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PROJECT EVALUATION BASELINE REPORT

Improving Quality of Life of Persons with Disabilities in Provinces Heavily Sprayed with Agent Orange (Inclusion Project)

October 2022

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ABSTRACT

USAID requested USAID Learns to conduct a disabilities project evaluation to examine the extent to which the quality of life (QOL) of persons with disabilities receiving USAID-supported assistance changed over time (EQ1), the factors affecting the success of rehabilitation, social services, and disability policies interventions (EQ2), and the extent to which the availability, accessibility, and quality of rehabilitation and social services in two USAID-targeted provinces changed over time (EQ3). Under the scope of USAID Learns, this evaluation includes a baseline survey to learn about the current status of EQ1 and EQ3 and address EQ2. There will be a follow-up survey (planned to be conducted in January 2023) to learn about changes in EQ1. The follow-up to examine changes in EQ3 over time will be decided by USAID in the coming years.

This baseline survey applies a mixed-methods approach, collecting qualitative and quantitative data in Quang Tri and Binh Dinh province. Quantitative data was collected by two standardized and validated measurement tools: the WHOQOL-BREF+DIS for adults (n=635) and ScoPeO-Kids for children (n=146) with disabilities who participated in the Inclusion Project. Qualitative data was collected through key informant interviews (n=30), site visits, and self-reported data from all health facilities in the two evaluation provinces.

The evaluation found that the QOL tools (WHOQOL-BREF+DIS & SCoPeO-Kids) are valid and reliable. In addition, **the QOL of persons with disabilities**, who were USAID's beneficiaries, varied significantly, not only by level and type of disabilities, but also by sex, age, education level, working status, participation in organizations of persons with disabilities (OPDs), ownership of health insurance, and standards of living.

Regarding **the factors affecting the success of rehabilitation, social services, and disability policies interventions**, key informants perceived USAID's interventions to be successful overall. Rehabilitation interventions were considered the most successful thanks to the expertise provided by and through implementing partners (IPs), project alignment with needs identified by the Government of Vietnam (GVN), and the amount of time and budget invested by USAID. With an enabling policy environment and USAID's historical support, the level of success of the policy interventions was mostly perceived as moderately or highly successful across its three sub-components: reducing discrimination toward persons with disabilities, strengthening OPDs, and achieving a barrier-free society. Social services intervention, given its newly-implemented status, was ranked less positively in terms of its level of success.

USAID's support has contributed to the improvement of **the availability and quality of services for persons with disabilities, especially rehabilitation professionals and services**. Remaining gaps include trainings to increase the number of licensed professionals; support for the most vulnerable populations including persons with mental and intellectual disabilities and persons with multiple disabilities; limited services at the commune level where persons with disabilities could afford to access on regular basis over an extended period of time; and systematic quality control and measurement in the health system.

BASELINE REPORT

Improving Quality of Life of Persons with Disabilities in Provinces Heavily Sprayed with Agent Orange (Inclusion Project)

USAID Learns

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ACRONYMS

Acronym	Definition
ACDC	Action to the Community Development Institute
ADL	Activities of Daily Living
AP	Assistive Product
CCIHP	Center for Creative Initiatives in Health and Population
CCRD	Center for Community Health Research and Development
COR	Contracting Officer's Representative
COVID-19	Coronavirus Disease 2019
CSIP	Center for Social Initiatives Promotion
CSO	Civil Society Organization
DEPOCEN	Development and Policies Research Center
DIS	Disability Information System
DOH	Department of Health
DOLISA	Department of Labour - Invalids and Social Affairs
DPO	Disabled People's Organization
DRD	Disability Research and Capacity Development
EQ	Evaluation Question
ET	Evaluation Team
GCD	Government's Classification of Disability
GSO	General Statistic Office
GVN	Government of Vietnam
HBC	Home-based care
HI	Humanity & Inclusion
HIS	Health Information System
IP	Implementing partner
IRB	Institutional Review Board
KII	Key Informant Interview
M&E	Monitoring and Evaluation
MEL	Monitoring, Evaluation, and Learning

Acronym	Definition
MOH	Ministry of Health
MOLISA	Ministry of Labour - Invalids and Social Affairs
NACCET	National Action Center for Toxic Chemicals and Environmental Treatment
NCD/VFD	Vietnam National Coordination Committee for People with Disabilities/Vietnam Federation on Disability
OPD	Organization of Persons with Disabilities
OT	Occupational Therapy
P&O	Prosthetic & Orthotic
PHAD	Institute of Population, Health and Development
PRM	Physical Rehabilitation Medical
PT	Physical Therapy
QOL	Quality of Life
SaLT	Speech and Language Therapy
SI	Social Impact, Inc.
SOW	Statement of Work
SRDT	Self-reporting Data Table
ST	Speech and Language Therapy
TOC	Theory of Change
UNCRPD	Convention on the Rights of Persons with Disabilities
USAID	United States Agency for International Development
VAVA	Vietnam Association for Victims of Agent Orange/dioxin
VNAH	Vietnam Assistance for the Handicapped
VSS	Vietnam Social Security
WGQ	Washington Group Questions
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND & PURPOSE

A 2016 survey led by the General Statistics Office (GSO) of Vietnam demonstrated that seven percent of people in Vietnam aged two and over – a population of about 6.2 million – were disabled (GSO 2018). A concurrent study conducted by the United States Agency for International Development (USAID)/Vietnam showed low quality of life (QOL) among persons with disabilities across Vietnam; in fact, less than eight percent of persons with disabilities surveyed rated their QOL as "*good*" or "*very good*" (USAID 2016).

USAID has been assisting persons with disabilities in Vietnam since 1989 through various grants, and USAID/Vietnam started a new project in 2019 with the goal to "*improve QOL for persons with disabilities in USAID's Target Provinces.*" This project focuses on expanding rehabilitation services, social services, and improving disability policies and partners' capacity in disability service management in Binh Dinh, Quang Nam, Dong Nai, Tay Ninh, Binh Phuoc, Quang Tri, Thua Thien Hue, and Kon Tum.

To gauge progress against the project's goals, USAID contracted SI to conduct a performance evaluation of the Disabilities Project under the scope of the USAID Learns activity. The evaluation results will be used primarily by USAID, its implementing partners (IPs), its host government partner, the National Action Center for Toxic Chemicals and Environmental Treatment (NACCET), and other interested stakeholders to help identify programmatic gaps and/or challenges which require addressing in future efforts. The three following evaluation questions (EQs) were developed collaboratively by USAID/Vietnam and SI:

> **EQ1:** To what extent has the QOL for persons with disabilities receiving USAID-supported assistance changed over time?
>
> **EQ2:** What are the factors affecting the success of the three intervention areas targeted for USAID support (rehabilitation, social services, and disability policies)?
>
> **EQ3:** To what extent have the availability, accessibility, and quality of rehabilitation and social services in USAID-targeted provinces changed over time?

Under the scope of this assignment, EQ1 will be fully answered by the findings from a longitudinal cohort study (which includes a baseline and a six-month follow-up survey that is now scheduled for January 2023). The baseline survey will also address EQ2 (the factors affecting the success of USAID's rehabilitation, social service, and disability policy interventions) and the baseline for EQ3 (the status of the availability, accessibility, and quality of rehabilitation and social services in two USAID-targeted provinces).[1] This report presents the findings from the baseline survey on each of these questions.

METHODS

The evaluation is a rigorous, mixed-methods performance evaluation, collecting quantitative and qualitative data in two provinces, Quang Tri and Binh Dinh. The two provinces were selected purposively to prioritize representation of USAID implementing partners, areas unsaturated with USAID interventions, and ease of government approval.

QUANTITATIVE

Quantitative data was collected through a longitudinal cohort study (which includes a baseline and a six-month follow-up survey) for adults and children with disabilities who participated in the Inclusion Project. The evaluation team (ET) initially estimated a target sample size of 483 adults with disabilities and 483 children (966 total) in order to detect the desired effect size; however, due to a lack of children enrolled in Inclusion during the baseline data collection period, the ET included all eligible

[1] USAID will decide on the examination of the changes over time of the availability, accessibility, and quality of rehabilitation and social services in the targeted provinces when the time comes.

children and oversampled adults. In Binh Dinh, the ET completed 157 interviews with adults and 31 interviews with children; in Quang Tri, the ET completed 478 interviews with adults and 115 interviews with children (781 total). These samples represent the adult and child beneficiaries in two instead of three provinces as in the original plan.

As part of the quantitative survey, the ET measured QOL using two standardized and validated measurement tools: the World Health Organization (WHO) WHOQOL-BREF for adults, and ScoPeO-Kids for children. The ET completed a thorough pretest and pilot of the survey questions, validating the QOL measurement tools prior to finalizing the instruments.

QUALITATIVE

Qualitative data was collected through key informant interviews (KIIs) with a range of stakeholders including persons with disabilities or proxies, caregivers, IPs, service providers, USAID/Vietnam, and key government counterparts. The ET also conducted site visits to health facilities and education/rehabilitation units and collected secondary data from service providers. The ET sampled qualitative respondents purposively using contact information provided by USAID/Vietnam. In total across provinces, the ET completed 53 qualitative interviews, 14 site visits, and collected secondary data from 313 health facilities.

FINDINGS & CONCLUSIONS

EQ1: QOL FOR PERSONS WITH DISABILITIES RECEIVING USAID-SUPPORTED ASSISTANCE

The mean QOL score for adults using the WHOQOL-BREF was 56.3, and 55.7 using the DIS-Module. The mean score for children using the ScoPeO-Kids tool was 73.5. Though the absolute values of the QOL score do not have intuitive meaning as there are no established thresholds for different levels of QOL, they can provide important insights in relative terms or comparisons across sub-groups.

Factors associated with a higher QOL among both adults and children with disabilities included having a lower level of disability, having a mobility disability, not self-identifying as a person with a disability, being male, having a higher education level, working, and being a member of an Organization of Persons with Disabilities (OPD). Among adults, having health insurance and being older were associated with higher QOL, as well. Factors associated with a lower QOL among adults included having a speech, intellectual or mental disability and living in a near-poor family. Among children, having a hearing, intellectual or mental disability, being older, and living in a poor family were associated with lower QOL. Among adults, 42 percent perceived their QOL to be the same at the time of data collection compared to six months ago, 45 percent perceived their QOL to be worse or a lot worse, and only 13 percent perceived their QOL to be a lot better or better relative to six months ago. This perspective was different among children: though the proportion of respondents reporting no change over six months was about the same, far more children reported positive changes in QOL in the last six months. 49 percent of children perceived their QOL to be the same at the time of data collection compared to six months ago, 11 percent perceived it to be worse or a lot worse, and 40 percent perceived their QOL to be a lot better or better relative to six months ago. COVID-19 appears to have had a negative effect on QOL in both adults and children: 58 percent of adults and 55 percent of children reported that COVID-19 made their QOL worse or a lot worse over time.

EQ2: FACTORS AFFECTING THE SUCCESS OF THE TWO INTERVENTION AREAS

Rehabilitation

Rehabilitation interventions were seen by qualitative interview respondents as largely successful. The most successful subcomponents were expanding and strengthening the workforce and increasing the availability of rehabilitation services. The most common facilitator to success discussed was the expertise provided by and through IPs. Additionally, respondents cited government buy-in and support, engagement of local stakeholders, alignment with country needs, the amount of money invested by

USAID, and USAID's time investment in the disability sector as facilitators to the rehabilitation interventions. Though facilitators were more frequently discussed than barriers, respondents cited the current IP approach, choice of ministry partners, insufficient resources, the system strengthening approach versus direct assistance, and lack of engagement from local authorities as barriers to the rehabilitation interventions.

Social Services

The level of success of social services interventions were considered less positively because some interventions are newly developed or still under development, and the term "social services" was newly introduced in this phase. The most discussed facilitators were family involvement or support and USAID investment. The most successful subcomponent discussed was increased participation of persons with disabilities. The main facilitating factors of social services were family involvement and USAID investment. Conversely, these two aspects were also identified as being barriers to success; family members being very tired or having other work to do outside of caregiving and the acknowledgement that as the support for social services is largely dependent on IPs, they are not sustainable. A related barrier was the lack of formal engagement with MOLISA for many of the sub-components. Another barrier that limited success was that many components within "social services" (e.g., home care, psychological support) lack clear definition; this leads to inconsistency in understanding, implementation, and results.

Disability Policies

USAID's interventions in disability policies were seen as successful overall, with similar levels of success across the three subcomponents: reducing discrimination toward persons with disabilities, strengthening OPDs, and achieving a barrier-free society. The most common facilitator discussed was the Convention on the Rights of Persons with Disabilities (UNCRPD). In addition, USAID's historical support in this area has created a strong foundation for ongoing and future work. Barriers discussed included low USAID investment in this area, the lack of interest in policy change interventions from the GVN partner (MOH/NACCET), the lack of IP capacity in this area, and discontinued Vietnam National Coordination Committee for People with Disabilities/Vietnam Federation on Disability (NCD/VFD) investments.

EQ3: AVAILABILITY, ACCESSIBILITY, AND QUALITY OF REHABILITATION AND SOCIAL SERVICES

Rehabilitation

Availability: The evaluation finds that 12.6 percent of facilities (22 of 175 facilities) in Binh Dinh and 13.8 percent of facilities (19 of 138 facilities) in Quang Tri provide rehabilitation services. There are 0.57 licensed staff providing rehabilitation services per 10,000 population in Binh Dinh, and 0.99 per 10,000 population in Quang Tri, while 64 percent of all staff providing rehabilitation services are licensed in Binh Dinh, and 52 percent in Quang Tri. Interestingly, the proportion of staff licensed relative to the total staff providing these services decreased from 2019 to 2022 in both provinces.

Accessibility: In both Binh Dinh and Quang Tri, less than 10 percent of health facilities have rehabilitation interventions that could be covered by Vietnam Social Security (VSS), primarily due to the lack of VSS-qualified human resources and services at the commune level. Accessing rehabilitation services was reported to be neither difficult nor easy by the majority of respondents. For assistive products (APs), nearly one-third of respondents reported difficulty accessing products. Seeking rehabilitation services on a monthly basis was not considered a common practice as respondents thought they did not need it, or in the case of child respondents, due to a lack of information or awareness of rehabilitation services.

Quality: The quality of rehabilitation services was rated from average to good overall. The majority of qualitative interview respondents of those who could access rehabilitation services reported being satisfied with the services.

Social Services

Availability: Exploring stakeholder perceptions on availability of social service support was challenging, primarily due to inconsistent interpretation of these services. The most common themes discussed in qualitative interviews regarding availability of social services included psychological support not yet being available, home-based care only being available in some locations, and caregiver capacity building existing but there being a high degree of dependence on family and volunteers. According to data from the ET's document review and site visits, two USAID IPs (Vietnam Assistance for the Handicapped [VNAH] and Institute of Population, Health and Development [PHAD]) have been directly involved in providing support to home-based care initiatives. The number of people trained in home-based care varied greatly across provinces: 745 people have been trained in Binh Dinh with support from PHAD, but no one has been trained yet in Quang Tri.

Accessibility: The most common reasons for not seeking or receiving social services included lack of information or awareness of service availability, perceived absence of need, and unaffordability. Though disability benefits are provided by local government budgets, they are very limited in amount to cover the essential daily living needs of persons with disabilities. Some OPDs receive government support, but there is no evidence of support to home-based care services in government budgets. Additionally, VSS does not cover any element of social services.

Quality: When asked about home care, respondents were divided among "not sure," "poor," and "average" quality, though there was confusion around the definition of home-based care. In addition, there is no standardized tool to measure quality of social services provided through USAID support. Interestingly, a majority of quantitative survey respondents who had accessed the services reported being satisfied or very satisfied with social services.

RECOMMENDATIONS

Given the positive reflection of the stakeholders on the success and contributions of USAID's disability project, it is recommended that USAID continues long-term support in both direct assistance and system strengthening for rehabilitation and social services. For comprehensive improvement in the QOL of persons with disabilities, USAID should consider expanding program opportunities to include support for not only health but also education, employment, social services, and livelihood to cover multiple components of rehabilitation, multiple dimensions of both QOL and disability, and the complex interactions among them. Acknowledging that health is still a major domain and selective expansion will be shaped by many other factors such as available resources, USAID's priorities, and/or government priorities, we recommend that USAID, its IPs, and government partners co-create to find potential opportunities and areas for program expansion.

USAID should apply and promote the use of the tools that were used and validated in this evaluation to strengthen rehabilitation and social service data for monitoring and evaluation (M&E) and evidence-based policy development. Promotion of these tools should target not only the project IPs and sub-grantees but also larger stakeholders who are working on rehabilitation and social inclusion. It would be best if these tools could be integrated into relevant government databases and used on a regular basis. Detailed recommendations in the areas of continued long-term support, expanding programmatic opportunities, and applying the tools to strengthen M&E and evidence-based policy development are provided by Activity subcomponent in the body of the report.

BACKGROUND

INTRODUCTION

USAID/Vietnam has been assisting persons with disabilities in Vietnam since 1989; in 2015, USAID started a new Disabilities Project focusing on improving service provision, rehabilitation systems, and policy support to expand opportunities for persons with disabilities. This project, originally intended to expire in 2019, has since been modified and extended through 2024. As of 2019, the project's objective, theory of change, and results framework are centered on "*Improved quality of life (QOL) for persons with disabilities in USAID's target provinces.*" These targeted provinces are Binh Dinh, Quang Nam, Dong Nai, Tay Ninh, Binh Phuoc, Quang Tri, Thua Thien Hue, and Kon Tum. The 2019 amendment further operationalizes opportunities to improve synergy and standards between IPs through issuance of new local awards which will make subawards to local and international organizations working in the disabilities sector.

A Vietnam Disability Survey, conducted in 2016 and led by the GSO of Vietnam, demonstrated that seven percent of people in Vietnam aged two and over – a population of about 6.2 million – were disabled (GSO 2018). According to the same report, most persons with disabilities within Vietnam live in rural areas, where the prevalence of disability is estimated to be 1.5 times higher than in urban areas. Women also suffer disproportionately – this report indicated a disability rate of about 10 percent for female adults compared to seven percent for their male counterparts. A concurrent USAID/Vietnam survey showed that QOL remained low for persons with disabilities across Vietnam, wherein less than eight percent of persons with disabilities surveyed rated their QOL as "*good*" or "*very good*" (USAID 2016). There have been very few disability surveys conducted in Vietnam, especially in-depth studies. Additionally, studies assessing the QOL of persons with disabilities are even more limited in both quality and quantity.

USAID has called for a performance evaluation of its overall Disabilities Project to better understand how QOL and access to rehabilitation and social services has changed for targeted persons with disabilities since program implementation. This evaluation will be used primarily by USAID, its IPs, its host government partner, NACCET, as well as other interested stakeholders. Information on the current landscape of available rehabilitation and social services in targeted areas, the QOL of persons with disabilities, and outcomes of targeted interventions will help identify gaps and/or challenges to be addressed in future efforts.

RESULTS FRAMEWORK

USAID uses the WHO's definition of QOL: "*individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns*" (Nakane, Tazaki, and Miyaoka 1999). USAID/Vietnam's Disabilities Project aims to address pervasive QOL constraints faced by persons with disabilities in Vietnam.

Several constraints are believed to affect QOL for Vietnam's population with disabilities, but empirical evidence supporting this relationship is lacking. These possible constraints include (1) a lack of supporting policy - including weak enforcement of existing legislation at sub-national levels, (2) poor coordination among technical ministries, (3) lack of advocacy for disability rights, (4) low levels of awareness in the community about disability and the needs of persons with disabilities, (5) an underdeveloped network of social workers and social services, and (6) a lack of access to quality rehabilitation services including physical therapy (PT), occupational therapy (OT), and speech and language therapy (SaLT) services due to insufficient medical facilities that can provide OT and SaLT services, and a lack of adequately trained professional staff. Collectively, this leaves persons with disabilities and their families and caregivers with unmet needs and presumably low QOL.

USAID adopts the revised results framework, shown below in Figure 1, which identifies three results areas: rehabilitation, social support (specifically for people with severe disabilities), and disability policies. The Disabilities Project's development hypothesis is: "*if persons with (severe) disabilities receive rehabilitation and social services within an improved disability context, then their quality of life will be improved.*"

[2] This theory of change (TOC) explicitly recognizes and operationalizes the need for integration and simultaneous programming across various levels of the disabilities sector "ecosystem", recognizing that policy and the enabling environment are critical factors to facilitate and sustain improved service delivery at the community and individual levels.

Expanding rehabilitation services encompasses efforts to strengthen governance, improve service delivery, strengthen workforce, increase finances, increase data, and augment provision of APs. The expansion of social services focuses on the strengthening of the quality of home care services (assisting with activities of daily living [ADLs] and in-home accessibility), improving the psychosocial environment to encourage interpersonal interaction and participation, and helping persons with disabilities understand and access their rights.

Figure 1: Revised results framework

STAKEHOLDERS & MAIN ACTIVITIES

USAID's Disabilities Project has funded numerous activities that support persons with disabilities under the aforementioned results framework (see above) since 2015. The beneficiaries of all USAID activities that were active between 2015 and 2023 are described in Annex I: Disability Project Activities with Anticipated Beneficiaries between 2015 and 2023, which provides a view of how QOL is changing across USAID's portfolio.

Since 2020, USAID's Disabilities Project started a new phase with recruitment of three new IPs, with all projects under this phase known as "Inclusion." Inclusion 1 is being implemented by the Center for Creative Initiatives in Health and Population (CCIHP) in Thua Thien Hue, Quang Nam, and Quang Tri province. Inclusion 2 is being implemented by the Centre for Community Research and Development (CCRD) in Binh Dinh and Kon Tum provinces. Inclusion 3 is implemented by the Centre for Social Initiatives Promotion (CSIP) in Tay Ninh, Dong Nai and Binh Phuoc provinces. Activities under the

[2] Revised theory of change as of August 2019, as per the Amendment to Project Appraisal Document: Intermediate Result 2.3.

three Inclusions are overall very similar and have beneficiaries and target populations which include persons with disabilities as well as rehabilitation and social service providers. Persons with disabilities who are participating in the Inclusions are screened and then selected for appropriate interventions on a rolling-basis.

EVALUATION PURPOSE, QUESTIONS & AUDIENCE

EVALUATION PURPOSE

SI is an American global developmental consulting firm contracted by USAID/Vietnam to assist with monitoring, evaluation, and learning (MEL) activities through the USAID Learns project. Under this project, USAID/Vietnam requested an evaluation of their Disability Project with the overarching goal of providing information to improve the QOL of persons with disabilities in selected provinces supported by USAID/Vietnam.

EVALUATION SCOPING

USAID Learns conducted a feasibility assessment in 2020 to determine the optimal approach for answering a set of preliminary EQs defined by USAID/Vietnam (USAID Learns 2019). Though the preliminary EQs originally planned to contain a causal component, which would allow for attribution of change to USAID's interventions, Learns determined - through a feasibility assessment - that a comparison group could not reliably be obtained, limiting the evaluation's ability to attribute change to the Disabilities Project interventions. Following the findings of the feasibility assessment, Learns collaborated with USAID/Vietnam to agree upon a revised set of EQs that balance learning value to USAID with a feasible and rigorous survey design. It is important to note when interpreting the findings and conclusions detailed in this report that while the evaluation is designed to inform USAID's understanding of its contribution to observed changes, it is not designed to facilitate attribution of these changes to USAID's interventions alone.

EVALUATION QUESTIONS

This evaluation is meant to address the following EQs which were collaboratively developed by USAID and USAID Learns:

1. To what extent has the QOL for persons with disabilities receiving USAID-supported assistance changed over time?
2. What are the factors affecting the success of the three intervention areas targeted for USAID support (rehabilitation, social services, and disability policies)?
3. To what extent have the availability, accessibility, and quality of rehabilitation and social services in USAID-targeted provinces changed over time?

An additional but not any less important objective of this effort is to pilot tools, processes, and lessons learned related to baseline data collection. The two key tools most relevant to future analyses are the QOL measurement tools (for adults and children with disabilities) and the health facility Self-Reporting Data Table (SRDT) which provides data on existing rehabilitation-related workforce and services.

METHODOLOGY

SURVEY DESIGN

To address the evaluation questions, the evaluation includes a rigorous, mixed-methods performance evaluation using both quantitative and qualitative data collected at two points in time. Quantitative data are collected through a longitudinal cohort study with a baseline and a six-month follow-up survey for adults and children with disabilities who participated in the Inclusion Project. Qualitative data are collected through KIIs with a range of stakeholders including persons with disabilities - or proxies, caregivers, IPs, service providers, USAID, and key government counterparts. In addition to these sources of primary data, the ET collected secondary data from service providers as well. Table 1 below summarizes the quantitative and qualitative methods used by EQ.

The baseline survey aims to answer EQ2, providing information on the factors affecting the success of USAID's rehabilitation, social services, and disability policies interventions. It also provides baseline information for EQ1 on the extent to which the QOL of persons with disabilities receiving USAID-supported assistance changed over time and EQ3 regarding the status of the availability, accessibility, and quality of rehabilitation and social services interventions in two USAID-targeted provinces, Binh Dinh and Quang Tri.

At this stage, changes over time for EQ1 have not been assessed as they require findings from the follow-up survey, which is planned in January 2023. The same element of EQ3 - the changes *over time* of the availability, accessibility, and quality of rehabilitation and social services in USAID-targeted provinces – is beyond the scope of this assignment and dependent on USAID's future decision.

Table 1: Summary of quantitative and qualitative methods by evaluation question

	Quantitative	Qualitative
EQ1. To what extent has the quality of life for persons with disabilities receiving USAID-supported assistance changed over time?	• Measure QOL & changes (baseline & follow-up after 6 months) by using available QOL tools • Associations between socio-economic factors & QOL	• Perspective of participating partners on QOL and USAID's interventions • QOL perceptions of caregivers and of those individuals who have difficulty communicating
EQ2. What are the factors affecting the success of the three intervention areas targeted for USAID support (rehabilitation, social services, and disability policies)?	N/A	• Three intervention areas: rehabilitation, social services, policies to support people with disabilities • Stakeholders' perceptions on level of success, barriers and facilitators for each area

	Quantitative	Qualitative
EQ3. To what extent have the availability, accessibility, and quality of rehabilitation and social services in USAID-targeted provinces changed over time?	• Describe availability, accessibility, quality of service & change over time	• Baseline data on availability of rehab services • Baseline data on quality of rehabilitation services • Perception of availability, accessibility, quality of rehabilitation and social services • Document review: report M&E and statistics

EVALUATION SITES

Per USAID's interest in focusing the evaluation on three provinces (one for each of its three geographic clusters), the ET initially selected Binh Dinh, Dong Nai, and Quang Tri Provinces as the sites for data collection. These provinces were selected purposively to prioritize: 1) representation of all USAID implementing partners, 2) areas less saturated with USAID interventions, and 3) locations most likely to receive government approval. After this initial selection, there were significant delays in the IPs receiving approval from provincial authorities in Dong Nai, which translated to a high risk of the ET not receiving approval in time to conduct the baseline survey. In discussion with USAID, the ET considered Tay Ninh as a replacement province; however, the ET faced similar challenges with provincial approvals in Tay Ninh. Accordingly, the ET determined, in collaboration with USAID, to drop the Southern cluster (including Dong Nai and Tay Ninh) from the baseline survey while increasing the sample size in other provinces. As a result of this decision, the evaluation includes only two provinces: Quang Tri in the Central geographical cluster and Binh Dinh in the South-Central cluster.

QUANTITATIVE POPULATION-BASED SURVEY

SURVEY DESIGN

The quantitative survey follows a longitudinal cohort design, where data are collected from the same individuals at two points in time: baseline and a six-month follow-up. In the absence of a comparison group, this approach minimizes the effects of non-intervention factors in QOL measurements relative to a cross-sectional design, where changes in QOL measurements may be affected by differences in individuals surveyed at the baseline versus follow-up. Given that intake for the interventions happened on a rolling basis, the ET administered a rolling baseline survey with persons with disabilities selected to receive services from IPs over the first three months of Inclusion project implementation.

QUALITY OF LIFE MEASUREMENT

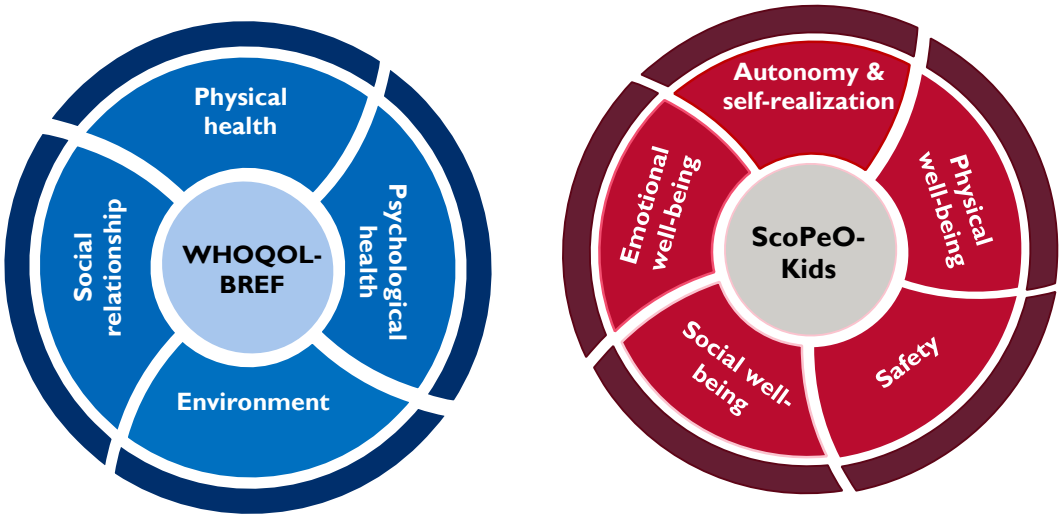
The ET sought to identify a standardized, validated tool that was appropriate for use in a population with disabilities in Vietnam and sensitive to the aspects of QOL that USAID's interventions are likely to change. Availability of the tools in a timely manner and cost were other factors for consideration. Details of the selection process and comparison across different QOL measurement tools are provided in Annex IV. The final QOL measurement tools that were selected and used in the evaluation include:

- WHOQOL-BREF with Disabilities Module (developed by WHO) for adult beneficiaries aged 18 years old or older; and

- ScoPeO-Kids (Score of Perceived Outcomes, developed by Humanity & Inclusion (HI)) for child beneficiaries aged 5 to 17 years old.

Both tools reflect the multiple dimensions of QOL or a holistic approach to health and health care that go beyond traditional health indicators. WHOQOL-BREF includes 26 Likert-scale items covering 24 facets in four domains: physical health, psychological health, social relationship, and environment. WHOQOL-Disabilities module is an adapted generic version of WHOQOL for use with adults with disabilities. It includes 13 items assigned to three facets: discrimination, autonomy, and inclusion. ScoPeO-Kids includes 20 items covering five domains: physical well-being, emotional well-being, safety, autonomy and self-realization, and social well-being.

Figure 2: Structure of WHOQOL-BREF & ScoPeO-Kids



WHOQOL-BREF was translated and validated in Vietnam with the general population, but WHOQOL-Disabilities module has not been validated in Vietnam, and both tools have not been validated with the population with disabilities in Vietnam. ScoPeo-Kids has not been validated in Vietnam. Validation with 100 adults and 100 children with disabilities was conducted to validate these QOL measurement tools before use in the baseline survey The validation results showed that the QOL tools (WHOQOL-BREF+DIS & SCoPeO-Kids) showed validity and reliability, but should be cautious in drawing conclusions based on the individual domain scores. Further details - see Annex V.

TARGET RESPONDENTS

Target respondents of the survey are people with disabilities who are beneficiaries of the Inclusion project. Further inclusion and exclusion criteria are detailed in Annex VI: Target Respondent Selection Criteria

Assisted interviews & proxy

If adults and children with disabilities selected for the survey were capable of comprehending the majority of the questions in the QOL modules but needed help clarifying questions or help communicating responses to the data collector (e.g., if a stranger would have difficulty understanding their speech), the ET asked the caregiver to assist the adult/child with disabilities with the interview. In these cases, the interview was still conducted directly with the person with disabilities, and the

other person only assisted with responses when necessary (i.e. it is an *assisted interview* using the main person with disability survey tool; not a proxy survey).

In cases where an adult or child with a disability was not capable of responding to the QOL module on their own due to the nature of their disabilities (e.g., severe intellectual disability or speech impairment), a proxy survey tool was administered - this is in accordance with WHOQOL-DIS manual guidelines and piloting. This meant that the data collector asked the proxy to complete the survey on behalf of the person with disabilities - with the beneficiary's assent. This was done through a separate survey module that was identical to the original, other than a shift in wording from first person to third person and slight variation in instructions for survey modules.

Proxy selection criteria

In cases where a proxy completed the survey, the selection criteria stated that the individual identified as a proxy should be an adult who is trusted and close to the person with disability and is very familiar with their day-to-day life. This was to be someone who felt capable of responding close to what the person with a disability would answer - by using all their knowledge and experience of that person and their life. As noted in the WHOQOL-BREF+DIS tool, for adults, this person could be a partner, a member of their family, a close friend, an in-home paid care provider, or an advocate (a person formally or legally appointed to help them), provided that they meet the aforementioned criteria.

QUESTIONNAIRE

Questionnaires for adults and children with disabilities were developed to collect information for the evaluation. Contents of the questionnaires for adults and children were similar with eight components:

A. Pre-survey information: for enumerators to fill in known information of the respondent before the start of the interview
B. Introduction & consent form
C. Socio-economic characteristics of the respondent
D. Quality of life: WHOQOL-BREF+DIS for adults & ScoPeO-Kids for children
E. Health and disability
F. Rehabilitation and social services
G. Household information
H. Wrap-up and contact for follow-up survey

The questionnaires for adults and children are provided in Annex VII: Data Collection Tools, 7.1 and 7.2 respectively.

The survey was administered by a local company, DEPOCEN, under training and technical support of SI. Enumerators used tablets and a survey app, SurveyCTO, to collect data. On average, it took one hour to complete an interview, but there was a large variation depending on the communication ability of the respondent. More details on the duration of quantitative interviews are provided in Annex IX: Duration of Quantitative Interviews.

SAMPLING STRATEGY

The sample was designed to be representative of adults and children with disabilities living in the two targeted provinces who would benefit from a USAID Disabilities Project activity that was actively recruiting new beneficiaries at the time of the baseline survey. The sample is not representative of the full population of persons with disabilities in these provinces, given the focus of EQ1 and associated performance indicators on USAID beneficiaries, nor is it representative of USAID activities in other provinces.

For similar reasons of development of inclusion/exclusion criteria for target respondents, the sampling went through a rigorous review and revision process. Details of this process are provided in Annex X: Sampling & Sample.

The survey, conducted in June and July 2022 when Inclusion activities began recruiting new beneficiaries, successfully completed the following interviews:

- In Binh Dinh: 157 interviews with adults and 31 interviews with children.
- In Quang Tri: 478 interviews with adults and 115 interviews with children.

DATA ANALYSIS

The ET used Stata 17 software to complete all data cleaning and analysis using replicable programming files. The team followed the WHOQOL-BREF and DIS manuals and ScoPeO-Kids manual to prepare and analyze QOL data (e.g., reverse negative scales, impute means for missing data in permitted cases, calculate domain scores, transform to 0-100 scale). The ET also analyzed QOL and other indicators present in the survey, including participation in OPDs, challenges in accessing services, and other factors that can inform USAID programming. Descriptive, bivariate, and multivariate analyses were applied to gain responses to EQ1 and EQ3.

QUALITATIVE ASSESSMENT

APPROACH

The ET applied various qualitative methods to answer EQ2, EQ3, and provide supplementary information related to QOL (EQ1). Methods included qualitative interviews, service provider site visits, health facility SRDT (see Annex XI: Self-Reporting Data Table (SRDT), home visits, and document review).

DATA COLLECTION TOOLS

The ET developed a variety of tools designed to address the key questions posed through this baseline assessment. All tools used in the qualitative survey are in Annex VII: Data Collection Tools.

The KII Stakeholder tool captured stakeholder perceptions on the level of success for each of the subcategories within the three intervention areas. Further, respondents were asked to identify the key barriers/facilitators (factors that enhanced or limited success) that influenced their perception.

Key indicators were developed to frame the measures of availability, accessibility and quality of rehabilitation and social services (EQ3). In addition to the indicators, data was collected through five tools specific to EQ3, and included in the *KII Stakeholder tool* and the *QOL Survey tool***.** A review of the different tools is provided below while summarizes the indicators and tools used to inform EQ3:

- *KIIs for stakeholders* to identify the perception of the availability, accessibility, and quality of services.
- *Health facility SRDT* to collect quantitative data on the availability of rehabilitation (workforce and services), and accessibility of rehabilitation services (insurance coverage).
- *KII for health sites and rehabilitation units* focused on availability of services, coverage by health insurance and the organization and processes for providing rehabilitation.
- *Site visit guide to rehabilitation units* provided evidence of different documents or procedures in place to influence quality of rehabilitation services.
- *KIIs for persons with disabilities and KII for caregivers* focused on perceived outcomes or benefits of intervention.
- *Data included in the quantitative QOL survey* asked questions about the individual's perception on the availability, accessibility, and quality of rehabilitation and social services.
- *Document review* focused on collecting data about the availability of social services and the number of people trained to provide home care services.

RESPONDENTS

Qualitative data was collected through site visits in Binh Dinh and Quang Tri, in-person interviews in Hanoi, Quang Tri, Binh Dinh, and three virtual interviews. In addition, all health facilities in Binh Dinh and Quang Tri submitted SRDTs.

Table 2 provides details on respondents and is summarized below:

- 53 interviews (three virtual) with 80 people (42 men and 38 women)
- 24 site visits (14 facility visits and 10 home visits),
- 313 health facilities submitted SRDTs.

Table 2: Information on qualitative data sources and respondents

Question	Data source	Survey respondents
EQ1 (QOL) – narrative for proxy-dependent persons	**KIIs** with people having severe disabilities who depend on proxy for communication	• **10 proxy-dependent interviews** (5 Binh Dinh and 5 Quang Tri)
EQ2 (levels of success; factors contributing to success and barriers limiting success for rehab, social services, disability)	**KIIs for stakehold**ers to include IPs, M/DOH, M/DOLISA, OPDs, USAID.	• **25 stakeholder interviews** IP (12); USAID (3); DOH (2); DOLISA (1+1), OPD/VAVA (3), MOLISA (1) Rehabilitation Health Central, Bach Mai Hospital (1) MOH (1) No VSS or NACCET interviews.
EQ3 (availability, accessibility, quality of rehabilitation and social services)	**SRDT**– rehab information from all health facilities in 2 provinces **KIIs** health facilities and rehab units **Site visits** to rehab units, and caregiver interviews. KIIs key stakeholders (same as EQ2).	• **313 SRDT responses** Binh Dinh (175), Quang Tri (138) • **14 KIIs health sites and rehab units** (7 health facilities, 1 education, 6 rehab units) • **24 Site visits:** 14 (as above); 10 home visits, • **4 CG interviews** • **25** interviews (same as EQ2)

QUALITATIVE DATA ANALYSIS

All three qualitative team members were present in 51/53 KII stakeholder interviews. Additionally, the full qualitative team visited all 14 health sites. The two Vietnamese team members on the team jointly conducted the remaining two KIIs as well as all of the home visits, including interviews with caregivers and persons with disabilities.

All interviews and site visits were recorded while each team member took detailed notes. Afterwards, a single written summary, in English, was drafted and circulated among the team. All team members reviewed the draft and provided edits - checked against recorded content. Both forms of record-keeping (written notes and recordings) were coded for anonymity and were uploaded to an internal data storage site (SharePoint). Data quality control was conducted (randomly selected recordings were reviewed against written notes) and found the notes to be of very high quality.

Data analysis was done manually and focused on highlighting repeat messaging and specific responses to the relevant indicators. Data collected from all health facilities (through the SRDT prepared in Excel format) was submitted electronically and transferred to SPSS for analysis. The ET used descriptive statistics to calculate the frequencies or means stratified by level of health facilities and provinces. The ET manually estimated the ratio per 10,000 population.

DATA SECURITY, QUALITY ASSURANCE, AND ETHICAL CONSIDERATIONS

Various methods were applied in both quantitative and qualitative data collection to ensure data quality and security. Learns obtained Institutional Review Board (IRB) approval from both SI's IRB and the Hanoi University of Public Health. These applications detailed potential risks to respondents and mitigation strategies (see Annex XII: Risks, Limitations, and Mitigation Strategy). The ET followed strict procedures to protect respondent data and maintain confidentiality. Every interview was preceded by an informed consent process that reinforced the voluntary nature of participation. To respect patient privacy, service providers needed to obtain permission to submit new beneficiaries' contact information to the ET before the ET could administer the full informed consent.

The ET took strong precautions to prevent the spread of COVID-19 during data collection and followed all local guidelines. Data collectors were required to confirm lack of symptoms or positive COVID tests within their household prior to data collection. Social distancing and prevention measures like masks were employed as appropriate.

All data collectors were carefully trained in ethical procedures and sensitive interviewing techniques for this population by trained experts in the sector. At the conclusion of the evaluation, the ET de-identified all data and submitted it to SI's IRB for compliance review prior to submission to USAID's DDL, per policy.

FINDINGS

BENEFICIARY PROFILE: DEMOGRAPHIC & SOCIO-ECONOMIC BACKGROUND

KEY FINDINGS

- Almost all beneficiaries (95 percent) were persons with at least severe disabilities and one-third were persons with very severe disabilities. The majority of the beneficiaries (74 percent of adults and 63 percent of children) were persons with multiple disabilities.
- Most respondents with severe disabilities were found to be older, have a low level of education, out of work, and come from low income families.
- Regardless of their condition, nearly 10 percent of adult and 30 percent of child beneficiaries did not perceive themselves to be a person with a disability.
- Nearly all of the beneficiaries had health insurance and about one-third were reported to be a member of an Organization for Persons with Disabilities (OPD).
- The Washington Group Questions (WGQs) have a strong correlation with both the Government's Classification of Disability (GCD) and the respondent's self-perception of disability. Moreover, the WGQs provided richer information on disabilities than the other tools, reflecting a continuum of disability rather than a simple dichotomous status.

DEMOGRAPHIC & SOCIO-ECONOMIC STATUS

Table 3 provides a profile of the beneficiaries, including the proportion of beneficiaries living in urban areas (26 percent of adult and 16 percent of children) which was lower than the national average (34.4 percent nationwide, 30.9 percent in Quang Tri, and 31.9 percent in Binh Dinh: authors estimated from results in GSO, 2020: Table 1)(GSO 2020). These findings are consistent with the most recent national survey on persons with disabilities, which finds the disability prevalence in rural areas to be higher than that of urban areas (GSO 2018, p.14).

There were also more males than females among adult (57 percent males) and child beneficiaries (59 percent males). There existed variation by age, with more than half of adults being 56 years old or older (the mean age for adults was 54.4) and more than half of children being 10 years old or older (mean age was 10.4). The proportion of adult beneficiaries who were currently married (55 percent) was lower than that of the general population of the same age (about 70 percent)[3](GSO 2020). About one out of five adult beneficiaries (22.4 percent) were working. More than half of those who were working (57 percent) were self-employed and an additional 37 percent were working for their family; only six percent of beneficiaries worked for someone else.

The beneficiaries had poorer education levels than the general population. Nearly a quarter of the adult beneficiaries (24.3 percent) never attended school, and only 59.8 and 17.6 percent of the beneficiaries completed primary and secondary school respectively. These rates are significantly lower than the education completion rates found amongst the general adult population of the same age in the country (about 90 percent and two-thirds of the adult population completed primary and secondary school respectively)[4] (GSO 2020: p. 404). The proportion of child beneficiaries of primary school age (aged seven to eleven) who were attending primary school was 56 percent, significantly lower than the national average at 98.0 percent[5] (GSO 2020, p. 349).

[3] Authors estimated from results in Table 6, GSO, 2020: p.309.
[4] Authors estimated from results in Table 14, GSO, 2020: p.404.
[5] Authors estimated from results in Table 9, GSO, 2020: p.349.

Amongst the beneficiaries, 20.9 percent of adults and 17.1 percent of children were living in a low income household, while poor households accounted for less than 11 percent of the total population.[6] Additionally, 17.1 percent of adult and 19.9 percent of child beneficiaries were living in near-poor families, while the near-poor accounted for less than six percent of the total population (MOLISA 2021). This finding was expected by the ET given well-observed evidence of the linkage between disability and poverty worldwide (Banks, Kuper, and Polack 2017).

Lastly, the majority of the beneficiaries (97.3 percent of adults and 95.1 percent of children) reported that they owned a valid health insurance card. This is also expected given the Government's policies on free health insurance for people with severe disabilities and the poor.

Table 3: Demographic & socio-economic status of the beneficiaries

Characteristics	Adult		Child	
	%/Mean(SD)	N	%/Mean(SD)	N
Province				
Quang Tri	75.3%	479	78.8%	115
Binh Dinh	24.7%	157	21.2%	31
Place of residence				
Rural	74.1%	471	83.6%	122
Urban	25.9%	165	16.4%	24
Sex				
Male	57.4%	365	58.9%	86
Female	42.6%	271	41.1%	60
Age	54.4 (18.4)	636	10.4 (3.7)	
Education: completed level [a]				
None	24.3%	152	49.3%	72
Less than primary	16.0%	100	25.3%	37
Primary	42.2%	264	25.3%	37
Secondary+	17.6%	110		
Vocational training				
Yes	15.9%	101	0.7%	1
No	84.1%	535	99.3%	145
Marital status				
Single	34.0%	216	NA	NA
Married/Cohabited	55.2%	351	NA	NA
Separated/Divorced/Widowed	10.6%	69	NA	NA
Working				
Yes	22.4%	141	NA	NA
No	77.7%	490	NA	NA
Owned a valid health insurance card				
Yes	97.3%	614	95.1%	136
No	2.7%	17	4.9%	7

[6] Self-reported: Respondents were asked if their household is classified by the Government as a poor, near-poor, or non-poor household.

Characteristics	Adult		Child	
	%/Mean(SD)	N	%/Mean(SD)	N
Household size	3.8 (1.8)	636	4.5 (1.6)	
Household's living standards				
Poor	20.9%	133	17.1%	25
Near poor	17.1%	109	19.9%	29
Non-poor	62.0%	394	63.0%	92

Note: [a] Education includes three categories for children: none, less than primary, primary or higher.

DISABILITY STATUS

Table 4 shows the disability status of the beneficiaries interviewed for this evaluation. Almost all beneficiaries (95 percent of adults and 94 of percent children) were persons with severe disabilities (severe and very severe level) and one-third of beneficiaries (28 percent of adults and 33 percent of children) were persons with very severe disabilities (as self-reported using the Government's classification). Most of the beneficiaries with disabilities (99 percent of adults and 100 percent of children) had disabilities for at least one year. Results from the WGQ on functional difficulties likewise show a disproportionate representation of persons with many difficulties or the inability to perform a function. These results reflect the priority and success of USAID in supporting persons with severe conditions.

While all of the beneficiaries were identified by local partners as persons with disabilities, there was a noticeable proportion (8.7 percent of adults and 28.8 percent of children) that did not identify themselves, either by self or by a proxy response, as a person with a disability. The majority of beneficiaries (74 percent of adults and 63 percent of children) were persons with multiple functional difficulties or disabilities; on average, each adult beneficiary had at least three types of disabilities and most child beneficiaries had more than two types of disabilities simultaneously.

By type of disabilities with GCD, mobility disabilities were found to be dominant (75.8 percent), followed by mental (20.9 percent) and intellectual disabilities (13.2 percent) among adult beneficiaries (see Figure 3). The patterns were similar for child beneficiaries as intellectual disabilities (49.3 percent) were most common, followed by mobility disabilities (36.3 percent), speech disabilities (20.6 percent), and mental disabilities (18.5 percent). The WGQ assessment resulted in similar patterns and contained richer information - as GCD usually tied persons with disabilities to one type of disabilities, even if they may have multiple types of disabilities as evidenced above. For adult beneficiaries, for example, the WGQ showed that about 72 percent of beneficiaries had walking difficulties (using the cut-off point of "a lot of difficulties" as recommended by the WGQ for dichotomous categorization). However, the proportion of beneficiaries having difficulties in other domains was considerably higher than that as measured by the GCD: the proportion of the beneficiaries with seeing difficulties was found to be 34 percent compared to 6 percent for the GCD, the proportion of beneficiaries with speaking difficulties was 38 percent compared to 7.7 percent using the GCD, and the proportion of beneficiaries with hearing difficulties was found to be 20 percent compared to 7.5 percent using the GCD.

The majority of children with disabilities were reported to have birth defects as their main cause of disability (78.2 percent). The second most common reason was reported to be a consequence of illness (9.8 percent). However, reported disability causes amongst adult beneficiaries were found to be more diverse, with illness reported as the most common reason (38.5 percent) followed by birth defects (25.3 percent), accidents (20.8 percent), and finally war consequences (12.1 percent reported injury during war time and 5.8 percent reported Agent Orange).

Table 4: Disability status of the beneficiaries

	Adult %/Mean (SD)	N	Child %/Mean (SD)	N
Level of disability as classified by the Government				
Mild	4.9%	31	6.2%	9
Severe	67.1%	427	61.0%	89
Very severe	28.0%	178	32.9%	48
Type of disabilities				
Mobility	75.8%	482	36.3%	53
Hearing	7.5%	48	10.3%	15
Speaking	7.7%	49	20.6%	30
Vision	6.0%	38	5.5%	8
Mental	20.9%	133	18.5%	27
Intellectual	13.2%	84	49.3%	72
Functional difficulties: 6 WGQ				
No difficulty	0.8%	8	2.1%	3
Some difficulties	9.9%	63	19.9%	29
A lot of difficulties	44.8%	283	35.6%	52
Unable	44.5%	282	42.5%	62
Number of functional disabilities	2.9 (1.8)	636	2.3 (1.7)	146
Self-perception of disability				
Not a person with disabilities	8.7%	53	28.8%	36
A person with disabilities	91.3%	557	71.2%	89
Member of a OPD				
Yes	28.9%	182	36.3%	53
No	71.1%	448	63.7%	93
Cause of disabilities				
At birth	25.3%	157	78.2%	104
Illness	38.5%	239	9.8%	13
Accident	20.8%	129	1.5%	2
Injury during wartime	12.1%	75	NA	NA
Agent orange (dioxin)	5.8%	36	3.0%	4
Old age	1.9%	12	NA	NA
Others	3.1%	19	4.5%	6
Duration of disability				
Less than one year	1.4%	9	0.0%	0
One year or more	98.6%	614	100.0%	133

Figure 3: Types of disabilities reported with the GCD

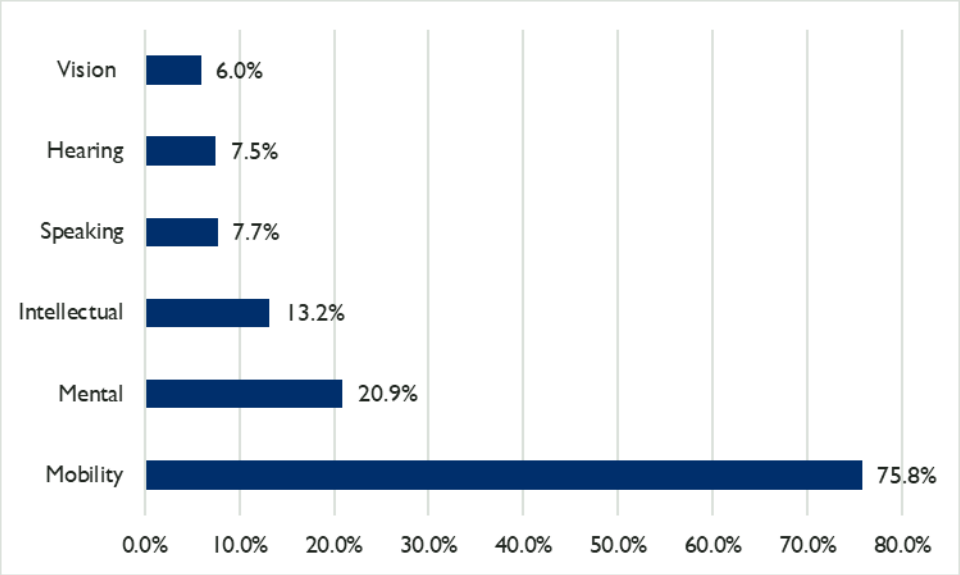
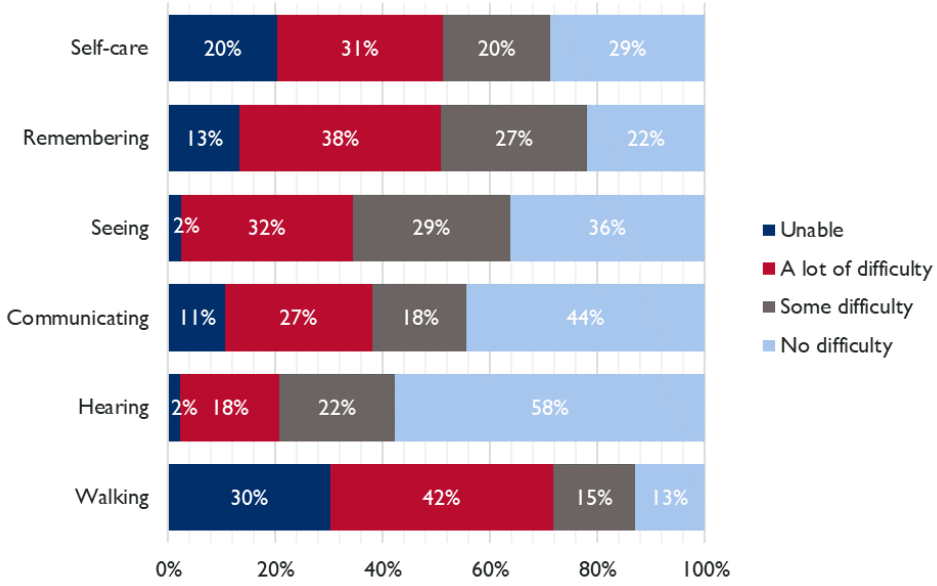


Figure 4: Types of disabilities reported with the WGQ



EQ1: QUALITY OF LIFE OF PERSONS WITH DISABILITIES

KEY FINDINGS

- Factors associated with better/higher QOL scores included:
    - Lower levels of disability, which can be either less severe disabilities, lower level of functional difficulties, or self-perceived lack of disabilities;
    - Children with intellectual or mental disabilities had significantly lower QOL scores than children without intellectual or mental disabilities.
- Better/higher QOL scores were also associated with adult demographic and socioeconomic factors, specifically:
    - Male adult beneficiaries had significantly higher QOL scores than females;
    - Those with higher levels of education had higher QOL scores than individuals with lower education levels;
    - Adults who were working had higher QOL scores than those who were not working;
    - Being a member of an OPD or having a family member serving as a representative at an OPD resulted in higher QOL scores;
    - Having a health insurance card was associated with a higher QOL score among the adult population;
    - Increases in adult age were associated with better QOL among adults, but poorer QOL for children;
    - Poverty also had differing impacts on the adult and child populations surveyed, with children living in non-poor families having significantly higher QOL scores than children from poor families; QOL scores of the near-poor were just slightly lower than those from non-poor families and higher than those from poor families. However, near-poor adults had the lowest QOL score among adult beneficiaries, partially due to diminished marginal financial differences between poor and near-poor adults and the fact that the poor are entitled to additional governmental assistance.
- Additionally, functioning difficulties, which were measured by the WGQ, had a higher explanatory power of QOL scores than other disability measurements (i.e. the GCD & self-perception).

QOL DISPARITIES BY DISABILITY STATUS

Mean QOL scores by categories of disability status, including t-test and all pairwise comparisons of means, are presented in Table 5. Overall, the analysis results showed that the mean QOL score using WHOQOL-BREF, DIS-Module, and ScoPeO-Kids was 56.3, 55.7, and 73.5, respectively. Note that the absolute value of mean QOL scores does not have intuitive meaning as there are no established thresholds for different levels of QOL; however, they can provide important insights in their relative terms or through comparisons across sub-groups.

Results from the WHOQOL-BREF and DIS-Module for adult beneficiaries are consistent. Being disabled was associated with poorer QOL regardless of disability measurement, QOL measurement, and age group (i.e., adults or children). For instance, the average score of adults who perceived themselves as a person with disabilities was 56.5, which is significantly lower than 59.9, or the average QOL score of adults who did not perceive themselves as a person with disabilities.

Level of disability was negatively associated with individuals' QOL score: those who had more severe levels of disabilities or higher levels of functional difficulties had significantly lower mean QOL scores than others. This pattern is also consistently found across all three QOL measurements for both adult and child populations, and for both measurements of disability (i.e., GCD & WGQ). Likewise, the results show that adults who had a higher number of functional difficulties had lower QOL scores.

By type of disabilities, those who had mobility disabilities had significantly higher QOL scores or better QOL than those who had other types of disabilities - this was found among both adult and child populations. On the other hand, adults who had speech, mental, or intellectual disabilities had significantly lower QOL scores than the others. Children with hearing disabilities had the lowest QOL score, and children with mental or intellectual disabilities also had significantly lower QOL scores than the rest of the surveyed sample.

Being a member of an OPD (including being represented by a family member in an OPD) was associated with a significantly higher QOL score for both adult and child beneficiaries.

Table 5: QOL disparities by disability status

	ADULT				CHILD	
	WHOQOL-BREF Mean score		DIS-Module Mean score		ScoPeO Mean score	
Level of disability as GCD		*** (e)		*** (g)		** (k)
Mild	64.2		62.2		77.4	
Severe	57.4		57.8		74.8	
Very severe	52.3		49.9		70.2	
Type of disabilities						
Mobility	56.9	**	57.2	***	75.4	**
Hearing	54.9		51.9	**	67.7	**
Speaking	50.8	***	47.6	***	72.5	
Vision	58.7		56.8		70.4	
Mental	53.1	***	50.1	***	70.3	**
Intellectual	51.5	***	45.6	***	70.7	***
Functional difficulties: 6 WGQ		*** (f)		*** (h)		*** (i)
No difficulty	74.2		79.3		85.6	
Some difficulties	66.2		62.9		81.7	
A lot of difficulties	58.8		59.4		74.6	
Unable	51.2		50.3		67.9	
Self-perception of disability						
Not a person with disabilities	59.9	**	57.7		73.5	**
A person with disabilities	56.5		56.2		77.4	
Member of a OPD						
Yes	58.3	***	57.7	**	75.6	**
No	55.7		55.1		72.2	
Number of functional disabilities		*** (e)		*** (e)		
0-1	65.1		64.3		NA	
2-3	56.6		56.0		NA	
4+	49.8		49.7		NA	

*Note: (e) *** all pairs; (f) *** all pairs except "some" vs "no difficulty"; (g): *** all pairs except Severe vs. Mild; (h): ** Some vs. No; (i) all pairs except Some vs. No and A lot vs. No; (k) except Sev vs. Mild and Very Sev vs. Mild; *** all other pairs except "A lot" vs "Some" difficulty.*

QOL DISPARITIES BY SOCIOECONOMIC STATUS

Similar to Table 5, Table 6 provides mean QOL scores by socioeconomic status and significant test results (t-test & all pairwise comparisons of means). The results again show consistent findings between WHOQOL-BREF and DIS-Module.

Education had a positive association with QOL for both adult and child beneficiaries: those with higher completed levels of education had significantly higher QOL scores. For adult beneficiaries, the difference was mainly between those who never attended school and those that did; the education effect remained consistent for higher levels of education but differences were not statistically significant. Attending vocational training was associated with a significantly higher QOL score among adult beneficiaries; this result was also observed for child beneficiaries but the difference was again not statistically significant.

Male beneficiaries had significantly higher QOL scores than female beneficiaries among adult beneficiaries. This was also seen with child beneficiaries, but the difference was not statistically significant. Differences by age group were also not found to be statistically significant. The results show that child beneficiaries in urban areas had higher QOL scores than their counterparts in rural areas, but the difference was marginally less significant (at p<=0.10).

Significant differences in QOL score were also found in marital status: those who were currently married or cohabited had significantly higher QOL scores than those who were single. No difference was found between those who had experienced marital disruption (i.e., separated, divorced, or widowed) and those who had not.

Working status had a very strong association with QOL as beneficiaries who were working had a high QOL score - much greater than those who were not working. Those who owned a health insurance card also had a significantly higher QOL score than those who did not have one, but this was only observed amongst the adult population.

For adult beneficiaries, the near-poor seemed to have the lowest QOL score, but that was not statistically significantly lower than that of the poor and the non-poor. Child beneficiaries who lived in non-poor families had significantly higher QOL scores than those living in poor families. The QOL score of the near-poor was not significantly different from the other groups, but was close to the QOL score of the non-poor.

Table 6: QOL disparities by socioeconomic status

	ADULT				CHILD	
	WHOQOL-BREF		DIS Module			
	Mean score		Mean score		Mean score	
Province						
Quang Tri	56.1		55.9		74.2	**
Binh Dinh	57.1		55.2		70.6	
Place of residence						
Rural	56.4		55.9		72.9	*
Urban	56.1		55.2		76.2	
Sex						
Male	57.4	***	56.8	**	73.9	
Female	54.9		54.3		72.8	
Age (group: adult | child)		***(a)		***(d)		
18-34 yo. | 4-7 years old	54.2		49.5		75.4	
35-51 yo. | 8-12 years old	56.5		56.2		72.7	
52-62 yo. | 13-17 years old	59.7		58.8		73.3	
63-70 yo.	55.4		56.9			
71+ yo.	55.6		57.2			
Education: completed level		***(b)		***(b)		***(e)

	ADULT				CHILD	
	WHOQOL-BREF		DIS Module			
	Mean score		Mean score		Mean score	
None	51.0		50.1		71.1	
Less than primary	55.9		55.0		72.8	
Primary	58.6		58.1		78.6	
Secondary	58.8		59.0			
Vocational training						
Yes	61.2	***	61.5	***	77.3	
No	55.4		54.7		73.4	
Marital status		** (c)		***(c)		
Single	54.9		52.1		NA	
Married/Cohabited	57.6		57.9		NA	
Separated/Divorced/Widowed	54.4		55.9		NA	
Working						
Yes	63.7	***	64.9	***	NA	
No	54.2		53.1		NA	
Owned a valid health insurance card						
Yes	56.5	**	56.0	**	73.5	
No	51.1		48.1		73.2	
Household's living standards						** (f)
Poor	56,2		57.3		68.2	
Near poor	54,5		53.3		73.5	
Non-poor	56,9		55.8		74.8	

*Note: *** p<=0.01 ** p<=0.05 * p<= 0.10; (a) *** 52-62 vs. 18-34; * 63-70 vs. 52-62; * 71+ vs 52-62; (b) ** Less than primary vs. None; *** Primary vs. None; *** Secondary vs. None; (c) ** Married/Cohabited vs. Single; (d) *** for all pairs compared with 18-34 yo.; (e) *** Primary+ vs None; ** Primary+ vs. Less than primary; (f) ** Non-poor vs. Poor.*

FACTORS ASSOCIATED WITH QOL

Table 7, Table 8, and Table 9 present results from regression models showing the independent association between disability and socio-economic status with QOL after controlling for other factors in the model.

The results again are consistent and show that the level of disabilities among adult beneficiaries was strongly and negatively associated with QOL, regardless of disability measurement or QOL measurement. They further show that this association was independent of socioeconomic status. The differences were slightly smaller after controlling for other socioeconomic characteristics, but those differences remained statistically significant. For instance, the QOL score of those with severe and very severe disabilities were respectively 5.8 and 8.7 points lower than that of those with mild disabilities (Model 1), but these differences reduced to 4.2 and 6.4 points after controlling for socioeconomic characteristics (i.e., if people with different levels of disability had the same socioeconomic status - they had similar age at mean age, they were of the same sex, they lived in the same province, same rural or urban areas, etc. See Model 4).

The WGQ shows similar results of strong and negative associations between the level of disability and QOL regardless of the control for socioeconomic characteristics of the beneficiaries (Model 2 and

Model 5). The difference is significant from the "some difficulty" cut-off point for adult beneficiaries. Moreover, the results (in Model 2, Model 5, and Model 14) show that the number of functional difficulties had a negative association with QOL regardless of the control for socioeconomic status, and it was independent from level of disabilities.

Self-perception of disabilities also had a significant negative association with QOL.

After controlling for level of disabilities, statistically significant differences by type of disability remained for adults with mental and intellectual disabilities in models using DIS-Module (Model 7 & Model 10) - adults with mental or intellectual disabilities had poorer QOL than other adults. Similar results were found for children (Model 13 & Model 16). Adults and children with mobility disabilities tended to have higher QOL scores than their counterparts, but the differences are not statistically significant.

After controlling for disability status and other socioeconomic characteristics of the beneficiaries, working status shows the strongest association (largest coefficients at $p<=0.01$) to QOL with a positive association: adults who were working had higher QOL scores than adults who were not working (Model 4, 5, 6, 10, 11, 12). Owning a health insurance card was strongly associated with better QOL with the WHOQOL models (Model 4, 5, 6), and these associations remained at a marginal level of significance with the DIS-Module ($p<=0.10$; Model 10, 11, 12).

Age was positively associated with QOL for adult beneficiaries (Model 5, 10, 11, 12), but it was negatively associated with QOL for child beneficiaries (Model 17 & Model 18).

After controlling for other covariates, differences in QOL by education level were no longer significant among adult beneficiaries, but they remained statistically significant for child beneficiaries; significant differences started at completion of primary or higher level of education.

Differences in QOL by household living standards became significant after controlling for disability status and other socio-economic characteristics of the beneficiaries. Adult beneficiaries living in near-poor households were associated with significantly lower QOL scores than those living in poor households after controlling for other covariates (Model 10, 11, 12). The effect, however, was different for child beneficiaries as it was linear and a higher level of living standards was associated with better QOL after controlling for other covariates (Model 16, 17, 18).

Table 7: Results from regression models predicting QOL score for adult beneficiaries using WHOQOL-BREF

ADULT - WHOQOL	Coeff		t	Coeff		t	Coeff		t	Coeff		t	Coeff		t	Coeff		t
Level of disability as classified by the Government (Ref.=mild)																		
Severe	-5.8	***	-2.7							-4.2	*	-1.8						
Very severe	-8.7	***	-3.8							-6.4	***	-2.6						
Type of disabilities																		
Mobility	-0.2		-0.2							0.0		0.0						
Hearing	1.5		0.7							1.9		0.9						
Speaking	-1.5		-0.7							-2.8		-1.3						
Vision	1.6		0.8							1.9		0.9						
Mental	-1.5		-1.2							-1.6		-1.2						
Intellectual	-0.3		-0.2							-0.8		-0.5						
Functional difficulties: 6 WGQ (Ref. = No difficulty)																		
Some difficulties				-8.1	**	-2.1							-9.5	**	-2.4			
A lot of difficulties				-8.9	**	-2.3							-9.9	***	-2.6			
Unable/Cannot do at all				-11.9	***	-3.1							-12.5	***	-3.2			
Number of functional disabilities				-2.4	***	-8.3							-2.5	***	-8.3			
Self-perceived as a person with disability							-3.9	**	-2.3							-4.6	***	
Member of a OPD	1.8	*	1.7	1.6	*	1.7	1.5		1.5	1.1		1.1	1.4		1.4	0.8		0.8
Quang Tri (vs. Binh Dinh)										-0.4		-0.8	-0.4		-0.8	-0.5		-0.9
Rural place of residence (vs. urban)										0.9		0.8	1.8	*	1.8	0.8		0.8
Being female (vs. male)										-1.3		-1.2	-1.2		-1.3	-1.0		-1.0
Age										0.0		-0.4	0.1	**	2.5	0.0		-0.4
Education: completed level (Ref. = None)																		
Less than primary										1.6		1.0	1.0		0.7	0.8		0.5

ADULT - WHOQOL	Model 1		Model 2		Model 3		Model 4			Model 5			Model 6		
	Coeff	t	Coeff	t	Coeff	t	Coeff		t	Coeff		t	Coeff		t
Primary							2.0		1.4	1.1		0.8	1.6		1.1
Secondary							2.4		1.4	0.5		0.3	1.6		0.9
Marital status (Ref.=Single)															
Married/Cohabited							-1.0		-0.7	-7.0		-0.6	-0.8		-0.6
Separated/Divorced/Widowed							-1.6		-0.9	-2.4		-1.4	-1.6		-0.9
Working							5.8	***	4.8	3.9	***	3.5	6.4	***	5.5
Owned a valid health insurance card															
Household size							0.4		1.6	0.3		1.3	0.4		1.5
Household's living standards (Ref.=Poor)															
Near poor							-1.1		-0.7	-1.3		-1.0	-0.8		-0.5
Non-poor							1.4		1.2	0.7		0.6	1.5		1.3
Proxy (Ref.=No help given)															
Some help	*-1.7*		*-1.4*	*0.1*		-2.9	**	0.0			1.4			-1.1	
Proxy entirely	*-9.3*	***	*-6.7*	*-5.8*		-10.8	***	-7.5	***		-4.0	***		-9.0	***
N	623			627		601		613			613			587	
R^2	16.5%			31.0%		12.8%		22.5%			34.9%			20.3%	

*Note: *** p<=0.01 ** p<=0.05 * p<= 0.10.*

Table 8: Results from regression models predicting QOL score for adult beneficiaries using DIS-Module

ADULT – DIS-Module	Model 7			Model 8			Model 9			Model 10			Model 11			Model 12		
	Coeff		t	Coeff		t	Coeff		t	Coeff		t	Coeff		t	Coeff		t
Level of disability as classified by the Government (Ref.=mild)																		
Severe	-3,4		-1,3							-3,5		-1,3						
Very severe	-8,1	***	-3,0							-7,3	**	-2,5						
Type of disabilities																		
Mobility	1,7		1,1							1,1		0,7						
Hearing	0,8		0,3							0,04		0,0						
Speaking	-2,1		-0,9							-2,9		-1,2						
Vision	0,6		0,3							1,1		0,5						
Mental	-2,4	*	-1,7							-1,7		-1,2						
Intellectual	-4,8	***	-2,8							-3,9	**	-2,1						
Functional difficulties: 6 WGQ (Ref. = No difficulty)																		
Some difficulties				-15,2	***	-2,6							-18,4	***	-3,3			
A lot of difficulties				-13,1	**	-2,3							-16,7	***	-3,1			
Unable/Cannot do at all				-16,7	***	-2,9							-20,7	***	-3,7			
Number of functional disabilities				-2	***	-5,7							-2,2	***	-6,2			
Self-perceived as a person with disability							-3,6	*	-1,65							-3,8	*	-1,7
Member of a OPD	1,5		1,3	0,9		0,8	1		0,86	0,2		0,2	0,1		0,1	-0,2	*	-0,2
Quang Tri (vs. Binh Dinh)										0,7		1,1	0,7		1,1	0,3		0,4
Rural place of residence (vs. urban)										0,6		0,5	1,5		1,3	0,5		0,4
Being female (vs. male)										-0,9		-0,8	-0,6		-0,5	-0,4		-0,3
Age										0,1	**	2,3	0,2	***	5,4	0,1	***	3,1
Education: completed level (Ref. = None)																		

ADULT – DIS-Module	Model 7			Model 8			Model 9			Model 10			Model 11			Model 12		
	Coeff		t	Coeff		t	Coeff		t	Coeff		t	Coeff		t	Coeff		t
Less than primary										-1,7		-1,0	-1,8		-1,0	-2,2		-1,2
Primary										-1,7		-1,0	-1,8		-1,2	-1,7		-1,0
Secondary										-0,4		-0,2	-1,3		-0,7	-0,6		-0,3
Marital status (Ref.=Single)																		
Married/Cohabited										-0,7		-0,4	-0,3		-0,2	-0,8		-0,5
Separated/Divorced/Widowed										-1,9		-0,9	-2,1		-1,0	-1,9		-0.9
Working										7,5	***	5,5	6	***	4,6	8,4	***	6,3
Owned a valid health insurance card										5,6	*	1,8	5,5	*	1,8	6,7	*	1.9
Household size										0,4		1,5	0,5			0,6	*	1,8
Household's living standards (Ref.=Poor)																		
Near poor										-3,3	**	-2,0	-3,2	**	-2,0	-2,9	*	-1,7
Non-poor										-1,1		-0,8	-1,6		-1,3	-1		-0,8
Proxy (Ref.=No help given)																		
Some help	*-6,4*	***	*-4,8*	*-5,9*	***	*-4,6*	-8,6	***	-6,6	-5,4	***	-3,9	-4,6	***	-3,5	-7,2	***	-5,2
Proxy entirely	*-10,1*	***	*-6,6*	*-10,4*	***	*-7,6*	-14,3	***	-10,4	-9,0	***	-5,3	-7,1	***	-4,5	-12,2	***	-7,3
N	615			615			590			597			611			572		
R^2	23,5%			27,5%			17,8%			29,8%			34,9%			25,7%		

*Note: *** p<=0.01 ** p<=0.05 * p<= 0.10.*

Table 9: Results from regression models predicting QOL score for child beneficiaries using ScoPeO-Kids

CHILDREN – ScoPeO-Kids	Model 13		Model 14		Model 15		Model 16		Model 17		Model 18	
	Coeff	t	Coeff	t	Coeff	t	Coeff	t	Coeff	t	Coeff	t
Level of disability as classified by the Government (Ref.=mild)												
Severe	0.1	0.0					2.7	0.9				
Very severe	-2.7	-0.8					0.4	0.1				
Type of disabilities												
Mobility	1.1	0.6					1.6	0.9				
Hearing	-5.4	-1.6					-3.1	-1.0				
Speaking	1.8	0.7					0.6	0.2				
Vision	-1.7	-0.5					-1.5	-0.5				
Mental	-4.0 *	-1.9					-3.9 **	-2.0				
Intellectual	-4.5	-2.7					-3.0 *	-1.8				
Functional difficulties: 6 WGQ (Ref. = No difficulty)												
Some difficulties			-4.3	-0.8					-4.9	-0.96		
A lot of difficulties			-7.9	-1.5					-8.5	-1.65		
Unable/Cannot do at all			-12.4 **	-2.2					-13.2 **	-2.44		
Number of functional disabilities			-1.6 **	-2.2					-0.9	-1.21		
Self-perceived as a person with disability											-2.6	-1.5
Member of a OPD												
Quang Tri (vs. Binh Dinh)							1.5	1.5	1.4	1.59	-0.1	-0.1
Rural place of residence (vs. urban)							-1.3	-0.6	-1.4	-0.74	-1.9	-0.9
Being female (vs. male)							-1.1	-0.7	-0.8	-0.56	-2.6	-1.6
Age							-0.6	-2.6	-0.5 **	-2.13	-0.7 **	-2.6
Education: completed level (Ref. = None)												

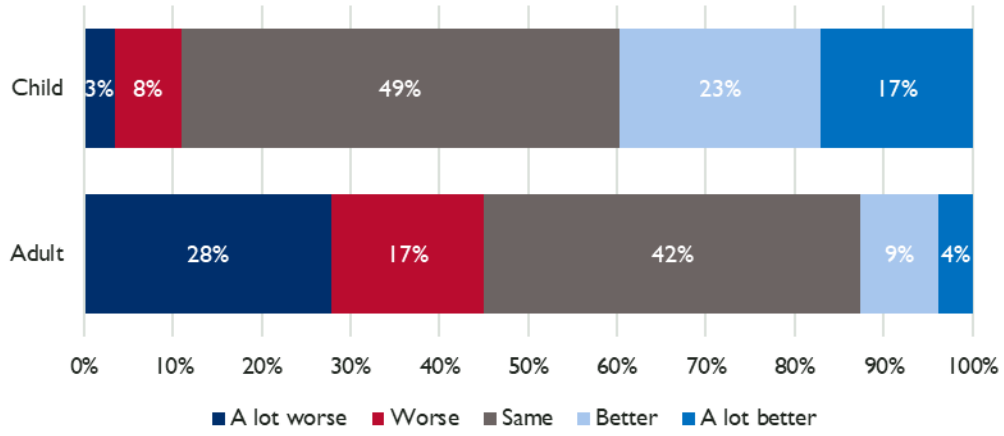
CHILDREN – ScoPeO-Kids	Model 13		Model 14		Model 15			Model 16			Model 17			Model 18		
	Coeff	t	Coeff	t	Coeff		t	Coeff		t	Coeff		t	Coeff		t
Less than primary								-1.1		-0.5	-2.3		-1.14	-0.9		-0.4
Primary +								6.9	***	2.8	4.1	*	1.75	7.6	***	3.3
Owned a valid health insurance card								0.2		0.4	0.2		0.47	1.1		0.3
Household size																
Household's living standards (Ref.=Poor)																
Near poor								5.2	**	2.1	4.1	*	1.76	3.8		1.5
Non-poor								6.6	***	3.2	6.0	***	3.11	5.7	***	2.7
Proxy (Ref.=No/Some help given)																
Proxy entirely	*-3.3*	*-1.8*	*1.0*	*0.5*	-4.6	***	-2.8	-3.5	*	-1.8	-0.9		-0.5	-3.7	**	-2.0
N	145		145		125			145			145			125		
R^2	22.1%		32.5%		11.5%			37.5%			43.8%			30.9%		

*Note: *** p<=0.01 ** p<=0.05 * p<= 0.10.*

PERCEIVED QOL COMPARED TO QOL 6 MONTHS AGO

When the beneficiaries were asked to compare their QOL at the time of interview to six months prior, there were more adult beneficiaries who felt a negative trend of QOL over time: 17 percent felt it was 'worse' and 28 percent felt it was 'a lot worse' over the past six months, while only nine percent and four percent felt it was 'better' and 'a lot better', respectively, over the same period. However, the situation is reversed for child beneficiaries as there were more beneficiaries who felt a positive trend of QOL over the past six months (see Figure 5).

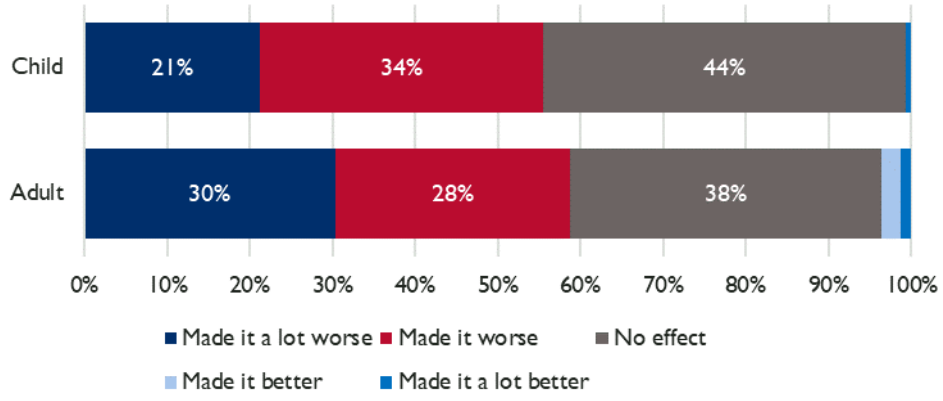
Figure 5: Perceived current QOL compared to six months ago



PERCEIVED IMPACTS OF COVID-19 ON QOL

The COVID-19 pandemic had a negative effect on QOL for many people, including more than half of the beneficiaries: 21 percent and 34 percent of child beneficiaries (or their proxies) reported that the COVID-19 pandemic made their QOL 'a lot worse' and 'worse' respectively. Likewise, 30 percent and 28 percent of adult beneficiaries reported that their QOL got 'a lot worse' and 'worse', respectively, as a consequence of the COVID-19 pandemic (see Figure 6).

Figure 6: Perceived impact of COVID-19 on QOL



EQ2: FACTORS AFFECTING THE SUCCESS OF USAID'S INTERVENTIONS IN 3 TARGETED AREAS

KEY FINDINGS

Rehabilitation

Rehabilitation interventions were seen by qualitative interview respondents as largely successful overall. The most successful subcomponents were expanding and strengthening the workforce and increased availability of rehabilitation services. The main facilitators that helped USAID achieve success in rehabilitation included: expertise provided by and through implementing partners, project alignment with needs identified by the GVN, and the amount of time and money invested by USAID. The main barriers to success in rehabilitation and its sub-components stemmed from the limited formal engagement with the MOH to jointly address challenges with licensure, rehabilitation data integrated within the health information system (HIS), and addressing the limited availability of APs at health facilities.

Social Services

The level of success of social services interventions was considered less positively because some interventions were newly developed or still under development. The subcomponent that was most frequently discussed as successful was the increased participation of persons with disabilities. The main facilitators that helped USAID achieve success for social services were family involvement and USAID investment. Conversely, these two aspects were also identified as being barriers to success; family members being very tired or having other work and the acknowledgement that, as social services are largely dependent on IPs, they are not sustainable. A related barrier was the lack of formal engagement with MOLISA for many of the sub-components. Another barrier that limited success was that many components within "social services" (e.g., home care, psychological support) lack clear definition; this led to inconsistency in understanding, implementation, and results.

Disability Policies

USAID's interventions in disability policies were seen as successful overall, with similar levels of success across the three subcomponents: reducing discrimination toward persons with disabilities, strengthening OPDs, and achieving a barrier-free society. The biggest facilitator in helping USAID achieve success within this domain was the existence of legal documents, laws and the UNCRPD. In addition, USAID's historical support in this area has created a strong foundation for on-going and future work. The main barriers in achieving success were identified as GVN's lack of enforcement of laws, USAID's reduced focus and investment in this area, and reliance on just two IPs to do this work when the disability portfolio encompasses all IPs.

USAID'S LEVEL OF SUCCESS RELATED TO REHABILITATION INTERVENTIONS

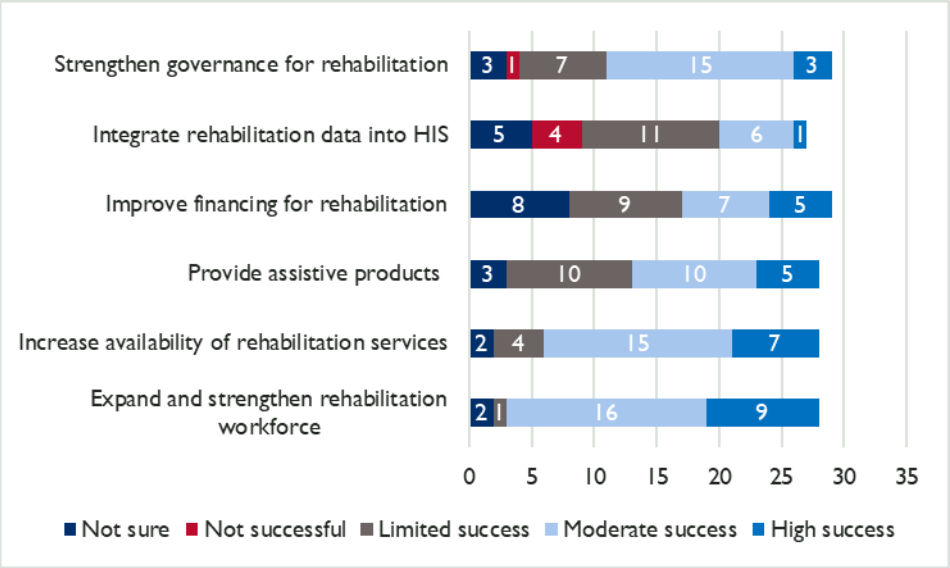
Perceived levels of success

Overall, USAID's interventions in rehabilitation were largely perceived as successful by key informants. As displayed in Figure 7, the intervention subcategory with the highest level of success was USAID's efforts to expand and strengthen the workforce, where 25 of 30 KII respondents identified the interventions as moderately or highly successful, followed by increasing the availability of rehabilitation services where 22 respondents identified the interventions as moderately or highly successful. Respondents who rated the rehabilitation interventions highly often attributed their success in part due to increased VSS coverage for rehabilitation services. One KII respondent explained, "There has been a lot of work to get rehab techniques covered by VSS. This went from a small number to over 200 techniques. This was really great work and important for sustainability."

The subcategory described as the least successful was integrating rehabilitation data into the health HIS where 15 respondents identified the interventions as not successful or having limited success. Note that respondents referenced the Disability Information System (DIS) rather than routine data

collection within the health system. Respondents attributed the lack of success to the lack of updated information in the DIS. One KII respondent said, "Although the DIS is a big database, it is not useful. The data doesn't reflect the actual situation."

Figure 7: Perceived levels of success of USAID's rehabilitation interventions



While the sections that follow describe barriers and facilitators specific to each subcomponent of the rehabilitation interventions, respondents also discussed common barriers and facilitators to the rehabilitation interventions generally. The most common facilitator discussed was the expertise provided by and through IPs. Specifically, respondents discussed the benefit of bringing experts from outside of Vietnam, with one KII respondent explaining, "We have had the opportunity to learn from best practices around the world." Additionally, respondents cited government buy-in, support engagement of local stakeholders, alignment with country needs, the amount of money invested by USAID, and USAID's time investment in the Disability sector as facilitators to the rehabilitation interventions overall. USAID's money and time investment were considered one of the keys to its success as one stakeholder noted, "it is rare to have a donor with such lasting engagement in a sector; the amount of time invested has helped achieve results."

Though facilitators were more frequently discussed than barriers, the current IP approach, choice of ministry partners, insufficient resources, the system strengthening approach versus direct assistance, and the lack of engagement from local authorities stood out from KIIs as barriers to the rehabilitation interventions. Regarding the IP approach which was most commonly discussed, respondents described the approach as piecemeal, inconsistent, and duplicative. One KII respondent explained, "Many IPs work with the same partners. The local partner only has so much bandwidth and sometimes has to choose which IP gets their attention."

Barriers and Facilitators

Rehabilitation Subcomponent: Expand & Strengthen Rehabilitation Workforce

The most discussed facilitators for USAID's success in expanding and strengthening the rehabilitation workforce among the 30 KII respondents were the increase in the number of rehabilitation professions (14 respondents), the increase in availability of training courses (11 respondents), and subsequently an increase in the number of people trained (11 respondents). Regarding the increase in rehabilitation professions, respondents explained that "there is big improvement in the sector – especially OT and ST; we created a foundation for the future workforce training in Vietnam."

Though the availability of training courses was discussed as a facilitator to an expanded and strengthened rehabilitation workforce, the quality of short courses was considered a barrier in some

interviews. Some KII respondents cited deficiencies in the quality and consistency of intermediate training and explained that it is not aligned with GVN legal documents. One noted "Training is not consistent with MOH direction/documents. Formats of training are not consistent among training facilities, not clear, not based on state documents, not approved by MOH, and do not meet MOH's expectation." Two other barriers raised by respondents were a lack of interest of medical doctors to specialize in rehabilitation, the limited number of rehabilitation doctors and challenges with obtaining a license to practice. Respondents connected the challenges with training and licensing, explaining that participants have experienced delays or refusal for licensure after completing short courses for upgraded training due to the lack of alignment or compliance with GVN regulations. Additionally, the fact that some participants were selected for training but did not or could not utilize the training material in their role in the health facility lessens the intended impact of the training interventions.

Rehabilitation Subcomponent: Increase the Availability of Rehabilitation Services

There is a direct link between expanding the rehabilitation workforce and increasing the availability of rehabilitation services. Just as USAID's support has facilitated the expansion of the workforce, it has also helped increase the availability of rehabilitation services. Though respondents commonly discussed the increase in number and type of services available (16 respondents), there were few facilitators mentioned specific to this subcomponent. The key barrier limiting the availability of rehabilitation services aside from the workforce is health facility readiness or leadership for rehabilitation. The availability of rehabilitation services is inconsistent across geographic regions and there are little or no services at the commune level. Taking Quang Tri and Binh Dinh as examples, SRDT quantitative data showed that only 21 communes in Binh Dinh (13.2% of the total communes) and 34 communes in Quang Tri (27.2%) can provide rehabilitation services. In general, each commune can provide two out of 144 techniques required by MOH (see EQ3 for more details).

Rehabilitation Subcomponent: Provide Assistive Products

While expanding the rehabilitation workforce and increasing the availability of rehabilitation services were seen as highly successful or moderately successful by most respondents, providing APs was rated as moderately successful or with limited success. Provision of individualized APs and support and USAID's previous investment in local AP innovation were identified as facilitators for success. Barriers were more frequently discussed than facilitators. The most commonly mentioned barrier was the limited diversity of APs. Respondents explained that USAID's AP support focuses mainly on mobility products and currently lacks support for provision of APs for those with communication or cognitive support needs. Additionally, respondents noted the lack of health insurance coverage for APs as a barrier. Other commonly discussed barriers were that AP provision is led mainly by IPs with little systems strengthening, and the workforce directly involved in APs (e.g., prosthetists and orthotists) is underdeveloped. One respondent explained, "accessibility to APs is difficult. Availability and training are limited. Service is underdeveloped. Systems and personnel are not in place." Another respondent said, "from the project side, products are mainly financed by USAID. From the government side, it is very limited, only some prostheses and orthoses, and mainly for veterans. Most people rely on external funding for assistive devices, basic stuff like wheelchairs and walking aids, not advanced products (like communication aids)."

Rehabilitation Subcomponent: Rehabilitation Financing

As with provision of APs, most respondents rated rehabilitation financing as moderately successful or with limited success. The most common facilitator discussed by respondents was an increase in the number of techniques financed by the VSS. USAID IPs supported this effort through advocating for improved health insurance policies, specifically the development and issuance of Circular 18 on VSS payments for rehabilitation services. Respondents explained that increased health insurance coverage for rehabilitation is a source of income for health facilities and generates interest to develop this service. VSS pays for techniques delivered by licensed professionals and health facilities focus on staff training to get licensure.

Barriers to success in rehabilitation financing stemmed from the lack of a specific line item for rehabilitation in government budgets, projects not working in this area, and limited VSS coverage.

Regarding government budgets, respondents explained that the lack of a specific line item for rehabilitation in MOH/Department of Health (DOH) budgets makes it difficult to track GVN investment in rehabilitation or conduct a cost benefit analysis, which could contribute to advocacy efforts for rehabilitation. One respondent further explained this point, saying, "Government budget for health is generally limited. There is no budget line for rehabilitation in the state budget. At the local level, finance is really limited, finance for rehab is almost zero and mainly relies on support from projects."

Rehabilitation Subcomponent: Integrating Rehabilitation Data in HIS

Integrating rehabilitation data in HIS was seen as the least successful subcomponent of rehabilitation, with 15 respondents categorizing the interventions as having limited or no success. The limited success was linked to the DIS. Although many respondents identified the existence of this DIS as positive, they identified multiple challenges related to DIS that need to be addressed to make it a useful source of information. The common challenges related to DIS were that it is not kept up-to-date and data are inaccurate or incomplete. In addition, there are challenges with the usability of the DIS as access to data is limited and it is not known who uses this data. While USAID had previously invested in creating the DIS, there is little or no recent investment in this area. For rehabilitation information included in the HIS, respondents explained that the MOH does not mandate data collection on rehabilitation, affecting the timeliness and completeness of the data coming from health facilities.

Rehabilitation Subcomponent: Strengthen Governance for Rehabilitation

Strengthening governance for rehabilitation was largely seen as one of the least successful subcomponents. That said, respondents identified the development of treatment guidelines, increased attention given to rehabilitation from the government, and the emerging National Rehabilitation Strategy as key facilitators. While treatment guidelines may help clinical outcomes, the National Rehabilitation Strategy provides a framework for USAID to anchor existing programming to align with government priorities.

The main barrier to success in governance for rehabilitation was linked to GVN policy on merging traditional medicine and rehabilitation. Although this may be an attempt to reduce costs (having one department instead of two), many doctors prescribe both and there is duplication of efforts. The integration of traditional medicine and rehabilitation was also mentioned as a barrier to success in service provision. One respondent explained this concept further, saying, "Merging rehab and traditional medicine is a policy that moves rehabilitation backwards. In Vietnam, traditional medicine has been around for a long time – so when you merge this with rehab, the visibility of rehab is reduced."

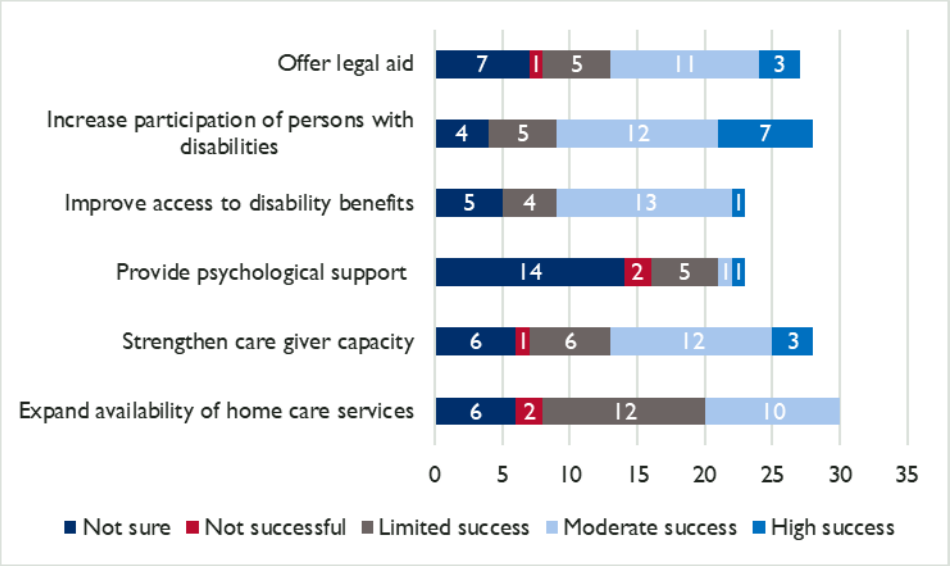
USAID'S LEVEL OF SUCCESS RELATED TO SOCIAL SERVICE INTERVENTIONS

Perceived levels of success

Key informants perceived the success of USAID's social services interventions to be more mixed than the rehabilitation interventions. As displayed in Figure 8, the participation of persons with disabilities was identified as moderately or highly successful by 19 out of 30 KII respondents. Strengthening caregiver capacity and improving access to disability benefits were also identified as successful interventions.

The subcategories frequently identified as less successful included psychological support (with nearly 50 percent of respondents saying they were not sure about the status of this action) and expanding the availability of home care services. Limited success was attributed to the fact that many elements of social services are only implemented by IPs (and not available outside USAID project areas) and that some sub-categories are still in the early stages of implementation.

Figure 8: Perceived levels of success of USAID's interventions on social services



While the following sections describe barriers and facilitators specific to each subcomponent of social services, respondents also discussed common barriers and facilitators to USAID's success across social services in general. The key facilitators to USAID's success were identified as family engagement, government support and USAID's investment. The most commonly cited barriers to success (from most mentioned to least mentioned) were USAID's lack of investment in livelihood, education and employment, the lack of a consistent approach or model, and lack of engagement of social workers in the project. One respondent emphasized "The program focuses on health too much to balance with other important issues such as livelihood/vocational training/job creation."

Social Services Subcomponent: Expand the Availability of Home Care Services

The home care services subcomponent was seen to be moderately successful or have limited success. The main facilitators were family engagement and USAID's investment in this area. This was balanced by one respondent noting "This service is still very limited. 90 percent of persons with (severe) disabilities are at home and cared for in a traditional way. They depend on their family." Some respondents highlighted that this subcomponent is still emerging and that only two IPs have provided this service. One respondent noted "Home-care is a new element in the Inclusion project." The lack of clear definitions of home care services and under-developed approaches to delivering these services is also attributed to this nascent service. One respondent highlighted this by saying, "There are no standard guidelines for home-based care and this impacts the quality and safety of services." Another barrier was the lack of a systems approach and concern for sustainability if this activity is linked only to USAID projects. One respondent reinforced this message by commenting "We need a network of collaborators. This service is not covered by VSS – how can we link DOH and DOLISA for this work?"

Social Services Subcomponent: Strengthen Caregiver Capacity

The main facilitator discussed by KII respondents for USAID's success in strengthening caregiver capacity was training provided through the project. Respondents recognized that training helps to improve caregiver capacity; this was seen as especially true for caregivers of children with disabilities. One of the examples was the nine-month caregiver training for children with disabilities which provided adequate time and attention to address the individual needs of the child and the caregiver.

The training was widely considered successful, yet challenges remain with the training methods and design if caregiver training is not systematic or routine and there is no pathway for caregivers of persons with newly acquired disabilities to access training. Regarding the timing of training, respondents also raised that group training for two to three days is too short and is not adequate to address the individual needs of either the caregiver or the person with disability.

Engaging family members as caregivers was seen as both a facilitator and a barrier to success. When asking 680 people, including both adults and children, about the reasons for not accessing HBC services for adult beneficiaries, the disrespectful care or attitude of caregivers who are non-family members was the second most common reason (see EQ3 for further details). However, with family members being caregivers, when busy with other work or fatigue at the end of the day, the facilitator becomes a barrier with a negative impact on the quality of care for persons with disabilities and the relationship between the caregiver and their family member. Additionally, respondents discussed issues with social services systems as barriers to success in strengthening caregiver capacity. Respondents explained that outside of the USAID project, there is no system or policy to provide caregiver training or support, and unless caregiver support is framed within a health or social system in Vietnam, it is unlikely to be sustained. Although there is some involvement of health staff providing care services, social workers are not engaged in the project. As one KII respondent explained, "Recently, since the Decision 32 took effect, MOLISA has implemented activities on social work and psychological support for persons with disabilities. USAID, therefore, no longer invests in this area."

Social Services Subcomponent: Provide Psychological Support

Findings on the success of the psychological support subcomponent were much less positive than other social services interventions primarily because this activity has not yet started; nearly half of the respondents were unsure about the level of success. Respondents described some related initiatives that could contribute to USAID success in providing psychological support. These included: IPs providing six-month training in psychological support for rehabilitation workers, integration of psychological support to caregiver training for children with disabilities, psychological support included as a component of social worker training, and the MOH having approved a list of techniques used for psychological support.

Respondents noted that one main barrier to USAID achieving success in this subcomponent is that psychological support is not commonly used in Vietnam, even for people without disabilities. One KII respondent said, "Vietnam is more focused on material life, not mental health." Respondents also described the limited workforce and workforce capacity for psychological support, and mentioned the lack of psychological support for family members. These respondents explained that there is ample discussion around support for persons with disabilities, but little emphasis on psychological support for family members who are often caregivers and provide income for the household.

Social Services Subcomponent: Improve Access to Disability Benefits

An individual must have a "disability determination" to access a disability allowance. The improvement in accessing disability benefits is believed to stem from increased awareness about and instruction on accessing a formal disability determination. One respondent said, "Many projects focus on training for disability classification. With a certificate, persons with disabilities are eligible for benefits - those considered severe and very severe get a cash allowance - free health insurance." Although increased access to a disability allowance was generally seen as positive, respondents also noted that a disability allowance might counter USAID's vision on supporting individuals to have improved functioning in order to return to society and earn a living independently.

Another important facilitating factor that contributed to the improvement of access to disability benefits was the inclusion of disability benefits in Vietnam's existing laws and policies. USAID has made significant contributions to the development and issuance of the Law on Persons with Disabilities 2010 and the adoption of the UN Convention on Persons with Disabilities in 2014.

Social Services Subcomponent: Increased Participation of Persons with Disabilities

One of the most common facilitators to success mentioned by the KII respondents with regard to increased participation of persons with disabilities was the disability club model. As explained by one respondent, "Clubs for persons with disabilities are important as it helps them share stories and get support." Though respondents credited both Action to the Community Development Institute

(ACDC) and Disability Research Capacity Development (DRD) with good work in supporting participation of persons with disabilities, respondents specifically mentioned DRD's work with the disability club model as supporting success in this area. One respondent described the benefits of the model, saying, "DRD helps support clubs, involves persons with disabilities to provide peer support for others. It is a really good model." Some respondents noted that GVN policies toward OPDs can be restrictive and the club model is more informal and not subject to these limitations.

Independent living skills training was mentioned by some respondents as a facilitator in helping to increase participation of persons with disabilities. Respondents shared mixed views on bringing persons with disabilities to events. Some respondents felt this was a facilitator while others specified that passive participation at an event misses the intent of promoting meaningful engagement. There were additional comments related to children with disabilities, "We have to make sure parents are sensitized on the benefits of participation. If the family doesn't agree, then the child will not be able to attend."

Social Services Subcomponent: Legal Aid

Overall, legal aid was considered successful as the majority of the KII respondents rated it as having moderate or high success. Through discussions, it was evident that respondents were considering "legal awareness" rather than legal aid. Respondents mentioned the support provided by two IPs (ACDC and DRD) as the main facilitators of success. Respondents explained that ACDC and DRD facilitated improvements in legal awareness within the project, sharing information about laws and rights, but did not provide direct legal aid. Additionally, some respondents also noted that USAID's interventions in this subcomponent are currently on a limited scale and the quality of service or impact from this work is not well known. Outside of the USAID interventions, the presence of legal aid centers available in all provinces is considered a potential facilitator, with one respondent mentioning that all law firms have a section for persons with disabilities.

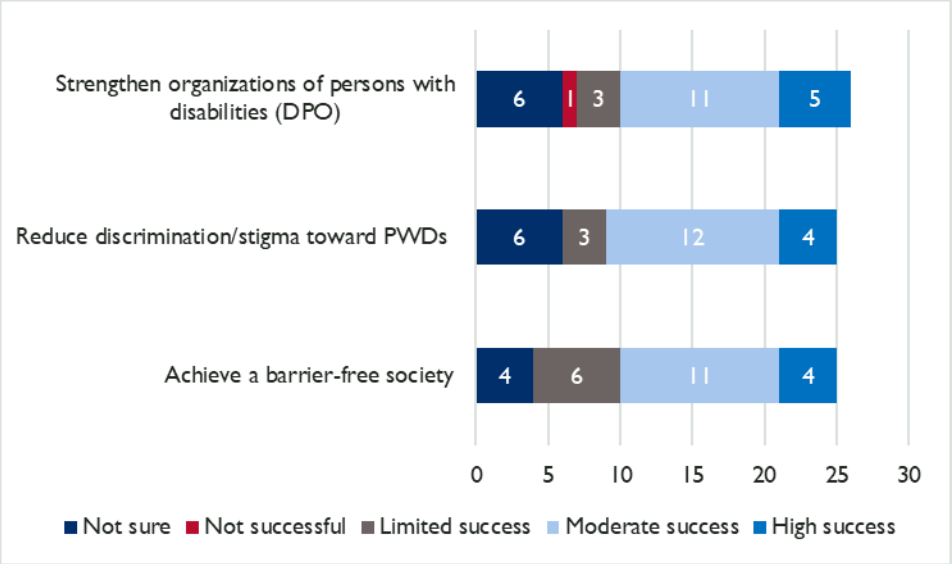
USAID'S LEVEL OF SUCCESS RELATED TO DISABILITY POLICIES

This section presents stakeholder perceptions of USAID's level of success related to disability policy interventions, then synthesizes key barriers and facilitators for these interventions as a whole followed by each of the subcategories contained within this domain. A full list of all facilitators and barriers to each subcategory discussed is provided in Annex XIV.

Perceived levels of success

USAID's interventions in disability policy were perceived to be successful overall. As displayed in Figure 9, each of the three subcomponents (reducing discrimination toward persons with disabilities, achieving a barrier-free society, and strengthening organizations of people with disabilities) showed similar perceptions of success. About half of all KII respondents rated each subcomponent as moderately or highly successful.

Figure 9: Perceived levels of success of USAID's interventions on disability policies



While the following sections describe barriers and facilitators specific to each subcomponent of the disability policy interventions, respondents also discussed a few common barriers and facilitators to USAID's success across the disability policy interventions. The most common facilitators were identified as USAID's historical investment in this area and Vietnam's existing legal framework on disability – including ratification of the UNCRPD. One respondent explained, "USAID's financial investment is a decisive factor. It creates motivation and pressure." Respondents also recognized that this is a difficult area to measure as reflected in one key informant interview, "Working with disability policy is not easy. Hard to see success and hard to count and measure." The main barriers to achieving success were the lack of government enforcement of policies and laws, perception that USAID's investment in this area is waning, low prioritization from the current GVN partner (MOD/NACCET) on promoting policy change, and lack of follow-on engagement with historical partners in this domain (NCD/VFD).

Disability Policy Subcomponent: Achieve a Barrier-Free Society

The most commonly discussed facilitators to achieving a barrier free society were the current policies and legislation in place such as the Law on Persons with Disabilities enacted in 2010 and ratification of UNCRPD in 2014 with guiding principles to different ministries/sectors to support persons with disabilities. USAID supported these processes. Though key informants praised the policies in place, implementation and enforcement were acknowledged as being weak. One respondent remarked: "USAID and partners have achieved a foundation. We worked 15 years on this and have basic laws so others can carry-on. But implementation is poor."

Many key informants offered examples of increased accessibility in either Vietnam's built environment (new buildings following universal design principles, targets of 10 accessible buses in each province) or with communication (sign language on airplane videos or television programs). Respondents noted a barrier to success is the level of difficulty and expense in making existing buildings accessible. Respondents also noted as a barrier to success that the concept of "barrier-free" is not well understood by all IPs and attention focuses on ramps as opposed to a more comprehensive set of interventions. One respondent explained, "The amount of effort in rehabilitation is much more than the social inclusion level. We are preparing the physical condition, but not so much work in environment – understanding of IPs in this area is still low. People think once there is a ramp, their job is done."

Disability Policy Subcomponent: Reduce Discrimination Toward Persons with Disabilities

The primary facilitator in reducing discrimination is awareness-raising in USAID provinces. One respondent gave an example that when they first began work in a province, persons with disabilities

sang songs that were more aligned with pity and sadness. This has changed and now the songs have messages such as "we can do it." Though respondents spoke of improvements in reducing stigma toward people with physical disabilities, they also noted there is little change toward those with intellectual disabilities, which merits attention from USAID. One respondent described these differences in perceptions of persons with disabilities across demographics, saying, "There is a lot of communication on this but mainly focus on physical disability. Discrimination against people with mental disability is still a big problem. When I use the bus, I can see how people are looking at kids with autism."

Other facilitators discussed included the GVN policy against discrimination and USAID's updated terminology as important facilitators to success in reducing discrimination. Though three respondents said anti-discrimination laws are currently in place in Vietnam, four respondents explained that businesses and schools continue to refuse to recruit persons with disabilities for jobs and refuse school entry for children with disabilities. Respondents applauded USAID's use of contemporary terminology related to disability (e.g., shifting from Disabled People's Organization (DPO) to Organization of Persons with Disabilities (OPD)) which reinforces good practices among other stakeholders.

The most discussed barrier to success in reducing discrimination toward persons with disabilities was self-stigmatization among persons with disabilities. Key informants explained that self-stigmatization occurs through a lack of self-confidence and stated that USAID should continue to balance creating societal change with building healthy self-esteem among persons with disabilities in future interventions. Related to this, charity efforts were also raised as one of the barriers to reducing discrimination – either providing charity to persons with disabilities because they have a disability or identifying persons with disabilities as objects of charity. One example is the culture of bringing gifts to persons with disabilities on holidays or during special events. One respondent elaborated, "Stigma can be created by persons with disabilities themselves – afraid to communicate or rely on others to do things for them."

Disability Policy Subcomponent: Strengthen Organizations of Persons with Disabilities

The primary facilitator to success in this subcomponent was USAID's support through ACDC and DRD, especially DRD's work with disability clubs. Respondents noted that USAID investment has helped expand OPD formation in Vietnam at the central and provincial levels, and explained that ACDC and DRD are recognized as playing key roles within the disability policy sector in Vietnam. Four respondents cited DRD's work with disability clubs as a facilitator of its own, explaining that disability clubs are highly regarded and offer space and opportunity for persons with disabilities to gather and engage.

KII respondents identified several barriers to success in strengthening OPDs. One challenge is GVN policies related to civil society organizations. One respondent explained, "In the past it was more open to set up an organization. Now it is more difficult to establish OPDs in the provinces." Another barrier is sustainability. In the past, some OPDs received government support. Now this support is reduced or no longer available. Some respondents also noted OPDs' lack of organizational capacity which may also impact sustainability. Finally, respondents expressed a lack of clarity around how USAID supports these initiatives, OPDs' mandate, and the expected output of interventions under this subcomponent.

EQ3: REHABILITATION AND SOCIAL SERVICES FOR PERSONS WITH DISABILITIES – AVAILABILITY, ACCESSIBILITY, AND QUALITY

REHABILITATION SERVICE: OVERALL KEY FINDINGS

Availability

Since 2019, there has been a noticeable increase in the number and type of rehabilitation professionals and services. That said, the number of rehabilitation professionals (especially prosthetists & orthotists (P&O), speech therapists, and occupational therapists (OT)) is still low, and rehabilitation is not readily available at the commune level. Moreover, only about 50 to 60 percent of rehabilitation staff are licensed to provide services. Finally, availability of APs was linked primarily to project activities and focused on mobility products.

Accessibility

Coverage by VSS for rehabilitation techniques has increased, but does not yet cover APs. It is difficult to access rehabilitation or AT services at the commune level and outside of USAID project areas.

Quality

Setting treatment goals and measuring functional outcomes have yet to become a standard practice. However, APs provided through USAID were seen as higher quality than those available through government or other donations.

REHABILITATION SERVICES: AVAILABILITY

Indicators on rehabilitation service availability include:

1. The percentage of health facilities that provide rehabilitation services - facilities that have one or more rehabilitation professionals.
2. Number of staff providing rehabilitation services in each discipline per 10,000 people with program support.
3. Number and type of APs available in health centers.

Routine data on rehabilitation services and the rehabilitation workforce across health facilities was not collected nor consolidated at the provincial DOH or central level, i.e., MOH. In order to determine baseline information for the indicators on availability of rehabilitation services, a health facility SRDT was developed by the ET and together with the DOH in Binh Dinh and Quang Tri provinces, it was electronically distributed to all health facilities with 100 percent return rate on responses.

The baseline information on the percentage of health facilities that provide rehabilitation services in Binh Dinh is 12.6 percent (22 of 175 facilities). In Quang Tri, 11.6 percent of health facilities provide rehabilitation services (16 of 138 facilities). Although all provincial health facilities have these services and most or nearly all facilities at the district level have them, only about four percent of facilities at the commune level provide rehabilitation services. Detailed information is provided in Table 10.

Table 10: Number of health facilities that provide rehabilitation services*

Level	Provincial	District	Commune	Private (all levels)	Total	
					Number	% [a]
Binh Dinh province						
Number of facilities	***3***	***11***	***159***	***2***	***175***	***100%***
# facilities provide PRM	3	8	4	2	17	9.7%
# facilities provide PT	3	7	3	2	15	8.6%
# facilities provide OT	1	1	0	0	2	1.1%
# facilities provide ST	1	3	0	0	4	2.3%
# facilities provide P&O	0	0	0	0	0	0.0%
# facilities provide rehab	3	9	7	2	22	12.6%
Quang Tri province						
Number of facilities	***3***	***10***	***125***	***-***	***138***	***100%***
# facilities provide PRM	3	6	4	-	13	9.4%
# facilities provide PT	3	7	2	-	12	8.7%
# facilities provide OT	0	2	0	-	2	1.4%
# facilities provide ST	0	3	0	-	3	2.2%
# facilities provide P&O	1	0	0	-	1	0.7%
# facilities provide rehab	3	10	6	-	19	13.8%

*Note: [a] Percentage of the number of facilities (#facilities) providing a rehabilitation service over total number of facilities. * Facilities having one or more LICENSED rehabilitation professionals*

The SRDT also collected data on the number of staff in each discipline providing rehabilitation services, as well as on the percentage per 10,000 individuals, both in 2019 and 2022. The SRDT data enabled disaggregation over time (comparing 2019 and 2022) and by those with a license to provide rehabilitation. Table 11 provides summary results from SRDT data.

It is important to highlight the variance between total staff and those *licensed* to provide services. Only one-third of the total OT staff in the two provinces in 2022 are licensed (8 of 23); similarly, only four of 12 STs in the two provinces have a license to practice in 2022. If USAID is investing in training, there needs to be equal attention paid to licensing in order to ensure that these services will be recognized and covered by VSS.

The results for the baseline number of (licensed) staff who provide rehabilitation services in each discipline - per 10,000 people - for each province are presented in Table 11 with the summary data for both provinces (total population is 2,248,869 people) listed for the year 2022. This shows that overall, there are 0.69 licensed staff per 10,000 people, with that number ranging from approximately zero for P&O staff to 0.41 for physical therapist (PT) staff.

Table 11: Licensed staff demographics by discipline and province for 2019 and 2022

Province & Discipline	2019				2022			
	Total	Licens-ed	% Licensed	Lisc. staff to pop. ratio	Total	Licens-ed	% Licensed	Lisc. staff to pop. ratio
Binh Dinh								
PRM staff	44	15	34 %	0.10	51	29	57%	0.18
PT staff	53	49	92 %	0.33	69	52	75%	0.33
OT staff	2	2	100 %	0.01	13	4	31%	0.03

Province & Discipline	2019				2022			
	Total	Licens-ed	% Licensed	Lisc. staff to pop. ratio	Total	Licens-ed	% Licensed	Lisc. staff to pop. ratio
ST staff	0	0	-	-	7	4	57%	0.03
P&O staff	0	0	-	-	0	0	-	-
Any of the above	99	66	67 %	0.44	140	89	64%	0.57
Quang Tri								
PRM staff	31	18	58%	0.28	42	22	52%	0.33
PT staff	57	39	68%	0.62	70	40	57%	0.59
OT staff	8	5	63%	0.08	10	4	40%	0.06
ST staff	1	0	0%	0.00	5	0	0%	0.00
P&O staff	2	1	50%	0.02	3	1	33%	0.01
Any of the above	97	63	65%	0.99	130	67	52%	0.99

To calculate this, the Binh Dinh population in 2022 is 1,573,739, and the population figure used for Quang Tri in 2022 is 675,130 *(secondary data reported by the communes)*; population in Binh Dinh and Quang Tri in 2019 are 1,487,800 and 633,400 *(GSO 2019)*.

Data on the number and type of APs available in health centers was collected through site visits to health facilities and also through the use of the SRDT. Findings revealed that few, if any, APs were available to patients as none of the health facilities reported any within SRDT or during site visits. The site visits did identify one pilot project where this work was being started.

In addition to data collected from SRDT, data was also collected from KII stakeholders. The *perception of availability* from these key informants revealed that most respondents agreed that there was an increase in the number and type of rehabilitation services and professionals thanks to project support, but services at the commune level were not yet developed. Although respondents noted there were more training courses and more people trained, there was recognition that there were still gaps in the quality and quantity of rehabilitation professionals. Respondents also reflected that there were still gaps in the types of APs available and the workforce needed for provision of APs was underdeveloped.

Limited diversity of APs and the wider availability of mobility devices were also reflected through results from analyses of QOL survey data. Figure 10 and Figure 11 include two graphs that show the availability and use of APs among adult beneficiaries and child beneficiaries. These graphs show clear dominance of mobility devices.

Figure 10: Availability and use of APs among adult beneficiaries

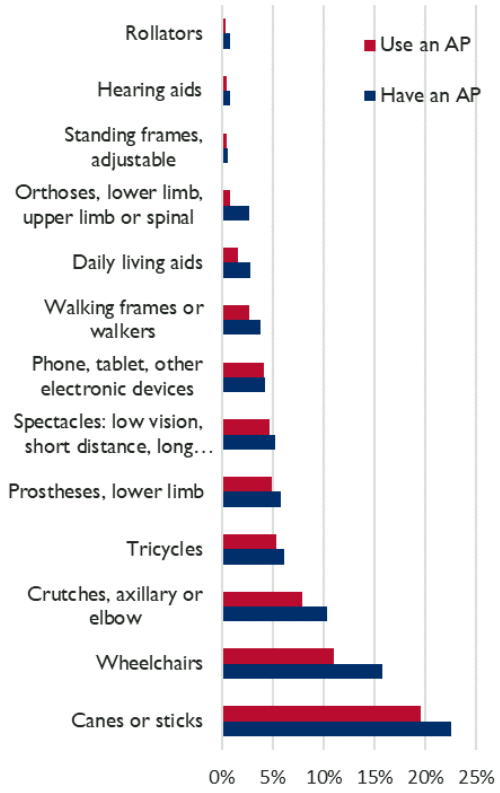
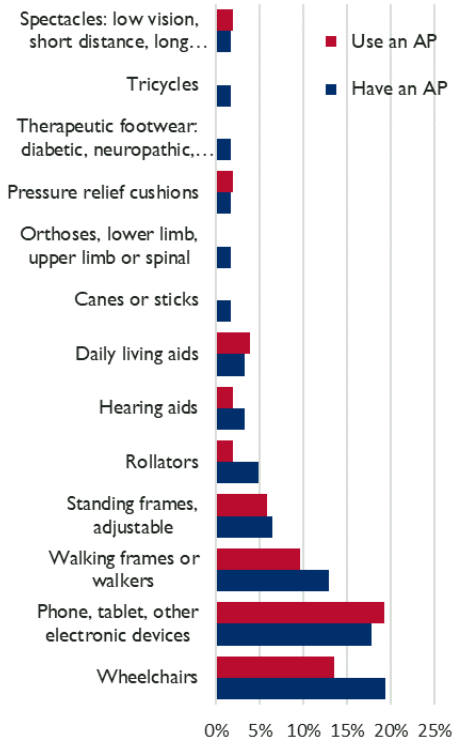


Figure 11: Availability and use of APs among child beneficiaries

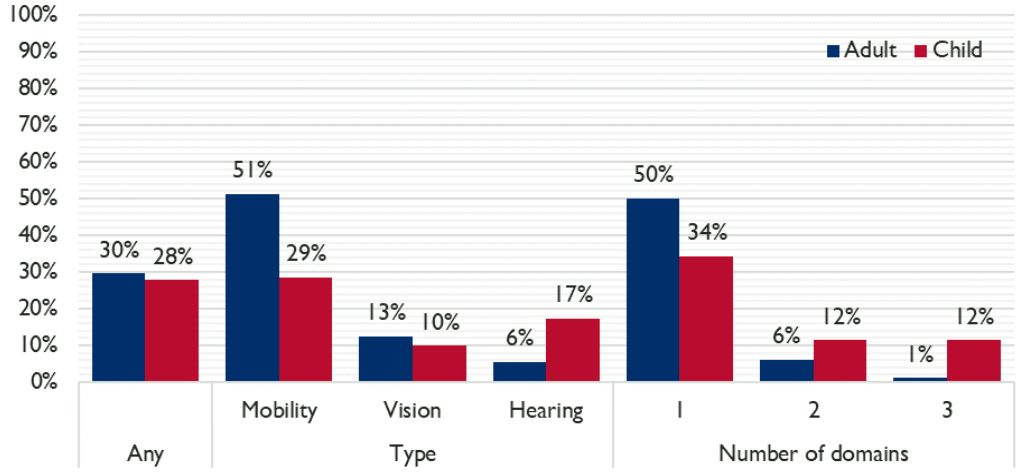


(N adult: 635; N child for having: 62; N child for using: 52)

Among individuals with mobility, vision, or hearing disabilities,[7] those who had mobility disabilities had the highest proportion of a mobility AP (51 percent of adult and 29 percent of child beneficiaries). Only 13 percent and 10 percent of adult and child beneficiaries, respectively, with vision disabilities had an AP; the rates of APs for those with hearing disabilities were six percent for adults and 17 percent for children.

The proportion of people who had APs for all types of disabilities reduced substantially depending on if the person had multiple types of disabilities. Specifically, the proportions of adult and child beneficiaries who had APs for their disabilities were 50 percent and 34 percent respectively for those with one type of disability; however, if they had two types of disabilities the proportion of people with two APs was six percent and 12 percent for adult and child beneficiaries respectively; likewise, the proportions of people who had three types of APs for their three types of disabilities was one percent and 12 percent for adults and children respectively (see Figure 12).

Figure 12: Proportion of beneficiaries who have an AP for their type of disability



REHABILITATION SERVICE – ACCESSIBILITY

Indicators on rehabilitation service accessibility include:

1. The percentage of health facilities providing rehabilitation interventions covered by insurance.
2. Stakeholder and persons with disabilities/caregiver perceptions of ease, or difficulty, accessing rehabilitation services

Baseline data on health facilities providing rehabilitation interventions covered by health insurance (VSS) was collected through SRDT. In both Binh Dinh and Quang Tri, less than 10 percent of health facilities had rehabilitation interventions covered by VSS. This was primarily due to the fact that VSS does not cover any services at the commune level. In Binh Dinh, nine of 175 health facilities (5.1 percent) provide rehabilitation covered by VSS while in Quang Tri this percentage is slightly higher (7.9 percent) as 11 facilities of 138 have this coverage – details can be found in Table 12.

[7] Measured by the WGQ at the cut-off point as recommended by the WG for dichotomization, i.e., at "a lot of difficulty."

Table 12: Health facilities providing rehabilitation interventions covered by insurance

Location				District			Commune			Private		
	#	VSS	%	#	VSS	%	#	VSS	%	#	VSS	%
Binh Dinh	3	3	100%	11	4	36%	159	0	0%	2	2	100%
Quang Tri	3	3	100%	10	8	80%	125	0	0%	0	0	0%

Further analysis, through SRDT, provides information on the number of required rehabilitation techniques that are to be provided at the provincial, district and commune levels. Table 13 provides comparison between 2019 and 2022 for the techniques provided and reimbursed against those that are required by the MOH.

Data shows that less than 50 percent of required techniques were provided at the provincial-level and only one to two percent of required techniques were provided at the commune level. In Binh Dinh, while the number of techniques provided between 2019 and 2022 increased, VSS reimbursement for techniques was unchanged. In Quang Tri, the number of techniques available at provincial level remained unchanged for techniques provided and reimbursed by VSS; this could be linked to the lack of licensing as mentioned in the previous section.

Table 13: Rehabilitation techniques required, provided, and reimbursed by VSS

Number of techniques required by MOH at each level	2019		2022	
	#techniques that can be provided (percent over #required)	#techniques that can be reimbursed by VSS (percent over #required)	#techniques that can be provided (percent over #required)	#techniques that can be reimbursed by VSS (percent over #required)
Binh Dinh				
Provincial level: 252	81 (32%)	81 (32%)	107 (42%)	81 (32%)
District level: 209	61 (29%)	36 (17%)	66 (32%)	41 (20%)
Commune level: 144	2 (1.5%)	0 (0%)	2 (1.5%)	0 (0%)
Quang Tri				
Provincial level: 252	81 (32%)	81 (32%)	107 (42%)	81 (32%)
District level: 209	61 (29%)	36 (17%)	66 (32%)	41 (20%)
Commune level: 144	2 (1.5%)	0 (0%)	2 (1.5%)	0 (0%)

Stakeholder perception on the ease or difficulty of accessing services was captured through 25 stakeholder KIIs. Only two components of rehabilitation services were selected for scoring, and results are presented in Table 14. Of the 30 respondents, two-thirds felt that accessing rehabilitation services was neither difficult nor easy. For APs, nearly one-third of respondents identified access as being difficult. This was attributed to the fact that most products are provided through the project and were not integrated into the health system nor covered by VSS.

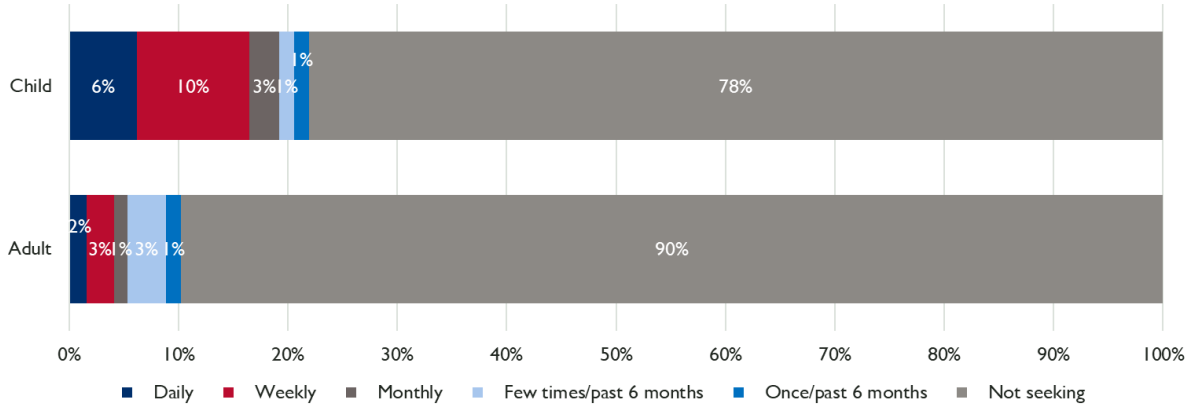
Table 14: Stakeholder perception on ease or difficulty accessing rehabilitation services

Stakeholder perception of accessibility	Not sure	Difficult	Neither difficult nor easy	Easy
Accessibility to rehabilitation services	1	2	19	1
Accessibility to assistive products	1	9	12	2

Stakeholder KIIs also revealed the perception that there are more rehabilitation techniques reimbursed by VSS, and IPs are primarily responsible for the provision of APs (as these are not yet covered by VSS).

Accessibility to rehabilitation services was also assessed, from the user perspective, through a quantitative survey (together with the QOL survey). Seeking rehabilitation services on a regular basis was not popular among the surveyed population. Apart from the services they received from the Inclusion partners, half of the beneficiaries (who were persons with disabilities) had sought or received rehabilitation services; however, many of these individuals did so a long time ago. For the most recent service, half of adult beneficiaries sought or received rehabilitation services three years ago (median: 36 months; mean: 74 months), and half of the child beneficiaries sought or received services two years ago (median: 21 months; mean: 34 months). In the last six months, consequently, the proportion of persons using rehabilitation services on a monthly basis was even smaller - less than six percent of adult beneficiaries and less than 20 percent of child beneficiaries (see Figure 13).

Figure 13: Frequency of seeking or receiving rehabilitation services in the past six months



Reasons for not accessing rehabilitation services varied by type of services and target population. Among 680 people (566 adults and 114 children) who did not seek rehabilitation services, the main reasons included: lack of information or awareness of services, unaffordability, unavailability of services, transportation, absence of family support, the belief or finding that the service can't help, or the thought that services were not needed (see detailed results in Table 15).

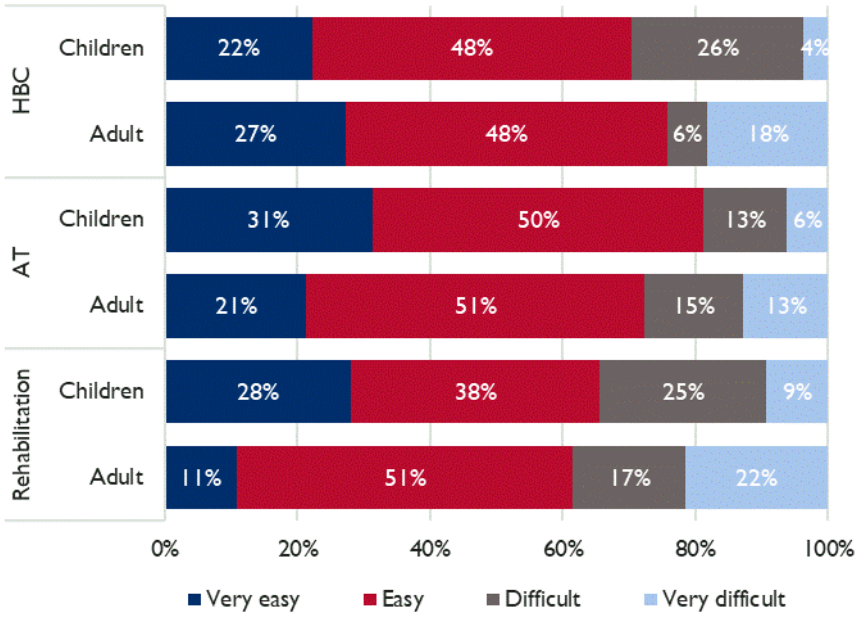
Table 15: Main reasons for not accessing rehabilitation, AT, and HBC services

	Rehabilitation		AT		HBC	
	Adult	Child	Adult	Child	Adult	Child
Don't know/lack of information	24%	27%	27%	42%	0%	32%
Too expensive/Could not afford	19%	27%	22%	12%	0%	21%
Think that I don't need the service	11%	6%	33%	27%	38%	29%
Not available in my area/ too far	14%	25%	3%	6%	0%	19%

	Rehabilitation		AT		HBC	
	Adult	Child	Adult	Child	Adult	Child
The service can't help	13%	5%	11%	7%	0%	0%
Disrespectful care	0%	0%	1%	0%	27%	0%
Don't know where to get it	5%	9%	6%	6%	18%	4%
Professional said I don't need service	2%	4%	1%	2%	16%	0%
Caregivers/family do not support it	12%	12%	1%	0%	0%	3%
No transport/Difficult to transport	14%	8%	1%	0%	3%	0%
N	**566**	**114**	**313**	**95**	**567**	**114**

Among those who could access rehabilitation, AT and HBC services, more than half of beneficiaries found it easy or very easy to access the services. However, there were still noticeable large shares of beneficiaries who found that it very difficult to access these services. For instance, more than one-fifth of those who used rehabilitation services found it very difficult and nearly one-fifth of beneficiaries found it difficult to access the services.

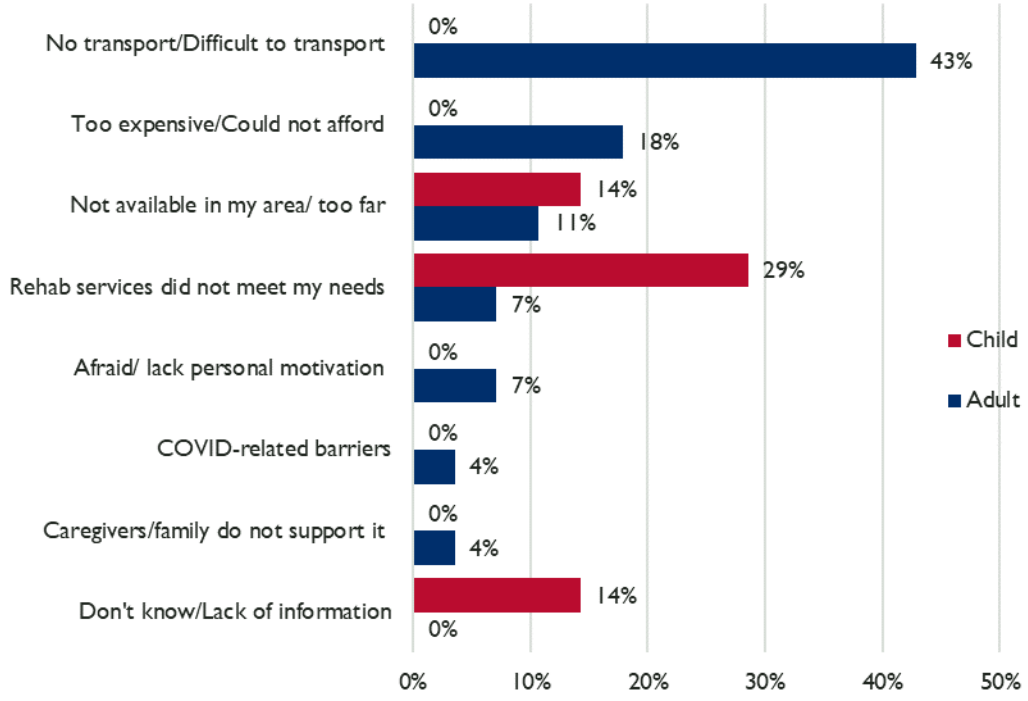
Figure 14: Ease of access to rehabilitation services among users



Note: N for adult: rehabilitation=65; AT=47; HBC=33. N for children: rehabilitation=32; AT=16; HBC=27.

Two-thirds of service users reported that they had no challenge in accessing rehabilitation, AT, and HBC services. Among those who reported at least one challenge, the main self-reported challenges included: transportation, local unavailability, and a lack of information for AT services. Unmet needs of rehabilitation services were also raised as a challenge, but this may be attributable to the small number of cases reporting this challenge. Figure 15 shows each of the self-reported challenges while accessing rehabilitation services among users.

Figure 15: Main challenges using rehabilitation services among users



Note: N for adult = 65. N for children = 32.

REHABILITATION SERVICE – QUALITY

Indicators on rehabilitation service quality include:

1. The percentage of beneficiaries reporting improvement in function.
2. The degree to which rehabilitation providers consistently write treatment goals and measure functional outcomes.
3. The degree to which rehabilitation providers utilize clinical practice guidelines
4. The degree to which new APs are provided with individual assessment and user training.
5. Persons with disabilities' satisfaction with service received.

Assessing the quality of rehabilitation services was conducted primarily through site visits to six rehabilitation units within the two provinces. Additionally, "perceptions of quality" were gathered from stakeholders and service users.

Of the 25 KII Stakeholder interviews (30 respondents) presented in Table 16, 25 identified the quality of rehabilitation services to be average to good. This was attributable mainly to more training for the workforce.

Results from the QOL survey revealed that the majority (around 90 percent) of those who could access rehabilitation services were satisfied (59 percent of adults and 50 percent of children) or very satisfied (31 percent of adults and 38 percent of children) with the services they received.

For APs, the majority of responses highlighted that the quality was "average" with a divided response on "good" and "poor." Those that selected poor were focused primarily on the limited types of products available rather than the quality of existing products. Additional information on the quality of APs has been provided below.

Table 16: Stakeholder perception on the quality of rehabilitation and assistive products

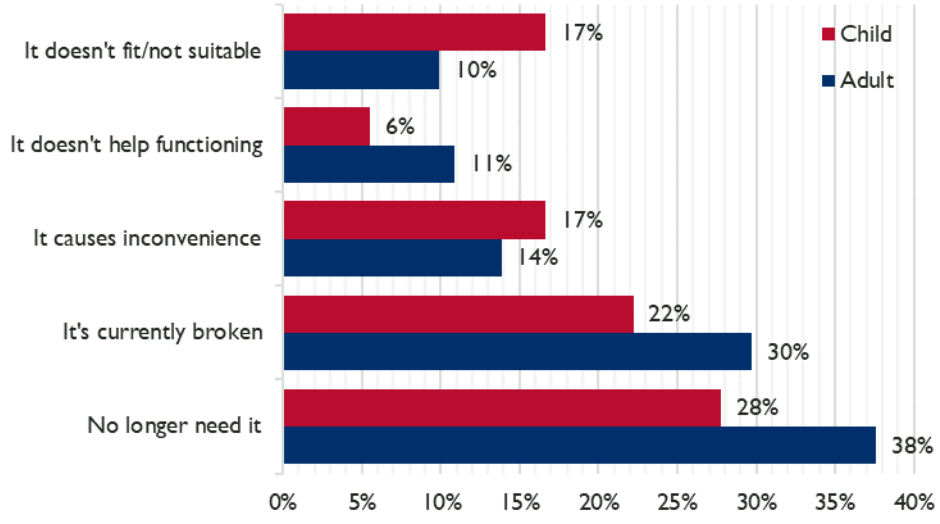
Stakeholder perception of quality	Not sure	Poor	Average	Good
Quality of rehabilitation services	3	3	16	9
Quality of assistive products	2	8	12	7

Data on rehabilitation quality, as seen through site visits to six rehabilitation units, has been presented in bulleted points mapped across the indicators established for this area. Overall, there was no standard tool used across services providers to consistently evaluate the quality of rehabilitation services.

- Percentage of beneficiaries reporting improvement in function: four out of six sites did not measure functional change.
- Degree to which providers write treatment goals: five out of six mentioned there were no written treatment goals/outcomes.
- Degree to which rehabilitation providers use clinical practice guidelines: five reported following MOH general treatment guidelines for different pathologies as there were no protocols for rehabilitation. One reported not being aware of MOH protocols.
- Degree to which APs were provided with individual assessment and training: only one rehabilitation site had a pilot for APs and provided individual assessment and training.

From the user perspective, one-third of beneficiaries (35 percent of child and 31 percent of adult beneficiaries) reported that they had an AP but did not use it. This could be influenced by the quality of the APs as well as other externalities. The main self-reported reasons for not using APs were that it was broken or that it was no longer needed. Other overwhelming reasons included: personal inconvenience, lack of fit or suitability, or that functioning was not improved (see Figure 16). Most of these reasons seem to be related to APs' provision steps and over-simplification of AP provision, a common practice in Vietnam.

Figure 16: Main reasons for not using an assistive product



Note: N for adult = 101. N for children = 18.

SOCIAL SERVICE: OVERALL KEY FINDINGS

The overarching finding for social services was that these services and their sub-components are not well defined nor understood. In addition, these services are seen as new and still evolving. This finding is reinforced by repeated responses, similar to the following, that were shared by respondents:

- Social service activities have not yet started; there isn't information on these topics.
- There is no information about what the USAID project is doing in this area.
- The meaning of the terms that are used, i.e., home based care and psychological support, are unclear.

With this backdrop, impressions shared on the overall availability, accessibility, and quality of social services are:

Availability is limited and difficult to sustain

- Social services are not available or only available in some areas.
- It's difficult to sustain; and they are not integrated into the MOLISA system.

Accessibility is limited due to limited availability and limited support resources

- Social service interventions are not covered by VSS.
- Many people don't know about these services.
- There are a limited number of IPs currently doing this work.

Quality is hard to measure

- Quality measurement tools for social services are underdeveloped.
- There is little formal measurement of quality in this area.

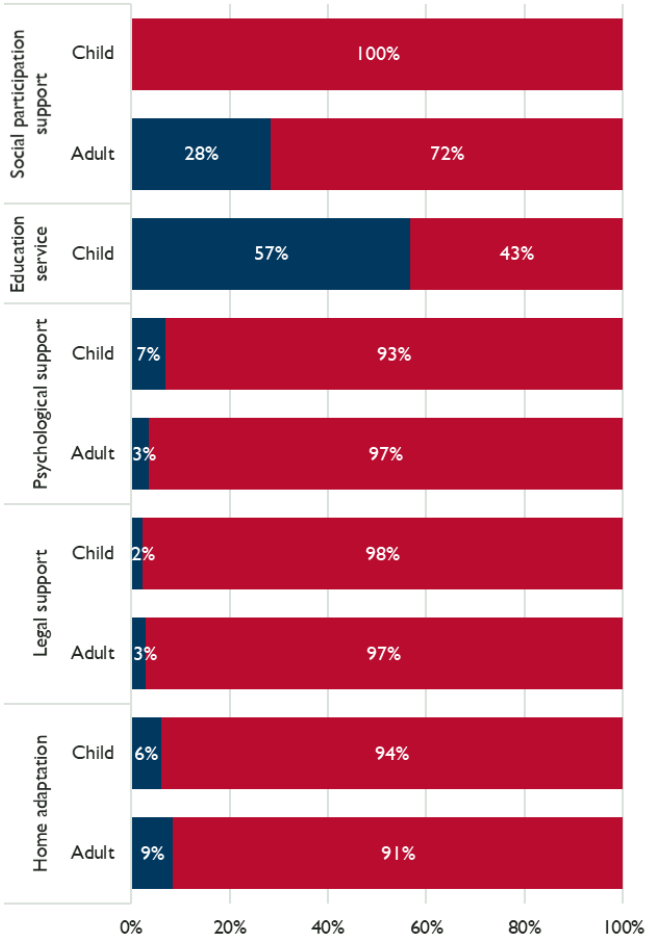
SOCIAL SERVICE: AVAILABILITY

Indicators on social service availability include:

1. Stakeholders and persons with disabilities/caregiver perceptions of adequate availability of various types of social service support.
2. Number of organizations providing home-based care services for persons with (severe) disabilities.
3. Number of people trained to provide home care for people with (severe) disabilities.

The *perceptions on availability of various types of social service support* were difficult to collect primarily due to the different interpretations of these services. That said, most respondents perceived home-based care to be available only in some locations within USAID targeted provinces and recognized that this service is still emerging. Caregivers are primarily family members or volunteers. There has been some training provided by IPs, but it is project based and not integrated into the GVN system. Psychological support was perceived to be largely unavailable as this activity has not yet started within the Inclusion project and is not part of Vietnam's culture. Although respondents acknowledged they did not have much information on what USAID is doing to support disability benefits, there was a perception that these benefits are more available as people are accessing the requisite disability determination. There was a perception that participation of persons with disabilities has increased – primarily due to disability clubs. On legal aid, most respondents identified two IPs who are doing this work but the emphasis was on legal awareness rather than legal aid. These findings are consistent with findings from the *service user perspective*, as there were large shares of the beneficiaries who did not seek or receive social services in the past six months (see Figure 17). The largest share was found for the purpose of education among child beneficiaries at 57 percent; much less than the proportion of school age children who are attending school (89 percent) (GSO, 2020: estimates from Table 20, Table 21, and Table 22). 28 percent of adult beneficiaries reported that they had sought or received social participation support. This was not reported amongst child beneficiaries. Additionally, psychological support, legal support, and home adaptation support seeking or receiving behaviors were found to be uncommon.

Figure 17: Proportion of people seeking social services in the past six months



Data on the *number of organizations providing home-based care* was retrieved from document reviews and interviews at site visits. At the time of this assessment, two of USAID's IPs (VNAH and PHAD) are directly involved in providing support to home-based care initiatives. Through site visits, one health facility (private) also provides medical home-based care service – but payment is out-of-pocket.

The third indicator seeking baseline data on the *number of people trained in home-based care* was again addressed through document review. To date, no one has been trained in Quang Tri and 745 people have been trained in Binh Dinh (with support from PHAD).

SOCIAL SERVICE: ACCESSIBILITY

Indicators on social service accessibility include:

1. Stakeholders and persons with disabilities or caregivers who report difficulty accessing social services.
2. Number of social services covered by insurance.
3. Local government budget for social services.

Perception on the accessibility of social services was collected through 25 KIIs with stakeholders (30 people) and discussions with persons with disabilities and caregivers. Two of the six content areas captured by social services were selected and are seen in Table 17. Nearly one-third of all respondents identified access to home care services as "difficult" - this was primarily due to the limited availability of these services (only through a USAID-funded project) and the fact that these services were not

covered by VSS. For psychological support, the top two responses were "difficult to access" and "don't know" - this was due to the fact that this component of the project has yet to begin.

Table 17: Stakeholder perception on the accessibility of social services

Stakeholder perception of accessibility	Not sure	Difficult	Neither difficult nor easy	Easy
Accessibility of home care services	4	9	9	1
Accessibility of psychological support	5	7	3	3

When addressing the indicator on the number of social services covered by insurance, the ET did not find any evidence of social services (specifically home-care, caregiver training, and psychological support) being covered by VSS.

Regarding the local government budget for social services, the ET found that:

- Disability benefits were provided by the GVN's budget.
- Some registered DPOs/OPDs also received some governmental support.
- There was no evidence of other social services funded by the government budget.
- VSS does not cover any element of social services.

From users' perspectives and among those who did not seek or receive social services, the perceived main reasons included: the lack of information or awareness of services, perceived absence of need, and unaffordability (see detailed results in Table 18).

Table 18: Main reasons for not accessing social services

Reasons	Home adaptation		Legal aid		Psychological support		Education	Social participation support	
	Adult	Child	Adult	Child	Adult	Child	Child	Adult	Child
Don't know/lack of information	20%	19%	84%	93%	57%	53%	5%	29%	28%
Think that I don't need the service	29%	40%	52%	0%	24%	22%	3%	20%	25%
Too expensive/Could not afford	44%	38%	1%	7%	5%	7%	6%	5%	2%
Think that I am unable	0%	0%	0%	0%	0%	0%	62%	16%	16%
Not available in my area/too far	5%	1%	11%	6%	17%	24%	10%	11%	5%
Caregivers/family do not support it	2%	1%	0%	0%	0%	0%	10%	11%	12%
The service can't help	2%	10%	0%	0%	1%	4%	0%	0%	0%
No transport/ Difficult to transport	0%	0%	2%	0%	1%	1%	3%	11%	5%
Don't know where to get it	3%	1%	8%	7%	6%	7%	0%	3%	4%

SOCIAL SERVICE: QUALITY

Indicators on social service quality include:

1. Percent with improvement in "measures of care" outcomes among persons with disabilities served by USAID-supported provinces.
2. Percent of caregivers with improved capacity (attitudes and perceived skills) to care for persons with (severe) disabilities.
3. Persons with disabilities who were satisfied with the services received.

Although not specifically represented through a sub-component indicator, the ET included a question regarding beneficiaries' perception of quality during the KII for stakeholders (25 interviews with 30 people; see Table 19). Regarding the quality of psychological support, half of all respondents said they did not know the quality due to the fact that this service is yet to start within the Inclusion project. For home-care services, respondents were divided between "not sure", "poor," and "average" - the confounding factor seemed to be the definition of home-care services and what was included in this term.

Table 19: Stakeholder perception on the quality of social services

Perception of quality	Not sure	Poor	Average	Good
Quality of home care services	7	5	9	4
Quality of psychological support	15	3	1	2

Conversely, through the QOL survey, the response from persons with disabilities was that the majority of those who could access services were satisfied/very satisfied with them.

Regarding a change in caregiver capacity (attitudes and skills), the situation was mixed. Of the four caregivers interviewed:

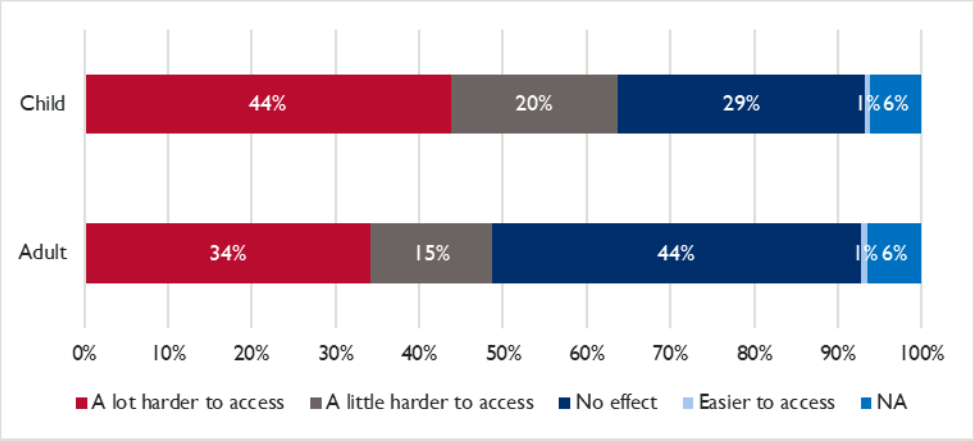
- A mother received training by a USAID-supported project recently but reported no change in capacity/attitude to care for her son with disabilities.
- A father reported he was trained almost 20 years ago on rehabilitation and it helped as he was able to train his son to sit and walk.
- The other two had not received any training.

Additionally, there seems to be no evidence regarding the measure of care outcomes for the caregivers interviewed.

IMPACT OF THE COVID-19 PANDEMIC

The COVID-19 pandemic, unsurprisingly, had a negative impact on disability service access. 44 percent of child and 34 percent of adult beneficiaries reported that the COVID-19 pandemic made it a lot harder to access disability services, an additional 20 percent and 15 percent of these two groups respectively found it a little harder to access services. The majority of remaining respondents reported no impact and a very limited proportion of beneficiaries found that the COVID-19 pandemic made it easier to access disability services.

Figure 18: Perceived impact of COVID-19 on accessing disability-related services



CONCLUSIONS

This evaluation was more than a baseline as it included information stemming from USAID's investment - since 2015 - and the start of the Inclusion Program – beginning in early 2021. This was especially true for identifying the rehabilitation workforce as many gains in the type and number of rehabilitation professionals have been made in the past five years. The assessment provides an illustrative understanding of stakeholder perceptions and some objective data on availability of services; the results may not accurately represent all USAID-supported provinces as this assessment only covered two out of eight project provinces. Hence, results should be read with caution while referring to USAID's interventions.

The QOL of persons with disabilities, who were USAID's beneficiaries, varied significantly not only by level and type of disabilities, but also by sex, age, education level, working status, participation in OPDs, ownership of health insurance, and standards of living. At this phase, these are associations and not much can be said about causality given this report's evaluation methodology; it is expected that richer understandings of QOL and its change over time can be found after an intended second round of surveying.

Evidence collected by the ET shows that the selected QOL tools (WHOQOL-BREF+DIS & SCoPeO-Kids) are valid and reliable, and that the health facility SRDT provides rich information that can be used to monitor and evaluate achievements of the GVN's objectives on rehabilitation.

The majority of key informants who represented the relevant stakeholders remarked that USAID's interventions were successful overall. Rehabilitation interventions were most frequently considered successful, especially the two subcomponents, expanding and strengthening the workforce and increased availability of rehabilitation services. Disability policy interventions were also seen as successful overall, with similar levels of success across the three subcomponents: reducing discrimination toward persons with disabilities, strengthening OPDs, and achieving a barrier-free society. Social services, on the other hand, received a less positive assessment from the key informants regarding its level of success although it should be noted that social service interventions, such as psychological support or home-based care, have only recently been implemented.

"The current USAID project is a breakthrough – previously there were small projects but now the project focuses not only on services but on supporting our system."

- Representative of a DOH -

There are various factors perceived to affect the success of these interventions; noticeable ones relate to system development and sustainability. Specific factors include the duration of intervention or investment, alignment with in-country needs, engagement of stakeholders, integration of the interventions into GVN's systems (e.g., MOH, MOLISA, and VSS), defining and understanding of services, availability of standards and protocols for service delivery, and awareness of disability inclusive development versus charity. Both direct support and system strengthening were highly rated and frequently raised as key factors contributing to the success of USAID's interventions.

"Allowing 5+ years really helped – it takes time to change a system and the long duration of investment is positive. The duration of investment and the vision of USAID are both very rare for donors."

- Respondent from an IP -

USAID's support has contributed to the improvement of the availability and quality of services for persons with disabilities, especially rehabilitation professionals and services, though noticeable gaps remain in the following areas:

1. Training for professionals to get the licenses so that they can practice legally and get reimbursed: an increase in the number of licensed professionals will lead to an improvement in accessibility to rehabilitation services for persons with disabilities;
2. Support for persons with non-mobility disabilities, especially those with mental and intellectual disabilities: this group is relatively more vulnerable;
3. Support for persons with multiple disabilities: this group is in significantly poorer positions (e.g., significantly lower access to services and poorer QOL) and they account for three quarters of the beneficiaries, compared to those with a single disability;
4. Accessibility and availability of rehab services at the commune level: there are service delivery gaps or accessibility dilemmas at the commune level where services for persons with disabilities are not readily available while seeking services at higher levels (i.e. district, provincial, and central levels) on a regular basis over a long period of time to improve their chronic conditions is challenging for persons with severe disabilities;
5. Monitoring and measuring service quality: USAID's interventions made positive contributions to the improvement of service quality but measuring the results is now a challenge as quality measurement tools are not well developed nor widely used. For effective monitoring and planning, systematic and routine data collection on rehabilitation in health systems has not yet been established. The DIS is not systematically updated and there is no evidence of quality control measures being put into practice.

"USAID increased the touch-points for interventions, and this helps, but still QOL is influenced by so much more than these project activities."

- Respondent from an IP -

RECOMMENDATIONS

OVERALL RECOMMENDATIONS

Given the positive reflection of the stakeholders on the success and contributions of USAID's disability project, it is recommended that USAID continues long-term support in both direct assistance and system strengthening for rehabilitation and social services. For comprehensive improvement in the QOL of persons with disabilities, USAID should consider expanding program opportunities to include support not only for health, but also education, employment, social services, and livelihood to cover multiple components of rehabilitation, multiple dimensions of both QOL and disability, and the complex interactions among them. Further assessments and discussions with GVN counterparts are recommended to identify priorities for investment expansion.

USAID should advocate for the development of a national M&E system to incorporate rehabilitation and social service data for promoting evidence-based decision-making of the GVN. USAID should apply and promote the use of QOL tools (WHOQOL-BREF+DIS & SCoPeO-Kids). Given its strengths and potential, QOL (including its domains) can be used to learn about the multidimensions of disabilities and their associations with rehabilitation and social services. USAID, therefore, should target not only the project IPs and its sub-grantees but also larger stakeholders who are working on rehabilitation and social inclusion (such as MOH and DOHs, MOLISA and DOLISAs, GSO, UN agencies and their implementing partners, iNGOs and local NGOs working on disability-inclusive development, as well as OPDs). It would be best if these tools could be integrated into the governmental disability data system for M&E nationwide and used on a regular basis. The DIS, if working properly, is one of the initiatives that can potentially lead to the development of the nationwide M&E system. To promote the QOL tool's application, USAID should consider piloting the tool or developing a knowledge-sharing mechanism among interested stakeholders. This may require further support for disability information system strengthening.

SPECIFIC ISSUES FOR CONSIDERATION

CONTINUATION OF LONG-TERM SUPPORT IN BOTH DIRECT ASSISTANCE AND SYSTEM STRENGTHENING

Strengthen service delivery

- Increased availability of rehabilitation and social services was frequently raised by stakeholders as a successful area of USAID's investment and should be continued.
- Direct assistance, e.g., provision of rehabilitation services and APs, should be equally provided to all adults with disabilities of any type. The current priority to persons with mobility disabilities may need to be reassessed as the population with the lowest QOL and poorer access to APs is not persons with mobility disabilities, but children with mental or intellectual disabilities.
- Priority criteria in direct assistance should include not only the level of severity of disabilities but also the number of types of disabilities, as they both have strong and independent effects on the QOL of persons with disabilities.
- Make use of the expertise of IPs to provide technical support and capacity building to families, community members, local OPDs and social clubs in providing services to persons with disabilities. Document these processes and share lessons learned to multiply service delivery models beyond the IPs as the current dependence on IPs is not sustainable.
- Clearly define and document social services, and raise their awareness for consistent understanding, implementation, and results across all relevant stakeholders.
- Continue to provide long-term support as this has been much appreciated as a facilitator that differentiates USAID's support from that of other short-term supports that are less sustainable.

- Assess mechanisms to scale-up and sustain HBC models as this is currently not provided through a system-level approach and consequently difficult to sustain once USAID funding ends.
- Explore possibilities (e.g., deliver services through outreach teams, provision of virtual or distant support for certain types of services) to sustainably increase availability of rehabilitation services at the commune level, which persons with disabilities could access more frequently over an extended period.
- Further explore possibilities to engage the private sector in service delivery in a systematic way.

Expand and strengthen rehabilitation & social service workforce

- Expanding and strengthening the rehabilitation workforce was also frequently raised by stakeholders as a successful area of USAID's investment and should be continued.
- Given the severe unavailability of the rehabilitation workforce and positive feedback on USAID's support in this area, USAID should continue support for the development and strengthening of training courses to increase the number and type of rehabilitation professionals.
- USAID should consider the larger picture with not only trainings, but also the development of a long-term strategy, formal workforce planning, post-training coaching and mentoring, effective use and career development of trained staff in health facilities. Selection of inappropriate participants for trainings as seen before should be avoided to improve the effectiveness of the investment.
- Advocate and prioritize trainings with formal licenses for practice and reimbursement from VSS.
- Evaluate impacts and sustainability of caregiver training as this activity is currently both a facilitator and barrier, and it is not provided systematically nor routinely. The evaluation should assess the engagement of social workers and other non-family members as alternative caregivers who may assist persons with disabilities who live alone or give family caregivers a break from their routine. The evaluation should also find a system for integration of caregiver training as it is unlikely to sustain on its own.

Strengthen (health & social) information system

- Integration of rehabilitation data into HIS was frequently raised by the stakeholders as "not successful" or having limited success, and this area should be strengthened.
- Support to strengthen and utilize the existing DIS, as this has great potential as a facilitator, but it is underdeveloped and challenging to use. This should include mandatory routine data collection on rehabilitation and social services required by the MOH and MOLISA.

Improve access to APs

- Continue to tailor individuals in AP provision, and follow all steps of AP provision, including follow-up after the provision.
- Explore possibilities of and invest in system strengthening for AP provision. Explore a mechanism to provide APs through government or local stakeholders as AP provision by IPs is not sustainable.
- Advocate for and support activities that aim to cover APs under health or social insurance.
- Support development of a priority list of APs for Vietnam following the WHO's APL.
- Reassess AP priority; consider changing current priority from mobility products to APs for other types of disabilities, especially APs for children with mental and intellectual disabilities.

Strengthen rehabilitation financing

- Continue to support IPs to increase the number of techniques covered by VSS.
- Prioritize trainings of licensed professionals to help health workers to practice in the areas that they were trained and ensure reimbursement by VSS for their services.

- Consider supporting cost-benefit analyses of rehabilitation and social participation of persons with disabilities, and use that as evidence to advocate for greater budget from MOH/DOHs and MOLISA/DOLISAs respectively for rehabilitation and social services for persons with disabilities.

Strengthen governance of rehabilitation & social services

- Governance for rehabilitation was frequently raised by the stakeholders as "not successful" or of limited success, and this area should be strengthened.
- Develop formal linkages and joint action plans with MOH and MOLISA to jointly address challenges with licensure, engagement of social workers, rehabilitation data integrated within the disability information system and health system in general, service delivery at commune level, and addressing the limited availability of APs at health facilities.
- Support the Government in enforcing disability policies and laws.
- Encourage (or even require) IPs and sub-grantees to document service delivery procedures and good practices routinely for all of the services, and share them with all other relevant stakeholders on a regular basis.
- Support MOH and MOLISA to develop service delivery protocols and guidelines (for all of the current services supported by the USAID). Documents on service delivery and good practices of IPs could form good reference for development of these protocols and guidelines; they also help to provide consistent understanding of the services and their components for delivery and roll-out with uniformity.
- Support family and promote community involvement, especially of engagement of social workers, in providing social services as families have been found as a facilitator while community engagement is still lacking.
- Assess the merge of rehabilitation with traditional medicine as it seems reasonable in the current context but it may result in negative effects on development of rehabilitation in the long-run (e.g., overlap and lack of differentiation between the two).
- Support development and application of quality measurement tools for rehabilitation and social services for quality monitoring and control.

CONSIDERATION TO EXPAND PROGRAM OPPORTUNITIES TO COVER MULTIPLE COMPONENTS OF REHABILITATION AND MULTIPLE DIMENSIONS OF QOL

- Promote and support persons with disabilities to participate in social groups, e.g., associations of persons with disabilities, OPDs, and social clubs.
- Criteria for consideration in prioritizing disability assistance should include not only severity of disability, but also sex (i.e., females), (poor) education attainment, (not) working status, the poor (for children) and the near-poor (for adults).
- Consider expanding psychological support to family members of persons with disabilities.
- Expand and strengthen support for independent living (which includes but is not limited to awareness raising, skill training, provision of independent living aids) as this was identified as a facilitator for participation of persons with disabilities and a fundamental part of rehabilitation to help improve function. This should be accompanied by the encouragement of meaningful engagement and active participation (not passive participation as frequently found) of not only adults, but also children, with disabilities in social events.
- Create a change in societal opinion on stigma against persons with disabilities and simultaneously build healthy self-esteem to reduce self-stigmatization for greater participation of persons with disabilities. This should be implemented along with a reduction of charity efforts as they are barriers to reducing discrimination against persons with disabilities.

APPLY THE TOOLS TO STRENGTHEN M&E AND EVIDENCE-BASED POLICY DEVELOPMENT

- Together with IPs, sub-grantees and local stakeholders, USAID should utilize WHOQOL-BREF+DIS and SCoPeO-Kid toolkits.

- Together with the MOH and DOHs, USAID should utilize SRDT tools in all provinces.
- Promote IPs and sub-grantees to use WGQs to measure disabilities given their simplicity and provision of additional information that are useful to learn about the intervention's progress and achievements.

ANNEXES

ANNEX I: DISABILITY PROJECT ACTIVITIES WITH ANTICIPATED BENEFICIARIES BETWEEN 2015 AND 2023

Activity, [implementer]	Targeted provinces (or sublocations) during evaluation period	Results Frame-work	Description / Interventions	Beneficiaries and other entities targeted
Disabilities Integration Services and Therapies Network for Capacity and Treatment (DISTINCT) *2015-December 2022* [VietHealth (VH)]	Tay Ninh Dong Nai Binh Phuoc	Sub-IR 2.3.1 Sub-IR 2.3.2	Rehabilitation services, capacity building; Implement ECDDI model among children 0-6 years old	**Children aged 0 to 6 with disabilities**; **Parents and caregivers of children with disabilities**; Community workers; Doctors, rehabilitation technicians, and health workers; Kindergarten teachers, special educators, and practitioners
Hold My Hand *2018- August 2021* [Institute of Population, Health and Development (PHAD)]	Quang Nam Binh Dinh	Sub-IR 2.3.1 Sub-IR 2.3.2	Home-based care for persons with severe disabilities, improve capacity of interdisciplinary rehabilitation service units.	**Persons with severe disabilities** receiving home-based care services. Within Binh Dinh Province, this includes indirect support through capacitating a home-based care model, and 10 hospitals and 3 special and educational centers providing interdisciplinary rehabilitation services.
Disability Rights Enforcement, Coordination, and Therapies (DIRECT) *2015-October 2023* [Vietnam Assistance for the Handicapped (VNAH)]	Tay Ninh Dong Nai Binh Phuoc	Sub-IR 2.3.1 Sub-IR 2.3.3	Strengthen enforcement of disability policies, improve occupational therapy services and training.	**Persons with disabilities in need of rehabilitation; service providers**
Raising Voices, Creating Opportunities (RVCO) *2018-August 2021* [Action for the Community Development	Thua Thien Hue Quang Nam Quang Tri	Sub-IR 2.3.3	Disability policy development; Enhance the capacity of policy implementing agencies; Advocacy for rights and policymaking participation of persons with	**Persons with disabilities** and disability leaders; service providers; provincial departments of construction, transportation, and health; and OPDs, self-help groups, and other disability advocacy groups. For remainder of current contract, all activities to enhance skills of providers are complete, and remaining months will focus on persons with disabilities as direct beneficiaries.

Activity, [implementer]	Targeted provinces (or sublocations) during evaluation period	Results Frame-work	Description / Interventions	Beneficiaries and other entities targeted
Institute (ACDC)]			disabilities at district, provincial, and central levels	
Advancing Medical Care and Rehabilitation Education (AMCRE) *2015-September 2023* [Humanity & Inclusion (HI)]	Quang Tri, Thua Thien Hue, Ha Noi	Sub-IR 2.3.1	Guidelines for medical and functional rehabilitation for persons with brain injuries country-wide; Comprehensive training to rehabilitation and medical staff; Strengthen university-level education programs for occupational and physical therapists in line with international standards	**Persons with physical impairments** due to brain lesions; Health rehabilitation service providers at both institutional and community levels as well as teachers and trainers in Universities, schools and hospitals; OPD officers
Moving Without Limits (MWL) *2015-September 2022* [International Center (IC)]	Thua Thien Hue Quang Nam Binh Dinh	Sub-IR 2.3.1 Sub-IR 2.3.3	Provide assistive devices; Capacity improvement for health practitioners; Policy and advocacy for assistive device services	**Persons with disabilities in need of assistive devices**; rehabilitation doctors, physical therapists, commune health station workers, social protection center workers.
Access for All *2017-July 2021* [Disability Research and Capacity Development (DRD)]	Tay Ninh Binh Dinh Dong Nai	Sub-IR 2.3.3	Increased awareness of disability rights among persons with disabilities and the wider public. Establish and strengthen self-help organizations/clubs at commune/district levels. Increased capacity (of people with disabilities and service providers) to promote accessibility right of people with disabilities. Improved capacity	**Persons with disabilities**; social service providers. While Access for All will be ending soon after baseline, the evaluation team will consider capturing this activity's beneficiaries, as they may later be linked to services through the Inclusion activities.

Activity, [implementer]	Targeted provinces (or sublocations) during evaluation period	Results Frame-work	Description / Interventions	Beneficiaries and other entities targeted
			of DRD staff and partners.	
Inclusion 1 *2020-December 2022* [Center for Creative Initiatives in Health and Population (CCIHP)]	Thua Thien Hue, Quang Nam, Quang Tri	Sub-IR 2.3.1 Sub-IR 2.3.2 Sub-IR 2.3.3	Rehabilitation service system strengthening; direct service to persons with disabilities based on needs assessment; strengthening local capacity for home-based care, peer support network, comprehensive care models; support coordination of rehabilitation and social services; improve data coordination; analytical studies; anti-discrimination and advocacy activities	**Persons with disabilities**; rehabilitation and social service providers
Inclusion 2 *2020-December 2022* [Center for Community Health Research (CCRD)]	Binh Dinh Kon Tum	Sub-IR 2.3.1 Sub-IR 2.3.2 Sub-IR 2.3.3	TBD following needs assessment. Kon Tum interventions will be more comprehensive while those in Binh Dinh may be more targeted to fill gaps. Generally, same as Inclusion 1.	**Persons with disabilities**; rehabilitation and social service providers
Inclusion 3 *2020-December 2022* [Center for Social Initiatives Promotion (CSIP)]	Tay Ninh Dong Nai Binh Phuoc	Sub-IR 2.3.1 Sub-IR 2.3.2 Sub-IR 2.3.3	Same as Inclusion 1.	**Persons with disabilities**; rehabilitation and social service providers

ANNEX II: FULL LISTING OF PERSONS INTERVIEWED

The full listing of persons interviewed was submitted separately in line with data de-identification policies. Please contact Mai Pham, mai.pham@socialimpact.com, to request the data.

ANNEX III: IP AND SERVICE PROVIDERS' BENEFICIARY ENROLLMENT DATA CAPTURE TOOL

List of the beneficiaries

NOTE: Use one SHEET for each and every sub-contractor. Change Sub1 in the name sheet to the abbreviated name of the sub-contractor. Write "NONE" for the sub-contractor if the IP provides services directly.

USAID IP name:	
Sub-contractor:	

#	Full beneficiary name	Sex	Year of birth (type 1900 if don't know)	Place of residence				Type of disability	Level of disability	Need help to respond?	Services received or will be receiving							Approximate date of first service (month/year)	Approximate duration of service (# of months)	Contact		Caregiver/Family		Consent to share information
				Province	District	Commune	Rural/ Urban				Rehab	Assistive products	Home-based care	Legal support	Advocacy training	Psychological support	Other (specify)			Phone	Address	Name	Phone	
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
10																								

ANNEX IV: SELECTION OF QOL MEASUREMENT TOOLS

The Health and QOL survey is designed to collect quantitative information to answer the first and the third evaluation questions. Since the QOL is a concept with broad connotations and many different measures, the ET has developed a literature review and selected the most suitable and feasible tool for measuring the QOL of persons with disabilities and under the scope of this evaluation.

1. **WHOQOL-BREF + DIS tool for measuring QOL for adults:** To measure QOL among **adults**, the ET sought to identify a standardized, validated tool that was appropriate for use in a population with disabilities in Vietnam and sensitive to the aspects of QOL that USAID's interventions are likely to change. While USAID had initially targeted use of the World Health Organization (WHO) Quality of Life (WHOQOL) tool, the ET investigated alternatives including the WHO Disability Assessment Schedule (WHODAS 2.0) and the Centers for Disease Control Health Related QOL tool (CDC HRQOL) and compared them all to select the best tool for this context through engagement in consultations with USAID and IPs regarding tools. Ultimately, the final selected tool that USAID felt best reflected its approach and goals is the WHO Quality of Life 26-item short-form instrument (WHOQOL-BREF) with an additional 13-item Disabilities Module (together we reference this as **WHOQOL-BREF+DIS**). This tool has been validated in various country contexts and measures subjective perceptions of one's QOL. Pilot validation results and scoring methodology are detailed in a WHO manual that the ET has followed in designing this evaluation.(WHO 2010) Based on validation studies that examined how results converged around distinct domains, results of the BREF tool are reported as four separate domain scores: Physical Health, Psychological Health, Social Health, and Environmental Health. All domains of this toolkit have been compared with existing USAID interventions and the comparison shows that it is a suitable toolkit to be able to evaluate USAID-supported interventions. In Vietnam, WHOQOL-BREF has been successfully tested and standardized by WHO, but the disability domain has not been tested and validated. This tool measures respondents' subjective perceptions of QOL. The ET used and followed WHO's guidelines when using this toolkit.
2. **ScoPeO-Kids tools to measure QOL for children**: The WHOQOL-BREF+DIS tool was developed for adults, so the ET researched child-focused QOL tools that would be suitable to capture the children targeted by the DISTINCT, MWL, AMCRE, and DIRECT activities, and likely at least some INCLUSION sub-activities. We first looked for the existence of a validated WHOQOL module that had been adapted for children that might permit child and adult data to be combined, as this would allow for an efficient sample size. We identified one adaptation in Thailand where researchers had modified and validated the WHOQOL tool for use among children aged 5-8 (Jirojanakul and Skevington 2000). However, the adapted tool resulted in additional domains, and overall combined analysis with adult data did not appear to be valid. Ultimately, while children's dimensions of QOL may be similar to those of adults, specific aspects of their lives within these dimensions as well as their relative weight and relationships may differ, making adapting adult instruments to children problematic (Ravens-Sieberer et al. 2014). The ET reviewed a number of available tools with a preference that it i) be validated in a population with disabilities, ideally in Vietnam or other low- and middle-income country contexts, ii) be sensitive to measurement of changes in QOL after a treatment intervention, iii) have modules for self-reporting[8] from children of various ages as well as proxy reporting in cases where a child's disability prevents their direct responses, iv) reflect similar domains as those in WHOQOL-BREF+DIS to allow the ET to discuss adult and child findings in a similar way, and v) be available for use and adaptation, if necessary, without tedious approval process. Based on this assessment, the ET proposes to use the Pediatric Quality of Life Inventory (PedsQL)TM **Generic Core Scales** tool, for assessment of QOL in child

[8] The above footnote reference summarized evidence to conclude that QOL measurements should ideally be self-reported by children age 8 and above using age-appropriate tools, given documented poor correlation of parent and child reporting.

beneficiaries aged 2-17. The PedsQL tool is a child self-report tool (with parent proxy report modules available) with questions addressing physical, emotional, social, and school-related well-being. A parent proxy module is also available for children aged two to four. It has already been translated to Vietnamese and validated among school children in Vietnam and in a population with disabilities elsewhere (Trang, Ha, and Ha 2019) (Thanh Ha, Thi Hanh Trang, and Thi Thu Ha 2018) (Viecili and Weiss 2015). While Sco-PeO-Kids, KINDL, and KIDSCREEN tools also had merits, PedsQL appears to be the best solution for this evaluation due to (i) the strongest relevance of the questionnaire content to target population and expected changes due to interventions, (ii) scoring categories similar to WHOQOL tool (results reported as both a single total score and four domain scores), (iii) broad age range captured, and (iv) the simplicity of use without facing intensive translation, validation, and permission roadblocks inherent in other tools. After careful consideration and consultation with USAID, the ET decided to use ScoPeO-Kids toolkit. The ScoPeO-Kids was designed for children to answer themself. This toolkit includes questions related to the five domains: physical well-being, emotional well-being, autonomy and self-realization, safety, social well-being. Like WHOQOL-BREF, ScoPeO-Kids is a composite indicator that reflects the awareness or perception of QOL from the perspective of children with disabilities. ScoPeO-Kids has been tested and validated in children with and without disabilities in three age groups (5-7, 8-12 and 13-18 years) in Thailand and Bangladesh. However, this toolkit has not been tested and validated in Vietnam. The ET will test and evaluate the reliability of this toolkit with children with disabilities who are direct beneficiaries of USAID-supported interventions before using it for the official survey in Binh Dinh. The ET has received warmly supported by HI – the developer of the ScoPeO-Kids toolkit – and followed HI's instructions during its use.

ANNEX V: VALIDATING THE QUALITY OF LIFE MEASUREMENT TOOLS

KEY FINDINGS

- Consistent with the analysis of the pilot data, validation analysis of the baseline data shows the evaluated tools used for adults and children with disabilities to be reliable and valid measures of QOL.
- The ET finds that each tool's domain scores do not measure different aspects of quality of life. Accordingly, the ET recommends the use of the evaluated tools as measures of QOL, but recommends caution in drawing conclusions based on the individual domain scores.

OVERVIEW OF VALIDATION APPROACH

To validate the QOL tools, we conducted analysis in three main areas: score distribution, reliability, and validity. We looked at each of these aspects separately for the adult and child tools by overall and domain-level score and by proxy response status. Below we present the main findings for each of these analyses.

DISTRIBUTION OF RESPONSES

A good tool effectively differentiates between those with varying degrees of QOL - since we are using the tool to measure QOL over time, it should allow for changes be they positive or negative. This has been assessed by looking at the distribution of the QOL scores - looking for variation in scores and minimal floor or ceiling effects (those scoring the lowest or highest possible score). In Figure 19 and Figure 20, we see that the overall and domain level scores for both the adult and child tools show a reasonable degree of variation (i.e. not all respondents are clustered at a particular score) and, with the exception of the safety domain in the child tool, they show minimal floor or ceiling effects.

Figure 19: Domain Score Distribution for Adult Population

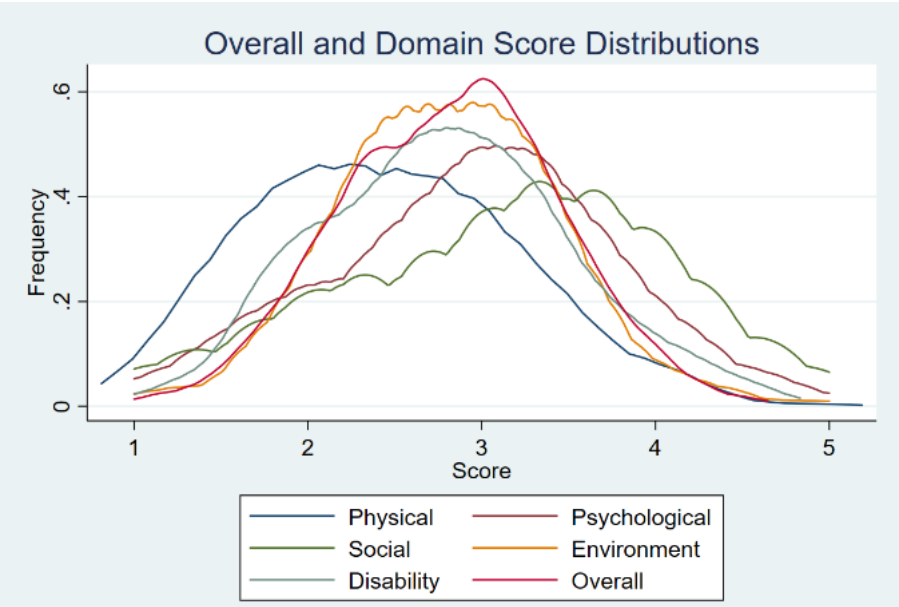
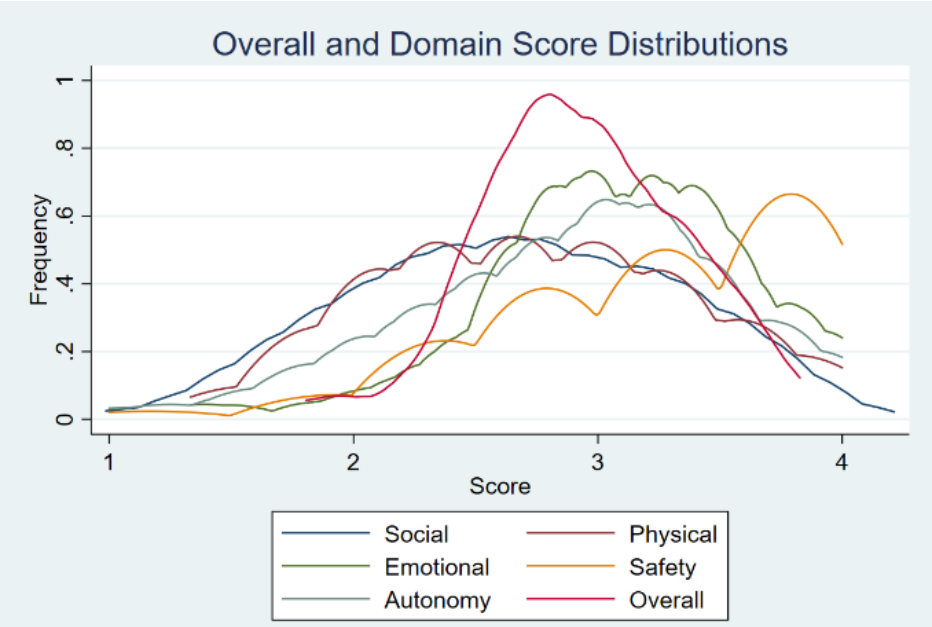


Figure 20: Domain Score Distribution for Child Population



RELIABILITY

Reliability, or consistency, tests whether the items in the module (overall and by domain) are correlated and therefore whether they measure the same concept. Two primary tests were used to assess reliability. First, Cronbach's alpha measures the overall consistency of the tool (or domain) and generally a score of 0.70 or above is considered sufficient. The second test, item-rest correlations, looks at the correlation between a given question and all the rest of the questions in the tool (or domain). If a tool/domain is measuring the same concept, then all questions within that tool should have positive as well as moderate to high correlation. Generally, item-rest correlations above 0.3 are considered sufficient. Table 20 shows the item rest correlations along with Cronbach's alpha for the overall adult and child tools. The table presents the Cronbach's alpha for the adult and child QOL modules overall and by domain, as well as the item-rest correlation values for each item within the full module. The values are color coded from low reliability in red to moderate reliability in yellow to high reliability in green.

Table 20: Rest Correlations and Cornbach's Alpha

Adult Overall : 0.85	Physical: 0.71	0.14	Physical Pain
		0.22	Need Treatment
		0.52	Energy
		0.43	Mobility
		0.41	Sleep
		0.55	Perform Daily Tasks
		0.62	Work
	Psychological: 0.67	0.37	Enjoy Life
		0.39	Meaningful
		0.40	Concentrate
		0.53	Bodily Appearance
		0.64	Satisfied with Self
		0.31	Negative Feelings
	Social: 0.59	0.45	Relationships
		0.43	Sex
		0.43	Support from Friends
	Environment: 0.62	0.41	Safety
		0.34	Healthy Environment
		0.38	Money
		0.31	Info Availability
		0.33	Leisure
		0.37	Living Conditions
		0.33	Access Health
		0.36	Transport
	Physical: 0.46	0.37	Health
		0.30	Enough Food

Child Overall: 0.75		0.47	Activities
	Emotional: 0.33	0.44	Happy
		0.48	Loved
		0.43	Reach Goals
		-0.09	Worried
		0.21	Sad
	Safety: N/A	0.08	Afraid To Go Out
		0.04	Fighting at Home
	Autonomy: 0.50	0.50	Learn New Things
		0.24	Time to Do What Like
		0.43	Parents Proud of You
		0.26	Parents Listen
	Social: 0.56	0.51	Friends
		0.27	Family Eats Together
		0.31	Talk about Concerns
		0.50	Participate in Community
		0.37	Other Kids Are Kind

The color in the table ranges from red (low reliability with Cronbach's alpha less than 0.4 or item-rest correlation less than 0) to yellow (moderate reliability with Cronbach's alpha equal to 0.6 or item-rest correlation of 0.3) to green (high reliability with Cronbach's alpha greater than 0.7 or item-rest correlation greater than 0.7).

The ET finds that both the adult and child QOL modules overall show high levels of reliability, including for both direct and proxy respondents. The domains, however, show lower levels of reliability, particularly in the child module, with only one domain from either module showing sufficient reliability. This indicates that while the questions as a whole seem to measure the same concept (QOL), the questions within each domain do not seem to measure sub-components of QOL distinct from other domains. If each domain measured a separate aspect of QOL, then we would expect to see high levels of reliability within each domain, which is not observed in the data.[9] Finally, at the question level, we find moderate to good levels of reliability on all but two questions for the adult tool. We find more

[9] We also conducted both exploratory and confirmatory factor analysis to test the domain structure of the tools and do not find strong evidence supporting the four domains in the adult tool and five in the child tool.

questions in the child module with lower levels of reliability; however, given the overall high reliability of both tools and because removing these items does not substantially improve overall reliability, we recommend keeping all indicators in the tools to improve comparisons across similar studies.

VALIDITY

Having established that both tools are consistently measuring the same concept, the ET then tested whether the concept being measured is QOL. The primary approach for testing validity was to look at the correlation between overall (and domain-level) scores with other variables believed to be indicative of QOL. For the adult tool, this included the two global QOL questions (related to overall QOL and satisfaction with health) and questions related to overall health such as the effect of disability on daily life (high effects on daily life are expected to represent lower QOL), and dependence on others (again, high dependence is expected to represent lower QOL). For the child tool, the ET looked at the correlation between self-reported overall happiness, health, and dependency on others. Table 21 and Table 22 show the results of bivariate regression analysis for the adult and child tools. Cells highlighted in blue demonstrate a statistically significant relationship ($p<0.1$) in the expected direction, while those highlighted in grey show null results. In the majority of cases, the results are significant and in the direction expected; this is the case for all tests on the overall tools. There were only two cases in which domains of the child module were not found to be significant. This provided evidence that the tool, as a whole, measures QOL.

Table 21: Correlation with other measurements of QOL for adults

	QOL			Satisfied			Health	Effect of disability	Dependency
	All	Direct	Proxy	All	Direct	Proxy			
Total Score	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Negative	Negative
Physical	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Negative	Negative
Psych	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Negative	Negative
Social	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Negative	Negative
Environment	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Negative	Negative
Disability	Positive	Positive	Positive	Positive	Positive	Positive	Positive	Negative	Negative

Table 22: Correlation with other measurements of QOL for children

	Happiness			Health	Dependency
	All	Direct	Proxy		
Total Score	Positive	Positive	Positive	Positive	Negative
Physical	Positive	Positive	Positive	Positive	Negative
Emotional	Positive	Positive	Positive	Positive	Negative
Safety	Null	Null	Null	Positive	Null
Autonomy	Positive	Positive	Null	Positive	Negative
Social	Positive	Positive	Positive	Positive	Negative

ANNEX VI: TARGET RESPONDENT SELECTION CRITERIA

Inclusion criteria:

- An adult 18+ or child aged 5 to 17.
- Living & receiving services in targeted provinces.
- Pre-selected or newly enrolled to receive new services as a direct beneficiary.
- Having not yet received the new intervention OR having only begun a treatment intervention no more than 30 days prior to baseline.
- Receiving a treatment that will continue after the time of the baseline interview.
- Providing informed consent/assent to complete a survey either by themselves or through a proxy caregiver.
- Consent AND presence of a parent or guardian at all times during the interview.

Exclusion criteria:

- Currently a beneficiary of direct services from another donor program .
- Planning to move out of the province in the next 6 months.
- The intervention is given as a pilot.
- Ethical concerns identified by IPs and Sub-grantees.
- Intervention is unlikely to happen before the first week of June.

ANNEX VII: DATA COLLECTION TOOLS

ANNEX 7.1: ADULT QUESTIONNAIRE

HEALTH & QUALITY OF LIFE SURVEY

BASELINE ADULT MODULE

Text's color codes: *Red: Notes for coders (or data entry programmers)*; *Blue: Notes for interviewers.*

Interviewer:

- Request to talk to [*beneficiary name: A2*].
- If the beneficiary needs help from another person to answer, invite that person to join the interview.
- Try to interview the beneficiary directly as much as you can; only interview another adult family member (must be 18 years old or older) on her/his behalf if the beneficiary cannot respond at all or you are guided to do so.

B	INTRODUCTION and CONSENT			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
B1	(*Automatic*) Start date & time stamp	*(automatically recorded)*		
B2	Does [*beneficiary name: A2*] need help from anyone to answer some or all questions?	No help needed Yes, need help to answer some questions Yes, depend entirely on another person to respond	0 1 2	0 -> B5.a
B3	What prevents [*beneficiary name: A2*] from being able to respond to questions?	The beneficiary's ability to communicate is limited The beneficiary does not communicate with same language as interpreter (including sign language) or difficult to understand (e.g. local accent) The beneficiary is cognitively unable to understand the questions Just don't feel comfortable Other (*specify*) _____ Prefer not to answer	1 2 3 4 -77 [ ] -88	
B4	What is the name of the person who will help the beneficiary?		[ ]	-> B5.b

B5. INFORMED CONSENT

B5.a Adult Self-Report

Hello. My name is _____, and I am here on behalf of DEPOCEN, a company called Social Impact, and USAID. I understand you are receiving some help for your health condition from [*UIP: A12*], with support from USAID. We are collecting data to understand quality of life for people who receive this support. What we learn will help these service providers and USAID improve their work in the future so they can provide better support.

I'd like to invite you to participate in a survey. I'll ask you some questions about your condition and your satisfaction with your life and the services you receive. This will take about 30 minutes to 1.5 hours of your time, with short breaks scheduled throughout. We randomly selected and will be visiting more than four hundred people who received or will be receiving the support from the USAID to do this.

Your participation in this study is completely voluntary. You can refuse to participate, even without giving a reason. You can also choose to just not answer any question that you don't like or don't feel comfortable to respond.

If you choose to participate in the survey, we will give you a 100,000 VND phone card. You will receive the phone card even if you skip some questions or choose to stop the survey part-way through. Your participation may also help us to improve services for you and other people in the future. Your responses will not change our current or committed support to you. If you become unavailable or start to feel tired at any time during the interview, please let me know; we can take another break or make a new schedule to complete the interview at your convenience.

Because of the COVID-19 pandemic we are working hard to reduce any risk of spreading the disease. Our full team is being tested at least weekly out of an abundance of caution, and I can confirm my last two tests have been negative. Our team is operating in full compliance with the COVID-19 regulations of the government of Vietnam. I will be wearing a face mask the entire time we are speaking and will sanitize my hands as needed. We are required to complete the survey outside to reduce the risk of COVID-19; however, we can make an exception if that would not work for you. If we need to complete the survey inside, we require that both of us wear a mask and we open the windows. Please advise if you have any additional safety requests or precautions you would like for us to take.

We work hard to protect your privacy. The information you share with me will be kept confidential. Even your service provider will not know what you say or if you choose to participate in this survey. We want you to feel free to be honest. Your personal information like name, address, contact information, and other things that could identify you will not be shared with anyone outside of a small research team. We will only use this information to contact you, and it will be password-protected. We will reach out to you in about six months for a follow up survey. You may also be contacted by someone from our team between now and then to participate in a very brief (5-10 minute) questionnaire about your experience with this survey.

After removing any information that could identify you, the data we collect may be combined with other study participants' data and shared publicly for future research purposes. If you have any questions or concerns about the survey or your rights as a participant, you may contact Ms. Nguyen Thi Phuong Mai via her cell phone 0912722494 or email mainguyen@depocen.org. You may also contact Social Impact's institutional review board at irb@socialimpact.com, or the University of Hanoi institutional review board at (024) 62663024, email: irb@huph.edu.vn.

I will leave a copy of this form with you if you want to keep this information about the study.

NO.	QUESTION	RESPONSE	OPT	SKIP
B6	Do you have any questions about the survey? *Interviewer: Respond if you can; be always honest. Contact your field supervisor if you do not have the answer.*	No Yes	0 1	
B7	Do you agree to participate in this study?	No Yes	0 1	0->B9

NO.	QUESTION	RESPONSE	OPT	SKIP
B8	We would like to record this interview for quality control purposes. We will delete the record within 3 months after this interview. Do you agree for this interview to be recorded? *Coder: Show a reminding message to Enumerator to record/not to record the interview before C1 if possible.*	No Yes	0 1	0->C1 without recording 1->C1 with recording
B9	Would you kindly share why you don't want to participate?	No time Not comfortable Concern about personal information Concern about COVID Concern about US government Other (*specify*) _____ Prefer not to answer	1 2 3 4 5 -77 [ ] -88	2☐END 3☐END 4☐END 5☐END -77 ☐☐ Address/ END -88☐END
B10	Is there a more convenient time that I could come back to talk to you?	No Yes	0 1	0☐END
B11	When would you like to reschedule for?		[ ]	☐END

B5.b Adult Proxy

Hello. My name is _____, and I am here on behalf of DEPOCEN, a company called Social Impact, and USAID. I understand [*beneficiary name: A2*] is receiving some help for [HIS/HER] health condition from [*UIP: A12*], with support from USAID. We are collecting data to understand quality of life for people who receive this support. What we learn will help these service providers and USAID improve their work in the future so they can provide better support.

I'd like to invite [*beneficiary name: A2*] participate in a survey. I'll ask [*beneficiary name: A2*] some questions about their condition, their satisfaction with life, and the services they receive. This will take about 30 minutes to 1.5 hours of your time, with short breaks scheduled throughout. We randomly selected and will be visiting more than four hundred people who received or will be receiving the support from the USAID to do this.

Your participation in this study is completely voluntary. You can refuse to participate, even without giving a reason. You can also choose to just not answer any question that you don't like or don't feel comfortable to respond.

If you and [*beneficiary name: A2*] both agree to participate in the survey, we will give [*beneficiary name: A2*] a 100,000 VND phone card. If [*beneficiary name: A2*] does not have a phone or is not able to answer for themselves, we will give the phone card to you. You or [*beneficiary name: A2*] will receive the phone card even if you skip some questions or choose to stop the survey part-way through. Your participation may also help us to improve services for [*beneficiary name: A2*] and other people in the future. Your responses will not change our current or committed support to you or [*beneficiary name: A2*]. If you become unavailable or start to feel tired at any

time during the interview, please let me know; we can take another break or make a new schedule to complete the interview at your convenience.

Because of the COVID-19 pandemic we are working hard to reduce any risk of spreading the disease. Our full team is being tested at least weekly out of an abundance of caution, and I can confirm my last two tests have been negative. Our team is operating in full compliance with the COVID-19 regulations of the government of Vietnam. I will be wearing a face mask the entire time we are speaking and will sanitize my hands as needed. We are required to complete the survey outside and at a 6-foot distance to reduce the risk of COVID-19; however, we can make an exception if that would not work for you. If we need to complete the survey inside, we require that both of us wear a mask and we open the windows. Please advise if you have any additional safety requests or precautions you would like for us to take.

We work hard to protect your privacy. The information you share with me will be kept confidential using passwords and other measurements. Even [*beneficiary name: A2*'S] service provider will not know what you say or if you choose to participate in this survey. We want you to feel free to be honest. Your personal information like name, address, contact information, and other things that could identify you or [*beneficiary name: A2*] will not be shared with anyone outside of a small research team. We will only use this information to contact you, and it will be password-protected. We will reach out to you in about six months for a follow up survey. You may also be contacted by someone from our team between now and then to participate in a very brief (5-10 minute) questionnaire about your experience with this survey.

After removing any information that could identify you or [*beneficiary name: A2*], the data we collect may be combined with other study participants' data and shared publicly for future research purposes.

If you have any questions or concerns about the survey or your rights as a participant, you may contact Ms. Nguyen Thi Phuong Mai via her cell phone 0912722494 or email mainguyen@depocen.org. You may also contact Social Impact's institutional review board at irb@socialimpact.com, or the University of Hanoi institutional review board at (024) 62663024, email: irb@huph.edu.vn.

I will leave a copy of this form with you if you want to keep this information about the study.

NO.	QUESTION	RESPONSE	OPT	SKIP
B12	Do you have any questions about the survey? *Interviewer: Respond if you can; be always honest. Contact your field supervisor if you do not have the answer.*	No Yes	0 1	
B13	Do you agree to participate in this study?	No Yes	0 1	0☐B16
B14	We would like to record this interview for quality control purposes. We will delete the record within 3 months after this interview. Do you agree for this interview to be recorded?	No Yes	0 1	
B15	*(Automatic)* Check B2 & B14 *Coder: Show a reminding message to Enumerator to record/not to record the interview before C1 if possible.*	B2=1 B2=2 & B14=1 B2=2 & B14=0	1 2 3	1☐B5.c 2☐C1 with recording 3->C1 without recording

NO.	QUESTION	RESPONSE	OPT	SKIP
B16	Would you kindly share why you don't want to participate? *Interviewer: Include reasons of both the beneficiary and caregiver/representative if the beneficiary cannot respond to all of the questions.*	No time Not comfortable Concern about personal information Concern about COVID Concern about US government Other (*specify*) _____ Prefer not to answer	1 2 3 4 5 -77 [ ] -88	 2☐END 3☐END 4☐END 5☐END -77☐☐ Address /END -88☐END
B17	Is there a more convenient time that I could come back to talk to you?	No Yes	0 1	0☐END
B18	When would you like to reschedule for?		[ ]	☐END

Interviewer: Request to talk to [*beneficiary name: A2*].

B5.c. Adult Assent

Hello. My name is _____. I am working with a company to gather information about people like you in Vietnam. We know that you receive some help for your health condition from an organization called [*UIP: A12*]. We want to learn about people's lives and happiness who receive this help so we can make it better in the future.

I just spoke to [*NAME: B4*], and s/he has agreed that it is okay for you to participate in this discussion if you want to. First, I will tell you more about what will happen, then it will be up to you whether you would like to do it.

If you participate, I would ask you some questions about your life in general, your health and happiness, your disability, the services you receive, and what your household is like. This will take no more than 1.5 hours of your time and we will take short breaks as we go. If you feel tired at any time, you can let me know and we will take another break. Whether you participate in this discussion is completely up to you. It is also okay if we start the conversation, and you change your mind and want to stop. You can also skip any questions you do not want to answer.

We are being very careful because of COVID-19. I want to let you know that I am not currently sick and have not been sick in the last two weeks. To help us stay healthy, I will wear this mask when we talk, I will sanitize my hands regularly, and we will have our discussion outside and sit far apart. Please let me know if there is anything else you'd like me to do to feel safe.

The information you share with me will only be shared with my small team and kept very secure. Later when we have this information from lots of other people, we will combine your information with others' and share it publicly, but we will not share things like your name with anyone else.

I left a copy of the information I've shared with you here with your family in case you have any questions later on.

NO.	QUESTION	RESPONSE	OPT	SKIP
B19	Do you have any questions about the survey? *Interviewer: Respond if you can; be always honest. Contact your field supervisor if you do not have the answer.*	No Yes	0 1	
B20	Do you agree to participate in this study?	No Yes	0 1	0☐B23
B21	We would like to record this interview for quality control purposes. We will delete the record within 3 months after this interview. Do you agree for this interview to be recorded?	No Yes	0 1	
B22	*(Automatic)* Check B21 & B14 *Coder: Show a reminding message to Enumerator to record/not to record the interview before C1 if possible.*	B21=0 B21=1 & B14=0 B21=1 & B14=1	1 2 3	1->C1 **without** recording 2->C1 **without** recording 3->C1 with recording
B23	Would you kindly share why you don't want to participate?	No time Not comfortable Concern about personal information Concern about COVID Concern about US government Other (*specify*) _____ Prefer not to answer	1 2 3 4 5 -77 [ ] -88	 2☐END 3☐END 4☐END 5☐END -77 ☐END Address/ END -88☐END
B24	Is there a more convenient time that I could come back to talk to you?	No Yes	0 1	0☐END
B25	When would you like to reschedule for?		[ ]	☐END

***Coder**: Replace "**you**" by "**[beneficiary name: A2]**" and "**your**" by "**[beneficiary name: A2]'s**" if B2=1 or B2=2.*

C	SOCIO-ECONOMIC CHARACTERISTICS of THE BENEFICIARY			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
C1	Can you please confirm the beneficiary name in full is [*beneficiary name: A2*]? *NOTE for Interviewer:* • *If it's not correct: Check with field supervisor to make sure that you are meeting the right person for the interview. If it is still correct (e.g. the beneficiary has 2 names), continue the interview. If it is not the right respondent, seek approval from your field supervisor, politely thank the respondent and END the interview.* • *If the beneficiary refuses to respond and there is no way to confirm that this is the right respondent, seek approval from your field supervisor, politely thank the respondent and END the interview.*	Yes, correct No, not correct Prefer not to answer	1 0 -88	 0☐NOTE -88☐NOTE
C1.a	Interviewer: Continue to interview?	No Yes		
C1.b	Interviewer: Please clarify why the beneficiary's name is incorrect and why the interview is discontinued		[ ]	END
C2	What is **your** gender?	Male Female Other gender Prefer not to answer	0 1 2 -88	
C3	Our record showed that your date of birth is: [*pre-filled from IP: A10*] or your age is [*Estimated from A10*] Is this correct? *Interviewer: If there is any missing information (e.g. month of birth), ask and correct if possible.*	No/Missing information Yes Don't know	0 1 -99	 1☐C5 -99☐C5
C4	Correct age:		[ ]	->C6
C5	Could you tell me your age range? *Coder: Fill automatically (using age estimated from A10) if C3=1.*	Under 18 years old 18-29 30-39 40-49	1 2 3 4	

C	SOCIO-ECONOMIC CHARACTERISTICS of THE BENEFICIARY			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		50-59 60+	5 6	
C6	(*Automatic*) Check age	Age>=18 (C4>=18 OR C5>1) Age<18 (C4<18 OR C5=1)	1 2	 2☐Confirm age & move to Child Module
C7	Are **you** currently in school? *Interviewer: Apply to formal education only. Include online programs. Exclude vocational training.*	No Yes Prefer not to answer	0 1 -88	
C8	What is the highest grade of schooling that **you** have attended? *Interviewer:* ● *Consider special education schooling the same as mainstream school categories. Special education programs such as special education for children with disabilities or have functional difficulties, supplemental education (continuing education), vocational secondary school and additional cultural studies, etc.* ● *Completed grade in formal education system (12-year system); write 0 if not going to school; write 13 if greater than 12 (e.g. graduate or post-graduate);*	Grade completed Prefer not to answer Don't know	[ ] -88 -99	
C9	Have **you** ever attended vocational training? *Interviewer: Do not count vocational training as a subject in formal education programs.*	No Yes	0 1	0 ☐ C11
C10	How long was the training? *Interviewer: Total months of all trainings. Do not count compulsory vocational training as a subject in formal education programs.*	*(Record in months: Numeric only)* Prefer not to answer Don't know	[ ] -88 -99	

C	SOCIO-ECONOMIC CHARACTERISTICS of THE BENEFICIARY			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
C11	What is **your** marital status?	Single Married Cohabited Separated Divorced Widowed Prefer not to answer	1 2 3 4 5 6 -88	
C12	What is **your** main work in the past 6 months? *Interviewer:* • *Grab is working for others; traditional "xe om" (bike taxi), self-selling lottery tickets are self-employed;* • *If the respondent says "No", follow-up and ask "Do you do housework?"*	Working for the family Working for others Self-employed Housework (for the family) Not working & not looking for a job Not working & looking for a job (unemployed) Prefer not to answer	1 2 3 4 5 6 -88	 5 ☐ C16 6 ☐ C16 -88 ☐ C15
C13	Describe your main work in the past 6 months		[ ]	
C14	On average, how many hours per week did **you** work in the past 6 months? *Interviewer:* • *For all jobs (paid and unpaid)* • *Calculate together with beneficiary name: A2 to figure out the number of hours if needed. You can calculate the average number of hours per day and multiply by 1 week. If the respondent does not remember exactly, try to ask for the best estimate and limit answering "don't know."*	*(Type in: Numeric only)* Prefer not to answer Don't know	[ ] -88 -99	
C15	Did **you** earn income from your works in the past 6 months? *Interviewer: Income in cash or in kind.*	No Yes Prefer not to answer	0 1 -88	
C16	Do you have any income that **does not** come from your work in the past 6 months? E.g. pension or subsidize.	No Yes	0 1	

C	SOCIO-ECONOMIC CHARACTERISTICS of THE BENEFICIARY			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Prefer not to answer	-88	

SECTION D. QUALITY OF LIFE

Coder:

- *Replace "**you**" by "**[beneficiary name: A2]**" and "**your**" by (target) "**[beneficiary name: A2]'s**" if B2=1 or B2=2.*
- *If B2=0 ☐ show question for the beneficiary only (i.e. D1, D2, D3, etc.); If B2=2 ☐ show question for the proxy only (i.e. questions end with p, e.g. D1p, D2p, D3p); If B2=1 ☐ start with the question for self-response, if the beneficiary needs the proxy, click on the proxy needed and use the question for the proxy.*

Please think about **[*beneficiary name: A2*]**'s life **in the last two weeks**:

The first two questions ask about **[*beneficiary name: A2*]**'s life and health overall.

	Interviewer: Use Flashcard #1 (red one)	Very poor	Poor	Neither poor nor good	Good	Very good	Prefer Not to Answer	Don't know	Proxy Needed to respond
D1	How would you rate your **quality of life**?	1	2	3	4	5	-88	-99	-55 If D1≠-55 ☐D2

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderate	Mostly	Totally	Prefer not to answer	Don't know
D1p	Is **[*beneficiary name: A2*]** **satisfied** with his/her **life**?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither dissatisfied or satisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D2	How **satisfied** are you with your **health**?	1	2	3	4	5	-88	-99	-55 If D2≠-55☐D3

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderate	Mostly	Totally	Prefer not to answer	Don't know
D2p	Is **[*beneficiary name: A2*]** **satisfied** with his/her **health?**	1	2	3	4	5	-88	-99

The following questions ask about **how much [*beneficiary name: A2*]** has experienced certain things in the **last two weeks**.

	Interviewer: Use Flashcard #8 (beige one)	Not at all	A little	A moderate amount	Very much	An extreme amount	Prefer not to answer	Don't know	Proxy Needed to respond
D3	To what extent do you **feel that physical pain** prevents you from doing what you need to do?	1	2	3	4	5	-88	-99	-55 If D3≠-55 ☐D4

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D3p	Does **(physical) pain** stop him/her from doing what he/she needs to do?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #8 (beige one)	Not at all	A little	A moderate amount	Very much	An extreme amount	Prefer not to answer	Don't know	Proxy Needed to respond
D4	How much do you **need any medical treatment** to function in your daily life? *For example, using medicines, visit health facilities, self-treatment.*	1	2	3	4	5	-88	-99	-55 If D4≠-55 ☐D5

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D4p	Does he/she **need** any **medical treatment** to help him/her in his/her daily life?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
	For example, using medicines, visit health facilities, self-treatment.							

	Interviewer: Use Flashcard #8 (beige one)	Not at all	A little	A moderate amount	Very much	An extreme amount	Prefer not to answer	Don't know	Proxy Needed to respond
D5	How much do you **enjoy life**?	1	2	3	4	5	-88	-99	-55 If D5≠-55 ☐D6

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D5p	Does he/she **enjoy** his/her **life**?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #8 (beige one)	Not at all	A little	A moderate amount	Very much	An extreme amount	Prefer not to answer	Don't know	Proxy Needed to respond
D6	To what extent do you **feel** your **life to be meaningful**? *For example, feel your life is important and has a purpose.*	1	2	3	4	5	-88	-99	-55 If D6≠-55 ☐D7

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D6p	Does he/she **feel** his/her life has **meaning**? *For example, feel your life is important and has a purpose.*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #8 (beige one)	Not at all	A little	A moderate amount	Very much	Extremely	Prefer not to answer	Don't know	Proxy Needed to respond
D7	How well are you **able to concentrate**?	1	2	3	4	5	-88	-99	-55 If D7≠-55 ☐D8

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D7p	Is he/she able to think clearly? *For example, able to pay attention, and think carefully about things.*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #8 (beige one)	Not at all	A little	A moderate amount	Very much	Extremely	Prefer not to answer	Don't know	Proxy Needed to respond
D8	How **safe do** you **feel** in your daily life? *For example, safe at home and in the places he/she goes to during the day.*	1	2	3	4	5	-88	-99	-55 If D8≠-55 ☐D9

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D8p	Does he/she **feel safe** in his/her daily life? *For example, safe at home and in the places he/she goes to during the day.*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #8 (beige one)	Not at all	A little	A moderate amount	Very much	Extremely	Prefer not to answer	Don't know	Proxy Needed to respond
D9	How **healthy** is **physical environment** of your place of residence? *For example, physical environment (infrastructure & natural environment): the noise, the traffic, the pollution, the weather.*	1	2	3	4	5	-88	-99	-55 If D9≠-55 ☐D10

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D9p	Does he/she feel the **local area** he/she lives in is **healthy**? *For example, the noise, the traffic, the pollution, the weather.*	1	2	3	4	5	-88	-99

The following questions ask about **how completely** [***beneficiary name: A2***] experienced or were able to do certain things **in the last two weeks**.

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Completely/Totally	Prefer not to answer	Don't know	Proxy Needed to respond
D10	Do you have **enough energy** for everyday life? *For example, able to do things through the day without feeling tired.*	1	2	3	4	5	-88	-99	-55 If D10≠-55 ☐D11

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D10p	Does he/she have **enough energy** for everyday life?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
	For example, able to do things through the day without feeling tired.							

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Completely/Totally	Prefer not to answer	Don't know	Proxy Needed to respond
D11	Are you able to **accept your bodily appearance**?	1	2	3	4	5	-88	-99	-55 If D11≠-55 ☐D12

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D11p	Is he/she able to **accept** the way his/her **body looks**?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Completely/Totally	Prefer not to answer	Don't know	Proxy Needed to respond
D12	Have you got **enough money to meet your needs**?	1	2	3	4	5	-88	-99	-55 If D12≠-55 ☐D13

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D12p	Does he/she have **enough money** for the things he/she **needs**?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard# 4 (purple one)	Not at all	A little	Moderately	Mostly	Completely/Totally	Prefer not to answer	Don't know	Proxy Needed to respond
D13	How **available** to you is the **information that you need** in your day-to-day life? *For example, information on weather, prices, health, health care, education, jobs, news, etc.*	1	2	3	4	5	-88	-99	-55 If D13≠-55 ☐D14

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D13p	Is he/she able to get the **information that he/she needs** in his/her day-to-day life? *For example, information on weather, prices, health, health care, education, jobs, news, etc.*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Completely/Totally	Prefer not to answer	Don't know	Proxy Needed to respond
D14	To what extent do you have the **opportunity for leisure activities**? *For example, do what you enjoy in your spare time, such as watching a movie, reading, hanging around, café, playing chess, playing sports, singing, etc.*	1	2	3	4	5	-88	-99	-55 If D14≠-55 ☐D15

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
D14p	Does he/she get the chance to do **leisure activities**? *For example, do what you enjoy in your spare time, such as watching a movie, reading,*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Total	Prefer not to answer	Don't know
	hanging around, café, playing chess, playing sports, singing, etc.							

	Interviewer: Use Flashcard #1 (red one)	Very poor	Poor	Neither poor nor good	Good	Very good	Prefer not to answer	Don't know	Proxy Needed to respond
D15	How well are you able to **get around**? In the house and outside.	1	2	3	4	5	-88	-99	-55 If D15≠-55 ☐D16

	Interviewer: Use Flashcard #3 (yellow one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D15p	Is he/she able to **get around** OK in the house and outside?	1	2	3	4	5	-88	-99

The following questions ask **[*beneficiary name: A2*]** to say **how good or satisfied [*beneficiary name: A2*]** have felt about various aspects of **[*beneficiary name: A2*]**'s life over the last two weeks.

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D16	How **satisfied** are you with your **sleep**?	1	2	3	4	5	-88	-99	-55 If D16≠-55 ☐D17

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D16p	Is he/she **satisfied** with his/her **sleep**?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D17	How **satisfied** are you with your **ability to perform your daily living activities**? *For example, looking after yourself, washing, dressing, eating.*	1	2	3	4	5	-88	-99	-55 If D17≠-55 ☐D18

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D17p	Is he/she **satisfied** with his/her **ability to do his/her daily activities**? *For example, looking after yourself, washing, dressing, eating.*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D18	How **satisfied** are you with your **capability for work**? *For example, to do your job, or your daily activities.*	1	2	3	4	5	-88	-99	-55 If D18≠-55 ☐D19

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D18p	Is he/she **satisfied** with his/her **ability to work**? *For example, to do your job, or your daily activities.*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D19	How **satisfied** are you **with yourself**? *For example, with the kind of person you are, in what you do, how you spend time, your friendship, your achievements.*	1	2	3	4	5	-88	-99	-55 If D19≠-55 ☐D20

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D19p	Is he/she **satisfied with himself/herself** as a person? *For example, with the kind of person you are, in what you do, how you spend time, your friendship, your achievements.*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D20	How **satisfied** are you with your **personal relationships**? *For example, how you get along with the people in your life, your friends, your family, the people you lives with.*	1	2	3	4	5	-88	-99	-55 If D20≠-55 ☐D21

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D20p	Is he/she **satisfied** with his/her **personal relationships**?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
	For example, how you get along with the people in your life, your friends, your family, the people you lives with.							

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D21	How **satisfied** are you with your **sex life**?	1	2	3	4	5	-88	-99	-55 If D21≠-55 ☐D22

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D21p	Is he/she **satisfied** with his/her **sex life**, or his/her **relationship** with his/her partner? *For example, your spouse, boyfriend/girlfriend.*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D22	How **satisfied** are you with the **support** you get from your **friends**?	1	2	3	4	5	-88	-99	-55 If D22≠-55 ☐D23

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D22p	Is he/she **satisfied** with the **support** he/she gets from his/her **friends**?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D23	How **satisfied** are you **with the conditions of your living place**?	1	2	3	4	5	-88	-99	-55 If D23≠-55 ☐D24

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D23p	Is he/she **satisfied** with what his/her **home** is like? *For example, thinking about his/her home and the place he/she lives in.*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D24	How **satisfied** are you with your **access to health services**? *For example, is it easy to see the doctors or health workers who look after you when you are unwell.*	1	2	3	4	5	-88	-99	-55 If D24≠-55 ☐D25

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D24p	Is he/she **satisfied** with his/her **access to health services?** *For example, is it easy to see the doctors or health workers who look after you when you are unwell.*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #2 (green one)	Very dissatisfied	Dissatisfied	Neither satisfied or dissatisfied	Satisfied	Very satisfied	Prefer not to answer	Don't know	Proxy Needed to respond
D25	How **satisfied** are you with your use of **transport**? *For example, how you get to the places you go to, e.g. bicycle, motorbike, car, taxi, bus, etc.*	1	2	3	4	5	-88	-99	-55 If D25≠-55 ☐D26

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D25p	Is he/she **satisfied** with the **transport** he/she can use? *For example, how you get to the places you go to, e.g. bicycle, motorbike, car, taxi, bus, etc.*	1	2	3	4	5	-88	-99

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

	Interviewer: Use Flashcard #5 (orange one)	Never	Seldom	Quite often	Very often	Always	Prefer not to answer	Don't know	Proxy Needed to respond
D26	How often do you **have negative feelings** such as blue mood, despair, anxiety, depression?	1	2	3	4	5	-88	-99	-55 If D26≠-55 ☐D27

	Interviewer: Use Flashcard #4 (purple one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
D26p	Does he/she feel very unhappy, sad, worried or depressed?	1	2	3	4	5	-88	-99

NO.	QUESTION	RESPONSE	OPT	SKIP
D27	Now I would like you to please think about your life six months ago, that is around [*month, year = Current time – 6 months*]. How would you say about your quality of life today compared to six months ago? *(Interviewer: Read respond options 1 to 5)*	A lot worse	1	
		A little worse	2	
		Same	3	3☐E1
		A little better	4	
		A lot better	5	
		Prefer not to answer	-88	-88☐E1
		Don't know	-99	-99☐E1
		Proxy needed to respond	-55	≠-55 ☐D27p
D27p	Now I would like you to please think about [name]'s life six months ago, that is around [*month, year = Current time – 6 months*]. How would you say about their quality of life today compared to six months ago? *(Interviewer: Read respond options 1 to 5)*	A lot worse	1	
		A little worse	2	
		Same	3	3☐E1
		A little better	4	
		A lot better	5	
		Prefer not to answer	-88	-88☐E1
		Don't know	-99	-99☐E1
D28	Can you tell me the things that you think caused your quality of life to get [*selected response option in D27 or D27p*]? *Interviewer:* • *Select ALL that apply.*	Received treatment/service related to disability	1	
		Change in acceptance/inclusion	2	
		Change in access/availability of service for disability	3	
			4	

NO.	QUESTION	RESPONSE	OPT	SKIP
	• *PROBE: Is there anything else?*	Change in pre-existing physical/mental health condition New injury/accident Economic/money issues Job/employment COVID-19 pandemic related Family/social relationship change (not related to acceptance, inclusion) Change to natural environment or natural disaster Other *(specify)* _____ Prefer not to answer Don't know	5 6 7 8 9 10 -77 [ ] -88 -99	-88☐E1 -99☐E1
D29	Out of these things you mentioned, which do you think is the most important factor that has changed your quality of life in the past six months?	*(Write code from D28; Skip this question if only 1 response option was selected in D28; Show only the selected response options in D28.)*		

E	HEALTH & DISABILITY			
NO.	QUESTION	RESPONSE	OPT	SKIP
E1	How is your health? *(Interviewer: Read respond options 1 to 5)*	Very poor Poor Neither poor nor good Good Very good Prefer not to answer	1 2 3 4 5 -88	
E2	Do you have a valid health insurance card?	No Yes Prefer not to answer Don't know	0 1 -88 -99	0☐E5 -88☐E5 -99☐E5

E	HEALTH & DISABILITY			
NO.	QUESTION	RESPONSE	OPT	SKIP
E3	Do you have a public or private health insurance or both?	Public only Private only Both Prefer not to answer Don't know	1 2 3 -88 -99	
E4	How often do you use it? *Interviewer: Read respond options if needed.*	Weekly Monthly (at least once a month) Quarterly (at least once/3 months) Semi-annually (at least once/6 months) Annually or less Never Prefer not to answer Don't know	1 2 3 4 5 6 0 -88 -99	

E5. The next questions ask about difficulties **[*beneficiary name: A2*]** may have doing certain activities because of a HEALTH PROBLEM.

	Interviewer: Use Flashcard #7 (white one)	No difficulty	Some difficulty	A lot of difficulty	Cannot do at all	Prefer not to answer	Don't know
E5a	Do you have difficulty **seeing**, even if wearing glasses? Would you say … *[Read the first 4 response options]*	0	1	2	3	-88	-99
E5b	Do you have difficulty **hearing**, even if using a hearing aid(s)? Would you say … *[Read the first 4 response options]*	0	1	2	3	-88	-99
E5c	Do you have difficulty **walking or climbing steps**? Would you say … *[Read the first 4 response options]*	0	1	2	3	-88	-99
E5d	Do you have difficulty **remembering or concentrating**? Would you say … *[Read the first 4 response options]*	0	1	2	3	-88	-99

	Interviewer: Use Flashcard #7 (white one)	No difficulty	Some difficulty	A lot of difficulty	Cannot do at all	Prefer not to answer	Don't know
E5e	Do you have difficulty with **self-care**, such as washing all over or dressing? Would you say … *[Read the first 4 response options]*	0	1	2	3	-88	-99
E5f	Using your usual language, do you have difficulty **communicating**, for example understanding or being understood? Would you say … *[Read the first 4 response options]*	0	1	2	3	-88	-99

NO.	QUESTION	RESPONSE	OPT	SKIP
E6	Do you have any other functional difficulties?	No Yes Prefer not to answer Don't know	0 1 -88 -99	0 ☐E9 -88 ☐E9 -99 ☐E9
E7	What are they?	*(specify)*	[ ]	
E8	What level of difficulty do you have? *Interviewer: Write the highest level if the beneficiary has more than one difficulty.*	Some A lot of difficulty Cannot do at all Prefer not to answer Don't know	1 2 3 -88 -99	
E9	Do you think you are a person with disability?	No Yes Prefer not to answer Don't know	0 1 -88 -99	
E10	Do you have a disability determination/certificate on disability?	No Yes Prefer not to answer Don't know	0 1 -88 -99	 1☐E12 -88☐E12 -99☐E12
E11	Why not? *Interviewer:* • *Select ALL that apply*	Not necessary Not interested Not approved Don't know how to get it	1 2 3 4	

NO.	QUESTION	RESPONSE	OPT	SKIP
	• *Probe: Anything else?*	Other (*specify*) _____ Prefer not to answer Don't know	-77 [ ] -88 -99	
E12	What is your level of disability? *Interviewer:* • *It's the level of disability that a person has been given (in the disability certificate) or perceived level of disability for those who do not have a disability certificate.* • *Read response options if needed*	Mild Severe Very severe Prefer not to answer Don't know	1 2 3 -88 -99	
E13	What types of disability do you have? *Interviewer:* • *Read response options if needed* • *Check disability certificate if possible.* • *Select ALL that apply.* • *Probe: Anything else?*	Physical Hearing Speech Vision Cognitive & Mental health Intellectual Others (*specify*)_____ Prefer not to answer Don't know	1 2 3 4 5 6 -77 [ ] -88 -99	
E14	Are you a member of a Organization of Persons with Disabilities (OPD)? *Interviewer: OPDs are organizations of persons with disabilities where persons with disabilities constitute a majority (at least 51%) of the staff and board at all levels of the organization. Include online OPDs.*	No Yes Family member participated on my behalf Prefer not to say Don't know	0 1 2 -88 -99	 1☐E16 -88☐E16 -99☐E16

NO.	QUESTION	RESPONSE	OPT	SKIP
E15	Why not? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Admission refused /Not qualified Not interested OPDs are not active OPDs don't exist Don't know how to join Too far/inaccessible No time Too weak (health) Cannot communicate with others Other (*specify*) _____ Prefer not to answer Don't know	1 2 3 4 5 6 7 8 9 -77 [ ] -88 -99	
E16	Can you list any government laws, policies, welfare, subsidizes supporting people with disabilities that you are aware of? *Interviewer:* • *Do not read respond categories and do not hint* • *Select ALL that apply.* • *Probe: anything else?*	Not aware of any Education fee exemption/reduction Other financial support on education (e.g. scholarship provision) Public transport fee exemption Social welfare/subsidy Loan with preferential interest rate Health care fee exemption/insurance Employment priority Law on Persons with Disability Vocational training Priority university admission Late school enrollment Other *(specify)* _____ Prefer not to answer	0 1 2 3 4 5 6 7 8 9 10 11 -77 [ ] -88	0 ☐E18
E17	Have you read or known content of the Law for Persons with Disabilities?	No Yes	0 1	

NO.	QUESTION	RESPONSE	OPT	SKIP
E18	(*Automatic*) Does this person has functional difficulty or disability? (i.e. Yes if (E5a/b/c/d/e/f)=2 or (E5a/b/c/d/e/f)=3 or E8=2 or E8=3 or E9=1)	No Yes	0 1	0☐F1
E19	Do you know what are the causes of your disability or functional difficulty? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Indicated at birth Illness/ Diseases Accident Injury during wartime Agent Orange (dioxin) Old age Others *(specify)* _____ Prefer not to answer Don't know	1 2 3 4 5 6 -77 [ ] -88 -99	
E20	For how long have you had a disability or functional difficulty? *Interviewer: Use the longer period if the beneficiary has more than one disability.*	Less than one year A year or more Prefer not to answer Don't know	1 2 -88 -99	.
E21	Given your current functional difficulties, what are the challenges you face in your community? *(Interviewer: Read response options 1 to 8 and -77)* *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Make friends: either direction*	Physical barriers or infrastructure Communication barriers Public attitudes/discrimination Participate in economic activities Participate in leisure activities Participate in social activities Make friends Medical care Other *(specify)* _____ No challenges at all Prefer not to answer Don't know	1 2 3 4 5 6 7 8 -77 [ ] 0 -88 -99	0 ☐ E23 -88 ☐ E23 -99 ☐ E23
E22	Which is the biggest challenge?	*(SKIP this question if only 1 respond option was selected in E21. Show selected respond*	[ ]	

NO.	QUESTION	RESPONSE	OPT	SKIP
		options in E21 only) Don't know	-99	

The next question asks about **[*beneficiary name: A2*]**'s functional difficulty or disability overall:

	Interviewer: Use Flashcard #6 (blue one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know	Proxy Needed to respond
E23	To what extent does your **disability or functional difficulty or disability** have a **negative (bad) effect on your day-to-day life**?	1	2	3	4	5	-88	-99	-55 E23 ≠ -55 ☐ E24

	Interviewer: Use Flashcard #6 (blue one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
E23p	Does he/she feel that his/her **disability or functional difficulty or disability** have a **negative (bad) effect on his/her day-to-day life**?	1	2	3	4	5	-88	-99

The following questions ask about how **[*beneficiary name: A2*]** has felt about certain things, how much certain things have applied to **[*beneficiary name: A2*]**, and how satisfied you have been about various parts of your life over the **last two weeks**.

	Interviewer: Use Flashcard #6 (blue one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
E24	Do you feel that some people **treat you unfairly**?	1	2	3	4	5	-88	-99
E25	Do you need **someone to stand up** for you when you have problems?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #6 (blue one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
E26	Do you **worry about what might happen** to you in the future? *For example, thinking about not being able to look after yourself, or being a burden to others in the future.*	1	2	3	4	5	-88	-99

		Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
E27	Do you feel in **control of your life**? *For example, do you feel in charge of your life?*	1	2	3	4	5	-88	-99
E28	Do you **make your own choices about your day-to-day life**? *For example, where to go, what to do, what to eat*	1	2	3	4	5	-88	-99
E29	Do you get to **make the big decisions** in your life? *For example, deciding where to live, or who to live with, how to spend your money*	1	2	3	4	5	-88	-99
E30	Are you **satisfied with your ability to communicate** with other people? *For example, how you say things or get your point across, the way you understand others, by words or signs.*	1	2	3	4	5	-88	-99
E31	Do you feel that **other people accept you**? *For example, play with you, treat you as anyone else.*	1	2	3	4	5	-88	-99
E32	Do you feel that **other people respect you**? *For example, do you feel that others value you as a person and listen to what you have to say?*	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #6 (blue one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
E33	Are you satisfied with **your chances to be involved in social activities**?	1	2	3	4	5	-88	-99

	Interviewer: Use Flashcard #6 (blue one)	Not at all	A little	Moderately	Mostly	Totally	Prefer not to answer	Don't know
	For example, meeting friends, going out for a meal, going to a party, playing sports, participating in cultural events, etc.							
E34	Are you **satisfied with your chances to be involved in local activities**? *For example, being part of what is happening in your local area or neighborhood.*	1	2	3	4	5	-88	-99
E35	Do you feel that **your dreams, hopes and wishes will happen**? *For example, do you feel you will get the chance to do the things you want, or get the things you wish for, in your life?*	1	2	3	4	5	-88	-99

F	**SOCIAL & DISABILITY SERVICES**			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
F0	*(Automatic)* Check the first date of service from the [UIP: A12] to see if it is before the date of interview? *Coder:* • *Compare A14 with current date* • *"Exclude …" = the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," in F1, F2, F12, F16, F25, F26, F32, F36, F39, and F44.*	No Yes Don't know	0 1 -99	0 ☐Remove "Exclude…" 1 ☐ Use "Exclude…" -99 ☐ Use "Exclude…"
Rehabilitation services				
F1	Exclude services that you may have been receiving from the *[UIP: A12]*, have you **ever** used **rehabilitation services**? *For example, PT, ST, ST to recover a function, such as moving, walking, communicating, etc.* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if rehabilitation service was not provided by the [UIP: A12], i.e. A13☐1.*	No Yes Prefer not to answer Don't know/Don't remember	0 1 -88 -99	0☐F10 -88☐F12 -99☐F12

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
F2	Exclude services that you may have been receiving from the *[UIP: A12]*, when was **the last time** you used **rehabilitation services**? *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if rehabilitation service was not provided by the [UIP: A12], i.e. A13☐1.*	*(write 0 if it's less than a month ago)* Prefer not to answer Don't know/Don't remember	[ ] -88 -99	>6m☐F11 -88☐F12 -99☐F12
F3	In the past 6 months, how frequent did you access rehabilitation services? *Interviewer:* • *Exclude ones provided by the [UIP: A12].* • *Read respond options if needed.*	Daily (at least once a day) Weekly (at least once a week) Monthly (at least once a month) Few times over the past 6 months Once over the past 6 months None Prefer not to answer Don't know/don't remember	1 2 3 4 5 6 -88 -99	6 ☐ Check F1 F2
F4	In the past 6 months, how easy or difficult has it been for you to access rehabilitation services to help your condition? *(Interviewer: Read respond option 1 to 4)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Very easy to access Easy to access Difficult to access Very difficult to access Prefer not to answer Don't know	1 2 3 4 -88 -99	
F5	In the past 6 months, what challenges have you faced in accessing rehabilitation services? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	No challenges Don't know/lack of information Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance payment is too small Not at all covered by insurance	0 1 2 3 4 5 6 7 8 9 10 11 12	(if F4=1 ☐ cant select F5=0)

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation Rehab services did not meet my needs COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	-77 [ ] -88 -99	-88☐F7 -99☐F7
F6	What was the biggest challenge?	*(Write code from F5: allow selected codes only; if only 1 code selected in F5 ☐ SKIP this question)* Don't know	-99	
F7	Where did you get rehabilitation services in the past 6 months? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	*Public sector* Central/Provincial hospital District health hospital/center Commune health center *Private sector* Private hospital Private clinics Traditional healer *Others* Home OPD NGO Social protection centers Other centers supporting persons with disabilities Other *(specify)*: _____ Prefer not to answer	1 2 3 4 5 6 7 8 9 10 11 -77 [ ] -88 -99	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Don't know		
F8	In general, how satisfied were you with quality of rehabilitation services that you have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	 2☐ F12 3☐ F12 -88☐ F12 -99☐ F12
F9	Why were you not satisfied? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Long waiting time Disrespectful care Condition didn't improve Not available in my area/ too far Workers not skilled/qualified Too expensive /Cannot afford Insurance covers too little Not at all covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify)* _____ Prefer not to answer Don't know	1 2 3 4 5 6 7 8 9 10 11 12 -77 [ ] -88 -99	☐ F12
F10	Why have you not accessed rehabilitation services? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Don't know/ lack of info on rehab Rehab can't help Rehab services do not meet my needs Doctor said I don't need rehabilitation	1 2 3 4 5 6 7	☐ F12

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Think that I don't need rehabilitation Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	8 9 10 11 12 13 14 15 16 -77 [ ] -88 -99	
F11	Why have you not accessed rehabilitation services in the past 6 months? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Don't know/ lack of info on rehab Rehab can't help Rehab services do not meet my needs Doctor said I don't need rehabilitation Think that I don't need rehabilitation Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	-77 [ ] -88 -99	
Assistive products				
F12	Exclude assistive products that you may have been receiving from the *[UIP: A12]*, have you ever looking for or received or self-made an **assistive product**? *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if assistive products were not provided by the [UIP: A12], i.e. A13☐2.*	Never Ever Prefer not to answer Don't know	0 1 -88 -99	0 ☐ F24 -88 ☐ F17 -99 ☐ F17
F13	When was the last time you were looking for or received or self-made an assistive product?	More than 6 months ago Within the last 6 months Prefer not to answer Don't know	1 2 -88 -99	1 ☐ F17 -88 ☐ F17 -99 ☐ F17
F14	In the past 6 months, how easy or difficult has it been for you to buy or access or self-made these assistive products? *(Interviewer: Read respond option 1 to 4)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Very easy Easy Difficult Very difficult Prefer not to answer Don't know	1 2 3 4 -88 -99	 -88 ☐F16 -99 ☐F16
F15	In the past 6 months, what challenges have you faced in accessing assistive products? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	No challenges Don't know/lack of information Not available in my area/ too far Workers not skilled/qualified Disrespectful care	0 1 2 3 4 5	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	• *Exclude ones provided by the [UIP: A12].*	Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation Service provision doesn't meet my needs COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	6 7 8 9 10 11 12 -77 [ ] -88 -99	
F16	Exclude assistive products that you may have received from the *[UIP: A12]*, do you currently have any assistive product? *Interviewer: Include ones that are old, broken, not in use.* *Coder: Remove the leading phrase "Exclude assistive products that you may have received from the [UIP: A12]," if assistive products were not provided by the [UIP: A12], i.e. A13 ☐2.*	No Yes Prefer not to answer Don't know	0 1 -88 -99	0 ☐ F24 -88 ☐ F25 -99 ☐ F25
F17	Which of the following assistive products do you currently **have**? *(Interviewer: Use assistive product sheet & read names of assistive products).* *Interviewer:* • *Select ALL that apply.* • *Ask to take a look at the assistive products if possible.* • *Excludes ones that are provided by [UIP: A12].*	Canes or Sticks Crutches, axillary or elbow Orthoses, lower limb, upper limb or spinal Pressure relief cushions Prostheses, lower limb Rollators Standing frames, adjustable Therapeutic footwear; diabetic, neuropathic, orthopedic Tricycles Walking frames or walkers	1 2 3 4 5 6 7 8 9 10 11	. . . .

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Wheelchair Spectacles; low vision, short distance, long distance, filters and protection White cane Hearing aids Phone, tablet, other electronic devices Daily living aids Others *(specify)* _____ None Prefer not to answer Don't know	12 13 14 15 16 -77 [ ] 0 -88 -99	. . 0 --> F24
F18	Which among them do you currently **use**? *Interviewer:* • *Select ALL that apply.* • *Exclude malfunction assistive products.* • *Ask to take a look at the assistive products if possible.* • *Excludes ones that are provided by [UIP: A12].*	*(Show ones that were selected in F17 only; may include none of the devices in F17)* None	0	
F19	Do you have any assistive product that you currently don't use?	No Yes Prefer not to answer Don't know	0 1 -88 -99	0 ☐ F21 -88 ☐ F21 -99 ☐ F21
F20	Why don't you use them?	It's currently broken It doesn't fit It causes inconvenience Don't know how to use it No longer need it It doesn't help functioning Other (*specify*): _____ Prefer not to answer	1 2 3 4 5 6 -77 [ ] -88	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
F21	Where did you get the current assistive products? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	*Public sector* Central/Provincial hospital District health hospital/center Commune health center *Private sector* Private hospital Private clinics Traditional healer Shops that sell assistive products Online stores for assistive products *Others* Home OPD NGO Social protection centers Other centers supporting persons with disabilities Self-made /made by friends or relatives Other *(specify)*: _____ Prefer not to answer Don't know	 1 2 3 4 5 6 7 8 9 10 11 12 13 . 14 -77 [ ] -88 -99	
F22	How satisfied are you with these assistive products that you currently have? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	 2☐ F25 3☐ F25 -88☐ F25 -99☐ F25
F23	Why are you not satisfied? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Poor quality Did not meet my needs Difficult to access related services Poor quality of related services	1 2 3 4 -77 [ ]	→ F25

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	• *Exclude ones provided by the [UIP: A12].*	Other *(specify)* _____ Prefer not to answer Don't know	-88 -99	
F24	Why don't you have an assistive product (AP)? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	Don't know/lack of information on AP AP could not help Available AP do not meet my needs Doctor said I don't need AP Think that I don't need AP Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 -77 [ ] -88 -99	
Home-based care services				
F25	Exclude services that you may have been receiving from the *[UIP: A12]*, have you ever received **home-based care services** that are provided by someone who are not your family member?	Never Received HBC guidance only Received HBC from a non-family Prefer not to answer	0 1 2 -88	0☐ F31 -88☐ F32

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if home-based care was not provided by the [UIP: A12], i.e. A13☐4.	Don't know/Don't remember	-99	-99☐ F32
F26	Exclude services that you may have been receiving from the *[UIP: A12]*, when was the last time you received home-based care services that were provided by someone who are not your family member? *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if home-based care was not provided by the [UIP: A12], i.e. A13☐4.*	*(write 0 if less than a month)* Prefer not to answer Don't know/Don't remember	[ ] -88 -99	>6m☐ F32 -88☐ F32 -99☐ F32
F27	In the past 6 months, how easy or difficult has it been for you to access home-based care services that were provided by someone who are not your family member? *(Interviewer: Read respond options 1 to 4)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Very easy Easy Difficult Very difficult Prefer not to answer Don't know	1 2 3 4 -88 -99	 -88☐ F32 -99☐ F32
F28	In the past 6 months, what challenges have you faced in accessing home-based care services that were provided by someone who are not your family member? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	No challenges Don't know/Lack of information Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation HBC does not need my needs	0 1 2 3 4 5 6 7 8 9 10 11 12 -77 [ ] -88	 -88 ☐ F30

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	-99	-99 ☐ F30
F29	What was the biggest challenge?	*(Write code from F28: show & allow selected codes only; if only 1 code was selected in F28 ☐ SKIP this question)* Don't know	[ ] . . -99	
F30	In general, how satisfied were you with quality of home-based care services that you have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	☐ F32
F31	Why have you not accessed home-based care services that are provided by someone who are not your family member? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	Don't need it Don't know/Lack of information HBC could not help HBC does not meet my needs Doctors said I don't need it I think I don't need it Don't know where to get it Not available in my area/ too far Career not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance Caregivers/family do not support it Afraid/ lack personal motivation	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 -77 [ ] -88	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	-99	
House adaptation services for in-home accessibility				
F32	Exclude services that you may have been receiving from the *[UIP: A12]*, have you used **house adaptation services** for **in-home accessibility** in the past 6 months? *For example, building a ramp, modify the toilet, put on a grab bar, etc.* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if house adaptation services were not provided by the [UIP: A12], i.e. A13☐3.*	No Yes Prefer not to answer Don't know/Don't remember	0 1 -88 -99	0☐ F34 -88☐ F35 -99☐ F35
F33	In general, how satisfied were you with quality of house adaptation services that you have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	☐ F35
F34	Why have you not accessed house adaptation services? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	Don't know/Lack of information It could not help Doctor/professional said I don't need it I think that I don't need it Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful attitude of provider Too expensive/Could not afford Insurance pays too little Not covered by insurance	1 2 3 4 5 6 7 8 9 10 11 12 13 14	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	-77 [ ] -88 -99	
Legal support services for persons with disabilities				
F35	*(Automatic) Check E9:* The beneficiary self-identified as a person with disabilities?	No: E9 ☐ 1 Yes: E9 = 1	0 1	0 ☐ F39
F36	Exclude services that you may have been receiving from the *[UIP: A12]*, have you used **legal support services for persons with disabilities** in the past 6 months? *For example, sue somebody, asking for rights, etc.* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if legal support services were not provided by the [UIP: A12], i.e. A13☐5.*	No Yes Prefer not to answer Don't know/Don't remember	0 1 -88 -99	0☐ F38 -88☐ F39 -99☐ F39
F37	In general, how satisfied were you with quality of legal support services that you have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	☐ F39
F38	Why have you not accessed legal support services for persons with disabilities? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	Don't need it Don't know/lack of information It does not meet my needs Don't know where to get it Not available in my area/ too far	1 2 3 4 5 6 7 8	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Workers not skilled/qualified Disrespectful attitude of provider Too expensive/Could not afford Insurance pays too little Not covered by insurance Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other (*specify*): _____ Prefer not to answer Don't know	9 10 11 12 13 -77 [ ] -88 -99	
Psychological support services				
F39	Exclude services that you may have been receiving from the *[UIP: A12]*, have you used **psychological support services** in the past 6 months? *For example, counseling and advising to reduce stress.* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if psychological support was not provided by the [UIP: A12], i.e. A13☐7.*	No Yes Prefer not to answer Don't know/Don't remember	0 1 -88 -99	0☐ F41 -88☐ F42 -99☐ F42
F40	In general, how satisfied were you with quality of psychological support services that you have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	☐ F42
F41	Why have you not accessed psychological support services?	Don't know/lack of information It could not help	1 2 3	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	Interviewer: • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	It does not meet my needs Doctors said I don't need it I think I don't need it Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful attitude of provider Too expensive/Could not afford Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other (*specify*): _____ Prefer not to answer Don't know	4 5 6 7 8 9 10 11 12 13 14 15 -77 [ ] -88 -99	
Social participation support				
F42	In the past 6 months, did you participate in any of the following activities? *(Interviewer: Read respond options 1 to 12 and -77)* *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Meet friends Call, SMS, e-chat with friends/relatives Call, SMS, e-chat with strangers Watch a movie (at cinema or home) Attend weddings, funerals, anniversaries Dining out Attend parties Shopping	1 2 3 4 5 6 7 8 9	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Play sports or exercise alone Play sports or exercise with others Attend festivals, cultural/community events Attend community/group/club meetings Other *(specify):* _____	10 11 12 -77 [ ]	
F43	In the past 1 month, did you participate in any of the following activities? *(Interviewer: Read respond options)* *Interviewer: Select ALL that apply* *Coder: Show respond options that were selected in F42 only.*	Meet friends Call, SMS, e-chat with friends/relatives Call, SMS, e-chat with strangers Watch a movie (at cinema or home) Attend weddings, funerals, anniversaries Dining out Attend parties Shopping Play sports or exercise alone Play sports or exercise with others Attend festivals, cultural/community events Attend community/group/club meetings Other	1 2 3 4 5 6 7 8 9 10 11 12 -77	
F44	Exclude services that you may have been receiving from the *[UIP: A12]*, have you used **social participation support** in the past 6 months? *For example, taking you out to seeing a friend, dining out, attending parties, playing sport, attending community meetings, etc.* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from*	No Yes Prefer not to answer Don't know/Don't remember	0 1 -88 -99	0☐ F46 -88☐ F47 -99☐ F47

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	the [UIP: A12]," if social participation support was not provided by the [UIP: A12], i.e. A13 ☐8.			
F45	In general, how satisfied were you with quality of social participation support that you have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	☐ F47
F46	Why have you not accessed social participation support over the past 6 months? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	I don't need it Not capable of participating social activities Don't know /Lack of information The support does not meet my needs Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Fear of discrimination/stigma if participating in social activities Too expensive/Could not afford No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other (*specify*): _____ Prefer not to answer Don't know	1 2 3 4 5 6 7 8 9 10 11 12 13 -77 [ ] -88 -99	
Other services				
F47	***(Automatic)*** *Check E9:* The beneficiary self-identified as a person with disabilities?	No: E9 ≠ 1 Yes: E9 = 1	0 1	0 ☐ F50

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
F48	Exclude services that you may have been receiving from the *[UIP: A12]* and any of the services we just discussed, have you used **any other services supporting persons with disabilities** in the past 6 months? *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if other supporting was not provided by the [UIP: A12], i.e. A13☐-77.*	No Yes Prefer not to answer Don't know/Don't remember	0 1 -88 -99	0☐ F50 -88☐ F50 -99☐ F50
F49	Please specify *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* *(Automatic) Select social protection support (code 1) if C17=1*	Social protection support Gifts or money on events Other *(specify):* _____	1 2 -77 [ ]	
F50	How has the COVID-19 pandemic affected your **ability to access** services you need for your condition? *(Interviewer: Read respond options 1 to 4)* *Interviewer: your condition = your disability or functioning condition.*	No effect A lot harder to access A little harder to access Easier to access N/A (didn't need support before pandemic) Prefer not to answer Don't know	0 1 2 3 4 -88 -99	
F51	To what extent do you believe the effects of the COVID-19 pandemic are impacting your current quality of life? *(Interviewer: Read respond options 1 to 5)*	Made it a lot worse Made it a little worse No effect Made it better Made it a lot better Prefer not to answer Don't know	1 2 3 4 5 -88 -99	

G	HOUSEHOLD			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
G1	How many people are your household members who are currently living here? *(Interviewer: including the beneficiary)* *Interviewer: Household members who are currently living here include a group of people living in the same house/shelter and share meals together on daily basis.*	*(Type in: Numeric only)*	[ ]	
G2	How many other people are your household members but not currently living here? *Interviewer: As defined by the respondent.*	*(Type in: Numeric only)*	[ ]	

G3. Household members

I would like to ask you few more questions about all of your household members, except [***beneficiary name: A2***] as we already collect most of his/her:

Cross check: G1+G2 = number of persons in G3; if it's not correct show a warning message.

#	Name	Group G1/G2	Gender	Age	Working & earning income in the past 6 months? *(for 15+ yo.)*	Relationship to the beneficiary	Completed education
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
1	(Beneficiary's name)	(G1)	(automatic: C2)	(auto: C3/C5)	(automatic: 1 if C15=1)	(The beneficiary)	(automatic: C8)
2			1=M; 2=F; 3=Other; -88= Prefer not to answer		0=No; 1=Yes; -99 DK		
3			1=M; 2=F; 3=Other; -88= Prefer not to answer		0=No; 1=Yes; -99 DK		
4			1=M; 2=F; 3=Other; -88= Prefer not to answer		0=No; 1=Yes; -99 DK		

#	Name	Group G1/G2	Gender	Age	Working & earning income in the past 6 months? *(for 15+ yo.)*	Relationship to the beneficiary	Completed education
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
5			1=M; 2=F; 3=Other; -88= Prefer not to answer		0=No; 1=Yes; -99 DK		
6			1=M; 2=F; 3=Other; -88= Prefer not to answer		0=No; 1=Yes; -99 DK		
7			1=M; 2=F; 3=Other; -88= Prefer not to answer		0=No; 1=Yes; -99 DK		
8			1=M; 2=F; 3=Other; -88= Prefer not to answer		0=No; 1=Yes; -99 DK		
9			1=M; 2=F; 3=Other; -88= Prefer not to answer		0=No; 1=Yes; -99 DK		
10			1=M; 2=F; 3=Other; -88= Prefer not to answer		0=No; 1=Yes; -99 DK		
11	…		1=M; 2=F; 3=Other; -88= Prefer not to answer		0=No; 1=Yes; -99 DK		

Codes for Column g: 1=Children; 2=Parent; 3=Spouse; 4=Sibling; 5=Grant-parent; 6=Grant-children; 7=Other

Codes for Column h: Completed grade in formal education system (12-year system); write 0 if not going to school; write 13 if greater than 12 (e.g. graduate or post-graduate); write -99 if don't know.

NO.	QUESTION	RESPONSE	OPT	SKIP
G4	Who is the household head? *Interviewer: Head of household according to self-identified respondents or household registration. The head of household must be the person named in section G3 or the beneficiary.*	*Drop list from G3* *(Write code from Column (a) in G3; show name, age, gender of HH head for interviewer to check again after entering the code)*	[ ]	
G5	Are you dependent on someone to help with your self-care activities (i.e. caregiver)? *(Interviewer: Read respond options 1 to 4)*	Not at all/Hardly at all A little bit Moderately Severely Prefer not to answer Don't know	1 2 3 4 -88 -99	1 ☐G7
G6	Who is your main caregiver? *Interviewer: Main caregiver as identified by the beneficiary or discussion among family members. If still do not know: it's the person who spend largest amount of time to assist daily activities of the beneficiary.*	*Drop list from G3* *(Write code from Column (a) in G3; show name, age, gender of the main caregiver for interviewer to check again after entering the code)* Non-household-member *(specify: sex, age, relationship to the beneficiary)* Prefer not to answer Don't know	[ ] -77 [ ] -88 -99	
G7	What is your household's living standard as officially classified by government office? *(Interviewer: Read respond options 1 to 3)*	Poor Near poor Not poor Prefer not to answer Don't know	1 2 3 -88 -99	

The following questions ask about your house and your household

NO	QUESTION	RESPONSE	OPT	SKIP
G8	How many square meters is your land?	*(Record in m2; numeric only)* *Don't know*	[ ] -99	
G9	What is total usable area of your house in square meter?	*(Record in m2; numeric only)* *Don't know*	[ ] -99	

NO	QUESTION	RESPONSE	OPT	SKIP
G10	Does this house own by your family members or someone else? *Interviewer: Read respond categories.*	*Owned by family members of the beneficiary* *Owned by someone else: rental/borrowed* Prefer not to answer Don't know	1 2 -88 -99	
G11	What is the main type of fuel (energy) that your household uses for cooking?	Electricity Gas/biogas Charcoal Firewood Others *(specify)* _____ Nothing Prefer not to answer Don't know	1 2 3 4 -77 [ ] 0 -88 -99	
G12	What is your main source of water for cooking?	Tap water Purchased water (tanks, bottles ...) Drilled well Protected dug well Unprotected dug well Protected borehole Unprotected borehole Rain water Others *(specify)* _____ Prefer not to answer Don't know	1 2 3 4 5 6 7 8 -77 [ ] -88 -99	
G13	What type of toilet does your household use?	Septic/semi-septic toilets in compound Septic/semi-septic toilet outside compound Others Don't have toilet	1 2 3 4	

NO	QUESTION	RESPONSE	OPT	SKIP
G14	Does your household currently have the following assets? *Interviewer:* • *Read response options* • *Select ALL that apply* • *Only count functioning ones*	Television Radio (radio/radio casetts) Computer (desktop, laptop) Landline/mobile/tablet phone Refrigerator Washing machine Hot and cold shower Air conditioning Motorcycles / mopeds / electric bicycles / electric motorbikes Bicycle Boats Car	1 2 3 4 5 6 7 8 9 10 11 12	

H	WRAP-UP. RECONTACT DETAILS			
NO.	QUESTION	OPTION	OPT	SKIP
H1	***[Interviewer: Do not ask]*** Did someone help the beneficiary respond to the interview?	No help given Yes, another person answered for few questions Yes, another person answered for less than a half of the questions Yes, another person answered about a half of the questions or more Yes, another person answered all of the questions	0 1 2 3 4	0☐H4
H2	Name of person helping with interview	*Drop list from G3* Other (*specify*): _____	[ ] -77 [ ]	≠-77☐H4
H3	Relationship to the beneficiary	_____	[ ]	
H4	Thank you so much for your time today! We would like to come back to visit you in six months' time to see how you are doing and if anything has changed. Is that OK with you?	No Yes Unsure	0 1 2	1☐ H6 2☐ H6

H	WRAP-UP. RECONTACT DETAILS			
NO.	QUESTION	OPTION	OPT	SKIP
H5	Why can we not revisit? *Interviewer: If needed, help them understand the procedures and try to work out a more suitable option.*	Will not be at home in 6 months Time consuming It bothers me Just don't want another visit Other (*specify*)_____	1 2 3 4 -77 [ ]	
H6	Primary phone number for recontact	*(Type in: Numeric only)* Not available	[ ] -99	
H7	Primary phone owner name	*Drop list from G3* Other (specify): _____	[ ] -77 [ ]	≠-77àH9
H8	Relationship to the beneficiary	_____	[ ]	
H9	Secondary phone number for recontact	*(Type in: Numeric only)* Not available	[ ] -99	
H10	Secondary phone owner name	*Drop list from G3* Other (specify): _____ Not available	[ ] -77 [ ] -99	
H11	*(Automatic)* End Timestamp	*(Automatically generated)*		
H12	***[Do not ask]*** GPS location	Lat Long Accuracy	[ ] [ ] [ ]	
H13	***[Do not ask]*** Notes about location for recontact *(for example, characteristics of the house, location, nearby landmarks, etc.)*	*(Type in)*	[ ]	
H14	***[Do not ask]*** Notes about nature of disability or disposition future data collector may need to know to do appropriate, sensitive outreach.	*(Type in)*	[ ]	
H15	***[Do not ask]*** Interviewer's comments about the interview	*(Type in)*	[ ]	

Thank you very much!

ANNEX 7.2: CHILDREN QUESTIONNAIRE

HEALTH & QUALITY OF LIFE SURVEY

BASELINE CHILD MODULE

Text's color codes: Red: Notes for coders (or data entry programmers); Blue: Notes for interviewers.

Interviewer:

- Request to talk to the **child respondent** [*child name: A2*] AND her/his **caregiver** or an adult member of the family
- Child respondent must be accompanied by an adult family member at ALL time.
- If the respondent needs help from another person to answer, invite that person to join the interview.
- For the QOL module, try to interview child respondent as much as you can; only interview adult family member on behalf of the child if the child cannot respond or you are guided to do so.

B	**INTRODUCTION and CONSENT**			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
B1	(*Automatic*) Date/time stamp	*(automatically recorded)*	[ ]	
B2	Does [*child name: A2*] need help from anyone to answer some or all questions?	No help needed Yes, need help to answer some questions Yes, depend entirely on another person to respond	0 1 2	0☐B5.a
B3	What prevent [*child name: A2*] from being able to respond to questions?	Child is unable (e.g. mute) to communicate or has a lot of difficulties in communication Respondent need an interpreter (e.g. use sign language, native language) Child does not have enough awareness Disability prevents understanding, e.g. intellectual disabilities, dementia Just don't feel comfortable Other (*specify*) _____ Prefer not to answer	1 2 3 4 5 -77 [ ] -88	
B4	What is the name of the person who will help the target respondent?		[ ]	

B5. INFORMED CONSENT

B5.a. Child Caregiver

Hello. My name is _____, and I am here on behalf of DEPOCEN, a company called Social Impact, and USAID. I understand [*child name: A2*] is receiving some help for your health condition from [*UIP: A12*], with support from USAID. We are collecting data to understand quality of life for people who receive this support. What we learn will help these service providers and USAID improve their work in the future so they can provide better support.

I'd like to invite you and [*child name: A2*] to participate in a survey. I'll ask you some questions about your household situation, the child's condition, [*child name: A2's*] satisfaction with their life and the services [*child name: A2*] received.

If it's OK with you and [*child name: A2*], I would like [*child name: A2*] to respond as much as possible under your supervision. There is one particular section of the survey where I would like to talk directly to the child if possible to hear their own feelings about their quality of life.

This survey will take about 30 minutes to 1.5 hours of your time, with short breaks scheduled throughout. We randomly selected and will be visiting more than one hundred children who received or will be receiving the support from the USAID to do this.

Your participation in this study is completely voluntary. You can refuse to participate, even without giving a reason. You can also choose to just not answer any question that you don't like or don't feel comfortable to respond.

If you choose to participate in the survey, we will give you a 100,000 VND phone card. You will receive the phone card even if you or [*child name: A2*] skips some questions or chooses to stop the survey part-way through. Your participation may also help us to improve services for [*child name: A2*] and other people in the future. Your responses will not change our current or committed support to you. If you or [*child name: A2*] becomes unavailable or starts to feel tired at any time during the interview, please let me know; we can take another break or make a new schedule to complete the interview at your convenience.

Because of the COVID-19 pandemic we are working hard to reduce any risk of spreading the disease. Our full team is being tested at least weekly out of an abundance of caution, and I can confirm my last two tests have been negative. Our team is operating in full compliance with the COVID-19 regulations of the government of Vietnam. I will be wearing a face mask the entire time we are speaking and will sanitize my hands as needed. We are required to complete the survey outside to reduce the risk of COVID-19; however, we can make an exception if that would not work for you. If we need to complete the survey inside, we require that both of us wear a mask and we open the windows. Please advise if you have any additional safety requests or precautions you would like for us to take.

We work hard to protect your privacy. The information you share with me will be kept confidential. Even your service provider will not know what you say or if you choose to participate in this survey. We want you to feel free to be honest. Your personal information like name, address, contact information, and other things that could identify you or [*child name: A2*] will not be shared with anyone outside of a small research team. We will only use this information to contact you, and it will be password-protected. We will reach out to you in about six months for a follow up survey. You may also be contacted by someone from our team between now and then to participate in a very brief (5-10 minute) questionnaire about your experience with this survey.

After removing any information that could identify you or [*child name: A2*], the data we collect may be combined with other study participants' data and shared publicly for future research purposes. If you have any questions or concerns about the survey or your rights as a participant, you may contact Ms. Nguyen Thi Phuong Mai via her cell phone 0912722494 or email mainguyen@depocen.org. You may also contact Social Impact's institutional review board at irb@socialimpact.com, or the University of Hanoi institutional review board at irb@huph.edu.vn.

I will leave a copy of this form with you if you want to keep this information about the study.

NO.	QUESTION	RESPONSE	OPT	SKIP
B6	Do you have any question about the survey? *Interviewer: Respond if you can; be always honest. Contact your field supervisor if you do not have the answer.*	No Yes	0 1	
B7	Do you agree to participate in this study?	No Yes	0 1	0☐B9
B8	We would like to record this interview for quality control purposes. We will delete the record within 3 months after this interview. Do you agree for this interview to be recorded?	No Yes	0 1	☐B5.b
B9	Would you kindly share why you don't want to participate?	No time Not comfortable Concern about personal information Concern about COVID Concern about US government Other *(specify)*_____ Prefer not to answer	1 2 3 4 5 -77 [ ] -88	2☐END 3☐END 4☐END 5☐END -77☐END Address/ END -88☐END
B10	Is there a more convenient time that I could come back to talk to you and [*child name: A2*]?	No Yes	0 1	0☐END
B11	When would you like to reschedule for?		[ ]	☐END

Interviewer: Request to talk to the **child respondent** [*child name: A2*]

B5.b INFORMED CONSENT (Child Assent)

Hello. My name is _____. I am working with a company in the United States to gather information about people like you in Vietnam. We know that you receive some help for your health condition from an organization called [*UIP: A12]*. We want to learn about people's lives and happiness who receive this help so we can make it better in the future.

I just spoke to [*NAME: B4*], and s/he has agreed that it is okay for you to participate in this discussion if you want to. First, I will tell you more about what will happen, then it will be up to you whether you would like to do it.

If you participate, I would ask you some questions about your health, your happiness, what it's like at home, and your friends. This will take about 10 minutes of your time. We will take a quick break halfway through and we can take more breaks if you want. Whether you participate in this discussion is completely up to you. It is also

okay if we start the conversation, and you change your mind and want to stop. You can also skip any questions you do not want to answer.

We are being very careful because of COVID-19. I want to let you know that I am not currently sick. To help us stay healthy, I will wear this mask when we talk, I will sanitize my hands regularly, and we will have our discussion outside. Please let me know if there is anything else you'd like me to do to feel safe.

The information you share with me will only be shared with my small team and kept very secure. Later when we have this information from lots of other people, we will combine your information with others' and share it publicly, but we will not share things like your name with anyone else.

I left a copy of the information I've shared with you here with your family in case you have any questions later on.

NO.	QUESTION	RESPONSE	OPT	SKIP
B12	Do you have any question about the survey? *Interviewer: Respond if you can; be always honest. Contact your field supervisor if you do not have the answer.*	No Yes	0 1	
B13	Do you agree to participate in this study?	No Yes	0 1	0☐B16
B14	We would like to record this interview for quality control purposes. We will delete the record within 3 months after this interview. Do you agree for this interview to be recorded?	No Yes	0 1	
B15	*(Automatic)* Check B8 & B14 *Coder: Show a reminding message to Enumerator to record/not to record the interview before C1 if possible.*	B8=0 B8=1 & B14=0 B8=1 & B14=1	1 2 3	1☐C1 **without** recording 2☐C1 **without** recording 3☐C1 with recording
B16	Would you kindly share why you don't want to participate?	No time Not comfortable Concern about personal information Concern about COVID Concern about US government Other *(specify)*_____	1 2 3 4 5 -77 [ ]	 2☐END 3☐END 4☐END 5☐END -77☐END Address/

NO.	QUESTION	RESPONSE	OPT	SKIP
		Prefer not to answer	-88	END - 88☐END
B17	Is there a more convenient time that I could come back to talk to you and [*child name: A2*]?	No Yes	0 1	0☐END
B18	When would you like to reschedule for?		[ ]	☐END

C	SOCIO-ECONOMIC CHARACTERISTICS OF THE RESPONDENT			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
C1	Can you please confirm the child's name in full is [*child name: A2*]? *NOTE for Interviewer:* • *If it's not correct: Check with field supervisor to make sure that you are meeting the right child for the interview. If it is still correct (e.g. the child has 2 names), continue the interview. If it is not the right respondent, seek approval from your field supervisor, politely thank the child and caregiver, and END the interview.* • *If the respondent refuses to respond and there is no way to confirm that this is the right respondent, seek approval from your field supervisor, politely thank the child and caregiver, and END the interview.*	Yes, correct No, not correct Prefer not to answer	1 0 -88	0☐NOTE -88 ☐ NOTE
C1.a	Interviewer: Continue to interview?	No Yes		
C1.b	Interviewer: Please specify why the beneficiary's name is incorrect and why the interview is discontinued.		[ ]	END
C2	What is [child *name*]'s gender?	Male Female Other gender Prefer not to answer	0 1 2 -88	

C	SOCIO-ECONOMIC CHARACTERISTICS OF THE RESPONDENT			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
C3	Our record showed that your date of birth is: [*pre-filled from IP: A10*] or your age is [*Estimated from A10*] Is this correct? *Interviewer: If there is any missing information (e.g. month of birth), ask and correct if possible.*	No/Missing information Yes Don't know	0 1 -99	 1☐C5 -99☐C5
C4	Correct age:		[ ]	☐C6
C5	Could you tell me your [child *name's*] age range? *Coder: Fill automatically (using age estimated from A10) if C3=1.* *Interviewer:* *If the child respondent is 18 or older, get approval from your field supervisor to use Adult Self-report Form or stop the interview.* *If the child respondent is younger than 5 years old, get approval from your field supervisor to stop the interview.*	<5 years old 5-8 years old 9-12 years old 13-17 years old 18 or older Prefer not to answer Don't know	1 2 3 4 5 -88 -99	1☐ END 5☐ ADULT MODULE -88 ☐ END -99 ☐ END
C6	*(Automatic)* Check age of the child	AGE <5 (C4<5 OR C5=1) AGE>=5 (C4>=5 OR C5>1)	1 2	1☐END
C7	Is [child *name*] currently in school? *Interviewer: Apply to formal education only. Include online programs. Exclude vocational training.*	No Yes Prefer not to answer	0 1 -88	
C8	What is the highest grade of schooling that [child *name*] has completed? *Interviewer:* ● *Consider special education schooling the same as mainstream school categories. Special education programs such as special education for children with disabilities or have functional difficulties, supplemental education (continuing education), vocational secondary school and additional cultural studies, etc.*	Grade completed Prefer not to answer Don't know	[ ] -88 -99	

C	SOCIO-ECONOMIC CHARACTERISTICS OF THE RESPONDENT			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	• *Completed grade in formal education system (12-year system); write 0 if not going to school; write 13 if greater than 12 (e.g. graduate or post-graduate);*			
C9	Has [child *name*] ever attended vocational training? *Interviewer: Do not count vocational training as a subject in formal education programs.*	No Yes	0 1	0☐C11
C10	How long was the training? *Interviewer: Total months of all trainings. Do not count compulsory vocational training as a subject in formal education programs.*	*(Record in months: Numeric only)* Prefer not to answer Don't know	[ ] -88 -99	
C11	*(automatic)* Check age of the child	AGE<15 AGE>=15 AGE= "Don't know" or "Prefer not to answer"	1 2 3	1 ☐ D1
C12	What is your [child name] main work in the past 6 months? *Interviewer:* • *Grab is working for others; traditional "xe om" (bike taxi) self-selling lottery tickets are self-employed;* • *If the respondent says "No", follow-up and ask "Do you do housework?"*	Working for the family Working for others Self-employed Housework (for the family) Not working & not looking for a job Not working & looking for a job (unemployed) Prefer not to answer	1 2 3 4 5 6 -88	5 ☐ C16 6 ☐ C16 -88☐C15
C13	Describe your [child name] main work in the past 6 months		[ ]	

C	SOCIO-ECONOMIC CHARACTERISTICS OF THE RESPONDENT			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
C14	On average, how many hours per week did you [child name] work? *Interviewer:* • *For all jobs (paid and unpaid)* • *Calculate together with NTL to figure out the number of hours if needed. You can calculate the average number of hours per day and multiply by 1 week. If the respondent does not remember exactly, try to ask for the best estimate and limit to -99.*	*(Type in: Numeric only)* Prefer not to answer Don't know	[ ] -88 -99	
C15	Did your [child name] earn income from the current works in the past 6 months? *Interviewer: Income in cash or in kind*	No Yes Prefer not to answer	0 1 -88	
C16	Do you have any income that does not come from your work in the past 6 months? E.g. subsidize.	No Yes Prefer not to answer	0 1 -88	

SECTION D. QUALITY OF LIFE

If possible, interviewer asks child directly this part

Interviewer: Please use the information from the socio-demographic sheet to adapt the wording for the following concepts:

1. *If child does not live with parents, replace the word 'parents' by the person who is taking care of the child (e.g. grand-parent, other family member, tutor, guardian).*
2. *When 'home' is mentioned, it refers to where the child is living now.*
3. *Give the child the response scale page so he/she can point his/her answer for each question.*

For each question, please choose the word or circle that best describes what you think or how you feel in general. Not necessarily today or yesterday but in your life in general. There is no right or wrong answer, it's your opinion.

In general, would you say …

Interviewer: Use Flashcard #10 (pink one)	Never	Not often/ a little	Often/ a lot	Always	Did not provide answer	Don't know	Proxy needed to respond
Physical well-being dimension							

Interviewer: Use Flashcard #10 (pink one)		Never	Not often/ a little	Often/ a lot	Always	Did not provide answer	Don't know	Proxy needed to respond
D1	… you are healthy?	1	2	3	4	-88	-99	-55 ≠-55 ☐D2
D1p	… [child name] is healthy?	1	2	3	4	-88	-99	
D2	… you can do activities other kids your age can do?	1	2	3	4	-88	-99	-55 ≠-55 ☐D3
D2p	… [child name] can do activities other kids their age can do?	1	2	3	4	-88	-99	
D3	… you have enough food to eat?	1	2	3	4	-88	-99	-55 ≠-55 ☐D4
D3p	… [child name] has enough food to eat?	1	2	3	4	-88	-99	
Emotional well-being dimension								
D4	… you are happy with your life?	1	2	3	4	-88	-99	-55 ≠-55 ☐D5
D4p	… [child name] is happy with their life?	1	2	3	4	-88	-99	
D5	… you feel loved	1	2	3	4	-88	-99	-55 ≠-55 ☐D6
D5p	… people around *[child name]* talk and show love to her/him?	1	2	3	4	-88	-99	
D6	… you feel you will be able to reach your goals, dreams when you are grown-up? (like earn money, continue schooling, have a family)?	1	2	3	4	-88	-99	-55 ≠-55 ☐D7
D6p	… parent of *[child name]* believe that she/he will achieve something in her/his life when she/he are grown-up? (like earn money, continue schooling, have a family)?	1	2	3	4	-88	-99	
D7	… you are worried?	1	2	3	4	-88	-99	-55 ≠-55 ☐D8
D7	… [child name] is worried?	1	2	3	4	-88	-99	

Interviewer: Use Flashcard #10 (pink one)		Never	Not often/ a little	Often/ a lot	Always	Did not provide answer	Don't know	Proxy needed to respond
D8	… you are sad?	1	2	3	4	-88	-99	-55 ≠-55☐D9
D8p	… [child name] is sad?	1	2	3	4	-88	-99	
Safety dimension								
D9	… you are afraid to go outside your house?	1	2	3	4	-88	-99	-55 ≠-55 ☐D10
D9p	… [child name] is afraid to go outside their house?	1	2	3	4	-88	-99	
D10	… there is fighting, quarrelling at home?	1	2	3	4	-88	-99	-55 ≠-55 ☐D11
D10p	… there is fighting, quarrelling at [child name]'s home?	1	2	3	4	-88	-99	

You are doing great! Let's continue. In general, would you say …

Interviewer: Use Flashcard #10 (pink one)		Never	Not often/ a little	Often/ a lot	Always	Did not provide answer	Don't know	Proxy needed to respond
Autonomy and self-realization dimension								
D11	… you have a chance to learn new things/develop new skills?	1	2	3	4	-88	-99	-55 ≠-55 ☐D12
D11p	… [child name] has a chance to learn new things/develop new skills?	1	2	3	4	-88	-99	
D12	… you have time to do things you like	1	2	3	4	-88	-99	-55 ≠-55 ☐D13
D12p	… you [i.e. child name] are free to do what she/he would like to do?	1	2	3	4	-88	-99	
D13	… your parents are proud of you	1	2	3	4	-88	-99	-55 ≠-55 ☐D14

Interviewer: Use Flashcard #10 (pink one)		Never	Not often/ a little	Often/ a lot	Always	Did not provide answer	Don't know	Proxy needed to respond
D13p	… [child name]'s parents are proud of them?	1	2	3	4	-88	-99	
D14	… your parents listen to what you think: your ideas or suggestions or opinions	1	2	3	4	-88	-99	-55 ≠-55 ☐D15
D14p	… [child name]'s parents listen to what they think: their ideas, suggestions, or opinions?	1	2	3	4	-88	-99	
D15	…you are doing chores/housework at home (for example, dish washing, cleaning the house, helping parents to cook or prepare food, folding clothes, fetching water, etc.)?	1	2	3	4	-88	-99	-55 ≠-55 ☐D16
D15p	… [child name] is doing chores, housework at home? (for example, dish washing, cleaning the house, helping parents to cook or prepare food, folding clothes, fetching water, etc.)?	1	2	3	4	-88	-99	
D16	you feel good about doing chores/housework at home?	1	2	3	4	-88	-99	-55 ≠-55 ☐D17
D16p	[child's name] feels good about doing chores/housework at home?	1	2	3	4	-88	-99	
D17	… you are good at making friends?	1	2	3	4	-88	-99	-55 ≠-55 ☐D18
D17p	… [child name] is good at making friends?	1	2	3	4	-88	-99	
D18	… you eat meals together as a family?	1	2	3	4	-88	-99	-55 ≠-55 ☐D19
D18p	… [child name] eats meals together as a family?	1	2	3	4	-88	-99	

Interviewer: Use Flashcard #10 (pink one)		Never	Not often/ a little	Often/ a lot	Always	Did not provide answer	Don't know	Proxy needed to respond
D19	… you have someone to talk to about your feelings, worries, or concerns?…	1	2	3	4	-88	-99	-55 ≠-55 ☐D20
D19p	… [child name] has someone to talk to about their feelings, worries, or concerns?	1	2	3	4	-88	-99	
D20	… you participate in activities in your community (going to church, wedding, sport day or other examples relevant for gender and country)…	1	2	3	4	-88	-99	-55 ≠-55 ☐D21
D20p	… [child name] participates in activities in their community (going to church, wedding, sport day or other examples relevant for gender and country)?	1	2	3	4	-88	-99	
D21	… Other kids are kind to you?…	1	2	3	4	-88	-99	-55 ≠-55 ☐D22
D21p	Other kids are kind to you [i.e. child name]	1	2	3	4	-88	-99	

HAPPINESS related questions

NO.	QUESTION	RESPONSE	OPT	SKIP
D22	In this question, we would like to know how happy you are. I am going to show you numbers from 0 to 5 (*Interviewer: show Flashcard #11 in blue to the child*). 0 means not happy at all and 5 means extremely happy. You can choose any number you want, 0, 5 or any number in between. Tell me or show me the number that best describes how happy you are in general.	<Write a number between 0 and 5> Proxy needed to respond	[ ] -55	If age >8 (check C3, C4 & C5) ☐ D23 ≠-55☐ D23

NO.	QUESTION	RESPONSE	OPT	SKIP
D22p	In this question, we would like to know how happy [child name] is. I am going to show you numbers from 0 to 5 (*Interviewer: show Flashcard #11 in blue to the child*). 0 means not happy at all and 5 means extremely happy. You can choose any number you want, 0, 5 or any number in between. Tell me or show me the number that best describes how happy [child name] is in general.	<Write a number between 0 and 5>	[ ]	If age>8 (check C3 & C4, and C5) ☐ D24

NO.	QUESTION	RESPONSE	OPT	SKIP
D23	In this question, we would like to know how you would rate your quality of life. I am going to show you numbers from 0 to 10 (*Interviewer: show Flashcard #12 in brown to the child*). 0 means worst quality of life possible and 10 means best quality of life you can imagine. You can choose any number you want, 0, 10 or any number in between. Tell me or show me the number that best describes how you would rate your quality of life in general.	0-10 Proxy needed to respond	1-10 -55	 ≠-55☐ D24
D23p	In this question, we would like to know how you would rate [child name]'s quality of life. I am going to show you numbers from 0 to 10 (*Interviewer: show Flashcard #12 in brown to the child*). 0 means worst quality of life possible and 10 means best quality of life you can imagine. You can choose any number you want, 0, 10 or any number in between. Tell me or show me the number that best describes how you would rate [child name]'s quality of life in general.	0-10	[ ]	

NO.	QUESTION	RESPONSE	OPT	SKIP
D24	Now I would like you to please think about your [child name]'s life six months ago [that is, around month, year = Current time – 6 months]. How would you say your [child name]'s quality of life today compared to six months ago? *(Interviewer: Read response options 1 to 5)*	A lot worse A little worse Same A little better A lot better Prefer not to answer Don't know Proxy needed to respond	1 2 3 4 5 -88 -99 -55	 3☐E1 -88☐E1 -99☐E1 ≠-55 ☐D25

NO.	QUESTION	RESPONSE	OPT	SKIP
D24p	Now I would like you to please think about [child name]'s life six months ago [that is, around month, year = Current time – 6 months]. How would you say [child name]'s quality of life today compared to six months ago? *(Interviewer: Read response options 1 to 5)*	A lot worse A little worse Same A little better A lot better Prefer not to answer Don't know	1 2 3 4 5 -88 -99	 3☐E1 -88☐E1 -99☐E1
D25	Can you tell me the things that you think caused your [child name's] quality of life to get [*selected response option in D24 or D24p*]? *Interviewer:* • *Select ALL that apply.* • *PROBE: Is there anything else?*	Received treatment/service related to disability Change in acceptance/inclusion Change in access/availability of service for disability Change in pre-existing physical/mental health condition New injury/accident Economic/money issues Job/employment COVID-19 pandemic related Family/social relationship change (not related to acceptance, inclusion) Change to natural environment or natural disaster Other *(specify)* _____ Prefer not to answer Don't know	1 2 3 4 5 6 7 8 9 10 -77 [ ] -88 -99	 -88☐E1 -99☐E1
D26	Out of these things you mentioned, which do you think is the <u>most important</u> factor that has changed your [child name's] quality of life in the past six months?	*(Write code from D25; Skip this question if only 1 response option was selected in D25; Show only the selected response options in D25.)*		

E	HEALTH & DISABILITY			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
E1	How is your [child name]'s health? *(Interviewer: Read response options 1 to 5)*	Very poor Poor Neither poor nor good Good Very good Prefer not to answer	1 2 3 4 5 -88	
E2	Do you [child name] have a valid health insurance card?	No Yes Prefer not to answer Don't know	0 1 -88 -99	0☐E5 -88☐E5 -99☐E5
E3	Do you [child name] have a public or private health insurance or both?	Public only Private only Both Prefer not to answer Don't know	1 2 3 -88 -99	
E4	How often do you [child name] use it? *Interviewer: Read response options 1 to 6 if needed.*	Weekly Monthly (at least once a month) Quarterly (at least once/3 months) Semi-annually (at least once/6 months) Annually or less Never Prefer not to answer Don't know	1 2 3 4 5 6 -88 -99	

Interviewer: For questions under E5: The child should answer the questions him/herself; encourage him/her to do so.

E5. The next questions ask about difficulties you [child name] may have doing certain activities because of a HEALTH PROBLEM.

	Interviewer: Use Flashcard #7 (white one)	No difficulty	Some difficulty	A lot of difficulty	Cannot do at all	Prefer not to answer	Don't know
E5a	Do you [/child name] have difficulty **seeing**, even if wearing glasses? Would you say … *[Read response option from 0 to 3]*	0	1	2	3	-88	-99
E5b	Do you [/child name] have difficulty **hearing**, even if using a hearing aid(s)? Would you say … *[Read response options from 0 to 3]*	0	1	2	3	-88	-99
E5c	Do you [/child name] have difficulty **walking or climbing steps**? Would you say … *[Read response options from 0 to 3]*	0	1	2	3	-88	-99
E5d	Do you [/child name] have difficulty **remembering or concentrating**? Would you say … *[Read response options from 0 to 3]*	0	1	2	3	-88	-99
E5e	Do you [/child name] have difficulty with **self-care**, such as washing all over or dressing? Would you say … *Read response options from 0 to 3]*	0	1	2	3	-88	-99
E5f	Using your usual language, do you [/child name] have difficulty **communicating**, for example understanding or being understood? Would you say … *Read response options from 0 to 3]*	0	1	2	3	-88	-99

NO.	QUESTION	RESPONSE	OPT	SKIP
E5g	***[DO NOT ASK]*** *Interviewer to fill:* Did the child answer these E5 questions by himself/herself?	No help needed Someone helps answered 1 question Someone helps answered 2 questions Someone helps answered 3-5 questions Someone helps answer 6 questions	0 1 2 3 4	

NO.	QUESTION	RESPONSE	OPT	SKIP
E6	Do you [child name] have any other functional difficulties?	No Yes Prefer not to answer Don't know	0 1 -88 -99	0☐E9 -88☐E9 -99☐E9
E7	What are they?	*(Specify)*_____	[ ]	
E8	What level of difficulty do you [child name] have? *Interviewer: Write the highest level if the respondent has more than one difficulty*	Some A lot of difficulty Cannot do at all Prefer not to answer Don't know	1 2 3 -88 -99	
E9	Do you think that you/ your [child name] is a person with disability?	No Yes Prefer not to answer Don't know	0 1 -88 -99	
E10	Do you [child name] have a disability determination/certificate on disability?	No Yes Prefer not to answer Don't know	0 1 -88 -99	 1☐E12 -88☐E12 -99☐E12
E11	Why not? *Interviewer:* • *Select ALL that apply* • *Probe: Anything else?*	Not necessary Not interested Not approved Don't know how to get it Other *(specify)* _____ Prefer not to answer Don't know	1 2 3 4 -77 [ ] -88 -99	
E12	What is your [child name's] level of disability? *Interviewer:* • *Read response options if needed* • *It's the level of disability that a person has been given (in the disability certificate) or perceived level of disability for those who do not have a disability certificate.* • *If the respondent said severe, ask "Is that severe or very severe?"; cross check with disability certificate if possible.*	Mild Severe Very severe Prefer not to answer Don't know	1 2 3 -88 -99	

NO.	QUESTION	RESPONSE	OPT	SKIP
E13	What types of disability do you [child name] have? *Interviewer:* • *Read response options if needed* • *Check disability certificate if possible.* • *Select ALL that apply.* • *Probe: Anything else?*	Physical Hearing Speech Vision Cognitive & Mental health Intellectual Other (*specify*)_____ Prefer not to answer Don't know	1 2 3 4 5 6 -77 [ ] -88 -99	
E14	Are you [child name] a member of a Organization of Person with Disabilities (ODP)? *Interviewer: OPDs are organizations of persons with disabilities where persons with disabilities constitute a majority (at least 51%) of the staff and board at all levels of the organization. Include online OPDs.*	No Yes Having a family representative to participate Prefer not to say Don't know	0 1 2 -88 -99	 1☐E16 -88☐E16 -99☐E16
E15	Why not? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Admission refused /Not qualified Not interested OPDs are not active OPDs do not exist Don't know how to join Too far/inaccessible Don't have time Too weak (health) Cannot communicate with others Other (*specify*)_____ Prefer not to answer Don't know	1 2 3 4 5 6 7 8 9 -77 [ ] -88 -99	
E16	Can you list any government laws, policies, welfare, subsidizes supporting people with disabilities that you [child name] are aware of? *Interviewer:* • *Do not read response categories and do not hint* • *Select ALL that apply.* • *Probe: anything else?*	Not aware of any Education fee exemption/reduction Other financial support on education (e.g. scholarship provision) Public transport fee exemption Social welfare/subsidy Loan with preferential interest rate	0 1 2 3 4 5 6 7	0☐E18

NO.	QUESTION	RESPONSE	OPT	SKIP
		Health care fee exemption/insurance Employment priority Law on Person with Disability Vocational training Priority university admission Late school enrollment Other *(specify)*_____ Prefer not to answer	8 9 10 11 -77 [ ] -88	
E17	Have you read or known content of the Law on Persons with Disabilities?	No Yes	0 1	
E18	(*Automatic*) Does this child has functional difficulty or disability? (i.e. Yes if (E5a/b/c/d/e/f)=2 or (E5a/b/c/d/e/f)=3 or E8=2 or E8=3 or E9=1)	No Yes	0 1	0☐F0
E19	Do you know what are the causes of your disability or functional difficulty? *Interviewer:* - *Do not read response options* - *Select ALL that apply* - *Probe: Anything else?*	Indicated at birth Illness/ Diseases Accident Injury during wartime Agent Orange (dioxin) Others *(specify)* _____ Prefer not to answer Don't know	1 2 3 4 5 -77 [ ] -88 -99	
E20	For how long have you [child name] had a disability or functional difficulty? *Interviewer: Use the longer period if the respondent has more than one disability.*	Less than one year A year or more Prefer not to answer Don't know	1 2 -88 -99	
E21	Given the current functional difficulties, what are the challenges you [child name] face in your community? *(Interviewer: Read respond options 1 to 8 and -77)* *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Make friends: either direction*	Physical barriers or infrastructure Communication barriers Public attitudes/discrimination Participate in economic activities Participate in leisure activities Participate in social activities Make friends	1 2 3 4 5 6 7 8	

NO.	QUESTION	RESPONSE	OPT	SKIP
		Medical care	-77	
		Other	[ ]	
		*(specify)*_____	0	0 ☐ F0
		No challenges at all	-88	-88 ☐ F0
		Prefer not to answer	-99	-99 ☐ F0
		Don't know		
E22	Which is the biggest challenge?	*(SKIP this question if only 1 respond option was selected in E21. Show selected respond options in E21 only)*		
		Don't know	-99	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
Rehabilitation services				
F0	*(Automatic)* Check the first date of service from the [UIP: A12] to see if it is before the date of interview? *Coder:* • *Compare A14 with current date* • *"Exclude …" = the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," in F1, F2, F12, F16, F25, F26, F32, F36, F39, and F44.*	No Yes Don't know	0 1 -99	0 ☐Remove "Exclude…" 1 ☐ Use "Exclude…" -99 ☐ Use "Exclude…"
F1	Exclude services that you [child name] may have been receiving from the *[UIP: A12]*, have you [child name] **ever** used **rehabilitation services**? *For example, PT, ST, ST to recover a function, such as moving, walking, communicating, etc.* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP:*	No Yes Prefer not to answer Don't know/Don't remember	0 1 -88 -99	0☐F10 -88☐F12 -99☐F12

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	A12],” if rehabilitation service was not provided by the [UIP], i.e. A13☐1.			
F2	Exclude services that you [child name] may have been receiving from the *[UIP: A12]*, when was **the last time** you [child name] used **rehabilitation services**? *Coder: Remove the leading phrase “Exclude services that you may have been receiving from the [UIP: A12],” if rehabilitation service was not provided by the [UIP], i.e. A13☐1.*	*(write 0 if it’s less than a month ago)* Prefer not to answer Don’t know/Don’t remember	[ ] -88 -99	>6m☐F11 -88☐F12 -99☐F12
F3	In the past 6 months, how frequent did you [child name] access rehabilitation services? *Interviewer:* • *Exclude ones provided by the [UIP: A12].* • *Read respond options if needed.*	Daily (at least once a day) Weekly (at least once a week) Monthly (at least once a month) Few times over the past 6 months Once over the past 6 months None Prefer not to answer Don’t know/don’t remember	1 2 3 4 5 6 -88 -99	6 ☐ Check F1 F2
F4	In the past 6 months, how easy or difficult has it been for you [child name] and the family to access rehabilitation services to help your [child name’s] condition? *(Interviewer: Read respond option 1 to 4)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Very easy to access Easy to access Difficult to access Very difficult to access Prefer not to answer Don’t know	1 2 3 4 -88 -99	
F5	In the past 6 months, what challenges have you [child name] and the family faced in accessing rehabilitation services? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	No challenges Don’t know/lack of information Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance payment is too small Not at all covered by insurance	0 1 2 3 4 5 6 7 8 9 10	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation Rehab services did not meet my needs COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	112-77[ ] -88 -99	-88☐F7 -99☐F7
F6	What was the biggest challenge?	*(Write code from F5: allow selected codes only; if only 1 code was selected in F5 ☐ SKIP this question)* Don't know	[ ] -99	
F7	Where did you [child name] get rehabilitation services in the past 6 months? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	*Public sector* Central/Provincial hospital District health hospital/center Commune health center *Private sector* Private hospital Private clinics Traditional healer *Others* Home OPD NGO Social protection centers Other centers supporting persons with disabilities Other *(specify)*: _____ Prefer not to answer Don't know	 1 2 3 4 5 6 7 8 9 10 11 -77 [ ] -88 -99	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
F8	In general, how satisfied were you [child name] with quality of rehabilitation services that [child name] has received in the past 6 months? *(Interviewer: Read response options 0 to 3* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	 2☐F12 3☐F12 -88☐F12 -99☐F12
F9	Why were you [child name] not satisfied? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Long waiting time Disrespectful care Condition didn't improve Not available in my area/ too far Workers not skilled/qualified Too expensive /Cannot afford Insurance covers too little Not at all covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify)* _____ Prefer not to answer Don't know	1 2 3 4 5 6 7 8 9 10 11 12 -77 [ ] -88 -99	☐ F12
F10	Why have you [child name] not accessed rehabilitation services? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Don't know/ lack of information about rehab Rehab can't help Rehab services do not meet my needs Doctor said I don't need rehabilitation Think that I don't need rehabilitation Don't know where to get it	1 2 3 4 5 6 7 8	☐ F12

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	9 10 11 12 13 14 15 16 -77 [ ] -8816 -99	
F11	Why have you [child name] not accessed rehabilitation services in the past 6 months? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Don't know/ lack of info on rehab Rehab can't help Rehab services do not meet my needs Doctor said I don't need rehabilitation Think that I don't need rehabilitation Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 [ ]	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	-88 -99	
Assistive products				
F12	Exclude assistive products that you [child name] may have been receiving from the *[UIP: A12]*, have you [child name] ever looking for or received or self-made an **assistive product**? *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if assistive products were not provided by the [UIP: A12], i.e. A13 ☐2.*	Never Ever Prefer not to answer Don't know	0 1 -88 -99	0 ☐ F24 -88 ☐ F17 -99 ☐ F17
F13	When was the last time you [child name] were looking for or received or self-made an assistive product?	More than 6 months ago Within the last 6 months Prefer not to answer Don't know	1 2 -88 -99	1 ☐ F17 -88 ☐ F17 -99 ☐ F17
F14	In the past 6 months, how easy or difficult has it been for you [child name] to buy or access or self-made these assistive products to help your [child name's] condition? *(Interviewer: Read respond option 1 to 4)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Very easy Easy Difficult Very difficult Prefer not to answer Don't know	1 2 3 4 -88 -99	 -88 ☐F16 -99 ☐F16
F15	In the past 6 months, what challenges have you [child name] and the family faced in accessing assistive products for you [child name]? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	No challenges Don't know/lack of information Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport	0 1 2 3 4 5 6 7 8 9 10	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Caregivers/family do not support it	11	
		Afraid/ lack personal motivation	12	
		COVID related barriers	-77	
		Service provision doesn't meet my needs Other	[ ]	
		(specify): _____	-88	
		Prefer not to answer	-99	
		Don't know		
F16	Exclude assistive products that you [child name] may have received from the *[UIP: A12]*, do you [child name] currently have any assistive product? *Interviewer: Include ones that are old, broken, not in use.* *Coder: Remove the leading phrase "Exclude assistive products that you may have received from the [UIP: A12]," if assistive products were not provided by the [UIP: A12], i.e. A13☐2.*	No	0	0 ☐ F24
		Yes	1	
		Prefer not to answer	-88	-88 ☐ F25
		Don't know	-99	-99 ☐ F25
F17	Which of the following assistive products do you [child name] currently **have**? *(Interviewer: Use assistive product sheet & read names of assistive products).* *Interviewer:* • *Read names of assistive products* • *Select ALL that apply.* • *Ask to take a look at the assistive products if possible.* • *Excludes ones that are provided by [UIP: A12].*	Canes or Sticks	1	
		Crutches, axillary or elbow	2	
		Orthoses, lower limb, upper limb or spinal	3	
		Pressure relief cushions	4	
		Prostheses, lower limb	5	
		Rollators	6	
		Standing frames, adjustable	7	
		Therapeutic footwear; diabetic, neuropathic, orthopedic	8	
		Tricycles	.	
		Walking frames or walkers	9	
		Wheelchair	10	
		Spectacles; low vision, short distance, long distance, filters and protection	11	
		White cane	12	.
		Hearing aids	13	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Phone, tablet, other electronic devices Daily living aids Others *(specify)* _____ None Prefer not to answer Don't know	14 15 16 -77 [ ] 0 -88 -99	0 ☐ F24
F18	Which among them do you [child name] currently **use**? *Interviewer:* • *Select ALL that apply.* • *Exclude malfunction assistive products.* • *Ask to take a look at the assistive products if possible.* • *Excludes ones that are provided by [UIP: A12].*	*(Show ones that were selected in F17 only)* None	 0	
F19	Do you have any assistive product that you [child name] currently don't use?	No Yes Prefer not to answer Don't know	0 1 -88 -99	0 ☐ F21 -88 ☐ F21 -99 ☐ F21
F20	Why don't you [child name] use them?	It's currently broken It doesn't fit It causes inconvenience Don't know how to use it No longer need it It doesn't help functioning Other (*specify*): _____ Prefer not to answer	1 2 3 4 5 6 -77 [ ] -88	
F21	Where did you [child name] get the current assistive products? *Interviewer:*	*Public sector* Central/Provincial hospital District health hospital/center Commune health center	 1 2 3	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	• *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	*Private sector* Private hospital Private clinics Traditional healer Shops that sell assistive products Online stores for assistive products *Others* Home OPD NGO Social protection centers Other centers supporting persons with disabilities Self-made /made by friends or relatives Other *(specify)*: _____ Prefer not to answer Don't know	 4 5 6 7 8 9 10 11 12 13 14 -77 [ ] -88 -99	
F22	How satisfied were you [child name] with the assistive products that you [child name] currently have? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	 2☐F25 3☐F25 -88☐F25 -99☐F25
F23	Why were you [child name] not satisfied? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	Poor quality Did not meet my needs Difficult to access related services Poor quality of related services Other *(specify)* _____ Prefer not to answer Don't know	1 2 3 4 -77 [ ] -88 -99	-> F25
F24	Why don't you [child name] have a functioning assistive product (AP)?	Don't know/ lack of information on APs	1	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	Interviewer: • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	AP could not help Available AP do not meet my needs Doctor said I don't need AP Think that I don't need AP Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 -77 [ ] -88 -99	
Home-based care services				
F25	Exclude services that you [child name] may have been receiving from the *[UIP: A12]*, have you [child name] **ever** received **home-based care services** that are provided by someone who are not your family member? *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if home-based care was not provided by the [UIP], i.e. A13☐4.*	Never Received HBC guidance only Received HBC from a non-family Prefer not to answer Don't know/Don't remember	0 12 -88 -99	0☐F31 -88☐F32 -99☐F32
F26	Exclude services that you [child name] may have been receiving from the *[UIP: A12]*, when was **the last time** you [child name] received home-based care services that were provided by someone who are not your family member?	*(write 0 if less than a month)* Prefer not to answer Don't know/Don't remember	[ ] -88 -99	>6m☐F32 -88☐F32 -99☐F32

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if home-based care was not provided by the [UIP], i.e. A13☐4.			
F27	In the past 6 months, how easy or difficult has it been for you [child name] to access home-based care services that were provided by someone who are not your family member? *(Interviewer: Read respond options 1 to 4)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Very easy Easy Difficult Very difficult Prefer not to answer Don't know	1 2 3 4 -88 -99	 -88☐F32 -99☐F32
F28	In the past 6 months, what challenges have you [child name] faced in accessing home-based care services that were provided by someone who are not your family member? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	No challenges Don't know/lack of information Not available in my area/ too far Workers not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation HBC does not meet my needs COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	0 1 2 3 4 5 6 7 8 9 10 11 12 -77 [ ]-88 -99	 -88 ☐ F30 -99 ☐ F30
F29	What was the biggest challenge?	*(Write code from F28; allow selected codes only; if only 1 code was selected in F28 ☐ SKIP this question)*	[ ]	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Don't know	-99	
F30	In general, how satisfied were you [child name] with quality of home-based care services that you [child name] have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	☐ F32
F31	Why have you [child name] not accessed home-based care services that are provided by someone who are not your family member? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	Don't need it Don't know/ lack of information HBC could not help HBC does not meet my needs Doctors said I don't need it I think I don't need it Don't know where to get it Not available in my area/ too far Career not skilled/qualified Disrespectful care Too expensive/Could not afford Insurance pays too little Not covered by insurance Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify)*: _____ Prefer not to answer Don't know	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 -77 [ ] -88 -99	
House adaptation services for in-home accessibility				
F32	Exclude services that you [child name] may have been receiving from the *[UIP: A12]*, have you	No	0	0☐F34

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	[child name] used **house adaptation services** for **in-home accessibility** in the past 6 months? *For example, building a ramp, modify the toilet, put on a grab bar, etc.* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if house adaptation services were not provided by the [UIP: A12], i.e. A13☐3.*	Yes Prefer not to answer Don't know/Don't remember	1 -88 -99	 -88☐F35 -99☐F35
F33	In general, how satisfied were you with quality of house adaptation services that you [child name] have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	☐F35
F34	Why have you [child name] not accessed house adaptation services? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	Don't know/ lack of information It could not help Doctor/ professional said I don't need it I think that I don't need it Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful attitude of provider Too expensive/Could not afford Insurance pays too little Not covered by insurance Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify)*: _____	1 2 3 4 5 6 7 8 9 10 11 12 13 14 -77 [ ] -88 -99	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Prefer not to answer Don't know		
Legal support services for persons with disabilities				
F35	*(Automatic) Check E9:* The respondent self-identified as a person with disabilities?	No: E9 ☐ 1 Yes: E9 = 1	0 1	0 ☐ F39
F36	Exclude services that you [child name] may have been receiving from the *[UIP: A12]*, have you [child name] used **legal support services for persons with disabilities** in the past 6 months? *For example, sue somebody, asking for rights, etc.* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if legal support services were not provided by the [UIP: A12], i.e. A13☐5.*	No Yes Prefer not to answer Don't know/Don't remember	0 1 -88 -99	0☐F38 -88☐F39 -99☐F39
F37	In general, how satisfied were you [child name] with quality of legal support services that you have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	☐F39
F38	Why have you [child name] not accessed legal support services? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	Don't need it Don't know/ lack of information It does not meet my needs Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful attitude of provider Too expensive/Could not afford Insurance pays too little Not covered by insurance Caregivers/family do not support it	1 2 3 4 5 6 7 8 9 10 11 12 13 -77	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Afraid/ lack personal motivation COVID-related barriers Other (*specify*): _____ Prefer not to answer Don't know	[ ] -88 -99	
Psychological support services				
F39	Exclude services that you may have been receiving from the *[UIP: A12]*, have you [child name] used **psychological support services** in the past 6 months? *For example, counseling and advising to reduce stress* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if psychological support was not provided by the [UIP: A12], i.e. A13☐7.*	No Yes Prefer not to answer Don't know	0 1 -88 -99	0☐F41 -88☐F42 -99☐F42
F40	In general, how satisfied were you [child name] with quality of psychological support services that you [child name] have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	☐F42
F41	Why have you [child name] not accessed psychological support services? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	Don't know/lack of information It could not help It does not meet my needs Doctors said I don't need it I think I don't need it Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful attitude of provider	1 2 3 4 5 6 7 8 9 10 11 12	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other *(specify):* _____ Prefer not to answer Don't know	13 14 15 16 -77 [ ] -88 -99	
Education services				
F42	Exclude services that you [child name] may have been receiving from the *[UIP: A12]*, have you [child name] used **education services** in the past 6 months? *Coder: <Automatic> fill in Yes (Code 1) if the child is attending school (C7=1)* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if education support was not provided by the [UIP: A12], i.e. A13☐12.*	No Yes Prefer not to answer Don't know/Don't remember	0 1 -88 -99	0☐F44 -88☐F45 -99☐F45
F43	In general, how satisfied were you [child name] with quality of education services that you [child name] have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don't know	0 1 2 3 -88 -99	☐F45
F44	Why have you [child name] not accessed education services? *Interviewer:* • *Select ALL that apply.*	Don't need it Inability to access Don't know/ lack of information	1 2 3 4	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	• *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	Education services does not meet my needs Don't know where to get it Not available in my area/ too far Workers not skilled/qualified Disrespectful attitude of provider Too expensive/Could not afford Insurance pays too little Not covered by insurance No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation Education/training institutions do not accept COVID-related barriers Other (*specify*): _____ Prefer not to answer Don't know	5 6 7 8 9 10 11 12 13 14 15 16 -77 [ ] -88 -99	
Social participation support				
F45	In the past 6 months, did you participate in any of the following activities? *(Interviewer: Read respond options 1 to 12 and -77)* *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?*	Meet friends Call, SMS, e-chat with friends/relatives Call, SMS, e-chat with strangers Watch a movie (at cinema or home) Attend weddings, funerals, anniversaries Dining out Attend parties Shopping Play sports or exercise alone	1 2 3 4 5 6 7 8 9 10 11	

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
		Play sports or exercise with others Attend festivals, cultural/community events Attend community/group/club meetings Other *(specify):* _____	12 -77 [ ]	
F46	In the past 1 month, did you participate in any of the following activities? *(Interviewer: Read respond options)* *Interviewer: Select ALL that apply.* *Coder: Show respond options that were selected in F45 only.*	Meet friends Call, SMS, e-chat with friends/relatives Call, SMS, e-chat with strangers Watch a movie (at cinema or home) Attend weddings, funerals, anniversaries Dining out Attend parties Shopping Play sports or exercise alone Play sports or exercise with others Attend festivals, cultural/community events Attend community/group/club meetings Other *(specify)*_____	1 2 3 4 5 6 7 8 9 10 11 12 [ ] -77	
F47	Exclude services that you [child name] may have been receiving from the *[UIP: A12]*, have you [child name] used **social participation support** in the past 6 months? *For example, taking you out to seeing a friend, dining out, attending parties, playing sport, attending community meetings, etc.* *Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP:*	No Yes Prefer not to answer Don't know	0 1 -88 -99	0☐F49 -88☐F50 -99☐F50

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	A12],” if social participation support was not provided by the [UIP: A12], i.e. A13☐8.			
F48	In general, how satisfied were you [child name] with quality of social participation support that you have received in the past 6 months? *(Interviewer: Read respond options 0 to 3)* *Interviewer: Exclude ones provided by the [UIP: A12].*	Not at all satisfied Somewhat unsatisfied Satisfied Very satisfied Prefer not to answer Don’t know	0 1 2 3 -88 -99	☐F50
F49	Why have you [child name] not accessed social participation support over the past 6 months? *Interviewer:* • *Select ALL that apply.* • *Probe: Anything else?* • *Exclude ones provided by the [UIP: A12].*	I don’t need it Not capable of participating social activities Don’t know /Lack of information The support does not meet my needs Don’t know where to get it Not available in my area/ too far Workers not skilled/qualified Fear of discrimination/stigma if participating in social activities Too expensive/Could not afford No transport/Difficult to transport Caregivers/family do not support it Afraid/ lack personal motivation COVID-related barriers Other (*specify*): _____ Prefer not to answer Don’t know	1 2 3 4 5 6 7 8 9 10 11 12 13 -77 [ ] -88 -99	
Other services				
F50	*(**Automatic**) Check E9:* The respondent self-identified as a person with disabilities?	No: E9 ☐ 1 Yes: E9 = 1	0 1	0 ☐ F53
F51	Exclude services that you [child name] may have been receiving from the *[UIP: A12]*, have you [child name] used **any other services supporting persons with disabilities** in the past 6 months?	No Yes Prefer not to answer	0 1 -88	0☐F53 -88☐F53

F	SOCIAL & DISABILITY SERVICES			
NO.	**QUESTION**	**RESPONSE**	**OPT**	**SKIP**
	Coder: Remove the leading phrase "Exclude services that you may have been receiving from the [UIP: A12]," if other supporting was not provided by the [UIP:12], i.e. A13☐-77.	Don't know	-99	-99☐F53
F52	Please specify *Interviewer:* • *Select ALL that apply* • *Probe: Anything else?*	Social protection support Gifts or money on events Other *(specify):* _____	1 2 -77 [ ]	
F53	How has the COVID-19 pandemic affected your [child name's] **ability to access** services you need for your [child name's] condition? *Interviewer: your condition = your disability or functioning condition.*	No effect A lot harder to access A little harder to access Easier to access N/A (didn't need support before pandemic) Prefer not to answer Don't know	0 1 2 3 4 -88 -99	
F54	To what extent do you [child name] believe the effects of the COVID-19 pandemic are impacting your [child name's] current quality of life? *(Interviewer: Read respond options 1 to 5)*	Made it a lot worse Made it a little worse No effect Made it better Made it a lot better Prefer not to answer Don't know	1 2 3 4 5 -88 -99	

G	HOUSEHOLD			
G1	How many people are your [child name] household members who are currently living here? *(Interviewer: including the respondent)* *Interviewer: Household members who are currently living here include a group of people living in the same house/shelter and share meals together on daily basis.*	*(Type in: Numeric only)*	[ ]	

G	HOUSEHOLD			
G2	How many other people are your [child name] household members but not currently living here? *Interviewer: As defined by the respondent.*	*(Type in: Numeric only)*	[ ]	

G3. Household members

I would like to ask few more questions about your [child name: A2] household members, except *[child name: A2]* as we already collect most of his/her:

Cross check: G1+G2 = number of persons in G3; if it's not correct show a warning message.

#	Name	Group G1/G2	Gender	Age	Working & earnin income in the past 6 months? *(for 15+ yo.)*	Relationship to the beneficiary	Completed education
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
1	(Beneficiary name)	(G1)	(automatic: C2)	(auto: C3/C5)	(automatic: 1 if C15=1)	(The beneficiary)	(automatic: C8)
2			1=M; 2=F; 3=Other; -88=Prefer not to answer		0=No; 1=Yes; -99 DK		
3			1=M; 2=F; 3=Other; -88=Prefer not to answer		0=No; 1=Yes; -99 DK		
4			1=M; 2=F; 3=Other; -88=Prefer not to answer		0=No; 1=Yes; -99 DK		
5			1=M; 2=F; 3=Other; -88=Prefer not to answer		0=No; 1=Yes; -99 DK		
6			1=M; 2=F; 3=Other; -88=Prefer not to answer		0=No; 1=Yes; -99 DK		
7			1=M; 2=F; 3=Other; -88=Prefer not to answer		0=No; 1=Yes; -99 DK		
8			1=M; 2=F; 3=Other;		0=No; 1=Yes; -99 DK		

#	Name	Group G1/G2	Gender	Age	Working & earning income in the past 6 months? *(for 15+ yo.)*	Relationship to the beneficiary	Completed education
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
			-88=Prefer not to answer				
9			1=M; 2=F; 3=Other; -88=Prefer not to answer		0=No; 1=Yes; -99 DK		
10			1=M; 2=F; 3=Other; -88=Prefer not to answer		0=No; 1=Yes; -99 DK		
11	…		1=M; 2=F; 3=Other; -88=Prefer not to answer		0=No; 1=Yes; -99 DK		

Codes for Column g: 1=Children; 2=Parent; 3= Spouse; 4=Sibling; 5=Grand-parent; 6=Grand-children; 7=Other

Codes for Column h: Completed grade in formal education system (12-year system); write 0 if not going to school; write 13 if greater than 12 (e.g. graduate or post-graduate); write -99 if don't know.

NO	QUESTION	RESPONSE	OPT	SKIP
G4	Who is the household head? *Interviewer: Head of household according to self-identified respondents or household registration. The head of household must be the person named in section G3.*	*Drop list from G3* *(Write code from Column (a) in G3; show name, age, gender of HH head for interviewer to check again after entering the code)*	[ ]	
G5	Are you dependent on someone to help with your [child name] self-care activities (i.e. caregiver)? *(Interviewer: Read respond options 1 to 4)*	Not at all/Hardly at all A little bit Moderately Severely Prefer not to answer Don't know	1 2 3 4 -88 -99	1☐G7

NO	QUESTION	RESPONSE	OPT	SKIP
G6	Who is your [child name] main caregiver? *Interviewer: Main caregiver as identified by the beneficiary or discussion among family members. If still do not know: it's the person who spend largest amount of time to assist daily activities of the beneficiary.*	*Drop list from G3* *(Write code from Column (a) in G3; show name, age, gender of the main caregiver for interviewer to check again after entering the code)* Non-household-member *(specify: sex, age, relationship to the beneficiaries)* Prefer not to answer Don't know	[ ] -77 [ ] -88 -99	
G7	What is your [child name] household's living standard as officially classified by government office? *(Interviewer: Read respond options 1 to 3)*	Poor Near poor Not poor Prefer not to answer Don't know	1 2 3 -88 -99	

The following questions ask about the house [child name] lives in and your [/child name] household

NO	QUESTION	RESPONSE	OPT	SKIP
G8	How many square meters is your [/child name] house?	*(record number of m2)* *Don't know*	[ ] -99	
G9	What is total usable area of your [/child name] house in square meter?	*(record number of m2)* *Don't know*	[ ] -99	
G10	Does this house own by your family members or someone else? *Interviewer: Read respond categories.*	Owned by family members of the respondent Owned by someone else: rental/borrowed Prefer not to answer Don't know	1 2 -88 -99	

NO	QUESTION	RESPONSE	OPT	SKIP
G11	What is the main type of fuel (energy) that your [child name] household uses for cooking?	Electricity Gas/biogas Charcoal Firewood Others *(specify)* _____ Nothing Prefer not to answer Don't know	1 2 3 4 -77 [ ] 0 -88 -99	
G12	What is the main source of water that your [child name] household uses?	Tap water Purchased water (tanks, bottles ...) Drilled well Protected dug well Unprotected dug well Protected borehole Unprotected borehole Rain water Others *(specify)* _____ Prefer not to answer 5Don't know	1 2 3 4 5 6 7 8 -77 [ ] -88 -99	
G13	What type of toilet does your [child name] household use?	Septic/semi-septic toilets in the house Septic/semi-septic toilet outside the house Others Don't have toilet	1 2 3 4	

NO	QUESTION	RESPONSE	OPT	SKIP
G14	Does [child name]'s household currently have the following assets? *Interviewer:* • *Read response options* • *Select ALL that apply* • *Only count functioning ones*	Television Radio (radio/radio casetts) Computer (desktop, laptop) Landline/mobile/tablet phone Refrigerator Washing machine Hot and cold shower Air conditioning Motorcycles / mopeds / electric bicycles / electric motorbikes Bicycle Boats Car Nothing	1 2 3 4 5 6 7 8 9 10 11 12 0	

H	WRAP-UP. RECONTACT DETAILS			
NO.	QUESTION	OPTION	OPT	SKIP
H1	***[Interviewer: Do not ask]*** Did someone help the child respondent to answer the questions?	No help given Yes, another person answered for few questions Yes, another person answered for less than a half of the questions Yes, another person answered more than about a half of the questions Yes, another person answered all of the questions	0 1 2 3 4	0☐H4
H2	Name of person helping with interview	*Drop list from G3* Other (*specify*): _____	[ ] -77 [ ]	☐ -77☐ H4
H3	Relationship to the respondent	_____	[ ]	
H4	Thank you so much for your time today! We would like to come back to visit you in six months' time to see how you [child name] are doing and if anything has changed. Is that OK with you?	No Yes Unsure	0 1 2	 1☐H6 2☐H6

H	WRAP-UP. RECONTACT DETAILS			
NO.	**QUESTION**	**OPTION**	**OPT**	**SKIP**
H5	Why can we not revisit? *Interviewer: If needed, help them understand the procedures and try to work out a more suitable option.*	Will not be at home in 6 months Time consuming It bothers me Just don't want another visit Other (*specify*)_____	1 2 3 4 -77 [ ]	
H6	Primary phone number for recontact	*(Type in: Numeric only)* Not available	[ ] -99	
H7	Primary phone owner name	*Drop list from G3* Other (*specify*): _____	[ ] -77 [ ]	☐ -77☐ H9
H8	Relationship to the respondent	_____	[ ]	
H9	Secondary phone number for recontact	*(Type in: Numeric only)* Not available	[ ] -99	
H10	Secondary phone owner name	*Drop list from G3* Other (*specify*): _____ Not available	[ ] -77 -99	
H11	*(Automatic)* End Timestamp	*(Automatically generated)*		
H12	***[Do not ask]*** GPS location	Lat Long Accuracy	[ ] [ ] [ ]	
H13	***[Do not ask]*** Notes about location for recontact	*(Type in)*	[ ]	
H14	***[Do not ask]*** Notes about nature of disability or disposition future data collector may need to know to do appropriate, sensitive outreach.	*(Type in)*	[ ]	
H15	***[Do not ask]*** Interviewer's comments about the interview	*(Type in)*	[ ]	

Thank you very much!

ANNEX 7.3: INTERVIEW GUIDES

In this interview, we'd like to discuss USAID's three main intervention areas for persons with disabilities in Vietnam – Rehabilitation, Social Services, and Disability Policies. For the first part of the interview, we'd like to understand your perception of USAID's level of success in these three areas, and things that may have helped or limited the success. For the second part, we'd like to explore your thoughts related to quality and accessibility of services.

I. Choosing the location and time of the interview

Location:

- The most suitable interview location is a quiet place without the presence of a third person. Due to the COVID-19 pandemic, an outdoor or well-ventilated interview location is the best.
- If a third person is present in the interview, the enumerator should require the third person to respect the respondent's answers and not to participate in the interview process.

Interview time:

- Each interview will last about 0.5 - 1.5 hours, so the enumerator needs to inform of the time in advance so that the respondents can prepare and arrange his/her time;
- If the respondent is busy, does not have enough time, or is not well, the enumerator should not insist on interviewing. Instead, the enumerator should say thank you and schedule an interview later (if necessary).

II. Preparing for the interview

Dressing code: The enumerator should choose neat and formal clothes, avoid offending the respondents, and wear a mask;

Documents: The enumerator needs to bring the following documents to the interview:

- Official approval letter from local authorities
- Survey fact sheet for respondents
- Back-up paper questionnaire (3 copies)
- Set of color cards (showcard)
- Handbook
- Sign-up list for participants of the survey
- Thank-you gifts for respondents
- Masks (for enumerators and respondents if needed), hand sanitizer, face shield
- Tablet
- Tablet battery charger

III. General interview guidelines

III.1. Interview attitude and skills

- The enumerator strictly complies with the pre-designed questionnaires. Regarding the language and appellation, the enumerator self-adjusts to suit the interviewee.
- Create a friendly, comfortable atmosphere and respect the respondent's answers. The enumerator needs to build trust so that the interviewee can share information;
- During the interview process, attitudes, gestures, actions, and other body languages should be used flexibly. Pay attention to the respondent to understand his/her health status. If the respondent is tired, suggest that he/she can rest for a few minutes before continuing the interview; focus on listening, avoid asking the respondent to repeat the information already

provided; do not express a negative attitude or judgment towards the respondent's views in the information shared.

- Do not ask questions after questions in a rush because it will make the respondent feel they are being questioned and become uncomfortable, leading to silence or non-cooperation.

III.2. Interview principles

- The enumerator asks questions in the order as defined in the questionnaire. Do not leave any unanswered.
- For multiple-choice questions, the enumerator just reads the question WITHOUT reading the choices for the respondent to select (unless there are other instructions such as "Read the choices of the answer, can read the choices of the answer");
- For questions for which the respondent gives different answers from the available options, the enumerator chooses "**OTHERS",** then specifies what "others" means. The content of **"OTHERS"** must be descriptive, easy to understand and comply with the rules for entering information.
- Ask questions as in the questionnaire, do not lead the respondent into a certain choice and do not suggest an answer.
- **Do not** read the options **"Don't know"** or **"Don't want to answer"** in the questionnaires. Only tick these two options after trying to collect the data, but the respondent still doesn't know the answer or refuses to answer. However, try to limit the use of these two options in the interview.
- For some questions, if the respondent gives a range instead of a specific number, the enumerator asks the respondent for the exact number, and do not automatically use the average of the range. If the respondent cannot give a number, the enumerator is allowed to take the average and confirm that average number with the respondent. If the respondent disagrees, the enumerator adjusts the number and re-confirms.
- The enumerator asks for the respondent's phone number and confirms the correct number by making a test call to the respondent. If the respondent does not want to give his/her phone number, the enumerator clearly explains to the respondent that the phone number is to prove the interview's authenticity and provide additional information if necessary. Commit that the phone number will not be used it for other purposes.

III.3. Using tablets

- The enumerator checks the tablet every day before doing the survey, making sure the tablet is functioning, and the battery is fully charged each day;
- Do not install any other software in the tablet;
- Do not use the tablet for personal purposes such as social networking, playing games, etc.

III.4. Some situations and suggestions for handling

- The respondent has not completed the interview because of sudden business: The enumerator will look at the collected information to handle the situation appropriately.
    - If the interview has just started and a lot of questions remain unanswered, the respondent is busy for a short time of 5-10 minutes, ask for permission to wait,
    - If the interview has just started and a lot of questions remain unanswered, the respondent is busy for a long time, reschedule the meeting and agree on the time of the next meeting or get the respondent's phone number to make an appointment later.
    - If the information to be collected is just a little, convince the respondent to spend 5-10 more minutes completing the questionnaire. For example: There are 5-10 minutes left, please let me ask you some more questions so as not to disturb you next time, etc.

- The respondent has not completed the questionnaire and refuses to continue answering: The enumerator can convince the respondent to continue participating, depending on the situation to persuade. If the respondent insists on not participating, respect their opinion.
- If the respondent (beneficiary/ their proxy) shows an uncomfortable uncooperative attitude with the questions (especially questions related to the satisfaction level of persons with disabilities), the enumerator pauses the interview to re-explain the purpose of the survey. The respondent may refuse to answer the questions if he/she feels uncomfortable.
- The enumerator stops the ongoing interview, says thank you, and presents a gift before leaving if:
    - The respondent is uncooperative and feels annoyed with questions (although the information related to the survey and the rights of respondents have been re-explained)
    - The respondent is found inappropriate: not the right person, beneficiary's proxy is under 18 years of age; the proxy of a child with disabilities is not a member of his/her family, while there is no other guardian of the child at the time of the interview, etc.
    - Persons with disabilities do not have enough communication ability to answer most questions and do not have a supporter to help
    - The supporter is not lucid enough, and does not understand the question.

- When the enumerator cannot conduct the interview, notify the supervisor to arrange an alternative, do not cancel the appointment on your own.

IV. Communication skills in working with persons with disabilities

IV.1. Principles in communication with persons with disabilities

- Prioritize direct communication with persons with disabilities, only ask his/her family member (must be an adult of 18 years or older) to answer on behalf if the respondent cannot answer on his/her own.
- Do not make assumptions about persons with disabilities: Do not assume that you know what persons with disabilities feel, need and want, instead you should ask persons with disabilities to get the best answer.
- Don't focus on their disability, don't stare at the disability of the persons with disabilities.
- Ask/ask for permission before you want to help persons with disabilities: If you want to help them, ask them first to get their consent. If needed, they can show you how you can help them.
- Avoid discriminatory words such as disabled person, handicapped, victim, amputee, etc.
- Treat persons with disabilities according to their age, and address persons with disabilities in the same way as non-disabled people
- Respect the private space of persons with disabilities.
- Be comfortable communicating with persons with disabilities.

IV.2. Things to be avoided when communicating with persons with disabilities

- Don't arbitrarily interrupt the respondent. If needed, notify the speaker or "ask for permission" in advance.
- Don't rebuke or use words that show stigma or sarcasm to the respondent.
- Don't beat around the bush, don't ramble, and don't show a lack of attention.
- Don't cross your arms, listen while looking at your watch, or using your phone.
- Don't talk too loudly when not necessary; use appropriate intonation in the communication process.

- Don't scratch the head and turn the chair around showing a lack of concentration when communicating.
- Don't ask the respondent again and again for the same information that has previously been provided.
- Some common phrases to pay attention to:

Positive	Negative
People with intellectual impairments; autism syndrome	Under-developed; Down; Mental problem; Crazy
People with visual impairments	Blind people
People with mobility impairments	Amputated, handicapped
People with hearing and speaking impairments	Deaf and dumb

IV.3. Some points of attention when communicating with groups of persons with disabilities

(i) Communicating with people with mobility impairments (especially those using wheelchairs)

- Sit at the eye level of people on wheelchairs when talking and working with them.
- Do not lean against wheelchairs or other supporting devices for persons with disabilities.
- Do not pad the head or shoulder of persons with disabilities using a wheelchair.
- Do not arbitrarily push wheelchair without the permission of persons with disabilities.
- If necessary, you can shake hands with persons with disabilities, even if that person has a prosthetic hand or loses an arm. If you cannot shake hands, smile, be open and friendly with persons with disabilities
- For people who use crutches, walkers, or some other assistive devices and need to use their hands for balance, do not hold their hands as this could cause them to fall.

(ii) Communicating with people with hearing impairment

- Being unable to hear, it is best to involve a sign language interpreter to ensure the effective transmission of information.
- Direct the hearing-impaired person's attention to you when communicating by waving.
- Look directly at the person with hearing impairment, even if a sign language interpreter is present. Speak slowly and clearly, using short, simple sentences.

(iii) Communicating with people with visual impairments

- Visual impaired people can sit still and listen for a long time, they have very good memory.
- Direct the conversation to the listener.
- Speak at a moderate speed, which is enough to hear.
- Describe specifically so that the visually impaired can visualize.
- Do not talk/ask questions outside the questionnaire about what they saw/witnessed.

(iv) Communicating with people with intellectual impairments

- Do not use abstract words.
- It is recommended that a guardian be involved, as some information may need to be verified through

the guardian.

(v) Communicating with people with speech impairments

- Listen attentively when talking to people with language difficulties. Wait patiently until they finish their story, don't interrupt or speak for them
- Create a quiet environment for communication.
- Communicate with a sufficient volume.

(vi) Listening skills

- Adjust body language: When actively listening, slightly lean forward and look at respondent's eyes. Friendly smiles and nods will show that you're interested and listening.
- Focus on the target of communication: Face the speaker and maintain eye contact: Pay attention to the person who is speaking, do not listen, and do other things at the same time, affecting the effectiveness of the reception of information, as well as make the speaker feel disrespected.
- Do not interrupt mid-way: When persons with disabilities are presenting a problem and need assistance, listen to their whole story, do not interrupt mid-way, as there is a chance that persons with disabilities will miss their point or talk about another issue.
- Empathize with the speaker: Listening is not only through your ears but also your eyes and heart, showing empathy and sharing with the speaker. Avoid giving a subjective opinion in a hurry to judge what you have just heard.
- Respect persons with disabilities: self-restraint is required. There should be no gestures or words showing negative or unpleasant attitudes towards persons with disabilities when presenting.

V. DETAILED INSTRUCTIONS FOR QUESTIONNAIRES

V.1. Questionnaires structure

The toolkit includes three (03) questionnaires:

- Self-completed questionnaire: Enumerators fill out the information in this questionnaire by themselves before conducting the interview based on information from the sample list provided by the supervisor. The questionnaire includes basic beneficiary information.
- Questionnaire for adults: Used for interviews with people 18 years of age and older

Notes:

- If the beneficiary needs help from another person to answer, invite that person to join the interview.
- Try to interview the beneficiary directly as much as you can; only interview another adult family member (must be 18 years old or older) on her/his behalf if the beneficiary cannot respond at all or you are guided to do so

- Questionnaire for children: used for interviews with children from 5 to 17 years of age

Notes:

- Child respondent must be accompanied by an adult family member at ALL time.
- If the respondent needs help from another person to answer, invite that person to join the interview.
- For the QOL module, try to interview the child respondent as much as you can; only interview adult family members on behalf of the child if the child cannot respond or you are guided to do so.

Structure of the questionnaires for adults and children:

No	Section	Questionnaire for adults	Questionnaire for children
1	B. Introduction and consent to participate	**25 questions (**including an introduction to the survey)	**18 questions (**including an introduction to the survey)
2	C. Socio-economic characteristics of the beneficiary	**16 questions**	**16 questions** Remove 1 question about marital status from the questionnaire for adults.
3	D. Quality of life	**29 questions** In which there are 27 questions with two ways of questioning for two types of respondents (the beneficiary or the person who supports the beneficiary for responses in the interview).	**26 questions** In which there are 24 questions with two ways of questioning for two types of respondents (the beneficiary or the person who supports the beneficiary for responses in the interview). Questions are completely different from the questionnaire for adults
4	E. Health and Disability	**35 questions.** In which: Question E5 consists of 5 sub-questions Question E23 has two ways of questioning for two types of respondents	**22 questions** Like the questionnaire for adults No questions from E23 to E35 as in the questionnaire for adults.
5	F. Social and disability services	**51 questions** - Rehabilitation service - Support tools - Care services at home - Home repair or home appliance installation services - Legal aids for persons with disabilities - Psychological support Support for participation in social activities	**54 questions** Like the questionnaire for adults Three additional questions related to Education

No	Section	Questionnaire for adults	Questionnaire for children
6	G. Household	**14 questions** Including question G3 that includes multiple questions about individual family members *(The same in two questionnaires)*	
7	H. Wrap-up and recontact details	**14 questions** *(The same in two questionnaires)*	

5.2. Format convention of paper questionnaires

Tables containing questions: Tables include 5 columns, equivalent to five parts of a question. Each question consists of five parts, corresponding to five columns as below. The "Skip to…" is only applicable in selected questions

No.	Questions	Options for response	OPT	Skip

The italic text inside the table contains the question: notes for enumerators in an interview (instructions, conventions for questioning, conventions for information entry, for examples to read aloud to beneficiaries if necessary)

Information outside the table containing questions: Notes to interviewers

Italics in square brackets (e.g. [*Beneficiary name: A2*]): Replaced with the information recorded in the referred question (Tablets will automatically display the information)

Questions marked with "do not ask": enumerators fill out information by themselves and do not ask beneficiaries

Questions marked "Automatic" are not displayed, tablets automatically fill out Detailed instructions for the adult questionnaire

Guidelines and rules applied to interviews related to the questions were maximally integrated with the questionnaire. In addition, some other notes will be included in this manual. Enumerators should clearly understand and master the stated guidelines and rules in the questionnaires and this manual right after participating in the training and the test survey.

Notes: Respondents should not see the content of the questionnaires during interviews, but in some cases enumerators let respondents look at the answers for their choices such as when:

- Respondents are hearing impaired
- Questions are interrelated and the preceding question is a multiple-choice one, then in the related answer that follows, respondents should be able to look at alternative answers for their choices. For example, F17 provides multiple choice answers (with various aid tools), then in F18, respondents can look at multiple choices for their answers.

SECTION B:

B5. Instructions for obtaining consent to participate: Enumerators only conduct interviews after having the consent of beneficiaries and/or caregivers

- If beneficiaries are adults who are able to answer the entire questionnaire on their own: it is necessary to get their consent to participate using form B5a
- If beneficiaries are adults who are able to answer the questionnaire on their own but still need a caregiver to participate in the interview: Enumerators introduce the survey and get the caregiver's consent first, and then the beneficiary's.
    - Obtain consent to participate from care-givers using form B5b
    - Obtain consent to participate from beneficiaries using form B5c
- If beneficiaries are adults who are unable to respond on their own and a caregiver is required to answer the entire question for them: the caregiver's consent to participate is required using form B5b

Notes: After collecting consents to participate in the survey, if beneficiaries ask what supports they would receive, enumerators should reply that they are not quite clear about the supports that beneficiaries would receive in the future (as this falls into the functions of other agencies) and responding to this survey does not affect the supports they are entitled to get.

B8: Enumerators apply the principle of 3 times. If enumerators contact/visit the household three times but still cannot conduct the interview, another person as replacement is interviewed instead.

SECTION C

C4: Refer to the year of birth and age of the beneficiary

If the beneficiary's year of birth is different from the information in the ID card, enumerators records the information as answered by the beneficiary

C7: Excluding cases of going to inclusive school and learning for functional improvement (not following the general education curriculum) such as classes for people with autism and attention deficit hyperactivity disorder (ADHD)

C8:

- Enumerators record 13 if beneficiaries completed 9th grade or are currently enrolled in/or completed a technical/vocational college program that includes an upper secondary education component/program
- If beneficiaries are enrolled in the 10-year education system, it is necessary to convert the highest grade they completed to the 12-year education system as shown in the table below:

Grade completed in the 10-year education system	Converted to the grade completed in the 12-year education system
1	1
2	2
3	4
4	5

Grade completed in the 10-year education system	Converted to the grade completed in the 12-year education system
5	6
6	7
7	9
8	10
9	11
10	12

C9: Beneficiaries participate in vocational trainings for the purpose of being able to get them a decent job, so the following cases will be counted as participation:

- Enrolling in vocational training courses at vocational training schools or centers, or apprenticeships at shops, businesses, and factories (e.g., carpentry apprenticeship in furniture workshops, barber training at barbershops, etc.), or trained by parents or neighbors. Compulsory apprenticeship period in high school is not included
- If beneficiaries are in-service trainees, or not formally trained but self-learn the skills through the process of working (observation), it is not counted as apprenticeship (for example, working and meanwhile learning to repair sewing machines by themselves for 4 years, and it is not possible to figure out when the apprenticeship takes place)
- Round off the number of months according to the normal rule. If someone has just learned the job for less than 15 days, 0 is recorded

C10:

- If beneficiaries have participated in various vocational trainings, calculate the total time of all trainings they did
- If beneficiaries have not completed a certain vocational training course, only the actual time that they have spent is counted.

C12:

- If beneficiaries are severely disabled and unable to work, choose the option "Not working and not looking for work"
- If beneficiaries do different jobs, the criteria for determining the main job are based on their opinions

C14:

- The question on the average for 6 months. In case the beneficiary has worked in only the last 1 month, and in the remaining 5 months he/she does not do any work, enumerators should divide the number of hours a week in the last one month by 6.
- The time period for which the beneficiary goes to school/training is not counted

C15:

- Only income from the beneficiary's work is counted, excluding salary, social benefits or gift/donation (these are counted for in C16)
- Including income in cash or in kind. For example, income in kind includes agricultural products produced for self-consumption in households, working for other households and not being paid but being fed and housed.
- If beneficiaries participate in household economic activities (such as helping parents in selling goods and livestock raising, etc., excluding housework), contributing to the shared income of the whole family, it is counted as having income.
- Including income received and to be received for the work done (i.e. not yet paid)

C16: Beneficiaries' non-employment income may include:

- Pension
- Allowances: include all benefits beneficiaries receive from local agencies/governments, organizations and businesses such as disability benefits, poor household supports, COVID-19 support, and supports to people impacted by natural disasters, floods, etc.
- Cash that beneficiaries are given and donated from organizations/people outside the household, charity funds, etc.
- Interest earned from savings

SECTION D

D1:

Quality of life is a term used to assess the overall well-being of life for individuals and society as a whole, as well as to assess the level of comfort and satisfaction, physically, mentally and socially.

Criteria for measuring quality of life include:

- The degree of physical well-being:
  + Health
  + Spirit
  + Eating, sleeping, travel (traffic, transportation)
  + Medicines (medical, healthcare)
- Mental well-being:
  + Psychological factors
  + Spiritual factors (belief, religion)
- Social well-being includes:
  + Social relationships including sexual relations
  + Living environment (including social environment: safety, security, economy, culture, politics, and natural environment)

D3 – D3p:

- "To-do" includes all activities in work, housework, daily life, etc.
- If beneficiaries are severely disabled and completely dependent on others, cognitive but unable to do any activity, then choose option "5. An extremely amount"
- If beneficiaries do not have any pain, select "1. Not at all"
- "Physical injuries" include all health-related problems, not just the beneficiary's type of disability.

D4 – D4p:

- Medical treatment includes taking medicine, going to a medical facility for treatment, or buying medicine without doctor's prescription, self-healing, practicing rehabilitation, NOT including the use of functional assistive devices when walking, eating, etc.
- In case the beneficiary has a particularly severe disability, is completely dependent on others, and there is no medical treatment that can improve the condition or support him/her to maintain activities in daily life, choose option "5. An extremely amount"
- "Needs medical treatment" for all health-related problems, not just the beneficiary's type of disability

D13 - D13p: In case more explanation is required for "the information that you need", enumerators should give an example according to the beneficiary's needs by asking one additional question "What information do you normally need?"

D14 – D14p: is the opportunity that other people (local authorities, relatives, etc.) create for the beneficiary and is unrelated to his/her ability

D15 – D15p:

- Including beneficiaries' ability to move on their own and when they use aid devices such as wheelchairs, crutches, etc.
- "Places around here" include around the house, places around the house such as neighbors' houses, garbage dump, market, etc.

D24: Excluding assessment of satisfaction with the service used, only that of satisfaction with easy access/to see a doctor/medical staff

D25 – D25p:

- Including beneficiaries' ability to move on their own and when they require someone else to get them, by means of transportation, to where they want to be
- Only means of transport, excluding vehicles that are assistive devices such as wheelchairs, shakers, etc.

D28:

- Option 2: For example, people around are less stigmatized
- Option 3: For example, there are more services for persons with disabilities at home, and wheelchair rental services are available, etc.
- Choose both options 6 and 7 if the reason is income (of the beneficiary and his/her household) increases/decreases due to changes in work (losing job, less/more job, changing job, etc.). Only choose option 6 if still doing the same job with no change but less salary
- Option 9: For example: The household has a new member (marriage, childbirth), a beloved family member has passed away, the conflict in the relationship with someone is resolved, etc.

SECTION E

E2 – E3: Private health insurance in this question includes the following types:

- Human accident insurance
- Commercial health insurance
- Health care insurance
- Life insurance with health care supplement package included

E4: Enumerators pay attention to the "often" of using health insurance cards to select the appropriate option. For example:

- During the year, the beneficiary uses the health insurance card twice: If once in January, and once in July ☐ choose the option "4. Semi-annually (at least once every 6 months). But if both times are in January ☐ select "5. Annually or less"
- During the year, the beneficiary uses the health insurance card 12 times: If every month he/she goes to get medicine once ☐ choose the option "2. Monthly". If the 12 uses only fell in January and July ☐ choose the option "4. Semi-annually". If 12 uses are concentrated in January ☐ select "5. Annually or less"

E5c – E5f: Asking the right questions about the difficulties experienced by the beneficiary when without aids and without assistance

E5c: In case the beneficiary is able to walk but unable to walk up the stairs or vice versa, choose the option with more difficulty level

Walking in this case is counted within about 100m

E5e – E5f: It should be emphasized that these difficulties are due to health problems. For children, if it is due to skill problems (being young), it is counted as not difficult

E6: Other difficulties may include difficulty in performing activities that require manual work such as carrying heavy objects, working with machinery (excluding self-care at E5e)

E9: If beneficiaries do not have cognitive abilities, ask the caregiver's cognitive abilities

E10: The certificate of disability in this question includes the certificate of disability, paper/book of social allowance for the disabled, certificate/card of the sick and invalids/wounded soldiers.

E12: Enumerators can see the information in the certificate of disability, the paper/book of social allowances for the disabled, the certificate/card of the sick and wounded soldiers; and seek more information from guides and health station's personnel for this question.

In case information cannot be obtained from the above sources, enumerators consult beneficiaries.

E13:

- Enumerators can see the information in the disability certificate, and seek more information from guides and health station's personnel for this question.
- Enumerators refer to the definition of six (06) types of disability
- If it is not possible to distinguish beneficiaries with disabilities as "5. Cognitive & Mental health" or "6. Intellectual" or both, enumerators choose "-77. Others" which has a full description

E16:

- If the beneficiary answers questions both by him/herself and with a person to support for answers, then ask the perception of both.
- Just hearing about it, knowing it is counted as yes, it is not necessary to know the content of that law or policy
- In case the beneficiary mentions the law/policy in the interview (he/she has heard and known about it), enumerators automatically records the appropriate answer option.
- Enumerators clearly distinguish between "laws, policies, welfare, subsidizes supporting persons with disabilities" and "perception of laws, policies, welfare, subsidizes supporting persons with disabilities". Beneficiaries may receive monthly benefit and be exempted from certain fees/charges but they may not know it is disability benefits that are covered by the law/policy.

E17: "Read or know" means having read or known the content of the law or policy; may only some articles and provisions and not necessarily all (awareness level is higher than E16)

E19:

If there are multiple causes as the beneficiary has more than one type of disability/functional difficulty, choose the cause that leads to the most severe disability, affecting the beneficiary's life (consulting the beneficiary)

Birth defects can be identified before birth, at birth, or later in life. If the beneficiary's disability/disabilities/are not evident at birth but is/are discovered months or years later, enumerators may ask more about whether he/she has seen a doctor and the doctor's conclusion to determine if it is birth defects or not.

Common birth defects are:

- Heart defects
- Cleft lip or cleft palate
- Spinal cord fracture
- Crooked legs
- Down syndrome

E21:

- If during the interview, beneficiaries mention various difficulties, but when asked this question, no answers are given or the difficulties mentioned before were missing, enumerators select the answers mentioned by beneficiaries earlier
- If beneficiaries answer "Unable to communicate/Do not participate in economic activities/Do not participate in recreational activities, etc.", enumerators select "Yes" at the corresponding difficulty.
- Option 1 – e.g.: no separate walkway for people with mobility impairments/visual impairments, no/lack of dedicated facilities/infrastructures for people with disability – including indoors and outdoors

E27: Enumerators can provide more explanation if asked many times but beneficiaries do not understand: Self-control means being able to make decisions and choices without being influenced by/dependent on other people's opinions

E35: If beneficiaries reply that they have no dreams, hopes or desires, choose option "-99. Don't know."

SECTION F

F1:

- Rehabilitation is the use of medical and sociological measures, etc., to reduce the impact of reduced ability and disability, to give persons with disabilities the opportunity to integrate, re-integrate into society, and have equal opportunities to participate in family and social activities, live a normal life as much as possible for their circumstances. Purpose of rehabilitation: to help disabled people with self-care, communication, mobility, occupation and income; maximize recovery of reduced physical, psychological, occupational and social capabilities; prevent secondary injuries; strengthen the remaining capacities to limit the consequences of disability; change attitudes and behavior of society, accepting disabled people as equal members of society; improve the environment, barriers for disabled people to integrate into society such as roads, offices, houses, places for cultural activities, tourism and sports; create favorable conditions for persons with disabilities to integrate and re-integrate into society so that they have a better quality of life such as self-care, job creation, entertainment and recreation.
- Including rehabilitation services provided at home or elsewhere

F3: If the beneficiary goes to a doctor and is instructed thereby, then practices at home by himself (without a qualified person's guidance), then only consider doctor visits and doctor's instructions as an attempt to seek rehabilitation services and disregard practice at home.

F7:

- If the beneficiary only says the name of the doctor/healer, and asks if it is a doctor, if so, select "5. Private clinics", otherwise select "6. Traditional healer"
- If the Doctor provides medical examination and treatment at home, select "5. Clinic"
- If the Doctor/healer has a registered private clinic, select "5. Private clinics"
- Option 11: include all centers/facilities/schools with supporting activities for persons with disabilities such as schools, special education centers for children with autism/hyperactivity disorder, vocational schools for persons with disabilities

F12: If toys, books, paintings and pictures are used for the purpose of helping persons with disabilities improve their functions, such as teaching aids for children with autism, hyperactivity disorder, etc., they are also considered assistive devices. They are not instead if used for entertainment purposes.

In addition to buying (discovering information, consulting, going to see, etc.), receiving (given by others), self-made, select "yes" if the beneficiary borrows or rents, etc.

F17: Refer to the device list (including device name, image and description)

- Living aids are tools that help the beneficiary to live more easily such as shower chairs, toilet seats, pressure relief cushions

F19: In the case that in F18 all options are selected (i.e. the beneficiary uses up all the assistive devices selected in F17), in F19, option "1. Yes" can still be selected (i.e. there may still be assistive devices that the beneficiary does not use). Example: the beneficiary has 2 crutches, 1 of which is used and 1 is not; or he/she has a lot of daily living aids (option 15 in F17) but does not use all of them.

F20: In case the beneficiary answers "it's inconvenient to use" including pain when using, discomfort when using, knowing how to use but having difficulty using, etc.

F21:

- If the beneficiary is given an assistive device, ask where they received it, do not ask who provided/donated it
- If the beneficiary only knows he/she received the assistive device at the Commune Health Station (in fact, it is sponsored by NGOs), then select option "3. Commune/ward health station"

F24: In case the beneficiary has received the assistive device provided by UIPs (under 30 days), ask why at that time the beneficiary has not received support.

F25:

- Including both paid and free services (someone comes to support, give care or teach a family member how to give care)
- Includes all health care services, mental health, psychological health care, feeding, washing (excluding rehabilitation care)
- Excluding cases where household members provide care, only consider cases where the beneficiary is given care by relatives outside the household, friends or other services

F32:

- Excluding cases where the beneficiary's family repairs or installs equipment by themselves
- Only including cases where the beneficiary gets support or rents and pays by themselves

F36:

- Legal support for persons with disabilities: when in need of legal aid, persons with disabilities with financial difficulties can rely on the provincial/city State Legal Aid Center for guidance and settlement. Persons with disabilities can receive free legal aid if they fall into the following categories: Belonging to near-poor households, people receiving monthly social allowances; people with meritorious services to the revolution; children with disabilities; Persons with disabilities being ethnic minorities residing in areas with extremely difficult socio-economic conditions.

F39: Psychological counseling for persons with disabilities is an interactive process between a psychologist (a person with expertise, skills, and professional ethics) and a person with disabilities. Thereby, persons with disabilities receive psychological counseling, through intimate and sincere dialogue and confiding to help persons with disabilities understand and accept their reality, and find their own potential to solve their own problems.

F41: If the beneficiary is not able to communicate select "2. It could not help"

F42: In case the beneficiary is blind but still turns on the TV to listen, still a select option "4. Watch a movie (at cinema or home)."

F44: Including support by people inside and outside the household

F48: Only including support for persons with disabilities by local agencies/authorities, organizations, businesses, philanthropic activities,…

Excluding support for the beneficiary or their family where the target group of support activities is not persons with disabilities. For example, if the beneficiary receives COVID-19 support in the same group with other local non-disabled people, it does not count. If the beneficiary receives COVID-19 support but this support is only for the disabled group, it is considered "yes" at F48

F50: If the beneficiary is severely disabled, unable to improve their conditions, hence doesn't seek any services, select option "4. Not applicable: No support or no use of services before the pandemic"

SECTION G

G1, G2:

- The beneficiary identifies household members by himself
- Household members do not include: maids, tenants

- In case the beneficiary is not able to identify household members by themselves, the following definition can be provided:

Household consists of family members living in the same house. Household members are not necessarily those registered on the household book.

With G1: If the beneficiary is not able to identify by himself, people who live and have meals together with them every day count.

If the beneficiary rents a room somewhere other than their hometown/where they have home then G1 is the number of members where they rent a room and G2 is the number of members in their hometown. Then, questions in section G are all about the house/activities where the beneficiary lives.

Example:

- The son/daughter's family who has been separated from the household, but still lives with his/her parents, lives and have meals together, still count as a household member.
- The son/daughter's family who has not yet separated from the household, but does not live in the same house, does not count as a household member.
- In case children or family members are out of town for work or study, but still return home during the summer or holidays to live, depend on or provide for the household economically, they still count as household members.

G3h: Similar to the rule of section C8

G8:

- If the household has more than 1 house, only the area of the house where they are living counts
- Including building area and outdoor area
- If the household lives in a rented/borrowed house, take into account the area of this house

G9:

- If the household rents/borrows the house, only take into account the area that the household rents/borrows
- If the house has many floors, take into account the total floor area. For example, if a house has 2 floors (i.e. ground floor and first floor), the area of the house is the total area of 2 floors. If the house has 1 floor and 1 loft, the area of the house is the total area of the floor and the loft. The beneficiary may not know the exact size of small parts of the house like the loft. In that case, estimate the area of this part based on the area of 1 floor.
- If the toilet is located outside the house, the area of this part is not included in the area of the house.

G10: If the beneficiary's family has a shared house (co-owned) with other people (including at least 1 person in the household), select option "1. Owned by family members of the beneficiary"

G13: Only the toilet that the household uses counts, not the toilet that the household owns

G14: Only equipment owned by the household count, not rented or borrowed ones

VI. Detailed instructions on the children's questionnaire

All instructions and notes in the children's questionnaire are integrated into the questionnaire and are applied similarly to the adult questionnaire.

B5. Instructions for obtaining consent to participate

Provide background of the evaluation and obtain the caregiver's consent to participate first, then the child's.

- Sample form to obtain the child caregiver's consent: form B5a
- Sample form to obtain the child's consent: form B5b

Only conduct the interview after obtaining the consent of the caregiver and the child.

D18: Ask about normal conditions, not special situations.

Example 1: In the past 2 weeks, if the child is sick, stays in bed and cannot have a seat to eat together, or needs to have many meals so can't not eat at the same time with others, this case does not count, ask about normal conditions where he is not sick.

Example 2: In case of young families where each family member has meal at a different time, including the child (due to being affected by working hours, activities, etc., not because of discrimination against the child), it will be still considered "eating with the family like other members", still select option 4.

D21: Other children refers to children in general, not just their friends

ANNEX 7.4: QUALITATIVE DATA COLLECTION TOOLS

BARRIERS AND FACILITATORS AFFECTING SUCCESS IN THREE INTERVENTION AREAS

Rehabilitation

USAID and WHO are encouraging rehabilitation to be integrated within health systems. There are six building blocks for health system strengthening (bolded below). For each of the six areas, *please select the column that best describes your opinion of USAID's level of success for that topic.*

Topic Areas	Not sure	Not Successful	Limited success	Moderate Success	High Success	*Why* *(please explain your selection)*
1. Expand and strengthen the **rehabilitation workforce**						
2. Increase the availability of **rehabilitation services**						
3. Provide **assistive products**						
4. Improve **financing** for rehabilitation						
5. Integrate **rehabilitation data** into health information systems						
6. Strengthen **governance** for rehabilitation						

7. For the topics identified as successful, what do you think helped USAID or its partners to achieve this success? How?

8. For the topics identified as not successful, what do you think has limited USAID or its partners in achieving success? How?

9. What changes has USAID, or its partners, already made in programming to strengthen rehabilitation? What additional changes should be made?

Social Service

Next, we'll move on to social services. For the purposes of our work, social services (like rehabilitation) have six main intervention areas. Unlike rehabilitation, which aims to be integrated within the health system, social services are person-focused interventions. These are shown in the table below. Do these six areas capture all the main areas under social services? Anything missing?

For each of the six areas, *please select the column that best describes your opinion of USAID's level of success for that topic.*

Topic Areas	Not sure	Not Successful	Limited success	Moderate Success	High Success	*Why* *(please explain your selection)*
10. Expand availability of **home care services**						
11. Strengthen **care-giver capacity**						
12. Provide **psychological support**						
13. Improve access to **disability benefits**						
14. Increase **participation** of persons with disabilities						
15. Offer **legal aid**						

16. For the topics identified as successful, what do you think helped USAID or its partners to achieve this success? How?

17. For the topics identified as not successful, what do you think has limited USAID or its partners in achieving success? How?

18. What changes has USAID, or its partners, already made in programming to strengthen social services? What additional changes should be made?

Disability Policies

Currently, USAID's disability programs emphasize accessibility, non-discrimination, and strengthening Organization of Person with Disabilities (OPDs). These are summarized below. Do these three areas capture all the main areas addressed through disability policy? Anything missing?

For each of the three areas, *please select the column that best describes your opinion of USAID's level of success for that topic.*

Topic Areas	Not sure	Not Successful	Limited success	Moderate Success	High Success	*Why (please explain your selection)*
19. Achieve a **barrier-free society**						
20. **Reduce discrimination** or stigma associated with persons with disability						
21. **Strengthen** Organization of Person with Disabilities (OPDs)						

22. For the topics identified as successful, what do you think helped USAID or its partners to achieve this success? How?

23. For the topics identified as not successful, what do you think has limited USAID or its partners in achieving success? How

24. What changes have USAID or its partners already made in programming to strengthen disability policies? What additional changes should be made?

25. Is there anything else you would like to add related to the factors affecting the success of the three intervention areas supported by USAID?

QUALITY OF REHAB AND SOCIAL SERVICES

This next part of the interview relates to your views on the **quality** of rehabilitation and social services **in USAID targeted provinces**. We are looking at your "overall" impressions, but recognize there

may be differences between provinces and you are welcome to give details in your explanation. *For the four services given below, please select the column that best describes your opinion of the quality of that service.*

Service Areas	Not sure	Poor	Average	Good	***Why*** *(please explain your selection)*	**How is this measured?** **(***What tools are available or used to measure quality?)*
26. How would you describe the quality of **rehabilitation services**?						
27. How would you describe the quality of **assistive products**?						
28. How would you describe the quality of **home care services**?						
29. How would you describe the quality of **psychological support**?						

30. What changes have USAID or its partners already made in programming to improve the quality of rehabilitation and social services? What additional changes should be made?

ACCESSIBILITY OF REHAB AND SOCIAL SERVICES

This next part of the interview relates to your views on the **accessibility** of rehabilitation and social services **in USAID targeted provinces**. This means how easy or how difficult is it for people to receive services. For the four service areas below, please *select the column that best describes your opinion of the accessibility for that service.*

Service Areas	Not sure	Difficult	Neither difficult nor easy	Easy	*Why* *(please explain your selection)*	What are the enablers or barriers that influence accessibility to these services?
31. How would you describe the accessibility of **rehabilitation services**?						
32. How would you describe the accessibility of **assistive products**?						
33. How would you describe the accessibility of **home care services**?						
34. How would you describe the accessibility of **psychological support**?						

35. What changes have USAID or its partners already made in programming to improve the accessibility of rehabilitation and social services? What additional changes should be made?

_____

_____

FINAL QUESTIONS:

36. The overall aim of USAID's interventions is to improve quality of life for persons with disabilities. Do you think investing in rehabilitation, social services and disability policies will achieve this aim?

37. Generally, how has COVID-19 impacted interventions related to people with disabilities?

1. PROBE: For Government programs? USAID programs? Other programs?
2. PROBE: For rehabilitation? Social services? Policy?

GUIDING QUESTION TO KEEP IN MIND: *To what extent have the availability, accessibility, and quality of rehabilitation and social services in USAID targeted provinces changed over time? Rehabilitation interventions are organized against the building blocks of health system strengthening (workforce, service, assistive products, information management and finance). The interview format follows this structure. With availability, quality, and accessibility questions highlighted accordingly.*

KII SITE VISIT: HEALTH FACILITY DIRECTOR/MANAGEMENT

Ideally, the respondent should be the Director or Deputy Director of the facility to gauge their understanding of the rehab situation in their facility. The head of the rehab department may be called upon and this is okay.

1. Can you provide information on whether your **facility is licensed to provide rehabilitation**?

Probe: Yes, no? When? Applied? Not yet applied? Why not? Explain. *(Triangulating data from desk review)*2. Can you provide details on the **rehabilitation workforce** in your facility? The number of licensed rehabilitation doctors, PTs, OTs, SLTs, prosthetists, orthotists, others? *(Triangulating data from desk review table)*

2a. How would you describe the number and type of your rehabilitation staff? (Prompt: sufficient, insufficient). Explain.

2b. What is your general assessment of the quality of the rehabilitation personnel? How do you measure it? What does your facility do to improve the quality of personnel?

2c. What are the best achievements you can think of related to rehabilitation workforce?

2d. What are the biggest challenges you face related to the rehabilitation workforce? How do you plan to address these?

3. When did your facility begin providing **rehabilitation services**? What rehabilitation services do you provide?

3a. How has this changed in the last two years? How do you record the uptake of these services?

3b. How would you describe the quality of rehabilitation services? Why? How do you measure quality?

3c. What are your thoughts on the accessibility of your rehabilitation services? (Prompt: difficult for people to access? Easy to access? Main barriers to accessing services? Main thing(s) that help people access services?)

3d. What is the impact of adding rehabilitation services to your facility? (Prompt: positive, negative) Explain.

3e. What are your biggest challenges related to rehabilitation services? How do you plan to address these?

4. What are the type(s) of **assistive products** available in your facility?

4a. How has this changed in the last two years?

4b. How would you describe the quality of the products? Why? How do you measure quality?

4c. What are your thoughts on the accessibility of assistive products? (Prompt: difficult for people to access? Easy to access? Main barriers to accessing services? Main thing(s) that help people access services?)

4d. What are the biggest challenges related to assistive products? How do you plan to address these?

5. What method or tool does your health facility use for routine reporting to DOH? (Prompt: DHIS2, electronic?)

5a. What **information is related to rehabilitation**? (Prompt: rehab workforce; patients receiving rehabilitation)

5b. How does your facility use the Disability Information System? How many patient profiles are in the system? How is it updated? What do you do with the information?

5c. What are the biggest challenges related to data collection or information sharing? Do you have recommendations on how to address these challenges?

6. How does your facility share information with other health facilities (prompt: referrals?) How does your facility link with other organizations (prompt: red cross, peoples committee, OPDs, VAVA)?

7. Can you describe the level of support that **VSS provides for rehabilitation services**?

7a. Total reimbursement for rehabilitation services in 2021? What percent of hospital income does this represent? What is the trend for reimbursement (increasing, decreasing) and potential reasons for this?

7b. What are the main challenges related to reimbursement for rehabilitation services? AT services? Do you have recommendations on how to address these challenges?

8. In your opinion, what is the relationship between rehabilitation and quality of life for persons with disabilities?

(Probe: direct link, indirect link, no link) Please explain your answer.

KII SITE VISIT: HEALTH FACILITY REHABILITATION UNIT

Ideally this person will be the head of the rehab department or maybe head of PT, OT ST section.

Okay if this is the same person who was interviewed Health Facility, but this interview should take place in the rehab unit itself.

We are interviewing you to understand more about rehabilitation services provided in your department/unit.

1. Can we confirm the number and type of staff in your unit? *(Triangulating)* Where are records kept regarding licensing?

1a. What rehabilitation techniques (services) is your department licensed to provide? What services are you unable to provide? Why? What are the biggest challenges related to workforce and service availability?

2. How do you monitor the quality of work in your department? (Probe: related to staff performance or service provided). What are the main challenges related to quality control?

3. About how many patients does your unit see per month (in-patient, out-patient, any treatments given at home?). How is this information recorded? What is the trend for rehabilitation uptake? (Prompt: increasing, decreasing). Why?

4. What percentage of rehabilitation treatments are covered by VSS? How about assistive products?

4a.What are the main challenges your department faces related to reimbursement for rehab/AT services? Why?

5. What is the **process for patient evaluation**? Is there a form that is used? Any changes in this process in the past two years? Might it be possible to see some examples? (*Note: check for patient goals). When reviewing the patient form, discuss if goals are set, if the patient is involved, if goals are reevaluated at discharge.*

6. Rehabilitation is all about improving function. How does your department **measure functioning** at the onset of treatment and again at discharge (or some other point)? What tool do you use? May we see some examples? (*Note: request to see patient forms where this is used*).

7. How does your department use **treatment protocols** (guidance on how to treat different pathologies)? Can we see some examples of them?

8. What **patient records** exist for rehabilitation? Are these hand-written or electronic? Who writes information or inputs data on the computer? What are the biggest challenges related to data collection and use? Why?

9. How are your staff involved in providing assistive products? What training have they received?

9a. Can you describe the **process of providing assistive products**? (Prompt: individual assessment, user training)

9b. How would you describe the quality of assistive products? What recommendations do you have about improving the quality of assistive products?

9c. How would you describe the accessibility of assistive products for people who need them? (Prompt: easy to access, difficult to access). What are the biggest barriers or facilitators to accessing products? How could access be improved?

10. What are the biggest challenges that the rehabilitation department faces? Why? What recommendations or plans do you have to address these challenges?

11. What overall recommendations do you have that could help improve the availability, accessibility and quality of rehabilitation services in your department?

Reminder: Information needed that contribute to QUALITY of rehabilitation services:

a. Degree to which rehabilitation providers consistently write treatment goals and measure functional outcomes.

b. Degree to which rehabilitation providers utilize clinical practice guidelines (treatment protocols)

c. Degree to which new assistive products are provided with individual assessment and user training

KII HOME CARE PROVIDER/DIRECT CARE PROVIDER

GUIDING QUESTIONS TO KEEP IN MIND: availability, accessibility and quality of social services

a. Percent with improvement in "measures of care outcomes among persons with disabilities served in USAID supported provinces.

b. Percent of care givers with improved capacity (attitudes and perceived skills) to care for persons with (severe) disabilities. Information collected in this interview also related to PIRS #6 related to social services- *Percentage of persons with disabilities with improved/stabilized measure of care outcomes within 3 months after service initiation.*

During this interview we would like to ask you about your own experience as a care provider and then some additional questions on the broader context of home care providers in this province or in Vietnam.

Introduction – information about the home care provider/direct care provider

1. Information about interviewee: family member, care provider who is not a family member?
a. PROBE: Relation to person with disability; job title as a care provider (care monitor, care collaborator)

2. In addition to your role in caring for (name of person with disability) do have other formal employment?

b. PROBE: Specific job, duties, full time, part-time, care provider for other individuals – how many?

c. PROBE: Do you receive any payment for being a care provider?

3. How long have you been a care provider for [name of person w/disability]?

Training /Supervision-Support for the home care provider/direct care provider (Quality)

4. What training or support did you receive to be a direct care provider?
    a. PROBE: Specific training modules, tools, duration,

5. I'd like to ask you some additional questions about the training:
a. What training topic was most helpful?
b. What topic was missing, or that you would like to have more training about?
c. Has the training made you a better care provider? If so, wow has the training made you a better care provider?

6. What support have you received after training?
a. PROBE: Supervisor or trainer visit during your work?
b. PROBE: Any feedback on the quality of your work?
c. If you have a very difficult case/situation, where can you go for help?
d. What recommendations do you have to improve the support you receive as a care provider?

Details about direct care provided (Quality)

7. How much time in a day or in a week do you provide direct care for (name of this person with disability)?

8. Can you describe what you do or how you help (name of this person with disability).
    a. PROBE: ADLs, communication, psychological support?
    b. PROBE: Any house modifications, or assistive products?

8a. How were these interventions decided?

9. Can you tell us about any specific goals you or (name of this person with disability) are working toward?
a. How were these goals determined?
b. If you set goals, is there a record of goals that have been achieved?
c. Can you describe some of the outcomes of the care you provided?
    a. PROBE: body condition, function, ADLs, emotional behavior?

10. Can you tell me about any written notes that you keep? What you do with them, who sees them?
a. PROBE: For example, any written forms, or instructions or other documents as a care provider?

11. How do you feel about your abilities as a care provider?
    a. PROBE: For example, fully confident, a little unsure, uncomfortable. Explain.

12. As a care provider, can you describe an experience that you feel proud of?

a. One example of something you have done well. In your role as a care provider.

13. What are the biggest challenges you face as a care provider?
a. PROBE: What do you find most difficult? What help do you need?

14. How has the quality of the care you provide changed over time?
a. PROBE: Explain. What led to the changes?

Attitude of home care provider (Quality)

15. In your view, what does it mean for [name of person w/disability] to have a good quality of life?
a. PROBE: For example: activities, relationships, participation, emotions, etc.

16. How has your role as a care provider improved (name of person with disability)'s quality of life?
a. PROBE: Can you give some examples.

17. In the past two years, how have <u>your</u> attitudes changed about persons with disabilities?
a. PROBE: What have you learned as a care provider? What is different from before?
b. What led to this change?

Availability of trained home care providers

18. How would you describe the number of trained care providers (family members or non-family members) in your province?
    a. PROBE: For example, sufficient, insufficient?
    b. PROBE: What is the reason you selected this response?
    c. PROBE: If insufficient, what recommendations do you have to increase the availability of trained care providers?
    d. PROBE: Who should do this?

Accessibility of (home) care providers

19. In your opinion, how difficult is it for a person with severe disability to access a trained home care provider?
    a. PROBE: For example, not difficult, very difficult? Why?
    b. PROBE: What limits someone from accessing a trained home care provider?
    c. PROBE: What can help a person with severe disability access a trained home care provider?
    d. PROBE: What recommendations do you have to increase the accessibility to trained home care providers?

Qualitative Questions to Supplement QOL Survey

These are potential questions for people with profound intellectual and multiple severe impairments whereby communication with the individual is extremely labored or time consuming and/or not yet well -developed.

1. Can you describe some of the main events in PERSON'S "normal" day? Start from the time PERSON wakes up until the time PERSON goes to bed. Please be as detailed as possible … to include toileting, hygiene, dressing, eating, day-time activities or positions.

2. How are you able to communicate with PERSON? (sounds, gestures, body movements, communication aids – e.g. equipment or sign boards)
    a. To what extent can PERSON understand what you're saying? How do you know? Give details.
    b. To what extent can you understand what PERSON wants? How do you know when PERSON is happy? What makes PERSON happy? Give details.
    c. How satisfied are you with your communication method? What could make it better?

3. What things can PERSON do for him/herself? (For example: eating, rolling over, sitting, dressing). Please describe how these different actions are done.

4. What assistive product (device) does PERSON have to help PERSON function better (for example: to help with eating, or moving or sitting)?

5. What assistive product (device) does PERSON need to function better? (For example: to help with eating, or moving, or sitting). Is this available? Explain.

6. What does PERSON do during the day? How does PERSON spend his/her time?

7. Who spends time with PERSON during the day? About how much time? What do you/they do together?

8. Can you describe PERSON's friendship with others? To what extent does someone from outside the family come to visit? (Who, how often?)

9. How do you show PERSON love or affection? How does PERSON return that affection? In what way?

10. What is PERSON's physical condition? Are there any wounds or contractures? What things do you do to prevent or treat these problems? Do these things help? Explain.

11. What things do you do to adapt the environment or help PERSON have more life experiences? (For example, providing things that are nice to see, things to listen to, changing the environment – going outside).

12. In your view, what does it mean for PERSON to have a good quality of life? (Probe: for example, activities, relationships, emotions, participation, health)

13. How do you think PERSON would rate his/her quality of life on a scale of 1 to 5 with 1 being very low and 5 being very high?

14. If PERSON has received any rehabilitation service, can you describe any improvements in PERSON's life that have resulted from this service?

OBSERVATIONS:

In addition to asking the specific questions, the interviewer should note the following:

A. Hygiene of PERSON – teeth, hair, nails, body, clothes.
B. Body condition of PERSON: contractures, any wounds, weight.
C. Respect for PERSON – level of engagement with PERSON (kindness, indifference, irritation).

ANNEX VIII: SUMMARY OF EQ3 INDICATORS AND DATA COLLECTION TOOLS/METHOD

REHABILITATION		
Topic	**Indicator**	**Tool/Method**
Availability	a. The percentage of health facilities that provide rehabilitation services - facilities that have one or more rehabilitation professionals.	SRDT, KII health site
	b. Number of staff providing rehab services in each discipline per 10,000 population with program support.	SRDT, KII health site
	c. Number and type of assistive products available in health centers.	SRDT, KII health site
Accessibility	a. The percentage of health facilities providing rehabilitation interventions covered by insurance.	SRDT, KII health site
	b. Stakeholder and persons with disabilities / caregiver perceptions of ease/difficulty accessing rehabilitation services	KII, QOL survey
Quality	a. The percentage of beneficiaries reporting improvement in function	Site visit guide for rehabilitation unit
	b. The degree to which rehabilitation providers consistently write treatment goals and measure functional outcomes.	
	c. The degree to which rehabilitation providers utilize clinical practice guidelines	
	d. The degree to which new assistive products are provided with individual assessment and user training.	
	e. Persons with disabilities satisfaction with service received	KII persons with disability; QOL survey
SOCIAL SERVICES		
Topic	**Indicator**	**Tool/Method**
Availability	a. Stakeholders and persons with disabilities/caregiver perceptions of adequate availability of various types of social service support.	KII Stakeholder; QOL survey
	b. Number of organizations providing home-based care services for persons with (severe) disabilities.	KII stakeholder; document review
	c. Number of people trained to provide home care for people with (severe) disabilities.	KII Stakeholder; document review

Access-ibility	a. Stakeholder and Persons with disabilities/caregivers who report difficulty accessing social services	KII Stakeholder; QOL Survey
	b. Number of social services covered by insurance.	SRDT; KII Site visit
	c. Local government budget for social services.	KII Stakeholder
Quality	a. Percent with improvement in "measures of care" outcomes among persons with disabilities served in USAID supported provinces	KII Caregiver, KII persons with disability; QOL survey
	b. Percent of caregivers with improved capacity (attitudes and perceived skills) to care for persons with (severe) disabilities	
	c. Persons with disabilities who are satisfied with services received.	QOL survey; KII Caregiver

ANNEX IX: DURATION OF QUANTITATIVE INTERVIEWS

	Adult	Child
Total	**~1 hour (30 mins – 3 hours)**	**~1 hour (30 mins – 3 hours)**
Part A Pre-survey information: for enumerators to fill in known information of the respondent before the start of the interview	~4 mins (2 mins – 12 mins)	~3 mins (2 mins – 11 mins)
Part B Introduction & consent form	~11 mins (6 mins – 30 mins)	~7 mins (6 mins – 13 mins)
Part C Socio-economic characteristics of the respondent	~8 mins (7 mins – 33 mins)	~31 mins (9 mins – 55 mins)
Part D Quality of life: WHOQOL-BREF+DIS for adults & ScoPeO-Kids for children	**~16 mins (7 mins – 48 mins)**	**~13 mins (7 mins – 44 mins)**
Part E Health and disability	~16 mins (7 mins – 43 mins)	~12 mins (7 mins – 24 mins)
Part F Rehabilitation and social services	~14 mins (11 mins – 44 mins)	~16 mins (11 mins – 39 mins)
Part G Household information	~9 mins (7 mins – 35 mins)	~9 mins (7 mins – 44 mins)
Part H Wrap-up and contact for follow-up survey	~4 mins (2 mins – 20 mins)	~4 mins (2 mins - 15 mins)

ANNEX X: SAMPLING & SAMPLE

Adult sample size

For adults, each of the five WHOQOL-BREF+DIS domain scores (scale of 0-100) will be the basis for sample size calculations.[10] To identify a reasonable effect size to build into sample size assumptions, the ET did a literature search of studies in Vietnam that utilized the WHOQOL tool and measured a change in scores before and after an intervention. The WHOQOL tool's disabilities module (DIS) has not been used in Vietnam to our knowledge, so the ET sought studies that collected pre/post measures with the WHOQOL-BREF tool in a population facing QOL hardships that might be somewhat similar to those with disabilities. Though options were scarce, the ET found a study of a one-year methadone treatment intervention among drug users (some with comorbidities) in mountainous provinces of Vietnam to be a reasonable reference point.(Tran et al. 2020) This study's baseline QOL scores (transformed to a 100-point scale) in each domain ranged from 50.5 to 61.4, which aligned very closely with pilot data reported in the WHOQOL Disabilities Module manual (average score of approximately 60). This reassured the ET that this Vietnam methadone study population's QOL might be within a similar range as the targeted population with disabilities. The researchers measured a significant 0.23 standard deviation (SD) change in WHOQOL-BREF score on average across all domains. This aligns just above a "trivial" (<0.2) effect size according to the well-known thresholds developed by Cohen,(Cohen 1988) and the ET therefore selected this as a conservative basis for effect size assumptions meant to identify a small but potentially meaningful change. Depending on the mean and SD the ET might measure in the USAID beneficiary population, this might translate to a 5-10 percent change in baseline score.

The ET used the Stata 15 software (College Station, USA) *sampsi* command for a repeated measures comparison of means using the following syntax:

sampsi 0 0.23, sd1(1) sd2(1) method(change) r01(.35) pre(1) post(1) power(0.8).

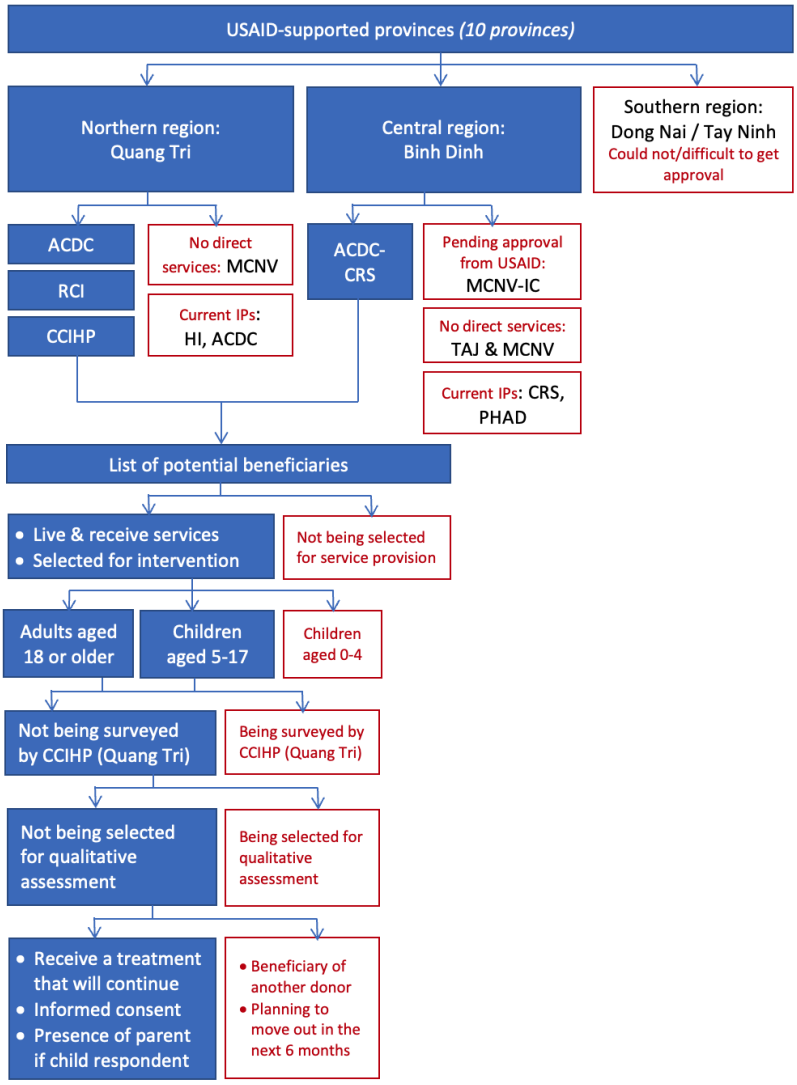
This reflects the following underlying assumptions:

- MDES of at least 0.23 standard deviation change in baseline WHOQOL-BREF+DIS domain scores
- Modest correlation of baseline measurements and outcome (0.35) (Cohen 1988)
- Two measurement points (baseline and follow-up)
- 80 percent power
- 95 percent confidence level ($\alpha = 0.05$, two-tailed)

By these assumptions, the evaluation will need 386 persons with disabilities, plus a 25 percent increase to account for the number expected to be lost to follow-up (due to decision not to participate or inability to re-contact). This results in a targeted baseline sample **total of 483 adults with disabilities**. The ET expects it will need to reach out to more than this number, as some will refuse to participate at baseline. The sample enrollment process is described in greater detail below.

[10] As a reminder, WHOQOL-BREF+DIS scores are reported as five separate numbers reflecting distinct domains of QOL. While the ET will be required to deviate from WHO guidance to calculate single "percent change" and "percent with improved QOL" metrics solely for the purpose of PMP reporting (as described in Table 2), the follow-up report will represent the true QOL outcome measure as the five separate domain scores. It is these metrics that are the basis for sample size calculations.

Figure 21: Sample Enrollment Process



Child sample size

The sample size for children will be developed using the same assumptions above. However, the ET expects that the number of children the IPs recruit as new beneficiaries during the rolling baseline period will be much smaller than that of adults, making it improbable to obtain a sample size of 483. The ET will assess the expected number of beneficiaries IPs and their supported service providers plan to recruit during the baseline period and will then estimate the MDES feasible with that sample. The next section details how the ET will approach sample size decisions.

SAMPLING APPROACH

Given the expectation that it will take approximately three months for IPs to recruit a sufficient number of new beneficiaries to comprise the baseline sample, the ET will collect data from **all beneficiaries** that meet eligibility criteria during the rolling baseline period up until the desired sample size target within specified subcategories is met. This means the ET will not do cluster-based random sampling and has therefore not built clustering into sample size assumptions above.

Three or more months prior to the 2022 baseline, the ET will request each IP to submit the expected number of new beneficiaries it will recruit, by month and province, over the rolling baseline period. They will be asked to disaggregate these expected beneficiaries by: adult/child; direct/indirect

beneficiaries (for supported service providers who have agreed to cooperate); and rehabilitation/social service. The ET will assume approximately 75 percent of direct and 25 percent of indirect beneficiaries[11] will participate and apply these assumptions to help confirm whether a suitable number of beneficiaries will be available for baseline data collection within three months or less. This process will also help the data collection team plan personnel and logistics. If this process reveals an insufficient number of beneficiaries to meet sample size for a 0.23 effect size above, the ET will discuss with USAID the option to extend baseline data collection longer than three months. Or if it is not possible to achieve 483 based on the expected number of new beneficiaries that IPs and service providers will recruit, the resulting MDES will be larger, as shown in the table below.

ILLUSTRATION OF SAMPLE SIZE REQUIREMENTS FOR VARIOUS MINIMUM DETECTABLE EFFECT SIZES

MDES (keeping all other assumptions constant)	Total sample required (including 25 percent increase for attrition)
0.23	n=483
0.25	n=408
0.3	n=284
0.35	n=209
0.4	n=160

[11] A low expectation for indirect beneficiary participation was intentionally chosen to be conservative and realistic about the challenges the ET may face in gaining cooperation from these external providers. It is hoped that this number will be higher with strategic outreach and IP support.

ANNEX XI: SELF-REPORTING DATA TABLE (SRDT)

1. General information

No	Content	Data	Instruction
1	Full name of Reporter		
2	Reporter's mobile number		
3	Rehabilitation Unit's mobile number		
4	Name of Health Facility		
5	Name of Rehabilitation Unit		
6	Type of Health Facility		1=government; 2=private
7	Has at least 1 trained staff who is able to provide or currently providing rehabilitation services		1=yes 2=no ☐ If "no", skip the item 2
8	Is licensed by DOH to provide rehab services		1=yes; 2=no
	Rehabilitation Services reimbursed by VSS		1=yes; 2=no

2. Personnel

Please write the number or note "no data" if you do not have data on the item

No	Content	2019		2020		2021		4/2022	
		Male	Female	Mal	Female	Male	Female	Male	Female
1	Total number of PMR doctors								
	Total number of PMR doctors getting license								
2	Total number of PTs								
	Total number of PTs getting license								
3	Total number of OTs								
	Total number of OTs getting license								
4	Total number of STs								
	Total number of STs getting license								
5	Total number of ATs								
	Total number of ATs getting license								
6	Total number of other technicians								
	Total number of other technicians getting license								

3. Data on service provision of rehab facilities according to MoH's requirement

Please write: 1= yes and 2- no; P* means that the technique could be provided; R** means to be reimbursed by VSS

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
A	***Physical therapy techniques***								
1	Soft wave								
2	Ultra soft wave[a]								
3	Micro wave[a]								
4	Magnetic[a]								
5	Galvanic currents[b]								
6	Drug-conducting electrolysis[b]								
7	Pulsed currents[b]								
8	Ultrasonic[b]								
9	Shockwave[b]								
10	Interference currents[b]								
11	Infrared								
12	Low Power Laser[a]								
13	Biological dosimetry in UV treatment								
14	Spot UV								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
15	Full body UV								
16	Heat therapy (hot packs)								
17	Cold therapy (cold packs)								
18	Paraffin								
19	Treatment with whirlpool or jacuzzi[a]								
20	Sauna (steam bath)[b]								
21	High pressure water jet[a]								
22	Full body hydrotherapy (swimming pool, soaking tub)[b]								
23	Mud								
24	Mineral water[b]								
25	Hyperbaric oxygen[a]								
26	Spinal Traction[b]								
27	High-voltage electric field[a]								
28	Electrostatic ion[a]								
29	Gas ion[a]								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
30	Electrostatic field[a]								
31	Trans-cranial magnetic[a]								
32	Microcurrent								
33	Low-power laser treatment on motor points and acupuncture points[b]								
34	Intravascular low power laser [b]								
35	Wormwood								
36	Hydrotherapy with traditional medicine								
37	Hydrotherapy for Burned patients								
38	Contrast bath Therapy – Hot & Cold Hydrotherap [a]								
39	Galvanic bath[a]								
40	Hydromassage bath[a]								
B	***Kinesiological therapy techniques***								
41	Positioning for Hemiplegia								
42	Positioning for Patients with Spinal Cord Injury								
43	Upper extremity exercises for Hemiplegia								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
44	Standing and Walking exercises for Hemiplegia								
45	Rolling exercises in lying position								
46	Changing position from lying to sitting								
47	Static and Dynamic balance training in Sitting position								
48	Changing position from sitting to standing								
49	Static and Dynamic balance training in Standing position								
50	Gait training								
51	Walking exercises in Parallel bars								
52	Walking exercises with Walking frame								
53	Walking exercises with Crutches (Axillary crutches, Elbow crutches)								
54	Walking exercise with cane								
55	Walking exercises with Fishbone device								
56	Treadmill Walking exercises								
57	Walking Up and Down stairs exercises								
58	Walking exercises on different surfaces								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
59	Walking exercises with above-knee prosthesis								
60	Walking exercises with below-knee prosthesis								
61	Standing with hanging frame								
62	Passive exercises								
63	Active-assistive exercises								
64	Active exercises								
65	Active exercises for Four limbs								
66	Resisted exercises								
67	Stretching exercises								
68	Exercise-on-Ball Therapy[b]								
69	Exercise in ball tub[b]								
70	Proprioceptive Neuromuscular Facilitation for upper extremities[b]								
71	Proprioceptive Neuromuscular Facilitation for lower extremities[b]								
72	Proprioceptive Neuromuscular Facilitation in Functional recovery[b]								
73	Wall ladder exercises								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
74	Extremities exercises with Suspension frame								
75	Pulley exercises								
76	Shoulder wheel exercises								
77	Rowing machine exercises								
78	Wobble board exercises								
79	Exercises with Balance equipment								
80	Quadriceps strengthening exercises with Quadriceps chair								
81	Exercise Bikes workouts								
82	Incline board exercises								
83	Different types of Breathing exercises								
84	Breathing exercises with Assistive tools								
85	Assisted coughing techniques								
86	Percussion and Vibration techniques								
87	Postural drainage techniques								
88	Stretching techniques[a]								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
89	Joint mobilization techniques[a]								
90	Soft tissue mobilization techniques[a]								
91	Open and Closed Kinetic Chain exercises[a]								
92	Techniques to inhibit the Spasticity of the Upper Extremities								
93	Techniques to inhibit the Spasticity of the Lower Extremities								
94	Techniques to inhibit the Spasticity of the Trunk								
95	Spot massage techniques								
96	Whole body Massage techniques								
97	Frenkel techniques								
98	Techniques to inhibit and release the Pathological reflexes								
99	Techniques to control head, neck and trunk								
100	Movement coordination exercises								
101	Strengthening the pelvic floor muscles								
102	Spinal exercises								
103	Mechanical Massage techniques								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
104	Lymphatic Drainage Massage								
105	Postural control techniques (sitting, crawling, standing, walking)								
106	Facilitating Motor Development for Children (rolling, sitting, crawling, standing, walking)								
107	Health Preservation								
108	Rehabilitation for Upper Extremity using Robotics[a]								
109	Movement exercises on a specific machines[a]								
110	Stretching techniques for Children with Torticollis caused by Sternocleidomastoid fibrosis[a]								
111	Movement exercises for a child with fibrosis								
112	Physiotherapy for Children with Spine Deformity (scoliosis, kyphosis, lordosis)								
113	Accelerated Therapy the Exhalation of Children								
114	Postural control and Mobility techniques for patients with Parkinson[a]								
115	Postural control techniques for Post-fall syndrome[b]								
116	Practice Getting up from the floor[b]								
117	Endurance training with Heart Monitoring devices[b]								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
118	Endurance training without Heart Monitoring devices								
119	Relaxation techniques								
120	Biofeedback training for Strengthening muscles								
121	Strengthening muscles using Isokinetic machine[b]								
122	Walking training on Treadmill with Partial body weight-supported[b]								
C	***Occupational therapy techniques***								
123	Using and controlling wheelchair techniques								
124	Instruct the patients with Diplegia to move in and out the wheelchair								
125	Instruct the patients with Hemiplegia to move in and out the wheelchair								
126	Practice the Gross motor skills of the hands								
127	Practice the Fine motor skills of the hands								
128	Practice hand-hand coordination								
129	Practice eye-hand coordination								
130	Practice hand-mouth coordination								
131	Practice Activities of Daily Living (eating, bathing, body sanitation, entertainment)								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
132	Practice Sensory Integration								
133	Practice Perception and Awareness								
134	Practice Activities of Daily Living with Adaptive devices								
135	Constraint-induced Movement Therapy[b]								
136	Mirror therapy[b]								
D	***Speech therapy techniques***								
137	Swallowing exercises								
138	Speaking exercises								
139	Chewing exercises								
140	Pronunciation exercises								
141	Communication exercises								
142	Practice for patients with Aphasia								
143	Voice exercises								
144	Practice to correct pronunciation mistakes								
145	Applied Behavior Analysis[b]								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
146	Early Communication training with Stimulation for Children								
147	Speech-Language Therapy								
148	Oral motor exercises for Children's speech								
149	Techniques to control Facial, Chewing and Swallowing muscles								
E	***Functional exploration, assessment, diagnosis and treatment***								
150	Functional Assessment								
151	Assessment of Cardiovascular systems								
152	Assessment of respiratory systems								
153	Psychological Assessment								
154	Assessment of Awareness and Perception								
155	Language Assessment								
156	Gait Assessment								
157	Balance Assessment								
158	Assessment of the Activities of Daily Living								
159	Vocational Assessment[b]								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
160	Manual Muscle Testing[b]								
161	Range of motion measurements								
162	Measure the Pressure of the Bladder using the Urology machine[a]								
163	Measure the Pressure of the Bladder using Uroflowmetry[a]								
164	Measure the Pressure of the Anorectal[a]								
165	Assess the Development of Children by Age								
166	Assess the Neuropsychiatric Development of Children using the Denver Development Screening Test[a]								
167	Measure the Pressure of Children's Bladder[a]								
168	Using Phenol for Nerve block in Treatment of Spasticity[a]								
169	Botulinum Toxine type A Injection in Treatment of Spasticity[a]								
170	Botulinum Toxine Injection into the Bladder wall muscles in Treatment of Overactive Bladder[a]								
171	The Intermittent Catheterization techniques in Spinal Rehabilitation								
172	Bowel training for Patients with Spinal Cord Injuries								
173	Biofeedback training for Encopresis[a]								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
174	Ponsetti method for Clubfoot[b]								
175	Bandaging and Splinting techniques to protect the Functional hand (quadriplegia)[b]								
176	Hip Spica Cast techniques in Treatment of Developmental Dysplasia of the Hip[a]								
177	Wrapping techniques for Upper extremity amputation								
178	Wrapping techniques for Lower extremity amputation								
179	Electromyography[a]								
180	Assessment of Developmental Progress using the Ages and Stages Questionnaires[b]								
181	Assessment of Children's Language and Communication skills								
182	Assessment of Children's Fine motor skills and Daily living skills								
183	Assessment of Children with Autism using Diagnostics Statistical Manual of Mental Disorders – IV (DSM – IV)								
184	Assessment of Children with Autism using Childhood Autism Rating Scale (CARS)[b]								
185	Assessment of Children with Autism using Modified Checklist for Autism in Toddlers (M-chat)[b]								
186	Assessment of Children with Autism using Gross Motor Function Measure (GMFM)[b]								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
187	Assessment of Children with Cerebral Palsy using Gross Motor Function Classification System (GMFCS)[b]								
188	Assessment of Spasticity using Modified Ashworth Scale (MAS)								
189	The Mini-Mental State Examination (MMSE)								
190	Maximum Oxygen Consumption Measurement								
191	Median Oxygen Consumption Measurement								
192	The Six Minute Walk Test								
193	The Rikli method								
194	The Tinetti Test								
195	Time up and Go Test								
196	Stops Walking When Talking Test								
197	Assessing foot pressure mechanically to consultation on shoes/sandal use for patients with diabetes[b]								
198	Psychological counselling for patients or their family members[a]								
199	Botulinum Toxin Injection in Treatment of Cervical Dystonia[a]								
200	Botulinum Toxin Injection in Treatment of Focal Dystonia (Upper, Lower Extremities)[a]								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
201	Biofeedback training for Encopresis[a]								
202	Nasal Saline Rinse technique for Children[a]								
203	Treatment of Pressure Ulcers stage I, II								
204	Treatment of Pressure Ulcers grade III,IV[b]								
205	Vacuum-assisted Closure Therapy in Treatment of Pressure ulcers (VAC) [a]								
206	Silicone gel in Treatment for Burn scars[b]								
207	Treatment for Burn scars using a combination of Compression Bandages Therapy and Silicone gel[b]								
208	Treatment for Burn scars using a combination of Burn masks and Soften scar creams[b]								
209	Treatment for Burn scars using a combination of Pressure Garment Therapy and Soften scar creams[b]								
210	Treatment for Burn scars using a combination of Pressure Garment Therapy and Soften scar creams[b]								
211	Treatment for Burn scars using corticoid injection[b]								
212	Treatment for Keloids using a combination of Compression Bandages Therapy, Soften scar creams and Silicone gel[a]								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
213	Treatment for Keloids using a combination of Compression Bandages, Soften scar creams, Silicone gel and cellular product[a]								
F	***Orthopedic and assistive devices***								
214	Prosthetic training on above elbow Prosthesis use								
215	Prosthetic training on below elbow Prosthesis use								
216	Training for the S.W.A.S.H Orthosis use (Standing, Walking, and Sitting Hip Orthosis)								
217	Prosthetic training on hip disarticulation Prosthesis use								
218	Prosthetic training on above knee Prosthesis use								
219	Prosthetic training on below knee Prosthesis use								
220	Training for the Thoraco-lumbosacral Orthosis use (to treat the scoliosis)-TLSO								
221	Training for the lumbosacral Orthosis use (to treat the scoliosis)-LSO								
222	Training for the WHO use (Wrist Hand Orthosis)								
223	Training for the HKAFO use (Hip Knee Ankle Foot Orthosis)								
224	Training for the KAFO use (Knee Ankle Foot Orthosis)								
225	Training for the AFO use (Ankle Foot Orthosis)								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
226	Training for the FO use (Foot Orthosis)								
227	Footwear use training for Leprosy patients								
228	Training for the Hard back brace use								
229	Training for the Soft back brace use								
230	Orthopedic Shoe, Orthosis in Treatment of Foot deformities (Flat feet, Pes cavus, Varus feet, Valgus feet)[b]								
231	Orthopedic Shoe, Orthosis in Treatment of Foot problems due to diabetes[b]								
232	Orthopedic devices to position the neck of patient after burned[b]								
233	Orthopedic devices to position limbs of patient after burned[b]								
234	Lumbargo-pelvis casting without pressure to mold a hip brace[b]								
235	Lumbargo-pelvis casting with pressure to mold a hip brace[b]								
236	Lumbargo-pelvis casting without pressure to mold a spine and hip splint[b]								
237	Lumbargo-pelvis casting with pressure to mold a spine and hip splint[b]								
238	Forearm-hand casting without pressure to mold a hand splint[b]								
239	Forearm-hand casting with pressure to mold a hand splint[b]								
240	Arm-forearm-hand casting without pressure to mold a above-albow hand splint[b]								

No	Content	2019		2020		2021		4/2022	
		P*	R**	P*	R**	P*	R**	P*	R**
241	Arm-forearm-hand casting with pressure to mold a above-albow hand splint[b]								
242	Pilot hat casting without pressure to mold a skull brace[b]								
243	Pilot hat casting with pressure to make a plastic neck brace[b]								
244	U-shaped casting to make a hip brace[b]								
245	Casting for Clubfoot[b]								
246	Casting for Congenital hip dislocation[b]								
247	Below Knee-foot Casting to mold AFO[b]								
248	Hip-pelvis and spine Casting to mold KAFO[b]								
F	***Others***								
249	Spine and joint stretching[b]								
250	exercises for joint stiffness								
251	Moving with assistive devices								
252	Air compression massage								

a means "*required for provincial level only*" b means "not *required for commune level only*"

ANNEX XII: RISKS, LIMITATIONS, AND MITIGATION STRATEGY

Evaluations in this complicated intervention context are inherently challenging to design. The design and approach described above were chosen because the ET believes their advantages outweigh the limitations. This effort will benefit from a realistic examination of risks that could jeopardize plans as well as limitations of the design and approach so as to preemptively mitigate these risks if they occur. These are outlined in the table below.

RISKS, LIMITATIONS, AND MITIGATION STRATEGIES

EVALUATION LIMITATIONS AND MITIGATION STRATEGIES			
	RISK/LIMITATION	MITIGATION STRATEGY	CONCERN LEVEL (WITH MITIGATION)
1	Lack of a counterfactual (comparison) group prevents attribution of QOL changes to the project and poses a risk that external factors could drive broader trends in QOL changes (either positive or negative).	Apart from the standardized QOL modules, the survey tool will also include questions about how the person with disability feels their QOL changed in the past year and which factors were most responsible for the change. These questions along with demographic questions like poverty level, in addition to knowledge about general changes in conditions in Vietnam will help the ET assess the degree to which external conditions such as a recession or pandemic or disaster affected QOL nationwide. The ET will also complete qualitative interviews with persons with disabilities concurrent with the follow-up survey to inform this same understanding. The choice to schedule the baseline in 2022 is expected to mitigate the influence of the COVID-19 pandemic on baseline QOL, as the ET anticipates lockdowns, health, and economic conditions are likely to return to near-normal states by that time.	Medium
2	WHOQOL-DIS module has not been academically validated in Vietnam.	The ET will carry out robust piloting according to standard psychometric validation procedures on a sufficient sample size. The validation of these tools in other countries also lends confidence they will likely be appropriate in this context.	Low
3	Wide variation in types of interventions, their duration, and types and severity of disabilities addressed introduce a lot of variation and uncertainty in the degree of QOL changes to expect and when they are most detectable. Our plan to complete follow-up data collection with all persons with disabilities at a six-month follow-up constrain measurement of final outcomes of treatment, if treatment timelines end long before or after this time	It is impossible to design an evaluation that calibrates separate follow-up periods for each specific intervention, without intensive IP involvement in data collection. Such involvement by IPs was found to be infeasible at an IP consultative meeting. However, our plan to re-measure QOL six months after treatment began seems a reasonable timeframe within which QOL changes should be detectable, particularly given USAID hopes to reach some beneficiaries with multiple types of interventions.	Medium
4	Some persons with disabilities will have already started receiving services up to two weeks before baseline data collection can occur, which may attenuate the measured QOL change.	While not ideal, the expectation is that these people will have not yet realized their full QOL changes and therefore should still have detectable QOL change at endline. The nature of recruitment from health facilities and other	Low

EVALUATION LIMITATIONS AND MITIGATION STRATEGIES			
	RISK/LIMITATION	MITIGATION STRATEGY	CONCERN LEVEL (WITH MITIGATION)
		service providers in particular would not realistically allow for pre-treatment data collection.	
5	It is possible that only few USAID-supported service providers will participate in collecting new patient names and consents for the baseline.	The ET will adopt an active rather than passive system for gathering new patient data each month. This might be done through scheduled SMS reminders to designated staff at cooperating facilities and IPs and follow-up phone calls in cases where new patient names are not submitted on schedule. Piloting will include consultations with various providers to examine their patient data tracking systems and ensure the ET introduces forms and processes that work within each facility's processes. The Learns office will provide ongoing follow-up and support to encourage data submissions and coach providers through challenges. Anticipating participation of individual providers may still be low, the ET has built this into its estimated baseline timeline.	Medium
6	COVID-19-related travel restrictions intensify and prevent international ET travel, rendering oversight and participation of US-based ET members difficult.	As of May 2021, restrictions on international travelers have heightened to the point that the ET will not be able to send international travelers. Qualitative interviews with IPs, USAID, and even some government officials can be done by Ms. Eitel via video conferencing, and our local specialist, Ms. Hanh Ta, and another local rehabilitation sector specialist will be able to continue to carry out interviews in person. The ET has highly capable Learns field office staff who are prepared to facilitate training and oversight for 2021 survey piloting and qualitative data collection, along with local consultants. By the time the baseline data collection begins in 2022, it is expected the pandemic will be over and the international team members will be able to travel to support launch of data collection.	Low
7	COVID-19-related domestic travel or interaction restrictions prevent in-person interviews.	The ET expects this will be more relevant to the survey piloting and qualitative phase of data collection in 2021 than survey data collection in 2022. The ET foresees the ability to use telephone and video conferencing for qualitative interviews with IPs, USAID, and government counterparts. However, interviewing persons with disabilities for survey piloting or qualitative interviews over the phone is not expected to be a feasible way to obtain quality data, other than with some who are more connected to technology and capable of detailed phone conversations. While the ET can shift to virtual interviews for other stakeholders, if local restrictions prevent in-person interviews with persons with	Medium

EVALUATION LIMITATIONS AND MITIGATION STRATEGIES			
	RISK/LIMITATION	MITIGATION STRATEGY	CONCERN LEVEL (WITH MITIGATION)
		disabilities, the ET recommends a delay in data collection until in-person is feasible.	
8	It may be difficult to locate persons with disabilities at home or to relocate them for follow-up data collection.	Social Impact is well acquainted with cohort tracking best practices and has successfully carried out similar efforts in many settings. The ET will ensure patient tracking forms include multiple phone numbers and detailed address information. Once at the home, the enumerator will complete area maps and directions to facilitate recontact.	Low
9	Slow government or IRB approval may delay or prevents data collection.	The ET will rely on support from USAID and IPs to help facilitate approvals. The ET will prepare a translated brief summary of the activity to be used in those interactions.	Medium
10	Proxy-administered surveys may not accurately estimate QOL for persons with disabilities	The ET will try to minimize use of proxies and encourage use of persons to assist the person with disability to respond rather than to respond on behalf of them. However, it is impossible to avoid this altogether in a population that includes people with severe disabilities. In cases where a proxy must respond, they will be included in the survey. The ET will note limitations in the report, citing studies that have shown the degree to which proxies underestimate QOL.	Medium

ANNEX XIII: BASELINE SURVEY SAMPLE ENROLLMENT PROTOCOL

The rolling baseline will be carried out simultaneously in each of the three provinces by three separate teams of data collectors. This rolling baseline approach will require IPs and cooperating service providers to compile contact information for all new adult and child beneficiaries meeting the criteria above. As they screen and recruit new beneficiaries, they would provide contact information to the province-based data collection teams, which would contact these beneficiaries (or their caregivers by proxy) to schedule baseline survey interviews prior to—or at most within the first month of—an ongoing new service (see inclusion criteria details above). This approach ensures data are collected from confirmed USAID beneficiaries. While logistically more complex, the ET has confirmed with IPs that they are willing and able to cooperate by providing new beneficiary lists to data collectors as soon as they become available. IPs have also indicated some select service providers they support could also cooperate by providing new beneficiary lists, with some encouragement and training. The ET has also confirmed the local data collection firm is able to deploy well trained enumerators based in the provinces to carry out data collection on a rolling basis. This enrollment process will follow the steps outlined below. Given the baseline survey with persons with disabilities will not begin until all INCLUSION activities are able to begin recruiting beneficiaries in 2022, these steps will not occur until closer to that known time, to ensure estimates are accurate and plans are up-to-date.

1. **Identify cooperative service providers:** The ET will develop a Vietnamese language brief letter describing the survey purpose and design as well as a kind request for local service providers to voluntarily cooperate with the survey effort to provide lists of new indirect beneficiaries. It will detail the simple actions requested (i.e. compiling and providing a list of new beneficiaries meeting inclusion criteria, with beneficiary consent to share this basic information). The letter will be sent from USAID via the IPs. For providers that agree to cooperate, the ET will then work through IPs to identify relevant points of contact and clarify detailed inclusion/exclusion criteria for that provider based on which of their services are supported through the Disabilities Project activity. This will feed into provider-specific training protocols that the ET will administer prior to baseline data collection.
2. **Estimate/plan for sample balance:** Three month prior to baseline data collection, the ET will ask all IPs to submit estimated numbers of new beneficiaries to be enrolled, by month, over the anticipated three-month rolling baseline timeframe, with a buffer of two additional months. They will do this for both their direct beneficiaries and for indirect beneficiaries of the cooperating service providers they support. This will support assessment of sample balance across categories described above. For example, the ET might close off cohort recruitment from an IP with heavy beneficiary recruitment in the first month of the baseline once we reach that IP's sample proportion threshold. If some IPs do not have this information three months prior, it will be acceptable to collect this information closer to the start of data collection.
3. **Train IPs and service providers to capture beneficiary contacts:** The ET will develop a simple annotated electronic form to be used to capture and submit basic beneficiary data to the ET. The ET will also provide a paper form in cases where electronic submission is not possible (e.g. at a poorly equipped rural health facility). The ET will work with each IP individually to confirm a logistical plan for data capture that works and to train both them and their supported service providers to complete the process on a regular basis throughout the baseline period.
4. **Collect new beneficiary contacts:** During their beneficiary screening processes or at intake, the IP or service provider will collect pre-interview data for all beneficiaries that have been screened and selected to receive new services. Data will include name, home address, and contact phone number for the person with disability and ideally a backup number of a caregiver or family member. The IP or service provider will note the type of service planned and anticipated start date. They must get permission from the beneficiary before passing their

information along to the ET. To facilitate this, the ET will provide an abbreviated consent script the IP or service provider will share in written form or orally (based on respondent literacy and provider preference) to get consent to share their information. It is intentionally short to prevent burden on providers. The full informed consent will be administered by the ET prior to data collection. However, providers will have a copy of the full informed consent they can share if the beneficiary requests additional information that early stage. The ET will provide forms that document refusals.

IP and Service Provider-Administered Consent to Share Personal Contact Data

"USAID has provided some support for the services we'll give you. They are doing a survey about quality of life with people like you who are planning to receive these services. They are doing this to learn how to improve their support in the future. ***Is it OK with you if I provide your contact information to them?*** *If so, they may call you to give more information about the study and ask if you want to participate. It is completely voluntary, and they will keep your information confidential. Only the independent research team would have access to your information. Even I (service provider) will not know whether you chose to participate, or the information you give them in the survey.*

Is it OK to give your name and contact information and service plan?" MUST DOCUMENT: Yes / No

5. **Establish recurrent beneficiary list collection:** The IP or service provider will compile and provide these lists to the local data collection firm study coordinators based in each province at least every two weeks (e.g. 1st and 3rd Monday of each month), or according to their screening schedule if less frequent. The data collection firm provincial team will actively solicit these lists if they are not received on the prescribed dates from each IP or provider. This will ensure new beneficiaries are not missed.
6. **Contact beneficiaries/proxies to schedule baseline visits:** The data firm will call all persons on the lists to explain the evaluation procedures and schedule interviews if the person is willing. For children, the caregiver will be called. For adults, the data collector will first have indication from the IP and service providers' beneficiary enrollment data capture tool (Annex III: IP and Service Providers' Beneficiary Enrollment Data Capture Tool) whether the person is likely to need a proxy. In these cases, data collectors will reach out first to the caregiver contact number on the form to communicate the evaluation procedures and schedule an interview, with permission of both the caregiver and person with disability. There may also be cases where there is no such indication on the form, but when talking to the person with disability the data collector will identify signs that either a proxy or assisting person is appropriate. They will receive training to identify such signs and politely and sensitively request assistance or call the caregiver directly.
7. **Administer the baseline survey**: The province-based data collection teams would travel to the individual's home at the scheduled date and time to administer the electronic survey using a tablet.
8. **[Six months later] Schedule and complete follow-up data collection:** The baseline survey ends with a request to revisit six months later and additional contact information to support such outreach. The province-based data collection team of the data collection firm will follow the same process to schedule follow-up visits and administer surveys.

ANNEX XIV: REPEATED KEY MESSAGES FROM KEY INFORMANTS ON OVERALL FACILITATORS & BARRIERS

1. Repeated key messages from key informants on overall facilitators & barriers for rehabilitation (number of key informants raised the message in parentheses)

   Overall facilitators for rehabilitation

   - Expertise provided by and through implementing partners (11)
   - Government buy-in and support (6)
   - Engagement of local stakeholders -universities, professional groups, provincial government, etc. (5)
   - Project aligns with in-country needs (5)
   - Amount of money invested by USAID (5)
   - Time investment by USAID for the sector (2)

   Overall barriers for rehabilitation

   - Current IP approach- piecemeal, inconsistency, overlap, duplication (6)
   - Choice of ministry partners (3)
   - Insufficient resources to do everything (3)
   - System strengthening versus direct assistance (3)
   - Lack of engagement from local authorities (2)

2. Repeated key messages from key informants on facilitators & barriers for rehabilitation workforce (number of key informants raised the message in parentheses)

   Facilitators for rehabilitation workforce

   - Availability of training courses - preservice and short courses (11)
   - Increase in number of rehabilitation professions (14)
   - Increase in the number of people trained (11)

   Barriers for rehabilitation workforce

   - Not yet enough quality, quantity (6)
   - Attaining a license to practice (2)
   - Lack of time for coaching/mentoring (2)
   - Rehab doctors - limited number / interest in rehab (3)
   - Participants selected for training not always appropriate (2)
   - Intermediate training – quality, consistency, not aligned with GVN (3)

3. Repeated key messages from key informants on facilitators & barriers for rehabilitation services (number of key informants raised the message in parentheses)

   Facilitators for rehabilitation services

   - Increase in the number and type of services available (16).
   - Services are available at different levels – province, district (3)

   Barriers for rehabilitation services

   - Little or no service at commune level (6)
   - Inconsistent service availability e.g., geographic (4)
   - Health facility readiness, leadership for rehab (3)
   - Little investment for autism or mental issues (2)
   - Rehab merging with traditional medicine (2)
   - Limited private sector engagement (1)

4. Repeated key messages from key informants on facilitators & barriers for provision of APs (number of key informants raised the message in parentheses)

   Facilitators for provision of APs

   - Individualized products and support (3)
   - Previous investment in local innovation (2)

   Barriers for provision of APs

   - Limited diversity of assistive products; mainly mobility focused (6)
   - No policy for health insurance coverage for assistive products (6)
   - Provision is mainly by IPs, not government (6)
   - Workforce for assistive products is underdeveloped (6)
   - Lack of follow-up after provision (2)
   - Individual-based intervention; not systems-based (2)

5. Repeated key messages from key informants on facilitators & barriers for rehabilitation financing (number of key informants raised the message in parentheses)

   Facilitators for rehabilitation financing

   - Number of techniques financed by VSS has expanded (9)
   - Assistive products supported by project (3)
   - More donor support for rehab (2)

   Barriers for rehabilitation financing

   - No specific budget line for rehabilitation in government budgets (5)
   - Project didn't really work in this area (3)
   - VSS not up to date; pricing delays (3)

6. Repeated key messages from key informants on facilitators & barriers for rehabilitation data (number of key informants raised the message in parentheses)

   Facilitators for rehabilitation data

   - MOH DIS created for persons with disabilities (14)

   Barriers for rehabilitation data

   - DIS is not updated (6)
   - DIS data inaccurate or incomplete (5)
   - Little or no recent investment in this area (5)
   - Data on rehab in MOH software is not clear (4)
   - Data collection on rehabilitation is not mandated (3)
   - Not accessible to external users (3)
   - Not sure how DIS data is used (2)

7. Repeated key messages from key informants on facilitators & barriers for rehabilitation governance (number of key informants raised the message in parentheses

   Facilitators for rehabilitation governance

   - Development of treatment guidelines (5)
   - More attention to rehabilitation than before (4)
   - Mention of the National Rehabilitation Strategy (4)

Barriers for rehabilitation governance

- Merging traditional medicine and rehab (2)
- Unclear which IP to support strategy or WHO work (2)

8. Repeated key messages from key informants on overall facilitators & barriers for social services (number of key informants raised the message in parentheses)

   Overall facilitators for social services:

   - Family involvement/support (4)
   - Government support (3)
   - USAID investment (2)
   - Former work with MOLISA/OPDs (2)
   - IP expertise (1)

   Overall barriers for social services:

   - Lack of investment in livelihood, education and employment (8)
   - Lack of consistent approach/model (4)
   - Lack of MOLISA involvement (4)
   - Lack of social worker engagement (4)
   - Limited resources to do everything (3)
   - Lack of health/social connection (2)
   - Unclear meaning of terms (2)
   - Lack of expertise (1)

9. Repeated key messages from key informants on facilitators & barriers for home care services (number of key informants raised the message in parentheses)

   Facilitators for home care services

   - Mention of urban models for elderly (2)
   - GVN looking toward CBR to do this work (1)
   - Private care may be an option (1)
   - Hanoi Medical Univ family practice (1)

   Barriers for home care services

   - Only available in some locations (10)
   - Difficult to sustain, no system level (10)
   - Ad-hoc, no guidelines, policy, model (4)
   - Service is new (3)
   - Lack of consistent approach/meaning (2)

10. Repeated key messages from key informants on facilitators & barriers for caregiver capacity building (number of key informants raised the message in parentheses)

    Facilitators for caregiver capacity building

    - Training provided through project (5)
    - 9-month caregiver training for children with disability (2)
    - Job code for personal assistant (1)

    Barriers for caregiver capacity building

    - Dependence on family/volunteers (7)
    - No system/policy for this (5)

- Social workers not involved (2)
- Training method/design (2)
- Lack of access outside project (2)
- Lack of follow-up after training (2)

11. Repeated key messages from key informants on facilitators & barriers for psychological support (number of key informants raised the message in parentheses)

    Facilitators for psychological support

    - Peer support model (4)
    - Related initiatives (4):
    - 6-month training rehabilitation workers (1)
    - Integrated in caregiver training for children with disability (1)
    - Included in social work training (1)
    - MOH list of techniques (1)

    Barriers for psychological support

    - Not yet started, no information (12)
    - This doesn't really exist in VN (5)
    - Limited workforce/capacity (3)
    - No psych support for family (2)
    - Psychologists not yet part of multi-disciplinary team (1)

12. Repeated key messages from key informants on facilitators & barriers for delivering disability benefits (number of key informants raised the message in parentheses)

    Facilitators for delivering disability benefits

    - Increased access to disability allowance (8)
    - Disability determination (5)
    - Already part of disability policy/law (3)
    - Social worker units in hospitals provide info (1)

    Barriers for delivering disability benefits

    - No information what project is doing (5)
    - Social workers not involved (2)
    - Persons with disability awareness outside project is limited (3)

13. Repeated key messages from key informants on facilitators & barriers for participation of persons with disabilities (number of key informants raised the message in parentheses)

    Facilitators for participation of persons with disabilities

    - Disability club model (3)
    - ACDC/DRD work (3)
    - Independent living skills training (2)
    - IPs bring persons with disabilities to events (2)

    Barriers for participation of persons with disabilities

    - Participation of persons with disability is passive (4)
    - Local government limitations (3)
    - Persons with disabilities lack awareness of rights (2)
    - Children with disabilities dependence on family to do this (1)

14. Repeated key messages from key informants on facilitators & barriers for legal aid (number of key informants raised the message in parentheses)

Facilitators for legal aid

- IPs provide support ACDC/DRD (4)
- Legal aid centers in all provinces (2)
- All law firms have a section for persons with disabilities (1)

Barriers for legal aid

- Project legal awareness, not aid (4)
- Small scale and only in some areas (2)
- Unknown quality of services (1)
- Sensitive topic for Vietnam (1)

15. Repeated key messages from key informants on overall facilitators & barriers for disability policies (number of key informants raised the message in parentheses)

Overall facilitators for disability policies:

- UNCRPD (2)
- IP implementation capacity (1)
- Government influencers (1)

Overall barriers for disability policies:

- Not much USAID investment in this (3)
- GVN partner (MOD/NACCET) isn't into policy change (3)
- Lack of IP capacity in this area (2)
- Discontinued NCD/VFD past investments (2)
- Need to update 2010 Disability Law (1)

16. Repeated key messages from key informants on facilitators & barriers for barrier-free society (number of key informants raised the message in parentheses)

Facilitators for barrier-free society

- Policies/legislation in place (7)
- Examples of accessible places (8)

Barriers for barrier-free society

- Implementation is limited (2)
- Difficult to enforce policies (3)
- Retro-fitting buildings is difficult (3)
- IP understanding; focus on ramps (1)

17. Repeated key messages from key informants on facilitators & barriers for reducing discrimination (number of key informants raised the message in parentheses)

Facilitators for reducing discrimination

- Stigma against persons with disabilities is reduced especially in young urban populations (7)
- GVN policy against discrimination (3)
- USAID uses updated terminology (3)

- Good communication messages about physical disability (1)

Barriers for reducing discrimination

- Persons with disabilities self-stigmatize (5)
- Business refuse to recruit Persons with Disabilities (4)
- Charity efforts are a barrier (2)
- Persons with intellectual disability suffer (2)
- Difficult to measure and track (2)

18. Repeated key messages from key informants on facilitators & barriers for OPD strengthening (number of key informants raised the message in parentheses)

Facilitators for OPD strengthening

- USAID support has helped expansion (3)
- Disability "clubs" and DRD work (4)
- ACDC and DRD are strong (3)
- Local government support (1)

Barriers for OPD strengthening

- GVN attitude to OPD/CSO (7)
- Activity is difficult to sustain (3)
- Lack of OPD capacity to raise voice (3)
- Unclear what USAID does to support this (3)
- Not sure what OPDs do (2)
- Unclear about expected output (2)
- Lack of support for organizational development (2)
- Government policy to consolidate CSOs (2)

ANNEX XV: DATA SECURITY & QUALITY ASSURANCE

The ET hired an experienced data collection firm, DEPOCEN, which was proven to have capabilities in collecting high quality quantitative data in the social sciences. All data collectors received multi-day training on both the methodology and tools as well as training from a sector expert on key topics that will help them to become conversant with disability issues, including familiarization with types of disabilities and how they may impact the interview, and terminology and sensitive interviewing techniques that convey dignity and empowerment. All trainings were facilitated or supported by ET members.

- **Data entry**: inclusive of validity checks, logic checks, automatic warnings in SurveyCTO; Tested; "Double" entry check.
- The majority of interviews were *digitally recorded* (except for ones who did not give consent).
- *Multiple layers of supervision* with written protocols: SI HQ, DOPOCEN office-based, field supervision
  - Random spot check using digitally recorded interviews; Outlier check, e.g. high-frequency check
- Pretest
- Survey team training
- Data cleaning: Use digital records to confirm information
- Data security: Using project SharePoint on SI' secured server; data sharing requires passwords

The ET maintains a strict data quality assurance plan. For the persons with disability survey, the data collection firm is required to complete regular supervisor checks, accompany at least five percent of interviews to ensure quality, and complete back-checks of at least 10 percent of the sample using a back-check tool. Learns programmed an electronic survey tool that includes internal quality checks and identifies and prevents logic errors. GPS and time stamps for each interview also facilitate accountability. The US-based ET carry out regular check-ins with the firm management by phone, and local team members accompany field teams, particularly during start-up to support continued training. All quantitative data was cleaned using .do files in Stata software to facilitate quality assurance and replicability. Data derived from document review (for EQ3) was assessed for quality and completeness prior to use for the evaluation.

For qualitative data, detailed notes were reviewed and elaborated immediately following each interview. Audio recordings were consulted to clarify and fill gaps in notes.

Data cleaning & storing

The data from the quantitative survey was entered directly into the tablet during the interview and uploaded to the SurveyCTO server as soon as the interview was completed. Only relevant employees of the data collection team and members of the ET will be given an account to access the data. The enumerators downloaded the data sets electronically and performed completeness and logic checks and then compiled the findings and related information weekly by email to the ET. The ET also conducted an independent check of the quality of the data downloaded directly from the server on a weekly basis, sending any questions or feedback to the data collection team after each test. A data dictionary was developed to define all the variables and encode them. There was a file that summarizes all available document types (e.g. Excel files, Stata datasets) as well as all the programs that were written during the data analysis.

The interview notes were saved in Word files and the interview recording was recorded in the portable recorders before being uploaded to SharePoint and deleted. Only evaluation team members have access to SharePoint to securely share all data. Computers that store research documents were password-protected, for each file also required a password to be accessed. Qualitative interview notes

were labeled and kept in a locked box at USAID Learns office. All data/information (including completed questionnaires and electronic datasets) of this evaluation will be destroyed within three years after the evaluation is completed and the final report has been submitted.

Data saving and restoring

The ET was responsible for backing up the data every week during the ongoing evaluation, as well as during the analysis phase of the evaluation. Data from all surveys was downloaded from the SurveyCTO server daily and uploaded to a secure data sharing platform (SharePoint). All files will also be protected with their own password. During data access, if after 15 minutes there is no activity, the system will ask for re-authentication. The ET was log out or secured the computer when it's not in use.

Access to data

Social Impact and USAID only can access the survey dataset after it has been de-identified. The ET is responsible for (a) ensuring that appropriate procedures are in place to protect the integrity, confidentiality, and availability of information used or generated, (b) applying access control for any users by granting different permissions to different members of the Team. Only Team Leaders and data analysis members are allowed access to the raw research dataset with personally identifiable information; and (c) In the event that someone accidentally modifies the final dataset, the error must be rectified using a version of the dataset that can only be accessed by team members.

Data monitoring

The ET also acted as data supervisors and was responsible for data management and storage, that included:

- Ensure the final datasets used for analysis and reporting are of the highest possible quality, securely stored with password protection. Record and monitor all revisions and changes (if necessary) in the final datasets.
- Manage the access to the final dataset: the list of people who can access the dataset.
- Develop a data dictionary with clear definitions for each data point/variable to ensure that data users (data analysts) fully understand the content.
- Ensure that data is analyzed for the purpose of answering evaluation questions. Monitor and report team lead any misuse of the final datasets. For example, using data to generate findings unrelated to the EQs. Use of data for any purposes other than that stated in the kickoff meeting must be agreed upon by all parties: USAID and Social Impact.

Data users

Data users will be those who have been granted permission to read, enter, analyze or update data/information. Data users must keep personal credentials (e.g., passwords) confidential. Data users include:

- Team lead
- Data analyst
- ET members
- USAID Vietnam

Research data must be used for research purposes only, i.e. to answer EQs. While datasets may be shared with USAID Vietnam, if USAID has any specific data analysis requirements, they should request the assistance of the ET.

Data Security

All research data will be securely stored and strictly confidential and access to the data will be limited to the ET and relevant staff of the data collection team. All interviewees have been given a unique identifier (ID) to replace their name. After identifier generation, all analyzes would be conducted using

de-identified data. All personal identifiable information was collected and stored in a separate file. No individual names were used/ analyzed for reporting, but their contact information was kept for tracking/ tracing (or COVID prevention). None of the analytics data will include identifying information.

All field staff will be required to sign a non-disclosure agreement – demonstrating their understanding of ethical behavior in the field – and handling their confidential and private information. respondents, including personally identifiable information, as appropriate.

ANNEX XVI: DISCLOSURE OF ANY CONFLICTS OF INTEREST

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Nguyen Thanh Liem
Title	Team Leader for Disability Evaluation
Organization	Social Impact
Evaluation Position	[x] Team Leader [ ] Team member
Evaluation Award Number *(contract or other instrument)*	NA
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Disability Evaluation
I have real or potential conflicts of interest to disclose.	[x] Yes No [ ]
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* *1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* *2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* *3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* *4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* *5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* *6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	I have been working as a consultant (on project evaluation) for PHAD and IC.

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	 Digitally signed by Liem Nguyen Date: 2021.10.21 09:05:39 +07'00'
Date	October 21, 2021

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Nguyen Thi Minh Thuy
Title	Rehab and Health System Strengthening Specialist
Organization	Social Impact
Evaluation Position	☐ Team Leader ☐ X Team member
Evaluation Award Number *(contract or other instrument)*	NA
USAID Project(s) Evaluated *(Include project name(s), implementer name(s) and award number(s), if applicable)*	Disability Evaluation
I have real or potential conflicts of interest to disclose.	☒ **Yes** No ☐
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* *1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* *2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* *3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* *4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* *5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* *6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	I am now working for IC, an USAID IP that implementing the project in Binh Dinh, Quang Nam and Thua Thien Hue

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	 **Nguyễn Thị Minh Thủy**
Date	June 25, 2021

ANNEX XVII: REFERENCES

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