Community Based Inclusive Development (CBID) Demonstration Model Assessment

Baseline Survey Report

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Authors:

Liem Nguyen
Wesley Pryor
Manjula Marella
Alex Robinson
Fleur Smith

Contributors
Approval and coordinator agent: National Committee for Disabled People and Elderly, Ministry of Labour and Social Welfare

Technical contributors:

Respondents (data providers)

1. Representative from Provincial Department of Labour and Social Welfare from Xieng Khouang and Savannakhet Provinces
2. Representative from Provincial Department of Health from Xieng Khouang and Savannakhet Provinces
3. Representative from Provincial Rehabilitation Center from Xieng Khouang and Savannakhet Provinces
4. Representative from Provincial Department of Vocational from Xieng Khouang and Savannakhet Provinces
5. Representative from District Health Office from Kham and Xayphouthong Districts
6. Representative from District Hospitals from Kham and Xayphouthong Districts
7. Villagers and village authorities in 7 target villages in Kham District (Ban Nahom, Ban Kornhiew, Ban Bouamphieng, Ban Chormthongtay, Ban Sun, Ban Nathong and Ban Namuaeng
8. Villagers and village authorities in 8 target villages in Xayphouthong District (Ban Muangkhai, Ban Dontoum, Ban Namphou, Ban Dongposy, Ban Nakham, Ban Phorntan, Ban Khamsan and Ban Kuordam.

Local Research Team
Alounny Keosouvanh, Local Research Coordinator
24 quantitative enumerators and 4 qualitative interviewers

USAID Okard Team (World Education Inc. and Humanity and Inclusion)

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Abbreviations

AP	Assistive product
AT	Assistive technology
CBID	Community Based Inclusive Development
CI	Confidence Interval: A range of plausible values based on available data
OPD	Organization of Persons with Disabilities
FGD	Focus group discussion
GoL	Government of the Lao People's Democratic Republic
KII	Key informant interview
KAP	Knowledge, attitudes and practices
OR	Odds Ratio: A ratio of the likelihood of two occurrences being associated controlling for other known factors
PPS	Probability proportional to size (sampling)
PSU	Primary sampling unit
RAD	Rapid Assessment of Disability
SDG	Sustainable Development Goal
SWLS	Satisfaction with life scale
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WG Short Set	Washington Group Short Set of questions on disability
WHO	World Health Organization

Foreword

The United States Agency for International Development (USAID) Okard project supports Disability Inclusive Development (DID) in Lao PDR. World Education implements USAID Okard in partnership with the National Committee for Disabled People and the Elderly (NCDE), Ministry of Health, Humanity & Inclusion, and civil society organizations. The project aims to increase and sustain the independent living and functional ability of people with disabilities, regardless of factors such as age, sex, gender expression, ethnicity or the cause of their health condition that reduces functioning.

To understand DID, it is important to understand *'human diversity'* and *'inclusion'*. Human diversity is a fact and takes many forms. People are diverse in age, sex, gender expression, race, and ethnicity. People also have diverse levels of functioning. Celebrating diversity means members of the community recognize, understand, and appreciate, with empathy and respect, the diversity of human beings. Inclusion is a choice, a choice for government and nongovernment actors to take tangible actions that remove barriers to participation.

In close consultation with persons with disabilities, the USAID Okard interventions apply a cohesive system strengthening approach and person-centered approach to engage government actors to develop and implement disability inclusion policies and inform community stakeholders about the ways they can contribute to an inclusive community. Underpinned by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), USAID Okard aims to foster a society where persons who have long-term physical, mental, intellectual or sensory impairments due to a health condition and who achieve their optimal level of functioning after accessing rehabilitation and using assistive products; and who interact in a barrier free community, enjoy equal, full and effective participation and opportunities in society. A society where communities celebrate diversity and understand that disability is part of human diversity.

USAID Okard applies a cohesive approach to contribute to disability inclusive development. World Education sub-contracts several government and non-government partners to implement mutually reinforcing interventions that each play a tangible role toward disability inclusion. USAID Okard therefore assumes that if the government and non-government stakeholders are equipped and cohesively engaged in taking tangible actions that contribute to remove barriers to inclusion (systems-based approach), and if primary healthcare professionals effectively provide rehabilitation and assistive products services (receive training on essential rehabilitation techniques, rehabilitation equipment and supply simple assistive products); and if the managers of private enterprises receive advisory services on accessibility and mainstreaming disability in the global workforce and hire persons with disabilities on equal basis with others; and if the members of organizations of persons with disabilities are enabled and empowered to effectively represent the voice of all person with disability and to advocate for their rights in national and regional policy maker forums and if the changed knowledge, attitude and practice of Laotians toward disability, enhance behavior that appreciates and respects diversity; then we can expect a lasting change in society where persons with disabilities enhance and sustain their independent living (livelihood) and optimal functional ability.

The Community Based Inclusive Development (CBID) Demonstration Model, designed by USAID Okard, is a key element of the project, and is a community-level synthesis of the operationalization of national disability inclusion and rehabilitation laws, policies and strategies, stakeholder engagement through community dialogue to take tangible actions that remove barriers to participation, and the individualized case management that enables persons with disabilities to achieve their optimal level of functioning and increase their potential to participate in a more inclusive society.

To ensure that USAID Okard applies an evidence-based approach to measure the outcomes of the CBID Demonstration Model on full and effective participation of persons with disabilities on equal basis with others in society, WEI contracted the Nossal Institute for Global Health from the University of Melbourne to undertake a baseline survey in both districts.

The CBID Baseline findings will not only provide all USAID Okard stakeholders with valid and reliable data to measure the effectiveness of the CBID Demonstration Model on the participation of persons with disabilities in their society but will also inform future adjustments and improvements to the approach and tools.

My wish for those reading this report is twofold. First, to provide access to accurate data on disability prevalence in Lao PDR and an evidence-based analysis of the remaining challenges that need to be addressed to ensure that persons with disabilities fully and effectively participate in society on an equal basis with others. Second, to support and encourage the mainstreaming of disability in programming of development initiatives at the government and civil society levels as a lasting approach toward disability inclusion.

I would like to share my deep gratitude to the Government of Lao PDR, particularly to the Ministry of Foreign Affairs and NCDE, for their close cooperation and administrative support, which made this CBID baseline possible.

I am grateful to the NOSSAL team for sharing their disability inclusive development expertise with great passion throughout the design, implementation, and analysis of this CBID Baseline.

A great thanks to all the enumerators that, under the coordination of Alouny Keosouvanh, committed their time to travel hours in the community and interview people with professionalism and empathy.

This baseline could not have been effectively implemented without the strong commitment and collaboration of World Education and Humanity and Inclusion staff. I am grateful for their involvement at all stages of the baseline.

Last but not least, my deepest respect and appreciation goes to all persons with disabilities and their families that shared their stories. Their experiences are the key to ensuring the CBID Demonstration Model better understands their unmet needs and how it can contribute to meeting those needs.

Kind regards,

Bernard Franck, Chief of Party - USAID Okard, World Education, Inc.

Acknowledgements

The team at the Nossal Institute is grateful to the World Education team and their project consortium for their collaborative approach to implement the survey and interviews used to conduct this baseline analysis. We were very grateful to Government of Lao PDR authorities for providing the necessary support and permissions required to work in and with local communities.

The enumerators involved in the quantitative and qualitative component went above and beyond to conduct thousands of individual surveys, and we were grateful to them.

We gratefully acknowledge the financial contribution of USAID to the USAID Okard project which funded this work.

Finally and most importantly, we are grateful to the survey and interview participants and their community leaders who were generous with their time, hospitality, information and expertise.

I. Executive Summary

Persons with disabilities are a large and growing proportion of the population and are at risk of exclusion from social and economic participation. Community-based inclusive development (CBID) is a strategy of targeted support for people to achieve their goals in areas including health, wellbeing, livelihoods and community participation.

This mixed-methods baseline study provides evidence to inform the Lao PDR USAID Okard project overall and particularly the CBID demonstration model.

1. Summary of study design

The baseline study was designed with the following elements:

- A quantitative screening survey to determine disability prevalence and identify participants for further surveying (5173 people screened; 48% male, 52% female; 21% 5-15y, 67% 16-59y, 12% ≥60y).
- A comprehensive quantitative case-control study to determine the baseline situation for key program results (321 and 326 people with and without disabilities respectively were surveyed)
- A qualitative study of knowledge, attitudes and practice (KAP) using 14 focus group discussions and 28 key informant interviews
- Where possible, findings from the qualitative component were used to help interpret quantitative results for results other than KAP

→ More information about the methods are provided in part III (page 9)

Determining disability: Note for the reader:

In this baseline survey, disability was identified using the Washington Group (WG) Short Set Questions on Disability that screen for seeing, hearing, mobility, remembering and concentrating, self-care and communication. Individuals reporting 'a lot of difficulty' or 'cannot do at all' on any one domain of functioning (DISABILITY3 threshold according to WG protocol) were identified as having a disability.

2. Prevalence of disability increased with age and was higher than previous estimates

In the two districts surveyed, estimated disability prevalence (combining people who report having 'a lot of difficulty' or 'cannot do at all' in doing functioning activities to create an estimate of 'disability') was 11.7%, with 13.4% in Kham district and 9.9% in Xayphouthong district. Disability prevalence was strongly associated with increasing age and poverty. Difficulty communicating and self-care were less common than seeing, walking, remembering and hearing difficulties. These estimates were higher than 2015 Census estimates, which was 2.8% prevalence, even though WG questions were used. The variation is due to differences in the methods with this survey which used more reliable, internationally-accepted methods of obtaining individual level data.

→ Prevalence of disability results are described in part IV-1 (page 23)

3. Social and demographic characteristics associated with functional difficulties

In Xayphouthong district, but not in Kham district, persons with disabilities were less likely to report having as much work as they need. Persons with disabilities were less satisfied with work than persons without disabilities in both districts. Access to work was the most infrequent among people with higher levels of difficulty in functioning. Access to work was also associated with increasing age.

Persons with disabilities were less likely to have attended school, and less likely to progress to secondary or higher levels of education than others. Of the 20 school age children with disabilities surveyed, 4 (20%) had never attended school, while less than 2% (2/110) of children without difficulties had never attended school.

These findings highlight that age-specific strategies, taking into account fewer opportunities for education among persons with disabilities, are required in component 2 *economic empowerment* strategies.

Similarly, adults with difficulties were also less likely to have ever attended school compared to adults without disabilities. However, most of the differences in education are probably associated with age; older people are less likely to have attended and completed school than younger generations. Targeted CBID support needs to consider access to school for young people, but also account for education levels among older beneficiaries. Persons with disabilities were more likely to have ever been married, but also more likely to be divorced or separated, when compared to persons without disabilities in both districts. This finding highlights how family arrangements and structure might intersect with access to work.

→ Social and demographic characteristics associated with disability are reported in part IV-2 (page 28)

→ Access to vocational training (linked to project result **ER 2.1**) is reported in part IV-3 (page 34), with additional analysis of access to education, work satisfaction and barriers to livelihoods.

4. Persons with disabilities experience poorer health and wellbeing

Compared with 14.4% of persons without disabilities, 73.3% of persons with disabilities self-reported poor health, and about twice as many persons with disabilities had been sick enough to miss three or more days of work or school. Persons with disabilities were 10 times more likely to report having poor health than those without disabilities after controlling for other socio-demographic variables.

Having poor health was also associated with increased age, not completing secondary or higher levels of schooling and being from Xayphouthong district.

While the statistical associations were not strong, persons with disabilities expressed less satisfaction with life overall. People in Kham district reported lower levels of life satisfaction than people in Xayphouthong district.

→ The health of people with and without disability (linked to project indicator **HI-4**) is reported in section IV-4 (page 46)

5. Persons with disabilities require more access to health care

Compared to persons without disabilities (27.5% in Kham district and 22.1% in Xayphouthong district), about twice as many persons with disabilities (56.0% and 43.1% in Kham and Xayphouthong districts respectively) reported needing health care in the last three months. Having disabilities did not affect how much people could access mainstream health services or the main health-seeking behaviors, but access to assistive products and rehabilitation services were low. Persons with disabilities could access health care, but the type of care they access is not necessarily appropriate for addressing functional difficulties.

→ The need for healthcare and current access to health services (linked to project indicator **HI-2 & HI-3**) is reported in section IV-5 (page 52)

→ Results linked to the user experience of health (project results **HR 1.1** and **1.2**) are reported separately in section IV-5 (page 52)

6. Community voice among persons with disabilities

Persons with disabilities overall had less voice in their community. Being an active member of community decision-making is also associated with increasing age, more education and higher living conditions. Barriers to participating in community activities and groups were more common among people with 'a lot' of difficulties, and none of the respondents in this survey who 'could not do at all' in at least one domain of functioning reported participating in any community organizations.

→ Results concerning stakeholder engagement in government processes (indicator **SI-2**) and engagement in community actions (linked to **enabling environment** and **SR 3.3**) are reported in section IV-7 (page 70)

7. What the community know and do about functioning and disabilities

Nearly 60% of persons with disabilities in Kham district and nearly 75% in Xayphouthong district identified with the WG questions did not self-report having a disability. Three quarters of people reported that they know someone with a disability. The likelihood of interacting with persons with disabilities increased with age but was lowest among people with the most difficulties themselves. People in the middle socioeconomic status were more likely to know and interact with persons with disabilities, while people from Xayphouthong district were half as likely to interact with persons with disabilities as those in Kham district.

Between a third and half of all respondents reported that persons with disabilities have either the same or less access to healthcare, work, and education when compared with persons without disabilities. A smaller but important proportion of the population reported that persons with disabilities have *more* access to services than others. Generally, this does not reflect the reality of the experience of exclusion among persons with disabilities and is an important area of community perceptions that can be addressed.

Overall, there were positive self-reported attitudes towards persons with disabilities. More than 90% of people reported that they would have no issues with working with or living near persons with disabilities. However, people were likely to respond more positively than they

act in reality. Further, the 10% of people that self-reported *negative* attitudes are a concern for equity.

Negative or inequitable attitudes were more frequent concerning the right of persons with disabilities to get married, and to have children. Persons with disabilities expressed fewer positive attitudes towards equity concerning women with disabilities having the right to work. In Xayphouthong district, fewer persons with disabilities reported that they should be able to get married.

→ Qualitative and quantitative findings concerning the enabling environment (SI-2 and SR 3.3) are reported section IV-8 (page 84)

→ Qualitative results concerning current knowledge, attitudes and practice linked to the **enabling environment for sustainability of health and economic program** components are described specifically in section IV-8, part C (page 99)

8. Key findings to inform CBID planning

Prevalence of disability and impairment

- Using internationally accepted methods, disability prevalence was higher than previously reported.
- Overall, people understood functioning and disability differently. This is evidenced by a mismatch between frequency of functional difficulties and self-reported disability.
- More people experienced difficulty functioning as they got older.
- Persons with disabilities experienced different types of barriers and exclusion through the life course.
- People who experienced difficulties seeing and hearing, and people with difficulties communicating and remembering could be at the most risk of exclusion.
- While less than 1% of the population reported they 'cannot do at all' in at least one domain, this group was at higher risk of exclusion and may have higher needs than other groups.

Living conditions and inclusion

- The living conditions of people generally and especially persons with disabilities in Xayphouthong district was poorer than in Kham district.
- Persons with disability were often as included in areas of social life as people without disability, but the *quality* of their experience is poor. Examples included access to health where people were able to access health, but persons with disabilities reported limitations in services specific to their needs, and in work, where people reported being able to work, but were less likely to be paid.
- Persons with disabilities were around 60% less likely to have completed higher (primary+) levels of education.

- Barriers to school access included negative social attitudes, skills and knowledge of educators, stigma and bullying. Social attitudes preventing school access included perceptions of the value of education among parents and caregivers.

Health, rehabilitation and assistive technology

- Persons with disabilities were more likely to experience poor health and have more frequent and complex health service needs. Persons with disabilities could access health, but the services offered were often inadequate.
- There was a high unmet need for assistive products overall.
- Rehabilitation was poorly understood, including among persons who are likely to need it. Most rehabilitation in Lao PDR has been targeted to war-related injury and may not be responsive to the complex health needs of a changing population (increase of noncommunicable diseases and ageing).

Women and women with disabilities

- Women overall (controlling for all other factors including functioning) experienced lower levels of education and vocational training, work, and some dimensions of social inclusion.
- Women appeared to assume most (but not all) caregiver responsibilities.

Government benefits

- Persons with disabilities accessed government benefits as much as or more than others.
- People who reported 'cannot do at all' in any one domain were more than four times more likely to have accessed government benefits than people with no difficulty.
- Access to social benefits for caregivers was infrequent and a prominent issue reported by caregivers and families of persons with disabilities.
- Benefits were mostly targeted to UXO accident survivors and war veterans.

Knowledge and attitudes about disability

- How people understand disability in themselves and in other people is a key driver of attitudes and practice. In general, there was a narrow understanding of disability, limited to highly visible and more profound impairments.
- People reported positive and inclusive attitudes about disability, but other findings point to exclusionary and stigmatizing practice.
- The community tends to understand that persons with disabilities should be able to, but cannot, participate with others. There are social norms that seem to imply persons with disabilities should not have to work and should be taken care of.

9. Further overall findings

- The baseline findings highlight the profound and urgent need to re-think disability, functioning and how CBID services respond to them in Lao PDR.

- Complex interactions between functioning and how the community understands and responds to disability demonstrates the relevance of USAID Okard's approach, which emphasizes a comprehensive and individualized approach to functioning, combined with community programming to address persistent and potentially harmful attitudes about disability.
- There were important differences between Kham and Xayphouthong districts, especially concerning living conditions and self-reported health, which were both lower in Kham district than in Xayphouthong District.
- Findings underscore the importance of understanding the quality of services, rather than 'access' alone. That is, people at risk of, or with disabilities, appear to have similar access to many services including health, social benefits, and many aspects of social life – but the quality of those interactions appear to be inadequate.
- Findings highlight particularly at-risk groups. These include older people; people with the most difficulty functioning (who are unable to do at all at least one domain); school-aged children with disabilities who are still commonly excluded from education; women with disabilities especially in areas of vocational training and work; younger people looking for work, and men with disabilities in accessing social interactions.

II. Background

1. The context for the USAID Okard project

Persons with disabilities face discrimination and exclusion from the social, cultural, political and economic life of their communities [1]. In many contexts, persons with disabilities are more likely to experience poverty and yet are excluded from development programs [2-4]. There is growing recognition of the need to understand the prevalence of disability and attitudes and barriers to inclusion in order to support the design, implementation and monitoring of effective inclusive development programs [1].

In the Lao PDR, there are different estimates on the prevalence of disability. Earlier estimates in 1996 and 2005 estimated 0.7%-1% and 1.3% prevalence of disability respectively. The 2015 Lao PDR census estimated a disability prevalence of 2.8% [5]. Another disability survey in selected areas of Lao PDR in 2016 reported a significantly higher disability prevalence at 10.8% [6]. This variation in the estimates is due to different methods used for measuring disability in the two surveys. Further information on participation of persons with disabilities in their communities and their access to health and social services is not well studied in the surveys conducted so far in the Lao PDR.

World Education is a non-governmental organization working in the Lao PDR since 1992 in partnership with the Government of Lao PDR. World Education is currently managing and implementing the USAID Okard Activity, which is a 5-year program that intends to improve and sustain the independent living and functional ability of persons with disabilities and their households in Lao PDR. It will be implemented in three target provinces – Vientiane Capital, Xieng Khouang and Savannakhet.

The Activity utilizes a flexible two-tiered approach that integrates the systems and individual level interventions within the three components:

- Health (Component 1)
- Economic Empowerment (Component 2)
- Stakeholder Engagement (Component 3)

World Education is the lead implementing agency with close support from Activity partners including Humanity & Inclusion (HI), Ministry of Health (Department of Healthcare and Rehabilitation), Center for Medical Rehabilitation (CMR), Ministry of Labor and Social Welfare (MoLSW) National Committee for Persons with Disabilities and the Elderly (NCDE), Quality of Life Association (QLA) and Association for Rural Mobilization and Improvement (ARMI).

As part of the Activity, the Community Based Inclusive Development (CBID) evidence-based demonstration model is implemented in two target districts to demonstrate the effectiveness at community level of both the Government of Lao PDR National Disability Policy and related strategy, and the National Rehabilitation Medicine Strategy. The CBID district teams implement innovative and effective interventions that directly address the health, livelihoods, and social needs of persons with disabilities, with a focus on individuals, families, and communities. The lessons learned on the change created for persons with disabilities and

their households should drive adjustments at the systems level (by increasing demand and utilization for inclusive services) and the societal level (by engendering new beliefs about the abilities of persons with disabilities). This will support the execution of the National Rehabilitation Medicine and National Disability Strategies and Action Plans by the Government of Lao PDR (i.e., Tier 1 system-level activities) and serve to address the overall disabling environment for persons with disabilities in the Lao PDR.

The CBID demonstration model is implemented in Kham District in Xieng Khouang Province and Xayphouthong District in Savannakhet Province. There is a need for baseline data in these two targeted districts on the level of activity and participation (function) and wellbeing of people living in target areas; and to understand the knowledge, attitudes and practices (KAP) of community stakeholders including persons with disabilities themselves and their family, regarding disability and inclusion. Having this data will support the planning of targeted interventions in the two districts and to assess the impact of the USAID Okard interventions.

2. CBID baseline survey aims

The Nossal Institute for Global Health, The University of Melbourne was contracted to undertake a baseline survey in both districts. The research questions for the baseline survey were:

1. What is the impact of disability on the level of participation, access to services and wellbeing and what are the barriers that restrict participation and access?
2. What do people in the community know and believe about disability, and how do they behave about including persons with disabilities in their community?

The baseline survey was conducted using mixed methods which involved quantitative and qualitative data collection. A quantitative population-based survey was undertaken to address Research Question 1, i.e. to determine the prevalence and correlates of disability, and the level of participation of persons with disabilities in their communities, their wellbeing and access to services, and barriers to participation.

Qualitative research comprising key informant interviews (KII) and focus group discussions (FGD) was undertaken to address Research Question 2, i.e. to explore community and selected stakeholder attitudes to disability and participation of persons with disabilities in community and social life.

III. Methods

1. Study location

The USAID Okard Technical Committee had consulted with the Government of Lao PDR to identify the target areas for the CBID project. The baseline survey was conducted in the two selected districts: Xayphouthong district (Savannakhet province) and Kham district (Xieng Khouang province).

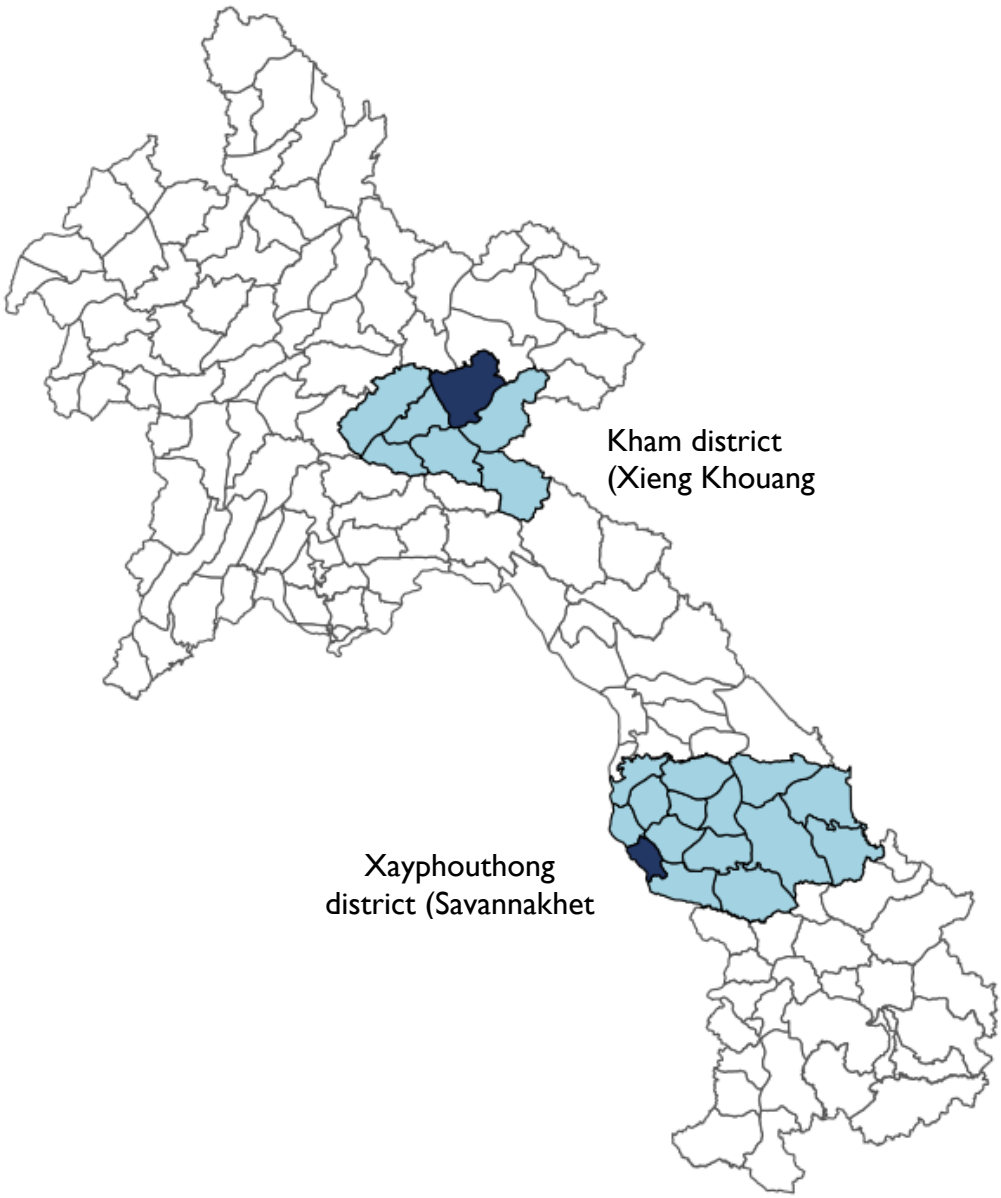


Figure 1 Map of survey districts and provinces

Xieng Khouang province is in the Xieng Khouang Plateau in the north-east of Lao PDR. The province is mostly mountainous, bordering Vietnam to the east and Vientiane province to the southwest. Kham is a remote district within the province where 80% of people live in rural situations with limited transportation. Kham city is a main circulation point between Phonesavanh and the remote north bordering province of Houaphan.

Savannakhet province is the southern part of the country and is the largest province in Lao PDR. The province borders Vietnam to the east and Thailand to the west and is an important trading post between Thailand and Vietnam. Xayphouthong district within the province has a flat topography being part of the Mekong plain and 76% is rural.

2. Quantitative component

a. Sampling strategy

A cross-sectional population-based household survey was undertaken in the two selected districts. Based on the estimates of disability prevalence available for the Lao PDR that ranged from 1% to 10.8%, we assumed a mid-range disability prevalence estimate of 5% to calculate the required sample for this survey. Assuming 5% disability prevalence with a 95% confidence level, sampling error of 20%, an estimated design effect of 1.5, and a non-response rate of 20%, a sample size of nearly 3,300 individuals was required per district. Assuming 5% disability prevalence, around 160 persons with disabilities and 160 people without disability were planned to be recruited.

A two staged cluster random sampling was used. Figure 1 summarizes the sampling stages and key quantitative survey steps. Using publicly available information concerning the population demographics (population, age distribution, broad local economic status, rurality), individual primary sampling units (villages or sub-villages) were divided into clusters. Clusters were then stratified into rural and urban areas. Clusters within each stratum were randomly selected with a probability proportionate to size (PPS), ensuring representation from each cluster. This resulted in 8 clusters from Xayphouthong District and 7 clusters from Kham district.

Participants were identified by local enumeration teams who were allocated to the sampled villages, where all households were approached, and all eligible household members were invited to participate in the screening survey. The inclusion criteria were individuals aged 5 years and older currently living in the sampled households, consented to participate, and available for interview within three visit attempts. Village or sub-village heads and Provincial and District Labor and Social Welfare departments were notified of the visits in advance and provided the necessary local authorizations for the survey teams.

The screening survey identified people with functional difficulties, (referred to as persons with disabilities hereafter) based on their responses to a short survey. Following the initial screening of the sampled households, a number equivalent to 5% of the cluster population was calculated to recruit persons with disabilities using the simple random sampling method. The same number of persons without disabilities were also recruited randomly from the same cluster. This resulted in around 300 people with and without disabilities being randomly selected from each of the two districts (total of about 600 people). It was ensured that

participants without disabilities were selected from the households that did not include a person with disabilities.

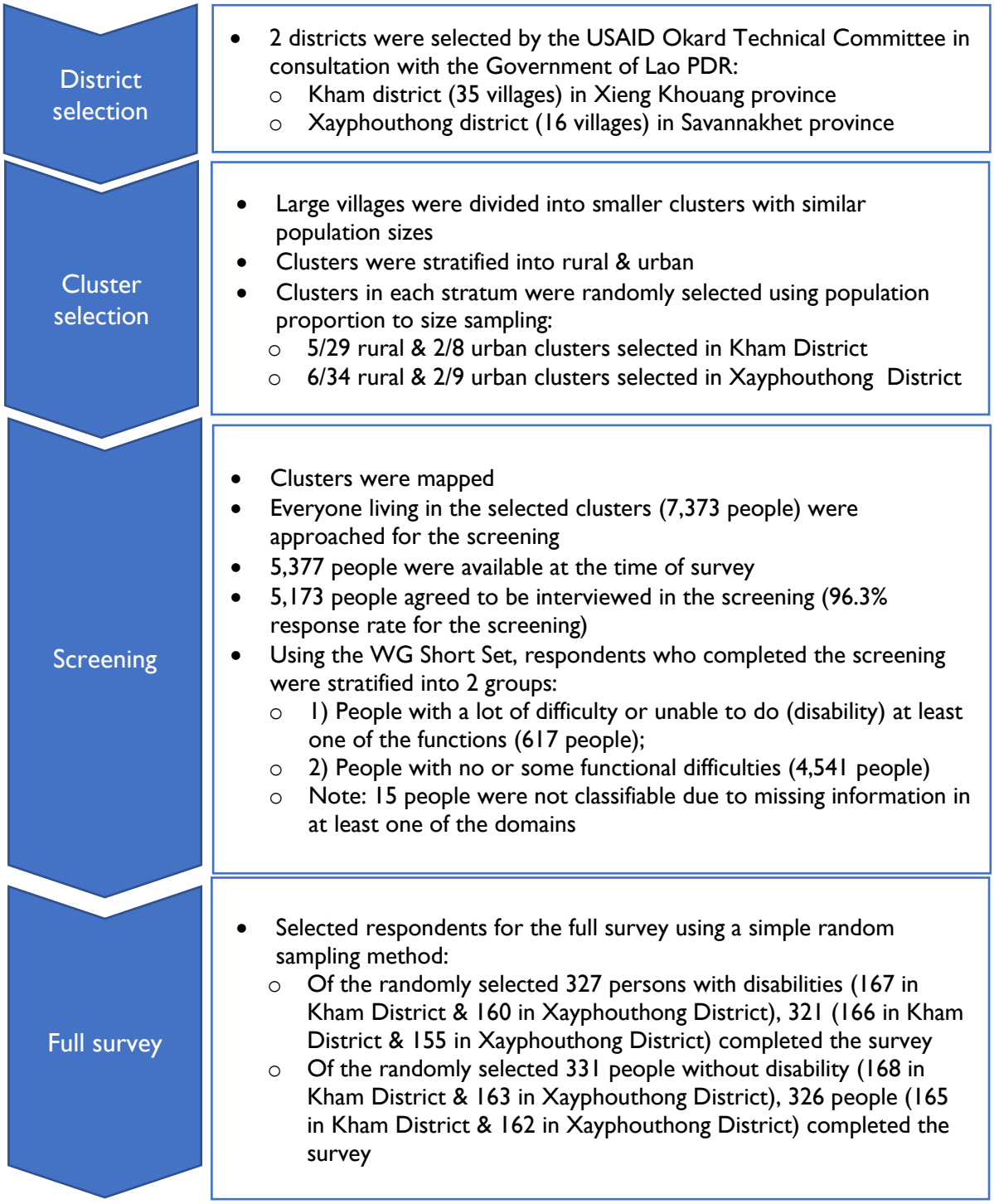


Figure 2: Summary of sampling strategy

b. Questionnaires and data collection

Screening survey

The screening tool is included as a link to a web form.[1] The screening instrument was developed with the USAID Okard team drawing on the Washington Group (WG) Short Set questions on disability. The screening instrument comprised of:

- **Preliminary information:** including district, village and household identification, unique identifying features (to guide return visits if re-sampling or otherwise required), number of people usually living in the household, and global positioning system (GPS) coordinates.
- **Functioning:** for each consenting household member an individual ID was created, and individual functional difficulties were screened using the Washington Group (WG) Short Set of questions on disability, which screen for difficulty in hearing, seeing, mobility, remembering and concentrating, self-care and communicating. Each question asks about difficulties in doing the activity due to a health problem using the 4-point Likert scale: 'no difficulty,' 'some difficulty,' 'a lot of difficulty,' and 'cannot do it at all.' Individuals reporting having 'a lot of difficulty' or 'cannot do it at all' on any one domain of functioning were identified as having disability.

After introducing the survey, explaining the purpose to the household, and obtaining consent, the screening took between 5-7 minutes per person.

Full survey

Data collected in the full survey is included in Appendix , and a web form.[2] The full survey had 8 main sections:

1. **General information** including whether the person is available and prepared to be interviewed;
2. **Consent** question bank;
3. **Sociodemographic status**: Age, sex, education, work, marital status & number of children (for respondents aged 12 years or older);
4. **Health:** Health conditions, health seeking behavior, the WG extended set questions on functioning, Patient Health Questionnaire (PHQ)-2 for assessing signs of depression, assistive product use/unmet needs;
5. **Wellbeing**: Overall life satisfaction module derived from existing instruments (modified for age groups 5-9, 10-14, 15+);
6. **Access to community**: Frequency of and unmet need for participation in community domains including shopping, social gatherings, community decision-making, cultural and leisure activities, social benefit schemes, support groups (modified for age groups 5-9, 10-14, 15+);

[1] https://ee.humanitarianresponse.info/x/#1Rd65HzU
[2] https://ee.humanitarianresponse.info/x/#OpaVK2bl

7. **Knowledge and attitudes on disability:** Self-identification; contributions of persons with disabilities, rights and inclusion, community responses to disability;
8. **Household information:** Information on dwelling, water, cooking, animals and inventory to construct wealth index.

The survey instrument was developed specifically for this CBID baseline assessment to provide a baseline of results and indicators for the three major project components. Survey development drew on other validated approaches and tools including the Rapid Assessment of Disability (RAD). The RAD was developed by the University of Melbourne's Nossal Institute for Global Health and the Centre for Eye Research Australia as a population-based household survey designed to identify persons with disabilities and measure wellbeing and access to the community for persons with disabilities. RAD has been tested and validated in Bangladesh and Fiji; and has been used in various settings including the Philippines, Vanuatu and India, and implemented with more than 30,000 people.

Self-rated health was assessed based on three indicators – general health status rating based on a 4-point Likert scale (very good to very poor), ever been sick for at least 3 days, and the likelihood of depression.

The likelihood of depression was measured using patient health questionnaire-2 (PHQ-2).[3] The PHQ-2 asks about the frequency of depressed mood and anhedonia (inability to gain pleasure from activities) over the past two weeks. Scores range from 0 to 6, with a score of 3 or higher indicating that major depressive disorder is likely. However, it should be noted that PHQ-2 was not validated before this survey.

Wellbeing was measured using the satisfaction with life scale (SWLS). SWLS has been used as a measure of the life satisfaction component of subjective wellbeing. Scores on the SWLS have been shown to correlate with measures of mental health and can be predictive of future behaviors such as suicide attempts. In the field of health psychology field, the SWLS has been used to measure the subjective quality of life of people experiencing serious health concerns. In this study, the SWLS uses 5 questions with 4-point Likert scale; its score ranged from 5 to 20. Scores between 5 and 13 indicate the respondent is dissatisfied with life, whereas scores between 16 and 20 indicate the respondent is satisfied.

This study includes two scales: one about SWLS in general applying to population aged 9 years or older, and another SWLS in the past 3 months applying to population aged 15 years or older. The scale has not been validated for the Lao context but has shown strong internal consistency and reliability in other countries.

Use of assistive products was studied using the World Health Organization's Rapid Assistive Technology Assessment (rATA) tool. This tool comprised of questions on different types of assistive products for different domains of functioning.

Questions in the full survey were culturally adapted by a group comprising the USAID Okard team and their collaborators, including persons with disabilities and service providers. The

[3] See: https://www.hiv.uw.edu/page/mental-health-screening/phq-2 for details.

full survey tool took between 40 and 75 minutes to administer. Both surveys were translated into Lao language and back-translated into English by independent translators.

c. Communication arrangements and proxy interviews

In case of adult participants who are deaf, home-sign language facilitated by family members or a proxy respondent was requested. If the enumerators were uncertain of the individual capacity to provide consent, or respondents were not able to convey their own capacity to consent, a proxy respondent in the household was asked to provide consent and to be interviewed. This was alongside the best attempt to obtain agreement from the participant.

Decisions about when it was appropriate to use a proxy and how to make reasonable attempts to communicate with all individuals was considered in enumerator training. Training was provided through detailed role play, feedback and information from organizations for disabled persons' representatives about the importance of understanding consent and the capacity to give consent.

d. Mobile tools for data collection

Survey software

The survey was administered using mobile hand-held Android based tablets[4], and 'KoBoToolbox' survey software.[5] The KoBo platform is a free and open-source, fully-featured software suite, developed for field-surveys with poor or varied internet connections. The suite is comprised of an online survey development tool, a password secured and encrypted database feature, and an Android 'app' installed on each device.

The survey was hosted on the KoBo server, and retrieved onto handheld devices using a password and the KoBo app. The survey can be used offline on the handheld devices and uploaded to the database when a connection is available with data deleted from the handheld device at the completion of surveying each cluster.

Electronic survey design

Screening and full surveys were coded using the XLS-Form[6] language. Both English and Lao questions could be viewed at any time, using a simple drop-down menu.

The survey skip logic was coded to only populate relevant questions based on previous responses. This minimized enumerator error, shortened the time for each survey, and integrated questions for different age groups. This skip logic included only issuing survey questions if the enumerator selects and verifies the option for consent having been given by the participant. Constraints were used to minimize data entry errors, and time-gates (duration between different questions) were generated to assist data verification.

Data monitoring, verification and quality assurance

Data were downloaded from KoBo Toolbox into Excel, for preliminary cleaning during data collection for verification and follow up with the survey teams. Verification included checks for duplicate or skipped households and individual numbers, general checks of GPS

[4] Samsung ™ Galaxy ™ Tab 3, 8.0 4G enabled or similar
[5] http://www.kobotoolbox.org/
[6] XLSForm.org

coordinate positions against sampled sub-villages and checks for missing data. Where errors were found, enumerators were contacted for verification, and the data were adjusted directly in the database.

The following data quality assurance measures were employed:

- Use of tablet-based data collection tools with built in quality control measures, including validity checks, skip patterns and logic checks to minimize data collection errors and uploading of data for real-time remote monitoring.
- Establishing communication protocols for the Nossal team to provide support to in-field supervisors and/or coordinators during data collection.
- Provision of practical training to local survey team.
- Where possible, provision of onsite support by the Nossal team at critical periods, such as in initial stages of data collection and/or tool testing.
- Use of professional quantitative software to minimize errors in data analysis.
- Regular communication between the Nossal team and the USAID Okard Technical Committee.

e. Survey teams

Surveys were administered by enumerators after a five day training on working with and interviewing persons with disabilities, specific consent methods and requirements for this survey, and data management protocols. Enumerators were appointed through advertisements and through links with OPDs to ensure there was at least one person with disabilities in each survey team. In each district, enumerators worked in two teams of five enumerators, including at least one woman and one man in each team.

Enumerator training

Training included five days of formal training and five days of accompanied field-surveying. Training sessions included:

- The USAID Okard project;
- Disability in Lao PDR;
- Personal experiences of disability;
- Research ethics, consent;
- Interviewing techniques including preparation for conducting the survey in local ethnic languages;
- Interviewing persons with disabilities;
- Adverse event protocols;
- Working with children;
- Experiential learning on interviews and survey specifics;
- Mapping villages, team allocation;

- Data management; backup, file management, hard-copy management;
- Tablet use;
- Accompanied implementation, debriefing, troubleshooting.

Photo Series1: USAID Okard MEL unit and experts from Nossal Institute for Global Health conducted Enumerator training for the CBID baseline on 13 - 17 May 2019. Photo credit: Souliya Ounavong

Photo series 2: The USAID Okard MEL unit conducted the CBID Baseline Quantitative Survey in Savannakhet and Xiengkhuang province from 19 May to 5 June 2019.

f. Data analysis

Data were first downloaded into Microsoft Excel for preliminary cleaning and verification using field running sheets and expected numbers of responses. Data were then transferred to the statistical package STATA SE (Ver15) for further cleaning and analysis. Data variables were re-coded, re-labelled, or calculated as necessary. Disability variables were created using the Washington Group protocols and the recommended (DISABILITY3) threshold, wherein selecting 'a lot of difficulty' or 'cannot do at all' on any one domain of functioning from the

WG questions is considered to represent the presence of disability.[7] Weighted disability prevalence estimates were calculated with 95% confidence intervals (CIs) for the prevalence of disability in each district and both districts combined.

Variables on employment were guided by the United Nation's key labor market indicators[8]. Based on the employment status and type of working situation, working status was eventually categorized as a binary variable (working or not). A household wealth index was used as a proxy indicator for wealth status. The asset index was constructed using principal component analysis on data from household asset questions (see Section H in Appendix 4). The asset index was then divided into three household groups (tertiles): high, middle and low living standards.

The level of education was categorized into none, less than primary, primary school and secondary school or higher. Vocational training status was a binary variable – ever received vocational training or not.

Univariate, bivariate and multivariate (logistic regression) analyses were performed to examine associations between disability and socio-demographic factors. In a regression model, all risk factors are analyzed together to avoid effects from interaction of different factors with each other (i.e. confounding effects). The result is presented in odds ratios for the response variable that is adjusted for the other exposure variables that may be interacting with each other.

Initially, a binary logistic regression model was created to understand the socio-demographic factors influencing the presence or absence of disability (response variable). Exposure variables were sex, age, urban/rural residence, marital status, school attendance, level of education, vocational training, current activity status, working status and living standards.

Separate logistic regression models were undertaken to understand factors influencing self-rated health status, access to services (education/skills training, work, healthcare, assistive products, and rehabilitation) and participation in the community (social gatherings and community events) in general. In these regression models (binary and multinomial), disability was considered as an exposure variable along with age, sex, urban/rural residence, marital status, education level, working status and living standards. This type of analysis was undertaken with the understanding that there are multitude of factors that might influence access to services and participation in the community other than disability. This provides new information about the general situation of the target communities for planning appropriate and feasible interventions through the CBID demonstration model

[7] Washington Group. 2019. Analytic Guidelines: Creating Disability Identifiers Using the Washington Group Short Set (WG-SS) SPSS Syntax. http://www.washingtongroup-disability.com/publications/implementing/
[8] ILO. 2016. Key Labor market Indicators: Analysis with household survey data. ILO, Geneva. https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_519717.pdf

3. Qualitative survey component

a. Respondents and sampling

The overall purpose of the qualitative component was to understand the knowledge, attitudes and practices (KAP) concerning disability inclusion of a broader range of stakeholders. Whilst the quantitative component compared people with and without disabilities, the qualitative component targeted additional stakeholders using focus group discussions (FGDs) and semi-structured key informant interviews (KIIs) in Kham District and Xayphouthong District. FGDs were conducted in one village in each district purposively selected using data on persons with disabilities from the screening survey to ensure a range of disability types were present in the villages.

Table 1: Respondents for FGDs

	FGD Target group	Gender	Total number of FGDs for 2
A	Community members with disability	Female	2
		Male	2
B	Community members without disability	Female	2
		Male	2
C	Caregivers of persons with disabilities	Female	2
		Male	2
D	CBID facilitators	Mixed	2
			14

Table 2: Respondents for KIIs

		Target group	Administrative level	Number of Interviews
A	*i*	Village heads	Village	2
	ii	Village health workers	Village	4
	iii	Women's Group Leaders	Village	2
B	*i*	Ministry of Health officials	District	6
			Province	2
	ii	Ministry of Labor & Social Welfare officials	District	2
			Province	2
	iii	Ministry of Education and Sports officials	District	2
			Province	2
C	*i*	Organizations of Persons with Disabilities (OPD)	Province	2
D	*I*	Employer	District	2
				28

Respondents were selected by purposive sampling in consultation with the USAID Okard Technical Committee. Selection of respondents included consideration of gender and disability status to ensure balanced representation. However, in some cases a male bias was hard to avoid due to structural limitations, for example, amongst national and local government officials.

5173 people were screened during the quantitative short survey

21% 5-15 years

67% 16-59 years

12% 60 years and over

48% male **52%** female

For the quantitative long survey

321 persons with disabilities

©Plan International

and **326** persons without disabilities participated.

When collecting qualitative data on knowledge, attitude and practices

14 people participated in Focus Group Discussions

and **28** people participated in Key Informant Interview

b. Data Collection and tools

Focus group discussions

Semi-structured question guides were used to facilitate focus group discussions with the respective FGD group respondents. FGD question guides included questions about inclusion and participation in community events, work and social activities; community awareness and attitudes to disability; access to education and health care; and experiences of discrimination. The question guides included suggested prompts for further probing on each issue.

Key informant interviews

Interview guides were developed for the different stakeholder groups interviewed. All guides included general questions relating to community attitudes and awareness of disability, inclusion and participation by persons with disabilities in community events, knowledge of policies and programs related to disability, but also included specific questions related to access and inclusion of persons with disabilities in the specific sector of the interviewee.

All FGD and KII guides were developed according to the project requirements identified by, and in consultation with, the USAID Okard team. These guides were translated into Lao language by the USAID Okard project translator and back translated into English in-country.

Data collection

During preparation for data collection, sample transcriptions from the enumerators completed during training and from field trials were translated into English by the USAID Okard team and provided to the Nossal team for review and feedback. Once transcriptions were of sufficient clarity for analysis, data collection proceeded under the lead of the local research coordinator recruited by the USAID Okard team. This process established expectations of the data quality required in the transcripts to be analyzed by the Nossal team.

FGDs were conducted in appropriate locations identified in advance by the USAID Okard team. The USAID Okard team considered privacy, accessibility and convenience for participants when selecting the locations. Participants were asked to attend a 1-1 ½ hour group discussion. This included a welcome by the facilitators, introduction to the research, and a facilitated discussion concerning knowledge and attitudes to disability alongside exploring issues of inclusion and barriers to accessing services.

KIIs were conducted in the place of work of participants in the main and as identified by the USAID Okard team and agreed with the participant. At initial contact by the USAID Okard team, participants were asked to make an appointment at a convenient time within a specified research period. Testing of the question guides indicated that 60 minutes was sufficient to review and receive consent and conduct the interview. Participants were asked to answer respective semi-structured questions and questions arising from prompts and open-ended discussion.

FGDs and KIIs were digitally recorded with the informed consent of the participants; however, being recorded was not a condition of participation in the FGDs. The data from both the FGDs were transcribed and translated to English by the USAID Okard team for analysis by the Nossal team.

c. Enumerator teams and training

Enumerator team

Focus group discussions and key informant interviews were completed by a team of four (4) enumerators (two woman and two men) after a five day training on working with and interviewing persons with disabilities, specific consent methods and requirements for the FGD and KII, and data management protocols. Enumerators were appointed through advertisements and selected based on previous significant experience conducting FGD and KII. In each district, enumerators worked in pairs with one enumerator asking KII questions or facilitating the FGD, and one enumerator transcribing responses in conjunction with audio recording. When respondents were mixed sexes, enumerator pairs would include one man and one woman. When respondents in FGD were separated into groups of women or men, two female enumerators would conduct the FGD with female respondents, and two male enumerators would conduct the FGD with male respondents

Enumerator training

Training included five days of formal training. Training sessions included:

- The USAID Okard project;
- Disability in Lao PDR;
- Personal experiences of disability;
- Research ethics, consent;
- Focus group discussion and key informant interview techniques;
- Interviewing persons with disabilities;
- Adverse event protocols;
- Experiential learning on interviews and FGD and KII specifics;
- Audio recorder use
- Translation and transcription protocols including coding of respondents to respect confidentiality
- Data management; backup, file management of audio recordings and transcriptions;
- Tablet use.

Once in the field collecting data, enumerators were accompanied by the local research coordinator during all the qualitative data collection for debriefing and trouble shooting.

d. Analysis of qualitative data

Following transcription and translation, data from the FGDs and KIIs were entered into the NVivo software. Thematic analysis was conducted by the Nossal team to identify pre-determined and emergent themes. The analysis for FGDs and KIIs were combined for reporting purposes unless otherwise stated. Where possible data from qualitative component was used for triangulating quantitative survey findings.

4. Research ethics

The study was approved by the Human Research Ethics Committee at the University of Melbourne. Administrative approvals in Lao PDR were obtained by the USAID Okard team from relevant agencies. Potential participants were informed about the survey and were invited to participate in quantitative or qualitative interviews. Potential participants were encouraged to ask questions or request additional information prior to being invited to provide consent. For participants who were unable to sign the consent form, the consent form was read to them and their verbal agreement was recorded by the enumerator.

IV. Results

Sub-section IV.1 presents findings on prevalence of functional difficulty and its variations using screening data. Of the 7,373 people enlisted as living in the selected clusters of both districts, 5,377 people were available at the time of survey. A total of 5,173 people agreed to be interviewed in the Screening (96.3% response rate).[9] They represent 24,649 people aged 5 years or older living in the 2 districts. The samples for analyses in this section for Kham and Xayphouthong Districts included 2,861 and 2,297 people respectively; they represented 12,831 and 11,818 people aged 5 years or older respectively. There was nearly equal distribution of men and women screened in both districts with 48.9% and 45.8% men in Kham and Xayphouthong districts respectively. In total, there were 21.3% children aged 5-15 years, 67% for adults aged 16-59 years, and 12% adults aged 60 years or older in both districts, and there was difference in age distributions between the two districts.

Sub-sections IV.2 to IV.8 present findings using long-form survey data. The sample included 648 people who consented and completed the interview (331 people in Kham district and 317 people in Xayphouthong district); the sample represents 11,111 and 13,336 people aged 5 years old or older who were actually living in Kham and Xayphouthong districts respectively. This does not include people who did not live in the district, who are mainly permanent or temporary out-migrants.

1. Prevalence of functional difficulty

- Estimated disability prevalence (people with a lot or more difficulty in any domain) was 13.3% (95% CIs: 12.2%-8.35) in Kham district and 9.9% (95% CIs: 8.4%-11.7%) in Xayphouthong district.
- A further 18.7% (95% CIs: 15.5%-22.4%) and 25% (95% CIs: 22.3%-27.3%) in Kham and Xayphouthong districts respectively reported 'some' difficulty in at least one domain.
- Disability prevalence was not significantly different between women and men, between the districts, or between rural and urban populations.
- Less than 1% of the population reported 'cannot do' in any one domain, but this population is among the most important targets for programming.
- People reporting 'a lot' of difficulty in any one domain account for most of the disability prevalence.
- As people age, they are more likely to report functional difficulties.
- The most common domains of difficulty were in walking and seeing.
- About half of people with disability experience a lot or more difficulty in more than one domain.

[9] There were 15 people (difference between 5,173 and 5,158) whose information on functional difficulties was missing in at least 1 domain of difficulty; they were excluded from analysis. Given their small proportion (less than 0.3%), their exclusion resulted in very minor to no effect on the results.

a. Kham district (Xieng Khouang province)

An estimated 13.3% (95% CIs: 12.2%-8.35) of people (14.3% of men and 12.3% of women) in Kham district experienced a lot of difficulty or were unable to perform activities in at least one domain (Figure 3). This comprised mostly of people who identified 'a lot' of difficulty as there was less than 1% of people who were unable to perform activities in at least one domain. An additional 18.7% (95% CIs: 15.5%-22.4%) of the population (17.0% of men and 20.3% of women) experienced some difficulty in at least one domain.

b. Xayphouthong district (Savannakhet province)

In Xayphouthong district, 9.9% (95% CIs: 8.4%-11.7%) of people (9.7% of men and 10.1% of women) experienced a lot of difficulty or were unable to perform activities) in at least one domain. Similar to Kham district, fewer than 1% of the population reported they were unable to do activities in at least one domain. An additional quarter (25%, 95% CIs: 22.3%-27.3%) of the population (22.1% of men and 27.4% of women) experienced some difficulty in at least one domain.

In the two districts combined (Figure 4), two-thirds (66.7%, 95% CIs: 64.2%-68.1%) of the population experienced no difficulty, 21.7% have some difficulty, 10.8% have a lot of difficulty, and 0.9% were unable to perform activities in at least one domain. Using the Washington Group recommended cutoff for the Short Set questions on disability, this represented an adjusted disability prevalence estimate of 11.7% (95% confidence interval/CI: 10.7%-12.6%).

c. Adjustment for unavailable or out-migrant population

About a quarter of people in Kham District and nearly one-third of people in Xayphouthong District were not available for the screening interview, mostly due to travel elsewhere in Lao PDR or neighboring Thailand for paid work or education. It is unclear whether this population would require support from CBID. If data is adjusted to account for this missing population and assumes they experience no functional difficulty, the prevalence of disability in the two districts reduces to 10.22% and 6.14% in Kham and Xayphouthong Districts, respectively.

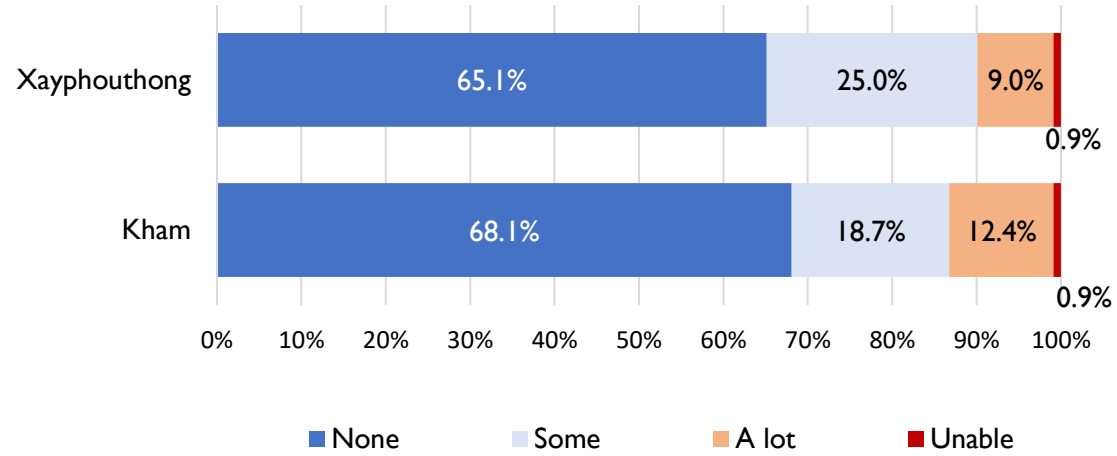


Figure 3: Proportion of the population experiencing functional difficulty in 2 study districts

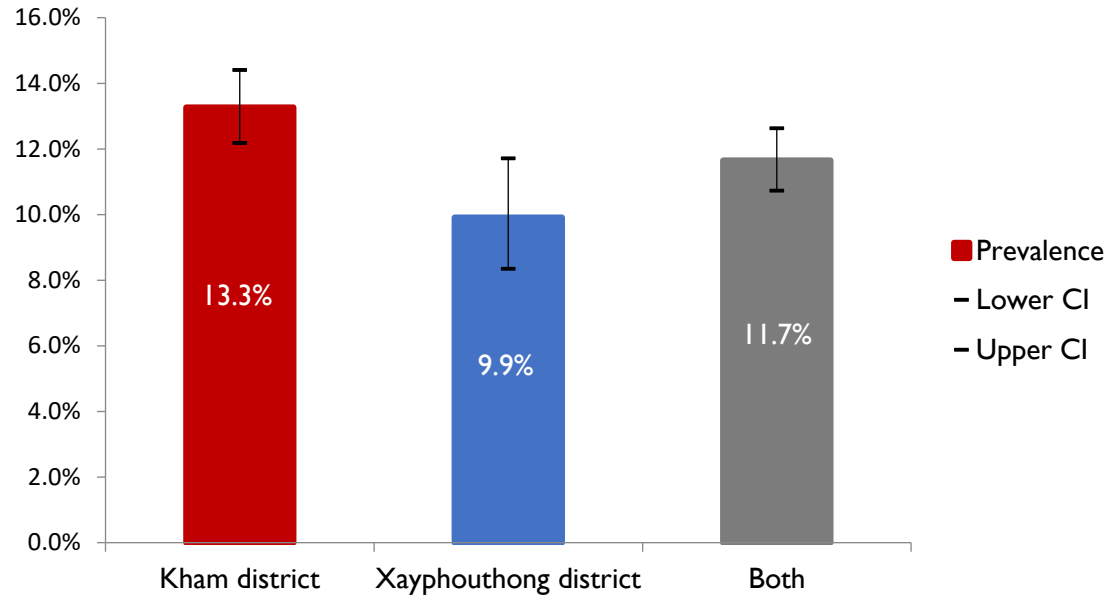


Figure 4: Prevalence of disability at district level

d. Variation of functional difficulty

The prevalence of disability was similar for rural and urban settings, between women and men, and between the two districts. As expected, the prevalence of disability was positively associated with increasing age in both districts (Adjusted OR 1.06; 95% CI 1.04-1.05; p<0.01).

"Figure 5 presents the proportion of the population (women and men combined) with a lot or more difficulty by age, for both survey districts. There is a steady increase in the proportion of the population reporting some or more difficulty, with a trend towards a more rapid increase around 45 years. The proportion of those reporting at least some difficulty in one domain increases from 79% at ≥60 years to 90% at ≥80 years. Data for people who reported they cannot do one or more activities were limited by sample size but followed a similar trend of steady increase with age."

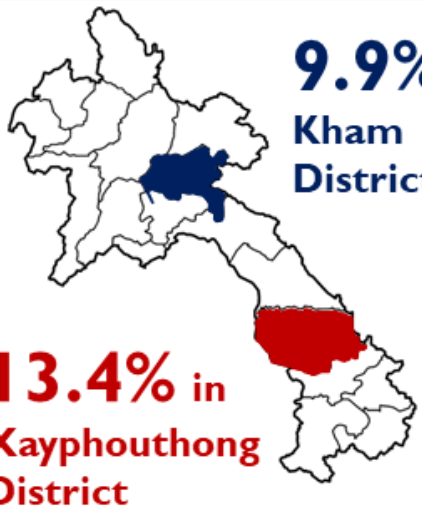
e. Domain of functional difficulty

Variation of the reported functional difficulties in the two districts were very similar. As shown in Figure 6, the most frequently reported difficulties at the 'a lot' or 'cannot do at all' levels were with seeing and walking, followed by difficulties with remembering and hearing. There were not many people that reported significant difficulties in communicating and self-care.

Multiple disabilities were common in both districts. Among those with disabilities, 42.4% & 41.5% in Kham & Xayphouthong districts had difficulties in multiple domains (2 districts combined: 23.1% in 2 domains, 13.5% in 3 domains, and 5.5% in 4 or more domains), respectively.

Disability Prevalence

Overall prevalence 11.7%



9.9% in Kham District

13.4% in Xayphouthong District

(Definition of disability – a lot of difficulty/ cannot do at all)

The proportion of the population experiencing difficulties in functioning by domain

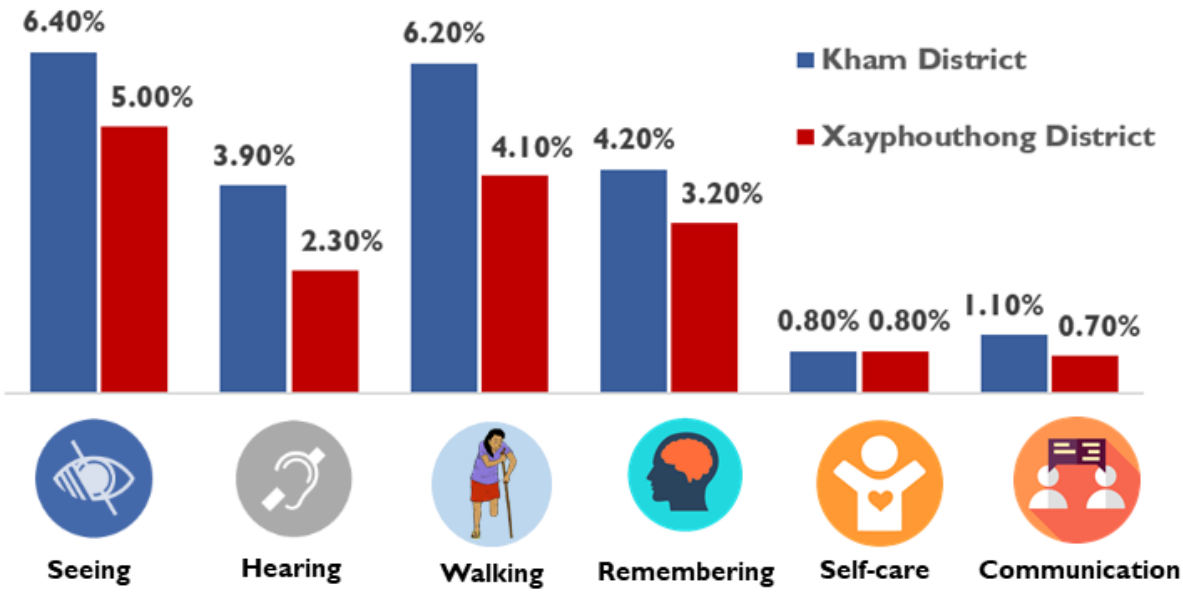


Table 3: Prevalence of functional difficulty by sex, age, and place of residence

	Level of difficulty			
	None % (95% CIs)	**Some % (95% CIs)**	**A lot % (95% CIs)**	**Unable % (95% CIs)**
Kham District				
Sex				
Male	68.8 (64.8-72.5)	17.0 (13.0-21.9)	12.5 (11.6-15.7)	0.8 (0.5-1.2)
Female	67.3 (62.6-71.7)	20.3 (15.7-25.9)	11.4 (9.0-14.2)	1.0 (0.5-1.9)
Age ***				
Mean	24.7	44.7	55.3	63.8
95% CI	18.2-31.3	31.2-58.2	37.1-73.6	19.2-108.3
Place of residence				
Rural	67.4 (62.2-72.2)	19.4 (14.9-25.0)	12.3 (11.0-13.8)	0.9 (0.6-1.4)
Urban	70.3 (66.0-74.2)	16.2 (11.0-23.2)	12.6 (9.7-16.3)	0.9 (0.4-2.0)
Xayphouthong District				
Sex				
Male	68.2 (64.6-71.6)	22.1 (18.8-25.8)	8.8 (7.0-10.9)	0.9 (0.2-4.0)
Female	62.5 (58.5-66.4)	27.4 (25.2-29.7)	9.3 (7.0-12.2)	0.8 (0.3-2.5)
Age ***				
Mean	28.3	47.6	58.6	50.2
95% CI	24.8-31.8	45.2-50.0	55.5-61.7	32.5-67.9
Place of residence				
Rural	63.3 (60.0-66.8)	25.8 (23.0-28.8)	10.0 (8.1-12.2)	0.9 (0.2-4.0)
Urban	71.1 (67.0-74.8)	22.3 (19.2-25.7)	5.9 (4.8-7.2)	0.7 (0.3-1.5)

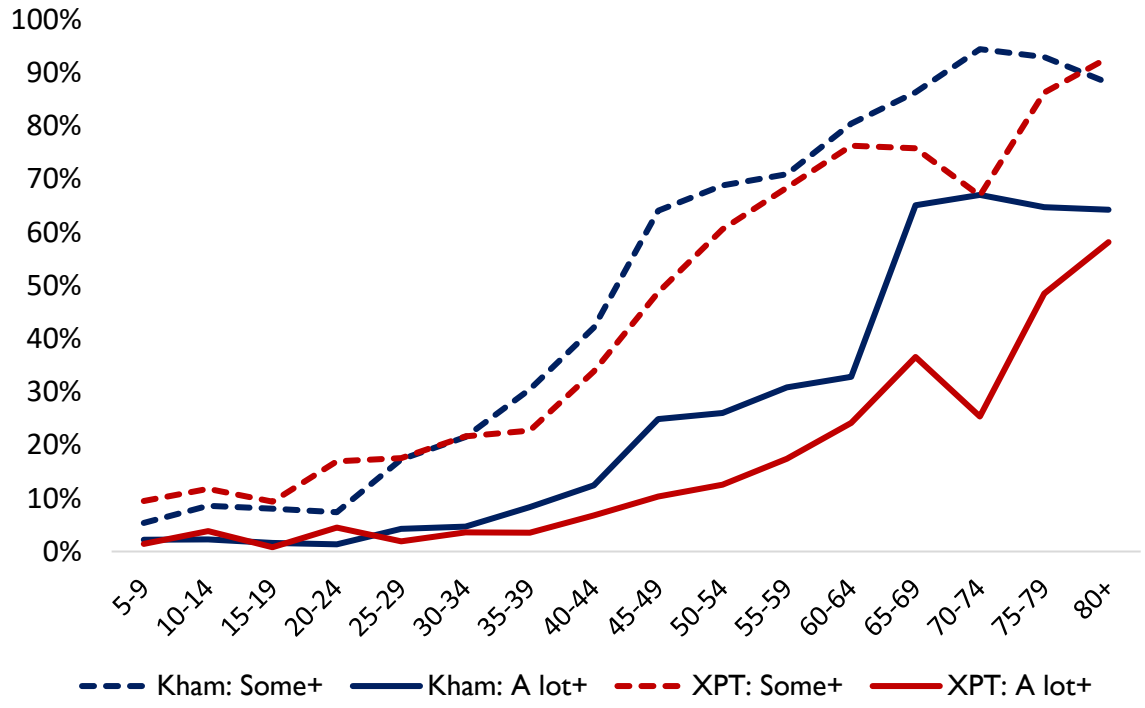


Figure 5: Proportion of the population experiencing functional difficulty by age

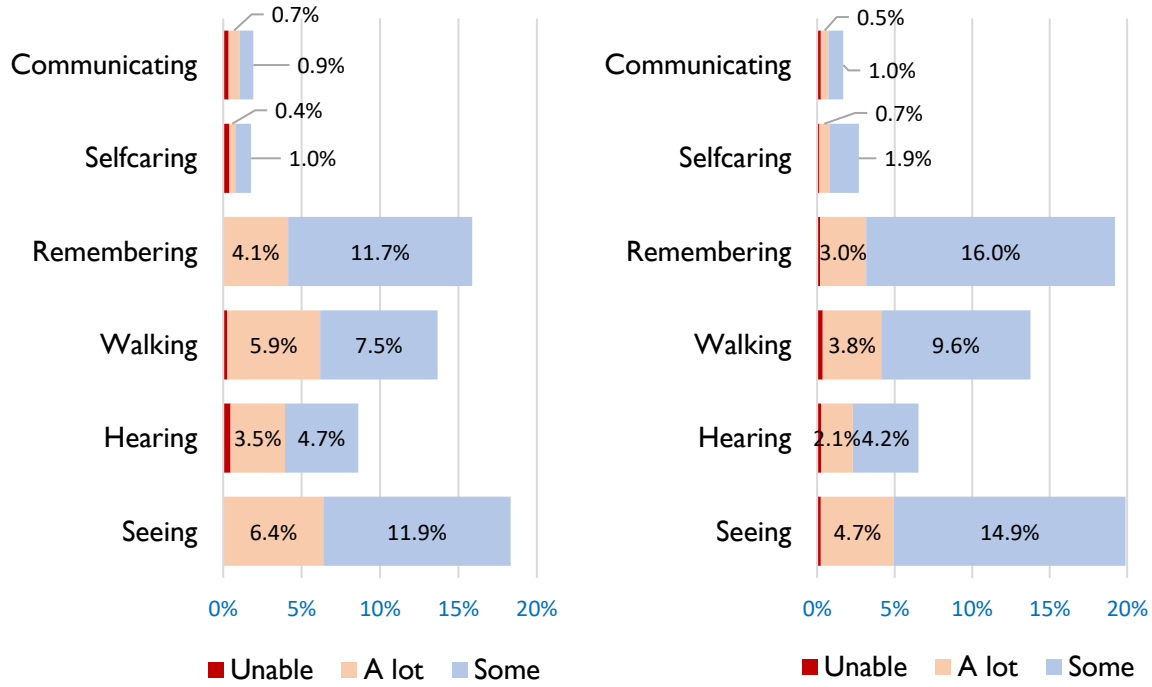


Figure 6: Proportion of the population experiencing functional difficulty by domain in Kham District (on the left) and Xayphouthong District (on the right)

2. Demographic and socio-economic characteristics of the population with different levels of difficulty

- More women (52.7% of the sample) than men (47.4%) were surveyed.
- Being unmarried is associated with higher levels of functional difficulty.
- Persons with disabilities had lower levels of education.
- 17.9% and 12.1% of the overall population in Kham and Xayphouthong districts, respectively, reported having skills or vocational training. There was a trend towards persons with disabilities having more vocational training than people without disability in Xayphouthong district. In Kham district, people with disability had less skills and vocational training than in Xayphouthong district.
- Persons with disabilities report working as often as persons without disabilities but are less likely to be paid.
- Persons with disabilities were half as likely to report high living conditions than persons without disabilities.

a. Demographics of people with and without functional difficulty

Table 4 below provides information on basic demographic and socio-economic characteristics of the population at different levels of difficulty in Kham and Xayphouthong districts. There were slightly more females than males in both districts, and this pattern was similar for populations with and without disabilities. Similarly, 23.1% and 20.8% of people in Kham and Xayphouthong districts, respectively, lived in urban areas. There was no difference in the prevalence of disability between rural and urban areas.

Disability prevalence increased with age. About two-thirds (68.7% and 68.6% in Kham and Xayphouthong districts, respectively) of the sample that were married, a quarter (25.3% and 23.4%) were never married, and the remaining 6% in Kham district and 8% in Xayphouthong, respectively) reported being divorced or separated in both districts. In both districts, being unmarried is associated with higher levels of functional difficulty.

There were significant variations in education levels between people with and without disabilities. In both districts, persons with disabilities were significantly more likely to stay out of school and had lower levels of education completed.

Nearly 2 out of 10 (17.9%) and 1 out of 10 (12.1%) people in Kham and Xayphouthong districts, respectively, have received skills or vocational training. Although the difference in proportions was not statistically significant, persons with disabilities (25.6%) were more likely to have received vocational training in Xayphouthong district compared to persons without disabilities (16.5%). Whereas the difference in proportion was significantly higher in Kham district with 12.8% of persons without disabilities receiving vocational services compared to 6.5% persons with disabilities.

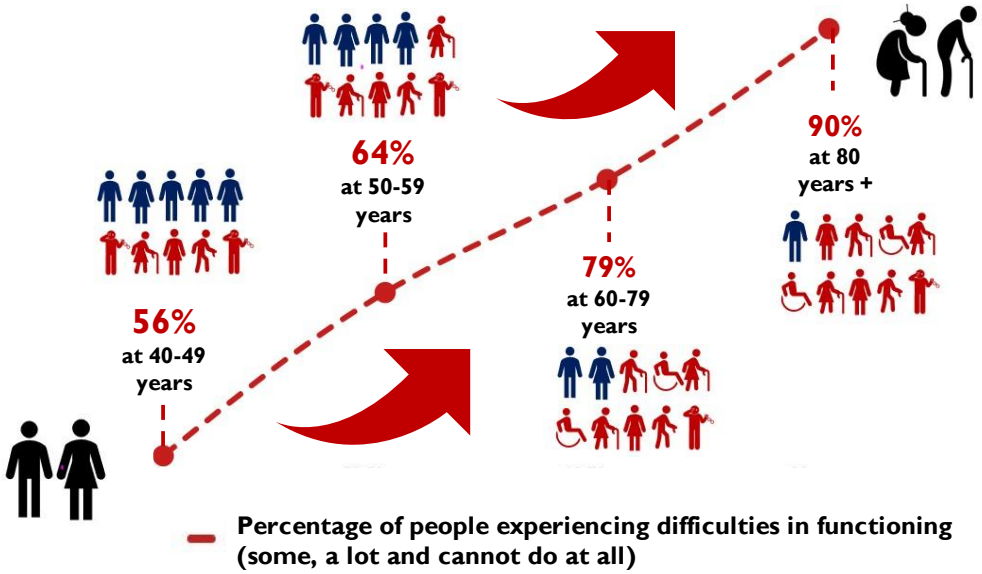
In both districts combined, nearly two-thirds (67.6%) of persons with disabilities were working (paid/unpaid). This proportion was similar to that of persons without disabilities (67.5%). However, persons with disabilities were significantly less likely to have paid work (39.4% vs 10.2%), more likely to be unemployed (14.0% vs 2.3%), and less likely to be a student (10.7% vs 28.6%) compared to persons without disabilities.

Although the difference is not statistically significant, persons with disabilities tended to live in households with lower living standards in Xayphouthong district. There was no variation in the living standards among persons with disabilities in Kham district.

b. Factors associated with functional difficulty

An ordered logistic regression was used to determine how different sociodemographic characteristics are associated with the level of functional difficulty. The results in Table 5 show age and living standards were independently associated with disability in both districts. As expected, older people were more likely to have higher levels of functional difficulty. After controlling for other factors or all else being equal (i.e. when people had the same age, same sex, same marital status, same level of education completed, same vocational training experience, same working status, living in the same rural or urban setting, and living in the same district), people with higher living standards were 50% less likely to have a disability compared to those reporting lower living standards.

Disability prevalence increases with age



People with higher living standards

were **50%** less likely to have a disability

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compared to those reporting lower living standards

Table 4: Characteristics of the population with different levels of difficulty

	Level of difficulty					
	Kham District			Xayphouthong District		
	None/ Some	A lot/ Unable	Both	None/ Some	A lot/ Unable	Both
Sex						
Male	40.7%	47.3%	41.7%	47.9%	43.3%	47.4%
Female	59.3%	52.7%	58.3%	52.1%	56.7%	52.7%
Age	***			***		
Mean	28.7	54.7	32.7	35.0	48.5	36.7
95% CI	26.7-30.7	48.1-61.3	31.1-34.4	27.3-42.7	48.1-61.3	28.8-44.7
Place of residence						
Urban	23.6%	20.3%	23.1%	21.5%	16.1%	20.8%
Rural	76.4%	79.7%	76.9%	78.6%	83.9%	79.2%
Marital status	**			***		
Never married	29.8%	4.9%	25.3%	25.4%	8.8%	23.4%
Currently married/cohabited	66.6%	78.2%	68.7%	69.2%	63.8%	68.6%
Divorced/Separated/Widowed	3.6%	16.9%	6.0%	5.3%	27.3%	8.0%
Ever attended school	***			**		
Never attended school	7.5%	22.3%	9.7%	9.2%	32.1%	12.1%
Currently attending	32.6%	2.6%	28.0%	23.4%	17.1%	22.6%
Attended before	60.0%	75.1%	62.3%	67.5%	50.8%	65.4%
Level of education completed	*			**		
None	12.4%	24.3%	14.2%	11.4%	38.5%	14.9%
Less than primary	25.7%	36.7%	27.4%	29.5%	38.5%	30.7%
Primary	35.6%	28.0%	34.4%	40.0%	13.4%	36.6%
Secondary or higher	26.3%	11.0%	24.0%	19.1%	9.6%	17.9%
Vocational training	**					
Have received any skills or VT	16.5%	25.6%	17.9%	12.8%	6.5%	12.0%
Have not	83.5%	74.4%	82.1%	87.2%	93.5%	88.0%
Main activity status	***			**		
Student	32.6%	2.6%	28.0%	25.4%	18.8%	24.5%
Not working & not looking for work	2.1%	9.6%	3.2%	0.2%	10.0%	1.4%
Not working and looking for work	0.8%	3.3%	1.2%	1.6%	5.2%	2.1%
Retired	0.8%	4.6%	1.4%	0.0%	2.0%	0.3%
Full time homemaker/housewife	7.6%	10.7%	8.1%	11.7%	14.6%	12.1%
Contributing family worker	13.1%	15.3%	13.4%	18.7%	23.3%	19.3%
Employee	7.1%	4.4%	6.7%	12.8%	3.5%	11.6%
Self-employed	35.1%	47.7%	37.1%	28.3%	15.6%	26.7%
Other	0.8%	1.9%	1.0%	1.3%	7.1%	2.1%
Working status	***			**		
Not working	2.9%	12.9%	4.4%	1.8%	15.2%	3.5%
Having a paid work	7.1%	4.4%	6.7%	12.8%	3.5%	11.6%

	Level of difficulty					
	Kham District			Xayphouthong District		
	None/ Some	A lot/ Unable	Both	None/ Some	A lot/ Unable	Both
Having un-paid work	55.8%	73.7%	58.6%	58.7%	53.5%	58.0%
Student	32.6%	2.6%	28.0%	25.4%	18.8%	24.5%
Others	1.7%	6.4%	2.4%	1.3%	9.1%	2.3%
Living Standards						
Low	24.4%	32.4%	25.6%	33.0%	45.9%	34.6%
Average	31.4%	33.7%	31.7%	31.8%	37.0%	32.5%
High	44.3%	33.9%	42.7%	35.2%	17.2%	32.9%
Total	100%	100%	100%	100%	100%	100%
n	163	168	331	196	121	317
N	9,403	1,708	11,111	11,630	1,706	13,336

*Note: * shows test results from bivariate analysis; *p<0.10 **p<0.05 ***p<0.01.*

Table 5: Factors associated with functional difficulty

	Odds ratios		95% Confidence Interval	
			Lower limit	Upper limit
Sex				
Male (ref.)	1			
Female	0.96		0.63	1.46
Age	1.06	***	1.04	1.08
Place of residence				
Urban (ref.)	1			
Rural	0.78		0.48	1.27
Marital status				
Never married (ref.)	1			
Currently married/cohabited	1.51		0.52	4.37
Divorced, separated, widowed	1.56		0.56	4.34
Education level				
None (ref.)	1			
<Primary	1.57		0.71	3.51
Primary school	0.83		0.34	2.00
Secondary school +	0.73		0.27	2.01
Vocational training	0.99		0.54	1.81
Working	0.55		0.23	1.32
Living standards level				
Low (ref.)	1			
Middle	0.99		0.62	1.58
High	0.49	*	0.19	1.23
District				
Kham (ref.)	1			
Xayphouthong	0.93		0.59	1.46
n	647			
N	24,426			

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

3. Disparities in education, vocational training and work

- Persons with disabilities were about 60% less likely to have completed higher education levels.
- Disability was not significantly associated with access to vocational training opportunities, however people reporting 'cannot do' in any domain were much less likely to work than people with no disabilities and people with 'a lot' of difficulty.
- Being divorced, unmarried or separated was associated with lower educational standards.
- Women, people in Xayphouthong district, and people with lower living standards, were less likely to have vocational training.
- Children with disabilities were less likely to attend school compared to children without disabilities. 1 out of 5 school-aged children with disabilities have never attended school.
- Persons with disabilities were less likely to be working compared to those without disabilities (OR = 0.17; 95% CI: 0.05-0.52).
- Older age (OR = 1.10; 95% CI: 1.07-1.13) and higher levels of education (OR = 5.25; 95% CI = 1.26-21.93) were independently associated with having work (paid/unpaid).

a. Factors associated with the level of education and vocational training

Disparities in education and vocational training were presented earlier under socio-economic characteristics of respondents. This section explores associations between the level of difficulty and the level of education completed, and vocational training after controlling for other socioeconomic factors (Table 6). All else being equal (i.e. when people had the same age, same sex, same marital status, same working status, same living standards, living in the same rural or urban setting, and living in the same district) persons with disabilities were nearly 60% less likely to complete a higher level of education compared to those having no functional difficulty. Although differences were not statistically significant, there was a similar tendency towards an association between the level of functional difficulty and participation in vocational training, with notable differences between the districts.

Overall, females and those who were divorced/separated/widowed were less likely to have higher levels of education and people from higher living standards were more likely to have higher levels of education. Females and those living in Xayphouthong district were less likely to have vocational training and people from higher living standards were more likely to have vocational training.

Table 6: Factors associated with level of education & vocational training

	Level of education			Vocational training		
	Odds ratios	95% CI		Odds ratios	95% CI	
		Lower	Upper		Lower	Upper
Difficulty level						
None (ref.)	1			1		
Some	0.87	0.46	1.65	0.85	0.25	2.95
A lot	0.44 **	0.21	0.91	0.66	0.34	1.31
Unable	0.37 **	0.17	0.81	0.25	0.03	2.40
Sex						
Male (ref.)	1			1		
Female	0.65 *	0.40	1.05	0.45 *	0.15	1.35
Age	0.99 *	0.97	1.00	1.02 **	1.00	1.05
Place of residence						
Urban (ref.)	1			1		
Rural	0.96	0.57	1.63	1.46	0.67	3.16
Marital status						
Never married (ref.)	1			1		
Currently married/cohabited	0.68	0.33	1.42	3.14	0.42	23.30
Divorced, separated, widowed	0.14 ***	0.05	0.43	1.73	0.22	13.69
Working	3.93 ***	1.85	8.37	1.92	0.34	10.71
Living standards level						
Low (ref.)	1			1		
Middle	1.35	0.66	2.77	1.25	0.58	2.70
High	1.79 *	0.80	4.02	2.19 *	0.92	5.23
District						
Kham (ref.)	1			1		
Xayphouthong	0.84	0.55	1.29	0.50 **	0.28	0.90
n	647					
N	24,426					

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

Access to Education

1 out of 5
school aged children with disabilities


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had never attended school


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compared to
1 out of 20
children without disabilities

22% in Kham District

32% in Xayphouthong District


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persons with disabilities had never attended school


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Main barriers to education


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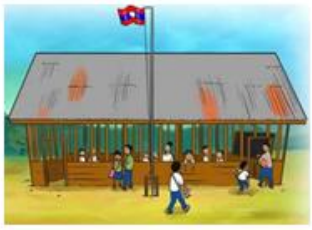
Distance to travel to school and difficulty reaching

Educators with limited specialized skills on inclusive education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Inaccessible school facilities

b. Participation in school among school-aged children

Disparities in school attendance among school-aged children, i.e. 5 to 18 years old, are shown in Figure 7 Children with disabilities were less likely to attend school compared to children without disabilities. One out of 5 school-aged children with disabilities had never attended school, while 1 out of 20 school-aged children with no disabilities had never attended school in both districts.

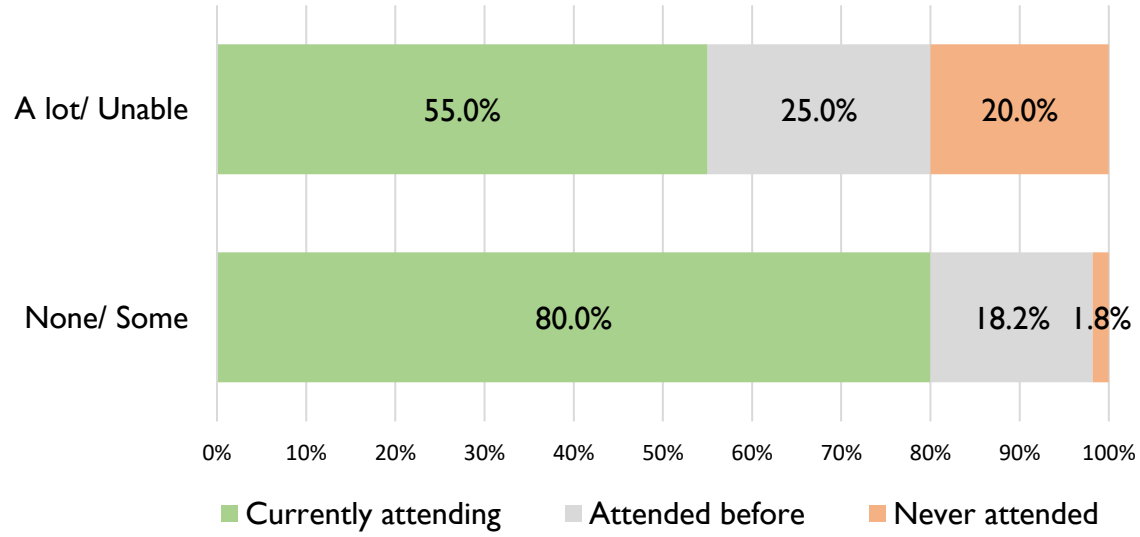


Figure 7: School attendance of school-aged children aged 5 to 18 years old

c. Qualitative findings: school participation

Analyzing in-depth interviews provided additional and richer information to understand school participation. Discussions of access to education for children with disabilities in the FGDs and KIIs focused almost entirely on mainstream village schools. There was very little mention of special schools for children with disabilities by any respondent, except one participant noting that these schools do not exist in rural areas. Most respondents identified that if children with disabilities did attend school it was generally only for primary school and did not continue into secondary education, but it was not clear whether this was different between children with and without disabilities.

Persons with disabilities themselves reported mixed experiences of having attended school. Some reported that they attended school, some started at an older age, many did not complete their education, and others did not attend at all – often despite their siblings having attended school. Some persons with disabilities reported that they did not ever want to go to school, with fears of bullying or an assumption of being unable to learn cited as reasons. There was a sense from several participants (all adults) that children with disabilities were more likely to go to school now than when they had been of school age.

> *"The school was not as open for all as it is nowadays. These days, schools are more for everyone." (FGD, Males with disabilities, Savannakhet)*

There were also mixed experiences and beliefs from caregivers about whether children with disabilities do or should attend school. There was a general perception that many children with disabilities cannot go to school, or only children with certain types of impairments can attend school. Some participants reported their child had attended school up to a particular grade but did not continue, and some questioned the value of their child attending school. These perceptions and beliefs were consistent between the male and female caregiver groups, and between provinces.

> *"From what I have observed, children with disabilities who can see, speak and walk can go to school….children who cannot help themselves cannot go." (FGD, Male caregivers, Xieng Khouang)*

> *"It depends on their difficulties, if someone who can walk and communicate with others they can [go to school], no problem, but if someone who does not be able to do as such, they should not go." (FGD, Males with disabilities, Savannakhet)*

One caregiver stated –

> *"They can study but when seizure happen it can be a challenge for learning, so I decided not to let them go to study." (FGD, Female caregivers, Xieng Khouang)*

While another parent of a child with a vision impairment said –

> *"Although she goes to school, she can't really study." (FGD, Male caregivers, Xieng Khouang)*

Some reported successful experiences of children with disabilities attending school and being well-supported.

> *"People actually support children with disabilities to go to school, there are not any negative thoughts about this. They support a child with disability to attend the grade 6 this year." (FGD, Male caregivers, Xieng Khouang)*

Community members without disabilities reported that they believed children with disabilities should be able to attend school, and that this should be in the same classes as children who do not have disabilities.

> *"I feel that they are different, but our children are normal. I want children with disabilities to feel as they are the same as us." (FGD, Female community members without disabilities, Xieng Khouang)*

> *"I think they are just like another child." (FGD, Male community members without disabilities, Savannakhet)*

Interestingly, in contrast, a group of caregivers reported that there should be separate classes for children with disabilities so as not to disrupt the children without disabilities.

"They may disturb or distract one another. I want to have the segregated special class for persons with disabilities." (FGD, Male caregivers, Savannakhet)

Several barriers to education for children with disabilities were identified. These included family economic status, distance to school, the physical inaccessibility of school facilities, the need for a family member to accompany them, and parental awareness or attitudes towards the value of education for their child with disabilities.

Poverty was a key barrier to education identified by persons with disabilities in the focus groups. Some participants stated that while their impairment was a factor in discontinuing their education, the costs associated with schooling was also a significant factor to dropping out of school. It was not clear whether cost was also a barrier for children without disabilities to the same extent.

"I quit school because I lost my eye and I did not learn anything like my friends did……The reason I left school was my parents were both very poor. I did not have clothes and could not afford to buy books, and pencils at that time." (FGD, Males with disabilities, Xieng Khouang)

"It was difficult, because my legs hurt so I quit school. My parents could not afford to buy books, pens, and pencils for me and secondly, it was very challenging for me, so I quitted." (FGD, Males with disabilities, Xieng Khouang)

Q: "Why didn't you continue your study?" A: "Didn't have money. (FGD, females with disabilities, Savannakhet)

School facilities that are not accessible for children with physical disabilities was frequently cited as a barrier to education.

"The physical accessibility of school also limited, the toilet, the door or even the entrance for children who use wheelchair will still be challenges." (FGD, CBID workers, Xieng Khouang)

"We can see that school are not yet really accessible physically especially in getting to the building or toilet. (FGD, CBID workers, Savannakhet)

Distance to schools was also considered a barrier, particularly in rural areas, in addition to the other challenges of reaching schools.

"In the rural area, the villages are scattered over a large area and the school is quite far from their villages, so it's difficult for parents to send their children to school which is different from children who live in the city" (OPD, male, Xieng Khouang)

"They need to use a wheelchair and for their parents to pick them up when they finish school. They cannot get there by themselves." (FGD, Male community members without disabilities, Savannakhet)

"The place itself is not inaccessible. It is difficult for them to come to the place, because there is no one accompany them." (FGD, Male community members without disabilities, Xieng Khouang)

There was a common perception that parents of children with disabilities do not value education as much for a child with disabilities as for a child without disabilities.

"They think that their children are different and not complete so there is no point to send them to school, they better be out of school helping the household chores or doing some work." (FGD, CBID workers, Xieng Khouang)

"Sometimes some children who has difficulties with their brain, their parent think that they should not go to school, because they (children with intellectual impairment) do not know anything." (FGD, Males with disabilities, Savannakhet)

"Sometimes people think that there is no need for their children with disabilities to go to school because they think children with disabilities may not use knowledge, better that they stay at home and do something else." (FGD, Female community members without disability, Savannakhet)

And finally, the skills of education staff in teaching children with disabilities was a perceived barrier to education for children with disabilities.

"He went to school and learned it by his own way and didn't know if it's wrong or right because there was no specialized teacher to teach him." (FGD, Male caregivers, Savannakhet)

"The school in our village can only accept children without disabilities, teacher do not know how to deal with person with disabilities." (FGD, Female caregivers, Savannakhet)

d. Disparities in work & satisfaction with current activities

Disparities in current activity and working status were presented earlier under socio-economic characteristics of respondents. Figure 8 provides further details about dissatisfaction with the current activity status; persons with disabilities were more dissatisfied with their current activity status than persons without disabilities.

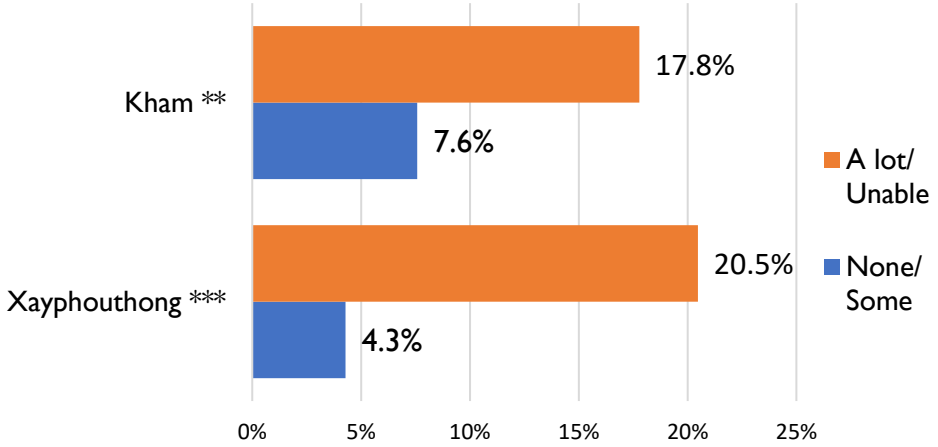


Figure 8: Dissatisfaction with current activity status

e. Factors associated with working status

Working status was strongly associated with higher levels of functional difficulty after controlling for socioeconomic factors (Table 7). Controlling for other factors, people with more functional difficulty were less likely to be working. Compared to people with no difficulties, people who reported being 'unable to do' at least one functional domain were much less likely to work. Overall, working status was associated with age and education status.

Table 7: Factors associated with working status

	Odds ratios		95% Confidence Interval	
			Lower limit	Upper limit
Difficulty level				
None (ref.)	1			
Some	1.63		0.63	4.21
A lot	0.23	**	0.08	0.72
Unable	0.01	***	0.00	0.05
Sex				
Male (ref.)	1			
Female	1.27		0.76	2.11
Age	1.10	***	1.07	1.13
Education level				
None (ref.)	1			
<Primary	2.48		0.47	13.09
Primary school	3.17	*	0.94	10.66
Secondary school +	5.25	**	1.26	21.94
Have received vocational training	1.28		0.48	3.41
Living standards level				
Low (ref.)	1			
Middle	0.67		0.28	1.57
High	0.64		0.30	1.41
Place of residence				
Urban (ref.)	1			
Rural	1.04		0.68	1.60
District				
Kham (ref.)	1			
Xayphouthong	0.98		0.61	1.59
n	647			
N	24,426			

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

f. Need to work & associated factors

Overall, most people with and without disabilities reported that they needed to work in the last 3 months. In Kham district, persons with disabilities were less likely to report they needed to work compared with persons without disabilities. Persons with disabilities in Xayphouthong District were less likely to report working as much as needed, but the difference was not statistically significant.

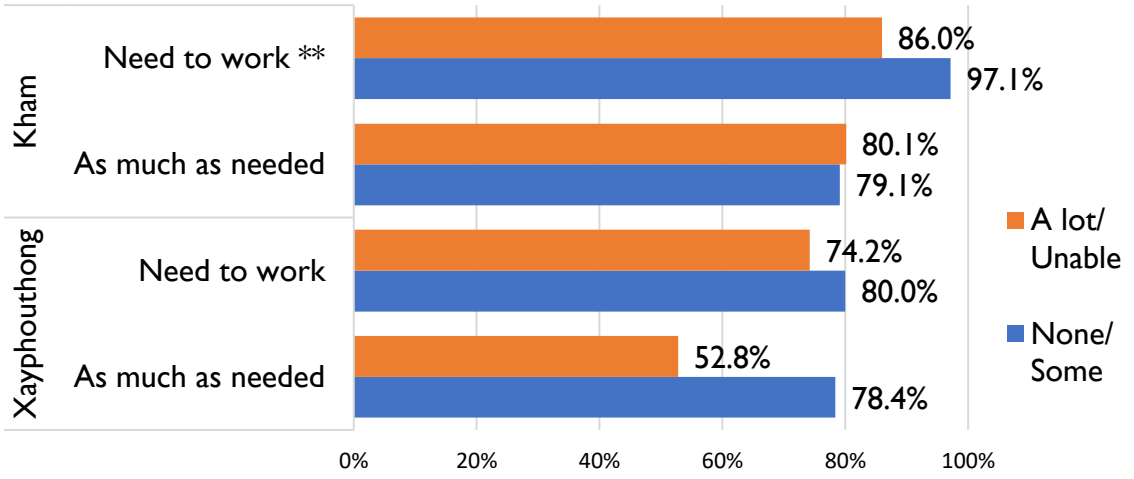


Figure 9: Need to work in the past 3 months and ability to work as much as needed/all of the time

g. Barriers to work and livelihoods

Qualitative findings showed limited formal and informal[10] work opportunities for persons with disabilities. A few persons with disabilities interviewed reported having work and, of those, most reported periodic or casual home-based work. Some persons with disabilities reported doing gardening or agricultural work. Another reported working as an occasional construction laborer. One veteran who was an amputee was previously a teacher and is now a village head.

There was general reflection, on the part of caregivers and persons without disabilities, that some persons with disabilities could do easy work and tasks. This included light household chores and possibly feeding livestock or rearing small animals. Persons with disabilities reported wanting to work and needing appropriate work. A woman with disabilities reflected that she had applied to work for a beauty product firm making wigs and hair extensions. However, she did not get the job and reflected that she was 'not very quick in doing things.' A caregiver reflected that his work opportunities were also limited:

> *"There are several impacts [of being a caregiver]. I can't do jobs, such as trading that mean I have to go to other places. Because if I leave my house for one or two*

[10] We defined any paid work as formal work, while explicitly unpaid work was considered informal. Working on family farms or household duties were considered informal, but neither the quantitative questionnaire examined whether that type of work was paid or unpaid.

days I would be so worried about things at home and especially about my disabled daughter." (FGD, Male caregivers, Xieng Khouang).

One respondent noted that there were also seasonal difficulties for caregivers. He noted that during the rice harvesting periods everyone wants the opportunity to earn money. This leads to arguments in his family over who will care for their relative with disabilities.

In several discussions, respondents noted that people with either psychosocial or intellectual disability cannot work.[11] While it was noted that a few employers would employ a person with disabilities, it was noted in discussions that it was highly unlikely anyone would hire a person with a psychosocial disability. Parents of children with disabilities voiced concerns about the future for their child:

"I saw that when he [Deaf son] was watching TV he was interested in a program about hairdressing. He would like to become a barber. […] I want him to go back to school if there is a sign language teacher available." (FGD, Male caregivers, Savannakhet)

Self-perceptions also acted as a barrier to work. One respondent with disabilities (male) noted that because they are 'unhealthy' he could not work with other people as it would cause problems for the other people. Despite a demand for work from persons with disabilities, few could articulate what that work may look like. Aside from some mention of the need for vocational training, responses reflected highly limited work opportunities for persons with disabilities in USAID Okard work domains and for children with disabilities in the future.

[11] In Lao PDR (as in many other contexts), psychosocial disability is poorly understood, and it is often difficult to discern whether respondents are referring to psychosocial disability or intellectual disability.

Access to Education and Employment

Persons with disabilities were

< 60%

less likely

to have completed higher education levels

Women with disabilities were

more likely to be deprived of attaining higher levels of education

Persons with disabilities more likely to be unemployed

and less likely to be paid

compared to persons without disabilities

14%

unpaid

2.3%

39.4%

unemployed

10.2%

4. Disparities in Health & Wellbeing

- Persons with disabilities were more likely to experience poor health. Around three quarters of persons with disabilities (73.3%) in Kham district and about half (54.2%) in Xayphouthong district report poor health.
- Persons with disabilities reported having been very sick much more than those without disabilities.
- This study found that the likelihood of depression was not common (less than 5%) overall, and that there was no difference between persons with and without disabilities.
- People with the most difficulties were less likely to report poor health than persons with 'a lot' of difficulty.
- Persons with disabilities were less likely to be satisfied with their lives than persons without disabilities.
- People with more education were more likely to report higher satisfaction with their lives.
- People in Kham district were less likely to be satisfied with their lives than people in Xayphouthong district.

a. Disparities in self-rated health status

Around 1 in 4 people reported poor health overall, however self-rated health was significantly poorer amongst persons with disabilities (Table 8). In Kham district, 73.3% of persons with disabilities reported poor health, compared with only 14.4% with no disabilities. In Xayphouthong district, 54.2% of persons with disabilities reported poor health compared with 8.6% of persons with disabilities. People in Xayphouthong district rated their health better in general compared to Kham district.

Compared with a self-rating of health, a more objective measure of health is whether the respondent has ever been very sick. About one-third of persons without disabilities reported that they had been very sick, compared with nearly two-thirds of persons with disabilities.

Self-rated likelihood of depression was less than 5% overall and was not associated with functioning in this population (Table 8).

Table 8: Self-rated health indicators

Level of difficulty	None/ Some	A lot/ Unable	Both
Kham District			
Poor health (self-rated) ***	14.4%	73.3%	23.5%
Ever been very sick ***	33.3%	61.9%	37.7%
Depression likelihood	3.5%	5.2%	3.7%
Xayphouthong District			
Poor health (self-rated) ***	8.6%	54.2%	14.4%
Ever been very sick **	30.5%	58.1%	34.1%
Depression likelihood	4.4%	6.5%	4.7%

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

b. Factors associated with self-rated health

Self-rated health was strongly associated with the level of difficulty (Table 9), but people with the most difficulty were *less* likely to report poor health than people with 'a lot' of difficulty. Controlling for other sociodemographic characteristics, the likelihood of reporting poor health increased with the level of difficulty, being highest i.e. 20 times more likely among those with a lot of difficulty and dropping to 10 times among those who were unable to do any one of the functions compared to people with no functional difficulty. Results also show that relationships between self-rated health and other social determinants of health are as expected. By district of residence, people in Xayphouthong district were less likely to report poor health than people in Kham district.

Table 9: Factors associated with poor health (self-rated)

	Odds ratios	95% Confidence Interval	
		Lower limit	Upper limit
Difficulty level			
None (ref.)	1		
Some	4.40 **	1.31	14.80
A lot	20.25 ***	6.15	66.67
Unable	10.26 ***	2.68	39.35
Being sick in the past 3 months	3.26 *	0.90	11.85
Have health insurance	0.45 *	0.19	1.06
Sex			
Male (ref.)	1		
Female	1.25	0.63	2.48
Age	1.03 **	1.01	1.06
Place of residence			
Urban (ref.)	1		

	Odds ratios	95% Confidence Interval	
		Lower limit	Upper limit
Rural	1.56	0.46	5.26
Marital status			
Never married (ref.)	1		
Currently married/cohabited	1.52	0.40	5.83
Divorced, separated, widowed	2.98	0.30	29.72
Education level			
None (ref.)	1		
<Primary	2.20	0.66	7.41
Primary school	2.31 **	1.05	5.11
Secondary school +	0.96	0.27	3.36
Vocational training	0.97	0.42	2.20
Working	0.46 *	0.20	1.07
Living standards level			
Low (ref.)	1		
Middle	0.70	0.33	1.48
High	0.56	0.21	1.49
District			
Kham (ref.)	1		
Xayphouthong	0.31 ***	0.15	0.64
n	646		
N	24,414		

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

c. Disparities in wellbeing

In general, the proportion of people dissatisfied with life was larger among persons with disabilities compared to persons without disabilities (Figure 9). This pattern was true in both districts: 36.5% vs 23.3% in Xayphouthong district, and 44.4% vs 34.5% in Kham district. People in Kham district seemed to be less satisfied with their life than people in Xayphouthong district.

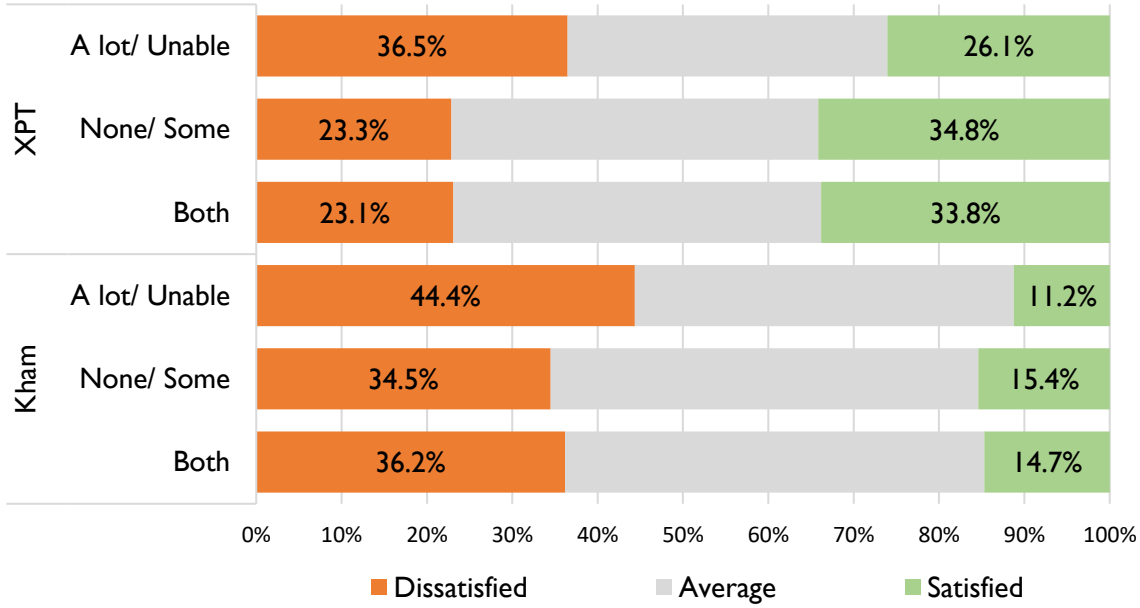


Figure 10: Satisfaction with life in general among the population aged 9 years or older

Similar patterns of disparities were found when looking at SWLS in the past 3 months among the population aged 15 years or older (Figure 10). However, the SWLS difference between people with and without disabilities was even larger in Xayphouthong district (43.1% vs 20.3%).

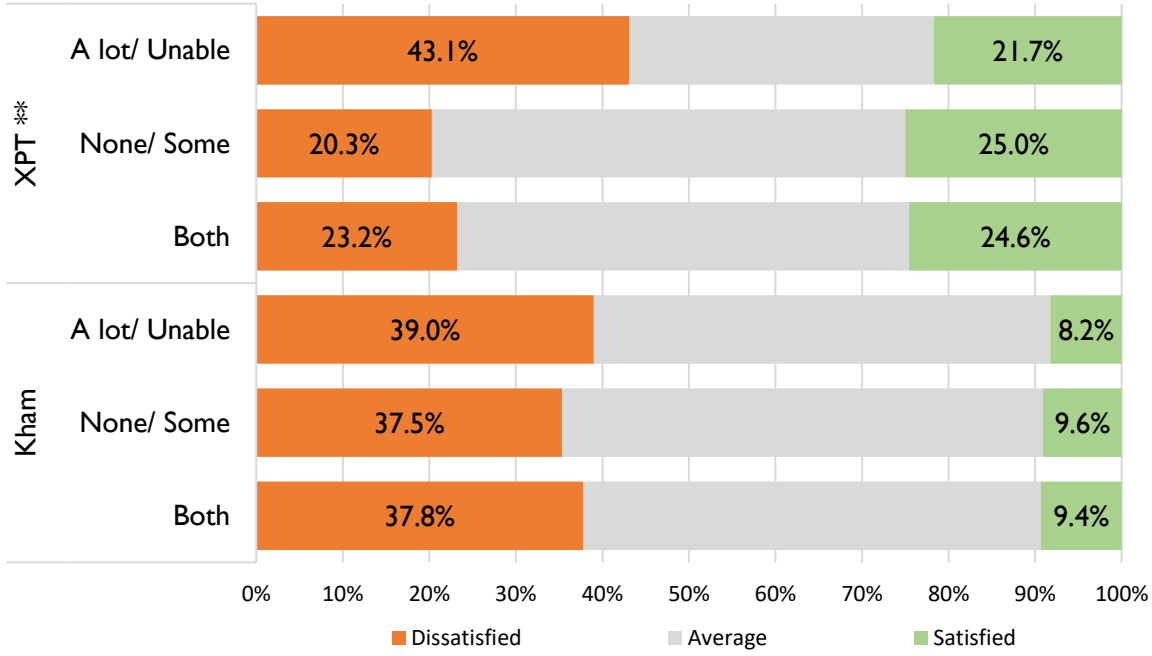
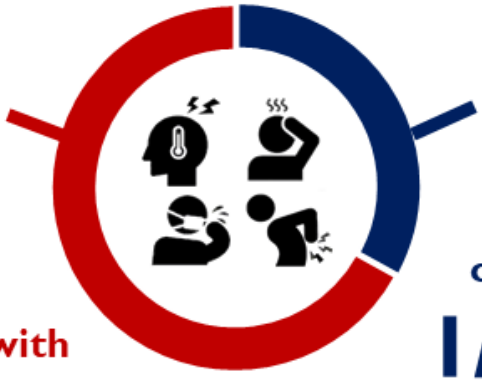


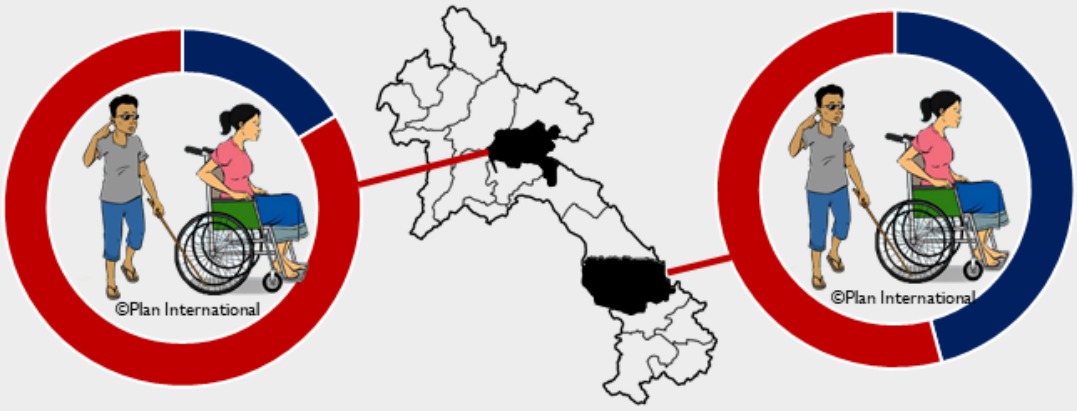
Figure 11: Satisfaction with life in the past 3 months (15y+)

Persons with disabilities experience poorer health and wellbeing



2/3 of persons with disabilities reported they had been 'very sick'

compared to **1/3** of persons without disabilities



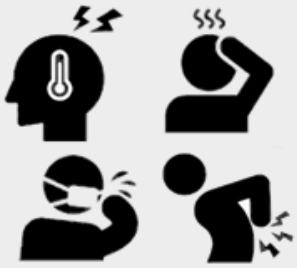
73.3%

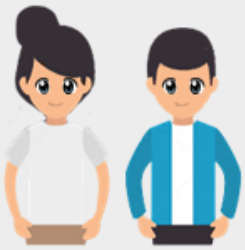
persons with disabilities in Kham District

54.2%

persons with disabilities in Xayphouthong District

reported that they had been 'very sick'





compared to persons without disabilities

Table 10: Factors associated with SWLS

	General SWLS among population 9 years or older			SWLS in last 3 months among population 15 years or older		
	Odds ratios	95% CI		Odds ratios	95% CI	
		Lower	Upper		Lower	Upper
Difficulty level						
None (ref.)	1			1		
Some	0.91	0.35	2.38	0.74	0.40	1.38
A lot	0.72	0.38	1.38	0.55 *	0.28	1.08
Unable	0.98	0.18	5.47	0.92	0.23	3.76
Being sick in the past 3 months	0.71	0.30	1.73	1.79	0.42	7.68
Having health insurance	1.35	0.86	2.14	1.65 *	0.90	3.03
Sex						
Male (ref.)	1			1		
Female	0.92	0.45	1.89	0.51 *	0.22	1.18
Age	1.00	0.98	1.03	1.01	0.99	1.02
Place of residence						
Urban (ref.)				1		
Rural	1.28	0.76	2.17	1.12	0.51	2.49
Marital status						
Never married (ref.)	1			1		
Currently married/cohabited	1.02	0.26	4.03	1.57	0.67	3.69
Divorced, separated, widowed	0.35	0.06	2.24	0.61	0.15	2.56
Education Level						
None (ref.)	1			1		
<Primary	1.22	0.57	2.62	0.41 *	0.14	1.19
Primary school	1.07	0.47	2.40	0.37 *	0.12	1.11
Secondary school +	1.22	0.56	2.63	0.69	0.23	2.06
Received skill/vocational training	1.29	0.49	3.43	1.13	0.46	2.77
Currently working	0.79	0.36	1.72	1.79	0.71	4.49
Living standards level						
Low (ref.)	1			1		
Middle	1.15	0.73	1.81	1.40	0.80	2.43
High	1.87 **	1.09	3.23	1.83 *	0.96	3.49
District						
Kham (ref.)	1			1		
Xayphouthong	2.57 ***	1.80	3.67	2.24 ***	1.32	3.81
n	600			550		
N	21,689			18,800		

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

After controlling for other factors, it was found that it is not people who were unable to do one of the functions, but people with a lot of difficulty who have the lowest SLWS (Table 10). Females aged 15 years or older had lower SWLS in the past 3 months than males. SWLS was associated with living standards and district of residence; people with higher level of living standards have higher SWLS, people living in Xayphouthong district have higher SWLS than those living in Kham district.

5. Need and access to healthcare services

- A high proportion of the population overall (31.9% and 24.8% in Kham and Xayphouthong districts respectively) reported that they needed to access health services in the last three months.
- Persons with disabilities were more likely to report needing healthcare. About half of all persons with disabilities reported needing health care in the last three months.
- Persons with and without disabilities were able to access health care as frequently as each other, and access overall was high.
- While access for persons with and without disabilities was high, persons with disabilities experience transport barriers, a lack of appropriate services, and negative staff attitudes.
- Attitudes and knowledge among health providers were barriers for persons with disabilities and a prominent theme in focus groups and individual interviews.
- Access to assistive products was low, especially for those who need them the most.

a. The need and ability to access healthcare services

As shown in Table 11, 31.9% and 24.8% of participants in Kham and Xayphouthong districts, respectively, said that they needed to access healthcare services in the last 3 months. The likelihood of requiring healthcare services was significantly greater for persons with disabilities. 56.0% and 43.1% of persons with disabilities in Kham and Xayphouthong districts, respectively, reported a need to access healthcare services, compared with 27.5% and 22.1% of persons with no disabilities in these districts respectively.

Despite higher needs for healthcare among persons with disabilities, there was no difference between persons with and without disabilities concerning their ability to access healthcare services when it was needed. More than 90% and 80% of people in Kham and Xayphouthong districts, respectively, who required healthcare in the last 3 months said they were able to access it, whether or not they had any functional difficulties, at all of the time.

Table 11: Need and ability to access healthcare services

	Level of difficulty		
	None/ Some	**A lot/ Unable**	**Total**
Kham District			
Needed access over the past 3 months **	27.5%	56.0%	31.9%
Able to access all of the time [a]	97.0%	91.3%	95.4%
Xayphouthong District			
Needed access over the past 3 months **	22.1%	43.1%	24.8%
Able to access all of the time [a]	84.4%	81.2%	83.7%

*Note: ** significantly different at p<0.05; [a] Among those who needed.*

From the qualitative findings, all groups reported that there was no disparity in health services available for persons with or without disabilities. Village health centers provide basic services and did not differentiate between persons with or without disabilities in the services they provide. If the case was more complex and cannot be managed by the health center, they may be referred to the district or provincial hospital.

Persons with disabilities themselves reported that when visiting health services that they were happy with the services they received and were able to access health care as much as they need. They described service providers as polite and friendly and that health services were convenient, however the discussion of access to healthcare in the FGDs with persons with disabilities was limited, hence any challenges may not have been fully elicited.

Information provided by caregivers of persons with disabilities, adds to the picture of the experience of persons with disabilities in accessing health care. Caregivers reported that persons with disabilities face a lot of difficulties in accessing health care and cannot access as much health care as needed, or that the services they received were of variable quality.

> *"The hospital cannot fulfil all the needs of persons with disabilities and how doctors treat patients is different each time we visit the clinic. Sometimes they provided good care, but sometimes they didn't. There are some changes between now and before….. it seems that they now don't give full care like before." (FGD, Male caregivers, Savannakhet)*

Community members without disabilities had very poor awareness of the healthcare needs of persons with disabilities, with these groups reporting that they had not seen any persons with disabilities when they were visiting the health center themselves, with some stating that "persons with disabilities do not really get sick".

b. Factors associated with the need of healthcare services

Significantly higher needs for healthcare services among those with higher levels of functional difficulty remain after controlling for age, being sick in the past 3 months, and other socio-economic factors (Table 12). Compared to those with no functional difficulty, those who have a lot of functional difficulty are three times more likely to need healthcare services, and

those who were unable to do at least one of the functions are five times more likely to need health services.

Table 12: Factors associated with the need of healthcare services

	Odds ratios	95% Confidence Interval	
		Lower limit	Upper limit
Difficulty level			
None (ref.)	1		
Some	1.39	0.56	3.42
A lot	3.16 **	1.29	7.75
Unable	5.14 **	1.05	25.03
Being sick in the past 3 months	4.34 **	1.32	14.24
Sex			
Male (ref.)	1		
Female	1.40	0.81	2.40
Age	1.01	0.98	1.03
Place of residence			
Urban (ref.)	1		
Rural	1.41	0.64	3.12
Marital status			
Never married (ref.)	1		
Currently married/cohabited	2.34 *	0.93	5.91
Divorced, separated, widowed	2.09	0.62	7.07
Education level			
None (ref.)	1		
<Primary	1.34	0.60	2.97
Primary school	1.80	0.54	6.01
Secondary school +	3.35 ***	1.38	8.15
Working	0.36 **	0.15	0.86
Living standards level			
Low (ref.)	1		
Middle	2.44 ***	1.55	3.85
High	1.07	0.52	2.24
District			
Kham (ref.)	1		
Xayphouthong	0.74	0.46	1.17
n		646	
N		24,399	

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

c. Barriers to accessing healthcare services

Overall among those who reported they could not access healthcare services, a lack of information (including not knowing where to go), lack of assistance to attend healthcare facilities (e.g. no one taking the person to the healthcare facility), family not wanting the respondent to visit healthcare facility, or costs accounted for most of the barriers (Figure 11). However, the reasons for not accessing healthcare services are very different between persons with and without disabilities. Besides a lack of information, which was a major barrier to both groups, family is a dominant barrier for persons without disabilities. By comparison, the major self-reported barriers for persons with disabilities include direct cost of healthcare services, distance to healthcare facility (too far) and transportation.

Availability of healthcare services, accessibility of transportation means, and attitude of health staff were reported by persons with disabilities while none of the others reported them as barriers. While the results are interesting, they should be read with caution given the small sample sizes for analysis (11 people without disability and 17 persons with disabilities who could not access healthcare services all of the time).

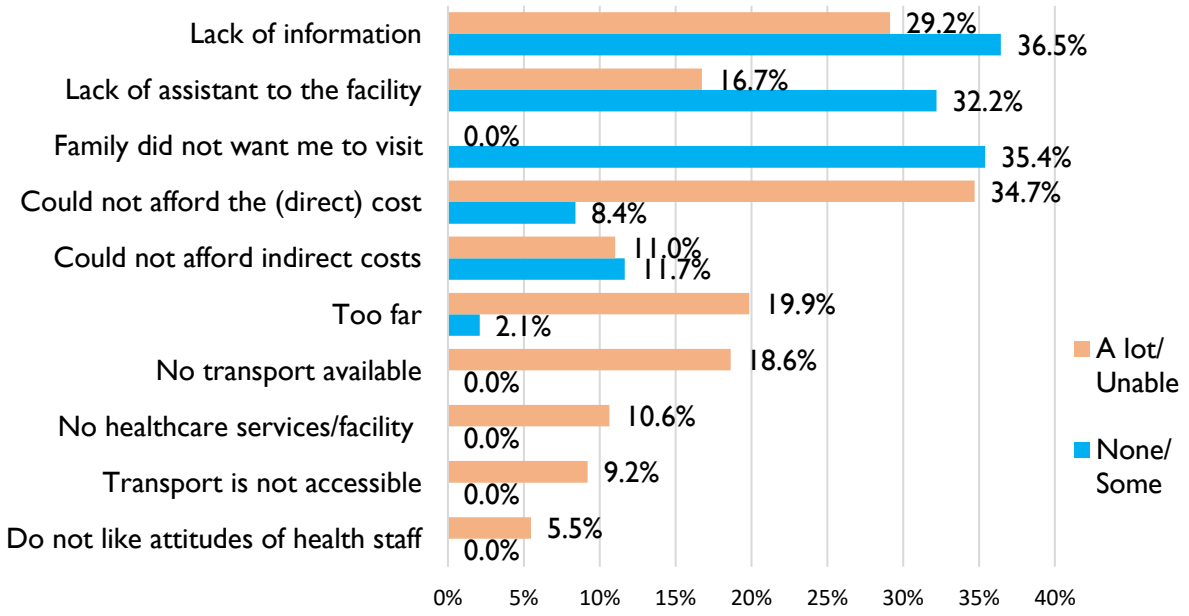


Figure 12: Barriers to accessing health care - percentage of respondents who reported reasons for not being able to access healthcare services all of the time

When asked about the most important reasons or barriers to access healthcare services (Figure 12), the most frequent responses for persons with disabilities included direct cost of healthcare services, lack of information, distance to health facility, lack of assistance to get to the health facility, while there was a lack of information and a lack of assistance to get to health facility among those without disabilities.

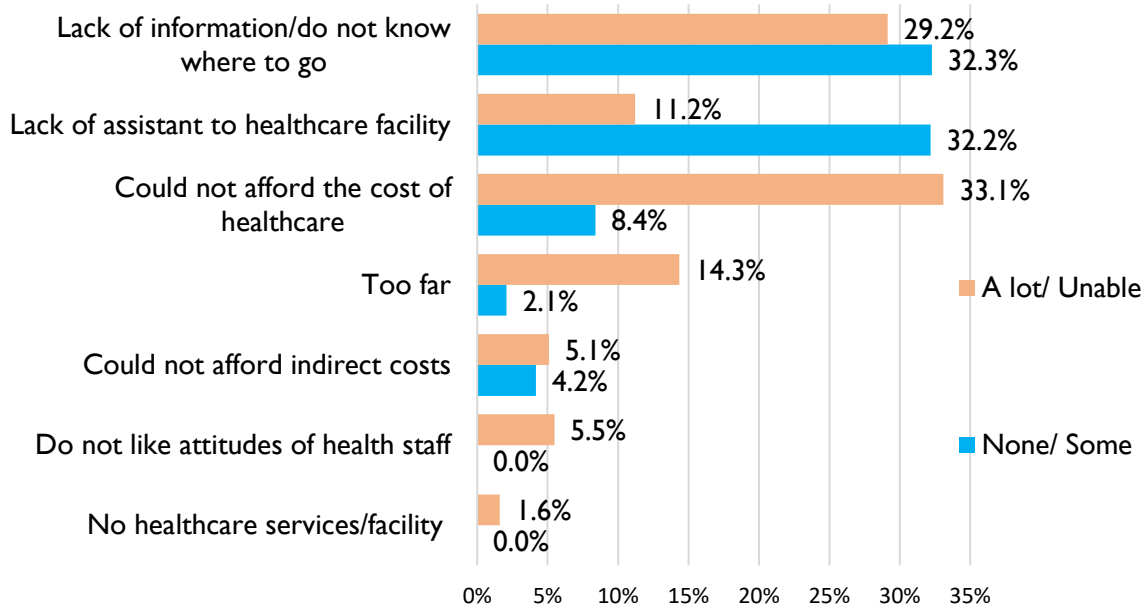


Figure 13: Barriers to accessing health care - percentage of respondents who reported most important reasons for not being able to access healthcare services all of the time

The survey results were mostly supported and extended by the qualitative findings. Despite a general belief that persons with disabilities can access health care services as much as they need to, several potential barriers to healthcare were identified. Barriers included direct and indirect costs, communication difficulties between persons with disabilities and health providers, lack of staff training and knowledge in interacting with persons with disabilities, and a lack of appropriate facilities and equipment to manage the needs of persons with disabilities.

> *"If you look at the facilities you cannot see the room for person with disabilities, bed that designed to match their need, or even the toilets are not specific for them, they just use with others which sometimes hard for them to use" (FGD, Female community members without disability, Savannakhet)*

Cost was a key barrier identified that impacts the ability to access healthcare, despite National Health Insurance being available to all people, which was mentioned by most respondents. There were no known healthcare subsidies specifically for persons with disabilities. Although the National Health Insurance reduced the cost of services, cost of medicines, transport and loss of income for accompanying family members, the remaining costs still incurred presented as a barrier for many people. Some reported selling livestock or borrowing money from friends to cover the costs of transport and healthcare.

> *"It is just sometimes we do not have money, when we do not have money what we are going to pay? Sometimes person with disabilities are very poor. As we all know, when you got sick and you have to get services in Mahosot hospital (Vientiane), you could not, if you do not have money. This is the same. If you have money you can access to whatever level you want." (FGD, Males with disabilities, Savannakhet)*

> *"I didn't go to the health center because if I went there again, I would receive the same pain relief medicine. That would have wasted my money I didn't have money. I am a person with disabilities, and it is difficult to make money. Only my children and wife can earn some money." (FGD, Males with disability, Xieng Khouang)*

Transportation to health centers was identified particularly by caregivers as a key barrier to healthcare access. Distance to health centers and a lack of accessible transport required family members to accompany persons with disabilities and may have even required hiring a car, thereby incurring extra costs in addition to the loss of household income.

> *"It is difficult, because we don't have transportation to take the persons with disabilities to the health center. Those who are not disabled can walk to the local public healthcare center unlike those who are disabled need someone to take them there which is one of the difficulties." (FGD, Male caregivers of persons with disabilities, Xieng Khouang)*

> *"If they come to the services in the province. It is really a big task for them. Let's imagine one small family of 5 people. If the father is not well they have to come for services, for sure the mother has to come with him, and the children surely cannot be left at home by themselves therefore it is really a big task for family when they have to come for services (Health sector, male, Xieng Khouang)*

Strategies needed to improve health care access identified by respondents included health promotion activities specifically for persons with disabilities to inform them of the health services available to them and improving the physical accessibility of health centers.

d. Health seeking behavior

Health seeking behaviors after being sick enough to stay at home or rest for at least 3 days over the past 3 months were assessed. Most people regardless of their level of functional difficulty visited health facilities (Figure 13). However, self-medication (accessing drugs without prescription) was also common. There was also a high proportion of people who adopted other unfavorable health seeking behaviors, including doing nothing, home remedy (traditional methods but not drugs from pharmacy or similar), visiting a traditional healer, seeking spiritual support, and buying medicine from a pharmacist over the counter (without prescription).

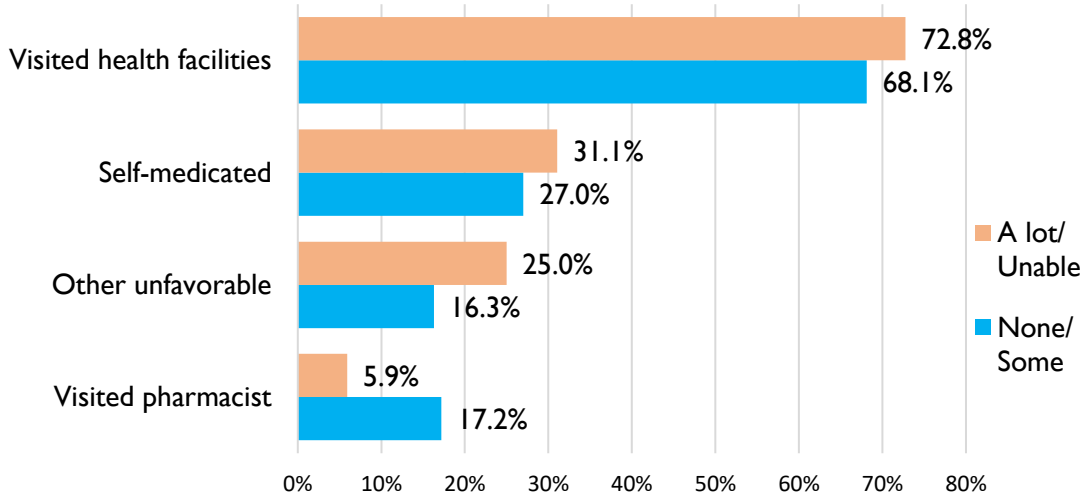


Figure 14: Health seeking behavior after being sick in the past 3 months

Note: Unfavorable = Did nothing, home remedy, visited traditional healer, seek spiritual support

In the FGDs, persons with disabilities reported that they visit their village health center when they are sick and need health care. If there is no health center in their village respondents would instead buy medicines from the pharmacy when they are sick.

There was a belief among some that doctors may not know how to help people with more severe disabilities and that this may impact whether they would access health services.

> *"For some simple case like getting fever, sore throat the doctor can help, but if it is more complex than that like someone who has severe disabilities, [or someone who is bedridden], the doctor do not know what and how to help them." (FGD, Male community members without disabilities, Xieng Khouang)*

e. Health service provision

Health service providers reported that persons with disabilities attend their health services, but mostly identified that these were people with vision or hearing impairments and that they were less aware of people with other types of impairments attending. Some reported that they believed people with physical impairments were less likely to access health services than other types of impairment.

> *"Some (children) who can walk, can stand (deaf or blind) do get weigh, but someone who cannot move at all, we do not have any interaction with him" (Health sector, female, Savannakhet)*

While others reported the opposite and were more confident in providing services to people with physical impairments than those with difficulty hearing or seeing, or psychosocial impairments.

Access to quality healthcare

Main barriers for persons with disabilities when needing to access healthcare

©Plan International

Distance to health facility

Cost

©Plan International

Lack of information about services

Lack of transportation

Persons with and without disabilities who accessed healthcare

©Plan International

©Plan International

reported the quality of the services was limited and did not always meet their needs.

"Mostly we can handle disabilities on lower and upper limb.... beside this, the vision impaired, arm, intellectual, deaf, blind we are not confident" (Health sector, female, Savannakhet)

"It is difficult when we talk to them [people with a hearing impairment] and they don't understand. Sometimes we need to use hands [gesture], but it is difficult. Second is persons with an eye problem….When their cousins did not come with them it is more difficult because sometimes nurses and doctors cannot help them. We rely on their cousins or children to help." (Health sector, female, Xieng Khouang)

Some health sector respondents felt that because persons with disabilities did not attend health services frequently that they lacked the opportunity to develop their skills in supporting persons with disabilities. In addition, a lack of training and assistive devices made them feel inadequate in what they were able to provide.

"Because we do not have enough specialist and skill to help them [wheelchair user], even when they come to the district health office sometimes, we could not help" (Health sector, female, Savannakhet)

They acknowledged the insufficient facilities to treat some needs and that they would refer to other more well-resourced services.

"We must acknowledge the fact that our health center doesn't have sufficient human resources and tools. But we always do our best to help patients with the resource that we have, if we are unable to heal patients probably than we will transfer patients to another health sector for a better treatment. We are a health center with limited resource of health service, we don't have any materials to support persons with disabilities, so they might go to somewhere else that could respond to their needs." (Health sector, female, Savannakhet)

Most health sector stakeholders reported that they did not provide any specific services or programs for persons with disabilities, although district health services reported specific programs for UXO survivors and visiting international specialists for cleft palate and cataract surgeries.

There were some reports of providing outreach services for those who were unable to attend the health center for preventative health activities, for example during vaccination campaigns.

"Even if I have made an announcement for vaccinations, persons with disabilities still do not come. Therefore, I have to go to their houses." (Health sector, female, Savannakhet)

6. Access to assistive products & rehabilitation

- 11.8% of participants overall used an assistive product, while 28.7% with disabilities reported using AP.
- While not everyone with functional difficulties needed or wanted an AP, unmet need for assistive products was high; 71.3% of persons with disabilities did not use AP.
- Access to AP was lower for people who reported 'unable to do' than others with 'a lot' of difficulty.
- Women were significantly less likely to use AP than men.
- People in Xayphouthong district were more likely to use AP than those in Kham district.
- Services for AP access included community-level screening and rehabilitation centers, but barriers to access and quality included costs, transport, reliable information, and availability of the right products.
- Among people who reported knowing what rehabilitation is, 3.3% of the population reported needing rehabilitation in the last 3 months.
- Half of the people in Xayphouthong district with disabilities did not know what rehabilitation was.
- People with more potential need for rehabilitation were not more likely to report knowing what rehabilitation is or being able to access it.

a. The use of assistive products

Figure 14 shows the proportion of people who used AP across the different functional domains. 11.8% of the total participants used at least one assistive product (AP). The proportion of persons with disabilities using AP was 28.7%. This result probably implies a high level of unmet AP needs as nearly three-quarters of those with disabilities did not have an AP, though not all persons with a difficulty needed or wanted to use assistive products. The use of AP among those with some functional difficulties was similar to those with a lot or higher levels of difficulty; together, AP prevalence among those with some or higher levels of difficulty was 28.8%.

Among those using any AP, 69.2% used one product, 19.2% used 2 products, 10.2% used 3 products.

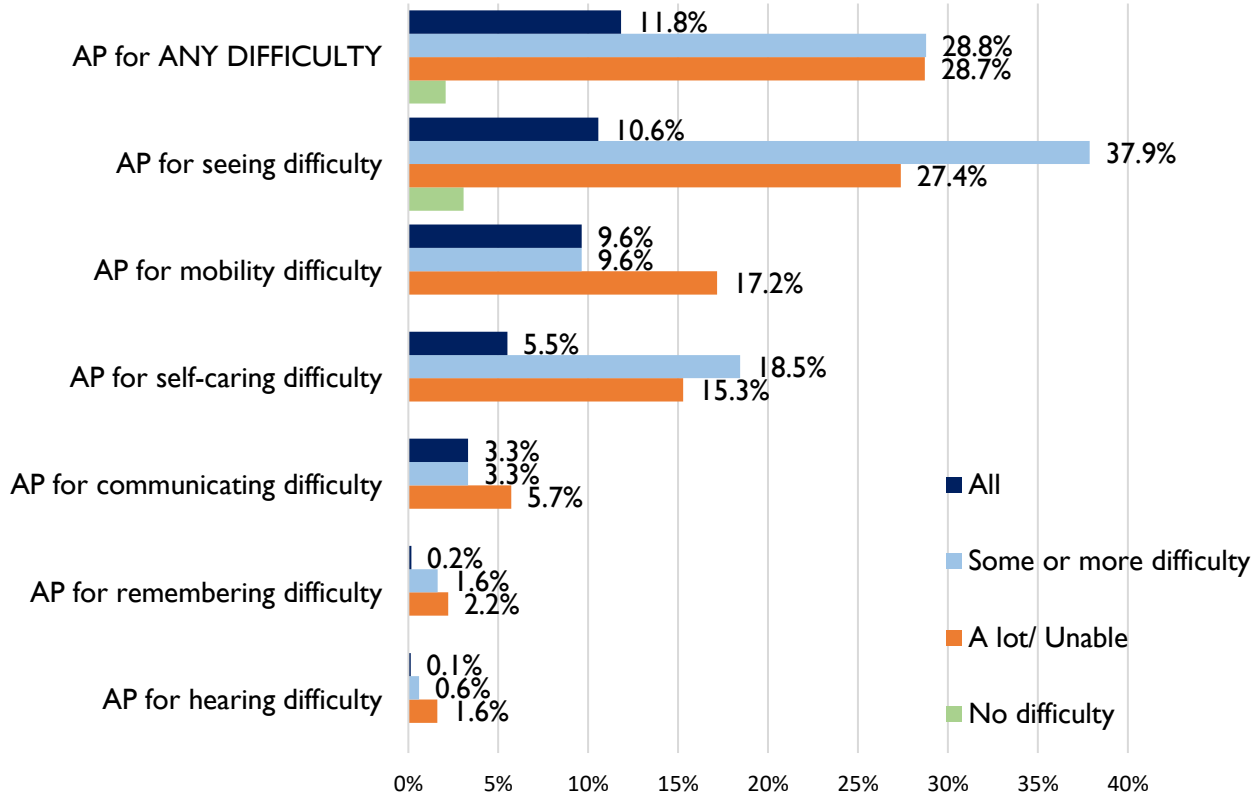


Figure 15: Use of assistive products (AP) - % using AP for all difficulty levels

After controlling for age and other socio-economic factors, compared with persons without functional difficulties, the likelihood of using assistive products was highest among those with 'some' functional difficulties (nearly 10 times more likely), followed by those with 'a lot' of difficulties (nearly 9 times more likely) (Table 13). Gender differences were also very clear as females were 68% less likely to use AP than males. People in Xayphouthong district were also 2.5 times more likely to use AP than people in Kham district.

Table 13: Factors associated with the use of assistive products

	Odds ratios		95% Confidence Interval	
			Lower limit	Upper limit
Difficulty level				
None (ref.)	1			
Some	9.50	**	1.50	60.05
A lot	8.68	***	2.42	31.21
Unable	6.35		0.38	106.80
Sex				
Male (ref.)	1			
Female	0.32	***	0.14	0.73
Age	1.06	***	1.03	1.10
Place of residence				
Urban (ref.)	1			
Rural	2.77	*	0.89	8.66
Marital status				
Never married (ref.)	1			
Currently married/cohabited	3.30		0.31	35.45
Divorced, separated, widowed	0.66		0.03	16.18
Education level				
None (ref.)	1			
<Primary	1.83		0.51	6.53
Primary school	1.63		0.41	6.53
Secondary school +	4.04	*	0.69	23.61
Working	0.30	*	0.07	1.31
Living standards level				
Low (ref.)	1			
Middle	1.00		0.36	2.82
High	0.89		0.34	2.31
District				
Kham (ref.)	1			
Xayphouthong	2.45	**	1.06	5.62
n	647			
N	24,426			

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

b. Access to assistive products

Assistive products such as prosthetics, crutches, wheelchairs and eyeglasses were mostly unavailable or difficult to access, especially outside provincial or more urban areas. To access products, people reported needing to travel to the provincial rehabilitation centers for assistive products, or that they could purchase products at shops in larger urban centers. War veterans reported that they were able to access assistive products with support from the Ministry of Defense, but that other persons with disabilities did not have the same access.

> *"No one is giving them [persons with disabilities] wheelchairs. For me I am a veteran, the government through the ministries (National Defense) has support this to me." (FGD, Males with disability, Savannakhet)*

There were some reports of specific projects by non-government organizations that provided assistive products such as wheelchairs, crutches or eyeglasses, but not all people were aware of these or how to access products through these programs so had missed out. Some reported that referrals for assistive products mostly occurred via the village head.

> *"Every year there is someone coming to collect information on eyeglasses, or the wheelchair and then the health center will ask the head of village and then refer based on the referral process." (Health sector, female, Savannakhet)*

Lack of access to assistive products was seen as a key barrier to the participation of persons with disabilities in community activities such as festivals and in being able to access health care and education.

> *"Normally, the caregivers carried them to the gathering place to have injection/vaccination, apart from that they have to stay at home mostly. For other persons with disabilities, they all can walk or hop to places, but they don't have any assistive devices to support them." (Education sector, male, Xieng Khouang)*

For ongoing monitoring and maintenance of assistive products it was stated that people needed to return to the provincial rehabilitation centers. For many persons with disabilities this is not feasible, therefore assistive products fall into disrepair and are not able to be used.

> *"I have someone I know who has a leg amputation, he used to get the assistive product - crutches and prosthesis. But years passed these things have been used a lot and have not be maintained in good condition. He now cannot use it and do not know where to get it. Now when you visit him you will see he hangs his assistive products as a decoration on his house as he cannot practically use it anymore." (FGD, CBID workers, Xieng Khouang)*

c. Access to rehabilitation services

Among those who felt they understood what rehabilitation is and what it aims to do, 3.3% of the participants in both districts reported a need to access rehabilitation in the last 3 months. One quarter of people overall reported they did not know what rehabilitation was.

Importantly, nearly half of persons with disabilities in Xayphouthong district did not know what rehabilitation was.

There was a trend towards people with more functional difficulty being more likely to report a need for rehabilitation in the last 3 months. Figure 15 shows 4 out of 5 (81.2%) of people with no difficulties were able to access rehabilitation when they needed it, compared with around 3 out of 5 (63.3%) people with functional difficulties.

Table 14: Need and ability to access rehabilitation

	Level of difficulty		
	None/ Some	A lot/ Unable	Total
Kham District			
Needed to access rehabilitation *			
Yes, need rehabilitation	2.8%	11.7%	4.2%
No, do not need rehabilitation	75.3%	75.0%	75.3%
Don't know what rehabilitation is	19.0%	13.3%	18.1%
Know rehab but don't know if it's needed	2.9%	0.0%	2.5%
Need to access rehabilitation among those who know about rehabilitation & their need	3.6%	13.5%	5.2%
Xayphouthong District			
Needed to access rehabilitation **			
Yes, need rehabilitation	2.5%	2.7%	2.6%
No, do not need rehabilitation	66.5%	42.5%	63.4%
Don't know what rehabilitation is	27.6%	46.1%	29.9%
Know rehabilitation but don't know if it's needed	3.4%	8.7%	4.1%
Need to access rehabilitation among those who know about rehabilitation & their need	3.7%	6.1%	3.9%

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

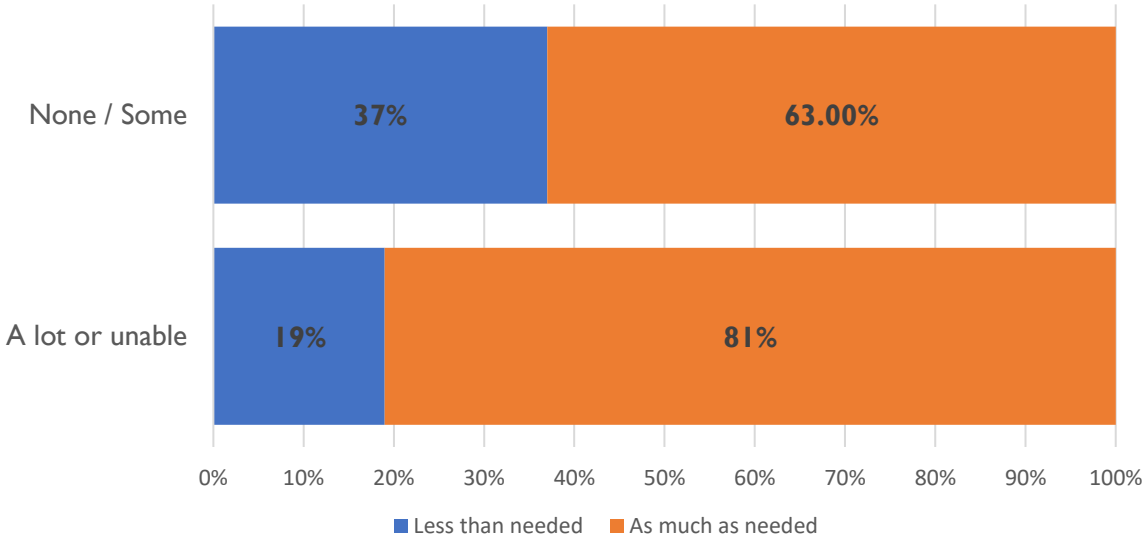


Figure 16: Proporion of people reporting access to rehabilitation 'as much as needed'

Figure 16: Proportion of people reporting access to rehabilitation ‘as much as needed’.

d. Factors associated with poor awareness of rehabilitation

Although it is not statistically significant (Table 16), people with higher needs of rehabilitation or levels of functional difficulties were either less likely to be aware of rehabilitation at all, or to understand their own needs for rehabilitation. As expected, persons living in rural areas and people with lower levels of education were more likely to have poor awareness of rehabilitation.

Table 15: Factors associated with poor awareness of rehabilitation

	Odds ratios		95% Confidence Interval	
			Lower limit	Upper limit
Difficulty level				
None (ref.)	1			
Some	1.19		0.30	4.73
A lot	1.56		0.76	3.21
Unable	2.68		0.33	21.69
Sex				
Male (ref.)	1			
Female	0.90		0.52	1.54
Age	0.98		0.95	1.02
Place of residence				
Urban (ref.)	1			
Rural	5.48	***	2.23	13.44
Marital status				
Never married (ref.)	1			
Currently married/cohabited	1.07		0.38	3.05
Divorced, separated, widowed	1.83		0.40	8.50
Education level				
None (ref.)	1			
<Primary	0.80		0.44	1.46
Primary school	0.47	*	0.20	1.10
Secondary school +	0.67		0.29	1.55
Working	0.91		0.27	3.02
Living standards level				
Low (ref.)	1			
Middle	1.01		0.44	2.31
High	1.59		0.77	3.30
District				
Kham (ref.)	1			
Xayphouthong	2.24		0.66	7.62
n	645			
N	24,403			

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

e. Rehabilitation service provision

Respondents from the FGDs and KIIs reported that people, such as those who have had a stroke or limb amputation, may need rehabilitation services. They identified that rehabilitation services were not available at the village level but required people to travel to a Provincial Rehabilitation Centre, although these are not available in every province.

Travelling to these centers was inaccessible to many persons with disabilities who may benefit from rehabilitation.

> *"The rehabilitation center is mainly available in the main city but not every province has this kind of center. This is difficult because if the main city has the rehabilitation center for persons with disabilities, other provinces and other districts also need to have this center or office like disabled people association. This is because persons with disabilities live in different places." (Education sector, male, Xieng Khouang)*

> *"We have a rehabilitation at the center. And [only] one outreach visit a year for one district for the whole province. It is very hard to get the services and equipment there, so we have encouraged them to come to the rehabilitation center in the province instead." (Health sector, male, Savannakhet)*

Some respondents suggested that rehabilitation should be available at village health centers to improve access to rehabilitation services.

> *"There was one man who has paralyzed, he come to us [at the village health center] for physical therapy, but we could not help because we do not know what to do. He has to go to the PRC in the province, but I think if we had that unit on rehabilitation in the community health center people will come to us more because we are closer than in the province when you have to travel for 60-70 km." (Health sector, female, Xieng Khouang)*

Rehabilitation and Assistive Products

Nearly **75%** of persons with disabilities did not have an assistive product

High level of unmet needs

Women were significantly less likely to use assistive products compared to men

Generally access to assistive products was low

25% of people did not know what rehabilitation is

7. Participation in social gatherings, community activities and access to benefits

- Persons with disabilities reported less participation in most community activities, but overall, differences were small.
- People with the most difficulty (reporting 'cannot do at all' in any domain) were much less likely to participate in community life than all others.
- Women participated more in festivals than men.
- Social participation was associated with higher levels of education and living standards.
- Xayphouthong district appeared to have less participation of persons with disabilities.
- Negative community attitudes that are likely to exclude persons with disabilities persist, but people were unlikely to self-identify their own biases.
- Access to government benefits was lower in Xayphouthong district than in Kham district.
- More persons with disabilities than persons without disabilities accessed benefits.
- Only half of people in Kham district, and about one in 10 people in Xayphouthong district (whether with or without disability) reported accessing the benefits they needed.
- Assistance for caregivers and families was a commonly reported need for better social protection and assistance.

a. Social & community participation

Compared with persons without disabilities, persons with disabilities tend to report they participated less in social gatherings with friends, peers, relatives or families over the past 3 months. Neither sex nor age affected social participation overall, but controlling for other factors, women were around twice as likely to participate in festivals than men.

Differences between persons with and without disabilities were small, except for participation in social gatherings with friends or peers in Xayphouthong district (Figure 17). In Kham district, more persons with disabilities attended festivals than persons without disabilities. The proportion of people who said they have participated as much as needed was consistently lower among persons with disabilities compared to persons without disabilities.

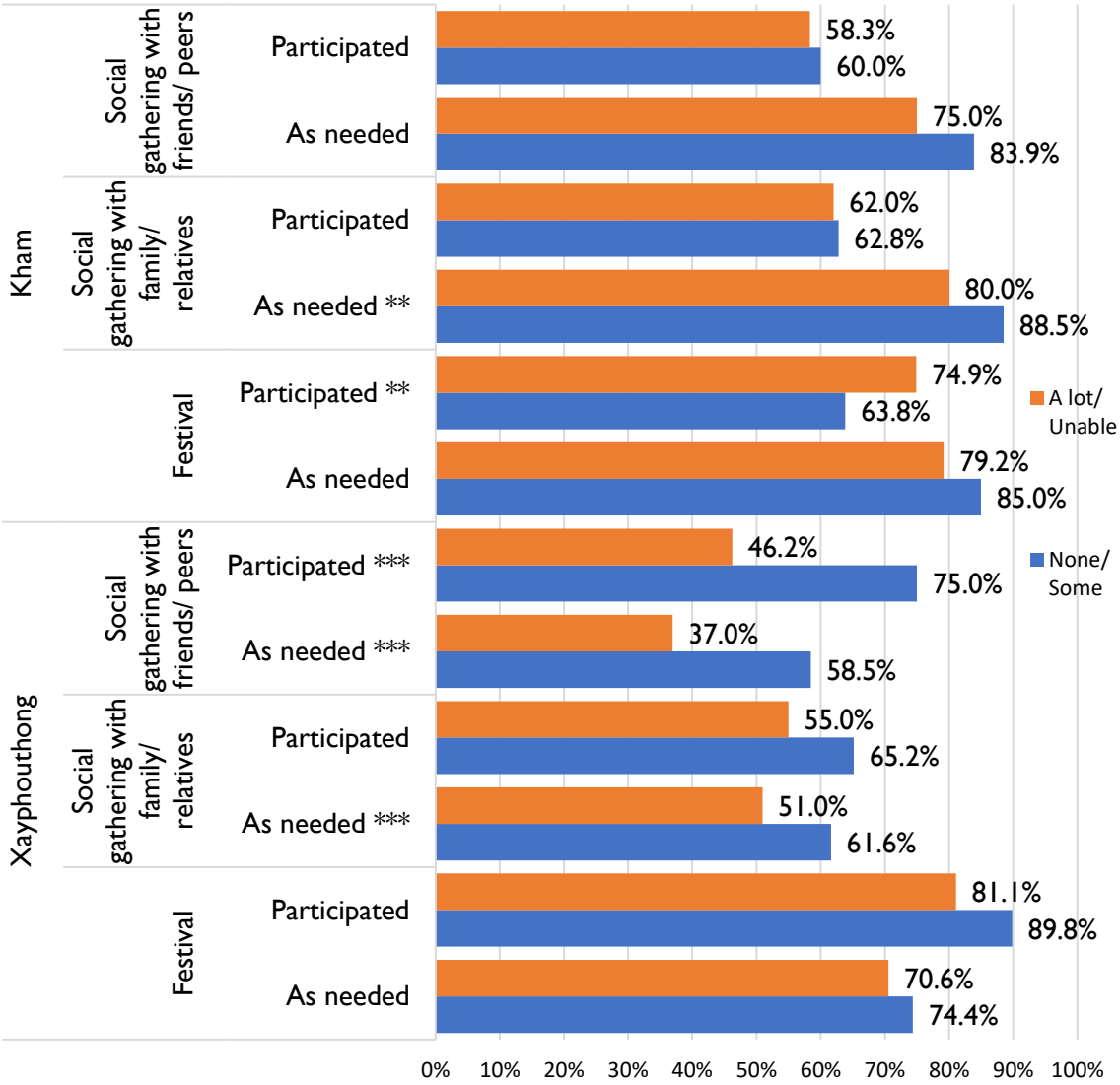


Figure 17: Participation in social events and festivals

Note: Participated = Participated in the past 3 months; As needed = Participated as much as needed

People with higher levels of difficulty in functioning (a lot or unable) were less likely to participate in social activities than those with some or no difficulties. Table 16 shows that people who *reported they were 'unable' in at least one functional domain* were significantly less likely to participate in gatherings with friends and gathering with families respectively than those with no difficulties. People with some or a lot of difficulties did not demonstrate significantly less participation than people with no difficulties.

Table 16: Factors associated with participation in social events & festivals

	Gathering with friends or peers			Gathering with families or relatives			Participating in festivals		
	Odds Ratios	95% CI		Odds Ratios	95% CI		Odds Ratios	95% CI	
Difficulty level									
None (ref.)	1			1			1		
Some	0.93	0.39	2.22	0.90	0.39	2.09	0.92	0.37	2.29
A lot	0.91	0.40	2.03	0.91	0.40	2.09	1.08	0.56	2.11
Unable	0.10 ***	0.03	0.30	0.19 ***	0.07	0.57	0.32	0.06	1.70
Sex									
Male (ref.)	1			1			1		
Female	1.04	0.75	1.45	0.96	0.63	1.46	2.14 **	1.01	4.53
Age	1.00	0.98	1.02	1.00	0.98	1.01	1.02 *	0.99	1.05
Place of residence									
Urban (ref.)	1			1			1		
Rural	0.85	0.43	1.69	0.74	0.39	1.42	0.69	0.28	1.73
Marital status									
Never married (ref.)	1			1			1		
Currently married/cohabited	0.98	0.31	3.09	3.60 **	1.26	10.27	1.00	0.27	3.75
Divorced, separated, widowed	0.70	0.13	3.66	1.31	0.26	6.51	0.44	0.07	2.91
Education level									
None (ref.)	1			1			1		
<Primary	1.61	0.60	4.36	0.55 *	0.27	1.12	2.42 *	0.79	7.44
Primary school	2.14	0.47	9.69	0.62	0.16	2.39	2.79 ***	1.23	6.30
Secondary school +	7.35 ***	2.24	24.11	1.74	0.49	6.20	2.35 **	1.03	5.35
Working	1.35	0.51	3.60	0.97	0.45	2.09	1.80	0.60	5.34
Living standards level									
Low (ref.)	1			1			1		
Middle	2.08 *	0.89	4.85	2.18 ***	1.24	3.84	1.34	0.73	2.48
High	2.70 **	1.04	7.02	2.06 **	0.99	4.27	1.15	0.53	2.53
District									
Kham (ref.)	1			1			1		
Xayphouthong	2.23 *	0.96	5.16	1.28	0.58	2.78	4.69 ***	1.82	12.10

*Note: n=647; N=24,426; *p<0.10 **p<0.05 ***p<0.01.*

In FGDs and KIIs, prevailing attitudes towards persons with disabilities were most evident in discussions about community events. Community events included community meetings, communal work activities and festivals. Meetings referred to regular village meetings, farmers' group meetings, youth organization meetings, women's group meetings, village guard meetings and one-off meetings, such as on women's health, and husband and wife relations in the household (latter assumed to be on gender-based violence). One-off meeting events in villages may be conducted by government outreach workers or NGOs.

Additional community activities included occasional communal village cleaning activities and village road (infrastructure) repair. Festivals included religious festivals and New Year festivals. Drinking parties were mentioned by some men as a part of festival celebrations. The only life cycle event referred to in community discussions were weddings. Community meetings were considered a key event in the surveyed villages and several respondents noted that all households should attend. However, others noted that rarely did a representative from each household attend every meeting. Attendance was considered a matter of personal preference and/or of interest in the topic of the meeting. Community members without disabilities expressed that if something was important they would be informed soon enough by the sub-village head. Some older respondents (without disabilities) also reflected that when they were younger they were invited to community events, but not so often now.

In line with the discussion of community attitudes (Section 8), initial responses in discussions and interviews were that persons with disabilities could participate in community events just like all community members. Later responses during discussions indicated limited participation of persons with disabilities in community events. While physical barriers, including location and mobility restrictions, were noted, other barriers referred to, either directly or indirectly, were attitudinal.

> *"[Persons with disabilities do not normally attend festivals] because, firstly, it's difficult for them to travel. Secondly, because of their disabilities they can't really enjoy the festival, such as eating and drinking, like other people." (FGD, Male caregivers, Xieng Khouang).*

Responsibility concerning the decision to attend, or more commonly not, was often placed on persons with disabilities. That is, persons with disabilities choose not to attend rather than being excluded from attending. However, it was noted that certain persons with disabilities should be excluded:

> *"People who have seizures should stay at home and not go out. They shouldn't [be allowed] to get close to other people in community events." (FGD, Female community members [without disability, Xieng Khouang)*

Other respondents noted that some persons with disabilities did attend some community events. However, another qualified that persons with disabilities may be treated differently if they attend, while suggesting persons with disabilities could actually take it upon themselves to be part of the group:

"If they [persons with disabilities] go to events, we tend to give them separate food on their own. If they want to eat dessert, we will also give this to them separately and ask them to sit somewhere else. But if they want to join us, we will not have any objection. We have to help them and feed them." (FGD, Female community members without disability, Xieng Khouang)

b. Voice in the community & Participation in activities of DPOs

There were large differences between Kham and Xayphouthong districts in terms of participation of persons with disabilities in community activities (Figure 18). Compared with people with no or some difficulties, a higher proportion of people with a lot of difficulties or unable to do from Kham district participated in community meetings or presented opinions on community issues to the village chief personally than those with no or some difficulties. But the opposite tendency was found in Xayphouthong district. Similarly, while there is a higher proportion of people with a lot of difficulties or unable to do participating in activities of OPDs in Kham district, the opposite was found in Xayphouthong district. The proportion of people who said they have participated in these community activities as much as needed were significantly lower in Xayphouthong district compared to Kham district.

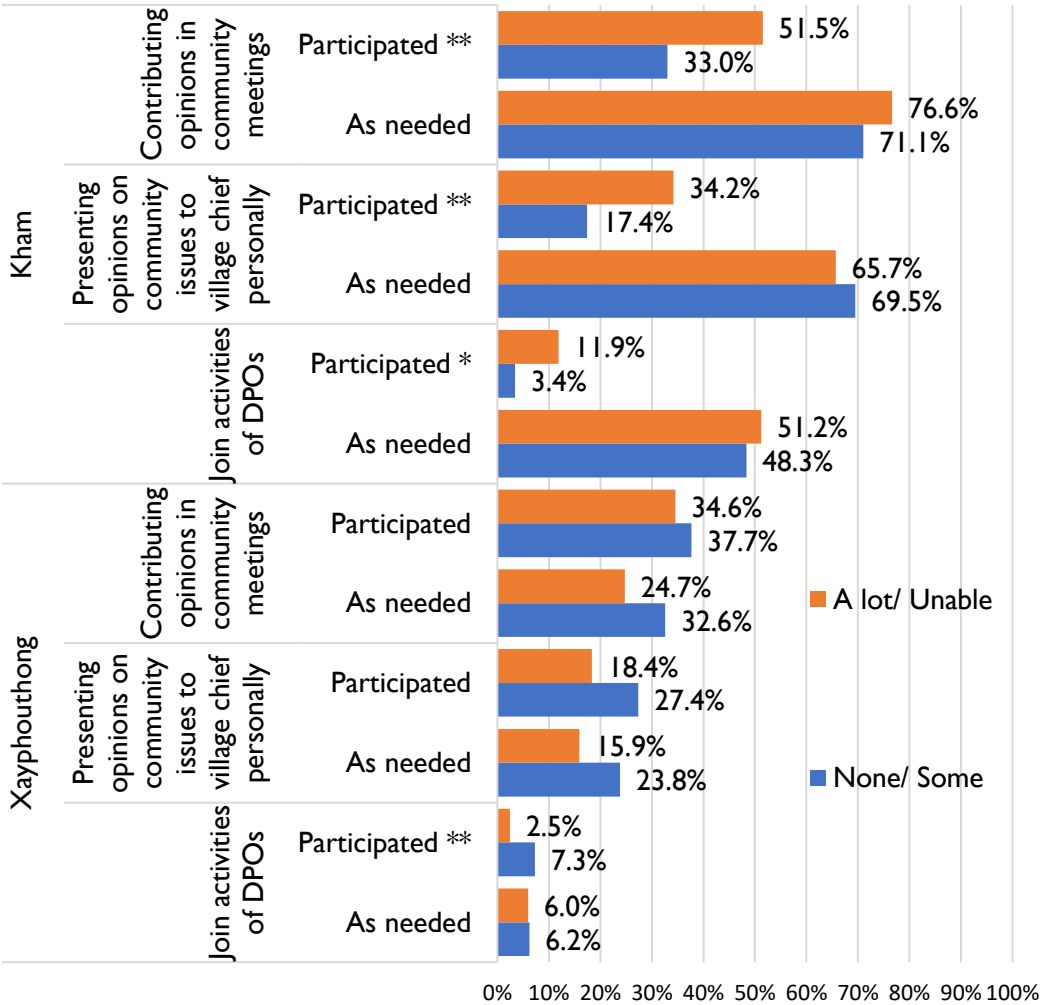


Figure 18: Voice in community & participation in DPO

Note: Participated = Participated in the past 3 months; As needed = Participated as much as needed

Participation in community meetings and contributing voice to the village chief depended on various factors. After controlling for other factors, the likelihood of participation in community activities decreased as the level of functional difficulty increased (Table 17). Those who reported being 'unable to do' in at least one functional domain were the least likely to participate and very few of these people. reported attended community meetings, and none met with village chiefs to share opinions on community issues.

In qualitative interviews, respondents also reflected that although persons with disabilities could attend meetings and events, it was unlikely they would have anything, or be able, to contribute. It was also noted that persons with disabilities may not be invited.

At-risk groups

Increased risk for older women and men due to poor health and difficulties in functioning and isolation due to decreased participation.

Increased risk for persons with disabilities with severe difficulties in functioning i.e.'cannot do at all' in multiple domains and barriers to accessing support and services that meets their complex needs

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Lifelong impact on learning, achievement and employment opportunities due to lack of access to education for school aged girls and boys with disabilities.

Table 17: Factors associated with the voice in community

	Contribute or present opinions in community meetings			Present opinions on community issues to the village head		
	Odds ratios	95% CI		Odds ratios	95% CI	
		Lower	Upper		Lower	Upper
Difficulty level						
None (ref.)	1			1		
Some	0.81	0.31	2.14	0.86	0.36	2.04
A lot	0.73	0.16	3.33	0.55	0.12	2.51
Unable	0.00 ***	0.00	0.16	[a]	-	-
Sex						
Male (ref.)	1			1		
Female	0.64	0.30	1.37	0.61 *	0.31	1.21
Age	1.07 ***	1.03	1.11	1.05 ***	1.02	1.08
Place of residence						
Urban (ref.)	1			1		
Rural	1.05	0.57	1.94	1.75	0.62	4.92
Marital status						
Never married (ref.)	1			1		
Currently married/cohabited	1.79	0.58	5.52	9.30 ***	2.07	41.69
Divorced, separated, widowed	1.29	0.36	4.61	10.19 **	1.13	92.01
Education level						
None (ref.)	1			1		
<Primary	2.99 **	1.00	8.91	1.59	0.53	4.79
Primary school	4.99 ***	2.04	12.23	2.76 *	0.85	8.96
Secondary school +	5.83 ***	1.76	19.26	3.17 *	0.93	10.78
Working	5.15 ***	1.58	16.78	3.31 *	0.88	12.36
Living standards level						
Low (ref.)	1			1		
Middle	2.77 **	1.09	6.99	4.10 ***	1.77	9.50
High	1.26	0.54	2.95	1.62	0.73	3.58
District						
Kham (ref.)	1			1		
Xayphouthong	0.71	0.36	1.39	1.06	0.49	2.29
n	647					
N	24,426					

*Note: [a] None of respondents in this category did this; *p<0.10 **p<0.05 ***p<0.01.*

More than three-quarters of people in both districts did not participate in any local organization or association (Figure 19). One out of five people in the two survey districts participated in mass-organizations, and the proportions of people participating in other organizations/associations were very small (less than 3%). It is important to note that participation in OPDs is nearly zero, but this is expected given nearly absence of OPDs outside the capital city.

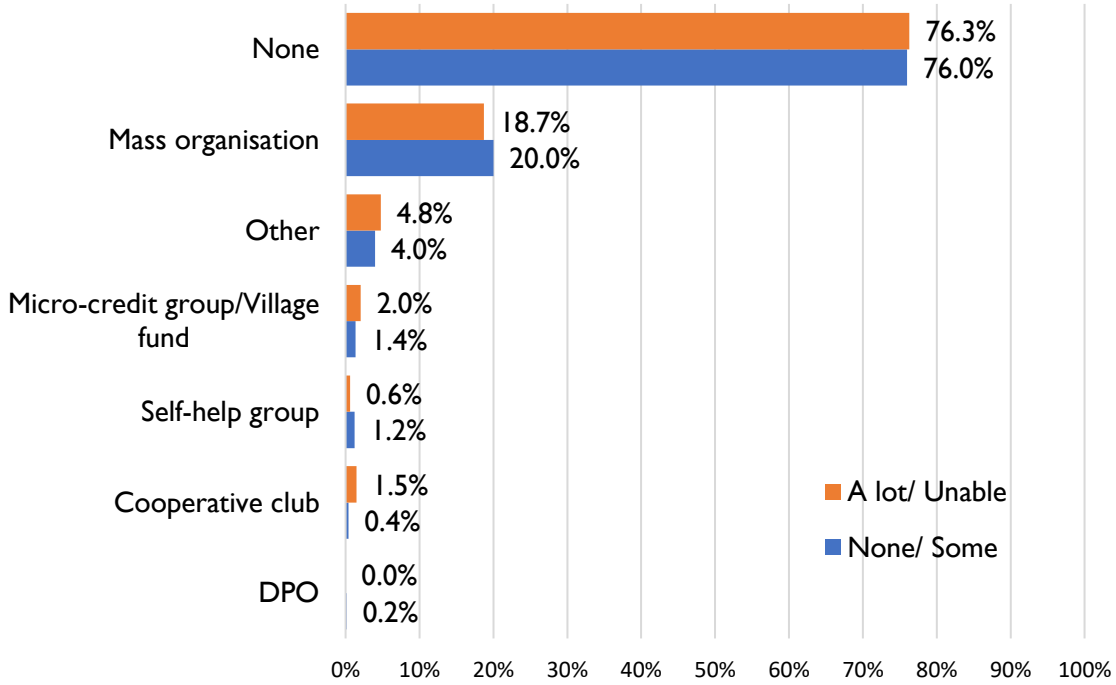

Figure 19: Participation in local organisation/association

Not one person with disabilities reported participating in local organizations or associations. As seen in Table 18, participation in local organizations/associations was not associated with disability. However, people with primary or secondary school education were significantly *less* likely to participate, which is possibly due to the types of activities explored during community groups targeting people with less socioeconomic means, such as groups activities related to self-help or microcredit.. Participants from Xayphouthong district were nearly 3 times more likely to participate in local organizations/associations compared to participants in Kham district.

Table 18: Factors associated with participation in local organization/association

	Odds ratios		95% Confidence Interval	
			Lower limit	Upper limit
Difficulty level				
None (ref.)	1			
Some	0.77		0.26	2.25
A lot	1.18		0.35	3.96
Unable	[a]			
Sex				
Male (ref.)	1			
Female	0.77		0.47	1.27
Age	0.98		0.95	1.01
Place of residence				
Urban (ref.)	1			
Rural	1.45		0.61	3.46
Marital status				
Never married (ref.)	1			
Currently married/cohabited	0.38		0.07	1.89
Divorced, separated, widowed	0.25		0.02	3.01
Education level				
None (ref.)	1			
<Primary	0.32		0.07	1.58
Primary school	0.32	*	0.08	1.26
Secondary school +	0.06	***	0.01	0.29
Working	0.49		0.18	1.37
Living standards level				
Low (ref.)	1			
Middle	0.95		0.43	2.09
High	1.02		0.46	2.28
District				
Kham (ref.)	1			
Xayphouthong	2.92	***	1.45	5.88
n	647			
N	24,426			

*Note: [a] None of respondents in this category participated in this; *p<0.10 **p<0.05 ***p<0.01.*

c. Access to government benefits

About 21.7% of persons with disabilities and 13.2% of persons without disabilities in Kham district respectively had accessed government benefits (e.g. social security fund) (Figure 16). In Xayphouthong district, however, there was no difference in proportions (at around 10 percent) of people with and without disabilities accessing government benefits. Slightly more than half of people in Kham district reported that they have accessed government benefits as much as needed, while this rate was only slightly more than 10 percent in Xayphouthong district. Most common reasons included lack of knowledge about available benefits and how to get them.

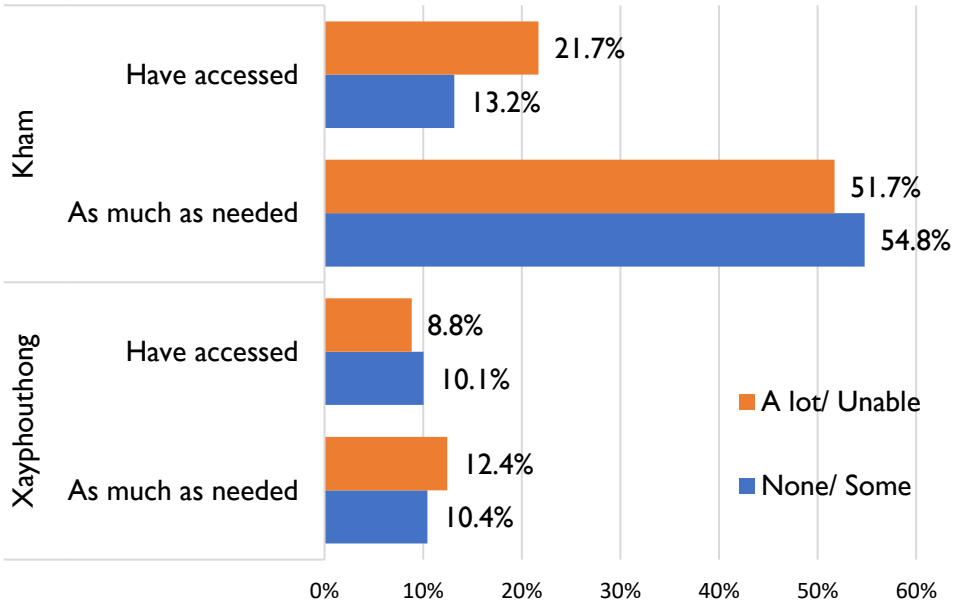

Figure 20: Access to Government benefits

Table 19 reports how different demographic characteristics were associated with poor access to government benefits. Persons with disabilities were more than 4 times less likely to have accessed to government benefits than persons without disabilities despite the probable greater need among that group. People in Xayphouthong district were about 12 times less likely to access Government benefits than people in Kham district.

Table 19: Factors associated with poor access to government benefits

	Odds ratios	95% Confidence Interval	
		Lower limit	Upper limit
Difficulty level			
None (ref.)	1.00		
Some	0.94	0.41	2.14
A lot	1.20	0.57	2.54
Unable	4.27 **	0.87	20.92
Sex			
Male (ref.)	1.00		
Female	1.12	0.67	1.87
Age	0.98	0.95	1.01
Place of residence			
Urban (ref.)	1.00		
Rural	0.85	0.25	2.82
Marital status			
Never married (ref.)	1.00		
Currently married/cohabited	0.80	0.27	2.41
Divorced, separated, widowed	0.63	0.09	4.18
Education level			
None (ref.)	1.00		
<Primary	1.28	0.55	2.97
Primary school	0.70	0.33	1.46
Secondary school +	0.44 **	0.21	0.92
Working	1.14	0.52	2.53
Living standards level			
Low (ref.)	1.00		
Middle	1.49	0.59	3.75
High	0.51	0.17	1.58
District			
Kham (ref.)	1.00		
Xayphouthong	12.42 ***	4.26	36.19
n	647		
N	24,426		

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

Qualitative findings revealed a mixed understanding of the government benefits that may be available to persons with disabilities and their families.

Caregivers of persons with disabilities reported varied knowledge and experiences of accessing government benefits. Some stated that they received some government support whereas others reported that they hadn't received any assistance. There was also a suggestion that those in rural areas received less than those in urban areas.

> *"I am looking after my daughter, she's 9 years old. She has been disabled since she was born. The government hasn't provided any kind of assistance or support to our family, there are only the both of us (parents) looking after her." (FGD, Male caregivers, Xieng Khouang)*

Caregivers expressed that it could be difficult caring for a family member with a disability and a desire to be able to access some supports, with an awareness that this is available in some other countries.

> *"It's quite troublesome to look after a disabled person, but it would be really good if the government can provide some assistance for families that have members with disabilities like the case of my daughter" (FGD, Male caregivers, Xieng Khouang)*

The main government benefit that people reported being able to access was the National Health Insurance, which was mostly understood to be available to all people in Lao PDR once they had completed the appropriate administrative processes. But there were some that believed that national health insurance was not available for persons with disabilities.

> *"The government have the health insurance scheme, but that does not cover for persons with disabilities." (Person with disability, male,)*

It was also understood by some that there are government supports for children with disabilities to access education, through school fee subsidies and providing financial support for materials and clothing.

> *"Recently there is support from the government represented through a scholarship for disabled children." (FGD, Male caregivers, Xieng Khouang)*

> *"For education sector they have a policy for persons with disabilities, such as getting a fee waiver or getting a discount. They also facilitate them by providing materials." (Labor and Social Welfare sector, male, Xieng Khouang)*

There was also a belief that there are income tax exemptions for persons with disabilities that run small enterprises.

> *"The only law that we can see clearly is in income tax. They mentioned that persons with disabilities are all tax exempt for his/her income." (Person with disability, male,)*

Some reported there was a government benefit for people who had been in accidents, as well as specific benefits available for war veterans who had been wounded during military service.

> *"If people had an accident and became disabled, we have accident benefits for the person with disabilities, but the paperwork is needed prior to receiving that sum of money. Person with disability will also get monthly payment which will be calculated in accordance with severity of their disabilities." (Health sector, male, Savannakhet)*

> *"Yes, there is [benefits for war veterans] and this depends on their performance case by case because these people fought for our nation and when they pass away, their families will receive some benefits" (Labor and Social Welfare sector, female, Savannakhet)*

8. Knowledge, attitudes and practice in disability

- Disability seemed to be understood as profound difficulties among a few impairment types. People with psychosocial and intellectual disability appeared to be very poorly understood and highly marginalized.
- People were less likely to report interaction with persons with disabilities in Xayphouthong district than Kham district.
- People with more severe disabilities were less likely to report interacting with other people with disability
- People self-report mostly (but not completely) positive and inclusive attitudes about disability, but these are not reflected in findings about how people are actually included.

a. Quantitative findings

Self-identification of disability

Overall, 8.6% of respondents self-identified as having a disability. The proportion was higher in Kham district (12.4%) than Xayphouthong district (5.5%). Similar difference between the two districts is found for all levels of difficulty.

As expected, people with higher level of functional difficulty were more likely to self-identify as a person with disability. As seen in Table 20, 40.9% and 24.2% of people who reported a lot of difficulty or unable to do in Kham and Xayphouthong districts respectively identified themselves as a person with disability.

Table 20: Self-identification as a person with disability

	Level of difficulty		
	None/ Some	A lot/ Unable	Both
Kham ***			
No	92.7%	59.1%	87.6%
Yes	7.3%	40.9%	12.4%
Refused	0%	0%	0%
Xayphouthong ***			
No	97.3%	73.6%	94.3%
Yes	2.7%	24.2%	5.5%
Refused	0.0%	2.3%	0.3%
Total	100%	100%	100%

Note: $^{***}p<0.01$.

Awareness of and interaction with persons with disabilities

When asked whether respondents from the quantitative survey knew anyone with a disability, around three-quarters of respondents in both districts reported that they knew of someone with disabilities among their family members, relatives, friends, neighbors or villagers. People with a lot of difficulties or unable to do were more likely to know of someone with disabilities, but the difference was statistically significant only in Kham district.

About one-thirds of respondents reported that they knew of a neighbor with disability; but this rate was higher among persons with disabilities (39.3%) while lower among persons without disabilities (26.1%) in Kham district.

Between 6.5% and 14% of respondents in Xayphouthong and Kham districts respectively reported that there was a person with disability among their friends.

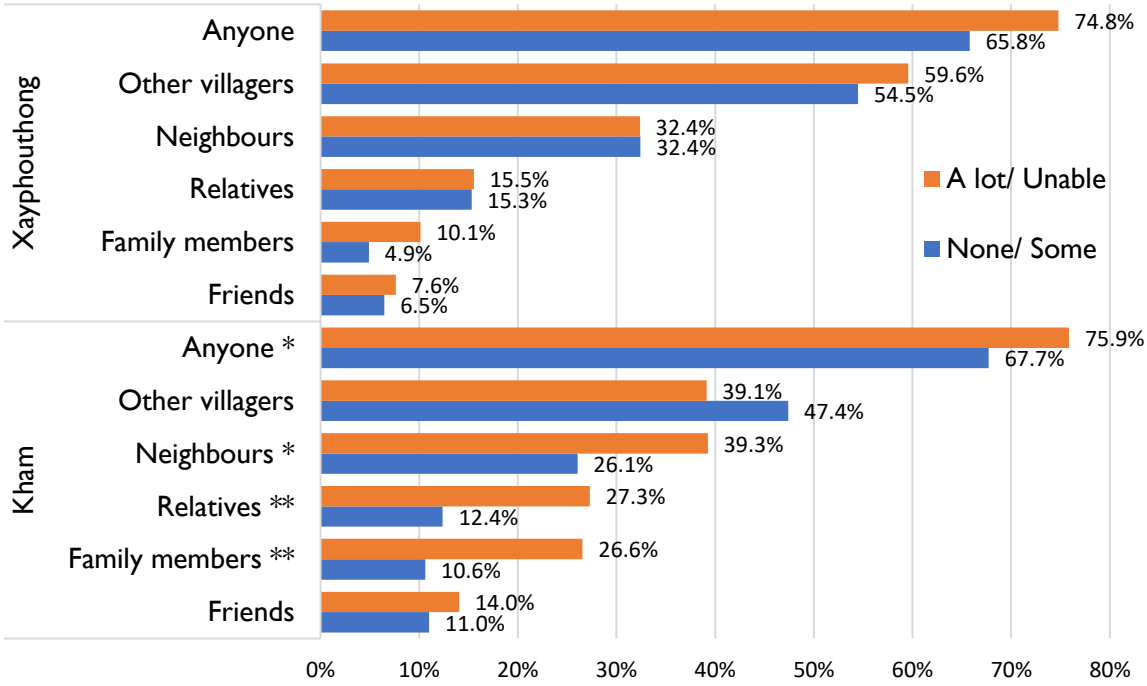

Figure 21: Awareness of persons with disabilities around

Among those who knew of someone with disability, not all of them communicated or interacted with persons with disabilities. About 40% of people in Xayphouthong district and 20% of people in Kham district never communicated or interacted with persons with disabilities whom they knew. In Kham district, the proportion of people who interacted with persons with disabilities were significantly higher among persons with disabilities and those without disabilities.

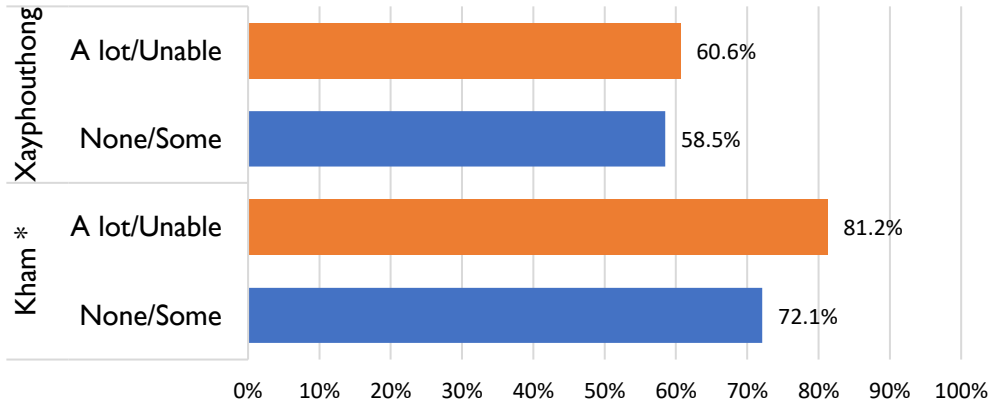

Figure 22: Interaction with persons with disabilities among those who reported awareness of anyone with a disability

Interaction with persons with disabilities was higher for people with 'some' difficulty and 'unable to do' than for people with 'a lot' of difficulty after controlling for other socio-economic factors. People in Xayphouthong district were less likely to interact with persons with disabilities than people in Kham district.

Table 21: Factors associated with interacting with persons with disabilities

	Among everyone			Among those who knew a person with disability		
	Odds ratios	95% CI		Odds ratios	95% CI	
		Lower	Upper		Lower	Upper
Difficulty level						
None (ref.)	1			1		
Some	2.20 *	0.90	5.41	2.87 *	0.74	11.19
A lot	1.53	0.83	2.82	1.60	0.57	4.46
Unable	0.34 **	0.14	0.79	0.54	0.11	2.71
Sex						
Male (ref.)	1			1		
Female	1.01	0.57	1.80	0.93	0.45	1.92
Age	1.02 **	1.00	1.04	1.01	0.99	1.04
Place of residence						
Urban (ref.)	1			1		
Rural	1.41	0.71	2.80	0.88	0.46	1.68
Marital status						
Never married (ref.)	1			1		
Currently married/cohabited	1.13	0.48	2.68	1.62	0.55	4.82
Divorced, separated, widowed	0.45	0.11	1.76	1.24	0.37	4.21
Education Level						
None (ref.)	1			1		
<Primary	1.15	0.69	1.93	1.21	0.45	3.21
Primary school	1.08	0.42	2.75	1.39	0.54	3.61
Secondary school +	1.14	0.53	2.47	1.90	0.55	6.60
Currently working	1.10	0.43	2.81	0.80	0.20	3.18
Living standards level						
Low (ref.)	1			1		
Middle	1.50 *	0.90	2.49	1.64 *	0.83	3.25
High	0.98	0.54	1.77	1.14	0.48	2.70
District						
Kham (ref.)	1			1		
Xayphouthong	0.50 *	0.22	1.13	0.41 ***	0.21	0.77
n	646			432		
N	24,406			16,551		

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

Community attitudes to disability

Positive self-reported attitudes to disability were evident from the quantitative survey. Sorting by proportion of people agreeing to the statements provided, higher proportions (greater than 90%) were seen for statements related to accepting persons with disabilities, but lower proportions on capability and participation of persons with disabilities.

More than 90% of respondents (including persons with and without disabilities) said there would 'be no problem if a person with disability was' either a colleague, neighbor or classmate.

Reflecting on attitudes of others, 85% suggested children with disabilities play equally with others, and more than 95% suggested that health professionals would know what to do if a person with a disability sought their care.

Fewer people agreed with statements concerning persons with disabilities living independently, ability to contribute to their village and having the same opportunities for work as persons without disabilities.

Around 1 in 4 or 1 in 5 people felt persons with disabilities were the subject of jokes and humiliation and that people have negative attitudes towards persons with disabilities.

In general, persons with disabilities were more negative about community attitudes to disability on various issues. This may reflect both external stigma and self-stigma or lower level of self-confidence among persons with disabilities.

Table 22: Proportion of respondent agreed to opinions on disability

Opinion	Kham			Xayphouthong			Total
	None/ Some	A lot/ Unable		None Some	A lot/ Unable		
Health care providers know what to do if a person with disability needs their help	97.3%	97.6%		92.5%	98.0%	*	95.1%
There would be no problem if you had a person with disabilities as your colleague or partner at work	94.3%	90.9%		92.0%	85.9%		92.4%
There would be no problem if you had a person with disabilities as your neighbour	95.2%	82.7%	**	91.8%	89.3%		92.3%
There would be no problem if you had a person with disabilities as your classmate	95.2%	91.8%		89.8%	85.0%		91.7%
Women with disabilities should be able to work	90.3%	87.1%		94.0%	74.1%	* * *	90.7%
In this village, children play with children with disabilities as much as children without disabilities	90.2%	75.1%	**	84.9%	69.6%	* *	85.2%
Persons with disabilities should be able to get married the same as other people	89.1%	85.2%		81.6%	63.7%	*	83.5%
Persons with disabilities should be able to have children	82.5%	83.3%		74.6%	64.5%		77.5%
People in this village frequently support persons with disabilities	84.0%	74.7%	*	69.5%	71.3%		75.6%
Persons with disabilities are able to participate in family income generation activities as much as other members of the family	76.5%	69.8%		73.1%	61.5%		73.3%
Persons with disabilities should be encouraged to live independently	75.3%	83.6%	*	64.7%	75.3%		70.8%
Persons with disabilities make positive contribution to this village	64.8%	66.2%		65.5%	51.2%		64.3%
Persons with disabilities receive adequate benefits from the Government	63.6%	59.1%		64.2%	49.9%	*	62.6%
More women with disabilities than men with disabilities work	59.7%	49.3%	*	66.9%	57.2%		62.2%
Persons with disabilities have the same opportunities to become famous doctor, government staff, business person	72.3%	66.1%		52.5%	63.2%	*	61.8%
Persons with disabilities attend village meetings as much as other villagers	60.5%	51.8%		55.6%	40.7%	*	56.2%
Persons with disabilities are subject to unacceptable jokes, comments, or humiliation	30.0%	32.9%		17.9%	24.9%		24.1%
People in this village have negative attitude towards persons with disabilities	17.5%	33.4%	**	23.7%	26.2%		22.2%

Note: % >=90% are highlighted in green; %>75% and <90% are highlighted in blue.

Community awareness of access to services of persons with disabilities

In the quantitative survey, nearly half of the participants in Kham district thought persons with disabilities could access services about the same as the others. The proportion was slightly lower in Xayphouthong district with nearly one-third responding that persons with disabilities can access services as much as other people in the community. One-thirds to about half of people in both Kham and Xayphouthong districts thought that persons with disabilities can access services, especially paid work and education, less than other people in the community.

Table 23: Proportion of respondents think that persons with disabilities can access services as much as other people

Level of difficulty	None/ Some	A lot/ Unable	Total
Kham district			
Health services			
More	16.5%	15.2%	16.3%
About the same	48.6%	40.6%	47.4%
Less	27.5%	37.4%	29.0%
Paid work			
More	3.7%	7.4%	8.0%
About the same	43.3%	45.9%	43.7%
Less	45.0%	42.9%	44.6%
Education			
More	2.2%	3.0%	2.3%
About the same	51.6%	47.4%	51.0%
Less	44.4%	44.6%	44.5%
Xayphouthong district			
Health services			
More	12.9%	7.7%	12.2%
About the same	40.1%	32.0%	39.1%
Less	34.3%	44.2%	35.6%
Paid work			
More	10.6%	3.3%	9.7%
About the same	28.1%	41.5%	29.8%
Less	53.5%	39.9%	51.7%
Education			
More	7.30%	11.23%	7.80%
About the same	45.45%	39.78%	44.72%
Less	43.1%	32.3%	41.7%
Total	100%	100%	100%

Community self-reported reasons for disparities in access to services

The main reasons perceived by the participants for poorer access to health services for persons with disabilities included the absence of services or facilities, lack of assistant to accompany them to health facilities, physical accessibility (accessible transportation and distance to services), indirect costs, and lack of information. Similar reasons except direct costs were given as main reasons for poorer access to paid-work for persons with disabilities. For education, the main reasons for poorer access were due to disability, poor health, lack of means of transportation, and lack of proper teaching aids and approaches.

Table 24: Perceived reasons for persons with disabilities accessing services less (2 districts combined)

Level of difficulty	None/ Some	A lot/ Unable	Total
Health services			
No healthcare services/facility	27.4%	32.9%	28.3%
Lack of assistant to healthcare facility	25.2%	34.0%	26.7%
Transport is not accessible	24.9%	32.8%	26.3%
Too far	20.3%	23.7%	20.9%
Could not afford indirect costs	17.5%	22.6%	18.4%
Lack of information/do not know where to go	17.9%	16.0%	17.5%
No transport available	13.8%	11.3%	13.3%
Could not afford the cost of healthcare	10.6%	19.7%	12.2%
Do not like attitudes of staff at health facility	5.0%	0.3%	4.2%
Absence of reasonable accommodation at healthcare facility	3.6%	0.9%	3.1%
Family did not want them to visit	2.3%	6.7%	3.1%
Do not like attitudes of others at health facility	1.6%	0.3%	1.4%
Was previously badly treated	1.3%	0.3%	1.1%
Tried but denied at healthcare facility	0.0%	4.6%	0.9%
Other	8.6%	9.0%	8.6%
Don't know	9.0%	4.1%	8.2%
Paid work			
No opportunities	35.5%	55.0%	37.9%
Means of transportation is not accessible	16.0%	16.8%	16.1%
Lack of assistant to work place	15.8%	16.8%	15.9%
Lack of job placement/support services	15.5%	16.6%	15.7%
Difficult applying for a job	16.0%	11.2%	15.4%
Lack of employment information	13.6%	16.7%	14.0%
No transport available	13.6%	11.8%	13.3%
Too far	12.8%	7.6%	12.2%
Absence of reasonable accommodation at workplace	9.7%	0.1%	10.0%
Family did not want them to work	8.5%	10.2%	8.7%
Do not like the attitudes of others	2.8%	7.2%	3.4%
Could not afford the cost of transport	2.6%	3.9%	2.7%
Not interested in work	2.4%	3.5%	2.6%
Other	21.4%	17.0%	20.8%

Level of difficulty	None/ Some	A lot/ Unable	Total
Don't know	7.7%	2.2%	7.0%
Education			
Disability	62.2%	67.3%	62.8%
Poor health	30.0%	52.1%	32.7%
Means of transportation is absent or difficult to use	26.9%	18.3%	25.8%
Absence of specific teaching aids and approaches	15.9%	18.3%	16.2%
Absence of personal assistance	13.7%	11.2%	13.4%
Family has difficulty assisting them to go to school	11.7%	12.4%	11.8%
School is not physically accessible	10.1%	12.8%	10.5%
School is too far away	9.4%	7.6%	9.1%
Cost of attending school	5.8%	11.7%	6.6%
Difficult road conditions to school	4.9%	8.0%	5.3%
Taking care of family	5.6%	2.6%	5.2%
Family did not want them to go to school	4.0%	7.4%	4.5%
Needed to get paid job	4.2%	2.6%	4.0%
Treated badly at school	2.6%	1.7%	2.5%
Being expelled from school	0.0%	0.1%	0.0%
They reached the level that they wanted			
Other	4.2%	1.6%	3.9%
Don't know	11.0%	0.0%	9.7%

Note: Sorted by % in total column in each domain; % >15% are highlighted in orange.

b. Qualitative findings

In previous sections, qualitative findings of community knowledge, attitudes and practices specifically relating to access to services (education, health care, rehabilitation and assistive products) and social participation (festivals, community meetings, family gatherings) for persons with disabilities have been described. This section focuses on the knowledge, attitudes and related behaviors towards disability more generally within the community, with a particular focus on the perceptions of community members both with and without disabilities. It is assumed that these findings may impact on interventions to improve practices of service delivery.

Community knowledge about disability

Qualitative interviews identified that persons with disabilities as a group were viewed as different and distinct from most persons without disabilities. Respondents described their understanding of disability in terms of impairments; however, this was largely limited to visible physical impairments, vision impairments, and people who are deaf or hard of hearing.

Respondents from all groups were able to identify that they were aware of persons with disabilities living in their community, although again predominantly referred to people with vision, communication and physical impairments. The presence of people with psychosocial disabilities were generally only discussed following prompting from the interviewer after other impairments had been identified. People with possible psychosocial disability in the community were variably described by respondents in terms of behaviors such as *"wandering along the roads", "slow learner", "cannot concentrate"* or *"poor socialization"*.

Knowledge and awareness of psychosocial disabilities thus appeared particularly poor, both among community members with and without disabilities. These were sometimes referred to as "brain impairment" or "brain disabilities", with no clear differentiation between intellectual disability and the disabling effects of mental illness.

Limited knowledge and poor understandings of psychosocial disabilities and individuals with epilepsy may be contributing to particular discrimination against the individuals concerned. For example, there was a dominant view reported that epilepsy is contagious.

> *"That person should be discriminated as epilepsy is incurable and it can be contagious. So they should be restricted not to attend events." (FGD, Male caregivers, Xieng Khouang)*

There was a sense among respondents that those with a person with disabilities in their family were more likely to have a better understanding of disability, while others found it harder to express how they understood the concept of disability.

> *"I don't really know the detailed definition of the disability and understand that it's difficult to define what it is." (FGD, Male caregivers, Xieng Khouang)*

> *"Q: Do you think people in the village know the word" disabilities"? A: Some may not know because they don't have it happened to their family" (FGD, female caregivers, Savannakhet)*

Some described disability in terms of people being "sick", and others as being an experience of "feeling pain". There was some understanding from discussion in one FGD that disability can present differently in different people.

> *"Persons with disabilities are different from one to another .It could be the arms and legs disabled, such as his daughter who can't walk…..There are number of problems that disabled people have" (FGD, Male caregivers, Xieng Khouang)*

There was some knowledge amongst respondents of the varying causes of impairment , that is that some people are born with impairments and some have impairments due to injuries or illnesses and infections.

> *"Some people were paralyzed at birth and some elder people fall down by accident and became paralyzed……. Some people were blind at birth and some had gotten infectious flu and became disabled after" (FGD, Female community members without disability, Xieng Khouang)*

Additionally, there was some knowledge that one type of impairment (e.g. difficulty walking) may be due to a number of different causes (e.g. polio, amputation, condition from birth).

However, there was also a common belief that disability is a result of sin or negative past karma.

> *"[If] person have disabilities since birth they will think that it is a sin or a karma from the previous life, as they may done something wrong. But after, they have accident and become disabilities they also will think it is a sin of that person or his/her family" (FGD, CBID workers, Xieng Khouang)*

There was little evidence of a recognition or understanding that persons with disabilities have agency or the capacity to change their situation or lot in life. Instead disability was reported in terms of being an inevitability, for example:

> *'We help as much as we can, but it [their fate] is what they [persons with disabilities] are." (FGD, Female community members without disability, Savannakhet).*

At-risk groups

Barriers to accessing vocational training for woman with disabilities leading to lower skill levels and decreased opportunities for income generation

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Younger women and men with disabilities facing barriers to accessing quality work putting them at greater risk of poverty

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Community attitudes to disability:
Framing responses on attitudes

Attitudes to disability were explored through discussing persons with disabilities' access to services, and their participation in employment and community activities and events, alongside some more direct questioning on discrimination. This was to provide a tangible context and starting point for respondents to voice their awareness or opinions about the experience of persons with disabilities, and to help avoid self-censoring that can result from direct questioning on potentially sensitive issues such as disability.

In FGDs and KIIs, initial responses relating to community attitudes to disability painted a positive picture. These initial responses did not differ greatly from the, generally, positive attitudes identified in the quantitative survey (as above). Respondents reported that persons with disabilities were not discriminated against and that persons with disabilities were 'the same as others' and that respondents did not treat persons with and without disability differently. However, more nuanced and contested attitudes emerged as discussions progressed.

Respondents reflected on how persons with disabilities were sometimes considered 'incomplete' and not whole or, at times, weak or sick. Ideas of incompleteness were not only in terms of physical attributes, such as a 'missing body parts', but also in terms of persons with disabilities' ability to participate in everyday activities.

> *Q: "Do you know why they did not want you to join [school]?"*
>
> *A: "I don't know….because I am not complete like others" (FGD, Males with disabilities, Savannakhet)*

In turn, these understandings were extended to the social sphere with persons with disabilities considered unable to contribute to household or community life and being a burden for their families.

> *"Our relatives may visit us once in a blue moon. But we have to provide care every day [to respondent's father]. They [the relatives] don't come because they have already assigned that burden to us". (FGD, Male caregivers, Savannakhet).*

Understandings of disability were frequently framed in terms of pitying persons with disabilities or seeing disability in line with a charity model of disability. While there was no evidence from FGDs and KIIs at the community level of what may be considered more rights-based understandings, there was some acknowledgement that children with disabilities should be able to go to school and that some, but not all, persons with disabilities can work.

It was also the case that 'distancing' or 'deferral' would be used as strategies in discussion of attitudes. For example, it was not uncommon to hear: 'people may discriminate against persons with disabilities in that village over there, but not here'. This distancing indicates that certain attitudes and behaviors towards persons with disabilities were present, even if elsewhere, but may be interpreted as unreasonable by peers or outsiders – including interviewers. Such tensions were evident in discussions that related to attitudes and behaviors towards persons with disabilities.

"In our village we do not bully each other whether people are blind, deaf, or [have an] intellectual [disability]. We just feel pity for them [persons with disabilities] and would like to help them." (FGD, Male community members without disability, Savannakhet.)

Stigma and prejudice

Despite the outward facing positive messaging from respondents that persons with disabilities are treated the same as persons without disabilities, stigma and prejudice against persons with disabilities in the target communities was common.

A 'hierarchy of prejudice' emerged from discussions. Amputees, and particularly war veterans, were often considered more accepted and likely to participate in community life, including meetings, work and celebrations. It is also notable that the (male) head of one village surveyed had a physical impairment. People with visual or hearing impairments and the deaf were considered less able to participate and contribute to community life. People with psychosocial disabilities were the most prejudiced against of all. Although, not frequently mentioned this extended to the practice of caging people with psychosocial disabilities.

"Most of the time it's [the discrimination is targeted to] the ones who can't control themselves, and they have to be tied or caged." (FGD, Male community members without disabilities, Savannakhet).

The stigma associated with disability is not limited to perceptions of the individual with disability. Discussions showed that stigma extended to the family directly, understood as a result of past sins or karma, or can be extended to other people in the community simply by association.

"I feel pity for them [persons with disabilities], but I also used to be afraid of being like them [acquiring a disability]. I definitely kept myself away from them [persons with disabilities], because [they are] contagious. I was taught to think like that. There was one family where I'm from, the son has severe disabilities, and his mother opened a noodle shop. But very few people visited her shop. They were afraid that they would get bad luck from interacting with that family." (FGD, CBID workers, Savannakhet)

As noted previously, some community members reported that either they themselves, or other people, hold the belief that disability could be contagious. While this was particularly noted as being the case for people with epilepsy, the idea that disability could be passed on by physical contact or by proximity was extended beyond individuals to the source of individual's livelihood, and by association existence:

"I used to be a vocational skills trainer for persons with disabilities. I trained persons with disabilities on how to take care of livestock. We had a study visit to a village near the training center. The villagers reacted in very negative way. They told everyone else in the village they should keep their animals away from the persons

with disabilities because they [the animals] may catch some disease from them [persons with disabilities]." (FGD, CBID workers, Savannakhet)

Self-perceptions

In general, respondents with disabilities and caregivers were negative about their situation and how they were treated. Implications and limitations to having a disability were accepted.

> *"I am a bit disappointed because I never expected that my child would be born with a disability. I wish they [my child] could be as healthy and complete as others [children without disability], but we don't have a choice." (FGD, Female caregivers, Xieng Khouang).*

In discussions, caregivers of persons with disabilities noted how other community members without disabilities would feel 'disgusted' when they saw them with their child. Some respondents reflected that they accepted this practice, or at least did not wish to argue, stating variously:

> *"I have no arguments with them" (FGD, female caregivers, Xieng Khouang)*

and

> *"I [also] don't want to argue because it is true that my child is a disabled person." (FGD, Females caregivers, Xieng Khouang)*

Another woman with a disability reflected that when she had been 'bullied' and 'ridiculed' she could not help but feel upset. '*I didn't want to [feel upset], but it just happened.'*

However, several persons with disabilities reflected they would like to be 'better' or able to do things that persons without disabilities can do, particularly in terms of work.

> *"I am not very satisfied because I could not work as much as normal people. I am not satisfied because I could not work, I want (to be) like normal people" (FGD, Male with disability, Xieng Khouang)*

A few respondents indicated directly and indirectly of how stigma and prejudice was internalized and impacted on their self-esteem. As one man with a disability (male) reflected, he did not go, and did not want to go to school, because he was 'stupid'. A respondent with a disability recalled she had been to a community meeting but:

> *"I just listened. Although I wanted to speak, I wasn't brave enough because I was scared, I might say something wrong […] I am scared that when I speak, other people will interpret it [what I say] in other ways." (FGD, Females with disabilities, Savannakhet)*

In short, stigma and prejudice seemed common in Kham and Xayphouthong districts and may be contributing to the disempowerment of persons with disabilities.

c. Community practices and behaviours toward persons with disabilities

Language and labelling

It was noted that persons with disabilities would usually be verbally 'stamped', or labelled, as having a disability. That is, people are defined by their impairment. Persons with disabilities confirmed it was common to be referred to by their impairment, for example: 'cleft lip person', 'Mr. Broken Leg' or 'Mr. Blind'. During discussions, people with psychosocial disabilities would be referred to as 'mad', someone who has 'lost their mind', or 'crazy'.

> *"They [people in the community] think person with intellectual disabilities are crazy, and they do not respect" (FGD, Male community members without disability, Savannakhet)*

Making jokes at the expense of persons with disabilities was commonly reported. This was justified in a number of ways. For example:

> *"Some people may call them [persons with disabilities] names, but it's not serious or an insult […] it's alright." (FGD, male caregivers, Savannakhet).*

Alternatively:

> *"[…] it's not like they [the name callers] hate persons with disabilities." (FGD, male community member without disability, Savannakhet).*

One respondent noted that name calling depended on the age, with older and presumably more respected individuals less frequently subjected to name calling:

> *"It's only the young ones [persons with disabilities] who are called names, not the old ones." (FGD, Female caregivers, Xieng Khouang).*

Persons with disabilities indicated that name calling and being made fun of did not upset them, however, one person noted that they "made up their mind not to be upset", hence indicating that this may not have been their initial response but they felt they had to make an active choice to accept this behavior.

> *"When I go here and there, my friends also make fun of me like calling me 'Mr. blind' but I was not upset (he said with laughing)" (FGD, Males with disabilities, Xieng Khouang)*

> *"Sometimes they can make fun of me like Mr. broken leg, or arm impairment, what are you doing here?... But I feel nothing because I know that they are just making fun of me. I don't feel anything I am an easy person. I make up my mind not to be upset." (FGD, Males with disabilities, Xieng Khouang)*

Bullying and exclusion

Aside from name-calling and labelling, qualitative findings provided some insights into the behaviors experienced by persons with disabilities, both positive and negative.

Many respondents stated that persons with disabilities were treated the same as all other people in the community. However, this idea ran counter to many statements that indicated evidence of bullying and exclusion of persons with disabilities.

One caregiver noted she was afraid for her child to attend school, and a CBID worker noted that it is common children with disabilities do not go to school due to bullying based on their physical appearance and differences.

> *"When the child with disabilities go to school, they may experience bullying from other friends or someone in school, and that make they feel that going to school is unpleasant so their parents might decide not to send them to school." (FGD, CBID workers, Savannakhet)*

Other respondents referred to persons with disabilities being imitated by others, people playing jokes on them, being stared at when out in public, being shouted at or chased away.

> *"If person with disabilities go to the noodle shop, there will be a moment of silence when everyone stares at that person with disabilities." (FGD, CBID workers, Savannakhet)*

These behaviors appeared to be particularly prevalent towards people with psychosocial disabilities, with a sense of people in the community avoiding interactions with people with psychosocial disabilities.

> *"Based on what I see, for someone from my village who has mental disabilities, when he walks past the ceremony at someone house people will shout at him and chase him to go away." (Person with disability male, Savannakhet)*

> *"Some people said just stay away from this madman, he may hit you" (FGD, male caregivers, Savannakhet)*

Additionally, there was evidence of persons with disabilities being excluded from public places as a result of bullying and intimidatory behaviors by community members.

> *"I have experience when the shop owner chases a person with disability away, as he comes early and brings a bad omen to her shop on that day" (Health sector, male, Savannakhet))*

> *"It was in the temple, and he chased the person with disabilities to go away because he felt that person with disabilities is dirty" (Health sector, male, Savannakhet)*

The findings also suggest that assumptions are made about what persons with disabilities can and cannot do and are subsequently excluded from participating in community activities and social occasions such as meetings and weddings.

> *"For example, in the wedding, and the person with disabilities are not invite, but he would like to join, when he tries to get in he will be ask to move out." (FGD, CBID workers, Xieng Khouang)*

"I think because we are disabled and [people think] we cannot do anything and go anywhere. When they need to do something, they would never mention about us or ask us to help" (FGD, Males with disability, Xieng Khouang)

Empathy and a desire to help

In contrast to the many negative behaviors experienced by persons with disabilities, there was also evidence of positive behaviors and interactions exhibited towards them by others in the community. Caregivers reported generally feeling a sense of empathy from others in the community:

"As, I have a disabled daughter, people are empathetic for the hardships we face." (FGD, male caregivers, Xieng Khouang)

Other stakeholders identified a sense of responsibility to initiate interactions with persons with disabilities to facilitate inclusion.

"Many times, these people they feel embarrassed they have disabilities they don't dare to go out, we have to approach them and make them feel comfortable" (Health sector, male, Xieng Khouang)

Several respondents described offering assistance to persons with disabilities that they come across in their community. For example, the following statements were made by participants during FGDs involving community members without disabilities:

"Participant 1: If I encountered an elderly man who has legs pain then I would go and help.
Participant 2: I help out by leading the way for them if they are blind, helping them to cross the street, or if they call upon me then I'd also help."

And:

"When we see children with disabilities, we want to give them food and snack, unlike meeting person without disabilities. Because you obviously see that they born different and need some help."

Although there was an acknowledgement that others in the community may not do the same or want to help or interact with persons with disabilities but feel unsure of how to do so.

"We see persons with disabilities, like the old blind guy, he is already very old, and I don't know what to say to him" (Health sector, female, Savannakhet)

Knowledge, attitudes and practices in communities on disability

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Limited knowledge and awareness about disabilities especially psychosocial disabilities and persons with disabilities experiencing stigma, prejudice and discrimination.

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V. Discussion of key findings

This baseline survey was undertaken to support planning interventions for the CBID projects in Kham and Xayphouthong districts by providing robust data concerning the impact of disability on social participation, access to services and on social attitudes to disability.

In Kham and Xayphouthong districts, persons with disabilities had significantly poorer access to health, education and employment sectors and lower participation in the community compared to persons without disabilities. Strong associations were found between disability and socio-economic factors such as age, living standards, education and employment. Further, key barriers were identified related to community attitudes, disability awareness in the community, lack of opportunities for persons with disabilities and costs for accessing services and participating in the community for persons with disabilities. There were complex and unexpected interactions between disability, education levels, and community participation. These key findings are discussed below with their implications for planning CBID interventions in the two districts.

There were significant differences in disability prevalence and proportions of people accessing services or participating in the community in general between Kham and Xayphouthong districts. These differences could possibly be explained due to the geographical and socio-political differences between both districts. Xayphouthong district is in Savannakhet province which has better infrastructure and services. Savannakhet province likely has better opportunities for accessing services compared to Kham district which is remote with limited infrastructure and development.

1. Prevalence of disability and its impact

a. Disability prevalence

The prevalence of disability was 13.3% and 9.9% in Kham and Xayphouthong districts, respectively, with a combined prevalence of 11.7%. These prevalence estimates are much higher than the previous estimates at 1.3% in the 2005 census and 2.8% in the 2015 census [5]. The lower estimates from the census surveys are due to the method of data collection used. In the 2005 census, self-identification based on impairments was used. This method has been proven to result in lower estimates of disability [7]. Although the WG Short Set of disability questions were used in the 2015 census, a representative of the household responded to the questions for all individuals in the household. This is likely to have resulted in a lower estimate in the 2015 census. This survey estimate is similar (10.8%) to a disability survey conducted in 2016 in Vientiane, Savannakhet and Sayaboury provinces which also used the WG questions asked at the individual level [8].

In this baseline survey, self-identification of disability was also investigated for comparison (Section 8a). Only a little more than one-third of persons with disabilities from Kham district and nearly a quarter from Xayphouthong district identified using the WG questions self-identified as a person with disability. Questioning on self-identification often captures obvious and severe disabilities and responses could be biased by various factors, such as stigma and awareness or knowledge of disability [7, 9]. Psychosocial disabilities are poorly understood. Interviews and focus groups revealed limited community knowledge about psychosocial

disabilities, whereas most participants identified visible impairments such as physical, vision and hearing as disability (section 8b).

The most commonly reported functional difficulties were seeing, walking and remembering in both districts. In an earlier study, Thorsen et al. reported 2.6% of their sample from three provinces in the Lao PDR had cognitive difficulties based on the responses to the WG questions on remembering or concentrating [10]. They also reported a strong association between cognitive difficulties and ageing with 10.2% of adults aged 60 years and over reporting 'a lot of difficulty' on this item. Thorsen et al. also identified poor understanding and stigmatization of people with intellectual/cognitive disabilities and the need for raising awareness and expanding services in Lao PDR. The quantitative and qualitative findings from our survey support these findings on the need to improve awareness in the community in general about less obvious or hidden disabilities such as psychosocial disabilities.

People who experience functional difficulties commonly do not self-identify as a person with a disability. This underscores a need for individualized approaches, and that people might need, want and benefit from services independent of how they identify. This is consistent with the CBID approach, which is both sensitive to persons with disabilities (who identify as such) and others who experience functional difficulties but do not identify as having disabilities. This is distinct from approaches that use self-identification or government certification as a starting point for allocating services.

Finally, while disability prevalence is based on 'a lot of difficulty' or 'cannot do', at least 20% of the population also experienced at least 'some' difficulty in any one domain. This is potentially an important group for CBID and other services. Generally speaking, it is likely that people with more serious self-reported difficulties will be the priority for most programs, but this should not dismiss the needs of people with less severe difficulties, especially those who have progressive health conditions or who experience multiple difficulties.

b. Socio-economic factors associated with disability and their implications

The prevalence of disability was strongly associated with age, being unmarried, poorer health and wellbeing, lower levels of education, unemployment, and lower living standards. The prevalence was similar for males and females and for those living in urban and rural areas.

Age

As seen in Figure 4, the prevalence markedly increased with age in both districts. The disability prevalence was higher in Kham district than in Xayphouthong district, which could be due to the differences in the age distribution in both districts. There were more people in older age groups in Kham district reporting higher levels of difficulty than in Xayphouthong district (Figure 4).

Lao PDR is experiencing a demographic shift as evidenced by the 2015 census report [5]. The population aged 15-64 years has increased from 54% in 2005 to 64% in 2015. Life expectancy has also increased from 59 years in 2005 to 62 years among males and from 63 to 65 years among females in 2015. There is also increasing migration of young individuals in Lao PDR for education and employment. This type of demographic shift might result in older

people mostly living on their own and missing out on traditional family support. This type of demographic shift is similar to many other low- and middle-income countries and calls for strategies for health and rehabilitation systems, particularly at primary and community level to support older persons experiencing difficulties in functioning due to ageing and older persons with disabilities.

Health

A larger proportion of persons with disabilities reported poorer health compared to persons without disabilities. This finding was further supported by a higher need for healthcare services among persons with disabilities compared to persons without disabilities. However, there was no difference found between persons with and without disabilities accessing healthcare. While this is a promising finding in terms of accessible health, access alone does not indicate the appropriateness and effectiveness of that care or whether it is what people need. This is particularly the case for people with functional difficulties who might require more complex and long-term care, or who require services that are unlikely to be available in traditional healthcare settings. Further, barriers to accessing health services were different for persons with and without disabilities. Accessible transport, absence of appropriate services, costs and staff attitudes were important for persons with disabilities, but not for people without difficulties who were unable to access health care. Service providers acknowledged their limited knowledge and skills for managing patients with different types of disabilities.

Further to general healthcare needs, this survey has identified that most persons with disabilities were unaware of what rehabilitation was. Most rehabilitation services are based at the provincial level making rehabilitation inaccessible for many. Similarly, assistive product services are also available in urban settings making it difficult for those living in rural areas to access them and to receive support for maintenance and ongoing management. People in Xayphouthong district were around 2.6 times more likely to use assistive products than in Kham district, which may be due to better services in Xayphouthong district. Access to assistive products was low among persons with disabilities in both districts. A little over a quarter of persons with disabilities used an assistive product and it was more common among those with some difficulty in functioning. Not everyone with functional difficulties requires an assistive product, but access to assistive products was poor overall, particularly for those who need them the most.

These findings on health and rehabilitation are in line with recent systematic reviews from 127 low- and middle- income countries, which highlight that persons with disabilities experience higher health care needs, but poorer coverage and more healthcare expenses compared to those without [11]; and have poorer access to rehabilitation and assistive technology [12]. Disability-related skills and information is often missing in professional healthcare training in many countries [13]. Findings from this baseline survey and reports from other low- and middle-income countries emphasize the need for immediate actions for improving healthcare systems and policies. It is critical to ensure equal access to health care and reduce barriers for persons with disabilities as part of the Universal Health Coverage agenda and to achieve Goal 3 of the United Nations Sustainable Development Goal 3 (*ensure*

healthy lives and promote well-being for all at all ages). Kuper and Heydt [13], recommended health worker training on disability, health provider accessibility audits, and making health information accessible as some of the immediate actions that could be considered to ensure disability inclusion in health.

Using a common measure of likelihood of depression, this study found that depression was uncommon overall, and that there were no differences between persons with and without disabilities. The lack of relationship between functional difficulties and depression was unexpected; a previous multi-country study using a similar metric of depression [14] found that in all countries combined, the likelihood of depression is associated with physical health, and people with physical impairment in Lao PDR specifically were about 5 times more likely than others to report depression. It is probably self-evident that any CBID programming that does not take mental health into account is incomplete. However, these findings suggest that for most people who are likely to be CBID participants, other concerns and barriers to participation might be more common, but mental health and psychosocial support should remain an important aspect of programming. This finding further reinforces the merit of good screening to systematically understand peoples' overall health and functioning experience before carefully refining individualized interventions to make the best match of available resources for the most important needs.

Education and employment

Persons with disabilities were less likely to attend school in both districts and lower education level was strongly associated with having a disability. Being poor and being female were also independently associated with lower education levels. These findings are in line with current evidence from other countries [2]. As identified in the 2015 census, women in general were less likely to have higher education levels in the two districts surveyed [5]. Although we were unable to test for interactions in the regression models, it is reasonable to conclude that women with disabilities are more likely to be deprived of attaining higher levels of education. This survey has identified that those with higher levels of schooling were more likely to be employed, suggesting the importance of education for being financially independent.

Focus groups and in-depth interviews helped us further understand more about the barriers for persons with disabilities attending school. Although initial community attitudes were generally positive for children with disabilities attending school, further exploration in FGDs and KIIs highlighted that stigma and prejudice are one of the main challenges for sending children with disabilities to schools. Caregivers and persons with disabilities expressed fears of bullying at school from other children and believed that children with disabilities cannot go to school and that they should be separated from other children. This finding was also supported by adult participants with disabilities who shared experiences of their families not being supportive of them attending school due to their poor awareness and negative attitudes. The survey also identified other barriers such as inaccessible school facilities, difficulties travelling to school and families' low economic status in both quantitative and qualitative components.

Findings reveal that there was no difference between the proportions of people with and without disabilities working, but persons with disabilities are less likely to be paid. This points to the importance of ensuring safe, dignified and equitable employment, rather than a focus on ensuring persons with disabilities can work at all. This finding could be associated with perceptions that persons with disabilities are unhealthy and therefore unfit for work. There was also little awareness of what types of work persons with disabilities could do, with limited options suggested by respondents – so while persons with disabilities do have employment, social norms and poor knowledge about inclusive work appear to constrain the types of opportunities available.

Barriers to work are not limited to people with personal experience of disabilities. Caregivers of persons with disabilities face difficulties in being able to work away from home and limiting the type of work they can do. This finding on the financial and work impacts for caregivers is not uncommon, even in high-income countries. Organization for Economic Co-operation and Development (OECD) reports suggest that caring activities have negative impacts on household income, continuation of careers and job choices [15, 16]. Although this survey did not directly target caregiver challenges, evidence from the current literature suggests that caregivers of chronically ill family members experience poor mental and physical health [17, 18]. Qualitative findings from this survey provide some indication that caregivers of persons with disabilities experience challenges to their emotional well-being and support findings from the wider literature. These findings justify the CBID project's focus on caregiver wellbeing. Information from the Modular Tool will be used for individual level assessment of needs and caregiver needs to further inform the current situation of caregivers in the two study locations.

Poverty

Socio-economic status was measured indirectly based on the living standards of the household in this survey. This methodology is commonly used in surveys including the Demographic Health Surveys and Living Standard Surveys. Lower living standards were associated with disability in this survey supporting the current evidence on poverty and disability. Further, lower living standards were independently associated with lower levels of education, less likelihood of having undertaken vocational training, unemployment and more likely to experience poor wellbeing. While we did not analyze interactions between having a disability and poverty with other factors and did not have data to study causality, it is reasonable to assume the findings are supportive of the theory of a cyclical relationship between poverty and disability. Economic empowerment is one of the major components of USAID Okard's Activity and findings from this baseline survey justify the need for financially empowering persons with disabilities in the two districts, specifically targeting most at-risk groups among persons with disabilities overall.

2. Community participation

Participation in social activities and having a voice in community decision making were associated with having no disability, higher levels of education and having higher living standards. This association highlights intersections between wealth, education, and disability.

Persons with disabilities, in general, participated in fewer social gatherings and community activities in both districts. Qualitative findings suggested that negative attitudes in the community largely contributed to persons with disabilities not participating in community events as they were treated differently or sometimes considered they should not participate, for example, due to their health conditions such as epilepsy (believed as contagious).

In Kham district, persons with disabilities were more likely to report they contributed to community meetings compared to persons without disabilities. Whereas in Xayphouthong district, participation overall was lower. These findings could be explained by different local political structures and engagement in the two districts, with more effective measures to engage with people in general, and specifically persons with disabilities in Kham district. Another likely contributor is the association between age and participation, with older people possibly more likely to participate in community activities. Disability being strongly associated with age, there is a possibility that older persons with disabilities were participating more in community activities. Controlling for individual characteristics including functional difficulties, women were twice as likely to participate in social activities. This might reveal both a greater impact if women with disabilities are excluded from social participation, and the tendency for men to interact in different ways compared with women. Together, these findings are a reminder of the importance of gender sensitive programming overall but did not point to clear intersectionality between disability and gender when exploring social interactions.

The type of disability and reason appeared to influence how persons with disabilities participated in the community. It was identified that war veterans, including some with a physical impairment, received respect in the community and could even hold high-level positions, such as the village head. On the contrary, people with vision impairments, psychosocial disabilities and hearing difficulties were considered less able to participate and contribute to community life.

3. Knowledge, attitude and practice in disability

The quantitative survey identified that while three-quarters of respondents know someone with a disability, less than 10% report that they have a person with disabilities among their friends. These findings demonstrate how few people have close personal contact with persons with disabilities and that people tend not to understand how people experience disability. This lack of interaction and persistent negative attitudes lead to discriminatory ideas and practices.

While quantitative findings suggest positive attitudes towards disability in general, further probing in FGDs and KIIs identified negative attitudes and poor understanding of disability being prevalent in both districts. During the qualitative component, initial responses would also be generally positive towards disability; however, further discussion revealed that low awareness of disability, stigma and prejudice are common. Persons with disabilities were called names and sometimes the subject of jokes. Further, these attitudes were considered normal in some instances and persons with disabilities reported accepting this as normal. The disempowering effect of negative attitudes towards persons with disabilities came across

strongly in the qualitative component. It was evident from the interviews that community members did not recognize some attitudes or behavior were negative and stigmatizing for persons with disabilities and their families. How persons with disabilities themselves respond to cultural and societal norms about well-meaning name calling was not clear from this analysis. This is important because attaching labels to people with functional impairment or persons with disabilities was very common among respondents. In some cultures, persons with disabilities find value in attaching labels to themselves – even pejorative labels – as a way of 'taking back' or reclaiming how people perceive disability. Caution is required when interpreting the meaning and impact of name-calling among persons with disabilities in Lao PDR.

These findings around ignorance in the community in general imply *behavior change* activities to tackle persistent negative attitudes should illuminate the experience of persons with disabilities (including through providing platforms for their own advocacy and messaging) concerning the impact of name-calling and social inclusion. Findings demonstrate a disconnection between what persons without disabilities say they do, and how persons with disabilities describe their own experiences. Persons with disabilities are not universally socially excluded. Evidence provided here shows that some sociodemographic characteristics like education, work and living conditions can be protective of exclusion overall, and that people with the most severe disabilities are especially at risk of negative and exclusionary social attitudes. The individualized CBID approach combined with well-evidence and targeted behavior change strategies have the potential to combine in powerful new ways to deliver a more enabling environment and individual support and capability strengthening to deliver the program objectives.

4. Strengths and limitations of this survey

There are several strengths to this baseline survey. First, the mixed methods study design has allowed better understanding of the current situation of persons with disabilities in Kham and Xayphouthong districts. While the quantitative survey provided an assessment of the magnitude of differences in participation, wellbeing and access to services between people with and without disabilities, the qualitative component gathered perspectives of different community members including people with and without disabilities, caregivers, services providers and other key stakeholders. The qualitative component provided richer data to comprehensively understand certain barriers identified in the quantitative survey and to better understand prevailing community attitudes and practices towards persons with disabilities.

Second, reliable methods were used for data collection. In the quantitative survey, data were collected directly from the individuals unless there was a need for a proxy in the case of children and those with cognitive difficulties. This method captures reliable information on the level of difficulty and challenges from the individuals experiencing them. Qualitative interviews were conducted by trained local interviewers who could probe further and collect detailed information related to the local context.

Third, the survey used standard and validated tools, where applicable. We have used the WG Short Set of questions to identify persons with disabilities making the data from this survey comparable to other surveys. Other tools used were the SLWS, PHQ-2 and WHO Rapid Assessment of Assistive Technology tool. Although these tools were used for the first time in the Lao context, necessary steps for translation, cultural adaptation and cognitive testing were undertaken.

Finally, the survey has identified some key findings, which are in line with existing evidence from other countries suggesting comparability. Further, there are key findings in this baseline survey that are critical for planning CBID projects in both districts.

This survey has some limitations. One of the limitations is disability in children was assessed using the WG Short Set questions on disability which can miss cognitive, behavioral and developmental disabilities. Although the UNICEF/WG Child Functioning Module was available at the time of survey, it was not used due to its length and time needed for the screening survey, given the limited resources available for this survey. However, we were able to capture the situation of persons with disabilities, including children with disabilities in both districts with the mixed methods design. There were some important findings on schooling, attitudes towards certain types of disabilities and caregiver issues that are relevant for children with disabilities and provide necessary information for the USAID Okard team to design their CBID projects.

Another limitation was that we did not perform sub-group analyses and run regression models for investigating interaction between different socio-economic factors. This was not feasible with the limited sample size in sub-groups. However, the analyses undertaken in this report provides good evidence for the needs of persons with disabilities and considerations for planning CBID projects in both districts.

VI. Conclusion and implications for CBID projects

There were a significant proportion of persons with disabilities in both districts with a prevalence of 13.3% in Kham and 9.9% in Xayphouthong districts. Persons with disabilities are more likely to be older, have lower living standards, have lower education levels, be unemployed and have poorer health and wellbeing than persons without disabilities. Persons with disabilities are less likely to participate in the community and social gatherings and have poorer access to services. Barriers to participation and accessing services can be largely attributed to negative attitudes in the community, lack of accessible services and means to travel to services.

The CBID evidence-based demonstration model is targeted to address the health, livelihoods, and social needs of persons with disabilities, with a focus on individuals, families, and communities. Based on baseline survey findings, the priority areas for planning interventions are around:

- Individual assessments of needs based on directly assessing the individuals rather than proxies to capture reliable information on their needs and challenges. This will be possible with the CBID Modular Tool.
- Behavior change strategies should focus on understanding disability and challenges of persons with disabilities and their families, disability inclusion at the community level and its benefits, and attitudes towards persons with disabilities and their families.
- Disability awareness and training programs at the systems level to ensure service providers and policy makers are familiar with disability concepts and plan disability inclusion in mainstream services.
- Developing training curricula for health workers on disability inclusion.
- Ensuring access to health for persons with disabilities considers the type and quality of healthcare provided, rather than 'access' alone. This could include referrals from healthcare services back to CBID or other services to provide long-term, individualized programming at home and in the community.
- Working with existing rehabilitation services to widen the range of services to complement healthcare and CBID programming, and to ensure better knowledge of who might benefit from rehabilitation.
- Consulting persons with disabilities and their representative organizations in planning and implementation of the project.
- Provision of rehabilitation services at the district level, which is closer than the current provincial level centers.
- Consideration for availability of assistive products that are appropriately prescribed and ensure ongoing support for management and maintenance of assistive products.
- Providing information on the activities of the project and community level interventions in accessible formats for different types of disabilities.

- Ensuring caregivers are not only engaged in care planning for individuals with disabilities but also ensuring their own health and wellbeing is considered and supported.
- Consider the particular needs and constraints of caregivers of people with different impairments and of different ages.
- Collecting data on the needs and challenges over time to capture outcomes and the impact of interventions from the CBID project. This is feasible through the CBID Modular Tool.

Appendices

Appendix 1: Overview of survey

Objectives	Study design, method & tools	Data analysis	Target population
Identify the level of activity and participation (function), wellbeing and access to communities among persons with disabilities and persons without disabilities. (*Note*: measurement of the changes after the interventions is carefully considered under the study design of baseline survey).	- Study design: Population-based surveys in two districts with rapid screening in the first step, followed by long-form survey with structured questionnaires. Multi-stage stratified random sampling is considered and will be discussed with WE and local research team for final decision. - Tool: Structured questionnaires at the individual and household level. - Modified RAD survey tool, which was developed by Nossal, contextualised for Lao PDR. - Data collection: local enumerators will use tablet-computers for higher accuracy; Nossal team will provide training and technical support to local research team.	- Type: Quantitative data analysis with survey data (i.e. controlling for design effect). - Approach: Comparisons across different groups of target population to identify the gaps. - Data analysis: Data will be transferred to Stata format for cleaning. Univariate, bivariate and multi-variate analyses with appropriate significant tests using Stata or other statistical packages, such as SPSS or SAS or R+. - Controlling for sex, age and other socio-economic characteristics.	Children with disabilities Children without disabilities Adults with disabilities Adults without disabilities
Understand the knowledge, attitudes and practices (KAP) of persons with disabilities and different community stakeholders.	- As above plus KAP module. - Study design: Qualitative research study involving IDIs with the beneficiaries and stakeholders. - Tool: Semi-structured questionnaires and question guides. - Data collection: Local and international researchers. Nossal team will provide training and technical support to local research team. Nossal team may participate directly in some interviews.	- As above. - Type: Qualitative. - Approach: as above. - Data analysis: Content analysis, narrative analysis, and framework analysis with assistance of NVivo or other qualitative data software, such as Atlas ti.	- As above Persons with disabilities Persons without disabilities Caregivers and household members of persons with disabilities; Service providers (health, TVET, local businesses, education); National and local officials; Representatives of economic and socio-political organizations; OPDs Project staffs or facilitators who are directly involved to the interventions.

1. Appendix 1 Gantt chart of the CBID baseline survey

			2019							
			Jan	Feb	Mar	Apr	May	Jun	July	Aug
D1	Design and Implementation Plan	Development, planning and design of quantitative component including drafting Ethics Application								
		Development, planning and design of qualitative component including drafting Ethics Application								
		Ethics approval process (Melbourne)								
D2	Survey Tools	Questionnaire development								
		Data entry package development								
		In-country workshop to finalize the questionnaire								
		Testing the data entry package and updating								
		Development of survey guidelines for enumerators & supervisors								
		Development of qualitative tools								
D3	Training package for local survey team	Development of training package and materials								
		In-country training for local survey team								
		Training of local qualitative survey team & finalizing tool								
		Quantitative survey- data collection								
		Qualitative survey- interviews								
D4	Data quality assurance reports	Technical support for survey data collection & database monitoring								
		Technical support to qualitative data collection and supporting initial data collection								
D5	Database, initial data analysis and presentation of initial findings	Data synchronizing & merging								
		Data cleaning								
		Development of report structure and data analysis plan								
		Data analysis								
		Graph, chart, table preparation								
		In-country presentation of preliminary quantitative findings								
		Qualitative data analysis								
D6	Reporting	Writing up quantitative finding report								
		Writing up qualitative finding report								
		Finalizing quantitative report								
		Finalizing qualitative report								

2. Appendix 2: Quantitative survey tool – Long-form

2019 Community-Based Inclusive Development Survey

USAID Okard, Lao PDR

Note: [red] variable name; *(blue)* Note to interviewer/KoBo

[start] *(start)* Time at the start of survey *(automatically recorded)*

A. GENERAL INFORMATION

1. [a1dist] *(Interviewer to complete)* District:
   1 = Kham district (*Xienkhuang province*)
   2 = Xayphouthong district (*Savannakhet province*)

2. [a2village] *(Interviewer to complete)* Village: *(select from the list: run between 1 and 15)*

3. [a3nouy] *(Interviewer to complete)* Nouy: *(select from the list)*

4. [a4hhid] *(Interviewer to complete)* Household number: *(enter from screening)*

5. [a5indid] *(Interviewer to complete)* Individual identification of the respondent *(IID from screening)*

6. [a6rural] *(Interviewer to confirm)* Rural/Urban place of residence: *(automatically generated from village name/code; Interviewer to confirm)*
   1 = Rural 0 = Urban

7. [a7enum] *(Interviewer to complete)* Interviewer's name or ID: *(select from the list)*

8. [a8visit] *(Interviewer to complete)* Number of visit *(maximum 3)*: 1 2 3

9. [a9sampleg] *(Interviewer to complete)* Sampling group from the screening?
   1 = Persons with difficulties
   0 = Persons without difficulties

10. [a10avail] *(Interviewer to complete)* Was the respondent available?
    1 = Yes 0 = No, I could not meet the respondent → ***END THE SURVEY***

11. [a11elig] *(Interviewer to complete)* Is the respondent eligible? *(examples of illegible respondents: the person does not exist, out-migrated, younger than 5 years old)*

    1 = Yes

    0 = No, the respondent is not eligible → ***END THE SURVEY***

12. [a12cons] We would like to ask you some questions about you and your community. Is that OK?

    1 = Yes, OK

    0 = No, it's not OK → ***END THE SURVEY***

B. PARTICIPANT INFORMATION SHEET & CONSENT

PLEASE READ ALOUD

My name is _____. I am working for an organisation called World Education. In partnership with Humanity and Inclusion, Nossal Institute for Global Health, QLA and ARMI, and under approval of Ministry of Labor and Social Welfare National Committee for Disabled and Elderly (NCDE), we are conducting a survey to strengthen health and community based inclusive development in 2 districts of Lao.

We would like to invite you to participate in this survey. We do not provide any direct incentive for your participation, but we expect findings from this study will contribute to health and community development in general, especially for vulnerable persons. We respect your privacy and so your identity and personal information will be kept confidential. Your participation is totally voluntary; you can refuse to participate, refuse to answer questions that you don't want to, stop the interview at any time you want without any risk to you or your family. I am also providing you a hard copy of further detail information and contact if you have any concern, complain or need of any further information. The project has been approved by the Human Research Ethics Committee (HREC) at the University of Melbourne in Australia and the Ministry of Labor and Social Welfare National Committee for Disabled and Elderly (NCDE).

The survey will take about 45 to 60 minutes. We will delete your name from surveyed data, and data will be destroyed after 5 years. If you participate, your honest responses are important to us because we want your critical feedback so we can improve.

CONSENT

PLEASE READ ALOUD

Please indicate whether you agree with these statements *(select as acknowledged)*.

- ☐ I understand the previous statements read to me, the purpose and risks of this project.
- ☐ I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- ☐ I freely agree to participate in this research and I understand that my participation will involve participating in an interview for up to 60 minutes, and if I agree, my responses will be entered into a tablet computer, saved, and analysed.
- ☐ I acknowledge that:

- o participation in this interview is voluntary and I am free to withdraw from the interview at any time without explanation or prejudice.
- o The interview is for the purpose of strengthening health and community development in Lao PDR.

 I have been informed that information from my interview will be kept securely for 5 years after the last time it is used and then destroyed.

Interviewer check*: If not all the points have been acknowledged, please return and check, or conclude the interview if the person doesn't want to continue.*

If you have any questions, you can ask me or contact the Survey Coordinator, Ms. Alounny XXXX through email at XXXXX, cell phone XXXXX, or mail address at XXXXX). The contact details are also in the form I have given you. If you have any concerns or complaints about the conduct of this research project, there are details in the document I gave you about other people to contact.

1. [b1yob] What year were you born in? ……. *(record year of birth)*

2. [b2age] *(Interviewer to confirm or ask if year of birth is not available; use best estimate if exact age is not available)* Enter or verify age: ……. *(record age in years)*

C. SOCIO-DEMOGRAPHIC BACKGROUND

1. [c1sex] What is your sex?

   1 = Male 2 = Female

2. [c2ethnic] What is your ethnicity?

   1 = Lao 2 = H'mong 3 = Khmou

   4 = Phouthay 5 = Phong 6 = Tai

   7 = Others (*specify*) ……[c2o] ……

3. [c3marstat] *(SKIP if age<12)* What is your <u>current</u> marital status?

   1 = Currently married 2 = Stay together 3 = Separated

   4 = Divorced 5 = Widowed 0 = Never married/ Never cohabitated

4. [c4child] *(SKIP if age<12)* Do you have any children?

   1 = Yes 0 = No → ***SKIP to C.6***

5. [c5nchild] How many children do you have? …….

6. [c6schoolatt] Have you ever attended school?

   0 = No → ***SKIP to C.12***

   1 = Yes, currently attending → ***SKIP to C.10***

2 = Yes, attended before

7. [c7] When did you leave school?

a. *Month:* …… *b. Year:* ……..…….

8. Why did you leave school? *(Select all that apply)*

[c8_1] 1 = I reached the level that I wanted

[c8_2] 2 = Poor health

[c8_3] 3 = Needed to get paid job

[c8_4] 4 = Taking care of family

[c8_5] 5 = Disability

[c8_6] 6 = Absence of personal assistance/caregiver

[c8_7] 7 = Family did not want me to go to school

[c8_8] 8 = Family has difficulty assisting me to go to school

[c8_9] 9 = School is too far away

[c8_10] 10 = Means of transportation to school is absent or difficult to use

[c8_11] 11 = Difficulty road conditions to school

[c8_12] 12 = School is not physical accessible

[c8_13] 13 = Absence of specific teaching aids and approaches

[c8_14] 14 = Cost of attending school (e.g. tuition fees, uniform, transport)

[c8_15] 15 = Being expelled from school

[c8_16] 16 = Treated badly at school (e.g. bullied or discriminated by friends or teachers or staffs or other people met at school)

[c8_88] 88 = Other (*specify*) ..…[c8o]…..

[c8_98] 98 = Don't know /Don't remember

→ *SKIP to C.10 if less than 2 options were selected in C.8*

9. [c9] What is the most important reason? *(Write one of the selected codes above)* ……..

10. [c10] What level of school did you COMPLETE?

1 = Primary

2 = Junior secondary

3 = Senior secondary or higher

11. [c11] What is the highest class that you have COMPLETED in school?

0	1 2 3 4 5	6 7 8 9	10 11 12 13=13 or higher

→ ***SKIP to C.14***

12. Why have you never gone to school? *(Select all that apply)*

[c12_1] 1 = I think it's not necessary

[c12_2] 2 = Poor health

[c12_3] 3 = Needed to get paid job

[c12_4] 4 = Taking care of family

[c12_5] 5 = Disability

[c12_6] 6 = Absence of personal assistance

[c12_7] 7 = Family did not want me to go to school

[c12_8] 8 = Family has difficulty assisting me to go to school

[c12_9] 9 = School is too far away

[c12_10] 10 = Means of transportation to school is absent or difficult to use

[c12_11] 11 = Difficulty road conditions to school

[c12_12] 12 = School is not physical accessible

[c12_13] 13 = Absence of specific teaching aids and approaches

[c12_14] 14 = Cost of attending school (e.g. tuition fees, uniform, transport)

[c12_15] 15 = School did not admit me

[c12_16] 16 = Treated badly at school (e.g. bullied or discriminated by friends or teachers or staffs or other people met at school)

[c12_88] 88= Other (*specify*) …[c12o]…

[c12_98] 98 = Don't know /Don't remember

→ *SKIP to C.14 if less than 2 options were selected in C.12*

13. [c13] What is the most important reason? *(Write one of the selected codes above)* ……..

14. [c14] Have you ever received any skills or vocational training (for example from a TVET center or from a technical trainer?)

1 = Yes 0 = No

15. [c15] Over the past 3 months, have you needed any skills or vocational training?

1 = Yes 0 = No → ***SKIP to C.19***

16. [c16] To what extent have you been able to receive skills or vocational training as much as you needed?

1 = All of the time → ***SKIP to C.19*** 2 = Most of the time

3 = Some of the time 4 = Never

98 = Don't know /Can't remember → ***SKIP to C.19***

17. Why did you give that answer? *(Select all that apply)*

[c17_1] 1 = Lack of information /Do not know where to go

[c17_2] 2 = No services/facility for vocational training

[c17_3] 3 = Absence of the training in area that I wanted

[c17_4] 4 = Too far

[c17_5] 5 = Means of transportation is absent or difficult to use

[c17_6] 6 = Means of transportation is not accessible

[c17_7] 7 = Poor road condition or road is not accessible

[c17_8] 8 = Could not afford the cost of skills or vocational training

[c17_9] 9 = Nobody to accompany me

[c17_10] 10 = Do not like the attitudes of the staff at the training centre/school

[c17_11] 11 = Do not like the attitude of other trainees at the training centre/school

[c17_12] 12 = I was previously badly treated (e.g. bullied or discriminated by friends or teachers or staffs or other people met at skills or vocational training centres)

[c17_13] 13 = Tried but denied training / Training centre did not admit me

[c17_14] 14 = Absence of reasonable accommodation at the training centre/school

[c17_15] 15 = Family did not want me to participate in skills or vocational training

[c17_88] 88 = Other (*specify*) ……[c17o] ……

[c17_98] 98 = Don't know /No response

→ *SKIP to C.19 if less than 2 options were selected in this C.17*

18. [c18] What is the most important reason? (*Write one of the selected codes above)* ……..

19. [c19] What is your **current main** activity status?

1 = Student

2 = Not working and not looking for work

3 = Not working and looking for work (unemployed)

4 = Retired

5 = Full time homemaker/housewife

6 = Contributing family worker (helping without pay in a household/family business)

7 = Employee /paid work for someone else (including paid apprentice or intern)

8 = Self-employed (Employer with regular employees OR own-account worker without regular employees)

88 = Other (*specify*): ……[c19o] ……

20. [c20] How do you feel about this current activity status? Very satisfied, satisfied, unsatisfied, or very unsatisfied?

1 = Very satisfied 2 = Satisfied

3 = Unsatisfied 4 = Very unsatisfied

21. [c21] Do you <u>currently</u> earn any income from your current and/or previous work?

1 = Yes 2 = No or Not applicable → ***SKIP to C.23***

22. [c22] How much in the following range do you currently earn <u>per month</u>? *(**Interviewer**: READ response options)*

1 = <180,000 *LAK/month* 2 = 180,000 - <500,000 *LAK/month*

3 = 500,000 - < 1 mil *LAK/month* 4 = 1 mil - <2 mil *LAK/month*

5 = 2 mil - <5 mil *LAK/month* 6 = 5 mil - <10 mil *LAK/month*

7 = 10 mil or more *LAK/month* 98 = Don't know/Refused

23. [c23] Over the past 3 months, have you needed to work?

1 = Yes 0 = No → ***SKIP to C.27***

[c24] To what extent have you been able to work as much as you needed?

1 = All of the time → ***SKIP to C.27*** 2 = Most of the time

3 = Some of the time 4 = Never/Not at all

98 = Don't know /Can't remember → ***SKIP to C.27***

24. Why did you give that answer? *(Select all that apply)*

[c25_1] 1 = Lack of employment information /do not know where to go

[c25_2] 2 = No opportunities

[c25_3] 3 = Lack of job placement/support services

[c25_4] 4 = Not interested to work

[c25_5] 5 = Difficult applying for a job

[c25_6] 6 = Family did not want me to work

[c25_7] 7 = Lack of assistant to workplace

[c25_8] 8 = Too far

[c25_9] 9 = No transport available

[c25_10] 10 = Means of transportation is not accessible

[c25_11] 11 = Could not afford the cost of transport

[c25_12] 12 = Do not like the attitudes of others

[c25_13] 13 = Absence of reasonable accommodation at workplace

[c25_14] 14 = Disability

[c25_88] 88 = Other (*specify*) ……[c25o] ……

[c25_98] 98 = Don't know

→ *SKIP to C.27 if less than 2 options were selected in this C.25*

25. [c26] What is the most important reason? (*Write one of the selected codes above)* ……..

26. Are you participating in any local organizations/association? *(Select all that apply)*

[c27_0] 0 = None

[c27_1] 1 = Micro-credit groups / Village fund

[c27_2] 2 = Self-help Group

[c27_3] 3 = OPD

[c27_4] 4 = Cooperative clubs

[c27_5] 5 = Mass organizations, such as Youth Union, Farmer Associations, etc.

[c27_88] 88 = Others (*specify*) ……[c27o] …….

D. HEALTH & ACCESS TO HEALTH SERVICES

1. [d1] How do you rate your current health status in general? Very good, good, poor, or very poor?

1 = Very good 2 = Good

3 = Poor 4 = Very poor

2. [d2] Do you have health protection/insurance?

1 = Yes 0 = No

3. [d3] Have you ever been sick enough to stay home or rest for at least 3 days?

1 = Yes 0 = No → ***SKIP TO D.8***

4. [d4] When was the last time you got sick and had to stay at home or rest for at least 3 days?

1 = <3 months ago 2 = 3 to <6 months ago

3 = 6 months to <1 year ago 4 = 1 to <3 years ago

5 = 3+ years ago

5. What did you do during the week immediately after that? *(Select all that apply)*

[d5_1] 1 = Did nothing [d5_2] 2 = Home remedy

[d5_3] 3 = Self-medicated [d5_4] 4 = Visited pharmacist *(without prescription)*

[d5_5] 5 = Visited public health facilities [d5_6] 6 = Visited private health facilities

[d5_7] 7 = Visited traditional healer [d5_8] 8 = Seek spiritual support (*e.g. visited religious leader /Imam /Priest*)

[d5_88] 88 = Other (*specify*) ……[d5o] …… [d5_98] 98 = Can't remember

6. [d6] Did your sickness get worse, same or better <u>after one week</u>?

   1 = Worse 2 = Same

   3 = Better 98 = Don't remember

7. What did you do <u>after the first week</u>? *(Select all that apply)*

   [d7_1] 1 = Did nothing [d7_2] 2 = Home remedy

   [d7_3] 3 = Self-medicated [d7_4] 4 = Visited pharmacist *(without prescription)*

   [d7_5] 5 = Visited public health facilities [d7_6] 6 = Visited private health facilities

   [d7_7] 7 = Visited traditional healer [d7_8] 8 = Seek spiritual support (*e.g. visited religious leader /Imam /Priest*)

   [d7_88] 88 = Other (*specify*) ……[d7o] …… [d7_98] 98 = Can't remember

8. [d8] Over the past 3 months, have you needed to access healthcare services?

   1 = Yes 0 = No → ***SKIP to D.12***

9. [d9] To what extent have you been able to access healthcare services as much as you need?

   1 = All of the time → ***SKIP to D.12*** 2 = Most of the time

   3 = Some of the time 4 = Never

   8 = Don't know /Can't remember → ***SKIP to D.12***

10. Why did you give that answer? *(Select all that apply)*

    [d10_1] 1 = Lack of information /do not know where to go

    [d10_2] 2 = No healthcare services/facility

    [d10_3] 3 = Family did not want me to visit healthcare facility

    [d10_4] 4 = Lack of assistant to healthcare facility / Nobody accompany me

    [d10_5] 5 = Too far

    [d10_6] 6 = No transport available

    [d10_7] 7 = Transport is not accessible

    [d10_8] 8 = Could not afford the cost of healthcare

    [d10_9] 9 = Could not afford indirect costs, e.g. transportation, food, accommodation, accompanied person

    [d10_10] 10 = Do not like the attitudes of staff at health facility

    [d10_11] 11 = Do not like the attitudes of others at health facility

    [d10_12] 12 = Was previously badly treated or discriminated

    [d10_13] 13 = Tried but denied at healthcare facility

    [d10_14] 14 = Absence of reasonable accommodation at healthcare facility

[d10_88] 88 = Other (*specify*) ……[d10o] ……

[d10_98] 98 = Don't know

→ *SKIP to D.12 if less than 2 options were selected in D.10*

11. [d11] What is the most important reason? (*Write select one of the codes above)* ……..

12. [d12] Have you EVER needed to access health services?

1 = Yes 0 = No

13. [d13] In general, how satisfied are you with healthcare services that you have received?

1 = Very satisfied 2 = Satisfied

3 = Unsatisfied 4 = Very unsatisfied

Interviewer, read: Now I am going to ask you some questions about your ability to do different activities, and how you have been feeling.

14. [d14] Do you use any assistive product such as glasses or other products to help seeing; such as to read, write, seeing in distance or up-close?

1 = Yes 0 = No → ***SKIP to D.16***

15. What assistive product do you use to manage your seeing difficulty? *(**Interviewer**: Show the respondent Showcard #1 and read all options)*

[d15_53] 53 = Glasses/spectacles prescription [d15_54] 54 = Reading glasses

[d15_52] 52 = Magnifiers, Optical [d15_4] 4 = Magnifiers, Digital

[d15_3] 3 = Braille displays [d15_6] 6 = Braille writing equipment

[d15_46] 46 = Watches, talking/touching [d15_8] 8 = Pill organizers

[d15_34] 34 = Recorders [d15_10] 10 = White cane

[d15_55] 55 = Smartphone app [d15_12] 12 = Other *(specify)*…[d15o]...

16. [d16] You said you had <*enter level of difficulty from the Screening*> **<u>seeing</u>**, [*for those wearing glasses*: even when wearing your glasses]. Is that right?

***Interviewer**: Select option that is confirmed by the respondent.*

0 = No difficulty → ***SKIP to D.18*** 1 = Some difficulty

2 = A lot of difficulty 3 = Cannot do at all /Unable to do

7= Refused 8 = Don't know

17. [d17] When did your vision become that difficult?

1 = <3 months ago 2 = 3 to <6 months ago

3 = 6 months to <1 year ago 4 = 1 to <3 years ago

5 = 3 years ago or before that

18. [d18] Do you use any assistive product to help hearing; such as hearing aid or other devices?

1 = Yes 0 = No → ***SKIP to D.20***

19. What assistive product do you use to manage your hearing difficulty? *(**Interviewer**: Show the respondent Showcard #2 and read all options)*

[d19_17] 1 = Hearing aid [d19_88] 2 = Others *(specify)* …[d19o]...

20. [d20] You said you had <*enter level of difficulty from the Screening*> **<u>hearing</u>**, [*for those using hearing aid:* even when using a hearing aid(s)]. Is that right?

***Interviewer**: Select option that is confirmed by the respondent.*

0 = No difficulty → ***SKIP to D.22*** 1 = Some difficulty

2 = A lot of difficulty 3 = Cannot do at all /Unable to do

7 = Refused 8 = Don't know

21. [d21] When did your hearing become that difficult?

1 = <3 months ago 2 = 3 to <6 months ago

3 = 6 months to <1 year ago 4 = 1 to <3 years ago

5 = 3 years ago or before that

22. [d22] You said you had <*enter level of difficulty from the Screening*> **<u>walking</u>** or **<u>climbing</u>** steps. Is that right?

***Interviewer**: Select option that is confirmed by the respondent.*

0 = No difficulty → ***SKIP TO D.24*** 1 = Some difficulty

2 = A lot of difficulty 3 = Cannot do at all /Unable to do

7 = Refused 8 = Don't know

23. [d23] When did your mobility become that difficult?

1 = <3 months ago 2 = 3 to <6 months ago

3 = 6 months to <1 year ago 4 = 1 to <3 years ago

5 = 3 years ago or before that

24. [d24] Do you use any assistive product to manage your mobility difficulty?

1 = Yes 0 = No → ***SKIP to D.26***

25. What assistive product do you use to manage your hearing difficulty? *(**Interviewer**: Show the respondent Showcard #3 and read all options)*

[d25_5] 5 = Walking Canes/sticks simple or quadripod

[d25_45] 45 = Walking Frames/rollator

[d25_22] 22 = Orthoses, lower limb

[d25_31] 31 = Prostheses, lower limb

[d25_56] 56 = Joint support (cervical collar, knee support and arm slings)

[d25_47] 47 = Wheelchair - Manual for active

[d25_48] 48 = Wheelchair - assistant-controlled

[d25_49] 49 = Wheelchair - manual with postural support

[d25_57] 57 = Tricycles

[d25_11] 11 = Crutches – Axillary

[d25_58] 58 = Crutches - elbow

[d25_59] 59 = Standing Frames, Adjustable

[d25_60] 60 = Seating system (pediatric wheelchair)

[d25_29] 29 = Pressure Relief Cushions

[d25_30] 30 = Pressure Relief Mattresses

[d25_28] 28 = Positioning wedges / cushions

[d25_16] 16 = Hand Rails/Grab Bars

[d25_8] 8 = Club foot braces

[d25_88] 88 = Others *(specify)* ……[d25o] ….

26. [d26] You said you had <*enter level of difficulty from the Screening*> **communicating**, for example understanding or being understood, when using your usual (customary) language. Is that right?

***Interviewer**: Select option that is confirmed by the respondent.*

0 = No difficulty → ***SKIP TO D.28***

1 = Some difficulty

2 = A lot of difficulty

3 = Cannot do at all /Unable to do

7 = Refused

8 = Don't know

27. [d27] When did your communication become that difficult?

1 = <3 months ago

2 = 3 to <6 months ago

3 = 6 months to <1 year ago

4 = 1 to <3 years ago

5 = 3 years ago or before that

28. [d28] Do you use sign language?

1 = Yes

0 = No

98 = Refused /Don't know

29. [d29] Do you use any assistive product to manage your communicating difficulty?

1 = Yes

0 = No → ***SKIP to D.31***

30. What assistive product do you use to manage your communication difficulty? *(**Interviewer**: Show the respondent Showcard #4 and read all options)*

[d30_1] 1 = Lao talk app

[d30_2] 2 = Communication board

[d30_88] 88 = Others *(specify)* …… [d30o] …….

31. [d31] You said you had <*enter level of difficulty from the Screening*> **remembering or concentrating**. Is that right?

***Interviewer**: Select option that is confirmed by the respondent.*

0 = No difficulty → ***SKIP TO D.33*** 1 = Some difficulty

2 = A lot of difficulty 3 = Cannot do at all /Unable to do

7 = Refused 8 = Don't know

32. [d32] When did your remembering/concentrating become that difficult?

1 = <3 months ago 2 = 3 to <6 months ago

3 = 6 months to <1 year ago 4 = 1 to <3 years ago

5 = 3 years ago or before that

33. [d33] Do you use any assistive product to manage your difficulty remembering?

1 = Yes 0 = No → ***SKIP to D.35***

34. What assistive product do you use to manage your remembering difficulty?
*(**Interviewer**: Show the respondent Showcard #5 and read all options)*

[d34_27] 27 = Pill organisers

[d34_34] 34 = Recorders

[d34_37] 37 = Simplified mobile phones

[d34_41] 41 = Time management products

[d34_25] 25 = Personal digital assistant (PDA)

[d34_42] 42 = Travel aid, portable

[d34_15] 15 = Global positioning system (GPS) locator

[d34_13] 13 = Fall detectors

[d34_26] 26 = Personal emergency alarm system

[d34_88] 88 = Other *(specify)* ……[d34o] ……

35. [d35] You said you had <*enter level of difficulty from the Screening*> **self-care**, such as washing all over or dressing. Is that right?

***Interviewer**: Select option that is confirmed by the respondent.*

0 = No difficulty → ***SKIP TO D.37*** 1 = Some difficulty

2 = A lot of difficulty 3 = Cannot do at all /Unable to do

7 = Refused 8 = Don't know

36. [d36] When did your self-care become that difficult?

1 = <3 months ago
2 = 3 to <6 months ago
3 = 6 months to <1 year ago
4 = 1 to <3 years ago
5 = 3 years ago or before that

37. [d37] Do you have difficulties **raising a 2 litter-bottle of water** from waist to eye level? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

0 = No difficulty → ***SKIP TO D.39***
1 = Some difficulty
2 = A lot of difficulty
3 = Cannot do at all /Unable to do
7 = Refused
8 = Don't know

38. [d38] When did that activity become that difficult?

1 = <3 months ago
2 = 3 to <6 months ago
3 = 6 months to <1 year ago
4 = 1 to <3 years ago
5 = 3 years ago or before that

39. [d39] Do you have difficulties **using your hands and fingers**, such as picking up small objects, for example, a button or pencil, or opening or closing containers or bottles? Would you say no difficulty, some difficulty, a lot of difficulty, or cannot do at all?

0 = No difficulty → ***SKIP TO D.41***
1 = Some difficulty
2 = A lot of difficulty
3 = Cannot do at all /Unable to do
7 = Refused
8 = Don't know

40. [d40] When did your use of hands and fingers become that difficult?

1 = <3 months ago
2 = 3 to <6 months ago
3 = 6 months to <1 year ago
4 = 1 to <3 years ago
5 = 3 years ago or before that

41. [d41] Do you use any assistive product to help you eat; for toileting or washing; to dress by yourself or to manage other daily activities?

1 = Yes
0 = No → ***SKIP to D.43***

42. What assistive product do you use?

[d42_22] 22 = Orthoses, lower limb
[d42_32] 32 = Prostheses, upper limb
[d42_16] 16 = Hand rails /Grab bars
[d42_65] 65 = Continence products
[d42_66] 66 = Chairs for shower/bath/toilet
[d42_62] 62 = Adapted cutlery
[d42_63] 63 = Adapted cooking tools
[d42_64] 64 = Adapted drinking tools
[d42_67] 67 = Transfer board
[d42_88] 88 = Others *(specify)* …[d42o] ….

43. [d43] Do you use any other assistive products that were not listed previously?

0 = No → ***SKIP to SKIP after D.46*** 1 = Yes

44. [d44] How many other assistive products (which were not listed previously) do you use? ……

    a. [d44a] Other assistive product number 1: ……
    b. [d44b] Other assistive product number 2: ……
    c. [d44c] Other assistive product number 3: ……

45. [d45] From the assistive products you use, please select three most important ones: <*write codes of up to 3 assistive products*> ……

46. [d46] May we take a picture of this/these assistive devices?

    0 = No 1 = Yes

→ ***SKIP to D.54 if*** *the respondent does not use any assistive product*

The next questions asking about your 3 most important assistive devices:

	AP 1	AP 2	AP 3
	(a)	(b)	(c)
47. Code/name	[d47a]	[d47b]	[d47c]
48. Approximately how much did you pay for the device?	[d48a] *KIP*	[d48b] *KIP*	[d48c] *KIP*
49. Does the device meet your needs? (does it do everything that you want it to do?)	[d49a]	[d49b]	[d49c]
50. Where did you get it from?	[d50a]	[d50b]	[d50c]

Response codes:

D.47: 1 = Glasses/spectacles prescription; 2 = Reading glasses; 3 = Magnifiers, Optical; 4 = Magnifiers, Digital; 5 = Braille displays; 6 = Braille writing equipment; 7 = Watches, talking/touching; 8 = Pill organizers; 9 = Recorders; 10 = White cane; 11 = Smartphone app; 12 = Walking Canes/sticks simple or quadripod; 13 = Walking Frames/rollator; 14 = Orthoses, lower limb; 15 = Prostheses, lower limb; 16 = Joint support (cervical collar, knee support and arm slings); 17 = Wheelchair - Manual for active; 18 = Wheelchair - assistant-controlled; 19 = Wheelchair - manual with postural support; 20 = Tricycles; 21 = Crutches – Axillary; 22 = Crutches – elbow; 23 = Standing Frames, Adjustable; 24 = Seating system (pediatric wheelchair); 25 = Pressure Relief Cushions; 26 = Pressure Relief Mattresses; 27 = Positioning wedges / cushions; 28 = Hand Rails/Grab Bars; 29 = Club foot braces; 30 = Lao talk app; 31 = Communication board; 32 = Orthoses, upper limb; 33 = Prostheses, upper limb; 34 = Continence products; 35 = Chairs for shower/bath/toilet; 36 = Adapted cutlery; 37 = Adapted cooking tools; 38 = Adapted drinking tools; 39 = Transfer board; 40 = Others *(specify)* ……

D.49: 0 = No, not at all; 1 = Partly; 2 = Mostly; 3 = Yes

D.50: 1 = Rehabilitation centre; 2 = Hospital; 3 = Other health care facilities; 4 = Local market; 5 = Pharmacist; 6 = Made by self, friend or family; 7 = Made by artisan; 8

= NGO or Charity; 9 = Religious organisations; 10 = Government; 11 = Provided by healthcare professional; 12 = Ministry of Labour and Social Welfare; 88 = Others *(specify)* ……

51. [d51] Do you think you might benefit from an assistive device that you do not already have?

1 = Yes 0 = No → ***SKIP TO D.54***

98 = Don't know

52. Which of the following reasons restrict you from using an assistive device?

[d52_1] 1 = Lack of information /Don't know about specific assistive devices

[d52_2] 2 = Assistive device is not available locally

[d52_3] 3 = Cannot afford (to buy) the assistive devices

[d52_4] 4 = They are not worth to buy (I think it is more expensive than its value)

[d52_5] 5 = Family did not want me to have it

[d52_6] 6 = Concern about their negative or side effects

[d52_88] 88 = Other (*specify*) ……[d52o] ……

[d52_98] 98 = Don't know

53. [d53] What is the most important reason? (*Write one of the selected codes above)* ……..

54. [d54] Do you need any assistive device that you currently don't have?

1 = Yes 0 = No → ***SKIP TO D.57***

98 = Don't know → ***SKIP TO D.57***

55. Why don't you have them? *(Select all that apply)*

[d55_1] 1 = Lack of information /Don't know about specific assistive device

[d55_2] 2 = Assistive device is not available locally

[d55_3] 3 = Cannot afford (to buy) the assistive devices

[d55_4] 4 = They are not worth to buy (I think it is more expensive than its value)

[d55_5] 5 = Family did not want me to have it

[d55_6] 6 = Concern about their negative or side effects

[d55_88] 88 = Other (*specify*) ……[d55o] ……

[d55_98] 98 = Don't know

→ *SKIP to D.57 if less than 2 options were selected in this D.55*

56. [d56] What is the most important reason? (*Write one of the selected codes above)* ……..

57. [d57] Over the <u>past 3 months</u>, have you needed to access rehabilitation services?

0 = No 1 = Yes → ***SKIP to D.62***

2 = Don't know what rehabilitation is → ***SKIP to D.62***

3 = Know rehabilitation but don't know if it's needed → ***SKIP to D.62***

58. [d58] Have you <u>ever</u> needed to access rehabilitation services?

1 = Yes 0 = No → ***SKIP to D.62***

98 = Don't know → ***SKIP to D.62***

59. [d59] To what extent have you been able to <u>use</u> rehabilitation services as much as you need?

1 = All of the time → ***SKIP to D.62*** 2 = Most of the time

3 = Some of the time 4 = Never

98 = Don't know /Can't remember → ***SKIP to D.62***

60. Why did you give that answer? *(Select all that apply)*

[d60_1] 1 = Lack of information /do not know where to go

[d60_2] 2 = No rehabilitation services/facility

[d60_3] 3 = Family did not want me to access rehabilitation

[d60_4] 4 = Lack of personal assistant to access rehabilitation /Nobody accompany me

[d60_5] 5 = Too far

[d60_6] 6 = No transport available

[d60_7] 7 = Transport is not accessible

[d60_8] 8 = Could not afford the cost of rehabilitation

[d60_9] 9 = Could not afford indirect costs, e.g. transportation, food, expenses for accompanied person, accommodation

[d60_10] 10 = Do not like the attitudes of staff at rehabilitation facility

[d60_11] 11 = Do not like the attitudes of others at rehabilitation facility

[d60_12] 12 = Was previously badly treated or discriminated

[d60_13] 13 = Tried but denied at rehabilitation facility

[d60_14] 14 = Absence of reasonable accommodation at rehabilitation

[d60_88] 88 = Other (*specify*) ……[d60o] ……

[d60_98] 98 = Don't know

→ *SKIP to D.62 if less than 2 options were selected in this D.60*

61. [d61] What is the most important reason? (*Write one of the selected codes above)* ……..

62. [d62] In general, how satisfied are you with rehabilitation services that you have received?

1 = Very satisfied 2 = Satisfied

3 = Unsatisfied 4 = Very unsatisfied

63. [d63] Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?

0 = Not at all 1 = Several days

2 = More than half the days 3 = Nearly every day

64. [d64] Over the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless?

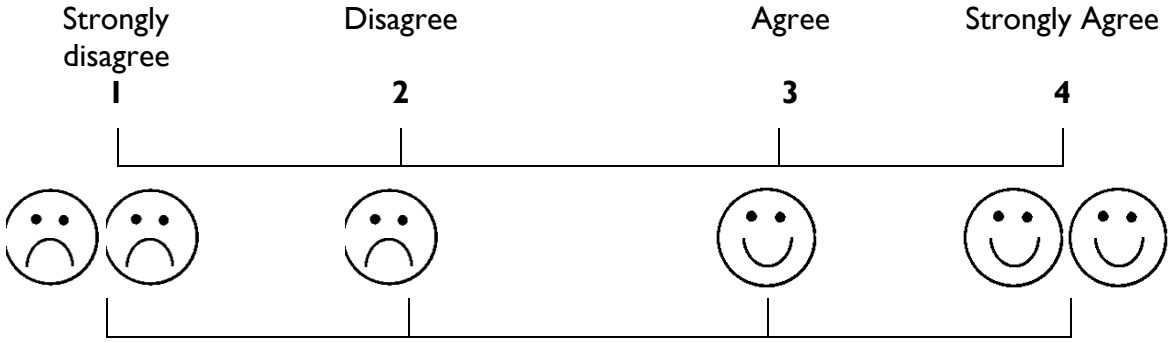
0 = Not at all 1 = Several days

2 = More than half the days 3 = Nearly every day

E. WELL-BEING

Check E1: *If respondent <9 years old → SKIP to F.1*
Check E2*: If respondent aged between 9 and <15 years old → SKIP to E.6*

Interviewer*: Give respondent the flashcard below during this section.*



I am now going to ask how you feel about life in general in the last 3 months. Below are five statements that you may agree or disagree with. Using the 1to 4 scale in flashcard, indicate your opinion with each item by telling me the appropriate number for that item.

#	Question	Strongly disagree	Disagree	Agree	Strongly Agree
1.	[e1] Generally speaking, my life closely corresponds to my ideals	1	2	3	4
2.	[e2] My living conditions are excellent	1	2	3	4
3.	[e3] I am satisfied with my life	1	2	3	4
4.	[e4] So far, I have obtained the main things I wanted from life	1	2	3	4
5.	[e65] If I could start my life again, there is very little I would change	1	2	3	4

I am now going to ask how happy you feel with your life. Below are five sentences about life in general. Using the 1to 4 scale in flashcard, indicate your opinion with each item by telling me the appropriate number for that item.

#	Question	Strongly disagree	Disagree	Agree	Strongly Agree
6.	[e6] In most ways, my life is close to the way I want it to be	1	2	3	4
7.	[e7] The things in my life are excellent	1	2	3	4
8.	[e8] I am happy with my life	1	2	3	4
9.	[e9] So far, I have gotten the main things I want in my life	1	2	3	4
10	[e10] If I could start my life again, I would have it the same way	1	2	3	4

F. ACCESS TO THE COMMUNITY

The following questions ask you about your activities and access to services over the **LAST 3 MONTHS**.

Activities/Access	How often do you <…>?	To what extent have you been able to <…> as much as you need?	Why not 'all of the time'?	Most important reason?
	(a)	(b)	(c)	(d)
1. Go shopping / Going to the market	[f1a] 0 1 2 3 4 5 6	[f1b] 1 2 3 4 5 98	[f1c_1 to f1c_10 f1c_88 f1c_98] 1 2 3 4 5 6 7 8 9 10 88 98	[f1d]
2. Have a social gathering (e.g. playing sport, singing) with friends or peers (who are not family or close relatives)	[f2a] 0 1 2 3 4 5 6	[f2b] 1 2 3 4 5 98	[f2c_1 to f2c_10 f2c_88 f2c_98] 1 2 3 4 5 6 7 8 9 10 88 98	[f2d]
3. Have a social gathering (e.g. playing sport, singing) with family /relatives	[f3a] 0 1 2 3 4 5 6	[f3b] 1 2 3 4 5 98	[f3c_1 to f3c_10 f3c_88 f3c_98] 1 2 3 4 5 6 7 8 9 10 88 98	[f3d]
4. Contribute or present your opinions in community meetings	[f4a] 0 1 2 3 4 5 6	[f4b] 1 2 3 4 5 98	[f4c_1 to f4c_10 f4c_88 f4c_98] 1 2 3 4 5 6 7 8 9 10 88 98	[f4d]
5. Present your opinions on community issues to the village head personally	[f5a] 0 1 2 3 4 5 6	[f5b] 1 2 3 4 5 98	[f5c_1 to f5c_10 f5c_88 f5c_98] 1 2 3 4 5 6 7 8 9 10 88 98	[f5d]
6. Participate in community festivals	[f6a] 0 1 2 3 4 5 6	[f6b] 1 2 3 4 5 98	[f6c_1 to f6c_10 f6c_88 f6c_98] 1 2 3 4 5 6 7 8 9 10 88 98	[f6d]
7. Access Government benefit/s, such as any government social assistant or social security funding	[f7a] 0 1 2 3 4 5 6	[f7b] 1 2 3 4 5 98	[f7c_1 to f7c_10 f7c_88 f7c_98] 1 2 3 4 5 6 7 8 9 10 88 98	[f7d]
8. Join activities of disability-specific support groups, such as disabled people groups or organizations	[f8a] 0 1 2 3 4 5 6	[f8b] 1 2 3 4 5 98	[f8c_1 to f8c_10 f8c_88 f8c_98] 1 2 3 4 5 6 7 8 9 10 88 98	[f8d]

Response categories for column:

(a) 0 = Never; 1 = Daily; 2 = Twice-three times a week; 3 = Weekly; 4 = Two times a month; 5 = Monthly; 6 = Two-three times in three months or less

(b) 1 = All of the time → ***SKIP to Next Activity/Access or G.1***; 2 = Most of the time; 3 = Some of the time; 4 = Never; 5 = Not applicable: No need at all; 98 = Don't know → ***SKIP to Next Activity/Access or G.1***

(c) & (d): 1 = Lack of information; 2 = No services/facility; 3 = Physical accessibility; 4 = Absence of reasonable accommodation; 5 = Negative attitudes towards me at the services/facility; 6 = Cost of service/facility; 7 = Difficulty getting to services/facility from home; 8 = Absence of personal assistance; 9 = Family did not want me to access services/facilities; 10 = Family has difficulty assisting me to access services/facility; 88 = Other *(please specify* [f#co]*)*; 98 = Don't know; *Note:* → ***SKIP*** *column (d) if less than 2 options are selected in column (c).*

G. KNOWLEDGE & ATTITUDE TO INCLUSIVE DEVELOMENT

1. [g1] Do you identify yourself as a person with disability?

   1 = Yes 0 = No 7 = Preferred not to answer /Don't know

2. Is there any person with disability among your … *(**Interviewer**: read response category one by one and select all that apply)*

   [g2_1] 1 = Family members [g2_2] 2 = Relatives

   [g2_3] 3 = Friends [g2_4] 4 = Neighbours

   [g2_5] 5 = Other villagers

   [g2_88] 88 = Any other groups *(specify)* … [g2o] …

   [g2_0] 0 = None → ***SKIP to G.4***

3. [g3] How often do you communicate or interact with them?

   0 = Never 1 = Daily

   2 = Twice-three times a week 3 = Weekly

   4 = Two times a month 5 = Monthly

   6 = Two-three times in three months 7 = Less than twice a year

I am now going to ask you about how persons with disabilities access major services.

4. [g4] Do you think persons with disabilities can access HEALTH SERVICES as much as persons without disabilities?

   1 = A lot more → ***SKIP to G.6*** 2 = A little more → ***SKIP to G.6***

   3 = About the same → ***SKIP to G.6*** 4 = A bit less

   5 = A lot less 98 = Don't know

5. What are the main reasons persons with disabilities access HEALTH SERVICES less than other people? *(Select all that apply)*

   [g5_1] 1 = Lack of information /do not know where to go

   [g5_2] 2 = No healthcare services/facility

   [g5_3] 3 = Family did not want them to visit healthcare facility

   [g5_4] 4 = Lack of assistant to healthcare facility / Nobody accompany them

   [g5_5] 5 = Too far

   [g5_6] 6 = No transport available

   [g5_7] 7 = Transport is not accessible

   [g5_8] 8 = Could not afford the cost of healthcare

   [g5_9] 9 = Could not afford indirect costs, e.g. transportation, food, accommodation, accompanied person

[g5_10] 10 = Do not like the attitudes of staff at health facility

[g5_11] 11 = Do not like the attitudes of others at health facility

[g5_12] 12 = Previous experience of stigma or discrimination

[g5_13] 13 = Persons with disabilities are denied at healthcare facility

[g5_14] 14 = Absence of reasonable accommodation at healthcare facility

[g5_88] 88 = Other (*specify*) ……[g5o] ……

[g5_98] 98 = Don't know

6. [g6] Do you think persons with disabilities can access PAID WORK as much as persons without disabilities?

1 = A lot more → ***SKIP to G.8***	2 = A little more → ***SKIP to G.8***
3 = About the same → ***SKIP to G.8***	4 = A bit less
5 = A lot less	98 = Don't know

7. What are the main reasons persons with disabilities access PAID WORK less than other people? *(Select all that apply)*

[g7_1] 1 = Lack of employment information /do not know where to go

[g7_2] 2 = No opportunities

[g7_3] 3 = Lack of job placement/support services

[g7_4] 4 = Not interested to work

[g7_5] 5 = Difficult applying for a job

[g7_6] 6 = Family did not want them to work

[g7_7] 7 = Lack of assistant to work place

[g7_8] 8 = Too far

[g7_9] 9 = No transport available

[g7_10] 10 = Means of transportation is not accessible

[g7_11] 11 = Could not afford the cost of transport

[g7_12] 12 = Do not like the attitudes of others

[g7_13] 13 = Absence of reasonable accommodation at workplace

[g7_88] 88 = Other (*specify*) ……[g7o] ……

[g7_98] 98 = Don't know

8. [g8] Do you think persons with disabilities can access EDUCATION as much as persons without disabilities?

1 = A lot more → ***SKIP to G.10***	2 = A little more → ***SKIP to G.10***
3 = About the same → ***SKIP to G.10***	4 = A bit less
5 = A lot less	98 = Don't know

9. What are the main reasons persons with disabilities access EDUCATION less than other people? *(Select all that apply)*

[g9_1] 1 = They reached the level that they wanted

[g9_2] 2 = Poor health

[g9_3] 3 = Needed to get paid job

[g9_4] 4 = Taking care of family

[g9_5] 5 = Disability

[g9_6] 6 = Absence of personal assistance

[g9_7] 7 = Family did not want them to go to school

[g9_8] 8 = Family has difficulty assisting them to go to school

[g9_9] 9 = School is too far away

[g9_10] 10 = Means of transportation to school is absent or difficult to use

[g9_11] 11 = Difficulty road conditions to school

[g9_12] 12 = School is not physical accessible

[g9_13] 13 = Absence of specific teaching aids and approaches

[g9_14] 14 = Cost of attending school (e.g. tuition fees, uniform, transport)

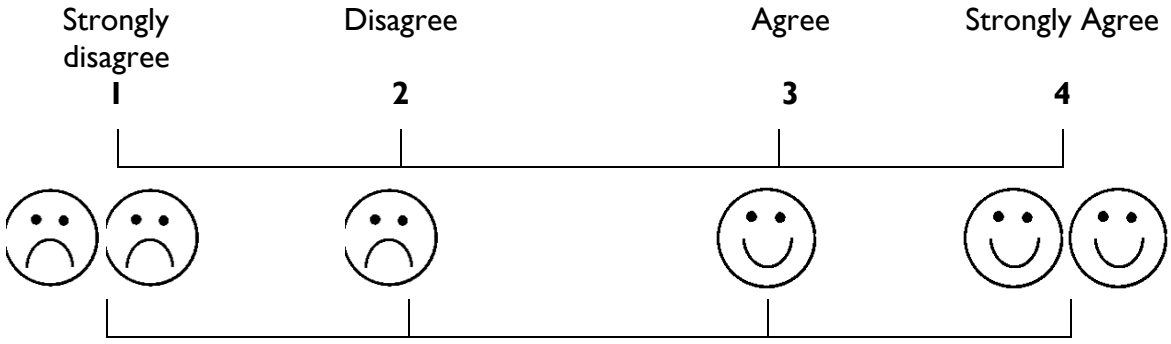
[g9_15] 15 = Being expelled from school

[g9_16] 16 = Treated badly at school

[g9_88] 88 = Other (*specify*) ……[g9o] ……

[g9_98] 98 = Don't know /Don't remember

***Interviewer**: Give respondent the flashcard below during this section.*



What do you think of the following opinions? Would you strongly disagree, disagree, agree, or strongly agree?

Opinion	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
10. [g10] Persons with disabilities attend village meetings as much as other villagers	1	2	3	4	98

Opinion	Strongly disagree	Disagree	Agree	Strongly agree	Don't know
11. [g11] Persons with disabilities make positive contribution to this village	1	2	3	4	98
12. [g12] Persons with disabilities have the same opportunities to become famous doctor, government staff, businessperson	1	2	3	4	98
13. [g13] Persons with disabilities are subject to unacceptable jokes, comments, or humiliation	1	2	3	4	98
14. [g14] Persons with disabilities are able to participate in family income generation activities as much as other members of the family	1	2	3	4	98
15. [g15] More women with disabilities than men with disabilities work	1	2	3	4	98
16. [g16] People in this village have negative attitude towards persons with disabilities	1	2	3	4	98
17. [g17] People in this village frequently support persons with disabilities	1	2	3	4	98
18. [g18] Persons with disabilities receive adequate benefits from the Government	1	2	3	4	98
19. [g19] In this village, children play with children with disabilities as much as children without disabilities.	1	2	3	4	98
20. [g20] There would be no problem if you had a person with disabilities as your neighbour	1	2	3	4	98
21. [g21] There would be no problem if you had a person with disabilities as your classmate	1	2	3	4	98
22. [g22] There would be no problem if you had a person with disabilities as your colleague or partner at work	1	2	3	4	98
23. [g23] Persons with disability should be encouraged to live independently	1	2	3	4	98
24. [g24] Persons with disabilities should able to get married the same as other people	1	2	3	4	98
25. [g25] Persons with disabilities should be able to have children.	1	2	3	4	98
26. [g26] Women with disabilities should be able to work	1	2	3	4	98
27. [g27] Health care providers know what to do if a person with disability needs their help	1	2	3	4	98

28. In your opinion, what do most people think are the main cause/s of disabilities? *(Select all that apply)*

[g28_1] 1 = Fate
[g28_2] 2 = Genes
[g28_3] 3 = Sin of family
[g28_4] 4 = Religious practices
[g28_5] 5 = UXO
[g28_6] 6 = Health conditions
[g28_7] 7 = Traffic
[g28_8] 8 = Other accidents
[g28_9] 9 = Diet
[g28_88] 88 = Other (Specify) … [g28o] …
[g28_98] 98 = Don't know

H. HOUSEHOLD INFORMATION

1. Who do you live with? (*Read response options and select all that apply*)

[h1_1] 1 = No body
[h1_2] 2 = Father (bio/in-law)
[h1_3] 3 = Mother (bio/in-law)
[h1_4] 4 = Spouse
[h1_5] 5 = Brother
[h1_6] 6 = Sister
[h1_7] 7 = Daughter
[h1_8] 8 = Son
[h1_9] 9 = Other female relative
[h1_10] 10 = Other male relative
[h1_11] 11 = Female non-relative
[h1_12] 12 = Male non-relative

2. [h2] Could you please tell me the total income of <u>all household members</u> over the last year?

1 = <10,000,000 LAK
2 = 10,000,000 to <20,000,000 LAK
3 = 20,000,000 to <30,000,000 LAK
4 = 30,000,000 to <40,000,000 LAK
5 = 40,000,000 to <50,000,000 LAK
6 = 50,000,000 to <60,000,000 LAK
7 = 60,000,000+ LAK
98 = Refused to answer

3. [h3] What is the sum again if you make a more accurate estimate? ……..……. LAK

4. What assets does this household own which are currently in working order? *(Read name of all assets one by one*)

	Assets
1.	[h4_1] Tractor
2.	[h4_2] Car or van
3.	[h4_3] Motorcycle or scooter
4.	[h4_4] Bicycle
5.	[h4_5] Boat with a motor
6.	[h4_6] Radio
7.	[h4_7] Television
8.	[h4_8] Fixed Telephone
9.	[h4_9] Mobile phone
10.	[h4_10] Computer or tablet
11.	[h4_11] Washing machine
12.	[h4_12] Air conditioner
13.	[h4_13] Electric fan
14.	[h4_14] Refrigerator/freezer
15.	[h4_15] Agricultural plots of land
16.	[h4_16] Tuk-tuk
17.	[h4_17] CD/DVD player/Home theatre
18.	[h4_18] Water pump
19.	[h4_19] Steamed/Rice cooker
20.	[h4_21] Tractor motor
21.	[h4_22] Rice thresher
22.	[h4_23] Rice mill machine
23.	[h4_2] Grass cutter
88	[h4_88] Other *(specify)* …[h4o]..

5. How many of the following livestock/animals do your household own? (*Read respond options*)

[h5_0] 0. None

[h5_1] 1. Buffaloes ……[h5_n1] …….

[h5_2] 2. Cows ……[h5_n2] …….

[h5_3] 3. Horses ……[h5_n3] …….

[h5_4] 4. Fishes

[h5_5] 4. Goats/Sheep ……[h5_n5] …….

[h5_6] 5. Pigs ……[h5_n6] …….

[h5_7] 6. Ducks ……[h5_n7] …….

[h5_8] 7. Chicken ……[h5_n8] …….

[h5_88] 88. Other livestock/animals/poultry ……[h5_n88] ……

6. [h6] What is the main material of the roof of the dwelling?

1 = No roof 2 = Tile/Sipax/Concrete

3 = Zinc/Metal/Tin 4 = Wood

5 = Bamboo/Palm 6 = Grass/Thatch/Palm leaves

88 = Other *(specify)* ……[h6o] …….

7. [h7] What is the main material of the wall of the dwelling?

1 = Brick /Concrete 2 = Wood

3 = Bamboo 88 = Others (*specify*) ……[h7o] ….

8. [h8] What is the main material of the floor of the dwelling?

1 = Ceramic tiles 2 = Concrete

3 = Wood 4 = Bamboo/Palm

88 = Others (*specify*) ……[h8o] …….

9. [h9] What is this household's main source of drinking water?

1 = Piped water in/outside 2 = Protected Well/ Borehole

3 = Unprotected Well/Borehole 4 = River/Stream/Dam/Lake

5 = Rain water 6 = Bottle/can water

88 = Other (*specify*) ……[h9o] …….

10. [h10] What is the type of toilet facility mainly used by this household?

1 = Flush/pour flush	2 = Pit latrine ventilated
3 = Pit latrine others	4 = Composting toilet
5 = Bucket	6 = Hanging toilet
7 = No facility /Bush /Field	98 = Other (*specify*) ……[h10o] ……

11. [h11] Does this dwelling have electricity?

1 = Yes with own meter	2 = Yes with shared meter
3 = Yes with own generator	4 = No – use batteries
5 = No electric or batteries	

12. [h12] What is the household's main source of energy for cooking?

1 = Electricity	2 = Paraffin/fuel
3 = Wood	4 = Coal
5 = Charcoal	6 = Sawdust
7 = Gas	88 = Other *(specify)* ……[h12o] ….

13. [h13] Does your household currently hold any loan?

1 = Yes 0 = No 7 = Refused 98 = Don't know

14. [h14] Does your household currently have any saving?

1 = Yes 0 = No 7 = Refused 98 = Don't know

Interviewer: Please read aloud:

Thank you for answering these questions. I have finished asking my questions now. Do you have any questions, or would you like to discuss any other issues?

Thank you for participating in this survey!

Interviewer to complete:

15. [h15] *Who answer the questionnaire?*

1 = Totally by the respondent	*2 = Mainly (>50%) by the respondent*
3 = Mainly by another person	*4 = Totally by another person*

16. *Interviewer's note:* ……

END INTERVIEW!

[end] *(end)* Time at the end of survey *(automatically record*

3. Appendix 3: Focus Group Discussion Guide for community people with disability

USAID Okard CBID Baseline: Qualitative Data Collection

People with Disabilities: Focus Group Discussion (FGD) Guide

A. General

A	General data		Number of participants
1	*FGD No.*		
2	*FGD location.*		
3	*Sex*	Female	
		Male	
4	*Age*	Under 18 years	
		18 years +	
5	*Participants with disability?*	Physical	
		Hearing	
		Vision	
		Psychosocial	
		Speech and communication	
		Intellectual	

Note: throughout consider and explore if there are differences for different types of disabilities.

If has not already been done, read through the Plain Language Statement, and obtain written or verbal consent from the participants.

B. Inclusion and participation in the community

We are going to begin by talking generally about your community – this may be your family or household, or the wider community around you. We want to talk about how well people are included in and participating in family and community life, and whether there are people or groups of people that may be left behind when it comes to community life and activities.

B	Core item: Inclusion and Participation	Follow up questions	Notes & prompts	✓
1	What are the key activities and events that you and	• What are the main social events or meetings? • Where are these held? • Who organises them?	*Prompt to think about any social events (e.g. religious, recreation,*	

	your family members participate in, in your community?	• Who attends them? • Who from your household does/doesn't attend these activities or events? • Why/why not? • Are there other people in the community that you have noticed also do not attend these activities or events? • Why do you think this is? • Are there some groups of people more excluded than others?	*community solidarity events) or community meetings that happen in their community.* *E.g. older people, poor people, people from different ethnic groups, people with disability, sick people.*	
2	How are decisions made in your community?	• Who makes the decisions? • How are decisions made? • What about in your family, how are decisions made? • Are there members of the community/your family that do not have the opportunity to participate in decision making? If so, who? Why are they not involved?	*Will need to gauge whether asking about family decision making is too sensitive for discussion within the group. May wish to keep to community decisions only.*	

C. Awareness & attitudes to disability

We are now going to talk more specifically about knowledge and attitudes about disability. We are really interested in hearing your opinions and experiences of how people respond to disability in your community.

C	Core item: Awareness	Follow up questions	Notes & prompts	✓
1	What do you think people in this community think when they hear the word 'disability'?	• Do people in the community think about disability as only certain impairments (e.g. physical) and not about others (e.g. vision, psychosocial) • Is it usual to see people with disability in public places in your community?	*Prompt them to think of their own experiences in the community and of other people with disabilities with different impairment types.*	

		• How would you describe people's attitudes to disability in the community? • What do people do or say when they meet a person with disability? • What has been your experience? How have people treated you?		

D. Work & social participation

Next we are going to talk about participation in work and social activities in the community for people with disabilities?

D	Core item: Work	Follow up questions	Notes & prompts	✓
1	Are participants currently working?	If yes: • What kind of work? • How did they start in that work? • Do they think they have enough work? • Do they enjoy their work? • Is there other work they would prefer to be doing?	*Use work to introduce idea of social participation as it is a common activity. Working includes non-paid work e.g. looking after the house (house wife/husband). Always ask why or why not as appropriate.*	
		If no: • Why not? • Is anything preventing you from working? • What do you need to be able to work? • If people are not working, how do they support themselves financially?	*If not working is the person in school/studying? What do they do? Use to explore barriers.*	
2	What is needed to change in your community so that people with disabilities have greater access to work opportunities?		*Prompt participants to think about changes to attitudes, physical access, transport policies etc.*	
3	Do participants	If yes:	*What sort of events or meetings?*	

	take part in any community events or meetings?	• Which meetings do you participate in and why? • What do you do in these meetings /events? Can you describe? Can you participate as much as you would like? Why? Why not?	*Explore what makes events accessible. How do people participate? Do they speak? Are they listened to?*	
		If no: • Would you like to attend? • Why not? • What is preventing you from attending? What can you suggest that would help you to participate more in the things you would like to do?	*Do people feel unwelcome? Are there physical barriers? Do you receive information on meetings? Are you invited?*	

E. Access to services

The next part of the discussion will focus on access to services such as education and health for people with disabilities in your community.

E	Core item: Education	Follow up questions	Notes & prompts	✓
1	Did you go to school?	If yes: Which school? To what age? What was your experience like? • What could have made your school experience better? If no: • Why not? • Did other family members go to school?	*If they didn't complete school, why not?* *Prompt to discuss their experience of all levels of education – primary, secondary and tertiary/vocational education.*	
2	Do most children with disability in this community go to school now? Has anything changed since your childhood?	If yes: • Which school/s? • What do you think their experience would be like? • Are there any extra supports for children with disabiliites to help them attend school?	*To start, elicit what schools are in this community/area? What level? Consider Special or inclusive schools. Primary, secondary, tertiary?*	
		If no: • Why not? • Is anything preventing children from going to school?	*Do you think other community members would be happy if children with disability went*	

		• What needs to be done to ensure children with disability go to school?	*to school here? The same school or different school as children without disability?* *Do you know if any children with disability drop out of school? Why?*	
3	Do you ever go the health centre? Or receive health care in another way? (e.g. doctor visiting the house)	If yes: • Where? Which health centre? • What is your experience at the centre? Did you experience any problems when trying to access health care?	*Start by eliciting what health services there are in the village/area?* *Prompt participants to think about all levels of healthcare, i.e. prevention (e.g. vaccination), promotion (e.g. hand washing), treatment (e.g. medical services).* *Were you ever referred to other services? If so, what, why and when?*	
		If no: Why not? Is anything preventing you from going to the health centre? What needs to be done so you can go to the health centre/get the health care you need?	***Attitudes:*** *Are staff helpful, friendly or otherwise?* ***Physical:*** *Can they physically get into health services?* ***Financial:*** *are there costs for health care?*	
3	Do you think people with disability in this community are able to access health care as often as they need to?	Do people without disabilities also have any difficulties accessing health care? How are the experiences the same/different for people with and without disabilities?	*Why / not?* *What about yourselves personally?*	

F. Barriers

Note: If you think this has already been covered in your discussion you do not need to ask the following question.

F	Core item: Barriers	Follow up questions	Notes & prompts	✓
1	Do you think people with disability can participate in community life and access services in the same way as people without disability?	• Why do you think that? • Is it the same for all people with disability? • What are the main barriers/obstacles/ challenges do people with disability face in this community? • How can this be changed? What needs to be done?	*Consider: physical, hearing, visual, psychosocial. Why / not?*	

G. Questions on discrimination

The following should be answered as a group and should be used as a basis for exploring experiences of discrimination. Introduce what is meant by discrimination as in prompts below.

G	Questions/core items	Response	Prompts	✓
1	Over the last 12 months, how often have you experienced discrimination?	*1. All the time*	*[READ the responses in this section.] For example, being treated rudely, with disrespect, ignored, insulted or refused access to a place or goods or services.*	
		2. Most of the time		
		3. Some of the time		
		4. Rarely		
		5. Never		
2	Where did this discrimination occur?		*In this community, at a health centre, market, work place etc?*	
3		*1. Disability*	*Explore.*	
		2. Caste		

	Was this discrimination due to…? [can choose as many as you like]	*3. Race / ethnicity*	*Inc. language.*	
		4. Age		
		5. Gender		
		6. Sexuality		
		7. Other [please specify]		

H. Is there anything else you would like to share?

[END]

VII. References

1. World Health Organization and World Bank, *World report on disability*. 2011, Geneva, Switzerland: World Health Organization.
2. Filmer, D., *Disability, poverty, and schooling in developing countries: results from 14 household surveys.* The World Bank Economic Review, 2008. **22**(1): p. 141-163.
3. Marella, M., et al., *Prevalence and correlates of disability in Bogra district of Bangladesh using the Rapid Assessment of Disability survey.* BMC Public Health, 2015. **15**.
4. Trani, J.-F., et al., *Disability and Poverty in Morocco and Tunisia: A Multidimensional Approach.* Journal of Human Development and Capabilities, 2015: p. 1-31.
5. Lao Statistics Bureau, *Results of population and housing census 2015*. 2016, Ministry of Planning and Investment: Vientiane Capital.
6. Fielding, A., et al., *Improving Access to Social and Economic Services for People with Disability in Lao PDR.* 2017.
7. Loeb, M.E., A.H. Eide, and D. Mont, *Approaching the measurement of disability prevalence: the case of Zambia.* ALTER-European Journal of Disability Research/Revue Européenne de Recherche sur le Handicap, 2008. **2**(1): p. 32-43.
8. Fielding, A., et al., *Report on research findings: Improving access to social and economic services for people with disability in Lao PDR.* 2016.
9. Mont, D., *Measuring disability prevalence. Social protection discussion paper No. 0706.* 2007.
10. Thoresen, S.H., et al., *A snapshot of intellectual disabilities in Lao PDR: Challenges for the development of services.* Journal of Intellectual Disabilities, 2017. **21**(3): p. 203-219.
11. Bright, T. and H. Kuper, *A systematic review of access to general healthcare services for people with disabilities in low and middle income countries.* International journal of environmental research and public health, 2018. **15**(9): p. 1879.
12. Bright, T., S. Wallace, and H. Kuper, *A systematic review of access to rehabilitation for people with disabilities in low-and middle-income countries.* International journal of environmental research and public health, 2018. **15**(10): p. 2165.
13. Kuper, H. and P. Heydt, *The missing billion: Access to health services for 1 billion peopl with disabilities*. 2019: London.
14. Stubbs, B., et al., *Depression and physical health multimorbidity: primary data and country-wide meta-analysis of population data from 190 593 people across 43 low- and middle-income countries.* Psychol Med, 2017. **47**(12): p. 2107-2117.
15. Colombo, F., et al., *Help Wanted? Providing and Paying for Long-Term Care*. 2011, OECD Publishing.
16. Grimmond, D., *The economic value and impacts of informal care in New Zealand. Infometrics report for Carers NZ and the NZ Carers Alliance*. 2014: New Zealand.
17. Chang, H.-Y., C.-J. Chiou, and N.-S. Chen, *Impact of mental health and caregiver burden on family caregivers' physical health.* Archives of gerontology and geriatrics, 2010. **50**(3): p. 267-271.
18. Savage, S. and S. Bailey, *The impact of caring on caregivers' mental health: a review of the literature.* Australian health review, 2004. **27**(1): p. 111-117.