EVALUATION SYNTHESIS

ADDRESSING DISABILITY IN ETHIOPIA THROUGH COMMUNITY-BASED REHABILITATION AND HOSPITAL-BASED PHYSIOTHERAPY SERVICES: 10-YEAR EFFECTS (1994 – 2005)

Introduction

The evaluation, commissioned by Handicap International, is co-funded by the associative consulting firm of the *Fonds pour la promotion des Etudes préalables, Etudes transversales et Evaluations* (F3E). 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 and handed over to the Ministry of Labour and Social Affairs (MoLSA) and to the Ministry of Health (MoH) respectively. Since then, while acting as a chairman for the National Forum of NGOs working with disabilities, the current NGO activities are not focussed on physical rehabilitation but on food security. Another project with an important HIV/AIDS component is expected to start during the course of 2006.

The objectives of this evaluation were to document what has been left of the projects. In particular it meant to assess the effects in relation to the community based-rehabilitation (CBR) and to the hospital-based physical rehabilitation (HBPR) projects. The technical and financial[1] support to the CBR projects took place from 1994 to 1996 in collaboration with MoLSA and its CBR teams in Nazareth and Asella, two cities located in the Oromiya region. A team of four expatriates, with expertise in physiotherapy care and prosthetic appliances, provided training and technical assistance to the CBR teams in the development of outreach for physiotherapy care and provision of appliances, vocational training, income generating and awareness clubs.

The HBPR project covered eleven hospitals located in five different regions during the 1998-2000 period and was implemented with the health personnel and technicians in collaboration with the Rehabilitation and Development Organization (RaDO), a local NGO. Handicap International provided financial support[2] and expertise with a team of two expatriates who assisted the project implementation and follow-up.

Under these projects there was an emphasis on providing institutional care support for individuals suffering from physical disabilities. The route chosen to achieve this end was through integrating physical rehabilitation services into secondary care and developing a community-based model of care. Building of workshops for the manufacturing of orthopaedic appliances, training of health staff, technicians and CBR workers on basic delivery of physiotherapy care, and awareness sessions for health professionals and the population formed the core activities.

The information generated is intended to be lessons learned and will serve as a basis for a set of strategic recommendations for future HI involvement in disability.

[1] The total costs for the CBR project amounted 635,000 Euros. The Ethiopian Government contributed to 50% of the total costs. Other sources of funding included the Dutch Embassy, Caritas Netherlands and HI.

[2] The total costs for the HBPR amounted 774,000 Euros. The European Union covered 65%, HI 27% and the Ethiopian Government the remaining 8%.

The Ethiopian context

Located in the Horn of Africa, the Federal Democratic Republic of Ethiopia has a population of 69 million, with a per capita income of US$ 100 in 2002. Approximately 85% of households rely on agriculture for their main source of livelihood. Although the country has operated a free-market economy since 1991, poverty remains widespread and severe, with 40 percent and 37 percent of the rural and urban population respectively classified as poor. There are many reasons for the low development ranking. The country has suffered from three decades of war, most recently from the Ethiopian-Eritrean conflict in 1998-2000 which displaced thousands of persons from the border areas, and left an estimated 20,000 soldiers and civilians disabled. The prevalence of poverty is also associated with low growth and low productivity of subsistence agriculture.
While agriculture productivity is highly vulnerable to external shocks as droughts, the rapidly growing population is putting pressure on agricultural lands.

Infant and maternal mortality rates are associated with high fertility and lack of prenatal and delivery care. Diarrhoea and pneumonia are the main causes of early death among children under five. Moderate to severe malnutrition among children is higher than in any other countries of Eastern Africa. In addition the HIV epidemic, which has been estimated at 6.6 percent of the adult population in 2002, has spread rapidly over the last few years.

The disability context

According to the Population and Housing Census of 1994, there were 988,849 people with disabilities but to date this figure is outdated. While a survey currently carried out by the World Bank should allow for a more accurate picture of disabilities in the country, the World Health Organisation estimates that, in developing countries, 10% of the population are disabled persons. 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. For the 2000-2001 period accidents accounted among the ten leading causes of inpatient visits.

Ethiopia formulated a Developmental Social Welfare Policy in 1997 and a National Programme of Action for Rehabilitation of Persons with Disabilities in 1999. The Rehabilitation Agency for Disabled Persons acted as the institutional framework until 1996, when it was dissolved, to be established as a Department for Rehabilitation Affairs within the Ministry of Labour and Social Affairs (MOLSA). This Department coordinates disability issues at the federal level and is responsible for providing policy guidance and technical support concerning social and economic integration of disabled persons. In each of the eleven regions of Ethiopia, there is a Bureau for Labour and Social Affairs (BOLSA) responsible for employment and social issues at regional level, in a policy framework defined by MOLSA. As part of their mandate, the BOLSAs are responsible for mobilizing public and private services and for promoting integration of persons with disabilities.

Although committed to providing services to disabled persons; this remains 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 Government, regional offices and other ministries such as the Ministry of Health (MoH).

The most visible service for physical disability is nationally operated through five Prosthetic and Orthotics Centres (POC) under MoLSA and World Bank support and with ICRC expatriate's technical support. The POCs serve as referral centres for 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 the new professional category of physiotherapist has not been included within the cadre of health workers identified as necessary within the health system framework. In addition several concerns remain: due to limited availability of placements 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, functional physiotherapy departments and budget support.

Other important features of the health sector

In Ethiopia, health care is delivered through the MoH. Ethiopia has launched a Health Sector Development Program for implementation over a period of twenty years. The adoption of Federal state has created regions with significant autonomy in the health sector. Since 1998 public services are experiencing an extensive decentralization process. The rapid decentralization has however highlighted issues related to rebalancing allocations, lack of clarity on responsibilities and expenditure assignments.

Despite efforts made by the government to ensure basic social services, an estimated 49% of the population lacks access to medical services. Human resources are scarce and out of balance; there is an average of one physician per 35,603 inhabitants and only one nurse per 10,000 persons. Currently more than 55% of the health budget is allocated to wages and the country is spending 5.7 percent of its GDP on health, with a large share of public money being allocated to hospital care. Per capita health expenditures in 2002 were estimated at $US 4 and are significantly lower than the Sub Saharan Africa average of $US 42. For the period 1999-2000 out of pocket spending, including direct payments to private practitioners, traditional healers and private pharmacies, represented thirty-six percent of the total health spending.

A number of bilateral, multilateral and philanthropic organizations are involved in the health sector. In 2001 Official Development Assistance (ODA) has been high, at about 18% of Gross Domestic Product. 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. For the health sector donor funding is difficult to capture as a significant proportion has been flowing through extra-budgetary channels.

Cost-recovery represents a small share of expenditures. Patients are exempted if they obtain a free paper from the local administration certifying a monthly income of less than US$12. Persons qualifying for full exemptions include the disabled. The financial law of 1997, which requires all revenues to be remitted to the Ministry of Finances, 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.

As pointed out in the 2004 Country Status Report on Health and Poverty issued by the MoH and the World Bank, reaching the Millennium Development Goals (MDGs) is not without leading and daunting challenges:

- The number of health-care facilities has increased, but utilization of curative services has not;
- The price of health care is highest in public hospitals and lowest in health posts;
- Transportation costs represent a high proportion of health care costs;
- Poor groups do not invest much in health care;
- Only 0.9 percent of total household expenditures is spent on medical and health care;
- Per capita health spending remains among the lowest in the world;
- The human resource base is very limited;

Evaluation design and methodology

Due to a lack of baseline survey, an impact evaluation was not feasible. 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.

From the beginning the evaluation team was aware that the evaluation could not cover the total Handicap International experience which included eleven hospitals in five regions and two CBR locations. 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 services and; (iii) the inclusion of CBR projects.

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?

Two members composed the evaluation: one international consultant specialized in public health and health economics and one national consultant with a social research background. The Terms of Reference provided the team with an eleven-week period, in which six were to be spent in the preparatory phase and five for the field work undertaken in six sites during January 2005 and February 2006.

The design for this evaluation, mainly qualitative, was a five-step process. The first step, carried out by the national consultant, consisted of a preparatory work including document review, file study and a series of interviews with officials to establish contacts and to become knowledgeable about the health and social sectors. The objective of this phase was also to facilitate the fieldwork by organizing the logistics and disseminating information concerning the evaluation. The assistant visited the six selected sites, met with key individuals and identified potential data collectors in each of the sites.

The second step included searching additional key documents in relation to official statistics, policy and planning documents in order to crosscheck the information and identify the gaps in what had been collected. The preliminary data gathered through the interviews helped to complete the stakeholders' analysis. 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.

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. Phase three consisted of the design of specific questionnaires for the key informants and the beneficiaries of both projects. Guidelines for topics to be discussed during the Focus Group Discussions (FGDs) were also developed to direct the discussion process.

Although the practical aspects of the evaluation, including extensive geographical area to cover in a very short time and incomplete data, did not allow for a quantitative study design, the qualitative information gathered was substantiated with data collected in a series of semi-structured interviews conducted with individuals who previously benefited from the projects. Purposive sampling was utilized to attain the stated objectives: the selection of patients included different criteria based on sex (male, female, and children), location (urban and rural), and type of disabilities.

As the fourth phase, the fieldwork, lasting twenty-five days, primarily involved a second round of interviews with key informants, FGDs with trained staff, observations, and semi-structured interviews with beneficiaries. 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.

The combination of the site criteria led to the following itinerary: (i) Nazareth and Asella for the CBR project; (ii) 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. For the most part the field schedule was completed on time even though a rescheduling of activities was arranged following the sudden death of the father's national consultant.

A significant amount of time was spent on explaining the evaluation's objectives to the different stakeholders in order to minimize misunderstandings and circumvent expectations. The general experience of the team with the persons interviewed was positive and there was a general welcoming of the evaluation. The local administration offices, the health centres and local NGOs provided a great deal of help, especially to identify beneficiaries.

In total thirty-three key informant interviews were conducted. The participants who included regional and local authorities, administration and NGO representatives, and hospital managers were informed about the purpose of the discussion and the confidentiality of their views and opinions. Four FGDs were conducted with trained health staff, technicians and CBR-workers. The composition of the groups was based on promotion of group dynamics through common training on disabilities. The participative nature of the discussion allowed the evaluation team to explore and contrast the view of the different participants. The discussions were held in Amharic or local dialect.

Observations included visiting in-patient, out-patient and physiotherapy departments as well as orthopaedic workshops and CBR offices. It provided a valuable insight on the physical aspects of the buildings and on the way the work was organized and managed.

Beneficiary interviewing was limited and opportunistic: interviewees were chosen purposively for their previous involvement in the projects from the hospital and CBR records. 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 specialized services. A total of twenty-seven interviews were carried out with individuals who benefited from the HBPR services. Fifty interviews were completed with CBR beneficiaries.

In each site two to four data collectors were selected and trained. Most of them had completed secondary school, spoke basic English, and were residents of the area. In order to minimize potential biases all were recruited outside project's staff. During the data collection, the evaluation 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.

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.

During the fifth phase, an initial feedback was provided to stakeholders before leaving the country. The one-day feedback session, which involved exchange and debate with key stakeholders, was convened in Addis Ababa. Out of the 23 individuals who were sent an invitation, sixteen attended the workshop. The main objectives were to present the main findings and to discuss and debate how best to design a future HI strategy in the field of physical rehabilitation. 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.

LIMITATIONS

The evaluation suffered from several limitations:

- The problem of meeting with health officials who have extremely tied and busy agendas;
- The historical conditions of the activities being studied (a ten-year period): records on the CBR projects were limited, which proved problematic to understand the project background and the institutional changes. Events had to be reconstructed from incomplete evidence using additional interviews and triangulating the information collected.
- The problem of gaining access to beneficiaries: identifying and tracking down the beneficiaries proved to be problematic and time consuming;
- The lack of baseline data and time constraints made the selection of beneficiaries opportunistic in the sense that the team interviewed only those who directly benefited from the project.
- In Dire Dawa and Sodo, the services are not functional, a situation that forced the team, in the light of the one and half day data collection, to disregard the search for beneficiaries.

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

Main findings for the CBR services

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[3] in its widest sense. In addition the organization gave attention to the staff's needs, provided them with a 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.

But a lack of integration within an institutional framework: By now, the two CBR projects are in serious difficulty. They first experienced a major setback due to institutional changes, with a vacuum of leadership at the BOLSA. As a result of this disruption, there were further delays in project implementation and the support to the activities continued to be poor. This situation generated an atmosphere of instability, which later led to decreased allocation of funds.

[3] The main CBR activities included outreach for physiotherapy care and provision of appliances; vocational training, income generating activities and awareness clubs.

Why did local authorities not sustain activities? The absence of monetary benefits when the project ended was a disincentive to them. In addition 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 neither from HI nor from the MoLSA. 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. Under these circumstances project implementation continued to suffer and deteriorate.

Currently 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. The perceived unfairness has eroded the confidence of CBR workers in government policies and is a source of permanent frustration.

None of the projects fulfill 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. As such the project is highly vulnerable: if to morrow those individuals 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.

The issues at stake: Within the current institutional context, social affairs receive little attention as compared to health, education or rural development sectors. As a matter of act it is the POC construction which has been influential in raising the MoLSA 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.

A very precarious situation for the disabled persons: 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. Their quality has been questioned and 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 is biased towards urban areas despite the fact that the overwhelming majority of the disabled is residing in rural areas. All this combination of factors has 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.

Main findings for the HBPR services

Increasing the visibility of physical rehabilitation: Handicap International and RaDO were the main project drivers and played a critical role in introducing the concept of physical rehabilitation at hospital level and in promoting physiotherapy departments and building orthopaedic workshops. From the onset there was a risk that rapid expansion of the physical infrastructure 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, had been over ambitious. 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.

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. By 2006 none of the sites visited had gained sufficient support from the different stakeholders within the health system to become fully operational. This situation is not only relevant to the four sites visited but has been reportedly portrayed for the other seven-supported hospitals. 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.

In general 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. The investment in training benefited a few individuals who are still in the same position and having a positive impact on those affected by their work. The fact that the HBPR services were not linked to surgical wards but were essentially designed to function as autonomous units made collaboration and integration more difficult. 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.

From the interviews it is not clear 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 most hospitals are attempting to keep up their health care delivery system driven in large part by shrinking budgets, projects using funds from external donors are attractive, no matter how relevant or sustainable they are.

Vulnerable to the changing nature of actors and environment: While decentralization and civil sector reform have potentially opened up the policy environment to many new actors, reforms have put huge pressures upon health system and health staff. In general there is no institutional memory of the past project activities at hospital management level. 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 a significant amount of human and financial resources.

Not seen as a priority: 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.

A lack of recognition from the health system: The current staff situation was marked by sentiments of frustration, helplessness and sadness. 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 two trained individuals for completing the 2-year formal physiotherapy 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. As a matter of fact 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.

Poor collaboration between hospital managers, doctors and staff trained: 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. There is a feeling of ongoing fight to get basic material and equipment, a situation that has worsened over the years. While the staff recurrent complain has been on the lack of support from hospital managers and doctors, there were no clear guidelines of whom will supervise the staff trained, which led to little accountability from both hospital managers and staff.

Medical directors expressed serious doubts about the health staff performance which may, in part, explain the limited prescriptions for physiotherapy care. This scepticism is further reinforced by the fact that the 3-month basic training was neither followed by supervision nor upgrading course. The role of frequent re-training to sustain efforts in hospitals was probably underestimated.

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 but most beneficiaries recognize that the services are limited in terms of skills and supplies. Although the 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 limited awareness on the services available and who have to bear extra costs -other than narrowly defined treatment costs – such as transport, food and lodging for the carers.

Who will pay for the services? 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 cost recovery within the broader financing context. 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 how the services will be financed n the longer-term and who will subsidize the costs incurred by the disabled.

Conclusions 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.

The importance of the institutional context: 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. In particular the evaluation found that structural and contextual factors influenced sustainability. While the role of MoH and MoLSA is important in sustainability, these were limited in sustaining physical rehabilitation, both at hospital and outreach due to competing needs and priorities, lack of capacity to continue efforts on their own.

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. In addition there are multiple barriers to utilizing hospital services that were not taken into account. 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 1996. Since then HI has gradually moved from an interventionist approach to more development-oriented practices.

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.

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. The type of project implemented in the past was over ambitious and for a too short commitment. The findings reveal also that, while sustainability is a shared responsibility from all stakeholders, changes perceived as being brought from the outside are problematic to sustain. Ultimately 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.

Integrating physical rehabilitation within the health system: still in its infancy. The results for integrating physical rehabilitation into the health system are disappointing as both projects helped little to design a national policy. The government commitment to addressing the needs of disabled persons is weak and explicit moves to integration have not taken place. 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. 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 are 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.

Institutional support to MoLSA: the case of 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.

What are the alternatives?:

1. 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 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".

2. 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 Counsellor 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.

3. Acting as a catalyst: 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 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. to the problem of seeing

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 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.