

Strengthening Wheelchair Services in India

End of Project Report for LDS Charities



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Contents

Table of figures.....	3
Executive Summary.....	4
1 Introduction	6
2 The evaluation.....	7
2.1 Data gathering.....	7
2.2 Who we heard from	8
2.3 Limitations of the study.....	9
2.4 The report.....	9
3 Findings on service quality, systems and procedures.....	10
3.1 Referrals and appointments.....	11
3.2 Assessment and prescription	12
3.3 Funding, ordering, preparation and fitting	13
3.4 Training for users, families and caregivers.....	14
3.5 Follow up, maintenance and repair	14
3.6 Conclusions.....	16
4 Findings on wheelchair users' quality of life.....	18
4.1 Health	19
4.2 Social inclusion and participation.....	20
4.3 Livelihoods.....	20
4.4 Independent living and family life.....	21
4.5 Conclusions.....	22
5 Service sustainability.....	22
5.1 Funding.....	23
5.2 Staffing.....	25
5.3 Advocacy.....	25
5.4 Conclusions.....	27
6 Overall conclusions and recommendations.....	27
6.1 Service quality, systems and procedures	27
6.1.1 Recommendations	27
6.2 Wheelchair users' quality of life.....	28
6.2.1 Recommendations	28

6.3	Service sustainability	29
6.3.1	Recommendations	29
6.4	Partnerships.....	30
6.4.1	Recommendations	31
Annex 1.	Methodology	32
Annex 2.	List of service delivery partners participating in evaluation.	35
Annex 3.	Wheelchairs provided by partners participating in the evaluation.	36
Annex 4.	Wheelchair service capacity following the LDS-funded projects	37
Annex 5.	Barriers faced in wheelchair provision	38

Table of figures

Figure 1: Training places delivered.	7
Figure 2: Age range of the wheelchair users represented in the evaluation.	8
Figure 3: Number of training places provided at each partner organization.	10
Figure 4: Frequency of maintenance vs frequency of issues with the wheelchair.	15
Figure 5: Livelihood activities of the wheelchair users participating in the evaluation	18
Figure 6: Wheelchair users' family income	18
Figure 7 Barriers facing services in wheelchair provision.	22
Figure 8 Financial contribution to cost of wheelchair.	23
Figure 9 Wheelchair service views on financial sustainability.....	24

Executive Summary

With funding from LDS Charities, Motivation India delivered two projects to develop sustainable wheelchair services in India between June 2017 and December 2019.

This report presents the findings of an external evaluation of the completed projects. The evaluators heard from 151 wheelchair users or their families/caregivers, and 17 wheelchair service delivery partners, via twenty group discussions and two extensive questionnaires.

The projects resulted in improved quality of life for 4,920 people with mobility disabilities, including health, social inclusion, livelihoods, family life and independent living. This was achieved through partnerships between Motivation India and wheelchair service providers across India, which built staff capacity and infrastructure for the provision of appropriate wheelchairs to World Health Organization standards, focusing on assessment, prescription, preparation, fitting and user training. A hundred and thirty-seven training places were provided through the projects.

This was the first training of this type for all the service staff involved. The participants noted changes in the quality of their practice, with changed perspectives on wheelchair provision and increased understanding of the positive impact appropriate provision had on many aspects of wheelchair users' lives.

Most organisations (11 out of 17) fitted people with their customized wheelchair within two weeks of assessment but in a few cases, in remote areas, took more than a month. Wheelchair users indicated they received their wheelchair within the time they expected. Many also spoke about liking the customization of the wheelchairs, noting that their previous experience had been of wheelchairs that were distributed without understanding whether it was appropriate for them.

The clinical and technical staff used their training to train wheelchair users and their families/caregivers in wheelchair skills, including: safe mobility; use on even and uneven surfaces; assisted stair climbing; transfers; basic repair, maintenance and modifications. Of 151 the people consulted during the evaluation, the majority (130) rated the training they received as 'Excellent' (61) or 'Good' (69). Around two thirds (109) of the wheelchair users were aware of the eight-steps of WHO wheelchair service provision and the service and standards they are entitled to.

When there were repair and maintenance issues with wheelchairs, the usual response time from services receiving the message to providing the support was less than a week.

The evaluators assessment of the service partners' capacity indicates that all of the services now provide an 'Average' to 'Excellent' level of wheelchair provision, as set out in the WHO guidelines.

Almost 100% of the wheelchair users reported that that they gained confidence, independence and dignity and benefitted in both their economic and social life when using the appropriate wheelchairs provided via these projects. Examples they gave include meeting friends and relatives (133), participating in sports (39), and increased self-employment (82 people) and employment (53).

Through these two projects Motivation established and continues to support a network of capacity throughout India, in part by partnering with larger government systems at the regional level and with national institutes. However, limitations of resources to support and sustain appropriate

wheelchair provision in India remain a significant challenge and the evaluators conclude that the issue of sustainability was a concern for the majority of the partner organizations.

Eight of the 17 organizations engaged in the evaluating agreed that ‘A wheelchair clinic is possible to sustain after the project’—through public donations, corporate funding or service fees from wheelchair users— and seven organizations stated that provision would not be sustainable.

In terms of staffing, responses suggested that existing practitioners are not able to build a sustainable career in this sector, especially in smaller cities/towns and rural areas, as funding remains limited and inconsistent, and it is therefore not seen as a viable livelihood option. A particular gap in availability of human resources, especially remote rural areas, was observed.

A key action towards sustainability identified by the services consulted for this evaluation was advocacy, particularly with regards to funding and particularly with government offices.

Overall, the evaluation team find that the project delivered the desired results. They note that the projects successfully engaged participants across social, economic and geographical spectrum in the country and conclude that the positive responses of the wheelchair users and service delivery partners during the evaluation indicate that the projects were relevant and effective and so have significant potential to be scaled up.

The team also note a significant tendency for partners to expect too many and too diverse a range of support from Motivation, many of which are only remotely related to Motivation’s core activities.

The reports concludes with a series of recommended actions for services, funders, Government and Motivation on service quality, systems and procedures, wheelchair users’ quality of life, service sustainability, and partnerships. These include:

- Seek to continue user training: wheelchair skills, peer, parent/caregiver, repair and maintenance;
- Support wheelchair user’s peer exchange and learning and sharing of good practice between services;
- Seek to roll out clinician/technician training: refresher and training of trainers (Basic, Intermediate, Managers);
- Seek to ensure ready availability of spare parts and basic repairs in wheelchair users’ local community;
- Maximise alignment and use of Indian Government’s Rights of Persons with Disabilities Act 5% funding allocation;
- Advocate and facilitate advocacy with Government and donors for funding for appropriate provision, including establishment of wheelchair clinics at district level;
- Review and strengthen partnership set up and management and continue pro-active work with partners.

1 Introduction

Motivation is an international disability inclusion charity and social enterprise that has working towards social impact for over 30 years. Its mission is to enable greater independence and opportunity for disabled people through the design and provision of wheelchairs, services, and training. Motivation India was established in 2011 and currently works with 82 partners across the country.

Motivation was a key partner in developing the World Health Organization (WHO) guidelines that set out global standards for wheelchair provision. It remains committed to meeting or bettering these standards.

It delivers its work by collaborating with non-governmental organizations (NGOs), Disabled Peoples' Organizations, government institutions, community groups and health and rehabilitation facilities on training, wheelchairs, technical and mentoring support. At the same time its work helps to break down barriers facing persons with disabilities by working with communities to tackle stigma and promote inclusion. In this way Motivation supports disabled people to access the educational, livelihood and social opportunities they are entitled to, so they can fulfil their potential.

According to the Indian Government's Census of 2011, there are 27 million people in India with some form of disability. Twenty percent of the population with disabilities has a mobility challenge, which means at least half a million people need wheelchairs.

With funding from LDS Charities, Motivation India delivered two projects to develop sustainable wheelchair services in India. A state government project and a network project—implemented with NGO partners and government partners, respectively—started in June 2017 and, following LDSC approval of a 12 month, no-cost extension, ended in December 2019.

Motivation India connected to local partners to provide training to users, technicians, and clinicians; and help raise awareness, knowledge and commitment to the significant advantages and benefits to users and wider society when due care and attention is given to appropriate wheelchair provision.

The projects provided 137 training places to 100 personnel from the partner organizations, under five training programs:

1. Wheelchair Services Training Package: Basic (for wheelchair users who are able to maintain an unsupported upright seated position);
2. Wheelchair Services Training Package: Intermediate (for wheelchair users who need additional support an upright seated position);
3. Product familiarization;
4. Wheelchair Services Training Package: Managers;
5. Referral, screening and follow-up.

The Wheelchair Service Training Packages were based on the WHO materials, with additional practicals and modules provided by Motivation. The International Committee of the Red Cross (ICRC) also supported some of the partner organizations with training and assistive devices.

Figure 1: Training places delivered.

Training Course	# Participants
WSTP: Basic	52
WSTP: Intermediate	15
WSTP: Managers	11
Product familiarization	46
Referral	13
Total	137

Through the projects and partners, 4,920 people with mobility conditions including poliomyelitis, muscular dystrophy, spinal injury and cerebral palsy are now using appropriate wheelchairs¹.

2 The evaluation

In September 2020, Motivation India released the Terms of Reference for the project for competitive tender. Shodana Consultants (Pune, India) was selected to conduct the evaluation. After an initial process to design the research methodology, data gathering, analysis, and reporting was planned for October/November 2020, but was delayed due to Covid restrictions.

Fieldwork started in early 2021, but government restrictions on social interaction and movement in response to the pandemic meant that the initial project design could not be implemented, and a new approach was swiftly developed, which sought to mitigate these unforeseen challenges with the primary mode of inquiry moved online, combining questionnaires and semi-structured interviews with key stakeholders across the length and breadth of the country.

Full details of the methodology are included in Annex 1, with a brief overview provided here.

2.1 Data gathering

The evaluators triangulated quantitative and qualitative data from the three key stakeholder groups:

1. The wheelchair users, their family or other caregivers;
2. Wheelchair technicians and clinicians delivering the products, training, and services;
3. Strategic leaders (of the partner organizations and government) involved in building and sustaining wheelchair services.

With end users, the evaluators sought to find out about their experiences with the wheelchair assessment and fitting, and the training and follow-up support they received. With delivery and

¹ **Motivation commentary:** By the beginning of 2020, Motivation had completed most of the activities except for the provision of some wheelchairs. Although the products were delivered to partners, Covid restrictions meant there were delays in assessing and providing all the wheelchairs.

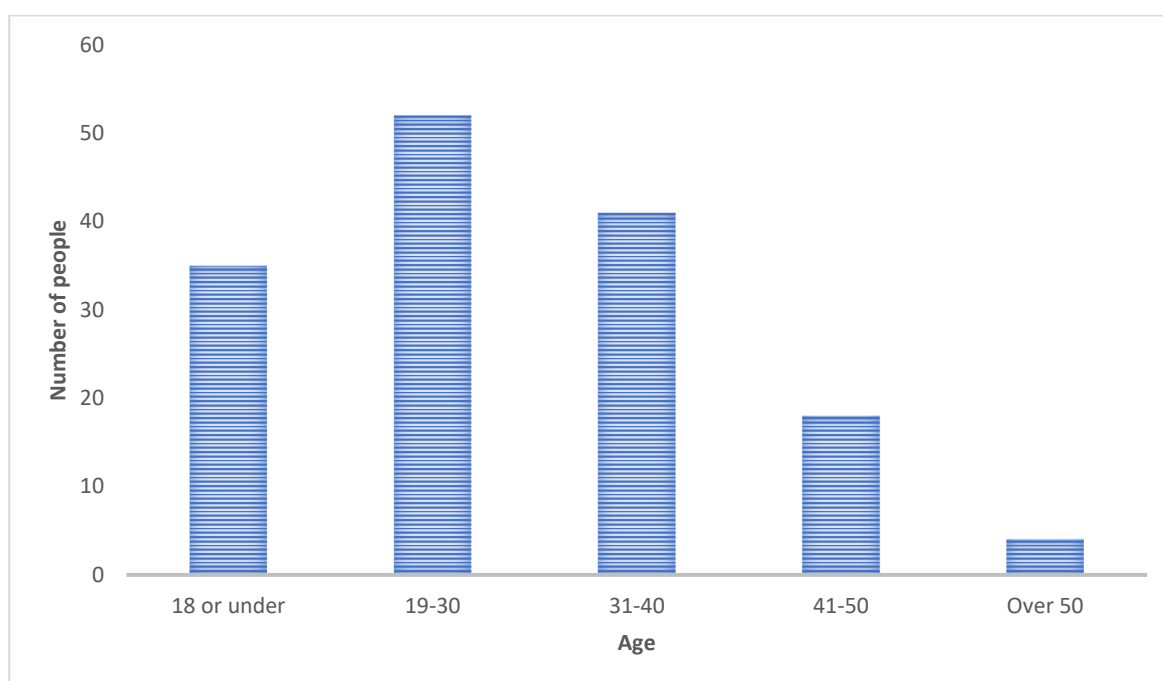
management staff, the evaluators explored the capacity-building outcomes of the projects, as well as their experience in fitting, adjusting, and maintaining the wheelchairs.

The qualitative data was analyzed by theme to draw out commonalities and key learnings. To complement, sense-check and build on the qualitative data, qualitative questionnaire data was also gathered.

2.2 Who we heard from

The twenty group discussions and the two questionnaires enabled the team to hear from 116 wheelchair users and 35 parents/caregivers of children who are wheelchair users. The total of 151 people represents 3% of the wheelchair users involved in the projects—68 were female and 83 were male, and 101 lived in rural and 50 in urban areas. The wheelchair users represented ranged in age from five² to 60 years old.

Figure 2: Age range of the wheelchair users represented in the evaluation.



This group report using their using their wheelchairs for between one and ten years, with most using them between 1–3 years, and 146 stated that they use their appropriate wheelchair on daily basis, with around a third of them (50 users) using their wheelchair for more than five hours a day.

Of Motivation India’s 82 service delivery partners, 17 from across 14 states engaged in the evaluation. Sampling aimed to ensure that as many voices and experiences as possible were included across the widest possible geographical area³, length of partnership and type of service.

² The child’s parent or caregiver took part in the evaluation.

³ E.g. the potential differences created by the terrain of Ladakh and Sikkim; the economic disparity between states such as Chhattisgarh and Tamil Nadu; or differences between high-density urban areas such as Delhi and rural areas of Gorakhpur in Uttar Pradesh and Chhatarpur in Madhya Pradesh.

Some partners operate a ‘clinic’ model, from dedicated premises providing machine/workshops, spare parts repository, and assessment facilities which could be visited by the wheelchair users and their caregivers. Other partners adopted an ‘outreach’ model where clinicians and technicians travelled with the necessary equipment to the users’ home/village.

The organizations that participated in this evaluation fitted and distributed 2,771 appropriate wheelchairs (56% of the total distributed) through the lifespan of these projects.

By interviewing both service managers and clinicians—usually a mixture of clinical professionals (occupational therapy, physiotherapy, etc.) and technicians (skilled at wheelchair repair, fitting, and maintenance)—the evaluation team sought to understand how their participation in the project changed wheelchair provision and users’ experiences, and their reflections and experiences regarding the long-term sustainability of the services across the country.

2.3 Limitations of the study

Shodana Consultants formulated the detailed proposal and methodology in October 2020 with the intent of gathering the data between January and May 2021.

The initial plan was to gather experiences by visiting partner organizations and gaining insight from service users, practitioners and managers, supported by other ethnographically informed practices such as transect walks⁴.

However, the social contact restrictions and travel limitations caused by the Covid 19 pandemic meant that the methods had to be amended as follows:

- Questionnaires were distributed electronically (using Google Forms) resulting in 151 responses, rather than in hard copy;
- The number of group discussions was increased from ten to 20, to mitigate the impact of the shift to online and its potential to hinder discussions. Of the 20, three were conducted in person and 17 online;
- Only two transect mapping exercises were possible.

2.4 The report

This report presents the findings of the external evaluation of the completed projects. Following the evaluation, the quantitative data has been independently reviewed and the Shodana content edited by Motivation for flow and clarity. Where Motivation has added commentary that was not in the main Shodana report, this is clearly marked.

The report sets out the projects’ outcomes with service providers—organized in line with the eight steps of appropriate service provision set out by WHO: Referral and appointment; Assessment; Prescription; Funding and ordering; Product preparation; Fitting; User training; and Maintenance, repairs, and follow-up.

⁴ For more information see https://web.worldbank.org/archive/website01408/WEB/IMAGES/1_TRANSE.PDF

It then sets out the findings around the outcomes for wheelchair users in terms of health, social inclusion and participation, livelihoods and independent living and family life.

Finally, it provides findings on service sustainability and ends with conclusions and recommendations.

3 Findings on service quality, systems and procedures

This section reports the evaluation findings with regard to outcomes of the project for partner services, mapped to the WHO's eight steps for wheelchair provision. The steps that were the core aims of these projects are assessment, prescription, preparation, fitting and user training.

The table below sets out which staff were trained in each of the partner organizations included in the evaluation. Four partners⁵ (P2, 5, 12, 14) did not provide data.

Figure 3: Number of training places provided at each partner organization.

Partner	Type	Clinicians	Technicians	Managers
BPA	Clinic	3	5	1
Christian Hospital	Clinic	2	2	0
DDRC East Godavari	Clinic	2	1	1
CIIT	Clinic	1	2	1
Kiran Society	Outreach	3	1	1
Margadarshi	Outreach	0	0	0
DDRC Burdwan	Outreach	0	1	0
Asha the Hope	Outreach	2	2	1
NIEPMD	Outreach	4	0	1
APD	Clinic	3	5	2
SPASTN	Outreach	1	1	0
PAGIR	Outreach	3	3	1
RDT	Outreach	3	4	0
Samuha Samarthya	Outreach	0	0	1
PGSS	Clinic	3	1	1

Three organizations did not have trained clinicians (P8, 9, 19) and three organizations did not have trained technicians (P8, 13, 19) to participate, and so other, non-clinical, staff were trained. At five of the organizations no-one participated in the Managers' Training (P3, 8, 9, 16).

⁵ Full names and code numbers of all partners taking part in the evaluation can be found in Annex 2. The partner (P) numbers correlate to the number of the group discussions referred to throughout the text.

For all of the trainees, this was the first WHO Wheelchair Service Training they had participated in. All of the respondents stated that the training was ‘Excellent’ and ‘Useful’. All of them stated that the sequencing of the Basic and Intermediate courses was important and should remain as is.

A striking outcome was that most of the physiotherapists and occupational therapists interviewed said that they had come to the training with low expectations. They thought that there was not much for them to learn as they already dealt with wheelchair users, doing functional assessments and advising on wheelchairs where necessary. A respondent (P2) said:

“When the question came regarding training on wheelchairs, we thought that there was nothing new that we would be learning since we are qualified physiotherapists and occupational therapists. We have learnt everything about wheelchair, its use and components during our college days. In addition, we are associated in recommending and supplying of the wheelchairs (ALIMCO and others) to numerous mobility impaired patients who come from far and wide.

Hence, we had a casual approach prior to undergoing the training. We also thought why five days were required for a physiotherapist to attend the training? However, we were completely taken aback when the WHO training module begun and by end of the training we realized that we knew very little about the wheelchair technology, the importance of the customization and what it really means to an individual user to enhance his/her dignity by bringing him/her much nearer to the society. We think that this training should be given to all physiotherapists and occupational therapists in the same way that we had received the training”.

Another respondent, a physiotherapist (P14), said that the wheelchair training was a new concept that had helped him understand the need of wheelchair users and importance of appropriate wheelchair in every patient’s life. Similarly, a department head said that before the partnership with Motivation, he was completely unaware of customized wheelchairs and the extent that it they can help disabled people.

Another, a clinician (P15) said she learned about providing a quality service for wheelchair user, prescription, ordering, funding, follow up, etc. Other individuals also spoke about realizing the importance of a wheelchair in the life of disabled people, better understanding how to deal with the needs for various types of locomotor disability, finding the training easy to understand, learning how to get user feedback and teach basic skills to wheelchair users. Another (P16) remarked that she thought the combination of training and wheelchairs that *“makes it outstanding”*.

Some spoke about going on to share the learning with others in their organization. Four organisations reported providing regular refresher training to staff.

3.1 Referrals and appointments

The WHO guidelines state that “The objective of good practice in referrals and appointment is to ensure that users have equitable access to wheelchair service delivery, to increase efficiency and productivity of the service, and minimize waiting lists”. Good practice includes establishing files when a person is referred, supporting referral networks and managing waiting lists effectively.

Progress towards these standards was indicated in the following evaluation findings:

- Twelve of the 17 service delivery partners maintain a comprehensive database of wheelchair users—from assessment to follow-up;

- Fourteen out of 17 service delivery partners maintain waiting lists of wheelchair users. The size of the waiting lists ranged from 5 to 125.

Motivation commentary: The WHO referral form was introduced to all the service delivery partners in the projects. In addition, outreach service staff and community-based workers were trained on how to select, refer and manage waiting lists during the two projects. However, this was done informally/additionally to the core project work as this area of the WHO eight steps was not a focus for the projects evaluated here. There remains a significant need for ‘Referral, screening and follow-up’ training amongst the service delivery partners.

3.2 Assessment and prescription

The objective of good assessment practice is to “accurately assess the needs of each individual user in order to prescribe the most appropriate wheelchair available”.

Training participants spoke about the changes in the quality of their practice as a result of the trainings, saying the training had changed their perspective towards the wheelchair and its features and helped them to understand the relevance of customization, comfort, and durability and user friendliness. For example:

- A technician (P4) said that, before the training, he believed that one type of wheelchair is suitable for all users, but he now understood the importance of customized wheelchairs and the needs of individual disabled people. Another professional said with the knowledge and skills received through the trainings, he was now able to do the assessment and fitments appropriately for users;
- A physiotherapist (P20) spoke about using his learning from the Basic training to assess 20 disabled people and customize the wheelchairs based on the assessment. An orthotics and prosthetics engineer (P16) said the training was an “*eye opener*” as he learned completely different aspects of wheelchairs. He specified learning more about the usage of various parts of the wheelchair like foot rest, pelvic supporter, cushion, spine, neck support, etc. during the Intermediate training, which he was unaware of beforehand;
- Other professionals reported that the distinctive features of the WHO basic training module were that it included assembling and customization of wheelchairs and the users’ training which were not covered in their undergraduate clinical curriculum.

One wheelchair user commented on the impact of this increased understanding and service quality, saying that she had never experienced a clinical assessment and customization of a wheelchair based on her needs before.

Professionals said their previous work pattern had been routine—the provision of physiotherapy services and preparation of routine assistive devices. With the LDS-funded project, they found that involvement with the client in assessing, prescribing, and fitting the wheelchair had to be more intensive, accurate and considered as they customized products for every individual’s need. They described finding this challenging, exciting and fulfilling work.

Although some trainees had managed to put their training into immediate use, the Covid pandemic and lockdown in India had a significant impact on the ability of the partner organizations to complete assessment and prescription as they rely on personal contact by the clinician or technician.

Given this, 11 organizations sought to provide services at the users' home, using appropriate hygiene and personal protection equipment. Where that was not possible, users visited the clinic or advice was given over the phone.

In terms of systems and procedures, service provider partners reported using WHO standard assessment sheets and checklists, shared through the projects. One organization shared that they fill all the details of assessment in hard copy, and it was then digitized. This meant that key information about the wheelchair users' assessment, fitting and follow-up can now be easily accessed by any member of the team regardless of location. Another said assessment records of wheelchair users are now maintained at the clinic in the format prescribed by Motivation India and follow up details are noted in the register.

3.3 Funding, ordering, preparation and fitting

Good practice in funding and ordering is to "order or procure the selected wheelchair for the users, as early as possible". This is followed by product preparation to 'prepare the wheelchair for the fitting, including modifications or custom postural support components' and finally fitting, where the wheelchair user tries the chair and checks the size, fit, posture and comfort with the clinician, 'to ensure the selected wheelchair has been correctly assembled and to make final adjustments'.

When asked about ensuring the eight-step standards of wheelchair service provisions, 13 organizations stated that they did not face any issues. However, four mentioned difficulties, including funding for wheelchairs, if provided at full cost, and funding, training infrastructure, service provision for the rural 'last mile'. Funding is discussed further in Section 5 Service sustainability.

The data showed that users received their customized wheelchair within a week from six partners; within two weeks from five partners, within a month for three partners; and after more than a month for three partners.

Those that provided after more than a month mentioned the remoteness of the wheelchair user for assessment and delivery. Wheelchair users from remote areas were called back to the clinic only after the wheelchair was assembled and adjusted, with minimal final fitting needed. This meant wheelchair users could go home with their customised wheelchair, so reducing the need for them to travel long distances.

These conversations with wheelchair users indicated they received their wheelchair within the time they expected. Many wheelchair users also spoke about liking the customization of the wheelchairs, noting that their previous experience had been of wheelchairs that were distributed without understanding whether it is appropriate for the user or not.

The professionals also spoke about customizing the wheelchair based on the users need, mentioning choices around the size of the cushion, modification of the foot rest and belt, and the cushion materials so that the cushion is comfortable to persons with intermediate needs. They had also taken the learning from the courses to adapt, as much as possible, other wheelchairs for greater user comfort by providing cushions, back rests, etc.

3.4 Training for users, families and caregivers

Good practice in user training is to “ensure that all users are given the information and training they need to be able to use their wheelchair safely and effectively”.

Through these projects the training was tailored to the wheelchair user and took between 30 minutes and two hours. The skills learnt included: how to handle the wheelchair; safe mobility; use on even and uneven surfaces; assisted stair climbing; navigating slopes; transfers; folding and unfolding the wheelchair; storage; and basic repair, maintenance and modifications. It may be completed in one session, but if there are time constraints or users did not have the energy for training following the assessment process, more skills were taught during follow-up visits.

Of 151 wheelchair users and family/caregivers consulted via the questionnaire, 140 stated that they had received training on the use of their wheelchair. The majority thought the training was ‘Excellent’ (61) or ‘Good’ (69). Fifteen users thought the training was ‘Satisfactory’ and three thought it was ‘Average’.

Through the training and their experience of the process, 109 wheelchair users were aware of the eight-steps of WHO wheelchair service provision and the service and standards they are entitled to.

Of the 17 partners participating in the evaluation, 14 stated that they also provide basic training regarding wheelchair repair to wheelchair users (142 of the 151 wheelchair users had been trained) and their family or care givers (107 had been trained). All of the trained wheelchair users said that they thought that the clinicians / technicians were fully competent to train them on repair and maintenance of their wheelchair. This indicates that the training the clinicians and technicians had received has equipped them to deliver the training effectively. Five users had not had the training and four did not comment on this aspect.

There were some examples of additional support to wheelchair users, e.g. one service partner (P15) had designed a repair and maintenance manual which they hand over to the users at the time of wheelchair delivery.

Also, within the project ten clinics were established and skills units were built with, for example, (P4) ramps, big and small steps, speed breakers, different terrains such as slippery, sandy, uneven roads, etc. These enable users to learn and practice using their wheelchair on different terrains. People using prosthetic and orthotics and other assistive devices also practice here. Other clinicians also specified using local surroundings to practice skills on using the wheelchair.

Wheelchair users who had had the training spoke about it boosting their confidence, about wanting to take more training and about arranging for their own additional mobility training.

3.5 Follow up, maintenance and repair

The aim of good practice in follow-up, maintenance and repair is to “evaluate the effectiveness of the wheelchair in maximizing the user’s functioning, comfort and stability, and ensure the equipment has been maintained appropriately and is in good condition”.

In terms of repair and maintenance, all of the organizations stated that the process from initial response to delivering spare parts was completed in a timely way. This is largely backed up by feedback from the users, with 145 people stating that they had never faced any service-related

issue. Three people said they faced a problem with the availability of spare parts and three did not answer the question.

From the users' point of view, 148 people answered about issues they faced and maintenance they carried out on their chair. When asked about the frequency of issues with their wheelchair, 107 people said they had not had any problems to date and 29 said they'd had an issue three or four times a year.

Most of the issues faced were reported as minor. In the majority of cases, wheelchair users did minor repairs themselves or via local bicycle repair shops. Almost all users stated that they can complete regular and minor maintenance of the wheelchair themselves.

Thirty-nine people said they did monthly wheelchair maintenance, 44 said they do it weekly and 27 reported daily maintenance. This indicates that the 142 people who took part in repair and maintenance training were using their skills regularly. Thirty-eight people had never undertaken any wheelchair maintenance.

One service delivery partner (P15) mentioned that they provide guidance about local shops and the availability of basic materials like washers, inner tubes, plywood, and cushions. Another (P8) spoke about conducting monthly maintenance drives where they contact the wheelchair users and, if any repair and maintenance is required, it is done immediately. If this is immediate attention is not possible, people can join quarterly repair and maintenance camps held by Motivation India at district level.

Figure 4: Frequency of maintenance vs frequency of issues with the wheelchair.

Frequency of issues	Frequency of maintenance				
	Daily	Weekly	Monthly	Never	Total issues
No problems	23	18	29	37	107
Once in a year	0	2	0	0	2
1 or 2 times a month	1	3	1	0	5
3 to 4 times in a year	3	19	6	1	29
Always	0	2	3	0	5
Total maintenance	27	44	39	38	

A third (37) of the people who reported no problems also said they never maintain their wheelchairs. This indicates, perhaps surprisingly, that in this data how often users maintained their wheelchairs did not have a big impact on how often they experienced issues with their wheelchair. The number of issues may, however, be related to the amount of use the chair has. Also, even if issues are not arising, lack of maintenance may affect the wheelchair's performance and longevity.

When there is an issue, users usually call the clinician/technician directly or, occasionally, relatives report the issue to the service center. Eleven of the 17 partner organizations reported that they maintain the log of issues raised by the wheelchair users. The average response time from receiving the message to providing the service sometimes took more than a month, but most issues were dealt with in less than a week.

During the group discussions, one clinician stated that many of the users forget the instructions given in the training and so even small maintenance and repair issues come to the services. Although this only came up once, it may be useful for the services to consider providing information for users to take away with them, such as the repair and maintenance manual provided by P15) and using a system of triage calls to see if they can be sorted out via phone, such as those in place in other service delivery partners.

Most of the partner organizations (11 out of 17) deal with repair and maintenance issues at the user's home. Otherwise, the wheelchair user visits the wheelchair clinic—for example P7 runs two-monthly repair and maintenance clinic staffed by five—or the issue is addressed via a phone or video call⁶. One example is of P4, whose staff have created a host a monthly Zoom meeting with the wheelchair users to identify and assist with any issues. One organisation (P18) runs a mobile repair and maintenance workshop.

Ninety-six of the wheelchair users reported that clinicians/ technicians had visited their home to provide the services and that they usually reach them the same day.

If the clinician/technicians had to wait for spare parts or if users are in remote areas, the time between report and repair extends to 'Within a week' or occasionally 'More than a week'. One reason for this was found to be that the skilled professionals were mainly available only at the main service center, so outreach services to users took longer to deliver.

All the users who were visited by a clinician/ technician said they were able to resolve the problem, indicating that the clinician/technicians' skills and the knowledge of the specifics of the wheelchairs gained through training enable them to fulfil this repair role effectively. The clinicians /technicians had repair kits with basic parts, but for more complex issues had to order spares.

In terms of getting spare parts, 93 users stated they got them within two days, 28 received them within a week, and seven users had to make more than a week. Twenty-two users did not answer this question.

Finally, many of the service delivery partners gave examples in the group discussions of setting up WhatsApp groups, making regular follow-up calls and providing further training sessions on repair and maintenance to their community of wheelchair users to support users beyond the immediate need for repairs or maintenance.

3.6 Conclusions

Overall, this data indicates that wheelchairs users feel supported, find the wheelchairs reliable and, where issues are found, can fix themselves or get support to fix them quickly and effectively. The data shows that 133 of the wheelchair users consulted were satisfied with the follow-up support they received. Fifteen people did not answer this question and three people stated they were not satisfied. It is reasonable to assume that at least some of the 15 people who did not answer the questions did not receive any follow up or were not satisfied with it. Not including them still leaves an 88% satisfaction rate.

⁶ Especially during the pandemic.

This points towards good practice in the WHO guidelines, ensuring the equipment has been maintained appropriately and is in good condition.

Most clinical/technical staff had taken the basic training, while a few had undergone the intermediate and managerial training. All of them had undergone this training for the first time.

A significant insight from this research was the response to training of the clinical staff. As skilled professionals, they were surprised by how much they learnt through the trainings, the ways in which appropriate wheelchairs can be fitted to the individual needs of the user, and the ways that such appropriate products impacted positively on so many aspects of their lives.

For example, clinicians (P7) noted that the service used to distribute wheelchairs without knowing the individual user's needs but, following the training, they understood the importance of wheelchair in user's life and the diversity in individual needs. The service manager (P7) noted he could now link managerial perspectives and the ground realities in a better way.

All of the wheelchair users engaging in the questionnaire or group discussions said that the wheelchairs they received were customised for them and had been received within six weeks of assessment, and that the Motivation chairs were more comfortable than their previous chairs.

Almost all stated that they are able to manage the regular and minor maintenance of the wheelchair themselves and most stated that they received spare parts in between 3 to 6 months.

The evaluation team was not able to identify any service gaps while going through the records maintained (during physical visits only) by the partner organizations or through the interaction with the user groups.

Thirteen partner organizations (76%) stated that they do not face any difficulty in delivering the eight-step WHO provision. However, four organizations identified issues or concerns, including:

- Funding of the wheelchair, which is difficult if it is provided at full cost;
- Brakes, front wheel, tube tyres, cushion require replacement;
- Funding, training infrastructure, service provision in remote areas.

Clinicians/technicians reported significant job satisfaction, which kept them in the sector, despite higher paid opportunities elsewhere. Working across the lifecycle of wheelchair services, training and follow up was described by some as providing "unique experiences, since each one of the clients are different from the other which they cherish as a continuous learning process". Similar feelings were expressed throughout the study, together with other benefits, such as (if working for a government organization) greater job security.

In general, the training allowed all practitioners (clinicians and technicians) to improve the comfort, fit, and ergonomics of the wheelchairs to the users' individual needs, which improved outcomes for the users.

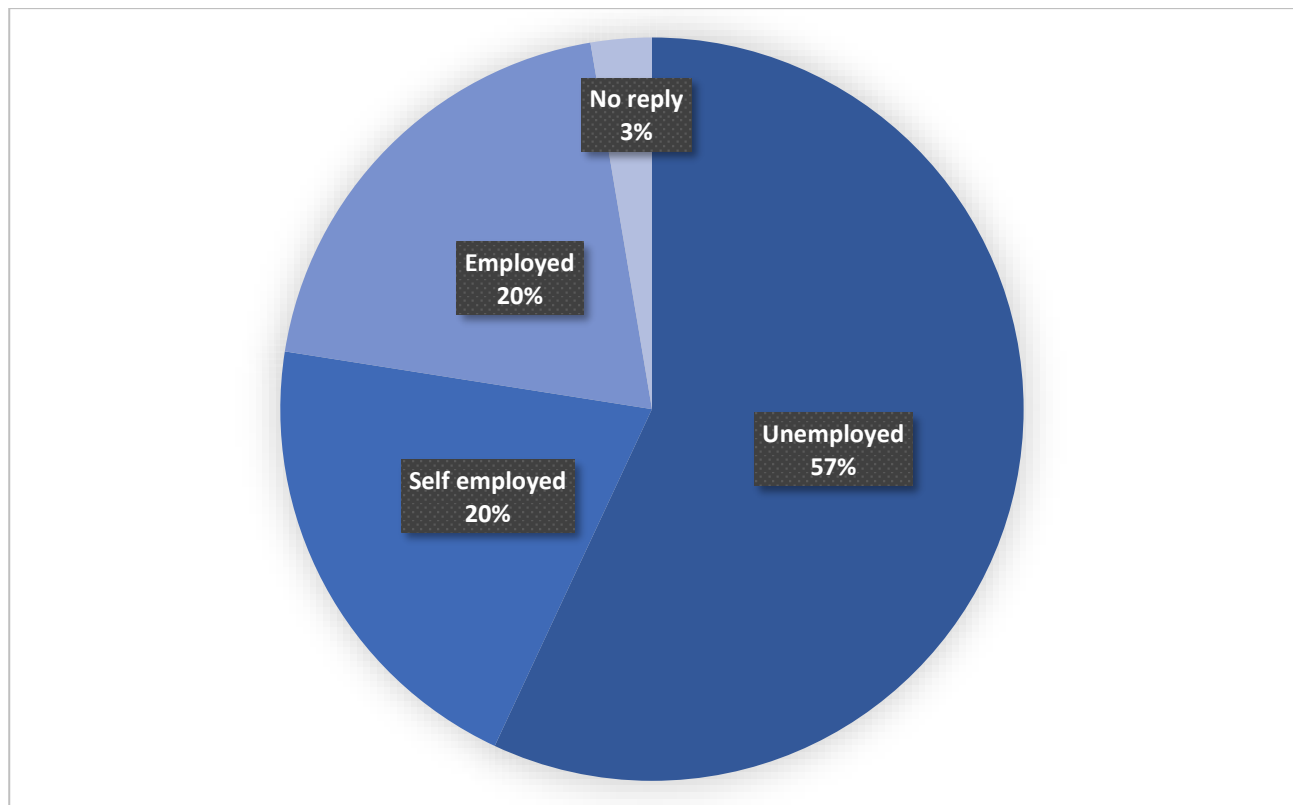
The evaluators assessment of the service partners' capacity in the WHO steps is shown in the table in Annex 4. It indicates that all of the services now provide an acceptable level of wheelchair provision, as set out in the WHO guidelines. It shows that five services provide average to good, 13 provide good to excellent, and two provide excellent services.

4 Findings on wheelchair users' quality of life

The wheelchair users and parent/caregivers who agreed to take part in the evaluation shared some demographic data with the evaluation team.

In terms of livelihoods, 86 were currently unemployed, 26 were self-employed and 23 (15%) were in a private job. Of the remaining 11 wheelchair users, five had their own business, three earn a daily wage, four had a government job and four did not respond to that question.

Figure 5: Livelihood activities of the wheelchair users participating in the evaluation

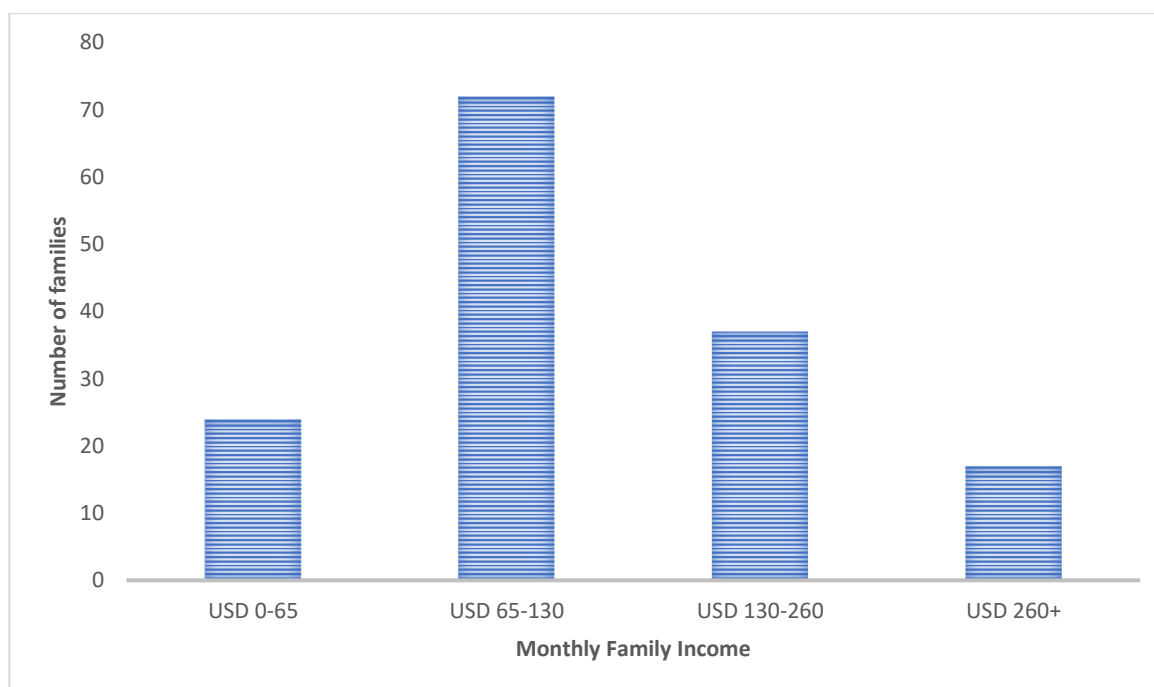


In terms of monthly family income, 24 wheelchair users' family income was below USD 60 (INR5000); 72 was between USD60 and USD120 (INR5,000–10,000); 37 had between USD120 and USD 240; and 17 families have a monthly income of more that USD 240 (INR20,000). One wheelchair user did not answer this question.

The estimated living expenses for a rural family of four in India is USD260 (INR19,000)⁷, meaning that all but 17 of the 150 wheelchair users who answered had a family income of less than the amount required for a decent standard of living. This does not account for the additional costs—such as medicines, incontinence supplies, and equipment—that a disabled person may have.

Figure 6: Wheelchair users' family income

⁷ Global Living Wage coalition 2020 [Living Wage Update: Rural India](#)



Feedback during the group discussions noted that the time needed to be right for newly injured people to participate fully in projects such as this one or social and livelihoods activities, as they make the physical and psychological adjustments to the significant changes in their lives.

The sub-sections below set out the information the wheelchair users shared in group discussions and questionnaires about the changes they had made to their lives.

4.1 Health

A key area spoken about by both clinicians and wheelchair users was how use of appropriate and well provided wheelchairs helped to prevent debilitating, and potentially fatal, pressure injuries.

Wheelchair users (P4, 5 and 15) spoke of being ‘saved’ from pressure sores, about how pressures sores meant some people had to stay constantly in bed and/or at home for up to 12 months—preventing them for taking part in social, education, livelihood or wider family activities—and of a vicious cycle where the money they had to spend on treating pressure sores meant they were not able to afford a wheelchair themselves. One parent (P8) related how the appropriate device has helped her son to sit with minimal support and his sitting balance has significantly improved.

Service delivery partner staff (P1, 2, 19) spoke about how appropriate wheelchairs prevent such injuries, and the availability pressure reducing cushions with appropriate chairs that they had not experienced with other wheelchairs.

This links into the ability of wheelchair users to remain safely in their chairs and mobile for longer periods of time, with around a third (50 people) of the wheelchair users involved in the evaluations using their wheelchair for more than five hours a day.

Wheelchair users (P6, 12, 17, 20) spoke about experiencing significant pain when sitting and maneuvering inappropriate wheelchairs and tricycles, which was significantly reduced or entirely absent when using wheelchairs that were appropriate and provided via assessment and customization through the project. They spoke about how pain and discomfort, and the levels of

energy needed to propel their inappropriate wheelchairs, had in some cases prevented them from using previous products at all.

As well as the cushions mentioned by clinicians, wheelchair users spoke about the height of wheelchair enabling good posture when working at their office desk and clinicians spoke about the adjustability of the back rest, foot rest, arm rests and brakes make the Appropriate wheelchairs more comfortable, better for disabled children and paraplegic patients and easier to transfer into and out of.

4.2 Social inclusion and participation

The feedback that wheelchair users gave via the questionnaire indicated changes in their social life once they had their appropriate wheelchair fitted and taken part in the users' training. They reported:

- Meeting friends and relatives – 133 people;
- Participating in community activities – 122 people;
- Participating leisure activities – 96 people;
- Participating in sports – 39 people.

There was a wealth of examples in the group discussions of the types of things people were now taking part in, such as:

- Exploring the neighborhood/district (P3);
- Meeting with friends and neighbors (P3, 6, 8 and 20);
- Going to restaurants (P1, 2), shopping malls (P1, 2) and markets (P3);
- Taking part in hobbies such as dance performances and modelling (P6);
- Taking part (and winning) in sports including marathons (P3), basketball (P18) and table tennis at Paralympic level (P1, 2);
- Visiting the temple (P3).

People also spoke about going out more often (P18), being able to climb stairs (P1, 2), going out in the car (P1, 2), giving children a ride on the chair (P3), travelling further independently (P3)' and being able to travel to where they wanted to go more quickly (P3, 12).

However, the world is, of course, still not fully accessible. People also spoke about difficulties caused by living on the first floor of a building and barriers in places such as the multiplex, restaurants and government offices which continue to inhibit their full inclusion.

4.3 Livelihoods

The questionnaire also found significant changes in the economic life of the wheelchair users as they moved to using the wheelchairs provided appropriately via the projects. These included increased:

- Self-employment – 82 people;
- Employment – 53 people;
- Family business – 38 people;

- Non-farm sector – 36 people.

In some cases, people's livelihoods activity had been supported by service delivery partners through inputs such as seed funding (P4).

Specific work mentioned by the wheelchair users the evaluation team heard from included Anganwadi (childcare centre) worker (P3), tailoring (P4), company director (P20), shoe maker specializing in shoes for foot disabilities (P6), CorelDraw designer (P14) and transportation business (P9).

One person mentioned that the fact that he can work more efficiently with the new wheelchair means he can now teach skills to other people. People also spoke about being able to earn more within their employment, with one saying his earnings had increased fourfold, although the pandemic had also impacted on people's ability to find or take part in livelihood activity (P1, 2, 4, 15).

Many people in business spoke about the tricycle being particularly useful as it is comfortable and maneuverable (P20), can travel long distances (P9) and can carry goods (P20).

The impact of livelihood work is, of course, wider than income. For example, one user spoke about the sense of achievement and freedom of getting to work independently by climbing the staircase in her wheelchair (P1, 2). Another person spoke about (P4) the impact on his children, who had been able to take up State Government funded studentships in another town because he was now able to live independently and confidently.

4.4 Independent living and family life

A hundred and eight of the 151 people consulted reported significant changes in their participation in family life since starting to use the wheelchair provided via these projects.

During the group discussions, wheelchair users elaborated on the experience before having an appropriate wheelchair and training via the project.

A key issue spoken about was the previous need to have assistance to push the chair and the sense of dependence on others (P3 4, 12, 18) and discomfort at having to ask for help (P18).

People also spoke about the difficulty and hardship of moving around their home or moving outside their home (P4, 12, 18), and fear of going out (P12).

In contrast, when speaking about life after they began to use the appropriate wheelchair—in many cases specifying the importance that it was customized for their specific needs—people spoke about being independent (P1, 2, 3, 12, 14, 18,), confident (P3, 14, 18), self-reliant (P18) and living with dignity (P16, 18). The independent living and family activities the wheelchair users spoke about included everyday tasks (P1, 2, 3, 6, 8,) and specifying household chores (P3), cooking (P6), cleaning, shopping and child care (P1, 2)

Many also mentioned being able to move within their home (P1, 2) and travel independently (P3, 4, 6), including to meet with relatives. One spoke about being able to ascend staircases up to 5th floor or above.

The evaluation team also noted that the construction of the wheelchairs meant that they adhered within the culture and religion of many of the project participants, as they have no leather parts,

and that the projects had successfully engaged participants across social, economic and geographical spectrum in the country.

Stairs and other barriers in the environment still continued to disable people, however, with informants talking about living in small spaces that make movement difficult, having stairs and no handrails or lift, making going in/out problematic, and living in an area with narrow alleys and streets.

4.5 Conclusions

Almost 100% of the wheelchair users reported that that they gained independence and dignity and benefitted in both their economic and social life when using the appropriate wheelchairs provided via this project.

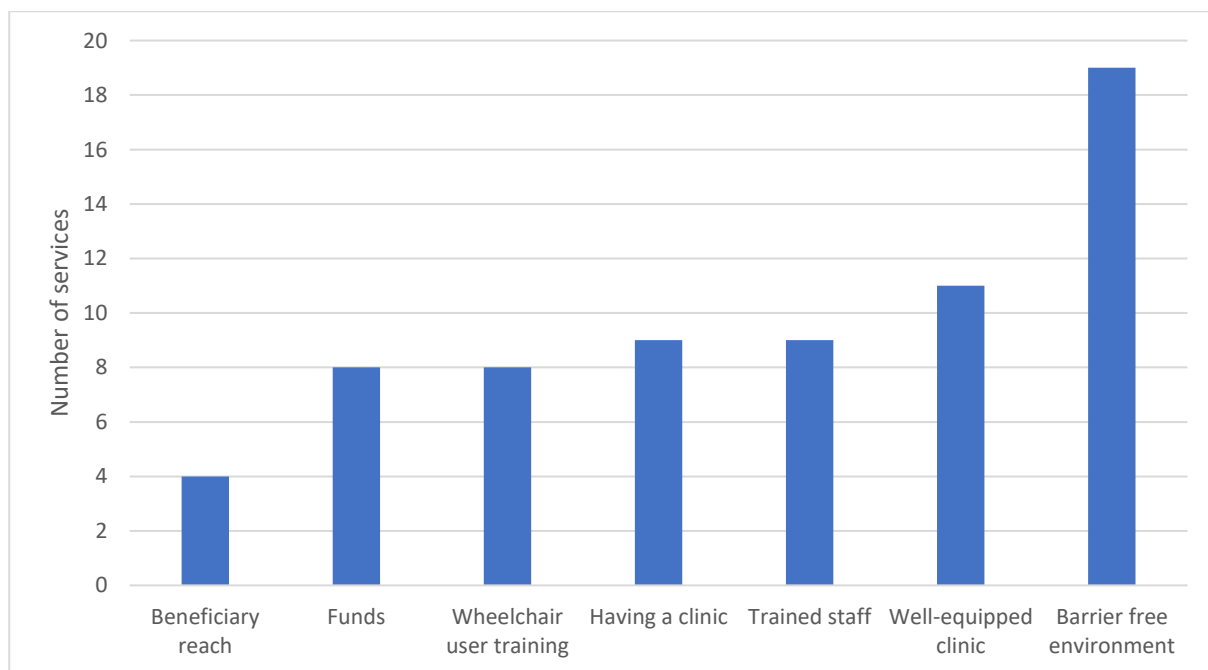
These results for improvements in quality of life related to appropriately provided wheelchairs align with the findings in the sector literature.

5 Service sustainability

The evaluation team asked group discussion and follow-up questions about services' plans for sustainability in terms of continued services to users after these projects had been completed.

The delivery partners reported the following barriers to service provision, around funding, staffing and the enabling environment.

Figure 7 Barriers facing services in wheelchair provision.



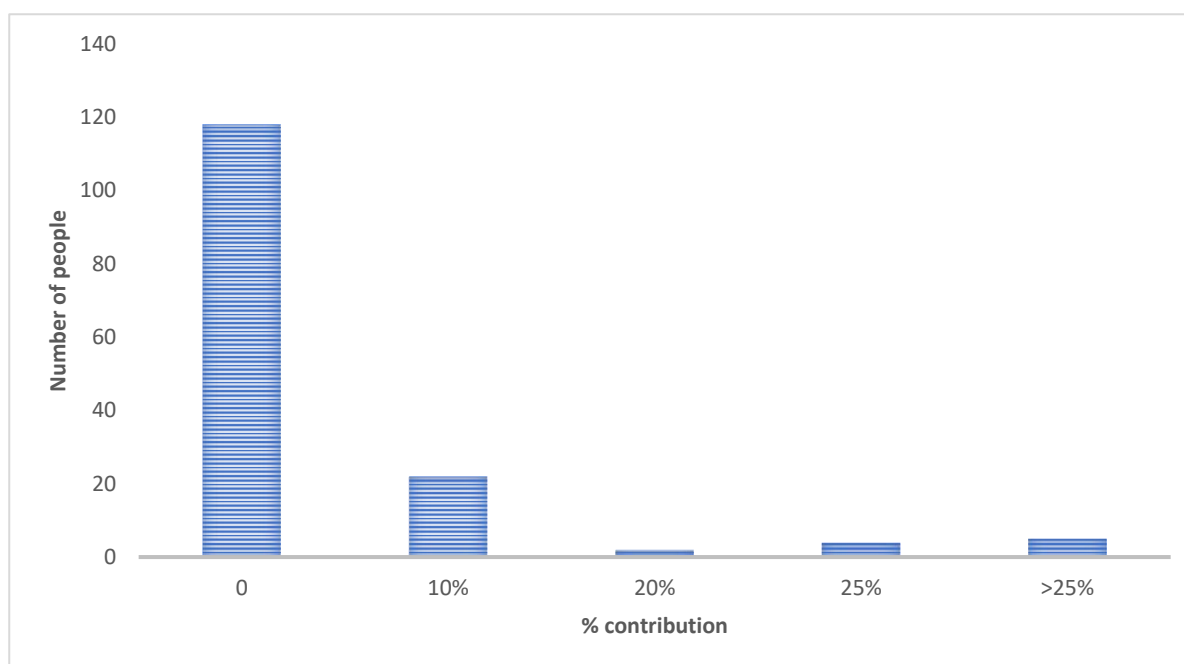
5.1 Funding

Firstly, considering the costs of the products themselves, in these projects LDS Charity's funding covered 25%–100% of the costs of wheelchairs, depending on the users' financial means. Partners contributed additional funds through various means including corporate social responsibility (CSR) funds, local donors and other NGOs.

Individuals also contributed. Of the 151 people consulted, 22 made a 10% contribution, two people made a 20% contribution and four people contributed 25%. Five users were able to contribute more than 25% of the wheelchair cost. Organizational and individual contributions towards the costs of wheelchairs were more prevalent in the richer states such as Gujarat, and to a lesser degree from Tamil Nadu and Karnataka.

The evaluation team noted that 22% of low-income households were able to contribute to wheelchair costs. One organisation (P15) said that, if the wheelchair users themselves were not able to contribute, they worked with neighbors and community to contribute and observed that this has worked well in their experience. An issue that came up several times (P4, 8, 14) in relation to individual contributions was the fact that disabled people had to pay for their medical treatment, including surgery and rehabilitation, which made it difficult or impossible for them to afford a wheelchair and/or repair and maintenance.

Figure 8 Financial contribution to cost of wheelchair.



Services (P1, 2, 6, 11, 20) also spoke about the ongoing costs of repair and maintenance, with some thinking users would find it difficult (P1, 2) and some (P6, 11, 20) stating that individuals and services were willing and able to pay for repair and maintenance.

As well as the initial wheelchair cost, lifetime value was discussed in the groups. Participants noted that appropriate chairs last longer due to being designed for the landscape/environment (P14), robust (P3, 4, 5, 7, 10, 15, 20) and locally repairable (P3, 4, 5, 14, 15, 19, 20).

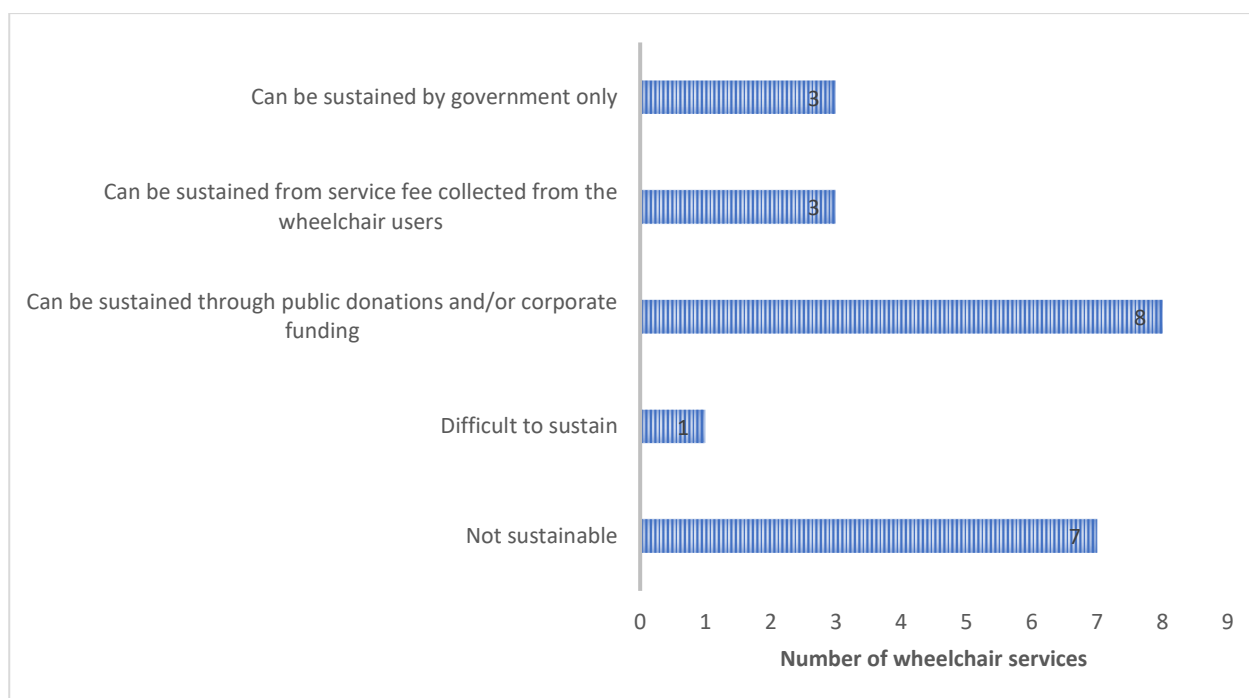
Overall, there was a mixed reaction amongst the services regarding sustaining a supply of wheelchairs to their clients. While services in Tamil Nadu, Karnataka, Gujarat, Chhattisgarh and one organization from Uttar Pradesh were confident of raising at least 50% of the funds needed through donor agencies, others felt that they may not be able to sustain provision without government or continued philanthropic support.

In terms of sustaining the services, in the group discussions organisations views ranged from stating that funding was ‘not an issue’ (P2) as there are many corporate and NGOs who are presently supporting this user group, to those that looked for an ongoing 50/50 partnership with Motivation (P16, 19) or an extension of the full support provided under the projects (P6).

When speaking about receiving funds from international donors, one organisation (P18) mentioned the impact of the new FCRA rules and another spoke about the impact of currency fluctuations on the cost of imported wheelchairs (P4). Two others (P7, 11) mentioned that pivoting funding to address the impact of the Covid pandemic had affected their funding for wheelchair provision.

In the questionnaire, eight organizations agreed in the statement that ‘A wheelchair clinic is possible to sustain after the project’, further identifying public donations and/or corporate funding and service fees collected from the wheelchair users as sources of funding. Three organisations thought services could only be sustainable with Government support and seven organizations stated that services were not sustainable.

Figure 9 Wheelchair service views on financial sustainability.



Overall, the evaluators found varying capacity to fund ongoing appropriate wheelchair provision, regardless of the demand for and value of these services. Some services recognized that buying appropriate products would be difficult after the projects and other subsidized schemes had ended, and they would revert to providing inappropriate products with a shorter lifespan on the grounds of purchase cost (P7, 12).

5.2 Staffing

Another key issue in wheelchair provision sustainability is the availability of staff with the relevant training to work in the sector.

Of the 15 service delivery partners who provided data, three have six or more clinicians / technicians, seven have three or four, two services have just one or two. Three organizations did not have and trained clinicians (P8, 9, 19) and three organizations did not have and trained technicians (P8, 13, 19). In addition, the evaluators observed that there was a very little availability of human resources in rural, and especially remote rural, areas.

Responses suggest that existing practitioners are not able to build a sustainable career in this sector, especially in smaller cities/towns and rural areas, as funding remains limited and inconsistent, and it is therefore not seen as a viable livelihood option. For example, one organisation (P9) had had eight staff members but lack of funds meant they were unable to pay their honorarium and so they left, with just one member of staff remaining, and another (P16) reported that during the Covid pandemic funding was moved and they only managed to survive via a cost reduction of 5 to 20% on staff salaries.

In the organizations that did not have trained clinical or technical personnel, staff thought the training received via these projects meant they would choose to remain within and serve the organization rather than move to the open market. On the other hand, one organisation (P4) noted that the member of staff who had taken the intermediate training had left the organization.

As well as stating they found their roles in wheelchair provision challenging, exciting and fulfilling work (see Section 3.2), clinicians also noted (P1, 2) they were working later hours to meet wheelchair users' needs.

While their work pattern changed as a result of the projects, the data also revealed that only five organizations stated that the clinicians and technicians were fully occupied. Given that almost every organization has a waiting list, this suggests lack of adequate finances or supply of products is hindering provision.

5.3 Advocacy

A key action towards sustainability identified by the services consulted for this evaluation was advocacy, particularly with regards to funding and particularly with government offices. Examples of current Government funding mechanisms were given (P6, 7 and 8).

- Rolling two- to five-year agreements with all 29 state governments and an office in every state capital from where they coordinate with all the districts. They gave the example of Maharashtra, where they signed the first agreement in 2011, and renewed in 2015 and 2020. After signing the agreement, the Department of Health & Family Welfare and the Department of Medical Education provided a space for their office in J.J. Medical College, Mumbai, and a clinic in Sion Hospital from where they provide services to all the districts. When approaching state governments, they present their role as that of facilitator—rather than an independent entity creating a parallel system—with the activities seen as a State Government program where they ensure implementation quality (P6).

- Working via the Deendayal Disabled Rehabilitation Scheme, a government project for education for disabled children, through which the cost of assistive devices is covered. They note that funds get delayed due to the complex government procedures around the document submission, enquiry and verification process (P7).
- The Disability Commissioner who came into post in 2006 is an advocate for effective channeling of the 5% disability rehabilitation fund, which sits with Central and State Government and is routed by the Disability Commissioner to district and block governments. The state has significant human, financial and infrastructure resources via District Disability Rehabilitation Centers (DDRCs), including an MP fund of around 10 lakhs. Karnataka is the only state that spends Member of Legislative Assembly (MLA) funds for procurement of assistive devices. Until 2011, it only funded assistive devices for mobility disabilities but is now available to people with other disabilities too. He is expecting the DDRCs to provide repair and maintenance center for the assistive devices. The aim is for Karnataka to be a model for rehabilitation services in other states (P8);
- Collaboration through multi-sectoral linkages with Departments of State Government such as Health, Education, Welfare, Rural Development, Women Development to increase cost effectiveness and reach (P16).

Some of the services also spoke about advocacy work they have done including:

- Advocating with government for 100% budget allocation for procurement of appropriate wheelchairs and having permanent staff at the wheelchair clinic (P2);
- Sharing information on the concept of appropriate wheelchairs and wheelchair services to District Collector, District Disability Welfare Officer and other district level officers by organizing a two-day workshop (P8);
- Participating in camps run by the district administration, to raise the awareness of appropriate wheelchairs and the existing wheelchair clinics (P11);
- Having a specific policy and advocacy team that interfaces and networks with the Ministry of Women and Child Welfare, Ministry of Social Justice and Empowerment (including the Department of Empowerment of Persons with Disability and Senior Citizens), Ministry of Health and Family, Ministry of Primary and Higher (Public Instruction) Education, Ministry of Urban and Rural Development, Ministry of Skill Development and Entrepreneurship across all areas of their work (P15).
- Ensuring money spent by Government of Karnataka, MPs and MLAs is used for appropriate wheelchairs only, including by donating an appropriate wheelchair to the Deputy Commissioner's office to be displayed and raise awareness (P19).

They also spoke about advocacy and awareness raising with disabled people, organizing awareness camps, and providing information on the availability of government schemes for disabled people (P8).

Other service delivery partners (P6, 8, 9, 13) also expressed willingness to take an active role in advocating for funding and appropriate wheelchair provision, although noting that there were limits for some due to their place within the Government structure or their funding sources.

Finally, one organization (P15) spoke about their work in raising awareness in the community about the possibility of accessing the 5% funds reserved for the disability sector and has established the Rights of People with Disabilities task force where disabled people are advocates for this work and monitor the use of fund to ensure they are reaching disabled people.

5.4 Conclusions

Through these two projects Motivation has established and is supporting the ‘network’ capacity throughout the country, in part by partnering with larger government systems at the regional level and with national institutes attached to the Ministry of Social Justice and Empowerment.

However, limitations of resources to support and sustain appropriate wheelchair provision in India remain a significant challenge and the evaluators conclude that the issue of sustainability was a cause of concern for the majority of the partner organizations. A particular gap in availability of human resources in the rural areas and especially remote rural areas was observed.

6 Overall conclusions and recommendations

Given the resources and time available, the evaluation team conclude the project delivered the desired results.

The evaluation team also note that the projects successfully engaged participants across social, economic and geographical spectrum in the country.

The team conclude that the positive responses of the wheelchair users and service delivery partners during this evaluation indicate that the projects were relevant and effective and have significant potential to be scaled up.

The team also note a significant tendency for partners to expect too many and too diverse a range of support from Motivation, many of which are only remotely related to Motivation’s core activities.

6.1 Service quality, systems and procedures

The projects built the capacity of the 82 service delivery partners to provide wheelchair to WHO standards and the evaluation team were impressed by the motivation and commitment of the clinicians and technicians involved.

The services they provided following participation in the projects the service staff involved assessing and delivering the customized wheelchair within 15 days to remote areas and within three days in more urban areas, and training and following up with users effectively.

The steps of the WHO global standards which were the focus of the projects—assessment, prescription, preparation, fitting and basic user training—were being delivered in line with best practice.

The evaluators were not able to identify any service gaps through the records maintained by the services or through interaction with the user groups.

6.1.1 Recommendations

- Seek to put in place regular refresher training for all service partners;

- Develop a pool of Master Trainers who can roll out Basic, Intermediate and Manager's training;
- Translate and make available the training modules and user training packs into regional languages;
- Include information on the major provisions of the Government's Rights of Persons with Disabilities Act 2016 within training modules;
- Facilitate and advocate with funding agencies to collaborate with service delivery partners, especially for access to products;
- Understand and engage with work around the Rights of Persons with Disabilities Act 2016 that states that 5% of all development program resources should be focused on support for disabled people;
- Prepare an evidence-based document highlighting the differentiating features of appropriate wheelchairs for use in advocacy and fund mobilization.

6.2 Wheelchair users' quality of life

The projects successfully enabled 4,920 people to get the appropriate wheelchairs they are entitled to. The evaluation team note that almost 100% of the wheelchair users engaging in the group discussions and questionnaires reported increased quality of life as a result of being assessed, fitted, trained and followed up with on their appropriate wheelchairs.

The wheelchair users did not suggest any significant modifications to the activities and processes used in these programs. However, there were recommendations that arose during the group discussions and through the questionnaires.

6.2.1 Recommendations

- Ensure user training is a mandatory and funded part of all wheelchair service provision or projects⁸;
- Increase availability of repair and maintenance training;
- Seek funding for parent/caregiver training for the parents of children with developmental disabilities such as cerebral palsy;
- Develop a pool of Master Peer Trainers, as experienced and expert wheelchair users are the best placed to share the learning about wheelchair use⁹;
- Develop a short training video for wheelchair users and family/caregivers on how to do minor repairs and maintenance;

⁸ **Motivation commentary:** many users were trained when they received their wheelchair. However, these projects did not include funding for follow-up training so, particularly outreach services, found it difficult to do basic and advance skills (or repair and maintenance training) for all users.

⁹ **Motivation commentary:** Motivation runs Peer Training projects—which include wheelchair skills and discussion of areas such as relationships—in several countries and is working to fund work to expand and extend this to more locations and to include family and community in the learning and advocacy.

- Create a mechanism such as a sharing workshop for wheelchair users and partners to share learning around small improvisations of the wheelchairs to suit users' needs;
- Collaborate with flagship programs to facilitate livelihood activities for wheelchair users;
- Set up regular wheelchair users meetings;
- Work with or facilitate the formation of disabled people's groups through partner organisations to advocate for accessibility and inclusion in an organized and concerted manner.

6.3 Service sustainability

The issue of financial sustainability was a concern for the majority of service delivery partners involved in this evaluation. Services in Tamil Nadu, Karnataka, Gujarat, Chhattisgarh and Uttar Pradesh were confident of raising at least 50% of the funding required through donor agencies. Other services thought they would not be able to sustain the access to appropriate wheelchairs without Government support or continued philanthropic funding. No individual who the team heard from was able to afford the full cost of a wheelchair, although some could partially contribute.

Another aspect of concern was sustaining a skilled workforce and the availability of a career in wheelchair provision. The evaluators note that affording and retaining such professionals is almost impossible for small and medium NGOs.

The evaluators also note that the establishment of wheelchair clinics is of paramount importance. While this is possible with larger partners, problems remain for smaller organisations.

6.3.1 Recommendations

- Collaborate with State Government to facilitate the establishment of wheelchair clinics at district level in all DDRCs;
- Advocate, with partners, for State Government to invest in recruiting and retaining professional service staff¹⁰, including use of Rights of Persons with Disabilities Act 2016 funding;
- Advocate for Central and State Government to include the appropriate wheelchairs in their approved list of assistive devices;
- Put in place an awareness generation program around disability and its prevalence;
- Frame a methodology which Motivation and partners can use while visiting Government partners to facilitate collaboration between the Government and service partners.

Suggestions received from the partner organizations regarding sustainability of wheelchair services were:

¹⁰ **Motivation commentary:** Motivation is currently delivering a project in Africa to include wheelchair service provision within the undergraduate curriculum of professionals such as physiotherapists, occupational therapists, etc. With donor and Government support, this could be rolled out in India as well.

- Continued pro-active partnership between Motivation and partner organizations beyond wheelchair distribution;
- Develop local NGOs to carry out basic repairs which are within a 10 km radius of the user;
- Ensure availability of low-cost spare parts at wheelchair clinics;
- Empower users, so they can choose and buy appropriate wheelchairs.

Motivation commentary: On reviewing the evaluation report, Motivation also identified the following actions for itself:

- Follow up with organisations to check that action has been taken for the five users who reported having issues every time they used their wheelchair;
- Review and, where possible, strengthen the wheelchair use training (15 trainees rated it 'Satisfactory' and three 'Average', meaning more than 10% of the people consulted may not have entirely had their needs met);
- Share examples of good practice of follow-up support—such as the repair and maintenance manual, monthly Zoom calls and two-monthly drop-in clinics, advice on local repair shops and material sources, block coordinators, mobile repair and maintenance workshops—across the network of service delivery partners and via training materials;
- Pool data about repair and maintenance issues for Motivation to include in design and development work.

6.4 Partnerships

Working with multiple partner organizations allowed these projects to deliver to a wide geographic spread of users. Each partner operates, develops, and learns in their own way, influenced by their funding, experience, capacity, and ambition, as well as their local conditions and user needs.

Thirteen organizations stated that they had an 'Excellent' experience working with Motivation India and four organizations had a 'Good' experience. None of the partners rated the experience 'Average' or 'Fair', indicating that Motivation India has built effective partnerships with the services.

During the group discussions (P3, 4, 19, 20), service delivery partner staff spoke about the ongoing support they received from Motivation India, extending beyond the funded project activities, which included advice and guidance via calls or webinars, quarterly repair and maintenance camps, etc.

The success of such projects largely depends on the efficiency and effectiveness of the partner organizations and thus the choice of partner is of utmost importance.

The evaluation team thought that one of the organisations (P9) was not in a position to carry the project outcomes forward, and notes that efforts for geographical spread should not compromise the quality of project delivery.

In another organization's case (P10) the evaluators concluded that the model of cascading the projects via them to their partners meant these secondary partners did not have sufficient knowledge of the projects and that the projects did not have an effective feedback system, centralized data collection from partners or sufficient knowledge of the end users.

They also noted that smaller organisations operating in remote regions (e.g. P 17) require additional and ongoing support.

6.4.1 Recommendations

- Provide additional WHO Basic training to Ramji Trust and PAGIR;
- Ensure rigorous due diligence and clear expectations around standards in partner selection, including results-based management;
- Ensure sufficient resources and time to build partner capacity and provide ongoing support and mentoring before the end of the partnership are including in project planning and funding;
- Ensure sufficient initial training and human resources are available for smaller, more remote partners and develop a separate strategy to support and ensure they can sustain the activities after a project ends;
- During such projects, Motivation should maintain a central management information system for continuous monitoring of partners' activities and checks and balances on products and services.

Annex 1. Methodology

The evaluation study used both primary and secondary data collection through physical and virtual mode wherever possible physical mode was used but the pandemic prevented from continuing the physical mode and was converted into virtual method of interaction. Earlier it was thought that 10 Ps would be sufficient for the purpose of qualitative data collection. Since, most of them were thought to be undertaken physically at the community level through physical visits. This was increased to 20 Ps keeping in view that India is still at the infancy level when it comes to communication with the community through the digital media. While the communities are used to direct physical interactions they feel intimidated when it comes to screen presence. Hence it was thought that more number of Ps would at least partly compensate the physical interactions. However, some of the areas where the evaluation team had to compromise was the community transact walk that could not be achieved except for two districts i.e. Ahmedabad in Gujarat and Chhatarpur in Madhya Pradesh where the evaluation team had gone for physical visits just before the unfortunate second wave of the pandemic. Hence the observational and tertiary data was limited to only 3 physical visits.

Three levels of respondents were part of the study. Firstly, the leadership level of the organizations, secondly the clinicians & technicians and thirdly the user group. Again we had to compromise the virtual organizational visit since most of the institutions remained closed due to the pandemic and the interaction had to happen mostly through their respective homes. However, the sessions were trifurcated amongst the organizational leadership, the staff & clinicians and the wheelchair users. The government interactions had to be done with the specialized institutes that included the National Institutes and the DDRCs both of which are under the Ministry of Social Justice and Empowerment (MoSJE), Government of India, which is the nodal ministry for disability in India. In addition, data was also collected through questionnaire method by using Google forms – one for the organization and the other for the user group. A total of 17 organizations and 151 users formed the part of the study. The study was geographically spread out to 11 states of the country. Basic statistical tools were used for analysis of the data.

The idea of framing and testing hypothesis was also dropped since it was found that the pattern of the answers were similar from all the 3 sections of the respondents, i.e. the leadership level, the staff and clinicians and the wheelchair users. The other cross-sections of the respondents such as parents and friends (as planned earlier) had to be dropped, again due to severity of the Covid-19 spread and digitally it was not possible due to internet issue in the villages. Thus, the variation was not thought to be sufficient for framing & testing of the hypothesis and assumptions. Hence the methodology of inquiry substantially rested on the Focus Group Discussions by virtual means and the data collection through Google forms.

For conducting the evaluation study in a systematic manner following sampling method was followed;

- Universe - The universe of the study comprised of 19 states, 82 partners with specifically defined households, the surrounding community, the state government and the local bodies.
- Scope - The scope of the study within the universe was limited to the geographical area of the 20 partner organizations (Clinic partners and Outreach partners) (shortlisted based on the geographical variation, partner type and beneficiary reach), their identified beneficiaries,

families, the community that they live in and only those state government and the government bodies, who have partnered with Motivation India.

- Sampling – Both purposive and non-purposive sampling technique was used to reach the various targeted stakeholders. The purposive technique was used since the states are defined and the interviews were limited to the wheelchair users, their families, wheelchair clinicians/technicians, the defined partner organizations (Clinic partners and Outreach partners) and the selected government institutions. The non-purposive sampling technique was used by applying Quota sampling. The beneficiaries (wheelchair users and the wheelchair clinicians / technicians) were homogenous in nature. Thus quota sampling was used by defining 10 to 15 wheelchair users were selected by the respective partner organizations who recorded their responses by filling in the questionnaire. Out of the expected 170 responses at the minimum, 151 responses were received.

As far as qualitative technique is concerned, Focus Group Discussion was used as method of enquiry. Accordingly, Ps with a total of 20 partner organizations were held which included 3 physical visits and 17 were conducted virtually by using digital platform.

Interactions were also held with all the clinicians / technicians of the partner organizations who were present during the Ps.

STUDY APPROACH

All ethical considerations were maintained including:

- Informed consent: information on the methodology was shared with all the project partners via two webinars. Partners were asked to share the information with wheelchair users. Questionnaires were explained by the evaluation team at the group discussions.
- Voluntary participation: Motivation India contacted each partner to invite their participation, and they in turn invited their service users to participate. Participation was voluntary and both users and partners contributed to the evaluation sufficiently understanding the scope of the questions to be asked. All questionnaires related to the evaluation.
- Confidentiality: all participants were assured that the data would be used for the purpose of this evaluation only. The evaluation team maintained confidentiality and data collected will only be used according to the scope of user permissions.
- Anonymity: the names and contact details of participants were not collected or stored by the evaluation team.

PHASE ONE: PREPARATION AND INCEPTION PERIOD

In order to brief the partners about the MI evaluation study and the exclusive focus group discussion with each partner along with their team and few wheelchair users, two webinars were conducted on 19th and 21st January 2021 respectively. In the first webinar 10 partners participated and in the later 9 participated. All the partners gave a short introduction about their organization and work specifically in the area of disability highlighting the wheelchair distribution & services thereon in particular.

During the webinar, tentative dates for physical visits to the organizations were chalked out. Based on these dates, physical visits to 3 organizations were undertaken in the month of February 2021 but later due to the second wave of the pandemic further visits came to standstill. Thus focus group discussions with the 20 organizations and the wheelchair users were conducted virtually, insights of which are mentioned in the subsequent section.

PHASE TWO: PRIMARY DATA COLLECTION / FIELD SURVEY

The evaluation study used both primary and secondary collection through physical and virtual mode wherever possible physical mode was used but the pandemic prevented from continuing the physical mode and was converted into virtual method of interaction. Three levels of respondents were part of the study. Firstly, the leadership level of the organizations, secondly the clinicians & technicians and thirdly the user group. In addition, data was also collected through questionnaire method by using Google form – one for the organization and the other for the user group. A total of 17 organizations and 151 users formed the part of the quantitative data collection.

PHASE THREE: DATA ANALYSIS AND REPORTING

20 organizations with proper mix of clinic and outreach were shortlisted from the total 82 partner organizations of Motivation India and Google forms were shared with them. Out of these 20 partner organizations, 17 have responded and three who have not responded include one government service delivery partner (Government Spine Institute, Ahmedabad) and two other organizations – Ramji Trust, Tamil Nadu and Ganga Spinal Injury Foundation, Tamil Nadu). A total of 151 wheelchair users or their family/caregivers responded to the Google forms. Basic statistical tools were used for analysing the data collected through Google forms which include frequency counts, arithmetic mean, cross tabulations and graphical presentation. The insights drawn based on the data gathered are mentioned in the appropriate section.

Annex 2. List of service delivery partners participating in evaluation.

The partner (P) number correlate to the number of the group discussion referred to throughout the text.

Acronym	Partner	Type	P
BPA	Blind People's Association, Ahmedabad, Gujarat	Clinic	1
GSI	Government Spinal Institute (), Ahmedabad, Gujarat	Clinic	2
	Christian Hospital, Chhatarpur, Madhya Pradesh	Clinic	3
DDRC, AP	District Disability Rehabilitation Centre, Andhra Pradesh	Clinic	4
	Ramji Trust, Theni, Tamil Nadu	Outreach	5
CIIT	Cure International India Trust, New Delhi, Delhi	Clinic	6
	Kiran Society, Varanasi, Uttar Pradesh	Outreach	7
	Margadarshi, Bengaluru, Karnataka	Outreach	8
DDRC, B	District Disability Rehabilitation Centre, Burdwan	Outreach	9
ICRC	International Committee of the Red Cross, Delhi	Outreach	10
	Asha the Hope, Raigarh, Chhattisgarh	Outreach	11
JSR	JSR Special School, Nainital, Uttarakhand	Outreach	12
NIEPMD	National Institute for Empowerment of Persons with Multiple Disabilities, Chennai, Tamil Nadu	Outreach	13
GSIRC	Ganga Spine Injury and Rehabilitation Foundation, Tamil Nadu	Clinic	14
APD	The Association of People with Disability, Karnataka	Clinic	15
SPASTN	The Spastics Society of Tamil Nadu, Chennai, Tamil Nadu	Outreach	16
	PAGIR, Ladakh, Jammu & Kashmir	Outreach	17
RDT	Rural Development Trust, Ananthapur, Andhra Pradesh	Outreach	18
	Samuha Samarthya, Koppal, Karnataka	Outreach	19
PGSS	Purvanjal Gramin Seva Samiti, Gorakhpur, Uttar Pradesh	Clinic	20

Annex 3. Wheelchairs provided by partners participating in the evaluation.

Partner	District	People with mobility impairment ¹¹	% of people with a disability	Wheelchairs distributed	Waiting list
BPA	Ahmedabad	1276196	17	293	25
GSI	Ahmedabad	1276196	17	380	Unknown
Christian Hospital	Chhatarpur	54530	37	155	125
DDRC	E. Godavari	2195215	42	215	74
Ramji Trust	Theni	400806	32	45	0
CIIT	New Delhi	44177	31	31	20
Kiran Society	Varanasi	595648	16	34	5
Margadarshi	Bengaluru	1067030	11	270	50
DDRC	Burdwan	1960261	25	10	Unknown
ICRC	New Delhi	44177	31	0	Unknown
Asha the Hope	Raigarh	732351	49	0	20
JSR School	Nainital	286095	30	5	Unknown
NIEPMD	Chennai	976278	21	50	No waitlist
GSIRC	Coimbatore	921915	26	174	Unknown
APD	Bengaluru	1067030	11	741	80
SPASTN	Chennai	976278	21	50	No waitlist
PAGIR	Ladakh	23147	17	4	Unknown
RDT	Ananthapur	1361063	33	161	No waitlist
Samuha Samarthya	Koppal	501622	36	43	40
PGSS	Gorakhpur	781153	17	120	53
Nationally (India)		341097847	28	4920	Unknown

1 ¹¹ As defined by the Rights of Persons with Disabilities Act, 2016

Annex 4. Wheelchair service capacity following the LDS-funded projects

Indicator	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	P14	P15	P16	P17	P18	P19	P20
Referrals and appointments	5	3	5	5	1	5	5	3	1	3	3	1	5	5	5	3	1	5	3	5
Assessment and prescription	5	3	3	5	1	3	3	1	1	1	3	1	3	5	5	5	1	3	3	3
Funding and ordering	5	5	5	5	1	5	3	3	1	5	3	1	5	3	3	3	3	3	3	5
Product preparation	5	5	5	5	5	5	5	3	5	5	3	5	3	5	5	5	5	3	3	3
Fitting	5	3	3	5	5	3	3	3	5	5	3	5	3	5	5	5	5	3	3	3
User training	5	3	3	5	3	3	3	3	1	1	3	3	3	5	5	5	1	3	3	3
Maintenance, repair and follow-up	5	1	5	5	1	5	5	3	1	1	5	1	3	5	5	3	1	5	3	5
Total	35	23	29	35	17	29	27	19	15	21	23	17	25	33	33	29	17	25	21	27
Average	5.0	3.3	4.1	5.0	2.4	4.1	3.9	2.7	2.1	3.0	3.3	2.4	3.6	4.7	4.7	4.1	2.4	3.6	3.0	3.9

Where 0 = below acceptable standard, 1 = Average, 3 = Good, 5 = Excellent.

Annex 5. Barriers faced in wheelchair provision

Partner	Type	Barrier free environment	Funds	No clinic	Well-equipped clinic	Trained staff	Beneficiary reach	User training
BPA	Clinic	√	×	×	×	×	×	√
GSI	Clinic	√	×	×	√	×	×	×
Christian Hospital	Clinic	√	√	×	×	√	×	×
DDRC East Godavari	Clinic	√	√	×	×	√	×	×
Ramji Trust	Outreach	√	√	√	√	√	√	√
CIIT	Clinic	√	×	×	√	×	×	×
Kiran Society	Outreach	√	×	×	×	×	×	×
Margadarshi	Outreach	√	×	√	√	√	×	√
DDRC Burdwan	Outreach	√	√	√	√	√	√	√
ICRC	Outreach	√	×	√	√	√	×	√
Asha the Hope	Outreach	√	×	×	×	×	×	×
JSR Sp. School	Outreach	√	√	√	√	√	√	√
NIEPMD	Outreach	√	×	√	√	×	×	×
GSIRC	Clinic	√	√	×	×	×	×	×
APD	Clinic	√	×	×	×	×	×	×
SPASTN	Outreach	√	√	√	√	×	×	×
PAGIR	Outreach	√	×	√	√	√	√	√
RDT	Outreach	√	×	×	×	×	×	×
Samuha Samarthya	Outreach	√	√	√	√	√	×	√
PGSS	Clinic	√	×	×	×	×	×	×