in Addis Ababa and (ii) the fact that the information will remain confidential and will only be used for analysis of results. The FGD should not take more than two hours.

Date:……..……...
Place of interview: ……..
Number of participants involved in the FGD: …….
Name of participants: …….
……
……
Name of interviewer: ……
……

Checklist of topics to be explored:

How was the selection process for the training course?

What were the main motivations for joining the training course? (better understanding of people with disabilities, search for new learning opportunities)

What have been the main benefits of HI support? (improved management of disabilities, better understanding on the impact of disabilities, recognition from BoLSA and from the communities, improved relationships with beneficiaries, increased access to appliances through cost recovery)

What have been the main limitations of this support? (lack of financial sustainability, lack of awareness from BoLSA, lack of proper follow-up/supervision, no recognition for the new training, workload, lack of referral system, poor collaboration with other institutions)

What would be your recommendations in relation to a similar project?

Trained health staff and technicians

Before starting the FGDs, the interviewer will introduce himself/herself and present the purpose of the interview. He/she will also mention (i) the objective of the 1-day workshop in Addis Ababa and (ii) the fact that the information will remain confidential and will only be used for analysis of results. The FGD should not take more than one hour and half.

Date:……..……...
Place of interview: ……..
Number of participants involved in the FGD: …….
Name of participants: …….
……
……
Name of interviewer: ……
……

Checklist of topics to be explored:

How was the selection process for the training course?

What were the main motivations for joining the training course? (better understanding of people with disabilities, search for new learning opportunities)

What have been the main benefits of the training ? (improved management of disabilities, better understanding on the impact of disabilities, recognition from the public and from the government health system, opportunities for salary supplement, for career development and private activities, improved relationships with doctors and patients)

What have been the main limitations in implementing your new skills? (lack of financial support including equipment and incentives, lack of awareness from the hospital managers and doctors, limited demand, lack of proper follow-up/supervision, no recognition for the new training, increased workload)

What would be your recommendations in relation to this type of project?

ANNEX 8. BENEFICIARY'S QUESTIONNAIRE

SEMI-STRUCTURED INTERVIEW (CBR beneficiary)

Before starting the interview, the interviewer will introduce himself/herself, present the purpose of the interview and ask for permission to proceed. He/she will also stress that all the information will remain confidential and will only be used for analysis of results. The interview should not take more than one hour.

Date:…….
Place of interview ……..
Name of interviewer: ……..
Respondent Name: ……
Place of residence during the project period: ……..

RESPONDENT PROFILE					
CBR1. Sex	CBR.2. How old are you?	CBR.3. How many members are currently living in this household?	CBR.4. What is your marital status?	CBR.5. What is your level of education?	CBR.6. What is your main source of income?
1. Male 2. Female			1. Married 2. Single 3. Widow 4. Divorced/Separated 5. Not applicable 6. Others (Specify): ……..	1. Illiterate 2. Primary education 3. Secondary education 4. Tertiary education 5. Others (Specify) ……	1. Formal sector 2. Informal sector 3. Jobless 4. Pension 5. Support from relatives 6. Others (Specify): ……..

EXPOSURE TO THE CBR PROJECT AS A BENEFICIARY						
CBR.7. What is your main disability problem? (Different answers are possible. Circle all)	CBR.8. What type of support did you receive from the project? (Different answers are possible. Circle all)	CBR. 9. When did you get this support?	CBR.10. Did you access this support for free?	CBR.11. Can you tell us the average amount you spent to access this support?	CBR.12. Was the support helpful to you?	CBR.13. Can you describe how this support was helpful? (Different answers are possible. Circle all)
1. Hand/arm problem 2. Leg problem 3. Hearing/speaking disabilities 4. Total blindness 5. Partial blindness 6. Leprosy	1. Access to education 2. Vocational training 3. Access to income generating activities 4. Counselling 5. Physiotherapy services		1. Yes (Go to 12.) 2. No (Go to 11.)		1. Yes (Go to 13) 2. No (Go to 14) 3. Other (Specify) ……..	1. The support provided me with increased access to jobs 2. The support improved the relationships with the community 3. The support helped me

7. Intellectual disabilities 8. Other types (Specify) …… ……	6. Orthopaedic appliances 7. Awareness & information sessions 8. Others …… ……					psychologically 4. The support increased my participation into social events 5. The support helped me to improve my autonomy in daily activities 6. The support provided me with increased access to education 7. Others (Specify) ……

	BENEFICIARY'S CURRENT SITUATION AS A COMMUNITY MEMBER		
CBR.14. Can you describe why this support was not helpful? **(<u>Open question</u>)**	CBR.15. In your daily life are you still experiencing obstacles due to your situation?	CBR. 16. Please describe in details the obstacle(s) you are facing.	CBR.17. What will be your recommendations to a similar type of project in relation to your situation?
	1. Yes (Go to 16) 2. No (Go to 17)		

Interviewer's observations and comments

SEMI-STRUCTURED INTERVIEW (HBPR beneficiary)

Before starting the interview, the interviewer will introduce himself/herself, present the purpose of the interview and ask for permission to proceed. He/she will also stress that all the information will remain confidential and will only be used for analysis of results. The interview should not take more than one hour.

Date:…….
Place of interview: ……..
Name of interviewer: ……..
Respondent Name: ……

RESPONDENT PROFILE					
01. Sex	02. How old are you?	03. How many members are currently living in this household?	04. What is your marital status?	05. What is your level of education?	06. What is your main source of income?
1. Male 2. Female			1. Married 2. Single 3. Widow 4. Divorced/Separated 5. Not applicable 6. Others (Specify): ……..	1. Illiterate 2. Primary education 3. Secondary education 4. Tertiary education 5. Others (Specify) ……	1. Formal sector 2. Informal sector 3. Jobless 4. Pension 5. Support from relatives 6. Others (Specify): ……..

EXPOSURE TO HEALTH SERVICES AS A PATIENT						
07. What is your main disability problem? (Different answers are possible. Circle all)	08. What type of services did you receive at the hospital? (Different answers are possible. Circle all)	09. Did you get these services for free?	10. Can you tell us the average amount you spent for these services?	11. Were these services helpful to you?	12. Can you describe how these services were helpful? (Different answers are possible. Circle all)	13. Can you describe why these services were not helpful? (Different answers are possible. Circle all)
1. Hand/arm problem 2. Leg problem 3.Hearing/speaking disabilities 4. Total blindness 5. Partial blindness 6. Leprosy 7. Intellectual disabilities 8. Other types (Specify) …… ……	1. Massages 2. Exercises 3. Crutches 4. Walking aids 5. Wheelchair 5. Others …….	1. Yes (Go to 11.) 2. No (Go to 10.)		1. Yes (Go to 12) 2. No (Go to 13) 3. Mixed	1. The services provided me with increased access to jobs 2. The services improved the relationships with the community 3. The services helped me psychologically 4. The services increased my participation into social events 5. The services helped me to improve my autonomy in daily	1. The staff did not have knowledge on my problem 2. Trained staff were not available 3. The staff showed negative attitudes towards my problem 4. The staff paid no attention to my problem 5. The costs for the services were expensive

					activities 6. The services provided me with increased access to education 7. Others (Specify) ……	6. There was no follow up after leaving the hospital 7. Others (Specify) …….

PATIENT'S CURRENT SITUATION AS A COMMUNITY MEMBER			
14. In your daily life are you still experiencing obstacles due to your situation?	15. What are these obstacles? (Different answers are possible. Circle all)	16. Please describe in details the obstacle(s) you are facing.	17. What will be your recommendations to public health services in relation to your situation?
1. Yes (Go to 15) 2. No (Go to 17)	1. Lack of job opportunities 2. Stigma in relation to my disability 3. Lack of proper health services for disability 4. Lack of follow-up 5. Others (Specify): ……		

Interviewer's observations and comments

ANNEX 9. PERSONS MET AND SCHEDULE OF THE MISSION

January 2006

Sunday, 22	Travel Toulouse – Addis Ababa
Monday, 23	Document review Briefing with Vanessa Rousselle (HI Country Representative), Bethelehem Zwede (HI Deputy Country Representative), and Habtamu Demele, national assistant for the evaluation Methodology design
Tuesday, 24	Methodology design (continued) Tools development and translation
Wednesday, 25	Search for document review: University of Addis Ababa and World Bank libraries Finalizing data collection tools, including translation of questionnaire
Thursday, 26	Travel to Axum (by plane) Introduction meeting with Dr Abdulkadir FMoHamed, Director, St Mary Hospital, Axum Introduction meeting with Mr Haïlé Kidane, Trained physiotherapist, HI/RaDO Unit, St Mary Axum Hospital Training Mr Alene Meressa, male data collector Identifying one female data collector
Friday, 27	Training Ms Askale Adana , female data collector Key informant interview with Dr Abdulkadir FMoHamed Said, Medical Director, St Mary Hospital, Axum Observation: visit of the hospital Pre-testing patient questionnaire Purposive sampling for discharged disabled patients through record searching FGD with M. Haïlé Kidane, Trained physiotherapist and M. Kindeya Bezabeh, Trained technician. Search for hospital beneficiaries in Okrow/ interview
Saturday, 28	Beneficiary searching and interview in Tataimajo rural area Beneficiary searching and interview in Aksum town
Sunday, 29	Continued beneficiary searching in Aksum town and data collection for half a day Data analysis Assistant's debriefing on key informant interviews
Monday, 30	Travel to Addis Ababa Final arrangements for logistics and workshop
Tuesday, 31	Travel to Jimma (by car) Meeting of the evaluation team for planning data collection in Jimma

February 2006

Wednesday, 01	Arranging meetings with key informants Observation: Jimma Specialized hospital Meeting with the local administration (Jimma town and Zonal) for general data information FGD with Mrs Yeshi Terefe and Mrs Meseret Tadese, Nurse-trained physiotherapists; Mr Ankosa Keni and Waqshum Tadesse, Trained technicians. Key informant interview with Dr Tsinuel Girma, Medical Director Training of Mr Netsanet Negusse and Ms Miraf Mesele, data collectors Debriefing among the evaluation team
Thursday, 02	Purposive sampling for discharged disabled patients through hospital record searching Meeting with the acting deputy director of Cheshire Foundation Key informant interview with Mr Tadesse Getahun, Hospital Manager Continued beneficiary interview in Jimma town
Friday, 03	Discussion with the local FMoLSA team Searching for beneficiaries: contact with local administrations and health centres in Yebu, Ghembe and Agaro *Woredas* Conducting interviews
Saturday, 04	Data analysis
Sunday, 05	Travel to Addis Ababa
Monday, 06	Travel to Dire Dawa Arranging meetings with RHB and hospital staff representatives Meeting with Mr Febade Girma, Assistant Project Manager, HI Office in Dire Dawa Key informant interview with Mr Ahmed FMoHammed, BoLSA representative Meeting with Dr Tsegereda Klife, Head of Health Council Finalizing data collection tools for the CBR project, including questionnaire translation

Tuesday, 07	Discussion with Mr Habte Tefaye, trained technician Observation: hospital visit Key informant interview with Dr Omar Mohammed, Acting Medical Director, Dire Chora Hospital Data analysis
Wednesday, 08	Data analysis Meeting with Dr Tsegereda Kifle, Head of Health Council Travel to Addis Ababa Debriefing with HI team
Thursday, 09	Key informant interview with Mr Belay Zeleke, BoLSA Oromiya Region Visit to the FMoH library and to the FMoH health financing department, Addis Abeba Contact with Mr Asefa Ashengo, Head of RA Department, FMoLSA
Friday, 10	Travel to Nazareth Key informant interview with Mrs Aksale Habte, CBR Project Coordinator (under FMoLSA) FGD with trained CBR staff: Mr Tiruneh Negash (physiostherapist assistant), Getachew Asfaw (health worker), Ebabe Gebre (orthopaedic technician), Tilahun Tura (CBR worker), Salomon (leather worker)
Saturday, 11	Training 4 data collectors Data collection (CBR project beneficiaries)
Sunday, 12	Data analysis
Monday, 13	Travel to Sodo Introductory meeting with Dr Abera Geleta, Medical Director, Sodo General Hospital Meeting with Mr Amanuel Otoro Jibo, Wolayta Zone Chief Administrator (Social Affairs) Meeting with World Vision Manager Meeting with IMC Medical Manager
Tuesday, 14	Key informant interview with Mr Matthews Zema, trained health assistant and Mr Haïlé Gebele, trained technician Key informant interview with Dr Abera Geleta, Medical Director, Sodo General Hospital Meeting with Sr Mareshete, Head for Zonal Health Department Meeting with Dr Desalegn Enaro, Director for the Christian Mission hospital
Wednesday, 15	Travel to Awasa Meeting with Dr Alemayehu Belayneh, Planning and Information Services Head, RHB for SNNPR in Awasa Continued travel to Asella
Thursday, 16	Introductory meeting with CBR project coordinator Meeting with Mr Jo Nagels, Head of Project, ICRC Key informant interview with Mr. Leaulseged Hundie, CBR project coordinator FGD with Mr Shube Kaya and Mr. Mekonnen Tadesse, Trained CBR workers Arranging permission for data collection with Zonal FMoLSA
Friday , 17	Training Mrs Lemlem Tibebu, Mrs Kulichwork Tashoma and Mr Sulti Gena, data collectors Data collection in Asella town (CBR project beneficiaries)
Saturday, 18	Data collection in Sagure Data analysis (Sodo)
Sunday, 19	Data analysis (Asella)
Monday, 20	Meeting with Mr. Leaulseged Hundie, CBR project coordinator (phone discussion) Data analysis Travel to Addis Ababa
Tuesday, 21	Meeting with Mr Gebremedhin Bekele, Country Representative, VVAF Ethiopia and Mr David Shehigian, Deputy Director, VVAF Key informant interview with Dr Zenebech Yadete, Deputy Director, Oromiya's RHB for Oromiya Key informant interview with Mr Asefa Ashengo, Head of Rehabilitation Affairs Department, FMoLSA
Wednesday, 22	Workshop preparation, including main agenda and findings presentation
Thursday, 23	Workshop: presentation of findings
Friday, 24	Meeting with Mr. Gilles Landrivon, Regional Counsellor for Health, Embassy of France in Ethiopia Key informant interview with Mr. Azemtsehay Maru, Cheshire Foundation Ethiopia Debriefing with HI team Continued: draft report
Saturday, 25	Travel Addis Ababa – Toulouse

ANNEX 10. MINUTES OF THE WORKSHOP

Morning session:

(1) Bethelehem Zewde, Handicap International Deputy Director, opened the workshop and welcomed everyone. The sixteen participants introduced themselves. Despite an invitation, nobody from the FMOH attended the workshop.
(2) Vanessa Rousselle, Handicap International Country Director, introduced the NGO and the main objectives of the evaluation
(3) The evaluation team (Habtamu Demele and Christine Bousquet) presented the main findings and lessons learned from the evaluation of the two projects.

The key points from the discussion of findings with the participants are summarized below:

- The future plans of HI were asked ant it was explained that this question could not answer immediately and required further strategic planning.
- Gaps in information sharing between the different ministries
- MoE: is involved only with curriculum, and accreditation not with the deployment of graduated physiotherapists
- The HBPR project looked over-ambitious and recommendation was given to better concentrate in specific areas
- Integration of a 3-month basic training is not sustainable as it will not accredited.
- In relation to the physiotherapists who will graduates from Gondar University, there is a lack of placement and mentoring. Instructors are not in place: HI could play an important role as mentor. At the moment there is a yearly intake and no mechanisms to ensure that the graduates will be integrated within the health system.
- Limited awareness between the different ministries that should not duplicate activities but pay due attention to financial support.
- Policy on disability prevention is lacking
- Jimma specialized hospital will have potential for physical rehabilitation with a newly constructed POC and trainees from Tanzania.
- CBR activities are not a main priority but GoE in the future should provide full support.

Afternoon session :

CASE STUDY:

After this assessment has been conducted, you are tasked to design a strategic plan for addressing disabilities in Ethiopia in the context of limited human and financial resources. Given the current situation as previously described, what would be the most realistic and feasible strategy to adopt?

Group 1 presentation:

Key issues to address:
- To strengthen the expansion of CBR including economic issues
- To be geographically limited at regional level
- To be developed in partnership with RHBs, BoLSAs, hospitals, CBR and private actors

How?
- Awareness raising at all levels;
- Identification on the magnitude of the problem and its cause ;
- Integration of CBR course into the curriculum of Development Agents ;
- Mobilization of resources.

Group 2 presentation:

Key issue to address:
- To develop policy and structures at national level
- To Strengthen partnership and integration: collaboration between GoE ministries and NGOs
- To develop human resources: career structure, mobility within career; incentives through continued education in order to retain the staff; continuous assessment of salary; on-job training.
- To raise awareness within different sectors; ministries and within communities
- To train physiotherapist students to train community workers.

Group 3 presentation

Currently there is a gap between policy and implementation. All the current system would need to be restructured, including the creation of a Disability Action Council that will take responsibilities for overseeing the implementation of policies and for improving coordination with key stakeholders. The Disability Action Council will help to increase awareness.

PARTICIPANT'S RECOMMENDATIONS TO HI:

The participants stressed that (i) their participation should be meaningful and (ii) their comments should be taken into account.

At policy level:

- Adopt a holistic approach
- Integrate disability with social development
- Integrate disability within the health system
- Create a Physical Rehabilitation Committee
- Build partnerships between GoE institutions, INGOS and DPOSs
- Participate into the development of a national policy
- Support policy implementation

Coverage and scope of activities:

- Prioritise the area of intervention based on the NGO capacity and maintain the focus rather than expanding in different places.
- Focus on a limited number of hospitals
- Focus on POC instead of sporadic support

At implementation level:

- Support physiotherapy care
- Develop project at grassroots level
- Reinforce the existing HBPR services
- Revitalise the CBR activities including income generating in rural areas
- Support monitoring and supervision
- Ensure sustainability

Capacity-building:

- Mentor the physiotherapists newly graduated
- Support training for CBR
- Support training for physiotherapist
- Support upgrading training for staff trained at HBPR services

CONCLUDING REMARK:

Vanessa Rousselle thanked all participants for their contribution and collaboration during the evaluation field work. She pointed out that some of the recommendations were beyond the NGO capacity and that the future strategy should be build from the lessons learned.