Assessment of Quality of Life for Towards Sustainable Income Generating Activities for Landmine / UXO Victims of Battambang Province (TIGA), 2008-2010; Handicap International

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Terminology used in this report
- Q of L score: Quality of Life score from the T.I.G.A. Quality of Life Assessment; the survey consists of 14 questions, each with a possible score of 1-4 points
- Global Q of L score: The total score obtained per beneficiary on the Quality of Life Assessment
- Change in Q of L score: The difference between the baseline score and the final score (may refer to global or category)
- Category Q of L score: the score of a particular category relating to the Quality of Life Assessment (for example ‘family situation’)
- Change in individual category of Q of L score: - refers to that category, rather than individual person
- Q of L categories: refers to the categories such as those listed in Figure 19
- Q of L criteria: refers to the criteria such as those listed in Figure 19
- QL+: EPHs who scored an ‘acceptable’ level on their baseline Quality of Life Assessment
- QL-: EPHs who scored an ‘unacceptable’ level on their baseline Quality of Life Assessment (this group qualified for additional support)
- EPH – economic project holder: project beneficiary, selected for IGA activity
Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>EPH</td>
<td>Economic Project Holder</td>
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<tr>
<td>IGA</td>
<td>Income Generating Activity</td>
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<tr>
<td>Q of L</td>
<td>Quality of Life</td>
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<tr>
<td>TIGA</td>
<td>Towards Sustainable Income Generating Activities for Landmines/UXOs Victims of Battambang Province Project</td>
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Layout of Report

Graphs are followed by explanations. Below each explanation, key points are simplified and summarized with arrow bullets. These key bullet points give enough of an overview to explain graph results.

1. Executive Summary

The objectives of the study are to:

- Measure which improvement in the socio-economic situation has been mainly achieved of the beneficiary households due to the project’s intervention
- Verify if in case of quality of life improvement as per data set the same experience of improvement has been made in the beneficiary households, and how they rate the impact in their quality of life improvement
- Measure the potential individual sustainability of the improved quality of life of beneficiary Households
- Identify main factors and/or obstacles, in the opinion and experience of the beneficiaries, for the improvement or not of the quality of life (including sustainability and risk factors)
- Make recommendations on how to strengthen the Quality of Life Assessment tool, based on project needs
- Make recommendations on project operational changes to strategically enhance quality of life
Those who were less vulnerable at the start of the project (those with a higher quality of life score (QB+) during the baseline assessment) showed a higher average change in their quality of life score over the course of the project than those who were more vulnerable (Figure 1), even though those who were more vulnerable qualified for additional support services. Those who are more vulnerable may have more difficulties coping, and additional constraints such as higher debt burdens.

Figure 2 Average Change of EPHs per Q of L Category
The Quality of Life Assessment showed that household budget and community participation categories had the highest changes (Figure 2). Discussion group results showed that community participation had a high change, while their economic/asset condition had a medium change. The difference between the medium and high ratings comes from slightly different criteria in the measurements used between the quality of life assessment and the focus group discussions.

Income from IGA activities was an important factor in multiple areas of quality of life, either through direct change (increase in economic/asset situation), or through EPGs channeling money where they felt most important (such as education, food security, and health). Increase in economic status also contributed directly to an increase in social status, leading to more inclusion in the community. Economic/assets were routinely indentified as the most important category to see a change in.

Rehabilitation referrals, particularly for prosthetics, have made considerable changes in ability to work, leading to higher household income, food security, and community perception. Health care referrals and sanitation training have led to changes not only in health status but community perception. Those that were most vulnerable at the start of the project (QB-) showed more change than those who were less vulnerable, although this may be partly due to the additional services provided to QL- EPHs.

EPHs had high levels of change in social participation, community decision making, and perception from others. However, physical access within the community is still limited, and formal mainstreaming of issues to the village and commune level is not yet in place.

Economic Project Holders (EPHs) felt that their businesses were sustainable, as they had the investments already to start them and keep them going, along with training and technical knowledge. They also felt the businesses were able to expand without additional help. For health, there was a mixed reaction regarding sustainability, but people felt they now had the confidence to approach health clinics they otherwise wouldn’t have, although in some cases are reluctant to pay more money for higher quality of services. For social referrals, EPHs felt that sustainability was low, and worried about accessing and paying for services in the future. However, the project responded in 2009 by increasing flexibility of services, and services currently accessed through other NGOs will still be available.

Recommendations to improve quality of life include:

- Focus on increasing IGA profit, which will have a ripple effect to a variety of areas of quality of life. Farming activities are particularly good at enhancing food security for females, and allow higher flexibility to consume or sell goods, although don’t bring in a higher profit than non-farming activities, and are prone to external risks such as environmental and market effects
- Toilets contribute to health, sanitation and comfort standards, and there is benefit to providing both adapted toilets and standard ones
Focus should be kept on those who are most vulnerable; they showed less overall change in quality of life, even with a greater range of specialized services. Coping skills for those more vulnerable may be poorer than those who are less vulnerable.

Increase monitoring of those who are chronically sick, and consider specialized cases of support for those with heavy burdens due to illness, for example additional monitoring to ensure IGA activities are running according to plan.

Access to microfinance is particularly important to those most vulnerable; an emphasis on low interest rate loans rather than high interest loans from informal money lenders or a dependency on loans from product buyers should be further encouraged through referrals.

Further government support and promotion is needed to 1) hear from and understand the voice and needs of residents with disabilities; 2) promote rights understanding among the general public, and 3) encourage support of facilities most needed (for example health centers, community accessibility changes). Priority planning of needs should be incorporated into Commune Investment Plans, in consultation at a village level.

Recommendations to improve the Quality of Life Assessment Survey include:

- A uniform framework will ensure ease of comparison for examining Q of L, taking into consideration areas important to project objectives and areas important to beneficiaries.
- When selecting criteria consider if it looks at change due to the project (is change in Q of L really due to the project), or will help in the selection of distribution of social services.
- Ensure there are no inherent biases in criteria measures selected (is change in Q of L really being measured).
- Ensure categories have been considered in relation to ‘weighing’ issues, if appropriate.
- The tool is appropriate to ID vulnerable families and help ID those who should receive additional services, but a double-check mechanism can ensure no one falls through the cracks. However, the tool has limitations in identifying who has best benefited through additional services.

2. Introduction and Background

2.1. Project Description

The overall objectives of the TIGA (Towards Sustainable Income Generation) Project are:

- The social exclusion and poverty of landmines victims and affected communities (including other people with disabilities) is reduced.
- The capacities of local actors (partners and duty-bearers) to understand and efficiently meet the needs of people in disabling situations are improved.

The specific objective is long-term improvement of the living conditions of landmine victims and other people with disabilities residing in 4 districts of Battambang province.
Activities included IGA (income generating activities), referrals for social and health needs, awareness training for the community at large, and capacity strengthening for NGO and government counterparts. The project was executed together with Enfants du Cambodge (OEC), implemented from April 2008 – December 2010.

2.2. Objectives
The objectives of the study are to:

- Measure which improvement in the socio-economic situation has been mainly achieved of the beneficiary households due to the project’s intervention
- Verify if in case of quality of life improvement as per data set the same experience of improvement has been made in the beneficiary households, and how they rate the impact in their quality of life improvement
- Measure the potential individual sustainability of the improved quality of life of beneficiary Households
- Identify main factors and/or obstacles, in the opinion and experience of the beneficiaries, for the improvement or not of the quality of life (including sustainability and risk factors)
- Make recommendations on how to strengthen the Quality of Life Assessment tool, based on project needs
- Make recommendations on project operational changes to strategically enhance quality of life

2.3. Methodology
The study was carried out through two means. A database analysis was conducted on the Quality of Life Assessment Study that was given to all EPHs at the project start, mid-term, and closure. Assessment was done on all those who had completed a full cycle of services and evaluations, which was 320 of 560 EPHs at the time of study. Starting (baseline) and closure scores of the Q of L Assessment were considered. Focus groups and key interviews were carried out in all four target districts. The key project Decision Committee (DC) members were met and interviewed, along with the local authorities. A questionnaire was filled out by the project team, including the Project Manager, Project Manager Deputy, Project Assistant, Livelihood Field Officers, and Community Field Workers.
**Figure 3 Methodology of Analysis**

**TIGA Q of L Survey (Database Analysis)**

- What are areas of quality of life that showed the biggest changes? [database analysis]
- Are results consistent?
- Can TIGA survey method be validated? if big discrepancy probe into criteria classifications
- What activities led to the biggest changes, and why? Differentiate social/health activities vs economic activities; economic can be further classified into farming and non-farming
  - Is the activity sustainable?
  - Suggestions for continuation, improvement?

**Field Study Follow-Up**

- What areas of quality of life that showed the biggest changes? [focus group of top and bottom third; individuals with overall change, according to survey] MSC; ranking Q of L areas of change
- Are results consistent?
- What areas of quality of life are the most important to them to see changes in? [same focus groups and individuals] ranking
- Which activities were meant to target the quality of life areas that are most important to them? Differentiate social/health activities vs economic activities; economic can be further classified into farming and non-farming; probe external vs internal constraints
  - Why were the results of the activity not satisfactory enough? Eg, were activities appropriate? Targeted correctly?
  - Is the activity sustainable?
  - Suggestions for continuation, improvement?
2.4. *Focus Group Selection*

Focus group discussions were conducted to elicit:

- Areas of quality of life most important to see changes in
- Areas of quality of life where most changes were seen
- Underlying reasons to changes in areas of quality of life
- Constraints in areas that did not see expected changes
- Changes in quality of life from IGA activities vs changes in quality of life from social/health activities
- Constraints to changes and suggestions for improvement

Focus groups were selected based on comparisons of those who showed the most change vs the least change (from the baseline Quality of Life Assessment to the final evaluation), and those who were the most and least vulnerable at the start (QB+ and QB-). A mix of males and females were used, with the focus groups divided by gender for certain questions, and all four districts were included. Annex 1 outlines the statistical method for focus group selection.

2.5. *Key Informant Interviews*

Individual follow-up interviews were selected from each focus group. Additional key interviews were held with relevant staff from the District Office of Women’s Affairs, District Office of Agriculture, District Office of Social Affairs (all also members of the TIGA Decision Committee involved in selecting and validating EPHs and monitoring and follow-up), one representative commune council, and one village chief. Field staff were also interviewed on-the-spot about various issues, and a written questionnaire was given to staff.

3. **Changes in Quality of Life From the Quality of Life Assessment Survey**

The following graphs are intended to make comparisons between categories; they are for comparative purposes only, and are not meant to directly quantify scale of change. Differences in scale mean direct comparisons can not be taken from these graphs between scale of global Q of L (which could receive a score up to a maximum of 56 points) and individual category Q of L (which could receive a maximum score of 4 points). In cases where direct comparisons were needed the tables were converted to percentages, but for the most part this was not required; separate graphs were produced for global vs individual categories. The graphs are intended to demonstrate where changes occur in respect to different variables, with the information used to compare with focus group discussions to identify where and why changes occurred.
3.1. General Trends

Figure 4 Average Change in Global Q of L Score by Gender

Females showed an overall higher change in Quality of Life than males. Note though the difference is less than one point on the Q of L survey.

Figure 5 Percent of EPHs Change of Global Quality of Life Score

The distribution of changes was looked at to classify who was in the ‘top third’, ‘middle third’, and ‘bottom third’ of amount of change. EPH’s were assigned a category based on their average change of Q of L. The group they were assigned to was determined by the
number of EPHs, range of their change of scores, and their actual score. A detailed explanation, along with a sample calculation to illustrate the method, is found in Annex 1. Assuming a normal distribution of change values, it is expected the ‘middle third’ category to be the highest, which is the case, apart from a higher number of males reflected in the ‘bottom third’ category. A few data outliers can sway results, but here the high showing of males in the bottom third category is not due to individual outliers, but a larger spread of males with a lower average Q of L change (more males had a smaller change than expected). This was not satisfactorily explained through further analysis, and comments are found in section 7.4.

- Females showed slightly higher overall Q of L changes (end of section 3.4.2 has potential explanation)
- More males showed a ‘smaller’ level of change than expected

Figure 6 Average Global Change in Q of L of Those Originally QL+ vs Those Originally QL-

EPHs that were originally QL+ showed greater changes in Global Q of L than those who were QL-, even though those who were QL- had access to a greater range of specialized services. While this may be taken as an indication that specialized services may need strengthening, those that those who are less vulnerable to begin with likely have better coping abilities to help improve their situations (those who were QL+ to start with, for instance, had a better household budget situation, so may have been less debt-prone).

3.2. Improvements to Socio-Economic Situation
Categories with the highest change are household budget and community participation categories (change in economic situation was considered the most important aspect for EPH’s to see a change in). The area of least change is ‘occupying conditions’; this is not unexpected as the project objectives did not directly address legal occupation of housing, and the transition towards house and property ownership require much more of an income change than other categories. It is also highly dependent on external factors not controllable through the project (political and legal situations).

Discussion group results showed that community participation indeed had a very high change (see sections 4.3 and 4.4). Results showed only a medium perceived change in EPH’s economic situation.

The results do not need to be viewed as conflicting; while people’s balance of income has improved, on an individual level it may not have improved enough to balance family needs to a level perceived as ‘high’. This is particularly so if people’s change in ‘household budget’ above was from a very poor to a medium score, as opposed from a medium score to a higher score (which would likely reflect in focus groups as ‘higher’ due to ability to cover payments where needed; an improvement in Q of L score from poor to medium still means the household does not have additional income). The household budget score here only shows average change, not the upper or lower range of changes. Analysis below (section 3.4) on budget and economics show some constraints / limits to what information we can get from the ‘household budget’ Q of L category

- Household budget and community participation have shown the biggest changes according to the Q of L survey; focus group participation indicates a high change for participation, but a medium change for economic situation

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\[1\] This does not necessarily conflict with the QoL survey result of ‘high’. The household budget above reflect income vs expenditure (and takes into account debt payments, etc), while focus group discussion included income, debts, ability to invest, ability to invest in health, education, and so forth.

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Direct comparison between ‘household budget’ from the survey and focus group discussion should allow for differences in criteria.

3.3. Changes for Different Disability Types

Figure 8 Average Change in Global Q of L Score for EPHs with Disabilities vs EPHs Without Disabilities

There was little difference in global change of Q of L scores between EPHs with disabilities vs those without, except for a greater change for females who did not have
disabilities. This may be related to results in Figure 4 showing females had more overall change than males. Note that some categories aside from physical impairment and N/A have low numbers of EPHs in them.

Among different types of impairment, the biggest change (for both males and females) in global Q of L score was for those with physical impairments. Feedback from those who have received prosthetic devices indicated a dramatic difference in ability to work. Those who had other impairments such as visual may not have experienced such a difference in ability to work (due to the impairment itself before and after rehabilitation intervention, not in reference to implemented IGA activities), which could account for the difference. A further breakdown of changes in Q of L for different disability types is shown in Annex 2.

3.4. Comparison of Economic Activities to Changes in Q of L

IGA Project kit types were compared between global change in Q of L scores (averaged by kit type and gender) and with IGA income (averaged by kit type and gender) to examine correlations between global Q of L change and direct IGA income. There was no direct correlation between IGA income earned and change in household budget Q of L category (not graphed). This is not unexpected, as the household budget category looks at entire household expenses and income, so reflects debts and payments for health, education, etc.

3.4.1. IGA Activities vs Q of L

Figure 10 Average Change of Q of L for Different IGA Activities
Note: The fish raising category had only one participant, so unusually high change here compared to other areas should be treated with some caution; this has also led to an equal change in ‘farming’ between males and females, although in individual categories females showed more change.

Those participating in farming activities reflected a greater change in Q of L than those participating in non-farming activities. Males participating in non-farming activities tend to show larger Q of L change than females. Females overall tend to show larger change than males.

3.4.2. IGA Activities vs Profit

Figure 11 Range of Yearly Profit Earned from IGA Activities

Note: $1 US = approximately 4200 riel
IGA profit was selected for comparison as opposed to ‘household budget’ category of Q of L survey as IGA income is a more direct result of IGA activities.

Males showed more profit than females for both farming and non-farming activities. Non-farming activities are more profitable for females in general than farming activities.

It is interesting to note that while females averaged higher profits on non-farming activities, those that undertook farming activities have a slightly higher change in their Q of L score than those who did non-farming activities. When the category of food security from the Q of L survey was examined (how many meals a day people ate), it showed that females who undertook farming activities had slightly higher levels of change in food security (Figure 13) than those who undertook non-farming activities, likely from producing their own food (chickens, for example, are more likely to be eaten than sold). This could explain why females had higher profits from non-farming activities than farming activities but higher Q of L changes for farming activities. This may also explain why global Q of L change is higher for farming activities in general than non-farming activities.

It is unclear why farming males had comparably small food security changes compared to females. Information from discussion groups indicated medium to high changes in food security for males and females.

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2 Note: carpentry and masonry only had one participant, and rice four. The high values need to be examined further in regards to their business plans, reporting period, and other factors to determine reasons for much higher income, before it can be assumed these are higher profitability activities than the others.
Figure 13 Average Change in Q of L category “Food” (Number of Meals per Day) for Farming Activities vs Non-Farming Activities

Figure 14 Change in Household Labour and Household Budget Q of L Categories for Male and Female EPHs

Females had slightly less change than males in regards to household labour, but slightly more change in household budget. Males having more change in labour category than females may be because more males than females had physical impairments (many females are wives/family members of those killed my mines), so due to rehabilitation and prosthetics it may be that more males are physically able to work than were able to before. A higher change in household budget for females is not easily explained by data presented, particularly as they showed a lower amount of actual IGA profit than males. It
may have to do with the way females manage money for the household in comparison with males, and the allocation of money in the household (debt payment and so forth), although this is conjecture and not shown in the data.

3.5. Q of L Changes for Social, Health, and Microfinance Referrals

3.5.1. Access to Microfinance

Figure 15 Change in Global Q of L: Those Who Accessed Microfinance vs Those Who Didn’t
Those who originally were QL+ who did not access microfinance institutes showed greater global change in Q of L than those who did (both for participants with disabilities and those without). On the other hand, those who were originally QL- who accessed microfinance institutes showed a greater global change in Q of L than those who didn't (both for disabled and non-disabled participants). The same trend was reflected when individual categories of household budget were looked at.

- Access to microfinance is both more important for those who are QL-, and has more of a change for those who are QL- (compared to QL+)

The above analysis does not take into account other forms of borrowing (money lenders, etc), which still occurs, although this in reflected to some extent in the household budget category as it measure overall balance of finance. The number of microfinance referrals overall was not large, so representation within categories have small sample numbers.
3.5.2. **Referral Services for Health**

Figure 17 Change in Global Q of L for EPHs Who Accessed Health Referral Services vs Those Who Didn’t

![Bar Chart: Change in Global Q of L for EPH's Who Accessed Health Referral Services vs Those Who Didn't](image)

In both cases, a bigger change was seen for those who were QL-. However, those in this category also qualified for financial coverage for health services.

Figure 18 Change in Health Category Q of L for EPHs Who Accessed Health Referral Services vs Those Who Didn’t

![Bar Chart: Change in Health Category Score for EPH's Who Accessed Health Referral Services vs Those Who Didn't](image)
Group discussion indicated that EPHs felt changes from trainings, such as sanitation education, had high impacts on health categories, which is not reflected in chart above.

4. Results from Focus Groups and Key Interviews

4.1. Defining Quality of Life for Discussions

Discussions on Quality of Life categories were held on 7 categories. Categories were selected based on Handicap International suggestions according to important aspects to examine. Criteria within each category was selected based on common-sense issues pertaining to the category, using ideas and concepts already touched on in the Q of L survey and the project in general.

<table>
<thead>
<tr>
<th>Category of Quality of Life</th>
<th>General Criteria Guidelines (focus groups were asked to keep in mind during discussions)</th>
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<tbody>
<tr>
<td>Economic / Assets</td>
<td>• Income&lt;br&gt;• Family debt situation&lt;br&gt;• Capital available to invest&lt;br&gt;• Owned assets&lt;br&gt;• Ability to direct income (health, education, quality of house, etc)</td>
</tr>
<tr>
<td>Health</td>
<td>• Access to quality medical care – knowledge and confidence to access system; ability to pay&lt;br&gt;• Change in amount of sicknesses</td>
</tr>
<tr>
<td>Education / Skills</td>
<td>• Technical knowledge for business and changes this has brought&lt;br&gt;• Awareness of social / health issues and changes this has brought</td>
</tr>
<tr>
<td>Access to Food</td>
<td>• Ability to buy food&lt;br&gt;• Ability to grow food&lt;br&gt;• Ability to feed family year round</td>
</tr>
<tr>
<td>Water / Sanitation</td>
<td>• Access to clean water (cooking, drinking)&lt;br&gt;• Knowledge of hygiene issues and changes this has brought</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>• Changes brought by access to rehabilitation services</td>
</tr>
<tr>
<td>Inclusion</td>
<td>• Participation in community activities&lt;br&gt;• Participation in decision making in the</td>
</tr>
</tbody>
</table>
Discrimination by community members

The criteria above are not set in stone, and there are often direct links from issues in one category to issues in other categories. They are meant to serve as a basis for discussion, and to focus thinking on changes in categories of Q of L.

The approach taken was to examine each category from a perspective of overall importance, actual change, and reasons behind the change.

4.2. Overall Importance

The overall importance of categories was discussed to verify if the project is targeting areas of interest to beneficiaries, and to go into further details where necessary in cases where smaller amounts of change were seen in categories of importance to find out why.

The top three topics of most importance to beneficiaries were asked of each group. The categories are order below from the number of times most selected overall downwards:

- Economic/assets  5
- Education   4
- Sanitation   4
- Health    3
- Food access   3
- Rehabilitation   2
- Participation   1

In all focus groups except one, economic/assets was always the first selection, as that was considered a key category that can influence most others through the ability to direct finances (an increased economic situation allows payment for health services, ability to buy food, etc). Women had a slight preference to choose education (from their children’s education point of view) over men.

Some issues were inextricably linked for some participants. Health and labour were often considered as important as one another (‘you can’t have one without the other’), with changes being seen equally (without good health they could not have a good economic situation, and vice versa). Sanitation was also considered a very important groundwork to more than one area, including access to food, and health. Others saw a direct link between education/skills and community participation (without community participation they can not increase their skills training).

There was a higher focus on ‘tangible’ vs ‘intangible’ category changes. Concepts such as economic change are more familiar and easy to picture than concepts such as

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3 The chart can be adapted for the next round of programming to be used as a basic Q of L framework.
community participation change, so these categories are more naturally thought of. The importance of ‘intangible’ categories came out as discussions progressed and categories were examined one by one.

A note on the importance of ‘intangible’ categories

Inclusion ranked the least important activity to see change in, but more than any other category, showed consistent results of very high change (all reported a very high change in participation in weddings and other social activities, community decision making, and a dramatic decrease in discrimination; change was perceived by both EPHs and other project stakeholders). Discrimination came not only from community members, but also family members, including spouses. It is therefore important to not underestimate the value of inclusion, even though it does not receive a ‘high importance’ ranking. Inclusion is more of an ‘intangible’ category, and the other categories are for the most part more associated with day-to-day survival. However, when one’s own family members and spouses are also looking negatively towards them, their vulnerability is severely increased, and confidence levels to try activities (and perhaps chances of success) are low.

Likewise, rehabilitation ranked low. Again, this is a harder area to conceptualize, and at an initial glance not as directly linked with day-to-day survival issues such as economic situation or food security. However, as discussions developed, people acknowledged the high level of changes brought about through rehabilitative assistance, allowing them to engage in labour and earn a living (particularly those with prosthetic device assistance).

4.3. Actual Change

<table>
<thead>
<tr>
<th>Category of Quality of Life</th>
<th>Actual Change</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic / Assets</td>
<td>Medium</td>
<td>Income generated often self-sustaining; reinvestment leads to business expansion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Able to spend earned income on other areas that are important (children’s education, healthcare, food)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduction on money lenders for materials (eg seeds), decreasing debt</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase in income allows more time for training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase in ability to work labour jobs due to rehabilitation</td>
</tr>
<tr>
<td>Health</td>
<td>Medium - High</td>
<td>Increased health means less labour lost</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decrease in healthcare related costs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Corresponding increase (closely linked) with Economic/Assets category</td>
</tr>
<tr>
<td>Category</td>
<td>Importance</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------</td>
<td>------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Education / Skills | Medium – High (emphasis on the high end is impact on children’s education rather than personal skills) | Children able to attend school when were unable to before  
More income available to spend on children’s school and books  
More income means children not required as much as home for household/farm labour  
EPH training situation - people had initially been reluctant to take training as they felt it would be too hard; now have more confidence  
More income means more time available to spend on training (less time needed for ‘daily survival’ needs such as obtaining food |
| Access to Food    | Medium - High | Many can eat three times a day now when could not before  
EPHs are concerned about chemicals in market foods – some prefer to grow their own to avoid chemicals |
| Water / Sanitation | High       | Increased sanitation means less diseases such as diarrhea; leads to less labour lost and decreased health costs  
Increase in hygienic standards assists with community integration |
| Rehabilitation    | High       | Prosthetic devices mean people can work instead of sitting at home; improved economic situation (closely linked to economic category)  
Confidence is boosted, particularly when EPHs can do work not possible previously (‘don’t view self as disabled anymore’)  
Improved social standing (ability to work, strength)  
Increased confidence to contact social services directly |
| Inclusion         | High       | Feel included in society (perception widely seen, from EPHs and government / project stakeholders; change is uniformly large and agreed upon)  
Those with disabilities now included in ceremonies, community decision making, and feel less discrimination (some cited no more |
### 4.4. Reasons for Change

Key points drawn out in discussion groups and individual interviews are summarized in Figure 21.

**Figure 21 Reasons Underlying Changes Seen to Different Areas of Q of L**

<table>
<thead>
<tr>
<th>Category of Quality of Life</th>
<th>Contribuition of IGA Activities to Q of L Category</th>
<th>Contribution of Social / Health Activities to Q of L Category</th>
<th>Impact of IGA Activities to Q of L Category</th>
<th>Impact of Social / Health Activities to Q of L Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic / Assets</td>
<td>Medium</td>
<td>Medium</td>
<td>Benefits received from IGA activities (materials, technical training) redirected to areas of Q of L important to EPH (house repair, children’s education, and so forth)</td>
<td>Knowledge of hygiene issues has increased social perception of business abilities, thereby increasing local support of businesses</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Common to reinvest directly into business expansion, or into another business</td>
<td>Access to health services leads to fewer labour days lost; access to rehabilitation services leads to the direct ability to do labour</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Children’s school attendance increased as they are not needed as much to work around the home/farm</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Future plans often developed on what savings will be spent on (eg build a toilet)</td>
<td></td>
</tr>
<tr>
<td>Health</td>
<td>Medium</td>
<td>Medium - High</td>
<td>Can arrange for themselves for doctor / medicine</td>
<td>Understand services available; will contact HI if get sick if needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Can pay for transport for health issues</td>
<td>Now have confidence to approach health clinic on own if they get sick</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Increased nutrition through increased income has led to better health</td>
<td>Boil water so don’t spend as much treating</td>
</tr>
<tr>
<td>Category</td>
<td>Level</td>
<td>Level</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Education / Skills</td>
<td>High</td>
<td>med?</td>
<td>Increase in income means children not needed as much for household / farm</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low-med?</td>
<td>labour, so can now attend school</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ability to pay for children’s schooling and books (one saving for bicycle)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(This category is higher as perception of child’s educational increases is</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>high)</td>
<td></td>
</tr>
<tr>
<td>Access to Food</td>
<td>Medium</td>
<td>Medium - High</td>
<td>Increase in business activity leads to increased ability to purchase food</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Many farming business activities such a poultry raising and rice mean people can supply own food</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>One recipient use his earnings to have his land cleared of mines, allowing substantial expansion of agricultural activities</td>
<td></td>
</tr>
<tr>
<td>Water / Sanitation</td>
<td>Medium</td>
<td>High</td>
<td>Higher income has meant ability to buy inputs related to sanitation, such as kettles and pots, filters, ice</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Water for children is boiled more now, not only due to availability of material and knowledge, but an increase in income means mothers have more time to think about appropriate child care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Training on sanitation led to high understanding of importance of sanitary practices, and a noticeable reduction in illnesses such as diarrhea</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Toilets provided have helped towards this, and some plan to build their own toilets when they can</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Higher sanitation has also helped contribute to higher social acceptance and</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Low</td>
<td>High</td>
<td>No direct effect of IGA activities on rehabilitation category (not unexpected as EPHs do not cover prosthetic costs themselves)</td>
<td>Access to prosthetic leg means recipients can now farm, work land, care for oxen /cows (before would often sit at home doing nothing) Corresponding increase in income Increase in social perception; before they would often sit at home and do nothing;</td>
</tr>
<tr>
<td>----------------</td>
<td>------</td>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Inclusion</td>
<td>High</td>
<td>High</td>
<td>Ability to generate money and the perception that they are now wealthier and can run a business means community members are more interested in social interaction with those with disabilities. Higher participation in weddings, social activities (one women went from 0 wedding invitations per year to 10). The wealth factor was cited by EPH’s to be by far the most important factor in perception change from others</td>
<td>Less discrimination due to prosthetic devices, allowing work and letting people see them as ‘strong’ and ‘whole’ Training with community in general has had some impact on public perception (way they treat people with disabilities and the language they use to talk to them or describe them) Hygiene training contributed to positive perceptions (people no longer think they are unclean) Rehabilitation treatments have helped in other areas such as pain reduction</td>
</tr>
</tbody>
</table>

IGA activities generated money, which was typically re-invested into either the same activity, or used for expansion to other activities. The overall precariousness families’ financial situation was lowered, allowing less time to be devoted to basic food security issues and more time available for training, child care and sanitation issues (boiling water
for children, for instance). One of the biggest advantages to changes in the economic category is that families can redirect the benefits to most areas of Q of L where they want. The most limiting areas where they can not self-redirect their earned money to improve certain categories is to their own education and to their accessibility needs. Increased capabilities for labour due to prosthetics have had an important impact to a variety of areas of Q of L, including economics, rehabilitation, and perception categories. Covering the costs of prosthetics and access to them was an important contribution to these.

Hygiene training is acknowledge to be particularly important to understanding of disease reduction, and direct impacts were seen in child care practices (boiling water), and reduction of sickness (diarrhea). Corresponding changes were seen in contributions to economic Q of L, as less labour was loss and less money was needed for healthcare costs. Both interests in sanitation issues, and the change noticed in this category, were high.

People were more likely able to pay for healthcare. In addition, social standing and community acceptance and participation increased, mainly due to neighbors now thinking that participants were no longer poor, as they now ran a business. Beneficiaries reported much better relations with their neighbors, and presence at social events (for instance going from not ever being invited to weddings to being invited to 10 a year). They felt this was a direct result of having more money, although acknowledged that hygiene training did play a role.

Perception of government stakeholders is that community trainings (television adverts, awareness raising days, and so forth) have raised awareness; the perception of beneficiaries is awareness has changed due to an increase in their economic situation, in addition to people seeing them as able to work, and being strong and more hygienic (social standing is a direct result of having a successful business and increased income).

4.5. Relating EPH Feedback and Q of L Survey Results

The combination of the two techniques gives a better overall view than either technique on its own. The Q of L survey is suited to identifying overall vulnerabilities of EPH’s, making comparisons and looking for changes within specific categories, and assisting in service provision. Direct discussion is a better way to clarify what the underlying causes of changes are. A direct comparison can not always be made between results of the two techniques, as the same categories were not always used. They may be more comparable if adjustments to categories and criteria are made in the next round (see Annex 3, sections 8.2.1-8.2.4).

**Figure 22 Application of the Quality of Life Assessment Survey vs Direct Feedback through Focus Groups and Key Informant Interviews**

<table>
<thead>
<tr>
<th></th>
<th>Q of L Survey</th>
<th>Direct Feedback</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification of most vulnerable EPHs</td>
<td>X</td>
<td></td>
<td>Currently acceptable, some adjustments recommended (see</td>
</tr>
<tr>
<td>Service provision guidance</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Constraints and Sustainability Issues

5.1. Constraints

Constraints in areas that did not see as much change as expected were identified by focus group discussions, but not in-depth. Either participants were ‘happy with what had already changed’ and had difficulties conceptualizing what further changes may be possible (particularly for intangible categories), or did not want to openly say something they felt was negative against the project. However, constraints and issues for improvement often came up indirectly at unexpected times during focus discussions, so were explored at these opportunities.

According to focus groups and individual follow-up, economic/assets, education, and sanitation, health, and food access were top priorities (in that order). Of these categories, sanitation saw the highest change. Economic / assets, education, health, and food access are areas that could see more improvement in the future.
To examine constraints to the economic/assets category, IGA activities need considering. People expressed satisfaction with training and material provision, and kit selection and approval goes through a multi-step process with a selection committee. Although training itself is not likely an issue, some participants cited not having enough time to attend all trainings.

IGA profits may have been lower than expected due to farming constraints. This year saw drought and pig diseases, and external issues such as climate and diseases may be a reason why IGA farming incomes are below non-farming incomes. However, farming activities have added benefits of more direct contributions to food security.

The economic/assets category must be examined from a larger perspective than only IGA income, as overall household budget balance is measured. People with large/ongoing debts to begin with may not be reaching enough of a profit level to get out of the debt cycle, meaning benefits can not accrue and be passed to other Q of L areas. Risks and failures in the IGA activity can mean little or negative impacts to economic/assets category, meaning smaller changes to other areas. IGA activity profit level was examined against global Q of L changes and household budget changes (Figure 23); it was expected that both global Q of L and household budget would be higher for those with profitable activities. This was not the case. There was no difference in either category based on IGA profit income, which was surprising. This could mean a few things. 1) The profit change for most people is not enough to make a difference, or 2) The measure is not accurate enough. The second choice may be more relevant here: the global change was still a 6 point average change, even for those who made negative profit. It is likely that looking at the average of change between individuals in a category shows too much overall fluctuation, and direct and indirect impacts can not be sorted and identified this way. According to discussion groups, they were earning more than before, although not always enough. Still, there was room for people to divert some savings to other areas such as children’s education.

- IGA profits have some impact to changing quality of life, but not enough. This area is important to strengthen.
- Using average global Q of L scores can not accurately separate direct and indirect effects; individual categories with carefully selected criteria are important to produce better analysis in the future.
Examining why families are still poor and have debt may benefit from an income analysis as part of the final evaluation, and preferably also at the start of the project. A brief breakdown of percentage of income (IGA, non-IGA, farming, non-farming, etc) vs a breakdown on expenditures (food, health, education, etc) may pinpoint trends in spending and identify those struggling with debt problems. It can also show those with abnormally high health expenditures who may be more vulnerable, and reflect other issues such as high expenditures on weddings and ceremonies that was not previously spent.

Health issues are difficult for participants to measure changes, as changes in access are often more intangible, while direct sickness is more tangible. All beneficiaries expressed a satisfaction in health services as ‘satisfactory’ or higher\(^4\), with most being ‘very satisfied’. Staff feedback indicated that local health centers did not always have good quality care, although several issues such as vaccinations are referred to the district level.

Results from section 4.4 show that participants feel their health Q and L has increased due to increased confidence in accessing the healthcare system, and an increase income allowing them to cover costs. However, the reality of being willing to cover costs is not as straightforward. Even though they express that they can pay for medical treatment due to higher incomes, there is still reluctance to pay more for treatment that may be higher quality. People are more likely to take the cheapest option available, even if the quality is substandard, or not authorized. This can be both a constraint and a sustainability issue. Further education may be needed to really understand the benefits of high level health care. In addition, strengthening of medical service providers, through government or other NGO support, can help increase health Q of L, particularly at a local health center level, where standards of services can vary.

\(^4\) TIGA Second Interim Narrative Report
Paying for healthcare and medicine was identified by beneficiaries as something they wished the project to cover for more family members, not just the EPH. It was not indicated by people, however, that they were unable to access medical services (due to lack of funds or other reasons), although the example in the above paragraph indicates some reluctance to do so.

Access to food issues: the best direct way to address this is an increase in farming activities to allow for own food production and consumption. Farming IGA activities should be examined in detail during the final project evaluation. While popular, and bringing positive changes to Q of L, they run the risk of external threats (climate issues such as drought and flooding, diseases such as those this year hitting the pig industry, market fluctuations, and difficulty in finding pig food during the dry months due to land conversion. Overall profit generated was not as high as non-farming activities, but additional benefits are worth perusing these activities. A more in-depth analysis on the reasons profits are not too high is worthwhile to determine if profits can be raised due to increased technical support and management, or if limits have been reached due to external reasons.

**Education / skills:** no constraints were identified for the area of increased schooling for children. Although transport was mentioned (lack of bicycles), people were satisfied at the increased ability to send their children to school. Where there was a lower impact was on EPHs own education. A wide range of results occurred in this category, from people feeling very happy with training, and feeling that training will lead to sustainability of their business activity (and not feeling they needed more), to problems with having the time to attend trainings. Constraints here are more likely to involve sustainability issues. Some EPHs felt they would benefit from additional trainings to address vegetable growing, safe pesticide use, animal vaccinations, and other agricultural technical issues.

### 5.2. Sustainability

In general, feedback from EPHs indicate they feel they can keep going with their IGA activity independently, and even increase it (expanding their current business or investing in others), as they have the materials they need and have had training. Their knowledge from sanitation training will allow them to continue to prevent diseases from unsanitary practices.

On the surface health was not a worry, as people felt they now knew how to access the local system, and ‘were able to pay for it’. However, even though EPHs say they are comfortable with accessing services on their own, and have more ability to pay for services, in reality they will still choose a cheaper option over quality. This can lead to sustainability issues for health quality of life. An additional issue is that accessible services are still variable in quality. Increased quality of healthcare facilities in general, particularly at a local level given lack of willingness to travel long distances to district health centers, is important.
Participants felt rehabilitation and accessibility have low sustainability, however, recent project changes have been made to address this. Ongoing referrals for prosthetics are essential for EPHs to maintain Q of L, and participants worry they will no longer be able to access what they need without the project; some felt they would not be able to afford prosthetics on their own, or be able to cover travel costs to major center to obtain them. Once the TIGA project comes to an end, EPHs will still have access to referrals through various NGOs they are currently referred to. Changes to referrals in 2009 (increase in flexibility), along with the access to resource publications, allow for increased understanding in resources available. Further communication with EPHs to let them know what resources are available (and what costs they would be responsible for and what would continue to be covered) would clarify the situation for EPHs further.

For other accessibility issues, more toilets were definitely requested to promote hygiene and sanitation; there was a mix of responses, and although many wanted project to provide more, several people had plans to build their own.

Integrating the issues of the community members with disabilities into village action plans and up to the commune level is considered crucial for sustainability, for project staff and government stakeholders alike. One village chief has already found success in increasing community accessibility – through input from residents with disabilities in her community, planning was able to achieve disabled access to the local school. However, cases of community accessibility are few and far between. Further government support and promotion is needed to 1) hear from and understand the voice and needs of residents with disabilities; 2) promote rights understanding among the general public, and 3) encourage support of facilities most needed (health centers, for example). Government representatives involved directly in the project had a very high understanding of rights and needs of people with disabilities, and a genuine interest in helping. It was not determined, however, the extent of interest and willingness to help from government bodies not directly involved. Mainstreaming into commune council level plans will likely have highly varying results from one commune to another.

6. Recommendations on Upgrades to the Quality of Life Assessment Tool

The Q of L survey is used to measure changes in different aspects of the project, and to determine who qualifies for various additional services. The Quality of Life Assessment Survey sets the cut-off to determine the most and least vulnerable, assess changes in quality of life of various categories, and helps determine distribution of services.

The assessment found that a uniform framework should be established to ensure ease of comparison for examining Q of L, taking into consideration areas are important to project objectives and areas important to beneficiaries. When selecting criteria, it is important to ensure that criteria looks at change due to the project (is change in Q of L really due to the project), or will help in the selection of distribution of social services. It is also important to ensure there are no inherent biases in criteria measures selected (change in Q of L really being measured), and that categories have been considered in relation to
‘weighing’ issues, if appropriate. The tool is appropriate to ID vulnerable families and help ID those who should receive additional services, but a double-check mechanism can ensure no one falls through the cracks. However, the tool has limitations in identifying who has best benefited through additional services. A detailed assessment of the survey is found in Annex 3.

7. Conclusions

7.1. Summary and Key Findings

7.1.1. Perception of Quality of Life

Some areas of Q of L are more tangible and easier to visualize than others. Economic/assets, health, access to food, and education (particularly in respect to children) were easier concepts to grasp when discussing changes, subsequent impacts, and causes than accessibility, water and sanitation, rehabilitation and assistive devices, and inclusion. As such, tangible aspects were more likely to be discussed, and may contribute more to people’s perception of importance. Some of these intangible issues tended to come out more in discussion as people started linking categories and exploring reasons of change.

7.1.2. IGA Activities

Participants of focus group discussions routinely identified economic/asset changes the most important to see change in. Changes to direct economic situation can have direct and indirect impacts to almost every aspect of Q of L, and EPHs have some control over changing certain facets of Q of L depending on where they direct their income. It is also one of the most tangible and visible results, with even small changes having the capability to spread. While changes were identified in this category, the change was considered medium.

Farming IGA activities have lower profit, but contribute to higher Q of L (likely to an increase in food security). They also carry additional external risks (environmental influences, market influences). They are also more popular among EPHs. Planting activities are particularly beneficial to females.

7.1.3. Health / Social Referrals

Referrals to health services were more important and showed a bigger change to those who were QL- to begin with, although this may be partly due to the additional services provided to QL- EPHs.

The health/social referral component led to significant changes for EPHs, particularly prosthetic referrals. Other areas of health referrals are more difficult to judge and monitor. Current services may have limited sustainability, and quality in some cases is variable due to the state of local health services in rural areas. Although respondents say they now understand how to access the health system and have more income to pay for it, there is still resistance in paying more money for higher quality care. Families with more than one family member with a disability had higher difficulties coping.
A limitation that was not evident in direct analysis but came up informally during discussion was chronic health problems. Those with ongoing health issues were unable to work, and giving no change to Q of L. Ongoing referrals were not always able to adequately address chronic health problems, due to the nature of illness and level of healthcare services available.

7.1.4. Inclusion
Inclusion changes uniformly saw the largest amount of change, and EPHs have seen major inroads into social participation, community decision making, and perception from others. While various aspects of personal accessibility have improved, community-level accessibility is still limited. EPHs are included more in village-level decisions making, but more formal mainstreaming of issues to the village and commune level are needed.

7.1.5. Quality of Life Changes for Those with Disabilities vs Those Without
Of those with disabilities, the biggest changes were for those with physical impairments (due to change in ability to work due to prosthetics); those with hearing impairments had the lowest change. The project is limited to referrals if certain services are not available in the area, or certain impairments can not be improved.

7.1.6. Other Changes
Children’s education has improved, but as an indirect result of activity implementation. This is a good multiplication effect, as benefits spread. Several EPHs (primarily female) requested more support to children’s education (ideas included helping with school fees and building schools). However, when additional money is available it is directed towards children’s education (fees, books). Focusing resources to enable families to increase their income, thereby covering fees themselves, is preferable to direct payments for schooling, in order to foster independence and not promote dependency, although allowances can be made in extreme cases if future programming wishes to cover this issue. Availability of schools is a separate issue, not addressed under TIGA programming objectives.

Community accessibility has had little change (access to public places such as schools, public buildings).

7.2. Key Recommendations

Focus on increasing IGA profit. Higher profits will contribute to sustainability, and allow business activities to expand of their own accord. A comparison of success vs original business plan projections for various types of activities vs actual success can give indications of what activities can be the most profitable, but it is important to include the value of goods consumed in cases of IGA activities producing food, to include impacts on food security. This would need tracking of overall quantity of produce grown, in addition to profit. Increases in IGA profits will have multiplier effects through all the areas of Q of L where EPHs have the ability to make changes for themselves but are currently restricted by their household income situation. It is also an important step in reducing debt. Explore means to ensure EPHs can reduce dependence of loans or
middlemen ‘up front lending’ of supplies help can ensure maximum profits. Focusing on farming IGA activities will enhance food security, particularly for females.

**Focus on farming IGA activities to enhance food security.** Increasing farming activities is particularly beneficial to female quality of life, and do double-duty by supplementing both income and food resources. Families have higher flexibility to consume or sell products, depending on personal needs and market conditions. Note though that these are not necessarily the activities that bring the highest profit. Focus groups for the most part would be interested in more training, particularly with animal health and vaccination issues. More inputs were also widely requested, however, this could lead to higher levels of dependency. The lessons learned evaluation and final evaluation can help draw out additional activity-specific constraints.

**Toilets** are highly appreciated and make a big difference in health, sanitation, and comfort standards. More toilets were requested. If budgetary constraints are an issue, this may be an area to facilitate through other NGOs for future expansion. There is benefit to providing both adapted toilets and standard toilets (depending on family need) from a hygiene/health point of view.

**Keep focus on those that are most vulnerable.** Those EPHs who were QL- at the beginning of the project (and therefore more vulnerable) had less overall change than those who were QL+, even with a greater range of specialized services. This may indicate that specialized services can be strengthened, but also indicate that those who are less vulnerable to begin with likely have better coping abilities to help improve their situations (those who were QL+ to start with, for instance, had a better household budget situation, so may have been less debt-prone). Families with more than one member with a disability have more coping difficulties.

**Increase monitoring and service evaluation for those most vulnerable, and for those who are chronically sick.** Addressing full health issues extends beyond the direct capacities of the project – while an increase in monitoring for those who are chronically sick, along with referrals to higher levels of healthcare (district, provincial), can be further implemented, it ultimately depends on the healthcare system itself. Other forms of support to the family could be considered in cases such as these, such as *select specialized cases of increased inputs, or additional monitoring to ensure IGA activities are running according to the submitted business plan.*

**Emphasize the importance of seeking quality care** when people are seeking medical treatment on their own.

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5 Other project reviews have shown interest on loans, particularly from private lenders, can quickly erode into profits, and in the case of cash crops, farmers are often forced to sell their crops immediately upon harvest to pay debt, losing the chance to store the crop until the market value increases. Dependence on loans from middlemen can lead to obligatory selling of crops back to the middlemen for below-market prices.
Continue assistance with microfinance, particularly to those who are the most vulnerable. Access to microfinance is particularly important to those who were originally QL-. Assist in finding financing with low interest rates, along with including those in the project regardless of previous microfinance history, can promote more positive changes for those who are more vulnerable. If it is preferable to the project to limit involvement of microfinance services due to programming parameters, the focus can be kept to only referring those who are QL-.

Streamlining into government planning. Further government support and promotion is needed to 1) hear from and understand the voice and needs of residents with disabilities; 2) promote rights understanding among the general public, and 3) encourage support of facilities most needed (health centers, public accessibility needs). Priority planning of needs should be incorporated into Commune Investment Plans, in consultation at a village level.

7.3. Recommendations for Upgrading the Quality Of Life Assessment Tool

The current survey tool has been carefully thought out, has objective measures, and in general is good method of identifying vulnerable families. However:

- A uniform framework will ensure ease of comparison for examining Q of L, taking into consideration areas important to project objectives and areas important to beneficiaries
- When selecting criteria consider if it looks at change due to the project (is change in Q of L really due to the project), or will help in the selection of distribution of social services.
- Ensure there are no inherent biases in criteria measures selected (is change in Q of L really being measured)
- Ensure categories have been considered in relation to ‘weighing’ issues, if appropriate
- The tool is appropriate to ID vulnerable families and help ID those who should receive additional services, but a double-check mechanism can ensure no one falls through the cracks. However, the tool has limitations in identifying who has best benefited through additional services.

7.4. Shortfalls of the Study

Reasons behind changes to different categories were well identified, but reasons behind why some groups experienced large changes and some experienced small changes were not satisfactorily identified either through the Q of L survey or through focus groups, partly due to the very high number of variables involved. Adjustment of the criteria for the next round to ensure project impact is included, and examining the results in light of a final project evaluation (looking more at strengths and weaknesses of actual activities), plus a brief income analysis (section 5.1), can help with this in the future. Discussion with focus groups alone is not likely to bring out this information, although they can be a valuable tool to use in parallel for this aspect.
7.5. Lessons Learned on Methodology Approaches to Discussing Q of L with Focus Groups / Individuals

A logical approach to analysis is to start with discussions on changes in Q of L categories, then work backwards to where there are the largest and least amounts of change to areas to probe to identify contributing activities (along with corresponding successes/constraints as appropriate).

This is particularly challenging, as participants tend to think in terms of activities, rather than categories of change (typical answers to ‘what changes have you seen in the hygiene Q of L category for you/your family’ would be ‘we attended the hygiene training’).

To frame participants thinking in terms of changes to categories instead of changes in individual activities, a few sample participants were asked what problems they experienced before the project started (a typical answer would be ‘my family was poor / my family situation was bad’, and they were further asked what problems they experienced due to that). If an answer was ‘my family was poor, so we did not have enough food; now we have a boat; before my disabled husband had to walk in the water to catch fish’ the categories of economic/assets, food security, and accessibility were drawn to participants attention, and category changes discussed. The group was then asked to think of how similar category changes applied to them. It was found this was a good approach for framing the discussion group as a whole. A chart was used for continual reference (Figure 19) through discussions.

It was also challenging for participants to compare changes between categories (for example, “in the following Q of L categories, which one saw the least amount of change”, or “were there any categories that you would like to see more change in than you did”. Questions were therefore refocused to changes within categories (for example, for the category of ‘economic/assets’ [remind what criteria were for that category], did you experience ‘no change’, small change’, medium change’, or big change’). Results could then be compared between categories. Integral to this were discussions on reasons behind the levels of changes, which tended to automatically draw out successes and constraints.
Annex 1– Determination of Focus Group Members

A pre-analysis was done to determine
   a) ranking to show ‘top half’ and ‘bottom half’ of rate of change in Quality of Life Assessment based on baseline and closure data from the Quality of Life survey. The absolute value of change was listed for each beneficiary, and the range of all scores divided by two. Those with a change value higher than the mid-range were classified as “top change” (those showing the biggest amount of change), those with a change value lower than the mid-range were classified as “bottom change” (those showing the least amount of change). This was calculated using the change in the total score of each individual’s quality of life survey (each individual’s change in their total score is referred to as their global change, as opposed to later analysis which breaks down changes within different categories per individual). This gave us comparison groups of the ‘largest change’ vs the ‘smallest change’.

Note: focus groups were initially planned on top and bottom thirds, but samples to choose from were too small. Database analysis itself was done on and top and bottom thirds.

Sample Calculation
Example: if a range of values, such as a Q of L change of score, were as follows, with each value representing the average Q of l change of one individual: 2,2,2,3,3,4,6,8
Then: the range would be 6 (8-2)
Six is divided by three (to obtain the ‘thirds’) = 2
Therefore intervals of two are used to classify scores into ‘thirds’
2-4 is bottom third
5-6 is middle thirds
7-8 is top third

Therefore in this example, the first six values (2,2,2,3,3,4) fall in the ‘bottom third’ category, one (6) falls in the ‘middle third’, and one (8) falls in the ‘top third’ category.
The graph would look this:
b) A separate analysis was done to show those whose baseline scores for quality of life were considered acceptable at the start of the project, and those that fell below acceptable (called here QL+ and QL- respectively). Those who fell below the acceptable line (QL-) were given additional project support (direct support for health, pregnancy, rehabilitation, and housing repairs). Those who were QL+ qualified for referrals only (no direct support) for health, pregnancy, rehabilitation, and toilet modification (depending in disability type). This allowed focus of certain questions to groups receiving additional support vs those who didn’t.

Within these parameters, focus groups were selected by villages with the largest amount of participants fitting the particular requirements, to avoid logistical problems of EPHs needing to travel large distances to meet. A balance was ensured with males vs females (again, small sample selection size within villages meant separate groups were not feasible unless naturally occurring). Where gender selective questions were required, males and females were separated within the focus group. A comparison was done between global change in quality of life between the four districts. No significant difference was found, therefore geography by district was not a prime consideration for selection in and of itself. All four districts were visited, and a total of five focus groups (30 EPHs in all – more were invited but were not always available) were held. In some cases spouses or other family members attended in place of or in addition to the EPH. In cases where they attended in addition to the EPH, they were not counted as an additional body in the focus group.
Annex 2 – Additional Graphs For Disability Types

Figure 25 Change in Average Q of L (by type) for Selected Categories, Female

Figure 26 Change in Average Q of L (by type) for Selected Categories, Male

Figure 27 Community Participation Change in Global Q of L for Different Disability Types
Community Participation Change for Different Disability Types

- Physical impairment
- Speech impairment
- Hearing impaired
- Visual impairment
- Mental impairment
- N/A

Average Change of QoL (QoL scale)

- Female
- Male

45
8. Assessing the Quality of Life Assessment Tool

8.1. The Current Quality Of Life Assessment

When discussing project impacts below, it is not meant that the Q of L survey is meant to replace a standard evaluation. Impacts of the project refer to areas of Q of L, not actual individual successes of particular activities, as usually evaluated during the M&E process.

The measures in the current Quality of Life Assessment were carefully selected to be uniformly and unambiguously measured. All answers are objective (aside from ‘general dwelling conditions’, which has a subjective measure). From this point of view the survey was well designed, and these factors should all be applied to any future surveys. Overall, it can be considered a good indication of an EPH’s vulnerability, and parts of it are good indicators of project change. Some suggestions for strengthening the survey include ensuring questions belong to defined Q of L categories, ensuring that categories are ‘weighted’, ensuring that criteria do not have inherent biases, and selecting criteria that will not only measure vulnerability, but also project impact. These issues will be explored below.

8.2. Category and Criteria of Q of L Survey Recommendations

The following section discusses ‘category’ vs ‘criteria’ selection. Figure 28 shows examples of each.

<table>
<thead>
<tr>
<th>category</th>
<th>criteria</th>
<th>Measure (scoring method)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food security</td>
<td>Meals per day</td>
<td>2, 2 to 3, 3, etc…</td>
</tr>
<tr>
<td>Health</td>
<td>Type of cure</td>
<td>No cure, traditional, doctor, etc…</td>
</tr>
</tbody>
</table>

8.2.1. Set a Category Framework

What the project doesn’t set out currently is set category definitions for quality of life. A set framework (such as that in Figure 19) should be defined by the project team and understood by stakeholders and EPHs. Establishing a standard framework as mentioned above can give categories that can be used for all aspects of project reflection. This will assist in making comparisons to changes in aspects of Q of L more straightforward, particularly for validating future results with field discussions.

The categories in Figure 19 can be used for the framework, or adjusted as needed to reflect changes in project objectives for future projects. Potential changes include combining health/sanitation into one category\(^6\), and adding accessibility (which during

\(^6\) Discussions on sanitation almost always directly led to an perception of increase in health (less sicknesses, diarrhea etc); the health category on its own was often though of in terms of major illnesses (eg, those who had no major illness didn’t always recognize changes to their health category because ‘they have
this survey was considered as a direct effect of rehabilitation, rather than a category in itself). A separate accessibility category is intangible, and difficult to discuss, but may help shed light to overall community accessibility issues, not just individual ones (eg wheelchair accessible schools, etc). One other issue raised to consider for the future was exposure to risk (eg working on mined land), which was not looked at in this study as an area of Q of L.

It is not recommended to have too many categories, as separating issues pertaining to each is complicated. It was also recommended by staff that the Q of L survey itself not be made any longer than it currently is. The current categories as they stand show a good reflection of issues covered by the TIGA project, and can be used again directly in the next round of programming. They can be adjusted as needed if there is a change of programming objectives, or to incorporate team suggestions.

8.2.2. Relate Questions to Specific Q of L Categories

Several current questions are selected to measure certain aspects of Q of L in relation to project services. However, current questions don’t always fall into easily identifiable categories to examine Q of L. Once categories are decided, then questions (criteria) can be chosen that reflect changes to monitor, for the purpose of determining overall vulnerability, distributing social services, and selecting relevant measures (scoring system).

Current questions such as number of meals a day consumed clearly relate to food security, however, others such as size of rice land could relate to food security, but also economic income, so interpreting the change can be ambiguous. If the category framework is decided on first, then there will be no ambiguity in what different questions are meant to be measuring, leading to a clearer ability to interpret results.

8.2.3. Choosing Criteria and Measures

This can be thought of as akin to selecting indicators to measure project objectives. Many areas can be kept simple, with one criteria measure. Some areas, such as the health category, may need additional criteria. Criteria to look at impacts of the project to health may include the current measure of level of medical access (no cure, traditional cure, ask chemist, ask doctor), plus a measure of change in labour days lost to sickness. Criteria to measure which social services should go to who may wish to examine those who have the most number of sick days, or those who currently don’t seek a doctor when ill (which can be extracted by the answers given). The food security can look for example at the number of meal per day and number of hungry months. By carefully selecting criteria, overall vulnerability of the EPH should be reflected in the outcome of the survey, while allowing examination of project changes and service distribution.
8.2.4. Establishing Measures of Project Success / Impacts
When looking at the criteria rating, consider if the measure will take into account the project impact / success. Certain questions currently reflect a change, but success is not always taken into account. For example, for the current question on animals, if people are given animals by the project, their score will increase, but there is no reflection of success. Using a measure such as the increase in animals due to management/care (not just initial stock) can give a clearer result. Corresponding percentage of income can be used, although may be misleading in cases where products are consumed rather than sold.

The current category of ‘rice land’ is another example. It can be used to gauge overall vulnerability, but is not a good measure of project change. The more direct the measure relates to project objectives, the more clearly it can be used to show changes attributed to the project (the size of rice land may be too indirect, as there is no project intervention meant to directly alter land, and assistance with IGA rice activities is dependent on having land, rather than the change in land size being dependent on IGA rice activity). Number of meals per day, by comparison, can measure direct impacts to the ‘food’ category, and can be used to measure vulnerability levels and areas of project success.

8.2.5. Establishing Social and Health Services
The current system of those who are QL- (‘most vulnerable’) receiving additional benefits is for the most part a good way to identify who qualifies, and overall staff and project stakeholders are satisfied with it. It is difficult to gauge beneficiary satisfaction with it; contentment was expressed about services received but not always able to judge what additional help would be good. Some recommendations about using the survey for service selection are found in section 8.3.

8.2.6. Ensuring No Inherent Biases for Criteria Measures
An example of an inherent bias is seen in the ‘animal’ category of the survey. EPHs who select chicken raising will have a lower score increase than those who select pig raising, as having pigs gives a high score than having chickens.

Another potential inherent bias may be reflected in the ‘education’ section. The actual impact of the project on EPHs’ ability to send their children to school is not necessarily shown. The score may change up or down if during the project children move into or out of school-age categories (turn 6 or 17 years old during the project). The ability of the EPH to send them to school will still be reflected (thus reflecting overall vulnerability), but changes can not necessarily be attributed to project impacts (changes in ability of EPH to send them to school). This is very difficult to address with changes in methodology to measure, and the overall change due to this is small (changes are more likely to be from project impacts than from this), but it should be kept in mind when interpreting results.

8.2.7. Balance of Categories Within Q of L Survey
One final consideration is a balance between categories and questions. Two areas can be considered with the current survey format: weighting between categories, and weighting between actual criteria.
8.2.8. Weighting Between Categories

Currently, most issues (those that can be easily classified into a category such as health) have one question each. Housing has three questions (some were added to help ID social services). An increase in housing may actually show a much larger score increase than an increase in health, just due to there being three different questions.

There are a few ways around this. For cases where there is more than one question per category (e.g., two housing questions and one health question), each category can have the same percent value as every other category. Thus, if there are two health questions, each individual question within that category can count as 0.5 (or .33 if there are three questions, etc) of the total of that category.

Figure 29 Example of weighting if there categories do not all have the same number of questions

<table>
<thead>
<tr>
<th></th>
<th>Given Score</th>
<th>Weigh</th>
<th>Weighted Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q 1</td>
<td>2</td>
<td>100%</td>
<td>2</td>
</tr>
<tr>
<td>Health Total</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q 1</td>
<td>3</td>
<td>50%</td>
<td>1.5</td>
</tr>
<tr>
<td>Q 2</td>
<td>2</td>
<td>50%</td>
<td>1</td>
</tr>
<tr>
<td>Housing total</td>
<td></td>
<td></td>
<td>2.5</td>
</tr>
</tbody>
</table>

If this method is used, the Global Q of L is the sum of all weighted total categories (here: 2 + 2.5 = 4.5 global score). However, it is important to note that if individual criteria are examined, for instance to assess social service distribution, the Given Score (without weighting) should be used for that category. For example, during analysis Health Q1 may want to be correlated with Economic Q1, and one was weighted while the other wasn’t. The original whole values must be used.

8.2.9. Weighting Between Criteria

While measure of criteria may be important for that particular category of criteria, they may not be comparable to other categories (an increased score of 1 within the ‘media equipment’ category for the addition of a VCD player can not be compared with an increased score of 1 within the ‘education’ category for an increase in children attending school).

One approach to this is considering if any categories or criteria should have more overall importance than others. This can be tricky given direct and indirect relationships between issues, EPH identified importance, and relation to project objectives. However, the team, with input from EPHs, may want to make an overall decision if certain areas should carry more importance than others. However, the more carefully criteria are selected to represent each category, particularly if there is EPH input, the less likely the need for this should be.
If EPHs could be involved during the first phase of the project to help identify important criteria for each category (a bit the way wealth-ranking self-identifies criteria) criteria would be relevant to them on their terms. This would take time to establish however, and final criteria should still follow guidelines mentioned in this report.

8.2.10. No Weighting
The survey can still be used with no weighting alterations. However, if this is the case, there should be more emphasis put on relevant individual categories when thinking about referrals, as opposed to only relying on the global score.

8.2.11. Summary of Category and Criteria Issues
The current survey is well thought out, has objective measures, in general is good method of identifying vulnerable families. However:

- A uniform framework will ensure ease of comparison for examining Q of L, taking into consideration areas important to project objectives and areas important to beneficiaries
- When selecting criteria consider if it looks at change due to the project, or will help in the selection of distribution of social services.
- Ensure there are no inherent biases in criteria measures selected (is change in Q of L really being measured)
- Categories have been considered in relation to ‘weighing’ issues, if appropriate

8.3. Cut-off Point and Service Selection Recommendations

8.3.1. Selection of Social Services
While all beneficiaries qualify for certain services, the Quality of Life survey is used to determine the most vulnerable beneficiaries, who also qualify for an additional sub-set of support services (such as house repair, and health and rehabilitation payments). The following section examines the classification of those considered above the QoL threshold vs those below as a means of determining who qualifies for additional services.

The key question here is ‘were the ones who most needed the additional help the ones who received the additional help?’ Two areas need to be considered:
- Does the cut off line (35 points) adequately classify who most needs additional services?
- Does looking solely at the global score accurately classify who needs and doesn’t need additional services?

This was done by:
- examining how the global score relates to selected individual category scores
- examining who in the ‘acceptable’ category of Q of L (therefore not eligible for additional service) still had a particularly low Q of L category score (thereby perhaps needing a particular additional service)
Housing and health were chosen for examination as they were areas that provided additional service to selected beneficiaries, while also having correlating Q of L categories (housing has two, for dwelling condition and roof condition). There was no direct category of the Q of L survey to compare rehabilitation referrals. Results for the housing and health categories reflected the same findings in this regard; only the housing results are shown below.

The results show that those with unacceptable starting Q of L had both poorer ratings in their global score, and in their related individual category scores. Therefore, in general, changes in individual categories are reflected by global changes. The global conditions of Q of L is poorer for those in the QL- category is worse is a moot point (as that is the basis for QL+ QL- separation), it is the mirroring in the individual categories we are interested in.

- Individual categories reflect global changes to some extent
- QL- do indeed need have a bigger need for special services (as a whole), even when looking at individual categories (also seen in section 3.1).

However, this does not mean that all those who are QL+ have a good individual category rating, and vice versa. There are cases where an individual is QL+ but has a very poor housing score. The closer that acceptable Q of L (QL+) beneficiaries get to the cut-off point, the more likely they are to have a poor rating in the individual categories (not graphed).

- while the current QL+ / QL- classification catches most cases in special need of attention, those who are QL+ should still be checked
the closer QL+ beneficiaries are to the cut-off, the more likely the potential is that they may to ‘fall through the cracks’ for particular service needs

8.3.2. Ensuring no one ‘falls through the cracks’ for additional support services

No adjustments need to be made in the scoring system for this, but an extra scan can be put in place. The cut-off can be set the way it is now, or at a similar reflective level. Applicants are divided the way they currently are (QL+ vs QL-). Those who are QL-qualify for additional services (all of them). Those who are QL+ are examined in their relevant individual category to see if any have particularly poor ratings. They are then looked at on a case-by-case basis. A rapid scan through the database can quickly identify if there are additional cases to look at – the process is not expected to be time consuming. This can be done for any special circumstances the project wishes to look at (eg those who don’t currently seek any medical treatment, or those who lose many labour days to sickness, or current state of housing).

8.3.3. Case-by-case Analysis

It is good to keep in mind the global score, as that is an overall indication of vulnerability. In addition, a better economic situation may reflect less of a need for an individual service, even if that particular category had a poor ranking, as the person is in a better position to cover expenses themselves (a poor ranking may not only be due to a lack of ability to pay). In general, those with a higher global score should be more economically secure, but individual cases that may be ‘borderline’ in particular categories (for instance those who have scored an ‘acceptable’ on the Q of L score (particularly if they are close to the cut-off), but still have a particularly poor housing score, should be examined on a case by case basis.

- when looking at individual cases, consider global score and economic situation (either through economic category score or on actual income situation); those closest to the cut-off Q of L score are most likely to need extra attention

As mentioned above, a quick scan through the database to look for individual cases can be done, with follow-up analysis from LFO’s and CWs, or from the Decision Committee. This is not intended to add much more time to the current process or become cumbersome.

Most field staff felt the current system of cut-off was an appropriate method way to determine additional services, although some felt looking at additional selected categories was warranted. One Decision Committee (DC) member felt that the current method of

7 It was also brought up during the discussion that applicants selected to the project should not be rejected on the basis that they may already have access microfinance loans, as those with small loans still needed various assistance; the feeling was the criteria in that regard was too rigorous. Although applicant selection for the project is beyond the scope of this study, results of this study show that more vulnerable families (according the baseline) had poorer household budget situations (therefore likely more debt), as well as poorer coping abilities; these families are in greater need of help.
allowing select services to only QL- EPHs was too strict, and the rules should be somewhat flexible. This method should satisfy changes mentioned.

8.3.4. Where to set the cut-off?
The cut-off is currently carefully selected. Each question is evaluated one by one by T.I.G.A. team members. Based on the scoring method of each question, an ‘acceptable’ score for that question is decided. The total of these scores was selected as the cut-off point. This is actually good way to balance and mitigate potential biases in the survey referred to in section 8.2.9 regarding importance between different criteria. The same method should be followed in the future. The only comment on the current scoring, based on results of this study, is to consider the importance of household budget / potential debt.

Summary of Q of L Assessment Tool
The Q of L survey is suitable for identification of the most vulnerable EPHs, and to provide as a service provision classification guide. It can be valuable to track gender changes, to some extent changes within Q of L categories, and an overall level of change for general monitoring. It is not a satisfactory tool to determine reasons behind changes or reasons for certain levels of change. In general, these are better explored through focus groups (with additional data from the final evaluation to provide additional input), although changes to categories and criteria in the future can allow for a more direct analysis through the Q of L tool.

The current survey tool has been carefully thought out, has objective measures, and in general is good method of identifying vulnerable families. However:

- A uniform framework will ensure ease of comparison for examining Q of L, taking into consideration areas important to project objectives and areas important to beneficiaries
- When selecting criteria consider if it looks at change due to the project (is change in Q of L really due to the project), or will help in the selection of distribution of social services.
- Ensure there are no inherent biases in criteria measures selected (is change in Q of L really being measured)
- Ensure categories have been considered in relation to ‘weighing’ issues, if appropriate
- The tool is appropriate to ID vulnerable families and help ID those who should receive additional services, but a double-check mechanism can ensure no one falls through the cracks. However, the tool has limitations in identifying who has best benefited through additional services.
Annex 4 – Data Sheets for Focus Group Discussion and Key Informant Interviews

Key Informant Sheet Government Counterparts
Interviewee Name:
Position:
Department:
Interviewers:
Date:
Location:

What is the biggest change you have seen as a result of the project?

What have the biggest changes in Quality of Life that you have seen (in project/commune, as appropriate to interviewee).

What has been the role of (your department) in bringing changes of QoL?

What contribution has this lead to for change in Quality of Life for project beneficiaries?

How has the awareness of the community changed? (getting along with neighbors, participation in community events or decision making…)

What further changes to Quality of Life can your department bring to beneficiaries in the future? (what role would you like to see your department be in the future?)

Are there areas of Quality of Life that your department would like to contribute further to but do not have the resources? What resources would be needed? (What support/interaction do you need to carry this out, and who do you need it from?)

What suggestions do you have to strengthen project activities?

What should stay the same?

Individual Meetings – Case Study
Interviewee Name:
Interviewers:
Date: 
Location: 
Sex _____ Age _____ QL Base _____ QL Closing ______
Disability Type:
Landmine Survivor or PwD:
Economic Kit (type, S or E):
Referral Details:

- Looking back since the Handicap International you became involved in this project, what do you think was the most significant change (biggest change) in the quality of life for you and your family?

- Why is this significant (important) to you?

- What activities led to these changes, and how?

- [For specific disability, situation]: What parts of the project have been particularly beneficial to assisting you with [particular disability]

- What would your priorities be for changes in other areas of QoL?

- Do you get along with neighbors better than before? – give examples if yes

- Do you talk more often with the village chief? – give examples if yes

- Do you participate more often in community activities? – give examples if yes

- Do you participate more in community decision making? – give examples if yes

**HI / OEC Staff Sheet**

Name:
Position:
Economic or Social:
Email:
Phone number:
HI or OEC:

1. What outcomes of the project most exceeded expectations?

2. What do you think the most significant change (biggest change) in the overall quality of life for EPHs (beneficiaries) has been?
3. Why do you feel this was?

4. What areas of Quality of Life changes have not met expectations?

5. Why do you feel this was?

6. List most important contributors to sustainability (eg level of information transfer, confidence levels, stakeholder involvement, etc). Is the current level of these adequate, and if not, how can they be improved?

7. Are there any major constraints that you feel may affect the sustainability of the project? (For example, if you feel beneficiaries particularly benefitted from financial support for referrals, but they will not maintain these benefits without ongoing support).

8. What government bodies (ministry, commune, etc) contributions have been important to the running and/or sustainability of the project (specify what and by who). Please discuss what services were provided and the differences they made.

9. What government support to the project would you like to see added or strengthened? (please clarify current situation for comparison, ie no current support, some but would like more). Please also add your idea how this can happen.

10. How has the awareness of the community changed?

11. Did the project design adequately include activities meant to improve Quality of Life?

12. Did the project design adequately address targeting, participation and gender issues?

Focus Group Discussion Sheet

Interviewers: 
Date: 
Location: 
Interviewee Names, Sex, F/M: 
Group Selection Details: 

List areas of change for Q of L

- economic / assets [household income, household goods (motorbike, etc), housing situation (better house, roof, tenure, etc)]

- health [personal/family health situation, type of sicknesses, number of visits for medical care, type of medical care]
• education/skills [*children’s access to school, personal education and knowledge*]
• access to food [*food access (buy or grow), family consumption, nutrition*]
• water and sanitation
• rehabilitation / assistive devices [*access, improvements due to them*]
• social inclusion/participation in community activities
• discrimination

For questions 1 to 3 and 5, separate males and females into separate groups

1. What are the three categories that are most important to you to see changes in? Note: this is only *personal importance in general*, not changes they have seen due to the project, and it does not matter if the project was meant to directly address the category or not. (rank 1 to 3)

2. What were your biggest problems before the project? Which category do those problems belong to?

3. For each category, on a scale of 0 to 5, how much change did you see (look at the factors listed in each) – can think of the problems rather than the category if it helps
   1 – no change
   2 – small change
   3 – medium change
   4 – big change
   What was the change?

4. For categories / problems with no / small change:
   • What were any constraints to helping the problem
   • Can HI do anything differently to make more change?

5. *Which activities led to the biggest changes (social/health, economic)* [note: this question is to compare overall contributions of economic vs social/health in relation to each other]

The following questions apply to the three categories identified in question [Erreur ! Source du renvoi introuvable.](categories that people experienced the biggest changes in)
Keeping in mind the:

- Economic activities (business training, business kits, other?)
- Social & Health activities (referrals for health, pregnancy, rehabilitation, housing, toilets, if applicable, community participation days, referral manual, other?)

- When comparing economic vs social and health activities (as a whole), on a scale of 0 to 5, how much contribution did the activities make to each of the categories of Quality of Life?

<table>
<thead>
<tr>
<th>Economic Activities</th>
<th>Social/Health Activities</th>
<th>Comments and Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>example: economic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>example: health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>example: social inclusion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6.

- What was good about the economic kits
- What was not good about the kits / economic services
- How can they be better?
- What was good about the social / health referrals?
- What was not good about the social / health referrals
- How can they be better?
7. What will change about your current situation once HI is no longer involved? (what will continue ok, what might get worse again)

8. *How has awareness of disabilities by the community changed*

   - Do you get along with neighbors better than before?
   - Do you talk more often with the village chief?
   - Do you participate more often in community activities?
   - Do you participate more in community decision making?

9. For people with difficulty to walk:
   - What was the biggest help for them?

For people with difficulty to see:
   - What was the biggest help for them?

For people with difficulty to hear:
   - What was the biggest help for them?

For people with difficulty to learn:
   - What was the biggest help for them?
Annex 5: Participants Met With

*Focus Groups (complete list of names and personal details are in separate attachment).*
*Independent follow up interviews were selected from the same groups.*

Focus Group 1: Ta Kot, Kdol Tahen, Bavel  
Focus Group 2: Tumpung Cheung, Kdol Tahen, Tmor Kol  
Focus Group 3: Reak Smey Sangha, Sdau, Rattanak Mondul  
Focus Group 4: Pcheav, Traeng, Rattanak Mondul  
Focus Group 5: Doun Troek, Ta Sahn, Samlot  

*Government Counterparts*  
Office of Agriculture, Bavel  
Office of Women’s Affairs, Thmor Kol  
Office of Social Affairs, Rattanak Mondul  
Commune Council, Ta Meun  
Village Chief, Ta Sahn, Samlot

In addition, Staff Questionnaire was filled out by management and field staff, with additional questions and follow-up in person.
Annex 6 – Terms of Reference

QUALITY OF LIFE (QOL)

1. Objective

The main objective of the Quality of Life Survey is to analyse the improvement of quality of life through the socio-economic impact of the TIGA project in the beneficiary households. A data base with baseline information on quality of life will be the backbone of the analysis.

2. Expected Results

A. Survey the collected data on quality of life in the project area (from data base)

B. Measure which improvement in the socio-economic situation has been mainly achieved of the beneficiary households due to the project’s intervention

C. Consider for all analysis to disaggregate the data and findings according to gender, and check whether there are different findings with regards to gender in the improvement of quality of life

D. Verify if in case of quality of life improvement as per data set the same experience of improvement has been made in the beneficiary households, and how they rate the impact in their quality of life improvement

E. Measure the potential individual sustainability of the improved quality of life of beneficiary Households

F. Identify main factors and/or obstacles, in the opinion and experience of the beneficiaries, for the improvement or not of the quality of life

G. Detailed report and recommendations for future quality of life enhancing activities

3. Methodology

Approach

To achieve the above mentioned results and objectives the following activities should be part of the Quality of Life Survey participatory approach:

A. Analysis of baseline information (database, TIGA project forms, reports)

B. Meetings with relevant stakeholders (TIGA team, other NGOs included in the referral list, Decision Committee members, PWDs from BDPO or SHG in Battambang)
C. Based on TIGA quality of life assessment, identify key criteria to assess quality of life in rural Cambodia (differentiate between criteria measuring economic, health, social integration, accessibility, assets, education/skills, quality of food, food stock conditions)

D. Assess the sustainability and/or risk factors for the achieved improvement in the quality of life improvement

E. Facilitate focus group discussion and/or individual interviews with a prepared questionnaire for Economic Project Holders

F. Field visits (including households who benefited from infrastructure support)

**Duration**

Considering the amount of information already collected by the TIGA team on monthly basis the Quality of Life Survey is expected to be conducted in 10 working days, and an additional 10 days for report writing. During this period all the analysis of data, meetings and field visits should be conducted.

**4. Budget**

Budget proposition should include the following:

- Transportation, accommodation and food costs for all staff involved in the process of data collection and analysis.
- Field visit costs.
- Communication Costs
- Photocopies and office material

**5. Requirements**

- Proven background in facilitating qualitative and quantitative research, monitoring and evaluation and/or surveys in rural Cambodia
- Familiarity with data base analysis and quantitative as well as qualitative methods
- At least 5 years experience in rural development sector (preferably in the NGO sector)
- Familiarity with approaches to reduce poverty and increase food security in Cambodia
- Demonstrated experience in analytical work, gender based and participatory approach
- Preferably experience in working with and analysing situation of marginalized groups, such as Persons with Disabilities
- Excellent English language skills in written and oral