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Health and Disability in International Development Policy

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Abstract

This research has focused on the complex question of mainstreaming health and disability in the international development policy. The project has focused on five countries altogether: three donor countries (Finland, Japan and the United Kingdom) and two developing countries (Ethiopia and Kenya). A set of two case studies were conducted. The first focused on the process of mainstreaming disability in Japanese and Finnish development policies and practices with a special focus on civil society actors. The second was on mainstreaming of health issues in the United Kingdom and Japanese development policies in Ethiopia and Kenya. Altogether 65 persons were interviewed in the methodological framework of a process study.

The project's main finding is that mainstreaming a marginalized theme (disability) in the arena of international development cooperation is a complex and major struggle. On the other hand, even when a theme is well mainstreamed (health) priority-setting can still be a politically challenging negotiation process. While mainstreaming themes and getting all stakeholders to contribute more is an arduous task, implementation remains the most complex and challenging task facing the international community in efforts to reduce poverty and reach the Millennium Development Goals. On the basis of the findings on negotiation process and implementation strategies of mainstreaming, we analyzed the results of the two case studies in terms of mainstreaming a theme into a policy and actor politics. In the end, we provided three practical implications and four recommendations to relevant actors in this field.

2. Introduction

> "We will have time to reach the Millennium Development Goals – worldwide and in most, or even all, individual countries – but only if we break with business as usual. We cannot win overnight. … And we must more than double global development assistance over the next few years. Nothing less will help to achieve the Goals." *Then United Nations Secretary-General Kofi Annan*[1]

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[1] http://www.un.org/millenniumgoals/ (Visited on August 28, 2007).

In September 2000 world leaders adopted the United Nations (UN) Millennium Declaration, committing their nations to stronger global efforts to reduce poverty, improve health and promote peace, human rights and environmental sustainability. The framework of eight goals and 18 target areas known as Millennium Development Goals (MDGs) has a timeline to year 2015. A basis for setting this timeline was the requirement for donor countries to reach the 0.7% of Gross National Income (GNI) devoted for official development assistance (ODA) as recommended three decades ago by the UN. Health is the most crucial element covering six of the MDGs. On the other hand, the analysis of disability interventions on the basis of the MDGs framework is authenticated by the words of the former WHO director, Gro Bruntland, who said that: "Given the vast numbers of people with disabilities and the complexity of disability issues, it is necessary for UN agencies to put together a common agenda on disability and to implement it."[2] While health features so prominently in the MDGs, disability issues have not enjoyed a similar articulation. This is the arena of this study.

Trends for overseas development assistance (ODA) show a notable increase since the declaring of the MDGs in 2000 from US$53.7 billion to US$78.6 billion in 2004, 0.42% of donor countries' average Gross National Product (GNP) (OECD/DAC, 2005). However, estimates indicate that donors should substantially increase their ODA-to-GNP ratios more rapidly during 2006–15. The important point is that the increase of financial commitment does not automatically lead to the eradication or reduction of poverty. Increasing the quantifiable number is currently a vocal policy agenda particularly paramount in the MDGs, while the actual process is left to each actor and thus unclear including the way how the different themes are mainstreamed into policy and implemented in practice. This study, therefore, take health and disability as examples to elaborate the extent to which these themes have been mainstreamed at policy level, the process of mainstreaming and implementation in practice using specific country cases.

3. The Project

In order to reduce and eventually eradicate poverty around the world, various global development policies have been ratified including MDGs. This poverty reduction ideology has been mainstreamed at the international policy level. However, poverty is a diverse concept of multidimensional deprivation of opportunities (UNDP, 1997). Therefore, the actual practices are frequently different in terms of the definition of poverty, focus, approaches and modalities depending on different actors while actors themselves have been diversified. That is, different actors negotiate to mainstream their priorities to the development policy discourse. Studies on thematic focus on health and disability in development policy are scanty. Those that exist (e.g., STAKES, 2003; Owen and Roberts, 2005; Watanabe, and Takahashi, 1997), however, take the policy for granted and do not elaborate to what extent the issues are mainstreamed in the policies and implemented in the field. This study sought to fill these gaps. Health and disability are the two main thematic focuses. On the one hand, health has been mainstreamed widely in

[2] http://www.healthlink.org.uk/PDFs/DD1.pdf

development policy as essential part of social development component in the MDGs. On the other hand, disability has been marginalized and not mentioned in MDGs. In this regard, focusing on these two fields makes the study interesting as it elaborates the extents of their mainstreaming in development policy and practice at a valuable juncture in the international development intervention efforts. At the same time, we paid special attention to the role of NGOs firstly because of the increasing recognition on local ownership and committed participation in the process of development (Fowler, 2000; Chambers, 1997; Korten, 1990; Sen, 1999) and secondly because of the understanding that development takes place as a result of changes in all different levels (Katsui, 2005). NGOs have gained visibility and importance in development discourse because of their expected participatory characteristics. Civil society participation and partnerships in poverty eradication was a central framework of the study.

The project is a process study[3] on policy and implementation. The study had two focuses: 1) the mainstreaming process of health and disability in the donor country development policy; and 2) implementation practices particularly of NGOs[4] on the ground in developing countries. The objective of the study was to investigate the mainstreaming process of health and disability into development policy and practices, thereby reveal the role of NGOs in reflecting the voices of people in participatory development from policy process and implementation. The study tried to contribute to the dialoguing of social understanding of participation, policy-making and implementation analysis, processes that comprise current international aid efforts for poverty alleviation. Our case studies were on 1) mainstreaming of disability issues in Japanese and Finnish development policies and practices and 2) mainstreaming of health issues in the British and Japanese development policies on the ground in Ethiopia and Kenya. We analyzed how stated policies of international development cooperation from three countries (Finland, Japan and the UK) are created and translated into practices. The study utilized two main methods to achieve its goals: systematic policy analysis and institutional analysis and development framework (Ostrom et al, 2002). This involved documentary policy and literature reviews, evaluation and consultations with key informants in the field. Policy and contexts reviews were undertaken in the analysis to see the extent to which health and disability issues had been mainstreamed. Key indicators of this were the explicit nature of the policy statements and the commitment. Various interviews were conducted with relevant governmental and non-governmental actors and experts (15 in Japan, 14 in Finland, 13 in Kenya, 21 in Ethiopia and 2 in the UK). The process approach allowed us to use a descriptive analysis of the contextual factors facing the development policies and their implementation. The findings from each case study are separately

[3] Process studies deal with questions of context and decision-making and seek to understand how planning data and the relationships and interactions among various actors affect policy choices and strategies (Gilbert, Specht and Terrell, 1993: 17-18).

[4] We follow the NGO concept of United Nation which defines NGO as follows: A non-governmental organisation (NGO) is any non-profit, voluntary citizens' group which is organized on a local, national or international level. Task-oriented and driven by people with a common interest, NGOs perform a variety of services and humanitarian functions, bring citizens' concerns to Governments, monitor policies and encourage political participation at the community level. They provide analysis and expertise, serve as early warning mechanisms and help monitor and implement international agreements. Some are organized around specific issues, such as human rights, the environment or health (United Nations, 2003).

written (please see Attachment 1 and 2). On the basis of the findings this final report was formulated.

4. Results

This part summarises the results from two case studies separately: first findings from the North and second those from the South. A discussion of the common findings is made in the next section.

4.1. Mainstreaming of Disability Issues in Japanese and Finnish Development Policies and Practices

The first case study was on the mainstreaming of disability issues in Japanese and Finnish development policies and practices. The mainstreaming status, perception on the mainstreaming status, and the process of mainstreaming in the Northern contexts were elaborated.

A. Mainstream Status of Disability in Japan

In Japan, its development policy (ODA Charter) mentioned "disabled people" in the previous version produced in 1992 as one group of socially vulnerable people. The current one issued in 2003, however, does not mention it any more. Instead, it is considered to be included into "socially vulnerable people." The key actors in the framework of governmental development cooperation are Ministry of Foreign Affairs, JICA and Japan Bank for International Cooperation (JBIC)[5] which are in charge of grant, technical support and ODA loan respectively. JICA started its activities on disabled people in 1976 by sending an occupational therapist to Malaysia (Kinoshita, 2005). JICA created a report on participation of disabled people in 1995 and 1996. Until recently, projects for disabled people were centred to medical rehabilitation, education and vocational trainings by non-disabled professionals.

The only activity that involved disabled people as a central actor of development cooperation was the leadership training that started in 1986. In 2002, JICA started a bilateral technical cooperation project with Thailand to work on empowerment of disabled people and mainstreaming of disability into development. Asia-Pacific Development Center on Disability (APCD) project was planned, implemented and evaluated by disabled people and their organisations. In 2003, JICA created a guideline for the development cooperation for disabled people together with a special committee composed of disabled people's organisations (DPOs) and NGOs for disabled people (JICA, 2003). Since 2004, JICA created Social Security Team that is in charge of disability projects and mainstreaming of this field into JICA activities. At present, JICA has more than 10 training courses for disabled people with different impairments in Japan that are mostly outsourced to Japanese civil society actors. In addition, it also implements bilateral projects in this field. However, disabled people had been objects rather than

5 The function of JBIC dealing with ODA loans will be merged into JICA from 2008 onwards.

subjects of these projects until very recently (Kinoshita, 2005, 152). When it comes to JBIC that loans large amount of money mainly to infrastructure projects, disability has not been specifically mentioned neither in its policy nor guidelines. It is considered to be included in one of the poverty reduction aspects. There has not been any disability-specific project in its history. However, JBIC has implemented various infrastructural projects mainly since 1995 that paid reasonable attention to disabled people in the form of barrier-free designs (Dobashi, 2006, 160). JBIC has also started to appoint a staff to deal mostly with disability issues since 2003. The current staff is a disabled person himself and has been working in this position since 2005. In 2005, a mailing list on disability and development was created by a Deaf researcher belonging to a governmental research institute. That is, the governmental actors started to focus on the activities of disabled people in this field. In the framework of human security whose concept has been promoted by Japanese government, disability in development has drawn more attention than ever before.

When it comes to non-governmental activities in this field, both DPOs and NGOs for disabled people have been mostly implementing their projects in Asia and Pacific region. Activities in Africa are rare. In 1993, Japan NGO Network on Disabilities (JANNET) was established to function as a network among Japanese DPOs and NGOs that work in this field. The number of organisations dealing with disability in development is gradually increasing. Major DPOs with different impairments have been implementing JICA funded trainings and projects. At the same time, a few non-governmental foundations focus on grants and scholarships to disabled people. The series of superficial facts both from governmental and non-governmental actors seem to verify that disability in development is an emerging issue in Japan particularly during the last decade.

B. Mainstream Status of Disability in Finland

In Finland, disability in development has drawn attention at around the same time but has been more visible both at policy and practice levels. In late 1980s, mainstreaming disability particularly in international development policy has become a Finnish focus and commitment to UN. In development policy made in 1993, one of the three goals of it development cooperation was already promotion of equality and human rights. In 1996, National Research and Development Centre for Welfare and Health (STAKES) published the Manual for Inclusive Planning for the UN. This manual included Rapid Disability Analysis, which is the foundation of current Rapid Handicap Analysis (RHA). RHA is a practical tool for mainstreaming disability into development. Ministry for Foreign Affairs of Finland (1996) produced a policy as follows, “To attain the goal of poverty reduction, the Government will draw particular attention to the status of disabled people in the developing countries.” In 2000, the Nordic countries had a conference, “Conference on Disability in Nordic Development Cooperation,” to mainstream the disability aspect into development project plans. However, mainstreaming disability in development was left as a recommendation and not as a binding policy. In 2002, an external disability expert was appointed to support disability-related activities of the Foreign Ministry. In 2003, Foreign Ministry commissioned an evaluation study to STAKES (2003) on this field, which clarified the following points: 1) Finland allocates 5% of its ODA into disability-

related activities, 2) most of the activities are outsourced to NGOs which means that bilateral and multilateral activities are limited, and 3) most of such activities are disability-specific ones and not mainstreaming ones. In 2003, the first Global Partnership of Disability in Development (GPDD) meeting was held in Helsinki. In 2004, Finnish disabled activist and disability expert became task force group members of GPDD. Finnish government is one of the three governments that financially support this multilateral mainstreaming activity of disability in development. At present, Finnish Development Policy 2004 articulates disability as one of the cross-cutting issues in Finnish development policy together with gender and environment (Ministry for Foreign Affairs of Finland, 2004, 8). In this way, disability has been mainstreamed at policy level as a relevant issue to tackle in all development cooperation activities. Disability in development, therefore, seems to have been paid reasonably good attention in Finnish development policy.

When it comes to civil society activities in this field, both DPOs and NGOs for disabled people have been implementing majority of their projects in Africa and about a quarter in Asia. Projects in Latin America are rare (STAKES, 2003, 42). Non-governmental activities in this field started at around 1980s. In 1989, Finnish Disabled People's International Development Association (FIDIDA) was established. It has facilitated the cooperation of different organisations in this field. At the same time, this organisation is the channel between the government and DPOs in this field for mainstreaming disability into development. In 1991, the Foreign Ministry decreased the self-funding share for disability-specific projects to half of non-disability-specific projects: 10% and 20% respectively. In 2004, FIDIDA was assigned to screen project applications by NGOs and DPOs in this field for the Foreign Ministry to make the decision on granting project funding to high quality projects. In 2005, self-financing share for disability-specific projects was further decreased to 7.5%, while for non-disability-specific ones to 15%. In 2007, there are about 50 on-going disability-specific projects that are supported by Finnish ODA and implemented by NGOs and DPOs (FIDIDA, 2007). It is about 2 million Euros in volume this year. As this part summarised, Finnish recent history also seems to highlight that this field has become increasingly visible.

C. Perception on Mainstream Status of Disability in Japan and Finland

This sub-chapter summarises the subjective perceptions of the interviewed key actors on the status of mainstreaming in Japan and Finland respectively. Many Japanese actors feel some "development" of this field. For instance, at policy level, disability in development started to be recognised. Therefore, the recognition of this field is growing. However, the recognition or consciousness does not lead to a concrete action, which thus verifies that mainstreaming has not been promoted much in Japanese development practice. Few good examples were introduced. A disability expert was included in the government delegation members for the Social Development Summit Plus Five in 2000. Infrastructural aspect has also included the concepts of "barrier-free" or "universal design". For instance, there are JBIC funded projects that have paid attention to the accessibility of disabled people. JICA also made its domestic facilities accessible in 2004. These are the few examples of mainstreaming. Infrastructure is considered to be easy to tackle for Japanese people as it is the strength of Japanese society and development cooperation. However, this aspect of

Japanese development cooperation is not known because Japanese governmental actors are not good at advertising their achievements. When good examples are not known much, analysis on actual implementations are naturally missing. Thus theories and principles are discussed much but that does not lead to concrete action on the basis of the analysis of good practices.

Aside from these good examples, other activities in this field of disability in development are mostly disability-specific and thus focus is on empowerment rather than mainstreaming. Some research participants think that it is not high time to act on mainstreaming yet because empowerment has to come first. They think that people with different kinds of impairments are not included into the development discourse much and thus they have to be empowered first. Another example that verifies the underdevelopment of mainstreaming is the availability of fund for activities in this area. There are not many foundations or government money available for disability in development as a whole. Research on this field did not receive fund until very recently either and thus experts are either on disability or development and not disability in development. Under this circumstance, Japanese actors feel that mainstreaming has not been achieved much even though positive changes have been made.

In Finland, both governmental and non-governmental actors mostly share a common perception that disability is mainstreamed at a policy level. At the same time, Finnish actors realise that the policy was not the solution in practice. Finnish actors typically have ownership to mainstreaming on the Finnish development policy and practices because they lobby their issues to the government particularly through FIDIDA. They feel that they have made this field forward. On the other hand, the governmental actors also feel ownership to this issue because Finnish administration of the government body is quite small and each staff plays a significant role in raising some issue forward. However, these achievements are considered to be negative in a wider context. For instance, the existence of FIDIDA is not totally a direct channel to the government because it is an outsider. Thus FIDIDA and other DPOs cannot receive essential information from the Ministry. The preferable self-financing percentage is also criticised for hiding the underdevelopment of this field as a cross-cutting issue in the Ministry. The same percentage is also criticised for discouraging mainstreaming activities but rather forcing Finnish NGOs to choose either disability-specific or non-inclusive activities.

Good practices in the field have been accumulated to some extent particularly strongly in education field. For instance, Finnish bilateral support that started in 1974 in Zambia developed into sector-wide approach by involving Denmark and Ireland. The long-term involvement enabled local capacity building of DPOs, special education teachers and decision makers among others to understand the importance of “Education for All”. This seems to have led to national policy development (STAKES, 2003). Some NGOs have witnessed mainstreaming as a result of their disability-specific projects over a long period of time. However, many other fields including urgent humanitarian aid and bilateral projects do not mainstream this field much. The government is also criticised for outsourcing the interventions of this field mostly to NGOs (STAKES, 2003). As a result, most of the interventions are disability-specific because Finnish NGOs work on empowerment of Southern DPOs as the first step which is expected to result in mainstreaming in the South. Furthermore, new development modalities such as budget support and sector-wide approach tend to ignore disability in the South but Finnish

disability activists cannot do much about it. This part will be mentioned further. Under this circumstance, Finnish actors are quite critical to the current situation except for their positive perception to their policy.

Actors from both countries, therefore, are not satisfied with the current situation in terms of mainstreaming. Actors in both countries work on prerequisite conditions for implementing it in practice.

D. Five Primary Factors Affecting Mainstreaming Status of Disability in Japanese and Finnish Development Policies and Practices

Mainstreaming of disability into development policy and practices is a very complicated process due to various factors in the North. The findings indicate five main factors that deeply affect the changes and stagnation of the mainstreaming status of disability in the selected case contexts: 1) personal factors, 2) national factors, 3) international factors, 4) disability-specific factors and 5) development-specific factors.

Firstly, **personal factors** are quite crucial particularly for the very beginning stage of this field to be developed. Politically powerful disabled parliamentarians, namely Eita Yashiro and Kalle Könkkölä, have contributed to make disability visible in the mainstream discourse in respective countries. At the same time, personally created networks of disabled people around the world have been very important assets to develop this field further at present.

Secondly, **national factors** also explain the mainstreaming status. Superficially good relationship has been created between the governments and civil society actors working on this field. Nevertheless, asymmetrical power relationship in favour of the governments still hinders the development of this field to be mainstreamed. Moreover, the development of disability issues within Northern contexts is well-reflected into development cooperation activities. When some aspect develops in the North, it tends to be implemented also in the South through their development cooperation activities. Thus the development of disability rights in Finland was considered a positive factor, while that of infrastructure in Japan was the same. However, disability activists in Japan are preoccupied with domestic issues, which limit the overall efforts of this field in Southern contexts.

Thirdly, **international factors** seem to play a bigger role than national ones in pressuring the change of government policy and practices particularly in this field. UN year of disabled people in 1981, UN decade, appointment of Judy Heumann as a disability advisor in the World Bank have all led to significant positive changes. International networks have been widely used to create bigger pressure on own governments. UN Convention exemplifies this point very well. At the same time, showing the capacity of disabled people in international sphere also succeeded in convincing non-disabled people to understand the power and capability of disabled people.

Fourthly, **disability-specific factors** are both positive and negative in mainstreaming efforts. While disabled people show solidarity around the world to act for the peers in poorer conditions, other factors have been hindering the mainstreaming. Disability often loses in the heated competition among different themes to be mainstreamed because it is not a life or death situation. Moreover, it is considered to be

special with little information, which often ends up excluding disability due to its seemingly complicated and unknown theme. Different impairments under the general theme of disability all need different attention, which give the impression that understanding disability is too difficult. This difference also makes different DPOs isolated from each other without much cooperation among them. Due to the multiple discriminations, interventions have to be long-term to observe visible changes. However, capacity of civil society actors which often implement activities in practice is limited. Thus these disability-specific factors are not negligible in understanding the slow mainstreaming process.

Fifthly and lastly, **development-specific factors** make the situation more complicated. In the development cooperation system, the new modality of budget support and sector wide approach started to attract attention. In these modalities, disability is often ignored on the process of discussion among multiple donors and the recipient Southern governments. Disability is a minor issue, which is hard to be included at such a high level. Another difficulty stems from the power of funders. Money available for mainstreaming effort is small, while paper works take lots of time and energy. At the same time, making quantifiable, objective impact in short-period of time in this field is also extremely difficult due to the severe discrimination and poverty. In this regard, the mainstreaming of disability is not prioritized despite the urgency.

As has become clear from the above findings of the five factors, mainstreaming disability in development policy and practices is extremely difficult where many factors have to be properly intertwined to fabricate a visible change as a result. The significant roles of disabled people themselves and their organizations in promoting the mainstreaming were observed at different levels of the process. They have been the central actors in the politics of mainstreaming disability into the development policies or at least in the discourse of disability in development. The relationship among the NGOs indicates the sensitive nature of disability as well as the difficulty as a result. As for the relationship between governments and NGOs, the study found out how it has developed since the contact was made in 1980s. The direction of the development of cooperative relationship, or at least superficially “good relationship”, gives hopeful impression, while the crucial gap between them seems not to be filled in the nearest future. When the civil society started to play significant political role in the governments’ decision making, the crucial decision making power continues to remain in the governments which themselves do not automatically promote such a marginal issue as disability on the table of discussion when many more competing themes are pushing the ways through to the table. The idea that disability as disabled people’s issue is hindering the process of mainstreaming along with the fact that empowerment of disabled people is as important as mainstreaming. At present, the empowerment process is understood to be easier to tackle with, which scatters the resources away from direct mainstreaming efforts, while indirectly promoting the theme of disability in development as such.

4.2. Mainstreaming of Health Issues in the British and Japanese Development Policies on the Ground in Ethiopia and Kenya

This case study attempted to assess the nature and extent of mainstreaming of health in the UK's and Japan's ODA in Ethiopia and Kenya. By "on the ground" it was meant to explore the mainstreaming of health in both donor countries' development assistance policies in the two recipient countries, the scope of the aid and the specific projects funded as well as the institutional mechanisms for the delivery and implementation of the aid to the health sector citing NGO implementation. The finds regarding these areas are summarized in these five headings as follows.

A. Mainstreaming of Health in DFID and JICA's Development Policies in Ethiopia and Kenya

The UK has mainstreamed health in its overall framework for support to health sector development in developing countries as contained in the 2000 DFID's Target Strategy Paper (TSP) for health. Still DFID orients its support to each country's context and circumstances; Ethiopia reliance on donors for financing its huge health needs is 16% (FMOH, 2003). DFID's framework for bilateral support in Ethiopia is contained in a Memorandum of Understanding (MOU) agreed with the Ethiopian government. Specifically, DFID uses the Country Assistance Plan (CAP) for Ethiopia (DFID, 2003). Although the CAP at that time did not contain health sector support except for HIV/AIDS, it recognized the MDGs under which health is a major part. On the other hand, recent DFID policy-practice in Ethiopia shows an increased re-emphasis on health. The main health focus for DFID is on strengthening health systems essential to the effective delivery of health services provided through other donor initiatives.

In Kenya, DFID does not have a framework agreement with the Kenyan government. Hence each project is negotiated individually with the government and financing and programming decisions are made at the country level by DFID health advisors. DFID's support is based on the Kenya government's long-term program, Economic Recovery Strategy for Wealth and Employment Creation (ERS). Hence all of DFID's supported programs are consistent with the government's National Health Sector Strategic Plan (NHSSP). Nevertheless, DFID has developed a Kenya CAP for 2004-2007 that states DFID's aid objectives (DFID, 2004). As pointed out in the CAP, health is the single most important focus area for UK assistance to Kenya. The main focus of the funding is in the HIV/AIDS area which DFID regards as the "single largest threat to sustainable development in Kenya" (ibid. 2).

On the other hand, Japan's approach, philosophy and principles to international development are based on ODA Charter of 2003, wherein ODA is anchored upon a framework of 'partnership' with recipient countries and 'ownership' of the development process by the developing partner countries. In 2005 Japan also published the Health and Development Initiative (HDI), the country's framework for contributing to the MDGs for health. Japanese aid policy to Ethiopia is consistent with, among others, the HDI, international aid frameworks including the MDGs and the New Partnership for Africa's Development (NEPAD) and Ethiopia's national development plan, the Sustainable Development and Poverty Reduction Paper (SDPRP) which addresses key priority sectors including health. Since 2003 cooperation with Ethiopia has been formulated through biannual 'policy dialogue meetings' between local JICA Task Force in Addis Ababa and Ethiopian government officials. JICA's support to the health sector in

Ethiopia focuses on combating infectious diseases, capacity building of health administration, population and reproductive-health, promoting community-based prevention and early disease detection.

JICA's overall agreement with Kenya is not specific and only clarifies its office status in Kenya. Japan was a major donor to Kenya's health sector standing at third largest donor during 2001-2004. JICA's share of the health sector to total ODA support was 12% in 2006 (JICA, 2007). The priorities for Japan's ODA to Kenya's health sector are concentrated in three major areas: district health systems development, HIV/AIDS control and prevention; and infectious disease control.

B. The Institutional Mechanisms Used by DFID and JICA in Channeling and Implementing ODA to Ethiopia's and Kenya's Health Sectors

Ethiopia receives donor funding through various channels. In Ethiopia, until 2005 DFID's main funding mechanism has been direct budgetary support through the government finance system, i.e., the Ministry of Finance and Economic Development (MOFED). Following the political crisis in Ethiopia after the 2005 General Elections, DFID as well as other major donors to Ethiopia withdrew from general direct government funding under channel 1. A new mechanism called the Protection of Basic Services Program (PBS) was established with the World Bank leadership through which now DFID provides support. Although funding goes through government channels the controls donors can now more closely target and monitor how, and track the sectors in which, their assistance is spent. The PBS has four components; component 2 is called the Health MDG Performance Facility. Under this component DFID has allocated a share of its ODA to Ethiopia directly to the federal Ministry of Health. Under PBS component one DFID also funds health activities. Specifically in this component, funds are given to the federal government to top up its transfers to the *woredas* (districts). Here, the federal government is required to match the grant and transfer the sum to the decentralized *woredas* through the intergovernmental fiscal transfer and the regional block grant system. The PBS mechanism is channel 2 financing.

DFID also provides other funding for the health sector through the multilateral system such as the Global Fund to fight HIV/AIDS, TB and Malaria and through international NGOs. In the Ethiopia CAP's itemized funding, one component supporting HIV/AIDS projects was given through the International Partnership Against AIDS in Africa (IPAA), a multilateral coalition of actors comprised of African Governments, the United Nations agencies, donors, the private sector and the community sector.

In channeling ODA to Kenya's health sector DFID uses a mix of instruments such as direct budgetary support and specific projects implemented by the line Ministry of Health and NGOs. Nevertheless, DFID believes that supporting nationally-lead initiatives by the Kenya government is the best mechanism for achieving positive change in the long run hence it channels aid mainly through direct budgetary support. Under direct budgetary support goes to the government's financing system, i.e., the Ministry of Finance (MOF). Under this system, the government then appropriates the support according to its priorities. Direct health sector support through the government system goes directly to the implementing agency. For instance, DFID HIV/AIDS support goes to the government agencies charged with implementing the National Strategy on HIV/AIDS,

namely: the National Aids Control Council (NACC) and the National AIDS and STD Control Program (NASCOP). DFID also channels aid to Kenya with a variety of national and international bilateral and multilateral agencies such as the European Union and the Global Fund as well as through international and local NGOs in Kenya.

JICA does not channel its ODA to Ethiopia through either direct support to MOFED or the PBS mechanism to the federal Ministry of Health (FMOH). JICA's policy to Ethiopia recognizes the decentralized governmental and health system in its funding framework. Hence funding and technical cooperation such as equipment support is channelled directly to the regional health bureaus (RHB). On the other hand JICA's assistance is largely comprised of technical support, namely sending Japanese personnel (experts and lay volunteers) and equipment to work through the health system. In addition, Japan provides support through the multilateral system and programs such as the Global Fund. The major program of Japanese support has been for upgrading Ethiopia's polio inspection system and in providing polio and measles vaccines. This assistance was channeled through mainly UNICEF.

In Kenya, Japan has channelled its health sector support through both the government system and NGOs. The primary channel is direct support to the Ministry of Health. JICA provides financial aid, technical expertise as well as materials and equipments. JICA funding goes to rehabilitating government hospitals and facilities, and in training health personnel and developing research institutes, most notably the Kenya Medical Research Institute (KEMRI), Kenya's leading medical research institution, founded in 1982 by Japanese grant and supported since then. JICA works very closely with the MOH in Kenya but also channels aid to Kenya through the multilateral system such as the Global Fund.

C. The Scope and Outcomes of the ODA for Health by DFID and JICA to Ethiopia and Kenya

Ethiopia is the 5th largest recipient of UK aid to Africa. DFID is the 3rd largest bilateral donor to Ethiopia. DFID provides significant support to Ethiopia's health sector. During June 2006 to June 2007, about US$30 million or 15% of DFID's total bilateral ODA was allocated under the health MDGs component of the PBS to the federal Ministry of Health for procuring and distributing 6.5 million insecticide treated bed nets for malaria and 2 million doses of malaria treatment, as well as contraceptives for 3 million women (DFID, 2007). In addition, through PBS component one DFID has during the same period contributed over US$14 million to the costs of implementing the Health Extension Program (HEP), which was initiated by the Ethiopian government with the support of donors in 2004. The HEP is an effort to increase the number of health extension workers (HEWs) in the rural areas. By June 2007 17,653 HEWs had been trained and deployed, and over 8,850 health posts had been built. Estimates for reaching all rural communities with basic health services are 30,000 HEWs and 15,000 health posts. The amount of funding under the current three health projects (ongoing in 2007/08) amounts to US$38 million. Overall, since 1987 DFID has funded 35 with over 26.4 million British pounds (US$52) million.

As mentioned earlier, DFID main sector support to Kenya is health. DFID works in all the major health areas namely health reforms and decentralization, district health

systems, health financing systems, HIV/AIDS, and infectious disease control (TB and malaria). The main focus is on HIV/AIDS. In the Kenya CAP, DFID targeted to support Kenya's health sector by UK£7 million in during 2004/05 and 2005/06 for each year and targeted funding to the HIV/AIDS area of UK£7 million and UK£8 million in each year, respectively. Overall, DFID support to Kenya's health sector is about US$17.7 million a year. During 1997-2007 DFID was funding six health projects in different parts of the country to the tune of US$132 million. During 2001-2007 the malaria project was targeted to distribute 11 million insecticide treated bed nets (ITNs). The overall funding for NGOs constituting 25.8% of the total ODA of US$132 million during this period is quite significant.

Japanese aid to Ethiopia has increased over the last ten years. In addition, the country has increasingly become an important partner for Japan. Whereas in 1997 the country was the 7th largest recipient of Japanese aid in Africa, by 2002 it was placed 3rd. Total ODA rose from US$50 in 2002 to US$56 million in 2003. During 1999-2003 Japan provided 1.9 billion yen (an equivalent of 16 million in current US dollars) in health sector grants to Ethiopia. This represented 9.2% of all the overall grant aid totaling 20.7 billion yen in the same period. Comprehensive data from an external Organization of Economic Cooperation and Development (OECD) source show that JICA is currently supporting 12 projects in multiple health sub-sectors with a modest funding of US$2.6 million. Japanese support to Ethiopia's health sector has helped the country eradicate polio and improve maternal and community health through funding the construction of health centers and health posts as well as in improving human resources through technical cooperation.

Although Japan plays an important role in financing development in Kenya, the scope of Japanese aid to the country has decreased over the years from Japan being the largest donor to Kenya in 1997 and largest recipient of Japanese aid in Africa in 1998. In 2005 Japan was the largest bilateral donor to Kenya with US$61 million or 7.9% of all aid to Kenya in that year. During 2001-2004, Japan was the third largest donor in the health sector providing a total of Ksh1,094 million (16.4 million in current US dollars). This accounted for 9.5% of total development partner support in the sector. In 2006, JICA's share of the health sector support to the total ODA was 12%. About half of JICA's ODA to Kenya has been in technical support not in grant aid. In 2004, the ratio was US$26.63 million to US$14.36 million, respectively (JICA, 2007). In the same year the number of experts dispatched totaled 127, with 88 new and 39 engaged in ongoing projects. KEMRI, an institute of Kenya's Ministry of Health established with JICA support in 1982, absorbs most of the experts. For in stance, during May 2001 to April 2006, JICA had 15 and 48 long-term and short-term technical experts, respectively, working in KEMRI while a further 21 Kenyan experts were training in Japan. In 2002, Japan had six ongoing health projects whose overall established funding amounted to US$28.6 million. From 2003 to present, the project scope was 20 with a total funding of US$27.4 million.

JICA's support for research and training activities in the detection, control and prevention of infectious disease are the hallmark of health related assistance to Kenya. JICA has also been a major supporter of the Kenya Expanded Program on Immunization (KEPI) with measles and polio vaccines, transportation vehicles, coldchain equipment, and injection materials. Positive results of this support have been achieved in the

prevention of diarrhoea, hepatitis, AIDS and acute respiratory disease, which is the leading cause of death among children. JICA's long-term support to KEMRI has enabled KEMRI to locally develop much-needed testing kits for Hepatitis B Virus (HBV) and HIV-1 and 2 which have been previously imported. JICA has continued to support the mass production of these kits for use in Kenya and in the region. The HEPCELL II kit for HBV and the PA and Kemcon kits for HIV will reduce cost up to a third and a half of imported kits, respectively.

D. NGO Implementation of DFID's and JICA's Assistance to the Health Sector in Ethiopia and Kenya

DFID support directly to health NGOs in Ethiopia is very limited. Most of the support that may end up being implemented by NGOs goes through multilateral channels such as the Global Fund. The £1.25 million annual funding for HIV/AIDS during 2002-2005 cited in the 2003 CAP was channeled through the International Partnership Against AIDS in Africa (IPAA), a multilateral coalition of actors comprised of African Governments, the UN agencies, donors, the private sector and NGOs. It is not possible to trace the share of DFID funding under the multilateral mechanisms. Presently DFID has just one project being implemented by the US-based international social marketing NGO DKT International. DFID has funded the NGO with £3 million to distribute contraceptives through social marketing during 2005-2008. In Ethiopia, the NGO's contraceptive distribution in 2005 reached about 1.5 million couple years of protection (CPYs).

As pointed above, DFID's primary channel for aid to Kenya's health sector is through the government mechanism. However, DFID has supported NGOs to implement health projects. For instance, during 2002-2007, DFID has funded the US-based Population Service International (PSI), the leading social marketing NGO in the world, with US$26.5 million to distribute insecticide treated nets (ITNs). During 1997-2002, DFID also supported capacity building of 14 health NGOs in the reproductive health area in four provinces with US$34.5 million. Implementation of this project was done by the NGOs together with the Ministry of Health and other partners. DFID has funded other local NGOs such as the well-established African Medical Research Foundation (AMREF). One such project was the Health Development in Nomadic Communities: An Inter-Sectoral Approach in Lokichogio Division, Turkana District, Kenya. The project funded with £500,000 was implemented during 1999-2002 where AMREF was to build two static dispensaries and one semi-static unit for this nomadic community.

The Japan ODA policy to Ethiopia recognizes the participation of local NGOs and encourages collaboration between Ethiopian and Japanese NGOs. This is especially contained in the 2002 JICA Partnership Program (JPP). Through this framework, JICA has commissioned the Ethiopian NGO umbrella agency CRDA to provide information to Japanese NGOs wishing to carry out projects in Ethiopia (MOFA, 2005). At the time of the study in June 2006 JICA was supporting only one JPP project implemented by World Vision Japan in collaboration with one community on the ground in Amhara region. The two year (July 2005 – July 2007) US$412,744 grassroots project for HIV/AIDS was targeting 475,000 children 5-15 years with HIV prevention and youth and adults 15-49 with VCT and STI services. The project was implemented with the support of local staff and experts as well as by a Japanese management team.

At the time of the study, JICA did not have health projects implemented by NGOs. We did not find information on the JPP in Kenya. However, the Embassy of Japan in Nairobi administers a similar program by the name Grant Assistance for Grassroots Projects (GGP). In this program, local NGOs and community-based organizations can apply for funding directly to the Embassy in Nairobi. At the time of the research, the Embassy had funded two local and one international NGO to implement health-related activities in different parts of the country with US$181,000 for 2005/06.

5. Analysis

On the basis of the two case studies, the findings on mainstreaming can be summarized around two themes: 1) the negotiation process and 2) the implementation strategies. After a brief discussion, further analysis is given within the common framework of the study.

Firstly, the case studies shed light on the negotiation process of mainstreaming health and disability issues into policies and practices. Negotiation for both health and disability has to take place particularly for the operationalisation. In the study countries, health has been mainstreamed at the policy level to a greater extent while disability has been mainstreamed to a limited extent. The Northern case study traced back the development of mainstreaming activities on disability in development, which clarified the negotiation process into today's agenda, not necessarily into policy in a written, development policy (cf. ODA Charter). The theme has been vigorously negotiated primarily by disabled people themselves in the North despite of the marginal status of this issue and limited number of supporters. The individual promoters including certain governmental officials in charge of this matter have been playing key roles in negotiating the space for this theme and pushing it forward. Even if the final decision making on policy making is made by the governments in both countries, different actors have been accumulating particularly empowerment-oriented activities rather than mainstreaming ones to negotiate the theme into the mainstream agenda. That is, mainstreaming-oriented activities are limited. This is an interesting strategy whether it is effective or not. The mainstreaming has been promoted in a sensitive manner in terms of disability.

Unlike in the negotiation process of mainstreaming disability in the North, the mainstreaming process of health in the South seems to be quite a given in the donor countries and recipient frameworks. This is likely the case because all development intervention concerns combating poverty in one way or the other whether in projects addressing agriculture or infrastructure where health is a fundamental concern for improving productivity of the human capital. Hence policies for improving economic growth to reduce poverty must address the issue of health. In the least developing countries such as Ethiopia and Kenya the biggest challenges concern the health of the population. The international development regime has recognized and firmly embraced this fact, hence, the development of the Millennium Development Goals which have put health at the center of all aid efforts. Consequently, the donor countries have adopted and committed themselves to the universal goals. This has also meant that recipient countries can expect to receive donor aid if they have set their priorities so as to reach the MDGs to which they themselves are part of. As Fowler (2003: 16) points out, "MDGs define what priorities governments must adopt if they wish to access (greater) development funding

and indicate where aid flows will probably be directed". In targeting aid then, donors and recipients do not negotiate mainstreaming of health as a theme but the specific sub-sectors and geographical focus are subjects of ongoing political considerations.

Secondly, we found out that the implementation strategies of mainstreaming are more modest for disability. As health is already mainstreamed to a greater degree among the countries, there are nevertheless challenges in the implementation. This begins with the channeling of the aid from the donor to the recipient. As the case studies in Ethiopia and Kenya show, donors chose to channel their aid through different mechanisms. In both Ethiopia and Kenya, JICA favors providing technical expertise through the decentralized Ministry of Health system to giving direct budgetary support. Hence its grant aid is lesser in financial terms than in technical support, at least for Kenya. In doing this, JICA favors working directly with regional health governments than with the federal Ministry of Health. In contrast, DFID favors the federal government mechanism. While previously it provided direct budgetary support through the government's central financial system it still favors to work through the government system though directly with the health sector in the new PBS mechanism. Both donors also favor channeling support for health through the multilateral systems. Such funding is less easy to monitor but the assumption may be that such systems are more trustable and have comparative advantage. Although NGOs are recognized actors by both donors, the donors did not channel significant resources through this mechanism. On the other hand, donors may favor using large international NGOs and consortia that have a well-known comparative advantage. This is seen in the case of DFID in both Ethiopia and Kenya. In the case of JICA, the NGO mechanism is rather small and, in the case of Ethiopia, tied largely to Japanese NGOs.

Overall, **mainstreaming a theme into a policy both in North and South** are difficult when the theme is a minor one like disability. On the other hand, both health and disability have diverse sub-sectors under the themes, which complicate the mainstreaming process rather than facilitating it particularly in terms of its implementation. In health, for instance, the three MDGs for health concern improving maternal and child health as well HIV/AIDS, malaria and tuberculosis. As the evidence from the health case studies show, donor countries may chose to focus on specific health areas or specific regions of the country. While it is understandable that a donor do not enter in the same region to implement a project similar to one already being implemented, it is not very clear what influences the choice of one program over another. While a specific donor may endeavor to provide support in areas the donor has specific experience or good working relationship, it may not be the area with the greatest need. An example is a project of the European Union in Kenya implemented by the EU in partnership with the Kenya Ministry of Health during 2006-2007. Aimed at strengthening the provincial health administration to strengthen service delivery in the districts including supporting community-based delivery systems, one province targeted is well known to have the best health indicators in the country, hence, from a strategic point of view should not have been chosen. Nevertheless, it was for the reason that someone in the government wanted it to be one of the two benefiting provinces. The negotiation process of putting a theme on a table as an agenda for a policy necessitates various pressure both nationally and internationally, as has been clarified from the policy making process of Northern contexts. It is further complicated by the Southern contexts as the process involves many bilateral donors, international agencies and the Southern

government and other stakeholders, as has been clarified from the implementation strategies of Southern contexts.

Furthermore, even if the theme is properly included at a Northern or international policy level, they are often evaporating along the operationalisation process due to the mechanism of current policy implementation. Development policies under the study seem to work more as voluntary goals rather than as binding commitments. For instance, the 0.7% target of share of donor countries' GNP set in the 1970s has been reached by only five countries, not including Japan and the UK. Yet this is a commitment the countries have pledged to in knowledge of the fact that the MDGs would not be reached without that increased aid. This anomaly between policy and practice is also due to the peculiar development cooperation system. At the same time, the different modalities in the South do not necessarily secure sustainable, positive outcomes. For instance, multilateral support including direct budget support and sector wide approach is introduced to increase coordination among donors and ownership of the concerned Southern government and actors. However, they blur Northern commitment to certain issues at the moment and allow enough room for marginalized themes such as disability to evaporate more easily when Southern priorities are different from the ones raised by the Northern actors and policies. Thus mainstreaming disability into implementation in the South is more challenging than health.

When it comes to priorities of sub-sectors under the bigger themes of health and disability, the priorities and expertise of Northern countries on certain sub-sectors tend to be more easily implemented than others particularly when the interventions are project-based. In addition, the implementation of health- or disability-specific projects do not necessarily promote mainstreaming of these themes but rather specialize them, particularly so for disability theme. That is, financial commitment to the theme does not equal to commitment to mainstreaming the issues. When only project-based funding is available, mainstreaming is left out from agenda once again. This mechanism of development cooperation is part of the fundamental reasons why the mainstreaming of marginalized issues has been difficult particularly when it comes to the implementation in the South.

Another important analysis made on the basis of the findings is on the **actor politics related to the mainstreaming**. We shed lights on the role of NGOs and the relationship between NGOs and the governments in respective contexts. We observed that NGOs have played significant roles in this development field in different ways in different countries and contexts in terms of mainstreaming process. In Northern countries, NGO actors and individuals have been the driving force in taking the initiative to mainstream disability, while governmental actors were still ignorant to this issue then. This is also true with regard to HIV/AIDS. Although not discussed in the Ethiopia and Kenya case study, elsewhere it was shown that NGOs in Kenya played the most central role in bringing the HIV/AIDS issue into mainstream focus by the government. But perhaps this is one of the most documented areas in which NGOs were the key actors in drawing government to action in many countries including South Africa. Such initiatives were crucial in constructing current relationships between NGOs and the governments in the study countries.

Especially in the disability theme, the relationship between NGOs and the government was previously thin but was gradually strengthened to better maintain good

relationship to move the issue forward together. The good relationship was regarded as important when the government was lacking expertise on this issue, while NGOs lacked resources. In Finland, most of the NGOs currently use the government funding to implement their projects and programmes in the South. In Japan, several disabled people are deeply involved into the government agencies as special advisors, while increasing number of NGOs also receive funding from the government. In this way, NGOs are "independent" in their individual policies and actions and at the same time interdependent with the governments in the discourse of disability and development.

NGOs in both countries have some networking/umbrella structures to make their voices heard (JANNET in Japan and FIDIDA in Finland). Nevertheless, asymmetrical power relationship in favour of the government is one of the hindrances in mainstreaming of disability. The mainstreaming of disability was not much exercised in any particular form of activities by both NGOs and the governments except for several individuals and NGOs in both countries who are concerned with it. Actually in both countries, disability-specific activities are ample, while mainstreaming activities are extremely limited. Mainstreaming a theme was considered out of the scope of any single NGO in both countries but the job of networking/umbrella NGOs which were to raise common issues rather than specific activities. In this way, actually nobody is responsible of the mainstreaming in the North except for those limited number of NGOs.

When it comes to the Northern governments, they are already too busy with balancing competing themes to mainstream and hardly work on the mainstreaming of disability without domestic and/or international pressure. The elaboration on actor politics in this discourse revealed that the relationship between NGOs and the governments in the Northern contexts explains the fundamental failure of the development mechanism why disability or any other marginalized theme have had difficulty in being mainstreamed particularly in practice.

The closer look at the actor politics revealed another interesting aspect that international networking is made use of in mainstreaming disability in the Northern policy. As the governments' decision making power is much bigger and cannot be reached easily by NGOs, they pressure the governments from outside as well as inside by networking with different actors abroad. The governments seem to have bigger ears to international community than to NGOs, which is the perception by the interviewed NGOs in the study. They make bigger voices by collaborating internationally to mutually benefit from the bigger movement. The UN Convention on the Rights of Persons with Disabilities is an illuminating example of such effort.

The role of NGOs in the health area in the Southern case studies was elaborated. Quite clearly, the nature of the relationship NGOs have with their country governments impacts on their work as well on their relationship with donors. In Ethiopia, the conflictual relations with the government render them subjects of suspicion and can lead to delays in the implementation of planned projects. Yet some interventions such as the delivery of ARVs, malaria treatments or cholera medication need to be implemented without delay. When this happens the targeted population suffers even more. It is also noteworthy that in Ethiopia, because of the perceived threat to human freedoms and the emasculation of civil society by the government, donors may opt to fund NGOs working in the governance and advocacy areas to try to capacity build them to be more active so as to foster human rights and a culture of democracy. Hence, DFID main focus on

funding NGOs in Ethiopia together with other donors is on advocacy and governance. Thus, the political context of the country can draw away donors from supporting health NGOs. This is also based on donors' own preferences and ideologies.

We can also view the framework of mainstreaming in implementation, it in the context of the actors involved in the specific theme. In health, both donors used the government mechanisms in channeling their funding as well as in implementation. It can be said that among many concerns of donors and governments, health is one sector that is strongly advocated to be primarily provided by the government rather than the market (WHO, 2000). Hence, it can be expected that donors use the central government mechanisms even when, like in Kenya, there is a large health NGO system. On the other hand, precisely the fact that there is a significant NGO health system in both countries is a renders a good case for them to receive donor and government support. In Kenya funding from these sources is limited. This means that NGOs have to charge user fees to run their health facilities causing a good and a burden on the poor and perhaps replacing the government's obligatory role to provide healthcare. This fact is contrary to the perennial idea that NGOs are workers of mercy (Tvedt, 1998).

Implications of the Findings

The **implications** from the Northern case study are the followings: 1) Relevance has to be understood by mainstream actors, 2) Northern DPOs and disabled people have to be empowered, 3) political will of the governments is inevitable, 4) good practices have to be accumulated and lessons should be learned from bad practices, and 5) Southern disabled people have to be empowered. (Please read the Attachment 1 for more detailed implications from the Northern case study).

The implications from the Southern case study are the followings: 1) while health is a mainstreamed theme in the development policies of donor and developing countries, much more needs to be done to reach the health MDGs both in terms of massive increases in financing and in collaboration and coordinating of the funding and implementation efforts; 2) in fact, lack of collaboration and coordination of donors and recipient country actors is stifling efforts to improving health outcomes; 3) donors need a much greater understanding of the main players and key decision-makers who can create and sustain change in the recipient countries so as to target such persons and institutions; 4) cost-benefit analysis is crucially needed by donors in determining the most effective channel through which to provide funding so as to achieve the greatest good for the least amount of money; 5) there is a dire need for evaluation of donor projects without which it is not known what contribution or added value the aid has produced.

Common implications of the case studies can be summarized in three headings: 1) relevance, 2) multiple approaches, 3) need of evidence-based knowledge on planning and the implementation mechanism and its outcomes.

1. **Relevance of Development Themes:** Relevance is to be shared among different actors to be able to mainstream a theme into development policy and its implementation practices both in the North and the South. Contextual understanding is largely missing among the mainstream actors such as non-disabled people. When gender was mainstreamed in the policy in different countries, the relevance was

understood in the social contexts where males played significant roles in creating the reality of females and thus males were to share the relevance of the issue. When it comes to disability, this relevance among mainstream actors is still largely missing when disability is considered as disabled people's specific issues. Relevance, therefore, is both means and goals for promoting the mainstreaming process. Regarding the already mainstreamed health theme, selecting relevant sub-sectors for the Southern contexts becomes important but yet difficult to negotiate among different actors with different priorities and expertise. It is clear that donors are selective of certain sub-sectors, geographic regions where to work, as well as the channel favoured in implementation. This involves a negotiation process with the actors, mainly governmental actors. All these decisions are influenced by politics and the philosophies of the different stakeholders of both donor and recipient countries as well as international trends.

2. **Multiple Approaches:** Secondly, the analysis of the actor politics revealed that mainstreaming activities require multiple approaches. Three main approaches were prominent in mainstreaming disability and health in development policy and practices: networking among NGOs (bottom-up approach), political will (top-down approach) and networking with international actors to pressure the governments (bottom-oriented top-down approach). Concerned NGOs are networking in their countries to make their voices heard so that their issues are to be included properly into the mainstream development policy and practices. This bottom-up approach has become one of the legitimate procedures for the governments to make policies due to the participatory nature of civil society. Nevertheless, the decision making power of the governments are inevitably big, which cannot be so easily influenced merely by the bottom-up approach. Therefore, political will for a positive change also remains important. This leads to the next approach of bottom-oriented top-down approach in which NGOs network internationally to create bigger pressure from outside. For instance, this type of approach affected the UN Convention draft making process, which will be expected to pressure the governments to ratify it and implement it. The same type of international civil society activism was evident in the declaration of the Millennium Development Project/Goals as well as numerous other visionary programs addressing the needs of poor people and developing countries.The balance of these three major approaches to synergize effects is an important strategy.
3. **Evidence-based Planning and Implementation of Development Interventions:** Thirdly, the Southern case study indicated the difficulty in following and monitoring the actual effects of international and Northern policies particularly when the Southern governments make their decisions on what to implement and how with how much money out of the common basket. It is notoriously difficult to procure information on donor funding. This is true at both the recipient country (national) level as well as at the local/regional level. "A lack of data makes it impossible not only to track progress, but also to assess the effectiveness of measures taken" (Nature, 2007: 347). It also hinders planning at both levels. For instance, effective regional-based planning in Ethiopia and district-based planning in Kenya requires good knowledge of what donors operate in the area, what projects they are implementing and how much funding is being exacted. Proposals for mechanisms that enable recipient countries to monitor donor aid have been there: the Aid Management

Platform (AMP) in Ethiopia and the Joint Program of Work and Funding (JPWF) in Kenya; the SWAP has been around for sometime. Both countries express the need to have these mechanisms to improve planning. For instance, knowing what resources the country planners have from donors for what period of time can allow them to make implementable plans. This lack of information creates uncertainty in planning. Interviewees of the study both in the North and South were uncertain about whether their priorities were included or not. The case study in Ethiopia and Kenya also made it clear that donors often fail to or cannot (in the case of multilaterally funded programs) evaluate projects to show the impact of their interventions. Hence, it is often difficult to know the real contribution a donor project/program has made to health performance outcomes. Hence, **more evidence-based knowledge** on the mechanism for not only the negotiation process and implementation but also the outcomes for the final beneficiaries in the South is absolutely vital.

6. Conclusions and Recommendations

This research has focused on the complex question of mainstreaming health and disability in the international development policy. The project has focused on five countries altogether: three donor countries (Finland, Japan and the United Kingdom) and two developing countries (Ethiopia and Kenya). A set of two case studies were conducted. The first focused on the process of mainstreaming disability in Japanese and Finnish development policies and practices with a special focus on civil society actors. The second was on mainstreaming of health issues in the United Kingdom and Japanese development policies in Ethiopia and Kenya. The project's main finding is that mainstreaming a marginalized theme (disability) in the arena of international development cooperation is a complex and major struggle. On the other hand, even when a theme is well mainstreamed (health) priority-setting can still be a politically challenging negotiation process. In either case, mainstreaming has to be done both in the donor world and in the developing world. Furthermore, once a theme is mainstreamed, funding and collaboration/coordination among actors still remain the greatest challenges.

Aside from the North-oriented mainstreaming, one possibly more powerful means for promoting mainstreaming of marginalized themes both at policy and practice levels is to raise the voices of the Southern stakeholders, namely disabled people's organizations and NGOs concerning health issues. When they are strong enough, possibilities to negotiate with professional, governments and/or donors started to increase. In the current era of globalization, it is the norm in the international development system that southern governments, NGOs, communities and actors participate in the development of policies affecting them at every relevant level. For instance, the Poverty Reduction Strategy Papers (PRSP) preparation process requires participation of civil society actors to validate the relevance of the PRSP. Once these documents are written, i.e., once mainstreaming has been articulated in the policies, it is another thing to implement them in practice. It was beyond the scope of this study to focus on this question.

This research has raised many implications that generate good questions for further research. Further study is necessary to gain understanding of how Northern and international policy changes can affect the actions and outcomes from the perspectives of

Southern stakeholders who are expected to finally benefit from mainstreaming and policy changes. Further research is needed on the perspective of the Southern stakeholders whose lives and institutions are at stake once these themes are mainstreamed. Now that the background of mainstreaming disability is elaborated in the selected Northern contexts and implementation mechanism in the selected Southern contexts, further research has to focus on the actual outcomes to the Southern people as well as their self-determination in the operationalisation of the mainstreaming of these themes in the Southern contexts. Without this perspective of the Southern stakeholders, this study is never complete because they are crucial actors involved in this discourse of development. Some key questions are: What guides priority setting? How is sub-sector and regional targeting determined? What are the ethical considerations in resource and program prioritization of the international aid regime in the recipient countries? How do the final beneficiaries/"rights-holders" participate in determining the policy agenda and operationalising it? Clearly, often, donor programs fail to start off or even achieve meaningful or sustainable outcomes beyond initial impacts. This is a theme that has been told time and again. Hence there are major implementation challenges that need to be addressed. The starting point for doing so is through evidence amassed through research. This is the very impetus to start the second JIP project, which is applied for from the Tokyo Foundation in the separate project application form.

Recommendations

We organize a number of recommendations as follows.

1. Policy Mainstreaming in the North

The MDGs are not a complete package of goals because many more ambitious goals and unquantifiable issues related to poverty also should be included. Having mentioned that, the MDGs are a powerful tool to promote the relevance of the Southern issues to the Northern discourse. The MDGs will fail if disabled people are not included properly in the mainstream discourse of development. However, the relevance of the Southern disability issue has encountered difficulty in being mainstreamed particularly in practices of development cooperation by Northern countries. International Disability and Development Consortium, to which international DPOs that act on disability in development belong, claims the significant relevance of disabled population to the MDGs in the following statements[6]:

MDG 1: Eradicate extreme poverty and hunger

- 82% of disabled people live below the poverty line in developing countries.
- 20% of impairments are caused by malnutrition

MDG 2: Achieve universal primary education.

- 98% of children with disabilities in developing countries do NOT attend schools.
- The global literacy rate for adults with disability is 3%.

MDG 3: Promote gender equality and empower women

[6] http://iddc.org.uk (Visited on October 1, 2007)

- Abuse of disabled women and disabled girls: a survey in Orissa, India, found that 100% of disabled women and girls were beaten at home, 25% of women with learning disabilities had been raped and 6% of disabled women had been forcibly sterilized.

MDG 4: Reduce child mortality

- Mortality for disabled children is as high as 80% even in countries where under-five mortality is below 20%.

MFG 5: Improve maternal health

- 20 million women per year experience disability from complications during pregnancy and in childbirth.

MDG 6: Combat HIV/AIDS, malaria and other diseases

- Disabled people are most vulnerable to HIV and AIDS: victims of sexual abuse, restricted access to information or services; prevalence of HIV infection in mothers of children with disabilities is twice that of other groups.

MDG 7: Ensure environmental sustainability

- 100 million people have disabling conditions due to malnutrition, inadequate sanitary facilities and inadequate health care. Poor environmental planning perpetuates exclusion.

MDG 8: Develop a global partnership for development

- The international disability movement successfully mobilized for a UN Convention on the Rights of Disabled Persons.
- The African Decade of Disabled Persons 1999-2009: endorsed by the African Union to promote disability empowerment in Africa.

When the disability relevance is taken into account, Northern development policies can no longer exclude disability aspect from the mainstream discourse.

We recommend that:

- *Northern countries mainstream disability into policy, which then should be followed by proper action in practice. Disability should not remain as one recommendation but should be stipulated as a positive value added to mainstream development cooperation activities of the North.*

2. Donor Programming in the South

Achieving the MDGs and other poverty eradication goals in developing countries is a complex and often slow progress. At the same time, efforts towards this are absolutely vital. As the former UN Secretary General, Kofi Annan, once remarked, "*wherever we lift one soul from a life of poverty, we are defending human rights. And whenever we fail in this mission, we are failing human rights*"[7] Since the commitment by the international community to the MDGs in 2000, donors have increased funding and some achievements have been made in some countries in Asia and Latin America. However, Africa is not on track to reach any of the MDGs. To reach these goals it is not only more money that is needed. Implementation remains a challenge even when money is available. Meanwhile, in an effort to fuel the enthusiasm and synergy, donors continue to come up with more initiatives in the Global Campaign. These may add layers to existing ones without

[7] http://www.unhchr.ch/development/poverty-01.html (Visited on September 29, 2007).

necessarily increasing resources, coordination or joint sharing and learning. The fact that there are many donors and agencies makes the implementation complex due to inevitable in-country coordination problems. More than that, it is absolutely vital for donors to embrace an evaluation and monitoring discipline as this is the only way to measure the impact of the donor efforts. Another imperative is learning 'best practices' among donors (Murray, Frenk and Evans, 2007).

We recommend that:

- *To accelerate the pace for reaching the MDGs and to improve aid effectiveness: donors radically and urgently increase funding; coordinate aid in pooled mechanisms on sector basis; build up evidence-based cost-effective interventions through systematic evaluation and monitoring; and keep up the momentum.*

3. Aid Recipient Governments in the South

The international community has defined priorities as contained in the MDGs which governments in developing countries must adopt to access donor support. It is acknowledged that countries have different needs and differing incidences of poverty and diseases. The most important in the Global Campaign to eradicate severe poverty is ownership of initiatives by the developing countries. Therefore, it is imperative that poverty reduction strategies of recipient countries explicitly state their priorities and undertake steps towards making progress on them. Achieving progress will require an infrastructure of competent and dynamic institutions, human resources and, perhaps most importantly, a concerted political will and commitment. Often many bilateral and multilateral donors peg their aid to progress on governance and political commitment to the path of development. Hence developing countries' governments must come up with good policies and governance strategies that are fundable, implementable and which reflect the people's desires. At the same time, achieving a high level of aid coordination is of significant value towards the overall progress on poverty.

We recommend that:

- *Aid recipient countries to exert a great effort in developing sound and realistic policies that clearly identify the most urgent priorities; strengthen implementation systems and institutions; and create mechanisms for coordinating donor aid and in-country initiatives.*

4. NGOs in the Health Field in the South

NGOs play a significant role in fighting poverty. At the same time, they occupy an intricate and often delicate position in relation to donors, country governments and the poor people they serve. To maintain their mandate they must balance these relations. Without funding from donors their work would be inhibited. Without recognition by the country government they would not be able to operate. And without the poor they would have no work to do. But their highest loyalty should be to the people they represent and serve. As stakeholders in development, NGOs should contribute to policy making at the governmental and donor levels to constantly represent and defend poor people's interests. In order to do this effectively, NGOs need to maintain a high level of legitimacy among

donors and governments. This can be achieved through willingness to work alongside the objectives and priorities set in the country, the production of impeccable results and transparent reporting and sharing as well as to challenge the status quo when changes are needed. Although it is clear that donors typically work with governments' implementation mechanisms and big international NGOs, there are many opportunities for aid in the areas where local NGOs have comparative advantage.

We recommend that:

- *NGOs exert themselves as part of the mainstream aid implementation system in order to take more opportunities for aid that targets the most vulnerable individuals, households and communities in society; adopt the prioritization set by the national frameworks; work in a coordination fashion among themselves and with donors and the government; and challenge the status quo when changes are needed.*

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