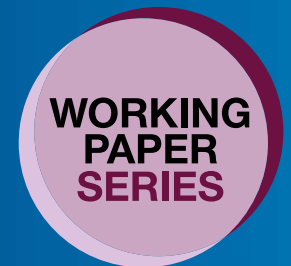




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Barriers to and Facilitators of Health Services for People with Disabilities in Cambodia

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SUMMARY

Background

In Cambodia, access to mainstream health services is a significant challenge for large segments of the population, including people with disabilities. This study identified many of the specific barriers and facilitators in accessing health services for people with disabilities.

Methods

Sixty-three in-depth semi-structured interviews were conducted with people with disabilities, their supporters and health professionals and administrators in Cambodia. Transcripts were reviewed and barriers and facilitators identified. Barriers were categorised based on Bigdeli and Annear's (2009) framework and then ranked by significance to people with disabilities during four focus group discussions. Median and mode rank values were calculated to determine the final order of ranking. In total, 98 participants were involved in the study.

Findings

Access to health services for people with disabilities is influenced by several factors. Barriers to access were:

- finances, namely transport costs to the health facility, unofficial user fees and the costs of a carer to accompany the person with disabilities
- quality of care, particularly health professionals' knowledge and skills related to disability as well as their discriminatory attitudes based on the patient's ability to pay
- people with disabilities having poor knowledge of where to seek appropriate services and of their rights and entitlements

- sociocultural negative beliefs and attitudes associated with disability
- long distances to health facilities, lack of appropriate transport options and inaccessibility of health facilities.

Of these, financial barriers ranked as most significant. Different ranks were obtained when using the mode and median ranks for non-financial factors. However, overall, quality of care and user knowledge barriers were more significant than sociocultural and physical barriers.

Facilitators of access were:

- a high level of commitment and policy development related to disability
- enhanced coordination between disability and health professionals and administrators
- improved service quality
- empowerment of people with disabilities.

Conclusions

The barriers and facilitators identified here have the potential to contribute to improvements in policy and practice in disability and health. Several targeted recommendations emerged from this study, including setting up coordination mechanisms between health and disability administrators and professionals, engaging disability service organisations in identifying people with disabilities for inclusion in health equity fund schemes and raising the awareness of health service providers on how to engage with people with disabilities. It is hoped that, if implemented, these will help to make a positive difference in the lives of people with disabilities in Cambodia.

INTRODUCTION

The recently adopted United Nations Convention on the Rights of People with Disabilities (United Nations 2008) emphasises the right of people with disabilities to enjoy equal access to all spheres of society, including the right to access mainstream health services (Article 25). However, in several developing countries, where access to appropriate and affordable health care is already a challenge for many, people with disabilities face significant difficulties in accessing these services. A recent global survey of experts on research questions in disability, including health policy and practice, ranked understanding ‘What barriers do people with disabilities have in accessing health services at appropriate levels ... [and] How can these barriers be overcome?’ as most important (Tomlinson, Swartz et al 2009).

The survey sought greater evidence on these barriers in low income countries to inform the development of appropriate national policies and health services that include the disabled. Using exploratory methods, this study identifies the barriers to and facilitators of access to health services for people with disabilities in Cambodia.

Cambodia is estimated to have one of the highest rates of disability in the world, between 10 and 15 per cent (World Bank 2006; UNESCAP 2002). Currently, very little is known about the health needs of people with disabilities in Cambodia. This case study aims to contribute to understanding and, in turn, stimulate policy discussions on how to facilitate access to health services for people with disabilities in developing countries. The results of this research will be of interest to a wide range of those involved, including the Cambodian government, donors and others working in disability and health in the country.

BACKGROUND

Disability and health in Cambodia

As in other developing countries, accurate data on the population size and socio-economic situation of people with disabilities in Cambodia are not readily available (Thomas 2005). The most recent Cambodian Socio-Economic Survey (CSES), undertaken in 2004, estimates the prevalence of disability nationally at

roughly 5 per cent (Knowles 2005). However, this figure is likely to be an underestimate, as others have estimated national disability prevalence at closer to 10-15 per cent (WHO 2011). Data also suggest that Cambodian people with disabilities are more likely to experience poverty: the 2004 CSES found that the average income of people with disabilities was 65 per cent less than that of people without disabilities, and that their household wealth was about half that of the general population (Knowles 2005). The evidence on social exclusion of people with disabilities is more varied. A 2009 study in the province of Kandal revealed that 84 per cent of people with disabilities believed that their family members treated them well, another 69 per cent saying they were also treated positively by neighbours (Hak 2007). Another study suggests a range of attitudes, from experiences of being teased or called names to abandonment of children with severe disabilities (Thomas 2005).

Cambodia's health system has rapidly evolved over the last decade into a mixed public and private system; however, its performance has largely been constrained by the availability of resources. Financial barriers particularly, user fees, have hindered access to health services for large segments of the population (Annear 2010). The burden of health costs may be more acute for people with disabilities in Cambodia, given that evidence from developed countries suggests that people with disabilities: (1) have a greater demand for specialist services, (2) incur higher expenditures on health and (3) spend a larger proportion of their income on health needs than people without disabilities (WHO 2011). Indeed, a Cambodian study found: ‘All disabled people with acquired disabilities had stories of asset sales and/or loans to cover medical and other health related expenditure that they sought in the hope of curing their impairments’ (Gatrell 2004). The Ministry of Health (MoH) has undertaken a number of initiatives to support access to health services, including the operation, since 2000, of health equity funds (HEFs) to finance exemptions from payment of user fees by the poor (Ministry of Planning 2010; Annear 2010), some of whom may be people with disabilities. A MoH decision in 2004 also states that poor people with disabilities should be exempt from health services fees. This decision, however, has yet to be followed by concrete action.

While all mainstream health services in Cambodia are coordinated by the MoH, affairs related to disability

are the responsibility of the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY). Currently there is little coordination between the two ministries, which impacts on the quality and continuity of care provided to people with disabilities (VanLeit, Samol et al 2007). Basic disability-specific services, such as rehabilitation and the provision of aids and equipment, though available free or at low cost through international donors and local non-government organisations (NGOs), reach only a small percentage of people with disabilities. Estimates of disability service coverage vary, but in many rural areas no regular or ongoing services exist. Services for people with disabilities are also concentrated in urban areas or where land mine injuries are prevalent (VanLeit, Samol et al 2007).

Local and international disability service providers, as well as a handful of established disabled people's organisations (DPO), have mainly been providing support to people with disabilities. A study commissioned by the *Deutsche Gesellschaft für Internationale Zusammenarbeit* on health care for vulnerable groups in Cambodia found that people with disabilities clearly preferred private options to community health care, citing cost, quality of services and staff attitudes as the main factors influencing their selection of service provider (Platt 2010). Other than this, little is known about the factors that facilitate or hinder access to health services for Cambodians with disabilities.

The objectives of this study were:

- to identify the barriers to and facilitators of access to mainstream health services for people with disabilities in Cambodia; and
- to provide practical recommendations, based on the above findings, that can be implemented over the short to medium term to improve access to health services for people with disabilities in Cambodia.

METHODOLOGY

This study consisted of qualitative field-based research involving 63 semi-structured interviews and four focus group discussions with people working in disability and health in Cambodia. Study participants were initially identified through formal and informal disability and health networks in the country. Additional participants

were identified through referrals from individuals who had been contacted initially. A total of 98 participants were involved in the interviews and discussions, taking into account that some participants were engaged in both mechanisms of data collection. Of the 98 participants, 28 were people with disabilities, 34 were women and seven were parents or carers of children with disabilities. Others represented government, non-profit and academic institutions (see Table 1 for breakdown).

The interviews were conducted between April 2010 and August 2011 across four provinces: Phnom Penh, Takeo, Kandal and Kampot. Participants were asked open-ended questions covering four main themes:

- (1) barriers experienced in accessing health services and how these differed based on gender
- (2) perception of quality of health services and how this varied depending on income, disability and type of provider
- (3) facilitators of access to services
- (4) priority service needs for people with disabilities.

Interviewees were prompted when questioned on types of facilitators so as to enable stratification—such as household, community or health system.

TABLE 1. SECTORS REPRESENTED BY STUDY PARTICIPANTS

Sector	Number of participants
People with disabilities—Disabled People Organisations (DPO) leaders and members	24
Ministry of Social Affairs, Veterans and Youth Rehabilitation	11
Ministry of Health—national and provincial	16
Ministry of Planning	1
Health NGOs	12
Disability service NGOs	18
Parents of children with disabilities—leaders and members of group	7
Health professional academic institutions	2
International donors	7
Total	98

Transcripts of the interviews were reviewed, and the barriers identified were categorised based on Bigdeli and Annear's framework (2009). This framework outlines five main categories of barriers:

- **physical**, such as distance to facilities, restricted opening hours and long waiting times;
- **financial**, including direct and indirect costs of accessing health services and the opportunity cost of seeking these services;
- **sociocultural**, encountered due to gender, age or cultural beliefs;
- **quality of care**, relating to both the subjective experiences of patients and objective measures such as availability of drugs or equipment or the skills of health care providers;
- **user knowledge**, such as a lack of awareness of available services or weak confidence in health facilities.

Following a classification of the barriers based on the categories outlined above, four focus group discussions, involving 49 participants, were undertaken in June 2011. The purpose of these consultations was to present the findings and then rank the identified barriers based on the degree of importance to people with disabilities and others involved. Barriers were ranked on a scale of 1 to 5, with 1 being most significant. Data across all four focus group discussions were then analysed to determine the final ranking accorded to each barrier. This was determined by calculating the percentage of total responses obtained for each rank by type of barrier (and thereby also determining the mode rank for each barrier) and comparing these results with the median values obtained for each barrier.

Facilitators of access to health services were identified during key informant interviews and related to four main themes: (1) government commitment to equity for people with disabilities, (2) enhanced coordination, (3) improved service quality and (4) empowerment of people with disabilities. These four themes, as well as the key facilitators within each, were cross-checked with participants in the focus groups.

FINDINGS

This section presents the health services barriers and facilitators for people with disabilities in Cambodia and the results from the ranking exercise for barriers.

Barriers

Physical barriers

If you can travel from your home in the village, along the path, beside the road, on to the transport to the hospital, you find a way to get in [there]. But if you see a ramp, you feel more welcome. (Wheelchair user)

There are many high steps and the nurses are not happy to carry them [people with a disability]. (Disability service provider)

The physical distance to a health centre was reported on a number of occasions as a barrier to access, mainly due to people with disabilities requiring reliable, physically accessible and affordable transport—affordability being emphasised as the most important factor. Respondents provided examples of people in wheelchairs having to be lifted on to motorbikes, tuk-tuks and buses when necessary—logistical issues that often deterred health-seeking behaviour. There were also stories of people with disabilities being charged for the extra space taken up by mobility devices on buses, or even being denied access due to the additional space required.

People with disabilities not only experience difficulties in reaching the health facility but also face additional physical barriers once there. Respondents reported that it was common to see health facilities without ramps, accessible toilets, wide doorways, appropriate signage or other basic accessibility features. Where ramps did exist, these were often steep and narrow. The informants noted that these accessibility challenges were often overcome through the assistance of family or carers who accompanied the person with disability.

Financial barriers

The health services are far, it costs much money just to reach them. (Person with disability)

Persons with disabilities always need someone from their family to go to a health service. (Disabled People Organisation (DPO) leader)

The direct and indirect financial costs involved in

visiting a health facility were repeatedly described as the greatest barrier to access. Of all the costs incurred, that of transport to a district or provincial hospital was deemed most significant. Transport costs, which were reported by many respondents to be more than any official or unofficial fees, were described as a ‘demotivator’ when households were seeking health care for a member.

The next most important cost was the unofficial fees payable at facilities for a range of purposes such as reducing the waiting time for consultations or receiving particular services such as injections. Responses with regard to unofficial fees were so strong that it was clear that this practice was widespread within the public health system, namely among doctors and nurses—though variation was noted to exist across institutions, some hospitals having a greater ‘culture’ of unofficial fees than others. Several interviewees also disclosed that unofficial fees were not only a barrier to access but also a determining factor in the quality of care. There were numerous accounts of people with disabilities having to wait longer for services, experiencing ‘uncaring attitudes’ or even being denied treatment due to inability to pay the unofficial fees. Interestingly, responses to the levying of unofficial fees varied according to the profile of the interviewee. In general, interviewees who worked for the government suggested that people with disabilities were never denied treatment on the basis of poverty, nor were unofficial fees requested. In contrast, informants working for organisations that represented or closely worked with people with disabilities consistently reported that unofficial fees were almost always requested, and costs seemed to be based on the patient’s ability to pay. The costs of specialist medical or disability services were also described as being a financial burden, particularly in cases in which financial support was not received from the commune or NGOs.

The opportunity costs of accessing health services were also revealed as a barrier. It was consistently reported that people with disabilities had to be accompanied by someone, often a family member, when visiting a health facility. The additional expenses incurred for travel and accommodation of the carer, as well as the opportunity costs of income foregone, were described as a deterrent to seeking health services. Delayed seeking of services was more likely during the planting and harvesting seasons for people living in

rural areas, because the costs of carers missing work during this time were higher. Opportunity costs were also likely to be higher when the person with disability was a woman. According to one disabled people’s organisation leader, cultural norms dictated that women with disabilities needed constant monitoring by a family member when at a health facility due to fear of sexual exploitation.

Socio-cultural barriers

People with disabilities feel inferior and afraid; they are the last to get service. (Disabled people’s organisation representative)

Sometimes people with disabilities act strangely; it is not easy to help them. (Provincial health department member)

Respondents suggested that families were protective of people with disabilities, and neglect by family was not often reported. However, this ‘protective’ attitude was described as also limiting the independence and chance of realising their full potential of the persons with the disability. Informants from the disability sector disclosed that people with disabilities were not encouraged to participate in community events or forums or in family decision making due to the shame associated with disability and reduced mobility. Key informant interviews did not suggest any difference in parents’ readiness to access and pay for health services for a child with a disability. Parents’ attitudes also did not vary based on the gender of the disabled child.

Quality of care barriers

When you walk in, they do not look at your disability; they look to see if you can pay. If you cannot pay you wait a long time near the door. (Person with disability)

The health staff can’t diagnose Down syndrome, and they don’t know about the disability services in their area; there is no referral. (Disability service provider)

The quality of services offered at the health facility was deemed as the second most important barrier to seeking health services. Respondents regularly reported low quality of care in both government and

private facilities, the most commonly cited issues being uncaring attitudes and inadequate knowledge and skills of health professionals when dealing with people with disabilities, as well as shortages in the supply of appropriate medicines.

Several representatives from the disability sector reported that there was a poor sense of responsibility or 'morality' among health professionals, particularly with regard to delivering adequate and appropriate treatment to poor people with disabilities. Quality of care and discriminatory attitudes, irrespective of the type of provider, were frequently reported to vary depending on the patient's ability to pay rather than type of disability. Waiting times tended to be longer or less attention to be given when the patient was deemed to have a low ability to pay. Still, in some cases there was a difference in how people with different disabilities were treated. Attitudes were less likely to be caring if the person had disabilities which providers believed to be contagious. In the words of one informant, 'If it is polio we feel sorry, acid attacks we wonder what they did, and leprosy we worry it is contagious'. Parents of children with disabilities more commonly reported uncaring and potentially discriminatory behaviour of health professionals.

Key informants reported that health professionals' early detection of disability was very poor. Few community health workers were found to diagnose conditions accurately, such as Down syndrome in children, and provide referrals to appropriate disability services. According to the director of a disability service provider, 'Health workers don't have the skills even at the provincial level to diagnose basic ear problems. They [people with hearing impairment] all have to be referred to the national hospital'. When persons with disabilities or parents of children with disabilities were questioned regarding referral to disability services, only a very small number reported observing or experiencing referrals from a general health service facility to facilities offering disability services, or vice versa. There was some evidence of referrals being given at provincial and Phnom Penh hospitals; however, elsewhere the likelihood was low.

User knowledge barriers

People with disabilities do not know about their health. (Disability service provider)

Even people with the ID Poor card don't use it; they don't know what it does. (Disabled people's organisation leader)

Many informants working in disability reported that people with disabilities lacked knowledge of their basic rights, including their right to health care, the entitlements they could claim and where to seek appropriate services. Respondents outlined that people with disabilities and their families were unaware or uncertain of the costs they might incur in accessing health services at government facilities. They also didn't know that the possession of the beneficiary identity card for those deemed poor entitled access to free services, especially with regard to transport to health facilities. This poor knowledge was mainly attributed to a lack of education, social mobility and economic independence. Respondents added that people with disabilities commonly did not attend village health information sessions.

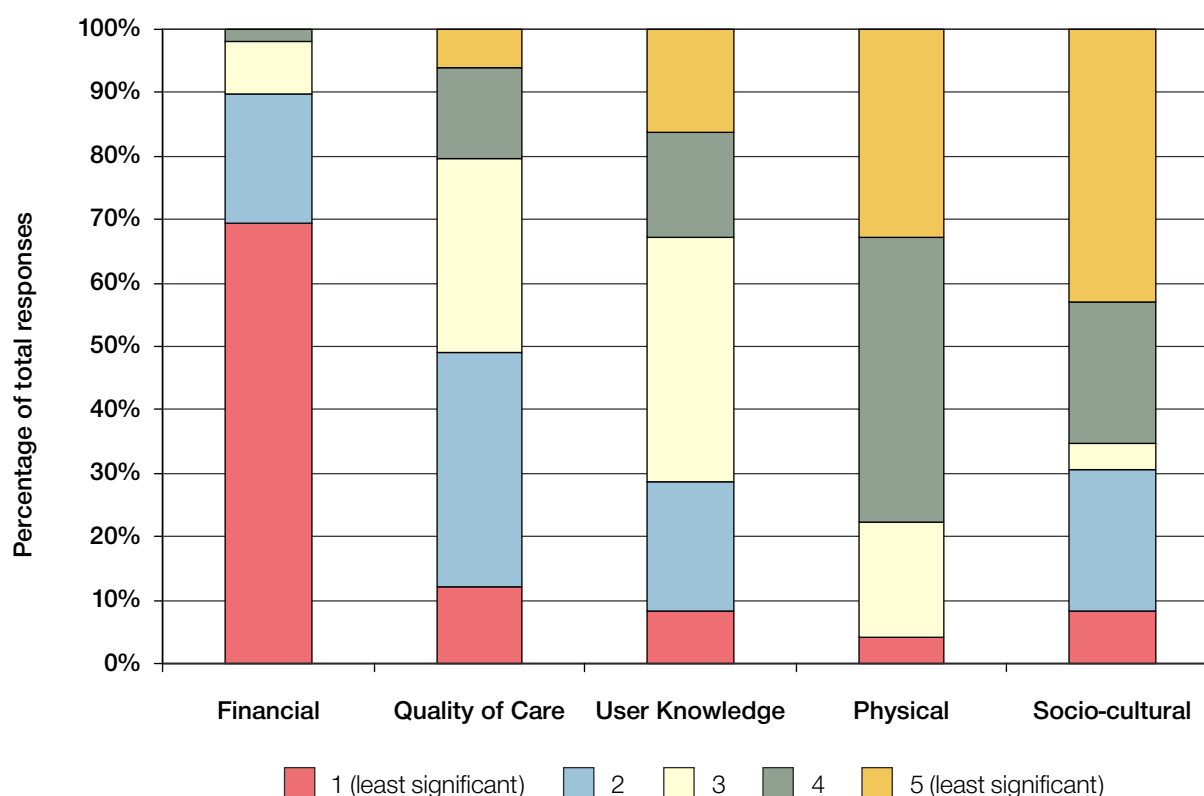
Ranking and Significance of Barriers

Forty-nine participants across four focus group discussions ranked the five types of barriers, as outlined above, by degree of significance to people with disabilities—1 being most significant and 5 least significant. Figure 1 shows the percentage of total responses obtained for each rank by type of barrier.

As can be seen from Figure 1, financial barriers were overwhelmingly ranked as most significant, 69 per cent of the 49 responses according a value of 1 and no responses assigning the value of 5. Quality of care barriers have the next highest percentage of responses at rank 1, at just over 10 per cent, and the highest percentage of responses at rank 2. User knowledge and sociocultural barriers had an equal percentage of total responses at rank 1, at 8 per cent; however, the

TABLE 2. MEDIAN AND MODE RANKS FOR EACH TYPE OF BARRIER

Type of Barrier	Median Rank	Mode Rank
Financial	1	1
Quality of care	3	2
User knowledge	3	3
Physical	4	4
Socio-cultural	4	5

FIGURE 1. PERCENTAGE OF TOTAL RESPONSES ACCORDED TO EACH RANK* BY TYPE OF BARRIER

* Rank given on a scale of 1 to 5, where 1 is most significant and 5 least significant

greatest percentage of responses for user knowledge barriers was at rank 3 (39 per cent) and for sociocultural barriers at rank 5 (43 per cent). Physical barriers had the second highest percentage of responses at value 5 (33 per cent); however, these barriers were ranked most at a value of 4 (45 per cent). The mode ranking of barriers is presented in Table 2.

Median ranks were also calculated for each barrier, as shown in Table 2. Again, it is clear from the results that financial barriers are most significant, with an overall rank of 1. Here, however, quality of care and user knowledge barriers were ranked equally at 3, and physical barriers and sociocultural barriers equally at 4. Nonetheless, the overall order in which barriers are ranked is still similar to the mode ranks.

Facilitators

Four main types of facilitators of access to health services for people with disabilities were identified during key informant interviews and focus group discussions.

High-level commitment and policy development

Respondents repeatedly pointed to high-level commitment and inclusive health policies as important facilitators of access for people with disabilities. Top-down approaches, wherein health providers are provided guidance or instructed on how to address the needs of people with disabilities, were requested particularly by government-based informants. One provincial health department director commented that little could be done to address the barriers to access without the higher level support of the national MoH. One MoSVY employee reiterated this message, stating that provisions on access to health care had to be included within Cambodian disabilities laws as an impetus for the MoH to act. Several interviewees also felt that implementation of the MoH decision on exemption from user fees for people with disabilities would help to address the financial barriers impeding access.

Enhanced coordination

Respondents familiar with disability and with health officials and administrators, in particular the MoH and the MoSVY, strongly suggested that enhanced linkages between people with disabilities, health care providers and these ministries—including their provincial, district and local –departments—were important in facilitating access.

Improved service quality

Interviewees strongly felt that improved service quality would increase access. Greater ethical behaviour among health services providers was particularly seen as paramount. Suggestions on how to achieve this revolved around capacity development within the health sector, namely raising awareness among health service providers on how to address the needs of and engage with people with disabilities, as well as on ensuring timely and appropriate referrals. A few interviewees also commented on the need for fair remuneration within the health sector in order to decrease disparities in service quality between the public and private systems.

Empowerment of people with disabilities

Several respondents suggested that people with disabilities needed to know about their ‘right to health’, their own health, health services available and the various forms of support available—particularly issuance of beneficiary identity cards for those who are poor and covered under the HEFs. Many felt that more people with disabilities should be recognised as being poor and allowed to access the corresponding benefits, and some interviewees also suggested that support for livelihood development be extended. Respondents working within the disability sector also emphasised the need for people with disabilities to engage with their commune councils and to be involved in forming commune development plans.

DISCUSSION AND RECOMMENDATIONS

This study sought to identify the barriers to and facilitators of access to health services for people with disabilities in Cambodia. Interviews and focus group discussions with 98 participants from various sectors related to health and disabilities revealed

that access is determined by a range of factors, both financial and non-financial. Of these, as determined by the ranking of barriers to access, financial factors are most significant. Of the non-financial factors, quality of care and user knowledge have more impact on access than physical and sociocultural barriers. Considering all factors together, it is important to note that while they are not necessarily unique to people with disabilities, their impact on this population is likely to be more pronounced. In addition, they should not be considered in isolation but rather be recognised as interacting and impacting on each other. For example, people with disabilities not knowing about their financial entitlements worsens the financial barriers they experience.

The dearth of information on disability in Cambodia means that there is little evidence with which to compare the findings of this study. However, financial costs (direct and indirect) ranking as the most significant barrier to access is in line with, and further substantiates, existing evidence which shows that (1) financial costs are an important barrier to access for many segments of the Cambodian population (Annear 2010) and (2) people with disabilities struggle as a result of the burden of health costs (Gatrell 2004). Findings from this study that specifically transport costs and the costs associated with requiring a carer to accompany the person with disability are significant barriers to access also concur with those of previous studies. A study by Jacobs and Price (2004) reported that transport costs accounted for over a third of the total cost of visiting a district referral hospital. While the study did not focus on people with disabilities, it is likely that costs would be higher for this population given their restricted mobility. Similarly, McColl, Jarzynowska, et al (2010) also found that the opportunity costs of a carer having to accompany the person with disability were a barrier to seeking health services.

Taken together, previous evidence and the findings from this study outline the urgent and strong need to address financial barriers to access to health services for people with disabilities. This is particularly crucial because financial barriers also impact on other barriers. As reported here, experiences of quality of care in health facilities depended more on the patient’s ability to pay than on their type of disability. Likewise, in terms of physical barriers, affordability of transport was noted as being more important than distance to or accessibility at the health facility.

Quality of care barriers were mainly related to health professionals' poor knowledge and skills in the area of disability, as well as their discriminatory attitudes based on the patient's income status. Another recent study in Cambodia also found that 'knowledge and perception of service providers on disability at the community level were quite limited' (Handicap International 2009). This suggests the need to address weaknesses within the broader health system, related to regulation of quality of care, remuneration of health professionals and capacity building. Interestingly, respondents did not mention the lack of available equipment as a quality of care barrier. While shortages in supplies of medicines were reported as affecting quality of care, this barrier was not as strongly emphasised as issues relating to health professionals. Financial barriers and quality of care among the most significant barriers concurs with Platt's study (2010), which found that staff attitudes, quality of services and costs were factors taken into account by people with disabilities when selecting a service provider.

The findings related to user knowledge, sociocultural and physical barriers provide new insights that have important implications for disability and health policies and programs. It is clear that efforts must be intensified to provide targeted information to people with disability on their basic rights, benefits of health care and available services and benefit schemes. Knowledge of entitlements and social services might, in turn, help to alleviate the financial barriers experienced by people with disabilities. Awareness must also be raised on disability among the general population and policy makers in order to shape positive attitudes and help ensure that transport and health facilities are more accessible. Surprisingly, study participants noted that gender had an influence on access only when discussing financial barriers, which suggests that gender might not have an important impact on access. Further studies will need to be undertaken on gender and access to provide a stronger evidence base.

The facilitators of access to health services named here corresponded to the health barriers identified. Not surprisingly, all of the facilitators were directly or indirectly related to policy around health and disability, as well as stewardship of the health system. This thus emphasises that national commitment to disability issues is crucial to ensure the development of appropriate and inclusive policies and the implementation of these policies at all levels of the political system. 'Disability-friendly' policies will help to create environments where the empowerment of people with disabilities is promoted and discriminatory attitudes are not condoned.

While the findings of this study provide an important foundation for understanding access to health services for people with disabilities in Cambodia, the limitations must be recognised. First, the sample in this study comprised only a few people with disabilities who were actively seeking care and limited numbers of community health service providers. Greater representation of both these populations might have provided further insights on the types of barriers to and facilitators of access. Secondly, this study did not explore differences between urban and rural populations, or between people with different types of impairment. Disaggregation of findings in these areas would have provided a more detailed understanding of access issues and enabled further recommendations. Lastly, this study did not have a comparison group of people without disabilities. This would have allowed identification of issues specific to people with disabilities, and those which are common to all users of the health system.

While noting the limitations of this study, the findings still have important implications for policy and practice in disability and health. Based on the barriers and facilitators identified, several recommendations, targeted at various actors, can enhance access to health services for people with disability. These recommendations are detailed in Table 2.

TABLE 2. RECOMMENDATIONS FOR IMPROVING ACCESS TO HEALTH SERVICES FOR PEOPLE WITH DISABILITIES IN CAMBODIA

Body	Recommended Approaches
National Government	Ratify the UN convention and continue to strengthen national support for disability, ensuring full implementation of the national Law on the Protection and Promotion of the Rights of People with Disabilities (RGC 2009). Review the Ministry of Planning's assessment criteria for identity cards for the poor to determine if appropriate sensitivity to disability has been developed in selection programs and processes, particularly in households of children with a disability.
MOH/MoSVY	Further develop policy dialogue and coordination between MoH and MoSVY through to provincial and district levels. Better integrate disability into health sector strategic plans and policies. For example, ensure disability is built into vertical health programs, such as sexual reproductive health, and in all health education, promotion and prevention campaigns. Strengthen the continuum of care between health and rehabilitation. Utilise rehabilitation practitioners (for example, physiotherapists) in the health system as a focal point and link between health rehabilitation services based in the community. Commit to ensuring that health facilities are accessible for people with disabilities using universal design principles that enable accessibility and ease of use regardless of age or ability. Integrate disability into health training curricula and professional development schemes. Suggested steps include undertaking a training needs analysis regarding disability across the health sector and developing targeted training courses. Ensure disability disaggregation is built into future health surveillance mechanisms.
Health NGOs and Operators, HEFS and NGOs	Integrate disability into health services policy and programs to ensure people with disabilities access and benefit equally. Monitor inclusion through disaggregated data and project monitoring tools. Partner with organisations that represent people with disability for advice and support, and to ensure that people with disabilities are included in health education, promotion and prevention campaigns. Provide extra support for people with disabilities when necessary, for example financial assistance for carers where the person with disability is eligible. Support pilot programs in which the awareness of disability issues is raised through training of HEF staff members, ensuring data collection mechanisms are disability sensitive and working with disability service organisations to identify families to be included in the list of poor households that receive HEF benefits.¹
Disability Service Providers	Proactively build relationships with mainstream health services, share knowledge of disability issues and related services, develop referral mechanisms and build continuity of care. Promote better understanding of health issues among people with disabilities in areas such as eligibility criteria and benefits of the identity card for the poor and of HEFs. Act as liaisons for people with disabilities and their families in negotiating the mainstream health system. Collect and publish data on health issues of people with disabilities to inform health program development.
Disabled People Organisations	Collect and disseminate data on health services access and exclusion experiences of people with disabilities At national level, conduct advocacy and provide advice to government and other health actors on inclusion of people with disabilities in health. Empower local self-help groups and leaders of disabled people to represent their issues; do advocacy and awareness raising with local decision makers, either through commune councils or with direct engagement with health, for example with the health centre management committees. Ensure that the specific issues of women with disabilities are included in advocacy and other campaigns.

Body	Recommended Approaches
International Donors	Support implementation of the UN convention, and utilise it to build on the awareness and knowledge regarding disability in the donor community. Ensure that inclusion of people with disabilities (as a specific and named vulnerable group) is a priority within the Health Sector Support and other social protection programs. Support MoH to strengthen progressive and achievable inclusion goals, measured, for example, by the proportion of people with disabilities accessing services or included in health campaigns. Support the government to develop a coordinated approach to disability and health, with funding for improved coordination, advisory roles and secondments. Support further research in this area, particularly by encouraging government, HEFs and others to collect and report on disability disaggregated data. Provide capacity development funding to DPOs and others in the ability to hold government accountable for inclusion commitments. Model good practice in mainstreaming and inclusion.

¹ This model has been established with HIV organisations currently working in Phnom Penh.

CONCLUSION

This study provides preliminary exploratory evidence on health services access barriers and facilitators for people with disabilities in Cambodia. It was undertaken to contribute to the evidence base on disability in the country, and to help inform discussion on the policies and practices of those working in the area.

The main barriers identified by study participants were organised into physical, financial, sociocultural, user knowledge and quality of care barriers. Of these, the majority of informants found financial barriers to be the most important, highlighting both the direct and indirect costs. Quality of care was ranked as the second most important barrier, particularly the inadequate skills of health care professionals in interacting with people with disabilities.

The study also sought to identify key facilitators for enhancing equity for people with disabilities in health services through interviews with key informants and then cross-verification with focus groups. Key facilitators identified during this process were (1) the presence of high-level commitment to health equity for people with disabilities, (2) enhanced coordination between those working in the health and disability sectors, (3) improved quality of health services offered to people with disabilities through awareness raising

and capacity development of health service providers and (4) empowerment of people with disabilities.

Several targeted recommendations on how to enhance access to health services for people with disability have emerged from this study. Some of these are that it is crucial for health and disability administrators to work collaboratively, particularly the MoH and the MoSVY, in order to strengthen each other's services and systems and ensure that affordable and appropriate services are available to people with disabilities. In addition, disability-related data must be systematically and routinely collected as part of the health information system in order to better understand the needs and health-seeking behaviours of people with disabilities, to ensure that disability programs and services are meeting their goals and to provide an evidence base for advocacy. This goes hand in hand with the need for in-depth studies into the experiences of people with disability and their interactions with the health system in Cambodia, namely those which disaggregate findings based on social categories such as income, gender and location. Enhancing the capacity of health service providers to engage better with people with disabilities will require targeted training and mentoring beginning with a training needs assessment. Lastly, and importantly, people with disabilities need to be made aware of and meaningfully engaged in issues and processes that affect them.

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