Accelerating Core Competencies for Effective Wheelchair Service and Support (ACCESS) Project

EVALUATION OF ACCESS PROJECT IN FIVE COUNTRIES

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World Vision

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ACRONYMS

ACCESS	Accelerating Core Competencies for Effective Wheelchair Service and Support
PWD	People with disabilities
CWD	Children with disabilities
ADP	Area Development Program
CVA	Citizen Voice Action
IDI	In depth Interview
FGD	Focus Group Discussion
WC	Wheelchair
IDI	In-Depth Interview
WC User	Wheelchair User
NGO	Non-Governmental Organization
TOT	Training of Trainers
USAID	United States Agency for International Development
WHO	World Health Organization
WSTP	Wheelchair Service Training Package
WVI	World Vision India
WV	World Vision
WVN	World Vision Nicaragua
WVK	World Vision Kenya
WVES	World Vision El Salvador
WVR	World Vision Romania

EXECUTIVE SUMMARY

The ACCESS project, led by World Vision, was implemented from 2014 to 2017 in five countries- El Salvador, India, Kenya, Nicaragua, and Romania - with the goal to strengthen the wheelchair sector through enhanced service capacity, provision of diverse range of wheelchairs, engagement with national and local governments and increased participation of wheelchair users. The design of the project was collaborative, with World Vision mobilizing people in hard to reach communities to refer clients for wheelchair services, local service providers providing WHO complaint wheelchair services, and wheelchair technical expert organizations: Motivation UK, Motivation Romania, and UCP- Wheels for Humanity, providing capacity building and technical support for appropriate wheelchair service. At the same time, World Vision spearheaded advocacy and awareness raising to build an enabling environment for wheelchair service and disability inclusion. Wheelchair Service Training Package (WSTP) trainings were provided to service providers by the technical experts as well as host training institutes like Mobility India and APDK in Kenya.

A qualitative evaluation of the project was undertaken in all five countries with the aid of in depth interviews and focus group discussions with a variety of stakeholders including service providers, wheelchair users or clients, Citizen Voice and Action (CVA) group members, World Vision staff, ACCESS staff, and technical experts. Quantitative evaluation was conducted through analysis of service statistics extracted from the project database.

The evaluation reveals that the project adequately addressed the goals - to strengthen the wheelchair sector and ensure that all people with mobility limitations, especially women and children, are able to access appropriate products through qualified service providers and enjoy full participation in their communities. 92% of respondents indicated increased social inclusion over the life of the project. Community participation increased among wheelchair users in all domains of social and personal life as measured by the social inclusion scale. Variation in participation was seen among age groups with the younger clients showing an increase in educational activity as well as in other activities compared to the oldest age group. Qualitative data highlighted a number of enabling and impeding factors in social participation common as well as unique to the countries: education, family support, CVA efforts, life skills training program as enablers, and gender, advanced disabilities, lack of access to public transport, poor condition of roads, and internalized and external stigma as barriers.

Quantitative data indicates that out of 8,019 assessments, product provision was made to 7,258 clients, roughly 91%, which suggests a sufficiently good coverage of people who were referred and assessed. Service capacity increased for all 43 service centers; however, only a few reached the highest level of capacity as "well-functioning" service centers which may indicate the need for further support to make capacity building change sustainable. All eight steps of the WHO service protocol were rigorously followed. However, follow up was the most challenging step, with 30% of clients not having been followed up after receiving a wheelchair, representing a lost opportunity to address issues of maintenance and repairs and ensure social inclusion. Qualitative data indicates a number of operational issues – lack of clarity regarding roles and responsibilities for follow up, low involvement of local World Vision offices in some countries, and in some cases, a lack of coordination between service providers, technical experts and World Vision community staff.

The 8 Steps + model, developed out of the ACCESS project and based on co-operation of relevant stakeholders for smooth integration of appropriate wheelchair services alongside efforts to reform infrastructural and systemic barriers to inclusion, has shown that diverse organizations with very different missions and goals can come together to strengthen the wheelchair sector. The sustainability of the model depends on continued support from World Vision area development programs in sustaining the flow of referrals, supporting outreach, and conducting advocacy efforts through Citizen Voice and Action groups. Senior management of service centers must ensure a smooth supply of appropriate wheelchairs for WHO-compliant services. Ultimately, networks

created with the government departments responsible for disability rights and the Ministry of Health, which saw some positive results within the project, must be continued and strengthened in order for WHO-compliant wheelchair services to become the norm in every country.

Through the ACCESS program, World Vision's strategy shifted from a one-off distribution approach to wheelchair programs, to learning from technical partners about implementing the 8-step, WHO-compliant wheelchair service model. Technical partners learned ways of reaching hard to reach populations and building an enabling environment for appropriate wheelchair service. All partners learned that models such as the 8 Steps +, which combine technical expertise with development strategies, must be built on equal partnership to guarantee achievement of outcomes without compromising quality.

BACKGROUND

The Accelerating Core Competencies for Effective Wheelchair Service and Support (ACCESS) Project, a collaboration led by World Vision (WV), was implemented from 2014 to 2017 in five countries with the goal to strengthen the wheelchair sector through enhanced service capacity, provision of diverse range of wheelchairs, and engagement with national and local governments resulting in increased participation of wheelchair users.

The global demand for wheelchairs exceeds the availability of appropriate products, and surpasses the number of personnel trained to provide quality services. WHO estimates that only 5-15% of the 70 million people relying on wheelchairs for basic mobility have access to appropriate devices. In the absence of appropriate devices, a person with disability cannot be expected to fully and effectively participate in society, and would be excluded from many of the rights granted by national laws and the UN Convention on the Rights of Persons with Disability (UNCRPD). Despite this fact, it is seen that organizations often distribute wheelchairs without proper assessment, fitting, or follow-up as outlined in the WHO Guidelines, as service providers are unaware of the guidelines and untrained on wheelchair provision, with the result that wheelchair users (WC users), not being provided with the appropriate wheelchair, are excluded from many activities in both personal and professional life.

In order to address the problems inherent in such a situation, the ACCESS project, supported by USAID and JSI, was implemented as a model that harnessed the technical capacity of professional wheelchair organizations, leveraged the community based strengths of World Vision, and built necessary networks and local capacity to reach out to an intended 5,000 people (incl. 2,000 children and 2,000 females) whose diagnoses range from spinal cord injuries to post-polio, cerebral palsy, spina bifida, hydrocephalus, amputation, or stroke. The program was anticipated to generate data for decision making and learning on strengthening of the wheelchair sector.

PROJECT DESIGN

The project was designed to carry out a standardized set of interventions to support wheelchair service development across the five project countries, El Salvador, India, Kenya, Nicaragua, and Romania. In this design, World Vision would support the referral and follow-up of clients within its existing areas of influence, called Area Development Programs (ADPs) and would conduct stakeholder engagement and advocacy to support disability inclusion and better understanding of appropriate wheelchair service on the part of local governments, NGOs, and DPOs. Technical experts in wheelchair provision – Motivation Charitable Trust, Motivation Romania Foundation, and UCP – Wheels for Humanity, would strengthen local service providers through training, hands-on mentorship, and organizational strengthening services such as providing tools, equipment, and guidance for procedural changes that support appropriate wheelchair service development. Local service providing organizations, supported by these technical partners, would provide wheelchair services to those referred in World Vision communities.

PROJECT GOALS AND OBJECTIVES

Project Goal

Mobilize World Vision's long-term local presence in El Salvador, India, Romania, Kenya, and Nicaragua to strengthen the wheelchair sector and ensure that all people with mobility limitations, especially women and children, are able to access appropriate products through qualified service providers and enjoy full participation in their communities.

The goal was expected to be reached through the following objectives:

Project Objectives

Objective 1: Foster an enabling environment toward effective wheelchair service and management through stakeholder engagement and mobilization and local and national level advocacy efforts.

Objective 2: Expand wheelchair service provision in all five project countries by diversifying the range of available products and bolstering the management and service capacity of local organizations.

Objective 3: Deliver WHO Basic and Intermediate training to wheelchair service personnel to increase the human resource capacity for quality wheelchair service delivery in each country.

DESCRIPTION OF PROJECT IMPLEMENTATION

As ACCESS began implementation, it became clear that differing country contexts and varying levels of existing service capacity and commitment required interventions to be tailored to each country and service provider. At the same time, the global nature of the project required strong central coordination across all five project countries and collaboration among technical partners and World Vision to ensure that while interventions may roll out differently, the intended results were still the same.

El Salvador

In El Salvador, World Vision does not have staff located within ADPs, so World Vision activities were managed centrally and focused on conducting Citizen Voice and Action (CVA), World Vision's local level advocacy tool, to raise awareness and spur support for disability inclusion in local communities. Referral networks were built in 5 ADP areas; however, due to lack of referrals from those areas, services were opened to clients outside ADPs as well.

Service providers gathered referrals themselves, provided wheelchairs and conducted service follow-up as well as providing repairs as needed. Service providing organizations included two government-affiliated organizations and one NGO supported by a regional network for rehabilitation. Although these organizations had agreements with wheelchair donors, they had limited existing capacity or commitment to conduct appropriate wheelchair service. Initial service assessments revealed that 11 of the 14 service centers were early in their wheelchair service development, one was developing, and two were maturing in basic wheelchair service.

Services were conducted within existing service centers and wheelchair service was offered one day per week in each of the participating centers. In this case, the technical partner interventions included conducting all Wheelchair Service Training Package (WSTP) courses and managing the wheelchair warehouse where products were assembled and modified before being sent to service centers. The technical partner also supported service centers through a service assessment and capacity building process that included individual mentorship and service visits to support organizational change.

India

In India, remote ADPs (n=15) required service centers to conduct wheelchair outreach services. World Vision's local ADP staff mobilized referral actors to identify those in need of wheelchairs and worked with local stakeholders to ensure appropriate outreach venues, tools, and necessary food and water for service providers and clients. Five service centers, supported by the technical partner,

conducted wheelchair service outreach within ADPs, after which World Vision, supported by the technical partner, conducted follow-up visits to ensure social inclusion and re-refer clients who may need additional service.

Each of these service centers were small organizations, with only limited existing wheelchair service capacity. Initial service assessments showed one service center to be early in their wheelchair service development, one developing, two maturing, and one well-functioning for basic wheelchair service. The only wheeled mobility devices regularly available to these service centers were tricycles distributed by the government-affiliate ALIMCO. During the project, staff from these service centers were trained by the training host organization which was also supported by the technical partner. The training host organization had strong understanding of wheelchair service and a commitment to WHO compliance, although initially they did not have capacity for training at the intermediate level. The technical partner conducted service assessments of each of the five service centers and supported in developing service capacity as well as facilitating and supporting training hosted by the training organization. They also procured wheelchairs, housed them in a central warehouse, and shipped unassembled wheelchairs as needed to centers prior to outreach services. World Vision conducted CVA and stakeholder engagement to support all people with disabilities in ADP communities, including wheelchair users, to access their rights and entitlements under Indian laws and policies.

Kenya

In Kenya, the project operated in 11 ADPs, two of which closed during the life of the project. Because service centers were not located within these communities, a mixed model of provision was adopted with provision happening at the center and through outreach services.

World Vision's central staff supported referral networks that identified clients and brought them to outreach services as well as conducted community level follow-up for social inclusion and re-referral as needed. Outreach service was conducted by six service centers, three of which were affiliated with a government supported organization. One of these organizations had experience with wheelchair service prior to ACCESS; however, the others had only experienced wheelchair distribution. Of the six service centers, four were initially rated as developing on basic wheelchair service, one maturing, and one well-functioning. Service providers attended training hosted by the government-supported organization but facilitated and supported by the technical partner. The technical partner conducted service assessments of each of the six centers and supported services to develop capacity. World Vision spearheaded CVA in communities as well as national level advocacy, forming a Wheelchair Taskforce that reviewed national disability policy.

Over the life of the project, outreach services were enhanced to provide an "outreach +" service in which World Vision brought together service providers, bicycle repair artisans trained in wheelchair repair, wheelchair peer mentors, and local government service providers, allowing clients to access a range of services in one outreach event.

Nicaragua

In Nicaragua, World Vision used central staff to mobilize referral networks and conduct CVA in six ADPs. Service providers conducted wheelchair service within their service centers for clients living within and outside ADPs, with those living in ADPs referred by World Vision networks. Service providers were trained by the technical partner with trainings located at a local training host organization. Trainings were conducted at the wheelchair hub that also served as warehouse and central workshop for all wheelchair assembly and preparation. Services were conducted at the hub as well as by 12 other service centers affiliated with one government agency and one DPO. These organizations had only experienced wheelchair distribution prior to the ACCESS project. Twelve of the thirteen service centers were ranked as early in their basic wheelchair service development and one was ranked as developing at the start of the project, the lowest scores of the ACCESS project.

The technical partner facilitated all trainings, and provided capacity building support through service assessment and development and individual mentorship.

Romania

In Romania, the technical partner also acted as the service provider, which meant a high degree of commitment for appropriate wheelchair service even before the project began. The five regional service centers assessed at the start of the program showed four as maturing for basic service and one as developing. World Vision worked in six ADPs to link referral actors to the service provider regional teams who would conduct home-based wheelchair service. World Vision utilized strong local ADP staff to facilitate CVA and conduct follow-up of all clients within ADP areas. The technical partner conducted WSTP training courses and provided service assessment and mentorship for new regional teams. Although the project was only in six ADPs, services were also provided outside of ADPs through existing referral mechanisms nationwide. The service provider ensured appropriate follow-up and linkages with social inclusion activities.

The table represents the partners and their roles in the different countries.

Table 1. Partners and roles in ACCESS

	Technical Partners	**Local Service Providers/Training Host Organizations**		**World Vision**
El Salvador	**UCP- Wheels for Humanity**: oversee training and capacity building for service providers and managers, and procure and prepare wheelchairs in a central warehouse		Salvadoran Institute of Integral Rehabilitation **(ISRI**), Teleton Association Pro-Rehabilitation (**FUNTER**), and The Salvadoran Social Security Institute (**ISSS**)- provision of wheelchair services per standards and guidelines.	**WVES**: coordination, communication, and management of the implementation process; referral and follow-up in ADPs; local and national level advocacy and stakeholder engagement.
India	**Motivation**: oversee training and capacity building for service providers and managers; procure wheelchairs and transport to service centers.	**Mobility India**: Conduct WSTP Basic training, host other WSTP training courses with Motivation support; provide wheelchairs during training events and follow-up on clients.	5 service centers: **Mangalam**, **BCM Hospital**, **Kiran Society**, **Herbertpur Christian Hospital**, **Kalyanam Karoti**: wheelchair service provision according to standards and guidelines.	**WVI**: coordination, communication, and management of the implementation process; referral and follow-up in ADPs, local and national level advocacy and stakeholder engagement, mobilize communities to host wheelchair outreach services

Kenya	**Motivation**: oversee training and capacity building for service providers and managers; procure wheelchairs and transport to service centers.	**The Association of the Physically Disabled Kenya** (**APDK**): conduct WSTP basic training, host other WSTP training courses with Motivation support, provision of wheelchair services in 3 service centers according to standards and guidelines	3 additional service centers: **AIC Kijiado, Nyabondo Rehabilitation Center, and Bethany Kids Joy Town Center**: wheelchair service provision per standards and guidelines	**WVK**: coordination, communication, and management of the implementation process; referral and follow-up in ADPs, local and national level advocacy and stakeholder engagement, mobilize community to host wheelchair outreach events.
Nicaragua	**UCP- Wheels for Humanity**: oversee training and capacity building for service providers and managers.	**Future Nicaragua** (**FN**): establish a regional wheelchair hub responsible for the assembly, maintenance, and repair of all wheelchairs, host WSTP courses with UCP support, and provide appropriate wheelchair services.	**Los Pipitos** and **MINSA**: provide wheelchair services per standards and guidelines, provide physical space for client assessments, evaluations, and wheelchair fittings, clinical staff for training.	**WVN**: coordination, communication, and management of the implementation process; referral and follow-up in ADP areas; local and national level advocacy and stakeholder engagement.
Romania	**Motivation Romania**: oversee training and capacity building for service providers and managers, and procure and prepare wheelchairs in a central warehouse, conduct wheelchair user life skills training		17 local teams (**Motivation Romania**): wheelchair service provision according to standards and guidelines.	**WVR**: coordination, communication, and management of the implementation process; referral and follow-up in ADPs, local and national level advocacy and stakeholder engagement.

The 8+ model of service provision

Over time, it became clear that the role of the community development organization in wheelchair service is not just to refer and follow-up on clients. In each of the project countries World Vision was educating communities on appropriate wheelchair service and disability inclusion, facilitating inclusive communities, collaborating with a range of partners, and advocating not only for appropriate service to be mandated in laws and policies but also for disability inclusion writ large. This realization led to the development of the 8 Steps + approach to wheelchair programs, captured by this diagram:

Figure 1. The 8 Steps + model of wheelchair service provision

In the twin-track approach, trained service providers, supported by technical experts conduct the 8 steps of wheelchair service with community development organizations such as World Vision leveraging their strengths to support the process and disability inclusion in their communities. Within ACCESS, this was operationalized through the education of referral and follow-up actors, facilitation of community based support for outreach services, collaboration with trained service providers in all countries, and advocacy at the local and national level. Because the project was coordinated at an international level, the partners could analyze the common themes across countries and coalesce around this new approach of ensuring disability inclusion as well as appropriate service in wheelchair programs.

METHODS

Evaluation Design: A mixed methods design was adopted to evaluate the ACCESS project with qualitative research conducted among stakeholders and supplemented by quantitative data from project statistics. The purpose of the qualitative evaluation was to review how the activities, methodologies and intervention model allowed the achievement of the objectives, in particular to assess the progress and challenges in achieving the outcomes. Quantitative data from the project database was analyzed to contextualize the qualitative data and to answer specific questions around the processes and outcomes of the project.

Evaluation Personnel: A lead evaluator supported by four country evaluators conducted the qualitative evaluation. The lead evaluator conducted it in India while the country evaluators conducted it in their respective countries: El Salvador, Nicaragua, Kenya and Romania. After the country evaluations were complete, the lead evaluator synthesized the country findings, conducted further analysis on quantitative data, and triangulated the data to arrive at the overall report.

Evaluation Objectives: The evaluation attempts to answer the following questions based on the project goal and project objectives:

1) **Evaluation of project goal:**
- How well does the project address the needs of women, men, boys, and girls with mobility limitations?
- How well does the design of the project address the need for capacity building of the wheelchair sector?

2) **Evaluation of outcomes based on project objective 1: Foster an enabling environment**
- In what ways do ACCESS clients participate in their communities? Do levels of community participation vary between men, women, boys and girls? Do they vary across those clients within ADP communities and those outside ADP communities? What factors affect community participation?
- Do CVA groups include and effectively address the needs of men, women, boys, and girls with disabilities? What CVA efforts have led to increased community participation of wheelchair users?
- What activities in the community are sustainable?

3) **Evaluation of outcomes based on objective 2- wheelchair provision and capacity building:**
- Do service providers who increased knowledge of wheelchair service provision work at service centers showing improved capacity?
- What mentorship activities led to increased capacity of wheelchair service centers to manage service provision?
- Was the Zoho database effective for capturing necessary information for client management? What aspects of the database might be sustainable within service centers? What would make the database more useful for service providers?
- What activities under objective 2 are sustainable?

4) **Evaluation of outcomes based on objective 3- wheelchair service training package (WSTP) trainings:**
- Are participants of WSTP training courses using the knowledge learned in the training? Why or why not?
- Has facilitation of WSTP trainings been sustainably passed to local trainers and training institutions?

- What activities under objective 3 are sustainable?

5) **What challenges were faced when implementing activities to build an enabling environment for wheelchair service and disability inclusion?**

Qualitative Data Collection: The qualitative evaluation, which included focus group discussions (FGD) and in depth interviews (IDI), was conducted over a two-week period in March- April, 2017 in each of the five countries. Interviews were conducted among key stakeholders: wheelchair users or clients of the project, service providers, ACCESS and WV staff, and technical partners. As it was considered necessary to include the global perspective of the project, a further 8 representatives of the technical expert organizations from Motivation UK, Motivation Romania, and UCP- Wheels for Humanity were interviewed by the lead evaluator through skype calls.

The qualitative data collection in the field was supported by local WV teams through arranging and overseeing logistics of the field work. The evaluators in each of the countries were supported by note takers, either from WV, who were not attached to the project, or was an outside consultant. Each interview/FGD was recorded with the prior permission of the study participants. Interviews were conducted in private settings and lasted from 30 minutes to an hour and a half.

Study Sample: A total of 516 participants were interviewed in 112 IDI and 45 FGD. The sample was purposive based on willingness to participate, availability, and knowledge of the project. WC users were categorized according to gender and age (children younger than 18 years, younger adults <25 and >18, older adults >40 years). To capture the experience of children with disabilities (CWD) and adults with advanced disabilities, parents or guardians were interviewed. Service providers included service managers and physiotherapists of service centers. The WV project teams in each country selected participants according to the sampling guidelines. The following table presents the breakdown of participants and methods.

Table 2. Sample frame of qualitative study participants

	WC Users		Service providers		Technical Partners		ACCESS staff/WV staff		CVA	Total # Interviews	Total # participants
	IDI	FGD	IDI	FGD	IDI	FGD	IDI	FGD	FGD		
India	12	6	3	1	1		6	1	3*	33	107
Romania	23	1		2	2		6		1	32	67
Kenya	12	8	4	2	2		2			32	122
El Salvador	9	6	3	2	1		4		2	27	132
Nicaragua	14	6	3	2	4		1		2	30	88
Total	70	27	13	9	10		19	1	8	154	516

*One FGD was conducted with National NGO forum having members from several DPO/NGO

Study Sites: Two study sites were initially selected in each country and wherever possible both ADP as well as non-ADP areas were sampled for comparison. In some cases, the study sites were expanded to obtain a wider representation of participants. In India, the qualitative study was conducted in three villages in Sitapur district and two urban slum communities in Kanpur city while in Kenya, it was conducted in Nairobi and Nakuru. In Romania, the counties of Ialomita and Valcea were covered along with Bucharest. In Nicaragua, data were collected from 5 project municipalities- Managua, Tipitapa, Ciudad Sandino, Malpaisillo, and Esteli while in El Salvador, data were collected from San Salvador and Usulutan.

Evaluation Instruments: IDI and FGD guides were developed for the separate categories of participants by the lead evaluator. After developing the guides, they were circulated among ACCESS

country teams and the Project Director. The guides were then revised based on feedback and suggestions. After finalizing, the guides were translated into local languages: Hindi, Spanish, Swahili, and Romanian with the help of the ACCESS country teams. The interview guides included questions that incorporated the major domains of evaluation based on the objectives and goals of the project (instruments are appended in Appendix 1). A separate IDI guide was developed for conducting interviews with the global technical partners with topics related to the global overview, project operations and partner relationships.

Qualitative Data Analysis: Audio recordings were transcribed by external agencies. Transcripts were coded and analyzed using the *apriori* developed codebook (codebook is appended in Appendix 2). Coding and analysis were conducted using qualitative software: Nvivo QRS or ATLAS.ti, according to the familiarity and usage by the different country evaluators. Codes were compared across cases and memos written to capture the main themes emerging out of the interview segments. Comparisons, wherever possible, were made across gender, age, rural/urban setting, and socio- economic conditions. Findings were written based on the specific evaluation questions.

Quantitative Evaluation: Besides the above, quantitative analyses of service statistics were conducted to substantiate the qualitative findings, and to answer specific questions on service provision, follow-up, service capacity and social inclusion. After a process of data cleaning, descriptive analysis was conducted for comparison across demographic categories. Microsoft Excel 2010 and Stata SE13 were used for statistical analyses.

For social inclusion scale, mean score analysis and domain analysis was conducted. Time variant analysis was conducted for service steps assessment. Relevant charts and graphs were prepared for easier viewing and understanding.

For service capacity analysis, the scoring system of the Service Assessment Monitoring and Evaluation Tool was used wherein service providers are assigned scores 0-3 to correspond to different stages of capacity along the three major domains of products and technical equipment, service provision and service management for both basic and intermediate services. Individual scores are added and percentages computed out of a possible total score and assigned as early, developing, maturing or well-functioning capacity level. In order to compute capacity score for service management domain, a composite index was developed which comprised six indicators of service management with a composite score that ranged between 0-17 (baseline: 0-13.5 and endline: 4-17). The scores were added for each indicator, then divided by the total possible score (18) and multiplied by 100 to get the final percentage. Level of capacity was defined as Early (<=25%), Developing (26-50%), Maturing (51-74%) and Well-functioning (75+%)

RESULTS

1.EVALUATION OF OUTCOMES BASED ON PROJECT OBJECTIVE 1: FOSTER AN ENABLING ENVIRONMENT

1.1 In what ways do ACCESS clients participate in their communities? Do levels of community participation vary between men, women, boys and girls? Do they vary across those clients within ADP communities and those outside ADP communities? What factors affect community participation?

A total of 9,628 people with mobility limitations were registered at intake by the project (approximately 44% of female and 56% of male). Age wise distribution of clients was almost equal. More than half of the clients responded "not applicable" to attend school. Out of this, 48.2% were above the age of 56 years, 41.2% were between the ages of 18 and 55, and 10.5% were children below the age of 17 years. Only 2.4% worked full time while the majority was unemployed or unable to work.

Table 3. Demographic characteristics of ACCESS clients

Demographic characteristics	Groups	N	%
Gender	Female	4,228	43.9
	Male	5,400	56.1
Age	0-17	2,958	30.7
	18-55	3,641	37.8
	56+	3,029	31.5
Education	Attending school	1,018	11.3
	Not applicable*	5,359	59.4
	Not attending	2,633	29.2
Work status	Full time	221	2.4
	Not applicable	4,367	47.4
	Not working	4,148	45.0
	Part time	477	5.2

*Not applicable category was self-identified by respondents in the client data intake

Of the 9,628 registered, 8,016 received an assessment to determine their need for mobility device, and 7,319 received a wheelchair, tricycle, or product improvement on an existing wheelchair. Those who did not receive wheelchairs either dropped out of the program prior to provision or were determined to need support other than wheelchair service. Some clients with advanced needs did not receive wheelchair service through the ACCESS program due to a lack of appropriate devices and wheelchair service available for their advanced need.

1.1.1 Findings of community participation from qualitative data

An overwhelming majority of ACCESS clients reported improved mobility and functionality with their new wheelchair allowing them increased accessibility and participation in their homes and communities. This quote by a family member of a wheelchair user in Nicaragua illustrates the

difference in comfort and mobility obtained from the new wheelchair. "*These chairs are stronger, more stable. They are superior and much easier to use. They are accessible because we can move them with ease. It allows us to get around easier.*" Reported increase in self-confidence as a result of functional independence was noted in the qualitative interviews across the five countries. Additionally, improvement in economic participation was reported in Kenya, India and El Salvador, and participation in educational activity was reported mostly in India and Kenya, supported by quantitative data from the social inclusion scale (described in section 1.1.2 below). Two interviewees in Kenya and India reported feeling empowered to do other work instead of begging, indicating the tremendous change facilitated by an appropriate wheelchair in one's motivation and self-efficacy "*I do business with its help…Earlier I used to sit in temples (to beg) and I would get Rs100. Now I sell mats and TV covers from my WC and get Rs200 every day*". (Male WC user, FGD, Kanpur).

Parents of children living with disabilities in India and caregivers of adults living with disabilities in Romania reported feeling less socially isolated. In India, parents reported a decrease in time consuming caregiving and attributed it to the wheelchair as it came fitted with a tray for eating or playing which eased their burden of holding their child during these activities. The wheelchair design also facilitated being outside their home in the neighborhood as the child was more comfortable sitting in it than in any other previous wheelchairs. In Romania, the life skills training program offered an opportunity for caregivers to have a break from their activities and for the wheelchair user to increase independence from their caregivers.

Gender differences in wheelchair usage and social participation were seen mostly in India, while age and type of disability, as well as structural barriers played a factor in social participation across most countries. ADP communities in Romania and Kenya had a significant effect on participation, whereas the non-ADP area sampled in India had a history of ongoing wheelchair programs along with social support and therefore, did not differ from ADP areas. In El Salvador and Nicaragua, low involvement of ADP offices as well as ADP communities being concentrated in remote, rural areas affected participation. There are commonalities as well as unique characteristics in the five countries in terms of factors affecting participation which we will present under the categories, 1) enablers and 2) barriers.

Table 4. Factors affecting community participation among ACCESS clients

Common Enablers	Common Barriers
Greater access to appropriate wheelchair increased comfort, mobility and independence	Age affected participation- Older people living with disabilities
Citizen Voice Action (CVA) efforts in promoting community activities, advocating for rights and entitlements of PWD, sensitizing and awareness building	Advanced disability and poor physical health affected participation
Family and community support	Distance from residence to service center, rehabilitation center or vocational and training center
Self -efficacy of individual PWD	Poor condition of roads especially in rural areas, and lack of accessible facilities like ramps in public institutions
	Poor transportation –lack of accessible transport, negative attitude of bus drivers to PWD, scarce transport in rural areas
	Perception of stigma and discrimination in community and larger environment

		Lack of accessible housing resulting in less maneuverability of wheelchair and participation inside household
		Client mentality- lack of motivation due to low self- efficacy or feelings of worthlessness
Unique Enablers		**Unique Barriers**
Romania	Life skills training provided by Motivation Romania	Cold weather and physical health among aged PWD
Nicaragua	Involvement of local government in one municipality enabling structural change	
Kenya	People living with disabilities as community role models	
India	• Age- younger male PWD in both rural and urban areas • Education- educated PWD, specifically, educated females more likely to participate than less educated	• Gender-Female clients less likely to participate • Socio cultural norms- cultural norms and traditions restricting freedom of movement of women particularly in rural areas

Thus, overall, while clients reported increased mobility, there were factors that either enabled or hindered participation. Some of these findings are substantiated by quantitative data. Measurement of social inclusion at endline revealed an increase from baseline for most clients across all five countries. The table below provides a snapshot of the social inclusion results.

1.1.2 A) Findings of community participation from quantitative data

A social inclusion scale consisting of 12 items or domains was administered at baseline to all registered clients and at endline to a statistically representative sample of clients (social inclusion scale is appended in Appendix 3). The domains represent different activities in personal and community life, measured on a scale ranging from least difficult to do to most difficult to do. The sections below present results at various levels of analysis.

In the table below, we see that there have been statistically significant reductions in social exclusion from baseline to endline for all clients across demographic variables in all the countries, indicating an increase in social inclusion. Variations are however seen when sub groups are compared at endline. At endline, the greatest reduction in social exclusion is seen for those in ADP areas versus non-ADP areas, those with full time employment versus other categories of employment, and those who are members of DPO versus those who are not members.

Table 5. Comparison of social inclusion average scores at baseline and endline

Country	Baseline average score	Endline average score	P (t-test) on average score*	P (t-test) on average score at endline**
El Salvador	6.16	2.57	0.000	
India	7.08	3.83	0.000	

Kenya	8.42	2.59	0.000	
Nicaragua	6.32	2.37	0.000	
Romania	8.01	6.42	0.000	
Gender				
Female	8.22	4.77	0.000	-0.5685
Male	7.94	4.85	0.000	
Age group				
0-17 years	8.43	4.38	0.000	0.3822
18-55 years	7.53	4.42	0.000	
56+ years	8.36	5.55	0.000	
Working status				
Full Time	5.53	2.36	0.000	0.000
Not Applicable	8.51	5.21	0.000	
Not Working	7.85	4.44	0.000	
Part time	6.81	2.76	0.000	
Schooling				
Attending	7.59	3.49	0.000	0.0807
Not Applicable	8.12	5.11	0.000	
Not Attending	8.09	3.81	0.000	
ADP area				
No	7.64	5.27	0.000	0.000
Yes	8.39	4.03	0.000	
Participated in DPO				
No	8.15	4.94	0.000	0.000
Yes	7.39	2.85	0.000	

*t-test on average score to test the difference between baseline and endline by subgroups.
** t-test on average score to test the difference between sub groups on "least difficult" responses at endline.

As seen in the table above, all the five countries reduced their aggregate social exclusion scores, indicating an increase in social inclusion. Compared to other countries, Romania did not have a big reduction probably due to its client demographic- older people with advanced disability- who were unable to participate widely. It could also be a cultural mindset of skepticism resulting from a communist past. While there were significant decreases in social exclusion between baseline and endline for all groups, when sub groups are compared on the average score at endline, it is seen that clients having a full time job, belonging to an ADP area or to a DPO were more likely to decrease social exclusion compared to those not working, not belonging to ADP and not participating in DPO. While gender had no effect overall on social inclusion, qualitative data in India found a significant difference. Regarding age of clients, younger age groups reduced social exclusion scores more than the older age group, a finding supported by qualitative data. In terms of schooling, clients classified under "not applicable" reduced their scores less than the other categories, perhaps as a reflection of clients with advanced functional disabilities who could not participate fully. "Not applicable" also included older clients who did not attend school any longer, again indicating that older clients exhibited less decrease in social exclusion than younger clients.

1.1.2 B) Results from Domain analysis of social inclusion scale

When we examine the domains of social inclusion registering the biggest change from baseline to endline, we find that educational participation is ranked the highest followed by mobility within the house, mobility in the immediate neighborhood and maintaining social and family relationships.

Table 6: Percentage change in Domains of Social Inclusion

Domains	Baseline	Endline	Difference	% change	Ranking of domains
1. How difficult is it for the client to move in and around his/her home?	7.92	4.17	3.75	47.37	2
2. How difficult is it for the client to move outside his/her home in the immediate neighborhood?	8.52	4.65	3.87	45.45	4
3. How difficult is it for the client to carry out his/her daily activities of living (e.g. washing, dressing, eating, etc.)?	7.68	4.93	2.74	35.73	11
4. How difficult is it for the client to access medical care and treatment for general health conditions (not related to the mobility limitation)?	8.01	4.92	3.09	38.57	7
5. How difficult is it for the client to go to school/college?	8.36	4.30	4.05	48.50	1
6. How difficult is it for the client to earn income?	8.14	5.15	2.99	36.76	10
7. How difficult is it for the client to use public transport?	8.91	6.19	2.72	30.56	12
8. How difficult is it for the client to go to public places (e.g. market, bank, shops, etc.) in your community?	8.80	5.26	3.55	40.28	6
9. How difficult is it for the client to maintain social and family relationships (e.g. visiting family and friends, going for gatherings of family and friends)?	8.00	4.23	3.77	47.13	3
10. How difficult is it for the client to join leisure/cultural/recreational activities in your community (e.g. sports, arts, music, informal meetings etc.)?	8.53	5.04	3.49	40.92	5
11. How difficult is it for the client to participate in political	8.23	5.10	3.14	38.11	9

life in your community (e.g. voting, joining a political party, etc.)?					
12. How difficult is it for the client to obtain and maintain respect from others in his/her community?	6.11	3.77	2.34	38.30	8

The clients across all countries experienced positive change in all the domains of social inclusion as shown in the table above. These have been ranked in terms of % change in difference between baseline and endline. Thus, we see that there are a few domains which registered the maximum change (% change>45%). The biggest change is seen in educational participation followed by improved mobility: inside the house and in the immediate neighborhood, and improving social relationships. Using public transport had the least change which is also supported by the qualitative data. Similarly, participation in areas of increasing difficulty such as getting a job and earning an income, political participation, and visiting public places and accessing medical care did not show the same level of change as participating in the house and in the neighborhood.

> *The chair has been amazing. Really, it has changed everything for him. I mean he loves, loves that chair. He says the chair is his feet and now he can do everything that other children do. He goes to school and he is able to play with other children.* - Mother of child WC user, Ciudad Sandino

Table 7: Comparison of change (%) in each domain of Social Inclusion among countries

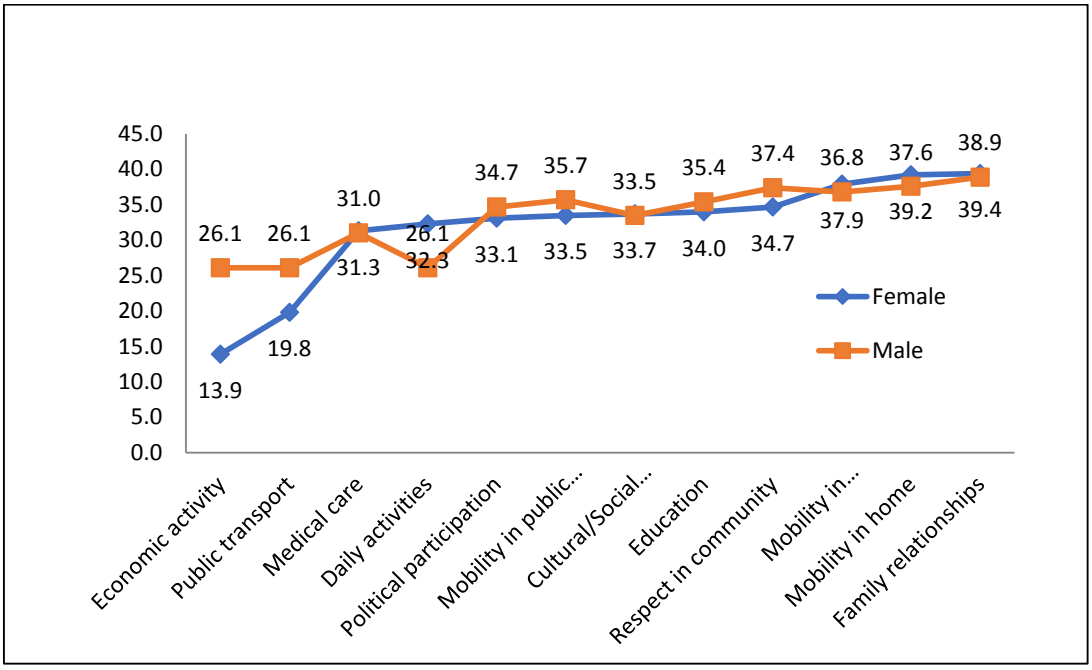
Domains	% change in score of each domain				
	El Salvador	India	Kenya	Nicaragua	Romania
1. How difficult is it for the client to move in and around his/her home?	12.14	39.73	67.11	50.98	33.01
2. How difficult is it for the client to move outside his/her home in the immediate neighborhood?	33.76	35.89	61.51	54.05	28.98
3. How difficult is it for the client to carry out his/her daily activities of living (e.g. washing, dressing, eating, etc.)?	20.44	37.63	49.91	32.65	22.72
4. How difficult is it for the client to access medical care and treatment for general health conditions (not related to the mobility limitation)?	10.17	47.97	52.28	36.52	25.00
5. How difficult is it for the client to go to school/college?	-9.55	38.76	46.86	44.16	30.09
6. How difficult is it for the client to earn income?	19.16	14.56	65.64	4.74	20.92
7. How difficult is it for the client to use public transport?	-9.28	15.67	43.89	24.42	22.28

8. How difficult is it for the client to go to public places (e.g. market, bank, shops, etc.) in your community?	42.64	36.66	46.39	51.72	26.17
9. How difficult is it for the client to maintain social and family relationships (e.g. visiting family and friends, going for gatherings of family and friends)?	39.01	47.85	55.15	55.06	30.32
10. How difficult is it for the client to join leisure/cultural/recreational activities in your community (e.g. sports, arts, music, informal meetings etc.)?	24.26	43.85	47.96	50.97	25.69
11. How difficult is it for the client to participate in political life in your community (e.g. voting, joining a political party, etc.)?	26.74	48.76	53.97	63.65	22.78
12. How difficult is it for the client to obtain and maintain respect from others in his/her community?	35.10	50.19	61.24	51.90	28.73

Note: cells highlighted in green represent "highest change", cells highlighted in blue represent "least change". Percent change >45% is considered high and percent change <30% is considered low.

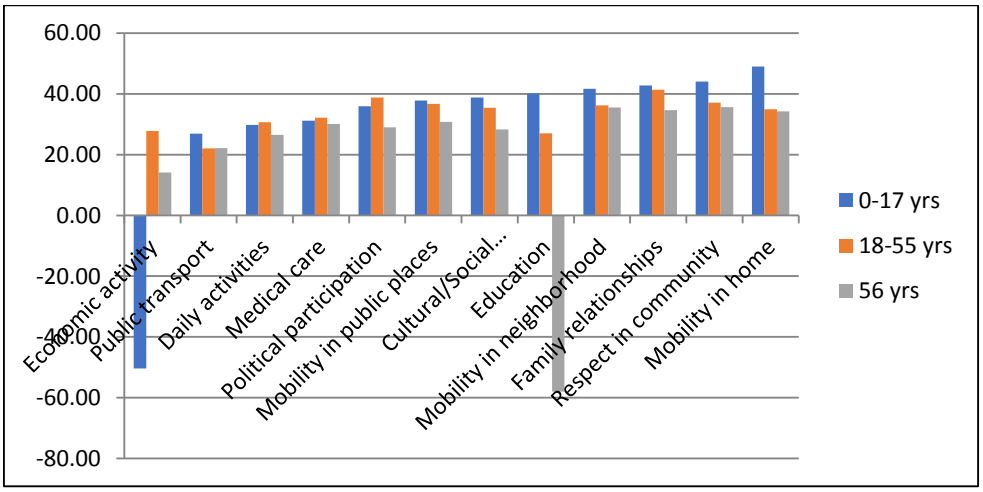
Kenya and Nicaragua followed by India recorded the highest changes in most of the domains. El Salvador and Romania, in comparison, recorded the least changes. In El Salvador, this may be because there was less scope of building relationship with clients and thereby there was less "push" or motivation for clients to engage in activities. Low engagement with the community resulted from staff turnover of WV, low involvement of ADP office in community, disgruntlement of clients with services which could have affected the results. In Romania, the demographic profile of clients included mostly older PWD with severe health problems which would have affected their social inclusion. Another reason could be sampling bias as wheelchair users from ADP areas in Romania were administered the scale which did not have a large representative population of people living with disabilities. It is interesting that use of public transport was recorded as low in all the countries which again reiterates the issue of pervading structural barriers to social inclusion of people living with disabilities. In Kenya, this domain had the least change compared to other domains. Similarly, problems in having a livelihood and earning an income prevailed for people living with disabilities in most countries. Increase in respect is another big change in India, Nicaragua and Kenya, supported by qualitative data from clients that highlighted feelings of self-confidence and perception of respect from community members after receiving their wheelchairs.

Figure 2. Comparison of change (%) in domains of social inclusion among male and female clients



Interestingly, men and women showed the same trend in change in different domains of social inclusion with mobility inside home and neighborhood, and maintaining social relationships showing the greatest increase, and earning income, using public transport and accessing health care showing the least change. Women, however, have expressed less change than men in the latter domains while expressing more change in ability to carry out daily activities, indicating more independence in personal grooming which is perhaps a factor of gender and cultural difference. Correspondingly, women also showed a higher increase in their ability to move inside homes than men, again suggesting that they spend more time inside home and are therefore likely to participate in daily household activities. In contrast, they exhibited less change than men in their ability to move outside home, go to school/colleges or gain respect. The Indian qualitative data supports these notions, thus validating the quantitative scale.

Figure 3. Comparison of change in domains of social inclusion among age groups



Among age groups, the youngest age group (<17 years) was seen to have gained favorably in education activities, and mobility inside and outside home compared to the older age groups. Earning income did not change for children while the middle age group (18-55 years) showed the highest change in this domain, along with change in political participation. The oldest clients showed the least change, compared to younger clients, in all domains. It is evident that earning income, using public transport, carrying out daily activities and joining recreational activities remain a challenge for older people with disabilities.

Thus, participation increased in the domains of education, household and immediate neighborhood overall, with variations seen among countries, gender and age groups. Older people living with disabilities in general, Indian women with disabilities in particular, and those with advanced disabilities form vulnerable groups for whom participation is far less and can be improved with innovative strategies in future projects.

1.2 What CVA efforts have led to increased community participation of wheelchair users?

CVA groups formed in all the countries advanced the cause of people with disabilities by advocating for enforcement of legislation on accessibility and other disability-friendly policies, raising awareness among people living with disabilities about their rights and entitlements, and sensitizing community members and government officials about issues of people with disabilities. Varying methods were adopted such as meetings, disability marches, events and sports matches to advocate for rights of people living with disabilities and to improve social inclusion. In addition, innovative strategies such as involvement of children in CVA activities in Romania helped bridge community engagement with people living with disabilities. Through various activities performed by children such as reading books to elderly PWD, visiting their homes, singing carols and making cards, there was direct exposure of the community to the needs of people living with disabilities and facilitated an enhanced understanding of disability which is likely to remain so after the project. In Kenya, CVA approach has empowered people with disabilities to participate in county budget making process which has increased the chances of fund allocation for PWD, something that was not possible before ACCESS.

CVA efforts also resulted in infrastructural improvements within ADP areas like building ramps in schools and hospitals in Kenya through strong advocacy as reflected in this quote from a CVA member, "*In one hospital there was a gate that was raised and a person on a wheelchair could not cross over unless someone lifts them across, so we went in and talked to the management and now they have since erected a ramp which people on wheelchairs can easily pass through.*" Similarly, in Nicaragua, engaging with local authorities in a municipality led to structural and social change evidenced by the construction of ramps to improve access to public parks, health centers, government building, schools and community centers. Another positive aspect of CVA in Nicaragua is the effort to engage the transport sector by holding meetings with taxi and bus cooperatives in two municipalities. If these activities continue, a major problem identified by clients will be addressed by making transport services more accessible to people living with disability.

In Kenya and India, CVA groups encouraged people living with disability to access funds from the government to start their own business. In Kenya, community groups of PWD were organized to access government funds while in India, some people living with disabilities were helped by CVA groups to access loans for small businesses.

However, the functionality, organization and effectiveness of CVA groups varied, specifically across municipalities in Nicaragua and across urban and rural areas in India. This may be a consequence of varied levels of understanding and involvement by WV ADP staff in the community aspect of ACCESS, numerous responsibilities of WV field workers and distances in rural areas to effectively collect and mobilize people in a unit. Nevertheless, in India too, CVA efforts in urban areas have seen increased participation especially among male PWD, as well as strong linkages with the state

government through the formation of national NGO forum, a collective of DPOs. As regards actions taken, CVA members in the urban area in India reported advocating for government loans for self-employment, writing to government officials about access to marriage payments, acquiring certificates of disability for people living with disabilities in the slum areas. They had positive stories of individuals who started going to school, or starting a business through efforts of the CVA groups. However, in India, it was observed that parents of children with disability had limited interaction with CVA, and whatever information they possessed about benefits entitled for their children was through hearsay, a finding that can be addresses in future projects.

> *I want everybody to know that as a person with disabilities the CVA, through ACCESS, taught me that I'm useful...I think I can contribute to community if I get the opportunity. Through ACCESS we were taught that there are three types of barriers: one: architectural, two: institutional, and three: personal, those we place on ourselves when we say we can't do something. But ACCESS taught us how useful we are and that our disabilities are much less than our abilities.* - Wheelchair user, El Salvador

While clients mentioned that their awareness of their rights have increased, there is not enough evidence in the qualitative data to suggest that CVA efforts led to increased community participation among all clients. Clients were more likely to attribute their mobility to the new wheelchair than to CVA efforts. Although quantitative results in El Salvador did not show significant changes in social inclusion compared to other countries, qualitative data indicated that empowerment trainings provided by CVA had increased some clients' participation by changing their deep-seated notions of helplessness and internalized stigma. This indicates that despite lack of intensive community engagement in El Salvador, whatever efforts were made did bear results, showcasing the continued need for this kind of advocacy efforts. In considering all the different efforts undertaken by CVA, it may be justified to say that these have an indirect effect on participation as improved access to public institutions, improved awareness of rights, and increased access to and utilization of government benefits has the potential to ensure wider participation in community. Indeed, quantitative social inclusion results (table 2) show that belonging to ADP area increased participation which is probably a direct result of WV efforts in ADP communities. Qualitative data from El Salvador, Romania, and Kenya also support the idea that people living with disabilities had more opportunities to learn of their rights through CVA groups formed in ADP communities. The fact that DPO participation increased social inclusion suggests the importance of mobilizing people living with disabilities and giving them a voice in addition to providing them appropriate wheelchairs.

1.3 What activities under objective 1 are sustainable?

CVA groups have most often been formed by WV and therefore resources from WV for their continuance are imperative. In places where CVA groups were initiated by WC users and service providers such as in a municipality in Nicaragua, these groups are more likely to be sustained. Similarly, in India, the CVA groups in the urban center and the network of NGOs are likely to continue their activities contingent upon the support of the local ADP office, the support being in the nature of providing space and being involved in meetings. This may require an additional input of staff time. In Romania, given the previous experience of WV in engaging children and teachers in community development and doing the same for ACCESS, these activities are likely to continue with the continued presence of WV in the communities. In El Salvador, although efforts are on to transition CVA groups to official consultant groups whereby their position becomes more established, there is again the possibility that volunteers may not be able to provide the time and energy without support and guidance.

Sustainability, to a great extent, is dependent on large scale ownership and adoption of the intervention model by the government. Despite efforts to engage the national and local governments, success has been varied. National level efforts led by WV to promote the model has not yet resulted in a formal agreement with the National Authority for People with Disabilities- the

central authority in Romania. In Kenya, the ACCESS project facilitated a review of current policy for people living with disability to make it more comprehensive by including appropriate wheelchair service provision as a mandatory requirement. Efforts are also ongoing to integrate service provision with the government community based health system network in Kenya. In India, it is up to the NGO forum to continue advocacy with the state government.

2. EVALUATION OF OUTCOMES BASED ON OBJECTIVE 2- WHEELCHAIR PROVISION AND CAPACITY BUILDING

2.1 Wheelchair service provision

A description of service provision in the project along the continuum of WHO 8-step wheelchair service protocol is provided based on quantitative and qualitative data.

2.1.1 Referral and Assessment

Referral of clients was envisioned to be facilitated by CVA members or community based workers, and therefore, this part of service provision was the responsibility of World Vision. In countries like El Salvador, Nicaragua and Romania, CVA members formed part of the referral network while in India, separate referral actors were recruited and trained. As referring a person with disabilities required a minimum level of clinical knowledge, referral trainings were provided by World Vision and the technical partners. World Vision's presence in hard to reach areas made it possible for persons living with disabilities who were previously out of reach of services , to be referred and fitted with appropriate wheelchairs.

Appropriately designed wheelchairs are generally inaccessible to clients living in remote areas, and a great achievement of ACCESS project was, therefore, covering an underserved population. A total of 7,258 people with disabilities were provided with appropriate wheelchairs across the five countries over the project period. Innovative referral strategies such as visiting institutions and schools where people with disabilities could be found were developed in Kenya and El Salvador to bring service to the client rather than to take the client to the services.

Initially only ADP areas were planned to be covered for service provision. However, problems of coverage due to low numbers of people living with disabilities in ADP areas and the existing reach of some service providers outside ADP areas forced the project to expand to non-ADP areas. While this strategy worked in widening coverage, the absence of WV staff in these areas limited the linkage of wheelchair users to support services. In Romania, to mitigate this, Motivation Romania hired new staff for non-ADP areas to serve as social workers. In India, mostly people from ADP areas were served, with one service provider also providing services to the clients in the immediate vicinity of their service center. In Nicaragua, the referral network formed in ADP areas did not function as envisioned due to a number of factors: 1) lack of clarity on who should be involved in referral network, 2) lack of understanding of the roles between CVA and referral network 3) lack of inclusion of technical partner in the initial stage of formation and training and 4) lack of involvement of WV staff based in ADP communities. Referrals in non-ADP areas were mostly done through service provider outreach or word of mouth. In El Salvador, similar problems were observed which is largely due to lack of WV staff in ADPs to support the project. It is worth noting that during the life of the project both WV El Salvador and WV Nicaragua moved from a structure in which they had local staff at ADP level to a structure where staff were limited and clustered to cover several ADP areas. This meant that by 2015-2016 there were no staff at the ADP level in either of these countries. This was a huge problem for referral network. Furthermore, particular problems of communication between WV ADP and other stakeholders were noted in these two countries

perhaps due to less engagement of WV national offices in the project which may be a reflection of insufficient planning of local collaboration in the initial stage.

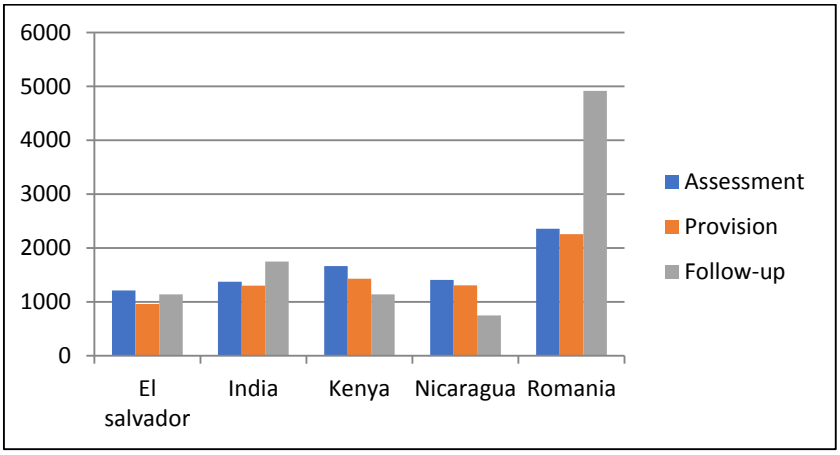
Examining the data for service provision (table 8) we notice that **out of 8,019 assessments, product provision was made to 7,258 clients,** roughly 91%, which indicates a sufficiently good coverage of people who were referred and assessed. The number of follow-ups (follow-ups indicate both social as well as clinical) is higher than provision as follow-up could be conducted multiple times for one client. Also, some clients who were on a waiting list prior to start of the project were followed up in the beginning, and some others received product improvement, rather than product provision (modifications on their used wheelchair), who were then followed up. A total of **4,972 clients (62%) received assessment, provision and follow-up**, while a total of **5,089 clients (70.1%) were followed up at least once.**

Table 8. Overall service provision in 5 countries

Service date (Quarterly)	Assessment	Provision	Improvement	Follow-up
2014Q1	37	2	0	0
2014Q2	107	119	0	2
2014Q3	64	65	0	4
2014Q4	89	83	0	10
2015Q1	116	100	0	13
2015Q2	473	351	4	365
2015Q3	813	474	1	365
2015Q4	912	625	2	500
2016Q1	1,029	914	7	791
2016Q2	1,104	954	2	1,184
2016Q3	1,345	972	19	1,439
2016Q4	793	808	14	1,272
2017Q1	694	818	8	2,163
2017Q2	438	967	7	1,579
2017Q3	3	3	0	4
2017Q4	2	3	0	0
Total	8,019	7,258	64	9,691

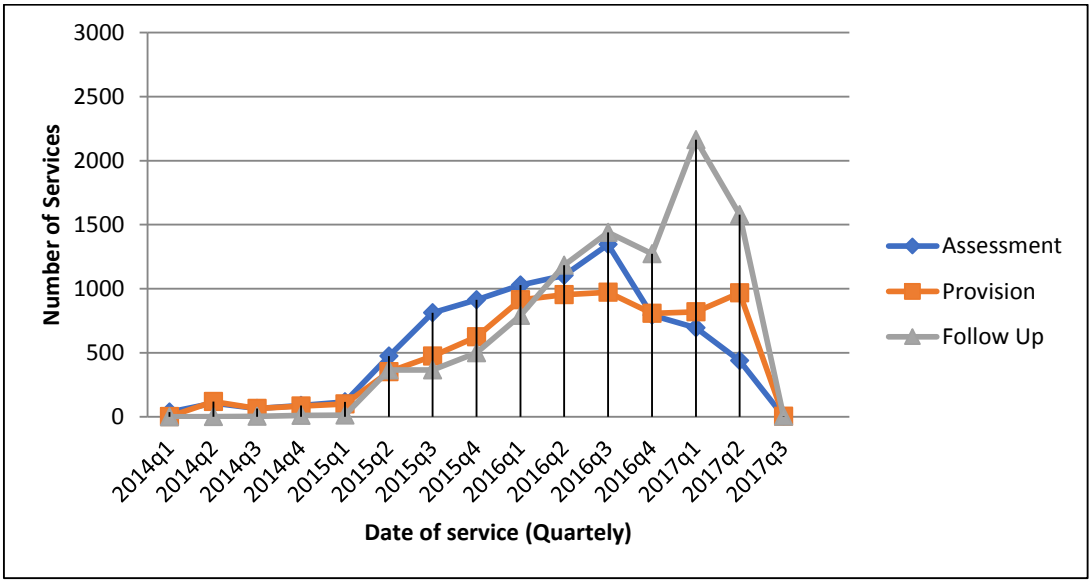
Note: The quarters depicted here do not correspond to financial year quarters but to regular years (eg, Q1 is Jan- Mar and so on).

Figure 4. Comparison of service steps among the five countries (number of assessments, product provisions, follow-ups)



Provisions were fewer than assessments in all countries, especially in El Salvador and Kenya. This could be a result of people being assessed as not needing a wheelchair. The maximum number of follow-ups was conducted in Romania indicating that clients were visited more than once. In India too, clients were followed up more than once, a finding supported by the qualitative client data. Nicaragua had the least follow-up, a finding again supported by qualitative data. (For more details on follow-up, refer to section 2.1.3).

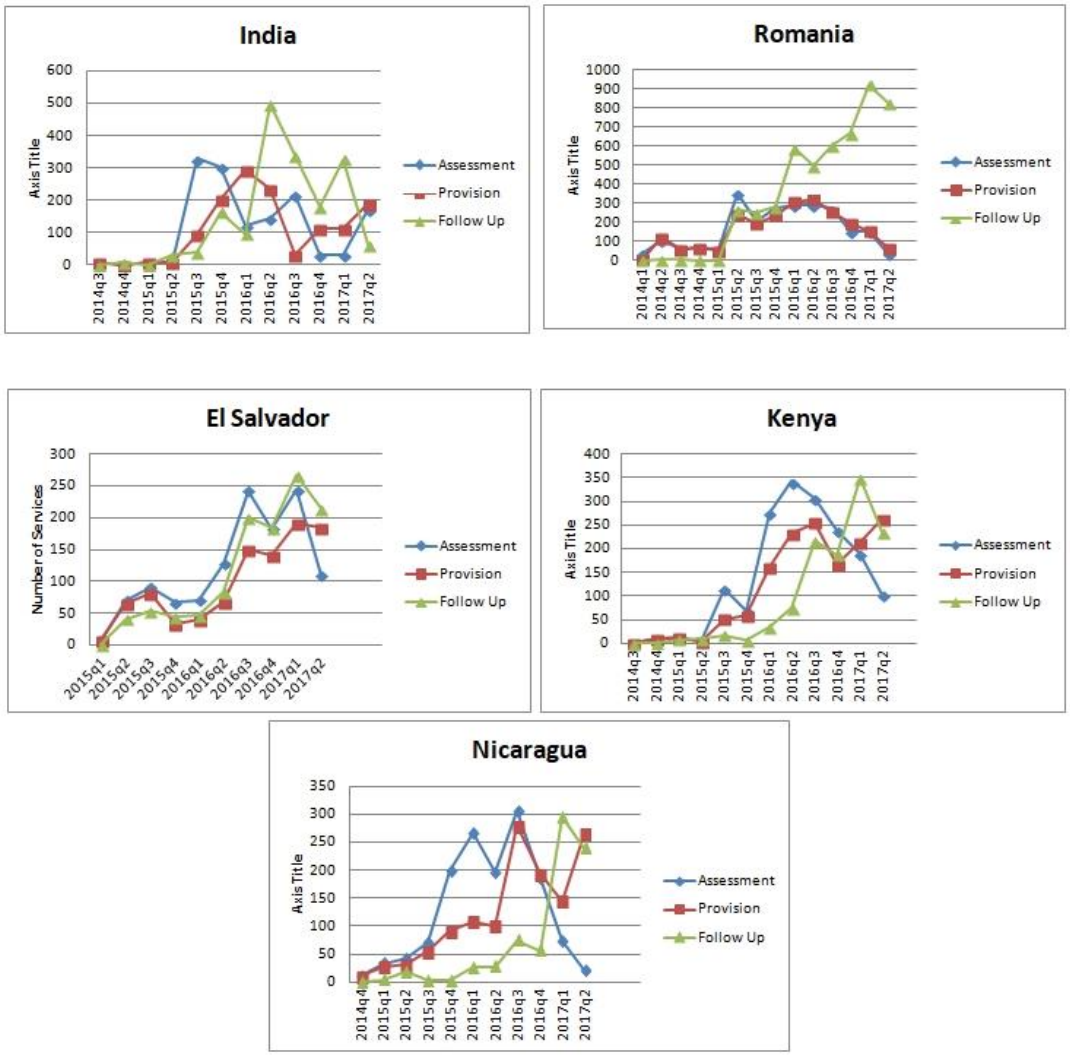
Figure 5. Overall service provision depicting the steps of assessment, product provision and follow-up over project period



A high number assessments and low number of provisions is seen for the period from second quarter of 2015 to third quarter of 2016. This may be due to pressure from the number of referrals coming in and the urgency to begin each client's service cycle as quickly as possible, especially in light of delayed start dates and concerns over meeting targets. Additionally, range of products available and training of service staff dictates when intermediate services can be offered. In places where wheelchair shipments were delayed, assessments continued while some clients waited for wheelchairs to arrive. In the latter part of project period, in several countries, provision is found to be higher than assessments which shows service providers conducting provision for clients assessed

in previous quarters and winding down new assessments due to lack of continuous supply of wheelchairs beyond the life of the project.

Figure 6. Service steps over project period in five countries



Note: Charts are depicted up to 2017Q2 as data entry is inconsistent over the consequent months and, in addition, there were few services provided after quarter2 (FY Q3) of 2017.

All countries had corresponding trends in assessment and provision. In the initial quarters of the project period, assessments were higher than provisions in El Salvador, Kenya, India and Nicaragua whereas Romania had similar numbers of assessments and provisions. This may be an indication of the fact that El Salvador, Kenya, India, and Nicaragua were all relatively new to appropriate service and were entering communities that didn't have established services before. Whereas, in Romania, the service providers were experienced and already had a set rhythm of service provision. Furthermore, because of ongoing service provision, Romania did not experience a huge spike in the number of people needing wheelchairs as in the other countries.

In the latter part of the project period (approximately 2017 quarter 1-2, in India beginning from 2016 quarter 4), provision was higher than assessments in all four countries except Romania. The timelines between assessment and provision in India, Nicaragua and Kenya show gaps at certain time periods due to the long wait time in these countries. These wait times may have been caused by

delayed arrival of wheelchairs into the country or an emphasis by service providers on one service step at a time, to the exclusion of others. Whatever the reason, these graphs show that high numbers of assessments followed by high numbers of provisions are indicative of erratic service trends and delays for individual clients.

Regarding follow-up, which was a mandate for all five countries to be done after two weeks and then every six months after that, El Salvador was doing follow-up consistent with provision whereas in Nicaragua and Kenya, follow-up was consistently lower than provision indicating that not many clients who were provided with wheelchairs were followed up. In Nicaragua, the referral network didn't function, meaning that anyone who received a wheelchair had to be followed up by the service provider since they were self-referred or came off a waiting list. However, poor communication between community referral networks and service providers resulted in low numbers of follow-up. In Kenya, again, follow-up was not consistent as service providers reported in the qualitative interviews that following up entailed traveling far to reach just one client which may have been a huge burden on the service providers. However, in that situation, 50% of follow-ups were conducted by WV or community based organizations, which is a very positive aspect in terms of continuation of community based services. In Romania, the follow-ups increased over time, probably because of compounding follow-up needs. India's follow-up services increased over time indicating that the problem of poor follow-up was subsequently identified and addressed.

2.1.2 Product provision

A total of 5,104 basic wheelchairs, 1,551 intermediate wheelchairs and 600 tricycles were provided to clients.[1] India provided a higher number of intermediate chairs followed closely by Kenya. In the other remaining countries, provision of basic wheelchairs was significantly higher. This may be because El Salvador and Nicaragua were starting with very low capacity, so the service providers needed practice with basic service before going on to intermediate clients. On examining the type of wheelchair provided according to age, it is seen that the youngest age group of children were provided with more intermediate than basic wheelchairs reflecting the reality of disability needs of children and adults. Children with cerebral palsy often need intermediate service, while adults who acquire disabilities due to spinal cord injury or other accidents typically need basic wheelchair service. Therefore, in Romania, intermediate wheelchair provision is low due to its adult clientele. Another reason could be the higher availability of appropriately designed wheelchairs for children with advanced disabilities, compared to those for adults.

As regards the intervention sites, we see more provision of intermediate wheelchairs in ADP areas compared to non-ADP areas- 59% of wheelchairs provided within ADPs were basic and 41% were intermediate compared to 81% basic and 19% intermediate in non-ADP areas. This could be a result of selection bias- more people requiring intermediate wheelchairs being identified and referred by referral actors in ADP communities. ADPs are in remote areas and some have never had appropriate wheelchair service before. Over time, as clients' conditions worsen they may go from needing a basic product to an intermediate product and therefore there may be a higher prevalence of people in ADP areas with intermediate needs. Furthermore, WV's child centered focus could also indirectly result in providing more intermediate wheelchairs in ADP areas.

[1] This number differs from total number of provisions listed in table 8 as the former included double entries but which did not exceed 2% of data indicating that the errors would not make any change in accuracy of the results

Figure 7. Type of wheelchairs provided to ACCESS clients

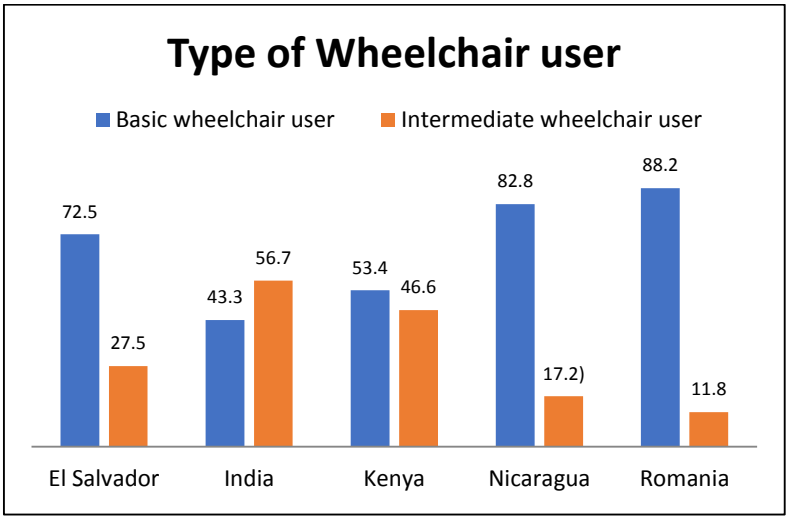
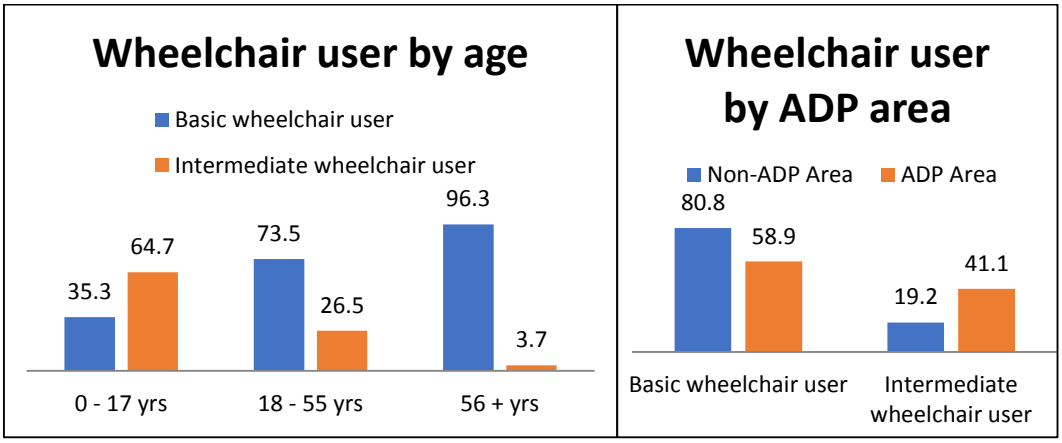


Figure 8. Type of wheelchair provided by age and ADP area



Wait time between assessment and product provision

The **mean waiting time between referral and assessment was 66.4 days** (95% CI: 50.5 – 82.3), and that **between assessment and wheelchair provision was 73.9 days** (95% CI: 71.6-76.1).

Table 9. Mean waiting time between assessment and product provision

Mean waiting time between assessment and product provision	
Country	Mean Time (days)
El Salvador	53.0
India	90.4
Kenya	72.6
Nicaragua	148.9
Romania	35.7

From the users' as well as service providers' perspective in the qualitative data, in El Salvador and Nicaragua, waiting time between when they were assessed and when they were provided

wheelchairs was long and this eroded the credibility of referral actors in the community. The table above does show that Nicaragua had the longest wait time. However, in El Salvador, it was relatively shorter (53 days) which suggests that the qualitative data reflected a few uncommon cases. Nevertheless, the qualitative data from El Salvador further indicates that long periods of waiting time forced some service providers to provide wheelchairs to those waiting in line from other donor organizations, perhaps thus mitigating the long delay. The technical partners maintained that an infrequent supply chain and a ban on imports from China that was lifted only after one year into the project compounded the problem of timely provision.

Technical partners also posited that in wheelchair service, it is the quality and not quantity that matters because providing a wrong chair damages a person's health, and therefore, the focus was on provision of appropriate wheelchairs rather than moving wheelchairs quickly or reaching high volumes, but this message was not completely understood by service providers and WV staff. A clear communication between service providers and clients at the time of assessment and reinforced by referral actors in the community could have eased the situation and improved the relationships between the different stakeholders. In India, long wait time was felt to be a drawback by WV project staff; however, the interviews with clients did not reflect this as a major problem. As Motivation Romania provided their own wheelchairs without having to rely on an external source, the waiting time is thus the shortest in Romania.

2.1.3 Follow-up

Follow-up with clients is the last step in the WHO 8 step protocol for wheelchair service provision. Follow-up allows feedback from clients about their wheelchairs while also identifying and addressing problems of repairs and maintenance. **A total of 5,089 clients (70.1%)** were followed up at least once, and **2,949 (36.7%) have not been followed up.** A total of **702 clients (8.73%) moved/died/ or left the program** during the evaluation period.

Table 10. Waiting time between product provision and follow-up

Wait time	Freq.	Percent	Cum.
<1mo	2,267	45.6	45.6
1-4mo	1,458	29.32	74.92
5-8mo	502	10.1	85.02
8-18mo	675	13.6	98.61
19-24mo	59	1.13	99.74
24-30mo	11	0.26	100

The longest period between provision and first follow-up – that of 18 months and above- was experienced by only 70 clients. Approximately 14% (N=675) were followed up between eight and 18 months, and approximately 46% (N=2267) had their follow-up within less than one month of product provision. Thus, although the ACCESS project mandated the first follow-up after 15 days and thereafter every 6 months, only close to half of the clients were followed up within a short time interval. WHO Guidelines suggest best practice of follow-up within the first six months of product provision. Among those who were followed up, 82.3% (N=4,094) were followed up within the first six months, thus indicating a reasonably high compliance with WHO guidelines.

The qualitative data indicates this step as the most challenging. There was a lack of clarity in a few countries about whose responsibility it was to follow-up with clients. While the project design

included both WV referral actors and service providers supported by technical partners for this role, a few service providers understood follow-up as not a regular but a more needs-based intervention when they would be required to advise on repairs and maintenance. Furthermore, the provision of budget was felt to be insufficient for this activity. In India, follow-up, at least twice after getting a wheelchair, was largely taken up by referral and other ADP community based workers. This helped in identifying problems in wheelchairs which were then communicated to the service centers, and clients were referred for further service. In Romania, mobile teams of Motivation Romania staff as well as ADP staff maintained follow-up. Romania had the maximum number of follow-ups with India close behind (see figure 4 and 6).

Additionally, quantitative data indicates that the maximum number of follow-ups were done by service centers followed by World Vision and DPOs. In India, echoing the qualitative findings, WV staff was seen to have conducted most of the follow-up compared to service centers. In Nicaragua and El Salvador, again supporting the qualitative data, it was found that service centers followed up more than the other organizations. In Kenya, apart from service centers, community based organizations played a major role, evidencing a synergistic collaboration with organizations in the community. Romania had equal ratio of follow-up conducted by service centers as well as WV.

Table 11. Number of follow-up conducted by types of service organizations

	El Salvador	India	Kenya	Nicaragua	Romania	TOTAL
# of service center follow-ups	923	265	457	624	4,033	6,302
# of DPO follow-ups	28		264	3		295
WV follow-ups	8	1243	37	42	760	2,090
gov follow-ups	10		37		10	57
CBO follow-ups	1		113			114
No affiliation follow-ups	1		0	4		5
FBO follow-ups			4			4
NGO follow-ups				8		8
other follow-ups					3	3
TOTAL FOLLOW-UPS	971	1,508	912	681	4,806	8,878

2.1.4 Repairs and maintenance

Qualitative interviews with clients revealed that some of them experienced damages to their wheelchairs in the nature of broken brake locks, loose tires and issues with headstock tube. According to technical partners, this occurs when wheelchairs are not taken care of or they are used for purposes for which they are not fit. Road conditions can also lead to damages. Occasionally, service centers fail to assemble the wheelchair properly. Whatever the reason, addressing these issues of repair and maintenance was often tied to operational challenges: distance of service centers and poor transportation which made it difficult for clients to travel for repairs; lack of spare parts in the more remote areas where clients lived; insufficient expertise in repairing in some service centers; and delayed communication with service providers which prevented them from timely action. In India and Kenya, attempts were made to address this issue with local artisans trained in repair and maintenance.

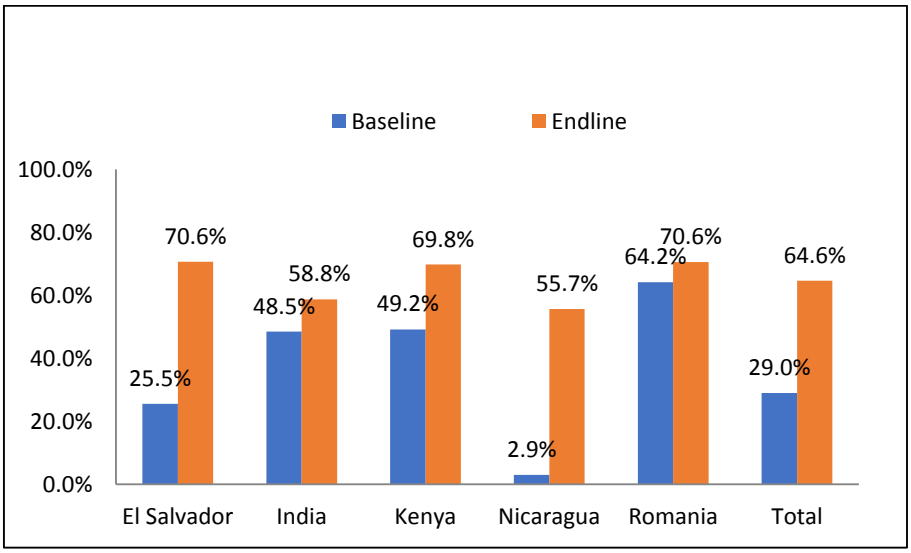
2.2 Increased Capacity for Wheelchair Service Development

The physiotherapists and service managers interviewed in the qualitative evaluation were highly appreciative of the new skills they learnt from the WSTP training and the guidance and capacity building provided by the technical partners. They reported improved capacity to provide patient-centered services by following the WHO 8 step wheelchair service provision protocol, as illustrated in this quote from a physiotherapist in India, "*Actually previously I was not doing anything with the wheelchair, nothing was happening, in my physiotherapy course I just learnt what is wheelchair that's all, nothing about measurements, I had no idea. After joining this project only, after they trained us about the basic level, intermediate level, so from that I came to know. I did not know anything before, how to take measurement, what is an appropriate wheelchair.*"

> *When someone donates wheelchairs and wants them to be given out we now can say NO, and tell them that the person has to be assessed first for us to prescribe the right type of wheelchair*- Wheelchair service manager, Kenya

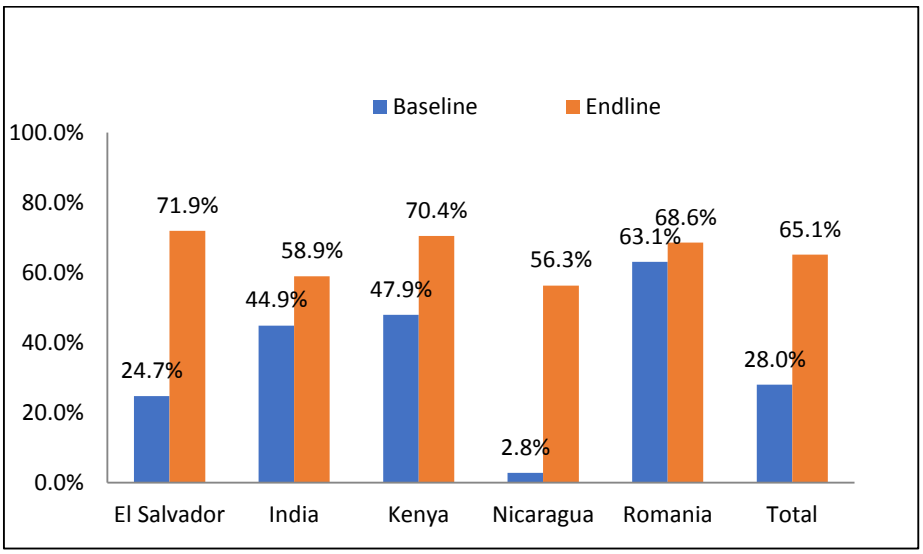
In a comparison of service assessments pre and post capacity building,[2] all 43 service centers showed increased capacity for wheelchair service. Capacity was measured on a number of different domains, with points assigned for each domain (appendix 4). The total possible score for basic service capacity is 72 and the total possible score for intermediate service capacity is 84 points. Services are then ranked by the percentage of possible points obtained. Rankings include: 0-25%= Early, 26-50%= Developing, 51-74%= Maturing, and 75%= Well-functioning.

Figure 9. Average score for Basic Capacity by country



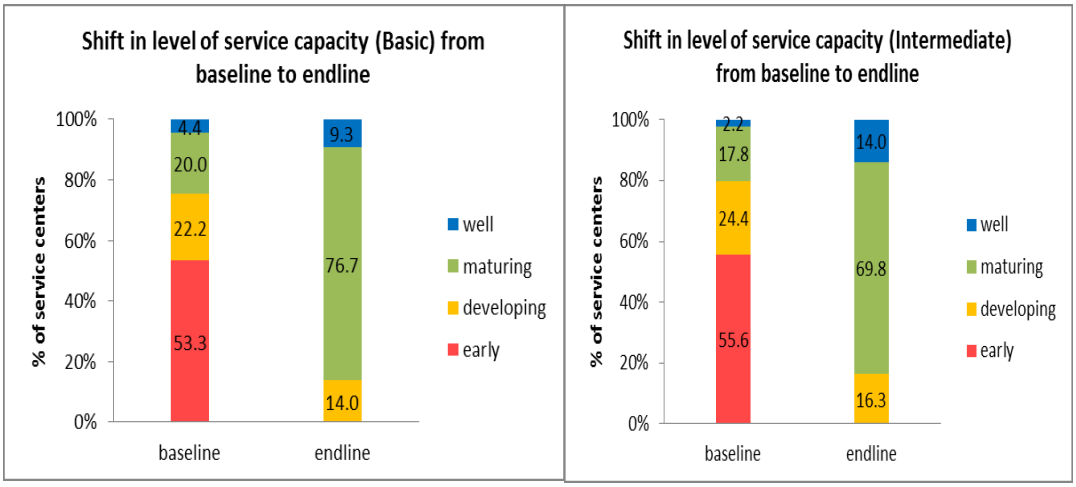
[2] The tool was developed by Motivation Charitable Trust in collaboration with Handicap International

Figure 10. Average score of Intermediate Capacity by country



Baseline capacity of service centers varied across countries due to maturity of the overall wheelchair sector within that country context. Overall, 56% of service centers achieved the level of early service development for basic and intermediate wheelchair service at baseline. In El Salvador and Nicaragua service centers showed the least capacity at baseline with 11 out of 14 centers in El Salvador and 12 out of 13 centers in Nicaragua ranking as early service development in basic wheelchair service. Therefore, the difference in increase in capacity is much bigger than other countries which started at a developing stage. Romania showed the highest level of initial capacity with four of five service centers ranked maturing for basic service at baseline, and therefore, the improvement in Romania is marginal.

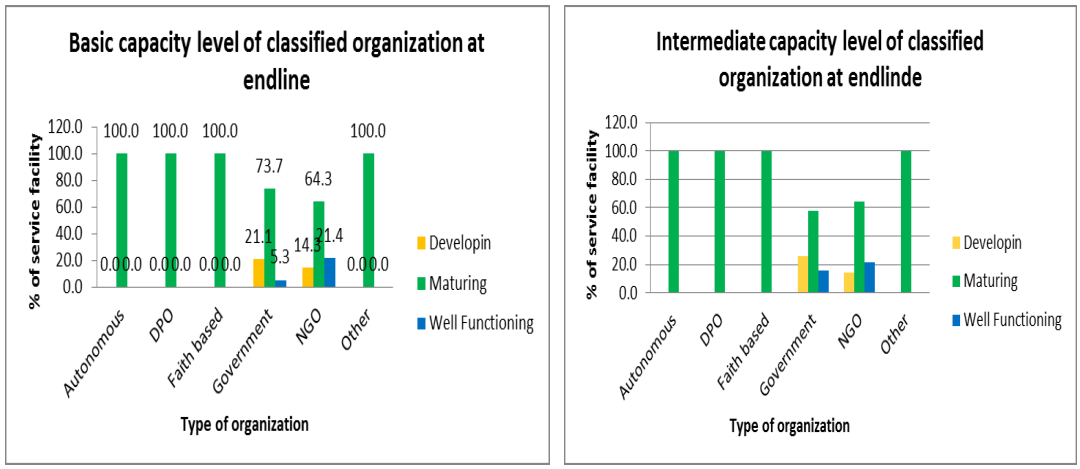
Figure 11. Shift in level of overall service capacity from baseline to endline in basic and intermediate services.



At the close of the project, service assessments were conducted again to determine the change in service capacity. Although all services increased their scores in wheelchair service capacity, not all services increased scores enough to achieve a higher ranking. By the end of the project 77% of service centers were ranked as maturing in basic wheelchair service and 70% were ranked as

maturing in intermediate wheelchair service. The greatest change in service capacity was in the stages of "early" and "maturing." At endline, there was no service center which was in the early stage, for both basic and intermediate services. A higher number of service centers reached maturing stage at endline compared to baseline which is a significant achievement as many service centers were new to WHO-compliant services in the beginning. There was only a moderate increase (14%) in the number of service centers that were "well-functioning" at endline. This finding should be treated with caution as to achieve a ranking of "well-functioning" a service center requires a long period wherein profound changes in systems are introduced and get established including access to funding. Thus, to shift capacity level to a well-functioning stage may require further support and time.

Figure 12. Capacity level of service organizations for basic and intermediate wheelchair provision

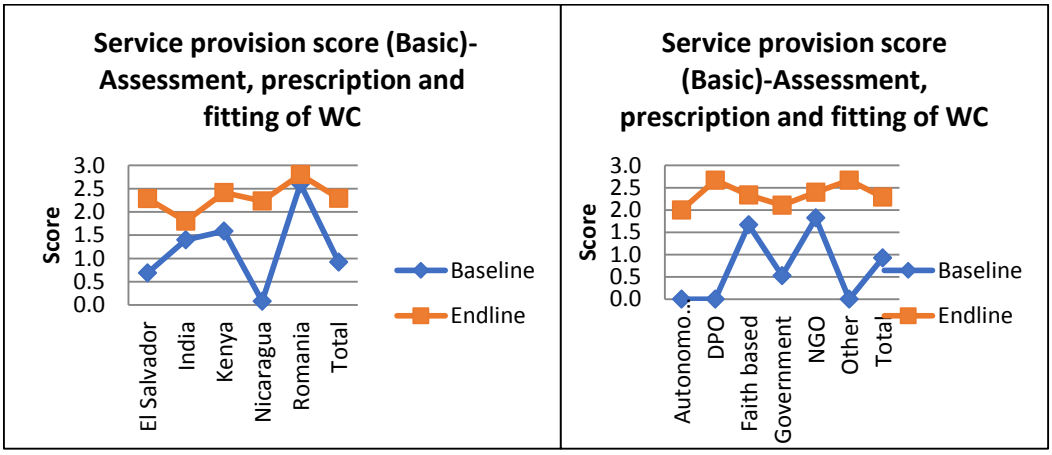


Service centers that are NGOs made the most significant gain in capacity in both basic and intermediate services at the end of the project- 57% of them reached the well-functioning stage in intermediate services compared to 16% government run service centers and none in the other type of organizations. All the others reached "maturing" stage in capacity at the end of the project. This could be a result of the fact that NGO were providing more intermediate services than the others (65.5% compared to 7.6% by government, 10.3% by faith based organization, 5.1% by DPO, and 11.5% by others) which affected their capacity as the latter is dependent on hands on practice, and hence the more they provided intermediate wheelchairs, the more their capacity was built. Interestingly, a few service centers within the NGO and government sector were still at a "developing" stage compared to other organizations at endline reflecting perhaps the diverse contextual organizational systems and cultures that made one center highly capable while another was still developing.

Comparison of service capacity in the key domains of Service Provision and Service Management

Capacity was built in two major domains: clinical and organizational. Reported increase in capacity was specifically noted in qualitative interviews for the steps of assessment of clients, prescription, product preparation, and fitting and modification. Quantitative data indicates the highest increase in El Salvador and Nicaragua as these countries started at a very low capacity, followed by Kenya, India and Romania. Technical partners, too, remarked on improved clinical capacity as one of the biggest achievements of the project. DPO and other organizations appear to have made the most increase in capacity as they started at a very early stage. The figure below presents the change from baseline to endline in clinical capacity by country and by type of organization for these specific steps.

Figure 13. Capacity level in service provision steps (Assessment, Prescription, Fitting) by country and by type of organization



Note: 0=early,1=developing,2=maturing,3=well-functioning

In qualitative interviews, improvement in processes and systems was reported in some service centers but not all, depending on the maturity and history of previous wheelchair provision of the centers as well as buy in from senior management especially in government run service centers. In Kenya, APDK had an established wheelchair provision system and with increased trust among senior management in the new model of provision, organizational capacity could be built successfully. In El Salvador and Nicaragua, service centers being at a nascent stage, more efforts were put into building basic technical capacity. Moreover, as pointed out by a technical partner, insufficient project resources and lack of intentionality in the project design contributed to a bifurcation in attention toward clinical capacity development and away from managerial/organizational development. However, when we examine the quantitative indicators, we find that capacity in service management has also increased considerably over the project period, as shown in the table below,

Table 12. Service management capacity by country and by type of organization

Service management score by country(%)			Service management score by organization(%)		
Country	**Baseline**	**Endline**	**Type of organization**	**Baseline**	**Endline**
El Salvador	22.2	64.7	Autonomous	16.7	61.1
India	47.2	54.4	DPO	0.0	55.6
Kenya	51.9	68.5	Faith based	46.3	65.7
Nicaragua	1.9	46.2	Government	13.0	52.0
Romania	55.6	65.6	NGO	50.8	63.7
Total	26.8	58.5	Other	22.2	70.4
			Total	26.8	58.5

Nicaragua and El Salvador started at a very low stage and while Nicaragua reached a developing stage at endline, El Salvador made significant progress and reached a "maturing" stage. This could be a result of increased efforts made by technical partners in El Salvador, " *in terms of mentoring toward the administrative components- sitting with the administrators, talking about the need for staffing, need for a weekly clinic, need for supporting staff through their clinical times, allowing them blocks of time dedicated to WC provision*." All other countries were developing at baseline and became maturing at endline, and none reached well-function stage. India did not show a significant increase as the focus here was not

on improving administrative systems as service centers did not deal directly with procurement of wheelchairs. A technical partner suggested that the focus in India was more on wheelchair provision and capacity building was directed toward that. Since Romania was already following standard practices, it did not show much increase at endline. In terms of types of organizations, all organizations reached maturing stage with none reaching well-functioning levels. DPO, government and autonomous organizations had the maximum increase in capacity as they started from an early stage. Therefore, although government run service centers were old and established, their capacity for appropriate wheelchair service management was not very well developed which increased significantly over the project period.

2.3 Mentorship Activities Leading to Increased Capacity for Wheelchair Service

Capacity was built in a variety of ways: hands-on guidance at assessments and fittings, ongoing mentoring through clinic visits or electronic media, trouble-shooting through electronic communication. Strategies used in mentoring varied as per the needs of the service providers, particular organizational culture of service centers, staff interest, time and motivation as well as the evolving needs of the project. There was no standardized tool that was used as contexts varied, according to this technical partner from Motivation UK"*I think in terms of the WSTP that was standardized, that's the way it is taught across the 5 countries. In terms of the capacity building I think that was in different ways but I don't think that that is a problem. I think that you have to contextualize….you can't have a standard model of capacity building. So I think it is standardized to an extent that it needed to be but I think that each country flexed and delivered things in a different way that to me was a country level need."*

Wheelchair users who were interviewed narrated their experience in how they were screened, assessed, fitted, and trained on how to maneuver their wheelchairs, thus corroborating the adherence of service providers to the standard guidelines.

In terms of capacity building in systems and processes, service centers underwent an initial assessment of physical space which helped them in acquiring provisions and equipment for screening of clients, and in some cases for user training. Capacity in streamlining processes of ordering and inventorying was not a focus for those service centers that were not involved in direct procurement of wheelchairs whereas centers which were involved in procuring and had established systems in place, like APDK in Kenya and Future of Nicaragua, were further trained on this aspect. Administrative procedures in established quasi government organizations were difficult to streamline initially as there was an unwillingness to change established ways of doing things. However, with continuous training and mentoring, and seeing positive results in organizing in the new way, as in the case of APDK in Kenya, practices changed to align with appropriate service provision. Therefore, as evidenced by the quantitative data, government service centers are seen to improve their managerial capacity over the project period.

However, no single set of tools for evaluation and mentoring were available though it was a felt need expressed by all stakeholders. This led to the development of the service operations manual by Motivation which was further adapted for local use by service providers in Kenya. However, the guide has not been used in other countries. This is perhaps because it was developed in the later stages of the project period and arose out of a need for standardization of capacity building. According to a technical partner, however, although it was useful to have a single guideline or module for service provision, it may not be practical to stick to only this as contexts differ: organizational cultures, administrative procedures and resource cycles vary making standardization of capacity building measures difficult, instead necessitating a culture of adaptation. This sentiment was echoed by all technical partners.

As previously mentioned, mentoring of service providers by technical partners took various forms depending on the need of the service center, type of service center and culture of communication. In all countries, initial wheelchair provision was observed by technical partners as a key part of capacity building approaches. In Romania, a system of between and within mentoring existed whereby senior personnel guided and advised new or junior therapists. Communication by technical experts with service providers in the field in Romania, El Salvador and Nicaragua was ongoing through online platforms including Google Drive and WhatsApp application. In the latter two countries, case studies were presented and discussed with the technical partner. Service providers from El Salvador stated that clinic visits made by UCP-WFH staff were very helpful in reviewing materials taught in the WSTP courses, and also in helping them to use concepts learned to evaluate new clients. This quote from a service provider in El Salvador is illustrative of the feelings of service providers about mentoring visits, " *What they taught us is fine (in the WTSP courses), but visits from the people who trained us are always necessary because it's when you're doing things in practice that doubts come up. When the person who trained us visited we always went up to him and asked, because you learn along the way with the help of people who can guide you."*

In India, some unique challenges posed difficulty in ensuring smooth communication between service centers and technical partners. One was the distances to service centers which made it impossible for a single staff to undertake continuous mentoring visits. The low number of technical partner staff might also have been the reason why certain problems faced by service providers were not resolved immediately. Another reason mentioned by the technical partners was the focus on numbers of wheelchairs to be provided which reduced the time to build capacity of service providers. Furthermore, it was seen in India that lack of materials for intermediate postural devices in some local markets made it challenging to modify a wheelchair to fit the needs of individual clients. However, as India provided more intermediate wheelchairs than many other countries, this incident could be related to just one service center, and is not common to all service centers.

2.4 Was the Zoho database effective for capturing necessary information for client management?

Documentation was streamlined and all data were entered in the Zoho database. The use of the database in managing service operation varied with most centers handling it as another data entry platform. Irregular internet connection in El Salvador and Nicaragua added to the difficulty of entering data. While all stakeholders opined that electronic data is useful, the state of technological development in some countries, the nature of service centers, the work culture of organizations, staff turnover necessitating retraining on database all contributed to its low usage in managing project operations. However, service providers found it useful to refer to any client and knowing about his/her status along the stages of service provision at one glance. In Kenya, service providers remarked on the ability to get information real time on the number of people who have been served as innovative, and the data was used for decision making to an extent in the country, as expressed by this service manager "*...and it can help to guide decisions actually you can see so many referrals but not assessed so you can even know where to intervene. So it makes coordination of the entire project very easy and effective.*" In India, the database was useful for policy advocacy as information on the client demographic and services rendered could be easily used at meetings and interactions with the government. In Romania, the database currently works as an alert system for providing services particularly regarding maintenance, repairs and follow-up. Thus, continuity of the database is varied and those aspects deemed most useful have been adapted for use in various countries.

2.5 Sustainability of Capacity Building

The provision of WHO-compliant wheelchair services will continue in all service centers across all countries as the skills acquired and the effects of results seen of such provision are not likely to disappear. However, the biggest concern is about the supply of appropriate, high quality wheelchairs after the project ends. Service providers indicated that without resources from ACCESS they will

not be able to provide appropriate wheelchairs unless the government decides to adopt the model. Several initiatives are underway to continue service provision. In India, for example, according to a technical partner, four out of the five service centers would form part of a network of services and will continue to provide wheelchairs through Motivation India and The Church of Jesus Christ of Latter Day Saints (LDS) which have a supply of available wheelchairs. In Kenya, the support of senior managers would ensure continuation of WHO-compliant service provision with Motivation UK providing annual evaluation of their service capacity. Again, in Kenya, Motivation is in discussion with LDS regarding supply of wheelchairs through ACCESS service centers.

Technical partners were of the opinion that it was not just continuation of the services but also the confidence of service centers to jettison the old ways of distributing donated wheelchairs that would enable sustainability of the model. In the words of one technical partner from UCP- Wheels for Humanity, "*We've seen that the administrators of these service centers also have said that they have seen better client service; they have seen better response from family members of clients in terms of satisfaction. So I think that model is sustainable. The big question is with products. So what we've been teaching all our partners, all our service centers is that in 2 weeks or 4 weeks or 4 months organization X is going to arrive at your doorstep and say we want to give you 1,500 wheelchairs but we have them in our car parking lot- then all of these organizations have to have the strength to say we appreciate your donation, but these are our clients, our people, and your wheelchairs have to go through the channels which we have established. So therefore we cannot do it on a parking lot on a Saturday, we have to do it in our center and provide them a process of evaluation, prescription that people are appropriate for and we'll happily do it. As soon as the service centers have the professional confidence and independence to say those things then I think we'll start to see the model really expand*."

As the 8 Steps + project model is based on a novel coordination between community based organization and technical services for a smooth flow of referrals, provisions and follow-ups, sustainability of the model also depends on the commitment and involvement of WV ADP offices. To this end, disability needs to be a focus in the overall programming of ADPs. In Romania, according to a technical partner, Motivation Romania will continue delivering wheelchair services both in ADPs and outside ADPs, continuation of social inclusion activities within ADPs will depend on the eventual resources identified by WVR or local communities.

3. EVALUATION OF OUTCOMES BASED ON OBJECTIVE 3- WHEELCHAIR SERVICE TRAINING PACKAGE (WSTP) TRAININGS

A total of 911 service providers were trained on WSTP training package. Apart from the WSTP courses, service providers were also trained on User Life Skills Training (N=216) and Intermediate Technical training (N=26).

3.1 Are participants of WSTP training courses using the knowledge learned in the training? Why or why not?

WSTP training	Female	Male	Total
Basic	180	229	409
Intermediate	80	117	197
TOT	39	29	68
Manager	85	152	237
N	**384**	**527**	**911**

Qualitative data indicates that all service providers who underwent the WSTP training have benefited from the skills they acquired of providing a new model of services- that which ensures quality products to people living with disabilities through a standardized approach. This quote from a service provider in Nicaragua reflects the gains from the training, "*The training was excellent and a great opportunity to specialize in wheelchair provision and services. I think in our case we have the confidence in the material. We have been trained well and feel confident with the 8-step model.*" Application of the new skills and knowledge in providing services to clients of the project as well as to those outside of the project in a service center is a testament to the practical usage of the training courses.

Operational limitations in a few countries, such as long wait periods between referral and assessments due to unavailability of wheelchairs, led to a loss of learned skills in the initial stages of the project, necessitating the holding of refresher trainings which was not always possible due to budget constraints. Similarly, staff turnover in Romania and Kenya as soon as training was received led to much pressure on capacity building as new staff had to be taught and capacitated again. Furthermore, certain steps of the WHO model could be focused on and concretized to make them more productive. For example, in India and El Salvador, addressing repairs were challenging due to unavailability of spare parts. In such instances, follow-up with clients was not useful as service providers were unable to provide the necessary service. In India and Kenya, this was dealt with by referrals to local cycle repair shops that had been trained in basic wheelchair repair. In El Salvador, several service providers raised concern about follow-ups since spare parts may not be available to make necessary repairs. Practical ways of resolving such issues could be integrated into the training course.

The WSTP training was additionally extended to physiotherapists and rehabilitation personnel outside the project in several countries. In Romania, several government employees participated in community seminars while in India the WSTP course was provided to hospitals and rehabilitation training and research institutions. The trained personnel from these institutes were highly appreciative of the training and reported that whereas earlier they gave out any available wheelchair to a client without assessing its appropriateness, after the training they attempted to follow the WHO guidelines, conducted physical assessment, provided user training and if required, prescribed customization of wheelchairs. However, they also reported that they did this out of personal motivation and interest which limits its wider application without institutional mandate and support.

> *We all thought we knew how to do a complete assessment but after taking the training we realized that we consolidated the knowledge and our services are now better and more efficient, beneficiaries are more satisfied, they get what they need*- ACCESS staff, Romania

3.2 Has facilitation of WSTP trainings been sustainably passed to local trainers and training institutions? What activities under objective 3 are sustainable?

While the skills learned in the training are most likely to sustain as they would be applied to new clients after the project, facilitation of training by local service providers would require investment in time and money. Furthermore, although they may be able to provide basic WSTP course, they would require the support of technical experts for their intermediate course and TOT course. In Nicaragua, UCP- Wheels for Humanity and Futuro de Nicaragua are also in the process of working with the La Universidad Nacional Autonoma de Nicaragua (UNAN) to integrate WSTP training in the university's physical therapy program, which is an important step to developing the knowledge and capacity of the local workforce. According to a clinical lead at UCP Wheels, the relationship with UNAN cannot be over stressed, once the model is integrated into the curriculum, training of

future providers can easily be sustained without depending on outside resources. In Romania, Motivation Romania is willing to train government employed physiotherapists and technical assistants depending on availability of resources. Similarly, in India, the application of the WSTP training would continue but needs to be reinforced with refresher training for service center personnel. In- country capacity was built in India for Mobility India and in Kenya for APDK by Motivation but there is a lack of funding or a plan to continue trainings. Thus, no sustainable model was planned for trainings across all countries.

4. PROJECT CHALLENGES

Challenges in terms of delay of project, delayed supply of wheelchairs, insufficient time and focus on building collaboration, environmental conditions, organizational factors and policy or systemic factors were experienced. While addressing certain factors was outside the project scope, attempts to address some of the other challenges were successfully made.

Timing and sequencing of project activities: With the start of the project one year later than the expected start date, the focus became one of achieving outputs i.e., the number of wheelchairs to be provided to clients. This put pressure on service centers to deliver. Meanwhile unavailability of wheelchairs after conducting assessment damaged the relationship between WV referral actors and clients in some countries due to not meeting client expectations. Technical inputs of the project appeared to have suffered due to lack of understanding of technical matters in wheelchair provision which optimally requires time and patience to ensure quality of service. According to the project leaders, not enough time was spent on relationship building between partners which prevented complete understanding of one another's work culture and priorities. This occasionally affected smooth inflow and outflow of activities between different organizations. Although monthly meetings were organized with different stakeholders, certain factors like staff turnover, individual motivation, and the sheer scale of the project that demanded a high level of outputs were responsible for maintaining the status quo.

Organizational values and culture: World Vision's goal of community strengthening and its culture of distributing products at grassroots combined with insufficient technical experience and skills in appropriate wheelchair provision differed from the goal of highly technical organizations like Motivation and UCP-Wheels for Humanity, thus creating miscommunication in a few countries. This is one of the major lessons learned in the project which is tied to the first challenge – that a project life must include an incubation period when meetings and engagement with different stakeholders need to be nurtured for a more cohesive work collaboration.

Environmental conditions: Structural and environmental conditions often impose limitations in the mobility and participation of PWD despite being equipped with appropriate wheelchairs. Lack of adequate transportation has been identified as a major barrier in both quantitative and qualitative data indicating a need for increased advocacy around this sector. Additionally, lack of access to public institutions and poor condition of roads further limit participation. Although CVA advocacy was directed at constructing ramps and accessible facilities, success was sporadic- seen only in places where there was active support from local authorities. This is another major lesson learned- that to build an enabling environment for disability inclusion, including government officials in advocacy and action groups, rather than merely as objects of advocacy efforts, needs to be a priority.

Policy or systemic factors: Despite national laws protecting the rights of people living with disabilities and enabling their participation, the implementation of these laws and policies is low in many countries. In India, although benefits and entitlements exist for people living with disabilities, not very many of them are aware of these, and those who are aware and try to access the benefits are faced with intricate bureaucratic challenges including having to pay bribes to officials. In Romania, although

the government funds a wheelchair for up to 250 euros, there is no additional funding for the needed services such as assessments, user training, repair and maintenance. Indeed, this is also the case in India (with the government providing wheelchairs at subsidized rates or for free) as in most other countries.

SUMMARY OF FINDINGS

HOW WELL DOES THE PROJECT ADDRESS THE NEEDS OF WOMEN, MEN, BOYS, AND GIRLS WITH MOBILITY LIMITATIONS?

Both qualitative and quantitative evaluation indicates that the ACCESS project achieved its goal of addressing mobility limitations among adults and children living with disabilities and facilitated improvement in not only their mobility but participation in others aspects of life as well, thus adhering to the principles of the UNCRPD and in the context of pervading structural and environmental barriers, gearing toward the fulfillment of the rights enshrined there.

Participation in educational activity increased due to provision of an appropriate wheelchair as also participation in household activities and improvement of social relationships. Although there was less social exclusion recorded for all areas of participation at the end of the project, economic activity, use of public transport, political participation and visiting public places was still low suggesting a need for improvement in interventions in these areas in future. However, this finding has to be examined in context as those people who have severely advanced disabilities may be functionally restricted to participate in economic activities. Qualitative data also highlighted certain exceptions such as an increase in economic activity seen among young, educated adults in India and Kenya. Women with disabilities in India did not increase their participation at the same level as men except when the women were educated or had family support and experienced less cultural restraints on free movement. This group would need an added focus in future projects.

Highest increase in social inclusion was seen among children (<17 years old) except in the area of economic participation, while older adults with disabilities were the most vulnerable, exhibiting low participation in all areas. The greater participation evidenced in educational activities among children aligns with World Vision's child focused activities highlighting the child- inclusive design of this project. As severe health problems rile most older people limiting their participation, perhaps the nature of the indicator should move toward physical well- being and comfort and social inclusion among care takers. Indeed, the provision of appropriate wheelchairs appear to have lessened the time consuming care taking among parents of children with cerebral palsy and increased their social inclusion.

Qualitative data is mixed about social inclusion as this kind of data picks up unique cases which may be outliers but which shines a light on limitations that could be improved in future projects. For instance, there was no difference reported by a few clients on their mobility or their children's mobility as the wheelchairs provided were heavy and bulky, required arm strength to propel, and were ill equipped to move over long distances to reach educational or vocation training centers or to maneuver over slopes and inclines. These reports highlight 3possible scenarios: 1) assessments may have been poorly done whereby the physical, psychological, and economic needs of the clients were not considered to the extent they should have been; 2) possible lack of accessible housing for people living with disabilities, preventing the movement of bulky wheelchairs, which is related to poverty and housing policies; 3) user training may have been inadequately done as many clients reported difficulty in maneuvering obstacles.

Regarding Citizen Voice and Action groups facilitating social participation, results are by and large positive although clients attributed their improved mobility to wheelchairs, perhaps as these are appropriately fitted and the difference from previous wheelchairs is glaringly obvious. Nevertheless, where there were active CVA groups, clients did mention being empowered by the CVA meetings and participating in sensitization programs. Moreover, the direct impact of CVA on social inclusion

may not be seen in the short term, but indirectly, it has a profound effect as improved access to public institutions, improved awareness of rights, and increased access to and utilization of government benefits has the potential to ensure wider participation in community.

CVA mobilization depended on WV ADP efforts which varied in different contexts. The most obvious gains have been in advocacy for easy accessibility such as construction of ramps, increase in clients' awareness of rights and entitlements, and increase in sense of empowerment through sensitizations. CVA methodology is noteworthy in its empowering structure and wide reach and must be continued to tackle problems such as lack of accessible transport, an area from which most people living with disabilities feel excluded, as evidenced by the data. This is a vital platform to ensure fulfillment of all fundamental rights granted to people living with disabilities.

HOW WELL DOES THE DESIGN OF THE PROJECT ADDRESS THE NEED FOR CAPACITY BUILDING OF THE WHEELCHAIR SECTOR?

The fact that 53% of service providers who were at a very early stage of functioning in the beginning of the project reached the capacity of "maturing" at the end of the project, and that 30% of wheelchairs provided were of the intermediate type, representing a range of products and services, speaks of the significant strides made by the project in strengthening the wheelchair sector. Client satisfaction in the wheelchair as well as in the steps of provision illustrates as well the quality of service. A high coverage of 91% of people with disabilities who were referred from hard to reach communities reflects the successful collaboration between service providers, technical experts and community based organizations.

The process of referring and assessing clients, prescribing and providing appropriate products, and following up was, however, not without its challenges. The qualitative data, supported by quantitative indicators, indicate lack of coordination in follow-up and referrals. Countries also differed based on the level of engagement of WV national and ADP offices. A high focus on outputs in the beginning of the project put pressure on service centers to deliver in light of waiting referrals, thus possibly compromising their quality of services. Government service centers and hospitals took time to change to new standards and guidelines due to the existence of already established practices and task roles of the staff.

Furthermore, insufficient resources allocated for staff time resulted in low numbers of in- country technical partner staff which put pressure on their time and engagement, hindering effective communication with service providers. Lack of coordination between ADP and service centers in some countries placed additional responsibility on technical partners to ensure that dates for assessments were decided and outreach services organized.

While waiting time between assessment and provision is dependent on the supply and availability of wheelchairs, a proper system of organizing the number of assessments, prescriptions and inventorying, such that timely provision follows timely assessments, is needed to reasonably reduce this time. Average waiting periods of three to five months after assessment does not seem reasonable from the perspective of the client who would indeed feel frustrated about the delay.

The fact that one third of the clients were never followed up is a severe limitation of wheelchair service provision as issues of maintenance and repairs would not be addressed for these clients. Equally important is the lost opportunity to follow-up on children whose wheelchair needs may change over short periods of time and the lack of intentional engagement with clients regarding their social inclusion activities.

A total of 911 service providers were trained and assessed on the standardized WSTP basic, intermediate, TOT and Manager's training. The training proved to be beneficial in increasing the capacity of service providers. Only in circumstances when waiting time between assessment and provision was long, the absence of practice or application of knowledge potentially led to a loss of skills- an aspect to bear in mind in future such capacity building. Repairing knowhow and the best and most practical ways to follow-up could be another area to strengthen in future trainings.

Service capacity was additionally enhanced with mentoring provided at several levels by technical partners. Although no standardized capacity building tools exist except for the WSTP training courses, the sector may be seen to be moving toward development of tools that could be used for mentoring purpose, with the service operations manual as one such tool that evolved out of the needs of the project. Varying levels of capacity at start time also determines the needed amount of capacity building and mentoring which can be further developed and refined to apply in various capacity contexts. There was a clear correlation between provision of intermediate wheelchairs and improved service capacity thus exemplifying the need to diversify products and provide more complex services, commensurate with the needs and requirements of people with disabilities. In the context of ACCESS, while intermediate wheelchairs were mostly provided to children (~65%), technical partners spoke of the need to develop intermediate wheelchairs for adults, a sector that is still at a nascent stage. Meanwhile, to address this need immediately, postural support devices were used, specifically in India and Kenya, to adapt a basic wheelchair for intermediate seating needs, indicating a need to move toward further training of such skills in resource constrained settings.

In summary, despite varying contexts of country wise collaboration, varying levels of start capacity of organizations, varying cultures and administrative systems between organizations, the positive outcomes in service provision point to adequate capacitating of the wheelchair service sector with further improvements needed in identified areas.

RECOMMENDATIONS

Recommendations are made based on the following domains: project design, building an enabling environment, wheelchair provision, and wheelchair service capacity building.

PROJECT DESIGN

The successful implementation of the 8 Steps +model illustrates its replication on a larger scale. However, sufficient time for partner organizations to understand each other's work culture, values and core competencies must be built in, in any future project, for collaborations of such complexity to work successfully. Differing expectations of the project goal between World Vision and technical partners put pressure on quality of wheelchair service provision which could have been resolved by a clearer understanding of the technical aspects of the project as well as the community driven development goals of WV.

Lack of clear articulation in the project design, of involvement of World Vision national office as well as local government and non- government collaboration created misunderstanding about expectations of support. In future projects, a well-structured and clearly articulated stakeholder engagement plan with well-defined roles and responsibilities needs to be laid down.

Communication problems between service providers, local community based organizations, and technical partners need to be identified early and course correction adopted through meetings, face to face interaction, individual meetings as communication problems can arise out of many reasons: individual personality and motivation, misunderstanding of roles and responsibilities, lack of information about how a particular area of operation should progress- in other words- the nuts and bolts of running a program in varying country contexts requiring varying solutions.

BUILDING AN ENABLING ENVIRONMENT

Vulnerable groups of people living with disabilities identified by the evaluation must be given renewed focus in future in order to ensure their full and complete community participation. Women in India, girl children in India, older people in all countries should be targeted for innovative strategies in increasing participation. At the same time, indicators of social participation can be differently measured for people with advanced disabilities. Furthermore, interventions and measurement indicators must be developed for social participation among caregivers of people living with disabilities.

The gains seen in CVA efforts must be continued with inclusion of disability as a development issue in the community development projects of WV. Resources in terms of staff time for CVA work need to be integrated in ongoing projects.

Findings indicate common barriers to social inclusion among people living with disabilities that include the lack of adequate or appropriate transportation, lack of accessible public facilities and institutions, and lack of proper road infrastructure. Since these are systemic and structural barriers requiring government support and input, CVA groups must continue their engagement with local and national governments to influence decision making around transportation sector, infrastructure development sector, and other social sectors of the government dealing with disability issues.

Societal stigma and discrimination is another structural barrier to social inclusion of people living with disabilities. CVA groups need to continuously work in raising awareness of others in the

community to issues of disability. It was also found that internalized stigma prevented people living with disabilities from venturing forth into public places and participating in community life. To that end, psychological assessment and counseling can be built into wheelchair provision programs by linking with counseling services. Peer training, as provided in Romania and Kenya, can be integrated in service provision as an additional way of addressing this issue.

WHEELCHAIR PROVISION

The gains in capacity of service providers to provide WHO-compliant wheelchair services must be ensured to continue with ongoing support from local WV and technical partners, in order that enthusiasm for the learned service provision is retained and a practical and realistic sustainability plan is put into effect.

Findings indicate that referral networks did not work as per expectation in a few countries. As the successful implementation of the project is based on a smooth flow of referrals, assessments, provisions and follow-ups, it is imperative that community based referral networks be strengthened by allocating time and staff and articulating their specific roles. At the same time, management of service centers must ensure a smooth working relationship with community networks and organizations by holding regular meetings, planning on common goals and objectives, and strategizing service provision priorities. A clear communication between service providers and clients at the time of assessment about issues of provision and reinforced by referral actors in the community can reset expectations of clients and improve the relationships between the different stakeholders.

As follow-up was the most challenging service step due to reasons related to budgetary constraints as well as lack of coordination between community actors and service centers, it is important that sufficient resources be planned and allocated for this service. At the same time, steps must be taken similar to those described above to facilitate a smooth working relationship between community based organizations and service centers. Additionally, the database can be adapted for use in timely follow-up of clients.

An organized system of referral, assessment, prescription and ordering based on quality rather than quantity needs to be established in service center operational systems. A process that results in a steady flow of wheelchairs unencumbered by supply chain issues, and that balances the cycle of assessment, provision, and follow-up so that a service step is not overloaded thereby causing pressure to move quickly on the subsequent steps must be adopted. This would reduce waiting time for assessments as well as provisions.

The Zoho database, while useful for streamlining huge volumes of data, can be made simpler to fit into one template with linked tabs and with built in checks that recognize data entry errors which can be rectified there and then. A cultural shift in working with electronic data will occur only with refresher trainings and must be ensured by WV.

Mechanisms must be put in place to ensure that materials and spare parts needed for repairs are available to the service centers and innovative ways must be found to bring repair closer to communities including training local bicycle repair shops on basic repair and maintenance.

The execution of the WHO client assessment is needed to improve in order to reduce client dissatisfaction, in the few cases that it occurs, and improve their social participation. Thus, the patient centered, WHO-compliant 8 Steps + model, different from the distribution model, needs to reinforced through refresher trainings or through a system of annual evaluation built by the technical partners.

The sourcing and continuous supply of appropriate wheelchairs must be ensured to continue service provision. The government, being the largest distributor of wheelchairs in some countries, must be prevailed upon through continuous advocacy to encourage the manufacture and development of appropriately designed wheelchairs.

WHEELCHAIR SERVICE CAPACITY BUILDING

The expectation of standardization of capacity building could not be met due to ground realities of contextual differences that made a potential single tool impractical. Instead capacity building was conducted in varying ways depending on the nature of service centers, start capacity, and organizational culture of these centers. For a more systematic way of building capacity which could be used in future replications, and which will be useful for service providers in addressing gaps and challenges, developing modular templates will be helpful which then can be adapted to different contexts. Since a service template operations manual developed by Motivation already exists, it can be further refined to include all possible domains of service provision and management, and can be so designed as to fit into different contexts.

It is important that products and referrals are in place so that as soon as trainings are completed, service providers can practice their skills on immediate assessments and prescriptions, thereby ensuring there is no loss to the skills and knowledge gained at the training.

Additional training is needed to include and adapt repairing knowhow and practical solutions to address maintenance and repair issues by service providers.

As time and intensive capacity building is a requisite for service centers to be well functioning, future projects must ensure sufficient time to build capacity.

In future projects, more attention and resources allocated to wheelchair-user training would presumably contribute to improved self-efficacy in wheelchair user skills. Clients in the qualitative interviews spoke of their lack of skills and strength in maneuvering their wheelchairs, and therefore an improved focus on this step is essential. Similarly, peer training, which enhances self-efficacy and psychological well-being, needs to have sufficient resources to be implemented as part of service provision.

CONCLUSION

The WHO complaint 8 Steps + wheelchair services model adopted by World Vision in collaboration with technical partners and local service providers has evidenced its strengths in providing holistic services to people living with disabilities who not only benefited physically from an appropriate wheelchair but were enabled to be socially included, thus, moving toward the fulfillment of rights accorded by national governments as well as by the United Nations Convention on Rights of Persons with Disability. The model is potentially replicable on a larger scale and efforts must be continued to engage governments to adopt it with improvements in the gaps identified in the evaluation. All in all, the success of the 8 steps + Model in strengthening the wheelchair sector is expected to lead to a global application of appropriate service provision for people living with disabilities specifically in poor and middle income countries.

APPENDIX 1: QUALITATIVE EVALUATION INSTURMENTS

FOCUS GROUP DISCUSSION GUIDE: CVA MEMBERS

Instruction: *The moderator will introduce herself and the note taker, and explain briefly about the purpose of the FGD. It must be ensured that the discussion take place in a private space with no outside noise. Participants must be made to sit comfortably in a semi- circular pattern. Starting from the outermost individual, IDs are to be given to each participant in an ascending order. Names are to be written only for the purpose of identifying each participant and must under no circumstances be used in the transcription, analysis or report. The note taker must note the order of speakers (identified by their ID) and jot down the first one or two sentences spoken by each speaker. These notes (with the checklist and participant list) must later be handed over to Enisha Sarin along with the recordings.*

Demographic Checklist
Interview date:
Country:
Study site:
ADP / Non ADP
Interviewer name:
Note taker name:
Participant List

Participants	
ID	Name

Question Guideline

1. Can you tell me something about yourselves?
   Probes
   - Where do you work
   - How did the CVA come about
   - How did you get involved in CVA
   - What are your roles and responsibilities within CVA

2. Can you describe to me what activities your CVA has undertaken for wheelchair users and people with disability?

3. What do you feel about the work of the CVA?
   Probes

How do you think it has affected the people with disability?

4. How do you think the ACCESS project help in CVA activities?
   Probes
   - Do you feel it has been smooth working? Why? Why not?
   - What do you think are some of the gaps in making the voice of the people with disability heard? Give examples.

5. What are some of the larger policy and program issues that you feel have affected disability inclusion?

6. Has your CVA group experienced success getting local government to take action on items your group has prioritized? Please describe any actions taken by local government that align with your efforts.

7. How much do you think you can continue with your work after ACCESS project is over?

8. What do you feel are some of the things that need to happen in order for this work to be continued successfully?

FOCUS GROUP DISCUSSION GUIDE: PHYSIOTHERAPISTS

Instruction: *The moderator will introduce herself and the note taker, and explain briefly about the purpose of the FGD. It must be ensured that the discussion take place in a private space with no outside noise. Participants must be made to sit comfortably in a semi- circular pattern. Starting from the outermost individual, IDs are to be given to each participant in an ascending order. Names are to be written only for the purpose of identifying each participant and must under no circumstances be used in the transcription, analysis or report. The note taker must note the order of speakers (identified by their ID) and jot down the first one or two sentences spoken by each speaker. These notes (with the checklist and participant list) must later be handed over to Enisha Sarin along with the recording.*

Checklist
Interview date:
Country:
Study site:
Interviewer name:
Note taker name:

Participant List

Participants		Organizations	Area
ID	Name	Name	ADP/Non ADP

Question Guideline

1. Can you tell me something about your overall experience in wheelchair service provision and maintenance?
   Probes
   - How does your present experience/work (after ACCESS) compare to your previous experience? Describe
   - How has ACCESS supported you in your work: in referral, assessment/prescription, ordering, product preparation, fitting, user training, maintenance and repair, follow up (ask for each service)
   - Has this support helped you? If so, in what ways?

2. What kind of individual mentoring did wheelchair experts provide to you? Describe. How was it helpful?

3. Have all of you undergone WSTP training? (Take a head count). How many of you underwent managers training, how many basic, how many intermediate training, did anyone take the training of trainers? How has the training helped you? Give examples

   Probes
   - To what extent are you able to follow the 8-step process?
   - How has the training affected your capacity to do the following:
     Referral and appointment
     Physical Assessment of wheelchair users

Prescription and selection of appropriate wheelchairs
Funding and ordering
Product preparation (Planning and carrying out wheelchair and physical support device preparation, Materials and tools needed to make PSDs and modifications)
Fitting
User training (Skills for wheelchair users)
Maintenance repairs and follow up

- What are the specific challenges in following the 8 steps? How has the training helped in addressing these challenges?

4. Do you feel there has been any change in your working style? If so, describe.

5. What are the biggest challenges in integrating wheelchair provision into your work which you are still facing?

6. How do you think these challenges can be addressed?

7. What do you think of the referral networks?
   Probes
   - What kind of support have you received and by whom was this support provided?
   - How much of it has worked? Why or why not.
   - What are the biggest challenges for follow-up?

8. How do you feel your work has impacted the lives of people with disabilities? Describe/Give examples

9. Do you feel you can continue the present level and quality of service after ACCESS is gone? Why do you feel so? Why don't you feel so?

10. What do you feel about data maintenance and use at the field?
    Probes
    Can you tell me how data was used to support your work?
    How has it helped in follow up of clients?

11. What do you think should continue to happen in order for you to deliver services effectively to people with disabilities?

FOCUS GROUP DISCUSSION: WHEELCHAIR USERS

Instruction: *The moderator will introduce herself and the note taker, and explain briefly about the purpose of the FGD. It must be ensured that the discussion take place in a private space with no outside noise. Participants must be made to sit comfortably in a semi- circular pattern. Starting from the outermost individual, IDs are to be given to each participant in an ascending order. Names are to be written only for the purpose of identifying each participant and must under no circumstances be used in the transcription, analysis or report. The note taker must note the order of speakers (identified by their ID) and jot down the first one or two sentences spoken by each speaker. These notes (with the checklist and participant list) must later be handed over to Enisha Sarin along with the recordings.*

Checklist
Interview date:
Country:
Study site:
ADP / Non-ADP
Interviewer name:
Note taker name:

Participant List

Participants	
ID	Name

Question Guideline

12. Can you tell me a little about yourselves? How did you come here? From where? What do you do?

13. How comfortable are the wheelchairs you are using now?
    Probes *(If they say these have become more comfortable ask)*:
- In what way have they become comfortable? What do you think has made them more comfortable?
- Did you receive any wheelchair before the ACCESS project?
- If so, can you describe in what ways receiving it was different from receiving it through ACCESS?
- What is the difference between the previous and this wheelchair?
  (*If they say they are the same, ask*): How would you like them to be more comfortable?

14. Is there any difference in your experience before and now on your
    - Mobility
    - Daily activities
    - Lifestyle
    - If so, what do you think has facilitated this change?

15. How well do you feel you can participate in your family life and community life? Has it changed from before? In what ways and why? *(Although question refers to changes brought about by ACCESS, let respondents come up on their own to talk of ACCESS)* Describe

16. Do you feel you are still left out of a lot of activities? What are these activities? Can you tell me why this is so?

17. How do you feel people in the community relate to your disability? *(This question refers to before and after ACCESS. But wait for respondent to bring it up themselves. If they do not, then probe about ACCESS).* Describe.

18. *(If participants are from an ADP)*: What has been your experience in the ACCESS project?
    Probes

- What is the best thing you like about the project (what thing has been most helpful to you?)
- What are some of the things you think still have not been addressed? Please give examples.

(If Participants are from non-ADP area): Once you received your wheelchair, did you also receive any support to be able to join community activities? Describe.

19. I know that some of you are members of CVA/DPO. Can you describe to me your experience of the same?
    Probes
    - Can you share with me some of your major accomplishments?
    - Are there things you would do differently (some things that you feel strongly about but haven't been able to voice?)

20. Is there anything more you would like done so that you can participate fully in professional and personal life? Give examples.

IN DEPTH INTERVIEW: PARENTS OF WHEELCHAIR USERS

Instruction: The suggested questions provided in the guides below allow for in-depth and comprehensive interviews of participants. The questions are set to elicit their experiences and perceptions. Wherever necessary, the interviewer must ask about examples and experiences from the participant's life.

It is important to note that this type of interview is not an oral questionnaire. In no way should the interviewer use this guide as a survey tool but must use the questions as triggers to a deeper understanding. The open-ended questions allow for a maximum expansion of the answers as well as for additional questions which allow the interviewer to probe related issues which may arise during any stage of the in-depth interview. The interviewer should take comprehensive notes during the interview (even if a tape recorder is being used). The interviewer's impressions of the interview process should be put in writing as soon as the interview is over, including the difficulties that may have arisen, the participant's level of collaboration, as well as the interviewer's observations, comments and feelings.

Demographic Checklist
Interview date:
Country:
Study site:
ADP / Non-ADP
Interviewer name:
Note taker name:
Participant ID:

Question Guideline

1. Can you tell me a little about yourselves? How did you come here? From where? What do you do?

2. How comfortable are the wheelchairs your child is using now?
   Probes
   (*If they say these have become more comfortable ask*): In what way have they become comfortable?
   What do you think has made them more comfortable?
   Did you receive any wheelchair before the ACCESS project?
   If so, can you describe in what ways receiving it was different from receiving it through ACCESS?
   What is the difference between the previous and this wheelchair?
   (*If they say they are the same, ask*): How would you like them to be more comfortable?

3. Can you describe to me the steps of procuring your child's current wheelchair?
   Probes
   - How did you feel the need?
   - Whom did you approach/Who referred you?
   - Where did you have to go?
   - How was the fitting done?
   - How long did you have to wait?

4. Is there any difference in your experience before and now on your child's?
   - Mobility (especially about school, spending time with friends outdoor)
   - Daily activities
   - Lifestyle
   - Your own daily activities and lifestyle (*ask parents' experience*)
   - If so, what do you think has facilitated this change?

5. How well do you feel your child can participate in the family life and community life? Describe

6. Do you feel he/she is still left out of a lot of activities? Can you tell me why this is so?

7. How do you feel people in the community relate to your child's disability? *(This question refers to before and after ACCESS. But wait for respondent to bring it up themselves. If they do not, then probe about ACCESS).* Describe.

8. (If participants are from an ADP): What has been your experience in the ACCESS project?
   Probes
   What is the best thing you like about the project (what thing has been most helpful to you?)
   What are some of the things you think still have not been addressed? Please give examples.

   (If Participants are from non-ADP area): Once you received your child's wheelchair, did you also receive any support to be able to join community activities? Describe.

9. I know that some of you are members of CVA/DPO. Can you describe to me your experience of the same?
   Probes
   - Can you share with me some of your major accomplishments?
   - Are there things you would do differently (some things that you feel strongly about but haven't been able to voice?)

10. Is there anything more you would like done so that your child can participate fully in life? Give examples.

IN DEPTH INTERVIEW: WHEELCHAIR USERS

Instruction: The suggested questions provided in the guides below allow for in-depth and comprehensive interviews of participants. The questions are set to elicit their experiences and perceptions. Wherever necessary, the interviewer must ask about examples and experiences from the participant's life.

It is important to note that this type of interview is not an oral questionnaire. In no way should the interviewer use this guide as a survey tool but must use the questions as triggers to a deeper understanding. The open-ended questions allow for a maximum expansion of the answers as well as for additional questions which allow the interviewer to probe related issues which may arise during any stage of the in-depth interview. The interviewer should take comprehensive notes during the interview (even if a tape recorder is being used). The interviewer's impressions of the interview process should be put in writing as soon as the interview is over, including the difficulties that may have arisen, the participant's level of collaboration, as well as the interviewer's observations, comments and feelings.

Demographic Checklist
Interview date:
Country:
Study site:
ADP / Non-ADP
Interviewer name:
Note taker name:
Type of Participant:
Participant ID:

Question Guideline

1. Can you tell me a little about yourself? How did you come here? From where? What do you do?

2. How comfortable are the wheelchair you are using now?
   Probes
   (*If they say these have become more comfortable ask*): In what way have they become comfortable?
   What do you think has made them more comfortable?
   Did you receive any wheelchair before the ACCESS project?
   If so, can you describe in what ways receiving it was different from receiving it through ACCESS?
   What is the difference between the previous and this wheelchair?
   (*If they say they are the same, ask*): How would you like them to be more comfortable?

3. Can you describe to me the steps of procuring your current wheelchair?
   Probes
   - How did you feel the need?
   - Whom did you approach/Who referred you?
   - Where did you have to go?
   - How was the fitting done?
   - How long did you have to wait?

4. Is there any difference in your experience before and now with regard to your:
   - Mobility
   - Daily activities
   - Lifestyle
   - If so, what do you think has facilitated this change?

5. How well do you feel you can participate in your family life and community life? Describe

6. Do you feel you are still left out of a lot of activities? Can you tell me why this is so?

7. How do you feel people in the community relate to your disability? *(This question refers to before and after ACCESS. But wait for respondent to bring it up themselves. If they do not, then probe about ACCESS).* Describe.

8. (If participants are from an ADP): What has been your experience in the ACCESS project?
   Probes
   What is the best thing you like about the project (what thing has been most helpful to you?)
   What are some of the things you think still have not been addressed? Please give examples.

   (If Participants are from non-ADP area): Once you received your child's wheelchair, did you also receive any support to be able to join community activities? Describe.

9. I know that some of you are members of CVA/DPO. Can you describe to me your experience of the same?
   Probes
   Can you share with me some of your major accomplishments?
   Are there things you would do differently (some things that you feel strongly about but haven't been able to voice?)

10. Is there anything more you would like done so that you can participate fully in your academic, professional, personal life? Give examples.

IN DEPTH INTERVIEW GUIDE: WORLD VISION ACCESS PROJECT STAFF

Instruction: The suggested questions provided in the guides below allow for in-depth and comprehensive interviews of participants. The questions are set to elicit their experiences and perceptions. Wherever necessary, the interviewer must ask about examples and experiences from the participant's life.

It is important to note that this type of interview is not an oral questionnaire. In no way should the interviewer use this guide as a survey tool but must use the questions as triggers to a deeper understanding. The open-ended questions allow for a maximum expansion of the answers as well as for additional questions which allow the interviewer to probe related issues which may arise during any stage of the in-depth interview. The interviewer should take comprehensive notes during the interview (even if a tape recorder is being used). The interviewer's impressions of the interview process should be put in writing as soon as the interview is over, including the difficulties that may have arisen, the participant's level of collaboration, as well as the interviewer's observations, comments and feelings.

Demographic Checklist
Interview date:
Country:
Study site:
ADP / Non-ADP
Interviewer name:
Note taker name:
Type of Participant:
Participant ID:

Question Guideline

1. Can you talk a bit about your role in the project?
   Probes
   - What are your responsibilities?
   - How is the project implemented in the country? Describe
   - What are your personal accomplishments in the project?

2. What has been your experience in working on the project?
   - How do you think the project is addressing the needs of the people with disability?
   - What are some of the programmatic challenges you have faced/seen in implementing the project?

3. Can you tell me of some of your accomplishments as well as challenges in:
   - Reaching out to wheelchair users
   - Referring clients to services.
   - Providing appropriate wheelchairs (ask about assessment, product preparation, fitting, modification, user training).
   - Facilitating integration of wheelchair users in community

4. Please describe the work with the referral network and local stakeholders. Has working with these groups been successful? What have been the success factors? What would you change about this work?

5. How do you think being an ADP community affected services provided to people with disability? Describe.

6. What do you feel about the CVA in your country?
   Probes
   - Do you think they managed to advocate successfully on behalf of people with disability? Why do you think so? Why don't you think so?
   - What, according to you, were their achievements if any?
   - How do you think the momentum can be kept going? What needs to be in place?

7. Can you tell me what you think of the wheelchair service providers' capacity?
   Probes
   - Are they being able to meet the needs of wheelchair users? Why? Why not?
   - How do you think the project influenced their capacity to deliver wheelchair services? Give examples.
   - How do you think the training influenced their service delivery capacity? Give examples.
   - Do you feel they will be able to continue with the present level of services? Why? Why not?

8. How do you feel the current policies in your country on issues of people with disability affected the project?

9. Do you think the project influenced or would influence policies around people with disability in your region/country? Elaborate.

IN DEPTH INTERVIEW GUIDE: WHEELCHAIR SERVICE MANAGERS

Instruction: The suggested questions provided in the guides below allow for in-depth and comprehensive interviews of participants. The questions are set to elicit their experiences and perceptions. Wherever necessary, the interviewer must ask about examples and experiences from the participant's life.

It is important to note that this type of interview is not an oral questionnaire. In no way should the interviewer use this guide as a survey tool but must use the questions as triggers to a deeper understanding. The open-ended questions allow for a maximum expansion of the answers as well as for additional questions which allow the interviewer to probe related issues which may arise during any stage of the in-depth interview. The interviewer should take comprehensive notes during the interview (even if a tape recorder is being used). The interviewer's impressions of the interview process should be put in writing as soon as the interview is over, including the difficulties that may have arisen, the participant's level of collaboration, as well as the interviewer's observations, comments and feelings.

Demographic Checklist
Interview date:
Country:
Study site:
ADP / Non-ADP
Interviewer name:
Type of Participant:
Participant ID:
Organization:

Question Guide

1. Can you describe to me what exactly your service center does or how exactly you help people with disabilities?

2. Can you tell me of your experience in working with the ACCESS project?
   Probes
   - How often did a wheelchair expert visit your service center?
   - What were those visits like?
   - How has ACCESS impacted your professional ability and competence? Please describe.
   - Is there anything additional that needs to be done to make your work more effective in terms of meeting the needs of people with disability?

3. How did you feel your service center affected the lives of the people with disability before ACCESS?

4. How do you feel now about the impact of your work on people with disability?
   Probes
   - Has there been any change?
   - If so, describe. If not, why do you think it has not been so?

5. How easy or difficult has it been to communicate with ACCESS staff? Describe.

6. Did your service center undergo a service assessment and capacity building process? If so, please describe.

   Probes:

- How much were you involved in the service assessment and development of the capacity building work plan?
- Are you satisfied with the capacity building provided?
- How have your center's systems and processes to conduct wheelchair programs changed due to the capacity building?
- How can this capacity building be expanded across other service centers within your organization (if there are any)?

7. Have all of you undergone WSTP training? (Take a head count). How many of you underwent basic, how many intermediate, how many ToT? How has the training helped you? Give examples

   Probes
   - To what extent are you able to follow the 8 step process?
   - How has the training affected your capacity to monitor the following:
     - Referral and appointment
     - Physical Assessment of wheelchair users
     - Prescription and selection of appropriate wheelchairs
     - Funding and ordering
     - Product preparation(Planning and carrying out wheelchair and physical support device preparation, Materials and tools needed to make PSDs and modifications)
     - Fitting
     - User training (Skills for wheelchair users)
       Maintenance repairs and follow up
   - What are the specific challenges in following the 8 steps? How has the training helped in addressing these challenges?

8. Do you feel there has been any change in your working style? If so, describe.

9. What are the biggest challenges in your line of work which you are still facing?

10. How do you think these challenges can be addressed?

11. How do you feel about follow up of clients?
    Probes
    - What kind of support have you received and by whom was this support provided?
    - How much of it has worked? Why or why not.

12. What do you feel about the data management system for ACCESS?
    Probes
    How is it different from previous systems of data management in your organization?
    How has it helped you? Give examples

13. What do you think should continue to happen in order for you to deliver services effectively to the disabled?

IN DEPTH INTERVIEW GUIDE WITH ACCESS PARTNERS

1. Describe your understanding of the project's intended collaboration/structure

2. To what extent is this project new or different than other projects your organization has worked on in the past?

3. To what extent did the project design envision standardizing approaches to wheelchair service support?

4. To what extent did the project design take into consideration local context for wheelchair service and disability inclusion? What made the countries where you worked unique?

5. Looking back, what are the inherent limitations within the project design? What would you change?

6. What was World Vision's role in this project as laid out in the design?

7. How does the design of this project fit into the global context of rights-based approaches to disability inclusion and adherence to the UNCRPD?

ACCESS in Practice:

1. Once the project got started, how did the partners collaborate globally? Was global collaboration effective?

2. How did global collaboration affect country-level collaboration and coordination? Was the structure at global and country level effective to reach project goals?

3. To what extent was standardization carried out across the five countries and what conditions in the countries where you worked influenced the level of standardization?

4. To what extent were service capacity building approaches standardized across countries? What conditions impact the capacity building process and level of standardization?

5. How did the sequencing and timing of project interventions affect project efficiency and outcomes? What would you change about sequencing and timing of interventions?

6. What role did World Vision play in the implementation of the project interventions? How was this different than envisioned in design? Was this effective?

7. The country evaluations identified factors that were enabling as well as factors that were hindrances to full participation of WC users- an aspirational right recognized by UNCRPD. Do you think it's important to address these factors and if so, how do you think the project model should address them?

Successes and Lessons Learned

1. The project developed an approach to community development organization engagement in wheelchair service called 8+. To what extent do you think this has affected your organization's view of engaging with community development organizations in future wheelchair programs?
2. What do you feel are the successes of global collaboration in ACCESS? What are the successes of country-level collaboration?

3. What are the key conditions to success of the 8+ approach? What are the limitations?

4. What were the lessons learned from global collaboration? Country-level collaboration?

APPENDIX 2: CODEBOOK

Coding List: Service Managers

Code	Inclusion criteria
Work_PWD	Description of all that they do with PWD (people living with disabilities)
Exp_WC expert	Experience with wheelchair expert
Infl_ACCESS	Description of influence of ACCESS on their professional ability
Sup_ACCESS	Description of all kinds of support received from ACCESS. Also include gaps in support
Needs	Everything that pertains to views on what more needs to be done to deliver services effectively
Comm_ACCESS	Views on communication with ACCESS staff
Mentor	Description of mentoring services received
Serv Assess_Inv	Involvement in service assessment and capacity building
Serv Assess_Satis	Views on how service assessment and capacity building helped or not helped
Chang_Sys	Change in systems and processes due to capacity building
Expan_Cap	Examples or plans of expansion of capacity building to other organizations
Train_Cap	Everything related to training and building capacity in 8 steps of WSTP
Impact_Past	Impact on PWD before ACCESS
Impact_Present	Impact on PWD after ACCESS
Chang_Workstyle	Changes in working style after ACCESS
Chall	Description of present challenges in work
Chall_Add	All about respondent's views on addressing challenges
Supp_FU	Description of support received in referral and follow up of clients/challenges in referral and follow up
Sustain	Views on sustainability of areas of activities
View_Data	Views and experiences of data management system and how it helped in their work

Coding List: Physiotherapists

Code	Inclusion criteria
Exp_Present	Experiences in WC service provision after ACCESS
Exp_Past	Previous experience of WC service provision
Sup_ACCESS	Description of all kinds of support received from ACCESS. Also include gaps in support
Comm_ACCESS	Views on communication with ACCESS staff
Mentor	Description of mentoring services received
Train_Cap	Everything related to training and building capacity in 8 steps of WSTP
Impact_Past	Impact on PWD before ACCESS
Impact_Present	Impact on PWD after ACCESS

Chang_Workstyle	Changes in working style after ACCESS
Chall	Description of present challenges in work
Chall_Add	All about respondent's views on addressing challenges
Supp_FU	Description of support received in referral and follow up of clients/challenges in referral and follow up
Sustain	Views on sustainability of areas of activities/sustain present level and quality of work
View_Data	Views and experiences of data management system and how it helped in their work
Needs	Everything that pertains to views on what more needs to be done to deliver services effectively

Coding List: CVA members

Code	**Inclusion criteria**
Work	Description of work they do- outside of CVA
CVA origin	Origin of CVA
CVA Inv	Process of getting involved in CVA
CVA Role	Role and responsibility within CVA
Activity_PWD	Activities undertaken by CVA
Impact	Impact of CVA on PWD
Rel_ACCESS	Description of relationship with ACCESS- whether work is smooth, what gaps are there etc
Chall_Adv	Gaps in advocacy
View_Policy	Views on larger policy issues that influenced inclusion of PWD
Local Govt_Inv	Views and experiences of local government involvement
Sustain	Views on sustainability of areas of activities/sustain present level and quality of work
Needs	Everything that pertains to views on what more needs to be done to deliver services effectively

Coding List: Wheelchair Users

Code	**Inclusion criteria**
Pers Life	All about individual's background
Comfort_WC	View on WC comfort and suitability
Exp_Proc WC	All about the process of getting the WC- how need was felt, where did they go, who referred, waiting period
Diff_Mob	Difference in mobility after ACCESS
Diff_Activity	Difference in daily activity and lifestyle
Partic_Fam	Description of participating or not participating in family life and activities
Partic_Com	Description of participating or not participating in community life and activities
Exc_Present	Experience of being excluded from activities currently- even after ACCESS
Soc_Res	Description of how people in community look at disabled
Exp ACCESS_Sup	Experience with ACCESS project- what kind of help and support did they get
Exp ACCESS_Gap	Experience with ACCESS project- what are the gaps

Exp_CVA	Experience of working or being part of CVA- accomplishments and view on doing things differently
Needs	What more needs to be done so that they can participate fully in all areas of life

For parents and relatives of WC users: same as above with the additional code

Diff_Par life	Experience of difference in lifestyle of parents/relatives after ACCESS

Coding List: ACCESS staff

Code	**Inclusion criteria**
Role_ACCESS	Description of role and responsibilities in project
Imp_ACCESS	Description of implementation of project- difficulties, ease
Accom_Pers	Personal accomplishments within project
Accom_ACCESS	Perception of accomplishments of project
Impact_ACCESS	Description of the project's impact on PWD and examples of major achievements
Chall_ACCESS	All about gaps that still remain in project
Exp_Outreach	Description of experience in reaching out to clients
Exp_WC Prov	Description of experience in providing WC to clients
Exp_Incl	Description of experience in facilitating integration and inclusion of clients in community
Exp_Ref	This includes experience of referring clients, working with referral actors, successes and gaps
Impact_ADP	Description of influence of ADP on PWD issues and services
View_CVA Adv	Views on CVA advocacy efforts, success and accomplishments, gaps
View_CVA Needs	Views on what more needs to be done to sustain advocacy efforts of CVA
View_ SP Capacity	Perception of service providers' capacity- whether it changed, how and why it changed
View_Train	Perception of how training influenced service providers
View_Policy	Views about whether and how policies of PWD affected project and whether project affected larger policy issues
View_Data Sup	Experience of using M&E system and how it supported project activities
View_Data Chall	Experience of challenges using data system and anything that needs to be done differently
Gaps-Current	Perception of gaps in project that have still not been addressed

APPENDIX 3: SOCIAL INCLUSION SCALE

ACCESS Project: CLIENT FORM #1.c SOCIAL INCLUSION SCALE

This form should be filled out by World Vision or the service provider (if outside the ADP area). The scale is intended to provide information on the magnitude of difficulty faced by wheelchair users in their daily life in the communities where there they live. All the questions are intended to assess the level of difficulty faced because of the mobility disability and not because of other reasons. Each item is to be rated by the wheelchair user according to the level of difficulty s/he faces on a 10 point scale, with 0 = no difficulty and 10 = maximum difficulty. If an item is not applicable, it is to be marked as 'x'. The average score for answered questions should be placed at the end of the sheet. This scale is to be used twice for each wheelchair user: in conjunction with the client intake form and the end of the ACCESS project.

Personnel Information

Personnel Name:*		Date:
Organization:	Phone	Email:

Client Information

Name:*			Client registration no. (to be generated by database)
Date of birth:			☐ Male ☐ Female
Phone no.:		E mail:	

RATING SCALE: 0= No difficulty, 1 =minimal difficulty, 10 =maximum difficulty, ×= not applicable

How difficult is it for you to…	**Rating**
1. Move in and around your home?	
2. Move outside your home in the immediate neighborhood?	
3. Carry out your activities of daily living (e.g. washing, dressing, eating etc.?	
4. Access medical care and treatment for general health conditions (not related to the mobility limitation)?	
5. Go to school/college?	
6. Earn income?	
7. Use public transport?	
8. Go to common/public places (e.g. market, bank, shops, etc.) in your community?	
9. Maintain social and family relationships (e.g. visiting family and friends, going for gatherings of family and friends)?	
10. Join leisure/cultural/recreational activities in your community (e.g. sports, arts, music, informal meetings etc.)?	
11. Participate in political life in your community (e.g. voting, joining a political party, etc.)?	
12. Obtain and maintain respect from those in your community?	
Average score: (Total score/number of questions answered)	

APPENDIX 4: SERVICE EVALUATION TOOL

Service Assessment Monitoring and Evaluation Tool (MET) and Work Plan (M&E: S4)

Developed by: Motivation Charitable Trust and Handicap International

Please contact Motivation if replicating or adapting this tool[3]

'Wheelchair service delivery requires careful planning and management of resources.'[4]

Purpose

This tool guides the process of monitoring and evaluation of a wheeled mobility and positioning device (WM&PD) service in relation to the standards set out in the WHO Wheelchair Guidelines. The tool measures the baseline functioning of the service and determines the progress needed in order to professionally and sustainably build it to meet the needs of users. This tool is aimed mainly at Project Managers, or staff in similar roles, who are responsible for the development of a WM&PD service.

Methodology

This tool can be used to determine the baseline percentage of a new partner organisation that is already running a wheelchair service. If there is no wheelchair service active then the starting point of this tool is considered as 0%. The tool becomes most useful when it is repeated at intervals of 6 to 12 months to evaluate progress. An open transparent discussion with the service is needed. A completed Service Assessment Tool, observations of service delivery as well as user feedback will help to generate the most useful results.

The tool is divided into three **sections**:
1: Products, technical equipment and resources
2: Service provision
3: Service management.

Each section has a number of areas to score. For each area you are given four boxes representing what would be expected of a service at an early stage, developing stage, maturing stage and well-functioning stage. The evaluator should work with the organisation to objectively choose the box that best correlates to the current status of that area. Questions, answers and scoring of this tool all relate to Wheelchair service provision.

Once a stage is agreed the box can be highlighted /shaded in a dark grey and/or an x can be placed in the appropriate box. If it is not possible to decide between 2 stages, then highlighted both and give the appropriate half point ie if developing (1 point) and maturing (2 point) were both highlighted then 1.5 points would be allocated – write this in the comments column and explain clearly.

Each stage has a score.
Early = 0
Developing = 1

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[3] www.motivation.org.uk

[4] WHO Wheelchair Guidelines, p. 72.

Maturing = 2
Well-functioning = 3
The tool can be used to evaluate a Basic or an Intermediate service. The evaluator must ascertain what the goal of the service is ie are they aiming to meet the needs of Basic level users or are they also focusing on Intermediate users. Once this has been established the evaluator will know if they should score areas 2 and 4 in the 1st section and areas 6 and 7 in the 2nd section.
At the end of the evaluation, add up the score for each section and record it alongside either the Basic or Intermediate section scores. Once complete move the scores to page 3 and add them up. Divide the total by either the Basic of Intermediate Total score and multiply by 100 to get the final percentage.

A basic service is scored out of total possible **72** points.(this excludes the Intermediate areas which are shaded in light grey).
An intermediate service is scored out of a total possible **84** points (this includes all intermediate sections which are shaded light grey).

Example: Intermediate service evaluation

1. 17
2. 20
3. 8

Total 45 out of 84.
Total % 54%

It is important to write notes in the 'comments' boxes during the assessment. Refer to these comments, and the score awarded when setting 'performance targets' for the service. Performance targets and evaluation methods are described in the WHO Wheelchair Guidelines, pp. 91-93.

Resources
Meetings with key members of WM&PD service team, completed Service Assessment Tool, relevant feedback from observations of service delivery and user feedback. Pens and paper are required for this tool.

Time required
Approximately three hours of discussion will be needed to complete this tool.

Preparation needed
Service management or representative needs to be briefed on the purpose of the tool and join in all discussions.
Carry out a service assessment using the Service Assessment Tool, observe any service delivery possible and get user feedback using the Service User Feedback Tool.

Wheeled mobility and positioning device Service monitoring and evaluation tool

Service Name		**Location**	

Final results: *Basic total 72* *Intermediate 84* *(*) Early stage 0-25%* *Developing 26-50%* *Maturing 51 - 74%* *Well –functioning: 75 to 100%*

Date	Evaluator	Service Level assessed	Service Team members present	Score
				1.
Recommendations				2.
				3.
				Total
				%*

Date	Evaluator	Service Level assessed	Service Team members present	Score
				1.

Recommendations	2
	3
	Total
	%*

Copy this page for further evaluations

1. **Products, technical equipment and resources** **Total: Basic _____(24) Intermediate _____(30)**					
Area	**Early** (0 pt)	**Developing** (1 pts)	**Maturing** (2 pts)	**Well-functioning** (3 pts)	**Comments**
1. Basic level products for adults and children (Tool PP3 part 1)	No or only inappropriate products available	Products may be available however only one partly or fully WHO appropriate manual wheelchair (p21)	One appropriate adult and one child manual wheelchair available or two types of appropriate adult wheelchairs	A full, WHO appropriate range available for rural and urban use	
Intermediate Level 2. Intermediate level products for adults and children (Tool PP3 part 1) (not for basic service)	No or only inappropriate products available	Technical skills and technology available to modify a manual wheelchair	One type of appropriate adjustable seating product available and skills to modify manual wheelchairs	A range of appropriate seating products with tilt in space and built in adjustability and skills to modify wheelchairs and seating products for individual users	
3. Cushions	No cushions available	One type of cushion is available however properties are not adequate for pressure care and durability	One type of cushion is available and is appropriate for pressure care management and can be modified for individual users	Appropriate range of cushions is available and issued with every wheelchair	

Intermediate Level 4. Additional positioning devices (not for basic service)	No additional positioning devices	Skills available to provide low tech solutions for lying, floor sitting or standing but no specific devices for lying or standing	One additional specific product available e.g. standing frames, corner and lying support and skills to provide low tech solutions	A range of products and skills to issue individualised products for all 24 hour positions inc. lying, standing, walking, floor sitting	
5. Tricycles and trike attachments	No tricycles available	Skills available to produce one off tricycles on an ad-hoc basis. Inconsistent quality	Provision of tricycles or trike attachments is a component of the service	Provision of tricycles is a regular component of the service and can be adapted for individual users	
6. Technical facilities, equipment and tools	No or only inappropriate facilities used, equipment, tools.	Facility is available however not fully appropriate. Equipment and tools are available but inadequate for level of technical requirements.	Facilities are appropriate however could be better organised. Majority of equipment and tools are available however not fully meeting technical needs.	Facilities are appropriate, well organised and safe. Equipment and tools are available and maintained in good working order. Tools and equipment allow broad range of wheelchair assembly, modifications and production (if appropriate)	
7. Quality control and fault reporting	No quality control of products before trialling with a user and final issuing	Ad hoc and inconsistent technical quality control. No reporting of faults to supplier	Full clinical and technical quality control carried out on every product before final issuing products. All faults identified and repaired. Ad hoc reporting of faults to supplier	Full clinical and technical quality control carried and documented on every product before issuing. Formal and consistent fault reporting to supplier	
8. Funding	No government provision for	Some funding for assistive devices from government	Some funding for wheelchairs from	Funding for products is readily available from the	

	wheelchairs. Funding sought per individual product on an ad-hoc basis by the user or donor	but not yet for wheelchairs. Wheelchairs are sometimes funded through donors	government, but not enough and not necessarily that well managed. Wheelchairs are sometimes funded through donors	government and /or full cost recovery is achieved for all wheelchairs	
9. Service step 8: maintenance, repair and refurbishment	No maintenance or repair facilities in, or known to the service	Basic maintenance training given to users and available through the service	Full maintenance services available and some repair of local and imported products including welding	Full services available in the service or easily accessible from the service to full maintenance, repair and refurbishment	
10. Stock control (Tool S1, appendix, part 8)	No stock control systems	Ad hoc stock level management and reordering. No written or systemised tracking	Basic written records of stock level, regularly managed and controlled	Automated, consistent record of stock levels and reordering systems Optimised stock levels well maintained	

2. **Service provision** **Total: Basic _____(30)** **Intermediate____(36)**					
Area	**Early** (0pt)	**Developing** (1pts)	**Maturing** (2pts)	**Well-functioning**(3pts)	**Comments**
1. Clinical equipment and facilities	No specific equipment used and area is not private or appropriate for service	Private area is available however it is not equipped for clinical service and is not accessible to everyone.	Private area is available. It is only partially equipped and equip is not always easily accessible The space available does not fully meet the	Dedicated clinical area is appropriate and fully accessible. It is ventilated, private and has sufficient space for the service level of activity. All equipment required is easily accessible	

		Partially equipped but not managed systematically	service requirements. It is not fully accessible		
2. Documentation of user information	No individual user documentation or service records available	Assessment forms are used but incomplete and stored in disorganised manner	Each user has their own confidential file which includes assessment, prescription and product information. Files easily found	Individual files are maintained Active waiting list and appointment system. Statistics are recorded and easily reported on	
3. Service step 1: referral and appointment	Few ad hoc individual / private walk-ins or only from within one partner organisation. Potential referral sources are uninformed about the scope or structure of the service and no systems to effectively manage in coming users	Referral form available. Some referral sources informed of the service but referrals are few and processes for receiving referrals are not effective.	Training provided to referrers and potential referral sources (Referral network training). Referrals only from one or two sources. Systems to accept referrals	Referral protocols and partnerships well developed with all relevant stakeholders i.e. health, education and social welfare services. Referral system is effective and well recorded and well managed	

4. Staff training received for basic level provision	No training received	On the job experience and some input from more skilled practitioners	Some staff have had formal WHO level 1 training however the full team working with users has not	All staff involved in service delivery have received formal training to WHO level of Level 1 service. The level of training is acceptable for the service	
5. Service step 2, 3, 6: basic assessment, prescription and fitting of manual wheelchairs	No individual service provision. No user assessment	Ad-hoc individualised service delivery including assessment, prescription, fitting. Assessments and fittings are not appropriate	Clinical professional involved with service provision on a regular basis. Individualised service delivery including assessment, prescription, fitting. Inconsistent quality	Integrated service provision. Team communicate and work together. Consistent individualised and appropriate assessment, prescription, fitting. Access to home environments is assessed for every user	
Intermediate Level 6. Staff training received for intermediate level provision (not for basic service)	No training received	On the job experience and some input from more skilled practitioners	Some staff had had formal training however the full team has not	All staff involved in service delivery have received formal training to WHO accepted level of intermediate service	

Intermediate Level 7. Service step 2, 3, 6: intermediate service provision: Postural support and supportive seating (not for basic service)	Incomplete assessments, inappropriate fittings, unaware of the need to improve service.	Ad hoc individualised service delivery including assessment, prescription, fitting. Fittings not always appropriate and low team confidence	Access to clinical knowledge within the team or consultation, regular individualised service delivery including assessment, prescription, fitting and modifications according to needs	Clinical knowledge in team and minimum of one staff member with Advanced skills, communicating and working together and regular individual assessment, prescription, fitting. Consideration of user's broader postural needs	
8. Service step 7: user training	No user training provided with products issued	Partial user and assistant training delivered by non-disabled service providers and is not consistently effective or user centred	User and assistant training delivered by using a checklist. Training does not cover all relevant points and does not take place in an appropriate dedicated place with relevant equipment. Written information available	Comprehensive and individualised user and assistant training available from team including peer trainers. Training takes place in an appropriate area with appropriate equipment. Written information available in the form of pamphlets / hand outs	

9. Service step 8: follow-up of users	No follow-up carried out	Follow-up is carried out on an ad hoc basis when service is alerted to the need or has funding	Follow-up is carried out according to a programme but is funding dependent High priority cases (e.g. children are seen more often)	Follow-up is an integral part of the service, with clinical, technical and training inputs, users contacted to attend follow-up; broader community network involved in follow-up, accessibility to home environments integral to follow-up	
10. Service delivery models and numbers	Users can only access services through their own means of travelling to the centre. Service has no specified schedule. Very few products are distributed to users each month	Users can access centre based services on agreed days when personnel are available. The available days are not sufficient to meet the need. Small number of products are delivered per month	Users can access services through a combination of centre visits, home or satellite visits. However, there are large groups or users who are still unable to access the service. Service could aim to deliver a higher number of products to users	Users can access services through various models such as centre visits, home or satellite visits, mobile service. The services have procedures and systems in place for each model and cater for the majority of users in the target area. A reasonable amount of products are delivered each month	
11. User participation	Users not involved in assessment or product choice	Users choice and preference are considered when selecting products and intervention	Users participate in decisions about product and user feedback is sought and included in service evaluations	Users fully informed through user-centred approach; participate in service planning, implementation, management and evaluation.	

12. Service coordination	No clear roles and responsibilities. No-one playing the role of coordinator	Seating personnel clear about roles but are not working as a team. No-one playing the role of coordinator. Lack of communication between management and team.	Seating personnel are clear about their and each other's roles. Coordinator is in place but communications may still be ad hoc and inconsistent. Some communication tools are used but not always effective	Seating personnel are clear about their and each other's roles. Coordinator is in place and internal communication and coordination is effective	1-

3. **Service management** _____**(18)**				**Total:**	
Area	**Early** (0pt)	**Developing** (1pts)	**Maturing** (2pts)	**Well-functioning** (3pts)	**Comments**
1. Service plans, policies and procedures	No short term or long term service plans – documented or considered. No policies or procedures in place.	Some service planning is evident but not aligned with national and/or international standards. No or ineffective policies in place and some procedures but not fully documented / understood / followed by all.	Service planning, guided by national and/or international standards, is in place and documented. Process could be more inclusive of all relevant stakeholders. Plans are partially integrated into organisational plans and planning	Long-term plans in place, planning integrated into broader organisational systems (if relevant). Relevant stakeholders ,including users, included in planning. All relevant and policies and	

			procedures (if relevant) Some policies and procedures are in place and attempts are made to operate accordingly.	procedures documented and followed Training strategy in place for on-going service delivery	
2. Monitoring (WHO Wheelchair Guidelines P91 - 92)	No records kept No user feedback No performance targets (P92)	Records and user feedback collected but not analysed Performance targets set but progress not measured	Internal monitoring of user statistics takes place and user feedback analysis Some results are analysed and responded to however this could be done more regularly and more effectively	Monitoring system of quality and effectiveness in place and functioning well with feedback gathered from users in various ways (e.g. questionnaires, comments box). Data is routinely analysed and responded.	
3. Evaluation (WHO Wheelchair Guidelines P93)	Service has never been evaluated internally or externally and there are no immediate plans in place for this.	Service evaluation has taken place but no report available. Evaluation is planned.	Service evaluation has taken place and report is available. Evaluation process could be improved and recommendations should be implemented.	Six monthly and/or annual reviews automatically carried out. External evaluator periodically invited and users always consulted. Past reports available	

				and evidence of results impacting plans and on-going service.	
4. Collaboration and broader networks	Working in isolation although there may be an awareness of other relevant organisations.	Collaboration with one other organisation, however type of partnership and roles are not clear.	Collaboration with many relevant organisations. Some relationships are historical and understood by some but not all. Benefits and roles of some partnerships are not clear. There is scope to increase the partners to benefit the users.	Extensive collaboration with relevant private, DPO, NGO and government structures. Partnerships are clearly understood between all stakeholders and staff and mutual benefits are optimised for the benefit of the users. Periodic partner meetings take place to review.	
5. Awareness and advocacy	No awareness of national or international policies, standards or guidelines on wheelchair provision	Aware of the WHO Wheelchair Guidelines, relevant conventions and national policies (if available). Service working in isolation from national and international efforts to effect change	Ad hoc involvement in advocacy and lobbying activities. Service mostly, or as far as possible, being operated in line with national and international policies	Service contributing to advocacy and lobbying activities and at times initiating. Service being operated in line with national and international policies	

6. Sustainability – service financing	No regular funding available to cover service provision or overheads. Staffing is dependent on product sales	Funds available may cover staff costs but not all overheads required for consistent service delivery. Ad hoc funding available through product sales (self-funding) or for specific projects funded by International NGO's	Funds cover staff costs and all overheads required for consistent service delivery. Additional funds are often sought to pilot new programmes or implement various models of service delivery. Funds are not readily available for staff development.	Service provision is incorporated into government/organisation finance structures and consistent service provision is of good quality. Financial strategies are in place to ensure sustainability and growth of the service.	

Work plan (to be adapted as needed)

Based on the above analysis, please complete the below table with a summary of actions needed to increase the quality of service provision. This should include as much detail as needed to meet recommendations outlined above. Please insert rows as required.

Name of Service:					
Location of Service:					
What is the long-term goal for the service? *(Section 1 of the Service Assessment Tool could help guide this)*					
Area of focus	**Action required**	**Whose responsibility**	**Deadline for completion**	**Level of Priority[5]**	**Date of review**
Products, technical equipment and resources	1. 2. 3.				

[5] *Priority rating 1-3 with 1 the highest level*

Service provision	1. 2. 3.				
Service management	1. 2. 3.				