

Hospital-Based Rehabilitation Services in Ethiopia

July 2000

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ACRONYMS

CBR	community-based rehabilitation
ENA	Ethiopian Nurses Association
EPTA	Ethiopian Physical Therapy Association
HI	Handicap International
ICRC	International Committee of the Red Cross
LWVF	Leahy War Victims Fund
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
NGO	nongovernmental organization
PWD	people with disabilities
RaDO	Rehabilitation and Development Organization
STD	sexually transmitted diseases
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Julia Plotnick and Cathy Savino traveled to Ethiopia from February 18 through March 1, 2000, on behalf of the Leahy War Victims Fund (LWVF) to evaluate an unsolicited proposal from the Rehabilitation and Development Organization (RaDO), an Ethiopian nongovernmental organization (NGO). The proposal (dated November 15, 1999), “Establishment of Basic Rehabilitation Services in 8 Hospitals and Strengthening of the Previous Rehabilitation Services in 11 Hospitals in Ethiopia,” spanned two years and cost \$640,485 (with RaDO, Handicap International (HI), and the Ministry of Health (MOH) contributing an additional \$275,173).

Before being evaluated, the proposal was reviewed by three experts: Betty Kay, physical therapist; Don Cummings, certified prosthetist; and Mel Stills, certified orthotist. All three experts were highly critical of individuals with little training or supervision providing professional physical therapy, prosthetic or orthotic services to patients, and the subsequent evaluation incorporated their questions and concerns.

Background

RaDO and HI began their initial project in 1997 in 11 hospitals with the goal of introducing basic physiotherapy units within the selected hospitals and establishing small orthopedic workshops within the hospitals’ maintenance workshops.

Hospitals with the greatest need and the greatest catchment area were chosen. Participating hospitals agreed to the following conditions:

- Selection of two nurses and two technicians for three months of full-time training
- Regularly scheduled time for trainees to conduct physical therapy after their training
- Specific locations for both the rehabilitation area and the workshop
- Assumption of the cost of materials (i.e., consumables) following an 18-month supervised program

In turn, RaDO and HI offered the following goods and services to each hospital:

- Construction and equipping of an orthopedic workshop (at no cost to the hospital)
- Materials (i.e., consumables) for training and 18 months of post-training
- Training and supervision of selected nurses and technicians for 18 months
- Improved patient outcomes (20 patients per hospital per month to receive rehabilitation services)

Initially, 11 hospitals accepted the partnership with RaDO and HI. For the most part, hospital personnel who were interviewed thought the experience was positive. Although the promise of a workshop attracted them initially, the impact of the nurses' work on patients' health made the most convincing argument to continue the project.

Most information about the partnership was anecdotal, however, and the status of several of the hospitals was precarious because of the shortage of trained personnel. Any personnel changes such as retirement, absences, or transfers, therefore, had a direct, drastic effect on the program.

The evaluation team could not reconcile the proposed expansion of the partnership to eight additional hospitals with the obvious continuing needs of the original 11 hospitals. The prudence and viability of the expansion are questionable. At least one complete round of training, with transfer of responsibility for the hospitals from RaDO back to the MOH, must occur to test out the planned sustainability of the expanded project. In addition, other areas that were not well supported in the initial project merit attention in the expansion phase.

Recommendations

The evaluation team made the following recommendations:

- Submission of a proposal describing ways to maintain and strengthen the existing programs in the original 11 hospitals
- Reinforcement of the training, education, and supervision of nurses and technicians
- Training for new personnel when others have been transferred or have left the program
- Possible inclusion of those individuals in the training program at hospitals where the project is flourishing
- Strengthening of public awareness of program services by recognizing the following components:
 - Community: In areas where the services exist, an awareness campaign to inform the public about those services focusing on creating the demand and recognizing the benefits.

- Nurses: Outreach to institutional nursing programs and health assistant programs raise the level of awareness among nurses, who are the project implementers.
- Physicians: Medical schools, physician groups and medical staff will be made aware of the rehabilitation services that are offered, the location of services, the benefits, and the referral process for patients.
- Creation of a network that includes governmental institutions and professional associations involved in the improved care and rehabilitation of the public (e.g., Ethiopian Physical Therapy Association [EPTA], Prosthetics and Orthotics Center, Ethiopian Nurses Association [ENA], International Committee of the Red Cross [ICRC], Cheshire, Alert).
- Initiation of a record keeping system that documents all physiotherapy treatments and assistive devices that are dispensed as proof of the efficacy of services (photos of pre- and post-conditions and clear documentation of all services provided to be the initial steps).
- Adjustment of the existing curriculum for nurses when health assistants are to be trained because of the differences in their educational levels.

INTRODUCTION

Team

Julia Plotnick and Cathy Savino traveled to Ethiopia from February 18 through March 1, 2000, on behalf of the Leahy War Victims Fund (LWVF) to evaluate an unsolicited proposal from the Rehabilitation and Development Organization (RaDO), an Ethiopian nongovernmental organization (NGO). The proposal (dated November 15, 1999), “Establishment of Basic Rehabilitation Services in 8 Hospitals and Strengthening of the Previous Rehabilitation Services in 11 Hospitals in Ethiopia,” spanned two years and cost \$640,485 (with RaDO, Handicap International (HI) and the Ministry of Health (MOH) contributing an additional \$275,173).

Scope of Work

The team based its recommendations on documents, interviews, site visits, and technical review by three professionals in the fields of prosthetics, orthotics, and physical therapy. The proposal was evaluated in terms of its relationship to other LWVF activities, its contribution to the LWVF’s overall philosophy, and its contribution to sustainability and the improved welfare of people with disabilities (PWD) in Ethiopia.

Methodology

The report begins with a summary of the previous grant that had initiated the rehabilitation project and the general environment for rehabilitation in Ethiopia. It analyzes the proposal’s four main components: training, treatment, education, and sustainability. The team used the existing project to evaluate the proposed services because it is a continuation of that project.

BACKGROUND

Proposal

The proposal is a continuation and extension of a previous project—a joint effort between HI and RaDO. The purpose of the initial project was to introduce basic physiotherapy units and establish small orthopedic workshops within the maintenance workshops of 11 hospitals. It began in 1997 and ended in December 1999. The target population for program services is acute-care surgical patients. Given the state of medical conditions and public health in Ethiopia, hospitals (rather than clinics or other community-level centers) afforded the best opportunity to reach those patients, thereby preventing further disability and providing positive results in the short term.

The program could be broadly defined as providing improved patient care. There is an element of community-based rehabilitation when nurses train family members to assist with exercises or treatments for the patient. However, no follow-up is provided to these families. The program is improving the immediate health of hospital patients with acute injuries. It is introducing the concept of rehabilitation and may be sustainable in a way that few expatriate-managed programs can be.

Medical Situation in Ethiopia

Ethiopia's current war with Eritrea is creating hardships throughout the country and is affecting the health system in particular. As the war consumes resources at increasing levels, hospitals function under stressful conditions. Plaster of Paris is unavailable in one hospital, drugs are in shorter and shorter supply, and the only latex gloves to be seen were worn by a physician as he went from patient to patient. Buses are being commandeered, and prosthetics and orthotics are essentially available only to the military. Some immediate and positive results have been seen with the rehabilitation program, thus reinforcing the efforts of nurses, doctors, and technicians. The conflict is a serious constraint on moving the system forward, however.

Types of Injuries/Diseases

The conditions that are most often seen by the selected hospitals—fractures and burns (90 percent)—respond well to the treatments provided. Anecdotal evidence suggests that patients receiving such treatments are released from the hospital earlier and with fewer complications

than those patients who do not receive physical therapy services. Any intervention that gets patients out of the hospital quicker can be viewed as a positive impact. Stories of patients with simple fractures who were languishing in hospital beds for months were common. Rehabilitation in the form of exercises, movement, and the provision of simple assistive devices appears to improve patient outcomes. This evidence was supported with testimony from nurses, doctors, and physiotherapists.

One major concern was whether the training prompted people to work beyond their capabilities. In other words, did the training allow the potential for harm? Observation and discussion led the evaluation team to conclude that personnel trained in this program do not provide treatment beyond their capabilities. Although the technicians may be mechanically inclined, they have little formal education and work under the supervision of a nurse when making assistive devices. They are accustomed to taking orders. In interviews, the technicians seemed pleased with their training because the skills they learn are broadly useful. They were careful to get accurate measurements so that crutches would fit; they understood that walking frames must be level.

Concern was also voiced that perhaps the technicians were a threat to more formally trained prosthetic or orthotic technicians. That concern proved to be unfounded. Orthotics professionals in the country viewed the technicians' work as complementary to their own, allowing them to concentrate on more complex cases. With an overabundance of patients, the technicians were filling a real need.

RaDO's Methodology

Hospitals with the greatest need and the greatest catchment area were chosen as candidates for the project. Then, RaDO and HI first approached district medical personnel to request the necessary cooperation. Eleven hospitals were invited to participate. In return, the hospitals agreed to the following conditions:

- Selection of two nurses and two technicians for three months of full-time training
- Regularly scheduled time for trainees to conduct physical therapy after their training
- Specific locations for both the rehabilitation area and the workshop
- Assumption of the cost of materials (i.e., consumables) following an 18-month supervised program
- Continued employment of trained rehabilitation nurses on the basis of their performance

In turn, RaDO and HI offered the following goods and services to each hospital:

- Construction and equipping of an orthopedic workshop (at no cost to the hospital)
- Materials (i.e., consumables) for training and 18 months of post-training

- Training and supervision of selected nurses and technicians for 18 months
- Improved patient outcomes (20 patients per hospital per month to receive rehabilitation services)

The 11 hospitals that were selected covered a large geographic area of Ethiopia. The hospitals were chosen on the basis of their access to a large population, their surgical capabilities, and the willingness of the hospital administrators and regional authorities to make the commitment of space, personnel, and money for supplies at the end of the funding period. Generally, the offer of the workshop and equipment draws immediate interest, but after the training period the nurses and patient improvement ultimately “sell” the program.

COMPONENTS OF THE PROPOSAL

The proposal addresses four components. In looking at each component, the evaluation team described the proposed activity, analyzed how the activity actually works (its theoretical versus practical application), and reviewed the effort. The main components are training, program impact on patient outcomes, community awareness/education, and sustainability. The team addresses the overall strength and weakness of the program and follows with recommendations.

Training

Nurses

Proposed Activity. Under the proposed expansion, the plan is to choose two employees of the hospital who are nurses or health technicians. They are to be trained by a two-person ICRC-trained team of physiotherapists. The objective is to train the nurses or health technicians in basic physiotherapy techniques for three months and to provide refresher training and technical support thereafter. Having those people on the hospital staff removes the need to hire additional staff to perform the new duties.

Actual Activity. The selection process for the nurses is difficult. First, there are not enough nurses to meet demand. Second, the nurses' responsibilities are so overwhelming that there is no time for them to take on additional duties. Health technicians are a secondary choice for training because their skill level is much lower than that of trained nurses. In most cases, the hospital chooses the candidates with little or no input from the candidates themselves. This practice has resulted in some unfortunate selections. In several instances, the charge nurse on a busy surgical unit was trained rather than a more junior person with an interest in rehabilitation. There is the expectation among many nurses and technicians that rehabilitation skills involve extra work that warrants extra compensation.

Analysis of Activity. Though the training of nurses has been well thought out, their integration back into the hospital mainstream has not gone so smoothly. While the nurses or health assistants are given three months' leave for training, they must continue to perform their regular duties in addition to their new rehabilitation responsibilities when they return to work.

RaDO, hospital administrators, and nurses need to address the issue. In the present situation, the nurse alone is responsible for finding the time to practice the rehabilitation skills.

The compensation question seems to be more of an issue with the technicians than with the nurses. On the one hand, the team agrees with RaDO's philosophy that no extra pay should be given for the rehabilitation work. On the other hand, the team is also in accord with RaDO's thinking that the nurses need institutional support to continue rehabilitation services.

There is no depth in the current training scheme. If a trained nurse or technician drops out of the system, it is only by luck or special accommodation that there is coverage. The next proposal needs to systematically address the problem. Two nurses and two technicians per hospital have proved to be insufficient coverage for the populations served.

Technicians

Proposed Activity. Under the proposed expansion, the plan is to choose two hospital employees who are maintenance workers or who have the potential or interest to become maintenance workers. Those employees are trained by two ICRC-trained Category II prosthetists. The objective is to train the selected individuals to make simple repairs around the hospital (thus obviating the need to spend funds on outside contracting for the work) and to train them to make simple assistive devices, crutches and walking frames in particular. Those individuals are also trained to make traction frames, intravenous poles, and canes at the request of a nurse or doctor who prescribes the treatment for a particular patient. In all cases, the patient must pay something for the device. Often the payment is just a token, but it is a key requirement in patient ownership.

Actual Activity. There is no selection process for the technicians. Some of the technician trainees think that the additional work required once they are trained merits additional compensation. That attitude largely depends on the motivation of the technician. If the technicians are interested in the training and see it as an opportunity to upgrade their skills rather than as a cause for extra work, there seems to be no problem. For those individuals drafted into the training, other motivations (e.g., increased income) are more common. The technicians are trained by RaDO to perform simple hospital maintenance repairs. The savings to the hospital in not having to contract out a job was seen as an opportunity to support the consumable supplies for the workshop.

Analysis of Activity. One of the selling points of sustainability in the RaDO proposal was that all the trainees would already be working for the hospital. Consequently, the employee pool is limited and in fact very restrictive with regard to maintenance personnel. In Dire Dawa, one trainee was also the hospital guard. In Bahir Dar, both technicians were close to retirement. This situation meant that their replacements would not be RaDO-trained. It is not feasible to expect that the current technicians, with three months' training, could legitimately pass the skills on to new staff—yet that was the only option available.

The workshop, the actual building and equipment, and the upgrading of workers' skills attract hospital administrators first. While the administrators must locate a suitable building site, select

personnel for training, and allow time for training, they are often impressed with the skill level achieved by the technicians. Furthermore, any savings that have been realized are not used for the purchase of consumable supplies because the supplies provided by RaDO for 18 months are still sufficient. Critical to the sustainability of the program are additional funds to replenish the inventory of supplies after the initial period.

Impact of the Program on Patient Outcomes

Proposed Activity. The theory underlying the program is that immediate and correct treatment for specific acute conditions will improve patient outcomes. Improved outcomes range from quicker overall recovery, including earlier release from the hospital and improved mobility, to the prevention of further complications associated with hospitalization (e.g., nosocomial infections, bed sores, stricture).

Actual Activity. Anecdotally, the premise of the proposals appears to be true. The evaluation team looked at hospitals with and without the RaDO program. They all faced overwhelming numbers of patients and had insufficient staff and personnel. For the surgical conditions most frequently seen—fractures and burns—the treatment most commonly prescribed is bed rest. No one is assigned—or even available—to treat patients beyond immediate basic care. And that basic care is still not inclusive enough to assist bedridden patients.

Analysis of Activity. With RaDO's rehabilitation program, surgical patients are "created." They are encouraged to get out of bed, walk using parallel bars, use small weights, bend, move, and think about improving their condition.

Taking into consideration the nature of public health in Ethiopia and as well as endorsement of the nurses' association, the physical therapists' association, ICRC (informally), and the Ethiopian Prosthetics and Orthotics Center, the evaluation team endorsed the theory of the proposal. By any definition, patients are improving because of the program. Whether this trend expands or continues remains to be seen, but documenting these changes is key to any further improvement.

Community Awareness/Education

Proposed Activity. Plans for action and materials for raising awareness as well as for education in the prevention of disability are to be developed for health personnel and patients. Posters, T-shirts, and additional awareness materials are to be developed for hospital staff and the general public.

Actual Activity. Wall paintings by local artists were seen at every hospital. Posters illustrating the do's and don'ts of rehabilitation were also prominently displayed. In addition, the project calls for a two-day seminar for hospital medical staff to raise their awareness.

Analysis of Activity. The awareness/education component of the proposal, which can be divided between professionals and the public, is weak. In terms of educating the public, very

little information about the services is reaching them. At the same time, the absorptive capacity of the hospital rehabilitation services needs to be monitored. Because the services are provided to hospitalized patients who are referred postoperatively by their surgeon, there is no community awareness of the physiotherapy services. Individuals in the community cannot access this service except on rare occasions. Patients pay for services and appliances on a sliding fee scale. Even if a patient has a certificate of poverty from the local authorities, there is the expectation that the patient will make some payment for services.

For medical personnel, physiotherapy and physical rehabilitation are not included in medical or nursing education. This area can be strengthened. The nursing educators were very interested in hearing and learning about the training, but they had never been contacted. To reach the number of nurses who will be needed in the future to sustain this effort, keeping medical personnel informed and educated merits attention.

Sustainability

Proposed Activity. The proposal discusses sustainability in three areas: institutional, managerial, and technical. According to the proposal, the nurses and technicians who are trained within the framework of the project are already employed by the MOH. They will continue to be so employed after the training; in that sense, their “new” jobs are sustained. The hospital, in agreeing to such an arrangement beforehand, has a vested interest in making use of the new skills of the nurses and technicians.

On the managerial and administrative levels, the proposal notes that all concerned parties are involved in the project. The administration must comply with procurement requirements and deal with equipment and consumables. Familiarity with the process allows easy integration into the hospital’s supply system once reordering supplies becomes necessary.

In the technical area, the proposal offers a two-day awareness workshop for physicians to raise their understanding of disability. The specific purpose is to facilitate good working relationships among medical personnel and offer ways to integrate the new service into the medical routine. An additional feature of the proposal is recognition by the MOH of the RaDO-trained health workers at their graduation with the presentation of a certificate.

Actual Activity. While each of the factors described above contributes to sustainability of the program, the overriding concerns are time, money, and patient outcomes. The hospitals must allow staff the time to perform the rehabilitative skills they have learned, and according to their initial agreement, they must assume the cost of consumable materials for the workshop. The cost is estimated to be 30,000 Birr (\$4,000) per year. Not enough time has passed (the initial project ended in December 1999) to draw conclusions about whether or not rehabilitation will be integrated into the hospital’s system.

The evaluation team observed little in the way of systematic record keeping of patient outcomes. Even for records that are kept in the hospital, data analysis (e.g., age and sex of patient, his or her condition, type and duration of treatment [including any device], discharge information) was not

available. Such information not only would be vital in an evaluation of patient outcomes, but would also allow the training to address those conditions that are seen most often.

The effects of polio are often seen in Ethiopia. Sheshire Home manages the disease for the country with a well-respected outreach program for children under the age of 13 years, a treatment regime, and a community awareness component.

Analysis of Activity. There is some sense that staff will continue to perform their new duties. Discussions with nurses and technicians show that they are motivated to take on their new rehabilitation responsibilities. Medical directors have indicated that allowing time for those services is difficult, though. Nurses are expected to perform the additional work on top of their regular workload. Technicians are expected to make appliances, repair equipment, and maintain the hospital without additional compensation. And instances of abuse of the system, though infrequent, are serious enough to jeopardize the project. Underlying the idea of sustainability is the need to nurture, preserve, and protect the rehabilitation services. What is less clear is whether there is a budgetary commitment to do so.

OVERALL STRENGTH AND WEAKNESS

Strengths

Staff

The outstanding strength of the proposal is the RaDO personnel. The manager, the technical coordinator, the two orthopedic technicians, and the two physiotherapists are well-educated, motivated, committed individuals with many years of experience. Written and verbal reports indicate that the RaDO personnel respect one another and work well together as a team. The technicians and therapists have received teacher training and curriculum development courses during the past two years.

Curricula

Two well-designed curricula have been used in the 11 selected hospitals. Each curriculum has undergone revisions after each course presentation. The technical advisors and training staff appear to be satisfied that the curricula achieve the objectives of the course—a determination they have reached by evaluating the trainees' work during quarterly supervisory visits.

Trainee Satisfaction

The nurses who had the opportunity to discuss their program with the assessors felt that their training has allowed them to improve the quality of care for the surgical patients whom they serve. It seems that patients receiving the physiotherapy are discharged earlier than patients with similar conditions who do not receive the therapy, and that sequelae of fractures and burns are minimized. The ability to provide assistive devices such as crutches, canes, and walking frames on site speeds up the discharge of patients, thereby releasing space and personnel for the many other patients requiring admission.

Physician Interest

Physicians who were interviewed have begun to realize the value that basic physiotherapy has brought to their patients. Physicians, particularly surgeons, are enthusiastic about their ability to refer patients for that service. Other specialists either have not been made aware of the service or are not encouraged to access it for their patients.

Weaknesses

Sustainability

There has been insufficient time to prove that this concept can work. Hospitals need to show their willingness to support rehabilitation by devoting time and resources to it. RaDO needs to show unequivocally that the results achieved are better than no intervention at all. Until those results are clear, further expansion is not warranted.

Cost recovery is another option that RaDO has proposed. It was not appropriate to fully explore that possibility in the first phase, but it would be useful to develop the concept in the next.

Selection of Trainees

The number of individuals who receive the training at each hospital is too limited to meet the demand. Nurses are selected for the training by the medical director of the hospital. There did not appear to be any input from the matron of the hospital or from the nurses themselves. Nurses who receive training are expected to continue with their nursing duties as they provide physiotherapy services to referred patients. In two hospitals, the charge nurse of the surgical service had been one of the two individuals to receive the training. The day-to-day responsibilities of the charge nurse are so overwhelming, though, that this particular person would not be an appropriate choice for added tasks.

Awareness among Professionals and the Public

The mechanism to make the community aware of the hospital rehabilitation services is a weak component of the proposal. Because the services are provided to hospitalized patients who are referred postoperatively by their surgeon, there is no community awareness of the physiotherapy services. Individuals in the community cannot access this service except on rare occasions. Patients pay for services and appliances on a sliding fee scale. Even if a patient has a certificate of poverty from the local authorities, there is the expectation that the patient will make some payment for services.

Physiotherapy and physical rehabilitation are not included in medical or nursing education. The proposal includes plans to conduct a two-day seminar for the medical staff of the selected hospitals.

Addendum on Nursing

Contact was made with the Ethiopian Nurses Association through the International Council of Nurses and the Canadian Nurses Association, which have established a partnership with the ENA.

There are approximately 5,000 qualified registered nurses in Ethiopia and eight schools of nursing that prepare them. The ratio of nurses to population is 1:13,000. The ratio recommended by the World Health Organization (WHO) is 1:750. Approximately 90 percent of the nurses work in hospitals. Except in Addis Ababa, where a referral from a health center is necessary before admission to a hospital, the regional hospital is the primary source of care for the Ethiopian population. The ENA was reestablished two years ago. With help, including a funded project from the Canadian Nurses Association, the ENA is attempting to create regional centers that are accessible to their membership.

One of the members of the RaDO Board of Directors is Sister Dinkerish Amassu. She has a strong background in community health and pediatrics and is a nurse tutor at Black Lion Hospital. At her invitation, visits were arranged to two health centers in Addis Ababa, one center in Zone 3, and another center in Zone 4. The large, full-service health center in Zone 3 has 43 staff members (including 23 nurses) educated at various levels. The center provides maternal and child health care, including antenatal, delivery, postpartum, and reproductive health services. Staff members see 80–100 adult clients a day in the medical clinic and approximately 25–30 children a day in the pediatric clinic. The laboratory has facilities for blood, urine, stool, and sputum testing. A tuberculosis clinic is conducted every afternoon, and a pharmacy is located on the center's premises. The cost of a visit is 1 Birr (about \$0.12) Prenatal care is 5 Birr. Normal delivery, postpartum care, family planning, sexually transmitted disease (STD) services, immunizations, and treatment for tuberculosis are free of charge. The health center is well attended, well organized, and clean.

The health center in Zone 4 had been established as an STD treatment center. It now offers pediatrics, adult medicine, prenatal care, family planning, and tuberculosis testing. There is a pharmacy, but no laboratory, on site. There are no facilities for maternal deliveries or postpartum services either. The most impressive aspect of Zone 4's health center was the number of colorful, informative, and (for the most part) culturally appropriate health education posters. The medical director of the center has a strong community health/public health background.

SCOPE OF WORK

Julia Plotnick and Cathy Savino will travel to Ethiopia from February 18 through March 1, 2000, under the LWVF to assess the viability of an unsolicited proposal from RaDO. The two-year, \$915,658 proposal entitled “Establishment of Basic Rehabilitation Services in 8 Hospitals and Strengthening the Previous Rehabilitation Services in 11 Hospitals in Ethiopia” was delivered by hand to the LWVF offices on November 18, 1999.

The evaluation team will examine the existing HI-funded RaDO program and assess its impact. The team will look at hospitals that no longer have RaDO input but continue to use its methodology, hospitals that are currently part of RaDO’s program, and hospitals that will be included in RaDO’s program if the next grant is funded.

The team will make recommendations regarding future directions and try to address the current institutional and administrative gaps in addressing the needs of the disabled in Ethiopia.

Background

The Rehabilitation and Development Organization is an indigenous organization that obtained its legal authority in August 1997. RaDO is a group of rehabilitation professionals with the same philosophy who joined to form the association. RaDO’s objectives are as follows:

- Establish community-based rehabilitation (CBR) for people with disabilities (PWD)
- Enhance employment opportunities for PWDs
- Establish physical rehabilitation centers close to major hospitals
- Provide vocational training for PWDs
- Develop awareness programs
- Work with the government and other donors to improve rehabilitation services for PWDs.

Suggested Visits

- USAID Mission
 - Getahun Dendir
 - Doug Sheldon (Mission Director)

Questions

Overall

- What is the overall state of rehabilitation in Ethiopia?
- What is the government's position on CBR?
- Who else is involved in the field? What level of support exists from other professions?
- Why should U.S. Agency for International Development (USAID) get involved in rehabilitation efforts?
- Why RaDO versus other rehabilitation NGOs?

RaDO-Specific

- What has been the impact of RaDO's programs?
- How many people are being reached?
- Who is being trained? How is the training being done?
- Are RaDO's rehabilitation programs effective in addressing the problems?
- How are the hospitals faring that no longer have RaDO's support?
- What level of rehabilitation services are offered by the hospitals where RaDO is involved?
- How does RaDO choose which hospitals it will support?
- What is the expected benefit for the hospital and patients?
- How will RaDO assess its impact on the hospital?

Organizational

- As an NGO, is RaDO capable of managing a grant this large?
- What recommendations does RaDO have to support its application?
- What financial background does RaDO have?
- What are the staffing pattern and level of staff training? What materials are used? How do the staff members work with other professional organizations?
- Are there gaps in RaDO's management? If so, how might those gaps be addressed?
- Are there gaps in training, materials, or equipment?
- What is the role of RaDO's Board of directors?

- Site visits to three hospitals
- Site visit to the nurses training facility (school and association)
- Organizations and individuals in Ethiopia who are familiar with RaDO
 - Handicap International
 - World Bank

- United Nations Children’s Fund (UNICEF)
- United Nations High Commissioner for Refugees (UNHCR)
- Government officials

Reporting

The team will write and submit a report within two weeks of their departure from Ethiopia. Before departing the country, the team will leave a summary of its recommendations with the USAID Mission. Finally, the team will make a formal presentation to LWVF Manager Lloyd Feinberg, who will contact the Mission regarding further decisions.

Existing RaDO Network of 11 Hospitals
<p>Strengths</p> <ul style="list-style-type: none">StaffCurriculumImproved patient outcomesProfessional satisfaction among traineesPhysician interest
<p>Weakness</p> <ul style="list-style-type: none">Selection of personnel (at the selected sites)Limited supervisionSustainability of personnel and fundingCost recoveryLimited awareness on the part of professionals and the public

CONTACTS IN ETHIOPIA

Organization	Person	Title
Rehabilitation and Development Organization (RaDO) Phone: 251-1-15-99-81(h) Email: rado@telecom.net.et	Tilahun Kidan	Director
	Alemayehu Mitiku	Tech Director
	Tessfa Ortho	Tech Trainer
	Ayelo Ortho	Tech Trainer
	Getahun	Physio Trainer
	Capta	Physio Trainer
	Mulu Haile	Chairperson of the Board
	Dinknesh Admasu	Member of the Board
	Yiberta Taddesse	Member of the Board
Amha Asfaw	Member of the Board	
Felegehiwot Hospital	Dr. Firew Kebede	Hospital Director (pediatrician)
Bahir Dar, Ethiopia	Minitiwab Gete	Nurse
	Etakerahu Simariam	Health Assistant
	Haimanot Abun	Electrician (new)
	Zegeye Birhanu	Welder (new)
	Hunachew Gessese	Head Carpenter
	Getaneh Derseh	Director, Regional Health Bureau
Debre Berhan Hospital PO Box 8 Debre Berhan, Ethiopia Phone: 251-1-81-13-33	Dr. Zegene Taye	Orthopedic Technician
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	Mekuria Bayou	Vice President
	Weineshet Seyoum	Public Relations Director

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Organization	Person	Title
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United Nations Children's Fund (UNICEF) Phone: 251-1-51-51-55 Fax: 251-1-51-16-28 Email: rmccarthy@unicef.org	Robert McCarthy	Director
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Organization	Person	Title
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