Research and Studies

Using ScoPeO to measure quality of life:
Methodological approach and analysis of results in 13 HI projects

Innovation, Impact & Information Division
2023

RS ı 11, n°2

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A publication of Handicap International - Humanity & Inclusion

Innovation, Impact & Information Division (3i)

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This survey is the result of several years of research on measuring quality of life and a desire to better report on our outcomes at the level of projects financed by Luxembourg cooperation. The research carried out by HI and its academic partners on the measurement of quality of life has given rise to the ScoPeO tool, which is available in two versions, one for children (5 to 17 years old) and the other for adults (18 years old and over). Both versions are based on the same conceptual (quality of life is subjective, multidimensional and dynamic) and operational (the tool is generic, applicable regardless of gender, health status or disability) principles. ScoPeO serves the same purpose of monitoring a project: to measure the outcomes of HI interventions on the quality of life of beneficiaries.

General and specific objectives

Within the framework of the funding granted by the Luxembourg Ministry of Foreign Affairs between 2018 and 2022, 13 countries have committed to carrying out a survey to estimate the contribution of projects to improving the quality of life of populations. This report presents the overall approach to deploying the ScoPeO tool on a large scale, which made it possible to meet this commitment, the results of the data analysis and also the elements that emerged from the sharing of experiences at different times during the projects.

Methods

The choice of the approach to be adopted for the deployment of the ScoPeO tool was mainly guided by the desire to encourage the appropriation of the ScoPeO tool by the HI teams, as well as to carry out the necessary learning for future surveys of this type. Support from the head office made it possible to guide and support the teams in carrying out these surveys, to carry out transversal analyses based on all the data collected, and to centralise the various learning elements. This initiative demonstrated the relevance of the ScoPeO tools in highlighting the contribution of HI projects and partner organisations to improving the quality of life of the populations they work with.

Results from the data analysis

Several results could be highlighted. Firstly, the quality of life scores obtained at baseline, as well as the influence of gender, age and disability were studied. For adults, the overall quality of life score was 49 out of 100. This average total score conceals significant variations according to the dimensions. Indeed, the dimension of material well-being has a

low reference score (35 out of 100) while the dimension of social and family participation has a high reference score (62 out of 100). Moreover, the quality of life of adults appears to be significantly influenced by gender, age and disability. Being a woman induces a significant difference in the overall quality of life score. Women have a significantly lower score than men for social and family participation, subjective well-being and health. Being older also leads to a lower quality of life. It is when we look at the different dimensions of quality of life that significant differences appear between age categories: the score for the health dimension decreases significantly with age, as does the score for basic needs; in contrast, the score for social and family participation is significantly higher for all age categories than for the under 25s. **Disability is the most discriminating characteristic in terms of quality of life. Living with a disability makes a significant difference.** The overall quality of life score decreases significantly with the intensity of the disability. Between respondents without a disability and those with a disability, there are significant differences across all dimensions, but it is within the health dimension that the differences are most pronounced. The greater the intensity of the disability, the lower the health score. A similar trend can be seen in the dimensions of subjective well-being, basic needs and social and family participation.

As far as children are concerned, the overall score for children is particularly high compared to that of adults (66 compared to 49 out of 100). When we look at the scores per dimension, they are particularly high and homogeneous. **Unlike adults, it seems that gender and age do not significantly influence children's quality of life. On the other hand, as with adults, it is in relation to disability that the differences in scores are most significant.** Thus, compared to respondents without a disability, respondents with a disability have a significantly lower overall score, which decreases with the intensity of the disability.

The evolution of the scores between baseline and endline provides information on the outcomes of the HI programmes on the quality of life of the beneficiaries. **For both adults and children, an improvement in the quality of life during the project period is evident. Furthermore, it appears that, depending on the dimension considered, between 60% and 80% of adult respondents believe that the projects have improved their quality of life.** This question was not asked of the children. Thus, there was indeed a significant improvement in the perception of quality of life by the people benefiting from HI's interventions.

By analysing the evolution of the scores according to the profile of the respondents, we seek to verify the contribution to the increase or reduction of inequalities between the groups, in other words, to discuss the sensitivity of the projects to the three aspects of gender, age and disability. For adults, there is a similar improvement in the overall quality of life between men and women on the one hand, and people with and without disabilities on the other. **It seems, therefore, that within the framework of the activities implemented for AC5, HI programming for adults has been relatively gender and disability sensitive. The data analysed also seem to indicate age-sensitive programming:** while the under-

35s see their quality of life improve to a lesser extent compared to other age groups, it should be remembered that they also had higher quality of life scores at the time of the baseline. As far as children are concerned, while boys and children without disabilities saw their overall and dimensional quality of life improve during the project period, this was not the case for girls and children with disabilities. **These results should be of concern to us, in that they seem to show a lack of gender and disability sensitivity in programming for children's activities.** And while it is difficult to interpret the age-related results given the diversity of the interventions, we cannot rule out a possible lack of age sensitivity as well.

Learning elements

This survey was an opportunity to learn a lot. These learnings allow us to make a number of recommendations for future uses of the ScoPeO tools:

- Closer support should be offered to teams in analysing and writing reports following endline data collection.
- The quality of the survey also depends on adequate anticipation and budgeting. It is therefore important to be able to carry out comprehensive training and to give interviewers the means to spend the necessary time with each respondent.
- There is also a need to recruit specific interviewers, dedicated solely to collecting data from children, for countries deploying ScoPeO-Kids.
- For real learning opportunities, it is necessary to ensure that the information needed for processing and analysis is well integrated into the surveys. This could include, for example, knowing what activities each person has benefited from in order to carry out more in-depth analyses of the outcomes on quality of life according to the intervention modalities.
- Where longitudinal approaches are most relevant, it is important to ensure good data management, which requires an appropriate procedure for assigning identifiers: for example, it is possible to modify the procedure proposed with the ScoPeO tools, when the project has already assigned a unique number to each beneficiary or when this has already been done in baseline.
- When teams do not know the exact profile of respondents in advance, the tagging of complete non-responses (inability to respond or refusal to respond) remains an essential source of learning to understand more precisely the conditions of use of the ScoPeO tools.
- As with any survey, while the tool is important, it is the interviewers who are the pillars of the quality of the data collected. The composition of the teams (women, people with disabilities, people used to working with children) as well as the training offered, which should include a pre-test stage, are essential in this sense.

- In view of the analyses carried out, which show an influence of age, gender and disability on the perception of quality of life, it seems important to ensure that the sample structures are sufficiently similar between the Baseline and the Endline to reflect only the actual evolution of quality of life during the project period.
- When using the matrices dedicated to the analysis of ScoPeO-Kids and ScoPeO-Adults, it might be interesting to indicate the confidence intervals to ask whether the differences are significant between the scores.
- The reference values listed here are intended to facilitate the analysis of the data, starting from the Baseline, and it is therefore advisable to mobilise them by comparing them with the results of future surveys. These values could be consolidated and refined by establishing a database of all ScoPeO surveys by programme.

Foreword

Measuring the real effects of our actions on our beneficiaries is a central issue that our organisation has focused on for several years. Indeed, how can we ensure that the energy and resources deployed through our actions have a positive effect on those who need them? Beyond our duty of accountability to our partners, beneficiaries and donors, we are also driven by the desire to "do good". However, if understanding and improving the effects of our actions are at the heart of our strategy, trying to measure the effects of our multidisciplinary actions with a heterogeneous vulnerable population, in often fragile and complex contexts, and with limited means, is a real challenge.

The conceptualisation of quality of life and its measurability have been the subject of work within Humanity & Inclusion (HI) since 2013. ScoPeO-Adults and ScoPeO-Kids are the results of a process of reflection that combines a scientific approach with our operational approaches. They are tools for evaluating our activities, measuring the changes perceived by beneficiaries in their living conditions at two distinct points in the project cycle: before (or at the beginning) and after (or at the end).

The ScoPeO-Adults and ScoPeO-Kids tools are primarily intended for HI practitioners in the field. We now have at our disposal practical tools for measuring perceived quality of life, whose methodology has been tested on a large scale. They allow us to build "quality of life" benchmarks and offer us the possibility of conducting comparative analyses, both at the project and organisational levels, with a view to collective learning. The result of ambitious data collection work in 14 countries over nearly 5 years, this study has demonstrated the scientific robustness of the tool, but also the positive effects of HI interventions on the quality of life of the people with whom the teams work, although differentiated according to the gender, age and disability of the respondents. Many lessons have been learned from this experience, which will feed the future use of these tools and the reflections on our intervention methods. It is on this link between the activities carried out and the effects observed that we should now focus our analytical efforts. Finally, this study also made it possible to enrich the "ScoPeO suite" with two new tools to respond to the need for measurement among specific audiences of the organisation: ScoPeO Proxy and ScoPeO Family.

To achieve this large-scale deployment, it was necessary to involve all the people who were kind enough to respond to the ScoPeO survey. They are almost 4,500 people in 14 different countries. There was also a social commitment to go out and meet all these people: thanks to all the interviewers who were in the field. It took motivation and tenacity to get involved in the ScoPeO scientific adventure. Thank you to all the focal points in the countries targeted by this survey who had this flame in the long term, during the 5 years of this Framework Agreement. Finally, thanks to the rigorous work, analysis and support of the 3i teams at headquarters - Lise Archambaud, François Campagne, Aude Brus, Evans Engliz-Bey and Chloé Charpentier in particular.

Pierre Gallien, Director of Information, Impact & Innovation Division

Introduction

The conceptualisation of quality of life and its measurability have been the subject of work within Humanity & Inclusion (HI) since 2013. HI has developed a set of tools called ScoPeO (*Score of Perceived Outcomes*) to measure the evolution of quality of life as perceived by people. In order to learn about the methodology and the outcomes of its interventions, HI and its financial partner, the Ministry of Foreign and European Affairs (MAEE) of Luxembourg, have committed to observing one of the expected outcomes thanks to a large ScoPeO survey: a possible improvement in the quality of life of the beneficiaries of the projects financed by the Luxembourg cooperation (16 countries from 4 continents).

The objectives of this report are multiple. Firstly, to report on the approach taken to measure the outcomes of the interventions on the quality of life as perceived by the beneficiaries of the AC5 projects, and to outline the learning points that we can draw from this experience. Secondly, this large-scale survey has created a unique opportunity to gather data on the quality of life of people with and for whom HI teams work. Thus a global analysis to determine the influence of age, gender and disability on quality of life was carried out. This report aims to present the results of this analysis. Thirdly, the data produced also allowed us to further question the relevance and validity of the quality of life measurement tool promoted by HI, ScoPeO. The aim is therefore to report on the findings concerning the tool itself and the implications for the conditions of use.

To meet these objectives, the report is divided into four parts. In the first part, we present the context in which this measurement of multi-country outcomes is taking place and which influenced the decisions taken regarding the approach adopted. The second part presents the methodology - illustrated by concrete examples from the field - and the resources produced to accompany the survey. The third part, which forms the core of this document, presents the results of the analysis of the data from this major ScoPeO survey. In particular, it reveals the influence of gender, age and disability on the quality of life scores as measured by the tool. Finally, the many global learning points that could be drawn from this experience are listed in a fourth section. This last part lists the learnings on the process of deploying such a multi-country survey, but also the new knowledge that could be produced to complete what we knew about the ScoPeO tool itself.

Part 1 - Context

Improving the quality of life of vulnerable people can be seen as the ultimate goal of HI's Theory of Change, as formalised in 2015. HI has been conducting research on the measurement of quality of life for several years, through academic partnerships[1] . The first research (from 2013 to 2015) resulted in the creation of a tool to measure the quality of life of adults (18 years and older) - ScoPeO-Adults. The second (2016 to 2018) resulted in an equivalent tool to measure the quality of life of children aged 5 to 17 - ScoPeO-Kids. At the end of this work, it was natural to operationalise this research work, and to disseminate ScoPeO as a reference tool within HI to measure the outcomes of interventions in terms of changes in quality of life as perceived by the targeted individuals. This transfer of research results into a MEAL approach integrated into field operations - i.e. into a tool for monitoring projects - was made possible by the opportunity provided by the Framework Agreement 5 concluded between HI and the Ministry of Foreign and European Affairs (MAEE) of Luxembourg. This AC5 opportunity made it possible to deploy the ScoPeO tools in different countries, at the level of different types of intervention. As the outcomes measured were very diverse, it was agreed from the outset that this initiative was not intended to compare countries/projects with each other. However, it was envisaged that this opportunity would be used to carry out analyses to compare interventions involving one sector with interventions involving several sectors, in order to feed into the ongoing reflections on multi-sectoral approaches.

1. ScoPeO, a set of tools designed to measure the outcomes on quality of life

The "Impact and Quality of Life" project was launched at HI in December 2012, thanks to funding from the Luxembourg Ministry of Foreign Affairs within the framework of CA3. The internal reflections quickly oriented the research towards the design of a tool for measuring quality of life, both to adapt to the particularities of HI's intervention contexts and to meet the specific needs of the organisation in terms of project monitoring and measuring impact indicators. The creation of the ScoPeO-Adults tool[2] is based on several activities carried out internally: a literature review on the definitions and tools for measuring quality of life, well-being, social participation and living conditions; a summary analysis of experiences and, in particular, of the tools already developed by different teams; and consultation of a group of

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[1] For ScoPeO-Adults, the UMI 3189 ESS of the CNRS, which has research expertise on the quality of life in low and middle income countries for ScoPeO-Kids, the CRIR (Centre de recherche en réadaptation) of the University of Montreal, which has expertise in the participation and social inclusion of people with physical disabilities.

[2] For more information on ScoPeO-Adults: BRUS Aude, DUBOZ Priscilla, LEFEBVRE Céline, LEGOFF Stéphanie. **ScoPeO-Adults: Measuring the quality of life, safety and social and family participation of project beneficiaries.** Lyon: Handicap International, 2019 (third edition), 87 p.

14 partners in 7 intervention countries on the dimensions constituting quality of life. This served as a basis for the following stages, carried out via an academic partnership: interviews with HI teams (headquarters and field); testing of the different versions of the form in Senegal. On the basis of this experience, and knowing that children (5 to 17 years old) make up a large proportion of the people targeted by HI projects (34% between 5 and 17 years old in 2021), a new round of research was launched to enable the measurement of quality of life among children. ScoPeO-Kids is not, however, a simple adaptation of the original adult version, but is the result of independent research focusing on the specificities of younger audiences and appropriate administration. The design of ScoPeO-Kids[3] followed an 8-step process: literature search; workshop with HI professionals (representing various sectors and programmes); focus groups with children and their parents in 2 countries, Bangladesh and Thailand; production of a set of items and selection of response options; quantitative survey (testing of the first version of the questionnaire); checking the validity of the tool; cognitive debriefing with children; and revision of the tool to the version we are currently using. Thus, the dimensions, number of questions, response categories and administration procedures are not the same for ScoPeo-Adults and ScoPeO-Kids. However, HI has endeavoured to maintain consistency between the two tools, so that they can be used together in the same project.

The founding principles of the ScoPeO tools

Both tools are based on the same principles:
- Conceptual principles: quality of life is subjective, multidimensional and dynamic;
- Operational principles: the tool is generic, applicable regardless of the gender, health status or disability situation of the people studied in the survey; it serves the same purpose of monitoring a project (measuring the outcomes of HI interventions on the quality of life of the beneficiaries);
- Methodological principles: the same data collection (direct interview with beneficiaries) and analysis (score and partial scores) methods are recommended.

Thus, the ScoPeO tools are tools that focus on collecting people's perceptions of their quality of life. They are intended to be deployed through a quantitative baseline and endline survey, in order to capture the evolution in terms of quality of life perceived by the target populations between the beginning and the end of the intervention. The deployment of these tools is therefore based on the assumption that HI projects can contribute, at least in part, to these changes.

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[3] For more information on ScoPeO-Kids: BRUS Aude, HIGINS Johanne, POISSANT Lise. **ScoPeO-Kids: a tool to measure the quality of life of children aged 5 to 17 years.** Lyon: Handicap International, 2019, 82 p.

The dimensions that make up quality of life as defined by HI

Through ScoPeO, different dimensions that contribute to quality of life are assessed:

- **ScoPeO-Kids**: Physical well-being; Emotional well-being; Autonomy and achievement; Perceived safety; Social well-being.
- **ScoPeO-Adults**: Physical and mental health; Social and personal relationships; Subjective well-being; Coverage of basic needs; Material well-being; Perceived safety; Social and family participation.

In 2018, at the time of the AC5 baseline surveys, there had not yet been a large-scale deployment of the ScoPeO tools. As a result, some knowledge was still missing about potential difficulties in administering the questionnaire, but also about the sensitivity of the tool to the age, gender and disability of the respondents. In addition, some validation tests of the tools could not yet be carried out.

The structure of the ScoPeO tools

ScoPeO-Adults: The ScoPeO-Adults questionnaire used in Baseline is administered to future beneficiaries aged 18 years or older. The questions can be divided into 4 sections: information about the survey and the interviewer (11 questions), quality of life questions (27 questions), socio-demographic information about the respondent (7 questions), and the Washington Group questions[4] on identifying disability situations (6 questions). In addition, there is an open-ended question to collect any additional information that the respondent and/or interviewer may wish to provide. The ScoPeO-Adults questionnaire used in Endline differs slightly from the one used in Baseline: it contains 7 additional questions aimed at collecting the perception of the outcomes of the interventions on the various dimensions of quality of life.

ScoPeO-Kids: The ScoPeO-Kids questionnaire is administered to children, aged 5 to 17, who are going to or have received an intervention. This unique questionnaire is used both in Baseline and in Endline. It consists of 46 questions which, like the ScoPeO-Adults questionnaire, can be divided into 4 sections: survey and interviewer information (8 questions), socio-demographic information about the respondent (10 questions), Washington Group questions about disability (6 questions) and quality of life questions (22 questions). In addition, there is an open-ended question to collect any additional information that the respondent and/or interviewer may wish to provide.

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[4] The Washington Group is a task force of the United Nations Statistical Commission whose primary function is to promote and coordinate international cooperation in the production of disability statistics.

2. A diversity of countries, a diversity of interventions

The measurement of AC5 outcomes is part of the financing of 16 action programmes by the Ministry of Foreign and European Affairs (MAEE - Luxembourg).

Countries participating in the AC5

The 16 countries participating in the AC5 are:
- West Africa division: Niger, Mali, Senegal, Burkina Faso;
- CESAN division (North, East and Southern Africa): Ethiopia, South Sudan, Madagascar;
- Asia division: Nepal, Laos, Myanmar, Cambodia;
- Middle East division: Palestine;
- Magritte division: Haiti, Rwanda, Burundi, and the Democratic Republic of Congo.

Of these 16 countries, 12 conducted their Baseline surveys in 2019 and their Endline surveys between September 2021 and May 2022. One country (Myanmar) adopted a *case management* approach: data collection was therefore carried out throughout the project, at the beginning and at the end of the person's care - which explains why there are no fixed dates for the Baseline or Endline.

Finally, 3 countries encountered various difficulties and did not carry out all or part of this survey:
1. Burundi where, HI had to close its operations in January 2019;
2. Laos, which did not receive funding from the framework agreement and was unable to conduct baseline and therefore endline evaluations;
3. Mali, where the project targeted children with Down's syndrome and multiple disabilities with significant cognitive functional limitations. It soon became apparent that the direct survey method and the wording of certain questions were not adapted to the profile of these targets. The endline was therefore replaced by an exploratory study in 2022 in order to determine the interest and conditions for using a tool to measure quality of life at the family level rather than at the child level (see report).

In addition to the diversity of intervention contexts, and although all countries had the objective of improving the quality of life of the targeted people, it should be noted that the content of the interventions and the way in which they were implemented differed from one country to another. Thus, each country attempted to measure the outcomes of specific activities through its ScoPeO survey, which is summarised in Table 1 below.

Table 1 - What is the outcome of (by country)?

Country	Areas of intervention	What are we measuring the outcome of?
Burkina Faso	Health and Rehabilitation	Outcome of an equity fund
Mali	Rehabilitation and economic inclusion economic inclusion	Outcome of care for children with cerebral palsy, Down's syndrome and epilepsy and the outcome of socio-economic integration on parents of children with multiple disabilities
Niger	Education, Vocational and Socio-Economic Socio-economic	Outcome of personalised economic integration support
Senegal	Socio economic	Outcome of taking care of beneficiaries in their workplace
Ethiopia	Socio-economic and economic and rehabilitation	The outcome of socio-economic integration care on adults and parents of children with disability
Madagascar	Health and Rehabilitation	Outcome of early pregnancy management and post-natal follow-up
RDC	Education and Rehabilitation	Outcome of rehabilitation care for children with disabilities attending school
Rwanda	Health and Rehabilitation	Outcome of medical and psychosocial care of children with epilepsy
South Sudan	Socio economic	Outcome of accompanying IGA activities
Cambodia	Socio-economic integration and rehabilitation	Outcome of rehabilitation management; joint outcome of rehabilitation management and socio-economic integration
Myanmar	Socio-economic and economic integration and rehabilitation	Outcome of rehabilitation care and socio-economic integration
Nepal	Health and socio-economic socio-economic integration	Outcome of rehabilitation and health care

Haiti	Socio-economic integration	Outcome of accompanying IGA activities
Palestine	Education	Outcome of the Individual Education Plan

The interventions whose outcomes are sought to be measured via the ScoPeO survey show the diversity of sectors whose activities were implemented during AC5, but also the desire, in some cases, to support populations in a multisectoral manner, within the same country.

3. A desire to deepen the analysis of multi-sectoral approaches

The main sectors of intervention selected for the AC5 are health, especially maternal and child health (MCH), rehabilitation, inclusive education and socio-economic integration. This agreement differs from the previous ones (AC4, AC3) by a willingness to commit HI missions to initiate a **multisectoral approach (comprehensive approach to disability)**, thus opening up access to several interventions to beneficiaries, depending on the needs identified. In other words, the action programmes seek to promote people's access to medico-social services, while giving some beneficiaries access to complementary sectors as a lever for accessing the first services and/or to reinforce their outcomes. For example, programmes aiming at social or economic inclusion (access to education, access to employment) have been able to hypothesise problems related to mobility and autonomy among the targeted people, and have therefore proposed the implementation of complementary actions with the rehabilitation sector (Niger; Democratic Republic of Congo; Palestine; Nepal; Haiti; Laos). Other programmes (Cambodia, Mali, Ethiopia, South Sudan), put the vulnerability of parents/caregivers into perspective: parents were considered as beneficiaries (income generating activities) or as actors participating in the social inclusion of their children, and therefore users of social and rehabilitation services for example.
Like these examples, all AC5 programmes should thus, during the period 2018-2022, attempt to implement an integration of the various sectoral interventions, or at least a complementarity between them. It is in these conditions that **the desire to deepen the analysis of multisectoral approaches** emerged, **making the hypothesis of cumulative outcomes on quality of life**. Through this survey, it was therefore envisaged to verify the greater improvement in quality of life for beneficiaries who had access to several sectors, compared to those who had access to only one sector of intervention. Reflections on this topic are presented at the end of this report in Part 4 - Learning Points.

Part 2 - Methodology

The large-scale deployment of the ScoPeO tools brought out the need to frame the exercise and to support the teams in carrying out the survey. This logically led to the **production of specific guidelines** but also documents from the participating countries that could be used as a reference at different stages of the survey. It is essential to bear in mind that the use of the ScoPeO tools involves the same processes as any other quantitative survey: the same key steps should be followed and the same activities implemented (for more details, refer to the survey cycle). These steps and the associated recommendations must be followed to ensure the production of quality data. These are the steps that we follow below to present the approach adopted for this Baseline-Endline survey with the ScoPeO tools.

1. A global approach oriented towards the appropriation of ScoPeO tools by HI teams

The choice of the approach to be adopted for the deployment of the ScoPeO tool was mainly guided by the **desire to encourage the appropriation of the ScoPeO tool by HI teams.** Thus, the deployment of the survey by HI teams directly was favoured over the use of consultants.

In order to initiate a common dynamic for the 16 AC5 countries, **a seminar was organised from 5-9 November 2018 in Senegal**. Although the intention was to be able to bring together two people for each country involved so that they could act as relays for the implementation of the ScoPeO survey, this was only possible for 12 countries. For the others, only one person was available to participate in the seminar. The profiles of the participants were Project Managers, MEALs or technical coordination positions. The objectives of this seminar were threefold: 1) to explain the concept of quality of life and the construction of the ScoPeO tools; 2) to ensure that the basic principles of conducting a quantitative survey such as the ScoPeO survey were appropriated by the participants; 3) to set a work schedule and share experiences and materials to facilitate the deployment of the survey once each participant returns to his or her country.

Following this seminar, the participants (the ScoPeO focal points) had to write the **protocol of their ScoPeO survey**, taking into account the **specificities of their context and of the intervention implemented by HI in the framework of AC5**. To do this, they were **accompanied by a research officer at headquarters, dedicated specifically to this task for almost 10 months**[5] .

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[5] For more information on the seminar and the protocol design support, please refer to the report written after the Baseline data collections: Lysette Boucher-Castel. **Using ScoPeO for the evaluation of Humanité & Inclusion's AC5 programmes: Methodological approach and results of the data collection**. Lyon: Humanity & Inclusion, 2019.

2. Identifying the people to be surveyed: multiple considerations

Since one of the objectives of the ScoPeO survey is to measure the outcomes of HI interventions on beneficiaries, particular attention was paid to the issue of sampling. Several criteria were used to **determine the population for which the project could claim to contribute to the improvement of the quality of life**, in other words the target population of the survey.

2.1 Inclusion and exclusion criteria: a need for rigour and pragmatism in defining the target population

The definition of the target population for the survey was based firstly on those who were benefiting from activities in the so-called priority sectors, i.e. the sectors that are predominant in this AC5. These were rehabilitation, health, economic inclusion and inclusive education. Secondly, the notion of intervention was interrogated, in order to identify the modalities that would be likely to make a difference between the beginning and the end of the project. **In order to claim an outcome on quality of life, only beneficiaries of care (e.g. health, rehabilitation) or sustained support (e.g. economic inclusion) were considered**. As a result, activities such as awareness-raising, training, advocacy and disability detection were not included.

In the same spirit, exclusion criteria were established in order to allow for a certain homogeneity of approaches between the different countries and thus to preserve the relevance of an overall analysis, at the level of the entire AC5 action programme. Thus, **people who benefited from the intervention before 2019 were excluded from the target population of the survey.** In a number of countries, 2018 was indeed dedicated to the recruitment of teams and the training of partners, and the seminar dedicated to the training of teams on the ScoPeO tool could only be organised at the end of 2018. Similarly, it was decided not to deploy the survey among beneficiaries of previous framework agreements (e.g. CA4 which had just ended) in order to consider only people with a similar status from the project's point of view, namely future beneficiaries.

>< **The particular case of Palestine: an exclusion criterion created by the security situation**

> Part of the population initially targeted by the project in Palestine through socio-economic integration activities could not be considered as the survey population. Indeed, while the first data collection was supposed to take place in May 2019, the HI mission offices closed between April and May due to the security situation. When the offices reopened, the socio-economic sector activities were postponed to a later date, much later, and the beneficiaries of these activities could not be included in the data collection.

In total, for the 14 countries (excluding Burundi and Laos), while the beneficiaries of HI's activities through AC5 projects were initially estimated at 80,000 people over the project period, taking into account the inclusion and exclusion criteria mentioned above reduced the target population for the survey to 25,000 people.

2.2 A simple probability sampling approach

For the deployment of ScoPeO, **the question of sampling required questioning the methods of identifying beneficiaries, depending on the time needed to carry out this identification and the capacity of the projects**. Reasoned choices were also made regarding the location of these beneficiaries, in order to respect the minimum number of surveys to be carried out to allow the expected analyses to be carried out, while complying with the resources available to carry out this survey. A simple probability draw (95% confidence interval) was carried out, separating the child population from the adult population. Once the sample was drawn, a **proportional distribution was made according to age groups and gender by sector of activity.**

The resulting samples for administering the ScoPeO questionnaires had a total of about 3600 beneficiaries in baseline across all participating countries.

2.3 Respondents with varied profiles

Due to the diversity of the planned interventions (see Table 2 below), the profiles to be surveyed varied from one country to another. While this challenged the comparability of results between countries as we will see below (see 2.6), it also allowed the tools to be deployed to a variety of audiences and thus to test their relevance to the wide range of people with whom HI works.

Table 2 - **Profiles of respondents**

Country	Target population of the survey	Tools deployed
Burkina Faso	Children and young people in need of rehabilitative care	ScoPeO-Kids; ScoPeO-Adults
Mali	Children with epilepsy, Down's syndrome and multiple disabilities and their families	ScoPeO-Kids **(but has encountered difficulties - see Part 4 of this report**); ScoPeo-Adults
Niger	Children and young adults with disabilities	ScoPeO-Kids; ScoPeO-Adults

Senegal	Children and adults living with severe hearing loss	ScoPeO-Adults
Ethiopia	Economically vulnerable adults with disability and parents of children with disability	ScoPeO-Kids; ScoPeO-Adults
Madagascar	Young girls and young adults who are pregnant and/or need post-partum follow-up	ScoPeO-Kids; ScoPeO-Adults
RDC	Children with disability at school in need of rehabilitative care	ScoPeO-Kids
Rwanda	Children with epilepsy	ScoPeO-Kids; ScoPeO-Adults
South Sudan	Heads of economically vulnerable households	ScoPeO-Adults
Cambodia	Young people and adults with disabilities and their families (family carers)	ScoPeO-Adults
Myanmar	Young people and adults in need of rehabilitation care and access to employment	ScoPeO-Kids; ScoPeO-Adults
Nepal	Children and adults with disabilities and their families (family carers)	ScoPeO-Kids; ScoPeO-Adults
Palestine	Children with disabilities	ScoPeO-Kids
Haiti	Young people and adults in need of rehabilitative care	ScoPeO-Adults

It should be noted that the selection of the project targets, i.e. the way in which the project beneficiaries are identified (entry point), has had an impact on the choice of how to deploy the ScoPeO tools.

3. Customised deployment modalities by country

One of the key requirements for scaling up the measurement of the impact of projects on the quality of life of the target population is the use of reliable tools. The ScoPeO tools were used for this purpose - **countries were not left to choose their own tool, in order to allow for the compilation of data for the purpose of conducting a global analysis**. However, the diversity of country situations (in terms of intervention, population profile) meant that **choices had to be** made **on a case-by-case basis in terms of deployment**

modalities[6] . This was made possible thanks to the support of a researcher throughout the process of developing the approach for implementing the baseline survey, and a mission to three countries by a MEAL specialist also dedicated to this evaluation.

3.1 The ScoPeO tools, tools with proven reliability and adapted to project monitoring

The ScoPeO tools (ScoPeO-Adults and ScoPeO-Kids) aim to measure a person's perception of their quality of life, and thus to monitor changes between two distinct periods (at the beginning of an intervention or care and at the end of it). **A necessary condition for ensuring the relevance of such measures is the availability of valid and reliable tools.** The identification and selection of the quality of life dimensions present in the ScoPeO tools were guided by the debates and reflections underway at the time of the tool's development, both in the academic sphere and within HI and other international solidarity actors. The development of these tools is also based on contributions from the people with whom HI works in different countries. All of this process, carried out with academic partners (see 1.1), ensures the validity of the tools.

❯•❮ Further analysis of the reliability of ScoPeO-Adults

While the reliability of the ScoPeO-Kids tool had been tested in its development, **the analysis of the data collected through this AC5 initiative has allowed the reliability of the ScoPeO-Adult tool to be further questioned**. Indeed, Cronbach's alpha coefficients[7] were calculated for quality of life as a whole and for each of the dimensions. These coefficients can theoretically vary from 0 to 1. The closer the value of the coefficient is to 1, the greater the consistency of the measure and therefore the reliability of the tool[8] . However, according to the analyses carried out, the quality of life measure as a whole has a coefficient of between 0.86 when the data from the Baseline are analysed and 0.96 when the data from the Endline are analysed - **i.e. a coefficient greater than 0.7, which is commonly accepted as the minimum threshold of acceptability for the reliability of an instrument's measurement**. We also find results above 0.7 for each dimension, with the exception of the health dimension (a coefficient of 0.64 is obtained from the Baseline data and 0.69 from the Endline data). This lower consistency is explained by the fact that this dimension contains a question on mental health, which is less correlated

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[6] By deployment modalities we refer to the choice of survey timing in relation to the beneficiaries' care pathway (e.g. all surveys at one point in time or as beneficiaries are identified), the type of follow-up of respondents (cross-sectional or longitudinal) and the sampling method (simple random or stratified).

[7] Cronbach's alpha is a statistic used in psychometrics to measure the internal consistency (or reliability) of questions asked in a test.

[8] However, a coefficient too close to 1 should alert us to the redundancy of certain questions.

with the other two questions of the dimension, which concern the evaluation of general health and physical pain. This dimension therefore seems to include two slightly different concepts. However, as the homogeneity of the dimensions is not the only reliability criterion to be taken into account for a given tool, it was considered important to keep both the physical and mental health questions, as both are directly linked to a more global definition of health[9] , which is a component of a good quality of life.

An important element that emerges from the analyses of the data from this deployment, and which confirms the potential of the ScoPeO tools as an impact measurement tool (i.e. suitable for project monitoring), is **the completion time**. The latter is measured automatically[10] during the administration of the questionnaires via SurveyCTO. For **ScoPeO-Adults**, the median completion time[11] in Baseline is about 25 minutes, which means that 50% of respondents completed the questionnaire in less than 25 minutes. Even more, about **92% completed it in less than 40 minutes**. It is also interesting to explore the completion time according to the characteristics of the respondent. If the completion time is too long for one or more categories of respondents, this would mean that the tool is not well adapted to this population. The analyses show that there are no significant differences in median time by age, gender or disability (the differences do not exceed 4 minutes). For **ScoPeO-Kids, the** median completion time was approximately 17 minutes. About **86% of respondents completed the questionnaire in less than 30 minutes**. The completion time for ScoPeO-Kids is therefore more contained than for ScoPeO-Adults. This could be explained, among other things, by a slightly shorter questionnaire and by the same response modalities for the quality of life questions, thus facilitating their administration. As for adults, there was no significant difference in median completion time by age, gender or disability (differences did not exceed 4 minutes). **Both tools, ScoPeO-Adults and ScoPeO-Kids, therefore appear to be suitable for all respondents**.

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[9] https://www.who.int/fr/about/governance/constitution

[10] Given that there may be a delay between the end of the questionnaire and its computer validation by the interviewer in the mobile data collection tool. To limit this overestimation, completion times greater than or equal to 100 minutes were considered invalid data (note that this is a very rare case, since only 7 respondents had completion times greater than or equal to 100 minutes for ScoPeO-Adults and 2 respondents for ScoPeO-Kids).

[11] We are interested in median values rather than averages, as the latter are more sensitive to extreme values.

>•< The importance of following up on complete non-responses

Although we have just seen that people who respond to the ScoPeO-Adults and ScoPeO-Kids questionnaires do so quickly and without any particular difficulty, this observation should be qualified, since a certain number of beneficiaries with particularly disabling disabilities were unable to participate in the questionnaire. For example, in Mali, data collection from children with Down's syndrome and children with multiple disabilities was stopped due to a high rate of non-response to the questionnaire. Some children did not seem to understand or be able to express their answers. Thus, further thought must be given to defining even more precisely the profiles of people who cannot respond (or not directly) to a quantitative survey of the ScoPeO type. Some elements of response and possible solutions are presented in Part 4.

3.2 The type of monitoring: countries that are mostly oriented towards a cross-sectoral approach

The ScoPeO tools were developed so that they could be deployed longitudinally (people interviewed in the Baseline are re-interviewed in the Endline) but also transversally (a representative sample of the target population is taken in the Baseline, then in the Endline, independently). The way in which the project is implemented, as well as the profile of the populations, often determine the choice of one approach over the other. In the case of this AC5 initiative, the majority of countries opted for a cross-sectional approach, as shown in Table 3 below, as they did not feel able to guarantee the monitoring of beneficiaries throughout the duration of the project.

Table 3 - Types of approach by country

Cross-sectional approach (before/after the intervention)		Haiti; Ethiopia; Madagascar; DRC; Rwanda; Niger; Senegal; Cambodia; Mali
Longitudinal approach	Simple	Nepal; Palestine; South Sudan
	In cohorts	Burkina Faso
	Individual follow-up	Myanmar (survey integrated in a *case management* approach)

A total of four countries have therefore deployed the ScopeO tools by adopting a longitudinal approach[12] . While longitudinal approaches make it possible to limit the risk of bias when comparing baseline and endline results, they are still restrictive in terms of population monitoring and data management. Thus, **of these five countries, it was only possible to match the responses of respondents in baseline and endline for one country**, Myanmar. **For the others, the management of respondents' identifiers made it impossible to match them**. As a result, all the data, with the exception of Myanmar, were treated as being from a cross-sectional approach at the time of the analyses.

3.3 Additional deployment support for some countries

Once the survey protocol was developed with the support of the dedicated researcher, it became apparent that some countries had unstable data collection environments, relatively larger sample sizes than others, or human resource shortages to carry out the first data collection. Steps have been taken to further strengthen support to countries with these problems. For example, Ethiopia, Nepal and Southern Sudan received direct support from a MEAL specialist who came to the country to help train the interviewers and start the data collection in the field.

3.4 Pre-testing, an essential practice to ensure data quality

In order to carry out this type of data collection, a pre-test is essential. It consists of reinforcing the theoretical training of the interviewers by enabling them to put into practice all the instructions and advice given and to administer the questionnaire to beneficiaries in situ. **This stage is all the more important when there are issues of translation of the questionnaire, when we suspect that certain questions are not adapted to the categories of people we wish to interview, when we sense reluctance to answer or when we suspect that certain targeted people will not be able to understand or express their response.** Thus, the methods chosen and the proposed adaptations in terms of administering the questionnaire[13] can be tested in real conditions before the start of the

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[12] We distinguish here between three types of longitudinal follow-up. Simple longitudinal follow-up, which consists of randomly selecting people to be surveyed at the baseline at the beginning of the project, and surveying them again at the endline at the end of the project. Longitudinal cohort follow-up, where all (or a sample of) identified individuals are interviewed at the beginning and end of a given period (for example, at the beginning and end of a school year, so there will be as many cohorts as there are school years covered by the project). Individual follow-up consists of administering the baseline questionnaire when the person "enters" the project, and the endline questionnaire when he or she "leaves" it. Thus, data are collected on a case-by-case basis, generally in an exhaustive manner (all persons benefiting from the project).

[13] The ScoPeO tools have been tested and validated as they stand, and it is not possible to change the questions that address quality of life, nor their order (at the risk of calling into question their reliability). The modalities and adaptations we are talking about here concern elements related to the presentation of the interviewer and the objective of the survey, or for example the use of a sign language interpreter, or the choice of specific locations for the administration of the survey (is it a problem to interview children in a reception area and not in their homes or not?)

survey, and the final adjustments can be made without affecting the quality of the data that will be analysed later. In order to highlight the difficulties that ScoPeO interviewers might encounter, a guide was prepared to frame the interviewer's posture towards respondents on the one hand, and to consider what might cause a respondent to be unable to answer the questions on the other.

This large AC5 survey, as we shall see below, thanks to the support provided, generally respected the pre-test rules, which made it possible to guarantee the quality of the data. This is confirmed by the analysis of partial non-response to the questionnaire. Partial non-response can be defined as the absence of a response to a given question, whereas complete non-response is the absence of a response to the entire questionnaire. **Partial non-response generally reflects questions that are less well understood or too sensitive. However, the rate of partial non-response is particularly low for both ScoPeO-Adults and ScoPeO-Kids, in both the Baseline and Endline**. For ScoPeO-Adults, the partial non-response rate is 0.9% for each question, which means that out of 100 respondents, less than 1 person did not answer the question.

For ScoPeO-Kids, the average partial non-response rate was 0.6%. In the end, **these particularly low non-response rates show that the respondents adhere well to the questionnaires and that there are no noticeable difficulties in completing them.**

>•< More difficult to pass the question on the overall quality of life of ScoPeO-Kids in Burkina Faso

While on average all two questionnaires, ScoPeO-Adults and ScoPeO-Kids, were relatively easy to administer, one question was identified as being a little more complex for the survey conducted in Burkina Faso. This is the question on overall quality of life, which appears at the end of the ScoPeO-Kids questionnaire. Indeed, the non-response rate for this question was 9.2% in the Endline. In other words, out of 100 children, slightly less than ten were unable to answer this question. This question was not taken into account for Burkina Faso in the analyses presented in the rest of this report.

It is also true that the last two questions of ScoPeO-Kids, on happiness and on overall quality of life (administration of one or the other according to the age of the child) were reported as more complex by the investigators of different teams during the pre-tests, but overall solutions in terms of translation or explanations given to the child could be found in the vast majority of cases.

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4. A global analysis of the data

This large-scale ScoPeO survey opened up important learning opportunities, which had to be seized. Thus, to carry out **the processing and analysis of all the data** made available by the countries participating in AC5, **a dedicated specialist was recruited for a period of 2.5 months** at headquarters during the summer of 2022.

The processing of the databases made it possible to identify invalid values (extreme values, inconsistent values). The decision was also taken not to take certain socio-demographic information into account during the analysis, due to a too high number of non-responses, or due to responses that were too disparate from one country to another, suggesting a different understanding of the question. This was the case, for example, for the question on the number of people in the household and the question on travel status, which are found in both the ScoPeO-Adults and ScoPeO-Kids questionnaires.

❯•❮ Data processing on disability

As mentioned earlier, the collection of data on disability was carried out via the administration of the Washington Group questions, in its short form, which consists of 6 questions. Each of these 6 questions deals with the ability to carry out a specific 'activity': seeing, hearing, walking and climbing stairs, remembering and concentrating, caring for oneself (washing, dressing), communicating and being understood by others. There are 4 options for answering: "No, no difficulties", "Yes, some difficulties", "Yes, many difficulties" or "I can't manage at all".

The choice of a threshold for qualifying disability situations - There are several approaches to identifying disability situations. We have chosen a narrow approach, i.e. people who answer that they have "a lot of difficulty" or that they "cannot manage at all" to perform at least one activity are considered to be in a situation of disability.

A specific treatment of non-responses to disability data - Non-response to these questions was subject to a specific treatment. Thus, even if not all the disability-related questions were completed, when the answer to at least one activity is "Yes, many difficulties" or "I can't manage at all", the respondent is considered to be in a disability situation. On the other hand, when not all questions were completed and none of the questions were answered with "Yes, many difficulties" or "I can't manage at all", the information on disability is considered missing. We cannot assume what the answers to the uncompleted questions would have been and therefore that the respondent is indeed not living with a disability. For the same reasons, when we look at disability in terms of the number of activities in which the person has difficulties, we will only take into account those persons who answered all the questions related to disability. It should be noted that, given the low rate of non-response to these questions, the number of exploitable data varies only slightly in this case.

The analysis was based on total and dimensional quality of life scores. For ScoPeO-Adults, the response modalities differ according to the question. Each response modality is associated with a score ranging from 1 to 5 for questions relating to health, social relations, basic needs, perceived security and social and family participation; with a score of 1 to 7 for questions relating to subjective well-being and with a score of 1 to 4 for questions relating to material well-being. These scores were all scaled from 0 (worst score) to 100 (best score). The score of a dimension is obtained by averaging the scores of the questions within it. This average is calculated only if at least 2 questions are filled in for dimensions with 2 or 3 questions and if at least 3 questions are filled in for dimensions with 4 or 5 questions. The overall quality of life score is the average of the dimension scores and is only calculated if all dimensions are completed. For ScoPeO-Kids, all 20 questions have the same four response options, ranging from "Never" to "Always". Each response mode is assigned a score from 0 to 4. The calculation of the overall score then follows the same methodology as for adults. In addition, ScoPeO-Kids includes two specific questions on the respondents' overall quality of life. One is intended for children under 8 years of age, where the child is asked to rate his or her level of happiness from 0 to 5. The other is for children aged 8 or older, where the child is asked to rate his or her quality of life from 0 to 10. These questions have also been scaled to 100.

The analysis of the data was carried out in three stages. Firstly, **descriptive statistics** were carried out on the entire survey population. The focus was on the proportion of respondents by gender, age and disability, globally and by country, in order to **check the comparability of the baseline and endline data** on these criteria.

Secondly, **the influence of gender, age and disability** was explored, using the baseline data. At this stage, it was necessary to analyse the data in such a way as to attribute the differences in scores to one and only one characteristic of the respondents (gender, or age, or disability). For example, if the raw data for the different age groups are compared, is the difference in score that is then highlighted due solely to age (which is what we are trying to show) or to a higher proportion of respondents with a disability as age increases? **In order to eliminate these potential structural outcomes, which may bias the interpretation of the results, multiple linear regression models were used**. These models allow the results to be presented 'all things being equal', and therefore only highlight the influence of one characteristic at a time (the 'net' outcome of that characteristic) on the quality of life scores. This approach allows us to study the significance of these outcomes, i.e. whether the difference between two scores, for example the score for women and the score for men, is large enough to be interpreted.

Thirdly, the analysis focused on **the evolution of scores between Baseline and Endline, in a global way**, in order to verify whether the quality of life of the people targeted through AC5 had improved, in accordance with the objective set by HI.

🔍 Schooling, a criterion that is most likely essential to children's quality of life but not retained for this analysis

It should be noted that for children - i.e. for data collected via ScoPeO-Kids - the choice was made not to include information on schooling ("does the child go to school?") in the model. Indeed, this information evolves between the Baseline and the Endline due to the activities proposed by HI. Thus, at the beginning of the project, the children interviewed might not be attending school, but they would be enrolled at the end of the project. Comparing the Baseline and Endline quality of life scores by separating children who were in school from those who were not, was to run the risk of minimising the outcome of the programmes on the children's quality of life.

This analysis of the Baseline and Endline scores was then broken down by gender, age and disability. The aim was to check whether, for example, the quality of life of older people improved as much as that of young adults between the beginning and end of the project. In other words, the aim was to **initiate an analysis of the sensitivity of the projects to gender, age and disability through the differentiated outcomes produced**.

📋 The objectives set by HI's Disability-Generation-Age policy

This analysis by respondent profile is based on HI's Disability-Gender-Age (DGA) policy. This policy defines the different levels of commitment of the organisation with regard to disability, gender and age, as well as the changes to be made in the way the organisation works. In particular, it states that, in order to ensure that no one is left behind, all humanitarian and development work
and development work must take into account the extent of discrimination
It stipulates in particular that, in order to leave no one behind, any humanitarian or development action must take into consideration the extent of discrimination linked to disability, gender and age, and actively take corrective measures to ensure equality of opportunity. In general, **HI, through this policy, has set the objective of being sensitive to disability, gender, and age** in all its areas of activity. In other words, HI must ensure that its programming allows anyone discriminated against on the basis of disability, gender or age to benefit from the organisation's actions on an equal basis with others. Or to put it another way, **HI aims to have at least the same impact on all beneficiaries regardless of their gender, age or disability**.

Once again, the significance of the differences was checked, in order to be able to decide whether or not there was an improvement in the scores between Baseline and Endline. These three stages of analysis are presented in Part 3.

5. Taking into account ethical aspects, inspiring practices of the teams

The ethical aspects to be considered are not specific to the use of the ScoPeO tool and should be applied to each survey. The 8 ethical recommendations that need to be followed when conducting a survey are listed in the dedicated guidance note: "Studies and research at HI: Towards ethical data management". We specify here how these different aspects have been taken into account in the framework of these data collections and to share some of the practices developed by the different teams involved. We also highlight the points of attention that should be kept in mind in the future.

Recommendation 1: Ensure the safety of participants, partners and teams

- For the teams using ScoPeO-Kids, consideration was given to identifying the safest places to administer the questionnaires, where the children and young people could feel most comfortable, sometimes leaving it up to the young people to choose the place of discussion. Generally, the choice was made to carry out the surveys at home. However, one team carrying out Inclusive Education activities encountered difficulties, because while HI teams were regularly in contact with schools and teachers, this was less the case with parents, and the interviewers found themselves faced with rather reluctant parents. It was therefore necessary to communicate with them beforehand and then to re-launch the survey afterwards.
- As already mentioned, the COVID-19 pandemic and its consequences forced a change in working methods. Thus, in order to guarantee the deployment of ScoPeO surveys while ensuring the safety of participants by respecting the rules of social distancing, some teams administered the tool by telephone[14] .

Recommendation 2: Ensure a person/community-centred approach

- Particular efforts were made to ensure that the survey respected everyone's needs. For example, the pre-test helped to refine and validate the translations. For some languages and dialects, the audio recording of the translated version of the questionnaire was an asset for the interviewers.
- The recruitment of interviewers with specific skills, dedicated solely to collecting data from children (i.e. administering ScoPeO-Kids), had the outcome of making the survey easier to conduct. Interviewers who were generally used to collecting data from adults found working with children very difficult.

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[14] For information on how to adapt and carry out a telephone survey,please refer to the COVID guidance: Conducting a quantitative or qualitative telephone survey.

- A very interesting initiative for taking into account the specific needs of the people HI works with was the implementation of the ScoPeO survey via tripartite videos between the interviewer, a hearing impaired beneficiary and a sign language translator (or a facilitator using visual aids). This was set up via Whatsapp, and enabled the collection of perceptions of their quality of life, when it was not possible to meet them.
- The analysis of refusal rates (i.e. complete non-responses) could not be carried out following the AC5 survey. Indeed, no record was kept of people refusing to answer the questions completely. In practice, the questionnaires were then cancelled and invalidated by the survey team and therefore not included in the database. However, this information should be kept and analysed separately for future surveys, in order to understand the profiles of people who are unwilling or unable to respond to ScoPeO.

Recommendation 3: Obtain free and informed consent from participants

- Particular attention was paid to the issue of informed consent. Thus, all teams followed the procedures related to the collection of consent before asking the selected beneficiaries questions. Two forms were available. One was for adults (18 and above) and the other for children. For adults, a signature was required. For children, the parents or caregivers were the signatories. However, it was also important to obtain the assent of minors interviewed via ScopeO-Kids, which had to be collected using a more appropriate procedure. A two-stage procedure (double consent) was therefore proposed[15].

Recommendation 4: Provide referral mechanisms

- When conducting the ScoPeO survey, as with any survey, it is possible to encounter beneficiaries whose situation requires specific care / referral. Thus, having a map of services available to be able to react to such cases is essential.

Recommendation 5: Ensure the security of personal and sensitive data throughout the activity

- Although the questions addressed in ScoPeO are not sensitive, as with any data collection, it is important to ensure that these are protected. In the case of the AC5 survey, it was therefore decided to separate the consent form, which is nominative, on paper, and the questionnaire, on a tablet, which is identified only by a number and is therefore directly anonymous. The fact of having obtained the person's consent or not was reported in the SurveyCTO form.

Recommendation 6: Plan and ensure the use and sharing of information

- The sharing of information related to the survey took two forms. Firstly, feedback surveys following the Baseline, to understand and try to find solutions to potential

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[15] Consent forms are available for both adults and children.

difficulties, as well as the holding of an experience-sharing workshop at the end of the project period, to take stock with all the countries involved of their perceptions of this data collection exercise on quality of life. Secondly, cross-sectional analyses were carried out on the basis of all the data collected, the results of which were disseminated to the teams first of all, but also more widely afterwards (Hinside article, Talk, webinars).

- These data have therefore all been formalised in this report, and will be used in the planning of the ScoPeO survey planned under CA6. Dissemination of the key messages and learnings in other formats is also planned.

- However, future deployments of the ScoPeO tools should also allow for country-specific learning, through the design of protocols linked to a learning issue directly related to each project.

Recommendation 7: Ensure the expertise of the teams involved and the scientific validity of the activity

- First of all, the support of the major ScoPeO survey by the head office was done by people with the profiles of research officers (proven experience in research), with a great mastery of methodologies and data collection approaches.

- To ensure the expertise of the teams, the seminar held in Senegal before the launch of the Baseline made it possible to train two people designated as focal points for almost all the countries on the tool, on the methods for carrying out quality training for the interviewers, and on the rules of an ethical approach.

- An educational sheet was created to train field investigators to adopt an ethical posture when interviewing people who agreed to answer the ScoPeO questionnaire.

Recommendation 8: Obtain approval from the relevant authorities and provide for an external review of the proposal

- All of the protocols were reviewed and validated by the researcher responsible for supporting the Baseline surveys at headquarters. There was therefore a first external validation stage (external to the project team).

- In two countries, Burkina Faso and Rwanda, approval was sought from an ethics committee under the Ministry of Health.

Going before the ethics committee, a process to be anticipated

Where an ethical committee is required by the law of the land, this step should be respected. On the other hand, it is important to be aware of the laws of the country when designing the project. On the one hand, because this requires considerable anticipation before the baseline is launched (the ethics committees sometimes meet on fixed dates, so the procedure can take several weeks or even months depending on the case). On the other hand, because this approach can lead to additional costs that must be integrated into the budget.

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6. An investigation limited by the global context and local realities

Despite the care taken in deploying the ScoPeO surveys in each country, some limitations were encountered. These mainly concern the scope of the analyses.

6.1 Survey results influenced by cyclical events

Based on the same principle as all the impact measurements carried out at HI, this survey aims to analyse the evolution of the quality of life as reported by the beneficiaries over the project period. The changes produced and detected cannot therefore be strictly attributed to the intervention of HI and its partners, but may be influenced by external events as well as by the decisions of other stakeholders in particular.

Contribution of the project to change versus attribution of changes to the project

The way data is collected from beneficiaries at the beginning and at the end of the project does not allow to fully attribute the evolution (or not) of quality of life to HI activities: in the absence of other information (in-depth contextual analysis), or of a specific deployment methodology (such as an impact evaluation involving a control group that did not receive the intervention), HI activities are considered as one of the factors among others influencing quality of life. While there is a series of questions in the ScoPeO-Adults questionnaire that collects respondents' perception of the direct influence of the project on the different dimensions of quality of life, and which can be very useful when the context has changed significantly between the Baseline and the Endine, there is no similar question in ScoPeO-Kids.

The impact of the Covid pandemic from 2020 onwards has been relatively significant and very varied depending on the different contexts of intervention. For the populations, the consequences were an inability to carry out economic activities (due to confinement), sometimes very substantial inflation, and greater difficulty in accessing public services, particularly health services. Some interventions had to be interrupted for varying periods of time by decision of HI, due to exceptional circumstances (such as the closure of schools or the requisitioning of health workers needed for rehabilitation) or due to a change in priorities for beneficiaries or their households. In addition, **other crises have arisen during the years 2020 and 2021[16] complicating the working conditions and even humanitarian access on our programmes**. As a result, over the 2018-2022 period, which is the period of AC5, many beneficiaries have been confronted with events that can negatively affect their quality of life, regardless of HI's actions. Potentially, the results of the ScoPeO survey minimise the outcomes of the activities carried out by our teams.

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[16] https://www.acaps.org/countries

6.2 An overall analysis that masks local disparities

The choice of a global analysis of the data was based on the need to learn about the tool itself (reliability, response rate, sensitivity to a certain number of elements linked to the profile of the respondents, ability to report on changes) on the one hand, and on the need to propose an analysis at the level of the whole AC5 in order to be able to fill in the outcome indicator which had been agreed with the Luxembourg MFA on the other hand. In addition, it was decided not to conduct comparative analyses between countries, mainly due to the differences in terms of activities and population targeted by the projects, which significantly influenced the way the ScoPeO tools were deployed in each intervention zone. As a result, some of the information was not processed, and the particular influences of local realities, which are fundamental to understanding and improving HI practices at project level, were left out. To compensate for this, it was strongly recommended that each team analyse its own data at its own level, in order to allow a detailed analysis of the results, in line with the specificities of the intervention context, and a relevant interpretation based on the knowledge of the people with whom HI works. The learning elements reported through these ScoPeO reports written by the country teams have been integrated in the rest of this document, in Part 4.

6.3 Quality of life measures that follow different time frames

Measuring the outcomes of interventions on quality of life using the ScoPeO tools requires a Baseline survey and then an Endline survey. These two surveys therefore delimit what is considered to be the period of care. Thus, the earlier the person is in the intervention process, the more it will be possible to capture a perception of his or her quality of life that has not yet been influenced by the project activities. Most of the action programmes involved in AC5 had also received CA4 funding for the period 2014-2018, and of these, some were in the loop of previous framework agreements (CA3: 2010-2014). This was important to take into account in order to limit the risk that the results might understate the actual change in quality of life to which the project may have contributed. Similarly, it is advisable to reduce the time interval between when a person "exits" the project and when they complete the ScoPeO Endline questionnaire. In practice, for this major survey, and in view of the support issues that required collective working time, **this time frame differed from one country to another**. While some people were interviewed at the time of their last contact with an HI team (for example, after their last rehabilitation session), others were interviewed at the end of the project, potentially several months later. In the following analyses, these differences have not been taken into account.

A potential learning area: temporality of emergence and sustainability of outcomes on quality of life

At present, we have no information on how quality of life evolves in the longer term, once the project has ended. Therefore, based on our knowledge, it is advisable to reduce the time interval between the moment when a person "exits" the project and the moment when he/she answers the ScoPeO Endline **questionnaire in** order to better capture the changes that could have been produced thanks to the project and to limit the outcomes of important external events (one can consider that the likelihood of such events increases as the period of time extends). However, it may be of great interest to interrogate how the changes to which HI and its partners' projects contribute emerge over a slightly longer period of time, and their sustainability. To do this, it would be necessary to be able to deploy ScoPeO at the beginning of the intervention, at the end of the care (at the end of the intervention) and then several months later (according to a time frame to be defined according to the type of activities implemented). It would thus be possible to account for outcomes that only emerge later, if any, but also for dimensions of quality of life that might deteriorate at the end of the project.

Part 3 - Results of the ScoPeO data collections

The results of the ScoPeO data collections are presented in three stages of analysis. Firstly, the structure of the data in terms of the respondents' profile is analysed, and compared between baseline and endline, according to gender, age and disability. Secondly, the quality of life scores were compared according to the profile of the respondents, to identify the influence of these 3 factors. Finally, to check whether the project's objectives have been achieved, the evolution of the quality of life scores was analysed between the Baseline and the Endline. The third part of the presentation of the results therefore focuses on demonstrating whether or not the quality of life of the beneficiaries of the AC5 projects has improved, in general, and then according to their profile.

1. Profile of respondents: moderate variation between baseline and endline

As mentioned, two versions of ScoPeO were deployed: ScoPeO-Adults and ScoPeO-Kids. As the tools follow the same principles but are different in terms of questions, two separate databases were built. Here we discuss the number and profile of respondents for each of the two tools.

1.1 Number of respondents

The number of respondents varies by country (Figure 1). These differences by country are mainly explained by the varying number of beneficiaries and therefore by sample sizes adapted to the target population. A total of 2,253 adults responded to the ScoPeO-Adults questionnaire in Baseline and 2,317 in Endline. Some countries have more surveys in Baseline than in Endline. This is generally due to difficulties in finding the beneficiaries to be surveyed in the Endline (Burkina Faso, Myanmar) or a context that makes it difficult to conduct the survey (Haiti). For Mali, we only have Baseline data, as the difficulties in deploying the tool led to a change of approach for the Endline. Conversely, some countries have more respondents in the Endline than in the Baseline, mainly because the sampling frames considered were not the same: the number of beneficiaries in the Baseline was much lower than the number of beneficiaries accumulated over the duration of the project in the Endline (Nepal, Madagascar).

Figure 1 - Number of ScoPeO-Adults respondents per country (Baseline and Endline)
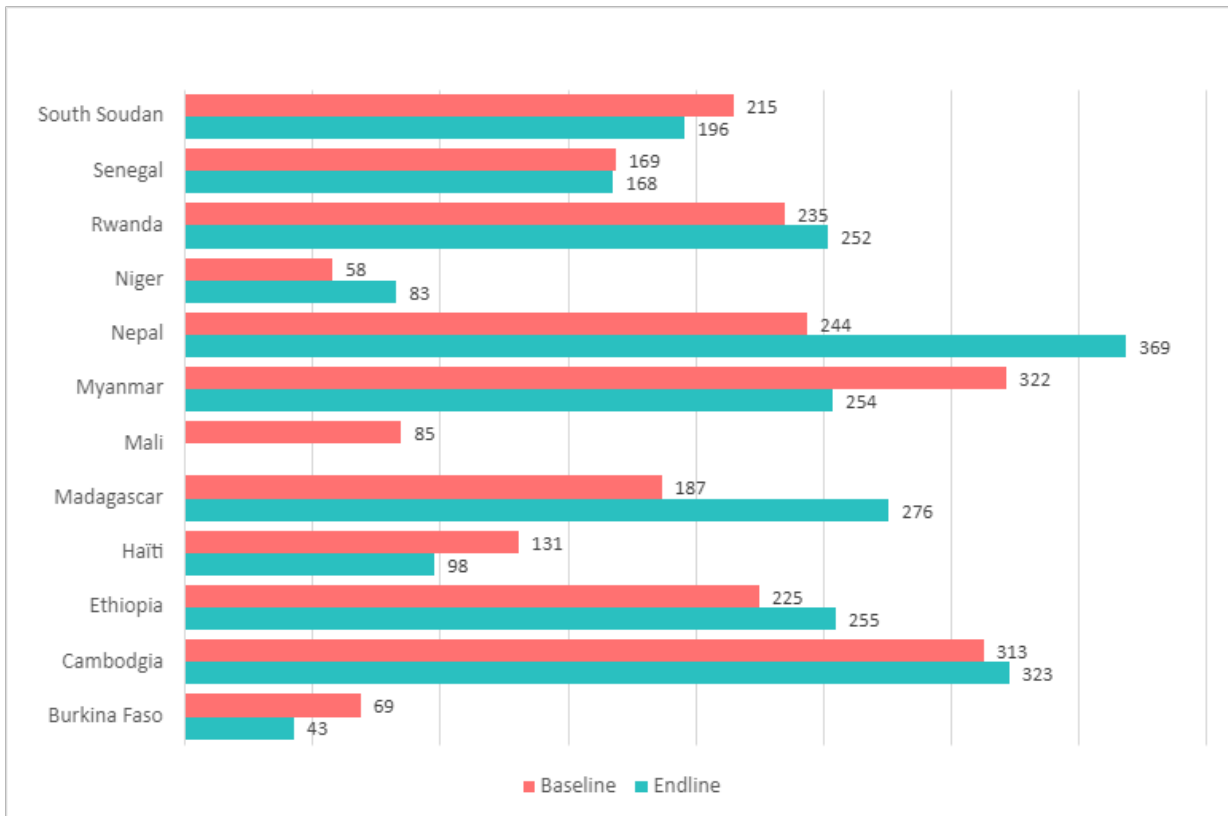
For ScoPeO-kids, 843 children responded to the questionnaire in Baseline and 756 in Endline. As with adults, the number of respondents varies by country and therefore by the size of the target population (Figure 2). And as for adults, we only have Baseline data for Mali.

Figure 2 - Number of ScoPeO-Kids respondents per country (Baseline and Endline)
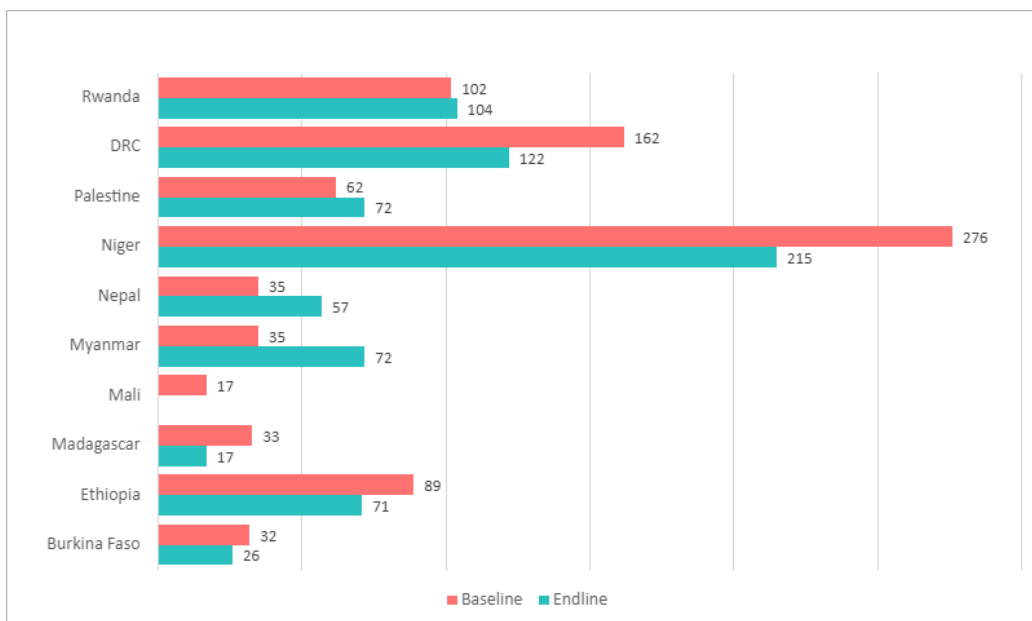
1.2 Age, gender and disability of ScoPeO-Adults respondents

The majority of the analyses on quality of life that will be presented below were carried out on disaggregated data (essentially by age, gender and disability) in order to limit potential structural outcomes that could bias the interpretation of the results. However, in order to account for the overall outcome of the AC5 action programme on the quality of life of beneficiaries, it is necessary to look at the variation in scores between Baseline and Endline at the level of all respondents. To do this, it is essential to have a population whose profile does not vary too much between the Baseline and the Endline. Otherwise, the differences in scores between the Baseline and the Endline could be attributable to changes in the structure of the respondents and not to real changes. For this reason in particular, we will look at the age, gender and disability profile of respondents in the Baseline and Endline[17] .

Average age, median age

The average age is calculated as the sum of the ages of the ScoPeO respondents, divided by the number of respondents. The median age is the value that divides the total series of responses into two series of equal size. There are therefore as many people with an age below the median age as there are people with an age above the median age among the ScoPeO respondents.

In order to compare the age between the Baseline and the Endline we prefer the median value to the mean value. Indeed, the latter is more sensitive to extreme values.

The median age of all ScoPeO-Adults respondents is 38 years in Baseline and 40 years in Endline (Table 4). The median age varies between countries. This is mainly due to different intervention sectors, and therefore different beneficiary profiles. In Madagascar, the intervention sector is maternal and child health, and the median age is particularly low (24 years in Baseline and 26 years in Endline). In contrast, in Cambodia, where the intervention is based on rehabilitation, the median age is 50 in Baseline and 53 in Endline.

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[17] As a reminder, in Baseline, we do not have information on age and gender for South Sudan or on gender for Burkina Faso.

Table 4 - **Age by country and gender of ScoPeO-Adults respondents (Baseline and Endline)**

			Median	Standard deviation	Min	Max
COUNTRY	Burkina Faso	Baseline	45	16	19	82
		Endline	50	16	18	74
	Cambodia	Baseline	50	15	18	87
		Endline	53	15	18	86
	Ethiopia	Baseline	40	20	18	100
		Endline	40	17	18	90
	Haiti	Baseline	48	15	18	84
		Endline	45	16	18	87
	Madagascar	Baseline	24	8	18	60
		Endline	26	7	18	49
	Mali	Baseline	34	12	18	77
	Myanmar	Baseline	46	17	18	82
		Endline	48	16	18	80
	Nepal	Baseline	44	15	18	86
		Endline	43	15	18	82
	Niger	Baseline	24	12	18	73
		Endline	27	12	18	72
	Rwanda	Baseline	32	14	18	83
		Endline	38	15	18	81
	Senegal	Baseline	29	8	16	55
		Endline	30	8	17	56
	South Sudan	Baseline	-	-	-	-
		Endline	48	17	18	90
GENDER	Male	Baseline	40	16	16	90
		Endline	44	16	17	90
	Woman	Baseline	35	17	17	100
		Endline	37	16	18	90
	Other	Baseline	25	6	20	29
		Endline	38	18	31	75
	All respondents	**Baseline**	**38**	**16**	**16**	**100**
		Endline	**40**	**16**	**17**	**90**

The differences in median age between the Baseline and the Endline (all countries combined) do not exceed 5 years and the standard deviations, which tell us about the dispersion of age in relation to the mean, are relatively close between the Baseline and the Endline. **The age profile of the respondents can therefore be considered to be roughly identical between the Baseline and the Endline.** The age of the respondents should therefore not introduce any bias in the comparison of the overall Baseline and Endline scores.

In terms of gender (Graph 3.), women represent 53% of respondents in the Baseline category compared to 56% in the Endline category. This variation also remains relatively small.

Figure 3 - **Gender distribution of ScoPeO-Adults respondents (Baseline and Endline)**
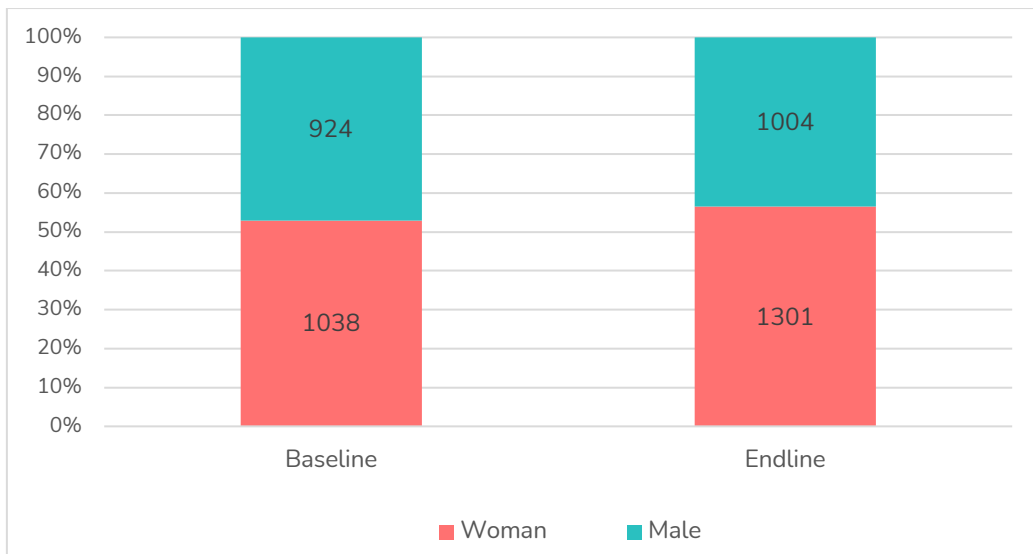
Figure 4 shows that the median age of women is 35 in Baseline and 37 in Endline. The median age for men is 40 in Baseline and 44 in Endline.

Figure 4 - **Age pyramid of ScoPeO-Adults respondents (Baseline and Endline)**
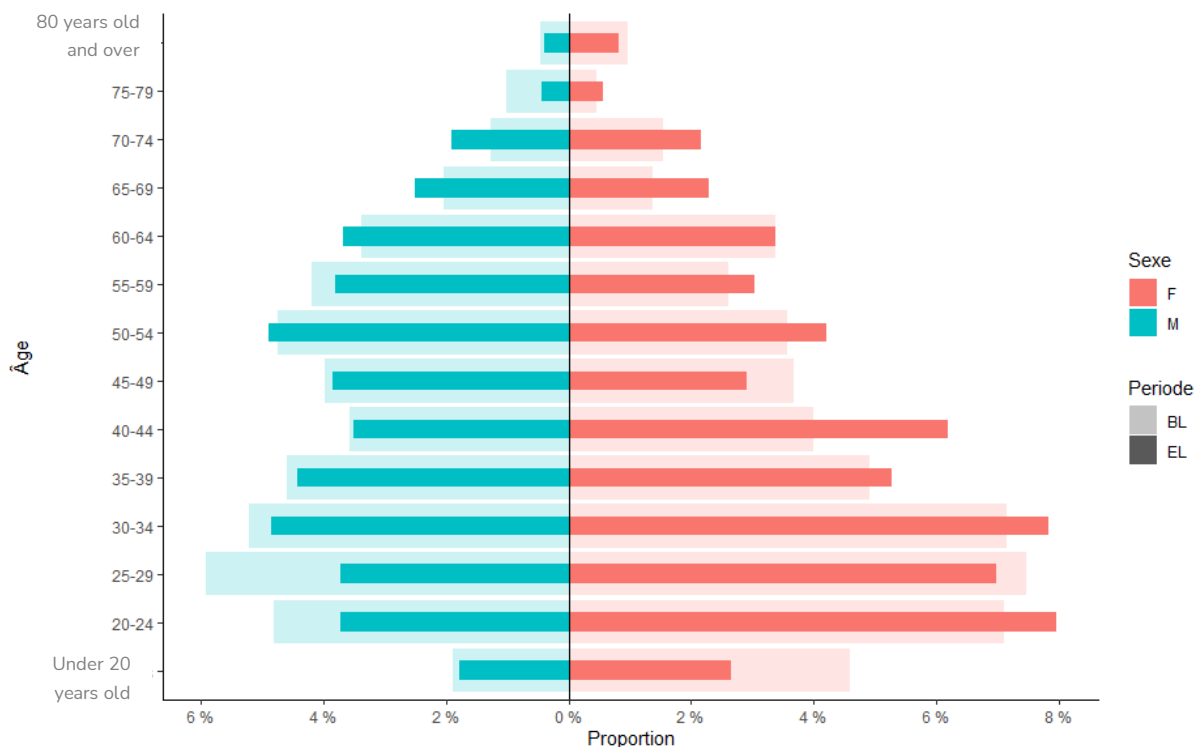
The differences in the proportions by age and gender category do not exceed 2.3 percentage points. **Despite slight differences in age and gender, the profile of respondents according to these characteristics is relatively close in Baseline and Endline.**

With regard to disability, the ScoPeo questionnaires (Adults as well as Kids) all incorporate a block of six questions developed by the Washington Group to identify disability. These questions address difficulties in performing the following basic activities: seeing, hearing, walking, self-care, concentrating/recalling, and communicating. Thus, as can be seen in Graph 5, 63% of ScoPeO-Adults respondents in Baseline are in a disability situation compared to 46% in Endline, a difference of 17 points.

Figure 5 - Prevalence of disability among ScoPeO-Adults respondents (Baseline and Endline)
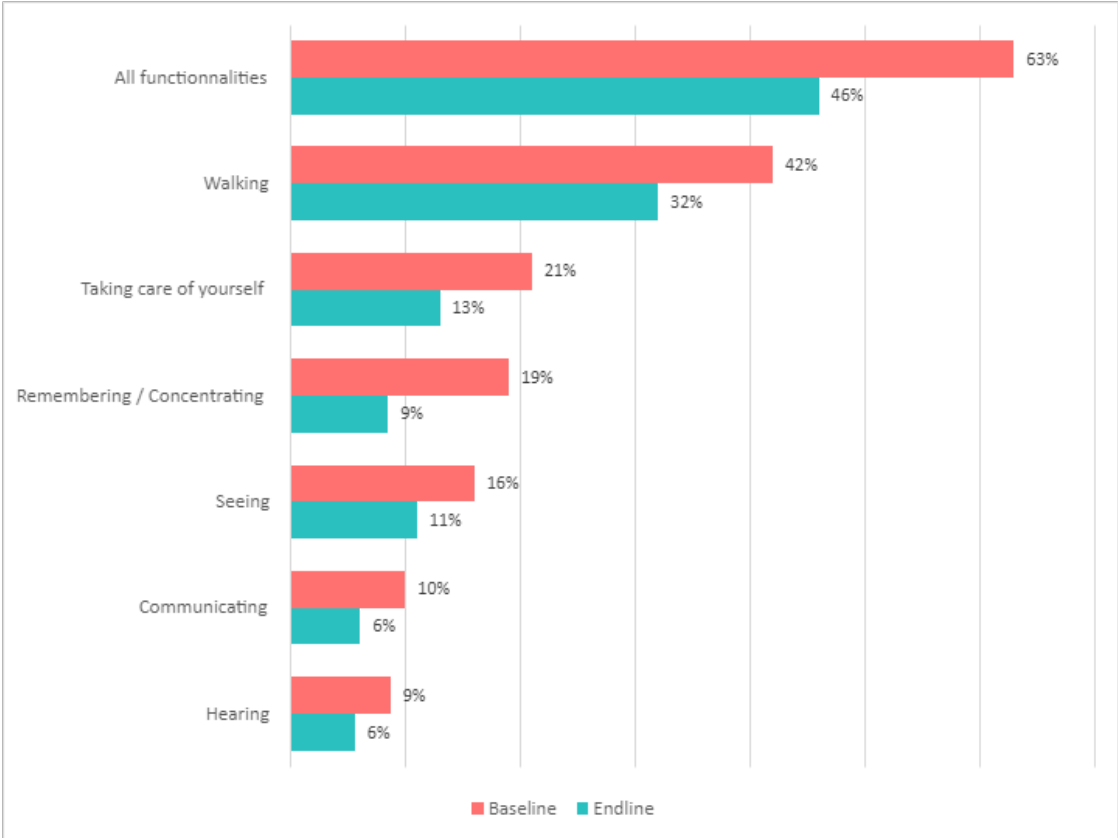
This difference does not appear to be solely related to the capture of respondents with a different profile between the Baseline and the Endline, which as we have seen are relatively close in age and gender. **This could be partly explained by a bias at the time of the Baseline, if respondents preferred to answer that they had a lot of difficulty on the assumption that this would enable them to get more help, and partly by a change in the prevalence of disability among respondents, as difficulties may have decreased over the project period (e.g. from 'a lot of difficulty' to 'some difficulty').** The most significant decreases were in the activities of 'walking' and 'concentrating/recalling' (-10 points) and caring for oneself (-8 points).

⟩·⟨ Exploring the issue of disability intensity

When disability is explored in terms of the number of activities affected, 31% of respondents in Baseline have a lot of difficulty or cannot do one activity at all, 17% two activities and 14% three or more activities (compared to 26%, 12% and 7% respectively in Endline). It is worth noting that as the number of activities affected increases, so does the proportion of respondents who stated in at least one activity 'I can't manage at all'. The analysis through the prism of activities therefore also provides indirect information on the intensity of the disability.

When we look at the prevalence of disability according to the socio-demographic characteristics of the respondents (graph 6), it emerges that in Baseline, there is no notable difference according to gender (59% of women are in a disability situation compared to 60% of men). These differences widen slightly in Endline (44% of women have a disability compared to 49% of men). Whether in the Baseline or Endline, the prevalence of disability increases almost linearly with age.

Figure 6 - Prevalence of disability among ScoPeO-Adults respondents by gender and age (Baseline and Endline)
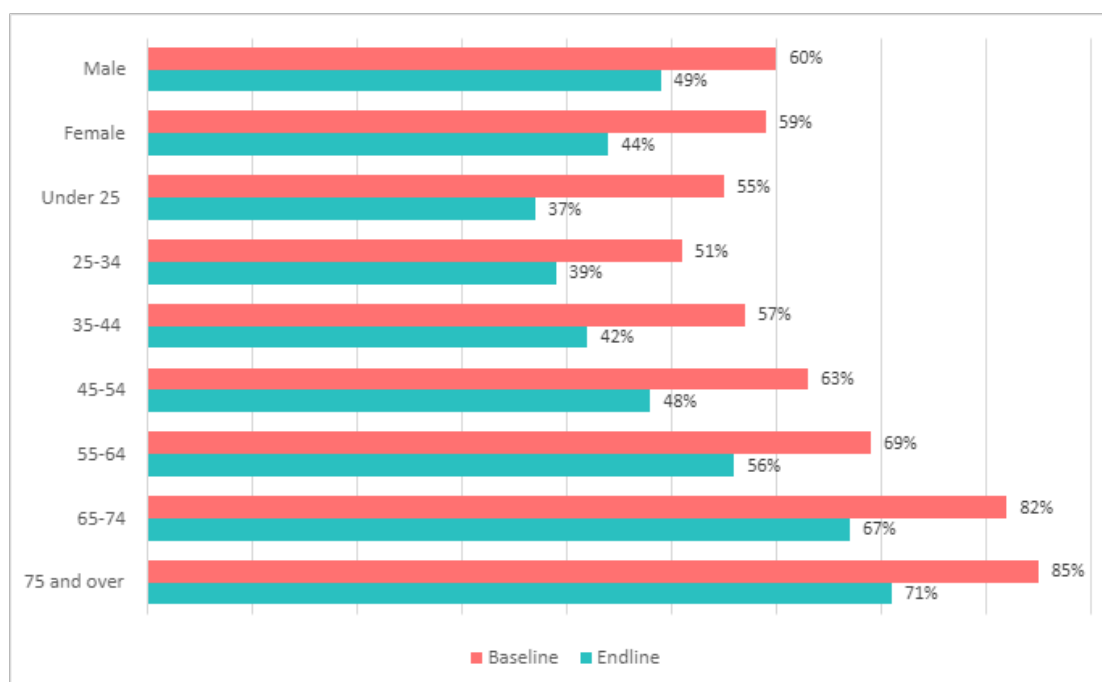
Thus, in Baseline, 55% of people under 25 years old are people with disabiliies, 63% of the 45-54 years old and 85% of the 75 years old and over (these proportions are 37%, 48% and 71% respectively in Endline). **This increase in the prevalence of disability with age is an element to be considered when we look at quality of life scores according to age**.

Finally, it should be noted that, as with age and gender, the prevalence of disability varies according to the sector of intervention and therefore the country[18] . For example, in Senegal, where the intervention sector is mainly economic integration, the prevalence of disability among Baseline respondents is 35%. In contrast, in Burkina Faso, where the intervention is based on rehabilitation, the prevalence of disability is 77% in Baseline.

1.3 Age, gender and disability of ScoPeO-Kids respondents

We follow the same approach as above to present the profiles of the children who responded to the survey.

The median age of all ScoPeO-Kids respondents is 11 years in the Baseline and 12 years in the Endline (Table 5). The difference in median age between Baseline and Endline for children is therefore smaller than for adults.

Table 5 - Age by country and gender of ScoPeO-Kids respondents (Baseline and Endline)

			Median	Standard deviation	Min	Max
COUNTRY	Burkina Faso	Baseline	10	4	5	16
		Endline	9	3	5	16
	Ethiopia	Baseline	10	4	5	18
		Endline	11	4	5	17
	Madagascar	Baseline	16	1	13	17
		Endline	17	1	15	17
	Mali	Baseline	8	3	5	15
	Myanmar	Baseline	9	4	5	17
		Endline	10	4	5	17
	Nepal	Baseline	11	3	7	17
		Endline	14	3	5	17
	Niger	Baseline	11	3	5	17
		Endline	13	2	5	17
	Palestine	Baseline	9	1	6	12
		Endline	12	2	6	15
	RDC	Baseline	11	4	5	17
		Endline	13	3	7	17
	Rwanda	Baseline	12	4	5	17
		Endline	13	4	5	17

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[18] For example, a maternal health project will focus on young women, while an inclusive education project will focus on children with disabilities.

GENDER						
	Boy	Baseline	11	3	5	18
		Endline	13	3	5	17
	Girl	Baseline	11	4	5	17
		Endline	12	3	5	17
	Other	Baseline	10	6	5	14
	All respondents	Baseline	11	3	5	18
		Endline	12	3	5	17

When we look at the median age by country, we see that it is higher in Endline than in Baseline, except for Burkina Faso. These variations in median age (all countries combined) do not exceed 3 years and the standard deviations are relatively close. **Thus, the age profile of children remains relatively close between the Baseline and the Endline.**

In terms of gender (Figure 7), girls represent 43% of respondents in Baseline compared to 47% in Endline. The median age of girls is 11 years in Baseline and 12 years in Endline, and that of boys is 11 and 13 years respectively. The increase in median age is therefore slightly more marked for boys.

Figure 7 - **Gender distribution of ScoPeO-Kids respondents (Baseline and Endline)**
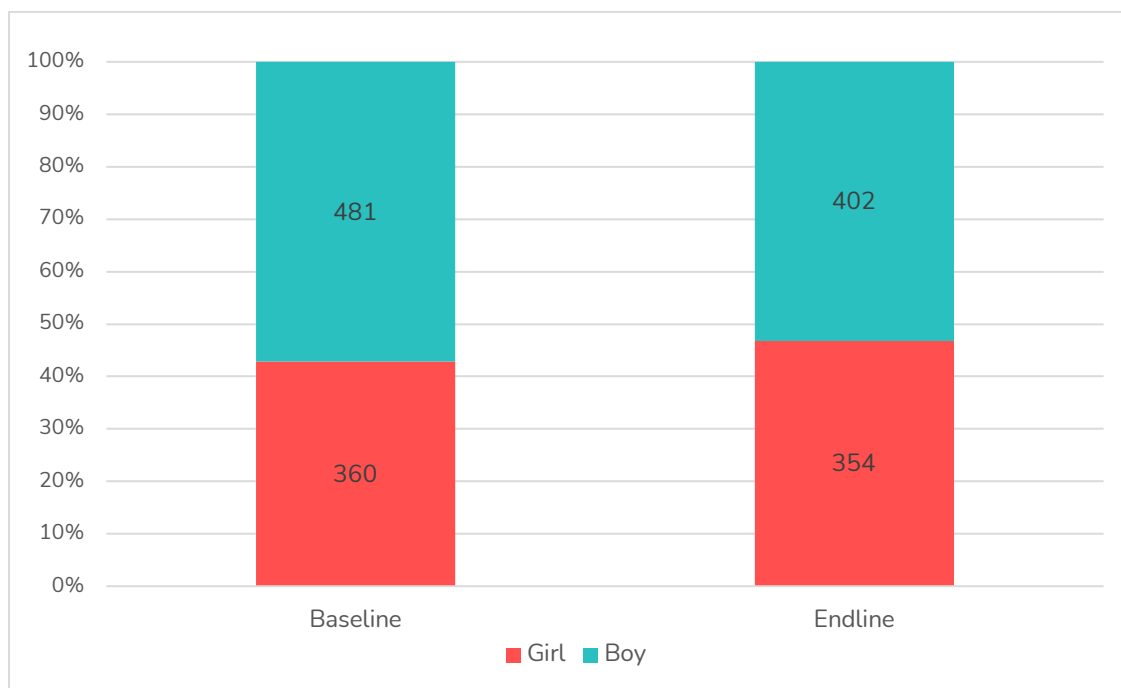
When looking at the age and gender structure of ScoPeO-Kids respondents (Figure 8), it can be seen that the age and gender structure is more differentiated between Baseline and Endline than for adults. The differences in the proportions by age and gender category are as high as 6.8 points (for boys aged 13-14). However, as the age categories are less extensive than those for adults, the transition from one category to another is easier between the Baseline and the Endline.

Figure 8 - **Age pyramid of ScoPeO-Kids respondents (Baseline and Endline)**
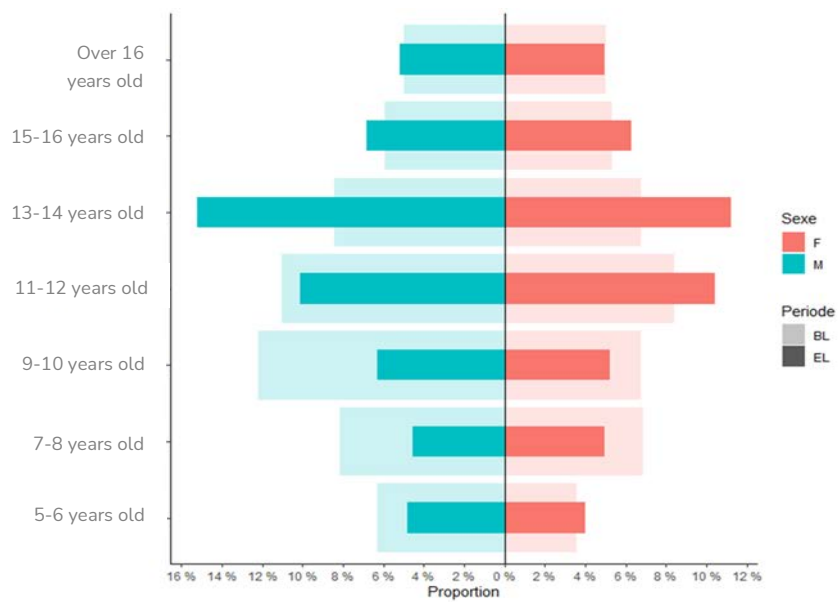
In the end, despite greater differences in age and gender than for adults, **the profile of children remains relatively close on these characteristics between the Baseline and the Endline**.

Concerning disability (graph 9), in the Baseline, 65% of ScoPeO-Kids respondents are in a disability situation compared to 43% in the Endline[19] (a difference of 22 points). The drop in prevalence between the Baseline and the Endline is therefore greater than for adults.

Figure 9 - Prevalence of disability among ScoPeO-Kids respondents (Baseline and Endline)

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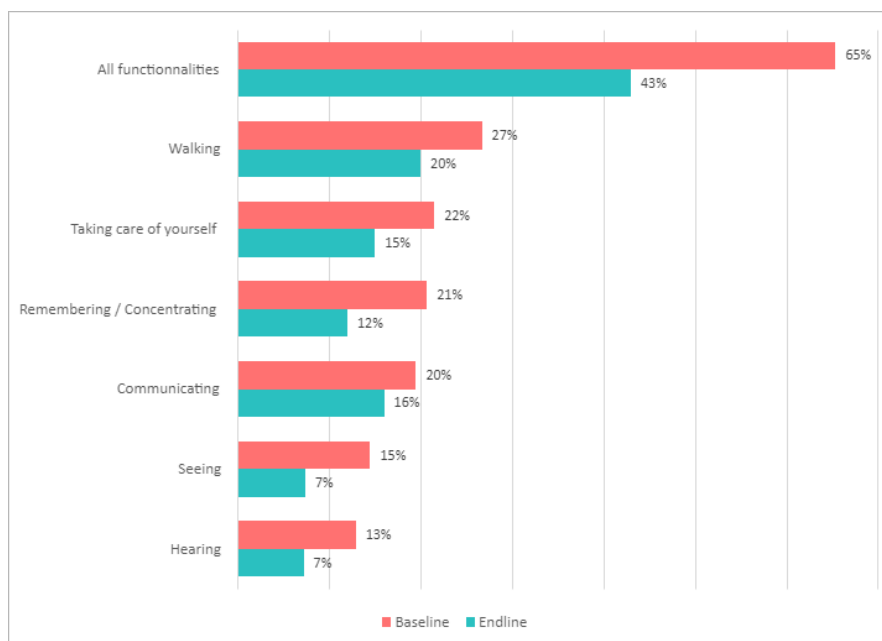
[19] For this calculation, data from Mali was removed from the sample, as only baseline data is available for this country.

Whatever the activity considered, the prevalences all decreased between the Baseline and the Endline. Difficulties in "remembering / concentrating" decreased the most between the Baseline and the Endline (-9 points).

Figure 10 - Prevalence of disability among ScoPeO-Kids respondents by gender and age (Baseline and Endline)
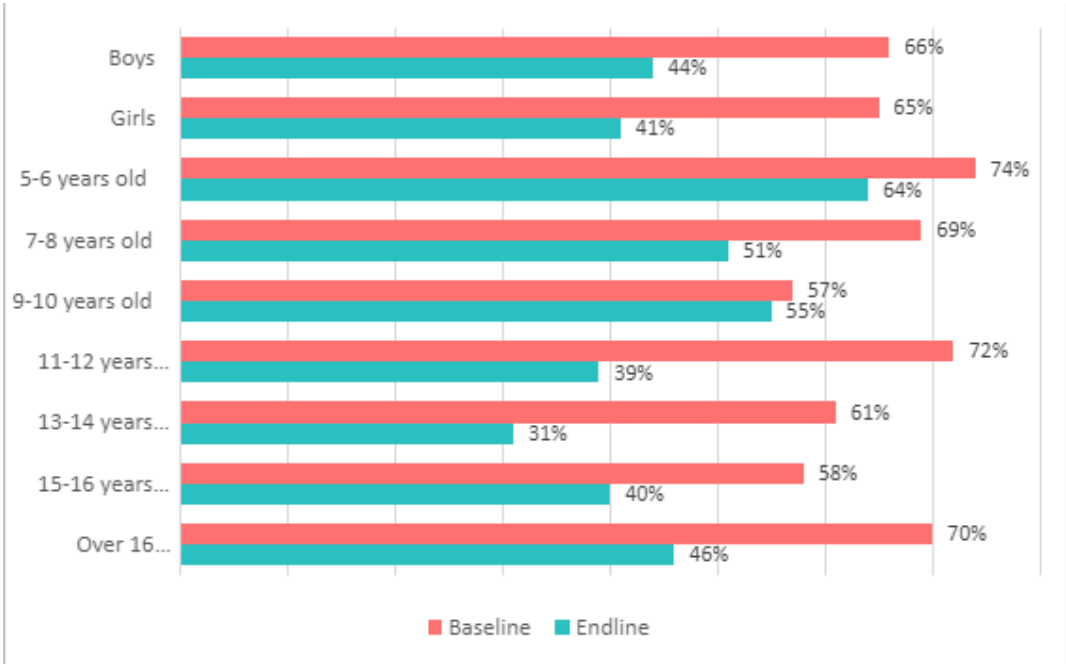
In Baseline, there is no notable difference in prevalence according to gender (65% of girls have a disability compared to 66% of boys). The differences widen slightly in Endline (41% of girls have a disability compared to 44% of boys). The prevalence of disability decreased for all age groups between the Baseline and the Endline. The decreases are more significant for the over 10s (and in particular for the 11-14s).

It should also be noted that, as with adults, the prevalence of disability varies according to the intervention sector and therefore the country. For example, in Palestine, where the intervention is based on inclusive education, the proportion of respondents with a disability is 29%, whereas this proportion is 72% in Burkina Faso, where the intervention is based on rehabilitation.

2. Quality of life: a perception influenced by gender, age and disability

In what follows, we analyse in more detail the data from the Baseline survey. We present, for adults and then for children, the average values of the scores of the different dimensions as well as the influence of being female, elderly or people with disability on the quality of life scores.

2.1 Quality of life of adults

2.1.1 Low overall reference values for material well-being and high for social and family participation

Baseline quality of life scores correspond to the scores before the various HI interventions. In table 6 below, the green boxes correspond to scores above 50/100, and the closer the score is to 100, the darker the box will be green. The red boxes correspond to scores below 50/100, and the closer the score is to 0, the darker the box will be red.

Scale :

0   100
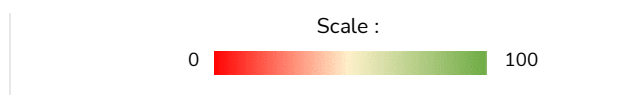
Analysis by dimension and then by question allows us to identify any disparities. In Baseline, the overall quality of life score for all respondents was 49 out of 100. This average total score conceals significant variations by dimension.

Table 6 - Average scores for the different quality of life dimensions and their component questions (ScoPeO-Adults Baseline)

		Question score	Score dimension
Health	General health	36	
	Physical pain	52	48
	Mental health (anxiety, despair…)	58	
Social relations	Relationships with family members	58	
	Relationships with friends	56	56
	Relations with neighbours	56	
	Relations with colleagues, clients, partners…	53	
Subjective well-being	Correspondence between life and ideals	43	
	Living conditions	41	
	Life satisfaction	49	42
	Getting the important things in your life	37	
	Would like to change things in his life	41	
Basic needs	Food	39	
	Water	56	
	Care (consultations, medication…)	38	46
	Schooling of children	43	
	Housing satisfaction	52	
Perceived safety	Safety at work / during economic activities	47	
	Security in the home	56	50
	Safety of daily activities / travel	46	

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Material well-being	Individual resources	34	35
	Household resources	36	
Social and family participation	Family celebrations	66	62
	Opinion taken into account decision within the family	64	
	Social participation (association, neighbourhood discussions…)	62	
	Opinions taken into account decisions that concern him	65	
	Opinions taken into account decision within the neighbourhood	55	
Overall score			49

Material well-being, with a score of 35, is **particularly degraded** (both in terms of individual and household resources). This is **consistent with the target population** of **the** adult **interventions** as at least 5 countries that are part of AC5 will deploy economic inclusion projects. **Subjective well-being**, with a score of 42, is also **strongly degraded**. Basic needs and health are close to the theoretical average with scores of 46 and 48 respectively. However, the scores of the questions that make up these areas are heterogeneous. Thus, **among the basic needs, care needs (38 out of 100) and food needs (39 out of 100) appear to be particularly degraded**. For the health dimension, it is **general health that is particularly degraded with a score of 36. In contrast, mental health seems more favourable with a score of 58**. The perceived safety score is equivalent to the theoretical average (50 out of 100). It should be noted that for this dimension, perceived safety within the home is more favourable with a score of 56. Finally, **the dimensions of social relations and social and family participation are those with the highest scores (56 and 62 respectively)**. The scores on the questions that make up these two dimensions are all above the theoretical average. It should be noted, however, that within the social relations dimension, **the more the question refers to people in the immediate circle, the higher the associated score**. It should also be noted that, **for social and family participation**, the scores for the constituent questions are relatively close, with the exception of **taking the respondent's opinion into account in decisions within the neighbourhood**, where the score is **lower (55 out of 100)**.

2.1.2 A significant influence of gender, age and disability

Based on these baseline data, we wanted to check the influence of gender, age and disability on the quality of life as perceived by the adults who responded to the survey.

In order to be able to interpret the differences that seem to materialise between men and women, different age groups, and people living with or without disabilities, we first check their significance. As explained in section 2.4.3 Analysis procedure, we used multiple linear regressions to account for the 'net' outcomes of each variable. The results of these regressions are presented in Table 7.

Table 7 - Linear regression models: quality of life scores by respondent characteristics (ScoPeO-Adults Baseline)

	Health	Social relationships	Subjective well-being	Basic needs	Perceived safety	Materiel well-being	Social and family participation	Global
Dependent variables								
Reference : Under 25 years old								
25-34 years old	-3.407** (1.355)	-1.719 (1.335)	-0.922 (1.560)	-2.310* (1.217)	-0.833 (1.576)	-4.667** (2.309)	3.710*** (1.325)	-1.432* (0.863)
35-44 years old	-7.025*** (1.518)	-4.538*** (1.496)	-2.853 (1.749)	-3.980*** (1.363)	-3.105* (1.766)	-6.939*** (2.588)	2.600* (1.485)	-3.683*** (0.967)
45-54 years old	-8.265*** (1.587)	-3.282** (1.564)	-0.528 (1.828)	-4.603*** (1.426)	-2.008 (1.846)	-7.325*** (2.706)	6.309*** (1.552)	-2.822*** (1.011)
55-64 years old	-10.972*** (1.681)	-1.624 (1.656)	-2.455 (1.936)	-2.508* (1.510)	-0.985 (1.955)	-3.511 (2.864)	6.324*** (1.644)	-2.259** (1.070)
65-74 years old	-11.624*** (2.107)	-1.025 (2.076)	-2.459 (2.427)	-3.737** (1.892)	-3.459 (2.451)	-4.450 (3.590)	7.306*** (2.061)	-2.792** (1.342)
75 years old and over	-14.762*** (2.801)	1.046 (2.760)	-3.395 (3.226)	-4.362* (2.515)	-4.637 (3.258)	-7.065 (4.772)	5.336* (2.739)	-3.999** (1.783)
Reference : Male								
Female	-2.387** (0.944)	-1.209 (0.930)	-3.167*** (1.087)	-1.186 (0.848)	-1.133 (1.098)	-1.726 (1.609)	-3.522*** (0.923)	-2.033*** (0.601)
Reference : Adults without disability								
Disability : 1 functionnality	-4.363*** (1.065)	-0.565 (1.049)	-3.364*** (1.227)	-4.063*** (0.956)	1.029 (1.239)	-7.289*** (1.815)	-2.141** (1.041)	-2.966*** (0.678)
Disability : 2 functionnalities	-11.630** (1.307)	-1.766 (1.288)	-7.158*** (1.506)	-7.263*** (1.174)	-2.362 (1.520)	-12.658** (2.228)	-5.053*** (1.278)	-6.838*** (0.833)
Disability : 3 functionnalities	-14.643** (1.631)	-7.143*** (1.607)	-9.040*** (1.879)	-10.585*** (1.465)	-7.896*** (1.897)	-10.479** (2.788)	-13.415*** (1.595)	-10.400*** (1.042)
Observations	1887	1887	1887	1887	1887	1884	1887	1884
R^2	0.263	0.354	0.179	0.165	0.131	0.092	0.196	0.272

Level of significance : *$p<0.1$; **$p<0.05$; ***$p<0.01$

Reading note: Each column corresponds to a model and aims to explain the score on one dimension of quality of life (as well as the overall score). The rows contain the modalities of the explanatory variables (the characteristics of the respondents). For each variable, a reference modality is set (e.g. being male for gender). This means that we will compare the differences in scores induced by a characteristic with the reference modality. At the intersection of the columns and rows are the estimated coefficients. These coefficients can be negative or positive. They are comparable to the difference in score induced by a characteristic compared to the reference mode, all other things being equal (for example, being a woman rather than a man). The standard error of the coefficients is given in brackets. Before any interpretation, it is important to ensure that the differences are statistically significant. The level of significance is represented by the asterisks on the coefficients. The more asterisks there are, the more significant the difference. If there is no asterisk, the significance of the result is rejected. **Note:** Countries are included in the models to control for the outcome of the models. However, they are not presented in the results.

Let us first look at the influence of gender[20], the results of which were highlighted in orange in the previous table. It emerges that the overall quality of life score is significantly differentiated by gender. Indeed, the difference in the overall score for women compared to men is significant (note the presence of 3 asterisks), and this difference is -2.003. Thus, being a **woman induces a significant difference in the overall score of about -2 points**. When we look at the quality of life dimensions, **women score significantly lower than men on social and family participation, subjective well-being and health (with respective differences of -3.5, -3.2 and -2.4 points)**. Scores on the dimensions of perceived security, basic needs and material well-being do not differ significantly between women and men.

Let us now look at the influence of age[21]. The results highlighted in blue in Table 7 should be looked at more closely. It can be seen that **the overall quality of life score is significantly higher for those under 25**. However, the outcome of age on the overall score is relatively small: the differences for this score (compared to that of the under-25s) range from -1.4 points for the 25-34s to -4 points for the 75s and over. It **is when we look at the different dimensions of quality of life that significant differences appear between age categories**. Thus, **the score for the health dimension decreases significantly with age and in a linear fashion**. In the end, the health score of those aged 75 and over is significantly lower than that of the under-25s by -14.8 points. Other dimensions show significant differences according to age (but to a lesser extent). **The basic needs score is significantly lower for all age categories than for the under-25s** (the differences range from -2.3 points for the 25-34s to -4.6 points for the 45-54s). In **contrast, the social and family participation score is significantly higher for all age categories than for the under-25s**. It should be noted that the differences in scores for this dimension are particularly marked from the age of 45 onwards. For the other dimensions, the differences between the scores of the under-25s and those of the other age groups are not significant.

Finally, let us consider the influence of disability[22]. We are interested in the results highlighted in purple in the previous table. This is the **most discriminating characteristic in terms of quality of life**. Thus, in terms of the overall quality of life score, compared to respondents without a disability, **the fact of having a disability makes a significant difference**. This **difference is -3 points when the difficulties encountered by the person affect one of the six activities covered by the Washington Group, -6.8 points for two activities and -10.4 points for three or more activities.** It can thus be said **that the overall quality of life score decreases significantly with the intensity of the disability**. Between respondents without and those with disabilities, there are significant differences in all dimensions, but it is **within the health dimension that the differences are most**

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[20] Here, the regression model eliminates the influences of age, disability and country and shows only the influence of gender.

[21] Here, the regression model eliminates the influences of gender, disability and country and shows only the influence of age.

[22] Here, the regression model eliminates the influences of gender, age and country and shows only the influence of disability.

pronounced. Thus, compared to respondents without a disability, living with a disability leads to a significant difference in the health score. This **difference is -4.4 points when the difficulties encountered by the person affect one activity, -11.6 points for two activities and -14.6 points for three activities**. We can thus say that **the health score decreases significantly according to the intensity of the disability. The same trend is found for the dimensions of subjective well-being, basic needs and social and family participation** (with a particularly strong drop-off from three activities for this last dimension). **The material well-being score is also significantly lower for respondents with a disability**, but the differences are significant from the first activity affected.

Thus, the characteristics that negatively affect quality of life are, in order of importance, living with a disability, being elderly, and finally being a woman.

2.2 Quality of life of children

2.2.1 High overall reference values in all dimensions

As with adults, we are interested in the scores of children who responded to the survey in Baseline, i.e. before or at the very beginning of their care in the project.

⟩•⟨ Quality of life score(s), a specificity of ScoPeO-Kids

As a reminder, ScoPeO-Kids includes a specific question on the respondents' overall quality of life, which comes in two versions depending on the age of the child. Each child answers only one of these two questions. The first version is intended for children under 8 years of age, and involves the child rating their level of happiness from 0 to 5. The other is for children aged 8 or older, where the child is asked to rate his or her quality of life from 0 to 10. These scores were averaged over 100.

The calculated overall quality of life score (i.e. the score that represents the average of the scores per dimension) is 66, while the score on the general quality of life/happiness question is 67. It should be noted that the calculated score therefore seems to be a good estimate of the score on the general question. For this reason, and given the higher non-response rate to the general question, when we discuss the overall score later on we will limit ourselves to the calculated score.

The overall score for children, at 66, is particularly high compared to that for adults (which was 49). When we look at the **scores by dimension** (Table 8), they are particularly **high and consistent**.

Table 8 - Scores on the different quality of life dimensions and their component questions (ScoPeO-Kids Baseline)

		Question score	Score dimension
Physical well-being	Health	62	65
	Possibility of carrying out activities of children of his age	59	
	Power supply	74	
Emotional well-being	Happy	69	67
	Feeling of being loved	77	
	Reaching your dreams/goals later	72	
	Concern	58	
	Sadness	60	
Perceived safety	Fear of going out	62	64
	Disputes in the home	66	
Autonomy and personal fulfilment	Learning new things / skills	55	66
	Time for leisure	65	
	Proud parents	79	
	Parents listening	64	
	Happy to help with family tasks	67	
Social welfare	Making friends easily	67	66
	Having meals together as a family	77	
	Possibility to confide in others (emotions, fears…)	59	
	Activities in the community	59	
	Other nice children	67	
Overall score		66	

The lowest score was for perceived safety (64) and the highest was for emotional well-being (67), a differential of just 3 points. This homogeneity between the dimensions contrasts with the heterogeneity observed for adults, with score differentials between dimensions of up to 27 points for the latter.

The scores on the component **questions of** the dimensions are all relatively high (the lowest score being 55). However, there are **greater disparities** than at the level of the dimensions, with differentials of up to 24 points. Thus, **the most degraded scores are those on the possibility of learning new things/skills (55 out of 100) and to a lesser extent on worry (58 out of 100). In contrast, the scores on parental pride and feeling of being loved are the most favourable with scores of 79 and 77 respectively.**

2.2.2 A significant influence of disability

Based on these baseline data, we wanted to check the influence of gender, age and disability on the quality of life as perceived by the children who responded to the survey.

Again, **in order to interpret the differences that appear to materialise between girls and boys, different age groups, and children living with and without disabilities, we first check for significance**. As explained in section 2.4.3 Analysis procedure, we used multiple linear regressions to account for the 'net' outcomes of each variable. The results of these regressions are presented in Table 9.

Table 9 - Linear regression models: quality of life scores by respondent characteristics (ScoPeO-Kids Baseline)

	Dependent variables					
	Physical well-being	Emotionnal well-being	Perceived safety	Autonomy and peronnal achievement	Social well-being	Global
Reference : 9-10 years old						
5-6 years old	-4.817	0.373	5.537	-8.197***	-3.838	-1.995
	(3.086)	(2.560)	(4.366)	(2.970)	(3.012)	(1.984)
7-8 years old	-2.965	1.540	0.322	-1.857	-1.104	-0.767
	(2.587)	(2.146)	(3.634)	(2.461)	(2.507)	(1.663)
11-12 years old	-3.198	2.074	8.788**	-1.824	-1.411	0.939
	(2.452)	(2.035)	(3.444)	(2.333)	(2.376)	(1.576)
13-14 years old	-2.285	-1.003	3.579	-0.106	-1.852	-0.264
	(2.639)	(2.189)	(3.708)	(2.512)	(2.558)	(1.696)
15-16 years old	-5.547*	-6.838***	1.758	-5.620**	-4.180	-4.012**
	(2.966)	(2.460)	(4.167)	(2.822)	(2.875)	(1.906)
Over 16 years old	-5.635*	-3.245	1.612	-0.491	-4.188	-2.316
	(3.093)	(2.566)	(4.345)	(2.943)	(2.998)	(1.988)
Reference : Girls						
Boys	-0.256	-0.806	-2.034	-2.800*	0.847	-1.002
	(1.562)	(1.294)	(2.193)	(1.487)	(1.514)	(1.004)
Reference : Children without disability						
Disability 1 funtionnality	-1.767	-4.979***	-8.743***	-1.902	-2.083	-3.879***
	(1.856)	(1.539)	(2.612)	(1.769)	(1.802)	(1.193)
Disability 2 funtionnalities	-6.905***	-3.866**	-4.673	-4.990**	-5.538**	-5.178***
	(2.345)	(1.942)	(3.291)	(2.231)	(2.273)	(1.507)
Disability 3 funtionnalities	-15.212***	-13.393***	-7.733**	-14.993***	-14.883***	13.202***
	(2.558)	(2.119)	(3.590)	(2.443)	(2.480)	(1.645)
Observations	823	822	821	821	822	823
R^2	0.283	0.229	0.075	0.212	0.183	0.275

Level of significance : *$p<0.1$; **$p<0.05$; ***$p<0.01$

Reading note: Each column corresponds to a model and aims to explain the score on one dimension of quality of life (as well as the overall score). For each variable, a reference modality is set (e.g. being a girl for gender). This means that we will compare the differences in scores induced by a characteristic with the reference modality. At the intersection of the columns and rows are the estimated coefficients that represent the difference in score induced by a characteristic compared to the reference mode, all other things being equal. The level of significance is represented by asterisks on the coefficients. If there is no asterisk, the significance of the result is rejected.

Note: Variables on countries, schooling and who the children live with are included in the models to control for their outcomes. However, they are not presented in the results.

Let us first look at the influence of gender[23] . We can see that the overall quality of life score of children does not differ significantly according to gender. Thus, being a **girl or a boy does not seem to make a difference to the level of quality of life**.

Let us now look at the influence of age[24] . The results highlighted in blue in Table 9 should be looked at more closely. It should be noted that the reference modality chosen for age in the regression models is the 9-10 year olds (as they have the best quality of life scores). **The results are roughly identical for all age groups with few significant differences**. In terms of the overall score, only the 15-16 year olds scored significantly lower than the 9-10 year olds. At the level of the dimensions, the differences are essentially for the 15-16 year olds as well. Thus, the latter have a significantly lower score than the 9-10 year-olds for emotional well-being (-6.8 points) and for autonomy and personal fulfilment (-5.6 points). Other significant differences include: 5-6 year olds have a significantly lower autonomy and fulfilment score than 9-10 year olds (-8.2 points); 11-12 year olds have a significantly higher perceived safety score than 9-10 year olds (+8.8 points). **Overall, the age of the children does not seem to make a major difference to their perception of quality of life**.

Finally, let us consider the influence of disability[25] . We are interested in the results highlighted in purple in the previous table. **As with adults, it is in relation to disability that the differences in scores are most significant**. Thus, compared to respondents without a disability, **respondents with a disability have an overall score that is significantly lower by 3.9 points when the disability affects one activity, 5.2 points for two activities and up to 13.2 points for three activities**. Large and significant differences exist regardless of the dimension considered when the child encounters difficulties in two or more activities, with the exception of perceived safety. **Children experiencing difficulties with one activity had a negative impact on their emotional well-being and perceived safety, i.e. two of the five dimensions**. Thus, the fact of living with a disability affects the dimensions of the child's quality of life according to the intensity of the disability.

3. Evolution of quality of life scores between baseline and endline: overall encouraging results

We will now look at the changes in these scores between the Baseline and the Endline. These changes will provide us with information on the outcome of the HI programmes on the quality of life of the beneficiaries, i.e. on the changes observed during the intervention period and the likely contribution of the project to these changes (even if it is not a question

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[23] Here, the regression model eliminates the influences of age, disability, country, whether or not the child attends school, and who the child lives with, and shows only the influence of gender.
[24] Here, the regression model eliminates the influences of gender, disability, country, whether or not the child attends school, and who the child lives with, leaving only the influence of age to be seen.
[25] Here, the regression model eliminates the influences of gender, age, country, whether or not the child attends school, and who the child lives with, and shows only the influence of disability.

of establishing a strict causal link between the two). Firstly, the analysis of the evolution of the scores of all the respondents, between baseline and endline, will make it possible to discuss whether or not the objectives set by HI were achieved. Secondly, the evolutions between baseline and endline will be put into perspective according to the profile of the respondents (according to gender, age, disability), in order to verify the contribution to the increase or reduction of inequalities between the groups, in other words, to discuss the sensitivity of the projects to the three aspects of gender, age and disability

3.1 Improving the quality of life of AC5 beneficiaries, an objective achieved!

Under AC5, it was planned to "identify the degree of improvement in the living conditions of programme beneficiaries". In what follows, we will attempt to show what this is.

3.1.1 Overall analysis of the evolution of scores for adults: an improvement between baseline and endline

In order to demonstrate the improvement or otherwise of the quality of life of the people for whom HI has worked in AC5, we will compare the Baseline and Endline scores for quality of life.

Once again, in order to be able to interpret the differences that should appear between Baseline and Endline, we run **linear regression models**. Even if the structure of the respondents is not very different between the Baseline and the Endline, as we have seen earlier in this report, it is **important to ensure that the changes in scores are not linked to a structure outcome, i.e. attributable to a change in the respondents' profiles between the Baseline and the Endline**. Linear regression models are also used to assess the significance of differences (see section 2.4.3 Analysis procedure). The results of these regressions are presented in Table 10.

Table 10 - Linear regression models: differences in scores between Baseline and Endline within each adult sub-population

	Health	Social relations	Subjective well-being	Basic needs	Perceived safety	Material well-being	Social and family participation	Overall score
				Dependent variables :				
Reference: Baseline								
All respondents	9.051*** (0.645)	5.148*** (0.624)	10.246*** (0.773)	6.116*** (0.574)	8.308*** (0.707)	12.643*** (1.046)	6.821*** (0.592)	8.314*** (0.441)
Male	9.059*** (0.907)	4.859*** (0.858)	12.381*** (1.071)	6.254*** (0.810)	7.017*** (1.038)	12.460*** (1.517)	7.737*** (0.833)	8.538*** (0.627)
Woman	8.819*** (0.913)	5.298*** (0.897)	8.381*** (1.103)	5.871*** (0.813)	9.217*** (0.970)	12.824*** (1.450)	5.930*** (0.838)	8.016*** (0.621)
Under 35 years old	7.505*** (0.997)	4.077*** (0.992)	5.170*** (1.241)	4.499*** (0.916)	6.916*** (1.108)	8.629*** (1.616)	5.381*** (0.930)	5.997*** (0.699)
35-64 years	10.171*** (0.918)	6.715*** (0.886)	13.383*** (1.072)	7.014*** (0.794)	8.717*** (0.988)	15.507*** (1.486)	8.350*** (0.833)	9.953*** (0.620)
65 years and over	9.126*** (2.077)	1.526 (1.858)	15.593*** (2.339)	7.904*** (1.890)	12.022*** (2.362)	14.936*** (3.474)	5.818*** (1.991)	9.560*** (1.330)
No disability	12.078*** (0.832)	6.164*** (0.898)	7.133*** (1.093)	6.068*** (0.777)	8.226*** (0.945)	9.440*** (1.457)	8.823*** (0.752)	8.235*** (0.608)
In a situation of disability	5.477*** (0.965)	3.595*** (0.869)	12.216*** (1.075)	5.222*** (0.836)	7.327*** (1.026)	14.851*** (1.496)	4.802*** (0.897)	7.640*** (0.622)

Significance level : *p<0.1; **p<0.05; ***p<0.01

Reading note: Each row represents a sub-population. At the intersection of the rows and columns are the estimated coefficients and in parentheses is the standard error of the coefficients. These coefficients represent the difference in score, all else being equal, between the Endline and the Baseline.

Table 10 (see green boxes) shows that **the overall quality of life score increased significantly between the Baseline and the Endline**, by **8.3 points**. The same trend is also observed for all dimensions. The largest increases were in the material well-being score (+12.6 points), subjective well-being (+10.3 points) and health (+9.1 points). There was **indeed a significant improvement in the perception of quality of life by people benefiting from HI interventions,** despite the fact that overall conditions tended to deteriorate.

3.1.2 Overall analysis of the evolution of scores for children: an improvement between baseline and endline

In order to demonstrate the improvement or otherwise of the quality of life of the people for whom HI has worked in AC5, we compare this time the Baseline and Endline scores on quality of life for children. To do this, we proceed as before, using regression models to remove the outcome of changes in age, gender, country, disability, and who the children live with. We present the results in Table 11.

Table 11 - Linear regression models: differences in scores between Baseline and Endline within each child sub-population

	Dependent variables :					
	Physical well-being	Emotional well-being	Perceived safety	Autonomy and personal fulfilment	Social welfare	Overall score
Reference: Baseline						
All respondents	2.643** (1.165)	1.705* (0.982)	4.863*** (1.490)	1.789 (1.142)	3.576*** (1.145)	2.904*** (0.778)
Boy	3.084* (1.583)	2.676** (1.314)	5.202** (2.053)	3.374** (1.535)	3.666** (1.531)	3.557*** (1.032)
Girl	2.004 (1.737)	0.274 (1.471)	4.221* (2.173)	-0.536 (1.703)	3.179* (1.725)	1.848 (1.171)
5-6 years	8.077* (4.521)	10.196*** (3.627)	3.671 (5.092)	13.386*** (4.312)	13.470*** (4.230)	9.065*** (2.845)
7-8 years	-0.867 (3.375)	-2.273 (2.739)	0.364 (4.474)	2.201 (3.333)	2.807 (3.324)	0.423 (2.251)
9-10 years	-1.354 (2.926)	-0.174 (2.766)	7.236* (4.335)	-1.624 (3.182)	-0.409 (3.245)	0.832 (2.101)
11-12 years	2.371 (2.604)	1.526 (2.081)	2.016 (3.315)	3.631 (2.513)	5.024** (2.367)	2.937* (1.706)
13-14 years	5.013** (2.470)	2.960 (2.126)	8.840** (3.484)	-1.831 (2.407)	1.486 (2.471)	3.280** (1.660)
15-16 years	6.390* (3.602)	6.090* (3.241)	9.286** (4.295)	8.456** (3.584)	8.618** (3.476)	7.768*** (2.453)
Over 16 years old	2.850 (3.999)	-3.249 (3.204)	10.084** (4.415)	-5.388 (3.538)	1.457 (3.873)	1.002 (2.439)
No disability	7.784*** (1.562)	3.909*** (1.406)	6.917*** (2.080)	4.951*** (1.522)	6.893*** (1.514)	6.089*** (1.065)
Disability status	-1.682 (1.658)	-0.088 (1.367)	3.751* (2.145)	-0.624 (1.670)	1.139 (1.680)	0.468 (1.092)

Significance level : *p<0.1; **p<0.05; ***p<0.01

Note: each row represents a sub-population. At the intersection of the rows and columns are the estimated coefficients and in parentheses is the standard error of the coefficients. These coefficients represent the difference in score, all else being equal, between the Endline and the Baseline.

In the end, Table 11 shows that, all other things being equal, **children's overall quality of life score did increase significantly between the Baseline and the Endline (+2.9 points).** In terms of the dimensions, with the exception of autonomy and personal fulfilment, all experienced significant increases in their scores (ranging from +1.7 points for emotional well-being to +4.9 for perceived safety).

Partial processing of data from longitudinal follow-ups

As mentioned earlier in this document, the teams in the different countries were accompanied before the launch of the Baseline in the design of their survey protocol. This protocol was adapted to the intervention context but also to the project's programmatic specificities (based on the teams' knowledge and the situation at the time). Some protocols thus provided for longitudinal data collection (people surveyed in the Baseline were surveyed again during the Endline), while others provided for cross-sectional data collection (surveys were conducted on two independent samples).

The difficulty of outcomeively carrying out longitudinal monitoring - which requires specific data management and the ability to maintain contact with beneficiaries over a long period of time - led us to carry out the analyses as if all the information had been produced via a cross-sectional collection. However, by doing so, we may be underestimating the real evolution of scores. For example, when we include the variable 'disability' in the regression models, this is in fact equivalent to eliminating the outcomes linked to the evolution of the number of people with disability. In other words, to consider that the evolution of the score is partly attributable to the evolution of the proportion of people with disability (who, as we now know, have lower quality of life scores). In this case, we do not take into account (and cannot take into account given the data) the potential shift from one category to another for the same respondent.

It could have been different if the means to comply with the survey protocol as defined with the teams at the time of the Baseline had been available, allowing for more in-depth analyses.

### 3.1.3 Some elements to confirm the contribution of the project to the improvement of the quality of life

With few exceptions, for adults, quality of life scores improved for all respondents across all characteristics and dimensions during the project period. However, although it is likely that the projects had an outcome on the quality of life of the beneficiaries, other elements may also have contributed to this outcome.

However, the specific ScoPeO-Adults questionnaire for the Endline contains 7 additional questions (one per dimension) that aim to approach the question of the project's contribution to the observed change in quality of life a little more closely. These questions are in the form "Do you think that, thanks to the project, your [dimension under consideration] has:" with the response modalities "Much improved" / "Improved" / "Neither deteriorated nor improved" / "Deteriorated" / "Much deteriorated".

These questions (Figure 11) show that, depending on the dimension considered, between 60% and 80% of respondents believe that the projects have improved their quality of life.

Figure 11 - Opinion on the outcome of projects by ScoPeO-Adults respondents (Endline)
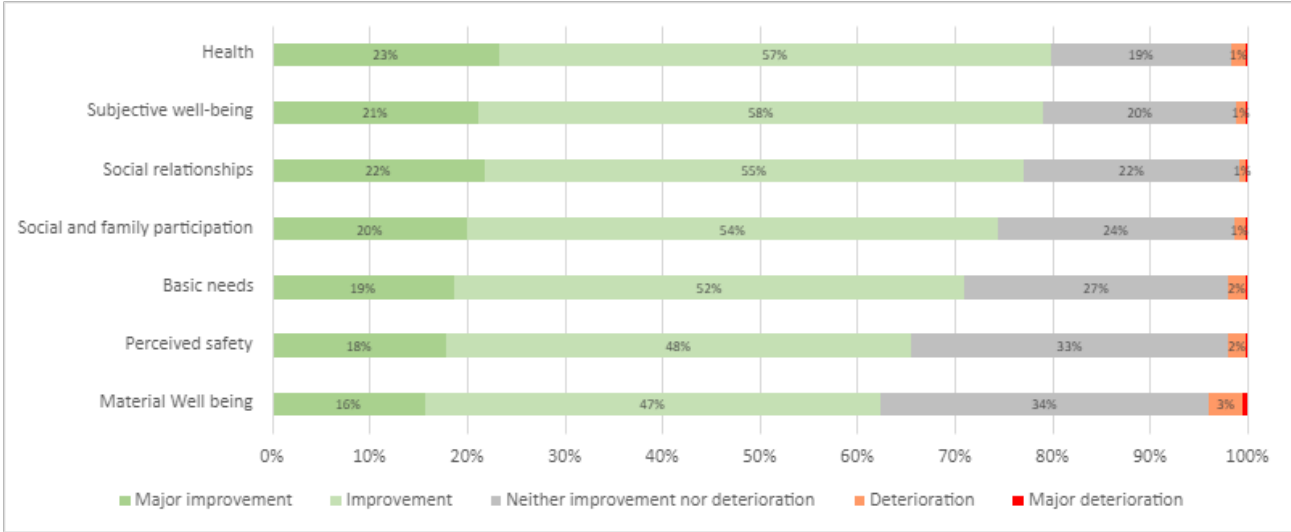
In detail, 80% of respondents believe that their health has improved or strongly improved thanks to the projects, 79% for subjective well-being, 77% for social relations, 75% for social and family participation, 71% for basic needs, 66% for perceived security and 62% for material well-being[26] . These are therefore three dimensions that are particularly sensitive to the context (economic, political, etc.) and for which the projects have brought about the least improvement.

However, these questions have a drawback. Even if they allow us to approach the outcomes of the project, they do not completely eliminate the outcome of the context. For example, when a respondent considers that his or her material well-being has neither improved nor deteriorated as a result of the project, this does not lead to the conclusion that the project is inoutcomeive, as the project may have prevented the deterioration in material well-being that would have been caused by other factors. This is particularly relevant given that the project period covers the start of the COVID-19 pandemic, during which project beneficiaries had to cope with its multiple consequences.

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[26] It is worth noting that 4% of respondents feel that their material well-being has deteriorated. Of these 4%, the majority come from Madagascar, which has benefited from a project aimed solely at health (50 out of 89 respondents).

Other limitations regarding these questions are, in our opinion, firstly the difficulty for people to identify what is called "project" in some cases (do all beneficiaries make the link between the different activities and HI?) and secondly a possible social desirability bias (is a beneficiary always inclined to express some dissatisfaction with the support of an organisation such as HI?)

However, given the cyclical events that influence the implementation of the projects, to be able to confirm an improvement in the quality of life of the beneficiaries between the beginning and the end of the intervention period was almost unexpected. **It is very encouraging to see this improvement in quality of life.** By definition, quality of life (which is a multidimensional concept) can be influenced by many elements. The projects implemented deploy both care activities and more systemic activities (e.g. improving the quality and inclusiveness of policies and services) that affect the living environment of people in a broad way and can indirectly influence the quality of life of beneficiaries. Finally, if other actors contribute to improving the quality of life of people, both adults and children, we can only welcome this, and continue the work undertaken to contribute ever more to improving the quality of life of the people with whom HI works.

3.2 Projects aimed at adults who are generally gender, age and disability sensitive

While an improvement in perceived quality of life has been shown above for all adult respondents, we now need to refine the analysis by looking at possible disparities between different population groups. Thus, in what follows we ask ourselves the following questions:

- How has the quality of life of the women changed compared to the male beneficiaries of the project?
- How has the quality of life of older people changed compared to that of the young adult beneficiaries of the project?
- How has the quality of life of people with disabilities changed in comparison to other beneficiaries of the project?

In doing so, we attempt to verify the level of sensitivity of the projects carried out to age, gender and disability, in other words, to verify whether the projects make it possible to reduce inequalities, or at least not to increase them, between people who do not benefit from the same opportunities, the same access to services, and the same initial level of quality of life. To make these comparisons, we once again use regression models, the results of which are listed in table 10, earlier in this document.

Let us start with the evolution of quality of life by gender. The results that interest us are identified by orange boxes in Table 10. First of all, we can see that **the overall quality of life score has increased in similar proportions between men and women**, by around +8 points. The same is true for **almost all dimensions of quality of life**. The scores of women and men increased in the same order of magnitude for material well-being, health, social

relations and basic needs. The subjective well-being score increased more for men than for women (+12.3 points compared to +8.3 for women), as did the social and family participation score (+7.7 points for men compared to +5.9 points for women). Conversely, the perceived safety score increased more for women (+9.2 points versus +7 for men).

Let us turn to the evolution of quality of life by age. It is the blue boxes that highlight the significant results that we mention here. For ease of reading, the age categories have been grouped into three classes consistent with the previous results: under 35, 35-64 and 65 or over. We can see that, all other things being equal, **the overall score was significantly improved for each age category, and in similar proportions for the 35-64 year olds and for the over 65s** (between +9 and +10 points). In contrast, people aged between 18 and 35 experienced a slightly smaller improvement in quality of life over the project period (around +6 points). This weaker evolution of quality of life scores for the under-35s is found in all dimensions, except for social and family participation (with an improvement of more than 5 points, close to that of the over-65s) and social relations (with an improvement of 4.1 points, while the over-65s do not perceive any significant evolution on this dimension). Furthermore, there was a greater improvement in the perceived safety score for the over-65s: +12 points, compared with +8.7 points for the 35-64 age group and +6.9 points for the under-35s.

Let us now consider the evolution of quality of life according to disability, this time looking at the purple boxes in table 10. Overall, between the Baseline and the Endline, there is a **significant improvement in quality of life (global score) for people with and without disabilities, and in the same proportions**. However, the evolution by dimensions reveals differences between these two groups. While there was a significant improvement in all dimensions, the improvement was less marked for people with disabilities in terms of health[27] (+5.5 points compared to +12.1 points for people living without disabilities), social relations (+3.6 compared to +6.2), social and family participation (+4.8 points compared to +8.8 points), and perceived safety (+7.3 compared to +8.2). Conversely, respondents with disabilities had a greater improvement in their scores for subjective well-being (+12.2 vs. +7.1), and material well-being (+14.8 vs. 9.4).

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[27] Again, the evolution of quality of life scores may be underestimated for respondents with disabilities, as longitudinal data that could have given indications on the change in category of people (a person whose situation improved significantly over the project period and who therefore no longer declares himself/herself being with a disability at the end of the project) could not be treated as such.

In the end, for adults, there was a similar improvement in the overall quality of life between men and women on the one hand, and people with and without disabilities on the other. **It seems, therefore, that in the context of the activities implemented for AC5, HI programming has been relatively gender and disability sensitive**. However, there are nuances when looking at developments in each of these dimensions. Indeed, people with disabilities experience less improvement in several of the dimensions that make up quality of life, which we should keep in mind for the implementation of future projects. **The data analysed also seem to indicate age-sensitive programming**: while the under-35s see their quality of life improve to a lesser extent compared to other age groups, it should be remembered that they also had higher quality of life scores at the time of the baseline.

3.3 More attention to be paid to children on the basis of gender and disability?

To analyse the level of gender, age and disability sensitivity of programming with children, we proceed in exactly the same way as above. The results presented here are based on Table 11, which can be referred to for more detail.

Let's look at the evolution of the quality of life between the girls and boys who benefited from the project. Again, the results of interest to us are identified by orange boxes. **While the boys' overall score increased significantly between the Baseline and the Endline, as did the score for each of the dimensions, for the girls the change in the overall score was not significant**. Only the dimensions related to perceived safety and social well-being improved, although the improvement was slightly less than that for boys (+4.2 and +3.2 points respectively for girls, compared to +5.2 and +3.7 for boys).

Let's turn to the evolution of quality of life by age (blue boxes)[28] . **With the exception of the 7-10 and over-16 age groups, for whom the overall quality of life score remained stable over the project period, all age groups saw an increase in this score between the Baseline and the Endline**. The improvement in quality of life is greatest for 15-16 year olds, but also for 5-6 year olds. For children in these age groups, this remains true for all dimensions, with a very marked evolution (between +8 and +13.5 points depending on the dimensions for 5-6 year olds; between +6 and +9.2 points for 15-16 year olds). For the other age groups, the trends are more contrasted. Only the perceived safety score seems to have improved significantly for almost everyone: +7.2 points for 9-10 year-olds, +8.8 points for 13-14 year-olds, +10.1 points for the over-16s.

Let us now consider the evolution of quality of life according to disability, this time looking at the purple boxes in Table 11. The linear regression models confirm that, all other things being equal, **the overall quality of life score of respondents without a disability improved significantly (+6.1 points)**. Scores on all dimensions also improved significantly. **For**

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[28] For the children, the choice was made not to group the age groups together for lack of consistency in the situations experienced (age of transition between the different school levels differing from one context to another), and in the scores (strong heterogeneity).

respondents with a disability, the changes do not appear significant between the Baseline and the Endline, with the exception of perceived safety, which improved significantly (+3.7 points) but to a lesser extent than children living without a disability (+6.9 points).

Finally, as far as children are concerned, the developments are different depending on the sub-population considered. While boys and children without disabilities see their overall quality of life and quality of life per dimension improve during the project period, this is not the case for girls and children with disabilities. **These results should be of concern to us, as they seem to show a lack of gender and disability sensitivity in programming for children's activities**. In terms of age, the gaps in quality of life widened between 5-6 year olds and 15-16 year olds on the one hand, and children in other age groups on the other, as only the former saw their scores increase. At this stage, it is difficult to interpret these results, given the diversity of the interventions, which are aimed at different groups. However, we have to keep these results in mind as we cannot exclude a possible lack of sensitivity to age as well.

Part 4 - Learning elements

This large-scale deployment of the ScoPeO tools has been an opportunity to learn a great deal about the tools themselves and their conditions of use (MEAL perspectives), about quality of life and its influence on it (general perspectives) and about what the results reveal about the implementation of the projects (operational perspectives). As the launch of CA6 is being prepared at the same time, it is crucial to be able to formalise these lessons and above all to mobilise them for future projects. It is in this spirit that we attempt to identify, in what follows, the different elements of learning that we were able to gather during the project and via a specific experience-sharing exercise conducted in December 2022. These include the need to mobilise the necessary resources to ensure data quality, the need to improve data management between the project and the surveys to allow for relevant analyses, the need to know the target population well to identify the appropriate means for carrying out the survey, and finally the need to take into consideration the results of the analyses presented in this report to improve our projects and learn more about the quality of life of the beneficiaries.

1. The need to deploy adequate resources to ensure the quality of data collection

The question of resources, which guarantee the quality of the data, arises at several levels. First of all, it is a question of ensuring the availability of the skills needed to carry out the ScoPeO surveys, which, as far as this AC5 opportunity is concerned, is achieved by providing specific support via the teams at headquarters. Secondly, there is obviously a need for a budget that corresponds to the reality of the context and the modalities of the intervention.

1.1 Too much fragmented support offered by headquarters during the project

During AC5, support was organised by the head office, with the main objective of enabling the teams to appropriate the tool and advising the people in charge of the survey to ensure the quality of the data. We summarise below the support methods proposed, as well as the lessons that we can draw from them.

As noted above, using the ScoPeO tools involves the same processes as any other survey: the same key steps related to the survey cycle should be followed. These are the steps we follow below to summarise the support that was provided to programme teams.

1- Identify and decide. It was decided at the time of the design of AC5 that the overall objective would be to improve quality of life, and that the tool to measure this change would be ScoPeO. This decision was then applied to all countries involved.

2- Planning. A research officer joined the MEAL team at headquarters to accompany the preparatory work and the realisation of the Baseline for almost 10 months. A major seminar was organised over 5 days in Senegal to build the capacity of the survey managers (also called focal points) in each country. The aim was to improve the internal ownership of the ScoPeO tools. All the material needed to train the interviewers was distributed at that time. Following this seminar, the coaching was oriented towards the design of country-specific protocols, through 3 questions: 1) In my project, what is supposed to have an outcome on the quality of life? 2) Who is supposed to be the beneficiary of the intervention? 3) What information is available to design a relevant representative sample? During the course of the project, discussions were initiated to try to identify potential outcomes of COVID-19 on quality of life dimensions. At the time of the Endline, the IM and MEAL team at headquarters organised webinars and bilateral coaching for countries requesting it (Burkina Faso, Niger, Nepal, Mali). For the latter, a total revision of the approach was carried out, and the recruitment and monitoring of a research officer was carried out to explore another way of capturing quality of life, this time at the family level.

3- Collecting data. Due to the complexity of the protocol and/or the lack of human resources on the ground, three countries (South Sudan, Ethiopia, Nepal) benefited from additional close support during the Baseline, with the arrival of a member of headquarters to support data collection. While this was not done during the Baseline, support for mobile data collection and setting up the ScoPeO tools on SurveyCTO could be put in place during the project, which facilitated mobile data collection during the Endline.

4- Processing the data. After the teams had collected their Baseline data, the researcher organised a discussion on the difficulties encountered by the interviewers during the survey in order to find solutions.

5- Analyse the interpretations. During the Baseline, the data was centralised, and the researcher who accompanied the teams at that time began to carry out the first analyses. A summary report of the whole process was written at this time. Similarly, once the Endline data had been collected in each country, it was centralised at headquarters, and it was necessary to employ a dedicated analyst for 2.5 months. The analyst conducted cross-sectional analyses, the results of which are presented in this report. Each country team was responsible for the analysis and reporting for their country, which allowed them to complete the process of taking ownership of the survey. A webinar was organised to provide guidance to survey managers and/or MEAL units in the use of the matrices and data analysis. A report template was also made available.

6- Share, use and pool. A compilation of the learning elements from the available country reports and the lessons learned exercises carried out by the teams was made. In addition, an experience-sharing session (in the form of a distance workshop) was held with all available teams at the end of AC5. This session was also an opportunity to disseminate the results of the cross-cutting analyses and to look back on the path we have taken together. All the key documents (protocols, guidelines, training materials, survey reports, etc.) were

made available to everyone on Hinside or in Teams. A large part of them will be used as a basis for measuring the outcomes of AC6.

This support proved to be fruitful for some points, and more limited for others. The seminar held in Senegal was declared particularly useful by all the participants, especially because it provided an opportunity to exchange and practice with the tool before having to launch the survey. This ensured that they were able to train interviewers in their respective countries afterwards, as the seminar was designed as a training of trainers, with all the necessary guidance provided. Two other forms of support that were highly appreciated were: firstly, individualised support for drafting the protocols, which made it possible to obtain answers to the questions that the teams had; and secondly, SurveyCTO technical support throughout the project, which enabled the vast majority of countries to carry out the Endline survey via tablets. On the other hand, regarding the aspects that did not work so well, it was deplored that the survey started almost a year after the official start of the project. In addition, the teams mentioned both the turnover on the programmes - with the consequence of losing the information and knowledge acquired during the seminar, but also the difficulty for the head office to know who to contact to ensure the follow-up - and the change of contact person at the head office - leading to a lack of clarity in the person to be contacted in case of need by the project teams, and the feeling of being less accompanied. This feeling was reinforced by the lack of collective time once the seminar had passed, as well as an unclear ARCI on the roles and responsibilities of each person in this survey.

>·< A valuable centralized support to deal with cross-cutting issues

The fact of offering centralised support (in this case from headquarters) is interesting for several reasons: it allows time for collective work between different programmes, which is conducive to enriching discussions and sharing of experience; it allows for the pooling of efforts and resources needed to produce guidelines; it also allows for learning about the tools deployed, and for the production of more transversal knowledge. On the other hand, this centralisation is only possible with the mobilisation of a budget and specific resources, which was facilitated by the AC5. Moreover, this centralised support must not be at the expense of more localised learning, which is essential at the level of each project to improve HI activities.

1.2 Budget and time requirements should not be neglected

In the course of this major ScoPeO survey, some teams seem to have encountered budgetary limitations. In some cases, this led to a reduction in the number of people surveyed, and therefore the representativeness of the sample. In other cases, the choice was made to focus on the people who were easiest to interview (in particular to limit the cost of travel for interviewers). In other cases, the time allocated to training interviewers,

particularly during the endline, was reduced, as was the time spent with each respondent, leading to a drop in the quality of the relationship and therefore potentially in the quality of the data collected.

Several teams reported that respondents had high expectations of the assistance that HI and its partners could provide after completing the questionnaire. These same teams therefore needed more time than had been anticipated and planned to explain in detail the objectives of the survey and the absence of consequences for answering or not answering questions. Generally, the time allowed for data collection is very short: many surveys to be carried out by each interviewer each day, which does not allow them to adapt to the needs of their interlocutor, and indirectly can lead to a decrease in the reliability of the data produced. As mentioned earlier (see paragraph 2.3), the time taken to complete ScoPeO-Kids appears to be lower than for ScoPeO-Adults. However, it was noted that interviewers who had to interview both adults and children often had problems with the latter, while interviewers who only interviewed children did not find any problems.

Some areas for improvement

While the value of centralised support was not questioned at any point, it seems necessary to provide for a more continuous system, providing clear benchmarks for the RCI of the survey from the beginning of the process, and including a system to facilitate the integration of new staff in the event of turnover. Closer support should be provided for analysis and report writing, following the endline data collection.

The quality of the survey also depends on adequate anticipation and budgeting. It is therefore important to be able to carry out comprehensive training and to give interviewers the means to spend the necessary time with each respondent. The need to recruit specific interviewers, dedicated solely to collecting data from children, can also be highlighted for countries deploying ScoPeO-Kids.

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2. The need to improve the link between project activities and survey data

The large-scale deployment of ScoPeO is an undeniable learning opportunity, however, during AC5, some of the analyses and thus potential learning areas were limited. In order to make the most of the efforts made to measure the outcomes on quality of life (and even more generally), this question of learning must be anticipated, and this involves choosing survey deployment and data analysis methods that are adapted to the project and the context and that are linked to the team's knowledge needs.

2.1 Consider measuring the outcomes of the project on quality of life as a learning opportunity

Viewing the measurement of project outcomes - and thus the ScoPeO surveys - as learning opportunities should help to give meaning to the efforts and resources mobilised to carry out this activity.

Socio-demographic questions are a good example. Data on age, gender and disability can be considered mandatory in HI for such a survey, since they are indispensable for disaggregation according to these criteria. The analyses in this report that concern the influence of age, gender and disability on quality of life, as well as the question of the sensitivity of HI's programming to age, gender and disability, could not have been addressed without this information. It is equally crucial at the level of a given project. This is particularly important as the results for AC5 show a potential lack of gender and disability sensitivity for the children targeted by HI's activities, contrary to the organisation's objectives. Thus, this comparison will be important to carry out wherever relevant, to better understand the phenomena behind these results. Conversely, questions on status, or on the number of people living in the household, (which have not been clarified beforehand, since in the same country, several interviewers did not have the same understanding of the question) should only be collected if they meet a need[29]. This need is determined by: 1) project-wide, country-specific learning questions and 2) cross-cutting learning questions where they exist (usually only in the case of multi-country projects, of which AC5 is one).

One ambition that was posed as a cross-sectional analysis of the ScoPeO dataset from KT5 was whether or not there was a greater improvement in quality of life with multi-sectoral care (compared to sectoral care). However, this was not possible because in the vast majority of cases we were not able to know in an outcomeive way what type of intervention each person had received. One of the lessons learned from this exercise is the need to strengthen the techniques for monitoring beneficiaries in order to conduct analyses that compare changes in quality of life by type of service received.

Finally, asking one or more clearly defined learning questions could also reduce the difficulties of some teams who are uncertain about what could be analysed from the survey data. For example, when a project is deployed in two different geographical areas with different populations and through different partners, it might be relevant to compare the evolution of quality of life in these two areas (instead of analysing all the data as a single block).

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[29] Reference can be made here to recommendation 6 - planning and ensuring the use and sharing of information - of the HI Guidance note: Ethical Data Management, but also to the notion of minimisation, which is one of the principles of data protection (Methodological Guide: How to integrate data protection into our operations).

2.2 Define deployment and analysis methods adapted to the project and the context

A significant part of the support offered by the headquarters for this survey was devoted to the joint design of protocols, to ensure a relevant deployment of ScoPeO, according to the specific contexts and activities in each country. This effort was recognised as particularly useful by the teams, although two major pitfalls were encountered.

Firstly, the occurrence of the COVID-19 pandemic, which had a significant impact on the quality of life. This made it difficult to distinguish between the part related to the context and the part related to the contribution of the project to the evolution of the quality of life of the people HI works with. One of the initiatives concerning this issue was to analyse the results of ScoPeO by distinguishing the dimensions strongly influenced by the project and the dimensions strongly influenced by the context, including the consequences of the pandemic. This allows for a better understanding of the contribution of the project to the observed changes in the quality of life of the beneficiaries. Additional questions to be added to the ScoPeO questionnaire during the Endline were proposed to the teams, however, as the influence of the pandemic, its consequences and the actions taken to contain it (containment, closure of services, etc.) differed according to the country, the zones within the same country, and the profiles of the people, it was not possible to carry out this differentiated analysis exercise on all the data.

Secondly, despite the precautions taken when designing the protocols, most of the teams that opted for a longitudinal survey were not able to complete the process. Longitudinal approaches should be reserved for some types of projects and certain types of population, when we are sure that we can survey the people previously interviewed in the baseline in the endline. The obstacles encountered concern, on the one hand, the difficulty of keeping in touch with people whose care ended long before the Endline survey was carried out (wrong telephone number or one that was no longer valid at the time of the survey) and, on the other, the management of identifiers. This may have been the case when new identifiers were assigned to people during the Endline, instead of using the identifiers from the Baseline, preventing the answers given at the beginning and end of the project for the same person from being matched. This last point is however essential when analysing the data following a longitudinal survey. One last aspect should be borne in mind: when young people under 18 years of age are surveyed in the Baseline, and at the time of the Endline they are over 18 years of age, it is important to have decided beforehand which tool to use (ScoPeO-Kids or ScoPeO-Adults, depending on the composition of the rest of the sample) and not to change it between the Baseline and the Endline.

⟩•⟨ Some areas for improvement

To make impact surveys real learning opportunities, it is important to ensure that 1) a project-wide learning question is identified and tools are deployed accordingly (e.g., "are the impacts the same in intervention areas A and B"), and 2) a cross-cutting learning question is identified (for multi-country deployments) and the information needed for processing and analysis is well integrated into the surveys. This could include, for example, knowing what activities each person has benefited from in order to carry out more in-depth analyses by sector.

In order to limit the impact of major events (natural disasters, conflicts, etc.) on the survey data, the risk of which increases with the duration of the project, it could be envisaged to collect data at the halfway point, in a lighter format, in order to take stock of the outcomes already produced or not thanks to the project, in a logic of continuous learning.

Furthermore, where longitudinal approaches are most relevant, it is important to ensure good data management, which requires an adapted procedure for assigning identifiers: for example, it is possible to modify the procedure proposed with the ScoPeO tools, when the project has already assigned a unique number to each beneficiary or when this has already been done in Baseline.

3. Knowing the target population well to plan the survey

A key element of quality data collection is a good knowledge of the population targeted by the survey. This knowledge will enable the most appropriate tool and approach to be selected according to the profile of the respondents, and will ensure that the interviewers are recruited and trained appropriately.

3.1 A set of quality of life measurement tools covering the diversity of the populations for which HI is committed

Concurrently with this major survey, complementary initiatives have explored alternative means of measuring quality of life, when the ScoPeO tools have been faced with certain limitations, which are linked in particular to the specific profiles of the respondents. Indeed, HI sometimes works with people who are not always able to understand and/or express themselves in relation to the questions of the ScoPeO-Adults and ScoPeO-Kids tools in their current form.

Thus, **research was conducted between 2019 and 2021 in Rwanda to analyse the differences in children's and parents' responses to ScoPeO-Kids**. The objective here was to determine the extent to which it was possible to ask parents about the quality of life of

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their children instead of the children. This question was raised in response to specific situations in which children could not express themselves without relatively substantial accommodation in terms of the survey. The aim was to check the level of agreement between the child-parent responses in order to decide whether or not the parent could be interviewed when it was not possible for the child to answer the questionnaire on their own. The level of agreement between children and their parents was assessed using intra-class coefficients (ICC). A total of 81 dyads (parent-child) completed the questionnaire independently. The results indicate a moderate level of agreement (ICC ranging from 0.493 to 0.766). **This suggests that it is possible to ask a parent about their child's quality of life in specific cases where it is not possible to find reasonable adjustments to ask the child directly. The use of ScoPeO-Kids Proxy should be done with caution - not least because the results also indicate that parents tend to underestimate their child's quality of life overall - and is not intended to replace the use of ScoPeO-Kids with children, which is the only way to proceed in a person-centred way**.

In another programme **in Mali,** where the AC5-funded intervention involved **children with epilepsy, Down's syndrome and multiple disabilities and** their families, the ScoPeO-Kids Baseline survey encountered significant difficulties: the trained interviewers were faced with a particularly low response rate. This was linked to the difficulties of these children in understanding the quality of life questions. When people with disabilities that do not allow them to answer the ScoPeO-Kids or ScoPeO-Adults questionnaires represent all or at least the majority of the people targeted through the activities, then there is no longer any question of using a proxy version. Often, in this case, the project focuses on the person with disability but also on his or her living environment, and tries to address issues that concern the whole family. In Mali, the activities implemented within the framework of AC5 corresponded to this double objective. HI therefore decided to explore tools for measuring family quality of life[30] to capture the interconnectedness between family members and how individual needs and well-being affect the well-being of the whole family. A study[31] was therefore carried out to identify the constituent dimensions of family quality of life using two pre-existing tools (the Beach Center's Family Quality of Life questionnaire and the Family Quality of Life Survey 2006) and produced a first version of what ScoPeO-Family could be. The study highlighted two interesting aspects. Firstly, that the person most likely to speak on behalf of the family is the primary carer of the person with disability, specifically the mother or grandmother. Secondly, that there is a strong interest in distinguishing between what is self-assessment of the situation in the different dimensions (what constitutes the perception of the quality of family life) and aspects related to the opportunities available (what characterises the environment) and the initiatives developed by the family (what is valued by the family, where it focuses its efforts).

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[30] The deployment of ScoPeO-Kids in Mali encountered a very high rate of complete non-response (around 75%), forcing the adoption of a different approach than that initially planned through the large ScoPeO survey.
[31] For more information, see the full report of the ScoPeO-Family study.

A comprehensive set of ScoPeO tools is now available to teams (ScoPeO-Adults, ScoPeO-Kids, ScoPeO-Kids Proxy version, ScoPeO-Family), allowing them to respond to the diverse realities of HI's work in the field.

Furthermore, in some specific cases, some questions may not be completely relevant to the respondents' situation. In this case, there is always the possibility of not asking the question, and choosing "Not Applicable" (NA) as the response mode - when these questions represent only a very small part of the questions in the tool[32] . For example, for unaccompanied minors it will not be relevant to ask the question about the child's perception of their parents' ability to listen to them and their willingness to take their suggestions and opinions into account.

3.2 Well-trained interviewers guarantee good relations with respondents and data quality

The testimonies of the teams tell us about the importance of recruiting and training interviewers to ensure that data collection goes smoothly and to guarantee the quality of the surveys. In Burkina Faso and Niger, interviewers were selected from the community in which the beneficiaries had been identified. While this is not always a recommended practice (because of the potential for too much proximity between respondents and interviewers, which can affect the quality of the data), in this case it facilitated contact and communication, while limiting the difficulties associated with mastering local dialects. Other teams chose to recruit female interviewers and/or people with disabilities to carry out the surveys, always with the aim of facilitating communication and allowing a quicker trust between respondents and interviewers. Another good practice to highlight is the use of tripartite video via Whatsapp during the critical period of confinement in Senegal to ensure the inclusiveness of the survey among people with hearing impairments, as reported above in paragraph 2.5 on Taking ethical aspects into account, inspiring team practices. Finally, the pre-test stage, which consists of putting into practice the more theoretical aspects of the interviewer training with a limited sample of people, is a crucial stage: in many cases, the pre-test has made it possible to check the understanding of the questions and therefore the quality of the translation, but also the time needed for each survey and therefore better planning of the data collection afterwards. It also allows interviewers to feel more comfortable with the forms and therefore to interact more fluidly, adopting the appropriate posture with HI beneficiaries.

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[32] If many of the questions seem unsuitable, then the question of the choice of tool must be asked. Indeed, choosing NA as a modality for several questions may make it impossible to calculate ScoPeO scores and thus render the data collected unusable.

The analysis of partial non-responses showed that the vast majority of respondents understood all the questions. However, complementary studies were conducted in parallel to the major ScoPeO survey and made new tools available for specific cases not covered by ScoPeO-Adults and ScoPeO-Kids until then. However, especially when teams do not know the exact profile of respondents in advance, the tagging of complete non-responses (inability to respond or refusal to respond) remains a source of learning that should not be neglected. It is possible, for example, to add questions after "Respondent agrees to participate", in order to specify the reason for the refusal and/or information about the person's inability to respond. This is particularly important as it would appear that people with stigmatising conditions are less likely to agree to participate in the survey.

As with any survey, while the tool is important, it is the interviewers who are the pillars of the quality of the data collected. The composition of the teams (women, people with disabilities, people used to working with children) as well as the training offered, which should include a pre-test stage, are essential in this sense.

4. Take into account the results of this data analysis to improve the quality of future surveys

The analysis of the data on all respondents to the survey of the AC5 countries involved presented in this paper is, as we have said, about learning within HI. But learning can only take place if the new knowledge acquired is integrated into practice. This will include taking into account the influence of age, gender and disability and matching data where necessary. Furthermore, referring to the reference values we highlight here will provide additional answers to the question of "what to analyse" once the ScoPeO data has been collected. Finally, in order to overcome the heterogeneity of some of the dimensions, one should not hesitate to analyse the questions that make up the dimension separately.

4.1 Matching data by gender, age and disability

The analyses conducted above have shown that for adults, quality of life is influenced by gender, age and disability. Thus, women, older people and people with disabilities have a lower quality of life than others. While this is an interesting result in itself, it also becomes important when comparing quality of life scores between Baseline and Endline in a cross-sectional approach. For example, since the quality of life of women appears to be lower, surveying a different proportion of women in Baseline and Endline may result in a change in the mean score, solely due to the influence of a different proportion of women in the two

samples. Similarly, a different proportion of elderly and/or people with disability would lead to an evolution. However, what we want to highlight is the evolution of the quality of life linked to the contribution of the project. Therefore, we need to ensure that the proportions of women, older people and people with disabilities in the Baseline and Endline samples are similar. To do this, it will be necessary to calculate these proportions in the Baseline, and, when constructing the Endline sample, to respect these proportions as much as possible. For children, quality of life seems to be influenced by disability only. Similarly, in cross-sectional follow-up, it will be necessary to survey a similar proportion of children with disability in Baseline and Endline.

4.2 Reference values to enable one to take a critical look at one's own data

What we can also learn from the data of this large ScoPeO survey are the average values for each dimension of quality of life. These mean values from several countries allow us to establish orders of magnitude about the quality of life of the people HI works with, but also about the difference in quality of life between different groups. The average Baseline scores per dimension and per question are listed in table 7 for ScoPeO-Adults, and in table 9 for ScoPeO-Kids. The average score differences by respondent profile in terms of gender, age and disability are summarised in Table 12 below for adults.

Table 12 - Average score differences by gender, age and disability for adults

	Average score difference for women	Average score difference for people over 65	Average score difference for people with disabilities
Health	- 2.4 points	- 13.2 points	- 10.2 points
Social relations	NS	NS	NS
Subjective well-being	- 3.2 points	NS	- 6.5 points
Basic need	NS	-4.0 points	- 7.3 points
Perceived safety	NS	NS	NS
Material well-being	NS	NS	- 10.2 points

Social and family participation	- 3.5 points	+6.3 points	- 6.8 points
Total score	- 2.0 points	- 3.4 points	- 6.7 points

*NS = Non-significant difference

The average score differences according to the respondents' disability profile at baseline are summarised in Table 13 below for children. Gender and age differences did not appear to be significant in the analyses presented in this report.

Table 13 - **Average difference in scores by for children with disability**

	Average score difference for children with disabilities
Physical well-being	- 7.4 points
Emotional well-being	- 7.4 points
Perceived safety	- 5.5 points
Autonomy and personal fulfilment	- 6.7 points
Social welfare	- 6.8 points
Total score	- 7.3 points

These benchmarks can be used to put the results of future ScoPeO surveys into perspective. If the data are close to these reference values, this will gradually confirm the robustness of these values. If, on the other hand, the results are far from these values, it will be interesting to look further into the issue and identify the potential causes of these differences.

>•< **An intersectional analysis to be deepened**

As part of the overall analysis of the data from this major ScoPeO survey, the influence of gender, age and disability on people's quality of life were initially analysed separately. However, the numerous studies on intersectionality seem to indicate that people who have several of these characteristics are more vulnerable. Exploratory analyses were carried out to try to verify this. A regression model was established in order to identify the difference in score induced by the fact of accumulating at least two of the vulnerability factors taken into account here. For example, since it was established on the one hand that being a woman led to a lower quality of life, and on the other hand that living with a disability led to a lower quality of life score, the regression model sought to highlight the additional drop in

quality of life score that could have resulted from being a woman with disability. These initial exploratory analyses do not reveal any additional deterioration in quality of life, whatever the vulnerability criteria considered. The data do not allow us to conclude that quality of life is lower for women with disability, for elderly with disability, or for elderly women. However, these are only the first attempts to analyse the data through an intersectionality lens, and more robust analyses should be carried out at the next opportunity.

4.3 Heterogeneity of dimensions: the possibility of analysing questions individually

The analyses showed that some dimensions were more heterogeneous than others. In ScoPeO-Adults, these were the Health dimension, and the Basic Needs dimension. In ScoPeO-Kids, these are the Perceived Safety dimension and the Autonomy and Personal Fulfilment dimension. Therefore, the scores for these dimensions potentially hide different realities, which need to be qualified. For example, a person may perceive very good mental health (high score) but poor physical health (low score), resulting in a Health dimension score of around 50. This dimensional score does not attract attention in itself, while underneath it there are much more polarised aspects that are probably more significant for the analysis.

>•< Some areas for improvement

In view of the analyses carried out, which show an influence of age, gender and disability on the perception of quality of life, it seems important to ensure that the sample structures are sufficiently similar between the Baseline and the Endline to reflect only the actual evolution of quality of life during the project period, and hence the contribution of the project to these changes. In the same vein, in order to assess the evolution of quality of life scores between Baseline and Endline, it is advisable to use the matrices dedicated to the analysis of ScoPeO-Kids and ScoPeO-Adults. It might be interesting to indicate the confidence intervals to ask whether the differences are significant between Baseline and Endline.

The reference values listed here are intended to facilitate data analysis, starting with the Baseline, and it is therefore advisable to mobilise them by comparing them with the results of future surveys. These values could be consolidated and refined by establishing a database of all ScoPeO surveys by programme.

In addition, the matrices dedicated to ScoPeO-Adults and ScoPeO-Kids provide an interesting aid for carrying out the analyses. However, depending on the learning questions to be answered, and depending on the project (i.e. the dimensions of quality of life that HI is directly seeking to improve), it is possible to dispense with the matrix in order to carry out adapted, more relevant analyses, if necessary.

Conclusion

Within the framework of the funding granted by the Ministry of Foreign Affairs of Luxembourg between 2018 and 2022, **13 countries have committed themselves to carrying out a survey to estimate the contribution of projects to the improvement of the quality of life of the populations.** After years of research into quality of life and its measurement, a set of tools has been developed by HI - ScoPeO - with a version for children aged 5 to 17 (ScoPeO-Kids) and a version for adults aged 18 and over (ScoPeO-Adults). The major survey conducted here is the first large-scale deployment of these tools. Specific resources were mobilised both to support the teams in carrying out the data collection and to analyse the data across the board in order to draw out the overall lessons learned, both in terms of the implementation of the projects and of the ScoPeO tools themselves.

In an effort to promote the appropriation of the ScoPeO tools by the teams, this opportunity led to the production of various guidelines, which are now available to all (training materials, analysis matrices, report templates, etc.). However, the data collection was confronted with the occurrence of the COVID-19 pandemic from 2020 onwards, which affected all the intervention countries. Furthermore, the analysis was limited by a lack of articulation between the survey data and the project data.

Despite this, several results could be highlighted. Firstly, the quality of life scores obtained at baseline were studied. For adults, the overall quality of life score was 49 out of 100. Furthermore, **the quality of life of adults appeared to be significantly influenced by gender, age and disability.** Being female induces a significant difference in the overall quality of life score. Being elderly also induces a lower quality of life. As for disability, it is the most discriminating characteristic in terms of quality of life. Living with a disability makes a significant difference. The overall quality of life score decreases significantly with the intensity of the disability.

For children, the overall score is particularly high compared to that of adults (66 versus 49 out of 100). **In contrast to adults, it seems that gender and age do not significantly influence the quality of life of children.** However, as with adults, it is in relation to disability that the differences in scores are most significant. Thus, compared to respondents without a disability, respondents with a disability have a significantly lower overall score, which decreases with the intensity of the disability.

The evolution of the scores between baseline and endline provides information on the outcomes of the HI programmes on the quality of life of the beneficiaries. **For both adults and children, a significant improvement in the quality of life during the project period can be observed.** Furthermore, it appears that, depending on the dimension considered, between 60% and 80% of adult respondents believe that the projects have improved their quality of life. This question was not asked of children.

By analysing the evolution of the scores according to the profile of the respondents, we seek to verify the contribution to the increase or reduction of inequalities between the groups, in other words, to **discuss the sensitivity of the projects to the three aspects of gender, age and disability**. For adults, an improvement in the overall quality of life is observed for men and women on the one hand, and for people with and without disabilities on the other, in similar proportions. Thus, it seems that in the context of the activities implemented for AC5, **HI programming for adults was relatively sensitive to age, gender and disability. For** children, while boys and children without disabilities saw their overall and dimensional quality of life improve over the project period, this was not the case for girls and children with disabilities. **These results should be of concern to us, as they seem to show a lack of gender and disability sensitivity in programming for children's activities**. And while it is difficult to interpret the age-related results given the diversity of the interventions, we cannot rule out a possible lack of age sensitivity as well.

The lessons learned from this large-scale experiment should be used to improve the measurement of quality of life in future HI projects.

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Annexes

Annex 1 - Scores for the different quality of life dimensions and their component questions (ScoPeO-Adults Endline)

		Question score	Score dimension
Health	General health	47	59
	Physical pain	62	
	Mental health (anxiety, despair…)	66	
Social relations	Relationships with family members	66	63
	Relationships with friends	63	
	Relations with neighbours	63	
	Relations with colleagues, clients, partners…	60	
Subjective well-being	Correspondence between life and ideals	52	52
	Living conditions	52	
	Life satisfaction	57	
	Getting the important things in your life	49	
	Would like to change things in his life	50	
Basic needs	Food	46	54
	Water	64	
	Care (consultations, medication…)	49	
	Schooling of children	51	
	Housing satisfaction	58	
Perceived safety	Safety at work / during economic activities	59	61
	Security in the home	66	
	Safety of daily activities / travel	58	
Material well-being	Individual resources	49	47
	Household resources	47	
Social and family participation	Family celebrations	74	71
	Opinion taken into account decision within the family	74	
	Social participation (association, neighbourhood discussions…)	70	
	Opinions taken into account decisions that concern him	75	
	Opinion taken into account decision of the neighbourhood	65	
Overall score		**58**	

Annex 2 - Scores for the different quality of life dimensions and their component questions (ScoPeO-Kids Endline)

		Question score	Score dimension
Physical well-being	Health	66	70
	Possibility of carrying out activities of children of his age	67	
	Power supply	75	
Emotional well-being	Happy	73	71
	Feeling of being loved	80	
	Reaching your dreams/goals later	71	
	Concern	65	
	Sadness	68	
Perceived safety	Fear of going out	69	72
	Dispute in the home	75	
Autonomy and personal fulfilment	Learning new things / skills	63	69
	Time for leisure	68	
	Proud parents	80	
	Parents listening	67	
	Happy to help with family tasks	69	
Social welfare	Making friends easily	69	71
	Having meals together as a family	80	
	Possibility to confide in others (emotions, fears...)	69	
	Activities in the community	63	
	Other nice children	73	
Overall score		71	

Using ScoPeO to measure quality of life :

Methodological approach and analysis of results in 13 HI projects

Through a Framework Agreement covering 16 countries, Humanité & Inclusion (HI) and its financial partner, the Ministry of Foreign and European Affairs of Luxembourg, have committed themselves to observing a result: a possible improvement in the quality of life of the beneficiaries targeted by the intervention projects. To this end, a baseline survey and an endline survey with the ScoPeO tools were carried out.

This document presents the whole process that allowed the surveys to be carried out, the main results of the data analysis as well as the elements that emerged from the experience sharing that was carried out at different moments of the deployment of this major ScoPeO survey.