Australian Aid

PACIFIC ISLANDS
FORUM SECRETARIAT

Pacific Community
Communauté du Pacifique

Pacific Disability Forum

unicef

THE UNIVERSITY OF MELBOURNE

Pacific Regional Guidebook on Disability Statistics

Pacific Regional Guidebook on Disability Statistics

Pacific Community
Communauté du Pacifique

Noumea, New Caledonia
2025

Authored by: Nossal Institute for Global Health with the Pacific Group on Disability Statistics and SPC

Cover picture: SPC

Prepared for publication at SPC's Headquarters,

B.P. D5, 98848 Noumea Cedex, New Caledonia

Contents

Abbreviations

CFM	Child Functioning Module (WG/UNICEF)
CFM-TV	Child Functioning Module – Teacher's version
DFAT	Department of Foreign Affairs and Trade
HIES	Household income and expenditure surveys
IAEG-SDGs	Inter-agency and Expert Group on Sustainable Development Goal Indicators
ICF	International Classification of Functioning, Disability and Health
ILO	International Labour Organization
LFS	Labour Force Survey
LFS-DM	Labour Force Survey – Disability Module
MDS	Model Disability Survey
MICS	Multiple Indicator Cluster Survey
NSO	National statistics office
OPDs	Organisations of Persons with Disabilities
PDF	Pacific Disability Forum
PGDS	Pacific Group on Disability Statistics
PICTs	Pacific Islands countries and territories
PIFS	Pacific Islands Forum Secretariat
PFRPD	Pacific Framework for the Rights of Persons with Disabilities
rATA	rapid Assistive Technology Assessment
SDGs	Sustainable Development Goals
TRAPD	Translation, Review, Adjudication, Pretesting, and Documentation
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDESA	United Nations Department of Economic and Social Affairs
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WG	Washington Group on Disability Statistics
WG-SS	Washington Group Short Set on Functioning
WG-ES	Washington Group Extended Set on Functioning
WHO	World Health Organization
WHODAS	WHO Disability Assessment Schedule

List of Tables

List of Figures

List of Boxes

Acknowledgements

This guidebook is the result of extensive collaboration between the Pacific Community, Pacific Island countries and territories (PICTs), the Pacific Group on Disability Statistics, and the Nossal Institute for Global Health (University of Melbourne). It is testament to what can be achieved through collaboration towards the shared goals of disability inclusion and data-driven development. None of this work would have been possible, however, without the financial support of the Government of Australia, which is fully committed to the region to ensure that the rights of persons with disabilities are respected.

Our sincere appreciation goes to the expert consultants (Dr Manjula Marella, Ms Fleur Smith and Dr Thiago Melo Santos) who meticulously drafted and developed the sections of the guidebook, ensuring their accuracy and clarity. We also acknowledge the active participation, feedback and suggestions provided by the Pacific Group on Disability Statistics Steering Committee members on behalf of their respective organisations: Ms Taiaopo Faumuina (Samoa Bureau of Statistics), Mr Neori Kete (Fiji Bureau of Statistics), Ms Taobwe Tasie (Kiribati National Statistics Office), Ms Laisa Vereti (Pacific Disability Forum), Ms Talei Tuinamuana (Pacific Islands Forum Secretariat), Mr James Kaphuka and Mr Akuila Sovanivalu (UNICEF), Ms Evelyn Wareham and Ms Elsie Mehoba (Pacific Community). A special thanks to the Washington Group on Disability Statistics for their valuable inputs and commitment. Our gratitude also goes to the participants from Fiji, Guam, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu and Vanuatu, who attended the two-day design workshop held in Nadi (Fiji) on 8–9 May 2025. Finally, we would like to extend our sincere appreciation to Ms Sainimili Tawake and Ms Violet Savu from PDF, and Ms Alison Culpin, Mr Toga Raikoti and Ms Amandine Sourd from SPC, who reviewed and contributed to this work.

We express our profound appreciation to the persons with disabilities, whose experiences and advocacy continue to inspire and guide our work. Their representative organisations' persistent efforts to highlight the importance of disaggregated data have been a driving force behind this initiative.

Faumuina.

Taiaopo Faumuina

Co-chair of the Pacific Group on Disability Statistics,
Assistant Chief Executive Officer of Census and Survey

Samoa Bureau of Statistics

Evelyn Wareham

Co-chair of the Pacific Group on Disability Statistics,
Deputy Director Statistics for Development Division

Pacific Community (SPC)

Foreword

The development of the first *Pacific Regional Guidebook on Disability Statistics* represents a significant turning point in improving data collection and use for persons with disabilities. It reinforces a collective effort to ensure that no one is left behind. Disaggregated, accurate and reliable disability data and statistics are not merely numbers; they are foundational for evidence-based policies, targeted programmes, and effective resource allocation to promote the rights and inclusion of persons with disabilities. In addition, they are useful to highlight progress towards the Sustainable Development Goals, the *2050 Strategy for the Blue Pacific Continent* priorities and the commitments in the United Nations Convention on the Rights of Persons with Disabilities.

This comprehensive guidebook provides knowledge on disability concepts and measurement in the Pacific region. It also provides practical guidance on disability data collection tools and their use in censuses and household surveys, methods and guidance to address challenges faced in data collection in the Pacific region, and translation considerations and methodology. Furthermore, practical guidance on disability data analysis, indicators calculation, and dissemination strategies are highlighted in this guidebook. Finally, analytical codes in R and Stata statistical software and a disability monograph template are developed as an additional guidance note and statistics toolkit to support national statistics offices in analysing and dissemination of data.

The guidebook also aims to empower national statistics offices, government agencies and civil society organisations with the tools necessary to generate robust disability statistics that truly reflect the realities hindering the full participation and inclusion of persons with disabilities in society.

©SPC

Executive summary

The *Pacific Regional Guidebook on Disability Statistics* has been developed to strengthen the quality, reliability and usability of disability data in the Pacific region. Valid and reliable disability data can support evidence-based policy and programming and developing targeted interventions to improve the lives of persons with disabilities.

The Pacific context is unique because of its geography, with several small, remote island nations and its diverse cultures, languages and ethnic groups. This diversity and uniqueness influence the experience of disability and disability-inclusive practices in the region, which must be considered in data collection, analysis and reporting.

The guidebook also serves as a practical tool, addressing unique challenges for disability data collection, analysis and reporting in the Pacific region. It specifically focuses on incorporating the question sets developed by the Washington Group on Disability Statistics (WG) into the population and housing censuses and national sample surveys. It targets Pacific stakeholders – national statistics offices (NSOs), relevant government departments, organisations of persons with disabilities (OPDs), and development actors – who are responsible for disability data collection and will use the guidebook for policy and programming.

The guidebook aims to:

- support collection of high-quality, internationally and regionally comparable disability data;
- facilitate disaggregated analysis of development indicators by disability status;
- ensure accountability to the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD), the Sustainable Development Goals (SDGs) and the *Pacific Framework for the Rights of Persons with Disabilities* (PRFPD); and
- ensure that persons with disabilities are counted and included in the region's development agenda.

Key recommendations

1. Standardise the use of WG-Short Set (WG-SS) in censuses and surveys across the region.

All Pacific Island countries and territories should adopt the WG-SS questions on functioning as a minimum set of disability questions in all population and housing censuses and national sample surveys. The questions should be used without modification, as recommended in this guidebook to ensure data validity and comparability.

2. Consider using other WG tools in national sample surveys.

Where additional information can be collected on disability and the increase in the questionnaire length can be justified, national sample surveys, such as the household income and expenditure survey (HIES) and the multiple indicator cluster survey (MICS), are recommended to use suitable question sets.

3. Ensure that OPDs are engaged throughout the process of surveys.

Representatives from OPDs should be engaged meaningfully from the beginning of the survey's design phase to the results dissemination phase. Resources should be allocated to compensate for their time and contribution, and reasonable accommodation should be provided where needed.

4. Ensure appropriate methods for translations and cognitive testing of WG question sets.

Translation of WG question sets should follow recommended guidance, which aligns with standard methods, such as TRAPD (Translation, Review, Adjudication, Pretesting and Documentation). Cognitive testing of the translated WG question sets will ensure that respondents understand the questions clearly and there are no errors in data collection due to language and translation issues.

5. For all data collections, strengthen enumerator training regarding the collection of disability data and the inclusion of persons with disabilities.

Enumerators should be trained on the concepts of disability, question specifications, dos and don'ts of disability data collection, ethical principles, and interviewing techniques. OPDs should be involved in developing and conducting training sessions.

6. Ensure ethical standards in all disability data collection.

All surveys must respect the dignity and rights of persons with disabilities. Ethical principles related to informed consent, privacy and confidentiality, and accessibility needs should be addressed in the enumerator training and should be monitored during data collection.

7. Invest in strengthening the technical capacity of NSOs and OPDs.

Adequate resources and budget should be allocated to building the technical capacity of people involved in disability data collection, analysis and reporting. There should be ongoing support for NSOs through technical partners, such as academic institutions and OPDs, in strengthening their technical capacity.

8. Develop disability monographs.

Countries should prioritise producing disability monographs following a census and national surveys, using the recommended templates provided. Findings from the monographs should be used for promoting disability inclusion advocacy, policies and programming. In addition to the monographs, countries should prioritise reporting and using disaggregated disability data on indicators to monitor progress on UN CRPD and SDG indicators.

9. Promote regional coordination through the Pacific Group on Disability Statistics (PGDS).

The PGDS should continue its leadership in coordinating regional efforts on disability data collection, analysis and reporting. Production of disability dashboards, monographs and fact sheets should be continued for promoting disability inclusive development in the region. In addition, the PGDS should support technical capacity in the region through peer learning by organising regional workshops to share success stories on disability data collection, analysis, reporting and usage for policy and programming.

Considering this guidebook as a roadmap, the next steps will focus on practical application, strengthening all stakeholders' capacity, and including persons with disabilities in the disability data production chain to ensure data collected are used in a meaningful way to improve the lives of persons with disabilities across the Pacific region.

Implementation of the guidebook includes integrating the Washington Group standard set of questions recommended into all censuses and household surveys by 2030. This step is important to ensure that data are internationally comparable within and beyond the Pacific region.

Finally, the *Pacific Regional Guidebook on Disability Statistics* aims to translate data into concrete action by identifying and addressing disparities experienced by persons with disabilities, ensuring inclusive outcomes for all.

Introduction

One of the core principles of the 2030 Agenda for Sustainable Development and its Sustainable Development Goals (SDGs) is to *"Leave no one behind"*. Inclusive development in the Pacific region cannot be achieved without the full participation of persons with disabilities in the development agenda. Disability data to measure disability prevalence, the needs of persons with disabilities, their level of participation in the community and their access to services are critical to monitor the extent to which persons with disabilities are included in the development agenda.

Disability inclusion is increasingly recognised globally as a core part of the development agenda. The Pacific region has made commitments towards disability inclusion through the adoption of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) and endorsing 132 SDG indicators as part of the *Pacific Roadmap for Sustainable Development*. The SDG 17 on data, monitoring, and accountability highlights the importance of good quality, timely and reliable data disaggregated by disability. Furthermore, the Implementation Plan for the *2050 Strategy for the Blue Pacific Continent*, developed by the Pacific Islands Forum, recognises that:

> *"Continued investments in national statistical and monitoring systems are important to ensure collection, analysis and use of high quality quantitative and qualitative disaggregated gender and disability inclusive data to track progress against outcomes (page 23)."*

Despite these commitments, persons with disabilities in the Pacific region are still facing challenges. They experience inequitable barriers to infrastructure, information, communication and technologies, healthcare, education, employment, and disaster management. These challenges are exacerbated by limited evidence on their situation to guide and support policy and programming. Having good quality disability data would facilitate evidence-based disability inclusive interventions through policy and programming, including monitoring their impact over time. However, most Pacific Island countries still find it challenging to generate disability data that are valid, reliable and comparable, using internationally recommended methods.

Strengthening disability data systems can support national governments and regional stakeholders to promote disability-inclusive programmes and policies so that no one is left behind. Internationally, the Washington Group on Disability Statistics (WG) question sets on disability are recognised for their valid and reliable methods of collecting disability data that align with UNCRPD principles. These question sets are designed to generate cross-culturally comparable data on disability across various settings; they can be used to report on the prevalence of disability and can disaggregate outcomes by disability status in order to assess inequalities in the health, education and employment sectors. They are increasingly being used as part of national censuses, household surveys and administrative systems to identify persons with disabilities and support disability-inclusive policies and programming.

While the standard methodologies and guidance on using the WG question sets have been developed, there are challenges to their implementation and analysing the data appropriately. The adoption of these question sets has been inconsistent in the Pacific region for various reasons, but particularly relating to their intended use, translations into local languages and dialects, technical aspects, and lack of adequately trained enumerators.

In some contexts, the question sets have been modified, affecting data validity and comparability. Modifications have included changing the phrasing of questions, omitting questions, and modifying the response categories. Some terms in English may not have a direct translation into the local language, and some dialects do not have a script, requiring enumerators to translate the questions in the field, leading to errors. Accurate translation of WG question sets into local languages requires collaboration among translators, national statistics officers, and organisations of persons with disabilities. Careful processes, technical oversight and pre-testing are also needed to avoid inaccuracies. The WG has provided guidance on best practices for developing and testing translations.

Enumerator training also remains a key challenge. While there is standard enumerator training for undertaking population and housing censuses and national sample surveys, training on WG question sets may not be fully incorporated into this training. Moreover, while adequate training may be provided at the supervisory level, this training is not appropriately transmitted to enumerators. The WG training requires an introduction to specific disability concepts and ensures that enumerators have the context of disability as per the UNCRPD and understand the difference between activity limitations and impairments.

Lack of training could lead to enumerators misinterpreting questions, paraphrasing questions and thereby inadvertently changing the meaning, and using inaccurate prompts while asking questions. Stigma on disability can further complicate data collection, requiring additional training on cultural sensitivity and locally appropriate methods. It is also necessary for supervisors to monitor data collection processes throughout the collection period to ensure that data collection guidelines are being implemented.

Another key challenge is the limited technical and human resource capacity of Pacific NSOs in supporting disability data collection processes, analysis and reporting. In many cases where disability data are collected, analysis is either not prioritised or NSOs are unable to analyse, interpret and report the data in meaningful ways that can support advocacy, policy and programming.

At times, external consultants are recruited to undertake data analysis and develop a report. This approach is problematic, as the stakeholders are not engaged in ownership and implementation of the recommendations in the report. Engagement of key stakeholders, including OPDs, must be a recommended approach for developing disability monographs, as done in Kiribati, Samoa and Palau.[1]

The Pacific Group on Disability Statistics

In 2020, representatives from NSOs, SPC, the Pacific Islands Forum Secretariat (PIFS), the United Nations Children's Fund (UNICEF) and the Pacific Disability Forum (PDF) formed the Pacific Group on Disability Statistics (PGDS) under the aegis of the Washington Group on Disability Statistics (WG) to ensure that Pacific countries produce disability statistics aligned to international recommendations. The aim of the PGDS project is to address the challenges of collection, analysis and use of disability data in the region. The project supports Pacific Island countries and territories in collecting disability data within the censuses and other national surveys, and analysis of these data to develop disability indicators and reports. Collecting reliable and valid data will also support monitoring of disability inclusion through the SDGs, the *2050 Strategy for the Blue Pacific Continent*, and CRPD indicators.

The PGDS is leading a multi-year project to strengthen Pacific disability statistics, with financial support from the Government of Australia. This project enables the PGDS and SPC to provide technical support to Pacific Island countries and territories in the production and use of reliable, valid, and comparable disability statistics through facilitation, cooperation, engagement, and capacity building, including peer-to-peer collaboration. This project addresses the significant gaps in disability data and promotes evidence-based policymaking to enhance the inclusion and well-being of persons with disabilities in the region.

---

[1] Disability Statistics | Statistics for Development Division

The PGDS coordinates multiple activities among member countries to achieve its goals. Some are described below.

- **Data collection and analysis:** The PGDS project supports efforts to collect, compile, and analyse disability-related data in Pacific Island countries. This includes conducting surveys, assessments, and studies to gather information on the prevalence, experiences, and needs of persons with disabilities across various domains, such as health, education, employment, and social participation. The PGDS and SPC have ensured that the 2020/2021 population round of censuses in the region included the short versions of the Washington Group questions. This was a strong step forward in progress on data availability, enabling further analysis on disability.
- **Capacity development:** The project focuses on developing the capacity of national statistics offices, government agencies, disability focal points, OPDs and other relevant stakeholders in disability data collection, analysis and use. This involves providing training, south-south attachments between NSOs and with partners by working alongside others, technical assistance, and resources to strengthen the skills and knowledge of personnel involved in data collection, management and use.
- **Development of this guidebook and resources:** One of the key components of the PGDS project is to develop and disseminate a standardised regional guidebook, including resources tailored to the context of Pacific Island countries. These resources may include the WG survey instruments, data collection protocols, and analytical frameworks designed to capture disability-related information accurately and comprehensively.
- **Dissemination of disability statistics for use:** Statistics are effective when they are used by persons with disabilities, governments, international organisations and others for planning, decision-making and advocacy. The PGDS project develops and disseminates national disability monographs based on recent censuses and surveys, usable short publications (such as infographic fact sheets), and an interactive dashboard and regional dataset. A regional disability statistics report will also be developed by the end of the project, including all Pacific Island countries disability data.
- **Advocacy and awareness:** The project advocates for the importance of disability-inclusive development and the use of disability data in policymaking and programme planning. Through awareness-raising activities, knowledge-sharing events, and advocacy campaigns, the PGDS project seeks to promote greater understanding and appreciation of the rights and needs of persons with disabilities, the barriers they face and the support they require to be included and participate meaningfully among policymakers, development practitioners, statistics organisations and the public.
- **Collaboration and partnerships:** The PGDS project fosters collaboration and partnerships among governments, development organisations, academic institutions, and civil society organisations working in the disability sector. By leveraging expertise, resources, and networks, the project aims to maximise impact and sustainability in advancing disability-inclusive development goals in the Pacific region.

Overall, the PGDS project plays a crucial role in strengthening the evidence base for disability-inclusive development efforts in the Pacific region. By improving data quality, availability and accessibility, the project contributes to more informed decision-making, better-targeted interventions and, ultimately, greater inclusion and empowerment of persons with disabilities in the region.

Contents of this guidebook

This guidebook addresses the challenges of disability data collection and provides strategic guidance on collecting disability data in the Pacific region, specifically in the use of WG question sets. The guidebook targets stakeholders who are responsible for disability-inclusive development – government departments, NSOs, OPDs, and development actors. It outlines Pacific context-specific approaches to collecting, analysing, interpreting, disseminating and using data on the situation of persons with disabilities. It offers practical guidance that is informed by international standards, while considering the unique sociocultural and geographic realities of the region.While there are different approaches to measuring disability, this guidebook focuses on the WG question sets that can be integrated into population and housing censuses and other national sample surveys, such as the household income and expenditure surveys, labour force surveys and multiple indicator cluster surveys. This reflects the WG objective of mainstreaming the collection of disability data into and across core national data systems to estimate disability prevalence and to determine if the population with disabilities is participating at the same rate as those without disabilities. Information on other types of surveys, including disability-specific surveys, is briefly provided in the guidebook, but detailed guidance is not included; only key indicators from the CRPD and SDGs that can be collected in the population and housing censuses and other national sample surveys.

This guidebook is organised into seven sections covering the following content.

Section 1 presents the current understanding of disability and the situation of persons with disabilities in the Pacific context.

Section 2 outlines the need for measuring disability for disability-inclusive development, and approaches to measuring disability, highlighting WG methods. Information on what does not work in disability measurement is also included.

Section 3 presents WG question sets that can be integrated into the population and housing censuses and national sample surveys. Other data collection tools are also included as additional information.

Section 4 provides guidance on how to interpret questions and response categories in each of the question sets, with examples that are context-specific for adoption.

Section 5 provides guidance on ethical considerations and logistics when collecting disability data in the Pacific region.

Section 6 presents priority indicators identified by Pacific stakeholders to monitor CRPD and SDG indicators on disability and how to analyse them using the data from the WG question sets.

Section 7 provides guidance on how to interpret and report the outputs from the data analysis.

The electronic version of this guidebook can be found at: Disability statistics | Statistics for Development Division.

©SPC - Nabil El Halwani

1. Disability concepts

1.1 Disability in the Pacific context

While it is believed that there are around 1.7 million or 17% of the population have disability in the Pacific region, this statistic is not based on standard methodology that is internationally recommended. In recent years, there has been increased disability data available in the region using the Washington Group Short Set on Functioning (WG-SS), a recommended set of standard questions for censuses and other national sample surveys. Based on the data analysed using the WG-SS methodology, disability prevalence ranges between 2% and 5.7% in the region (See Table 1).

TABLE 1. Estimated disability prevalence using WG-SS questions and the cutoff of at least a lot of difficulty on one or more domains of functioning

Country	Prevalence estimates (year)[2]
Cook Islands	4.3% (2016)
Fiji	3.3% (2017)
Kiribati	5.6% (2020)
Marshall Islands	3.8% (2019)
Nauru	2.5% (2019)
Niue	5.7% (2017)
Palau	3.1% (2020)
Samoa	2.5% (2021)
Tonga	3.8% (2021)
Tuvalu	2.6% (2022)
Vanuatu	3.3% (2020)

Persons with disabilities in the Pacific face challenges similar to those faced by persons with disabilities globally. In the Pacific region, persons with disabilities are more likely to live in poverty, experience poorer health outcomes and have more limited access to essential services, such as health and education. They are also more likely to experience social exclusion and a range of barriers to participation in community life than persons without disabilities. While the situation varies in different Pacific Island countries and territories (PICTs), contextual factors – such as geography, resource capacity and climate vulnerability, common across the region – can exacerbate challenges for persons with disabilities. These variations place the region in a unique context with regard to promoting disability inclusion.

---

[2] Pacific Data Hub. Disability Dashboard https://pacificdata.org/disability-dashboard (accessed 13 June 2025) and country data.

1.2 What is disability?

The meaning and understanding of disability may vary in different contexts. When measuring disability, however, it is important to have a clear and common definition to ensure that the data collected are comparable.

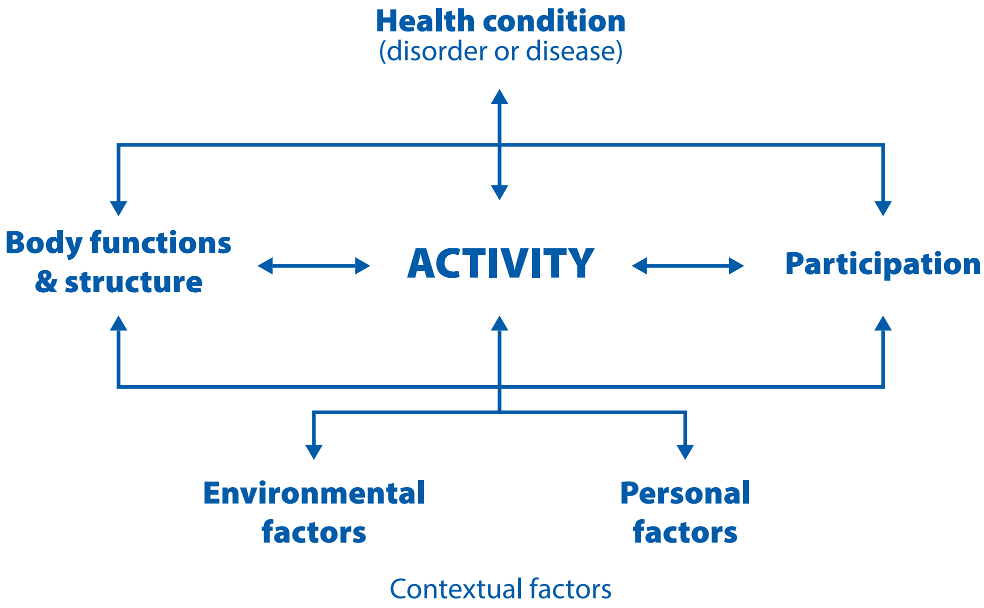
This guidebook uses the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)[3] and the World Health Organization's (WHO) International Classification of Functioning, Health and Disability (ICF)[4] as guiding frameworks for defining and understanding disability.

The UNCRPD describes persons with disabilities as those who have:

- long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder a person's full and effective participation in society on an equal basis with others.

The barriers referred to in this definition can include all types of barriers: physical, attitudinal, communication, financial and institutional barriers.

FIGURE 1. International classification of functioning, disability and health model



Similarly, the ICF model (Figure 1) considers disability to be the result of the negative interaction between a person's health condition and the personal context or environment in which they live. The ICF defines 'disability' as an umbrella term for impairments, activity limitations and participation restrictions, as defined below.

- **Impairment:** problems in body function or structure (includes mental and sensory functions)
- **Activity limitations:** difficulties in completing everyday tasks or actions (e.g. walking, speaking)
- **Participation restrictions:** problems in engaging in everyday life situations (e.g. school, work, community activities)

---

[3] United Nations. (2006). Convention on the Rights of Persons with Disabilities. New York: United Nations. Available at: https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-articles

[4] World Health Organization. (2011). International classification of functioning, disability and health: ICF. Geneva: World Health Organization.

A person's experience of disability may, therefore, be lesser or greater, depending on their personal and environmental context. For example, a person with a mobility impairment who uses a wheelchair may be more restricted in their ability to participate in activities in the community in some contexts compared to others, where physical barriers in the community have been addressed. By identifying and addressing barriers, persons with disabilities can realise their rights to equal participation across all areas of daily and community life.

This conceptualisation of disability as relating to functioning, rather than a diagnosis or condition, enables more consistent identification and, therefore, measurement of disability. This will be addressed further in section 2.

a) Cultural perceptions of disability

Cultural factors and traditional belief systems in many Pacific Island countries affect how people perceive and experience disability. While understanding of disability and its aetiology varies across Pacific Island contexts, traditional cultural beliefs remain present in some communities. Traditional beliefs about disability can attribute functional impairments to supernatural causes, such as sorcery, evil spirits or ancestral curses.[5] This can exacerbate experiences of stigma and social exclusion for persons with disabilities and their families, as well as how individuals might respond to questions about disability. This is particularly worrying for children born with disabilities, whose disability may be perceived as a violation of the mothers' moral responsibilities and may have further implications for caregiving.[6] Persons with invisible disabilities, such as sensory, intellectual, or psychosocial disabilities, may also be at greater risk of discrimination, for example, by being avoided due to fear or superstition.[7]

Cultural beliefs also inform healthcare-seeking behaviour for persons with disabilities and their families. Individuals may delay or avoid seeking medical care or accessing services due to their perceptions of disability. Traditional healers, medicines and other cultural practices are common avenues for seeking care, particularly for conditions believed to have supernatural origins.[8] These practices can include massage, herbal remedies or spiritual rituals and, despite the growing acceptance of western medicines, they remain an important source of care for persons with disabilities in many Pacific Island communities. Further to this challenge at the individual level, systemic level challenges due to negative attitudes and limited understanding of disability by healthcare workers affect the timely and effective management of the healthcare needs of persons with disabilities.

b) Barriers to participation

Challenges to the inclusion of persons with disabilities in the Pacific exist across all sectors. Common barriers relate to the limited availability of high-quality data, resource constraints, inaccessible infrastructure, and challenges related to the unique geography of Pacific Island countries. To ensure that persons with disabilities are included, participating meaningfully and effectively, the barriers need to be removed and necessary support systems should be developed.

---

[5] Kuzma, J., Ramalingam, K. P., & Karthikeyan, P. (2016). Traditional beliefs and care system towards persons with disabilities in Papua New Guinea. Contemporary PNG Studies 25:13–23.

[6] Gartrell, A., Jennaway, M., Manderson, L., Fangalasuu, J., & Dolaiano, S. (2018). Social determinants of disability-based disadvantage in Solomon Islands, Health Promotion International, 22(2):250-260. https://doi.org/10.1093/heapro/daw071

[7] Picton, C., Horsley, M., Knight, B. A. (2016). Exploring conceptualisations of disability: A talanoa approach to understanding cultural frameworks of disability in Samoa. Disability CBR & Inclusive Development, 27(1). https://www.researchgate.net/publication/304955470_Exploring_Conceptualisations_of_Disability_A_Talanoa_approach_to_Understanding_Cultural_Frameworks_of_Disability_in_Samoa

[8] Byford, J., Veenstra, N. (2004). The importance of cultural factors in the planning of rehabilitation services in a remote area of Papua New Guinea. Disability and Rehabilitation, 26(3):166-175. https://doi.org/10.1080/09638280320001159167

Persons with disabilities in the Pacific region are less likely to attend school and often receive fewer years of education compared to their peers without disabilities. The *2022 Pacific Sustainable Development Report* found that less than 10% of all children with disabilities attend school, compared to 70% of children who do not have a disability.[9] A recent review of inclusive education from 15 countries in the region outlined a range of gaps and challenges for achieving equitable and inclusive education for children. The review found that, while countries have laws to support education for all, putting these into practice remains difficult. Specific challenges include workforce capacity to support inclusive education, poor coordination between different government departments, lack of availability of services to support learners, and making schools physically accessible and safe.[10]

In several Pacific Island countries, available data indicate that persons with disabilities are much less likely to be employed than persons without disabilities. However, understanding work or livelihood participation among persons with disabilities is limited due to a lack of good quality, disability-disaggregated data.[11]

The Pacific's heightened vulnerability to climate-related disasters disproportionately affects persons with disabilities. Despite growing awareness, the integration of disability considerations into mainstream disaster risk reduction policies and practices remains limited, as was reflected in the 2023 midterm review of the Sendai Framework for Disaster Risk Reduction.[12] The review found that limited resourcing and minimal budget allocations are barriers to implementing disability-inclusive disaster risk reduction measures. Findings from the report highlighted a lack of disability-disaggregated data specific to Pacific disaster contexts, with only four out of 12 Pacific Sendai Framework Monitor reports addressing disability data since 2015.

There are also known barriers to inclusion for persons with disabilities in healthcare settings. There is a lack of support services[13] and health systems are not adequately resourced to provide comprehensive disability-inclusive care, timely rehabilitation and assistive technology services, or access to longer-term disability support. Workforce shortages remain a significant challenge in many Pacific Island countries, particularly in allied health professions, which limits access to specialised healthcare for persons with disabilities. The absence of a sign language interpreter prevents deaf people from accessing health services. A study in Fiji found that a lack of health worker awareness of disability and referral pathways is a barrier to timely care and support for children with disabilities, and likely applies to all ages.[14] Additional barriers to health care access include geographical isolation, limited transport options, physical inaccessibility of infrastructure, as well as experiences of stigma and discrimination in healthcare settings. These factors collectively contribute to reduced healthcare participation and a higher likelihood of poor health outcomes among persons with disabilities in the Pacific Islands.

---

[9] Pacific Islands Forum Secretariat. (2022). Second quadrennial Pacific sustainable development report. Available at: https://library.sprep.org/sites/default/files/2023-06/2022-06-12-PIF-Final-Report.pdf (accessed 13 June 2025)

[10] United Nations Children's Fund. (2022). Pacific regional inclusive education review. Available at: https://pacificdisability.org/wp-content/uploads/2023/04/Pacific-IE-Report_2022.pdf

[11] The Economic and Social Commission for Asia and the Pacific. (2021). The shaping of disability-inclusive employment in Asia and the Pacific. Available at: https://www.unescap.org/sites/default/d8files/knowledge-products/DAG2021-Final.pdf

[12] United Nations Office for Disaster Risk Reduction. (2023). Midterm review of the Sendai Framework for Disaster Risk Reduction 2015–2030: Thematic report on disability inclusion in disaster risk reduction in the Pacific. Available at: https://www.undrr.org/publication/thematic-report-disability-inclusion-pacific

[13] Support services – services that are specific to persons with disabilities to enable their immediate participation and inclusion

[14] Smith, F., Perera, S., & Marella, M. (2023). The journey to early identification and intervention for children with disabilities in Fiji. International Journal of Environmental Research and Public Health. 20(18):6732. https://doi.org/10.3390/ijerph20186732

c) Intersectionality

There are many intersecting factors that can influence the experience of disability. Intersectionality highlights that people can belong to multiple marginalised identity groups and therefore experience 'intersecting' forms of disadvantage. It is important to recognise diversity among persons with disabilities and understand that the challenges faced by them are often amplified by other forms of disadvantage.

Women and girls with disabilities, for instance, are among the most marginalised. In the Pacific region, women with disabilities are far more likely to live in poverty, have less access to education and employment opportunities, and face greater barriers to full participation in political, economic and social life than men with disabilities or women without disabilities.[15] Women and girls with disabilities are two to three times more likely to be victims of violence, rape and sexual abuse than women without disabilities.[16] This risk is exacerbated for women who have intellectual disabilities; they are approximately 10 times more likely to experience abuse compared to women without disabilities.[17]

Age is another factor that influences experiences of disability. Older persons often under-report their disabilities due to traditional beliefs or the assumption that the decline in functioning cannot be addressed, whilst young persons with disabilities face exclusion from employment opportunities, stemming from limited educational access and a lack of accessible work environments. Persons with disabilities in rural and remote islands may experience specific challenges as a result of geographic isolation, which, for example, may compound issues of transportation, accessible infrastructure and access to services.

There is also a direct and cyclic relationship between poverty and disability. Persons with disabilities are more likely to live in poverty, and those who live in poverty have an increased likelihood of acquiring a disability and having that disability exacerbated. Barriers to education and employment constrain economic opportunities for individuals with disabilities, while the experience of living with disability can create additional household costs associated with healthcare, assistive technology, and transportation.

There are many diverse experiences of disability, and these should be considered through holistic approaches to addressing disability needs.

©UNFPA - Carly Learson

---

[15] Pacific Disability Forum. (2018). From recognition to realisation of rights: Furthering effective partnership for an inclusive 2030. Available at: https://pacificdisability.org/sdg/

[16] Heinicke-Motsch, K. and Sygall, S. eds (2004). Building an inclusive development community. A manual on including people with disabilities in international development programs. Mobility International USA. Available at: https://www.fsnnetwork.org/sites/default/files/building_and_inclusive_development_community.pdf.

[17] ibid

d) Policy and legislative frameworks

Despite these challenges, there is a strong regional commitment to disability-inclusive development in the Pacific region. Most Pacific Island countries have ratified the UNCRPD. Table 2 shows the UNCPRD ratification status and date in the region.

TABLE 2. UN Convention on the Rights of Persons with Disabilities (CPRD) ratification status by country

Country	UNCRPD ratification status (date)[18]
Cook Islands	Ratified (2009)
Fiji	Ratified (2017)
France (New Caledonia, French Polynesia, Wallis and Futuna)	Ratified (2010)
Kiribati	Ratified (2013)
Marshall Islands	Ratified (2015)
Micronesia (Federated States of)	Ratified (2016)
Nauru	Ratified (2012)
Palau	Ratified (2013)
Papua New Guinea	Ratified (2013)
Samoa	Ratified (2016)
Solomon Islands	Ratified (2023)
Tonga	Signatory (2007)
Tuvalu	Ratified (2013)
United States of America (American Samoa, Guam, Northern Mariana Islands)	Signatory (2009)
Vanuatu	Ratified (2008)

At a regional level, the 2016–2025 Pacific Framework for the Rights of Persons with Disabilities (PFRPD)[19] is a framework developed, in line with the Pacific Regional Strategy on Disability, to support Pacific countries in addressing the unique challenges and needs of persons with disabilities. The framework aims to provide a coordinated approach to implementing disability-inclusive development commitments within the specific cultural, geographical and economic contexts of the region. It is anticipated that the Pacific Framework for the Rights of Persons with Disabilities will be updated later in 2025.

A number of Pacific Island countries have developed or are developing national disability policies or action plans. In these policy documents, the definition of disability is typically aligned with the description of disability in the CRPD. Although there is consistency in the description in policy documentation, understanding of disability may vary between contexts and the ways in which disability

---

[18] United Nations Human Rights Office of the High Commissioner. Status of Ratification Interactive Dashboard. Available at: https://indicators.ohchr.org/

[19] Pacific Islands Forum Secretariat. (2016). Pacific Framework for the Rights of Persons with Disabilities 2016-2025. Available at: https://pacificdisability.org/wp-content/uploads/2024/04/Pacific-Framework-Rights-of-PWD.pdf

is measured and reported in national census and sample survey figures.

e) Role of organisations of persons with disabilities

Organisations of persons with disabilities (OPDs) are led and governed by persons with disabilities, and they work to ensure that the rights of persons with disabilities are realised and upheld. OPDs play a representative and advocacy role and may provide services and peer support for persons with disabilities.

The Pacific Disability Forum (PDF) is a regional OPD based in Suva, Fiji. PDF's members are national OPDs from 20 Pacific Island countries and territories (PICTs). PDF is a leader and non-governmental focal point on disability issues, providing support to national OPDs, donors and development partners, civil society and the private sector. PDF aims to ensure that persons with disabilities in PICTs live in an inclusive, barrier-free and rights-based society.[20]

PDF has been instrumental in having the UNCRPD ratified in almost all Pacific Island countries, and in the development and adoption of the PFRPD 2016–2025 by the Pacific Islands Forum Secretariat (PIFS). PDF supports PIFS to implement the framework, chairs the Regional Reference Group on Disability and is a steering committee member of the Pacific Group on Disability Statistics (PGDS).

OPDs throughout the region provide support and advocacy for their members to enable their inclusion and active participation in all areas of daily and community life, from education and healthcare to electoral participation and disaster preparedness, including advocacy for accessible infrastructure, resource allocation and inclusive policies and laws. Their involvement in disability measurement is also critical to ensure data collected is context-specific and is used for advocacy, policy and programming.

f) Data for disability inclusion

Persons with disabilities in the Pacific region have much in common with persons with disabilities around the world, but the unique context of PICTs in terms of culture, geography, climate vulnerability, and availability of services and resources present additional challenges and barriers to the health, well-being, inclusion and participation of persons with disabilities in the region.

While the disability movement in Pacific Island countries is strong, led and supported by PDF and the OPDs of each country, good quality data are still needed to better understand the experiences of Pacific persons with disabilities, their needs, strengths and challenges.

Strengthening data on disability can support advocacy efforts, provide evidence to guide policy and programming, and monitor progress on achieving equity and the realisation of rights for persons with disabilities in the Pacific region.

---

[20] Pacific Disability Forum. (2021). Strategic Plan 2021-2025: Towards an inclusive and resilient Pacific for all persons with disabilities. Available at: https://pacificdisability.org/wp-content/uploads/2022/06/Towards-An-Inclusive-And-Resilient-Pacific.pdf (accessed 28 April 2025).


Data
List of Activ
1. Confrence - 3 Days
2.
3
4.
5.
* List Of Participants
- OPDs
- NSOs

©SPC

2. Measuring disability

Disability cannot be fully measured using a single indicator or approach, like a simple medical diagnosis or a yes/no question. Disability is a complex and multidimensional concept and may require multiple methods to capture its various dimensions. Measuring disability is not just about counting how many people have a disability. It is about identifying the types (socio-demographic and other characteristics) of individuals with disabilities, the types and extent of difficulties they experience, their needs, their level of access to services, participation in the community, barriers experienced, and other health and social outcomes. While most of these indicators can be measured using quantitative data, qualitative data is also required to capture richer information on the situation of persons with disabilities and to monitor progress on disability inclusion. This guidebook focuses on quantitative methods of measuring disability.

2.1 Why measure disability?

BOX 1 | Reasons for measuring disability

Measuring disability is essential to:

- fulfil CRPD and SDGs international commitments;
- ensure that persons with disabilities are seen, counted and included;
- design evidence-based disability inclusive policies and programmes;
- support data-driven advocacy and accountability; and
- resource allocation and budgeting.

To achieve the core commitment of the *Pacific Roadmap for Sustainable Development – Leave No One Behind* – the measurement of disability is not optional, but essential. Persons with disabilities will remain invisible in statistics and excluded from the development agenda if disability data are not collected. Disability disaggregated data will enable countries to monitor SDG progress among persons with disabilities. Valid and reliable disability data facilitate understanding of the situation of persons with disabilities in a population and identify key barriers to inclusion. They allow Pacific Island countries to promote key principles of the *Pacific Framework for the Rights of Persons with Disabilities* (PRFPD) and UNCRPD, such as full and effective participation of persons with disabilities and equal opportunities. Reliable data on disability inform policymakers and development actors to tailor evidence-based disability-inclusive interventions and to monitor the effectiveness of these interventions.

Globally and in the Pacific region, donors and development partners increasingly mandate results-based investments, and there is a growing need to demonstrate how investments are genuinely reaching the target populations. There is also an increasing commitment to disability inclusion as part of development investments, and a need for accountability and transparency on how persons with disabilities are included. Disability disaggregated data are needed to report on the progress of regional frameworks, such as the PRFPD and SGD indicators endorsed for the Pacific community, and the *2050 Strategy for the Blue Pacific Continent*. High-quality disability data enable monitoring disability inclusion over time, demonstrating value for money and transparent reporting of how commitments to disability inclusion are being met as part of development initiatives and investments. This kind of reporting provides accountability to ensure disability-inclusive development is meaningful and not tokenistic.

Disability is a cross-cutting issue affecting people from all walks of life, regardless of age, gender, socio-economic status, ethnicity, geographic location and other factors. The socio-cultural and geographic characteristics of Pacific Island countries, as outlined in the previous chapters, create unique identities and needs for Pacific populations. These intersecting factors can shape how different people experience disability and how inequities occur. It is essential to consider contextual factors in analysing disability data, and it is critical to disaggregate disability data along with other socio-demographic variables, such as age, gender, income level, ethnicity, geographic location, cultural norms and practices and other factors. Intersectional analysis enables a nuanced understanding of which groups are uniquely affected by disability, and highlights which populations need greater investments and targeted interventions to ensure equity. This information is critical for governments and development actors to prioritise and justify investments.

One of the key goals of PRFPD is to develop leadership and enabling environments. This is proposed through strengthening the representation of persons with disabilities in all relevant decision-making bodies, and their active involvement in the development and monitoring of policies and legislation affecting them. Access to reliable disability data empowers Pacific OPDs to actively co-design and develop policies, programmes and evaluations – aligning with the principle of "Nothing without us". It strengthens the advocacy for the rights of persons with disabilities, highlighting inequities around preconditions such as accessibility, support services, access to assistive technology, social protection and non-discrimination.

Disability data can enable Pacific Island countries to ensure that persons with disabilities are visible, counted, and included in their journey towards disability-inclusive sustainable development.

2.2 Approaches to measuring disability

This guidebook adopts the ICF framework for measuring disability, as described in section 2.1. This framework provides a model that applies to all people, and not just those with visible and significant impairments. It is a recommended framework for disability measurement globally and is the foundation for internationally recognised standard disability measurement tools. It is, however, a framework and not a data collection tool. It is necessary to develop a variety of tools under the framework to address different needs for data. This guidebook recommends some of the standard methodologies described below to support disability data collection in the population and housing censuses and national sample surveys in Pacific Island countries.

Multiple indicators are required to measure disability fully because of its multidimensionality but censuses and household surveys are required to be short, simple and easy to administer to large diverse groups of individuals and households with varying abilities, literacy levels and linguistic backgrounds. Large and complex modules for full disability assessment are time consuming, need adaptations to make them context-specific and increase the cost of data collection. Further, specialised training to administer the questions is required. If the questions are not administered appropriately, there are risks of misinterpretation and collecting unreliable data.

The key goals of censuses are to enumerate different population characteristics and collect essential and basic information about various sectors such as health, education and employment. In-depth data collection on any one specific issue, such as disability, requires a dedicated survey. The key objective of collecting disability data in a census is to identify the population with disabilities, calculate prevalence rates, and disaggregate other indicators collected in the census by disability status.

a) What doesn't work?

In the past, disability questions included in the census were simple, with a binary 'yes/no' response to a single question, or they asked about specific categories of impairments or health conditions, or they asked respondents to report themselves as having a disability. The aim was to identify the population with disabilities and classify those with a disability. While these methods were simple, not space-consuming, cost little and did not require technical capacity to include in the census forms, they did not provide reliable or comparable data and under-reported disability prevalence. These approaches are no longer recommended to be used to collect data on disability in population and housing censuses and national sample surveys.

Single question

A single question asking, *"Do you have a disability?"* or *"Does anyone in your household have a disability?"* requires people to respond using yes or no options. While this was assumed to be a straightforward method for identifying disability in the population, it is inconsistently interpreted and significantly underestimates disability prevalence. It assumes that all people have the same understanding of what disability is and that understanding is consistent with the current approach used in the UNCRPD and ICF. This has been shown not to be the case.

Evidence suggests that the use of a single or direct question on disability captures only one-third of the persons with functional difficulties and can identify only those with the most significant and visible impairments.[21] It often fails to identify mild to moderate conditions and those with invisible and hidden conditions, such as sensory and intellectual disabilities.

Directly asking if someone has a disability is stigmatising in many cultures, including the Pacific Islands, and not everyone experiencing functioning limitations identifies themself as having a disability. In Pacific Island communities, disability is sometimes understood in a spiritual context rather than a medical or functional perspective (See section 1.2.a). Age-related functional decline is also often not seen as a disability, but a 'normal' part of the aging experience. Those experiencing this decline can continue to participate in society if accommodations (e.g. hearing support or accessible transportation) are instituted.

There may also not be a single directly translatable word for disability in many Pacific languages so it is difficult to convey this direct question. The words that could be used could be misunderstood and often have negative connotations.

Medical diagnosis or impairments

Some censuses in the past used questions related to specific medical conditions or broad impairment categories. Examples of such questions are shown in Box 2. These types of questions are no longer recommended for disability data collection because they misrepresent and underestimate disability prevalence.

Asking for a medical diagnosis does not work in the Pacific context, as access to health services is limited for some populations because of a lack of services, costs, distance and stigma. Also, asking for a medical diagnosis assumes the respondent understands those conditions, and it may not be the case in many communities where literacy levels are low.

---

[21] Schneider, M. (2019). Why the Washington Group questions ask about 'difficulties' and not 'disabilities'- How a single word can make a difference. Washington Group on Disability Statistics. https://www.washingtongroup-disability.com/wg-blog/why-the-washington-group-questions-ask-about-difficulties-and-not-disabilities-how-a-single-word-can-make-a-difference-108

Impairment-specific questions can also be misunderstood or misinterpreted because of the way they are translated into the local languages. Some of these terms could be considered stigmatising and derogatory. Also, people may not specifically recognise themselves under these labels and may be reluctant to self-identify.

BOX 2 | Example questions of specific medical conditions and impairments

Example question of specific medical conditions:

"Has anyone in your household ever been diagnosed with the following conditions?"

- Blindness
- Deafness or hearing loss
- Intellectual disability
- Mental illness
- Epilepsy
- Paralysis
- Cerebral palsy
- Speech impairment
- Other

Example question of impairment types:

"Does anyone in your household have any of the following impairments?"

- Physical impairment
- Visual impairment
- Hearing impairment
- Intellectual or developmental impairment
- Mental or psychological disability
- Other

2.3 Standardised methods for measuring disability

Standardised methods for disability data collection are necessary to ensure that data on disability are valid, reliable and comparable across different contexts and settings. Applying internationally recommended standards will ensure Pacific disability data are comparable and meaningful to inform disability-inclusive policies and programmes. Standardised methods are especially critical for monitoring progress on global level indicators related to SDGs and CRPD, and regional frameworks such as PRFPD. Standardisation enables alignment to national monitoring systems and these international commitments. Given the unique cultural and logistical contexts of Pacific Island countries and their populations, it is crucial to ensure that context-specific methods are used while adhering to the internationally recommended standards.

a) Washington Group on Disability Statistics (WG)

To address the limitations and complexities of disability data collection in censuses and surveys, the Washington Group on Disability Statistics (WG)[22] was established in 2001 as part of the United Nations Statistical Commission City Groups. Since then, WG has developed a suite of question sets for use in population and housing censuses and other household surveys. The development of the WG tools involved the NSOs of the WG member countries, international subject matter experts, and collaboration with development organisations and OPDs. The questions were cognitively tested and field tested across many countries by regional and international data collection programmes.

Reflecting advances in the conceptualisation of disability under the ICF framework, the WG question sets focus on functioning in basic universal activities, particularly related to activity limitations of the ICF framework, rather than medical conditions or bodily functions/impairments. They focus on basic activities of functioning that are universal – seeing, hearing, walking, remembering, communicating, and self-care. Using this approach is advantageous over other methods discussed above because:

- they do not use the word "disability" in the question, reducing the risks of stigma and under-reporting;
- the use of activity limitations related to basic functions keeps it neutral and translatable to other languages, including Pacific Island languages; and
- reflects the social model of disability, aligning with the CRPD and the ICF.

While these questions do not include all domains of functioning and do not address environmental factors, they are still valid and reliable in identifying the majority of people who are at risk of exclusion from participating in society. When disaggregated data on disability using these question sets are analysed with other variables, comparisons of the situation of persons with disabilities compared to those without disabilities is enabled. These comparisons provide assessments of inequities.

These question sets have been widely adopted and tested globally, including in many PICTs. They were subjected to cognitive testing, field trials and translations across different settings, including low-resource, multilingual and diverse cultural settings. The wide use and adoption of these question sets prove their feasibility to be included in large-scale data systems such as censuses.

The question sets are endorsed by global committees such as the UN Statistical Division, the Inter-agency and Expert Group on SDG Indicators and the UN Department of Economic and Social Affairs due to their effectiveness in identifying people with function difficulties. This endorsement reflects the global consensus on using these question sets as best practice methods for disability data collection.

In the Pacific region, PGDS, which was established as a Regional Disability Statistics Group under the umbrella of WG, supports the NSOs and governments in disability data collection by adopting WG methodologies. This guidebook provides Pacific-specific guidance on using the WG question sets and methodologies. These standardised methods of data collection will support reporting on relevant indicators of PRFPD, SDGs and the *2050 Strategy for the Blue Pacific Continent*.

---

[22] For more information see https://www.washingtongroup-disability.com/
https://www.washingtongroup-disability.com/about/about-the-wg/

Pacific Group on Disability Statistics (PGDS) Project

Multi-Year Work Plan

024-2026

roved by PGDS

9 M

Australian

©SPC

3. Disability data tools

3.1 The Washington Group question sets

The Washington Group developed a suite of question sets to identify persons with disabilities. The most common tools used in the population and housing censuses and other household surveys in Pacific Island countries and globally are:

- the Washington Group Short Set on Functioning (WG-SS);
- the Washington Group Short Set on Functioning – Enhanced (WG-SS Enhanced);
- the Washington Group Extended Set on Functioning (WG-ES); and
- the Washington Group/UNICEF Child Functioning Module (CFM).

This guidebook focuses on these four question sets and describes their purpose, strengths and limitations for use in censuses and national sample surveys. Further details on the questions, their purpose and guidance on how to administer the questions in each of these question sets are provided in section 4.

The WG-SS is increasingly being used in Pacific censuses and surveys, facilitating comparable disability data in the region. While the WG-SS Enhanced and WG-ES are not used in their entirety in Pacific household surveys, such as the household income and expenditure surveys (HIES) and the Labour Force Survey (LFS), some of the additional domains included in these question sets are included in addition to WG-SS. The Child Functioning Module (CFM) has been implemented in the Pacific region as part of multiple indicator cluster surveys and some administrative data systems for education.

The Washington Group has also developed specific modules on disability to be included in broader surveys, such as the Labour Force Survey Disability Module in collaboration with the International Labour Organization; the WG/UNICEF Child Functioning Module – Teacher's Version and the WG/UNICEF Inclusive Education Module in collaboration with UNICEF to be used for informing inclusive education policies and programming. These modules still need to be tested in different Pacific settings and have not yet been used in the region. For more details, see https://www.washingtongroup-disability.com/question-sets/.

a) The Washington Group Short Set on Functioning

The WG Short Set on Functioning (WG-SS) was designed specifically for use in the population and housing census and other household surveys that require a short module that can be easily adopted in different contexts. It comprises a core set of six questions related to the basic function domains that are considered universal across all cultures and settings.

The primary purpose of WG-SS is to identify persons at risk of exclusion from participating in society due to difficulties in these core domains. When WG-SS data are disaggregated by disability status alongside the other demographic and socio-economic variables in surveys, analysis of equity between persons with disabilities and persons without disabilities is enabled.

The six functioning domains are:

- vision (seeing, even when wearing glasses);
- hearing (even when using a hearing aid);
- mobility (walking or climbing steps);

- cognition (remembering or concentrating);
- self-care (such as washing all over or dressing); and
- communication (understanding or being understood).

For each domain, respondents are asked to rate their level of difficulty on a four-point response scale from 'No difficulty' to 'Cannot do at all' (See Box 3). The response scale helps to capture varying degrees of functional difficulty, including situations where people may experience difficulties or those who may not identify as having a disability.

While the WG-SS has more advantages than other tools for inclusion in censuses and surveys due to its brevity, it has limitations. It does not cover all domains of functioning and may not capture people with upper body limitations, psychosocial disabilities, pain and fatigue. The WG-SS seems to identify most people with functional limitations in basic actions, but including more domains is often beyond the scope of the population and housing census. Depending on the purpose of the surveys, other WG question sets that include questions on additional domains can be considered.

The WG-SS is designed for use in censuses and surveys of the general population aged five years and above, with a proxy respondent (e.g. parent) providing information on children. While the WG-SS can be used with children over five years, it is acknowledged that the WG-SS questions were not designed specifically for use with children. They can provide an indication of child functioning in the domains covered, such as children with seeing, hearing and mobility difficulties, but may miss children with other disabilities, particularly developmental or psychosocial disabilities. For data collection specific to child populations, the CFM should be considered.

BOX 3 | Washington Group Short Set on Functioning questions

The next questions ask about difficulties you may have doing certain activities.

- Do/does you/he/she have difficulty seeing, even if wearing glasses?
- Do/does you/he/she have difficulty hearing, even if using a hearing aid(s)?
- Do/does you/he/she have difficulty walking or climbing steps?
- Do/does you/he/she have difficulty remembering or concentrating?
- Do/does you/he/she have difficulty with self-care, such as washing all over or dressing?
- Using your/his/her usual language, do/does you/he/she have difficulty communicating, for example understanding or being understood?

Response options:

Would you say:

- No difficulty
- Some difficulty
- A lot of difficulty
- Cannot do at all

b) The Washington Group Short Set on Functioning – Enhanced

The Washington Group Short Set Enhanced (WG-SS Enhanced) is an expanded version of the six WG Short Set (WG-SS) questions with additional questions on upper body functioning and psychosocial functioning (depression and anxiety). It maintains the strengths of the WG-SS – such as brevity, comparability, and alignment with the ICF – but includes additional questions to improve the identification of persons with disabilities, particularly those who may be excluded from WG-SS due to the limited number of domains covered.

The WG-SS Enhanced covers eight domains, with the first six being the WG-SS domains:

- vision;
- hearing;
- mobility;
- cognition;
- self-care;
- communication;
- upper body functioning; and
- psychosocial functioning (depression & anxiety).

There are two upper body questions that focus mainly on the use of arm, shoulder, hand and wrist movements. The questions ask about gross and fine motor activities as examples, which may not be captured fully by the self-care question in WG-SS. The response scale is the same as the WG-SS for this domain, asking about the level of difficulty on a four-point scale ranging from 'No difficulty' to 'Cannot do at all'.

The questions on psychosocial functioning ask about the frequency and intensity of experiencing anxiety (two questions) and depression (two questions). The questions on frequency have a five-point scale: 'daily', 'weekly', 'monthly', 'a few times a year', and 'never'. The questions asking about intensity of feelings related to anxiety and depression have a three-point response scale: 'a little', 'a lot', and 'somewhere in between a little and a lot'.

The additional questions are taken from the WG Extended Set (WG-ES) that has been tested and widely used (see below). The questions are designed for adults aged 18 years and above in a population-based health survey or disability-specific survey.

This question set is increasingly being used globally but has not been used in its full entirety in the Pacific region.

c) The Washington Group Extended Set on Functioning (WG-ES)

The WG Extended Set (WG-ES) was developed to collect more comprehensive information on functioning for use in specialised household and disability-specific surveys. It addresses the limitations of WG-SS by adding domains of functioning and including more questions under each domain to assess functioning at greater depth.

The WG-ES is for use with adults aged 18 years and above. The response categories are the same as for the WG-SS.

The WG-ES comprises the six domains included in the WG-SS and additional domains:

- upper body functioning;
- pain;
- fatigue;
- psychosocial functioning; and
- additional cognitive domains.

The WG-ES also includes additional questions in the domains of seeing, hearing, cognition and walking. Questions added under each domain are more specific in WG-ES by asking about the use of assistive products for the seeing, hearing and walking domains. In the walking domain, additional questions are included on functioning difficulties with and without the use of assistive products, where applicable, walking different distances and climbing steps. This additional information using WG-ES enables analysis of the severity and frequency of the functional limitations and the availability of support systems that would be useful for planning services and policy making.

The response options vary according to the type of question asked. The WG-SS use the same response categories for the six domains to keep them consistent. Additional questions on cognition, psychosocial functioning, pain and fatigue use frequency scales.

The WG-ES has been widely used in specialised household surveys such as the HIES and LFS globally. It has been extensively cognitively tested in a range of countries. It can support intersectional analysis across various demographic and socio-economic groups to ensure no one is left behind.

While the tool provides greater depth of information on functioning, the WG-ES is not recommended to be used in censuses because of its length and complexity. It requires more training for enumerators and complex data analyses to determine disability status and interpret the data. Careful planning of resources and logistics is required to include this question set in surveys in the Pacific region because it is resource-intensive, and logistics could vary between different countries in the region.

The questions in the WG-ES are designed for the population aged 18 years and above. They are not designed for capturing functioning difficulties among children and adolescents. They do not include questions on developmental aspects that are age-appropriate, and the wording may not be suitable for children and adolescents.

d) The Washington Group/UNICEF Child Functioning Module

The WG, in collaboration with UNICEF, developed the Child Functioning Module (CFM) specifically for collecting reliable and comparable disability data on the child and adolescent population. The CFM addresses the limitations of the WG-SS and WG-ES that may miss identifying many children with developmental disabilities. The CFM enables a standardised method for identifying functioning difficulties among children aged between two and 17 years or at risk of participation restrictions. The

CFM is designed for inclusion as a component of national surveys or in surveys on specific topics, such as health or education.

The CFM includes a range of age-appropriate developmental domains with a version for children in two age groups: 2 to 4 years and five to 17 years. Each version has questions tailored specifically for that age group, recognising that functioning expectations change as children grow. The functional domains included in the CFM are shown in Box 4.

BOX 4 | Functional domains in the Washington Group Child Functioning Module

All ages:

- Vision
- Hearing
- Mobility
- Communication/Comprehension
- Behaviour
- Learning

2–4 years:

- Dexterity/Hand skills
- Playing

5–17 years:

- Self-care
- Memory
- Attention
- Coping with change
- Relationships
- Emotions

Similar to the WG-ES, the questions in CFM include additional details on the use of assistive products, functioning difficulties with and without assistive products, and more than one question in some domains.

The questions are designed to be administered to proxy respondents (e.g. parents or primary caregivers) and, where appropriate, the questions are prefaced with "compared to other children of the same age…". Aligning with WG-SS and WG-ES, standard response options are developed in a rating scale capturing either the level of difficulty or frequency. This type of questioning helps identify children who are at risk of exclusion, compared to children of the same age in the population.

The CFM is an essential tool for the Pacific region, where children form a significant proportion of the population and where access to health, education and community services can vary widely between countries. Identifying children with functioning difficulties early could enable early interventions. This information can help policymakers and service providers in evidence-based planning and resource-allocation to provide inclusive health, education and rehabilitation programmes.

The tool has been extensively tested in a range of countries and translated into different languages. So far, the CFM has been used in the Pacific region as part of MICS in Fiji, Kiribati, Samoa, Tonga, Tuvalu, Vanuatu, Nauru and Federated States of Micronesia, with more surveys planned in the region. These surveys will enable disaggregation of child data to monitor SDG and CRPD indicators in the region.

However, the CFM has limitations because of its complex design, and it is not recommended for censuses. The CFM questions are designed with skip patterns, and the number of questions increases the length of the administration time. The local cultural understandings and perceptions of child development patterns may influence how proxies respond to functioning difficulties of children and may need some adaptations on how questions are translated and administered in the Pacific region. These considerations require specialised training of enumerators and careful planning of resources and logistics unique to the Pacific context.

TABLE 3. Summary of key WG tools

	WG-SS	WG-SS Enhanced	WG-ES	CFM
Population	All people 5 yrs+	Adults	Adults	2–4 years; 5–17 years;
Use	Censuses and household surveys	Household surveys	Household surveys	Household surveys
Purpose	To enable disaggregation of data by disability status	To enable disaggregation of data by disability status	To collect detailed information on disability and functional status in the adult population	To collect detailed information on disability and functional status in the child population
Number of questions	6	12	34 (+3 optional)	2–4 years: 16 5–17 years: 24
Strengths	Short module Widely used and endorsed globally for censuses and surveys Provides comparable data Effective in identifying people who are at risk of participation restrictions	More inclusive than WG-SS alone Enhances identification of invisible disabilities Compatible with census or household surveys	Captures a wide range of functioning domains Richer information for policy and programming	Age-appropriate questions Captures a wide range of functioning domains, including psychosocial, development and learning difficulties Early identification of developmental challenges
Limitations	May miss psychosocial, upper body limitations, pain and fatigue Not for screening specific types of impairments Not designed for children and youth	Slightly longer than WG-SS Requires training on complex questions on psychosocial distress May require contextual adaptation and pre-testing for cultural relevance and clarity Not designed for children and adolescents	Lengthy Resource-intensive Not for censuses May require contextual adaptation and pre-testing for cultural relevance and clarity Not designed for children and adolescents	Complex structure and logic Resource-intensive

3.2 Other tools for measuring disability

While the focus of this guidebook is on disability data collection for censuses and other household surveys, there are also stand-alone tools specifically developed for measuring disability. Disability-specific surveys enable a more comprehensive assessment of disability by collecting detailed information on all domains of the ICF, including impairments, activity limitations, participation restrictions, and contextual factors. This information is critical to understanding the lived experiences of persons with disabilities, their needs, and barriers to accessing services and participation in society. While censuses can provide important information on broader population estimates about disability, and can be used for disaggregation, disability-specific surveys can provide more information on needs for supports and environmental barriers, allowing governments, development actors and service providers to tailor policies and programmes according to the local context.

Some examples of disability data collection tools that can be used in disability-specific surveys are listed here. The Model Disability Survey (MDS) and the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) are widely recognised tools for disability assessments that cover various domains of the ICF framework. These tools need adaptation for the Pacific context, with translations and considerations for socio-cultural contexts. While they are not used in the Pacific region yet, they are briefly described below, along with some other tools.

Disability surveys are being undertaken in the Pacific region as part of disability-inclusive development programmes, with survey tools adapted for specific purposes. Some examples are the Tonga National Disability Survey 2018, the Rapid Assessment of Disability survey as part of disaster response in Vanuatu 2016, and the disability survey as part of a water, sanitation and hygiene (WASH) programme in Vanuatu 2019.

a) Model Disability Survey

The Model Disability Survey (MDS) is a population-based household survey developed by the WHO and the World Bank. It is a comprehensive assessment of disability covering all domains of the ICF and including measures of levels of functioning, health conditions, participation restrictions and environmental barriers. The MDS data allow analysis of the severity of disability and comparisons of inequalities between persons with and without disabilities.

The MDS has been piloted and tested in many countries, including in low-resource settings. The target group for is adults aged 18 years and above. The full survey takes two to two and a half hours to administer. Data analysis requires a high level of technical statistical knowledge.

Further information on the MDS can be found here:
https://www.who.int/publications/i/item/9789241512862.

b) WHO Disability Assessment Schedule 2.0

The WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) is a tool developed by the WHO as a standardised method for measuring health and disability across cultures, based on the ICF framework. Data are collected on functioning in six domains (cognition, mobility, self-care, getting along, life activities, participation). Data from WHODAS 2.0 provide a measure of the effect of any health condition in terms of functioning.

The WHODAS 2.0 was designed for adult populations aged 18 years and above. There are different versions which vary in length. The full version has 36 questions and takes approximately 20 minutes to administer. The version with 12 questions takes about five minutes to administer. The tool also includes versions for self-administration, for interviews and for proxies. There is a standard scoring method developed for analysing data from WHODAS 2.0.

The tool has been translated into many languages and has been extensively tested for validity and reliability in different cultural settings. It has been used as part of population-based surveys and health assessments of individuals in clinical practice.

Further information on the WHODAS 2.0 can be found here:
https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health/who-disability-assessment-schedule

c) The WHO rapid Assistive Technology Assessment

The WHO rapid Assistive Technology Assessment (rATA) is a population-based household survey tool developed by the WHO to collect data on access to assistive technology (AT) for persons with functional difficulties. This survey is not specific to persons with disabilities, but targets anyone with functioning difficulties needing AT. The rATA survey is designed to be a quick method of estimating the need for and use of assistive products within a population. It enables countries to gather nationally representative data that inform policies and services to improve access to essential AT, such as glasses, hearing aids, wheelchairs, prosthetics, and communication devices.

The rATA survey captures data across several key domains, including the types of assistive products used, unmet needs, satisfaction levels, and barriers to access, such as cost, stigma, and availability. It builds on the functional domains commonly used in disability data collection and is intended to support planning and monitoring for universal health coverage, SDGs, and CRPD.

In the Pacific context, access to AT remains limited due to geographic isolation, a shortage of trained providers, and logistical and economic barriers. The rATA survey is especially relevant for Pacific Island countries, as it provides a way to identify population-level needs. The rATA survey is being implemented in some Pacific countries.

Further information on WHO rATA can be found here:
https://www.who.int/tools/ata-toolkit/rata

Key resources:
https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/
https://www.washingtongroup-disability.com/question-sets/wg-extended-set-on-functioning-wg-es/
https://www.washingtongroup-disability.com/question-sets/wg-unicef-child-functioning-module-cfm/


©SPC


©SPC

4. Guidance on including disability questions in surveys

4.1 Recommendation on disability data collection tools in the Pacific surveys

The Pacific Group on Disability Statistics (PGDS), in line with international best practice, makes the following recommendations.

- All national population and housing censuses and national sample surveys conducted in the Pacific region must include the Washington Group Short Set on functioning (WG-SS) with six core functional difficulty questions to collect data on disability.
- For national sample surveys (e.g. HIES, LFS and MICS) and disability-specific surveys, where additional disability data are feasible to collect and an increase in the questionnaire length can be justified, Pacific Island countries and territories are strongly encouraged to use:
    - the Washington Group Short Set on Functioning – Enhanced;
    - the Washington Group Extended Set on Functioning for adults aged 18 years and above; and
    - the WG/UNICEF Child Functioning Module for children aged 2–17 years.
- National statistics offices and relevant survey implementing agencies must incorporate WG-SS questions word-for-word, following approved translations and cultural adaptation protocols recommended in this guidebook.

This recommendation applies to:

- all Pacific Island countries and territories;
- national statistics offices;
- ministries and relevant government agencies conducting household surveys; and
- development actors (e.g. UN agencies, donors, non-governmental organisations, service providers) supporting or conducting surveys.

The PGDS will support technical capacity-building, training (including pre-testing and pilot) and quality assurance for the standard implementation of the question sets. PGDS, in collaboration with OPDs will monitor and report progress in adoption and data quality as part of the regional disability statistics initiative.

4.2 Guidance on the WG question sets for surveys

This guidance outlines the intended purpose and clarifies the meaning of each question. It also provides linguistic and implementation considerations specific to the Pacific context.

a) The WG Short Set on Functioning

The WG-SS has six questions on core functional domains: seeing, hearing, walking, cognition, self-care, and communication. It is recommended to use these core questions as a standard minimum set and not to use a subset of questions in censuses. Omitting any of the questions could lead to underestimates of disability prevalence and discriminating against an impairment group.

Introductory statement

The introduction to the questions is provided below:

- “The next questions ask about difficulties __ may have doing certain activities.”

This statement is specifically designed to support transitioning from one topic to another in censuses. It alerts respondents to a change in the topic and the focus of the next questions (WG-SS) in the new topic. The introduction should be read before administering the questions.

While the questions were developed to be asked directly, many censuses use a household respondent to obtain all information requested. To reflect this usage, the statement is worded for a proxy respondent, which is the usual case in census surveys. For more information on the use of proxy respondents, see the WG website on frequently asked questions: “Can the Short Set be answered by a proxy respondent?” and “Can I ask the WG questions to a single household respondent for all household members?”

The blank space (___) provided in the statement should include a reference to the respondent (i.e. you) or the name of the household member they are responding on behalf of.

Some alternative statements that the WG suggests for consideration are:

- “The next questions ask about difficulties __ may have in doing different activities.”
- “Now I am going to ask you some questions about __’s ability to do different activities.”

The phrasing of this statement DOES NOT include the word ‘disability’ to make sure there is no stigma or negative connotations associated with responding to the questions.

The survey MUST NOT ask a screening question, such as “Does anyone in the household have a disability?” before introducing or asking WG-SS.

It is recommended that enumerators avoid words like “physical difficulties”, “physically challenged”, or “disability” in the heading/title of the topic or sub-section in the census form and the introductory statements. Using these words in headings and introductory statements could mislead the respondents.

The statement does not include any timeframe, allowing the respondents to consider responding according to their usual state of functioning. Testing showed that temporary difficulties were rarely reported when WG-SS was used in its recommended format.

The questions were designed to address difficulties related to the general domain of experiences because of a health condition, not because of a lack of resources, such as having difficulty walking because of not having good roads.

Response categories

Each question asks for the level of difficulty using a four-point rating scale. Enumerators are advised to read out these standard response options after each question.

1. No, no difficulty
2. Yes, some difficulty
3. Yes, a lot of difficulty
4. Cannot do at all

The understanding of 'some difficulty' and 'a lot of difficulty' categories could be difficult to differentiate in some cultural settings and languages. The response categories attempt to describe the level of difficulty along a continuum, as described below.

- 'No difficulty' means no problem at all in doing the activity independently. In other words, it is very easy to do effortlessly without any need for human support or assistive products.
- 'Some difficulty' means it is a little bit hard to do but can still manage it with some minor effort - with a little support, through assistive products or with some adaptations. In some Pacific countries, the translation could be easier with the use of 'a little difficulty'.
- 'A lot of difficulty' means the activity is very hard to do independently and requires a lot of effort, or help from others or use of assistive products.
- 'Cannot do at all' means unable to do the activity independently because it is extremely difficult and needs a significant amount of help from others.

Respondents need to imagine that '*no difficulty*' and '*cannot do at all*' are at each end of the spectrum, with the middle two options spread at an equal distance from the other options. Here is a visualisation that WG recommends explaining the response categories.

To support enumerator training on the descriptors of these response categories, please refer to the guidance document on using the WG/UNICEF Child Functioning Module in the Fiji Education Management Information System.[23]

Questions and their purpose

In Table 4, guidance on each question is provided to ensure that the meaning and intent of the questions are clear, as specified by WG.[24] There are also some comments that could be useful for local adaptation and translations. More information on question specifications is available from the WG website.

---

[23] Fiji Ministry of Education. (2022). Fiji Education Management Information System (FEMIS) Disability disaggregation Package. Guidelines and forms. Available at: https://www.education.gov.fj/wp-content/uploads/2024/09/FEMISdisabilitydisaggregationpackage_March2022.pdf

[24] For more information, see: https://www.washingtongroup-disability.com/implementation/implementation-guidelines/

TABLE 4. WG-SS question specifications and guidance

Domain	Question	Purpose/definitions	Comments
Seeing	Do/does you/he/she have difficulty seeing, even if wearing glasses?	To identify people who have problems with their vision, even when wearing glasses (if they wear glasses). Vision difficulties could be related to seeing things from far or near. For example, to recognise people's faces across the room, reading a sign or a symbol from across the street, or watching TV from a sofa. Examples of near work include reading small font, finding small objects on a table, or threading a needle. The question includes 'even if wearing glasses' to emphasise that respondents need to consider reporting vision difficulties when using glasses, if they use them. Glasses could include any spectacles used for distance or near vision and contact lenses. This question is about their current situation and NOT asking about how their vision would be if glasses were provided.	Glasses or spectacles are most commonly used in many settings. Most times, vision can be improved to the normal expected levels with glasses. In some cases, where there may be a need to change glasses because their vision has changed, the respondent should specify their vision difficulties at that moment. If respondents who use glasses report vision difficulties when they do not use them, the prevalence of disability is overestimated, including those who are not vision impaired.
Hearing	Do/does you/he/she have difficulty hearing, even if using a hearing aid(s)?	To identify people who have problems of any kind with hearing – Hearing in one ear or both ears; hearing in a noisy or quiet environment; or distinguishing sounds from different sources. Some examples of hearing difficulties could be: not hearing when someone is calling them from behind, needing to turn up the volume of TV or radio louder than others do, feeling like people are mumbling, and having trouble hearing in a noisy place like a market.	Hearing aids may not be commonly available and used. In settings where they are not common, it may be difficult for enumerators to explain what hearing aids are. In such cases, asking "…even if wearing a hearing aid" could be omitted. This omission needs to be carefully considered before each survey because there could be an increase in awareness of the need for hearing aids and improved service availability.

Domain	Question	Purpose/definitions	Comments
Hearing (Cont'd)		Hearing aids are products that can help improve hearing ability. If the respondent uses one, they need to consider their hearing difficulty even after using the product. They need to report the current situation and NOT what it would be if they were provided with a hearing aid.	
Mobility	Do/does you/he/she have difficulty walking or climbing steps?	To identify people who have problems with their ability to move around using their legs. Problems could include walking short or long distances, or up or down the steps. The question asks about the capacity to walk or move around without any assistance from another person or an assistive product (e.g. walking stick, crutches or wheelchair). Walking could be related to short distances, long distances, slopes, and unfamiliar areas. Climbing steps refers to walking up or down stairs.	Some of the difficulties in moving or climbing could be because of impairments related to a wide range of conditions affecting their lower limbs (legs), such as amputation, paralysis, cerebral palsy, injury, and arthritis. Some people may also find it difficult to move around because of cardio-pulmonary conditions. This question tries to capture any difficulty walking that is considered a problem.
Cognition	Do/does you/he/she have difficulty learning, remembering or concentrating?	To identify people who have problems with remembering or focusing attention on any task that contributes to difficulty in doing their daily activities. Learning is not included in the standard WG-SS questionnaire, but Pacific stakeholders agreed to include it to capture children with learning difficulties, as census questions are administered to everyone aged five and above. Remembering refers to the use of memory to recall something that happened in the past, which could be in the recent past or a long time ago. It also refers to forgetting things often and needing someone or something to remind them.	This question is NOT asking about remembering and concentrating because of daily life stresses or occasional experiences that may happen to most people. It is also NOT asking about experiences as a result of substance abuse. In Pacific censuses, learning is also included in this question.

Domain	Question	Purpose/definitions	Comments
Cognition (Cont'd)		Examples are forgetting where they keep things, not remembering people they know from the village, or needing someone to remind them what needs to be done next while cooking, weaving or gardening. It may be common to forget some things at times, but if these experiences happen regularly, there could be difficulties with remembering. Concentrating means keeping focused on one thing or a task, the ability to complete a task or learn something new. Some examples are having difficulty paying attention during church, school, or village meetings; trying to plant in the garden but easily getting distracted by other things that are happening around; and needing people to repeat instructions because they cannot focus. If these kinds of things happen often, it may mean that they have trouble concentrating.	
Self-care	Do/does you/he/she have difficulty with self-care, such as washing all over or dressing?	To identify people who have difficulties taking care of themselves for everyday activities. The phrasing of the question uses examples of two self-care activities – washing all over and dressing. 'Washing all over' refers to bathing or cleaning the entire body with water and soap as per the local cultural norms, independently. 'Dressing' refers to putting on clothes independently in a culturally appropriate manner. It includes activities related to gathering clothes that need to be worn, buttoning, zipping and tying a knot.	This question asks for activities that are considered basic day-to-day tasks for managing personal care and hygiene. Examples could be adapted according to the local contexts.

Domain	Question	Purpose/definitions	Comments
Self-care (Cont'd)		Some examples of difficulties with self-care include needing someone to help with cleaning and washing their body; missing parts of the body when washing; finding it hard to put on a shirt, shorts, sulu or dress; needing help buttoning clothes or tying shoelaces; or taking a long time to dress because they find it complicated or too tiring.	
Communication	Do/does you/he/she have difficulty communicating and being understood by others using your/his/her usual language?	To identify people who have problems conveying what they want to say to others using their speech, or understanding what others are saying. The wording of this question is similar to the original WG-SS without changing the intent. This wording is agreed to be used as a standard by Pacific stakeholders to help with translation into local languages. Communication refers to the exchange of information, messages or ideas between people, using their usual language. In this question, communication using speech, sign language and writing is considered. Difficulty communicating focuses on skills related to speech – speaking, listening and understanding speech. The difficulties may be due to hearing or speech impairment, or inability to process the information and respond using words and sentences. Some examples include not speaking words clearly, mixing up words or forgetting words they would normally know, taking a long time to answer, and finding it hard to follow simple spoken instructions.	Communication problems because of language barriers are NOT included in this question.

b) The Washington Group Short Set on Functioning – Enhanced

The Washington Group Short Set on Functioning – Enhanced (WG-SS Enhanced) has 12 questions, with the standard six WG-SS questions and additional questions – two on upper body functioning, four on psychological distress (two on anxiety and two on depression).

The WG-SS Enhanced questionnaire is available from https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-enhanced-wg-ss-enhanced/

Introductory statement

It is recommended to have an introductory statement before asking these questions, the same statement as that of the WG-SS directed to individuals. Since the WG-SS Enhanced is primarily used in household surveys, it is recommended that the subject respond for himself or herself and the wording of the introduction reflects this. Proxies can be included only when individual subjects cannot respond by themselves due to a health problem or functional limitation.

The suggested introduction to the questions is:

- "The next questions ask about difficulties you may have doing certain activities."
- "Now I am going to ask you some questions about your ability to do certain activities."

It should be ensured that the term 'disability' is not used in the introductory statement or the title of the topic, or the sub-section within the survey. It could influence how a respondent answers should they see the form, and it could affect enumerator behaviour. It is not recommended to use any screening questions on disability before introducing the WG-SS Enhanced questions.

Response categories

In the WG-SS Enhanced, three types of response categories are used, depending on the focus of each question. The response category types are:

- level of difficulty;
- frequency of feelings; and
- intensity of feelings.

The domains of seeing, hearing, mobility, cognition, self-care, communication, and upper body functioning have the same response scale as the WG-SS, asking about the level of difficulty on a four-point scale. (See above)

For domains related to psychological distress, questions use response categories that measure frequency and the intensity of feelings, with varying numbers of response options.

Questions and their purpose

Guidance on each question is provided in Table 5 to ensure that the meaning and intent of the questions are clear. There are also some comments that could be useful for local adaptation and translations.

TABLE 5. WG-SS Enhanced question specifications and guidance

Domain	Question	Purpose/definitions	Comments
Seeing	Do you have difficulty seeing, even if wearing glasses?	To identify people who have problems with their vision, even when wearing glasses (if they wear glasses). Vision difficulties could be related to seeing things from far or near. For example, recognising people's faces across the room, reading a sign or a symbol from across the street, or watching TV from a sofa. Examples of near work include reading small font, finding small objects on a table, or threading a needle. The question includes 'even if wearing glasses' to emphasise that respondents need to consider reporting vision difficulties when using glasses, if they use them. Glasses could include any spectacles used for distance or near vision and contact lenses. However, this question is about their current situation and NOT about how their vision would be improved if glasses were provided.	Glasses or spectacles are commonly used in many settings. Most times, vision can be improved to the normal expected levels with glasses. In some cases, where there may be a need to change glasses because their vision has changed, the respondent should specify their vision difficulties at that moment. If respondents who use glasses report vision difficulties when they do not use them, the prevalence of disability is overestimated, including those who are not vision impaired.
Hearing	Do you have difficulty hearing, even if using a hearing aid(s)?	To identify people who have problems of any kind with hearing - Hearing in one ear or both ears; hearing in a noisy or a quiet environment; or distinguishing sounds from different sources. Some examples of hearing difficulties could be: not hearing when someone is calling them from behind, needing to turn up the volume of TV or radio louder than others do, feeling like people are mumbling, and having trouble hearing in a noisy place like a market.	Hearing aids may not be commonly available and used. In settings where they are not common, it may be difficult for the enumerators to explain what hearing aids are. In such cases, asking "…even if wearing a hearing aid" could be omitted. This omission needs to be carefully considered before each survey because there could be an increase in awareness of the need for hearing aids and improved service availability.

Domain	Question	Purpose/definitions	Comments
Hearing (Cont'd)		Hearing aids are products that can help improve hearing ability. If the respondent uses one, they need to consider their hearing difficulty, even after using the product. They need to report the current situation and NOT what it would be if they were provided with a hearing aid.	
Mobility	Do you have difficulty walking or climbing steps?	To identify people who have problems with their ability to move around using their legs. Problems could include walking short or long distances, or up or down steps. The question asks about the capacity to walk or move around without any assistance from another person or an assistive product (e.g. walking stick, crutches, Zimmer frame or wheelchair). Walking could be related to short distances, long distances, slopes, and unfamiliar areas. Climbing steps refers to walking up or down stairs.	Some of the difficulties for moving or climbing could be because of impairments related to a wide range of conditions affecting their lower limbs (legs), such as amputation, paralysis, cerebral palsy, injury and arthritis. Some people may also find it difficult to move around because of cardio-pulmonary conditions. This question tries to capture any difficulty walking that is considered a problem.
Cognition	Do you have difficulty learning, remembering or concentrating?	To identify people who have problems with remembering or focusing attention on any task that contributes to difficulty in doing their daily activities. Learning is not included in the standard WG-SS questionnaire, but Pacific stakeholders agreed to include it to capture children with learning difficulties, as census questions are administered to everyone aged five and above. Remembering refers to the use of memory to recall something that happened in the past, which could be in the recent past or a long time ago. It also refers to forgetting things often and needing someone or something to remind them.	This question is NOT asking about issues with remembering and concentrating because of daily life stresses or occasional experiences that may happen to most people. It is also NOT about experiences as a result of substance abuse. In Pacific censuses, learning is also included in this question.

Domain	Question	Purpose/definitions	Comments
Cognition (Cont'd)		Examples are forgetting where they kept things, not remembering people they know from the village, or needing someone to remind them what needs to be done next while cooking, weaving or gardening. It may be common to forget some things at times, but if these experiences happen regularly, there could be difficulties with remembering. Concentrating means keeping focused on one thing or a task, the ability to complete a task or learn something new. Some examples are having difficulty paying attention during church, school, or village meetings; trying to plant in the garden but easily getting distracted by other things that are happening around; and needing people to repeat instructions because they cannot focus. If these kinds of things happen often, it may mean that they have trouble concentrating.	
Self-care	Do you have difficulty with self-care, such as washing all over or dressing?	To identify people who have difficulty taking care of themselves for everyday activities. The phrasing of the question uses examples of two self-care activities – washing all over and dressing. 'Washing all over' refers to bathing or cleaning the entire body with water and soap as per the local cultural norms, independently. 'Dressing' refers to putting on clothes independently in a culturally appropriate manner. It includes activities related to gathering clothes that need to be worn, buttoning, zipping and tying a knot.	This question asks for activities that are considered basic day-to-day tasks. Examples could be adapted according to the local contexts.

Domain	Question	Purpose/definitions	Comments
Self-care (Cont'd)		Some examples of difficulties with self-care include needing someone to help with cleaning and washing their body; missing parts of the body when washing; finding it hard to put on a shirt, shorts, sulu or dress; needing help buttoning clothes or tying shoelaces; or taking a long time to dress because they find it complicated or too tiring.	
Communication	Do you have difficulty communicating and being understood by others using your usual language?	To identify people who have problems with conveying what they want to say to others using their speech, or understanding what others are saying. The wording of this question is similar to the original WG-SS without changing the intent. It was agreed to be used as a standard by the Pacific stakeholders to help with translation into local languages. Communication refers to the exchange of information, messages or ideas among people using their usual language. In this question, communication using speech, sign language and writing is considered. Difficulty communicating focuses on skills related to speaking, listening and understanding speech. The difficulties may be due to hearing or speech impairment, or the inability of the mind to process the information and respond using words and sentences. Some examples are not speaking words clearly, mixing up words or forgetting words they would normally know, taking a long time to answer, and finding it hard to follow simple spoken instructions.	Communication problems because of language barriers are NOT included in this question.

Domain	Question	Purpose/definitions	Comments
Upper body	UB_1. Do you have difficulty raising a two-litre bottle of water or soda from waist to eye level? UB_2. Do you have difficulty using your hands and fingers, such as picking up small objects, for example, a button or pencil, or opening or closing containers or bottles?	The purpose of these questions is to assess the difficulty in using upper body parts – shoulder, arms, wrists, hands, back and torso. The activities using upper body parts requires coordination of these body parts. UB_1 specifically asks about gross motor skills requiring the use and coordination of arms/shoulders/wrists/hands. The example provided here is a two-litre bottle of water or soda, which is a common object in many country contexts, including the Pacific. UB_2 asks about fine motor skills requiring coordination of hands and fingers to pick up small objects. The examples provided are picking up small objects, for example, a button or pencil, or opening or closing containers or bottles, which are also universally common things to do in many settings, including the Pacific.	These two questions are included to adequately capture the full spectrum of upper body functioning. While the WG-SS Self-care question will identify more complex difficulties of using the upper body, some specific aspects related to gross and fine motor skills cannot be captured.
Psychosocial functioning/ Affect – Anxiety	ANX_1. How often do you feel worried, nervous or anxious? ANX_2. Thinking about the last time you felt worried, nervous or anxious, how would you describe the level of these feelings?	Response categories: ANX_1 • Daily • Weekly • Monthly • A few times a year • Never ANX_2 • A little • A lot • Somewhere in between a little and a lot	The questions are not meant to capture feelings for short-term events. For example, they don't assess the nervousness one might feel when speaking in public or before doing a new activity.

Domain	Question	Purpose/definitions	Comments
Psychosocial functioning/ Affect – Anxiety (Cont'd)		The purpose of these questions is to identify anxiety, which is a condition where people feel worried, afraid, or uneasy, even when there may be no clear reason. It is more than normal worrying, and they often feel something is troubling them, even when there is no danger close by. They could feel shaky, restless, and sometimes have trouble sleeping. Some examples of anxiety could be feeling the heart beating fast, even when resting; finding it hard to sit still and relax; feeling very worried about leaving the house or going to the market, even when there is no danger; or having trouble sleeping because of thinking something bad is going to happen. ANX_1 asks for the frequency of these feelings in terms of days – ranging from daily to never. ANX_2 asks for the intensity of their feelings based on their most recent experience (because the intensity could vary from time to time).	
Psychosocial functioning/ Affect – Depression	DEP_1. How often do you feel depressed?	Response categories: DEP_1 • Daily • Weekly • Monthly • A few times a year • Never	The questions are not meant to capture feelings for short-term events. For example, they don't assess the experience of sadness after losing a loved one, or general feelings of frustration or disappointment when things don't go as planned.
	DEP_2. Thinking about the last time you felt depressed, how depressed did you feel?	DEP_2 • A little • A lot • Somewhere in between a little and a lot	

Domain	Question	Purpose/definitions	Comments
Psychosocial functioning/ Affect – Depression (Cont'd)		The purpose of these questions is to identify depression, which is when someone feels very sad or tired most days. They stop enjoying things around them and find it hard to feel happy, even being around their family and friends. It is more than feeling sad for a day, and it lasts for many days or weeks. Some examples of depression could be feeling heavy and tired, even after resting; feeling hopeless and life not worth living; feeling like a burden on others; or not wanting to join feasts or community events. DEP_1 asks for the frequency of these feelings in terms of days – ranging from daily to never. DEP_2 asks for the intensity of these feelings based on their most recent experience (because the intensity could vary from time to time).	


©DFAT

c) The WG Extended Set on Functioning

The WG-ES includes the core set of WG-SS and additional data on domains related to upper body, psychosocial functioning, pain and fatigue. Additional questions are added under selected domains, such as hearing and walking, and include assessing difficulties with and without assistive products. There are about 35 questions in WG-ES, depending on the skip pattern. If a digital data collection tool is used, the skip logic is usually automated.

The WG-ES questionnaire is available from https://www.washingtongroup-disability.com/question-sets/wg-extended-set-on-functioning-wg-es/

Introductory statement

The introductory statement for this question set follows the standard wording of both the WG-SS and the WG-SS Enhanced. Similarly, it is phrased on the assumption that the respondent is also the subject of the questioning. Where possible, proxy respondents should not be included to answer these questions but can be used if the subject cannot respond for themselves due to functional limitation. In case of children, proxies can be used, but it is highly recommended to use CFM when obtaining information on children because CFM is designed for children and is to be asked to a parent or a primary caregiver.

The introduction to the questions is provided below.

- "The next questions ask about difficulties you may have doing certain activities."

This statement is specifically designed to support transitioning from one topic to another in large surveys. This statement alerts respondents to a change in the topic and what the focus of the next questions (WG-ES) is in the new topic. The difficulties asked about are related to the health context, not a lack of resources, e.g. having difficulty walking because of not having good roads.

Some alternative statements that the WG suggests for consideration are given below.

- "The next questions ask about difficulties you may have in doing different activities."
- "Now I am going to ask you some questions about your ability to do different activities."

These statements DO NOT include the word 'disability' to make sure there is no stigma or negative connotation associated with responding to the questions.

The enumerator MUST NOT ask a screening question, i.e. if the respondent has a disability, before introducing or asking WG-ES.

It is recommended that words like "physical difficulties", "physically challenged", and "disability" in the heading/title of the topic or sub-section in the survey form and the introductory statements are avoided. Using these words could still mislead the respondents if they see them and can also change the behaviour of the enumerator.

The introductory statement does not include any timeframe, except for the pain and fatigue related questions (e.g. during the past six months). The questions were designed to obtain information on the usual state of functioning. Testing showed that temporary difficulties are rarely reported.

Response categories

In the WG-ES, different types of response categories are used, depending on the focus of each question. The response category types are:

- binary: yes/no;
- level of difficulty;
- frequency of feelings;
- intensity of feelings; and
- type of assistive products used.

The same four-point response scale for the level of difficulty used in WG-SS is used for the domains of seeing, hearing, mobility, cognition, self-care, communication, and upper body functioning.

For domains related to psychosocial functioning and parts of cognition, questions use response categories that measure frequency and the intensity of feelings, with varying numbers of response options.

A binary response scale is included for questions that ask whether a person uses assistive products and medication. Questions on the use of assistive products are included in the domains of vision, hearing, mobility and communication. A skip pattern is triggered when an individual reports using assistive products, which directs them to the next relevant question on the level of difficulty, with or without the use of assistive products.

Only the mobility domain includes a question on what type of assistive product is used and also includes questions on walking two distances.

Questions and their purpose

In Table 6, guidance on each question is provided to ensure that the meaning and intent of the questions are clear. There are also some comments that could be useful for local adaptation and translations. Considering the different response categories used, details on response categories and skip logic are also included in the next tables.

TABLE 6. WG-ES question specifications and guidance

Domain	Questions	Response options	Purpose and comments
Vision	VIS_1. Do you wear glasses? Yes/No	• Yes • No	Response to this question will trigger a skip pattern for the next question. Glasses could include any spectacles used for distance or near vision and contact lenses.
	If VIS_1 is Yes: VIS_2a. Do you have difficulty seeing, even if wearing glasses? If VIS_1 is No: VIS_2b. Do you have difficulty seeing?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of these questions is the same as those in the WG-SS. The question includes "…even when wearing glasses" ONLY if they responded 'yes' to using glasses in VIS_1. This phrasing makes it easier for the respondent to understand, as it is more specific. For details on the purpose and examples, see section 3.1.a).
	VIS_3. Do you have difficulty clearly seeing someone's face across a room [even when wearing glasses]?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	This is an optional question. The question asks about difficulty with distance vision activity with an example. If VIS_1 is 'Yes', the question should be asked with '…even when wearing glasses'. If a digital data collection tool is used, the skip logic works automatically.
	VIS_4. Do you have difficulty clearly seeing the picture on a coin [even when wearing glasses]?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	This is an optional question. The question asks about difficulty with near vision activity with an example. Countries may choose to replace "the picture of a coin" with an equivalent item. For example, weaving, threading a needle, and reading small print. If VIS_1 is 'Yes', the question should be asked with '…even when wearing glasses'. If a digital data collection tool is used, the skip logic works automatically.
Hearing	HEAR_1. Do you use a hearing aid? Yes/No	• Yes • No	Response to this question will trigger a skip pattern for the next question.

Domain	Questions	Response options	Purpose and comments
Hearing (Cont'd)	If HEAR_1 is Yes: HEAR_2a. Do you have difficulty hearing, even if using a hearing aid? If HEAR_1 is No: HEAR_2b. Do you have difficulty hearing?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of these questions is the same as those in the WG-SS. The question includes "… even when using a hearing aid" ONLY if they responded 'yes' to using a hearing aid. This phrasing makes it easier for the respondent to understand, as it is more specific. For details on the purpose and examples, see section 3.1.a).
	If HEAR_1 is Yes: HEAR_3. How often do you use your hearing aid(s)?	• All of the time • Some of the time • Rarely • Never	This is an optional question. It uses a frequency scale to assess the use of the hearing aid. This question is asked if HEAR_1 is 'yes'.
	HEAR_4. Do you have difficulty hearing what is said in a conversation with one other person in a quiet room [even when using your hearing aid(s)]? HEAR_5. Do you have difficulty hearing what is said in a conversation with one other person in a noisier room [even when using your hearing aid(s)]?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	These are additional questions to what was included in the WG-SS, and they intend to identify the severity of hearing difficulty. The first question asks about the ability to hear in a quiet room (easier activity), and the second one asks for the ability of hearing in noisier room (more difficult activity). Most people may find it hard to hear in a noisier room, but difficulty hearing in a quiet room indicates moderate to severe hearing impairment and may be more likely to be at risk of participation restriction.
Mobility	MOB_1. Do you have difficulty walking or climbing steps?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	Same as the WG-SS. For details on the purpose and examples, see section 3.1.a).

Domain	Questions	Response options	Purpose and comments
Mobility (Cont'd)	MOB_2. Do you use any equipment or receive help for getting around?	• Yes • No	Response to this question will trigger a skip pattern for the next question. Equipment refers to mobility products (e.g. cane or walking stick, walker or Zimmer frame, crutches, wheelchair or scooter, prosthesis (artificial limb), or someone's assistance) used to assist with moving around or postural support – see the list in MOB_3. These products are designed to help people move around independently and safely.
	If MOB_2 is Yes: MOB_3. Do you use any of the following?	• Cane or walking stick? • Walker or Zimmer frame? • Crutches? • Wheelchair or scooter? • Artificial limb (leg/foot)? • Someone's assistance? • Other (please specify):	This question is asked only for those who respond 'yes' to the question above. The most commonly used mobility products are listed in the response options. Other commonly used products can be added to the list as needed. These products can be prescribed or self-made.
	MOB_4. Do you have difficulty walking 100 metres on level ground, i.e. about the length of one football field or one city block [without the use of your assistive device]? MOB_5. Do you have difficulty walking half a km on level ground, i.e. about the length of five football fields or five city blocks [without the use of your assistive device]?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	These are additional questions in the mobility domain to capture varying levels of difficulty walking based on different circumstances – short or long distances and climbing about 12 steps. For those who use mobility products, all questions are asked to assess difficulty walking with and without products. Questions about walking **without** an assistive product assess the individual's capacity to walk, while asking **with** the assistive product captures their performance with support. For those who do not use an assistive product, MOB_4 and MOB_5 are asked without reading the text in the brackets. If a digital data collection tool is used, the skip logic will adjust the wording automatically.

Domain	Questions	Response options	Purpose and comments
Mobility (Cont'd)	MOB_6. Do you have difficulty walking up or down 12 steps? MOB_7. Do you have difficulty walking 100 metres on level ground, i.e. about the length of one football field or one city block, when using your aid? MOB_8. Do you have difficulty walking half a km on level ground, i.e. about the length of five football fields or five city blocks, when using your aid?		Walking a short distance should be easier for someone who is able to walk longer distances. For those who have difficulty walking short distances, this indicates severe mobility difficulties. And for those who have difficulty walking long distances but no difficulty walking short distances, this indicates mild to moderate mobility difficulties, and that they may have participation restrictions. While an example is provided for short and long distances, other examples could be used. Some examples are provided below. **Short distances:** • Walking from the garden to your house • Walking across the street to go to a neighbour's house • Walking across the school yard **Long distances:** • Walking from your house to the village meeting place • Walking from home to the local market • Walking to the church or school MOB_6 is asked for all respondents, irrespective of the use of a mobility product. It does not refer to climbing up a ladder or climbing rocks – it refers to steps in a home, building or a path. Climbing up 12 steps refers to going up a staircase without stopping. This could be something like going up one floor in a building, going up stairs to a raised house, or climbing up a small hill path that has built steps.
Communication	COM_1. Using your usual language, do you have difficulty communicating (for example understanding or being understood by others)?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	Same as the WG-SS. For details on the purpose and examples, see section 3.1.a).

Domain	**Questions**	**Response options**	**Purpose and comments**
Communication (Cont'd)	COM_2. Do you use sign language?	- Yes - No	Sign language is used by people with hearing and speech impairments to communicate with others. When combined with the COM_1 response, this question will help to understand how many are reporting communication difficulties, even with sign language. When someone's usual language of communication is sign language, they may have no difficulty communicating when others can sign, but may experience difficulty when others don't use sign language.
Cognition	COG_1. Do you have difficulty remembering or concentrating? COG_2. Do you have difficulty remembering, concentrating, or both? COG_3. How often do you have difficulty remembering? COG_4. Do you have difficulty remembering a few things, a lot of things, or almost everything?	COG_1, COG_2, COG_3 - No, no difficulty - Yes, some difficulty - Yes, a lot of difficulty - Cannot do it at all COG_3 - Sometimes - Often - All of the time	COG_1 and the terms 'remembering' and 'concentrating' are the same as the WG-SS question. See section 3.1.a) for details on its purpose and examples. The additional questions enable assessment of the extent of difficulties with cognitive functioning. COG_2 differentiates the two concepts and asks whether they have difficulties with one or both aspects of functioning. COG_3 asks about the frequency, and COG_4 asks about the extent of difficulty remembering.
Self-care	SC_SS. Do you have difficulty with self-care, such as washing all over or dressing?	- No, no difficulty - Yes, some difficulty - Yes, a lot of difficulty - Cannot do it at all	Same as the WG-SS. For details on the purpose and examples, see section 3.1.a).

Domain	Questions	Response options	Purpose and comments
Upper body	UB_1. Do you have difficulty raising a two-litre bottle of water or soda from waist to eye level? UB_2. Do you have difficulty using your hands and fingers, such as picking up small objects, for example, a button or pencil, or opening or closing containers or bottles?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of these questions is to assess the difficulty in using upper body parts – shoulder, arms, wrist, hands, back and torso. The activities using the upper body parts require coordination of these body parts. UB_1 specifically asks about gross motor skills requiring the use and coordination of arms/shoulders/wrists/hands. The example provided here is a two-litre bottle of water or soda, which is a common object in many country contexts, including the Pacific. UB_2 asks about fine motor skills requiring coordination of hands and fingers to pick up small objects. The examples provided are picking up small objects, for example, a button or pencil, or opening or closing containers or bottles, which are also universally common things to do in many settings, including the Pacific.
Psychosocial functioning / Affect – Anxiety	ANX_1. How often do you feel worried, nervous or anxious?	ANX_1 • Daily • Weekly • Monthly • A few times a year • Never	The purpose of these questions is to identify anxiety, which is a condition where people feel worried, afraid or uneasy, even when there may be no clear reason. It is more than normal worrying, and they often feel something is troubling them, even when there is no danger close by. They could feel shaky, restless, and sometimes have trouble sleeping. Some examples of anxiety could be feeling the heart beat fast even when resting; finding it hard to sit still and relax; feeling very worried about leaving the house or going to the market, even when there is no danger; or having trouble sleeping because of thinking something bad is going to happen. ANX_1 asks for the frequency of these feelings in terms of days – ranging from daily to never.
	ANX_2. Do you take medication for these feelings?	ANX_2 • Yes • No	ANX_2 asks for the use of medication. Some people may be using medication for their anxiety issues. People may choose to respond about their feelings and emotional status after taking their mood-regulation medication in this domain.

Domain	Questions	Response options	Purpose and comments
Psychosocial functioning / Affect – Anxiety (Cont'd)	ANX_3. Thinking about the last time you felt worried, nervous or anxious, how would you describe the level of these feelings?	ANX_3 • A little • A lot • Somewhere in between a little and a lot	ANX_3 asks for the intensity of their feelings based on their most recent experience, because the intensity could vary from time to time.
Psychosocial functioning / Affect – Depression	DEP_1. How often do you feel depressed? DEP_2. Do you take medication for depression? DEP_3. Thinking about the last time you felt depressed, how depressed did you feel?	DEP_1 • Daily • Weekly • Monthly • A few times a year • Never DEP_2 • Yes • No DEP_3 • A little • A lot • Somewhere in between a little and a lot	The purpose of these questions is to identify depression, which is when someone feels very sad or tired most days. They stop enjoying things around them and find it hard to feel happy, even when being around their family and friends. It is more than feeling sad for a day, and it lasts for many days or weeks. Some examples of depression could be feeling heavy and tired even after resting, feeling hopeless and life not worth living, feeling like a burden on others, or not wanting to join feasts or community events. DEP_1 asks for the frequency of these feelings in terms of days – ranging from daily to never. DEP_2 asks for the use of medication. Some people may be using medication for their depression. People may choose to respond about their feelings and emotional status after taking their mood-regulation medication in this domain. DEP_3 asks for the intensity of their feelings based on their most recent experience, because the intensity could vary from time to time.
Pain	PAIN_1. In the past 3 months, how often did you have pain?	PAIN_1 • Never • Some days • Most days • Every day	The purpose of these questions is to identify people who experience pain, whether it is physical or psychological, that can limit their participation in daily life. Pain is an experience and not a core domain of functioning. However, people may have participation restrictions because of the extent and frequency of pain.

Domain	Questions	Response options	Purpose and comments
Pain (Cont'd)	PAIN_2. Thinking about the last time you had pain, how much pain did you have?	PAIN_2 • A little • A lot • Somewhere in between a little and a lot	Pain could be experienced by people in different ways with varying intensity and frequency, and may not be related to a diagnosable condition. Pain is measured using both frequency (PAIN_1) and intensity (PAIN_2) measures. The response categories are different to the earlier questions. People may choose to respond to their experience of pain with medication, if they use any.
Fatigue	TIRED_1. In the past 3 months, how often did you feel very tired or exhausted? TIRED_2. Thinking about the last time you felt very tired or exhausted, how long did it last? TIRED_3. Thinking about the last time you felt this way, how would you describe the level of tiredness?	TIRED_1 • Never • Some days • Most days • Every day TIRED_2 • Some of the day • Most of the day • All of the day TIRED_3 • A little • A lot • Somewhere in between a little and a lot	The purpose of these questions is to identify people who experience tiredness physically, mentally or through the senses, or a combination of those. Similar to pain, fatigue is an experience and not a core functioning domain. The level and frequency of fatigue could affect how people participate in society. Fatigue or tiredness is measured by its frequency and intensity. TIRED_1 asks about the frequency of the experience. TIRED_2 asks about how long the most recent occurrence lasted. TIRED_3 asks about the extent of tiredness based on their most recent experience. The level of fatigue can vary from time to time, so TIRED_3 focuses on the most recent experience.

d) The WG/UNICEF Child Functioning Module

The CFM was developed to identify disability among children, and it has two versions, one for children aged 2–4 years and one for children aged 5–17 years. There are 16 questions in the 2–4 years version and 24 questions in 5–17 years old version, across 13 domains: vision, hearing, mobility, communication/comprehension, behaviour and learning (all ages); dexterity and playing (2–4 years); and self-care, remembering, focusing attention, coping with change, relationships and emotions (5–17 years). This questionnaire also uses a skip pattern to ask questions, and can be automated with a digital data collection tool.

The questions are designed to be administered to the child's mother or a primary caregiver. The questionnaire administration is estimated to take an average 5 to 10 minutes per child, but may take longer, depending on the respondent.

For further guidance on CFM questions and their administration, see https://data.unicef.org/resources/module-on-child-functioning-manual-for-interviewers/.

Introductory statement

The introductory statement to CFM is similar to that of other WG question sets but worded for asking a proxy.

The introduction to the questions is provided below.

- "I would like to ask you some questions about difficulties your child may have."

Some alternative statements for consideration are given below.

- "Now I am going to ask you some questions about the child's ability to do certain activities. Please tell me how your child usually does these things, compared to children of the same age."
- "Now I'd like to ask you some questions about your child's everyday activities. These questions help us understand how children learn, play, move, see, hear, and communicate. There are no right or wrong answers. Please tell me how your child usually does these things, compared to children of the same age."

The phrasing of these statements DOES NOT include the word 'disability' to make sure there is no stigma or negative connotations associated with responding to the questions.

The survey MUST NOT ask a screening question, such as "Does your child have a disability?" before introducing or asking CFM.

Words like "physical difficulties", "physically challenged", or "disability" in the heading/title of the topic or sub-section should be avoided in the census form and the introductory statements. Using these words in the headings and the introductory statements could still mislead the respondents if they should see them and can influence enumerator behaviour.

The introductory statement does not specify a reference period, thereby enabling respondents to provide answers that reflect the child's usual functioning difficulties.

Response categories

The CFM includes multiple response categories, depending on the focus of each question. The response category types are:

- binary: yes/no;
- level of difficulty;
- frequency of feelings; and
- intensity of certain behaviours.

The same four-point response scale for the level of difficulty used in WG-SS is used for all domains, except for behaviour and emotions. The frequency of feelings is asked for emotions in the 5–17 years old version. The behaviour question in the 2–4 years old version asks about the intensity of certain behaviours.

A binary response scale is included for questions that ask whether a person uses assistive products for the domains of vision, hearing and mobility.

The response categories may not always be easy for respondents to understand and rate the level of functioning of their child. Descriptors to assist in selecting the appropriate response categories that are close to the child's situation are provided in a guidance document for using CFM in the Fiji Education Management Information System (FEMIS). These descriptors could be used for the training of enumerators.[25]

Questions and their purpose

In Table 7, guidance on each question is provided to ensure that the meaning and intent of the questions are clear. There are also some comments that could be useful for local adaptation and translations. For more information on the implementation of the CFM and other important logistical details, see the Module on Child Functioning: Manual for interviewers.[26]

---

[25] Fiji Ministry of Education 2022. Fiji Education Management Information System (FEMIS) Disability disaggregation Package. Guidelines and forms. Available at: https://www.education.gov.fj/wp-content/uploads/2024/09/FEMISdisabilitydisaggregationpackage_March2022.pdf

[26] United Nations Children's Fund 2018. Module on child functioning: Manual for interviewers. Available at: https://data.unicef.org/resources/module-on-child-functioning-manual-for-interviewers/

TABLE 7. WG/UNICEF Child Funtioning Module question specifications and guidance

Domain	Questions	Response options	Purpose and comments
Vision	**2 to 4 years** CF1. Does (name) wear glasses? CF2. When wearing his/her glasses, does (name) have difficulty seeing? CF3. Does (name) have difficulty seeing? **5 to 17 years** CF1. Does (name) wear glasses or contact lenses? CF2. When wearing his/her glasses, does (name) have difficulty seeing? CF3. Does (name) have difficulty seeing?	CF1 • Yes • No CF2 and CF3 • No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	Response to CF1 will trigger a skip pattern for the next question. If yes, CF2 is asked and if no, CF3 is asked. This question identifies children with vision difficulties. The term 'glasses' is used in this question but it could also include contact lenses. However, contact lenses are rarely used among younger children (2–4 years) not asked in that group. CF2 and CF3 are the same for both age groups. The purpose of vision questions is the same as WG-SS. For details on the purpose and examples, see section 4.2.a).
Hearing	CF4. Does (name) use a hearing aid? CF5. When using his/her hearing aid, does (name) have difficulty hearing sounds like people's voices or music? CF6. Does (name) have difficulty hearing sounds like people's voices or music?	CF4 • Yes • No CF5 and CF6 • No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	Response to CF4 will trigger a skip pattern for the next question. If yes, CF5 is asked and if no, CF6 is asked. The questions are the same for both age groups. The purpose of hearing questions is the same as WG-SS. For details on the purpose and examples, see section 4.2.a).

Domain	Questions	Response options	Purpose and comments
Mobility	**2 to 4 years** CF7. Does (name) use any equipment or receive assistance for walking? CF8. Without his/her equipment or assistance, does (name) have difficulty walking? CF9. With his/her equipment or assistance, does (name) have difficulty walking? CF10. Compared with children of the same age, does (name) have difficulty walking? **5 to 17 years** CF7. Does (name) use any equipment or receive assistance for walking? CF8. Without his/her equipment or assistance, does (name) have difficulty walking 100 yards/metres on level ground, i.e. about the length of one football field?	CF7 • Yes • No CF8-CF10 (2–4 years) and CF8-CF13 (5–17 years) • No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	Response to CF7 will trigger a skip pattern for the next question. If a digital data collection tool is used, the skip logic will adjust the wording automatically. The purpose of this domain is to identify children with walking difficulties. For children who use mobility products (e.g. wheelchairs, walking sticks, and crutches), all questions are asked to assess difficulty walking with and without the products. Questions about walking **without** an assistive product assess the child's capacity to walk, while asking **with** the assistive product captures their performance with support. The questions for 2–4 years old are only asked about their ability to walk in general and in comparison to children of the same age, recognising that children at this stage are still developing their walking abilities. Since most children would independently walk by the age of two, the question focuses on the physical activity of walking rather than distance. For children aged 5–17 years, more specific questions on walking short and long distances are asked. The questions ask with and without mobility products, where applicable and compared to children of the same age. Walking a short distance should be easier for someone who is able to walk longer distances. Walking short distances with difficulty indicates severe mobility difficulties. Those who have difficulty walking long distances but no difficulty walking short distances, experience mild to moderate mobility difficulties, and may have participation restrictions.

Domain	Questions	Response options	Purpose and comments
Mobility (Cont'd)	[Or insert country specific example]. CF9. Without his/her equipment or assistance, does (name) have difficulty walking 500 yards/metres on level ground, i.e. about the length of five football fields? [Or insert country specific example]. CF10. With his/her equipment or assistance, does (name) have difficulty walking 100 yards/metres on level ground, i.e. about the length of one football field? [Or insert country specific example]. CF11. With his/her equipment or assistance, does (name) have difficulty walking 500 yards/metres on level ground, i.e. about the length of five football fields? [Or insert country specific example]. CF12. Compared with children of the same age, does (name) have difficulty walking 100 yards/metres on level ground, i.e. about the length of one football field?		While an example is provided for short and long distances in the questions, other examples could be used. Some other examples are provided below. **Short distances:** • Walking from the garden to your house • Walking across the street to go to a neighbour's house • Walking across the school yard **Long distances:** • Walking from your house to the village meeting place • Walking from home to the local market • Walking to the church or school

Domain	Questions	Response options	Purpose and comments
Mobility (Cont'd)	[Or insert country specific example]. CF13. Compared with children of the same age, does (name) have difficulty walking 500 yards/metres on level ground, i.e. about the length of five football fields?		
Self-care	**5 to 17 years** CF14. Does (name) have difficulty with self-care such as feeding or dressing him/herself?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	This question is only asked for 5–17 years as children aged 2–4 years may not develop these skills to perform independently. This question is similar to the one in WG-SS, but asks for feeding and dressing, the basic tasks most children can perform independently within the age group in many cultures. For details on the purpose and examples, see section 4.2.a).
Fine motor skills	**2 to 4 years** CF11. Compared with children of the same age, does (name) have difficulty picking up small objects with his/her hand?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of this domain is to capture difficulties in coordinating hands and fingers. Typically, most children would develop fine motor skills by about 12 months, being able to pick up small objects using their fingers. Some examples could be picking up small pebbles, marbles and shells. Fine motor skills are covered in the question related to feeding and dressing (CF14) for 5–17 years old, so this question is not asked.
Communication/ comprehension	**2 to 4 years** CF12. Does (name) have difficulty understanding you? CF13. When (name) speaks, do you have difficulty understanding him/her?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of this domain is to identify children with difficulties conveying what they want to say to others, or understanding what others are saying. Speech may not be fully developed for children aged 2–4 years but they use a combination of communication methods with speech, and non-verbal communication such as signs/gestures and body language.

Domain	Questions	Response options	Purpose and comments
Communication/ comprehension (Cont'd)	**5 to 17 years** CF15. When (name) speaks, does he/she have difficulty being understood by people in this household? CF16. When (name) speaks, does he/she have difficulty being understood by people outside this household?		CF12 focuses on the ability of the child to understand what is communicated to them, including instructions and everyday conversation. CF13 focuses on the clarity of the child's speech to express what they want to say to others. For 5–17 years old, this domain focuses on more specific questions about the speaking ability of the child. Understanding other people's communication is covered in the cognition related domains. CF15 focuses on the familiar context, among the household members, and CF16 focuses on less familiar people outside the household. Household members are family members and are familiar to the child. They may be able to understand what the child says, even when they have difficulty speaking because they may be used to the child's body language and gestures (non-verbal communication). However, less familiar people, i.e. people who don't live with the child (e.g. teachers, neighbours) may find it difficult to understand if the child has difficulties speaking.
Learning	**2 to 4 years** CF14. Compared with children of the same age, does (name) have difficulty learning things? **5 to 17 years** CF17. Compared with children of the same age, does (name) have difficulty learning things?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of this domain is to identify children with cognition difficulties specifically related to their ability to learn new things, e.g. new words, songs, or how to do new tasks. The questions are the same for both age groups.

Domain	Questions	Response options	Purpose and comments
Remembering	**5 to 17 years** CF18. Compared with children of the same age, does (name) have difficulty remembering things?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of this question is to identify people who have problems with the use of memory to recall something they have been told or experienced. These may include remembering people, names, songs, routines, and things learned at school. It may be common to forget some things at times, but if these experiences happen regularly, there could be difficulties with remembering. Remembering is not a skill that children aged 2–4 years are expected to have developed. Therefore, this question is not included in the 2–4 years version.
Playing	**2 to 4 years** CF15. Compared with children of the same age, does (name) have difficulty playing?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of this question is to identify children who find it harder than most children their age to play. For example, playing alone or with others, using toys, games, or engaging in make-believe or group activities. Playing is a general indicator of overall development and participation in a child's social life. This question is asked only of the 2–4 years age group. Play is an important activity as part of the development in this age group. It helps with social, emotional, cognitive and physical skills. For 5–17 years, skills related to emotions, relationships, and attention are included in other domains.

Domain	Questions	Response options	Purpose and comments
Attention and concentrating	**5 to 17 years** CF19. Does (name) have difficulty concentrating on an activity that he/she enjoys doing?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of this question is to identify children who have problems focusing on any task. Concentrating means keeping focused on one thing or a task, the ability to complete a task or learn something new. These include paying attention at school, drawing, listening to a story or playing games. If they frequently lose interest quickly, easily get distracted by other things that are happening around and need people to repeat instructions because they cannot focus, it may mean that they have trouble concentrating. Children aged 2–4 years do not have the ability to stay focused for more than a few minutes. Therefore, this question is not included in the 2–4 years old version.
Coping with change	**5 to 17 years** CF20. Does (name) have difficulty accepting changes in his/her routine?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of this question is to identify children with cognitive and emotional difficulties who have trouble adjusting when things do not go as they expected or when regular activities or schedules are disrupted. The question may help identify children with challenging behaviours and those who experience anxiety and distress, which are seen in certain developmental conditions. Some examples are a child becoming angry or upset if their usual food is not served or their usual caregiver is not home as expected; refusing to go to school if the usual transport changes; or has trouble calming down if plans for visiting somewhere are unexpectedly cancelled. For 2–4 years old children, difficulties in understanding changes to routine is an expected behaviour, so the question is not included.

Domain	Questions	Response options	Purpose and comments
Controlling behaviour	**2 to 4 years** CF16. Compared with children of the same age, how much does (name) kick, bite or hit other children or adults? **5 to 17 years** CF21. Compared with children of the same age, does (name) have difficulty controlling his/her behaviour?	2 to 4 years CF16 • Not at all • The same or less • More • A lot more 5 to 17 years: CF21 • No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of this domain is to identify children of different ages who have difficulty with emotional regulation and self-control. CF16 asks about aggressive behaviour in younger children and about the intensity of the behaviour when compared to other children. Examples are kicking, biting, hitting, throwing things and screaming. Most children aged 2–4 years might express these behaviours, but this question captures children with intense behaviours that are beyond what is typical for their age. CF21 focuses on the child's ability to demonstrate self-control over their emotions. Examples of a lack of self control are not following rules, getting into fights or overreacting emotionally.
Relationships/ making friends	**5 to 17 years** CF22. Does (name) have difficulty making friends?	• No, no difficulty • Yes, some difficulty • Yes, a lot of difficulty • Cannot do it at all	The purpose of this question is to identify children experiencing difficulties in social interactions related to making friends with children of a similar age. This may be due to developmental, behavioural, or emotional difficulties. For example, a child is often left out, struggles to socialise or play with other children, and has trouble getting along with peers. Since children 2–4 years old typically do not build relationships with new people other than their family and familiar people, this question is not included.
Emotions	**5 to 17 years** CF23. How often does (name) seem very anxious, nervous or worried?	• Daily • Weekly • Monthly • A few times a year • Never	The purpose of these questions is to identify children with anxiety and depression observed over time. CF23 focuses on anxiety, which is a condition where people feel worried, afraid, uneasy, even when there may be no clear reason. Examples are excessive worry about school or daily activities, and avoiding situations or people due to nervousness.

Domain	Questions	Response options	Purpose and comments
Emotions (Cont'd)	CF24. How often does (name) seem very sad or depressed?		CF24 focuses on persistent sadness, or low mood. Children can be unhappy, lack interest in play and activities they used to enjoy, withdraw from others or appear hopeless. They may sit alone or cry, even when their peers are enjoying themselves.

©SPC

4.3 Translation considerations and methodology

The Pacific region is one of the most linguistically diverse regions in the world, its many languages and dialects spread across thousands of islands. Countries such as Fiji, Kiribati, Solomon Islands and Vanuatu have multiple dialects spoken within the country. Survey translations in the region should consider this rich diversity and ensure the survey's cultural relevance and accuracy.

National level surveys in the Pacific region are often translated from English into local languages to ensure clarity and cultural relevance. Some terminology in English may not, however, have direct translations into many Pacific languages. Care should be taken when translating WG questions on disability into Pacific languages to ensure cultural relevance and local sensitivities. Translations should consider dialectal variations and language structures that could be unique to Pacific languages, while maintaining the intent of the question and the response categories. The translation and testing approach outlined in this section follows the Washington Group's recommended methodology[27], ensuring consistency and comparability of data across contexts. This methodology can also be applied to the translation, adaptation and cognitive testing of the broader survey instrument, supporting good quality, culturally appropriate data collection that reflects local linguistic and social nuances.

To translate WG question sets, the team translation approach is recommended. This is an adapted version of the TRAPD model (Translation, Review, Adjudication, Pretesting, and Documentation), which is increasingly being adopted by researchers to address issues related to cultural relevance and conceptual equivalence, especially where it is difficult to have direct translations. It can, however, be resource intensive. The recommended methodology in this guidebook is less resource intensive.

The team translation approach recommends recruiting a team comprising a minimum of three experts:

- a professional translator who is familiar with English, the local language, and the most commonly spoken dialect;
- a reviewer from the survey team who is familiar with English and the local language, the survey design and the local cultural context; and
- a reviewer from the local OPD, who is familiar with English and the local language, the survey design and the local cultural context.

In addition to this minimum set, more reviewers could be included, depending on the resources available.

The recommended steps (Figure 2) for translation are described below.

1. **Preparation:** The translation team should be recruited. The number of dialects spoken in a Pacific Island could vary, and some of these dialects may not have a script. The team should agree on the language the survey should be translated into. The language may be the most commonly spoken language/dialect.
2. **Translate:** The professional translator translates the WG questions into the target language. The translator should be provided with training on the context of the survey, the disability data collection and the intended purpose of each question in the WG question sets. Translators should also consider clear and culturally appropriate terms that can be understood by most people in the community. Conceptual translations should be prioritised when a direct translation of a word is not available in the local language. An equivalent term or phrase should be considered in such situations.

---

[27] https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/Cognitive_Testing_of_the_Washington_Group.pdf

FIGURE 2. Steps in translating the survey

Prepare	• Identify the most commonly spoken language or dialect in the country for translation. • Form a translation team (translator, reviewer for the survey team, OPD member).
Translate	• The translater translates the survey into the local language. • Use culturally appropriate and clear terms that can be understood by most people in the community.
Review	• Reviewers compare translations with the English version. • The translator and reviewers resolve discrepancies. • Revise translations.
Pre-test	• Conduct a small scale pilot testing with community members for cognitively testing the translated survey. • Note any confusing or misunderstood questions or terms.
Finalise	• Revise the translations and finalise the survey. • Train enumerators using the final tool, including agreed terminology for some dialects that do not have a script.

3. Review: The reviewers (i.e. representatives from the survey team and the local OPD) should review the translations and provide feedback. This review should ensure that the translations are not just direct translations of the words but are of the concepts each question and the response categories represent. The feedback should be provided to the translator in person, and all three members should work as a team to resolve conflicts by agreeing on the most appropriate translation. Once translations are agreed, the original translator considers the feedback from the team and develops the revised version.

When reviewing the translations, consider the following questions.

- Does the translation accurately convey the intended meaning of the original question?
- Does the translation meet the conceptual equivalence for the terms that do not have direct translations?
- Are there any typos or grammatical errors?
- Are the terms easy to understand in the local communities?
- Is the translation culturally appropriate?
- Are the response choices likely to be understood and used as in the original question?

4. Pre-testing: Pre-testing on a convenience sample of community members should be considered to cognitively test the translated questions and response categories. See more details below. Any confusing or misunderstood questions and words should be identified.

5. **Finalisation:** Revisions should be made based on the pre-testing. The reviewers ensure all feedback is considered and approve the final translation. During this finalisation process, words should be considered for oral translations in the field for dialects that do not have a script. This guidance is important for training enumerators.

For further guidance on translations, see WG guidance here:
https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/Cognitive_Testing_of_the_Washington_Group.pdf

Listen and hear

During data collection, it is important to explain the questions clearly.

For example, the question must differentiate between listen and hear. The question "Does Jone have difficulty hearing, even if using a hearing aid?" does not do this.

So it might get the response: "Yes. Jone never listens. I must call several times but he never responds but keeps on watching TV or playing with friends." (Samoa Bureau of Statistics)

4.4 Cognitive testing

Cognitive testing of the questionnaires should be performed to ensure that the respondents understand the questions as intended and that responses accurately reflect what is being asked. Common problems encountered by respondents in answering questions are described below.

- **Comprehension:** If the respondent does not understand the question or response options as intended by the survey designers, drawing accurate conclusions from the respondent's answers may be difficult. Another possibility is that the same question could be understood differently by different respondents, and they could effectively be answering different questions.
- **Recall:** The design of questions may assume respondents have the information required to respond to the questions. However, respondents may find it difficult to recall or may not have learned or experienced the required information.
- **Judgement:** The phrasing of the question or response options provided may influence the way the respondent makes a judgment about the question. The respondent may choose to provide a more socially accepted or desirable answer.
- **Response:** In cases where response options may be incomplete or do not fit with the understanding or judgment of the question, the respondent is forced to choose from the given response options. Responses may also be influenced by the respondents' willingness to provide information in the required format.

These issues are very common when a new survey tool is being used in a new context, so it is important to test and refine the survey tool very carefully.

Cognitive testing is essentially a qualitative method of data collection that involves semi-structured and in-depth interviews with a purposive sample representing the target population. The sample should be comprised of people in different age groups, impairment types and levels and, where possible, from different socio-demographic backgrounds as sub-groups (e.g. gender, education status, and geographic location).

The interviewers should be trained in the survey tool, the context, and interviewing techniques. The interviews involve 'verbal probing' after each question to assess the participants' understanding of questions and to identify poorly phrased questions. This process will also identify any difficulties related to recall, judgment, and response.

TABLE 8. Example of cognitive testing probes for disability questions

Question example	Probe purpose	Example probe
Does (name) have difficulty remembering or concentrating?	Clarify question meaning	In your own words, what is this question asking? • What does concentrating mean to you? • Can you give me some examples of when (name) had difficulty paying attention?
	Clarify response options	In your own words, what does each response option mean to you? You mentioned there is "some difficulty" concentrating. What do you mean by that?
	Understand reasoning	Can you tell me why you answered this question that way? What kind of difficulties were you thinking of when responding to this question?

Interviewers should be encouraged to obtain as much detail as possible from the respondent. In addition, the interviewer's observations should be recorded in the following format for each question

BOX 5 | Interviewer's observations

Did the respondent:

• need you to repeat any part of the question?	☐ Yes	☐ No
• has any difficulty using the response options?	☐ Yes	☐ No
• seem uncomfortable or distressed with the questions?	☐ Yes	☐ No
• refuse to answer?	☐ Yes	☐ No
• ask for clarification?	☐ Yes	☐ No

Observations, clarifications, and comments by the interviewer:

General comments from the respondents about the questionnaire:

For data analysis, responses should first be organised by question for all respondents in order to identify patterns, any misunderstandings of the terminology, clarifications needed to be provided by the interviewers, and cultural relevance. The analysis should be summarised in a structured format that includes key findings, translational issues, recommended revisions and considerations for enumerator training. In the Pacific context, any challenges with oral translations for certain dialects should be documented clearly, where tested. Revisions should be made to the questions, and the translations should be finalised, based on these findings.

For further guidance on cognitive testing, see WG guidance here: https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/Cognitive_Testing_of_the_Washington_Group.pdf


©SPC


©ADB


©DFAT

©SPC

5. Guidance on ethics and data collection in the Pacific

Population and housing censuses and national sample surveys collect large-scale personal and sensitive data critical to inform policies and resource allocation. They must consider local ethical protocols, cultural values and perspectives, unique geographic contexts for planning logistics, and interviewing techniques when approaching households and administering surveys. This guidebook covers these considerations in the sections below, aligning with the Pacific research principles.[28]

- Respect for relationships
- Respect for knowledge holders
- Reciprocity
- Holism
- Using research to do good

5.1 Ethical considerations for collecting disability data

The population and housing censuses and surveys, such as HIES, LFS and MICS, have standard procedures and protocols and are mostly approved by relevant government ministries. While standard ethical approvals from institutional review boards are not sought, the surveys are expected to follow ethical standards when designing and implementing the findings. Some additional factors should be considered for disability-inclusive data collection as part of these surveys. This guidebook adopts the key considerations recommended in Research for all: Making research inclusive of persons with disabilities.[29]

a) Engaging with organisations of persons with disabilities

Meaningful engagement of organisations of persons with disabilities (OPDs) at every stage of the survey process will ensure ethical and effective implementation of disability-inclusive, context-specific and rights-based surveys. For meaningful participation of OPDs, their engagement should start at the survey design phase and continue to the results dissemination phase. OPDs should be actively involved in the census advisory committees, planning, enumerator training, monitoring, and public awareness campaigns. This engagement should be adequately resourced and funded to respect their time and contribution to the survey.

Input from OPDs is critical to ensure that:

- survey questions on disability are valid and translations are contextually relevant;
- key indicators for disaggregating data on disability are chosen and included according to the local context of persons with disabilities;
- there is guidance on the recruitment of participants and interviewing techniques with different types of disabilities;
- underrepresented groups who may otherwise be missed due to stigma or other challenges are identified and reached;

---

[28] Meo-Sewabu, L., Hughes, E., & Stewart-Withers, R. 2017. Pacific research guidelines and protocols. Auckland: New Zealand: Massey University. Available at: https://www.massey.ac.nz/documents/1055/PRPC_Pacific_Research_Guidelines_2017.pdf

[29] CBM-Nossal Partnership for Disability-inclusive Development and Research for Development Impact Network. 2020. Research for all: Making development research inclusive of people with disabilities. .Available at: https://rdinetwork.org.au/wp-content/uploads/2020/06/RDI-Network-R4All-Accessible-PDF-1.pdf

- there is capacity-building of leadership and implementation teams of the surveys; and
- dissemination of findings is disability inclusive.

b) Accessibility and reasonable accommodation

The population and housing censuses and national sample surveys, whether or not they include the topic of disability, should be designed to be fully accessible to all individuals, including persons with disabilities. This requires the provision of reasonable accommodation to remove physical, communication, information, attitudinal, and systems level barriers and to ensure the direct, effective and meaningful participation of persons with disabilities. This involves planning and designing all survey materials, methodology, and processes to be disability-inclusive. Reasonable accommodation is immediate, and denial of reasonable accommodation can be discrimination on the basis of disability. Reasonable accommodation should not be too expensive or create an undue burden.

The survey materials, including the questionnaires, instruction manuals, and consent forms, should be in accessible formats, such as large print, easy-to-read versions, Braille, and sign language. People with different types of functional impairments should be considered when designing the survey, especially those with hidden or invisible disabilities, such as sensory impairments and intellectual or psychosocial disabilities.

Persons with disabilities can be recruited as enumerators, and reasonable accommodation provided to ensure that they can perform the role. Reasonable accommodation could include personal assistants, sign language interpreters and a support person. Some of the enumerators may need accessible transport, additional time to collect data, and alternative formats of the survey materials. Reasonable accommodation needs to be resourced adequately.

Dissemination of survey findings, whether reports, monographs or data dashboards, should be accessible in several formats and should be user-friendly, depending on the target audience (technical and non-technical). This will ensure transparency and data will be appropriately analysed and used for disability advocacy, policy and programming.

c) Informed consent

While participation in censuses is usually mandatory, household surveys should ensure voluntary participation of individuals and obtain informed consent. Informed consent is a critical ethical principle that must be followed for all individuals, including persons with disabilities, in all data collections. Certain cultural practices and stereotypical understandings of the capacity of persons with disabilities to provide consent or participate in a survey may result in persons with disabilities:

- not making their own decisions;
- being forced to participate; and
- participating in surveys without fully understanding the purpose and consequences of their participation.

The informed consent process for individuals should follow locally appropriate methods, such as oral consent, which may be used for everyone participating in the survey. The Pacific cultural context may often involve family and community leaders when making decisions about or by an individual, particularly for persons with disabilities. Local cultural practices should be respected, while also balancing the rights of the individual to make their informed decisions. Enumerators should be trained on these sensitivities and how to directly engage with persons with disabilities to seek their informed consent. Consent should never be assumed but should be actively sought from the individual. Where needed, support persons such as the primary caregiver or family members should be engaged to support communication with the participant.

Accessible plain language information sheets about the survey should be made available in accessible formats, and should include information on:

- the purpose of the survey;
- what is expected of the respondents;
- potential benefits of the survey;
- how the data will be used;
- how their privacy and confidentiality will be maintained; and
- their right to decline participation with no negative consequences if they choose to do so.

In data collections that do not ask a household member to respond for everyone in the household, proxies are often asked to respond to the surveys on behalf of persons with disabilities. While proxies may be included for children and for those with severe cognitive or intellectual disabilities, where the respondents may not fully understand the questions, it is recommended that enumerators question individuals, and include the WG question sets on functioning.

In the Pacific region, informed consent may extend from the individual to the community level, depending on local cultural practices. There may be certain protocols/customs to be followed before entering communities. These may include seeking permissions from the village chiefs, the council of elders, or the church leaders before entering communities and performing certain ceremonies.

Where possible, enumerators from the local communities should be recruited so that they are familiar with local dialects and cultural practices. They should understand the cultural sensitivities, particularly around the topics of the survey related to collecting certain socio-demographic information on sexuality, religion, and asset ownership.

d) Privacy and confidentiality

It is essential to respect the privacy and confidentiality of persons with disabilities and all participants as part of the ethical conduct of surveys. In settings like Pacific Island countries and territories, most communities are small, and households are often related to each other. In such settings, collecting confidential information using a household survey methodology is logistically challenging. Information could easily spread if data collection is not conducted privately, stored appropriately and used responsibly. This could lead to unwanted consequences, given the risks of stigma and discrimination in communities.

Although the word ‘disability’ is not used in the surveys when collecting data using the WG question sets, the data on functioning determines the disability status. Information on functioning or disability status must be treated as sensitive and personal data.

Enumerators should be trained in interviewing techniques in all data collections, including how to handle situations where maintaining privacy during the household surveys is challenging, ensuring how data confidentiality will be managed as part of the information provided to participants, and asking questions discreetly in private when possible. This information should be provided in accessible formats and culturally appropriate ways.

Where community leaders are involved in censuses or surveys, enumerating teams should discuss the need to ensure privacy and confidentiality and how to manage logistics to collect data in private and discreetly. For persons with disabilities who rely on family members or caregivers for communication, enumerators should discuss confidentiality requirements with families and ensure they understand and agree not to disclose sensitive information.

All data, whether in physical or digital format, should be securely stored and should be accessed by authorised personnel only. Personal identifiable data related to names, addresses, and other potential information should not be used in any publications. Data should be anonymised or de-identified for analysis.

These strategies will ensure the community and persons with disabilities gain trust in the survey processes and may cooperate and participate in surveys.

e) Disability-inclusive dissemination

Disseminating disability related findings from the population and housing censuses and other surveys is important for disability-inclusive development. Although most censuses and household surveys in the Pacific region increasingly collect disability data, reporting and analysis of these data remain limited and undervalued. It is an ethical responsibility to reciprocate (i.e. give back) to the community by sharing the research findings with the community that contributed to the surveys. Disability-inclusive dissemination involves sharing survey findings on disability with persons with disabilities and OPDs in formats that are accessible and culturally appropriate. Dissemination could be in the form of reports, monographs, journal articles, newsletters, websites and blogs, data dashboards, working papers and conference presentations and should be translated into local language(s) if necessary. Some examples of accessible dissemination include:

- accessible PDFs and Word versions that can be accessed by screen readers;
- easy-to-read summaries with clear messaging, simple language, and visuals;
- large print and braille versions;
- ensuring good colour contrast in the reports produced with visuals and graphs;
- all visuals and graphs have a narration to describe the visuals and graphs; screen reader software cannot read the visuals and sometimes this is not accessible;
- audio versions or sign language interpretations of key findings; and
- captioned videos and infographics in local languages.

OPDs should be engaged and consulted in producing dissemination materials to ensure that the content is not only accessible but also relevant in order to empower persons with disabilities and be useful for policy and advocacy. The findings should also consider intersectionality among persons with disabilities, including analysis of gender, age, location and type of disability.

For further information on analysing disability data and relevant indicators and reporting, see sections 6 and 7.

5.2 Logistics for disability-inclusive data collection

The methodology for census and other national sample surveys is standardised, and logistical considerations should meet the overall objectives of the surveys. To make them disability-inclusive, some additional logistical and resource considerations should be made. These considerations are provided as a checklist in the box below.

BOX 6 | Checklist of logistical considerations for disability-inclusive data collection

☐ Budget and resources for accessible venues for engaging OPD stakeholders in all stages of the survey.

☐ Recruitment of persons with disabilities as part of enumerator teams, which promotes representation and demonstrates inclusive employment.

☐ Enumerators should be selected from the local communities so that they speak local languages and dialects and understand community norms and culture.

☐ Enumerator training should include modules on disability awareness, administering WG question sets and interviewing people with different disabilities.

☐ Budget and resources for accessible survey materials, including questionnaires, manuals and other administrative forms.

☐ Budget for reasonable accommodation, such as hiring accessible vehicles and accommodation facilities, and providing a support person or sign language interpreter to facilitate recruiting enumerators with disabilities.

☐ Collaborate with local health clinics, schools and churches to identify and connect with persons with disabilities who are hard to reach, ensuring they are included in the surveys.

☐ Provide budget and resources for monitoring data on the disability modules in real time and flagging errors and gaps to the teams while they are still in the areas.

☐ Ensure there is a referral mechanism if persons with disabilities are identified with immediate support needs.

☐ Establish a communication system between the survey team leads, local OPDs and community leaders to report and establish helplines if persons with disabilities are identified as missing or need additional support.

5.3 Training of enumerators

Proper training of enumerators is critical for conducting disability-inclusive censuses and other household surveys effectively. This guidebook focuses on training enumerators to collect disability-related data ethically and respectfully, while also assuring that data are collected accurately. As a best practice, all surveys should include training on disability-inclusion to ensure that persons with disabilities are included in the surveys broadly, not just to collect data on disability-specific questions. It is critical to ensure that persons with disabilities respond to **all** survey questions.

Below are key modules to be included as part of enumerator training, and it is recommended that these modules be developed in collaboration with the Pacific Disability Forum and national level OPDs and facilitated by them to ensure relevance and effectiveness. The training modules can follow the sections of this guidebook to introduce the concepts of disability, training on the question sets and ethics of data collection.

BOX 7 | Checklist for training enumerators in disability-inclusive data collection

- ☐ Overview of disability in the Pacific region
- ☐ Understanding disability and its impact
- ☐ Survey module on functioning
- ☐ Potential errors while collecting data on the survey module on functioning
- ☐ Recruitment of participants with disabilities
- ☐ Interviewing persons with disabilities with different impairment types
- ☐ Reasonable accommodation and accessibility considerations
- ☐ Practice exercises
- ☐ Ethical principles
- ☐ Referral processes for participants with immediate supports needs

The training should also include the expectations for good quality data collection and disability-inclusive practice. The introduction to supervision and monitoring protocols will be generally covered in the overall survey training, but they should be emphasised during the training on disability concepts.

Pilot testing or field practice sessions should also ensure purposive sampling of households with persons with disabilities to identify potential errors in data collection and support troubleshooting in the early stages of the survey. During the data collection, supervisors should routinely undertake monitoring visits to ensure quality assurance to data collection and quality of the data.

For detailed tips on interviewing persons with disabilities, see: https://www.washingtongroup-disability.com/fileadmin/uploads/wg/Documents/WG_Implementation_Document__8_-_Interviewer_Guidelines__February_2023_.pdf.

Some key considerations of dos and don'ts are provided in Box 8.


©SPC

BOX 8 | Dos and don’ts on interviewing persons with disabilities

Dos

☐ Before the interview, try to gather information on the person, whether he or she needs a sign language interpreter or a family member to assist, or a quiet space, or a proxy. If unsure, ask them directly.

☐ Speak to persons with disabilities directly, even when there is a sign language interpreter or a family member present during the interview.

☐ Speak slowly and clearly.

☐ Try to maintain eye contact when talking and adjust your seating level to the same eye level as the person.

☐ Use a normal tone and volume when speaking.

☐ Introduce yourself clearly and ensure they understand the information about the nature of the survey and that they can decline or stop the interview at any time.

☐ Start with general questions to build up a rapport before asking the survey questions, and make sure the person is comfortable.

☐ Ensure extra time for the interview, especially for those with cognitive or intellectual disabilities.

☐ Some people may need to be offered a rest or break during the interview. Ask if they need a break.

☐ Listen carefully to what the person is saying. If you don’t understand what they are saying, ask for clarification.

☐ Answer any questions they may have.

☐ Always be respectful.

☐ Focus on the person and not their functional limitation.

Don’ts

☐ Do not forget to take consent to participate in the survey.

☐ Do not assume anything about their abilities or inabilities.

☐ Do not assume their needs but ask them directly.

☐ Do not pretend to understand what they are saying if you have difficulty understanding their speech. It is better to repeat what you understood and ask for clarification.

☐ Do not go too close to the person to talk.

☐ Do not interfere with the interpretation. Let them finish what they are saying and then clarify or ask for clarification.

☐ Do not ask the assistant or sign language interpreter any questions; ask the person with disabilities.

☐ Do not rush them to answer quickly.

Example of a collaboration between the Pacific Disability Forum and the Fiji Bureau of Statistics

The Fiji Bureau of Statistics (FBoS) is actively collaborating with the Pacific Disability Forum (PDF) to improve the collection of disability data. This partnership involves the integration of the Washington Group Short Set of Questions, which addresses six key domains of functioning, into national population censuses and various sample surveys. Where relevant, extended questions are also included to align with specific survey objectives.

To ensure the high quality of data collected from the field, FBoS is dedicated to engaging with professional stakeholders who specialise in relevant thematic areas. In line with this commitment, FBoS and PDF formalised their collaboration by signing a memorandum of understanding. This partnership began with the training of enumerators, a crucial step in enhancing data collection methodologies. The specific commitments agreed on by FBoS and PDF, including the training of enumerators, aim to strengthen the overall process of disability data collection in Fiji.

6. Analysing disability data

6.1 Introduction to indicators and measures of prevalence

a) Introduction to indicators

An indicator is a quantitative measure used to track progress towards a specific outcome. For example, the "percentage of the population that has ever attended school" is an indicator of school attendance. When an indicator is measured in the same population at different points in time, it allows planners and policy-makers to measure progress towards meeting a programme's objectives.

For the purpose of this guide, an indicator is described using eight items, listed below.

- **Theme:** the thematic group to which the indicator belongs. Example: Education
- **Short name:** a brief name (one to four words) used to quickly refer to the indicator. Example: Ever attended school
- **Complete name:** a phrase, usually beginning with "Percentage of...", that describes the indicator and what it measures. Example: Percentage of the population that has ever attended school
- **Age group:** the age group for which the indicator is calculated. Example: 5 years or older
- **Associated Sustainable Development Goal (SDG):** the SDG goal or target most closely related to the indicator, if applicable. Example: SDG 4.5
- **Source:** the typical data source for the indicator in the Pacific context. Example: National census
- **Notes:** technical notes providing additional information about the indicator. Example: Purely religious education that does not include a general curriculum is usually excluded from this indicator, but the final decision should reflect the national context.
- **Estimates:** a numeric value that measures progress for an indicator within a well-defined group of people. Example: In country A, 75% of persons with disabilities and 82% of persons without disabilities have ever attended school.

b) Measures of prevalence

All indicators described in this guidebook are measures of prevalence. They represent the proportion of individuals in a defined population at a certain point in time who have a particular characteristic. Estimates of prevalence are expressed as a percentage (ranging from 0% to 100%), representing the proportion of the population that exhibits the characteristic described by the indicator, such as the prevalence of disability or the prevalence of unemployment.

BOX 9 | Why measures of prevalence?

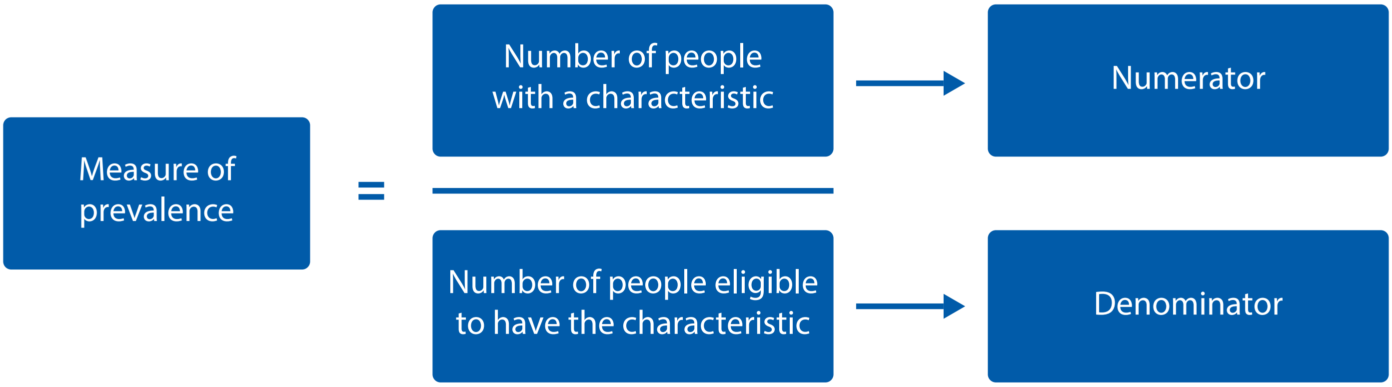
Indicators don't necessarily need to be measures of prevalence. They can also be based on ratios, incidence rates, and other measures. However, a quick look at some of the most widely used international indicators – such as those from the Sustainable Development Goals – shows that measures of prevalence are a very popular choice.

We have purposefully chosen to use only measures of prevalence for two reasons.

- **Ease of interpretation:** the 0 to 100% scale makes most indicators straightforward to understand, especially for non-technical audiences. The consistency in scale also facilitates comparison of indicators.
- **Ease of calculation:** measures of prevalence are simple to calculate using census and survey data. Furthermore, consistency across indicators allows for easier analytical coding and capacity-building of local teams.

All measures of prevalence are calculated using the formula in Figure 3.

FIGURE 3. Calculating measures of prevalence



In summary, to calculate prevalence, one divides the number of people with the characteristic of interest (the numerator) by the number of people eligible to have that characteristic (the denominator). Eligibility for inclusion in the denominator is important: individuals with a 0% chance of having that characteristic should be excluded from the denominator. Here are two examples, from fictional country A, with a sample of 3,256 people.

Example 1: Disability

Indicator	**Percentage of the population with disabilities**
Numerator	512 persons with disabilities in the sample
Denominator	3,256 people in the sample (anyone can have a disability)
Prevalence	512/3,256 = 15.7%

Example 2: Unemployment among people with disabilities

Indicator	**Percentage of the labour force with disabilities that is unemployed**
Numerator	98 unemployed persons with disabilities
Denominator	310 persons with disabilities in the labour force
Prevalence	98/310 = 31.6%

Note: In Example 2, only persons with disabilities who were in the labour force were included in the denominator. The labour force represents those who are part of the economically active population – either currently working or actively seeking and available to start work. It is defined in such a way that people who do not want to work, are not looking for work, or are not available or capable of starting work are excluded from the denominator – a common standard for unemployment indicators.

Example 2 illustrates that, while calculating a measure of prevalence is relatively simple, selecting the appropriate numerator and denominator can be complex. Subject matter expertise and internationally recognised standards should be used to define how indicators should be calculated properly.

c) Indicators for persons with disabilities

Relevant indicators for persons with disabilities can be divided into two major groups.

- **Indicators of disability:** these relate to whether people have a disability (also known as disability status), the severity of that disability and the level of difficulty they face in specific domains, such as vision or mobility. Their main purpose is to describe the distribution of disabilities in a population of interest.
- **Indicators of outcomes for persons with disabilities:** these relate to how persons with disabilities are faring in their lives, health, and community participation. They reflect both positive outcomes to be achieved and negative outcomes to be avoided. These indicators often concern education, employment, safe and healthy living, appropriate housing conditions and other factors related to the well-being of persons with disabilities. They are based on international and regional frameworks (such as the Pacific Roadmap for Sustainable Development), national and regional strategies (e.g. PRFPD), and the priorities of persons with disabilities (often represented by organisations of persons with disabilities). Their main goal is to track the progress of disability-inclusive development over time. Outcomes for persons with disabilities may be compared to outcomes for persons without disabilities to investigate inequalities between the two groups.

6.2 Indicators of disability status

Indicators of disability status reflect the distribution of disability within a population. Different indicators of disability status can be created, based on varying cut-off points along the difficulty scale of the Washington Group Short Set on Functioning (WG-SS) and by combining different domains of functioning. Following the recommendations of the WG, and for consistency in statistical reporting, **a person with disability is defined in the analysis as someone who reported "a lot of difficulty" or "cannot do at all" in any of the functioning domains**.[30] Other cut-off points are explored in the Indicators of Difficulty Severity section below.

Recommended indicator:

Indicator: Prevalence of disability		
Complete name: Percentage of the population with disabilities		
Theme: Disability	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to have a disability if they reported "a lot of difficulty" or "cannot do at all" in any of the functioning domains of the WG-SS.		

Estimates for the indicator of disability status should be calculated for the following groups.

- **All people** (entire sample combined)
- Sex:
    - Females
    - Males
- Age groups:[31]
    - Under 18
    - 18 to 29
    - 30 to 39
    - 40 to 49
    - 50 to 59
    - 60 to 69
    - 70 to 79
    - 80+
- Area of residence:
    - Urban
    - Rural
- **National regions** (known as Administrative Division Level 1, the first division in the country, usually states, provinces or regions)

---

[30] Analytic Guidelines: Creating disability identifiers using the Washington Group Short Set on Functioning (WG-SS) Stata Syntax. Available at: https://www.washingtongroup-disability.com/analysis/wg-short-set-on-functioning-wg-ss-syntax/

[31] Countries with smaller populations may instead choose to report the following age groups: (1) under 18, (2) 18 to 49, and (3) 50+.

- Education:
    - No formal education
    - Up to complete primary
    - Up to complete secondary
    - Any tertiary
- Marital status:
    - Never married/in union
    - Married/in union
    - Divorced/separated/widowed
- Number of household members:
    - 1
    - 2 to 5
    - 5+
- Other groups of particular national importance may also be included.

6.3 Indicators of difficulty severity

Indicators of difficulty severity recognise the varying levels of difficulty that people face when performing activities in their daily lives. They are based on the WG's Highest Level of Difficulty indicators.[32]

Recommended indicators:

Indicator: No functional difficulty		
Complete name: Percentage of the population with no functional difficulty		
Theme: Difficulty severity	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to have no functional difficulty if they reported "no difficulty" in all of the functioning domains of the WG-SS.		

Indicator: Some functional difficulty		
Complete name: Percentage of the population with some functional difficulty		
Theme: Difficulty severity	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to have some functional difficulty if they reported "some difficulty" in at least one of the functioning domains of the WG-SS, but DO NOT report "a lot of difficulty" or "cannot do at all" in any domain.		

---

[32] For more information on other possible indicators of disability severity, please see: Analytic Guidelines: Creating disability severity indicators using the WG Short Set on Functioning (WG-SS) STATA. Available at: https://www.washingtongroup-disability.com/analysis/disability-severity-indicators-using-the-wg-short-set-on-functioning-wg-ss/

Indicator: A lot of functional difficulty		
Complete name: Percentage of the population with a lot of difficulty		
Theme: Difficulty severity	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to have a lot of functional difficulty if they reported "a lot of difficulty" in at least one of the functioning domains of the WG-SS, but DO NOT report "cannot do at all" in any domain.		

Indicator: Cannot do at all		
Complete name: Percentage of the population who cannot do some activities at all		
Theme: Difficulty severity	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to not be able to do some activities at all if they reported "cannot do at all" in at least one of the functioning domains of the WG-SS.		

6.4 Domain specific indicators

Domain-specific indicators reflect the distribution of **difficulties in specific functioning domains within a population**. Similar to the indicator of disability status, a person with difficulty in a specific functioning domain (such as vision) is defined as someone who reported "a lot of difficulty" or "cannot do at all" in that domain. Other cut-off points can be explored but are not included as standard indicators.

Recommended indicators:

Indicator: Seeing difficulties		
Complete name: Percentage of the population with at least a lot of vision difficulties		
Theme: Difficulties	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to have seeing difficulties if they reported "a lot of difficulty" or "cannot do at all" in the vision domain of the WG-SS.		

Indicator: Hearing difficulties		
Complete name: Percentage of the population with at least a lot of hearing difficulties		
Theme: Difficulties	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to have hearing difficulties if they reported "a lot of difficulty" or "cannot do at all" in the hearing domain of the WG-SS.		

Indicator: Mobility difficulties		
Complete name: Percentage of the population with at least a lot of mobility difficulties		
Theme: Difficulties	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to have mobility difficulties if they reported "a lot of difficulty" or "cannot do at all" in the mobility domain of the WG-SS.		

Indicator: Cognition (remembering and concentrating) difficulties		
Complete name: Percentage of the population with at least a lot of cognition difficulties		
Theme: Difficulties	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to have cognition difficulties if they reported "a lot of difficulty" or "cannot do at all" in the cognition domain of the WG-SS.		

Indicator: Self-care difficulties		
Complete name: Percentage of the population with at least a lot of self-care difficulties		
Theme: Difficulties	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to have self-care difficulties if they reported "a lot of difficulty" or "cannot do at all" in the self-care domain of the WG-SS.		

Indicator: Communication difficulties		
Complete name: Percentage of the population with at least a lot of communication difficulties		
Theme: Difficulties	**Age group:** 5+	**Associated SDG:** 17
Source: National Census		
Notes: Someone is considered to have communication difficulties if they reported "a lot of difficulty" or "cannot do at all" in the communication domain of the WG-SS.		

6.5 Disability indicators for children

The WG-SS is the recommended question set for disability assessments for censuses in the Pacific region, and it targets people aged five years or older. If a multiple indicator cluster survey (MICS) is available for the country, the Washington Group/UNICEF Child Functioning Module (CFM) should be used for estimating disability prevalence among children. Data from MICS is an opportunity to expand reporting in disability monographs by including a supplementary MICS module.

This section describes indicators of disability for children (aged two to 17 years) based on MICS surveys. Reporting those is optional.

Note: The MICS includes the CFM, which is administered to children aged 2 to 4 years and 5 to 17 years (See sections 2 and 4). This creates an overlap in the age group 5 to 17 years, where disability data may also be collected for the population and housing censuses using WG-SS. While the CFM is more comprehensive and specifically designed to capture a broader range of functioning difficulties, particularly among children with developmental disabilities, it is implemented as a household sample survey rather than a full enumeration of the population, as in the population and housing census. Because of these differences, the prevalence estimates for children aged 5 to 17 years will not align with those derived from the censuses. If MICS data are included in the disability monographs, users are advised to provide clear explanation on the differences in methodology and potential implications for interpreting and comparing census and MICS data.

a) Indicator of disability status

The purpose and specifications of questions in CFM versions for 2–4 years and 5–17 years are described in sections 5 and 6 of this guidebook. Please refer to those sections for further details on domains, questions and response categories.

Indicator: Disability status		
Complete name: Percentage of children with disabilities		
Theme: Child disability	**Age group:** 2 to 17 years	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: **2–4 years** A child is considered to have a disability if they were reported having “a lot more” difficulty for the question on controlling behaviour, or “a lot of difficulty” or “cannot do at all” for all other questions of CFM – either with or without supportive equipment or assistance, or compared with children of the same age. **5–17 years** A child is considered to have a disability if they are reported experiencing emotions related to anxiety and depression “daily”; or having “a lot of difficulty” or “cannot do at all” for all other questions of the CFM – either with or without supportive equipment or assistance, or compared with children of the same age.		

b) Domain-specific indicators[33]

Indicator: Vision difficulties		
Complete name: Percentage of children with vision difficulties		
Theme: Child difficulties	**Age group:** 2 to 17	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: A child is considered to have vision difficulties if they are reported to have "a lot of difficulty" or "cannot do at all" in any of the vision domain questions of the CFM – either with or without glasses.		

Indicator: Hearing difficulties		
Complete name: Percentage of children with hearing difficulties		
Theme: Child difficulties	**Age group:** 2 to 17	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: A child is considered to have hearing difficulties if they are reported to have "a lot of difficulty" or "cannot do at all" in any of the hearing domain questions of the CFM – either with or without hearing aids.		

Indicator: Mobility difficulties		
Complete name: Percentage of children with mobility difficulties		
Theme: Child difficulties	**Age group:** 2 to 17	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: A child is considered to have mobility difficulties if they are reported to have "a lot of difficulty" or "cannot do at all" in any of the mobility domain questions of the CFM – either with or without equipment, assistance, or compared with children the same age.		

Indicator: Self-care difficulties		
Complete name: Percentage of children with self-care difficulties		
Theme: Child difficulties	**Age group:** 5 to 17	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: A child is considered to have self-care difficulties if they are reported to have "a lot of difficulty" or "cannot do at all" in any of the self-care domain questions of the CFM.		

---

[33] For the domain-specific indicators for children, the term *'at least a lot of'* was not included in the full indicator name because the questions used to create the indicators do not all use the same response scale (see *Controlling behaviour difficulties* as an example).

Indicator: Difficulties with fine motor skills		
Complete name: Percentage of children with fine motor difficulties		
Theme: Child difficulties	**Age group:** 2 to 4	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: A child is considered to have difficulties with activities that need fine motor skills if they are reported to have "a lot of difficulty" or "cannot do at all" in the fine motor skills domain of the CFM.		

Indicator: Communication difficulties		
Complete name: Percentage of children with communication difficulties		
Theme: Child difficulties	**Age group:** 2 to 17	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: A child is considered to have communication difficulties if they are reported to have "a lot of difficulty" or "cannot do at all" in any of the communication domain questions of the CFM.		

Indicator: Learning difficulties		
Complete name: Percentage of children with learning difficulties		
Theme: Child difficulties	**Age group:** 2 to 17	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: A child is considered to have learning difficulties if they are reported to have "a lot of difficulty" or "cannot do at all" in the learning domain of the CFM.		

Indicator: Remembering difficulties		
Complete name: Percentage of children with remembering difficulties		
Theme: Child difficulties	**Age group:** 5 to 17	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: A child is considered to have remembering difficulties if they are reported to have "a lot of difficulty" or "cannot do at all" in the remembering domain of the CFM.		

Indicator: Concentration difficulties		
Complete name: Percentage of children with concentration difficulties		
Theme: Child difficulties	**Age group:** 5 to 17	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: A child is considered to have concentration difficulties if they are reported to have "a lot of difficulty" or "cannot do at all" in the concentration domain of the CFM.		

Indicator: Playing difficulties

Complete name: Percentage of children with playing difficulties

Theme: Child difficulties | **Age group:** 2 to 4 | **Associated SDG:** 17

Source: Multiple Indicator Cluster Survey

Notes: A child is considered to have playing difficulties if they are reported to have "a lot of difficulty" or "cannot do at all" in the playing domain of the CFM.

Indicator: Difficulties coping with change

Complete name: Percentage of children with difficulties coping with change

Theme: Child difficulties | **Age group:** 5 to 17 | **Associated SDG:** 17

Source: Multiple Indicator Cluster Survey

Notes: A child is considered to have difficulties accepting changes if they are reported to have "a lot of difficulty" or "cannot do at all" in the coping with change domain of the CFM.

Indicator: Controlling behaviour difficulties

Complete name: Percentage of children with controlling behaviour difficulties

Theme: Child difficulties | **Age group:** 2 to 17 | **Associated SDG:** 17

Source: Multiple Indicator Cluster Survey

Notes:

2–4 years

A child is considered to have difficulties with controlling behaviour if they are reported to have "a lot more" difficulty in the controlling behaviour domain of the CFM.

5–17 years

A child is considered to have difficulties with controlling behaviour if they are reported to have "a lot of difficulty" or "cannot do at all" in the controlling behaviour domain of the CFM.

Indicator: Difficulties making friends

Complete name: Percentage of children with difficulties making friends

Theme: Child difficulties | **Age group:** 5 to 17 | **Associated SDG:** 17

Source: Multiple Indicator Cluster Survey

Notes: A child is considered to have difficulties making friends if they are reported to have "a lot of difficulty" or "cannot do at all" in the relationships/making friends domain of the CFM.

Indicator: Emotional difficulties		
Complete name: Percentage of children with emotional difficulties		
Theme: Child difficulties	**Age group:** 5 to 17	**Associated SDG:** 17
Source: Multiple Indicator Cluster Survey		
Notes: A child is considered to have emotional difficulties if they are reported experiencing anxiety or depression symptoms "daily" in the emotions domain of the CFM.		

Note: Indicators of severity for functional difficulties in children using the CFM are not included in the guidebook, as there are currently no standardised guidelines or recommended methods available for grading the severity of functioning difficulties based on CFM responses.

6.6 Measuring outcomes for persons with disabilities

Sections 6.2 to 6.5 list disability indicators that are related to measuring disability prevalence. Their main interest is whether someone has or does not have a disability/functioning difficulty, and the severity. This section focuses on **indicators of outcomes** for persons with disabilities, compared to persons without disabilities, and are used to:

- monitor progress on the international and regional commitments to improve the level of access to services and community participation for persons with disabilities; and
- investigate inequalities between persons with and without disabilities.

Estimates of outcome indicators should be calculated and presented for the following groups:[34]

- All people
- All persons with disabilities
- Women with disabilities
- Men with disabilities
- All persons with disabilities
- Women without disabilities
- Men without disabilities

a) Standard set of indicators – Census

The standard set of indicators selected for this guide is based on census data. The selection process was informed by technical consultation with experts, availability of data from censuses conducted in the region, alignment with international standards, and input from a workshop with Pacific stakeholders.

---

[34] See Section 7 for instructions on how to report and compare groups.

Recommended indicators:

Education

Indicator: Ever attended school		
Complete name: Percentage of the population that has ever attended school		
Theme: Education	**Age group:** 5+	**Associated SDG:** 4.5
Source: National Census		
Notes: The Household Income and Expenditure Survey (HIES) includes a question on the main reason for never attending school. If available, it is recommended that the most common reasons – and their respective percentages – be presented separately for persons with and without disabilities. This information should be included either as a separate table or alongside the text discussing the "Ever attended school" indicator.		

Indicator: Currently attending school		
Complete name: Percentage of the population currently attending school		
Theme: Education	**Age group:** 5 to 18	**Associated SDG:** 4.5
Source: National Census		
Notes: The Household Income and Expenditure Survey (HIES) includes a question on the main reason for leaving school. If available, it is recommended that the most common reasons – and their respective percentages – be presented separately for persons with and without disabilities. This information should be limited to people aged 5 to 18 years and should be included either as a separate table or alongside the text discussing the "School attendance" indicator.		

Indicator: Literacy		
Complete name: Percentage of the population with basic reading and writing skills		
Theme: Education	**Age group:** 15+	**Associated SDG:** 4.6
Source: National Census		
Notes: None		

Indicator: Primary education		
Complete name: Percentage of the population that completed primary education		
Theme: Education	**Age group:** 18+	**Associated SDG:** 4.1
Source: National Census		
Notes: None		

Indicator: Secondary education		
Complete name: Percentage of the population that completed secondary education		
Theme: Education	**Age group:** 18+	**Associated SDG:** 4.1
Source: National Census		
Notes: None		

Indicator: Vocational education		
Complete name: Percentage of the population that completed vocational or technical education		
Theme: Education	**Age group:** 25+	**Associated SDG:** 4.3
Source: National Census		
Notes: Vocational or technical education refers to post-secondary non-tertiary education.		

Indicator: Tertiary education		
Complete name: Percentage of the population that completed tertiary education		
Theme: Education	**Age group:** 25+	**Associated SDG:** 4.3
Source: National Census		
Notes: None		

Indicator: Post-secondary education		
Complete name: Percentage of the population that completed vocational, technical, or tertiary education		
Theme: Education	**Age group:** 25+	**Associated SDG:** 4.3
Source: National Census		
Notes: None		

Economic activity

Indicator: Labour force		
Complete name: Percentage of the population in the labour force		
Theme: Economic activity	**Age group:** 15+	**Associated SDG:** 8.5
Source: National Census		
Notes: According to the International Labour Organization, people in the labour force are those actively engaged in the labour market. This includes individuals who are employed (in paid employment or self-employed, including those working for pay or profit payable to the household or family) and those who are unemployed (not working but currently available and actively seeking work). It does not include people permanently unable to work, or those whose main activity is unpaid domestic work, studying, volunteering, or retirement. A more detailed explanation is available in the *Resolution concerning statistics of work employment and labour underutilization* adopted at the 19th International Conference of Labour Statisticians (ICLS), with updates from the 21st ICLS (October 2023, Resolution II).[35]		

Indicator: Unemployment		
Complete name: Percentage of the labour force that is unemployed		
Theme: Economic activity	**Age group:** 15+	**Associated SDG:** 8.5
Source: National Census		
Notes: According to the International Labour Organization, unemployed people are those who are not working but are currently available for work and actively seeking employment. A more detailed explanation is available in the *Resolution concerning statistics of work employment and labour underutilization* adopted at the 19th International Conference of Labour Statisticians (ICLS), with updates from the 21st ICLS (October 2023, Resolution II).		

Indicator: Paid work		
Complete name: Percentage of the population engaged in paid work		
Theme: Economic activity	**Age group:** 15+	**Associated SDG:** 8.5
Source: National Census		
Notes: None		

---

[35] Resolution II. Resolution to amend the 19th ICLS resolution concerning statistics of work, employment and labour underutilization. 21st International Conference of Labour Statisticians, Geneva 11–20 October 2023. Available at: https://ilostat.ilo.org/about/standards/icls/icls-documents/

Indicator: Self-employment		
Complete name: Percentage of the population that is self-employed		
Theme: Economic activity	**Age group:** 15+	**Associated SDG:** 8.5
Source: National Census		
Notes: None		

Living conditions

Indicator: Improved water		
Complete name: Percentage of the population living in households with improved water drinking source		
Theme: Housing	**Age group:** 5+	**Associated SDG:** 6.1
Source: National Census		
Notes: According to the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP)[36], improved water sources include piped water, boreholes or tubewells, protected dug wells, protected springs, rainwater, and packaged or delivered water. If information on water collection time is available in the census, this indicator can be complemented by the JMP's basic water indicator, which is defined as using an improved drinking water source, provided that collection time does not exceed 30 minutes for a round trip, including queuing. This indicator is calculated at the household level, meaning that every person living in the same household will have the same outcome. Therefore, it does not capture any intra-household inequalities.		

Indicator: Basic sanitation		
Complete name: Percentage of the population living in households with basic sanitation		
Theme: Housing	**Age group:** 5+	**Associated SDG:** 6.2
Source: National Census		
Notes: According to the WHO/UNICEF JMP[37], improved sanitation facilities include flush/pour flush toilets connected to piped sewer systems, septic tanks or pit latrines, pit latrines with slabs (including ventilated pit latrines), and composting toilets. This indicator is calculated at the household level, meaning that every person living in the same household will have the same outcome. Therefore, it does not capture any intra-household inequalities.		

---

[36] United Nations Children's Fund & World Health Organization. 2023. Joint monitoring programme for water supply, sanitation and hygiene – Progress on household drinking water, sanitation and hygiene 2000-2022.

[37] United Nations Children's Fund & World Health Organization. 2023. Joint monitoring programme for water supply, sanitation and hygiene – Progress on household drinking water, sanitation and hygiene 2000-2022.

Indicator: Improved flooring materials		
Complete name: Percentage of the population living in households with improved flooring materials		
Theme: Housing	**Age group:** 5+	**Associated SDG:** 11.1
Source: National Census		
Notes: Improved flooring materials include finished materials such as cement, concrete, tiles, ceramic, parquet, vinyl, carpet, and wooden floors. In contrast, unimproved flooring materials are made from natural or rudimentary materials such as earth, mud, sand, dirt, clay, soil, sticks, and bamboo.[38]		

Indicator: Clean cooking fuels		
Complete name: Percentage of the population living in households with clean fuels for cooking		
Theme: Housing	**Age group:** 5+	**Associated SDG:** 7.1
Source: National Census		
Notes: According to the WHO[39], the fuels and technologies that are considered clean include electricity, natural gas, liquified petroleum gas, biogas, ethanol, and solar. This indicator is calculated at the household level, meaning that every person living in the same household will have the same outcome. Therefore, it does not capture any intra-household inequalities.		

Indicator: Electricity		
Complete name: Percentage of the population living in households with electricity		
Theme: Housing	**Age group:** 5+	**Associated SDG:** 7.1
Source: National Census		
Notes: This indicator is calculated at the household level, meaning that every person living in the same household will have the same outcome. Therefore, it does not capture any intra-household inequalities.		

Indicator: Living in poorest households		
Complete name: Percentage of the population living in the poorest 20% of households		
Theme: Housing	**Age group:** 5+	**Associated SDG:** 1.1
Source: National Census		
Notes: This indicator is calculated at the household level, meaning that every person living in the same household will have the same outcome. Therefore, it does not capture any intra-household inequalities.		

---

[38] Legge, H., Pullan, R. L., & Sartorius B. 2023. Improved household flooring is associated with lower odds of enteric and parasitic infections in low- and middle-income countries: A systematic review and meta-analysis. PLOS Glob Public Health,3(12). Available at: https://doi.org/10.1371/journal.pgph.0002631

[39] https://www.who.int/data/gho/indicator-metadata-registry/imr-details/4673

Communications

Indicator: Mobile phone ownership		
Complete name: Percentage of the population that owns a mobile phone		
Theme: Communication	**Age group:** 15+	**Associated SDG:** 17.8
Source: National Census		
Notes: None		

Indicator: Internet access		
Complete name: Percentage of the population with access to the Internet		
Theme: Communication	**Age group:** 15+	**Associated SDG:** 17.8
Source: National Census		
Notes: None		

Health and well-being

Indicator: Tobacco use[40]		
Complete name: Percentage of the population that smokes or uses tobacco products		
Theme: Health and well-being	**Age group:** 15+	**Associated SDG:** 3.a
Source: National Census		
Notes: If information on the use of electronic cigarettes is available, it is recommended to include a separate indicator.		

Indicator: Food insecurity		
Complete name: Percentage of the population who experienced food insecurity in the past 12 months		
Theme: Health and well-being	**Age group:** 5+	**Associated SDG:** 2.1
Source: National Census		
Notes: This indicator is calculated at the household level, meaning that every person living in the same household will have the same outcome. Therefore, it does not capture any intra-household inequalities.		

---

[40] Additional separate indicators of substance use, such as *kava* and betel nut, may be included, depending on national context and priorities.

Indicator: Non-communicable diseases		
Complete name: Percentage of the population diagnosed with a non-communicable disease or chronic illness		
Theme: Health and well-being	**Age group:** 30+	**Associated SDG:** 3.4
Source: National Census		
Notes: None		

Indicator: Early childbearing		
Complete name: Percentage of the women who had a live birth before age 18		
Theme: Health and well-being	**Age group:** 20 to 24	**Associated SDG:** 3.7
Source: National Census		
Notes: None		

Indicator: Self-assessed good health		
Complete name: Percentage of the population that considers themselves to be in good health		
Theme: Health and well-being	**Age group:** 15+	**Associated SDG:** –
Source: National Census		
Notes: None		

Indicator: Binge drinking		
Complete name: Percentage of the population that binge-drinks alcohol at least 2 times per month		
Theme: Health and well-being	**Age group:** 15+	**Associated SDG:** 3.5
Source: National Census		
Notes: One episode of binge drinking is defined as consuming five or more standard drinks for males, or four or more for females, on a single occasion.[41] There is a substantial variation in how alcohol consumption is measured across national censuses in the region. Currently, countries do not include the necessary questions to report the binge drinking indicator, which requires information on both the number of drinks consumed and the frequency of binge drinking episodes. Countries that cannot report on binge drinking may instead choose to report the percentage of the population that consumes alcohol in an average week.		

---

[41] Fillmore MT, Jude R. 2011. Defining "binge" drinking as five drinks per occasion or drinking to a .08% BAC: which is more sensitive to risk? The American Journal on Addictions. 20(5):468-75. https://doi.org/10.1111/j.1521-0391.2011.00156.x

b) Supplementary indicators – MICS

The multiple indicator cluster surveys (MICS) are household surveys developed by UNICEF. They provide a unique opportunity for monitoring life outcomes for persons with disabilities, particularly children. MICS include the WG question sets, as well as an extensive list of internationally recognised indicators, based on longer questionnaires more suitable for samples of the population. The selection of MICS indicators was informed by technical consultation with experts, alignment with standard MICS indicators, and input from a workshop with Pacific stakeholders. Some adaptations were necessary to account for regional characteristics and the expected small sample sizes – particularly for children with disabilities in small island nations.

Recommended indicators:

Child health

Indicator: Full immunisation		
Complete name: Percentage of children who had received all vaccinations recommended in the national immunisation schedule		
Theme: Child health	**Age group:** 24 to 35 months	**Associated SDG:** 3.8
Source: Multiple Indicator Cluster Survey		
Notes: This indicator should be presented with a brief description of the national immunisation schedule for children aged 24 to 35 months.		

Indicator: Care-seeking for illness		
Complete name: Percentage of children with diarrhea, acute respiratory infection symptoms, or fever in the last two weeks for whom advice or treatment was sought from a health facility or provider		
Theme: Child health	**Age group:** 2 to 4	**Associated SDG:** 3.8
Source: Multiple Indicator Cluster Survey		
Notes: None		

Indicator: Wasting		
Complete name: Percentage of children who fall below minus two standard deviations (moderate and severe) of the median weight for height of the WHO standard		
Theme: Child health	**Age group:** 2 to 4	**Associated SDG:** 2.2
Source: Multiple Indicator Cluster Survey		
Notes: MICS instructs not to weight or measure a child that "is physically deformed, which will interfere with or give an incorrect measurement", which can lead to the exclusion of children with disabilities from the indicator.		

Indicator: Stunting		
Complete name: Percentage of children who fall below minus two standard deviations (moderate and severe) of the median height for age of the WHO standard		
Theme: Child health	**Age group:** 2 to 4	**Associated SDG:** 2.2
Source: Multiple Indicator Cluster Survey		
Notes: MICS instructs not to weight or measure a child that "is physically deformed, which will interfere with or give an incorrect measurement", which can lead to the exclusion of children with disabilities from the indicator.		

Indicator: Overweight		
Complete name: Percentage of children who are above two standard deviations (moderate and severe) of the median weight for age of the WHO standard		
Theme: Child health	**Age group:** 2 to 4	**Associated SDG:** 2.2
Source: Multiple Indicator Cluster Survey		
Notes: MICS instructs not to weight or measure a child that "is physically deformed, which will interfere with or give an incorrect measurement", which can lead to the exclusion of children with disabilities from the indicator.		

Child development and education

Indicator: Stimulation and care		
Complete name: Percentage of children engaged in four or more activities to provide early stimulation and responsive care in the last 3 days with any adult household members		
Theme: Child health	**Age group:** 2 to 4	**Associated SDG:** 4.2
Source: Multiple Indicator Cluster Survey		
Notes: There are other versions of this indicator that examine whether the activities are performed with the child's mother or father. These indicators can be included as well but should not replace the primary indicator.		

Indicator: Early childhood development		
Complete name: Percentage of children who are developmentally on track in health, learning, and psychosocial well-being		
Theme: Child development and education	**Age group:** 2 to 4	**Associated SDG:** 4.2
Source: Multiple Indicator Cluster Survey		
Notes: None		

Sexual and reproductive health

Indicator: Family planning with modern methods		
Complete name: Percentage of women currently married or in union who have their need for family planning satisfied with modern contraceptive methods		
Theme: Sexual and reproductive health	**Age group:** 15 to 49	**Associated SDG:** 3.7
Source: Multiple Indicator Cluster Survey		
Notes: A detailed definition of the need for family planning and modern contraceptive methods in provided elsewhere.[42]		

Indicator: Antenatal care		
Complete name: Percentage of women with a live birth in the last 2 years who during the pregnancy of the most recent live birth were attended at least eight times by any provider		
Theme: Sexual and reproductive health	**Age group:** 15 to 49	**Associated SDG:** 3.8
Source: Multiple Indicator Cluster Survey		
Notes: None		

Indicator: Skilled attendant at delivery		
Complete name: Percentage of women with a live birth in the last two years whose most recent live birth was attended by a skilled health personnel		
Theme: Sexual and reproductive health	**Age group:** 15 to 49	**Associated SDG:** 3.1
Source: Multiple Indicator Cluster Survey		
Notes: None		

Violence and exploitation

Indicator: Violent discipline		
Complete name: Percentage of children who experienced any physical punishment and/or psychological aggression by caregivers in the past month		
Theme: Violence and exploitation	**Age group:** 2 to 14	**Associated SDG:** 16.2
Source: Multiple Indicator Cluster Survey		
Notes: According to MICS: "While teaching children self-regulation is an integral part of parenting in all countries and cultures, a large body of evidence confirms that violent discipline is both ineffective and can have negative consequences, ranging from immediate impacts to long-term harm".[43]		

---

[42] Bradley, S. E. K., Croft, T. N., Fishel, J. D., & Westoff, C. 2012. Revising unmet need for family planning. DHS Analytical Studies No. 25. ICF International. Available at: https://www.dhsprogram.com/publications/publication-AS25-Analytical-Studies.cfm

[43] More information is available at: https://data.unicef.org/topic/child-protection/violence/violent-discipline/

Indicator: Birth registration

Complete name: Percentage of children whose births are reported registered with a civil authority

Theme: Violence and exploitation | **Age group:** 2 to 4 | **Associated SDG:** 16.9

Source: Multiple Indicator Cluster Survey

Notes: None

Indicator: Child labour

Complete name: Percentage of children who are involved in child labour

Theme: Violence and exploitation | **Age group:** 5 to 17 | **Associated SDG:** 8.7

Source: Multiple Indicator Cluster Survey

Notes: According to MICS: "Child labourers are defined as children involved in economic activities or in household chores above the age-specific thresholds. While the concept of child labour includes exposure to hazardous working conditions, and this is collected in MICS and was previously included in the reported indicator, the present definition, which is also used for SDG reporting, does not include children who are working under hazardous conditions".

Indicator: Child marriage

Complete name: Percentage of women who were first married or in union before age 15

Theme: Violence and exploitation | **Age group:** 20 to 24 | **Associated SDG:** 5.3

Source: Multiple Indicator Cluster Survey

Notes: None

Indicator: Safety

Complete name: Percentage of people feeling safe walking in their neighbourhood after dark

Theme: Violence and exploitation | **Age group:** 15 to 49 | **Associated SDG:** 16.1

Source: Multiple Indicator Cluster Survey

Notes: None

Indicator: Domestic violence

Complete name: Percentage of women who have experienced physical, sexual, or emotional violence committed by husband/partner in the past 12 months

Theme: Violence and exploitation | **Age group:** 15 to 49 | **Associated SDG:** 5.2

Source: Multiple Indicator Cluster Survey

Notes: None

Indicator: Sexual violence		
Complete name: Percentage of women who have experienced any sexual violence (committed by husband or anyone else) in the past 12 months		
Theme: Violence and exploitation	**Age group:** 15 to 49	**Associated SDG:** 5.2
Source: Multiple Indicator Cluster Survey		
Notes: None		

Indicator: Discrimination		
Complete name: Percentage of the population having personally felt discriminated against or harassed		
Theme: Violence and exploitation	**Age group:** 15 to 49	**Associated SDG:** 10.3
Source: Multiple Indicator Cluster Survey		
Notes: None		

Indicator: Disability discrimination		
Complete name: Percentage of the population having personally felt discriminated against or harassed on the basis of disability		
Theme: Violence and exploitation	**Age group:** 15 to 49	**Associated SDG:** 10.3
Source: Multiple Indicator Cluster Survey		
Notes: None		

Well-being

Indicator: Life satisfaction		
Complete name: Percentage of the population that are satisfied with their lives		
Theme: Well-being	**Age group:** 15 to 49	**Associated SDG:** –
Source: Multiple Indicator Cluster Survey		
Notes: None		

c) Supplementary indicators – HIES

The household income and expenditure surveys (HIES) are household surveys that provide information on household expenditure, income and living conditions of households. Similar to MICS, HIES includes the WG-SS as well as an extensive list of internationally recognised indicators, based on longer questionnaires that are more suitable for population samples. The selection of HIES indicators was designed to complement information available from censuses and MICS and was informed by technical consultation with experts, alignment with standard HIES indicators, and input from a workshop with Pacific stakeholders.

Recommended indicators:

Living conditions

Indicator: Basic hygiene		
Complete name: Percentage of the population living in households with a handwashing facility, soap and water		
Theme: Housing	**Age group:** 5+	**Associated SDG:** 6.2
Source: Household Income and Expenditure Survey		
Notes: This indicator is calculated at the household level, meaning that every person living in the same household will have the same outcome. Therefore, it does not capture any intra-household inequalities.		

Economic inclusion

Indicator: Youth not in education, employment or training (NEET)		
Complete name: Percentage of the population that is not engaged in education, employment, or training		
Theme: Economic inclusion	**Age group:** 15 to 24	**Associated SDG:** 8.6
Source: Household Income and Expenditure Survey		
Notes: None		

Indicator: Financial inclusion		
Complete name: Percentage of the population with an account at a bank or other financial institution or with a mobile-money-service provider		
Theme: Economic inclusion	**Age group:** 15+	**Associated SDG:** 8.10
Source: Household Income and Expenditure Survey		
Notes: None		

Indicator: Social protection		
Complete name: Percentage of the population covered by at least one social protection floor or system		
Theme: Economic inclusion	**Age group:** 15+	**Associated SDG:** 1.3
Source: Household Income and Expenditure Survey		
Notes: None		

Indicator: Remittances		
Complete name: Percentage of the population living in a household receiving cash remittances from a non-household member		
Theme: Economic inclusion	**Age group:** 5+	**Associated SDG:** 17.3
Source: Household Income and Expenditure Survey		
Notes: None		

6.7 Other considerations

a) Applying intersectionality in the analysis

When analysing group estimates for persons with disabilities, it is important to recognise that they do not form a homogeneous group. Rather, there is considerable diversity among them. The life experiences of persons with disabilities are shaped simultaneously by multiple and intersecting social positions and identities – such as disability status, gender, and nationality – under the influence of broader systems and structures of power, including ableism, sexism and colonialism.[44] These intersecting factors can have a profound impact on their participation in society and cannot be treated as though they act independently.[45]

While there is considerable ongoing debate on how to best address these intersecting identities in quantitative research[46], this guide recommends some important steps, described below.

- Separate estimates for men and women with disabilities should be reported for all life outcome indicators (see reporting templates).
- Some indicators – such as child marriage and sexual violence – are reported only for women in line with international standards. These indicators do not imply that men and boys do not experience those scenarios, but rather recognise the larger burden on women and girls. If data are available, it is recommended that estimates for men and boys be reported as well.
- Monitoring can be strengthened by further stratifying results with additional characteristics – such as area of residence, wealth, education, and others relevant to the regional context. This requires careful consideration of decreasing sample size (see section 6.7.b), and the use of thoughtful language to avoid implying that individuals are responsible for the barriers they face (see section 7.3.b).

b) Denominator size for reporting

When estimating some indicators – particularly those based on samples of naturally smaller population groups (e.g. children with disabilities aged 24 to 35 months for the Full immunisation indicator) – it is common to encounter very small denominators. Estimates based on such small groups may be unreliable. In accordance with international practices, including those used in MICS, it is recommended

---

[44] Bauer, G. R., Churchill, S. M., Mahendran, M., Walwyn, C., Lizotte, & D., & Villa-Rueda, A. A. 2021. Intersectionality in quantitative research: A systematic review of its emergence and applications of theory and methods. SSM - Population Health 14:100798. https://doi.org/10.1016/j.ssmph.2021.100798

[45] For more details on the concept of Intersectionality: Crenshaw, Kimberlé. 1991. Mapping the margins: Intersectionality, identity politics, and violence against women of color. Stanford Law Review 43 (6): 1241–1299. https://doi.org/10.2307/1229039

[46] Ibid.

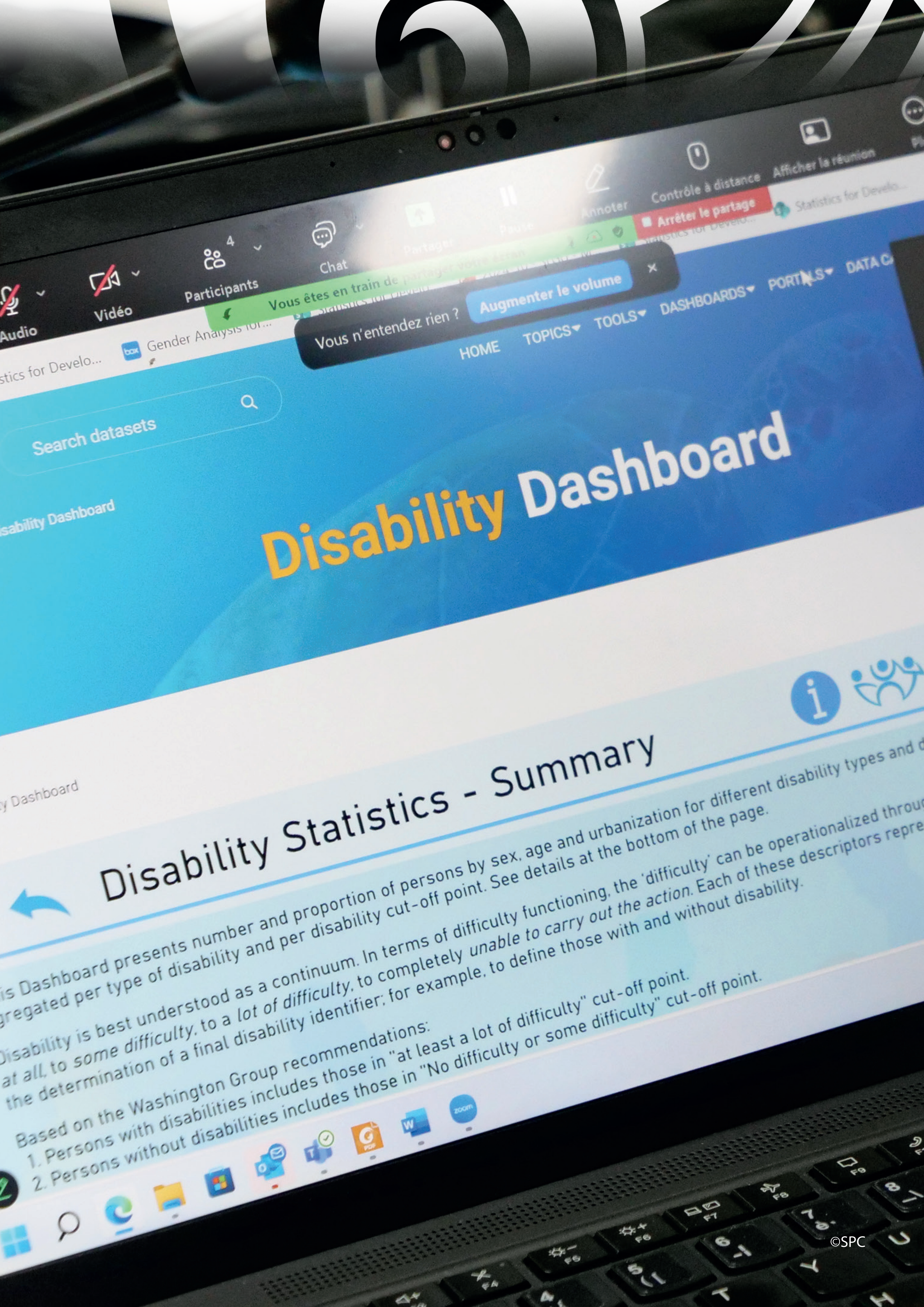
that estimates be reported only if the denominator includes at least 25 cases.
If the denominator is between 25 and 49 cases, the estimate should be accompanied by a cautionary footnote indicating the small sample size.

c) Complex survey design

Unlike censuses, surveys like MICS often rely on complex survey designs to balance national representativeness with logistical feasibility. These designs typically involve stratifying the country by region, (often based on administrative and urban/rural divisions), selecting clusters of households (often based on census enumeration areas), and using sampling procedures that give households varying probabilities of selection. In such scenarios, simply dividing the numerator by the denominator to calculate an estimate is not appropriate. A detailed discussion of how to account for complex survey designs is beyond the scope of this guidebook and is available elsewhere.[47] Statistical software such as Stata (via the svy command) and R (via the survey package) have dedicated routines to correctly incorporate survey weights, clustering and strata, and code examples are provided in monograph template.

---

[47] Survey data analysis with R: https://stats.oarc.ucla.edu/r/seminars/survey-data-analysis-with-r/
Survey data analysis with Stata: https://stats.oarc.ucla.edu/stata/seminars/survey-data-analysis-in-stata-17/



Disability Dashboard

Disability Statistics - Summary

is Dashboard presents number and proportion of persons by sex, age and urbanization for different disability types and d
gregated per type of disability and per disability cut-off point. See details at the bottom of the page.

Disability is best understood as a continuum. In terms of difficulty functioning, the 'difficulty' can be operationalized throu
at all, to *some difficulty*, to a *lot of difficulty*, to completely *unable to carry out the action*. Each of these descriptors repre
the determination of a final disability identifier: for example, to define those with and without disability.

Based on the Washington Group recommendations:

1. Persons with disabilities includes those in "at least a lot of difficulty" cut-off point.
2. Persons without disabilities includes those in "No difficulty or some difficulty" cut-off point.

©SPC

7. Reporting disability data

While disability data are increasingly being collected as part of various data collection methods, including censuses and other national sample surveys, they are often not reported. There are indicators for monitoring UNCRPD and SDG indicators that are agreed internationally (and in the Pacific region as listed in Section 6) but disability data get neglected in reporting as part of the standard dashboards and other formats. To address this issue, this guidebook recommends reporting formats for NSOs to disseminate findings from the analysis of disability data. Different dissemination methods can be used, depending on each country's context and OPD requirements for advocacy, policy and programming. Some possible methods of reporting include:

- as part of the census dashboards;
- Pacific Data Hub's Regional Dashboard https://pacificdata.org/disability-dashboard;
- country-specific disability monographs;
- as part of the statistical yearbook from different agencies such as UN ESCAP, SPC;
- infographics that can be promoted through social media and press releases; and
- disability factsheets, e.g. Kiribati Disability Factsheet.

This guidebook focuses on country-specific disability monographs developed using censuses and national sample surveys data, analysing indicators on disability and life outcomes indicators listed in section 6. This section provides recommendations on key considerations for reporting disability data.

7.1 Reporting in text

a) Referring to persons with disabilities

The WG question sets – particularly WG-SS, WG-SS Enhanced, WG-ES and CFM – are designed to collect information on the activity limitations component of the ICF framework but are referred to as functioning to enhance clarity. Evidence shows that these tools identify most persons 'at risk' of restricted participation in their communities. Data from the WG question sets can be used to disaggregate life outcome indicators (e.g. education and employment) between persons with difficulties and without difficulties in obtaining information on restricted participation. While the most accurate term for those identified as at risk of restricted participation may be 'persons with functional limitations', the term that is generally used is 'persons with disabilities' for ease of reporting.

Different terminologies are used, depending on the context: people with disability, people with disabilities, persons with disability, and disabled people or disabled persons. Person-first language is recommended when reporting on disability in the Pacific region. As agreed by the Pacific stakeholders and aligning with the language of UNCRPD, this guidebook recommends using the term "persons with disabilities" when reporting about persons identified as having difficulties with activities using WG question sets. When reporting on children, the term "children with disabilities" is recommended.

b) Reporting estimates

As discussed in section 6, all indicators included in the disability monographs are expressed as percentages, ranging from 0% to 100%. When reporting their estimates in text, one – and only one – decimal place should be included, followed by the percentage sign. For example, in a country with 100,000 people, of whom 15,000 have a disability, the prevalence of disability should be reported as

15.0% (not 15% or 15.00%). All estimates should be reported in the past tense. For example, 15.0% of the population in Country A had disabilities.

In the disability monographs, indicators fall into three main categories.

1. Indicators of functional difficulty
2. Indicators of disability status
3. Indicators of life outcomes for persons with and without disabilities

Functional difficulty indicators should always include the level of difficulty alongside their estimate. For example: "8.3% of the population in Country A had at least a lot of difficulties with vision, and 1.5% could not see at all."

Disability status, as outlined in section 6, is defined for the purposes of the disability monographs as having reported "a lot of difficulty" or "cannot do at all" in any of the functioning domains. Since that definition is provided in the methodology section of the monograph, it does not need to be repeated throughout the main text, but rather only when first mentioned, in the titles of figures and tables, and in footnotes where relevant. Other cut-off points should be avoided. The term "persons with disabilities" should refer exclusively to those who meet this definition. Examples of recommended reporting include:

- 14.8% of the population in Country A had disabilities;
- 46.7% of people aged 50 to 59 years were persons with disabilities; and
- among people with no formal education, 23.5% had disabilities.

Life outcome indicators should follow the wording established in section 6, and each estimate should clearly specify the population group it refers to – particularly when the denominator is not the entire population or the indicator has a more specific age group. Examples of recommended reporting include:

- 65.7% of persons with disabilities aged 18 or above had completed secondary education;
- 5.4% of persons in the labour force without disabilities were unemployed[48];
- 14.7% of women with disabilities aged 20 to 24 had a live birth before age 18.

c) Reporting inequalities

All estimates of life outcome indicators should be reported for persons with and without disabilities, allowing for the investigation of inequalities between the two groups. Even though inequalities can be monitored in many ways, we recommend the simple approach of presenting separate estimates of percentages for persons with and without disabilities while reporting on comparisons of which group has a higher or lower percentage, or if percentages are relatively similar. Examples of recommended reporting are given below.

- 65.7% of persons with disabilities aged 18 or above had completed secondary education, compared to 74.3% of persons without disabilities.
- Unemployment for persons with and without disabilities was relatively similar: 5.2% and 5.4%, respectively.
- Live births before age 18 were less common among women with disabilities aged 20 to 24 (14.7%) than among women without disabilities (21.2%).

---

[48] Since all economic activity indicators refer to the same age group (15+), it can be stated at the beginning of the economic activity section and does not need to be repeated throughout the text.

The absolute difference between groups can optionally be reported. The difference between two percentages should be reported using percentage points (often abbreviated as pp), not with the percentage sign. For the first example above, instead of reporting: "The proportion of people with complete secondary education was 8.6% lower for persons with disabilities", one should report: "The proportion of people with complete secondary education was 8.6 percentage points lower for persons with disabilities".

7.2 Reporting in tables and charts

a) Tables

Most estimates in the disability monograph template are presented in tables. An example is shown in Table 9, which presents the prevalence of disability for specific population groups. It includes three columns: the group described in each row, the number of persons with disabilities in that group, and the prevalence of disability in that group. Similar to all standard tables in the disability monograph template, Table 9 includes only two types of numbers: percentages (see section 7.1.b) and absolute counts.[49] In tables, percentages should be reported with one decimal place and without the percentage sign, as the column or table titles already indicate the values are percentages.

---

[49] Absolute counts are presented only in the initial tables that describe the population with disabilities and different levels of functional difficulties. To avoid overcrowded tables – requiring additional page space and smaller fonts – tables presenting outcomes for persons with disabilities are limited to percentages only. When reporting counts based on complex sampling designs that require weighting, the counts should also be weighted.

TABLE 9. Example of a standard table in disability monograph template used for reporting the prevalence of disability

Group of people	Prevalence of disability	Number of persons with disabilities
Overall population	Example: 13.0	Example: 17,427
Sex		
Female		
Male		
Age groups		
Under 18		
18 to 29		
30 to 39		
40 to 49		
50 to 59		
60 to 69		
70 to 79		
80+		
Area of residence		
Urban		
Rural		
National region		
Region 1		
Region 2		
Region 3		
Region 4		
Education		
No formal education		
Up to complete primary		
Up to complete secondary		
Any tertiary		
Marital status		
Never married/in union		
Currently married/in union		
Divorced/separated/widowed		
Number of household members		
1		
2 to 5		
5+		

To populate the table, include both the number of persons with disabilities and the prevalence of disability within each group. In Table 9, for example, 17,427 people in the overall population had disabilities, representing 13.0% of the population. A list of pre-selected population subgroups is provided in the standard tables, and it is recommended that all be included in the disability monographs. Additional groups may be included, based on data availability and national priorities, following the same reporting format.

Table 10 presents the standard format used for reporting outcomes for persons with and without disabilities. Each row refers to a specific indicator. The first column lists all indicators in a specific theme, as outlined in section 6. The second column specifies the age range associated with each indicator. The remaining columns should present the estimates of each specific indicator for the following groups, in order.

- All people (e.g. 92.0%)
- All persons with disabilities (79.2%)
- Women with disabilities (81.5%)
- Men with disabilities (77.7%)
- All persons without disabilities (93.3%)
- Women without disabilities (94.6%)
- Men without disabilities (92.1%)

TABLE 10. Example of a standard table in a disability monograph template used for reporting the estimates of education indicators

			Total		**Females**		**Males**	
Indicator	**Age**	**Total**	**With disability**	**Without disability**	**With disability**	**Without disability**	**With disability**	**Without disability**
Ever attended school	5+	Ex:92.0	Ex: 79.2	Ex: 93.3	Ex: 81.5	Ex: 94.6	Ex: 77.7	Ex: 92.0
Currently attending school	5–18							
Literacy	15+							
Primary education	15+							
Secondary education	15+							
Vocational education	15+							
Tertiary education	15+							
Post-secondary education	15+							

More detailed information on specific tables is presented in the disability monograph template.

b) Charts

Charts can be used to visually present data at a glance. They often make data comparisons easier and help visually identify and interpret overall trends and patterns, but they can also limit access to information for people with vision or cognitive difficulties.

Charts can be included in disability monographs, but should never be the sole source of information. Whenever charts are used, they should be accompanied by:

- **alternative text** (alt text), which describes the chart's content in words and can be read by screen readers for accessibility; or
- **plain language interpretation** of results and patterns within the main text, with direct reference to the figure; or
- **an associated table**, potentially included in an appendix, presenting the underlying estimates in a format that is easier to extract by users.

For disability monographs, three types of charts are recommended: bar charts, equiplots, and line charts. They are described in the following sections.

Bar charts

Bar charts are simple and effective tools for displaying disability data (see Figure 4 for an example). They enable comparison across multiple indicators or population groups, provided that the bars are aligned at a common baseline and a consistent scale is used.[50]

Bar charts may be horizontal or vertical. Horizontal bar charts, such as Figure 4, allow labels to be presented in a horizontal format. Therefore, they are recommended when category labels are longer than a few characters to avoid rotated or vertical text, which reduces readability.

It is also recommended to display values with one decimal place outside of the bar, providing more precise estimates in the figure. The bars allow for quick visual comparison, while the text presents detailed information.

---

[50] When using charts to represent percentages, it is strongly recommended that the percentage axis starts at zero to avoid exaggerating differences between groups.

FIGURE 4. Example of a bar chart presenting the prevalence of disability and functional difficulties

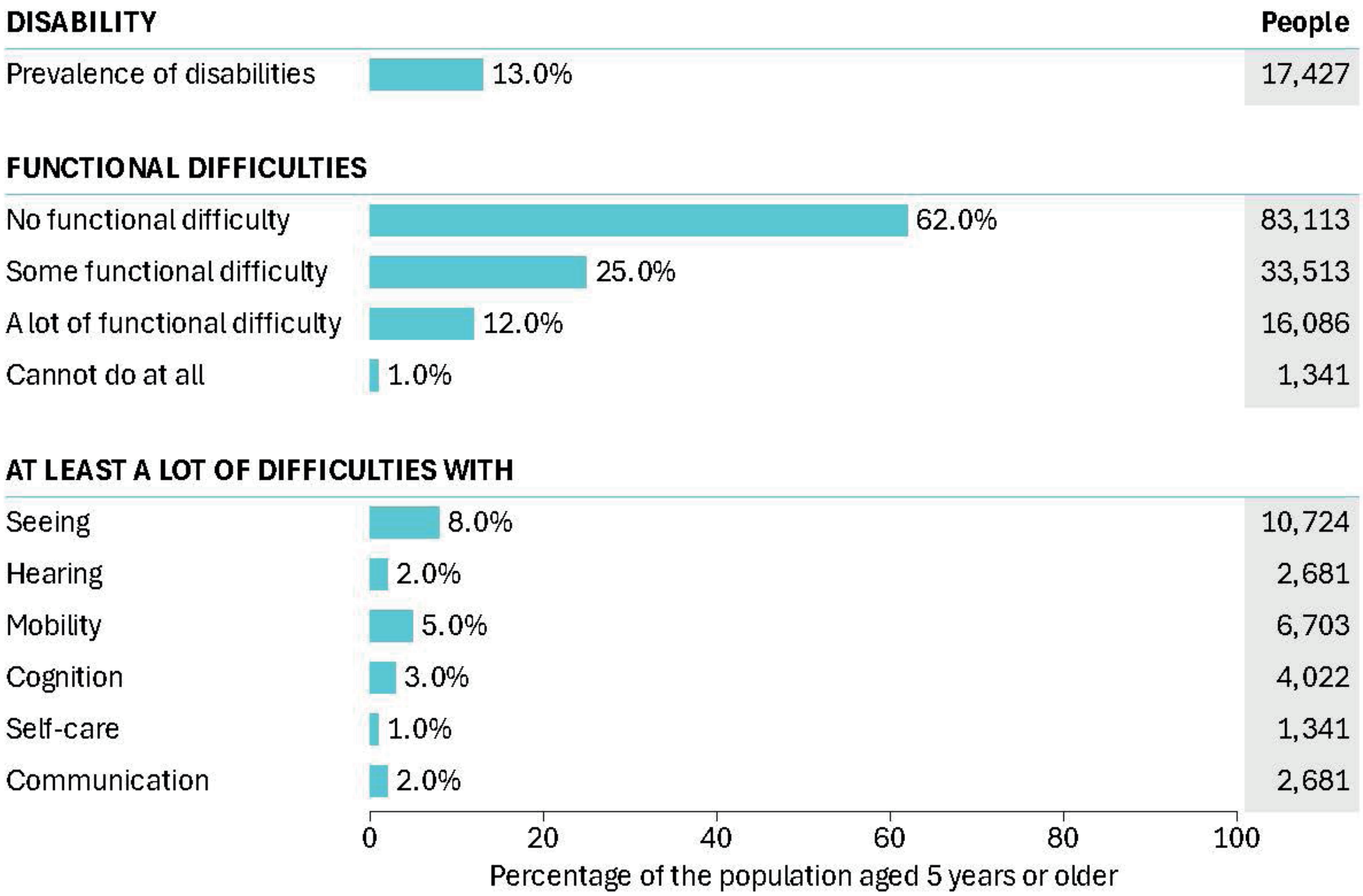


Figure 4 was designed for the executive summary of disability monographs. It displays the prevalence of disability, levels of functional difficulty and functional difficulty by domain. The figure also shows the absolute number of persons with disability and functional difficulties in the country.

Equiplots

Equiplots, also known as dumbbell charts, are designed to display inequalities between groups (see Figure 5 for an example). In disability monographs, they are particularly useful for examining inequalities between persons with and without disabilities. Equiplots are relatively easy to interpret and can present large amounts of information in a clear and organised manner. They are constructed[51] using:

- **coloured**[52] **circles** to represent the estimates of the outcome of interest for each group. Optionally, rounded percentages may be displayed within each circle; and
- **grey bars** to represent absolute inequalities between groups. The wider the bar, the greater the absolute difference.

---

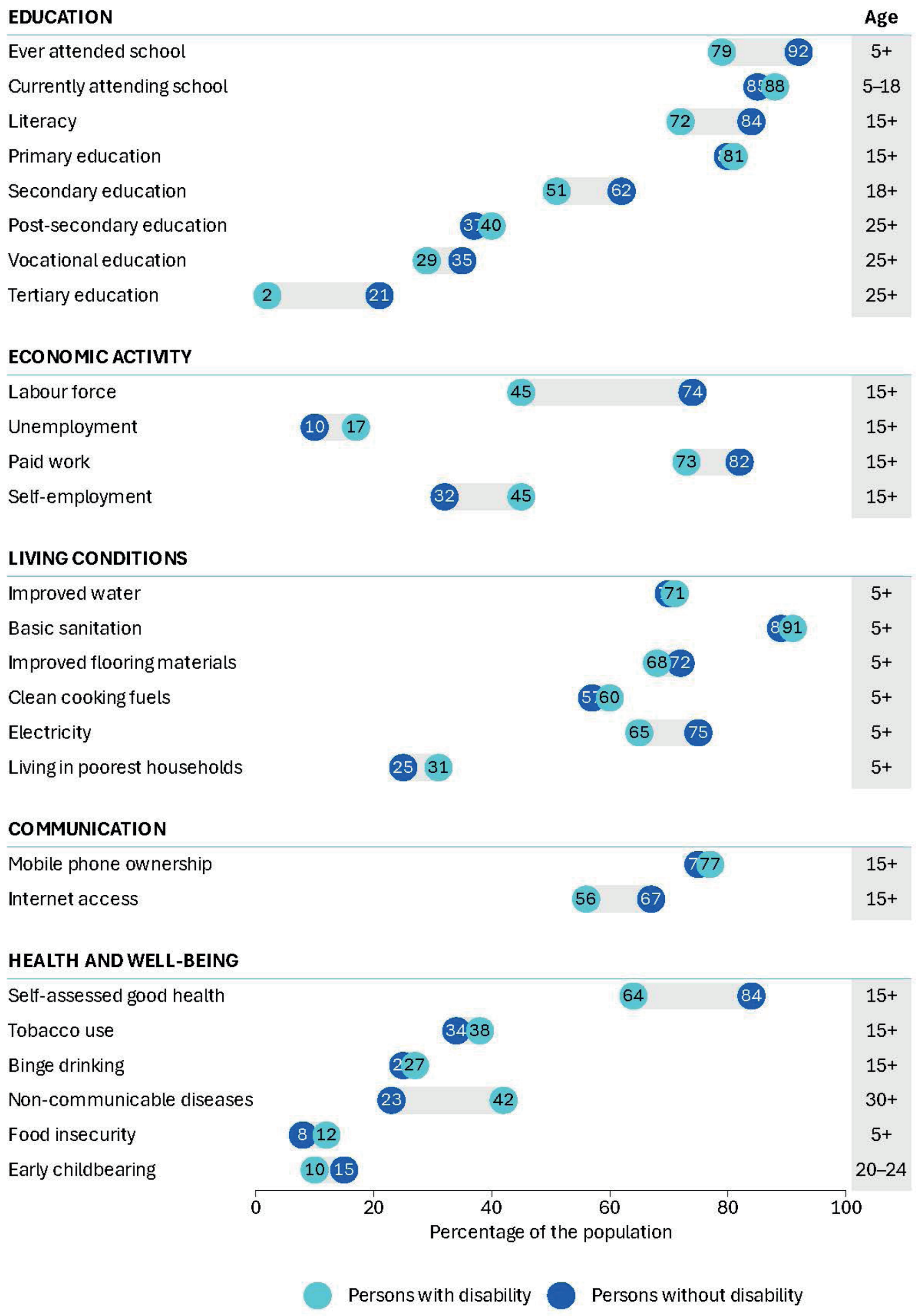
[51] Equiplots can be created using the R code provided in the Disability Statistics Toolkit or with the Equiplot Creator Tool from the International Center for Equity in Health | Pelotas (https://equidade.org/en/equiplot_creator).

[52] Given that people vary in their ability to distinguish colours, it is important to choose colour schemes that are easily differentiated – not relying solely on hue differences (e.g. green vs blue), but also incorporating variations in lightness (e.g. darker vs lighter colours) to improve contrast.

Figure 5 was designed to summarise all standard life outcome indicators included in disability monographs. It presents the indicator estimates for persons with and without disabilities, and highlights the inequalities between them. Each row represents one indicator (e.g. improved water or internet access), and indicators are grouped by theme (e.g. living conditions or communication). As each indicator is associated with a specific age group, this information is shown on the right side of the chart.

For example, Figure 5 reports that 2% of persons with disabilities and 21% of persons without disabilities aged 25 years or older have completed tertiary education.

FIGURE 5. Example of an equiplot presenting the estimates of life outcome indicators for persons with and without disability



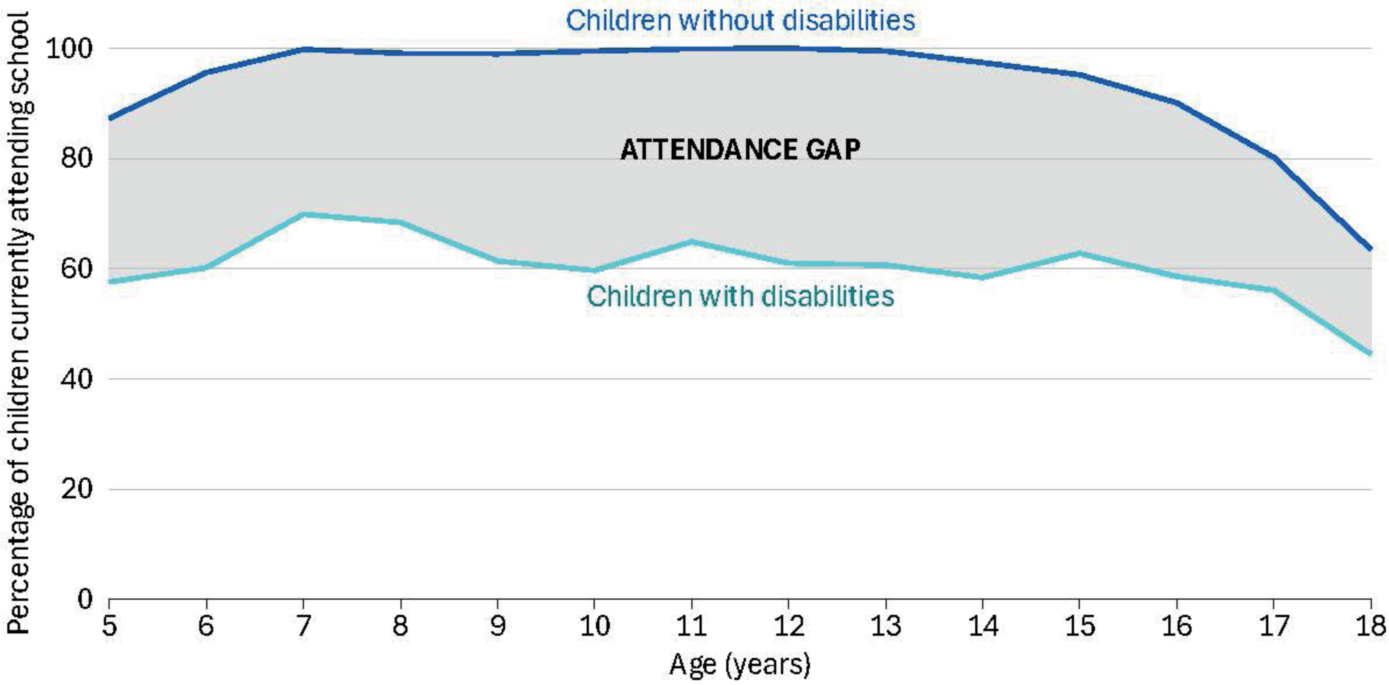
Line charts

Line charts are useful for showing how a specific outcome varies according to a numeric or ordered set of categories. They can be used to compare trends between different groups by displaying multiple lines (see Figure 6 for an example). Line charts can become cluttered, however, if many lines are included or when lines cross. Therefore, they should be used sparingly and with caution.

In disability monographs, line charts can be used, for example, to compare how the estimates of an outcome changes with age for persons with and without disabilities. Since only two lines are shown, the area between them can be shaded to illustrate the difference in percentages. This shaded area helps to visualise the size of the inequality.

In Figure 6, this shaded area is referred to as the attendance gap – the difference in current school attendance between children with and without disability. The larger the shaded area, the larger the inequality

FIGURE 6. Example of a line chart showing the percentage of children currently attending school, by disability status



7.3 Transparency and acknowledgement of limitations

a) Acknowledging the limitations of Washington Group Question Sets

While the WG question sets are the recommended tools for measuring disability as part of the population and housing censuses and for monitoring UNCRPD and SDG indicators on disability, they are designed for a specific purpose. They aim to collect data on disability status that is comparable across different settings by using questions on basic functioning activities; they do not provide comprehensive information on their own. Acknowledging this is important when reporting on the data collected using WG question sets.

The key limitations are listed below.

- WG-SS has only six questions on basic activities and is not effective for identifying psychosocial disabilities.
- While WG-SS Enhanced and WG-ES collect data on psychological distress, a full spectrum of psychosocial functioning is not captured.
- WG-SS, WG-SS Enhanced and WG-ES are designed for adults and are less effective for children aged between 5 and 18 years. This limitation should be acknowledged when reporting on WG-SS data in censuses.
- These question sets are designed to identify populations with functional difficulties and not to capture other aspects of disability, such as age of onset, type of impairment, cause of disability, barriers, or the impact of assistive devices (except for walking in the WG-ES).
- Although CFM targets the most common functions that are age-appropriate among children aged 2–17 years, proxy reports may not be reliable for older children, as they are dependent on the primary caregiver's perceptions.

Considering these limitations, the monograph should acknowledge the limitations that are applicable, based on the type of WG question set used. In addition, any specific methodological limitations related to the survey methodology should also be included. Some examples are listed here for consideration.

- Some surveys, including censuses, may exclude institutionalised populations.
- Small numbers in certain sub-groups, either due to their geographic location or minority groups, may limit further analysis to compare differences in participation between persons with and without disabilities (See section 7.3.c) for more information).
- The number of indicators included in the survey may be limited, due to resource constraints or the nature of the survey to allow meaningful comparisons and monitoring of progress on some key indicators.

b) Contextualising disability data

While outcome estimates derived from census and survey data are highly informative, they have limited capacity to explain the underlying causes of inequalities, what is needed to address the inequalities or the lack of progress experienced by persons with disabilities. Additional qualitative information and in-depth disability surveys that capture contextual information can help explain the environmental and systemic factors that generate or exacerbate inequalities. Presenting contextual information alongside outcome indicators provides a more complete picture, helping to identify structural barriers and inform targeted interventions. However, care must be taken to ensure that such information is framed in a way that does not imply a lack of agency or inadvertently suggest that persons with disabilities are responsible for the barriers they face, but rather highlights the role of social, institutional and attitudinal factors in shaping their experiences.

c) Analysing small subgroups of the population

When reporting disability data – especially for subgroups within the population of persons with disabilities, such as women with disabilities or young children at risk of disability – it is common to encounter groups with a small number of individuals to analyse. This issue is particularly important in the Pacific context, where countries and territories often have relatively small populations. In practice, this means that any estimates produced are highly dependent on a small number of cases, and results can shift dramatically, based on the outcomes of just a few individuals.

This can lead to some challenging scenarios, such as those described here.

- When comparing multiple small groups, results may appear scattered and inconsistent, rather than following predictable patterns. For example, when examining school attendance among children with disabilities by age – as shown in the monograph template – the data might form a zigzagging line instead of a smoother, more expected curve.
- When comparing results across monographs from the same country over time, indicators based on small groups (e.g. early childbearing among women aged 20 to 24) may change dramatically without a reasonable explanation or any known change in the country context to account for them.

The challenge with these scenarios is that it is not possible to determine, based solely on data, whether the observed patterns are:

- fluctuations due to the small number of people analysed;
- unexpected patterns that accurately reflect reality; or
- a combination of both.

In censuses – if conducted properly – large changes in small groups may simply result from the fact that it takes fewer people to shift outcomes in smaller populations. However, in surveys such as MICS and HIES, which are based on samples rather than full populations, changes may be due to chance and the natural variability that comes with sampling, requiring extra caution in interpretation.

When reporting and interpreting estimates in monographs and other reports, analysts should be mindful of:

- the source of the data and whether sampling was performed;
- the number of people in the denominator of each estimate; and
- the size of the standard errors or confidence intervals for each estimate.

As a rule, as established in section 6, results should only be reported for groups with at least 25 people, and for groups with 25 to 49 people, estimates should be marked with an asterisk. These rules are a good starting point but should be complemented in the text with some acknowledgement of limitations – particularly for the optional MICS and HIES modules. When necessary, use footnotes and explicitly note the small number of individuals being analysed, and avoid drawing strong conclusions, favouring instead language that reflects the uncertainty of the estimate.

Annexes

Disability Monograph Template

This template includes the minimum set of results recommended to be published in disability monographs for Pacific Island countries and territories. Countries are encouraged to include additional analyses, tables, and figures based on data availability, national priorities and capabilities. Publishing statistics in a consistent format and using standard definitions ensures comparability across countries in the region and over time. The template is available in editable form on the disability statistics page on the SPC website here: https://www.spc.int/digitallibrary/get/7rqzi

Analytical Code

This provides general guidance and specific examples on how to conduct the statistical analysis required for creating a disability monograph. The examples include code in both Stata and R, selected for their relevance to the Pacific region and to offer an open-source option for users https://www.spc.int/digitallibrary/get/o5xip.

Code for generating figures is provided only in R, due to its significantly more powerful graphics capabilities. The code is available online here: https://github.com/PacificCommunity/sdd-disability-statistics-toolkit/

For more information, please refer to the complete Statistical Toolkit:
https://www.spc.int/digitallibrary/get/dp8m5

References

Bauer, G. R., Churchill, S. M., Mahendran, M., Walwyn, C., Lizotte, & D., & Villa-Rueda, A. A. 2021. Intersectionality in quantitative research: A systematic review of its emergence and applications of theory and methods. SSM - Population Health 14:100798. https://doi.org/10.1016/j.ssmph.2021.100798

Bradley, S. E. K., Croft, T. N., Fishel, J. D., & Westoff, C. 2012. Revising unmet need for family planning. DHS Analytical Studies No. 25. ICF International. Available at: https://www.dhsprogram.com/publications/publication-AS25-Analytical-Studies.cfm

Byford, J., & Veenstra, N. 2004. The importance of cultural factors in the planning of rehabilitation services in a remote area of Papua New Guinea. Disability and Rehabilitation 26(3):166-175. https://doi.org/10.1080/09638280032000159167

Fiji Ministry of Education 2022. Fiji Education Management Information System (FEMIS) Disability disaggregation Package. Guidelines and forms. Available at: https://www.education.gov.fj/wp-content/uploads/2024/09/FEMISdisabilitydisaggregationpackage_March2022.pdf

Fillmore MT, Jude R. 2011. Defining "binge" drinking as five drinks per occasion or drinking to a .08% BAC: which is more sensitive to risk? The American Journal of Addictions 20(5):468-75. https://doi.org/10.1111/j.1521-0391.2011.00156.x .

Gartrell, A., Jennaway, M., Manderson, L., Fangalasuu, J., & Dolaiano, S. 2018. Social determinants of disability-based disadvantage in Solomon Islands. Health Promotion International 22(2):250-260. https://doi.org/10.1093/heapro/daw071

Heinicke-Motsch, K. and Sygall, S. eds. 2004. Building an inclusive development community. A manual on including people with disabilities in international development programs. Mobility International USA. Available at: https://www.fsnnetwork.org/sites/default/files/building_and_inclusive_development_community.pdf.

Kuzma, J., Ramalingam, K. P., & Karthikeyan, P. 2016. Traditional beliefs and care system towards persons with disabilities in Papua New Guinea. Contemporary PNG Studies, 25:13–23.

Legge, H., Pullan, R. L., & Sartorius B. 2023. Improved household flooring is associated with lower odds of enteric and parasitic infections in low- and middle-income countries: A systematic review and meta-analysis. PLOS Glob Public Health 3(12). https://doi.org/10.1371/journal.pgph.0002631

Meo-Sewabu, L., Hughes, E., & Stewart-Withers, R 2017. Pacific research guidelines and protocols. Auckland: New Zealand: Massey University. Available at: https://www.massey.ac.nz/documents/1055/PRPC_Pacific_Research_Guidelines_2017.pdf.

Pacific Data Hub. Disability Dashboard. https://pacificdata.org/disability-dashboard

Pacific Disability Forum 2018. From recognition to realisation of rights: Furthering effective partnership for an inclusive 2030. Available at: https://pacificdisability.org/sdg/

Pacific Disability Forum 202). Strategic Plan 2021-2025: Towards an inclusive and resilient Pacific for all persons with disabilities. Available at: https://pacificdisability.org/wp-content/uploads/2022/06/Towards-An-Inclusive-And-Resilient-Pacific.pdf

Pacific Islands Forum Secretariat 2016. Pacific Framework for the Rights of Persons with Disabilities 2016-2025.Available at: https://pacificdisability.org/wp-content/uploads/2024/04/Pacific-Framework-Rights-of-PWD.pdf

Pacific Islands Forum Secretariat 2022. Second Quadrennial Pacific Sustainable Development Report. Available at: https://library.sprep.org/sites/default/files/2023-06/2022-06-12-PIF-Final-Report.pdf

Picton, C., Horsley, M., & Knight, B. A. 2016. Exploring conceptualisations of disability: A talanoa approach to understanding cultural frameworks of disability in Samoa, Disability CBR & Inclusive Development 27(1). https://doi.org/10.25946/13387271

CBM-Nossal Partnership for disability-inclusive development and research for development impact network. 2020. Research for all: Making development research inclusive of people with disabilities. https://rdinetwork.org.au/wp-content/uploads/2020/06/RDI-Network-R4All-Accessible-PDF-1.pdf

Schneider, M. 201). Why The Washington Group questions ask about 'difficulties' and not 'disabilities'- How a single word can make a difference. Washington Group on Disability Statistics. Available at: https://www.washingtongroup-disability.com/wg-blog/why-the-washington-group-questions-ask-about-difficulties-and-not-disabilities-how-a-single-word-can-make-a-difference-108

Smith, F., Perera, S., & Marella, M. 2023. The journey to early identification and intervention for children with disabilities in Fiji. International Journal of Environmental Research and Public Health, 20(18), 6732. https://doi.org/10.3390/ijerph20186732

The Economic and Social Commission for Asia and the Pacific. 2021. The shaping of disability-inclusive employment in Asia and the Pacific. Available at: https://www.unescap.org/sites/default/d8files/knowledge-products/DAG2021-Final.pdf

The Pacific Community 2024. Challenging perspectives around disability. Available at:https://www.spc.int/updates/blog/2024/04/challenging-perspectives-around-disability

United Nations 2006. Convention on the Rights of Persons with Disabilities. Available at: https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-articles

United Nations Children's Fund 2018. Module on child functioning: Manual for interviewers. Available at: https://data.unicef.org/resources/module-on-child-functioning-manual-for-interviewers/

United Nations Children's Fund 2022. Pacific Regional Inclusive Education Review. https://pacificdisability.org/wp-content/uploads/2023/04/Pacific-IE-Report_2022.pdf

United Nations Children's Fund & World Health Organization 2023. Joint monitoring programme for water supply, sanitation and hygiene – Progress on household drinking water, sanitation and hygiene 2000-2022.

United Nations Human Rights Office of the High Commissioner. Status of ratification interactive dashboard. Available at: https://indicators.ohchr.org/

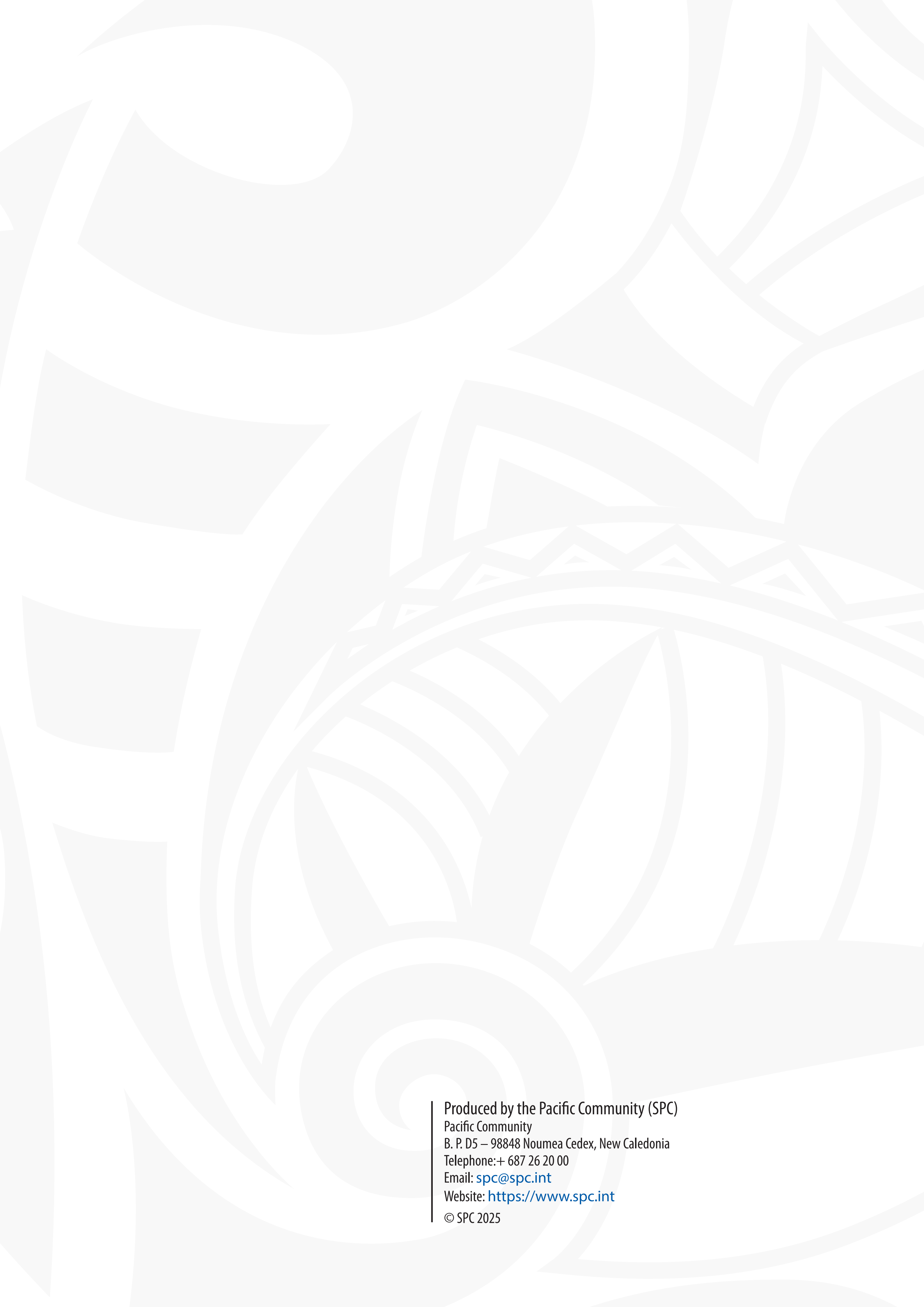
United Nations Office for Disaster Risk Reduction 2023. Midterm review of the Sendai Framework for disaster risk reduction 2015–2030: Thematic report on disability inclusion in disaster risk reduction in the Pacific. Available at: https://www.undrr.org/publication/thematic-report-disability-inclusion-pacific

World Health Organization 2001. International classification of functioning, disability and health: ICF. Geneva: World Health Organization.

World Health Organization 2019. Harmonizing vaccination coverage measures in household surveys: A primer. World Health Organization. Available at: https://cdn.who.int/media/docs/default-source/immunization/immunization-coverage/surveys_white_paper_immunization_2019.pdf?sfvrsn=7e0fb0ae_9

Notes

Notes



Produced by the Pacific Community (SPC)
Pacific Community
B. P. D5 – 98848 Noumea Cedex, New Caledonia
Telephone:+ 687 26 20 00
Email: spc@spc.int
Website: https://www.spc.int