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WOMEN WITH DISABILITIES ACCESS TO SERVICES: A QUALITATIVE STUDY

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Disclaimer

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I hope that this research and its findings contribute to strengthening your power as women with disabilities to make decisions, to access the services you are entitled to when you wish. I hope that service providers, program designers and policy makers learn from these women's stories and in turn, you know how to support them and their households even better.

Dr Alexandra Gartrell

List of Acronyms

ADD	Action on Disability and Development
CDPO	Cambodian Disabled People's Organisation
DAC	Disability Action Council
DoSS	District Office for Social Services
DWPWD	Department of Welfare for Persons with Disabilities
GBV	Gender-based violence
MoEYS	Ministry of Education, Youth and Sport
MoWA	Ministry of Women's Affairs
NAPVAW	National Action Plan to Prevent Violence Against Women
NDSP	National Disability Strategic Plan
NGO	Non-government organisation
OPDs	Organisations of Persons with Disabilities
PAfID	People's Action for Inclusive Development
PDAC	Provincial Disability Action Council
PoSVY	Provincial Social Affairs, Veterans and Youth
RGC	Royal Government of Cambodia
PRC	Provincial Rehabilitation Centre
PWDF	Persons with Disabilities Foundation
UN	United Nations
UN CRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDESA	United Nations Department for Economic and Social Affairs
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

This study investigated women with disabilities access to provincial rehabilitation centre-based (PRC) services in Cambodia. Findings demonstrate that when women with disabilities have an enabling home and community environment where practical, emotional and financial supports are available to her, she is able to access PRC services when she requires. Women with disabilities in this study identified individual and structural barriers to access PRC services. They suggested that low self-confidence, isolation at home and poor health literacy can be addressed by investment in women with disabilities networks and organisations of disabled persons (OPDs) as hubs of information, emotional and practical support and advocacy that are well networked with local authorities, Provincial Office for Social Affairs, Veterans and Youth (PoSVY), Provincial Disability Action Councils (PDAC) and District Offices for Social Services. At the systems level, development of PRC focal points within Commune, District and Provincial health care systems would strengthen referral pathways and access to rehabilitation services. Ongoing commitment, resource allocation and professional development of the rehabilitation workforce is also required to ensure the consistent provision of quality, user-centred, free rehabilitation services into the future.

Access to appropriate rehabilitation services and assistive devices is a pre-condition to inclusion. International evidence shows that 1 in 3 (2.41 billion) people globally have conditions that would benefit from rehabilitation and yet there are less than 10 skilled rehabilitation practitioners per million persons in low- and middle-income countries (Cieza et al, 2021). Consequently, it is estimated that only 5-15 per cent of people in need of assistive devices have received them (ibid). It is also well recognised that women with disabilities have considerably lower attendance at rehabilitation centres than men (Barth et al, 2020). COVID-19 lockdowns, movement restrictions and social distancing measures have added additional barriers to accessing support services, particularly for women with disabilities. Further investigation into the accessibility of rehabilitation services for women and girls with disabilities is needed.

Methodology

This study has taken a positive deviance approach to investigate the factors that support women with disabilities to access rehabilitation services. Qualitative research methods – in-depth semi-structure interviews - have been conducted in three provinces: Kompong Speu, Kompong Cham and Siem Reap. Six provincial women with disabilities (two in each province) were supported by and trained in qualitative research methods by the People's Action for Inclusive Development (PAfID) research team (made up of the Lead Researcher and two female staff members with disabilities). In pairs provincial women with disabilities conducted a total of 29 interviews with women with disabilities who were between 16 and 65 years of age. This report presents the key issues and factors that shaped their access to rehabilitation services. Based upon these findings, recommendations have been identified to strengthen women with disabilities access to PRC services.

Participant demographics

Most women in this study were between 21 and 39 years of age (40 per cent), have never married (48 per cent) and were living with immediate family members. Just over a third (34 per cent) have never been to school and primary school was their highest level of education for a quarter of women (24 per cent). Just over half (52 per cent) did not work for money in the seven days prior to interview which explains why they reported a lower standard of living than others. The majority (19 of 29) of women have mobility impairments, followed by women who experience difficulties remembering and concentrating (11 of 29), difficulties communicating (10 of 29) and difficulties with self-care (2 of 29).

Women with disabilities in this study are well connected socially with most women (24 of 29) reporting being friends with women and girls. Less women with disabilities reported being friends with other women and girls with disabilities (20 of 29). Most women with disabilities require a support person - typically their mothers, husbands or their own children to socialise with their friends.

Key findings

Women with disabilities in this study identified individual and structural level barriers to accessing services, most importantly low self-confidence (25.7 per cent), financial barriers (42.8 per cent) (lack of transport [25.7 per cent] and no money to pay for transport [17.1 per cent]) and lack of support persons (17.1 per cent). Women with disabilities low self-confidence is a consequence of negative gendered socio-cultural attitudes, discrimination and social stigma towards disability, low levels of education and engagement in paid work plus almost half have never married – a key cultural marker of status in a woman's life. Women with disabilities described how important being encouraged and motivated by their families is to their self-confidence and bravery, both qualities they considered important to seeking services.

In the absence of having their own source of income, most women with disabilities – more than half the women in this study - have to ask their parents or husband or older siblings for support with money and transport, and to accompany them to the PRC. These significant others were not always available and often women had to wait before they were able to access the services they required. Service provision itself may take several days during which women need to remain at the centre, organise others to take on childcare and other domestic responsibilities they may have. This gender-specific barrier is poorly examined in the research literature reviewed as part of this study, and needs greater consideration by the PRC themselves and in social protection, health and rehabilitation service provision and policy.

Women with disabilities employment patterns and high levels of unpaid work increases their risk of poverty which in turns increases financial barriers to, and the affordability of rehabilitation services. Although the Royal Government of Cambodia (RGC) is committed to free health and rehabilitation services for all persons with disabilities, indirect expenditures related to transport, food and accommodation continue to represent barriers for some persons with disabilities to access services. Rehabilitation services are being provided free of charge in 11 PRCs, with previous experiment of sliding fee currently halted following a letter issued by the Persons with Disabilities Foundation (PWDF). The principle of free service provision will not change until a formal legal

document is issued by the RGC. Despite these policies and commitments, they are not uniformly applied or known about by service users and providers.[1] Moreover, in the context of transition of the funding and management of some PRCs from NGO/IOs to RGC, different systems of cost reimbursement for transport, meal and accommodation are applied that may be relatively far from the real expense incurred by the client.[2]. Consequently, women with disabilities in this study encountered financial barriers to services and requested these financial supports continue, including for the repair of their devices.

Effective rehabilitation supports women with disabilities to maximise their wellbeing and participation in all areas of life. Women with disabilities have multiple needs that extend beyond physical rehabilitation and includes psychosocial, mental health, education, skills and employment training as well as access to information. Rehabilitation services with a wholistic approach to addressing women with disabilities physical, social and economic needs are required. Such an approach would strengthen service users demand for PRCs as a service and social hub that positively enhances their wellbeing, socio-economic participation and inclusion as well as networks them with organisations of persons with disabilities, particularly women's networks.

Women with disabilities were happy with the services that they received and described PRC staff as attentive, friendly and kind. The one woman who was not happy with the service she received raised an important point that was echoed by key informants –the need for service providers to build trust and rapport with service users so that they feel confident enough to self-advocate and return home with well fitted, comfortable and pain free assistive devices. Rehabilitation professionals and workforce development needs to ensure individualised rehabilitative services that are user-centred; a one size fits all approach is inappropriate.

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1. The Ministry of Health is committed to provide free health care services for persons with disabilities as stated in the latest legal document dated 19 Nov 2015 and signed by His Excellency Morm Bunheng. All 11 PRCs provide free of charge services although there is not legal framework.
2. The 5 PRCs under PWDF provide transportation reimbursement of 10,000 riels (to cover a return trip) and 3,000 riels/day/person. For other PRCs under IO/NGOs support they also provide top-up for transport and meal to keep the reimbursement as close as possible to the real expenses.

Cost-sharing arrangements need to continue to be piloted by the RGC, international donors and other stakeholders to address ongoing resourcing challenges. Ultimately however, the perception that rehabilitation is a disability-specific service only required by a few is counter to current evidence which shows that at least one in three people worldwide need rehabilitation at some point in their illness or injury (Cieza et al 2021). As the women with disabilities in this study and global evidence recommends, rehabilitation services need to be brought close to communities as an integral part of primary health care to make services much more accessible, available and affordable to those who need them.

Recommendations

To improve the availability of quality, coordinated, affordable and user-centred rehabilitation services the following actions are recommended:

Individual-level supports to build self-confidence, support and access to information

1 – **Strengthen networks of women with disabilities, their organisations and OPDs:** One of the biggest barriers women with disabilities identified in this study was their own lack of confidence to seek services. Women with disabilities are best supported emotionally and practically by other women with disabilities and would benefit from being better connected to networks of women with disabilities.

2 – **Increase access to information on PRC services and disability rights:** Women with disabilities would like to receive more specific information about PRC services and have suggested that this be provided through the networks of women with disabilities and community outreach services. Women were not well informed about services, including costs, and how particular services such as physiotherapy, could address their needs. Information needs to be shared in multiple formats such as infographics, brochures, posters, captioned videos on social media, radio, community outreach and face -to-face at health centres.

3 – **Invest in self-advocacy and empowerment programs for women with disabilities:** Directing support to strengthen women with disabilities as pro-active self-advocates and service-users who know their rights and are readily able to access the information

they need will strengthen their access to services. Women in this study spoke about being too scared to seek services and needing to be courageous and brave in order to do so. Already empowered and confident women with disabilities themselves are best placed to provide such support to yet to be empowered women so that they are best able to negotiate household, community and other barriers to services.

4 – Strengthen women with disabilities health literacy

Women with disabilities require access to information about PRC services, including the types of services offered and women's own needs as service users. Strengthening women's health literacy would mean that women with disabilities know where to go and what they can expect when they seek services.

Family and local-level stakeholders supported to build non-discriminatory attitudes

1 – Engage families of women with disabilities in disability awareness and advocacy:

Families including parents, siblings, husbands and children are critical stakeholders and facilitators of women's access to services. Their support is critical to women being able to access the practical, financial and transport that they require to be able to get to PRCs. To promote non-discrimination at the household and community level awareness raising and behaviour change programs for them, as well as Local Authorities and other locally-based stakeholders - Health Care providers - is essential. These are best delivered by women with disabilities/OPDs themselves.

Rehabilitation, health and social protection system-level supports that deliver access

1 – Comprehensive and consistent delivery of free rehabilitation services:

All rehabilitation and health care service providers are responsible for implementing RGC commitments to free health care services for persons with disabilities as stated in the NDSP II and the UN CRPD. Ongoing RGC commitment to adequately funding the PRCs, workforce development and performance management is required to translate this commitment into practice. Placing PRCs within the health portfolio and under the Health Insurance Scheme would be one way to deliver free services.

2 – Invest in mobile outreach services at the Commune/District level:
Women with disabilities want services that are locally available, easy to access and require minimal transport expenses. The few women in this study who had previously experienced outreach services valued being able to address their needs locally. Community-based rehabilitation initiatives financed through Commune Development and Investment Plans need to be actioned.

3 – Strengthen referral pathways between health and rehabilitation services:
Streamline referral and entry points to PRC services is required by those with pre-existing and newly acquired injuries and impairments at Commune, District and Provincial levels. Ideally, rehabilitation services are integrated, prioritised and resourced from within the health system.

4 – Strengthen the rehabilitation workforce capacity:
Ongoing professional development in all rehabilitation services including prosthetics and orthotics, physio and occupational therapists, counsellors, mental health and beyond is required to ensure ongoing quality of services (Cambodian Association of Prosthetist and Orthotics, and the Cambodian Physical Therapy Association).

5 – Strengthen PRC's links to psychosocial, economic and social supports:
Effective rehabilitation includes the provision of devices and physical therapies as well as counselling, employment and training, emotional and psychosocial support, and networking with ongoing sources of support, including those provided by women with disabilities networks and OPDs. PRC's can play a role as an inclusion hub.

6 – Social Protection Policy and cash payment system builds independence:
The newly established COVID-19 recovery cash payment system needs to be paid directly to persons with disabilities. Barriers to persons with disabilities financial literacy and access to banking systems, including WINGS and other cash transfer systems, need to be removed to ensure persons with disabilities are able to independently use these services and to directly access benefit systems without third party involvement.

SECTION 1: INTRODUCTION

It is well recognized that worldwide women and girls with disabilities experience gender, disability and poverty related stigma, discrimination and multiple compound disadvantages (UN ESCAP 2018; UN Women 2017; WHO & WB, 2011). Compared to men with disabilities, women with disabilities in the Asia Pacific region are:

- two times more likely to be poor;
- two times more likely to not have nutritious and sufficient food;
- three times more likely to have unmet needs for health care;
- three times more likely to be illiterate;
- two times less likely to be employed, and
- two times less likely to use the Internet (UN ESCAP, 2018:117).

Despite these heightened risks and vulnerabilities, women and girls with disabilities have poor access to basic, let alone specialist health and social services, including rehabilitation services. Women and girls with disabilities are often invisible in national policies and programs, and their needs and perspective are inconsistently included in national gender and disability coordination mechanisms (ibid:278). Many countries continue to address gender and disability issues separately with little consideration for the intersections between them. Consequently, women and girls with disabilities miss out on the support that access to quality services and programs would offer them. This research aims to identify locally driven strategies to bridge gaps in access to services for women with disabilities, and between gender and disability service sectors and issues.

Background

The Australia Government's ACCESS program is a five years initiative that seeks to improve the sustainability, quality and inclusiveness of services for persons with disability and women affected by gender-based violence (GBV) whilst building greater integration between the gender and disability sectors in Cambodia. To do so, ACCESS provides direct technical assistance to the Royal Government of Cambodia to support the implementation of the National Disability Strategy Plan (NDSP) and the National Action Plan to Prevent Violence Against Women (NAPVAW). ACCESS works directly with the Ministry of Women's Affairs (MoWA), the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY), including its Department of Welfare for Persons with Disabilities (DWPWD) and the Persons with Disabilities Foundation (PWDF), the Disability Action Council – Secretariat General and the Ministry of Economy and Finance. The Program also works closely–with 14 implementing partners across the gender-based violence and disability sectors.

During the first two years of ACCESS program implementation, it was identified that women and girls with disabilities face specific barriers to access disability-specific rehabilitation services. This qualitative research project aims to examine these barriers from the perspectives of women with disabilities and service providers, and to identify the necessary changes that they consider will improve their access to, and ability to provide quality and accessible services respectively.

Research aim and objectives

This research seeks to understand, and in turn redress women and girls with disabilities poor access to disability-specific rehabilitation services, including the identification of barriers particular to the COVID-19 pandemic. To do so, this research asks three specific questions:

1 – What factors prevent and facilitate women with disabilities access to disability-specific PRC services?

2 – What factors prevent and facilitate the provision of accessible and inclusive services that respond to the needs of women with disabilities?

3 – What solutions/strategies do women with disabilities and service providers identify as critical to strengthening the receipt of accessible, quality services?

This research provides practical recommendations to strengthen the preconditions of inclusion, remove barriers and support women with disabilities receipt of, and service provider capacity to provide accessible and inclusive services. Study findings will be shared with women with disabilities and their representative organisations (Women with Disabilities Forums and OPDs), Royal Government Cambodia Ministries, in particular ACCESS's Ministerial partners, implementing NGO partners and UN organisations to inform program planning and implementation for the remaining life of the program.

This study focused on access to physical rehabilitation services provided by Provincial Rehabilitation Centres (PRCs). These include:

- Assistive device provision: prosthesis, orthosis, wheelchair, crutches
- Physiotherapy
- Social counselling
- Outreach

Conceptual Approach

A rights-based approach informed by social model of disability underpins the conceptual framework of this study. We adopt the UN CRPD broad definition of disability as an interaction between impairment and barriers in physical and social environments and institutions, and the principle of accessibility as foundational to women with disabilities being able to claim their rights. In practice this means that women with disabilities immediate environment (household, family and community) as well as the societal and service sector context are be critically examined to identify barriers and facilitators of access to services.

An inclusive and participatory research approach that is grounded in women with disabilities, service providers and stakeholder experiences is used in this research. We adopt a critical interpretative socio-structural perspective where lived experiences and the multiple meanings attached to them are situated within the cultural, economic and political context of Cambodia. In-country program experience, national and

international research and evidence base also inform this research. In this research we seek to contribute to, and deepen current knowledge, service system and institutional practices to the benefit of women with disabilities, their representative organisations, households and communities.

We draw on the principles of co-design and participatory research processes that are locally led and culturally appropriate. This project aimed to empower and maximise women with disabilities voice and agency. Women with disabilities themselves have been trained and supported to collect women's stories that capture their lived experiences, and the solutions and supports that they consider most important to increasing their access to services. This study recognizes that women with different types of impairments, household situations including the availability of formal and informal sources of support, education, and employment profiles as well as marital status, experience different barriers and stigmas. Women with disabilities were purposively sampled to maximise the diversity of voices captured and to identify the full spectrum of barriers experienced by women with different impairments.

A positive deviance approach has been utilized where successful behaviours and strategies that enable some women to better access the services that they need were critically examined. This approach has allowed identification of success factors and explored the potential to scale these.

Story telling approaches has been utilized to ensure that research methods are accessible to women with a diversity of impairments. The interview process was deliberately kept simple to ensure ease of the data collection process for Provincial Focal Point women with disabilities (see below).

Guiding principles

This research is guided by the following principles:

- Women with disabilities are supported as leaders through the use of an inclusive partnership approach.
- Women with disabilities agency and voice are strengthened through the research process as well as its findings.
- Women with disabilities diverse experiences are represented.
- Women with disabilities benefit from being involved in this research project.

Literature review

The World Bank (2020) estimates that the economic impacts of COVID-19 in Cambodia will see an increase in poverty from 3 to 11 per cent as the key growth sectors of tourism and the garment industry slowdown and 1.7 million jobs are at risk. Groups that were already amongst the poorest are the most severely impacted by the downturn – persons with disabilities, particularly women and female headed households. Women with disabilities face greater risk of contracting COVID-19, are more vulnerable to gender-based violence and are the least likely to access the formal and informal supports that they need, including rehabilitation and other services and public health information about protective measures for COVID-19 (Australian Aid, ACCESS and Cowater International, 2021).

Globally, women with disabilities face compound barriers to health and other services and experience higher rates of not receiving the services that they need when compared to people without disabilities (Van der Heijden 2020, UNESCAP 2018; WHO & WB, 2011). In general terms women with disabilities face four types of barriers to services that playout in specific ways when women with disabilities seek services, including rehabilitation services. The four barriers are:

1 – **Environmental barriers:** lack of accessibility in physical environments;
2 – **Attitudinal barriers:** negative attitudes, discrimination and stigma;
3 – **Institutional barriers:** discriminatory laws and policies, lack of access to assistive technology and to rehabilitation, and lack of measures to promote the independent living of persons with disabilities, and
4 – **Communication barriers:** inaccessible information and communication including digital technology and other communication systems (UN ESCACP 2018:18).

Barriers to disability support services are greater in lower middle-income countries such as Cambodia. Current evidence on access to services in Cambodia identifies a range of barriers from cost of transportation, to distance and lack of support persons to accompany women with disabilities when they wish to seek services. Many women with disabilities are not aware of services and programs, and therefore do not access services, resulting in a high level of unmet need and increased risk of ill-health (Astbury and Walji,

2013). Evidence suggests that many women with disabilities have little voice, power and agency within their households which curtails the extent to which they are able to ask for support to address their needs; draw upon household resources such as financial and practical support to access services; self-advocate, and actively make choices and decisions that shape their lives (Gartrell 2017, Astbury and Walji 2013).

With COVID-19 mobility has been even more limited, as have financial resources whilst communication difficulties with service providers and poor access to information are ongoing challenges (DFAT, ACCESS and Cowater International, 2021:1). Restrictions on travel and social gathering has seen a reduction in the number of persons with disabilities receiving services from six Provincial Rehabilitation Centres (PRCs) (DFAT, ACCESS and Cowater International, 2021). In 2020, the number of clients receiving services dropped to 65 per cent of 2019 levels.[3] PRC clients cited the main barriers as distance, travel costs and absence of someone to accompany the individual to the PRC (ibid:10).

There are however, women with disabilities who have continued to access services and secure the support they need. It is to these women – positive deviant cases – we have turned to learn the strategies and identify the supports that they successfully use, and in turn share these with other women so that they too can apply them in their own lives.

Rehabilitation services: a pre-condition to inclusion

Rehabilitation is a broad term that encompasses a set of interventions to address impairments—activity limitations, and participation restrictions, as well as personal and environmental factors that have an impact on functioning. Rehabilitation services seek to optimize the functioning of people with impairments (Bright et al, 2018), and services include physiotherapy, occupational therapy, speech therapy and hearing therapy. The WHO define rehabilitation as a:

[3] In 2020, the total number of persons receiving PRC services was 6,567 (1,830 female) or 28 per cent of clients.

"set of measures that assist individuals who experience or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments" (WHO & World Bank, 2011).

Rehabilitation encompasses a broad range of therapeutic measures. These include provision of assistive technologies and devices, but also exercise, training, education, support and counselling, and adaptation of the environment to eliminate barriers. Information and communication technologies (ICTs) are increasingly integral parts of rehabilitation programmes and in the development of assistive technologies (HI and Global Rehabilitation Alliance (2019).

Access to assistive technology is a human right, and a pre-condition for equal opportunities and participation. Rehabilitation is part of universal health coverage,[4] and is a precondition for a full and productive life for persons with disabilities because one's health and well-being affect one's ability to participate fully in work, in education and in the community. (UNDESA 2018:47-8). Rehabilitation is person-centred and supports individuals in achieving their full potential by focusing on a person's abilities rather than limitations which benefits them, and also their families, communities and economies (HI & Global Rehabilitation Alliance, 2019:4). An estimated 2.5 billion people would benefit from an assistive product in their day-to-day lives:

"Assistive products can enhance performance in all key functional domains such as cognition, communication, hearing, mobility, self-care and vision. They may be physical products such as wheelchairs, spectacles, hearing aids, prostheses, orthoses, walking devices or continence pads; or they may be digital and come in the form of software and apps that support communication, time management, monitoring, etc. They may also be adaptations to the physical environment, for example ramps or grab-rails" (WHO & UNICEF 2022: xi).

While the need for rehabilitation services is rising, the majority of people who would benefit from them do not have sufficient access (ibid). Unmet need for rehabilitation constitutes a failure to uphold the human right to health and wellbeing. Global data on

[4] Universal Health Coverage (UHC) is defined as, "ensuring all people have access to needed promotive, preventive, curative, rehabilitative, and palliative services they need, of sufficient quality to be effective, while ensuring that the use of these services does not expose the user to financial hardship" (Bright et al, 2018)

unmet need for rehabilitation services is extremely sparse (WHO & World Bank, 2011). Evidence on access to rehabilitation services for people with disabilities in low- and middle-income countries is limited, however what is available demonstrates that rehabilitation services are not always available for persons with disabilities who need them (UN 2018; Bright et al, 2018). In many low to middle income countries 5–15 per cent of people with disabilities have access to assistive devices and there is likely to be very limited capacity to meet demand for these services (WHO, 2018). The WHO estimates that there are less than ten skilled rehabilitation practitioners per 1 million population in low to middle income countries (ibid).

The RGC is committed to the provision of free services as stated in the Disability Law. However, some rehabilitation centres are still mostly financed by international development partners and are thus financially unsustainable. Budget allocation to disability continue to be low. The MoSVY's average annual budget (2019-2022) for disability related interventions was just 0.99 per cent of its total budget or nearly 20 per cent of its non-personnel budget excluding social protection benefits for retired public servants and veterans [5] (ACCESS 2022). Ministerial budget allocation for disability from other Line Ministries is difficult to track in the absence of specific budget lines; however, MOWA and MOEYS allocated respectively average 0.70 per cent and 0.76 per cent of their respective non-personnel budget for disability over the past four years. MOSVY allocated around 0.20 per cent of its non-personnel budget excluding social protection benefits for retired public servants and veterans for GBV activities (trainings on positive parenting and safe migration) in 2019, and further downward to 0.09 per cent in 2020, 0.06% in 2021 and none in 2022 [6] (ibid). There are no women with disability specific

[5] It should be noted that personnel spending is not spread across programs of MoSVY (and also other ministries), and that of the total MoSVY budget, a very high proportion (nearly 90 per cent) is for social protection benefits to retired civil servants and veterans. Therefore, it would be more sensible to present the disability budget as a share of MoSVY's non-personnel budget excluding the two social protection programs.

[6] The RGC revised the originally approved 2020 Budget Law as part of its measures to focus on the key priorities in response to COVID-19 pandemic, resulting in reductions of up to 50% in recurrent expenditures (covering trainings, meeting, campaign, mission, etc.). The preparation of the 2021 budget was strongly influenced by such downward revisions of the 2020 budget, and so was the 2022 budget.

legal, advocacy, shelter or other support services for GBV and mainstream services lack the appropriate knowledge and tools to adequately provide accessible and inclusive services to them (Astbury and Walji, 2013). A range of service guidelines and standards including the formulation of Minimum Package of Services for Provincial Rehabilitation Centre's (PRCs) have been adopted by the RGC.

Ongoing training and professional development in all areas of rehabilitation from physiotherapy to occupational therapists requires ongoing investment to ensure quality services are consistently provided and is notably missing from data on public health sector staff spending (2014 - 2018) (ibid:78). The absence of expenditure into staff development in these areas demonstrates the point noted in the Plan that the delivery of health services remains unresponsive to health problems caused by non-communicable and chronic diseases, mental illness and other public health problems (ibid:80). Within the Plan disability is added under the National Policy on Social Protection Framework 2016-2025 where it is noted that access to health care services has improved as financial barriers have been reduced through the ID poor card and Equity Fund program.

Barriers to rehabilitation services

Summary points: Barriers' women with disabilities face to accessing services

Well document barriers to disability specific and gender-based violence services include:

1 - **Physical barriers:** Such as lack of ramps and accessible transport, distance, cost.

2 - **Attitudinal barriers in community and family:** Negative attitudes of health staff, limited access to support person to accompany them, and domestic workloads.

3 - **Communication barriers:** Women with disabilities are not aware of programs and therefore do not access services and resources; lack of information about services and service providers have limited capacity to communicate using mixed formats.

Persons with disabilities consistently have a poorer uptake of both general and specialized health-care services when they are needed (UNDESA, 2018). They experience multiple barriers that relate to three broad factors: individual level factors; health care provider capacity and skills, and rehabilitation and health care systems. A review of literature on women with disabilities access to rehabilitation services has been conducted and commonly reported barriers include:

- **Knowledge and attitudinal factors** including perceived need, fear, lack of awareness about the service and overall low health literacy (Bright et al, 2018);
- **Individual barriers** related to age, gender, type and extent of functional difficulty, living environment and socio-economic status (WHO & UNICEF, 2022).
- **Logistical factors** such as distance to service, lack or cost of transport (Bright et al, 2018);
- **Financial factors** including inability to pay for services, treatment and associated costs, including transport that relate to poverty and unemployment (Matin et al 2021; UN 2018). Many studies cited that women with disabilities experience financial problems when accessing healthcare. In some cases, women with disabilities who were married, usually relied on their family income and reported better access to different financial resources in comparison to single women with disabilities. (Matin et al 2021);
- **Socio-cultural barriers** that are rooted in negative attitudes and assumptions about disability, play out in health and rehabilitation settings: erroneous assumptions, being ignored, judged, violence, abuse, insult and impoliteness (Matin et al 2021; Gartrell et al 2017);
- **Capacity gaps in rehabilitation and assistive technology workforce** including low level of skills, knowledge and capacity and communication skills and low profile of the sector itself (WHO & UNICEF, 2022, Jesus et al. 2017);
- **Lack of services** including inadequate product quality, range and quantity, and procurement and supply chain challenges (WHO & UNICEF, 2022);

- **Structural factors** including lack of insurance coverage, inaccessible equipment and transportation facilities, lack of knowledge, lack of information, lack of transparency, and communicative problems (Matin et al 2021).

To provide a clear and user-friendly way of categorising barriers, sorting them according to abilities from the perspective of the service user is helpful, see Figure 1 (Levesque et al, 2013). Access to health care, in this case to rehabilitation services is defined as the opportunity to have rehabilitation needs fulfilled. Figure 2 provides examples of the personal and structural barriers that are examples of each of the five dimensions.

Figure 1: Dimensions of Access to Rehabilitation Services

Dimension	Ability	Factors included
Approachability	Ability to perceive	People's ability to identify existing healthcare services
Acceptability	Ability to reach	Relates to cultural and social aspects that affect access to services like gender, beliefs, education, and race
Availability	Ability to seek	Whether or not services are available in the place and at the time that they are needed
Affordability	Ability to pay	Financial capacity for people to spend resources and time to use appropriate services
Appropriateness	Ability to engage	Degree of fit between services and clients' needs, its timeliness, the amount of care and the quality of the services provided

Figure 2: Personal and Structural barriers to services based on 5 Dimensions

Dimension	Personal barriers	Structural factors
Approachability	*Difficulty to use available information *Limited knowledge	*Lack of the needed information *Lack of transparency within service *Limited/poor knowledge *Lack of or negative experience *Using unfamiliar biomedical jargon

Acceptability	*Lack of autonomy *Distrust *Physical discomfort *Social isolation *Cognitive deficits *Past negative experiences *Stress and anxiety *Embarrassment *Feeling of pain and being tortured	*Insufficient social supports *Erroneous assumptions *Negative attitudes *Stigma *Discriminatory attitudes *Being judge *Being ignored *Reluctance to provide care *Violence or abuse *Verbal, physical and sexual abuse *Impoliteness/rudeness *Insult
Availability	N/A	*Inaccessible equipment and accommodations *Transportation *Lack of Internet access *Physical access *Lack of practice guides *Lack of assistive devices *Lack of consultation and/or notification
Affordability	*Unaffordability to pay *Poverty *Financial dependence *High transportation costs *Being single	*Insurance reimbursement *Lack of insurance coverage *Social protection schemes to provide free services
Appropriateness	*Communicative problems *Low health literacy	*Disconnected services *Lack of communicative tools in service setting *Lack of skills and trainings among providers

Supports to improve access to rehabilitation services

The research literature identifies a range of initiatives that different countries have taken to improve access to rehabilitation and health services more generally. The WHO recommends that rehabilitation services be integrated into health systems at all levels to maximise access, coordination, referral pathways and information sharing (Bright et al, 2018).

Many countries have taken steps to improve accessibility in terms of infrastructure and communication formats, such as using mixed modalities: radio services, closed captioning, easy-to-read format, sign languages and braille/audio formats (UNDESA 2018). Involvement of persons with disabilities and their organisations in the planning of health care services and dissemination of health information through training of persons with disabilities and peer support are also identified as strategies to support greater access to services. Increased access to information means that persons with disabilities are better prepared, aware and informed to make decisions about their own health and of the services they can benefit from (ibid). Improving health literacy through better access to information in appropriate formats is a critical step to increase service access.

Telemedicine and the use of mobile technology is a growing area in the provision of rehabilitation and may help overcome the geographical barriers commonly reported in the literature. In Kenya, for example, smartphone-based assistive technologies have been tested for students with visual impairment with positive impact on access to education, and participation in everyday life. A smartphone-based educational intervention for people with physical impairments following stroke in India (Sureshkumar et al., 2015). The delivery of services at or close to home, text-message reminders, and vouchers may be beneficial for improving access to services, but more evidence is needed on "what works" to improve access for people with disabilities (Bright et al, 2018).

Impact of COVID-19 on Women with Disabilities

Women are bearing the brunt of measures to respond to the COVID-19 pandemic (Lancet 2021), and these are impacting the lives of women with disabilities in distinctive ways. Women with disabilities are the first to lose employment or to have reduced hours and those in informal sector employment are in increasingly precarious situations (UNFPA, n.d.; Mwenda 2020 and Roesch et al, 2020). The secondary economic impacts of COVID-19 have seen household incomes drop by as much as 75 per cent and debt levels have increased (ibid). In addition to experiencing reduced ability to earn an income, women with disabilities are less able to access basic needs, essential health

and social welfare services, including medicines, personal assistants and carers, rehabilitation and other support services, social security payments and benefits. Moreover, their unpaid domestic work and carer responsibilities have increased alongside home schooling.

The pandemic has seen women with disabilities experience even greater risk of violence (Lancet 2021; Mwenda 2020; Roesch et al, 2020; Plan 2020; ADD 2020; Sharma and Das, 2021). Women and girls with disabilities face a disproportionate risk of sexual violence with nearly 80 per cent having experienced violence; they are four times more likely than other women to suffer sexual violence (Mwenda, 2020). Levels of violence, particularly domestic violence against women and girls with disabilities have grown as security, health and financial worries have risen, and confined living conditions persisted with lockdowns (Mwenda, 2020; Roesch et al, 2020). For women already in abusive relationships, or at risk of such abuse, staying at home to curb the spread of COVID-19 has increased their risk of partner and non-partner violence (Roesch et al, 2020). Early in the pandemic UNFPA (2020) estimated that if lockdowns continued for six months, the world would witness around 31 million cases of domestic violence. The pandemic is likely to cause a one-third reduction in progress towards ending gender-based violence by 2030 (ibid).

COVID-19 has disrupted social and protective networks and women with disabilities may have less contact with family and friends, reducing their access to support and protection from violence (Roesch et al, 2020). Women with disabilities who were assisted and protected by personal assistants have become more exposed to sexual violence when assistants contracted COVID-19 and are unable to provide assistance (Mwenda, 2020). Perpetrators may further restrict access to services, help and psychosocial support from formal and informal networks (Roesch et al, 2020). Domestic and family violence makes a women's home the least safe place she can be and getting to safety often means finding somewhere new to live which is particularly challenging with COVID-19.

In Cambodia, persons with disabilities have been among the first to lose employment and informal sector employment opportunities with many no longer able to earn an income. A recent study on the impact of COVID-19 found that 2 in 5 respondents with

disabilities reported an increase in the risk of psychological, physical and/or sexual and economic violence with risk felt both at home and in the community (ADD, 2020). Risks were most pronounced among older respondents and those who were already experiencing risk of violence before the pandemic began. Despite these increases, access to services decreased. PRCs for example closed during COVID-19 and the traffic light system severely restricted travel and access to all services. Only CDPO and OPD's have supported persons with disabilities during COVID (key informant, June 2022).

During and following COVID-19 women with disabilities have faced greater discrimination. Increased economic pressure and crisis in families has shifted perception back to family members with disabilities being seen as a burden. Whilst the recent introduction of a disability pension to cover the extra costs association with impairment is positive, payment of it to a household member – rather than to the person themselves - reinforces dependence on others and the view that disability is a burden (key informant, June 2022).

SECTION 2: METHODOLOGY

Methodological Summary

Positive deviance approach where women with disabilities who are already accessing PRC services were interview to identify critical success factors.

29 semi-structured interviews with women with a diversity of disabilities were conducted by provincial focal point women with disabilities.

Women with disabilities – provincial focal points - were supported by other women with disabilities (PAfID staff /team members).

Women with disabilities were involved in the design, conduct and analysis of the data collected and the development and reviewed of the Recommendations.

This research adheres to the eight general principles outlined in the UN CRPD and the disability rights movement moto of 'nothing about us without us."[7] Women with disabilities have played a central role in the design, collection and reflection upon the data collected and recommendations. PAfID staff – women with disabilities themselves – with the support of the Lead Researcher held eight to ten training sessions that lasted several hours each, plus on the ground face-to-face and telephone-based support has meant women with disabilities themselves are central to all stages of this project.

This research has gone beyond a 'do no harm' approach and seeks to benefit women with disabilities who chose to be involved. To achieve this goal, the following steps were taken over and above standard confidentiality, consent and anonymity procedures.

1 – **All interviewees were given information on available services in their province.**
The information included the following information:

- available services in local area/province (health, disability specific), on right to health; free health care for ID poor including address and contact details
- OPD/Women with Disabilities Forum information and contact details
- Helpline number (Department for People with Disabilities)
- Ministry of Women's Affairs focal point person and contact details

[7] The ethical research guidelines of the Australian Research Council and the Australian National Health and Medical Research Council have also been followed.

2 – **Women's safety** during the recruitment and interview process was ensured in three main ways.

- A private quiet place was chosen to conduct interviews. Women were asked where they would like to sit and were encouraged to find a place where they felt comfortable.
- As discussed above, women's name and identity have been removed from all data collected. Recordings of the interview, notes and any electronic files have been de-identified and password protected. Only the PAFID Cambodia team are able to access these files.
- Summary findings were shared and discussed in an online workshop with Provincial Focal Point women who were invited to add anything else should they wish to. Recommendations were translated into Khmer and also shared discussed in a separate online workshop.

3 – **Responding to distress**

- If woman became distressed during interviews Provincial Focal Point women responded with warmth and care. They reminded interviewees that they are in control of the interview process and can take a break if they wish, cease the interview all together or finish the interview at another time. Our aim was to ensure that the woman being interviewed felt in control of the process.
- The expression of emotion can be expected given current circumstances with COVID-19 and with women with disabilities living situations and greater risk of violence. Listening and witnessing women's stories in itself has therapeutic value and is validating, particularly for women who may not have shared their stories previously.

Data collection, sampling and recruitment

This research collected qualitative data that achieved interpretative sufficiency – that is, a full, rich and deep explanation of the multiple causes of women with disabilities access to services (Scheper-Hughes, 1993). This study aimed to understand the diversity of women with different impairments decision-making, the factors that shape behaviour and access to services. Multiple sources of data were collected and enabled triangulation

of research findings. In-depth interviews were conducted with key informants and women with disabilities and findings from these have been interpreted in light of current research literature. Basic quantitative demographic information was also collected and describes the overall characteristics of interviewees.

Data was collected by women with disabilities themselves and followed a cascading model of guidance and support that our Team developed.[8] Field work was originally planned to be conducted by PAfID staff – two women with disabilities – with the assistance of two women with disabilities based in each province- – Siem Reap, Kompong Cham and Kompong Speu. National COVID-19 lockdowns in 2021 consequent travel restrictions meant however that PAfID staff were unable to travel. Consequently, the research methodology was adjusted and provincially-based women with disabilities - hereon Provincial Focal Points - conducted the interviews with remote support from PAfID staff. Provincial Focal Point women with disabilities were recruited through PAfID's women with disabilities leadership program and through Women with Disabilities Forums/OPD networks. Two women in each province were selected and invited to an initial project launch online meeting.

The Provincial Focal Point women were supported remotely by two PAfID Cambodia Field Work Team Leads who were in turn be supported by the Team Lead. This approach maximised mentoring and support for women with disabilities as leaders, and to build on their insights within the interview and data interpretation process as well as the identification of recommendations. Provincial Focal Points were trained in basic interviewing and research skills including ethics, interview practice, data collection and recording, and protocols. Field Work Team Leads have been given a Certificate of Appreciation and were paid. Provincial Focal Points were also provided with practical support – phone cards/credit and money to cover all transport costs.

As the provincial women with disabilities had different levels of experience interview questions were pre-recorded and played to each woman being interviewed. Kobo was also used to enable easy recording of data during interview. When field work finally took

[8] Current COVID-19 inter-provincial travel restrictions has required adjustment of the initial field work approach.

place in April – May 2022, travel restrictions had lifted and PAfID staff supported the Focal Point women face-to-face. Provincial women with disabilities limited experience with conducting semi-structured interviews has limited the depth of the data collected.

The PRC's provided a list of women with disabilities who had received services. The Provincial Focal Point women then contacted each woman and invited her to take part in an interview at a time and place convenient to them. These women are positive deviant cases as they have successfully accessed rehabilitation services. A total of 29 women with disabilities were interviewed: 9 in Siem Reap and ten in both Kompong Speu and Kompong Cham. Interviews were conducted in different locations in each province. In Kompong Speu, 6 of the women with disabilities travelled to the PRC and 4 were interviewed at the OPD office; in Kompong Cham two women were interviewed at the PRC, 7 were interviewed at local pagoda and one at home, and in Siem Reap, all women were interviewed at home.[9]

Written consent was given prior to the collected of any data. Prior to asking for consent, the purpose of the research was explained to interviewees as well as how the data collected with be used and shared. All data collected was de-identified and given a code number to ensure confidentiality and anonymity.

Pilot interviews

Provincial Point Persons conducted two pilot interviews each with Field Team Leads – PAfID staff support. These pilot interviews tested the interview process itself – including using the pre-recorded questions and Kobo software. Field Team Leads were present during the first two interviews in Kompong Cham and Kompong Speu. In Siem Reap the Provincial Point Persons had considerable interviewing experience. The PAfID staff conducted follow-up phone calls with each field team to de-brief, and in turn de-briefs were held with the Lead Researcher.

[9] All interviews with women with disabilities will be conducted by the Provincial Focal Points face-to-face and socially distanced. They will be done by pairs of Provincial Focal Points to ensure their safety and to support one another. Pairs took turns in leading the interview, and entering the data into Kobo.

Data recording and analysis

Interview data was recorded directly into Kobo on women's phones and later uploaded into Kobo. The PAfID team and Research Lead have password protected access to the Kobo data. Translation of data entered into Kobo was done by PAfID team member in consultation with the Team Lead, who then analysed the descriptive and qualitative information. Findings were then shared with the PAfID team for discussion and an online workshop was held with all six provincial women to critically discuss and review findings and recommendations.

Women's direct quotes have been used to capture her experience as closely as possible. Key cases as identified by the Provincial Focal Points and Field Team leads were reviewed to identify the key decision-making/turning points and determinants of access to services are investigated fully. These discussions will form the basis of data analysis and identification of key themes that will be developed into the key findings. The most significant stories were then identified and are now presented in this report.

Recruitment criteria for women with disabilities

Well document barriers to disability specific and gender-based violence services include:

1 - **Women who have received PRC services** (assistive device provision – prosthetics, orthotics, wheelchair, crutches); physio, social counselling, outreach;

2 - **Women with a range of impairments** (mobility, sensory, intellectual), social and situational differences (age, marital status, education level and livelihood).

DFAT's Child Protection policy has been adhered to when seeking permission with the one participant who was under 18 years of age.

Key informant interviews

Key informants were identified by PAfID and the ACCESS team. Key government Ministerial, provincial and district level officials, Provincial Rehabilitation Providers, government, provincial health providers, NGO partners and representatives were invited to participate in a key informant interview. Not all key informants responded to invitations to participate in this research and were not able to be included.

Key informant interviewees were asked a series of open-ended questions regarding disability-related policies, services and programs, barriers and facilitators to service access for women with disabilities. They were also be asked open ended questions about service accessibility; staff knowledge, awareness and skills in the provision of rehabilitation services; staff capacity needs and other emergent issues. Draft interview checklists for key informants and women with disabilities shared with the Field Team Leads and with the ACCESS GESI and Disability Strategic Advisor for input. The checklists were translated and back translated between Khmer and English.

Write up and dissemination of findings

The Team Lead wrote up the final report and key findings will be developed into simple messages for the infographic and final PowerPoint presentation. Findings, the infographic and policy and implementation brief will then be shared with key stakeholders across the disability service sectors at national, provincial and commune levels.

A Final Project Workshop is planned to be held in either a face-to-face or online format. The aim of the workshop is to be women with disabilities, OPDs including Women with Disabilities Forums, government and non-government representatives and services providers in the disability service sector together to critically discuss the research findings and next steps.

SECTION 3: FINDINGS

This section presents the findings from the semi-structured interviews conducted with women with disabilities by women with disabilities and key informants. Amost all (26 or 29) women with disabilities had previously accessed PRC services. Women who had not accessed services did not recognise a need them, for example a 20 year old women had a mobility impairment that did not require an assistive device.[10] Findings show that when women with disabilities have an enabling environment – that is supports around them, they are able to access the services that they need. Access to emotional, practical and financial supports is critical.

Participant demographic summary

Women with disabilities who took part in this study were between the ages of 16 and 65, with an average age of 38 years.

Just under half (14 of 29) of women with disabilities have never married.

Almost a third (9 of 29) of women are currently married.

Over a third of women (10 of 29) have never attended school.

Of those women who have attended school, primary school is the highest level attained for most women (7 of 29).

Just over half (15 of 29) of women with disabilities had not worked for income in the seven days prior to interview.

Among those who had worked (12 of 29) only 5 are the primary income earner in their households.

The majority (19 of 29) of women interviewed have mobility impairments.

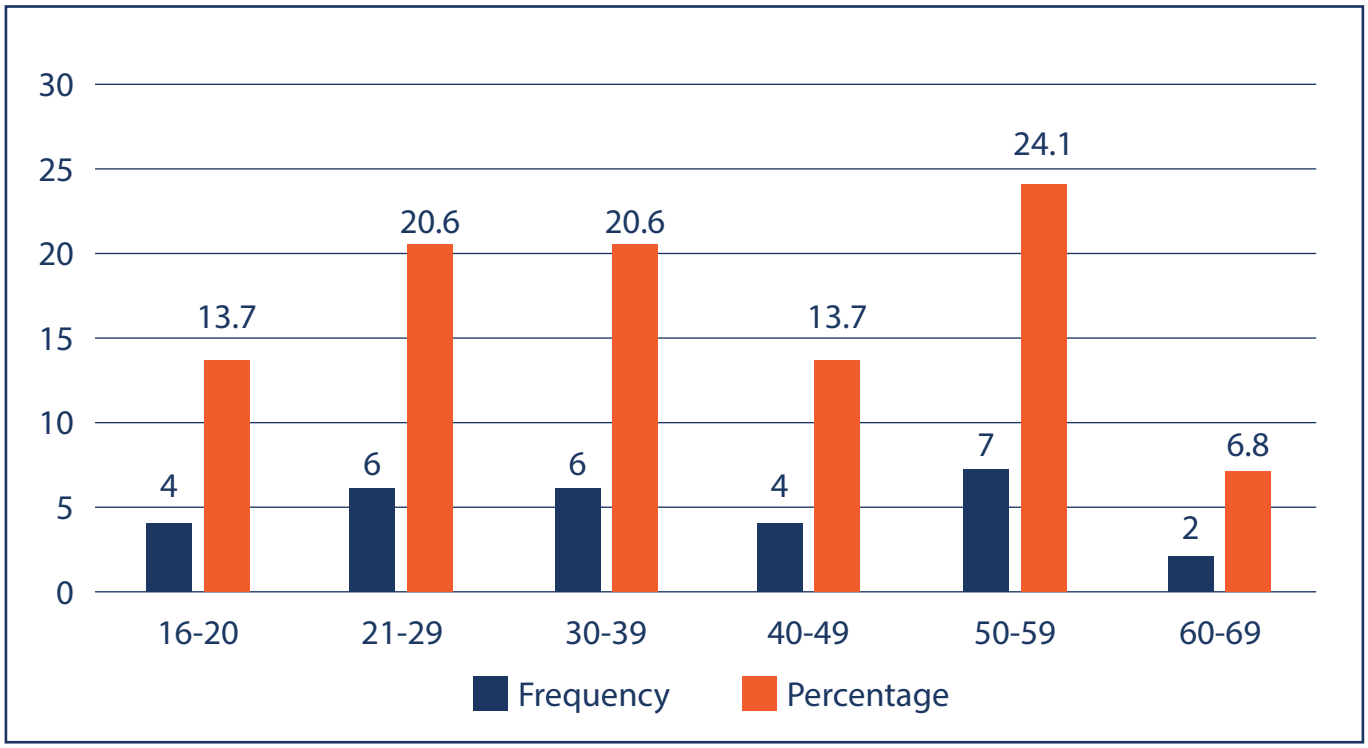
Just over a third of women (11 of 29) women had multiple impairments.

[10] There were two cases of missing data.

Basic Demographics

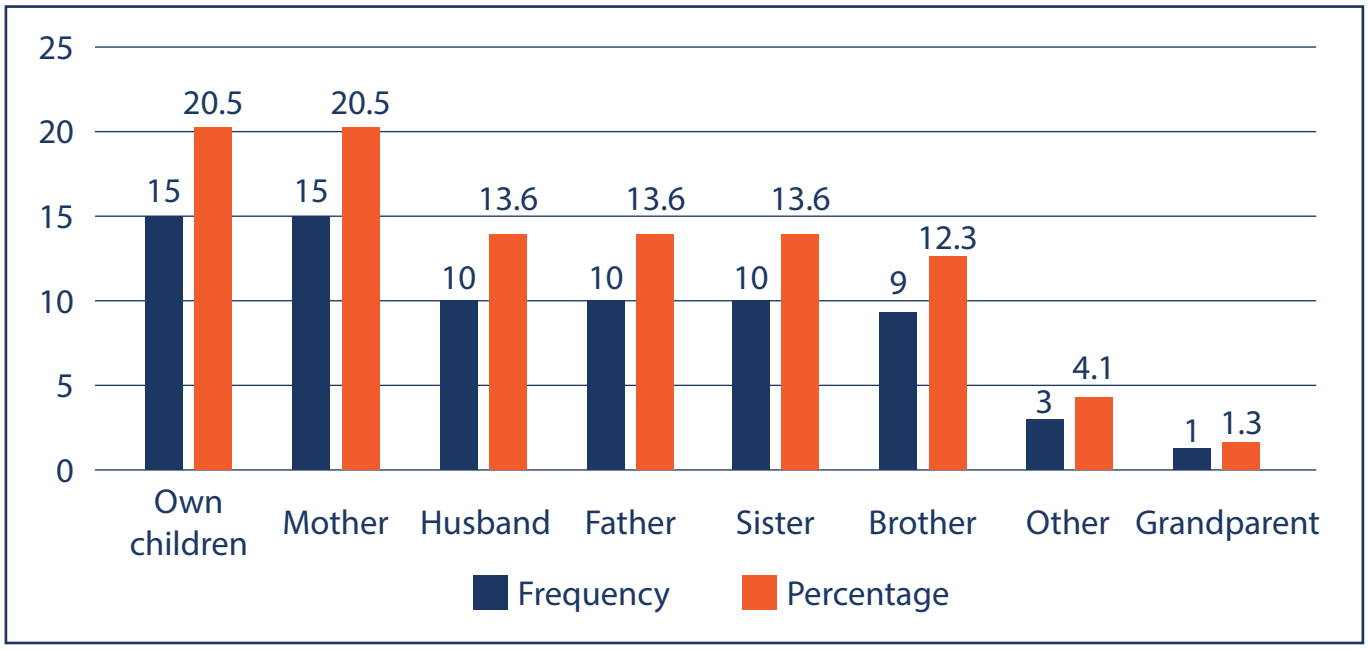
Women with disabilities who took part in this study were between the ages of 16 and 65, with an average age of 38 years (see Figure 3). They are living in households made up of immediate family members –either parents and siblings, or their husbands and own children, often with the addition of the women's mothers (see Figure 4). The data suggests that women with disabilities are most likely to become heads of their households as older women. Only seven women are heads of their households, and of these five women are in their 50's and two in their 40's. Most women live in households where their husbands (7), fathers (6), mothers (4) sisters (3) or Aunts (1) are the head.[11]

Figure 3: Women with disabilities age distribution



[11] There was one case of missing data.

Figure 4: Women with disabilities living arrangements



Marital status

Just under half (14 of 29) of women with disabilities have never married (see Figure 5). Of these 9, two are still teenagers and the remaining 7 are in their 20's. The other 5 women are over 40 years of age and these women are all living with siblings or have return to live with their natal families (i.e., parents and siblings). Almost a third (9 of 29) of women are currently married and the remaining women are either divorced, separated or widowed. Half of the women with disabilities (15 or 29) have children, with an average of 2.3 children.

Education

Over a third of women (10 of 29) have never attended school, two of these are young women (20 and 22 years of age) (see Figure 6). Of those women who have attended school, primary school is the highest level attained for most women which affirms national data that show women and girls with disabilities have lower education levels than women and girls without disabilities and lower than men and boys with disabilities. Among the younger women (those between 16 and 29 years of age) there are in post-secondary education and five are in secondary school. There are too few cases to draw any clear conclusions regarding changes in girls with disabilities access to education.

Figure 5: Women with disabilities marital status

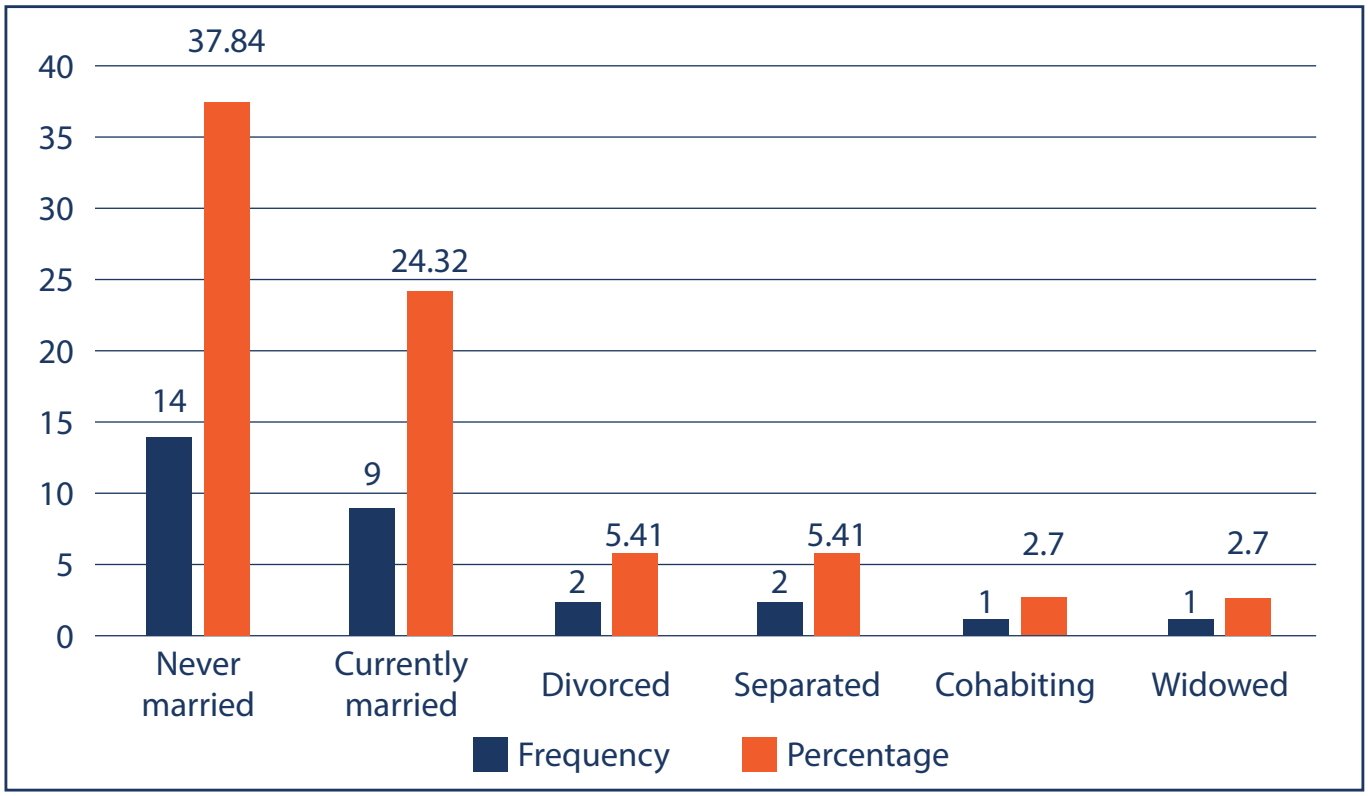
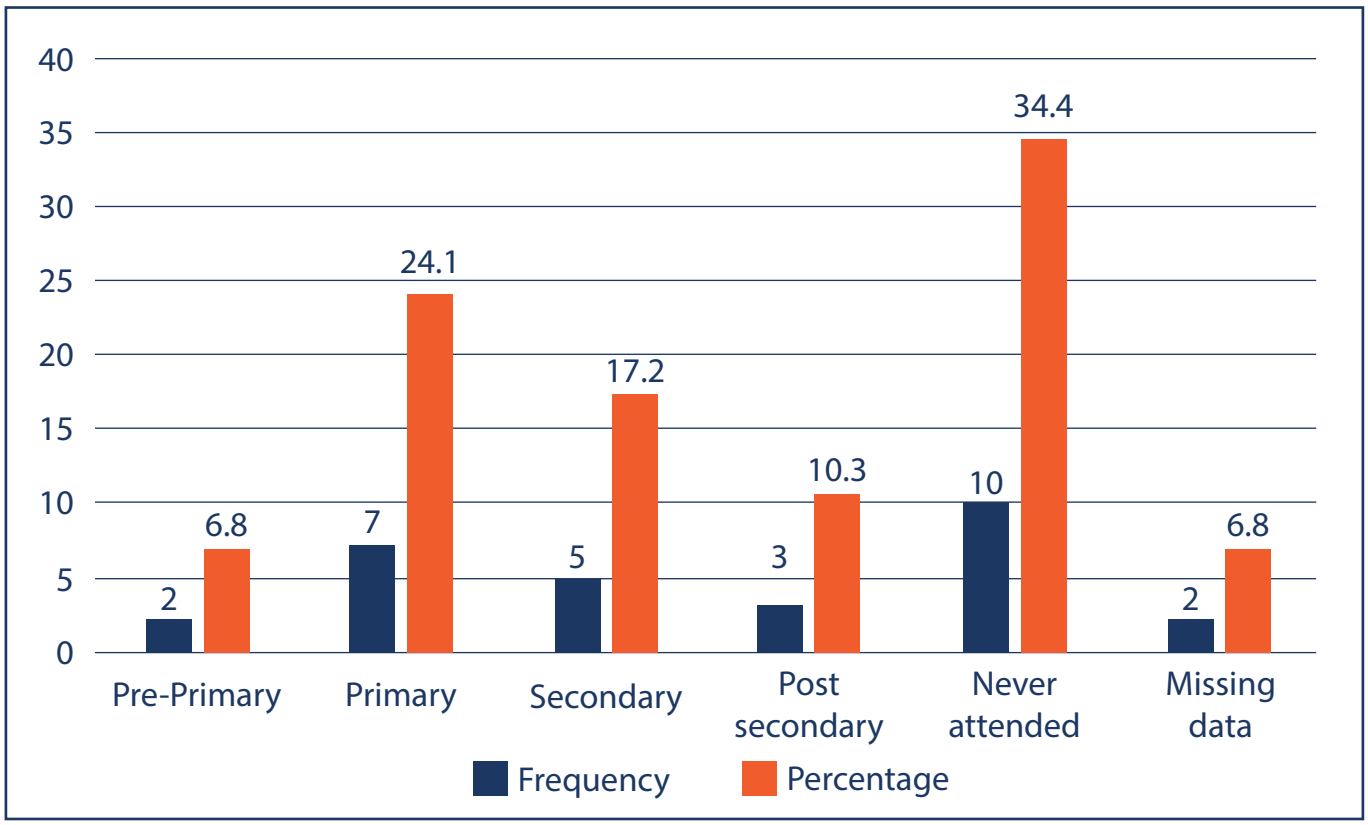


Figure 6: Women with disabilities level of education

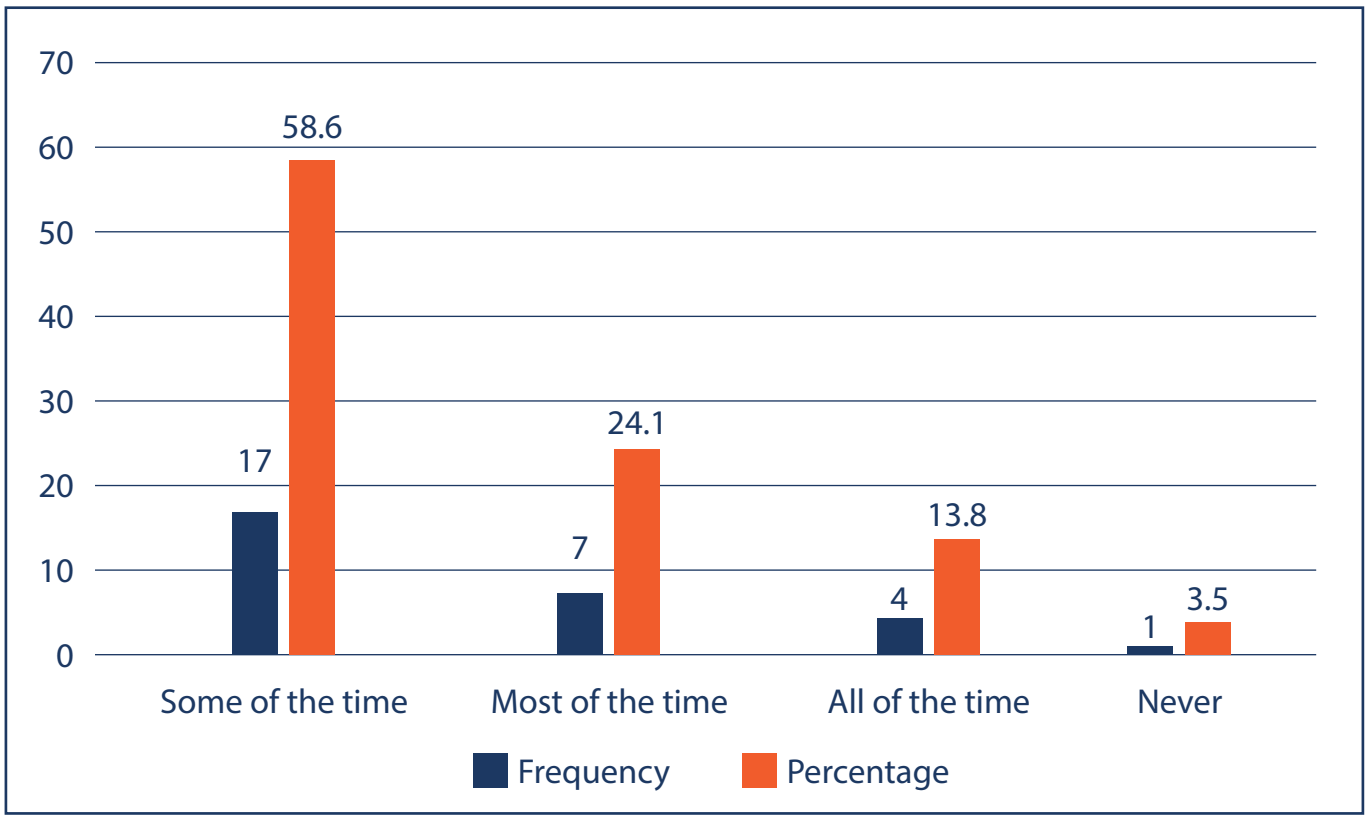


Just over half (15 or 29) of women with disabilities had not worked for income in the seven days prior to interview. Of these two are students. Among those who had worked (12 of 29) only 5 are the primary income earner in their households (see Figure 16, Appendix 7). Overall, women with disabilities perceive their living standards to be less than others (see Figure 7).

Disability

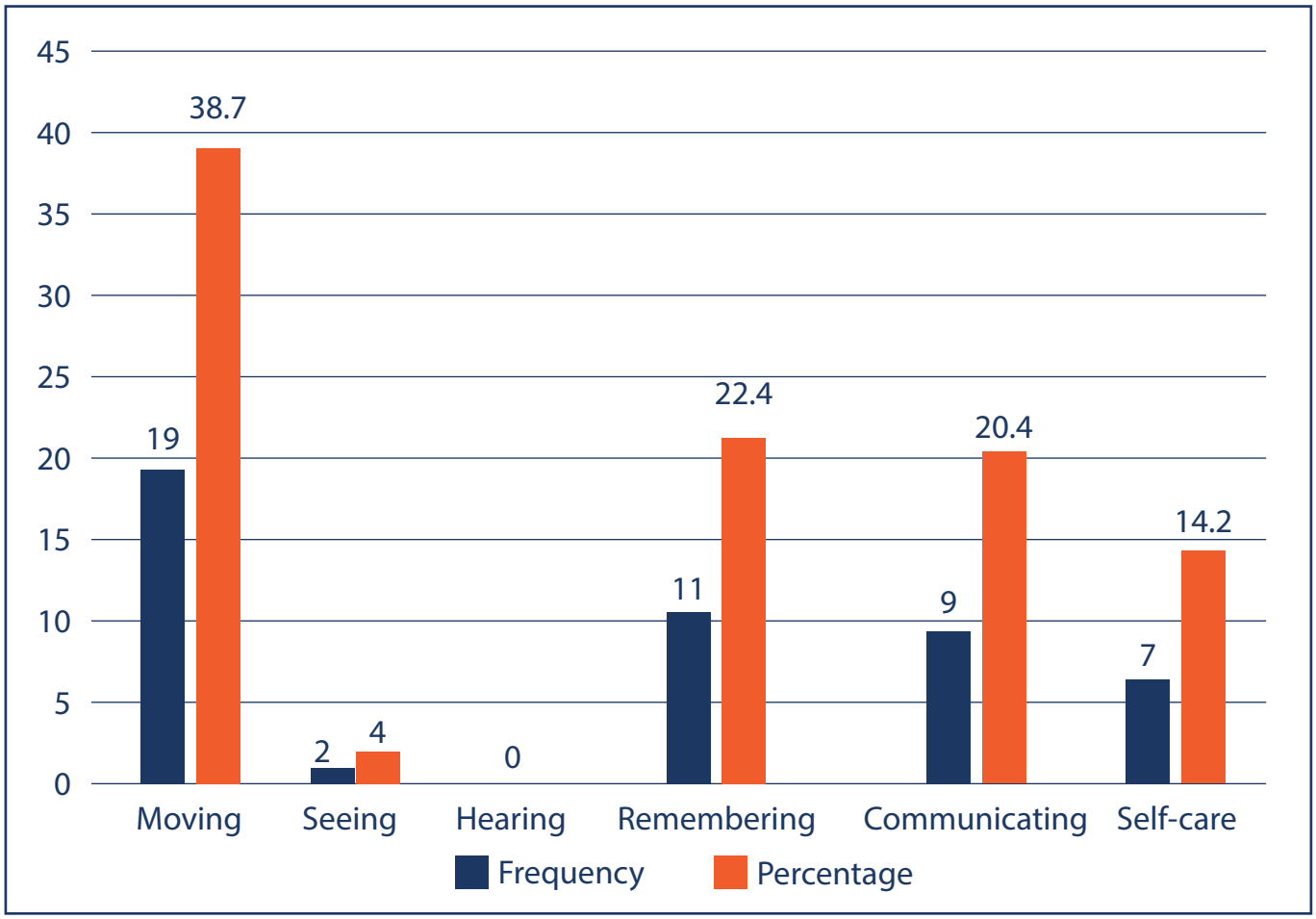
The majority (19 of 29) of women interviewed have mobility impairments, followed by women who experience difficulties remembering and concentrating (11 of 29), difficulties communicating (9 of 29) and difficulties with self-care (7 of 29). Only 2 women had visual impairments and no women had hearing impairments (see Figure 8). Just over a third of women (11 of 29) had multiple impairments; all but one included difficulty remembering[12]. More than half of women (16 of 29) depend on someone for self-care.

Figure 7: Women with disabilities perception of their standard of living



[12] See Appendix 7 for breakdown of data by type of difficulties.

Figure 8: Women's impairment type

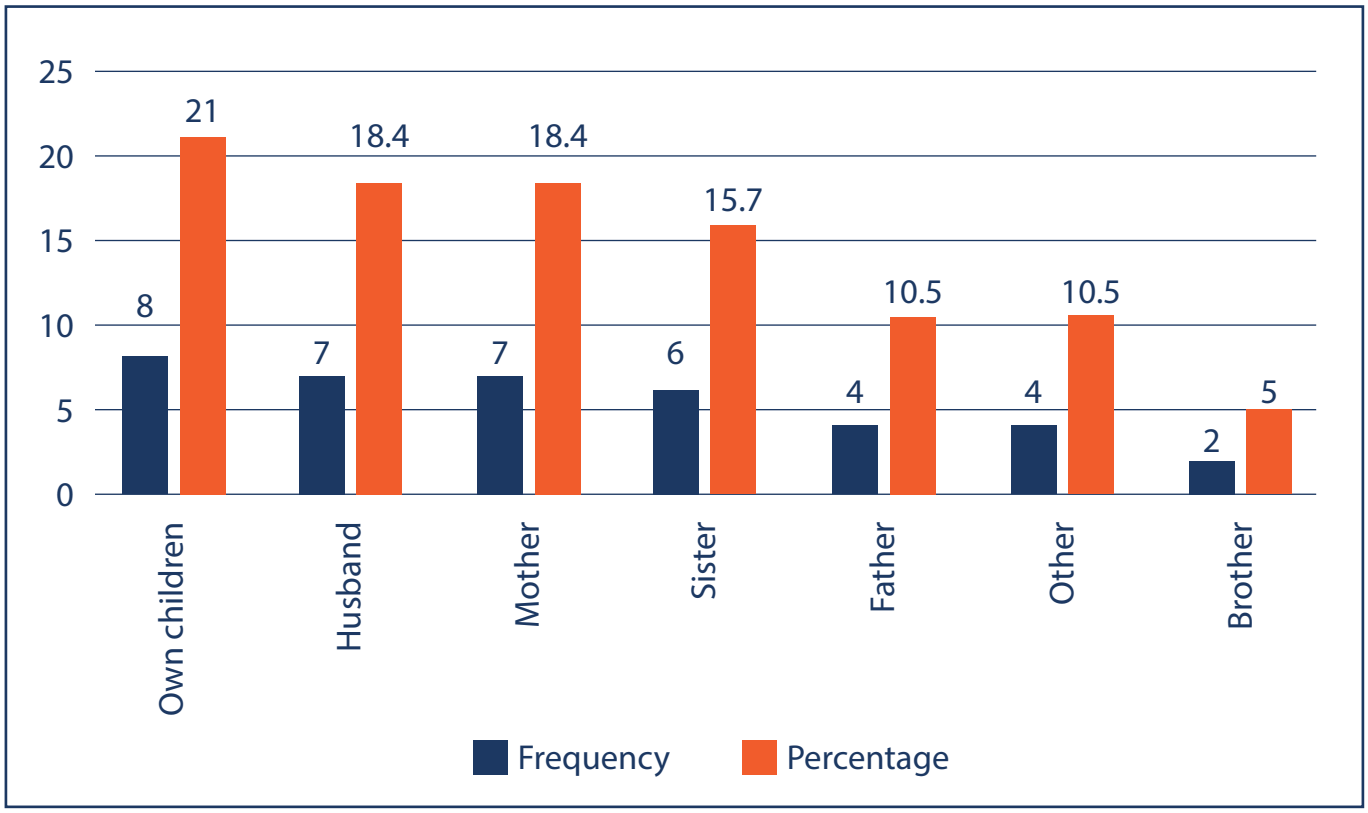


Social connection

> *"The most important thing for women is some of them can make friends when they play basketball and they can share things that they face, so they support one another and help each other"* (interviewer observation, June 2022).

Women with disabilities in this study are well connected with women and girls with most (24 of 29) women reporting being friends with women and girls. Less women with disabilities reported also being friends with other women and girls with disabilities (20 of 29). They either meet at one another house, or those that live in the same village go for walks together. Six women were connected with Women and Girls with Disabilities Forums and groups and would spend time together at these meetings. Two made new friends whilst seeking services at the PRC itself.

Figure 9: Women with disabilities support person



All women except 5 women, require support to visit friends and support persons tended to be women's own children, their husband, mother's or sisters (see Figure 9). Those who are did not have friends with disabilities tend to be younger women [13] and could

suggest they have greater difficulties accessing the support required to meet and spend time with friends, or that they have had fewer opportunities to meet other women. Women reported that distance is a challenge to meeting friends as is discrimination. For example:

> *"[There are] challenges when meeting friends including living a long way away from each other"* (53-year-old women with multiple impairments).

> *"Discrimination,…[I] lost a friendship when they did not listen when I spoke and they did not focus on me – I was treated poorly….discriminated from the friend…we are no longer friends"* (26 year old women with mobility impairment).

[13] Four are under the age of 26 and have never married which could suggest they have had fewer opportunities to interact and meet other women and girls with disabilities.

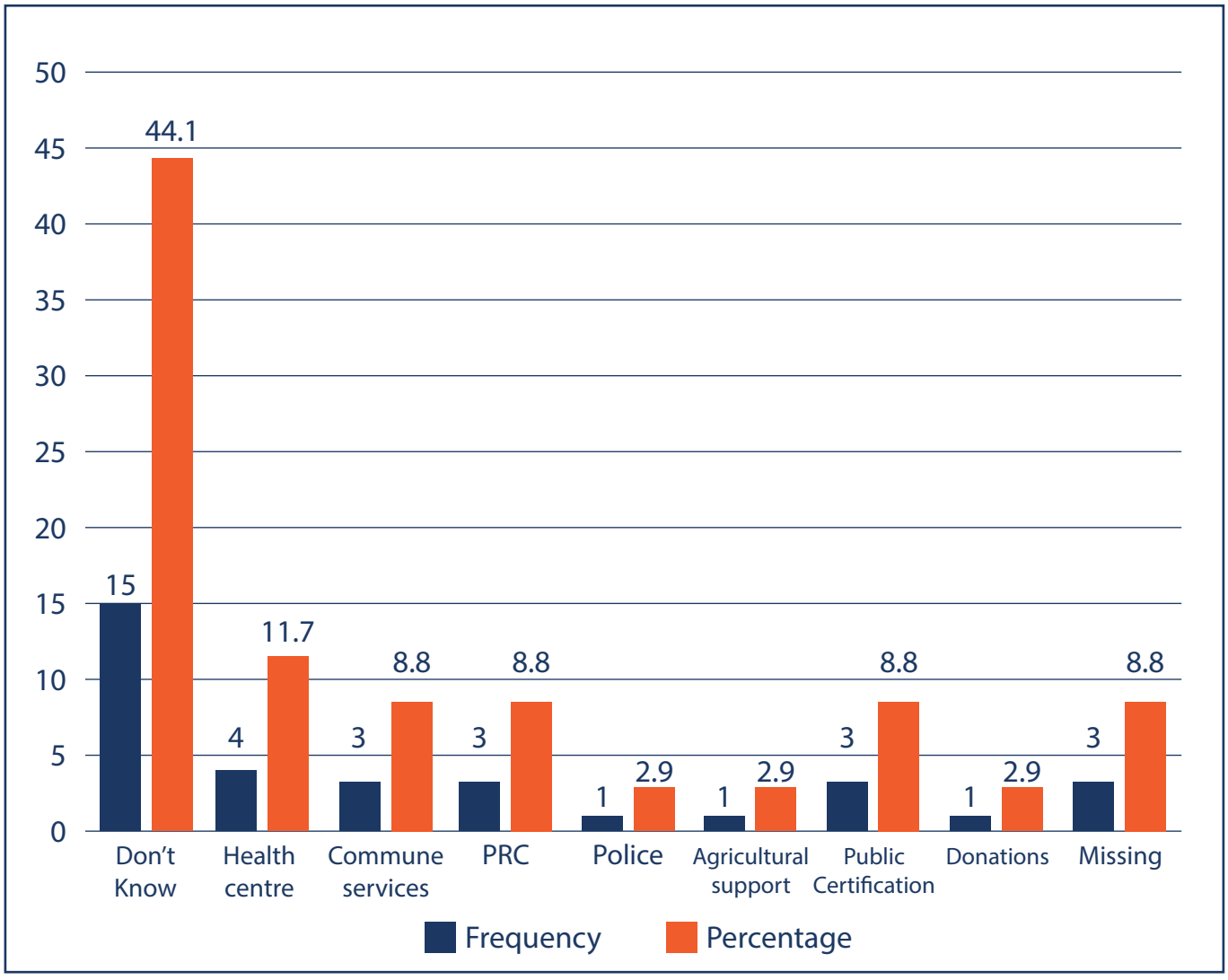
Summary points

Women with disabilities in this study are well connected with women and girls with 83% (24 of 29) of women reporting being friends with women and girls.

Younger women were less likely to have other friends with disabilities.

All women except 5 (17%) require support to visit friends and support persons tended to be women's own children, their husband, mother's or sisters.

Figure 10: Women with disabilities awareness of services



Access to, and awareness of services

Women with disabilities have a low level of awareness and knowledge of available community services, including PRC's (Figure 10). Almost half of women reported that they do not know any services. Women with disabilities were most aware of the Commune Health Centre and Commune level services including certification processes such as getting a wedding, birth and death certificates, identity papers, ID poor cards (Figure 10). More than half of women with disabilities (19 of 29) would like to access additional services such as training, kindergartens, schools, and support from Local Authorities and the Commune Office.

Alongside awareness of services, women with disabilities need to know their rights to access and receive quality services and to recognise that they are equally important as other women. As a key informant explained:

> *"Women with disabilities should not be shy about seeking services that they are entitled to…they cannot demand something [services] if they do not know about their rights"* (key informant, June 2022).

Access to community and PRC services: Barriers and Facilitators

Summary points

Most women have to ask for money from either their husband, parents or siblings to visit health and other services.

Individual (low self-confidence), financial (no available transport and no money to pay for transport) and lack of available support persons are the most common factors that prevent women with disabilities from accessing services

Women with disabilities were not all aware that transport costs are paid for by PRCs on arrival, and some PRCs do not cover travel costs.

Women with disabilities reported not having information about the PRCs and the services that they provide

Individual (low self-confidence), financial (no available transport and no money to pay for transport) and lack of available support persons are the most common factors that prevent women with disabilities from accessing services (see Figure 11).

1 – Individual factors: Motivation and confidence

Women described feeling scared to go to seek services and needing to be brave:

> *"It is scary [to go]"* (37-year-old woman with mobility impairment).

> *"I have to be brave and dare to go on my own"* (34-year-old women with multiple impairments).

Women with disabilities tend to stay at home and can isolate themselves. For example:

> *"She fell over in bathroom and cannot move her hands up and down and cannot walk. She feels hopeless and has stopped going out of the house and isolated herself. Even as she started to talk with us, she was emotional. She lives with her children"* (interviewer observation, June 2022).

> *"I never go out and am busy with work"* (53-year-old woman with mobility impairment).

One-fifth of participants in this study stated that they found it 'easy to go' to seek services at PRCs. Figure 12 shows that women's own motivation to secure services is one of the key drivers together with family support. For example:

> *"[With] self-motivation, and it's easy"* (22-year-old women with mobility impairment).

> *"[I] have traveling cost…and I want new legs"* (42-year-old women with multiple impairments).

> *"I need it [a prosthetic] and wear to go to work and when having legs is more easy to walk" (26 year old women with multiple impairments).*

> *"I expected that I will recovery and my children will support me"* (65-year-old women with multiple impairments).

2 – Social factors: Family support

Adequate family support in the form of motivation, encouragement and the provision of transport provides additional elements of an enabling and accessible environment women with disability within which women are able to access services. For example:

> *"My husband accompanies me to get service once he is free from his work"* (28 year old women with mobility impairment).

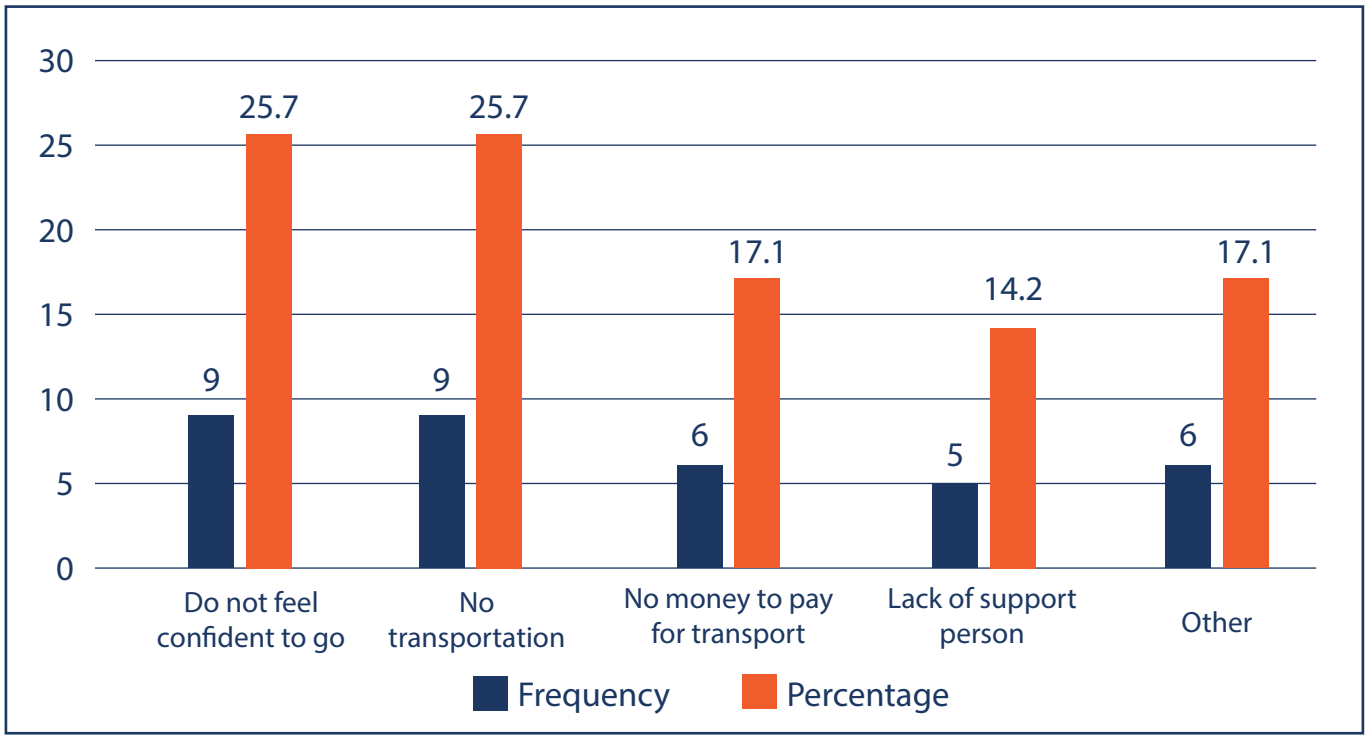
> *"It's easy to move around [accessible]"* (53 year old women with remembering impairment).

Women did not always have someone to go to the PRC with them. Some women have to wait until they or those going with them are available and have time when they are not working

> *"It's difficult to find someone to accompany me to PRC. I have brothers and sisters' but Ihave to pay them money"* (56-year-old, divorcee who lives with her child and siblings and has a mobility and visual impairment).

> *"I have no one to accompany me"* (42-year-old women with multiple impairments).

Figure 11: Barriers to access services



3 – Systems level factors: Transport

Women with disabilities were not all aware that transport costs are paid by PRCs on arrival. Women with disabilities reported that PRC's only cover travel costs if you are within their target area and that not all PRC's cover travel costs (key informant, June 2022). When women have to pay for their transport costs upfront, they may not be able to afford it, particularly if the PRC is a long way from home and when seeking services means time away from work and a loss of income (key informant, June 2022). For example:

> *"I want to get traveling cost"* (20-year-old women with multiple impairments).

> *"I do not go to get services because it is difficult to travel. There is no one to accompany me and I have health problems"* (61-year-old with multiple impairments).

Remote rehabilitation service provision and outreach models make services much more accessible to service-users. With COVID-19 travel restrictions service users were no longer able to access PRC services and with empty centres, staff began to think differently about how they could reach their persons with disabilities. As one key informant explained:

> *"Rather than waiting for clients to come, [we decided] to go to them and ask them 'how are you?' [We] used videos to show how to do exercises on tables and using dolls"* (key informant, May 2022).

Priority clients who needed ongoing services were identified first, such as children with cerebral palsy and their parents / guardians and the benefit of remote rehabilitation services were explained to them, as well as the benefits of savings in travel time and cost. Service providers struggled to locate women and girls with disabilities at home as phone numbers change (key informant, June 2022). With the return to face-to-face service provision, physiotherapists no longer have time to provide outreach services as the number of clients presenting for face-to-face services has increased to pre-COVID numbers of around 20 persons per day (key informant, June 2022).

4 – Financial barriers

Most women (22 of 29) have to ask for money from either their husband, parents or siblings to visit health and other services. Women reported that if they had their own money, they would be able to access health care more readily. '

Women with disabilities noted, however, that they need to cover food and transport costs themselves and that reimbursement practices vary between PRCs and by type of service being sought.[14] Women with disabilities understand that transport costs are only covered when new devices are provided and not for repairs on pre-existing devices. In the absence of adequate reimbursement of food and transport costs, financial resources and independent income generation shapes women's access to services. Without money, women with disabilities simply go without their needs being attended to with flow on impacts on their wellbeing, social and economic participation. Access to appropriate rehabilitation services and assistive devices is a pre-condition to inclusion.

[14] Full costs continue to be covered in Kompong Speu PRC but not in Kompong Cham. All 11 PRCs provide free of charge services although there is no legal framework. The 5 PRC's under PWDF provide transportation reimbursement of 10,000 riels (to cover a return trip) and 3,000 riels/day/person. For other PRCs under IO/NGOs support they also provide top-up for transport and meal to keep reimbursement as close as possible to the real expenses"

Communication and access to information

Although access to information is recognised in legal and policy frameworks there are gaps in practices. Women with disabilities access to information is related to several factors: education level, movement patterns and family attitudes, particularly the level of importance that they give to sharing information with their wives, daughters and sisters with disabilities (key informant, June 2022). In this study, women with disabilities reported not having information about the PRCs and the services that they provide:

> *No one tells me…I don't have any information* (20 year old women with multiple impairments).

> *I really don't know much information [about PRC and other services* (56 year old woman with multiple impairments).

Although prosthetics and orthodics services have been provided since the early 1990's and are a well establish sector, it can not be assumed that women with disabilities know where to go (key informant, June, 2022). Women gain information about services that are available through their own networks of family and friends. The following story was shared:

> *One lady had an accident and did not have any information about the PRC from anyone in Kompong Cham. She heard about the PRC from her friends in Kompong Spue. Her relatives also told her that there is a PRC service in Kompong Cham* (interviewer reflection, June 2022).

Women noted that they need to be informed about services so that in the presence of their own motivation and household level support means that they can increasing access services. Women with disabilities values the role of women with disabilities support groups as both a source of support and information:

> *Get information from my aunties and I was motivated by my family* (28-year-old women with multiple impairments).

> *Women's networking group* (58-year-old women with mobility impairments).

These data suggests that some women with disabilities are increasingly health literate and have the information that they need to make makes decisions to secure the services that they need. For example:

> *"It's easy [to access services], [I] get attention, and they have accommodation"* (37-year-old women with multiple impairments).

Key informants noted that PRC's do not provide women with disabilities with concrete information regarding their services. In its absence women were reported to feel uncomfortable reaching out for support at the PRCs and thus seek information from their peers (key informant, June 2022. Coaching was identified as one way to inform women as to why they need services and how they will support them in their lives. The delivery of coaching and mentoring as an integrated part of rehabilitation services that address physical needs as well as life skills and income generation would maximise the value of travelling to PRC for women with disabilities (key informant, June 2022).

Summary points

Adequate family support in the form of motivation, encouragement and the provision of transport provides additional elements of an enabling and accessible environment

One-fifth of participants in this study stated that they found it 'easy to go' to seek services at PRCs.

Women also noted that they need to be informed about services.

Women with disabilities values the role of women with disabilities support groups as both a source of support and information.

Some women with disabilities are increasingly health literate and have the information that they need to make decisions to secure the services

Types of services sought

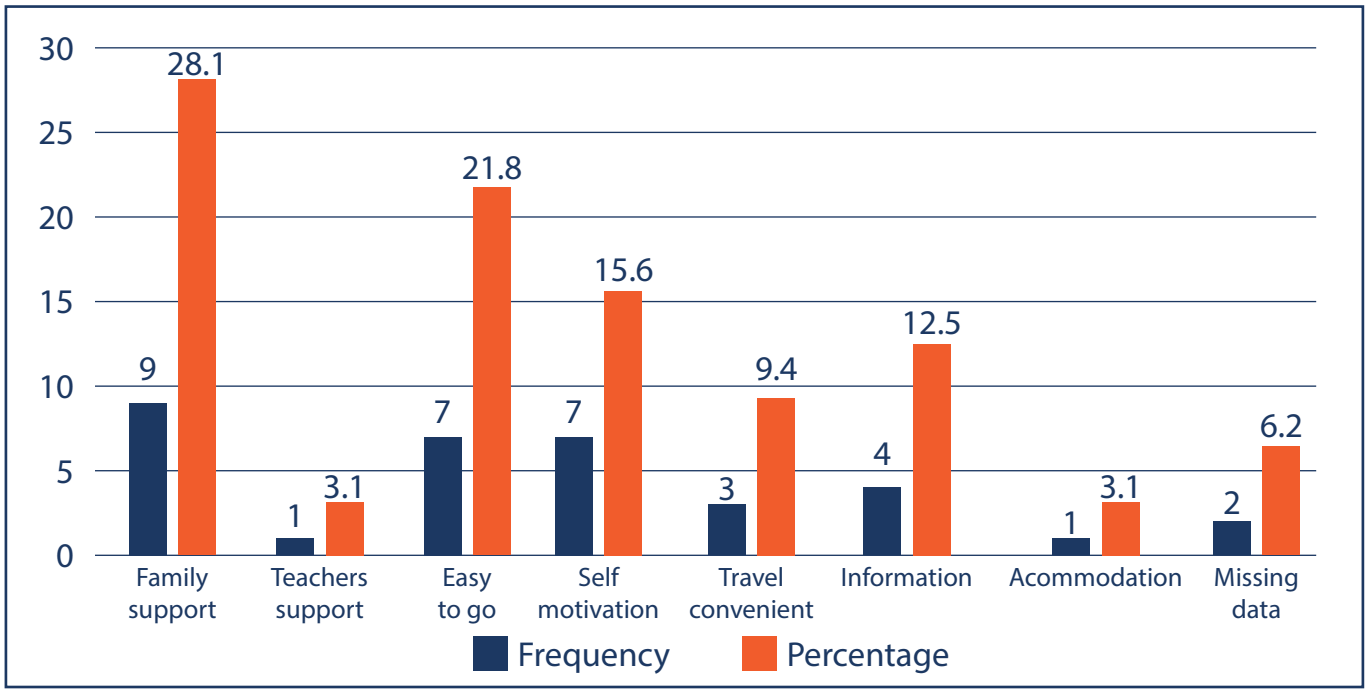
Almost two thirds of women with disabilities sought assistive devices (prosthetics, wheelchairs, crutches and walking sticks) at the PRC (see Figure 13). As PRC's were originally established to provide prosthetics and other assistive devices to survivors of landmine and related accidents and later for other mobility impairments, these data are not surprising. Women also sought auxiliary rehabilitation services such as physiotherapy and employment services that the PRC's provide. Some women were hoping for ongoing support from the PRC. Women with disabilities also sought support with accommodation, food and travel costs from the PRC. These supports make PRC services affordable for women with disabilities and enables them to be able to stay and be fed whilst they are receiving services.

Most women were happy with PRC services because they were provided with food, accommodation and their transport costs.

Delivery of consistent quality services is an ongoing issue particularly for physiotherapy where the standard is currently limited (key informant, June 2022). Prosthetic and orthotic standards are not yet in place. Furthermore, quality of supplies and parts are declining and less long lasting as noted by women with disabilities and key informants. For example:

> "*The quality of PRC services is not as good as before in terms of materials, they have a with short life span and so people do not trust PRC services anymore*" (key informant, June 2022).

Figure 12: Facilitators of women's access to services



Rehabilitation

Women received a range of services primarily focused on the receipt of assistive devices (prosthetics, wheelchairs, crutches and walking sticks), as well as physiotherapy, outreach services and information about the PRC.

> *"PRC/staffs come to ask information and do assessment at house, got attention from PRC's staff, distribution leaflets of PRC… I received counselling and the staff study patient's situation and give crutch to walk"* (40 year old woman with cognitive impairment).

> *"The staff provided physiotherapy treatment and taught my guardian how to do physio therapy so that they can teach their children at home. They also provided a walking stick"* (16 year old woman with multiple impairments).

> *"PRC's staff taught me how to walk and they paid attention"* (32 year old women mobility impairment).

Adapting and understanding client needs and goals and adjusting treatment to suit these was reported to be a challenge within the sector (key informant, June 2022). Individualised treatment plans that apply a multi-disciplinary approach require staff to have good knowledge and awareness of referral pathways and where to go to for assistance which is not always the case. Staff are not yet able to see each client as an individual suggesting the need for ongoing professional development (key informant, June 2022).

Practical supports

Women also valued the provision of accommodation, meals and transport costs being covered and overall described that the PRC provides good service.

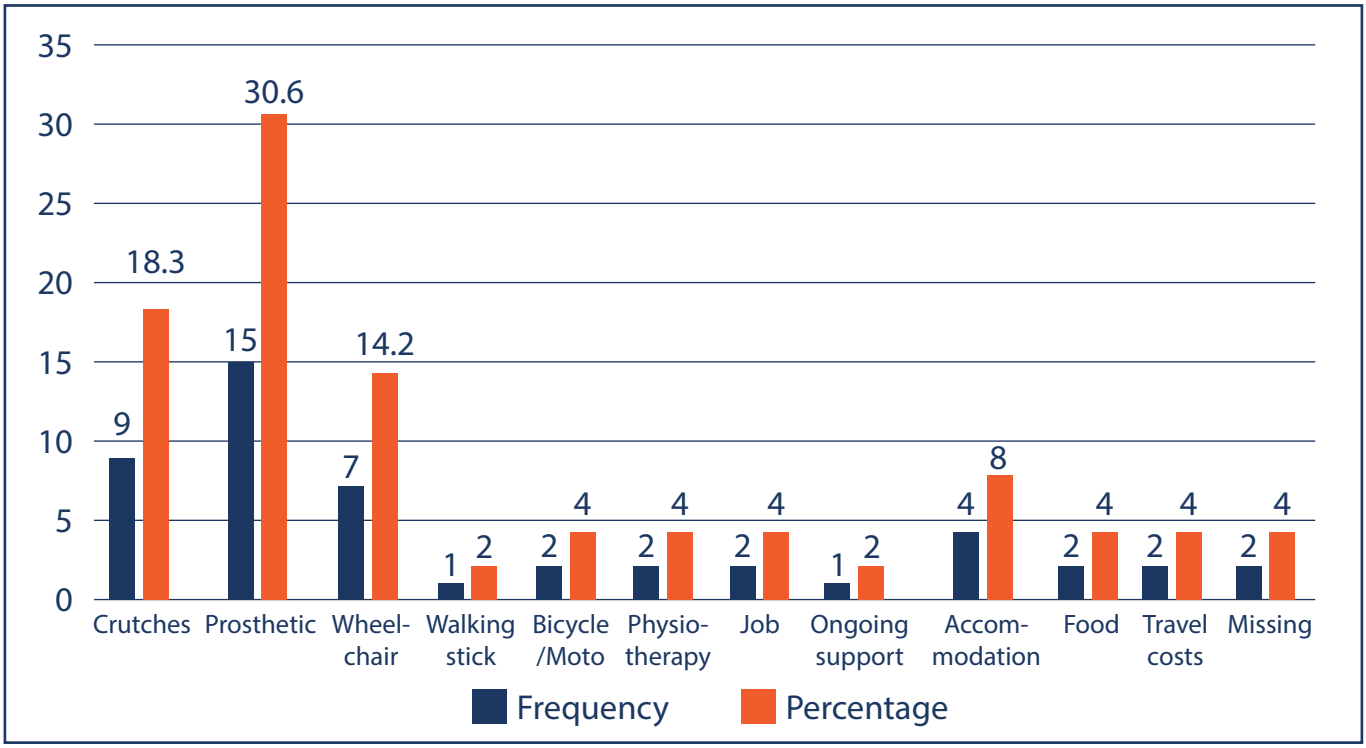
> *"Staffs of PRC are friendly, they give crutches for free of charge…I got accommodaion, three meals and my travel costs were covered"* (53 year old woman with multiple impairments).

Social networking

One woman described meeting friends whilst receiving services the PRC which illustrates that women value the opportunity to come together with other women with disabilities.

> *"I got wheelchair to use and know many friends"* (31 year old woman with multiple impairments).

Figure 13: Services sought by women with disabilities at the PRC



Summary box

Almost two thirds (65.1%) of women with disabilities sought assistive devices (prosthetics, wheelchairs, crutches and walking sticks).

Women also sought auxiliary rehabilitation services such as physiotherapy and employment services that the PRC's provide.

Women with disabilities had positive experiences at the PRC's.

Women with disabilities experience of PRC service delivery

Women with disabilities had positive experiences at the PRC's with 25 of 29 women stating that they were happy with PRC services (Figure 14). Most importantly, staff were described positively by just under half and were commended for their attentiveness and friendliness.

> *"PRC's staff are friendly and paid attention [to me]"* (31 year old woman with mobility impairment).

> *"Staff at the PRC pay attention and [do] no discriminate [against me]"* (58 year old women with mobility impairment).

> *"Staff at the PRC paid attention and give money for travelling cost"* (42 year old woman with multiple impairments)

Self-Advocacy

Only one women was not happy with services at the PRC. This woman explained that her new prosthetic was not comfortable:

> *"Staff at the PRC were friendly and they paid attention [to me]. I'm happy when I got my leg. Before I got meals but now [I] do not have enough food. Last time when I got my leg it was easy to wear but this new leg is not easy at all. I feel bored and sad"* (27 year old women with mobility and cognitive impairment).

The experience of this woman demonstrates the need to strengthen women with disabilities confidence as service users, who are aware of their needs and rights and able to communicate these effectively with service providers.

Age was reported by key informants to make a difference to women's advocacy skills with older women with greater life experience claiming their rights. For example:

> *"No one can tell her not to go to the PRC – she is very outspoken and no one needs to tell her her rights – she is not young and has life experience"* (key informant, June 2022).

Building alliances with other stakeholders and networks to collectively hold service providers to account is appropriate. Knowledge and skills are the first step to increased power and confidence, and can include knowing what rehabilitation services are and can do.

Peer support and self-help groups do just this - support women with disabilities to be confident to meet with service providers and local authorities and more importantly, to recognise what they are entitled to and to come to such meetings with specific demands (key informant, June 2022). Women with disabilities awareness, confidence and knowledge of the part they play in addressing the social norms that exclude and patronise them including in service provision contexts requires ongoing attention. A key informant phrased it in this way:

> *"It is a Constitutional right to be heard and to access services… When community members start to talk to each other – local authorities and residents…understanding of rights-based approaches and service providers duty of care sinks in and when family are involved it becomes a story of the heart – it [inclusion] is no longer a duty to do it but rather my obligation to listen to and hear relatives…for civil servants it is an obligation – to serve people is one thing and patronising is another….patronising attitudes need to be transformed"* (key informant, June 2022).

Support required to increase access community and PRC services

Women with disabilities identified three key supports that would increase their access to community services and to PRC services: emotional support, financial support and better access to information (see Figures 15).

Emotional support

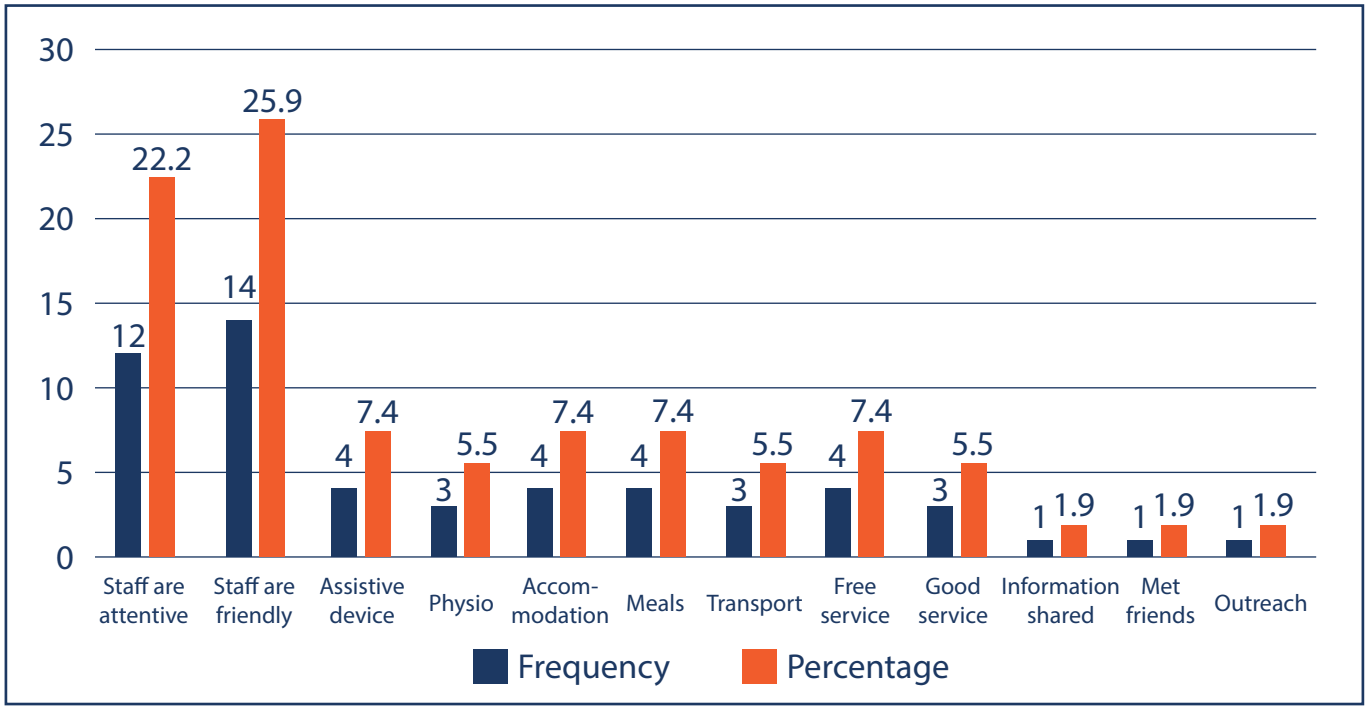
Women with disabilities would like emotional support in the form of motivation and encouragement to build their confidence to seek services:

> *"[I need my] husband and family to help to encourage me"* (31-year-old women with intellectual impairment).

> *"Family members (parents), organisations give support to me, I'm happy"* (44-year-old woman with mobility impairment).

Mobile peer support within community through SHG which graduate into OPDs are an excellent source of emotional support for women with disabilities and an effective way to building their confidence and knowledge of their entitlements (key informant, June 2022).

Figure 14: Women with disabilities experience at the PRC



Financial support: Free services

Women with disabilities would like PRC services, including repairs to be provided for free including transport costs:

> *"At the PRC there is no need to pay money – [it is a] free service"* (27-year-old woman with mobility impairment).

> *"I want to get traveling cost, and I want to get information about PRC services"* (20-year-old women with multiple impairments).

Access to information

When women with disabilities have information about services, they are at least able then to make decisions as to whether they then seek out these services. Women with disabilities want greater access to information including what papers they need to have when visiting the PRC:

> *"Increase the promotion of services widely to women especially women and girls with disabilities"* (28-year-old with multiple impairments).

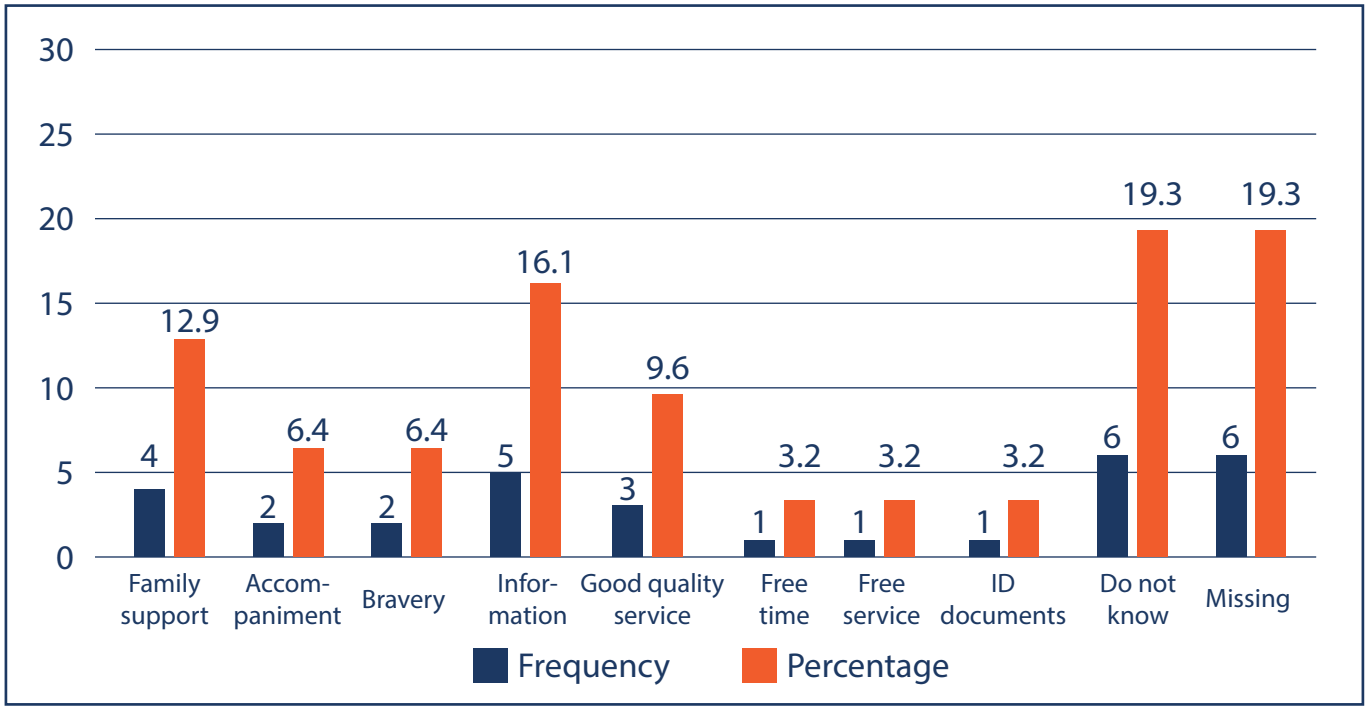
> *"My neighbours give information and my children support me"* (65-year-old woman with cognitive impairment).

“ *Need an organisation give information* ” (56-year-old women with communication impairment).

“ *Get information from Women and Girl with Disabilities Forum in Kompong Cham and request to get crutches* ” (20-year-old women with cognitive impairment).

“ *[You] require important documents to confirm identity [to be able to access services]* ” (27-year-old woman with mobility impairment).

Figure 15: Supports women with disabilities need to access community services



Suggested improvements to PRCs

Women with disabilities had several suggestions on how to improve their access to PRC services and to the service itself.

1 – **Women would like outreach services at the community or village level** as this would remove the difficulties they face with travel and associated costs. For example:

“ *I want to have services to help me at home because it is difficult for me to travel* ” (42 year old women with multiple impairments).

> *To make it easy, I suggest that the PRC to come to the community more often so it's easy to get information and to get services quickly* (29 year old woman with mobility impairment).

Service providers reported that using videos on tablets and dolls to show women with disabilities and other household members how to do exercises was effective (key informant, June 2022). Women suggested that PRC visits to communities every 3-6 months would be appropriate.

2 – **Women with disabilities would also like PRC services to be promoted in their communities** to ensure that they have accurate and specific information about the types of services provided. For example:

> *Getting information related to PRC is not really specific yet…specific information [would be helpful]* (34 year old women with mobility impairment).

> *[I would like] to have promotion in the community about PRC services* (53 year old women with mobility impairment).

3 – **Women with disabilities also requested that PRC staff strengthen their capacity** to understand the experiences of service users with prosthetics and other assistive devices. The more significant issue here is around the capacity of PRC staff to build trust and rapport with service users so that women with disabilities feel comfortable to express themselves honestly and openly. The provision of quality services rests upon the quality of this relationship so that women feel confident to express their needs, particularly around the fittting of assistive devices. As one woman explained:

> *Please teachers (staffs) open their mind and heart to listen patients because sometime wearing artificial legs is uncomfortable but I don't dare to say because I am afraid they will not be happy. If I wear the artificial legs and feeling comfortable, I am satisfied so I have good physical and mental health* (34 year old woman with mobility impairment).

4 – **Women with disabilities would like an anonymous complaints process** that provides a confidential means for them to provide feedback on services received. A feedback box would also promote accountability amongst service providers to them as service users:

> *"Increase the promotion of PRC service, creat feedback box for patients so when they have problems, they can write down problem and keep confident for them"* (40 year old woman with mobility impairment).

SECTION 4: CONCLUSION & RECOMMENDATIONS

Access to assistive devices is a pre-condition to social inclusion (WHO & UNICEF, 2021). Economic and social benefits as well as policy requirements make the case for health and welfare systems to invest in assistive products and related services (ibid). Investments to improve women with disabilities access to rehabilitation services benefits women themselves as well as their families and communities because their independence and participation in all areas of socio-economic and cultural life is maximised. Attention needs to be given to improved access – in terms of affordability, availability and acceptability - to safe, effective rehabilitation services that are informed by rights-based approaches and individual user needs.

Attention needs to be given to building environments that enable and empower women with disabilities as service-users whilst simultaneously addressing ongoing institutional challenges particularly around funding and workforce development in rehabilitation, health and social protection policy and systems. Increasing public awareness to combat stigma would ensure all the key stakeholders – including policy makers, duty bearers, especially health, education, social service providers, media and public at large – are aware of the need for, and benefit of rehabilitation services, including its return on investment.

Actively involving services users and their families as partners in the provision of rehabilitation and assistive technology provision more broadly, from service delivery design to ongoing feedback is required to ensure quality and appropriate services are consistently delivered. PRC services need to be designed around the individual and their daily living environments. Extending outreach mobile services to the Commune level would greatly enhance accessibility and could include peer-to-peer training and support to share information on rights and services.

Findings from this study show that when women with disabilities have an enabling social environment that supports them emotionally, practically and financially, and with information, they are able to access the PRC services that they require. In the absence of supportive family – parents, siblings, husbands and children – neighbours and other community members and organisations, women with disabilities lack the confidence, health literacy, money and transport to secure the services that they need, including repairs to their devices. Without support the individual and structural barriers - in rehabilitation, health and social protection policy and systems - are difficult for women with disabilities to mitigate. Too often women with disabilities go without the supports that they are entitled to, and their quality of life as well as that of their families is significantly diminished.

Recommendations

To improve the availability of quality, coordinated, affordable and user-centred rehabilitation services the following actions are recommended:

Individual-level supports to build self-confidence, support and access to information

1 – **Strengthen networks of women with disabilities, their organisations and OPDs:** One of the biggest barriers women with disabilities identified in this study was their own lack of confidence to seek services. Women with disabilities are best supported emotionally and practically by other women with disabilities and would benefit from being better connected to networks of women with disabilities.

2 – **Increase access to information on PRC services and disability rights:** Women with disabilities would like to receive more specific information about PRC services and have suggested that this be provided through the networks of women with disabilities and community outreach services. Women were not well informed about services, including costs, and how particular services such as physiotherapy, could address their needs. Information needs to be shared in multiple formats such as infographics, brochures, posters, captioned videos on social media, radio, community outreach and face -to-face at health centres.

3 – Invest in self-advocacy and empowerment programs for women with disabilities: Directing support to strengthen women with disabilities as pro-active self-advocates and service-users who know their rights and are readily able to access the information they need will strengthen their access to services. Women in this study spoke about being too scared to seek services and needing to be courageous and brave in order to do so. Already empowered and confident women with disabilities themselves are best placed to provide such support to yet to be empowered women so that they are best able to negotiate household, community and other barriers to services.

4 – Strengthen women with disabilities health literacy
Women with disabilities require access to information about PRC services, including the types of services offered and women's own needs as service users. Strengthening women's health literacy would mean that women with disabilities know where to go and what they can expect when they seek services.

Family and local-level stakeholders supported to build non-discriminatory attitudes

1 – Engage families of women with disabilities in disability awareness and advocacy: Families including parents, siblings, husbands and children are critical stakeholders and facilitators of women's access to services. Their support is critical to women being able to access the practical, financial and transport that they require to be able to get to PRCs. To promote non-discrimination at the household and community level awareness raising and behaviour change programs for them, as well as Local Authorities and other locally-based stakeholders - Health Care providers - is essential. These are best delivered by women with disabilities/OPDs themselves.

Rehabilitation, health and social protection system-level supports that deliver access

1 – **Comprehensive and consistent delivery of free rehabilitation services:** All rehabilitation and health care service providers are responsible for implementing RGC commitments to free health care services for persons with disabilities as stated in the NDSP II and the UN CRPD. Ongoing RGC commitment to adequately funding the PRCs, workforce development and performance management is required to translate this commitment into practice. Placing PRCs within the health portfolio and under the Health Insurance Scheme would be one way to deliver free services.

2 – **Invest in mobile outreach services at the Commune/District level:** Women with disabilities want services that are locally available, easy to access and require minimal transport expenses. The few women in this study who had previously experienced outreach services valued being able to address their needs locally. Community-based rehabilitation initiatives financed through Commune Development and Investment Plans need to be actioned.

3 – **Strengthen referral pathways between health and rehabilitation services:** Streamline referral and entry points to PRC services is required by those with pre-existing and newly acquired injuries and impairments at Commune, District and Provincial levels. Ideally, rehabilitation services are integrated, prioritised and resourced from within the health system.

4 – **Strengthen the rehabilitation workforce capacity:** Ongoing professional development in all rehabilitation services from prosthetics and orthotics, to physio and occupational therapists, counsellors, mental health and beyond is required to ensure ongoing quality of services (Cambodian Association of Prosthetist and Orthotics, and the Cambodian Physical Therapy Association.

5 – **Strengthen PRC's links to psychosocial, economic and social supports:** Effective rehabilitation includes the provision of devices and physical therapies as well as counselling, employment and training, emotional and psychosocial support, and networking with ongoing sources of support, including those provided by women with disabilities networks and OPDs. PRC's can play a role as an inclusion hub.

APPENDIX 1: KEY INFORMANT INTERVIEW CHECKLIST

Your service / program

Please tell me about the services that your organisation / program provides.

Access to information about your service

1 – How do women with disabilities find out about your service?

Women's help seeking

2 – Please tell me about the women with disabilities who access your service(s)?
- a – What types of support are they looking for?
- b – What issues / challenges do they present with?
- c – How does your service/program address these?

3 – Based on your experience, what prevents women with disabilities from accessing disability specific services such as PRCs? experiencing violence?
- a – What challenges /barriers do women with disabilities face to accessing services? (individual, family, community, financial, institutional, other)

4 – Please tell me about women with disabilities and GBV. Do you notice any disability specific forms of violence that women with disabilities experience?
For example – use these as probes
- a – verbal or emotional abuse targeting their disability,
- b – denial of care or medication or being over-medicated,
- c – being physically neglected or refused help,
- d – controlling and /or coercive behaviour

5 – What issues/ challenges have emerged around women with disabilities access to PRCs services with COVID-19?
- a – What about for disability specific services like Provincial Rehabilitation Centres?
- b – Have you made any adjustments to ensure women with disabilities access?

Responding to needs of women with diverse disabilities

6 – What barriers do you/ your service face to meeting women with disabilities needs?
- a – What about women with hearing impairments?
- b – Visual /low vision?
- c – Intellectual / mental health / psychosocial impairments?

7 – How do you feel about providing services to women with disabilities? (positive/challenges?)

Facilitators of successful access to and provision of safe, accessible and quality services

8 – When your service / program is best supporting women with disabilities, what is happening? What have you noticed works well?

Access to informal supports and disclosure

9 – What changes do you think need to happen to build stronger support structures around women with disabilities who are experiencing violence at the community level?

10 – What sources of support do women with disabilities have at the village level?

11 – Do women with disabilities ever disclose violence to you? If so, how do you respond?

- a – Who might they go to for help when they have a domestic issue?
- b – Who might they disclose violence to?
- c – Why is it that women with disabilities are reluctant to disclose their experience of violence?
- d – What do you think would support women with disabilities to find safety within their households?

Women's confidence and agency in their households

12 – What are your observations of women with disabilities power in their households?

- a – In their relationships with their spouse/ caregivers/ extended family / community

13 – How can we build up women with disabilities confidence?

Safe, accessible and quality services

14 – What do you think safe and accessible services for women with disabilities would look like?

15 – Is there anything else you would like to add?

APPENDIX 2: IN-DEPTH SURVEY QUESTIONS

Basic demographic information will be collected and the Washington Group Questions will be asked to identify disability. All responses will be recorded in Kobo. These questions may be asked at the end of the in-depth interview to reduce potential negative impact of asking structured questions and recording on a tablet may have on building trust and establishing rapport in a conversation with a purpose.

1 – Tell me a bit about yourself.
- a – What kind of things do you enjoy doing?
- b – How long have you been living here?
- c – Who lives in your household?
  - i – Mother
  - ii – Father
  - iii – Husband
  - iv – Grandmother/father
  - v – Brother
  - vi – Sister
  - vii – Own children
  - viii – Other

2 – Are you friends with other women and girls?

YES / NO (circle answer)

3 – Are you friends with other women and girls with disabilities?

YES / NO (circle answer)

If yes,

Where to you go to meet them?

4 – Do you need to support to meet your friends?

YES, I need support / NO I do not need support to visit my friends (circle answer)

- a – If YES, who supports you to visit them?
  - i – Mother
  - ii – Father
  - iii – Husband
  - iv – Grandmother/father
  - v – Brother
  - vi – Sister
  - vii – Own children
  - viii – Neighbour
  - ix – Friend
  - x – Other

If no, what challenges do you face to meeting and socializing with friends??

5 – What health services are you aware of in your community?

In your Commune?
District?
Province?

5a – What disability and social services are you aware of in your community?
In your Commune?
District?
Province?

6 – Are there any services for women/girls that you would like to access?

YES / NO (circle answer)

Which ones? (Please list)

If yes,

a – What prevents you from accessing these services?

i – Lack of support person to go with you
ii – No transportation
iii – No money to pay for transport
iv – Do not feel confident to go
v – Other (please specify)

b – What would support you to be able to access these services?

If no, why not?

7 – Have you ever been to the PRC to receive services? **YES / NO**

What service were your seeking?

If yes, what factors supported you to go?
If no, why not? What prevented you from going?

8 – Tell me about your experience of receiving services at the PRC?

9 – Were you happy with the service that you received? **YES / NO**

If yes, what did you like about the service and how it was provided to you?
If no, how could service provision be improved?

10 – Is there anything else that would make it easier for you to access PRC services?

11 – Are there places in the village where you feel **most** comfortable, confident and safe in? **YES / NO**

If yes, what makes this place feel comfortable and safe for you?
If no, why not?

12 – Are there places in the village where you feel uncomfortable, not confident or unsafe?

If yes, which places are they?

What makes these places uncomfortable or unsafe for you?

13 – How do you think her family/neighbours / peers respond to a woman with disabilities who has been raped or sexually assaulted?

14 – What can women and girls with disabilities do to protect themselves from violence?

Probe

- a – What supports do they have?
- b – What could the family do to protect them?
- c – What could the community do to protect them?
- d – What could her peers do to protect her?

15 – How comfortable do you feel in your household to:
(1 to 5 scale where 1 is not comfortable at all, 3 is neither comfortable or uncomfortable; 5 is extremely comfortable)

- a – ask for money to address your needs (eg buy medicine);
- b – ask for physical support (someone to go to a service with your or to help you with a domestic task eg collecting water)
- c – to advocate /speak up for yourself and your concerns within your household, and
- d – to make key decisions that shape your life.

16 – Is there anything else you would like to add?

Basic Demographics				
No	**Question**	**Code**		**Skip**
1	**How old are you?**			
1.1	**What is your marital status?**	Never married	1	
	1.1	Currently married	2	
	1.1	Separated	3	
	1.1	Divorced	4	
	1.1	Widowed	5	
	1.1	Cohabitating	6	
	1.1	Do not want to answer	7	

1.2	**Who is the head of your household?**	Do not want to answer		
1.3	**Do you have children?**	Yes	1	
		No	0	**Skip to 2**
1.4	**How many children do you have? (write number)**			
2	**Have you ever attended school?**	Yes	1	
		No	0	**Skip to 2.2**
2.1	**What is the highest level that you have completed in school?**	Pre-primary	1	
		Primary school	2	
		Secondary school	3	
		High school	4	
		College/ Tertiary		
		Low literacy		
2.2	**Have you worked for income in the last 7 days?**	Yes	1	
		No	0	
2.3	**What is your current occupation?**	Primary occupation	1	
		Secondary occupation	2	
		Housewife	3	
		Student	4	
		Unemployed	5	
		Other	6	

2.4	**What type of income do you get from your work?**	Cash only	1	
		Cash and in-kind	2	
		In-kind only	3	
		Fixed salary	4	
		No paid	5	
		Other	6	
2.5	**In the last 6 months, how often have your living conditions been as good as others in your household?**	All of the time	1	
		Most of the time	2	
		Some of the time	3	
		Never	4	
2.6	**Do you depend upon on someone in your household for self-care?**	If Yes, who?	1	
		No	2	
2.7	**Do you need to ask for money from your family to be able to access health and other services?**	If Yes, who?	1	
		No	2	
2.8	**If you have your own money, can you independently decide to go to health and other services if you wish?**	If Yes, who?	1	
		No	2	

Functional difficulties – Washington Group Questions		
No	**"The next questions ask about difficulties you may have doing certain activities because of a health problem"**	
	DESCRIPTION	
F1	**Do you have difficulty seeing, even if wearing glasses?**	NO - NO DIFFICULTY .....1 YES – SOME DIFFICULTY .....2 YES – A LOT OF DIFFICULTY.....3 CANNOT DO AT ALL .....4 NO RESPONSE 999
F2	**Do you have difficulty hearing, even if using a hearing aid?**	NO - NO DIFFICULTY .....1 YES – SOME DIFFICULTY .....2 YES – A LOT OF DIFFICULTY.....3 CANNOT DO AT ALL .....4 NO RESPONSE 999
F3	**Do you have difficulty walking or climbing steps?**	NO - NO DIFFICULTY .....1 YES – SOME DIFFICULTY .....2 YES – A LOT OF DIFFICULTY.....3 CANNOT DO AT ALL .....4 NO RESPONSE 999
F4	**Do you have difficulty remembering or concentrating?**	NO - NO DIFFICULTY .....1 YES – SOME DIFFICULTY .....2 YES – A LOT OF DIFFICULTY.....3 CANNOT DO AT ALL .....4 NO RESPONSE 999
F5	**Do you have difficulty (with self-care such as) washing all over or dressing?**	NO - NO DIFFICULTY .....1 YES – SOME DIFFICULTY .....2 YES – A LOT OF DIFFICULTY.....3 CANNOT DO AT ALL .....4 NO RESPONSE 999
F6	**Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?**	NO - NO DIFFICULTY .....1 YES – SOME DIFFICULTY .....2 YES – A LOT OF DIFFICULTY.....3 CANNOT DO AT ALL .....4 NO RESPONSE 999

APPENDIX 3: TRAINING CONTENT FOR PROVINCIAL FOCAL POINTS

Session 1: RESEARCH PROCESS, PURPOSE AND RECRUITMENT

1: **Aim** – Statement of research purpose

What do we want to know and why

How are we going to do achieve these goals

This research will examine the following questions:

1. What barriers do women with disabilities face to accessing disability specific services? (individual, family, community, service sector/institutional)
2. What enables women with disabilities to access services?
3. What barriers do disability specific service providers face to meeting the needs of women with disabilities?
4. What enables service providers to respond to the needs of women with disabilities?
5. What solutions/strategies do women with disabilities and service provides identify as critical to better access disability specific services?

Three priority provinces

2: **Who** – Provincial focal point women

Two women needed as provincial focal points (Siem Reap, Kompong Cham, Kompong Speu)

3: **Recruitment – A two-pronged approach**

1 – Women with disabilities and PAFID networks/ via OPDs

2 – PRC service providers themselves (contact details; telephone call / arrangement)

4: **Selection criteria**

- **Women with disabilities** (maximise diversity by impairment type; age; marital status; education level; rurality; employment / livelihood)
    - **Women with disabilities who have received /or not services at PRC** (assistive device provision – prosthetics, orthotics, wheelchair, crutches); physio, social counselling, outreach)

5: **How many** – Identify number of potential women/ interviewees in each province using recruitment strategies 1 and 2.

Secondary recruitment strategy

Women with hearing impairments

Depth over quantity

6: Interviewing – Conversations with purpose: Laying the foundations

Building the foundations
Ethics - Consent and confidentiality
Ensuring safety and responding to distress
Building trust and rapport
Follow her lead
Active listening
Re-iterate what your heard to check your interpretation
Review the questions
Information sharing

7. Interview process and working together

Teamwork – interview lead and support person
Recording/note taking process – capturing stories, key moments / decisions / challenges / successes; verbatum;
Reporting in after the interview (SN/ST/AG)
De-briefing
Follow-up with interviewees and sharing information back

Brainstorm

What do we want to know about women with disabilities access to services?
What do we already know?
What else do we want to know?

7: Accessibility

Asking and Adjusting
    Oral description of pictures
Supports
    Credit, transport, information

SESSION 2: SUPPORTING PROVINCIAL WOMEN AND INTERVIEWING

1: Mentoring and support: From PAFID Cambodia to Provincial Focal Point women

How can we (PAFID Cambodia) best support you?

What do you need?

What is best way for us to give this to you?

What does success look like? Feel like? How do we know when we are getting this right?

Other?

2: Mentoring and support: From Provincial Focal Point women to interviewees

Safety and distress: being present (for / with / to)

Referral and information sharing

Follow up

Other

3: Questions

APPENDIX 4: LIST OF KEY INFORMANTS

Disability service providers

- ADD – Inclusive Disability Enhancement in ACCESS (IDEA)
- CDPO
- UNDP
- Humanity and Inclusion – work with PRCs and health facilities
- Voice

APPENDIX 5: RELEVANT CRPD ARTICLES

The rights of women and girls with disabilities to equal and quality service provision are articulated in international rights instruments and development policy frameworks, most significantly the United Nations Conventions on the Rights of Persons with Disabilities (UNCRPD) and the Sustainable Development Goals. The UN CRPD recognizes the double discrimination associated with gender and disability, and states that women and girls with disabilities are often at greater risk, both within and outside the home of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation (Preamble). The CRPD underlines the importance of adopting a gender perspective and approaches that are embedded in the intersection of gender and disability. In practice gender and disability issues continue to be addressed separately rather than focusing on the intersection between the two (UN ESCAP 2018).

Five Articles of the CRPD are most relevant to this study:

- **Article 6** recognises that women with disabilities are subject to multiple discrimination and that State Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women.
- **Article 8** calls for awareness raising to combat stereotypes, prejudices and harmful practices relating to persons with disabilities including those based on sex
- **Article 20** demands taking effective measures to ensure personal mobility with the greatest possible independence, including by providing training in mobility skills and mobility aids, devices, and assistive technologies.
- **Article 25** recognizes the right of persons with disabilities to the enjoyment of the highest attainable standard of health, without discrimination based on disability, and responding to individual needs.
- **Article 26** of the UNCRPD is specifically dedicated to habilitation and rehabilitation and requires Member States to organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes (see Appendix 5).

Preamble

(q) Recognizing that women and girls with disabilities are often at greater risk, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation,
(s) Emphasizing the need to incorporate a gender perspective in all efforts to promote the full enjoyment of human rights and fundamental freedoms by persons with disabilities,

Article 6 Women with disabilities 1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.

2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

Article 8 Awareness-raising

1. States Parties undertake to adopt immediate, effective and appropriate measures: (a) To raise awareness throughout society, including at the family level, regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities;
2. (b) To combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;
3. (c) To promote awareness of the capabilities and contributions of persons with disabilities

APPENDIX 6:

CAMBODIAN NATIONAL POLICY FRAMEWORK

Cambodia has a strong legal framework to protect the rights of persons with disabilities. The Royal Government of Cambodia (RGC) enacted the Law on the Protection and Promotion of the Rights of Persons with Disabilities (LPPRPWD) - here on the Law - in 2009, and ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2012. The RGC adopted a second National Disability Strategic Plan II (NDSPII) (2019-2023) in 2019. The NDSPII promotes gender equality and recognises the particular risk and disadvantages faced by women and girls with disabilities. Three Strategic Objectives are particularly relevant to this research:

- **Strategic Objective 2: Increase Access to Health and Rehabilitation Services** which aims to increase quality, sustainable and non-discriminatory provision of health services and to provide appropriate rehabilitation services;
- **Strategic Objective 6: Access to Justice and Rights and Freedoms** which aims to promote justice services to women and girls with disabilities as well as women's understanding of their own rights and services providers capacity to respond to their needs, and
- **Strategic Objective 7: Ensure Gender Equality** and to empower and build women and girls with disabilities capacities and confidence on gender violence and to reduce negative attitudes among service providers.

To implement the NDSP II the RGC has established Disability Action Working Group in 22 Ministries and institutions and 25 Capital and Provincial Disability Action Councils. The NDSP II recognises the need to strengthen coordinating mechanisms between women and disability sectors to support implementation of the NDSPII, Neary Rattanak V: Five Year Strategic Plan (2019-2023) for Strengthening Gender Mainstreaming and Women's Empowerment, as well as the National Strategic Development Plan (2019-2023).

The National Strategic Development Plan (2019-2023) (RGC 2019) recognises that persons with disabilities face social discrimination and experience physical and financial difficulties that prevent them from receiving health services, education as well as vocational training and ultimately from contributing to the economy (RGC 2019:85-86). The Plan notes that there is limited awareness and access to information about the physical rehabilitation services despite public dissemination (RGC 2019:86).

APPENDIX 7: FIGURES

Figure 16: Women with disabilities income

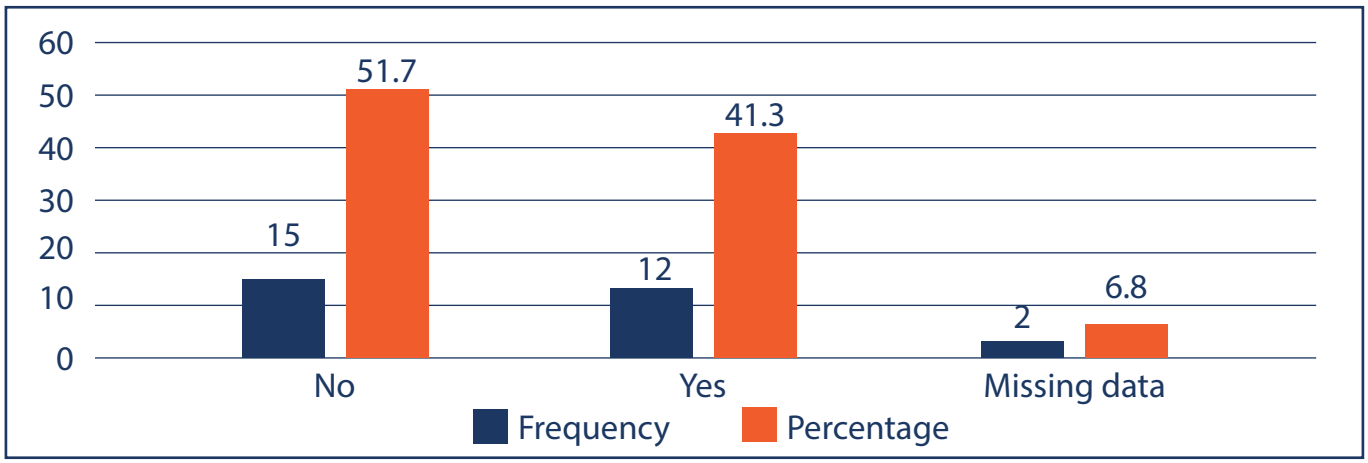


Figure 17: Employment status

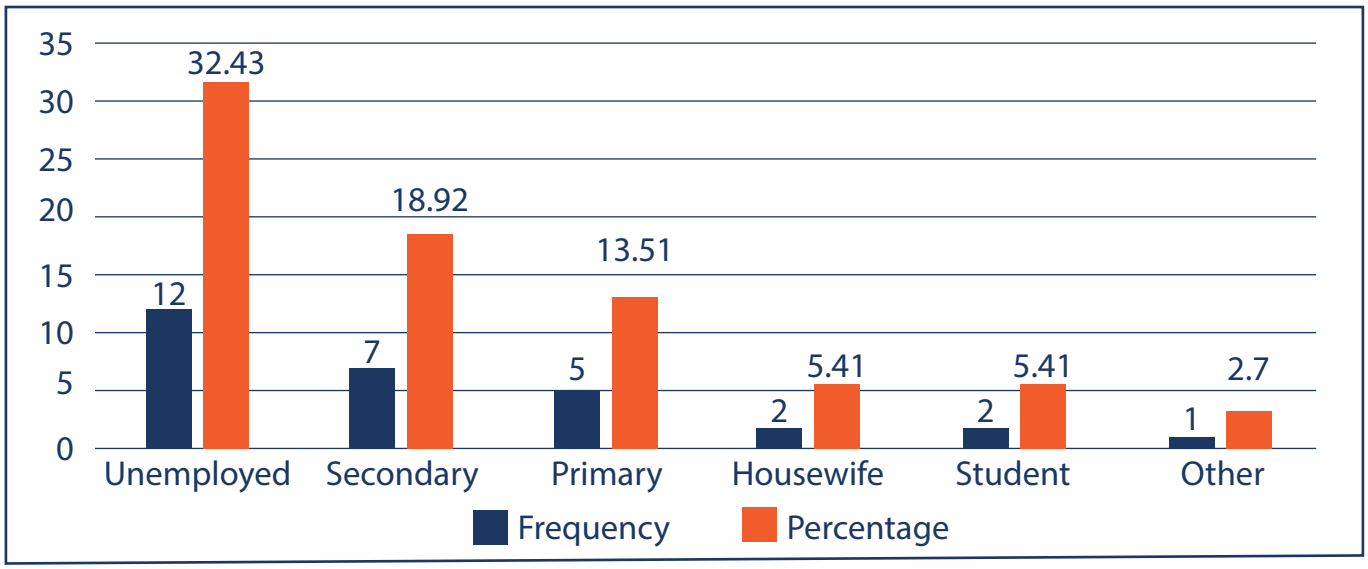


Figure 18: Friendships with other women

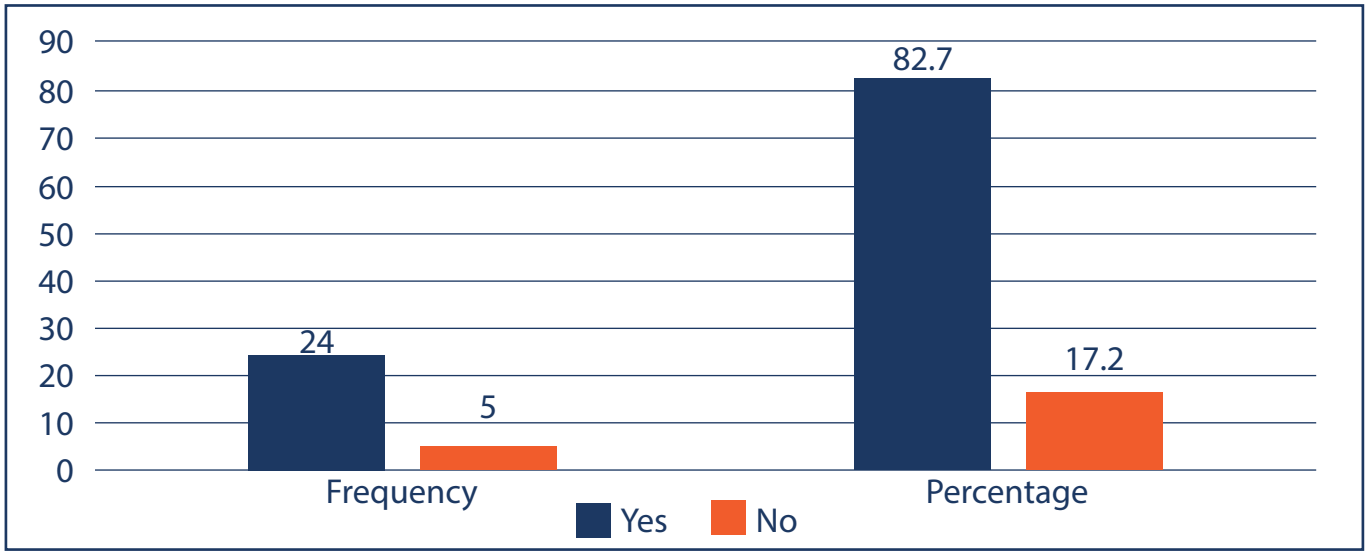


Figure 19: Friendship with women with disabilities

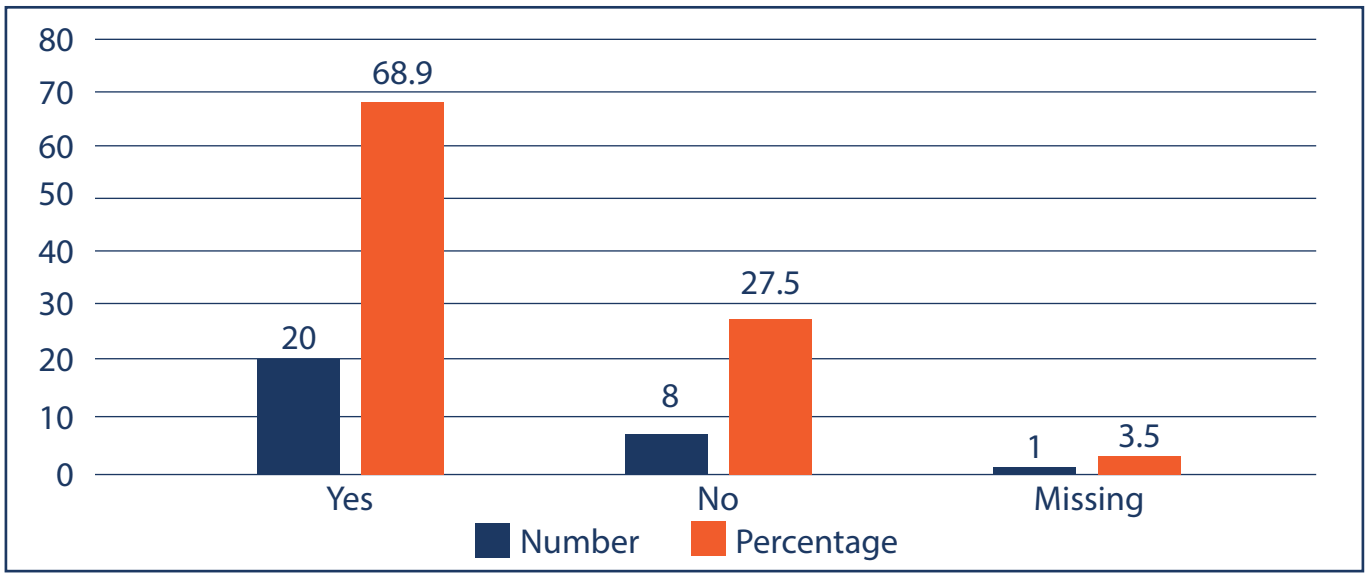


Figure 20: Supports needed for social connection

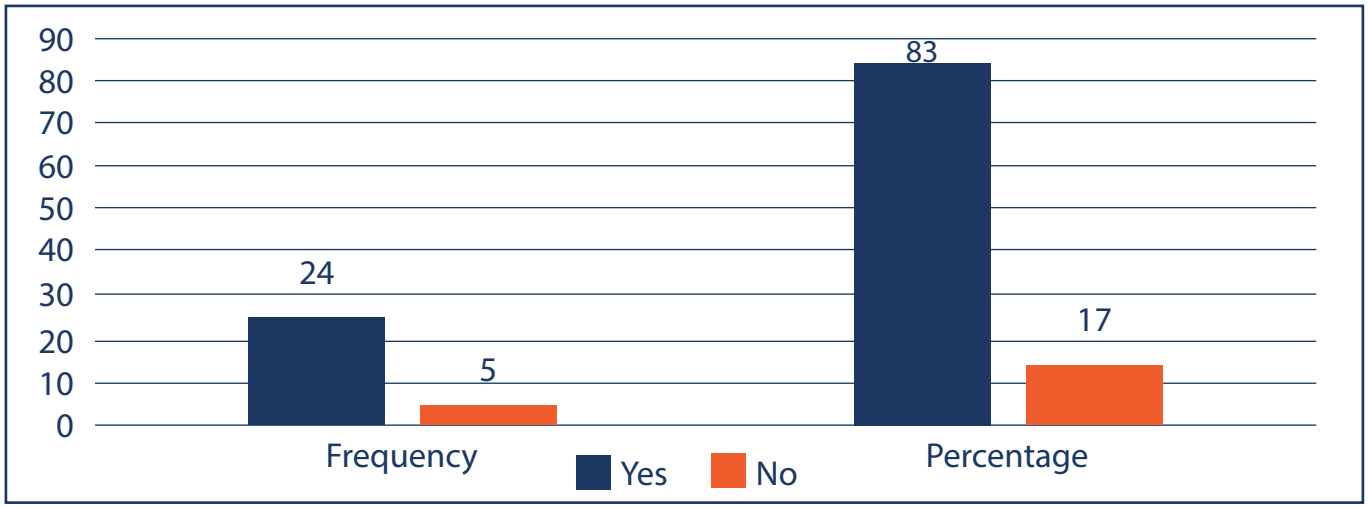


Figure 21: Desire to access services

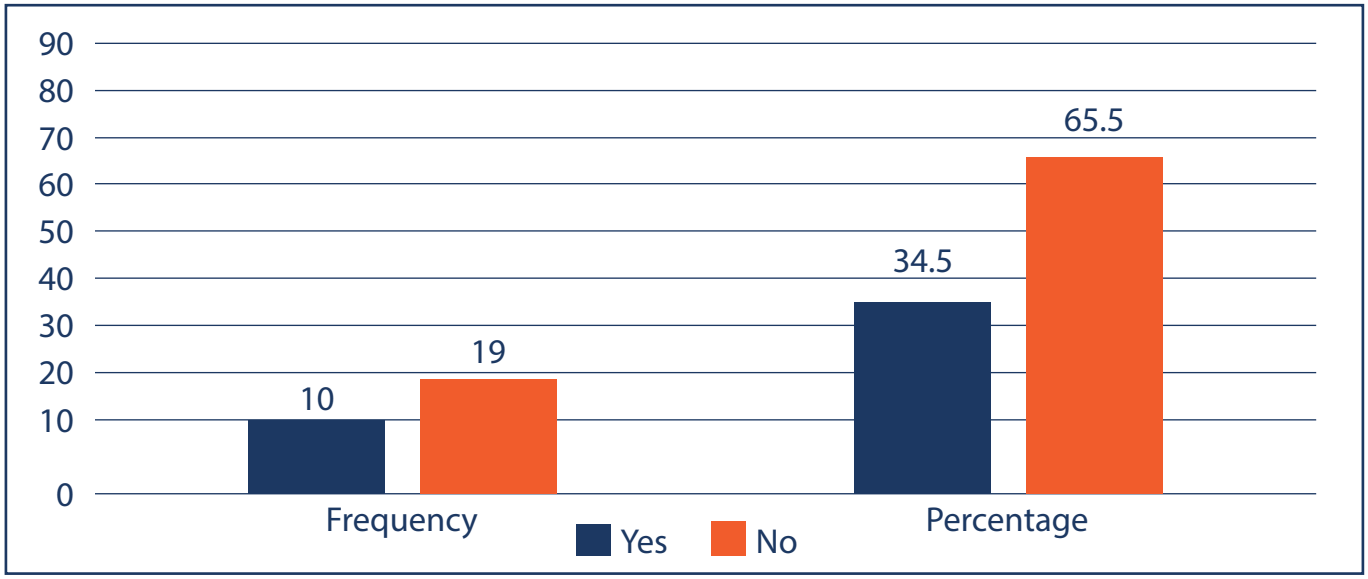


Figure 22: Women with visual impairments

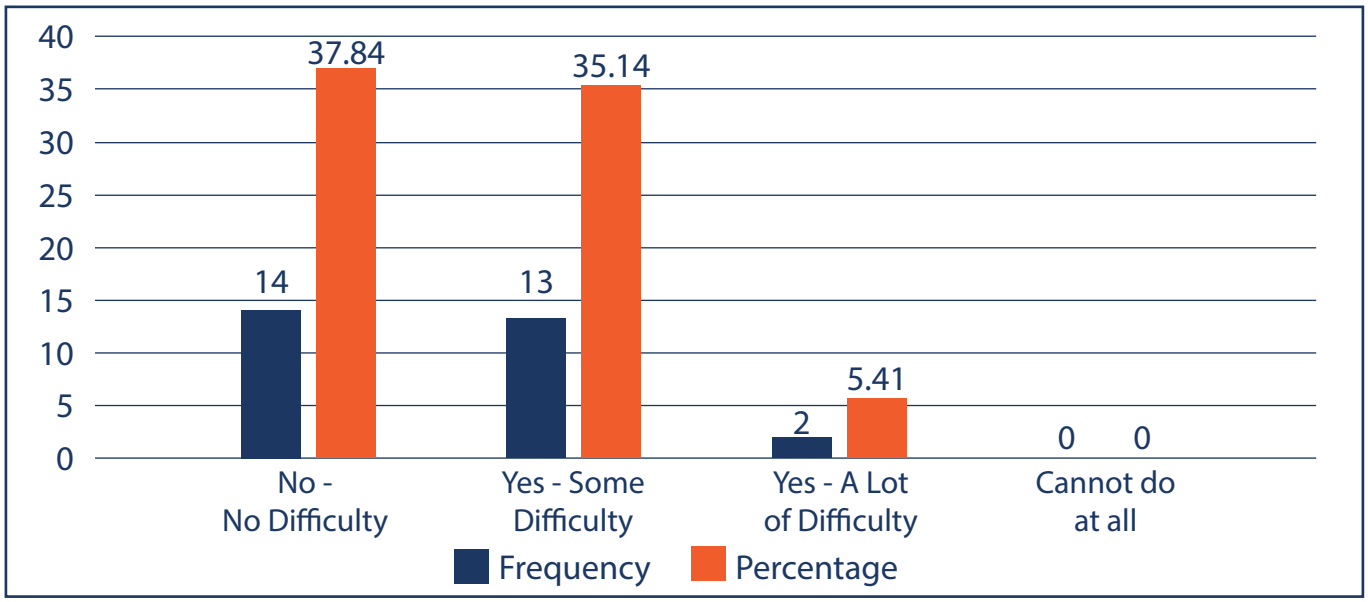


Figure 23: Women with hearing impairments

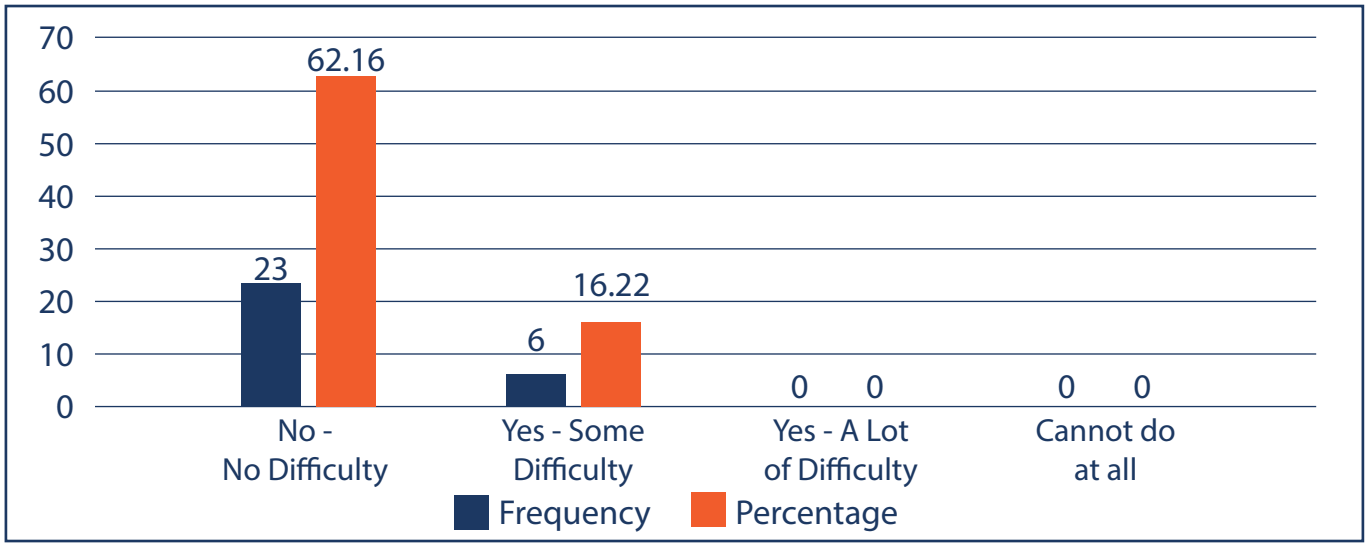


Figure 24: Women with mobility impairments

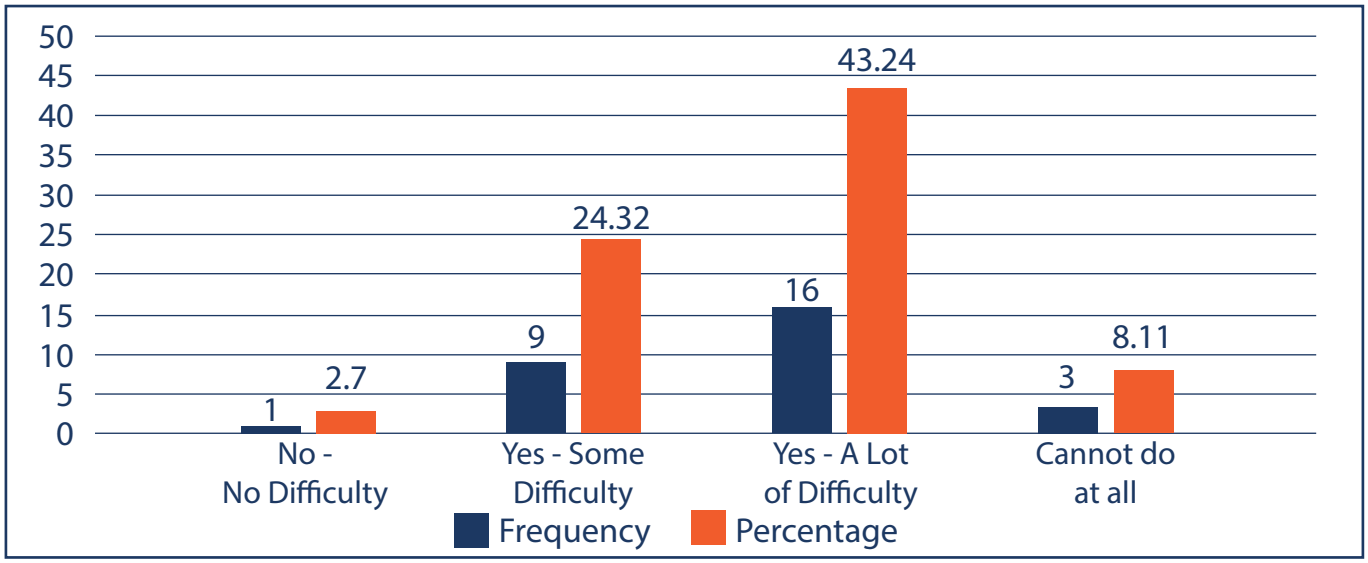


Figure 25: Women with cognitive impairments

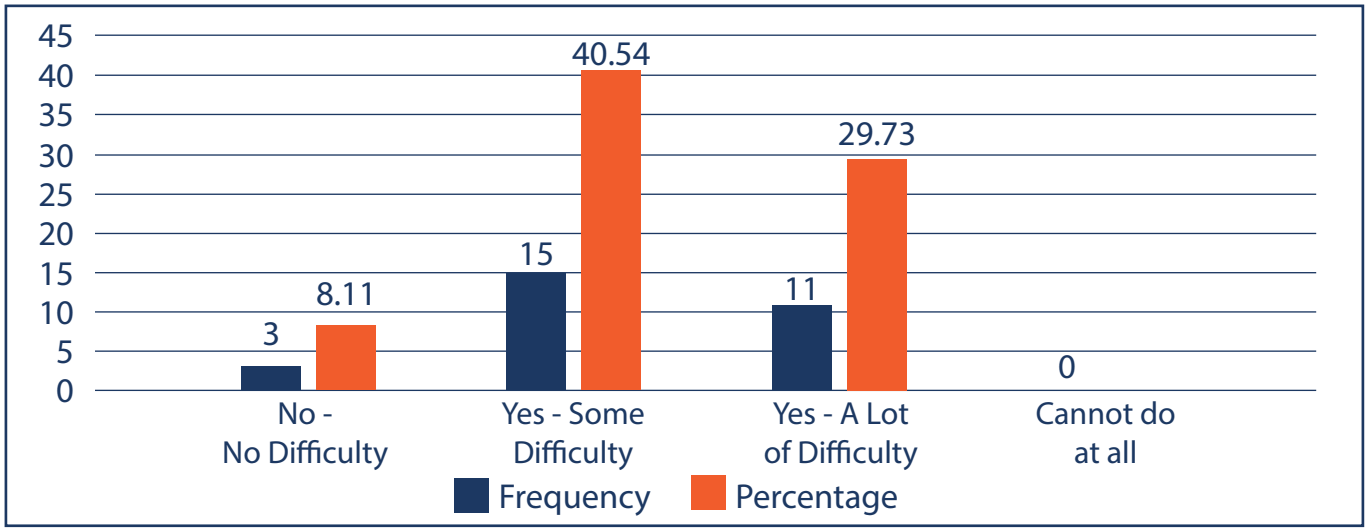


Figure 26: Women with difficulties with self-care

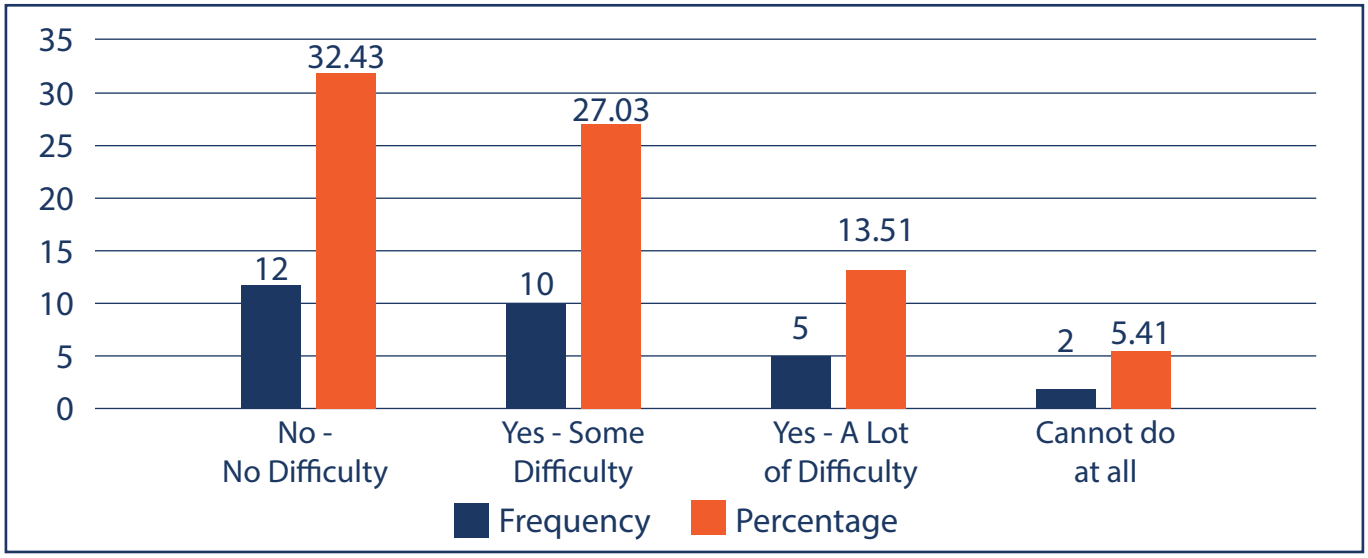
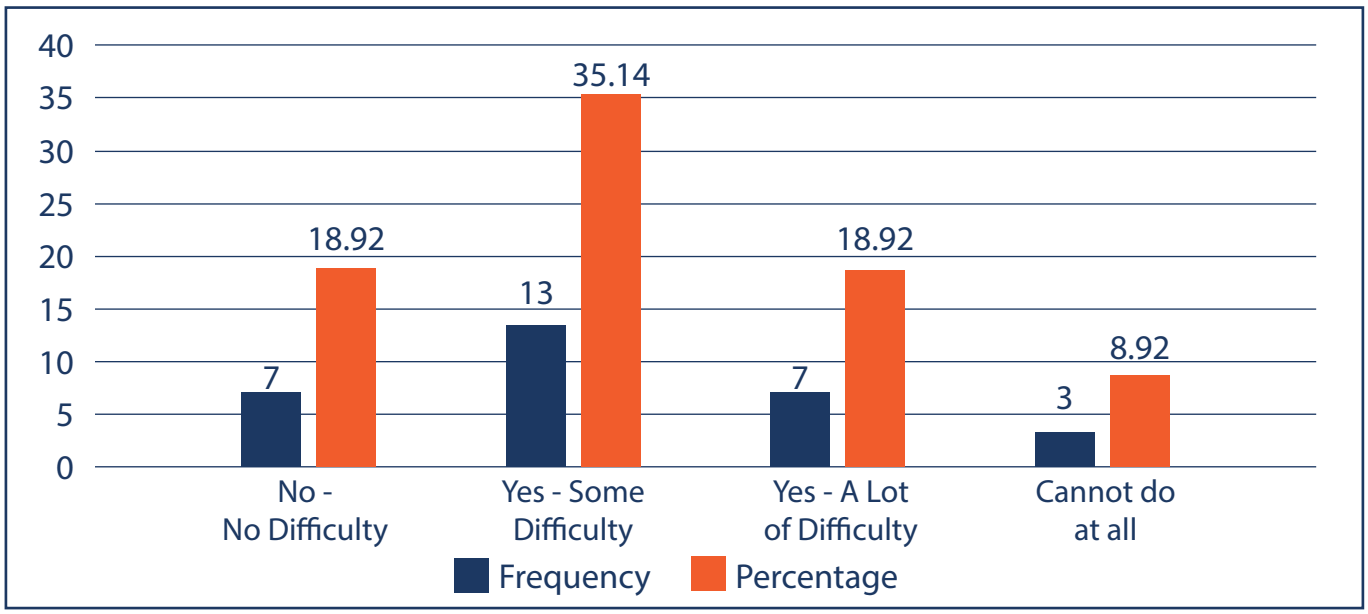


Figure 27: Women with communication impairments



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