



Federal Ministry
for Economic Cooperation
and Development



Every person counts

Promoting the inclusion of persons with disabilities
in the health sector in Cambodia

A publication in the German Health Practice Collection

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German Health Practice Collection

Showcasing health and social protection for development

■ Goal

The German Health Practice Collection (GHPC) aims to share good practices and lessons learned from health and social protection projects around the world. Since 2004, the Collection has helped assemble a vibrant community of practice among health experts, for whom the process of producing each publication is as important as the publication itself as it is set up to generate a number of learning opportunities: The community works together to define good practice, which is then critically discussed within the community and assessed by independent peer reviewers.

■ Scope

The Collection covers projects supported by German Development Cooperation (GDC) and its international and country-level partners around the world. GDC includes the Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing organisations: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and KfW Development Bank (KfW). The projects are drawn from a wide range of technical fields and geographical areas, at scales running from the local to the global. The common factor is that they make useful contributions to the current state of knowledge about health and social protection in development settings.

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■ **Front cover photo:** *Members of the Epic Encounters dance troupe during a performance of 'Our Family' in Kampot, Cambodia. Epic Encounters is part of Epic Arts, a non-governmental organisation which uses various art forms to bring together people with and without disabilities and to create dialogue about disability issues.*

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Acronyms and abbreviations

BMZ	Federal Ministry for Economic Cooperation and Development, Germany (Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung)
CRPD	Convention on the Rights of Persons with Disabilities
DPO	Disabled People's Organisation
ENT	Ear Nose Throat
GDC	German Development Cooperation
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
HEF	Health Equity Fund
HI	Handicap International
KfW	KfW-Entwicklungsbank (German financial cooperation)
UHC	Universal Health Coverage

Executive summary

Box 1. Key Messages

Situation. People with disabilities in Cambodia face multiple barriers when accessing health services. The public health system has limited capacity to prevent, detect and treat impairments that can be disabling.

Approach. German Development Cooperation has followed a ‘twin-track approach’ to promoting the inclusion of persons with disabilities. In addition to mainstreaming a focus on disability into on-going work on health financing, health system governance and health service delivery, the projects also supported interventions which built awareness of disability and the rights of persons with disabilities and strengthened the early detection of impairments among newborns and children in two provinces.

Results. There is greater understanding of need for inclusion of persons with disabilities in the health sector among partner institutions, local authorities and communities, and at the political level.

Lessons learned. In contexts where inclusion is not an established concept, it takes long-term commitment, partnerships with a range of stakeholders, and a flexible approach to testing and refining interventions in order to create and sustain the momentum and ownership for changes that result in a more inclusive health system.

This case study describes how technical cooperation projects funded by Germany’s Federal Ministry for Economic Cooperation and Development (BMZ) and implemented in cooperation with the Royal Government of Cambodia have systematically fostered the inclusion of persons with disabilities in the health sector in Cambodia.

Situation

According to the 2009 Cambodian Socio-Economic Survey, 6.3% of Cambodians live with a disability, although actual disability prevalence is likely to be higher. Many of the impairments associated with disability are preventable and are exacerbated by poverty and poor access to health services, clean water and sanitation.

Cambodia’s public health system is not well equipped to meet the needs of persons with disabilities, or to diagnose and treat impairments which could become disabling. Barriers encountered by persons with disabilities when accessing care include high direct and indirect costs, the physical inaccessibility of health facilities, communication barriers, and negative attitudes on the part of health care workers. There is no institutionalised screening for impairments among newborns, infants and children. Few specialised health services are available at the local level, coordination between service providers is inadequate, and there is not a functional referral system to support a continuum of care.

Approach

In line with the BMZ’s *Action Plan for the Inclusion of Persons with Disabilities*, the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) has systematically introduced a cross-cutting focus on the needs of persons with disabilities into two technical cooperation projects which are implemented on behalf of BMZ in cooperation with the Ministry of Health of Cambodia.

Together with provincial health departments and non-governmental organisations such as Handicap International and Epic Arts, the Social Health Protection project and the Rights-Based Family Planning and Maternal Health project designed and implemented a package of measures aimed at improving the accessibility and utilisation of health care services by persons with disabilities, making the health system itself more inclusive, and preventing impairments that can result in disability. The twin-track approach pursued by GIZ involves both ‘mainstreaming’ a focus on inclusion into the projects’ core work and providing specific support to persons with disabilities, their families and disabled people’s organisations (DPOs).

In Kampot and Kampong Thom provinces, the projects built awareness about disability and the rights of persons with disabilities through workshops, trainings and community events reaching more than 6,000 representatives of commune councils, Village Health Support Groups, health

officials and health workers, religious leaders, parents, and other community members. More than 5,000 people watched modern dance performances, created by a troupe of young deaf and disabled artists from Epic Arts, aimed at combating stigma and discrimination against persons with disabilities.

The projects supported measures aimed at improving the early detection of impairments and the prevention of disability among children. These included developing a set of screening tools, training health workers in their use, creating service directories, making screening available to more than 17,000 children, and supporting detected children to receive follow-up consultations.

DPOs participated in community forums and participatory planning processes aimed at making the health system more responsive to citizen needs. A voucher mechanism which reimburses the transportation costs incurred by persons with disabilities when travelling to local health centres has been developed and piloted; evidence about the high health expenditures incurred by persons with disabilities is also being brought into national-level policy discussions on the expansion of social health protection schemes.

Results

This case study, unlike those which have preceded it in the German Health Practice Collection, documents the early experiences of an important new approach, rather than the outcomes of an established development intervention.

Efforts to promote the inclusion of persons with disabilities in the health sector have yielded some preliminary results, although these are difficult to measure. There is now greater awareness of disability and of the need for inclusion of persons with disabilities among partner institutions, in communities where the projects work, and at a political level. The projects' investments in the development of tools and procedures for screening children for impairments have opened up the prospect that early detection could eventually become institutionalised in the health system. Work with commune councils and DPOs has led to DPOs' involvement in routine planning meetings, bringing the concerns of persons with disabilities into health-related governance processes.

Lessons Learned

Among the key learnings to date:

- **Introducing a focus on inclusion into a complex development intervention requires strong leadership, commitment across the project team, and an investment of both time and resources.** This case from Cambodia provides a positive example of how a systematic approach to promoting inclusion can be pursued, from collecting evidence on the challenge and identifying entry points within project frameworks, to consulting with partners, identifying appropriate collaborators, and integrating new approaches into project cycles.
- **Inclusion lends itself to sectoral mainstreaming approaches, but broader partnerships are required to tackle structural obstacles.** Structural challenges within the health system go beyond what can be addressed by projects through a mainstreaming approach, while social and economic factors with roots outside the health sector also constrain persons with disabilities from using health services. Cooperation beyond the health sector, in areas such as education and employment, might unlock new opportunities.
- **The early and active involvement of DPOs in designing, planning and implementing inclusion measures can encourage more persons with disabilities, and their families, to claim their rights.** DPO participation significantly changes the perception of disability in society and promotes understanding about the diversity of individual capacities.
- **A long-term commitment and a focus on building alliances are important to help create political ownership for inclusion.** It is possible to catalyse momentum around inclusion of persons with disabilities by leveraging existing relationships with government partners and by joining forces with key players, including local disability organisations. However for positive changes in the lives of persons with disabilities to be sustained, political ownership is essential.

Realising the right to health for persons with disabilities in Cambodia

'I just wish we knew what was wrong with him,' said Chreb Chhom, glancing at the young boy with soft brown eyes who was nestled in the arms of her sister, Sokny Chhom. 'Sometimes he doesn't seem to hear us when we call to him.'

Chreb Chhom sat on a woven mat spread out on a low wooden platform in front of her house, a traditional Khmer dwelling built on stilts to protect against annual floods. She lives here at the end of a rutted dirt path in the village of Chak Chrum, about an hour's drive from Kampot, with her sister, her elderly mother, the young boy – Bona Touch – who is her grand-nephew, and his cousin. Bona's parents live and work near Phnom Penh, and Chreb Chhom is his main caregiver.

The family understands little about Bona's developmental delays. They know that he was underweight at birth and remains small for his age. Although he is two years old, he cannot walk and does not bear weight on his legs. Bona has been seen by doctors at a hospital in Phnom Penh, but Chreb Chhom doesn't know what tests have been performed or how the medicine she has been instructed to give him may help him. Thus far the family sees little change in his condition. As Bona has grown bigger and heavier, they have begun to wonder whether they should look into getting him a wheelchair.

Bona is not the only member of the household living with disability. Chreb Chhom, who is now 44, lost her right arm just below the elbow during the war when a bomb exploded close to her. She does not have a job and is not able to work in the rice fields to contribute to food production for the household. 'I stay at home and take care of the children,' she explains.

Chreb Chhom also cares for her mother, Li Paur, who is 81 and in poor health. More than a third of Cambodians over 60 years of age have one or more impairments that affect their everyday functioning. Li Paur, who has difficulty moving unaided and requires assistance to eat and bathe, is the third member of the household with a disability.



■ Chreb Chhom (far right), with members of her family, outside their home in the Angkor Chey district of Kampot Province.

Multiple barriers to health services for persons with disabilities

Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) states that persons with disabilities are entitled to the highest attainable standard of health without discrimination on the basis of disability. This includes access to both general health services – such as treatment for illnesses and injuries, immunisation against diseases, and sexual and reproductive health services – and to additional services which may be required as a result of their specific impairments. Both types of services should be available as close as possible to where they live, should be of the same quality as those received by persons without disabilities, and should be delivered by health professionals with respect for their human rights, dignity, autonomy and individual needs.

The Kingdom of Cambodia has been a signatory to the Convention since October 2007 and ratified it in December 2012. However, a look at the barriers facing Chreb Chhom, Li Paur and Bona Touch in accessing quality, affordable, non-discriminatory health care reveals how far Cambodia – like many other countries – still has to travel until the rights enshrined in the Convention are realised in practice in the country's health system.

■ The direct and indirect costs of seeking health care

For Chreb Chhom and her family, the most immediate barriers are financial and logistical. The closest public health centre is five kilometres away, reachable via a series of unpaved roads. A larger health centre, which has a better selection of medicines and services, is located about 10 kilometres away, near the district hospital. To visit either of these facilities, the family has to organise transportation. Hiring a motorbike and driver to take them to the nearby health centre and back costs USD 2.50; a trip by auto rickshaw to the more distant one costs USD 12.50. This represents a significant cost for the family, whose monthly income, including remittances from the parents of the two boys, is approximately USD 50.

Li Paur cannot travel alone, so Chreb Chhom accompanies her if she needs to visit the health centre. While she is away, her sister or another adult cares for the children, taking them away from their normal income-generating activities. This represents an additional, indirect cost to seeking health care.

■ No access to specialised services

While basic health services are available relatively close by, the same is not true of specialised health services, such as those needed to diagnose Bona Touch's underlying health condition and to support his physical, social and intellectual development. The public health system in Cambodia concentrates primarily on maternal and child health and on treating acute illness; even at provincial referral hospitals, such as the one in nearby Kampot, disciplines such as neurology, orthopedics, speech-language pathology or developmental-behavioural paediatrics are not available. With almost no specialised services close by, the family has taken it upon themselves to make the 150-kilometre trip to Phnom Penh to consult with doctors there. Between visits, they monitor Bona's condition and hope for signs of progress. Physical and occupational therapy services, which can be instrumental in furthering the capabilities of children with developmental delays, are not available in their area.

■ Discriminatory attitudes

Beyond the barriers of cost and accessibility lurks another set of challenges for the family. Persons with disabilities in Cambodia experience widespread discrimination in their daily lives, including in the health sector. Chreb Chhom has not always felt welcome at her local health centre. She recalls one occasion when she and her mother were left to wait for a long time before being attended to, although the



■ *Residents of rural areas must often travel long distances to public health facilities. The lack of physically accessible and affordable transportation can be a barrier to access for some persons with disabilities.*

facility wasn't busy. Another time, she was forced to pay for a consultation, despite the sign hanging next to the registration desk indicating that persons with disabilities should be treated without charge.

'The nurses claimed that they didn't notice my impairment,' she said incredulously, gesturing at her arm. 'They said it was my responsibility to point it out to them.' She fell silent for a moment. 'I wish that people at the health centres would treat those of us with disabilities with respect.'

The long road to a more inclusive health system in Cambodia

In a country which struggles to provide basic health services to its citizens, making the health sector more accessible and responsive to the specific needs of persons with disabilities is a formidable task.

The Social Health Protection project, which is implemented by GIZ on behalf of Germany's Federal Ministry for Economic Cooperation and Development (BMZ), has taken up this challenge as part of its core work. Since 2009 it has gradually introduced a cross-cutting focus on the needs of persons with disabilities and older persons in the design and implementation of its activities in the areas of health financing, health system governance and health service delivery in order to address the types of challenges faced by Chreb Chhom and her relatives. Through its strategic advice to the Ministry

of Health, its implementation of social protection schemes and its efforts to strengthen decentralised health systems in Kampong Thom and Kampot provinces, the project has been experimenting with ways to improve the accessibility and utilisation of health care services by persons with disabilities, to make the health system itself more inclusive, and to prevent impairments that can result in disability.¹ Since 2012, it has been joined in these efforts by the Rights-Based Family Planning and Maternal Health project, also implemented by GIZ, which focuses on improving emergency maternal and child health and Rights-Based Family Planning services in four provinces.

Although they predate its adoption, these initiatives are currently implemented in the context of the BMZ's *Action Plan for the Inclusion of Persons with Disabilities* (2013-2015), whose goal is to ensure that inclusion of persons with disabilities is systematically fostered throughout German development cooperation. The plan is aligned with Germany's *National Action Plan to Implement the UN Convention on the Rights of Persons with Disabilities*, which was adopted in 2011.

■ **Chronicling difficult choices and dilemmas**

This publication describes how, over the past five years, the Social Health Protection and Rights-Based Family Planning and Maternal Health projects, with support from the GIZ-implemented Sector Initiative on Inclusion of Persons with Disabilities,² have approached the task of 'mainstreaming inclusion.' It is, in essence, a story about learning by doing and about the continuous assessments and readjustments that have been required in the course of implementing a commitment to inclusion of persons with disabilities in a specific bilateral development cooperation context.

The process has proven to be more complex than perhaps anyone imagined: against a backdrop of extreme need and little existing activity on disability in the health sector, the project has attempted to work with its counterparts in government, as well as with civil society organisations, to identify and implement practical measures to make the health system more inclusive. While some of these pilot efforts show promise, others have run into unanticipated challenges or have proven hard to sustain. Difficult choices and dilemmas confronted project personnel at all stages. Is it appropriate to screen for and diagnose impairments in a context where follow-up services are not readily available? How can disabled people's organisations be encouraged to advocate on health issues when the main issue concerning their members is not health, but livelihoods? In a context where many people prefer private over public health services, how can persons with disabilities be encouraged to visit local health centres for their health needs?

The decision to document this journey in some detail represents a departure from the German Health Practice Collection's historical focus on 'good and promising practices,' as measured by effectiveness and results, and a move towards more critical engagement with the questions of 'what works' in development cooperation – and how. As the German-supported projects in which an inclusive approach to development cooperation has been pursued most systematically, and for the longest period of time, the Social Health Protection and Rights-Based Family Planning and Maternal Health projects are pertinent examples for others within German Development Cooperation to learn from. They are also relevant for broader audiences, as enhancing the inclusion of persons with disabilities in development goals and measures is a topic of increasing significance in current international discussions about the post-2015 agenda. The implementation of the Sustainable Development Goals will require state and non-state actors to rethink models of cooperation and to take all members of society – including persons with disabilities – into account.

¹ The latter refers to the primary prevention of impairments as well as efforts to prevent the worsening of existing impairments and/or the development of additional impairments.

² Commissioned by BMZ, the Sector Initiative works to strengthen the inclusion of persons with disabilities in German Development Cooperation strategies, processes and programmes.

Disability in Cambodia

A human rights issue and a development challenge

According to the *World Report on Disability*, 15.6% of persons aged 15 and over (785 million people, based on 2010 population estimates) live with some form of disability, and 2.2% (110 million people) experience significant difficulties in functioning. Including children, more than one billion people are believed to live with disability (WHO, 2011).

Persons with disabilities are far from a homogeneous group. The impairments associated with disability are many and varied, and disability itself takes diverse forms: it can be visible or invisible, acquired or congenital, reversible or life-long (WHO, 2011). Disability is frequently equated with restricted mobility, but impairments affecting vision, hearing, speech, intellectual capacities and mental health can also be disabling if the environment is not fully accessible and the needs of persons with disabilities are not taken into account. As societies age, and non-communicable diseases, such as cancer and diabetes, become more widespread, an ever growing number of people will experience disability at some point during their lives.

Despite its prevalence, disability continues to be invisible in many settings around the world. Persons with disabilities often do not enjoy equal access to schools and higher education institutions, employment opportunities, or health and welfare systems. Their voices are not always heard in political processes and local decision-making. Many persons with disabilities are subject to stigma and discrimination in their own communities – and sometimes from their own family members. In the absence of strong self-representing organisations, the rights of persons with disabilities to full and equal participation in society can go unacknowledged and unfulfilled. Children with disabilities are particularly vulnerable to violations of their rights and often do not enjoy the legal protections to which they are entitled (UNICEF, 2013).

Disability is not only a human rights issue, however; it is also a development challenge. As a result of exclusion from the labour market and higher costs of living, persons with disabilities are more likely to be poor than those without. At the same time, people living in poverty are more likely than



■ Physical barriers can prevent people with certain impairments from full participation in their communities.

others to develop health conditions associated with disability and to become disabled as a result of those conditions. Globally, disability prevalence is higher in developing countries than in developed ones and higher, in all countries, among vulnerable population groups, such as women and older people (WHO, 2011).

■ From separation to inclusion

Perspectives on disability have been changing over the past four decades, thanks in large part to the international disability rights movement. If, in the past, disability tended to be viewed narrowly as a medical problem, current understandings of disability emphasise the physical, social and structural barriers which prevent people with certain impairments from playing a full and equal role in society (WHO, 2011).

The shift from a medical to a social model of disability has been accompanied by a new orientation on inclusion. Rather than supporting persons with disabilities through special institutions separate from the mainstream of society, current policies stress the need to remove the barriers which prevent the full participation of persons with disabilities in their communities. These ideas are reflected in the Convention on the Rights of Persons with Disabilities, which aims to promote and ensure the full and equal enjoyment of human rights and fundamental freedoms by persons with disabilities, and to promote respect for their inherent dignity. By early 2015, more than 150 countries had ratified the Convention.

What do we know about disability in Cambodia?

■ A higher prevalence of disability than statistics suggest

As is the case in many developing countries, there are few reliable sources of information about the prevalence of disability in Cambodia. Recent estimates among the general population range from 1.4 to 6.3%,³ but the actual prevalence is almost certainly higher. This is in part because the main sources of data, such as censuses and household surveys, rely on self-reported information which can lead to underreporting when compared to measured aspects of disability.⁴ Because disability is interpreted in relation to what is considered 'normal' functioning in a given context, some people who experience difficulties in functioning may simply consider this a natural part of getting older and not think of themselves as living with disability. Poorly phrased or insensitive questions, and concern about disability-related stigma, can also influence respondents' answers and lead to underreporting (WHO, 2011).

The most robust data about disability in Cambodia derive from a measured study of disability among children aged two to nine, conducted in 2011–2012 by a team of researchers in cooperation with the Ministry of Education, Youth and Sports (Evans et al., 2014). The two-phase study (referred to hereafter as the 'Evans study'), in which more than 19,000 children were screened and nearly 4,000 underwent detailed clinical assessments, found that 15.6% of children have impairments and 10.1% are living with a disability.⁵

Given that disability prevalence tends to rise with age, the results of the Evans study indicate that the country's actual disability prevalence may be much closer to the World Health Organization's global disability estimates than other data sources suggest. Applying these global rates to the current Cambodian population, there are probably at least two million Cambodians living with a disability and more than 320,000 who experience severe difficulties in functioning (Disability Rights Initiative Cambodia, n.d.).

Box 2. Cambodia at a glance

Since the conclusion of the Paris Peace Accords in 1991, which marked a negotiated end to years of genocide, civil conflict and foreign occupation, Cambodia has experienced marked improvements in its social and economic situation.

- Cambodia's score on the Human Development Index rose from 0.251 in 1980 to 0.584 in 2013, an increase of 132.7% (UNDP, 2014). Cambodia is ranked 136 out of 187 countries, placing it towards the bottom of countries with a 'medium' level of human development.
- Although Cambodia remains a low-income country, it has enjoyed strong economic growth in recent years. The per capita Gross Domestic Product quadrupled in the two decades between 1993 and 2013 (World Bank, 2013).
- Strong economic performance and rising per capital consumption has led to reductions in the proportion of the population living in poverty – from 53.2% in 2004 to 20.5% in 2011. However many Cambodians who have moved above the poverty line in recent years remain extremely vulnerable to falling back into poverty (World Bank, 2013).
- Cambodia has a particularly low urbanisation rate: only 20% of the population of approximately 14 million lives in urban areas, compared to 34% across South East Asia as a whole (WHO, 2014).

³ According to the 2008 General Population Census and the 2009 Cambodia Socio-Economic Survey, respectively.

⁴ The WHO's International Classification of Functioning, Disability and Health is the framework which is widely used for understanding and measuring disability.

⁵ The study defined 'impairment' as an abnormality or limitation in structure, but one which was temporary, easily treatable or reversible, or which did not affect the child's functioning compared to other children of similar age. 'Disability' was defined as an impairment which permanently affected the child's ability to function at the same level as his or her peers (Evans et al., 2014, p. 9).



■ *Failure to diagnose and treat minor ailments, such as ear infections, can result in permanent hearing loss.*

■ Patterns of disability

According to the 2013 Cambodia Socio-Economic Survey, the most commonly-reported disabilities in the country are vision-related (36% of persons reporting one or more difficulties), followed by difficulties with movement (30%) and hearing (15%).⁶ Difficulties in speech, feeling, learning and mental health are less commonly reported and are likely to be significantly underestimated (Cordier, 2014; McLaughlin & Wicker, 2012).

As in many countries, disability in Cambodia is more common among older than younger persons: 36% of Cambodians over the age of 60 report one or more difficulties, compared to 5% among those aged 30-44 (National Institute of Statistics, 2010). The incidence of disability is likely to rise as the country's currently young population ages. By 2050, persons 60 and above will account for more than one-fifth of the population, compared to less than one-tenth today (United Nations, 2013).

Most disabilities in Cambodia are preventable (Thomas, 2005). Poverty, poor access to health services, clean water and sanitation, and limited awareness of the links between health and disability all contribute to the high prevalence of avoidable impairments. Poor antenatal care and inadequate obstetric services during complicated deliveries put children

at risk of being born with impairments. The Evans study (2014), for example, found that a history of difficult delivery was a significant predictor of disability among children. The conditions in which children grow up are also important. Major injuries are another risk factor for disability (Evans et al.) and poor childhood nutrition can lead to stunting, developmental delays and intellectual disabilities. The failure to treat acute childhood illnesses, such as fever and respiratory infections, and to diagnose basic health problems, such as eye and ear infections, can lead to permanent disability later in life.

Beliefs and perceptions of disability

■ Disability causation

Cambodia is a predominantly Buddhist country and much has been made of the influence of the karmic belief system on understandings of disability among Khmers.⁷ Karma posits that one's present-day wellbeing, including physical health and bodily status, is a reflection of actions committed during previous lives. Through this lens, disability can be understood as payment for sins, bad character or unwholesome thoughts from a previous life (Gartrell, 2010).

The Khmer world view has also been shaped over the course of centuries by animist beliefs. Spirits and ancestors are the 'moral guardians' of Khmer society and can inflict sickness on humans in response to moral or social transgressions. Physical or mental illness is therefore widely understood to be caused by disruptions of one sort or another to the social, natural, or cosmological order (Oveson & Trankell, 2010).

This indigenous health cosmology, rather than biomedical understandings of health and disease, continues to hold sway for many Cambodians. In a baseline study of disability awareness supported by the Social Health Protection project in 2013, more than 40% of community members surveyed in Kampong Thom (n=50) and 20% in Kampot (n=50) agreed that disability 'can be' or 'may be' caused by spirits or bad karma. Views among health care workers (n=20 in each province) were similar to those of the general public (Handicap International, 2013).

⁶ Estimates, based on analysis of 2013 Cambodia Socio-Economic Survey data conducted by Social Health Protection project.

⁷ The Khmer are the predominant ethnic group in Cambodia.

■ The social construction of disability

Cambodian society is strongly hierarchical, with age followed by gender as the key determinants of social status. Disability overrides other attributes of the social hierarchy, however, and persons with disabilities enjoy lower social status than their peers at all levels of society (Gartrell, 2010). Charity and a culture of giving are integral aspects of Khmer life: the wealthy and those in high positions are obliged to help those beneath them by providing gifts or money. By acting on feelings of pity and compassion, they fulfil their responsibilities and accrue more karmic merit. Those who are lower on the social hierarchy are expected to receive this help (Carter, 2009). The belief in karma helps to 'naturalise disability with poverty and suffering' and to structure social expectations for persons with disabilities (Gartrell, 2010)

Perceptions of disability are also influenced by the central position of the family unit in Khmer culture. Great significance is attached to an individual's ability to contribute to family livelihood and wellbeing, and not being able to do so, regardless of the cause, 'upsets the accepted order and causes friction with the family and society' (Carter, 2009). In the subsistence economies that characterise rural communities in Cambodia, the core challenge for every household is to produce enough food. Mild and moderate impairments can limit people's ability both to work in the fields and to sell their labour (Thomas, 2005). Persons with disabilities who do not contribute to food production are seen as a drain on household resources and a burden for their families. Individuals or households which are unable to uphold norms of reciprocity, including various forms of mutual assistance, can be excluded from important social networks at community level. The same is true of those whose behaviour is seen to disrupt social harmony (Gartrell, 2010).

■ Social exclusion among persons with disabilities

Given the attitudes and beliefs described above, it is not surprising that many persons with disabilities in Cambodia experience stigma, discrimination, and social exclusion as a result of their impairments. Both children and adults living with disabilities report being teased and called names (Cooperation Committee for Cambodia, 2006; Thomas, 2005). Anecdotal evidence suggests that children with severe disabilities are sometimes hidden away from the community and kept in dire conditions (Thomas, 2005). Many parents of children with disabilities do not believe their children can be educated and do not consider enrolling them in school (Gartrell, 2010; Cooperation Committee for Cambodia, 2006).

Persons with disabilities number among Cambodia's poorest citizens and have fewer possibilities than others to improve their socio-economic situations. Only 58% of persons with disabilities in Cambodia are literate, compared to 80% of the general population (National Institute of Statistics, 2013). The economic activity rate among persons with disabilities is lower than that among the general population (69 versus 82%); only 61% of women with disabilities are economically active (National Institute of Statistics, 2013), making them particularly dependent upon their families and relatives.

The natural and built environment represents a major barrier to participation for many persons with disabilities. Many public buildings, including relatively new ones, are not barrier free, and typical Khmer houses are built on stilts. In rural areas, the location of one's house and the type of road and path (i.e. dirt or tarred) which connect it to the rest of the village are key factors influencing engagement with the broader community (Gartrell, 2010).

Persons with disabilities are sometimes excluded from community institutions and political processes. Reportedly, they are generally not welcome to join microcredit schemes, because they are seen as unlikely to repay loans; are often not invited to attend community meetings and events, including weddings and festivals; and are infrequently visited by monks and lay persons from the pagodas, neighbours and even family members (Thomas, 2005).

As in other countries (WHO, 2011), Cambodian women living with disabilities experience a 'double exclusion' on the basis of their gender and their impairment. They are less likely to marry than women without disabilities (Cooperation Committee for Cambodia, 2006) and are subject to much higher levels of sexual, physical and emotional violence within the family (Astbury & Walji, 2013).

The marginalised position of persons with disabilities in Cambodian society at large is also mirrored in the health system, where the overarching focus on maternal and child health and acute care leaves a multitude of gaps for persons with special health needs. The next chapter will discuss these in more detail.

Action to uphold the rights of persons with disabilities

The National Disability Strategic Plan, adopted in 2013, outlines the steps which the Kingdom of Cambodia intends to take to uphold its obligations under the CRPD and to improve the situation of persons with disabilities in the country. On paper, the strategy is promising. In practice, however, there are significant challenges to the government's ability to implement its provisions. The institutional framework for addressing the rights of persons with disabilities is complex: multiple government bodies, committees and working groups are involved, with overlapping responsibilities, varying levels of knowledge and experience with disability, and poor functional cooperation (Disability Rights Initiative Cambodia, n.d.). The Ministry of Social Affairs, Veterans and Youth Rehabilitation is formally responsible for the development of policies and laws related to disability and rehabilitation, but has extremely limited resources, while the Disability Action Council, an inter-ministerial body tasked with coordinating the implementation of the National Disability Strategic Plan, has only advisory power. This has posed challenges in terms of setting priorities, clarifying roles among various actors, and facilitating practical inter-ministerial cooperation.

Aware of the distance that must be travelled to realise the rights of persons with disabilities in the country, the Cambodian authorities have welcomed contributions from development partners. It is in this context that the Federal Republic of Germany and the Royal Government of Cambodia agreed to introduce gradually a focus on vulnerable groups, including persons with disabilities, into development cooperation measures in the field of health, and later into other sectors. The next chapter describes the genesis of this agreement and how the Social Health Protection project set out to operationalise an approach to inclusion in its activities.



■ The natural and built environments in Cambodia present many barriers to the full participation of persons with mobility impairments. A typical Khmer house, in the Angkor Chey District of Kampot Province.

How can German support to the Cambodian health sector promote inclusion?

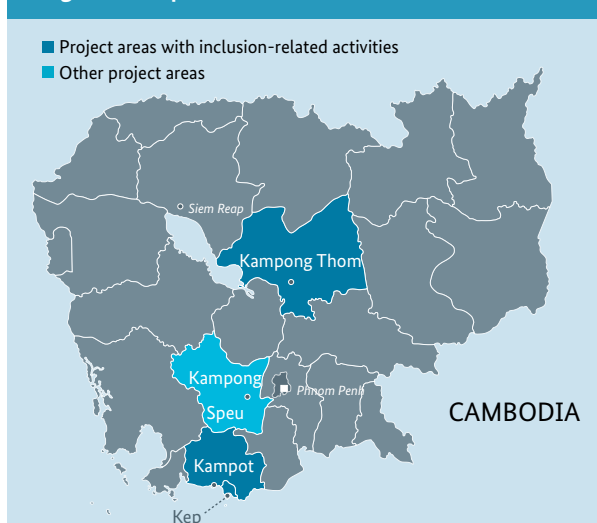
The German contribution

Few doctors and trained medical personnel survived the murderous rule of the Khmer Rouge (1975-1979), and during this period and the years of civil conflict which preceded and followed it the country's health infrastructure was largely destroyed. Over the past two decades, with extensive international support, Cambodia has made great strides in rebuilding its public health system and delivering basic health care services to the population. Key health outcomes, such as the maternal mortality and under-five mortality rates, have improved markedly, although significant gaps exist between poorer and more affluent Cambodians (World Bank, 2013).

Germany's Ministry for Economic Cooperation and Development has been supporting the Cambodian health sector for more than 20 years. It currently provides the Royal Government of Cambodia with financial and technical support for the implementation of the Second Health Strategic Plan (2008-2015), which is the roadmap for strengthening the country's health system. This support is aimed at improving the access of poor and vulnerable Cambodians to effective and affordable quality health care and at increasing the utilisation of such services. German development cooperation in the health sector currently comprises two technical and one financial assistance project, which are implemented in a complementary way as part of the Cambodian-German Social Health Protection Programme:

- The GIZ-implemented **Social Health Protection** project concentrates, in its current phase, on three of the five elements of the government's Health Strategic Plan: health financing, health system governance and health service delivery. Advisors with the project provide strategic advice to the Ministry of Health, help to design and implement social protection schemes, and work to strengthen the health system with provincial government partners in Kampong Thom, Kampong Speu and, since September 2015, Kep provinces (see Figure 1).
- The **Rights-Based Family Planning and Maternal Health** project, implemented by GIZ since 2012, aims to improve maternal and child health care and family planning services in Kampong Speu, Kampong Thom, Kampong Speu and Kep provinces. This most recent project is part of Germany's expanded commitment to improving reproductive health and family planning worldwide following the launch of the Muskoka Initiative on Maternal, Newborn and Child Health at the 2010 G8 summit in Canada.
- The KfW Entwicklungsbank administers Germany's **financial cooperation** in the health sector on behalf of BMZ. Since 2009 KfW has supported the Ministry of Health with financial contributions for mother and child health, family planning, and reproductive health care. In 2011, it launched a **voucher programme** which provides beneficiaries, including women of reproductive age and vulnerable populations, with free access to specific health services, such as long-term family planning, safe motherhood services, safe abortion, child growth monitoring and nutrition, cervical cancer screening, and treatment for cataracts.

Figure 1. Map of Cambodia



A growing policy focus on persons with disabilities

The idea of focusing explicit attention upon the needs of persons with disabilities in the health sector was first broached during German-Cambodian government negotiations in late 2009. At that time, disability issues were rising on the agenda in both countries: Germany had ratified the CRPD in February of that year while Cambodia had, in July, adopted the Law on the Promotion and Protection of the Rights of Persons with Disabilities, the country's first-ever legislation on disability.

Staff at the GIZ-implemented Sector Initiative on Inclusion of Persons with Disabilities were instrumental in getting disability onto the agenda. The Sector Initiative, based at the GIZ head offices in Eschborn and Bonn, advises the BMZ

This geographical map is for informational purposes only and does not constitute recognition of international boundaries or regions; GIZ makes no claims concerning the validity, accuracy or completeness of the maps nor assumes any liability resulting from the use of the information therein.

on policy issues related to disability and works closely with GIZ-implemented country programmes to support inclusion of persons with disabilities in development cooperation measures. In specific cases, with the explicit agreement of BMZ, it may also provide financial contributions to support inclusion measures at country level. Aware of BMZ's growing interest in addressing disability issues, the Sector Initiative recognised in Cambodia a promising opportunity to work towards greater inclusion in the health sector and facilitated an exchange of ideas about how inclusion could be fostered through German-supported activities.

When representatives of the German government proposed to introduce a focus on vulnerable groups – defined as persons with disabilities and older persons – into development cooperation in the health sector, their Cambodian counterparts readily agreed. Persons with disabilities and older persons were already included as target populations in health sector strategies, and efforts to identify and address their particular health needs were welcome.

The focus on persons with disabilities in the health sector was an early chapter in what would eventually become a much larger-scale commitment by BMZ to bring disability into the mainstream of German development cooperation. At the 2011 government negotiations, the Cambodian and German delegations agreed to extend the focus on inclusion

beyond the health sector to all current and future cooperation activities in the country. With this decision, Cambodia became one of the first countries where Germany fostered an inclusive design across its development cooperation activities. This was followed in 2013 by the launch of the BMZ's *Action Plan for the Inclusion of Persons with Disabilities* (see Box 3).

Identifying key issues and gaps

Once a commitment was made at a policy level to introduce a focus on persons with disabilities, it fell to project staff to operationalise this in practice. But where to start? Reflecting back on the early years, Bernd Schramm, the head of the Social Health Protection project, put it plainly: 'This was totally new to us. We didn't have expertise on disability within the project.'

The team set itself the goal of mainstreaming a focus on persons with disabilities systematically across all three project areas and identifying a range of suitable activities. It began by consulting available literature and commissioning an exploratory study (Platt, 2010) which assessed the availability, quality and accessibility of health services for persons with disabilities. Commissioned by BMZ, the Sector Initiative on Inclusion of Persons with Disabilities funded the study, which was carried out by HelpAge International and a team of Cambodian

Box 3. BMZ's Action Plan for the Inclusion of Persons with Disabilities

The BMZ's *Action Plan for the Inclusion of Persons with Disabilities* (BMZ, 2013) describes the steps to be taken to move gradually towards systematic inclusion of persons with disabilities in German development policy. The plan is based on **three main strategies**:

- Setting a good example internally (i.e. being an attractive, inclusive and barrier-free organisation);
- Fostering the inclusion of persons with disabilities in partner countries; and
- Cooperating with other actors in bilateral and multilateral engagements.

One of the fundamental principles of the *Action Plan* is the **twin-track approach**, which specifies that German development policy will, in parallel:

- Provide specific support to people with disabilities, their families, and disabled people's organisations; and
- Mainstream inclusion of persons with disabilities across the board in all development measures.

The *Action Plan* also acknowledges the **complementarity of inclusion and prevention**. Through its continued engagement in areas such as nutrition, preventive and rehabilitative health care, improved occupational health and safety, and improved environmental protection, German Development Cooperation helps to reduce the risks that may result in or worsen impairments.

researchers. More than 70 people took part in focus group discussions in Kampong Thom and Kampot provinces, and 38 key informant interviews were conducted with health care workers and officials at the provincial and national levels.

The main conclusions from this preliminary research included the following:

Persons with disabilities face barriers to accessing care at public health facilities. Not all health facilities are physically accessible for persons with restricted mobility; moreover, communication barriers can make it difficult for persons who are deaf, have speech impairments or experience hearing loss to interact with health personnel. Distances to public health facilities also pose a barrier to accessing care for some persons with disabilities. Many persons with disabilities need the physical and/or financial support of family members and caregivers to reach health facilities and to access services.

When they do access health care, persons with disabilities often have negative experiences. Long waiting times, and rude and disparaging treatment from health care workers, are common at public health facilities. Poor treatment was interpreted primarily as a reflection of persons with disabilities' low social status and inability to pay for consultations, rather than as discrimination against them on the basis of their impairments.

Services available through the public health system are perceived to be of inadequate quality. The health needs of persons with disabilities are not met under standard packages of care available at public health centres and hospitals. Persons with disabilities report dissatisfaction with diagnostic capacities, treatment options, and supplies of medicines available through public facilities. For persons with impairments who require rehabilitation services,⁸ the record-keeping systems, referral networks and cooperation between public and private sector health and rehabilitation providers, which would be needed to ensure a continuum of care, do not exist.

Health centres, district hospitals and even provincial hospitals have limited capacity to detect and diagnose impairments which are not yet disabling. There is no institutionalised screening of newborns, infants or children in Cambodia, and limited knowledge, among both health workers and the general public, that certain illnesses or developmental delays can lead to permanent disability. The absence of primary eye and ear care represents a major gap in basic health services.

Persons with disabilities are often deterred from seeking services because of direct and indirect costs. While financing schemes are available to help poor people access public health services in Cambodia (see p. 20), none specifically target persons with disabilities. Persons with disabilities express uncertainty about the costs incurred when seeking care at public facilities; they report that, even when exemptions are granted, the practice of health workers asking for under-the-table payments continues. Sometimes patients are forced to buy their own medicines from pharmacies when health centres run out of supplies. There are also significant indirect costs to accessing health care, including transportation, food and occasionally overnight accommodation.

Like most Cambodians, persons with disabilities prefer to seek care from private providers. Except in acute situations, persons with disabilities prefer to use private health services (village doctors, pharmacies, private clinics) over public health facilities because they are located closer to where they live (therefore easier and cheaper to access), do not require long waits, will offer treatment on credit, provide more polite treatment, and are perceived as being of better quality (e.g. better equipment, stronger medications). Provincial hospitals are preferred for serious conditions and for treatments that are not available through private providers.

There are few entry points for persons with disabilities to influence the health system. They have few avenues to provide feedback on their experiences in the health system, to challenge poor treatment, or to complain about violations of their rights. While the policymakers interviewed saw this as a logical role for Disabled People's Organisations to play, persons with disabilities in the study made no mention of collective action via DPOs.

⁸ Provision of rehabilitation services is the responsibility of the Ministry of Social Affairs, Veterans and Youth Rehabilitation. A network of 11 physical rehabilitation centres (PRCs), established by international NGOs and later turned over to this ministry, has evolved into the 'backbone' of services for Cambodians with physical impairments (DRIC, n.d.).

Operationalising inclusion

The authors of the study identified a number of measures that the Social Health Protection project could take, within its existing mandate, to improve the access of persons with disabilities to health care. These were clustered in three main areas:

- Building **capacity, information and awareness** about the needs of persons with disabilities among both service providers and users;
- **Policy actions** to bring the health needs of persons with disabilities into the mainstream of development planning and efforts to strengthen social protection systems; and
- Improving **financial access** to health for persons with disabilities by, e.g., adapting health financing schemes to better target persons with disabilities.

The study's findings and preliminary recommendations were presented in Phnom Penh to a group of key stakeholders, including representatives of the Ministry of Health, in late 2010.

■ Consultations with partners and stakeholders

Armed with the findings from the scoping study, staff at the Social Health Protection project consulted broadly with actors in the disability sector, including other development partners, to narrow down a set of practical measures which were aligned to the country's Health Strategic Plan as well as the project's focus areas, would not duplicate activities being supported by others, and would, with modest resources, add value against a backdrop of enormous need.

What they found was that there was little risk of overlap: the space at the intersection of health and disability was largely unoccupied. Health was not a major concern within the disability sector, which was primarily concerned with meeting basic needs (e.g. livelihood schemes, vocational training); at the same time, little was being done to address the needs of persons with disabilities within the health sector itself. While the government was placing great emphasis on measures to reduce maternal and infant mortality (e.g. safe deliveries), much less attention was being paid to children's health, including the early detection of impairments and acute care services (e.g. ear and eye care) to prevent disability.

Because the disability sector in Cambodia had been driven forward largely by civil society organisations, it had evolved separately from other development efforts in the country which were carried out in close cooperation with government. Disability-related programmes were typically not integrated with local structures – a significant obstacle to the goal of inclusion of persons with disabilities. The goal for the Social Health Protection project was to bridge this gap: to address disability within the health system, while drawing upon the expertise and insights of civil society organisations. Preliminary workshops with a wide range of stakeholders in Kampong Thom and Kampot revealed how challenging this would be: not only was access to health for persons with disabilities barely recognised as a topic, but there was little history of systematic cooperation between government and civil society in Cambodia.

Heike Krumbiegel, a former technical advisor with GIZ who introduced the twin-track approach to promoting inclusion between 2012 and 2014, recalls some of these early discussions. 'When we asked the Provincial Health Departments for their ideas about what we could do, the answer at first was that persons with disabilities don't have any problems in the health sector.' Surprisingly, this was the view of the Disabled People's Organisations and persons with disabilities who were part of the planning phase as well. 'We found that we really had to sensitise participants about the rights of persons with disabilities. Persons with disabilities didn't know and didn't ask for their rights,' Krumbiegel said.

■ Towards a twin-track approach

Starting in 2011, measures to foster inclusion of persons with disabilities were progressively integrated into the Social Health Protection project's three areas of focus. The technical advisors responsible for health financing, health service delivery and health system governance all ensured that the core activities in their areas reflected a disability perspective, while targeted activities aimed at empowering persons with disabilities were coordinated by an additional technical advisor with special expertise in mainstreaming and disability, who reported directly to the head of the project. This combination of mainstreaming and targeted interventions was in line with the 'twin-track approach' to inclusion which was later enshrined in the BMZ's Action Plan.

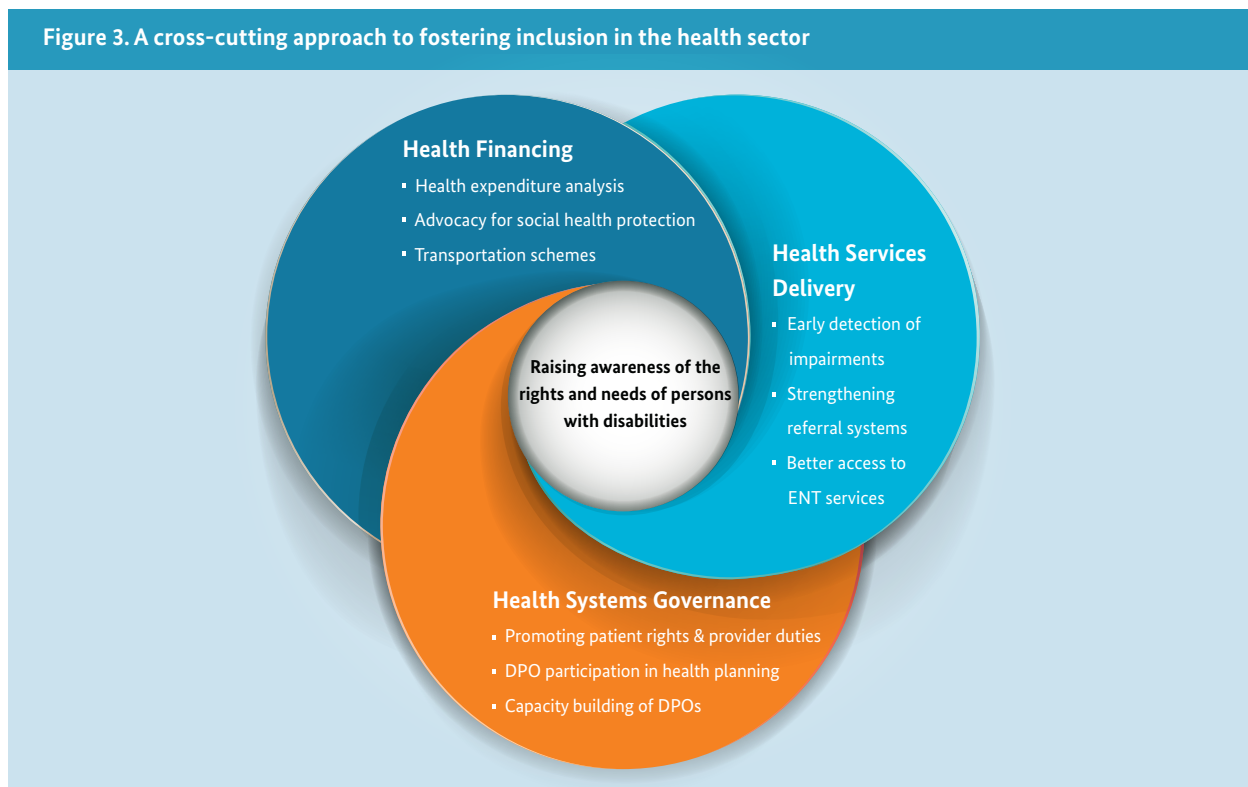
A multi-level approach, including both policy advice and practical interventions, was devised to foster inclusive development in the health sector. Rather than attempting to start at the national level, the Social Health Protection project decided to concentrate its efforts at the provincial level, where it enjoyed long-standing relationships with the Provincial Health Departments in Kampong Thom and Kampot. Here, the team foresaw a greater likelihood of practical results which could be scaled up further or used to open up policy discussions at the national level.

The supported measures (summarised in Figure 3, and described in detail in the following chapter) were designed to be mutually reinforcing, simultaneously addressing the health financing challenges faced by persons with disabilities, the need for better access to quality health services, and the limited awareness of disabilities and the rights of persons with disability within the health system. This ‘systems approach’ to fostering inclusion was intended to maximise synergies across different project areas and within the broader health system. Interventions were aimed at both service providers and users; local authorities and civil society organisations were also systematically engaged.

Where possible, measures in support of inclusion of persons with disabilities were integrated into existing workplans and undertaken by project personnel. However, in some cases, the planned measures required additional expertise, or were at a scale that went beyond what project staff could feasibly manage. In early 2013, the Social Health Protection and the Rights-Based Family Planning and Maternal Health projects entered into agreements with several partners on a package of interlinked interventions. The main collaboration was with the international NGO Handicap International (HI), which agreed to undertake a wide range of awareness-raising activities and capacity building measures with health care workers, local authorities and community members in Kampong Thom and Kampot provinces. Epic Arts, a Kampot-based inclusive arts NGO, was contracted to work alongside HI to raise awareness of disability in communities and to combat stigma and discrimination through innovative dances created and performed by persons with disabilities. At the same time, an Ear, Nose and Throat (ENT) specialist was hired to build the capacity to diagnose and treat hearing impairments at the provincial hospitals in Kampong Thom and Kampot.

The next chapter describes in detail the experience of implementing the twin-track approach.

Figure 3. A cross-cutting approach to fostering inclusion in the health sector



Implementing a twin-track approach

This chapter summarises what has been done in each of the project areas to foster inclusion of persons with disabilities, what has been achieved, and how staff addressed challenges which arose along the way.

Health financing: bringing evidence into the policy process

While the proportion of Cambodians living under the poverty line has declined sharply over the past decade, many of those who have escaped poverty have only barely done so and remain highly vulnerable to economic shocks. For Cambodia’s poor and ‘near poor,’ the direct and indirect costs of accessing health services are both a barrier to care and a major source of impoverishment. According to WHO (2014), private expenditure accounted for more than three-quarters of total health expenditure in Cambodia in 2011; of this, 80% was comprised of direct out-of-pocket payments by users.

There is strong political commitment on the part of the Royal Government of Cambodia to improve equity in access to good-quality health care and to extend social health protection to the poor and vulnerable. The country has endorsed the movement to Universal Health Coverage (UHC) and has drafted a comprehensive health financing policy to guide it on this long and complex journey (Jacobs et al., 2014). As in many developing countries, the Cambodian government plans to begin by supporting a number of parallel social health protection initiatives targeted at different segments of the population, i.e. salaried private sector employees, civil servants and veterans, and the poor. The intention is that these will at a later stage be harmonised into a single, overarching social health protection scheme.

Germany is one of the government’s main partners in the strategic development of social health protection and advocates for the extension of existing social health protection schemes for the poor to vulnerable groups, through mechanisms such as self-targeting and vouchers for priority services.

The position of vulnerable groups during the transition to Universal Health Coverage

The vision of UHC implies that all Cambodians, including those with special health needs, will be able to access the services they need without risk of financial ruin. However, at present the health needs of the majority of the population, including persons with disabilities, are not being adequately met and the question arises as to what can and should be done during the progressive transition to UHC to enable more equitable access to health care for the country’s most disadvantaged groups.

According to a 2004 government ‘prakas’ (ministerial decision), persons with disabilities are entitled to health services free of charge, i.e. are exempted from the standard user fees levied at health facilities. The ‘prakas’ has been poorly disseminated, however, and because it requires health facilities to cover the foregone income, it is not systematically implemented. An additional challenge is the lack of a mechanism for assessing, determining and formally recognising disability in Cambodia. In the absence of a system of official identification, front-line health workers must use their own understanding of disability in determining who does and does not qualify for an exemption.



According to the schedule of fees posted at health centres, persons with disabilities are among the categories of patients exempted from user fees. In practice, however, the exemption is not systematically implemented.

The exemption for persons with disabilities spelled out in the ‘prakas’ is similar to a system of user fee exemptions which has been in place for the country’s poor since the introduction of user fees in the 1990s. These too encountered difficulties at the level of implementation: fees were rarely waived for the poor, and studies suggested that the imposition of user fees deterred the poor from seeking care at public hospitals (Jacobs et al., 2014). By the early 2000s, the Cambodian authorities recognised these limitations and later introduced Health Equity Funds (HEF), a third-party payment mechanism which covers user fees on behalf of identified poor households (see Box 4).

Persons with disabilities who are identified as poor and are in possession of an ‘ID Poor’ card are eligible for free consultations and treatment at public health facilities via HEFs. However, where specific services are not available at a given facility, they, like other poor Cambodians, may incur additional out-of-pocket costs to access the care they need. Moreover, it is known that the utilisation of HEF services by members of eligible households remains low (Noy & Saing, 2012), suggesting that other barriers or factors, such as the acceptability of services at public health facilities, play a major role in decisions about when and where to seek care.

Disability is not an automatic qualifying criterion for receipt of an ID Poor card; the determination of poverty is made on the basis of household assets and revenues, not on risk factors or health needs of its individual members. Only the disability status of the head of household is considered.

There is, at present, no specific protection to mitigate risks or address the needs of vulnerable groups such as persons with disabilities who live in households which do not meet the poverty criteria.

As HEFs mature, there is a need to consider expanding the mechanism to people affected by risk factors, such as disability, old age or childhood, which are not currently part of the criteria for HEF coverage. However, responsibility for the development of strategies for such an expansion remains unclear, as HEFs are under the oversight of the Ministry of Health, which administers public health facilities, while the interests of people with disabilities are to be addressed by the Ministry of Social Affairs, Veterans and Youth Rehabilitation. Extending existing social health protection schemes and expanding benefit packages to meet the needs of those groups remains an advocacy and financing challenge.

■ Generating evidence to inform decision-making

To help the Cambodian government take informed decisions about inclusion of persons with disabilities in emerging social health protection schemes, the Social Health Protection project has used existing national datasets to generate evidence about the health financing challenges facing persons with disabilities and has brought this evidence into national policy discussions for the first time.

Box 4. Health Equity Funds

Health Equity Funds are third-party-administered schemes which reimburse public health facilities for services rendered to the poor. First piloted in the late 1990s by NGOs to cover health facility user fees which were deterring the poor from accessing care, HEFs have evolved into the most widespread social health protection scheme in Cambodia. They are currently active in all operational districts and, as of June 2015, cover nearly all public facilities.

HEFs target Cambodia’s poorest citizens, who are identified through household-based proxy means testing with community verification. This formal pre-identification process, known as ID Poor, is conducted under the auspices of the Ministry of Planning. Households determined to be poor receive an ID Poor card which entitles them to social benefits. Currently, these benefits are primarily limited to HEF coverage: free health services at public hospitals and health centres, reimbursement of transportation costs when referred from the health centre to the hospital, provision of food allowances, and coverage of other expenses related to hospital stays.

In addition to the formal pre-identification process, ‘HEF operators’ – the local non-governmental or community-based organisations which implement HEFs – also post-identify households that may have fallen into poverty between rounds of the ID Poor identification process, or who may have been missed during this process.

Staff with the project have analysed data from the 2004 through 2013 Cambodia Socio-Economic Surveys and sought to place trends in health financing and access to care for persons with disabilities into Cambodia's broader socio-economic and demographic context. They found that persons with disabilities are more than twice as likely to report being sick or injured than those without disabilities. On average, persons with disabilities spend five times more on health care – and significantly more on transportation to access health care – than those without disabilities. The incidence of debt is almost four times greater among households that have one or more disabled members than among households without.⁹

The analysis also showed, as mentioned previously, that the overlap between disability and old age is large and set to grow. Despite accounting for only 6% of the general population, persons over 60 accounted for 39% of persons with disabilities in 2014. A staggering 62% of disabilities were reported among people over 45 years of age.¹⁰

The preliminary findings from this analysis were presented at a regional workshop on health financing and social health protection for vulnerable groups which was held in Phnom Penh in early 2015 and attended by high-level representatives of the Ministry of Health. Finer-grained analysis is still underway and the results will be published in a series of policy briefs and technical notes over the coming year.

Box 5. Removing transportation-related barriers to care: a pilot scheme in Kampot

For persons with disabilities and their family members and caregivers, the costs of hiring transportation to travel to and from health facilities can be prohibitively expensive. From the earliest stages of its work on inclusion, the Social Health Protection project explored ways to mitigate or remove this particular barrier to care. The ultimate goal was to develop a transparent, participatory and sustainable approach to supporting the travel costs of persons with disabilities.



■ *Porn Sem, the head monk at the Troy Koh Pagoda in Kampot, has been working with Buddhism for Health and the Social Health Protection project to introduce a voucher scheme to reimburse the transportation costs of persons with disabilities when they travel to health facilities.*

During 2013-2014, the health financing team at the Social Health Protection project developed a voucher mechanism to reimburse the transportation costs incurred by persons with disabilities, as well as poor older persons, when they travel from their homes to local health centres. The pilot scheme, which is based on the team's previous experience with transport vouchers for the poor, began in September 2014 in one operational district and is gradually being scaled up to the rest of the province. Buddhism for Health, the HEF operator in Kampot, implements the scheme with support from the Social Health Protection project.

One of the distinctive elements of the pilot scheme is the central role played by faith-based organisations. Porn Sem, the head monk at the Troy Koh Pagoda, chairs a committee of 40 pagodas in the district which have agreed to collect and pool funds for this purpose (a similar committee exists for Muslim religious leaders). They also disseminate information in their communities, and via commune chiefs, about the availability of the transportation reimbursement and encourage people to seek health services.

Why is he moved to support such an effort? 'I can see the difficulties and challenges faced by the poor, and by older people and persons with disabilities. I feel sympathy for them and I help according to my capacities,' he explains.

The scheme is still in early stages and one of the challenges is to develop a systematic targeting mechanism. Staff with the Social Health Protection project in Kampot are currently supporting local authorities and DPOs to generate lists of persons with disabilities who are eligible for the benefit.

⁹ Unpublished analysis of 2004-2013 Cambodia Socio-Economic Survey data conducted by Social Health Protection project.

¹⁰ Ibid.

The prospect of mounting health care needs among distinct, but overlapping vulnerable populations poses a challenge for the resource-constrained Cambodian health system in the coming years. Ultimately, the government will have to decide how to gradually extend its social health protection coverage and to expand benefits to additional target groups.

Health system governance: promoting participation of persons with disabilities

Despite improvements in the public health system in recent years, less than one-third of Cambodians seek treatment at public facilities when they fall ill or are injured (National Institute of Statistics and ICF Macro, 2011). Private providers are perceived to be friendlier and more responsive to patient needs, although they are largely unregulated and care is often not better than in public facilities. Improving both the perception of public services and patient satisfaction is essential for increasing the utilisation of the public health system. Recognising this, the Health Strategic Plan (2008-2015) underscores the importance of making health service delivery more responsive to people's needs and more accountable to local populations.

A move towards greater local oversight of health services is in line with broader processes of decentralisation. Over the course of the next decade, subnational administrative structures, including district and commune councils, will gradually take over responsibility for a range of public services. Following years of centralised control, these reforms present important opportunities for the development of local, democratic decision-making practices (Plummer & Tritt, 2012). The challenges are significant, however: not only do councils require further technical support to assume new administrative, planning and budgeting functions, but community participation in local governance must also be encouraged.

It is in this context that the health system governance component of the Social Health Protection project aims to enhance local governance and community monitoring of health service efficiency in Kampong Thom and Kampot provinces. Its work is guided by the idea of an 'accountability triangle' in which interactions between three sets of actors – citizens and health service users, health providers, and policymakers (i.e. politicians, councils) – can lead to better-managed



■ *Community participation in local health system governance can lead to better-managed health facilities and greater utilisation of health services.*

health facilities, more efficient and effective service delivery, and greater utilisation of services. The project supports three main processes: the development and implementation of client feedback mechanisms, advocacy and capacity building on client rights and provider rights and duties, and the development of decentralised participative planning processes.

■ Where are the voices of the most vulnerable groups?

The concept of 'participation' as it has evolved in contemporary political discourse in recent decades 'has no historical precedent and little cultural resonance in Cambodia' (Plummer & Tritt, 2012, p.31). Citizens are not confident in their ability – individually and collectively – to influence decisions or to use their voices to bring about change. This is especially true for women, the poor, older persons, and persons with disabilities who have difficulty getting information, expressing their views, and influencing community priorities (GIZ, 2013).

Cambodia has a large civil society community focused on disability, with a national network of 61 DPOs affiliated to the Cambodian Disabled People's Organisation, hundreds of self-help groups, and other disability-related organisations, such as associations for persons who are deaf. In theory, these groups are well placed to advocate for the interests of persons with disabilities in local governance processes; however, in practice they are often excluded from 'invited' forms of participation, such as commune council meetings,

where many decisions of consequence are taken (Plummer & Tritt, 2012).¹¹ DPOs and self-help groups have historically been focused on livelihood concerns and most have not been active in lobbying for access to services, including health services, at a local level.

In Kampong Thom and Kampot, where the Social Health Protection project focuses its attention, commune councils have traditionally had limited contact with DPOs and persons with disabilities. More than half of the 34 council members surveyed by Handicap International in the two provinces as part of a baseline study for the project's inclusion activities said that they 'rarely' or 'never' met with individuals and groups representing persons with disabilities.¹² Less than two-fifths agreed with the statement that the commune council responds to the needs of persons with disabilities in their community. Indeed, the majority of those surveyed acknowledged that they had limited knowledge of disability (Handicap International, 2013).

■ Raising awareness of the rights and needs of persons with disabilities

Both the initial stakeholder consultations on inclusion activities and the baseline study undertaken by HI pointed to the same fact: there was an acute need to raise awareness of disability and the rights and needs of persons with disabilities in the two provinces as a prelude to efforts to improve the participation of persons with disabilities in local health system governance processes.

During the first half of 2013 Handicap International, Epic Arts and staff from the Social Health Protection project conducted two sets of introductory workshops on disability awareness for a wide range of stakeholder groups, including local authorities, in Kampong Thom and Kampot. Two-day disability awareness workshops held in March 2013 covered the prevalence and main causes of disability in Cambodia, the types of services and support needed by persons with disabilities and the barriers impeding access to them, and laws and policies on disability and disability rights. In addition to participants from the Provincial Health Departments and local NGOs, members of Village Health Support Groups

and the Commune Committees for Women and Children (linked to commune councils) attended these sessions. These were followed, in June 2013, by three-day workshops on disability advocacy and awareness which engaged a range of provincial authorities, including those from the departments of education and social affairs and the offices of the provincial governor, as well as NGOs and religious leaders. Here, emphasis was placed on disability rights and human rights, and on the national and international laws, policies and frameworks pertaining to disability. Handicap International and staff from the Social Health Protection project presented the findings from the provincial baseline studies and the results of focus group discussions which described barriers to and facilitators of service access for persons with disabilities in each province.

These preliminary workshops, which reached more than 100 stakeholders in the two provinces, laid the groundwork for the efforts, described in the next section, to start bridging the participation gap between DPOs and persons with disabilities and provincial and local governance processes in the area of health.

■ A seat at the table: bringing persons with disabilities into local governance processes

Given their marginalised position in Cambodian society, as well as their often greater than average health needs, it is particularly important that persons with disabilities have the opportunity to feed back their experiences about the health system and to engage alongside other members of the community in local-level discussions and decision-making about health. For many persons with disabilities, however, this is not a straightforward prospect. 'A lot of people with disabilities think that others look down on them,' explains Chantey Heng, the Vulnerable Group Advisor for the Social Health Protection project in Kampot. 'They say, "I'm just a disabled person, I don't have rights." We let them know that they do.'

Since 2013, the Social Health Protection project and the non-governmental organisations with which it works in the area of health system governance have systematically invited DPOs and persons with disabilities to all activities supported by the project in Kampong Thom and Kampot provinces.

¹¹ Plummer and Tritt (2012) have found that formal, 'open' participatory processes, such as village meetings, tend to be ineffective in terms of empowering citizen engagement, and that meaningful voice is to be found in 'invited participation' and informal engagement with authorities at village level. They note, however, that invited participation may not be representative of community preferences as women and marginalised groups are largely excluded (p. 7).

¹² The survey included 16 commune council members from 8 communes in Kampong Thom; and 18 members from 9 communes in Kampot.

This includes trainings on client rights and provider rights and duties, which seek to build community awareness of key health-related rights, such as the right to choice and informed consent, to confidentiality, to privacy, and to equal and non-discriminatory treatment. The facilitators who lead these trainings have been specially trained on the rights of persons with disabilities and are encouraged to use examples related to disability when conducting the sessions with health workers and members of the public. DPOs are also invited to attend public reflection forums which are convened following the training sessions to allow an open discussion of client experiences in the health system.

The health system governance team at the Social Health Protection project also works directly with commune councils to build their capacity to assume their health-related roles in the context of decentralisation. These include monitoring the quality of health services, managing and overseeing Health Centre Management Committees and ensuring that they act upon citizen feedback, and supporting the maintenance of health centre infrastructure. The commune councils also play a key role in the preparation of annual health centre operational plans, which should be developed with community participation. The Social Health Protection project supports this planning process by underwriting a series of joint planning workshops in each province which bring together representatives of commune councils, health centre chiefs, district authorities, and NGO representatives. Representatives of DPOs participated in the joint planning meetings for the first time in 2014, and have continued to do so ever since.

According to Por Pen, who works on health system governance issues in the Kampot provincial office of the Social Health Protection project, 'Mainstreaming disability has not been easy. We have had to build up the concept of inclusion with all stakeholders and to encourage their active support.' In the past, commune councils never planned their budgets with thoughts of persons with disabilities in mind, he explains, but now the councillor responsible for women and children has to be aware of challenges facing persons with disabilities, to know about the services that are available, and to mobilise forms of support for persons with disabilities. 'We are trying to bring change right into the system,' he continues. 'The commune councils need to have ownership. This is a really difficult challenge. Before, we didn't really grasp the need ourselves. But now we understand that persons with disabilities need the same things as everyone else, and have certain special needs, too.'

■ Building capacity for meaningful participation

The systematic engagement of DPOs in these local processes has created the possibility for more participatory planning in the communes in which the Social Health Protection project works. The regular attendance of DPOs and persons with disabilities at these events and meetings is an important first step, but much remains to be done to ensure the quality of participation. The mere presence of DPOs and persons with disabilities 'in the room' does not mean that the needs and rights of persons with disabilities will necessarily be advanced against a backdrop of competing priorities and limited resources (see example in Box 5). In the next phase of the project, beginning in September 2015, the Social Health Protection project and its partner NGOs will systematically collect information about the extent to which the DPOs and persons with disabilities who attend various trainings, forums and planning meetings actually contribute to discussions, and will track the types of issues they raise to monitor whether and how these are then addressed at health centre level.

The challenge going forward is to build on what has been done so far – and to take advantage of increased political attention to persons with disabilities – to move towards more meaningful participation of persons with disabilities in local governance in the health sector. According to Shana Dörr, a technical advisor who coordinates activities related to inclusion of persons with disabilities for GIZ in Cambodia, this involves, among others, intensifying efforts to build the institutional capacity and advocacy skills of DPOs. 'We are trying to respect the slogan "Nothing about us, without us" and are committed to involving DPOs and other civil society organisations in all stages of our programme, from planning to evaluation, and to supporting them to be able to advocate for their members' needs and rights.'

Vulnerable Group Advisors with expertise in disability advocacy have been working for the Social Health Protection and the Rights-Based Family Planning and Maternal Health projects in Kampong Thom and Kampot since spring 2014, with a major emphasis on strengthening the work of local disability organisations. In early 2015 contracts were concluded with three DPOs aiming at improving their core organisational capacities, consolidating their understanding of disability laws and rights, and building basic advocacy and lobbying skills (see 'Looking ahead,' p. 38, for further information).

Box 6. Engagement between commune councils and DPOs

The commune council: 'From now on we will engage persons with disabilities more'

Dambok Kpos Commune, in the centre of Kampot Province, has a population of just over 16,000 people spread across 11 villages. According to the commune chief, Phy Kem, there are more than 200 people with disabilities in his commune, most of them with war- or landmine-related physical impairments. His wife is one of them, and he is familiar with the challenges persons with disabilities face in daily life: 'The living conditions for persons with disabilities are sometimes difficult. It's hard for them to work and make money. They want to have a role in society, but they aren't very well educated.'



■ *The Dambok Kpos commune office.*

How does the commune council engage with the needs of persons with disabilities in the community, including in the area of health? 'We have regular monthly meetings,' Phy Kem explains. 'When persons with disabilities want to express themselves, they can do so. But this involves traveling and sometimes there are problems with accessibility. They can join meetings, but they don't always do so. And when they do come, it's difficult for them to participate,' due to a lack of awareness of the objectives of the meeting and a lack of confidence in bringing forth their views. He estimates that persons with disabilities are present at about half of the meetings they hold.

Phy Kem describes changes in the political environment which point in the direction of greater engagement of persons with disabilities in the future. 'In the past the government has not emphasised the needs of persons with disabilities, but now they have said that we need to make sure they have a voice in all activities. Now we have to invite them to all our meetings and we do this. From this year onwards we will engage persons with disabilities more.'

The DPO: 'Not getting special attention is also a form of discrimination'

Han Ing is the director of the Angkor Chey DPO, which has more than 200 members across five communes, including Dambok Kpos. He regularly attends commune council meetings and the authorities in Dambok Kpos acknowledge his role in bringing issues from the community of persons with disabilities to their attention.



■ *Han Ing (right) with Phy Kem (center) and the chief of Chak Chrum village, Chhel Mey.*

Health is an emerging area of focus for Angkor Chey DPO: for the past two years it has been working closely with the Social Health Protection project and HI to promote early detection of disabilities and early intervention services in the area (see next section).

One of the main results has been greater sharing of information. 'If there are special services that become available for persons with disabilities, for example through an NGO that works in the area, we learn about this from the commune authorities,' says Han Ing. 'We also report to the commune councils cases of discrimination against persons with disabilities in health centres. The problem is that they don't really get any special attention, which can also be considered a form of discrimination.'

While there is a long way to go, Han Ing believes that local authorities are now more aware of disability issues. 'When I go to village chiefs, they pay more attention than they used to,' he explains.

Health services: preventing disability through early detection and intervention

Early childhood is a critical time for children with disabilities to access interventions which can support them to reach their full potential (WHO, 2012). Early detection and early intervention refer to a range of actions aimed at preventing impairments (primary prevention), identifying signs of impairment (secondary prevention), supporting children with impairments or developmental delays through home- and community-based services (tertiary prevention), and working with families and community structures to enhance the social inclusion of children with disabilities, as well as their families.

Although the concept of early detection and early intervention is actively promoted by NGOs in the disability sector in Cambodia, it is not yet reflected within the health system. Pre-service training for health care workers does not cover disability issues and there is limited capacity to detect impairments or conditions that could lead to permanent disability. Critically, there is no system for comprehensive newborn screening in Cambodia, nor is there a system for periodic developmental checks of infants and young children, apart from weight and growth monitoring aimed at detecting signs of malnutrition. As a result, many parents and caregivers of children with mild and moderate disabilities (e.g. low vision, partial hearing loss) are unaware of their child's disability or the potential for it to become more serious over time (Evans et al., 2014).

A systematic approach to screening for impairments, referring and treating children at risk of developing permanent disabilities, and providing community-based services for children living with disabilities would help to prevent or mitigate many of the impairments which affect children's performance at school and can limit their prospects later in life.

■ An opportunity to bring early detection and intervention into the health system

The Social Health Protection project in Cambodia has a long history of providing technical support in the area of maternal and child health, particularly midwifery. Given this historical focus, and the identified need for early detection and intervention in Cambodia, it was therefore a logical starting point for the project to look for ways within the health system to identify children with impairments and to support them and their families to access appropriate care, treatment or services.

As the team at the Social Health Protection project began exploring potential approaches in 2012, it recognised that there were strands of ongoing activity which could be drawn together and expanded with the project's support. Handicap International had worked closely with the Ministry of Education, Youth and Sport on the implementation of the Evans study, which investigated the prevalence of disability among children in Cambodia, and was looking for ways to develop and roll-out a simplified screening tool for use at health centre level. The Social Health Protection project saw an



■ *The basic health of neonates is assessed immediately following birth, but detailed newborn screenings and periodic developmental checks of infants and older children are not yet part of the Cambodian health system. As a result, parents may be unaware of impairments in their children which could become more serious over time.*

opportunity to use its strong working relationship with provincial and national health authorities to engage the health sector in these efforts. In addition, the Rights-Based Family Planning and Maternal Health Project would soon begin in Cambodia¹³ and there was the prospect that KfW Entwicklungsbank could integrate disability screening into its voucher schemes, thereby addressing financial barriers to screening.

At the same time, however, the project team grappled with concerns about supporting early detection in a context where the coverage of specialised services was low and referral networks, including those between the health and rehabilitation systems, were not well-established. A national network of Physical Rehabilitation Centres, established in the 1990s by international NGOs and subsequently handed over to the Ministry of Social Affairs, Veterans and Youth Rehabilitation, provided certain impairment-related services free of charge, and a number of NGOs set up mobile ‘camps’ where people could access, for example, free ear and eye health services. Specialised paediatric services were also available, free of charge, at hospitals in Phnom Penh and Siem Reap. Referral procedures were unclear, or entirely lacking, however, and, in most of these cases, accessing services required families to travel with their children, sometimes long distances, from their rural homes to unfamiliar institutions in larger cities. It was clear from the Evans study that follow-up by parents would be a major challenge: even when provided with a scheduled appointment, free consultations and the reimbursement of transportation costs, many parents of children identified for detailed screening did not bring their children to appointments.

Heike Krumbiegel, the technical advisor who helped to structure the approach to inclusion, recalls the lengthy discussions within the team which led to the decision to support the ongoing work of the Cambodian government and HI in this area. ‘We knew that what we could do was only a small step: we could advise parents of the need to seek care or support and inform them where they could go,’ she said recently. ‘People have different views on this,’ she continued, alluding to the fact that the project could not guarantee follow-up care, ‘but I thought that parents have the right to know. If they don’t know, they can’t decide for themselves what steps to take to support their children.’

Ultimately, they agreed upon a two-pronged approach: first, to build links from the health system to the acute care and rehabilitative services which were available free of charge, but not always accessed because people with disabilities, and even health workers, were unaware of them; and second, to raise awareness in communities, including among parents of children with impairments, about the importance of non-medical forms of support for children with developmental delays, and to promote the existence of community-based initiatives, such as parent support groups and self-help groups, aimed at fostering the children’s social and intellectual development.

■ An innovative four-way partnership

After much discussion and planning, the Social Health Protection and Rights-Based Family Planning and Maternal Health projects, the Provincial Health Departments, Handicap International and Epic Arts embarked in early 2013 upon a joint programme of work in Kampong Thom and Kampot provinces.

The collaboration involved a wide range of activities both within and outside the health system. Inside the health system, the goal was to develop and pilot a set of screening tools (a simplified version of the tools used in the Evans study), to build the capacity of health workers to detect and refer children with impairments using these tools, and to strengthen referral networks so that children detected via screening could be directed to appropriate services. Outside the health system, a set of community-based activities aimed to raise awareness of disability and early detection/early intervention among DPOs, members of Village Health Support Groups, and the public at large. These two strands of activity would come together at a series of Health Centre Days, public events at 42 health centres designed to raise awareness of disability, to bring community members into closer contact with the health system, and to provide a chance for children to be screened for impairments.

¹³ As many impairments among Cambodian children are associated with prematurity and low birth weight, poor maternal health, and inadequate ante- and post-natal care, disability was directly related to the project focus.

■ Building capacity for disability screening: developing tools and training health workers

In March 2013, work got underway. HI, in cooperation with the National Pediatric Hospital in Phnom Penh, assembled a high-level technical steering committee whose task over the coming months was to develop, pilot and refine a set of disability screening tools. The committee brought together a wide mix of experts: Ministry of Health and Ministry of Education officials, clinical specialists, provincial-level health practitioners, and representatives from NGOs. Over the course of half a year, the committee members met monthly to debate every aspect of Cambodia's first disability screening tools for children. In addition to being clinically sound, the tools needed to be short and simple – suitable for use by nurses and midwives in the course of their routine work.

It was a challenging process. Adam Huebner, who led this effort on behalf of HI, recalls there were a lot of differing opinions and every point was argued. At the same time, according to Huebner, 'the committee members were highly motivated. Many of them had been involved in the Evans study; they knew the issues and the background,' he said. 'They also saw the need. We had eye specialists, audiologists and orthopaedic doctors involved and they all understood why this was important.'

By August 2013, the committee had developed three separate tools: for newborns (0-28 days), infants (9-12 months) and young children (5-6 years). Each tool was one page long, with four to seven main sections covering (depending on age) the child's medical history, a physical and functional examination, and basic assessments of motor skills, vision, hearing and cognition/language. The committee also prepared a Khmer-language training manual for each tool and a three-day training curriculum covering all three tools.

After the tools were piloted and further refined, 19 participants from Kampong Thom and Kampot provinces came to the National Pediatric Hospital to be trained as trainers in the screening methodology. These individuals, who included representatives from the Provincial Health Departments, the provincial hospitals, and two operational districts from each province, then cascaded the training to staff (primarily nurses and midwives) at 42 health centres in the two provinces.



■ Nurses and midwives at 42 health centres in Kampong Thom and Kampot provinces, including at the Dambok Kpos Health Centre, pictured here, were trained to detect impairments in children, using a standardised set of screening tools.

The training module involved two days of theoretical information and one day of clinical practice. It was clear, however, that health workers with no prior experience screening for impairments would not be able to use these tools with confidence with only basic training. Members of the technical steering committee then fanned out to participating health centres to provide supportive supervision and refresher training to 177 health centre staff over the course of 2013 and 2014. These follow-on trainings provided nurses and midwives with the opportunity to practice the screening protocol repeatedly.

Before they began using the tool routinely, each participating health centre received a copy of a specially-created referral directory outlining health and social services in their province and neighbouring provinces, as well as in Phnom Penh. They also received some basic medical equipment, including blood pressure measurement sets, hanging scales, stethoscopes, and pen lights and a 'tumbling E' chart for eye tests.

■ Introducing the concepts of early detection and early intervention in communities

In addition to this clinically-focused work, teams from HI also implemented a wide range of activities in the communities surrounding the participating health centres. These aimed to build awareness of disability, the main causes of disability among children, and the importance of intervening early to detect and treat impairments that can lead to permanent disability.

The programme of work was ambitious. HI conducted 84 community awareness sessions involving more than 4,600 people, including members of Village Health Support Groups, the Commune Councils for Women and Children and DPOs, as well as village chiefs, health centre staff and local residents. These sessions, which used already existing materials developed by HI in an earlier project, educated villagers about the ‘warning signs’ of disability: the so-called five ‘danger signs’ (i.e. diarrhoea, high fever, difficulty breathing, inability to eat or drink, convulsions) and 15 ‘special signs’ (e.g. Spinal Bifida, club foot, cleft lip/palate, hydrocephalous, floppy baby etc.). It stressed the importance of seeking medical consultation for children displaying any of these signs. Evaluations following the sessions showed that the ‘danger signs’ and ‘special signs’ were well understood by participants.

In addition, teams from HI provided more in-depth training on early detection and early intervention to more than 1,730 ‘community agents’: members of Village Health Support Groups and Commune Councils for Women and Children who are well-positioned in their communities to identify children with impairments and to encourage their parents to seek care. These two-day trainings covered the definitions of impairment and disability, risk factors and causes of disability, principles of child development, and basic forms of support for children with disabilities which can be provided at home (e.g. play stimulation).

The information conveyed during these trainings was reinforced through posters and other informational materials. More than 8,000 posters on ‘danger signs’, ‘special signs’, and child development were distributed to health centres, Village Health Support Groups and Commune Councils for Women and Children in the two provinces.

DPOs and other disability-related NGOs were actively engaged in this aspect of the project, both as participants in trainings and as conduits for sharing information in the community.

■ Health Centre Days generate an overwhelming response

Between December 2013 and August 2014, a total of 84 Health Centre Days, two at each participating health centre, were organised. According to Adam Huebner of HI, the goals of the Health Centre Days were three-fold: first, to build a relationship between the health centre and community members, many of whom normally sought care from private providers; second, to raise awareness of child



■ Heike Krumbiegel (back right), of the Social Health Protection project, watches as a doctor administers eye examinations to children at a Health Centre Day.

development and disability in the community; and third, to screen children for impairments. To fulfil this final goal, teams of clinicians invited by HI worked alongside health centre staff to screen children and to provide parents with referrals, where necessary.

The Health Centre Days were widely publicised and the turnout far exceeded expectations: a total of 17,052 children attended, an average of more than 200 per event. On the one hand, this was a welcome surprise. Heike Krumbiegel was stunned: ‘I couldn’t believe it when I went to my first Health Centre Day and there were 300 parents with children waiting for advice and screening. The health centres were usually empty – people didn’t trust them – and suddenly hundreds of mothers had turned up.’

On the other hand, the massive turnout meant that the teams of specialists who were present to conduct the screenings could not keep up with the volume of waiting children. The screening tools ideally require 15 to 20 minutes per child to complete, the hearing test requires a quiet room, and the eye test a dark room. These conditions simply couldn’t be met. The teams did the best they could, but only a quarter of the children who attended benefited from a full screening using the tool; the rest had brief consultations with health personnel.

Box 7. 'Audiences have never seen performers like us before'



■ *Members of Epic Encounters performing 'Recovery' at a Health Centre Day. The dance encourages audiences to visit health centres, rather than traditional healers, when they fall ill.*

Visitors to many of the Health Centre Days were treated to something absolutely unusual for rural Cambodia: modern dance performances by a troupe of young deaf and disabled artists. The Epic Encounters team – a group of eight men and women who study dance as part of the Inclusive Arts Project run by the Kampot-based NGO, Epic Arts – performed two different dances for audiences at Health Centre Days across Kampong Thom and Kampot provinces.

Both dances convey health messages: 'Recovery' is about the importance of seeking formal medical care when ill, and 'Our Family' addresses antenatal care and safe pregnancy. As important, if not more important, than the educational content of the dances, however, is the fact that they were created and performed by persons with disabilities.

saw the performers, I thought they were deaf,' said one health worker. 'But when I saw their ability, I thought they can do things by themselves and they can do them well.'

'I was really impressed by them,' admitted a woman in the audience, waiting to have her child screened. 'I admire the group.' 'All the people here liked it,' said another. 'They understood the idea that persons with disabilities can perform nicely like other people.'

While such views might sound patronising, it is important to put them into context: outside major towns, such as Kampot, persons with disabilities are often invisible, and understanding of disability is extremely limited. Buntheng Ou, a coordinator with Epic Arts who travelled with the Epic Encounters team to the Health Centre Day performances, recalls one day in Kampong Thom when several of the artists were stopped by police on the street. 'They were signing to one another,' he explained, 'but the police had never seen sign language before. I ran over and asked them what they had done wrong. "Nothing," the police replied, "They were just standing in the street not talking."'

Buntheng Ou and the Epic Encounters dancers all agree that the collaboration with GIZ was extremely important for exposing rural audiences to positive examples of disability. 'Audiences have never seen performers like us before,' said one of the team.

Audiences were captivated and initial scepticism quickly turned to admiration: 'Honestly, in my mind, when I first

saw the performers, I thought they were deaf,' said one health worker. 'But when I saw their ability, I thought they can do things by themselves and they can do them well.'

'I was really impressed by them,' admitted a woman in the audience, waiting to have her child screened. 'I admire the group.' 'All the people here liked it,' said another. 'They understood the idea that persons with disabilities can perform nicely like other people.'



■ *The Epic Encounters team performed at more than 50 Health Centre Days in two provinces, reaching an audience of over 5,000 people.*

■ **Supporting positively screened children to access services**

The parents of 721 children who were positively screened at the Health Centre Days or during routine visits to health centres were given referrals for further assessments. HI worked closely with health centre staff and the referred families to facilitate their access to services: they encouraged families to follow-up on referrals by explaining what the clinicians had identified during the screening, what would happen during a follow-up consultation and the possible consequences of not seeking follow-on care. Many parents needed to be convinced to take their children for further assessments – and also reassured that they would be able to manage visits with their children to large, unfamiliar cities.

While the health financing team of the Social Health Protection project was working on the design of a sustainable, community-based transportation voucher system (see Box 5, p. 21), there was a need to put interim measures in place to mitigate the risk that families with limited resources would not follow up on referrals. With financial support from GIZ, HI provided the families of 66 children with financial support (average of USD 20 per family) to reimburse the costs of transportation and related expenses, primarily for trips to Siem Reap or Phnom Penh. As a series of individual case studies prepared by HI (2014) showed, this was a facilitating factor for many families who would otherwise not have sought care.

Box 8. Diverse referral pathways



A first grader gets care for his low vision

At the suggestion of a Village Health Support Group member, the parents of six-year old Samedy brought him to a Health Centre Day at the Archar Leak Health Centre in Kampong Thom province. His parents had noticed that Samedy often squinted, and were angry that people in the village called him names. When the doctors diagnosed Samedy with low vision and referred him to the Angkor Children’s Hospital in Siem Reap for treatment, the parents were surprised. ‘We never thought that this was serious or an impairment,’ said his father, Kimsin Tem.

It took the family a few months to save enough money to make the trip to the hospital. Samedy’s eyes were tested and he was given a prescription for glasses for six months. The doctor explained that if his eyes didn’t improve, surgery could be required. The parents were very concerned by this prospect, but were also satisfied with the hospital. The doctor provided clear explanations and helped them understand that the goal was to prevent Samedy from developing a permanent disability. Samedy began wearing glasses every day and his eyes gradually improved. His parents plan to bring him to his scheduled follow-up appointment.



Treatment is difficult to access for a girl with glaucoma and a facial tumour

Four-year old Yada lives in the Stong District of Kampong Thom province. She was born with glaucoma and a facial tumour. When she was an infant, she spent a month at the Kantha Bopha Children’s Hospital in Phnom Penh, but the doctors decided that she was too young to be treated and told Yada’s parents to bring her back when she was older. She had not been seen again until she was screened at a Health Centre Day and referred for treatment at the Angkor Children’s Hospital in Siem Reap.

Shortly thereafter, with support from HI, Yada’s parents made the four-hour trip by taxi to Siem Reap and were seen by specialists at the hospital. The doctors prescribed pills and eye drops for Yada’s eyes, but explained that they could not undertake surgery on her: the parents would need to bring her to the National Paediatric Hospital or to Kean Kleang Hospital in Phnom Penh. The parents felt that they were treated well by the doctors and given the chance to ask questions. However for financial reasons they have not been able to bring Yada to the capital for further consultations and are fearful that, if they do, they will find out there are no hospitals in Phnom Penh which can perform the surgery. Yada attends school and is accepted in her community, but the family is unfortunately no closer to getting treatment for her impairments.

Source: Adopted from Handicap International, 2014.

While it was not possible to track the experiences of all the children who had been positively screened, staff from HI did successfully follow up with roughly one-fifth (136 cases) of those who had been referred for further assessments. Of these, just over half had sought referral services (n=73) and nearly one-third (n=42) had received some form of treatment. In Kampong Thom, 85% of those monitored had sought referral services (compared to only 32% in Kampot), a fact which likely reflects the relative proximity to free specialised services in Siem Reap.

The factors underpinning the uptake of referral services are well-known: the direct and indirect costs of seeking care at distant hospitals, the absence of a caregiver to travel with the child, prioritisation of family livelihood over the child's health concerns, long waiting times for appointments, and a belief that the child's impairment is not serious (Handicap International, 2014). Two of the many different experiences are illustrated in Box 8 on the previous page.

■ Taking stock: achievements and limitations

The collaboration between HI, Epic Arts, the Provincial Health Departments, and the Social Health Protection and Rights-Based Family Planning and Maternal Health projects accomplished an impressive amount in a relatively short period of time. According to an external evaluator who assessed the results of the intervention in late 2014, the awareness-raising activities in the community and the capacity-building work within the public health system answered a considerable interest on the part of both health staff and the population to learn more about disability. Moreover, the investment in screening tools laid an important foundation for the Ministry of Health to build upon in its next planning cycle (De Mey, 2014).

Officials with the Provincial Department of Health in Kampot were pleased with the collaboration. 'We see that we can help children by supporting early detection and intervention,' says Samedy Sor, the focal person for disability issues at the department. 'We can increase children's independence and their access to education, as well as reducing the stress experienced by the children and their families.'

In this respect, the collaboration with HI lived up to one of the Social Health Protection project's original objectives: to support concrete initiatives at provincial level which serve as 'examples of what is possible' in a difficult context. At the same time, the fundamental questions which the team grappled with at the outset remained relevant throughout.

As the external evaluator put it: 'Does screening without appropriate decentralised referral capacity make sense? Does screening without appropriate community care make sense?' The intervention was carried out in four operational districts where there were limited community-based support services for children with disabilities, and where referrals for specialised care had to be made regionally or nationally in the absence of organised referral pathways. Some children accessed services as a result of the intervention, but these represent a relatively low proportion of the overall number of detected children.

Certain aspects of the project design may have contributed to this result. The intense focus on implementing activities at a large scale with a minimum of staff meant that referral mechanisms could not be tackled properly, nor could detected cases be followed up as systematically as planned (De Mey, 2014). In addition, the screening database and follow-up monitoring system did not capture information in a way that allowed the output of the screenings to be compared with those from follow-on consultations (i.e. which would allow for insight into the validity of the screening tools). These weaknesses were recognised mid-way through the intervention and partially remedied by putting more resources into database management and systematically following up with a sub-set of the detected cases.

Ultimately, attention to screening and referral mechanisms needs to go hand in hand with investments in institutional and community-based rehabilitation services. As the evaluator noted, many disabling factors have no medical solutions, or only partial medical solutions, making community-based assistance – such as family support groups and play groups – particularly important (De Mey, 2014). Yet these types of initiatives remain extremely underdeveloped in Cambodia. It was beyond the scope of this intervention to systematically address these gaps and, indeed, one of its valuable contributions has been to demonstrate, in concrete terms, the need to bring the public health system closer to existing services for persons with disabilities. The external evaluator observed that early detection and early intervention 'has been interpreted by health staff mainly as early referral' and that health centre staff do not yet feel confident advising on appropriate referral services because they don't really know which services can be beneficial (De Mey, 2014). Much remains to be done.

■ **What comes next?**

In December 2014 the main results of the collaboration were presented and discussed at a national workshop in Phnom Penh which was opened by the Minister of Health – a sign of the rising prominence of disability issues on the national agenda. There is widespread interest, both within the Ministry and beyond it, to see the screening tools finalised, officially approved, and institutionalised.

The Rights-Based Family Planning and Maternal Health project is taking the work with the screening tools forward. It is cooperating closely with HI and the technical steering committee, which continues to meet quarterly, to resolve outstanding questions about the tools and to lobby the Ministry of Health for their adoption and institutionalisation. The intention is to rework the three existing tools into two: a medical screening tool for neonatal children, aimed at detecting birth defects, and a developmental screening tool for children between the ages of two months and five

years, aimed at assessing functional skills (i.e. developmental milestones).¹⁴ Once these tools have been finalised, they will need to be checked for reliability and scientific validity before they can be presented to the Ministry of Health for approval. The objective is to integrate the disability screening tools into the health system so that screening is performed routinely during newborn and child health checks.

The project also plans to collaborate with HI on the development of referral guidelines for common impairments which will support health workers in directing patients to appropriate medical and rehabilitation services, as well as to community-based rehabilitation services. This will be accompanied by the creation of a web-based, client-centred referral directory which will provide parents of positively screened children with up-to-date information about service providers' procedures for accepting new patients, their service capacity, how to make appointments, and costs/fee exemptions.

Box 9. Building capacity to manage hearing impairments in Kampong Thom Province



■ *Dr Vichet and colleagues at the opening of the new Ear Nose Throat unit at the provincial hospital in Kampong Thom.*

Hearing impairments affect an estimated 15% of Cambodians who report one or more difficulties in functioning, yet Ear Nose and Throat (ENT) services are not readily available to most of the population, including the roughly 690,000 people living in Kampong Thom province.

During 2013 and 2014, the Social Health Protection project supported the establishment of an ENT unit at the Kampong Thom provincial hospital to build capacity within the health system to manage hearing impairments. Dr Lucy Haurisa, a German-trained ENT specialist who works at a private clinic in Phnom Penh, provided intensive training on ear and hearing care to Dr Vichet, a surgeon from the Kampong Thom provincial hospital, so that he could offer consultations and perform minor procedures on an outpatient basis.

Some of the training was organised in Kampong Thom, involving local patients at the hospital there, while other parts were done in Phnom Penh, where the greater volume of patients allowed Dr Vichet ample opportunity to practice basic procedures. GIZ also supported the hospital in procuring essential equipment for the ENT clinic, which opened in July 2014.

The investment in Kampong Thom has helped to improve the availability of basic ENT services. The new unit, while modest, is now able to undertake basic procedures and to assist with inpatient emergencies in a way that was previously not possible. As a result of his improved familiarity with ENT as a field, and his visits to various ENT facilities and specialists in Phnom Penh, Dr Vichet is also better able to direct referrals for conditions he is unable to treat. In the coming year the Social Health Protection project will support intensive ENT training for a nurse from the hospital to join the new unit.

¹⁴ This will allow all children from birth through the age of five to be covered by a screening tool. Under the approach tested with three separate tools, children between the ages of one and nine months, and between one and four years, were not covered by any of the tools.

Discussion

Over the past five years the Social Health Protection and Rights-Based Family Planning and Maternal Health projects, with the active support of BMZ and the Sector Initiative on Inclusion of Persons with Disabilities, and in close cooperation with the Royal Government of Cambodia, have worked to put inclusion of persons with disabilities more squarely on the agenda within the Cambodian health sector. This final section draws together some key reflections from this journey. It describes the main achievements to date, highlights areas of difficulty, and flags questions which should be considered by programmes in other countries which are interested in promoting inclusion in the health sector.

Promising developments

The cross-cutting focus on inclusion of persons with disabilities has steadily built in intensity over the past five years, accelerating since the launch of the BMZ's Action Plan in 2013. While much has been done, there is a general feeling among the project teams in Cambodia that it is still too early to talk about measureable outcomes and impact. The past years are understood as a period of 'learning by doing,' both for the teams and their partners, as they have piloted a variety of approaches at different levels of the health system. While the results generated are difficult to measure, they are far from insignificant:

There is now greater awareness of disability and of the need for inclusion of persons with disabilities in the health sector among partner institutions and in communities. The projects have drawn attention to the topic of inclusion at multiple levels and with numerous different constituencies, from policymakers engaged with social protection frameworks at a national level to provincial and district health authorities, front-line health workers, local authorities and residents of rural communities. In all of these contexts, this has required a thorough sensitisation process: sensitising policymakers to the health financing situation facing persons with disabilities, sensitising health workers to the rights of persons with disabilities to health care, sensitising local authorities to the importance of engaging persons with disabilities in decision-making processes, sensitising persons

with disabilities themselves to their right to access services, and sensitising parents to signs of impairment and disability in their children. The projects have also helped to generate awareness of disability and to counter stigma and discrimination by exposing thousands of people to positive depictions of disability (i.e. via performances by Epic Arts).

'Some years ago, before this project, nothing was happening on disability,' says Chheng Tann, the Deputy Director of the Provincial Health Department in Kampot, who has been with the department for 20 years. 'Now the Ministry of Health builds new health centres with ramps, and GIZ has introduced a focus on this topic. The situation is changing.'

Inclusion of persons with disabilities in the health sector is now more firmly on the political agenda in Cambodia.

German support for inclusion of persons with disabilities in the health sector has coincided with growing attention to the rights of persons with disabilities in Cambodia in recent years. At the national level Germany is playing a leading role among development partners in highlighting needs of persons with disabilities in the emerging social health protection system. There are now some signs of growing political commitment, including ministerial-level representation at workshops on disability-related topics facilitated by the Social Health Protection project. While this has not yet translated into concrete implementation measures, it does suggest that the government is beginning to pay greater attention to the situation of persons with disabilities in the health sector.

DPOs increasingly have a seat at the table. Through its activities aimed at improving health system governance, as well as the sustained efforts of its Vulnerable Group Advisors at provincial level, the Social Health Protection project has encouraged DPOs and other civil society actors to engage directly with local authorities and health officials. It has also begun to build the capacity of DPOs to lobby and advocate for the health-related needs of persons with disabilities at a local and provincial level. In a context where the voices of civil society are not always welcome, or heard, it is an important accomplishment that DPOs now have a 'seat at the table' during routine planning meetings, public reflection forums about the health system, and provincial-level technical working group sessions.

Concrete tools and approaches have been developed which can be scaled up. The significant investment in the development of disability screening tools, with representatives from different departments of the Ministry of Health involved in the technical steering committee and the Provincial Health Departments involved in implementation, has contributed to increased awareness of childhood disability among high-level officials. These efforts have opened up the prospect that early detection could eventually become institutionalised within the health system. The collaborative intervention between the Provincial Health Departments, GIZ, HI and Epic Arts in Kampong Thom and Kampot provinces is viewed by the Ministry of Health as a practical example on which to build in the future. Similarly, the development of a community-funded transportation reimbursement scheme in Kampot Province, while still in early stages of roll-out, is another practical example with potential for scale-up.

The project teams have a new perspective on disability as a development issue. Staff with the Social Health Protection and the Rights-Based Family Planning and Maternal Health projects did not have expertise in disability issues when mandated to mainstream a focus on inclusion in their activities. Shana Dörr, the technical advisor currently responsible for inclusion issues, notes that ‘it was a long process to ensure that the project teams were not only aware of, but also invested in working towards the inclusion of persons with disabilities.’ The teams drew strategically upon the technical expertise of others, both within German Development Cooperation (i.e. the Sector Initiative on Inclusion of Persons with Disabilities) and in Cambodia itself (e.g. Handicap International, Epic Arts) to structure their approach and to build competence in this area.

Over the past years, both international and Cambodian personnel working with the two projects have increased their understanding of disability as a development issue and now view their portfolios through a different lens. This is particularly true at the provincial level, where Vulnerable Group Advisors are working closely with colleagues across project areas, resulting in a growing sense of ownership in the approach to inclusion. According to Dörr, ‘Technical staff from across project areas are now working together in an increasingly harmonised way to realise the full inclusion of persons with disabilities.’

Supported measures have made a difference in the lives of persons with disabilities. While it is too soon to speak in general terms about the impact of this work on persons with disabilities in the focus districts, there is anecdotal evidence to suggest that the measures are leading to positive changes in some people’s lives. Some children who were positively screened for impairments at health centres in Kampong Thom and Kampot now have an improved health-related quality of life thanks to successful referrals and support in accessing care. As a result of DPOs’ closer contact with health centres and local authorities, instances of discrimination are being highlighted, addressed and resolved.

Chreb Chhom, for example, whose story was featured at the start of this publication, has noticed some positive changes since the Angkor Chey DPO took up her complaints about discriminatory treatment at the health centre. ‘Last time when I went to fetch medicine, the nurses said that they wouldn’t charge me anymore. I can’t say why, but something has changed,’ she says. Channtey Heng, the Vulnerable Group Advisor for the Social Health Protection project in Kampot, also believes a shift is underway: ‘Not only are health officials, from provincial to health centre level, more knowledgeable about disability, but patients with disabilities are being welcomed and helped more than in the past.’

Joint action by complementary partners can pave the way for inclusion. The experience in Cambodia is noteworthy for the way it has brought together a diverse and complementary mix of institutions with specific roles and mandates to pursue a shared vision of greater inclusion of persons with disabilities in the health sector. The initial negotiations between the German and Cambodian governments created a strong basis for the mainstreaming efforts, and continued high-level political commitment on both sides has been an important factor throughout. Contributions from Handicap International and Epic Arts, who brought deep expertise in disability in the Cambodian context, were essential for both planning and carrying out inclusion measures of good quality. In addition, the strong commitment of the GIZ-implemented health projects, not only at the level of technical advisors, but also on the part of the project head, was crucial for pushing the focus on inclusion forward.

Key challenges

It is also instructive to look at the challenges and difficulties which have faced the Social Health Protection and Rights-Based Family Planning and Maternal Health projects as they have systematically promoted the inclusion of persons with disabilities. What lessons do their experiences hold for other countries considering such an approach?

Don't underestimate what it takes to start from scratch.

When the two technical cooperation projects introduced a cross-cutting focus on persons with disabilities into their activities, they did so against a backdrop of overwhelming need. Despite commitments on paper to fulfil the rights of persons with disabilities to health, very little was being done in concrete terms within the health system. The disability sector operated largely in parallel to mainstream development efforts. Although barriers to care for persons with disabilities were enormous, making the health system more inclusive was not initially a priority for Provincial Health Departments or for local authorities, nor did it align with the expressed concerns of persons with disabilities themselves. Inclusion of persons with disabilities was not an area where the government had approved tools or methods which could be applied: it required starting from scratch.

In introducing a focus on vulnerable groups, the teams have had to navigate a difficult tension between moving quickly and concretely (i.e. innovating measures within a time-bound framework) and proceeding more deliberately (i.e. building consensus and political ownership). An intensive sensitisation process with government partners and civil society groups was necessary to reach a shared understanding of the rights of persons with disabilities to health care and to identify areas for intervention. This process was complex and time consuming, but unavoidable if the measures to be supported were to stand a chance of sustainability. In this respect, an important lesson is that it takes significant time just to *begin* the process of fostering inclusion – to collect evidence on the issue, reach agreement with partners, identify appropriate collaborators, and integrate new approaches into a project cycle.

There are no 'quick fixes' to be had in an extremely challenging context. Equally important, it is necessary to be realistic about the time it takes, once started, to initiate changes on an issue as complex as this one. The topic of disability touches upon every aspect of the health system: applying a disability lens reveals what's not working, at every level and in every direction, from the availability of services to people's access to services to citizen participation in decision-making. While the projects' activities have led to greater awareness of disability and sensitivity to the rights of persons with disabilities, there are fundamental problems within the health system itself which defy easy answers. The lack of specialised services, the absence of referral mechanisms, and the inability to treat common impairments associated with disability (e.g. acute ear and eye care) at a decentralised level – as well as the lack of a mechanism for identifying persons with disabilities and the absence of financing schemes targeted at them – are structural challenges whose solutions fall well beyond what can be addressed through a mainstreaming approach.

This is not to suggest that the inclusion of persons with disabilities would ultimately be better served through stand-alone initiatives. Mainstreaming is a more cost-effective way to meet the specific needs of person with disabilities and, crucially, one which regards persons with disabilities as citizens with rights, just like those without disabilities. However, a mainstreaming approach implemented in the context of a specific development initiative can realistically only tackle small elements of a complex and systemic problem. Even when undertaken alongside targeted interventions aimed at empowering persons with disabilities, as was the case in Cambodia, it is necessary to be realistic about what can be achieved in a relatively short period of time.

It is also important to recognise the limits to promoting inclusion within a single sector – in this case, health – when the underlying factors which constrain persons with disabilities from utilising health services often extend well beyond the health sector. Cooperation beyond the health sector, in areas such as education and employment, might lead to greater progress or unlock new opportunities, but could be politically difficult to achieve in the Cambodian context and would extend beyond the boundaries of the projects' core work.

Building political ownership is a slow process that cannot be rushed. Upholding the rights of persons with disabilities is one of many issues facing the Royal Government of Cambodia; despite some promising signs, it is not yet a clear priority. At present, there is a risk that development partners might take on increasing responsibility for implementing programmes in support of persons with disabilities in Cambodia without securing clear commitments from government.

The experience in Cambodia shows that it is possible to catalyse momentum around inclusion of persons with disabilities by leveraging existing relationships with government partners and by joining forces with key players in the field. At the same time it is important to recognise that government counterparts feel overburdened by external demands and have to work through competing priorities. In this respect, a long-term, intersectoral commitment to promoting the inclusion of persons with disabilities which would go hand-in-hand with efforts to gradually strengthen political ownership appears a prudent strategy.

It can be cumbersome to steer the approach to inclusion in a complex development measure. The Social Health Protection and the Rights-Based Family Planning and Maternal Health projects have conscientiously pursued a focus on inclusion: each project has addressed disability issues in its core work and additional activities have been coordinated by an advisor focusing specifically on vulnerable groups. At present, responsibility for inclusion of persons with disabilities is dispersed across the teams – in other words, it has been successfully mainstreamed – and activities are being undertaken with the goal of generating mutually reinforcing results. As is often the case with mainstreaming approaches, however, it can be difficult to oversee and coordinate diverse measures as part of a common strategy. While the various elements of German Development Cooperation's portfolio in social health protection (i.e. technical and financial cooperation) offer many potential synergies when it comes to inclusion of persons with disabilities, not all of these have yet been effectively realised in practice.

Despite important gains, sustainable results can be elusive.

The Social Health Protection and Rights-Based Family Planning and Maternal Health projects kept the issue of sustainability in mind from the earliest stages. The goal was to ensure that all capacity building measures – whether the development and roll out of screening tools or the introduction of ENT services at provincial hospitals – be able to be handed over to partners to be taken forward. The results in this respect have been mixed. The collaboration with HI at provincial level is not being extended as originally envisioned, leaving a gap while national-level discussions continue about the possible integration of screening tools into the health system. While there is now interest on the part of Provincial Health Departments to continue and even expand disability screenings for children, the approach is not yet firmly enough anchored in the health system to be carried forward without external support.

Integrating screening for impairments into routine health services and establishing well-functioning referral mechanisms will require sustained efforts to build awareness of disability at provincial and national levels and to encourage multi-sectoral collaboration (between health, education and social affairs, in particular) in support of inclusion. Despite the involvement of representatives from various departments in the Ministry of Health in the technical steering committee which developed the screening tools and referral directories, it remains a major challenge to ensure the commitment of key high-level decision makers within the Ministry to adopt and implement the tools nationwide.

The experience from Cambodia suggests that generating sustainable results in such a challenging context requires a long-term commitment of personnel and resources, as well as long-term strategies and partnership agreements. Even where piloted approaches appear promising, they must be firmly rooted in the health system, something that can take several project cycles to achieve.

Looking ahead

Movement towards the greater inclusion of persons with disabilities in the health sector in Cambodia is now underway, however for further advances to be made in the years ahead, continuous support will be required.

Cambodia is one of the countries where Germany is committing long-term support for the achievement of Universal Health Coverage and where it has the opportunity to inform how the needs of vulnerable groups, including persons with disabilities, are addressed in the emerging social protection system. Working in concert, the Social Health Protection and Rights-Based Family Planning and Maternal Health projects are uniquely positioned both to promote inclusion in policy discussions at national level and to support provincial partner organisations to take concrete steps to improve access to health services for persons with disabilities.

■ Germany's continued commitment in Cambodia...

Going forward, the Social Health Protection and Rights-Based Family Planning and Maternal Health projects will continue to support a system-wide approach to promoting greater inclusion. On the 'health systems' side, the projects will work towards the goal of making health services accessible for persons with disabilities by focusing on health financing issues (i.e. advocating for HEFs to be extended to persons with disabilities) and by supporting the institutionalisation of disability screening tools, strengthening referral networks and developing referral guidelines for common impairments.

On the 'health users' side, they will work to ensure that people are aware of – and make use of – available services and benefits. This will include a new package of activities to be supported by the Rights-Based Family Planning and Maternal Health project aimed at raising awareness of sexual and reproductive health and rights among persons with disabilities, and making information about these topics in appropriate formats. Increasing understanding of disability rights will be a major theme in this area of work.

A central part of the strategy in the coming years involves building the organisational capacity of DPOs to play a more vital role in advocating for the health-related rights of persons with disabilities at a decentralised level. 'Direct engagement

with DPOs in the communities where they work is quite essential,' says Shana Dörr. 'We are working towards sustainable solutions, and DPOs are change agents for the future.' The first stage of this work is already underway and concentrates on improving the DPOs' core organisational capacities, their understanding of disability laws and rights, and their basic advocacy and lobbying skills. Later, support will turn to more health-specific issues, in order to enable DPOs to undertake awareness campaigns and to participate effectively in Health Centre Management Committee meetings and other technical meetings. The Social Health Protection project, through its Vulnerable Group Advisors at provincial level, will also support DPOs to develop strategies to expand their membership, as well as to systematically identify the needs of their members in order to be able to represent them adequately.

The project teams will continue to build practical linkages between government and civil society partners and to extend the community of actors who are committed to a more inclusive health sector. While the first phase of this work has proven that the demand for information about disability is greater than it may first appear, it has also brought into focus how much remains to be done to transform the Cambodian health system into one in which the health and wellbeing of every person does, indeed, count. Germany is well positioned to be a strong partner to the Royal Government of Cambodia in this endeavour.

■ ...and internationally

At a global level, Germany remains firmly committed to realising greater inclusion of persons with disabilities beyond the conclusion of the current BMZ Action Plan at the end of 2015 and has established itself as one of the main bilateral stakeholders promoting inclusion in development. As the German Minister for Development, Dr Gerd Müller, has said, inclusion and meaningful participation are 'marks of quality' in the work of German Development Cooperation.¹⁵ Germany's active support for the recognition and realisation of the rights of person with disabilities – its commitment to 'leave no one behind,' neither in Germany, nor internationally – will continue in the future, including through multilateral engagements aimed at ensuring that inclusion is incorporated into the post-2015 development agenda (BMZ, 2015).

¹⁵ www.bmz.de/de/presse/aktuelleMeldungen/2014/november/20141111_pm_109_Eroeffnung-des-Runden-Tischs-zur-Inklusion/index.html

Peer review

In reviewing this publication, two international experts in inclusive development concluded that the German-supported approach to fostering the inclusion of persons with disabilities in the health sector in Cambodia is a valuable experience which is worth documenting and sharing widely. In their view, the case study makes an important contribution to the still limited body of knowledge about disability-inclusive development practices in the health sector, providing disability-related organisations, development practitioners and policymakers in other contexts with an opportunity to learn from, and potentially translate aspects of, the experience in the health sector in Cambodia.

Promising aspects

The reviewers drew attention to several aspects of the approach as particularly promising.

The Social Health Protection and Rights-Based Family Planning and Maternal Health projects pursued a **flexible and practical approach** to fostering greater inclusion in the social health protection system in Cambodia. The supported interventions were informed by an underlying exploratory study and adapted continuously as implementation proceeded. Project teams demonstrated a capacity to learn from both achievements and setbacks.

The approach reflects a **deep understanding of the socio-cultural, economic and political context** of Cambodia. The decision to work in close partnership with local disability-focused organisations, and to concentrate efforts at the local, rather than central level, increased the likelihood of achieving results.

An innovative aspect of the approach is its **comprehensiveness**. By design, the approach involved many relevant stakeholders, from government counterparts to local-level civil society organisations, and stretched across three key topic areas within the health sector (i.e. governance, financing and service delivery). The supported interventions reflect a range of measures, including capacity building and advocacy at the policy level.

Meaningful linkages were built between the Social Health Protection and Rights-Based Family Planning and Maternal Health projects, enabling both inclusion and prevention of impairments to be addressed. In terms of the work in support of childhood screening, the reviewers pointed to the development and further refinement of practical screening tools, and efforts to strengthen follow-up and referral procedures, as particular strengths.

Critical observations

The reviewers also raised questions about certain aspects of the approach, including whether **more could have been done at an early stage to work more collaboratively with DPOs** at the grassroots level in the design, implementation and monitoring of inclusion-focused activities. While it may not have been possible to achieve within the constraints of cost and programme timelines, a slower and more deliberate approach to working with DPOs to build their understanding of the connection between health and income generation, at the individual and household level, might have helped them to assume greater ownership of advocacy efforts on behalf of persons with disabilities.

Box 10. Publication process of the German Health Practice Collection

In response to annual calls for proposals, experts working in GDC-supported initiatives propose projects that they regard as good or promising practice to the Managing Editor of the GHPC at ghpc@giz.de. All proposals are then posted on the [Collection's website](#) to allow GDC experts and the interested public to compare, assess and rate them. The proposals are also discussed in various technical fora in which German experts participate.

Informed by this initial peer assessment, an editorial board of GDC experts and BMZ officers select those they deem most worthy of publication. Professional writers then make on-site visits to collect information, working closely with the local partners and GDC personnel who jointly implement the selected projects.

Each report is submitted in draft form to independent peer reviewers who are acknowledged internationally as scholars or practitioners. The reviewers assess the broader relevance of the described case study, comment upon its strengths and weaknesses, and advise whether the documented approach is worth sharing with a larger audience.

Questions were also raised about the extent to which the projects have tried to engage with **other aspects of social protection** (e.g. work, livelihoods) which fall outside the health sector, but which are essential for supporting the inclusion of persons with disabilities.

The reviewers also noted that, in the future, the approach might benefit from greater attention to **gender** (e.g. tracking and addressing sex-based disparities among children with impairments in their access to services) and to issues of **confidentiality** when targeting persons with disabilities for particular benefits.

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References

- Astbury J and Walji F (2013). *Triple jeopardy: Gender-based violence and human rights violations experienced by women with disabilities in Cambodia*. AusAid Research Working Paper No. 1. Phnom Penh: Australian Agency for International Development.
- BMZ (2013). *Action Plan for the Inclusion of Persons with Disabilities (2013-2015)*. Bonn and Berlin: Federal Ministry for Economic Cooperation and Development.
- BMZ (2015). *Midterm report on the Action Plan for the Inclusion of Persons with Disabilities*. BMZ Strategy Paper 3. Berlin: Federal Ministry for Economic Cooperation and Development.
- Carter J (2009). *Preparing for the journey: A cooperative approach to service provision for children with intellectual disabilities in Cambodia*. Phnom Penh: UNICEF.
- Cooperation Committee for Cambodia (2006). *The challenge of living with disability in rural Cambodia: A study of mobility impaired people in the social setting of Prey Veng District, Prey Veng Province*. Phnom Penh: Analyzing Development Issues, Cooperation Committee for Cambodia.
- Cordier S (2014). Caring for people with intellectual disabilities in poor rural communities in Cambodia: Experience from ADD International. *Gender and Development*, **22**(3):549-561.
- De Mey P (2014). *MCH Inclusive Health Care Project. Evaluation*. Phnom Penh: Inddec.
- Disability Rights Initiative Cambodia (n.d.). *Joint Programme Document*. Phnom Penh: United Nations and Kingdom of Cambodia.
- Evans P et al. (2014). A population-based study on the prevalence of impairment and disability among young Cambodian children. *Disability, CBR and Inclusive Development*, **25**(2): 5-20.
- Gartrell A (2010). 'A frog in a well': The exclusion of disabled people from work in Cambodia. *Disability and Society*, **25**(3): 289-301.
- GIZ (2013). *Health systems governance. Empowering communities' voices – promoting the right to health*. Phnom Penh: Deutsche Gesellschaft für Internationale Zusammenarbeit.
- Handicap International (2013). *KAP baseline survey and focus group results. Kampong Thom/Kampot*. Phnom Penh: Handicap International and Deutsche Gesellschaft für Internationale Zusammenarbeit.
- Handicap International (2014). *Individual case studies: Experience of referral pathways in Handicap International Mother and Child Health Program, Kampong Thom, Cambodia*. Phnom Penh: Handicap International.
- Jacobs B et al. (2014). *Toward universal health coverage: The Cambodian experience formulating a health financing policy*. Phnom Penh: Deutsche Gesellschaft für Internationale Zusammenarbeit.
- McLaughlin D and Wickeri E (2012). *Special report: Mental health and human rights in Cambodia*. New York: Leitner Center for International Law and Justice, Fordham Law School.
- National Institute of Statistics (2010). *Cambodia socio-economic survey 2009*. Phnom Penh: Ministry of Planning.
- National Institute of Statistics (2013). *Cambodia inter-censal population survey 2013. Final report*. Phnom Penh: Ministry of Planning.

National Institute of Statistics and ICF Macro (2011). *Cambodia demographic and health survey 2010*. Phnom Penh, Cambodia and Calverton, Maryland, USA: National Institute of Statistics, Directorate General for Health, and ICF Macro.

Noy I and Sang H (2012). *Determinants of non-utilisation of public health services among poor households covered by a social protection scheme*. Phnom Penh: Deutsche Gesellschaft für Internationale Zusammenarbeit.

Oveson J and Trankell I (2010). *Cambodians and their doctors: A medical anthropology of colonial and post-colonial Cambodia*. Copenhagen: NIAS Press.

Platt A (2010). *Healthcare for vulnerable groups in Cambodia. Report of a study to prepare the integration of vulnerable groups, specifically the elderly and people with disability, into the Social Health Protection Programme (SHPP) in Cambodia*. Phnom Penh: HelpAge International/Deutsche Gesellschaft für Technische Zusammenarbeit.

Plummer J and Tritt G (eds). (2012). *Voice, choice and decision: A study of local governance processes in Cambodia*. Washington, DC and San Francisco: The World Bank and The Asia Foundation.

Thomas P (2005). *Poverty reduction and development in Cambodia: Enabling disabled people to play a role*. Disability Knowledge and Research. London: Department for International Development.

UNDP (2014). *Human development report 2014. Sustaining human progress: Reducing vulnerabilities and building resilience*. New York: United Nations Development Programme.

UNICEF (2013). *The state of the world's children. Children with disabilities*. New York: UNICEF.

United Nations (2013). *World population prospects: The 2012 Revision. Key findings and advance tables*. New York: United Nations.

World Bank (2013). *Where have all the poor gone? Cambodia poverty assessment 2013*. Washington, DC: The World Bank.

World Health Organization (2011). *World report on disability*. Geneva and Washington, DC: World Health Organization and The World Bank.

World Health Organization (2012). *Early childhood development and disability: A discussion paper*. Geneva: World Health Organization.

World Health Organization (2014). *World health statistics*. Geneva: World Health Organization.

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