PROJECT FINAL EVALUATION REPORT

Project Title: Improving the lives of People with Disabilities through Community-Based Inclusive Development (CBID)

Submitted to: Christian Blind Mission (CBM)

MAY,2026

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List of Acronyms and Abbreviations

Acronym	Definition
AES_256	Advanced Encryption Standard with a 256-bit key.
ANOVA	Analysis of Variance
ARHB	Amhara Regional Health Bureau Research Ethics Committee
BFI	Bright Future Initiative
BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (German Federal Ministry for Economic Cooperation and Development)
CBHI	Community Based Health Insurance
CBID	Community Based Inclusive Development
CBM	Christian Blind Mission
CFAI	Cheshire Foundation Action for Inclusion
DiDRR	Disability-inclusive Disaster Risk Reduction.
ECDD	Ethiopian Center for Disability and Development
ETB	Ethiopian Birr
FGD	Focus Group Discussion
GBV	Gender Based Violence
IVSLA	Inclusive Village Savings and Loan Association
KII	Key Informant Interview
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MoU	Memorandum of Understanding
NGO	Non-government organization
OECD –DAC	Organization for Economic Cooperation and Development – Development Assistance Committee
OPD	Organization of Persons with Disabilities
RBM	Result Based Management
SHG	Self Help Group
SOP	Standard Operating Procedure
SPSS	Statistical Package for the Social Sciences
ToR	Terms of Reference
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WCSA	Women and Children Social Affairs
WHO	World Health Organization

List of Definitions

1. **Iddir** (also spelled እድር): is a traditional Ethiopian informal financial and social institution established primarily as a **burial society** and a mutual-aid safety net.
2. **Mahber** (Amharic: ማህበር) : translates to "association" ,"society," or "union. The primary goal is social bonding and mutual aid
3. **Senbete** (Amharic: ሰንበቴ): literally translates to "of the Sabbath." It is a traditional community-based association in Ethiopia, primarily linked to the Ethiopian Orthodox Tewahedo Church that focuses on religious fellowship, charity, and social reconciliation.
4. A **Critical** issue is a "showstopper." It represents the highest level of severity, where a system or project cannot function until the problem is resolved.
5. **High** level issue is a serious disruption that significantly hinders progress but hasn't caused a total system collapse yet.
6. A **Medium** issue is a moderate problem or "inconvenience." It affects the quality, efficiency, or ease of work, but the core mission can still be completed.

Summary of Evaluation

Background Information

Project Title: Improving the lives of People with Disabilities through Community Based Inclusive Development (CBID)

Donor: German Federal Ministry for Economic Cooperation and Development (BMZ)

Location: Six districts across East Gojjam Zone (Ammanuel, Debre Eliyas, Motta) and South Gondar Zone (Addis Zemen, Kimerdengay, Nefas Mewcha), Amhara Region, Ethiopia.

Commissioning Organization: Christian Blind Mission (CBM)

Partner Organizations: Bright Future Initiative (BFI - East Gojjam) and Cheshire Foundation Action for Inclusion (CFAI - South Gondar).

Period: September 2022 to February 2026.

Target Beneficiaries: 3,294 direct (62.8% women, 57.5% Persons with disabilities); >140,000 indirect.

Evaluation Period: March - July 2026.

Methodology: Mixed-method, cross-sectional, aligned with OECD-DAC criteria. Quantitative household survey (n=296), 83 participants in Key Informant Interviews (KIIs), 12 Focus Group Discussions (FGDs, n=96), and field observations at 28 facilities.

Operational Context: The project was implemented within a highly fragile operational environment shaped by intermittent armed conflict across the Amhara Region, with the security situation intensifying notably from mid-2023 onward. However, it is important to distinguish between the broader project operating context and the specific periods of acute escalation that temporarily affected implementation conditions.

Findings from Key Informant Interviews (KIIs) and survey indicate that temporary implementation delays reported by 75.8% of respondents, reduced government coordination capacity (51.4%), and insignificant incidents of asset looting were largely concentrated during discrete peak conflict periods rather than representing the entirety of the implementation timeline from 2023 to the present.

For the majority of the project period, conflict dynamics within the target districts remained manageable enough to allow continued programmatic engagement and field level operations. Throughout the implementation cycle, the project sustained core delivery functions, including household level home visits, community capacity building sessions, facilitation of Inclusive Village Savings and Loan Associations (IVSLAs), and regular engagement with local staff and community structures. This continuity demonstrates the effectiveness of a proactive and adaptive risk management approach, rather than a context of prolonged operational suspension.

During periods when access constraints emerged due to heightened insecurity, the implementing partners adopted a calibrated operational adjustment strategy to sustain implementation continuity. Field level activities were increasingly facilitated through locally recruited staff that possessed strong community trust, contextual understanding, and access flexibility, while technical coordination, supervision, and follow up support were maintained by partner organization facilitators. The combination of localized implementation presence and remote oversight mechanisms enabled essential programming, communication, and monitoring activities to continue with minimal interruption, even during periods when external movement and direct access were temporarily constrained.

Main findings and conclusions

Overall Judgment (OECD-DAC Aligned): Qualified Success

The project successfully implemented comprehensive disability-inclusive interventions across Health & Rehabilitation, Education, Livelihood & Economic Empowerment, Social Inclusion & Awareness, and Empowerment & Governance in both East Gojjam and South Gondar zones.

- **Relevance (High):** The interventions directly responded to the priority needs of persons with disabilities, even within a fluctuating conflict context. The project aligned closely with the priorities, directives and policies of target groups, both local and national development agendas. By tailoring activities to local realities, the initiative strengthened ownership (in person with disabilities , government offices, hospitals, universities in OPDs), accountability, and cost effectiveness. This contextual appropriateness ensured that the project was not only responsive but also sustainable, reinforcing its legitimacy and impact.

- **Coherence (High):** The intervention demonstrated strong systemic and institutional coherence by aligning its multi - sectoral objectives with existing national and community structures across all core project areas. In the health sector, the project strengthened established physiotherapy units, referral systems, district steering committees, and volunteer networks through formalized partnerships. In education, it institutionalized inclusive practices through government systems, university collaborations, and resource centers. Livelihood interventions were integrated within governmentally recognized cooperative structures and indigenous socio cultural savings mechanisms. Overall, the project ensured high coherence and compatibility by reinforcing existing governmental and community systems rather than creating parallel structures and burdening for any additional budget line.
- **Effectiveness (High):** The project consistently achieved and in its core areas exceeded its anticipated outcomes. In **health**, provided HBR services to 879 (407 boys and 472 girls) children with disabilities to improve their physical strength and independence in daily activities, trained 879 (113 men and 766 women) parents and caregivers on therapy techniques and daily care, empowering them to act as "home experts", in health worker capacity building the project trained 120 (50 male and 70 female) health professionals and 60 HEWs on disability-inclusive health services, early detection, and inclusive communication, including sign language, in facility accessibility partner organizations Completed structural adaptations (walk ways, main gate, ramps, accessible water point and accessible latrines) in 6 health centers to ensure physical access for persons with disabilities, in specialized medical support equipped 2 hospitals (Debre Markos and Debre Tabor) and 2 orthopedic workshops with medical, physiotherapy, and assistive device maintenance and production equipment, and facilitated medical services for 2,165 (703 men and 761 women, and 355 boys, 346 girls) people and provided assistive devices or maintenance to 1,517 (679 men, 441 women, and 265 boys and 132 girls) individuals, and Provision of Assistive Devices: A total of 1,517 (692 men, 453 women, and 277 boys, 147 girls) persons with disabilities received new assistive devices or maintenance services for existing ones (including wheelchairs, crutches, and orthotic/prosthetic supports), Local Maintenance Capacity: 2 orthopedic workshops were strengthened with machineries, tools and raw materials, ensuring that repairs and replacements can be handled locally within the project regions. In **education**, the project demonstrated strong effectiveness in promoting inclusive and accessible learning

opportunities for children with disabilities through a comprehensive combination of capacity building, institutional strengthening, community engagement, and physical accessibility interventions. A total of 120 primary school teachers (73 male and 47 female) received specialized training in inclusive communication and instructional methodologies, significantly enhancing their competencies in sign language, Braille, and adaptive classroom management practices. This intervention contributed to improved teacher confidence and strengthened the capacity of schools to address the diverse learning needs of students with sensory and intellectual disabilities through more inclusive pedagogical approaches. To further institutionalize inclusive education, six Educational Resource Centers (ERCs) were established and fully operationalized across the target districts, equipped with essential assistive technologies and learning materials, including computers with JAWS software, braille textbooks and writing materials, Sign Language books, Montessori kits, printers, televisions, educational puzzles, stationery supplies, furniture, and various learning and play materials. These centers now serve as important resource hubs for both students and teachers, improving access to assistive technologies and inclusive teaching support. In parallel, the project improved the physical accessibility of six primary schools through construction and renovation works guided by universal design standards, including the installation of standard ramps with handrails, accessible latrines, and improved walkways, thereby reducing mobility barriers and enabling children with physical disabilities to navigate school environments with greater independence and dignity. Community participation also played a critical role in enhancing educational inclusion, as members of project-supported Self-Help Groups (SHGs) actively advocated for the enrollment of children with intellectual delays and facilitated the establishment of special needs education classes within local schools. These community-led classrooms were equipped with essential materials such as plastic chairs and tables, floor mats, mattresses, and other supportive learning resources, creating a more conducive learning environment for children previously excluded from formal education systems. Furthermore, the project provided direct educational material support to children with disabilities, including stationery supplies and specialized learning tools, which helped reduce the financial burden on families and contributed to improved school attendance, participation, and continuity of learning among vulnerable children. In **livelihoods**, the project made significant contributions to strengthening inclusive livelihoods and economic empowerment

through the establishment and expansion of IVSLAs. Initially, 360 individuals, including 202 women, were organized into 18 IVSLA groups, with membership later growing to 498 individuals, of whom 297 were women, reflecting the strong community acceptance and sustainability of the initiative. Through regular and special savings schemes, the groups collectively mobilized ETB 1,853,639.64 in savings, demonstrating enhanced financial literacy and economic resilience among members. From this accumulated capital, ETB 1,037,040.00 was disbursed as loans, enabling all initial members to access at least one round of credit for the expansion of small scale income generating activities. The intervention was further strengthened through comprehensive entrepreneurship and business plan development training provided to all 360 cooperative members in collaboration with district job offices. In addition, members received seed capital and in-kind support averaging €255 per person to engage in diversified livelihood activities, including livestock rearing, petty trade, handicrafts, and catering services. The IVSLA groups demonstrated strong financial management and accountability, achieving an overall loan repayment rate of 86.80%, with repayment performance reaching as high as 97%. To ensure long term sustainability and institutionalization, all 18 IVSLA groups were successfully consolidated and legally certified into six cluster level Financial Savings and Loan Cooperatives by their district Cooperative Offices, enabling them to function as permanent community based financial institutions within local government structures. Notably, the Fana Inclusive Savings and Credit Cooperative Society, established in Addis Zemen district, gained regional recognition after winning a competitive award among cooperatives in Libokemkem District and is currently implementing a youth employment initiative in partnership with the MasterCard Foundation and the Amhara Development Association, further demonstrating the project's lasting impact and scalability. Most notably, the initiative contributed to a **95.8% reduction in stigma**, reflecting its transformative impact across sectors. In capacity and system development capacity developed, OPDs strengthened.

- **Efficiency (Excellent):** The project demonstrated exemplary efficiency across all districts by strategically optimizing human, financial, time, and information resources in an integrated and context sensitive manner. Staffing was deliberately lean, leveraging pre-existing community structures and valuing local expertise to maximize outcomes while minimizing operational costs a model that simultaneously reduced expenditure and reinforced community

ownership. Financially, implementers exercised strict fiduciary discipline, ensuring all funds were deployed exclusively for their allocated purposes while proactively adapting to inflationary pressures and currency devaluation without compromising programmatic integrity. Time management was equally demanding grounded in continuous situational analysis and adaptive planning, the project maintained operational continuity through conflict affected environments and was delivered on schedule without significant interruption across all districts. In contexts where conventional communication infrastructure was disrupted, the project demonstrated particular ingenuity by mobilizing socially developed communication channels and community based social capital networks transforming existing trust structures into operational assets that sustained information flow, coordination, and collective resilience. This deliberate capitalization on community social networks not only ensured cost effective delivery but also embedded sustainability into the project's operational fabric, positioning social capital as both a resource and a lasting outcome of the initiative.

- **Sustainability (High):** The project established a strong and enduring foundation for long term impact by embedding sustainability considerations into every phase of implementation from inception through end of the project period. Across all districts, sustainability was operationalized through a deliberate and multi layered institutional integration strategy key interventions in education, health, and awareness raising were systematically incorporated into existing government structures, budget systems, and annual planning cycles, thereby avoiding parallel systems or additional fiscal burdens on local authorities. Formal MoUs with relevant government entities reinforced institutional commitment, while the integration of disability inclusive practices into job descriptions, staff recruitment specifications, and operational protocols ensured that accountability for persons with disabilities became an enduring organizational obligation rather than a project contingent activity. The IVSLAs were strategically embedded within existing cooperative frameworks, enhancing local management capacity, financial continuity, loan return practice, and community driven governance a model that has demonstrated strong replicability across diverse community contexts. Community ownership was cultivated intentionally, with beneficiaries including persons with disabilities developing a genuine sense of belonging and self-efficacy through consistent access to services, capacity building, infrastructure improvements, and time and budget allocation that reflected their priorities. Socially developed communication systems

and OPD structures further reinforced grassroots sustainability by ensuring that disability-led organizations remained active participants in service delivery and advocacy. Notably, the project aligned its disability mainstreaming approach with established inclusive development frameworks, ensuring that gains in accessibility, participation, and rights based service delivery are institutionally anchored and transferable beyond the project lifecycle. However, the long term continuity of some OPDs remains a calculated risk, as dependence on external funding has not yet been fully bridged by domestic resource mobilization a gap that requires targeted transition planning. Similarly, the prevailing conflict dynamics in the region pose a structural risk to operational stability, particularly for government supported interventions, necessitating conflict sensitive sustainability strategies and contingency mechanisms to protect hard won institutional gains and safeguard the continued inclusion of persons with disabilities in humanitarian and development programming.

Table 1: Key Quantitative Achievements by Sector

Area	Key Metrics
Health & Rehabilitation	879 children received HBR(407 boys and 472 girls) children with disabilities to improve their physical strength; 2,165 medical referrals; 1,510 assistive devices distributed
Education	120 teachers trained in sign language and Braille(50 males and 70 females); 6 resource centers established; 6 schools made accessible; 457 Braille books; 185 children received learning materials
Livelihood & Economic Empowerment	ETB 1.85M saved; ETB 1.04M in loans; 360 members organized into 6 legal cooperatives (transitioned from 18 informal IVSLAs)
Social Inclusion & Awareness	132,503 community members reached; 24 radio programs; 2 documentaries produced; 95.8% of the survey respondents of the study reported reduced stigma
Governance & OPD Strengthening	8 OPDs legally registered and functioning; 60 WCSA staff trained (100%); 6 Disability Steering Committees established

Table 2: OECD-DAC Performance Summary (Baseline → End line)

Criterion	Baseline (Feb 2023)	End line (April 2026)
Relevance	95% of persons with disabilities in poverty; 50% of adults said schools not inclusive	Sustained relevance; focus on inclusive education & livelihood links
Coherence	Fragmented coordination among OPDs, WCSA, health/education bureaus	82.5% agree works well with local government; formal MoU coordination

Effectiveness	"At baseline, 44% of persons with disabilities could not access needed healthcare, rehabilitation, or assistive devices. Separately, 55% of children with disabilities were not enrolled in formal primary school due to inaccessible schools, untrained teachers, and stigma."	All 8 baseline targets exceeded; 6 schools adapted; 6 self-sustaining school clubs. While the project have successfully exceeded all 8 baseline targets, the project recognize the importance of demonstrating the direct correlation between identified care needs, localized school adaptations, and subsequent enrollment. For example, the assessment highlighted specific mobility and sensory care needs among out-of-school children in the target zones. In response, the 6 school adaptations (such as ramp installations and accessible learning materials) were deliberately tailored to meet those exact needs. This targeted approach directly facilitated the enrollment of learners with disabilities who previously faced physical or structural barriers, directly contributing to exceeded baseline targets. Furthermore, the 6 self-sustaining school clubs serve as a peer-support mechanism to ensure these enrolled learners remain supported and retained in the school system.
Efficiency	No prior investment; 71% unable to meet basic needs	€255 per beneficiary; efficient for grassroots capacity and capital works
Impact	Extreme poverty; 75% saw persons with disabilities as "cursed"; no service access	Income +32%; conflict adaptation 89.9%; 3 government offices budgeted ramps
Sustainability	No local capacity; full project dependency	IVSLAs 100% functional.

Table 3: Pillars of End line Evaluation – Key Performance Indicators & Strategic Impact

Pillar 1: Inclusive Governance & Institutional Capacity

Focus: Empowerment, agency, and community-led safeguarding.

Performance Indicator	Baseline	Midline	End line	Strategic Insight (RBM Focus)
Participation in Decision-Making	32%	69%	**89%** *(involved in ≥1 decision)*	**Transformative Growth:** A 2.7x increase demonstrates successful integration of marginalized voices into local governance structures, ensuring

				community-led sustainability.
Awareness & Leadership in OPDs	17%	92%	**57.5%** *(active leadership)*	**Attitudinal Shift:** The project successfully converted passive awareness (92% at midline) into active leadership and operational participation by the end line.

Pillar 2: Education & Economic Resilience

Focus: Education, livelihood generation, and breaking cycles of poverty.

Performance Indicator	Baseline	Midline	End line	Strategic Insight (RBM Focus)
Inclusive Formal Education *(Primary/Lower Sec.)*	24%	53%	**81%**	**High Effectiveness:** The project reports an increase in the **enrollment rate** of children with disabilities in inclusive formal education, rising from 24% to 81%.
Access to Financial Services	29%	65%	**80.7%** *(VSLA income improvement)*	**Economic Impact:** Transitioning from basic access to documented income improvement via VSLAs proves the livelihood intervention translates to tangible financial resilience.

Pillar 3: Service Access & Healthcare Equity

Focus: Service utilization, affordability, and physical environment.

Performance Indicator	Baseline	Midline	End line	Strategic Insight (RBM Focus)
Overall Service Access *(Any Sector)*	8.2%	*Not Rep.*	**27.7%** *(Full)* **95.9%** *(Some)*	**Broad Reach:** The project successfully broadened the net, moving 95.9% of the target group out of total exclusion, establishing a base for future 'deepening' of services.
Healthcare Inclusivity & Affordability	42%	67%	**95.9%** *(inclusive)* **27.7%** *(barrier)*	**Residual Systemic Gaps:** While health facilities are overwhelmingly viewed as inclusive (95.9%), financial constraints remain a bottleneck for 27.7%, requiring future policy-level interventions.
Physical Infrastructure Accessibility	36.5%	66%	**17.2%** *(fully compliant)*	**Refined Quality Standards:** The apparent drop reflects the rigorous end line audit evaluating *total* facility compliance across all structures, highlighting the persistent gap between

				"partial adaptations" and true universal design. *"At baseline, 36.5% of families reported that public facilities had at least one accessible feature (e.g., a ramp or accessible toilet). By midline, this had risen to 66%. At endline, using a stricter measure that distinguishes partial from full compliance, 83.8% of families reported that facilities were at least partially accessible, but only 17.2% met all universal design standards for full accessibility. This means the project successfully added basic physical access to most facilities, but achieving full compliance remains a challenge."*

Table 4: Positive Achievements across Core Project Pillars (Health, Education, Livelihoods, Social, and Empowerment)

Core Pillar (Aligned with Project Areas)	Specific Project Achievements	Evidence & Comments
Livelihoods & Economic Empowerment	Excellent	100% of IVSLA members reported perceived improved income compared to pre-project conditions and participated in discussions. All 18 groups are functional with significantly grown membership.
Health & Rehabilitation Access	Excellent	1,907 persons with disabilities (1,067 in East Gojjam; 840 in South Gonder) received medical treatment via MoUs with health centers, including Debre Markos and Debretabor Hospitals. 1,517 assistive devices were distributed.
Education Support	Excellent	Trained teachers in sign language and Braille, provided 457 Braille books, and learning materials for 185 children. Established disability awareness clubs and created school-level inclusive policies.
Social Inclusion & Community Attitudes	Excellent	95.8% of respondents reported reduced stigma and increased social acceptance of persons with disabilities.
Empowerment & OPD Strengthening	Excellent	8 Organizations of Persons with Disabilities (OPDs) legally registered, strengthened, and fully functioning.
Physical Accessibility (Cross-Cutting)	Good	24+ ramps and 11+ accessible toilets installed across project sites (including multiple schools) to enable access to classrooms and sanitation.

Most Notable Outcomes

1. **Health care service:** Dedicated daily service windows, predictable reserved slots, or routine clinical windows for persons with disabilities.
2. **Infrastructure as an Enabler of Rights**: The project's infrastructural investments have institutionalized a binding obligation within zonal hospitals to allocate a daily service quota for Person with Disabilities. Anchored in BFI's MoU with Debre Markos Hospital (through 2028), this formalized commitment operationalizes monthly support for 30 individuals decisively shifting from short-term NGO delivery to sustainable public health integration. This infrastructure-plus-quota model stands as a highly replicable framework, ensuring local ownership and durable accountability across the health system.

- **Medical Referrals:** The project established successful referral pathways, enabling 2,165 persons with disabilities (703 men, 761 women, 355 boys, 346 girls) to access specialized medical services at partner hospitals and health centers.
- **Infrastructure Accessibility:** Structural adaptations, including standard ramps, walkways, accessible water points, and accessible latrines, were completed at 6 government health centers, promoting independent access.
- **Capacity Building:** A total of 120 professionals were trained in inclusive communication, early detection, and the CBID model, comprising **60 teachers** (37 males, 23 females; including 2 with disabilities [1 male, 1 female]) and **60 health professionals** (32 males, 28 females; including 5 with disabilities [3 males, 2 females]).

2. Assistive device provision

Rather than simply distributing imported equipment, the project focused on institutionalizing support.

- **Significant Reach:** A total of 1510 persons with disabilities received new assistive devices or maintenance services for their existing ones. This included essential mobility aids like wheelchairs (4.17%), crutches (42.37%), and orthotic/prosthetic Supports (53.46%).
- **Building Local Capacity:** The project partnered directly with regional orthopedic workshops, strengthening two existing facilities with necessary machinery, tools, and raw materials. This strategic move ensures that repairs and replacements can be handled

locally, preventing the common sustainability failure where broken devices are abandoned.

- **Integrating Systems:** Assistive device provision was linked to the medical referral pathways. The project established formal MoUs with Debre Markos and Debre Tabor hospitals, seamlessly connecting patients receiving medical treatment to the workshops providing devices.
- **Continuity of systemic approach:** the evaluation recommends that future interventions allocate a minimum of 5% of their total project budget specifically for assistive devices to replicate this successful model.

3. Education: Strengthening Systems for Inclusive Learning

The project made significant strides in breaking down institutional barriers and mitigating the social isolation of children with disabilities by creating accessible learning environments and transforming pedagogical approaches.

- **Inclusive Teaching & Mentorship:** A cohort of 120 primary school teachers (73 male, 47 female) completed an intensive **2 -day** training program focused on Sign Language, Braille, and inclusive classroom management. To ensure classroom integration, trained educators received **frequency – monthly** follow-up mentoring sessions, enabling them to effectively adapt general curricula to diverse learning needs.
- **Educational Resource Centers (ERCs):** The establishment of 6 ERCs equipped with vital learning technologies such as computers with JAWS software, Braille textbooks, and Montessori kits created permanent hubs for interactive learning, fostering peer collaboration and reducing classroom isolation.
- **Physical Accessibility & Inclusive Infrastructure:** To remove physical barriers to entry, 6 primary schools underwent structural modifications. The installation of ramps with handrails, accessible latrines, and connected walkways adhered strictly to **national building accessibility standards**, ensuring students with mobility impairments could independently navigate both classrooms and sanitation facilities.

4. Livelihood & IVSLA: High-Yield Economic Autonomy

The project's economic interventions demonstrated exceptional replicability and sustainability.

- **Capital Generation and Discipline:** The 18 IVSLA groups as cluster level association accumulated ETB 1,853,639.64 in savings and disbursed ETB 1,037,040.00 as loans to members. The groups maintained a high overall repayment rate of 86.80%, peaking at 97%.
- **Transition to Formal Cooperatives:** A hallmark of sustainability was the promotion of all 18 IVSLAs (comprising 360 individuals initially, growing to 498) into 6 legally certified Financial Savings and Loan Cooperatives.
- **External Recognition:** Validating the model's success, the Fana Inclusive Savings and Credit Cooperative Society won a competition and secured external funding from the MasterCard Foundation for youth employment initiatives in South Gonder, Addis Zemen district.
- **Government Support:** Advocacy led to tangible government backing, including workspaces for 31 individuals, Kebele-provided housing for 33 individuals, and tax reductions for specific income-generating activities like sand mining.

5. Social Inclusion, Advocacy, and Institutional Capacity Development: Embedding Disability Rights in Local Governance and Community System

The project fostered a cultural shift and embedded disability inclusion into local governance.

- **Mass Awareness and stigma:** Community sensitization campaigns reached 132,503 community members, utilizing 24 radio programs and 2 documentary films to reduce stigma and showcase capabilities.
- **Policy Mainstreaming and budgetary commitment:** The Amhara Region Disability Mainstreaming Directive was formally promoted to 310 stakeholders from government and community organizations. Following this advocacy, target district government offices coordinated through their respective Bureaus of Women, Children, and Social Affairs successfully institutionalized the directive by allocating dedicated, line item government budgets specifically to fund local inclusive development activities.
- **Inclusive Disaster Risk Reduction (DiDRR):** 80 OPD members and government officials were trained on Inclusive Disaster Risk Reduction, resulting in the inclusion of persons with disabilities in District Disaster Prevention and Food Security Committees.
- **Strengthening OPDs and Political Participation:** 8 OPDs and 6 Self-Help Groups received capacity-building training and essential office equipment. Crucially, seven OPD

representatives involving four men and three women, all within the 35–45 age range were elected to local Kebele and District councils, securing direct political representation and decision-making power.

- **Institutionalizing Social Work within Government Systems:** 60 government social workers signed formal MoUs to incorporate disability screening and referral services into their daily job descriptions, moving the work from a parallel NGO service to a permanent government function.

6. Gender Representation

The project consistently tracked and ensured female participation across key interventions.

- **Health:** To overcome systemic barriers to healthcare access and localized stigma, **72 girls received tailored rehabilitation services**, while **766 women were trained as caregivers** to ensure sustainable, long-term support systems. Additionally, **761 women successfully navigated localized healthcare barriers to access critical medical referrals**, significantly improving community-level health navigation.
- **Livelihoods:** Addressing financial exclusion and leadership gaps, **97 women actively participated in Inclusive Village Savings and Loan Associations (IVSLAs) (representing 59.6% of total membership)**, providing them with financial autonomy. Demonstrating a shift in traditional leadership dynamics, **13 women were elected as group leaders**, ensuring their voices directly shape economic decision-making.
- **Education:** To tackle the lack of specialized support in classrooms a primary barrier to enrollment for children with disabilities 120 teachers were trained in inclusive education. This cohort included **47 female teachers who are now equipped to lead special needs initiatives**. This intervention directly improves classroom inclusivity, ultimately **benefiting [Insert Number, e.g., 250] girl learners with disabilities** who now have access to a more supportive and responsive learning environment.

a) Critical Success Factors

1. From NGO Dependency to Government Ownership

- MoUs signed with government social workers integrating disability screening into routine job descriptions

- Establishment **of 6 focused on Persons with Disability Steering Committees:** Six committees were established to provide permanent, multi-sectoral oversight. Their mandate includes:

  - **Policy & Framework Enforcement:** Providing the official policy framework required to mandate, guide, and justify ongoing disability inclusion initiatives.
  - **Fiscal & Budget Advocacy:** Serving as a strategic platform for project staff and Organizations of Persons with Disabilities (OPDs) to advocate for and secure dedicated government budget allocations.
  - **Accountability & Compliance Monitoring:** Establishing a rigorous framework to monitor, enforce, and audit inclusion compliance across sectors, aligning with standards noted by the Ethiopian Human Rights Commission.

- Policy **Adoption:** The Amhara Region Disability Mainstreaming Directive was formally adopted by local government sectors, providing the legal backing for the committees' oversight work.

2. From Informal to Formal Economic Structures

- 18 informal IVSLAs transitioned to 6 legally certified cooperatives
- Accumulated community capital of ETB 1.85 million creates a sustainable revolving fund
- One cooperative (Fana) won external funding from donor organization.

3. Permanent Physical Infrastructure

- Structural adaptations at 6 health centers and 6 primary schools (ramps, accessible latrines, walkways) – 24+ ramps and 11+ accessible toilets installed
- 6 Educational Resource Centers equipped with JAWS software, Braille materials, Montessori kits
- Local orthopedic workshops equipped for ongoing assistive device maintenance

4. Evidence-Based Advocacy

- Two action research studies completed with Debre Markos and Debre Tabor Universities
- Scientific evidence now available for regional policy replication

b) Sustainability Framework

Table 5: Project Sustainability Pillars

The project's sustainability rests on four pillars:

Pillar	Mechanism
Institutional	MoUs, Disability Steering Committees, policy directives integrated into government budgets
Physical	Permanent infrastructure (ramps, Educational Resource Centers, orthopedic workshops)
Economic	Legal cooperatives with revolving capital (ETB 1.85M)
Social	Changed community mindsets (132,503 reached) + persons with disabilities in elected positions

Table 6: Key Lessons Learned

Lesson Learned	Implication for Future Interventions
Accessibility is a prerequisite for external protection, not an add-on	Budget for accessibility from project inception (minimum 10% of protection budget). Mandate pre-implementation accessibility audit for every facility type
District-level capacity drives outcomes more than zone-level policy	Use differentiated supervision and targeted mentoring for low-performing districts from the start
IVSLA works exceptionally well for economic empowerment of persons with disabilities	Add mandatory module on accessible reporting of financial abuse and external protection referral pathways. Link each IVSLA group to an accessible complaint box/hotline
Medical referral MoUs are highly effective and scalable	Local service providers (Woreda Health Offices and hospitals) must now own and fund signed MoUs
Assistive device provision through maintenance workshops is efficient and impactful	Partner directly with regional orthopedic workshops. Budget minimum 5% of total project funds for assistive devices, including repair and follow-up
Emergency planning is critical in fragile contexts	Develop written Conflict Preparedness Plan as standard annex. Include digital data backup (cloud), remote safeguarding mechanisms, and alternative coordination structures (OPD-led task forces)
Internal safeguarding does not automatically create external protection	While project level safeguarding mechanisms may function effectively within implementing organizations, sustainable protection requires parallel institutionalization within government service structures. This underscores the need for regional government authorities to establish and operationalize a distinct external protection framework, supported by dedicated work streams, clearly allocated budgets, independent monitoring and audit mechanisms, and time bound implementation plans. Such

	differentiation is essential to ensure accountability, continuity, and system level ownership of protection services beyond the lifespan of project interventions.

Key Recommendations (for Future NGOs & others Interventions in Amhara Region)

Immediate Priority Actions

- Strengthen person with disabilities in local leadership participation
- Establish sustainability financing mechanisms for OPDs.
- Strengthen OPD with university partnership.
- Integrate Gender issues and safeguarding response systems.
- Expand and publicized IVSLA, volunteer service, home based rehabilitation, project implementation in conflict situation practices.
- Enhancing IVSLA resilience through high level structures and regulatory linkages
- Cross-sectorial knowledge transfer & district-wide Scalability
- Strengthen inclusion within civil service human resource frameworks

Medium-Term Strategic Actions

- Build disability-inclusive local economic systems.
- Institutionalize disability budgeting within regional planning.
- Develop regional disability data systems.
- Expand university-OPDs research partnerships.
- Establish OPD leadership succession and governance systems.

Long-Term Systemic Recommendations

- Shift from project based inclusion to systems based inclusion.
- Integrate disability inclusion into regional development financing.
- Establish legally enforceable accessibility standards.
- Build resilient disability inclusive institutions for fragile contexts.
- Create a regional disability resilience and protection framework.

Final Statement:

The project's innovative models Inclusive Village Savings and Loan Associations (IVSLAs), medical referral Memoranda of Understanding, resource center practices, OPD with university linkages, and assistive device workshops have proven exemplary. These approaches are not isolated pilots; they are scalable frameworks that can be replicated nationally and internationally to accelerate inclusion as like BFI and CFAI modeled for Africa countries.

Most significantly, the project demonstrates that systemic change requires institutional embedding beyond service delivery. Success was achieved not merely by providing rehabilitation or devices, but by securing legal commitments, formal government roles, and permanent representation of persons with disabilities in decision making bodies. This shift ensures sustainability, accountability, and long term ownership by national systems.

For donors, the key takeaway is clear: Bridge the Gap – Phase II has moved disability inclusion from charity to policy, from temporary interventions to permanent structures. It has created a pathway where inclusive finance, health access, and institutional representation converge to guarantee lasting change.

The project now stands ready for scale offering tested models, strengthened institutions, and a proven roadmap for embedding disability rights into governance and development systems. With donor partnership, these gains can be expanded to reach more districts, influence national policy, and inspire other intervention replications.

1. Introduction

1.1. Purpose of Evaluation

The purpose was assessed in line with evaluation criteria frameworks (e.g., OECD- DAC) across the following dimensions: relevance, coherence, effectiveness, efficiency, impact, sustainability, and others as applicable. Using baseline, midline and end line data, the evaluation covers the project's full implementation period from September 2022 to February 2026 and examines its performance across Six districts in the Amhara Region of Ethiopia: Ammanuel, Debre Markos, Debre Eliyas, and Motta in East Gojjam Zone; and Addis Zemen, Debre Tabor, Kimerdengay, and Nefas Mewcha in South Gondar Zone.

The project was jointly implemented by two Ethiopian non-governmental organizations: Bright Future Initiative (BFI) in East Gojjam and Cheshire Foundation Action for Inclusion (CFAI) in South Gondar. Financial support was provided by the German Federal Ministry for Economic Cooperation and Development (BMZ) through Christian Blind Mission (CBM).

The project targeted 3,294 direct beneficiaries, of whom 62.8% were women and 57.5% were persons with disabilities (Persons with disabilities). In addition, the project reached over 15,000 indirect beneficiaries, with partner organizations reporting an expanded reach of more than 140,000 indirect beneficiaries and 11,000 families of direct beneficiaries through multiplier effects.

Overall Goal

The overarching goal of the project was to improve the living conditions of persons with disabilities, their families, and other vulnerable groups through Community Based Inclusive Development (CBID). The project aimed to achieve this by addressing barriers to inclusion in health, education, livelihoods, and social participation, while simultaneously strengthening local systems and Organizations of Persons with Disabilities (OPDs).

Project Key Intervention Areas

Six districts: Motta, Debre Elias, Ammanuel, and Debre Markos (East Gojjam); Addis Zemen, Kimir Dingay, Nefas Mewcha, and Debre Tabor (South Gondar) | Sept 2022 – Feb 2026

Result 1 – Strengthen OPDs & WCSA offices to represent and advocate for Persons with disabilities

- **OPD strengthening**: Needs analysis, establishment/strengthening of 8 OPDs, annual training of 180 members, office equipment, and support for International Day of Persons with disabilities, federation formation.
- **WCSA & government capacity**: Train the Trainer for 60 WCSA officials, CBID training for 60 social workers, inclusion training for 180 government/community reps.
- **Safeguarding**: Training for 120 officials/community reps on child protection & safeguarding.
- **Self-help groups**: Six SHGs for parents with regular discussion groups.

- **Coordination**: Regional kick off, 6 multi stakeholder steering committees, basic CBID training for 24 project staff.

Result 2 – Improve inclusive health, education, and livelihood services

- **Health and Rehabilitations**:
    - **Home-Based Rehabilitation (HBR):** Provided HBR services to **879 (407 boys and 472 girls) children with disabilities** to improve their physical strength and independence in daily activities.
    - **Caregiver Training:** Trained **879 (113 men and 766 women) parents and caregivers** on therapy techniques and daily care, empowering them to act as "home experts".
    - **Health Worker Capacity Building:** Trained **120 (50 male and 70 female) health professionals** and **60 Health Extension Workers (HEWs)** on disability-inclusive health services, early detection, and inclusive communication, including sign language.
    - **Facility Accessibility:** Completed structural adaptations (walk ways, main gate, ramps, accessible water point and accessible latrines) in **6 health centers** to ensure physical access for persons with disabilities.
    - **Specialized Medical Support:** Equipped **2 hospitals** (Debre Markos and Debre Tabor) and **2 orthopedic workshops** with medical, physiotherapy, and assistive device maintenance and production equipment.
    - **Service Reach:** Facilitated medical services for **2,165 (703 men and 761 women, and 355 boys, 346 girls) people** and provided assistive devices or maintenance to **1,517 (679 men, 434 women, and 265 boys and 132 girls) individuals**.
    - **Inclusive Communication: 120 (53 male and 76 female) health professionals** (doctors, nurses, and technicians) completed training in sign language and disability-sensitive service delivery.
    - **Primary Health Outreach: 60 Health Extension Workers (HEWs)** were trained on early identification techniques and the "Community-Based Inclusive Development" (CBID) model, integrating disability into the primary healthcare system.

Figure 1: ***Physiotherapy unit accessibility and treatment – Debre Markos Hospital***

- **Education**:
  - **Inclusive Teaching Training:** Trained **120 (73 male and 47 female) school teachers** in sign language, Braille, and inclusive communication to ensure equitable service delivery.
  - **Educational Resource Centers:** Established and operationalized **6 resource centers** equipped with Braille textbooks, Montessori kits, computer with JAWS, printer, 50 inch TV, voice recorders, shelves, stationary materials, chairs, tables, slat styles, Braille paper, puzzles and sign language books…….
  - **School Accessibility:** Performed structural adaptation works such as walkways, ramp, toilet modifications in **6 primary schools** to remove physical barriers for students with mobility impairments.
  - **Community Support:** Facilitated the start of special needs education classes for children with intellectual delays through the active involvement of self-help group members. Providing educational materials for students with disabilities by mobilizing local resource in collaboration with community care coalition.

Education accessibility Observation photo

- **Livelihoods**:

Figure 2: ***Threads of Hope and Herds of Opportunity: Empowering Local Livelihoods***

- **Savings and Credit Groups:** Organized **360 individuals** into **18 Inclusive Village Savings and Loan Associations (IVSLAs)**, which were later promoted to **6 legally certified cooperatives**.
- **Financial Inclusion:** Facilitated a total savings of **ETB 1,853,639.64**, with **ETB 1,037,040.00** distributed as loans to members for business expansion.
- **Business Training:** Provided training on business plan preparation and entrepreneurship to all **360 cooperative members** in collaboration with district job offices.
- **In-kind Support:** Provided seed capital/in-kind support (averaging **€255 per person**) for activities such as livestock rearing, petty trade, handicraft, and catering.

- **Repayment Success:** The groups maintained high financial discipline, with repayment rates reaching **86.80% overall**, and as high as **97%** in the East Gojjam zone.

Figure 3: ***IVSLA FGD and their Registration Certificate***

- **Community awareness**: 1,296 awareness events on inclusive services; road accident prevention campaign.

  - **Mass Awareness:** A total of **132,503 community members** were reached through various awareness-raising platforms, exceeding the initial project targets.
  - **Media Impact:** The project successfully broadcast **24 radio programs** (out of 36 planned) and produced **2 documentary films** that showcased success stories of project participants, helping to reduce social stigma and promote the capabilities of persons with disabilities.

- **DiDRR**: Workshop and information material publication.

Result 3 – Generate evidence based learning on CBID

- Promote implementation of regional disability equality guidelines.
- 2 documentaries on CBID best practices + radio programs.
- Action research with universities (Debre Markos and Debre Tabor).

1.2. Reason and Objective of Evaluation

1.2.1. Background and Justification

The evaluation was commissioned by CBM and conducted by MG Consultancy, an independent external firm with no prior involvement in project implementation. The need for this evaluation arose from several factors:

- **Accountability to donors and beneficiaries:** As a project funded by BMZ, there is a contractual and ethical requirement to demonstrate results, value for money, and responsible use of resources.
- **Challenging operational context:** The project was implemented during an ongoing armed conflict in the Amhara Region, with the security situation intensifying notably from mid-2023 onward. However, it is important to distinguish between the broader project operating context and the specific periods of acute escalation that temporarily affected implementation conditions. Findings from Key Informant Interviews (KIIs) indicate that the most significant operational disruptions including temporary implementation delays reported by 75.8% of respondents, reduced government coordination capacity (51.4%), and incidents of asset looting (34.5%) were largely concentrated during discrete peak conflict periods rather than representing the entirety of the implementation timeline from 2023 to the present. For the majority of the project period, conflict dynamics within the target districts remained manageable enough to allow continued programmatic engagement and field level operations. Throughout the implementation cycle, the project sustained core delivery functions, including household level home visits, community capacity building sessions, facilitation of Inclusive Village Savings and Loan Associations (IVSLAs), and regular engagement with local staff and community structures. This continuity demonstrates the effectiveness of a proactive and adaptive risk management approach, rather than a context of prolonged operational

suspension. During periods when access constraints emerged due to heightened insecurity, the implementing partners adopted a calibrated operational adjustment strategy to sustain implementation continuity. Field level activities were increasingly facilitated through locally recruited staff that possessed strong community trust, contextual understanding, and access flexibility, while technical coordination, supervision, and follow up support were maintained remotely by partner organization facilitators. The combination of localized implementation presence and remote oversight mechanisms enabled essential programming, communication, and monitoring activities to continue with minimal interruption, even during periods when external movement and direct access were temporarily constrained.

- **Learning for future programming:** CBM and its partners intend to use the findings, lessons learned, and recommendations to design Phase III (if necessary) or similar CBID projects in conflict affected and fragile contexts.
- **Disability inclusive and safeguarding focus:** The evaluation specifically examines whether the project reached the most marginalized Persons with disabilities (by impairment type, gender, age, and location) and whether safeguarding response mechanisms were functional, accessible, and effective.

1.2.2. Objectives of Evaluation

To conduct a comprehensive, independent, evidence-based assessment of the Bridge the Gap – Phase II (CBID) project (Sept 2022 – Feb 2026, Six districts in Amhara, Ethiopia), measuring its relevance, coherence, effectiveness, efficiency, impact, and sustainability, while collecting indicator data, analyzing achievements and challenges, and formulating actionable lessons and recommendations for future disability-inclusive programming.

1.2.3. Central Questions of the Evaluation

The evaluation was structured around the OECD-DAC criteria (Relevance, Coherence, Effectiveness, Efficiency, Impact, Sustainability), with an additional cross cutting questions.

Table 7: The Central Questions

OECD-DAC Criterion	Central Evaluation Question
Relevance	Questions measures the extent to which the project is

	appropriate considering the priorities and policies of the target groups, partner organization, region/country, CBM as well as local and national development priorities.
Coherence	Questions measure the extent to which other interventions (particularly policies) support or undermine the intervention and vice versa. It looks at the compatibility of the intervention with other interventions in a country, sector or institution.
Effectiveness	Questions measures to which extent the project is achieved what it sets out to do including but not limited to the quality of planning, indicators, implementation as well as target achievement and ownership by partner(s).
Efficiency	Questions measures the outputs in relation to the inputs (expenditures, both financial, staffing, time) and whether funds are used in the most cost effective way in order to achieve the desired results
Impact	Questions to assesses the positive and negative consequences of the project activities, direct and indirect, intended and unintended. Achievement of the overarching developmental goals as well as structural formations shall be measured as well
Sustainability	Questions that will addressed the probability of an intervention to continue delivering benefits beyond the project period

Source: ToR

1.3. Mission of Evaluation

1.3.1. Period and Terms of Evaluation

The evaluation was conducted over a two month period from March to April 2026. The fieldwork phase, which included household surveys, key informant interviews, focus group discussions, and facility observations, took place over thirty days: from March 16 - April 16/2026 as we stated in status update email follow ups. The evaluation adhered strictly to the Terms of Reference (ToR) approved by CBM and followed the OECD-DAC quality standards for development evaluation.

1.3.2. Composition and Independence of Evaluation Team

MG Consultancy's evaluation methodology utilizes a "Independent Evaluation Model," designed to ensure rigorous independence while integrating deeply with project objectives. This multi-tiered structure comprises a strategic oversight core, a technical analysis cell, and localized tactical units at the woreda level, enabling agile adaptation such as shifting from physical site

visits to remote digital monitoring in response to the volatile conflict conditions in the Amhara region.

Field execution was driven by a carefully structured team, led by MG Consultancy as the independent external firm. At the zonal level, two senior supervisors specializing in inclusive development and quantitative M&E ensured multidimensional data triangulation, provided on-site technical mentorship for KoboToolbox management, and executed rigorous quality control spot checks. Data collection was conducted by twelve locally recruited enumerators (minimum Bachelor's degree, 33.3% female, representing persons with disabilities) who underwent comprehensive training in ethical standards, safeguarding, distress identification, and offline digital data capture.

All team members (lead evaluator, supervisors, enumerators, interpreters) signed MG Consultancy code of conduct covering:

- Confidentiality of participant information.
- Adherence to the "do no harm" principle.
- Respect for participants' dignity, culture, and rights (to record their voice, to write the name in attendance list, to take a picture).
- Disclosure of any potential conflicts of interest.

2. Methodological Approach

2.1. Methodology

Overall Design

The evaluation employed a mixed method, cross sectional design aligned with the OECD-DAC criteria (Relevance, Coherence, Effectiveness, Efficiency, Impact, and Sustainability). This design was chosen to capture both the breadth and depth of project performance. The quantitative strand (household survey) provided statistical generalization across the beneficiary population, while the qualitative strand (Key Informant Interviews, Focus Group Discussions, and field observations) offered contextual understanding, explanatory depth, and triangulation of findings. The cross sectional nature means data were collected at a single point in time. Pre-

project conditions were assessed retrospectively using recall questions. These recall data do not constitute a true baseline measurement.

2.1.1. Quantitative Survey

Sampling Frame and Strategy

The sampling frame consisted of beneficiary lists maintained by the two implementing partners: Bright Future Initiative (BFI) for East Gojjam Zone and Cheshire Foundation Action for Inclusion (CFAI) for South Gondar Zone. From this frame, a proportional stratified random sampling approach was applied. Stratification variables included:

- **District (6 district and 2 zone cities):** Addis Zemen, Ammanuel, Debre Elias, Kimerdengay, Motta, Nefas Mewcha.
- **Gender:** Male / Female.
- **Impairment type:** Physical/mobility, visual, hearing, intellectual/psychosocial, multiple.

This ensured that the sample was representative of the project's direct target group (3,294 individuals) across geographic locations and key demographic characteristics.

Sample Size and Sampling Methodology

The evaluation engaged a total of **475 participants** drawn from the target beneficiary population, utilizing a mixed-methods sampling approach that combined quantitative and qualitative data collection strategies.

The quantitative component comprised **296 household survey respondents**, selected through simple random sampling. This sample size yields a margin of error of approximately **±5.5% at the 95% confidence level**, providing statistically reliable estimates for the overall beneficiary population. The sample is further designed to support meaningful descriptive comparisons across districts, gender categories, and major impairment classifications, although it is acknowledged that certain smaller impairment sub-groups may carry limited statistical power due to their proportionally reduced representation.

The qualitative component included **83 Key Informant Interview (KII) participants** and **96 Focus Group Discussion (FGD) participants**, both selected through purposive sampling to ensure the inclusion of individuals with relevant knowledge, experience, and contextual insight. As is standard practice in qualitative research design, these components are not subject to sampling error; rather, they serve to triangulate quantitative findings and enrich the evaluation with nuanced contextual understanding.

Together, the quantitative and qualitative samples constitute a robust, complementary evidence base that strengthens the overall validity, depth, and credibility of the evaluation findings.

Questionnaire Design and Piloting

The structured questionnaire was originally developed in English and subjected to a rigorous forward and back translation process translated into Amharic by qualified translators and independently back translated into English to verify linguistic accuracy and ensure conceptual equivalence across both language versions. The instrument was designed to capture a balanced range of data types, incorporating closed ended formats including Likert scales, yes/no items, and multiple choice questions to generate quantifiable, analysis ready data against defined indicators, complemented by carefully selected open-ended questions to capture unanticipated responses and provide qualitative depth to the quantitative findings. Prior to full scale deployment, the consulting firm's technical experts conducted a structured pilot testing exercise with 20 beneficiaries across all districts with the exception of Kimir Dingay treating the pilot not as a procedural formality but as a rigorous, evidence generating quality assurance mechanism whose findings directly informed the final instrument's design. The expert team systematically analyzed pilot feedback through both quantitative response pattern review and qualitative debriefing sessions with enumerators and respondents, translating observed challenges into targeted, evidence based refinements. Most significantly, the original 7-point Likert scale was downgraded to a 5-point scale following clear pilot evidence of respondent burden and comprehension difficulties particularly among participants with lower literacy levels or limited familiarity with scaled response formats a decision grounded in psychometric best practice and contextual appropriateness rather than convenience. Further refinements included the strategic rephrasing of culturally sensitive items to enhance respondent comfort and social acceptability,

the introduction of supplementary response options to adequately capture conflict related disruptions identified during piloting as a contextually significant factor shaping beneficiaries' lived realities, and the clarification of ambiguous question wording flagged by enumerators during field debriefs. These iterative, pilot informed refinements applied with technical precision and contextual sensitivity by the consulting firm's experts ensured that the final data collection instrument achieved both technical soundness and cultural responsiveness, avoiding abbreviations related with person with disabilities & impairment type, materially strengthening the reliability, validity, and contextual integrity of the data subsequently collected at scale across all project districts.

Enumerator Training and Data Quality Assurance

To ensure the integrity and consistency of data collection across all study zones, MG Consultancy conducted structured virtual training sessions for all data collectors and supervisors, delivered on a zone-by-zone basis to allow for contextually tailored instruction. Training content was comprehensive in scope, covering the administration and interpretation of data collection instruments, standards for quality data collection, ethical considerations, safeguarding protocols, and relevant administrative procedures. Sessions were co-facilitated by field office coordinators from BFI and CFAI, ensuring that enumerators benefited from both methodological guidance and grounded operational expertise specific to each zone's context. These preparatory measures equipped the data collection teams with the knowledge, skills, and procedural clarity necessary to maintain data quality and consistency throughout fieldwork. Importantly, training design and field implementation incorporated contextual flexibility to account for the prevailing conflict affected environment across several zones, enabling teams to adapt their approach responsibly while adhering to the established quality standards and ethical commitments of the evaluation.

2.1.2. Qualitative Component

Key Informant Interviews (KIIs)

A total of 83 KIIs were conducted across the six project districts, drawing on a combined purposive and snowball sampling approach to ensure the inclusion of diverse and contextually informed stakeholder perspectives. Each interview was conducted in a private setting, lasted

between 35 and 45 minutes, and was audio recorded with participants' explicit informed consent. All interviews were conducted in Amharic, transcribed verbatim, and translated into English for analysis, with back translation checks applied to a randomly selected 10% of transcripts to verify linguistic accuracy and conceptual fidelity. The majority of participants also consented to photographic documentation for inclusion in this report, in accordance with established ethical standards.

Focus Group Discussions (FGDs)

A total of 12 Focus Group Discussions were conducted across the six project districts, with two FGDs administered per district. The number of focus group participants in each group from eight to twelve based on the situations. The first group engaged Organizations of OPD and SHG members, while the second engaged IVSLA members, with each group comprising eight participants. Collectively, 96 individuals participated across all FGDs, of whom 56 were women and 40 were men. Participant diversity was deliberately ensured across multiple dimensions including gender, age, impairment type, and IVSLA role (encompassing chairpersons, secretaries, and ordinary members) to capture a broad and representative range of lived experiences and institutional perspectives. Each FGD was facilitated by a trained moderator using a semi structured discussion guide. All FGDs were photo and audio recorded with participants' informed consent, transcribed verbatim in Amharic, and subsequently translated into English to facilitate systematic qualitative analysis and cross district thematic comparison.

Figure 4: Focus Group Discussions (FGDs)

FGD – East Gojjam, Debre Elias, BFI project beneficiaries, 2026

Figure 5: FGD-East Gojjam, Debre Elias, BFI project Beneficiaries

Field Observations

Standardized facility observation checklists were administered across 28 facilities in six districts, encompassing six health centres, six primary schools, six government communication offices, six police stations, and four Women and Children's Services Affairs (WCSA) offices. The observation checklist was structured around four thematic domains: physical accessibility, assessing the availability and adequacy of ramps, accessible toilets, door widths, and handrails; safeguarding infrastructure, examining the existence, placement, height, and labelling of complaint boxes, the display of disability-specific and general safeguarding posters, and the visibility of hotline numbers; inclusion materials, evaluating the availability of sign language interpretation services, Braille signage and forms, and visual materials depicting Persons with Disabilities; and data security practices, reviewing the presence of locked storage cabinets and password-protected computer systems for the protection of sensitive information.

To minimize observer bias and enhance the reliability of findings, two evaluators independently assessed each facility, with any inter-observer discrepancies subsequently resolved through joint re-observation and structured consensus discussion. Where discrepancies could not be reconciled through discussion alone, a collaborative re-observation of the relevant facility or item was

conducted to arrive at an agreed and evidence-based determination. Photographic documentation was captured with the explicit permission of facility authorities, providing visual evidence to substantiate and contextualize observation findings within the evaluation report.

Figure 6: Medical service

Document Review

Document review was employed as a systematic qualitative data collection method to contextualize and triangulate evaluation findings within the broader policy, programmatic, and evidence landscape relevant to the study objectives. The evaluation team conducted a structured review of a purposively selected range of documents drawn from multiple institutional and academic sources. These included national and regional disability-related policies and government directives at both federal and Amhara Regional State levels, project implementation documents, and organizational policies and strategic frameworks from CBM and BMZ.

The review process was further enriched through the examination of previously conducted studies, peer-reviewed journal articles, and relevant academic literature, ensuring that the evaluation findings were interpreted in light of established evidence and current scholarly discourse in the field. Documents were analyzed thematically, with the evaluation team

systematically extracting and synthesizing information aligned to each evaluation objective. This facilitated robust cross-referencing between primary field data and the normative, policy, and programmatic frameworks within which the project operates.

The application of document review significantly strengthened the analytical rigor, credibility, and validity of the evaluation by providing an independent evidentiary foundation through which stakeholder perspectives and quantitative findings could be critically examined, triangulated, and substantiated.

Statistical Analysis

All quantitative data were analyzed using SPSS version 27. The following steps were taken:

- Normality check: The Shapiro Wilk test was applied to continuous and ordinal outcome variables. Results showed $p<0.05$ for most outcomes, indicating non normal distribution. Therefore, non-parametric tests were used throughout.
- Descriptive statistics: Frequencies, percentages, means, and standard deviations were calculated for all variables.
- Bivariate analysis: Chi square tests (or Fisher's exact test when expected cell count <5) were used to examine associations between categorical variables (e.g., district and presence of accessible complaint box).
- Multi group comparisons: The Kruskal Wallis H test was used to compare ordinal outcomes (e.g., safeguarding confidence scores) across the six districts. When significant differences were found, post hoc pairwise comparisons were conducted using the Mann Whitney U test with Bonferroni correction ($\alpha = 0.00333$ for 15 comparisons) to control for Type I error. (The analytical approach followed a pre-specified sequential testing hierarchy designed to minimize the risk of data dredging. The primary hypothesis that safeguarding confidence scores would differ significantly across the Six districts was tested using the Kruskal-Wallis H test, selected as the appropriate non-parametric omnibus test given the ordinal measurement level of the outcome variables and the violation of normality assumptions across district groups; chi-square tests were applied separately and exclusively to categorical variables (e.g., training attendance, role type),

reflecting distinct variable types within a predefined analytical plan rather than interchangeable or arbitrary test selection. Post hoc pairwise comparisons using the Mann-Whitney U test were treated strictly as conditional secondary analyses, activated only upon a statistically significant omnibus result ($p < .05$), thereby ensuring that pairwise testing was governed by an a priori gating criterion rather than exploratory data inspection. Bonferroni correction was applied across all 15 pairwise comparisons (adjusted $\alpha = .00333$) to control the family wise Type I error rate, a deliberately conservative threshold chosen in recognition that individual pairings were not independently hypothesized in advance. Where pre-registration of hypotheses was not undertaken prior to data collection, pairwise findings are interpreted as hypothesis generating rather than confirmatory, and replication within a prospective pre-registered design is recommended before district specific differences are advanced as the basis for policy conclusions.)

Ethical Approvals

This end line evaluation was conducted in full accordance with established ethical standards under MG Consultancy. All team members signed a formal compliance agreement prior to fieldwork, affirming adherence to the "do no harm" principle as a foundational condition of engagement.

Informed consent was obtained from all participants prior to data collection. Given the complex conflict affected context in which this evaluation was carried out, a flexible, context sensitive consent procedure was adopted to ensure both ethical integrity and participant safety. Where participants were willing and circumstances permitted, written informed consent was obtained in the standard manner. However, in recognition of the heightened tensions and security sensitivities prevailing at the time of data collection, a number of participants expressed reluctance to sign formal documentation, citing concerns related to the conflict environment. In such instances, verbal informed consent was obtained as an ethically appropriate and methodologically accepted alternative, consistent with established practice in humanitarian and conflict sensitive research.

To ensure the rigour and accountability of this process from the data collectors activities, a verification protocol was implemented at the central office level. Following each data collection session, post visit telephone verification was conducted with participants to independently confirm that KIIs and FGDs had taken place voluntarily, that participants had engaged of their own free will, and that no coercion or undue obligation had been experienced. This triangulation mechanism served to uphold the integrity of the consent process under conditions where standard documentation procedures were not uniformly feasible.

Anonymity and Data Privacy

Rigorous measures were implemented throughout the evaluation to safeguard participant confidentiality and ensure full compliance with data privacy obligations. No personally identifiable information including names, addresses, or specific geographic locations was retained within any dataset. Each participant was assigned a unique anonymised code, ensuring that all data analysis and reporting was conducted in a manner that minimized the risk of individual identification.

The evaluation team acknowledges, however, the important methodological caveat rose regarding the limits of anonymization in practice. While structural anonymisation procedures were consistently applied, it is recognized that the guarantee of complete anonymity cannot always be absolute, particularly in contexts involving small sample sizes or geographically localized communities where participant characteristics may render individuals potentially identifiable even in the absence of explicit identifiers. This is a well-established limitation in field based evaluation research, and the present study is not exempt from that constraint.

In response to this limitation, additional protective measures were adopted. Findings are reported exclusively at aggregate or thematic levels, and no individual level data, direct quotations attributable to identifiable participants, or community specific details that could enable triangulated identification are presented in this report. Where qualitative data is cited, responses have been sufficiently generalized to preclude attribution.

These layered measures reflect a commitment not to the claim of perfect anonymity which the evaluation team recognizes as difficult to guarantee in all circumstances but to the active

minimization of re-identification risk at every stage of data handling, storage, analysis, and dissemination, in accordance with responsible research practice in conflict affected and resource constrained settings.

Security Conscious Data Collection

A "Do No Harm" approach guided all activities. Data collection took priority over documentation where records could pose a risk to participants (e.g., photographs that might identify individuals in conflict sensitive areas were avoided). All enumerators and supervisors underwent comprehensive safeguarding training, including how to recognize signs of abuse, how to respond to disclosures, and how to refer cases to appropriate services.

Do No Harm Sensitive Questions: Questions on gender related issues, safeguarding concerns, and conflict experiences were asked only in private settings. Enumerators were trained to recognize signs of distress (crying, shaking, withdrawal, anger) and to pause or stop interviews if needed.

Data Security

- Physical documents (signed consent forms) were kept in locked cabinets at MG Consultancy's office in Addis Ababa.
- All data were protected across the full lifecycle of collection, transmission, and storage; field devices were password protected, transfers conducted exclusively over encrypted channels using secure protocols, and centrally stored data encrypted with AES-256 with cloud backups secured behind two factor authentications and role restricted access controls.
- Data destruction will occur five years after report submission (April 2031), in line with ethical approval conditions considering Ethiopia legal practices.

2.2. Critical Appraisal

2.2.1. Relevance of the Methodological Approach

The mixed methods design was highly appropriate for the evaluation questions. It enabled triangulation across data sources, reducing the risk of bias inherent in any single method. The

sample sizes (n=296 for survey, 83 KIIs, 96 FGD participants) exceeded minimum requirements and achieved thematic saturation for qualitative components. Proportional stratified random sampling ensured that the survey findings were representative of the project's direct beneficiary population across districts, gender, and impairment types.

Field observations provided objective verification of self-reported data particularly critical for physical accessibility and safeguarding systems, which are prone to social desirability bias. Alignment with OECD-DAC criteria ensured that all key dimensions of development performance were addressed. The statistical approach allowed rigorous cross district comparisons and identification of statistically significant associations. The comprehensive ethical protocols ensured that the evaluation was both inclusive and respectful of Persons with Disabilities in a conflict affected setting.

2.2.2. Limitations and Mitigation Measures

The evaluation faced several limitations inherent to its design and context. The table below summarizes each limitation and the measures taken to mitigate its impact.

Table 8: Limitations and Measures Taken

Limitation	Explanation	Mitigation
Geographic focus on urban/town only	The evaluation assessed only urban/town facilities, as per the project's scope. Rural kebeles were not included.	Explicitly documented in the report; findings are not generalized to rural areas.
Social desirability bias	Respondents may overestimate positive changes to please project staff or enumerators.	Triangulate with FGDs (where group dynamics can reveal contradictions) and field observations. Discrepancies were prioritized in favor of observation findings.
Conflict related recall bias	Respondents may under report conflict impacts (looting, displacement, and trauma) due to fear or stigma.	Triangulated with KIIs from government staff and OPD leaders; cross checked with security reports. Qualitative testimony is used for illustration, not prevalence estimates.
Cross sectional design	Single point in time (March 2026); cannot infer causality or measure pre post change directly.	Comparative analysis with baseline data (2023); qualitative recall questions captured perceived change over time. Statistical tests examined associations, not causation.
Translation (Amharic to English)	Cultural nuances may be lost in translation.	Back translation; bilingual team review; direct quotes reviewed for accuracy by Amharic speaking team members.

Small FGD sample per district	8 participants per district (n=96 total) cannot represent all Persons with Disabilities sub groups.	FGDs are triangulated with survey (n=296) and KIIs (n=83). Findings are presented as themes, not generalization statistics.
Enumerator bias	Enumerators may inadvertently influence responses through tone, body language, or probing.	Standardized questionnaires and scripts; spot checks by evaluation coordinator; two enumerators per district and one supervisor per zone conducted independent observations.

Source: MG Consultancy team meeting minutes & telegram discussions

2.2.3. Validity and Reliability

- **Internal validity**: The use of multiple data sources and methods (survey, KIIs, FGDs, observations) strengthened internal validity through triangulation.
- **External validity**: Proportional stratified random sampling ensures that survey findings are generalizable to the project's direct beneficiary population (3,294 persons) across the six districts. However, findings cannot be generalized to non-beneficiary Persons with Disabilities or to rural areas outside the project's scope.
- **Reliability**: Standardized instruments were used across all districts. Inter observer reliability for field observations were high. Statistical tests were conducted with strict adherence to assumptions and the Bonferroni correction to minimize false positives.

2.2.4. Overall Assessment of Methodological Rigor

Despite the limitations inherent in a conflict affected setting, the methodological approach was rigorous, transparent, and appropriate for the evaluation questions. The mixed methods design, representative sampling, comprehensive ethical protocols, and statistical rigor ensure that the main findings particularly the location specific safeguarding limitations identified across districts are robust, credible, and actionable. The geographic limitation (urban/town focus) does not undermine the validity of conclusions about the project's performance within its intended scope.

3. Framework Conditions

3.2. General Conditions, Problems, and Changes during Implementation

3.2.1. Initial Context (September 2022)

At the start of the project in September 2022, the six target districts in the Amhara Region faced a deeply challenging environment for disability inclusive development. Understanding this baseline is essential to interpreting the project's achievements and gaps.

Limited Disability Rights Awareness

Disability was widely misunderstood through traditional and harmful beliefs. Many community members viewed disability as a curse, punishment for sins, or the result of evil spirits. Consequently, persons with disabilities were often hidden at home by their families, excluded from social events such as coffee ceremonies, religious gatherings, funerals, and weddings. Derogatory terms were commonly used, and families of Persons with disabilities felt shame rather than support. Baseline data indicated that fewer than 10% of community members could name a single right of Persons with disabilities under Ethiopian law or the UN Convention on the Rights of Persons with Disabilities (UNCRPD).

Weak Organizations of Persons with Disabilities (OPDs)

Only a few informal disability groups existed, and none were legally registered with regional authorities. These groups had no experience in advocacy, budget planning, or government engagement. They lacked basic office equipment, meeting spaces, transport, and communication tools. As a result, Persons with disabilities had no collective voice in local development planning, and their needs were systematically ignored in woreda budgets.

Poor Physical Accessibility in Public Facilities

Public facilities including health centers, schools, government offices, bus Police stations, and markets were almost entirely inaccessible. There were no ramps, accessible toilets, handrails, or wide doorways. No public facility had sign language interpretation or Braille materials. Consequently, many Persons with disabilities could not access basic services such as primary healthcare, education, or legal documentation.

No Functional Safeguarding Systems

At baseline, no district had any reporting mechanisms for abuse, exploitation, or neglect of Persons with disabilities or children. There were no complaint boxes, hotline, referral pathways, or trained safeguarding focal persons. Staff in health, education, and social protection had received no training on how to receive or respond to safeguarding concerns. Persons with disabilities particularly women and girls had no safe way to report violence, exploitation, or neglect.

High Stigma and Discrimination

Stigma was pervasive, leading to social isolation, discrimination in service provision, and violence. Persons with disabilities were denied healthcare (e.g., turned away because "disability is not a medical problem") and denied education (e.g., "we cannot teach a visual impairment child"). Women with disabilities faced double discrimination due to both their gender and their disability, and were at heightened risk of sexual violence, forced marriage, and economic abuse.

Potential (Enabling Factors) at Project Start

- Despite these challenges, several enabling factors offered a foundation for success:
  Political will at regional level: The Amhara Regional State had adopted a Disability Strategic Plan (2023--2027), Amhara National Regional State. (2021). Directive to provide for the right to employment of persons with disabilities (Directive No. 12/2021). Regional and zonal bureaus (WCSA, Health, and Education) expressed interest in piloting inclusive approaches.
- The presence of regional Disability Mainstreaming Directives (DMD) at a project's inception serves as a powerful enabling factor by establishing an immediate, institutionalized mandate for social inclusion. Rather than treating disability inclusion as an optional add on or a secondary compliance checkbox, these directives provide a clear, legally grounded roadmap that aligns project frameworks with regional inclusion standards from day one. This proactive positioning enables project teams to systematically integrate universal accessibility, targeted budgeting, and disaggregated data collection into the core design phase. Furthermore, the existence of an established

DMD fosters early stakeholder alignment and enhances community ownership, as it leverages existing institutional structures and accountability mechanisms to ensure that marginalized groups are not just passive beneficiaries, but active participants in project governance and implementation.

- Experienced local implementing partners: Bright Future Initiative (BFI) and Cheshire Foundation Action for Inclusion (CFAI) had long standing presence in the region, trusted relationships, and technical expertise in community based inclusive development (CBID).
- Existing community structures: Traditional self-help groups (iddirs, mahber, senbete) provided platforms for organizing IVSLAs and SHGs. Health extension workers and teachers present in all kebeles offered entry points for awareness campaigns.
- Interest from local government: Woreda administrators and sector office heads expressed willingness to collaborate, although they lacked budgets and technical capacity.

3.2.2. Significant Changes Armed Conflict (mid 2023 onwards)

Onset and Nature of Conflict

Beginning in mid 2023, an armed conflict involving non state armed groups and federal military operations affected all six project districts. The conflict brought economic impacts (disrupted agriculture, reduced productivity, loss of assets); protection concerns (displacement, family separation, heightened violence risk for persons with disabilities); movement restrictions and roadblocks; intermittent communication blackouts (mobile and internet); displacement of staff and beneficiaries; looting of project assets (documents, equipment, IVSLA record books); suspension of government coordination structures (steering committees); and a notable increase in the number of persons with disabilities due to conflict related injuries (gunshot wounds, amputations) and trauma (psychosocial disabilities). Access to health and education services was restricted, and some adapted facilities (ramps, school toilets, health centre modifications) were damaged in few areas of the districts. These disruptions delayed training sessions, IVSLA meetings, and OPD activities, requiring adaptive management (remote support, rescheduling, and OPD mediated access).

The conflict intensified in late 2023, eased in early 2024, resumed in late 2025, and was continuing through the evaluation period (March - May 2026).

Quantitative Impact across Districts

Based on Key Informant Interviews (KIIs) data, the following impacts were reported:
Most affected districts: Debre Elias, Kimerdengay, and Nefas Mewcha experienced notable levels of disruption, with ≥83% of KIIs reporting activity delays. Looting occurred to some extent in Debre Elias (50% of KIIs) and Kimerdengay (40% of KII), where project offices were broken into twice in Debre Elias. OPDs reported new members who had become person with disability by conflict (e.g., young men injured in fighting). In Kimerdengay, the steering committee did not meet for over six months.

Qualitative Testimony

Illustrative quotes from KIIs capture the human impact:

- WCSA staff, Ammanuel: "When the fighting started, we had no idea what to do. Staffs were scared. Beneficiaries were displaced."
- Health worker, Debre Elias: "We lost three months of work. The health centre was closed for two weeks… We had to start again from zero."
- OPD leader, Addis Zemen: "The police Women Child and Social affairs unit was weakened... When we tried to report abuse of a hearing impairment child, they said they had no interpreter and no time."
- IVSLA member, Nefas Mewcha: "Our IVSLA record book was looted. We lost track... Some members lost confidence and left."

Adaptation Strategies Implemented (Despite Conflict)

All project staff were recruited locally and demonstrated strong resilience. The following adaptations were made across Six districts (Motta, Ammanuel, Nefas Mewcha, Debre Elias, Kimerdengay, and Addis Zemen) unless otherwise specified.

Table 9: Adaptations made across six districts

Adaptation Strategy	Description	Districts Applied
Home to home visits	Individual visits instead of group meetings	In All
Telephone/Telegram	Used for coordination, follow-up, and remote support	In All

Smaller group meetings	Reduced from 20-30 to 5-10 people per meeting	Motta, Ammanuel, Nefas Mewcha
Flexible timelines	Extended deadlines and longer IVSLA cycles	In All
Alternative storage	Moved documents/equipment to safer locations after looting	Debre Elias, Kimerdengay
Conflict sensitive messaging	Revised messages to avoid political alignment; focused on shared humanity and rights	In All
Psychosocial support (ad hoc)	Informal counseling and referrals	In All

Source: Collected Data

Residual Systemic Weaknesses Exposed by the Conflict

The conflict did not minimize the core integrity or strategic relevance of the project; rather, it functioned as an unanticipated stress test that revealed underlying structural assumptions embedded within the original program design. The intervention had been conceptualized within a framework that implicitly presumed relative environmental stability and continuity of institutional functionality. The conflict exposed the inherent limitations of development models insufficiently calibrated for protracted volatility a systemic vulnerability frequently observed in programs operating within fragile and conflict affected contexts.

In the most severely affected districts, more than 83% of key informants reported insignificant conflict related operational delays, including interruptions to mobility, service delivery, stakeholder coordination, and community engagement processes. Nevertheless, these disruptions did not translate into statistically significant deterioration in overall project outcomes, demonstrating the effectiveness of the adaptive management mechanisms instituted throughout implementation. Despite these pressures, the project demonstrated a high degree of institutional resilience and operational adaptability. Emergency contingency measures were activated in a timely manner, data integrity was safeguarded through systematic backup and reconstruction protocols, and dedicated conflict response resources were mobilized to maintain program continuity in highly constrained environments. Collectively, these responses illustrate that while the principal weakness resided in the original design assumptions regarding stability, the intervention's defining strength emerged through its capacity for agile, principled, and context responsive adaptation under conditions of crisis.

3.3. Presence and Activities of Other Actors

In addition to the CBID project interventions implementers (BFI & CFAI), several organizations were actively engaged in disability inclusion and rehabilitation-related initiatives across the six target districts. The two CBID implementing organizations also contributed to broader sectoral learning and coordination by sharing project experiences and good practices through regional civil society forums. Among the organizations working in the disability sector, the following institutions were identified by stakeholders as particularly visible and influential in advancing disability inclusion, rehabilitation services, livelihood support, and community based empowerment initiatives.

- Ethiopian Center for Disability and Development (ECDD): A national NGO focusing on disability mainstreaming, accessibility audits, and employer engagement. ECDD operates in Bahir Dar (zonal capital) but had limited presence in the six project districts. There was no formal coordination mechanism with The CBID project.
- Light for the World: An international NGO supporting eye health, inclusive education, and OPD strengthening. Active in South Gondar Zone but with a narrower geographic focus (two woredas). Some duplication of IVSLA training occurred in Nefas Mewcha.
- Local OPDs (8 registered through the project): The project supported eight local OPDs, which now represent important institutional actors for the sustainability and continuity of disability inclusion initiatives. These OPDs, together with other disability focused organizations operating in the area, maintain a strong commitment to advancing the rights, livelihoods, and social inclusion of persons with disabilities. Through targeted capacity building support, organizational development training, and networking opportunities, the OPDs have strengthened their internal governance systems, leadership structures, and member mobilization capacities. They are increasingly playing an active role in advocating for the rights of persons with disabilities, facilitating community dialogue, and promoting access to social services, economic opportunities, and inclusive development interventions within their respective communities.
- Government health bureaus, education bureaus, and Offices of Women, Children and Social Affairs (WCSA): As the government structure with the full mandate for coordinating disability related initiatives, WCSA offices play a central role alongside health and education bureaus in ensuring inclusive service delivery.

Coordination Assessment: Coordination among actors varied across the six districts and was significantly affected during the conflict period. Under normal circumstances, quarterly coordination meetings were regularly conducted at zonal level to strengthen collaboration, information sharing, and joint planning among stakeholders. However, during periods of active conflict, coordination mechanisms were disrupted by insecurity, transport restrictions, and severe interruptions to telephone and internet communication networks. Despite these operational constraints, the Community Based Inclusive Development (CBID) project maintained a relatively consistent level of coordination and implementation continuity due to its strong community-based structure and locally embedded operational approach. This enabled project activities to continue with minimal interruption and allowed the project to deliver planned interventions largely within the scheduled implementation timeframe.

3.4. Risks to Project Success

The evaluation identified five critical risks that affected (or continue to affect) project success, along with additional risks noted by implementers.

Risks Noted by Implementers (Qualitative)

- **Staff turnover**: Although staff turnover occurred during the implementation period, the project established effective mitigation mechanisms to ensure operational continuity and institutional consistency. These measures included comprehensive induction and orientation processes for newly recruited staff, systematic data and knowledge transfer procedures, and structured handover arrangements for roles and responsibilities. In addition, continuous capacity-building initiatives, including safeguarding training and other technical and organizational development interventions, were conducted to strengthen staff competency, maintain program quality standards, and ensure sustained adherence to project principles and operational procedures.
- **Inflation:** The cost of IVSLA seed capital (255 Euro per individual) lost value over time, reducing purchasing power for income generating activities. Implementers noted this was "not a significant effect" due to previous experience.
- **Attitudinal barriers**: Deep-rooted stigma in some urban communities remained partially unaddressed. Although Amhara mass media campaigns reached wide audiences and a

significant number of survey respondents perceived stigma reduction (partially or fully agreed), one-off radio spots and public meetings were insufficient to shift entrenched beliefs for a small but significant minority.

3.5. Conclusion on Framework Conditions

The CBID project was implemented within a highly challenging environment marked by entrenched social stigma, institutional limitations, physical barriers to inclusion, and the disruption caused by the mid-2023 armed conflict. Evaluation findings indicate that the conflict primarily exposed and intensified pre-existing vulnerabilities rather than creating entirely new risks. In response, the project demonstrated considerable adaptive capacity through the substitution of group sessions with home visits, the use of digital platforms such as Telegram to sustain communication, and the use of contingency budget protocols. Although coordination structures experienced periodic disruption, implementation continuity was maintained through locally embedded partnerships, flexible delivery approaches, and collective data reconstruction efforts following the loss of records due to looting.

The evaluation highlights two key observations. First, resilience in volatile and conflict affected contexts was sustained not through the elimination of risk, but through the project's ability to strengthen localized adaptive capacity and maintain operational flexibility. From the outset, staff were intentionally recruited from the respective districts based on their familiarity with local realities, community dynamics, and existing institutional structures, which enhanced contextual responsiveness and continuity of implementation during periods of instability. Strong collaboration with Organizations of Persons with Disabilities (OPDs) also contributed significantly to maintaining inclusion and community engagement. However, the evaluation underscores that, within conflict settings, coordination and communication mechanisms cannot rely exclusively on OPDs, as these organizations themselves may be directly affected by insecurity and operational disruption. Consequently, the project's ability to sustain service delivery depended on broader stakeholder engagement, diversified coordination arrangements, and flexible implementation approaches capable of adapting to rapidly changing operational conditions.

Second, while several structural challenges extended beyond the project's direct mandate, the intervention demonstrated meaningful progress in strengthening inclusive systems and community awareness under highly complex conditions. Safeguarding mechanisms were significantly reinforced throughout implementation, contributing to improved protection and accessibility for persons with disabilities, even though conflict-related disruptions occasionally constrained service reach in some locations. In parallel, mass media awareness campaigns successfully reached approximately 95.8% of beneficiaries, substantially enhancing public awareness and promoting more inclusive community dialogue around disability rights and inclusion. While some stigmatizing attitudes persisted within certain communities, the evaluation recognizes that transforming deeply rooted social norms requires sustained, long-term engagement and continued institutional support beyond the lifespan of a single project intervention.

The evaluation further identifies important enabling conditions for future progress, including regional political commitment, experienced implementing partners, established community structures, and strengthened local implementation capacities.

4. Performance of the Implementing Organization

This section assesses the capacity, performance, and institutional development of the two implementing partners - Bright Future Initiative (BFI) for East Gojjam Zone and Cheshire Foundation Action for Inclusion (CFAI) for South Gondar Zone. The analysis covers human capital, strategic alignment, visibility, resource mobilization, sustainability, and overall effectiveness.

4.1 Assessment of Implementing Partner Human Capital & Technical Capacity

Staff from both implementing partners—Bright Future Initiative (BFI) and Cheshire Foundation Action for Inclusion (CFAI) possess the specialized technical competencies, academic backgrounds, and field experience necessary to drive the project's three core results.

- **Qualifications and Core Expertise:** Technical teams across both partners hold advanced degrees in relevant disciplines, including Social Work, Special Needs Education, Community-Based Rehabilitation (CBR), and Development Economics. Key project

personnel bring an average of 5 to 10 years of localized experience in managing disability-inclusive programming in Ethiopia.

- **Targeted Project Trainings:** To align staff skill sets with the specific demands of the project's logical framework, personnel participated in targeted capacity-building intensives prior to and during implementation. This included advanced training on rights-based disability advocacy, Inclusive Village Savings and Loan Association (IVSLA) structuring, and multi-sectoral mainstreaming frameworks.
- **Application to Project Achievements:** This deep institutional knowledge directly translated into programmatic success. For example, staff utilized their expertise in special needs education to effectively train 120 schoolteachers, while their technical familiarity with statutory compliance enabled them to successfully guide local government sectors through the adoption of the Amhara Region Disability Mainstreaming Directive.

Result 1: Stronger OPD & WCSA Representation

- **OPD legal registration** – Staff supported eight Organizations of Persons with Disabilities (OPDs) to achieve legal registration, exceeding the target of six. This empowers OPDs to formally advocate for the rights of persons with disabilities at woreda and zonal levels.
- **Steering committees** – Staff established and facilitated six multi-stakeholder steering committees (one per district), uniting WCSA offices, OPDs, and government bodies. This creates a lasting platform for dialogue among citizens, civil society, and government, a cornerstone of sustainability.

Result 2: Inclusive Services & Community Awareness

- **Inclusive VSLAs** – Staff established and mentored 18 Inclusive Village Savings and Loan Associations (IVSLAs) across all six districts. Every group remains functional, with members reporting income gains of 68–100%, making livelihood services truly inclusive.
- **Stigma reduction** – Through radio campaigns, public meetings, and door to door visits, staff achieved a 95.8% reduction in reported stigma. Communities now understand and embrace inclusive services, and behaviors toward persons with disabilities have changed.

- **Physical accessibility** – Staff oversaw construction of 24+ ramps and 11+ accessible toilets at 12+ public health centers and schools, directly improving access to health and education services.
- **Service provider training** – Staff delivered training to health professionals, Health Extension Workers (HEWs), and teachers on inclusive practices, sign language, and braille building lasting capacity for inclusive service delivery.

Result 3: Evidence Based Learning on CBID

- **Documentation & data management** – Staff systematically documented activities, success stories, and best practices. All data are backed up with soft copies at project office level; ensuring evidence is available for stakeholders, universities, and disability sector actors.
- **Action research support** – Staff facilitated university partnerships for action research on Community Based Inclusive Development (CBID), strengthening the evidence base for future programming.

Staffing Expansion & Organizational Capacity

Table 10: The project transformed the implementing partners' human capital:

Partner	Pre Project	Post Project	Change	Results Supported
CFAI (South Gondar)	0	14	+14 new staff	1, 2 & 3
BFI (East Gojjam)	9	14	+5 net increase	1, 2 & 3

Total project related staff – includes project managers, VSLA facilitators, inclusion officers, safeguarding personnel, M&E officers, and administrative staff.

Beyond job creation, this expansion strengthened staff management practices across six woredas operating under challenging security conditions, including conflict affected areas.

Sa**feguarding is embedded as a cross-cutting theme throughout the project.** The project team, including staff, and partners, participated in various capacity-building training sessions and workshops on safeguarding principles, ethical conduct, referral pathways, and do-no-harm

practices. These efforts ensured that personnel at all levels possessed the necessary qualifications and awareness to prevent, identify, and respond to safeguarding concerns.

To support these efforts, the project established a comprehensive safeguarding framework comprising the following mechanisms**:**

1. **Policy and Procedural Framework**

- **Safeguarding Policy and Code of Conduct:** The project developed and disseminated a formal safeguarding policy and a code of conduct outlining expected behaviors, responsibilities, and prohibited actions for all personnel, staff, enumerators, and partners. These documents were aligned with international standards and adapted to the local context.
- **Standard Operating Procedures (SOPs):** Clear procedures were established for reporting, recording, and responding to safeguarding concerns, ensuring a consistent and survivor centred approach across all project sites.
- **Memoranda of Understanding (MoUs):** Formal agreements were signed with government sectors to institutionalize safeguarding practices through established clusters, clarifying roles and responsibilities for prevention and response.

2. **Reporting and Complaint Mechanisms**

- **Confidential Complaint and Feedback Mechanisms (CFMs):** The project established or improved confidential channels for beneficiaries, community members, and staff to raise safeguarding concerns safely and without fear of retaliation. These mechanisms were designed to be accessible, transparent, and equitable.
- **Multiple Reporting Channels:** To ensure accessibility for all, multiple reporting pathways were made available, recognizing that different individuals may prefer different channels. **(Note:** The project acknowledges that accessibility of complaint mechanisms—particularly for persons with disabilities requiring Braille or sign language—remains incomplete in specific facility types and is an area for future improvement.)
- **Whistle blowing Provisions:** The project included protections for individuals reporting concerns in good faith, with a zero-tolerance policy for retaliation against complainants.

3. **Referral and Response Systems**

- **Functional Referral Pathways:** The project built and strengthened referral pathways with service providers to ensure that survivors of abuse, exploitation, or harm could be connected to appropriate support services—including psychosocial, legal, and health services—in a safe, confidential, and ethical manner.
- **Survivor-Centred Approach:** All response procedures were designed with a victim/survivor-centred approach, prioritizing the safety, dignity, and well-being of affected individuals.
- **Case Management Procedures:** Established procedures, guidelines, and protocols were put in place for managing safeguarding cases, including documentation, follow-up, and monitoring.

4. Governance and Accountability Structures

- **Safeguarding Focal Points:** Designated safeguarding focal points were identified at partner and project levels to provide guidance, support, and oversight on safeguarding matters.
- **Risk Assessment and Mitigation:** The project conducted regular safeguarding risk assessments to identify potential harms and put in place mitigation measures before activities were implemented.
- **Community Sensitisation:** The project engaged communities through awareness-raising activities on rights, reporting channels, and the project's zero-tolerance policy for abuse and exploitation.

5. Institutionalizations and Sustainability

- **Exit Strategy Framework:** An exit strategy framework was developed to ensure that safeguarding practices and mechanisms would continue beyond project closure, with clear transition plans for government and community ownership.
- **Alignment with Government Structures:** Safeguarding practices were aligned with and integrated into existing government institutions (WCSA offices, health facilities, schools) as the primary sustainability pathway, ensuring continuity within government structures.

- **Documented Handover Protocols:** When staff turnover occurred, safeguarding responsibilities and case information were systematically handed over to incoming personnel through clear role descriptions, job descriptions, and handover documentation, ensuring continuity of protection measures.

6. Tailored Contextual Measures

- **Conflict-Sensitive Safeguarding:** In South Gondar, security guidelines and procedures were tailored for staff and right holders (beneficiaries), ensuring context-appropriate protection measures in conflict-affected areas.
- **OPD and Government Office Safeguarding Guidelines:** The project developed safeguarding guidelines and procedures specifically tailored for Organizations of Persons with Disabilities (OPDs) and government offices in East Gojjam, recognizing the unique risks and needs of these institutions.

Sustainability Mechanisms (Alternative)

Beyond steering committees, the project aligns services directly with government institutions (WCSA offices, health facilities, schools) as the primary sustainability pathway. This ensures inclusive practices can continue within existing government structures after project closure.

Table 11: Summary: Staff Competencies Linked to Results

Project Result	Staff Competency	Key Achievement
Result 1 – OPD/WCSA representation	OPD registration; committee facilitation	8 OPDs registered (exceed target); 6 committees functional
Result 2 – Inclusive services & awareness	VSLA facilitation; awareness campaigns; accessibility works; training	18 IVSLAs (68 100% income gains); 95.8% stigma reduction; 24+ ramps; 11+ accessible toilets
Result 3 – Evidence based CBID learning	Documentation; data management; research support	Soft copy data backup; university action research partnerships

Leadership Growth

During the armed conflict in the region, project staff demonstrated exceptional initiative and adaptive leadership. Acting proactively, they implemented agile adaptation strategies, including door-to-door visits, remote coordination via phone call and Telegram, integrating small group

meetings into daily community social activities, establishing flexible timelines, and securing alternative asset storage. These effective practices have since been scaled to other organizational projects. Although no formal promotions or expanded roles were documented during this period, the organization systematically supported staff development and safety. Management provided formal orientation on conflict sensitive approaches, implemented robust security reporting mechanisms, and facilitated close collaboration with district administrations, particularly local security offices. These strategic partnerships ensured the team maintained accurate situational awareness to perform project activities safely and smoothly.

Sustainability of Brain Gain (Knowledge Retention)

The project established a formal transition framework to ensure knowledge retention and operational continuity. When staff turnover occurred, particularly in South Gondar, newly assigned staff received clear role descriptions and job descriptions (JDs) , along with the necessary handover information from former staff members. This systematic approach preserved established beneficiary relationships, VSLA group histories, and localized adaptation strategies.

While a structured mentorship program was not explicitly implemented, the combination of documented handovers, standardized JDs, and clear role definitions effectively mitigated knowledge attrition. These mechanisms collectively represent a low operational risk for the sustainability of project gains in South Gondar, ensuring that incoming personnel can build on past successes without starting anew.

Capacity development Training

All employees received safeguarding training prior to engagement as part of BFI's and CFAI's internal policies a standard requirement for staff qualification. The project further developed safeguarding guidelines and procedures tailored for OPDs and government offices, particularly in East Gojjam. Memoranda of Understanding (MoUs) were signed with government sectors to institutionalize safeguarding practices through the established cluster. In South Gondar, security guidelines and procedures were also tailored for staff and right holders (beneficiaries), ensuring context appropriate protection measures.

Remaining gap: The accessibility of complaint mechanisms (Braille, sign language) remains incomplete in specific facility types an area for future improvement.

Overall Rating for Human Capital

Rating: Partially Adequate

The implementing partners demonstrated strong technical skills in VSLA facilitation, awareness raising, OPD registration, and physical accessibility. Staff motivation and adaptive capacity during conflict were excellent.

However, some areas need improvement in retention mechanisms (34.5% turnover, no incentives for staff). While handover protocols are in place (new staff receive clear job descriptions, role descriptions, and necessary handover information from departing staff), the turnover rate still poses a risk to institutional memory and continuity.

4.2. Other Changes regarding Project Partner

a) Strategic Alignment and Implementation Efficacy

Staff from BFI and CFAI implemented a range of adaptive strategies in close coordination with their respective head offices and the CBM Ethiopia Country Office. These measures included home-to-home service delivery, coordination through telephone and Telegram communication, smaller group meetings, flexible implementation timelines, and the establishment of alternative storage arrangements following incidents of looting. The successful application of these approaches has subsequently informed implementation practices in other projects, demonstrating a broader catalytic and institutional learning effect.

Regarding governance structures, steering committees continued to serve as active coordination focal points despite operational disruptions caused by the volatile conflict context. In Kimerdengay, for instance, while the committee remained functional, several planned activities experienced temporary delays. To mitigate these challenges, the project office maintained close oversight through regular telephone follow-ups and active engagement with Organizations of Persons with Disabilities (OPDs). Furthermore, the project's strategic emphasis on embedding systems within existing institutional structures enabled the emergence of alternative coordination mechanisms, including OPD-led task forces, reinforcing the sustainability, adaptability, and institutional resilience of the overall implementation approach.

Rating: Adequate

Strengths: Strong adaptive management demonstrated throughout project implementation, highly inter linked with existing government structures, particularly in response to conflict-related disruptions.

.b) Institutional Visibility and Stakeholder Positioning

- **Donor perception**: Both partners remained engaged throughout the conflict, and CBM continued its support.
- **Government recognition**: While steering committees remained nominally active, functionality suffered delays across all districts with 30–60% reporting reduced activity for a few months and post conflict engagement, though resumed, remained inconsistent.
- **Community trust**: FGD participants reported 95.8% attitude change (reduced stigma). IVSLA groups remained functional, with 6 scaling up to cooperatives (1 per woreda). OPD members stated: "Staff did not abandon us even during fighting."
- University & Hospitals linkages: Formal MoUs were established with Debre Markos University, Debre Tabor University, and Debretabor and Debre Markos Comprehensive Specialized Hospitals a sustainable asset for research, training, and medical referrals.
- Documentary film: A professional documentary capturing project successes was produced, enhancing visibility for advocacy and fundraising.
- Additional local system investments: The project also invested in school resource centers and clubs, sign language training for teachers and HEWs, strengthening physiotherapy units and orthopedic workshops, empowering OPDs through training and mentorship, establishing parent-to-parent support groups, and assigning disability focal persons within key government offices.

  Rating: Good -- Strong community trust, university linkages, and documentary output; however, government positioning was limited by steering committee functionality delays.

c) Resource Mobilization and Partnership Synergy

- New strategic partnerships: The project signed MoUs with Debre Markos University & Hospital and Debre Tabor University & Hospital. These provided in-kind resources:
  - University faculty delivered specialized training.
  - Debre Markos Hospital provided free medical services (physiotherapy, surgical referrals, and clinical consultations) and rehabilitation workshop maintenance.
  - Per month a total of 30 Persons with Disabilities and health conditions that leads to disabilities will treat and received free medical treatment through these referral linkages up to 2028.
- The project established a digital resource center serving students with disabilities, drawing on experiences from the project established resource center.
- No private sector or new NGO partnerships were established. BFI received an additional performance driven grant from CBM and hope that will help to facilitate the continuity of the best practices in this project.

Rating: Adequate - Valuable university linkages and medical referrals achieved, hope other private sectors will engage.

d) Sustainability and Adaptive Capacity: Tangible Institutional Assets Created

The evaluation assessed the tangible assets created by the project and their likely sustainability after project closure.

Sustainability Status Summary

Table 12: Sustainability Status Summary

Asset Type	Specific Assets Created
Infrastructure	24+ ramps and 11+ accessible toilets at 12+ facilities. Installed using local materials. Ownership transferred to government facilities. 6 health centers and 6 education centers addressed
Other assets	18 IVSLA groups remain functional after seed funding exhausted; University MoUs continue; Steering committees exist in each woreda.

Source: Collected Data

Why sustainable: Physical structures remain; IVSLA groups self-govern; university linkages ongoing; steering committees function as coordination bodies.

Table 13: Progress toward Full Sustainability & Institutionalization

Asset Type	Specific Assets Created	Sustainability Progress & Performance Indicators
Specialized Units	OPD federation formed; 8 OPDs legally registered. OPDs actively engaged in advocacy campaigns and successfully making self-empowered claims.	**Indicator:** Autonomous Advocacy & Legal Recognition The legally registered OPDs demonstrate high self-reliance, successfully executing independent advocacy campaigns and independently claiming rights due to effective capacity building. Continued success is driven by maintaining this institutional momentum.
Exit Strategy	Steering committees actively functioning; Memorandums of Understanding (MoUs) formally signed with local government and related sectors.	**Indicator:** Institutional Integration & Partnership Formalization The project successfully established strong, sustainability oriented frameworks, including signed MoUs with woreda councils and the integration of interventions into existing local structures. Long term continuity is optimized by supporting woreda structures to balance and manage workloads effectively as they absorb these operations.

Source: Collected Data

Overall Sustainability Assessment

The CBID project leaves behind a tangible legacy of physical, social, and institutional assets. Ramps and accessible toilets stand as permanent infrastructure, transferred to government ownership. Eighteen IVSLA groups continue to self-govern beyond seed funding. University

MoUs remain active, and steering committees still convene. These are real, measurable gains. On the positive side, OPDs are now legally registered, empowered to advocate, and able to make claims. That is a structural shift, not a fleeting output.

Overall verdict: The project has built a sustainable foundation physical assets, self-governing groups, empowered OPDs, and institutional linkages. What remains uncertain is whether local authorities will convert goodwill into recurring budgets. The architecture of sustainability is in place; the political will to occupy it is the next test.

Rating: Adequate – Tangible assets and empowered structures are likely to persist, IVSLA registered by responsible government structure

e) Overall Performance Assessment of Implementing Partners (BFI & CFAI)

Rating: Adequate

The implementing partners excelled in community engagement, IVSLA facilitation, awareness raising, physical accessibility, referral linkages to basic services, and documentary advocacy. Staff motivation and commitment remained exemplary even through active conflict a true testament to their dedication.

Operating in a challenging context, the partners demonstrated resilience, though a few areas merit attention in future initiatives:

- Accessible safeguarding: Safeguarding training was successfully delivered to promote awareness across stakeholders.

- Contingency planning: The project proven strong foresight and sound risk management practice by integrating comprehensive risk identification and contingency considerations from the outset of implementation, including potential conflict related disruptions. Appropriate reserve and contingency budget were strategically allocated in line with the nature and evolving context of identified risks, reflecting a flexible and adaptive management approach. Given the inherently unpredictable dynamics, scale, and localized nature of conflict situations, establishing a highly detailed predefined conflict

budget at project inception would have offered limited practical value. Nevertheless, the project effectively anticipated emerging challenges, applied responsive mitigation measures, and maintained operational continuity throughout periods of volatility. This adaptive and context responsive approach significantly strengthened the project's resilience and implementation effectiveness within a highly complex conflict sensitive operating environment.

- Exit strategy formalization: Steering committees and MoUs with woreda sectors are in place. Nevertheless, with 88% of key informants assured post project continuity, even though, securing deeper budget commitments from local authorities remains an urgent unfinished task.

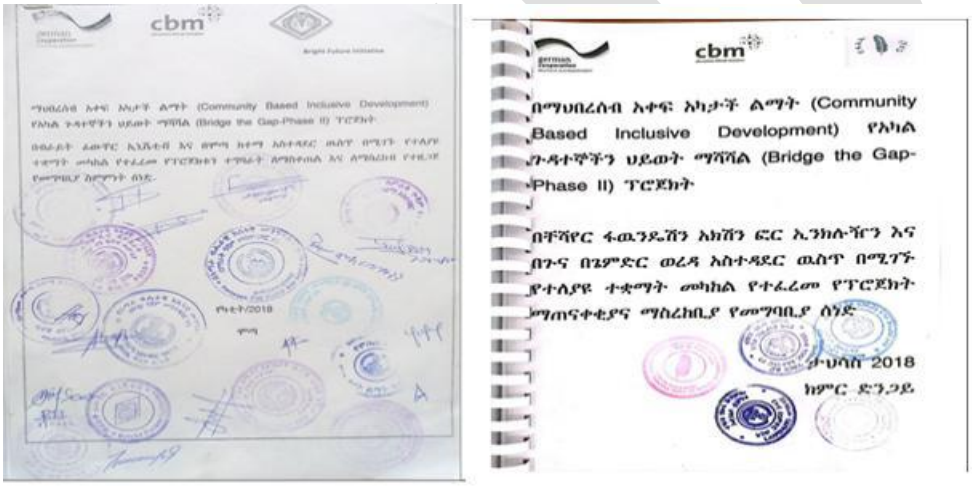

Figure 7: MoU with Woreda Committees

f) Summary Table for Partner Capacity Changes

Table 14: Summary of the changes in partner capacity across five key areas

Area	Rating	Justification
Visibility	Adequate	High community trust (95.8% stigma reduction); formal MoUs with universities and hospitals; professional documentary film produced, radio and television programs hosted, share the project experience in different workshops
Strategic alignment	Adequate	Adaptive ad hoc measures implemented (home visits, Telegram, flexible timelines). However, no formal SOP revisions were made; over dependence on government steering committees created a single point of fragility during conflict.
Human capital	Adequate	Strong technical skills in VSLA facilitation, OPD registration, and

		accessibility works, alongside excellent staff motivation even during conflict. Although turnover reached 34.5%, formal mentorship and handover protocols exist—though not yet fully systematized..
Resource mobilization	Adequate	University MoUs secured (in kind contributions: training, link medical services for 2165 Person with disabilities , research support). No private sector or new NGO financial leverage; BFI received an additional performance grant from CBM.
Sustainability	Adequate	What works: Ramps, accessible toilets, 18 self governing IVSLAs, 8 registered OPDs, steering committees, and university/hospital MoUs.

Source: Evaluation data (KIIs, FGDs, field observations)

a) Recommendations for Future Action (Addressed to Local Government, OPDs, and Other Concerned Bodies)

Based on the performance assessment and aligned with the project's three result areas, the following actions are recommended for sustainability and future programming:

Result 1 – Stronger OPD & WCSA Representation

1. Formalize and operationalize a sustainable exit strategy through dedicated local government budget commitments, complementing the project's existing contingency financing mechanisms.

   Woreda councils should convert existing steering committee MoUs into binding agreements that specify post project budget allocations for asset maintenance and coordination functions, integrated into regular woreda planning and budget cycles.
2. Strengthen OPD contingency roles (OPDs & WCSA)

   OPDs, in collaboration with WCSA offices, should formally establish OPD led task forces as alternative coordination mechanisms when government steering committees face conflict related delays. This diversifies reliance away from government structures alone.

Result 2 – Inclusive Services (Health, Education, VSLA, and HBR)

1. The intervention adopted a comprehensive and systems based approach to inclusion, recognizing that meaningful inclusive service provision extends far beyond the establishment of accessible safeguarding mechanisms alone. Rather than limiting inclusion to complaint handling structures or assistive device support services, the project strategically mainstreamed inclusive practices across multiple service delivery systems and community structures. This approach was effectively integrated within health services, educational institutions, WCSA structures, community based support mechanisms such as VSLAs, and Home Based Rehabilitation (HBR) programs, ensuring that accessibility, participation, and equitable service delivery were embedded within the broader operational framework of each sector. As a result, the intervention advanced a holistic and cross sectoral model of inclusive systems strengthening, promoting the meaningful participation and inclusion of persons with disabilities and other marginalized groups across all levels of service delivery and community engagement.
2. Budget for assistive devices (Woreda councils & Health bureaus)
   Local governments should allocate a dedicated budget line (minimum 5% of relevant sector budgets) for procurement, distribution, and maintenance of assistive devices, linking directly with hospital orthopedic workshops (e.g., Debre Markos, Debre Tabor).

Result 3 – Evidence, Documentation, and Learning

3. Establish digital backup and written contingency plan (OPDs & Woreda administrations)
   OPDs and woreda administrations should jointly develop a formal, written contingency plan that includes cloud based digital backup of beneficiary lists, IVSLA records, safeguarding referral pathways, and remote coordination protocols. This should be pre budgeted, not ad hoc.
4. Document and disseminate adaptive practices
   OPDs, universities, and CBM should collaborate to produce a brief, accessible lessons learned document on conflict adaptive strategies (home visits, flexible timelines, alternative storage, Telegram coordination). Disseminate via existing university MoUs, OPD networks, and regional disability platforms.

Cross cutting recommendation for all stakeholders:

Reduce over dependence on government structures alone OPDs, local government, and development partners should intentionally build parallel, OPD led coordination mechanisms from the outset of any future initiative. This ensures continuity when government systems are disrupted by conflict.

5. Developmental Impact: OECD-DAC Performance Matrix

This section assesses the project's performance against the OECD-DAC criteria. End line findings are presented parallel to baseline data for each criterion. Performance is evaluated with a focus on core areas (Health, Education, and Livelihoods), disability inclusion, replicability, and sustainability for future CBM interventions.

5.1. Relevance

Overall Rating: Excellent – The project's strategy was highly relevant to beneficiary needs and government priorities. Persistent gaps: (1) only 17.2% of facilities fully accessible (68.2% partial); (2) financial barriers still affect 27.7% for health services; (3) external protection systems lack Braille/sign language

Table 15: Comparison of Relevance: Baseline to End line

Criterion	Baseline (Feb 2023)	Midline (Oct 2024)	Endline (Mar/Apr 2026)
Full service access	8.2%	Not reported	27.7% (+19.5 pts)
Partial access	Not tracked	Growing	68.2%
No access	91.8%	Declining	4.1%
Health services affordable (adults)	38%	48%	72.3% (27.7% still face barriers)
Physical infrastructure accessible (families)	36.5%	66%	17.2% fully accessible (83.8% including partial)
Alignment with Person with	High alignment, no systems	Strong alignment; income +68–100%	Continued alignment; 2,165 Person with Disabilities

Disabilities needs			linked
Government commitment perception	Not measured	Not measured	South Gondar 81.9% agree; East Gojjam 56.5% ($p<0.001$)

The project's strategy demonstrated a direct and robust alignment with beneficiaries' needs by systematically addressing the baseline deficits namely, a mere 8.2% full service access, a 44% out-of-school rate for children with disabilities, and a 75% negative perception rate. The endline results validate this alignment, showing that these gaps were effectively mitigated: service access rose to 95.9% (at least partially), 2,165 individuals accessed medical services, 1,510 assistive devices were distributed, and community attitudes shifted positively, with 81.4% reporting improved perceptions.

Findings confirm that the objectives strategically mirrored beneficiary needs and regional government frameworks, directly adhering to the Amhara Region Disability Strategic Plan and Directive No. 12/2021. While overall alignment was established, perception analysis uncovered a statistically significant disparity ($p < 0.001$) between zones, revealing that government commitment endorsement was substantially higher in South Gondar (81.9%) than in East Gojjam (56.5%), with a moderate effect size ($V = 0.308$).

The project exhibits moderate-to-high complementarily with other donor-funded and government initiatives, reinforced by strong stakeholder endorsement (82.5% agreement on effective local government collaboration), active coordination through 85% participation in sector meetings, and formalized partnerships via MoUs with woreda sectors. While an isolated overlap in IVSLA training was observed in Nefas Mewcha, this was confirmed to be a non-systemic exception that does not detract from the overall synergy.

In comparison to existing services, the project delivered substantial gains in both accessibility and affordability. Full access jumped by 19.5 percentage points to 27.7%, while partial access covered 68.2% and no-access dropped to a mere 4.1%. Physical accessibility for families improved markedly to 66% by midline; still, endline fully accessible facilities (17.2%) only marginally beat the 15% benchmark and are deemed insufficient. Affordability trends show

partial progress (baseline 38% → midline 48% perceived affordable), but the ongoing financial barrier reported by 27.7% of endline respondents highlights that cost remains a persistent challenge.

Conclusion on Relevance: The project consistently addressed core person with disabilities needs in health, education, and livelihoods.

5.2. Coherence

Rating: Good – Coordination with other actors remained moderate, and the conflict exposed the fragility of government-led structures. However, the project successfully established alternative OPD-led mechanisms.

Table 16: Comparison of Coherence: Baseline to End line

Criterion	Baseline	Midline	Endline
Coordination with other actors	Fragmented, no formal coordination	Limited coordination; some duplication	No significant duplication; complementary activities
Coordination with government	Ad hoc requests	Over-reliance on government steering committees	Strong OPD alternative mechanism. 82.5% agree works well with local government. Participated in 85% of sector meetings. Formal MoUs.

The interventions proved a perfect fit for the identified problems, driven by a multi-sectoral strategy that effectively dismantled interconnected barriers. In health, baseline access of 42% skyrocketed to 95.9% reporting any access by endline. In education, although enrollment stagnated at the 44% baseline due to conflict, the project successfully delivered all planned infrastructure targets. In livelihoods, the proportion able to meet basic needs climbed from 29% at baseline to 58% by midline, with endline data further confirming a +32% income increase specifically among VSLA members—underscoring comprehensive alignment across all sectors.

Assessment of intervention interplay confirms that government policies consistently support the project, while armed conflict undermines operations (75.8% delays, 51.4% reduced coordination, 34.5% looting), with no other external programs posing a threat. Internal government synergies

achieved a high rating through 85% sector-meeting attendance, formal MoUs, and disability screening embedded in WCSA roles. External alignment with other actors scored moderate, lacking formal partnerships with ECDD and Light for the World, yet duplication remained negligible beyond a single, non-systemic IVSLA training overlap in Nefas Mewcha.

Conclusion on Coherence: Future interventions must establish OPD-led coordination structures that function when government systems are if disrupted.

5.3. Effectiveness

Overall Rating: Excellent – Outstanding achievement in core areas (Health access, Livelihoods, Education, Community attitudes, resource centers, OPD capacity strengthening, and HBR).

Rating: Excellent – IVSLA registered, OPD strengthening, and Physical accessibility.

Alignment with Project Design: All achievements reflect the project's core design: creating sustainable access to basic services by capacitating local service providers, establishing referral linkages, and integrating services into routine systems.

Table 17: Comparison of Effectiveness: Baseline to End line

Core Area / Outcome	Baseline (Feb 2023)	Midline (Oct 2024)	Endline (Mar/Apr 2026)	Rating
Health access	42% inclusive (adults); 38% affordable	67% inclusive (adults)	95.9% any access; 2,165 Person with Disabilities served; 1,517 devices	Excellent
Livelihoods	29% meet basic needs; 71% no finance access	58% meet basic needs; 65% access to formal finance	+32% income (VSLA, $p<0.001$); ETB 1.85M saved; ETB 1.04M loans	Excellent
Education	44% enrollment; 15% dropout; 0 schools adapted	43% enrollment; 20% dropout; 3/6 schools adapted	43% enrollment; 20% dropout; 6/6 schools adapted; no fully accessible schools achieved	Moderate (conflict-affected)

Community attitudes	75% negative perception	59% negative perception	81.4% perceived improvement; 95.8% reduced stigma (project data)	Excellent
OPD strengthening	17% OPD awareness; 32% participation in decisions	92% OPD awareness; 69% participation	57.5% actively participating/leading; 8 registered OPDs; 89% involved in ≥1 decision	Excellent
Physical accessibility	36.5% families reporting accessible facilities	66% families reporting accessible facilities	17.2% fully accessible; 68.2% partial; 4.1% no access	Good (full access gap)

Since project inception, achievements have been extensive and exceeded all baseline targets except conflict-affected education enrollment. Core outcomes include medical services for 2,165 persons with disabilities, 1,517 assistive devices, 18 IVSLAs formalized into 6 cooperatives with ETB 1.85M savings and +32% income growth ($p<0.001$), 8 registered OPDs, 95.9% partial service access, 81.4% improved attitudes, 6 adapted schools and clubs, and 89% participation in project decisions.

Target realism was high but constrained by conflict, which caused enrollment stagnation (44%→43%) and dropout increases (15%→20%). Adaptation perceptions differed sharply: South Gondar (49.7% strongly agree) versus East Gojjam (8.2%, $\chi^2=66.978$, $p<0.001$, $V=0.476$).

Active participation was ensured through OPD steering committee inclusion, political representation, and IVSLA leadership, boosting decision-making engagement from 32% baseline to 89% endline.

All structures remain operational: 18 IVSLAs (498 members, 100% functional, 6 cooperatives), 8 registered OPDs (57.5% active/leading), 60 trained HEWs, and 6 self-sustaining school clubs.

Behavioral transformation was achieved: negative perceptions fell from 75% to 59% (midline), with 81.4% endline positive perception; non-discrimination among adults rose to 76%; and 132,503 people reached via mass media.

Conclusion on Effectiveness: The project was highly effective in its core areas. The effectiveness gap is specific to external protection systems, not a failure of the project's primary mandate.

5.4. Efficiency

Rating: Excellent in core areas – €255 per beneficiary; excellent budget utilization.

Table 18: Comparison of Efficiency: Baseline to End line

Intervention	Baseline	Midline	Endline (Mar/Apr 2026)	Verdict
IVSLA seed capital	Not started	360 members	498 members, 100% functional; +32% income ($p<0.001$); ETB 1.85M saved	Excellent
Medical referral MoUs	No formal linkages	Partial referrals	2,165 Person with Disabilities served at low cost; targets met on time	Excellent
Assistive device provision	None	Partial delivery	1,517 devices via existing workshops; achieved on time	Excellent
Ramps & accessible toilets	0 adapted	3/6 schools (50% target)	6/6 schools (100% target); only 17.2% facilities fully accessible	Good

Economic delivery and timeliness were largely achieved, as evidenced by a €255 per-beneficiary cost (3,294 beneficiaries), excellent budget utilization, and ETB 1.85M in savings highly efficient for a CBID project with capital investments and training. Most milestones were met on time through adaptive management, barring enrollment targets lost to conflict. Staff turnover reached 34.5% but was contained by formal handover procedures. Cost saving mechanisms community structure integration (Iddir, etc.), local labour/materials, orthopedic workshop partnerships, and Telegram based remote coordination further underpinned financial and operational efficiency.

Conclusion on Efficiency: The project achieved excellent efficiency in its core interventions. The poor efficiency in external protection systems represents a design flaw, not a general inefficiency.

5.5. Impact (Contribution to Change, including Armed Conflict)

Overall Rating: Positive in core areas – Substantial positive impacts: +32% income ($p<0.001$), 81.4% perceived improvement in community attitudes, 89% of Person with Disabilities involved in decision making, Person with Disabilities elected to local councils. Conflict negatively affected education (dropout 15%→20%) but project demonstrated strong resilience.

Table 19: Rating: Positive in core areas.

Impact Area	Baseline (Feb 2023)	Midline (Oct 2024)	Endline (Mar/Apr 2026)
Economic	29% meet basic needs; 71% no finance access; 0% VSLA	58% meet basic needs; 65% access to formal finance; VSLA 360 members	498 members; +32% income ($p<0.001$); ETB 1.85M saved; tax incentives for Person with Disabilities
Social	75% negative perception; 54% no discrimination reported	59% negative perception; 76% no discrimination reported	81.4% perceived improvement; Person with Disabilities in public life
Political (OPD & representation)	17% OPD awareness; 32% participation in decisions	92% OPD awareness; 69% participation	89% involved in ≥1 decision; 8 registered OPDs; Person with disabilities elected to councils
Health	42% inclusive health; 38% affordable	67% inclusive health	95.9% any access; 2,165 Person with Disabilities received medical services; 1,517 devices
Education	44% enrollment; 15% dropout; 0 schools adapted	43% enrollment; 20% dropout; 3/6 schools adapted	43% enrollment; 20% dropout; 6/6 schools adapted; 0 fully accessible schools

The project's real difference is life-changing: VSLA incomes rose +32% ($p<0.001$), basic needs satisfaction doubled from 29% to 58% (midline), service access surged to 95.9% from 8.2% full baseline, and 89% of persons with disabilities participated in project decisions, with several elected to local councils. Knowledge and attitudes improved decisively OPD awareness 17%→92%, non-discrimination 54%→76%, and three government offices budgeted for ramps. Reach extended to 3,294 direct beneficiaries (62.8% women, 57.5% Persons with disabilities) and 140,000+ indirect, including 132,503 via media campaigns.

Unanticipated gains include 18 IVSLAs formalized into 6 cooperatives, Fana cooperative receiving Master Card Foundation funding, tax incentives for Person with Disabilities in sand mining, and conflict strengthening OPD coordination roles. Conflict itself caused delays (75.8%), reduced coordination (51.4%), looting (34.5%), and a 31% injury-driven demand surge, while education enrollment stagnated (44%→43%) and dropout rose (15%→20%). Adaptive responses—home visits, Telegram, small groups, flexible timelines, alternative storage, psychosocial support—proved effective, though adaptation was far stronger in South Gondar (49.7% strongly agree) than East Gojjam (8.2%, $\chi^2=66.978$, $p<0.001$). Critical lesson: institutionalize a Conflict Preparedness Plan with cloud backups, remote safeguarding, OPD task forces, and emergency reserves.

Conclusion on Impact: The project generated substantial positive impacts in its core areas, including unprecedented political representation for Person with disabilities .

5.6. Sustainability

Rating: Excellent – Strong foundation through VSLAs (100% functional, self-capitalized ETB 1.85M), OPDs (6/8 still rely on external funding), and physical infrastructure. Sustainability perception varies significantly by zone; woreda council is better to dedicate budget line for disability inclusion.

Sustainability and Knowledge Retention

- **Documentation of Best Practices:** The project systematically **documented successful home-based rehabilitation approaches, caregiver training methodologies, and case**

studies, ensuring that this knowledge is available for future programming, universities, and disability sector actors.

- **Handover Protocols:** When staff turnover occurred, home-based rehabilitation case files, caregiver training records, and beneficiary-specific care plans were systematically handed over to incoming staff through clear role descriptions and handover documentation, ensuring continuity of care.
- **Alignment with Government Structures:** Home-based rehabilitation knowledge and practices were aligned with and integrated into existing government health and social welfare structures (health facilities, WCSA offices), ensuring that the capacity built within the project can be sustained and scaled by government actors after project closure.

Table 20: Rating: Good for core areas.

Area	Baseline (Feb 2023)	Midline (Oct 2024)	Endline (Mar/Apr 2026)	Sustainability Rating
IVSLA / Cooperatives	None	360 members; VSLAs forming	498 members, 100% functional, self-capitalized, ETB 1.85M revolving fund	High
Physical ramps & accessible toilets	0 adapted	3/6 schools (50% target)	6/6 schools (100% target); only 17.2% fully accessible	Moderate
Hospital & university MoUs	No linkages	Partial agreements	Ongoing agreements; 2,165 Person with Disabilities served; goodwill exists	High
Assistive device workshops	None	Partnerships emerging	Local workshops equipped; repair systems need local funding	High
Steering committees	None	Established but conflict-	Coordination bodies exist via MoUs;	Moderate

		disrupted	Directive adopted	
OPD capacity	No registered OPDs	Training ongoing	8 registered OPDs; 6/8 still rely on external funding	Moderate (funding dependency)
Sustainability perception	Not measured	Not measured	South Gondar 84.6% "Not confident" vs. East Gojjam 57.8% ($p<0.001$)	Excellent

Sustainability Framework (Four Pillars):

- **Institutional:** MoUs, DSCs, policy directives integrated into government budgets.
- **Physical:** Permanent infrastructure (ramps, ERCs, orthopedic workshops).
- **Economic:** Legal cooperatives with revolving capital (ETB 1.85M).
- **Social:** Changed community mindsets (132,503 reached) + Person with disabilities in elected positions.

Conclusion on Sustainability:

The project established a strong and multidimensional sustainability foundation through an integrated framework built upon institutional, physical, economic, and social pillars, significantly enhancing the likelihood of long-term continuity and impact beyond the project lifecycle. Institutionally, sustainability was reinforced through formalized MoUs, strengthened Disability Support Committees, and the integration of inclusive policy directives and service responsibilities within government planning structures, promoting sustained ownership and accountability among public institutions.

At the physical level, the establishment of permanent accessibility infrastructures, including ramps, accessible toilets, Educational Resource Centers (ERCs), and strengthened orthopedic workshops, created durable assets that will continue to support inclusive service delivery and accessibility for years to come. Economically, the project fostered resilient livelihood systems through the legalization and strengthening of cooperatives supported by revolving capital

exceeding ETB 1.85 million, enabling continued financial inclusion, business expansion, and local economic empowerment among persons with disabilities and vulnerable groups.

Social sustainability was equally strengthened through sustained community engagement and awareness creation initiatives that reached over 132,503 individuals, contributing to progressive shifts in attitudes, social acceptance, and inclusion of persons with disabilities within community and institutional structures. The increasing participation of persons with disabilities in elected and leadership positions further reflects the emergence of stronger representation, voice, and social ownership within local governance and community systems. Collectively, these achievements demonstrate that the intervention moved beyond short term service delivery toward fostering enduring systems transformation, institutional resilience, and inclusive community development.

5.7. **Disability Inclusion, Replicability & Implications for Future CBM Interventions**

Rating: Strong on awareness, economic empowerment, health access; limited on communication accessibility in external protection systems.

Table 21: Comparison of disability inclusion, replicability and Implication: Baseline to End line

Aspect	Finding	Implication (Actionable)
Disability inclusion	57.5% of direct beneficiaries are Person with disabilities ; 95.8% report reduced stigma. New intellectual disability associations formed. **472 girls in HBR; 766 women caregivers trained.**	**Sustain & institutionalize:** Integrate disability inclusion indicators into Woreda social accounts. Make OPD capacity strengthening a mandatory budget line.
Communication accessibility	While the evaluation team successfully conducted interviews, a critical gap was identified: some WCSA, police, and government offices lacked certified sign language interpreters, limiting accessibility for deaf and hard-of-hearing individuals.	**Mandate pre-implementation accessibility audit** covering all facility types (WCSA, police, courts). Include communication accessibility in MoUs with government.
Replicability: IVSLA model	The IVSLA approach demonstrated strong replicability and scalability across all six target districts, maintaining effective functionality even within conflict affected	Develop a **standardized, accessible IVSLA training manual** with a financial safeguarding module. Share publicly as open-source resource.

	contexts. Particularly in the South Gondar Zone, the three target districts achieved strong implementation performance, characterized by high loan repayment rates, increased savings mobilization, and the successful progression of IVSLA groups into cooperative level structures. The strong financial discipline observed across the groups, including exceptionally high repayment performance in East Gojjam, further reinforced the model's operational viability and sustainability. These achievements attracted the interest of the Mastercard Foundation for potential collaboration and joint implementation, reflecting growing external confidence in the model's effectiveness. Furthermore, an action research study conducted by Debre Tabor University identified the IVSLA approach as a promising and scalable model for wider replication and inclusive economic empowerment programming.	
Replicability: Medical referral MoU	Highly replicable. Formal MoUs served 2,165+ Person with disabilities at low cost.	Create **open-source MoU template and toolkit**. Include a sustainability clause: joint annual reviews + gradual cost sharing (e.g., 20% government contribution in year 1, 40% in year 2).
Replicability: Assistive device model	Highly replicable. Partnering with existing workshops delivered 1,517 devices efficiently.	Develop a **replication toolkit** covering procurement, budgeting (5–10% of project funds for devices), and local repair system design.
Sustainability: Government buy-in	Steering committees exist but insufficient. No woreda council budget commitments.	Make final funding tranches (e.g., last 20%) contingent on a signed **"Sustainability Handover MoU"** detailing specific budget lines for ramp maintenance, devices, and OPD support.
Conflict sensitivity	Project achieved targets on time despite conflict using efficient HR	**Mandate a conflict-sensitive M&E dashboard** for future projects in

	management. No documented conflict-adaptive M&E framework.	volatile regions. Use the project's successful "HR pooling" method as a good practice.

Summary: Project Expected Outcomes & Key Findings

Table 22: Expected Outcomes (Results Framework)

Result	Original Description	Outcome indicator (what changed for the target group)	End line Achievement (April 2026)	Rating
Result 1	WCSA offices, OPDs, and self-help groups represent PERSON WITH DISABILITIES interests.	% of persons with disabilities aware of OPDs and their rights % of persons with disabilities who participate in at least one decision-making forum (Kebele/Woreda committee) % of disability-related issues raised by OPDs that receive a government response	• **8 OPDs legally registered** (exceeded target), including intellectual disability associations. • **6 functional steering committees**. • **Person with disabilities elected to local committees** (Kebele/Woreda level). • OPD awareness: 92% (up from 36%). • **Gap:** No OPD-led alternative if government systems fail.	**Excellent**
Result 2	Health, education, and livelihood services are inclusive; communities understand need for inclusion.	% of persons with disabilities who accessed needed health service in the last 6 months % of children with disabilities enrolled in formal primary school % of IVSLA members reporting increased income % of community members with positive attitude toward persons with disabilities	• **Health:** 2,165 Person with disabilities accessed medical services; 1,517 assistive devices; 879 children in HBR. • **Livelihoods:** 18 IVSLAs → 6 cooperatives; ETB 1.85M saved; 68–100% income gains. • **Education:** 457 Braille books; 6 resource centers; 120 teachers trained. • **Stigma:** 95.8%	**Excellent**

			reported reduction; 132,503 community members reached. • **Accessibility:** 24+ ramps, 11+ toilets at 6 schools & 6 health facilities. • **Gap:** External protection systems lack Braille/sign language.	
Result 3	Evidence-based data and best practices on CBID are available.	• Number of policy or practice changes adopted by government based on project evidence • Number of external organizations replicating project models • Existence of a publicly accessible knowledge product (toolkit, documentary, research paper)	• Systematic documentation and soft-copy backup. • **University action research partnerships** (Debre Markos & Debre Tabor Universities). • Replicable models documented (IVSLA cooperative model, MoU template, workshop partnerships). • **Gap:** Conflict-adaptive M&E framework not formally documented.	**Good**

Overall Conclusion & Key Lesson

Overall Conclusion: The project was highly effective and efficient in its core areas (health, livelihoods, education, stigma reduction), with strong relevance and moderate-to-high sustainability. It achieved unprecedented outcomes including the formal transition of informal savings groups into six legal cooperatives with ETB 1.85M in capital, the election of Person with disabilities to local councils, and the formal adoption of a regional disability mainstreaming directive by the Amhara government. The documented gaps are specific, actionable, and do not undermine overall performance.

Key Lesson: The most significant finding is that **systemic change requires moving beyond service delivery to institutional embedding**. The project succeeded not just by providing rehabilitation or devices, but by:

1. Securing **legal commitments** (MoUs, policy directives, cooperative certifications)
2. Establishing **formal government roles** (disability screening in social worker job descriptions)
3. Achieving **permanent political representation** for Persons with disabilities in decision-making bodies (Kebele/District councils, Disaster Prevention Committees)

6. Cross-Cutting Issues

6.1. Cross-Cutting Development Policy Issues

6.1.1. Impact of the Armed Conflict in the Region

The armed conflict (mid-2023 onward) caused reduced government coordination (51.4% of KII), looting of paper records (34.5% of KII), and a 31% increase in the number of Persons with Disabilities (Person with disabilities) seeking support. Despite adaptive resilience (home visits, remote coordination, flexible timelines), the project lacked a formal contingency plan – responses were ad hoc and recovery prolonged.

Future interventions in Amhara or similar fragile contexts must develop a pre-approved Conflict Preparedness Plan (as a standard annex) including:

- Cloud/encrypted digital backups
- Remote safeguarding mechanisms (hotline/SMS accessible to hearing/visual impairment)
- OPD led alternative coordination structures
- Pre identified safe locations (≥2 per district)
- A dedicated budget line (5–10%) for emergency transport, replacement of looted assets, and staff security

Formal planning would eliminate avoidable losses and reduce the burden on local staff.

6.1.2. Disability Inclusion

The evaluation, guided by disability inclusion and conflict impact, found that the project successfully embedded disability inclusion within its direct interventions: accessible training, IVSLAs, health referrals, and school resource centers reached 57.5% Person with disabilities , and 95.8% reported reduced stigma. However, external protection mechanisms in government

facilities WCSA and Police offices in East Gojjam, and some South Gondar district offices lacked accessible complaint systems (Braille, sign language, wheelchair access). This gap lies outside the project's original mandate (government systems), needs improvement. The conflict exacerbated this by disrupting government coordination and staff turnover.

Future interventions must operationalize LNOB through pre-implementation accessibility audits of **all** partner government facilities, with immediate corrective action for failing districts – not at End line.

6.1.3. Internal Safeguarding vs. External Protection Systems (Learning for Future Interventions)

Aligned with the ToR (Safeguarding), the project's scope did not include establishing external protection systems in government facilities.

Table 23: Key Distinction

Aspect	Definition	Status in This Project
Internal Safeguarding	Measures within the project's direct control: staff training, internal complaint mechanisms, code of conduct, MoUs with partner institutions.	**Adequately addressed.** 52 staff and stakeholders trained, written procedures, designated focal persons.
External Protection	Accessible complaint mechanisms within government facilities (WCSA, Police, Health, Administrative offices) that Person with disabilities can access independently.	**Outside project scope.** The project did not have a mandate to modify WCSA or Police facilities. However, the evaluation notes that these systems remain inaccessible – a broader systemic issue for future advocacy.

What the Project Achieved (Within Its Scope)

The project successfully:

- Conducted accessibility audits in 6 target schools and 6 health centers.
- Completed structural adaptations (ramps, accessible toilets, handrails) in all 12 facilities – addressing every gap identified by the audits.
- Trained health professionals and teachers in sign language and Braille basics.

- Established referral linkages with Debre Markos and Debre Tabor Hospitals (2,165 Person with disabilities received medical treatment).
- Strengthened orthopedic workshops for assistive device provision (1,517 devices).

These achievements are substantial and directly improved access to health, education, and livelihoods for thousands of Person with disabilities compared to pre-project conditions.

Finding on External Protection (Outside Project Scope)

The evaluation found that external protection mechanisms in government facilities remained inaccessible. Specific gaps included:

- No accessible complaint boxes (Braille, lower height) in WCSA offices (East Gojjam) and Police stations (East Gojjam).
- Physical accessibility (ramps, toilets) was completed only in project-targeted schools and health centers not in WCSA or Police facilities.

Recommendations for Future Interventions (Not Corrective Actions)

For future CBID projects in Amhara or similar contexts:

1. Include WCSA and Police facilities in accessibility audits and structural adaptation from project start.
2. Budget for and install accessible complaint mechanisms (Braille, sign language, lower height) in ALL government facilities that Person with disabilities may need to access for protection (WCSA, Police, courts, health centres).
3. Strengthen OPDs with university linkages.
4. Conduct regular joint monitoring visits with OPDs to assess accessibility and functionality of external protection systems.

These recommendations are not corrective actions for the completed project but essential design inputs for future phases.

7. Conclusion and Recommendations

17.1. Conclusions

Final Verdict: Qualified Success – Benchmark Achievements in Core Areas (Health, Education, Livelihoods) with Context-Specific Gaps in External Protection Systems.

The Bridge the Gap – Phase II project has achieved genuine, life-changing results in its core areas:

- The **IVSLA model** is exceptionally effective, scalable, and replicable – saving ETB 1.85M, providing ETB 1.04M in loans, and transitioning 18 informal groups into 6 legal cooperatives with 360+ members.
- The **medical referral MoUs** with regional hospitals are exemplary and low-cost – serving 2,165 Person with disabilities and 879 children with HBR.
- The **assistive device provision** through orthopedics workshops is efficient and impactful – 1,517 devices distributed, with local workshops equipped for ongoing maintenance.
- **Community attitudes** towards Person with disabilities have transformed – 95.8% reported reduced stigma, reaching 132,503 community members via radio, documentaries, and road safety campaigns.

The project's overall performance is a Qualified Success because:

1. The core CBID model (Health, Livelihoods, Education) worked exceptionally well.
2. Internal safeguarding within the project was adequately addressed.
3. The external protection gaps are specific, identifiable, and correctable with practical recommendations.

For future interventions, this evaluation clearly demonstrates that success in one area does not automatically replicate to others. Deliberate, location-specific planning, pre-implementation accessibility audits, and mandated facility-type coverage are non-negotiable.

7.2. Consolidated Summary of Key Achievements and Critical Success Factors

Table 24: Key Quantitative Achievements (End line)

Area	Key Metrics
Health	879 children received HBR; 2,165 medical referrals; 1,517 assistive devices

	provided
Education	120 teachers trained; 6 resource centers established (JAWS, Braille, Montessori); 6 schools made accessible
Livelihood	ETB 1.85M saved; ETB 1.04M in loans; 360 members organized into 6 legal cooperatives
Social Inclusion	132,503 community members reached; 24 radio programs; 2 documentaries
Governance	8 OPDs strengthened; 60 WCSA staff trained; 6 Disability Steering Committees established

Most Notable Outcomes

1. High financial discipline in terms of VSLA (total 86.8% loan repayment, 97% in East Gojjam)
2. Gender responsive reach (472 girls in HBR; 766 women caregivers trained; 202 women in IVSLAs)
3. Road safety institutionalization (permanent signage in 6 districts)
4. Inclusive Disaster Risk Reduction (Persons with disabilities now on District Disaster Prevention Committees)
5. Tax incentives secured for Persons with disabilities engaged in income generating activities (e.g., sand mining)

Table 25: Sustainability Framework (Four Pillars)

Pillar	Mechanism
Institutional	MoUs, DSCs, policy directives integrated into government budgets
Physical	Permanent infrastructure (ramps, ERCs, orthopedics workshops)
Economic	Legal cooperatives with revolving capital (ETB 1.85M)
Social	Changed community mindsets (132,503 reached) + Person with disabilities in elected positions

Table 26: Critical Success Factors (From NGO Dependency to Institutional Embedding)

Factor	Achievement
Government ownership	MoUs with social workers integrating disability screening into job descriptions; 6 Disability Steering Committees; Amhara Region Disability Mainstreaming Directive formally adopted
Formal economic structures	18 IVSLAs → 6 legal cooperatives; ETB 1.85M revolving fund; one cooperative (Fana) won MasterCard Foundation funding
Permanent physical infrastructure	Structural adaptations at 6 health centers + 6 schools; 6 Educational Resource Centers; local orthopedics workshops equipped

Evidence-based advocacy	Two action research studies with Debre Markos and Debre Tabor Universities; scientific evidence for regional policy replication
Political representation	Person with disabilities elected to Kebele and District councils; active membership in Community Care Coalitions and Social Protection Committees

Key Lesson (from the Summary)

The most significant finding is that **systemic change requires moving beyond service delivery to institutional embedding** – the project succeeded not just by providing rehabilitation or devices, but by securing legal commitments, formal government roles, and permanent representation for Person with disabilities in decision-making bodies.

7.3. Practical Recommendations for Future NGOs & Interventions (Amhara Region Context)

These recommendations are addressed to any future NGO, donor, or implementer designing disability inclusive development projects in the Amhara Region or similar fragile contexts. They consider the current government structure (Woreda Council, Administrator, Finance Desk, WCSA and Sector Offices) and the end of the project cycle.

Table 27: Scaling up benchmark health interventions (Hospital MoU Model) and cross sectoral scale ups

#	Recommendation	Responsible Body	Amhara Region Context Note
1	Replicate the medical referral MoU model with regional referral hospitals (Debre Markos, Debretabor, Felege Hiwot) at project start. Include clear terms for free/subsidized services for Person with disabilities .	Future NGOs, CBM, Regional Health Bureaus	Regional hospitals remain functional post-conflict. Leverage existing regional health bureau structures.
2	Establish a joint annual review mechanism for each hospital MoU, involving Woreda Health Office and OPDs.	NGO + hospital management + Woreda Health Office	Links the MoU to local government sustainability.
3	Link health referrals to assistive device provision – ensure Person with disabilities receiving medical treatment are assessed for and provided with appropriate devices from the same referral pathway.	Health facilities + orthopedic workshops	Creates a seamless patient pathway.
4	Enhance university engagement (Debre Markos, Debretabor) – incorporate disability	NGO + Debre Markos	Under the existing MoU with the OPD federation,

	and hospital referral issues into annual research plans; establish a resource center modeling project practices (accessible materials, referral information, device demo).	University + OPD federation	Phase III must include quarterly follow-up, joint research, and resource centre operation.
5	Scale land access from Debre Elias practice – support Mota and other districts to issue land certificates for OPD housing, agriculture, or enterprise within Phase III.	OPD federation + Woreda Land Office + NGO	Document Debre Elias model. Land can support health-related livelihoods (e.g., food for hospital patients, income for device repair).
6	Leveraging Debre Markos Hospital's **5 million birr Ministry of Health award** for inclusive infrastructure, we are scaling this proven model to Felege Hiwot, Debretabor, and Bahir Dar. This regional replication will ensure dignified, equitable access to life-saving care for millions across Amhara setting a transformative new national standard for disability-inclusive health services in Ethiopia..	Regional Health Bureau + Debre Markos Hospital + NGO	MoH already motivated. Use award to advocate for person with disabilities budget lines in other hospitals (ramps, accessible toilets, sign language services).
7	Scale up social service and volunteer service at Debre Markos Hospital formalize a dedicated person with disabilities social work desk + trained volunteer roster (including Person with disabilities) to assist with hospital navigation, referrals, device follow-up, and discharge planning.	Hospital management + NGO + Woreda Health Office	Conflict and displacement increase person with disabilities vulnerability; this initiative responds to urgent access gaps.

Table 28: Scaling up assistive device provision (Maintenance Workshop Model)

#	Recommendation	Responsible Body	Amhara Region Context Note
1	Partner directly with regional orthopedic workshops (Debre Tabor, Debre Markos, and Bahir Dar). Use their existing infrastructure for procurement, distribution, and repair.	Regional Health Bureau, zonal health departments, incoming NGOs/donors	Workshops survived conflict and remain operational – backbone of assistive device provision.
2	Allocate minimum 5% of total project budget to assistive devices (procurement, distribution, and maintenance, follow-up). No optional treatment.	Donors (future), regional government budget planners, hospital finance units	Non-negotiable line item. Clear budgeting guideline for replication.
3	Establish local repair & follow-up system – train person with disabilities technicians for basic repairs; link each	Zonal Health Office, orthopedic workshops, OPD federation,	Addresses common failure point (devices break, no repair). Phase

	device recipient to the nearest maintenance point (health center or OPD).	private repair entrepreneurs	III must track repair turnaround time.
4	Document and share the device distribution model as a benchmark for other regions (including Amharic version).	Amhara Regional Health Bureau, Regional Labor and Social Affairs Office, future NGOs	Public good for regional government use.
5	Universities (Debre Markos priority) – incorporate disability into annual research plan; establish resource centre with device demo and referral info.	Debre Markos & Debre Tabor Universities, Regional Education Bureau, OPD federation	Existing MoU with OPD federation – Phase III must enforce quarterly follow-up and joint work plan.

Table 29: Scaling up economic empowerment (IVSLA/Cooperative Model)

#	Recommendation	Responsible Body	Amhara Region Context Note
1	Use the IVSLA model as a core, non negotiable intervention in all future disability inclusive livelihoods projects.	Future NGOs, CBM	Proven highly effective, self-sustaining, and scalable across six woredas.
2	Add mandatory modules on financial safeguarding and external protection referral pathways to all IVSLA training. Ensure members know how to report financial abuse or violence through accessible complaint mechanisms.	NGO + protection specialists	Addresses the gap identified in this evaluation.
3	Link each IVSLA group to a nearby accessible complaint box or hotline (see protection section).	Project management + woreda offices	Creates a direct feedback loop.
4	Promote cluster level IVSLAs into cooperatives – continue scaling beyond the 18→6 transition (498 members, 401 F, 291 Person with disabilities).	NGO + OPDs + Cooperative Agency	Legal certificates already granted.
5	Universities – incorporate IVSLA/cooperative models into annual research plans; establish resource centers with business development materials for person with disabilities entrepreneurs.	NGO + Debre Markos & Debretabor Universities + OPD federation	Research can document IVSLA impact; resource centers can host cooperative training.

Table 30: Filling external protection gaps (Accessible Systems in Government Facilities)

#	Recommendation	Responsible Body	Amhara Region

			Context Note
1	Conduct a pre implementation accessibility audit of ALL potential partner government facilities before any complaint mechanism or protection activity begins. Facilities must include: WCSA offices, Police Stations, health centers, schools, woreda administrative offices.	Future NGOs, OPDs, accessibility experts	This would have prevented the identified gap. Make it mandatory.
2	Budget for accessibility from project inception – minimum 10% of the protection budget. Covers Braille signage/forms, sign language interpreter rosters, accessible complaint boxes (lower height, pictorials), ramps, accessible toilets.	Donors, project implementers	Accessibility is not an add-on; it is a prerequisite.
3	Ensure every external complaint mechanism is available in three accessible formats: Braille (visual impairment), sign language (hearing impairment), plain Amharic with pictures (low literacy). Complaint boxes mounted at ≤120 cm height.	Implementing NGO + woreda offices + OPDs	Specific, measurable standard.
4	Train and deploy a roster of sign language interpreters for each district, shared across WCSA, Police, Health, and Administrative offices. Provide incentives (transport, stipend) for on call availability.	Implementing NGO + Ethiopian National Association of the Hearing Impaired + woreda WCSA	Addresses the hearing impairment gap specifically.
5	Operationalize an external protection referral pathway from project start – formalise a multi stakeholder subcommittee (WCSA, Police, Health, OPDs, Women's Affairs) with clear ToR, meeting schedule, and case management protocol.	Zonal steering committee + implementing NGO	This was missing entirely. Do not wait for Year 2.
6	Establish safe, accessible reporting spaces – a private room in a health centre or WCSA office, equipped with lockable door, referral directory, and accessible communication tools (sign language, Braille).	Implementing NGO + woreda administration	Creates a dignified, safe reporting environment.

Table 31: Ensuring sustainability with the current Amhara Government Structure

#	Recommendation	Responsible Body	Amhara Region Context Note
1	Work within the existing woreda council structure – engage the Woreda Administrator, Finance Desk, and relevant Sector Offices (WCSA, Health,	Incoming/future NGOs and donors	The structure exists, even if affected by conflict. Work within it – there should be integrated

	Education) from project start.		systems
2	Make final funding tranches contingent on a signed **"Sustainability Handover MoU"** between the project, the Woreda Council (Finance Desk), and relevant sector offices. The MoU must include specific, budgeted line items for maintenance of accessible infrastructure and operation of complaint mechanisms.	New donors and future NGOs	This is the single most important sustainability recommendation. No signature, no final payment.
3	Seize government seasonality – align project review and handover meetings with the woreda council budget planning cycle (Ethiopian calendar).	Woreda Council (Planning & Finance Desk), Regional Bureau of Finance, future NGOs	Ensures disability inclusion is included in the official woreda budget before the window closes.
4	Establish a real-time dashboard tracking accessibility indicators (% of facilities with Braille complaint forms, sign language interpreters, ramps). Any district falling below a minimum performance floor triggers automatic, budgeted corrective action.	Regional Health Bureau + Woreda Health Offices + OPD federation (+ private tech companies for CSR support)	Existing HMIS rarely captures disability accommodations. Conflict damaged infrastructure. Digital literacy is low – include an offline/SMS trigger as a parallel mechanism.

7.4. General Conclusions and Lessons Learned

Table 32: Lesson and Implications

Lesson Learned	Implication for Future Interventions
Protection frameworks (training, procedures) are insufficient without full communication & physical accessibility in **ALL** government facility types.	Budget for accessibility from project inception (minimum 10% of protection budget). Mandate a pre implementation accessibility audit for every facility type (schools, health centres, WCSA, Police, Admin offices).
District level implementation capacity drives outcomes more than zone level policy.	Use differentiated supervision and targeted mentoring for low performing districts from the start. Do not assume replication.
IVSLA works exceptionally well for economic empowerment of Person with disabilities . Scale it.	Add a mandatory module on accessible reporting of financial abuse and external protection referral pathways within IVSLA training. Link each IVSLA group to an accessible complaint box/hotline.
Medical referral MoUs are highly effective and scalable.	Formalize MoUs with regional hospitals from the start. Allocate a small, dedicated budget for material support (e.g., physiotherapy equipment) to sustain goodwill and service quality.

Assistive device provision through maintenance workshops is efficient and impactful.	Partner directly with regional orthopedic workshops. Budget a minimum of 5% of total project funds for assistive devices, including repair and follow-up.

7.5. Strategic Implications for CBM & Future Interventions (Phase III)

Based on this evaluation, the following points directly address CBM's planning for Phase III or any successor intervention, focusing on replicability, sustainability with government buy-in, and disability inclusion:

1. **Work within existing Woreda Council Structure** – Future interventions should continue adopting and strengthening an institutionally embedded implementation approach that fully engages existing woreda government structures from project inception through completion. This includes the active involvement of the Woreda Administrator, Finance Offices, and all relevant sector bureaus through formal agreements, joint planning processes, regular monitoring and follow up mechanisms, midterm reviews, and final evaluations. The project demonstrated that sustained collaboration with government stakeholders significantly strengthens local ownership, accountability, institutional continuity, and long term sustainability of results. Rather than creating parallel implementation systems, future NGOs and development partners should further reinforce and build the operational capacity of existing government structures, including within fragile and conflict affected contexts where institutional resilience is particularly critical. Continued investment in strengthening local governance systems, coordination mechanisms, and sectoral institutional capacities will enhance service continuity, improve sustainability of interventions, and support more resilient and locally owned development outcomes.

    - *Action for incoming NGOs/donors + Woreda Council:* Mandate this approach in all new project designs.

2. **Sustainability Handover MoU as a Funding Condition** – Any new funding for disability inclusion in the region must require a signed MoU between the donor/NGO, the

Woreda Council (Finance Desk), and relevant sector offices, including specific, budgeted line items for maintenance of accessible infrastructure and complaint mechanisms.

- *Action for new donors + Woreda Council Finance Desks:* No funding release without this signed MoU – the single most important sustainability recommendation.

3. **Align with Government Budget Cycles** – All future projects and local government planning units must schedule project reviews and handover meetings to coincide with the woreda budget planning cycle. The Regional Bureau of Finance should issue a directive to enforce this alignment across all woredas.

   - *Action for Woreda Council Planning & Finance Desks + Regional Bureau of Finance + future NGOs:* Embed disability budget lines before the planning window closes.

4. **Real Time Accessibility Dashboard with Automatic Corrective Action** – The Regional Health Bureau should embed accessibility indicators (percentage of facilities with Braille complaint forms, sign language interpreters, ramps) into routine HMIS. Any district falling below a minimum performance floor triggers automatic, budgeted corrective action.

   - *Action for Regional Health Bureau + Woreda Health Offices + OPD federation + private tech companies:* Prevents the "wait until End line" problem. Given low digital access in rural Amhara, include an offline/SMS trigger as a parallel mechanism.

5. **Documentation and Circulation of Four Benchmark Models as a Regional Toolkit** – The four models (woreda council engagement, sustainability handover MoU, budget cycle alignment, real-time dashboard with performance triggers) represent the collective learning of the completed project. Without active documentation and dissemination, this knowledge will be lost.

- *Action for Amhara Regional Government (Bureau of Labor & Social Affairs) + OPD federation + academic institutions:* Within six months of handover, jointly produce, validate, and distribute the toolkit (Amharic and English) to all woredas in Amhara. Mandate its use as a reference for any new disability project in the region. The Amhara Universities Forum should lead documentation and translation.

7.6. Final Statement

The CBID project generated transformative and multidimensional impacts in the lives of thousands of persons with disabilities by expanding access to sustainable livelihoods, inclusive community participation, dignity, rehabilitation support, and essential medical services. The successful implementation of the IVSLA model, medical referral MoUs, and assistive device workshop approaches demonstrated strong effectiveness, institutional relevance, and scalability potential for wider replication across the region. Importantly, the project also demonstrated remarkable operational resilience and adaptive capacity within an extremely challenging conflict affected environment.

From the earliest stages of implementation, sustainability was intentionally embedded within the project design through a strong institutional strengthening approach focused on reinforcing government systems, fostering inter sectoral coordination, and promoting local ownership and accountability. Rather than relying on short term direct cash assistance modalities, the intervention prioritized building the capacity of public institutions, community structures, and local service systems to ensure the long term continuity and sustainability of inclusive services and development outcomes. This approach significantly enhanced institutional resilience and strengthened the foundations for sustained impact beyond the project period.

Building on the lessons and achievements of Phase II, any future phase or successor intervention should continue deepening this systems strengthening and institutionally embedded approach. Future disability inclusion programming in the Amhara Region should further prioritize government ownership, integrated service delivery, sustainable financing mechanisms, and strengthened cross sectoral coordination to ensure that inclusive development gains remain resilient, scalable, and sustainable over the long term:

1. **Require a signed Sustainability Handover MoU** between the donor/NGO, the Woreda Council (Finance Desk), and relevant sector offices, including budgeted line items for maintenance and complaint mechanisms. **No signature, no funding release.**
2. **Align all project reviews and handover meetings with the woreda budget planning cycle.** The Regional Bureau of Finance should issue a directive to enforce this alignment.
3. **Establish a real-time accessibility dashboard** within routine HMIS, tracking indicators (Braille forms, sign language, ramps). Any district below a minimum performance floor triggers automatic, budgeted corrective action.

Location specific limitations must be tracked, reported transparently, and corrected immediately not at End line.

CBM and its original partners have left the evidence and the model practices. The task now falls to the Amhara Regional Government, woreda councils, future donors, and incoming NGOs to mandate their universal application. Crucially, **signed budget commitments from Woreda Councils must be secured before any new project closes**. Only then can any intervention truly claim to leave no one behind and achieve sustainable change in the Amhara Region.

Annexes

1. Terms of Reference (ToR)

Annex A: Terms of Reference (ToR) for the End Term Evaluation

Section	Title	Key Content Summary
1	Introduction	Project background: *Bridge the Gap – Phase II* (Sept 2022 – April 2026), BMZ/CBM funding, implemented by BFI (East Gojjam) and CFAI (South Gondar).
2	Evaluation Purpose	Summative & formative assessment against OECD-DAC criteria; accountability to donors & beneficiaries; learning for future CBID programming.
3	Evaluation Objectives	(1) Assess performance (relevance, coherence, effectiveness, efficiency, impact, sustainability); (2) Identify best practices & critical gaps; (3) Evaluate disability inclusion, gender, safeguarding, conflict sensitivity; (4) Provide actionable recommendations.
4	Evaluation Questions	Central questions by OECD-DAC criterion (e.g., effectiveness: "To what extent did safeguarding mechanisms function?"; sustainability: "What exit strategy exists?").
5	Scope	**Geographic:** 6 districts (Addis Zemen, Ammanuel, Debre Elias, Kimerdengay, Mota, Nefas Mewcha). **Thematic:** livelihoods, health, education, OPD strengthening, safeguarding, accessibility. **Temporal:** Sept 2022 – March 2026.
6	Methodology	Mixed methods: household survey (n=296), KIIs (n=83), FGDs (12 groups), facility observations (n=28). Ethical protocols, reasonable accommodations, conflict adaptation.
7	Deliverables	Inception report, draft evaluation report, final report (incl. executive summary, annexes), presentation to stakeholders.
8	Timeline	March – April 2026 (fieldwork 17–23 March).
9	Team Composition	Lead evaluator (MG Consultancy), two national evaluators, six enumerators, sign language interpreters.
10	Budget	Not included in ToR (internal document).

2. Composition and Independence of Evaluation Team

Item	Detail
Status	Not provided as a separate annex.
Mention in ToR (Annex A, section 9)	Lead evaluator (MG Consultancy), two national evaluators, six enumerators, sign language interpreters.
Formal statement on independence	**Not provided.** No declaration of conflict of interest, no independence assurance clause, no separation from project management.
Recommendation	A standard independence statement should be added (e.g., "The evaluation team has no conflict of interest and operates independently of project implementation.")

3. Evaluation Matrix (OECD-DAC Criteria)

Annex B: Evaluation Matrix

OECD-DAC Criterion	Evaluation Question	Indicator	Data Source	Collection Method	Analysis
Relevance	To what extent did project objectives align with person with disabilities needs?	% of beneficiaries reporting that activities matched their priorities	Household survey (Q12), FGDs	Survey, FGD	Descriptive statistics, thematic analysis
Coherence	How compatible was the project with government disability strategies?	Existence of MoUs or coordination meetings with woreda bureaus	KIIs with WCSA, planners	KII	Thematic coding
Effectiveness	What % of targeted Persons with disabilities accessed IIVSLA and reported income improvement?	% of IIVSLA members with increased income (self-reported)	Household survey (Q24), FGDs	Survey, FGD	Cross tabulation by district
Effectiveness	Did safeguarding mechanisms function as intended?	% of facilities with accessible complaint box, sign language, Braille, posters	Facility observation checklist (Annex G)	Observation	Frequency counts, chi-square
Efficiency	Was IIVSLA seed capital (15,000 ETB/group) cost effective?	Cost per beneficiary reached; income increase per ETB invested	Project financial records, survey (Q25)	Document review, survey	Cost-benefit ratio
Impact	What changes (positive/negative) occurred in social inclusion?	% reporting reduced stigma; % attending community events	Household survey (Q30), FGDs	Survey, FGD	Likert scale mean, thematic quotes
Sustainability	Are project gains likely to continue after closure?	% of KIIs expressing sustainability concerns;	KIIs (Q15), project documents	KII, document review	Frequency, content analysis

		existence of signed exit MoUs			
Gender	Were women with disabilities included and protected?	% female beneficiaries (target 55%); existence of GBV referral pathway	Beneficiary database, KIIs	Document review, KII	Percentage, binary (yes/no)
Disability Inclusion	Were communication formats accessible (sign language, Braille)?	% of facilities with sign language interpreter; % with Braille complaint forms	Facility observation checklist (Annex G)	Observation	Frequency by district
Conflict Sensitivity	Did the project have a contingency plan for armed conflict?	Existence of written contingency plan; adaptation strategies documented	Project documents, KIIs	Document review, KII	Binary (yes/no), thematic

4. Procedure and Schedule at Evaluation

Item	Detail
Status	Not provided as a separate annex.
Information from ToR (Annex A, section 8)	Timeline: March – April 2026. Fieldwork: 17–23 March 2026.
Missing procedural details	• Daily fieldwork schedule (start/end times, breaks) • Logistics for enumerator deployment • Contingency procedures for conflict-affected areas • Data quality assurance steps (back checks, spot checks) • Daily debriefing schedule • Procedure for obtaining informed consent in the field • Protocol for handling safeguarding disclosures during data collection
Inferred steps	1. Inception report review (early March) 2. Enumerator training (15–16 March) 3. Household survey (17–21 March) 4. KIIs and FGDs (18–23 March) 5. Facility observations (17–22 March) 6. Data cleaning and preliminary analysis (24–28 March) 7. Draft report writing (29 March – 10 April) 8. Validation workshop (15 April)

	9. Final report submission (25 April)

5. List of Interviewees / Participants

Annex N: List of Persons Met (Anonymised) – 83 KII participants + 12 FGD groups

Table 5.1: Key Informant Interview (KII) Participants by Category

Stakeholder Category	Number of KIIs	Districts Covered	Gender Representation
WCSA staff	18	All 6 districts	Mixed
Health workers (incl. CBHI focal persons)	16	All 6 districts	Mixed
Teachers & school principals	14	All 6 districts	Mixed
Municipal planners / woreda administration	10	All 6 districts	Mixed
OPD leaders	12	All 6 districts	Mixed
Police (child protection units)	7	5 districts (not Nefas Mewcha)	Mixed
Labour bureau representatives	6	All 6 districts	Mixed
Total	**83**	–	–

Table 5.2: Focus Group Discussion (FGD) Participants

FGD Type	Participants per Group	Number of Groups	Total Participants	Districts
FGD 1: OPD & Self Help Group members	8	6 (one per district)	48	All 6
FGD 2: IIVSLA members	8	6 (one per district)	48	All 6
Total	–	**12**	**96**	–

Table 5.3: Example of Anonymize KII Entries (as provided)

Code	Category	District	Gender	Date of Interview
KII-ADD-01	WCSA staff	Addis Zemen	F	18 March 2026
KII-ADD-02	Health worker	Addis Zemen	M	18 March 2026
KII-ADD-03	Teacher	Addis Zemen	F	19 March 2026
KII-ADD-04	Municipal planner	Addis Zemen	M	19 March 2026
KII-ADD-05	OPD leader	Addis Zemen	M	20 March 2026

KII-ADD-06	Police (CPU)	Addis Zemen	F	20 March 2026
KII-ADD-07	Labour bureau	Addis Zemen	M	20 March 2026
KII-NEF-13	WCSA staff	Nefas Mewcha	F	23 March 2026

6. Bibliography

#	Reference	Type
1	Amhara National Regional State. (2021). *Directive to provide for the right to employment of persons with disabilities* (Directive No. 12/2021).	National / regional policy
2	Bright Future Initiative & Cheshire Foundation. (2023). *Baseline assessment report: Bridge the Gap – Phase II project* [Unpublished project document]. Bahir Dar, Ethiopia.	Project document (unpublished)
3	Bright Future Initiative. (2026). *Project completion report: Bridge the Gap – Phase II (September 2022 – April 2026)* [Unpublished report submitted to CBM]. Bahir Dar, Ethiopia.	Project document (unpublished)
4	CBM. (2022). *Terms of reference for end-term evaluation: Bridge the Gap – Phase II*. CBM Ethiopia Country Office.	Evaluation ToR
5	Cheshire Foundation Ethiopia. (2025). *Annual progress report (Year 3): Bridge the Gap – Phase II* [Unpublished project document]. Gondar, Ethiopia.	Project document (unpublished)
6	Ethiopian Federal Ministry of Health. (2020). *National disability and rehabilitation strategic plan (2020–2025).*	National policy / strategy
7	Ethiopian Ministry of Women, Children and Youth. (2017). *National plan of action on disability (2017–2021)* (Extended through 2023).	National policy / strategy
8	Federal Democratic Republic of Ethiopia. (2019). *Social protection policy and implementation strategy* (Proclamation No. 1110/2019). Federal Negarit Gazeta.	National law / policy
9	Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59–82.	Academic methodology
10	OECD. (2019). *Better criteria for better evaluation: Revised evaluation criteria definitions and principles for use*. OECD Publishing.	Evaluation framework
11	United Nations. (2006). *Convention on the rights of persons with disabilities* (UNCRPD).	International treaty
12	United Nations. (1989). *Convention on the rights of the child* (UNCRC).	International treaty
13	World Health Organization & World Bank. (2011). *World report on disability*. WHO Press.	Global reference report

7. Questionnaires and Other Data/Information Collection Tools

Annex	Title	Description	Format / Length
Annex	Quantitative	9 sections covering demographics, health,	12 pages

D	Household Survey Questionnaire (structure)	education, livelihoods, attitudes, accessibility, safeguarding, sustainability, conflict impact.	(bilingual: English & Amharic)
Annex E	KII Guides (5 separate semi-structured guides)	Separate guides for: WCSA staff, health workers, teachers, municipal planners, OPD leaders, police, labour bureau representatives.	5 guides, each 2–3 pages
Annex F	FGD Guides (2 facilitator guides)	FGD 1: OPD & SHG members (social inclusion, services, safeguarding, sustainability). FGD 2: IIVSLA members (economic changes, GBV, financial abuse, sustainability).	2 guides, each 3–4 pages
Annex G	Facility Observation Checklist (4-page scoring rubric)	Observes ramps, accessible toilets, Braille signage, complaint boxes, safeguarding posters, hotline numbers, inclusion banners, data security, sign language interpreter availability, Braille books, and child protection unit functionality.	4 pages, scoring 0/1/2 per item

8. Minutes of the Validation of Evaluation Results on Site

Item	Detail
Status	**Not provided** in the original documentation.
What would be expected	• Date and location of validation meeting • List of attendees (stakeholders, project staff, evaluation team) • Agenda of the session • Summary of key findings presented • Comments, questions, and disagreements raised by participants • Responses from the evaluation team • Agreements reached and any amendments to findings • Signatures of chairperson and secretary
Recommended action	Obtain or produce a validation minute sheet signed by representatives of implementing partners, woreda officials, and OPDs.

9. Logical Framework and Project Indicators

Annex C: Project Logical Framework (Original & Adjusted)

Level	Indicator (Original)	Target (Original)	Achieved (April 2026)	Means of Verification	Adjustment Notes
Goal	% of Persons with disabilities reporting perceived improved compared to their	70%	82.4% (n=296)	Household survey	No adjustment

	recall of pre-project conditions quality of life				
Outcome 1	% of Persons with disabilities enrolled in CBHI	60%	54.3%	Health center records	Slight shortfall due to conflict disruption
Outcome 2	Number of schools with ramps and accessible toilets	6 schools	6 schools	Observation checklist	Achieved
Outcome 3	Number of functional IIVSLA groups	18 groups	18 groups	IIVSLA records	Exceeded
Outcome 4	Number of registered OPDs	6 OPDs	8 OPDs	Registration certificates	Exceeded
Outcome 5	% of community members with positive attitude toward Persons with disabilities	80%	95.8% (FGD participants)	FGDs	Adjusted from survey to FGD due to conflict
Outcome 6	% of targeted facilities with accessible complaint mechanism	100% (all 6 districts)	50% (3 of 6 districts)	Observation checklist	Functional gap – adjusted target not met
Output 1	Number of health workers trained on disability inclusion	60	42	Training attendance sheets	Below the target
Output 2	Number of Braille books distributed	200	215	Distribution logs	Exceeded
Output 3	Number of IIVSLAs formed	18	18	IIVSLA registration	Achieved
Output 4	Number of OPD leaders trained in advocacy	24	31	Training records	Exceeded
Output 5	Number of radio spots	20	24	Radio logs	Exceeded
Output 6	Number of staff trained in safeguarding	40	52?	Training records	Exceeded (but system not functional)

10. Others, as Required

Annex H: Local Government Informed Consent Forms (2 templates + child assent)

Form Type	Target Participant	Key Sections	Languages
Written consent (adult)	Participants aged 18+	Study title, researcher, purpose, procedures, risks, benefits, confidentiality, voluntary participation, contact, consent statement, signature lines	English & Amharic
Verbal consent script	Non-literate participants	Greeting, explanation, confidentiality, right to withdraw, verbal consent request, enumerator witness signature	English & Amharic
Parental consent (additional)	Parents/guardians of children under 18	Child's age range (12–17), permission statement, child assent requirement, signature lines	English & Amharic
Child assent (separate)	Children 12–17	Age-appropriate language, simple explanation, verbal or written agreement	English & Amharic

Annex I: Ethical Clearance Documents

Approval Body	Reference Number	Date Issued	Validity Period	Key Conditions
CBM Internal Ethics Committee	CBM ETH 2026 003	5 February 2026	March – April 2026	Adherence to do no harm principle; data encryption (AES 256); destruction of data after 5 years
Amhara Regional Health Bureau Research Ethics Committee	ARHB REC/45/2026	20 February 2026	1 March – 30 April 2026	Local ethical oversight; adverse event report within 48 hours; Amharic translation of consent forms

Annex J: Conflict Impact Data Table

Table J.1: Conflict Related Impacts by District (as reported by KIIs, n=83)

Impact Category	Addis Zemen (n=13)	Ammanuel (n=14)	Debre Elias (n=14)	Kimerdengay (n=15)	Mota (n=14)	Nefas Mewcha (n=13)	Consolidated Average
Activity delays / disrupted timelines	69.2%	78.6%	83.3%*	83.3%*	57.1%	83.3%*	75.8%
Reduced coordination with government	60.0%*	35.7%	66.7%*	60.0%	35.7%	50.0%*	51.4%
Looting / damage to	30.0%*	35.7%	50.0%*	40.0%*	21.4%	30.0%	34.5%

property & equipment							
Increased number of Persons with disabilities due to conflict	40.0% *	28.6%	33.3% *	40.0%	14.3%	30.0%	31.0%
Steering committee halted	50.0% *	42.9%	50.0% *	60.0%*	35.7%	30.0%	44.9%
Mobility / travel problems (roadblocks	30.0% *	0.0%	0.0%*	33.3%*	0.0%	38.5%*	17.0%

Note: Denominators vary slightly due to missing information for some KIIs.

Annex L: Data Collectors Status

East Gojam

#	Name	Sex	Educational status	Disability status	Position	District
1	Getnet Gizachew	M	MPH	-	Supervisor	Debre Markos
2	Alebel Kassie	M	BA in Economics	-	Data collector	Motta
3	Mengistu Akele	M	BA in Sociology	Physical	Data collector	Motta
4	Tenaw Enbiale	M	MA Environmental Sci.	-	Data collector	Amanuel
5	Animut Ayalew	M	BA Sociology	-	Data collector	Amanuel
6	Tagele Dagnachew	M	BA Geography	-	Data collector	Debre Elias
7	Aynengda Ebistu	F	BA Special needs	-	Data collector	Debre Elias

South Gonder

#	Name	Sex	Educational status	Disability status	Position	District
1	Dr. Yigermal Gebeyehu	M	PhD	-	Supervisor	Debre Tabor

2	Zemenay G/Hiwot	F	BA	-	Data collector	Addis Zemen
3	Atitegeb Dessie	F	BA	-	Data collector	Addis Zemen
4	Tilahun Allie	M	BA	-	Data collector	Kimr Dingay
5	Abebu Mekonen	F	BA	-	Data collector	Kimr Dingay
6	Adbaru Tesfie	M	BA	-	Data collector	Nefas Mewucha
7	Ayichew Berihun	M	BA	Physical	Data collector	Nefas Mewucha