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EVALUATION REPORT
USAID OKARD ACTIVITY BASELINE EVALUATION

November 14, 2019

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ACRONYMS

AMELP	Activity Monitoring, Evaluation, and Learning Plan
AOR	Agreement Officer's Representative
ARMI	Association for Rural Mobilization and Improvement
BRAC	Building Resources Across Communities
CBID	Community Based Inclusive Development
CMR	Center for Medical Rehabilitation
COPE	Cooperative Orthotic and Prosthetic Enterprise
COR	Contracting Officer's Representative
DDL	Development Data Library
DH&R	Department of Healthcare and Rehabilitation
DMAS	Disability Mainstreaming Advisory Service
EDR	Evaluation Design Report
EQ	Evaluation Question
EST	Eastern Standard Time
ET	Evaluation Team
FGD	Focus Group Discussions
GIDAP	Gender and Inclusive Development Action Plan
GoL	Government of Lao PDR
HI	Humanity and Inclusion
IGA	Income Generating Activity
INGO	International Non-Governmental Organization
IP	Implementing Partner
IRB	Institutional Review Board
KII	Key Informant Interview
Lao PDR	Lao People's Democratic Republic
LCO	Lao Country Office
LDPA	Lao Disabled People's Association
LSR	Lao Social Research and Services, Inc.
MEL	Monitoring, Evaluation, and Learning
MHPSS	Mental Health and Psycho-social Support
MoES	Ministry of Education and Sport
MoH	Ministry of Health
MoLSW	Ministry of Labor and Social Welfare
MOU	Memorandum of Understanding
NCDE	National Committee for the Disabled and the Elderly
NHI	National Health Insurance
NIGH	University of Melbourne's Nossal Institute for Global Health
NPA	Non-Profit Association
PE	Performance Evaluation
PIRS	Performance Indicator Reference Sheet
POP	Period of Performance
Q2Y2	Quarterly Report for Quarter 2, Year 2
QLA	Quality of Life Association
RDMA	Regional Development Mission for Asia

RECU	Reach, Enter, Circulate, and Use
RF	Results Framework
SBCC	Social Behavior Change Campaign
SI	Social Impact, Inc.
STARS	Systematic Assessment of Rehabilitation Situation
SVK	Savannakhet Province
ToC	Theory of Change
TVET	Technical and Vocational Education and Training
TWG	Technical Working Group
USG	United States Government
USAID	United States Agency for International Development
UXO	Unexploded Ordinances
VTE	Vientiane Capital
WEI	World Education, Inc.
WHO	World Health Organization
XHK	Xieng Khouang Province

EXECUTIVE SUMMARY

ACTIVITY BACKGROUND

The United States Agency for International Development (USAID) Lao Country Office's (LCO) Okard Activity is a $15 million-dollar Activity implemented by World Education, Inc. (WEI) in Lao People's Democratic Republic (PDR) from October 2017 to September 2022. USAID Okard's goal is *to improve and sustain the independent living and functional ability of persons with disabilities, regardless of factors such as age, sex, gender expression, ethnicity, and their households in Lao PDR.* Activity interventions based in one district in Xieng Khouang Province (XHK), one district in Savannakhet Province (SVK), and Vientiane Capital (VTE). The Activity interventions are designed across three components and two tiers. The two-tiered approach integrates systems level (Tier 1)[1] and individual/community level (Tier 2)[2] interventions under three components of Health (Component 1), Economic Empowerment (Component 2), and Stakeholder Engagement (Component 3). The approach and more specifically the interventions of USAID Okard stem directly from the Government of Lao PDR's (GoL) National Disability Strategy and Action Plan and the National Rehabilitation Strategy and Action Plan.

EVALUATION PURPOSE AND QUESTIONS

USAID/LCO contracted Social Impact, Inc. (SI) to conduct a Performance Evaluation (PE) of USAID Okard. The overall purpose of the PE is to test and verify the logic and assumptions of the Activity's efforts in health, economic empowerment, and stakeholder engagement as detailed in the Theory of Change (ToC). At baseline, the evaluation: a) sets a framework for the overall measurement and evaluation of the Activity, b) determines reference points that can help inform the detailed implementation plan, and c) provides evidence to support validation of the ToC at later stages of the Activity. The evaluation baseline was conducted in 2019 and endline is anticipated four years after baseline at the end of USAID Okard in 2022. The Evaluation Questions (EQs) are outlined on the following page.

EVALUATION METHODS AND LIMITATIONS

The PE is mixed methods, including qualitative and quantitative data; and participatory, including implementing partners (IPs) and sub-partners, populations intended to benefit from USAID Okard interventions and services, and key stakeholders including USAID staff as much as possible in the evaluation planning and implementation. Furthermore, the PE utilizes a realist approach, meaning the evaluation team (ET) focused on gaining a better understanding of the USAID Okard ToC, what is happening on the ground, and what works versus what does not within different contexts.

This approach required the use of multiple methods and data collection activities.

- First, the ET conducted a detailed document review.
- Second, the ET with the support of Lao Social Research and Services, Inc. (LSR) collected primary qualitative data through Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). This sample totalled 119 respondents.
- Third, WEI with the support of the University of Melbourne's Nossal Institute for Global Health (NIGH) collected primary qualitative and quantitative data (through KIIs, FGDs, and a survey) related to the CBID model. The qualitative sample included 91 respondents, and the survey included 648

[1] USAID Okard defines 'systems' as involving supply side actors (national, provincial, and district level Government of Lao PDR (GoL); health and vocational training services/facilities – high and low government supply side) and the enabling environment.
[2] USAID Okard documents describe the 'individual/community level' (also called the person-centered level) to include the Community-Based Inclusive Development (CBID) Demonstration Model, a case management approach to working with persons with disabilities and their households.

respondents (289 with disabilities and 359 without disabilities). Both quantitative and qualitative data were collected from each of the Phase I CBID Demonstration Model sites (VTE, SVK, and XHK).

The PE has one comprehensive EQ about the validity of the ToC (see below). The sub-EQs that follow explore the ToC fully (A, B, D) and capture other information critical to understanding how and why the USAID Okard approach worked or did not, for whom, and under what circumstances (C, E). At baseline, the ET has identified and reported on the status of intended participants (at the community and systems level - sub EQs A and D) and Activity measurement, management, and implementation plans (sub-EQs C and E). Findings and conclusions are presented in this report for all sub-EQs *except for sub-EQ B* that examines unintended outcomes, as no baseline information is necessary to answer this at endline.

EVALUATION QUESTIONS	
To what extent did USAID Okard's Theory of Change explain changes in the health and economic self-sufficiency of persons with disabilities and their households? Is the Theory of Change valid?	
SUB-QUESTIONS	A. To what extent did: • the people-centered interventions (CBID model, Tier 2) and system-centered interventions (Tier 1) contribute to Activity results? • the CBID model serve to catalyze and test the implementation of the National Disability Policy Strategy and Action Plan, and the National Rehabilitation Strategy and Action Plan at the community level, and in what ways did the model feed into national level revision of these key documents? • components 1 (health), 2 (economic empowerment), and 3 (stakeholder engagement) contribute to Activity results, and how did they interact with each other? Was component 3 found to be a key requirement for the effective, efficient, and long-lasting implementation of the health and economic interventions? B. What were the unintended outcomes and/or consequences of the Activity (considering sex, age, type of difficulties in functioning,[3] and ethnicity)? C. To what extent did the USAID OKARD management structure and implementation plan contribute to effective achievement of results? D. To what extent were women, youth, persons with differing types of difficulties in functioning, and minority groups/ethnicities engaged effectively in the Activity in all locations and in each component? E. To what extent are results at national and community level likely to be sustainable beyond the Activity period of performance? What evidence exists to support the conclusion?

FINDINGS AND CONCLUSIONS

SUB-EQ A: THEORY OF CHANGE

To address sub-EQ A at baseline, the ET explored two topics. First, the ET explored the baseline status of two sets of Activity participants – (1) persons with disabilities (compared to persons without disabilities) and (2) system actors. Second, the ET explored the extent to which the USAID Okard ToC conceptualizes how participants at baseline believe independent living and functional ability can be improved and sustained in Lao PDR. This exercise is helpful at a baseline because it often identifies findings that reframe and provide nuance to an Activity ToC.

[3] This report uses the preferred terminology of 'difficulties in functioning,' however, all data collection protocols were designed with the term 'impairments.' Data collection protocols provided in Annex E preserve the original terminology used during fieldwork. The Lao translation was not affected by the change in English terms.

Baseline Status

In summary, quantitative findings at baseline (n=648) reveal that more than nine out of ten persons with disabilities are satisfied with the health services they receive. While access to health services for persons with disabilities is also relatively high, nearly one in eight persons with disabilities cannot access health services as much as needed, and access to specific rehabilitative services is mixed. Persons with disabilities most commonly receive services at central or provincial hospitals and are more likely than not to visit public sector health facilities over private. While nine out of 10 working-aged persons with disabilities are working in some capacity, one in five is both unsatisfied with his or her working status and not always able to access work when needed.

Two out of every three persons with disabilities did not complete primary school, a rate that is 75 percent higher than persons without disabilities. Only about one in six persons with or without disabilities report ever receiving technical or vocational training, and even fewer expressed a need for vocational training in the months preceding the baseline (these results were nearly equivalent for persons with or without disabilities). Finally, persons with disabilities are at a high risk of depression compared to persons without disabilities, with more than one in three persons with disabilities indicating that they felt uninterested in activities, down, or depressed at least "several days" in the past two weeks versus less than one in six among persons without disabilities.

The SI qualitative data collection asked respondents (n=26) about key aspects of **the system** involving the Ministry of Health (MoH) and the Ministry of Labor and Social Welfare (MoLSW). These aspects included: policies/laws, financial capacity, personnel, technologies and medicines, management and coordination, data sharing and systems, and commitment to advancing inclusion. At baseline, in summary, respondents reported most aspects of the system as either 'poor' or 'fair'. Respondents ranked 'government commitment and willingness', however, as fair/satisfactory. Also, GoL rankings for each aspect of the system were higher than other respondent types at baseline. Finally, persons with disabilities are somewhat engaged in the system. They are somewhat active socially and in their communities, though one in seven has never participated in a community event, and three in ten never participate in social gatherings.

Participant Theories of Change

At baseline, SI qualitative data collection asked groups of intended Activity participants – persons with disabilities (n=37), Technical and Vocational Education and Training (TVET) staff (n=23), health facility staff (n=21), GoL (n=8), and private sector representatives (n=3) – their opinions regarding what is keeping persons with disabilities from accessing health services and being economically self-sufficient (the problem). They were then asked the best way to solve this problem (pathways to change).

- Groups view the **problem** differently. Supply side actors (health and TVET staff, and GoL respondents) noted challenges related to funding, resources, materials, and infrastructure that keep persons with disabilities from accessing services. Persons with disabilities and caregivers, on the other hand, most frequently mentioned inability to pay for services; low society awareness, understanding, and perception of persons with disabilities; and inability to find/hold a job as key barriers.
- For **pathways to change**, groups largely agree on the best ways to address the problem faced by persons with disabilities in Lao PDR. Persons with disabilities and health/TVET staff all mentioned 'improvement in infrastructure' as necessary. All respondent groups also noted 'improvement in quality' of health care or TVET teaching as important. Access to TVET training is not a primary concern for persons with disabilities interviewed at baseline by SI, and the NIGH quantitative data shows that persons without disabilities had very low levels of vocational training. Persons with disabilities did not mention lack of technical/vocational training as a root problem, nor did they note training or increased access to TVETs as critical to becoming economically self-sufficient. Respondents explained that the problem was instead access to capital and willingness of employers to hire persons with disabilities.

In conclusion, the baseline status of intended participant groups – persons with disabilities and system actors – adds depth and increased nuance to the USAID Okard problem statement and the goal. The data serve to inform and ground sub-partner activities and interventions as they launch this year, ensuring they are keenly aware of those they are working with and supporting, and the barriers these individuals face, their lived experience, and the perceptions they hold of themselves and their environment.

The baseline status of the system offers, on the one hand, a positive enabling environment in which champions can be identified and buy-in can be garnered and maintained, and on the other hand, a low capacity environment in which inefficiencies exist. Indications of GoL commitment and willingness show a positive enabling environment for the Activity to launch its work in the Stakeholder Engagement Component. Simultaneously, however, the low capacity of all other aspects of the system pose an early and most likely consistent threat to work in Tier 1, and, specifically, to the likelihood that Tier 1 will promote more *efficient* progress than working at the individual level alone (Tier 2).

Participants reframed 'pathways to change' inherent in the Economic Empowerment Component. USAID Okard's intervention related to improving access to TVET as an approach to increasing economic self-sufficiency (within the Economic Empowerment component) did not resonate with all persons with disabilities. Their concerns centered on securing employment, accessing capital, and paying for services. While this conclusion does not necessarily warrant changes to the intervention, they are important to consider as the Activity identifies learning questions and sets targets for how much these interventions can achieve and/or contribute to improved outcomes for persons with disabilities.

SUB-EQ C: MANAGEMENT AND IMPLEMENTATION

At baseline, the ET explored the management structure, implementation approach, and measurement plans of USAID Okard. This provides a baseline for answering sub-EQ C at endline and identifies potential risks to successful implementation. In summary, the Activity has a Memorandum of Understanding (MOU) with the GoL as of May 2019; is managed by WEI in close coordination with HI, the main sub-recipient (via four committees); and is implemented through eight sub-partners. At baseline, management of the Activity and coordination with all Activity stakeholders was on the minds of respondents; it was brought up in over half of the SI interviews with IP and USAID/United States Government (USG) staff (7/13). Additionally, there is early evidence of capacity challenges with sub-partners. Furthermore, the MOU process and negotiations surrounding the National Committee for the Disabled People and the Elderly's (NCDE) in-kind support reveal some early misunderstandings and miscommunications with GoL as a sub-partner.

Regarding measurement and evaluation, the Activity's Monitoring, Evaluation, and Learning Plan (AMELP) was finalized in February 2019. Based on document review and SI qualitative data, at baseline, there is a lack of clarity regarding how the following are designed, contribute to the ToC and RF, and are measured: the Social Behavior Change Campaign (SBCC) and the Disability Mainstreaming Advisory Service (DMAS). Additionally, one of the key points for learning that will take place in Year 3 is the Midterm Redesign Workshop. IP staff explained that they will be looking for '*momentum*' in the CBID Demonstration Model and with the NCDE and MoH partnership in Year 3, but beyond this, they did not (nor does the AMELP) explain the data that will influence Year 3 decisions.

In conclusion, USAID Okard's careful management and implementation planning is evident at baseline. USAID Okard had time to set up detailed procedures and processes to promote effective and efficient management of the Activity while obtaining the MOU. **However, there are risks to the Activity's ability to collectively learn and flexibly adapt throughout the period of performance (POP).** At baseline, respondents noted that multiple stakeholders and layers of management are a risk, particularly if roles and responsibilities are not made clear and an intentional culture of learning is not created across all stakeholders, including GoL sub-partners. Other risks identified at baseline are a lack of planning for Year 3 decision-making and unclear measurement approaches for several Activity interventions in the AMELP.

SUB-EQ D: BASELINE VARIATION

USAID Okard intends to improve and sustain the independent living and functional ability of persons with disabilities, *regardless of factors such as age, sex, gender expression, ethnicity*, and their households in Lao PDR.[4] The Activity has taken intentional steps to ensure that gaps among persons with disabilities related to these disaggregates are considered in Activity implementation (via the Gender and Inclusive Development Action Plan (GIDAP)). The ET analyzed CBID quantitative data (n=648) collected by NIGH for the status of persons with and without disabilities disaggregated by sex, ethnicity, location, age, and type of difficulties in functioning.

In conclusion, baseline findings on variation of status of persons with disabilities provides additional nuance to the GIDAP in some notable ways. First, persons with disabilities who are women, of Lao ethnicity, from Xayphouthong District, younger (aged 5-44), and older (over 65) were, on average, substantially more vulnerable at baseline compared to all persons with or without disabilities. Second, across the full sample, persons with or without disabilities were most equally aligned on work-related outcomes and satisfaction with health services—when they access them—and most different in education and wellbeing. Third, across different types of difficulties in functioning (i.e. sight, hearing, mobility, etc.), persons with difficulties in communication and difficulties with self-care were substantially more vulnerable than persons with other types of difficulties in functioning. Fourth, the effects of different types of difficulties in functioning are manifest most often in work-related outcomes, and least often in health and wellbeing. Fifth, access to health and rehabilitative services were the most varied among different disaggregates of persons with disabilities (e.g. men and women, by age group, etc.) at baseline. Lastly, compared to persons without disabilities, persons with disabilities were at substantially higher risk of depression, had attained less education, were less likely to socialize in their communities, and were less likely to be satisfied with their current status (e.g., working).

SUB-EQ E: SUSTAINABILITY

At baseline, the ET explored both IP plans for sustainability (via document review and interviews) and KII/FGD respondents' opinions regarding key factors for Activity success and sustainability. USAID Okard Activity reports include a section titled 'Sustainability Mechanisms'. The Quarterly Report for Quarter 2, Year 2 (Q2Y2) made specific reference to several sustainability approaches including working with and building capacity of a) local Disabled Persons Organizations (DPO) and b) GoL; DMAS; and information and resource sharing. Baseline SI qualitative respondents identified similar factors they believe will be key to sustainability – in particular, the role of GoL and DPOs as sub-partners. The most mentioned factor regarding sustainability by SI qualitative baseline respondents was GoL collaboration and coordination. Nine (out of 29) KIIs/FGDs mentioned coordination with GoL as crucial for sustainability of USAID Okard results, at the central level and within line ministries at the provincial and district level. Respondents also highlighted that Activity success will depend on the quality of the CBID facilitators (mentioned in 4 out of 29 KIIs and FGDs). In discussions with IP staff, they acknowledged the significant task of identifying and training CBID facilitators. Other sustainability factors mentioned less frequently in KIIs and FGDs were clear handover to GoL at the conclusion of the Activity (two mentions), identifying a champion within the GoL (three mentions), and connecting with the private sector (two mentions).

In conclusion, strategic thought about success and sustainability is evident in USAID Okard's reports. USAID Okard IPs currently have several sustainability mechanisms identified, and these are confirmed by KII/FGD respondents at baseline as key factors to the ultimate success of the Activity. **Key factors include involving GoL and local DPOs as sub-partners in USAID Okard and building capacity of these stakeholders. CBID facilitators are another factor to Activity success.**

[4] World Education Inc. "USAID Okard Activity Monitoring, Evaluation, and Learning Plan (AMELP)." Vientiane: World Education, Inc., 2019.

RECOMMENDATIONS

1 **To ensure the USAID Okard Activity ToC adequately describes the problem, interventions, desired change, and underlying assumptions, USAID Okard IPs should**:

a. More clearly define the **problem statement** in the AMELP;
b. Expand stated **assumptions** in the ToC and/or RF to include additional conditions necessary for the achievement of USAID Okard results;
c. Define how DMAS and SBCC **interventions** contribute towards achievement and sustainability of the goal;
d. Remove final conditional phase from the **If-Then Statement** to ensure the ToC is measurable at endline;[5] and,
e. Establish **context monitoring** to ensure consistent checks of ToC assumptions (programmatic and contextual), the operating environment, and any emerging differences in the experiences of participants.

2 **USAID Okard IPs should reflect on Economic Empowerment component reframing offered by baseline respondents.** This should take place first, through adding a learning question to the AMELP related to whether and how TVET education contributes to improved economic empowerment for persons with disabilities. Second, the Activity should continue with their plan to promote saving at the household level. Lastly, USAID Okard IPs should tailor their work with the private sector (through DMAS) to ensure barriers they face in hiring persons with disabilities are removed/addressed.

3 **USAID Okard IPs and USAID/LCO should use and follow** (and most likely adapt in Year 3) **the ToC, RF, and related measurements as a roadmap for examining during the Activity.** Annex H presents a) the USAID Okard ToC components presented in this baseline report and b) the types of data that provide reference points to measure each component.

4 **USAID Okard IPs and USAID/LCO should jointly explore additional ways to foster a culture of learning.** To more intentionally create and continually foster a culture of learning that can support adaptation, and to promote IP unity, USAID Okard IPs should consider key USAID CLA resources.

5 **USAID Okard IPs and USAID/LCO should remain committed to sub-partner capacity building.** Given the role that local organizations and the GoL play in the Activity as sub-partners, and the baseline capacity findings relating to these stakeholders, USAID Okard IPs and USAID/LCO should remain committed to sub-partner capacity building, and ensure that allocated resources for the purpose of capacity building are utilized with each sub-partner in a strategic and targeted way. USAID Okard IPs should monitor capacity building progress and review at Year 3.

6 **USAID Okard IPs and USAID/LCO should jointly define what data Year 3 decisions will be based on.** Baseline findings indicate a lack of agreement on what data will contribute to Year 3 decision-making. The ET recommends USAID Okard IPs and USAID/LCO conduct a 'Defining Success' workshop that will discuss and identify critical indicators, context, and progress to review at Year 3, which will inform on-going decision-making.

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[5] Statement reads as follows, and portion of the conditional phrase requiring a counterfactual is underlined: ***If*** *USAID OKARD implements activities in each of the three components at both the systems and community level,* ***then*** *the activity goal will be achieved more effectively and efficiently than if the systems or the person-centered approaches were implemented alone at only one level.*

INTRODUCTION

OVERVIEW

The United States Agency for International Development (USAID)/Lao Country Office's (LCO) Okard Activity is a $15 million Activity implemented by World Education, Inc. (WEI) in Lao People's Democratic Republic (PDR) from October 2017 to September 2022. In collaboration with Humanity and Inclusion (HI), USAID Okard's goal is *to improve and sustain the independent living and functional ability of persons with disabilities, regardless of factors such as age, sex, gender expression, ethnicity, and their households in Lao PDR.*[6] The USAID Okard Activity has interventions based in one district in Xieng Khouang Province (XHK), one district in Savannakhet Province (SVK), and Vientiane Capital (VTE) from Years 1 – 3 (Phase 1). The Activity will award sub-awards in Years 1 and 2 to a select number of organizations (called sub-partners) to implement in these locations. In Year 3, USAID Okard stakeholders will consider potential expansion to new districts in existing provinces in addition to any intervention adjustments through a Midterm Re-Design Workshop (Phase II).

USAID/LCO contracted Social Impact, Inc. (SI) to conduct a baseline, Performance Evaluation (PE) of USAID Okard. The overall purpose of the PE is to test and verify the logic of the Theory of Change (ToC), which includes examining the Activity's efforts in health, economic empowerment, and stakeholder engagement. This independent baseline evaluation will complement and incorporate the Activity's internal monitoring, evaluation, and learning (MEL) efforts by focusing on the goal of the Activity and the logical link between components of the ToC. The primary audiences for this evaluation are the USAID's implementing partners (IP), their sub-partners, USAID/LCO, and the Government of Lao PDR (GoL). The secondary and tertiary audiences are other government and non-government organizations working in inclusive development in Lao PDR and elsewhere, and the interested public.

THEORY OF CHANGE

A ToC is an explanation of how an intervention plans to bring about a change or result.[7] Useful ToCs include several key components that help explain how a specific goal will be achieved. As John Mayne explains in his paper 'Useful Theory of Change Models' (2015): *To understand how and if an intervention is working, we need to understand how the activities of the intervention are expected to lead to the desired results— both (a) the causal pathway from activities to outputs to a sequence of outcomes to impacts and (b) the causal assumptions showing why and under what conditions the various links in the causal pathway are expected to work.*[8] The core components of a ToC, therefore, are the Problem Statement, If-Then Statement, Goal, Interventions, and Assumptions, depicted in Annex A for USAID Okard.

USAID Okard has defined its ToC in the AMELP that was finalized in February 2019. According to this guiding document, USAID Okard was designed to address a **problem**: *A disabling environment in Lao PDR creates barriers for persons with disabilities, particularly women and girls, which restricts them from optimal functioning and being able to enjoy the same level of participation and access the same health and livelihood opportunities as others in society.*[9] Details about the disabling environment are not included in the AMELP; however, the factors that create barriers for persons with disabilities are outlined in other documents including the project design document, the Gender and Inclusive Development Action Plan (GIDAP), the Formative Study preceding this evaluation, and are further explored in the baseline findings presented in this report.[10]

To respond to this problem, USAID Okard identified a **goal**: *to improve and sustain the independent living and functional ability of persons with disabilities, regardless of factors such as age, sex, gender expression, ethnicity, and*

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[6] World Education, Inc. "USAID Okard AMELP." Vientiane: World Education, Inc., 2019.
[7] USAID Learning Lab (accessed 8/5/2019).
[8] Mayne, John. "Useful Theory of Change Models." Toronto: *Canadian Journal of Program Evaluation* 30, no. 2, 2015.
[9] World Education, Inc. "USAID Okard AMELP." Vientiane: World Education, Inc., 2019.
[10] Social Impact Inc. "Formative Study Report: USAID Okard Baseline Evaluation." Vientiane: USAID, January 2019.

their households in Lao PDR. The Activity committed to achieving this goal through a set of **interventions**, designed across three components and two tiers. A two-tiered approach integrates systems level (Tier 1)[11] and individual/community level (Tier 2)[12] interventions under three components of Health (Component 1), Economic Empowerment (Component 2), and Stakeholder Engagement (Component 3). Much of the work in these components is conducted via a cross-cutting intervention in Tier 2 called the Community Based Inclusive Development (CBID) Demonstration Model *which is an evidence-based model to catalyze and test the implementation of the National Disability Policy, Strategy and Action Plan, and the National Rehabilitation Strategy and Action plan at the community level.*[13] CBID is a case management and community engagement approach to working with persons with disabilities and their households. The interventions of USAID Okard are in this way informed directly by the GoL National Disability Strategy and Action Plan and the National Rehabilitation Strategy and Action Plan.

Tier 2 is expected to feed into Tier 1 and vice versa during the course of the Activity. The impact of the systems work will be tested through the CBID's implementation and testing of some of the areas developed in the National Disability Policy, Strategy, and Action Plan and the National Rehabilitation Strategy and Action Plan at the community level through the work of CBID facilitators (or one-on-one case workers) directly supporting identified persons with disabilities, caregivers, and their households (see circular arrows in Annex A).[14]

With a problem, goal, and set of interventions identified, the next item in a ToC is the 'if-then' statement. This statement links a 'conditional' (interventions) with an 'implication' (goal) – **if** something is done with beneficiaries, **then** something should change. The **if-then statement** for USAID Okard reads: ***If*** *USAID OKARD implements activities in each of the three components at both the systems and community level,* ***then*** *the activity goal will be achieved more effectively and efficiently than if the systems or the person-centered approaches were implemented alone at only one level.* USAID Okard's goal will be achieved by the end of the period of performance (POP) *if* the following **assumptions** hold true:

1. *All government and non-government stakeholders have a better understanding about the reality and experience of being a person with disability in terms of difficulty of functioning, being included in their own communities, and having their voice heard; and,*
2. *Service providers, families and persons with disabilities work together to complement each other in their roles in health, education, business, and in public and private central, provincial and district institutions.*

The AMELP describes the three components (see center boxes in Annex A) as *mutually reinforcing and interconnected*. Furthermore, Component 3 (Stakeholder Engagement) is described as feeding into Components 1 and 2 as *a key requirement for the effective, efficient and long-lasting implementation of the planned health and economic interventions, and the Activity overall.*[15]

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[11] USAID Okard defines 'systems' as involving supply side actors (national, provincial, and district level GoL; health and vocational training services/facilities – high and low government supply side) and the enabling environment. Supply side in this context (as related to health) only refers to some medical services, rehabilitation services, and mental health and psychosocial support. Not all health-related services are covered under USAID Okard. Supply side also refers to private sector actors that USAID Okard will work with to facilitate the Income Generating Activity (IGA).

[12] USAID Okard documents describe the 'individual/community level' (also called the person-centered level) to include the Community-Based Inclusive Development (CBID) Demonstration Model.

[13] World Education, Inc. "USAID Okard AMELP." Vientiane: World Education, Inc., 2019.

[14] These plans and strategies are the guiding documents for how the Disability Law (December 2018) should be implemented in Lao PDR. More specifically: a) The National Rehabilitation Strategy and Action Plan was approved by the Minister of Health in October 2018. As of January 2019, this strategy is currently being printed but has not been disseminated yet to any MoH departments. In the USAID Okard Year 1 Report, the IP noted the following: *This achievement marks the foundation of the ownership for rehabilitation by Ministry of Health and paves the way for the effective implementation of the USAID Okard Health Component;* b) The Disability Strategy and Action Plan was put on hold by the National Center for Disabled and the Elderly (NCDE) as they prioritized the Disability Law. As of January 2019, no further revisions have been made to the strategy and action plan.

[15] World Education, Inc. "USAID Okard AMELP." Vientiane: World Education, Inc., 2019.

ACTIVITY RESULTS FRAMEWORK

Details regarding *how* specific component interventions lead to results and the goal are included in the Activity Results Framework (RF) (see Annex B). In summary, the focus on the systems level involves WEI and HI supporting key GoL ministries with in-kind resources and technical assistance and support. The impact of the systems work, as noted above, will be tested at the community level through the CBID approach. CBID facilitators will empower communities to become disability inclusive through stakeholder engagement, mobilization, awareness raising, training, and mentorship toward the goal of improving persons with disabilities access to services.

A brief summary of the components the Activity includes is provided here, though additional detail on these components and the activities within them can be found in Activity documents. The Health Component is composed of three interventions (H1, H2, H3) primarily involving the training of supply side actors (central, district, and provincial hospitals) and working with demand side actors to increase awareness among communities, households, and persons with disabilities, and encourage utilization of services. The Economic Empowerment Component is composed of three interventions (E1, E2, E3) primarily involving engagement with Technical and Vocational Education and Training (TVET) institutions and an Income Generating Activity (IGA) in partnership with private sector stakeholders. It also includes a Disability Mainstreaming Advisory Service (DMAS) grant, and provision of support to households through the CBID model.[16] The Stakeholder Engagement Component includes four interventions (S1, S2, S3, S4) primarily involving support to GoL and organizations to develop, implement, and monitor policies, plans, and strategies, and coordinate toward the ultimate goal of improving the lives of persons with disabilities in Lao PDR.

Overall, USAID Okard tracks its progress and achievements through 16 indicators (depicted in the RF and listed in Annex B). Monitoring data related to each of these indicators will come largely from sub-partner monitoring and the CBID modular tool,[17] but will also come from the CBID Assessment quantitative and qualitative data.[18] Annex H shows the USAID Okard ToC components and data collection plans for each component.

[16] DMAS is an intervention under the Economic Empowerment Component. At baseline, proposals were being collected for this intervention. The grantee will develop services to support various clients in creating or adapting workplaces to be accessible (in terms of infrastructure, etc).

[17] Documented in AMELP Performance Indicator Reference Sheets. This tool is used to collect intake, exit, and regular data on persons with disabilities/households working with CBID facilitators.

[18] Implemented by the University of Melbourne's Nossal Institute for Global Health (NIGH) in partnership with WEI. Publicly available on the Development Experience Clearinghouse (DEC).

EVALUATION METHODOLOGY

PURPOSE AND QUESTIONS

The purpose of the PE is to test and verify the ToC. At baseline, therefore, the evaluation will: a) set a framework for the overall measurement and evaluation of the Activity, b) determine reference points that can help inform the detailed implementation plan, and c) provide evidence to support validation of the ToC at later stages of the Activity that will be useful for adaptive management of current programming as well as future programming in inclusive development.[19] The evaluation baseline was conducted in 2019 and endline is anticipated four years after baseline at the end of the USAID Okard POP in 2022.

The Evaluation Questions (EQs) presented in Table 1 were adapted from those specified in the SOW and were finalized based on the findings from the Formative Study that preceded this evaluation and numerous consultations with USAID Okard stakeholders. There is one comprehensive EQ about the validity of the ToC. The sub-EQs that follow explore the ToC fully (A, B, D) and capture other information critical to understanding how and why the USAID Okard approach worked or did not, for whom, and under what circumstances (C, E).

Findings and conclusions are presented in this report for all sub-EQs *except for sub-EQ B* that asks about unintended outcomes, as no baseline information is necessary to answer this at endline. At baseline, the evaluation team (ET) has identified and reported on the status of intended participants (at the community and systems level - sub EQs A and D) and Activity measurement, management, and implementation plans (sub-EQs C and E). This baseline data provides reference points that will not only be useful in answering EQs at endline, but also in managing the Activity throughout the POP.

Table 1: Evaluation Questions

To what extent did USAID Okard's Theory of Change explain changes in the health and economic self-sufficiency of persons with disabilities and their households? Is the Theory of Change valid?	
SUB-QUESTIONS	A. To what extent did: • the people-centered interventions (CBID model, Tier 2) and system-centered interventions (Tier 1) contribute to Activity results? • the CBID model serve to catalyze and test the implementation of the National Disability Policy Strategy and Action Plan, and the National Rehabilitation Strategy and Action Plan at the community level, and in what ways did the model feed into national level revision of these key documents? • components 1 (health), 2 (economic empowerment), and 3 (stakeholder engagement) contribute to Activity results, and how did they interact with each other? Was component 3 found to be a key requirement for the effective, efficient, and long-lasting implementation of the health and economic interventions? B. What were the unintended outcomes and/or consequences of the Activity (considering sex, age, type of difficulties functioning, and ethnicity)?[20] C. To what extent did the USAID OKARD management structure and implementation plan contribute to effective achievement of results? D. To what extent were women, youth, persons with differing types of difficulties in functioning, and minority groups/ethnicities engaged effectively in the Activity in all locations and in each component? E. To what extent are results at national and community level likely to be sustainable beyond the Activity period of performance? What evidence exists to support the conclusion?

[19] See Statement of Work (SOW) in Annex F.

[20] This report uses the preferred terminology of 'difficulties in functioning,' however, all data collection protocols were designed with the term 'impairments.' Data collection protocols provided in Annex E preserve the original terminology used during fieldwork. The Lao translation was not affected by the change in English terms.

APPROACH AND METHODS

The PE applies a **mixed methods** design, including qualitative and quantitative data; and **participatory** approach, including IPs and sub-partners, populations intended to benefit from USAID Okard interventions and services, and key stakeholders including USAID staff as much as possible in the evaluation planning and implementation. Furthermore, the PE utilizes a **realist** approach, meaning the ET focused on gaining a better understanding of the USAID Okard ToC, what is happening on the ground, and what works versus what does not within different contexts. As described by Pawson et al, the realist approach explores 'what works, for whom, in what respects, to what extent, in what contexts, and how?' as opposed to merely exploring 'does it work?'.[21]

Figure 1: USAID Okard Phase 1 Sites

This approach required the use of multiple methods and data collection activities. First, the ET conducted detailed **document review** (including gray literature and the World Health Organization (WHO) Systematic Assessment of Rehabilitation Situation (STARS Report).[22, 23] Second, the ET with the support of Lao Social Research and Services, Inc. (LSR) collected primary qualitative data [through **Key Informant Interviews** (KIIs) and **Focus Group Discussions** (FGDs)]. The ET requested and received all appropriate research and ethics approvals (further detailed in Annex K). Third, WEI with the support of the University of Melbourne's Nossal Institute for Global Health (NIGH) collected primary qualitative and quantitative data (through a **survey** and additional KIIs and FGDs). The ET communicated with NIGH during their design and implementation and received cleaned data after survey completion.

SI qualitative data were collected from each of the Phase I CBID Demonstration Model sites: VTE, SVK; and XHK (Figure 1).[24] CBID quantitative and qualitative data were collected from SVK and XHK. For a summary of how each of these methods was used to address EQs, see the evaluation design matrix in Annex C. The matrix is organized by EQ and includes information on data sources, data types, methods and tools, and data analysis methods. All qualitative protocols are in Annex E.[25]

In this report, primary qualitative data collected directly by the SI/LSR teams (the ET) will be referred to as the *SI qualitative data*. Data (quantitative and qualitative) collected directly by WEI and NIGH will be referred to as *CBID quantitative and qualitative data*. A majority of the KIIs were conducted in Vientiane, but several were also conducted in the selected provinces/districts. Interviews lasted between 45 – 60 minutes. The SI Monitoring and Evaluation Specialist and Local Disability and Gender Specialist met with 21 respondents in Vientiane, with interviews conducted in English. The remaining respondents were interviewed by LSR in Lao or a local dialect. Further details about data collection activities can be found in Annex K.

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[21] Pawson, R. & Tilley, N. (1997). Realistic Evaluation. London: Sage. For a summary of the theory behind the realist approach, see https://www.betterevaluation.org/en/approach/realist_evaluation.

[22] See Annex J for a complete list of documents and literature reviewed for the baseline PE.

[23] The WHO STARS was launched in 2018 and led by an international consultant contracted with WEI. The assessment included: a) GoL completion of the WHO Rehabilitation Capacity Questionnaire (10 questionnaires were completed), b) consultant review of key documents (50 resource documents were reviewed), and c) consultant in-person data collection in-country (in March 2019). Data collection included KIIs, FGDs, Strengths Weaknesses Opportunities Threats analysis, and site visits to health and rehabilitation services in VTE and SVK. The analysis process (conducted after parts a – c were completed) compares the existing country situation against the 54 components of the Rehabilitation Maturity Model. More details are available in the WHO STARS Report.

[24] USAID Okard targets 35 out of 90 villages in Kham District, XHK and 16 out of 40 villages in total in Xayphouthong District, SVK.

[25] Annex E includes SI's primary data collection protocols only. See the NIGH CBID Baseline Report for full survey questionnaire.

BASELINE SAMPLE

A summary of baseline SI qualitative data sample is provided in Table 2. In total, the ET spoke with 119 respondents (65 women, 54 men) through 33 KIIs and 15 FGDs. Respondents were sampled purposively. For extended methodology details, see Annex K.

Table 2: Qualitative Data Sample

Respondent Category	SI Qualitative Sample			CBID Qualitative Sample		
	Men	Women	Total	Men	Women	Total
GoL and Technical Working Group (TWG) Members	8	0	8	3	1	4
Health Facility Staff	7	14	21	5	7	12
IP and Sub-Partner Staff	7	8	15	N/A	N/A	N/A
Other Experts	2	5	7	N/A	N/A	N/A
Private Sector Representatives	2	0	2	0	2	2
Persons with Disabilities	15	17	32	8	6	14
Caregivers of Persons with Disabilities	1	4	5	6	7	13
TVET/Education Staff	10	13	23	4	0	4
USAID/Other United States Government (USG)	2	4	6	N/A	N/A	N/A
CBID Team	N/A	N/A	N/A	9	4	13
Community Members without Disability	N/A	N/A	N/A	11	11	22
Disabled Persons Organization (DPO)	N/A	N/A	N/A	2	0	2
Village Leader	N/A	N/A	N/A	2	0	2
Women's Union Representative	N/A	N/A	N/A	0	2	2
TOTAL	**54**	**65**	**119**	**50**	**40**	**90**

In total, CBID qualitative data included 90 respondents (40 women, 50 men) in 28 KIIs and 14 FGDs (Table 2). Respondents were sampled purposively. For extended methodology details, see Annex K.

The CBID quantitative data was collected by NIGH, utilizing a multi-stage stratified random sampling (panel) methodology. The total sample included 648 people, 289 (45%) of whom were persons with disabilities and 359 (55%) without disabilities.[26] In order to reach a sufficient sample size to ensure statistical validity, NIGH oversampled persons with disabilities in target geographic areas. To account for this, population-based weights were applied to the dataset during analysis. The sample *without weights* is summarized in Table 3 by persons with disabilities and persons without disabilities.

Fifty-one percent of the total sample was in Kham District, and 54 percent were women. Sampled respondents were 43.3 years old, on average, though persons with disabilities were substantially older than persons without disabilities (55.8 years versus 33.1 years old, respectively). The sample was 73 percent of Lao ethnicity, and 27 percent was of other ethnicities. The distribution of difficulties in functioning among the full sample (n=648) was as follows: difficulties seeing (21%), difficulties hearing (11%), difficulties with mobility (21%), difficulties in communication (4%), cognitive difficulties(15%), difficulties with self-care (2%),

[26] 'Disability' was established if a respondent indicated having "lots of difficulty" or an "inability to" see, hear, walk, remember, concentrate, or take care of oneself. Respondents who indicated "some difficulty" or "no difficulty" doing the above activities were considered to be persons without disabilities. The ET acknowledges that respondents may have difficulties in functioning of varying severity; grouping of those with "some difficulty" into the "persons without disabilities" group was done purely for analysis purposes in this report, Creation of this variable was done with guidance from the Washington Group disability questions: http://www.washingtongroup-disability.com/wp-content/uploads/2016/12/WG-Document-4-The-Washington-Group-Short-Set-on-Functioning-Question-Specifications.pdf.

difficulties with upper limb strength (2%), and difficulties with hand-eye coordination (3%). Nineteen percent of the sample had two or more types of difficulties in functioning.

Table 3: CBID Quantitative Sample

Key Demographic Variables	Persons without Disabilities	Persons with Disabilities	Total
Kham District	163	168	331
Xayphouthong District	196	121	317
Male	171	130	301
Female	188	159	347
Average age (years)	33.1	55.8	43.3
Ethnicity: Lao	278	195	473
Ethnicity: non-Lao	81	94	175

DATA ANALYSIS

SI qualitative data was transcribed and translated by LSR and analyzed by the ET via a team-developed codebook. **CBID quantitative data** was collected and cleaned by NIGH and then submitted to the ET for secondary analysis. The ET applied relevant population-based weights, then further cleaned and reshaped the data and created new variables as necessary to carry out analysis as relevant to the EQs. The ET conducted descriptive analysis with basic measures such as summaries, tabulations, and cross-tabulations to arrive at baseline findings. All data cleaning and analysis by the ET was conducted in Stata. **CBID qualitative data** was transcribed and translated by WEI and analyzed by NIGH. Considering this dataset was still being analyzed at the time of writing, NIGH provided a summary of core findings only to the ET for inclusion in this report. Findings from all sources were captured in a Findings and Conclusions matrix and triangulated to verify findings and develop Recommendations.

To process all data, the ET first utilized **triangulation** to cross-verify and cross-validate the findings that emerged from each data collection method, and to identify correlations between findings and determine baseline conditions and overall ToC relevance at endline. Furthermore, the ET utilized methodological triangulation to develop parallel SI qualitative protocols with the same or similar questions across KIIs and FGDs. This enabled greater data triangulation because each method addressed sub-sets of the same EQs. The ET employed several additional data analysis methods to identify key findings from the collected data from all data collection methods noted above. Analysis methods included **comparative analysis,**[27] **gap analysis,**[28] **content analysis,**[29] and **quantitative analysis** (as described above)**.** At endline, other analysis approaches may be appropriate like Outcome Harvesting,[30] Stakeholder Mapping,[31] or Process Tracing.[32] With respect to the CBID quantitative data, considering the panel nature of the data, at endline the ET may

[27] This involved comparison of ToC models as mapped by FGD respondent groups (persons with disabilities, health facility staff, TVET staff, and GoL). The ET assessed convergence or divergence with the USAID Okard ToC.
[28] This involved identification of gaps in the USAID Okard ToC and causal pathways identified in the results framework.
[29] This involved intensive review of KII and FGD data to identify and highlight baseline contexts and circumstances in the system that may contribute to (or inhibit) the Activity.
[30] Outcome Harvesting collects ("harvests") evidence of what has changed ("outcomes") and, then, working backwards, determines whether and how an intervention has contributed to these changes.
[31] This would involve all stakeholders intended to change as a result of the intervention and result in a constructed narrative or visual map of each groups' engagement/interaction with their system (in terms of services, support, etc.).
[32] Process tracing is a case-based approach to causal inference which focuses on the use of clues within a case (causal-process observations) to adjudicate between alternative possible explanations. Process tracing involves four types of causal tests. More details here: https://www.betterevaluation.org/en/evaluation-options/processtracing

employ more sophisticated quantitative analysis techniques, such as t-tests, difference in difference, and bivariate and multivariate regression to better understand the programmatic impact of the Activity as well as the effects of certain explanatory variables on key outcomes of interest.

After submitting the first draft of the report, **the ET facilitated a two-day workshop** in Vientiane with USAID Okard stakeholders on September 19 and 20, 2019. The main purposes were to 1) present preliminary findings and recommendations to USAID Okard team and relevant partners/stakeholders; 2) validate the findings and recommendations and/or solicit inputs/ comments from the participants; 3) introduce the evaluation framework; and 4) to brainstorm applications of the framework and baseline data/ information that will be useful for finalization of the baseline evaluation report and early adaptation of the Activity to ensure its effectiveness. On day one, participants from USAID, WEI, and HI discussed baseline findings on the status of persons with disabilities, status of the system, and participant theories of change. In the morning of the workshop's second day, the ET held a briefing on baseline findings, recommendations, and utilization plan for USAID Okard sub-partners, including GoL. In the afternoon, final sessions were held with the same participants as day one to discuss baseline findings on implementation, management, and sustainability, recommendations, and ways to utilize baseline data. The workshop yielded productive discussions and detailed feedback that the ET incorporated into the final evaluation report.

LIMITATIONS

The main noteworthy limitation of this baseline study is **sampling error**. For SI qualitative data, the ET obtained information from a select group of individuals in VTE and in the two selected districts for the CBID Demonstration Model. Due to the purposive sampling approach used to identify respondents, responses from the sample are not representative of the larger population. Thus, findings do not capture the full range of experiences and nuances of persons with disabilities and stakeholders in Lao PDR. The ET cannot comment on the limitations of the CBID qualitative data but expect that this dataset faces a similar limitation as the SI qualitative data.

Though it was not the goal of these qualitative efforts to yield representative data, both organizations (SI and NIGH) attempted to purposively select respondents in a way that captured as much diversity in knowledge, experience, and opinion as possible. The ET worked with USAID, WEI, and Disabled Persons Organizations (DPO)/Non-Profit Associations (NPA) to develop sampling frames for the service centers and the persons with disabilities that are expected to receive interventions of the Activity. Further, while the three targeted districts included in the geographic scope of baseline sampling approach are suitable for baseline, endline sampling approach may be expanded to include additional provinces and/or districts in which USAID Okard will begin implementation from Year 3 onward (depending on the midterm redesign and other factors), and thus a potential expansion of the range of respondents and experiences in collected data.

The CBID quantitative survey implemented by NIGH was completed in a rigorous, representative manner and is expected to yield results generalizable to the targeted districts (Kham and Xayphouthong) in Lao PDR. The panel nature of the study ensures that the influence of bias due to unobservable variables over time is minimized. While the ET expects to compare data collected via the survey at baseline to endline data, the panel nature of the study introduces some risk. If, at endline, attrition—that is, the loss of respondents in the sample during follow-up—is high, it could negatively affect the statistical power of the study and threaten its internal validity. Replacing participants lost to the study between baseline and endline may help to maintain statistical power, but risks introducing unobserved bias into the results. The ET should work closely with NIGH to understand the sample at endline to mitigate any threats to robustness and internal validity.

FINDINGS AND CONCLUSIONS

THEORY OF CHANGE

SUB-EQ A: FINDINGS

To address sub-EQ A at baseline, the ET explored two topics. First, the ET explored the **baseline status of two sets of Activity participants** – (1) persons with disabilities and (2) system actors. Indicators that the ET explored to set the baseline status are related to changes that participants are expected to experience as a result of USAID Okard. By collecting information on these aspects at baseline, the endline PE will be able to more completely capture actual change and contribution of the Activity to this change. For persons with disabilities, therefore, findings relate to access to health and rehabilitative services, access to work and education, and wellbeing and attitudes, as these are areas in which the ET expects to see changes as a result of USAID Okard. Similarly, for system actors, the ET identified the baseline status indicators as those that are intended to change as a result of USAID Okard – in particular, system management and coordination and capacity to implement and monitor relevant policies. This section also explores persons with disabilities' current status of engagement with the system – GoL and their communities.

Second, in line with the realist approach to baselining a ToC, the ET explored the **extent to which the USAID Okard ToC conceptualizes how participants at baseline believe independent living and functional ability can be improved and sustained in Lao PDR**. In other words, at baseline, what do participant groups view as the problem and what do they view as the most effective ways to address the problem? This exercise is helpful at baseline because it often identifies findings that reframe and provide nuance to an Activity ToC. Findings for both topics serve as baseline for the USAID Okard ToC.

BASELINE STATUS: PERSONS WITH DISABILITIES

USAID Okard's individual-level component is the CBID Demonstration Model. The model is administered through CBID Facilitators, or local case workers who support households and persons with disabilities in accessing knowledge about available services, identifying appropriate income/employment opportunities (possibly through the USAID Okard IGA), etc. At baseline, the ET used the CBID quantitative data to establish the status of persons with disabilities with regard to: access to health and rehabilitative services; access to work and education; wellbeing and attitudes; and baseline levels of engagement in community and with GoL. Each of these areas are expected to be impacted by USAID Okard by the endline PE. The ET presents additional findings in Annex K. Additionally, SI qualitative data and CBID qualitative data are referenced where applicable.

In summary, findings at baseline reveal that more than nine out of ten persons with disabilities are satisfied with the health services they receive. While access to health services for persons with disabilities is also relatively high, nearly one in eight persons with disabilities cannot access health services as much as needed, and access to specific rehabilitative services is mixed. Persons with disabilities most commonly receive services at central or provincial hospitals and are more likely than not to visit public sector health facilities over private. While nine out of ten working-aged persons with disabilities are working in some capacity, one in five is both unsatisfied with his or her working status and not always able to access work when needed. Two out of every three persons with disabilities did not complete primary school, a rate which is 75 percent higher than persons without disabilities. Only about one in six persons with disabilities and one in six persons without disabilities report ever receiving technical or vocational training, and even fewer expressed a need for vocational training in the months preceding the baseline. Finally, persons with disabilities are at a high risk of depression compared to persons without disabilities, with more than one in three persons with disabilities indicating that they felt uninterested in activities, down, or depressed at least "several days" in the past two weeks, compared to less than one in six persons without disabilities.

ACCESS TO AND SATISFACTION WITH HEALTH AND REHABILITATIVE SERVICES

A total of 648 persons completed the CBID quantitative survey at baseline, including 289 persons with disabilities (45 percent) and 359 persons without disabilities (55 percent). Responses included in Figure 2 are those that relate to health and rehabilitative services among the full sample, *weighted* for population-based estimates.

At baseline, 18 percent of persons with disabilities reported having health insurance, slightly higher than the 16 percent of persons without disabilities (n=648). Of the sample that had indicated being sick at least once in the past 12 months (n=136), 76 percent of both persons with disabilities and persons without disabilities accessed health services at a physical location (either a pharmacy, public health facility, or private health facility). The distribution across these three health service points was different, though: 6 percent of persons with disabilities compared to 17 percent of persons without disabilities accessed a pharmacy, 69 percent versus 53 percent accessed a public health facility, and 9 percent versus 19 percent accessed a private health facility.

Of the sampled individuals who had needed to access health services in the past three months (n=232), about one in 10 persons without disabilities reported not being able to do so as much as needed compared to one in eight persons with disabilities.[33] Of those who had received healthcare services (n=372), 95 percent of persons without disabilities reported that they were 'satisfied' or 'very satisfied' with the health services they had received compared to 93 percent of persons with disabilities. See Figure 2 for more information.

Concerning rehabilitative services, only five percent of those sampled (31 individuals, of which 22 were persons with disabilities) had accessed rehabilitative services in the past three months, and 17 people (three percent) were not sure if they had accessed rehabilitative services. [34] Of these 49 individuals (7.4% of the sample), about one in four indicated they were unable to access rehabilitative services as much as needed: that was 37 percent of persons with disabilities and 19 percent of persons without disabilities. Of these 49 individuals who had accessed rehabilitative services, one in five persons with disabilities were unsatisfied with the services received, compared to just over one in six persons without disabilities. Of those individuals who had not accessed rehabilitative services in the past three months (n=472), only four percent (18 individuals) had ever accessed rehabilitative services, which means a total of 67 people (10.3% of the sample) had ever accessed rehabilitative services. As a proxy for access to rehabilitative services, the ET looked at the proportion of sampled respondents who used any type of assistive device. Seventy-one percent of persons with disabilities (n=289) did not use any assistive device (compared to 91 percent of persons without disabilities, n=359). While this means 29 percent of persons with disabilities used at least one assistive device, seven percent of persons with disabilities used two or more devices, compared to one percent of persons without disabilities.

SI qualitative data captured commonly utilized facilities by the 37 persons with disabilities and caregivers that participated in focus groups. Of the 37 individuals, 25 reported accessing a provincial hospital in the past for medical care. Other commonly referenced health facilities at baseline were central (12/37), district (11/37) and village health facilities (11/37); rehabilitation centers (7/37), and private facilities (6/37). These are in line with findings from the CBID quantitative data that persons with disabilities visit public sector health facilities at a much higher rate than private sector, though the survey does not break down the exact type of facility.

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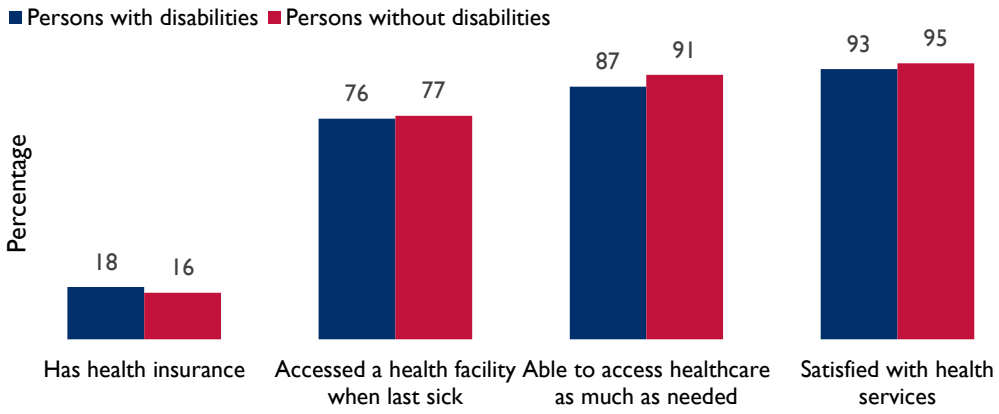
[33] Per the CBID survey, the question reads: *Over the past 3 months, have you needed to access healthcare services?* No additional definition of 'health services' is provided.

[34] Per the CBID survey, the question reads: *Over the past 3 months, have you needed to access rehabilitation services?* Follow up questions on ability to access rehabilitative services as much as needed and satisfaction with services received were predicated on receiving an affirmative answer to the initial question of needing to access rehabilitative services and therefore resulted in a small sample size for subsequent analyses. Results on rehabilitative services should therefore be interpreted cautiously. To explore the outcome of access to rehabilitative services, the ET used a proxy question related to use of assistive devices.

Figure 2: Baseline health outcomes for persons with (n=289) and without (n=359) disabilities



ACCESS TO WORK AND EDUCATION

At baseline, among people aged 16-64 (n=428), 89 percent of both persons with disabilities and persons without disabilities reported that they currently work. Among the same age group, 69 percent of persons with disabilities were currently earning income compared to 62 percent of persons without disabilities. Asked if they needed to access work in the past three months, 67 percent of persons with disabilities aged 16-64 said yes, compared to 79 percent of persons without disabilities. Among the same age group, 80 percent of persons with disabilities were able to access work all of the time when needed, compared to 88 percent of persons without disabilities. Finally, for those aged 16-64, 80 percent of persons with disabilities indicated they were satisfied or very satisfied with their current activity status (i.e. working or not working) compared to 93 percent of persons without disabilities (Figure 3).

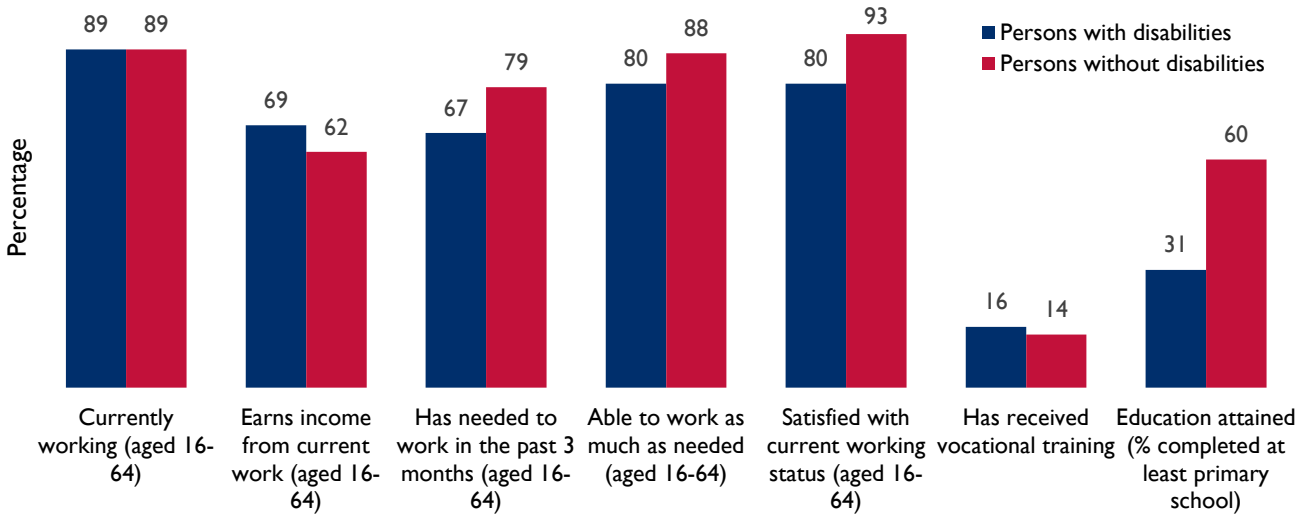
With respect to TVET, 16 percent of persons with disabilities (n=289) had received vocational training compared to 14 percent of persons without disabilities (n=359) (Figure 3). Three percent of persons with disabilities needed vocational training in the past three months versus nine percent of persons without disabilities.[35] Among those who had needed vocational training in the past three months, the sample size was too small (n=39) to disaggregate analyses by disability to understand the extent to which persons with or without disabilities were able to receive the vocational training as much as needed.

Of all respondents in the CBID survey, 31 percent of persons with disabilities (n=289) had completed no formal education compared to 12 percent of persons without disabilities (n=359). Thirty-eight percent of persons with disabilities indicated some primary school as the highest level of education completed compared to 28 percent of persons without disabilities; conversely, 21 percent of persons with disabilities indicated primary school as the highest level completed, compared to 38 percent of persons without disabilities. Ten percent of persons with disabilities had completed secondary schools as the highest level of education compared to 22 percent of persons without disabilities.[36]

[35] Note that the CBID survey asked respondents "In the past three months, have you needed vocational training?" A negative answer to the question does not necessarily mean that the respondent did not need vocational training previously or will not need it in the future.

[36] Officially education is compulsory in Lao PDR for eight years, from age six to fifteen. Primary school has five grades, middle school three grades, high school three grades.

Figure 3: Baseline work and education outcomes for persons with (n=171) and without (n=257) disabilities[37]



WELLBEING[38] AND ATTITUDES

The Social Behavior Change Campaign (SBCC) was not well defined at baseline (and so were not explicitly included in SI's qualitative data collection), though general conditions related to wellbeing and attitudes were explored in the CBID quantitative data collection. As an indication of mental health and wellbeing, the CBID survey asked how often respondents felt uninterested in doing activities, down, or depressed during the two weeks prior to the survey. The ET created a composite score with a range of answers from 0 to 6, where 0 indicated that a respondent never felt uninterested in activities, down, or depressed in the past two weeks, and 6 indicated they felt that way nearly every day. A score of 1 indicated that a respondent felt uninterested in activities, down, or depressed at least "several days" in the past two weeks. To ensure adequate variation for analysis, a respondent was considered "at risk for depression" if they scored any number above a zero score.[39] At baseline, 37 percent of persons with disabilities (n=289) surveyed reported feeling uninterested in doing activities, down, or depressed at least "several days" in the past two weeks compared to 16 percent of persons without disabilities (n=359). Fourteen percent of persons with disabilities replied that they felt this way "nearly every day" in the past two weeks compared to 1 percent of persons without disabilities.

BASELINE STATUS: SYSTEM

USAID Okard's Stakeholder Engagement component includes four system-level interventions, the goals of which are to support GoL and organizations to develop, implement, and monitor policies, plans, and strategies related to disability and rehabilitation, and coordinate together to ensure sustainability of gains made through USAID Okard.[40] This understanding of the system is informed by USAID's systems approach,

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[37] For this figure, the sample sizes for all work-related questions was n=428. The sample size for technical and vocational education and training questions was n=648.

[38] In this report we refer to "wellbeing and health" as "wellbeing," which is measured quantitatively (using the CBID survey) by a respondent's risk of depression. There are many other ways to supplement this measurement (including a life satisfaction index included in the survey), however, for this report, the ET has chosen to use the measurement of risk of depression as it aligns with analyses conducted by NIGH.

[39] There are many ways to establish a cutoff to determine risk of depression, or likelihood of having depression. Establishing the cutoff at any score above zero ensured that there was adequate variation in the results to understand which types of respondents were more at risk for depression than others. NIGH, the implementer of the CBID baseline survey, may use a different approach to define wellbeing and risk of depression.

[40] USAID Okard defines 'systems' as involving supply side actors (national, provincial, and district level GoL; health and vocational training facilities/institutions) and the enabling environment.

formally defined in April 2014.[41] It explains that a local (meaning partner country) system is "interconnected sets of actors – governments, civil society, the private sector, universities, individual citizens, and others – that jointly produce a particular development outcome." Local systems can be national, provincial, or community-wide in scope.

To explore the state of the system at baseline, the SI qualitative data collection asked respondents about key aspects of the system involving the Ministry of Health (MoH) and the Ministry of Labor and Social Welfare (MoLSW). These aspects included: policies/laws, financial capacity, personnel, assistive technologies and medicines, management and coordination, data sharing and systems, and commitment or willingness to advancing inclusion.[42] These aspects were identified as critical parts of the system that defines, manages, and supports rehabilitation and disability services in Lao PDR during the PE design, and mirror the domains[43] explored by the WHO STARS Report conducted in parallel with this evaluation. This section also details findings regarding persons with disabilities' engagement with the system – with GoL and their communities.

Figure 4 includes the average results from 26 respondents, rating system components on a scale from 1 to 5 (1 being very poor, and 5 being very satisfactory). The figure also includes a breakdown of GoL (6 respondents) and non-GoL respondents (20 respondents). GoL respondents included representatives from MoH (DH&R and CMR) and Ministry of Education and Sport (MOES). MoLSW (NCDE) did not participate in an interview so their views are not represented in the figure. Non-GoL respondents included private sector representatives, IP staff, USAID and other USG staff, and other experts and donors.

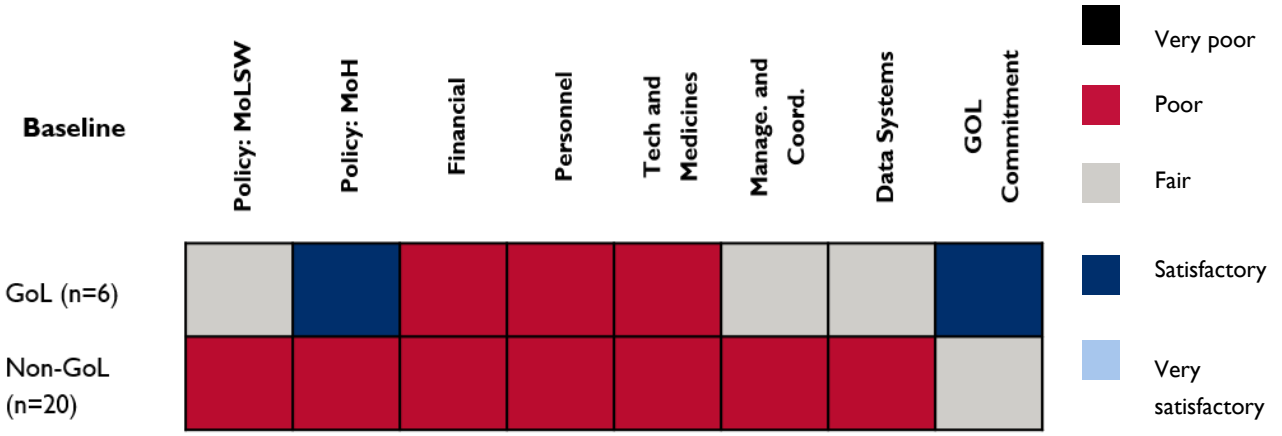
At baseline, respondents to SI qualitative data collection reported most aspects of the system as either 'poor' or 'fair', on average. The WHO STARS Report scores collected from GoL respondents also reflect low rehabilitation system capacity at baseline, with component scores ranging between 1 (*very limited, needs establishing*) and 2 (*needs a lot of strengthening*). Respondents to SI qualitative data collection ranked 'government commitment and willingness' as fair/satisfactory at baseline. The WHO STARS Report findings also recognize this, noting that MoH has demonstrated interest in and commitment to improving the rehabilitation sector in Lao PDR (evidenced in part by their willingness to support the Assessment). The USAID Okard Quarterly Report for Quarter 2, Year 2 (Q2Y2) also noted the dedication and commitment of all participants in the Assessment, which required completion of questionnaires, resource and data sharing, and participation in consultation meetings.

GoL rankings for several aspects of the system were higher than non-GoL respondents at baseline – for MoLSW policy, MoH policy, management and coordination capacity, data systems, and commitment/ willingness. This higher perception of system capacity from GoL respondents at baseline may be due to response bias, or possibly due to greater awareness among GoL respondents of the inner workings of the GoL system.

[41] USAID. "Local Systems: A Framework for Supporting Sustained Development." Washington, DC: USAID. 2014. https://www.usaid.gov/sites/default/files/documents/1870/LocalSystemsFramework.pdf

[42] See Annex E for protocols. Facilitators asked respondents: "I want to now ask you some questions about the current 'system' that defines, manages and supports rehabilitation and disability services in Lao PDR. I will ask you questions about different aspects of the 'system', and then ask you to rate your satisfaction level with each aspect of the system."

[43] Section 9 of the WHO STARS Report provides a baseline for rehabilitation in Lao PDR, divided into 7 domains and 54 components. The report compares the existing country situation in Lao PDR against the 54 components of the Rehabilitation Maturity Model. More details are available in the WHO STARS Report.



Key Policies

- 2018 Disability Law
- National Rehabilitation Strategy and Action Plan
- National Disability Strategy and Action Plan

In addition to the rankings, respondents in the 48 KIIs and FGDs conducted by the ET provided explanations regarding their perceptions of system capacity. Regarding the **policies** that serve as the foundation for USAID Okard, at baseline, the National Rehabilitation Strategy Paper was approved, but the MoH is drafting the National Action Plan. The National Disability Strategy and Action Plan is in the final stages of completion by MoLSW (National Committee for the Disabled and the Elderly (NCDE)) before endorsement by the GoL (as noted in the USAID Okard Quarterly Report forQ2Y2).[44] Additionally, the National Disability Law passed the National Assembly in 2018.

The KII and FGD respondents acknowledged that these strategies and action plans exist in draft form, though many were not aware of the content of the relatively new Rehabilitation Strategy. In 22 out of 48 interviews, respondents mentioned that the quality of policies or the implementation of policies was or will be a challenge in the future. These 22 interviews varied in their reason for concern. In general, individuals believed the quality of the written policies was low (not including all aspects that they should) and that the implementation would be difficult without adequate funding and monitoring. Similarly, the WHO STARS Report scored the National Rehabilitation Strategy and Action Plan (MoH) in the Rehabilitation Maturity Model as 'needs a lot of strengthening'.[45]

Additionally, KII respondents were concerned about the **funds** and other resources necessary to implement these policies. One provincial respondent explained: "This [the National Rehabilitation Strategy and Action Plan, and the Disability Strategy and Action Plan] is a new thing in our province. We think that implementation to succeed is still very challenging given a limited budget, limited personnel, infrastructure, and equipment limitations." Indeed, in 17 out of 48 interviews, respondents mentioned a concern about government funds for follow-through on these action plans and commitments to improve the lives of persons with disabilities.

While in nearly one-third of interviews (14/48 interviews), respondents expressed concern regarding the number and/or capacity of **personnel** at the national level (within the MoH and MoLSW) at baseline, slightly

[44] These plans and strategies are the guiding documents for how the Disability Law (December 2018) should be implemented in Lao PDR. More specifically: a) The National Rehabilitation Strategy and Action Plan was approved by the Minister of Health in October 2018. As of January 2019, this strategy is currently being printed but has not been disseminated yet to any MoH departments. In the USAID Okard Year 1 Report, the IP noted the following: *This achievement marks the foundation of the ownership for rehabilitation by Ministry of Health and paves the way for the effective implementation of the USAID Okard Health Component;* b) The Disability Strategy and Action Plan was put on hold by the National Center for Disabled and the Elderly (NCDE) as they prioritized the Disability Law. As of January 2019, no further revisions have been made to the strategy and action plan.

[45] Pg 37, Rehabilitation Maturity Model Scores and Details of the WHO STARS Report.

more than half (26/48 interviews) were concerned about personnel issues within health facilities in VTE and in the two demonstration model provinces. However, respondents were less concerned about personnel issues with TVETs (11/48 interviews). These data are further discussed below.

In one-third of interviews, respondents mentioned **medicines, assistive technology, and equipment** as limited or unavailable in Lao PDR health facilities (14/48 interviews). These data are supported by the WHO STARS Report that found that rehabilitation centers provide a limited number of assistive products; this is supplemented by private pharmacies in larger cities. The Assessment concludes that *until the Lao PDR government establishes policies for assistive products, they will likely remain inaccessible to the majority of the population*.

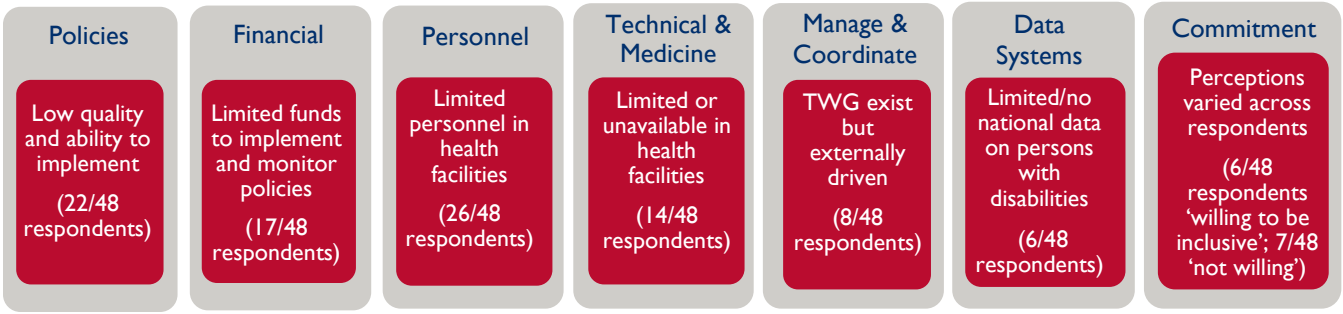
Regarding **management and coordination** within the ministries, between the ministries, and with other stakeholders [like Technical Working Groups (TWG)], respondents described the capacity as poor.[46] Respondents acknowledged the existence of several working groups and some information and data sharing amongst GoL ministries and between GoL and external stakeholders; however, these working groups are largely international non-governmental organization (INGO)/donor driven with the GoL taking a participant role. Furthermore, the WHO STARS Report documented a lack of a focal point for rehabilitation within the MoH, and a lack of coordination between MoH and MoLSW, both of which manage rehabilitation centers.

Moreover, respondents noted that **data systems** within ministries were poor, though GoL respondents reported a slightly higher level of satisfaction with this aspect of the system than did other baseline respondents. Non-GoL respondents explained that it is difficult to receive government data from the GoL, and requests must be formally made to the Laos Statistics Bureau. Even then, there is limited to no data available on persons with disabilities, their needs, and how or if they access services. Similarly, the WHO STARS Report found little evidence-based data on the rehabilitation services that may be needed in the country or the effectiveness of existing rehabilitation services in Lao PDR. The Assessment notes that this poses a challenge for planning, financing and overall decision-making. As the Assessment concludes: *Rehabilitation planning and decision-making is weakened when it is not driven by objective data*.

For **GoL commitment and willingness** to advance inclusion, though the rating above shows 'fair' or 'satisfactory' on average, respondents were varied in their views. A total of 6 out of 48 KIIs/FGDs noted that GoL was willing to be inclusive while close to the same number (7/48) noted that the GoL was unwilling to be inclusive. Those that noted the GoL was willing to be inclusive were from the following respondent groups: persons with disabilities, TVET, GoL, and other experts. Those that commented on unwillingness were from the following respondent groups: USG, IP, GoL, and other experts.

Figure 5 provides the frequency with which key system aspects were mentioned in SI qualitative data collection, as reported above.

Figure 5: System Perceptions of KII and FGD Respondents



[46] There are several TWGs that relate to disability and inclusion in Lao PDR. These include but are not limited to the following: Rehabilitation Task Force (and sub task forces) and the INGO Network.

USAID's **Journey to Self-Reliance** (J2SR) Fiscal Year 2020 Roadmap for Lao PDR offers additional data on the commitment and capacity of the country and the broader system. In J2SR, commitment is defined as "the degree to which a country's laws, policies, actions, and informal governance mechanisms – such as cultures and norms – support progress towards self-reliance."[47] The most relevant indicator of the seven indicators for commitment used in the Roadmap to USAID Okard is 'social group equality', which currently has a score of .4 (possible scores between 0 and 1).[48] Capacity is defined as "how far a country has come in its ability to manage its own development journey across the dimensions of political, social, and economic development, including the ability to work across sectors." The most relevant indicators of the 10 indicators for capacity matric to USAID Okard are 'government effectiveness' (.45), civil society and media effectiveness (.1), education quality (.39), child health (.73), and GDP per capita (.46).

Lastly, this section explores **persons with disabilities' engagement with the system – the GoL and their communities**. At baseline, persons with disabilities reported limited engagement with their communities and with the GoL. Of the nine FGDs that were conducted with persons with disabilities and caregivers (37 individuals) by the ET, only five individuals reported attending a community meeting or event in the last year. While some respondents reported awareness of government policies regarding inclusion and disability, only two respondents reported attending a policy dissemination event or interacting with government officials as a person with disability.

CBID qualitative interviews asked respondents about key community activities and events that, …*you and your family members participate in.* Preliminary results from this data indicate that persons with disabilities do not typically attend or participate in village meetings or events. Village level events mentioned by respondents were related to road maintenance, community cleaning, construction, agriculture, religion, and women's meetings. These data reveal findings related to local attitudes towards disability. While most respondents thought that persons with disabilities 'could' attend community meetings and events (one respondent noted, "*they are not banned"*), persons with disabilities commonly would not, or did not, attend such village meetings or events. Sometimes decisions to not attend community events were pragmatic. A person with difficulties with mobility may not attend an event because he/she cannot physically move there; a person with difficulties seeing may not attend an event that he/she would not be able to see. Other data indicate that persons with disabilities may not be invited and, if they are and they choose to attend, they do not contribute much. One person with disability noted that he had attended meetings, but, "*I did not catch everything that was said […] they do not understand me, so I don't contribute*."

The quantitative CBID survey also provided important information on participation of persons with and without disabilities in community and social events. Persons with disabilities participate less than persons without disabilities in some community events and social gatherings, and more so in others. For example, nearly two in five persons with disabilities never go to the market/shopping, compared to just under one in seven persons without disabilities, and half of all persons with disabilities never have social gatherings with friends, compared to about three in 10 persons without disabilities (n=648). However, 43 percent of persons with disabilities present opinions at community meetings (compared to 36 percent of persons without disabilities), and the two groups attend community festivals at the same rate (about one in five persons with or without disabilities have never attended a community event). Persons with disabilities (n=289) are also slightly more likely than persons without disabilities (n=359) to have presented their opinions to the village head personally (26% vs. 23%).

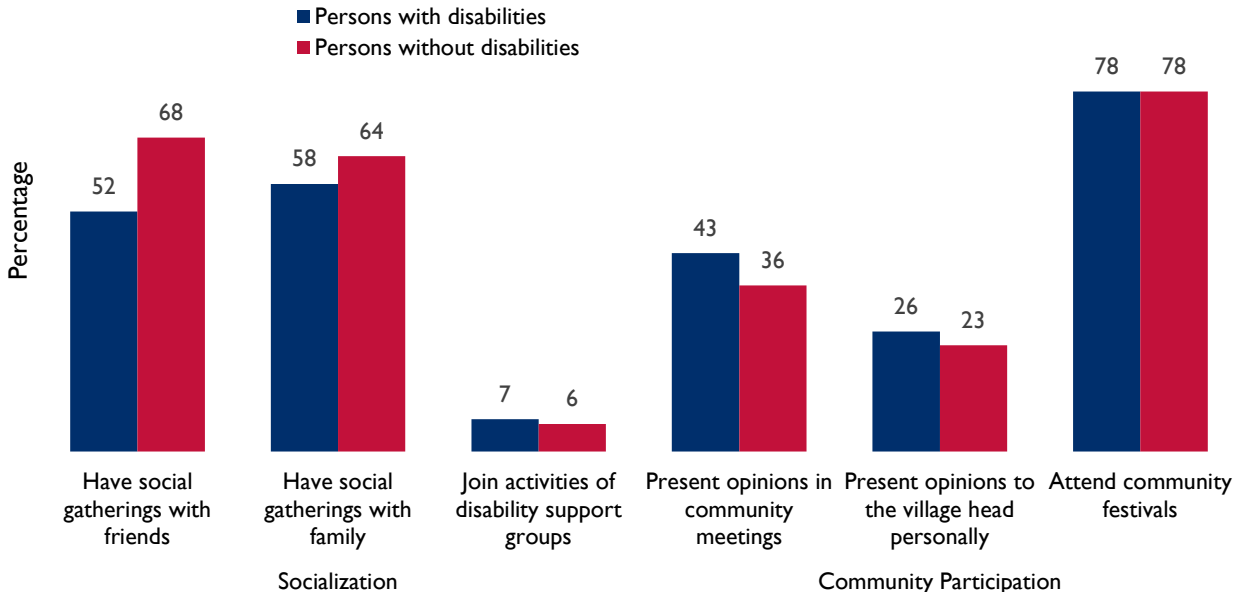
The ET grouped six of the above questions together into "socialization" and "community participation" indices. Analysis of the indices showed that 30 percent of persons with disabilities (n=289) never engage in social activities (e.g. gatherings with friends or family or joining activities of a disability support group)

[47] "Laos Journey to Self-Reliance: FY 2020 Country Roadmap," USAID, https://selfreliance.usaid.gov/country/laos.

[48] 'Social Group Equality' measures political equality with respect to civil liberties protections across social groups as defined by ethnicity, religion, caste, race, language, and region.
"V-Dem: Global Standards, Local Knowledge," Varieties of Democracy (V-Dem), https://www.v-dem.net/en/.

compared to 25 percent of persons without disabilities (n=359); for community participation, the two groups are nearly equal, with approximately one in six persons with or without a disability never participating in community events (e.g., attending festivals, or giving their opinions in community meetings or to the village head). The six individual questions that make up the socialization and community participation indices and their respective scores can be found in Figure 6. All CBID survey respondents were asked the reasons for not participating in various social or community events. Reasons cited the most by persons with or without disabilities, in order of most to least cited, were no services or facilities, lack of information about an event or gathering, the cost of a service or facility, and family did not want a respondent to access services.

Figure 6: Percentage of persons with (n=289) and without (n=359) disabilities who participated in social and community events at least once in the past three years



PARTICIPANT THEORIES OF CHANGE

The USAID Okard ToC was introduced in the Introduction section (see also Annex A). The ToC has several components including a problem statement, an approach (or way to address the problem), a goal, and assumptions. USAID Okard's approaches (or interventions) are organized in three components (health, economic empowerment, and stakeholder engagement) and at two tiers (Tier 1 = system; Tier 2 = people/individual). At baseline, respondents were asked their opinions regarding what the problem is, or what is keeping persons with disabilities from accessing health services and being economically self-sufficient (because these are the ultimate goals of the Activity – to increase economic empowerment and improve health). They were then asked the best way to solve this problem. The sections below present qualitative respondent views of the problem, pathways to change, the goal, and critical assumptions through KIIs and FGDs by the ET.

THE PROBLEM

Table 4 reports how intended participant groups – persons with disabilities and caregivers, health facility staff, TVET staff, private sector actors, and GoL and TWG members – viewed the problem and the best pathways to address these problems at baseline. Participant groups differ in how they understand the problem. Supply side actors (health and TVET staff, and GoL respondents) noted challenges related to funding, resources, materials, and infrastructure that keep persons with disabilities from accessing services. Private sector respondents, similar to supply side actors, also noted that infrastructure issues have kept them from hiring persons with disabilities. One private sector respondent in VTE explained: "*To be honest, the biggest challenge is the stairs. There is no lift in our office, and we do not have the budget to put in a lift. Hopefully*

in the future, we can change our building to make it more accessible." Persons with disabilities and caregivers, on the other hand, most frequently mentioned inability to pay for services; low society awareness, understanding, and perception of persons with disabilities; and inability to find and/or hold a job as key barriers. It is worth noting that the CBID Survey, as described above, reported relatively high rates of employment (89%), job satisfaction (80%), and ability to find work when needed (80%) among persons with disabilities although the survey did not capture employment retention. Regarding the ability to pay, one health professional provided additional insight: "*It's true that now we can use the national welfare's budget but in reality, we still need to charge a patient 15,000 kip every time they use our service*." This was due to operations at this particular health facility.

Each participant group, as shown in Table 4, understands the problem from their own vantage point, and this sheds additional light on how complex the problem is. While each group understands the problem in a way that most reflects their unique experience, it is important to note that at baseline, supply side actors do not articulate the problems facing persons with disabilities in the same way as persons with disabilities do. Additional findings on persons with disabilities' perspectives and status at baseline are also included in the section above (see 'Baseline Status: Persons with Disabilities').

PATHWAYS TO CHANGE

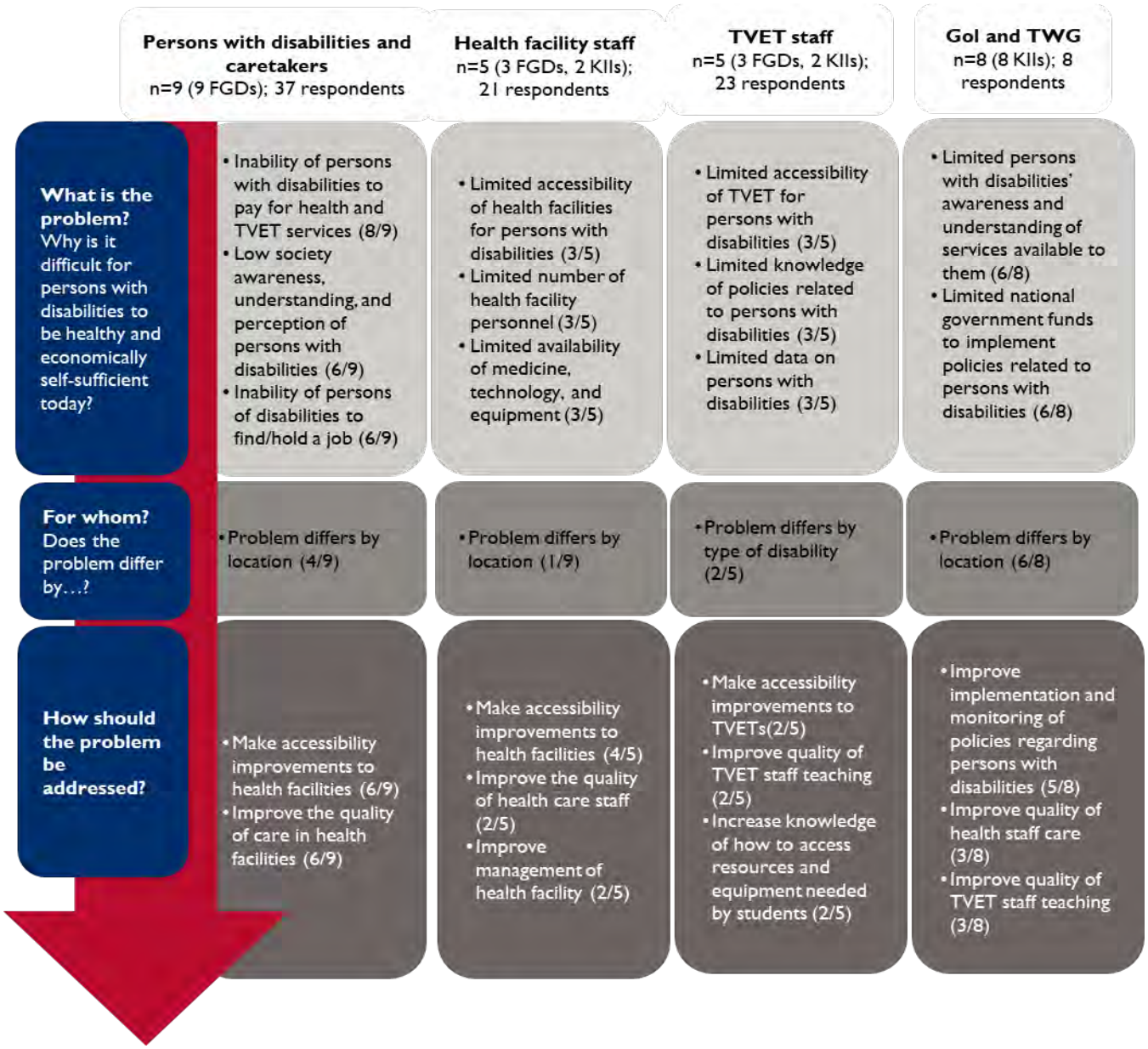
Table 4 also illustrates that although respondent groups differ in how they understand the problem, they are largely in agreement regarding what is most important to address the problem. Persons with disabilities and health/TVET staff all mentioned 'improvement in infrastructure' as necessary. All respondent types also noted 'improvement in quality' of health care or TVET teaching as important. Stakeholders agreed that improved quality care/services and improved infrastructure are critical to increasing access to services for persons with disabilities. USAID Okard health and economic empowerment components focus on improving the quality of care and teaching at health and TVET facilities respectively; this focus resonates with participants' viewpoints at baseline. Additionally, infrastructure challenges in homes (though not in facilities providing services) will be responded to in the recently approved incorporation of Reach, Enter, Circulate, and Use (RECU) into the CBID Demonstration Model. Additional pathways to change mentioned by respondents are reported in Table 4.[49]

> "*Yes [improving the quality of TVET training is important], but first we should check the* ***conditions of the employers****. Upon graduation, there should be a job position for people with disability [so that he/she can] work.*"
>
> (woman with disability, SVK)

Importantly, however, baseline respondents highlighted one issue that may impact the intended pathways change in the Economic Empowerment component. Access to technical and vocational is not a primary concern for persons with disabilities at baseline. Persons with disabilities did not mention lack of technical and vocational training as a root problem keeping them from economic self-sufficiency, nor did they note skills or increased access to TVET educational opportunities as critical to becoming economically self-sufficient. This is also reflected in the CBID quantitative data.[50] Respondents explained that the problem was instead access to capital and willingness of employers to hire persons with disabilities (mentioned in 8/9 FGDs, see quote in text box to the left). Respondents wanted to seek additional training, *but only if* the training was linked to suitable and available jobs with employers who are willing to hire and accommodate persons with disabilities.

[49] The RECU Principle states that *persons with disabilities should be able to Reach, Enter, Circulate, and Use* all facilities and services.
[50] CBID data confirms that rates of vocational training among persons with disabilities and without disabilities are close (14.5% vs. 16%, respectively). The sample size was too small to adequately analyze the question around ability to get TVET/vocational training when needed (disaggregated by persons with or without disabilities), because only 39 individuals (10 persons with disabilities and 29 persons without disabilities) said they needed vocational training in the past 3 months.

Table 4: Baseline Participant Theories of Change



Respondents also noted that entrance into technical/vocational institutions is for those who have completed Grades 11 or 12. This leaves out many persons with disabilities, particularly in rural areas and those living far from TVETs. Additionally, according to the 2017 Lao Bureau of Statistics Survey, seven percent of heads of household completed upper secondary school (Grades 11 and 12).[51] The CBID quantitative data reported above found that 10 percent of persons with disabilities completed junior secondary school compared to 22 percent of persons without disabilities.

Related to 'how the disabling environment differs' (or **variation**) at baseline (see Table 4), almost all respondent types identified 'by location'. It was widely noted that persons with disabilities face different

[51] Lao Statistics Bureau. 2018. Lao Annex J Survey II 2017, Survey Findings Report. Vientiane, Lao PDR: Lao Statistics Bureau and UNICEF.

challenges in accessing services depending on where they are in the country. While this does not mean that other gaps or inequities do not exist in these communities (they in fact do – see Sub-EQ D), SI qualitative respondents spontaneously commented on the role that location (urban vs rural) plays in whether or not persons with disabilities can access services and resources at baseline. Two out of five KIIs/FGDs involving TVET staff noted that variation in the problem exists based on the type of difficulties in functioning an individual has. For TVETs, staff explained that those individuals that have difficulties with mobility were able to access TVET services easier than individuals with other types of difficulties in functioning.

Though much time in FGDs and interviews was spent discussing what is not working and what prevents persons with disabilities from accessing various services, some respondents described **enabling conditions** that exist in their communities. For example, respondents from 11 of 48 KIIs/FGDs conducted by the ET believed that society was accepting of persons with disabilities, and aware of their needs (3 of the 11 were persons with disabilities' FGDs). Also, in 11 of 48 KIIs/FGDs, respondents expressed feeling optimistic because of recent policies regarding inclusion. A GoL respondent stated: "*Our country is ready to support persons with disabilities because we have a number of policies and a health program. We have our development partners and health working groups which have some capacity to support persons with disabilities.*" On a similarly optimistic note, a person with disability from VTE noted: "*I think the government understands and sees the importance of persons with disabilities...Now that the government places more importance on persons with disabilities, there are more associations applying for registration*." While the problem is complex, baseline data indicate that current enabling environment conditions exist for USAID Okard to make progress.

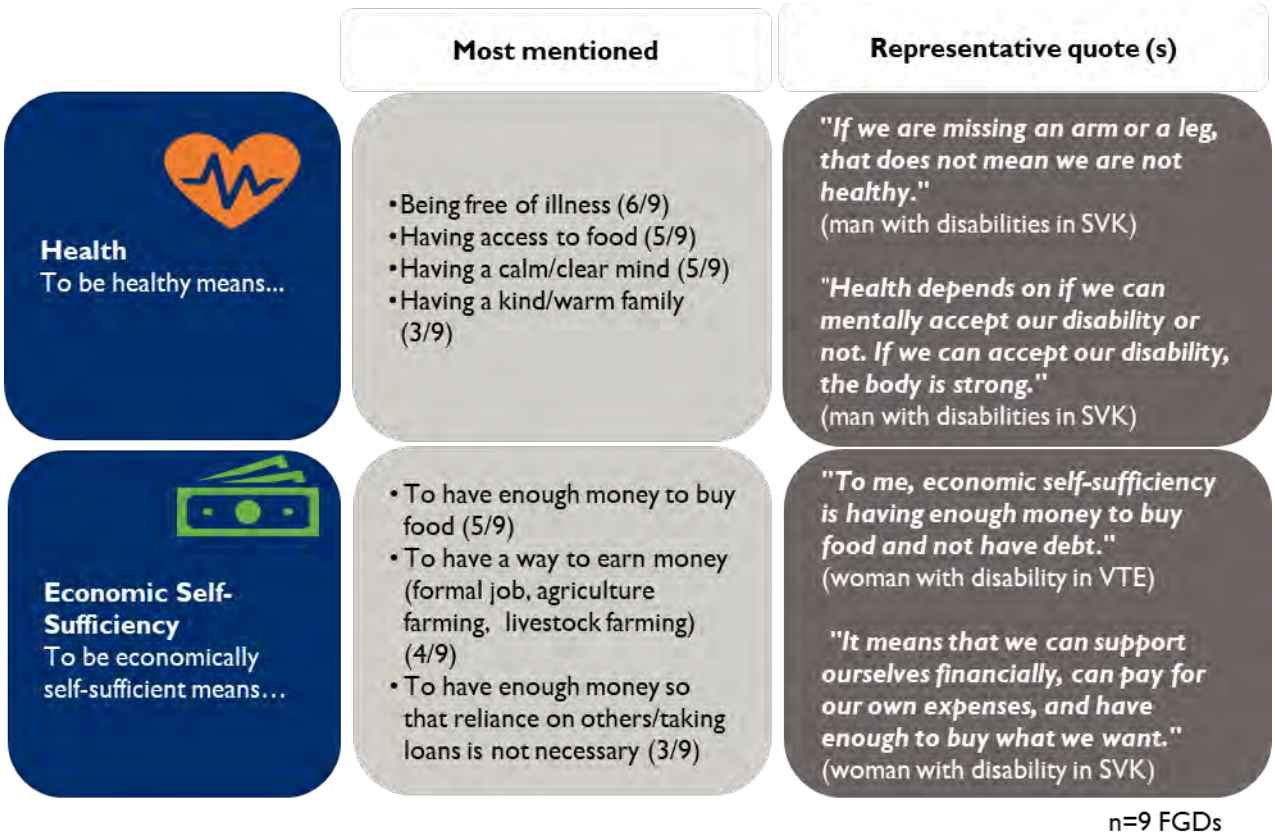
THE GOAL

USAID Okard's goal is '*the independence and wellbeing of persons with disabilities and their households in Lao PDR will continue to improve and be sustained over the long term*.' This goal is measured by two indicators: a change in the number of persons with disabilities and their households with a) improved 'function and wellbeing'; and b) improved 'economic self-sufficiency'. When asked about what health and economic self-sufficiency meant to them at baseline, persons with disabilities and caregivers noted the following (see Table 5).

Persons with disabilities at baseline identified as 'healthy'. This means that when persons with disabilities were asked what it means to be healthy, they first noted that they were healthy (not unhealthy), and then went on to define what 'healthy' meant to them. To these groups of persons with disabilities, health meant being free of illness, having access to food, having a clear or calm mind, and having a loving family. This reveals an awareness among persons with disabilities at baseline of the role of mental health and family/community in overall wellbeing, and also a holistic view of health.

Persons with disabilities described economic self-sufficiency primarily in relation to having sufficient funds to a) purchase food staples and b) have financial independence. 'Financial independence' was important to respondents in 3/9 FGDs while having enough money for food was important to respondents in 5/9 FGDs. The most commonly mentioned pathway to becoming more economically self-sufficient by persons with disabilities at baseline was access to capital and employment. Respondents did not mention 'having savings' in their definitions of economic self-sufficiency.

Table 5: Persons with Disabilities' Definitions of 'Health' and 'Economic Self-Sufficiency (n=9 FGDs)



ASSUMPTIONS

According to the AMELP, the USAID Okard ToC has several **logical assumptions** behind it (though these are not noted as formal "assumptions" – see finding below). It explains that there are *three mutually reinforcing and interconnected components – Health, Economic Empowerment, and Stakeholder Engagement* and that the Activity has *a cross cutting intervention called CBID Demonstration Model.* There is some explanation provided in the AMELP about how these assumptions play out within the RF, however, they are not well defined within the ToC itself. In particular regarding the latter assumption about the CBID Model, the blue arrows in the ToC (see Annex A) generally depict how the model will '*catalyze and test'* national level plans and strategies, but when the ET asked Activity staff to define more specifically how these feedback loops would occur, they noted *"through regular discussions and interactions with the GoL as sub-partners*." No specific activities or processes, therefore, are planned to ensure this part of the ToC occurs.

USAID Okard's ToC also has two **stated assumptions** (see gray textbox). The second assumption is helpful (albeit broad), but the first assumption is written as an output or outcome instead of a condition that – if not met – the Activity would not proceed as envisioned in the ToC. As a USAID/USG respondent expressed, "*the assumptions – stated and unstated – are big, and if they are not met, the Activity will not work*."

Stated Assumptions

1) All government and non-government stakeholders have a better understanding about the reality and experience of being a person with disability in terms of difficulty of functioning, being included in their own communities, and having their voice heard; and,

2) Service providers, families and persons with disabilities work together to complement each other in their roles in health, education, business, and in public and private central, provincial and district institutions.

Additionally, based on SI qualitative data, there are several other important assumptions that are not stated explicitly in the USAID Okard Activity documents. Respondents flagged the following assumptions as important to USAID Okard success:

- The passage and provision of funding for implementation of the National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action Plan.
- The availability and quality of DPOs and sub-partners (including GoL), as main implementers of complex interventions. Quarterly Reports have already noted challenges with identifying and preparing DPOs for USAID Okard grants, and finalizing relationships with GoL and with sub-partner offices – NCDE (MoLSW), and the Center for Medical Rehabilitation and the Department of Healthcare and Rehabilitation (DH&R) (MOH).
- The willingness of communities, families, and individual persons with disabilities to work with trained CBID facilitators.
- Stakeholders believing persons with disabilities are part of human diversity and an important part of society. This is a critical assumption for both Tier 1 and Tier 2 in the ToC.

Notably, these unstated assumptions mirror the learning questions in the AMELP Section 2 (see Annex I). There is, therefore, recognition by the Activity of these issues as critical. However, the Activity has not yet defined how to monitor the context, environment, and assumptions that inform implementation and management decisions. The AMELP states that ToC assumptions *will be tracked to ensure that these contextual factors remain stable and do not negatively impact the achievements of the USAID Okard Activity.* However, as of the February 2019 AMELP, the context monitoring table was not yet developed. Given the many conditions necessary for the ToC to be demonstrated at the end of the intervention, monitoring of programmatic and contextual assumptions is critical.

SUB-EQ A: CONCLUSIONS

The baseline status of intended participant groups – persons with disabilities and system actors – adds depth and increased nuance to the USAID Okard problem statement and the goal.

- Persons with disabilities at baseline report a relatively high level of access to and satisfaction with health services (note that this makes no statement about satisfaction with rehabilitative services), though one in seven cannot access health services as much as needed and seven in 10 do not use any assistive devices. At baseline, persons with disabilities have much lower level of education than persons without disabilities, and one in five struggles to find work. Economic-related outcomes at baseline for persons with disabilities are weak, with two-thirds of working-aged persons earning an income from their work and one in seven with any vocational training. At baseline, persons with disabilities are much more likely to feel depress compared to persons without disabilities, with one in three feeling down or depressed several days in the past two weeks, and one in seven feeling down or depressed nearly every day. Finally, though three in 10 persons with disabilities never engage in social gatherings, persons with disabilities participate in community events at the same rate as persons without disabilities, with nearly five in six doing so at least once in the past three years.
- Persons with disabilities have a holistic view of 'health' and do not self-identify as 'unhealthy' because they have a disability. Their views of economic self-sufficiency are straightforward and include a desire for financial independence and sufficient funds to buy food.
- At baseline, the system has low capacity to effectively operate. This is found across the investigated components – from policy framework to resources. The capacity of the system, both in general and regarding rehabilitation specifically, is low. These baseline details (and specifically Section 9 of the WHO STARS Report) provide reference points for the Activity.

This baseline status serves to inform and ground sub-partner activities and interventions as they launch this year, ensuring they are keenly aware of those they are working with and supporting, and the barriers these individuals face, their lived experience, and the perceptions they hold of themselves and their environment.

If-Then Statement

If the USAID Okard Activity interventions are implemented (and assumptions hold), "*the goal will be achieved more effectively and efficiently than if the systems or person-centered approaches were implemented alone at only one level*" [underline added for emphasis].

The baseline status of the system offers, on the one hand, a positive enabling environment in which champions can be identified and buy-in can be garnered and maintained, and on the other hand, a low capacity environment in which inefficiencies exist. Indications of GoL commitment and willingness show a positive enabling environment for the Activity to launch its work in the Stakeholder Engagement Component; ideally champions can be identified early on and buy-in can be maintained throughout the duration of the interventions. Simultaneously, however, the low capacity of all other aspects of the system pose an early and most likely consistent threat to work in Tier 1, and, specifically, to the likelihood that Tier 1 will promote more *efficient* progress than working at the individual level alone (Tier 2). The USAID Okard intervention will roll out in a system that is still finalizing several strategies and plans related to inclusion; has limited budget, materials, personnel, and technology; and faces challenges with internal and external communication, information/data sharing, and decision-making. Though it is unlikely that working at two levels (Tier 1 and 2) will result in achieving results *more efficiently* than at only one level given the baseline status of the system, the endline PE should explore the extent to which working at both the systems and person level more *effectively* achieved results.

Intended Activity participants reframed 'pathways to change' inherent in the Economic Empowerment Component. USAID Okard's intervention related to improving access to technical and vocational training as one of several approaches to increasing economic self-sufficiency (within the Economic Empowerment component) did not resonate with all persons with disabilities. Their concerns centered on securing employment, accessing capital, and paying for services. While the quality of technical and vocational training at institutions is clearly important, and increased access to these institutions through scholarships helpful, respondents more frequently made reference to a) challenges with job identification related to their training, and b) accessing capital to start a small business/IGA rather than access to TVETs. Furthermore, technical schools are unattainable for the majority of the population, and even more so for persons with disabilities. While USAID Okard provides TVET scholarships/opportunities for persons with disabilities, it is important to note that this intervention will only serve those who have already achieved a high level of education and will not provide opportunities for the most vulnerable. While this conclusion does not necessarily warrant changes to the interventions in this component, they are important to consider as the Activity identifies learning questions and sets targets for how much these interventions can achieve and/or contribute to improved outcomes for persons with disabilities.

The ToC does not adequately describe under what conditions (assumptions) the ToC is expected to hold/be demonstrated. The ToC will be put in jeopardy if the assumptions – stated and unstated – do not hold. There are well-targeted 'learning' questions in the AMELP that include monitoring/ checking enabling environment conditions, and there are two general assumptions, but more specificity is necessary in the ToC to ensure that it adequately describes under what conditions the ToC is expected to achieve targeted results. If these conditions are not stated as important assumptions, they may not be paired with context monitoring indicators/approaches.

MANAGEMENT & IMPLEMENTATION

SUB-EQ C: MANAGEMENT AND IMPLEMENTATION FINDINGS

At baseline, the ET explored the management structure, measurement plans, and implementation approach of USAID Okard. This provides a baseline for answering sub-EQ C at endline and identifies potential risks to successful implementation.

Partnership with the GoL was formally established in a **Memorandum of Understanding** (MOU) 14 months after the agreement was awarded by USAID. In the most recent Quarterly

Report, Q2Y2, USAID Okard explains the reasons for this timing, including a misunderstanding regarding the type of in-kind support NCDE would receive. After many meetings and seven versions of the MOU, it was signed by the Minister of Labor and Social Welfare on March 11, 2019 and moved to the Ministry of Foreign Affairs for final validation. The signing ceremony was conducted on May 16, 2019.

The USAID Okard Activity has multiple **funding sources/channels.** While it is not uncommon to have multiple funding sources for an Activity, one USAID/USG respondent expressed concern that the Activity was already being pulled in many directions, for each has different requirements." The Activity has adjusted indicators and reporting to ensure that all requirements are met. Some respondents noted that coordination between funding source representatives was going well since the Activity launch, despite the large number of stakeholders.

In terms of **management and implementation**, WEI is the primary IP, working in collaboration with HI. Both organizations manage sub-partners. At baseline, WEI plans to manage HI, MoH, CMR, the Cooperative Orthotic and Prosthetic Enterprise (COPE), and Quality of Life Association (QLA); and HI plans to manage NCDE, Lao Disabled People's Association (LDPA) VTE, Association for Rural Mobilization and Improvement (ARMI), and the DMAS sub-partners. Both manage a grant for the CBID Demonstration Model (WEI manages QLA and HI manages ARMI) and both have MEL coordinators. At baseline, it was unclear if both implementers will use the same or different approaches to CBID model management and implementation (through QLA and ARMI). WEI's team, as of April 2019, is detailed in an organogram.[52] HI, as of February 2019, had three staff members at 100 percent and five others at between 40–86 percent level of effort.

There are four committees that USAID Okard Activity implementers use to manage the Activity: the USAID Okard Executive Committee (EC); the USAID Okard Technical Management Committee (TMC); the USAID Okard Implementation Management Committee (IMC); and the USAID Okard Advisory Committee (AC).[53] Additionally, there are eight **sub-grants** planned, and as of March 2019, three were issued. The other five are in process. At the time of writing, the following grants are issued: QLA,[54] ARMI,[55] and LDPA.[56] The five in process at the time of writing are NCDE, DMAS sub-partner, COPE, CMR, and MOH – DH&R.

At baseline, management of the Activity and coordination with all Activity stakeholders was on the minds of respondents; it was brought up by respondents in over half of the interviews with IP and USAID/USG staff (7/13). Several respondents noted the importance of IP and stakeholder unity (and WEI leadership) to the ultimate impact and sustainability of the Activity. One respondent noted: "*Redundancies already exist. We need clear delegation of work to ensure sustainability*." Additionally, there is already evidence of capacity challenges with sub-partners as noted in the Quarterly Report Q2Y2. For example, related to governance, sub-partners do not have clear separation of powers between their Board of Directors and executives. Furthermore, the lengthy MOU process and negotiations surrounding NCDE's grant reveal some early misunderstandings and miscommunications.

Regarding **measurement and evaluation** of the Activity, the ToC and RF were defined in the Introduction section above. The Activity's AMELP, together with a Performance Indicator Reference Sheet (PIRS), was finalized in February 2019. Based on document review and SI qualitative respondents, at baseline, there is a lack of clarity regarding how the following contribute to the ToC *or* are measured:

- The **SBCC** was being designed at baseline (therefore the ET is not able to provide additional information here about the approach) but is not indicated in the ToC or in specific indicators. The first stated assumption references understanding, but the SBCC is not included in the TOC as an intervention that is expected to *cause change* among intended participants. Societal awareness and

[52] See Activity document titled 'USAID Okard team April 2019'.
[53] See Activity document titled 'USAID Okard Committees and meetings overview FINAL' for more details.
[54] Approved April 5, 2019.
[55] Approved April 24, 2019.
[56] Approved April 24, 2019.

understanding of persons with difficulties in functioning is a commonly mentioned disabling environment factor by respondents at baseline (see Table 5). Without change in perceptions, knowledge, and understanding of, at minimum, intended participants and their communities, USAID Okard interventions may not achieve their intended results. This is, therefore, an important intervention to not only design, but to measure and track through specific indicators and context monitoring.

- The **DMAS** is an intervention under the Economic Empowerment Component. At baseline, proposals were being collected for this intervention. There is no mention, however, of this intervention in the AMELP or in the ToC, and related indicators are absent.
- The **If-Then Statement** is written in a way that requires a counterfactual.[57] The Activity (and therefore the evaluation) were not set up to be able to validate (at baseline)/provide evidence to demonstrate (at endline) this statement, however.

Additionally, regarding measurement and evaluation, one of the key points for learning that will take place in Year 3 is the **Midterm Redesign Workshop** and shift from Phase I into Phase II. According to the AMELP Section 3.5, this will include a review of progress made in Phase I using *the results from a possible Mid-term External Evaluation (dependent on funding availability from USAID) and ongoing data and analysis extracted from the CBID modular tool*. Considering no additional details were provided in the AMELP regarding indications that *approaches are working* (and not working) by Year 3, the ET discussed this with baseline respondents. At baseline, IP staff explained that they will be looking for '*momentum*' in the CBID Demonstration Model at the community level and with the NCDE and MoH partnership. The status of these two items were flagged as having an impact on how the Activity will move forward into its final years. Beyond this, IP staff could not explain the data that will influence Year 3 decisions – for instance, whether to remain working in XHK and SVK or enter new provinces, Huaphan and Khammuan; or the level of progress they expect to see by Year 3 that would influence this decision.

SUB-EQ C: MANAGEMENT AND IMPLEMENTATION CONCLUSIONS

USAID Okard's careful management and implementation planning is evident at baseline. USAID Okard had time to set up detailed procedures and processes to promote effective and efficient management of the Activity while obtaining the MOU signing. At baseline, this careful planning was evident – there are established management committees; communication procedures are already being followed by different actors within the management structure; and IPs have been able to contract and onboard sub-partners efficiently following the MOU signing as planned. These processes and documents will most likely contribute to Activity success, and this can be explored at endline.

While the Activity has set up processes and structures that promote information sharing, there are risks to the Activity's ability to collectively learn and flexibly adapt throughout the POP. At baseline, respondents noted that multiple stakeholders and layers of management are a risk, particularly if roles and responsibilities are not made clear and an intentional culture of learning is not created across all actors, including GoL actors. Another risk identified at baseline was a lack of planning for Year 3 decision making, and in particular, in identifying what "success" of the interventions will look like by Year 3.

There are interventions that are not clearly articulated, tracked, or measured. The Activity ToC and RF do well to explain how the progress of most interventions will be tracked; however, these documents are not clear regarding measurement of the SBCC or DMAS interventions and these interventions' intended contributions to the overall goal. Furthermore, a core part of the ToC – the If-Then Statement – is not measurable in its current wording.

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[57] Statement reads as follows, and portion of the conditional phrase requiring a counterfactual is underlined: ***If*** *USAID OKARD implements activities in each of the three components at both the systems and community level,* ***then*** *the activity goal will be achieved more effectively and efficiently than if the systems or the person-centered approaches were implemented alone at only one level.*

VARIATION

SUB-EQ D: VARYING BASELINE STATUS FINDINGS

USAID Okard intends to improve and sustain the independent living and functional ability of persons with disabilities, *regardless of factors such as age, sex, gender expression, ethnicity,* and their households in Lao PDR.[58] The Activity has taken intentional steps to ensure that gaps among persons with and without disabilities related to sex, age, disability type, ethnic group, geography, etc. are considered in Activity implementation (via the GIDAP).[59] The findings presented here provide additional nuance to the GIDAP – in particular, Section 2.[60] The ET analyzed CBID quantitative data for the status of persons with and without disabilities disaggregated by sex, ethnicity, location, age, and type of difficulties in functioning.

SEX

> *"Disabled males get more chances to find jobs compared to disabled females because males are stronger, and females' families are usually worried about them and their safety."*
>
> (woman with disability, VTE)

Men and women with and without disabilities differed in a few key areas at baseline. Women with disabilities were half as likely to have health insurance[61] compared to men with disabilities (12% vs. 25%). Men with disabilities were also nearly twice as likely to have health insurance compared to men without disabilities (25% vs. 13%). This trend on having health insurance, however, was reversed for women (12% of women with disabilities vs. 18% of women with disabilities). Men with disabilities were substantially more likely to access any health facility when they were last sick compared to women with disabilities (90% vs. 64%). Similar to findings on health insurance, men with disabilities were more likely to have accessed a health facility when last sick compared to men without disabilities (90% vs. 69%), but the trend was reversed again for women (64% of women with disabilities vs. 82% of women without disabilities). At baseline, all persons sampled, regardless of type of difficulties in functioning and sex, noted generally high levels of access to and satisfaction with health services. At baseline, men with disabilities were substantially more likely than women with disabilities to use an assistive product (42% vs. 18%), a trend which was also mirrored among persons without disabilities (15% vs. 4%).

When it came to outcomes on work, employment, and income, sampled respondents had similar baseline levels of current working status, regardless of sex and type of difficulties in functioning. However, women with disabilities were more likely than both men with disabilities and women without disabilities to earn an income from their work (71% vs. 65% and 62%, respectively). Women with disabilities were also much less likely to have needed to work in the past three months compared to men with disabilities (62% vs. 76%), but less likely than both men with disabilities and women without disabilities to be able to access work when

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[58] World Education, Inc. "USAID Okard AMELP." Vientiane: World Education, Inc., 2019.

[59] The following data sources were utilized to determine the barriers and issues experienced by persons with disabilities, and how/to what extent these differ by age, sex, ethnicity, and other relevant factors: USAID Lao PDR Gender Analysis on Disability (Social Impact Inc. March 2018) and USAID Okard Technical Team Gender and Inclusion analysis of barriers (December 2018).

[60] Section 2 is titled "Gender and Inclusive Development Analysis Mitigation Plan". It includes a list of findings related to variation in barriers/issues by key disaggregates, followed by mitigation actions for ensuring these gaps are not widened during USAID Okard. The section also includes 'methods for verification' of mitigation action progress.

[61] The GoL introduced a tax-based National Health Insurance scheme (NHI) in 2016. NHI means that all Lao citizens can access treatment at public health facilities in 17 provinces, for very small out-of-pocket payments. Poor households identified by their village chiefs, pregnant women, children under five, and monks are exempted from these co-payments. In July 2019, Ministry took another step towards pooling funds and risks, with the merger of the formal- employment sector schemes into the NHI. This means that the NHI now covers people in formal employment (civil servants and private sector employees who previously came under the National Social Security Fund) and Lao people who either do not work, are self-employed or work in the informal economy. See the following article for a randomized analysis of participation in health financing schemes in Lao PDR: Sydavong T, Goto D, Kawata K, Kaneko S, Ichihashi M (2019) Potential demand for voluntary community-based health insurance improvement in rural Lao People's Democratic Republic: A randomized conjoint experiment. PLoS ONE 14(1): e0210355. https://doi.org/10.1371/journal.pone.0210355.

needed (76% vs. 87% and 92%, respectively). Men and women with disabilities were equally satisfied with their current working status. On vocational training, men with disabilities were more likely to have received any vocational training compared to both women with disabilities and men without disabilities (24% vs. 10% and 19%, respectively).

The discrepancy in highest education level attained between and among men and women with and without disabilities was very large at baseline. Women with disabilities were less likely than men with disabilities to have completed schooling (23% completed primary or higher vs. 41%) and even less likely to have done so when compared to women without disabilities (23% vs. 54%). Similarly, men with disabilities were less likely to have completed schooling compared to men without disabilities and women without disabilities (41% vs. 68% and 54%, respectively). With respect to wellbeing, women with disabilities were at a lower risk of depression compared to men with disabilities (31% vs. 44%). The discrepancy between men with disabilities and men without disabilities with respect to risk of depression was large at baseline (44% vs. 10%), and somewhat smaller between women with and without disabilities (31% vs. 20%). With respect to social engagements and community participation, women with disabilities were substantially less likely to have engaged in any social gathering (i.e. meeting with friends or family) in the past three years compared to men with disabilities, women without disabilities, and men without disabilities (64% vs. 78%, 76%, and 78%, respectively). On the other hand, women with disabilities were slightly more likely to have participated in a community event (attended a community festival; village meeting) in the past three years compared to men with disabilities (84% vs. 82%), equally likely as women without disabilities (84% vs. 84%), and substantially more likely than men without disabilities (84% vs. 78%). For more information on disaggregation by sex, please see Table 6.

These findings add to the data the GIDAP presents, namely that women are more vulnerable than men in literacy rates, access to education, access TVET, access to health providers, vulnerability to gender-based violence, and more vulnerable than men in terms of the power they have to make decisions (for example, related to employment).

ETHNICITY

To facilitate analysis by ethnicity and taking into account relatively small sample sizes across the six ethnicities[62] of respondents in the CBID survey, the ET grouped all respondents into two categories: Lao and non-Lao ethnicity.[63] Seventy-three percent of the sample was Lao ethnicity; with weights applied, this increased to 76 percent. With respect to outcomes on access to and satisfaction with health services, non-Lao persons with disabilities had health insurance at rates twice that of Lao persons with disabilities (27% vs. 14%) and more so than non-Lao persons without disabilities (27% vs. 21%). This trend was repeated when it came to accessing a health facility if sick in the past 12 months: 91 percent of non-Lao persons with disabilities accessed a pharmacy, private, or public facility compared to 67 percent of Lao persons with disabilities—a rate which was also substantially higher than Lao or non-Lao persons without disabilities (91% vs. 79% and 70%, respectively). Non-Lao persons with disabilities were also ten percentage points more likely to be able to access health care as much as needed compared to Lao persons with disabilities (94% vs. 84%), and more likely to use an assistive product (34% vs. 26%).

[62] The CBID sample had the following pre-weighting breakdown of ethnicities: Lao (73%, n=473), Khmou (15%, n=96), Tai (5%, n=33), Phong (4%, n=25), H'mong (2%, n=10), Phouthay (1%, n=6).

[63] At baseline, 95 percent of the non-Lao ethnic groups sampled were in Kham District, compared to 35 percent of ethnic Lao respondents. After weighting, this proportion was even lower for ethnically Lao respondents in Kham (30 percent). Considering the fact that respondents in Kham District have substantially better outcomes compared to those in Xayphouthong, the results in the section on ethnicity show that non-Lao groups in the CBID sample have generally much better outcomes compared to ethnically Lao respondents, a fact which is generally counterintuitive to the narrative in Lao PDR. Given this geographic imbalance in the sample between ethnicities, the ET suggests that results should be interpreted cautiously.

Table 6: Breakdown of health, work, education, wellbeing, and community participation outcomes, by key disaggregates

Outcome	Type of respondent	Sex (%)		Ethnicity (%)		District (%)		Age group (%)			
		Male	Female	Lao	Non-Lao	Kham	Xayph.	5-15	16-44	45-64	65+
Has health insurance	With disabilities	25	12	14	27	27	9	6	16	15	27
	Without disabilities	13	18	15	21	19	14	16	15	14	39
Accessed a health facility when last sick	With disabilities	90	64	67	91	93	60	48	41	83	90
	Without disabilities	70	82	79	70	84	70	84	60	89	87
Able to access healthcare as much as needed	With disabilities	89	86	84	94	91	81	92	71	97	80
	Without disabilities	91	91	89	100	97	84	90	94	95	53
Satisfied with health services	With disabilities	95	92	92	95	94	93	99	90	91	96
	Without disabilities	94	96	95	96	95	95	96	96	100	80
Uses an assistive product	With disabilities	42	18	27	34	30	27	1	13	31	43
	Without disabilities	15	4	10	6	4	13	9	1	32	30
Currently working	With disabilities	88	90	88	91	91	87	4	93	87	59
	Without disabilities	88	90	91	83	84	93	5	88	96	83
Earns income from current work	With disabilities	65	71	71	64	62	84	1	67	70	56
	Without disabilities	61	62	67	43	48	75	1	61	69	57
Has needed to work in the past 3 months	With disabilities	76	62	60	81	77	53	2	73	64	36
	Without disabilities	81	77	79	79	79	79	25	76	81	41
Able to work as much as needed	With disabilities	87	76	80	81	81	78	76	81	80	44
	Without disabilities	82	92	85	98	97	80	76	88	85	99
Satisfied with current working status	With disabilities	80	81	78	86	86	73	77	90	76	83
	Without disabilities	93	93	92	95	90	95	98	94	91	92
Has received vocational training	With disabilities	24	10	13	23	26	6	0	12	25	15
	Without disabilities	19	11	15	13	16	13	0	17	25	18
Education attained (at least primary completed)	With disabilities	41	22	29	36	39	23	14	30	44	25
	Without disabilities	68	54	61	57	62	59	40	76	63	12
At risk of depression	With disabilities	44	31	30	53	39	34	34	26	43	37
	Without disabilities	10	20	16	15	15	17	8	13	26	40
Socialization	With disabilities	78	64	68	77	78	63	60	76	79	63
	Without disabilities	78	76	79	68	72	81	69	75	88	79
Community participation	With disabilities	82	84	83	83	83	83	72	84	91	79
	Without disabilities	78	84	87	62	70	90	67	82	96	83

Note: shaded cells in grey were not factored into analysis since respondents aged 5-15 and 65+ were not expected to contribute to work-related outcomes.

When it came to outcomes around work, employment, and vocation, Lao persons with disabilities were more likely to be working compared to both non-Lao persons with disabilities and Lao persons without disabilities (91% vs. 88% and 83%, respectively). Lao persons with disabilities were more likely than any of their counterparts to be earning an income from their work (71% vs. 64% of non-Lao persons with disabilities and 67% of Lao persons without disabilities), but non-Lao persons with disabilities were 1.5 times more likely to be making income from their work compared to non-Lao persons without disabilities (64% vs. 43%). In the past three months, non-Lao persons with disabilities needed to work at a higher rate than Lao persons with disabilities (81% vs. 60%); non-Lao persons with disabilities also saw the largest discrepancy compared to non-Lao persons without disabilities when it came to being able to find work when needed (81% vs. 97%). In general, non-Lao persons with disabilities were more satisfied with their current working status compared to Lao persons with disabilities (86% vs. 78%) and were nearly twice as likely to have had any vocational training (23% vs. 13%).

Lao and non-Lao persons without disabilities had substantially higher levels of education attained compared to Lao and non-Lao persons with disabilities (61% of Lao persons without disabilities had completed primary or higher vs. 39%; 57% vs. 36% for non-Lao). With respect to wellbeing, non-Lao persons with disabilities had substantially higher risk of depression compared to their Lao counterparts (53% vs. 30%); this discrepancy was even larger between non-Lao persons with disabilities and non-Lao persons without disabilities (53% vs. 15%). With respect to community participation, persons with disabilities of Lao ethnicity engaged in social gatherings at a much lower rate than non-Lao persons with disabilities (68% vs. 77% had engaged in at least one social gathering in the past 3 years), though this rate was equivalent to that of non-Lao persons without disabilities (68% vs. 68%). Persons with disabilities, regardless of ethnicity, participated in community events at about the same rate (1 in 6 persons with disabilities, Lao or non-Lao, never participated in a community event in the past three years). This was substantially higher than non-Lao persons without disabilities (62% had participated in a community event), but slightly lower than Lao persons without disabilities (87%). For more information on disaggregation by ethnicity, please see Table 6.

These findings add to the data the GIDAP presents, namely that persons with disabilities in non-Lao groups are more vulnerable than others in terms of literacy rates, access to education, access to TVET, and experience of discrimination when accessing health services.

LOCATION (DISTRICT)

> *"In our standard system, a patient who comes to retrieve their equipment needs two months of therapy. This makes it hard for patients who live in the countryside because they cannot stay that long. At most, they can stay for one or two weeks and then hurry back home."*
>
> (Health Facility staff, XHK)

The location-related disaggregate was defined as Kham District (XHK province), accounting for 51 percent of all CBID respondents, and Xayphouthong District (SVK province) accounting for 49 percent (n=658). Persons with disabilities in Kham District had three times the rate of health insurance coverage compared to those in Xayphouthong (27% vs. 9%), and while overall persons with disabilities had higher health insurance rates than persons without disabilities, this trend was reversed in Xayphouthong (9% vs. 14%, respectively). Persons with disabilities in Kham were also substantially more likely compared to persons with disabilities in Xayphouthong to have accessed a health facility when they were sick in the past 12 months (90% vs. 63%). Within districts, trends on accessing health facilities when sick were opposite: persons with disabilities accessed health facilities more than persons without disabilities in Kham (93% vs. 84%), but less in Xayphouthong (60% vs. 70%). Persons with disabilities were able to access healthcare "as much as needed" at a higher rate in Kham compared to persons with disabilities in Xayphouothong (91% vs. 81%), though there were no differences in rates of satisfaction with health services between the two districts nor among type of difficulties in functioning. Xayphouthong District had nearly twice the rate compared to Kham District of persons with or without disabilities using an assistive device (15% vs. 8%).

With respect to outcomes around work, employment, and vocation, persons with disabilities in Xayphouthong District were also more vulnerable than Kham. Ninety-one percent of persons with disabilities in Kham were working at baseline compared to 87 percent in Xayphouthong. While the percentage of persons with disabilities who worked in Kham was greater than persons without disabilities there (91% vs. 84%), this was reversed in Xayphouthong (87% vs. 93%). Similar to findings in the sections above on sex and ethnicity, persons with disabilities in Xayphouthong were more likely to be earning income from their work compared to persons without disabilities as well as persons with disabilities in Kham (84% vs. 75% and 62%, respectively). In Kham, persons with disabilities were substantially more likely to be earning income from their work compared to persons without disabilities there (62% vs. 48%). Persons with disabilities in Xayphouthong were less likely to have needed to work in the past three months compared to persons with disabilities in Kham (53% vs. 77%), but also felt substantially less satisfied about their current working status compared to both persons with disabilities in Kham and persons without disabilities in Xayphouthong (73% were "satisfied" or "very satisfied" vs. 86% and 95%, respectively). With respect to the ability to work, persons with disabilities in Kham answered "as much as needed" at rates well below persons without disabilities in Kham (81% vs. 97%), but about in line with rates of persons with disabilities in Xayphouthong. On vocational training, the distribution across districts of persons with disabilities who had received any vocational training was very different at baseline (26% in Kham vs. 6% in Xayphouthong).

Education attainment rates across districts and between persons with and without disability were highly disparate at baseline. Thirty-nine percent of persons with disabilities in Kham had completed primary school or above compared to 23 percent in Xayphouthong. While the proportion of persons with disabilities in Kham who had attained no formal education was nearly twice that of persons without disabilities in Kham (24% vs. 12%), in Xayphouthong, this comparison was more than three times as great (39% vs. 12%). Finally, when it came to wellbeing, persons with disabilities in Xayphouthong were slightly less likely to be at risk for depression compared to persons with disabilities in Kham (35% vs. 39%). With respect to community participation, persons with disabilities in Kham District were substantially more likely to have engaged in a social gathering in the past three years compared to persons with disabilities in Xayphouthong District (78% vs. 63%), though this trend was reversed for persons without disabilities (72% vs. 81%). Persons with disabilities, regardless of location, participated in community events at about the same rate (17% of persons with disabilities in both Kham and Xayphouthong never participated in a community event in the past three years). This was substantially higher than Kham persons without disabilities (30% had never participated in a community event), but lower than Xayphouthong persons without disabilities (10%). For more information on disaggregation by location, please see Table 6.

FUNCTIONING

Disaggregates across different types of difficulties in functioning included difficulties seeing (21% of the sample, n=138), difficulties hearing (11%, n=74), difficulties with mobility (21%, n=135), difficulties in communication (4%, n=24), cognitive difficulties (14%, n=94), difficulties with self-care (3%, n=21), difficulties with upper limb strength (6%, n=41), and difficulties with hand-eye coordination (3%, n=22). The ET chose to analyze only the six dimensions of difficulties in functioning, as defined by the Washington Group questions on disability (we excluded the difficulties in functioning of upper limb strength and hand-eye coordination). Further, final results for some disaggregates should be cautiously interpreted given relatively small sample sizes (in particular, self-care and communication).

With respect to health outcomes, those with difficulties hearing and difficulties with mobility had the highest rates of health insurance coverage (28% and 23%, respectively), while persons difficulties with self-care and difficulties in communication had the lowest rates (12% and 9%, respectively). For persons with difficulties in functioning who had been sick in the past 12 months, those who had difficulties with self-care were less likely to access a health facility compared to all other types of difficulties in functioning, with about only three in five doing so. Persons with difficulties in communication were the least likely to be able to access health services (three in 10 were not able to access health services as much as needed) compared to all other types of difficulties in functioning. Nine in 10 persons with difficulties hearing or difficulties with self-care were able to access healthcare services as much as needed. Satisfaction with health services received was generally high (over 90%) for persons of all types of difficulties in functioning, except for persons with difficulties in communication, where 31 percent indicated they were not satisfied with healthcare services received. Broken out by type of difficulties in functioning, at least one in every three surveyed respondents were using an assistive device, though rates were highest among those with difficulties in communication (47% use an assistive device).

"The greatest challenge is working with persons with mental/intellectual difficulties in functioning; second is with those with difficulties hearing and seeing; third is those with difficulties hearing and difficulties with upper limb strength. Persons with disabilities that have difficulties with mobility and upper arm functioning would get more opportunities compared to others because they still can see and hear, and they can go anywhere they want."

(male expert, VTE)

When it came to outcomes on work, employment, and vocation, persons with difficulties in communication or difficulties with self-care were least likely to be working at baseline (17% and 31%, respectively), while those with difficulties seeing or difficulties with mobility were most likely to be working (75% and 65%, respectively). Persons with difficulties in communication and difficulties with self-care were least likely to be making an income from their work (17% and 31%, respectively), while those with difficulties seeing or difficulties with mobility were most likely to be making an income from their work (61% and 60%, respectively). While about one in five persons with difficulties in functioning was unsatisfied with their current working status, this rate was substantially higher among those who had difficulties with self-care and difficulties in communication (63% and 35% unsatisfied, respectively). However, with respect to accessing work, this trend was reversed for persons with difficulties in communication or difficulties with self-care: 100% (communication) and 80% (self-care) indicated being able to find work as much as needed, while those who had difficulties with mobility were least likely (two in five were unable to access work as much as needed). Vocational training, if received at all, was received by persons with difficulties seeing, difficulties hearing, difficulties with mobility, and cognitive difficulties, though for each, only about one in five of them received vocational training. For persons who had difficulties with self-care and difficulties in communication, nearly all had never received vocational training.

Following trends in the preceding findings, persons with difficulties in communication or difficulties with self-care had the lowest levels of educational attainment compared to their counterparts with other types of difficulties in functioning (20% and 8%, respectively, had completed at least primary schooling); conversely, between 35 and 37 percent of persons with difficulties seeing, difficulties hearing, difficulties with mobility, and cognitive difficulties had completed at least primary schooling. Finally, when it came to wellbeing, the difference in rates of risk of depression among disaggregates of type of difficulties in functioning were not exceptionally large, though they ranged from a low of 29 percent (persons who had difficulties with self-care) to 42 percent (persons with difficulties in communication). With respect to socialization and community participation, engagement in at least one social gathering in the past three years varied across type of difficulties in functioning. At the more vulnerable end, more than 1 in 2 persons with difficulties with self-care never engages in a social activity, and at the better end, 3 in 10 persons with difficulties hearing or difficulties with mobility never engage in social activities. While on average, 4 in 5 persons with difficulties in

functioning attended at least one community event in the past three years, this was true of less than 1 in 2 persons with difficulties in communication, and only 1 in 6 persons with difficulties with self-care. See Table 7 for more details.

These findings add to the data the GIDAP presents, namely that:

- Those with mental/intellectual difficulties in functioning have fewer services available to them; and,
- Persons with disabilities, especially those with difficulties with mobility can be more socially and physically isolated and miss important information and communication.

Table 7: Outcomes by Type of Difficulties in Functioning

Outcome	Type of difficulties in functioning (%)					
	Seeing	Hearing	Mobility	Comm.	Cognitive	Self-care
Has health insurance	19	28	23	9	18	12
Accessed a health facility when last sick	86	79	85	88	79	61
Able to access healthcare as much as needed	79	90	85	71	79	90
Satisfied with health services	90	92	95	69	91	97
Used an assistive product	39	32	42	47	34	37
Currently working	75	61	65	54	62	17
Earns income from current work	61	46	60	17	55	31
Has needed to work in the past 3 months	47	35	48	22	46	11
Able to work as much as needed	76	88	61	100	73	80
Satisfied with current working status	84	80	82	65	80	37
Has received vocational training	20	20	22	6	16	0
Education attained (at least primary completed)	37	37	36	20	35	8
At risk of depression	41	33	36	42	39	29
Socialization (index)	61	69	69	56	57	45
Community participation (index)	81	67	80	45	68	16

AGE

For ease of analysis, respondents of the CBID sample, both persons with and without disabilities, were broken down into four age groups for the purposes of disaggregating age at baseline. These consisted of ages 5–15 (non-working aged individuals, 16% of the sample, or 105 individuals), 16–44 (first half of working-age individuals, 33% of the sample, or 214 individuals), 45–64 (second half of working-aged individuals, 32% of the sample, or 206 individuals), and 65 and over (19% of the sample, or 123 individuals).

With respect to health-related outcomes, the youngest and oldest aged persons with disabilities are less likely to have health insurance compared to persons without disabilities in their same age group (6% vs. 16% for ages 5-15; and 27% vs. 39% for ages 65+). Among persons with disabilities who were sick in the past 12 months, the younger age groups (5-15 and 16-44) were much less likely than the older age groups (45-64 and 65+) to have accessed a health facility when sick, doing so at roughly half the rate of the older groups (48% and 41%, respectively, vs. 83% and 90%, respectively). When compared to persons without disabilities in the same age groups, these rates were similar for the older groups, however, there were large disparities among the younger groups, where persons without disabilities accessed health facilities at much greater rates than persons with disabilities (84% vs. 48% for ages 5-15; 60% vs. 41% for ages 16-44). With respect to access to healthcare services, nearly 3 in 10 persons with disabilities aged 16-44 were unable to access healthcare services as much as needed, a rate which was substantially lower than all other age groups of persons with disabilities and lower than persons without disabilities aged 16-44 (where 94% reported being able to access health services as much as needed). Persons with disabilities aged 65+ were substantially more likely to be able to access health services when needed (with 4 in 5 able to do so) compared to only about half of persons

without disabilities aged 65+ (80% vs. 53%). Among all persons with disabilities, 3 out of every 4 in the older age groups (45-64 and 65+) were using an assistive product.

With respect to work, employment, and vocational outcomes, there were no substantial differences between persons with and without disabilities among working aged individuals (aged 16-64), with relatively equal rates of working and earning income from work. However, about 1 in every 4 persons with disabilities aged 45-64 was not satisfied with their current working status, compared to only about 1 in 10 for persons without disabilities in the same age group. Further, for those aged 65+, persons without disabilities were more likely to be satisfied with their current working status compared to persons with disabilities (92% vs. 83%). The largest discrepancy was found among individuals aged 65+ when asked the extent to which they were able to find work as much as needed—99% of persons without disabilities aged 65+ said yes, compared to 44% of persons with disabilities in the same age range.

Similar to findings in other disaggregates described above, educational attainment results between persons with and without disabilities, examined by age, were highly disparate at baseline. Persons with disabilities have substantially lower levels of educational attainment compared to their counterparts who do not have disabilities in all age groups. At the 65+ age group, the trend switches, with persons with disabilities having about double the rate of completion of at least primary school compared to persons without disabilities (25% vs. 12%). With respect to wellbeing, persons with disabilities are substantially more likely to be at risk of depression compared to persons without disabilities in all age groups (oftentimes at more than twice the rate), except for the 65+ group where rates are similar (40% vs. 37%, respectively). In particular, almost 3 in 5 persons with disabilities aged 45-64 are at risk of depression, as are 1 in 3 aged 5-15, and 1 in 4 aged 16-44. With respect to community engagement, at baseline the youngest (5-15) and the oldest (65+) were more likely to have never participated in a social gathering in the past three years compared to the middle-aged groups of 16-44 and 45-64 (40% and 37% compared to 24% and 21%, respectively). All age groups of persons with disabilities were less likely to have participated in a social gathering compared to the same age groups of persons without disabilities, except for those aged 16-44, who were equally likely. Persons with disabilities aged 5-15 were also the most likely to have never participated in a community event in the past three years (28%) compared to persons with disabilities aged 16-44, 45-64, and 65+ (16%, 9%, and 21%, respectively). However, persons with disabilities among the youngest age groups (5-15 and 16-44) were more likely than persons without disabilities in the same age groups to have participated in a community event (72% vs. 67%, and 84% vs. 82%, respectively). These findings were reversed for the older age groups 45-64 and 65+ (91% vs. 96%, and 79% vs. 83%). See Table 6 for more details.

These findings add to the data the GIDAP presents, namely that:

- Older men and women have increased likelihood of age-related difficulties in functioning (seeing, hearing, mobility) and may need assistive technology (glasses/ hearing aids, etc.) to access information and communication; and,
- Persons with disabilities, especially older men and women with age related difficulties in functioning have an increased risk of depression related to social isolation.

SUB-EQ D: VARYING BASELINE STATUS CONCLUSIONS

When disaggregating by the key characteristics of sex, ethnicity, location, age, and functioning, persons with disabilities differed in notable ways among themselves and compared to persons without disabilities.

Persons with disabilities who are women, of Lao ethnicity[64], from Xayphouthong District, younger (aged 5-44), and older (over 65) were, on average, substantially more vulnerable at baseline compared to all persons with or without disabilities. Out of 15 key outcomes measured in health, employment, vocational skills, education, wellbeing, and community participation, persons with disabilities from Xayphouthong District had substantially below average scores in 10 outcomes, followed by

[64] Refer to footnote 63 above which further explains the counterintuitive discrepancy in outcomes between Lao and non-Lao ethnicities.

persons with disabilities aged 5-15 (substantially below average in nine outcomes), and women with disabilities (substantially below average in eight outcomes). Persons with disabilities who were ethnically Lao, aged 16-44, or aged over 65, were also more vulnerable compared to all people with or without disabilities, scoring substantially below average on four to five outcomes each. Conversely, men of non-Lao ethnicity, aged 45-64 had substantially above full-sample average scores in 4, 6, and 7 outcomes, respectively.

At baseline, across types of difficulties in functioning, persons with difficulties in communication and difficulties with self-care were substantially more vulnerable than persons with other difficulties in functioning. Persons with difficulties in communication and difficulties with self-care had substantially below average scores in 10 outcomes each of 15 analyzed in this report. Conversely, those with difficulties seeing, difficulties hearing, and difficulties with mobility scored substantially above the overall average in eight, nine, and 11 outcomes of interest, respectively. There were some key exceptions: those with difficulties with mobility were substantially less likely to be able to find work when needed, and those with difficulties seeing were at a higher risk of depression compared to persons with other difficulties in functioning. In general, those with cognitive difficulties had a mix of positive and negative outcomes at baseline compared to the overall average. It is important to note that the sample sizes for persons with difficulties in communication (n=24) and difficulties with self-care (n=21) were relatively small and thus results should be cautiously interpreted.

The effects of different types of difficulties in functioning are manifest most often in work-related outcomes, and least often in health and wellbeing-related outcomes. Comparing across seeing, hearing, mobility, communication, cognitive, and self-care difficulties in functioning, the highest variation in average scores was found in the work-related outcomes – a) currently working, b) earning income from work, and c) satisfaction with current (working) status – mostly in favor of those with difficulties seeing, difficulties hearing, and difficulties with mobility. Conversely, outcomes with the lowest variation – as in, scores the were the closest across all types of difficulties in functioning – were health-related such as a) having health insurance, b) ability to access healthcare services as much as needed, c) use of an assistive product (with some exceptions), and d) risk of depression.

Outcomes of access to health and rehabilitative services were the most inequal among persons with disabilities at baseline. Variations in rates of access to health facilities between persons with disabilities—male and female, Lao and non-Lao, Kham and Xayphouthong Districts, and across age groups—were extremely large and represented a key area of inequality within groups of persons with disabilities. Use of an assistive product, a proxy for access to rehabilitative services, was also inequal at baseline, particularly for women, the youngest (aged 5-44), and those with difficulties hearing and cognitive difficulties. When it came to outcomes that were more equal, satisfaction with health services and ability to access work as much as needed saw very little variation across key disaggregates of persons with disabilities.

Compared to persons without disabilities, at baseline, persons with disabilities were at substantially higher risk of depression, had attained less education, were less likely to socialize in their communities, and were less likely to be satisfied with their current status (e.g., working). Out of 10 key disaggregates (2 for sex, 2 for location, 2 for ethnicity, and 4 age groups) comparable across persons with or without disabilities, persons with disabilities had a greater number of substantially below average scores in the outcomes of wellbeing (seven disaggregates – male, non-Lao, both districts, and all age groups except 16-44), education (seven – female, Lao and non-Lao, Xayphouthong District, all age groups except 16-44), work satisfaction (six – both male and female, Lao ethnicity, Xayphouthong District, those aged 5-15 and 45-64), and socialization (five – female, Lao ethnicity, Xayphouthong District, those aged 5-15 and 65+) compared to the number of full-sample above-average or average scores.

Across the full sample, persons with or without disabilities had the smallest gaps in work-related outcomes and satisfaction with health services, and most different in education and wellbeing. Differences were either small or not notable between persons with and without disabilities for the work-related outcomes of currently working and able to access work as much as needed, and the health-

related outcome of satisfaction with health services. The largest variation in average scores among persons with or without disabilities was found in the outcomes of risk of depression and educational attainment, where persons with disabilities nearly always had scores lower than the full-sample average.

SUCCESS & SUSTAINABILITY

SUB-EQ E: SUCCESS AND SUSTAINABILITY FINDINGS

At baseline, the ET explored both IP plans for sustainability (via document review and interviews) and respondents' opinions regarding key factors for Activity success and sustainability. USAID Okard Activity reports include a section titled 'Sustainability Mechanisms'. The most recent Quarterly Report (Q2Y2) made specific reference to several sustainability approaches:

- The report explains that **working with and building capacity of a) local DPOs and b) GoL** are critical for Activity success and sustainability. The QR explains: *WEI's method of working is through local partners, to embed disability inclusion practices in their institution for sustainability. This is evident in the project design of working through sub-partners while at the same time developing managerial and organizational capacity of the local partners for their own sustainability*. Regarding coordination and collaboration with the GoL the report notes: *WEI and HI are conscious of the need for building ownership for disability inclusion policies and sustainability from the government and we are seeking opportunities to remind them of the linkages between the activities of USAID Okard and the National Disability Policy, Strategy and Action plan, National Disability Law and the National Rehabilitation Strategy and Action Plan*. Additionally, USAID Okard is currently strongly encouraging NCDE to lead a steering committee on CBID and to invite other DPOs and stakeholders to share their approaches, tools, and findings
- The report also noted that **DMAS** is intended to be a mechanism of sustainability: *In addition, USAID Okard's updated approach to the DMAS (opening the sub-grant to competition from all sectors) will likely yield a much more sustainable and business-efficient model of providing advisory services and supporting inclusive environments and services*.
- Lastly, the report notes that WEI and HI are actively looking for ways to **share information and resources**. The report made specific reference to HI's AC5 Luxembourg CBID project. See the report for more details.

Baseline respondents identified similar factors that will be key to sustainability as detailed in Activity reports – in particular, the importance of GoL and DPOs as sub-partners. The most mentioned factor regarding sustainability by SI qualitative baseline respondents was GoL collaboration and coordination. Nine (out of 29) KIIs and FGDs mentioned coordination with GoL as crucial for sustainability of USAID Okard results, at the central level and within line ministries at the provincial and district level. As one GoL respondent explained, "*If the USAID OKARD Activity works closely with Government agencies and tries to harmonize with the Government system, the activities will be more sustained because the Government will continue* [the USAID Okard activities] *as their routine work*." Several respondents (three) also explained the importance of building up '*champions*' within government agencies to promote sustainability.

Local DPOs will implement most of the USAID Okard interventions. Several respondents noted that building the capacity of these DPOs (particularly in fundraising) during the Activity will help ensure that USAID Okard Activity results remain, and that support services for persons with disabilities can continue (mentioned in 4/29 KIIs and FGDs). Moreover, improving capacity within local DPOs will improve sustainability of local DPOs in general, whether for the continuation of the USAID Okard intervention or for other advocacy/ intervention work that will serve persons with disabilities in the future. Other sustainability factors mentioned less frequently in KIIs and FGDs were clear handover to GoL at the conclusion of the Activity (two mentions) and connecting with the private sector (two mentions).

Respondents also highlighted that Activity success will depend on the quality of the **CBID facilitators** (mentioned in 4/29 KIIs and FGDs). In discussions with IP staff, they acknowledged the significant task of identifying and training CBID facilitators – key and sole implementers at the individual/community level. As

these respondents explained, the CBID facilitator does not need to be a professional, but someone who is good at interviewing, making people comfortable, listening, identifying and analyzing problems, and identifying and providing relevant information to the problem.

Persons with disabilities and caregivers also noted that identification of the right case workers will be key to Activity success. As a woman with disability in SVK explained (during participation in a FGD): "*People with disabilities like to think that they're not complete, so having a person without disabilities to talk to or give advice would be ineffective because they are not like us and they would think that it's easy. So, I think the best way is to have people with disability to encourage each other*." Participants in an FGD in VTE went further to recommend that trained CBID facilitators form or join existing DPOs, identify an area leader, and coordinate with village leaders to ensure sustainability of the approach and results.

Lastly, the KII/FGD respondents also explained that the supervision of and support provided to CBID facilitators will play a role in the success of the CBID model in supporting persons with disabilities. These facilitators working at an individual level will need support (monetary and emotional) from USAID Okard so they can sustain this challenging, on-on-one work. One respondent explained, "*Staff need to be taken care of so that they can handle inevitable emergency situations [with persons with disabilities]. There may be crisis situations.*"

SUB-EQ E: SUCCESS AND SUSTAINABILITY CONCLUSIONS

Strategic thought about success and sustainability is evident in USAID Okard's reports. USAID Okard IPs currently have several sustainability mechanisms identified, and these are confirmed by KII/FGD respondents at baseline as key factors to the ultimate success of the Activity. **Key factors include involving GoL and local DPOs as sub-partners in USAID Okard and building capacity of these stakeholders.** Indeed, given the challenges already encountered with capacity of local DPOs (see sub-EQ C) and the GoL (see sub-EQ A), USAID Okard's capacity building efforts are critical to Activity achievement of results and sustainability. **CBID facilitators are another factor to Activity success.** Respondents remarked that the selection and training of these facilitators will be critical, in addition to the supervision and support of these individuals as core implementers of the CBID Demonstration Model.

RECOMMENDATIONS

THEORY OF CHANGE AND MEASUREMENT

A ToC that adequately describes the problem, interventions, desired change (goal), and underlying assumptions is essential for monitoring and evaluating USAID Okard. The ToC can help Activity staff and future evaluators understand what the Activity is trying to achieve, how, and why. To this end, the ET recommends the following:

> *"To understand how and if an intervention is working, we need to understand* ***how the activities of the intervention are expected to lead to the desired results****— both (a) the causal pathway from activities to outputs to a sequence of outcomes to impacts and (b) the causal assumptions showing why and under what conditions the various links in the causal pathway are expected to work."*
>
> 'Useful Theory of Change Models' (2015)

1 **USAID Okard IPs should revise the ToC to:**

a. More clearly define the **problem statement** *and* state which factors of the disabling environment USAID Okard activities will and will not address. This is particularly important in communications with GoL and other external stakeholders considering USAID Okard cannot and will not address the *entire* problem, but it will address parts of the problem. Include this in the AMELP. Additionally, if the GIDAP will be used as the main document to explain differences by key disaggregates (as opposed to the ToC problem statement), ensure the document is updated with baseline information regarding baseline differences by sex, location, age, type of difficulties in functioning, and ethnicity.

b. Expand stated **assumptions** in the ToC to include additional conditions necessary for the achievement of USAID Okard results. See Findings for assumptions raised by respondents at baseline. Additionally, consider moving assumption 1 into the TOC and/or RF as an intermediate result given that it is about change the Activity hopes to achieve – increasing awareness and understanding of human diversity among Activity participants and stakeholders.

c. Define how DMAS and SBCC **interventions** contribute towards achievement and sustainability of the goal, either by clarifying how they contribute to the current indicators or by establishing new indicators to track the outputs/outcomes of these interventions. See text in red in Annex H for where clarifications on these interventions are necessary within the ToC. The DMAS and SBCC do not require custom indicators to be added to the RF, however, the IP should ensure internal tracking accounts for these interventions so that progress can be measured.

d. Remove final conditional phase from the **If-Then Statement** to ensure the ToC is measurable at endline (removing the need for a counterfactual) and focus on exploration of *effectiveness* of the Tier 1 and Tier 2 combined approach at endline, as opposed to *effectiveness* and *efficiency*. Given that the IP uses the wording of the If-Then Statement for advocacy and explanation of the USAID Okard approach to various audiences, this wording can continue to be used but should be removed from the formal Statement in the AMELP for the reasons noted above.

e. Establish **context monitoring** to ensure consistent checks of ToC assumptions (programmatic and contextual assumptions), the operating environment, and any emerging differences in the experiences of Activity participants. Given that differences in the baseline status were identified – in particular, relating to location, functioning, ethnicity, and sex – watch for how these differences play out in demonstration areas in particular (possibly through planned case studies/photo voice/journey maps), and prepare sub-partners for potential adaptations to their community interventions. There will be variance across the factors noted above because there was variance noted at baseline. Ensure learning-oriented

monitoring occurs on a regular basis, and document implementation in each location carefully.

2 **USAID Okard IPs should reflect on Economic Empowerment component reframing offered by baseline evaluation respondents** through:

a. adding a learning question to the AMELP regarding the role that TVET education plays in advancing economic outcomes for persons with disabilities. At the baseline, findings suggest that TVET interventions will not benefit the most vulnerable persons with disabilities. More investigation is necessary to ensure the intervention contributes to the goal and does not widen gaps. At the midterm, the ET encourages USAID Okard IP's to revisit indicators related to TVET work and ensure they remain feasible.
b. continuing with the plan to promote saving at the household level. At baseline, households did not mention 'ability to save' in their definitions of economic self-sufficiency, emphasizing the need for this type of education and support through Building Resources Across Communities (BRAC).
c. targeting engagement with the private sector for the promotion of jobs for persons with disabilities. At baseline, persons with disabilities explained that one of the main challenges they face in achieving economic self-sufficiency is finding a job (or put another way, employers who are willing to hire them). Employers explained that they face various challenges when seeking to hire a person with a disability, primarily related to infrastructure (accessibility of the building for those with a range of difficulties in functioning). As the Activity implements DMAS, it should ensure a tailored approach is used with each company/employer.

3 **USAID Okard IPs and USAID/LCO should use and follow** (and most likely adapt in Year 3) **the ToC, RF, and related measurements as a roadmap for examining results during the Activity.** Annex H shows the USAID Okard ToC components presented in this report and the types of data that provide reference points for measurement of each component.

MANAGEMENT AND IMPLEMENTATION

To promote learning, adaptive management, and ultimately sustainability, USAID Okard IPs and USAID/LCO should jointly:

4 **Explore additional ways to foster a culture of learning.** To more intentionally create and continually foster a culture of learning that can support adaptation, and to ensure ongoing stakeholder unity. USAID Okard IPs should consider key USAID CLA resources including Knowing When to Adapt Decision Tree and Creating an Adaptive, Action-Oriented Team Guidance Note.

5 **Remain committed to sub-partner capacity building.** Given the role that local organizations and the GoL play in the Activity as sub-partners, and the baseline capacity findings relating to these stakeholders, USAID Okard IPs and USAID/LCO should remain committed to sub-partner capacity building, and ensure that allocated resources for the purpose of capacity building are utilized with each sub-partner in a strategic and targeted way. USAID Okard IPs should monitor capacity building progress and review at Year 3.

6 **Define what data Year 3 decisions will be based on**. Baseline findings indicate a lack of agreement on what data will contribute to Year 3 decision-making. The ET recommends USAID Okard IPs and USAID/LCO conduct a 'Defining Success' workshop that will discuss and identify critical indicators, context, and progress to review at Year 3, which will inform on-going decision-making. The workshop should also focus on identifying what should be sustained and to what extent and reviewing the validity and reliability of indicators that measure each of the components of the TOC. Based on baseline findings, data to consider in Year 3 could include the following:

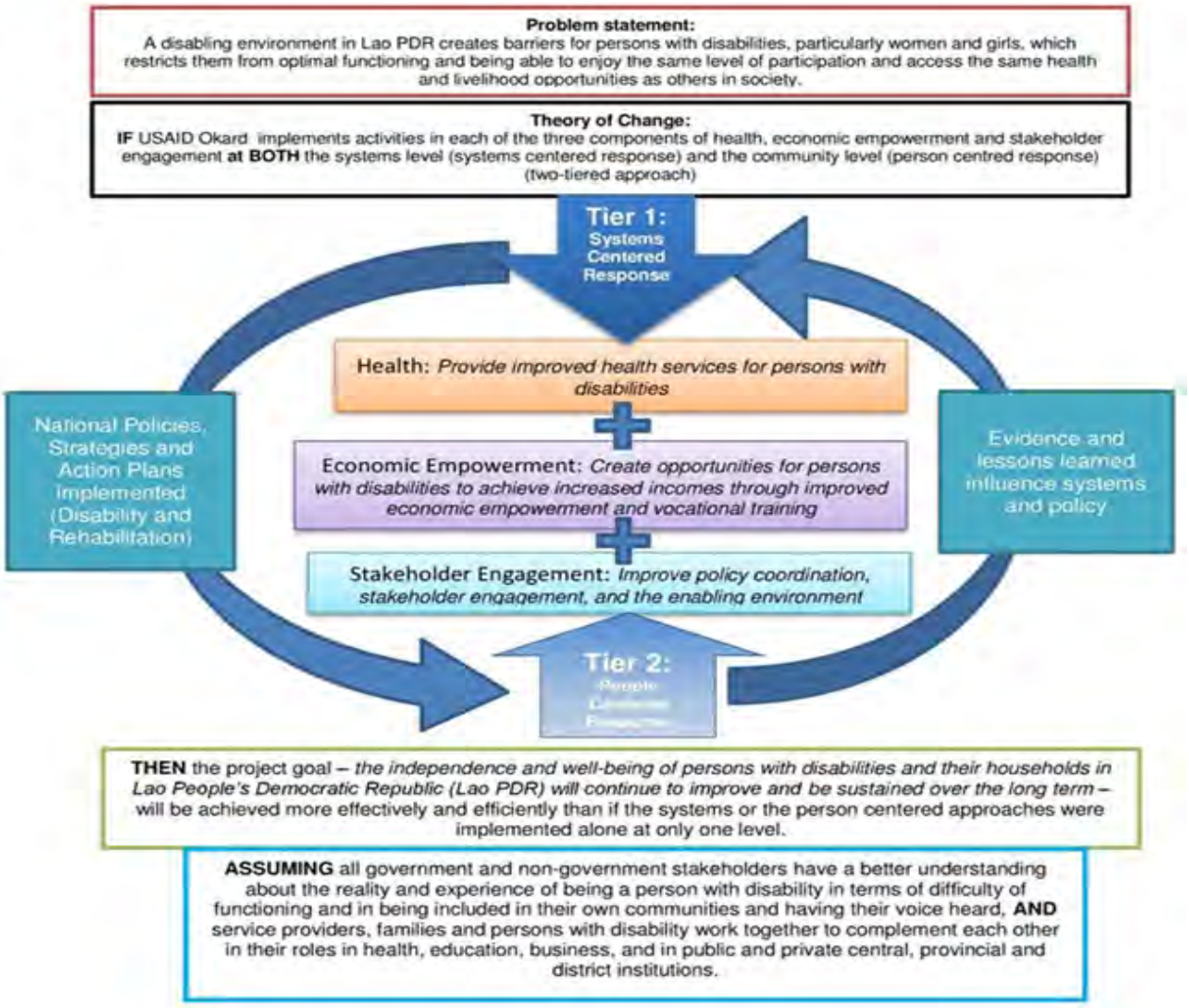
- Progress made against the target per key indicators in the AMELP;
- Data collected in the 'lived lessons learned document' and 'questions asked by sub-partners document'.[65]
- Status of key policies, strategies, and action plans (and other assumptions in the ToC); and whether funding has been allocated for implementation
- Answers to 'learning' questions from the AMELP (including notes about any changes observed in context monitoring);
- Sub-partner capacity and effectiveness of capacity building activities to date;
- Average timeframe required for persons with disabilities and households (with the support of CBID facilitators) to complete CBID Action Plans;[66]
- Receptiveness of communities to CBID approach in two pilot provinces;
- Wellbeing of CBID facilitators, and all Activity staff;
- Level of engagement from NCDE and other GoL sub-partners (within MOH); and,
- Evidence of improved practices in health facilities and TVETs that received training(s).

[65] These are documents WEI is maintaining during the POP to capture ongoing lessons learned and questions from sub-partners as they implement various interventions.

[66] CBID Action Plans are intended to be created by each supported household/person with a disability who coordinates with a CBID facilitator. These plans are based on the CBID modular tool results and needs of the household.

ANNEXES

ANNEX A: OKARD THEORY OF CHANGE



ANNEX B: USAID OKARD RESULTS FRAMEWORKS[67]

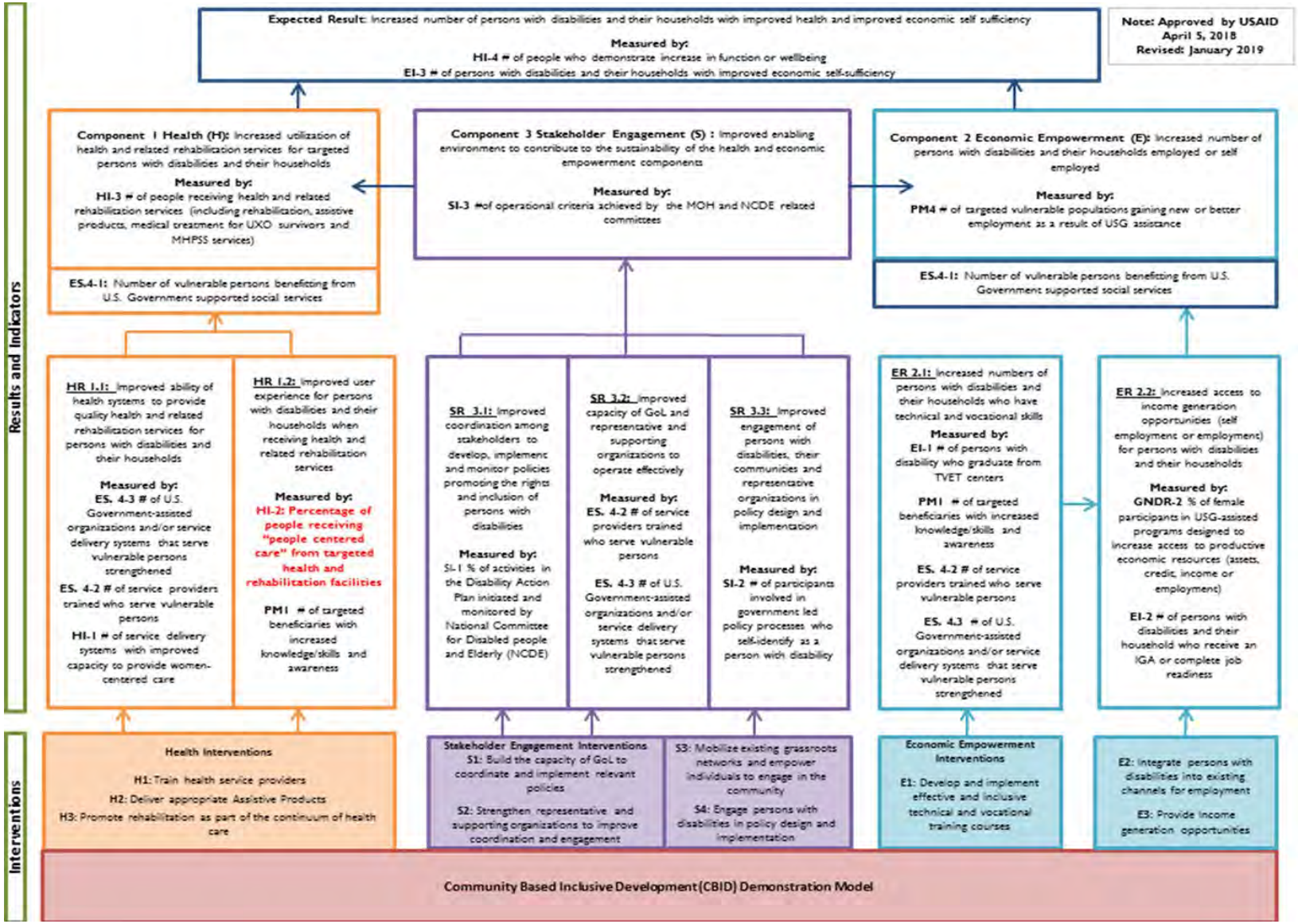
The indicators depicted in Framework 1 below are also listed here for easy reference:

- **Standard Federal (F) Indicators:** ES. 4-1: Number of vulnerable persons benefitting from U.S. Government supported social services; ES. 4-2: Number of service providers trained who serve vulnerable persons; ES. 4-3: Number of U.S. Government-assisted organizations and/or service delivery systems that serve vulnerable persons strengthened;
- **PMP Indicators:** PM1: Number of targeted participants with increased knowledge/skills and awareness; PM4: Number of targeted vulnerable populations gaining new or better employment as a result of USG assistance;
- **Gender-Sensitive Indicators:** GNDR-2: Percent of female participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income or employment);
- **Health Indicators:** H1-1: Number of service delivery systems with improved capacity to provide female-centered care; HI-2: Percentage of people receiving 'people centered care' from targeted health and rehabilitation facilities; HI-3: Number of people receiving health and related rehabilitation services (including rehabilitation, assistive products, medical treatment for unexploded ordnances (UXO) survivors and MHPSS services); HI-4: Number of people who demonstrate increase in function or wellbeing;
- **Economic Empowerment Indicators:** EI-1: Number of persons with disability who graduate from TVET centers; EI-2: Number of persons with disabilities and their household who receive an IGA or complete job readiness; EI-3: Number of persons with disabilities and their households with improved economic self-sufficiency; and
- **Stakeholder Engagement Indicators:** SI-1: Number of activities in the Disability Action Plan initiated and monitored by National Committee for Disabled people and Elderly (NCDE); SI-2: Number of participants involved in government led policy processes who self-identify as a person with disability; SI-3: Number of operational criteria achieved by the MoH (DH&R) and NCDE Strategy and Action Plan coordinating bodies.

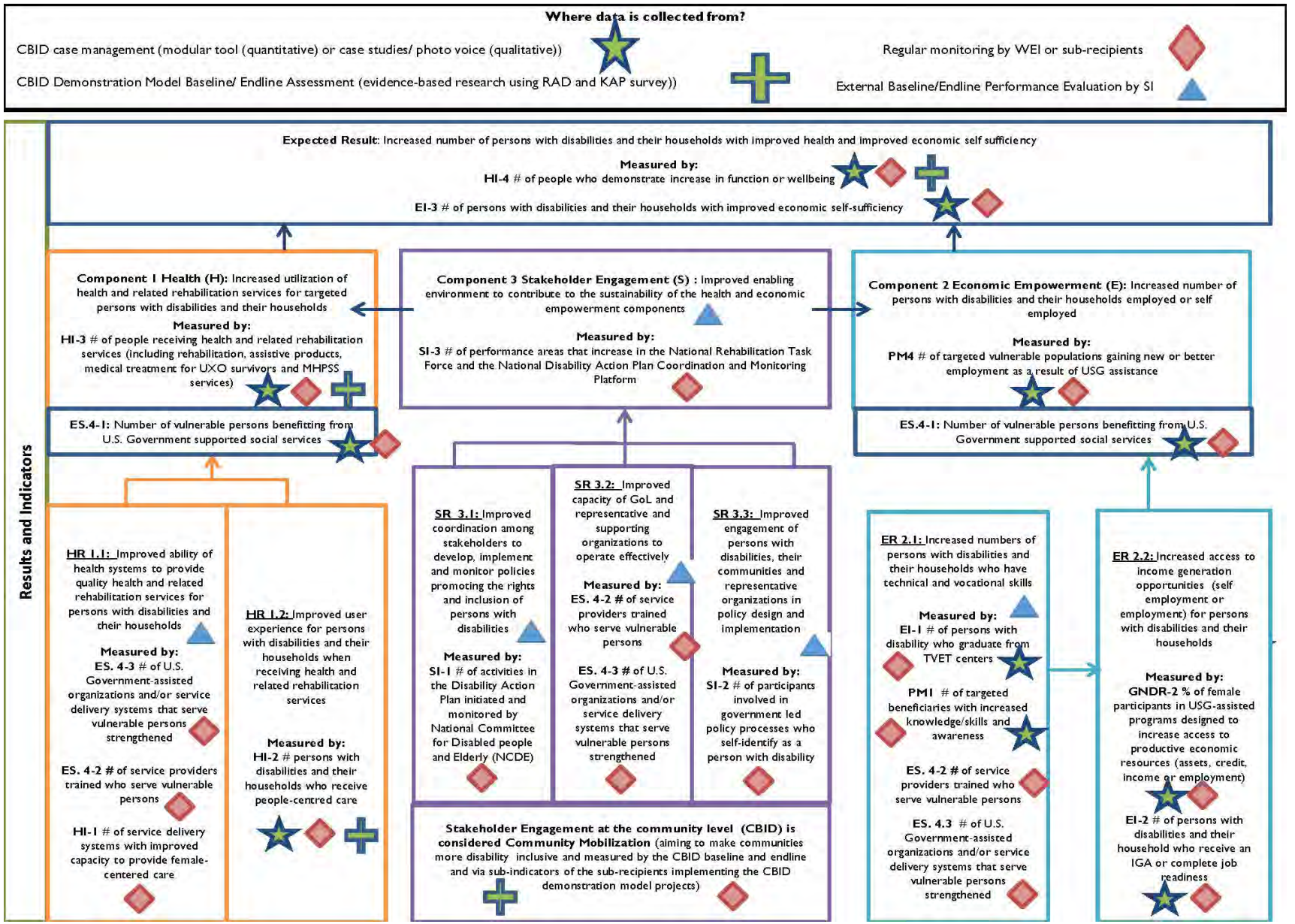
Wording of these indicators are from the February 2019 AMELP.

[67] Framework 1 includes the most up-to-date revisions in indicators. Framework 2 has outdated indicators but is included to show the mapping of data sources.

FRAMEWORK 1


Results and Indicators
Interventions
Expected Result: Increased number of persons with disabilities and their households with improved health and improved economic self sufficiency
Measured by:
HI-4 # of people who demonstrate increase in function or wellbeing
EI-3 # of persons with disabilities and their households with improved economic self-sufficiency
Note: Approved by USAID April 5, 2018 Revised: January 2019
Component 1 Health (H): Increased utilization of health and related rehabilitation services for targeted persons with disabilities and their households
Measured by:
HI-3 # of people receiving health and related rehabilitation services (including rehabilitation, assistive products, medical treatment for UXO survivors and MHPSS services)
ES.4-1: Number of vulnerable persons benefiting from U.S. Government supported social services
Component 3 Stakeholder Engagement (S) : Improved enabling environment to contribute to the sustainability of the health and economic empowerment components
Measured by:
SI-3 #of operational criteria achieved by the MOH and NCDE related committees
Component 2 Economic Empowerment (E): Increased number of persons with disabilities and their households employed or self employed
Measured by:
PM4 # of targeted vulnerable populations gaining new or better employment as a result of USG assistance
ES.4-1: Number of vulnerable persons benefiting from U.S. Government supported social services
HR 1.1: Improved ability of health systems to provide quality health and related rehabilitation services for persons with disabilities and their households
Measured by:
ES. 4-3 # of U.S. Government-assisted organizations and/or service delivery systems that serve vulnerable persons strengthened
ES. 4-2 # of service providers trained who serve vulnerable persons
HI-1 # of service delivery systems with improved capacity to provide women-centered care
HR 1.2: Improved user experience for persons with disabilities and their households when receiving health and related rehabilitation services
Measured by:
HI-2: Percentage of people receiving "people centered care" from targeted health and rehabilitation facilities
PM1 # of targeted beneficiaries with increased knowledge/skills and awareness
SR 3.1: Improved coordination among stakeholders to develop, implement and monitor policies promoting the rights and inclusion of persons with disabilities
Measured by:
SI-1 % of activities in the Disability Action Plan initiated and monitored by National Committee for Disabled people and Elderly (NCDE)
SR 3.2: Improved capacity of GoL and representative and supporting organizations to operate effectively
Measured by:
ES. 4-2 # of service providers trained who serve vulnerable persons
ES. 4-3 # of U.S. Government-assisted organizations and/or service delivery systems that serve vulnerable persons strengthened
SR 3.3: Improved engagement of persons with disabilities, their communities and representative organizations in policy design and implementation
Measured by:
SI-2 # of participants involved in government led policy processes who self-identify as a person with disability
ER 2.1: Increased numbers of persons with disabilities and their households who have technical and vocational skills
Measured by:
EI-1 # of persons with disability who graduate from TVET centers
PM1 # of targeted beneficiaries with increased knowledge/skills and awareness
ES. 4-2 # of service providers trained who serve vulnerable persons
ES. 4.3 # of U.S. Government-assisted organizations and/or service delivery systems that serve vulnerable persons strengthened
ER 2.2: Increased access to income generation opportunities (self employmens or employment) for persons with disabilities and their households
Measured by:
GNDR-2 % of female participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income or employment)
EI-2 # of persons with disabilities and their household who receive an IGA or complete job readiness
Health Interventions
H1: Train health service providers
H2: Deliver appropriate Assistive Products
H3: Promote rehabilitation as part of the continuum of health care
Stakeholder Engagement Interventions
S1: Build the capacity of GoL to coordinate and implement relevant policies
S2: Strengthen representative and supporting organizations to improve coordination and engagement
S3: Mobilize existing grassroots networks and empower individuals to engage in the community
S4: Engage persons with disabilities in policy design and implementation
Economic Empowerment Interventions
E1: Develop and implement effective and inclusive technical and vocational training courses
E2: Integrate persons with disabilities into existing channels for employment
E3: Provide income generation opportunities
Community Based Inclusive Development (CBID) Demonstration Model

FRAMEWORK 2


Where data is collected from?
CBID case management (modular tool (quantitative) or case studies/ photo voice (qualitative))
CBID Demonstration Model Baseline/ Endline Assessment (evidence-based research using RAD and KAP survey))
Regular monitoring by WEI or sub-recipients
External Baseline/Endline Performance Evaluation by SI
Results and Indicators
Expected Result: Increased number of persons with disabilities and their households with improved health and improved economic self sufficiency
Measured by:
HI-4 # of people who demonstrate increase in function or wellbeing
EI-3 # of persons with disabilities and their households with improved economic self-sufficiency
Component 1 Health (H): Increased utilization of health and related rehabilitation services for targeted persons with disabilities and their households
Measured by:
HI-3 # of people receiving health and related rehabilitation services (including rehabilitation, assistive products, medical treatment for UXO survivors and MHPSS services)
ES.4-1: Number of vulnerable persons benefitting from U.S. Government supported social services
Component 3 Stakeholder Engagement (S) : Improved enabling environment to contribute to the sustainability of the health and economic empowerment components
Measured by:
SI-3 # of performance areas that increase in the National Rehabilitation Task Force and the National Disability Action Plan Coordination and Monitoring Platform
Component 2 Economic Empowerment (E): Increased number of persons with disabilities and their households employed or self employed
Measured by:
PM4 # of targeted vulnerable populations gaining new or better employment as a result of USG assistance
ES.4-1: Number of vulnerable persons benefitting from U.S. Government supported social services
HR 1.1: Improved ability of health systems to provide quality health and related rehabilitation services for persons with disabilities and their households
Measured by:
ES. 4-3 # of U.S. Government-assisted organizations and/or service delivery systems that serve vulnerable persons strengthened
ES. 4-2 # of service providers trained who serve vulnerable persons
HI-1 # of service delivery systems with improved capacity to provide female-centered care
HR 1.2: Improved user experience for persons with disabilities and their households when receiving health and related rehabilitation services
Measured by:
HI-2 # persons with disabilities and their households who receive people-centred care
SR 3.1: Improved coordination among stakeholders to develop, implement and monitor policies promoting the rights and inclusion of persons with disabilities
Measured by:
SI-1 # of activities in the Disability Action Plan initiated and monitored by National Committee for Disabled people and Elderly (NCDE)
SR 3.2: Improved capacity of GoL and representative and supporting organizations to operate effectively
Measured by:
ES. 4-2 # of service providers trained who serve vulnerable persons
ES. 4-3 # of U.S. Government-assisted organizations and/or service delivery systems that serve vulnerable persons strengthened
SR 3.3: Improved engagement of persons with disabilities, their communities and representative organizations in policy design and implementation
Measured by:
SI-2 # of participants involved in government led policy processes who self-identify as a person with disability
Stakeholder Engagement at the community level (CBID) is considered Community Mobilization (aiming to make communities more disability inclusive and measured by the CBID baseline and endline and via sub-indicators of the sub-recipients implementing the CBID demonstration model projects)
ER 2.1: Increased numbers of persons with disabilities and their households who have technical and vocational skills
Measured by:
EI-1 # of persons with disability who graduate from TVET centers
PM1 # of targeted beneficiaries with increased knowledge/skills and awareness
ES. 4-2 # of service providers trained who serve vulnerable persons
ES. 4.3 # of U.S. Government-assisted organizations and/or service delivery systems that serve vulnerable persons strengthened
ER 2.2: Increased access to income generation opportunities (self employment or employment) for persons with disabilities and their households
Measured by:
GNDR-2 % of female participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income or employment)
EI-2 # of persons with disabilities and their household who receive an IGA or complete job readiness

ANNEX C: PERFORMANCE EVALUATION DESIGN MATRIX

Evaluation Question	Related USAID OKARD monitoring indicators/tools	Related CBID Assessment questions	Other PE Data Sources	Type of Data	Method and Tool	Data Analysis Methods
To what extent did USAID Okard's Theory of Change explain changes in the health and economic self-sufficiency of persons with disabilities and their households? Is the theory of change valid?						
A. To what extent did: - the people-centered interventions (CBID model, Tier 2) and system-centered interventions (Tier 1) contribute to Activity results? - the CBID model serve to catalyze and test the implementation of the National Disability Policy Strategy and Action Plan, and the National Rehabilitation Strategy and Action plan at the community level, and in what ways did the model feed into national level revision of these key documents? - components 1 (health), 2 (economic empowerment), and 3 (stakeholder engagement) contribute to Activity results, and how did they interact with each other? Was component 3 found to be a key requirement for the effective, efficient, and long-lasting implementation of the health and economic interventions?	- WHO STARS Report results related to government capacity and will - Capacity assessments of NCDE and MoH DH&R related to governance, information, financing, and workforce - All monitoring indicators (see footnote 5 in EDR)	- KAP questions, as available - All CBID Long Survey and relevant qualitative questions	- Literature (in particular, USAID Okard documents describing the ToC and defining aspects of the RF; the National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan; research/studies conducted in the education, health, and economic growth sectors in Lao PDR; USAID Okard documentation of interactions/meetings with MoH - Implementing partners (WEI and HI) - USAID - Technical working group representatives - GoL representatives - Education and Health service delivery system representatives - Experts and other donors - Private sector - NPAs/DPOs (may be sub-recipients) - Persons with disabilities	- Quantitative - Qualitative	- Desk review; Desk review matrix - KII; KII protocol - Participatory FGD; FGD protocol - CBID Survey	- Comparative/ alignment analysis between ToC models as mapped out by stakeholders - Content analysis - Stakeholder mapping - Gap analysis - Quantitative analysis

Evaluation Question	Related USAID OKARD monitoring indicators/tools	Related CBID Assessment questions	Other PE Data Sources	Type of Data	Method and Tool	Data Analysis Methods
B. What were the unintended outcomes and/or consequences of the Activity (considering sex, age, type of difficulties in functioning, and ethnicity)?	- WHO STARS Report results related to government capacity and will - Capacity assessments of NCDE and MoH DH&R related to governance, information, financing, and workforce - All monitoring indicators (see footnote 5 in EDR)	- KAP questions, as available - All CBID Long Survey and relevant qualitative questions	- Literature (in particular, USAID Okard documents describing the ToC and defining aspects of the RF; the National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan; research/studies conducted in the education, health, and economic growth sectors in Lao PDR; USAID Okard documentation of interactions/meetings with MoH - Implementing partners (WEI and HI) - USAID - Technical working group representatives - GoL representatives - Education and Health service delivery system representatives - Experts and other donors - Private sector - NPAs/DPOs (may be sub-recipients) - Persons with disabilities	- Quantitative - Qualitative	- Desk review; Desk review matrix - KII; KII protocol - Participatory FGD; FGD protocol - CBID Survey	- Comparative/ alignment analysis between ToC models as mapped out by stakeholders - Content analysis - Stakeholder mapping - Gap analysis - Quantitative analysis
C. To what extent did the USAID OKARD management structure and implementation plan contribute to effective achievement of results?	*No monitoring indicators/tools relate to this evaluation question*	*No CBID Assessment questions relate to this evaluation question*	- Literature (in particular, sub-recipient reports; USAID Okard progress reports) - Implementing partners (WEI and HI) - USAID - GoL representatives - Education and Health service delivery system representatives - NPAs/DPOs (may be sub-recipients) - Persons with disabilities	- Qualitative	- Desk review; Desk review matrix - KII; KII protocol - Participatory FGD; FGD protocol	- Content analysis

Evaluation Question	Related USAID OKARD monitoring indicators/tools	Related CBID Assessment questions	Other PE Data Sources	Type of Data	Method and Tool	Data Analysis Methods
D. To what extent were women, youth, persons with differing types of difficulties in functioning, and minority groups/ethnicities engaged effectively in the Activity in all locations and in each component?	- H1.2, H1.3, E1.1, E1.2, PM1, GNDR 2, ES 4.1, PM4 (see footnote 5 in EDR)	- KAP questions, as available	- Literature (in particular, gender and disability analyses and poverty/vulnerability research conducted in Lao PRD) - Secondary data (related education, economic and social wellbeing collected within the last decade) - Education and Health service delivery system representatives - Experts and other donors operating in Lao PDR - NPAs/DPOs (may be sub-recipients) - Persons with disabilities	- Quantitative - Qualitative	- Desk review; Desk review matrix - KII; KII protocol - FGD; FGD protocol - CBID Survey	- Gender analysis (distributional analysis of data by sex, age, ethnicity/group, and economic status) - Quantitative analysis *(at endline only)*
E. To what extent are results likely to be sustainable at the national and community level beyond the Activity period of performance? What evidence exists to support the conclusion?	- WHO STARS Report results related to government capacity and will - Capacity assessments of NCDE and MoH DH&R related to governance, information, financing, and workforce - USAID Okard learning questions (from AMELP)	*No CBID Assessment questions relate to this evaluation question*	- Literature (in particular, assessments, evaluations, research, and studies conducted in Lao PDR of persons with disabilities programming; USAID Okard progress reports) - Technical working group representatives - GoL representatives - Education and Health service delivery system representatives - Experts and other donors operating in Lao PDR - Private sector representatives - NPAs/DPOs (may be sub-recipients) - Persons with disabilities	- Qualitative	- Desk review; Desk review matrix - KII; KII protocol - FGD; FGD protocol	- Content analysis

ANNEX D: SI QUALITATIVE BASELINE RESPONDENTS

Respondent Category	Respondent Details	Men	Women
Caregivers of Persons with Disabilities	Caregivers of persons with difficulties in mental/intellectual functioning in Vientiane Capital	0	2
	Caregivers of persons with difficulties in mental/intellectual functioning in Savannakhet Province	1	1
	Caregivers of persons with difficulties in mental/intellectual functioning in Xieng Khouang Province	0	1
Health Facility	Provincial hospital, Xieng Khouang Province	1	1
	Kham District hospital, Xieng Khouang Province	2	5
	Public Health Office of Kham District, Xieng Khouang Province	1	0
	Mittapharb Hospital, Vientiane Capital	1	3
	Xayphouthong District Hospital, Savannakhet Province	2	5
Technical and Vocational Education and Training School /Education	Skill Development Center, Vientiane Capital	2	7
	Xaysombath Technology College, Savannakhet Province	0	1
	Technical and Vocational Education and Training School in Savannakhet Province	3	3
	Health Science College	2	1
	Technical and Vocational Education and Training School in Xieng Khouang Province	3	1
Government of Lao PDR and Technical Working Group	International Non-Governmental Organization Network	1	0
	Center for Medical Rehabilitation, Ministry of Health	4	0
	Department of Technical and Vocational Education and Training, Ministry of Education and Sport	1	0
	Department of Healthcare and Rehabilitation, Ministry of Health	1	0
	Inclusive Education Center	1	0
United States Agency for International Development Okard Implementing Partners and Sub-Partners	World Education, Inc.	4	3
	Humanity and Inclusion	1	4
	Quality of Life Association	1	0
	Association for Rural Mobilization and Improvement	1	0
	Lao Disabled People's Association Vientiane	0	1
United States Agency for International Development and other United States Government	United States Agency for International Development /Regional Development Mission for Asia	0	1
	United States Agency for International Development /Lao Country Office	1	1
	United States Government Bureau for Democracy, Conflict, and Humanitarian Assistance	0	2
	Office of Weapon Removal and Abatement/State Department	1	0
Other Experts and Private Sector Representatives	World Health Organization, Laos	1	1
	World Vision Laos	0	1
	Association of Southeast Asian Nations Call Center	1	0
	Women's Vocational Training Center	0	1
	Australian Chamber of Commerce Lao	1	0
	Disability Service Center	1	0
	Lao Disabled People's Association, Savannakhet Province	0	1
	Lao Association of the Blind	0	1
	TOTAL	**39**	**48**

Persons with Disabilities

FGD #	Location	Men	Women
1	VTE	4	0
2	VTE	0	6
3	SVK	6	0
4	SVK	0	5
5	XHK	0	6
6	XHK	5	0
	TOTAL	**15**	**17**

ANNEX E: DATA COLLECTION PROTOCOLS

CONSENT SCRIPTS

Focus Group Discussions with Persons with Disabilities

Hello, my name is _____ and I am with Lao Social Research, an independent data collection firm working on behalf of Social Impact, a U.S.-based research organization working under contract with the United States Agency for International Development (USAID). We are conducting research on people with disabilities in Lao PDR to learn what can be done to better support them in future years. Today we would like to conduct a group interview with you and 6-8 other individuals to better understand the experiences of people in your community living with disabilities, including their experience accessing health care, education, and employment, as well as their experience participating in civil society and the system that regulates and provides services.

You have been selected from a list of mobility challenged individuals receiving services from [name of DPO]/from a list of mobility challenged individuals working for [name of DPO] for involvement in this research because you are living in an area where a USAID Activity will be implemented this year (2019). In total, our research will involve speaking with between 36 and 48 persons with disabilities, and in total between 118 and 144 people who are considered stakeholders of this upcoming Activity.

The discussion today is expected to take 60-90 minutes, though you can stop participating or leave the room at any point without consequences. If during this group discussion, we ask any questions that you do not wish to answer, you don't have to respond. You are not expected to speak about your own personal experiences if you do not feel comfortable; rather, you may choose to speak more generally about the experiences of persons with disabilities in your community or in Lao PDR.

Your involvement in this discussion is completely voluntary and you are under no obligation to participate. We will be taking notes and recording the discussion so that we can remember later what you tell us. Neither our notes nor the recordings will include your name. Recordings will only be used for finalizing our notes and will be destroyed after the report is finalized. The team will not share any identifiable information to USAID. For reports we write about the research, your answers will be combined with those of other people and presented in a summary format. Any information you provide that might identify you will be kept confidential to the fullest extent possible under local law and U.S. Government policy.

You will receive a small cash reimbursement in the amount of 50,000 Lao Kip (just under $6 USD) at the completion of this FGD. Besides this, there is no direct benefit to you for participating in this discussion. Your participation and answers to any question have no bearing on any services that you currently have access to nor any bearing on access to other services in the future from [name of DPO] or USAID. We do not anticipate any major risks to you for participating other than losing time you could spend on other things. The nature of the group interview is that the research team cannot guarantee confidentiality, but we ask that all focus group participants agree not to share anything that is discussed with anyone outside this group.

If you have any concerns, you may contact XXX with Lao Social Research at XXX [phone] or XXX [email] or the Social Impact Institutional Review Board at irb@socialimpact.com or +1 703 465 1884 with questions about the study or results. Additionally, you may contact the Evaluation Manager at USAID, Ms. Nigoon Jitthai, at njitthai@usaid.gov or +66 2 257 3131. I will leave a copy of this form with you and also the Introductory Letter regarding this baseline evaluation from USAID's Regional Development Mission for Asia (RDMA).

Do you have any questions?

Do you understand that your participation is voluntary? Yes _____ No _____
Do you understand that you can stop participating at any time? Yes _____ No _____
CONSENT STATEMENT: I understand and agree to participate in this study.

Respondent provided consent (verbal):[68] Yes_____ No_____
CONSENT STATEMENT: I understand and agree to be recorded for note-taking purposes only.
Respondent provided consent for audio recording (verbal):[69] Yes_____ No_____

[68] Verbal consent will be collected for respondents with disabilities, but written consent will be obtained for all other informants.
[69] Verbal consent will be collected for respondents with disabilities, but written consent will be obtained for all other informants.

Focus Group Discussions with Health and Education Facility Staff

Hello, my name is _____ and I am with Lao Social Research, an independent data collection firm working on behalf of Social Impact, a U.S.-based research organization working under contract with the United States Agency for International Development (USAID). We are conducting research on people with disabilities in Lao PDR to learn what can be done to better support them in future years. Today we would like to conduct a group interview with you and 7-9 other individuals to better understand the experiences of staff in this facility with persons with disabilities. You have been selected for involvement in this research because [health and education facility respondents] you are working in a facility in an area where a USAID Activity will be implemented this year (2019). In total, our research will involve speaking with between 118 and 144 people who are considered stakeholders of this upcoming Activity.

The discussion today is expected to take 60-90 minutes, though you can stop participating or leave the room at any point without consequences. If during this group discussion, we ask any questions that you do not wish to answer, you don't have to respond. We will ask questions about persons with disabilities' experiences in your facility and about the best ways you see to better serve persons with disabilities.

Your involvement in this discussion is completely voluntary and you are under no obligation to participate. If you agree to participate in the discussion, we will be taking notes and recording the discussion so that we can remember later what you tell us. Neither our notes nor the recordings will include your name. Recordings will only be used for finalizing our notes and will be destroyed after the report is finalized. The team will not share any identifiable information to USAID. For reports we write about the research, your answers will be combined with those of other people and presented in a summary format. Any information you provide that might identify you will be kept confidential to the fullest extent possible under local law and U.S. Government policy.

You will receive a small cash reimbursement in the amount of 50,000 Lao Kip (just under $6 USD) at the completion of this FGD. Besides this, there is no direct benefit to you for participating in this discussion. Your participation and answers to any question have no bearing on your current employment or your potential involvement with the USAID Okard Activity or any USAID activity in the future. We do not anticipate any major risks to you for participating other than losing time you could spend on other things. The nature of the group interview is that the research team cannot guarantee confidentiality, but we ask that all focus group participants agree not to share anything that is discussed with anyone outside this group.

If you have any concerns, you may contact XXX with Lao Social Research at XXX [phone] or XXX [email] or the Social Impact Institutional Review Board at irb@socialimpact.com or +1 703 465 1884 with questions about the study or results. Additionally, you may contact the Evaluation Manager at USAID, Ms. Nigoon Jitthai, at njitthai@usaid.gov or +66 2 257 3131. I will leave a copy of this form with you and also the Introductory Letter regarding this baseline evaluation from USAID's Regional Development Mission for Asia (RDMA).

Do you have any questions?

Do you understand that your participation is voluntary? Yes _____ No _____
Do you understand that you can stop participating at any time? Yes _____ No _____
CONSENT STATEMENT: I understand and agree to participate in this study.
Respondent provided consent (written): Yes_____ No_____
CONSENT STATEMENT: I understand and agree to be recorded for note-taking purposes only.
Respondent provided consent for audio recording (written): Yes_____ No_____

Key Informant Interviews (all respondent categories)

Hello, my name is _____ and I am with Lao Social Research, an independent data collection firm working on behalf of Social Impact, a U.S.-based research organization working under contract with the United States Agency for International Development (USAID). We are conducting research on people with disabilities in Lao PDR to learn what can be done to better support them in future years. Today we would like to conduct an interview with you to better understand your perspective on the experiences of persons with disabilities in Lao PDR and about the best ways to better serve persons with disabilities. You have been selected for involvement in this research because you are a stakeholder of a USAID Activity that will be implemented this year (2019). In total, our research will involve speaking with between 118 and 144 people who are considered stakeholders of this upcoming Activity.

The interview today is expected to take 60 minutes, though you can stop participating at any point without consequences. If during this interview, we ask any questions that you do not wish to answer, you don't have to respond. We will ask you questions about the policy framework and system that supports inclusive development in Laos today.

Your involvement in this interview is completely voluntary and you are under no obligation to participate. If you agree to participate in the discussion, we will be taking notes and recording the interview so that we can remember later what you tell us. Neither our notes nor the recordings will include your name. Recordings will only be used for finalizing our notes and will be destroyed after the report is finalized. The team will not share any identifiable information to USAID. For reports we write about the research, your answers will be combined with those of other people and presented in a summary format. Any information you provide that might identify you will be kept confidential to the fullest extent possible under local law and U.S. Government policy.

There is no payment or direct benefit to you for participating in this interview. Your participation and answers to any question have no bearing on your potential involvement with the USAID Okard Activity or any USAID activity in the future. We do not anticipate any major risks to you for participating other than losing time you could spend on other things.

If you have any concerns, you may contact XXX with Lao Social Research/Social Impact at XXX [phone] or XXX [email] or the Social Impact Institutional Review Board at irb@socialimpact.com or +1 703 465 1884 with questions about the study or results. Additionally, you may contact the Evaluation Manager at USAID, Ms. Nigoon Jitthai, at njitthai@usaid.gov or +66 2 257 3131. I will leave a copy of this form with you and also the Introductory Letter regarding this baseline evaluation from USAID's Regional Development Mission for Asia (RDMA).

Do you have any questions?

Do you understand that your participation is voluntary? Yes _____ No _____
Do you understand that you can stop participating at any time? Yes _____ No _____
CONSENT STATEMENT: I understand and agree to participate in this study.
Respondent provided consent (written): Yes_____ No_____
CONSENT STATEMENT: I understand and agree to be recorded for note-taking purposes only.
Respondent provided consent for audio recording (written): Yes_____ No___

ENGLISH PROTOCOLS

KEY INFORMANT INTERVIEW WITH DOCTORS

We have two things we would like to discuss with you today. First, we want to discuss services available to persons with disabilities in this facility. Second, we want to discuss your facility's relevant policies, data, and monitoring activities.

PART I: SERVICES AVAILABLE TO PERSONS WITH DISABILITIES

1. **Please describe the types of services available for persons with disabilities in this facility.** Then describe if these services are utilized, and by whom (men/women/children, ethnicity, resident locations, types of impairment, etc). Is there data available that confirms this?
2. **Please describe your personal role in delivering services to persons with disabilities.** For example, describe your most recent interaction with a person with a disability in this facility – what care were they seeking? What role did you play in delivering that service to them? How often do you serve a person with a disability (number of times per month)?
3. **Do you think persons with disabilities *that utilize your services* are satisfied with the services they receive here?** Please rate on a scale of 1 – 5 (1 very satisfied, 2 satisfied, 3 ok, 4 dissatisfied, 5 very dissatisfied). Please explain your rating. Do you have evidence to support your view?
4. **For those persons with disabilities in this area *that do not come here for services*, what do you think is the primary reason they do not utilize the services you offer here?** What would need to change to increase their utilization of your services?
5. **What would need to change in the health facility to improve satisfaction of persons with disabilities with the health services they receive here?** As discussed above, how could the key drivers of dissatisfaction be addressed?
6. **Did you or this facility ever receive trainings on caring for persons with disabilities?** If yes, please describe the training (focus, duration, trainers) and when it was conducted.
7. **If you received training on caring for persons with disabilities, would this type of training help you?** What would be the impact of this type of training? *Would it impact the satisfaction of persons with disabilities and/or their utilization of services?*

PART II: SYSTEM FUNCTIONING (LAWS/POLICIES, DATA, AND MONITORING ACTIVITIES)

8. **Are you aware of the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018) regarding the provision of services for persons with disabilities?**
    a. If yes, how if at all do they dictate how this facility operates? Do they make a difference in your daily work here? How so?
    b. What would you need to be able to implement changes necessary to bring this facility in line with these new regulations (the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018)?
    c. Have you ever had the opportunity to meet with GoL and provide input on laws and regulations regarding disability and rehabilitation services? Please explain what, how, and what the results were.
9. **Are there other policies that dictate how this facility operates?**
    a. If yes, how if at all do they dictate how this facility operates? Do they make a difference in your daily work here?
10. **What data do you report to the MoH regarding services provided in this facility (if any)?** Is this data able to be disaggregated by type of impairment/service received? How often do you communicate with MoH?
11. **To what extent have you or anyone in this facility been involved in monitoring the implementation of the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018) regarding disability and rehabilitation support service provision?** Have you ever participated in any working groups on this topic? Please describe these experiences.

KEY INFORMANT INTERVIEW WITH PERSONS WITH DISABILITIES CARETAKER (OF COGNITIVELY IMPAIRED/MENTALLY ILL)

We have two things we would like to discuss with you today. First, we want to discuss services available for the person you care for. Second, we want to discuss the person you care for's engagement in the community.

PART I: HEALTH

1. **Regarding services that are currently available in this area for the person with disabilities that you care for:**
    a. List the current initiatives/projects/offices/facilities/organizations providing health services in this area.
    b. Is the person with disabilities you care for accessing these services? Why or why not?
    c. Are you satisfied with these services, as a caretaker? Why or why not? More specifically related to services the person with disabilities you care for receives from the local health facilities, please rate on a scale of 1 – 5 (1 very dissatisfied, 2 dissatisfied, 3 ok, 4 satisfied, 5 very satisfied) regarding your satisfaction with the way the person with disabilities you care for was treated on his/her most recent visit. Please explain your rating.
2. **What would be needed to improve the health situation of the person with disabilities you care for?**
3. **Now more specifically, I want to ask you two questions:**
    - If your local health facility staff were better trained on delivering services to disabled persons and other vulnerable individuals (and able to deliver higher quality care to persons with disabilities), what would happen? Would this improve the health of the person with disabilities you care for? How?
    - If you and your family were provided a case manager/worker to work with you specifically and help you identify health products and services (or referrals) in the area, what would happen? Would this improve the health of the person with disabilities you care for? How?
4. [Optional, if time permits] **To ensure these changes could happen (to ensure this type of intervention can be successful and have a long-term impact on you and your household), what would be necessary?**

PART I: ECONOMIC

5. **I have two questions for you about your household:**
    a. How many individuals are in your household (excluding you)?
    b. Does the person you care for have a job/conduct work?
6. **What level of satisfaction do you currently have regarding your household's economic well-being?** Please rate on a scale of 1 – 5 (1 very dissatisfied, 2 dissatisfied, 3 ok, 4 satisfied, 5 very satisfied) regarding your satisfaction with you and your household's economic well-being today.
    a. Please explain your rating. What are you satisfied and/or dissatisfied with? Why?
    b. What challenges (if any) has the person with disabilities that you care for faced in securing employment or maintaining employment? Please explain.
7. **What would be needed to improve the economic well-being of your household** (what would be needed to help the person with disabilities that you care for get employment/income)?
8. If you and your family were provided a **case manager/worker** to work with you specifically and help you identify an income-generating activity in the area, what would happen? Would this improve your economic well-being/improve your households well-being? How?
9. [Optional, if time permits] **To ensure these changes could happen (to ensure this type of intervention can be successful and have a long-term impact on you and your household), what would be necessary?**

PART II: ENGAGEMENT WITH THE SYSTEM

10. **Are you aware of the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018) regarding the provision of services for persons with disabilities?** If no, go to next question.
    a. If yes, are these important to you? Why (how do they make a difference in your daily life)?
11. Regarding engagement in the community:
    a. Have you ever had the opportunity to **meet with GoL** and provide input on laws and regulations (do you have access to any channels through which you can provide input to the government) regarding disability and rehabilitation services? Please explain what, how, and what the results were.
    b. Have you ever **participated in any community activities** or meetings? Please explain what, how, and what the results were.
12. Do you believe the a) GoL and b) members of your community understand the reality and experience of being a person with a disability? Is there any discrimination or stigma? Why or why not? What could be done to address this?

FOCUS GROUP DISCUSSIONS WITH PERSONS WITH DISABILITIES (PHYSICAL IMPAIRMENTS)

We have two things we would like to discuss with you today. First, we want to discuss what can be done to improve your health and economic well-being. Second, we want to discuss your awareness of/engagement with local facilities, services, and organizations intended to provide you rehabilitation and support services.

PART I: HEALTH

1. **What does this mean to you? What do you view as 'improved health'? *What aspect of your health is most important to you*?**
2. **Regarding services that are currently available in this area:**
    a. List the current initiatives/projects/offices/facilities/organizations providing health services to you (national, local, DPO/NPA, etc) in this area (specific village or district name).
    b. Are you accessing these services? Why or why not?
    c. Are you satisfied with these services? Why or why not?
    d. More specifically related to services you receive from the local health facilities, please rate on a scale of 1 – 5 (1 very dissatisfied , 2 dissatisfied , 3 ok, 4 satisfied, 5 very satisfied) regarding your satisfaction with the way you or a disabled member of your household was treated on your most recent visit. Please explain your rating.
3. **What would you need to have access to/learn about today to improve your health [as you defined above] that you currently do not have access to?**
4. **Now more specifically, I want to ask you two questions:**
    - If your local health facility staff were better trained on delivering services to disabled persons and other vulnerable individuals (and able to deliver you higher quality care), what would happen? Would this improve your health? How?
    - If you and your family were provided a case manager/worker to work with you specifically and help you identify health products and services (or referrals) in the area, what would happen? Would this improve your health? How?
5. [Optional, if time permits] **To ensure these changes could happen (to ensure this type of intervention can be successful and have a long term impact on you and your household), what would be necessary?**

PART 1: ECONOMIC WELL-BEING

6. **What does this mean to you? What do you view as economic well-being or sufficiency for your household? *What aspect of your economic well-being is most important to you*?**
    a. How many individuals are in your household (excluding you)?
    b. What do you do for a living? What means to you have to support your daily living?
7. **What level of satisfaction do you currently have regarding your economic well-being?** Please rate on a scale of 1 – 5 (1 very dissatisfied, 2 dissatisfied, 3 ok, 4 satisfied, 5 very satisfied) regarding your satisfaction with you and your household's economic well-being today.
    a. Please explain your rating. What are you satisfied and/or dissatisfied with? Why?
    b. What challenges (if any) have you faced in securing employment or maintaining employment? Please explain.
    c. In your opinion, do these challenges differ by age, sex, location, type of disability, ethnicity, etc for persons with disabilities in your community?
8. **What would you need to have today to improve your and your household's economic well-being [as you defined above] that you currently do not have access to?**
9. **Now more specifically, I want to ask you two questions:**
    - If your local TVET or education facility granted you entrance into a training program as a person with a disability, what would happen? Would this help you get a job? How?

- If you and your family were provided a case manager/worker to work with you specifically and help you identify an income-generating activity in the area, what would happen? Would this improve your economic well-being/improve your households well-being? How?

10. [Optional, if time permits] **To ensure these changes could happen (to ensure this type of intervention can be successful and have a long term impact on you and your household), what would be necessary?**

PART II: ENGAGEMENT WITH THE SYSTEM

11. **Are you aware of the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018) regarding the provision of services for persons with disabilities?** If no, go to next question.
    a. If yes, are these important to you? Why (how do they make a difference in your daily life)?
12. Regarding engagement in the community:
    a. Have you ever had the opportunity to **meet with GoL** and provide input on laws and regulations (do you have access to any channels through which you can provide input to the government) regarding disability and rehabilitation services? Please explain what, how, and what the results were.
    b. Have you ever **participated in any community activities** or meetings? Please explain what, how, and what the results were.
13. Do you believe the a) GoL and b) members of your community understand the reality and experience of being a person with a disability? Is there any discrimination or stigma against you? Why or why not? What could be done to address this?

FOCUS GROUP DISCUSSIONS WITH HEALTH FACILITY STAFF

We have two things we would like to discuss with you today. First, we want to discuss what can be done to increase the utilization of and satisfaction with health services provided in this facility. Second, we want to discuss your facility's current interaction with and services for persons with disabilities.

PART I: SERVICES FOR PERSONS WITH DISABILITIES

1. **Please describe the types of services available for persons with disabilities in this facility.** Then describe if these services are utilized, and by whom (men/women/children, ethnicity, resident locations, types of impairment, etc). Is there data available that confirms this?
2. **Please describe your personal role in delivering services to persons with disabilities.** For example, describe your most recent interaction with a person with a disability in this facility – what care were they seeking? What role did you play in delivering that service to them? *How often do you serve a person with a disability (number of times per month)?*
3. **Do you think persons with disabilities *that utilize your services* are satisfied with the services they receive here?** Please rate on a scale of 1 – 5 (1 very dissatisfied, 2 dissatisfied, 3 ok, 4 satisfied, 5 very satisfied). Please explain your rating. *Do you have evidence to support your view?*
4. **For those persons with disabilities in this area *that do not come here for services*, what do you think is the primary reason they do not utilize the services you offer here?** What would need to change to increase their utilization of your services?
5. **Discuss as a group what would need to change in the health facility to improve satisfaction of persons with disabilities with the health services they receive here**. As discussed above, how could the key drivers of dissatisfaction be addressed?
6. **If you were trained on how work with persons with disabilities, how would this type of training help you?** What would be the impact of this type of training? *Would it impact the satisfaction of persons with disabilities and/or their utilization of services?*
7. **Did you all or this facility receive trainings in the past on caring for persons with disabilities?** From whom? If yes, please describe the training (focus, duration, trainers) and when it was conducted.

PART II: SYSTEM

8. **Are you aware of the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018) regarding the provision of services for persons with disabilities?** If not aware, go to the next question.
    a. If yes, how if at all do they dictate how this facility operates? Do they make a difference in your daily work here? How so?
    b. What would you need to be able to implement changes necessary to bring this facility in line with these new regulations (the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018)?
    c. Have you ever had the opportunity to meet with GoL and provide input on laws and regulations regarding disability and rehabilitation services? Please explain what, how, and what the results were.
9. **Are there other policies that dictate how this facility operates?**
    a. If yes, how if at all do they dictate how this facility operates? Do they make a difference in your daily work here?
10. **What data do you report to the MoH regarding services provided in this facility (if any)?** Is this data able to be disaggregated by type of impairment/service received? How often do you communicate with MoH?
11. **To what extent have you or anyone in this facility been involved in monitoring the implementation of the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018) regarding disability and rehabilitation support service provision?** Have you ever participated in any working groups on this topic? Please describe these experiences.

FOCUS GROUP DISCUSSIONS WITH TVET STAFF

We have two things we would like to discuss with you today. First, we want to discuss what can be done to increase the number of persons with disabilities that are educated/trained and employed in this area. Second, we want to discuss your institution's structure and operations.

PART I: SERVICES FOR PERSONS WITH DISABILITIES

1. **Please describe the education and training opportunities available for persons with disabilities in this area, and particularly in this institution.** Then describe if the education/training is utilized, and by whom (men/women/children, ethnicity, resident locations, types of impairment, etc). Is there data available that confirms this, in particular the number of persons with disabilities being educated in this institution this year?
2. **Please describe your personal role in training/educating persons with disabilities in this institution.** For example, describe your most recent interaction with a person with a disability in this institution – were you teaching? Enrolling? Mentoring? How frequently to you interact with a person with a disability (# of times per month)?
3. **Do you think persons with disabilities *that attend this institution* are satisfied with the training they receive here?** Please rate on a scale of 1 – 5 (1 very dissatisfied, 2 dissatisfied, 3 ok, 4 satisfied, 5 very satisfied). Please explain your rating. Do you have evidence to support your view?
4. **For those persons with disabilities in this area *that are not participating in education/training*, what do you think is the primary reason they do not do so?** What would need to change to get them to attend trainings/this institution?
5. **Discuss as a group what would need to change in this institution to improve satisfaction of persons with disabilities with the training they receive**. As discussed above, how could the key drivers of dissatisfaction be addressed?
6. **If you were trained on how to teach persons with disabilities, how would this type of training help you?** What would be the impact of this type of training? *Would it impact the satisfaction of persons with disabilities with their education experience or increase their utilization of this institution?*
7. **Did you all or this facility receive trainings in the past on how to teach persons with disabilities?** From whom? If yes, please describe the training (focus, duration, trainers) and when it was conducted.

PART II: SYSTEM FUNCTIONING

8. **Are you aware of the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018) regarding the provision of services for persons with disabilities?** If no, go to next question.
    a. If yes, how if at all do they dictate how this facility operates? Do they make a difference in your daily work here? How so?
    b. What would you need to be able to implement changes necessary to bring this facility in line with these new regulations (the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018)?
    c. Have you ever had the opportunity to meet with GoL and provide input on laws and regulations regarding disability and rehabilitation services? Please explain what, how, and what the results were.
9. **Are there other policies that dictate how this facility operates?**
    a. If yes, how if at all do they dictate how this facility operates? Do they make a difference in your daily work here?
10. **What data do you report to the MoES regarding enrollment, graduation, students, etc (if any)?** Is this data able to be disaggregated by type of impairment/service received? How often do you communicate with MoES?
11. **To what extent have you or anyone in this facility been involved in monitoring the implementation of the National Rehabilitation Strategy and Action Plan National Disability Strategy and Action Plan, and the Disability Law (2018) regarding disability and rehabilitation support service provision?** Have you ever participated in any working groups on this topic? Please describe these experiences.

KEY INFORMANT INTERVIEW PROTOCOLS - EDUCATION-RELATED GOL AND TWG

Topic	No.	Question
Theory of Change	4	What are the main challenges persons with disabilities face in obtaining employment in Laos?
		PROBE for 4: Are these challenges the same for all persons with disabilities, or do they differ by sex/gender, age, locations, type of impairment, or ethnicity? Please explain.
	5	In your view, what are the steps that 1) the government (national, provincial, and district level); 2) TVET colleges, and 3) the private sector can take to improve the economic self-sufficiency of persons with disabilities?
	6	And what can the community (local DPOs, NPAs, care givers, local leaders) do to increase persons with disabilities access to training and income generating opportunities?
		PROBE 5 and 6: What are the necessary conditions for these steps to be completed? Laws, regulations, coordination among stakeholders, economy, etc. Is it necessary for the GoL and communities to work together? How?
	7	Where do persons with disabilities face the *most* challenges - **in accessing education, or accessing employment** in Laos (pick one)? Please explain.
	8	Do you think the government and TVET providers or the community is more important in improving the lives of persons with disabilities *(or - who is most important for improving the lives of persons with disabilities in Laos?)*? Why do you think that? Please explain.
The System Policy Framework	1	To your knowledge, what is the status of the new Disability Law, National Disability Policy, Strategy and Action Plan (MoLSW) and the National Rehabilitation Strategy and Action plan (MOH)?
	2	Currently, to what extent are these policies/plans implemented at the local level (in communities, in service centers, in local governments)? How so/in what ways? If not, why not? [GO TO Ranking Question on Laws and Regulations]
GOL Capacity	1	In your view, does the MoES have the necessary budget and personnel to implement (and monitor) these policies (or other current laws regarding rehabilitation and disability)? If not, explain any financial and personnel related challenges the MoES faces.
	2	In your view, does the MoES have the necessary technologies, materials, and tools to implement these policies (or other current laws regarding rehabilitation and disability)? If not, explain any technologies related challenges MoES faces. [GO TO Ranking Question on Financial, Personnel, Technology Capacity]

Topic	No.	Question
Coordination /communication	1	How would you describe current coordination and information sharing efforts a) within this ministry (central, provincial, district), b) across ministries in the GoL, and c) with external stakeholders like INGOs, DPOs, etc? Who coordinates and/or shares information? Are there supporting data systems? At what frequency? About what topics?
	2	Are there any type of coordination and information sharing (between Govt-donors or donors-INGOs, for example) that work better than others? Please explain. [GO TO Ranking Question on Coordination and Data Systems Capacity]
Commitment	1	In your opinion, is the country of Laos (and its diverse communities) ready for more inclusion of persons with disabilities in society? Why or why not?
	2	How has the MoES supported the implementation of this plan, or how do you plan to support it if you have not yet done so?
	3	Do you believe National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan will be successful at improving the lives of persons with disabilities? Why or why not? [GO TO Ranking Question on GOL Commitment and Society Willingness]
Persons with disabilities engagement in community	1	In your opinion, to what extent are persons with disabilities engaged with and involved in their communities?
	2	If not, what is preventing persons with disabilities from engaging with their communities?
Persons with disabilities engagement with the GoL	1	To your knowledge, to what extent and how are persons with disabilities able to meet with GoL (implementing) and provide input/feedback?
	2	Should persons with disabilities' participation and engagement be increased? Why or why not? How?
Sustainability/Success Factors	1	When we first started our discussion, you shared about the challenges persons with disabilities face in education and employment. What is important to ensure that persons with disabilities can get improved training and education in the long term?

[System Capacity Table (rating questions table) next page]

Respondent ID:					
System Capacity Topic	**Rating**				
	1 – Very Poor	2 - Poor	3 – Fair	4 – Satisfactory	5 – Very Satisfactory
National Disability/Rehabilitation Strategy and Action Plans (defining how to implement and monitor support services for persons with disabilities) Disability Law and the National Disability Strategy and Action Plan (MoLSW) National Rehabilitation Strategy and Action Plan (MoH)					
MoES Financial capacity (to implement and monitor plans/strategies)					
MoES Personnel (to implement and monitor plans/strategies)					
Technologies and medicines available within health facilities (to implement plans/strategies)					
MoES Coordination capacity (to implement and monitor plans/strategies)					
MoES and stakeholder data system capacity (to monitor plans/strategies)					
MoES commitment/seriousness (to implement plans/strategies)					
Society commitment/willingness (for more inclusion)					

KEY INFORMANT INTERVIEW PROTOCOLS - HEALTH-RELATED GOL AND TWG

Topic	No.	Question
Theory of Change	1	What are the main challenges for persons with disabilities in accessing health services in Laos?
		PROBE for 1: Are these challenges the same for all persons with disabilities, or do they differ by sex, age, locations, type of impairments, or ethnicity? Please explain.
	2	In your view, what can 1) the MoH; and 2) health services/facilities do to improve the health of persons with disabilities?
	3	And can the community (local people, local organization) do to improve access to health services of persons with disabilities?
		PROBE for 2 and 3: What are the necessary conditions for these steps to be completed? Laws, regulations, coordination among stakeholders, economy, etc? Is it necessary for the GoL and communities to work together? How?
	7	Where do persons with disabilities face the *most* challenges - **in achieving good health care,** in Laos? Please explain.
	8	Do you think the government and health providers or the community is more important in improving the health of persons with disabilities *(or - who is most important for improving the lives of persons with disabilities in Laos?)*? Why do you think that? Please explain.
The System Policy Framework	1	To your knowledge, what is the status of the new Disability Law, National Disability Policy, Strategy and Action Plan (MoLSW) and the National Rehabilitation Strategy and Action plan (MOH)?
	2	Currently, to what extent are these policies/plans implemented at the local level (in communities, in service centers, in local governments)? How so/in what ways? If not, why not? [GO TO Ranking Question on Laws and Regulations]
GOL Capacity	1	In your view, does the MoH have the necessary budget and personnel to implement (and monitor) these policies (or other current laws regarding rehabilitation and disability)? If not, explain any financial and personnel related challenges the MOH faces.
	2	In your view, does the MoH have the necessary technologies, materials, and tools to implement these policies (or other current laws regarding rehabilitation and disability)? If not, explain any technologies related challenges MoH faces. [GO TO Ranking Question on Financial, Personnel, Technology Capacity]
Coordination /communication	1	How would you describe current coordination and information sharing efforts a) within this ministry (central, provincial, district), b) across ministries in the GoL, and c) with external stakeholders like INGOs, DPOs, etc? Who coordinates and/or shares information? Are there supporting data systems? At what frequency? About what topics?
	2	Are there any type of coordination and information sharing (between Govt-donors or donors-INGOs, for example) that work better than others? Please explain.

Topic	No.	Question
		[GO TO Ranking Question on Coordination and Data Systems Capacity]
Commitment	1	In your opinion, is the country of Laos (and its diverse communities) ready for more inclusion of persons with disabilities in society? Why or why not?
	2	How has the MOH supported the implementation of this plan, or how do you plan to support it if you have not yet done so?
	3	Do you believe National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan will be successful at improving the lives of persons with disabilities? Why or why not? [GO TO Ranking Question on GOL Commitment and Society Willingness]
Persons with disabilities engagement in community	1	In your opinion, to what extent are persons with disabilities engaged with and involved in their communities?
	2	If not, what is preventing persons with disabilities from engaging with their communities?
Persons with disabilities engagement with the GoL	1	To your knowledge, to what extent and how are persons with disabilities able to meet with GoL (implementing) and provide input/feedback?
	2	Should persons with disabilities' participation and engagement be increased? Why or why not? How?
Sustainability/Success Factors	1	When we first started our discussion, you shared about the challenges persons with disabilities face in health. What is important to ensure that persons with disabilities can get improved health in the long term?

[System Capacity Table (rating questions table) next page]

Respondent ID:					
System Capacity Topic	**Rating**				
	1 – Very Poor	2 - Poor	3 – Fair	4 – Satisfactory	5 – Very Satisfactory
National Disability/Rehabilitation Strategy and Action Plans (defining how to implement and monitor support services for persons with disabilities) Disability Law and the National Disability Strategy and Action Plan (MoLSW) National Rehabilitation Strategy and Action Plan (MoH)					
MoH Financial capacity (to implement and monitor plans/strategies)					
MoH Personnel (to implement and monitor plans/strategies)					
Technologies and medicines available within health facilities (to implement plans/strategies)					
MoH Coordination capacity (to implement and monitor plans/strategies)					
MoH and stakeholder data system capacity (to monitor plans/strategies)					
MoH commitment/seriousness (to implement plans/strategies)					
Society commitment/willingness (for more inclusion)					

KEY INFORMANT INTERVIEW PROTOCOL: MOLSW

Topic	No.	Question
Theory of Change	1	What are the main challenges for persons with disabilities in accessing health services in Laos?
		PROBE for 1: Are these challenges the same for all persons with disabilities, or do they differ by sex, age, locations, type of impairments, or ethnicity? Please explain.
	2	In your view, what are the steps that 1) the MoLSW; and 2) MoH can take to improve the health of persons with disabilities?
	3	And what steps can the community (local DPOs, NPAs, care givers, local leaders) take to improve access to health services of persons with disabilities?
		PROBE for 2 and 3: What are the necessary conditions for these steps to be completed? Laws, regulations, coordination among stakeholders, economy, etc? Is it necessary for the GoL and communities to work together? How?
	4	What are the main challenges persons with disabilities face in obtaining employment in Laos?
		PROBE for 4: Are these challenges the same for all persons with disabilities, or do they differ by sex, age, locations, type of impairment, or ethnicity? Please explain.
	5	In your view, what are the steps that 1) the MoLSW; 2) MoES, and 3) the private sector can take to improve the economic self-sufficiency of persons with disabilities?
	6	And what can the community (local DPOs, NPAs, care givers, local leaders) do to increase persons with disabilities access to training and income generating opportunities?
		PROBE 5 and 6: What are the necessary conditions for these steps to be completed? Laws, regulations, coordination among stakeholders, economy, etc. Is it necessary for the GoL and communities to work together? How?
	7	Where do persons with disabilities face the *most* challenges - **in achieving good health care, accessing education, or accessing employment** in Laos (pick one)? Please explain.
	8	Do you think the government and health/TVET providers **or** the community (awareness, understanding, information) is more important in improving the lives of persons with disabilities? Why do you think that? Please explain.
The System Policy Framework	1	To your knowledge, what is the status of the new Disability Law, National Disability Policy, Strategy and Action Plan (MoLSW) and the National Rehabilitation Strategy and Action plan (MOH)?
	2	Currently, to what extent are these policies/plans implemented at the local level (in communities, in service centers, in local governments)? How so/in what ways? If not, why not? [GO TO Ranking Question on Laws and Regulations]
GOL Capacity	1	In your view, does the MoLSW have the necessary budget and personnel to implement (and monitor) these policies (or other current laws regarding rehabilitation and disability)? If not, explain any financial and personnel related challenges the MoLSW faces.

Topic	No.	Question
	2	In your view, does the MoLSW have the necessary technologies, materials, and tools to implement these policies (or other current laws regarding rehabilitation and disability)? If not, explain any technologies related challenges MoLSW faces. [GO TO Ranking Question on Financial, Personnel, Technology Capacity]
Coordination /communication	1	How would you describe current coordination and information sharing efforts a) within this ministry (central, provincial, district), b) across ministries in the GoL, and c) with external stakeholders like INGOs, DPOs, etc? Who coordinates and/or shares information? Are there supporting data systems? At what frequency? About what topics?
	2	Are there any type of coordination and information sharing (between Govt-donors or donors-INGOs, for example) that work better than others? Please explain. [GO TO Ranking Question on Coordination and Data Systems Capacity]
Commitment	1	In your opinion, is the country of Laos (and its diverse communities) ready for more inclusion of persons with disabilities in society? Why or why not?
	2	How has the MoLSW supported the inclusion of persons with disabilities, or how do you plan to support the Laos laws on disability inclusion if you have not yet done so?
	3	Do you believe National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan will be successful at improving the lives of persons with disabilities? Why or why not? [GO TO Ranking Question on GOL Commitment and Society Willingness]
Persons with disabilities engagement in community	1	In your opinion, to what extent are persons with disabilities engaged with and involved in their communities?
	2	If not, what is preventing persons with disabilities from engaging with their communities?
Persons with disabilities engagement with the GoL	1	To your knowledge, to what extent and how are persons with disabilities able to meet with GoL (implementing) and provide input/feedback?
	2	Should persons with disabilities' engagement with GoL be increased? Why or why not? How?
Sustainability/Success Factors	1	When we first started our discussion, you shared about the challenges persons with disabilities face in accessing health and training/education. What is important to ensure that persons with disabilities can get access to health and education/employment in the long term?

[System Capacity Table (rating questions table) next page]

Respondent ID:					
System Capacity Topic	**Rating**				
	1 – Very Poor	2 - Poor	3 – Fair	4 – Satisfactory	5 – Very Satisfactory
National Disability/Rehabilitation Strategy and Action Plans (defining how to implement and monitor support services for persons with disabilities) Disability Law and the National Disability Strategy and Action Plan (MoLSW) National Rehabilitation Strategy and Action Plan (MoH)					
MoLSW Financial capacity (to implement and monitor plans/strategies)					
MoLSW Personnel (to implement and monitor plans/strategies)					
Technologies and medicines available within health facilities (to implement plans/strategies)					
MoLSW Coordination capacity (to implement and monitor plans/strategies)					
MoLSW and stakeholder data system capacity (to monitor plans/strategies)					
MoLSW commitment/seriousness (to implement plans/strategies)					
Society commitment/willingness (for more inclusion)					

PRIVATE SECTOR – KII PROTOCOL

[For social enterprises/small companies]

1. Does your company employ persons with disabilities? How many? Is there a quota?
2. What are the main challenges you face in hiring and employing persons with disabilities? *PROBE: Do these challenges differ by sex, age, location, type of impairment, or ethnicity of the person with disability?*

[For chambers of commerce – *Australia Chamber of Commerce for the baseline*]

1. How many Australian companies are you aware of in Laos that employ persons with disabilities? How many? Is there a quota?
2. What are the main challenges they face that you are aware of in hiring and employing persons with disabilities? *PROBE: Do these challenges differ by sex, age, location, type of impairment, or ethnicity of the person with disability?*

[Questions below, for all private sector respondents]

Evaluation Topic	No.	Question
Theory of Change	4	What do you think are the main challenges persons with disabilities face in obtaining employment in Laos?
		PROBE for 4: Are these challenges the same for all persons with disabilities, or do they differ by sex, age, locations, type of impairment, or ethnicity? Please explain.
	5	In your view, what are the steps that 1) the government (national, provincial, and district level); 2) TVET colleges, and the private sector can take to improve the economic self-sufficiency of persons with disabilities?
	6	And what can the community (local DPOs, NPAs, care givers, local leaders) do to increase persons with disabilities access to training and income generating opportunities?
		PROBE 5 and 6: What are the necessary conditions for these steps to be completed? Laws, regulations, coordination among stakeholders, economy, etc. Is it necessary for the GoL and communities to work together? How?
	7	Where do persons with disabilities face the *most* challenges - **in accessing employment** in Laos? Please explain.
	8	Do you think the government and TVET providers or the community is more important in improving the lives of persons with disabilities *(or - who is most important for improving the lives of persons with disabilities in Laos?)*? Why do you think that? Please explain.
System Policy Framework	1	To your knowledge, what is the status of the new National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan?
	2	Currently, to what extent are these policies/plans implemented at the local level (in communities, in service centers, in local governments)? How so/in what ways? If not, why not?

Evaluation Topic	No.	Question
		[GO TO Ranking Question on Laws and Regulations]
GOL Capacity	1	In your view, does the GOL have the necessary budget and personnel to implement (and monitor) these policies (or other current laws regarding rehabilitation and disability)? If not, explain any financial and personnel related challenges they face.
	2	In your view, does the GOL have the necessary technologies, materials, and tools to implement these policies (or other current laws regarding rehabilitation and disability)? If not, explain any technologies related challenges they face. [GO TO Ranking Question on Financial, Personnel, Technology Capacity]
Coordination /communication	1	How would you describe current coordination and information sharing efforts among stakeholders working on inclusive development approaches (government - district, provincial, national -, INGOs, DPOs, private sector)? Who coordinates and/or shares information? Are there supporting data systems? At what frequency? About what topics?
	2	Are there any type of coordination and information sharing (between Govt-donors or donors-INGOs, for example) that work better than others? Please explain. [GO TO Ranking Question on Management/Coordination and Data Systems Capacity]
Stakeholder commitment	1	In your opinion, is the country of Laos (and its diverse communities) ready for more inclusion of persons with disabilities in society? Why or why not?
	2	How have you/your organization/company supported the implementation of this plan, or how do you plan to support it if you have not yet done so?
	3	Do you/your organization believe National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan will be successful at improving the lives of persons with disabilities? Why or why not? [GO TO Ranking Question on Commitment and Society Willingness]
Sustainability/Success Factors	1	What is necessary to improve the economic standing of persons with disabilities in the long term?

[System Capacity Table (rating questions table) next page]

Respondent ID:					
System Capacity Topic	**Rating**				
	1 – Very Poor	2 - Poor	3 – Fair	4 – Satisfactory	5 – Very Satisfactory
National Disability/Rehabilitation Strategy and Action Plans (defining how to implement and monitor support services for persons with disabilities) Disability Law and the National Disability Strategy and Action Plan (MoLSW) National Rehabilitation Strategy and Action Plan (MoH)					
GOL Financial capacity (to implement and monitor plans/strategies)					
GOL Personnel (to implement and monitor plans/strategies)					
Technologies and medicines available within health facilities (to implement plans/strategies)					
GOL coordination capacity (to implement and monitor plans/strategies)					
GOL and stakeholder data system capacity (to monitor plans/strategies)					
GOL commitment/seriousness (to implement plans/strategies)					
Society commitment/willingness (for more inclusion)					

USAID/USG LAOS STAFF - KEY INFORMANT INTERVIEW PROTOCOL

a. Please explain your current role USAID/USG Laos and the level of engagement you have had with USAID/Okard.
b. [*Disabling environment/problem statement*] What are the biggest challenges/obstacles persons with disabilities face regarding health and economic empowerment in Laos today? Why is it challenging for them to achieve improved health and economic self-sufficiency?
    a. How does this differ by location (VTE, SVK, XHK); gender; age; ethnicity; type of disability?
c. Regarding the USAID/Okard theory of change (sub-EQ A):
    a. Please describe the USAID/Okard theory of change, in your own words. How does USAID/Okard intended to respond to the challenges you just noted? *If not familiar, interviewer to explain and use graphic.*
    b. Based on your expertise and experience in Laos, what will be the most difficult result to achieve for USAID/Okard, and why?
    c. [*Assumptions/environment*] What are the necessary conditions to achieve the goal?
    d. Do you have any concerns or questions about the theory of change (*the problem statement, the intervention, or the stated assumptions; measurement of the TOC)?*
d. [*Baseline of the system*] I want to now ask you some questions about the current 'system' that defines, manages and supports rehabilitation and disability services in Laos. I will ask you questions about different aspects of the 'system', and then ask you to rate your satisfaction level with each aspect of the system.

Evaluation Question	No.	Question
Sub-EQ A Topic: **Policy Framework**, national level regulation and policy around disability inclusion, and operationalization at the community level	1	To your knowledge, what is the status of the new National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan?
	2	Currently, to what extent are these policies/plans implemented at the local level (in communities, in service centers, in local governments)? How so/in what ways? If not, why not? [GO TO Ranking Question on Laws and Regulations]
Sub-EQ A Topic: **GOL Capacity** (budget, personnel, technology) to implement and monitor policies/strategies/plans	1	In your view, does the GOL have the necessary budget and personnel to implement (and monitor) these policies (or other current laws regarding rehabilitation and disability)? If not, explain any financial and personnel related challenges they face.

Evaluation Question	No.	Question
	2	In your view, does the GOL have the necessary technologies, materials, and tools to implement these policies (or other current laws regarding rehabilitation and disability)? If not, explain any technologies related challenges they face. [GO TO Ranking Question on Financial, Personnel, Technology Capacity]
Sub-EQ A Topic: **Stakeholder coordination /communication** and information sharing	1	How would you describe current coordination and information sharing efforts among stakeholders working on inclusive development approaches (government - district, provincial, national -, INGOs, DPOs, health facilities, education facilities, donors)? Who coordinates and/or shares information? Are there supporting data systems? At what frequency? About what topics?
	2	Are there any type of coordination and information sharing (between Govt-donors or donors-INGOs, for example) that work better than others? Please explain. [GO TO Ranking Question on Management/Coordination and Data Systems Capacity]
Sub-EQ A Topic: **Stakeholder commitment,** ownership/buy-in to the OKARD approach and national policies/strategies/plans that form the foundation of Lao's inclusive development approach (enabling environment)	2	In your opinion, is the country of Laos (and its diverse communities) ready for more inclusion of persons with disabilities in society? Why or why not? [GO TO Ranking Question on GOL Commitment and Society Willingness]
Complete rating sheet and return to interviewer. e. Now I have a few more questions about how persons with disabilities in Laos currently engage with and are aware of the system (and its actors).		
Sub-EQ A and B Topic: persons with disabilities awareness of and engagement with community organizations conducting inclusive programming/interventions, and services (education and health)	1	In your opinion, to what extent are persons with disabilities aware of community organizations and service providers that offer service in education and health and economic empowerment?
	2	If not, what is preventing persons with disabilities from engaging with these organizations/service providers?

Evaluation Question	No.	Question
Sub-EQ A and B Topic: persons with disabilities awareness of and engagement with GOL and national groups designing, implementing, and monitoring disability and rehabilitation strategies and policies	1	To your knowledge, to what extent and how are persons with disabilities able to meet with GoL (and other organizations designing, implementing and monitoring these policies) and provide input/feedback?
	2	Should persons with disabilities' participation and engagement be increased? Why or why not? How?

f. I would now like to ask you a few questions about the sustainability of USAID/Okard intended results and impacts.

Sub EQ E	1	If the initiative is successful at improving the health and economic standing of persons with disabilities and their households, what would be the most important factor to ensuring the sustainability of this outcome?
	2	If you had to name one thing, what would be the biggest challenge to the implementation of this approach in Laos and achieving this outcome?

g. To close, is there anything else you would like to share with us? Do you have any comments or notes you want us to document at the baseline regarding USAID/Okard?

h. Additional document/data requests

KEY INFORMANT INTERVIEW PROTOCOL - WEI/HI LEADERSHIP

1. Please explain your current role at WEI/HI and USAID/Okard and how long you have been involved with USAID/Okard.
2. Please provide an update on the MOU and the scope and timing of each grant:
    a. WEI: HI, MOH (1), CMR (1), COPE (1), QLA (CBID, 1 2 3)
    b. HI: NCDE (3), LDPA VTE (2, 3), AMRI (CBID, 1 2 3), DMAS
3. Regarding the USAID/Okard theory of change (sub-EQ A):
    a. Please describe the USAID/Okard theory of change, in your own words. *Use theory of change graphic after they offer an explanation of the TOC.*
        i. Define 'the system' (Tier 1) and 'the community/people' (Tier 2).
        ii. How do the two tiers work together? *Systems work tested at the community level through CBID. Then CBID generates evidence for the system. This data (CBID) will then drive Activity iterations and provide feedback to strengthen government systems and decision making in support of the national disability and rehabilitation action plan implementation.*
        iii. Regarding '*mutually reinforcing and interconnected components*', how do you see Component 3 influencing Components 1 and 2 in practice? *Component 3 (Stakeholder Engagement) feeds into Components 1 and 2 as a key requirement for the effective, efficient and long-lasting implementation of the planned health and economic interventions.*
    b. What process was used to develop and refine this theory of change? How, if at all, was USAID/Laos involved?
    c. In your opinion, is there a new/untested part of the theory of change? If yes, explain.
        i. Use of government as a partner?
        ii. Two tiered approach?
    d. What will be the most difficult result to achieve and why?
    e. Do you have any concerns or outstanding questions about the theory of change (*the problem statement, the intervention, or the stated assumptions; measurement of TOC*)?
    f. Is there a process in place to allow for the theory of change to be adapted, updated, or revised based on Activity learning and data throughout the period of performance? If yes, please describe. If no, why not?
4. [*Baseline of the system*] I want to now ask you some questions about the current 'system' that defines, manages and supports rehabilitation and disability services in Laos. I will ask you questions about different aspects of the 'system', and then ask you to rate your satisfaction level with each aspect of the system.

Evaluation Question	No.	Question
Sub-EQ A Topic: **Policy Framework**, national level regulation and policy around disability inclusion, and operationalization at the community level	1	To your knowledge, what is the status of the new National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan?
	2	Currently, to what extent are these policies/plans implemented at the local level (in communities, in service centers, in local governments)? How so/in what ways? If not, why not? [GO TO Ranking Question on Laws and Regulations]
Sub-EQ A Topic: **GOL Capacity** (budget, personnel, technology) to implement and monitor policies/strategies/plans	1	In your view, does the GOL [insert ministry, department, etc. – or use 'you' if talking to GOL] have the necessary budget and personnel to implement (and monitor) these policies (or other current laws regarding rehabilitation and disability)? If not, explain any financial and personnel related challenges they ['you' if talking to GOL] face.
	2	In your view, does the GOL [insert ministry, department, etc. – or use 'you' if talking to GOL] have the necessary technologies, materials, and tools to implement these policies (or other current laws regarding rehabilitation and disability)? If not, explain any technologies related challenges they ['you' if talking to GOL] face. [GO TO Ranking Question on Financial, Personnel, Technology Capacity]
Sub-EQ A Topic: **Stakeholder coordination /communication** and information sharing	1	How would you describe current coordination and information sharing efforts among stakeholders working on inclusive development approaches (government - district, provincial, national -, INGOs, DPOs, health facilities, education facilities, donors)? Who coordinates and/or shares information? Are there supporting data systems? At what frequency? About what topics?
	2	Are there any type of coordination and information sharing (between Govt-donors or donors-INGOs, for example) that work better than others? Please explain. [GO TO Ranking Question on Management/Coordination and Data Systems Capacity]
Sub-EQ A Topic: **Stakeholder commitment,** ownership/buy-in to the OKARD approach and national policies/strategies/plans that form the foundation of Lao's inclusive	2	In your opinion, is the country of Laos (and its diverse communities) ready for more inclusion of persons with disabilities in society? Why or why not? [GO TO Ranking Question on GOL Commitment and Society Willingness]

Evaluation Question	No.	Question
development approach (enabling environment)		
Complete rating sheet and return to interviewer. 5. Now I have a few more questions about how persons with disabilities in Laos currently engage with and are aware of the system (and its actors).		
Sub-EQ A and B Topic: persons with disabilities awareness of and engagement with community organizations conducting inclusive programming/interventions, and services (education and health)	1	In your opinion, to what extent are persons with disabilities aware of community organizations and service providers that offer service in education and health and economic empowerment?
	2	If not, what is preventing persons with disabilities from engaging with these organizations/service providers?
Sub-EQ A and B Topic: persons with disabilities awareness of and engagement with GOL and national groups designing, implementing, and monitoring disability and rehabilitation strategies and policies	1	To your knowledge, to what extent and how are persons with disabilities able to meet with GoL (and other organizations designing, implementing and monitoring these policies) and provide input/feedback?
	2	Should persons with disabilities' participation and engagement be increased? Why or why not? How?

6. I would now like to ask you a few questions about the sustainability of USAID/Okard intended results and impacts.

Sub EQ E	1	If the initiative is successful at 'improving the health and economic standing of persons with disabilities and their households', what would be the most important factor to ensuring the sustainability of this outcome?
	2	If you had to name one thing, what would be the biggest challenge to the implementation of this approach in Laos and achieving this outcome?

7. To close, is there anything else you would like to share with us? Do you have any comments or notes you want us to document at the baseline regarding USAID/Okard?

8. Additional information/document requests - Can you provide me more information on the planned strategy/approach to:
    a. Stakeholder engagement
    b. Gender
    c. Behavior Change Communication

KEY INFORMANT INTERVIEW PROTOCOL - WEI/HI STAFF

1. Please explain your current role at WEI and USAID/Okard and how long you have been involved with USAID/Okard.
2. [*Disabling environment/problem statement*] What are the biggest challenges/obstacles persons with disabilities face regarding health and economic empowerment in Laos today? Why is it challenging for them to achieve improved health and economic self-sufficiency?
    a. How does this differ by location (VTE, SVK, XHK); gender; age; ethnicity; type of disability?
3. Regarding the USAID/Okard theory of change (sub-EQ A):
    a. Please describe the USAID/Okard theory of change, in your own words, related to your component/activity. Link it to the problem statement just explained.
        i. WEI: BCC, Gender, CBID, MEL
        ii. HI: CBID, partnership, MEL (training coordinator?)
    b. What will be the most difficult result to achieve and why/will it be difficult to achieve your component result, and why?
    c. How will you know if your component/activity is successful/achieved the goal? What is the indicator of success for you in your work?
    d. [*Assumptions/environment*] What are the necessary conditions to achieve the goal?
    e. Do you have any concerns or outstanding questions about the theory of change (*the problem statement, the intervention, or the stated assumptions; measurement of the TOC)?*
4. [*Baseline of the system*] I want to now ask you some questions about the current 'system' that defines, manages and supports rehabilitation and disability services in Laos. I will ask you questions about different aspects of the 'system', and then ask you to rate your satisfaction level with each aspect of the system.

Evaluation Question	No.	Question
Sub-EQ A Topic: **Policy Framework**, national level regulation and policy around disability inclusion, and operationalization at the community level	1	To your knowledge, what is the status of the new National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan?
	2	Currently, to what extent are these policies/plans implemented at the local level (in communities, in service centers, in local governments)? How so/in what ways? If not, why not? [GO TO Ranking Question on Laws and Regulations]
Sub-EQ A Topic: **GOL Capacity** (budget, personnel, technology) to	1	In your view, does the GOL have the necessary budget and personnel to implement (and monitor) these policies (or other current laws regarding rehabilitation and disability)? If not, explain any financial and personnel related challenges they face.

Evaluation Question	No.	Question
implement and monitor policies/strategies/plans	2	In your view, does the GOL have the necessary technologies, materials, and tools to implement these policies (or other current laws regarding rehabilitation and disability)? If not, explain any technologies related challenges they face. [GO TO Ranking Question on Financial, Personnel, Technology Capacity]
Sub-EQ A Topic: **Stakeholder coordination/communication** and information sharing	1	How would you describe current coordination and information sharing efforts among stakeholders working on inclusive development approaches (government - district, provincial, national -, INGOs, DPOs, health facilities, education facilities, donors)? Who coordinates and/or shares information? Are there supporting data systems? At what frequency? About what topics?
	2	Are there any type of coordination and information sharing (between Govt-donors or donors-INGOs, for example) that work better than others? Please explain. [GO TO Ranking Question on Management/Coordination and Data Systems Capacity]
Sub-EQ A Topic: **Stakeholder commitment,** ownership/buy-in to the OKARD approach and national policies/strategies/plans that form the foundation of Lao's inclusive development approach (enabling environment)	2	In your opinion, is the country of Laos (and its diverse communities) ready for more inclusion of persons with disabilities in society? Why or why not? [GO TO Ranking Question on GOL Commitment and Society Willingness]
Complete rating sheet and return to interviewer. 5. Now I have a few more questions about how persons with disabilities in Laos currently engage with and are aware of the system (and its actors).		
Sub-EQ A and B Topic: persons with disabilities awareness of and engagement with community organizations conducting inclusive programming/interventions, and services (education and health)	1	In your opinion, to what extent are persons with disabilities aware of community organizations and service providers that offer service in education and health and economic empowerment?
	2	If not, what is preventing persons with disabilities from engaging with these organizations/service providers?

Evaluation Question	No.	Question
Sub-EQ A and B Topic: persons with disabilities awareness of and engagement with GOL and national groups designing, implementing, and monitoring disability and rehabilitation strategies and policies	1	To your knowledge, to what extent and how are persons with disabilities able to meet with GoL (and other organizations designing, implementing and monitoring these policies) and provide input/feedback?
	2	Should persons with disabilities' participation and engagement be increased? Why or why not? How?

6. I would now like to ask you a few questions about the sustainability of USAID/Okard intended results and impacts.

Sub EQ E	1	If the initiative is successful at improving the health and economic standing of persons with disabilities and their households, what would be the most important factor to ensuring the sustainability of this outcome?
	2	If you had to name one thing, what would be the biggest challenge to the implementation of this approach in Laos and achieving this outcome?

7. To close, is there anything else you would like to share with us? Do you have any comments or notes you want us to document at the baseline regarding USAID/Okard?

8. Additional document/data requests

KEY INFORMANT INTERVIEW PROTOCOLS - SUB RECIPIENTS AND DPOS AND OTHER EXPERTS AND DONORS

1. What does your DPO/organization do related to inclusive development?
2. Where do you work (what geographic locations in Laos) and how long have you worked there?

Evaluation Topic	No.	Question
Theory of Change	1	What are the main challenges for persons with disabilities in accessing health services in Laos?
		PROBE for 1: Are these challenges the same for all persons with disabilities, or do they differ by sex, age, locations, type of impairments, or ethnicity? Please explain.
	2	In your view, what can 1) the government (national, provincial, and district level); and 2) health services/facilities do to improve the health of persons with disabilities?
	3	And can the community (local people, local organization) do to improve access to health services of persons with disabilities?
		PROBE for 2 and 3: What are the necessary conditions for these steps to be completed? Laws, regulations, coordination among stakeholders, economy, etc? Is it necessary for the GoL and communities to work together? How?
	4	What are the main challenges persons with disabilities face in obtaining employment in Laos?
		PROBE for 4: Are these challenges the same for all persons with disabilities, or do they differ by sex, age, locations, type of impairment, or ethnicity? Please explain.
	5	In your view, what are the steps that 1) the government (national, provincial, and district level); 2) TVET colleges, and 3) the private sector can take to improve the economic self-sufficiency of persons with disabilities?
	6	And what can the community (local DPOs, NPAs, care givers, local leaders) do to increase persons with disabilities access to training and income generating opportunities?
		PROBE 5 and 6: What are the necessary conditions for these steps to be completed? Laws, regulations, coordination among stakeholders, economy, etc. Is it necessary for the GoL and communities to work together? How?
	7	Where do persons with disabilities face the *most* challenges - **in achieving good health care, accessing education, or accessing employment** in Laos (pick one)? Please explain.
	8	Do you think the government and health/TVET providers or the community is more important in improving the lives of persons with disabilities *(or - who is most important for improving the lives of persons with disabilities in Laos?)*? Why do you think that? Please explain.
System Policy Framework	1	To your knowledge, what is the status of the new Disability Law, National Disability Policy, Strategy and Action Plan (MoLSW) and the National Rehabilitation Strategy and Action plan (MOH)?
	2	Currently, to what extent are these policies/plans implemented at the local level (in communities, in service centers, in local governments)? How so/in what ways? If not, why not? [GO TO Ranking Question on Laws and Regulations]

Evaluation Topic	No.	Question
GOL Capacity	1	In your view, does the GOL have the necessary budget and personnel to implement (and monitor) these policies (or other current laws regarding rehabilitation and disability)? If not, explain any financial and personnel related challenges they face.
	2	In your view, does the GOL have the necessary technologies, materials, and tools to implement these policies (or other current laws regarding rehabilitation and disability)? If not, explain any technologies related challenges they face. [GO TO Ranking Question on Financial, Personnel, Technology Capacity]
Coordination /communication	1	How would you describe current coordination and information sharing efforts among DPOs/INGOs/organizations working on inclusive development approaches? Who coordinates and/or shares information? At what frequency? About what topics? How do you share information with the GoL? Who coordinates and/or shares information? At what frequency? About what topics?
	2	Are there any type of coordination and information sharing (between Govt-donors or donors-INGOs, for example) that work better than others? Please explain. [GO TO Ranking Question on Coordination and Data Systems Capacity]
Stakeholder commitment	1	In your opinion, is the country of Laos (and its diverse communities) ready for more inclusion of persons with disabilities in society? Why or why not?
	2	How have you/your organization supported the implementation of the National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan, or how do you plan to support it if you have not yet done so?
	3	Do you/your organization believe National Disability Policy, Strategy and Action Plan and the National Rehabilitation Strategy and Action plan will be successful at improving the lives of persons with disabilities? Why or why not? [GO TO Ranking Question on Commitment and Society Willingness]
Persons with disabilities engagement in community	1	In your opinion, to what extent are persons with disabilities engaged with and involved in their communities?
	2	If not, what is preventing persons with disabilities from engaging with their communities?
Persons with disabilities engagement with the GoL	1	To your knowledge, to what extent and how are persons with disabilities able to meet with GoL (implementing) and provide input/feedback?
	2	Should persons with disabilities' engagement with GoL be increased? Why or why not? How?
Sustainability/Success Factors	1	When we first started our discussion, you shared about the challenges persons with disabilities face in health and employment. What is important to ensure that persons with disabilities can get improved health/economic sufficiency (as a DPO advocating to the GoL) in the long term?

Respondent ID:

System Capacity Topic	Rating				
	1 – Very Poor	2 - Poor	3 – Fair	4 – Satisfactory	5 – Very Satisfactory
National Disability/Rehabilitation Strategy and Action Plans (defining how to implement and monitor support services for persons with disabilities) Disability Law and the National Disability Strategy and Action Plan (MoLSW) National Rehabilitation Strategy and Action Plan (MoH)					
GOL Financial capacity (to implement and monitor plans/strategies)					
GOL Personnel (to implement and monitor plans/strategies)					
Technologies and medicines available within health facilities (to implement plans/strategies)					
GOL Coordination capacity (to implement and monitor plans/strategies)					
GOL and stakeholder data system capacity (to monitor plans/strategies)					
GOL commitment/seriousness (to implement plans/strategies)					
Society commitment/willingness (for more inclusion)					

CONSENT SCRIPTS (LAO)

ເນື້ອໃນຂໍ່ອະນຸຍາດເຂົ້າຮ່ວມການໃຫ້ຂໍ້ມູນ/ສົນທະນາກຸ່ມ

ການສົນທະນາກຸ່ມກັບຄົນພິການ

ສະບາຍດີ, ຂ້ອຍຊື່ _____ ແລະຂ້ອຍແມ່ນພະນັກງານ ບໍລິສັດວິໄຈຂໍ້ມູນຊຸມຊົນ,

ເປັນບໍລິສັດທີ່ເຮັດວຽກເກັບຂໍ້ມູນ ຕ່າງໜ້າໃຫ້ ບໍລິສັດ Social Impact, ທີ່ເຮັດວິໄຈ ປະຈຳຢູ່ ສະຫະລັດ ເຊິ່ງເຮັດວຽກພາຍໃຕ້ສັນຍາຂອງຕົວແທນລັດຖະບານສະຫະລັດເພື່ອການພັດທະນາສາກົນ (USAID).

ພວກເຮົາກຳລັງເຮັດຄົ້ນຄ້ວາວິໄຈກ່ຽວກັບຄົນພິການໃນ ສປປລາວ ເພື່ອຮຽນຮູ້ວ່າ ແມ່ນຫຍັງທີ່ສາມາດສົ່ງເສີມ ຄົນພິການໃນປີຂ້າງ ອານາຄົດ). ມື້ນີ້ພວກເຮົາຢາກຈັດສົນທະນາກຸ່ມກັບທ່ານ ແລະຜູ້ເຂົ້າຮ່ວມປະມານ 6
ຄົນເພື່ອເຂົ້າໃຈຕື່ມກ່ຽວກັບປະສົບການຂອງຄົນໃນຊຸມຊົນໃນການຢູ່ຮ່ວມກັບຄົນພິການ, ລວມທັງປະສົບການຂອງເຂົາໃນການເຂົ້າເຖິງ ການຮັກສາສຸຂະພາບ, ການສຶກສາ ແລະ ການຈ້າງງານ, ແລະປະສົບການຂອງພວກເຂົາໃນການເຂົ້າຮ່ວມສັງຄົມ ແລະ ລະບົບລະບຽບແລະ ການສະໜອງການບໍລິການ ຕ່າງໆ.

ທ່ານໄດ້ຖືກຄັດເລືອກຈາກລາຍຊື່ຈາກ mobility challenged individuals

ທີ່ໄດ້ຮັບການບໍລິການຈາກ [name of DPO ລະບຸຊື່ຂອງອົງການຈັດຕັ້ງດ້ານຄົນພິການ]/ ຈາກບັນຊີຂອງ mobility challenged individuals ທີ່ເຮັດວຽກໃຫ້ກັບ [ ] ລະບຸຊື່ຂອງອົງການຈັດຕັ້ງດ້ານຄົນພິການ ສຳລັບການເຂົ້າຮ່ວມໃນການວິໄຈຄັ້ງນີ້ເພາະວ່າທ່ານອາໃສໃນເຂດທີ ກິດຈະກຳຂອງ USAID ເຊິ່ງຈະເລີ່ມຈັດຕັ້ງປະຕິບັດໃນປີ (2019).
ການຄົ້ນຄ້ວາວິໄຈຂອງພວກເຮົາແມ່ນລວມມີການໂອ້ລົມກັບຄົນພິການ ໃນລະຫວ່າງ 36 ຫາ 48 ຄົນ, ແລະ ທັງໝົດແມ່ນມີລະຫວ່າງ 118 ຫາ 144 ຄົນທີ່ໄດ້ຮັບຟີຈາລະນາສຳລັບກິດຈະກຳ ໂຄງການທີ່ຈະຈັດຕັ້ງປະຕິບັດໃນອະນາຄົດທີ່ຈະເຖິງນີ້.

ການສົນທະນາມື້ນີ້ຈະໃຊ້ເວລາປະມານ 60-90 ນາທີ
ແຕ່ທ່ານສາມາດຢຸດການເຂົ້າຮ່ວມຫຼືອອກຈາກຫ້ອງນີ້ຍາມໃດ

ກໍ່ໄດ້ໂດຍບໍ່ມີຜົນຫຍັງ. ຖ້າວ່າໃນລະຫວ່າງການສົນທະນາ, ພວກເຮົາຖາມຄຳຖາມທີ່ທ່ານບໍ່ຢາກຕອບ, ທ່ານບໍ່ຕ້ອງຕອບ. ທ່ານບໍ່ຈຳເປັນຕ້ອງເວົ້າກ່ຽວກັບປະສົບການສ່ວນຕົວຂອງທ່ານເອງທີ່ທ່ານຮູ້ສຶກບໍ່ສະດວກ, ທ່ານສາມາດເລືອກທີ່ຈະເວົ້າທົ່ວໄປກ່ຽວກັບປະສົບການຂອງຄົນພິການໃນຊຸມຊົນຂອງທ່ານຫຼືໃນ ສປປລາວ.

ການເຂົ້າຮ່ວມການສົນທະນາຂອງທ່ານແມ່ນແບບສະໝັກໃຈແລະທ່ານບໍ່ໄດ້ຢູ່ພາຍໃຕ້ຂໍ້ບັງຄັບໃດໃນການເຂົ້າ ຮ່ວມ.
ພວກເຮົາຈະບັນທຶກການສົນທະນາເປັນລາຍລັກອັກສອນແລະອັດສຽງການສົນທະນາເພື່ອໃຫ້ພວກເຮົາຈື່

ວ່າທ່ານໄດ້ບອກຫຍັງເຮົາແດ່. ການບັນທຶກລາຍລັກອັກສອນແລະການອັດສຽງຈະບໍ່ລວມເອົາຊື່ ຂອງທ່ານ. ການບັນທຶກສຽງແມ່ນຈະໃຊ້ໄວ້ເພື່ອໃຫ້ທົບທວນບັນທຶກທີ່ເຮົາຈົດໄວ້ເທົ່ານັ້ນໃຫ້ສົມບູນແລະພວກເຮົາຈະລຶບ ບັນ

ທຶກສຽງທັງໝົດຫຼັງຈາກທີ່ເຮົາບັນທຶກລາຍລັກອັກສອນແລ້ວ, ທີມງານຈະບໍ່ເອົາຂໍ້ມູນສ່ວນໂຕຂອງທ່ານໃຫ້ USAID. ສຳລັບບົດລາຍງານທີ່ພວກເຮົາຈະຂຽນກ່ຽວກັບວິໄຈນີ້, ຄຳຕອບຂອງທ່ານຈະໄດ້ຮ້ອບຮວມເຂົ້າກັບຄົນອື່ນແລະນຳສະເໜີໃນລັກສະນະສະຫຼຸບລວມ. ຂໍ້ມູນໃດນຶ່ງທີ່ມີການບົ່ງຊີ້ກ່ຽວກັບຕົວຕົນຂອງທ່ານຈະຖືກເກັບເປັນຄວາມລັບຢ່າງເຕັມທີ່ພາຍໃຕ້ກົດໝາຍທ້ອງຖິ່ນແລະນະໂຍບາຍຂອງລັດຖະບານສະຫະລັດ.

ທ່ານຈະໄດ້ຮັບຄ່າຕອບແທນເປັນຈຳນວນເງິນ 50,000 ກີບ (ປະມານຫຼຸດ $6ໂດລາສະຫະລັດ ໜ້ອຍນຶ່ງ) ຫຼັງຈາກສຳເລັດການສົນທະນາກຸ່ມແລ້ວ. ນອກຈາກນັ້ນ, ບໍ່ມີຜົນປະໂຫຍດໂດຍຕົງອັນໃດທີ່ທ່ານ

ຈະໄດ້ຮັບໃນການເຂົ້າຮ່ວມການສົນທະນານີ້. ການເຂົ້າຮ່ວມຂອງທ່ານແລະຄຳຕອບຂອງທ່ານຕໍ່ທຸກຄຳຖາມແມ່ນບໍ່ມີຄວາມກ່ຽວຂ້ອງຕໍ່ການເຂົ້າເຖິງການບໍລິການອື່ນໆໃນອະນາຄົດຈາກ [ລະບຸຊື່ຂອງອົງການຈັດຕັ້ງ

ດ້ານຄົນພິການ [ ] ຫຼື USAID. ພວກເຮົາຄາດວ່າການເຂົ້າຮ່ວມຂອງທ່ານຈະບໍ່ສົ່ງຄວາມສ່ຽງອັນໃດສຳລັບທ່ານ ໃນການເຂົ້າຮ່ວມນອກຈາກໃຊ້ເວລາໃນການສົນທະນາທີ່ທ່ານອາດຈະນຳໃຊ້ໄປເຮັດວຽກອື່ນ. ຮູບແບບຂອງການສຳພາດກຸ່ມແມ່ນທີມງານວິໄຈບໍ່ສາມາຮັບປະກັນຄວາມລັບ, ແຕ່ພວກເຮົາ ຂໍໃຫ້ຜູ້ເຂົ້າຮ່ວມສົນທະນາກຸ່ມໃຫ້ຕົກລົງວ່າບໍ່ຄວນແລກປ່ຽນການສົນທະນາພາຍໃນກຸ່ມນີ້ໃຫ້ຜູ້ອື່ນທີ່ນອກເໜືອຈາກຜູ້ທີ່ເຂົ້າຮ່ວມການສົນທະນາກຸ່ມນີ້.

ຖ້າທ່ານມີຄວາມກັງວົນ, ທ່ານສາມາດຕິດຕໍ່ກັບ ນ ບົວສະຫວັນ ຂັນທະພັດ ທີ່ Lao Social Research ເບີໂທ 020 5550 2806 ແລະ email: laosocialresearch@gmail.com ຫຼື ຄະນະບໍລິຫານຂອງ Social Impact Institutional Review ໄດ້ທີ່ irb@socialimpact.com ຫຼື +1 703 465 1884 ພ້ອມດ້ວຍຄຳຖາມກ່ຽວກັບການສຶກສາແລະຜົນຂອງການສຶກສານີ້. ນອກຈາກນັ້ນ, ທ່ານສາມາດພົວພັນກັບຫົວໜ້າປະເມີນຜົນທີ່ USAID, ທ່ານ ນາງ. ນິກູນ ຈິດໄທ (Nigoon Jitthai) ທີ່ njitthai@usaid.gov ຫຼື +66 2 257 3131. ຂ້າພະເຈົ້າຈະປະສຳເນົາແບບຟອມປະເມີນຜົນພື້ນຖານນີ້ໄວ້ກັບທ່ານ ແລະ ຈົດໝາຍແນະນຳກ່ຽວກັບ ການປະເມີນຜົນຈາກ ທີມພັດທະນາເຂດພາກພື້ນຂອງອາຊີຂອງ ຕົວແທນລັດຖະບານສະຫະລັດເພື່ອການພັດທະນາສາກົນ ຫຼື USAID's Regional Development Mission for Asia (RDMA).

ທ່ານມີຄຳຖາມຫຍັງບໍ?

ທ່ານເຂົ້າໃຈບໍການເຂົ້າຮ່ວມຂອງທ່ານແມ່ນສະໝັກໃຈ? ແມ່ນ_____ ບໍ່ແມ່ນ _____

ທ່ານເຂົ້າໃຈວ່າທ່ານສາມາດຢຸດການເຂົ້າຮ່ວມໄດ້ທຸກເມື່ອ? ແມ່ນ_____ ບໍ່ແມ່ນ _____

ຂໍ້ຄວາມອະນຸຍາດ: ຂ້າພະເຈົ້າເຂົ້າໃຈແລະເຫັນດີໃນການເຂົ້າຮ່ວມການສຶກສານີ້.

ຜູ້ຕອບອະນຸຍາດເຂົ້າຮ່ວມ (ອະນຸຍາດໂດຍປາກເປົ່າ 1): ແມ່ນ_____ ບໍ່ແມ່ນ _____

ຂໍ້ຄວາມອະນຸຍາດ: ຂ້າພະເຈົ້າເຂົ້າໃຈແລະເຫັນດີໃນການບັນທຶກ ສຽງເພື່ອຈຸດປະສົງການບັນທຶກຂໍ້ມູນເທົ່ານັ້ນ.

ຜູ້ຕອບອະນຸຍາດສຳລັບການບັນທຶກສຽງ (ອະນຸຍາດໂດຍປາກເປົ່າ 2): ແມ່ນ_____ ບໍ່ແມ່ນ _____

ການສົນທະນາກຸ່ມກັບພະນັກງານອ່ານອອຍຄວາມສະດວກດ້ານສຸຂະພາບແລະສຶກສາ

ສະບາຍດີ, ຂ້ອຍຊື່ _____ ແລະຂ້ອຍແມ່ນພະນັກງານ ບໍລິສັດວິໄລຂໍ້ມູນລຸມລຸ່ມ,

ເປັນບໍລິສັດທີ່ເຮັດວຽກເກັບຂໍ້ມູນ ຕ່າງໜ້າໃຫ້ ບໍລິສັດ Social Impact, ທີ່ເຮັດວິໄຈ ປະຈຳຢູ່ ສະຫະລັດ ເຊິ່ງເຮັດວຽກພາຍໃຕ້ສັນຍາຂອງຕົວແທນລັດຖະບານສະຫະລັດເພື່ອການພັດທະນາສາກົນ (USAID).

ພວກເຮົາກຳລັງເຮັດຄົ້ນຄ້ວາວິໄລກ່ຽວກັບຄົນພິການໃນ ສປປລາວ ເພື່ອຮຽນຮູ້ວ່າ
ແມ່ນຫຍັງທີ່ສາມາດສົ່ງເສີມ ຄົນພິການໃນປີຂ້າງ ອານາຄົດ). ມື້ນີ້ພວກເຮົາຢາກຈັດສົນທະນາກຸ່ມກັບທ່ານ ແລະຜູ້ເຂົ້າຮ່ວມປະມານ 6
ຄົນເພື່ອເຂົ້າໃຈຕື່ມກ່ຽວກັບປະສົບການຂອງຄົນໃນຊຸມຊົນໃນການຢູ່ຮ່ວມກັບຄົນພິການ,
ລວມທັງປະສົບການຂອງເຂົາໃນການເຂົ້າເຖິງ ການຮັກສາສຸຂະພາບ, ການສຶກສາ ແລະ ການຈ້າງງານ,
ແລະປະສົບການຂອງພວກເຂົາໃນການເຂົ້າຮ່ວມສັງຄົມ ແລະ ລະບົບລະບຽບແລະ ການສະໜອງການບໍລິການ ຕ່າງໆ.

ທ່ານໄດ້ຖືກຄັດເລືອກຈາກລາຍຊື່ຈາກ mobility challenged individuals

ທີ່ໄດ້ຮັບການບໍລິການຈາກ [name of DPO ລະບຸຊື່ຂອງອົງການຈັດຕັ້ງດ້ານຄົນພິການ]/ ຈາກບັນຊີຂອງ mobility challenged individuals ທີ່ເຮັດວຽກໃຫ້ກັບ [ ] ລະບຸຊື່ຂອງອົງການຈັດຕັ້ງດ້ານຄົນພິການ
ສຳລັບການເຂົ້າຮ່ວມໃນການວິໄລຄັ້ງນີ້ເພາະວ່າທ່ານອາໃສໃນເຂດທີ ກິດຈະກຳຂອງ USAID
ເຊິ່ງຈະເລີ່ມຈັດຕັ້ງປະຕິບັດໃນປີ (2019).
ການຄົ້ນຄ້ວາວິໄລຂອງພວກເຮົາແມ່ນລວມມີການໂອ້ລົມກັບຄົນພິການ ໃນລະຫວ່າງ 36 ຫາ 48 ຄົນ, ແລະ ທັງໝົດແມ່ນມີລະຫວ່າງ 118 ຫາ 144 ຄົນທີ່ໄດ້ຮັບຜົລກະທົບສຳລັບກິດຈະກຳ
ໂຄງການທີ່ຈະຈັດຕັ້ງປະຕິບັດໃນອະນາຄົດທີ່ຈະເຖິງນີ້.

ການສົນທະນາມື້ນີ້ຈະໃຊ້ເວລາປະມານ 60-90 ນາທີ
ແຕ່ທ່ານສາມາດຢຸດການເຂົ້າຮ່ວມຫຼືອອກຈາກຫ້ອງນີ້ຍາມໃດ

ກໍ່ໄດ້ໂດຍບໍ່ມີຜົນຫຍັງ. ຖ້າວ່າໃນລະຫວ່າງການສົນທະນາ, ພວກເຮົາຖາມຄຳຖາມທີ່ທ່ານບໍ່ຢາກຕອບ,
ທ່ານບໍ່ຕ້ອງຕອບ. ທ່ານບໍ່ຈຳເປັນຕ້ອງເວົ້າກ່ຽວກັບປະສົບການສ່ວນຕົວຂອງທ່ານເອງທີ່ທ່ານຮູ້ສຶກບໍ່ສະດວກ,
ທ່ານສາມາດເລືອກທີ່ຈະເວົ້າທົ່ວໄປກ່ຽວກັບປະສົບການຂອງຄົນພິການໃນຊຸມຊົນຂອງທ່ານຫຼືໃນ ສປປລາວ.

ການເຂົ້າຮ່ວມການສົນທະນາຂອງທ່ານແມ່ນແບບສະໝັກໃຈແລະທ່ານບໍ່ໄດ້ຢູ່ພາຍໃຕ້ຂໍ້ບັງຄັບໃດໃນການເຂົ້າ
ຮ່ວມ.
ພວກເຮົາຈະບັນທຶກການສົນທະນາເປັນລາຍລັກອັກສອນແລະອັດສຽງການສົນທະນາເພື່ອໃຫ້ພວກເຮົາຈື່

ວ່າທ່ານໄດ້ບອກຫຍັງເຮົາແດ່. ການບັນທຶກລາຍລັກອັກສອນແລະການອັດສຽງຈະບໍ່ລວມເອົາຊື່ ຂອງທ່ານ.
ການບັນທຶກສຽງແມ່ນຈະໃຊ້ໄວ້ເພື່ອໃຫ້ທົບທວນບັນທຶກທີ່ເຮົາຈົດໄວ້ເທົ່ານັ້ນໃຫ້ສົມບູນແລະພວກເຮົາຈະລຶບ ບັນ
ທຶກສຽງທັງໝົດຫຼັງຈາກທີ່ເຮົາບັນທຶກລາຍລັກອັກສອນແລ້ວ. ທີມງານຈະບໍ່ເອົາຂໍ້ມູນສ່ວນໂຕຂອງທ່ານໃຫ້ USAID. ສຳລັບບົດລາຍງານທີ່ພວກເຮົາຈະຂຽນກ່ຽວກັບວິໄລນີ້,
ຄຳຕອບຂອງທ່ານຈະໄດ້ຮວບຮວມເຂົ້າກັບຄົນອື່ນແລະນຳສະເໜີໃນລັກສະນະສະຫຼຸບລວມ.

ຂໍ້ມູນໃດນຶ່ງທີ່ມີການບົ່ງຊີ້ກ່ຽວກັບຕົວຕົນຂອງທ່ານຈະຖືກເກັບເປັນຄວາມລັບຢ່າງເຕັມທີ່ພາຍໃຕ້ກົດໝາຍທ້ອງຖິ່ນແລະນະໂຍບາຍຂອງລັດຖະບານສະຫະລັດ.

ທ່ານຈະໄດ້ຮັບຄ່າຕອບແທນເປັນຈຳນວນເງິນ 50,000 ກີບ (ປະມານຫຼຸດ $6ໂດລາສະຫະລັດ ໜ້ອຍນຶ່ງ) ຫຼັງຈາກສຳເລັດການສົນທະນາກຸ່ມແລ້ວ. ນອກຈາກນັ້ນ, ບໍ່ມີຜົນປະໂຫຍດໂດຍຕົງອັນໃດທີ່ທ່ານ

ຈະໄດ້ຮັບໃນການເຂົ້າຮ່ວມການສົນທະນານີ້. ການເຂົ້າຮ່ວມຂອງທ່ານແລະຄຳຕອບຂອງທ່ານຕໍ່ທຸກຄຳຖາມແມ່ນບໍ່ມີຄວາມກ່ຽວຂ້ອງຕໍ່ການເຂົ້າເຖິງການບໍລິການອື່ນໆໃນອະນາຄົດຈາກ [ລະບຸຊື່ຂອງອົງການຈັດຕັ້ງ

ດ້ານຄົນພິການ [ ] ຫຼື USAID. ພວກເຮົາຄາດວ່າການເຂົ້າຮ່ວມຂອງທ່ານຈະບໍ່ສົ່ງຄວາມສ່ຽງ
ອັນໃດສຳລັບທ່ານ
ໃນການເຂົ້າຮ່ວມນອກຈາກໃຊ້ເວລາໃນການສົນທະນາທີ່ທ່ານອາດຈະນຳໃຊ້ໄປເຮັດວຽກອື່ນ.
ຮູບແບບຂອງການສຳພາດກຸ່ມແມ່ນທີມງານວິໄຈບໍ່ສາມາຮັບປະກັນຄວາມລັບ, ແຕ່ພວກເຮົາ ຂໍໃຫ້
ຜູ້ເຂົ້າຮ່ວມສົນທະນາກຸ່ມໃຫ້ຕົກລົງວ່າບໍ່ຄວນແລກປ່ຽນການສົນທະນາພາຍໃນກຸ່ມນີ້ໃຫ້ຜູ້
ອື່ນທີ່ນອກເໜືອຈາກຜູ້ທີ່ເຂົ້າຮ່ວມການສົນທະນາກຸ່ມນີ້.

ຖ້າທ່ານມີຄວາມກັງວົນ, ທ່ານສາມາດຕິດຕໍ່ກັບ ນ ບົວສະຫວັນ ຂັນທະພັດ ທີ່ Lao Social Research ເບີໂທ 020 5550 2806 ແລະ email: laosocialresearch@gmail.com ຫຼື ຄະນະບໍລິຫານຂອງ Social Impact Institutional Review ໄດ້ທີ່ irb@socialimpact.com ຫຼື +1 703 465 1884
ພ້ອມດ້ວຍຄຳຖາມກ່ຽວກັບການສຶກສາແລະຜົນຂອງການສຶກສານີ້. ນອກຈາກນັ້ນ,
ທ່ານສາມາດພົວພັນກັບຫົວໜ້າປະເມີນຜົນທີ່ USAID, ທ່ານ ນາງ. ນິກູນ ຈິດໄທ (Nigoon Jitthai) ທີ່ njitthai@usaid.gov ຫຼື +66 2 257 3131. ຂ້າພະເຈົ້າຈະປະສຳເນົາແບບຟອມປະເມີນຜົນຜົນຖານນີ້ໄວ້ກັບທ່ານ ແລະ ຈົດໝາຍແນະນຳກ່ຽວກັບ ການປະເມີນຜົນຈາກ ທີມພັດທະນາເຂດພາກພື້ນຂອງອາຊີຂອງ ຕົວແທນລັດຖະບານສະຫະລັດເພື່ອການພັດທະນາສາກົນ ຫຼື USAID's Regional Development Mission for Asia (RDMA).

ທ່ານມີຄຳຖາມຫຍັງບໍ?

ທ່ານເຂົ້າໃຈບໍການເຂົ້າຮ່ວມຂອງທ່ານແມ່ນສະໝັກໃຈ? ແມ່ນ_____ ບໍ່ແມ່ນ _____

ທ່ານເຂົ້າໃຈທ່ານສາມາດຢຸດການເຂົ້າຮ່ວມໄດ້ທຸກເມື່ອ? ແມ່ນ_____ ບໍ່ແມ່ນ _____

ຂໍ້ຄວາມອະນຸຍາດ: ຂ້າພະເຈົ້າເຂົ້າໃຈແລະເຫັນດີໃນການເຂົ້າຮ່ວມການສຶກສານີ້.

ຜູ້ຕອບອະນຸຍາດເຂົ້າຮ່ວມ (ອະນຸຍາດໂດຍປາກເປົ່າ 3): ແມ່ນ_____ ບໍ່ແມ່ນ _____

ຂໍ້ຄວາມອະນຸຍາດ:
ຂ້າພະເຈົ້າເຂົ້າໃຈແລະເຫັນດີໃນການບັນທຶກເພື່ອຈຸດປະສົງການບັນທຶກສັງລວມຂໍ້ມູນເທົ່ານັ້ນ. ຜູ້ຕອບອະນຸຍາດສຳລັບການບັນທຶກສຽງ (ອະນຸຍາດໂດຍປາກເປົ່າ 4): ແມ່ນ_____ ບໍ່ແມ່ນ _____

ການສຳພາດ (ສຳລັບການຕອບທຸກປະເພດ)

ສະບາຍດີ, ຂ້ອຍຊື່ _____ ແລະຂ້ອຍແມ່ນພະນັກງານ ບໍລິສັດວິໄຈຂໍ້ມູນຊຸມຊົນ,

ເປັນບໍລິສັດທີ່ເຮັດວຽກເກັບຂໍ້ມູນ ຕ່າງໜ້າໃຫ້ ບໍລິສັດ Social Impact, ທີ່ເຮັດວິໄຈ ປະຈຳຢູ່ ສະຫະລັດ
ເຊິ່ງເຮັດວຽກພາຍໃຕ້ສັນຍາຂອງຕົວແທນລັດຖະບານສະຫະລັດເພື່ອການພັດທະນາສາກົນ (USAID).

ພວກເຮົາກຳລັງເຮັດຄົ້ນຄ້ວາວິໄຈກ່ຽວກັບຄົນພິການໃນ ສປປລາວ ເພື່ອຮຽນຮູ້ວ່າ
ແມ່ນຫຍັງທີ່ສາມາດເຮັດໃຫ້ສິ່ງເສີມ ຄົນພິການໃນອະນາຄົດຂ້າງໜ້ານີ້. ມື້ນີ້ພວກເຮົາຢາກຂໍ ສຳພາດທ່ານ
ເພື່ອເຂົ້າໃຈຕື່ມກ່ຽວກັບປະສົບການຂອງຄົນໃນຊຸມຊົນໃນການຢູ່ກັບຄົນພິການ,
ລວມທັ້ງປະສົບການຂອງເຂົາໃນການເຂົ້າເຖິງ ການຮັກສາສຸຂະພາບ, ການສຶກສາ ແລະ ວຽກງານ,
ແລະປະສົບການຂອງພວກເຂົາໃນການເຂົ້າຮ່ວມສັງຄົມແລະລະບົບລະບຽບແລະການສະໜອງການບໍລິການຕ່
າງໆ.

ທ່ານໄດ້ຖືກຄັດເລືອກຈາກລາຍຊື່ຈາກ mobility challenged individuals ທີ່ໄດ້ຮັບການບໍລິການຈາກ [
ລະບຸຊື່ຂອງອົງການຈັດຕັ້ງດ້ານຄົນພິການ]/ ຈາກບັນຊີຂອງ mobility challenged individuals ທີ່ເຮັດວຽກໃຫ້ກັບ
[ລະບຸຊື່ຂອງອົງການຈັດຕັ້ງດ້ານຄົນພິການ]
ສຳລັບການເຂົ້າຮ່ວມໃນການວິໄຈຄັ້ງນີ້ເພາະວ່າທ່ານອາໃສໃນເຂດທີ່ ກິດຈະກຳຂອງ USAID
ເຊິ່ງຈະເລີ່ມຈັດຕັ້ງປະຕິບັດໃນປີ (2019).
ການຄົ້ນຄ້ວາວິໄຈຂອງພວກເຮົາແມ່ນລວມມີການໂອ້ລົມກັບຄົນພິການໃນລະຫວ່າງ 36 ຫາ 48 ຄົນ, ແລະ
ທັງໝົດແມ່ນມີລະຫວ່າງ 118 ຫາ 144
ຄົນທີ່ໄດ້ຮັບພິຈາລະນາສຳລັບກິດຈະກຳໂຄງການທີ່ຈະຈັດຕັ້ງປະຕິບັດໃນອະນາຄົດທີ່ຈະເຖິງນີ້.

ການສົນທະນາມື້ນີ້ຈະໃຊ້ເວລາປະມານ 60 ນາທີ
ແຕ່ທ່ານສາມາດຢຸດການເຂົ້າຮ່ວມຫຼືອອກຈາກຫ້ອງນີ້ຍາມໃດ

ກໍ່ໄດ້ໂດຍບໍ່ມີຜົນຫຍັງ. ຖ້າວ່າໃນລະຫວ່າງການສົນທະນາ, ພວກເຮົາຖາມຄຳຖາມທີ່ທ່ານບໍ່ຢາກຕອບ,
ທ່ານບໍ່ຕ້ອງຕອບ. ທ່ານບໍ່ຈຳເປັນຕ້ອງເວົ້າກ່ຽວກັບປະສົບການສ່ວນຕົວຂອງທ່ານເອງທີ່ທ່ານຮູ້ສຶກບໍ່ສະດວກ,
ທ່ານສາມາດເລືອກທີ່ຈະເວົ້າທົ່ວໄປກ່ຽວກັບປະສົບການຂອງຄົນພິການໃນຊຸມຊົນຂອງທ່ານຫຼືໃນ ສປປລາວ.

ການເຂົ້າຮ່ວມການສົນທະນາຂອງທ່ານແມ່ນແບບສະໝັກໃຈແລະທ່ານບໍ່ໄດ້ຢູ່ພາຍໃຕ້ຂໍ້ບັງຄັບໃດໃນການເຂົ້
າ

ຮ່ວມ.
ພວກເຮົາຈະບັນທຶກການສົນທະນາເປັນລາຍລັກອັກສອນແລະອັດສຽງການສົນທະນາເພື່ອໃຫ້ພວກເຮົາຈື່
ວ່າທ່ານໄດ້ບອກຫຍັງເຮົາແດ່. ການບັນທຶກລາຍລັກອັກສອນແລະການອັດສຽງຈະບໍ່ລວມເອົາຊື່ ຂອງທ່ານ.
ການບັນທຶກສຽງແມ່ນຈະໃຊ້ໄວ້ເພື່ອໃຫ້ທີມທອນບັນທຶກທີ່ເຮົາຈ້ດໄວ້ເທົ່ານັ້ນໃຫ້ສົມບູນແລະພວກເຮົາຈະລຶບ
ບັນ

ທຶກສຽງທັງໝົດຫຼັງຈາກທີ່ເຮົາບັນທຶກລາຍລັກອັກສອນແລ້ວ.
ທີມງານຈະບໍ່ເອົາຂໍ້ມູນສ່ວນໂຕໃນຂອງທ່ານໃຫ້ USAID.
ສຳລັບບົດລາຍງານທີ່ພວກເຮົາຈະຂຽນກ່ຽວກັບວິໄຈນີ້,
ຄຳຕອບຂອງທ່ານຈະໄດ້ຮ້ອບຮອມເຂົ້າກັບຄົນອື່ນແລະນຳສະເໜີໃນລັກສະນະສະຫຼຸບລວມ.
ຂໍ້ມູນໃດນຶ່ງທີ່ມີການບົ່ງຊີ້ກ່ຽວກັບຕົວຕົນຂອງທ່ານຈະຖືກເກັບເປັນຄວາມລັບຢ່າງເຕັມທີ່ພາຍໃຕ້ກົດໝາຍ
ທ້ອງຖິ່ນແລະນະໂຍບາຍຂອງລັດຖະບານສະຫະລັດ.

ບໍ່ມີຜົນປະໂຫຍດໂດຍກົງຫຼືງົບປະມານໃດໆທີ່ທ່ານຈະໄດ້ຮັບ ໃນການເຂົ້າຮ່ວມການສົນທະນານີ້.
ການເຂົ້າຮ່ວມຂອງທ່ານແລະຄຳຕອບຂອງທ່ານ
ຕໍ່ທຸກຄຳຖາມແມ່ນບໍ່ມີຄວາມກ່ຽວຂ້ອງຕໍ່ການເຂົ້າເຖິງການບໍລິການອື່ນໆໃນອະນາຄົດຈາກ ກິດຈະກຳ ຂອງ USAID OKARD ຫຼື ກິດຈະກຳໃດໆຂອງ USAID ໃນປະນາຄົດ.
ການເຂົ້າຮ່ວມຂອງທ່ານຈະບໍ່ສົ່ງຄວາມສ່ຽງອັນໃດສຳລັບທ່ານ ນອກຈາກໃຊ້ເວລາໃນການສຳພາດ ທີ່ທ່ານອາດຈະນຳໃຊ້ ໄປເຮັດວຽກອື່ນ.

ຖ້າທ່ານມີຄວາມກັງວົນ, ທ່ານສາມາດຕິດຕໍ່ກັບ ນ ບົວສະຫວັນ ຂັນທະພັດ ທີ່ Lao Social Research ເບີໂທ 020 5550 2806 ແລະ email: laosocialresearch@gmail.com ຫຼື ຄະນະບໍລິຫານຂອງ Social Impact Institutional Review ໄດ້ທີ່ irb@socialimpact.com ຫຼື +1 703 465 1884
ພ້ອມດ້ວຍຄຳຖາມກ່ຽວກັບການສຶກສາແລະຜົນຂອງການສຶກສານີ້. ນອກຈາກນັ້ນ, ທ່ານສາມາດພົວພັນກັບຫົວໜ້າປະເມີນຜົນທີ່ USAID, ທ່ານ ນາງ. ນິກູນ ຈິດໄທ (Nigoon Jitthai) ທີ່ njitthai@usaid.gov ຫຼື +66 2 257 3131. ຂ້າພະເຈົ້າຈະປະສຳເນົາແບບຟອມປະເມີນຜົນພ້ອມຖານນີ້ໄວ້ກັບທ່ານ ແລະ ຈົດໝາຍແນະນຳກ່ຽວກັບ ການປະເມີນຜົນຈາກ ທີມພັດທະນາເຂດພາກພື້ນຂອງອາຊີຂອງ ຕົວແທນລັດຖະບານສະຫະລັດເພື່ອການພັດທະນາສາກົນ ຫຼື USAID's Regional Development Mission for Asia (RDMA).

ທ່ານມີຄຳຖາມຫຍັງບໍ?

ທ່ານເຂົ້າໃຈບໍການເຂົ້າຮ່ວມຂອງທ່ານແມ່ນສະໝັກໃຈ? ແມ່ນ_____ ບໍ່ແມ່ນ _____

ທ່ານເຂົ້າໃຈທ່ານສາມາດຢຸດການເຂົ້າຮ່ວມໄດ້ທຸກເມື່ອ? ແມ່ນ_____ ບໍ່ແມ່ນ _____

ຂໍ້ຄວາມອະນຸຍາດ: ຂ້າພະເຈົ້າເຂົ້າໃຈແລະເຫັນດີໃນການເຂົ້າຮ່ວມການສຶກສານີ້.

ຜູ້ຕອບອະນຸຍາດເຂົ້າຮ່ວມ (ອະນຸຍາດໂດຍປາກເປົ່າ 5): ແມ່ນ_____ ບໍ່ແມ່ນ _____

ຂໍ້ຄວາມອະນຸຍາດ:
ຂ້າພະເຈົ້າເຂົ້າໃຈແລະເຫັນດີໃນການບັນທຶກເພື່ອຈຸດປະສົງການບັນທຶກສັງລວມຂໍ້ມູນເທົ່ານັ້ນ.ຜູ້

ຜູ້ຕອບອະນຸຍາດສຳລັບການບັນທຶກສຽງ (ອະນຸຍາດໂດຍປາກເປົ່າ 6): ແມ່ນ_____ ບໍ່ແມ່ນ _____

ການສົນທະນາກຸ່ມກັບພະນັກງານອໍານວຍຄວາມສະດວກດ້ານສຸຂະພາບ

ພວກເຮົາມີສອງຢ່າງທີ່ຢາກສົນທະນາກັບພວກທ່ານມື້ນີ້ແມ່ນ.

1. ຫນຶ່ງ,ພວກເຮົາຢາກສົນທະນາແມ່ນຫຍັງທີ່ສາມາດເຮັດໄດ້ເພື່ອເພີ່ມການບໍລິການແລະຄວາມພຶງພໍໃຈກັບການບໍລິການດ້ານສຸຂະພາບທີ່ໄດ້ສະຫນອງຢູ່ສະຖານທີ່ນີ້.

2. ສອງ,ພວກເຮົາຢາກສົນທະນາ
ການພົວພັນໃນປັດຈຸບັນຂອງສິ່ງອໍານວຍຄວາມສະດວກຕໍ່ກັບການບໍລິການໃຫ້ຄົນພິການ.

ພາກທີ I: ການບໍລິການທີ່ມີແກ່ຄົນພິການ

1. **ກະລຸນາອະທິບາຍປະເພດຂອງການບໍລິການສໍາລັບຄົນພິການໃນສະຖານທີ່ບໍລິການແຫ່ງນີ້.**
ຈາກນັ້ນໃຫ້ອະທິບາຍເຖິງການບໍລິການດັ່ງກ່າວໄດ້ຖືກນໍາໃຊ້ມີຄືແນວໃດ ແລະແມ່ນໃຜທີ່ນໍາໃຊ້ (ຊາຍ/ຍິງ /ເດັກນ້ອຍ, ຊົນເຜົ່າ,ສະຖານທີ່,ປະເພດຂອງຄວາມພິການ,ອື່ນໆ). ມີຂໍ້ມູນອັນໃດບໍ ທີ່ສາມາດຢັ້ງຢືນຂໍ້ມູນການນໍາໃຊ້ດັ່ງກ່າວ?

2. **ກະລຸນາອະທິບາຍຫນ້າທີ່ຂອງທ່ານໃນການສະຫນອງການບໍລິການໃຫ້ຄົນພິການ.**

ຕົວຢ່າງ:ອະທິບາຍກ່ຽວກັບການພົວພັນໃນມໍ່ໆນີ້ກັບຄົນພິການທີ່ມາໃຊ້ບໍລິການໃນສະຖານທີ່ນີ້–ພວກເຂົາມາຊອກຫາການປິ່ນປົວຫຍັງ?

ທ່ານມີບົດບາດແນວໃດໃນການສະຫນອງການບໍລິການໃຫ້ພວກເຂົາ?

ທ່ານໄດ້ໃຫ້ບໍລິການແກ່ຄົນພິການເລື້ອຍປານໃດ? (ຈໍານວນຄັ້ງຕໍ່ເດືອນ)?

3. **ທ່ານຄິດວ່າຄົນພິການທີ່ນໍາໃຊ້ການບໍລິການຂອງທ່ານມີຄວາມພໍໃຈໃນການບໍລິການທີ່ພວກເຂົາໄດ້ຮັບຢູ່ນີ້ບໍ?** ກະລຸນາໃຫ້ຄະແນນ 1 ຫາ 5 (1 ບໍ່ພໍໃຈຫລາຍ, 2 ບໍ່ພໍໃຈ, 3 ທໍາມະດາ, 4 ພໍໃຈ, 5 ພໍໃຈຫຼາຍ). ໃຫ້ອະທິບາຍການໃຫ້ຄະແນນຂອງທ່ານ.

ທ່ານມີຂໍ້ມູນຫລັກຖານ ໃນການອ້າງອີງຄໍາເຫັນຂອງທ່ານບໍ?

4. **ສໍາລັບຄົນພິການໃນເຂດນີ້ທີ່ບໍ່ໄດ້ມາໃຊ້ບໍລິການຢູ່ນີ້, ທ່ານຄິດວ່າອັນໃດແມ່ນເປັນເຫດຜົນຫຼັກທີ່ເຮັດໃຫ້ເຂົາບໍ່ມາໃຊ້ບໍລິການຢູ່ນີ້?**
ແມ່ນຫຍັງທີ່ຄວນໄດ້ຮັບການປ່ຽນແປງເພື່ອເຮັດໃຫ້ພວກເຂົາມານໍາໃຊ້ການບໍລິການຂອງທ່ານເພີ່ມຂຶ້ນ?

5. ສົນທະນາເປັນກຸ່ມ:
ແມ່ນຫຍັງທີ່ຄວນໄດ້ຮັບການປ່ຽນແປງໃນການສະຖານທີ່ບໍລິການສຸຂະພາບເພື່ອເພີ່ມຄວາມພໍໃຈສໍາລັບຄົນພິການ ຕໍ່ກັບການບໍລິການດ້ານສຸຂະພາບທີ່ພວກເຂົາໄດ້ຮັບຢູ່ທີ່ນີ້? ຄືດັ່ງສົນທະນາຂ້າງເທິງ, ທ່ານຄິດວ່າບັດໃຈທີ່ບໍ່ພໍໃຈ ອັນໃດຄວນໄດ້ຮັບການແກ້ໄຂ?

ຖ້າທ່ານໄດ້ຮັບການຝຶກອົບຮົມໃນການເບິ່ງແຍງດູແລຄົນພິການ. ທ່ານຄິດວ່າການຝຶກອົບຮົມ ລັກສະນະນີ້ ຈະຊ່ວຍ ທ່ານໄດ້ແນວໃດ? ຜົນກະທົບໃນການຝຶກອົບຮົມດັ່ງກ່າວມີຫຍັງແດ່?

ມັນສົ່ງຜົນກະທົບຕໍ່ຄວາມພໍໃຈ ຂອງຄົນພິການໃນການໃຊ້ບໍລິການບໍ?

ຫລື ຈະມີຜົນຕໍ່ຄວາມພຶງພໍໃຈຂອງຄົນພິການແລະ/ຫຼື ການນໍາໃຊ້ການບໍລິການ ຂອງພວກເຂົາບໍ?

ທ່ານ ຫຼື ສູນບໍລິການແຫ່ງນີ້ ເຄີຍໄດ້ຮັບການຝຶກອົບຮົມການດູແລເບິ່ງແຍງຄົນພິການບໍ ?ຈາກໃຜ? ຖ້າໄດ້ຮັບ, ກະລຸນາອະທິບາຍກ່ຽວກັບການຝຶກອົບຮົມ (ຫົວຂໍ້ທີ່ຝຶກ, ໄລຍະເວລາ, ຄູຝຶກ) ແລະ ໄດ້ຝຶກເມື່ອໃດ?

ພາກທີ II : **ການເຮັດວຽກຂອງລະບົບ**

8. **ທ່ານຮູ້/ໄດ້ຍິນກ່ຽວກັບ ກົດລະບຽບ ຫຼື ກົດໝາຍ ກ່ຽວກັບ ການສະໜອງການບໍລິການ ໃຫ້ຄົນພິການບໍ?** ຖ້າບໍ່ຮູ້,ໃຫ້ຖາມຂໍ້ຕໍ່ໄປ

   a. ຖ້າຮູ້, ທ່ານຮູ້ບໍ່ວ່າລະບຽບ/ກົດໝາຍດັ່ງກ່າວໄດ້ກຳນົດບໍ່ວ່າສະຖານ ທີ່ການບໍລິການ ຄວນມີການດຳເນີນງານແນວໃດ?
   ມັນສ້າງຄວາມແຕກຕ່າງໃນການເຮັດວຽກປະຈຳວັນໃນການບໍລິການຢູ່ນີ້ບໍ? ແຕກຕ່າງຄືແນວໃດ?

   b. ທ່ານຕ້ອງການຫຍັງເພື່ອເຮັດໃຫ້ສາມາດປະຕິບັດ ການປ່ຽນແປງທີ່ຈຳເປັນ ເພື່ອເຮັດໃຫ້ ສະຖານທີ່ການບໍລິການແຫ່ງນີ້ສອດຄ່ອງກັບລະບຽບໃໝ່ເຫຼົ່ານີ້?

   c. ທ່ານມີໂອກາດໄດ້ພົບກັບພາກລັດ ແລະ ໄດ້ສະເໜີຄຳຄິດເຫັນຕໍ່ກົດໝາຍ ແລະ ກົດລະບຽບກ່ຽວກັບການບໍລິການສຳລັບຄົນພິການ ແລະ ການຟື້ນຟູໜ້າທີ່ການບໍ?
   ກະລຸນາອະທິບາຍວ່າແມ່ນຫຍັງ, ມີຄືແນວໃດ ແລະ ຜົນໄດ້ຮັບມີຄືແນວໃດ?

9. ມີນະໂຍບາຍອື່ນບໍ ທີ່ກຳນົດວ່າ ສະຖານທີ່ບໍລິການນີ້ ຄວນມີການດຳເນີນງານແນວໃດ?

   a. ຖ້າມີ, ນະໂຍບາຍດັ່ງກ່າວໄດ້ກຳນົດບໍ່ວ່າສະຖານທີ່ການບໍລິການນີ້ ຄວນມີການດຳເນີນງານແນວໃດ?
   ມັນສ້າງຄວາມແຕກຕ່າງໃນການເຮັດວຽກປະຈຳວັນໃນການບໍລິການຢູ່ນີ້ບໍ?

10. ທ່ານລາຍງານຂໍ້ມູນຫຍັງໃຫ້ທາງກະຊວງສາທາກ່ຽວກັບການບໍລິການໃຫ້ກັບຄົນພິການທີ່ທ່ານສະໜອງ (ຖ້າມີ)?

ຂໍ້ມູນເຫລົ່ານີ້ສາມາດຖືກແຍກອອກໂດຍເປັນປະເພດຂອງຄວາມບົກຜ່ອງຂອງຄວາມພິການ/ຫລືແຍກເປັນປະເພດການຮັບບໍລິການບໍ? ທ່ານໄດ້ມີການສື່ສານພົວພັນກັບ ກະຊວງສາທາ ເລື້ອຍປານໃດ?

11. ທ່ານຫລືຄົນອື່ນທີ່ເຮັດວຽກງານສູນບໍລິການນີ້ໄດ້ເຂົ້າຮ່ວມໃນການຕິດຕາມການປະຕິບັດນະໂຍບາຍແຫ່ງຊາດກ່ຽວກັບການສະໜອງການບໍລິການຄົນພິການແລະການຟື້ນຟູໃນລະດັບໃດ?

   ທ່ານເຄີຍເຂົ້າຮ່ວມເຮັດວຽກກັບກຸ່ມຈັດຕັ້ງປະຕິບັດໃນຫົວຂໍ້ນີ້ບໍ? ກະລຸນາ
   ອະທິບາຍກ່ຽວກັບປະສົບການດັ່ງກ່າວ.

ການສົນທະນາກຸ່ມກັບຜູ້ດູແລຄົນພິການ

ພວກເຮົາມີສອງຢ່າງທີ່ຢາກສົນທະນາກັບພວກທ່ານມື້ນີ້ແມ່ນ.

1. ຫນຶ່ງ,ພວກເຮົາຢາກສົນທະນາການໃຫ້ບໍລິການຕໍ່ກັບຄົນພິການທີ່ທ່ານດູແລ.
2. ສອງ,ພວກເຮົາຢາກສົນທະນາ ການມີສ່ວນຮ່ວມໃນສັງຄົມຂອງຄົນພິການທີ່ທ່ານດູແລ.

ພາກທີ I <u>ສຸຂະພາບ</u>

1. ກ່ຽວກັບການບໍລິການທີ່ເປີດໃຫ້ບໍລິການປັດຈຸບັນໃນເຂດນີ້ ສໍາລັບຄົນພິການທີ່ທ່ານດູແລ**:**

a**.** ລະບຸການບໍລິການສຸຂະພາບ/ ສະຖານທີ່ /ສິ່ງອໍານວຍຄວາມສະດວກ /ອົງການຈັດຕັ້ງທີ່ສະຫນອງ ການບໍລິການດ້ານສຸຂະພາບໃນປັດຈຸບັນ ມີອັນໃດແດ່ ໃນເຂດນີ້?

b. ຜູ້ພິການທີ່ທ່ານດູແລໄດ້ເຂົ້າເຖິງການບໍລິການເຫລົ່ານັ້ນບໍ? ຍ້ອນຫຍັງຈຶ່ງໄດ້ເຂົ້າ ຫລື ບໍ່ໄດ້ເຂົ້າເຖິງ?

c. ໃນນາມຜູ້ດູແລຄົນພິການ, ທ່ານພໍໃຈກັບການບໍລິການເຫລົ່ານັ້ນບໍ? ຍ້ອນຫຍັງພໍໃຈ ຫລື ຍ້ອນຫຍັງບໍ່ພໍໃຈ?

ລະບຸສະເພາະການບໍລິການຜູ້ພິການທີ່ທ່ານດູແລໄດ້ຮັບບໍລິການຈາກສະຖານທີ່ການບໍລິການສຸຂະພາບທ້ອງຖິ່ນ,

ກະລຸນາໃຫ້ຄະແນນ1 ຫາ5 (1 ບໍ່ພໍໃຈຫລາຍ, 2 ບໍ່ພໍໃຈ, 3 ທໍາມະດາ, 4 ພໍໃຈ, 5 ພໍໃຈຫຼາຍ)ສໍາລັບຄວາມ

ພໍໃຈຂອງທ່ານຕໍ່ວິທີທີ່ທ່ານຫຼືຜູ້ພິການທີ່ທ່ານດູແລໄປນໍາໃຊ້ການບໍລິການແຕ່ລະຄັ້ງກ່າວໃນອ່າງມ່ຽມມານີ້.
ພ້ອມໃຫ້ອະທິບາຍການໃຫ້ຄະແນນຂອງທ່ານ.

2. ແມ່ນຫຍັງເປັນສິ່ງທີ່ຕ້ອງການປັບປຸງໃຫ້ສຸຂະພາບຂອງຜູ້ພິການທີ່ທ່ານດູແລໃຫ້ດີຂຶ້ນ?
3. ຕໍ່ໄປ ພວກເຮົາ ຂໍຖາມສອງຄໍາຖາມສະເພາະເຈາະຈົງ:

- ຖ້າວ່າພະນັກງານໃນສູນບໍລິການສຸຂະພາບທ້ອງຖິ່ນໄດ້ຮັບ ຝຶກອົບຮົມດີກ່ອນເກົ່າໃນການໃຫ້ບໍລິການ ແກ່ຄົນພິການ (ແລະ ສາມາດບໍລິການປິ່ນປົວໃຫ້ໄດ້ຄຸນະພາບສູງກວ່າເກົ່າແກ່ຄົນພິການ), ທ່ານຄິດວ່າຈະເກີດຫຍັງຂຶ້ນ**?** ຄິດວ່າ ມັນຈະຮັດໃຫ້ສຸຂະພາບຂອງທ່ານດີຂຶ້ນບໍ? ຖ້າດີແມ່ນແນວໃດ?
- ຖ້າທ່ານ ແລະ ຄອບຄົວຂອງທ່ານໄດ້ມີ ພະນັກງານຮັບຜິດຊອບ (ຜູ້ອໍານວຍຄວາມສະດວກ) ເພື່ອຮັດວຽກກັບທ່ານ ເພື່ອກໍານົດຄວາມຕ້ອງການດ້ານອຸປະກອນ ແລະ ການບໍລິການ ດ້ານສຸຂະພາບ (ຫຼືສິ່ງຕໍ່)ໃນພື້ນທີ່, ທ່ານຄິດວ່າຈະເກີດຫຍັງຂຶ້ນ?
ຄິດວ່າມັນຈະຊ່ວຍຮັດໃຫ້ສຸຂະພາບຂອງຄົນພິການທີ່ທ່ານດູແລດີຂຶ້ນບໍ? ຖ້າດີແມ່ນແນວໃດ?

4. [ສໍາຮອງ, ຖາມຖ້າມີເວລາພໍ],
ເພື່ອຮັບປະກັນສອງສິ່ງເຫລົ່ານີ້ສາມາດເກີດຂຶ້ນໄດ້(ແລະມີຜົນໃນໄລຍະຍາວຕໍ່ທ່ານແລະຄອບຄົວຂອງທ່ານ), ແມ່ນຫຍັງເປັນສິ່ງຈໍາເປັນທີ່ຮັດໃຫ້ມັນເກີດໄດ້?

ພາກທີ II <u>ຄວາມເປັນຢູ່ທາງດ້ານເສດຖະກິດ 25ນາທີ</u>

5. ພວກເຮົາຂໍຖາມກ່ຽວກັບຄອບຄົວຂອງທ່ານ:
    a. ໃນຄອບຄົວທ່ານມີຈັກຄົນ (ຍົກເວັ້ນທ່ານ)?
    b. ຄົນພິການທີ່ທ່ານດູແລເຮັດວຽກຫຍັງບໍ ເພື່ອສ້າງລາຍຮັບ?

6. **ລະດັບຄວາມພຶງພໍໃຈຂອງທ່ານ**ໃນປັດຈຸບັນ**ຕໍ່ຄວາມເປັນຢູ່ທີ່ດີທາງດ້ານເສດຖະກິດຂອງ**ຄອບຄົວ**ທ່ານ** ຢູ່ໃນລະດັບໃດ**?** ກະລຸນາໃຫ້ລໍາດັບຄະແນນ 1 ຫາ 5 (1 ບໍ່ພໍໃຈຫລາຍ, 2 ບໍ່ພໍໃຈ, 3 ທໍາມະດາ, 4 ພໍໃຈ, 5 ພໍໃຈຫຼາຍ).
    a. ໃຫ້ອະທິບາຍການໃຫ້ຄະແນນຂອງທ່ານ. ແມ່ນຫຍັງທີ່ເຮັດໃຫ້ທ່ານພໍໃຈ ແລະ /ຫຼື ບໍ່ພໍໃຈ? ຍ້ອນຫຍັງ?

b. ສິ່ງທ້າທາຍໃດ(ຖ້າມີ)ຕໍ່ຄົນພິການທີ່ທ່ານດູແລໄດ້ພົບໃນການຊອກວຽກຫຼືການຮັກສາວຽກຂອງລາວແມ່ນຫຍັງ? ກະລຸນາອະທິບາຍ.

7. **ຕ້ອງການປັບປຸງຫຍັງເພື່ອ ສົ່ງເສີມການເປັນຢູ່ທາງດ້ານເສດຖະກິດ**ໃຫ້ດີຂຶ້ນ**ຂອງ**ຄົວເຮືອນທ່ານ**(**ຄວາມຊ່ວຍເຫລືອອັນໃດຕໍ່ຄົນພິການທີ່ທ່ານດູແລເພື່ອໃຫ້ໄດ້ວຽກ**/**ມີລາຍຮັບ**)?**

8. ຖ້າທ່ານ ແລະ ຄອບຄົວຂອງທ່ານໄດ້ມີ ພະນັກງານຮັບຜິດຊອບ (ຜູ້ອ່ານວຍຄວາມສະດວກ) ເພື່ອເຮັດວຽກກັບທ່ານ ເພື່ອກຳນົດຄວາມຕ້ອງການດ້ານການຈ້າງງານໃນເຂດພື້ນທີ່ນີ້, ທ່ານຄິດວ່າຈະເກີດຫຍັງຂຶ້ນ? ຄິດວ່າມັນຈະຊ່ວຍເຮັດໃຫ້ເສດຖະກິດຂອງທ່ານ/ເສດຖະກິດຂອງຄອບຄົວທ່ານດີຂຶ້ນບໍ? ຖ້າດີແມ່ນແນວໃດ?

9. [ສຳຮອງ, ຖາມຖ້າມີເວລາພໍ], ເພື່ອຮັບປະກັນສອງສິ່ງເຫລົ່ານີ້ສາມາດເກີດຂຶ້ນໄດ້(ແລະມີຜົນໃນໄລຍະຍາວຕໍ່ທ່ານແລະຄອບຄົວຂອງທ່ານ), ແມ່ນຫຍັງເປັນສິ່ງຈຳເປັນທີ່ເຮັດໃຫ້ມັນເກີດໄດ້?

ພາກທີ II <u>ການພົວພັນກັບລະບົບ</u> (20 ນາທີ)

10. **ທ່ານຮູ້/ໄດ້ຍິນກ່ຽວກັບນະໂຍບາຍ ລະດັບຊາດ ຫຼືກົດໝາຍກ່ຽວກັບ ການສະໜອງການ ບໍລິການ ໃຫ້ຄົນພິການບໍ**? ຖ້າບໍ່ຮູ້, ໃຫ້ຖາມຂໍ້ຕໍ່ໄປ.

a. ຖ້າຮູ້, ລະບຽບກົດໝາຍດັ່ງກ່າວສຳຄັນແນວໃດຕໍ່ທ່ານ? ຍ້ອນຫຍັງ(ລະບຽບກົດໝາຍດັ່ງກ່າວສ້າງຄວາມແຕກຕ່າງໃຫ້ກັບຊີວິດປະຈຳວັນຂອງທ່ານແນວໃດ?

11. ກ່ຽວກັບການມີສ່ວນຮ່ວມໃນສັງຄົມ**:**

a. ທ່ານເຄີຍມີໂອກາດພົບກັບລັດຖະບານລາວ ແລະ ໄດ້ສະເໜີຄຳຄິດເຫັນຕໍ່ກົດໝາຍ ແລະ ກົດລະບຽບ(ທ່ານໄດ້ເຂົ້າເຖິງຊ່ອງທາງໃດບໍ ເພື່ອສາມາດສະເໜີຄຳຄິດເຫັນຕໍ່ພາກລັດ)ກ່ຽວກັບການບໍລິການຄົນພິການ ແລະ ການຟື້ນຟູໜ້າທີ່ການບໍ? ກະລຸນາອະທິບາຍວ່າແມ່ນຫຍັງ, ມີຄືແນວໃດ ແລະ ຜົນໄດ້ຮັບເປັນແນວໃດ?

b. ທ່ານເຄີຍເຂົ້າຮ່ວມວຽກງານຂອງຊຸມຊົນຫລືກອງປະຊຸມບໍ? ກະລຸນາອະທິບາຍປະສົບການດັ່ງກ່າວວ່າແມ່ນຫຍັງ, ເປັນແນວໃດ ແລະຜົນໄດ້ຮັບເປັນຄືແນວໃດ?

12. **ທ່ານເຊື່ອບໍ່ວ່າລັດຖະບານ a)** ລັດຖະບານ **b) ສະມາຊິກໃນຊຸມຊົນຂອງທ່ານເຂົ້າໃຈສະພາບຕົວຈິງແລະປະສົບການຂອງການເປັນຄົນພິການ** (ໃນຄວາມຫຍຸ້ງຍາກໃນການໃນມາ, ການໄດ້ເປັນສ່ວນຫນຶ່ງຂອງຊຸມຊົນ, ແລະ ການໄດ້ອອກຄຳຄິດເຫັນ)?

ມີການຈຳແນກຫລືຈຸດຄົງຄ້າງໃດບໍ? **ເປັນຫຍັງຈຶ່ງເຊື່ອຫຼືບໍ່ເຊື່ອ? ແມ່ນຫຍັງທີ່ສາມາດເຮັດໄດ້ເພື່ອແກ້ໄຂບັນຫາ ຊ່ອງຫວ່າງນີ້?**

ການສົນທະນາກຸ່ມກັບຄົນພິການ

ພວກເຮົາມີສອງຢ່າງທີ່ຢາກສົນທະນາກັບພວກທ່ານມື້ນີ້ແມ່ນ.

1) ພວກເຮົາຢາກສົນທະນາວ່າ ແມ່ນຫຍັງທີ່ສາມາດເຮັດໄດ້ເພື່ອໃຫ້ປັບປຸງດ້ານສຸຂະພາບແລະເສດຖະກິດຂອງພວກທ່ານ.

2) ພວກເຮົາຢາກສົນທະນາ ເພື່ອເຂົ້າໃຈກ່ຽວກັບ ການຮັບຮູ້/ການພົວພັນຂອງທ່ານຕໍ່ ສະຖານທີ່ໃຫ້ບໍລິການ, ສິ່ງອຳນວຍຄວາມສະດວກໃນທ້ອງຖິ່ນ, ແລະອົງການຈັດຕັ້ງທີ່ມີແຜນຈະສະໜອງການບໍລິການ ແລະ ສິ່ງເສີມດ້ານການຟື້ນຟູໜ້າທີ່ການ.

ພາກທີ I <u>ສຸຂະພາບ</u> 25ນາທີ

1. **ທ່ານຄິດວ່າ 'ການມີສຸຂະພາບທີ່ດີ' ແມ່ນຫຍັງ? ຫລື ມັນໝາຍຄວາມວ່າແນວໃດສຳລັບທ່ານ?**

   ອົງປະກອບອັນໃດ ກ່ຽວກັບສຸຂະພາບຂອງທ່ານ ທີ່ສຳຄັນທີ່ສຸດສຳລັບທ່ານ?

2. ກ່ຽວກັບ**ການບໍລິການ**ທີ່ເປີດໃຫ້ບໍລິການປັດຈຸບັນໃນເຂດນີ້:

   a. ລະບຸການບໍລິການສຸຂະພາບ/ ສະຖານທີ່ /ສິ່ງອຳນວຍຄວາມສະດວກ /ອົງການຈັດຕັ້ງສຳລັບຄົນພິການທີ່ສະໜອງການບໍລິການໃຫ້ແກ່ທ່ານ(ຂັ້ນສູນກາງ, ທ້ອງຖິ່ນ, ອົງການເຮັດວຽກກັບຄົນພິການ/ສະມາຄົມບໍ່ຫວັງຜົນກຳໄລ,ອື່ນໆ) ໃນເຂດນີ້(ລະບຸຊື່ບ້ານແລະຊື່ເມືອງ)?

   b. ທ່ານໄດ້ເຂົ້າເຖິງການບໍລິການດັ່ງກ່າວບໍ? ຍ້ອນຫຍັງຈຶ່ງໄດ້ເຂົ້າ ຫລື ບໍ່ໄດ້ເຂົ້າເຖິງ?

   c. ທ່ານມີຄວາມພໍໃຈກັບການບໍລິການດັ່ງກ່າວບໍ? ເປັນຫຍັງຈຶ່ງພໍໃຈ ຫລື ບໍ່ພໍໃຈ?

   d. ລະບຸສະເພາະການບໍລິການທີ່ທ່ານໄດ້ຮັບຈາກສະຖານທີ່ການບໍລິການສຸຂະພາບທ້ອງຖິ່ນ, ກະລຸນາໃຫ້ຄະແນນ1 ຫາ 5 (1 ບໍ່ພໍໃຈຫລາຍ, 2 ບໍ່ພໍໃຈ, 3 ທຳມະດາ, 4 ພໍໃຈ, 5 ພໍໃຈຫຼາຍ)ສຳລັບຄວາມພໍໃຈຂອງທ່ານຕໍ່ວິທີທີ່ທ່ານຫຼືຄົນພິການໃນຄົວເຮືອນທ່ານໄດ້ໃຊ້ການບໍລິການ ແຫລ່ງດັ່ງກ່າວໃນອ່ານມໍ່ໆມານີ້. ພ້ອມໃຫ້ອະທິບາຍກ່ຽວກັບການໃຫ້ຄະແນນຂອງທ່ານ.

3. ທ່ານຕ້ອງການຈະເຮັດຫຍັງ ເພື່ອໃຫ້ເຂົ້າເຖິງການປັບປຸງສຸຂະພາບຂອງທ່ານ [ຄືດັ່ງທີ່ທ່ານເວົ້າມາຂ້າງເທິງ] ທີ່ທ່ານຄິດວ່າ ທ່ານຍັງບໍ່ທັນໄດ້ເຂົ້າເຖິງເທື່ອໃນປັດຈຸບັນນີ້?

4. ຕໍ່ໄປ ພວກເຮົາ ຂໍຖາມສອງຄຳຖາມສະເພາະເຈາະຈົງ:

   - ຖ້າວ່າພະນັກງານໃນສູນບໍລິການສຸຂະພາບໄດ້ຮັບ ຝຶກອົບຮົມດີກ່ອນເກົ່າໃນການໃຫ້ບໍລິການ ແກ່ຄົນພິການ (ແລະ ສາມາດບໍລິການປິ່ນປົວໃຫ້ໄດ້ຄຸນະພາບສູງກວ່າເກົ່າ), ທ່ານຄິດວ່າຈະເກີດຫຍັງຂຶ້ນ**?** ຄິດວ່າ ມັນຈະເຮັດໃຫ້ສຸຂະພາບຂອງທ່ານດີຂຶ້ນບໍ? ຖ້າດີແມ່ນແນວໃດ?
   - ຖ້າທ່ານ ແລະ ຄອບຄົວຂອງທ່ານໄດ້ມີ ພະນັກງານຮັບຜິດຊອບ (ຜູ້ອຳນວຍຄວາມສະດວກ) ເພື່ອເຮັດວຽກກັບທ່ານ ເພື່ອກຳນົດຄວາມຕ້ອງການດ້ານອຸປະກອນ ແລະ ການບໍລິການ ດ້ານ ສຸຂະພາບ (ຫຼືສິ່ງຕ່ຳ)ໃນພື້ນທີ່, ທ່ານຄິດວ່າຈະເກີດຫຍັງຂຶ້ນ? ຄິດວ່າມັນຈະຊ່ວຍເຮັດໃຫ້ສຸຂະພາບຂອງທ່ານດີຂຶ້ນບໍ? ຖ້າດີແມ່ນແນວໃດ?

5. [ສຳຮອງ, ຖາມຖ້າມີເວລາພໍ], ເພື່ອຮັບປະກັນສອງສິ່ງເຫລົ່ານີ້ສາມາດເກີດຂຶ້ນໄດ້(ແລະມີຜົນໃນໄລຍະຍາວຕໍ່ທ່ານແລະຄອບຄົວຂອງທ່ານ), ແມ່ນຫຍັງເປັນສິ່ງຈຳເປັນທີ່ເຮັດໃຫ້ມັນເກີດໄດ້?

ພາກທີ II <u>ຄວາມເປັນຢູ່ທາງດ້ານເສດຖະກິດ</u> 25ນາທີ

6. ການກຸ້ມຕົນເອງທາງດ້ານເສດຖະກິດ ທ່ານຄິດວ່າມັນມີຄວາມໝາຍຫຍັງຕໍ່ກັບທ່ານ? ທ່ານຄິດແນວໃດຕໍ່ ການກຸ້ມຕົນເອງທາງດ້ານເສດຖະກິດສຳລັບຄອບຄົວຂອງທ່ານ? ປັດໃຈໃດ ຂອງການເປັນຢູ່ທີ່ດີທາງດ້ານເສດຖະກິດ ທີ່ສຳຄັນທີ່ສຸດສຳລັບທ່ານ?

a. ໃນຄອບຄົວທ່ານມີຈັກຄົນ (ຍົກເວັ້ນທ່ານ)?
b. ທ່ານໄດ້ເຮັດຫຍັງແດ່ເພື່ອສ້າງລາຍຮັບ?
ມັນມີຄວາມໝາຍແນວໃດທີ່ທ່ານຕ້ອງລຸກຍູ້ການດຳລົງຊີວິດປະຈຳວັນຂອງທ່ານ?

7. **ລະດັບຄວາມພຶງພໍໃຈຂອງທ່ານ**ໃນປັດຈຸບັນ**ຕໍ່ຄວາມເປັນຢູ່ທີ່ດີທາງດ້ານເສດຖະກິດຂອງທ່ານ** ແລະ ຄອບຄົວຂອງທ່ານຢູ່ໃນລະດັບໃດ**?** ກະລຸນາໃຫ້ລຳດັບຄະແນນ 1 ຫາ 5 (1 ບໍ່ພໍໃຈຫລາຍ, 2 ບໍ່ພໍໃຈ, 3 ທຳມະດາ, 4 ພໍໃຈ, 5 ພໍໃຈຫຼາຍ).

a. ໃຫ້ອະທິບາຍການໃຫ້ຄະແນນຂອງທ່ານ. ແມ່ນຫຍັງທີ່ເຮັດໃຫ້ທ່ານພໍໃຈ ແລະ /ຫຼື ບໍ່ພໍໃຈ?ຍ້ອນຫຍັງ?

b. ສິ່ງທ້າທາຍໃດ(ຖ້າມີ)ທີ່ທ່ານໄດ້ພົບໃນການຊອກວຽກຫຼືການຮັກສາວຽກຂອງທ່ານແມ່ນຫຍັງ? ກະລຸນາອະທິບາຍ.

c. ໃນຄວາມຄິດຂອງທ່ານ, ສິ່ງທ້າທາຍເຫລົ່ານີ້ແຕກຕ່າງກັນບໍ ດ້ວຍ ອາຍຸ, ສະຖານທີ່, ປະເພດຂອງຄວາມພິການ, ຊົນເຜົ່າ,ອື່ນໆ ສຳລັບຄົນພິການໃນຊຸມຊົນຂອງທ່ານ?

8. **ທ່ານຕ້ອງການປັບປຸງຫຍັງໃນປັດຈຸບັນເພື່ອ ສົ່ງເສີມການເປັນຢູ່ທາງດ້ານເສດຖະກິດຂອງທ່ານ ແລະຄອບຄົວຂອງທ່ານ [ດັ່ງທີ່ທ່ານເວົ້າມາຂ້າງເທິງ] ທີ່ທ່ານຍັງບໍ່ທັນໄດ້ເຂົ້າເຖິງໃນປັດຈຸບັນ?**

9. **ຕໍ່ໄປ ຂ້າພະເຈົ້າຂໍຖາມສອງຄຳຖາມສະເພາະເຈາະຈົງ:**

- ຖ້າວ່າ ໂຮງຮຽນອາຊີວະສຶກສາ ຫຼື ສະຖານທີ່ອຳນວຍຄວາມສະດວກດ້ານການສຶກສາໃນເຂດທ້ອງຖິ່ນຂອງທ່ານ ໃຫ້ທ່ານໄດ້ເຂົ້າຮ່ວມຝຶກອົບຮົມ ສຳລັບຄົນພິການ, ມັນຈະເກີດຫຍັງຂຶ້ນ? ມັນຈະຊ່ວຍໃຫ້ທ່ານ ໄດ້ວຽກຫຼືບໍ? ໄດ້ແນວໃດ?
- ຖ້າທ່ານ ແລະ ຄອບຄົວຂອງທ່ານໄດ້ມີ ພະນັກງານຮັບຜິດຊອບ (ຜູ້ອຳນວຍຄວາມສະດວກ) ເພື່ອເຮັດວຽກກັບທ່ານ ເພື່ອກຳນົດການຈ້າງງານໃນພື້ນທີ່, ທ່ານຄິດວ່າຈະເກີດຫຍັງຂຶ້ນ? ຄິດວ່າມັນຈະຊ່ວຍເຮັດໃຫ້ປັບປຸງເສດຖະກິດຂອງທ່ານ/ເສດຖະກິດຄົວເຮືອນທ່ານດີຂຶ້ນບໍ? ຖ້າດີແມ່ນແນວໃດ?

10. [ສຳຮອງ, ຖາມຖ້າມີເວລາພໍ],
ເພື່ອຮັບປະກັນສອງສິ່ງເຫລົ່ານີ້ສາມາດເກີດຂຶ້ນໄດ້(ແລະມີຜົນໃນໄລຍະຍາວຕໍ່ທ່ານແລະຄອບຄົວຂອງທ່ານ), ແມ່ນຫຍັງເປັນສິ່ງຈຳເປັນທີ່ເຮັດໃຫ້ມັນເກີດໄດ້?

ພາກທີ III <u>ການພົວພັນກັບລະບົບ</u> **(20 ນາທີ)**

11. **ທ່ານຮູ້ /ໄດ້ຍິນກ່ຽວກັບນະໂຍບາຍ ລະດັບຊາດ ຫຼືກົດໝາຍກ່ຽວກັບ ການສະໜອງການ ບໍລິການ ໃຫ້ຄົນພິການບໍ**? ຖ້າບໍ່ຮູ້, ໃຫ້ຖາມຂໍ້ຕໍ່ໄປ.

a. ຖ້າຮູ້, ລະບຽບກົດໝາຍດັ່ງກ່າວສຳຄັນແນວໃດກັບທ່ານ?
ຍ້ອນຫຍັງ(ລະບຽບກົດໝາຍດັ່ງກ່າວຈະສ້າງຄວາມແຕກຕ່າງໃຫ້ກັບຊີວິດປະຈຳວັນຂອງທ່ານແນວໃດ?

12. ກ່ຽວກັບການມີສ່ວນຮ່ວມໃນສັງຄົມ**:**

a. ທ່ານເຄີຍມີໂອກາດພົບກັບລັດຖະບານລາວ ແລະ ໄດ້ສະເໜີຄຳຄິດເຫັນຕໍ່ກົດໝາຍ ແລະ ກົດລະບຽບ(ທ່ານໄດ້ເຂົ້າເຖິງຊ່ອງທາງໃດບໍ
ເພື່ອສາມາດສະເໜີຄຳຄິດເຫັນຕໍ່ພາກລັດ)ກ່ຽວກັບການບໍລິການຄົນພິການ ແລະ ການຟື້ນຟູໜ້າທີ່ການບໍ?
ກະລຸນາອະທິບາຍວ່າແມ່ນຫຍັງ, ມີຄືແນວໃດ ແລະ ຜົນໄດ້ຮັບເປັນແນວໃດ?
b. ທ່ານເຄີຍເຂົ້າຮ່ວມວຽກງານຂອງຊຸມຊົນຫລືກອງປະຊຸມບໍ?
ກະລຸນາອະທິບາຍປະສົບການດັ່ງກ່າວວ່າແມ່ນຫຍັງ, ເປັນແນວໃດ ແລະຜົນໄດ້ຮັບເປັນຄືແນວໃດ?

13. **ທ່ານເຊື່ອບໍວ່າລັດຖະບານ a)** ລັດຖະບານ
b)ສະມາຊິກໃນຊຸມຊົນຂອງທ່ານເຂົ້າໃຈສະພາບຕົວຈິງແລະປະສົບການຂອງການເປັນຄົນພິການ
(ໃນຄວາມຫຍຸ້ງຍາກໃນການໄປມາ, ການໄດ້ເປັນສ່ວນຫນຶ່ງຂອງຊຸມຊົນ, ແລະ ການໄດ້ອອກຄຳຄິດເຫັນ)?

ມີການຈຳແນກຫລືຈຸດຄົງຄ້າງໃດບໍ? **ເປັນຫຍັງຈຶ່ງເຊື່ອຫຼືບໍ່ເຊື່ອ?**
ແມ່ນຫຍັງທີ່ສາມາດເຮັດໄດ້ເພື່ອແກ້ໄຂບັນຫາ ຊ່ອງຫວ່າງນີ້?

ການສົນທະນາກຸ່ມກັບພະນັກງານວິທະຍາໄລອະຊີວະ

ພວກເຮົາມີສອງຢ່າງທີ່ຢາກສົນທະນາກັບພວກທ່ານມື້ນີ້ແມ່ນ.

1. ຫນຶ່ງ,ພວກເຮົາຢາກສົນທະນາແມ່ນຫຍັງທີ່ສາມາດເຮັດໄດ້ເພື່ອເພີ່ມຈຳນວນຄົນພິການໄດ້ເຂົ້າສຶກສາ/ຝຶກອົບຮົມ ແລະມີວຽກເຮັດໃນເຂດນີ້.

2. ສອງ,ພວກເຮົາຢາກສົນທະນາ ໂຄງຮ່າງສະຖາບັນຂອງທ່ານແລະການດຳເນີນງານ.

ພາກທີ I: **ການບໍລິການທີ່ມີແກ່ຄົນພິການ**

1. **ກະລຸນາອະທິບາຍ**ໂອກາດດ້ານການສຶກສາແລະເຂົ້າຮ່ວມການຝຶກອົບຮົມ**ສຳລັບຄົນພິການໃນສະຖານທີ່ບໍລິການ**ແຫ່ງ**ນີ້,**ແລະໂດຍສະເພາະໃນສະຖາບັນທີ່ນີ້**.**

   ຈາກນັ້ນໃຫ້ອະທິບາຍເຖິງການບໍລິການດ້ານການສຶກສາແລະເຂົ້າຮ່ວມການຝຶກອົບຮົມດັ່ງກ່າວໄດ້ຖືກນຳໃຊ້ມີຄືແນວໃດ ແລະແມ່ນໃຜທີ່ນຳໃຊ້ (ຊາຍ/ຍິງ /ເດັກນ້ອຍ, ຊົນເຜົ່າ,ສະຖານທີ່,ປະເພດຂອງຄວາມພິການ,ອື່ນໆ). ມີຂໍ້ມູນອັນໃດບໍ ທີ່ສາມາດຢັ້ງຢືນຂໍ້ມູນການນຳໃຊ້ດັ່ງກ່າວ,ໂດຍສະເພາະ ຈຳນວນຂອງຄົນພິການທີ່ໄດ້ສຶກສາຢູ່ທີ່ນີ້?

   ກະລຸນາອະທິບາຍໜ້າທີ່ຂອງທ່ານໃນການສະໜອງການບໍລິການດັ່ງກ່າວ**ໃຫ້ຄົນພິການ**ຢູ່ສະຖານທີ່ນີ້**.**

   ຕົວຢ່າງ:ອະທິບາຍກ່ຽວກັບການພົວພັນໃນມໍ່ງນີ້ກັບຄົນພິການຢູ່ສະຖາບັນນີ້–ພວກເຂົາ ເປັນອາຈານ?ນາສຶກສາ?ເປັນຄູຝຶກ?

   ທ່ານມີການພົວພັນກັບຄົນພິການເລື້ອຍປານໃດ? (ຈຳນວນຄັ້ງຕໍ່ເດືອນ)?

3. **ທ່ານຄິດວ່າຄົນພິການທີ່**ເຂົ້າຮຽນຢູ່ສະຖາບັນນີ້ພໍໃຈກັບຝຶກອົບຮົມທີ່ພວກເຂົາໄດ້ຮັບ**?** ກະລຸນາໃຫ້ຄະແນນ 1 ຫາ 5 (1 ບໍ່ພໍໃຈຫລາຍ, 2 ບໍ່ພໍໃຈ, 3 ທຳມະດາ, 4 ພໍໃຈ, 5 ພໍໃຈຫຼາຍ). ໃຫ້ອະທິບາຍການໃຫ້ຄະແນນຂອງທ່ານ.

   ທ່ານມີຂໍ້ມູນຫລັກຖານ ໃນການອ້າງອີງຄຳເຫັນຂອງທ່ານບໍ?

4. **ສຳລັບຄົນພິການໃນເຂດນີ້ທີ່ບໍ່ໄດ**້ເຂົ້າຮ່ວມໃນດ້ານການສຶກສາ**/**ຝຶກອົບຮົມ**,**
ທ່ານຄິດວ່າອັນໃດແມ່ນເປັນເຫດຜົນຫຼັກ ທີ່ເຮັດໃຫ້ເຂົາເຈົ້າບໍ່ໄດ້**ມາ**ມີສ່ວນຮ່ວມຢູ່ທີ່**ນີ້?**
ແມ່ນຫຍັງທີ່ຄວນໄດ້ຮັບການປ່ຽນແປງເພື່ອເຮັດໃຫ້ພວກເຂົາໄດ້ມາເຂົ້າຝຶກອົບຮົມ/ຮຽນໃນສະຖາບັນນີ້?

5. ສົນທະນາເປັນກຸ່ມ**: ແມ່ນຫຍັງທີ່ຄວນໄດ້ຮັບການປ່ຽນແປງໃນການສະຖາ**ບັນນີ້ **ເພື່ອເພີ່ມຄວາມພໍໃຈ ສຳລັບຄົນພິການ ຕໍ່ກັບການ**ຝຶກອົບຮົມ**ທີ່**ພວກເຂົາໄດ້ຮັບຢູ່**ທີ່**ນີ້?** ຄືດັ່ງສົນທະນາຂ້າງເທິງ, ທ່ານຄິດວ່າບັດໃຈທີ່ບໍ່ພໍໃຈ ອັນໃດຄວນໄດ້ຮັບການແກ້ໄຂ?

6. ຖ້າທ່ານໄດ້ຮັບການຝຶກອົບຮົມໃນການສອນຄົນພິການ. ທ່ານຄິດວ່າການຝຶກອົບຮົມ ລັກສະນະນີ້ ຈະຊ່ວຍທ່ານໄດ້ແນວໃດ? ຜົນກະທົບໃນການຝຶກອົບຮົມດັ່ງກ່າວມີຫຍັງແດ່?

   ມັນສົ່ງຜົນກະທົບຕໍ່ຄວາມພໍໃຈ ຂອງຄົນພິການກັບປະສົບການດ້ານການສຶກສາຂອງເຂົາເຈົ້າບໍ?

   ຫລື ເຮັດໃຫ້ພວກເຂົາມາຮຽນຢູ່ນີ້ຫລາຍຂຶ້ນ?

7. ທ່ານ ຫຼື ສູນບໍລິການແຫ່ງນີ້ ເຄີຍໄດ້ຮັບການຝຶກອົບຮົມການສອນຄົນພິການບໍ ?ຈາກໃຜ? ຖ້າໄດ້ຮັບ, ກະລຸນາອະທິບາຍກ່ຽວກັບການຝຶກອົບຮົມ (ຫົວຂໍ້ທີ່ຝຶກ, ໄລຍະເວລາ, ຄູຝຶກ) ແລະ ໄດ້ຝຶກເມື່ອໃດ?

ພາກທີ II **: ການເຮັດວຽກຂອງລະບົບ**

8. **ທ່ານຮູ້ /ໄດ້ຍິນກ່ຽວກັບ ກົດລະບຽບ ຫຼື ກົດໝາຍ ກ່ຽວກັບ ການສະໜອງການບໍລິການ ໃຫ້ຄົນພິການບໍ?** ຖ້າບໍ່ຮູ້,ໃຫ້ຖາມຂໍ້ຕໍ່ໄປ

a. ຖ້າຮູ້, ທ່ານຮູ້ບໍ່ວ່າລະບຽບ/ກົດໝາຍດັ່ງກ່າວໄດ້ກຳນົດບໍ່ວ່າສະຖານທີ່ການບໍລິການທີ່ນີ້ ຄວນມີການດຳເນີນງານແນວໃດ? ມັນສ້າງຄວາມແຕກຕ່າງໃນການເຮັດວຽກປະຈຳວັນຢູ່ທີ່ນີ້ບໍ? ແຕກຕ່າງຄືແນວໃດ?

b. ທ່ານຕ້ອງການຫຍັງເພື່ອເຮັດໃຫ້ສາມາດປະຕິບັດ ການປ່ຽນແປງທີ່ຈຳເປັນ ເພື່ອເຮັດໃຫ້ ສະຖານທີ່ການບໍລິການແຫ່ງນີ້ສອດຄ່ອງກັບລະບຽບໃໝ່ເຫຼົ່ານີ້?

c. ທ່ານມີໂອກາດໄດ້ພົບກັບພາກລັດ ແລະ ໄດ້ສະເໜີຄຳຄິດເຫັນຕໍ່ກົດໝາຍ ແລະ ກົດລະບຽບກ່ຽວກັບການບໍລິການສຳລັບຄົນພິການ ແລະ ການຟື້ນຟູໜ້າທີ່ການບໍ? ກະລຸນາອະທິບາຍວ່າແມ່ນຫຍັງ, ມີຄືແນວໃດ ແລະ ຜົນໄດ້ຮັບມີຄືແນວໃດ?

9. ມີນະໂຍບາຍອື່ນບໍ ທີ່ກຳນົດວ່າ ສະຖານທີ່ບໍລິການນີ້ ຄວນມີການດຳເນີນງານແນວໃດ?

a. ຖ້າມີ, ນະໂຍບາຍດັ່ງກ່າວໄດ້ກຳນົດບໍ່ວ່າສະຖານທີ່ການບໍລິການນີ້ ຄວນມີການດຳເນີນງານແນວໃດ? ມັນສ້າງຄວາມແຕກຕ່າງໃນການເຮັດວຽກປະຈຳວັນຢູ່ທີ່ນີ້ບໍ?

10. ທ່ານລາຍງານຂໍ້ມູນຫຍັງໃຫ້ທາງກະຊວງສຶກສາກ່ຽວກັບການຮັບສະໝັກ, ການຈົບຊັ້ນ, ຈຳນວນນັກຮຽນ,ອື່ນໆໃຫ້ກັບຄົນພິການທີ່ທ່ານສະໜອງ (ຖ້າມີ)?

ຂໍ້ມູນເຫລົ່ານີ້ສາມາດຖືກແຍກອອກໂດຍເປັນປະເພດຂອງຄວາມບົກຜ່ອງຂອງຄວາມພິການ/ຫລືແຍກເປັນປະເພດການຮັບບໍລິການບໍ? ທ່ານໄດ້ມີການສື່ສານພົວພັນກັບ ກະຊວງສຶກສາເລື້ອຍປານໃດ?

11. ທ່ານຫລືຄົນອື່ນທີ່ເຮັດວຽກງານສູນບໍລິການນີ້ໄດ້ເຂົ້າຮ່ວມໃນການ<u>ຕິດຕາມ</u>ການປະຕິບັດນະໂຍບາຍແຫ່ງຊາດກ່ຽວກັບການສະໜອງການບໍລິການຄົນພິການແລະການຟື້ນຟູໃນລະດັບໃດ?

ທ່ານເຄີຍເຂົ້າຮ່ວມເຮັດວຽກກັບກຸ່ມຈັດຕັ້ງປະຕິບັດໃນຫົວຂໍ້ນີ້ບໍ? ກະລຸນາ ອະທິບາຍກ່ຽວກັບປະສົບການດັ່ງກ່າວ.

ທ່ານໜໍ – ການສຳພາດ

ພວກເຮົາມີສອງຫົວຂໍ້ທີ່ຢາກສົນທະນາກັບພວກທ່ານມື້ນີ.

ໜຶ່ງ,ພວກເຮົາຢາກສົນທະນາວ່າ ການໃຫ້ບໍລິການແກ່ຄົນພິການໃນສະຖານທີ່ບໍລິການແຫ່ງນີ້.

ສອງ,ພວກເຮົາສົນໃຈວ່າສະຖານທີ່ບໍລິການຂອງທ່ານໄດ້ມີການພົວພັນແລະການໃຫ້ບໍລິການກັບຄົນພິການໃນປັດຈຸບັນຄືແນວໃດ.

ພາກທີ I: ການບໍລິການທີ່ມີແກ່ຄົນພິການ

1. **ກະລຸນາອະທິບາຍປະເພດຂອງການບໍລິການສຳລັບຄົນພິການໃນສະຖານທີ່ບໍລິການແຫ່ງນີ້.** ຈາກນັ້ນໃຫ້ອະທິບາຍເຖິງການບໍລິການດັ່ງກ່າວໄດ້ຖືກນຳໃຊ້ມີຄືແນວໃດ ແລະແມ່ນໃຜທີ່ນຳໃຊ້ (ຊາຍ/ຍິງ /ເດັກນ້ອຍ, ຊົນເຜົ່າ,ສະຖານທີ່,ປະເພດຂອງຄວາມພິການ,ອື່ນໆ). ມີຂໍ້ມູນອັນໃດບໍ ທີ່ສາມາດຢັ້ງຢືນຂໍ້ມູນການນຳໃຊ້ດັ່ງກ່າວ?

2. **ກະລຸນາອະທິບາຍໜ້າທີ່ຂອງທ່ານໃນການສະໜອງການບໍລິການໃຫ້ຄົນພິການ.**

   ຕົວຢ່າງ:ອະທິບາຍກ່ຽວກັບການພົວພັນໃນມ່ຽນນີ້ກັບຄົນພິການທີ່ມາໃຊ້ບໍລິການໃນສະຖານທີ່ນີ້–ພວກເຂົາມາຊອກຫາການປິ່ນປົວຫຍັງ?

   ທ່ານມີບົດບາດແນວໃດໃນການສະໜອງການບໍລິການໃຫ້ພວກເຂົາ?

   ທ່ານໄດ້ໃຫ້ບໍລິການແກ່ຄົນພິການເລື້ອຍປານໃດ? (ຈຳນວນຄັ້ງຕໍ່ເດືອນ)?

3. **ທ່ານຄິດວ່າຄົນພິການທີ່ນຳໃຊ້ການບໍລິການຂອງທ່ານມີຄວາມພໍໃຈໃນການບໍລິການທີ່ພວກເຂົາໄດ້ຮັບຢູ່ນີ້ບໍ?** ກະລຸນາໃຫ້ຄະແນນ 1 ຫາ 5 (1 ບໍ່ພໍໃຈຫລາຍ, 2 ບໍ່ພໍໃຈ, 3 ທຳມະດາ, 4 ພໍໃຈ, 5 ພໍໃຈຫຼາຍ). ໃຫ້ອະທິບາຍການໃຫ້ຄະແນນຂອງທ່ານ.

   ທ່ານມີຂໍ້ມູນຫລັກຖານ ໃນການອ້າງອີງຄຳເຫັນຂອງທ່ານບໍ?

4. **ສຳລັບຄົນພິການໃນເຂດນີ້ທີ່ບໍ່ໄດ້ມາໃຊ້ບໍລິການຢູ່ນີ້, ທ່ານຄິດວ່າອັນໃດແມ່ນເປັນເຫດຜົນຫຼັກທີ່ເຮັດໃຫ້ເຂົາບໍ່ມາໃຊ້ບໍລິການຢູ່ນີ້?**
ແມ່ນຫຍັງທີ່ຄວນໄດ້ຮັບການປ່ຽນແປງເພື່ອເຮັດໃຫ້ພວກເຂົາມານຳໃຊ້ການບໍລິການຂອງທ່ານເພີ່ມຂຶ້ນ?

5. **ແມ່ນຫຍັງທີ່ຄວນໄດ້ຮັບການປ່ຽນແປງໃນການສະຖານທີ່ບໍລິການສຸຂະພາບເພື່ອເພີ່ມຄວາມພໍໃຈສຳລັບຄົນພິການ ຕໍ່ກັບການບໍລິການດ້ານສຸຂະພາບທີ່ພວກເຂົາໄດ້ຮັບຢູ່ທີ່ນີ້?** ຄືດັ່ງສົນທະນາຂ້າງເທິງ, ທ່ານຄິດວ່າບັດໃຈທີ່ບ ່ ພໍໃຈ ອັນໃດຄວນໄດ້ຮັບການແກ້ໄຂ?

6. ທ່ານ ຫຼື ສູນບໍລິການແຫ່ງນີ້ ເຄີຍໄດ້ຮັບການຝຶກອົບຮົມການດູແລເບິ່ງແຍງຄົນພິການບໍ ? ຖ້າໄດ້ຮັບ, ກະລຸນາອະທິບາຍກ່ຽວກັບການຝຶກອົບຮົມ (ຫົວຂໍ້ທີ່ຝຶກ, ໄລຍະເວລາ, ຄູຝຶກ) ແລະ ໄດ້ຝຶກເມື່ອໃດ?

7. ຖ້າທ່ານໄດ້ຮັບການຝຶກອົບຮົມໃນການເບິ່ງແຍງດູແລຄົນພິການ. ທ່ານຄິດວ່າການຝຶກອົບຮົມ ລັກສະນະນີ້ ຈະຊ່ວຍ ທ່ານໄດ້ແນວໃດ? ຜົນກະທົບໃນການຝຶກອົບຮົມດັ່ງກ່າວມີຫຍັງແດ່?

   ມັນສົ່ງຜົນກະທົບຕໍ່ຄວາມພໍໃຈ ຂອງຄົນພິການໃນການໃຊ້ບໍລິການບໍ?

   ຫລື ຈະມີຜົນຕໍ່ຄວາມພຶງພໍໃຈຂອງຄົນພິການແລະ/ຫຼື ການນຳໃຊ້ການບໍລິການ ຂອງພວກເຂົາບໍ?

ພາກທີ II :

ການເຮັດວຽກຂອງລະບົບ(ກົດໝາຍ/ນະໂຍບາຍ,ຂໍ້ມູນ,ແລະການຕິດຕາມວຽກງານ)

8. **ທ່ານຮູ້ /ໄດ້ຍິນກ່ຽວກັບ ກົດລະບຽບ ຫຼື ກົດໝາຍ ກ່ຽວກັບ ການສະໜອງການບໍລິການໃຫ້ຄົນພິການບໍ?**

a. ຖ້າຮູ້, ທ່ານຮູ້ບໍ່ວ່າລະບຽບ/ກົດໝາຍດັ່ງກ່າວໄດ້ກຳນົດບໍ່ວ່າສະຖານ ທີ່ການບໍລິການ ຄວນມີການດຳເນີນງານແນວໃດ?
ມັນສ້າງຄວາມແຕກຕ່າງໃນການເຮັດວຽກປະຈຳວັນໃນການບໍລິການຢູ່ນີ້ບໍ? ແຕກຕ່າງຄືແນວໃດ?

b. ທ່ານຕ້ອງການຫຍັງເພື່ອເຮັດໃຫ້ສາມາດປະຕິບັດ ການປ່ຽນແປງທີ່ຈຳເປັນ ເພື່ອເຮັດໃຫ້ ສະຖານທີ່ການບໍລິການແຫ່ງນີ້ສອດຄ່ອງກັບລະບຽບໃໝ່ເຫຼົ່ານີ້?

c. ທ່ານມີໂອກາດໄດ້ພົບກັບພາກລັດ ແລະ ໄດ້ສະເໜີຄຳຄິດເຫັນຕໍ່ກົດໝາຍ ແລະ ກົດລະບຽບກ່ຽວກັບການບໍລິການສຳລັບຄົນພິການ ແລະ ການຟື້ນຟູໜ້າທີ່ການບໍ?
ກະລຸນາອະທິບາຍວ່າແມ່ນຫຍັງ, ມີຄືແນວໃດ ແລະ ຜົນໄດ້ຮັບມີຄືແນວໃດ?

9. ມີນະໂຍບາຍອື່ນບໍ ທີ່ກຳນົດວ່າ ສະຖານທີ່ບໍລິການນີ້ ຄວນມີການດຳເນີນງານແນວໃດ?

ຖ້າມີ, ນະໂຍບາຍດັ່ງກ່າວໄດ້ກຳນົດບໍ່ວ່າສະຖານທີ່ການບໍລິການນີ້ ຄວນມີການດຳເນີນງານແນວໃດ?
ມັນສ້າງຄວາມແຕກຕ່າງໃນການເຮັດວຽກປະຈຳວັນໃນການບໍລິການຢູ່ນີ້ບໍ?

10. ທ່ານລາຍງານຂໍ້ມູນຫຍັງໃຫ້ທາງກະຊວງສາທາກ່ຽວກັບການບໍລິການໃຫ້ກັບຄົນພິການທີ່ທ່ານສະໜອງ (ຖ້າມີ)?

ຂໍ້ມູນເຫລົ່ານີ້ສາມາດຖືກແຍກອອກໂດຍເປັນປະເພດຂອງຄວາມບົກຜ່ອງຂອງຄວາມພິການ/ຫລືແຍກເປັນປະເພດການຮັບບໍລິການບໍ? ທ່ານໄດ້ມີການສື່ສານພ້ອພັນກັບ ກະຊວງສາທາ ເລື້ອຍປານໃດ?

11. ທ່ານຫລືຄົນອື່ນທີ່ເຮັດວຽກງານສູນບໍລິການນີ້ໄດ້ເຂົ້າຮ່ວມໃນການຕິດຕາມການປະຕິບັດນະໂຍບາຍແຫ່ງຊາດກ່ຽວກັບການສະໜອງການບໍລິການຄົນພິການແລະການຟື້ນຟູໃນລະດັບໃດ?

ທ່ານເຄີຍເຂົ້າຮ່ວມເຮັດວຽກກັບກຸ່ມຈັດຕັ້ງປະຕິບັດໃນຫົວຂໍ້ນີ້ບໍ? ກະລຸນາ
ອະທິບາຍກ່ຽວກັບປະສົບການດັ່ງກ່າວ.

ລັດຖະບານ ສປປ ລາວ – ການສຳພາດ KII – HEALTH-RELATED GOL AND TWG

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ພາກທີ 1 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: USAID Okard ທິດສະດີການປ່ຽນແປງ	1	ສິ່ງທ້າທາຍສຳລັບການເຂົ້າເຖິງການບໍລິການ: ດ້ານສຸຂະພາບ,ການຟື້ນຟູຫນ້າທີ່ການສຸຂະພາບທາງຈິດຂອງຄົນພິການ ໃນສປປລາວມີຫຍັງແດ່?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ : ມີສິ່ງທ້າທາຍອັນໃດແດ່ ທີ່ຄົນພິການທຸກປະເພດພົບພໍ້ຄືກັນ ຫລື ແຕກຕ່າງກັນ ໂດຍອີງໃສ ເພດ, ອາຍຸ, ສະຖານທີ່,ປະເພດພິການ, ຊົນເຜົ່າຂອງເຂົາເຈົ້າ?
	2	1) ກະຊວງສາທາ; ແລະ 2) ການບໍລິການສຸຂະພາບ/ສິ່ງອຳນວຍຄວາມສະດວກ ຄວນຈະເຮັດອັນໃດ ເພື່ອສົ່ງເສີມປັບປຸງສຸຂະພາບຂອງຄົນພິການ?
	3	ຊຸມຊົນ ຫລືວ່າ ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ, ອົງການຈັດຕັ້ງທາງສັງຄົມ,ຜູ້ດູແລ, ອຳນາດການປົກຄອງທ້ອງຖິ່ນ) ຄວນຈະເຮັດຫຍັງເພື່ອສົ່ງເສີມການເຂົ້າເຖິງການບໍລິການດ້ານສຸຂະພາບຂອງຄົນພິການ?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ເງື່ອນໄຂຈຳເປັນທີ່ເຮັດໃຫ້ ຂັ້ນຕອນດັ່ງກ່າວສຳເລັດໄດ້ມີຫຍັງແດ່? ກົດໝາຍ, ລະບຽບ, ການປະສານງານລະຫວ່າງພາກສ່ວນທີ່ກ່ຽວຂ້ອງ,ການສ້າງລາຍຮັບ(ເສດຖະກິດ) ແລະ ອື່ນໆ? ມັນມີຄວາມຈຳເປັນບໍ ທີ່ລັດຖະບານແລະຊຸມຊົນຈະເຮັດວຽກຮ່ວມກັນ? ຮ່ວມກັນແນວໃດ?
	7	ສິ່ງທ້າທາຍຫລາຍທີ່ສຸດທີ່ຄົນພິການປະສົບ ໃນການບັນລຸ ການຮັກສາສຸຂະພາບທີ່ດີ ?
	8	ທ່ານຄິດວ່າ ພາກລັດ ແລະຜູ້ໃຫ້ບໍລິການດ້ານສຸຂະພາບ ຫຼື ຊຸມຊົນ ສຳຄັນກວ່າກັນໃນການປັບປຸງຊີວິດຂອງຄົນພິການ *(ຫຼື - ແມ່ນໃຜທີ່ສຳຄັນທີ່ສຸດສຳລັບການປັບປຸງຊີວິດຂອງຄົນພິການໃນປະເທດລາວ?)*? ເປັນຫຍັງທ່ານຈຶ່ງຄິດແນວນັ້ນ? ກະລຸນາອະທິບາຍ.
ພາກທີ2 ຄຳຖາມປະເມີນຍ່ອຍ EQ A	1	ທ່ານໄດ້ຮັບຮູ້ກ່ຽວກັບເອກະສານນິຕິກຳ 2 ສະບັບນີ້ບໍ: 1)ນະໂຍບາຍແຫ່ງຊາດວ່າດ້ວຍຄົນພິການ(ຮ່າງ), ຍຸດທະສາດແລະແຜນຈັດຕັ້ງປະຕິບັດ(ນະໂຍບາຍ) ແລະ 2) ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດຟື້ນຟູຫນ້າທີ່ການແລະແຜນຈັດຕັ້ງປະຕິບັດ?

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ຫົວຂໍ້: **ໂຄງຮ່າງນະໂຍບາຍ,** ກົດລະບຽບແຫ່ງຊາດແລະນະໂຍບາຍກ່ຽວກັບການມີສ່ວນຮ່ວມຂອງຄົນພິການ, ແລະການຈັດຕັ້ງບໍລິຫານຂັ້ນຊຸມຊົນ	2	ໃນປັດຈຸບັນ, ການປະຕິບັດນະໂຍບາຍ /ແຜນໄດ້ມີການຈັດຕັ້ງປະຕິບັດໃນລະດັບໃດ (ຂັ້ນສູນກາງ, ແຂວງ,ເມືອງ,ໃນຊຸມຊົນ, ສູນບໍລິການຕ່າງໆ)? ປະຕິບັດແນວໃດ? ຖ້າບໍ່ຖືກປະຕິບັດ, ຍ້ອນຫຍັງ? [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບນະໂຍບາຍແລະແຜນຈັດຕັ້ງປະຕິບັດ]
ພາກທີ3 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: **ຄວາມສາມາດຂອງພາກລັດ** (ງົບປະມານ, ບຸກຄະລາກອນ, ເຕັກໂນໂລຢີ) ໃນການຈັດຕັ້ງປະຕິບັດແລະຕິດຕາມນະໂຍບາຍ /ຍຸດທະສາດ /ແຜນ	1	ທ່ານຄິດວ່າ ກະຊວງສາທາ ມີງົບປະມານແລະບຸກຄະລາກອນທີ່ຈຳເປັນ ໃນການຈັດຕັ້ງປະຕິບັດ ແລະຕິດຕາມ ນະໂຍບາຍເຫຼົ່ານີ້? ຖ້າບໍ່ມີ, ໃຫ້ອະທິບາຍສິ່ງທ້າທາຍທາງດ້ານການເງິນແລະບຸກຄະລາກອນ ທີ່ພວກເຂົາ(ກະຊວງສາທາ)ປະສົບ.
	2	ທ່ານຄິດວ່າ, ກະຊວງສາທາ ມີ ເຕັກໂນໂລຢີ,ອຸປະກອນ ແລະເຄື່ອງມືທີ່ສຳຄັນໃນການປະຕິບັດນະໂຍບາຍເຫຼົ່ານີ້? ຖ້າບໍ່ມີ, ໃຫ້ອະທິບາຍເຕັກໂນໂລຢີ ທີ່ກ່ຽວຂ້ອງເຖິງສິ່ງທ້າທາຍທີ່ພວກເຂົາ(ກະຊວງສາທາ)ປະສົບ. [ໃຫ້ໄປຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມສາມາດທາງດ້ານ ການເງິນ, ບຸກຄະລາກອນ, ເຕັກໂນໂລຢີ]
ພາກທີ4 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: **ການປະສານງານ /ສື່ສານ ແລະການແລກປ່ຽນຂໍ້ມູນພາກສ່ວນທີ່ກ່ຽວຂ້ອງ**	1	ຂໍໃຫ້ທ່ານອະທິບາຍກ່ຽວກັບລະບົບການປະສານງານແລະການແລກປ່ຽນຂໍ້ມູນ ພາຍໃນDPOs(ອົງການເຮັດວຽກກັບຄົນພິການ)/INGOs/ອົງການຈັດຕັ້ງ (ຂັ້ນສູນກາງ, ແຂວງ, ເມືອງ) ຄືແນວໃດ? ລະບົບການປະສານງານ ແລະ ແລກຂໍ້ມູນ ລະຫວ່າງພາກລັດກັບອົງການຈັດຕັ້ງສາກົນ,ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ,ຜູ້ໃຫ້ທຶນມີແນວໃດ?ແມ່ນໃຜທີ່ເປັນຜູ້ປະສານງານແລະ/ຫລືແລກປ່ຽນຂໍ້ມູນ? ລະບົບຂໍ້ມູນອ້າງອີງອັນໃດບ໋? ຢູ່ໃນລະດັບໃດ?ມີຫົວຂໍ້ກ່ຽວກັບຫຍັງ?
	2	ມີລະບົບແລະຮູບແບບການປະສານງານແລະການແລກປ່ຽນຂໍ້ມູນອັນໃດແດ່ ທີ່ເຮັດໄດ້ດີກວ່າ?(ຍົກຕົວຢ່າງ ການປະສານງານລະຫວ່າງລັດຖະບານແລະຜູ້ໃຫ້ທຶນຫລືຜູ້ໃຫ້ທຶນແລະອົງການຈັດຕັ້ງສາກົນ) ກະລຸນາອະທິບາຍ [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມສາມາດດ້ານການປະສານງານແລະລະບົບຂໍ້ມູນ]
ພາກທີ5	1	ທ່ານຄິດວ່າປະເທດລາວ (ແລະບັນດາຊຸມຊົນທີ່ຫຼາກຫຼາຍ) ພ້ອມບໍ່ສຳລັບການ ເຮັດໃຫ້ ຄົນພິການມີສ່ວນຮ່ວມໃນສັງຄົມ? ເປັນຫຍັງຈຶ່ງພ້ອມແລະບໍ່ພ້ອມ?

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: **ຄຳໝັ້ນສັນຍາ,** ການເປັນເຈົ້າການ/ຄວາມສົນໃຈ ຂອງພາກສ່ວນກ່ຽວຂ້ອງຕໍ່ກັບ ວິທີການຂອງ OKARD ແລະ ນະໂຍບາຍ/ຍຸດທະສາດ/ແຜນລະດັບຊາດ	2	ກະຊວງສາທາ ໄດ້ສະໜັບສະໜູນ ການຈັດຕັ້ງປະຕິບັດແຜນງານເຫລົ່ານີ້ແລ້ວບໍ ຫຼືວ່າ ມີແຜນທີ່ຈະສະໜັບສະໜູນ ແນວໃດ ຖ້າຍັງບໍ່ໄດ້ຖືກຈັດຕັ້ງປະຕິບັດ?
	3	ທ່ານມີຄວາມເຊື່ອໝັ້ນຕໍ່ນະໂຍບາຍແຫ່ງຊາດຄົນພິການ, ຍຸດທະສາດ ແລະ ແຜນງານແລະ ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດການຟື້ນຟູໜ້າທີ່ການ ວ່າຈະປະສົບຜົນສຳເລັດໃນການປັບປຸງຊີວິດຂອງຄົນພິການ? ຍ້ອນຫຍັງຈຶ່ງເຊື່ອ ຫຼື ບໍ່ເຊື່ອ? [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄຳໝັ້ນສັນຍາຂອງລັດຖະບານລາວ]
ພາກທີ່ 6 ຫົວຂໍ້: ການຮັບຮູ້ຂອງ ຄົນພິການກ່ຽວກັບ: ອົງກອນຊຸມຊົນ ທີ່ເຮັດແຜນງານ/ ອົງການແລະການບໍລິການ	1	ທ່ານຄິດວ່າ ຄົນພິການ **ຮັບຮູ້ເຖິງ** ສະຖານທີ່ ບໍລິການສຸຂະພາບ ແລະ ສູນຟື້ນຟູໜ້າທີ່ການ, ສະຖາບັນການສຶກສາ ແລະ ການຈ້າງງານ ແລະ ອົງການຈັດຕັ້ງຊຸມຊົນທີ່ເຮັດວຽກກ່ຽວກັບ ຄົນພິການ **ຢູ່ໃນລະດັບໃດ ?**
	2	ຖ້າເຂົາບໍ່ຮູ້, ແມ່ນຫຍັງທີ່ສະກັດກັ້ນ/ຈຳກັດ?
ພາກທີ່ 7 ຫົວຂໍ້: ການຮັບຮູ້ຂອງຄົນ ພິການ ກ່ຽວກັບພາກລັດ ແລະກຸ່ມຜູ້ທີ່ອອກແບບ, ຈັດຕັ້ງປະຕິບັດແລະຕິດຕາມຍຸດທະສາ ດແລະນະໂຍບາຍກ່ຽວກັບ ຄວາມພິການແລະການຟື້ນຟູ	1	ທ່ານຄິດວ່າຄົນພິການມີໂອກາດໄດ້ພົບປະ ແລະ ສະໜອງຂໍ້ມູນ/ຄຳຄິດເຫັນຕໍ່ພາກລັດ ແລະ ບັນດາອົງການຈັດຕັ້ງທີ່ມີ ອອກແບບ, ຈັດຕັ້ງປະຕິບັດ ແລະ ຕິດຕາມນະໂຍບາຍເຫຼົ່ານີ້ໃນລະດັບໃດ?
	2	ທ່ານຄິດວ່າ ຄົນພິການ ຄວນໄດ້ເຂົ້າມາມີສ່ວນຮ່ວມ ໃນການພົບປະ ແລະ ສະໜອງຂໍ້ມູນ/ຄຳຄິດເຫັນໃຫ້ພາກລັດ ເພີ່ມຂຶ້ນຄືບໍ? ຍ້ອນຫຍັງຈຶ່ງເພີ່ມຂຶ້ນ ຫຼື ບໍ່ເພີ່ມຂຶ້ນ? ຄວນຈະ ເຮັດແນວໃດ?
ພາກທີ່ 8 ຄຳຖາມປະເມີນຍ່ອຍ EQ E	1	ທ່ານໄດ້ ເວົ້າເຖິງສິ່ງທ້າທາຍການເຂົ້າເຖິງ ການບໍລິການສຸຂະພາບ, ການສຶກສາ ແລະ ການຈ້າງງານ ແລະ ວິທີທາງໃນການປັບປຸງເພື່ອສົ່ງເສີມຄົນພິການໄດ້ຮັບບໍລິການ ສະນັ້ນ **ແມ່ນຫຍັງຄືບັດ ໃຈທີ່ສຳຄັນທີ່ສຸດ ເພື່ອຮັບປະກັນ/ສະກັດກັ້ນ ບໍ່ໃຫ້ເກີດສິ່ງທ້າທາຍເຫລົ່ານີ້ ອີກ** (ຄວາມຍືນຍົງຂອງຜົນໄດ້ຮັບນີ້)?

[ຕາຕະລາງຄວາມສາມາດຂອງລະບົບ (ຕາຕະລາງຄຳຖາມກ່ຽວກັບການຈັດລຳດັບ) ແມ່ນຢູ່ໜ້າຕໍ່ໄປ]

ລະຫັດຂອງຜູ້ຕອບ:					
ຫົວຂໍ້ລະບົບດ້ານຄວາມສາມາດ	**ການຈັດລຳດັບ**				
	1– ອ່ອນຫຼາຍ	2 - ອ່ອນ	3 – ປານກາງ	4 – ພຶງພໍໃຈ	5 – ພຶງພໍໃຈຫຼາຍ
ນະໂຍບາຍ, ຍຸດທະສາດ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ (ສຳລັບຄົນພິການ)					
ກົດໝາຍດ້ານຄວາມພິການແລະຍຸດທະສາດແຫ່ງຊາດດ້ານຄວາມພິການ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ(ຂອງກະຊວງແຮງງານ)					
ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດຟື້ນຟູໜ້າທີ່ການ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ(ຂອງກະຊວງສາທາ)					
ຄວາມສາມາດທາງດ້ານການເງິນຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະແຜນປະຕິບັດງານ) (ຂອງກະຊວງສາທາ)					
ບຸກຄະລາກອນຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງສາທາ)					
ເຕັກໂນໂລຢີ ແລະຢາທີ່ມີສຳລັບສິ່ງອຳນວຍຄວາມສະດວກດ້ານສຸຂະພາບ (ໃນການຈັດຕັ້ງປະຕິບັດແລະປະຕິບັດແຜນ /ຍຸດທະສາດ)					
ຄວາມສາມາດຂອງພາກລັດໃນການປະສານງານ ແລະ ແລກປ່ຽນຂໍ້ມູນ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງສາທາ)					
ຄວາມສາມາດຂອງພາກລັດໃນການປະສານງານ ແລະ ແລກປ່ຽນຂໍ້ມູນຂອງພາກລັດກັບຜູ້ຮ່ວມຈັດຕັ້ງປະຕິບັດ(ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງສາທາ)					
ຄວາມມຸ່ງໝັ້ນ ແລະ ຕັດສິນໃຈຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງສາທາ)					
ຄວາມມຸ່ງໝັ້ນ ແລະ ຕັດສິນໃຈຂອງສັງຄົມ (ສິ່ງເສີມໃຫ້ທຸກຄົນໄດ້ມີສ່ວນໃນສັງຄົມທີ່ເພີ່ມຂຶ້ນ)					

ລັດຖະບານ ສປປ ລາວ – ການສຳພາດ KII – EDUCATION-RELATED GOL AND TWG

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ພາກທີ I ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: USAID Okard ທິດສະດີການປ່ຽນແປງ	4	ແມ່ນຫຍັງທີ່ເປັນສິ່ງທ້າທາຍ ສຳລັບຄົນພິການປະເຊີນໃນການຊອກວຽກວຽກເຮັດງານທຳ?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ມີສິ່ງທ້າທາຍອັນໃດ ທີ່ຄົນພິການທຸກປະເພດພົບພໍ້ຄືກັນ ຫລື ແຕກຕ່າງກັນ ໂດຍອີງໃສ ເພດ, ອາຍຸ, ສະຖານທີ່, ປະເພດພິການ ຫຼື ຊົນເຜົ່າຂອງເຂົາ?
	5	I) ລັດຖະບານ(ຂັ້ນສູນກາງ, ແຂວງ, ເມືອງ); ແລະ 2) ;ວິທະຍາໄລອະຊີວະ ແລະ 3) ພາກເອກະຊົນ ສາມາດເຮັດຫຍັງໄດ້ແດ່ເພື່ອປັບປຸງ ດ້ານເສດຖະກິດ ຂອງຄົນພິການ?
	6	ຂັ້ນຊຸມຊົນ ຫລືວ່າ ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ, ສະມາຄົມບໍ່ຫວ້ງຜົນກຳໄລ,ຜູ້ເບິ່ງແຍງ, ອຳນາດການປົກຄອງທ້ອງຖິ່ນສາມາດເຮັດຫຍັງໄດ້ແດ່ ເພື່ອເພີ່ມການເຂົ້າເຖິງການຝຶກອົບຮົມແລະການຈ້າງງານຂອງຄົນພິການ?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ເງື່ອນໄຂຈຳເປັນທີ່ເຮັດໃຫ້ ຂັ້ນຕອນດັ່ງກ່າວສຳເລັດໄດ້ມີຫຍັງແດ່? ກົດໝາຍ, ລະບຽບ, ການປະສານງານລະຫວ່າງພາກສ່ວນທີ່ກ່ຽວຂ້ອງ,ການສ້າງລາຍຮັບ(ເສດຖະກິດ) ແລະ ອື່ນໆ? ມັນມີຄວາມຈຳເປັນບໍ ທີ່ລັດຖະບານແລະຊຸມຊົນຈະເຮັດວຽກຮ່ວມກັນ? ຮ່ວມກັນແນວໃດ?
	7	ສິ່ງທ້າທາຍຫລາຍທີ່ສຸດທີ່ຄົນພິການປະສົບ ໃນການບັນລຸ ການຮັກສາສຸຂະພາບທີ່ດີ, ການເຂົ້າເຖິງການສຶກສາ, ການເຂົ້າເຖິງການຈ້າງງານ (ໃຫ້ເລືອກຫນຶ່ງຄຳຕອບ)?
	8	ທ່ານຄິດວ່າ ພາກລັດ ແລະ ວິທະຍາໄລອະຊີວະສຶກສາ ຫຼື ຊຸມຊົນ ສຳຄັນກວ່າກັນໃນການປັບປຸງຊີວິດຂອງຄົນພິການ (ຫຼື - ແມ່ນໃຜທີ່ສຳຄັນທີ່ສຸດສຳລັບການປັບປຸງຊີວິດຂອງຄົນພິການໃນປະເທດລາວ?)? ເປັນຫຍັງທ່ານຈຶ່ງຄິດແນວນັ້ນ? ກະລຸນາອະທິບາຍ.
ພາກທີ2 ຄຳຖາມປະເມີນຍ່ອຍ EQ A	I	ທ່ານໄດ້ຮັບຮູ້ກ່ຽວກັບເອກະສານນິຕິກຳ 2 ສະບັບນີ້ບໍ: I)ນະໂຍບາຍແຫ່ງຊາດວ່າດ້ວຍຄົນພິການ(ຮ່າງ), ຍຸດທະສາດແລະແຜນຈັດຕັ້ງປະຕິບັດ(ນະໂຍບາຍ) ແລະ 2) ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດຟື້ນຟູຫນ້າທີ່ການແລະແຜນຈັດຕັ້ງປະຕິບັດ?

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ຫົວຂໍ້: ໂຄງຮ່າງນະໂຍບາຍ, ກົດລະບຽບແຫ່ງຊາດແລະນະ ໂຍບາຍກ່ຽວກັບການມີສ່ວນຮ່ວມ ຂອງຄົນພິການ, ແລະການຈັດຕັ້ງບໍລິຫານຂັ້ນລຸ່ມລຸ່ມ	2	ໃນປັດຈຸບັນ, ການປະຕິບັດນະໂຍບາຍ /ແຜນໄດ້ມີການຈັດຕັ້ງປະຕິບັດໃນລະດັບໃດ (ຂັ້ນສູນກາງ, ແຂວງ,ເມືອງ,ໃນລຸ່ມລຸ່ມ, ສູນບໍລິການຕ່າງໆ)? ປະຕິບັດແນວໃດ? ຖ້າບໍ່ຖືກປະຕິບັດ, ຍ້ອນຫຍັງ? [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບນະໂຍບາຍແລະແຜນຈັດຕັ້ງປະຕິບັດ]
ພາກທີ3 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ຄວາມສາມາດຂອງພາກລັດ (ງົບປະມານ, ບຸກຄະລາກອນ, ເຕັກໂນໂລຢີ) ໃນການຈັດຕັ້ງປະຕິບັດແລະຕິດຕາມ ນະໂຍບາຍ /ຍຸດທະສາດ /ແຜນ	1	ທ່ານຄິດວ່າ ກະຊວງສຶກສາ ມີງົບປະມານແລະບຸກຄະລາກອນທີ່ຈຳເປັນ ໃນການຈັດຕັ້ງປະຕິບັດ ແລະຕິດຕາມ ນະໂຍບາຍເຫຼົ່ານີ້? ຖ້າບໍ່ມີ, ໃຫ້ອະທິບາຍສິ່ງທ້າທາຍທາງດ້ານການເງິນແລະບຸກຄະລາກອນ ທີ່ພວກເຂົາປະສົບ.
	2	ທ່ານຄິດວ່າ, ກະຊວງສຶກສາ ມີ ເຕັກໂນໂລຢີ,ອຸປະກອນ ແລະເຄື່ອງມືທີ່ສຳຄັນໃນການປະຕິບັດນະໂຍບາຍເຫຼົ່ານີ້? ຖ້າບໍ່ມີ, ໃຫ້ອະທິບາຍເຕັກໂນໂລຢີ ທີ່ກ່ຽວຂ້ອງເຖິງສິ່ງທ້າທາຍທີ່ພວກເຂົາປະສົບ. [ໃຫ້ໄປຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມສາມາດທາງດ້ານ ການເງິນ, ບຸກຄະລາກອນ, ເຕັກໂນໂລຢີ]
ພາກທີ4 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ການປະສານງານ /ສື່ສານ ແລະການແລກປ່ຽນຂໍ້ມູນພາກ ສ່ວນທີ່ກ່ຽວຂ້ອງ	1	ຂໍໃຫ້ທ່ານອະທິບາຍກ່ຽວກັບລະບົບການປະສານງານແລະການແລກປ່ຽນຂໍ້ມູນ ພາຍໃນDPOs(ອົງການເຮັດວຽກກັບຄົນພິການ)/INGOs/ອົງການຈັດຕັ້ງ (ຂັ້ນສູນກາງ, ແຂວງ, ເມືອງ) ຄືແນວໃດ? ລະບົບການປະສານງານ ແລະ ແລກຂໍ້ມູນ ລະຫວ່າງພາກລັດກັບອົງການຈັດຕັ້ງສາກົນ,ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ,ຜູ້ໃຫ້ທຶນມີແນວໃດ?ແມ່ນໃຜທີ່ ເປັນຜູ້ປະສານງານແລະ/ຫລືແລກປ່ຽນຂໍ້ມູນ? ລະບົບຂໍ້ມູນອ້າງອີງອັນໃດບ໋? ຢູ່ໃນລະດັບໃດ?ມີຫົວຂໍ້ກ່ຽວກັບຫຍັງ?
	2	ມີລະບົບແລະຮູບແບບການປະສານງານແລະການແລກປ່ຽນຂໍ້ມູນອັນໃດແດ່ ທີ່ເຮັດໄດ້ດີກວ່າ?(ຍົກຕົວຢ່າງ ການປະສານງານລະຫວ່າງລັດຖະບານແລະຜູ້ໃຫ້ທຶນຫລືຜູ້ໃຫ້ທຶນແລະອົງການຈັດຕັ້ງສາກົນ) ກະລຸນາອະທິບາຍ

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
		[ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມສາມາດດ້ານການປະສານງານແລະລະບົບຂໍ້ມູນ]
ພາກທີ5 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ຄຳໝັ້ນສັນຍາ, ການເປັນເຈົ້າການ/ຄວາມສົນໃຈ ຂອງພາກສ່ວນກ່ຽວຂ້ອງຕໍ່ກັບ ວິທີການຂອງ OKARD ແລະ ນະໂຍບາຍ/ຍຸດທະສາດ/ແຜນລະດັບຊາດ	1	ທ່ານຄິດວ່າປະເທດລາວ (ແລະບັນດາຊຸມຊົນທີ່ຫຼາກຫຼາຍ) ພ້ອມບໍ່ສຳລັບການ ເຮັດໃຫ້ ຄົນພິການມີສ່ວນຮ່ວມໃນສັງຄົມ? ເປັນຫຍັງຈຶ່ງພ້ອມແລະບໍ່ພ້ອມ?
	2	ກະຊວງສຶກສາ ໄດ້ສະໜັບສະໜູນ ການຈັດຕັ້ງປະຕິບັດແຜນງານເຫລົ່ານີ້ແລ້ວບໍ ຫຼືວ່າ ມີແຜນທີ່ຈະສະໜັບສະໜູນ ແນວໃດ ຖ້າຍັງບໍ່ໄດ້ຖືກຈັດຕັ້ງປະຕິບັດ?
	3	ທ່ານມີຄວາມເຊື່ອໝັ້ນຕໍ່ນະໂຍບາຍແຫ່ງຊາດຄົນພິການ, ຍຸດທະສາດ ແລະ ແຜນງານແລະ ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດການຟື້ນຟູໜ້າທີ່ການ ວ່າຈະປະສົບຜົນສຳເລັດໃນການປັບປຸງຊີວິດຂອງຄົນພິການ? ຍ້ອນຫຍັງຈຶ່ງເຊື່ອ ຫຼື ບໍ່ເຊື່ອ? [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄຳໝັ້ນສັນຍາຂອງລັດຖະບານລາວ]
ພາກທີ່ 6 ຫົວຂໍ້: ການຮັບຮູ້ຂອງ ຄົນພິການກ່ຽວກັບ: ອົງກອນຊຸມຊົນ ທີ່ເຮັດແຜນງານ/ ອົງການແລະການບໍລິການ	1	ທ່ານຄິດວ່າ ຄົນພິການ ຮັບຮູ້ເຖິງ ສະຖານທີ່ ບໍລິການສຸຂະພາບ ແລະ ສູນຟື້ນຟູໜ້າທີ່ການ, ສະຖາບັນການສຶກສາ ແລະ ການຈ້າງງານ ແລະ ອົງການຈັດຕັ້ງຊຸມຊົນທີ່ເຮັດວຽກກ່ຽວກັບ ຄົນພິການ ຢູ່ໃນລະດັບໃດ ?
	2	ຖ້າເຂົາບໍ່ຮູ້, ແມ່ນຫຍັງທີ່ສະກັດກັ້ນ/ຈຳກັດ?
ພາກທີ່ 7 ຫົວຂໍ້: ການຮັບຮູ້ຂອງຄົນ ພິການ ກ່ຽວກັບພາກລັດ ແລະກຸ່ມຜູ້ທີ່ອອກແບບ, ຈັດຕັ້ງປະຕິບັດແລະຕິດຕາມຍຸດທະສາດແລະ ນະໂຍບາຍກ່ຽວກັບ ຄວາມພິການແລະການຟື້ນຟູ	1	ທ່ານຄິດວ່າຄົນພິການມີໂອກາດໄດ້ພົບປະ ແລະ ສະໜອງຂໍ້ມູນ/ຄຳຄິດເຫັນຕໍ່ພາກລັດ ແລະ ບັນດາອົງການຈັດຕັ້ງທີ່ມີ ອອກແບບ, ຈັດຕັ້ງປະຕິບັດ ແລະ ຕິດຕາມນະໂຍບາຍເຫຼົ່ານີ້ໃນລະດັບໃດ?
	2	ທ່ານຄິດວ່າ ຄົນພິການ ຄວນໄດ້ເຂົ້າມາມີສ່ວນຮ່ວມ ໃນການພົບປະ ແລະ ສະໜອງຂໍ້ມູນ/ຄຳຄິດເຫັນໃຫ້ ພາກລັດ ເພີ່ມຂຶ້ນຄືບໍ? ຍ້ອນຫຍັງຈຶ່ງເພີ່ມຂຶ້ນ ຫຼື ບໍ່ເພີ່ມຂຶ້ນ? ຄວນຈະເຮັດແນວໃດ?
ພາກທີ່ 8 ຄຳຖາມປະເມີນຍ່ອຍ EQ E	1	ທ່ານໄດ້ ເວົ້າເຖິງສິ່ງທ້າທາຍການເຂົ້າເຖິງ ການບໍລິການສຸຂະພາບ, ການສຶກສາ ແລະ ການຈ້າງງານ ແລະ ວິທີ ທາງໃນການປັບປຸງເພື່ອສົ່ງເສີມຄົນພິການໄດ້ຮັບບໍລິການ ສະນັ້ນ ແມ່ນຫຍັງຄືບັດໃຈທີ່ສຳຄັນທີ່ສຸດ ເພື່ອ ຮັບປະກັນ/ສະກັດກັ້ນ ບໍ່ໃຫ້ເກີດສິ່ງທ້າທາຍເຫລົ່ານີ້ ອີກ (ຄວາມຍືນຍົງຂອງຜົນໄດ້ຮັບນີ້)?

[ຕາຕະລາງຄວາມສາມາດຂອງລະບົບ (ຕາຕະລາງຄຳຖາມກ່ຽວກັບການຈັດລຳດັບ) ແມ່ນຢູ່ໜ້າຕໍ່ໄປ]

ລະຫັດຂອງຜູ້ຕອບ:					
ຫົວຂໍ້ລະບົບດ້ານຄວາມສາມາດ	ການຈັດລຳດັບ				
	1– ອ່ອນຫຼາຍ	2 - ອ່ອນ	3 – ປານກາງ	4 – ພຶງພໍໃຈ	5 – ພຶງພໍໃຈຫຼາຍ
ນະໂຍບາຍ, ຍຸດທະສາດ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ (ສຳລັບຄົນພິການ)					
ກົດໝາຍດ້ານຄວາມພິການແລະຍຸດທະສາດແຫ່ງຊາດດ້ານຄວາມພິການ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ(ຂອງກະຊວງແຮງງານ)					
ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດຟື້ນຟູໜ້າທີ່ການ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ(ຂອງກະຊວງສາທາ)					
ຄວາມສາມາດທາງດ້ານການເງິນຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະແຜນປະຕິບັດງານ) (ຂອງກະຊວງສຶກສາ)					
ບຸກຄະລາກອນຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງສຶກສາ)					
ເຕັກໂນໂລຢີ ແລະຍາທີ່ມີສຳລັບສິ່ງອຳນວຍຄວາມສະດວກດ້ານສຸຂະພາບ (ໃນການຈັດຕັ້ງປະຕິບັດແລະປະຕິບັດແຜນ /ຍຸດທະສາດ)					
ຄວາມສາມາດຂອງພາກລັດໃນການປະສານງານ ແລະ ແລກປ່ຽນຂໍ້ມູນ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງສຶກສາ)					
ຄວາມສາມາດຂອງພາກລັດໃນການປະສານງານ ແລະ ແລກປ່ຽນຂໍ້ມູນຂອງພາກລັດກັບຜູ້ຮ່ວມຈັດຕັ້ງປະຕິບັດ(ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງສຶກສາ)					
ຄວາມໝຸ່ງໝັ້ນ ແລະ ຕັດສິນໃຈຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງສຶກສາ)					
ຄວາມໝຸ່ງໝັ້ນ ແລະ ຕັດສິນໃຈຂອງສັງຄົມ (ສິ່ງເສີມໃຫ້ທຸກຄົນໄດ້ມີສ່ວນໃນສັງຄົມທີ່ເພີ່ມຂຶ້ນ)					

ວັດຖະບານ ສປປ ລາວ – ການສຳພາດ KII - MoLSW

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ພາກທີ I ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: USAID Okard ທິດສະດີການປ່ຽນແປງ	I	ສິ່ງທ້າທາຍສຳລັບການເຂົ້າເຖິງການບໍລິການ: ດ້ານສຸຂະພາບ,ການຟື້ນຟູຫນ້າທີ່ການສຸຂະພາບທາງຈິດຂອງຄົນພິການ ໃນສປປລາວມີຫຍັງແດ່?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ : ມີສິ່ງທ້າທາຍອັນໃດແດ່ ທີ່ຄົນພິການທຸກປະເພດພົບພໍ້ຄືກັນ ຫລື ແຕກຕ່າງກັນ ໂດຍອີງໃສ ເພດ, ອາຍຸ, ສະຖານທີ່,ປະເພດພິການ, ຊົນເຜົ່າຂອງເຂົາເຈົ້າ?
	2	I) ກະຊວງແຮງງານແລະສະຫວັດດີການສັງຄົມ; ແລະ 2) ກະຊວງສາທາ ຄວນຈະເຮັດອັນໃດ ເພື່ອສົ່ງເສີມປັບປຸງສຸຂະພາບຂອງຄົນພິການ?
	3	ຊຸມຊົນ ຫລືວ່າ ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ, ອົງການຈັດຕັ້ງທາງສັງຄົມ,ຜູ້ດູແລ, ອຳນາດການປົກຄອງທ້ອງຖິ່ນ) ຄວນຈະເຮັດຫຍັງເພື່ອສົ່ງເສີມການເຂົ້າເຖິງການບໍລິການດ້ານສຸຂະພາບຂອງຄົນພິການ?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ເງື່ອນໄຂຈຳເປັນທີ່ເຮັດໃຫ້ ຂັ້ນຕອນດັ່ງກ່າວສຳເລັດໄດ້ມີຫຍັງແດ່? ກົດໝາຍ, ລະບຽບ, ການປະສານງານລະຫວ່າງພາກສ່ວນທີ່ກ່ຽວຂ້ອງ,ການສ້າງລາຍຮັບ(ເສດຖະກິດ) ແລະ ອື່ນໆ? ມັນມີຄວາມຈຳເປັນບໍ ທີ່ລັດຖະບານແລະຊຸມຊົນຈະເຮັດວຽກຮ່ວມກັນ? ຮ່ວມກັນແນວໃດ?
	4	ແມ່ນຫຍັງທີ່ເປັນສິ່ງທ້າທາຍ ສຳລັບຄົນພິການປະເຊີນໃນການຊອກວຽກວຽກເຮັດງານທຳ?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ມີສິ່ງທ້າທາຍອັນໃດ ທີ່ຄົນພິການທຸກປະເພດພົບພໍ້ຄືກັນ ຫລື ແຕກຕ່າງກັນ ໂດຍອີງໃສ ເພດ, ອາຍຸ, ສະຖານທີ່, ປະເພດພິການ ຫຼື ຊົນເຜົ່າຂອງເຂົາ?
	5	I) ກະຊວງແຮງງານແລະສະຫວັດດີການສັງຄົມ; ແລະ 2) ກະຊວງສຶກສາ ແລະ 3) ພາກເອກະຊົນ ສາມາດເຮັດຫຍັງໄດ້ແດ່ເພື່ອປັບປຸງ ດ້ານເສດຖະກິດ ຂອງຄົນພິການ?

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
	6	ຂັ້ນຊຸມຊົນ ຫລືວ່າ ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ, ສະມາຄົມບໍ່ຫວັງຜົນກຳໄລ,ຜູ້ເບິ່ງແຍງ, ອຳນາດການປົກຄອງທ້ອງຖິ່ນສາມາດເຮັດຫຍັງໄດ້ແດ່ ເພື່ອເພີ່ມການເຂົ້າເຖິງການຝຶກອົບຮົມແລະການຈ້າງງານຂອງຄົນພິການ?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ເງື່ອນໄຂຈຳເປັນທີ່ເຮັດໃຫ້ ຂັ້ນຕອນດັ່ງກ່າວສຳເລັດໄດ້ມີຫຍັງແດ່? ກົດໝາຍ, ລະບຽບ, ການປະສານງານລະຫວ່າງພາກສ່ວນທີ່ກ່ຽວຂ້ອງ,ການສ້າງລາຍຮັບ(ເສດຖະກິດ) ແລະ ອື່ນໆ? ມັນມີຄວາມຈຳເປັນບໍ ທີ່ລັດຖະບານແລະຊຸມຊົນຈະເຮັດວຽກຮ່ວມກັນ? ຮ່ວມກັນແນວໃດ?
	7	ສິ່ງທ້າທາຍຫລາຍທີ່ສຸດທີ່ຄົນພິການປະສົບ ໃນການບັນລຸ ການຮັກສາສຸຂະພາບທີ່ດີ, ການເຂົ້າເຖິງການສຶກສາ, ການເຂົ້າເຖິງການຈ້າງງານ (ໃຫ້ເລືອກຫນຶ່ງຄຳຕອບ)?
	8	ທ່ານຄິດວ່າ ພາກລັດ ແລະຜູ້ໃຫ້ບໍລິການດ້ານສຸຂະພາບ/ວິທະຍາໄລອະຊີວະສຶກສາ ຫຼື ຊຸມຊົນ ສຳຄັນກວ່າກັນໃນການປັບປຸງຊີວິດຂອງຄົນພິການ (ຫຼື - ແມ່ນໃຜທີ່ສຳຄັນທີ່ສຸດສຳລັບການປັບປຸງຊີວິດຂອງຄົນພິການໃນປະເທດລາວ?)? ເປັນຫຍັງທ່ານຈຶ່ງຄິດແນວນັ້ນ? ກະລຸນາອະທິບາຍ.
ພາກທີ2 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ໂຄງຮ່າງນະໂຍບາຍ, ກົດລະບຽບແຫ່ງຊາດແລະນະໂຍບາຍກ່ຽວກັບການມີສ່ວນຮ່ວມຂອງຄົນພິການ, ແລະການຈັດຕັ້ງບໍລິຫານຂັ້ນຊຸມຊົນ	1	ທ່ານໄດ້ຮັບຮູ້ກ່ຽວກັບເອກະສານນິຕິກຳ 2 ສະບັບນີ້ບໍ: 1)ນະໂຍບາຍແຫ່ງຊາດວ່າດ້ວຍຄົນພິການ(ຮ່າງ), ຍຸດທະສາດແລະແຜນຈັດຕັ້ງປະຕິບັດ(ນະໂຍບາຍ) ແລະ 2) ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດຟື້ນຟູຫນ້າທີ່ການແລະແຜນຈັດຕັ້ງປະຕິບັດ?
	2	ໃນປັດຈຸບັນ, ການປະຕິບັດນະໂຍບາຍ /ແຜນໄດ້ມີການຈັດຕັ້ງປະຕິບັດໃນລະດັບໃດ (ຂັ້ນສູນກາງ, ແຂວງ,ເມືອງ,ໃນຊຸມຊົນ, ສູນບໍລິການຕ່າງໆ)? ປະຕິບັດແນວໃດ? ຖ້າບໍ່ຖືກປະຕິບັດ, ຍ້ອນຫຍັງ? [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບນະໂຍບາຍແລະແຜນຈັດຕັ້ງປະຕິບັດ]
ພາກທີ3 ຄຳຖາມປະເມີນຍ່ອຍ EQ A	1	ທ່ານຄິດວ່າ ກະຊວງແຮງງານແລະສະຫວັດດີການສັງຄົມ ມີງົບປະມານແລະບຸກຄະລາກອນທີ່ຈຳເປັນ ໃນການຈັດຕັ້ງປະຕິບັດ ແລະຕິດຕາມ ນະໂຍບາຍເຫຼົ່ານີ້? ຖ້າບໍ່ມີ, ໃຫ້ອະທິບາຍສິ່ງທ້າທາຍທາງດ້ານການເງິນແລະບຸກຄະລາກອນ ທີ່ພວກເຂົາປະສົບ.

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ຫົວຂໍ້: ຄວາມສາມາດຂອງພາກລັດ (ງົບປະມານ, ບຸກຄະລາກອນ, ເຕັກໂນໂລຢີ) ໃນການຈັດຕັ້ງປະຕິບັດແລະຕິດຕາມ ນະໂຍບາຍ /ຍຸດທະສາດ /ແຜນ	2	ທ່ານຄິດວ່າ, ກະຊວງແຮງງານແລະສະຫວັດດີການສັງຄົມ ມີ ເຕັກໂນໂລຢີ,ອຸປະກອນ ແລະເຄື່ອງມືທີ່ສຳຄັນໃນການປະຕິບັດນະໂຍບາຍເຫຼົ່ານີ້? ຖ້າບໍ່ມີ, ໃຫ້ອະທິບາຍເຕັກໂນໂລຢີ ທີ່ກ່ຽວຂ້ອງເຖິງສິ່ງທ້າທາຍທີ່ພວກເຂົາປະສົບ. [ໃຫ້ໄປຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມສາມາດທາງດ້ານ ການເງິນ, ບຸກຄະລາກອນ, ເຕັກໂນໂລຢີ]
ພາກທີ4 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ການປະສານງານ /ສື່ສານ ແລະການແລກປ່ຽນຂໍ້ມູນພາກ ສ່ວນທີ່ກ່ຽວຂ້ອງ	1	ຂໍໃຫ້ທ່ານອະທິບາຍກ່ຽວກັບລະບົບການປະສານງານແລະການແລກປ່ຽນຂໍ້ມູນ ພາຍໃນDPOs(ອົງການເຮັດວຽກກັບຄົນພິການ)/INGOs/ອົງການຈັດຕັ້ງ (ຂັ້ນສູນກາງ, ແຂວງ, ເມືອງ) ຄືແນວໃດ? ລະບົບການປະສານງານ ແລະ ແລກຂໍ້ມູນ ລະຫວ່າງພາກລັດກັບອົງການຈັດຕັ້ງສາກົນ,ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ,ຜູ້ໃຫ້ທຶນມີແນວໃດ?ແມ່ນໃຜທີ່ ເປັນຜູ້ປະສານງານແລະ/ຫລືແລກປ່ຽນຂໍ້ມູນ? ລະບົບຂໍ້ມູນອ້າງອີງອັນໃດບ໋? ຢູ່ໃນລະດັບໃດ?ມີຫົວຂໍ້ກ່ຽວກັບຫຍັງ?
	2	ມີລະບົບແລະຮູບແບບການປະສານງານແລະການແລກປ່ຽນຂໍ້ມູນອັນໃດແດ່ ທີ່ເຮັດໄດ້ດີກວ່າ?(ຍົກຕົວຢ່າງ ການປະສານງານລະຫວ່າງລັດຖະບານແລະຜູ້ໃຫ້ທຶນຫລືຜູ້ໃຫ້ທຶນແລະອົງການຈັດຕັ້ງສາກົນ) ກະລຸນາອະທິບາຍ [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມສາມາດດ້ານການປະສານງານແລະລະບົບຂໍ້ມູນ]
ພາກທີ5 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ຄຳໝັ້ນສັນຍາ, ການເປັນເຈົ້າການ/ຄວາມສົນໃຈ ຂອງພາກສ່ວນກ່ຽວຂ້ອງຕໍ່ກັບ ວິທີການຂອງ	1	ທ່ານຄິດວ່າປະທດລາວ (ແລະບັນດາຊຸມຊົນທີ່ຫຼາກຫຼາຍ) ພ້ອມບໍ່ສຳລັບການ ເຮັດໃຫ້ ຄົນພິການມີສ່ວນຮ່ວມໃນສັງຄົມ? ເປັນຫຍັງຈຶ່ງພ້ອມແລະບໍ່ພ້ອມ?
	2	ກະຊວງແຮງງານແລະສະຫວັດດີການສັງຄົມ ໄດ້ສະໜັບສະໜູນ ການຈັດຕັ້ງປະຕິບັດແຜນງານເຫລົ່ານີ້ແລ້ວ ບໍ ຫຼືວ່າ ມີແຜນທີ່ຈະສະໜັບສະໜູນ ແນວໃດ ຖ້າຍັງບໍ່ໄດ້ຖືກຈັດຕັ້ງປະຕິບັດ?

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
OKARD ແລະ ນະໂຍບາຍ/ຍຸດທະສາດ/ແຜນລະດັບຊາດ	3	ທ່ານມີຄວາມເຊື່ອໝັ້ນຕໍ່ນະໂຍບາຍແຫ່ງຊາດຄົນພິການ, ຍຸດທະສາດ ແລະ ແຜນງານແລະ ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດການຟື້ນຟູໜ້າທີ່ການ ວ່າຈະປະສົບຜົນສຳເລັດໃນການປັບປຸງຊີວິດຂອງຄົນພິການ? ຍ້ອນຫຍັງຈຶ່ງເຊື່ອ ຫຼື ບໍ່ເຊື່ອ? [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄຳໝັ້ນສັນຍາຂອງລັດຖະບານລາວ]
ພາກທີ 6 ຫົວຂໍ້: ການຮັບຮູ້ຂອງ ຄົນພິການກ່ຽວກັບ: ອົງກອນຊຸມຊົນ ທີ່ເຮັດແຜນງານ/ ອົງການແລະການບໍລິການ	1	ທ່ານຄິດວ່າ ຄົນພິການ ຮັບຮູ້ເຖິງ ສະຖານທີ່ ບໍລິການສຸຂະພາບ ແລະ ສູນຟື້ນຟູໜ້າທີ່ການ, ສະຖາບັນການສຶກສາ ແລະ ການຈ້າງງານ ແລະ ອົງການຈັດຕັ້ງຊຸມຊົນທີ່ເຮັດວຽກກ່ຽວກັບ ຄົນພິການ ຢູ່ໃນລະດັບໃດ ?
	2	ຖ້າເຂົາບໍ່ຮູ້, ແມ່ນຫຍັງທີ່ສະກັດກັ້ນ/ຈຳກັດ?
ພາກທີ 7 ຫົວຂໍ້: ການຮັບຮູ້ຂອງຄົນ ພິການ ກ່ຽວກັບພາກລັດ ແລະກຸ່ມຜູ້ທີ່ອອກແບບ, ຈັດຕັ້ງປະຕິບັດແລະຕິດຕາມຍຸດທະສາດແລະ ນະໂຍບາຍກ່ຽວກັບ ຄວາມພິການແລະການຟື້ນຟູ	1	ທ່ານຄິດວ່າຄົນພິການມີໂອກາດໄດ້ພົບປະ ແລະ ສະໜອງຂໍ້ມູນ/ຄຳຄິດເຫັນຕໍ່ພາກລັດ ແລະ ບັນດາອົງການຈັດຕັ້ງທີ່ມີ ອອກແບບ, ຈັດຕັ້ງປະຕິບັດ ແລະ ຕິດຕາມນະໂຍບາຍເຫຼົ່ານີ້ໃນລະດັບໃດ?
	2	ທ່ານຄິດວ່າ ຄົນພິການ ຄວນໄດ້ເຂົ້າມາມີສ່ວນຮ່ວມ ໃນການພົບປະ ແລະ ສະໜອງຂໍ້ມູນ/ຄຳຄິດເຫັນໃຫ້ ພາກລັດ ເພີ່ມຂຶ້ນຄືບໍ? ຍ້ອນຫຍັງຈຶ່ງເພີ່ມຂຶ້ນ ຫຼື ບໍ່ເພີ່ມຂຶ້ນ? ຄວນຈະເຮັດແນວໃດ?
ພາກທີ 8 ຄຳຖາມປະເມີນຍ່ອຍ EQ E	1	ທ່ານໄດ້ ເວົ້າເຖິງສິ່ງທ້າທາຍການເຂົ້າເຖິງ ການບໍລິການສຸຂະພາບ, ການສຶກສາ ແລະ ການຈ້າງງານ ແລະ ວິທີ ທາງໃນການປັບປຸງເພື່ອສົ່ງເສີມຄົນພິການໄດ້ຮັບບໍລິການ ສະນັ້ນ ແມ່ນຫຍັງຄືບັດໃຈທີ່ສຳຄັນທີ່ສຸດ ເພື່ອ ຮັບປະກັນ/ສະກັດກັ້ນ ບໍ່ໃຫ້ເກີດສິ່ງທ້າທາຍເຫລົ່ານີ້ ອີກ (ຄວາມຍືນຍົງຂອງຜົນໄດ້ຮັບນີ້)?

[ຕາຕະລາງຄວາມສາມາດຂອງລະບົບ (ຕາຕະລາງຄຳຖາມກ່ຽວກັບການຈັດລຳດັບ) ແມ່ນຢູ່ໜ້າຕໍ່ໄປ]

ລະຫັດຂອງຜູ້ຕອບ:					
ຫົວຂໍ້ລະບົບດ້ານຄວາມສາມາດ	ການຈັດລຳດັບ				
	1– ອ່ອນຫຼາຍ	2 - ອ່ອນ	3 – ປານກາງ	4 – ພຶງພໍໃຈ	5 – ພຶງພໍໃຈຫຼາຍ
ນະໂຍບາຍ, ຍຸດທະສາດ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ (ສຳລັບຄົນພິການ)					
ກົດໝາຍດ້ານຄວາມພິການແລະຍຸດທະສາດແຫ່ງຊາດດ້ານຄວາມພິການ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ(ຂອງກະຊວງແຮງງານ)					
ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດຟື້ນຟູໜ້າທີ່ການ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ(ຂອງກະຊວງສາທາ)					
ຄວາມສາມາດທາງດ້ານການເງິນຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະແຜນປະຕິບັດງານ) (ຂອງກະຊວງແຮງງານ)					
ບຸກຄະລາກອນຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງແຮງງານ)					
ເຕັກໂນໂລຢີ ແລະຍາທີ່ມີສຳລັບສິ່ງອຳນວຍຄວາມສະດວກດ້ານສຸຂະພາບ (ໃນການຈັດຕັ້ງປະຕິບັດແລະປະຕິບັດແຜນ /ຍຸດທະສາດ)					
ຄວາມສາມາດຂອງພາກລັດໃນການປະສານງານ ແລະ ແລກປ່ຽນຂໍ້ມູນ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງແຮງງານ)					
ຄວາມສາມາດຂອງພາກລັດໃນການປະສານງານ ແລະ ແລກປ່ຽນຂໍ້ມູນຂອງພາກລັດກັບຜູ້ຮ່ວມຈັດຕັ້ງປະຕິບັດ(ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງແຮງງານ)					
ຄວາມໝຸ່ງໝັ້ນ ແລະ ຕັດສິນໃຈຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງກະຊວງແຮງງານ)					
ຄວາມໝຸ່ງໝັ້ນ ແລະ ຕັດສິນໃຈຂອງສັງຄົມ (ສິ່ງເສີມໃຫ້ທຸກຄົນໄດ້ມີສ່ວນໃນສັງຄົມທີ່ເພີ່ມຂຶ້ນ)					

ພາກເອກະຊົນ – ການສຳພາດ KII

[ສຳລັບວິສາຫະກິດທາງສັງຄົມ /ບໍລິສັດຂະໜາດນ້ອຍ]

ບໍລິສັດຂອງທ່ານໄດ້ຮັບຈ້າງພະນັກງານທີ່ເປັນຄົນພິການບໍ? ມີຈັກຄົນ? ແມ່ນຈຳກັດປະລິມານບໍ?

ແມ່ນຫຍັງທີ່ເປັນສິ່ງທ້າທາຍທີ່ສຳຄັນທີ່ທ່ານປະເຊີນໃນການຈ້າງພະນັກງານທີ່ເປັນຄົນພິການ? ສິ່ງທ້າທາຍນັ້ນແຕກຕ່າງກັນບໍລະຫວ່າງເພດ, ອາຍຸ, ສະຖານທີ່, ປະເພດຂອງຄວາມພິການ ຫຼືຊົນເຜົ່າຂອງຄົນພິການ?

[ສຳລັບສະພາການຄ້າ]

ມີຈັກບໍລິສັດຂອງອົດສະຕາລີທີ່ທ່ານຮູ້ທີ່ຮັບຈ້າງພະນັກງານທີ່ເປັນຄົນພິການ?ມີຈັກຄົນ? ແມ່ນຈຳກັດປະລິມານບໍ?

ແມ່ນຫຍັງທີ່ເປັນສິ່ງທ້າທາຍທີ່ສຳຄັນທີ່ທ່ານປະເຊີນໃນການຈ້າງພະນັກງານທີ່ເປັນຄົນພິການ? ສິ່ງທ້າທາຍນັ້ນແຕກຕ່າງກັນບໍລະຫວ່າງເພດ, ອາຍຸ, ສະຖານທີ່, ປະເພດຂອງຄວາມພິການ ຫຼືຊົນເຜົ່າຂອງຄົນພິການ?

[ຄຳຖາມຂ້າງລຸ່ມນີ້ແມ່ນສຳລັບຜູ້ຕອບທີ່ມາຈາກພາກເອກະຊົນ]

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ພາກທີ I ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: USAID Okard ທິດສະດີການປ່ຽນແປງ	4	ແມ່ນຫຍັງທີ່ເປັນສິ່ງທ້າທາຍສຳລັບຄົນພິການໃນການຊອກວຽກ ໃນສປປລາວ?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ມີສິ່ງທ້າທາຍອັນໃດບໍ່ທີ່ຄົນພິການທຸກປະເພດປະເຊີນຄືກັນ ຫລື ແຕກຕ່າງກັນ ໂດຍອີງໃສ ເພດ, ອາຍຸ, ສະຖານທີ່, ປະເພດພິການ ຫຼື ຊົນເຜົ່າຂອງເຂົາເຈົ້າ?
	5	ທ່ານຄິດວ່າ,1) ລັດຖະບານ (ຂັ້ນສູນກາງ, ແຂວງ, ເມືອງ); ແລະ 2) ວິທະຍາໄລອະຊີວະ,ແລະພາກເອກະຊົນຄວນຈະເຮັດຫຍັງເພື່ອປັບປຸງເສດຖະກິດຂອງຄົນພິການ?
	6	ຂັ້ນທີ່ຊຸມຊົນ ຫລືວ່າ ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ, ສະມາຄົມບໍ່ຫວັງຜົນກຳໄລ, ຜູ້ເບິ່ງແຍງ, ອຳນາດການປົກຄອງທ້ອງຖິ່ນ ສາມາດເຮັດຫຍັງໄດ້ແດ່ເພື່ອເພີ່ມການເຂົ້າເຖິງການຝຶກອົບຮົມແລະການຈ້າງງານ?

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ເງື່ອນໄຂຈຳເປັນທີ່ເຮັດໃຫ້ ຂັ້ນຕອນດັ່ງກ່າວສຳເລັດໄດ້ມີຫຍັງແດ່? ກົດໝາຍ, ລະບຽບ, ການປະສານງານລະຫວ່າງພາກສ່ວນທີ່ກ່ຽວຂ້ອງ,ການສ້າງລາຍຮັບ(ເສດຖະກິດ) ແລະ ອື່ນໆ? ມັນມີຄວາມຈຳເປັນບໍ ທີ່ລັດຖະບານແລະຊຸມຊົນຈະເຮັດວຽກຮ່ວມກັນ? ຮ່ວມກັນແນວໃດ?
	7	ສິ່ງທ້າທາຍຫລາຍທີ່ສຸດທີ່ຄົນພິການປະສົບ ໃນການການເຂົ້າເຖິງການຈ້າງງານ ?ກະລຸນາອະທິບາຍ
	8	ທ່ານຄິດວ່າ ພາກລັດ ແລະວິທະຍາໄລອະຊີວະສຶກສາ ຫຼື ຊຸມຊົນ ສຳຄັນກວ່າກັນໃນການປັບປຸງຊີວິດຂອງຄົນພິການ (ຫຼື - ແມ່ນໃຜທີ່ສຳຄັນທີ່ສຸດສຳລັບການປັບປຸງຊີວິດຂອງຄົນພິການໃນປະເທດລາວ?)? ເປັນຫຍັງທ່ານຈຶ່ງຄິດແນວນັ້ນ? ກະລຸນາອະທິບາຍ.
ພາກທີ2 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ໂຄງຮ່າງນະໂຍບາຍ, ກົດລະບຽບແຫ່ງຊາດແລະນະ ໂຍບາຍກ່ຽວກັບການມີສ່ວນຮ່ວມ ຂອງຄົນພິການ, ແລະການຈັດຕັ້ງບໍລິຫານຂັ້ນຊຸມຊົນ	1	ທ່ານໄດ້ຮັບຮູ້ກ່ຽວກັບເອກະສານນິຕິກຳ 2 ສະບັບນີ້ບໍ: 1)ນະໂຍບາຍແຫ່ງຊາດວ່າດ້ວຍຄົນພິການ(ຮ່າງ), ຍຸດທະສາດແລະແຜນຈັດຕັ້ງປະຕິບັດ(ນະໂຍບາຍ) ແລະ 2) ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດຟື້ນຟູໜ້າທີ່ການແລະແຜນຈັດຕັ້ງປະຕິບັດ?
	2	ໃນປັດຈຸບັນ, ການປະຕິບັດນະໂຍບາຍ /ແຜນໄດ້ມີການຈັດຕັ້ງປະຕິບັດໃນລະດັບໃດ (ຂັ້ນສູນກາງ, ແຂວງ,ເມືອງ,ໃນຊຸມຊົນ, ສູນບໍລິການຕ່າງໆ)? ປະຕິບັດແນວໃດ? ຖ້າບໍ່ຖືກປະຕິບັດ, ຍ້ອນຫຍັງ? [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບນະໂຍບາຍແລະແຜນຈັດຕັ້ງປະຕິບັດ]
ພາກທີ3	1	ທ່ານຄິດວ່າ ລັດຖະບານມີງົບປະມານແລະບຸກຄະລາກອນທີ່ຈຳເປັນ ໃນການຈັດຕັ້ງປະຕິບັດ ແລະຕິດຕາມ ນະໂຍບາຍເຫຼົ່ານີ້? ຖ້າບໍ່ມີ, ໃຫ້ອະທິບາຍສິ່ງທ້າທາຍທາງດ້ານການເງິນແລະບຸກຄະລາກອນ ທີ່ພວກເຂົາປະສົບ.

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ຄວາມສາມາດຂອງພາກລັດ (ງົບປະມານ, ບຸກຄະລາກອນ, ເຕັກໂນໂລຢີ) ໃນການຈັດຕັ້ງປະຕິບັດແລະຕິດຕາມ ນະໂຍບາຍ /ຍຸດທະສາດ /ແຜນ	2	ທ່ານຄິດວ່າ, ລັດຖະບານມີ ເຕັກໂນໂລຢີ,ອຸປະກອນ ແລະເຄື່ອງມືທີ່ສຳຄັນໃນການປະຕິບັດນະໂຍບາຍເຫຼົ່ານີ້? ຖ້າບໍ່ມີ, ໃຫ້ອະທິບາຍເຕັກໂນໂລຢີ ທີ່ກ່ຽວຂ້ອງເຖິງສິ່ງທ້າທາຍທີ່ພວກເຂົາປະສົບ. [ໃຫ້ໃບຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມສາມາດທາງດ້ານ ການເງິນ, ບຸກຄະລາກອນ, ເຕັກໂນໂລຢີ]
ພາກທີ4 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ການປະສານງານ /ສື່ສານ ແລະການແລກປ່ຽນຂໍ້ມູນພາກ ສ່ວນທີ່ກ່ຽວຂ້ອງ	1	ຂໍໃຫ້ທ່ານອະທິບາຍກ່ຽວກັບລະບົບການປະສານງານແລະການແລກປ່ຽນຂໍ້ມູນ ພາຍໃນDPOs(ອົງການເຮັດວຽກກັບຄົນພິການ)/INGOs/ອົງການຈັດຕັ້ງ (ຂັ້ນສູນກາງ, ແຂວງ, ເມືອງ) ຄືແນວໃດ? ລະບົບການປະສານງານ ແລະ ແລກຂໍ້ມູນ ລະຫວ່າງພາກລັດກັບອົງການຈັດຕັ້ງສາກົນ,ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ,ຜູ້ໃຫ້ທຶນມີແນວໃດ?ແມ່ນໃຜທີ່ເປັນຜູ້ປະສານງານແລະ/ຫລືແລກປ່ຽນຂໍ້ມູນ? ລະບົບຂໍ້ມູນອ້າງອີງອັນໃດບໍ? ຢູ່ໃນລະດັບໃດ?ມີຫົວຂໍ້ກ່ຽວກັບຫຍັງ?
	2	ມີລະບົບແລະຮູບແບບການປະສານງານແລະການແລກປ່ຽນຂໍ້ມູນອັນໃດແດ່ ທີ່ເຮັດໄດ້ດີກວ່າ?(ຍົກຕົວຢ່າງ ການປະສານງານລະຫວ່າງລັດຖະບານແລະຜູ້ໃຫ້ທຶນຫລືຜູ້ໃຫ້ທຶນແລະອົງການຈັດຕັ້ງສາກົນ) ກະລຸນາອະທິບາຍ [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມສາມາດດ້ານການປະສານງານແລະລະບົບຂໍ້ມູນ]
ພາກທີ5	1	ທ່ານຄິດວ່າປະເທດລາວ (ແລະບັນດາຊຸມຊົນທີ່ຫຼາກຫຼາຍ) ພ້ອມບໍ່ສຳລັບການ ເຮັດໃຫ້ ຄົນພິການມີສ່ວນຮ່ວມໃນສັງຄົມ? ເປັນຫຍັງຈຶ່ງພ້ອມແລະບໍ່ພ້ອມ?

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ຄຳໝັ້ນສັນຍາ, ການເປັນເຈົ້າການ/ຄວາມສົນໃຈ ຂອງພາກສ່ວນກ່ຽວຂ້ອງຕໍ່ກັບວິທີການຂອງ OKARD ແລະ ນະໂຍບາຍ/ຍຸດທະສາດ/ແຜນລະດັບຊາດ	2	ທ່ານ/ອົງການຈັດຕັ້ງຂອງທ່ານ/ບໍລິສັດຂອງທ່ານ ໄດ້ສະໜັບສະໜູນ ການຈັດຕັ້ງປະຕິບັດແຜນງານເຫລົ່ານີ້ແລ້ວບໍ ຫຼືວ່າ ມີແຜນທີ່ຈະສະໜັບສະໜູນ ແນວໃດ ຖ້າຍັງບໍ່ໄດ້ຖືກຈັດຕັ້ງປະຕິບັດ?
	3	ທ່ານ/ອົງການຈັດຕັ້ງຂອງທ່ານມີຄວາມເຊື່ອໝັ້ນຕໍ່ນະໂຍບາຍແຫ່ງຊາດຄົນພິການ, ຍຸດທະສາດ ແລະ ແຜນງານແລະ ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດການຟື້ນຟູໜ້າທີ່ການ ວ່າຈະປະສົບຜົນສຳເລັດໃນການປັບປຸງຊີວິດຂອງຄົນພິການ? ຍ້ອນຫຍັງຈຶ່ງເຊື່ອ ຫຼື ບໍ່ເຊື່ອ? [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄຳໝັ້ນສັນຍາຂອງລັດຖະບານລາວ]
ພາກທີ 6 ຫົວຂໍ້: ການຮັບຮູ້ຂອງ ຄົນພິການກ່ຽວກັບ: ອົງກອນລຸ່ມລຸ່ມ ທີ່ເຮັດແຜນງານ/ ວຽກງານແລະການບໍລິການ		ແມ່ນຫຍັງຄືບັດໃຈທີ່ສຳຄັນ ເພື່ອປັບປຸງຄຸນນະພາບເສດຖະກິດຂອງຄົນພິການ ໃຫ້ມີຄວາມຍືນຍົງ?

[ຕາຕະລາງຄວາມສາມາດຂອງລະບົບ (ຕາຕະລາງຄຳຖາມກ່ຽວກັບການຈັດລຳດັບ) ແມ່ນຢູ່ໜ້າຕໍ່ໄປ]

ລະຫັດຂອງຜູ້ຕອບ:					
ຫົວຂໍ້ລະບົບດ້ານຄວາມສາມາດ	ການຈັດລຳດັບ				
	1– ອ່ອນຫຼາຍ	2 - ອ່ອນ	3 – ປານກາງ	4 – ພຶງພໍໃຈ	5 – ພຶງພໍໃຈຫຼາຍ
ນະໂຍບາຍ, ຍຸດທະສາດ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ (ສຳລັບຄົນພິການ)					
ກົດໝາຍດ້ານຄວາມພິການແລະຍຸດທະສາດແຫ່ງຊາດດ້ານຄວາມພິການ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ(ຂອງກະຊວງແຮງງານ)					
ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດຟື້ນຟູໜ້າທີ່ການ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ(ຂອງກະຊວງສາທາ)					
ຄວາມສາມາດທາງດ້ານການເງິນຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະແຜນປະຕິບັດງານ) (ຂອງລັດຖະບານ)					
ບຸກຄະລາກອນຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງລັດຖະບານ)					
ເຕັກໂນໂລຢີ ແລະຢາທີ່ມີສຳລັບສິ່ງອຳນວຍຄວາມສະດວກດ້ານສຸຂະພາບ (ໃນການຈັດຕັ້ງປະຕິບັດແລະປະຕິບັດແຜນ /ຍຸດທະສາດ)					
ຄວາມສາມາດຂອງພາກລັດໃນການປະສານງານ ແລະ ແລກປ່ຽນຂໍ້ມູນ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງລັດຖະບານ)					
ຄວາມສາມາດຂອງພາກລັດໃນການປະສານງານ ແລະ ແລກປ່ຽນຂໍ້ມູນຂອງພາກລັດກັບຜູ້ຮ່ວມຈັດຕັ້ງປະຕິບັດ(ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງລັດຖະບານ)					
ຄວາມໝຸ່ງໝັ້ນ ແລະ ຕັດສິນໃຈຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ) (ຂອງລັດຖະບານ)					
ຄວາມໝຸ່ງໝັ້ນ ແລະ ຕັດສິນໃຈຂອງສັງຄົມ (ສິ່ງເສີມໃຫ້ທຸກຄົນໄດ້ມີສ່ວນໃນສັງຄົມທີ່ເພີ່ມຂຶ້ນ)					

ຜູ້ໄດ້ຮັບຜົນປະໂຫຍດຍ່ອຍຂອງ USAID OKARD /**ອົງການຈັດຕັ້ງສໍາລັບຄົນພິການ – ການສໍາພາດ** KII

1. ອົງການເຮັດວຽກກັບຄົນພິການ(DPO)/ ອົງການຈັດຕັ້ງຂອງທ່ານເຮັດຫຍັງແດ່ກ່ຽວກັບການພັດທະນາ?

2. ທ່ານເຮັດວຽກຢູ່ບ່ອນໃດ(ໃນລາວ) ແລະເຮັດວຽກດ້ານປານໃດ?

ຄໍາຖາມປະເມີນຜົນ	ລໍາດັບ.	ຄໍາຖາມ
ພາກທີ I ຄໍາຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: USAID Okard ທິດສະດີການປ່ຽນແປງ	I	ສິ່ງທ້າທາຍສໍາລັບການເຂົ້າເຖິງການບໍລິການ: ດ້ານສຸຂະພາບ,ການຟື້ນຟູຫນ້າທີການ ສຸຂະພາບທາງຈິດຂອງຄົນພິການ ໃນສປປລາວມີຫຍັງແດ່?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ : ມີສິ່ງທ້າທາຍອັນໃດແດ່ ທີ່ຄົນພິການທຸກປະເພດພົບພໍ້ຄືກັນ ຫລື ແຕກຕ່າງກັນ ໂດຍອີງໃສ ເພດ, ອາຍຸ, ສະຖານທີ່,ປະເພດພິການ, ຊົນເຜົ່າຂອງເຂົາເຈົ້າ?
	2	I) ລັດຖະບານ (ຂັ້ນສູນກາງ, ແຂວງ, ເມືອງ); ແລະ 2) ການບໍລິການດ້ານສຸຂະພາບ /ສິ່ງອໍານວຍຄວາມສະດວກຄວນຈະເຮັດອັນໃດ ເພື່ອສົ່ງເສີມປັບປຸງສຸຂະພາບຂອງຄົນພິການ?
	3	ຊຸມຊົນ ຫລືວ່າ ອົງການຈັດຕັ້ງສໍາລັບຄົນພິການ, ອົງການຈັດຕັ້ງທາງສັງຄົມ,ຜູ້ດູແລ, ອໍານາດການປົກຄອງທ້ອງຖິ່ນ) ຄວນຈະເຮັດຫຍັງເພື່ອສົ່ງເສີມການເຂົ້າເຖິງການບໍລິການດ້ານສຸຂະພາບຂອງຄົນພິການ?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ເງື່ອນໄຂຈໍາເປັນທີ່ເຮັດໃຫ້ ຂັ້ນຕອນດັ່ງກ່າວສໍາເລັດໄດ້ມີຫຍັງແດ່? ກົດໝາຍ, ລະບຽບ, ການປະສານງານລະຫວ່າງພາກສ່ວນທີ່ກ່ຽວຂ້ອງ,ການສ້າງລາຍຮັບ(ເສດຖະກິດ) ແລະ ອື່ນໆ? ມັນມີຄວາມຈໍາເປັນບໍ ທີ່ລັດຖະບານແລະຊຸມຊົນຈະເຮັດວຽກຮ່ວມກັນ? ຮ່ວມກັນແນວໃດ?
	4	ແມ່ນຫຍັງທີ່ເປັນສິ່ງທ້າທາຍ ສໍາລັບຄົນພິການປະເຊີນໃນການຊອກວຽກວຽກເຮັດງານທໍາ?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ມີສິ່ງທ້າທາຍອັນໃດ ທີ່ຄົນພິການທຸກປະເພດພົບພໍ້ຄືກັນ ຫລື ແຕກຕ່າງກັນ ໂດຍອີງໃສ ເພດ, ອາຍຸ, ສະຖານທີ່, ປະເພດພິການ ຫຼື ຊົນເຜົ່າຂອງເຂົາ?

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
	5	1) ລັດຖະບານ (ຂັ້ນສູນກາງ, ແຂວງ, ເມືອງ); 2) ວິທະຍາໄລ ອາຊີວະສຶກສາ, ແລະ 3) ພາກເອກະຊົນ ສາມາດເຮັດຫຍັງໄດ້ແດ່ເພື່ອປັບປຸງ ດ້ານເສດຖະກິດ ຂອງຄົນພິການ?
	6	ຂັ້ນຊຸມຊົນ ຫລືວ່າ ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ, ສະມາຄົມບໍ່ຫວັງຜົນກຳໄລ,ຜູ້ເບິ່ງແຍງ, ອຳນາດການປົກຄອງທ້ອງຖິ່ນສາມາດເຮັດຫຍັງໄດ້ແດ່ ເພື່ອເພີ່ມການເຂົ້າເຖິງການຝຶກອົບຮົມແລະການຈ້າງງານຂອງຄົນພິການ?
		ຖາມຕື່ມຖ້າຜູ້ເຂົ້າຮ່ວມຍັງບໍ່ເວົ້າ: ເງື່ອນໄຂຈຳເປັນທີ່ເຮັດໃຫ້ ຂັ້ນຕອນດັ່ງກ່າວສຳເລັດໄດ້ມີຫຍັງແດ່? ກົດໝາຍ, ລະບຽບ, ການປະສານງານລະຫວ່າງພາກສ່ວນທີ່ກ່ຽວຂ້ອງ,ການສ້າງລາຍຮັບ(ເສດຖະກິດ) ແລະ ອື່ນໆ? ມັນມີຄວາມຈຳເປັນບໍ ທີ່ລັດຖະບານແລະຊຸມຊົນຈະເຮັດວຽກຮ່ວມກັນ? ຮ່ວມກັນແນວໃດ?
	7	ສິ່ງທ້າທາຍຫລາຍທີ່ສຸດທີ່ຄົນພິການປະສົບ ໃນການບັນລຸ ການຮັກສາສຸຂະພາບທີ່ດີ, ການເຂົ້າເຖິງການສຶກສາ, ການເຂົ້າເຖິງການຈ້າງງານ (ໃຫ້ເລືອກຫນຶ່ງຄຳຕອບ)?
	8	ທ່ານຄິດວ່າ ພາກລັດ ແລະຜູ້ໃຫ້ບໍລິການດ້ານສຸຂະພາບ/ວິທະຍາໄລອະຊີວະສຶກສາ ຫຼື ຊຸມຊົນ ສຳຄັນກວ່າກັນໃນການປັບປຸງຊີວິດຂອງຄົນພິການ (ຫຼື - ແມ່ນໃຜທີ່ສຳຄັນທີ່ສຸດສຳລັບການປັບປຸງຊີວິດຂອງຄົນພິການໃນປະເທດລາວ?)? ເປັນຫຍັງທ່ານຈຶ່ງຄິດແນວນັ້ນ? ກະລຸນາອະທິບາຍ.
ພາກທີ2 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ໂຄງຮ່າງນະໂຍບາຍ, ກົດລະບຽບແຫ່ງຊາດແລະນະ ໂຍບາຍກ່ຽວກັບການມີສ່ວນຮ່ວມ	1	ທ່ານໄດ້ຮັບຮູ້ກ່ຽວກັບເອກະສານນິຕິກຳ 2 ສະບັບນີ້ບໍ: 1)ນະໂຍບາຍແຫ່ງຊາດວ່າດ້ວຍຄົນພິການ(ຮ່າງ),ຍຸດທະສາດແລະແຜນຈັດຕັ້ງປະຕິບັດ(ນະໂຍບາຍ) ແລະ 2) ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດຟື້ນຟູຫນ້າທີ່ການແລະແຜນຈັດຕັ້ງປະຕິບັດ?
	2	ໃນປັດຈຸບັນ, ການປະຕິບັດນະໂຍບາຍ /ແຜນໄດ້ມີການຈັດຕັ້ງປະຕິບັດໃນລະດັບໃດ (ຂັ້ນສູນກາງ, ແຂວງ,ເມືອງ,ໃນຊຸມຊົນ, ສູນບໍລິການຕ່າງໆ)? ປະຕິບັດແນວໃດ? ຖ້າບໍ່ຖືກປະຕິບັດ, ຍ້ອນຫຍັງ? [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບນະໂຍບາຍແລະແຜນຈັດຕັ້ງປະຕິບັດ]

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ຂອງຄົນພິການ, ແລະການຈັດຕັ້ງບໍລິຫານຂັ້ນລຸ່ມລົ່ນ		
ພາກທີ3 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ຄວາມສາມາດຂອງພາກລັດ (ງົບປະມານ, ບຸກຄະລາກອນ, ເຕັກໂນໂລຍີ) ໃນການຈັດຕັ້ງປະຕິບັດແລະຕິດຕາມ ນະໂຍບາຍ /ຍຸດທະສາດ /ແຜນ	1	ທ່ານຄິດວ່າ ລັດຖະບານ ມີງົບປະມານແລະບຸກຄະລາກອນທີ່ຈຳເປັນ ໃນການຈັດຕັ້ງປະຕິບັດ ແລະຕິດຕາມ ນະໂຍບາຍເຫຼົ່ານີ້? ຖ້າບໍ່ມີ, ໃຫ້ອະທິບາຍສິ່ງທ້າທາຍທາງດ້ານການເງິນແລະບຸກຄະລາກອນ ທີ່ພວກເຂົາປະສົບຢູ່.
	2	ທ່ານຄິດວ່າ, ລັດຖະບານ ມີ ເຕັກໂນໂລຍີ,ອຸປະກອນ ແລະເຄື່ອງມືທີ່ສຳຄັນໃນການປະຕິບັດນະໂຍບາຍເຫຼົ່ານີ້? ຖ້າບໍ່ມີ, ໃຫ້ອະທິບາຍເຕັກໂນໂລຍີ ທີ່ກ່ຽວຂ້ອງເຖິງສິ່ງທ້າທາຍທີ່ພວກເຂົາປະສົບ. [ໃຫ້ໄປຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມສາມາດທາງດ້ານ ການເງິນ, ບຸກຄະລາກອນ, ເຕັກໂນໂລຍີ]
ພາກທີ4 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ການປະສານງານ /ສື່ສານ ແລະການແລກປ່ຽນຂໍ້ມູນພາກ ສ່ວນທີ່ກ່ຽວຂ້ອງ	1	ຂໍໃຫ້ທ່ານອະທິບາຍກ່ຽວກັບລະບົບການປະສານງານແລະການແລກປ່ຽນຂໍ້ມູນ ພາຍໃນDPOs(ອົງການເຮັດວຽກກັບຄົນພິການ)/INGOs/ອົງການຈັດຕັ້ງ (ຂັ້ນສູນກາງ, ແຂວງ, ເມືອງ) ຄືແນວໃດ? ລະບົບການປະສານງານ ແລະ ແລກຂໍ້ມູນ ລະຫວ່າງພາກລັດກັບອົງການຈັດຕັ້ງສາກົນ,ອົງການຈັດຕັ້ງສຳລັບຄົນພິການ,ຜູ້ໃຫ້ທຶນມີແນວໃດ? ແມ່ນໃຜທີ່ເປັນຜູ້ປະສານງານແລະ/ຫລືແລກປ່ຽນຂໍ້ມູນ? ລະບົບຂໍ້ມູນອ້າງອີງອັນໃດບ໋? ຢູ່ໃນລະດັບໃດ?ມີຫົວຂໍ້ກ່ຽວກັບຫຍັງ?
	2	ມີລະບົບແລະຮູບແບບການປະສານງານແລະການແລກປ່ຽນຂໍ້ມູນອັນໃດແດ່ ທີ່ເຮັດໄດ້ດີກວ່າ?(ຍົກຕົວຢ່າງ ການປະສານງານລະຫວ່າງລັດຖະບານແລະຜູ້ໃຫ້ທຶນຫລືຜູ້ໃຫ້ທຶນແລະອົງການຈັດຕັ້ງສາກົນ) ກະລຸນາອະທິບາຍ

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
		[ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມສາມາດດ້ານການປະສານງານແລະລະບົບຂໍ້ມູນ]
ພາກທີ5 ຄຳຖາມປະເມີນຍ່ອຍ EQ A ຫົວຂໍ້: ຄຳໝັ້ນສັນຍາ, ການເປັນເຈົ້າການ/ຄວາມສົນໃຈ ຂອງພາກສ່ວນກ່ຽວຂ້ອງຕໍ່ກັບ ວິທີການຂອງ OKARD ແລະ ນະໂຍບາຍ/ຍຸດທະສາດ/ແຜນລະດັບຊາດ	1	ທ່ານຄິດວ່າປະເທດລາວ (ແລະບັນດາຊຸມຊົນທີ່ຫຼາກຫຼາຍ) ພ້ອມບໍ່ສຳລັບການ ເຮັດໃຫ້ ຄົນພິການມີສ່ວນຮ່ວມໃນສັງຄົມ? ເປັນຫຍັງຈຶ່ງພ້ອມແລະບໍ່ພ້ອມ?
	2	ອົງການຈັດຕັ້ງ ຂອງທ່ານໄດ້ສະໜັບສະໜູນ ການຈັດຕັ້ງປະຕິບັດແຜນງານເຫລົ່ານີ້ແລ້ວບໍ ຫຼືວ່າ ມີແຜນທີ່ຈະສະໜັບສະໜູນ ແນວໃດ ຖ້າຍັງບໍ່ໄດ້ຖືກຈັດຕັ້ງປະຕິບັດ? [ໃຫ້ ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄວາມພໍໃຈຂອງສັງຄົມ]
	3	ທ່ານມີຄວາມເຊື່ອໝັ້ນຕໍ່ນະໂຍບາຍແຫ່ງຊາດຄົນພິການ, ຍຸດທະສາດ ແລະ ແຜນງານແລະ ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດການຟື້ນຟູໜ້າທີ່ການ ວ່າຈະປະສົບຜົນສຳເລັດໃນການປັບປຸງຊີວິດຂອງຄົນພິການ? ຍ້ອນຫຍັງຈຶ່ງເຊື່ອ ຫຼື ບໍ່ເຊື່ອ? [ໃຫ້ຈັດລຳດັບຄຳຖາມກ່ຽວກັບຄຳໝັ້ນສັນຍາຂອງລັດຖະບານລາວ]
ພາກທີ 6 ຫົວຂໍ້: ການຮັບຮູ້ຂອງ ຄົນພິການກ່ຽວກັບ: ອົງກອນຊຸມຊົນ ທີ່ເຮັດແຜນງານ/ ວຽກງານແລະການບໍລິການ	1	ທ່ານຄິດວ່າ ຄົນພິການ ຮັບຮູ້ເຖິງ ສະຖານທີ ບໍລິການສຸຂະພາບ ແລະ ສູນຟື້ນຟູໜ້າທີ່ການ, ສະຖາບັນການສຶກສາ ແລະ ການຈ້າງງານ ແລະ ອົງການຈັດຕັ້ງຊຸມຊົນທີ່ເຮັດວຽກກ່ຽວກັບ ຄົນພິການ ຢູ່ໃນລະດັບໃດ ?
	2	ຖ້າເຂົາບໍ່ຮູ້, ແມ່ນຫຍັງທີ່ສະກັດກັ້ນ/ຈຳກັດ?
ພາກທີ 7 ຫົວຂໍ້: ການຮັບຮູ້ຂອງຄົນ ພິການ ກ່ຽວກັບພາກລັດ	1	ທ່ານຄິດວ່າຄົນພິການມີໂອກາດໄດ້ພົບປະ ແລະ ສະໜອງຂໍ້ມູນ/ຄຳຄິດເຫັນຕໍ່ພາກລັດ ແລະ ບັນດາອົງການຈັດຕັ້ງທີ່ມີ ອອກແບບ, ຈັດຕັ້ງປະຕິບັດ ແລະ ຕິດຕາມນະໂຍບາຍເຫຼົ່ານີ້ໃນລະດັບໃດ?

ຄຳຖາມປະເມີນຜົນ	ລຳດັບ.	ຄຳຖາມ
ແລະກຸ່ມຜູ້ທີ່ອອກແບບ, ຈັດຕັ້ງປະຕິບັດແລະຕິດຕາມຍຸດທະສາດແລະນະໂຍບາຍກ່ຽວກັບ ຄວາມພິການແລະການຟື້ນຟູ	2	ທ່ານຄິດວ່າ ຄົນພິການ ຄວນໄດ້ເຂົ້າມາມີສ່ວນຮ່ວມ ໃນການພົບປະ ແລະ ສະໜອງຂໍ້ມູນ/ຄຳຄິດເຫັນໃຫ້ພາກລັດ ເພີ່ມຂຶ້ນຄືບໍ? ຍ້ອນຫຍັງຈຶ່ງເພີ່ມຂຶ້ນ ຫຼື ບໍ່ເພີ່ມຂຶ້ນ? ຄວນຈະເຮັດແນວໃດ?
ພາກທີ 8 ຄຳຖາມປະເມີນຍ່ອຍ EQ E	1	ທ່ານໄດ້ ເວົ້າເຖິງສິ່ງທ້າທາຍການເຂົ້າເຖິງ ການບໍລິການສຸຂະພາບ, ການສຶກສາ ແລະ ການຈ້າງງານ ແລະ ວິທີທາງໃນການປັບປຸງເພື່ອສົ່ງເສີມຄົນພິການໄດ້ຮັບບໍລິການ ສະນັ້ນ ແມ່ນຫຍັງຄືປັດໃຈທີ່ສຳຄັນທີ່ສຸດ ເພື່ອຮັບປະກັນ/ສະກັດກັ້ນ ບໍ່ໃຫ້ເກີດສິ່ງທ້າທາຍເຫລົ່ານີ້ ອີກ (ຄວາມຍືນຍົງຂອງຜົນໄດ້ຮັບນີ້)?

[ຕາຕະລາງຄວາມສາມາດຂອງລະບົບ (ຕາຕະລາງຄຳຖາມກ່ຽວກັບການຈັດລຳດັບ) ແມ່ນຢູ່ໜ້າຕໍ່ໄປ]

ລະຫັດຂອງຜູ້ຕອບ:					
ຫົວຂໍ້ລະບົບດ້ານຄວາມສາມາດ	ການຈັດລຳດັບ				
	1– ອ່ອນຫຼາຍ	2 - ອ່ອນ	3 – ປານກາງ	4 – ເຫຼົ່ງໝໍ່ໃຈ	5 – ເຫຼົ່ງໝໍ່ໃຈຫຼາຍ
ນະໂຍບາຍ, ຍຸດທະສາດ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ (ສຳລັບຄົນພິການ)					
ຍຸດທະສາດແຫ່ງຊາດດ້ານການແພດຟື້ນຟູໜ້າທີ່ການ ແລະ ແຜນຈັດຕັ້ງປະຕິບັດ					
ຄວາມສາມາດທາງດ້ານການເງິນຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະແຜນປະຕິບັດງານ)					
ບຸກຄະລາກອນຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ)					
ເຕັກໂນໂລຍີ ແລະຢາທີ່ມີສຳລັບສິ່ງອຳນວຍຄວາມສະດວກດ້ານສຸຂະພາບ (ໃນການຈັດຕັ້ງປະຕິບັດແລະປະຕິບັດແຜນ /ຍຸດທະສາດ)					
ຄວາມສາມາດຂອງພາກລັດໃນການປະສານງານ ແລະ ແລກປ່ຽນຂໍ້ມູນ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດດທະສາດ ແລະ ແຜນປະຕິບັດງານ)					
ຄວາມສາມາດຂອງພາກລັດໃນການປະສານງານ ແລະ ແລກປ່ຽນຂໍ້ມູນຂອງພາກລັດກັບຜູ້ຮ່ວມຈັດຕັ້ງປະຕິບັດ(ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ)					
ຄວາມມຸ່ງໝັ້ນ ແລະ ຕັດສິນໃຈຂອງພາກລັດ (ໃນການຈັດຕັ້ງປະຕິບັດຍຸດທະສາດ ແລະ ແຜນປະຕິບັດງານ)					
ຄວາມມຸ່ງໝັ້ນ ແລະ ຕັດສິນໃຈຂອງສັງຄົມ (ສົ່ງເສີມໃຫ້ທຸກຄົນໄດ້ມີສ່ວນໃນສັງຄົມທີ່ເພີ່ມຂຶ້ນ)					

ANNEX F: STATEMENT OF WORK

PURPOSE

The overall purpose of the USAID Okard evaluation is to test the logic/assumption of selected components of the Theory of Change (ToC). USAID anticipates a before-after type of PE fill the knowledge gaps on validity of the assumptions that Activity's efforts on health, economic empowerment, and stakeholder engagement, as well as the top-down and bottom-up approaches are equally important to drive the goal to improve and sustain the independent living, functional ability and economic self-sufficiency among Persons with Disabilities (persons with disabilities) and their households.

The objectives of this baseline evaluation are to: a) set a framework for the overall USAID Okard evaluation, b) determine key reference points that can help inform the detailed implementation plan as well as examining evidence to what high level changes towards the goal are triggered by the Activity at later stages of the Activity, and c) provide evidence to support validation of the ToC at later stages of the Activity that will be useful for adaptive management of current programming as well as the future program. This evaluation is focused at the end result of the Activity and the linkage between components of the ToC that are beyond the learning agenda/questions identified by the Activity that are focused more that the implementation level, thus, will complement the Activity's internal MEL efforts. However, parts of this evaluation will utilize MEL data/information captured internally by the Activity.

The evaluation results will primarily benefit the IP, its sub- partners, USAID, and the Government of Lao (GoL) in gaining evidence and data/information to support decision making on appropriate approaches/interventions to maximize the results. The secondary and tertiary audiences of this evaluation are other government and non-government organizations working on similar issues in Lao and elsewhere, and the interested general public.

BACKGROUND

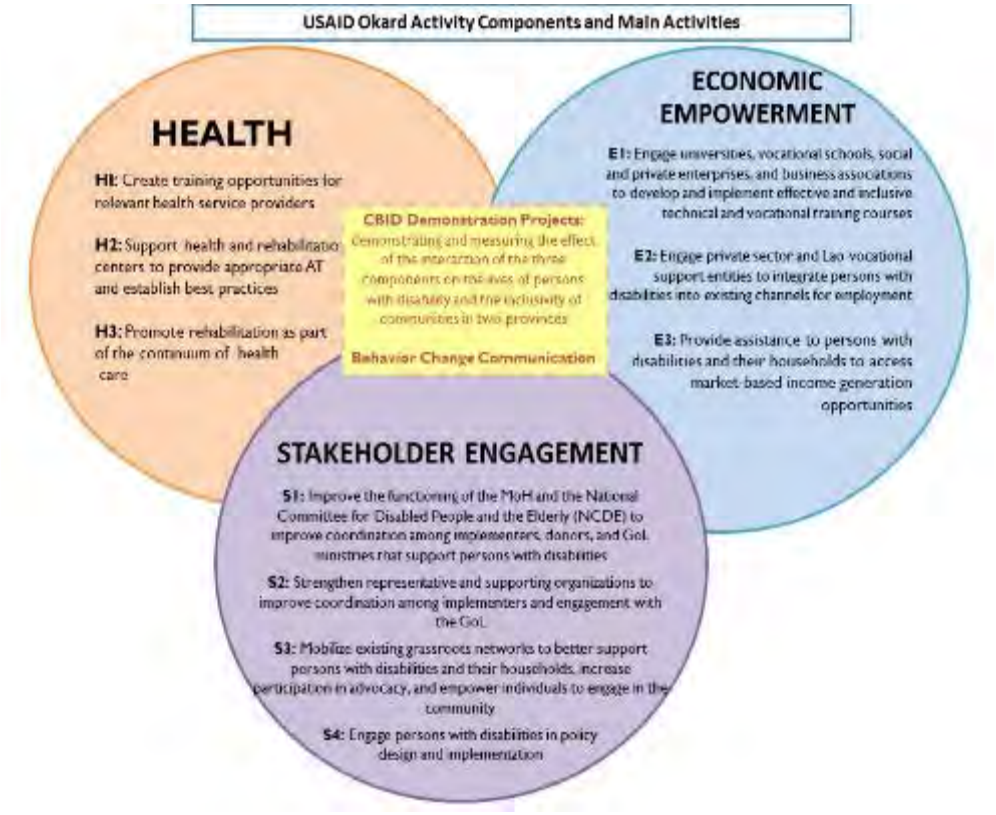
Award Information

Project Title (I.R.2.2)	Rights of Vulnerable People Enhanced
Activity Title	Disability Sector Support Activity (USAID Okard)
Period of Performance	From October 1, 2017 to September 30, 2022
Total Estimated Cost	USD15,000,000.
Implementers	World Education, Inc. (WEI) Humanity and Inclusion (HI)
AOR/Alternate AOR	Tinaflor Chaingam/Patrick Bowers

Activity Information

Persons with disabilities in the Lao PDR have limited possibilities to achieve their full potential in society. In addition, they constitute a particularly vulnerable segment of the population, suffering from poorer health outcomes, experiencing higher rates of poverty, and being excluded from broader society. Depending on how disability is defined, and which source is cited, Persons with disabilities in Lao PDR represent between three to eight percent of the population. While disabilities may occur at birth or result from an injury (e.g., vehicle and industrial accidents), illness or disease, a significant number of them were victims of unexploded ordnances (UXOs) that remain as a result of the Vietnam War.

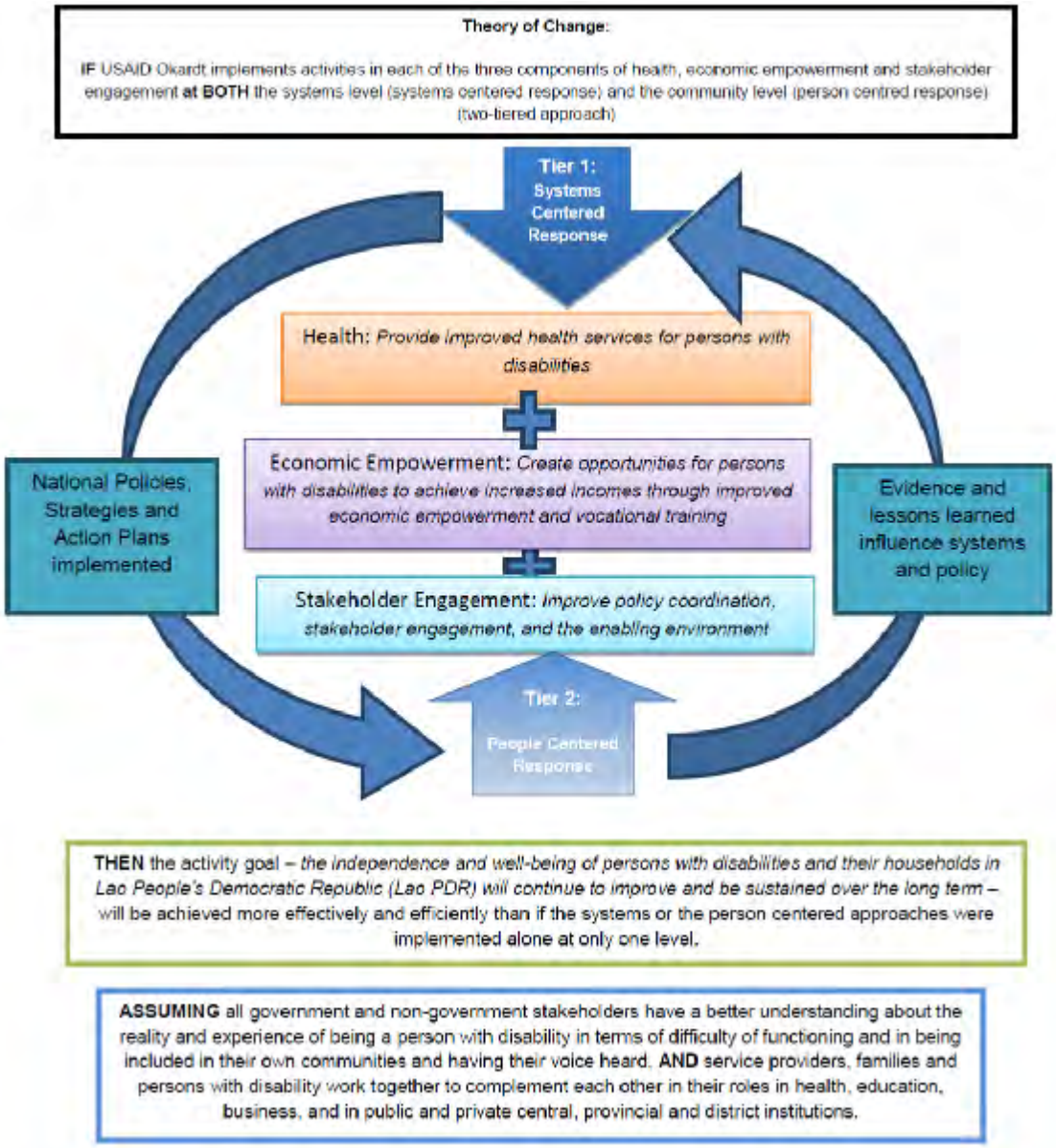
USAID Okard intends to improve and sustain the independent living and functional ability of persons with disabilities, regardless of factors such as age, sex, gender expression, ethnicity, and their households in Lao PDR. The Activity has three main components as shown in the figure below.



Intended Results

Below is a Results Framework with key indicators and indications of the data sources.

USAID Okard describes its ToC as shown in the texts and the diagram below.



Note: The assumptions described in the box might not be valid as they are parts of what USAID Okard tries to achieve

Approach & Implementation

USAID Okard will take a two-tiered approach to reach its goal as shown in the ToC diagram. Tier 1 is a systems-centered approach focused on the GoL ownership and long-term sustainability; i.e., structural changes that create an enabling environment for persons with disabilities. Tier 2 is to examine and support individual needs of persons with disabilities and the communities that support them. Each of the components are interconnected and mutually reinforcing. Each uses interventions from each tier to create a "top down, bottom up" model. Multiple feedback loops are built into USAID Okard, with the CBID Model as a paramount importance to illustrate to the GoL that when services are made accessible for the persons with disabilities and if all relevant actors are made aware of the barriers to access these services, and there is proper training and mentoring, and all parties work together in one catchment area, then the disability strategy can have tangible impact on the life of the persons with disabilities and their households. CBID will

provide the connection between the improved service provision systems down to the individual needs of persons with disabilities and their households, and the results of the CBID Model will feed relevant National level revision of policies.

Geographical Coverage & Targeted Participants

USAID Okard is divided into two phases. Phase I (year 1 to 3) will be implemented in selected districts in Xieng Khouang, Savannakhet, and Vientiane Capital. Through the CBID Model that will provide empirical data on effectiveness of the approach/implementation, USAID and WEI will determine whether the Phase II should be expanded to Houaphan and Khammouane or to remain in existing provinces.

The intended participants for USAID Okard are persons with difficulties with mobility (includes also UXO survivors) and their households in the targeted areas. Other key targeted participants are relevant government services providers and decision makers, persons with disabilities organizations, and community entities/members.

EVALUATION QUESTIONS

The evaluation will seek to answer only one comprehensive question:

> "Considering the ToC and the Results Framework as demonstrated in the diagrams, as well as the context in a very resource-constrained (both financial and human) country like Lao PDR; to what extent has the hypothesis held true that the two-tiered approach would result in more effective and efficient improvement of the independence and wellbeing of persons with disabilities and their households as opposed to if the systems or the person-centered approach were implemented alone at only one level?"

According to the USAID Okard's Program Description, the independence and wellbeing are defined as improved and sustained independent living (includes also economic) and functional ability of persons with disabilities, regardless of factors such as age, sex, gender expression, ethnicity, and their households.

To answer the evaluation question, the Contractor will analyze relevant data/information and determine a set of sub-questions that help forming evidence-based answers to the question. Below are some examples of sub-questions:

a) Did any of the three components (health, stakeholder engagement, economic empowerment) contribute more substantially to the goal than another? Are there any differences in terms of sex/gender, age groups, and ethnicities?

b) Was/were any of the three components (health, stakeholder engagement, economic empowerment) not critical or not essential in achieving the goal (i.e., nice to have rather than a must)?

c) To what extent was the systems approach the catalyst to drive the goal of improving independence and wellbeing of persons with disabilities and their households?

d) To what extent was the person-centered approach drive or advance the goal of improving independence and wellbeing of persons with disabilities and their households?

e) What evidence exists that the systems approach at the national level would have resulted in sustainability of the services? What about at the peripheral/community level?

EVALUATION DESIGN AND SUGGESTED METHODOLOGIES

Study Design, Data Collection and Analysis Methods

This study is a baseline, PE. The evaluation will utilize mixed methods, and will be collaborative and participatory, including implementing partners (IPs), key and vulnerable populations benefitting from the Activity interventions/services, and key stakeholders, as much as possible in evaluation planning and implementation. It will be divided into three phases.

1. ***Desk Review, Consultations and Evaluation Design***: The Contractor is required to unpack the key evaluation question, develop sub-questions to guide development of detail evaluation methods and tools/instruments for data collection that will be required to answer the evaluation question. This will be accomplished by conducting a thorough desk study of related documents provided by USAID and the IPs (e.g., details on the CBID Model and related operation research, and monitoring records) as well as relevant public and gray literature (e.g., key research/publications/articles and related policies and laws), virtual and/or face- to-face consultations with the IPs, subject matter experts and stakeholders within and outside of Lao PDR. The Contractor will triangulate the data/information obtained to develop a formative study report and a detail evaluation design based on findings from the formative study. This shall be conducted in the most comprehensive and rigorous manners to ensure specific focuses of and to limit required time for the field data collection. The formative study report and the evaluation design must specifically cite and/or present with evidence for the design and methodologies chosen. USAID recommends doing also rigorous process tracing to understand contributions of the interventions to expected results. The design must be approved by USAID prior to the field data collection.

2. ***Field Data Collection***: Based on the evaluation design derived from the formative study, the Contractor will conduct data collection in (selected) targeted communities and other relevant areas as deemed necessary. USAID anticipated a rigorous sampling, data collection, and analysis methods. The data collection may also include secondary data collection, e.g., relevant data from the CBID study commissioned by the IP, to be analyzed as part of the phase 3 below.

3. ***Data Analysis and Reporting***: As agreed through the approved evaluation design, the Contractor will conduct thorough data analysis. Triangulations of qualitative and quantitative data as well as across data sources must be conducted and specifically cited and presented in the evaluation report.

The Contractor will be accountable for ensuring that data collection and analysis methods are in line with best practices. Data analysis methods must correspond to the kind of data collected. For both quantitative and qualitative data, the Contractor will need to articulate methodologies for analyzing collected data, including any software programs to be used. For qualitative data specifically, the Contractor will need to ensure recording and transcribing of the data collected to the extent possible. Qualitative data should be coded, either by hand or using software, systematically analyzed, and used interpretively and not just descriptively.

Geographical Coverage & Informants/Respondents

The formative study, data analysis, and reporting could be conducted wherever deemed appropriate. The field data collection will primarily be focused in selected or all targeted communities in Lao PDR. Selected data collection may take place in locations other than Lao PDR, e.g., for data collection among key stakeholders or subject matter experts.

The Contractor is expected to spend most of their field work in the three targeted provinces/capital during phase I of the USAID Okard, with a few days in Bangkok, Thailand. Majority of the persons with disabilities and their household should be able to speak Laotian, whereas some of them may speak other ethnic languages.

USAID Okard Documents For Review

1. USAID Okard Cooperative Agreement and Modifications (Attachment J.4, the remaining documents will be shared upon the award issuance)
2. Annual work plan
3. Progress reports
4. Monitoring, Evaluation, and Learning (MEL) plan
5. Gender and Social Inclusion Action plan (GSIAP)
6. Relevant documents, tools/instruments, data and report from: the CBID model, application of World Health Organization (WHO) Standard Assessment of Rehabilitation (STAR), and any other monitoring records and study/research conducted/commissioned by WEL and its partners

ANNEX G: USAID OKARD DATA COLLECTION ACTIVITIES

Component	Objectives	Method/Tool	Frequency	Type of Data	Sample
External PE	Test and validate the Theory of Change and assumptions of the Okard Activity (focusing most attention on the use of a two-tiered approach to persons with disabilities programming.	KIIs FGDs Secondary data Desk review	Baseline and Endline	Qualitative	Purposive sample KIIs including: - Implementing partners - Intended sub-recipients - USAID/USG - GoL and technical working group representatives - Experts and other donors - DPOs/NPAs (national and provincial/local) - Private sector Purposive/convenience sample FGDs including: - Service delivery system representatives (health facility staff; TVET staff) - Persons with disabilities (separate M, F) - Caregivers
External PE	Identify reference points that can help inform adaptation and the implementation plan throughout the period of performance.	KIIs FGDs Secondary data Desk review	Baseline and Endline	Qualitative	Same as above
CBID Assessment	Identify the level of activity and participation (function), wellbeing and access to services among persons with disabilities and persons without disabilities.	Long Survey	Baseline and Endline	Quantitative	Screening: 7 out of 35 target villages in Kham District and 8 out of 16 target villages in Xayphouthong District. Two-stage cross-sectional survey using multi-stage stratified random sampling. The sample included both children and adults aged 5 or older, with and without disabilities. A short screening survey using the Washington Group short set of 6 questions on functional difficulties was conducted to identify disability prevalence and construct sampling frames in the first stage. Persons with and without disabilities were selected for a long-form interview in the second stage. 5,173 persons completed the screening and 648 persons completed the long-form survey.
CBID Assessment	Explore the knowledge, attitudes, and practices (KAP) towards people with disabilities and of select	KIIs FGDs	Baseline and Endline	Qualitative	Purposive sample from each of the districts, including: FGDs with: - Community members with disabilities (separate M and F)

Component	Objectives	Method/Tool	Frequency	Type of Data	Sample
	community and government stakeholders.				- Community members without disabilities (separate M and F) - Caregivers of community members with disabilities (separate M and F) KIIs with: - Head of village - Women's Union - Provincial Health Department - District Health Center (District Health Office, district hospital, nurse) - Community health center (separated staff and head of health center) - Provincial Labor and Social Welfare - District Labor and Social Welfare - Provincial Department for Education and Sport - District Department for Education and Sport - Disabled people's organization - Private sector/potential employer
Modular Tool	Understand and prioritize initial unmet needs and measure the changes in the level of function, wellbeing, economic self-sufficiency, utilization of health services and participation of persons with disabilities.	Modular tool survey Photovoice/walking interview/case stories guided by BCC	Intake and Exit (continuous)	Quantitative and Qualitative	Persons with disabilities identified during community screening that received CBID interventions (all direct beneficiaries)
Monitoring	Rack achievement of outputs and some outcomes and indicate when/if course corrections are needed. Answer learning questions.	See PIRS	Continuous	Quantitative and Qualitative	See PIRS Context/learning question monitoring (TBD)

ANNEX H: MEASUREMENT OF THEORY OF CHANGE

Theory of Change Component	Component Text/Activity (approved AMELP)	Measurement	
		Monitoring Indicators (via regular Monitoring, Modular Tool, or case studies/photo voice)	**Evaluation** (via External PE, CBID Assessment, STARS Assessment)
Problem Statement	A disabling environment in Lao PDR creates barriers for persons with disabilities, *particularly women and girls*, which restricts them from optimal functioning and being able to enjoy the same level of participation and access the same health and livelihood opportunities as others in society.	*Context monitoring table (AMELP Section 3.4)*	**External PE:** Formative Study; EQA, EQD **CBID Quantitative** A1: location B5/B6: covers age C2: covers sex, but not necessarily gender. Limited to male and female, with no "other" option. C3: Ethnicity covers ethnic origin/indigenous status. D5: accessing health services D10: access to health services D27.2/ D28.2: barriers to access D31.2: access to adequate services D12.1/ D12.4/ D12.5; D13.4/ D135/ D14.1/ D15.1/ D16.1/ D17.1/ D18.1/ D19.1: type of difficulty in functioning
If Then	**If** USAID Okard implements activities in each of the three components of health, economic empowerment, and stakeholder engagement at both the system level (system centered response) and the community level (person centered response) (two tiered approach) **then** the project goal will be achieved more effectively and efficiently than if the systems or the person centered approaches were implemented alone at only one level.		**External PE:** EQA, B, D, E
Activity Goal/Result (R)	[GOAL] The independence and well-being of persons with disabilities and their households in Lao PDR will continue to improve and be sustained over the long term. [RESULT] Increased number of persons with disabilities	**H1.4:** The number of people who demonstrate an increase in function or wellbeing **E1.3:** Number of persons with disability and their households with improved economic self-sufficiency	**CBID Quantitative** A1: location B5/B6: covers age C2: covers sex, but not necessarily gender. Limited to male and female, with no "other" option.

Theory of Change Component	Component Text/Activity (approved AMELP)	Measurement	
		Monitoring Indicators (via regular Monitoring, Modular Tool, or case studies/photo voice)	**Evaluation** (via External PE, CBID Assessment, STARS Assessment)
	and their households with improved health and improved economic self-sufficiency.		C3: Ethnicity covers ethnic origin/indigenous status. C16: on satisfaction with their main activity D1: on satisfaction with their health D3: sickness D4: sickness D24.2/ D25.2/ D26.2: increase in functioning D32: increase in desire to do activities D33: change in depression levels E1-10: wellbeing F1-F8: functioning
Development Objective	Vulnerable populations more able to address risks that transcend borders (RDCS DO 2)	ITT	
Assumption	All government and non-government stakeholders have a better understanding about the reality and experience of being a person with disability in terms of difficulty of functioning, being included in their own communities, and having their voice heard	*Context monitoring table (AMELP Section 3.4)*	**External PE:** Formative Study; EQA, B
Assumption	Service providers, families and persons with disabilities work together to complement each other in their roles in health, education, business, and in public and private central, provincial and district institutions	*Context monitoring table (AMELP Section 3.4)*	**External PE:** Formative Study; EQA, B
Component 1: Health Sub IR 1.1	Activities H1: Create training opportunities for relevant health service providers H2: Support health rehabilitation centers to provide appropriate AT and establish best practices H3: Promote rehabilitation as part of the continuum of health care *MHPSS* *CBID Demonstration Model* **Sub-IR: HR 1.1**	**Standard Indicator ES 4.2:** Number of service providers trained who serve vulnerable persons **Standard Indicator ES 4.3:** Number of U.S. Government-assisted organizations and/or service delivery systems that serve vulnerable persons strengthened **H1.1:** Number of service delivery systems with improved capacity to provide women-centered care	**External PE:** EQA, B, D

Theory of Change Component	Component Text/Activity (approved AMELP)	Measurement	
		Monitoring Indicators (via regular Monitoring, Modular Tool, or case studies/photo voice)	**Evaluation** (via External PE, CBID Assessment, STARS Assessment)
	Improved ability of health systems to provide quality health and related rehabilitation services for persons with disabilities and their households *(improved knowledge and capacity)*		
Component 1: Health Sub IR 1.2	Activities Activities H1, H2, H3, *CBID Demonstration Model, MHPSS* **Sub-IR: HR 1.2** Improved user experience for persons with disabilities and their households when receiving health and related rehabilitation services *(persons with disabilities more satisfied)*	**H1.2:** Percentage of people receiving 'people centered care' from targeted health and rehabilitation facilities **PM 1:** Number of targeted beneficiaries with increased knowledge/ skills and awareness	**CBID Quantitative** D7: return visits to clinics D10.2: reasons for not accessing clinic D11: satisfaction with healthcare services D31.3: reasons for not able to get adequate access D31.6: satisfaction with rehabilitation services
Component 1: Health IR 1	Activities H1, H2, H3, *CBID Demonstration Model, MHPSS* Sub-IRs 1.1 and 1.2 **IR H (1):** Increased utilization of health and related rehabilitation services for targeted persons with disabilities and their household	**H1.3:** Number of people receiving health and related rehabilitation services (including rehabilitation, assistive products, medical treatment for UXO survivors, and MHPSS **Standard Indicator ES 4.1:** Number of vulnerable persons (i.e. Persons with disabilities and their household) across the health and economic empowerment components (benefiting from USG supported social services)	**CBID Quantitative** D5: accessing health facilities D12.2/ D13.2/ D14.3/ D14.4/ D15.4/ D15.5/ D16.3/ D16.4/ D20.1/ D20.2/ D21.1: receipt of rehabilitative services/assistive products. D24.3/ D25.3/ D26.3: receipt of services D31.2: access to adequate rehabilitation services – range/spectrum of access
Component 2: Economic Empowerment Sub IR 2.1	Activities E1: Engage universities, vocational schools, social and private enterprises, and business associations to develop and implement effective and inclusive technical and vocational training courses. *DMAS* *CBID Demonstration Model* **Sub IR 2.1:** Increased numbers of persons with	**E1.1**: Number of persons with disability who graduate from TVET courses **PM 1:** Number of targeted beneficiaries with increased knowledge/ skills and awareness **Standard Indicator ES 4.2:** Number of service providers trained who serve vulnerable persons **Standard Indicator ES 4.3:** Number of U.S. Government-assisted	**External PE:** EQA, B, D

Theory of Change Component	Component Text/Activity (approved AMELP)	Measurement	
		Monitoring Indicators (via regular Monitoring, Modular Tool, or case studies/photo voice)	**Evaluation** (via External PE, CBID Assessment, STARS Assessment)
	disabilities and their households having technical and vocational skills	organizations and/or service delivery systems that serve vulnerable persons strengthened	
Component 2: Economic Empowerment Sub IR 2.2	Activities E2: Engage private sector and Lao vocational support entities to integrate persons with disabilities into existing channels for employment E3: Provide assistance to persons with disabilities and their households to access market-based income generation opportunities (CBID Demonstration Model) **Sub IR 2.2:** Increased access to income generation opportunities (self-employment or employment) for persons with disabilities and their households	**E1.2:** The number of persons with disabilities and their household who receive an IGA or complete job readiness **GNDR 2:** Percentage of female participants in USG-assisted programs designed to produce increase access to productive economic resources (assets, credit, income and employment)	**External PE:** EQA, B, D
Component 2: Economic Empowerment IR 2	Activities E1, E2, E3 Sub IRs 2.1 --> 2.2 **IR E (2):** Increased number of persons with disability and their household employed or self-employed	**PM4:** The number of targeted vulnerable populations gaining new or better employment as a result of USG assistance **Standard Indicator ES 4.1:** Number of vulnerable persons (i.e. Persons with disabilities and their household) across the health and economic empowerment components (benefiting from USG supported social services)	
Component 3: Stakeholder Engagement Sub IR 1	Activities S1: Improve the functioning of the MoH and the National Committee for Disabled People and the Elderly (NCDE) to improve coordination among implementers, donors, and GoL ministries that support persons with disabilities. S2: Strengthen representative and supporting organizations to improve coordination among implementers and engagement with GoL. **Sub IR 3.1**: Improved coordination among stakeholders to develop, implement, and monitor policies promoting the rights and inclusion of persons with disabilities	**S1.1:** Number of activities in the Disability Action Plan initiated and monitored by the NCDE	**External PE:** EQA, B, D **WHO STARS**

Theory of Change Component	Component Text/Activity (approved AMELP)	Measurement	
		Monitoring Indicators (via regular Monitoring, Modular Tool, or case studies/photo voice)	**Evaluation** (via External PE, CBID Assessment, STARS Assessment)
Component 3: Stakeholder Engagement Sub IR 2	Activities S1: Improve the functioning of the MoH and the National Committee for Disabled People and the Elderly (NCDE) to improve coordination among implementers, donors, and GoL ministries that support persons with disabilities. S2: Strengthen representative and supporting organizations to improve coordination among implementers and engagement with GoL. **Sub IR 3.2:** Improved capacity of GoL ad representatives and supporting organizations to operate effectively	**Standard Indicator ES 4.2:** Number of service providers trained who serve vulnerable persons **Standard Indicator ES 4.3:** Number of U.S. Government-assisted organizations and/or service delivery systems that serve vulnerable persons strengthened	**External PE:** EQA, B, D **WHO STARS**
Component 3: Stakeholder Engagement Sub IR 3	Activities S3: Mobilize existing grassroots networks to better support persons with disabilities and their households, increase participation in advocacy, and empower individuals to engage in the community. S4: Engage persons with disabilities in policy design and implementation. *CBID Demonstration Model* **Sub IR 3.3:** Improved engagement of persons with disabilities, their communities, and representative organizations in policy design and implementation	**S1.2:** Number of participants involved in government-led policy process who self-identify as a person with a disability	**External PE:** EQA, B, D **WHO STARS**
Component 3: Stakeholder Engagement IR 3	Activities S1, S2, S3, S4 Sub IRs 1, 2, 3 **S IR (3):** Improved enabling environment to contribute to the sustainability of the health and economic empowerment components	**S1.3:** Number of operational criteria achieved by the MoH (DHR) and NCDE Strategy and Action Plan coordinating bodies (in a maturity matrix)	**External PE:** EQA, B, D **WHO STARS**
Cross Cutting/Community Mobilization	*Activities* *CBID Demonstration Projects* *Social Behavior Change Communication (SBCC)* *Sub IR: TBD*	*TBD*	**CBID Quantitative** **CBID Qualitative**

ANNEX I: COMPLETE LIST OF USAID OKARD EVALUATION AND RESEARCH QUESTIONS

In addition to the PE questions, this table includes questions intended to be answered through WEI-managed data collection efforts (including the CBID Assessment, the Modular Tool, and ongoing monitoring), therefore presenting a wholistic view of the questions guiding USAID Okard.

The other USAID Okard MEL Component – Screening – is not included in this table because it does not have a research, evaluation, or learning question.

External PE	Comprehensive Question: To what extent did USAID Okard's Theory of Change explain changes in the health and economic self-sufficiency of persons with disabilities and their households? Is the theory of change valid?
External PE	Sub-Question A: a) To what extent did people-centered interventions (CBID model, Tier 2) and system-centered interventions (Tier 1) contribute to Activity results? b) In what ways did the CBID model serve to catalyze and test the implementation of the National Disability Policy, Strategy and Action Plan, and the National Rehabilitation Strategy and Action plan at the community level, and in what ways did the model feed into national level revision of these key documents? c) To what extent did components 1 (health), 2 (economic empowerment), and 3 (stakeholder engagement) contribute to Activity results, and how did they interact with each other? Was component 3 found to be a key requirement for the effective, efficient, and long-lasting implementation of the health and economic interventions?
External PE	Sub-Question B: What were the unintended outcomes and/or consequences of the Activity (considering sex, age, and ethnicity)?
External PE	Sub-Question C: To what extent did the USAID OKARD management structure and implementation plan contribute to effective achievement of results?
External PE	Sub-Question D: To what extent were women, youth, and minority groups/ethnicities engaged effectively in the Activity in all locations and in each component?
External PE	Sub-Question E: To what extent are results likely to be sustainable at the national and community level beyond the Activity period of performance? What evidence exists to support the conclusion?
CBID Assessment	1. Has the level of participation and wellbeing changed compared to the results of baseline?
CBID Assessment	2. Has access and utilization of services changed compared to the results of baseline?
CBID Assessment	3. Has knowledge, attitude and practices changed in the community related to disability inclusion?
Modular Tool	1. What changed in the level of function, wellbeing, economic self-sufficiency, utilization of health services and participation of persons with disabilities after participation in USAID Okard?

Learning Question[70]	1. Are the enabling conditions (including government capacity and will) in place to support more women-centered health care?
Learning Question	2. What are the most impactful approaches and techniques to build the capacity of TVET staff to address gender stereotypes and diversify opportunities for women with disabilities?
Learning Question	3. What are the critical factors (and their interactions with each other) that will contribute to the successful coordination and implementation of the National Disability / Rehabilitation Strategies and Action Plans?
Learning Question	4. What are the capacity and needs of each of the pre-identified local partners to deliver as expected?
Learning Question	5. What will lead to meaningful change in people's/ communities' attitudes and behavior with regard to disability inclusion in the Lao context?

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ANNEX K: EXTENDED DATA COLLECTION DETAILS, METHODS, AND ANALYSIS

EVALUATION TEAM

The ET consisted of a five-person SI team, composed of both international and local experts specializing in inclusive development programming and evaluations. SI also worked with a local subcontractor, LSR, to support the ET's data collection efforts. The experience and qualifications of the team members are included below.

- Ms. **Amanda Stek** (Monitoring and Evaluation Specialist) is a monitoring and evaluation professional with ten years of experience in international development, specializing in the Asia region. Her expertise is in performance monitoring, performance and impact evaluation, and research in multiple sectors including human security, health, education, and environment. With Social Impact, she works on multiple projects where she has served as both the Team Leader and Evaluation Specialist. As a Senior Program Manager at SI, she manages personnel, coordinates fieldwork and data collection, and contributes to key deliverables. She also serves as a technical specialist for multiple evaluations and field offices, conducting outcome mapping, contribution analysis, comparative analysis, and gender analysis and providing guidance on qualitative coding schemes, data collection protocol development, and Collaborating, Learning and Adapting work.
- Mr. **Andrew Carmona** (Quantitative Specialist, Project Director) is a monitoring and evaluation professional with over ten years experience in international development and seven years experience in monitoring and evaluating education, international health, WASH, agriculture, and economic development projects. As a Senior Program Manager at Social Impact, Mr. Carmona manages or oversees a portfolio of impact and PE focusing on early grade reading, public financial management, health systems strengthening, at-risk youth, leadership, disability, WASH, and agriculture in Central America, Asia, and Sub-Saharan Africa. He contributes to impact and PE design utilizing a mix of experimental, quasi-experimental, and non-rigorous research methods employing both quantitative and qualitative techniques. He designs, tests, and implements digital instruments using ODK software and SurveyCTO platform, including large-scale household, school-based, public institution, and enterprise surveys, as well as focus group and KII discussion guides. Previously, Mr. Carmona was a Research Activity Manager on the USAID Strengthening Health Outcomes Through the Private Sector Project where he led or participated in evaluations of the private health sector in Senegal, Niger, Benin, and Burundi. He holds an M.P.A. in Development Practice.
- Mr. **Phothong Siliphong** (Local Disability and Gender Specialist) brings over 25 years of experience working on donor funded projects in international development. His areas of expertise include disabilities, social inclusion, gender, community development, and livelihoods. In the field of monitoring and evaluation, Mr. Siliphong has conducted over 45 research projects, and using both qualitative and quantitative methodologies. Recently Mr. Siliphong has served as a Team Leader for a social inclusion policy assessment, which includes persons with disabilities, gender and ethnicity. As a social inclusion and gender specialist, he has facilitated learning events in all aspects such as gender analysis, gender mainstreaming, and the important promotion of women advancement. Mr. Siliphong is a skilled writer, and has over 30 publications, written in both English and Lao.
- Ms. **Erica Holzaepfel** (Team Leader) is a senior evaluation, research, and learning professional with more than 15 years of experience acquired through technical and management positions with private and non-profit organizations, universities, USG, United Nations, foundations, and INGOs. As a technical evaluation specialist, she has extensive experience designing and implementing complex and sensitive evaluations of policies, strategies, country portfolios, programs, and activities. Ms. Holzaepfel has served as Team Leader, Primary Investigator, and Evaluation Director on more than 40 evaluations, assessments, and reviews conducted in over 30 countries around the world. She has experience as the Head of the Monitoring and Evaluation Unit for the World Food Programme in Lao PDR and as the Team Leader on the 2018 USAID Gender and Disability Analysis in Lao

PDR. Through these and other assignments, she has honed her technical expertise in research and evaluation design, implementation, and management with specializations in forced migration, humanitarian emergencies, counter-trafficking-in-persons, nutrition, food security, livelihoods, conflict, human rights, agriculture, youth, and gender.

- Ms. **Denise Buchner** (Disability Specialist) has over 15 years of experience providing research, monitoring, and evaluation services for international organizations, government agencies, and non-governmental, private, and community-based organizations. This experience includes significant time spent in Lao PDR for PhD research on disability and inclusion. Ms. Buchner has expertise in the management of monitoring, evaluation, and research projects with expertise in large and complex mixed-methods studies and integrating cross-cutting themes such as gender equality, environment, and governance into evaluation plans. She has experience with developing baseline, mid-term, and end-line evaluations using standardized and *de Novo* data collection tools for international and local projects. Ms. Buchner is skilled in developing monitoring and evaluation systems using results-based management strategies to track project outcomes, as well as developing and managing both qualitative and quantitative evaluations including methodological design, tool development, database development and management, data analysis (NVivo, SPSS, Excel), and dissemination of results.

EVALUATION DESIGN AND PLANNING

The PE baseline began with a kick-off meeting on September 27, 2018 Eastern Standard Time (EST), during which the ET, evaluation Contracting Officer's Representative (COR), and USAID personnel discussed the evaluation scope, evaluation use, and management of the contract. The kick-off was followed by an internal Team Planning Meeting during which the ET members and SI managers discussed expectations for the evaluation and planned the development of the Formative Study and draft Evaluation Design Report (EDR). The ET also held a kick-off call with WEI on October 10, 2018 (EST) during which the ET and WEI representatives discussed WEI-planned data collection activities (CBID quantitative and qualitative data collection) and expectations for the PE.

After kick-off meetings and consultations, the ET conducted a Formative Study to thoroughly explore the Lao context and inclusive development programming to ensure PE questions, design, and methods were appropriate, efficient, complementary, and non-duplicative (of WEI data collection). SI conducted the study in a rigorous manner using collaborative and participatory approaches to ensure all required data to address study questions were gathered efficiently. The study informed the PE approach and methods by identifying lessons learned from persons with disabilities programming on international, regional, and local levels; identifying gaps in data and information; and informing PE sampling strategies. For more details about the study, see the Formative Study Report conducted by SI and submitted in December 2018.

With the completed Formative Study as an input, the ET drafted the EDR. The ET formulated an evaluation approach, determined appropriate data collection methods, produced a preliminary fieldwork schedule, and designed data collection protocols and consent scripts. As part of the drafting process, the ET held a virtual evaluation design workshop with WEI on December 4, 2018 (EST). This workshop allowed WEI the opportunity to comment on the proposed evaluation questions, approach, and methods, and generated buy-in for the overall USAID Okard evaluation approach. During the design and planning phase, the ET also held several calls with NIGH to discuss data collection timelines, focus/content areas, and plans for data sharing. The ET determined that NIGH would share raw quantitative data for ET analysis and reporting against PE EQs. For CBID qualitative, only summary results was shared for the baseline report. A finalized EDR was submitted to the COR after the in-brief with USAID/Laos in Vientiane, Lao PDR in March 2019 and after the piloting of SI's qualitative data collection instruments.

Lastly, the ET requested all appropriate research and ethics approvals during the planning phase. The ET submitted all data collection protocols and consent scripts to SI's Institutional Review Board (IRB) in December 2018. The IRB reviewed and provided approval for baseline data collection activities in

February (for SI) and March (for LSR) 2019. The ET requested and received research and data collection approvals from appropriate entities for national, provincial, and district level research through LSR. The ET also coordinated with WEI prior to data collection to ensure all approval requirements were met.

For dissemination and utilization, the ET presented the findings of the baseline evaluation to all interested stakeholders in September 2019 in VTE. This on-site Evaluation Framework Workshop/Out-brief was conducted by the ET with WEI and its consortium and/or sub-partners, USAID, and any other interested stakeholders (e.g., government representatives). This workshop provided the ET an opportunity to give a comprehensive presentation and facilitate a participatory workshop with USAID Okard stakeholders and aimed to: 1) present key findings, conclusions, and recommendations from the report and will allow stakeholders to provide verbal feedback (in addition to the standard written feedback provided to the ET after USAID review), 2) ensure all stakeholders understand the USAID Okard evaluation framework outlined by the ET and how baseline sets up future evaluations, and 3) support WEI's MEL implementation plan, including identification of key reference points for management decisions.

METHODS

Additional details here are provided for each of the methods utilized for baseline.

SI Document Review

In addition to the document review conducted for the Formative Study, the ET conducted a review of documents produced by and relevant to USAID Okard in order to better understand the Activity design, mine for initial findings related to EQs, develop an initial response to the EQs, and develop data collection protocols to capture primary data to supplement or cross-check against information provided in the background documents. While most of the document review was completed before fieldwork to inform data collection plans and tools, the document review continued throughout the evaluation fieldwork and analysis phase as more documents became available.

An overview of the types of documents reviewed and referenced for baseline are included below. A complete list is provided in Annex J.

- USAID Policies and Documents
- USAID Okard Activity Documents (including WEI-generated MEL data, as available)
- GoL Policies and Regulations related to rehabilitation and disability
- Reports, assessments, and evaluations on persons with disabilities programming internationally, regionally, and locally
- Lao studies/research including:
    - Research/studies conducted in the education, health, and economic growth sectors (for example, publications of local DPOs/Non-Profit Associations (NPAs))
    - Gender and disability analyses
    - Poverty/vulnerability research
- Secondary data (as identified in the Formative Study)

SI KIIs and FGDs

KIIs were conducted one-on-one or in small groups. The ET conducted KIIs with USAID/USG staff; IP and sub-partner staff/consultants; private sector representatives; other experts and donors; and GoL and TWG staff. The sampling frame for KIIs was developed from USAID Okard documents, USAID and WEI consultations, and the Formative Study process. These individuals were all purposively

sampled based on relation to the Activity and knowledge of the inclusive development sector in Laos.[71] A majority of the KIIs were conducted in Vientiane, but several were also conducted in the selected provinces/districts. Interviews lasted between 45 – 60 minutes. The SI Monitoring and Evaluation Specialist and Local Disability and Gender Specialist met with 21 respondents in Vientiane. The remaining respondents were interviewed by LSR in Lao or a local dialect.

Each KII was guided by an interview protocol adjusted for different types of respondents (See Annex E for KII protocols). KIIs addressed each of the sub-EQs. While most of the ToC questions, namely sub-EQ A and B, were included in the FGD protocols, KIIs included several "if, then, because"-framed questions to explore intended pathways to USAID Okard outcomes and Activity success with a select number of key informants (for example, GoL representatives). KIIs were semi-structured, meaning while there was a common format and questions, the protocols allowed for enumerators to deviate from the set format to investigate relevant alternate avenues of questioning that arose.

FGDs included between 5 and 8 individuals and were conducted by a facilitator and a note taker. FGDs were conducted with persons with disabilities; caregivers; health facility staff; and education facility staff.[72] These individuals were selected for FGDs because they are the intended participants of USAID Okard, and therefore the ET wanted to speak to as many individuals as possible at baseline. The sample was both purposive and convenience for these groups, and LSR worked in collaboration with local DPOs/NPAs to identify available and appropriate participants.[73] In particular:

- **Persons with disabilities:** The ET sampled persons with difficulties with mobility over the age of 18 only.[74] Individuals were identified for the FGD sampling frame from DPO/NPA lists available for site locations. The ET intentionally sex-segregated these FGDs based on findings from the Formative Study and the differing experiences and perspectives of men and women with disabilities in Lao PDR.
- **Caregivers of persons with disabilities:** The ET sampled caregivers of persons with difficulties in mental functioning only at baseline. This allowed for representation of another type of difficulties in functioning in the SI baseline sample. Caregivers were purposively sampled from DPO/NPA information lists.
- **Health facility staff:** Nurses and rehabilitation staff were purposively sampled, and then convenience sampling was used when necessary if individuals were not available at the time of the FGD. Doctors will not be included in FGDs at baseline considering nurses and rehabilitation staff provide frontline services to persons with disabilities and vulnerable populations (due to potential bias they would introduce). Doctors may be added as a separate group of respondents at endline. FGDs were mixed sex.
- **TVET staff:** Teachers and management staff were purposively sampled, and then convenience sampling was used when necessary if individuals were not available at the time of the FGD. FGDs were mixed sex.

FGDs were guided by semi-structured protocols (see Annex E) and lasted 60 – 90 minutes. SI/LSR worked closely with WEI, WEI sub-partners, and local DPOs/NPAs to select locations that were convenient and safe for FGD participants. In addition, when conducting interviews with persons with disabilities, LSR ensured that meeting venues and facilities such as washrooms were accessible to everyone, regardless of their type of difficulties in functioning. FGDs will be used to confirm the ToC,

[71] A purposive sample is a non-probability sample that is selected based on characteristics of a population and the objective of the study. Purposive sampling is also known as judgmental, selective, or subjective sampling.
[72] This report uses the preferred terminology of 'caregiver', however, all data collection protocols were designed with the term 'caretaker.' Data collection protocols provided in Annex E preserve the original terminology used during field work. The Lao translation was not affected by the change in English terms.
[73] A convenience sample is made up of people who are easy to reach.
[74] At baseline, the ET did not interview children with disabilities. This was due to logistical and ethical challenges of identifying respondents at a baseline (when USAID Okard databases/documentation were not available to form a sampling frame). This subset of the population can be explored at endline, as necessary.

problem statement, and assumptions as initially designed by USAID Okard and described Activity documents and the AMELP at the beginning of the POP (sub-EQ A). For this reason, the respondent categories included were selected as intended participants of USAID Okard, or those that are expected to change their behavior to improve the system that persons with disabilities are interacting with.

Respondent Category	SI Qualitative Sample			CBID Qualitative Sample		
	Men	Women	Total	Men	Women	Total
GoL and Technical Working Group (TWG) Members	8	0	8	3	1	4
Health Facility Staff	7	14	21	5	7	12
IP and Sub-Partner Staff	7	8	15	N/A	N/A	N/A
Other Experts	2	5	7	N/A	N/A	N/A
Private Sector Representatives	2	0	2	0	2	2
Persons with Disabilities	15	17	32	8	6	14
Caregivers of Persons with Disabilities	1	4	5	6	7	13
TVET/Education Staff	10	13	23	4	0	4
USAID/Other United States Government (USG)	2	4	6	N/A	N/A	N/A
CBID Team	N/A	N/A	N/A	9	4	13
Community Members without Disability	N/A	N/A	N/A	11	11	22
Disabled Persons Organization (DPO)	N/A	N/A	N/A	2	0	2
Village Leader	N/A	N/A	N/A	2	0	2
Women's Union Representative	N/A	N/A	N/A	0	2	2
TOTAL	**54**	**65**	**119**	**50**	**40**	**90**

In selecting both KII and FGD respondents, the ET was cognizant of **saturation** and **representation**. The ET ensured minimum saturation rates (the point when incoming data produce little or no new information) of all USAID Okard stakeholder groups. A minimum saturation rate requires that the ET to talk to a certain number of individuals from the same group in order to maximize understanding of the group's experiences, perspectives, and opinions. Multiple studies have found that 5–6 interviews for each homogenous group in similar setting/context reaches 75 to 80 percent saturation, and that additional interviews are unlikely to add substantial new information.[75] If a study has less than 5 respondents from a given group, researchers might miss what group at large has to say about a given topic or question. Similarly, it would take substantially more interviews than 5–6 in order to uncover additional useful findings. For this reason, the ET sampled a minimum of 5–6 individuals from each USAID Okard respondent category to ensure equal representation and balanced perspectives in the baseline PE.

The ET ensured balanced representation of USAID Okard stakeholder groups and across components, to the extent possible. In order to explore baseline contexts for each USAID Okard component and the broader system, the ET spoke to similar numbers of respondents from the health (21), economic empowerment (23), and CBID components (37).

CBID Quantitative

The CBID quantitative data, collected by NIGH, utilized a multi-stage stratified random sampling (panel) methodology. First, NIGH screened over 3,000 people in 35 villages in Kham District and 16

[75] Research for Evidence, 'Riddle me this: How many interviews (or focus groups) are enough?' (25 April 2017) https://researchforevidence.fhi360.org/riddle-me-this-how-many-interviews-or-focus-groups-are-enough, referencing Guest et al (2006) and Morgan (2002).

villages in Xayphothong District. From these screenings, NIGH identified 658 people for its panel study, 327 of which were persons with disabilities (as defined by the Washington Group disability questions) and 331 without disabilities.[76] The sampling captured both adults and children with and without disabilities and was stratified by sex and district. Data collection tools were translated to Lao and data were collected in Lao.

CBID Qualitative

Detailed information on the methods and sampling approach used for CBID qualitative data collection can be found in the September report from NIGH. At the time of writing, the ET knows that each respondent group was purposively sampled, and the total sample is presented in the main body of this report. Data collection tools were translated to Lao and data were collected in Lao.

DATA ANALYSIS

SI Qualitative Data

The ET utilized the following methods for qualitative analysis at baseline:

- **Comparative/Alignment Analysis** (sub-EQ A and D) - The ET compared ToC models as mapped by FGD respondent groups (persons with disabilities, health facility staff, education facility staff, and private sector representatives). The ET assessed both convergence or divergence with the USAID Okard ToC.
- **Gap Analysis** (sub-EQ A and D) - Gap analyses by the ET involved identification of gaps in the USAID Okard ToC and causal pathways identified in the RF.
- **Content Analysis** (sub-EQ A, D, and E) - Content analysis entailed the ET's intensive review of KII and FGD data to identify and highlight baseline contexts and circumstances in the system that may contribute to (or inhibit) the Activity.
- **Gender Integration** (sub-EQ D) - A key component of the ET's social analysis was the capture of gender-based results. All data collected through KIIs and FGDs was disaggregated by sex and analyzed for effects on both male and female participants to show any significant differences. Consistent with USAID evaluation policy, SI applied a gender perspective throughout the evaluation. The SI Gender Specialist worked with the ET to ensure compliance and gender sensitivity on data collection protocols and tools, as well as on other contract deliverables. SI completed a gender scorecard for the evaluation report.

All raw qualitative datasets and records related to primary data collected by SI at baseline were anonymized for submission to USAID and the Development Data Library (DDL).

CBID Quantitative Data

For the purposes of this report, the ET only analyzed data of the 327 persons with disabilities captured in the CBID baseline data collection.

Given that the survey did not determine the type of difficulties in functioning a respondent had, the ET created variables to determine functioning status. When a respondent was asked what level of difficulty they had in seeing, hearing, walking, communication, remembering, self-care, lifting objects, and manipulating objects, an answer of 'a lot of difficulty' or 'cannot/unable to do' designated the respondent as having a challenge in functioning for the respective functional area (seeing, hearing, moving, communication, cognitive, self-care, upper-limb strength, hand-eye coordination).

[76] http://www.washingtongroup-disability.com/wp-content/uploads/2016/12/WG-Document-4-The-Washington-Group-Short-Set-on-Functioning-Question-Specifications.pdf

United States Agency for International Development
Lao Country Office
Vientiane, Lao PDR