

# Poverty reduction and development in Cambodia: Enabling disabled people to play a role



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## Abbreviations and acronyms

ABC	Association of Blind Cambodians
ADB	Asian Development Bank
ADD	Action on Disability and Development
APPT	Alleviating Poverty through Peer Training
ARPU	Asia Regional Policy Unit
CBR	Community-based rehabilitation
CC	Commune councils
CCSP	Commune Council Support Project
CDPO	Cambodian Disabled Person's Organisation
CHAD	Conflict and Humanitarian Affairs Department
CIDA	Canadian International Development Agency
CMAA	Cambodian Mine Action Authority
COMFREL	Committee for Free Elections
CSCF	Civil Society Challenge Fund
CSD	Council for Social Development
CSO	Civil society organisation
CSP	Country strategy paper
DAC	Disability Action Council
DANIDA	Danish International Development Agency
DDP	Deaf Development Programme
DDSP	Disability Development Services Pursat
DFID	Department for International Development
DPO	Disabled people's organisation
EMIS	Education Management Information System
ERJ	Exclusion, Rights and Justice
ESSP	Education Sector Support Programme
EU	European Union
FINIDA	Finnish International Development Agency
GPDD	Global Partnership for Disability and Development
GTZ	Gesellschaft für Technische Zusammenarbeit (German)
ICF	International Classification of Functioning, Disability and Health
ICRC	International Committee of the Red Cross
IE	Inclusive education
ILO	International Labour Organization
JICA	Japanese International Cooperation Agency
KaR	Knowledge and research
MDGs	Millennium Development Goals
MoEYS	Ministry of Education, Youth and Sport
MoH	Ministry of Health
MoP	Ministry of Planning
MoSALVY	the Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation (now MoSAVY)
MoSAVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
NCDP	National Centre of Disabled Persons
NEC	National Electoral Commission
NEP	NGO Education Partnership
NGO	Non-governmental organisation
NIS	National Institute of Statistics
NPRS	National Poverty Reduction Strategy

PIT	Provincial Implementation Teams
PPA	Participatory Poverty Assessment
PRSP	Poverty Reduction Strategy Programme
PTSD	Post-traumatic stress disorder
RBA	Rights-based approach
RGC	Royal Government of Cambodia
SEO	Special Education Office
SHG	Self-help groups
SIDA	Swedish International Development Agency
SWAP	Sector-wide approach
UN	United Nations
UN ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UXO	Unexploded ordnance
WB	World Bank
WHO	World Health Organization
WVI	World Vision International

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## Executive summary

This report has been produced by the Disability Policy Officer for the Policy Project of the Disability Knowledge and Research (KaR) programme, funded by the UK Department for International Development (DFID). It is the first part of a three-country study, taking place in Cambodia, Rwanda and India, to:

- explore how disability relates to DFID's work on reducing poverty and social exclusion and the achievement of the Millennium Development Goals (MDGs)
- map disability-focused activities in each country
- identify examples of best practice
- explore the opportunities and constraints for raising the profile of disability within each DFID programme
- identify potential partners for DFID to take forward work on disability.

## Methodology

The research for this study was conducted by the Disability Policy Officer. The research comprised a desk review of literature and an 18-day field visit to Cambodia during December 2004. The primary research method was key informant semi-structured interviews and visits to three disability organisations. It also involved a focus group discussion with disabled people and follow-up interviews with four disabled individuals in Pursat Province.

## Disability in Cambodia

### Defining disability

There is no universally agreed definition of disability. Historically, disability has been seen primarily as a medical condition – a problem located within the individual. Since then, this medical, or individual, model has been challenged by disability activists who reconceptualised disability as primarily a social phenomenon. This social model of disability draws a clear distinction between 'impairments' and 'disability'. It argues that it is society that disables people who have impairments, through its failure to recognise and accommodate difference, and through the attitudinal, environmental and institutional barriers that it erects against people with impairments. Disability thus arises from a complex interaction between health conditions and the context in which they exist. This social understanding of disability informs this report.

### Scale, prevalence and causes of disability

As in most developing countries, accurate statistics on the number of disabled people in Cambodia are not available. Numbers and percentages differ from publication to publication. Nevertheless, it is estimated that Cambodia has one of the highest rates of disability in the developing world (UN ESCAP 2002).

### *Disabled people in Cambodia: overall figures* (Table cont. overleaf)

<b>Number/percentage of disabled people</b>	<b>Source</b>
<b>Adults</b>	
170,000 (1.5% of 11,000,000 population)	<i>Socio-Economic Survey</i> (NIS 2003)

9.8%	<i>Skills Training as a National Strategy for Poverty Reduction in Cambodia (ADB 1997)</i>
1.4 million (15%)	<i>Identifying Disability Issues Related to Poverty Reduction: Cambodia Country Study (ADB 1999)</i>
<b>Children</b>	
32,000 (21%)	MoSAVY (2002)

### ***Disabled people in Cambodia, by type of impairment***

<b>Type of disability</b>	<b>Number/ percentage of disabled people</b>	<b>Sources</b>
<b>Landmine injuries</b>	40–50,000	<i>Action for Victim Assistance (DAC 2003b)</i> UN ESCAP (2002)
<b>Polio</b>	60,000	UN ESCAP (2002)
<b>Deafness</b>	300,000 (130,000 profoundly deaf)	Deaf Development Programme (DDP)/Krousar Thmey (2004)
<b>Blindness</b>	144,000 (108,000 50+ years, 28,000 15–50 years, 8,000 under 15)	Association of the Blind in Cambodia (ABC) (2004)
<b>Mental health</b>	–	No national data
<b>Intellectual disabilities</b>	–	No national data

The most common types of disability in Cambodia are moving difficulties, followed by seeing and then hearing difficulties. The main causes of disability are illnesses and disease, followed by congenital causes, then accidents. A relatively low percentage of disabilities are caused directly by conflict and mines. Currently, approximately 3 people per day in Cambodia are killed or injured by mines and unexploded ordnance (UXO), but road traffic accidents are responsible for significantly much more disability. In November 2004 in Phnom Penh alone there were 628 road accident casualties reported, of whom 4 per cent died and 35 per cent suffered severe injuries warranting surgery and/or intensive care treatment (Handicap International 2004).

The vast majority of disability in Cambodia is preventable. Poverty is a major cause of disability, and one of its major consequences (Bonnet 1997).

### **Disability, poverty and social exclusion**

The National Poverty Reduction Strategy states that 36 per cent of the population live below the poverty line of US\$0.40–0.63.

#### *Disability and poverty*

Disability and poverty are inextricably intertwined. Poverty is a significant cause of disability. It is poor people who are usually the victims of mine and UXO accidents, as they are forced to live near and enter mine affected areas to collect food or firewood (International Campaign to Ban Landmines 2004). They are also forced to use less safe methods of transport and to work in risky environments. In addition, their lack of access to basic health care means that simple infections, illnesses and injuries often result in permanent disability because they go untreated or are mistreated. For example, untreated common childhood ear infections are a major cause of permanent hearing loss in children (DDP, personal communication).

Grinding poverty often brings psycho-social mental health problems such as depression and anxiety, which can be very disabling. Women are particularly vulnerable to these (Chapuis 2004, Dubois *et al* 2004). Poor nutrition is another cause of disability. By the age of two, half of all Cambodian children are stunted (RGC/CSD 2002) and malnourishment is a major cause of developmental delay and long-term intellectual disability. Iron deficiency can reduce intelligence by as much as 13–21 IQ points and the first national goitre survey by the Cambodian Ministry of Health in 1997 projected a goitre rate of 12 per cent among children aged 8–12 years, rising to 45 per cent in some areas. Vitamin A deficiency is the leading cause of childhood blindness (RGC/CSD 2002).

Poverty is not only a cause of disability – it is also a major consequence of disability. In this study, all the informants who became disabled later in life said they became poorer after they were disabled, and most said they had become much poorer.

Cambodians spend a high proportion of their income on health care – approximately 10 per cent (Nguyen 2004). Health expenditure is a major cause of personal debt, and disabled people generally require more health services. All the members of the adult focus group for this study commented that they had been ill more often since they became disabled.

However, disability impacts upon an individual's ability to work and earn a living. The intensity of this impact depends on the nature of the individual's impairment. Most Cambodians are employed in agricultural activities, and even fairly mild or moderate physical impairments can limit one's capacity to work in the fields, with a consequent impact on the household economy, resulting in negative social attitudes. Some disabled people need to learn new skills to earn a living, but vocational training opportunities are limited and only available in urban areas, and are generally not linked to the market.

#### *Disability and exclusion*

Disabled people in Cambodia experience significant exclusion. They suffer from direct discrimination and stigma, and from varying degrees of social isolation. They are also largely excluded from the political process and development.

#### *Discrimination and social isolation*

Throughout the world, disabled people face discrimination and stigma. The high rates of disability in Cambodia has meant a higher than usual exposure of disabled people to non-disabled people, however teasing and name-calling is common. Family members and the wider community routinely call disabled children names related to their disability rather than the names given to them by their parents. Anecdotal evidence suggests that some children who are born with severe disabilities are never even given a proper name, and are referred to only by their disability name. Severely disabled children, although given basic care, are often hidden away, given less food and are sometimes encountered by fieldworkers living without clothes, unwashed and even tied up.

Disabled children – especially those who are severely disabled – do get abandoned, though it is impossible to measure the extent of the practice. What is more common is women who give birth to a disabled child, or who themselves become disabled, being abandoned by their husbands. Disabled women find it particularly hard to get married, and in Cambodia there is a stigma attached to unmarried women.

All the disabled people interviewed spoke of some degree of isolation and exclusion from community social events.

#### *Political exclusion*

Disabled people also suffer exclusion from the formal political process. First, voter registration centres and polling booths are located in physically inaccessible buildings and are often at some distance from disabled people's homes. Second, disabled people are often denied access to the information they need in order to register to vote. The Association of the Blind in Cambodia (ABC) reported that in the past two elections, blind people had often been denied the right to register to vote and in some cases, despite being registered, were not allowed to cast their votes on polling day. There is no use of tactile ballots yet. Data on the participation of disabled people in elections, either as candidates or as voters, is not gathered in the way that it is for women and members of minority ethnic groups.

#### *Exclusion from development*

The disabled people interviewed complained that they were not told about village meetings or development activities in their neighbourhood. Disabled people are often excluded from joining micro-credit programmes run by non-governmental organisations (NGOs) because they often lack assets to secure a loan and are seen to be a bad risk and unlikely to repay. Even though some disabled people did have the capacity to take part in local food-for-work initiatives, they were excluded from doing so, either actively, by the village chief, or passively, by not being told about the activity.

Furthermore, many development initiatives require potential members to have some resources to join micro-credit schemes. The very poorest – and disabled people are often in this category – literally do not have the time or assets to take part because they are continually on survival mode. The disabled informants said that non-disabled people see them as weak and unable to work like their able-bodied peers or to contribute to the household and community economy.

Disabled people are not a homogenous group. The most vulnerable and excluded disabled people are those with severe impairments, deaf and blind people, people with mental health problems, and disabled women and children. However, all disabled people in Cambodia have to struggle against the difficulties of their impairments, as well as the negative attitudes of society, which fails to recognise their abilities, and actively and passively discriminates against them. Disabled people become trapped in a cycle of poverty, with limited opportunities to escape.

### **The disability sector in Cambodia**

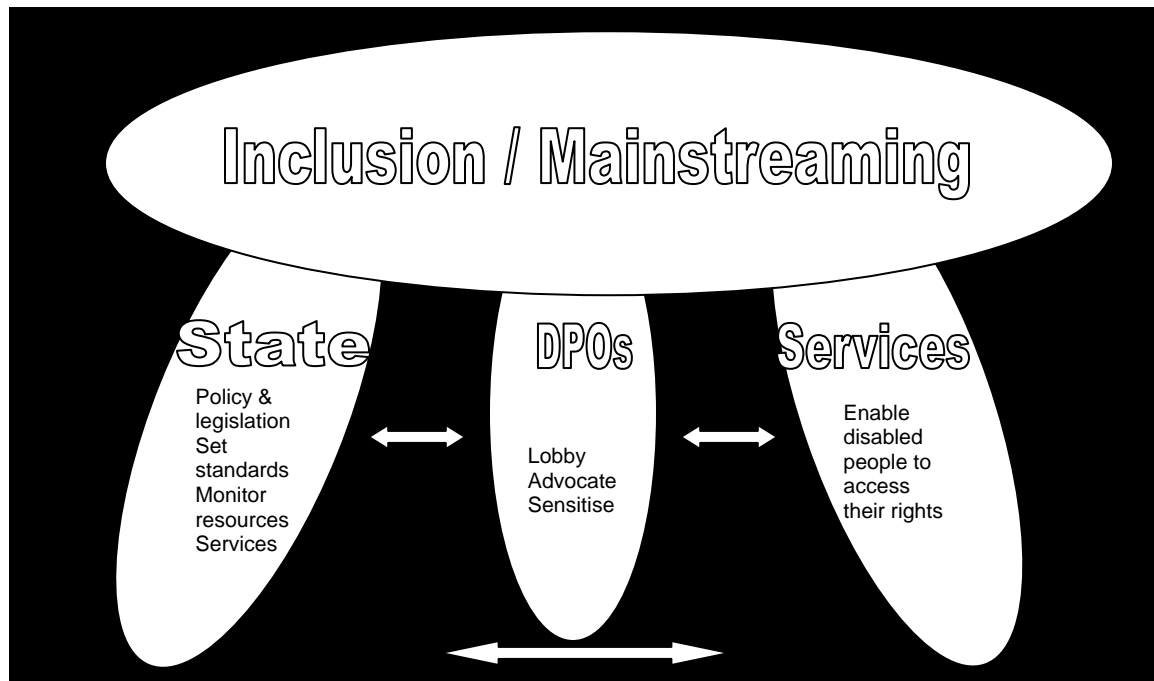
In order to develop and ensure the rights and equal opportunities of disabled people, three key actors need to work in a coordinated and mutually supportive manner:

- the state
- service providers
- disabled people's organisations (DPOs).

The roles and responsibilities of these actors are illustrated in the figure below.



## Roles and responsibilities in the disability sector in Cambodia



In Cambodia, there is considerable imbalance between these three key actors, as follows.

### The state

The Royal Government of Cambodia (RGC) is a signatory to:

- all the key legally binding United Nations human rights treaties
- the UN Declaration on the Rights of Disabled Persons
- the World Program Of Action Concerning Disabled Persons
- the UN Standard Rules on the Equalisation of Opportunity for Disabled Persons
- the UN Economic and Social Commission for Asia and the Pacific (ESCAP) Decade of Disabled Persons 1993-2002 (DAC 2001b).

It has also expressed support for the Biwako Millennium Framework for Action towards Inclusive, Barrier-Free and Rights-Based Society for Persons with Disabilities in Asia and the Pacific 2003–12, which represents an extension of the ESCAP Decade of the Disabled (DAC 2002).

A draft law on disability has been prepared, following wide consultation with stakeholders, but it is yet to be presented to the Council of Ministers. The Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSAVY) is the line ministry with responsibility for disability issues, but in practice, the government and the ministry have delegated virtually all responsibility for disability to civil society.

In 1997, the government established a semi-autonomous government body, the Disability Action Council (DAC), to coordinate the sector and advise on disability issues. At the time, it was an innovative and pragmatic decision. The DAC was seen as a means

of harnessing the skills, energy and resources of the NGO sector for a new government that had low capacity and extremely limited human and financial resources. The DAC has achieved much, and all the informants in the disability sector saw the organisation as playing a critical role for the future, but its progress is constrained by the lack of government interest in disability issues.

**The Disability Action Council (DAC)** provides a forum to bring together all stakeholders in the sector. The governing board comprises representatives from the leading government ministries, DPOs, NGOs, donors and the business community. A permanent secretariat was established within the Ministry of Social Affairs. The secretariat facilitates a number of committees and working groups covering areas such as women and children with disabilities, medical rehabilitation, legislation, community work with disabled people and vocational training. The committees act as a mechanism for information sharing, coordination and cooperation.

Its key achievements include:

- creating a single classification system for disability used in all data-gathering exercises
- reducing duplication and improved geographical spread of services
- representing Cambodia at all international disability conferences and meetings, acting as a central resource and information centre for the sector.

Currently, state support for disability is extremely limited, confined to providing office space for the DAC, a small contribution of 1000 Riels (US\$0.25) per day to patients in some rehabilitation centres, and the veterans and civil servants' pension scheme. This pension scheme represents the only state social protection system of cash transfers. However, the system is in some disarray and subject to significant corruption. The main difficulties with the scheme are:

- irregular payments, which are often delayed
- difficulty in accessing payments
- the need to pay bribes to officials to access payments and maintain one's name on the register
- recipients selling all or part of their pension entitlements for significantly reduced amounts at times of need.

As far as can be ascertained, the system has never received any support from donors, whether technical or financial, and since 1993 the responsibility for the pension has ricocheted between the Ministry of Social Affairs and the Ministry of Women's Affairs.

### **Services**

Services for disabled people include providing assistive devices, medical rehabilitation, physiotherapy, education and training. These services are essential to enable disabled people to participate and access their rights. Virtually all services for disabled people in Cambodia are delivered by NGOs. Despite the impressive number of organisations working in the sector, services for disabled people are inadequate, and are particularly lacking in remote and rural areas. Where services do exist, disabled people find them inaccessible or inappropriate. Because of Cambodia's recent history, disability and rehabilitation services have largely focused on the needs of those disabled by war, mines and polio, to the exclusion of other types of impairments. Services for blind and deaf people and those with mental health problems are extremely limited (DAC 2001b).

The almost total reliance on NGOs to provide services raises serious questions about the current sustainability of services – let alone future service expansion to meet the needs of Cambodia's disabled population. The current funding climate is uncertain and several key NGOs have had their resources cut. In the past year, three rehabilitation centres have closed, primarily prompted by reduced resources and the need to rationalise services. The focus on services is also problematic, as it can become a substitute for self-help. As one disabled Cambodian activist put it, 'To give is to disempower.'

### **Disabled people's organisations**

Disabled people's organisations (DPOs) are associations run and managed by disabled people, for disabled people. They have a critical role to play in representing disabled people, raising awareness about disability, and advocating for the rights of disabled people to government and other actors.

Cambodia's disability movement is weak, and the national DPO, the Cambodian Disabled Person's Organisation (CDPO), has been undergoing an extensive period of restructuring. Cambodian DPOs have tended to focus on delivering services, often to the detriment of developing their own capacity to advocate for disabled people's rights.

### **Mainstreaming disability in development**

The physical visibility of disabled people in Cambodia, along with the international focus on landmines, has resulted in a conflation of visibility with inclusion. There is a misplaced perception by those working outside the disability sector that disability receives a lot of funding and that it is well supported and 'moving forward.' In fact, the reality is rather different. Research for this study has revealed that most disabled people in Cambodia are among the very poorest in the country. Because of their disabilities, they experience poverty more intensely and have fewer opportunities to escape poverty than their able-bodied peers, and they find it much harder to utilise the assets they may have to improve their economic situation.

The disability sector is well coordinated, but there has been an overemphasis on service provision, driven by international agendas and funding sources and insufficient focus on empowering disabled people. The government's almost total reliance on civil society to address disability issues has meant that disability has become largely divorced and isolated from mainstream development and has seriously undermined the sustainability of existing services.

Disability is a cross-cutting issue but receives far less attention in national development strategies than other issues, such as gender, ethnicity and HIV/AIDS. Despite the lack of accurate statistics on the percentage of the population that is disabled, even very conservative estimates suggest that the numbers are comparable to, if not greater than, those for indigenous people at 4 per cent (CIA World Factbook) and those with HIV and AIDS, at 2.7 per cent (DFID 2004).

Disability affects not only the individual but their family as well. Cambodia's progress towards reducing poverty and achieving the MDGs will be constrained unless efforts are taken to remove the barriers to the full participation of disabled people.

The table below presents an analysis of the strengths, weaknesses, opportunities and constraints of the disability sector in Cambodia, followed by specific recommendations for enhancing donor support for disability in Cambodia and facilitating mainstreaming.

**SWOC analysis of the disability sector in Cambodia**

<p style="text-align: center;"><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• Well-coordinated and organised</li> <li>• Existence of the DAC</li> <li>• Draft disability law</li> <li>• High profile and range of services for landmine survivors</li> <li>• Diverse and committed number of CSO service providers</li> </ul>	<p style="text-align: center;"><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Growing donor harmonisation to support RGC's Rectangular Strategy</li> <li>• Donor and RGC's emphasis on good governance, decentralisation and deconcentration</li> <li>• Commune councils and Seila programme offer mechanism for disability issues to be raised at local levels</li> <li>• Equity funds and systems to target the most vulnerable households</li> <li>• Growing donor interest in supporting CSOs</li> <li>• Veterans and civil servants' pension scheme</li> </ul>
<p style="text-align: center;"><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• Severely limited services for deaf, blind and people with mental health problems</li> <li>• Over-emphasis on landmine survivors and those with physical impairments</li> <li>• Weak and unrepresentative disability movement</li> <li>• Limited engagement with mainstream development processes</li> <li>• Almost total reliance on CSOs</li> <li>• Sustainability very questionable</li> </ul>	<p style="text-align: center;"><b>Constraints</b></p> <ul style="list-style-type: none"> <li>• Current aid modalities (budgetary support, sector-wide approaches) that limit support for projects and particular issues</li> <li>• Insufficient data on disability and analysis of links between disability and poverty</li> <li>• Perception and funding of disability as a specialist issue</li> <li>• Limited government interest in disability and weak capacity of MoSAVY</li> </ul>

It is critical that the disability sector re-engages with mainstream development, that the government is supported to resume more responsibility for its disabled citizens, and that disabled people are empowered. The following recommendations suggest ways in which donors can facilitate and support these necessary steps.

**Recommendations**

**Improve data and information on disability**

Bird has highlighted the significant role that donors play in influencing the policy agenda and the 'framework of the possible', not only in the resources that they provide, but also in identifying key development and poverty reduction problems (Bird 2004).

The commitment of the World Bank, the Asian Development Bank (ADB), the UK Department for International Development (DFID) and the United Nations to work with the government to develop a single national development plan is highly significant. However, any new plan will fail unless it is based on a real understanding of poverty in Cambodia. Disability did not feature in the ADB's 2001 Participatory Poverty Assessment (PPA). Conscious efforts need to be made to ensure that forthcoming studies (the new ADB PPA and World Bank's 'Moving out of Poverty' study) capture the

dynamics of poverty and disability in the same way as is done with issues of gender and ethnicity.

### **Enact disability legislation**

To provide a framework for the future, Cambodia needs specific legislation promoting and enshrining the rights of disabled people, designating clear roles and responsibilities for government and civil society, and defining benefits and entitlements for disabled people. A draft disability law has been prepared, in wide consultation with stakeholders. Donors are currently encouraging the government to pass an anti-corruption law, and a similar approach could be taken with the draft disability law.

### **Strengthen the participation of disabled people in local planning**

For most donors, supporting the government's programme of decentralisation and deconcentration is a priority. To ensure real social accountability, it is essential that excluded groups are supported to participate in local-level planning processes. Donors may consider commissioning a consultancy to examine various options for strengthening the participation of disabled people and other excluded groups.

### **Review existing social protection mechanisms, and identify options for developing social protection to reduce poverty and facilitate inclusion**

In recent years, understanding of social protection has broadened to encompass far more than mere social safety nets. Social protection is increasingly recognised as a key tool for reducing poverty and supporting rights. Donors may consider commissioning a consultancy study to review existing social protection mechanisms and identify opportunities for establishing and strengthening social protection in Cambodia. The current Veterans and Civil Servants' Pension represents a potential opportunity, but is currently not effective and is subject to significant corruption. Such a study would complement current donor interest in developing harmonised approaches, particularly in determining the criteria and procedures for developing a national system for identifying and targeting the most vulnerable households.

### **Support the Ministry of Education, Youth and Sport to develop Inclusive education**

In its Education Strategic Plan of 2001–2005 (MoEYS 2001), the Ministry of Education, Youth and Sport accepted inclusion as its vision for the sector, and acknowledged the needs of disabled children. In 2000, the ministry established the Special Education Office (SEO), which has been implementing an inclusive education programme with the DAC and a consortium of NGOs, with the support of UNICEF and UNESCO. The initial pilot has grown from nine primary schools to encompass 95 in nine provinces, but the programme still remains largely divorced from mainstream education initiatives.

Inclusive education should be seen as a key strategy to achieve education for all, and improve the quality of Cambodian education. The inclusive education programme should be formally evaluated and options identified for further upscaling. Donors may also wish to consider including specific indicators relating to the educational achievement of disabled children and minority ethnic groups in agreements with MoEYS.

In India, DFID agreed with other donors and the government an indicator that stressed improved educational achievement for scheduled castes and tribes and disabled children – and in particular girls within these groups. For three years, the SEO has been collecting disaggregated data on the numbers of disabled children in school. Options

could now be explored for harmonising this initiative with data collection carried out for the Education Management Information System (EMIS).

It is also important that the current MoEYS practice of excluding disabled people from training to be teachers, and removing teachers who become disabled from active classroom teaching to administrative roles, should be discontinued.

### **Support the development of linkages between mainstream health services and rehabilitation**

Although current specialist rehabilitation services are well coordinated, they are divorced from the mainstream under the responsibility of the Ministry of Social Welfare (MoSAVY). While the Ministry of Health (MoH) receives considerable donor support through the health sector-wide approach, MoSAVY is seriously underfunded. Government support for rehabilitation is minimal, and the services are completely dependent on international NGOs, which compromises their sustainability.

Informants for this study clearly felt that the overall responsibility for rehabilitation should ultimately lie with the MoH, but such a shift cannot be quickly or easily achieved. However, donors have shown some interest in upscaling and harmonising the current pilot equity fund systems. Disabled people generally require more health services than non-disabled people. In recognition of this reality, and to reduce the cost burden of health care, it is recommended that disability be included among the criteria for equity fund entitlements.

Furthermore, as the treatment costs under the equity fund schemes come from specific donor budgets, donors may also wish to consider extending the equity fund system to cover part or all of the rehabilitation costs currently provided by international NGOs under the auspices of MoSAVY. The system could thus act as a mechanism for establishing greater linkages between MoH and MoSAVY as well as diversifying the funding base for rehabilitation services.

### **Facilitate the re-engagement of the disability sector with the mainstream by supporting disability-specific activities out of mainstream donor budgets**

Most disability-specific activities in Cambodia are currently funded out of specialised donor budgets. For example, USAID support for disability comes from its humanitarian aid budget and from the Leahy War Victims Fund. DFID support for disability is funded from the UK via the Civil Society Challenge Fund and the Programme Partnership Agreement (PPA) with Action on Disability and Development (ADD). Support to organisations such as the DAC, in particular, and DPOs, in general, could be viewed as part of donor support to good governance and social accountability.

### **Improve donor awareness and understanding of disability issues**

Research for this study reveals that disabled people are largely excluded from development in Cambodia. The failure to consider the disability perspective in the design of programmes and activities often results in unwitting exclusion of, and discrimination against, disabled people. Donors should seriously consider including representatives from the disability sector in all external consultations. Furthermore, donors might wish to explore options for disability sensitisation for their staff. For example, DFID could draw on the expertise of ADD, with whom it has a PPA in providing advice on disability issues and short disability-awareness training for staff.

**Support the RGC to fulfil its commitments, under the Biwako Framework, towards achieving a barrier-free environment**

Donor support to health and education, in particular, has enabled numerous schools and health facilities to be built and renovated. Donors should ensure that future budgets for all infrastructure projects are sufficient to enable accessibility features to be included.

**Support disability prevention**

Donors have been supporting immunisation programmes, mine awareness campaigns and other activities to prevent disability. Alongside continued support for these activities, they may also wish to consider working with the RGC and NGOs to develop a comprehensive, nationwide road safety campaign. Road traffic accidents are now a very significant cause of disability, far outweighing the deaths and injuries caused by mines and UXO. The problem has increased dramatically as the roads have been improved and continued support to road building and renovation needs to be accompanied by measures to prevent road accidents reaching epidemic proportions.

## 1 Introduction

This report has been produced by the Disability Policy Officer for the Policy Project of the Disability Knowledge and Research (KaR) programme funded by the UK Department for International Development (DFID).

The second phase of the DFID Disability Knowledge and Research (KaR) programme began in September 2003, managed by a consortium of the Overseas Development Group at the University of East Anglia and Healthlink Worldwide. The Disability KaR has developed a focus on mainstreaming disability in development. The programme comprises several components, including:

- research on disability mainstreaming and the links between disability and poverty
- developing training course on disability and development
- regional roundtables on disability and development themes
- the disability policy project, which has seen the placement of a technical adviser (the Disability Policy Officer) on disability issues within the Policy Division of DFID.

One of the first activities of the Disability Policy Officer was the completion of a report mapping what DFID is currently doing to support disability worldwide. The main findings of the report were that:

- DFID has not mainstreamed disability, but there is a solid bedrock of disability-specific activities being carried out, largely via NGOs and civil society organisations (CSOs).
- DFID's work on disability is largely hidden, and often DFID staff and country offices are unaware of disability-focused activities being carried out by NGOs and CSOs.
- While DFID staff broadly recognise the links between poverty and disability, they do not necessarily see disability as an essential part of their work on poverty reduction and the achievement of the Millennium Development Goals (MDGs).
- DFID staff need more information on disability – in particular, practical tools and examples of best practice – to enable them to implement the twin-track approach outlined in DFID's issues paper *Disability, Poverty and Development* (DFID 2000).

It was decided that this mapping exercise should be followed up with three studies on disability mainstreaming, each focusing on a different country in which DFID works. The aim of these studies is to:

- explore how disability relates to DFID's work on reducing poverty and social exclusion and the achievement of the MDGs
- map disability-focused activities in each country
- identify examples of best practice
- explore the opportunities and constraints for raising the profile of disability within each DFID programme
- identify potential partners for DFID to take forward work on disability.



Specific terms of reference are agreed for each country. This Cambodia report is the first of the three studies, with research in Rwanda and India to follow. A final report synthesising the findings from the research will be produced.

The Disability Policy Officer works closely with the Exclusion, Rights and Justice (ERJ) team within DFID's Policy Division. In spring 2005, DFID will publish a new strategy on social exclusion, led by the ERJ team. It is hoped that this study will contribute to this new strategy and will complement research on social exclusion in Cambodia, carried out by a Social Development Adviser within the ERJ team. In conducting this research, the Disability Policy Officer worked closely with the ERJ Social Development Adviser.

This report is a companion piece to the report *How Donors Can Tackle Exclusion in Cambodia* (Chambers 2005).

## **Methodology**

The research for this study was conducted by the Disability Policy Officer. The research comprised a desk review of literature and an 18-day field visit to Cambodia during December 2004. The primary research method was key informant interviews (see Annex 5 for a full list). Field visits were made to:

- Action on Disability And Development (ADD) in Kompong Chhnang, where discussions were held with the Federation leader of Kompong Trawlach district and members of a self-help group in Kompong Trawlach district, Kompong Chhnang
- Landmine Disability Support, Kompong Chhnang
- Disability Development Services Pursat (DDSP).

The visit to DDSP comprised:

- Interviews with the Adviser and the Programme Manager
- a group discussion with DDSP staff
- Interviews at home with four disabled clients (one male and three female), of whom three were paraplegics and one was facially disfigured
- a focus group discussion with 13 disabled adults and another focus group discussion with four disabled children in Prohal village, Bakan district, Pursat
- home visits to four disabled children (three with cerebral palsy and one with Down's syndrome)
- a visit to a primary school in the national 'inclusive education' programme

Information was also gathered from four respondents.

## **Constraints**

Time was a serious constraint, and it was not possible to meet with all relevant stakeholders. In particular, few representatives of the government were interviewed, and overall, the majority of interviews were carried out with expatriates. However this is a reflection of the dominance of expatriate personnel in the development sector in Cambodia.

The disabled people who took part in the interviews, focus group discussions and field visits cannot be said to be representative of the majority of disabled people in Cambodia because they were all receiving some support from a disability organisation, or were

involved in a self-help group. The majority of disabled people in Cambodia receive no such support. However, where possible, such as in the focus-group discussions, efforts were made to ensure that there was a good age and gender mix and that participants had a range of impairments.

## **Outline**

The following section provides a summary of disability in Cambodia, examining the existing data on disability rates, prevalence and causes. Section 3 looks at disability in relation to poverty and social exclusion in Cambodia, and seeks to provide a snapshot of the lives of disabled people there, based largely on the interviews and focus group discussions with disabled people conducted in Pursat. Section 4 provides an overview and analysis of the disability sector in Cambodia highlighting some examples of good practice. Section 5 examines the relationship of disability to the mainstream development process and suggests opportunities and possible areas for taking forward work on disability.

## **Acknowledgements**

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Thanks to Eleanor Stanley and Georgina Kyriacou for copy-editing and formatting.



*Participants in a focus-group discussion in Pursat*

## 2 Disability in Cambodia

“Cambodia’s tragic and recent history of war has left it with the highest proportion of disabled people in the world.”  
(UN ESCAP 2002, p 15)

### **Defining disability**

There is no universally agreed definition of disability. Historically, disability has been seen primarily as a medical condition – a problem located within the individual. Since then, this medical or individual model has been challenged by disability activists who reconceptualised disability as primarily a social phenomenon. This social model of disability draws a clear distinction between ‘impairments’ and ‘disability’. It argues that it is society that disables people with impairments, through its failure to recognise and accommodate difference, and through the attitudinal, environmental and institutional barriers that it erects against people with impairments. Disability thus arises from a complex interaction between health conditions and the context in which they exist.

This social understanding of disability has gained widespread acceptance, and is reflected in the UN World Programme of Action for Disabled Persons, the Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, the World Health Organization’s International Classification of Functioning Disability and Health (ICF), and by the World Bank, the UK Department for International Development (DFID), and the Asian Development Bank (ADB), among others.<sup>1</sup>

### **Perceptions of disability in Cambodia**

The draft law on the ‘Rights of People with Disabilities,’ developed by Disabled People’s Organisations (DPOs), government and representatives of local and international organisations, defines a disabled person as:

“any citizen who lacks any physical organ or capacity or suffers any mental impairment, which causes decent restriction on his/her daily life or activities such as loss of limbs, quadriplegia, visual or hearing impairment or mental handicap etc., and obtains a certified document issued by the Ministry of Health.”  
(DAC Legislation Working Group 2003, Article 2)

If the Rights of People with Disabilities law is passed, this definition will be used for benefit entitlements, but it is legalistic. The Ministry of Social Affairs Veterans and Youth Rehabilitation (MoSAVY) – the line ministry with responsibility for disability – has directed all stakeholders in the disability sector to follow and use the disability-related definitions outlined in the table overleaf (cont. on p21).

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<sup>1</sup> See *Disability, Poverty and Development* (DFID 2000), ADB’s draft *Disability Brief* (ADB 2004), World Bank publications, and statements by the Global Partnership on Disability and Development.

### **Disability-related definitions**

<b>Type of disability</b>	<b>Definition</b>	<b>Disabilities</b>
Seeing difficulties	Person who is short sighted, low vision or could not see any objects	Blind one eye/both eye, optic nerve damage, dislocated eyes (could not see), ptosis (eyes with weak muscles), corneal scar, trichinosis, hypohema, retinitis, retinitipigmentosa
Hearing difficulties	Person who has a hearing impairment (at birth or due to injury or disease) or due to the ageing process	Deaf, earless person, ear without ear drum(s), perforation of ear drum(s)
Speaking difficulties	Person who has difficulty in saying words and can not say clearly enough or at all, or not enough to be understood by other people	Speaking impaired person, cleft lip and cleft palate, big tongue, mute, slurred (speech not clear), stick teeth
Moving difficulties	Person who has physical difficulty in moving from one place to another or in moving a part of hi/her body, or who cannot move at all	Amputee arm(s)/leg(s), polio, muscular dystrophy, contracture, tight muscles, Cerebral Palsy, club foot/feet, bowed legs, congenital defect, dwarf, paraplegia, hemiplegia, quadriplegia, paralysis, spinal cord curve (kyphosis/ lordosis), dislocated hip, broken bone (fracture), juvenile arthritis, osteoarthritis, TB bone deformity, osteoporosis, scoliosis
Feeling difficulties	Person who has lost sensation or does not feel anything while touching objects	Third degree of leprosy (Hansen's disease), person who has severe beriberi (numbness) of the hands or legs, parahemiplegia, kwashiorkor
Psychological difficulties (strange behaviour)	Person who changed behaviour so much that now he/she behaves like a different person, it happens regularly and they have difficulty in feeling, thinking and/or behaviour	Schizophrenia, paranoia, neurosis, mania, stress, anxiety, depression, psychosis
Learning difficulties	Person who has low memory, could not remember or do things like other people of the same age	Intellectual disability, down syndrome, slow learner, cerebral palsy, autism
People who have fits	Person who often has convulsions and foams at the mouth	Epilepsy, hypoglycaemia, hyperglycaemia

Other	Person who has restrictions in physical and social functioning	Disfigurement/deformity, chronic illness, dwarfs, midgets, hydrocephalus, HIV/AIDS-related conditions, severe keloid
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Source: Mackinlay (2004)

The definitions in the table above were developed and agreed following a long process of discussions among all stakeholders, and represent a significant breakthrough in coordinating future data on disability in Cambodia. They are easy to use and ideal for enabling local people to describe the functional problems of disabled people in their communities (Mackinlay 2004).

Understanding of disability among Cambodians has not been systematically studied. In Khmer culture, disability is usually defined as 'the loss of one or more senses', but the definition of a 'sense' is wider than that generally understood in the West. Two small-scale surveys on education for disabled children, conducted in the provinces of Svay Rieng and Ratanakiri, suggest that indigenous hill-tribe people may have different perceptions of disability than Khmers. When answering the question, 'What is disability?', Khmers responded with a list of impairments (such as blindness, deafness, and loss of limbs), while the hill tribe people gave answers closer to the social model of disability, listing disabled people as 'those who could not work in the fields or get married' (DAC 2001 (2001d)).

The Khmer understanding of, and attitudes towards, disability are said to be shaped by the national religion – Buddhism. In Buddhist belief, disability is the result of sins in a previous life. This belief is often cited by disabled Khmers and international staff working in the disability sector as a significant cause of the discrimination faced by disabled people. However, it is likely that the real impact of this belief is exaggerated (Thomas 2003, Hughes and Conway 2003).

## Statistics and causes of disability

In 2003, the National Institute of Statistics (NIS) stated that the current Cambodian population was 13.77 million, based on the 1998 population census, using a yearly projected increase of 2.5 per cent. Approximately 84 per cent of people live in rural areas, with Cambodia's 16 per cent urban population located in two main areas: Phnom Penh and Kompong Cham. Approximately 51.8 per cent of the population is female, and at least half the population is under 18 years of age (NIS 2003).

As in most developing countries, accurate statistics on the number of disabled people in Cambodia are not available. Numbers and percentages differ from publication to publication.

### ***Disabled people in Cambodia: overall figures*** (Table cont. p 22)

Number/percentage of disabled people	Sources
<b>Adults</b>	
170,000 (1.5% of 11 million population)	<i>Socio-Economic Survey</i> (NIS 2003)

9.8%	<i>Skills Training as a National Strategy for Poverty Reduction in Cambodia</i> (ADB 1997)
1.4 million (15%)	<i>Identifying Disability Issues Related to Poverty Reduction: Cambodia Country Study</i> (ADB 1999)
<b>Children</b>	
32,000 (21%)	MoSAVY (2002)

### ***Disabled people in Cambodia, by type of impairment***

<b>Type of impairment</b>	<b>Number/percentage of disabled people</b>	<b>Sources</b>
<b>Landmine injuries</b>	40–50,000	<i>Action for Victim Assistance</i> (DAC 2003b) UN ESCAP (2002)
<b>Polio</b>	60,000	UN ESCAP (2002)
<b>Deafness</b>	300,000 (130,000 profoundly deaf)	DDP/Krousar Thmey (2004)
<b>Blindness</b>	144,000 (108,000 50+ years, 28,000 15–50 years, 8,000 under 15)	ABC (2004)
<b>Mental health</b>	–	No national data
<b>Intellectual disabilities</b>	–	No national data

The wide range of statistics in the table below are due to differing definitions of disability and limited capacity to identify different types of disability – particularly intellectual and learning disabilities and mental health problems. The MoSAVY categories of disability were used in a survey in 2002 in Kompong Spue Province with the following results:

### ***Type of difficulty, by gender***

<b>Type of difficulty</b>	<b>Female (%)</b>	<b>Male (%)</b>
Seeing difficulty	20.70	15.70
Hearing difficulty	12.80	8.50
Speaking difficulty	11.00	8.50
Moving difficulty	38.40	52.40
Feeling difficulty	5.40	4.80
Psychological difficulty	4.50	1.20
Learning difficulty	1.30	2.50
Fits	3.70	3.60
Other difficulty	2.20	2.80

Source: (DAC *et al* 2002)

Broadly, three main factors are responsible for Cambodia's high disability rates:

- past war casualties
- the ongoing risk of mines
- the lack of prevention and primary care for various disabling diseases (UN ESCAP 2002).

The government's 1997 socio-economic survey (MoP/NIS 1997) identified the causes of disability illustrated in the table below:

***Causes of disability***

<b>Cause</b>	<b>Female (%)</b>	<b>Male (%)</b>
Accident	12	14
Illness/disease	35	28
Mine accident/explosion	2	11
War/conflict	2	18
Congenital	34	20
Other	9	4
Not stated	6	5

Source: MoP/NIS (1997)

The majority of disability in Cambodia is preventable. Poverty is a major cause of disability, and one of its major consequences (Bonnet 1997).

### 3 Disability, poverty and social exclusion

“Disability means my life has no meaning because I cannot work, walk or move by myself. I cannot be involved in the community.”  
(Sameth, 41-year-old paraplegic man, Sampeau Meas district, Pursat Province)

#### Conceptual understandings

The government and development actors in Cambodia widely use an holistic conceptualisation of poverty that encompasses concepts such as vulnerability, voicelessness and access to natural resources and services, as well as income deprivation. However, the concept of social exclusion is not so widely recognised and used. DFID’s working definition of exclusion is:

“The experience of certain groups who suffer discrimination on the basis of their social identity and are excluded from economic, social or political opportunities as a result. This discrimination may operate at the level of state policy, institutional bias, social practices, or historic neglect.”  
(Chambers 2005)

Social exclusion complements holistic understandings of poverty by adding a dimension of causality – namely, that someone, or something, is doing the excluding. Social exclusion is a particularly useful concept for understanding the dynamics of disability and poverty. The concept chimes with the social model of disability, which emphasises that it is the institutional, attitudinal and environmental barriers in society that disable people who have impairments.

All the informants for this study recognised that most disabled people in Cambodia are among the very poorest in the country. Most saw disability as primarily a poverty issue, though a minority also identified it as a rights issue. No one identified it as predominately a medical issue.

The World Bank, Asian Development Bank, DFID and UN bodies target their assistance towards poor people, and generally do not differentiate between different groups of poor people in their activities, except when emphasising gender disparities. However, certain UN agencies – particularly UNICEF and UNESCO – have a particular focus on women and children.

All the informants working in the development community understood the concept of social exclusion and, although it is far less used than poverty in the development discourse in Cambodia, identified disabled people as socially excluded, along with:

- people with HIV/AIDS
- members of minority groups (Cham, Vietnamese and indigenous people)
- people who have been trafficked
- the elderly
- children.

those who were not involved directly with disability, and particularly expatriates, thought that because Cambodia’s disabled people are highly visible, they are less excluded than



other less visible groups. However, this perception is misplaced. For a fuller discussion on socially excluded groups, in Cambodia see the companion report (Chambers 2005).

There is no national data on the nature and depth of poverty experienced by disabled people as compared to able-bodied people. Studies on disability in Cambodia are carried out by those working in the sector and do not make comparisons with other poor and vulnerable groups. Evidence for this chapter is drawn from existing small-scale research, but primarily from interviews for this study, a focus-group discussion with disabled people, and home interviews with disabled people in Pursat Province. The aim is provide a snapshot of the lives and situation of disabled people in Cambodia and to capture some of their voices and their stories.

## **The situation of disabled people in Cambodia**

The National Poverty Reduction Strategy (RGC/CSD 2002) states that 36 per cent of the population live below the poverty line of US\$0.40–0.63. Seventy per cent of Cambodia's poor have household heads employed in agriculture and 12–15 per cent have no agricultural land. Poor health is a major cause of impoverishment. Poor people typically lack access to basic social services such as health centres, schools and roads. Illiteracy is a major barrier, excluding them from the development process, as is their lack of access to the law and to their rights. Disabled people, members of minority groups, people with HIV/AIDS, the elderly and children are particularly vulnerable. Women are generally disadvantaged in society.

### **Disability, mental health and well being**

A 2001 psychiatric morbidity survey conducted in 50 villages in Kompong Cham reveals a stark picture of the lives of Cambodians. The research involved 1370 adults aged 20 or over – 55 per cent female.

More than 60 per cent described themselves as illiterate. Of the 37.5 per cent who went to school, 32.5 had less than five years' education.

The proportion describing themselves as disabled was 6.5 per cent. Among those, 32.5 per cent ascribed their disability to disease, 15 per cent to road accidents, 12.5 per cent to consequences of armed combat, 7.5 per cent to mine injuries, 5 per cent to disability from birth, and 27.5 per cent to an unknown cause.

Of the sample, 27.7 per cent had acute diseases (measles, acute respiratory infection, dengue, malaria, acute diarrhoea and others) and 12.8 per cent had chronic diseases (TB, HIV/AIDS, diabetes or heart conditions). Just over 12 per cent had both chronic and acute disease.

Over 40 per cent (42.4 per cent) reported symptoms that met the criteria for depression, 7.3 per cent for post-traumatic stress disorder (PTSD) and 53 for for symptomatic anxiety. In addition, 29.2 per cent had symptoms of both depression and anxiety, and 7.1 per cent had triple comorbidity (depression, anxiety and PTSD).

*Box continued page 26*

### Disability, mental health and well being *continued*

The potentially traumatic events that participants had experienced during their lifetime tended to relate either to poverty or to mass violence. They included experience of:

- lack of food and water (69.7 per cent)
- lack of access to medical care (40.1 per cent)
- frightening situations or having felt great danger (34.1 per cent)
- feeling close to death (32.7 per cent)
- brainwashing (20.4 per cent)
- forced separation from family (18.9 per cent)
- armed combat (18.7 per cent)
- serious accidents (16.9 per cent)
- the murder of a family member or friend (16.4 per cent)
- torture (7.9 per cent)
- sexual violence (3.3 per cent)

More than half (55.7 per cent) had experienced traumatic events related to both poverty and mass violence.

Source: Dubois *et al* (2004)

### **Poverty and disability**

Disabled people typically share the profile of the general poor in Cambodia. However, because of their disabilities they are more vulnerable to poverty, their experience of poverty is more intense, and their opportunities to escape from poverty are more limited.

In Cambodia, as elsewhere in the developing world, poverty is recognised to be a major cause of disability, and most disability is preventable or treatable (DFID 2000, Elwan 1999). In Cambodia in 2003, approximately three people a day were killed or injured by mines or unexploded ordinance (UXO). Almost all the casualties (97 per cent) were civilian, and most of the incidents were associated with livelihood activities. Poor people are predominately the victims of landmines because they are forced to live near and enter mine-affected areas to collect food or firewood (International Campaign to Ban Landmines 2004).

Because poor people lack access to basic health care, simple infections, illnesses and injuries often result in permanent disability because they go untreated or are mistreated. For example untreated common childhood ear infections are a major cause of permanent hearing loss in children (DDP, personal communication).

Grinding poverty often brings psychosocial mental health problems, such as depression and anxiety, which can be very disabling. Women are particularly vulnerable to these (Chapuis 2004, Dubois *et al* 2004). By the age of two, half of all Cambodian children are stunted (RGC/CSD 2002), and malnourishment is a major cause of developmental delay and long-term intellectual disability. Iron deficiency can reduce intelligence by as many as 13–21 IQ points, and the first national goitre survey by the Ministry of Health in 1997 projected a goitre rate of 12 per cent among children aged 8–12 years, rising to 45 per cent in some areas. Vitamin A deficiency is the leading cause of childhood blindness (RGC/CSD 2002).

Poverty is not only a cause of disability – it is also a major consequence of disability. All the informants who became disabled later in life said they became poorer after they were disabled, and most said they had become much poorer.

**Case study: Bopha**

Bopha is 50 years old. When she was 45, she damaged her back carrying a bag of rice. She went to the doctor and received an injection, which left her paralysed with only a little sensation in one leg. Before her accident, she had been a moderately wealthy woman despite being abandoned by her husband several years before when her son was just three months old. She had several large rice fields, a buffalo, cows and chickens. She also had a small business. Since her accident, in order to pay for her treatment and to survive, she has had to sell all of her animals and nearly all her rice fields. She now only has half a hectare, and she can no longer conduct her business. She and her son rely on renting out her land support from her extended family. Talking about her disability, she says, 'I lose confidence. Now I stay at home all day. Before I did business, but I am lucky because children play near me and people visit me.'

Interview, Sampeu Meas District, Pursat

**Disability and livelihood**

Cambodians spend a high proportion of their income on health – approximately 10 per cent (Nguyen 2004) and health expenditure is a major cause of personal debt. Disabled people generally require more health services than non-disabled people. All the members of the adult focus group said that they had been ill more often since they had become disabled. A common complaint included an increase in fevers, and amputees said that if they worked hard their stumps became chafed, sore and sometimes infected.

Disability impacts on a person's ability to work and earn a living. The intensity of this impact depends on the nature of their impairment. Most Cambodians are employed in agricultural activities, and even fairly mild or moderate physical impairments can limit one's capacity to work in the fields, with a consequent impact on the household economy.

During difficult times, one of several strategies that poor people employ, along with selling assets and borrowing, is to sell their labour. At the time of conducting the research Cambodia was experiencing a drought, and several of the disabled respondents in Pursat said that family members had left recently to sell their labour – often at considerable distances – in areas as far away as Takeo and Pailin. Disability impacts upon an individual's capacity to travel to seek manual work, and negative attitudes towards disabled people compound this difficulty. Some disabled people need to learn new skills to earn a living, but vocational training opportunities are limited and only available in urban areas, and are generally not linked to the market.

**Discrimination and social exclusion**

Throughout the world, disabled people face discrimination and stigma. The high rate of disability in Cambodia has meant a higher than usual exposure of disabled people to non-disabled people. Amputees are very common, and broadly face less discrimination than people with other disabilities. Nevertheless, teasing and name-calling is widespread.

One non-disabled villager in Kompong Trawlach district, Kompong Chhnang Province, said that before ADD helped establish the self-help group for disabled people, he used to call disabled people names. He said it was only playful and that he had not understood that it upset them. This attitude is likely to be fairly typical of the wider Cambodian able-bodied population. Family members and the wider community routinely call disabled children by names related to their disability rather than the names given to them by their parents. It is impossible to know if this name-calling is little more than a form of nicknaming, or if it signifies real discrimination that the children find it really distressing.

Anecdotal evidence suggests that some children who are born with severe disabilities are never given a proper name at all, and are referred to only by their disability name. Does this perhaps indicate that these families and communities do not consider these children to be 'fully human'? Severely disabled children, although given basic care, are often hidden away and given less food than the others, and fieldworkers sometimes encounter them living without clothes, unwashed and even tied up.

#### **Common disability names in Cambodia**

**a\* kon kaep (frog)** – used for people who crawl, or people with cerebral palsy

**a da doch rom ('dancing walk')** – name for various kinds of physical disability and cerebral palsy

**a swet (malnourished, emaciated)** – name for people with withered and weakened limbs

**a kwak** – used for blind people

**a chkuart, a lob lob, a lee lee (stupid, crazy, mad)** – used for people with mental health problems and intellectual disabilities

**a kwun (useless, cannot do anything)** – used for people with severe disabilities and cerebral palsy

**a chkuart chrook ('mad pig')** – used for people with epilepsy

**a kbak** – name for someone with a physical disability, such as a leg amputation

**a kbot** – used for people with amputated arms

\* The prefix 'a' turns ordinary language into derogatory terminology.

Disabled children, especially those who are severely disabled, do get abandoned, though it is impossible to measure the extent of the practice. What is more common is women who give birth to a disabled child, or who themselves become disabled, being abandoned by their husbands. Disabled women find it particularly hard to get married and in Cambodia there is a stigma attached to unmarried women, meaning that single disabled women experience a 'double dose' of social exclusion.

**Case study: Samith**

Samith was a soldier. He was shot in 1994. Initially, he recovered from his injury, but two years later, following a heavy fever, he found himself paraplegic. He was lucky, and was referred to the Spinal Cord Injuries Unit in Battambang, where he received treatment, counselling and rehabilitation.

Samith has a wife and two children. His wife is tremendously supportive, and after he left the hospital they moved to Pursat to live with his mother-in-law. In 2004, he bought a very small plot of land and built a little straw house. He has taught himself to weave baskets, but he uses a wheelchair and the state of the road means that he cannot go out to sell them, so he is dependent on customers coming to his house to buy them.

Samith's wife supports the family by selling her labour. Often, she is away for several weeks travelling to far-flung provinces. She is frightened to do this, and scared what will happen to her husband and children while she is away. Samith is also worried when she leaves: worried for her safety and whether she will return. He knows that her family and neighbours have been urging her to leave him because they say he is useless and cannot support his family. Samith comforts himself that his wife loves him very much, and that she has stayed with him during the last eight years since he became paralysed.

Interview, Sampeau Meas District, Pursat

All the disabled people interviewed spoke of some degree of isolation and exclusion from community social events. They all said that that they were rarely or never visited by monks or lay-people from the pagoda – a central focus of community life. Many spoke of not being visited by friends or neighbours – or even, sometimes, family members – as they had been before they were disabled. They complained that often, they were not invited to weddings or festivals. They were also not told about village meetings or development activities in their neighbourhood.

The DDSP staff confirmed these stories. They also noted that disabled people were often excluded from joining micro-credit programmes run by NGOs, as they were seen to be a bad risk and unlikely to repay. Even though some disabled people did have the capacity to take part in local food-for-work initiatives, they were excluded from doing so either actively, by the village chief, or passively, by not being told about the activity.

Furthermore many development initiatives require some resources to join. The very poorest – and disabled people are often in this category – literally do not have the time or assets to take part because they are continually on survival mode. The disabled informants said that non-disabled people see them as weak and unable to work like their able-bodied peers or to contribute to the household and community economy.

Studies on poverty, and attitudes to poverty, stress the importance that all Cambodians place on an individual's responsibility to contribute to the family. Among the non-poor, a distinction is often drawn between those who are poor because they are lazy, lack ideas or indulge in vices such as drinking and gambling, and those who work hard but never escape from poverty. More generously, some Cambodians see the inability of poor people to escape from poverty as being due to physical weakness, hopelessness or lack of confidence (Hughes and Conway 2003).

The onset of disability is a life-changing experience for the individual and for the family. Everyone affected has to come to terms with a changed identity and, in most cases, reduced financial circumstances. This is reflected in a loss of confidence – and even depression – in the disabled individual, who may respond by hiding away or seeking solace in drinking. The whole experience puts great strain on the family, and may lead members of the community at large to begin to view the individual and family as being responsible for their own misfortune. As a result, they begin to shun the family and exclude them from community life – a situation ultimately leading to a vicious cycle of poverty and social exclusion.

**Case study: Theara**

Theara is 66 years old. When she was 62, she fell down heavily, hitting her spine, and was paralysed. Now she lives alone in a small house. Her daughter lives nearby and Theara depends completely on her and the rest of her family. Before her accident, Theara was a traditional birth attendant and was a respected member of the community because of her skills.

Before her accident, Theara would visit the pagoda on every Buddhist holy day and join in with the other elderly people. Since her accident, she has not been to the pagoda, but she longs to go again. Now, no one comes to see her or ask for her advice. She does not take part in any of the activities in the village, and friends and neighbours do not visit her. About her disability she says, “I feel like I am a ghost already, like I am already dead.”

Interview, Sampaeu Meas District, Pursat

**Disability and political exclusion**

Disabled people are not only excluded from their local communities – they also suffer exclusion from the formal political process. This happens in various ways. First, most voter registration centres and polling booths are located in physically inaccessible buildings, often at some distance from disabled people’s homes. This excludes those with moving difficulties (Personal communication, COMFREL/ADD 2003).

Second, disabled people are often denied access to the information they need in order to register to vote. All the most severely disabled people interviewed (blind and paraplegics) said they had not been told about registering to vote. It was unclear whether this was accidental or a deliberate omission on the part of families and village authorities. All the paraplegics interviewed said that they had never voted since they became disabled, although they all had done so regularly before their accidents.

The Association of the Blind in Cambodia (ABC) reported that in the past two elections, blind people had often been denied by officials to register to vote and in some cases, despite being registered were not allowed to cast their votes on polling day. ABC had approached the National Electoral Commission (NEC) to ask for tactile ballots before the election, but was told that there was not a budget or time to prepare them. At the time of research ABC was planning to approach the NEC again over the issue so that tactile ballots could be adopted in time for the forthcoming commune council elections.

In the 2003 national election, ADD facilitated 200 disabled people to act as election observers. The organisation also produced voter education materials for disabled

people. In the areas observed, of the disabled people who did vote, the overwhelming majority had a physical impairment (81.82 per cent). Hearing impaired people accounted for only 4.2 per cent, people who had both hearing and speaking impairments 3.75 per cent, mental disabilities 2.67 per cent, and only 1.76 per cent of the disabled voters were visually impaired (ADD 2003).

The NGO COMFREL (Committee for Free Elections) commented that it too has raised the issue of access to the political process by disabled people to the NEC, but that the NEC currently considers this issue to be only a 'minor problem'. COMFREL does not collect any data on the number of disabled people elected at national and commune level, although it does this for women and ethnic minorities.

**Case study: Phalla**

Phalla is 21 years old. When she was one, she was badly burned in a fire in a refugee camp in Thailand. The fire killed her father and left her with severe facial disfigurement. Phalla is still is deeply self-conscious about her appearance and lacks confidence. During the last election, she did not register to vote because the registration process required having her photograph taken.

Interview, Bakan district, Pursat

**Disability and education**

Significant numbers of disabled children do attend school. Statistics gathered by the Special Education Office of the Ministry of Education, Youth and Sport in 2004 recorded 80,203 disabled children in school nationally, of whom 32,255 were girls. However, the reliability of this data is questionable, as identification is carried out by school principals. The most common form of disability in children is learning difficulty, which almost doubles the next-highest category: speaking difficulties. If the children in these two categories could be properly assessed, it is likely that most of them would not be identified as 'disabled'.

A small-scale survey in 2000 of one school cluster and surrounding villages in Svay Rieng found that almost 50 per cent of disabled children in the area were attending school (DAC 2001c). While this was a much higher number than expected, it still meant that half the disabled children were not at school. What is more, access to school is only part of the solution. Disabled children need to receive an education that is appropriate to their needs, and in which they are not just physically present, but are fully included in the life of the school. Despite considerable efforts, teaching methods in most Cambodian schools still rely heavily on rote learning, and corporal punishment is common.

Parents of disabled children are also often over-protective and worry that their child will be bullied and have an accident, so they keep the child at home. Often a non-disabled sibling will miss school too, to care for their disabled sibling.

**Case studies: Vanna, Polikar and Sam Moly (continued page 32)**

**Vanna** is 12. He has a learning difficulty, but he goes to school and is in the third grade. He says he likes school and has friends, but he is bullied. His teacher hits him if he is late or gets his answers wrong.

**Polikar** is also 12. She has polio and learning difficulties. She did go to school, but

the teacher used to beat her, so she stopped. She would like to learn to read and write, but now she stays at home and helps the family by collecting cow dung. Her older sister, who is 20, looks after her but hits her almost every day.

**Sam Moly** is 12. She has polio too. She did not go to school before because she was worried she might fall over or be teased. She is now in the first grade. She likes school, but some children, and even some teachers, tease her and call her 'tun', a disability name. Her parents are worried to let her go to school in case she has an accident.

Interviews, Bakan district, Pursat

## Conclusion

Disabled people are not a homogenous group. Not all disabled people are poor, but they are over-represented among poor people. All disabled people suffer from some discrimination and exclusion, but the degree and severity often depends on the nature of their impairment and their personal situations. Disabled children and women are particularly vulnerable, as are those with severe physical and intellectual impairments such as paraplegia, hemiplegia, quadriplegia, cerebral palsy, and those with severe mental health problems. Blind people face considerable difficulties.

Among disabled people, deaf people are probably the most excluded:

"Blindness cuts you off from things, but deafness cuts you off from people... Most deaf people in Cambodia have never met another deaf person."  
(Charlie Dieltmeier, DDP, person communication)

Deaf people lack a common language with the hearing world, and as yet there is no Cambodian national sign language, so they even lack a common language among themselves. It is symptomatic of the isolation that deaf people in Cambodia face that for this research, the author had to rely on input from a partially deaf expatriate working as an advisor for the national deaf development programme.

Disabled Cambodians share most of the problems faced by their non-disabled peers, but to participate fully in society they require some additional help. They need society to recognise and accommodate their special needs. Mainstream programmes and development initiatives are unwittingly likely to exclude disabled people, unless they remember their particular needs and make modest modifications to accommodate them. However, when this does happen, disabled people can excel as others do and make a full contribution to the development of their country.

"I am a man like the others. My disability I don't mind, because it only affects my mobility, I am an amputee – not so difficult. I can work... If you have education, your life depends on knowledge and capacity. I don't see myself as disabled in my work, but I see my disability when I walk side-by-side with other non-disabled people."

(Son Song Hak, founder and former Executive Director of CDPO, working as a consultant on a World Bank Water and Sanitation programme)





*Phalla makes a living cooking and selling food at a stall by the roadside*

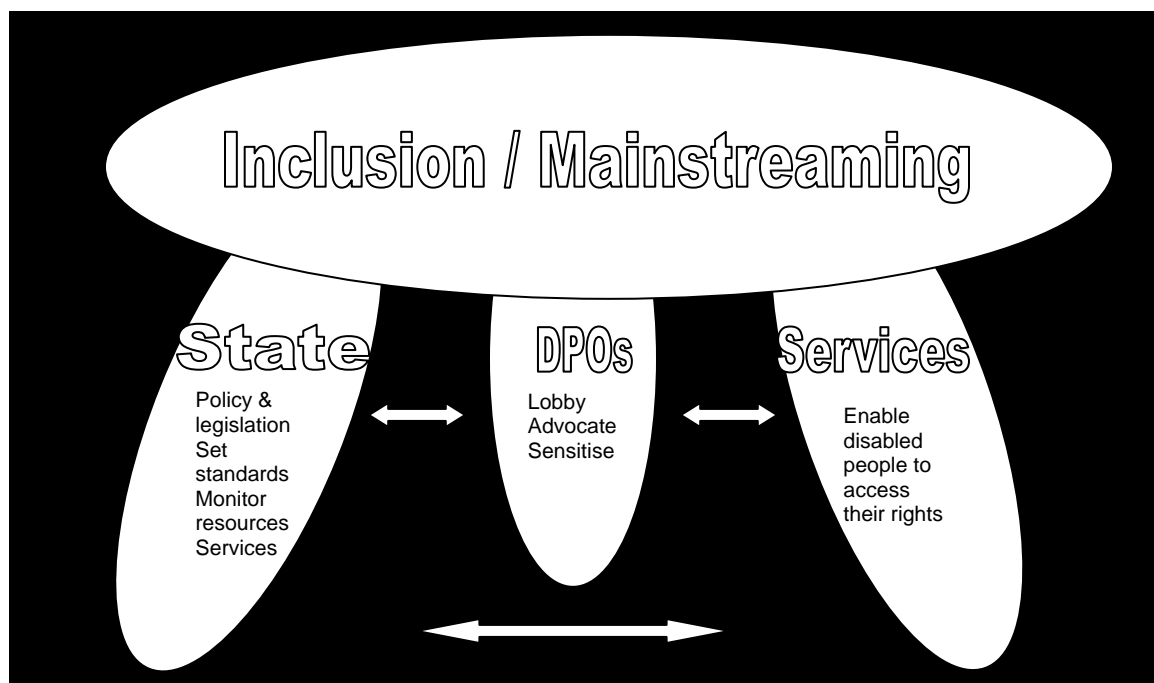
## 4 The disability sector in Cambodia

In order to develop and safeguard the rights and equal opportunities of disabled people, three key actors need to work in a coordinated and mutually supportive manner:

- the state
- service providers
- disabled people's organisations (DPOs).

### Roles and responsibilities in the disability sector in Cambodia

The roles and responsibilities of these actors are illustrated in the figure below.



In Cambodia, there is considerable imbalance between these key actors, as follows:

#### The state

The Royal Government of Cambodia (RGC) is a signatory to:

- all the key legally binding UN human rights treaties
- the Convention on the Prohibition of the Use, Stockpiling and Transfer of Anti-Personnel Landmines
- the UN Declaration on the Rights of Disabled Persons
- the World Program Of Action Concerning Disabled Persons
- the UN Standard Rules on the Equalisation of Opportunity for Disabled Persons
- the UN Economic and Social Commission for Asia and the Pacific (ESCAP) Decade of Disabled Persons 1993–2002 (DAC 2001b).

It has also recently expressed support for the Biwako Millennium Framework for Action towards Inclusive, Barrier-Free and Rights-Based Society for Persons with Disabilities in

Asia and the Pacific 2003–12, which represents an extension of the ESCAP Decade of the Disabled (DAC 2002).

Nationally, Article 31 of the Cambodian Constitution recognises and respects fundamental human rights, liberty and equality of all, and prohibits discrimination. Article 74 states:

“The State shall assist the disabled and the families of combatants who sacrificed their lives for the nation.”  
(Cambodian Constitution 1993)

The rights of disabled Cambodians are directly and indirectly covered by a range of further royal decrees, government decisions, sub-decrees, and ministerial decisions and regulations.<sup>2</sup> However, there are anomalies – for example, disabled people are currently barred from training to be teachers (Thomas 2003).

A draft law on the ‘Rights of People with Disabilities’ has been developed, coordinated by MoSAVY, CDPO and the Disability Action Council (DAC), and with wide consultation with stakeholders. The election of 2003 and the subsequent political stalemate delayed the presentation of the draft law to the Council of Ministers. Currently, MoSAVY is awaiting some clarification about the role of the DAC before presenting the law to the government.

MoSAVY<sup>3</sup>, and in particular, the Department for Rehabilitation, has overall responsibility for Cambodia’s disabled people, and views the government’s role for the foreseeable future as:

- consulting with institutional stakeholders and coordination agencies
- developing overall policy and legislation
- setting standards
- monitoring and evaluating compliance.

The responsibility for service provision rests primarily with the third sector (NGOs). This approach is informed by:

“[an] evolving government policy preference that service delivery should be provided by the third sector as a matter of principle; and on-going, pragmatic and financial realities that make it impossible to secure adequate government funded service delivery without the fullest possible participation of the third sector, and the increasing realization that the government may never be in a position to provide all the services that are required under UN-ESCAP.”  
(DAC 2002, p 12)

Since the 1993 elections, MoSAVY has been an underfunded and largely overlooked ministry, despite being responsible for some of Cambodia’s most vulnerable groups, and

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<sup>2</sup> For a fuller outline of these, see the DAC *Study on Persons with Disabilities* (DAC 2001b).

<sup>3</sup> Formerly MoSALVY (the Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation). Under the new government, responsibility for labour affairs has been transferred to a new ministry. MoSAVY has also regained responsibility for veterans, which it held under the first administration but which was transferred to the Ministry of Women and Veterans Affairs under the second administration. The precise responsibilities of MoSAVY were being defined at the time of publication.

its responsibilities have shifted throughout the administrations . The ministry is not an attractive proposition for young civil servants because it offers limited possibilities for supplementing the meagre government salary. MoSAVY's current support to disability lies in providing buildings and utilities to rehabilitation centres and making a daily contribution of 1000 Riels (US\$0.25) per patient at some of the rehabilitation centres. MoSAVY also operates a small database of potential disabled employees and assigns them to work with NGOs . The disabled employees then receive a salary supplement from the NGOs concerned. MoSAVY has provincial and district offices throughout the country.

In 2004, the Prime Minister, Hun Sen, outlined the 'Rectangular Strategy', which promises 'expanded rehabilitation programs for the disabled' and increased social sector interventions through enhanced cooperation with national and international organisations. The strategy states:

"The Royal Government continues to support the disabled people and veterans and their families, especially those who have sacrificed their lives for the country."  
(RGC 2004, p 39)

This 'support' presumably refers to the pension system for civil servants and veterans – a system that represents the only state social protection mechanism of cash transfers. Despite targeting only civil servants and veterans, its reach is potentially large, given the size of the Cambodian bureaucracy and the number of veterans and military personnel. All disabled former civil servants and government soldiers are potentially entitled to this pension, and although the amount is modest, it nevertheless represents a regular and vital source of income.

However the system appears to be in some disarray and is a site of significant corruption (see the box below). The main difficulties with the scheme are:

- irregular payments, which are often delayed
- difficulty in accessing payments
- the need to pay bribes to officials to access payments and maintain one's name on the register
- recipients selling all or part of their pension entitlements for significantly reduced amounts at times of need.

As far as can be ascertained, the system has never received any support from donors – either technical or financial – and since 1993, the responsibility for the pension has ricocheted between the Ministry Of Social Affairs and the Ministry of Women's Affairs. At the time of writing, it was back with the Ministry of Social Affairs. The pension system is ripe for external support. It could provide the beginnings of a wider state social protection system, as well as proving a significant test of the government's stated intention to tackle corruption.

**The civil servants and veterans pension system** (continued page 37)  
Nine of the disabled people who took part in the focus group discussion were veterans and thus entitled to receive the pension, but only three were actually receiving it. All those entitled to the pension complained of the need to pay bribes. One individual said that his identity, and thus his entitlement,

had been sold without his knowledge in Phnom Penh. His former commanding officer had helped him obtain another identity, but it had taken six years before he could secure access to his pension with this new identity. Most of the participants who were not receiving the pension said that they could not afford the bribes necessary to register. One person said that he had to sell a cow in order to pay the bribes.

Focus group results, Pursat

Broadly, the RGC has abrogated responsibility for disability issues to civil society – and to the Disability Action Council, in particular.

### **The Disability Action Council**

The DAC was established in 1997 and became fully operational in 1998. In October 1999, the government formally recognised the status of the DAC as the permanent, semi-autonomous, national coordinating and advisory body on disability and rehabilitation (MoSALVY/Prakas 1999). The legal status of the DAC was reconfirmed in 2001, when the government established the Cambodian Mine Action Authority (CMAA) to coordinate work in this area, and delegated work on victim assistance to the DAC.

The DAC is a unique body in the developing world, acting as a forum to bring together all stakeholders, including the government, donors, UN bodies, international and local NGOs, DPOs and the business sector. From the outset, the DAC was seen as a way of harnessing the skills, energy and resources of the NGO sector to a new government that had low capacity and extremely limited human and financial resources. The DAC received core-funding from USAID through its humanitarian assistance budget and grew rapidly from 1998 to 2002, firmly establishing its status and reputation as the peak player in the sector.

The achievements of the DAC are many. In its early days, it prevented an NGO ‘free for all’, securing a range of services for disabled people, preventing duplication and ensuring a reasonable geographical spread of services given the constraints of the national security situation. As a result, it has earned the respect of all the stakeholders. All the organisations working in the sector are either full or affiliate members of the DAC, and it is the key source of information on, and for, the sector. In 2001, in a brief evaluation of the DAC, USAID acknowledged the organisation’s achievements:

“In the history of humanitarian aid and development investment, it is almost unprecedented that NGOs coordinate their work effectively. There are even fewer precedents where NGOs and government bodies decide to work closely together in the interests of their clients. DAC has broken new ground.”  
(USAID 2001, p 4)

However, the evaluation also highlighted some shortcomings:

- The role of the DAC needed to be clarified, because the organisation had become involved in implementing activities, rather than just coordinating them.
- Its governing board was ineffectual.
- The organisation had grown too rapidly, becoming more responsive to the needs of its powerful and mainly international patrons while insufficiently supportive of nascent national organisations.

- Its sustainability was questionable.

As a result, USAID initiated a process of restructuring. Despite continued technical and financial support from USAID, the restructuring process has been tortuous and has taken much longer than anticipated. The process has undermined the effectiveness of the organisation and damaged its reputation, and several key staff have left. In a sense, the medicine has almost killed the patient. However, the DAC seems on the brink of a new start, and a new transitional manager started work in January 2005.

All the informants for this study who worked in the disability sector, whether in the government, donors, international or local NGOs, or DPOs, stressed the critical importance of a strong and effective DAC for the future of the sector. USAID's continued support to the DAC throughout this difficult period should be acknowledged along with all the efforts of several key individuals from the sector.

Korten identified three generations of assistance: first-generation relief and welfare, second-generation local self-reliance, and third-generation sustainable systems development (Korten 1987).

Third-generation assistance focuses on collaboration:

“...working in a catalytic, foundation-like role rather than an operational service-delivery role – directing its attention to facilitating development by other organisations, both public and private, of the capacities, linkages and commitments required to address designated needs on a sustained basis.”  
(Korten 1987, p 149).

The DAC was founded at a time of humanitarian aid, but from the start, its outlook was third generation. Now that Cambodia is entering a long-term development phase, the vision that inspired the DAC should come into its own. The DAC should be seen as an integral part of the mechanisms to ensure good governance, and should be funded accordingly. Despite its current weakened state, it still offers a potentially useful model for those inside Cambodia and beyond.

## **Services**

Virtually all services for disabled people in Cambodia are delivered by NGOs – mainly international NGOs. Funding is received from several multi- and bi-lateral donors, including include USAID, DFID, World Bank, UN, EU, ADB, GTZ, JICA, FINIDA, DANIDA, SIDA and CIDA, as well as a host of funding organisations, foundations and from private donations.

Of the UN bodies currently working in Cambodia, only the ILO and UNICEF are implementing specific programmes targeting disabled people and children, but several international and local NGOs receive funding via UN bodies for their activities.

A summary of services for disabled people is presented in the table below:

**Overview of services for disabled people** (continued page 40)

<b>Type of service</b>	<b>Details</b>
Number of NGOs providing services	30+
Physical rehabilitation centres	11 (Phnom Penh, Battambang, Sihanoukville, Kompong Cham, Kompong Spue, Siem Reap, Takeo, Kandal, Prey Veng, Kratie, Kompong Chhnang). All supported by international NGOs
Medical rehabilitation	Spinal Cord Injury Unit, Battambang Emergency Hospital, Battambang (international NGO) Hope Hospital (international NGO), Phnom Penh Angkor Children's Hospital (international NGO), Siem Reap Seven government hospitals in Phnom Penh and Kandal Surgical teams from overseas providing general and orthopaedic surgery services
Eye units	Located in government hospitals in Siem Reap, Battambang, Kompong Cham, Kompong Thom, Kratie, Kandal (Takmau and Neak Loung), Phnom Penh (Russian and Municipal Hospital), Kompong Spue, Sihanoukville, Kompong Chhnang, Banteay Meanchey, Pursat, Stung Treng, Svay Rieng, Kampot. All supported by international organisations.
Assistive devices (such as prostheses, orthoses, wheelchairs, Braille machines and canes)	Cambodia Trust, Veterans International, International Committee of the Red Cross, Development Technology Workshop, Handicap International, Jesuit Services Cambodia
Community-based rehabilitation	Handicap International (Belgium), Veterans International, Cambodia Trust, Disability and Development Services Pursat, Servants
Deaf services	Deaf Development Programme (developing sign language, deaf self-help groups) All Ears Cambodia, international NGO (audiology, Phnom Penh, Kompong Chhnang and Pursat) Jesuit Services Cambodia, international NGO (audiology, primary ear care, some surgery), Phnom Penh, Battambang, Pailin and Sisophon)
Vocational training centres	There are eight, three in Phnom Penh, supported by international and local NGOs ILO Alleviating Poverty Through Peer Training programme (APPT), Siem Reap and Pursat provinces
Institutional care	Main government orphanage in Phnom Penh Two small group homes (Phnom Penh and Kandal) supported by international NGOs
Mainstream education	Inclusive education programme currently in 95 schools in Svay Rieng, Battambang, Sihanoukville, Kompong Spue, Kompong Thom, Prey Veng, Pursat, Siem Reap, Banteay Meanchey, implemented by MoEYS, DAC, UNICEF, local and international NGOs, and with additional financial support from UNESCO
Special schooling	Four schools for the deaf (Phnom Penh, Battambang, Kompong Cham) and four schools for the blind (Phnom Penh and Battambang, Siem Reap) along with 28 integrated classes for deaf and blind children in the provinces provided by local NGO Krousar Thmey. One school for children with physical disabilities, Kandal Province supported by a religious group. Class for children with multiple disabilities at the government

	orphanage in Phnom Penh, supported by private donations
Mental health	Centre for Child Mental Health, Kandal Province Limited provincial services provided by one international and one local NGO.
Disabled people's organisations	Cambodian Disabled Person's Organisation (CDPO) Association of Blind Cambodians (ABC) National Centre of Disabled Persons (NCDP)
Self-help groups	International NGO Action on Disability and Development (Kompong Chhnang and Kompong Spue) International NGO Landmine Disability Support (Kompong Chhnang) Also support to self-help groups provided by Cambodia Trust, Handicap International, Belgium, American Friends Service Committee and others.

Sources: DAC (2001b), NEP (2003), Mackinlay (2004)

Despite the impressive number of organisations working in the sector, services for disabled people are inadequate, and are particularly lacking in remote and rural areas. Where services exist, disabled people find it difficult to access them, or find them inappropriate. In a recent survey (DAC *et al* 2002), the main barriers were:

- lack of money (77.6 per cent)
- no service responding to needs (6.3 per cent)
- no means of transportation (3.1 per cent).

Cambodia's recent history has meant that disability and rehabilitation services have largely focused on the needs of those disabled by war, mines and polio, to the exclusion of other types of impairments. Services for blind and deaf people and those with mental health problems are extremely limited. Accessibility is also poor, with very few public buildings having disabled access features, and awareness of accessibility issues is minimal outside those organisations working on disability (DAC 2001b). It is understood that in 2004 new school and health facilities were being constructed with basic accessibility features, such as ramps, but it was not possible to ascertain if this included accessible toilets and whether the guidelines were being followed.

In rural areas, the condition of roads is often so bad that even people with access to wheelchairs find it difficult to get about – particularly in the wet season. Cambodia is currently developing a system of sign language (DAC 2002) and at present very few materials are available in Braille. There also appears to be virtually no information in accessible formats for the visual and hearing impaired on key public health issues such as HIV/AIDS.

The almost total reliance on NGOs to provide services raises serious questions about the current sustainability of services – let alone future service expansion to meet the needs of Cambodia's disabled population. The current funding climate is uncertain and several key NGOs have had their resources cut. In the past year, three rehabilitation centres have closed, primarily prompted by reduced resources and the need to rationalise services. The focus on services is also problematic, as it can become a substitute for self-help. As one disabled Cambodian activist put it, "To give is to disempower."



## Disabled people's organisations

Cambodia's disability movement is weak, and the national disabled people's organisation the Cambodian Disabled Person's Organisation (CDPO) has been undergoing an extensive period of restructuring. The focus has been primarily on service delivery. Meanwhile, support for developing national disability movement to effectively represent the voice of disabled Cambodians and lobby for their rights has been somewhat neglected. Cambodian DPOs have also tended to focus on delivering services often to the detriment of developing their own capacity to advocate for disabled people's rights.

One exception is the international NGO Action on Disability and Development (ADD). It has been working on developing self-help groups at village level and federations at district and provincial levels in two provinces. ADD does not engage in service delivery, focusing only on empowering disabled people to advocate for themselves.

The emphasis given to service delivery is understandable. Basic services, such as rehabilitation and providing assistive devices, are essential to enable disabled people to begin to access their rights. The focus on these services reflected donor priorities at the time.

More recently, some donors, and in particular DFID, have emphasised a rights-based approach over services. Several international NGOs in the sector are responding by placing an increased emphasis on developing self-help groups, but many of these still have a stronger focus on community development rather than disability rights. Some international NGOs also encourage mixed self-help groups, made up of disabled and non-disabled members. They argue that this encourages integration and inclusion and also prevents disabled people being seen as getting preferential attention over other equally poor but non-disabled individuals. The approach is interesting but it is too early to judge its success. It may well promote genuine inclusion but there is also the risk that the particular needs and perspective of disabled people may become overshadowed.



*to grow vegetables in a self-help group in Kompong Spue*

*Above: Accessible building for ADD's Federation of Disabled People in Kompong Chhnana.*

## 5 Mainstreaming disability development in Cambodia

“The situation of disabled people provides a microcosm of the whole development debate and process.”  
(Coleridge 1993, p 4)

There is a growing consensus between the RGC and the leading donors that:

“Cambodia is at a critical juncture in its development as it moves away from a post-conflict situation and towards a more normal development paradigm.”  
(DFID 2004, p 1).

The country has made significant progress in establishing peace and security, rebuilding institutions and infrastructure, securing a stable macro-economic environment, and developing democratic processes.

However, enormous challenges remain. Poverty rates are high, inequality is increasing, maternal and child mortality has grown, and the country is unlikely to achieve the MDG targets – except perhaps in primary education. Two areas have been highlighted for particular attention: good governance and the need to tackle almost endemic corruption, along with better donor coordination (World Bank 2004, DFID 2004, Hun Sen 2004).

Cambodia has attracted considerable international assistance since the early 1990s, but while the donors have been generous, the failure to harmonise assistance has been problematic. Until very recently, there were three parallel national development plans,<sup>4</sup> each promoted by different agencies and working through different ministries and government processes. In July 2004, the Prime Minister, Hun Sen, announced the government’s own plan, the Rectangular Strategy for Growth, Employment, Equity and Efficiency (RGC 2004). The leading donors are responding, and the World Bank, UN, ADB and DFID have agreed to work together with the RGC to develop a single, shared national development strategy.

The physical visibility of disabled people in Cambodia, along with international focus on landmines, has resulted in a conflation of visibility with inclusion. There is a misplaced perception by those working outside the disability sector that disability receives a lot of funding and that it is well supported and ‘moving forward.’ In fact, the reality is rather different. Research for this study has revealed that most disabled people in Cambodia are among the very poorest in the country. Because of their disabilities, that they experience poverty more intensely and have fewer opportunities to escape poverty than their able-bodied peers, and they find it much harder to utilise the assets they may have to improve their economic situation.

The disability sector is well coordinated compared to mainstream development in Cambodia, but there has been an overemphasis on service provision, driven by international agendas and funding sources, with insufficient focus on empowering disabled people. The government’s almost total reliance on civil society to address disability issues has meant that disability has become largely divorced and isolated from

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<sup>4</sup> The National Poverty Reduction Strategy, promoted by the World Bank (RGC/CSD 2002), the Socio-Economic Development Plan (SEDP 1 and 2) with the Asian Development Bank, and the UN’s Cambodian Millenium Development Goals.

mainstream development as well as seriously undermining the sustainability of existing services.

Disability is a cross-cutting issue, but other issues, such as gender, ethnicity and HIV/AIDS receive far more attention in national development strategies. Despite the lack of accurate statistics on the proportion of the population that is disabled, even very conservative estimates suggest that the numbers are comparable to, if not greater than, those for indigenous people, at 4 per cent (CIA World Factbook) and those with HIV/AIDS, at 2.7 per cent (DFID 2004).

The impact of disability reaches far beyond the individuals directly affected. Cambodia's progress towards reducing poverty and achieving the MDGs will be constrained unless efforts are taken to remove the barriers to the full participation of disabled people.

### SWOC analysis of the disability sector

The table below presents an analysis of the strengths, weaknesses, opportunities and constraints of the disability sector in Cambodia.

<p style="text-align: center;"><b>Strengths</b></p> <ul style="list-style-type: none"> <li>• Well-coordinated and organised</li> <li>• Existence of the DAC</li> <li>• Draft disability law</li> <li>• High profile and range of services for landmine survivors</li> <li>• Diverse and committed number of CSO service providers</li> </ul>	<p style="text-align: center;"><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Growing donor harmonisation to support RGC's Rectangular Strategy</li> <li>• Donor and RGC's emphasis on good governance, decentralisation and deconcentration</li> <li>• Commune councils and Seila programme offer mechanism for disability issues to be raised at local levels</li> <li>• Equity funds and systems to target the most vulnerable households</li> <li>• Growing donor interest in supporting CSOs</li> <li>• Veterans and civil servants' pension scheme</li> </ul>
<p style="text-align: center;"><b>Weaknesses</b></p> <ul style="list-style-type: none"> <li>• Severely limited services for deaf, blind and people with mental health problems</li> <li>• Over-emphasis on landmine survivors and those with physical impairments</li> <li>• Weak and unrepresentative disability movement</li> <li>• Limited engagement with mainstream development processes</li> <li>• Almost total reliance on CSOs</li> <li>• Sustainability very questionable</li> </ul>	<p style="text-align: center;"><b>Constraints</b></p> <ul style="list-style-type: none"> <li>• Current aid modalities (budgetary support, sector-wide approaches) that limit support for projects and particular issues</li> <li>• Insufficient data on disability and analysis of links between disability and poverty</li> <li>• Perception and funding of disability as a specialist issue</li> <li>• Limited government interest in disability and weak capacity of MoSAVY</li> </ul>

## 6 Conclusion and recommendations

Policy makers need a greater awareness and understanding of disability in Cambodia and its dynamic relationship with poverty. It is critical that the disability sector re-engages with mainstream development, that the government is supported to resume more responsibility for its disabled citizens, and that disabled people are empowered. The following recommendations suggest ways in which donors can facilitate and support these necessary steps.

### **Improve data and information on disability**

Bird has highlighted the significant role that donors play in influencing the policy agenda and the 'framework of the possible', not only in the resources that they provide, but also in identifying key development and poverty reduction problems (Bird 2004).

The commitment of the World Bank, the Asian Development Bank (ADB), the UK Department for International Development (DFID) and the United Nations to work with the government to develop a single national development plan is highly significant. Currently three poverty studies are planned, or being undertaken, that will feed into the development of the unified national poverty reduction and development plan. The first – the Socio-Economic Survey conducted by the National Institute of Statistics – is well underway and preliminary results were available in January 2005. It is understood that this survey does include a question about disability, but that it is focused only on identifying the numbers of disabled people.

In addition, the ADB is planning a second participatory poverty assessment, and the World Bank, with additional funding from DFID, is developing a 'Moving Out of Poverty' study. It is hoped that the design of these two studies will be complementary. Their timeframe is tight, but if it is at all possible, it is essential that they look specifically at the issue of disability. Disability was not mentioned at all in the ADB's previous PPA in 2001, though it did make a conscious effort was to look at issues of gender and ethnicity. A similar conscious effort is needed with regard to disability. Otherwise, yet again, it will be overlooked in the final analysis.

### **Enact disability legislation**

To provide a framework for the future, Cambodia needs specific legislation promoting and enshrining the rights of disabled people, designating clear roles and responsibilities for government and civil society, and defining benefits and entitlements for disabled people. A draft disability law has been prepared, in wide consultation with stakeholders. Donors are currently encouraging the government to pass an anti-corruption law, and a similar approach could be taken with the draft disability law.

### **Strengthen the participation of disabled people in local planning**

The establishment of local government through democratically elected commune councils (CCs) in 2002 is a key initiative of the RGC's commitment to decentralisation and deconcentration. Commune councils are potentially a very powerful mechanism through which citizens can hold government to account. There is considerable donor interest in CCs as a vital way of ensuring that Cambodia develops good governance systems and tackles corruption.

The nationwide Seila programme is supported by pooled funds from eight donors. It disburses some US\$40 million each year to support the RGC's programme of decentralisation and deconcentration. Two-fifths (40 per cent) of the funds go to the commune level to assist communes to develop three-year investment plans that include a social development component. Commune priorities are aggregated at the district level, effectively establishing mini poverty reduction plans for communities. NGO inputs are included in the district- and commune-level planning processes.

Commune councils and the Seila programme probably offer the greatest opportunity for the mainstream to acknowledge and address the needs and concerns of disabled people. The DAC and disability organisations broadly recognise this, but so far there has been limited engagement.

Disability organisations generally seem unclear about how CCs and the Seila programme operate, and how to raise their concerns. This suggests that awareness-raising and information initiatives carried out by Seila and others (such as the Commune Council Support Project, or CCSP) have not reached disability organisations – yet another example of how far the disability sector is isolated from mainstream development activities.

However, some disability organisations have succeeded in raising disability issues at the commune level. One DPO federation supported by Action on Disability and Development (ADD) secured support from the Social Fund of Cambodia to build a federation building in Kompong Chhnang. Self-help groups supported by the UK NGO Landmine Disability Support have also raised disability issues. One disabled focal person of a self-help group has been invited to act as the registrar for Chong Morn commune council in Teuk Pos District, Kompong Chhnang, because of his writing and minute-taking skills.

Nevertheless, the DAC commented that when disability issues were raised at the provincial level, officials were 'nervous' about taking things forward without a lead from the national Seila task force. The DAC and CDPO see the need for discussing disability issues with the programme at the national level. Some smaller disability NGOs also commented that engaging with the Seila programme is potentially very time consuming in terms of attending meetings especially as they had limited staff and worked in several communes and districts.

To ensure real social accountability, it is essential that excluded groups are supported to participate in local-level planning processes. Donors may wish to consider commissioning a consultancy to examine various options for strengthening the participation of disabled people and other excluded groups.

### **Review existing social protection mechanisms, and identify options for developing social protection to reduce poverty and facilitate inclusion**

There is a growing interest among donors and the government in developing a harmonised approach (both in terms of criteria and procedures) to establish a national system for identifying and targeting the most vulnerable households. Such a system could be used for granting entitlements. It could provide a powerful mechanism to ensure assistance really reaches the poorest. Careful consideration should be given to the inclusion of disability as one of the criteria for establishing the most vulnerable households.

In recent years, understanding of social protection has broadened to encompass far more than mere social safety nets. Social protection is increasingly recognised as a key tool for reducing poverty and supporting rights. Donors may wish to consider commissioning a consultancy study to review existing social protection mechanisms and identify opportunities for establishing and strengthening social protection in Cambodia. The current Veterans and Civil Servants' Pension represents a potential opportunity but is currently not effective and is subject to significant corruption.

**Support the Ministry of Education, Youth and Sport to develop Inclusive education**

In its Education Strategic Plan of 2001–2005 (MoEYS 2001), the Ministry of Education, Youth and Sport accepted inclusion as its vision for the sector, and acknowledged the needs of disabled children. Inclusive education (IE) is a key strategy for achieving education for all and improving the quality of education.

In 2000 MoEYS, with the support of the DAC, established the Special Education Office (SEO) within the Primary Education Department, with the responsibility for supporting the needs of the most marginalised children – namely girls, disabled children, ethnic minorities, and street and working children.

Also in 2000, the DAC began implementing a pilot IE programme in one school cluster in Svay Rieng Province, with MoEYS and the SEO. The IE programme has grown to encompass 95 schools in nine provinces. The programme has a particular emphasis on disability. The programme's provincial implementation teams (PITs) bring together representatives from MoEYS and MoSAVY, along with representatives from local and international disability NGOs and DPOs, with the aim of providing holistic support to the children in the programme.

The programme's focus is on identifying children with special needs, in and out of school, and on providing training and sustained follow-up support for teachers dealing with their needs. The involvement of the NGOs and DPOs facilitates referrals for rehabilitation and assistive devices along with community awareness-raising on the rights and abilities of disabled children. The programme is supported by UNICEF and UNESCO.

Recent research by the SEO suggests that schools in the IE programme perform better than schools outside the programme, in terms of better enrolment and progression rates and fewer drop outs. Both UNICEF and UNESCO are eager to see further expansion of the programme, but a thorough evaluation is recommended. An evaluation would not only determine the effectiveness of the IE programme, but could also highlight important lessons for the whole sector.

The World Bank has just agreed to support a new programme to improve access to basic education focusing on girls, disabled children and other marginalised groups, with funds from the Japanese Social Development Fund. The programme will be implemented by Voluntary Service Overseas (VSO) and will link with the existing IE programme.



Disabled children attend a primary school taking part in Cambodia's inclusive education programme

However, the Special Education Office currently lacks capacity and is not fully engaged with sector planning processes. It did not share data that it collected on the performance of the schools in the IE programme, or on the overall numbers of disabled children attending schools throughout the country, with MoEYS staff and consultants working on the new sector plan. Further, the new draft Education Sector Support Programme 2004 (ESSP 2004) makes no mention of disability.

Clearly, more work needs to be done to raise awareness of the IE programme and to link it with mainstream sector plans and initiatives, and with data collected by the Education Management Information System (EMIS). Donors may also wish to consider including specific indicators relating to the educational achievement of disabled children and minority ethnic groups in agreements with MoEYS. In India, DFID agreed an indicator with other donors and the government that stressed improved educational achievement for scheduled castes and tribes and disabled children – and in particular, for girls within these groups.

Currently, MoEYS institutionally discriminates against disabled people by refusing them access to train as teachers. As far as can be ascertained, this is because MoEYS adopts a particularly literal interpretation of the civil service law that requires civil servants to be sound in body and in good health (personal communication). The position is illogical as well as being impractical and discriminatory. There are many disabled people currently working as teachers who either became disabled after training, or who are untrained, or who have been in the profession since the early and mid-1980s when teachers were desperately needed. This policy should be discontinued.

## **Support the development of linkages between mainstream health services and rehabilitation**

A recent report on the disability sector highlighted the need for mainstreaming, and noted that, “A service focus needs to be promoted as opposed to a facility focus, for example a number of specialist medical rehabilitation services could be delivered through hospitals or health centres” (Mackinlay 2004, pp 84). Currently, state health services generally lack awareness of the specialist rehabilitation services available for disabled people, provided by rehabilitation centres and hospitals with specialised units funded by international NGOs and foundations.

Informants for this study clearly felt that overall responsibility for medical and physical rehabilitation should lie with the Ministry of Health (MoH), rather than with the Rehabilitation Department of MoSAVY, as it currently does. The DAC has been striving to establish stronger links with the MoH and MoSAVY and with the international NGO specialist rehabilitation services, through its Medical Rehabilitation Project. The project has made progress, but both ministries lack capacity. Also, it is currently not possible for the ministries to share budgets, and MoSAVY is severely disadvantaged compared to the MoH in terms of resources.

A small-scale survey in Svay Rieng in 2001 revealed that MoH personnel had a very poor knowledge and understanding of disability issues (DAC 2001c). Physiotherapists are trained by the MoH but, given the low government salaries, most leave to work for NGOs providing rehabilitation services. Consequently, physiotherapy is virtually non-existent for patients in government health facilities. As a result, injuries that should not result in permanent disability often do. The lack of awareness of rehabilitation services among the state health staff means that often patients are not referred and fail to get the treatment and rehabilitation available. Furthermore, the lack of coordination between MoH and MoSAVY means that visiting surgical teams are often unregulated. Health workers need much more awareness and training on disability.

The cost of obtaining healthcare is recognised as significantly contributing to vulnerability and poverty (DFID 2004). All rehabilitation services are heavily subsidised by the providing organisations, and contributions from clients and their families are usually very modest – confined primarily to transport and/or subsistence for the individual.

Service providers with MoSAVY are about to undertake a review and analysis of rehabilitation provision, and the issue of establishing user fees similar to that operating in MoH facilities will be considered. However, even if a user fee system is adopted, it is very unlikely that it would make any significant contribution towards the funding of rehabilitation services. This is because those in need are often extremely poor and the a fee system might well discourage individuals from seeking help.

Some donors supporting the mainstream health sector have recently established an equity fund system. This scheme, piloted by NGOs, WHO and UNICEF in several provinces and districts, provides the poorest households with a card entitling them to free or reduced cost health care, with the donor or NGO picking up the cost of treatment. The system is still being piloted, and the criteria for identifying the poorest households vary. However, there has been increased utilisation of health services by poor people, and it seems likely that the system will be rolled out more widely. The use of equity funds



show that the donor community recognises that free health care subsidised by international aid is very necessary for Cambodia's poorest.

Disabled people generally require more health services than non-disabled people. A recent evaluation of the equity fund system operated by UNICEF in Svay Rieng recommended that disability should be considered among the criteria for identifying the poorest households (Nguyen 2004). Including disability among the entitlement criteria for is strongly encouraged as a way of increasing disabled people's access to health care. Furthermore, as treatment costs under the equity fund schemes come from specific donor budgets, it should also be possible for the system to be extended to cover rehabilitation services currently provided by international NGOs under the auspices of MoSAVY. The system could thus act as a mechanism for establishing greater linkages between the MoH and MoSAVY, as well as diversifying the funding base for rehabilitation services.

### **Facilitate the re-engagement of the disability sector with the mainstream by supporting disability specific activities out of mainstream donor budgets**

Most disability-specific activities in Cambodia are currently funded out of specialised donor budgets. For example, USAID support for disability comes from its humanitarian aid budget and from the Leahy War Victims Fund. DFID support for disability is funded from the UK via the Civil Society Challenge Fund and the Programme Partnership Agreement (PPA) with Action on Disability and Development (ADD). Support to organisations such as the DAC, in particular, and DPOs, in general, could be viewed as part of donor support to good governance and social accountability.

### **Improve donor awareness and understanding of disability issues**

Research for this study reveals that disabled people are largely excluded from development in Cambodia. The failure to consider the disability perspective in the design of programmes and activities often results in unwitting exclusion of, and discrimination against, disabled people. Donors should seriously consider including representatives from the disability sector in all external consultations. Furthermore, donors might wish to explore options for disability sensitisation for their staff. For example, DFID could draw on the expertise of ADD, with whom it has a PPA in providing advice on disability issues and short disability-awareness training for staff.

### **Support the RGC to fulfil its commitments, under the Biwako Framework, towards achieving a barrier-free environment**

Donor support to health and education, in particular, has enabled numerous schools and health facilities to be built and renovated. Donors should ensure that future budgets for all infrastructure projects are sufficient to enable accessibility features to be included.

### **Support disability prevention**

Donors have been supporting immunisation programmes, mine awareness campaigns and other activities to prevent disability. Alongside continued support for these activities, they may also wish to consider working with the RGC and NGOs to develop a comprehensive, nationwide road safety campaign. Road traffic accidents are now a very significant cause of disability, far outweighing the deaths and injuries caused by mines and UXO.

Approximately three people a day are killed or injured in mine accidents, but road traffic accidents account for a far higher number of deaths and permanent disability, and the

rates are rapidly increasing. In November 2004 in Phnom Penh alone, there were 628 road accident casualties reported, with a death rate of 4 per cent, and 35 per cent suffered severe injuries warranting surgery and/or intensive care treatment (Handicap International 2004). The problem has increased dramatically as roads have been improved. Continued support to road building and renovation needs to be accompanied by measures to prevent road accidents reaching epidemic proportions.

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## Annex 1: Organisations working in the disability sector

<b>Association for Aid and Relief – Japan (AAR-Japan)</b>
International NGO (Japan)
PO Box 141, #3 Mao Tse Toung, Phnom Penh Tel: 023 430 195 Email: aar.pp@online.com.kh
<ul style="list-style-type: none"> <li>• Wheelchair production</li> <li>• Vocational training</li> </ul>

<b>Association of the Blind in Cambodia (ABC)</b>
Local NGO/DPO
PO Box 175, #3 Street 55, Phnom Penh Tel: 023 213 882 Email: abc@online.com.kh
Advocacy Self-help groups Vocational training

<b>Action on Disability and Development (ADD)</b>
International NGO (UK)
PO Box 1123, #133 Street 95, Boeung Trabek, Phnom Penh Tel: 023 216 917 Email: add@online.com.kh
<ul style="list-style-type: none"> <li>• Advocacy</li> <li>• Self-help groups</li> </ul>

<b>AFP Fish Farm Association for Disabled and Poor</b>
Local NGO
Yim Sambath, (Takeo Province) Tel: 012 447 211

<b>American Friends Service Committee</b>
International NGO (United States)
PO Box 604, #102 Street 113/304 Phnom Penh Tel: 023 216 400 Email: afsc@online.com.kh
Self-help groups Community-based rehabilitation

<b>Aide aux Handicappes du Cambodge</b>
Local NGO
#172B-Eo, Street 132, Phnom Penh Tel: 012 857 580
<ul style="list-style-type: none"> <li>• Advocacy</li> </ul>

<b>Association for Supporting Disabled People</b>
Local NGO
#991, Street 3, Gr.9, Kompong Svay Village, Kompong Svay, Sereysorphorn District, Banteay Meanchey Tel: 054 958 526
<ul style="list-style-type: none"> <li>• Self-help groups</li> </ul>

<b>Caritas Cambodia</b>
International NGO (UK)
PO Box 128, Wat Sarawan, Phnom Penh Tel: 023 211 372 Email: caritasrbc@online.com.kh
<ul style="list-style-type: none"> <li>• Rehabilitation (particularly for blind people)</li> <li>• Surgery referral</li> </ul>

<b>Centre for Child Mental Health</b>
International NGO
Takmau Hospital, Kandal Tel: 023 300 543
<ul style="list-style-type: none"> <li>• Counselling</li> <li>• Mental health assessment and support</li> </ul>

<b>Cambodian Disabled People's Organisation (CDPO)</b>
Local NGO (DPO)
<ul style="list-style-type: none"> <li>• Self-help groups</li> <li>• Advocacy</li> </ul>

<b>Cambodia Trust</b>
International NGO (UK)
PO Box 122, Calmette Hospital, Monivong Boulevard, Phnom Penh Tel: 023 368 241 Email: camtrust@online.com.kh
<ul style="list-style-type: none"> <li>• School of prosthetics and orthotics</li> <li>• Rehabilitation</li> <li>• Assistive devices</li> <li>• Advocacy</li> <li>• Self-help groups</li> </ul>

<b>Cambodian War Amputees Rehabilitation Society</b>
International NGO
PO Box 1027, #12 Street 323, Phnom Penh Tel: 012 803 804
<ul style="list-style-type: none"> <li>• Rehabilitation</li> </ul>

<b>Disability Action Council (DAC)</b>
Semi-autonomous government body
PO Box 115, #28 Street 184, Phnom Penh Tel: 023 215 341 Email: dac@dac.org.kh
<ul style="list-style-type: none"> <li>• National coordinating and advisory body</li> </ul>

<b>Deaf Development Programme</b>
Local NGO
PO Box 2469, #23A Street 304&113, Phnom Penh Tel: 023 987 931 Email: DDPgeneral@online.com.kh
<ul style="list-style-type: none"> <li>• Developing sign language</li> <li>• Self-help groups</li> </ul>

- Education
- Advocacy

<b>Disability Development Services Pursat</b>
Local NGO
PO Box 9206, Department of Social Affairs, Pursat Tel: 012 774 840 Email: ddsp@cambodiacic.org
<ul style="list-style-type: none"> <li>• Community-based rehabilitation</li> <li>• Inclusive education</li> <li>• Advocacy</li> </ul>

<b>Development Technology Workshop</b>
International NGO (UK)
PO Box 1244, #17, Street 528, Toul Kork, Phnom Penh Tel: 023 884 470 Email: dtw@dtworks.org
<ul style="list-style-type: none"> <li>• Assistive devices</li> </ul>

<b>Emergency</b>
International NGO
Emergency Hospital, Battambang Tel: 012 866 202
<ul style="list-style-type: none"> <li>• Rehabilitation and surgery</li> </ul>

<b>Handicap International (Belgium)</b>
International NGO (Belgium)
PO Box 838, #18 Street 400, Phnom Penh Tel: 023 217 300 Email: dp.hicambodge@online.com.kh
<ul style="list-style-type: none"> <li>• Community-based rehabilitation</li> <li>• Rehabilitation</li> <li>• Assistive devices</li> <li>• Inclusive education</li> <li>• Advocacy</li> <li>• Vocational training</li> </ul>

<b>Handicap International (France)</b>
International NGO (France)
PO Box 586, #6 Street 348, Phnom Penh Tel: 023 214 504 Email: hif_cambodia@everyday.com.kh
<ul style="list-style-type: none"> <li>• Rehabilitation</li> <li>• Inclusive education</li> <li>• Community-based rehabilitation</li> <li>• Advocacy</li> <li>• Self-help groups</li> <li>• Vocational training</li> </ul>

<b>International Committee of the Red Cross</b>
International NGO (UK)
PO Box 408, #788A Monivong Boulevard, Phnom Penh



Tel: 023 308 023 Email: icrcphn@camnet.com.kh
<ul style="list-style-type: none"> <li>• Wheelchairs and assistive devices</li> <li>• Rehabilitation</li> </ul>

<b>Jesuit Services</b>
International NGO
#96 Street 592, Phnom Penh Tel: 023 880 139 Email: jrscam@forum.org.kh
<ul style="list-style-type: none"> <li>• Audiology, hearing aids</li> <li>• Rehabilitation</li> </ul>

<b>Krousar Thmey</b>
Local NGO
#4 Street 257, Avenue Kampuchea, Phnom Penh Tel: 023 366 184 Email: krousar-thmey@bigfoot.com
<ul style="list-style-type: none"> <li>• Special education (deaf and blind) and integrated classes</li> </ul>

<b>Landmine Disability Support</b>
International NGO (UK)
PO Box 947, Phnom Penh Mong Baraing, Paer Commune, Kompong Chhnang Tel: 026 988 907 Email: lmds@camintel.com
<ul style="list-style-type: none"> <li>• Self-help groups and community development</li> <li>• Advocacy</li> </ul>

<b>Marist Mission Australia, Lavalla</b>
International NGO (Australia)
PO Box 2013, Prek Reang, Kompong Samnang, Takhmau, Kandal
<ul style="list-style-type: none"> <li>• Special school (for the physically disabled)</li> <li>• Education</li> <li>• Advocacy</li> </ul>

<b>Nutrition Centre</b>
Government orphanage, supported by largely private funding
#59 Monivong Boulevard, Phnom Penh Tel: 023 986 090
<ul style="list-style-type: none"> <li>• Residential care for disabled orphans</li> <li>• Special schooling</li> </ul>

<b>National Centre of Disabled Persons (NCDP)</b>
DPO
PO Box 170 #3 Norodom Boulevard, Phnom Penh
<ul style="list-style-type: none"> <li>• Advocacy</li> <li>• Vocational training, income generation and job referral</li> <li>• Self-help groups</li> <li>• Community-based rehabilitation</li> </ul>

<b>Operations Enfants du Battambang</b>
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<b>Local NGO</b>
#229, 11 Sophy 1, Khum Rattanak, Battambang Tel: 053 952 752
<ul style="list-style-type: none"> <li>• Education (inclusive education and non-formal)</li> <li>• Advocacy</li> <li>• Community support</li> </ul>

<b>Rehab Craft</b>
Local NGO
PO Box 1278, #69 Street 315, Phnom Penh
<ul style="list-style-type: none"> <li>• Vocational training and income generation</li> </ul>

<b>Spinal Cord Centre</b>
Battambang Hospital
<ul style="list-style-type: none"> <li>• Rehabilitation</li> </ul>

<b>Servants to Asia's Urban Poor</b>
International NGO (United States)
PO Box 538, #3 Street 374, Phnom Penh Tel: 023 425 045
<ul style="list-style-type: none"> <li>• Community-based rehabilitation</li> <li>• Education</li> <li>• Advocacy</li> </ul>

<b>Sihanouk Hospital Center of Hope</b>
Street 134, Sangkat Veal Vong, Phnom Penh
<ul style="list-style-type: none"> <li>• Rehabilitation and surgery</li> </ul>

<b>Social Services of Cambodia</b>
Local NGO
PO Box 2457 National Institute of Public Health, Toul Kork, Phnom Penh Email: ssc@online.com.kh
<ul style="list-style-type: none"> <li>• Mental health</li> </ul>

<b>Transcultural Physcosocial Organisation</b>
International NGO
PO Box 1124 #209 Street 63, Phnom Penh Tel: 023 219 182
<ul style="list-style-type: none"> <li>• Mental health</li> </ul>

<b>Veterans International</b>
International NGO
PO Box 467 #16, Street 21, Phnom Penh Tel: 023 217 204
<ul style="list-style-type: none"> <li>• Rehabilitation</li> <li>• Assistive devices</li> <li>• Advocacy</li> <li>• Community-based rehabilitation</li> </ul>

<b>World Vision</b>
International NGO

PO Box 479 #20 Street 71, Phnom Penh Tel: 023 216 052 Email: cambodia@wvi.org
<ul style="list-style-type: none"><li>• Vocational training</li></ul>

<b>X-Pact Society</b>
International NGO (Singapore)
#75 Street 588, Phnom Penh Tel: 011 774 442
Group home

## Annex 2: Terms of reference for the study

### Background

The second phase of the DFID Disability Knowledge and Research (KaR) programme began in September 2003, managed by a consortium of the Overseas Development Group at the University of East Anglia and Healthlink Worldwide. The programme comprises several components:

- **Six competition projects** These small-scale projects were selected through competition under the first phase of the programme. They include two projects with a focus on healthcare technology and four disability-focused projects.
- **Enabling disabled people to reduce poverty** This research component focuses on producing working papers, briefing papers and briefing notes on such topics as the social model of disability, disability policies of leading development agencies, lessons learned from gender mainstreaming for disability, the role of disabled people and their organisations in poverty reduction work.
- **Mainstreaming disability in development training** This strand involves developing introduction and short courses on mainstreaming disability in development for development practitioners (see the section below.)
- **Thematic research on mainstreaming disability in development** Commissioning up to eight separate pieces of research on identified gaps under the overall theme of mainstreaming disability in development.
- **Disability Policy Project** Supporting DFID to develop policies and processes to mainstream disability and to ensure that the Disability KaR's knowledge and research outputs are responsive to DFID's needs and effectively communicated to DFID (see the section below).

### The Disability Policy Project

The Disability Policy Project has seen the placement of a Disability Policy Officer to work four days a week within DFID, providing technical advice on disability. The officer is based within the Central Research Department but links primarily with DFID's Diversity Adviser and Gender and Human Rights Adviser, and with the newly established Exclusion, Rights and Justice (ERJ) team within Policy Division.

The first major output of the Disability Policy Project was the completion of a mapping study of DFID's current work on disability. The full text of the report, 'DFID and Disability: A Mapping of the Department for International Development and Disability Issues,' can be downloaded from the Disability KaR's website at: [www.disabilitykar.net](http://www.disabilitykar.net)

### Mainstreaming disability in development action research

The Disability Mapping Report (Thomas 2004) aimed to provide a snapshot of what DFID was doing to address disability issues. It identified the following key issues:

- DFID has not mainstreamed disability, but there is a solid bedrock of disability-specific activities being carried out, largely via NGOs and CSOs.

- DFID’s work on disability is largely hidden, and often DFID staff and country offices are unaware of disability-focused activities being carried out by NGOs and CSOs.
- While DFID staff broadly recognise the links between poverty and disability, they do not necessarily see disability as an essential part of their work on poverty reduction and the achievement of the Millennium Development Goals.
- DFID staff need more information on disability – in particular, practical tools and examples of best practice, to enable them to implement the twin-track approach outlined in DFID’s issues paper *Disability, Poverty and Development* (DFID 2000).

It is proposed to build on and extend the initial DFID mapping by conducting three pieces of action research on disability mainstreaming in three countries where DFID works.

### **Research objectives**

- to explore how the DFID programme with the ADB, World Bank and UN in Cambodia see the issue of disability in relation to their work on poverty reduction, social exclusion and the MDGs
- to explore how the inclusion of disability issues can contribute to the reduction of poverty and social exclusion and the achievement of the MDGs
- to map what the DFID programme with the ADB, World Bank and UN in Cambodia are currently doing to address disability issues and identify examples of best practice<sup>5</sup>
- to identify opportunities and potential partners for the DFID programme in Cambodia to take forward work on disability, particularly in relation to key sectors such as health, education, rural livelihoods and its work on decentralisation and public and financial management
- to inform the development of a planned DFID policy on exclusion and the Exclusion, Rights and Justice Team’s workstream on inclusive development.

### **Outputs**

- short reports for each country. Each country report would contain:
  - a summary of the current situation of disabled people in the country
  - summary mapping of current initiatives addressing disability implemented by the national government, multi-lateral and bi-lateral development agencies and civil society organisations
  - analysis of current practice in the DFID programme, and the ADB, World Bank and UN in Cambodia on disability issues and the relevance for their overall work on the achievement of the MDGs and the reduction of poverty and social exclusion
  - identification of opportunities and constraints for the DFID Programme with the ADB, World Bank and UN to take forward work on disability
  - identification of potential partners to support work on disability
  - Recommendations
- overall synthesis report.

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<sup>5</sup> The identification of best practice could extend beyond the work of the identified groups to include government, other development agencies (bi-lateral and multi-lateral) and NGOs or CSOs.

## **Outcomes**

- identifying good practice, barriers to change and opportunities to move forward
- identifying useful tools for implementation and evaluation
- identifying a network of support partners for DFID and others.

The outputs of the action research will, it is hoped, be relevant and useful to the DFID country offices themselves, as well as the work of Policy Division and in particular, the new Exclusion, Rights and Justice (ERJ) Team.

## **Proposed scope of work**

The Disability Policy Officer of the Disability KaR Programme will be the principal researcher. The research will be carried out in the UK and in the selected countries. It is proposed that the Disability Policy Officer will be assisted in the in-country research by a local researcher. This assistant researcher will be able to assist the Disability Policy Officer in the following areas:

- identifying interviewees, especially from local CSOs
- facilitating meetings
- interpreting interviews
- providing local contextualisation and understanding.

The Disability Policy Officer will be responsible for:

- identifying country offices through close consultation with DFID, especially the ERJ team and the Senior Social Development Advisers for Asia and Africa
- communicating with chosen DFID country offices and ensuring that all relevant DFID staff (the ERJ team, Central Research Department and Senior Social Development Advisers) and Disability KaR Programme Management are kept fully informed
- developing a costed work plan for the whole programme of research and specific work plans for each chosen country
- developing a research tool in consultation with DFID
- identifying and reviewing key documents
- identifying a local research assistant, developing their work plan and managing them
- conducting in-country research: review of documents, holding semi-structured interviews with key DFID personnel and external stakeholders, and carrying out programme or project field visits
- preparing three country reports and one overall summary report
- providing support to country offices in identifying means to take any recommendations forward

## **Selecting DFID country offices**

It is essential that the selected DFID country offices are broadly supportive of the research activity. Therefore, the choice of country offices is likely to be largely self-selected (in other words, respective country offices are willing to participate in the research activity).

It is hoped that two country offices from Asia Division and one country office from Africa Division will be willing to participate. It would also be helpful if the Asia Division country offices included two out of the five pilot countries for Asia Regional Policy Unit (ARPU) work on social exclusion (China, Bangladesh, India, Nepal and Vietnam). In addition, it is hoped that at least one of the countries identified was a PRSP country.

### **Role of DFID country offices**

The Disability KaR programme and the Disability Policy Officer do not wish to inconvenience or significantly add to the workload of the DFID country offices in conducting this research activity. However, it is hoped that each DFID country office could ensure the following support to the Disability Policy Officer in conducting the research:

- providing information on the work of the country office in addition to that which is available on Insight and PRISM as appropriate
- ensuring the participation of key country office staff in semi-structured interviews.

All costs associated with the research will be covered by the Disability KaR Programme.

The Disability Policy Officer will be responsible for all logistical arrangements (travel to and within country, accommodation, and so on) for in-country visits.

### **Time frame**

<b>Activity</b>	<b>Date completed</b>
Desk Review of documents in UK	End November 2004
Country visit	December 7–20 2004
Initial draft report submitted to DFID Cambodia	End of December 2004

### Annex 3: Interviewees

Tom Beloe	Social Development Adviser, DFID South-East Asia
Lizzie Smith	Health Adviser and Head of Office, DFID Cambodia
Michel le Pechoux	Project Officer, Seth Koma Programme, UNICEF, Cambodia
Scott Leiper	Seila Programme
Ngay San	Deputy Executive Director, Disability Action Council, Cambodia
Thomas Keusters	Country Director and Representative, World Food Programme, Cambodia
Maha Ahmed	Programme Adviser, World Food Programme, Cambodia
Sue Fox	Project Officer, Non-Formal Education, UNESCO, Cambodia
Dr Supote Prasertsri	Education Programme Specialist, UNESCO, Cambodia
Pam Foster-Ojajuni	Program Officer, USAID, Cambodia
Ellen Minotti	Adviser, Social Services of Cambodia, Cambodia
Laurent Chapuis	Consultant for Social Policy and Institutional Strengthening, seconded to Directorate of Ministry of Social Affairs, UNICEF, Cambodia
Mao Moni Rattana	Poverty Consultant, Asian Development Bank, Cambodia Resident Mission
Srey Vanthorn	Country Representative, Action on Disability and Development, Cambodia
Steve Harknett	Adviser, Disability Development Services, Pursat, Cambodia
Keo Sophat	Programme Manager, Disability Development Services, Pursat, Cambodia
Yi Dara	Education and Advocacy Coordinator, Landmine Disability Support, Cambodia
John Lowrie	Country Programme Manager, Landmine Disability Support, Cambodia
Alison Rhodes	Country Director, The Cambodia Trust
Sujaya Misra	Adviser, Ministry of Planning, Cambodia



Tim Conway	Poverty Specialist, World Bank, Cambodia
Anne Holopainen	Associate Expert on Vocational Training, ILO Sub-Regional Office, Bangkok
Khem Sam Ath	Programme Officer, Allieviating Poverty through Peer Training, ILO, Cambodia
Khieu Kola	National Project Manager, Allieviating Poverty through Peer Training, ILO, Cambodia
Doekle Wielinga	Liaison Officer/Chief Technical Adviser, ILO, Cambodia
Young Vin	National Project Coordinator, Expansion of Employment Opportunities for Women, ILO, Cambodia
Chun Bora	National Project Coordinator, HIV/AIDS Workplace Education Programme, ILO, Cambodia
Ginnette Forgues	Local Strategies for Decent Work Senior Specialist, ILO Sub-Regional Office, Bangkok
Sophorn Tun	Project Coordinator, Informal Economy Project, ILO, Cambodia
Keo Suon	Director, Department for Rehabilitation, MoSAVY
Koul Panha	Executive Director, Committee for Free and Fair Elections in Cambodia, Cambodia
Charlie Dietmeier	Adviser, Deaf Development Programme, Cambodia
Vanna Nil	Social Development Specialist, World Bank, Cambodia
Ngin Saorath	Executive Director, Cambodian Disabled People's Organisation, Cambodia
Boun Mao	Executive Director, Association of the Blind in Cambodia, Cambodia
Vince Whitehead	Technical Adviser, Development Technology Workshop, Cambodia
Nhean Saroeun	Deputy Director, Special Education Office, Ministry of Education, Youth and Sport, Cambodia
Un Siren	Disability Officer, Special Education Office, Ministry of Education, Youth and Sport, Cambodia
Reaksa Dam	Special Needs Officer, Special Education Office, Ministry of Education, Youth and Sport, Cambodia

Edith van Wijngaarden Handicap International, Belgium

Jean Vanwetter Road Safety Project Coordinator, Handicap International, Belgium

Son Son Hak Project Coordinator Consultant, Centre for Development, Cambodia, and founder and former Executive Director of the Cambodian Disabled Person's Organisation

Yvonne Theboud Country Director, Handicap International, France

Liz Cross Medical Rehabilitation Project Coordinator, Disability Action Council; Country Coordinator, Christian Blind Mission, Cambodia

Kong Vichetra Education and Children with Disabilities Coordinator, Disability Action Council, Cambodia

## Annex 4: Semi-structured interview questions

Name	
Position and organisation	
Contact details	

### **A: Disability and your work**

- 1) Could you give me a brief summary of what your job involves?
- 2) How relevant is disability is to the overall goals and work of your organisation?
- 3) Are you aware of any policies or statements produced by your organisation on disability issues?
- 4) Do you consider disability to be a relevant issue in your work? If not, why not? If yes, why?
- 5) How have you sought to address disability issues? Please give examples.
- 6) Do you know of any specific initiatives, programmes or projects specifically targeting disabled people that your organisation is supporting?
- 7) What difficulties have you faced in trying to address disability issues?
- 8) What areas would you like more help with?

### **B: Disability and development in Cambodia**

- 9) What do you know about the situation of people with disabilities in Cambodia (for example, scale/prevalence of disability, causes of disability, socio-economic situation of people with disabilities and so on)?
- 10) Are you aware of any legislative or policy commitment on the part of the Government of Cambodia towards people with disabilities?
- 11) Outside of your own organisation, are you aware of any disability-specific programmes or activities being delivered in Cambodia (for example, government, international and local NGO activities)?
- 12) Are there any disability programmes or activities in Cambodia that you consider examples of best practice? What are they? Why have you chosen them?
- 13) What progress has been made in addressing the needs of people with disabilities in Cambodia?

- 14) What more needs to be done in addressing the needs of people with disabilities in Cambodia?
- 15) What is, or should be, the role of the government, multi and bi-lateral donors, international and local NGOs, and wider civil society in addressing the needs of people with disabilities in Cambodia?
- 16) What do you see as the main opportunities and constraints for taking forward work on disability issues in Cambodia?
- 17) What does 'mainstreaming disability' mean to you?

**C: Knowledge about disability**

- 18) What do you understand by the term 'disability'?
- 19) In Cambodia, what is the most useful way of looking at disability? For example, is it a medical issue, a poverty issue or a human rights issue?

**D: Conclusion**

- 20) Can you recommend anyone else I should contact?