PROGRAMME EVALUATION OF KARUNA FOUNDATION'S INSPIRE2CARE PROGRAMME IN NEPAL

Submitted by: Kaarak Enterprise Development Service Pvt. Ltd.

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Glossary

CBR	Community Based Rehabilitation
CBRF	Community Based Rehabilitation Facilitator
DPO	Disabled Persons' Organisation
DPWA	Disabled Protection and Welfare Act
ECDC	Early Childhood Development Centres
FCHVs	Female Community Health Volunteers
GoN	Government of Nepal
HFOMC	Health Facility Operation and Management Committee
ID	Identification
I2C	Inspire2Care
KF	Karuna Foundation, Netherlands
KFN	Karuna Foundation, Nepal
MCBRF	Master Community Based Rehabilitation Facilitator
MoU	Memorandum of Understanding
SHG	Self Help Group
UBS OF	UBS Optimus Foundation
VDC	Village Development Committee
VDRC	Village Disability Rehabilitation Committee
WHO	World Health Organisation

Executive Summary

About the Programme

Karuna Foundation Nepal (KFN) is a sister organisation of Netherland-based Karuna Foundation (KF), an organisation working on addressing disability amongst children and adults. Karuna Foundation Nepal became an independent organisation in 2015.

Inspire2Care (I2C), KFN's flagship programme, is a time-bound, community-led and innovative programme that began in 2011 and has been upscaled in three phases - in 2015 (Phase 1), in 2016 (Phase 2: Current) and in 2017 (Phase 3).

The current phase (or Phase II) of the programme has been funded by UBS Optimus Foundation (UBS OF) in fifteen villages of Ilam and one village of Jhapa District. The four proposed outcomes of the project are:

- **Outcome 1:** *Improved health status of mothers and children*
- **Outcome 2:** *Improved quality of life of persons with disability through community based rehabilitation*
- **Outcome 3:** *Reduced prevalence of violence against children*
- **Outcome 4:** *Strengthened organisational capacity and community support system*

It is a five-year programme based on a cost-sharing model with the community where the community's share steadily increases from the first to the third year, and KFN's contribution decreases in the ratio of 80:20 (Year 1), 50:50 (Year 2) and 30:70 (Year 3). In the fourth and the fifth year, the community bears all the costs and KFN would only provide technical support.

(Note that this only includes the running cost of the programme, KFN also makes significant investments in the first two years in the form of the "investment cost" which it bears completely).

The I2C model is executed through the Health Facility Operation and Management Committee (HFOMC), a community health institution established in every village. The programme partners with all key village level institutions including the village development committee (VDC)[1], village disability rehabilitation committee (VDRC), schools and teachers, child clubs, etc. The focal point for the village level implementation is the Community Based Rehabilitation Facilitator (CBRF) that the programme has hired for each VDC; the CBRF is hired from the community and is responsible for executing the core activities at the community level.

About the Evaluation

UBS OF commissioned Kaarak Enterprise Private Limited (henceforth, Kaarak) to undertake an independent evaluation of the Phase II of the I2C programme, that began in 2016.

The **specific objectives** of the study were:

- To understand the performance of the programme against the programme indicators
- To understand the suitability of the programme for future funding to contribute towards scaling across the entire Ilam District

[1] In the recent political restructuring of the country, VDCs have been dismantled, and instead rural municipalities have been formed; each rural municipality subsuming more than one VDC. However, since this is a recent development, the programme has been working with the VDCs during the first 2 years (the period that this evaluation is looking at) and hence they will continue to be mentioned in the document.

Kaarak employed a mixed-method approach, using secondary data collection as well as primary data collection to collect the findings for the evaluation along the standard criteria of - relevance, effectiveness, efficiency, impact and sustainability. A two-member team undertook a six day visit to Nepal, which included two full day visits to two project villages of Ilam, meeting with district government officials, national stakeholders and detailed group discussions with KFN's district and national teams.

Key Findings

Relevance and Validity of Design

The policy environment in Nepal and the selected districts were found to be conducive for the programme. Over the last few years, the Government of Nepal (GoN) has taken significant steps to recognize persons with disabilities and has established institutions/policies to work with this demographic.

The government recognizes seven categories (recently expanded to 10) and four degrees of disabilities. Special identification (ID) cards of different colours were provided for persons with different degrees of disability. Each village was required to have a VDRC to provide rehabilitation support to persons with disabilities. The country has also implemented and amended the Disabled Protection and Welfare Act (DPWA), which includes the "Accessibility Guideline, 2013" and the "Inclusive Education Policy, 2017".

However, despite these policies/structure being in place, the implementation of these systems was found to be sorely lacking, and the policies still in need of revision. I2C used its technical know-how and efficient management system to complement and ensure better implementation of these policies. It provided a model for the government to incorporate and be guided by in their policy decisions. The KFN team were also found to leverage on the changing policy climate and challenging situations to secure provisions for the programme beneficiaries.

The programme was found to be largely relevant to the needs of the project locations, i.e. Ilam and Jhapa Districts. The coverage of institutional delivery and antenatal care in the selected districts was significantly less than the national average. The population of persons with disabilities, although high in absolute numbers, was not the highest in terms of percentage compared to other districts of the country. The locations were selected on the suggestion of the government, which was important to ensure ownership of the programme.

KFN's mandate is aligned with UBS OF's vision; and I2C uses a coherent model with strategies that are clearly aligned with the proposed outcomes. However, Outcome 3 (to reduce violence against children) was found to have weak linkages with the other three outcomes. Also, despite doing significant work with adults with disabilities, the results matrix or the project reports do not clearly reflect this work.

Overall, the programme works in close coordination and partnership with all relevant government, civil society and private institutions and has strong linkages with existing programmes/ resources/ interventions.

Effectiveness

The evaluation found the programme design under Outcome 1 (with respect to prevention of disabilities) highly strategic and effective. The interventions have made significant strides in improving the maternal care and childcare in the project areas, which is found to have direct linkage with the prevention of avoidable disabilities.

In Outcome 2 (or the rehabilitative aspect of I2C), the health-component was found to be the strongest and the livelihood component to be the weakest- sole dependence on self-employment strategies with its high failure rate was found to be problematic. The strategies under the social-inclusion and empowerment components were not very clear; and more attention on family-level intervention would need to be given. The education component is still in its nascent stage, and the programme strategies are still evolving. Moving forward, the *quality* of education and inclusion in schools would need greater attention.

Under Outcome 3 (violence against children), the programme would need to include clear strategies and indicators to understand and address violence against children *with disabilities*. As of now, the strategies are broad and cover all children, resulting in this outcome being somewhat weakly linked with the other three outcomes which specifically focus on disability.

In terms of strengthening organisational capacity and community support system (Outcome 4), the programme was mainstreamed into existing government administrative systems and the community institutions express willingness and preparedness to take responsibility of the programme after phase out of KFN.

Efficiency

KFN has been effective in linking the project with community institutions, which helped in leveraging the existing financial and human resources of the community and the local government. This has helped them ensure high impact through minimal human resource investment. KFN has maintained a lean and robust team at the national and district levels with very strong communication and coordination systems. They also have an effective and efficient internal monitoring system, with regular reviews, assessments and planning.

At the CBRF level, the evaluation found the work/ time requirements were demanding and her capacities stretched. There are extensive reporting requirements at her level, many of which were found to be irrelevant. The reporting would need to be simplified keeping the usefulness of the data in perspective. Also, the monitoring at the village/ HFOMC/ CBRF level was found to be weak, with a lack of alignment to the outcomes/ goals of the programme. They have an input/ activity focus and the goals/ outcomes are the responsibility of the KFN team.

Impact

The immediate impact of the programme has been on the increased visibility of persons with disability and the issues faced by them. Access to disability ID cards has increased by almost 30 per cent points, which has increased their status within the family as well as community, their access to basic provisions

and pension (for the red and blue card holders) and has also increased accountability of the community institutions to them.

Table 1: Impact Snapshot Table

		Data
Access to Disability ID Cards		83% (Increased from 45% to 83%)
Access to Social Security Allowance	Adults	78% [N=536]
	Children	78% [N=128]
Access of Children with Disability to Education		61%
Institutional Delivery (as a proportion of reported deliveries)		72% (Increase from 39%)
Proportion of Malnourished Children		0.14 (Decreased by 91.25% from 1.6 proportion)

The programme has also significantly improved the maternal and childcare provisions in the project areas, which are important steps for the prevention of avoidable disabilities.

In terms of the impact on the beneficiaries' quality of life, I2C has had some immediate impact in terms of the improvement in the physical well-being of the beneficiaries and financial relief for those eligible for monthly pensions. It has also helped enrol a small percentage of children with disabilities into schools. The physical health needs, quite expectedly, have received the most attention and have had a visible impact. However, it is too early to notice any marked change in the quality of life.

KFN and I2C have also contributed to some important policy level changes with respect to disabilities. This includes expansion of categories of disabilities from seven to ten types and the provision of a Master CBRF in the Government of Nepal's 10-year health strategy.
The evaluation also noted some indirect impact of the programme in terms of the ripple effect in neighbouring areas (as was observed during the visit to the non-project village), and a general improvement in the health well-being of all the people in the community, with or without disabilities.

Sustainability

KFN, as an integral part of the I2C model, has established the cost-sharing model from the inception stage to ensure ownership and sustainability of the model by the local stakeholders. KFN signed MoUs with the relevant villages (now rural municipalities/ municipalities) and district level institutions clearly demarcating the cost-sharing planning.
In the first two years of the programme, the community successfully raised 20 per cent and 50 per cent of the programme's running cost. This was a significant achievement. Further, all the relevant stakeholders expressed awareness and preparedness for taking up more of the cost-burden in the coming years, after KFN's phase out.
However, the evaluation found that KFN had made significant investment in terms of the "capital investment" in the programme, which was borne entirely by KFN. This was a sizeable amount and may prove to be a challenge while scaling up of the programme on a large scale.

Table 2: Cost-Sharing Model

Project Year	Planned Running Cost (Operating or Recurring Cost)		Planned Investment Cost (Capital Expenditure)
	Project Contribution	Community Contribution	Project Contribution
1	80%	20%	100%
2	50%	50%	100%
3	30%	70%	Technical Support
4	Technical Support	100%	Technical Support
5	Technical Support	100%	Technical Support

Table 3: Cost Sharing Achieved

	Total cost (NPR.)	Investment Cost	Running Cost		Community Allocated
		KFN	KFN	Community	
Year 1	19,437,841	9,874,412 (100%)	7,750,730 (80%)	1,937,682 (20%)	2,800,000
Year 2	17,294,580	9,280,510 (100%)	4,004,625 (50%)	4,004,625 (50%)	3,788,820

Despite the challenges foreseen in generating this capital investment, the evaluation team finds the I2C model itself very coherent and replicable in other parts of Nepal or any other developing country on not just the issue of disability but other development issues as well. Further, due to the recent overhauling of the political structure of Nepal, and the existing rapport built by the KFN team with the GoN, I2C has the advantage of positioning itself as an essential component to include in the new strategies and programmes that are being designed at the village or municipality level.

Recommendations

1. **Simplifying Casework and Strengthening of M&E at the Community Level**
   - Better and regular follow up with beneficiaries after one round of complete support (especially in cases of assisted devices).
   - Two-way instead of one-way communication- Develop systems to facilitate the beneficiaries (persons with disability) to communicate with the CBRF in a proactive manner. Use of technology, i.e. mobile-based app, could be considered for development of the same.
   - The new MIS software should be designed to simplify and reduce reporting systems at the level of the CBRF.
   - Make goal setting and quality of life matrix more specific and standard (as per different categories and degreed set by the GoN).
   - Strengthen community level accountability systems to monitor and evaluate outcomes and goals rather than only activities.
2. **Work towards Developing Guidelines for Institutionalization of CBRF**
   - Develop standards and systems for CBRF's eligibility, selection, training, monitoring and evaluation based on project experience.
   - Undertake a realistic time-effort estimation vs. expected role.
   - Develop a standardized guideline on working hours, activities and tasks and accountability structures.

3. **Look into the Financial Sustainability of the Model**
    - Consider both the running and the investment cost when thinking of the scalability of the model; facilitate and capacitate the government institutions to understand and prepare for bearing the burden of both the costs when scaling the model to other areas.
4. **Strengthening the Work with Children with Disabilities**
    - Violence against children: Situation assessment of both psychological and emotional needs and issues. Based on this, take strategic measures to address such violence.
    - More effort required to ensure inclusion at the school and community levels.
5. **Strengthen Engagement with the Families of Persons with Disability**
    - Counselling for family members to better understand the needs and conditions of persons with disability.
    - Build the capacity of families to provide greater psychological and emotional support.
    - Psycho-social support to care-givers; care-giver groups can be formed for the same.
6. **Amend the Results Framework**
    - Capture all the results of the intervention with adults (with disability).
    - The targeted numbers of beneficiaries to be covered need to be disaggregated: preventive and rehabilitative support.
7. **Livelihood Promotion to be Supported with Close and Specialised Inputs**
    - Rethinking of self-employment as a major employment generation strategy.
    - Consider mainstreaming of employment of persons with disabilities in public and private institutions.
    - Learn from successful livelihood promotion models.

Section 1: Introduction

Country Context

The World Health Organisation (WHO) defines disability as: *a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives; overcoming these difficulties faced by people with disabilities requires interventions to remove environmental and social barriers.*

The Government of Nepal (GoN) has recognised seven types of disability (recently expanded to 10 types), and has divided each type into four degrees of severity- complete disability, severe, moderate and mild disability. GoN defines persons with disability as those "who have long-term physical, mental, intellectual or sensory impairments or functional impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". In 1982, the government implemented the Disabled Protection and Welfare Act (DPWA), and has thereafter amended the Act multiple times, and developed various policies and provisions for persons with disabilities. This includes the "Accessible Physical Structure and Communication Service Directive for People with Disability, 2013"; "Accessibility Guideline, 2013" and the "Inclusive Education Policy, 2017". The government also ratified the UN Convention on the Rights of People with Disability in 2009. These are important steps taken by the administrative structure of the country to develop and implement policies to create an inclusive social environment.

The National Study examining the "living conditions among persons with disability in Nepal" (Eide, Neupane and Hem, 2016)[2], found that persons with disability had significantly less access to education and sources of employment and were found to fare worse than others on almost all indicators examining quality of life. The situation was worse in rural areas, as compared to urban areas, and females with disability were found to be the most vulnerable, subjected to more disadvantages because of their disability and gender. Thus, despite the efforts made by the government, the living conditions of persons with disabilities are still a matter of concern and require technically sound and sustainable interventions and better implementation of the policies already in place.

About the Project

Karuna Foundation (KF) is a Netherland based organisation working on addressing disability amongst children. The organisation selected Nepal as the first project country for their programme, and established a sister organisation to implement the programme in Nepal. In 2015, Karuna Foundation Nepal (KFN) became an independent local organisation with a shared vision and goals of KF Netherlands.

KF began working in 2008 through the "Share&Care" programme. Later in 2011, the I2C programme was begun, similar to and drawing on the learnings from the Share&Care model. After the success and scalability demonstrated by the 2011 I2C programme through various independent research studies and evaluations, the organisation decided to upscale the programme in three phases - in 2015, 2016 and 2017.

[2] Link to the study: https://www.sintef.no/globalassets/sintef-a27656-nepal-printversionfinal.pdf

During Phase-II of upscaling the programme in 2016, KFN partnered with UBS OF, along with other Netherland based organisations. With the UBS OF grant, the programme was implemented in fifteen villages of Ilam and one village of Jhapa District of Nepal. This evaluation is being undertaken for this (UBS OF funded) component of the programme.

GOALS of Karuna Foundation Nepal

1. *To decrease the number of children who are born with or who develop disabilities*
2. *To improve the quality of life for children and adults living with a disability*
3. *To build an evidence-based, sustainable, and replicable health care model for prevention of childhood disabilities.*

OBJECTIVES of Karuna Foundation Nepal

A. *To improve maternal child health indicators by 40%*
B. *To achieve 30-40 % reduction in the number of children acquiring a disability through illnesses, malnutrition, accidents or infections*
C. *To create sustainable access to improved maternal child health care services for 50.000 people.*
D. *To develop a proven, successful, sustainable, and replicable model which can be implemented in Nepal and in other countries around the world.*

The I2C programme is a time-bound and community led innovative programme developed by KFN. It has been designed as a five-year programme implemented by the Health Facility Operation and Management Committee (HFOMC) in each village on a cost-sharing basis, with the cost born by the community (or the Village Development Committee) steadily increasing from the first to the third year; in the fourth and fifth year, the project cost is completely borne by the community and KFN only provides technical support.

The four proposed outcomes of the project are:

- **Outcome 1:** *Improved health status of mothers and children*
- **Outcome 2:** *Improved quality of life of persons with disability through community based rehabilitation*
- **Outcome 3:** *Reduced prevalence of violence against children*
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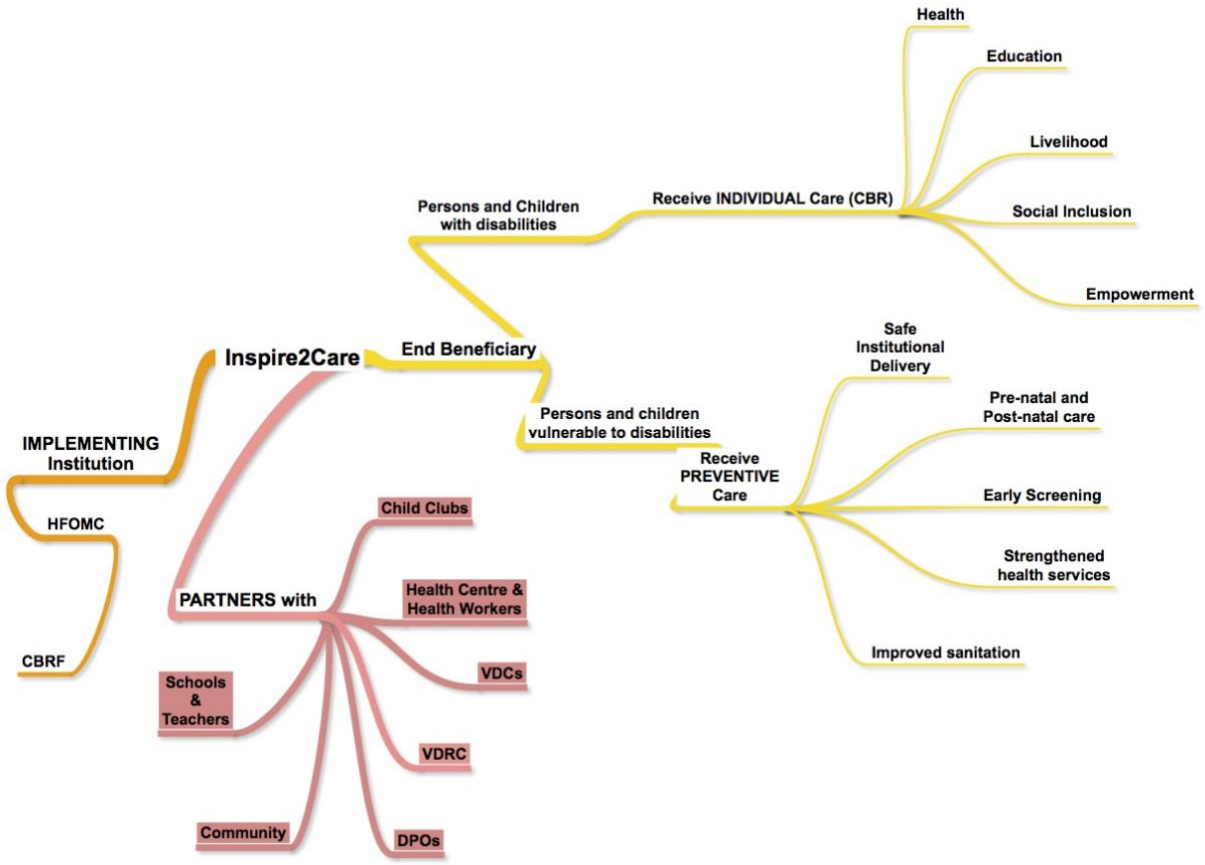


About the Evaluation

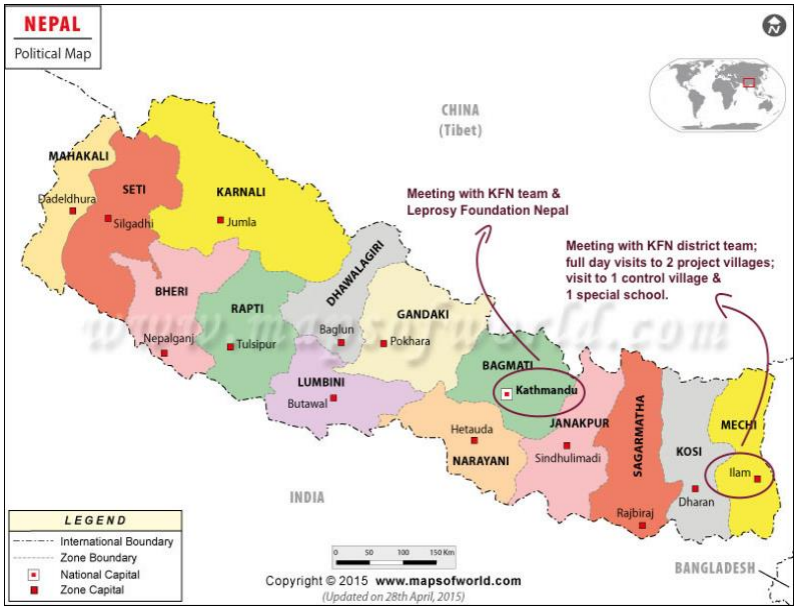
UBS OF commissioned Kaarak Enterprise Private Limited (henceforth, Kaarak) for an independent evaluation of the Phase II component of the I2C programme that began in 2016. The main aim of the study is to observe the changes brought about by the programme among its target population and to help in deciding the future funding and scaling up of the programme in other areas. As per the agreement between UBS OF and KFN, the upscaling and continuation of the programme beyond the initial two-years period, would depend on the independent end-line evaluation undertaken at the end of the funding period.

The **specific objectives** of the evaluation are:

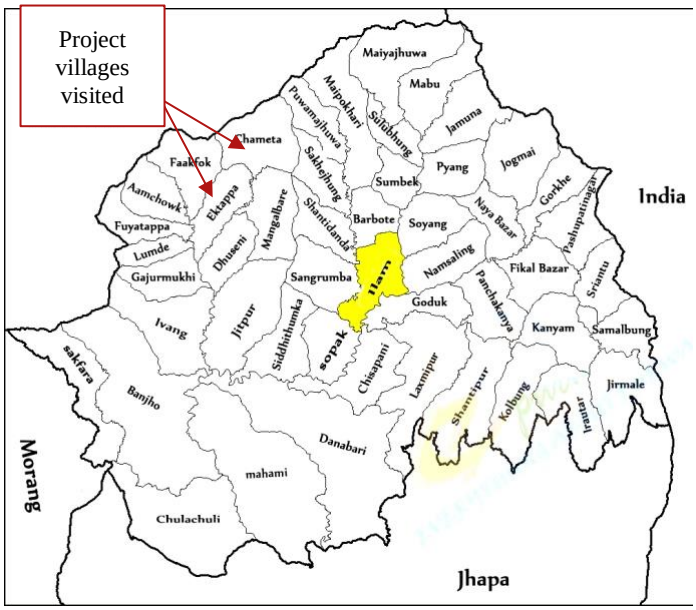
- To understand the performance of the programme against the programme indicators
- To understand the suitability of the programme for future funding to contribute towards scaling across the entire Ilam District

Methodology

The evaluation team held an inception meeting (via Skype) with UBS OF. This meeting helped the team develop a preliminary understanding and impression of the programme, and understand the logic behind the selection of the I2C programme and its alignment with UBS OF's overall mandate. The meeting was also used to develop a common understanding of the assignment's objectives and logistics.



Thereafter, as per UBS OF's suggestion, the evaluation team coordinated with the KFN team to undertake the field-mission. The evaluation team undertook a six-day visit to Nepal, which included four days in Ilam and two days in Kathmandu. They undertook full-day visits to two VDCs in Ilam (under the UBS OF funded project), where detailed group as well as individual interactions were held with all the relevant stakeholders. The team also visited a non-intervention village and held an in-depth interview with the elected village chief, to understand the difference in quality of life and institutional mechanisms in place for persons with disabilities; this helped the evaluation team better understand the achievements observed in the project villages



The Table below lists all the respondents the team interviewed and interacted with.

Table 4: Respondent List

Category	Respondent	Method of Data Collection
KFN, Kathmandu	Executive Director M&E Manager Technical Expert	In-depth interviews
National Stakeholder and KFN partner	Netherland Leprosy Relief	In-depth interview
KFN, Ilam	Programme Director	In-depth interview & Group

	Programme Manager Programme Officers Community Coordinators M&E Officer	Discussion
Government Officials (District level)	Chairperson, District Coordination Committee; Secretary, District Coordination Committee; Secretary, District Child Welfare Board	Consultation
VDC level (project)	HFOMC members DPO representatives Child club representatives Teachers Parents (including parents of children with disabilities) Health workers Adults and children with disabilities	Group Discussion
	Community Based Rehabilitation Facilitators (CBRF)	In-depth interviews
VDC Level (non-intervention)	Village (ward) Chairperson	Consultation
District School (which has a special classroom for children with hearing disability)	Principal Teachers	Consultation

After the visit to the villages, the evaluation team held a debriefing meeting with the district team where some of the preliminary impressions were shared and clarifications sought. This was also used to gather more information and deeper understanding of the programme's functioning and strategies for the future.

Evaluation Findings

1. Programme Results

The Table below illustrates the programme's key results, as reported by KFN to UBS OF. These results were reported in June 2017, and the numbers may have increased as of date when this report is being submitted.

The programme followed a census approach and all persons detected with disabilities in the project locations were covered through the rehabilitative component. The target setting seemed to be ambitious, and the evaluation found the number of actual children with or vulnerable to disabilities lower than that anticipated by the programme.

As of October 2017, the total number of persons with disability covered by the project was **1250 (Adults – 988 and Children – 262)**.

Table 5: Results Snapshot

	Target	**Results** *(as of June 2017)*
Number of people (including children) affected directly	6100	6135
Number of children (under 18 years) affected directly	4560	2685[3]
Number of people trained / educated / counselled in the course of the project	990	1553
Total number of people (including children) impacted indirectly	34,978	18,952
Number of children (under 18 years) impacted indirectly	15,701	8390

2. Relevance and Validity of Design

Relevance to the country's policy environment

As per the 2011 statistics, Nepal has more than 500,000 persons and more than 200,000 children with disabilities living in the country[4]; these numbers may have increased after the 2015 earthquake. With such high numbers of persons with disabilities living in the country, many of them in difficult terrain and circumstances, the country does not yet have adequate mechanisms in place to create inclusive services or opportunities for them. Although the GoN has made some attempts at working with this demographic, and included funds, provisions and subsidies for persons with disabilities in its various policies, there is lack of enough technical expertise, knowledge or capacities to develop effective strategies to implement

[3] This includes both children with disabilities and all children under 5 years covered through preventive care.

[4] Source: Nepal Census

these policies. Within this scenario, KFN is able to use their technical know-how to make the best use of the conducive policy environment and provisions in place for the benefit of persons with disabilities, and have been able to establish themselves as a knowledge centre and technical body that the government and civil society organisations look to on matters related to disability.

The government recognizes seven categories of disabilities (recently expanded to 10 categories) and has created national level umbrella organisations and National Organisation of Disabilities, for each category. These organisations have a rights-based approach to disability but do not yet have the required funding, awareness or capacity to bring in a health and wellbeing based approach. Further, in each erstwhile VDC, around three to five per cent of the government funds were available for persons with disabilities; despite having the mandate and willingness to spend this amount, these VDCs often did not have the know-how or the avenues to spend these funds. The I2C programme has provided a technically sound alternative to spend these funds, facilitating the VDC representatives in investing and taking ownership of the programme.

Thus, the evaluation team found the programme to be aligned with the policy environment of the country and an essential technical addition to complement and facilitate the government institutions in making a meaningful impact with the existing resources and legislative environment in the country.

Flexibility to respond to the emerging needs and changes in the policy environment

During the last two years that I2C has been functioning, Nepal went through huge political and environmental turmoil. In 2015, the country developed its Constitution and moved into a provincial government system; it is still in the process of developing the mechanisms to manoeuvre this new system. In the same year, the country also grappled with an earthquake that killed more than 9,000 and injured more than 22,000 people. Within this context, the programme was able to effectively function for only about 1.5 years of the two-year period. However, the evaluation found the KFN team was able to create opportunities out of these changes, and effectively use the emerging changes to serve their broader objective.

The VDC, as an administrative unit, was dissolved as part of the political restructuring. Instead *gaupalikas* or rural municipalities incorporating multiple VDCs were formed (in 2017), and these have been divided into wards. These gaupalikas have been given more power than the VDCs, with elected representatives being directly accountable to the community that voted for them. Each gaupalika has been assigned a funding of 10 million Nepali Rupees (NPR) by the government. Soon after the formation of these rural municipalities, KFN initiated dialogues with the representatives and government officials to discuss the modalities of continuing the programme within the changed context. During the period of the evaluation, the KFN team had already signed MoUs with five rural municipalities and four urban municipalities. As per these agreements, the municipalities have committed to continuing the work and partnership of the VDCs and also extending it to other villages/ areas that have been included into the municipality. The programme was thus not only able to adapt to the changing scenario, but also leverage on it, to expand its scope and reach.

Similarly, when the earthquake garnered the attention of many interventions and programme on disability in the region; the programme was again able to leverage and partner with these initiatives to access equipment and resources, needed by the beneficiaries in their project locations.

Relevance to the needs of project locations and beneficiaries identified

Drawing on the strong component of government ownership and participation incorporated into the programme, the project districts (Ilam and Jhapa) were selected based on the government's recommendation[5]. In terms of percentage, the national average of percentage of persons with disabilities in Nepal is 1.94 per cent and it ranges between one to more than five per cent across different districts in Nepal. Within this range, Ilam has 2.63 per cent and Jhapa has 1.89 per cent of persons with disabilities.[6]

Jhapa has one of the highest numbers of persons with disabilities amongst all the districts (around 15,000 persons with disabilities and Ilam (which forms the major proportion of the UBS OF funded programme) has only about 7,000 persons with disabilities in the district.

Even though the two districts do not have the highest incidence of disability in terms of number or percentage of persons with disabilities, the research team finds their selection strategically sound, due to greater buy-in of the government and very little presence of aid agencies, NGOs or international donors. Thus, despite having a significant population of persons with disabilities, these districts do not have enough support/ intervention for these persons; and due to the high education and exposure levels of these districts, they are ideal locations for piloting a new programme to demonstrate success stories that the government can replicate in other parts of the country.

In each of the districts, the villages were again selected on the recommendation of the district governments. In each village, a census approach was used where all the persons and children identified with disabilities were covered through direct intervention by the programme, and all mothers and children were covered for preventive care by the programme. In the project villages, the average percentage of adults with disabilities was 1.96 per cent and children with disabilities was 0.68 per cent.[7] The CBRF in each village was also selected by the VDC as per the guidelines developed by KFN and the district authority, Involvement of the key institutions in each stage of the programme was essential for them to own, manage and continue the programme beyond the five-year I2C programme.

Due to the difficult terrain in Ilam, the evaluation team found that most of the locations where the programme is operational is difficult-to-reach by vehicle or foot, with limited connectivity of public transport. This increases the disadvantages faced by the persons with disabilities, making their mobility and access to essential facilities much more difficult than that of those living in the plains.

Further, Ilam also has low coverage of institutional delivery (only 14%) and first antenatal care (53%) against the national average (of 38% and 83% respectively). Due to the low institutional coverage of such

[5] As per the interview with the Executive Director, Karuna Foundation Nepal.
[6] Source: *Disability Atlas of Nepal; Disability Research Centre, Kathmandu University, with support of UNICEF; 2016*
[7] Source: Data Shared by KFN Monitoring and Evaluation team.

care, the programme inputs related to maternal and child care (for prevention of disabilities) is highly relevant to the needs of the region.

Coherence and logic of programme outcomes, outputs and strategies

The I2C programme has a logical and holistic model that looks at all possible factors causing or aggravating different kinds disabilities. The evaluation team found the model to be well-thought out, context and need specific, with strategies in place to sustainably prevent the advent of disabilities as well as improve the quality of life of those with disabilities, by intervening in all parts of their lives and partnering with all the community level institutions and groups that have an interface with or influence the lives of persons with disabilities. These strategies are clearly linked to the four outcomes defined by the programme (explained in Section 1).

The evaluation team also observed that the programme indicators along which KFN reports to UBS OF every six months, does not measure a large portion of the I2C work, i.e. KFN's work related to adults with disabilities.

As a programme working on disabilities, I2C takes a census approach and provides individual care to all persons identified with disabilities, which includes both children and adults. Further, children with disabilities account for only 25 per cent of the programme's Community Based Rehabilitation (CBR) work, and the evaluation team finds the indicators inadequate to capture the other 75 per cent of the work. Further, since both KFN and UBS OF's mandate is to work with the children, yet the programme's logic and regional needs demand the important work being done with the adults too, the team will need to find a way to justify and account for the work being done with the adults by redefining the indicators and establishing linkages of the work with adults with that with the children.

The evaluation team also found that Outcome 3 (reducing violence against children) had weak linkages with the other three outcomes. As a programme working on disability, the work being done on violence against children will need clearer focus on violence against children *with disabilities* to align it with the other outcomes and the overall programme mandate.

Linkages of Programme Approach with overall vision and mandate of UBS OF and Karuna Foundation

UBS OF funds projects that work with vulnerable children, specifically projects with an entrepreneurial approach that are able to take a "business-minded" approach to utilizing the funds for maximum impact.

I2C's work with children with disabilities covers one of the most vulnerable demographics amongst children. KFN's mandate of "*saving children from disability"* is aligned with UBS OF's vision of helping children to "reach their full potential". Within this mandate, I2C provides an entrepreneurial, cost-effective and sustainable model working with children with disabilities living in extremely harsh conditions in the hills of Nepal.

The programme was first developed and implemented in 2011, and the UBS OF funded component was built from the successful example and learning of the 2011 pilot. The UBS OF funded component also paid greater attention to "prevention of violence against children" by dedicating one out of the four

outcomes to it. This was done to better fit into the mandate of UBS OF, and the KFN team exhibit flexibility and willingness to commit to UBS OF's overall vision.

However, it is important to note that a large part of the programme involves working with adults with disabilities which (as mentioned in the previous sub-section) will need to be better justified and linked with the work being done with children with disabilities in order to measure and account for that work under UBS OF's vision.

Coherence with other programme and institutions

The programme has been working in close coordination and partnership with all relevant government, civil society and private institutions, bodies and committees. The programme works on a partnership model with the VDCs and the health committees in the villages, maintains open lines of communication with all relevant ministries in the government, and also partners with the Disabled Persons' Organisations (DPOs) at the village, district and national level.

The programme was found to be highly coherent with other programmes and interventions in the programme locations. It's effective linkages with these institutions and programmes are key to its sustainability and ownership by all the relevant stakeholders. KFN has established itself as the technical expert on disability in Nepal, and many of the government and civil society institutions approach them with requests for guidance and partnerships.

Relevance & Validity of Design Snapshot

The I2C model was found to be highly relevant to the existing policy environment in the country. The government institutions were found to be willing to work on the issue of disability with policies and funds in place for persons within the demographic. The programme helped complement its technical know-how and efficient management system. The KFN team leveraged on the changing policy climate and challenging situations to secure provisions for the programme beneficiaries - for instance, after restructuring of the VDCs into rural municipalities, KFN has been able to secure MoUs with these municipalities for the project and the neighbouring regions.
The programme was also found to be largely relevant to the needs of the project locations. The selected districts' coverage of institutional delivery and antenatal care was significantly less than the national average. Further, the districts had a significant population of persons with disabilities. The population, although high in absolute numbers, were not the highest in terms of percentage in the country. But the locations were selected on the government's suggestion, which was an important step to ensure ownership of the programme.

KFN's mandate was found to be aligned with UBS OF's vision; and the I2C employed a coherent model with the strategies executed clearly aligned with the proposed outcomes. However, Outcome 3 was found to have weak linkages with that of the other three outcomes; and the work being done with the adults with disabilities, despite forming a large component of the programme, was not clearly articulated in the programme mandate or the indicators.

Overall, the programme works in close coordination and partnership with all relevant government, civil society and private institutions, bodies and committees and has strong linkages with existing programmes/ resources/ interventions.

3. Effectiveness

Effectiveness of Programme Design

Outcome 1: Improved health status of mothers and children

Action Areas:

- Strengthening health centres to provide better maternal and childcare.
- Capacity building of health workers for providing better early care to children
- Capacity building of Female Community Health Volunteers (FCHVs) to facilitate better access to institutional delivery and maternal/ child care and better reporting of institutional deliveries in their area.
- Screening of children at Early Child Development Centres (ECDC) for early signs of disabilities, hearing/ vision defects or malnutrition

Results:

- *All* the Primary Health Care Out Reach Clinics have been strengthened through furniture and equipment support; and *all* the health facilities in project locations have been strengthened to provide better maternal and child care support.
- Ninety-seven per cent of the health workers have been trained in "Helping Babies Breathe".
- All the FCHVs have been trained in mobile messaging for pregnancy registration and service utilization updates.

Outcome 1 works on the preventive aspects of disabilities in children by working on maternal and childcare, and with primary school children for early screening of diseases. The impact study undertaken in Sunsari District for the pilot intervention of the I2C programme (2013) observed that almost 50 per cent of the disabilities in the project locations had developed before or during birth. Thus, addressing the preventive component of disability and working with mothers-and-children forms an essential component for a programme working on disabilities in children.

Infrastructure support to health centres

KFN's initial support to most of the VDCs was providing infrastructural support to the health centres. Health centres were renovated or new centres built in areas where there were no centres. This infrastructural investment helped the programme get the initial buy-in from the community and the government, due to the tangible difference observed in these spaces.

Capacity building of front line field workers

Thereafter, through the programme's capacity building of the FCHVs and the health workers, the institutional care received by mothers and infants has significantly improved. Institutional delivery (as a percentage of reported deliveries) has increased from 39 to 72 per cent over the programme period in the project area. In fact, even the number of reported deliveries has significantly increased over this period.[8] The I2C programme helped improved both the reporting and the access to institutional care for mothers.

[8] Note that these changes are due to both the I2C as well as government efforts to improve reporting and institutional delivery.

Best wishes programme - mHealth

One of the innovative practices implemented by KFN to ensure safe pregnancy and safe delivery is the Best Wishes Programme. KF partnered with a United States of America (U.S.A.) based company, called Medic Mobile, to develop a mobile based app and trained the community health workers to provide instant mobile text-based reports tracking the pregnant women in their region– their ANC visits and institutional delivery. The programme also devised a small incentive system to reward the workers for each institutional delivery reported by them. Once pregnant mothers are registered through the app, FCHVs reminds them to visit health facilities for timely ANC, delivery and PNC check-ups. This strategy has been effective in bringing all pregnant women in the villages within the government reporting system, increased their access to effective care before, during and after delivery. Safe motherhood and safe delivery can also help prevent various avoidable birth defects such as spina bifida or anencephaly.

"Helping Babies Breathe" Programme

Further, the nurses/ health workers at the primary health care clinics and birthing centres have been trained in skilled birth attendance. The "Helping Babies Breathe" intervention was developed to raise the nurses' awareness on ways in which reducing delivery time and increasing oxygen intake by the infant during the first few minutes after her/his birth could significantly reduce the prevalence of cerebral palsy.

These interventions have helped improve the maternal and childcare services in the project locations, as well as safe delivery practices in the project locations. These are important steps for the prevention of avoidable disabilities. There is not enough data to estimate percentage reduction of preventable disabilities through these interventions. However, considering the correlation between inadequate pre-natal and post-natal care with some of the avoidable birth defects, the evaluation team estimates that the significant improvement in institutional maternal and child care (provided through the programme) has helped prevent many preventable disabilities over the last two years. More rigorous quantitative research will be needed to substantiate this claim.

Early screening

I2C is also working with all relevant stakeholders in the early detection of health issues in children, to prevent more serious diseases or disabilities developing. This is being done through screening of children in the ECDCs and immediately addressing nutritional deficiencies, hearing or vision defects, minor diseases and cases of neglect by helping the child and her/his family access the relevant health/ nutritional provisions and government.

Another important component under this programme has been the work undertaken with respect to hygiene and sanitation in the villages, which has significantly improved over the last two years (according to the accounts of community members). The programme has thus ensured a 360-degree vision with respect to identifying and working on all possible aggravating factors for disability.

Outcome 2: Improved Quality of Life of Persons with Disability through Community Based Rehabilitation

Action Areas:

- Individualized community based rehabilitation (CBR) plan developed for every individual identified with disabilities.
- Rehabilitative intervention provided along the five aspects of CBR (as developed by WHO) - Health, Education, Livelihood, Social and Empowerment.

Results:

- 1250 persons (988 Adults and 263 Children) have been identified in the 16 project villages with disabilities.
- Individual profile and rehabilitation plan have been prepared for each of these 1250 persons.
- 27 per cent of the persons with disabilities have received medical intervention (this includes 101 children and 176 adults)
- 27 per cent of the persons with disabilities have received assistive device support (this includes 32 children and 244 adults)
- 14 children with disabilities have been enrolled into schools
- 40 children with disabilities have been provided with home-based education
- 261 persons with disabilities have received vocational training
- 27 parents/guardians of children with disability trained on self-care

Under this outcome KFN follows the CBR matrix developed by WHO to improve the quality of life of persons with disabilities and the CBRF is the focal point of programme delivery for each of the five components. The different components have been discussed separately below.

As per the design of the programme, the CBRF develops yearly plans and five-yearly goals in consultation with the persons/ children with disabilities and their families. This is done to ensure participation of the direct stakeholders and their ownership of the goals set. However, the beneficiaries are yet to understand and take ownership of these goals.

Health

The health component was found to be strongest of all the rehabilitative components in place in the programme. Despite being a multi-disability programme, I2C has been able to address the health needs of the different kinds of disabilities, and has constantly evolved as new needs are identified in the beneficiaries.

The CBRFs have been capacitated to provide immediate physical care to facilitate persons with disabilities so that they can access medical care from relevant institutions. They are trained on providing physiotherapy, assisting in self-care routines and in prescribing and helping access assistive devices. All this has helped improve the physical well-being of persons/children with disabilities. This component has been especially effective for those with physical disabilities. The programme has also paid special attention to cerebral palsy, with different modules developed to train CBRFs on handling cerebral palsy cases. Considering the complicated nature of cerebral palsy, this has helped make the daily lives of the persons with cerebral palsy much smoother.

However, the programme will need to consider the availability of the kind of high-level technical expertise that the KFN team provides to the CBRF and community in the scale up phase. In the absence of such expertise, the CBRF's capacity to identify and address complicated health needs of persons with disabilities may be limited.

Education

Under the education component, the programme tried to develop the schools in the VDCs into inclusive spaces, and worked with the teachers as well as the District Education Officer to enrol students with disabilities into the schools and provide them with similar opportunities as other students. Some of the children (with vision/ hearing/ intellectual disabilities) were facilitated in getting admission in one of the three special schools in the district; while others were provided with short term home schooling options.

At the school level, the evaluation team found the inclusivity still at a very nascent stage. Although teachers had a more positive outlook towards the possibility of having students with disabilities in the schools, their understanding of their capacities was still quite limited.

The programme has helped enrol 14 children with disabilities into schools; most of these students have minor degrees of disabilities. The educational opportunities available for those with more severe disabilities remain limited. Even the district level special schools are limited to primary education, and the home-schooling opportunities provided by the programme were restricted to the basic alphabet and word identification.

Caselet
Name: Yuvraj Magar
Age: 24 years old
Village: Chamaita VDC

Yuvraj lives with his mother in a rented house- both his father and brother died in quick succession three years ago. Yuvraj suffers from a foot deformity, which makes his daily living in the difficult terrain of Chamaita very difficult. He has studied till 7th grade, and makes his living by working in their rented field.

The I2C programme has helped him access a disability ID card (yellow), though he hasn't had occasion to use it yet. The programme provided him with three-day entrepreneurship training, after which he and others chose to take up "beekeeping". The programme provided them with beehives and training on beekeeping; however, all the bees in his hive have died, and he is no longer pursuing beekeeping.

He has also received a special toilet seat and specially designed shoes from the programme. During the visit of the evaluation team, the shoe had worn out and was no longer being used. Due to the heavy daily physical labour he engages in, the shoe lasted 8 months, before wearing out.

In the absence of enough institutions/ programme/ schools providing such opportunities, the programme has been able to effectively leverage on the limited existing institutions. However, the evaluation found the aspirations and thinking with respect to the educational outcomes of persons with disabilities quite limited; and since the programme is currently offering more than what the government systems offer, there is no aspirational pressure from the community to offer more either.

Livelihood

Under the livelihood component, persons with disabilities or the family members of children with disabilities were organised into self-help groups (SHGs). These SHGs were provided with initial seed money of 150,000 NPR and thereafter a credit and saving system was begun. Further, persons with disabilities and the family members of children with disabilities were also provided with livelihood training on a mutually decided occupation. So far, the trainings provided have included those on beekeeping, mushroom farming, lollipop making, ginger/ tea/ dairy farming.

The training has helped some of the persons begin their own businesses/ small shops, but it's too early to comment on the profitability of such ventures. Similar to other self-employment programmes, this one has also seen high failure rates, as many of those trained have been unable to begin or sustain their ventures. Follow-up strategies for those who have not been able to begin their own businesses are also not very clear.

Entrepreneurship or self-employment has a high failure rate and when the livelihood component is driven primarily by an entrepreneurship model it is problematic. Assuming all beneficiaries have an entrepreneurial inclination is not practical. Even for those who are so inclined, selecting an occupation will need more strategic thinking involving economic viability and market demands, along with the person's individual desires. Further, after the end of the programme, expecting seed money for such ventures from the municipality or ward funds may not be feasible, i.e. when the government completely owns the programme, especially in the face of mounting evidence of its low success rate.

More practical and sustainable alternatives (along with the self-employment model) will need to be introduced, especially for those with minor and moderate levels of disabilities - for example, the schools, government positions as well as positions in small enterprises can be made more inclusive to help mainstream persons with disabilities into such jobs in a sustainable manner.

Social Inclusion and Empowerment

The programme's strategy under these components is not very clear, and will need greater attention moving forward.

I2C has worked with the community to create inclusive spaces for persons/ children with disabilities. As of now, the community has incorporated a welfare approach towards these persons/ children, and there are no examples of a rights-based inclusive approach yet. Even in spaces/ platforms, where efforts have been made to include persons/ children with disabilities (like in the child clubs), it is yet to go beyond head counting or a token inclusion, towards spaces which enable the persons/ children to participate in decision making and raise their voices. This understandably is difficult for a multi-disability programme to bring about in such a short amount of time. However, the programme does not have clear strategies or goals set for this either.

The SHGs developed under the livelihood component has helped provide a sense of confidence and economic and social inclusion to the persons with disability. But the evaluation team feels that greater attention will need to be paid to inclusion at the family level, when looking at the social inclusion component. Further, under empowerment, a clear strategy needs to be in place. Although, some of the strategies under the other components (like livelihood and education), would help contribute to the empowerment of the persons/ children with disabilities, the linkages need to be clearly defined in the programme strategy. Further, the component of sexual empowerment should also be included, especially when working with adolescents and adults with disabilities.

KFN has recently included the menstrual and reproductive health component in the refresher trainings organized for the CBRFs, but the evaluation team suggests that the concern/ outlook should go beyond just the health component, and the empowerment component should be included as well.

Outcome 3: Reduced prevalence of violence against children

Results:

- 124 school teachers trained on positive discipline
- 302 school teachers trained on inclusive education
- 99 parents trained on positive discipline

Under this outcome, KFN worked with different stakeholders working with children in the villages. The programme worked with the child clubs at the school and village level, capacitating the members of the executive-body to be sensitive to the needs of children with disabilities and develop the child club, including the executive-body, into inclusive spaces with representation from children with disabilities. This has helped increase visibility of the issue of persons with disabilities and encouraged peer learning. Further, the child clubs are emerging as models for inclusive decision-making platforms to help normalize the equal participation of persons with and without disabilities from an early age.

The programme has also provided trainings to teachers in the project locations on inclusive education and positive discipline techniques. Training has also been provided to resource persons at the district education office. The parents of children (with or without disabilities) have also been provided with training on skilful parenting. KFN partnered with ICS (Investing in Children and their Societies) to train its staff members to provide such training. Twenty-one staff members have participated in the training of trainers (ToT) programme, and sixteen of them have been trained on delivering a ten-weeks course on skilful parenting in their project areas.

However, as a component of a disability programme, the evaluation team feels that the prevention of violence component should pay greater attention to violence against children with disabilities. As per the UNICEF report (State of the World's Children, 2013), children with disabilities are a high-risk group when it comes to violence - they are 3.6 times more likely to be victims of physical violence and 2.9 times more likely for sexual violence than their peers without disabilities.[9] As such, this would be an important area to address, and help better align the activities under this outcome with that of other outcomes.

This would require evidence-based understanding of the *prevalence and kinds* of violence faced by the children with disabilities- including physical, emotional, verbal and sexual. Neglect and violence faced by children within the family and peer settings will need extra attention.

Outcome 4: Strengthened organisational capacity and community support system

The I2C model depends on the initial buy-in and ownership by the government as well as the community. Each village first signs a MoU with KFN. They then conduct a baseline study and present the findings. Further, an implementation agreement is developed by the KFN and the community together, and signed by the HFOMC. The HFOMC remains the focal point of all the decisions, fund allocation and activities

[9] Source: https://www.unicef.org/sowc2013/focus_violence.html

undertaken by the I2C programme. The evaluation team observed real ownership by the health committee and the community for the programme.

The evaluation team found all the relevant community institutions and government departments closely involved in each stage of the programme, and because of their participation as well as the cost-sharing component, the ownership levels are quite high.

One of the strategic decisions taken by the KFN team has been to facilitate developing the HFOMC as the implementing agency for the programme. This has helped integrate the programme into the governments' management and administrative system. Throughout the process, the KFN team has been providing technical support and has capacitated the representatives to develop a shared understanding and vision for working with persons with disabilities. Due to their close involvement in the management and implementation of the programme, government officials as well as community workers were found to have a clear understanding of the logistics of the programme, and the funds, efforts and management it would require. There is also expressed willingness and preparedness to take full ownership and responsibility of the programme after KFN's phase out; in fact, the evaluation team were impressed to note that some of the community organisations have already begun saving and preparing for supporting the programme after KFN stops funding it.

Although the various institutions and their representatives understand the administrative responsibilities that the I2C programme involves, their understanding and expertise on the issue of disability, and the needs and challenges faced by the persons with disabilities and also their vision and aspiration of persons with disabilities is still limited. Going forward the programme will need to work more closely with these institutions/ representatives on their issue based understanding and capacity, so that they can continue the work begun by KFN with the same vision and aspiration.

Effectiveness Snapshot

The evaluation found the programme design under Outcome 1 (with respect to prevention of disabilities) highly strategic and effective. The interventions have made significant strides in improving maternal and child care in the project areas - which is found to have direct linkage with the prevention of avoidable disabilities.

Under Outcome 2 (or the rehabilitative aspect of I2C), the health-component was found to be the strongest. Under the livelihood component, more sustainable and practical alternatives would need to be explored; and the sole dependence on self-employment strategies with its high failure rate was found to be problematic. The strategies under the social-inclusion and empowerment components were not very clear; and more attention will need to be given to family-level intervention. The education component was still in its nascent stage, and the programme was still evolving its strategies under it- moving forward, the *quality* of education and inclusion in schools would need greater attention.

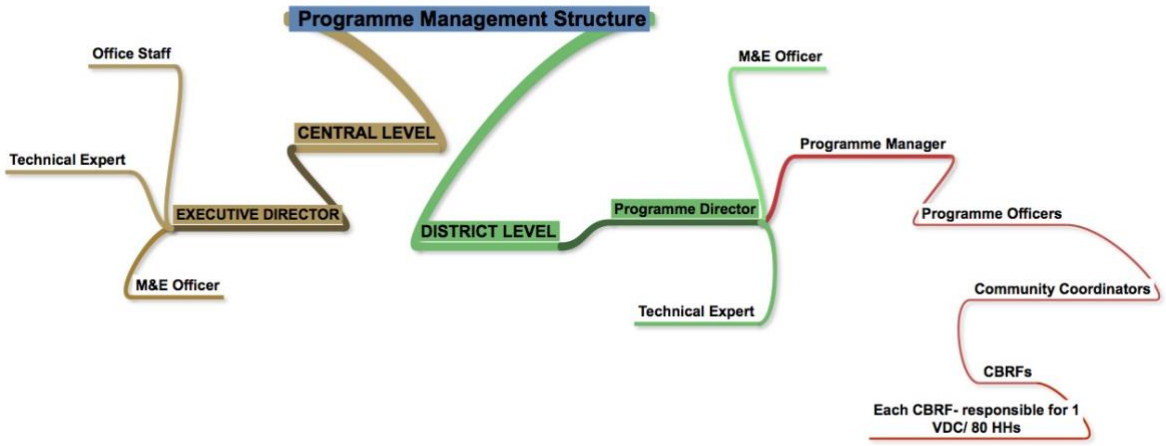
Under Outcome 3 (violence against children), the programme would need to include clear strategies and indicators to understand and address violence against children *with disabilities*. As of now, the strategies are broad and covers all children, making this outcome somewhat weakly linked with the other three outcomes, which have a specific disability focus.

In terms of strengthening the organisational capacity and community support system (Outcome 4), the evaluation team found the programme to be mainstreamed into existing government administrative systems and the community institutions expressing willingness and preparedness to take responsibility of the programme after KFN's phase out.

4. Efficiency

Programme Management

KFN employed a robust and lean programme management structure, which has been shown below.



The team at the national and the district level were found to be well qualified and diligent, and the members maintain close communication and monitoring between each other.

Due to the close linkages with the government and community institutions, KFN is able to provide a high level of assistance and long-term impact through minimal human resource investment. All preventive health-care components are executed through the government health workers in the village, and the administrative, funding and reporting responsibilities are undertaken by the HFOMC. The CBRF is the focal point of all interventions at the individual and VDC level; with the community, the HFOMC, VDC as well as the DPOs monitoring and supporting her work. However, moving forward, the programme will need to consider the overburdening of the CBRF and manage her time and efforts in a better manner.

The evaluation team found the CBRF's time and capacity (at the moment) to be stretched by the demands placed by the programme on her. Moving forward, a mapping of time and effort demands on the facilitator will need to be undertaken and her/ his responsibilities realigned accordingly. The demands of paper work and reporting on the CBRF were found to be especially high, and some of it unnecessary.

Monitoring and Evaluation System

At the district and the national level, the programme employs an efficient and systematized management system, with clear role divisions and strong communication maintained at each level. The team also had an effective internal monitoring system in place. The data from the community level is collated on a quarterly basis and half-yearly reviews are undertaken with the community where the results of the programme are shared against the objectives, and the next steps deliberated on in a participatory manner. This helps maintain open lines of communication with all the stakeholders and facilitates a mutual accountability mechanism.

However, the evaluation team found the monitoring at the community level (that is at the VDC/HFOMC/ CBRF level) somewhat weak. As of now, the accountability systems in the community are geared around inputs, with not enough monitoring is in place with respect to the proposed/ planned outcomes and goals. Since the community will be the unit that carries forward the programme beyond five years, this unit will need to feel more closely connected with the outcomes planned, which as of now, are mainly the responsibility of the senior KFN team.

Reporting Formats - Time Management

Further, the reporting formats at the CBRF level and at the KFN level (submitted to UBS) will need to be relooked at. The accompanying Text Box lists out the reporting formats filled out by the CBRF. These are lengthy and cumbersome, with much of the data being irrelevant and not useful to the programme monitoring or implementation system. Further, currently, the CBRF uses common-sense logic when deciding which forms/ sections need to be filled and which are to be skipped for different kinds of disability; lack of systematization of such logic could be harmful to the monitoring system as crucial data may go unrecorded. KFN is in the process of developing an online MIS system for collecting data from the VDCs, this could potentially take care of some of these challenges and the workload of the CBRF. The data collected at each step will need to be reviewed considering its utility. Customized logic can be incorporated for different types and severity of disabilities into the software to ensure skips in the forms are logical and systematized. However, KFN will also need to assess the feasibility of an internet-based MIS system considering the unreliable connectivity in the locations in the project area.

Reporting formats filled by the CBRF

1. *Disability History Assessment Form*
2. *Primary Health Assessment Form*
3. *Goal Setting Form*
4. *Assessment of Situation of Disability, Activities of Daily Living and Social Participation Form*
5. *Questionnaire for measuring quality of life*
6. *Record of regular home visit*
7. *Change Mapping Form*

The "goal-setting form" which is an important determinant of the work being done by the CBRF with the beneficiaries will need greater attention. The evaluation team found that even though the programme involves individual care for each identified person or child with disability, the goals and plans set are quite similar across disabilities, and do not reflect the nuanced needs of different kinds of disability; this is especially true in cases of intellectual disorders. However, this is an obvious challenge of the multi-disability programme, and the team is open to learning and adapting as new challenges come up with each new beneficiary group.

Similarly, the reporting format of UBS OF was also found to be limiting for accommodating the range of activities and results of the programme. The evaluation team found a large amount of the activities, achievements and complexities of the programme going unrecorded in these formats.

Overall, the programme has been able to make effective and efficient use of the existing funds and human resources at the disposal of the community. By demonstrating the impact of and need for I2C, it has been able to build the trust of the community to mainstream these existing resources into the programme. Moreover, the team found that every decision of resource utilization had been made in a strategic manner.

Efficiency Snapshot

Through effective linkages with the community institutions, the programme has been able to leverage on the existing financial and human resource at the disposal of the community. This has helped them ensure high impact through minimal human resource investment. KFN has maintained a lean and robust team at the national and district level with very close communication and coordination. They also have an effective internal monitoring system, with regular collation and sharing of data and deliberating on future steps.

However, at the CBRF level, the evaluation found the work/ time requirements to be demanding and her capacities stretched by the demands of the programme. There are extensive reporting requirements at her level, many of which were found to be irrelevant. The reporting would need to be simplified and reduced keeping the usability of the data in perspective. Also, the monitoring at the village/ HFOMA/ CBRF level was found to be weak, with a lack of alignment with the outcomes/ goals of the programme. They have an input/ activity focus and the goals/ outcomes are the responsibility of the KFN team.

5. Impact

Table 6: Key impact level indicators

		Data
Access to Disability ID Cards		83% (Increased from 45% to 83%)
Access to Social Security Allowance	Adults	78% [N=536]
	Children	78% [N=128]
Access of Children with Disability to Education*		61%
Institutional Delivery (as a proportion of reported deliveries)		72% (Increase from 39%)
Proportion of Malnourished Children		0.14 (Decreased by 91.25% from 1.6 proportion)

*The evaluation team expresses caution when looking at this percentage. Under education, it would be important to look at *quality* of education and follow-up of the education input. A significant proportion within this percentage is of those receiving home schooling, some of which are short-interventions, with no noticeable improvement in literacy/ educational indicators of the beneficiaries.

On awareness and visibility of issues of disabilities

One of the immediate impacts of the programme has been the greater visibility and reporting of persons with disabilities in the project locations. The evaluation team found that in locations without the I2C programme, there is a lack of clear understanding of the exact numbers of persons or children with disabilities there.

I2C has helped clearly identify and report on the exact numbers of persons/ children with disabilities and the kinds of disabilities they have; this also forces the village/ district authorities to be accountable to the needs and rights of these persons.

Further, the programme has helped bring in greater attention on the issue of disabilities, i.e. the need for inclusive spaces and the difficulties and discrimination faced by them; this has helped begin and further the dialogue on this topic, and although the community spaces/ groups are yet to be truly inclusive, there are efforts being made to make them so. From being an invisible part of the population, with not enough avenues to leave their home, this demographic has now become a visible part of the community and their discussions. Although the community is still using a welfare approach using expressions and symbolisms

of pity/ sympathy for persons with disabilities, it has helped reduce the community's outright discrimination/ neglect and indifference for this demographic. Moving forward, the programme will have to focus on translating the rights perspective held by the KFN team at the national and district level to the community as well.

On prevention of disabilities

It is difficult to estimate the percentage of disabilities prevented at this stage of the project, and a longitudinal study would need to be undertaken estimating the percentage of disabilities before project intervention and after 5, 10 and 15 years of project intervention.

However, what we can observe and report on is the improvement of maternal and childcare in the project locations which has direct consequence on the reduction of avoidable disabilities.

The percentage of institutional delivery in the project locations has increased from 39 per cent to 72 per cent, and the proportion of malnourished children has reduced from 1.6 to 0.14 (a reduction of 91%). All the health workers/ nurses working in the Primary Health Care units of the project locations have been trained in providing early care to infants, including training in "Helping Babies Breathe" which as mentioned earlier has significant implications on some of the preventable disabilities like Spinal Bifida. Further, as per the account of the FCHVs, the HFOMC representatives and community members, pregnant women accessing antenatal care has also significantly improved in the project locations. This has been helped by the mHealth intervention and the constant mobile reminders and reporting that it has ensured for all pregnant women in the project areas, and through strengthening of the health posts in all the project locations.

On quality of life of persons/ children with disabilities

It is too early to observe any significant impact on "quality of life" of persons/ children with disabilities. As noted earlier, the programme has been on the ground for only about 1.5 years and over this period, the first few months were spent on identifying persons/ children with disabilities amongst the project locations. Thus, most persons identified have had just over a year of individual intervention.

Despite the short duration, the evaluation team noted significant strides in the direction of improving the lives of the identified persons and children with disabilities.

Access to Disability ID Cards

One of the immediate changes in their lives has been brought about through the provision of disability ID cards. More than 80 per cent of the persons/ children identified with disabilities now have access to disability ID cards, which at least for the two most severe degrees means access to a monthly remuneration from the government. Those with complete disability receive 2,000 NPR per month and those with severe disability receive 600 NPR per month. This of course helps bring some financial relief for the persons with disabilities or their families. Also, the ID cards for all four degrees of disabilities provide access to various provisions and subsidies from the government for such persons. However, the evaluation team finds the awareness of the provisions that they are eligible for, quite limited amongst the persons with disabilities or family members of children with disabilities. Thus, as of now, the cards have

not yet helped in accessing provisions other than the pensions received by the red and blue card holders- as it would need greater outreach work and information sharing.[10]

Physical Well-Being of Beneficiaries

The second most important impact has been on the physical health wellbeing of persons with disabilities. The programme works on multiple aspects of the lives of persons with disabilities; however, the health component has received the most attention during the first two years. Due to the urgent nature of such needs, the programme provided assistive devices, surgeries or medical interventions and has also been providing regular physiotherapy to the individuals needing such care. All this has helped improve the physical wellbeing of persons and children with disabilities, especially those with physical disabilities (which is the most common type of disability) in the project area.

Access to Education

Fourteen of the children with mostly minor and moderate disabilities (5% of the identified children with disabilities) have also been enrolled into schools, and 40 of them (15%) have been provided with home schooling by the programme. Thus, the programme has helped improve the educational outcomes of the children; however, greater attention and follow-up will be needed on these outcomes (as covered in the Effectiveness Section).

On policy environment

KFN has established itself as a technical agency that the government seeks out for any input/ guidance with respect to policies on disability. KFN's guidance and support as well as the model established by the I2C model has helped inspire or contribute towards some important policy level changes with respect to disability. This includes the new Disability Act expanding the categories of disabilities from seven to ten types, exhibiting maturity in its understanding of the unique needs and challenges of the different types of disabilities. Further, the social security allowance has been doubled from 300 NPR and 1000 NPR for those holding blue and red disability ID cards respectively, to 600 NPR and 2000 NPR. Another significant development has been the provision of MCBRF (Master CBRF) in the 10 years Health Strategy by the GoN- the strategy plans for one MCBRF in each health post within five years.

Although it is difficult to attribute these policy changes completely to KFN, the KFN team were closely involved in each of these decisions.

Unintended/ Indirect Impact

The evaluation team also noted some indirect/ unintended impacts of the programme, wherein a wider audience could benefit from the programme inputs.

[10] Note the evaluation team was informed about a recent effort by the KFN team to provide diaries to all the identified persons/ children with disability; these diaries along with providing space for these persons and their families to share their experiences, also includes information about schemes and provisions that persons with different degrees of disabilities can access. As of this report, this is yet to be introduced in the programme locations.

One of these impacts was the improvement in health facilities and wellbeing noticed across the community members, with or without disabilities, in the project locations. Since the programme included strengthening the health and sanitation systems in the project locations, it helped improve the access to better health services for all persons living in the area. The improvement in the physical infrastructure of the health posts and birthing centres and the awareness on proper child and maternal care has far reaching consequences, beyond just the prevention of disabilities, it also has an effect on the general physical and intellectual growth and wellbeing of all children and persons in the community.

Another interesting impact observed was the ripple effect in neighbouring villages and districts. The programme was able to create visibility on the issues of persons with disabilities beyond just the project areas. The evaluation team found the neighbouring areas finding inspiration from the I2C making attempts at provisions for persons with disabilities.

Impact Snapshot

The immediate impact of the programme has been on the increased visibility of persons with disability and the issues faced by them. Access to disability ID cards has increased by almost 40 per cent points, which has increased their visibility, their access to basic provisions and pension (for the red and blue card holders) and has also increased the community institutions' accountability to them and improved the persons' status in the community/ family.

The programme has also significantly improved the maternal and childcare provisions in the project areas, which are important steps towards the prevention of avoidable disabilities.

In terms of impact on the beneficiaries' quality of life, I2C has had some immediate impact in terms of the improvement of physical wellbeing of the beneficiaries and also financial relief for those eligible for monthly pensions. It has also helped enrol a small percentage of children with disabilities into schools. However, it is too early to notice any marked change in their quality of life. Due to the urgent nature of physical health needs, as of now that has received the most attention.

KFN and I2C have also contributed to or inspired some important policy level changes with respect to disabilities. This includes expansion of categories of disabilities from 7 to 10 types and the provision of MCBRF in the 10-year health strategy of the Government of Nepal.
The evaluation also noted some indirect impact of the programme - in terms of the ripple effect to neighbouring non-project areas, and also improvement in health wellbeing for all persons in the community, with or without disabilities.

6. Sustainability

The I2C programme has been designed with close attention to the sustainability and scalability of the model. The model has been developed for mainstreaming into the existing government structure, and the KFN team has paid careful attention to reducing their footprint and ownership of the programme.

Community Ownership

The cost-sharing model used by the programme ensures its ownership by the village level government system from the inception stage. This is systematized through the MoUs and agreements signed between the KFN and the VDC. Thereafter, the HFOMC has been assigned the implementer's role, which helps shift accountability of the programme from the KFN to the HFOMC representatives. These are important steps taken to ensure the effective management of the programme after KFN's phase out.

Linkages with Existing Systems

Similarly, at each step of the programme, the I2C team makes linkages with relevant government or private departments in the state to assist project beneficiaries in a cost-effective manner. For instance, all assistive devices are provided free of cost to the persons with disabilities through efficient linkages with government schemes or private organisations working on disability.

Capacity Building

The programme is capacitating the government representatives and the government workers to both implement and manage the programme. Although there is still some way to go for the government systems to align their vision with that of the KFN team, the different stakeholders at the village and district level are keenly aware of the logistics involved in continuing the programme, and were found to be prepared for the same.

Knowledge Products

The KFN team has also developed important knowledge products, which will be useful replacements for the technical guidance that the KFN is providing to the programme at present. This includes an updated asset book with an exhaustive list of the different assistive devices and equipment that can be potentially needed by persons with disabilities and the different schemes, institutions, and programmes through which they can be accessed in a cost-effective manner.

Sustainability of the role of Community Based Rehabilitation Facilitator

The key feature of the programme is the CBRF in the VDCs. (S)he is the main implementing agent in the programme, and mainstreaming her position into the village administrative system will be a pre-requisite for the scaling up of the programme by the government. One of the significant steps taken by the Government of Nepal in this regard has been the incorporation of "Master CBRF" into their recent 10-year Health Strategy Document. However, going forward, the role of the CBRF will need greater standardization to help the government in creating a government position for the same. Presently, the evaluation team finds the functioning of the CBRF is quite dependent on the technical guidance and monitoring provided by the KFN team. Despite the rigorous training provided to the CBRFs, their capacities were found to be insufficient to take charge of the duties in the absence of the KFN team. Thus, along with the annual refresher trainings provided by the programme to the CBRFs, standardization of their job description will be required including detailed guidelines on the action areas for the different types and degrees of disabilities for both adults and children. Considering the complexities of a multi-disability programme, this will be one of the key challenges that the programme will face in the coming years.

Financial Sustainability

The entire I2C project is built on a cost-sharing model between KFN and the local governance systems at the village and district level. This cost sharing is established from the beginning of the intervention through the MoUs signed with the VDCs.

Each VDC has a certain percentage of funds for persons with disabilities. During the visit to the non-project village and through the consultations held with the government representatives, the evaluation

team found that in villages that do not yet have the I2C programme, there is a lack of direction for the use of these funds. In most villages, the entire budget for the persons with disabilities is handed to the DPOs in the village; in the absence of DPOs, the funds often go unused.

The KFN team has helped establish the I2C model as an alternate more effective avenue to spend these funds. Along with the disability component, a portion of other relevant funding components - like funds for child protection, women development, the elderly, Dalits and indigenous groups - are also given by the VDCs to the I2C programme, as part of the community's contribution to the project. This is complemented by the matching fund component of the VDCs. Further, the entire community is being mobilized to provide individual and group contributions.

Table 7: Fund-sharing by the community (example of the 2 VDCs visited)

S.no	Sector	Ektappa VDC			Chamaita VDC		
		Year 2016	Year 2017	Total	Year 2016	Year 2017	Total
1	Children	50,000	70,000	120,000	0	81,000	81,000
2	Disability	70,000	45,000	115,000	30,000	0	30,000
3	Indigenous Groups	10,000	10,000	20,000	0	0	0
4	Women	50,000	65,000	115,000	0	0	0
5	Dalit	10,000	10,000	20,000	0	0	0
6	Elderly	10,000	0	10,000	0	0	0
7	Matching Fund	0	0	0	170,000	200,000	370,000
	Total	200,000	200,000	400,000	200,000	281,000	481,000

Ensuring community contribution from the beginning has been important to establish ownership of the programme and as a step towards sustainability of the programme. As per the I2C model, KFN steadily reduces its share in the programme from the first to the third year (KFN: Community-80:20 in the first year, 50:50 in the second and 30:70 in the third year). In the last two years of the programme KFN proposes to provide only technical support and the entire financial cost of the programme is to be borne by the VDCs or the gaupalikas. This is clearly described in the different agreements signed with the government authorities and representatives at the village and district level were found to be aware of this scenario and prepared to take up increasing financial burden of the programme in the coming years.

The Tables below describe the cost distribution model as well as the cost sharing achieved for the first two years in the project villages. The programme has largely followed this model and generated the planned percentage of resources.

Table 8: Cost- Sharing Model

Project Year	Running Cost		Investment Cost
	Project Contribution	Community Contribution	Project Contribution
1	80%	20%	100%
2	50%	50%	100%
3	30%	70%	Technical Support
4	Technical Support	100%	Technical Support
5	Technical Support	100%	Technical Support

Table 9: Cost-Sharing Achieved

	Total Cost (NPR.)	Investment Cost	Running Cost		Community Allocated
		KFN	KFN	Community	
Year 1	19,437,841	9,874,412 (100%)	7,750,730 (80%)	1,937,682 (20%)	2,800,000
Year 2	17,294,580	9,280,510 (100%)	4,004,625 (50%)	4,004,625 (50%)	3,788,820

However, as shown in the Table, the cost sharing at the community level is for the "running cost", while KFN makes significant "investment cost" which it bears completely during the first two years. Thus, for the government to scale the programme to other locations, this "investment cost" will be a significant additional cost to bear, and might prove to be a challenge. Since the whole logic of the sustainability of the model depends on the eventual complete cost bearing of the programme by the community, this will need more thinking to generate funds for the 'investment cost'.

The evaluation team recognizes the difficulty of raising funds at the community and government level, and found the funds raised over the two years quite significant and commendable. Moreover, the community and the government were found expressing preparedness for the phase-out of the programme, and the different VDCs have already starting raising "sustainability funds" to help bear the cost in the coming years.

Sustainability: long-term planning

As mentioned before, the KFN team has already managed to secure MoUs with the newly formed municipalities. As per their agreement, each municipality will select a programme unit (which will include 2-3 wards) and each of these units will have a CBRF. Other than the project villages, they have agreed to include the remaining areas that have become part of the municipalities into the programme as well.

Further, it was found that the team had certain long-term plans keeping in mind KFN's phase out. KFN has already established a prosthetics organisation, which will manufacture special shoes for those with physical deformities, and later develop various other kinds of assistive devices. This will help the government secure reliable, cost-efficient, locally manufactured and easily accessible devices for the programme beneficiaries. Similarly, KFN is thinking of partnering with accredited institutions (like the Centre for Technical Education and Vocational Training) to facilitate the beginning of a course for the training of CBRFs. KFN is also planning to establish a resource centre themselves with the approval of such institutions. This will again help in the large-scale training and development of CBRFs across the country, in the absence of the KFN team providing such trainings.

The DPOs/ SHGs/ other relevant institutions at the local level will be capacitated to take on the daily

Sustainability Snapshot

KFN has established the cost sharing model from the inception stage to ensure ownership and sustainability of the model by the local stakeholders. KFN has signed MoUs with the relevant village (now rural municipalities) and district level institutions clearly demarcating such cost sharing planning.

In the first two years of the programme, the community has successfully raised 20 per cent and 50 per cent of the programme running cost, as per the model. This is a significant achievement. Further, all the relevant stakeholders expressed awareness and preparedness for taking up more of the cost-burden in the coming years, after KFN's phase out.

However, the evaluation found significant investment being made by the KFN in terms of the "investment cost" of the programme, which is completely borne by KFN. This may prove to be a sizeable amount and a challenge in the event of scaling up of the programme, when the government will need to bear the entire cost burden from beginning to end.

management and monitoring of the programme in the absence of KFN. However, this will need greater thinking and piloting, as the evaluation team found the capacities of the local groups/ institutions quite inadequate to take on such a task.

7. Recommendations

Simplifying casework and strengthening monitoring and evaluation at the community level

- Standardize goal setting and quality of life matrix for the 40 (10 types x 4 degrees) categories of disabilities that the CBRF is likely to encounter, including some room for individual level specification of goals.
- Ensure regular and better follow-up with beneficiaries after every round of complete support. In the advent of an unsuccessful intervention (at the level of livelihood, education or health), immediate follow-up and alternate measures will need to be taken; especially for persons receiving assistive devices, immediate follow-up should be done in the case of malfunctioning, or wearing out of devices.
- As part of this regular follow-up, the programme needs to find ways to develop systems that will facilitate a two-way communication between beneficiaries and the CBRF. The persons with disabilities or their families need to know when and whom to approach with their concerns, instead of depending on the CBRF to come to them. Use of technology/ software or even a mobile-based platform could be considered for this.
- Simplify and reduce the reporting demands on the CBRF. The new MIS software should be designed with the perspective of simplifying the data entry at the CBRF level and also the usability of the data collected (for decision making or monitoring).
- Strengthen the overall monitoring mechanism at the community level. Accountability at the community level will need to go beyond input/ activity level to include an outcome/goal level approach. The ownership and responsibility of the outcomes should filter down from the district and national level of KFN to the community level. This must be ensured since the community institutions will be responsible for the everyday monitoring of the CBRF's work.

Work towards developing guidelines for institutionalization of CBRF

- Develop standardized guidelines for the CBRF's role that can be easily institutionalized by the government. This will involve the development of standards and systems for CBRF's eligibility, selection, training, monitoring and evaluation based on the project's experience.
- The systems developed will need to be corruption-proof and will need to pre-empt all possible difficulties that any community level government posting can have.
- Undertake a realistic time-effort estimation of the CBRF's work against her expected role. Based on this, a standardized and practically viable guideline on working hours, activities and tasks and accountability structure can be developed. This will also help the GoN mainstream the CBRF's work into the government mechanism, and help standardize both the quantity and quality of the work undertaken across locations.

Strengthening the work with children with disabilities

- Give greater attention to the unique issues of children with disabilities.

- Especially with regard to violence against children, develop strategies to address violence against children with disabilities. This will help align the work under the outcome with the overall programme goal as well UBS OF's and KFN's broader vision.
- In order to do this, a situational assessment should be undertaken to understand the prevalence and kinds of psychological/ emotional as well as physical violence faced by children with disabilities, and the spaces or situations in which they are most vulnerable to such violence. Based on this, strategic measures to address such violence will need to be taken, not just at an individual level, but also at the community and policy level, to raise awareness about and prevent it in a sustainable manner.
- Even with respect to inclusion, more effort will be required at the school and community level to move beyond a token inclusion of a handful of persons with minor disabilities towards creating spaces and platforms accessible to persons with moderate and severe disabilities as well. Further, "inclusion" should go beyond the mere presence of persons with disabilities in meetings/ discussions to demonstrate their representation, to enable active participation of both persons with and without disabilities at the decision-making level in equal measures.

Strengthen engagement with the families of persons with disability

- Give greater attention to family level work, with clear strategies and modules in place on the different components that the CBRF would need to focus on for interventions with the families. This is important since the family are the primary and immediate care givers.
- The family-level intervention should include counselling for family members to better understand the conditions and needs of the persons with disability.
- Capacity building of family to provide, not just physical support, but also emotional support to persons/ children with disabilities. For children with disabilities, the families will need to be capacitated on understanding and addressing the psychological vulnerabilities and/ or anxieties faced by these children.
- The programme should consider including provision for the emotional hand holding of care-givers of persons with disabilities, especially for severe and complete disabilities. Considering the limited resources, care-giver groups can be created to facilitate them in supporting each other within the community.

Livelihood promotion to be supported with close and specialized inputs

- Rethinking of self-employment as a major employment generation strategy. Include multi-strategy approach where self-employment is *one* of the strategies. Thus, a greater variety of interventions under this component will need to be thought of.
- The programme can consider mainstreaming of employment of persons with disabilities in government and civil society institutions at the community (palika and ward/ village) and district level (especially those with minor and moderate disabilities).
- The programme can also consider partnering with private organisations to provide training for computer-skills, accounting, data entry and other such employable skills, which persons with minor disabilities can pick up, and then facilitate them in securing jobs through those skills.
- The programme can look at and learn from other successful livelihood promotion models.

Amend results framework

- Amend the results framework to capture the results of the work being done with adults (with disability) under the programme. Specify programme indicators to capture the CBR efforts and funds being expended on the work with adults.
- Disaggregate the targeted and the impacted numbers of beneficiaries between those receiving preventive and those receiving rehabilitative support when reporting on results. This will help bring clarity on programme targets and impact to the funder (UBS OF) as well.
- Consider changing the reporting formats used for UBS OF, in order to enable such multi-layered reporting.

Strengthen social inclusion and empowerment component

- Specify clear goals and strategies for the social inclusion and empowerment components.

Look into the financial sustainability of the model

- Consider both the running and the investment cost when thinking of the scalability of the model; Facilitate and capacitate the government institutions to understand and prepare for bearing the burden of both the costs when scaling the model to other areas.

8. Conclusion

The I2C model was found to be a well-planned, coherent and relevant model that leverages on the existing human and financial resources and complements the conducive policy environment to work for persons and children with all kinds of disabilities in a well-rounded manner. The programme has a beginning to end model, with clear strategies in place for fund generation, access to resource and programme management structures. Within a very short period, it has been able to increase visibility of the issues faced by persons with disabilities and significantly improve maternal and child care in the project locations - thereby helping prevent avoidable disabilities. It provides almost a complete rehabilitative package for all persons identified with disabilities, which includes interventions along all parameters of quality of life, as per the WHO model. It has created linkages with all possible community level institutions and leverages support from every system/ structure that persons/ children with disabilities have any interface with.

The I2C model was found to be scalable and replicable in any of Nepal's regions or other developing countries. In the absence of any other programme by the GoN for persons with disabilities, the success demonstrated by the programme, and willingness shown by the community and the government to incorporate it, can facilitate mainstreaming of this model into the existing administrative structure. Further, due to the overhauling of the political structure, and development of new strategies and programmes, I2C can establish itself from the beginning as an essential component.