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This publication was produced for review by the United States Agency for International Development (USAID). It was prepared by EnCompass LLC with contributions from Amy Mulcahy-Dunn, Anna Martin, Daniel Mont, Emma Venetis, Ted Rizzo, and Jaime L. Jarvis for the Data and Evidence for Education Programs (DEEP) activity (Contract No. GS-10F-0245M/Task Order No. 14). The views expressed in this publication do not necessarily reflect the views of USAID or the United States Government.

# MAPPING OF TOOLS FOR DISAGGREGATION BY DISABILITY STATUS: REPORT

DATA AND EVIDENCE FOR EDUCATION PROGRAMS  
(DEEP) ACTIVITY

May 2020

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# ACRONYMS AND ABBREVIATIONS

CFM	Child Functioning Module
DEEP	Data and Evidence for Education Programs
IP	Implementing Partner
USAID	United States Agency for International Development
WGES	Washington Group Extended Set
WGSS	Washington Group Short Set

# EXECUTIVE SUMMARY

Despite calls by the UN, United States Agency for International Development (USAID), and all other major donor organizations for equitable and high-quality education for all children, marginalized children<sup>1</sup> remain underrepresented in schools throughout the world. This underrepresentation is particularly pronounced among children with disabilities.<sup>2</sup> Having reliable, accurate, and comparable data that can be disaggregated by learners' disability status is essential to effectively monitor progress in reaching marginalized children and to provide the information needed to continue to strengthen the quality of education for these learners.

USAID's Office of Education is committed to collecting, analyzing, and using disability data in USAID education programming to ensure that efforts are inclusive of learners with disabilities and meet the Agency's Education Policy priority of "expanding access to quality education for all, particularly marginalized and vulnerable groups."<sup>3</sup> USAID's 2018 guidance<sup>4</sup> on generating disability-disaggregated data in education programming promotes the social model of disability and, in particular, the use of two survey tools: the Washington Group Short Set (WGSS) and the Child Functioning Module (CFM). The WGSS and the CFM ask respondents questions about basic activity limitations in order to identify those who are at risk of having a disability in an unaccommodating environment.

The WGSS was designed and validated as a self-reporting tool for use in national census and household surveys with respondents older than 17 years. The CFM was designed and validated to collect data from primary caregivers of children aged 2 to 17; however, as most USAID's early-grade learning programs take place in schools, USAID activities must rely on responses from learners and/or teachers. The use of learners and/or teachers as respondents to these tools had not been validated at the time of USAID's 2018 guidance, and Implementing Partners (IPs) have reported some challenges in the application of these tools in schools. In response, USAID commissioned a study under the Data and Evidence for Education Programs (DEEP) project to gather information from IPs on tools and approaches used in gathering this data and, most importantly, lessons gleaned in their application. USAID will use this information to enhance its guidance moving forward.

From this mapping study, the DEEP team gained insights into how USAID's guidance was being applied in the field; why data were being collected; how tools were being adapted and applied; and importantly, challenges and solutions that the IPS encountered. Based on these insights, we have formulated preliminary recommendations which will be reviewed and refined through a series of virtual consultative meetings with IPs and other stakeholders in May and June of 2020.

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<sup>1</sup> USAID defines marginalized and vulnerable children as including children with disabilities, girls, children affected by or emerging from armed conflict or humanitarian crisis, children in remote or rural areas (including those who lack access to safe water and sanitation), religious or ethnic minorities, indigenous peoples, orphans and children affected by HIV/AIDS, child laborers, married adolescents, and victims of trafficking, or those who are denied, or have very limited access to, privileges enjoyed by the society-at-large. USAID Education Policy 2018.

<sup>2</sup> UNESCO, 2016, *Education for people and planet: Creating sustainable futures for all: Global Education Monitoring Report Team*. Paris: United Nations Educational, Scientific and Cultural Organization (UNESCO).  
<https://unesdoc.unesco.org/ark:/48223/pf0000245752>

<sup>3</sup> USAID Education Policy 2018

<sup>4</sup> USAID. 2018. "How to Note: Collecting Data on Disability in Education Programming." *Education Links*.  
<https://www.edu-links.org/resources/how-note-collecting-data-disability-education>

1. IPs who participated in the mapping study reported many purposes for data collection; however, the tools recommended in USAID guidance have a validated purpose that did not always align with the IPs' purposes. **Update USAID guidance note with the inclusion of a decision tree that links a suite of diverse tools with information on their purpose.** This approach will help IPs in selecting the best tool(s) for their particular purposes.
2. The use of the WGSS with child respondents has not been validated, and only initial research has explored the use of the CFM with teachers. **Support research that will permit adaptation and validation of the WGSS and the CFM for use with the respondents and interviewers who are more likely to be available for school-based applications.**
3. IPs have observed challenges in the consistent interpretation of response options used in establishing respondents' level of functional difficulty. This inconsistency has consequences for the comparability of findings across respondents, interviewers, and countries. **Support research on the use of different response option language to more accurately and reliably identify learners with disabilities in the school setting.**
4. IPs reported a wide range of approaches used in preparation for (e.g., adaptation, accommodation, translation, cognitive interviewing, interviewer training) and administration (e.g., interviewer training, data interpretation) of the WGSS and CFM tools. This variation can have implications for data quality and comparability. **Strengthen guidance on best practices for adaptation, preparation, and administration of tools used to collect data on functional difficulties and disabilities.** This guidance should be based on industry standards and implementing partners' own experience to ensure greater quality and comparability of results.

# I INTRODUCTION

The United Nations Sustainable Development Goal (SDG) 4 calls for education for *all* children.<sup>5</sup> Yet, marginalized children<sup>6</sup> remain underrepresented in schools. This is particularly true among children with disabilities, who globally make up at least one-third of out-of-school children.<sup>7</sup> Even when they are in school, learners with disabilities continue to face barriers. Schools frequently are not equipped to create learning environments that effectively accommodate and engage learners with disabilities. As a result, learning outcomes among learners with disabilities tend to lag behind those of their peers, and dropout rates tend to be higher<sup>8</sup>. To track the progress being made in addressing these crucial gaps, identify barriers and approaches to successfully engaging learners with disabilities, and inform programs designed to increase high-quality education among learners with disabilities, it is essential to have information that permits disaggregation of education data by learners' disability status.

This report refers to persons with disabilities as 'persons with functional limitations/functional difficulties' when discussing the identification of persons with disabilities using the social model questionnaire and screening tools. This language is used for data collection purposes for reasons discussed further in the report. The preferred terminology when discussing this population outside of measurement discourse is 'persons with disabilities'. See USAID's "[Disability Communications Tips](#)" for more information

The United States Agency for International Development (USAID)'s Office of Education is committed to collecting, analyzing, and using disability data in USAID education programming to ensure efforts are inclusive of learners with disabilities and meet the Agency's Education Policy priority of "expanding access to quality education for all, particularly marginalized and vulnerable groups."<sup>9</sup> For this reason, USAID Standard Foreign Assistance Indicators ("F" indicators) for education programming include disability disaggregates among other demographic disaggregates, such as sex.

At the program level, this commitment means using secondary data to inform inclusive education sector strategies and, as applicable, to identify data gaps and research needs to fill those gaps. At the project and activity levels, it means putting in place monitoring, evaluation, and learning frameworks that guide partners to report disability-specific and/or disability-disaggregated indicators using agreed-upon, consistent, and valid methodologies. However, reporting by these disaggregates is currently sparse, and

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<sup>5</sup> United Nations, 2019, "Sustainable Development Goal 4. *Sustainable Development Goals Knowledge Platform*. <https://sustainabledevelopment.un.org/sdg4>

<sup>6</sup> USAID defines marginalized and vulnerable children as including children with disabilities, girls, children affected by or emerging from armed conflict or humanitarian crisis, children in remote or rural areas (including those who lack access to safe water and sanitation), religious or ethnic minorities, indigenous peoples, orphans and children affected by HIV/AIDS, child laborers, married adolescents, and victims of trafficking, or those who are denied, or have very limited access to, privileges enjoyed by the society-at-large.

<sup>7</sup> UNESCO, 2016, *Education for people and planet: Creating sustainable futures for all: Global Education Monitoring Report Team*. Paris: United Nations Educational, Scientific and Cultural Organization (UNESCO). <https://unesdoc.unesco.org/ark:/48223/pf0000245752>

<sup>8</sup> Graham, N., 2014, *Children with Disabilities. Paper commissioned for Fixing the Broken Promise of Education for All: Findings from the Global Initiative on Out-of-School Children.*, (UIS/UNICEF 2015) Montreal: UNESCO Institute for Statistics (UIS); Wodon, Q.T., C. Male, C.E. Montenegro, and K.A. Nayihouba, 2018, *The Challenge of Inclusive Education in Sub-Saharan Africa (English). The price of exclusion: disability and education*. Washington, D.C.: World Bank Group: <http://documents.worldbank.org/curated/en/171921543522923182/The-Challenge-of-Inclusive-Education-in-Sub-Saharan-Africa>.

<sup>9</sup> USAID Education Policy 2018.

the Agency’s guidance for collecting such data is limited to reporting on older children, youth, and adults. A validated method for collecting data on learners with disabilities in USAID education programming remains a challenge.

## I.1 CHALLENGES IN COLLECTING DISABILITY-DISAGGREGATED DATA IN EDUCATION

USAID’s 2018 “How-To Note: Collecting Data on Disability in Education Programming” recommends the use of the Washington Group’s Short Set (WGSS) and the Child Functioning Module (CFM) data collection tools<sup>10</sup>. These tools are based on the social model of disability, which conceptualizes disability as emerging from the interaction between a person’s functional limitations (from an impairment or health condition) and barriers in the environment. Functional limitations and environmental barriers work together to create disability, as explained further in [Section 2.2](#) The Social Model. To monitor whether environmental barriers are disabling learners in this sense, it is necessary to identify those children with functional limitations who may be at risk of exclusion. The WGSS and the CFM were designed for this purpose. The WGSS and the CFM ask questions about difficulties that, without an inclusive environment, can inhibit learning and are thus useful for education planning, monitoring, and evaluation across the USAID Program Cycle. These evaluations ask questions to obtain information on aspects of basic activity limitations in order to identify those at risk of restricted participation in an unaccommodating environment.

The WGSS, however, has been shown to underestimate the proportion of children with developmental and cognitive disabilities when used directly on young children (aged 5-10 years), so USAID’s guidance encourages the use of the Child Functioning Modules for Children Under Age 5 (designed for 2-4 year-olds) or the Child Functioning Module for Children 5-17, which were designed to address that shortcoming.<sup>11</sup> These particular protocols were co-developed with UNICEF and were designed to provide more detailed and accurate information about children’s functional limitations.

The WGSS and the CFM were both designed and validated as self-reporting tools for use in national census and household surveys with respondents older than 17 years (adults with disabilities and parents and caregivers of learners with disabilities as proxy respondents). The expectation of being completed by adult respondents presents a challenge for USAID education programming because most early-grade learning programs take place in schools and enumerators are often unable to access parents or caregivers as data sources. Interviewers must often, therefore, rely on responses from learners and teachers. Implementing partners (IPs) report that applying the CFM and the WGSS with these respondents is problematic. There is concern that learners may underestimate their functioning as they are not able to compare their functioning levels to those of their peers. While teachers, who are able to observe learners in the classroom setting, will have insights that parents may not, there is some concern that teachers are typically not as familiar with their learners as are parents, especially if asked at the beginning of the school year or if the class size is very large. It should be noted that a new version of the CFM has been developed specifically for use with teachers, and pilot applications have shown promising results.

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<sup>10</sup> USAID. 2018. “How to Note: Collecting Data on Disability in Education Programming.” *Education Links*. <https://www.edu-links.org/resources/how-note-collecting-data-disability-education>

<sup>11</sup> Washington Group, 2016, “Child Functioning,” *Washington Group on Disability Statistics* (December 18). <http://www.washingtongroup-disability.com/washington-group-question-sets/child-disability/>

## 1.2 PURPOSE AND ORGANIZATION OF THIS REPORT

Given these challenges, USAID has enlisted the Data and Evidence for Education Programs (DEEP) project to conduct a mapping of tools and protocols used to gather school-based data on learner disability status in USAID programming. Working with IPs, DEEP gathered lessons learned from the application of USAID's guidance on disaggregating data by disability status. Findings from this study will inform discussions on revisions to the existing guidance, potentially including amendments in recommendations related to tools or protocols.

The remainder of this report is organized as follows:

- Section 2 provides background on the major classes of tools used to gather data on disability status
- Section 3 describe the methodology DEEP used to conduct this mapping study
- Section 4 presents the findings from the tool mapping study
- Section 5 presents reflections on these findings
- Section 6 concludes with a set of preliminary recommendations

Final recommendations will be co-developed during an interactive meeting with IPs and stakeholders, planned for May 2020.

## 2 MEDICAL AND SOCIAL MODEL-BASED TOOLS

There are multiple tools used in collecting data on disabilities, and these tools have different characteristics and serve different functions. Most data collection tools derive from either the **medical model** or the **social model** of disability. We briefly describe these models and the types of tools derived from them below.

### 2.1 THE MEDICAL MODEL

The **medical model** conceptualizes disability as a problem that needs to be fixed. It describes disability as a consequence of a condition, disease, or trauma that can disrupt a person's functioning. This approach focuses on preventing, treating, or curing the condition that is perceived as causing the disability. The disability is placed within the person. The main types of medical model tools include:

- **Medical screenings:** These involve doctors or health professionals observing and running tests to make a diagnostic determination about a child's disability, including the cause and possible treatment.
- **Medical questionnaires:** These include questions that ask, for example, whether a child has a disability or more specifically whether the child has cerebral palsy, autism, or Down syndrome. There are no questions to determine the child's level of functioning, only acknowledgment that limitations exist as a result of a condition. Some tools using this approach are especially objectionable because they apply labels to children that can be dangerous due to stigmatization and stereotypes.

## 2.2 THE SOCIAL MODEL

The **social model** conceptualizes disability as a situation where an unaccommodating environment prevents individuals “who have long-term physical, mental, intellectual, or sensory impairments” from participating fully in society (UNCRPD<sup>12</sup>). This model is based on the bio-psycho-social framework of the International Classification of Functioning, Disability, and Health. This model seeks to make positive changes in society by identifying and changing negative attitudes and systemic barriers that cause people to be stereotyped as “persons with disabilities”. Unlike the medical model, which places the disability within the person, the social model and its tools focus on the environment in which the individual lives. This model analyzes a child’s functional limitations in conjunction with educational outcomes and information on the environment to gain a fuller picture of how disability is created. The main types of social model tools include:

- **Functional questionnaires:** The CFM, the WGSS, and the Washington Group Extended Set (WGES) tools are considered functioning tools, and ask questions such as “Does this child have difficulty seeing?” or “Does this child have difficulty walking [x] meters?” By asking questions about functional challenges rather than the presence of a disability, these tools avoid further stigmatization and increase the reporting of functional difficulties faced by individuals in the household.
- **Functional screening:** A functional screening tool consists of a set of questions and exercises (e.g., reading an eye chart or walking up a short set of steps) that can be used to determine a person’s difficulty undertaking a set of basic activities. A functional screening tool can span all functional domains or can focus on a subset of domains.

As noted in the Introduction, USAID’s 2018 “How-To Note: Collecting Data on Disability in Education Programming”<sup>13</sup> promotes the social model and more specifically the use of the WGSS and the CFM tools.

Exhibit I highlights the key characteristics of these different types of social and medical model tools. While this review primarily focuses on the social model tools recommended by USAID, we also include the medical model below as some IPs did report using medical model tools.

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<sup>12</sup> United Nations, n.d, “Convention on the Rights of Persons with Disabilities – Article I – Purpose.” <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-1-purpose.html>

<sup>13</sup> USAID. 2018. “How to Note: Collecting Data on Disability in Education Programming.” *Education Links*. <https://www.edu-links.org/resources/how-note-collecting-data-disability-education>

Exhibit 1: Key Characteristics of Original Tools

<b>TYPE</b>	<b>Social Model/ Functional Questionnaire</b>	<b>Medical Model Questionnaire</b>	<b>Social Model/ Functional Screening</b>	<b>Medical Model/Medical Screening</b>
<b>Purpose</b>	Prevalence rates and disaggregation by disability status	Prevalence rates and disaggregation by disability status	Screen individual children	Screen individual children
<b>Data Collection Method</b>	Self-report	Self-report	Objective assessment	Objective assessment
<b>Question Type</b>	Asks about functional limitations	Asks about existence of disability	Exercises to measure functional ability	Questions related to diagnoses and disease that result in disability; exercises, and medical exam
<b>Interviewer/Administrator</b>	Non-medical	Non-medical	Non-medical but can also be done by medical professional	Medical professional
<b>Identification of Individual Children</b>	No	No	Yes	Yes

As noted above, there are different social model tools. Exhibit 2 highlights the key characteristics of the three best known social model questionnaires (WGSS, CFM, WGES).

Exhibit 2: Key Characteristics of Social Model Functional Tools

	<b>WGSS</b>	<b>CFM</b>	<b>CFM FOR TEACHERS</b>	<b>WGES*</b>
<b>Type</b>	Social Model/ Functional	Social Model/ Functional	Social Model/ Functional	Social Model/ Functional
<b>Purpose</b>	Prevalence rates and disaggregation by disability status	Prevalence rates and disaggregation by disability status	Prevalence rates and disaggregation by disability status	Prevalence rates and disaggregation by disability status
<b>Data Collection Method</b>	Self-report for adults, Subjective assessment when responding for child	Subjective assessment	Subjective assessment	Self-report
<b>Interviewer/Administrator</b>	Non-medical	Non-medical	Non-medical	Non-medical
<b>Respondent</b>	Parent/Caregiver	Parent/Caregiver	Teacher	Person
<b>Child Age Range</b>	5–17	5–17	5-17	18+
<b>Vision</b>	✓	✓	✓	✓
<b>Hearing</b>	✓	✓	✓	✓
<b>Walking/Mobility</b>	✓	✓	✓	✓
<b>Self-Care</b>	✓	✓		✓
<b>Communication/Comprehension</b>	✓	✓	✓	✓
<b>Learning</b>		✓	✓	
<b>Cognition</b>		✓	✓	✓
<b>Remembering</b>	✓	✓	✓	✓
<b>Concentrate</b>		✓	✓	✓
<b>Routine</b>		✓	✓	
<b>Behavior</b>		✓	✓	
<b>Friends</b>		✓	✓	
<b>Upper Body</b>				✓
<b>Pain</b>				✓
<b>Fatigue</b>				✓

	WGSS	CFM	CFM FOR TEACHERS	WGES*
Affect (Anxiety)		✓	✓	✓
Affect (Depression)		✓	✓	✓

A brief description of each of the social model functioning tools is provided below.

## WGSS

The United Nations Statistical Commission formed the Washington Group and gave it the mandate to develop high-quality, internationally comparable measures of disability for quantitative analysis. This 2002 mandate was developed in response to the lack of comparable quality data on disability. The first tool developed by this group was the WGSS. This tool was designed to be incorporated into census tools for the identification of people with disabilities. The goal was to have a tool that would generate the data needed to calculate disability prevalence rates and to disaggregate outcome indicators by disability. Each of the six questions on the WGSS asks about a different functional domain (seeing, hearing, cognition, mobility, communication, and self-care). A person is said to have a disability if they have “a lot of difficulty” or “cannot do at all” one or more of the activities listed. The tool was tested and validated for use among adult respondents and among parents or caregivers who responded on behalf of their 5-17-year-old children. The tool was not tested or validated with child respondents. Applications of the WGSS have shown that, when administered as designed, this tool is able to identify the majority of individuals with a disability. Also, while the WGSS can identify the functional domain in which a respondent experiences a limitation, it doesn’t necessarily tell us what type of disability a person has. Furthermore, the WGSS is not suitable for the identification of children under the age of five and is known to under-identify people with psychosocial disabilities and children.<sup>14</sup>

## WGES

While the Washington Group designed the WGSS for inclusion in surveys that would include topics other than disability, the WGES was developed to gather more information on disability. The WGES underwent field and cognitive testing in several countries in 2009. This tool includes around 35 questions and was created for inclusion in standard household surveys or as part of larger disability surveys. Designed for adult populations (age 18+), the WGES is not meant to be used with children. The questions are meant to be asked directly to the person who experiences the functional difficulty unless they are unable to participate due to health problems or functional limitations. The WGES can identify the same functional domains as the WGSS (seeing, hearing, cognition, mobility, communication, and self-care) as well as several others. It can also identify affect (anxiety and depression), pain, fatigue, and upper body functioning. The WGES also gathers data on functioning with and without the use of devices/aids (where applicable), the age at the onset of functional difficulty, environmental factors that influence functioning/participation, and the impact of the functional difficulty on life activities.<sup>15</sup>

<sup>14</sup> Washington Group, 2016, “Extended Set of Questions on Functioning.” *Washington Group on Disability Statistics* (January 18). <http://www.washingtongroup-disability.com/washington-group-question-sets/extended-set-of-disability-questions/>

<sup>15</sup> Washington Group, 2018, *Disability Statistics: Joint report of the Secretary-General and the Washington Group on Disability Statistics*. 49<sup>th</sup> Session of the United Nations Statistical Commission. New York: March 6-9 *Washington Group on Disability Statistics* (January 18). <https://unstats.un.org/unsd/statcom/49th-session/documents/BG-Item3n-WG-on-Disability-Statistics-E.pdf>

## CFM

To address some of the shortcomings of the WGSS, the Washington Group partnered with UNICEF in 2011 to create the CFM. The CFM is designed to be incorporated into household surveys and is now included in UNICEF's Multiple Indicator Cluster Survey (MICS). The CFM consists of two modules, one appropriate for children ages 2-4, and another for children 5-17. Both modules have been tested and validated in several countries. Questions in the CFM are meant to be answered by a child's primary caregiver and ask about a child's ability to do a variety of activities, as compared to their peers. UNICEF and the Washington Group determined that caregivers were better able to make this assessment than children. The CFM can identify children with disabilities in a number of domains. For children ages 2-4, these include seeing, hearing, mobility, fine motor skills, communication, cognition (learning), playing, and controlling behavior. For children ages 5-17, these include seeing, hearing, mobility, self-care, communication, cognition (learning, remembering, concentrating), accepting change, controlling behavior, relationships, and affect (anxiety and depression). The CFM also identifies whether children use glasses or hearing aids. Due to its level of detail and reliability, the CFM can be used for statistical analysis to determine patterns of prevalence in disability (e.g., number of children with disabilities and differences by age, sex, or region) and the relationship of disabilities to outcome indicators such as school attendance rates for children with and without disabilities. Despite the wide range of domains and high reliability, the CFM is not a clinical tool and is not sufficient for determining a child's eligibility for a disability program. It can identify areas of difficulty but does not provide a diagnosis.<sup>16</sup>

### CFM for Teachers

With the increase in calls for inclusive education, the Washington Group and UNICEF saw the need for a simple school-based tool. Together they collaborated in the development of a simplified CFM tool designed for use by teachers in classroom settings. The CFM for teachers is designed to "identify children with functional limitations in a school context" and generate prevalence data that can be incorporated into "EMIS administrative systems in order to address student capabilities and needs and, over time, monitor their education outcomes."<sup>17</sup> The tool measures a slightly reduced set of functional domains captured in the CFM (see Exhibit 2). In this adaptation, teachers are asked to complete a form for each of the learners randomly selected to participate. In this form, the teacher is asked to indicate if the selected learner has "no difficulty," "a little difficulty," "a lot of difficulty," or "cannot do at all" along a set of twelve functional domains. The teachers are also asked to complete a summary sheet indicating the total number of learners in their classrooms that have each level of difficulty along a collapsed set of seven functional domains. Teachers are also asked to indicate the number of functional difficulties the learners have.<sup>18</sup> Pilot results from an application by Humanity and Inclusion have shown promising results with ease of use and a high level of inter-rater reliability among teachers.

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<sup>16</sup> Washington Group, 2018. *Disability Statistics: Joint report of the Secretary-General and the Washington Group on Disability Statistics*; Loeb, M., D. Mont, C. Cappa, E. De Palma, J. Madans, and R. Crialesi. The development and testing of a module on child functioning for identifying children with disabilities on surveys. I: Background. *Disability and Health Journal*, 11(4): 495-501.; Cappa, C., D. Mont, M. Loeb, C. Misunas, J. Madans, T. Comic, and F. de Castro. 2018. The development and testing of a module on child functioning for identifying children with disabilities on surveys. III: Field testing. *Disability and health journal*, 11(4): 510-518.

<sup>17</sup> Brus, Aude, M. Deleu, M. Loeb, 2019, *Testing a teacher version of the UNICEF/Washington Group Child Functioning Module (CFM-TV) in Senegal*. West Africa Program. A Humanity & Inclusion publication

<sup>18</sup> Brus, Aude, M. Deleu, M. Loeb, 2019, *Testing a teacher version of the UNICEF/Washington Group Child Functioning Module (CFM-TV) in Senegal*. West Africa Program. A Humanity & Inclusion publication.; Shuelka, M.J., C.J. Johnston,

# 3 METHODOLOGY

Through this mapping study, DEEP sought to gain a better understanding of which tools IPs are using, how they are applying these tools, and lessons learned from these applications. More specifically, DEEP catalogued the tools IPs were using and adapting to different contexts and needs; what protocols and approaches they were using in preparing for and administering these tools; who their interviewers and respondents were; and what challenges, lessons learned, and innovations they experienced. It should be noted that this report reflects self-reported feedback from IPs. Though some literature is referenced to strengthen statements, this report does not represent a complete literature review. Together, this information will be used to inform and strengthen USAID’s guidance on generating disability-disaggregated data in education programming. This mapping study comprised the following steps:

- Collection and review of data survey tools, protocols, and findings reports from IPs
- An online questionnaire, completed by IPs and individual follow-up discussions with IPs to learn more about challenges and solutions applied.
- A virtual focus group discussion with a subset of questionnaire respondents

USAID and DEEP introduced stakeholders to this mapping exercise during a brief webinar in September 2019. The DEEP team asked participants to submit their survey instruments and reports, and share their experiences and observations by completing a brief online questionnaire.

As noted above, in addition to identifying which tools IPs were using to collect this data, DEEP also gathered information on how IPs were adapting, preparing for, and administering these tools. It is difficult to evaluate the effectiveness of a tool without also considering how it was applied. The success of any survey, instrument, or tool depends in large part on three factors:

- **Fit for purpose:** Was this tool designed to generate the type of data needed to answer the researcher’s questions? This is an important consideration when choosing and evaluating a tool and its resulting data. A misalignment of tool design and the intended data use can result in inaccurate data.
- **Quality of the tool:** Are there concerns with the quality of the questionnaires as applied or issues with the tool’s ability to generate reliable and accurate data? Phrasing of questions and response options can introduce bias and impact reliability and accuracy of the resulting data.
- **Use of best practices in the preparation and administration of the tool:** What approaches were used in the application of this tool? Variations in preparation for and administration of the tool can vary substantially and can result in variations in the quality of the resulting data. Factors to consider include (a) interviewer training; (b) selection of respondents; and (c) language and accommodation.

As discussed below, our online questionnaire, follow-up discussions, and focus group discussion explored each of these factors. (Note that the follow-up discussions were used to gather missing information or pose clarifying questions and, as such, there is no sub-section describing these discussions).

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G. Thomas, and A.J. Artiles, eds, 2019, *The SAGE Handbook of Diversity and Inclusion in Education*. SAGE.; Sprunt B., M. Marella; 2018; Measurement accuracy: Enabling human rights for Fijian students with speech difficulties. *International Journal of Speech-Language Pathology* 20:1 (89-97).

### 3.1 ONLINE QUESTIONNAIRE FOR IPs

The online questionnaire was designed to gather information on IPs’ selection and use of the different tools and protocols for collecting school-based data on student disability status. The questionnaire, summarized in Exhibit 3, explored questions such as the origins of the tools IPs were using, what types of information were collected using the tool(s), and how the information would be used. The questionnaire also prompted respondents to provide information on how tool administrators were trained and how the tool was administered, as well as to weigh in on questions of data accuracy, concerns, and recommendations for adaptation or revision to the tools. Exhibit 3 presents an overview of the questions posed. See [Annex A](#) for the complete questionnaire.

Exhibit 3: Selected Questions from the Implementing Partner Questionnaire

TOPIC	SELECTED QUESTIONS
Tool Origins and Purpose	<ul style="list-style-type: none"> <li>• Who developed the tool and which organization funded its development (if different)?</li> <li>• What is the stated objective or purpose of the tool?</li> <li>• What is the age range of the target population?</li> <li>• What indicators are produced by the tool?</li> <li>• Who will use the resulting information and how?</li> </ul>
Tool Characteristics	<ul style="list-style-type: none"> <li>• Tool type: identification tools (functioning, disability) vs. screening tools (medical screening)</li> <li>• Data collection method: self-report, objective assessment, or a combination of the two</li> <li>• Approaches: functional domains and ranges covered (e.g., seeing, hearing, walking, cognition, self-care, communication, psychosocial)</li> </ul>
Training and Administration of the Tool	<ul style="list-style-type: none"> <li>• Where was the interview conducted?</li> <li>• Who was expected to administer the questionnaire?</li> <li>• What training did interviewers receive?</li> <li>• How long did the training last?</li> <li>• What evaluation or assessment of interviewers was conducted prior to fieldwork?</li> <li>• If it was piloted, where was it piloted? (pilot reports or a summary of pilot findings provided by some)</li> <li>• Who is/are the respondent(s) (e.g., parent/caregiver; teacher/service provider; child; mixture of respondents; other; don’t know)?</li> <li>• What languages were used? What guidance was given to interviewers that did not speak one of the languages available?</li> <li>• Were accommodations made for administering to respondents who were deaf, hard of hearing, blind, low-vision, deafblind, or any other person who might require other adaptations to make the survey more accessible to them?</li> </ul>
Summary of Strengths/Weaknesses	<ul style="list-style-type: none"> <li>• Data accuracy (only available when results of concurrent validity findings have been reported)</li> <li>• Concerns with the tool or the application of the tool</li> <li>• Revisions or adaptations recommended for the next version</li> </ul>

### 3.2 VIRTUAL FOCUS GROUP DISCUSSION

The DEEP team held a virtual focus group discussion on January 10, 2020, with nine representatives from the Washington Group and several IPs that had submitted tools. The aim of the 90-minute discussion was to provide more in-depth information about the online questionnaire responses while

allowing exploration of participants' experiences with the tools and recommendations for improving future data collection efforts. It generated insights related to adaptation protocols, training processes, data collection processes, lessons learned, and recommendations. See Annex B for the focus group discussion guiding questions and findings report.

## 4 FINDINGS FROM TOOL MAPPING

USAID received 14 responses to the online questionnaire and 13 tools were submitted. (Not all participants who responded to the questionnaire submitted tools and not all those who submitted tool completed the questionnaire.) Several organizations offered reports that provided data collected using the tools and offered further insight into the process involved in preparing the tool for implementation. Due to a lack of supporting documentation for many of the tools however, there are gaps in understanding the development of some of the tools, the training of the tool administrators, and associated challenges and successes. As noted above, the DEEP team reached out to those who provided a point of contact for follow-up information and invited some to participate in a virtual focus group discussion to help fill some of these gaps, yet some do still remain.

Exhibit 4 on the following page lists the tools that IPs reported using, the type of administrator and respondent, and whether any needed accommodation was provided for respondents with disabilities. Note that to maintain the respondents' anonymity, we do not provide project names, countries, or implementing partner names. Given USAID's guidance, it is not surprising that almost all of the IPs who responded reported using social model/functioning tools. Nine of the 13 instruments submitted were either the WGSS or incorporated features of the WGSS, and three were the CFM or were based on the CFM. Most applications of the WGSS and CFM tools retained their original form, and adaptations tended to reflect minor linguistic adaptations. Two instruments were not functionally based. It should be noted that some IPs also used a combination of instruments, applying functional questionnaires along with functioning screening or sometimes medical model questionnaires.

In the following sections, we review the adaption and application of the social model functional questionnaire, functional screening, and medical questionnaire respectively. More specifically, we review the use of these tools against the three factors that impact survey success: fit for purpose, quality of the tool, and use of best practices in preparation and administration of the tools, (all as reported by the IPs). Best practices are further broken down by topics raised by IPs, such as interviewers and training, respondent, and language and accommodation. We also share observations and suggestions shared by IPs. *Author reflections are presented in italics.*

Exhibit 4: Tools Used by Implementing Partners

PROJECT	WGSS/CFM	TOOL TYPE	TOOL ADMINISTRATOR	RESPONDENT	AVAILABLE ACCOMMODATIONS
A	<b>WGSS</b>	Social model/functional questionnaire	Experienced enumerators	Learners	None
B	<b>Incorporates the WGSS alongside vision and hearing screening tools</b>	Social model/functional questionnaire, functional screening	Teachers, medical officers, and school administrators	Learners	None
C	<b>WGSS</b>	Social model/functional questionnaire	Principal/teacher	Learners ages 8–15	No information provided
D	<b>Neither</b>	Social model/functional, medical questionnaire	Small local committees	Any person with a disability; any age	No information provided
E	<b>WGSS and CFM</b>	Social model/functional questionnaire	Experienced enumerator	Parents and learners ages 6-13	Used qualified sign language interpreters to help administer the survey instrument when respondents were hard of hearing or deaf
F	<b>Builds on the WGSS/uses the WGSS language</b>	Social model/functional questionnaire, medical questionnaire	Teachers	Teachers	None
G	<b>WGSS in addition to vision/hearing screening tools</b>	Social model/functional questionnaire and functional screening	Teachers	Teachers; parent responds to hearing questionnaire; learner responds during the testing	In progress
H	<b>CFM for Teachers</b>	Social model/functional questionnaire	Secondary school teachers, supervised by focal point from team	Secondary school teachers	No information provided
I	<b>CFM</b>	Social model/functional questionnaire	Teachers	Teachers and parents; learners ages 5–7 welcome to participate in the meeting where the Student Learning Profile is completed	Sign language interpreters available where needed, questions can be read out loud for people who are blind
J	<b>Based on the WGSS</b>	Social model/functional questionnaire	Trained interviewers	Parents/caregivers of learners ages 2–17	None
K	<b>Neither; single question on disability status</b>	Medical questionnaire	Ministry of Education enumerators	Teachers of learners ages 7–9	None
L	<b>Draws on and expands on the WGSS</b>	Social model/functional questionnaire	Enumerators read survey questions and responses aloud to teachers	Teachers of learners ages 7–12	Not applicable
M	<b>WGSS adapted to classroom environment with vision and hearing screening tools</b>	Social model/functional questionnaire, medical questionnaire, functional screening	Trained enumerators	Teachers and learners for Pupil Context Interview	None

## 4.1 APPLICATION OF SOCIAL MODEL/FUNCTIONAL QUESTIONNAIRES

### 4.1.1 FIT FOR PURPOSE

IPs were permitted to indicate multiple purposes for data collection. They indicated three broad purposes of data collection:

#### 1. Data disaggregation or prevalence:

- Identify disability status in order to disaggregate education outcome indicators by disability status
- Understand the proportion of learners with functional difficulties in lower grades

#### 2. Individual screening/identification:

- Screen learners in order to design and deliver services
- Determine eligibility for government special and inclusive education grants
- Collect information about the functional limitations of the learners in the class

#### 3. Program design/evaluation:

- Inform the design of technical materials
- Determine reading and sign language achievement

Of the 13 projects for which IPs reported information, four were collecting data for disaggregation by disability status and four were collecting data to screen learners and deliver services. One was collecting it to inform the design of project materials and one to measure improvements in reading and sign language achievement. In addition, three indicated that they were interested in both disaggregating data and screening learners. In reports submitted to complement the online questionnaire responses and tools, explanations for the tools' objectives or purposes included that they were "being used in service planning and assisting government with key strategic decisions by providing the government ministries with information on what people's needs are," or "locating where more people with disabilities are living and where provision of services would be most effective." One report stated that the collected data was used to identify learners who might need further medical screening. One tool, which was being piloted to see if teachers could be used as respondents with the Child Functioning Module, aimed to provide a picture from the teacher's perspective of a learner's functional ability within an educational setting.

*The purpose for which both the WGSS and the CFM have been designed and validated is to provide an estimate of the prevalence of disability and the disaggregation of important outcome indicators by disability status based on evidence from population-based surveys. Therefore, the first reason listed above (disaggregation and prevalence) aligns with the validated purpose for which both the WGSS and the CFM were designed. These tools were not validated as tools to diagnose or assess a child for service provision or eligibility for social benefits. They can be used as a screen to refer children for more detailed assessments suitable for service provision and eligibility determination, but they were not originally designed as screening tools.*

*During the virtual focus group discussion, each participant shared the purpose of their data collection efforts, the tool they used, and the reason for their choice of data collection tool. This led to a brief discussion that*

*highlighted the confusion involved in selecting appropriate tools, not only among the participants on the call but also among the field staff who use the tools. There was misalignment among the tools chosen for use and the purpose of that particular tool. More robust guidance on the WGSS and the CFM is necessary, along with guidance on other tools that might better fit the purpose of their data collection.*

#### 4.1.2 QUALITY OF THE TOOLS

The quality of the tools can be best assessed via concurrent validity and reliability studies. Few studies reviewed included concurrent data. One application of the CFM provided the most comprehensive data and compared parent and teacher responses against one another as well as to a clinical assessment. Comparisons between parent and teacher respondents in this study revealed high levels of agreement. Teachers' responses to questions related to cognitive functioning (remembering and focusing attention) were more accurate than those of the parents. Conversely, parent responses were found to be slightly more accurate than teachers with regard to vision, walking, and speech. Comparison of parent and teacher CFM responses with the clinical assessment data indicated good to excellent accuracy of the CFM for hearing, vision, speaking, and walking, and only fair to poor accuracy on cognitive domains such as focus, remembering, and learning.

The same project indicated broad interpretation of some response options. For example, learners who parents and teachers reported as having “some difficulty” included those who clinical studies classified as having mild, moderate, and even severe functional difficulties.<sup>19</sup> Other projects which used the WGSS reported similar challenges with response options. To address this issue, one IP created a matrix with a description of the kinds of limitation associated with each functional domain and difficulty level (“some,” “a lot”). The comparability of response option language has been flagged as a challenge in other research,<sup>20</sup> which has shown that while “a lot of difficulty” and “unable to do” responses are comparable across contexts, the “some difficulty” responses are less comparable.<sup>21</sup> Another IP experimented with limiting response option to binary (yes/no) responses only. They found that this led to less reliable data than when they provided respondents with a range of functional limitations options.

*IP's experiences provide useful insights into areas of strength and for potential improvement in these tools. Further concurrent validity studies are needed for school-based applications of these tools. In addition, further testing of response option language noted above is needed to increase the accuracy and reliability of the resulting data. It should be noted however, that even when there is a broad interpretation of learners having “some difficulty” this can still provide an important flag that additional support or further screening is needed, even if their difficulties are not considered disabilities.*

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<sup>19</sup> Sprunt, B., B. McPake, and M. Marella, 2019, The UNICEF/Washington Group Child Functioning Module—Accuracy, Inter-Rater Reliability and Cut-Off Level for Disability Disaggregation of Fiji's Education Management Information System. *International journal of environmental research and public health* 16(5). <https://doi.org/10.3390/ijerph16050806>

<sup>20</sup> Hoekstra N., and A. Hayes. (2019). *Opportunities and Challenges when using the Washington Group Questions to Determine Eligibility for Special Education*. Prepared for USAID.

<sup>21</sup> Altman, B. M. ed., 2016, *International measurement of disability: Purpose, method and application* 61.; Miller, K., D. Mont, A. Maitland, B. Altman, and J. Madans, 2011, Results of a cross-national structured cognitive interviewing protocol to test measures of disability. *Quality & Quantity* 45(4): 801-815.

### 4.1.3 USE OF BEST PRACTICES IN PREPARATION AND ADMINISTRATION OF THE TOOLS

As noted previously, the application of best practice in the preparation for and the administration of the selected survey/assessment tools plays a crucial role in the quality of the resulting data. Arranged in chronological order, the factors to consider include instrument adaptation/translation, type of respondent and interviewer chosen, interviewer training, evaluation, supervision, and finally, accommodations applied in administration.

#### LANGUAGE AND TRANSLATION

A critical early step in any data collection is the adaptation of the tool to the local context. In some cases, IPs reported adapting the WGSS to classroom settings, and others reported simplifying the response options, but by and large, most limited their adaptation to the translation of the tool. Translation and language considerations are of particular importance in many USAID-supported countries which frequently have multiple official languages. Limited information was available on translation procedures. One IP explained that in addition to translating materials into the numerous local languages, they tried to have trainers who had a mother-tongue level of proficiency in local languages used. If they could not obtain a trainer proficient in the local languages, they took steps to ensure someone was available to translate.

*The Washington Group provides guidance<sup>22</sup> to ensure translated questionnaires maintain equivalence of measurement across languages and dialects to ensure the resulting data is comparable across countries. Testing translations of the Washington Group questions in the field is critical to ensure that administrators use the languages respondents will understand and to ensure that there will be no bias attached, which often comes from literal translations. Maintaining continuity of concepts in the questions is much more important than producing a literal translation because certain words and phrases can carry different connotations. It is essential that translated questions undergo cognitive testing to ensure respondents are interpreting the translation as intended.<sup>23</sup>*

#### RESPONDENTS

As described in Section 2, the WGSS and CFM questionnaires were designed and validated for use with adult respondents—parents or caregivers, who were asked about their child’s functional abilities. Just as it is important to ensure that the tool used fits its intended purpose, it is equally important that implementers gather information from respondents for whom the tools have been validated. Given the challenges in interviewing parents in school-based assessments, USAID’s guidance calls on implementers to administer the questionnaires directly to learners. Three of the projects followed this guidance; the others relied on teachers, head teachers, or parents/caregivers to respond.

For the projects where learners were the respondents, some IPs noted a lack of accuracy in responses regarding functional limitations. One noted that using the WGSS directly with learners did not work well, though further elaboration was not provided. Similarly, another IP that used vision and screening tools alongside the WGSS with early grade learners saw a lack of correlation between the learners’

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<sup>22</sup> Washington Group, 2017, *Translation of the Washington Group Tools*. Washington Group on Disability Statistics.

<sup>23</sup> Washington Group, 2006, Appendix 3: *Cognitive Testing Interview Guide*. Washington Group on Disability Statistics (October 2). Forthcoming Washington Group, 2019, *Cognitive Testing of Translated Questions*.

responses and results from a vision and hearing screening test.<sup>24</sup> One IP reported that when working with 14-15-year-old respondents, there were challenges with concentration and memory questions, although the partner did not provide further detail regarding this difficulty.

Seven of the 13 reporting projects asked teachers to respond to questions about learners in their classrooms. Approaches used by IPs when using teachers as respondents varied, as did their reflections on the strength of this approach. Teachers were either interviewed or, as in the case of the CFM for teachers, were asked to complete a form on their own. In one instance, parents or caregivers were asked to provide supporting information in addition to that which teachers provided. This information request functioned as a way to keep the parents involved in the process and also obtain information on hearing difficulties observed at home that the CFM may have missed. However, the majority of questionnaires were completed solely by teachers in their classrooms. When working with teachers, one IP recommended that when teachers were the respondents, it would be more effective to administer the questionnaire later in the school year, when teachers have more familiarity with their students. This IP argued that if a tool is used at the beginning of the year, many difficulties could go undetected; if the teacher has had time to observe areas of difficulty for learners, more robust data about the learner's functioning could be obtained.

*A helpful model might be to track data over the course of the year. Using the tools from the beginning of the year could also help build teacher awareness of what to look for among the learners and ability to detect difficulties earlier. This method was not observed among any of the tools reviewed. Its potential, though, was acknowledged in one report.*

One IP noted that teachers at the secondary school level split their time across multiple classes and, for this reason, they speculated, have less familiarity with their students. This, they speculated, might have led to lower identification of learners with disabilities. Others raised concern that in large classroom settings, teachers may not be familiar enough with learners to accurately identify their functional limitations. Researchers have also raised the concern that bias against minority/immigrant groups may be unconsciously introduced by teachers or that they may not have the knowledge needed to capture mild or “invisible” difficulties.<sup>25</sup>

One IP expressed concern regarding teachers administering CFM questions on domains outside a teacher's purview, such as anxiety and depression. This respondent felt that parents were more suited to answer these types of questions on behalf of their children. Conversely, the pilot application of the CFM that was adapted specifically to teachers showed that secondary school teachers were able to use the tool well and that it encouraged them to better understand their students' abilities and needs. In this pilot, as a way to measure the reliability of responses, a subset of selected learners were evaluated twice by different teachers. On average, in this study, the two teachers spent 1-2 minutes completing the questionnaire and were quickly able to answer questions on basic functional domains like seeing, hearing,

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<sup>24</sup> To analyze these data, categories for the Washington Group Questions were condensed by grouping “cannot do at all,” “yes, a lot of difficulty,” and “yes, some difficulty” into a new group—“some difficulty.” This seems problematic and leads to unreliable data, as in case of the questionnaires that rely on yes/no responses. Categories in the hearing and vision screening tools were also condensed from “mild,” “moderate,” and “moderate-severe” into a single category labeled “some impairment.” Again, condensing a range of difficulty into a single category or binary is likely problematic for the ability to provide good, reliable data. It can also mask the impact of disability on outcomes. For example, if children with *a lot of difficulty* face strong barriers to participation, but those with *some difficulty* do not, then averaging their outcomes (especially since “some” responses generally outnumber “a lot” and “cannot do” responses) will mask the poor outcomes experienced by those with more significant impairments.

<sup>25</sup> Hoekstra and Hayes, 2019.

walking, and speaking, and with a little more difficulty, they were also able to answer questions on issues such as learning, remembering, concentrating, accepting changes in routine, behavior, anxiety, and depression. Depending on how well a teacher knew the learner, they were able to complete the questionnaire with more or less ease; however, it seemed that with consistency, the two teachers evaluated the learners' difficulty with functioning similarly, leading the researchers to believe that secondary teachers are equipped to conduct these questionnaires successfully.

*Many IPs noted concerns in using respondents for which these tools were not validated. Promising approaches were also noted and additional research is needed to explore and validate alternative respondents.*

## **INTERVIEWERS AND TRAINING**

The selection of interviewers is another important factor impacting the quality of a survey's resulting data. The WGSS and the CFM do not need to be administered by medical professionals, but, as with any survey, require the use of well-trained and, ideally, experienced interviewers. Other considerations such as the sustainability of the data collection approach may lead IPs to use ministry staff, school administrators, or teachers. The data collection exercise can also provide an opportunity to raise teachers' awareness of issues of functional difficulty. To do so, IPs may, therefore, elect to have teachers collect the data and receive appropriate training beforehand. As noted in Exhibit 4, when collecting data, six of the 13 projects used experienced interviewers, five used teachers, two used teachers and/or school administrators, and one project used a local community committee. IPs provided information on the training content, approach, duration, as well as interviewer supervision and evaluation.

Interviewer training on how to administer a tool and what information it is intended to gather is critical for ensuring the most effective use of the tools considered in this study. Key considerations include the need to communicate clearly about the value and importance of collecting data on disabilities for inclusive education, the type and length of training, and a need to provide interviewers with real-world opportunities to practice. However, much of the training reviewed in this study was reported as insufficient for the implementation of these tools.

**Clarifying Key Concepts and the Value of the Tools:** A key objective of disability data collection training is that interviewers have a solid understanding of disability as their culture conceptualizes it (versus solely in the way USAID does). Training should also ensure that interviewers have a clear understanding of the purpose and importance of this data collection. This is particularly important when school teachers or administrators, who have many competing responsibilities, are tasked with implementing these tools. One implementer suggested that it is crucial to convey the importance of the data being collected so that those who administer questionnaires have a full understanding of the purpose and intent of the tool. If provided with this training, administrators may be better equipped to administer these tools with the diligence required for effective use. It is also important for IPs to help school staff understand that these tools can help their teaching practice and improve their awareness of the range of learners in their classrooms, rather than being viewed as an externally imposed task to complete in addition to their other responsibilities.

**Type of Training:** As noted in Exhibit 5, respondents reported extensive variation in the type and length of training for interviewers. The majority of online questionnaire respondents (nine) reported that tool interviewers received in-person training. All but one trained all enumerators directly, while one IP reported applying a cascade training approach in which district administrators and school principals received training-of-trainers and then trained teachers to administer the questionnaire.

Exhibit 5: Training Provided by Implementing Partners on Disability Data Collection Tools

	TRAINING TYPE	DURATION	INTERVIEWER ASSESSMENT OR EVALUATION CONDUCTED?
A	In-person instruction, mock interviews in the training classroom, supervised practice interviews in the field, mock interviews in multiple languages	6+ days	Assessment conducted in the training classroom
B	In-person instruction, practical site visit to practice tools in school setting, mock interviews in training classroom, and multiple screening performance evaluations	2 days	All screeners participated in multiple evaluations of their performance in using the screening tools
C	No information provided	No information provided	No information provided
D	Guidance document: “Instructions: Use of Software Health Management Rehabilitation Disability”	No information provided	No information provided
E	In-person instruction, supervised practice interviews in the field	3–5 days	No information provided
F	In-person instruction	1–8 hours	No
G	In-person instruction, mock interviews in the training classroom, supervised practice interviews in the field	1–2 days	Follow-up interview
H	In-person instruction with general introduction to disability and discrimination and training on the Washington Group approach, its tools, the research, and the CFM-TV	2 days	No information provided
I	Mock interviews in the training classroom; training provided to district administrators and head teachers (principals) who then trained the teachers on how to administer	1–8 hours for head teachers and district administrators	Immediate feedback given during interviews, daily debriefing and reflection on data collection
J	In-person training and mock interviews in the training classroom	1–8 hours	No
K	In-person training, mock interviews in the training classroom, and supervised practice interviews in the field	No information provided	No information provided
L	Interviewers received brief training in the administration of the tool	30 minutes	No information provided
M	Participants practiced the application of each instrument, including with principals, teachers, and learners, in two schools	3 days	No information provided

**Opportunities to Practice:** Mock interviews are a crucial part of training as they allow interviewers to familiarize themselves with the content and flow of the instrument. Six respondents reported that they conducted mock interviews during training (with interviewers taking turns interviewing each other). Only one implementer indicated that the mock interviews were done in multiple languages, despite some country contexts where multiple languages were used during fieldwork.

Supervised practice in the field can also help ensure proper administration of the tool in less controlled settings and can help build interviewer confidence. Four reported supervised practice interviews in the field, of which three had also conducted mock interviews during training. When one IP went back to the teachers after a tool had been used to ask what else they might need, the teachers requested more training and the opportunity to practice in school settings (e.g., real-world administration settings) not just with fellow participants in the training setting.

**Interviewer Assessments:** In addition to hands-on training approaches, assessments of interviewers at the conclusion of training enable organizers to ensure that interviewers had acquired the skills necessary to administer the tools successfully. Three of the 13 projects reported confirming interviewer preparedness prior to fieldwork by conducting assessor assessments. Though this level of detail was not requested in the survey, these types of assessments typically involve having interviewers observe an interview and record responses. Their responses are then compared to the correct answers to ascertain accuracy. Interview assessments can also involve content assessment and observation of interviewers during mock interviews and in the field.<sup>26</sup>

**Length of Training:** The biggest difference reported by IPs was in the length of training, which ranged from less than an hour to six days (Exhibit 5). However, to draw deeper conclusions regarding the impact of training length, further exploration would be necessary to discover the range of content covered during training sessions, especially those of longer duration. Some IPs indicated that additional training would have been helpful for those who administered the tools.

*Shorter training sessions reduce the opportunity to conduct mock interviews, practice interviews in the field, and assess interviewers—activities that help ensure interviewers become comfortable with the questionnaire and protocol, develop a deep understanding of the concepts and the purpose of data collection, and are able to administer them reliably. The trainings that were able to do all three typically required at least two days—one for concepts and purpose of data collection, and a second for practice interviews and interviewer assessments.*

## ACCOMODATIONS

Making accommodations for respondents with disabilities can help ensure that they can participate effectively in the survey and that the final findings reflect their responses. Accommodations for respondents who are deaf or hard of hearing may include using local sign language, although this is may be difficult because there can be multiple regional sign languages in a country and a general lack of qualified sign language interpreters<sup>27</sup>. Two IPs reported making sign language available. No other accommodations were reported.

*Accommodations should be planned for at the outset of project design. This will ensure that all respondents are able to participate fully.*

## 4.2 APPLICATION OF SOCIAL MODEL/FUNCTIONAL SCREENING TOOLS

Three of the 13 tools submitted applied functional screening tools (for vision and hearing only). Projects that applied a screening tool also applied a social model functional questionnaire. The screening tools IPs reported used mobile apps and other methods to detect the degree of disability.

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<sup>26</sup> After training once interviewers are in the field, an important tool used to validate the quality of interviewers' work is inter-rater reliability. This important practice is one of the many recommendations included in USAID's guidance on conducting evaluations.

<sup>27</sup> USAID projects collecting Early Grade Reading Assessment Data have found it be effective to train deaf adults fluent in the local sign language as assessors. This can be useful in addressing sign language variation and eliminating dependence upon interpreters who may not be available or highly qualified in the language.

## 4.2.1 FIT FOR PURPOSE

As noted above, functional screening tools use objective assessments to identify individuals with functional difficulties. The findings from these tools are used to identify the need for additional screening and/or to refer individuals for needed support. The findings from the screening tools in one study were used to identify learners in program classrooms who needed disability-related accommodation. Teachers were provided with training on accommodation approaches to use with learners with low or no hearing or vision. These screening tools were used appropriately given the researchers' need and the tools' validated purpose.

The functional screening tools reviewed here focus on vision and hearing and are intended to detect the degree of disability a child might have. There were no screening tools used to measure any other domains in the Washington Group guidance.

## 4.2.2 QUALITY OF THE TOOL

IPs reported positive feedback from both the parents and teachers in ease of use as well as high levels of reliability of results across users. These tools were then used in other country contexts, following successful pilots.<sup>28</sup> Despite these successful applications, one IP noted that in-school screening posed challenges with regard to hearing screening because the extraneous noise, unavoidable in a school setting, led to some false-positive results in the hearing tests.

## 4.2.3 USE OF BEST PRACTICES IN PREPARATION AND ADMINISTRATION OF THE TOOLS

### INTERVIEWERS AND TRAINING

One IP used a teacher-led screening but recommended discontinuing that approach. In terms of cost-effectiveness and reliability, this IP suggested working alongside local health staff to make sure screenings were conducted accurately; there were concerns that teachers were not doing so. Conversely, keeping teachers involved in the screenings was suggested as important because it helped them better understand their learner population and know how to work more effectively toward the inclusion of all their learners.

Training typically lasted at least one day, although some IPs felt that additional training would have been useful or that there should have been refresher training sessions to remind interviewers how the screening tools worked. Simply providing time for mock interviews during the training was not seen as sufficient; those who were administering the tools requested to have practice interviews in the field. *This feedback from interviewers would also seem fitting for the social model/functional questionnaire reviewed.*

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<sup>28</sup> Examples of vision screening tools used include “Tumbling E” charts in which the learner views the chart, which shows a series of rows with the letter E facing different directions, and tells the administrator which direction the E’s legs are pointing. Another screening tool, the Lea chart (a much-preferred method) uses symbols, with the child naming the symbols they are able to see. The test can detect whether a child is experiencing difficulty seeing, at what severity level, and for which eye.

## RESPONDENTS

The screening tool respondents are children, who let the assessor know what they can or cannot hear or what they can or cannot see. One tool employed a mobile app for parents to use in screening their children. The accompanying questionnaires were answered by the learners, or by caregivers with the optional support of their child.

## 4.3 APPLICATION OF MEDICAL MODEL/MEDICAL QUESTIONNAIRE

Although medical model questionnaire and screening tools were not a focus of this study, we have included some information here since four of the 13 respondents reported applying a medical model questionnaire. All but one of the four respondents indicated that the medical questionnaire (which, in one case, was limited to a single question) was used in conjunction with a functional model questionnaire and/or a medical screening. As noted above, tools aligned with the medical model ask respondents whether they or the person for whom they are responding has a disability. This approach does not ask about the person's level of functioning in various domains, but rather asks, "Does the child have a disability?" or "Is the child deaf, blind, physically disabled, etc.?"

This approach has consistently been shown to under-identify people with disabilities, as conceptualized in the social model that serves as the basis for the United Nations' Convention on the Rights of Persons with Disabilities.<sup>29</sup> In addition to the concerns about underestimations of prevalence rates, as noted above, there are concerns that this approach encourages labeling and stigmatization of individuals with disabilities. For this reason, persons who would otherwise identify as a person with a disability might not say so in a survey for fear that they will be labeled and stigmatized.

Despite very limited information available on the use of this approach among USAID IPs, we can provide the following summary information:

### 4.3.1 FIT FOR PURPOSE

One IP reported using a medical model questionnaire to identify individuals with disabilities and recommend them for services. *To assess the need for services, a professional medical screening would be needed.*

### 4.3.2 QUALITY OF THE TOOL

As is common with tools that ask about the presence of disability, there is variation in terminology, definitions, and categorization of disability. In the medical model questionnaires, questions were often limited to one or two general question(s) about whether the child has a disability. Without language to explain "disability" to the respondent, "disability" remains quite open to the respondent's interpretation and can lead to unreliable data. In some of the tools reviewed, what constituted a disability, how the domains were categorized, and what was included under each domain was incorrect. For example, one tool categorized autism as a "mental-emotional" disability, which it is not. Some terminology did not

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<sup>29</sup> Mont, D, 2007, *Measuring disability prevalence*. Social Protection, Discussion Paper No. 0706. World Bank.; Altman, B. M. ed., 2016, *International measurement of disability: Purpose, method and application* 61.

follow best practice and, in some instances, could be considered derogatory, such as the use of the term “mental retardation.”

### 4.3.3 USE OF BEST PRACTICES IN PREPARATION AND ADMINISTRATION OF THE TOOLS

#### INTERVIEWERS AND RESPONDENTS

Among the four examples of medical questionnaire applications, one relied on a small local interview committee which, based on the interview, would determine an individual’s disability status. Other applications relied on trained interviewers, while others used teachers. Among these medical questionnaire applications, IPs reported using student, teacher, and community member respondents.

#### LANGUAGE AND ACCOMMODATION

In all questionnaires reviewed, materials were translated into the local language. No accommodations were reported in the examples provided.

## 5 DISCUSSION

This mapping study comprised a review of online questionnaire responses, instruments used in different contexts and by different IPs around the world, supporting documentation from the projects, and a combination of one-on-one and virtual focus group discussions. The results suggest some interesting findings that the DEEP team believes will lead to higher-quality data collected on learners with disabilities.

### 5.1 THE PURPOSE OF THE TOOLS

Many tools are in use to collect data on learners with disabilities (including others not submitted for this study), and these are often designed for specific purposes. USAID’s 2018 “How-To Note: Collecting Data on Disability in Education Programming” and many others in the global disability inclusive development community<sup>30</sup> encourage the use of the WGSS and the CFM and do not provide other tools to use for different purposes. As a result, several study respondents either used a tool that was not designed for their data collection purpose or used a tool for multiple purposes when it was only designed for one.

Some tools are designed to identify prevalence and patterns, while others are intended to identify learners with disabilities for specific services. The first of these purposes requires much less accuracy than the second. To identify learners with disabilities with the aim of looking at prevalence, patterns of prevalence (e.g., by gender), or disaggregating outcome indicators, missing 10–20 percent of the cases would not create significant problems. However, if applied to a purpose associated with service delivery, that level of accuracy would lead to problematic situations that could ultimately cause harm to a learner. Similarly, if a learner was identified as having a disability because of difficulty remembering or concentrating, but that difficulty was actually linked to a vision problem (e.g., not being able to see the

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<sup>30</sup> Including disabled persons organizations (DPOs), donor partners, and Sustainable Development Goal monitoring guidance.

board), this would not be problematic for determining, for example, overall dropout rates for learners with disabilities, but would be problematic for determining the learner’s needs in the classroom.

During the focus group discussion, several IPs mentioned that tools had been retrofitted to a purpose for which they were not been validated. Retrofitting tools in this way is unlikely to yield as accurate and reliable data as a tool for which this purpose has been validated. Guidance that outlines the many tools, specifies their validated purpose(s), and ensures IPs are aware of a suite of tools to use is essential for the collection of robust data that can be compared across countries.

USAID’s current How-To Note lacks adequate guidance on the purpose of the WGSS and the CFM. Lacking tight direction, IPs seem therefore to be trying to do more with the tools than they should. The note does provide some guidance on the use of these tools, but it might be necessary to provide more thorough guidance on other tools that are available for the purposes IPs are seeking.

Our study also noted observable differences in how IPs define disability and talk about learners with disabilities. Stronger definitions and communication guidance could support greater consistency in understanding of the learners being assessed in these programs and help avoid communication that could support unnecessary stigmatization.

## 5.2 TRAINING

The trainings varied widely in duration, content, and participants. Several IPs noted, on multiple occasions, the need for additional training. Tool interviewers would benefit if trainings included a review of the purpose of data collection and how the data will be used. A background session on what disability is, why it is important to collect data on learners with disabilities, and how to ask the questions appropriately in the target language would continue to improve the data quality because the interviewers would understand disability in a more nuanced way. Some time and effort should be spent to raise the awareness of interviewers who may not be comfortable or familiar with the terminology. This could mitigate some of the bias among those with less experience in the area of disability. These explanations must be clear to the person receiving the information. One IP suggested not linking the questionnaires to disability because the interviewers would have their own interpretations and understanding of disability. When focusing on “difficulties,” they tend to be less worried about asking these questions.

There was also a suggestion to include “red flags” to watch for, gleaned from pilots and previous data collection. For example, teachers using the CFM are told to compare the learner with others at the same age; one organization found that teachers were comparing learners to the top learner in the class, not to the average learner.

## 5.3 THE RESPONDENTS

The person who responds to these questions—whether a teacher, a parent or caregiver, or a learner—is important to the quality of the data. Very accurate data can be gathered from parents and other caregivers, and there is growing evidence that teachers can provide accurate data if the tools are adapted appropriately and training is sufficient. There are concerns that children may not reliably report their own level of functioning. This should be further investigated to ensure that these tools are valid for use with child respondents.

## 6 PRELIMINARY RECOMMENDATIONS

Below are some preliminary recommendations based on the information gathered to date. Final recommendations will be developed during a workshop in which implementing partners and other stakeholders in the field work to develop recommendations for revised guidance on generated disaggregated data by disability status.

1. IPs who participated in the mapping study reported many purposes for data collection; however, the tools recommended in USAID guidance have a specific purpose that did not always align with the IPs' purposes. **Update USAID guidance note with the inclusion of a decision tree that links a suite of diverse tools with information on their purpose.** This approach will help IPs in selecting the best tool(s) for their particular purposes.
2. The use of the WGSS with child respondents has not been validated, and only initial research has explored the use of the CFM with teachers. **Support research that will permit adaptation and validation of the WGSS and the CFM for use with the respondents and interviewers who are more likely to be available for school-based applications.**
3. IPs have observed challenges in the consistent interpretation of response options used in establishing respondents' level of functional difficulty. This inconsistency has consequences for the comparability of findings across respondents, interviewers, and countries. **Support research on the use of different response option language to more accurately and reliably identify learners with disabilities in the school setting.**
4. IPs reported a wide range of approaches used in preparation for (e.g., adaptation, accommodation, translation, cognitive interviewing, interviewer training) and administration (e.g., interviewer training, data interpretation) of the WGSS and CFM tools. This variation can have implications for data quality and comparability. **Strengthen guidance on best practices for adaptation, preparation, and administration of tools used to collect data on functional difficulties and disabilities.** This guidance should be based on industry standards and implementing partners' own experience to ensure greater quality and comparability of results.

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# 8 ANNEXES

## 8.1 ANNEX A: REQUEST FOR TOOLS, PROTOCOLS, AND LESSONS LEARNED FROM IMPLEMENTING PARTNERS



### **USAID DISABILITY DISAGGREGATION DATA: REQUEST FOR TOOLS, PROTOCOLS, AND LESSONS LEARNED**

*USAID's Office of Education is committed to collecting, analyzing, and using disability data in USAID Education Programming in order to ensure efforts are inclusive of children and youth with disabilities and that the Agency's Education Policy priority of 'expanding access to quality education for all, particularly marginalized and vulnerable groups' is being met.*

*Some Implementing Partners (IPs) already have or are developing disability data collection tools for use in education programming. USAID, through its Data and Evidence for Education Programs (DEEP) activity, plans to work with partners and disability stakeholders to determine and validate a data collection method and tool for use in USAID early grade education programming.*

*To achieve this goal, USAID will carry out a mapping of tools designed to identify children with disabilities currently being used by IPs in the context of education programming. Once the mapping has been completed, USAID will carry out a meta-analysis of disability data collected by IPs since February 2018 when USAID issued its guidance on collecting data on disability in education programs. The mapping of these tools, lessons learned from the application of current tools, and the findings drawn from the meta-analysis will inform the discussions in a workshop planned for 2020.*

*In order to carry out this work, DEEP asks all IPs who have applied questionnaires and/or screening tools to collect student disability data related to education programs (funded by USAID or by other donors) to please complete this survey form. Please complete one form for each instrument used. This survey gathers information about instrument design, piloting, and field applications. The final section of this survey provides an opportunity to upload documents for the DEEP team to review as part of the mapping exercise. Please note that your tools and protocols will not be shared beyond the USAID and DEEP team-members working on this tool. Lessons learned regarding successes and challenges will be reported at an aggregate level.*

*Please identify a person within your organization who is familiar with the tool used, with training in advance of data collection, and with the tool's administration at the pilot and field stages. This questionnaire should take between 15 and 20 minutes to complete. The deadline for completing this survey is October 11, 2019.*

*Thank you in advance for your contribution to this exercise. If you have any questions about this survey, please contact Amy Mulcahy-Dunn, DEEP COP at [amulcahy-dunn@encompassworld.com](mailto:amulcahy-dunn@encompassworld.com).*

## DESIGN

1. Your organization name:  
\_\_\_\_\_
2. Point of contact name for this survey response:  
\_\_\_\_\_
3. Point of contact email address for this survey response:  
\_\_\_\_\_
4. For which project was this survey/assessment instrument developed, adapted or used?  
\_\_\_\_\_
5. Who funded the development, adaptation, and/or use of this survey/assessment instrument?  
\_\_\_\_\_
6. For which country or countries was this survey/assessment instrument developed, adapted or used?  
\_\_\_\_\_
7. What is the purpose of the survey/assessment instrument?  
If selecting "other," please specify.  
*Check all that apply.*
  - Identify disability status in order to disaggregate education outcome indicators by disability status
  - Screen children in order to design and deliver services
  - Other: \_\_\_\_\_
8. Who are the survey/assessment instrument respondents?  
If selecting "other," please specify  
*Mark only one oval.*
  - Students
  - Teachers
  - Parents/caregivers
  - Other: \_\_\_\_\_
9. Please indicate the age range for the children you are targeting with this instrument:  
\_\_\_\_\_
10. Please indicate the grade(s) of the children you are targeting with this instrument:  
\_\_\_\_\_
11. What background did the instrument administrators have?  
Select all that apply. If selecting "other," please specify  
*Check all that apply.*

- Disability subject-matter specialists
- Medical providers
- Experienced interviewers
- First time interviewers
- Not sure or N/A
- Other: \_\_\_\_\_

12. What training did the administrators receive?  
 Select all that apply. If selecting "other," please specify  
*Check all that apply.*

- In-person training
- Mock interviews in the training classroom
- Supervised practice interviews in the field
- Reliability assessments conducted in the training classroom
- Mock interviews in multiple languages
- Mock interviews using different forms of accommodation (sign language interpretation, braille forms, etc.)
- Other: \_\_\_\_\_

13. How long was the training for administrators?  
*Mark only one oval.*

- 1-8 hours of training
- 1-2 days of training
- 3-5 days of training
- 6 or more days of training

**PILOT INFORMATION**

14. Please indicate the year(s) in which the pilot application was administered:  
 \_\_\_\_\_

15. Please indicate the sample size and units (student, school, household, etc.) of pilot application:  
 (For example, 500 students or 200 households.)  
 \_\_\_\_\_

16. Was concurrent data collected during the pilot stage (i.e., Did you assess the same children using an existing validated tool or screening approach)?  
*Mark only one oval.*

- Yes
- No
- Not sure or N/A

17. Please describe survey/assessment instrument revisions needed after the pilot application, including explanations of why each revision was required and whether this information was documented in the pilot or findings report.

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**FIELD APPLICATION**

18. Please indicate the year(s) in which the field application was administered:

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19. Please indicate the sample size and units (student, school, household, etc.) of field application: (For example, 500 students or 200 households.)

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**ADAPTATIONS**

20. Please share any recommendations regarding future adaptations of the survey/assessment instrument or administration protocol:

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21. Please describe any accommodations made for administering the survey/assessment instrument to respondents who are deaf, hard of hearing, blind, or deafblind:

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22. Was local sign language interpretation available?  
*Mark only one oval.*

- Yes
- No
- Not sure or N/A

23. If any other forms of adaptation were provided, please list them here:

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24. Please list the different languages in which this survey/assessment instrument is available:

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25. Are there other official languages of instruction used in the application country or countries that are not captured in the survey/assessment instrument?

*Mark only one oval.*

- Yes
- No
- Not sure or N/A

26. Please describe the guidance given to interviewers when encountering respondents who do not speak one of the languages available:

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## 8.3 ANNEX B: REQUEST FOR INSTRUMENTS AND DOCUMENTATION FOR IMPLEMENTING PARTNERS



### REQUEST FOR INSTRUMENTS AND DOCUMENTATION

To further inform our mapping exercise, we request that you please upload the following documents pertaining to this survey/assessment instrument.

If you have any questions about this survey, please contact Amy Mulcahy-Dunn, DEEP COP at [amulcahy-dunn@encompassworld.com](mailto:amulcahy-dunn@encompassworld.com).

1. Pilot instruments (English version if available)  
Files submitted: \_\_\_\_\_
2. Final instruments (English version if available)  
Files submitted: \_\_\_\_\_
3. Consent/assent forms (English version if available)  
Files submitted: \_\_\_\_\_
4. Administration protocol (unless included in instrument. English version if available)  
Files submitted: \_\_\_\_\_
5. Pilot report (unless included in final report. English version if available)  
Files submitted: \_\_\_\_\_
6. Final report (English version if available)  
Files submitted: \_\_\_\_\_
7. Do you have any other survey/assessment instruments to share with us? \*  
*Mark only one oval.*
  - Yes
  - No

Please use the link below to share additional survey/assessment instruments:  
<https://forms.gle/EGiCDjUgeFzBbhQu5>

Thank you for taking the time to complete this survey and providing supporting documents.

## 8.5 ANNEX C: FOCUS GROUP DISCUSSION GUIDE

TOPIC	QUESTIONS
Adaptation and Training	<ul style="list-style-type: none"> <li>• How many of you developed a brand-new tool for a specific context?               <ul style="list-style-type: none"> <li>○ Why did you feel like a new tool was needed?</li> </ul> </li> <li>• How many of you made adaptations to the tool you used to fit your purpose or context?               <ul style="list-style-type: none"> <li>○ Why did you feel the need to adapt the tool?</li> <li>○ Did anyone make any accommodations for respondents with disabilities? How was that process?</li> </ul> </li> <li>• When thinking back on how you adapted the tools to country-specific context, what processes did you use? <i>Probe for:</i> translation, translation verification, pre-piloting, cognitive interviewing.</li> <li>• Talk a bit about the training provided to data collectors.               <ul style="list-style-type: none"> <li>○ What aspects of the training did you find to be particularly effective or important?</li> <li>○ Are there changes you would make to the training for the next round of data collection?</li> <li>○ <i>Probe for:</i> length of training, topics covered, enough practice, various types of practice, interviewer assessments, who is involved in the training including people with disabilities (Who does the training—for example are people with disabilities involved?)</li> </ul> </li> <li>• IF TIME: What about training for data analysis? Those responsible for interpreting the data? Those in a position to use the data to inform programming or other decision making?</li> </ul>
Data Collection	<ul style="list-style-type: none"> <li>• Talk about the respondents you engaged with.</li> <li>• What types of respondents participated in your data collection activities? <i>Probe for:</i> children, parents, service providers.</li> <li>• When collecting data from particular groups of respondents, what worked well? Were there adaptations made for particular respondent groups that facilitated these successes? <i>Probe for:</i> children, parents, service providers.</li> <li>• What was challenging with particular respondent groups? What adaptations could be made in future to improve the data collection process from these groups? <i>Probe for:</i> children, parents, service providers.</li> <li>• Talk about the data collectors.</li> <li>• What went well with particular data collectors?</li> <li>• What challenges did you face with data collectors? How were you able to address these?</li> <li>• What feedback did you receive from data collectors? How were you able to incorporate that into the tools or training?</li> <li>• Were there any instances in which a respondent completed the form by themselves rather than the interview being conducted by a data collector? How did that go? Would you recommend it or do it again in a different way? Under what circumstances?</li> </ul>
Lessons Learned and Recommendations	<ul style="list-style-type: none"> <li>• Think about the data collected. Thinking about the original purposes of these data collection events discussed at the start of our conversation, did the final instrument used help you meet that purpose? Did good quality data come from using it?               <ul style="list-style-type: none"> <li>○ If not, or if you think you could have gotten better data, what would you do differently?</li> </ul> </li> </ul>

TOPIC	QUESTIONS
	<ul style="list-style-type: none"> <li>• If you used the WGSS or CFM, what would you do to make them better in the future? <ul style="list-style-type: none"> <li>○ Are there questions from the WGSS or CFM that you think could be omitted? Are there areas that weren't covered that you think should have been?</li> </ul> </li> <li>• If you used a different instrument, what would you do to make it better in the future? What worked well from using it?</li> <li>• What accommodation steps would you like to incorporate into future data collection rounds? <ul style="list-style-type: none"> <li>○ What benefits from these accommodations do you foresee?</li> <li>○ What challenges?</li> </ul> </li> <li>• Is there any standardization or guidance related to data collection and analysis that you would like to see? <i>Probe for:</i> tool preparation, training, administration, analysis.</li> </ul>
Concluding Questions	<ul style="list-style-type: none"> <li>• Of all the things we have discussed today, what would you say are the most important issues you would like to express about the WGSS, CFM, or other tools you used?</li> <li>• Is there anything else you would like to say about the WGSS and CFM or your use of these tools in your projects that we haven't talked about?</li> <li>• Moving into the future, what are your data needs and what help would you need to meet them?</li> </ul>

## 8.6 ANNEX D: FOCUS GROUP DISCUSSION REPORT

### METHODOLOGY

A virtual focus group discussion was conducted with nine individuals purposively selected because they lead the United States Agency for International Development-funded (USAID-funded) projects that have applied the Washington Group Short Set (WGSS), Child Functioning Module (CFM), or other tools for identifying learners with disabilities. The 90-minute discussion strived to explore experiences with these tools and recommendations for improving future data collection efforts. The discussion was audio-recorded and transcribed for analysis. All participants offered verbal consent to participate. Content analysis was performed, generating emerging insights along three key domains: adaptation protocols and training processes, data collection processes, and lessons learned and recommendations.

There are some limitations that should be noted. First, most respondents worked in the area of vision and hearing, because this is where more USAID resources are focused. This limited the discussion of how the WGSS, CFM, or other tools have been applied to identify learners with other disabilities. Second, for scheduling and logistics reasons, we only conducted one focus group discussion. Related, there was a range of experiences with and knowledge of the WGSS and CFM—some participants had limited experience, while others had deep knowledge of the tools' origins. More participants, however, had some peripheral knowledge and had applied these tools in one or more settings; therefore, they dominated the conversation.

### FINDINGS

#### HOW TOOLS WERE USED

Most respondents had used some adaptation of the WGSS questions, alongside other hearing and vision screening instruments, to identify individual learners in need of additional services. In some settings, the findings of these tools were also used to advocate for or otherwise leverage additional resources for the community and/or school. One respondent reported using the long version of the WGSS to measure prevalence, another described new tools that were being developed to screen learners across “disability domains and functioning areas” (P9). In most cases, teachers or others in the education sphere administered the tools. There were a few instances where caregivers were the respondents, including in a household survey that sought to determine type and percentage of disability. Another participant noted that when using the screening tools to identify intellectual and learning challenges, it can be hard to disentangle learning needs from other domains that might affect a learner's performance: “... you could say they have a disability, but really they're having a hard time concentrating because they haven't eaten in three days” (P8).

While there was an emphasis on using adapted WGSS, CFM, or other tools for screening of individual learners, there was also awareness that, for the CFM, this use was “inappropriate” and the CFM was “really effective in census and household” data gathering (P8). It was also mentioned that for teachers to effectively complete the WGSS, they would need to do so late in the academic year, after they had “developed some familiarity with the students to understand where they are. So, at the beginning of the school year, it'd probably be inappropriate for a teacher to administer a tool like that because they don't have that relationship yet or haven't had a chance to observe and understand how a learner is functioning within the school context.” (P9).

Despite some of these hurdles, however, one participant expressed that the act of having a teacher complete a screening tool like the CFM can improve the teacher’s awareness of disability within the classroom. The participants’ anecdotes indicated that through this process, teachers can start thinking about individual learner’s needs which “can have its own benefit” (P3).

Participants also raised the important issue of the need to select the right tool for the specific data collection purpose, as one participant clearly articulated:

*“[W]e really need to think about what’s the purpose ... The Washington Group questions were developed for a certain purpose ... And I think right now, there was a lot of this push to kind of retrofit it to other purposes where it does not seem to be quite appropriately suited for. But it really raises a difficulty, because there certainly are research questions or contexts where we don’t need fine-grained detailed assessment. But where we need to know—even an approximation would help to, for example, make a policy argument or similar. But in the case of the teacher, you’d likely want to have something that’s a little bit more refined such that they understand the strengths of the specific child” (P5).*

### **ADAPTATIONS, TRAINING, AND DATA QUALITY**

Adaptations were made to the WGSS and CFM to compensate for some of the challenges these tools present. For example, teachers using the long form of the CFM in a classroom is quite time-consuming; adaptations included preparing an abbreviated version. Another participant noted that a version of the CFM specifically designed for teachers to complete had been developed and that initial feedback indicated that teachers can use this modified version of the tool to assess learners at risk. Further, some questions were found to be “more difficult for a teacher to ... answer than some of the others,” such as questions around anxiety and depression (P3). One participant noted that in the three years since they implemented the WGSS, it has “become a little bit more into [sic] conversation now” however, at the time of their implementation, the respondent found that some questions, such as “do you have difficulty concentrating?” were not “practical” for learners themselves to answer. In that context, due to the purpose, age of learners, and the fact that learners were asked questions directly, the respondent revised the questions to be “more tangible, practical, every day,” particularly those around vision and hearing, which was the focus of the project. Interestingly, this participant also applied other hearing and screening methods and found little overlap between responses from learners on the hearing and vision-related WGSS questions and the results of these other screening methods (P5).

Training teachers to use these tools raised questions for participants about reliability, bias, and quality of the data. One participant observed that teachers would “compare [a child] to the best child, rather than the average,” leading to the conclusion that the learner being evaluated was having difficulty, but “they just weren’t the best in the class” (P3). Conceptualizations of what constitutes a disability may also vary across cultures, affecting accuracy. One respondent described their research on the CFM in which teachers using the tool “identified children that were obese in a couple countries as having a disability because they assume that they would have hard [sic] time walking. But learners who were blind and low-vision were not identified. So, I think by going through teachers it does allow for a high level of teacher bias versus a screening technique” (P8).

Other threats to data quality include language and timing of implementation. Translating the tools could also unintentionally introduce bias against those with disability, although it was noted that guidance on translation exists. Similarly, the timing of activities within the larger landscape of other community- or school-based events, such as vaccination campaigns, might also affect parental consent for screening. Key to mitigating these threats was first “to be aware that bias exists” and use the training as an opportunity

to “educate the enumerators around disabilities at some level.” It was also noted that it is important to use validated screening tools. A third suggestion for improving data collection was to shift away from text-heavy modalities of delivering information, including for informed consent, to more innovative practices that involve media to increase understanding.

## **FUTURE NEEDS**

Participants expressed the importance of having a range of tools that can aid in gathering data to feed into a country’s Education Management Information System and guide policy, while also having tools that could help teachers determine appropriate instructional strategies to meet the needs of the learners in their classrooms. Related to this is the importance of understanding when to use which tool and for what purpose. The WGSS was seen as widely accepted and validated for gathering information in the aggregate, but there was an expressed gap in a validated, standardized tool that would also be useful inside the classroom so “that we can have some kind of common language in what we’re talking about, rather than all doing different things” (P3). However, per one respondent, the application of multiple tools to meet diverse objectives might be outside a project’s budget and timeline.